Home Dialysis QI Project Report

A unit wide approach to increasing the uptake of peritoneal dialysis therapies

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Trust:	Oxford University Hospitals NHS Foundation Trust
Units:	Unit-wide
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Project end date:	

Problem and background

Historically Oxford had 120 patients on peritoneal dialysis in 2007. There was increased focus on promoting pre-emptive transplantation and this has resulted in a substantial reduction in the PD patient numbers to 58 in 2019. The proportion of home dialysis patients was around 15.5 % (against GIRFT target of 20 %)The project was initiated in 2019 to increase access to home dialysis for patients who may not have been otherwise routinely offered home dialysis due to staff bias and prejudices by promoting enhanced pre- dialysis education and shared decision making.

SMART aim

Increase the number of peritoneal dialysis patients to 100 by December 2024.

Increase the proportion of patients on home dialysis (both PD and home haemodialysis) to19 % by December 2024.

QI methodology

The project was led by a senior clinician with interest in PD and QI and supported by pre-dialysis nurses, senior clinician within the AKCC clinic and the PD nurses. reasons for low uptake of home dialysis were explored.

1. The AKCC clinic was set up in 2016 but referrals to this clinic was very low and patients were being referred late for RRT education.
2. There was no clear documentation of where patients were in their pre-dialysis pathway and their preferred RRT modality choice.
3. There were inherent biases within clinical teams on who may be suitable for home dialysis
4. There were no designated clinical leads for home dialysis

5. Clinicians were predominantly using GFR slope to predict ESRD and not taking in to account the level of proteinuria.

Following interventions were put in place

1. Clinical leads for PD and HHD established
2. Clinician with interest in PD started doing AKC clinics
3. Pre AKC clinic meeting with pre-dialysis team to discuss challenges/ barriers and suitability around home dialysis
4. Promoting the concept of presumed eligibility unless proven otherwise
5. Developed an electronic form on our electronic patient record to capture the AKC pathway for patients including modality choice, referral for transplant assessment, home visits.
6. Multiple audits to demonstrate the low and late referral rates to AKC clinic and engage clinicians at departmental audit meetings
7. Establish a weekly report of patients with GFR < 15 to identify patients who have not been referred to AKC and prompt clinicians
8. Introduction of automated Kidney failure risk equation reporting in lab systems to identify patients at higher risk of progression to ESRD. Unit guidelines to consider referral to AKC if KFRE 2 year risk was > 20%.
9. Patient surveys to evaluate that RRT education was satisfactory and understand any changes required.
10. Promoting NKF peer support helpline and local patients to provide support to patients who may be considering home dialysis.
11. Established a data collection tool to review home dialysis numbers on a monthly basis. Run charts were produced to monitor new patients starting PD, prevalent PD patients, PD drop outs and reasons for drop out, PD peritonitis rates.
12. Project team met on a monthly basis led by senior clinician with other members working on parallel initiatives such as shared care to review progress and address any challenges
13. Incremental PD was introduced in 2022 to gradually introduce the concept of PD and prevent burn out and loss of residual renal function
14. Ongoing monthly review of PD peritonitis rates and PD drop outs exploring reasons through RCA to understand any preventable cause that could have been anticipated.

