THJ1

Service evaluation of a multiprofessional Enhanced Supportive Kidney Care clinic for people receiving conservative kidney management

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

Introduction

Enhanced supportive kidney care (ESKC) is a person-centred approach that aims to improve quality of life for people living with chronic kidney disease (CKD). Core components of ESKC are identification of supportive care needs and advance care planning (ACP). In October 2023, a multiprofessional ESKC clinic was established in a hospice setting for patients receiving conservative kidney management (CKM), delivered jointly by a nephrologist, kidney nurse specialist and palliative care nurse specialist. This service evaluation assessed identification of supportive care needs, (including symptom burden and frailty) and ACP discussions within the ESKC clinic.

Methods

Demographic and clinical data were collected at first clinic attendance. Frailty was assessed using the Clinical Frailty Scale (CFS). Symptoms were measured using the Integrated Palliative care Outcome Scale–Renal (IPOS-Renal) at baseline (IPOS1) and 6 months (IPOS2). The IPOS-Renal includes 15 physical symptoms scored 0–4, with scores 2–4 (moderate to overwhelming) defined as clinically significant. Preferred place of care at the end of life and preferred place of death were recorded. Deaths were reviewed for cause and concordance with preferred place. Data were analysed descriptively using medians (IQR) and proportions.

Results

Twenty-nine patients completed IPOS1 between October 2023 and February 2025. Median age was 86 years (IQR 81–89), median eGFR 12 ml/min/1.73m² (IQR 10–15), and Charlson Comorbidity Index 9 (IQR 7–10); 14 (48%) were female. Median CFS score was 6 (IQR 5–6), with 26 individuals (90%) living with frailty (defined as a CFS score of 5 or higher). The median total symptom score at baseline was 13 (IQR 6–18). The most common moderate-to-overwhelming symptoms were poor mobility (72%), weakness (52%) and itching (41%). At 6 months, 23 patients completed follow-up (IPOS2): the median total symptom score was 9 (IQR 6–17.5). At follow-up, the most common 'moderate' to 'overwhelming' symptoms were poor mobility (70%), pain (48%) and weakness (43%). Figure 1 demonstrates symptom prevalence at baseline and 6 months. Preferred place of death was recorded for 24/29 patients. Thirteen patients (45%) died during follow-up; causes included frailty/old age/dementia (n=4), CKD (n=2), heart failure (n=2), infection (n=1) and malignancy (n=1). Eleven of thirteen patients died in their preferred place of death (home or hospice).

Discussion

Patients attending the ESKC clinic had a high frailty and symptom burden, with some symptoms improving whilst others worsening over time. The fluctuating nature of symptom trajectories highlights the need for regular symptom screening in people with advanced CKD. The high prevalence of symptoms related to poor mobility and weakness demonstrates the impact of frailty and associated geriatric impairments in older people receiving CKM. Most patients achieved their preferred place of death, underlining the importance of timely discussions around care preferences. This service evaluation demonstrates that a multiprofessional ESKC clinic in a hospice setting can facilitate supportive care needs identfication and advance care planning discussions, highlighting its value as a model of care to implement ESKC principles for people receiving CKM.

THJ2

What patients want to know about dialysis withdrawal: a qualitative study

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

Introduction -
Chronic kidney disease is estimated to affect 3.5 million people in the UK, with around 30,000 undergoing dialysis treatment. The annual mortality of dialysis patients is around 20%. Dialysis withdrawal has become an increasing cause of death amongst patients with end stage kidney disease. Despite this, there remains a paucity of research in the field, particularly relating to patients' perception of dialysis withdrawal. This study aims to explore patient understanding of dialysis withdrawal in those known to Renal Supportive Care (RSC)

Methods –
This project took place at a tertiary renal unit with recruitment by specialist nurses across six haemodialysis units. Patients were recruited from a local RSC register, for which the criteria for listing was based on results in four screening tools (Surprise Question, iPOS renal, Rockwood Frailty and a VAS Score of Health and Wellbeing). Four patients of twenty approached were recruited from the RSC register. Two further patients known to RSC nurses were subsequently recruited. Six patients were interviewed to achieve data saturation. A topic guide was created with input from the UK Kidney Association Special Interest Group for RSC. Interviews took place on the dialysis units. Themes were derived by three independent researchers.

