NSW Health

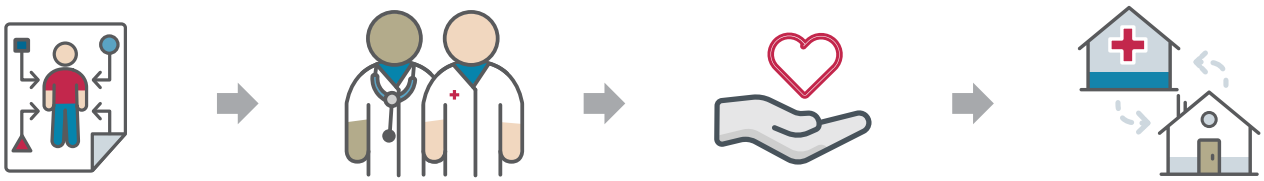
Leading Better Value Care

Renal supportive care

Organisational models

This document provides decision-makers with options to improve care in different service delivery settings. Building on *Renal supportive care: Clinical priorities (2020),* which describes *what* to improve, the focus here is on *how* to improve care. These documents are informed by research evidence about the best clinical care and the effectiveness of different delivery models, empirical evidence about current service delivery levels, and experiential evidence from clinicians and patients.

IMPROVING KEY PRIORITY AREAS



Share decision-making

- Patients, families and carers discuss with the renal multidisciplinary team the treatment options, expected progression of disease and support available
- Discussions include patient and family values, lifestyle and personal preferences
- Communication and decision-making includes end-of-life discussions and documentation

Refer to renal supportive care

- Refer patients with stage 4 or 5 kidney disease who require biopsychosocial support
- Establish referral pathways from a range of clinicians to a renal physician and associated renal supportive care services
- Depending on available resources, provide services to patients who are: on renal replacement therapy (RRT), are conservatively managed (no RRT), have chosen to cease dialysis, or are undecided

Minimise patient suffering

- A renal supportive care clinical nurse consultant (CNC) who is skilled in renal and palliative care principles coordinates care
- Establish patient access to a multidisciplinary team, with a renal physician providing overall medical leadership. The multidisciplinary team includes a dietitian, social worker and palliative care physician, and may include other allied health professionals

Ongoing supportive care

- Ensure timely review of emergency presentations by renal supportive care patients
- Provide continuity, integration and coordination of care between patients, families and carers in the community, renal supportive care clinic and acute inpatient settings
- Offer bereavement support to families and carers

IMPROVING THE OVERALL PATIENT JOURNEY

- The renal team responsible for long-term treatment remains with the patient from chronic kidney disease diagnosis to the end of life
- Care involves physical, psychological, emotional and spiritual dimensions and support for families and carers
- Provide care as close to home as possible, considering patient preferences
- Patient reported experience and outcome measures are collected and acted upon, such as iPOS (symptoms), Karnofsky (function), SGA 7 point (nutritional status) and EQ-5D (quality of life)

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OPTIONS FOR ORGANISATIONAL CONFIGURATIONS

A coordinated multidisciplinary team delivers the core components of renal supportive care. However, implementation of the model may vary due to local factors, such as demand and available resources. This results in key differences in how, where and by whom the core components are delivered. There are two broad models of renal supportive care summarised in the following implementation options.

Regardless of which model is selected, there are common elements of care:

- Holistic assessment and discussions
- Timely coordination with other specialties (to manage comorbidities)
- Telehealth follow up (including phone, email)
- Discussion and documentation of advance care planning
- Medication review
- Biopsychosocial review and plan
- Two-way communication about patient progress amongst renal supportive care staff and nephrologists, community and primary health teams and patients, and their families and carers

Option 1: Coordinated multidisciplinary model

This model is based on a multidisciplinary team. It is well suited to renal services with ready access to both specialist (renal, palliative) and other clinical staff (nursing and allied health). They may be part of the existing renal team or available in the facility.

Why choose this model?

- provides care in a central location (a one-stop-shop) for patients, carers and families
- ensures specialised care
- maximises the benefits of interdisciplinary care
- ensures availability of acute specialist care when required
- provides patients with multiple options

If you choose this, then...

- ensure sufficient space is allocated to the renal supportive care clinic
- integrate renal supportive care into the renal service model, with requisite support from renal physicians and other staff
- provide renal supportive care to all appropriate patient cohorts

Option 2: Outreach model

This model is based on a renal supportive care nurse. It is suited to areas where specialist medical care is not readily available, most often in remote parts of NSW. The nurse travels to patients' homes and telehealth is used to monitor their health status, and provide physical, emotional and spiritual support (including support for families and carers). The nurse liaises with community or larger site clinicians, who provide advice on symptom management and pharmacological requirements.

Why choose this model?

- less resource intensive
- suitable for sites where a multidisciplinary team is not available
- simple to start
- suitable where patients are unable to attend clinics

If you choose this, then...

- the renal supportive care nurse should have the seniority to work autonomously
- ensure there are strong links to community specialist services; medical input, (both renal and palliative), governance, advocacy and guidance
- reliable telehealth options must be available
- all patient cohorts may not be supported

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