

# NSW Renal Supportive Care

Service Model



AGENCY FOR  
**CLINICAL  
INNOVATION**

Collaboration. Innovation. Better Healthcare.

The Agency for Clinical Innovation (ACI) works with clinicians, consumers and managers to design and promote better healthcare for NSW. It does this by:

- *service redesign and evaluation* – applying redesign methodology to assist healthcare providers and consumers to review and improve the quality, effectiveness and efficiency of services
- *specialist advice on healthcare innovation* – advising on the development, evaluation and adoption of healthcare innovations from optimal use through to disinvestment
- *initiatives including guidelines and models of care* – developing a range of evidence-based healthcare improvement initiatives to benefit the NSW health system
- *implementation support* – working with ACI Networks, consumers and healthcare providers to assist delivery of healthcare innovations into practice across metropolitan and rural NSW
- *knowledge sharing* – partnering with healthcare providers to support collaboration, learning capability and knowledge sharing on healthcare innovation and improvement
- *continuous capability building* – working with healthcare providers to build capability in redesign, project management and change management through the Centre for Healthcare Redesign.

ACI Clinical Networks, Taskforces and Institutes provide a unique forum for people to collaborate across clinical specialties and regional and service boundaries to develop successful healthcare innovations.

A priority for the ACI is identifying unwarranted variation in clinical practice and working in partnership with healthcare providers to develop mechanisms to improve clinical practice and patient care.

**[aci.health.nsw.gov.au](http://aci.health.nsw.gov.au)**

## **AGENCY FOR CLINICAL INNOVATION**

Level 4, 67 Albert Avenue  
Chatswood NSW 2067

PO Box 699 Chatswood NSW 2057  
T +61 2 9464 4666 | F +61 2 9464 4728  
E [aci-info@nsw.gov.au](mailto:aci-info@nsw.gov.au) | **[aci.health.nsw.gov.au](http://aci.health.nsw.gov.au)**

SHPN (ACI) 180600, ISBN 978-1-76000-948-9.

**Produced by:** ACI Renal Network

Further copies of this publication can be obtained from the Agency for Clinical Innovation website at **[www.aci.health.nsw.gov.au](http://www.aci.health.nsw.gov.au)**

**Disclaimer:** Content within this publication was accurate at the time of publication. This work is copyright. It may be reproduced in whole or part for study or training purposes subject to the inclusion of an acknowledgment of the source. It may not be reproduced for commercial usage or sale. Reproduction for purposes other than those indicated above, requires written permission from the Agency for Clinical Innovation.

**Version:** 1 **Trim:** ACI/D17/6823

**Date Amended:** August 2018

**© Agency for Clinical Innovation 2018**

## Acknowledgements

The Agency for Clinical Innovation (ACI) would like to thank the Renal Supportive Care Working Group (RSCWG) for their input in the development of this renal supportive care model. The expertise and enthusiasm of the RSCWG was invaluable.

### Renal Supportive Care Working Group

Name	Role	Organisation
Mark Brown (Chair)	Renal Physician	St George Hospital, SESLHD
Michael Noel (Deputy Chair)	Palliative Care Physician	NBMLHD and Nepean Hospital
Troy Arnold	Renal Social Worker	John Hunter Hospital, HNELHD
Frank Brennan	Palliative Care Physician	St George Hospital, SESLHD
Hannah Burgess	Renal Social Worker	St George Hospital, SESLHD
Peter Choi	Renal Physician	John Hunter Hospital, HNELHD
Celine Foote	Renal Physician	Concord Repatriation General Hospital, SLHD
Anna Hoffman	Renal Supportive Care Clinical Manager	St George Hospital, SESLHD
Elizabeth Josland	Renal Supportive Care Clinical Nurse Consultant	St George Hospital, SESLHD
Kelly Li	Renal and Palliative Care Physician	St George Hospital, SESLHD
Kate Lloyd	Director, Acute Care	NSW Agency for Clinical Innovation
Patrina Marsden	Renal Nurse Practitioner	Wagga Wagga Hospital, MLHD
Linda McCorrison	Renal Clinical Nurse Consultant	Renal Services, SNSWLHD
Rachael Morton	Director, Health Economics	Sydney Medical School, The University of Sydney
Monica Nash	Network Manager, Renal	NSW Agency for Clinical Innovation
Stephanie Notaras	Renal Dietitian	Liverpool Hospital, SWSLHD
Jane Phillips	Professor, Palliative Nursing	Faculty of Health, University of Technology, Sydney

Alison Smyth	Renal Supportive Care Clinical Nurse Consultant	St George Hospital, SESLHD
Paul Snelling	Renal Physician	Royal Prince Alfred Hospital, SLHD
Jessica Stevenson	Renal Dietitian	St George Hospital, SESLHD
Kamal Sud	Head of Department, Renal Medicine	Nepean Hospital
Kayla Szymanski	Renal Clinical Nurse Consultant	John Hunter Hospital, HNELHD
Nina Vogel	Staff Specialist, Palliative Care	John Hunter Hospital, HNELHD

HNELHD: Hunter New England Local Health District;  
MLHD: Murrumbidgee Local Health District;  
NBMLHD: Nepean Blue Mountains Local Health District;  
SESLHD: South Eastern Sydney Local Health District;  
SLHD: Sydney Local Health District;  
SWSLHD: South Western Sydney Local Health District

## Glossary

CKD	chronic kidney disease
CNC	clinical nurse consultant
ESKD	end stage kidney disease
Hub	A central location that provides education, mentoring and support to the staff of local renal services, which provide care for their patients locally. All renal units across NSW are affiliated with one of the three hubs.
LHD	local health district
RSC	renal supportive care – an interdisciplinary approach to CKD and ESKD, integrating the skills of renal medicine and palliative care.

## Executive summary

Renal supportive care (RSC) is an interdisciplinary approach integrating renal medicine and palliative care. It supports patients with chronic kidney disease (CKD) and end stage kidney disease (ESKD) and their carers/families to live as well as possible by better managing their symptoms. It also encompasses advanced care planning and end of life care.

RSC comprises a series of networked services across NSW. The RSC service is embedded within existing renal services, rather than as an adjunct to these services.

This model was developed by the NSW Agency for Clinical Innovation (ACI) Renal Network, in consultation with the NSW Ministry of Health, NSW (LHDs) and other key stakeholders. It is intended to provide a framework for implementation of RSC services across renal units in NSW and inform NSW health policy and planning in regards to best practice care for people with CKD and ESKD.

The nurse-led, networked RSC model aimed at four groups of patients with CKD or ESKD:

- patients deciding whether or not to pursue renal replacement therapies (including patients in the pre-dialysis stage)
- conservatively managed patients opting not to pursue renal replacement therapies
- patients receiving renal replacement therapies but experiencing symptoms which significantly reduce their quality of life
- patients choosing to withdraw from dialysis.

The nurse is supported by other key health professionals, such as a palliative care physician, dietitian and social worker (where available).

The model is based around the establishment of three hubs across the state, which provide education, mentoring and long term support to the affiliated renal units within their network based at the following sites:

- St George Hospital
- Nepean Hospital
- John Hunter Hospital.

This model has been identified as a prototype for other specialties such as cardiac, respiratory and neurology.

