Peritoneal Dialysis Quality Improvement Collaborative

November 3rd 3-5pm

Interim Co-Leads

Dr Richard Corbett

Ms Elaine Bowes

LKN PD Quality Improvement Collaborative
3rd November 2021
Time: 1500-1700

Agenda

Item	Title	Lead
1. 3pm	Welcome	RWC/EB
2	**PD Quality Improvement Collaborative** ➢ What are we trying to achieve today and going forward? ➢ Ethos of co-production ➢ Objectives + time frames ➢ Meetings	RWC/RG
3. 3.10pm	**Current data collection - Peritonitis** ➢ UKKR/QSIS data source	PW/RWC
4. 3.20pm	**Break Out Rooms – 15 mins** ➢ Discuss and answer the posed questions ➢ Discuss the posed vignettes	RG/JS
5. 3.35pm	**Feedback and round table discussion** Share challenges & discussion points from breakout rooms	All
6. 4pm	**Revisit ISPD guidelines** ➢ What does good look like ➢ Define what we will capture across London ➢ How we will share it with one another ➢ What support is required to achieve this ➢ Agree objective for collection	RWC/EB/All
7. 4.20pm	PD Training and Workforce Presentation on current findings ➢ What does good look like? ➢ How do we get there? ➢ Agree next steps	KD/EB
8. 4.55pm	Summary and close	EB/RWC

PD Quality Improvement Collaborative

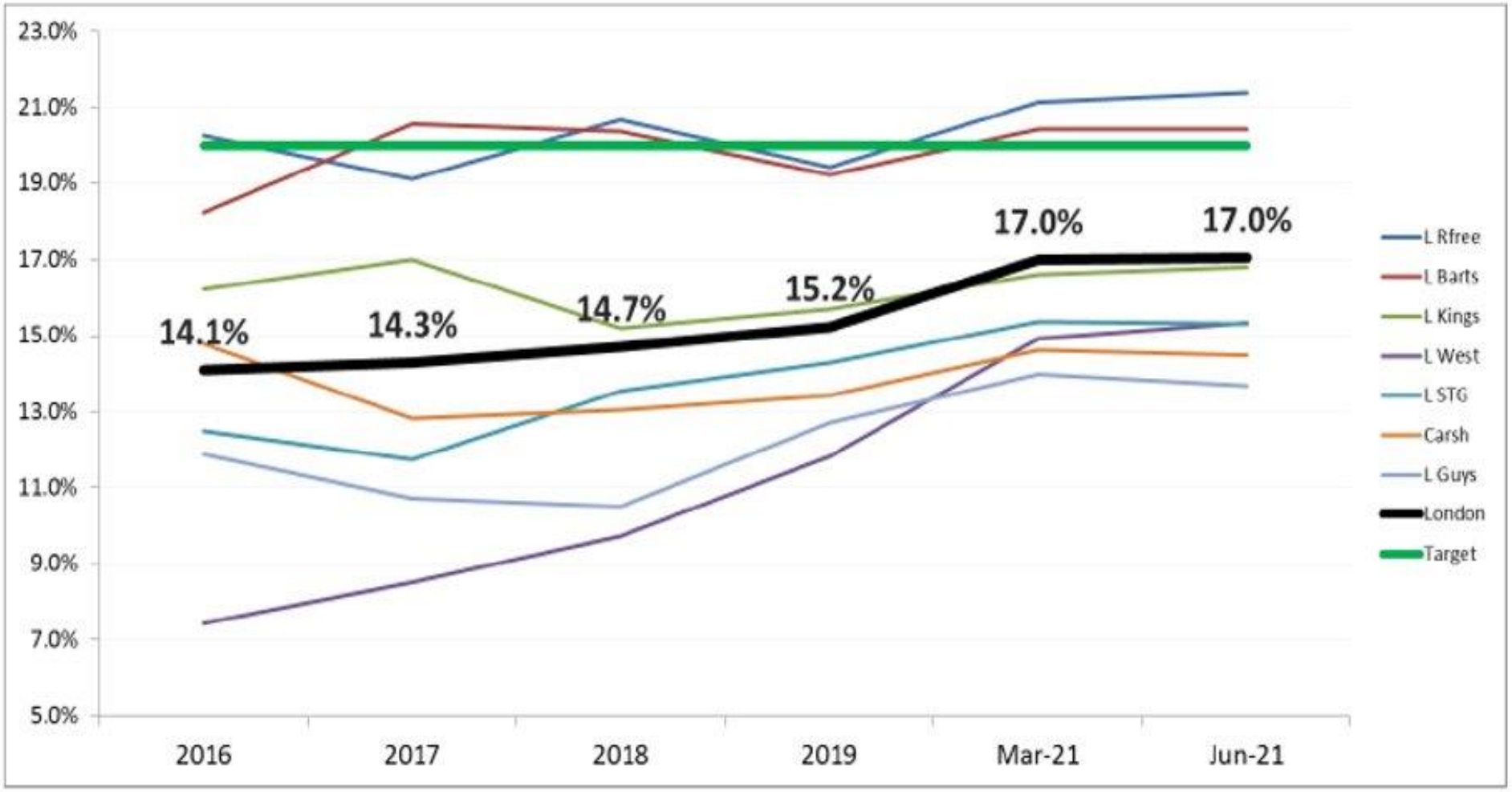
What are we trying to achieve today and going forward