Results –

Five key themes were identified
- Need for information
- Information relating to timelines
- Need for information about what would happen depending on their dialysis journey.
- Knowing who to consult for further information.
- Who to involve in decision making regarding dialysis withdrawal.

Patient experience was frequently raised with the following subthemes –

- Exhaustion associated with haemodialysis. “Dialysis days, I just feel absolutely done”

- Psychological impact and the feeling of having no choice about remaining on dialysis. “If I did a third day, mentally I would go downhill”

- Significant limitations to daily life. “It's just a bind being here”

- Preserving independence. “Having to depend on someone to push me around I think that would be a turning point”

Discussion -

This project has clearly highlighted key themes of what patients want to know with regards to dialysis withdrawal. However, this was a small, single-centre study, lacking ethnic diversity. Only four of twenty patients initially approached agreed to participate, suggesting that that dialysis withdrawal, for many, may not be something that patients feel comfortable discussing.

From this study, we will ensure that patients known to the RSC are offered education relating to dialysis withdrawal at the appropriate time for them and by clinicians well known to them. If patients do not wish to engage in discussions or if discussions have already taken place, they will not be repeated, to minimise distress. We will offer patients known to the RSC team a family meeting as family involvement was a key theme. The data relating to the patient experience of haemodialysis will be fed back locally to determine how we can better support patients, particularly in reference to quality of life on dialysis. Future research could explore the generalisability of these findings in other centres.

THJ3

Understanding patterns of illness trajectories in people approaching the end-of-life with advanced chronic kidney disease: a scoping review.

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

Background

People with advanced chronic kidney disease (advanced CKD) nearing the end of life often experience diverse and unpredictable patterns of illness progression, which have a profound impact on their health-related quality of life (HRQoL). These variable patterns challenge healthcare professionals’ ability to identify the optimal time for providing appropriate support for the patients, making it crucial to understand these trajectories to deliver effective, person-centred care that improves health and QoL outcomes. Therefore, this review aimed to identify patterns of patient-reported and health services outcome trajectories in people with advanced CKD approaching the end of life.

Methods

A scoping review was conducted following the framework proposed by the Joanna Briggs Institute, Preferred Reporting Items for Systematic reviews and Meta-analysis Extension (PRISMA-Scr). Three electronic databases, CINAHL, MEDLINE, and PsycINFO, were searched. The search was limited to peer-reviewed research papers involving human subjects, aged 18 years or older, published in English between January 2010 and December 2024. Additional relevant literature was identified through manual searching of the reference lists of eligible sources.

Results

The review included thirteen studies involving patients with advanced CKD (stages G4 or G5). The follow-up duration of the majority of studies ranged from twelve to eighteen months (n=7). The seven studies that sought to describe the course of symptoms indicated distinct patterns amongst patients who were alive and died during the study period, with certain differences across treatment modalities, either conservative management (non-dialysis) or dialysis. Conservatively managed (CM) patients in the last year of life exhibited moderate symptoms with a gradual increase over time, with a marked acceleration during the last two months of life. Dialysis patients reported widely fluctuating individual symptom scores over time. The functional status of CM patients in the last year of life was relatively stable, with a rapid decline during the last few months. CM patients who initiated dialysis showed a marked decline in HRQoL over the last six to twelve months of life, while those who remained under conservative management had relatively stable physical and mental QoL. Older patients with higher comorbidity scores receiving dialysis showed worse scores in most QoL dimensions than younger patients. Healthcare utilisation increased sharply during the last 6 months before death, whereas patients receiving dialysis relied more heavily on emergency health services compared to others.

