Bridging the Gap: Implementing the Transitional Care Approach for New Hemodialysis Patients

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MEET IRFAN

Irfan is married, a father of two teenagers, and an engineer. Irfan is diabetic, and due to medications taken as part of his cancer treatment, his kidney function declined. This eventually led him to the need to start dialysis.
On his first day, Irfan felt anxious and nervous. He sat on the dialysis chair and a nurse asked him if he wanted freezing prior to being cannulated.
Not knowing what freezing was, he declined the offer. Irfan recalls his first needle insertion as being the one of the most painful experiences he has ever had.
During his next dialysis session, he asked what freezing was and informed the nurse he wanted to have as much as allowed. Unfortunately, this is something that happens too often.

Starting dialysis can be a scary experience for new patients. In a busy hemodialysis unit, it is easy to forget that new patients may be unfamiliar with the language that different members of the care team use every day in providing care.
We want to make sure that the first few weeks of dialysis are easier by starting patients in a place where they can get a better feel for how dialysis might best fit the lifestyle they wish to continue.
The program helps patients learn about dialysis and other treatment options besides in-hospital dialysis.

THE STARTING POINT: A QUALITATIVE STUDY

We conducted a study to (i) understand the educational needs of patients from their point of view and, (ii) learn from patient and nurse clinician perspectives on facilitators and inhibitors of implementing an effective education program to promote self- management in new hemodialysis patients.

> "An orientation at the beginning of dialysis, consisting of a 15 minute explanation of how the machine works would have been helpful and also an explanation of what is happening in general." – Patient

> "I can try to set up the environment on the floor to be suitable for learning, but if I don't have the staff it is not going to be, really, all that helpful" – Clinical Nurse Leader

> "It's not only the patient that can be educated. It's also us." – Nurse Clinician

In summary, our findings raised the need to focus on the care transitions renal patients experience.

THE WHY: FOCUS ON THE TRANSITION

In the literature, transitional care encompasses a broad range of services and environments designed to promote the safe and timely passage of patients between levels of health care and across care settings.
The transition to hemodialysis is a high risk period. The first two weeks of dialysis are associated with a higher risk of mortality and hospitalization. Hemodialysis patients have a median hospitalization risk that is 3x greater than patients who are not undergoing dialysis. The median length of hospital stay is also longer for dialysis patients.

The first few weeks of the transition present the greatest challenge for patients. They face many physiological and emotional challenges as they go through the treatment plan and lifestyle changes. Patients report experiencing negative feelings associated with their condition (fear, grief, anxiety, depression and cognitive dysfunction) and express ambivalence towards dependence on treatment. During this period, education can play a key role in helping patients adjust to living with kidney disease and adhere to treatment.

WHY

Despite the comprehensive care in the dialysis unit, patients still feel overwhelmed by transitioning to dialysis treatment. We identified the need for a tailored approach to standardized patient education and staff training in a recent qualitative study.

WHO

Patients with Chronic Kidney Disease who are new to dialysis, and staff at the In-Center Hemodialysis Unit at St. Paul's Hospital.

HOW

We implemented the **Transitional Care Program (TCP)** to address the themes identified in the qualitative study.

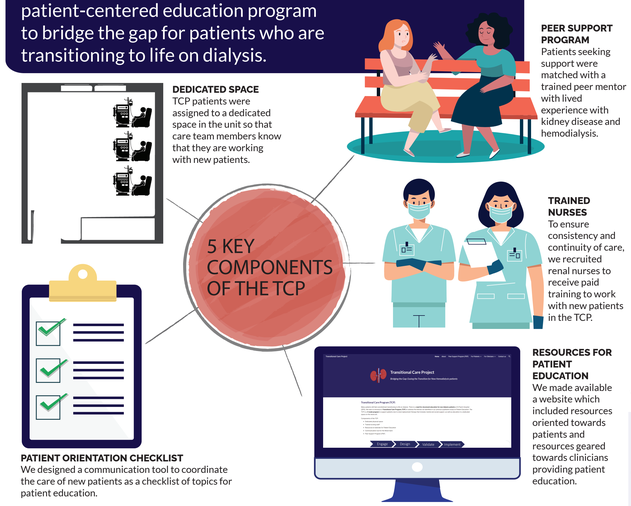
WHAT

The Transitional Care Program is a 4-week program in which patients who are starting dialysis receive care from specially trained nurses and other members of the renal team in a dedicated space in the Hemodialysis Unit.