# Contents

<b>Introduction</b> .....	<b>1</b>
Renal supportive care .....	1
Purpose and scope.....	1
Aim .....	1
<b>Target patient populations</b> .....	<b>2</b>
Priority populations .....	2
<b>Service delivery model for renal supportive care</b> .....	<b>4</b>
Key clinicians delivering RSC.....	4
Networked service model .....	4
Suggested standards for RSC services .....	5
RSC model components .....	5
Clinical tools .....	7
Advance care planning .....	7
<b>NSW networking arrangements</b> .....	<b>8</b>
Hub locations and role.....	8
Plan for education and training to be provided by the hubs .....	9
Key performance indicators and outcome measures .....	9
<b>References</b> .....	<b>10</b>
<b>Appendix 1: Alignment of renal units to renal supportive care hubs</b> .....	<b>11</b>
<b>Appendix 2: Key performance indicators and outcome measures</b> .....	<b>12</b>
Outcome and performance measures for NSW Renal Supportive Care program .....	12
2017/2018 service performance agreements indicators .....	12
<b>Appendix 3: Roles of the interdisciplinary team</b> .....	<b>13</b>
Role of the RSC Clinical Nurse Consultant (or equivalent).....	13
Role of the nephrologist .....	13
Role of the dietitian.....	13
Role of the social worker .....	14
Role of the palliative care specialist .....	14
Other staff.....	15
Role of the quality improvement officer.....	15
Role of the administration officer .....	15
<b>Appendix 4: Position descriptions for key roles</b> .....	<b>16</b>
RSC Clinical Nurse Consultant (CNC) .....	16
RSC Dietitian .....	20
RSC Social Worker.....	23

## Introduction

### Renal supportive care

Renal supportive care (RSC) is an interdisciplinary approach integrating renal medicine and palliative care. It supports patients with chronic kidney disease (CKD) and end stage kidney disease (ESKD) and their carers/families to live as well as possible by better managing their symptoms. It also encompasses advanced care planning and end of life care.

### Purpose and scope

This model has been developed by the NSW Agency for Clinical Innovation (ACI) Renal Network, in consultation with the NSW Ministry of Health, NSW local health districts (LHDs) and other key stakeholders.

Its purpose is to assist the implementation of a common approach to renal supportive care (RSC) services across all renal units in NSW. The model will also inform NSW health policy and planning in regards to best practice care for people with chronic kidney disease (CKD) and/or end stage kidney disease (ESKD).

### Aim

The model provides a framework for the operation of RSC services across NSW. This includes defining:

- RSC and the target patient groups
- service delivery, including the scope and relationship to existing renal and palliative care services
- the mechanism through which training and mentoring of clinicians delivering RSC services will be provided
- the approach to governance and networking of services
- reporting, monitoring and review processes, with a focus on clinical service delivery and outcomes.

## Target patient populations

RSC is aimed at four groups of patients with CKD or ESKD (Table 1).

**Table 1: Target patient groups for renal supportive care**

Patient group description	Nature of contact with the RSC service
Patients deciding whether or not to pursue renal replacement therapies. This includes patients in the pre-dialysis stage.	<ul style="list-style-type: none"> <li>• Introduction to the service as part of decision making about treatment options</li> <li>• May or may not continue with the service depending on their decision about treatment and/or the extent of their symptoms.</li> </ul>
Conservatively managed patients opting not to pursue renal replacement therapies.	<ul style="list-style-type: none"> <li>• Expected ongoing contact with the RSC service.</li> <li>• Will require greater support in the terminal phase.</li> </ul>
<p>Patients receiving renal replacement therapies but experiencing symptoms which significantly reduce their quality of life.</p> <p>This group may include patients:</p> <ul style="list-style-type: none"> <li>• considering whether to continue renal replacement therapy due to the burden of their symptoms</li> <li>• with a comorbid condition that has worsened</li> <li>• with an acquired condition that results in an imminent worsened prognosis.</li> </ul>	<ul style="list-style-type: none"> <li>• Contact with RSC service as required.</li> <li>• May receive education about the service and/or guidance on options if they are considering withdrawing from treatment.</li> </ul>
Patients choosing to withdraw from dialysis.	<ul style="list-style-type: none"> <li>• Management/coordination of care required at end of life.</li> </ul>

## Priority populations

Priority populations are those groups that are overrepresented in specific disease groups and/or for whom outcomes have traditionally been poorer than the general population.

The priority populations for RSC are:

- Aboriginal people
- people from culturally and linguistically diverse backgrounds
- people with cognitive impairment.

**Table 2: Considerations for priority populations**

Priority population	Key considerations
Aboriginal people	<ul style="list-style-type: none"><li>• Aboriginal people require consultation and linkages with Aboriginal liaison officers and Aboriginal medical services (where available) to ensure that health services are culturally appropriate.</li><li>• The hubs will have a role in creating resources for RSC services and researching approaches that are relevant to Aboriginal people.</li><li>• Kidney Health Australia has a collection of resources developed specifically for Aboriginal people (see <a href="http://kidney.org.au/your-kidneys/support/indigenous-resources">http://kidney.org.au/your-kidneys/support/indigenous-resources</a>).</li></ul>
People from culturally, religiously and linguistically diverse backgrounds	<ul style="list-style-type: none"><li>• People from culturally, religiously and linguistically diverse backgrounds require linkages with interpreters, multicultural officers/services and/or refugee services.</li><li>• The hubs will have a role in creating resources and researching approaches that are relevant for this population.</li></ul>
People with cognitive impairment	<ul style="list-style-type: none"><li>• It is often challenging for people with cognitive impairment to articulate the pain and discomfort that they might be experiencing.</li><li>• It is expected that the hubs will assist services with selecting tools/approaches suitable for use with patients with cognitive impairment.</li></ul>

## Service delivery model for renal supportive care

RSC comprises a series of networked services across NSW. The RSC service is embedded within existing renal services, rather than as an adjunct to these services. This incorporates the principle of non-abandonment – that is, patients with CKD or ESKD continue to receive care from their nephrologist and the renal unit, regardless of their decision to not embark on or cease renal replacement therapy.

The key principles are that:

- patients and their families are engaged early in the trajectory of CKD, including at the time of deciding on the best treatment pathway (including a non-dialysis pathway)
- RSC is provided to all patients in addition to usual renal care, and does not replace this care
- patients receive care as close to where they live as possible
- RSC is patient centred, focusing on reducing pain and suffering, and maximising quality of life
- RSC services deliver the best possible care – see *Suggested standards for RSC services*.

### Key clinicians delivering RSC

A clinical nurse consultant (CNC) or equivalent occupies the central role in delivering RSC. The CNC is skilled in both renal and palliative care principles of care delivery, including attention to the physical, emotional and spiritual dimensions of the patient's illness and care for the patient's family/carer.

The nurse is supported by:

- a palliative care physician (or other medical/nursing practitioner who can assist with the medical aspects of managing the high symptom burden of the patient)
- a dietitian (where available)
- a social worker (where available).

Local leadership is provided by a nephrologist who is already employed within the renal service and who acts as the director of RSC in that unit. The nephrologist provides clinical leadership for the RSC service, and oversees the implementation and governance of the local program.

This model may differ between metropolitan and rural services based on local requirements, staff availability (e.g. access to palliative care physician) and the distance of patients from the service.

See Appendices 3 and 4 for details about the team roles and some suggested position descriptions.

### Networked service model

A networked model is required to meet training and ongoing mentoring needs of RSC staff, and developing resources that can be shared. This model is based around the establishment of three hubs across the state, selected for geographic convenience and existing expertise.