Discussion

The analysis revealed that most patients with advanced CKD experienced a gradual health decline followed by a steep deterioration in symptoms, functional status, and QoL in the last six to twelve months before death. The heterogeneity of patient-reported outcome measures across studies and the availability of renal palliative care services in certain contexts made it difficult to compare findings and draw meaningful conclusions. Although most studies offered high-quality quantitative evidence, the exact timing of medical and supportive care needs spike remains unclear due to inconsistent findings influenced by individual variations, fluctuating health conditions, short follow-up periods, and various outcome measures. A longitudinal, standardised, mixed-methods study with frequent follow-ups could better capture individual variations and determine the best timing and configuration of care for these patients.

THJ4

Retrospective review of unplanned hospital attendances in supportive kidney care patients to two sister centres of Doncaster and Bassetlaw NHS foundation trust over 12-month period.

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

Introduction-

Supportive kidney care is an alternative to dialysis particularly in older individuals with multiple co-morbidities. It offers a patient centred approach aimed at improving quality of life and symptom control without dialysis. There is little data on the effectiveness of community services and hospital admission rates in this group of patients.

Methods-

Unplanned hospital attendance episodes in supportive kidney care patients over a 12-month period were reviewed using electronic data from the hospital trust portal. There were 58 patients under Renal supportive care service at the time of this review.

Results-

There were 95 hospital attendances between 37 supportive kidney care patients over a 12-month period. 70(74%) were unplanned admissions of which 67(96%) were admitted via the emergency department (ED). 46(69%) led to inpatient admission with 40(60%) staying >1 day. 21(31%) patients were discharged directly from ED. The longest wait in ED was 36 hours. Average ED waiting time was 11.64 hours with a median time of 10 hours. 54(81%) of ED attendances waited >4 hours in ED. The reason varied with 50% waiting for medical reviews/beds and 16% due to waiting for rapid access physiotherapist/social care.

Of 46 inpatient admissions, the longest stay was 113 days following stroke with average stay being 14.7 days and a median stay of 7 days. The reason for admission was mostly due to falls, infections and bleeds with a small proportion due to CKD complications. 12 patients had specialist renal review whilst inpatient and even fewer patients needed specialist palliative care input. There were no deaths in hospital. 4(9%) attendances were equally discharged to either rehabilitation hospital or care homes with the remaining 42(91%) being discharged to their own homes.

Out of 70 unplanned admissions, 14(20%) were readmitted within 30 days of discharge with inpatient stays of ≥1 day. These readmissions occurred between 7 patients. 20(29%) unplanned admissions were thought to be avoidable often relating to social issues or difficulty accessing community care.

Discussion

A considerable amount of supportive kidney care patients attended hospital mostly via ED. Most attendances were due to falls, infections and bleeds, which highlights their multi-morbidity and frailty. Only a small proportion of admissions were consequences of advanced CKD such as hyperkalaemia and anaemia with only 11 admissions having an eGFR <10ml/min. Patients would have benefitted with comprehensive geriatric assessments and potential involvement of falls prevention and frailty teams in community and in ED. Our next step is to work closely with our frailty teams in the community and hospital to highlight these patients early so timely intervention could prevent some of the unplanned hospital attendances.

THJ5

The development and initial evaluation of an Enhanced Supportive Kidney Care Service.

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

Introduction
Providing holistic care for people with chronic kidney disease, aligned to their preferences and wishes, remains a key priority. Enhanced Supportive Kidney Care (ESKC) aims to achieve this, however often remains an unmet need. Complexities in healthcare infrastructure and limitation of resources can impede the implementation of ESKC.
We describe development of an ESKC service, applying quality improvement methodology and collaborative working with no additional funding. We demonstrate working differently has the potential to impact positively on patient's experience.

Methods
In 2023 in two dialysis units we demonstrated, with an MDT approach and use of renal IPOS, improvement in patient's symptoms. We therefore developed an ESKC service. This involves an ESKC clinic, fortnightly MDT meeting and holistic assessment electronic document. An ESKC Specialist nurse allowed home visits and telephone reviews. Referral and vetting supported by the administration team. Collaborative working with regional teams ensured best practice and a standardised approach. We continue to develop using QI Figure 1 and 2 show initial Process Map and Driver Diagram.

