**The Role of Nurse Navigator (NN) and Peritoneal Dialysis (PD) Access Coordinator In Transitioning Patients To Home Dialysis**

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**PURPOSE**

To discuss the impact of having a new role of the NN and determine the effectiveness of having one dedicated nurse to provide modality education and Renal Failure Therapy (RFT) to patients in different areas of Nephrology (i.e. Renal Care Clinic patients, Nephrology in-patient, Urgent care and in the community home dialysis patients).

**BACKGROUND**

St. Michael’s is a large teaching hospital offering a nephrology program that encompasses hemodialysis, home dialysis (hemo and peritoneal), in-centre, self care, and Renal Care Centre (RCC). The program also focuses on vascular access and renal transplant.

Home program offers the patient the options of hemodialysis or peritoneal dialysis. We have had a growing number of patients choosing home dialysis over the past two years however due to the patients not staying in the program the growth within the program is not seen.

**INITIATIVE**

In its endeavor to increase the number of patients choosing home dialysis, St. Michael’s created and developed a Nurse Navigator (NN) and Peritoneal Dialysis (PD) Access Coordinator. This role includes:

- Provide standardized home dialysis modality education for patients so they have access to the same evidenced based information with the goal of making an informed modality decision.
- Review, identify and advocate patients eligible/excluded for referral home dialysis candidates throughout the hospital.
- Create a standardized referral so that all eligible home dialysis patients are assessed by the Nurse Navigator with a plan of care identified for designated patients.
- Create and manage the Nurse Navigator database to identify trends and gaps related to home dialysis continuum of care.
- Present and analyse key findings as a result of the implementation of the Nurse Navigator role.
- Management of PD access for both Radiology and Surgery (booking, triaging, location of use etc).
- Ongoing dialogue with all stakeholders to identify key issues & trends related to the home dialysis continuum of care.
- Bring awareness of the NN role to the Diabetes Comprehensive Care Program.
- Overcoming biases from the team e.g. Physician, Registered Nurse, Health Disciplines.
- Development of the role of PD Access Coordinator within the nephrology program.
- Collaborate with home dialysis to overcome the barriers to growing home e.g. Strategies for retaining patients within the program.
- Standardizing education and training approaches for independent dialysis in line with evidence based information.
- Bring awareness of the NN role to the Diabetes Comprehensive Care Program.
- Efﬁcient and effective management of the PD catheter insertion process.

**OBJECTIVES**

- Emphasize promotion of home dialysis
- Enhance the knowledge level surrounding independent dialysis within the nephrology program
- Standardizing education and training approaches for independent dialysis in line with best practices
- Standardizing tools and resources for home dialysis promotion in line with evidence based information
- Identifying and addressing barriers to home dialysis patient care
- Providing education for all patients receiving education by NN
- Providing education for all patients receiving education by PD Access Coordinator.
- Provide education on PD catheter insertion
- Develop and manage PD catheter insertion process
- Create and manage the Nurse Navigator database to identify trends and gaps related to home dialysis continuum of care
- Present and analyse key findings as a result of the implementation of the Nurse Navigator role
- Management of PD access for both Radiology and Surgery (booking, triaging, location of use etc)
- Ongoing dialogue with all stakeholders to identify key issues & trends related to the home dialysis continuum of care
- Bring awareness of the NN role to the Diabetes Comprehensive Care Program
- Overcoming biases from the team e.g. Physician, Registered Nurse, Health Disciplines
- Development of the role of PD Access Coordinator within the nephrology program

**ROLE OF NURSE NAVIGATOR/PD ACCESS NURSE COORDINATOR**

Another problem noted is that of the growing issue of suboptimal dialysis starts. Approximately 40-60% of incident patients start dialysis in an unplanned or undecided way. Many of these patients have the potential to do their own therapy in the home environment thus not getting that opportunity.

**FINDINGS**

**BASELINE**

Pre Nurse Navigator and PD Access Coordinator:

- Patients would not only be referred to physician to home dialysis
- Multiple nurses providing education
- Modality education provided patients did not have a standardized approach e.g. information varied depending on who provided it
- Lack of a streamline process to provide follow-up and education support
- Previously no designated PD Access coordinator, the role function was added to the Nephrology program
- Creation of a formalized pathway for referring patients for PD catheter insertion
- PD catheter insertions insured by interventional radiologist

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**NEXT STEPS**

- Develop a tracking tool to monitor patients who have received education and have made a choice for RFT
- Collaborate with home dialysis to overcome the barriers to growing home e.g. Strategies for retaining patients within the program
- Provide group education sessions for patients (page 3/5)