



Key Elements of Conservative Renal Care

Ontario Renal Network

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Table of Contents

Executive Summary	4
1.0 About This Document	6
1.1 Purpose and Use	6
2.0 Conservative Renal Care	6
2.1 Current State of Conservative Renal Care.....	7
3.0 FOUNDATIONS IN CARE	8
3.1 Person-Centred Approach	8
3.2 CRC Team	8
3.3 Care Coordination & Navigation	9
4.0 PATIENT AND CAREGIVER EDUCATION	9
5.0 CONSIDERATIONS FOR TREATMENT DECISIONS	11
5.1 Considerations for Conservative Renal Care Treatment Decision	11
5.2 Person-Centred Decision Making	12
6.0 DELIVERY OF CRC	13
6.1 Initiation of CRC.....	13
6.2 Frequency of Visits	13
6.3 Comprehensive & Holistic Assessment and Care Planning	14
6.4 Active Management of Renal Function.....	16
6.5 Crisis Management.....	17
6.6 Care Collaboration and Transitions in Care.....	19
7.0 END OF LIFE CARE	20
7.1 Conservative Renal Care Team Role During End of Life Care	20
7.2 Delivering End of Life Care.....	20
7.3 Considerations for Medical Assistance in Dying.....	22
8.0 BEREAVEMENT SUPPORT	22
9.0 APPENDIX A: ACKNOWLEDGEMENTS	24
CRC Task Group Members	24

Other Contributors	25
10.0 APPENDIX B: REFERENCES	26
11.0 APPENDIX C: GLOSSARY	27
12.0 APPENDIX D: DOMAINS OF CARE	29
13.0 APPENDIX E: CONSERVATIVE RENAL CARE TEAM FUNCTIONS	30

EXECUTIVE SUMMARY

Below is a summary of the key elements outlined in this document.

CONSERVATIVE RENAL CARE

Conservative Renal Care (CRC) is a holistic, person-centred and active treatment option for people with end-stage kidney disease (ESKD), which focuses on prioritizing quality of life, providing support and advice, addressing symptoms, and maintaining kidney function. By definition, CRC does not include renal replacement therapy - dialysis and transplant.

CRC EDUCATION AND TREATMENT DECISION

People receiving care in MCKC should receive education on all treatment modalities, including CRC when their 2-year KFRE is between 20% and 40% or when their eGFR is approaching 15mL/min. Those experiencing significant comorbidities, limited functional status, having self-reported high symptom burden or decreased quality of life may benefit from a detailed discussion about the CRC treatment option.

Treatment decisions for CRC should be person-centred and supported by a shared decision-making process.

DELIVERY OF CRC

CRC should be delivered by a multidisciplinary care team including, but not limited to, the person with ESKD, their substitute decision maker(s) (SDM), their family and caregiver(s), a nurse, a nephrologist, a pharmacist, a dietitian, a social worker and a spiritual care provider (where available and requested). A designated Care Coordinator should be identified (either at the program or through the community) as the central point of contact for the person, their SDM, family and caregiver(s).

The CRC team should complete a comprehensive assessment of the person, their SDM, family and caregiver(s)'s needs at least twice a year. Assessments should evaluate needs across all domains of care. More frequent assessment may be required based on severity of illness. The CRC Team should discuss, develop, document and share an individualized, person-centred comprehensive care plan with the person, their SDM, family and caregiver(s) as well as members from home and community care who fall within the circle of care.

The CRC Team should ensure people receiving CRC, their SDM, family and caregiver(s) understand that a crisis (e.g., severe or distressing event) may occur and what to do if they experience a crisis as their illness progresses. The SDM, family and caregiver(s) should be directed on who to contact in times of crisis (e.g., available on-call services), when to contact emergency medical services and what information to provide to healthcare providers outside the CRC Team.

People receiving CRC may follow many diverse care pathways based on their goals of care, preferences and treatment decisions, and also based on local treatment resources. Establishing a tailored, person-centered care plan is essential to high quality CRC.

END OF LIFE CARE & BEREAVEMENT SUPPORT

The CRC Team should continue to support the person receiving CRC, their SDM, family and caregiver(s) throughout end of life. As needs become more complex, the CRC team should consult with a palliative care specialist or other specialist and make referrals if the care required is beyond the competencies of the CRC team to deliver.

Planning and delivery of end of life care should focus on the relief of symptoms, with an emphasis on maintaining quality of life and maximizing comfort. Culturally safe bereavement support services and counseling should be offered proactively and throughout the care journey, including after the death of the person receiving CRC.

1.0 ABOUT THIS DOCUMENT

The Ontario Renal Network (ORN), part of Ontario Health, manages the delivery of chronic kidney disease (CKD) services in the province. Working with 27 Regional Renal Programs (RRPs), the ORN's evidence-based decisions and advice help provide effective planning, programs and funding to support a continuously improving kidney care system in Ontario. The ORN is guided by a four-year strategic plan, the Ontario Renal Plan. The Ontario Renal Plan 3 (2019-2023) lays out goals and strategic objectives for how to improve the lives of people at risk for and living with chronic kidney disease. The Ontario Renal Plan 3 outlines a strategic objective to strengthen the early identification and support for people who would benefit from a palliative approach to care.

The ORN is focusing efforts to facilitate early identification and support of people living with CKD who choose CRC and build capacity among renal care providers to integrate a palliative approach to care.

1.1 Purpose and Use

The Key Elements of Conservative Renal Care outlines a clear definition of CRC and the key components in the delivery of this care. This document will enable Ontario's Regional Renal Programs (RRP) to:

- Use the same terminology and delivery expectations.
- Offer and recommend CRC as a treatment modality, where appropriate.
- Facilitate the recognition of healthcare needs for people who may benefit from a palliative approach to care.

It is recognized that clinical processes for delivering CRC and availability of resources differ from region to region. This document is not intended to detail how this care is delivered, but to identify the key components of person-centred CRC. The delivery of the Key Elements of CRC will reflect each region's population needs and resources and thus will differ across regions and programs.

While the document focuses on the key elements of person-centred CRC, it is also important to recognize and address the needs of the substitute decision makers (SDM), family and caregivers. Throughout the document specific considerations are outlined for supporting the SDM, family and caregivers of someone receiving CRC, as they navigate the CRC journey.

This document was developed through consultation with a multidisciplinary task group, including patient and family advisors, partners in home and community care, the Ontario Palliative Care Network Secretariat, and clinical and administrative representatives from 11 Regional Renal Programs. The full membership list can be found at Appendix A. In preparing the Key Elements of Conservative Renal Care, the task group reviewed the ORN [Multi-Care Kidney Clinic \(MCKC\) Best Practices](#) document [1], expert opinion, the Ontario Palliative Care Network Health Services Delivery Framework [2], the British Columbia Renal Agency's Conservative Care Pathway [3] and Alberta Health Services' Conservative Kidney Management pathway and toolkit [4].