Ethos of co-production

Objective + time frames

Meetings

Home Therapies Growth in London



RSTP and GIRFT

Dialysis Work plan : Delivering safe & durable dialysis access

	Key deliverables	Timeline for delivery	Lead Resource & resources to implement change		What outcome are we working towards	Data for measuring change
D1	Minimising access infection	12 months / August 2022	National	Clinical Networks, GIRFT, NHSX/D, Medicines Optimisation	1. Fewer infections experienced by dialysis patients	1. Improve dialysis access bacteraemias& PD peritonitis rates per 1,000 at risk days by 10 percent
CKD7	Access to home therapies			Networks, CRG, Industry	1. Renal centres to ensure that home therapy options are effectively communicated to those patients for whom a pre-emptive transplant (Transplant First) or a conservative approach is not appropriate (GIRFT)	1. Home therapy prevalence 2. Aim to increase to 20 percent or additional 10 percent 3. Reduce variation across ICS/networks

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RTSP GIRFT and us

GIRFT objectives relate to increasing numbers

But clear discussions in the Pan-London PD forum:

As a network keen to get quality of care right

Peritonitis a great marker of care

Look to support keeping people on PD rather than growing numbers and improving outcomes in first instance

Challenges with workforce numbers in supporting the growing numbers on PD

QI WORKSTREAM: Home Therapies (Peritoneal Dialysis)
High Level Summary September 2021-March 2022

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AIMS

1. All units engaged in continuous quality improvement collaborative for peritonitis based on ISPD guidelines
2. A significant and sustained improvement in **peritonitis rates and outcomes**
3. Appropriately trained and resourced MDTworkforce able to deliver high quality care in community and hospital settings
4. Timely access to comprehensive, local, person-centred training for all people starting PD
5. Systems identified to enable 30% of all dialysis starting as PD

OBJECTIVES

1. Development of a multi-professional QI collaborative focused on peritonitis.
2. Quarterly sharing of peritonitis rates and outcomes across London.
3. Map existent workforce delivery across all units in PD to share models of good practice.
4. Identify and resolve the barriers to timely training for people starting PD.
5. Map dialysis starts across London to understand variations in practice and the barriers to choosing PD.

OUTPUTS

1. Identified QI medical and AHP leads from each London unit involved in PD QI collaborative.
2. Dashboard shared within LKN reporting on peritonitis rates and outcomes on a quarterly basis.
3. Quantitative and qualitative description of the LKN workforce supporting PD.
4. A detailed description of the resource required to support the training and support for people starting PD.
5. Data pack with quarterly description of incident dialysis starts across LKN by unit

MEASURES INCLUDE

1. Peritonitis rate across all centres including split by organism group.
2. Standardised reporting of peritonitis outcome across all units.
3. Estimation of workforce delivering PD across London
4. Time from PD catheter insertion to training.
5. Total time spent training individuals starting PD at a unit level.
6. Provision of commercial provider vs in-house training by unit.
7. Incident dialysis starts by modality by unit.

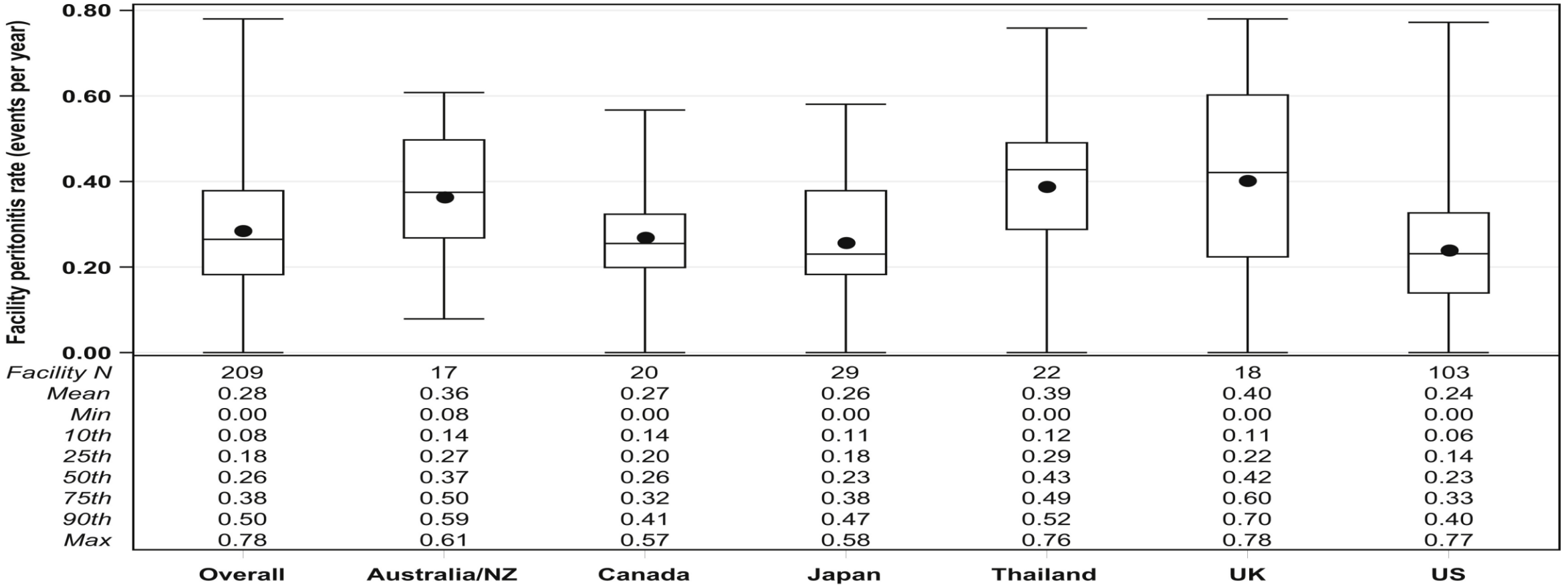
Related RSTP work items: CKD7, D7

Related GIRFT work items: 6

What do we want to achieve today?

