Integrating Renal and Palliative Care Project

A nursing initiative

Ballarat Hospice Care Inc. (BHCI) and Ballarat Health Services (BHS) Dialysis

**Background**
- Renal nurses challenged in planning and delivery of Advance Care Planning (ACP) and End of Life (EOL) care and family/career’s support.
- Identified gaps in service for ACP and EOL care for patients choosing either a conservative medical pathway, ceasing dialysis or deteriorating despite dialysis.
- Implemented a successful multi-professional collaboration and co-ordinated approach between renal and palliative care teams at local level Ballarat Health Services (BHS) and Ballarat Hospice Care Inc (BHCI).

**Integrating Renal and Palliative Care: A framework for implementation**

**Target groups**
- Patients opting not to start dialysis – conservatis medical management only
- Patients deteriorating despite dialysis
- > 75 age with multiple comorbidities e.g. HD, diabetes
- Dual diagnosis e.g. cancer/EERD on dialysis

**Areas of need**
- Symptom control
- Psychological and social support
- Advance Care Planning
- End of life care (terminal stage)
- Bersavement

**Care settings**
- In patient care
- Community based care

**Essentials for integration**
- Clinical champions
- Pre dialysis
- Palliative care
- Nurse initiated referrals
- Protocols and pathways
- Communication systems e.g. meetings, IT
- Cross specialty learning between palliative care and renal e.g. PEPA

**Pre Dialysis Pre Dialysis Coordinator**

**Shared Decision Model**
- Resources to support information consent and decisions
- Family meeting
- Patient held advance care plan
- Consider referral to palliative care
- Identify patients with “cause for concern”

**Dialysis Dialysis Unit**

**Shared Decision Model**
- Resources to support information consent and decisions
- Regular family meeting (annual heads based)
- Review patient held advance care plan
- Consider referral to palliative care
- Identify patients with “cause for concern”
- Palliative care representative at monthly renal meetings

**Post Dialysis Palliative care/GP**

**Shared Decision Model**
- Resources to support information consent and decisions
- Review patient held advance care plan
- Family meeting
- Refer to palliative care
- Support renal staff
- Bersavement follow up with family

**Prompts and triggers**
- Prognostic indicator guide
- Quality of life and symptom management tool (QOLS-5)
- Family meeting
- advance care plan

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**End of life**
- Needs-based care
- Care settings
- Choice of place of care
- Choice of place of death


**Progress since January 2009 Implementation of Framework**

Successfully addressing ANZSN Renal supportive Care Guidelines 2013 recommendations for renal nurses.

- Training in the use of palliative care tools and palliative care pathways.
- Participation in advance care planning.
- Rotation in a palliative care ward or hospice ( Possibly utilizing PEPA) or renal palliative care clinics.
- Support for renal staff – palliative care study days.

**FUTURE DIRECTIONS:**

Ongoing funds from Department of Health Victoria provided through GRPCC to:
- maintain collaboration.
- cross training.
- promote PEPA placement.