DCC Renal Pathway for RN and RD Diabetes Educators

Glomerular Filtration Rate (GFR)

GFR 30-60

NOTE: Specific renal nutrition intervention typically not required.

1. Is the patient already followed by a nephrologist?

If not, direct GP to CKD pathway (http://www.ckdpathway.ca) - suggest an updated ACR if not already complete.

NOTE: Acceptance is dependant on referral criteria; not all patients are accepted. Not all patients accepted by nephrology will see a RD or RN.

2. Does the patient have renal nutrition questions?

Patients can also self-refer to the AHLP "Your Kidney Health: What Should I Eat" for an RD lead class or "Your Kidney Health" class taught by a RN for general kidney information (1-844-527-1160 or www.ahs.ca/AHLP).

GFR <30

NOTE: Risk of hypoglycemia increases with advanced renal disease.

1. Is the patient already followed by Alberta Kidney Care - South (AKC-S)?

This may be by the nephrologist alone or the whole multidisciplinary team, depending on the patient's kidney failure risk equation (KFRE). You can confirm via RD team lead*.

YES

1. Patient already seeing renal RD:

Collaborate** with renal RD who will provide renal nutrition information and *basic* diabetes information (i.e. balanced meals, carbohydrate sources).

Diabetes educator continues providing more complex diabetes nutrition education and follow-up (ie. Carbohydrate counting, glycemic index, etc).

2. Patient not yet seeing renal RD:

All patients followed by a nephrologist can request to see a renal RD. In your letter to the nephrologist, request that they refer patient to the renal RD.

Refer to next page for key renal nutrition points while patient is waiting to see a renal RD.

NO

1. Recommend GP refer to nephrology. (http://www.ckdpathway.ca/referral) - suggest an updated ACR if not already complete.

2. Refer to DCC RD for basic renal nutrition advice until the patient is followed by RD at AKC-S *(see next page)*.

NOTES

- **Goal: limit restrictions on nutritious foods to ensure patient gets a balanced diet.**
- All patients should continue seeing their DCC RD re: nutrition management for diabetes.
- * RD team lead: Madeleine McIntyre, RD (madeleine.mcintyre@ahs.ca, 403-955-6396 or Connect Care in-basket).
- ** via Connect Care in-basket message.

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Developed by Nutrition Services and the Endocrinology and Metabolism Program

Key Renal Nutrition Points for RD Diabetes Educator

Nutrition Services

GFR <30

1. Referral received to see patient that is not currently or not yet followed by renal RD. Confirmed via RD team lead*

2. Review bloodwork and intervene as follows:

High potassium (K) ≥5.5mmol/L at repeated measures
(http://ckdpathway.ca/Content/pdfs/Management_of_elevated_serum_potassium.pdf)

1. **Assess for non-dietary factors** that can raise serum potassium, such as: hyperglycemia, constipation, new ACEi/ARB medication started. Advise on best practice for managing hyperglycemia and constipation. Document that new ACEi/ARB may be a contributing factor and direct GP to CKD pathway (as per above link).

2. **Assess dietary potassium intake:**

Focus on less nutritious sources first, such as processed meats with potassium additives (i.e. potassium lactate, phosphate or acetate) or salt substitutes (ie. potassium chloride in Half Salt™).

Collaborate with renal RD if further intervention is needed - discuss with RD Team Lead*.

Restricting whole grains, fruits and vegetables is a last resort measure. Do not provide patient with "Potassium Foods" handouts as this could add more confusion and over restriction.

Low Albumin <35g/L +/- proteinuria

1. **Instruct on moderate protein** (0.8-1g/kg IBW/day) **and low sodium** (<2300mg/day) **intake**.

KEY POINTS:

A. Avoid ultra processed foods

B. Instruct on label reading

C. Avoid adding salt to foods

Consider using the following handouts: "Cooking without salt" and "Sodium and Your Diet" found on the Nutrition Services Hub.

Vitamin and Mineral Supplements

- If GFR <30, do not recommend multivitamin/mineral supplements due to risk of vitamin A toxicity. Replavite (renal multivitamin) is not indicated unless patient is on dialysis; defer to renal team.
- Calcium and vitamin D: do not recommend calcium or vitamin D supplements, leave this to the nephrologist. Do not adjust doses if patient is already taking calcium and/or vitamin D supplements.

