

THC1

From disconnection to engagement: using trauma-informed pen portraits to support complex patients starting haemodialysis

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THURSDAY - Moderated Poster Session, HALL Q, March 12, 2026, 10:00 - 11:00

Introduction

Patients starting haemodialysis often present with complex psychosocial and behavioural challenges, including non-adherence, aggression and disengagement, which can compromise patient safety, staff wellbeing and continuity of care (Jones et al., 2014). Some disengage from services in the pre-dialysis period and commence dialysis in a health crisis. Others display non-adherent behaviour shortly after starting dialysis. As previous behaviour is often the strongest predictor of future behaviour, these groups are at heightened risk of a difficult transition to haemodialysis and of poor outcomes.

To support these patients, the Renal Psychology team introduced pen portraits to promote smoother transitions into the dialysis unit. A pen portrait is a concise, person-centred summary capturing essential biographical, psychosocial and clinical information (Spencer et al., 2020). Drawing on trauma-informed care principles, pen portraits aim to mitigate triggers, enhance trust and support continuity of care (Sweeney & Taggart, 2018).

Methods

This service development project used the Plan-Do-Study-Act cycle (PDSA) as a framework (Taylor et al., 2014). Patients commencing dialysis as inpatients with a history of non-adherence, mental health difficulties or psychosocial complexity were identified. The Renal Psychology team developed pen portraits in collaboration with the wider multidisciplinary team. Information was gathered from existing clinical systems (NOTIS, EMED, GP mental health records) and from direct conversations with patients.

Each pen portrait summarised background information, identified potential triggers and highlighted strategies that had previously supported engagement. The aim was to equip staff to engage more effectively with individuals whose previous patterns of non-adherence had made care challenging. Previous attendance at healthcare appointments was reviewed, and dialysis attendance during the first three months was monitored. Staff were also asked to provide qualitative feedback on the impact of the pen portraits on their practice.

Results

Between August 2024 and June 2025, five patients with complex needs were provided with pen portraits. Of the five patients, four had disengaged from all healthcare appointments and had started dialysis as inpatients. One had previously started dialysis but stopped attending, later presenting as an emergency admission after moving area.

Three months of data were available for four patients (one patient died after 10 weeks of dialysis treatment, having attended 38 of 40 sessions, 95%). At the three-month audit point, three patients had maintained full attendance (100%), and one had attended 28 of 40 sessions (70%).

Discussion

The introduction of pen portraits appeared to support improved engagement with dialysis, with evidence of fewer missed sessions among patients with complex presentations. Staff described pen portraits as “extremely comprehensive and essential” for enabling patient-focused care, noting that they enhanced understanding of patients’ needs, improved communication and reduced behavioural challenges. They valued the clear structure and practical strategies, highlighting how pen portraits provided reassurance and created safer, more supportive environments for complex patients starting dialysis.

Staff reported that pen portraits appeared to support a more consistent and collaborative team response when working with this patient group. They appear to be a feasible and impactful tool for operationalising trauma-informed, person-centred care in dialysis settings, benefitting both patients and staff.

THC2

Testosterone replacement therapy in chronic kidney disease: investigating safety and impact on cognition in a propensity score-matched cohort study.

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THURSDAY - Moderated Poster Session, HALL Q, March 12, 2026, 10:00 - 11:00

Introduction:

Testosterone deficiency is highly prevalent in men with chronic kidney disease (CKD) and contributes to frailty, fatigue, and cognitive decline. While testosterone replacement therapy (TRT) may alleviate these complications, concerns persist regarding its cardiovascular and oncologic safety in CKD. Evidence specific to this population is lacking.

Methods:

We performed a retrospective, propensity score-matched cohort study using the TriNetX Global Collaborative Network. Male patients aged 18–80 years with CKD stages 3–5 (mean eGFR 47.7+/-15mL/min/1.73 m²) and hypogonadism were included. Patients were stratified by TRT exposure within six months of diagnosis. Exclusions were prior transplantation, eGFR <10 mL/min/1.73 m², dialysis or dementia occurring within one month of CKD. Outcomes over five years included all-cause mortality (primary outcome), vascular dementia, Alzheimer's disease, stroke, myocardial infarction, heart failure, and prostate cancer. Propensity score matching (1:1) balanced demographics, comorbidities, and laboratory measures. Cox proportional hazards models estimated hazard ratios (HRs).