The hubs are affiliated with specific renal services, providing education and mentoring to the staff of these services who then provide care for their patients locally (rather than require patients to travel for treatment). The hubs will also have an important role in research to improve the RSC model over time, and to compile data for accountability of services and evaluation of the effectiveness of the model (see *Appendix 1: Alignment of renal units to renal supportive care hubs*).

For detailed information about the hubs, including the locations, see *NSW networking arrangements*.

## **Suggested standards for RSC services**

In order to deliver the best possible care, it is recommended that RSC services adhere to the following standards:

- The service should run a regular clinic (or outreach service) that is accessible to all patients managed by the service. The referral base for this clinic should be as wide as possible.
- A standard set of tools should be used to measure symptom burden and quality of life – see *Clinical tools*.
- Advance care planning should be part of normal practice and discussed with each patient.
- The service should have a commitment to gathering and analysing program data, and to using data to continually improve.
- There should be ongoing communication between the RSC service, palliative care services and the renal service.
- The specific needs of people who identify as Aboriginal; people from culturally, linguistically and religiously diverse backgrounds; and people with cognitive impairment should be considered and met appropriately.
- There is a commitment to ongoing education for individual staff members and sharing learning and resources with other staff members involved with the service.
- A renal memorial service is held annually to honour people who have died from CKD. Families and friends of the deceased can be invited to attend, and all staff involved in the program should be encouraged to attend.

RSC services across NSW are a series of networked services. RSC is a nurse led model embedded within existing renal services with local leadership provided by the nephrologist.

## **RSC model components**

Table 3 provides an overview of the components of the model.

**Table 3: RSC service components**

Dimension	Key components of service
Referrals to RSC service	<ul style="list-style-type: none"> <li>• Referrals to the RSC service may be from a nephrologist, nurse, allied health, GP, nurse practitioner or other specialist. In a clinic situation, written referral from a GP or nephrologist is required for billing purposes.</li> <li>• There should be a blanket referral to the RSC service for all ESKD patients managed conservatively.</li> </ul>
Care settings	<ul style="list-style-type: none"> <li>• Clinics are a key component of the RSC service. The frequency of clinics is to be determined by each service and will evolve over time according to demand and staff availability. Clinics will be led by the RSC CNC and may include a palliative care specialist, nephrologist and advanced trainee if available. Rural sites may require involvement of a GP or nurse practitioner with palliative care skills, where available.</li> <li>• Reviews of dialysis patients can be conducted by the RSC CNC during dialysis sessions.</li> <li>• Inpatient consults should be done by the RSC CNC or jointly with the palliative care physician/nephrologist or advanced trainee.</li> <li>• Home or nursing home visits should be arranged for patients unable to attend clinics (by the RSC CNC, medical palliative care component managed by community palliative care). The RSC CNC will share the care of the patient with a community-based palliative care team or other community based service where appropriate.</li> <li>• Patients will be followed up by telephone as needed as an adjunct to clinic visits (by the RSC CNC or allied health).</li> </ul>
Consultation liaison and mentoring	<ul style="list-style-type: none"> <li>• Clinicians from the networked hub are available for consultation and guidance, which is predominantly conducted via telephone/video-link.</li> </ul>
Cessation or transfer of care	<ul style="list-style-type: none"> <li>• After death, the RSC and/or palliative care service will continue to provide bereavement services to the family/carer. The RSC service may run an annual memorial service.</li> <li>• In some cases, the RSC CNC may continue to provide services but the majority of care is primarily managed by the palliative care team or other specialties. For example, this may occur when: <ul style="list-style-type: none"> <li>• the patient has another terminal illness, such as cancer, and its effects overwhelm the symptoms resulting from CKD/ESKD or complications of renal replacement therapy</li> <li>• the patient becomes unstable in the terminal phase of their condition, and is hospitalised or admitted to a hospice.</li> </ul> </li> <li>• For metropolitan hospital based services, care might be shared between the community palliative care team and the RSC CNC when the patient becomes frail and is unable to attend appointments within the hospital-based RSC clinics.</li> </ul>
Workforce	<p>Clinic attended by the RSC CNC, palliative care physician (or other medical or nurse practitioner with skills in palliative care), dietitian (as required), social worker (as required), and renal advanced trainee.</p>

## Clinical tools

The RSC service is guided by evidence based and validated tools for patient management. There are various tools advocated for use across the state:

- **Symptom burden** – The Integrated Palliative Care Outcomes Scale (iPOS Renal) is a validated tool for assessing the symptom burden of renal patients. The free tool is available online at <https://pos-pal.org> (registration is required for access).
- **Quality of life** – The EuroQol five dimensions (EQ-5D-5L) is used to measure and assess changes in quality of life. It can be used for renal patients being managed conservatively, as well as for those receiving renal replacement therapy.
- **Functional status** – The Australian Karnofsky Performance Scale classifies patients according to their functional impairment.
- **Nutritional status** – A technique called subjective global assessment assesses nutritional status based on features of the history and physical examination and assigns a seven-point score.

Additional support or alternative means of soliciting information may be required for patients from specific populations, including:

- Aboriginal people
- people from culturally, religiously and linguistically diverse backgrounds
- cognitively impaired people
- people with poor health literacy
- people who are vision impaired or blind.

The hubs will assist with these approaches.

## Advance care planning

Advance care planning is a central feature of RSC. It involves early conversations with the patient (while they are well enough to make decisions) about such issues as:

- identifying goals for current and future care/treatment
- identifying a substitute decision maker, in case the patient becomes unable
- the types of interventions/support that may help to achieve these goals
- wishes about treatment/care in the terminal phases of illness.

Ideally, these conversations occur between the patient and their carer and/or family, facilitated by a member of the RSC team or other healthcare provider a GP.

The key outcome of advance care planning is a documented plan, so that patient's informed decisions about their care can be effectively communicated to all people concerned (including their carer/family and care staff). This includes consideration of advance care directives. Any alerts regarding advance care directives should be included in the patient's electronic medical record, available for other clinical services in the LHD.

These conversations allow the opportunity to provide education to the patient and their carer/family about the patient's condition, prognosis, and a realistic appraisal of their treatment options (including benefits and drawbacks).

## NSW networking arrangements

RSC is a networked model and all renal units across the state are affiliated with one of three hubs. The hubs provide education, mentoring and long term support to each of the renal units within their network.

### Hub locations and role

The three hubs are based at the following hospitals:

- St George Hospital
- Nepean Hospital,
- John Hunter Hospital.

Refer to Appendix 1 for the alignment of renal units to the hubs.

The hubs are affiliated with specific renal services, providing education and mentoring to the staff of these services who then provide care for their patients locally (rather than require patients to travel for treatment). The hubs will also have an important role in research to improve the RSC model over time, and to compile data for accountability of services and evaluation of the effectiveness of the model (Appendix 1).

The hubs will only provide direct services to patients in their own LHDs (and services will not be provided to patients from other LHDs). This means that there should be an RSC service established in every renal unit. This does not preclude a service from making arrangements with the hubs (or other LHDs) for the provision of outreach, particularly for palliative medicine.

