DAYLife – Dialysis At Yours, Life Fulfilled

A Report on the KQuIP Home Therapies Programme Launch Event – 30 January 2019

The slide presentation from the day can be viewed here

Please note: details of the Teams' work on their projects throughout the day appear at the end of this report in Appendix A

Introduction

30 January 2019 saw 104 people gather in Birmingham – all eager to get going at the launch of the DAY Life initiative, which aims to increase the number of people receiving home therapies for their renal disease.

A planning event late last year resulted in nine teams from across the East and West Midlands at the event to move their projects on from the planning stages to getting going and agreeing what to work on first.

Richard Fluck, nephrologist from Derby and joint Project Lead with Daljit Hothi, opened the event with a review of the objectives for DayLife – to improve the care of people with end stage renal disease by

- Addressing variation
- Reducing unmet need
- Improving reliability
- Minimising harm for home dialysis therapies.

Variation in home therapies was shown be a global issue. The challenge of how rates had changed in the UK over the last 15 years was considered. Despite that, success for this programme of work is not necessarily a number. Rather, measuring change helps and measurement should be about improvement and not judgement. While the project teams from across the East and West Midlands units would define their own criteria of success, at a national level, success for DAYLife will be a composite of

1) Increased numbers of people on home dialysis
2) Improved patient experience and reported outcomes
3) Improved patient outcomes

The introduction was followed by an engaging and touching talk from Sam Mitchell who explained her experience of renal disease and of moving to home therapy and the impact this has had on her quality of life. Sam's words have been used to create this patient story which you can read here.

What's going well and what are the challenges?

The first session saw everyone in their respective teams diagnosing their current situation with regard to home therapies as they were charged with discussing and agreeing on three things that they are doing well currently in respect of home therapies and three challenges they face. Feedback on things going well ranged from good retention and low drop-out rates of people on home therapies to having a dedicated clinic for home therapies and an engaged and motivated team. Challenges were often about resources – both staffing and financial - to enable change to be driven through, training facilities for patients and issues of management after infection.

Following an opportunity for feedback from each team, Richard talked through the NHS Change Model, outlining how consideration of its component parts ensures that every aspect is considered and utilised for successful improvement projects.

Figure 1: The NHS Change Model

Some theory and drivers for change

A brief session on quality improvement theory followed, demonstrating some useful tools and resources for teams to use going forward with their projects, and introducing everyone to an online facility to help with project management, information sharing and communications. Richard talked about the drive for more personalised care and the elements it comprises that lead to patient centred care using the 'House of Care' model (figure 2). He reiterated that quality improvement should not be seen as a religion but as a fundamental part of how everyone does their job.

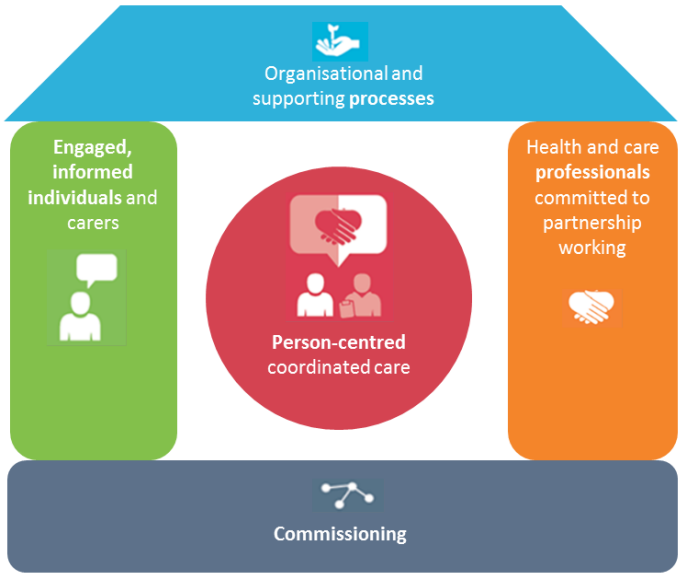


Figure 2: The House of Care

This session was followed by the chance for everyone to talk in mini networks, which had developed during the early planning phase of DAYLife, to compare dreams and challenges and to consider how teams might support and help each other.

The teams then moved on to their detailed driver diagrams for their projects following some theory. These were displayed and were discussed and explained over lunch.

Measures

Following lunch each team discussed the measures they would use to show progress on their improvement projects by refining their driver diagrams in the context of process maps for each element of the project they were focussing on. Everyone then 'walked the floor' to view the diagrams and discuss the measurement methods chosen that would demonstrate success.

These included, for example, an increase in the uptake of home therapies either by proportion or an increased number (simple but impactful), a reduction in post re-infection drop out rates, staff to patient ratios, patient experience and satisfaction, and upskilling staff and education.

Turning plans into action

The final session of the day saw teams deciding what their first PDSA cycles would be for their improvement projects, by creating a long list which is then reduced down to a shortlist of activity.

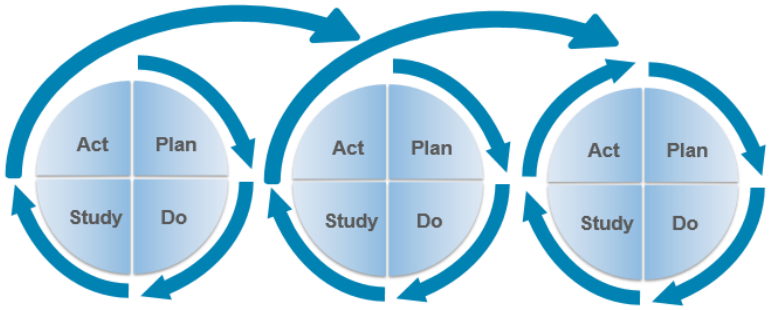


Figure 3: Plan-Do-Study-Act cycles

- Plan – the change to be tested or implemented
- Do – carry out the test or change
- Study – based on the measurable outcomes agreed before starting out, collect data before and after the change and reflect on the impact of the change and what was learned
- Act – plan the next change cycle or full implementation.

