Management of Chronic Kidney Disease – A Case Study

Introduction

Chronic kidney disease (CKD) affects approximately half a billion people worldwide and is often associated with several co-morbidities such as diabetes and hypertension (Wetmore and Collins, 2016). In the case study of Jean, a 55-year old woman, her symptoms are influenced by several lifestyle factors such as weight gain, heavy smoking, and heavy soft drink consumption. If the management of CKD for Jean is not done appropriately, it can potentially lead to end-stage renal disease, having a huge impact on her quality of life. In this scenario, it isn't sufficient for nurses to provide care for the patient, but to ensure patient education and advocacy regarding the condition (Garvey and McCarron, 2018).

Optimal management of Jean's chronic condition depends on active collaboration between nephrologists, dialysis team, and kidney transplant team to ensure that appropriate care is delivered based on the identified stage of the disease (Bryant-Lukosius and Dicenso, 2004). As diabetes and hypertension are the leading causes of CKD and given her rate of soft drink consumption and smoking, Jean needs to have appropriate referrals to identify and manage co-morbidities. Patient education followed by focused lifestyle changes is paramount to the successful management of CKD (Naylor et al., 2011). Anemia is a major complication of CKD and regular follow-ups with the patient need to rule out the diagnosis of anemia (Krishnan et al., 2017).

The fact that CKD is a chronic condition and often affects the quality of life of patients needs to be appropriately conveyed to patients and their families in a culturally sensitive and supportive manner. Based on the analysis of Jean's symptoms, her nurse needs to engage in Advanced Care Planning (ACP) keeping in mind treatment goals, diagnosis of co-morbidities, lifestyle factors, and other personal concerns of the patient and her family (Zhou et al., 2010).

Self-Management of Chronic Kidney Disease

People living with chronic conditions often go through an initial stage of powerlessness where they feel they do not have control over their health condition due to lack of knowledge and access to support. Feelings associated with powerlessness include denial, anger, sadness, depression, and total dependence on family members. It is the duty of the nurse to primarily focus on patient empowerment where the patient can voluntarily increase her authority to make informed decisions regarding her chronic health condition. This would require self-management of her condition to a large extent by acquiring the relevant knowledge, skills, attitude, and awareness that would help her make informed choices about treatment and management of her condition. Self-management of CKD would help the patient be more in control of her life and thus, have better health outcomes (Wang and Chiou, 2011).

The first step in promoting self-management of patient condition on the part of nurses would be to initiate appropriate referrals for management of CKD, anemia, dialysis and transplant evaluations, and diagnosis of possible co-morbidities such as diabetes and hypertension. This will ensure that a complete picture of the patient's condition is obtained and holistic management is initiated (Neyhart et al., 2010). Jean and her family needs to undergo several patient education and counseling sessions with

her nurse so that they have a complete overview of the condition, potential symptoms and complications, and treatment options (Constantini et al., 2008). This will help Jean analyze her lifestyle in relation to smoking and soft drink consumption and control these habits for a better prognosis of her condition.

As per Jean's case study, she does not trust the healthcare system, worries for lack of privacy, and often forgets to take her medication. In order to address these issues, Jean's nurse needs to encourage self-monitoring and assessment, where she develops awareness of her emotional and physical well-being. This will empower her to feel in control of her health condition at all times and stick to her medication schedule (Lorig and Holman, 2003). The nurse also needs to sensitively bring up the subject of an appropriate home-based weight management system, so that Jean can have better control over the impact of co-morbidities on her chronic health condition.

Plan of Care based on Local Resources available

Jean lives in South Grafton, which falls under the North Coast region of New South Wales (NSW). The area forms a part of the North Coast NSW Medicare Local which encompasses a group of 5 primary healthcare organizations (Northern NSW Local Health District, 2013). The closest healthcare centre to her place of residence is the Grafton Base Hospital which has several different departments of care including renal, acute medical, intensive and critical care, and geriatric care. The nurse can forward Jean's case details to this hospital and initialize referrals so that Jean can make use of the outpatient and other services of this facility. The nurse can also set up the services of NSW's Renal Network for Jean which can help her make use of renal ambulatory and home dialysis services as and when necessary (Agency for Clinical Innovation, n.d.). The Australian College of Rural and Remote Medicine also offers telehealth services in the NSW area, and the nurse can provide a list of important telephone numbers to Jean and her husband, so that they can contact relevant physicians for any support (ACRRM, n.d.).

As South Grafton is a scenic place with beautiful trees and a river, the nurse can encourage Jean to go for a walk and do light aerobic exercises to manage her weight as well as prevent and/or manage diabetes and hypertension. The nurse also needs to educate Jean about the harms of smoking and soft drink consumption and needs to provide her with a plan to slowly give them up. The nurse can refer Jean to a dietician who can help her choose healthy fruits and vegetables for her meals and help her incorporate them in her daily routine.

Challenges in the Implementation of Care Plan

In several cases where patients live in rural areas, studies have reported lack of time and access to resources in primary healthcare facilities to manage patients with co-morbidities. This may be a potential challenge in the case of Jean who also lives in a rural area and may not be able to access quality healthcare services in her area of residence. Specialist Nephrology services may not always be available and this may result in delays between patient follow-ups, during which time the symtoms may exacerbate significantly (Neale et al., 2020). In such cases, Jean must be encouraged to call emergency contact numbers of telehealth services if she is in urgent need of services and/or clarifications.

Another barrier to providing optimum care to Jean may be lack of collaboration between different specialists due to insufficient resources and manpower to sync patient data across different departments. In such a case, patient management plans provided to Jean may not be holistic in nature and may not encompass every aspect of Jean's condition (Lunney et al., 2018). One way to address this barrier could be to make sure that Jean follows up with just one physician who is completely aware of her condition and co-morbidities and who can provide a holistic management approach based on her most recent test results.

Conclusion

In reviewing Jean's case study in relation to her chronic kidney disease diagnosis and local health resources available for her treatment, I have developed an in-depth understanding of the need to provide optimum care to patients. In my future nursing practice, I intend to incorporate three important treatment goals when caring for patients suffering from chronic conditions. The first goal is to identify different stress points for the patients and help them cope with their new diagnosis. Being diagnosed with a chronic condition can be socially and financially stressful for patients and they often go through a transition phase before they reach a point of acceptance. As a nurse, I believe that it is important to support patients in their transition period so that patients can come out of it feeling confident, empowered, and ready to face their health challenges. This will not only improve the patient's quality of life, but also health outcomes for their chronic conditions (Leatherland, 2007).

The second treatment goal for my patients would be to prepare them adequately before dialysis or renal transplant by encouraging them to participate in information groups run by healthcare facilities. These sessions are very educational and give a chance to patients to share any concerns they may have in a secure environment. These are often group sessions and they give patients the chance to meet with other patients going through the same journey. Thus, patients not only gain knowledge but also companionship during the course of their chronic condition (Leatherland, 2007). Based on the cultural and ethical background of the patients, my third treatment goal would be to appoint social workers who can work with the patients and their families to overcome cultural barriers to treatment. These social workers should be able to communicate patient needs to the healthcare providers appropriately so that optimal care can be provided to the patients at all times (Alves et al., 2016).

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