Results:

After matching, 1 545 patients were included in each of the two cohorts (TRT treated or non-treated) with well-balanced characteristics. Median follow-up was 3.7 years. All-cause mortality was lower in the TRT group (HR 0.78, 95% CI 0.63–0.98). No significant differences were observed for cardiovascular outcomes, prostate cancer or dementia.

Discussion:

In men with CKD and hypogonadism, TRT was associated with improved survival and no excess risk of cardiovascular events, prostate malignancy or dementia. These findings suggest TRT is a safe therapeutic option in this high-risk population, warranting further prospective evaluation.

THC3

Enhancing inclusivity, representation, and diversity in renal research: a patient led educational and supportive approach.

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THURSDAY - Moderated Poster Session, HALL Q, March 12, 2026, 10:00 - 11:00

Introduction

People from ethnic minority backgrounds are up to five times more likely to start dialysis than people from White backgrounds. Despite this, their participation in research remains disproportionately low. Recommendations from health inequalities reports from Kidney Research UK highlight the need to enhance the inclusion of under-represented groups. The Salford Kidney Study (SKS) is a large prospective observational study where 97% of participants are White. However, the reality is that 17% of the SKS catchment population are from Bangladeshi, Black, Indian, Pakistani, and other White communities. We aim to address this through a culturally inclusive approach utilising expert by background and experience approach to recruit into this study.

Methods

Our evidence based approach deploys volunteers, with lived experience and passion. These volunteers reflect the target communities, and they educate and empower patients receiving haemodialysis to consider and then participate in research. They are empathetic volunteers who have a shared culture, faith, and language, are trusted and dedicated to address this issue. After completing accredited training, they provide clear, lay language information about the purpose and benefits of research involvement. By sharing their own experience and benefits of research, they help de-bunk myths and allay fears. They distribute a mandatory Patient Information Sheet, and because it is long and detailed, they explain why it is needed in an attempt to support informed consent. They aim to be fully transparent about what a patient's participation in research entails, as well as reaffirm confidentiality while emphasising the collective benefits. The research team subsequently visit patients for their formal consent.

Results

The volunteers received a qualification in recognition of their training and subsequent successful deployment. 5 volunteers attended one dialysis centre, visiting patients, at intervals over 9 months while in the waiting room or on dialysis. Compared to the previous 12 months, these volunteers helped increase the proportion of patients onto the cohort study as follows: 8% more Black patients recruited; 15% more South Asian patients and 1.6% increase in white patients.

The research staff who consented the patients believe that the volunteers' visits to patients is beneficial and helped decision making. The volunteers themselves, feel that a peer to peer approach, enhanced trust and understanding. This was particularly so when the volunteer

“looked like” the patient and/or spoke the same language as they were then well received and the patient, more receptive to what they had to say. In addition, in some cases, there was a familiarity with the volunteers who had dialysed (at the same unit), prior to transplant. Two of the volunteers went on to co-found KPACE (Kidney Patient and Carer’s Experience) which is fostering dialogue, building confidence, and encouraging greater patient and carer engagement with research.

Discussion

This culturally sensitive peer to peer pilot intervention is showing encouraging results in empowering and providing support for under- represented patients to participate in renal research. The team now intend to formally publish the results and apply for further funding to scale up and demonstrate further impact.

THC4

Using behavioural theory to explore barriers and facilitators to physical activity in haemodialysis patients: an updated systematic review of qualitative evidence

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THURSDAY - Moderated Poster Session, HALL Q, March 12, 2026, 10:00 - 11:00

Background: Physical activity (PA) plays an important role in improving health indicators for people receiving haemodialysis, such as cardiovascular measures, physical function, and number of hospitalisations. Despite these benefits and the recommendation of clinical practice guidelines, levels of engagement in PA are low for this population and provision for PA in routine care remains inconsistent. Numerous barriers and facilitators to PA have already been identified by previous research; therefore, this study builds on a previous systematic review by updating, exploring and integrating existing evidence through the lens of behaviour change. Applying behaviour change theory moves interventions beyond feasibility, helping identify components that improve efficacy, support integration into clinical care, and promote sustainable change for patients and staff.