The teams shared their ideas for early PDSA cycles with the whole group. These included:

- Increasing understanding, through use of a survey of staff awareness of home therapies, followed by nurse education and resurvey
- The appointment of inter-modality link nurses at both satellite and in-centre clinics
- Assessment of failing home therapy patients to establish how this can be reduced
- The introduction of satisfaction forms for monthly measurement and assessment for home therapy
- Reducing peritonitis rates using observation techniques at clinic visits and recording the length of time taken and analysing monthly statistics
- Collecting data on peritonitis to understand rates and reasons to then drive the conversation about how to improve

Teams were encouraged to share their learning of doing the PDSA activities so that even when things don't go to plan or fail, others' time is saved.

The day closed on a positive note with Richard suggesting that teams meet within two weeks to reflect and review on their plans and to help keep the energy up and motivation high for the next steps.

Catherine Stannard, Quality Improvement Programme Manager at the UK Renal Registry, described her role in supporting every aspect of the DAYLife programme, helping to make connections, share learning and create content for the website as well as visit the teams to contribute to their plans.

In summing up Richard described the day as energetic and productive with a commitment from all present to show people how a big quality improvement initiative programme can work for the benefit of our patients.

With thanks to the following organisations for supporting and sponsoring the DAYLife programme:

Appendix A

Workshop outputs from the Renal Teams attending the DAYLife Launch

Nottingham University Hospital

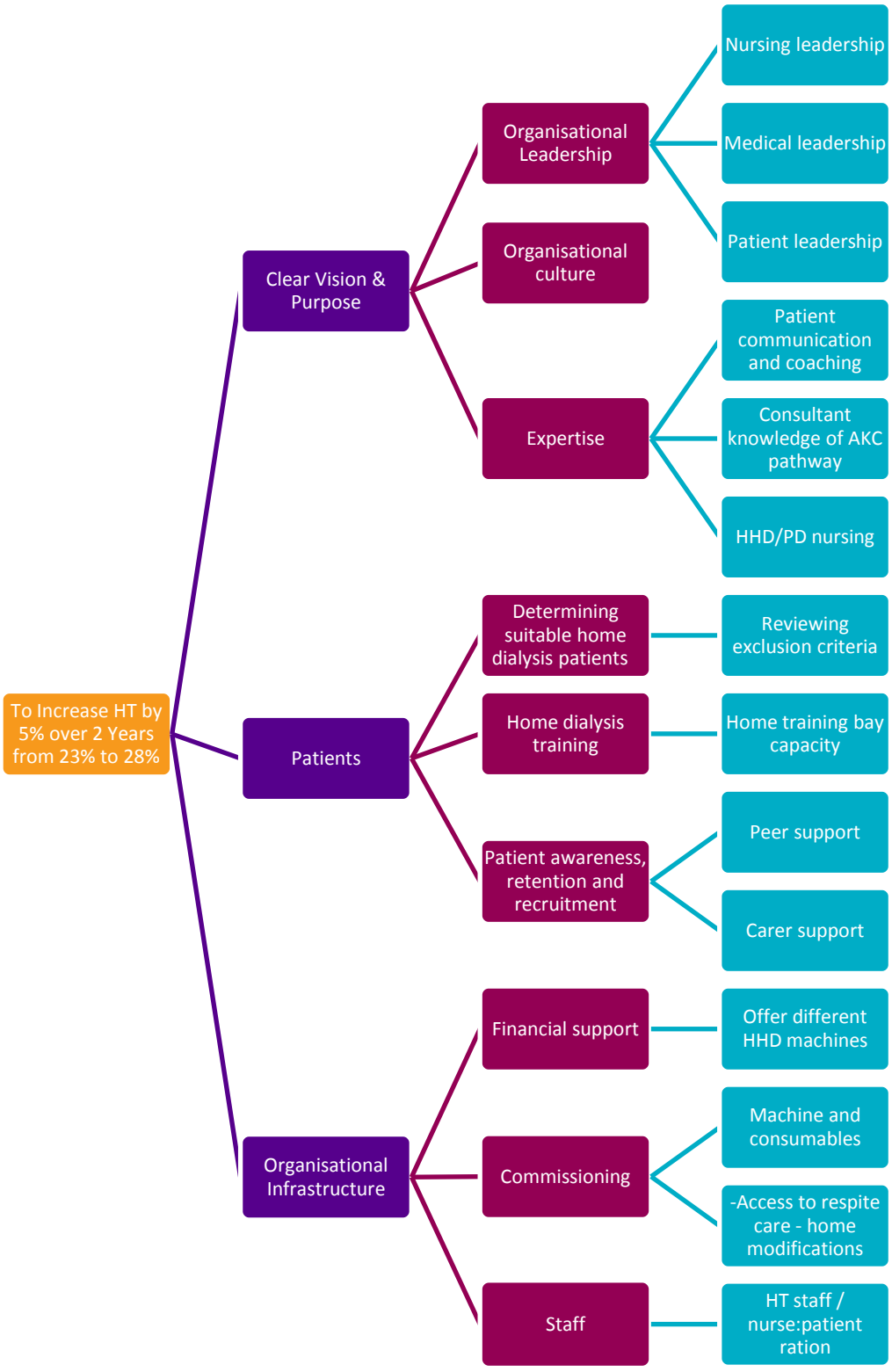
What we do well?

1. Team engagement and enthusiasm
2. Home support – including assisted
3. Advanced Kidney Care clinic and pathway

What are our challenges?

1. Finance
2. Ability to offer Assisted APD
3. Home haemodialysis training capacity

Our drivers:


To Increase HT by 5% over 2 Years from 23% to 28%
Clear Vision & Purpose
Organisational Leadership
Nursing leadership
Medical leadership
Patient leadership
Organisational culture
Expertise
Patient communication and coaching
Consultant knowledge of AKC pathway
HHD/PD nursing
Patients
Determining suitable home dialysis patients
Reviewing exclusion criteria
Home dialysis training
Home training bay capacity
Patient awareness, retention and recruitment
Peer support
Carer support
Organisational Infrastructure
Financial support
Offer different HHD machines
Commissioning
Machine and consumables
-Access to respite care - home modifications
Staff
HT staff / nurse:patient ration

Our measures:

Outcomes

- Number of patients on home therapies (n + %)
- Number of drop-outs and reasons
- Number of patients choosing home therapies (eGFR10+15)
- Patient satisfaction (measured)
- Whether patient starts on chosen treatment
- Peritonitis rates
- Number on assisted APD
- Number waiting for assisted APD
- Number on share HD

