

# Transforming Participation in Chronic Kidney Disease (CKD) Interventions Toolkit

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## Transforming Participation in CKD

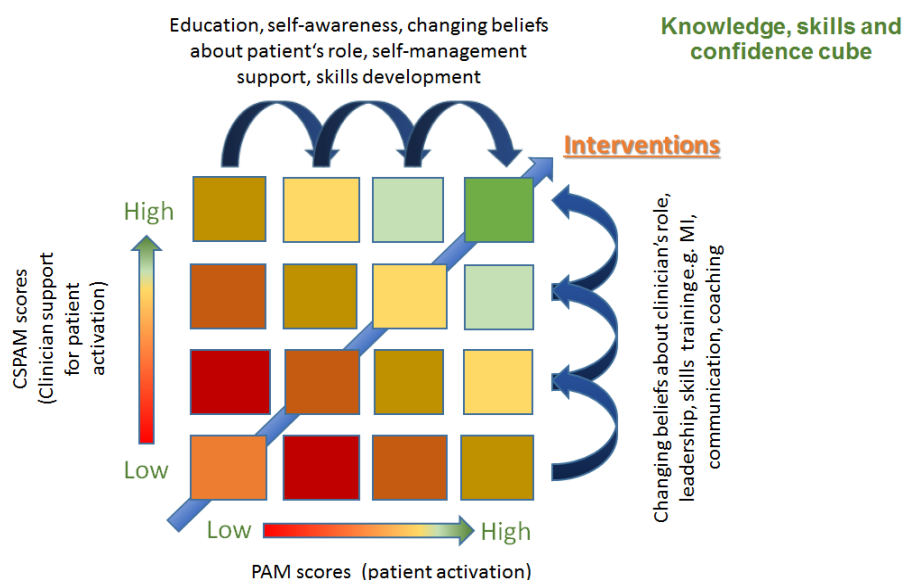
### Interventions Toolkit

One of the goals of NHS England is that the NHS becomes better at empowering patients and their carers to be involved in the management of their own care (1). Supporting people in this way can improve motivation, engagement in healthy behaviours, and can have an impact on symptoms and clinical outcomes, and change the ways in which people interact with health services. There is evidence that a person’s readiness to engage in self-management (their “level of activation”) may be increased by certain targeted interventions. This principle underlies the interventions described here.

NHS England and the UK Renal Registry have worked in partnership to develop a programme – Transforming Participation in CKD. One of the aims of this programme is to address the question “Can the use of intervention programmes help to improve the knowledge, skills and confidence of patients with kidney disease (Stage 3b or higher) to enable fuller participation in the management of their own health?”

The first step in answering this question was to identify a number of potentially useful patient and health professional interventions. A workstream of patients and health professionals was assembled to tackle this. One issue which rapidly became apparent was that targeting interventions solely at patients was unlikely to be very helpful in achieving the necessary culture change, since this would also require health professionals to be sufficiently “activated”. Figure 1: Skills, knowledge and confidence cube, illustrates an “activation space” defined by both patient and health professional levels of activation, in which the level of health professional activation may play a crucial role in motivating or demotivating patients with respect to engagement in self-management. Hence the workstream was also tasked with identifying interventions which might be helpful for patients and health professionals.

**Figure 1.** Knowledge, skills and confidence cube



Likelihood of achieving full involvement of patients in their own care is dependent on both their own level of activation and the level of activation of the people looking after them.

In figure 1 patient activation is measured by the Patient Activation Measure (PAM) survey and the health professional activation is measured by the Clinician Support for Patient Activation Measure (CS-PAM). This framework may be of use in selecting appropriate interventions, at appropriate stages, for both patients and health care professionals

