**Category: Quality Improvement**

**Home Therapies Service Redesign**

The geography covered by the Renal service is large with a varied demographic, from densely populated urban areas to remote rural expanses. Supporting our home therapies (HT) population has always been challenging but in recent times became so difficult that it led to the closure of our home training centre for Home Haemodialysis (HHD) training. In addition to providing community based support, at the tertiary site we supported drop in reviews, any Peritoneal Dialysis (PD) inpatients on our main renal ward alongside staffing the HHD training facility. This service became untenable early in 2017 due to staffing levels and skill mix with our patients experiencing unwarranted variation. Due to staffing across two sites we were unable to routinely provide ongoing education for our PD patients and did not offer 24/7 access to appropriate treatment for PD Peritonitis. We also did not have a robust PD patient pathway to identify steps that should be followed to continuously support and educate these patients. Despite these circumstances we still cared for approximately 90 home dialysis patients

Following discussions within our team including the Pathway Development Manager (PDM) at Baxter Healthcare we embarked upon a QI programme of work using standard lean methodology.

**Aim**

To develop and embed a robust PD patient pathway aiming to increase PD patient numbers and maintain patients on their first choice therapy. To ensure 24/7 access to appropriate treatment for PD Peritonitis. To do this without extra resource with the ultimate aim to be in the top 5 trusts in the UK for home therapies by 2021.

**Method**

The current state of our service was mapped out to identify relevant issues and a focus group identified to work specifically on the patient pathway leading into Home Therapies. This was a MDT approach with inclusion of ward staff that were challenged with perhaps the biggest change to practice to further our overall quality and efficiency objectives.

It was identified that staffing two sites approximately 15 miles apart was one of the main causes of resource difficulties and directly impacting patient care. Using lean methodology to identify system wastes and values we devised a plan to move the HT team to one site while ensuring that PD in-patients/out of hours presentations received the appropriate care. The process began with a training programme for the entire ward to enable them to become independent of the HT team. Once the majority of staff had completed competency based training the HT team moved entirely to the training facility. Enhanced levels of remote support were given to the ward to ensure safe care of any PD patients that were admitted, which included providing a weekend on-call service.

Working with the PDM from Baxter Healthcare we then developed our PD patient pathway which commenced from referral for PD catheter insertion to the point at which the patient is no longer able to undertake PD. During this overall PD QI work we have seen a significant improvement in our peritonitis rates from 1 in 13.8 patient months to 1 in 17.

**Conclusions**

Using Lean methodology and a MDT approach we were able to identify weaknesses in our patient pathway for PD. We have been able to create resource within our HT team without increased investment by moving to one site. As part of this process we have improved access to treatment for PD peritonitis out of ours and created greater capacity to invest in initial and follow up training for PD and HHD patients. We also now have the ability to provide preventative education to support PD patients to avoid infections and technique failure whilst improving PD peritonitis rates.