

**WESTERN UNIVERSITY  
NEPHROLOGY ROTATION OBJECTIVES  
PRD CLINIC- MULTI CARE KIDNEY CLINIC- WESTMOUNT MALL**

**Revised:** December 19, 2024

**Reviewed by Residency Program Committee:** March 2025

**Next review date:** June 2026

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**Preamble:** This rotation is designed to ensure that the Nephrology Trainee develops expertise in the management of out-patient renal disease.

- On PRD Clinics at Westmount, the Trainee is expected to attend **ALL** clinics during the week. The morning clinics are scheduled from 0830 hours to 11:30 hours and the afternoon clinics are scheduled from 1300 hours to 1700 hours.
- As well, attend **ALL** Tues PM GN Clinics.
- All clinics are conducted under the supervision of a staff Nephrologist. Most clinics deal with patients with chronic kidney disease approaching dialysis, but there are some specialized clinics which will be noted on the clinic schedule.
- Trainees are advised to spend at least two clinics a month with each consultant in order to experience the breadth of clinical practice among the consultants and to join the clinics of the consultant on first-call on any given week.
- The Trainee is expected to attend the MCKC (Multi-Care Kidney Centre) clinic to gain expertise in the management of patients approaching dialysis and to learn to work with a multidisciplinary team to provide comprehensive care to a patient with advanced chronic kidney disease. The multidisciplinary team consists of a Primary Nurse, Pharmacist, Dietician, and Social Worker.
  - Primary Nurse: The primary nurse follows the patient longitudinally in the MCKC clinic. Additionally, they provide education on living with chronic kidney disease and dialysis options, amongst other areas. The Trainee works with the Primary Nurse to complement this education.
  - Pharmacist: The Pharmacist reviews the medications of the patient to ensure proper dosing as well as follows anemia parameters. They help manage iron dosing/infusions as well as ESA prescriptions. The Trainee will work with the Pharmacist to ensure the patient is on optimal medications.
  - Dietician: The Renal Dietician follows the patient's potassium, mineral bone disease, and nutrition parameters. The Trainee is expected to collaborate with the Dietician to develop an optimal plan.
  - Social Worker: The Social Worker helps the patient navigate the patient's journey in living with chronic kidney disease. This includes emotional support, understanding the patient, and advocating for the patient on receiving social assistance.
- The Trainee is expected to dictate notes on all patients seen in the clinic within 24-hours of seeing the patients, and to follow-up on any laboratory or imaging tests ordered during the clinic.
- The Trainee is expected to attend any scheduled noon hour Interhospital Rounds and Journal Club Rounds held from 1200 - 1300 hours. Trainees are scheduled to present at Rounds throughout the year.

- The Nephrology Trainee will participate in the Nephrology Resident Call schedule (home call), as per PARO guidelines.
- As the Nephrology Trainee progresses in their stages of training, it is expected that they will be more independent as well as provide supervision of procedures to junior trainees. They will have more clinical and administrative autonomy that is deemed appropriate by the supervising Consultant.

#### **ROTATION FREQUENCY:**

- 1) Trainees will complete 4 PRD clinic rotations at the Multi Care Kidney Clinic, within a 2-year period.

#### **EVALUATION:**

- 1) ITER completion through One45.
- 2) EPA completion through Elentra.
- 3) Multi sourced feedback evaluations from allied health team.

#### **EDUCATIONAL RESOURCES AVAILABLE:**

- 1) Library facility.
- 2) Textbook- Renal Physiology 6<sup>th</sup> Edition and Handbook of Dialysis 5<sup>th</sup> Edition.
- 3) Online educational material.

#### **Achievable Entrustable Professional Activities**

The following EPAs have been identified as being achievable during this training experience:

##### **Transition to Discipline**

- EPA 1 Assessing patients with known kidney disease, identifying the unique concerns seen in Nephrology patients
- EPA 2 Recognizing Nephrology-specific emergencies/urgencies, demonstrating insight as to own limits and knowing when to seek appropriate help

##### **Foundations**

- EPA 2 Assessing and providing an initial plan for investigation and management for patients with CKD
- EPA 3 Assessing and providing an initial plan for investigation and management for patients with hematuria and/or proteinuria

##### **Core**

- EPA 3 Assessing and treating patients with difficult to control or suspected secondary hypertension
- EPA 4 Assessing and providing an initial investigation and management plan for patients with complex fluid and electrolyte abnormalities
- EPA 9 Monitoring patients receiving immune modulating therapy and managing complications
- EPA 10 Monitoring and providing medical management for patients with stable renal disease
- EPA 11 Providing comprehensive care for patients with progressive kidney dysfunction
- EPA 12 Facilitating patients' transition to an ESRD treatment modality, or to end of life care
- EPA 13 Providing longitudinal management for patients receiving chronic dialysis
- EPA 14 Assessing and managing the care of patients with complex complications of dialysis access