The RSC hubs will have the following key roles:

1. **Provide networked support and coordination of statewide RSC services**, overseen by the ACI Renal Network. This will include the provision of clinical leadership and liaison with the ACI, government and departmental decision makers on behalf of renal services across the state.
2. **Provide education and training for staff** of the affiliated services to gradually build capacity across NSW. The education and training will be supported by ongoing mentoring and clinical supervision, and may involve opportunities for secondments of staff to these services as a means of increasing expertise across the state.
3. **Support and govern a centralised resource system** whereby resources are easily accessible to all across the state via the internet and other means. The resources will include education materials, assessment tools, clinical guidelines, culturally appropriate materials for use with Aboriginal patients and patients from culturally, religiously, and linguistically diverse backgrounds. The ACI will also support and provide a RSC resource folder.
4. **Develop guidelines for quality and safety** of RSC service delivery and a program for auditing the achievement of the standards set.
5. **Develop a program of research** to evaluate RSC, build evidence for specific tools and approaches, and continually improve the service.

Plan for education and training to be provided by the hubs

The following points comprise the strategy for education and training to be provided by the hubs:

- Uniform content across all three hubs, regularly updated by doctors, nurses and allied health staff with advanced experience in RSC.
- Widespread delivery of the education material via links with nephrology and palliative care (CareSearch) websites. The links with these groups will be formalised.
- ACI will facilitate an annual face to face meeting of all staff involved in the NSW RSC program in order to share information and ideas, as well as undertake formal education.
- Interdisciplinary meetings will be held for all common topics, with additional specific sessions as required for each discipline.
- Staff from renal units will visit their relevant hub (and vice versa) to improve learning and skills, supported by the Program of Experience in the Palliative Approach (PEPA) program<sup>1</sup> or the Nurse Strategy Reserve Fund<sup>2</sup>.
- Knowledge and skills learned from the above processes will be applied locally within communities.

### **Key performance indicators and outcome measures**

The success of the NSW RSC model will be measured by key performance indicators (KPIs) and outcomes measures, including:

- hub and network unit KPIs, which will be reported in an annual KPI report to the Ministry of Health through the ACI RSCWG
- Leading Better Value Care KPIs
- Service level agreement KPIs between the Ministry of Health and LHDs.

Please see *Appendix 2: Key performance indicators and outcome measures* for detailed statewide RSC KPIs.

---

<sup>1</sup> See [www.pepaeducation.com](http://www.pepaeducation.com).

<sup>2</sup> Held by the NSW Nursing and Midwifery Office, and available to all LHDs for backfill for nurses while receiving education and training.

## References

1. Australia and New Zealand Dialysis and Transplant Registry. Thirty Fifth Annual Report 2012. 2013.
2. Noble H, Kelly D, Rawlings-Anderson K, Meyer J. *A concept analysis of renal supportive care: the changing world of nephrology*. Journal of Advanced Nursing. 2007;59(6):644-53.
3. Crail S, Walker R, Brown M, Renal Supportive Care Working Group. *Renal supportive and palliative care: position statement*. Nephrology. 2013;18(6):393-400.
4. NSW Ministry of Health. *Advance Planning for Quality at End of Life 2013-2018*. Sydney: NSW Ministry of Health, 2013.
5. Brown MA, Crail SM, Masterson R, Foote C, Robins J, Katz I, et al. *ANZSN Renal Supportive Care 2013: Opinion Pieces*. Nephrology. 2013;18(6):401-54.
6. Burgess T, Braunack-Mayer A, Crawford GB, Beilby J. *Australian health policy and end of life care for people with chronic disease: An analysis*. Health Policy. 2014;115(1):60-7.
7. NSW Ministry of Health. *The NSW Government Plan to Increase Access to Palliative Care 2012-2016*. Sydney: NSW Ministry of Health, 2012.
8. Levy JB, Chambers EJ, Brown EA. *Supportive care for the renal patient. Nephrology, dialysis, transplantation: official publication of the European Dialysis and Transplant Association - European Renal Association*. 2004;19(6):1357-60.
9. Palliative Care Outcomes Scale. *Palliative Care Outcomes Scale 2012*. Available from: <http://pos-pal.org>.

## Appendix 1: Alignment of renal units to renal supportive care hubs

**Table 4: RSC hubs and associated renal units**

St George Hospital Hub	Nepean Hospital Hub	John Hunter Hospital Hub
<p>Concord Hospital</p> <p>Royal Prince Alfred Hospital</p> <p>St George/Sutherland Hospital</p> <p>Prince of Wales Hospital</p> <p>Wollongong Hospital</p> <ul style="list-style-type: none"> <li>Wollongong Satellite</li> <li>Shellharbour</li> <li>Shoalhaven</li> </ul> <p>Royal North Shore Hospital</p> <ul style="list-style-type: none"> <li>Mona Vale satellite unit</li> </ul> <p>Dubbo Base Hospital</p> <p>Orange Base Hospital</p> <ul style="list-style-type: none"> <li>Bathurst Hospital</li> </ul> <p>Broken Hill Hospital</p> <p>St Vincent's Hospital</p>	<p>Western Renal Network</p> <ul style="list-style-type: none"> <li>Nepean Hospital</li> <li>Penrith Community Dialysis centre</li> <li>Auburn Satellite unit</li> <li>Blacktown Hospital</li> <li>Westmead Hospital</li> </ul> <p>Liverpool Hospital</p> <ul style="list-style-type: none"> <li>Liverpool Community Centre</li> <li>Bankstown Hospital</li> <li>Campbelltown Hospital</li> <li>Fairfield Hospital</li> </ul> <p>Wagga Wagga Base Hospital</p> <p>Goulburn Hospital</p> <ul style="list-style-type: none"> <li>Griffith Hospital</li> </ul>	<p>Gosford Hospital</p> <ul style="list-style-type: none"> <li>Gosford Satellite unit</li> </ul> <p>Lismore Hospital</p> <ul style="list-style-type: none"> <li>Ballina Hospital</li> <li>Grafton Hospital</li> </ul> <p>Port Macquarie Hospital</p> <ul style="list-style-type: none"> <li>Coffs Harbour Health Campus</li> </ul> <p>John Hunter Hospital</p> <ul style="list-style-type: none"> <li>Maitland Hospital</li> <li>Muswellbrook Hospital</li> <li>Singleton Hospital</li> <li>Wansey Dialysis Centre</li> </ul> <p>Tamworth Hospital</p> <ul style="list-style-type: none"> <li>Inverell Hospital</li> <li>Taree Hospital</li> </ul>

## Appendix 2: Key performance indicators and outcome measures

In addition to Hub KPIs, the below KPIs and outcomes measures will be used to measure of the statewide RSC model:

### Outcome and performance measures for NSW Renal Supportive Care program

Measures 1a-7 are to be collected as currently via the ACI RSC group. Measures 8-10 are to be collected by the Ministry of Health.

