Renal Geriatric Integration Project
Renal and Transplant Unit
Hammersmith Hospital
Imperial College Health Care NHS Trust

The challenge we wanted to address through the QI project

The older patient population on dialysis in the UK and in our renal units is increasing with the need for more supportive care related to old age and frailty. Frailty and its associated syndromes were shown to be more common in patients with chronic kidney disease and those on dialysis than in older people without renal impairment. This can result in adverse outcomes such as falls, disability, hospitalisation and mortality.

In frail older patients admitted to hospital geriatric assessments and post discharge home interventions have shown to reduce hospital stay and readmissions, the need for immediate nursing home placements and delay permanent placement. Similar outcomes should be possible if applied in the case of renal patients. As such, the Renal Geriatric Integration Project was set up to address this area of need and to reduce the risk of adverse outcomes for frail older dialysis patients.

The increasing supportive care needs of the elderly and often frail dialysis patients put extra demands on renal unit nursing teams. While the majority of staff were involved in organising support for patients some felt that that they did not have adequate time to deal with the increasing patients' needs (64% in HD unit and 40% in PD unit).

In our experience older renal patients do not often contact their primary care teams in the community and rely on nursing staff in the dialysis units to help deal with their issues, while GPs sometimes defer care to the dialysis teams.

What did you want to achieve with your QI project?

1. Improve overall supportive care for older dialysis patients and reduce the risk of adverse outcomes by integrating renal and geriatric care.
2. Improve patients' experience and satisfaction on dialysis.
3. Reduce time spent by dialysis nursing staff on organising supportive care needs, thereby allowing more time for dialysis care.
4. In the longer term we hope to reduce the need for hospitalisation and readmission.

Who was involved in this QI work?

Renal Elderly Care Liaison Nurse - responsible for the day to day management of the project
Renal Consultant- to oversee the project (PD Consultant)
Dialysis Unit Lead Nurse - part of the project team
Renal Consultant - part of the project team (HD Consultant)
Quality and Information Lead - part of the project team to assist with data analysis
Renal Dialysis Unit Manager and nursing team in the PD and 1 Satellite HD Unit
Geriatricians and older people teams involved in older renal patients' care

Renal Counsellors, Renal Social Worker and Renal Dieticians
Patients in the units > 70 years in the PD and HD Unit and those <than 70 deemed frail

Explanation of the project aims and benefits to staff and patients in the renal units involved and the role of the Renal Elderly Care Liaison Nurse in integrating renal and geriatric care and providing supportive care to patients the units.
Working with the nursing teams and being visible and available whilst addressing patients' needs.
Regular meetings with the Renal Counsellors and Social Worker to discuss patients referred for counselling and support and update and feedback on progress.
Liaising and meeting with the Geriatric Teams for collaborative working and patients input and management.
Regular feedback and meetings with the project and dialysis unit teams to communicate and discuss progress, issues, outcomes, future direction etc.
Attendance at MDT meetings to discuss and feedback about patients on the project

What did you do?

The project is initially funded for 18 months with a further 18 months funding secured to continue the work on the project. The funding is for a Band 7 Renal Elderly Care Liaison Nurse.

Patients aged 70 years and over in a single satellite haemodialysis unit and those on PD (attending the PD unit or outpatient clinic) were seen by the Renal Elderly Care Liaison Nurse, and a modified geriatric assessment was carried out. In addition nursing staff in both units were asked to refer patients aged 60-70 years who were deemed frail for assessment. Apart from geriatric assessments, the nurse also carried out frailty screening, a memory test (AMTS), a clock drawing test (CDT- Measure of executive function) and a measurement of distress and patients satisfaction. Patients were assessed depending on the time availability of the nurse and when they attend clinic or dialysis treatment.

The project is managed by a project team which consists of 2 Renal Consultants, 1 Dialysis Unit Lead Nurse, 1 Quality Information Lead. The team meets every 6-8 weeks to assess the work done on the project and discuss future planning to achieve outcomes.

What was the outcome of your QI work?