2.0 CONSERVATIVE RENAL CARE

CRC is a treatment for people with ESKD that does not include dialysis or transplant. In 2015, the ORN adopted the Kidney Disease Improving Global Outcomes definition of CRC [5]. Conservative renal care is planned holistic person-centred care for people with ESKD (e.g., stage 5 CKD) that includes:

- Active management, to maximize comfort and quality of life, to minimize adverse events or complications and delay, as much as possible, the progression of CKD.
- Providing those who choose CRC, their SDM, family and caregiver(s) with physical, practical, emotional, psychological, social, cultural and spiritual supports and referrals to additional support as needed.
- Engaging the person, their SDM, family and caregiver(s) in decision-making, and as members of the care team.
- Ongoing, comprehensive and holistic assessment of the person, their SDM, family and caregiver's needs across all domains of care (See Appendix D) [6].
- Collaborative development of a comprehensive person-centred care plan that documents the needs, preferences and decisions of the person receiving CRC across all domains of care [6], and aligns with their expressed wishes, values, beliefs, and identified Goals of Care [5].

Palliative care is an essential component of CRC that focuses on relieving the person's suffering and improving their quality of life. It should be integrated throughout the care trajectory.

CRC can sometimes be confused with dialysis discontinuation and dialysis with a palliative intent. In dialysis discontinuation, a person on chronic dialysis elects to withdraw from this treatment. In rare cases, a person may withdraw from dialysis because a viable access can no longer be attained. Without dialysis, ongoing care for people who choose to withdraw from dialysis will focus on comfort to end of life. Dialysis with a palliative intent is where dialysis is used, often near end of life, to manage symptoms such as dyspnea or to treat people who are unable to cope with a full dialysis prescription but who do not wish to discontinue dialysis altogether. People who choose CRC will not have any form of dialysis as part of their treatment.

QUALITY OF LIFE & SURVIVAL ON CRC

While dialysis prolongs life for most people with ESKD, those who are older and with higher levels of comorbidity and poorer functional status may experience decreased quality of life and limited survival advantage with dialysis initiation [7]. Alternatively, CRC can enable people to maintain a better quality of life, is less invasive than dialysis and, for some people, has shown similar survival rates to dialysis [8-12].

2.1 Current State of Conservative Renal Care

Across Canada, CRC is a recognized treatment for people approaching ESKD. In 2016, experts in Alberta developed a Conservative Kidney Management pathway and toolkit for patients and care providers focused on supporting people's quality of life, symptom management and living well without dialysis [4]. Similarly, in July 2017, the British Columbia Renal Agency developed a Conservative Care Pathway, which outlines five phases of care [3].

In 2017/18, the Ontario Renal Network conducted a current state analysis of Ontario's 27 Regional Renal Programs. Findings suggest that there is no consistent approach to supporting or treating people who choose this modality in Ontario. Many programs leverage their Multi-Care Kidney Clinic (MCKC) resources to support people who choose CRC. A small number of programs have specialized clinics for CRC or provide this care within palliative care clinics. A few programs follow a primary care led model, where the primary care provider manages the person's overall care and the Regional Renal Program provides secondary care for kidney management.

3.0 FOUNDATIONS IN CARE

The elements below are considered foundational to care delivery and should be considered throughout a person's CRC journey.

3.1 Person-Centred Approach

As highlighted in the MCKC Best Practices document, person-centred care is a fundamental element of all care delivered through the MCKC. Person-centred care is an approach to care that views people using health services as equal partners in planning, developing and monitoring care to make sure the care they receive meets their needs [1]. Full details on enabling a person-centred approach to care in Ontario's MCKC can be found in the ORN MCKC Best Practices. In addition, the Ontario Palliative Care Network Health Services Delivery Framework provides detailed recommendations for the delivery of person-centred palliative care [2].

3.2 CRC Team

People who choose CRC should have access to a multidisciplinary team of health care providers. The CRC team can be made up of staff within the MCKC or exist as part of a designated CRC clinic. This team should exist within the Regional Renal Program. It is important for members of the CRC Team to have the necessary renal and primary level palliative care competencies (see the [Ontario Palliative Care Network's Palliative Care Competency Framework](#)) and are working to their full scope of practice. Care team functions are outlined in Appendix E. The CRC Team includes but is not limited to:

- Person who chose CRC and their SDM,
- Family and Caregiver(s)
- Nurse
- Nephrologist
- Pharmacist
- Dietitian
- Social Worker
- Spiritual Care Provider (where requested and available).

Although not a member of the CRC Team at the RRP, a person's primary care provider should be engaged throughout their journey to support their on-going care in the community.

The most responsible medical provider (MRMP) co-ordinates the medical care for a person. Typically, for a person who chooses CRC the issues associated with ESKD are dominant, so the MRMP will be the Nephrologist in association with other CRC team members. However, the needs and preferences of the person who chooses CRC should be considered when determining the most appropriate MRMP. For example, in cases where the individual chooses to receive their care at home, the primary care provider may assume the role of MRMP and the nephrologist will be engaged as a secondary care provider. When closer to end-of-life, the primary care physician or a palliative care specialist may become the MRMP as palliative care issues become dominant. Good communication and timely transfer of the MRMP role is important. Refer to Section 8.3 for details on collaborations and transitions in care.

CONSIDERATIONS FOR THE SDM, FAMILY & CAREGIVER(S): The SDM, family and caregiver(s) of someone receiving CRC are critical members of the CRC team. Healthcare professionals should acknowledge these individuals and their active role in supporting the person receiving CRC.

BUILDING COMPETENCY TO DELIVER PALLIATIVE CARE

A palliative approach to care should be introduced early and integrated throughout the care trajectory for the person choosing CRC. The CRC Team will need to build their capacity to deliver palliative care and may require significant coordination with palliative care services in the hospital, home and community. The [Ontario Palliative Care Network's Palliative Care Competency Framework](#) outlines necessary skills to deliver palliative care according to professional scope of practice and should be consulted by the CRC team [2]. Building primary level palliative care competencies within the Regional Renal Program will be fundamental to caring for all people with CKD who would benefit from palliative care.

3.3 Care Coordination & Navigation

The CRC Team will work closely with partners in primary care, palliative care, hospice, and home and community care to deliver CRC. Care coordination and navigation with these partners are vital to ensuring that care is seamless and integrated.

CARE COORDINATOR

To ensure accountability for essential care coordination functions, a designated Care Coordinator should be identified. Programs can identify a Care Coordinator within the renal team (e.g., nurse or social worker) or the community (e.g. home and community care coordinator, HealthLinks coordinator, Indigenous navigator, etc.). For example, a single Care Coordinator could be identified in the community to ensure the person has access to one Care Coordinator throughout their CRC journey. Alternatively, when renal issues tend to be dominant, a nurse or social worker at the Regional Renal Program may be identified as the Care Coordinator. Later, as end-of-life issues predominate the Care Coordinator function could be transferred to a community or palliative care nurse. Communication around this transition of care is important to enable collaboration and ensure familiarity with the individual's case history and ongoing needs.

