

Study of limitations for the implementation of an assisted peritoneal dialysis program in Spain

Ana Sánchez Escuredo¹, Sara Nuñez², Ariel Tango², Maria Quero Ramos³, Jose Emilio Sanchez-Alvarez⁴, Miguel Perez Fontan⁵, Manuel Macia⁶ and Maria Fernanda Slon Roblero⁷

¹Hospital Moisès Broggi Sant Joan Despí, Sant Joan Despí, Spain

²Hospital Sant Joan Despí Moisès Broggi, Sant Joan Despi, Spain

³Hospital Universitari Bellvitge, Spain

⁴Hospital Universitario Cabueñes, Spain

⁵Hospital Universitario de A Coruña, Spain

⁶Hospital Universitario de Canarias, Spain

⁷Clínica Universidad de Navarra—Hospital, Spain

Background and Aims: Assisted peritoneal dialysis (APD), whether partial or total, is a home-based technique for patients who have lost their independence due to age or comorbidities, requiring some assistance to manage their treatment. It is also a viable option for patients ineligible for Peritoneal Dialysis (PD) due to social, cognitive, or physical barriers or those approaching the end of life. Moreover, APD has demonstrated lower hospitalization and mortality rates, lower costs, and similar quality of life compared to in center Hemodialysis (HD).

To understand the usual clinical practice in PD and the limitations for the implementation of an APD program in Spain.

Method: Cross-sectional observational study conducted through a survey with closed-ended questions distributed by email to the PD working group of the Spanish Society of Nephrology. Participation was voluntary and anonymous. The survey included four questions about the center's structure, six about usual practices, and six about potential barriers to the implementation of APD.

Results: A total of 74 responses from 59 centers were analyzed. Average PD programs were 40 ± 26 [2-100]. The median number of patients undergoing APD is 5 [3-10] per program. Among the respondents, 73% believe that APD should include support in organizing and preparing materials at home, connecting and disconnecting in APD/CAPD, and documenting the treatment.

Regarding the offering of APD, 48% of respondents answered it should be provided to patients who have initiated PD and need assistance to continue the technique, 47% in cases of family surrender, 39% to all patients wishing to undergo PD despite physical or mental impairment, 38% at any time if the patient requires it, and 22% during information sessions on techniques in CKD clinic.

Regarding who should perform APD, 73% responded with a caregiver, 63% with external nursing/assistant personnel not affiliated with the PD unit, 52% with a family member, and 48% with nursing/assistant personnel from the PD unit itself.

Perceived limitations by the respondents include lack of funding (80%), lack of experience in PD units (15%), lack of motivation in PD units (11%), lack of trained personnel (5%), and none of the above (7%).

Eighty percent of the respondents believe that implementing APD would increase the number of PD patients in their program.

Conclusion: Seventy-three percent considers that APD should include support in material preparation at home, connection-disconnection, and treatment documentation. There is no consensus on who should be offered APD or who should perform the treatment at the patient's home.

The primary perceived limitations are program funding and a lack of training and motivation among the teams.