Supportive Care Pathway – AKCC route

Step 1 **Entry Point into AKCC & Identification of possible Supportive Care patient**

Resources

Metric

Refer to AKCC/LCC:if ESRF in 18/12 months

- based on eGFR/PCR/bloods
- eGFR < 15 and symptoms
- Not suitable for transplantation

Identify who would benefit from SC

- Over 60 years or clinically indicated
- Baseline assessment using 5 questions – (CFS,SQ,QOL, POS-S, memory etc)

- CFS
- MoCA
- POS-S-Renal
- EQ5DL – QOL
- (5 questions to identify)

Metric 1
Evidence of identification (CFS/memory test)

Assessment completed/recorded

Step 2 **Education and Shared Decision Making**

Treatment options :

Choosing Supportive Care/Conservative management + all treatment options

- Tailored information , skilled conversations and time given
- Include family in supportive care discussions and treatment options early on

- Education sessions + peer support
- Supportive care booklet leaflet
- Supportive Care conversations
- Letter template
- Comms modules
- Posters
- YODDA/SDM aids

Metric 2
Discussion of SC as an option clearly recorded(pathway designated)

Decision to follow SC clearly recorded

Step 3 Management and care – early/stable

- Ongoing assessment/signposting/referral
- e.g memory clinic/ community hubs
- Medicine management
- Symptom management + CKD management
- Establish community support

Resources

- Commence care planning conversation + ACP
- Goal setting – values and preferences
- Frailty directory
- POS-S-Renal symptom (5/8) score
- Distress monitor
- Start/Stop drugs

Metric

Metric 3
ACP need defined
CFS – every 6 months
Hb/albumin/nutritional marker – surrogate marker

Step 4 Later Supportive Care – declining <10

- Symptom/CKD management
- Crisis management plan
- Medicine management
- DNAR status and discussion with family
- Review ACP + revisit goals and intentions
- in care plan

- DNAR leaflet
- ACP review
- Communication modules
- Goal setting – goals of care
- Medicine management

Metric 4
Review of ACP – commenced/declined recorded
(Community DNAR)
Preferred place of care recorded – in ACP)
POS-S - Renal

Step 5 End of Life care and beyond -

- Symptom management and assessment
- Palliative care and hospice support/connection/referral
- Psychosocial support for patient and family

- Comms modules
- ACP document
- Symptom score
- Bereavment care for family/memorial/cards /contact

Metric 5
ACP
POS-S
Preferred place achieved
Preferred place of death recorded
Actual place of death
Admission in last year
Treatment in last year
Symptom score

RRT Pathway

Supportive Care

Step 1 – identification	Resource	Metric
a. Patients arriving at RRT who are already in need of parallel supportive care approach **Identified by any of** ➢ **Over 60 years** ➢ **If < than 60 on hospital transport**	Clinical Frailty Score MoCA Clinical history Draft some and then refine • Managing own medicine _ @ boxes/dosset • Do you leave the house other than medical treatment/apt • Washing and dressing independently • Mobility – transfer/toileting independently/mobility aids • How many falls • How many emergency admissions • Do you still do your own banking • Barthel assessment • Alpha FIM tool (Helen to circulate) Every patient should have a goal setting consultation which is then followed up – involves the family SDM tools to cover consent, risks etc (is this recorded?) Template letter for final assessment prior to transition/transfer in AKCC - ? @eGFR 10 as a discussion point (this could be tested as an intervention) At access creation and discussion – briefer prompt about goals and plans for RRT Examples of template letters Ask David about a formal consent for commercial units – what is process? ? Just a scrap of paper RG FU SDM and how documented	CFS – as you start or at referral (latter preferable) % with a defined CFS Evidence of informed consent at dialysis start with risk, benefits and prognosis included

These patients then join common pathway which includes those newly identified as requiring parallel SC in those already receiving RRT

a. Identification of patients already receiving RRT as needing parallel SC By any of ➢ Over 60 years ➢ < than 60 on transport ➢ Experienced a life changing health issue	Clinical Frailty Score MoCA 5/7 questions – how often should they asked? ? Annually Protocol from The Lister – Helen – flags to deterioration Katie – look out Kings risk criteria risk ratio	(6/12 updated CFS in all RRT patients over 60 Annual clock drawing Annual needs review - 5 key questions) % of defined population with a CFS within last 6 months

Step 2 - supportive RRT - Early		
Vulnerable patient but either stable or declining slowly **Identification of patient through SQ** **Goal is QOL although you aren't actively new medication etc** **CFS >5** **SQ at a year is a question not surprised but not the prognosis** **(Define our questions for the group)**	CFS 5/7 questions MoCA SC template letter – example of – nod to symptom burden ACP needs assessment /goals STOP START drug tool – active review of drugs	% CFS up to date within 6/12 % with ACP status identified % with SC stable template completed

Step 3 - supportive care RRT - declining		
Patient clearly declining as identified by any of the below: • **Repeated hospital admissions - 2 in 6 months – 3 in a year (literature search – HA to identify)** • **Clear new events – (stroke, ICU admissions, amputation, life limiting cancer)** • **Significant fall in CFS in last year - >7** • **Significant change in MoCA in last year - <15** • **Goal setting – refer to withdrawal when appropriate**	CFS ACP – [plus family involvement Symptom tool for assessment – (distress thermometer) Symptom guideline for treatment (no official one) STOP START drug tool Crisis planning (admission avoidance – this can be accessed locally through AMed/Geriatric team network) Signposting – frailty directory Treatment plan to manage dialysis frequency – twice weekly considered – tailored decision to individual QOL	% identified as needed that are ACP % completed or declined Identification of PPC Symptoms score completed and plan made/signposting

Step 4 - supportive care RRT - end of life		
Patients reaching end of life as identified by: **Repeated hospital admissions** **CFS > or = 7** **Other life limiting diagnosis** **Patient/family driven discussions about withdrawing RRT treatment** **SQ – 3 months** **Intractable hypotension/failing VA** **Distress with treatment/HD - dementia**	CFS Symptom control guidance ACP DNAR Crisis planning	%DNAR status recorded %Achievement of PPC %Symptom score – (evidence of treatment plan – how)