

Nursing Management in Renal Supportive Care

Renal Supportive Care Symposium 2014

Elizabeth Josland
Renal Supportive Care CNC
St George Hospital

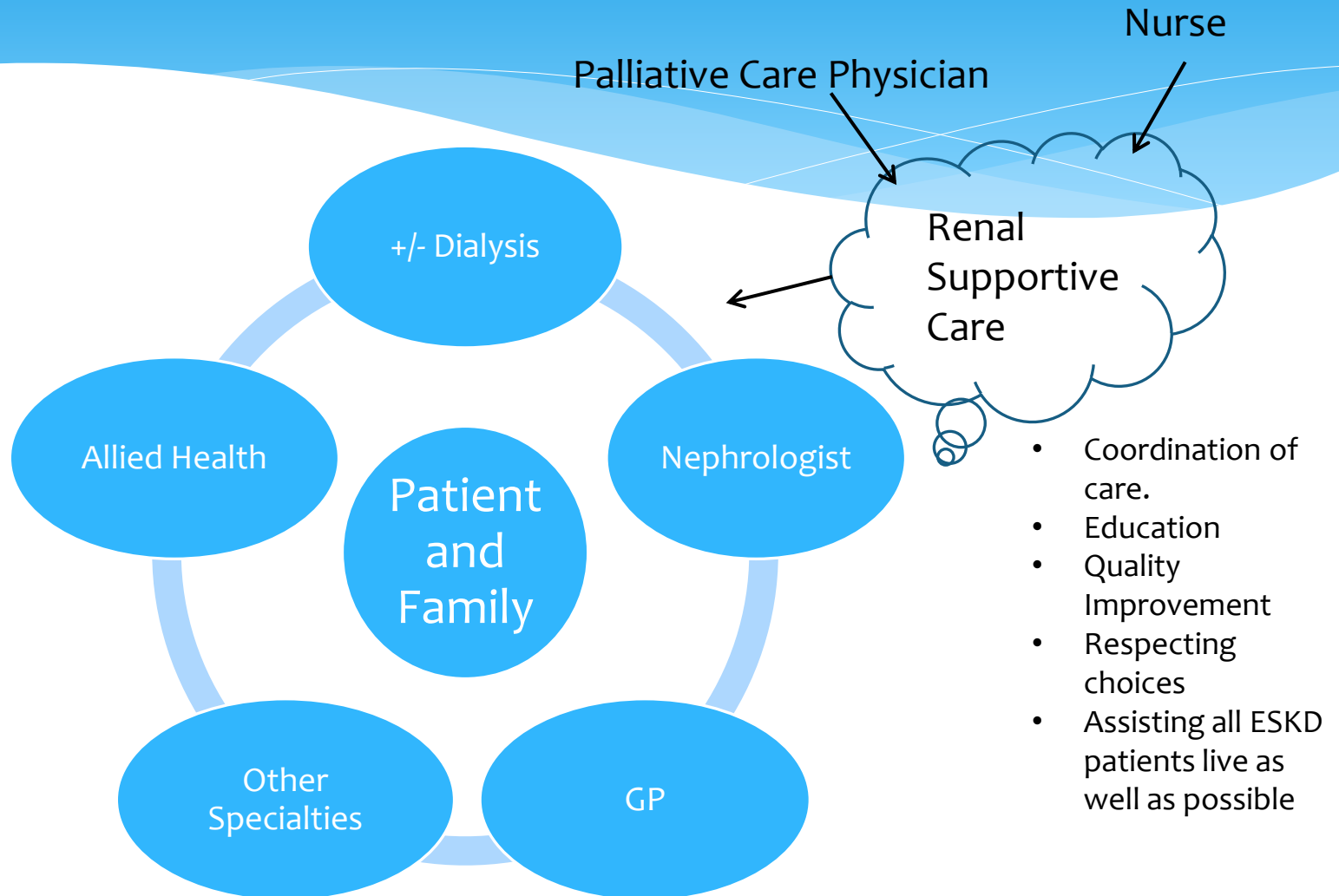
Aim

- * How did Renal Supportive Care begin at St George?
- * Role of the nurse
- * Management of Referrals
- * Inpatient management
- * Outpatients including dialysis
- * Linking to allied health and hospice
- * Withdrawal of dialysis
- * End of life care

How did Renal Supportive Care
begin at St George Hospital?

- * Pilot study in 2005 to measure symptoms of patients who attend hospital haemodialysis.
- * Consented and randomised for usual care (+/-) 3 visits with the palliative care consultant
- * Results showed a high symptom burden and also showed a great acceptance of the palliative service for symptom management
- * This is where the regular service was born commencing fortnightly from March 2009, weekly from November 2010, twice weekly August 2011.
- * Funding commenced in May 2012 (CNC1 0.5 FTE).
- * Service at Sutherland Hospital commenced Jan 2014. Inpatients and outpatients. Clinic held once a week.
- * Home visits commenced in Dec 2012

