**Engaging staff to deliver Shared Care by educating and implementing tools to close down perceived barriers through team work**

**Introduction**

Transforming the relationship between patients and staff to promote an environment where participation and partnership becomes the norm in our dialysis centre is the key desire of our shared care programme, with overwhelming benefits to patients as proven by research. The champions of shared care in the centre were not just satisfied with the wonderful care renal patients received by our nurses making them passive. We wanted to see our patients as active participant in their care as possible. These patients are individuals endowed with special skills which they use as they manage their lives between dialysis days. These skills should be transferable to their treatment centres as they participate in shared care.

Change was therefore necessary even as Robert Francis (QC) stated in his press conference of 06/02/2013 “we need a patient centred culture, and a caring, compassionate nursing. Royal College of Nursing's response to the Francis Enquiry included: Support for the role of the 'Named Nurse' as a mechanism to organise work around the needs of the patient rather than a series of tasks. Hence, the birth of Shared Haemodialysis cares.

**Aim/Objectives**

* Seek staff opinion, awareness and what they really think about engaging with patients to promote shared care in the unit.
* Establish educational/training needs of staff
* Establish who needs support and keen to begin working with us
* Identify barriers/obstacle to the uptake of Shared care by nursing staff.

**Methods**

A Shared care Haemodialysis care task training (summary chart) comprising of (14 tasks) were put in each patients folder. Initial assessment was carried out by the Shared care champion of what patients were interested in taking on, and Name nurses of each patient was to support and encourage patients to take up additional tasks via monthly review. Starting from 04/08/2017- 31/12/2017.

Discrepancies were spotted in the documentation process in most patients’ folder through the Plan-Do-Study-Act (PDSA). A nine item open questionnaire were distributed to 11 members of staff to express their honest opinion about shared care. The information collected were carefully studied and analysed.

**Results/Findings**

Two days was used to give out and collect results due to the shift pattern that runs in the unit, with 100% feedback from staff. All staff (100%) had a good knowledge of what shared care means and its benefits to the patient, and stating that “It is a partnership between patients and staff”. However, the findings stated otherwise.40% were concerned about time constraint and how low level of staff can sometimes put pressure on them especially when trying to juggle between patients care and the hospital transport. Hence the need not to count the shared care champion in the number. While 20% were concerned about the long term goal of its sustainability.98% of all the staff are positive and want to be more involved in moving Shared care forward in the unit with the possibility of some of them heading for self-care or Home haemodialysis.

Almost all staff (98%) are willing and happy to deliver Shared care in the unit when provided with appropriate knowledge and training.

**Conclusion:**

For Shared care to become sustainable it is imperative that all staff is on board in educating the patients and or carers to be involved in their treatment. Taking ownership of the project by key members of staff drives the programme forward thus empowering the patient to have their say in their health and well-being. This does however require the support uniformly by all team members to give consistency to its deliverance. Through implementation such as identifying the fears and gaps of knowledge ensures we can close the gap of resistance. This can be achieved through education programmes and various interventions to aid in the support of deliverance and monitoring. To change the culture that shared care is part of the daily routine and not an additional task support is required. We have a duty to deliver patient focused care which can be lost if the patient cannot be included in their treatment.