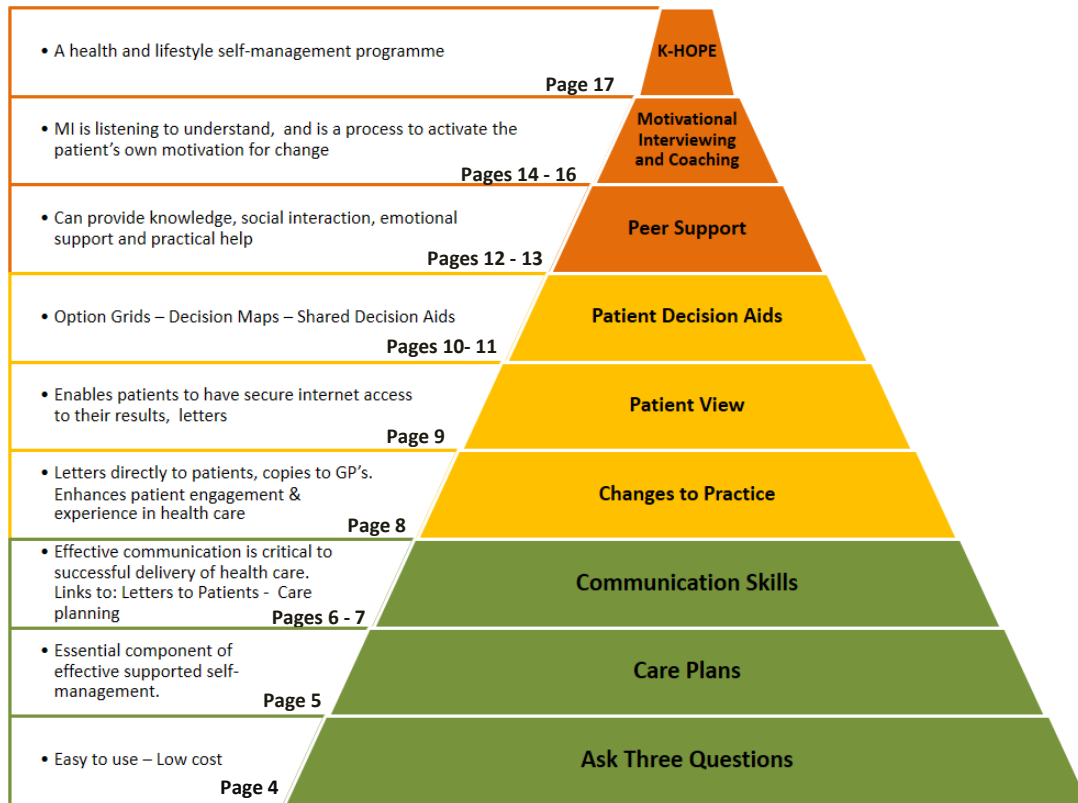
The workstream considered potential interventions against an agreed framework of criteria (Table 1)

**Table 1.** Framework of criteria for evaluation of interventions used to measure suitability of interventions

How will this intervention help change behaviours?
Which individuals will benefit and how will they be identified?
Are there examples available showing how this intervention works in practice?
What evaluated evidence is available?
What training will be needed to implement this intervention?
What resources would be required, both monetary and time?

The interventions identified are shown in Figure 2. They are depicted as a pyramid, the base of which is occupied by interventions which, in the opinion of the workstream members, are applicable to all patients with CKD stages 3-5 who have been referred to the renal team. Interventions which require more targeted application are in higher positions within the pyramid. Descriptions of the individual interventions follow in the document.

**Figure 2. The Intervention pyramid**



These interventions are recommended for both clinical teams and patients. Some are appropriate for patients and some for health professionals. All require engagement of both and potential benefit for both. These interventions are not prioritised. Those at the base of the pyramid are categorised as being easily implemented, applicable to all and requiring little resource, we recommend that all units consider implementing them. Those in the centre of the pyramid might be offered to all patients although not all will wish to participate. In order to implement these interventions some organisational change may be required. The interventions at the top of the pyramid are less easily implemented, not universally available and may involve organisational change and cost. We regard these top-level interventions as suitable for a specific cohort of patients or staff who will benefit from them.

## Ask Three Questions

‘Ask 3 Questions’ is a simple way of helping patients get more involved in their treatment and care. It supports the NHS’s aim of “no decision about me, without me’.

The three questions are:

1. What are my options?
2. What are the pros and cons of each option for me?
3. How do I get support to help me make a decision that is right for me?

An optional fourth question may also be asked: ‘What if I do nothing?’

Addressing these questions during a consultation can aid decisions about the best course of action for each individual patient.