The Care Coordinator serves as the central point of contact for the person receiving CRC, their SDM, family and caregiver(s) and acts as their advocate. The Care Coordinator does not need to be available on call but does need to have a care plan in place to respond to urgent and ongoing needs for home, social and community care services. The Care Coordinator should ensure care is delivered according to the comprehensive and holistic assessment and care plan (See Section 6.3).

4.0 PATIENT AND CAREGIVER EDUCATION

Most people being cared for in the MCKC will receive education on treatment options between a 2-Year Kidney Failure Risk Equation (KFRE₂) of 20% and 40% or when eGFR falls towards 15 mL/min(1). Refer to [MCKC Best Practices](#) for general components of effective treatment options education [1]. Healthcare providers should ensure that CRC education is provided, including information about the prognosis for people who choose CRC. Refer to [Approaches to Conservative Renal Care Conversations](#), a resource for providers, for tips on discussing CRC with people with advanced CKD, their families and caregiver(s).

CONCEPTS FOR CRC MODALITY EDUCATION FOR PEOPLE WITH ADVANCED CKD, THEIR SDM, FAMILY AND CAREGIVER(S):

- Ensure the person choosing CRC, their SDM, family and caregiver(s) understand what they can expect from this treatment option, including describing what treatments may be included and discussing the benefits and side effects of each treatment (See Section 6.4). Refer to **Approaches to Conservative Renal Care Conversations** for details.
 - It should be emphasized that CRC is an active treatment option that prioritizes quality of life and symptom management. Those choosing CRC should understand that with CRC their kidney function and overall health likely will continue to decline, but they will receive treatment to maintain their quality of life and manage their symptoms.
 - Discuss that, as long as they wish, the person will receive high quality medical management to delay the decline in their kidney function. Quality of life considerations and individual preferences will be used by the CRC team to help support treatment decisions to initiate or discontinue strategies to actively manage CKD.
- Describe the care team, team member roles and how often the person choosing CRC can expect to meet with each type of team member.
 - Identify the Care Coordinator and MRMP, what their roles are and how they can be contacted when needed.
 - Discuss the role and responsibilities of an SDM with the patient, their family and caregiver(s). Ensure that an SDM is identified and documented. For more information refer to ORN's [Person-Centred Decision Making Resources](#).
 - Describe any partners in home and community who will be involved in providing care.
- Define and introduce the concept of crisis (e.g., occurrence of acute and worsening of symptoms, urgent needs for personal care services, sudden change in functional status).
 - Crisis can be distressing for the person receiving CRC, their SDM, family and caregiver(s), so it is important to explain that early planning for crisis will be part of the care they will receive.
- Define the palliative approach to care and introduce how identifying and responding to the person's holistic needs will occur throughout the CRC journey.
 - Explain any palliative care services, which could be made available, when required.

Education is ongoing for the person receiving CRC, their SDM, family and caregiver(s). Concepts should be re-visited often to ensure they fully understand the type of care they are receiving.

CONSIDERATIONS FOR THE SDM, FAMILY & CAREGIVER(S): The SDM, family and caregiver(s) of someone receiving CRC have their own experiences in caring for someone with advanced kidney disease and should be encouraged to participate in CRC education.

The SDM, family and caregiver(s) should be informed on what they can expect in providing care for someone who chooses CRC. They should be informed of the support they will receive to help them feel comfortable in their role in delivering care, including respite support. Information on the support available to the SDM, family and caregiver(s) to address their needs, including social/peer support to maintain their well-being and prevent burnout should also be shared.

5.0 CONSIDERATIONS FOR TREATMENT DECISIONS

5.1 Considerations for Conservative Renal Care Treatment Decision

Some people may know they want to select CRC as their treatment modality and may express this wish to their care team. When this happens, the CRC team should support the person's right to make this decision. Others may not request CRC outright, but may specify a goal of care, which may indicate a preference for CRC as a treatment course. For example, if a person identifies they would *"want to maintain my quality of life and be in control of whatever time I have,"* the CRC team should explore this goal of care further to determine how it fits within their treatment modality options.

The CRC team is responsible for ensuring anyone considering CRC receive sufficient information to make an informed decision. It may be important to provide additional detail to those who are experiencing significant comorbidities, have limited functional status, have self-reported high symptom burden or decreased quality of life. These individuals may benefit from CRC and should have a tailored discussion about the modality. It is particularly important that those considering CRC understand that they will always have the choice to change their decision and initiate dialysis.

Someone experiencing some of the following may benefit from detailed and tailored discussions about CRC:

- Self-reported high symptom burden that will not likely be resolved with dialysis.
- Self-reported prolonged decreased quality of life that will not likely to improve with dialysis.
- Suffering from another advanced terminal disease.
- Showing signs of or is diagnosed with dementia.
- Having a life expectancy of less than 12 months.
- Those 80 years old or over and/or frail [11]. It is important to note that age is not a predictor of health status; individuals who are within this age group are diverse in their health status. Age should be considered secondary to other indications for choosing CRC.
- Those who are older and suffering from severe congestive heart failure [12].
- Those who are older with severe comorbidities (DCI ≥ 3) [11].
- Those who are older with a low functional status (PPS $> 50\%$) [11].
- Rapidly and likely irreversible decline in functional status (PPS loss $\geq 20\%$ annually).
- Frequent hospitalization, that is unlikely to change with dialysis.

CONSIDERATIONS FOR THE SDM, FAMILY & CAREGIVER(S): It can be difficult for the SDM, family and caregiver(s) to accept the person’s decisions and preferences for their care. People choosing CRC should be encouraged to include their SDM, family and caregiver(s) when they consider treatment options. The CRC team should support a person who chooses CRC as they share their treatment decision with their SDM, family and caregiver(s). The CRC team can help them to understand the person’s right to make this decision and the reasoning to enable them to better support their loved one. This will help in the event of a crisis or at a time when the person is unable to provide informed consent, the SDM can align treatment decisions to the person’s wishes, values and beliefs.

Refer to **[Approaches to Conservative Renal Care Conversations](#)** for tips on supporting people who choose CRC in sharing this treatment decision with their SDM, family and caregiver(s).

5.2 Person-Centred Decision Making

Person-Centred Decision Making is a continuum that includes Advance Care Planning, Goals of Care Discussions, Treatment Decisions and Informed Consent. For more information about Person-Centred Decision Making, see the ORN’s [Person Centred Decision Making: Resource for healthcare providers](#).

