Nurse Practitioner Roles and Responsibilities in the Nephrology Practice Setting

By Jennifer Branch

I have been fortunate to work in the field of nephrology my entire career, mostly as a registered nurse for the first 20 years and now as an advanced practice provider over the past 3 years. I currently serve as an inpatient nurse practitioner in transplantation at an academic health system. For the first 2 years, I also had experience in outpatient clinics and dialysis units.

Outpatient clinic experience

Seeing patients on an outpatient basis during my outpatient clinic experience allowed me to review labs, medications, and health issues with many minutes of teaching while completing a full examination. Health maintenance reminders and why they are important (e.g., for mammograms, vaccines, etc.) were always addressed, encouraged, and written for follow-up or referrals, as well as a review of kidney diagnoses and health in patients with chronic kidney disease (CKD). My responsibilities included reviewing charts, seeing patients and families at clinic visits, writing orders and notes with independent billing, and reviewing post-visit labs with follow-up while keeping a consistent plan of care for optimal personalized CKD care. I saw many patients for post-hospital follow-up, reviewing reasons for hospitalization and medication changes as well as the patient's status. This was a great opportunity for me to assist in a smooth transition of care, providing follow-up if details had been missed or dropped. As a nurse practitioner, I have the tools to tackle examinations and extensive education while keeping the patient at the center of holistic care.

Hospital follow-up visits always included a thorough review of inpatient records, including discharge summaries and a medication list. If patient medications were added or adjusted, I made sure those changes were being implemented and followed by the patient. If patients were missing medications or did not understand the purpose for a medication, information was given, and medications were ordered or arranged to be ordered. Labs were reviewed and explained. Oftentimes, patients and families did not understand why they were hospitalized or what treatment was received while being hospitalized, which was addressed and explained. For example, patients admitted for acute kidney injury (AKI) often did not understand the implications and risks of repeat AKI, what AKI meant, what kidney function was, stages of CKD, and preventative interventions, such as home blood pressure, daily weights, or medication recommendations. Preventative practices were addressed, explained, and strongly encouraged for inhibition of CKD progression and/or rehospitalization.

I enjoyed appointments that were specifically scheduled for CKD and end stage kidney disease (ESKD) education. The visits included discussing modality options, diet, signs and symptom of ESKD, and labs. Meeting with patients and their support systems allowed me to address the plan of care in a holistic way by getting a glimpse of the patient's family dynamics, past experiences, and values. A range of emotions, from scared and unknowing to increased confidence and empowerment, could be seen in such a short span of time.

Outpatient dialysis experience

We are given so much opportunity to make an impact on dialysis regimen wellness, seeking input about management of care with the patient, which often leads to improved adherence, decreased acute issues, and ultimately less frequent hospitalizations. Rounds in the unit allowed me time to address and educate patients about alternate modalities of treatment, such as peritoneal and home hemodialysis. There was always time to consistently educate patients about transplantation options; routine visits allowed me to follow up on pretransplant checklists and discuss what to expect posttransplant. I enjoyed participating in and leading care-plan meetings that included interdisciplinary team members all contributing to the dialysis regimen with the patient. Concise documentation of rounds with accurate billing is essential to communicating with other health care team members for subsequent visits and care. I was able to act as a resource for troubleshooting, educating, and ordering what the dialysis staff and patients needed with support from physicians never far away if needed.

Inpatient rounds and dialysis

There is something special about getting to see patients in an acute setting. They do not pick us to be there at their time of need, and we are fortunate to be able to contribute at a stressful time. Patients and families are often scared, do not feel well, and may not understand their health issues or what is being done for the plan of care. Verbalization of explanations may be difficult for patients to comprehend, and there is often little time for visits. Each morning, I review charts, including vitals, labs, medications, and trends, as well as any changes to the plan of care. I order recommended interventions, including dialysis treatments, labs, medications, or other changes to the plan of care, and communicate all these tasks with interdisciplinary team members. I round on my assigned patients daily, provide updates on their plan of care emphasizing nephrology- and transplant-related issues, conduct education daily, and document with consult or progress notes with billing components. My notes are separately billed under my position with intermittent review by my collaborating physician. I work independently but also frequently with the service attending, fellows, and residents throughout the day. This supports a more comprehensive health regimen in a time of acute care for patients and families.

I consider myself lucky for the fulfilled, enriched roles I've had throughout various practice settings in my nephrology career. Working across practice settings alongside interdisciplinary teammates keeps my contributions cohesive and patients' wellness possible. As an advanced practice provider, I have found my niche weaving in additional education for holistic care for patients and families affected by kidney diseases by increasing patient confidence and empowerment, ultimately leading to improved outcomes. ■

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Driving Change: The Role of Nurse Practitioners in Nephrology Care Delivery Redesign

By Candice Halinski

The suboptimal outcomes experienced by patients with chronic kidney disease (CKD) are a direct result of flaws in the design of the health care delivery model. This is evidenced by lack of pre-existing nephrology care, high rates of dialysis initiation using a central venous catheter, increased morbidity and mortality, and low rates of preemptive transplantation (1). Improvement on the associated outcomes can be facilitated by the creation and deployment of supportive interdisciplinary care delivery models.

Under the Advancing American Kidney Health initiative, ambitious targets have been identified to improve on the care delivery model for patients with kidney diseases, including the aim to increase the use of home dialysis therapies and transplantation. Little progress can be made on these initiatives without the identification of gaps in the existing care delivery model. This requires foundational knowledge of the disease trajectory, direct experience with the population, stakeholder management, organizational awareness, and expertise in population and community health initiatives. The direct patient access, advanced education and training, knowledge of evidence-based practice, and expanded clinical skills (2) of nurse practitioners (NPs) make these professionals ideal candidates to lead the co-creation of care delivery models.

NPs can integrate science into practice to design programs that improve clinical outcomes.

Launched in 2012, Northwell Health's Healthy Transitions program is evidence that the integrated use of NPs and nephrologists has positively affected health care delivery. Under this model, NP-driven care delivery design coupled with nephrologist collaboration, partnership, and medical direction results in positive patient outcomes. In affiliation with a medical director and under the clinical supervision and daily operational direction of an NP, the Healthy Transitions program was created to deliver evidence-based treatment interventions that improve coordination of care and education to decrease