Renal Palliative care

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Dialysis

Diffusion

Waste removal

Industrial

Abnormal

Endogenous

Renal

Avascular

Schematic

Primary uraemic syndrome

Nephron
Patient choice or?
Mortality/cause of death

• 20-25% 1 year
• 60% at 5 years
• 2014- 20 & 2015- 14
• 3 Home/4 Nursing home/7 hospital
• 1) Cardiovascular disease 50% (US)
• 2) Infection
• 3) Withdrawal from dialysis 15-25% (US)
Who would opt out or withdraw?

• I don’t want dialysis and choosing conservative care pathway.

• On dialysis in relative good health with decline over time.

• Poor prognosis from the start.
The typical disease trajectories identified in patients with different diseases.

How do we know when?

• Unable to cooperate with procedures
• Terminal illness
• > 75 years with many co morbidities, impaired functional status, severe chronic malnutrition
• Failure to thrive
• Surprise question- Would I be surprised if this patient died within the next 6-12 months?
• Advance care planning/Advanced health care directive.
my future
my choice
Quality of life
WHAT'S YOUR CHOICE?
"THE QUALITY, NOT THE LONGEVITY, OF ONE'S LIFE IS WHAT IS IMPORTANT."

- MARTIN LUTHER KING, JR.
What do we do?

Withdrawal or opt out.

- Patient choice/Clinical decision in best interest of patient in conjunction with family.
- Capacity /Depression/Duress
- Supportive care/Palliative care.
- 8-10 days or months up to 2 years
- Information and communication.
- Multidisciplinary approach.
- Advance care planning
"I'm writing you a prescription. Do you want a longer life with less quality or vice versa?"
One chance to get it right

Improving people’s experience of care in the last few day and hours of life

1) this possibility is recognised and communicated clearly, decisions made and actions taken in accordance with the person’s needs and wishes, and these are regularly reviewed and decisions revised accordingly.

2) Sensitive communication takes place between staff and the dying person, and those identified as important to them.
3) the dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants.

4) the needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible

5) an individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion.
• ‘We need to recognise that to provide good care in the last days of life we need to start earlier’
References

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• Hussain JA, Russon L. Supportive and palliative care for people with end-stage renal disease, British Journal of Hospital Medicine 2012; 73(11).