Methods: Five databases (MEDLINE, EMBASE, CINALH, Web of Science and PsycINFO) were systematically searched for new literature up to June 2025. Eligible studies included qualitative data on barriers and/or facilitators to PA (or its delivery) for adults undergoing maintenance haemodialysis, as well as data from dialysis staff facilitating and observing. Barriers and facilitators to patients engaging with PA and staff facilitating PA were extracted from each paper, organised and consolidated into a codebook. These barriers and facilitators were mapped to the domains of the Theoretical Domains Framework (TDF) and linked to associated components of the COM-B model of behaviour change. A frequency analysis identified prominent domains from staff and patient data, and inductive thematic analysis was performed within TDF domains to identify barrier and facilitator themes for the different participant types and refined through team discussions.

Results: Data from 18 eligible papers were included; 10 capturing patient perspectives, 1 focused on staff perspectives, and 7 including a mix of both. Eight studies were intervention-specific, of which 6 focused on intradialytic exercise. The remainder focused on general PA. Prominent domains (Figure 1) were 'Beliefs about Consequences' and 'Environmental Context and Resources' for both staff and patients; patients additionally highlighted 'Social Influences', while staff emphasised 'Knowledge'. Within these domains, themes such as 'Concerns and fears of adverse events' and 'Lack of priority for PA in dialysis setting' were defined as barriers. Themes such as 'PA could improve patient quality of life' and 'Minimising disruption to current dialysis processes' were defined as facilitators.

Conclusion: These findings identify areas of congruence in perceptions of barriers and facilitators across staff and patient groups and the corresponding TDF domains. This

demonstrates shared priorities in the dialysis setting and key areas to consider when developing future interventions and programmes involving PA. Addressing these domains and applying the Behaviour Change Wheel in future intervention development may enhance participation in PA and support sustained behaviour change.

Figure 1. Summary of results including prominent domains for staff and patients, example themes within these domains for barriers and facilitators, and supporting quotes.

THC5

Psychological Characteristics of Patients Who Miss Haemodialysis Sessions: A Single-Centre Retrospective Review

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THURSDAY - Moderated Poster Session, HALL Q, March 12, 2026, 10:00 - 11:00

Background: Nonattendance at scheduled haemodialysis (HD) sessions is a frequent form of treatment nonadherence. This is linked to poor clinical outcomes including higher rates of morbidity and mortality. Psychosocial factors are known contributors, yet the psychological profiles of frequent non-attenders remain underexplored.

Methods: We conducted a retrospective analysis of patients from a single United Kingdom HD centre who missed more than four HD sessions over a two-year period and were referred to renal psychology services. Data were extracted from psychological case notes using a structured pro forma designed by the renal psychology team, and included reason for referral, pre-existing mental health issues and history of adverse childhood experiences (ACEs). Information recorded by the dialysis nurses on the electronic patient record on the day of non-attendance for all patients referred to psychology was retrieved and analysed to identify and categorise recurring themes.

Results: Of 464 patients in the original cohort, 54 met criteria for frequent nonattendance. Twenty-two (40.7%) patients were referred to psychology, of whom 17 engaged with at least one session. Following psychological engagement, attendance improved in 29% of the patients who participated in a session. Analysis of psychological case notes and dialysis nursing records revealed that 88% of these patients had pre-existing mental health conditions, with depression (71%) and anxiety (47%) being the most common. Confirmed or possible ACEs were identified in 88% of assessed patients. Nursing records cited concurrent illness, limited disease understanding, family obligations, and logistical barriers as the most common reasons for missed sessions.

Conclusion: This study highlights the need for implementing an early, integrated psychological assessment within the dialysis care pathway, that includes screening for pre-existing trauma. The observed modest improvement in HD attendance 6 months after psychological intervention underscores the complexities associated with promoting and sustaining adherence and suggests that psychological models of intervention need to be embedded systemically to achieve optimal benefit. A tailored, trauma-informed, multidisciplinary model has the potential to improve access to support and sustain adherence over time and should be prospectively investigated.

