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CKJ Review

CKJ REVIEW

A learning process to deliver virtual staff training involving patients in shared haemodialysis care

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ABSTRACT

Shared haemodialysis (HD) care (SHC) is a person-centred approach delivering a flexible choice of options for centre-based HD patients to become more involved in their treatment. To support this, a 4-day course was developed to provide healthcare professionals with the confidence and skills to engage, involve, support and train patients in their care and has been accessed by >700 UK staff over 9 years. The disruption caused by the coronavirus disease 2019 pandemic in 2020 prompted a revision of what was deliverable within the restrictions. In response to this, we designed, developed and tested a virtual training program that was shorter and more accessible while remaining effective in meeting its core objectives. This provides a greater geographical reach and enables a collaborative team approach with patients and staff learning from and with each other, thus supporting a partnership approach advocated in shared decision making. In this review we explore the learning that informed the virtual training program 2022 and provide qualitative evaluation to demonstrate evidence of understanding, behavioural change and organisational benefit. Using a validated evaluation, we present key themes that support the initiation, development and sustainability of SHC in the form of a roadmap to guide strategic planning.

LAY SUMMARY

Shared haemodialysis care (SHC) is a method of working with patients that involves and supports them to manage aspects of their own dialysis treatment so that they remain more in control of their own healthcare. This review describes the development of a virtual educational course that involves healthcare staff and patients learning how to work together and support decision making to implement SHC using tried and tested methods and utilising the expertise and experience of each other for improvement. It reflects on and incorporates learning from previous SHC training programs, presents evaluation examples from patients and healthcare staff who have participated in the training and draws on educational theories to summarise the key components that impact on success.

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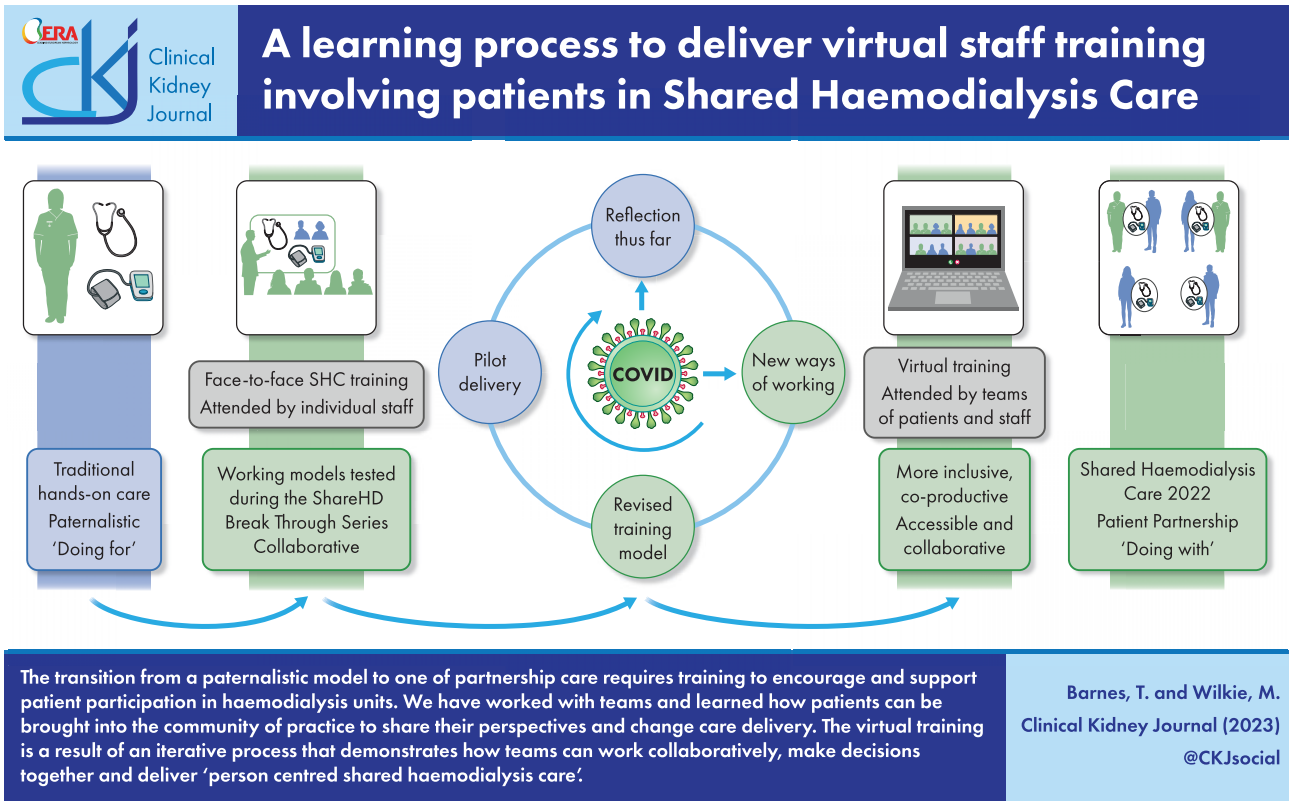
GRAPHICAL ABSTRACT