Processes

- Wait time for home HD training
- Length of home HD training (delays in training)

Balancing

- Ratio of staff: patients

Ideas for P-D-S-A cycles

1. Upskilling nursing staff and doctors:
   - Share HD in all units
   - Roadshow
   - Study day
2. Advanced Kidney Care clinic education pathway re-design
3. Home HD training
4. Home therapies process MDT – low clearance MDT
5. Develop assisted APD

University Hospital Leicester

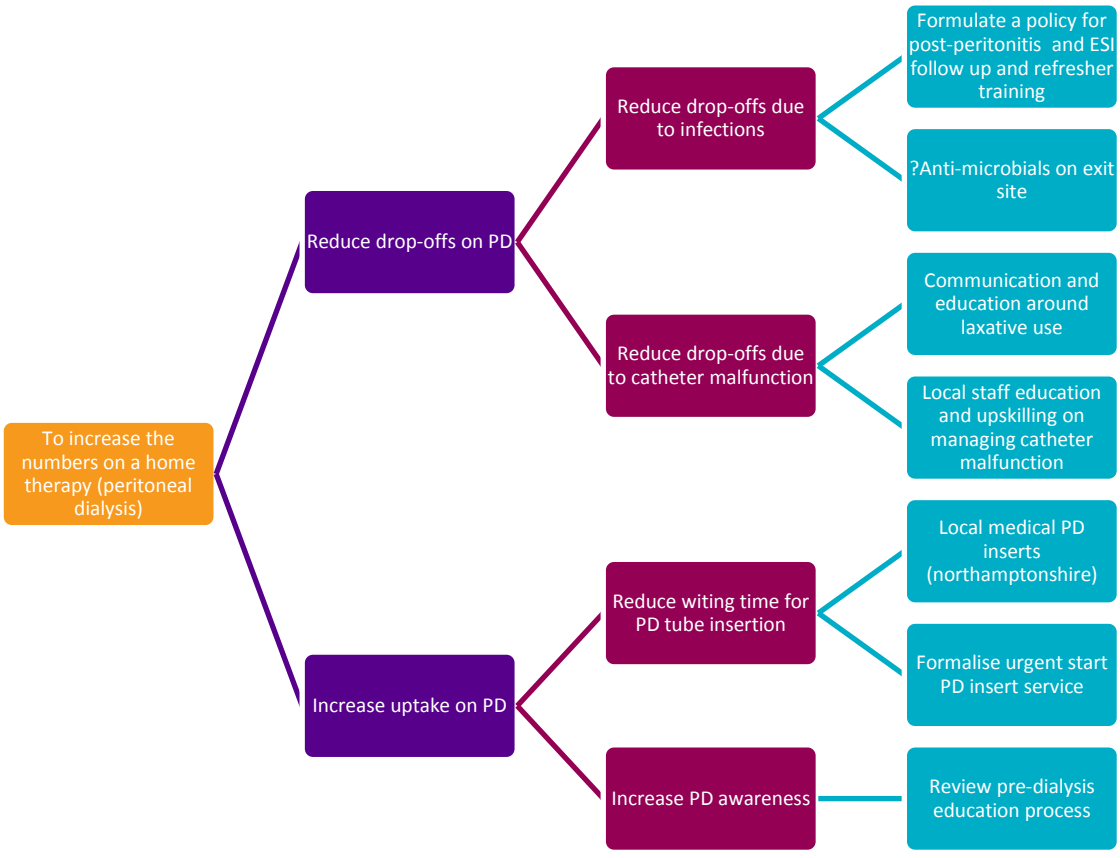
What we do well?

1. Patient choice and flexibility
   - (PD predominantly, may be not so much for home HD)
   - Patient feedback (feel supported)
2. Strong link between pre-dialysis and HCT
3. Pre-emptive transplant rates
4. Dedicated consultant (home therapies)
5. Working with outside agencies

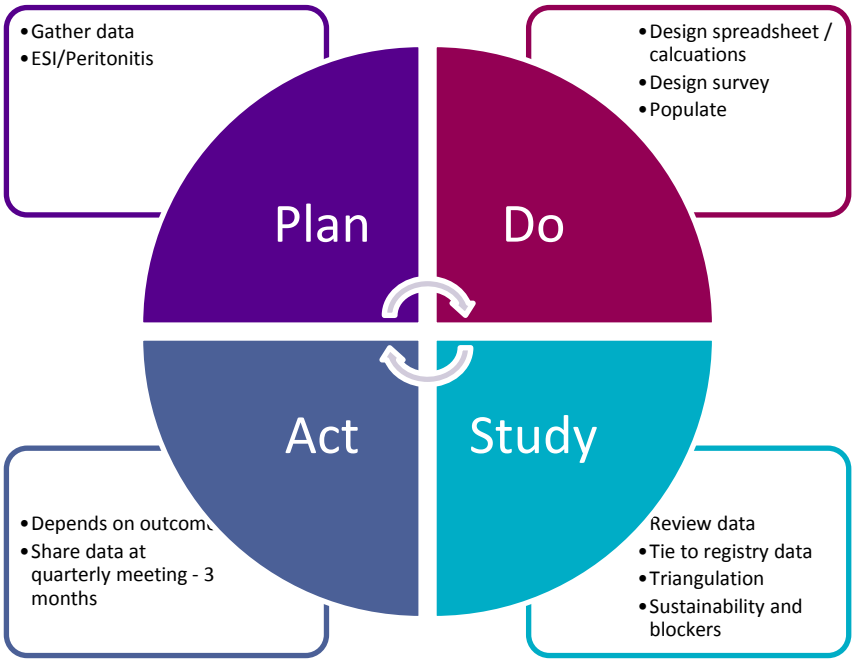
What are our challenges?

1. Variability
2. PD and HHD structures (different)
3. Training in HHD
   - Training facility
   - Links between pre-dialysis and home therapies (Northampton)
4. Timely access formation and trouble-shooting
5. Medical staff - PD vs. HHD (separate)
6. Links with different NHS trusts

Our drivers:



Our next P-D-S-A



Royal Derby Hospital

What we do well?