### **What are the benefits?**

Ask 3 Questions:

- is quick and effective, not expensive to use and easy to implement
- helps patients to have a better understanding of their health, encouraging them to get involved in managing their own healthcare
- improves communication between patients and health professionals.
- helps patients be more in control of their own health and care

### **How can it be used?**

#### **For patients**

- The key message for patients is to always be prepared to ‘Ask 3 questions’ when discussing your treatment options.
- It might find it helpful to think about these questions before each consultation

#### **For staff**

- Encourage the use of the “Ask 3 Questions” technique in your clinical practice
- When responding to questions, it is helpful to use plain language, simple illustrations, and check patients understanding of the main points of the information you’ve given.

### **References and resources**

<http://personcentredcare.health.org.uk/resources/developing-ask-3-questions-campaign-raise-peoples-awareness-of-shared-decision-making>

<http://www.cardiffandvaleuhb.wales.nhs.uk/ask3>

<http://www.pat.nhs.uk/downloads/patient-information-leaflets/other/Ask 3 Questions Leaflet.pdf>

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## Care Plans

Personalised **care-planning** is an essential component of effective supported self-management. People need to be supported to express their own needs and decide on their own priorities through a process of information-sharing, shared decision-making, goal-setting and action-planning. The emphasis in **care-planning** should be on proactive interventions to keep people as healthy as possible. The Department of Health have mandated that all people with a long-term condition have a '**care-plan**' by 2020.

**Care plans** have been in existence for many years and there are many good examples. In general though it seems that, as currently practised, they are often complex documents, difficult to implement and not always reflective of a shared approach to decision making. **Care plans** should reflect mutually agreed goals and actions, by patient and health professional, and be updated regularly. Such plans can support partnership working and increase patient self-efficacy behaviours.

In its most basic form the **care plan** could be part of a letter addressed to the patient and copied to their GP (see later section) which paraphrases the conversation which took place during a consultations and sets out the agreed goals and actions. This would also be available on **PatientView**. We recommend this simplified approach.

### Resources

People in control of their own health & care – The state of involvement. The kings fund in association with National Voices – November 2014

<http://www.kingsfund.org.uk/publications/people-control-their-own-health-and-care>

The personalised care planning e-learning course has been developed on behalf of DH by NHS Employers and is delivered by HEE e-Learning for Healthcare. <http://www.e-lfh.org.uk/programmes/personalised-care-planning/>

The Kings Fund: Delivering better services for people with long term conditions.

[http://www.kingsfund.org.uk/sites/files/kf/field/field\\_publication\\_file/delivering-better-services-for-people-with-long-term-conditions.pdf](http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/delivering-better-services-for-people-with-long-term-conditions.pdf)

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## Effective Communication Skills

Effective communication between the patient and healthcare team is key to successful outcomes in patient-centered care and in enhancing patient engagement in their own care. Effective communication between individuals involves more than just information exchange. It is a skilled activity consisting of various key skill areas including non-verbal communication, listening, explanation, questioning, negotiation, reinforcement, persuasion, reflecting, opening and closing and self-disclosure (Hargie 2006). It requires clusters of behaviours, values, traits, and attitudes as well as skills to exchange information, feelings and meaning verbally and non-verbally.

### What are the benefits?

- Effective communication helps build good rapport between patient and health professionals and ensures a clear understanding of patient concerns and worries.
- Good clear communication coupled with an empathetic understanding of patient needs helps build strong relationships and can enhance understanding and patient motivation.
- Listening skills are an important part of good communication; being an “active” listener helps avoid misunderstandings. Good listening skills enable health professionals to understand the deeper emotional issues affecting patients and help to contextualise management.
- Good writing skills are also an essential part of good communication. A patient’s level of understanding of written information can influence outcomes such as medication adherence or health behaviour change.

### How can it be used?

#### **For patients**

- To gain the knowledge skills and confidence to self-manage their condition
- To identify and address issues that impact upon everyday life beyond clinical outcomes
- To explain and clearly identify the reasons for making decisions about treatment and options based on the values and circumstances important to them
- To help build a relationship of equality with clinical teams where the experience and expertise of the patient can contribute to service provision and development.

#### **For staff**

Effective communication helps the healthcare provider focus on the whole person. This includes sharing information and decisions, providing compassionate and empowering care, and being sensitive to patient needs. The following skills help build good relationships with patients.