THC6

Development of the role of Dialysis Psychological wellbeing practitioner.

Claire Thompson, MS Lucinda Harris

THURSDAY - Moderated Poster Session, HALL Q, March 12, 2026, 10:00 - 11:00

Introduction: Preparing for and starting dialysis is regarded as a significant life changing event for patients. Despite this, mental health support in Renal units remains limited or insufficient. Recognizing this gap, our team sought to explore and address the mental health needs of renal patients throughout their treatment journey.

Methods: We used Quality Service Improvement and Redesign (QSIR) method to identify ways the service could be improved. We identified a specialized training program—the Psychological Wellbeing Practitioner course—that would enable a dialysis practitioner to deliver targeted mental health support. Funding was successfully sourced to support training and implementation.

Result: The Dialysis Psychological Wellbeing Practitioner role was successfully established and embedded within the renal unit. Since taking up the post, the practitioner has begun delivering structured psychological support to patients undergoing dialysis, focusing on issues such as emotional adjustment, anxiety, and low mood.

Preliminary feedback from patients indicates increased emotional resilience and a greater sense of psychological safety during treatment. Staff have reported improved communication and a more cohesive approach to holistic care. The integration of this role has also helped normalize conversations around mental health within the dialysis setting, fostering a more supportive and empathetic environment.

These early outcomes suggest that the role is both viable and impactful, with strong potential for wider adoption across renal services.

Discussion: To the best of our knowledge, this is the first role of its kind within UK renal services. The Dialysis Psychological Wellbeing Practitioner post represents an innovative and evolving approach to integrating mental health support into dialysis care. Early implementation has demonstrated promising results, with positive feedback from both patients and staff, suggesting that the role is meeting a previously unmet need. With further research, evaluation, and strategic implementation, this model has the potential to serve as a blueprint for Renal units nationwide. Embedding psychological support into dialysis services could significantly enhance holistic care, reduce mental health disparities, and improve overall patient outcomes. By addressing emotional wellbeing alongside physical treatment, we move closer to a truly person-centred approach among dialysis patients.

THC7

Attitudes of research engaged workforce and academics towards barriers and enablers of access to kidney research amongst under-represented patient communities

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THURSDAY - Moderated Poster Session, HALL Q, March 12, 2026, 10:00 - 11:00

Introduction

People from minority ethnic backgrounds are up to five times more likely to start dialysis than people from White heritage backgrounds. Recommendations from Kidney Research UK's health inequalities (HI) (2018, 2024) reports highlight the need to enhance inclusion in science so that prevention and care better serves diverse needs. There is a paucity of evidence to drive this effort. In this study, we therefore sought to understand the perspectives of research engaged workforce and academics towards widening access in kidney research.

Methods

This qualitative study involved 1-1 semi structured interviews, lasting an hour. Questions were designed to understand research participation priorities, challenges, and successful strategies to engaging those for whom language and/or culture is a barrier. There were 18 participants, with 50% being Nephrologists and 28%, male. They were approached either because they expressed an interest to be interviewed during an earlier survey or responded to invitations including through kidney organisations' membership e mailing lists. Each interview was digitally recorded, transcribed verbatim and analysis conducted in NVivo using thematic analysis (Braun & Clarke 2006).

Results

Six themes were identified which capture the perceptions of enablers and barriers to inclusive research. The themes were: Inclusion interventions, Need for trust, Lack of support and funding for inclusive research, Lack of HI understanding among professionals & lack of addressing HI at service level, Community enabled engagement, Understanding & meeting patients' needs.

Inclusion interventions included enablers such as language adaptation, (written and video) and Bilingual researchers as well as recruitment via familiar faces, such as known medical and nursing staff. Involving patients throughout the research process was recommended as important to ensure inclusive research. Interviewees also discussed the need to mandate and make funding adjustments to realistically enable inclusive research.

Need for trust as a theme resonated throughout. This included trust with clinical staff and researchers. Trust with someone from their community was particularly highlighted, such as Peer Educators. Allied to this, was the problem of not closing the feedback loop. It was felt that repeated failure to do this made participants less likely to trust.