ENGAGE

We engaged with key stakeholders (patient partners, nurses, members of the renal interdisciplinary team & departmental leadership) to co-design a TCP Program to address the needs of new dialysis patients.

Goal of the Transitional Care Program (TCP)
Improve the care of new patients by implementing a patient-centered education program to bridge the gap for patients who are transitioning to life on dialysis.



DEDICATED SPACE
TCP patients were assigned to a dedicated space in the unit so that care team members know that they are working with new patients.

PEER SUPPORT PROGRAM
Patients seeking support were matched with a trained peer mentor with lived experience with kidney disease and hemodialysis.

TRAINED NURSES
To ensure consistency and continuity of care, we recruited renal nurses to receive paid training to work with new patients in the TCP.

PATIENT ORIENTATION CHECKLIST
We designed a communication tool to coordinate the care of new patients as a checklist of topics for patient education.

RESOURCES FOR PATIENT EDUCATION
We made available a website which included resources oriented towards patients and resources geared towards clinicians providing patient education.

LESSONS LEARNED

Focus on Patient Transitions as part of patient and family centered care. Care transitions are a window of opportunity for patients and staff to work collaboratively and enhance patients overall sense of well-being.

Engage all stakeholders to understand the key dependencies and demonstrate how the work is linked to the overall goal of the program.

Use empathy, physical presence, and relational approach when engaging with staff and stakeholders. Trust is a key in fostering a safe and supportive work environment.

Ensure appropriate resourcing to ensure patients receive the care they need. Work closely with leadership to brainstorm and implement strategies to recruit and maintain appropriate nursing resources.

THE PILOT AT A GLANCE

47 patients participated in the TCP Pilot program

40% of TCP patients transferred to an independent modality

30% of TCP patients were paired with a TCP nurse in their dialysis runs

9 Dialysis nurses trained

15 TCP patients participated in the program evaluation component to provide feedback on the TCP

10 Peer Support connections facilitated

What we heard in interviews...

"There is so much going on at the beginning... You are kinda just observing... I have found that people are willing to give me a little course of what is involved... When you are in the thick of it when everything is going on, it makes it useful to know just what this is doing, and how it does it, and why it does it... And when you have questions and you remember them.... I think they did a good job, they tried to have a core group of nurses so you were just adjusting... They tried to have consistency of nurses for the first little while. It was helpful to have the same faces. I know what I want to know." —Family member of a TCP patient

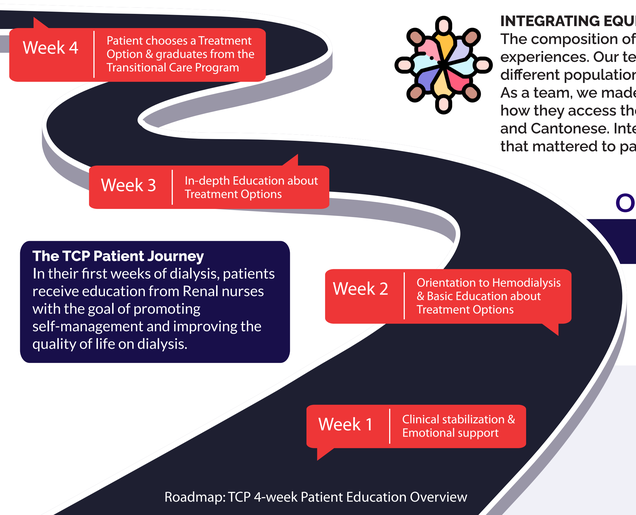
"Although it was just a short conversation [with the Peer Mentor], he did give me some encouragement and also reflected a real experience about him... It seems he is the right person to talk about [dialysis]... And then in a way gave me some hope too... Is [was] a very positive experience." —TCP patient

"It is not healing... [Dialysis is] just a treatment.... but as I say knowledge-wise... I know more about the disease... I can be helping out myself [...] to improve my problem... The knowledge is very important." —TCP patient