- Active and attentive listening for both verbal and nonverbal communication
- Understanding patient/family problems and working together to find manageable solutions
- Use of open questions where possible to elicit patient thoughts and ideas. Use closed questions in information giving.
- For written communication, use clear wording in plain English and explain medical terminology in lay terms.
- Involve patients and explain record keeping
- Learn and understand the barriers to communication



Communication skills training is now assuming a larger role in many undergraduate and postgraduate clinician training programmes. Some aspects are also covered in NHS mandatory training programmes. Effective communication is integral to many of the interventions referred to in this document including Ask 3 Questions, Care Planning, and Use of Decision Aids, Coaching and Motivational Interviewing. Training in advanced communication skills is often focused on particular speciality areas such as palliative care. A basic communications e-learning course can be accessed at <http://rcnhca.org.uk/46-2/principles-of-nursing-practice/>

## **References and resources**

Hargie O (ed). (2006). The Handbook of Communication Skills. Third edition. Hove: Routledge

Lewin S, Skea, Entwistle VA, Zwarenstein M & Dick J (2009). Interventions for providers to promote a patient-centred approach in clinical consultations (Review). The Cochrane Collaboration. John Wiley & Sons Ltd

How healthcare professionals in Scotland develop their communication skills, attitudes and behaviours: An independent report for NHS Education for Scotland Steven McCluskey, Susie Heywood, Niamh Fitzgerald Create Consultancy Ltd. [www.createconsultancy.com](http://www.createconsultancy.com)

Institute for Healthcare Communication – Impact of communication in Healthcare  
<http://healthcarecomm.org/about-us/impact-of-communication-in-healthcare/>

## **BMJ Learning**

A wide range of modules and events to assist doctors in their professional development. This includes the following communication skills modules:

- Communication skills: an up to date guide
- Advanced communication skills

The Respect model

<http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Effective-Patient-Physician-Communication>

## Changes to Practice

The routine ways in which care is organised and delivered can have a major influence on patient engagement in their own healthcare. Small changes to these established practices can make a big difference.

For example

- Letters can be written directly to patients and copied to GPs rather than vice versa
- Blood tests taken a few days before clinic allow real time discussion of results
- Footnotes on clinic letters with information on relevant websites

The information below relates specifically to “*letters addressed to patients*” as an example of a changes to practice

### **What are the benefits?**

This can encourage clear, non-technical communication, give ownership to patients, enhance their engagement in, and experience of health care as well as encouraging person-centre care among clinicians.

Patient comments:

*“I feel he is putting me first ...”*

*“It’s more personal to me”*

*“I feel I’m being treated with more respect”*

### **How can letters to patients be used?**

In centres which have adopted this initiative, feedback from patients and clinicians is generally positive. Templates have been developed that promote goal setting and action planning. An initial learning curve may be required to refocus style and avoid the unqualified use of medical jargon.

The letter can constitute a care plan.

### **References and resources**

#### **Examples of Letters to patients:**

British Journal of Renal Medicine 2013 volume 18(1); supplement, page 21

[http://www.institute.nhs.uk/quality\\_and\\_service\\_improvement\\_tools/quality\\_and\\_service\\_improvement\\_tools/patient\\_information.html](http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/patient_information.html)

#### **Evidence of benefit**

<http://www.bmj.com/rapid-response/2011/11/02/write-patient-and-send-copy-gp>

## Patient View

Patient View is a secure website system that gives patients on-line access to details about their kidney care. Patient View shows a person’s latest blood test results, online information about kidney conditions and treatment, and links to other helpful websites. A list of the tablets and medicines, plus an individual’s status on the transplant list is available in some Trusts. Patients can also enter information such as blood pressure readings or blood glucose results. A new development is being planned for units involved in the TP-CKD Programme to have access to their Patient Activation Measure and Patient Reported Outcome Measurement readings. There is also the possibility to take part in an on line forum, to interact with other patients about issues such as how to cope with kidney disease. An individual’s access to Patient View can be shared with family members and also with their GP.

### **What are the benefits?**

During 2011, 250 patients were asked for their opinions on using Patient View (NHS Kidney Care 2012) and they stated that Patient View gave them

- A better understanding of their kidney disease
- More control of their medical care
- More involvement in decisions about their care
- "Peace of mind" about their treatment

Some patients said they found it helpful to share their login details with staff from other renal units when they went on holiday. Others said

*"I now feel that I'm far more in control and I'm now able to see things a lot more clearly than I did before"*

*"I might ring the dietitian up and have a conversation about my blood results. I probably wouldn't have done that before I used Patient View"*

### **How can it be used?**

#### **For patients**

Patients who want access to Patient View should ask their health care professional to help provide a login and password. This allows patients to login to the site (see below) to access records.