Keywords: co-production, haemodialysis nurse training, peer training, shared haemodialysis care, virtual training

INTRODUCTION

Shared haemodialysis (HD) care (SHC) describes how people attending in-centre HD can have the opportunity, choice and support to learn about and participate in tasks relating to their own treatment (Fig. 1) [1]. The tasks, traditionally carried out by healthcare professionals, range from simple observations such as blood pressure or weight measurement, to more complex procedures such as machine preparation or vascular access care. In doing so, SHC provides opportunities for patients to take a greater role in their own care and potentially increase activation [2]. For some it can mean progression towards dialysing independently, either in-centre or at home [3]. Transitioning from a traditional role of providing hands-on care to one that supports aspects of self-care requires reimagining how staff work with in-centre HD patients. The model of SHC provides a flexible choice between patient activation and supportive care. In order to culture an environment that offers an individualised response with support for self-management, training is focused on a person-centred approach [4]. A 4-day face-to-face nurse training course to address this learning was developed and tested by a team from Yorkshire and the Humber in 2010 as part of a Health Foundation–funded 'Closing the Gap' improvement initiative to change relationships between healthcare staff and patients.

When the coronavirus disease 2019 (COVID-19) pandemic started in early 2020, the enforced restrictions tightly controlled clinical environments and reduced human interaction, which risked reversing the progress made to involve patients in their care. In the face of this challenge, it was a priority to maintain an ongoing national dialogue and provide methods of supporting active patient engagement. Given that the established training could no longer be delivered face to face, there was a requirement to take stock of the progress of SHC nationally in the UK, redesign the established course and take advantage of the benefits of an online platform. A key gain that came from this transition was increased participation from patient attendees who were able to contribute to the training of staff. This article describes an iterative journey of learning as a collaborative to develop models of practice that deliver impactful messages through a peer-driven accessible training program and network.

Recognising the SHC training gap

Traditionally, HD nurses have been trained to provide the technical expertise to efficiently manage a service that delivers treatment to scheduled shifts of patients. From the patient perspective however, staff working at pace may appear frantic in their mission to complete tasks. This environment encourages patients to take the path of least resistance rather than opt to participate in their care if it is going to delay their own treatment and put pressure on staff productivity. Achievement is measured by the efficiency of completing dialysis by both staff and patients and optimised by staff having uninterrupted control. Under these circumstances, patients are less likely to make decisions to contribute to their own care, not because they are unable, but because they do not have the opportunity or confidence to do so [5, 6].