Goals of Care conversations should occur between a care team member and a person who chooses CRC (or their SDM if the person is incapable) within their first three visits (either MCKC or education), or within one year of MCKC registration (whichever comes first) [1]. Goals of Care conversations should be ongoing and reassessed annually and with any change in health status. Goals of Care conversations should be documented in the person’s care plan (See Section 6.3).

Goals of care are used to support treatment decisions and informed consent. For people receiving CRC, decisions whether to use invasive diagnostic or therapeutic interventions (e.g., endoscopies, imaging, surgeries) should respect an individual’s preference to refrain from these types of invasive procedures. Healthcare providers should discuss the benefits and risks for each intervention in the context of the individual’s wishes and health status. It is important to ensure an appropriate level of illness understanding is established (e.g., the serious, progressive and incurable nature of their illness) before discussing such interventions.

DECISIONS ABOUT LIFE-SUSTAINING TREATMENTS AND CARDIOPULMONARY RESUSCITATION (CPR)

It is important for the CRC Team to discuss potentially life-saving and life-sustaining treatment options with the person choosing CRC, and/or their SDM as early as possible. Having these discussions early will help to support informed decision making and minimize conflicts. These discussions should be framed in the context of the person's current condition and should be informed by any previously expressed Goals of Care. These discussions are particularly important when the person expresses a preference for staying at home as long as possible and/or to die in their home.

When making decisions about CPR, the CRC Team should have honest conversations about its risks and benefits, and share concerns about performing CPR in cases where it may not be medically appropriate or where it would be outside the standard of care.

Decisions about life-sustaining treatments including CPR may change over time and as such, the CRC Team should review these decisions whenever appropriate to do so and particularly when the person's condition changes.

6.0 DELIVERY OF CRC

6.1 Initiation of CRC

When initiating CRC, the person, their SDM, family and caregiver(s) should receive an orientation to CRC. The orientation process should be person-centred and tailored specifically to the needs of each person, their SDM, family and caregiver(s). A Goals of care re-assessment should also take place. The orientation should include detailed education covering all concepts outlined for CRC Education (See Section 4.0 CRC Education). The orientation should also include: an overview of how the person, their SDM, family and caregiver(s) needs will be regularly assessed across all domains of care (See Appendix D) [6], a description of the programs and services that may be available to support them as their needs change, and information on clinic logistics (e.g., clinic hours, appointment times).

Ideally, the orientation should take place in person in a private setting. A multi-disciplinary approach should be taken to ensure appropriate expertise for delivering the information and responding to the questions and concerns of the person receiving CRC, their SDM, family and caregiver(s)'s. A take-home written handout or letter outlining what to expect from CRC is recommended to facilitate orientation (refer to ORN take-home handout: [Conservative Renal Care: What can I expect?](#)).

6.2 Frequency of Visits

The frequency of CRC visits should be based on the severity and stability of the person's overall health status and preferences as assessed through the comprehensive & holistic assessment (See Section 6.3). The CRC Team should respect any of the person's specified goals of care related to clinic visits (e.g., preference to self-manage rather than attend frequent clinic visits).

At a minimum, a person receiving CRC should be assessed comprehensively, ideally in person, by the CRC Team twice a year or with any change in their health status. The minimum visit frequency for each care team member should align with the [MCKC Best Practices](#) [1]. As a person receiving CRC progresses towards ESKD, they may need more frequent assessment and follow-up. People receiving CRC, their SDM, family and caregiver(s) should be supported between assessments and clinic visits with calls,

advice and referrals, as required. Programs should provide someone receiving CRC, their SDM, family and caregiver(s) with relevant contact information for who they should contact with any questions or concerns.

The CRC Team should take efforts to provide care for people who receive CRC in the person's preferred care setting and according to their health needs (e.g., where there is significant functional decline). The CRC Team may need to provide or coordinate care remotely, by phone, home visit, telemedicine, or through a virtual visit to ensure access for those who are unable to attend in-person.

6.3 Comprehensive & Holistic Assessment and Care Planning

The CRC Team should complete a comprehensive and holistic assessment of the person, their SDM, family and caregiver's current and future needs and preferences across all domains of care (See Appendix D) [6]. Assessments should include in-depth history from the person, their SDM, family and caregiver(s), physical examination and appropriate laboratory tests. The CRC Team and SDM should respect any of the person's specified Goals of Care related to assessments (e.g., cessation of laboratory and other tests).

The CRC Team should work with the person receiving CRC, their SDM, family and caregiver(s) to discuss, develop and document an individualized, person-centred comprehensive care plan according to the outcome of the comprehensive and holistic assessment. The comprehensive care plan should document what care will be provided directly by the CRC Team. Where referral is needed, the care provider should be identified in the care plan, including relevant contact information. The care plan should be easily accessible to the CRC Team including the person receiving CRC or their SDM, family and caregiver(s), as well as members from home and community care who fall within the circle of care.

The following should be given specific consideration during the assessment and care planning:

PHYSICAL SYMPTOMS

The person's medical history along with corroborative history from the SDM, family members or caregiver(s) is often helpful to understand common symptoms (e.g., pain, severe fatigue, itch, cramps, restless legs, anxiety). Standardized tools, such as ESAS-r: Renal can be used to assess symptoms. Such tools can be tiring for frail people to complete; they may prefer to provide personal accounts of their experience. Functional status and cognitive function should also be assessed. The comprehensive care plan should include:

- A plan for managing each of the physical symptoms identified as part of the assessment. Refer to [ORN symptom management resources](#) for healthcare providers and patients for more information on managing common symptoms [13].
 - Relief of pain is important. A prescription of opiates for severe pain may be appropriate.
- A review of what to expect as symptoms become increasingly severe, including leading up to end of life.
- Recommendations to promote overall wellness and instructions for self-management techniques.
- Details of any required modifications to medications including but not limited to de-prescribing, dose adjustments and additions.

It is important to remember that quality of life is a priority. Some people may not want to take any additional actions to manage physical symptoms (e.g., medication additions). For these people symptoms should be explained and acknowledged.

SOCIAL & PRACTICAL NEEDS

The CRC Team (e.g., a Social Worker) should review the person's social needs (e.g., relationships, safety, financial resources). Practical needs including activities of daily living (e.g., feeding, bathing, toileting, dressing), instrumental activities of daily living (e.g., using the telephone, shopping, preparing food, housekeeping, using transportation, handling finances), and caring for dependents should also be identified. The comprehensive care plan should include a plan for managing the person receiving CRC, their SDM, family and caregiver's social and practical needs, including:

- Identifying and supporting the person receiving CRC, their SDM, family and caregiver(s) in accessing practical support services (e.g., housekeeping and meals services, cultural services, personal support workers, physiotherapists, occupational therapists, social workers) at the Regional Renal Program or in their homes and community.
- Identifying and supporting the person receiving CRC, their SDM, family and caregiver(s) in accessing transportation services.
- Connecting the person receiving CRC, their SDM, family and caregiver(s) with appropriate income security benefit programs and related support services including assistance with Instrumental Activities of Daily Living such as managing finances, if needed.
- Recommendations for social support networks including, volunteer support services, respite, and individual, peer and/or group sessions.