#### **For staff**

Try to ensure that the process you have in place for patients to access Patient View is as patient friendly as possible. Training and support may be necessary. You might consider identifying a dedicated “Patient View Champion” responsible for informing, consenting and training patients. It might also be helpful to ensure that frontline staff are able and willing to talk with patients about Patient View.

### **References and resources**

NHS Kidney Care (2012) *Renal Patient View: a system which provides patients online access to their test results*. Final Evaluation Report.

**Patient View** website: <https://www.patientview.org/>

**PatientView** Recruitment toolkit: <http://www.rixg.org/patientview/pages/how-to/recruitment-toolkit.php>

**PatientView** YouTube account: <https://www.youtube.com/user/renalpatientview>

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## Patient Decision Aids

Patient Decision Aids (PDAs) are information resources specifically designed to help people make decisions about difficult healthcare options. They help people to think about why one option may be better for that individual than another, increasing their awareness and understanding of the potential risks and benefits of different choices and the likely outcomes. They facilitate shared decision-making. They are intended to complement, not replace, the information and advice given by clinicians.

In essence the Decision Aid consists of five steps which guide patients through the process:

1. **Introduction** – provides information about the health problem, treatment options and decisions which need to be made.
2. **Comparing options** - accurate information on the similarities and differences between treatment options
3. **Views of the individual** – establishing an individual’s preconceptions about treatment options in relation to their specific circumstances
4. **Trade-offs** – helping the individual think through trading-off the advantages and disadvantages of each option
5. **Decision** – supporting the individual in choosing the best treatment option for them

### **What are the Benefits?**

There is good evidence that PDAs improve people’s knowledge regarding options, and reduce their decisional conflict related to feeling uninformed and unclear about their personal values. PDAs may also stimulate people to take a more active role in decision making, and improve accurate risk perception (Stacey et al 2014).

### **How can Patient Decision Aids be used?**

There are a number of types of PDAs available.

The **Yorkshire Dialysis Decision Aid (YoDDA)** is produced as a booklet – the Dialysis Decision Aid Booklet. It can be downloaded or ordered from [Kidney Research UK](#). Many patients share it with family members

*“.....I’d have to give it ten out of ten. It’s answered a lot of me questions...there’s lots of things that it’s told me there that I think I’ve put it down just to be me, and it isn’t, it’s part of the illness’*

The **National Patient Decision Aid for established renal failure (NHS Right Care)** is an online PDA which patients can work through by themselves or supported by family and friends. Shared Decision Making sheets are shorter versions which present the treatment options.

**Discussion maps** are illustrated patient-friendly maps, showing decision points and commonly encountered experiences. The kidney map is used with patients who are expected to need renal replacement therapy in the following 12 months. Discussions usually take place in a small group (five to eight people), allowing participants the space and time to interact. A trained facilitator, often an experienced patient, supports and guides the group through the conversation.

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**Option Grids** are one page evidence-based decision aids that present a menu of treatment options and compare their potential benefits and risks. They are designed to be used during a consultation to help patients explore options and choose the best course of action for them.

### **References and resources**

#### ***General***

The Health Foundations MAGIC programme's professionals and patients favoured quick and easy-to-use tools such as options grids or brief decision aids. <http://www.health.org.uk/node/184>

#### ***Patient decision aids***

What are Decision Aids[16] <http://patient.info/decision-aids>

***Yorkshire Dialysis Decision Aid (YODDA)*** <http://www.yodda.leeds.ac.uk/Survey/Introduction>

#### ***National Patient Decision Aid for established renal failure: NHS Right Care***

<http://sdm.rightcare.nhs.uk>).

***Stacey et al.*** Decision aids for people facing health treatment or screening decisions. Cochrane Database Syst Rev. 2014 Jan 28;(1):CD00143. <http://www.ncbi.nlm.nih.gov/pubmed/24470076>

#### ***Discussion Maps***

**Palmer N and Pringle E.** Discussion Maps. British Journal of Renal Medicine 2013: 18 Suppl.1;15-17

<http://www.kidney.org.uk/about-us/conference/roadshow-2012/>

Parkinson's self- management programme.