1. Recruitment to home therapies
2. Leadership and vision (attitude and approach to change)
3. Home therapies culture

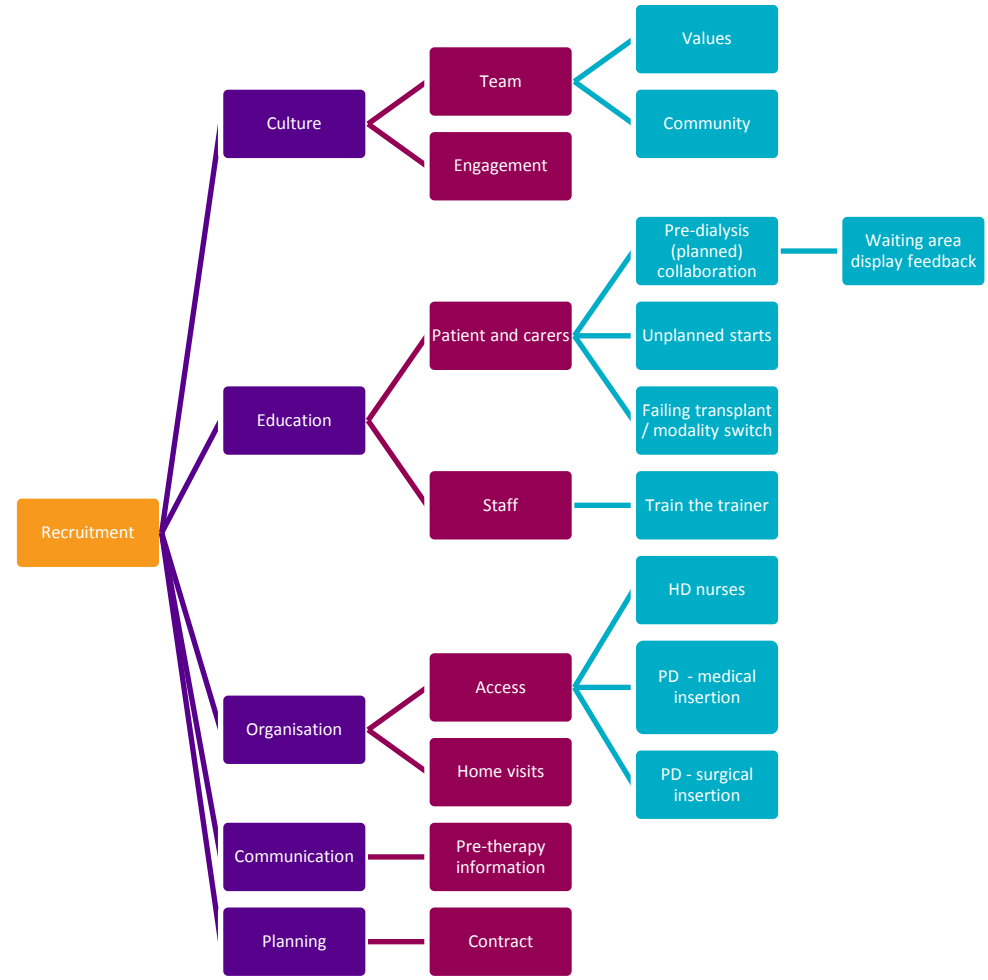
What are our challenges?

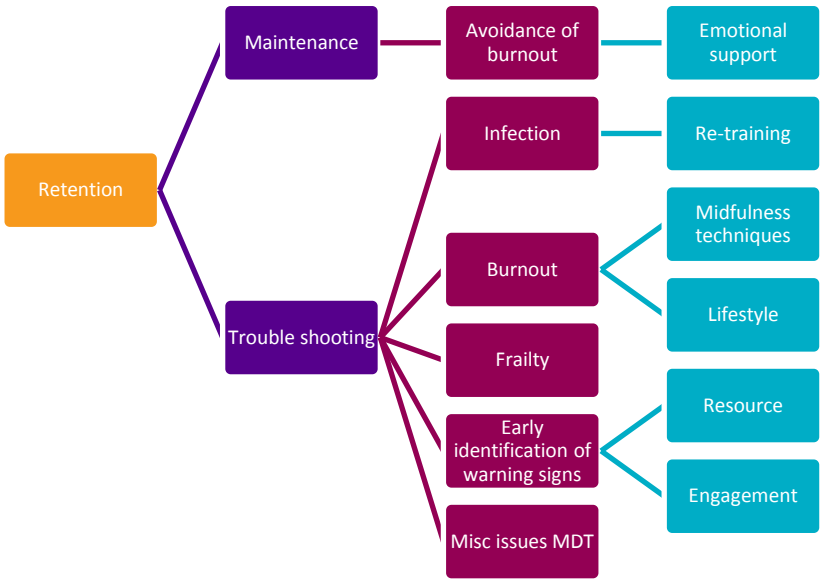
1. Retention
    - Frailty
    - Re-training
    - Pre-dialysis education

Our measures:

- Patient feedback
- Attendance at info sessions
- Time between info session and first renal replacement therapy
- Change within three months
- Contract % completed – of those: ESI / Peritonitis
- Retraining – within four weeks

Our drivers:


Recruitment
Culture
Team
Values
Community
Engagement
Education
Patient and carers
Pre-dialysis (planned) collaboration
Waiting area display feedback
Unplanned starts
Failing transplant / modality switch
Staff
Train the trainer
Organisation
Access
HD nurses
PD - medical insertion
PD - surgical insertion
Home visits
Communication
Pre-therapy information
Planning
Contract


Retention
Maintenance
Avoidance of burnout
Emotional support
Trouble shooting
Infection
Re-training
Burnout
Midfulness techniques
Lifestyle
Frailty
Early identification of warning signs
Resource
Engagement
Misc issues MDT

