Renal Social Work Staffing Recommendations by Treatment Modality

The Canadian Association of Nephrology Social Workers (CANSW) is a national organization, promoting renal social work excellence across the country. In making the following recommendations, CANSW recognizes that there are provincial, regional and local factors which may require advocating a different Full Time Equivalency (FTE) ratio based on the specifics of a health service funding structure. Also, the staffing ratios may need to be adjusted over time as health care services evolve. CANSW makes the following general renal social work staffing recommendations:

Treatment Setting/ Modality	Patient Numbers	**Social Work FTE ******
Pre-dialysis Clinic/ Stages 3-5 EGFR <15-59	150-500	1.0
Home Dialysis Clinic (Peritoneal Dialysis and Home Hemodialysis)	80-100	1.0
In Centre Hemodialysis Unit	75-100	1.0
Acute Care Renal Ward	20-30	0.75
Satellite Settings	100-250	1.0
Transplant Treatment Centre	175-200	1.0
Post Transplant Clinic	250-750	1.0

**Workload recommendations are based on a 37.5 workweek

Additional Considerations:

Additional FTE allotment should be considered when:

- The service area has unique challenges which may require increased social work involvement such as:
  - Unique populations: eg. Indigenous, Ethnic Group, Refugee, Migrant Worker, New Immigrant, LGBTIQ2, Veterans and Pediatrics
  - Complex social issues: eg. Poverty, Housing, Food Insecurity, Mental Health Issues and Addictions, HIV
  - Barriers to care: eg. Transportation, Program Capacity Issues, Need for Intra-Provincial Care/Services, Staffing, Technology
  - Geographic challenges: eg. Rural, Remote locations, Lack of infrastructure, distances
  - Complex care needs: Conservative Care, Supportive Care, Palliative Care

Smaller sized communities have different service needs compared to larger urban centres however either one may need to advocate for additional staffing based on local resources (eg. Kidney Foundation support groups may be available in larger centres but not in smaller ones).

- Travel time between points of service. This could include home visits, distance between satellite Hemodialysis units and the number of satellite units, visiting dialysis patients in acute care, traveling between treatment modality locations, and attending meetings. It is recommended that employees are paid for their travel time and compensated according to their local union agreement if applicable or by the Government of Canada Automobile Allowance Rates.

- Workload is mixed. In smaller communities one social worker may be responsible for two or more renal treatment modalities. (eg. one social worker may be responsible for ambulatory care patients as well as acute care patients). It is preferred that when two 0.5 positions are combined, they are both in the nephrology program as this builds capacity and allows for the natural variances of workload in the programs. When practice workload for one of the two areas exceeds allocation, it is important to consider increasing FTEs.

- The renal social worker is also doing discharge planning at the hospital. Discharge planning or case management can be a labour intensive activity, also subject to resource availability in the community (human resources, home care etc).

- Where there is a team service delivery model in place and/or an expectation to contribute to program development. Some examples would be renal program committees, developing education resources materials/groups, representing the renal program in community partnerships, developing new programs.

** Satellite Units: a general understanding regarding satellite hemodialysis units is that they serve a more stable population than in-centre hemodialysis units and may have a smaller turnover of patients. In-centre hemodialysis units usually stabilize patients before transfer to a satellite. Distance to travel to a satellite unit may need to be considered when determining appropriate social work staffing ratios.