<http://www.parkinsons.org.uk/content/self-management-programme-path-through-parkinsons>

#### ***Option Grids***

<http://optiongrid.org/>

## Peer Support

**Peer Support** occurs when patients are put in touch with each other for the specific purpose of giving and receiving assistance with issues related to their common goals (Dennis 2003).

Patients share their experiences all the time e.g. in clinic waiting rooms, when sharing a ward bay, whilst receiving treatment. However, formal peer support offers individuals contact with other patients who have been trained to provide such support, and has been shown to be more positively viewed than unplanned/untrained support (McCarthy 2014).

### What are the benefits?

Peer support has the potential to improve experience, psycho-social outcomes, behaviour, health outcomes and service use among people with long-term physical and mental health conditions and their carers'. Experience and evidence suggest that peer support is valued by those who take part and that it can improve how people feel and what they do. It may improve self-confidence ("you are not alone") and motivation.

*"I know the staff, and the nurses know about that sort of thing but it's different when it's the truth from a patient about how it's affected them"*

It may also enhance self-esteem in the supporter.

### How can it be used?

The top three most useful types of initiatives for improving emotional and physical wellbeing may be:

- Face-to-face groups run by trained peers which focus on emotional support, sharing experiences, education and specific activities such as exercise or social activities.
- One-to-one support offered face-to-face or by telephone. This may include information provision, emotional support, befriending and conversation. This type of one-to-one support may result in reciprocal benefits for supporters and may involve volunteers rather than paid peer support facilitators.
- Online platforms such as discussion forums. These have been found to be useful for improving knowledge and reducing anxiety, though people may use them only for a limited time.

### **For patients**

Talking to another patient who has had the same or similar experience may give a patient a better understanding of living with their condition and help them make decisions. In a unit with a peer-support service, a member of staff will be able to arrange a conversation with an appropriate peer supporter. Conversations can take place face-to-face, by phone or even email. Peer supporters are trained to listen, maintain confidentiality and share what they know. They don't provide education as this is too individualised and needs to be provided by a healthcare professional. Many units do not have a formal peer support service. However, even in these circumstances healthcare professionals may well be able to arrange a conversation with an appropriate person.

### **For staff**

Trained peer supporters can offer patients a level of understanding and shared experience that we, as healthcare professionals, are unable to do. Sharing common experience has been shown to improve experience, psycho-social outcomes, behaviour, and both physical and mental health outcomes.

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Though inexpensive to set-up and manage peer support does need organising and time investing in it. A training package has been developed and evaluated and is available free of charge (see resources section) (Wood 2014a 2014b, 2015). The package provides the training syllabus and resources needed. It is recommended that peer supporters are registered as hospital volunteers (ensuring a criminal record check) and, more importantly, that they are recognised for the support they are providing. Volunteer services may also cover the cost of transport and parking when peer support is being delivered.

Peer support does have its challenges; it takes staff time and effort to identify and train peer supporters. Maintaining the peer support service and getting healthcare professionals to refer patients requires regular reminders to the wider service. There will be a turnover of peer supporters due to changing life circumstances so we recommend only training a few supporters at a time, but training regularly. Ideally, having a wide range of patient experience, ages and ethnicity in your peer supporters makes it likely that people can be matched with someone they are able to relate to (McCarthy 2016).

### **References and resources**

The Health Foundation. Patient centred Care. 2014 <http://personcentredcare.health.org.uk>

Nesta UK. [People helping people: peer support that changes lives.](#) 2014

National Voices. [Peer support: what is it and does it work?](#) 2015

Dennis CL. Peer support within a health care context: a concept analysis. *Int J Nurs Stud*, Vol 40 (3): 321-332

McCarthy K, Sturt J, Adams A. Types of vicarious learning experienced by pre-dialysis patients. *SAGE Open Medicine*: Jan-Dec, Vol 3 <http://smo.sagepub.com/content/3/2050312115580403.full>

McCarthy K, Mastin S. Development and delivery of a diverse peer support programme for renal service users, their family and carers: An action research collaboration. *Foundation of Nursing Studies*: <http://www.fons.org/Resources/Documents/Project%20Reports/Development-and-Delivery-of-a-Diverse-Peer-Support-Programme-for-Renal-Service-Users,-their-Family-and-Carers-.pdf>

Wood E. Patient to patient peer support in renal care: what, why and how. *Journal of renal nursing*: 2014a Vol 6 (5) 239-243

Wood E. Patient to patient peer support in renal care: examining the role and attitudes of renal clinicians. *Journal of renal nursing*: 2014b Vol 6 (6) 293-297

Wood E. Peer support: increasing participation through clinician engagement. *Journal of renal nursing*: 2015 Vol 7 (4) 189-193

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## Coaching

Health coaching helps people set goals and take action to improve their health or lifestyle. Health coaches support people to find the answers themselves and plan to achieve their goals, rather than teaching, advising or counselling them.