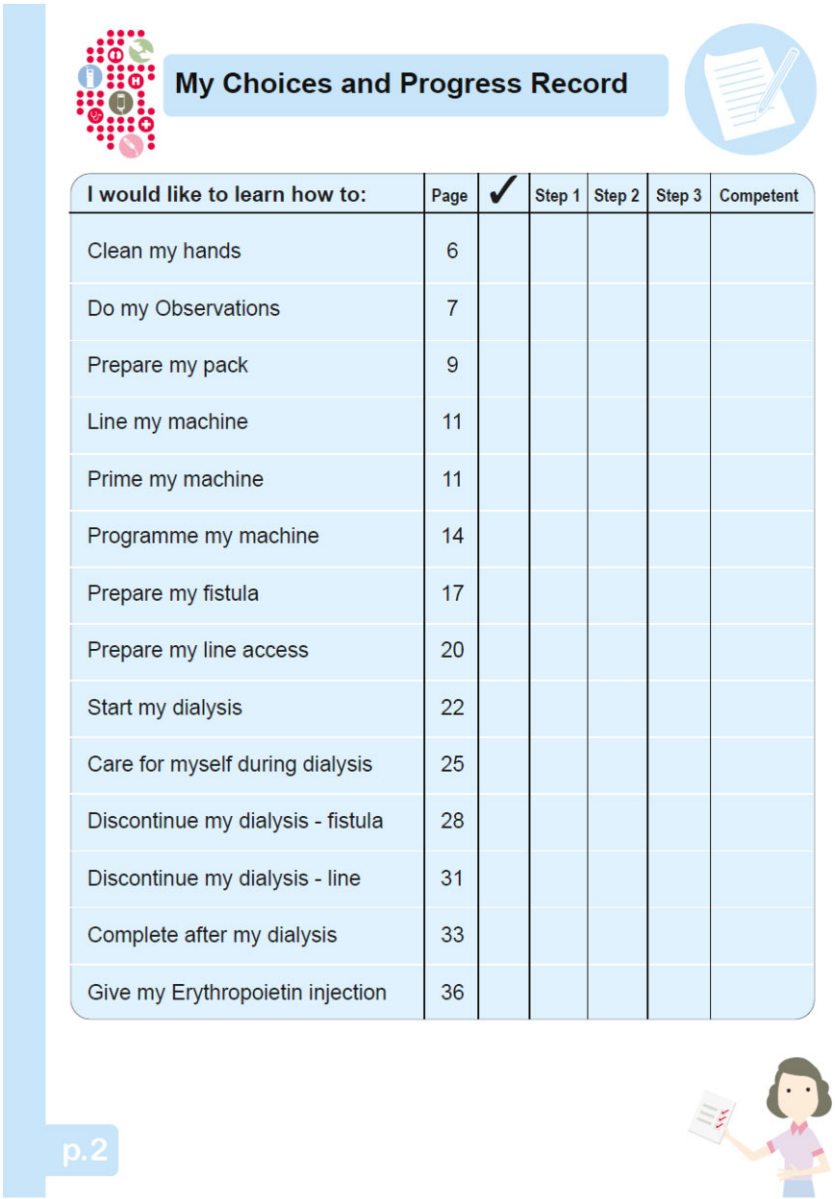


Figure 1: HD treatment tasks that patients can choose and be supported to achieve. Taken from the SHC patient competency record handbook [10].

In contrast, nurses focussing on home HD training work in an environment that is set up for teaching self-care [7]. This offers more time for learning and, in contrast, efficiency is measured by the adequacy of the training and the shift towards the patient being in control. To bridge the gap and train in-centre staff to establish an inclusive learning environment that accommodates varying levels of intermediary independence requires a mindset change where the locus of control shifts back and forth between nurse and patient in a partnership approach. A central part of SHC training is how to provide the mechanisms by which permission and opportunity is provided for patients to make choices about how active they wish to be in their own care and build an environment that facilitates a greater degree of self-efficacy through enhanced partnerships. By promoting choice for patients to participate voluntarily, they are supported to gradually gain confidence to undertake aspects of their own care and contribute to the efficiency of their own dialysis process.

During the pandemic we conducted a survey of UK dialysis units' ability to continue SHC. Despite the restrictions, a number of teams were maintaining a commitment to continue to support the independence of patients who were already undertaking their own tasks. An advantage for those patients was that they required fewer close contact interactions with nursing staff and retained a sense of control over their care. We explored the elements they had in place to establish the common factors that contributed to demonstrating greater resilience (Table 1).

Sources of learning to inform the virtual design

Our experience spans three consecutive models of training that have informed our understanding of the key components needed to provide a succinct format that is effective to instigate and improve SHC programs (Table 2). These models were the 4-day face to face course, a series of nursing manager overview

Table 1: Key components recognized in successful and resilient programs of SHC

Senior buy in and support
Integrating and utilising empowered patients to influence peers
Training staff for SHC and establishing communication methods to promote teamwork
Adopting a flexible attitude to work around barriers such as COVID-19 and short staffing
Engaging with medical staff to support the messages and promotion of SHC
Integrating SHC within the infrastructure, i.e. audit meetings and reports
Dedicated staff champions to keep it on the agenda
Dedicated training areas to initiate a formal approach

workshops and a multisite scaling up SHAREHD breakthrough series collaborative (BSC) [3].