Results
In the first 6.5 months of implementation there have been 19 referrals, 9 male, 10 female. Age ranged from 43 to 85 years, average of 65 years. 45% haemodialysis, 33% peritoneal dialysis and 22% Pre-dialysis patients. 18 referrals requested discussion in MDT and 10 clinic review. Charlson comorbidity index ranged from 3 to 12 with an average of 6.5. Frailty score was not applicable for 7 patients, it was assessed in 7, all scoring 5 or above. Figure 3 shows reason for referral.

Interventions of the ESKC MDT.
13 patients were discussed in MDT. 5 patients not discussed, 4 as they were admitted to hospital with acute problems and one patient died before discussion. 6 patients have been reviewed in clinic and 6 in home visits.
Direct clinical interventions have included 4 medication changes, 3 therapy and 1 Psychology referral, 3 future care planning conversations.
Advice to the teams following ESKC MDT involved 4 medication changes, 1 therapy referral, 1 renal Psychology review, 6 future care planning conversations, 3 community palliative care referrals.

Outcome

There was a significant burden of symptoms and Table 1 shows the trends in iPOS score. Five people have died, three of these deaths were in hospital and two were at home. We have had positive feedback from patients and clinicians. These have included the quotes “when asking ‘……’ if he has as much information as he wants he said he now feels he always does and in the ESKC clinic he feels listened to’ , ‘she explained that it has been the single most useful contribution to her care.’

Conclusion

We demonstrate an ESKC service can be implemented with reconfiguration of resources, rather than increased funding. Working differently can create the additional time and space needed for holistic assessment, listening to patients to tailor interventions to their specific needs and goals. Initial outcomes demonstrate the need for this service and the potential to impact positively on patient’s care. Ongoing learning to improve our approach is needed.

THJ6

Assessing advance care planning and factors associated with mortality in a dialysis cohort

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

Introduction:
Patients on haemodialysis have a significantly higher mortality rate than the general population. According to the most recent UK Renal Registry data, 14.6% of patients who were receiving in-centre haemodialysis died in a 12-month period. Holistic care for haemodialysis patients must therefore include advance care planning and palliative care where necessary. Although the Gold Standards Framework (GSF) suggests criteria for identifying patients with kidney disease who may be in the last year of life, these are not specific or not applicable to patients on haemodialysis. We therefore examined our in-centre haemodialysis patient cohort to identify potential indicators that patients might be in the last year of life.

Method:
This was a retrospective cohort study of in-centre haemodialysis patients at Whipps Cross Hospital who died between January 2023 and June 2024. Electronic patient notes were interrogated and data on cause of death, advance care planning, clinical frailty scores (CFS), unplanned admissions, dry weights and trough albumin were recorded.

Results:
45 patients died in this time period. Infection, malignancy, end-stage renal failure and ischaemic heart disease were the leading causes of mortality. 70% of patients had a DNACPR in place but only 17% had a Universal Care Plan (an advance care planning document shared with London-based community services). Only 44% of patients were known to the palliative care team, including referral on the day of death. 95% of patients had at least 1 unplanned admission in the last 12 months of life and 56% of patients had 3 or more. 78% of patients had a CFS of 3 or more; 36% of patients had a CFS of 7. 42% had a greater than 10% reduction in their post-dialysis dry weight compared to their target dry weight.

Discussion:
Advance care planning is a significant unmet need in our cohort of haemodialysis patients. In this study, frequent hospital admissions, frailty and significant weight loss were indicators that a patient might be in the last year of life. A high proportion of patients did not meet the GSF criteria for kidney disease; there is a significant burden of multimorbidity in haemodialysis patients which is not captured in these indicators. Our findings will be used to proactively identify haemodialysis patients who might benefit from advanced care planning and to establish a renal-palliative multidisciplinary meeting to optimise their care.