"You can tell that the patients are very receptive and very grateful actually... They do need special attention especially in the first few days of their treatment." —TCP nurse

"I think that it helps in the sense that it helps form a connection with the patients that you do work with because then they know someone, a nurse, better. So that they feel like when they are here, they meet a nurse and they are just more familiar with that nurse... And then they also have more information about the process." —TCP nurse

"The strengths are just that nurses that we have doing the [TCP] are highly experienced nurses and have done dialysis for a long time or are one of the leaders on our on our floor. And so are very familiar with our processes, and how a person's dialysis journey will progress. So that, in itself, has been a real bonus in making sure that the patients get the full benefit of the knowledge that they possess. It's just, you know, it definitely has promoted a lot of freedom 'cuz at the same time, when they're out there, I listen to them. And in a short timespan, they're talking as if they are seasoned dialysis patients, what would be considered a seasoned dialysis patient. They've become very much aware of the going ons of the actual aspect of dialysis, minus low nuances of the TV working or not working and stuff like that. But the actual process of dialysis, what's needed. I can see them understanding and fully participating in the care that's provided for them, and what they need to do in order to be a full participant within the program." —Clinical Nurse Leader



Roadmap: TCP 4-week Patient Education Overview

INTEGRATING EQUITY, DIVERSITY & INCLUSION

The composition of our research team includes members from diverse backgrounds which enhances our understanding of the complexities and nuances of patient experiences. Our team diversity allows us to approach data collection, analysis, and interpretation with a sensitivity to the unique challenges and barriers faced by different populations in the hemodialysis unit.
As a team, we made the joint decision to collect demographic information from the participants, including ethnic background, employment status, their support system, how they access their appointments to meaningfully situate study findings. For our mixed-methods evaluation, we collected data in English, Hindi, Punjabi, Mandarin, and Cantonese. Interested family members also participated in the interview component to lend their perspectives, allowing us to further explore intersecting factors that mattered to patients and families. Data analysis was a collaborative effort, also involving patient partners.

OUR APPROACH TO INTEGRATED KNOWLEDGE TRANSLATION

ENGAGE

PREPARING FOR KNOWLEDGE TRANSLATION
We identified that the need to bridge the gap in patient care could be addressed with the Transitional Care approach.
We recruited patient partners and key stakeholders to join our Core Team.
Through collaboration with members of interdisciplinary renal team, patient partners, and department leaders, we developed and submitted a grant proposal.

DESIGN

STAKEHOLDER ENGAGEMENT
We engaged stakeholders (patient partners, nurses and members of the renal interdisciplinary care team, leadership) and learned about current-state workflows as well as existing resources for new patients transitioning to hemodialysis.

VALIDATE

GATHERING FEEDBACK ON INITIAL DESIGN
We validated the TCP in collaboration with our stakeholders. We met regularly with our core group of stakeholders which includes the Vascular Access nurse, Dietitian, Patient Navigator, and Kidney Care nurse to solidify the 5 key components of the program. We sought feedback from our stakeholders and made changes to the TCP design.

IMPLEMENT & EVALUATE

IMPLEMENTATION
Trained nurses and implemented the 6-month Pilot.

EVALUATION
We conducted focus groups and interviews with TCP patients, TCP-trained nurses, and Clinical Nurse Leaders.

SUSTAIN

ADAPTATION & HANDOVER
We integrated feedback from key stakeholders and research participants to hand-over the program to the unit for long-term sustainability.

ACKNOWLEDGMENTS
Special thanks to the SPH Renal Leadership Team, our patient partners Ken Hume, Laura Bennett and Malcolm Wong, as well as members of the interdisciplinary Renal Team— Betty Sung, Shadi Balanji and Anna Lyn Delfino for their support and guidance. Thank you to Professor Rick Sawatzky and Liz Dogherty (mentors) for their advice and encouragement. Thank you to Analita, Adrian, Brittaney, CJ, Dennis, Jhoanna, Paulina, Renee and Su Han for your commitment to supporting new dialysis patients and in helping this program materialize.
This work is supported by the SPH Renal Program, PHC Practice-based Research Challenge 2018 and the Knowledge Translation Challenge 2021.

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Unique Abstract ID: SPOR001