- Agree objectives for next year
- Two predominant parts
  - Peritonitis
  - Workforce

Why peritonitis?- PDOPPS data peritonitis rates



	Overall	Australia/NZ	Canada	Japan	Thailand	UK	US
Facility N	209	17	20	29	22	18	103
Mean	0.28	0.36	0.27	0.26	0.39	0.40	0.24
Min	0.00	0.08	0.00	0.00	0.00	0.00	0.00
10th	0.08	0.14	0.14	0.11	0.12	0.11	0.06
25th	0.18	0.27	0.20	0.18	0.29	0.22	0.14
50th	0.26	0.37	0.26	0.23	0.43	0.42	0.23
75th	0.38	0.50	0.32	0.38	0.49	0.60	0.33
90th	0.50	0.59	0.41	0.47	0.52	0.70	0.40
Max	0.78	0.61	0.57	0.58	0.76	0.78	0.77

- Sahlawi et al. AJKD 2021

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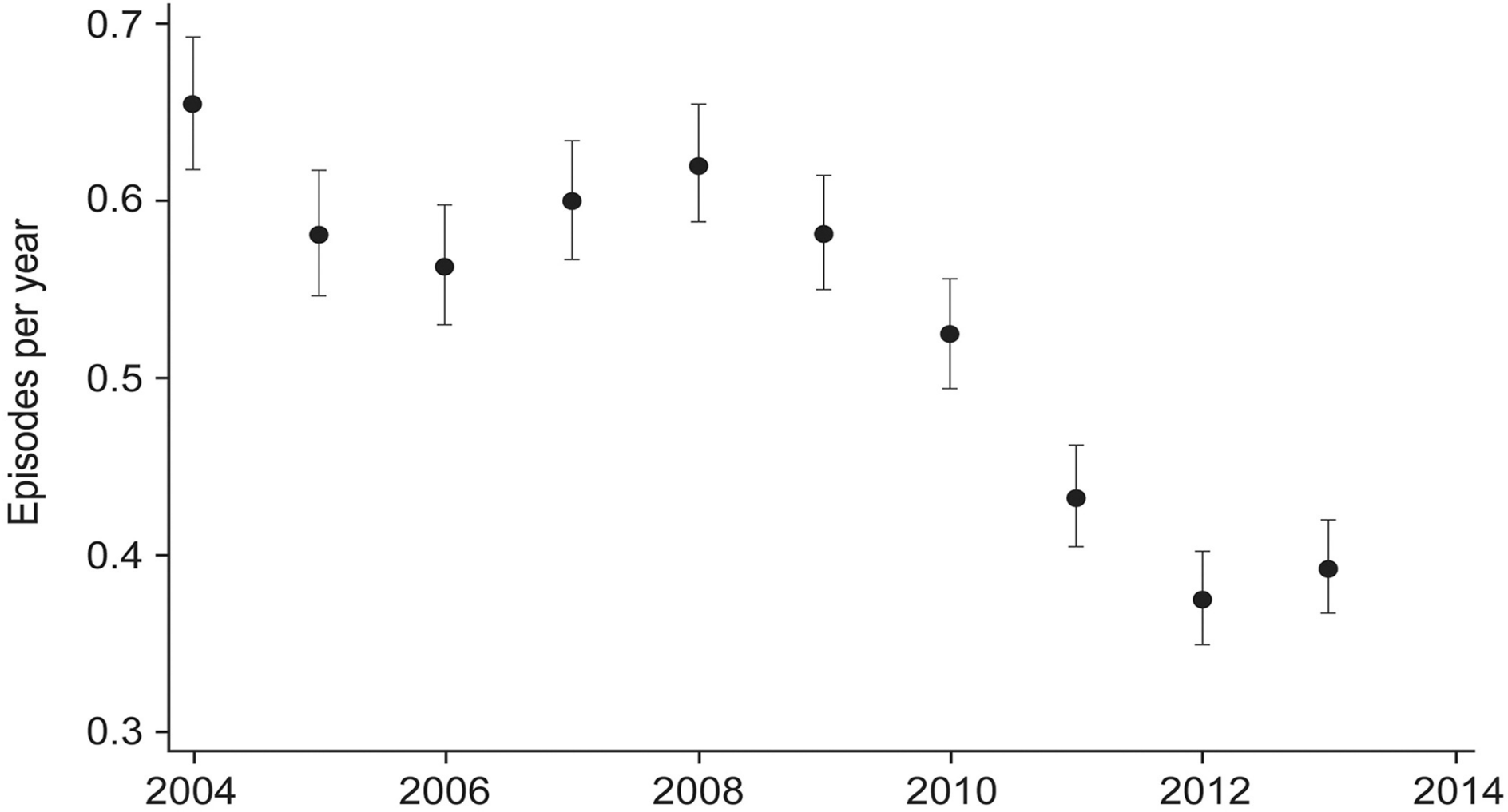
QiP work elsewhere



Australia/ New Zealand mean peritonitis rates 2004 - 2013

Meetings

Provisional dates for diary for 2022 to be shared

Avoid holiday periods

Rotating Wednesday/ Thursday afternoons

QI PD Collaborative QI leads meeting 6-weekly

PD London Network meetings 4-monthly with local chairs (as before)

March 2022 GOSH (tbc)

July 2022 RLH (tbc)

