Home Visits – More than just a cup of tea

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Introduction:

The perceived benefits of a robust home visit program are: reduce PD related infections, improved PD therapy longevity, reduced PD related admissions and increased patient satisfaction. The international society of Peritoneal Dialysis (ISPD), state that home visits should be part of any PD service. Currently there are no clear recommendations around visit frequency and types of assessment.

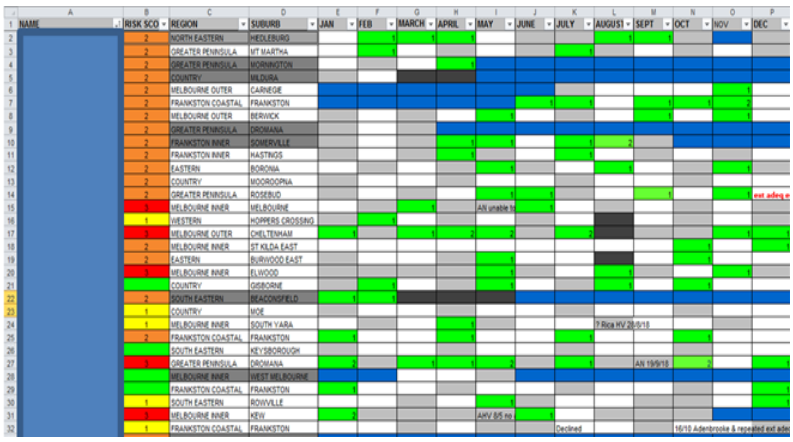
Method:

In 2013, the PD team at Alfred Health developed a home visit risk assessment tool to aid in prioritising patients and guide the frequency of visits i.e. low, moderate and high risk.

Risk Level	Home Visit Frequency
Low (0)	> 3 monthly
Moderate (1)	2 – 3 monthly
High (2)	1 – 2 monthly
Very High (3)	Fortnightly – 1 monthly

RISK FACTORS

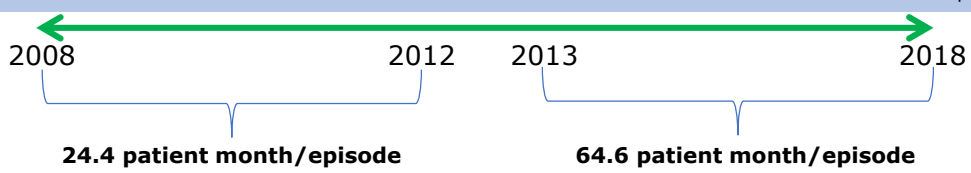
Age > 65 years
Hospital admission ≤ last month
Peritonitis/ESI ≤ last month
Concerns re compliance
Socially isolated/house bound
Difficulties with fluid management



Since the assessment tool was implemented positive outcomes observed – improved peritonitis rates comparing two era's, with **median time of therapy 686 days** (censored for transplant).

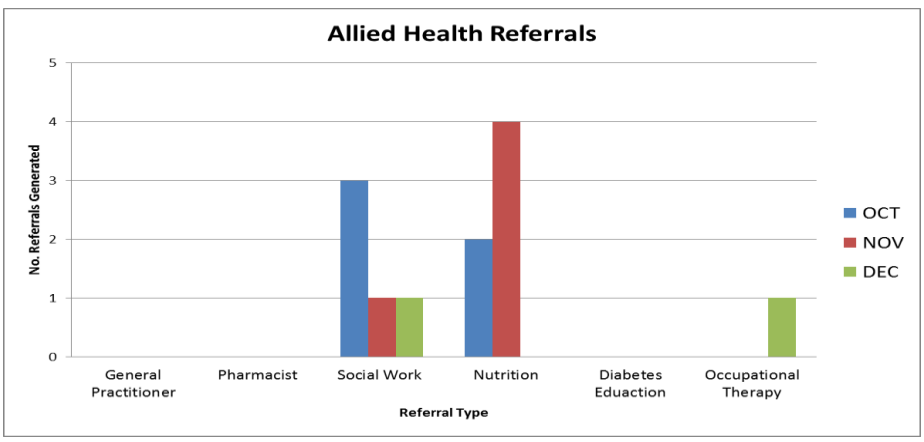
Mean monthly peritonitis rate per era

Pre Home visit tool (2008-2012) Vs. Post (2013-2018) *Observed retrospective analysis



24.4 patient month/episode **64.6 patient month/episode**

In conjunction with this risk assessment tool a 'home visit assessment form' was created to help guide and document the assessment. The outcomes from this form were audited prompting a **revised** 'home visit assessment form'. The audit demonstrated gaps in the referrals generated from home visits from an allied health / GP referral perspective. This prompted a change in the domains the new 'revised' assessment form will focus on.
(Figure 1, shows the audit results. Figure 2, shows the domains / assessment areas of both the original and revised assessment forms).



(Figure 1)

Original Domains	Revised Domains
Home visit goals – adequacy, re-training, line-change	Clinical assessment – vitals, fluid status, general health, exit site. (GP / Diabetes Ed / Other specialist referrals)
Exit site assessment	Dialysis – stock, storage, environment
Fluid assessment	Knowledge and skill – troubleshooting, protocols i.e. contamination
PD Set up technique	Medications – compare to records, education (pharmacy referral & GP)
Other PD techniques – dressings, troubleshooting Stock manage, environment	Family & Community – social screening (social work referral)

(Figure 2)

Conclusion

The next phase is to audit the revised '**home visit assessment form**' and compare the results with the original audit. The audit will ensure ongoing improvements in patient specific outcomes and increase PD patient support.