Conceptual Model



Renal Supportive Care Nurse Role

- * Inpatient referrals and reviews
- * Dialysis patient referrals and reviews
- * Liaise with allied health regarding outpatients
- * Clinics
 - * Palliative Care Physician
 - * Pre consult review (survey, social issues, wounds, answer questions etc)
- * Home Visits
- * Phone Consults
- * Research
- * Education (Conferences, in-services)

Supportive care - Nursing

- Being patient centred
- Involving the patient and significant other in all conversations
- Support for patients withdrawing dialysis
- Meticulous symptom management
- Advanced care planning
- Renal appropriate End of life pathways
- Aim for a comfortable and dignified death in the place of choice where possible at end of life

Management of Referrals

- * Clinic referrals require a letter from a consultant or preferably a GP
- * Referrals to the nurse only do not require a GP referral
- * Inpatient referrals are usually verbal and can be seen by the consultant or myself (or both)
- * Dialysis patients can be referred by the nurses, but always talk to the nephrologist first (or they can directly refer themselves)
- * Who is appropriate for a referral?

Who is appropriate for referral?

- * Dialysis patients with symptoms
- * Dialysis patients deliberating about withdrawal
- * Dialysis patients with a 2nd life limiting illness
- * Conservatively managed patients (clinic is currently 2/3 conservative)
- * 100 current clinic patients (excludes patients only seen as inpatients)

Consultative Team

- * Do not take over care
- * Adjuvant to their usual care
- * Always in consultation with the nephrologist and other treating teams

Inpatient Management

- * Talk to patient and family about symptoms, comfort, aim of care, discharge planning
- * Review medication chart
 - * Renal appropriate pain management
 - * Are medications correct?
 - * Is anything missing that should be there?
- * If there is a functional decline how much may be reversible?

Inpatient Management

- * Can the patient go home?
- * Do we need to talk about nursing home or hospice?
- * Family meetings
- * If medication is being changed, educate the patient/family/staff as appropriate
- * Changing from short acting to long acting opioids
- * Care of the dying
- * Care of the family and loved ones

Changing from short acting to long acting Opioids

- * Most commonly changing from hydromorphone to a patch or Oxycontin or Journista
- * Change over to long acting where appropriate at least 1-2 days before discharge allowing for a crossover time (Journista allow an extra 8 – 12 hours of crossover, patch 16 – 20 hours crossover)
- * Remember time required between stopping long acting and commencing short acting

Outpatient Management including Dialysis Patients

- * Clinics
 - * See patients before they have their consultation
 - * Provide information regarding dialysis when questions arise
 - * Follow up allied health if required
- * See patients on dialysis
- * Monitor changes in medications (does it help, or are there side effects?)
- * Advance care plans onto eMR, sent to GP

Linking to community resources

- * Know criteria for referral to the local hospice
- * Social worker is vital in assisting here
- * Ongoing knowledge of local palliative care community nurse referral pathway
 - * Every out-of-area patient may be different depending on where they live
- * Carer stress

Withdrawal of Dialysis

- * Usually as the result of a sentinel event
- * Nephrologist always involved
- * If there is time, hospice may be appropriate or transfer home with community palliative care support
- * If a patient wants to stop dialysis for psychosocial reasons, this usually happens after a long comprehensive consultations

End of Life Care

- * End of life medications adjusted for renal failure
- * PRN medications to relieve avoidable suffering
- * Offers closure to the family following a long illness
- * The priority is the comfort of the patient
- * Unrealistic expectations avoided
- * Communication skills are paramount (remember the patient may still be able to hear)
- * Diagnosis of dying is important (family have often never seen this before and rely on nurses to tell them that the patient's condition has changed and time may be short)

End of Life Care

- * Anticipatory prescribing
 - * Pain
 - * Hydromorphone 0.25-0.5mg Q2-4H sci prn for SOB or pain (may need regular dose if already using opioids)
 - * Agitation
 - * Haloperidol 0.5-1mg bd sci (nausea/delirium) can increase
 - * Midazolam 2.5-5mg Q2-4H sci prn for ongoing agitation
 - * Terminal secretions (renal failure)
 - * Glycopyrrolate 200-400mcg Q2-4H sci prn (can increase)

End of Life Care

- * Anticipatory prescribing
 - * Anxiety related to SOB
 - * Lorazepam 0.5-1mg SL bd – tds prn for anxiety
 - * Myoclonic jerks (or epileptic)
 - * Clonazepam 0.25-0.5mg bd SL prn

Bereavement

- * Renal Memorial Service
 - * Held once a year for families of patients who have passed away in the past 2-3 years
 - * Social worker organised this and sends invites as well as advertised in the local paper
 - * Usually held at 6pm
 - * Themed
 - * Staff are invited
 - * Refreshments afterwards

Remembrance



Renal Memorial Service

4th April 2012

Conclusion – The RSC Nurse

- * The RSC nurse is part of a collaborative consultative team.
- * Manages inpatient symptom management in consultation with the palliative consultant, but expected to be independent where able (cannot prescribe).
- * Ability to monitor and support people who are unable to attend clinics.
- * Can coordinate end of life care for the patient.
- * Can refer on to other services where needed such as community teams.
- * Coordinates consultations for dialysis patients in need of symptom management.
- * Participates in family meetings where required
- * Advance care planning in early stages of development