EMOTIONAL, PSYCHOLOGICAL & SPIRITUAL NEEDS

The person, their SDM, family and caregiver(s) should have their emotional and psychological needs (e.g., fear, anxiety, and depression) assessed in a culturally safe manner. Spiritual needs (e.g., search for meaning and purpose in life, spiritual distress) should also be assessed. The comprehensive care plan should include a plan for managing the person, their SDM, family and caregiver's emotional, psychological and spiritual needs, including:

- For some people, medications can be recommended to treat symptoms related to their emotional and psychological needs.
- Referral to appropriate support services to address emotional and psychological needs (e.g., social workers, grief counsellors and other mental health professionals).
- Recommendations for community resources (e.g., one-on-one counselling, peer and/or group sessions).
- Supporting the person, their family and caregiver(s) in accessing spiritual/religious care providers who represent their faith/spiritual beliefs.

CONSIDERATIONS FOR FAMILY & CAREGIVER(S): The family and caregiver(s) of someone receiving CRC play a critical role in providing care for the person through informal care. Delivering this type of care can have serious impacts on the family and caregiver(s)'s overall health and well-being. As such, it is important for the CRC Team to complete the comprehensive and holistic assessment regularly to assess the needs of the family and caregiver(s). Identifying family and caregiver(s) needs and providing proactive care and resources can help prevent burnout and ensure they are supported throughout the person's care journey.

Regular re-assessment and updates to the comprehensive care plan should occur according to the person's needs and requests. At a minimum, re-assessment and updates to the comprehensive care plan should occur with changes in health status or at least twice a year (see details in Section 6.2). The person's ability to be involved in making decisions may change as their condition changes, and the care plan should be updated accordingly.

6.4 Active Management of Renal Function

Many people who choose CRC will wish to take measures to preserve their renal function, including medications and dietary changes. Others may not wish to take such measures. The following should be discussed with people receiving CRC to enable informed decisions for initiating active management strategies for CKD:

- The CRC team should ensure the person receiving CRC understands that while some people may retain their kidney function for months to years, the rate of kidney function decline does vary from person to person.
- Quality of life considerations should be discussed when deciding to initiate strategies to actively preserve renal function. The CRC team should ensure people receiving CRC understand the balancing act between preserving kidney function and maintaining quality of life; some strategies may compromise a person's kidney function to maintain or even improve their quality of life.

For detailed description of strategies to actively manage CKD refer to Section 8 of the [MCKC Best Practices](#) [1]. The CRC team should identify and act on each person's preferences for using active management strategies to manage their CKD.

Table 1 below outlines considerations for using strategies to actively manage CKD for people who choose CRC. Burden and side effects of treatment as well as individual preferences can help determine the extent these strategies are included in the care plan. It is important that the person receiving CRC, their SDM, family and caregiver(s) understand their options for managing CKD.

Table 1 – Considerations for Active Management of CKD

Strategy	Considerations for maintaining kidney function	Considerations for maintaining quality of life
Employing strategies proven to decrease the rate of kidney function decline, manage anemia and other CKD-related complications.	Will involve comprehensive use of interventions to control proteinuria or treatment of metabolic acidosis. May involve avoiding nephrotoxic interventions.	May involve limited or no use of interventions to control proteinuria or treatment of metabolic acidosis. May allow nephrotoxic interventions which provide relief to the person.
Employing strategies proven to reduce a person’s cardiovascular risk.	Will involve comprehensive use of interventions to control blood pressure and lipid management.	May involve limited or no use of interventions to control blood pressure and lipid management.
Actively managing medications to maintain a person’s health.	Will involve medication alterations, including additions, dose adjustments and de-prescribing.	Will involve medication alterations but may be limited to dose adjustments and de-prescribing, as person prefers.
Monitoring diet and nutrition for the person’s health.	Will involve ongoing dietary reviews and restrictions to recommend therapeutic diet(s).	May involve limited or no dietary reviews or recommendations for therapeutic diet(s).

6.5 Crisis Management

As kidney function and overall health declines, people receiving CRC may begin to experience sudden and severe events related to their CKD. These events can be distressing for a person receiving CRC, their SDM, family and caregiver(s) and may lead them to seek care through the Emergency Department. Interaction with physicians who are not regularly part of the person’s circle of care may lead to sudden decisions to initiate dialysis. With proper education and tools, a person receiving CRC, their SDM, family and caregiver(s) can be better prepared for kidney-related and other crises. A crisis management plan can help people understand what to expect and what to do if they experience a crisis at home.

A crisis management plan should be discussed with the person receiving CRC, their SDM, family and caregiver(s) and documented in the care plan. Crisis management planning should be sensitive to the Goals of Care of the person receiving CRC and their readiness to discuss crisis management. It should include:

- Education on kidney-related crisis and what might happen (e.g., sudden and severe shortness of breath, profound weakness with falls, inability to move, loss of consciousness, confusion).
 - Common, often distressing symptoms (e.g., fatigue, weakness, shortness of breath) should be normalized as a natural part of end-stage disease.
- Education on other forms of crisis and what to expect (e.g., a crisis in meeting a person’s physical, practical, social, psychological or end of life care needs).

- Education on the different treatments that may be included as part of their crisis management plan, and the benefits and side effects of each treatment.
 - Pain management will be an important element of symptom management in times of crisis. The CRC Team should describe strategies for pain management that may be included in the care plan.
- Family and caregiver(s) education on their role in managing distressing symptoms particularly if a crisis occurs at home.
- Direction for the SDM, family and caregiver(s) on when to contact emergency medical services (EMS) and what information to provide to paramedics and other EMS staff (e.g., documented decision for CRC, wishes related to dialysis initiation, resuscitation, etc.).
 - The person receiving CRC, their SDM, family and caregiver(s) should be encouraged to use the [Conservative Renal Care Action Plan](#) in addition to the care plan to document specific crisis management plans.
 - The CRC team should prepare the person receiving CRC, their SDM, family and caregiver(s) on how to communicate with EMS and staff within local Emergency department.
 - Direction should be provided to keep relevant documentation (e.g., care plan, medication list, contact information for SDM and Power of Attorney for Personal Care form) easily accessible in case of a crisis.
- Relevant contact information for the person, their SDM, family and caregiver(s) to communicate with the Care Coordinator for advice and guidance in the event symptoms worsen quickly or become distressing.
 - Relevant contact information for 24/7 support services available to the person, their SDM, family and caregiver(s) in the event of distressing symptoms occurring overnight, on weekends or outside regular clinic hours.
 - As symptoms get worse, additional services may become available for people to receive care in their homes (e.g., home palliative care support). The Care Coordinator should ensure the person, their SDM, family and caregiver(s) understand when to contact these other care providers for additional assistance during times of crisis.
- Relevant contact information for the person choosing CRC, their SDM, family and caregiver(s) to communicate with the Care Coordinator in the event of a practical, social, psychological, palliative care crisis.
 - Relevant contact information for 24/7 support services available to the person, their SDM, family and caregiver(s) in the event of distressing events occurring outside regular clinic hours.

