Checklist: **CKD Patients on a Conservative Care Pathway**

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This Checklist is intended to support the systematic review of care provided to patients on the conservative care pathway and to ensure that specific activities and discussions occur at appropriate intervals. This Checklist outlines activities for patients on KCC's Conservative Care Pathway (starts at Phase 1c). Phases 1a (CKD Stage 3 - 4 Care) and 1b (CKD Modality Selection) are not shown because they are the same for all KCC patients irrespective of the selected modality.

Category	Activity	KCC Phase				
		1c	2	3	4	5
		Stage 5 CKD Care	Decompensation (<8 mos)	↑ symptoms; Prognosis <1 mo	Last Days	Bereavement
PCP Communication	Communicate patient's modality choice &/or significant changes in status. Confirm roles of KCC & PCP. Recommend both verbal & written communication.				KCC team available to PCP & other community supports, including hospice/ palliative care teams for consultation (mostly symptom mgt)	
ACP	Continue ACP discussion including: • Educating patient about process of identifying SDM. • Educating patient about process of developing representation agreement &/or advance directive, if desired. • Discussing what is important to patient (e.g., beliefs, values, spiritual & cultural needs, treatment preferences).					
	If patient open to same &/or as appropriate, review desires at end of life, including place of death (done by KCC team or via PCP/palliative care team).					
	Document ACP discussion in patient record.					
	Update ACP documentation in PROMIS.					
	If available, place copy of ACP & related documentation in patient record (hard copy &/or electronic files).					
	When patient/family ready, encourage patient to update will, power of attorney & other relevant forms (e.g., organ donation, bequest forms).					
Goals of care	Continue goals of care discussion, including continued desire for conservative care.					
	Provide education on palliative care services available in local community. If needed & desired, confirm referral sent to appropriate service (by KCC or PCP).					
	Confirm BC Palliative Care Benefits Program Application form has been submitted (PCP/palliative care team or KCC team). www2.gov.bc.ca/assets/gov/health/forms/349fil.pdf (HLTH 349)					
	If no CPR desired, confirm completion of No CPR form. https://www2.gov.bc.ca/assets/gov/health/forms/302fil.pdf (HLTH 302.1).					
Continued on next page...	If home death desired, confirm "Notification of Expected Death in the Home" form has been signed by the patient if the patient/family opts for no pronouncement (PCP/ palliative care team or KCC team). www2.gov.bc.ca (HLTH 3987). (form used outside urban areas only).					

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		Stage 5 CKD Care	Decompensation (<8 mos)	↑ symptoms; Prognosis <1 mo	Last Days	Bereavement
Goals of care (continued)	Ensure patient/family has copies of No CPR & "Notification of Expected Death at Home" forms, if relevant.				See notes on previous page.	
	Provide information on compassionate care benefits as appropriate. www.servicecanada.gc.ca/eforms/forms/sc-ins5216b(2012-01-007)e.pdf (SC INS5216B).					
Symptom assessment & management[3]	Assess symptoms using the modified ESAS (My Symptom Checklist) q 6 months & more often if significant KCC-related symptoms.					
	Enter results of ESAS into PROMIS.					
	Develop/update symptom management plan, incorporating symptom management algorithms (bcrenalagency.ca) & other best practices.					
	Review symptom management plan with patient/family & provide relevant handouts.					
	Contact PCP to discuss kidney-specific symptoms, including providing copies of ESAS & relevant symptom management algorithms.					
	Assess need for home care/home support. If needed & desired, confirm referral has been sent (by KCC or PCP) & relevant information communicated.					
Medication review	Review medications with patient & discontinue any non-essential medications.					
Blood work rationalization	Review blood work with patient &, if appropriate, reduce the number or frequency of tests.					
Crises education (acute worsening of symptoms, caregivers overwhelmed, etc)	Identify possible kidney-related crises & develop management plans					
	Provide anticipatory education to patient/family re possible crises.					
	Confirm patient/family has contact numbers & knows who & when to call (e.g., GP, KCC team, nephrologist, home care, palliative care/hospice team, spiritual care).					
Bereavement support	Acknowledge death with phone call, letter or card to family.					
	As appropriate, offer brief grief & bereavement counselling to the family/caregiver & provide resources such as funeral packages, community supports & grief counselling resources. e.g., BC Bereavement Helpline (www.bcbereavementhelpline.com), local counselling/grief support resources, local hospice society & PCP.					
Reflections on patient's death as a KCC team	Discuss and reflect upon the patient's death as a kidney care team.					

[3] Refer to symptom management protocols at: http://www.bcrenalagency.ca/health-professionals/clinical-resources/chronic-kidney-disease-(ckd)