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https://www.ukkidney.org/sites/renal.org/files/publication/file-attachments/UKKA%2026th%20Annual%20Report%202024-07-07.pdf

https://www.goldstandardsframework.org.uk/wp-content/uploads/2025/07/Proactive-Identification-Guidance.pdf

THJ7

An exploration of patient, caregiver, and healthcare professional perspectives of Kidney Supportive Care

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

Introduction

Kidney Supportive Care (KSC) aims to improve health-related quality of life of people with chronic kidney disease (CKD). There is variation in KSC provision within the UK and little research on stakeholder perceptions of KSC. This study aimed to: (1) establish patient, caregiver and healthcare professional (HCP) understanding of KSC; (2) define aspects of 'good' KSC from the perspectives of patients, caregivers and HCPs; and (3) describe barriers and facilitators to providing KSC.

Methods

Thirty-three participants (16 patients, 3 carers, 14 HCPs) participated in discussion groups between December 2024 and May 2025: 2 patient groups (1 face-to-face, 1 online), 1 online caregiver group, and 2 online HCP groups. Discussion group meetings were 60-90 minutes and moderated by 2 researchers with the aid of a topic guide. Meetings were audio recorded with participant consent. Transcripts were analysed using deductive, directed content analysis. Coding was guided by our pre-existing questions; initial codes generated for each transcript were checked by a second researcher. Researchers met to discuss and refine these initial codes, and search for and review themes before defining and labelling them.

Results

HCPs defined KSC as patient-centred, goal focused and holistic – focussing on quality of life, frailty, symptom management, prognosis and advance care planning, and of relevance for all patients regardless of treatment or age. Advanced communication skills training, co-ordination of care, culture change, working with other specialties and developing KSC within teams in a pragmatic way, were cited as essential components of providing good KSC. Barriers included: late referrals, lack of time, confidence, skills and access to allied HCPs.

Patients were unable to define KSC and instead focused on their lived experience of kidney care; they used examples of social/family/HCP support. They described the importance of receiving care, which is responsive to their needs and includes, psychological support, symptom management, family and carer support, having time and space for decision making, being able to communicate preferences and building rapport and trust with HCPs. Barriers included: lack of access to social care, psychologists, written educational materials, time for conversations, continuity of care and an over emphasis on clinical markers rather than patient-led discussions.

Carers expressed confusion about the term 'supportive care' and felt that it was perhaps synonymous with conservative and end of life care and a lack of treatment options. They described that KSC should be patient-centred, focussed on providing options, improving understanding and communication between patients/HCP/carers. Carers described feeling sidelined and wanted to be respected, valued and part of the team; they saw their role as crucial in making sense of and improving doctor/patient communication.

Discussion

HCPs, patients and carers held different views on how to define, conceptualise and provide KSC. However, all groups described the importance of communication and person-centredness for KSC. Both patients and HCPs perceived lack of time as being a barrier to KSC. Further research is needed to understand how best to implement quality KSC in UK kidney services.

THJ8

Promoting renal staff awareness of - and confidence in having conversations about - palliative and hospice care, tackling common misconceptions to improve patient decision making and increase early access to beneficial palliative care services.

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

Introduction

A project was initiated with renal teams in two acute trusts to improve patient decision making for those with kidney failure. It was decided that the project would focus on activity to improve clinician awareness of - and confidence in talking to patients about - palliative care and advance care planning, ultimately improving patient decision making and broadening access to palliative care.

Method

A staff awareness and confidence survey was sent to renal teams. This highlighted a lack of awareness / confidence in particular around palliative care (39%) and use of the Universal Care Plan, London's Advance Care Planning digital tool (63%).

Following review of quantitative and qualitative survey responses, and in partnership with renal Lead Supportive Care Nurses, a campaign was developed with the slogan:

'What matters to you? Let's talk about it. Palliative Care – let's make every moment matter'

Key messaging focused on tackling common myths with facts – such as palliative care is not just for end of life, and can happen alongside dialysis – and also conversation prompts for advance care planning with patients.

Materials for staff bearing the slogan and a link / QR code to new local palliative care web pages were developed, including water bottles, mugs, credit card sized folded handouts and lanyard attachments.