Coaching usually takes place face to face, but can be by telephone, email or online. It may be a one-off occurrence or it can be done regularly, say weekly or monthly for several months.

### **What are the benefits?**

Health coaching can help to improve a person's motivation to self-manage and to change their behaviour. Coaching can lead to improvements in health and clinical outcomes, improved health-related behaviours such as physical activity, eating healthily and smoking cessation, and has the potential to enhance the quality of life of people living with long-term conditions.

### **How can it be used?**

Health coaching can be used to support people with a range of long-term conditions and other health or lifestyle needs. It works best with people who are already motivated to change their behaviour or those who have the most to gain such as those with severe symptoms or poorly controlled conditions. It can be used effectively regardless of a person's age, sex or ethnicity.

### **For patients**

Coaches can support patients to define goals, and help to develop a plan to achieve them. The plan can then be broken down into bite size steps that are more easily achieved. Achievement of one goal helps build confidence and increases the ability to self-manage and achieve greater goals. Support by coaches can also help develop coping strategies to help prevent situations developing that might undermine desired change.

### **For staff**

Health coaches are often health care professionals, but they don't need to be. In recent years, there have been initiatives to train lay people to work with others with the same or similar medical conditions. Training is essential. The content and duration of training will vary depending on the type of coaching to be undertaken – whether coaches will be incorporating skills into existing consultations or undertaking separate 1:1 coaching sessions. Poorly trained “coaches” represent a risk to vulnerable patients. To gain most benefit, health coaching should be embedded as part of routine care delivery.

### **References and Resources:**

#### ***Evidence***

Does health coaching work? Summary of key themes from a rapid review of empirical evidence. The Evidence Centre, April 2014.

<http://www.health.org.uk/publication/heart-health-realising-value-people-and-communities> Feb 2016.

#### ***Examples***

<http://www.horshamandmidsussexccg.nhs.uk/your-health/health-coaches/>

<http://www.myhealthdorset.org.uk/>



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## Motivational Interviewing (MI)

MI is a collaborative person-centred form of guiding to elicit and strengthen motivation for change. MI uses the patient's own motivators and values to make achievable and healthy lifestyle changes including adherence to treatment.

Features of motivational interviewing (Rubak et al (2005)

1. Motivational interviewing relies on identifying patients' own values and goals, and uses them as a basis to stimulate behaviour change
2. Motivation to change will occur from patients skills, knowledge and ability, that is not imposed on them
3. It is designed to elicit, clarify and resolve ambivalence
4. Resistance and denial is a signal to roll with resistance and explore ambivalence
5. Eliciting agreement and reinforcing patient's ability to carry out and succeed in achieving an agreed specific goal is essential for success
6. The therapeutic relationship is a partnership that respects the patients thoughts and feelings
7. It is both a set of techniques and counselling style.

### What are the benefits?

#### **For patients**

MI can enhance patient self-efficacy - the degree to which a person feels successful or effective in managing their health or their life. Patients may often feel overwhelmed, hopeless or helpless, and consequently experience lower self-efficacy. MI can empower the patient and can instil hope, confidence and action.

Motivational Interviewing helps patients to voice concerns and find solutions. Patients involved in MI (compared to treatment as usual) have found they are more likely to: enter, stay in, and complete their treatment, attend and participate in follow-up visits, and make important improvements in general health and wellbeing. MI can improve medication adherence and may lead to fewer subsequent hospitalisations.

#### **For staff**

MI is a useful skill that can be used to enable patients to explore their options and hear themselves discuss pros and cons without pressure.