People receiving CRC, their SDM, family and caregiver(s) should be instructed to ensure their care plan is located in a place where it can be easily accessed and reviewed. An additional handout related to crisis management is recommended. Crisis management planning should be an on-going discussion with the person, their SDM, family and caregiver(s), initiated at orientation and discussed regularly throughout the person's healthcare journey.

CONSIDERATIONS FOR THE SDM, FAMILY & CAREGIVER(S): It can be particularly distressing for the SDM, family and caregiver(s) when the person receiving CRC experiences a crisis. It is important that caregivers are fully supported in navigating crisis management and know whom they can contact for additional support.

6.6 Care Collaboration and Transitions in Care

Delivering care according to the person's needs and preferences will require significant coordination with partners who deliver home, social community, primary and palliative care in the community.

CONSIDERATIONS FOR COORDINATING CARE WITH PARTNERS

The following should be considered in coordinating and connecting people to care in their homes and community:

- The CRC Team should establish and maintain relationships with partners across all domains of care (See Appendix D) [6].
 - The CRC Team should maintain an active list of home and community care partners. Care teams are encouraged to leverage existing resources for coordination of care (e.g., theHealthline.ca) [14].
 - The CRC Team should identify domains of care where there may be limited or gaps in services. Efforts should be taken to build capacity within the care team or in the community to respond to these care needs.
 - The CRC team should be well connected to local palliative care specialists and services who can provide consultation when a person's palliative care needs become more complex.
- The CRC Team should establish regular lines of communication with partners to stay informed about care delivered to people receiving CRC and any changes in their care.
 - People who choose CRC, their SDM, family and caregiver(s) should be encouraged to communicate any changes in care with the CRC Team as early as possible and as part of their comprehensive and holistic assessment.
- The CRC Team should establish regular lines of communication with the person's primary care provider (physician or Nurse Practitioner (NP)) to ensure integration of care.
 - If a person receiving CRC does not have a primary care provider, the program should make every effort to find him/her one.

CONSIDERATIONS FOR TRANSITIONS IN CARE

Transitions in care may be needed when the needs of the person, their SDM, family and/or caregiver(s) exceed the competency and/or comfort of the CRC Team. Such transitions may include transitioning the Care Coordinator from the RRP to one in the community or transitioning the MRMP role from the Nephrologist to a community medical provider (e.g., primary care provider or palliative care specialist). To ensure continuity of care and safe transitions in care, consider the following:

- Where possible, transitions in care should be led by the Care Coordinator in partnership with the Nephrologist (MRMP); who are familiar with the person’s health status, Goals of Care, plan of treatment, care plan, and health information needs [15].
- Processes should be in place for the CRC Team to be notified if a person is hospitalized; where possible, the CRC Team should liaise with the discharge team prior to discharge to ensure smooth transition back to the person’s preferred care setting.
- Prior to transitions in care, ensure a physician is available to medically manage the person following discharge. Timely and effective communication to the discharging team is necessary to ensure safe and integrated transitions [15].
- Continued collaboration with the receiving physician should occur, especially to provide collaborative renal care. A shared care plan is encouraged and should be available to providers within the circle of care, as well as the person receiving CRC, their SDM, family and caregiver(s).
- Close communication with the person, their SDM, family and caregiver(s) should occur to ensure that transitions in care are timely, appropriate, and safe by informing them about what to expect from the transition process and ensuring that supports continue to be available.

7.0 END OF LIFE CARE

The CRC Team plays an active role in preparing a person receiving CRC, their SDM, family and caregiver(s) for end of life, supporting them during the end of life and providing continued support to manage grief and loss.

7.1 Conservative Renal Care Team Role During End of Life Care

The CRC Team should provide direct support to the person receiving CRC, their SDM, family and caregiver(s), throughout end of life. The CRC Team may need to engage their primary care provider, a palliative care specialist or other disease specialists for consultation, advice and mentorship as the person’s needs become more complex.

Palliative care specialists include palliative physicians and other providers with advanced level palliative care competencies (e.g., nurses, palliative pain and symptom management consultants, social workers, etc.). People receiving CRC may be referred to these specialists when their needs are more extensive or complex than the CRC Team or their primary care provider can manage. Refer to Ontario Palliative Care Network’s Health Service Delivery Framework (Item 3.7) for information on when the CRC Team should consider seeking the involvement of palliative care specialists [2].

Even if the primary care provider or a palliative care specialist begins to provide direct care for the person receiving CRC, the CRC Team should continue to actively support the person, their SDM, family and caregiver(s). The CRC Team should remain within the circle of care and continue to address ongoing needs in those areas where competency exists within the care team.

7.2 Delivering End of Life Care

PLANNING FOR END OF LIFE CARE

Planning for the end of life should begin as early as possible, provided this is acceptable to the person receiving CRC. All plans for end of life should be documented as part of the care plan. The person

receiving CRC should be encouraged to share plans for end of life with their SDM, family and caregiver(s). The care team should consider the following:

- Ensuring the person, their SDM, family and caregiver(s) understands the philosophy of palliative care and the supports that are available.
- Ensuring the crisis management plan (see Section 6.5) is up to date, including providing education on what to expect as disease progresses, ensuring contact information for support at the Regional Renal Program and in the community are readily available, and clarifying when to use or avoid EMS.
- Identifying the person’s preferred place of death and ensuring appropriate planning. This preference may change as the end of life approaches and back-up plans may need to be made. If the person’s preference is to die at home, the care team should:
 - obtain consent for a ‘Do Not Resuscitate’ order and complete the ‘Do Not Resuscitate’ Confirmation Form (DNR-C). The DNR-C form should be made readily accessible in the home.
 - initiate local processes/procedures for managing an expected death in the home, (often called an “Expected Death in the Home” (EDITH) Protocol) and document it in the care plan. EDITH Protocols typically identify the plan for pronouncement and certification of death in the home, and help to ensure timely removal of the body to the funeral home. Having an EDITH Protocol in place can reduce the stress for the family when death occurs and supports physicians to provide end of life care in the community setting. If the care team is not familiar with their local policies, they should connect with their Regional Palliative Care Network to learn more.
- In communities where hospice residences and/or services exist, offering information about the hospice to the person, their SDM, family and caregiver(s), as needed. These services should be integrated and coordinated within the person’s care plan.
- Addressing questions and/or requests regarding Medical Assistance in Dying (MAID) if they arise (see Section 7.3).
- Exploring, respecting and planning for cultural, religious and spiritual preferences and practices of the person, their SDM, family and caregiver(s).