The following activities were undertaken to deliver the campaign:

- Tea trolley dashes - across two months, visiting 18 wards / units to deliver cake and campaign materials in goodie bags to staff, engaging with staff and delivering bite size learning sessions on the shop floor, where possible.
- Sensitive conversation workshops; providing a safe space to practice conversations going badly
- Educational hospice visits

- Palliative and hospice care webinar

Results

As at September 2025: The webinar and trolley dashes have been completed, with almost 500 goodie bags distributed and staff engaged with at 18 locations. Other activity is due for completion by November 2025, with full evaluation to follow.

Initial campaign evaluation shows that 100% of 93 evaluation survey respondents learnt something about palliative care from the trolley dashes, with 86% learning ‘a lot’. The percentage of respondents who learnt the following facts for the first time through the campaign is below – demonstrating the previous breadth of misconceptions and lack of awareness:

- 73%: Palliative care can be episodic
- 64%: A hospice is not just an inpatient setting / place you go to die; it also provides care in the community
- 63%: The sooner palliative care starts, the better
- 58% Palliative care can be given alongside other ongoing treatment, such as dialysis
- 58%: Hospice care is free
- 55%: Palliative care is not just for the last few days / weeks of life
- 49%: Palliative care isn't just for cancer, it’s for any life limiting condition

It is hoped the sensitive conversation workshops will improve staff confidence to initiate patient conversations using their new understanding.

Conclusion

Palliative care is everyone’s business. Helping renal staff to be more aware of – and confident in – palliative care is key to improving patient decision making, maximising quality of life.

THJ9

Palliative Care on the Renal Ward – The Nursing Experience

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

The National Audit of Care at the End of Life (NACEL) 2022 presented feedback from bereaved relatives' views on inpatient end of life care (EOLC). The feedback was mixed and related to both medical and nursing care. Studies have shown that renal clinicians find end of life care challenging due to mismatched patient expectations, medical complexity and assessment of quality of life. This project aimed to explore nursing views on provision of palliative care on a renal ward at a tertiary renal unit with the aim of improving the patient experience.

All nursing staff working on the three sampled days over a 3-week period were invited to take part in the study. Semi structured interviews with care support workers (CSW), ward nurses and inpatient dialysis nurses were conducted. Open questions were used to explore staff confidence in the provision of end of life care for patients and their families, difficulties they faced and their suggestions for improvement. Twelve nurses and 3 CSWs were interviewed. Transcripts were analysed by two independent researchers.

Nursing experience ranged from 1 to 20 years, with a median of 8 years. One of the twelve nurses trained in the UK and all CSWs trained in the UK. Further demographics are displayed in table 1.

Themes
Renal ward nurses are largely confident in looking after dying patients
"I'm very confident. I know what the policies are. I know how to deal with the patient and family. I know how to refer to the palliative care team."

Nurses are less confident in looking after families of dying patients
"Whenever I see the family members in that room with the patient, I always feel like, oh my God, I don't know what questions they are going to ask me now."

The difficulties were both emotional and practical–
"I think if you're attached to the patient that's the hardest thing. Like you see them on their last breath."
"The other thing would be my staff actually need more training on syringe drivers, managing syringe drivers and the palliative medications"

Uncertainty is challenging
"We keep on doing the observations because there's no straightforward decision that comes up from the medical team."

Communication difficulties
“I don't know like what the right words to say”

Cultural aspects
“I come from a different country where the end of life care is totally different.”

Nurses are largely confident in caring for patients but find communication with families challenging. The relationships renal nurses have fostered with their patients over time results in high emotions at the end of life. This study was a small, single centre study with a short interview period. Nurses requested resources to share with patients and families; the trust “What to expect when someone is dying” leaflet will be distributed on the ward. Nurses requested communication support for family discussions which will be delivered in a dedicated workshop by palliative medicine.