The 4-day face-to-face SHC course

The 4-day SHC course, which is accredited by the Royal College of Nursing and supported by Kidney Care UK and industry partners, has delivered training to >700 dialysis nurses across the UK over 9 years. Training was collaboratively designed and delivered by members of a project team with expertise in facilitating education and behavioural change. It is an iterative design, learning from a wide range of HD facilities. Patterns of cultural components demonstrating effective patient participation and sustained change emerged from our observations. A significant change agent was senior nurse buy-in, with insights into the benefits of SHC for patients and staff. This was demonstrated by their support for the team commitment required to prioritise patient-centred care. A second key component was staff selection for training. It was important that individuals were nominated based on their skills in influencing and leadership, regardless of their seniority. This resulted in a non-hierarchical course training environment that created an inclusive program benefiting from a diverse range of perspectives. This particular component was important for increasing the learning opportunities of the groups as well as for the development and recognition of contributions from more junior staff.

Manager overview workshops

The delivery of a series of nurse manager face-to-face workshops enabled the leadership component to be tested through an accessible scaled-down version of the course that provided an overview of SHC. These workshops equipped leaders with the information, confidence and motivation to initiate SHC at their own centres and to support staff attending the 4-day course. The single-day workshops demonstrated that motivated senior leaders could have a significant impact in their units by utilising their management expertise to quickly grasp the essentials and understand how to effect change.

A quality improvement breakthrough series collaborative

This experience involved designing, delivering and evaluating learning events as part of a multisite breakthrough series collaborative (BSC) of 12 dialysis centres from 2016 to 2018 [3]. We developed insights into the effectiveness of an approach of working with multiple committed teams in which patients were a

Table 2: SHC course content and approach

Time	Content	Approach method for learning
Pre-course	Exercise – learning styles	Self-directed to gain new perspectives
	Exercise – team placement on SHC roadmap	Localised team analysis
	Questionnaire – individual understanding and views	Individual perspective and awareness
Day 1	Group exercise – motivation for choice	Individual perspective and awareness
	Roadmap placing and initial plans	Group share and reflection
	Presentation – what is shared care?	Information and new perspective on approach to care
	Patient voices throughout – attendees, videos and stories	New perspectives and empathy through enlightenment
	Bespoke individual team exercises	Group share and reflection with peers
	Presentation on SHC delivery models	Information for knowledge gain and to inform own team plans
	Guest speaker's own story	Peer impact – realistic challenges and successes
	Reflecting on a patient story	Group share of individual learning and potential action
	Planning for change	Team reflection for turning learning into own action
Homework	Motivational interviewing technique and health literacy	Information and new perspectives on approach to care
	Choice of reading	Self-directed to broaden perspective
	Prepare short PowerPoint analysing impact of own plan	Expectation of action to reinforce learning
Day 2	Homework review of reading	Group share of individual learning and potential action
	Open questions exercise	Group share and reflection of learning
	Team plans presentations	Self and peer reinforcement and critique
	Presentation on measuring improvement	Information for knowledge gain
	Reflection on presentation	Turning learning into individualised team action
	Presentation on patients as partners co-production	Information for knowledge gain and to provoke thought
	Evaluation and sharing of next steps in team plans	Reinforcement of plans and measures
	Post-evaluation questions for individuals	Analysis of change in thinking and reflection of learning
Post-course	Invite to contact list for future forums for shared care	Continuous learning and maintenance of motivation through peers

Table 3: Examples of patient evaluation (anonymous quotations)

Without a doubt I think I would be able to teach others and talk about things in a different light now that I have the confidence. We have got our ideas over and have interacted with the professionals.
I have been to conferences to listen but never been to anything like this where we get chance to speak properly, and staff listen to you.
I appreciate being heard and knowing my opinion counts. I feel more comfortable with staff who treat me like that. Good to understand the challenges for nurses. Good to see the ideas put into action and seeing things happen.
Initially I thought shared care meant lining the machine, preparing the trolley, taking blood pressure. It appears it covers most aspects of dialysis.
I didn't feel confident to express my views before the workshop. I would score myself 6/10. After the study day I can score 8/10. I would like to encourage other patients.
I felt valued as a person.
You can give your first-hand experience to the staff so that they understand your thoughts and feelings.
I feel a great sense of accomplishment knowing I can make a difference, however small.
I feel the patients and staff can learn a lot from each other.

central part. This emphasised the power of co-production where patients were included as equal partners from the outset [8, 9]. It also demonstrated the impact that teams could be expected to deliver once they had made an initial commitment to participate. The collaborative effort of teams working within the BSC enabled rapid testing of change ideas and resources leading to repeatable measurement standards, accelerating the adoption of SHC.

