CONSERVATIVE KIDNEY MANAGEMENT GUIDELINES

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Reason for Change: New guideline

Original Date of Approval: 30th Nov 2010
Originally Approved By: [Signature]

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Approved By:

Date Effective From
30th Nov 2010

Superseded Documents

Review Date: Nov 2012
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Rationale – These guidelines are being introduced to provide nursing and medical staff with information and guidelines on the care of patients with End Stage Kidney Disease who opt not to undergo dialysis and for whom dialysis is not an option for clinical reasons. This document is the first of three proposed guidelines to provide guidance on End of Life Care for the patient with Chronic Kidney Disease.

An Bord Altranais (2009) stated that “Nurses can make a difference to older people and their families by creating and facilitating a therapeutic milieu that addresses their physical, psychological, social, cultural and spiritual needs. This includes collaboration with the other healthcare professionals in providing evidence based best practice and establishing mechanisms for consultation regarding practice and referral” “Providing relief from distress will facilitate a comfortable death and on that is remembered with peace and comfort by family and friends”.

SECTION 1
Irish Medical Council (2009)

“When Death is imminent, it is the responsibility of the doctor to take care that the said person dies with dignity, in comfort and with as little suffering as possible. In these circumstances a doctor is not obliged to initiate or maintain treatment which is futile and disproportionately burdensome.”

HSE/Irish Hospice Foundation

In 2006, the Health Service Executive (HSE) stated its commitment to develop a chronic disease management patient support programme.

World Health Organisation (2004) – recommended the provision of appropriate palliative care for all patients regardless of diagnosis.

Palliative Care for all - Integrating Palliative Care into Disease Management Frameworks (2008) recommends – “Collaboration between the relevant speciality / primary care team and SPC(specialist palliative care) has been found to be beneficial in meeting the palliative care needs of people with non – malignant diseases at all stages of their illness. In all cases of collaboration practice the development of local guidelines setting out the parameters for referrals or joint/shared care are recommended.

www.hospice–foundation.ie  www.hse.ie

Hospice Friendly Hospital (May 2010)
Prepared a development plan for implementation the Quality Standard for End of Life Care in Hospitals resulting from the National Audit of End of Life Care in Hospitals in Ireland 2008/2009 a number of quality standards where recommended for End of Life Care in Hospitals.

SCOPE
The implementation of this guideline will apply at the point on the disease trajectory where the patient would otherwise be preparing for commencing renal replacement therapy. CKD (Stage 3-4)

This guideline is in line with current corporate procedures whereby Beaumont Hospital is currently engaged in the next phase (2) of the HSE/HfH initiative. Practice Development Programme for End of Life Care. (Sept 2010 – April 2012)
**Key Staff** – All staff within the Nephrology Urology and Transplantation Directorate have responsibility in implementing and following through on this guideline.

**Responsibilities** – To use this guideline tool as recommended, and review at each clinic visit. To communicate and document any changes in the medical notes.

**PRINCIPLES** The basic belief on which this guideline is based is that it is our responsibility to support people with advanced kidney disease to live life as fully as possible and enable them to die with dignity in a setting of their own choice. In addition, Family members are supported throughout the illness of their relative, and are treated with compassion and in a caring manner following the death of their relative.

**SECTION 2**

**THE PPPG** – Consisting of:

The statement(s) of the standard that is to be achieved (What)

Patients on the Conservative Management Pathway will receive quality treatment and care which includes palliative care that focuses on managing pain and other distressing symptoms, providing psychological, social and spiritual support and support those close to the patient including bereavement care. (GMC 2010)
SECTION 3

THE PROCEDURE – Consisting of:

A step by step account of how the PPPG is to be achieved, including a flowchart in all but the simplest cases.
SECTION 4

DEVELOPMENT AND CONSULTATION PROCESS – Consisting of:

An outline of who has been involved in developing the PPPG (use template below)

<table>
<thead>
<tr>
<th>CONSULTANT SUMMARY</th>
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<td>Date PPPG issued for consultation</td>
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<td>Number of versions produced for consultation</td>
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End of Life Steering Committee –
Dr Mark Denton – Consultant Nephrologist
Dr Regina Mc Quillan – Consultant Palliative Medicine
Margie Kennedy – Renal Nurse Counsellor
Mary T Murphy – Patient Care Co-ordinator
Eileen McBrearty – Patient Care Co-ordinator
Caroline Cregan – CNM11 St Peter’s Ward
Teresa Byrne – Specialist Palliative Care Nurse
Louise McSkeane – Ambulatory Care
Olive Byrne – Ambulatory Care
Eimear O’Sullivan Staff Nurse

