ST. GEORGE HOSPITAL KIDNEY SUPPORTIVE CARE (KSC) REFERRAL PATHWAYS

REFERRALS – usually from Nephrologists

The KSC service provides:

- Renal appropriate drug and dosing advice
- Pain and symptom advice for patients with AKD
- Knowledge of discharge services and supports
- Platform for addressing Advance Care Planning
- End-of-life care and support to patients & families in their place of choice

INPATIENTS

Multi-DisciplinaryTeam (MDT) referrals

Dietitian referrals
Appetite / electrolytes
Weight loss/gain
Taste aversion,
Malnutrition risk

Occupational Therapy referrals
Assessment
Equipment needs

Social Work referrals
ACAT
Home services
Emotional support
EOL/ Bereavement

Physiotherapy referrals
Assessment of mobility
Equipment needs

Speech Pathology referrals
Assessment of swallow / speech

Pastoral Care
Culturally appropriate spiritual/religious care

Discharge Planning
***MDT** to organise D/C services if needed*
***KSC** service to schedule follow up at **KSC clinic** OR **home visit** / **telephone consult** if too difficult for patient to attend clinic*

OUTPATIENTS

Home & Residential Aged Care Facility visits

KSC Clinic

Access to KSC MDT Team
Palliative Care specialist doctor
CNC / SW /Dietitian
Taste aversion

For Occupational Therapy Physiotherapy or Community Services at home for >65yrs
*Referrals to be made through **'My Aged Care'** referral portal*
www.myagedcare.gov.au/

Progression to End of Life (EoL)

***Consider**:*

- patient's and family's wishes regarding preferences for EoL care
- whether these goals are appropriate and achievable
- palliative services available in the patient's council area

Home Death

Liaise with GP
- *Can GP do **home visits***
- *GP preferably agreeable to certify the death at home*
- *Pt **must** have been **seen** by the GP in the last **6 months***

KSC referrals
***Community Palliative Care Team (CPCT)** in patients area if complex pain / symptoms or if rapid deterioration expected / wishes for EoL care at home*
- *Send EOL medication pack home with patient for CPCT to access*

Hospice

KSC referrals
- *Refer to Hospice in patients council area– patient can be referred from the acute hospital or community setting*
- *An **NFR** order is usually part of the admission criteria to Hospice*
- ***NFR** orders should be flagged to the transport service*
- *Inpatient's should only be transferred to hospice only if rousable*

Acute Hospital

KSC service
KSC CNC to assist with advice on EOL care in the acute setting for pain and symptom management and support to patient and family. MDT referrals as needed

Residential Aged Care Facility (RACF)

KSC service / referrals
- *RACF can do EOL care (should be discussed with them to determine their ability / needs)*
- *If happy to do EOL care & patient being transferred back from acute hospital setting, KSC service can organise EOL medication pack to send back with patient*
- *Some **CPCT's** will liaise with RACF to provide advice and support for EOL care*
- *Important to provide effective handover and ensure GP is aware*
- *Patient should only be transferred if rousable*
- *NFR orders should be flagged to the transport service*

Phone follow-up by CNC