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URGENT-START PERITONEAL DIALYSIS AND PATIENT ENGAGEMENT: A CHANCE FOR A NEW BEGINNING OF A SMOOTH TRANSITION OF PERITONEAL DIALYSIS FROM HOSPITAL TO OUTPATIENT CENTRE

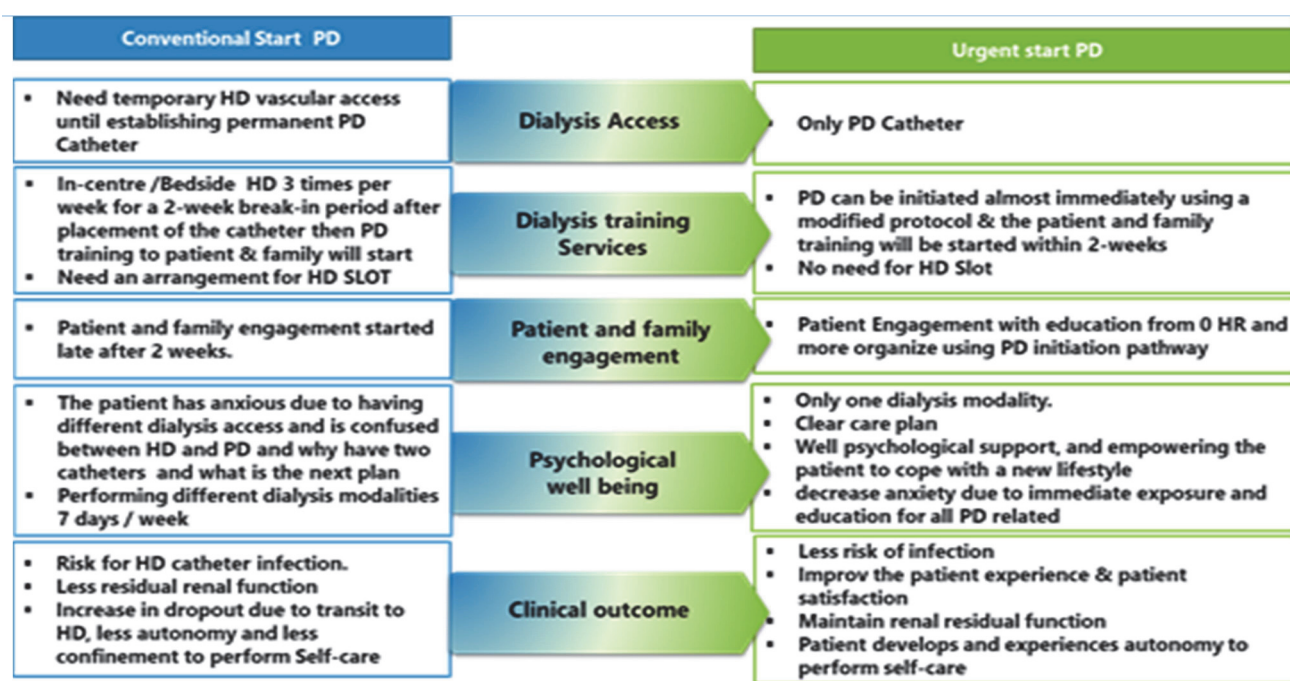
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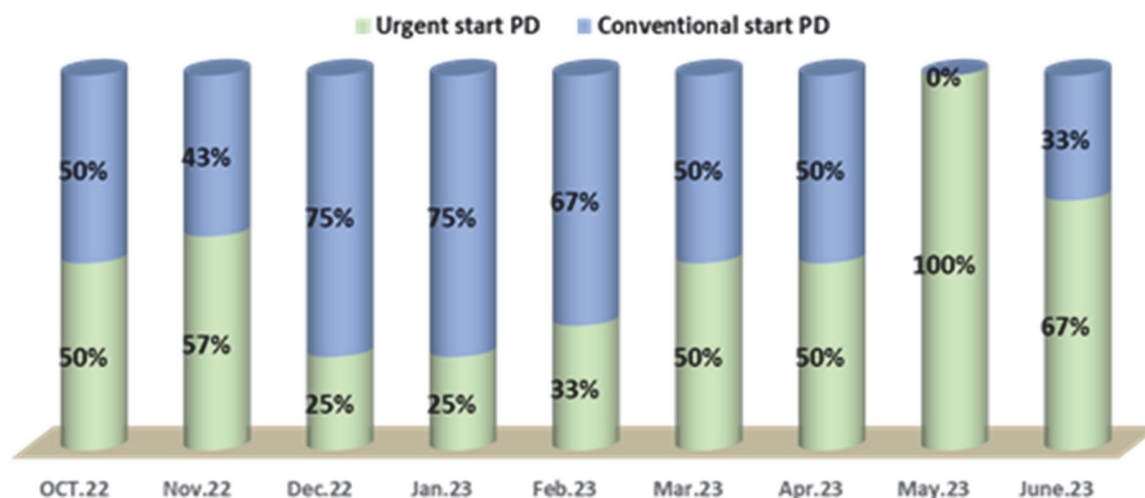
Background Drop-out from the Peritoneal dialysis (PD) Program impacts the service utilisation¹, with 35–50% of patients who initially started temporary hemodialysis (HD) through Permcath till the maturation of the Peritoneal dialysis catheter changing their mind and requesting permanent hemodialysis

and peritoneal dialysis catheter removal before starting Peritoneal Dialysis training, we started an urgent-start peritoneal dialysis (USPD) program by keeping chronic kidney disease patients eligible to start PD through one peritoneal catheter without Permcath insertion and start PD 48 hours post-peritoneal catheter insertion.² The program's safety and efficacy were assessed through monitoring mechanical complications to reach our aims of reducing infection risk, establishing permanent PD access, and reducing hospitalization, increased PD utilisation and patient satisfaction.