November 2022 Kings

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Current data collection - Peritonitis

UKKR QSIS data source

Peter Wilson – LKN Business Intelligence Lead

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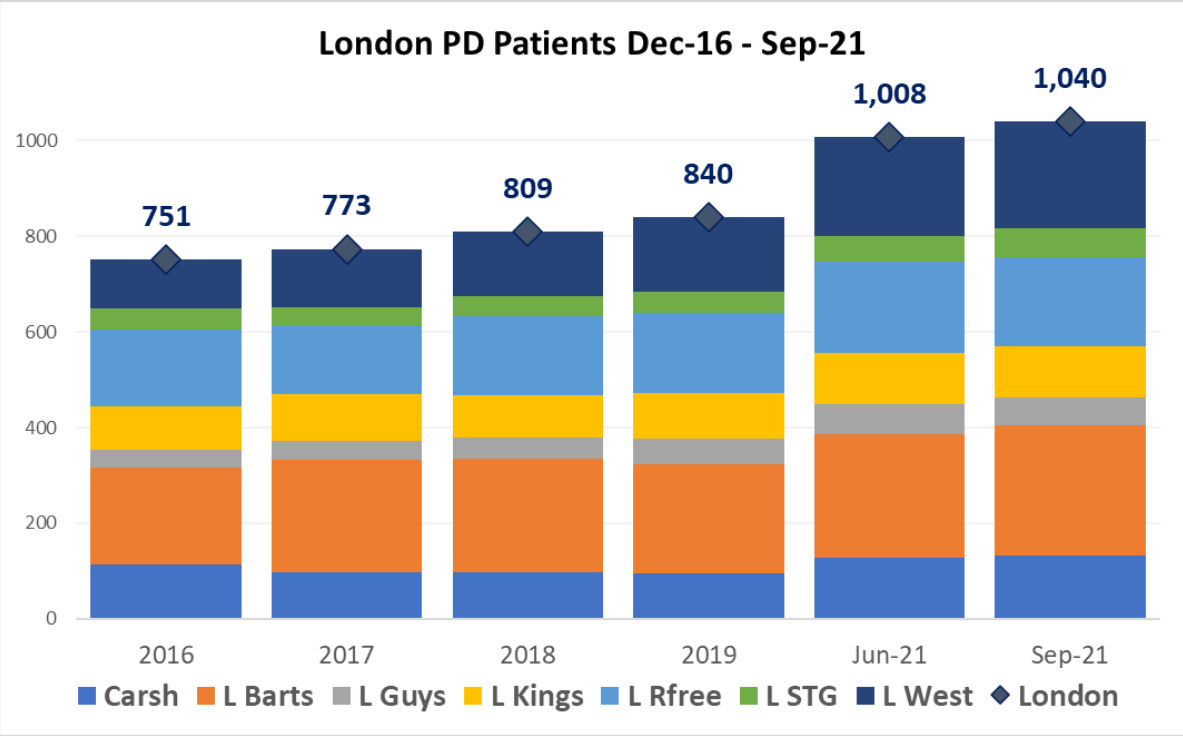
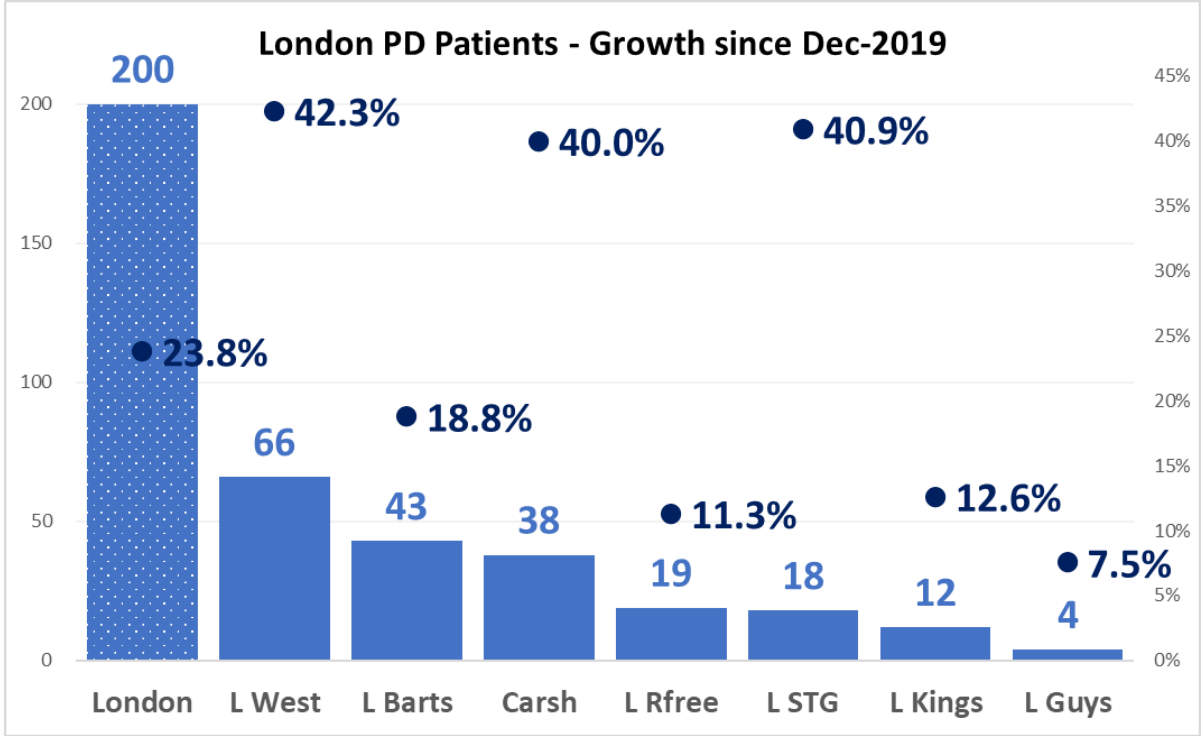
London PD Population





- Across London there are an additional **200** patients on the program as of Sep-21 than in Dec-19 (which crudely averages to **10.5** a month).
- 3 of the 7 trusts are seeing over **40%** growth in numbers in this period.
- The London average growth is just under **24%** with the range **7.5% to 42.3%.** For the previous three years (2017-2019) we were seeing an average growth of just over 3%.