The outcomes at 6 months is encouraging and the feedback from unit teams is that the role of the Elderly Care Liaison Nurse is valuable in meeting the supportive care needs of older and frail dialysis patients, with less time spent by them dealing with increasing patients' needs.
The initiative has identified a number of previously unrecognised geriatric syndromes and other patient needs which resulted in referrals to the appropriate community and hospital teams.
Frailty was shown to be high in the older dialysis patients and there was improvement in patients' experience with a reduction in distress thermometer scores and improvement in treatment satisfaction scores at 6 months follow-up.
The initiative is on-going so final success has not yet been evaluated.

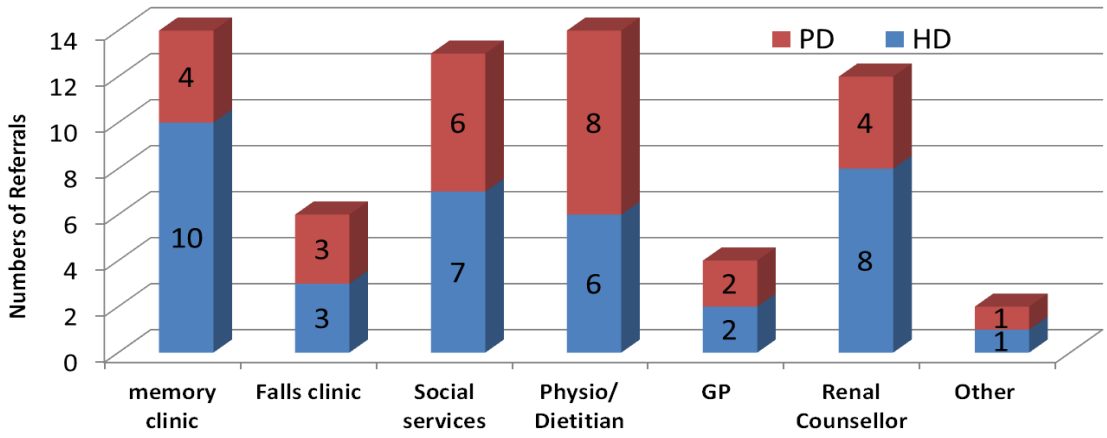
Results

Assessments	HD 1st Assessment (n=58)	PD 1st Assessment (n=32)
Mean Age	78.2 ± 5.5	76.8 ± 6.1
Mild frailty score = 5	20 (34.5)	7 (21.9)
Moderate to severe frailty score= 6&7	26 (44.8)	15 (46.9)
Abbreviated Mental Test Score ≤ 8	12 (20.7)	4 (12.5)
Clock Test Score <8	31 (53.4)	16 (50.0)
Distress Thermometer Score ≥ 5	16 (27.6)	8 (25.0)
Treatment Satisfaction Score ≤ 80%	23 (39.7)	4 (12.5)
Number of patients with falls in last year	15 (25.7)	9 (28.1)

6 months follow-up

	HD 6-month F'up Assessment (n=31)		PD 6-month F'up Assessment (n=17)	
	Pre	Post	Pre	Post
Mild frailty score = 5	11	10	3	4
Moderate to severe frailty score = 6&7	14	14	12	11
Distress Thermometer Score ≥ 5	12	3	4	4
Treatment Satisfaction Score ≤ 80%	11	7	4	0

Referrals to Community Teams and support services(37 HD cohort and 28 PD cohort)



What impact has your work had on patient care?

More integrated patient care working closely with the multi-professional and elderly care teams. Patient satisfaction and distress have improved with regular follow up and interventions by the Renal Elderly Care Nurse to meet patients' needs.
Dialysis unit staff are spending less time dealing with patients' supportive care needs (staff questionnaire results) and as such have more time for patient care.

What did you learn from this work?
As a quality improvement initiative measuring outcomes and demonstrating evidence that the project is of benefit to patients is hugely important to secure future funding for a new role. When creating a new role it is important to factor in the cost of specialist training. Working in a new role with no previous role to follow can be difficult at times and requires creativity, innovation and positive thinking. Ensure senior management involvement in the project for future success.
Describe the whole process in three words
Renal Geriatric Integration
Contact details for more information about your QI project
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9. **Tags**

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