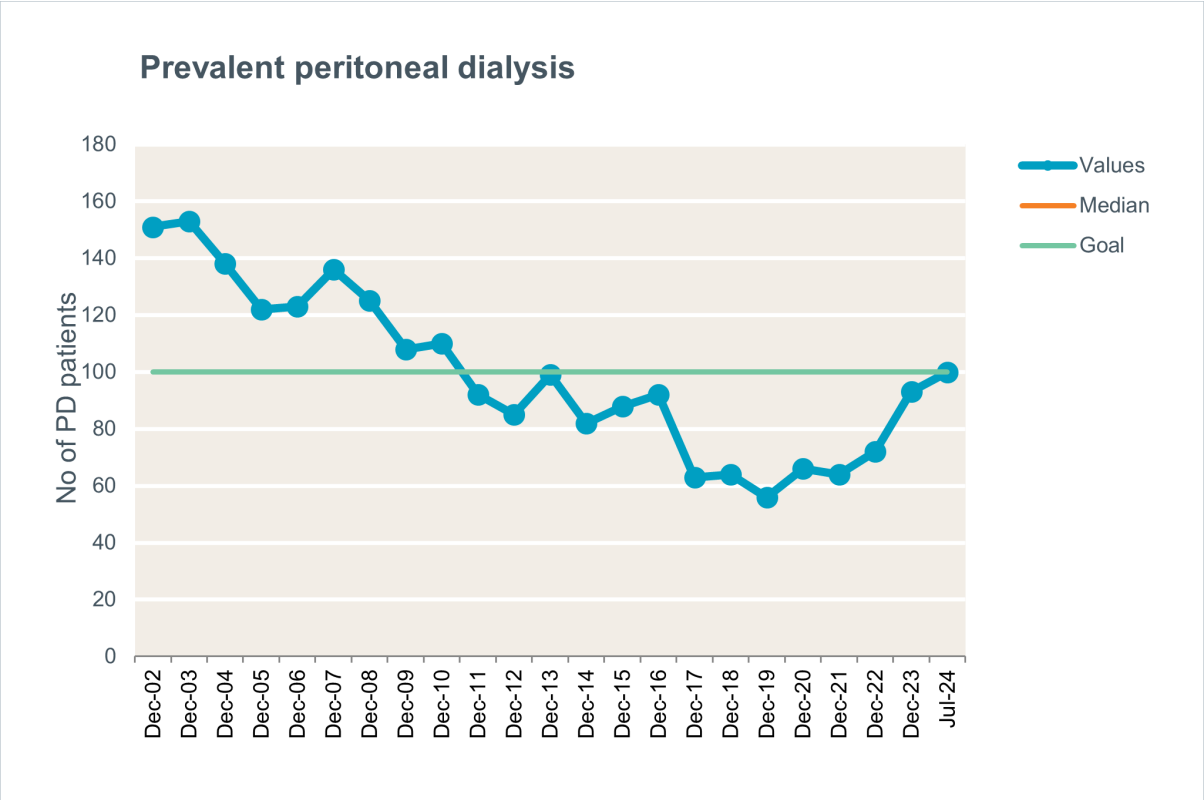
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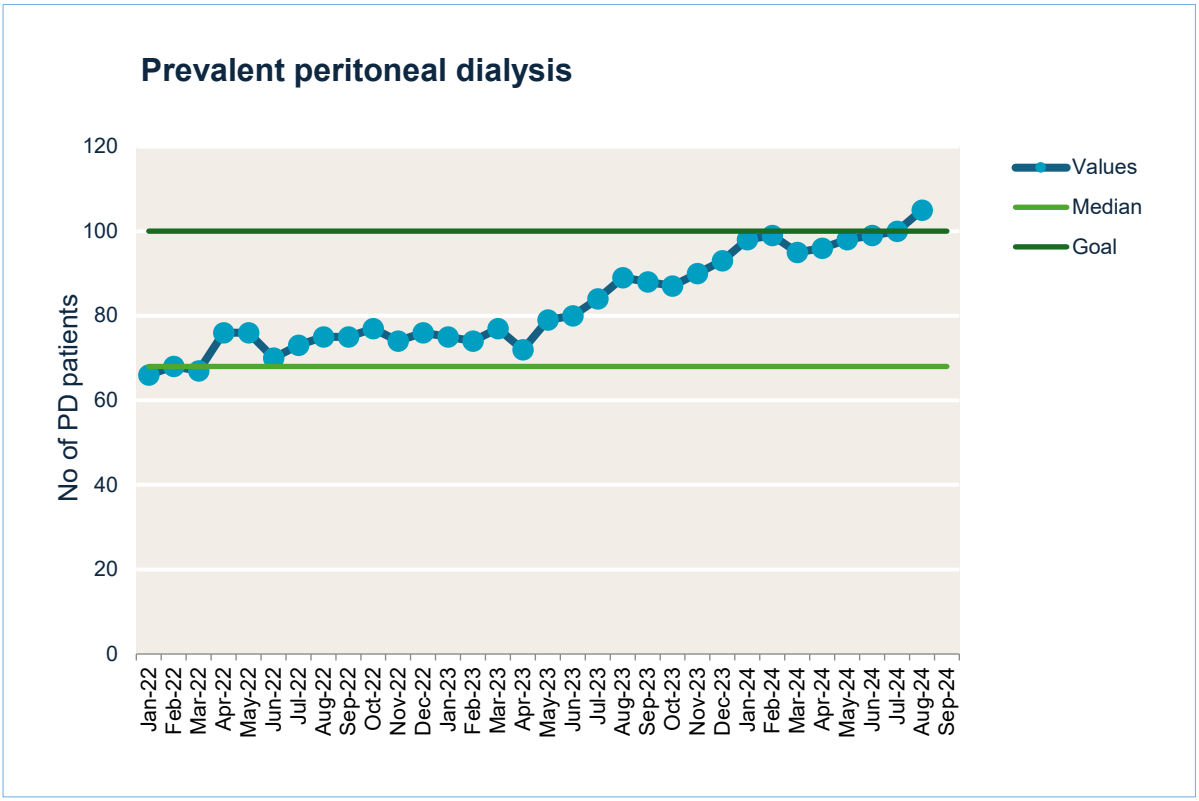
The PD numbers have progressively increased from 58 at its nadir in 2019 to 105 as of September 2024. Please see run charts, below.

The proportion of patients on home dialysis has increased to 19.8 % as of September 2024.

There has not been much growth in home haemodialysis in related project and this is an area that we are currently focussing.

Oxford Data (2022-2024)





Lessons learned

Having designated clinical leads and project teams helped with ownership

Systematic method of data collection to monitor progress

Monthly review meetings to support teams and maintain momentum

Systematically exploring the reasons and introducing change ideas to overcome those challenges

Sustainable way of incorporating AKC referral and follow up through electronic patient record form increased visibility of patient journey in the pathway

Supporting teams to have open conversations around home dialysis presuming eligibility for every patient and discuss these barriers in the pre AKC clinic meetings has helped staff confidence.