Phosphorus (PO4)

Low phosphorus diet education not required by DCC RD.

Elevated PO4 is very unlikely in this situation. If patient does have repeated measures of high PO4, instruct them on label reading to avoid PO4-additives (ie. ingredients with 'phos') which are often found in highly processed foods.

NOTES

- **Goal: limit restrictions on nutritious foods to ensure diet remains balanced.**
- Encourage patient to eat regular, balanced, low sodium, moderate protein meals/snacks.
- All patients should continue seeing their DCC RD re: nutrition management for diabetes.
- * RD team lead: Madeleine McIntyre, RD (madeleine.mcintyre@ahs.ca, 403-955-6396 or Connect Care in-basket message).

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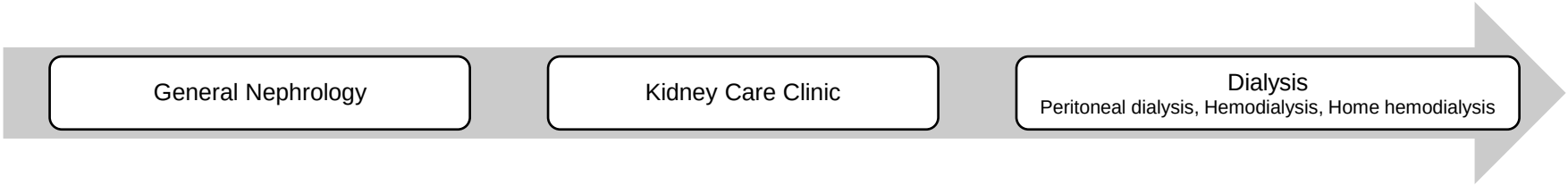
Additional Information

- Alberta Kidney Care – South (AKC-S)



- General Nephrology: GP can refer to nephrologist (http://ckdpathway.ca/referral), acceptance is dependent on referral criteria (i.e. GFR, ACR >30, persistent albuminuria/proteinuria, sustained hematuria, unexplained progressive decline in GFR ≥ 5 ml/min/1.73m^2 over 6 months, etc.).
    - Patients are only seen by the general nephrology RD upon nephrologist referral, usually for a one time consult. Patients can request this referral as well.
- Kidney Care Clinic (KCC):
    - A multidisciplinary care clinic: RN (case manager), RD, SWK.
    - Referral to this clinic is made by the nephrologist based on the patient's Kidney Failure Risk Equation (KFRE) >10% in 2 years (calculated at www.kidneyfailurerisk.com and based on age, gender, GFR, ACR)
- Dialysis:
    - When a patient starts dialysis depends on their uremic symptoms and choice, typically around a GFR 6-9 ml/min/1.73m^2.
    - Modality decision is made between the nephrologist and patient. There is a modality RN who helps educate patients so they can make an informed choice.
    - RDs follow patients in all modalities: peritoneal dialysis (PD; SMCHC), hemodialysis (HD; several sites across Calgary) and home hemodialysis (HHD; based out of SMCHC).
- Conservative care: AKC-S RDs do not follow conservative care patients unless consulted.
- Renal Diabetes Educator Nurse Clinician: There is a diabetes educator RN within AKC-S, Stefanie Latreille Banville. Stefanie will only see patients who are on PD and HD with Type 2 Diabetes at this time (Stefanie is covering for Breanne Magnus until 2026).
- Blood work in AKC-S: How often it's collected depends on GFR. In KCC: GFR ≥20 = q 3 months, GFR <20 = monthly; HD = q 8 weeks; HHD/PD = every 1-2 months. May accept variation of 3-5 ml/min/1.73m^2 especially at higher GFR (i.e. around 30+ vs. 15-20). GFR can change with fluid status, medications, etc. Watch for trends in bloodwork!
    - How recent do results need to be?
        - Depends on how abnormal the result is and if there are other reasons for this. Generally, results within past month are acceptable. GP can re-test bloodwork based on www.ckdpathway.ca recommendations (varies from 1-4 weeks depending on parameter).
    - What does 'repeated measures' or 'sustained' mean?
        - 2-3 results separated in time.

- Use your clinical judgement and consult the DCC Education Consultants and/or CDM RD Team Lead as needed.
- AHLP: AHLP RDs will no longer see patients for renal or diabetes concerns. Patients can still self-refer to classes.