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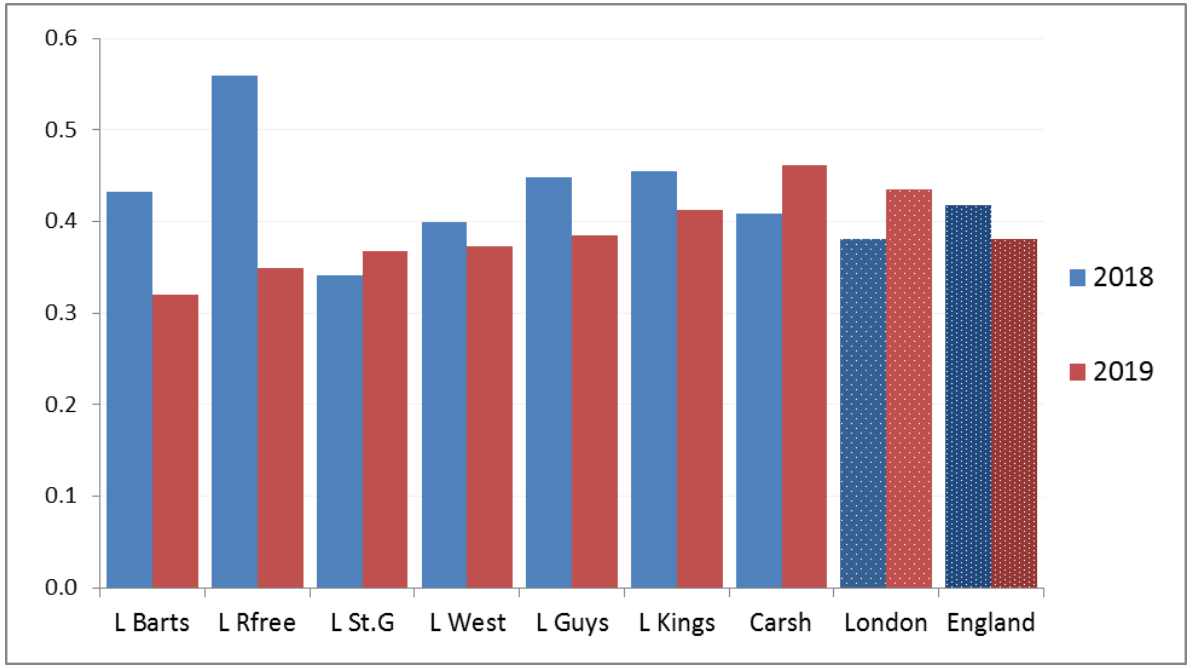
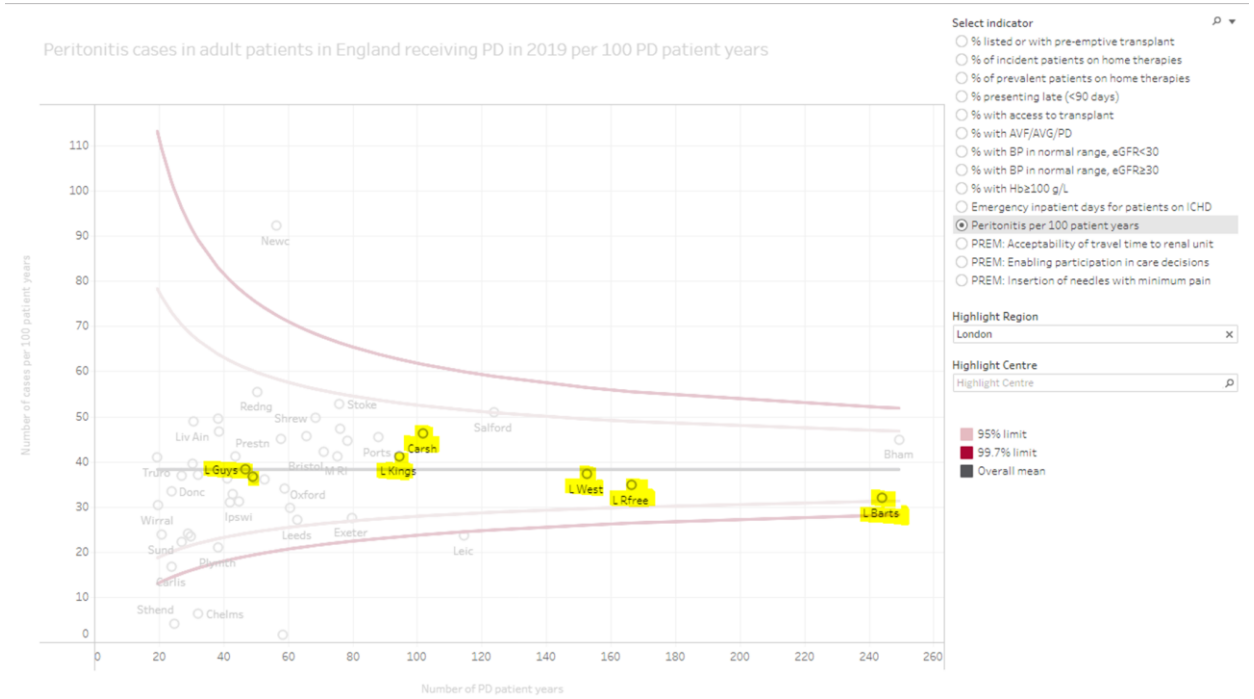
Peritonitis rate per 1 PD patient year