- EPA 18 Managing longitudinal aspects of care in a clinic
- Transition to Practice**
- EPA 1 Managing the multidimensional aspects of nephrology practice

Over the course of the Adult Nephrology Training Program at Western University, trainees will cover the competencies and objectives outlined in the Royal College Nephrology Competencies found [here](#). In this rotation, the following competencies will be emphasized:

**MEDICAL EXPERT (the integrating role):**

- 1) Possesses the basic scientific knowledge of complications in chronic kidney disease including fluid homeostasis, blood pressure regulation, acid-base regulation, electrolyte balance, mineral metabolism, and anemia.
- 2) Understanding of clinical pharmacology as it relates to drug prescribing and dose adjustments in renal disease.
- 3) Understanding the epidemiology of chronic kidney diseases, including conditions that commonly cause chronic kidney disease and end-stage renal failure.
- 4) Understands the impact of chronic illness on mental health.
- 5) Understands the effects of systemic disease of the kidney and how reduced kidney function affects systemic health, in relation to patients with severe chronic kidney disease.
- 6) History and physical examinations are complete, accurate and well organized.
- 7) Gathers and uses all the pertinent information to arrive at complete and accurate clinical decisions.
- 8) Accurately interprets laboratory findings in patients with chronic kidney disease.
- 9) Establishes a patient-centred management plan for the management of chronic kidney disease of all stages.
- 10) Possesses the knowledge to manage the complications of severe chronic kidney disease in patients approaching dialysis.
- 11) Determines the most appropriate therapies for renal protection including blood pressure management, reduction of proteinuria, and cardiovascular health.
- 12) Possesses the knowledge of the principles of end-of-life care as it pertains to end-stage kidney disease including symptomatic treatments.
- 13) Demonstrates an understanding of the indications for renal replacement therapy.
- 14) Demonstrates a thorough understanding of the different methods of renal replacement therapy, including indications and contraindications for organ transplantation.
- 15) Obtains and documents informed consent for renal replacement therapy.
- 16) Implements a patient-centred care plan that supports ongoing care, follow-up, and response to treatment for patients with chronic kidney disease, including coordination of care with other health care providers.
- 17) Provides safe transitions of care for patients between primary care and when beginning renal replacement therapy.

**COMMUNICATOR:**

- 1) Establishes therapeutic relationships with patients with chronic kidney disease approaching dialysis and their families.
- 2) Uses a patient-centred approach to encourage patient trust and autonomy in conversations regarding

progression and of kidney disease, initiating renal replacement therapy, or choosing conservative care.

- 3) Uses effective communication skills and strategies to help patients and families manage their health and make informed decisions.
- 4) Uses effective interviewing skills to gather relevant medical and psychosocial information from the patient and family.
- 5) Demonstrates the ability to synthesize the patient encounter into a clear and comprehensive management plan.
- 6) Accurately documents the clinical encounter in a timely manner in compliance with regulatory and legal requirements.

**COLLABORATOR:**

- 1) Establishes and maintains positive relationships with other health care professionals to support patient-centred collaborative care.
- 2) Negotiate overlapping and shared responsibilities with other physicians and colleagues with respect to comprehensive care for patients with chronic kidney disease.
- 3) Engages in respectful decision making with physicians and other health care professionals for patients with chronic kidney disease.
- 4) Understands the limitations of a nephrologist and determines when care should be transferred to another physician or health care provider.
- 5) Demonstrates safe handover of care, in both oral and written communication, during a patient transition (to another physician, health care setting, or treatment modality).

**LEADER:**

- 1) Apply evidence and management practices to achieve cost-effective care for patients with chronic kidney disease at the level of the health care system.
- 2) Applies knowledge of health care resources for optimal patient care in regards to dialysis initiation in patients with chronic kidney disease.

**HEALTH ADVOCATE:**

- 1) Works with patients to address determinants of health that affect them and their access to health services.
- 2) Identifies barriers to health care and social services of patients with chronic kidney disease.
- 3) Works with patients with chronic kidney disease and their families to adopt healthy behaviours and increase self-care/independence.
- 4) Ability to incorporate disease prevention and health promotion during interactions with patients.

**SCHOLAR:**

- 1) Identifies opportunities for learning by reflecting on their performance during clinical interactions with patients and health care providers.
- 2) Recognises knowledge gaps in clinical encounters and generates a plan to address them.
- 3) Identifies pre-appraised clinical resources and critically evaluates the reliability and applicability of the information to apply in their practice.

**PROFESSIONAL:**

- 1) Demonstrates honesty, integrity, humility, commitment, compassion, respect, and maintenance of confidentiality in all clinical encounters.
- 2) Recognizes and addresses ethical issues encountered in patients with chronic kidney disease including initiation of or withholding dialysis.
- 3) Demonstrates commitment to patient safety in clinical decision making.
- 4) Fulfils and adheres to the professional and ethical codes of conduct, standards of practice, and applicable laws.