**Introduction:** The Queen Elizabeth Hospital Birmingham (QEHB) renal unit has one of the largest dialysis programme in the UK looking after 1,000 patients on Hemodialysis and 165 patients on Peritoneal Dialysis [PD] spread across a large geographical area covering Birmingham, Worcestershire and Herefordshire. About 58% of our patients use APD (Automated Peritoneal Dialysis) machines. For the last 20 years, Baxter’s Home choice APD machine has been widely used across the UK. It uses a memory card (Procard) to store the machine programme and therapy data. Altering the programme and reviewing therapy data can only be achieved by physically accessing the Procard during clinic visits. Given the geographically dispersed catchment area, this poses significant practical challenges. Recently, the company has developed a new machine (Claria) that uses a two way cloud based technology platform (Sharesource) which enables the remote management of APD. This includes the option to set alerts (flag-rules) for individual patients that are visible to medical staff at base and that are triggered when pre-defined dialysis related conditions are met. This has the potential to increase patient visibility, reduce clinic visits and save nursing time. Remote patient management offers the opportunity to allow earlier identification of PD therapy related issues and facilitate prompt and timely intervention to prevent more significant complications.

**Aims:** To maximize the use of remote technology in APD; introduce a training package on the Sharesource flag-rules for education of the medical team and; to allow feedback on future development of the software.

**Method:** Following approval by the Chief Executive’s Advisory group at QEHB, a plan was developed to change 90 patients of APD patients on Homechoice to Sharesource. Around 10-14 patients were trained per week with a plan to transfer all patients to Sharesource at 12 weeks. All staff were trained on the Claria machine and received a basic overview of Sharesource during the conversion phase. Implementation of flag-rules was commenced once all patients had been converted, to enable an assessment of the impact of the new technology. An in-house training package is being developed to provide explanation for the flag-rules with suggestions as to how to manage the alerts. This will be used to educate renal trainees, nurses and patients.

**Result:** The development of a training package for Sharesource flags-rules is enabling the multi-disciplinary team to review and standardise their practice. This has the potential to improve quality of life of patients, reduce travelling and clinic visits, save nursing time and reduce PD related complications and hospital admissions. It, also, can improve Medical and Nursing teams’ knowledge and skill in managing PD therapy related problems due to the increased visibility of the PD patients that this technology avails. Data on the above will now be collected prospectively and compared with historical PD data to further evaluate the impact of this development.

**Conclusion:** The introduction of remote monitoring technology for APD patients at QEHB permits greater patient visibility and timely management of dialysis events. It may improve patients’ outcomes and result in increased patients and clinicians’ confidence in embracing this home based therapy. Educating staff and patients will optimise and maximise the use of this technology. It will aid future developments including research and encouraging clinicians to subspecialize in PD. Further future evaluation is required to fully appreciate its impact and employ strategies to widen its use.