Group Name	Number	Demographic details
Demographics	1a	Age
	1b	Comorbidity measure
	1c	Gender
	1d	Indigenous status
Group Name	Number	Indicator name
Appropriateness	2a	Number of conservatively managed Stage 4 or 5 CKD patients seen by the RSC service and time from access to this service until death
	2b	Percentage (%) of chronic dialysis patients withdrawing from dialysis seen by the RSC service and time from access to this service until death
	2c	Percentage (%) of chronic dialysis patients who are seen by the RSC service for symptom management or other non-end of life reasons?
Effectiveness	3a	Change in symptom burden (iPOS-Renal)
	3b	Change in functional status (Karnofsky)
	3c	Change in nutritional status (SGA-7)
	3d	Change in Quality of Life (EQ-5d-5L)
Experience	4a	Patient satisfaction
	4b	Family/carer satisfaction
Safety/appropriateness	5	Percentage (%) of patients managed by the RSC team with end of life care documented and available, or discussed but unable to be progressed
Appropriate nutritional management	6	Percentage (%) of patients managed by the RSC team consulted by a dietitian for nutritional assessment
Appropriate social work management	7	Percentage (%) of patients managed by the RSC team consulted by a social worker for social work assessment

Utilisation and economic data		
Measure		Purpose
8	Number of RSC HERO clinics established	Implementation progress
9	Impact on hospital utilisation, including unplanned admissions, ED presentations, separations, bed days, NWAUs	System impact
10	Telehealth utilisation, including emails, phone, video consultations and remote monitoring	System impact

### 2017/2018 service performance agreements indicators

- **Indicator MS2204** – Leading Better Value Care: Non-admitted service units established to support services provided to targeted patient cohorts (number)
- **Indicator MS2211** – Leading Better Value Care: Non-admitted patient service events provided to targeted patient cohorts (National Weighted Activity Unit [NWAU]).

## Appendix 3: Roles of the interdisciplinary team

The staffing for RSC services will depend on the availability of key positions to the renal unit and/or more widely within the LHD. The NSW RSC model is essentially a nurse-led model, so the crucial position within each health service is the RSC CNC or equivalent.

Other positions may be recruited locally or sourced through an outreach arrangement with the hubs or other LHDs.

This section provides more detail on the key roles. Suggested position descriptions for the CNC, dietitian and social worker positions are in Appendix 4.

### **Role of the RSC Clinical Nurse Consultant (or equivalent)**

The RSC CNC functions in a case worker capacity to directly provide clinical expertise and integrate the interdisciplinary components of care. This involves liaising with patients and their families, nephrologists, GPs, palliative care physicians, geriatricians, social workers, dialysis staff, dietitians, occupational therapists, physiotherapists and other care staff.

Key roles within renal, palliative and community services need to be identified as they are applicable to each renal unit, and the CNC will liaise with them.

The CNC at the hub will play an additional lead role in promoting best evidence based RSC. As RSC hinges on the capacity to deliver training to doctors, nurses and allied health staff from the hubs to staff at all networked sites, there is considerable coordination required. The CNC will play a role in the education programs and promote awareness of new developments in the field that should be implemented. Building the RSC capacity of health professionals will be a significant part of the CNC role within the hubs, as well as maintaining strong communication links with the RSC nurse at each renal unit linked with that hub.

### **Role of the nephrologist**

One nephrologist from each unit should be designated to lead the program in the renal unit. This person will be an existing staff member.

The nephrologist will liaise with the hub and work closely with the RSC nurse and other nephrologists and palliative care physicians (when available) in their unit to ensure that the principles of the RSC model are implemented and monitored. Although it is acknowledged that RSC has always been part of a nephrologist's role (despite it rarely being supported by a dedicated program), it is important to emphasise that this model is additional to usual nephrology care. That is, patients will continue to see their usual nephrologist, as well as receive RSC.

### **Role of the dietitian**

Attention to correct nutrition is a key component of the management of ESKD in general, but particularly so for those who are following a conservative non-dialysis pathway. The expertise of a dietitian is pivotal to this work in order to help delay and manage nutrition-related symptoms, electrolyte disturbances and malnutrition, which are associated with reduced quality of life, greater mortality and hospital admissions. There is extra time and effort required when working with patients on a conservative pathway or with troubling symptoms, compared to standard dietitian care of dialysis patients.

The dietitian will work closely with the RSC nurse and nephrologist in their clinics to ensure good nutrition guidance for patients and to ensure that family/carers have a good understanding of the specific dietary needs.

Dietitians are also key to the hubs, where they provide education and training for RSC to other dietitians in renal units across the state, and also participate in research and development related to nutrition for target groups of the RSC service.

### **Role of the social worker**

The social worker is pivotal in the team and assists with:

- counselling about decisions to initiate dialysis or withdraw from dialysis
- management of distress (for the family/carer and staff),
- providing access to relevant social support at a difficult time, including facilitating support groups for patients and carers
- financial assistance schemes
- advance care planning
- bereavement counselling.

Each of these are critical components of a successful RSC service and require adequate time and expertise.

Nephrologists will also be involved in each of these aspects of care, to a limited and variable degree.

Social workers based at a hub, will educate and mentor other social workers undertaking this role in the networked units, and will participate in research and development related to the role of the social worker in RSC.

### **Role of the palliative care specialist**

Where available, palliative care specialists at individual sites will provide expert symptom management and end of life care for patients of the RSC service, working closely with the RSC CNC. There will be strong linkage between the palliative care service and the renal unit.

Palliative care physicians from larger hospitals or the hubs may provide outreach services to units that do not have this service locally, by arrangement between the services. However, there will be some units (particularly those located in rural areas), where there are no provisions for palliative medicine. In these instances, the following roles may provide aspects of this service:

- GPs specialising in palliative care or with an interest in palliative care
- nurse practitioners specialising in palliative care or with an interest in palliative care.

Palliative care physicians from the hubs may provide a consultation-liaison service to these health professionals, by arrangement between the services.

In the hubs, there will be a full time palliative care specialist dedicated to RSC. Their role will include direct patient management, with an emphasis on symptom control, and the provision of education to senior and junior medical staff from all sites attached to their hub. Education can be facilitated through direct teaching (including regular seminars) or through webinar/videolink teaching as required. It is likely that different approaches to training will be required at differing sites. The overall aim is to increase the skills of current nephrologists and develop a new

generation of nephrologists and renal nurses who are comfortable at providing primary palliative care for patients with CKD/ESKD.

### **Other staff**

Where there is capacity, renal units should also consider the possible inclusion of an occupational therapist as part of the RSC service, particularly to support elderly frail patients. The role of an existing occupational therapist may be expanded to provide additional support for patients being managed as part of the RSC service.

### **Role of the quality improvement officer**

A collaborative program of RSC research is required to better understand the patient flow and quality outcomes in this emerging area of expertise. A quality improvement officer will be responsible for providing the necessary support to foster investigator driven research, including health service research and quality improvement. The quality improvement officer will also support investigators with ethics and governance applications, recruitment and follow up, and data extraction and data management.

This role is critical to the success and sustainability of the RSC program through enabling measurement and evaluation of the effectiveness of different aspects of the model.

### **Role of the administration officer**

The administration officer will provide support in relation to the educational component of the hubs, including online services and ongoing staffing and human resource administration.

## Appendix 4: Position descriptions for key roles

The following position descriptions are provided as a guide only. They must be adapted to meet local RSC circumstances and requirements.

For example, some of the dietitian and social worker responsibilities may be added as additional responsibilities to other existing positions to meet the needs of the RSC service. In these instances, a new position description need not be developed, but elements of the requirements for the RSC component will need to be added.

### **Renal Supportive Care (RSC) Clinical Nurse Consultant (CNC)**

**Position title:** Clinical Nurse Consultant [*insert appropriate grading*] – Renal Palliative Care

**Award/classification:** NSW Public Health System Nurses and Midwives (State) Award [*for appropriate grade*]

**Responsible to:** The position reports professionally to the [*insert appropriate Director of Nursing position*] with an operational report to the Director, Renal Service. This position will liaise with the [*insert appropriate position*] to ensure a professional link to the palliative care team.