Methods A multidisciplinary team triaged emergency and urgent need for PD, developed a clinical pathway for USPD, educate staff, referral to vascular surgeons for PD catheter insertion, then start PD 48 hours from insertion of PD catheter (figure 1). Sixteen patients were enrolled from October 2022 to June 2023, started on this new PD model.



Abstract 61 Figure 1 Comparison between urgent-start peritoneal dialysis and conventional-start peritoneal dialysis



Abstract 61 Figure 2 Percentage of urgent start peritoneal dialysis and conventional start peritoneal dialysis

Results After implementation of the new pathway, the percentage of USPD increased from 50% to 67% by June 2023 without any technical complications and switching to haemodialysis decreased from 35% to 8% by June 2023 (figure 2). All patients completed training without complications, and no longer required readmission for PD catheter removal if they changed their mind or Permcath removal.

Conclusion The transition to USPD was effective in reducing peritoneal dialysis drop-out, cost, and hospitalisation days, with improvements in patient experience.

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Ethical Approval/IRB Statement The project was approved as Quality Improvement by the Dialysis Services Director.

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IMPLEMENTATION OF NEW DISCHARGE PROCESS TO PROMOTE SAFE TRANSITION OF CARE HAMAD GENERAL HOSPITAL

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Background Discharging patients from hospital is a critical point of transition of care. Medication errors affect approximately 50% of adult patients discharged, with nearly 20% experiencing adverse drug events post-discharge.¹ Therefore,

good discharge medication reconciliation is crucial for safe discharge, reducing hospital readmission, and improving patient outcomes.^{2–3} At Hamad General Hospital (HGH), the discharge pharmacy faces challenges in dispensing medications to complex patients with multiple comorbidities and polypharmacy. Additionally, most discharge prescriptions are written by junior residents thus proper review by clinical pharmacists (CPs) is essential to ensure appropriateness. However, incidents of dispensing medications without CP review have been reported, leading to rework loops, delays in the discharge process, and increased workload for the healthcare team. We aimed to create a lean discharge process and avoid rework loops by standardized process and contribution of clinical pharmacists in refilling at least 20% of discharge orders by November 2022.

Methods A clinical pharmacy-led quality improvement project was undertaken in collaboration with HGH's discharge pharmacy and nursing leadership. The process involved multiple Plan-Do-Study-Act (PDSA) cycles (figure 1), including identifying causes of medication errors, developing a new discharge process, training CPs to refill orders, and implementing the new process. Additionally, efforts were made to ensure adherence to the new process.

Results By February 2023, Clinical pharmacists covering medical units were trained and actively involved in the new discharge process. They consistently contributed to verifying discharge orders, with a median of 22% which exceeded our target (figure 2).

Conclusion The implementation of the new discharge process has standardized practices, improved communication among the multidisciplinary team, and ensured clinical pharmacist review of discharge orders. By redistributing the pharmacy workload and involving CPs in verifying discharge orders, rework loops were minimized, leading to enhanced patient safety and more efficient discharge procedures.

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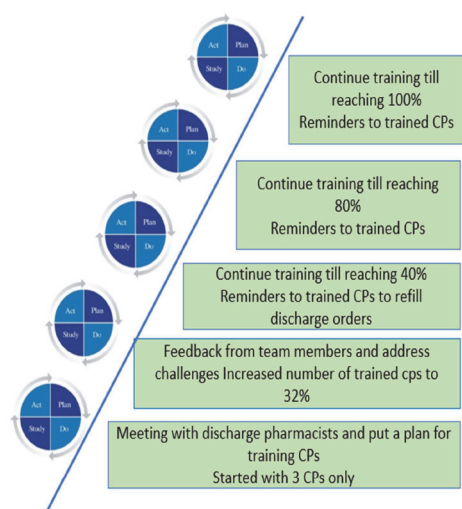


Figure 1a PDSA ramp1: Training of Clinical pharmacist

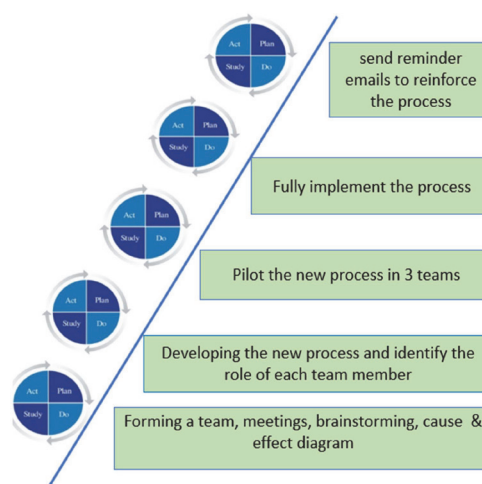


Figure 1b: PDSA Ramp2: Development of a new process

Abstract 62 Figure 1 Plan-do-study-act (PDSA) cycles implemented to improve the medication review process of patients being discharged from Hamad general hospital, Doha, Qatar