Lack of support and funding for inclusive research: a clear consensus was around prioritisation of funding for HI research and transparency in funding decisions from Funders and the NHS.

Lack of understanding among professionals and addressing HI at service level – this was deemed to be the case in clinical practice/NHS with a follow on impact on research.

The theme Community enabled engagement featured around embedding research into communities and using trusted and respected people such as religious leaders and Peer Educators.

In Understanding and meeting patients' needs, interviewees recommended personalised/targeted information and the need to address any concerns to facilitate research participation. Time and patience to respect and meet patients' needs was often stated.

Discussion

Collectively, the themes empathise how directives from funders can drive inclusive research. Overwhelmingly, participants advocated for the effective role of trusted community champions in improving participation, with clear implications therefore for future models of research design.

THC8

A feasibility study of a behavioural intervention for weight management in adults with non-dialysis chronic kidney disease (CKD)

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THURSDAY - Moderated Poster Session, HALL Q, March 12, 2026, 10:00 - 11:00

Introduction

A third of advanced kidney disease is attributable to overweight/obesity (1-3). Weight loss can delay the need for dialysis (4), reduce cardiovascular risk and improve quality of life (5). There is no funding for a renal weight management service in our area and local weight management services generally do not accept patients with CKD due to the complexity of the condition.

Methods

We designed a behavioural intervention for weight management in adults with non-dialysis CKD and delivered it to adults with a body-mass index (BMI) $\geq 30\text{kg/m}^2$ and CKD stage 3 or 4 attending general nephrology clinics. Participants received a follow-up call one week after a baseline appointment, a review appointment to discuss progress, and a semi-structured interview to explore their experience of participation. Outcomes included weight, Kidney Disease Quality of Life-Short Form (KDQOL-SF), General Self-Efficacy Scale (GSE) and Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS).

Results

Recruitment occurred from 18th March until 25th September 2024. Of 174 adults meeting eligibility criteria, 30 expressed interest and six agreed to participate, a 20% recruitment rate; one withdrew after baseline, a 17% attrition rate.

Mean weight [BMI] at baseline and review was 102.1 kg (SD 22.3) [37.5 kg/m² (SD 5.7)] and 101.6 kg (SD 20.3) [37.3 kg/m² (SD 5.3)] respectively.

Two participants were male, two female and one non-binary; mean age was 65.6 years (SD 12.4). Four were married/in a civil partnership; one was widowed. Three did paid work (one full-time, two part-time); two were retired. All participants chose a dietary option and three chose physical activity.

Mean duration of baseline appointments, follow-up telephone calls and review appointments were 59 mins (SD 24), 24 mins (SD 18) and 52 mins (SD 26) respectively. Two review appointments were held online. The mean intervention time (over three contacts) was 136 mins (SD 46) and the mean duration of the intervention (between baseline and review appointments) was 26 days (SD 4).

The two lowest KDQOL-SF mean subscale scores at baseline were 52 (overall health) and 35 (general health) that showed improvements at review to 75 and 55 respectively. The two highest KDQOL-SF mean subscale scores at baseline were 86.9 (effects of kidney disease) and 86.7 (cognitive function and social support) that showed improvements at review to 90.6, 90 and 100 respectively.

Thematic analysis of interviews with four participants indicated the recruitment process was acceptable, and they valued use of brief motivational techniques, behaviour change techniques and social support. Modifications to the intervention suggested by participants

were a longer duration with more sessions, and the option of group sessions (to obtain peer support) and pre-consent provision of educational materials in digital form that also included testimonials from people who had successfully completed the intervention.

Discussion

Results indicated that the intervention is feasible, and acceptable to participants. Widening inclusion criteria is warranted to maximise uptake of the intervention, along with strategies to engage patients with low KDQOL-SF, GSE and WEMWBS scores who have most to gain from the intervention.

References

1. Herrington et al. *PloS One*. 2017;12(3): e0173515.
2. Zhu et al. *JASN*. 2021;32(1):127–37.
3. Wang et al. *AJKD*. 2022;79(1):24-35.
4. Navaneethan et al. *CJASN*. 2009;4:1565–74.
5. Jacob & McCafferty. *Clin Med*. 2023;23(4):353–6.