CONSIDERATIONS FOR END OF LIFE CARE

As CKD progresses and end of life approaches, less emphasis should be placed on active management and more on the relief of symptoms, with an emphasis on quality of life and comfort. Needs across all domains of care (See Appendix D) should be regularly assessed and addressed through to the end of life [6].

In the final weeks and days of life, the focus of care moves towards managing the active dying process, which includes identifying that the person is near death and ensuring that the person, their SDM, family and caregiver(s) understand what to expect as death approaches. Care includes:

- Confirming the person’s preference for place-of-death and assessing whether sufficient supports can be put into place to ensure comfort.
- Planning for pain and symptom management and supporting the SDM, family and caregiver(s) to understand probable symptoms.
- Planning with the SDM, family and caregiver(s) for the pronouncement of death, completion of the death certificate, planning for post-death care, and sharing key contacts when death occurs.

For more information on end of life care, refer to Ontario Palliative Care Network’s Health Service Delivery Framework [2].

CONSIDERATIONS FOR THE SDM, FAMILY AND CAREGIVER(S): As someone receiving CRC nears the end of life, the scope of their care needs may exceed the physical and emotional capacity of the SDM, family and caregiver(s). The CRC Team can assist the caregiver(s) by identifying areas of care that may be beyond the family and caregiver(s)’s capacity to deliver, determining the levels and types of support services required, and coordinating care with community support to continue to meet the person’s needs.

The CRC Team should continue to ensure the caregiver(s) are receiving the support they need for their own holistic care. As someone receiving CRC approaches end of life, their SDM, family and caregiver’s needs should be continuously monitored and addressed. It will also be important to identify bereavement services and supports available in the community for the SDM, family and caregiver(s) leading up to and following the death of the person receiving CRC.

7.3 Considerations for Medical Assistance in Dying

In Canada, medical assistance in dying (MAiD) is legal under Bill C-14 passed by the Canadian Government on June 17, 2016 [16]. Under this legislation, physicians and nurse practitioners are legally able to provide assistance in dying to those people who meet certain criteria set out in the law.

Before a person receiving CRC requests MAiD, it is important to provide information about all the options that are available to treat their illness and relieve their suffering, including palliative care. Furthermore, a palliative approach to care should be provided to all people regardless of their choice and eligibility for MAiD.

If a person asks about MAiD, the CRC Team should follow existing protocols within their Regional Renal Program or hospital to facilitate discussions, requests and assessments of a person’s eligibility for MAiD and to administer MAiD.

The CRC Team should also direct people to Ontario’s Care Co-ordination Service [17]. Through this service people, their SDM, family and caregiver(s) can receive information about end of life options in Ontario, including information on hospice care, other palliative care options in their communities, and MAiD. Clinicians who are unable or unwilling to provide MAiD can contact this service to refer people to doctors or nurse practitioners who can provide these services. People, their SDM, family and caregiver(s) can also call the Care Co-ordination Service to request to be connected to a doctor or nurse practitioner who can provide MAiD services, such as eligibility assessments [17].

8.0 BEREAVEMENT SUPPORT

Grief and loss are part of every stage of advanced kidney disease, especially with CRC. Culturally safe support services and counseling should be offered proactively and throughout the care journey, recognizing that the SDM, family and caregiver(s) will experience grief and loss, both before and after death.

The CRC team should be attentive to the SDM, family and caregiver(s) needs, including those who may be at higher risk for difficulties in bereavement. The SDM, family and caregiver(s)'s need for support does not end with the death of their relative. The care team should support the SDM, family and caregiver(s) in transitioning their care to appropriate community resources that may include bereavement information and education, one-on-one counseling, peer and/or group sessions and their primary care provider.

If appropriate, the CRC Team may wish to offer bereavement support after a person's death through a telephone call or meeting. Members of the CRC Team may have played an important role in the healthcare journey for the person with ESKD, their SDM, family and caregiver and the opportunity for closure can be beneficial for everyone.

9.0 APPENDIX A: ACKNOWLEDGEMENTS

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11.0 APPENDIX C: GLOSSARY

CARE PLAN

A care plan is a written document that describes a person's health needs and goals and the care that will be provided to meet them. Care plans describe treatments customized for each person based on their values, wishes, goals, and unique health needs [15].

CONSERVATIVE RENAL CARE

Conservative renal care is active and holistic person-centred care for people with end stage renal disease that includes care meant to slow down kidney disease and lower the risk of complications, active symptom management, as well as emotional, social and family support; does not include dialysis or transplant [5].

DIALYSIS DISCONTINUATION

Dialysis discontinuation is the process by which a person who has been on chronic dialysis elects to withdraw from dialysis. In dialysis discontinuation, people retain little to no kidney function and care focuses on symptom control and end of life care.

END STAGE KIDNEY DISEASE (ESKD) or END STAGE RENAL DISEASE (ESRD)

End stage kidney disease is when kidney disease, where the kidneys have not been working properly to remove waste and extra fluids from the body, progresses to a point where the person needs renal replacement therapy (a treatment to carry out the function of the kidneys when they are not working) to survive. Options include kidney transplant or dialysis. Another option is to receive conservative renal care, which does not include renal replacement therapy [18].

HOSPICE

Hospice is a community-based organization (or a program offered by a multi-service organization) that provides support to individuals living with a progressive, life-limiting illness and their caregivers, family members, and friends [19]. Support is provided to the service recipient in a variety of settings, including where the individual lives or in a homelike setting. The goal of hospice care is to enhance the quality of life of the individual and the well-being of anyone that is impacted by the person's illness or death. A hospice provides services such as hospice-trained volunteers, day programs, psychosocial supports, grief and bereavement support, spiritual care, caregiver support, wellness programs, complementary therapies, children's programs, outreach/shared care teams, and end-of-life care within a hospice residence or person's home [19].

MOST RESPONSIBLE MEDICAL PROVIDER (MRMP)

The most responsible medical provider may be a Nurse Practitioner (NP) or a Medical Doctor (MD) (e.g., primary care provider, disease specific specialist, palliative care specialist) [2]. The MRMP will be responsible for ordering tests, making diagnoses, ordering treatments and prescribing medications. The MRMP will receive support from and, in turn, will provide support to the other members of the interdisciplinary care team.

SUBSTITUTE DECISION MAKER

The Substitute Decision Maker (SDM) is the person or persons who would have the legal authority to make health decisions if the person is not capable of making their own decisions. This would include treatment and care plan decisions, providing consent for those decisions and decisions about the sharing of the person's personal health information [2]. The person or persons identified as the SDM will be the highest ranking person(s) in the SDM hierarchy in the Ontario Health Care Consent Act and meets the requirements to be an SDM (Health Care Consent Act, 1996, S.O. 1996, c. 2, Sched. A) For more information on the SDM hierarchy in Ontario refer to the Speak Up Ontario Resources [20].