Source: UKRR





Current data collection - Peritonitis

Already submitting a lot of data to UKRR

Want to avoid duplicating work

But wanted to break down how at a unit level we are capturing peritonitis episodes, reporting and sharing this?

Peritonitis difficult episodes to capture

Keen to understand how we are measuring this at the beginning to share practice

Break out Rooms: There will be 3 Breakout rooms

Breakout Rooms	Room 1	Room 2	Room 3
• -Click the button on the screen to join the room you've been allocated to • Breakout rooms are for 15m • We have tried to keep the groups as with trusts but for purposes of numbers we've moved some of you around	Epsom and St Helier St Georges Facilitator Katie Durman Lavinia Ngwerume Edward Stern Kim Blair Marykutty Philip Alison McCarthy Caroline Omaguvwe Sally Holford	GSTT & King's Facilitor Elaine Bowes Jonathon Dick Dimitriosanestis Moutrouris Fatima Moreira Roxana Voici Hugh Cairns Trevor Farley Babakang Shakoane	Imperial & Bart's & Royal Free Facilitator Richard Corbett Charelle Serrano Fan Stanley Robyn Hodgson Catriona Goodlad Sally Punzalan Sidali Ouad Lilian Ekeh

Aim To understand the challenges and different ways that peritonitis data is collected in each centre and how this is then shared to help practice
1. Overall a) Do you think your data is accurate and how much may be missing? b) Do you share and discuss the peritonitis data in your unit with your senior management team as well as the team you work with?
2. Who? a) Who is responsible for recording and reporting peritonitis episodes from your service? b) Both collating the events as they happen and then reporting to the registry?
3. What? a) What is your process for recording peritonitis events? Do you record all potential presentations with peritonitis, or do you only include treated episodes? b) When counting episodes, do you include peritonitis episodes before a patient has started PD (e.g. after catheter inserted but before a patient has gone home)? c) What do you do about recording outcomes from peritonitis?
4. When? a) Is this the data recorded in real-time or completed retrospectively? b) How often you report the data? Monthly/ quarterly? c) When counting episodes, do you count peritonitis episodes that occur within 4 weeks of a previous episode (relapsing episodes)?
5. How? a) How is this recorded within your unit and captured – who does it – really drilling down into the detail b) How do you calculate the number of PD patient days in order to calculate rate of infections? c) How do you define outcomes?
6. **Where?** a) Where is it recorded / reported? b) Are there any other potential variations?

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Scenario 1

- Patient presents in hours to PD team
- Cloudy bag/ abdominal pain
- WCC >1000 with organism

- *How do you record this event?*

Scenario 2

- Patient on PD
- In-patient for 3 months
- Ward team identify peritonitis and treat it during the admission

- *How do you pick up and record this event?*

- Scenario 3
  - Patient presents out-of-hours
  - No abdominal pain and slightly cloudy bag
  - Not dialysed for 3 days
  - Started on antibiotics
  - WCC 180
  - 5 days later no growth and 90% monocytes
  - *Would you still record this as peritonitis- who decides?*

- Scenario 4
  - Patient presents with peritonitis
  - Treated for a coagulase negative staph (CNS) and completes treatment
  - 3 weeks after completing treatment represents with peritonitis- CNS again
  - *How would record this recurrent peritonitis?*
  - *How do you record outcomes from peritonitis?*

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Round Table Discussions

Finish: 4pm

Agree what good looks like

Agree what we want to measure

Peritonitis rates?

Outcomes?

More than this?

Agree how we share it locally

What support is needed to achieve this?

Timeframes

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QI WORKSTREAM: Home Therapies (PD) – July 2021- March 2022
High level summary of next steps and anticipated timeframes

AIMS	OBJECTIVES	OUTPUTS	MEASUREMENT
1. All units engaged in a continuous quality improvement collaborative for peritonitis based upon ISPD guidelines. 2. A significant and sustained improvement in both peritonitis rates and outcomes from peritonitis.	1. Development of a multi-professional QI collaborative focused on peritonitis. 2. Quarterly sharing of peritonitis rates and outcomes across London.	1. Identified QI medical and AHP leads from each London unit involved in PD QI collaborative. 2. Dashboard shared within LKN reporting on peritonitis rates and outcomes on a quarterly basis.	1. Peritonitis rate across all centres including split by organism group. 2. Standardised reporting of peritonitis outcome across all units.

Are these reasonable aspirations?

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Training and Workforce

Elaine Bowes
Katie Durman

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Training and Workforce

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Katie Durman

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Examining Patient Training to optimise outcomes

A look at where we are , share best practice and to consider what good looks like.