End of Life Steering Committee met on the following dates -
Dates: 7th April 2010
22nd April 2010
25th May 2010
31st August 2010
Sub Committee meeting – 21st September
12th October 2010
2nd November 2010

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<th>Where Received</th>
<th>Summary of Feedback</th>
<th>Actions/Response</th>
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<td>The first discussion on this guideline was at the End of Life Steering meeting on the 22nd April.</td>
<td>It was agreed that the first draft be designed and circulated to the entire group before the next meeting.</td>
<td>Work began on the design and wording for the guideline.</td>
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<td>End of Life Steering Group meeting 25th May 2010</td>
<td>A general discussion took place to review the first draft of proposed guidelines.</td>
<td>It was decided that it is a work in progress and to follow up again at the next meeting.</td>
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<td>End of Life Steering Group meeting 31st August 2010</td>
<td>It was decided to form a sub-committee to decide on the final wording and to research other areas to see what is in use.</td>
<td>The sub-committee met with the oncology department who have a similar plan in use. This was very productive. It gave the committee insight into how best to</td>
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End of Life Steering Group Meeting 12th October 2010

Work is progressing to the satisfaction of the Committee. One of the ambulatory care nurse’s will investigate getting a stamp designed for the patient chart to use for clinic appointments. Checking the best route for documentation.

Decision to make the necessary adjustments to the wording. Proceed to printing a copy of the guideline to bring to the next meeting.

End of Life Steering Group Meeting 2nd November 2010

Colour and Layout in the final discussion today. Two small areas in the wording need to be changed. Agreed to add the addressograph to both sides.

Agreed to meet again prior to Policy meeting with the final draft and if approved to start the pilot study in January 2011.

SECTION 5

REFERENCE DOCUMENTS – Consisting of:

A list of works that the author has used as a source of information, evidence or inspiration

An Bord Altranais (2009) Professional Guidance for Nurses working with Older People


General Medical Council (2010) Treatment and Care towards the end of life: good practice in decision making.

Gold Standards Framework (GSF) NHS End of Life Programme www.goldstandardsframework.uk


Noble H Kelly (2006) Supportive and Palliative Care in end stage renal failure: the need for further research: International Journal of Palliative Nursing 2006 (Vol12 no 8)


Palliative Care for all (2008) Integrating Palliative Care into Disease management Frameworks HSE/HfH Report on the Extending access study.
Dear Doctor

The above named patient has advanced chronic kidney disease/end stage renal disease. He/she has been attending the Department of Nephrology in Beaumont Hospital with this condition. It has been agreed between the patient, family, nursing staff and medical staff to pursue a conservative management strategy. This means that after being fully informed by the health care team, the patient is opting not to have dialysis of any kind should the renal failure worsen.

We will continue to manage the patient’s chronic kidney disease in the nephrology clinic (e.g. blood pressure, extracellular fluid volume, metabolic acidosis, calcium / phosphate balance and anaemia) and review medications, but we will not be making any plans for future dialysis (such as vascular access). We will continue to review the patient’s wishes, should the patient have a change of mind at a later date.

The rate of progression of kidney disease is highly variable and it may be that the patient’s level of renal function remains steady for some years. During this time the patient will be continued to be reviewed in the outpatient clinic or may even need to be admitted to hospital for an intercurrent illness. However as the renal function declines to very low levels, and the patient becomes symptomatic of uraemia we will communicate further with you because it may be better for the patient to be managed at home for end of life care. Symptoms of uraemia include loss of appetite, nausea, vomiting, itch, insomnia and restless legs. Symptoms can usually be controlled by anti-emetics, antihistamines and other medications. We will communicate closely with you during the later stages. Ultimately patients may develop loss of consciousness from uraemic encephalopathy.

Death from end stage renal failure is usually painless. However, if the patient has other co-morbid conditions, pain may be a feature and need to be managed. It may be necessary to refer to palliative care if available in your area. Otherwise please refer back to us for advice. Should you have any questions or concerns at any stage, for example regarding safe prescribing in chronic kidney disease, please do not hesitate to contact the Nephrology Registrar on 01 8093000, or Ambulatory Care nursing staff on 01 8528395.

Thank you

Registrar : Dr ……………………………
Medical Council Number…………………
Attending Consultant……………………..
c. PHN (if appropriate)
enc. Conservative Management Guideline