THJ10

Physical impacts of a Renal Transplant Weight Management Clinic (RTWMC): an initiative to improve healthcare for end-stage kidney disease

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

Introduction: A bespoke weight loss intervention, tailored to the individuals' needs for those with end-stage kidney disease (ESKD), and whose only barrier to transplant was body mass index (BMI)>35kg/m2 was implemented as an initiative to improve healthcare, equality, and cost efficiency.[1] Frailty is common in ESKD and is a marker of poor outcome[2] when measuring physical function.
Aim: to evaluate the impact of a bespoke intervention on physical function for individuals attending the clinic.

Methods: A retrospective evaluation of patients attending the RTWMC with repeated functional measures at baseline and follow-up were included. Characteristics including age, gender, Charlston Comorbidities Index (CCI), BMI, chronic kidney disease (CKD) stage or dialysis status, and Kidney Disease Quality of Life (KD-QOL) were collected. The functional outcomes, five repetition sit-to-stand (5RSTS) and hand grip strength (HGS right and left, where appropriate) were measured. A physiotherapeutic intervention was prescribed and reviewed regularly and based on an individualised approach. This was progressive and included resistance training, aerobic training, balance training and targeted therapy to improve functional movement and physical activity. Data was reported as mean difference ±standard deviation (MD±SD), percentage (%), median [IQR]. The % achieving the minimal clinical important difference (MCID) was reported being based on -4.2seconds (sec) for 5RSTS[3] and 5 kilograms (kg) for HGS[4].

Results: Of 140 patients referred, n=42 repeated functional measures at follow-up. Characteristics MD±SD, %, or Median[IQR]: Age 51±13 years; Gender 57% Female; CKD stage 5D receiving HD 36%, CKD stage 5D receiving PD 9% and CKD stage 4-5 55%; BMI 40.68±5.77kg/m2; CCI 4[2 – 4]. KD-QOL Symptoms 70.06±16.81, Effects 62.83±23.28 and Burden 49.74±22.08. N=2 successfully received a kidney transplant, 4 were listed and 4 were ready for listing (eGFR>15ml/min/1.73m2). There were positive improvements in the 5RSTS with nearly one third of individuals achieving the suggested MCID of -4.2sec3 and preserved HGS in both arms (Table 1).

Conclusion

For a representative sample of 42 individuals living with ESKD, co-morbidities, impaired quality of life and reduced physical function, a targeted and personalised physiotherapeutic intervention had the potential to improve and preserve physical function/strength, for those on a bespoke weight loss program, and in need of a kidney transplant.

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THJ11

Can physical function measures predict physiotherapy need and length of stay in individuals undergoing kidney transplant?

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

Background:
Physical function tests, such as short physical performance battery (SPPB), and frailty scores, such as clinical frailty scale (CFS), have been suggested for use in those undergoing kidney transplant to identify risks and predict clinical outcomes.
Aim:
To identify if physical function at time of admission predicts physiotherapy needs and length of stay for individuals undergoing kidney transplant
Methods
Individuals undergoing kidney transplant were scored on the CFS by the ward physiotherapy team, based on self-reported physical performance 2 weeks prior to admission. The clinicians also completed SPPB testing on admission prior to kidney transplant, and prior to discharge from physiotherapy or home, if sooner. Length of stay was the number of days between admission and discharge. Physiotherapy contacts were recorded as the number of individual sessions delivered by the physiotherapy team during admission on an as needed basis, determined by achievement of predetermined enhanced recovery programme physical function goals.
Normally distributed data are presented as means [confidence interval] and analysed using a ttest, and non-normally distributed data are presented as medians [interquartile range] and analysed using a Mann-whitey U test. Associations were analysed by multiple linear regression. Statistical significance was determined by p value <0.05.
Results:
Demographics:
234 individuals, 125 males, with a mean age of 50y, were admitted Jul 2024-Sept 2025.
Frailty:
157 (67%) individuals were non-frail, scoring 3 or lower on the CFS, with 67 (29%) and 10 (4.3%) scoring mild and moderately frail respectively. No individuals were severely frail.
SPPB:
Mean SPPB score on admission was 10.6 [9.9 – 11.3] out of twelve compared to 8 [7.3 – 8.7] on discharge, and a mean reduction of 1.9 [1.1 – 2.7] in SPPB was demonstrated from admission to discharge (p=0.002).
Physiotherapy need:
Physiotherapy needs were higher (p=0.002) in those identified as frail with a mean 8.3 [5.4 – 11.2] contacts compared to those who were not frail with a mean 5.2 [4.3 – 5.96] contacts. SPPB was moderately correlated with CFS returning a Pearson correlation coefficient of -0.54. Multiple linear regression indicated a moderate collective significant effect between the SPPB and CFS, and LOS, (p<0.001, R2=0.21) and physiotherapy contacts (p < .001, R2=0.19).
LOS:

LOS was greater in those demonstrating impaired physical function, scoring 9 or less on the SPPB (median 13 days [IQR 20]) compared to those scoring 10 or more (median 8 days [IQR 8]), though this did not reach statistical significance ($p>0.05$).
LOS was greater in those identified as having frailty (median 8d, IQR 8) compared to those who were not frail (median 10d, IRQ 8), however, this did not reach statistical significance ($p>0.05$).
Discussion:
Overall those demonstrating impaired physical function and frailty were likely to experience increased LOS in keeping with previous studies, and also required a greater number of physiotherapy contacts. This finding could be used to inform physiotherapy service planning. Further research is needed to investigate if stratified physiotherapy provision for those with frailty and physical impairment would impact clinical outcomes.

THJ12

Changes in body composition, frailty and multimorbidity in people with chronic kidney disease over one year

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Introduction

Body composition has a major impact on survival, functionality and outcomes in people with chronic kidney disease (CKD). However, measurement of body composition in clinical practice is not routine or standardised. The Multimorbidity and Sarcopenia Study in CKD (MaSS-CKD) aims to study the changes in body composition in people with CKD using bioelectrical impedance analysis (BIA) over a year, and study its association with frailty, multimorbidity and performance status.

Methods

People with CKD stage 3,4 and 5 were recruited with age and gender matched control group with no history of kidney disease (eGFR >60ml/min/1.73m2) in a single centre. Exclusion criteria included people with neuromuscular conditions, cardiac implantable electronic devices or were pregnant. Participants had body composition measured with the Inbody 770, frailty assessed with Clinical Frailty Scale (CFS) and Karnofsky Performance Status Scale and multimorbidity quantified with Cambridge Multimorbidity Score (CMS) at baseline and at one year.

Results

83 people were recruited to the study, and follow-up for the cohort is ongoing. Interim analysis was performed on 43 participants at one year, all with CKD (28 male, 15 female). At one year, 2 participants had died and one had become wheelchair bound and could not stand for the BIA. 4 participants had commenced renal replacement therapy, and 1 participant received a kidney transplant.

Table 1 shows the demographics and characteristics of the participants at baseline and one year. This was a cohort with low kidney function (mean eGFR 26ml/min/1.73 m2) with mean age of 67 years. There was a drop in mean skeletal muscle mass in the cohort after one year, but this was not statistically significant in the interim analysis. At one year, there were higher mean CMS and CFS scores, and lower Karnofsky Performance Status scores.

The BIA findings did suggest that body mass index (BMI) underestimated obesity both at baseline and at one year (Table 2). Mean whole body phase angle of the cohort were low (4.5° at baseline and 4.6° at one year).

Discussion

In this interim analysis, the study population exhibited low kidney function, high mean visceral adiposity and a low mean whole body phase angle, accompanied by a decline in skeletal muscle mass at 1 year. There was a negative change in performance status, frailty score and multimorbidity after 1 year of follow-up. The full analysis at the end of the follow-up period will further inform associations between body composition and frailty and multimorbidity.

Visceral fat area and percentage body fat, measured by BIA, classified more participants with obesity than BMI-based classification. Visceral adiposity has been linked to increased metabolic syndrome, cardiovascular events and mortality risk. These measurements from BIA are potentially useful markers in clinical practice to identify these individuals at risk of poorer health outcomes, as targeted interventions with novel therapies and weight management strategies could help improve clinical outcomes in this group.