The value of a forum where groups with a common interest learn together was a dominant theme that emerged from all three sources of learning. This collaborative forum provided an environment where patient and staff peers naturally supported and influenced each other by sharing experiences and advice, leading to realistic expectations and indications of what was deliverable in similar dialysis units, inspiring staff to improve. The lived experience of patients and staff was a powerful means to motivate teams and advance their determination to instigate their own changes. Subsequent achievement was reinforced through sharing improvement journeys. Patients attending as active volunteer participants altered traditional boundaries as they shared not only their stories, but also their opinions in design and training as equal partners (Table 3).

Key resources that support the adoption of SHC at pace have evolved through multiple iterations during this period of experiential learning and include online documents available to support patient and staff information, audit and competency. Together with an SHC roadmap, they provide tools to guide education, governance and direction of travel [10].

Design of the virtual course

The training is now delivered by a senior renal nurse with consistent experience in the three consecutive models of training and is facilitated by key clinical leads from participating dialysis centres.

The objective of the virtual design was to incorporate the key themes that our learning showed had contributed to success while taking advantage of an accessible platform through which we could broaden our reach and access. This included securing committed teams that involved patients and senior leaders as well as dialysis staff to provide strong foundations for initiating or improving SHC programs. Using blended learning, established online resources and a more focussed directional approach, we reduced the duration of the course to make the virtual option an accessible opportunity to continue training despite the pandemic.

Expectations from teams

Teams of up to four members from participating dialysis units are accepted onto each virtual course based on their readiness to commit, with sufficient managerial support to effect change and agreeing to complete the preparatory work and engage fully. They are strongly encouraged to involve patients as team members. Attendance is via Microsoft Teams, since this platform is available to all National Health Service staff and is accessible for patients whether in clinic or from their homes. Cohorts are made up of four teams, thus groups of up to 16, providing a comfortable size for active sharing, maintaining inclusivity and facilitating engagement from all group members. A mix of experiences is aimed for within each cohort to maximise learning by sharing successes and barriers.

Course content

The curriculum consists of a combination of slide presentations, free-form discussions and reflections. Interviews with staff and patients provide lived experiences and exercises for teams to conduct away from the screen, enabling less pressured thinking time during the workshop days. Approximately one-third of workshop time is allocated to discussion to facilitate a broader and deeper understanding and to enable teams to incorporate learning into their own plans. The blended learning includes course homework between sessions and focusses on providing background information to support awareness and understanding of the value of a person-centred approach using resources to aid communication and 'teach-back' techniques (Table 2).

The virtual course provides sufficient information through facilitated discussion and directs teams towards successfully tried and tested methods of SHC delivery options to support all stages of the roadmap [10]. Presentation of concrete information is interspersed with reflective sessions for more abstract and bespoke analysis [11]. It is important that time is specifically allocated to both of these elements to facilitate the transfer of learning into meaningful action [11, 12] (Table 2). This structure

Table 4: Examples of course evaluation using the Kirkpatrick model [14]