PALLIATIVE CARE

Palliative care or supportive care is care to address a person, their family and caregiver's full range of needs – physical, psychosocial and spiritual – at all stages of a chronic progressive illness. Within the renal context, palliative care is available to all people with CKD regardless of their modality or disease stage (e.g., dialysis, conservative renal care, and transplant).

DIALYSIS WITH PALLIATIVE INTENT

Dialysis with palliative intent is a strategy where dialysis continues to be administered to a person receiving chronic dialysis, often near end of life, to manage symptoms. The intention of dialysis with palliative intent is to curb symptoms, not as a life-sustaining therapy and thus administration may be modified according to symptom burden.

12.0 APPENDIX D: DOMAINS OF CARE

The ORN has adopted the Canadian Hospice Palliative Care Association’s Domains and Issues Associated with Illness and Bereavement as fundamental domains of care used by the CRC Team to identify and respond to person, their family and caregiver(s) needs.

Table 2 – Domains of Care

Domain	Description
Disease Management	Primary diagnosis, secondary diagnoses, comorbidities, adverse events, allergies
Physical	Pain and other symptoms, cognition, function and safety, nutrition, wounds, habits
Psychological	Personality, strengths, behaviours, depression & anxiety, emotions, fears, dignity, independence, stress, coping responses, self-esteem
Social	Cultural values, relationships, isolation, safety, privacy, routines, legal, family caregiver protection
Spiritual	Existential or faith-based concerns. Values, beliefs, practices. Advisors.
Practical	Activities of daily living (feeding, bathing, toileting, dressing), caring for dependents, instrumental activities of daily living (using the telephone, shopping, preparing food, housekeeping, laundry, using transportation, taking medications, handling finances).
End of life Care & Death Management	Life closure, gift giving, preparation for expected death, anticipation and management of physiological changes in last days and hours, rituals, pronouncement, perideath care, memorial services
Loss & Grief	Loss, grief (acute, chronic, anticipatory), bereavement planning, mourning

Adapted from Canadian Hospice Palliative Care Association’s Domains and Issues Associated with Illness and Bereavement

13.0 APPENDIX E: CONSERVATIVE RENAL CARE TEAM FUNCTIONS

The [MCKC Best Practices](#) provides detailed description of the key knowledge and skills needed to deliver MCKC care. Additionally, the [Ontario Palliative Care Network’s Palliative Care Competency Framework](#) provides detailed descriptions on the key knowledge and skills needed to deliver of palliative care. The CRC Team should build knowledge and skills in delivering comprehensive and holistic care according to the expectations outlined in both the MCKC Best Practices and the OPCN Palliative Care Competency Framework [1] [2].

The following functions of the CRC Team are suggested in addition to those outlined in the MCKC Best Practices.

Table 3 – Patient, Family and Caregiver(s) Education & Treatment Decisions

The following functions for person receiving CRC, family and caregiver(s) education & treatment decision align with assessment and care planning & education functions outlined in the MCKC Best Practices.

Function	Care Team Member
Engages the person receiving CRC (or their SDM), their family and caregiver(s) in discussions to educate on what CRC is and what to expect from this care.	Shared
Provides information to the family and caregiver(s) on delivering care and key contacts.	Shared
Supports the team and other physicians to understand and appreciate the value of CRC.	Nephrologist
Educates the person receiving CRC (or their SDM), their family and caregiver(s) and other care team members on medication use, side effects, burden and adherence.	Pharmacist
Engages the person receiving CRC (or their SDM), their family and caregiver(s) in discussions to clarify the nature and benefits of palliative care, what to expect, and available resources and supports.	Shared
Provides information to person receiving CRC (or their SDM), their family and caregiver(s) on options for setting of care and for place of death	Shared
Discusses prognosis, crisis management and end of life care with the person receiving CRC (or their SDM), their family and caregiver(s)	Nephrologist Nurse

Table 4 – Orientation & Comprehensive Assessment

The following functions for orientation and comprehensive assessment align with assessment and care planning functions outlined in the MCKC Best Practices.

Function	Care Team Member
Identifies a Care Coordinator to ensure services are assigned and care/supports are provided to the person receiving CRC, their family and caregiver(s)	Nephrologist Nurse
Arranges the orientation and the comprehensive assessment across all domains of care (See Appendix D).	Care Coordinator

Table 5 – Delivery of Conservative Renal Care

The following functions for delivery of conservative renal care align with assessment and care planning & education functions outlined in the MCKC Best Practices.

Function	Care Team Member
Ensures an MRMP is identified and the person receiving CRC (or their SDM), their family and caregiver(s) are always up-to-date and informed on who is responsible for care.	Nephrologist Nurse
Manages the person's needs for spiritual supports.	Shared
Assesses changes in overall psychosocial well-being.	Nurse Social Worker
Responds to increasing signs and symptoms of dementia, confusion, agitation and/or anxiety.	Shared
Limits unnecessary intervention and closely align all care with person's goals of care.	Nephrologist Nurse
Explores with the person receiving CRC, their family and caregiver(s) how adherence to a renal diet aligns with the person's identified goals of care.	Dietitian
Explores, understands and honours the meaning of food across cultural and personal values.	Dietitian
Discusses, a plan for crisis management with the person receiving CRC, their family and caregiver(s), and documents it within the care plan.	Shared
Supports the family and caregiver(s) in delivering care and responds to caregiver burden.	Shared

Table 6 – Care Collaborations and Transitions in Care

The following functions for care collaboration and transitions in care align with transitions functions outlined in the MCKC Best Practices.

Function	Care Team Member
Ensures the information in the care plan is up-to-date (including documentation of consent for key treatment decisions such as “no dialysis”) and shares it with other care providers	Shared
Collaborates with team members, community providers, volunteers to ensure clear pathways are defined to meet the needs of the person receiving CRC, their family and caregiver(s) across all domains of care (See Appendix D)	Shared
Maintains an active list of renal supports and home and community care partners.	Care Coordinator
Manages all transitions in care	Care Coordinator

Table 7 – End of Life Care

The following functions for End of Life Care align with Assessment and Planning & Education Functions in the MCKC Best Practices.

Function	Care Team Member
Provides the person receiving CRC (or their SDM), their family and caregiver(s) with information about options for setting of care and for place of death	Shared
Identifies a plan for end of life, and documents it within the care plan. Ensures the person receiving CRC (or their SDM), their family and caregiver(s) know what to expect and that resources are available to offer support.	Shared
Supports the family and caregiver(s) in transitioning their care to appropriate community resources that will include bereavement information and education, one-on-one counseling, peer and/or group sessions and their primary care provider	Care Coordinator