#### **Position summary**

The CNC Renal Palliative Care is an expert practitioner who, through leadership, facilitates research based clinical practice which is creative, visionary and relevant. The CNC will promote and develop the renal palliative care nursing service, fostering excellence in clinical, educational, research and professional leadership. She/he contributes to quality healthcare by collaborating with healthcare providers and consumer groups, developing clinical practice standards and evaluating their outcomes.

When based in a hub, the RSC CNC is responsible for providing professional support and expertise to other RSC CNCs in their wider network in the form of mentoring, education, research, facilitation of training and advocacy. This position will carry extra responsibility and will require a high level of expertise, proficiency and advance practice skills.

Essential criteria:

1. Registered nurse with at least five years post-registration experience, with at least five years experience in nursing, with minimum three years in renal nursing and/or palliative care.
2. Demonstrated understanding of nursing processes and their contributions to best practice principles.
3. Proven clinical leadership skills in research and/or education.
4. Relevant tertiary qualifications.
5. High level of interpersonal and communication skills.
6. Consulting experience in assessment and management of patients.
7. Computer literacy.
8. Current driver's licence.

#### **Key performance areas/duties**

The CNC – Renal Palliative Care is:

- a professional nurse clinician who effectively utilises a consultative process to optimise clinical practice and patient/client management within the area of renal palliative care
- responsible for facilitating the setting and reviewing of standards of nursing practice to achieve excellence in patient care
- accountable for the evaluation of outcomes through applied nursing research and development of best practice models
- responsible for facilitating the acquisition of specialised skills to nurses and other health care professionals by leading clinical practice
- committed to the ongoing development of self and others in the pursuit of professional excellence
- participates in the strategic development of the both the renal and palliative care services in the *[hospital]* and community areas.

### **Clinical service and consultancy**

The CNC provides expert clinical advice to patients, carers and other health care professionals within the defined speciality. The CNC develops and facilitates implementation, and evaluates care management plans for patients with complex health needs.

Functions:

- Maintains close clinical involvement in the management of renal supportive care patients, including home visits.
- Ensures that, when consulted, patients are assessed and strategies are formulated to enable nursing and medical staff to meet the patient's goals, including physical, psychosocial, educational and spiritual goals.
- Ensures that patients managed on a non-dialysis pathway are integrated into the full range of multidisciplinary care within the renal unit.
- Demonstrates expert clinical knowledge through advanced clinical problem solving and decision making. For example, considers interventions for the management of symptoms in advanced CKD.
- Identifies areas for the improvement of clinical practice and implements relevant quality activities and research.
- Develops specialised education resources for the patient/carer/community to be utilised by other healthcare professionals.
- Provides a complex and expansive clinical consultancy service within a mixed clinical environment and/or across multiple service groups (e.g. hospital, community, home) and/or patient populations (e.g. paediatric, adult, geriatric, and hospice) and incorporating a range of modalities (e.g. health promotion/preventative health, symptom management, treatment and goal-based care).
- Undertakes primary responsibility for formalised ongoing clinical supervision processes for CNC peers (e.g. peer review of clinical practice at CNC level).
- As an expert, conducts systematic evaluation of clinical practice including, if required, in conjunction with the Director, Renal Service *[and if position exists, the Director of Palliative Care]*.

### **Clinical leadership**

The CNC provides leadership that facilitates the ongoing development of clinical practice which is creative, visionary and relevant.

#### Functions:

- Provides leadership in the ongoing review of clinical practice for a complex service, i.e. a service provided at multiple sites or by multiple CNCs across the LHD.
- Establishes networks to enhance work practice with both the renal service and the palliative care service.
- Assumes leadership roles that promote broader advancement of clinical practice (e.g. membership of journal editorial boards, leadership of position papers, and development of advanced nursing practice standards).
- Provides leadership in state, national and/or international associations and/or specialist clinical groups.
- Initiates collaborative ventures with academic colleagues (e.g. major projects determining the current status and influencing future directions of renal supportive care nursing practice).
- Enhances clinical practice by initiating creative approaches to practice.

#### Research

The CNC utilises research to contribute to and influence the body of health knowledge. The CNC provides clinical leadership in research practice, whilst creating and promoting an environment for research that acknowledges nursing.

#### Functions:

- Demonstrates a systematic, planned and collaborative approach to research for self and others.
- Adapts and applies related scientific research to the clinical speciality, e.g. research from other scientific disciplines, such as palliative care, psychology, business, applied to nursing.
- Initiates original research projects.
- Disseminates own research results through specialised publications and presentations.
- Acts as principal researcher in significant/large scale research studies (i.e. those attracting research funding/grants at multiple sites, making a large contribution to nursing science).
- Works in collaboration with the Director of Renal Medicine and Professors of Nursing and/or other health care providers to identify, conduct, facilitate and promote research projects.
- Analyse all available research information and problem solving, enabling the implementation of change in clinical practice.

#### Education

The CNC identifies, facilitates, provides and evaluates educational processes to enhance the knowledge and skill base of self, health professionals and consumer groups.

#### Functions:

- Regularly liaises with the Director, Renal Service *[and if position exists, the Director of Palliative Care]*.
- Regularly liaises with the relevant Nurse Unit Manager and Nurse Educator in each department to identify staff educational needs and develop strategies for the education of staff, consumer groups, patients and others.
- Develops educational resources for target groups.
- Establishes links and participates with universities and other groups, providing education and skill development for health professionals.

- Develops, designs, implements and evaluates the education of patients with a life-threatening illness.
- Is actively involved in curriculum development and the review of specialist nursing courses conducted by the [hospital/LHD] to enhance renal palliative care.
- Participates in the development and delivery of postgraduate tertiary programs.
- Provides a significant contribution to the direction of clinical nursing education within the speciality, e.g. involvement in the development of expansive programs (extra-regional, state or national education programs, advanced practice speciality programs, or education involving large numbers of nurses within the speciality).
- Participates in staff education at ward level by provision of regular tutorials in all appropriate departments.

### **Clinical services planning and management**

The CNC participates in formal processes for the strategic and operational planning for the clinical service. The role also involves the organisation and delivery of specialised consultant service.

Functions:

- Provides ongoing comprehensive analyses of current practice and the impact of new directions on the clinical speciality service.
- Initiates, develops, implements and evaluates strategic changes for the clinical speciality/service.
- Undertakes primary responsibility for preparation, implementation and evaluation of annual plan for clinical service, e.g. interdisciplinary business plan.
- Manages complex projects relating to significant practice change for the organisation.
- Facilitates the development and evaluation of standards for nursing practice.
- Incorporates reflective practice and critical thinking amongst health professionals.
- Review procedures and policy relevant to the care of renal supportive care patients and be actively involved in formulation and updating of same when necessary.

### **Performance evaluation standards**

- The standard of specialised patient care as measured by evaluation of outcomes.
- The contribution to the nursing research body of knowledge.
- The contribution to professional development of nursing staff and other health care workers.
- The standard of own professional development as measured by engagement in education programs, conferences, seminars, publications and presentations.

### **General duties/responsibilities**

- Participates in quality improvement activities and provides a high level of customer service to patients, families, staff and others.
- Complies with the Code of Conduct, OHS, EEO, Smoke Free, Bullying and Harassment, and other [insert name of health service] policies and procedures.
- Maintains strict confidentiality in relation to all patient, staff, workplace and LHD matters.
- Uses resources efficiently, minimising cost and wastage, and ensures waste products are disposed of in line with waste management guidelines.
- Reports any risk identified (e.g. OHS, clinical, financial, technology, public image) to the manager and requests a risk assessment. Participates in risk management activities.

