Kidney Supportive Care Pathway Overview

Every **Kidney Supportive Care** (KSC) Service will be slightly different according to staffing, resources, geography and services available in that area and should be developed accordingly.

Referrals usually come from the Nephrologists, however patients are sometimes referred by concerned dialysis staff. If a nursing referral is received, it is courteous to contact the treating Nephrologist to ensure they are agreeable to KSC involvement.

The main aim of the KSC service is to provide an **inpatient** and **outpatient** service that can offer:

- Renal appropriate symptom management advice
- Knowledge of discharge services and supports for patient and families
- A platform for addressing Advance Care Planning (ACP)
- End-of-life (EoL) care and support to patients & families

This can take the form of **KSC Clinics** and/or a **consultative service** in the hospital setting, haemodialysis unit or other point of contact.

Knowledge of the roles of the **multi-disciplinary team** (MDT) and the appropriate **referral pathways** in your area is essential as is an understanding of **Aged care services**, which often are required to provide optimal care to our patients. It is useful to establish rapports with local **Palliative care services** and have an understanding of the referral pathways and the services available in **your own local health district**. Knowledge of this will help to support your patients and their families in meeting their end-of-life care wishes.

The **General Practitioner** (GP) is central to the care of our patients and should be kept informed of changes as the patient moves along the disease trajectory as they are likely to play a pivotal role, particularly if the patient decides they want to die at home.

Home visits by the KSC nurse may be an option for the service (this would of course depend on many factors) for patients who are too unwell, frail or immobile to come to clinic, or who reside in a **Residential Aged Care Facility** (RACF). Please note that some **RACF's** are well equipped to provide EoL, however this will need to be assessed on an individual basis.

Telephone consulting is also an option once the patient has had an initial consultation with the service. The KSC nurse can provide an assessment service and liaise with the nephrologist and palliative care specialist to provide pain and symptom advice that is renal appropriate. MDT or **community referrals** can also be facilitated following local policy.

The KSC nurse may also be involved in **family meetings** to provide advice about services and supports and options for **EoL care**. The KSC clinic also provides an extended platform for discussions about ACP in conjunction with the Nephrologist. Where possible, this documentation should be shared on any **electronic medical records** available.

This information is a guide only and should be adapted to suit each individual Kidney Supportive Care Service.