SFHRenRM6
Agree and monitor a plan to manage complications of established renal failure

Overview

This standard is about managing and minimising the risks of patients developing complications associated with established renal failure. Although this may be technically complex from a medical and care point of view, this standard emphasises the role of the patient as a partner in deciding what happens to them. Complications may be managed in primary care settings and in the patient's home, in main hospital units and satellite units. This is one of a group of standards about interventions. It also links to standards about decision making and boundary setting within the long-term relationship that exists between patients and practitioners.

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 develop treatment options in consultation with the patient, the multidisciplinary team and other practitioners (e.g. referring to a dietician to augment therapy for coronary heart disease)
- P2 enable individuals to make an informed choice on treatment options by providing access to information based on best evidence (e.g. giving a statin to lower cholesterol)
- P3 identify lifestyle changes that the individual may need to make (e.g. stopping smoking, nutrition, increasing exercise)
- P4 explore with individuals the risks/side effects associated with each treatment option (e.g. risk of bleeding with aspirin prophylaxis)
- P5 negotiate and agree a management plan with the patient and the team
- P6 ensure there is clear written documentation of management plan with achievable objectives in accordance with national and/or local agreed standards and guidelines
- P7 maintain an up-to-date picture of whether the patient is following the management plan, the tolerability of the treatment, and the response of the patient's condition
- P8 identify the significance of changes in the patient's condition (e.g. noting patient's account of changes in energy, incidence of discomfort, any acute episodes) by taking a history, examination, and investigations at intervals appropriate to the condition
- P9 evaluate the presence and progression of the complication (e.g. bone density scan, cardiac echo, Hb1Ac measurement for diabetes)
- P10 review and provide feedback to patient and carers about the effectiveness of the management plan, and obtain the patient's assessment of and opinion on its progress
- P11 identify the priorities of treatment with the patient, explaining the treatment options available and potential complications
- P12 record the review and make it available to relevant members of the care team
- P13 agree and implement the management plan

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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 prevention of avoidable complications (e.g. immunisation against Hepatitis B)
K10 good practice guidelines and the evidence-based practice for dealing with identified complications
K11 co-morbid conditions that frequently occur alongside renal failure (e.g. diabetes, peripheral vascular disease, cardiovascular disease)
K12 effects and side effects of medications
K13 up-to-date evidence on the efficacy of drugs
K14 the role of medication and the function of drugs commonly used with renal patients
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 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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