- Implements the principles of multiculturalism at work by ensuring services within their area of responsibility are accessible and culturally appropriate to consumers. This includes cultural sensitivity and appropriateness of services for Aboriginal people.
- Cooperates with other staff members to ensure that duty requirements and standards are being met and maintained.
- Performs all other delegated tasks appropriately and in line with grading and capabilities.

## **Renal Supportive Care (RSC) Dietitian**

**Position title:** Dietitian – Renal Palliative Care

**Award/classification:** NSW Health Service Health Professionals (State) Award - Dietitian [*for appropriate level*]

**Responsible to:** The position reports professionally to the [*insert appropriate Nutrition Manager/Allied Health Head position*] with an operational report to the Director, Renal Service. This position will liaise with the [*insert appropriate position*] to ensure a professional link to the Palliative Care team.

### **Position summary**

This position will take a leadership role within the specialty of renal nutrition specifically to:

- further develop, implement and promote renal nutrition based on evidence based practice, which provides high quality care that meets the needs of persons with renal disease, particularly those with end stage kidney disease not undergoing renal replacement therapies, and those undergoing therapy but experiencing a high symptom burden and/or with severe comorbidities
- provide a consultative nutrition service to other health care staff within the renal service and the health service more generally
- lead quality improvement activities and service evaluation in order to ensure continual improvement in clinical practice and service delivery
- contribute to the development and coordination of education activities related to renal nutrition within the [*insert name of health service*]
- inform and advise nutrition service management and the renal service on clinical service planning, development, practice and redesign in response to service demand and client needs.

When based in a hub, the Dietitian – Renal Palliative Care will be responsible for providing professional support and expertise to other renal dietitians in their wider network in the form of mentoring, education, research, facilitation of training and advocacy. This position will carry extra responsibility and will require a high level of expertise and proficiency and advance practice skills.

Essential criteria:

1. Eligible for full membership of the Dietitians Association of Australia.
2. Extensive experience in the provision of clinical nutrition services, especially within the area of renal nutrition and dietetic practice.
3. Demonstrated high level interpersonal, communication and negotiation skills.
4. Demonstrated ability to undertake and complete quality improvement and service evaluation processes.
5. Demonstrated ability to work autonomously and to perform novel and complex tasks.

6. Demonstrated ability to provide student supervision and clinical supervision for staff.
7. Demonstrated ability to contribute to service management via review of service provision, practice development and/or redesign to improve services, operations or outcomes.
8. Current driver's licence.

## **Key performance areas/duties**

### *Clinical*

- Contributes to the total health care needs and expectations of clients, clinicians and staff, and the community by providing and maintaining a high standard of nutritional care practice in the renal service.
- Complies and adheres to statutory requirements of the *[insert name of service]* and the nutrition and renal services, policies, practices and procedures.
- Complies with directives from management of nutrition services and renal services.
- Cooperates with other staff members to ensure that duty requirements and standards are being met and maintained.
- Adopts existing/established clinical practice guidelines and/or is responsible for the implementation of evidence based clinical practice guidelines for use with renal patients within *[insert the name of the service]*. For example, considers nutritional approaches to management of gastrointestinal symptoms in advanced CKD.
- Ensures the review and development of nutrition education resources specifically targeted to patients of the renal supportive care service and contributes to the review of other nutrition resources as required.
- Provides nutrition care intervention to patients of the renal supportive care service as follows:
  - a. coordinates the provision of adequate and appropriate nutrition and fluid management for patients referred for nutrition intervention
  - b. assesses the nutrition needs of patients prior to commencement of nutrition intervention, e.g. using subjective global assessment or other tools
  - c. prescribes and implements therapeutic diets to satisfy patients' medical conditions
  - d. educates patients and carers when appropriate regarding nutrition plans required to be followed on discharge and to arrange appropriate follow up
  - e. arranges for patients to attend appropriate follow up services.
- Participates in outpatient clinics for clients of the renal supportive care service.
- Provides group outpatient services as required.
- Records and updates patient nutrition progress in both medical notes and nutrition service records according to nutrition service standards.
- Liaises with other health professionals regarding the nutrition care of inpatients and outpatients.
- Attends team meetings and case conferences as required.
- Records and maintains statistics as required by the renal palliative care service and the nutrition service, and submits in a timely manner.
- Complies with the policies and procedures relating to the renal service and the nutrition service.
- Attends and is engaged in appropriate clinical dietitian/nutrition service/renal service team meetings.
- Attends seminars and conferences as appropriate to update knowledge and skills in clinical nutrition and dietetic, especially in relation to renal dietetics and specific work and project areas.

- Participates in staff development and yearly staff appraisal programs.
- Continues to acquire or update knowledge and skills which will enhance the performance of these duties especially in the area of renal dietetics.
- Complies with the Dietitian's Code of Professional Conduct and Statement of Ethical Practice.

### **Operational/advisory**

- Informs and advises nutrition service's management on renal service development, practice and design.
- Assists and provides guidance to nutrition service management in the development of clinical services that is responsive to renal service demand and the needs of renal patients.
- Acts as consultant in the area of renal nutrition and dietetic practice within *[insert name of service]*.
- Assists nutrition service management in the coordination and integration of renal nutrition services for patients of the renal supportive care service in the inpatient, outpatient and community setting in order to facilitate the efficient and effective delivery and continuum of care.
- Represents *[insert name of health service]* on relevant steering and advisory committees, working parties, forums and meetings as appropriate.
- Leads the development and implementation of policies and procedures which support the provision of an effective and efficient renal nutrition service specifically to patients of the renal supportive care service.
- Leads the application of evidence based practice and the development and implementation of standards of nutrition care practice within the area of renal nutrition.
- Provides induction to and ensures mentorship for newly employed clinical dietitians.

### **Quality improvement**

- Takes a leadership role within the quality improvement program for renal supportive care clients through:
- Promotes a culture of quality improvement in the workplace with staff.
- Identifies opportunities for improvement in clinical practice within, but not exclusive to, dietetics for patients of the renal supportive care service.
- Develops and leads quality improvement activities within but not exclusive to, dietetics for patients of the renal supportive care service.
- Assists with work practice reviews to ensure current standards and competencies are maintained.
- Leads implementation of recommendations for improvements that result from work practice reviews.

### **Strategic**

- Contributes significantly to strategic planning within renal services and nutrition services.
- Develops implements and reports on key performance indicators for the renal supportive care service.
- Leads the implementation of an operational plan for renal supportive care, and provides feedback regarding progress to the nutrition service and renal service management.
- Reports on the achievement of performance targets.

- Advises the nutrition service and renal service management regarding matters relating to delivery of current and future renal nutrition services to patients of the renal supportive care service.
- Consults to and advises renal clinical networks and other appropriate service stakeholders regarding renal nutrition.
- Assists in the preparation of enhancement submissions for resourcing of enhanced services and service delivery gaps.

### **Teaching and research**

- Provides supervision to nutrition and dietetic students and, in particular, oversees their learning within the area of renal dietetics.
- Provides clinical training particularly in the area of renal dietetics to level 1/2 dietitians and dietitian assistants.
- Leads the development and implementation of an education/in-service programme to medical, nursing and allied health within the area of renal nutrition.
- Supports and facilitates research in the workplace as appropriate and with due consideration given to service priorities and capacity of staffing levels.