MI helps the healthcare professional to:

1. Master core communication skills  
**OARS** – ask **O**pen questions, use well timed **A**ffirmations, listen **R**eflectively, **S**ummarise
2. Recognise 'change talk'  
**DARN** – the **D**esire, **A**bility, **R**eason, **N**eed -to change
3. Avoid triggering resistance – “roll with resistance”
4. Improve empathy

MI is a client-centred, empathic and yet directive interaction between patient and health professional designed to explore and reduce inherent ambivalence and resistance, and to encourage self-motivation for making positive change goals

Motivational interviewing uses a guiding style to engage with patients, clarify their strengths and aspirations, evoke their own motivations for change, and promote autonomy of decision making

### **How can it be used?**

- MI can be delivered by a range of healthcare providers and lay persons
- MI skills can be used for everyday face-to-face or telephone consultations.
- MI empowers the patient, unlike well- intentioned but overly directive helping approaches that may reinforce patient passivity or dependence on case management.
- MI skills can be readily learnt by health professionals and lay persons by attending a short 1 day or longer course depending on previous skills and knowledge. Three elements are involved: practicing a guiding rather than directing style, developing strategies to elicit the patient’s own motivation to change, and by refining listening skills and responding by encouraging change talk from the patient.

### **References and resources**

1. Rollnick et al : MI in practice BMJ 2010  
a. [www.bmj.com/content/340/bmj.c1900](http://www.bmj.com/content/340/bmj.c1900)
2. Rubak S, Sandbaek A, Lauritzen T, Christensen B. (72RCT’s).  
a. Motivational interviewing: a systematic review and meta-analysis. Br J Gen Pract 2005;55:305-12
3. Lundhal B, Burke B. The effectiveness and applicability of motivational interviewing: a practice-friendly review of four meta-analyses. J Clin Psychol 2009;65:1232-45
4. McKenzie KJ, Pierce D, Gunn JM. A systematic review of motivational interviewing in healthcare: the potential of motivational interviewing t address the lifestyle factors relevant to multi-morbidity. J of Comorbidity 2015;5:162-174
5. Motivational Interviewing: An Emerging Trend in Medical Management  
[http://www.patientadvocatetraining.com/wp-content/themes/patientadvocate/static/pdf/ppai\\_specialreport\\_mi.pdf](http://www.patientadvocatetraining.com/wp-content/themes/patientadvocate/static/pdf/ppai_specialreport_mi.pdf)
6. Et al training run ne day Motivational Interviewing workshops. Information can be found at <http://etaltraining.co.uk/>

## K-HOPE Programme©



### **How the Coventry University K-HOPE Programme© could work for people living with kidney disease and health professionals who support them**

#### **What is the K-HOPE programme?**

The K-HOPE programme is a self-management programme which aims to improve a person’s knowledge, skills and confidence, also referred to as patient activation, to manage the physical, psychological and social consequences of living with kidney disease. The K-HOPE programme is an innovative approach to self-management as it encourages psychological and behavioural change by fostering positive emotional states which builds on a person’s existing strengths and resiliencies, rather than focusing predominantly on skills deficit

The K-HOPE programme is delivered in 6 weekly sessions each of 2.5 hours to groups of between 8-12 participants. The programme includes evidence-based behavioural change techniques, such as person-centred goal-setting, action-planning, and problem-solving. Other activities include cognitive and behavioural self-management techniques to manage anxiety, depression and stress and relaxation. The K-HOPE programme also includes, identifying personal strengths, scheduling pleasant activities, mindfulness, gratitude diaries, and reviewing successes.

#### **What are the benefits of attending the K-HOPE programme?**

We have evaluated versions of the HOPE programme for people living with and affected by cancer, multiple sclerosis, HIV and parent caregivers of children with autism and we have found consistent improvements in depression, anxiety, positive mental wellbeing and hope. Participants value the peer support and sharing experiences with others who understand the challenges they face. Participants who are more hopeful and enjoy better mental health are more engaged with their health care regime and healthcare team.

#### **K-HOPE Programme facilitator training**

The K-HOPE programme can be co-delivered by NHS or social-care CKD workforce and people living with kidney disease. The facilitator training is a 2 day classroom-based course, involving training in motivational interviewing (e.g. reflective listening) and behaviour change skills (e.g. goal setting, action planning), group facilitation skills (e.g. managing challenging behaviours) and delivery practice of intervention activities. K-HOPE Programme is manualised to ensure consistency of delivery and content.

For further information including costs of the K-HOPE programme, please contact:

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