Ms Elaine Bowes

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Examining the evidence/ Guidelines

ISPD GUIDELINE/RECOMMENDATIONS: A SYLLABUS FOR TEACHING PERITONEAL DIALYSIS TO PATIENTS AND CAREGIVERS
A Figueirdo et al 2016

- This course syllabus is designed as a 5-day program of about 3-hours per day, but both duration and content may be adjusted based on the learner
- *"If widely adopted, it has the potential to improve a range of components including patient activation, technique failure, hospitalization, and quality of life."* Helen Hurst

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5 Day Programme of learning

Day 1

- Objective: To establish rapport, describe the goals and plan of the course, demonstrate steps of procedures, assess patient learning styles and barriers, explain how learning will occur, introduce concepts of PD

Day 2

- Objective: To review goals, provide repeated supervised practice sessions of PD exchange and exit-site care procedures with feedback from previous day, to review concepts of asepsis, peritonitis, residual renal function, fluid balance and documentation previously introduced, and to move from simple to more complex learning

Day 3

- Objectives: To continue supervised procedure practice with feedback, to review concepts through discussion and questions, to introduce problem solving .

Day 4

- Objectives: to continue supervised procedure practice with feedback, including acknowledgement of skills mastered, review concepts through discussion and questions, continue to problem solve through “what if” scenarios.

Day 5

- Objectives: To review all previously presented concepts and practice all procedures until proficiency demonstrated.

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Peritoneal Dialysis Training – practices in London.
Results of a quick survey
October 2021

Ms Katie Durman

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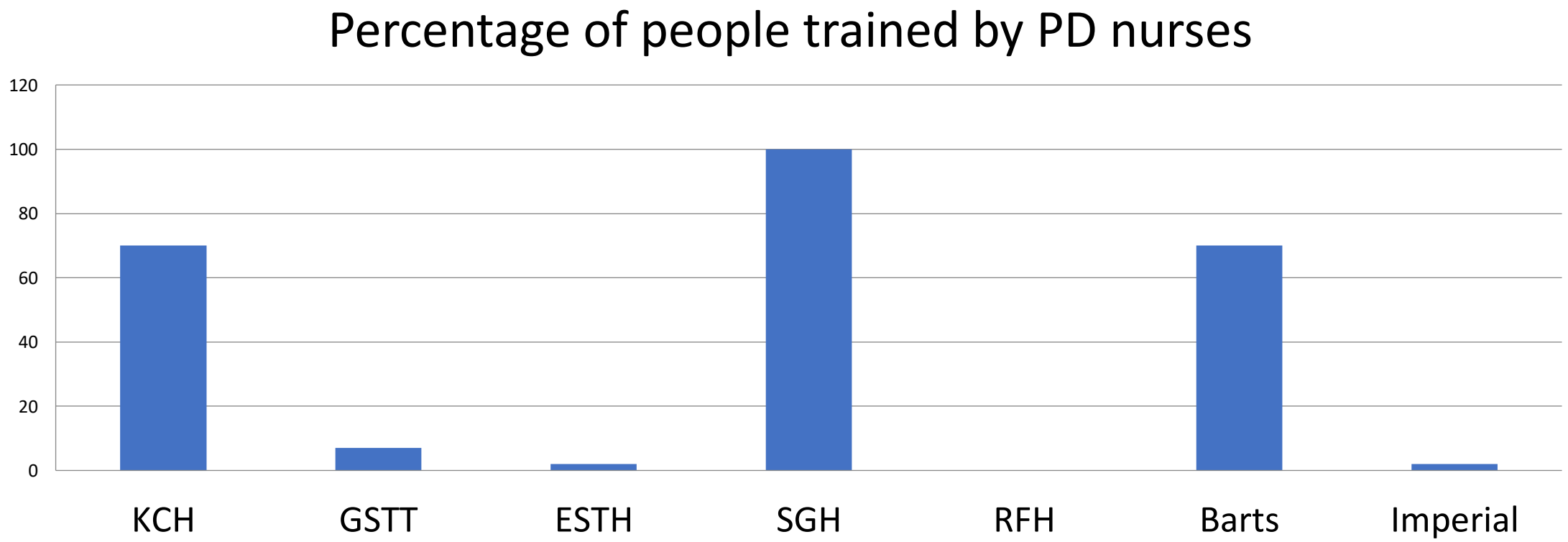
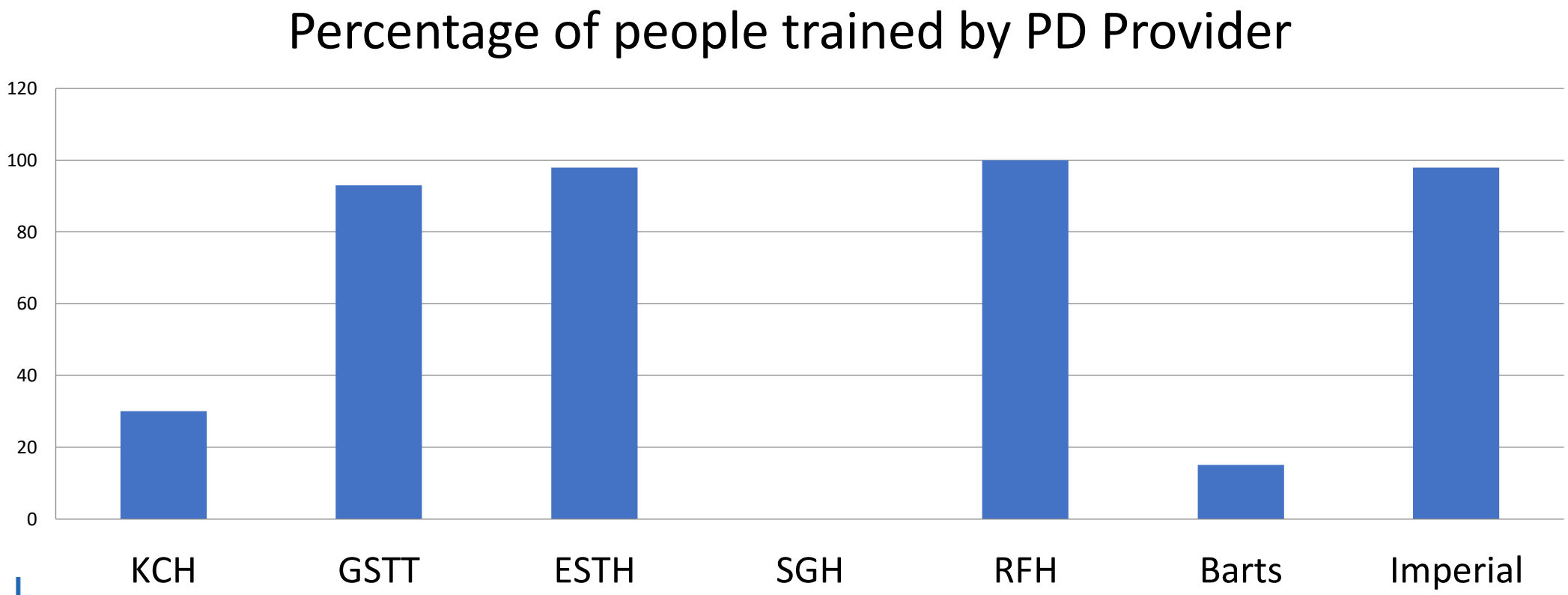
In 3 out of the 7 units the majority of people are trained in house by the PD nurses.