University Hospitals Coventry and Warwickshire

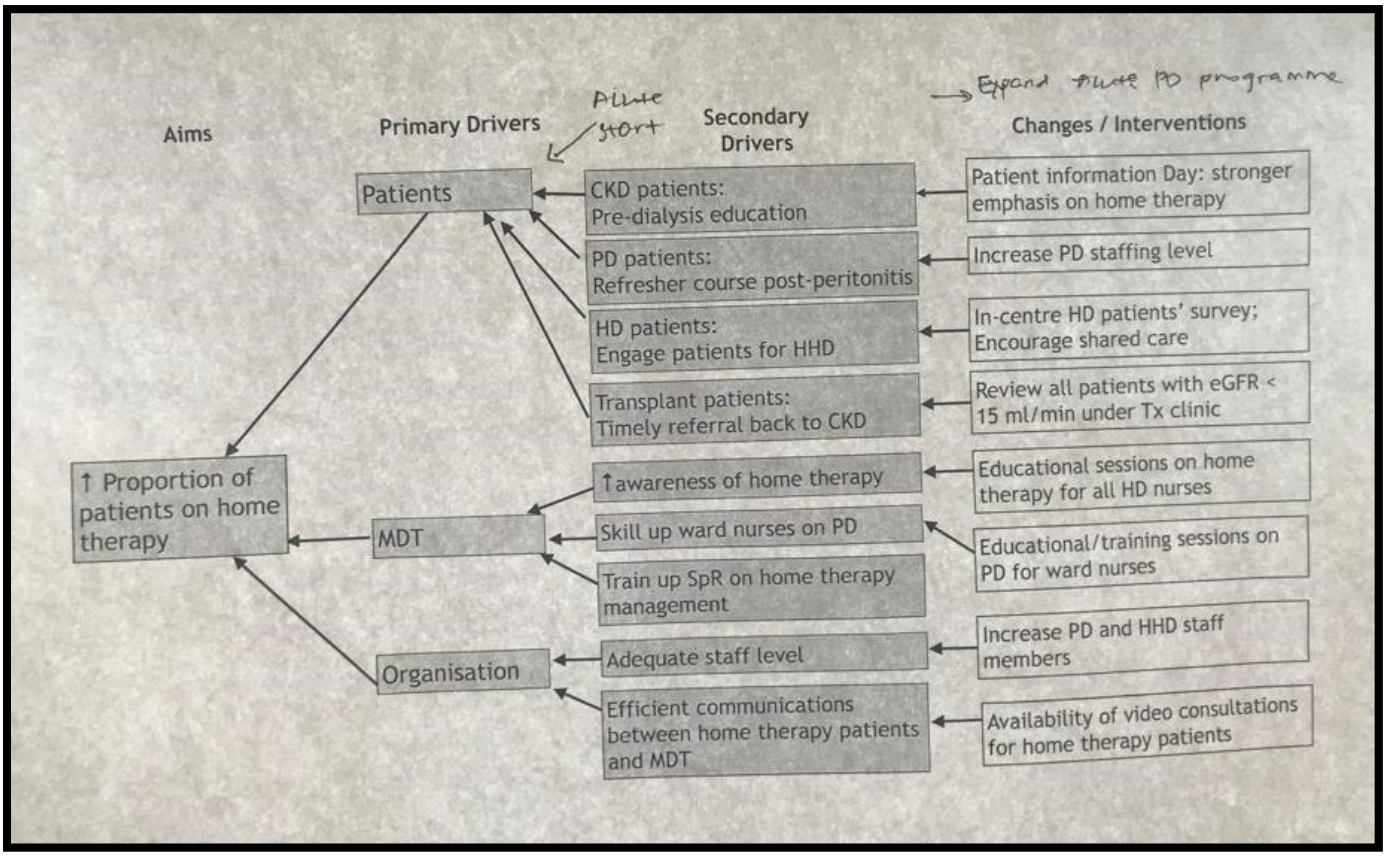
What we do well?

1. Improved access services
   - Joint medical/surgical clinic
   - reduced waiting times ~2 weeks
   - Improved PD catheter repositioning service
2. Dedicated PD/HHD MDT clinic
3. Strong PD team

What are our challenges?

1. Information day not well attended
2. No retraining/refresher post-peritonitis
3. Long waiting time for home haemodialysis

Our drivers:



Shrewsbury and Telford

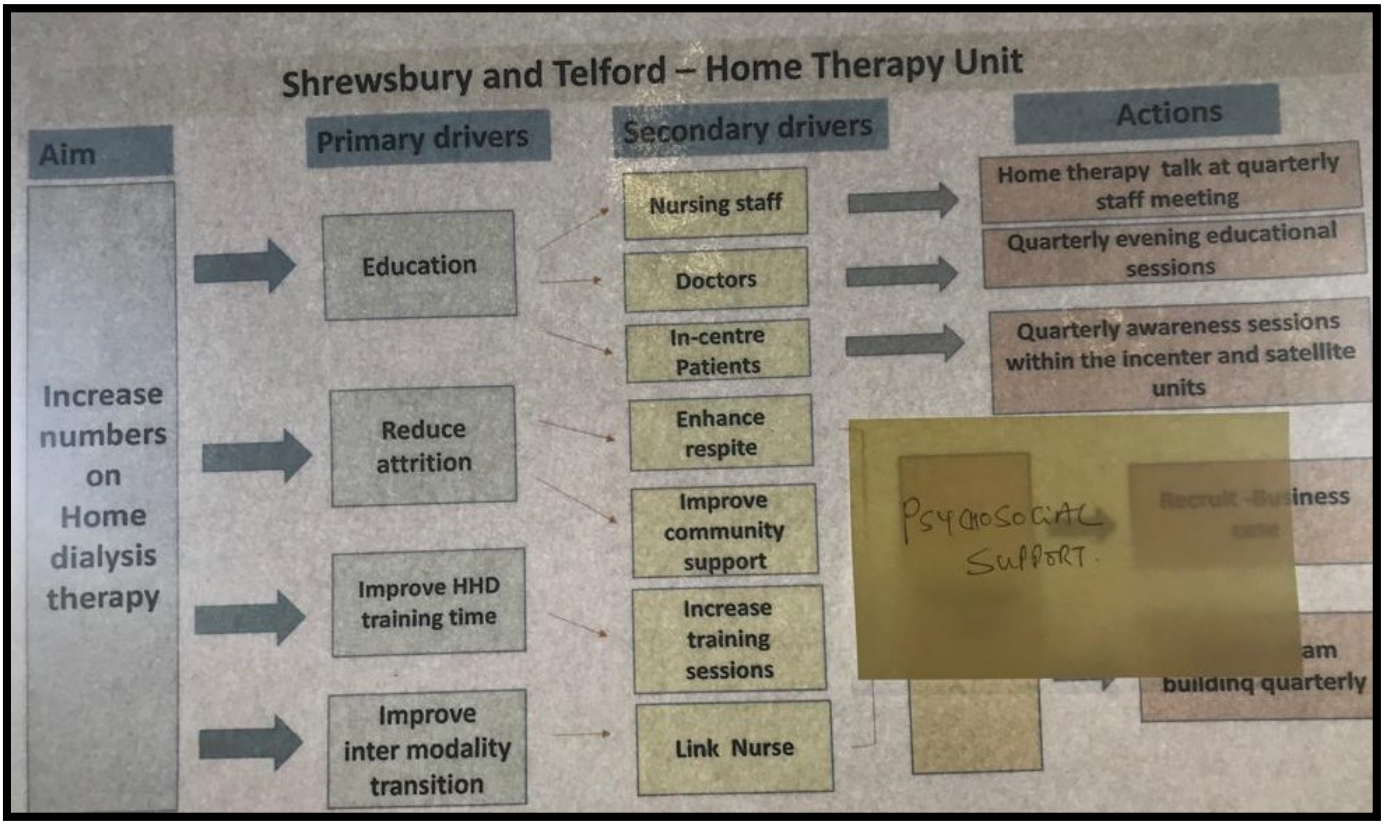
What we do well?

