SFHRenRM4
Agree and monitor a plan to manage a renal patient's co-morbid disease

Overview

This standard is about managing and minimising the effects of co-morbid illnesses in patients with established renal failure as well as the constraints on the management of renal disease. It is part of a group of standards about intervention by different teams of practitioners working together to provide coherent treatment and care in concordance with the patient. The setting can be a main hospital site, satellite site, in the community and in the patient's home. It is relevant to all healthcare workers in primary and secondary care working to address and improve the health and wellbeing of patients with established renal failure.

Users of this standard will need to ensure that practice reflects up to date information and policies.

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Performance criteria

You must be able to:

P1 provide information at a pace suitable to the individual and in a way that encourages participation, discussion and feedback

P2 check the patient's understanding of their co-morbid disease, its implications for the management of their renal disease and the risks/benefits of therapy (e.g. use of statins, anti-hypertensive agents)

P3 agree a treatment plan with the patient and relevant members of the multi-disciplinary team (e.g. decisions about the most appropriate formulation, packaging and method of administration for their medication, the importance of continuing to take other prescribed medications)

P4 discuss supporting lifestyle changes the patient can make (e.g. exercise, diet, reducing alcohol intake, stopping smoking)

P5 agree how to monitor the effectiveness of the co-morbid therapy (e.g. involving primary care), including what will be needed if the therapy is not effective or if the patient experiences serious side effects

P6 ensure the patient has the necessary social, psychological and medical support to enable their co-morbid illness to be treated (e.g. involving the dietician in the management of renal bone disease, prescribing a non-porcine insulin for people of the Muslim faith, arrangements relating to prescription charges and getting repeat prescriptions)

P7 record all decisions made, and communicate them to the relevant members of the multi-disciplinary team

P8 review the patient's progress and physical condition at appropriate intervals (e.g. according to therapy protocols or changes in the patient's condition)

P9 encourage the patient to act as an informed equal partner in the review process, and encourage and support patients and carers to contribute information to the review

P10 encourage the patient to discuss how they have felt while taking the medication

P11 identify any problems in taking medication and discuss ways of overcoming them

P12 check the individual's understanding of their treatment plan and find out if the full dose of prescribed medication has been taken on every occasion

P13 record the main points of the review in a form that can be followed by other members of the care team, the patient and the carer

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Knowledge and understanding

You need to know and understand:

K1 anatomy and physiology
K2 renal function as a component of the whole body function
K3 nature and consequences of renal failure
K4 treatment of renal disease, failure and associated conditions
K5 measuring physiological parameters (e.g. fluid, electrolytes, blood pressure, diabetic status)
K6 investigating for specific conditions associated with renal dysfunction and co-morbidities
K7 identification of complications and conditions associated with renal dysfunction or failure and their treatment (e.g. hypertension, renal bone disease, obstructive uropathy)
K8 best practice treatment and stabilisation of conditions for patients on renal replacement and those on conservative care
K9 co-morbid conditions that frequently occur alongside renal failure (eg diabetes, peripheral vascular disease, cardiovascular disease)
K10 effects and side effects of medications
K11 up-to-date evidence on the efficacy of drugs
K12 the role of medication and the function of drugs commonly used with renal patients
K13 why patients may comply with medication and why they may not
K14 the need for patients to understand the effect of medication
K15 contributions that patients can make to their own health and wellbeing (e.g. through lifestyle, diet, exercise, medication, self-testing)
K16 how to identify and respond to the concerns which patients may have regarding their disease and the way in which it affects their lives
K17 the effects of dependence and independence on the patient, carers and the provision of the service
K18 methods of administering and self administering various kinds of medication
K19 policies on prescribing
K20 patient group directives
K21 developing plans of care with patients and other members of the multidisciplinary team
K22 the role of other members of the multidisciplinary team, the support and information they can provide
K23 how to ask open-ended questions, listen carefully and summarise back
K24 methods of communicating sensitive information to individuals
K25 how to provide individuals with opportunities to ask questions and increase their
K26 how to adapt communications styles in ways which are appropriate to

different people (e.g. culture, language, or special needs)

K27 how information obtained from individuals should be recorded and stored

K28 how to obtain full and accurate information about individuals

K29 how to treat individuals fairly

K30 the effects of culture, religious beliefs, age and disabilities on individual communication styles

K31 the different features services must have to meet people's gender, culture, language or other needs

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Additional Information

External links

This National Occupational Standard was developed by Skills for Health.

This standard links with the following dimension within the NHS Knowledge and Skills Framework (October 2004):

Dimension: HWB6 Assessment and treatment planning

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