Kirk Patrick evaluation scale (levels 1–4)	Evidence measures within the training	Examples of training impact from evaluation
Level 1–reaction (e.g. satisfaction)	Visual engagement throughout the day. An increase in energy levels. Positive comments on evaluation related to motivation and interest	Average energy levels had increased by 2 points on scale of 0–10 at the end of the workshop 'Excellent presentation with strategies to utilise for discussion with patients and staff'.
Level 2–learning (increase in knowledge skills or experience)	Documentation of learning and value for their units in evaluation comments between pre and post	What are the benefits? Pre: thought there would be fewer tasks for staff. Post: realised more job satisfaction and time to spend with patients. 'I have picked up several good ideas from the guest patients and have been inspired listening to how SHC has improved the quality of their dialysis sessions'. 'After using the questionnaire, we discovered that many patients were scared that SHC was about needling. They didn't know they could participate in any task'.
Level 3–behaviour change (utilising learning)	What thinking has changed for staff based on their new understanding? What activities/conversations are new?	Pre: most patients are not aware of what SHC involves. Post: most patients are now fully aware and the number doing more than four tasks has increased. 'The results obtained have prompted me to keep on talking about SHC'. 'Two patients have reduced their blood pressure medication because they understand fluid balance better'.
Level 4–measurable impact at the organisational level	Follow-up measures from baseline pre-assessment to date. What has changed in practice to support sustainability of shared care based on the learning?	'We have Shared Care Champions in each clinic'. 'Shared care has been incorporated into our standard documentation and electronic patient record'. 'Six clinics currently have greater than 10% of patients doing five or more tasks (five of these clinics have participated in the virtual shared care workshops)'.

enables teams to build creatively from a solid knowledge base, individualising their programs and maintaining a sense of ownership and pride in their own initiatives.

This style of collaborative working provides a forum that engages and values all attendees' contributions with comments, advice and support for each other. It aims to replicate what would normally happen informally through casual conversations during the face-to-face course but has been systematically built into the virtual training as a method of learning and reflection. It is inclusive in its interactive nature and enables staff to recognise their successful impacts through recognition from peers. The skill of the trainer is to ensure that key messages are demonstrated and clarified through effective facilitation and contributions from more experienced attendees.

Effective communication skills fundamental to engaging patients are modelled as a theme throughout the course. The practice of SHC provides staff with a tangible method of employing the skills needed to develop meaningful relationships and productive partnerships. Patient attendance and participation in the conversations highlights to staff some of their inherent assumptions. These conversations frequently translate into immediate plans to improve patient care through a more complete understanding and empathy for the real rather than presumed patient experience.

Individual team plans and intended change ideas are shared within the cohort, providing another opportunity to influence and increase the breadth of learning for others. These plans are then tested in the period between the two training days and the results presented and analysed by peers within the cohort, thus providing further reflection on action through a range of expertise and perspectives [13].

Course evaluation

The Kirkpatrick model was used in conjunction with the redesign to provide a method of evaluating course content and examining the impact of training, particularly in relation to mindset and behavioural change (Table 4) [14]. The SHC roadmap provides a means to measure progress both for centre-based evaluation and subjective assessment (Fig. 2) [10].

After the course, staff delegates are invited to join events that continue to provide collaborative discussion around the challenges and successes of SHC. This provides further opportunity for learning, support and motivation for individuals and teams to maintain their programs through a faculty of peers.