1. Robust pre-dialysis education and post-care
   - MDT clinic (PD/HHD), Q/A, respite, refresher
2. Incident HHD/PD-HHD
3. Medical PD catheter repositioning

What are our challenges?

1. In-house training – shared care (consultant / junior doctors / HD nurses)
2. Failing transplants – Acute – link nurse
3. Staffing/training sessions

Our drivers:



The Dudley Group

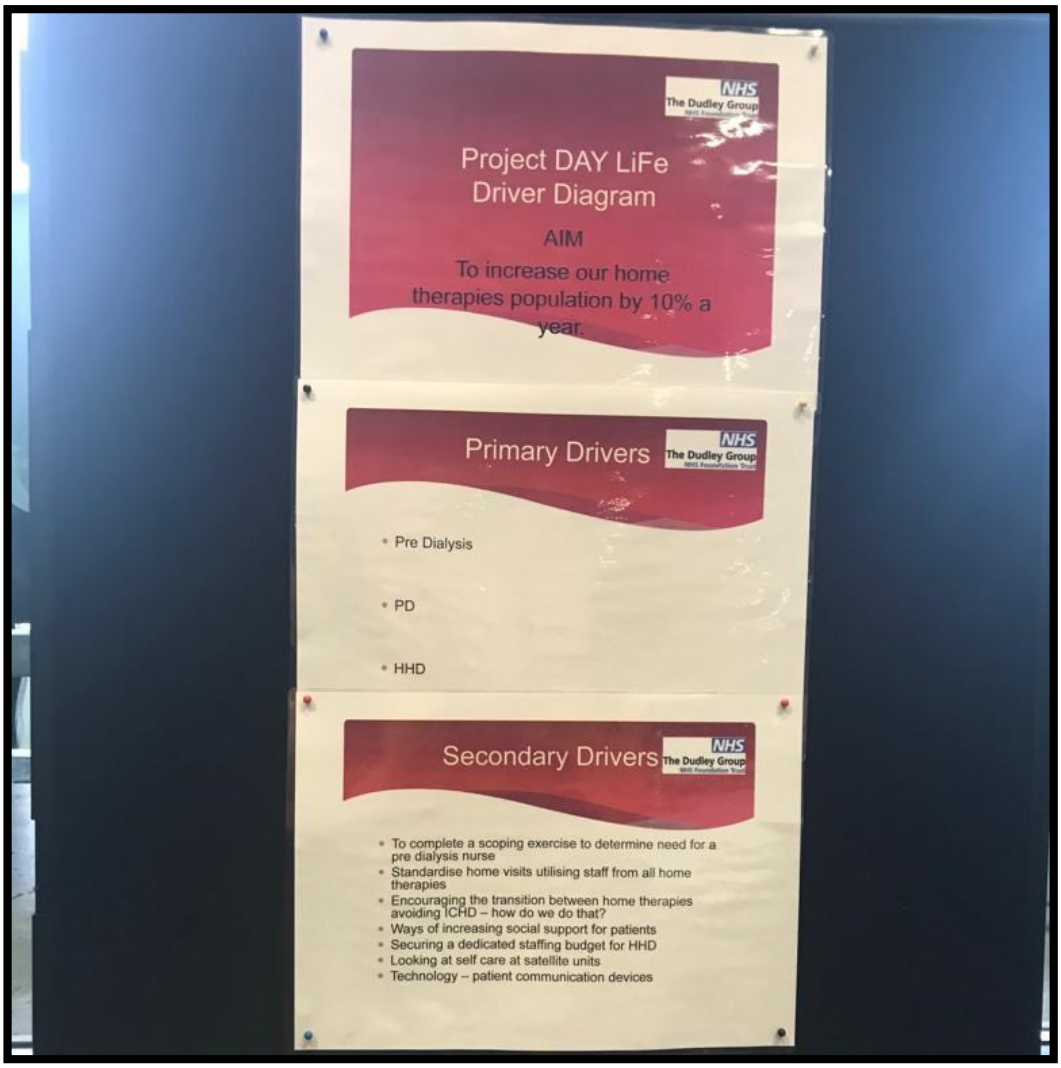
What we do well?

1. We have a good proportion of patients on a home therapy in relation to our population size (1/5th)
2. We already have dedicated training areas for our HHD and PD
3. We offer 24/7 nursing and technical on call support
4. Our home therapies team = our pre-dialysis team

What are our challenges?

