**Working Towards Greater Home Therapy Uptake Through Improved Patient Education**

**Background**

Home therapies and shared haemodialysis care have important benefits both for patients and for the renal unit compared with traditional in-centre haemodialysis (ICHD). However in our unit almost three quarters of our prevalent dialysis patients are being treated with ICHD, a figure which has not changed in several years, and we have also struggled to improve uptake of shared care. Many patients who would be suitable to undertake a home therapy or shared haemodialysis care are choosing not to do so, for reasons which are not clear.

**Aim**

To fully understand and subsequently to redesign the patient pathway in our renal unit in order to increase home therapy and shared care uptake, with a particular focus on our chronic kidney disease (CKD) patient education. By redesigning our pathway and patient education, we aspire to increase our prevalent home therapy population from 27% to 32% of our entire dialysis population by June 2019, and to 37% by June 2021. Secondary aims are to reduce the incident rate of ‘known’ patients starting dialysis without permanent access (29% in 2016), and to better integrate dietary and cardiovascular health advice into our patient education.

**Method**

We formed a core quality improvement project (QIP) team consisting of key CKD team members, and agreed the aim, scope and outcome measures to be used. We reached out to an industry partner to benefit from their previous experience in the use of LEAN methodologies.

Group and one-to-one interviews were conducted across the whole multi-disciplinary team (MDT) to capture and understand the patient journey up to initiation of RRT. We then held a workshop with representation from all teams within the renal unit to validate the constructed patient journey, and to further uncover potential obstructions and inefficiencies within that pathway. During this workshop we particularly focused on the areas of pre-dialysis education and counselling that had been highlighted during the initial interviews. A patient and their carer were invited to the workshop to provide us with their perspective, and their insights were supplemented with patient survey data.

Objective performance data which we had already collected for internal purposes, a regional peer review, and Renal Registry reporting was used to support the qualitative aspects of the project.

Following on from the initial work, smaller working groups have been formed to explore ideas for redesigning various elements of the pathway. Action plans and PDSA cycles have been developed to understand the impact of changes, along with clear measurement to track improvements and identify unintended consequences.

**Conclusion**

By engaging in a whole MDT approach and understanding the perspectives of staff at each stage of the pathway we were able form a more complete picture of our patient journey. LEAN methodologies and objective performance data enabled us to take a non-biased and honest look at our processes and uncover barriers to home therapy uptake. We now have action plans to support changes that we hope will provide measurable and sustainable improvement. The process of whole MDT engagement has fostered a positive environment for change and has positively impacted the culture of the unit as a whole.