### **General duties/responsibilities**

- Participates in quality improvement activities and provides a high level of customer service to patients, staff and others.
- Complies with the Code of Conduct, OHS, EEO, Smoke Free, Bullying and Harassment and other *[insert name of health service]* policies and procedures.
- Maintains strict confidentiality in relation to all patient, staff, workplace and LHD matters.
- Uses resources efficiently, minimising cost and wastage, and ensures waste products are disposed of in line with waste management guidelines.
- Reports any risk identified (e.g. OHS, clinical, financial, technology, public Image) to the manager and requests a risk assessment. Participates in risk management activities.
- Implements the principles of multiculturalism in their work by ensuring services within their area of responsibility are accessible and culturally appropriate to consumers. This includes cultural sensitivity and appropriateness of services for Aboriginal people.
- Cooperates with other staff members to ensure that duty requirements and standards are being met and maintained.
- Performs all other delegated tasks appropriately and in line with grading and capabilities.

## **Renal Supportive Care (RSC) Social Worker**

**Position title:** Social Worker – Renal Palliative Care

**Award/classification:** NSW Health Service Professionals (State) *[for appropriate level]*

**Responsible to:** The position reports professionally to the *[insert appropriate social work manager position]* with an operational report to the Director, Renal Service. This position will liaise with the *[insert appropriate position]* to ensure a professional link to the Palliative Care Team.

### **Position summary**

Social workers operate at the interface between people and their social, cultural and physical environments. The Renal Supportive Care (RSC) Social Worker will have an essential role in the

RSC team, promoting the wellbeing of clients and their families through the provision of support and counselling, assessment, advocacy, education, information provision, advance care planning and practical support. Social workers are involved throughout all the stages of RSC, from early decision making about treatment options through to bereavement support for families.

The RSC Social Worker will have a recognised speciality in the area of RSC and will contribute to quality health care in a RSC setting by collaborating with other health care providers and consumer groups, undertaking research and providing education and guidance to other team members based on a psychosocial model of care. The social worker will have the ability to operate autonomously and to apply professional knowledge and judgement in the area of RSC.

When based in a hub, the RSC Social Worker will be responsible for providing professional support and expertise to other renal social workers in their wider network in the form of mentoring, education, research facilitation of training and advocacy. This position will carry extra responsibility and will require a high level of expertise and proficiency and advance practice skills.

#### Essential criteria:

1. Eligibility for membership of the Australian Association of Social Workers (AASW) with at least three years clinical experience.
2. Demonstrated high levels of clinical experience, possessing extensive specialist knowledge in the area of renal social work and/or palliative care.
3. Experience working within a renal service supporting a wide range of renal patients and differing types of renal replacement therapies.
4. Experience in end of life care, including knowledge and experience in advance care planning, the psychosocial aspects of caring for dying people and their families, grief counselling and community supports for those impacted by chronic illness and an increasing decline in health status.
5. A high level of interpersonal and communication skills including an ability to plan and coordinate client care independently as well as being able to operate effectively within a multidisciplinary team.
6. Demonstrated understanding of the application of primary health care practice and principles, and the interface between acute, sub-acute and community based service provision.
7. An understanding and knowledge of Aboriginal social, cultural and economic issues; a capacity to flexibly develop local responses to community needs; and cross-cultural communication skills.
8. Demonstrated effective verbal and written communication and ability to use a computer keyboard and work with word-processing and e-mail software applications.
9. Current driver's licence and willingness to travel as required.

#### **Key performance areas/duties**

##### *Clinical*

- Demonstrate advanced clinical reasoning skills and operate autonomously with minimal direct supervision.
- Provide clinical services of a complex nature and exercise independent professional judgement.
- Participate in a social work capacity in all aspects of RSC to ensure that the psychosocial needs of clients and their families are met.
- Provide social casework services.

- Provide supportive and therapeutic counselling to renal palliative care clients and their families.
- Undertake psychosocial assessments of clients and their families who are at risk emotionally and where relationships are under strain, and who may be experiencing stressors relating to practical concerns such as financial, accommodation or transport issues.
- Participate in the delivery of educative and/or therapeutic programs for the RSC client group.
- Provide information and support in end of life decision making including advance care planning, guardianship, completion of wills and funeral planning.
- Provide support and information on accessing health and community services (including hospice) and to link clients with relevant resources and services as necessary.
- Advocate for clients and their families as they access services and negotiate the health system.
- Participate in multidisciplinary case conferences, intake, client reviews, ward meetings and training programs.

#### *Administrative*

- Provide the manager with monthly activity reports and other reports as requested.
- Complete occasion of service information within the required reporting period and other statistical information monthly, or as required.
- In line with healthcare record procedure, maintain up to date client and administrative records in accordance with NSW Ministry of Health and *[insert name of LHD]* procedure.
- Involvement in planning, implementing, evaluating and reporting on services.

#### *Professional*

- Participate in educational programs and maintain professional standards and links with other social workers in the health district.
- Have a consultative role in RSC and provide in-services and other education activities to other social workers and health workers.
- Identify gaps in services and assess for improvement in delivery.
- Take a leadership role in ongoing education programs and team quality improvement activities in order to maintain and improve the standard of care as per NSW Ministry of Health policies, ACHS Clinical Indicators and AASW requirements.
- Identify opportunities for improvement in clinical practise, develop and lead ongoing quality improvement activities with other staff.
- Liaise with the social work senior and renal managers to receive and provide peer support, consultative advice and supervision.
- Receive regular supervision from a social work senior manager according to the AASW guidelines.
- Provide supervision for undergraduate social work students as required.
- Provide supervision for lower graded health professionals, technical and support staff as required.
- May conduct clinical research as required.
- May be required to manage specific tasks, research or projects.

#### *Team*

- Actively participate in team activities.

- Participate in the relevant activities and meetings of the renal multidisciplinary team.
- Foster and maintain an effective communication framework that facilitates an information flow between team members, consumers and their families and other relevant professionals.
- Establish and maintain liaison with medical practitioners, healthcare providers and related community services as appropriate.
- Participate where relevant in case management activities with other relevant health staff and/or agencies within the confines of appropriate confidentiality/privacy statements.
- Provide support to staff where appropriate and to facilitate team meetings after stressful situations as needed.

#### *General duties/responsibilities*

- Participates in quality improvement activities and provides a high level of customer service to patients, staff and others.
- Complies with the Code of Conduct, OHS, EEO, Smoke Free, Bullying and Harassment and other *[insert name of health service]* policies and procedures.
- Maintains strict confidentiality in relation to all patient, staff, workplace and LHD matters.
- Uses resources efficiently, minimising cost and wastage, and ensures waste products are disposed of in line with waste management guidelines.
- Reports any risk identified (e.g. OHS, clinical, financial, technology, public image) to the manager and requests a risk assessment. Participates in risk management activities.
- Implements the principles of multiculturalism in their work by ensuring services within their area of responsibility are accessible and culturally appropriate to consumers. This includes cultural sensitivity and appropriateness of services for Aboriginal people.
- Cooperates with other staff members to ensure that duty requirements and standards are being met and maintained.
- Performs all other delegated tasks appropriately and in line with grading and capabilities.