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P253 -Challenges accessing rehabilitation leads to increased length of stay for haemodialysis patients

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Our renal unit covers a population of just over 1 million and our trust is a regional major trauma unit. We have approximately 380 Haemodialysis (HD) patients dialysing in our main unit and across our 3 satellite units. The main unit has 20 HD stations and a capacity of up to 300 HD sessions per week. There is a focus on ensuring central HD slots are utilised efficiently, with patients transferred out to satellite units in a timely manner, helping accommodate new patients and acute admissions.

We became aware of an apparent lack of availability of rehabilitation places for HD patients, particularly in those who had suffered trauma requiring surgical intervention. The pathway to rehabilitation seemed blocked or even non-existent when it became evident our patients needed thrice weekly treatment. This led to delayed discharge and a potentially avoidable increase in length of stay (LoS) for HD patients.

In addition to the impact on patients and their outcomes, the limitation on utilising rehabilitation beds affects the renal service in other ways. If patients are hospitalised for a prolonged period this means they 'block' acute HD slots in the main unit, meaning that, at times of surge, we may struggle to dialyse patients in the main unit.

Over 12 months, (1st Aug 2017 to 1st Aug 2018,) we collected data on HD patients who had surgery, required rehabilitation and were declined based on their need of HD. We identified 6 HD patients, 3 of whom were trauma patients. These 6 patients were referred to 6 separate rehab areas. Overall average LoS was 40.2 days (range 21-100 days). On average, LoS was increased by 9.7 bed days (range 5-18 days) due to a lack of rehabilitation space.

Extra bed days were incurred due to increased time in an acute bed receiving therapies, affecting LoS and patient management. Rehabilitation units understandably have concerns with accepting HD patients due to potential reduction in therapy time on dialysis days. Reasons for refusal to admit to rehab included: limitation of therapy due to HD attendance; implication of transport needs; a perception a HD patient had increased clinical needs 'due to their dialysis treatment'.

We discussed the lack of support for HD patients with the lead nurse in each Rehabilitation unit and have developed a pathway for our HD patients. We plan to ensure these patients are prioritised into Tuesday/Thursday/Saturday HD patterns, or evening HD shifts, to ensure they miss as little therapy as possible. We are working with our discharge team who can offer support with transport. We have offered rehabilitation units a direct contact route to the renal team and have asked our dietetic team to offer support and provide nurse education.

Ongoing, we are auditing LoS for HD patients, on or outside the renal ward, to ensure equality of access to rehabilitation.