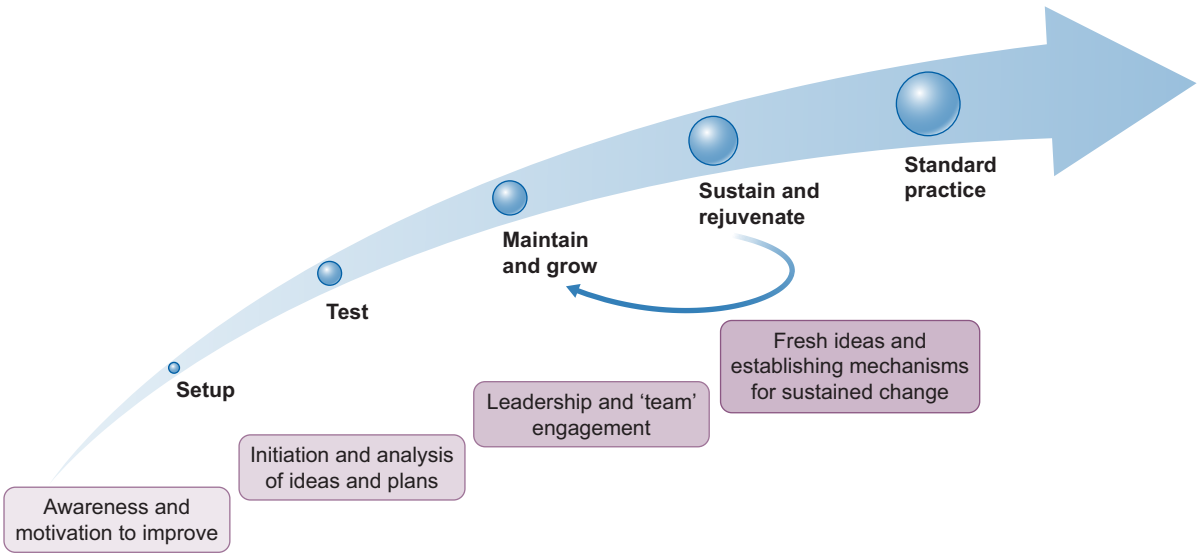


Figure 2: SHC roadmap. Awareness and motivation to improve requires a method of establishing staff and patient willingness, interest and capability (resources on website). Initiation and analysis of ideas and plans requires permission to be experimental, tests to be actioned, data measured and impact analysed. Leadership and team engagement requires mechanisms for utilising data, engaging staff to meet demand and sharing results to demonstrate continuous improvement. Fresh ideas and establishing mechanisms for sustained change is often a developmental stage where a relapse is indicative of a gap in the system that requires attention to move forwards again. Examples of this could include documentation such as job roles including SHC and a commitment to involving patients in all connecting services and departments so that it becomes standard practice. Prochaska *et al.* [16] describe how change typically moves from pre-contemplation through to contemplation, determination, action, relapse and finally to maintenance. Thus progression is not linear. Mixing the experience of teams provides a preview of expected reality, expertise to learn from and reassurance that it is normal.

DISCUSSION

The requirement to embrace a virtual format for the SHC nursing course stimulated a thorough review of its objectives and requirements, the impact of which is reported through the course evaluation (Table 4). It is important to reflect on the strengths and weaknesses of the virtual format and to consider on balance if this is to be retained long term.

Strengths of the virtual format include easier access and enhanced inclusion for patients and staff, providing a more democratic format uninhibited by geography. A distinct challenge is the impact on human interaction due to the lack of opportunity for informal conversation that helps participants to tailor their individual learning through discussion. The lack of non-verbal signals a presenter normally notes during an interactive session, as well as delegate engagement itself, present a potential risk to the social quality impact of the course. This has been mitigated somewhat through the reflective and inclusive format that places value on formally requesting every participant's perspective, enabling all individuals to feel part of the team through active engagement.

Screen fatigue is a commonly experienced problem resulting from the plethora of online meetings that are part of contemporary experience. It is important to build in a range of activities to maintain interest and energy levels to mitigate this. Examples include providing regular breaks during which attendees can access a video or work with their own team away from the pressure of the main meeting screen.

Experience and confidence in using online meetings increased during the pandemic, both domestically and professionally. This has been advantageous and important in terms of the willingness of patients to attend training forums. Confidence with virtual interaction has expanded opportunities for patients to attend from their own homes, an environment where they are comfortable and feel more in control. Alternatively, they attend with their staff team members from the familiar environment of the dialysis clinics. Accessing virtual training offers more flexibility in terms of physical attendance around patients' dialysis treatment and avoids lengthy travel times.

Working with peers across a range of units increases learning opportunities and reinforces what is working well for the more experienced while supporting those with less experience to adopt new ideas and practices in a collaborative community of practice [15]. This has been particularly welcomed as an engaging element within the virtual format and one that is dominant and most beneficial in feedback comments.

Prochaska *et al.* [16] describe how change typically moves from pre-contemplation through to contemplation, determination, action, relapse and finally to maintenance. Therefore, progression is not linear. Mixing the experience of teams provides a preview of expected reality, expertise to learn from and reassurance of what is normal. It is well recognised in change models that there needs to be a strategy for managing the 'relapse' when it occurs. Teams often need support at this stage to examine what they have already achieved and strategies that will enable them to rejuvenate by uncovering gaps that are contributing to their stasis. A critical and fresh look at their programs provides the impetus to move forward again through the improvement cycle and builds on their cultural change. This is reflected in the roadmap's rejuvenation phase (Fig. 2). This is mitigated through access to an SHC forum of peers who have accessed the training previously and can provide stimulus for continuous improvement.

An example of one of the biggest barriers to making and sustaining a change is the inherent perception of the time and effort involved in implementing SHC within a dialysis unit. Changing a mindset and attitude from one where engaging patients is viewed as an additional task to a model of working where it

is incorporated into practice routines that enables self-efficacy is complex and requires several interconnected components. While the first step is understanding the rationale, there are many long-standing practices that can make a simple conceptual change difficult. For instance, smaller, easier but persistent changes in language may begin to erode long-held beliefs, replacing them with fresh thinking without the upheaval of resistance.

