ST. GEORGE HOSPITAL RENAL SUPPORTIVE CARE CNC REFERRAL PATHWAYS

REFERRALS – usually from Nephrologists/Dialysis staff

The RSC service provides:

- Renal appropriate drug and dosing advice
- Pain and symptom advice for patients with Advanced Kidney Disease
- Knowledge of discharge services and supports
- A platform for addressing Advance Care Planning (ACP)

INPATIENTS

Multi-DisciplinaryTeam (MDT) referrals

Dietitian referrals
Appetite / electrolytes
Weight loss/gain
Taste aversion

Occupational Therapy referrals
Assessment
Equipment needs

Social Work referrals
ACAT
Home services
Emotional support
EOL/ Bereavement

Physiotherapy referrals
Assessment of mobility
Equipment needs

Pastoral Care
Culturally appropriate spiritual/religious care

Speech Pathology referrals
Assessment of swallow /speech

Discharge Planning

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

OUTPATIENTS

Home & Residential Aged Care Facility visits

Access to RSC MDT Team
Palliative Care specialist doctor
CNC / SW /Dietitian

RSC Clinic

For Occupational Therapy Physiotherapy or Community Services at home
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
- developing an adult 'Ambulance Palliative Care Plan' & ACP

Home Death

Liaise with GP

- *GP must agree to* ***home visits***
- *GP must be agreeable to certify the death at home*
- *Pt* ***must*** *have been* ***seen*** *by the GP in the last* ***3 months***

RSC 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*
- *Do not discharge on a FRIDAY, no support over weekend.*

Hospice

RSC referrals

- *Do* ***NOT*** *offer Hospice if patient is a permanent RACF resident*
- *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*
- *Patient should be transferred to hospice* ***only if rousable***

Acute Hospital

RSC service

RSC 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)

RSC service / referrals

- *Many 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, RSC service can organise an 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