1. We do not have a dedicated budget for HHD staffing
2. We need to update our educational tools
3. Although our population of home therapies is good, it has dropped in recent years
4. Doctors sometimes need to let the patients decide

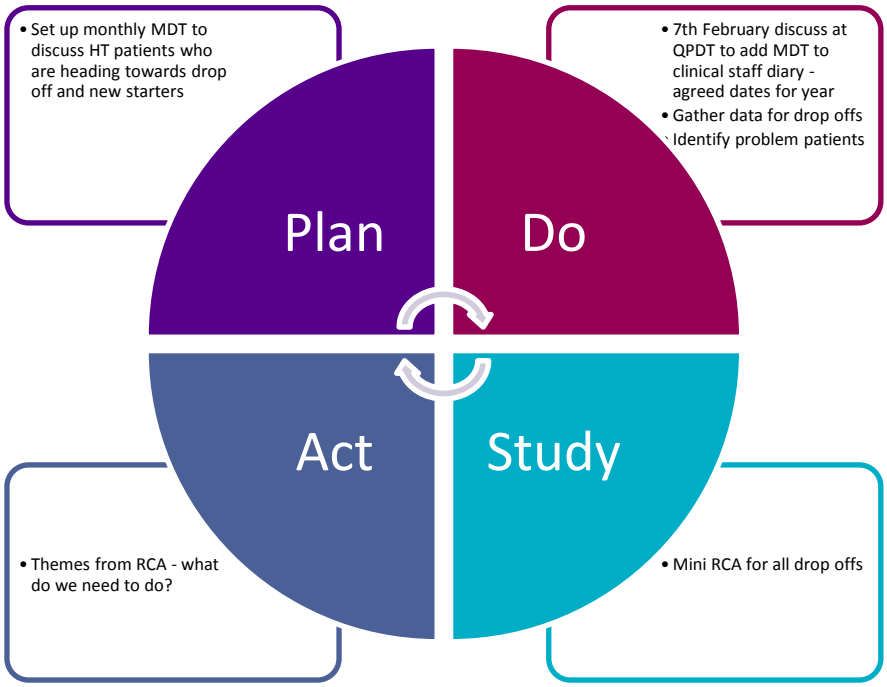
Our drivers:



Ideas for P-D-S-A cycles

- Audit why people come off a home therapy
- Look into rotation of staff between modalities
- Look at how we can move towards a home therapies unit, combining staff and skills
- Job plan/description for role of pre-dialysis nurse – scoping exercise
- Set up social media account for home therapies
- Update our website and renal registry website to make us attractive!
- Submit a business case for home HD staffing
- Write a business case and scope supportive multi-media technology for patients at home
- Identify staff with a desire to be a link nurse to provide social support for patients, training and time required
- Set up monthly MDT meetings for home therapies
- Look at holding a road show / work-shop for home therapies
- Speak to satellite service provider to see how we can develop self-care at our satellite centres

Our next P-D-S-A



University Hospital of North Midlands

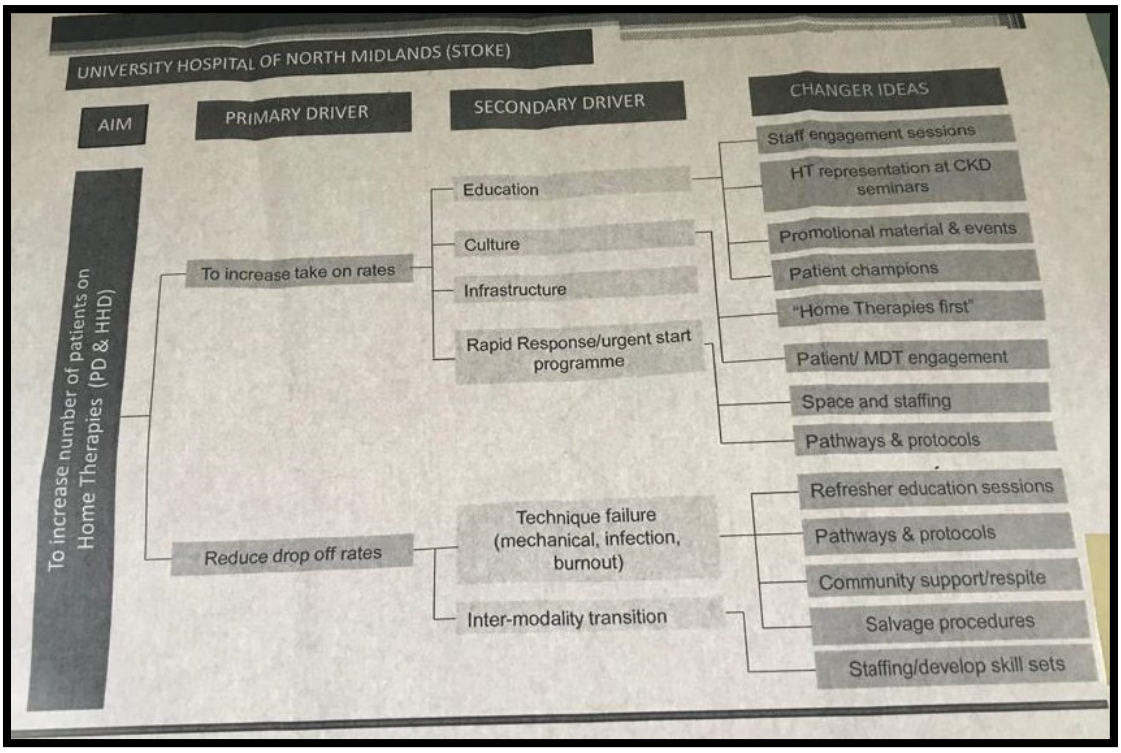
What we do well?

1. Diverse use of AAPD service
   - Unplanned starts
   - Bridge to independence
   - Respite
   - Loss of independence
2. Medical interventions to salvage PD catheters
3. Integrated home therapies service

What are our challenges?