The implementation models and change elements suggested for teams to experiment with accommodate for the various stages of unit change and the contribution of a range of change elements. A granular understanding of effective implementation models is essential, highlighted by a recent multicentred study from Canada where complex interventions designed to increase uptake of home dialysis based on existing evidence did not have the desired impact [17]. The complexities the trainees face can feel overwhelming; models and tools that have been used by peers provide a range of options that can be adopted and adapted locally. Understanding how a simple change of language makes a difference to patient engagement can produce a significant impact from a relatively small action. An example of this is using 'involvement' language and including the patient by asking 'What do you think?'. This encourages staff to think of the patient, the machine and the nurse as a team in any interactions or tasks. The balance of control then starts to shift and becomes more comfortably shared by both sides of the partnership through practice and behaviour.

It is important that dialysis units form part of an integrated pathway from pre-dialysis through to home dialysis, embracing patient empowerment as a strategy to encourage self-reliance. If enabling supported self-care is a holistic service goal, building patient confidence to develop self-belief in shared decision making and involvement is key. This then becomes a familiar concept for patients choosing HD as their preferred treatment mode in the knowledge that they can remain active within this area. Patients with chronic kidney disease report life participation as a key priority. SHC enables a greater level of participation in the dialysis unit supporting this goal [18]. If this is to be fully realized, healthcare teams need to collaborate with patient partners to understand effective training approaches for staff, providing the skills needed to embrace working together to support them in aspects of self-care [19]. The virtual course benefits from having an accessible space for collaborative conversation, creating an environment for partnerships with patients and training for staff.

Co-production is central to the implementation of complex interventions such as SHC, where patients are encouraged to take a role in their own care. A cross-sectional survey in Israel found that HD patients have greater interest in participating in dialysis tasks than their nurses perceive [5]. This is consistent with the experience reported by course attendees from multiple dialysis units. The degree to which patients are willing to be more active thus depends on how staff think and behave and requires a change in communication skills from a model of paternalistic instruction to one that encourages self-belief and self-efficacy. A key aspect of training is providing direct context by involving patients at the centre of SHC within their teams where discussions with patients as equal partners shine a light on their perspective. We can only make one-sided assumptions if they are not represented. A curriculum that places the person at the centre of his/her care in this process of co-production leads to an empathetic response that is a strong motivational factor for staff behavioural change [20]. Enabling patients to see themselves as experts not only in their own health and treatment, but with respect to what they have to offer from their perspective as receivers of care is challenging for both patients and staff [21]. Patients tell us they do not feel it is their place to tell healthcare professionals what to do and therefore staff often struggle to persuade them to attend the workshops. Providing a warm and informal environment, where patients recognise that what they have said is valued and acted upon, increases confidence to contribute (Table 3).

CONCLUSION

HD units are staffed by professionals who are ideally placed to expand their care beyond dialysis to influence learning environments that have the potential to enhance quality of life for patients. By increasing self-efficacy, providing choice and options, dialysis centres can be progressive environments for patients to participate and improve their life choices, including greater access to home HD. Initial success in any SHC program needs attention to a consistent approach to acknowledge and work through the relapse stage. Continued support and networking with a faculty of peers facilitates a forum where practice can be challenged and proactively improved beyond the training session. By reviewing the process of learning through a series of training environments and incorporating these changes into the design of a virtual course, active patient involvement has been brought to the centre of our attention so that our mutual goal can be realised in valued partnership discussions, harnessing elements that are consistent with team success.

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AUTHORS' CONTRIBUTIONS

TB conceptualised, drafted and revised the manuscript. MW reviewed and edited the draft, and wrote some of the text. TB has lead on course design, development and delivery.

DATA AVAILABILITY STATEMENT

No new data were generated or analysed in support of this research. Readers requiring more information about the Shared Haemodialysis Care virtual nurse training course or forums are welcome to contact Tania Barnes directly.

CONFLICT OF INTEREST STATEMENT

The results of original work presented in this review have not been previously published in whole or part, except in abstract form. TB receives salary support from Kidney Care UK.

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