In 4 out of the 7 units virtually all people are trained by the PD provider - mostly Baxter



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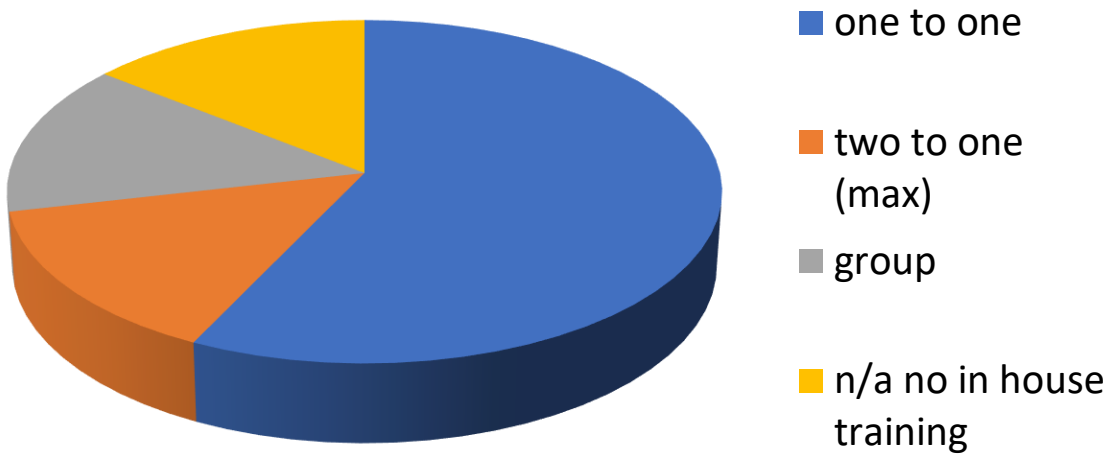
PD Training

- When trained in house the most common model is one to one training



- The same member of staff completes the training for each person
- Training takes between 4 and 30hrs over 1 to 4 days depending on the unit, the person being trained and whether CAPD or APD

PD Training

The 3 units who do most of the training in house train at the hospital outpatients

Those who do very little in house training tend to train people either in hospital or at home

We asked about follow up training, KCH and SGH provide follow up training for all, RFH has provided follow up training to a small number of patients.

All units keep a record of the training, 6 units keep an electronic record in the patients notes, one unit just keeps a paper record, two units also keep records in a separate database

4 units reported to undertake a cognitive assessment of learning needs

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PD Training

	Fresenius	Baxter
CAPD - length of training	1 day (5-7hrs) (most people need 1 day but can be extended)	1.5 days
APD – length of training	2 days (most people need 2 days but can be extended)	2.5 days
Who trains	Specially trained trainer (HCA equivalent)	2 nurses – one trains, one observes
Location	Home / hospital outpatients / training clinic	Mostly at training centre
Model of training	One to one or group (2-3)	group training (2-4)
Follow up training	If Trust requests, will call some people if they feel they need extra support	Everyone is offered a follow up call Group zoom call at 6-8 wks Theory training can be continued virtually for those who need it

PD Training - Summary

NHS London Kidney Network

Approximately 60% of people are trained by the PD provider

Group is the most common method of training

Length of training is variable from 1-6 days (4-30hrs); 3 days, 18hrs is possibly the most common time

Most trainers report to assess how people are learning and adapt training according to how they learn best, but unclear if anyone does a formal assessment of learning style

Training is documented, unclear exactly what is documented

Workforce

The ANN is undertaking a national survey of PD nursing workforce. Please complete the survey and prefix question 1 with the word London so that the Renal Registry can give us the regional data.

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- References
- Peritoneal dialysis international: journal of the International Society for Peritoneal Dialysis 36(6)
DOI:10.3747/pdi.2015.00277

Next Steps, Actions & Time Frames

Elaine Bowes

Summary and Close
Elaine Bowes
Richard Corbett