1. HT numbers remain static
   - Staffing
   - Expertise
   - Capacity – standardising pathways of training
   - Estates / home conversion
2. Infections – exit site / tunnel / peritonitis / line / button hole
3. Low clearance pathway / education / acute HHD pathway

Our drivers:



Wolverhampton

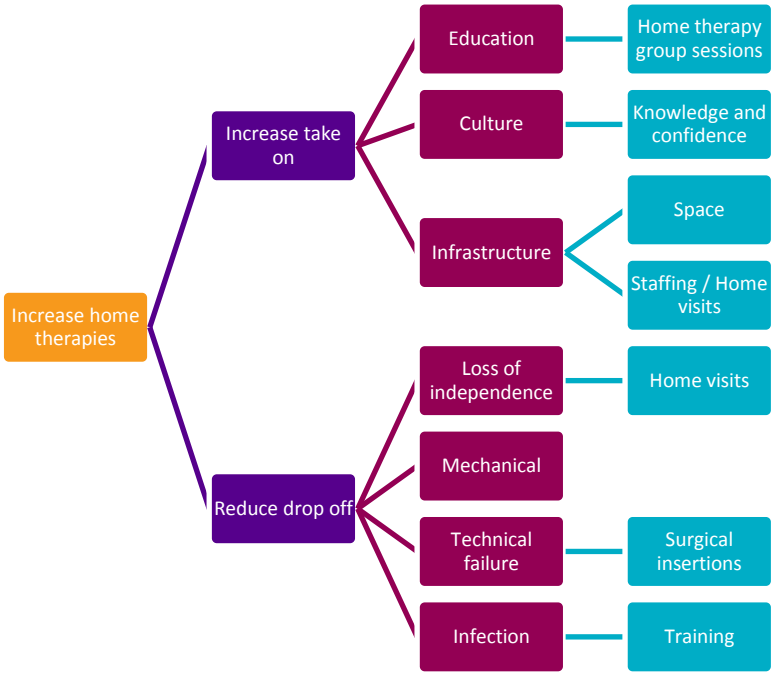
What we do well?

1. Good preparation of patients in low clearance clinic (including definitive access)
2. Good shared care – HHD
3. Good retention and low drop out
4. Low infection in PD patients

What are our challenges?

1. Space/infrastructure and the impact on training = resolved 2019
2. Resources – nursing staff
3. Timely surgical input in PD catheter placement (no dedicated OT team)

Our drivers:



Ideas for P-D-S-A cycles

1. EGFR 15-20 (select criteria)
2. Patients refusing to come to nephrology clinic (use room and Cannock and Cannock staff)
3. Capacity for surgical PD tube insertion
4. Reducing wait tie for complicated vascular access

University Hospitals Birmingham

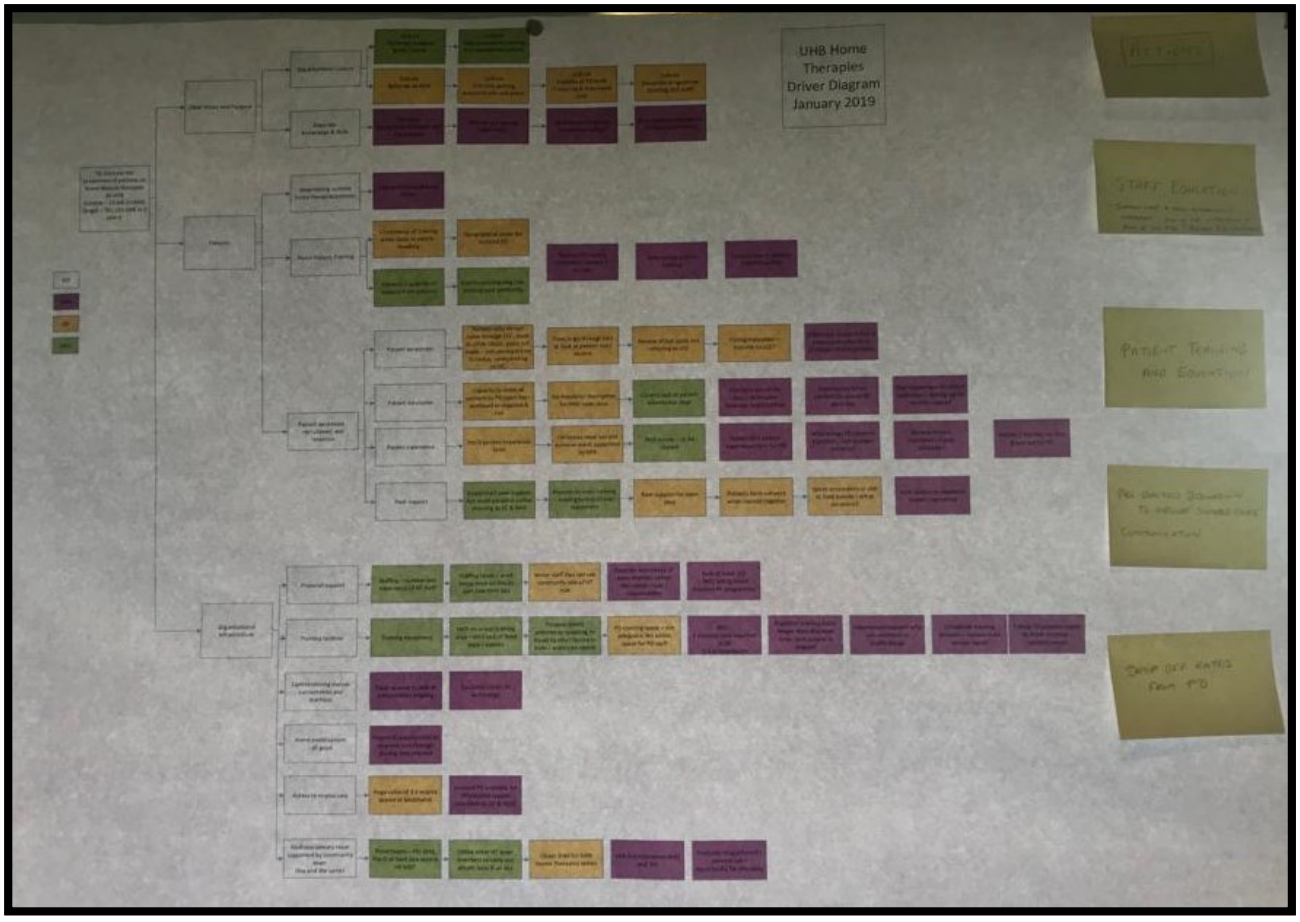
What we do well?

1. Growth in PD
2. Team integration (QEB / HGS)
3. Innovation

What are our challenges?

1. Staff retention and recruitment
2. Merger
3. Home HD growth

Our drivers:



Ideas for P-D-S-A cycles

- Mini PD road-show
- SPR PD champion

Our next P-D-S-A cycles: