TC1

Education of Health Professionals in Primary Care to Increase Uptake of urine Albumin: Creatinine monitoring and identification of Chronic Kidney Disease

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TUESDAY - Moderated Poster Session, HALL Q, March 10, 2026, 16:00 - 17:00

Introduction

Evidence strongly supports medications, such as ACE-inhibitors, ARBs and SGLT2-inhibitors, to reduce excess cardiovascular outcomes and slow the decline of kidney function associated with chronic kidney disease (CKD). However, effective management requires identifying patients through regular serum creatinine and urine albumin-creatinine ratio (uACR) testing. NICE recommends annual testing for at-risk groups. Locally, uACR screening rates were low, consistent with national CVD Prevent data.

To our knowledge, no existing training focuses on improving CKD screening and identification for non-clinical staff. Countywide CKD training was delivered during protected learning time, prompting requests for tailored in-practice sessions and the development of further training.

Methods

Informal discussions with lead clinicians identified screening as a priority topic to support CKD identification before addressing management. A senior clinical pharmacist with a CKD special interest developed a one-hour, in-practice session focused on screening and identification.

The training used a visual slide deck and props (e.g., a sieve for Bowman's Capsule, glitter water for protein in blood). Sessions were for clinical and non-clinical staff. The PCN serves ~67,000 patients and constitutes five practices in moderately deprived areas (IMD decile 4/5) where diabetes and hypertension prevalence exceed national averages (8.1% vs 7.7% and 15.1% vs 14.8%, respectively).

Results

Training sessions were delivered between September 2024 and April 2025 to 74 staff over 6 sessions. The largest staff group trained were GPs with 25 GPs, followed by non-clinical

staff, of which 16 were trained. The proportion of staff trained by their roles is shown in Figure 1.

Biochemistry data from May 2024 and May 2025 showed a relative increase of 35% in uACR tests across the PCN (567 to 765), compared to a 15% increase across the ICB (2,682 to 3,075). As shown in Figure 2, all practices improved testing rates of uACR. Practice 1 had the smallest increase but the highest baseline. Serum creatinine testing showed a modest decline.

Discussion

The training provision coincides with increases in uACR testing across the PCN, outperforming the wider ICB where similar training was not delivered. This suggests a positive impact of targeted education on CKD screening and highlights the value of practical, in-person sessions tailored to local needs.

While creatinine testing showed a modest decline, baseline rates were already high, so minimal change was expected. Although population growth may have contributed, the disproportionate rise in uACR testing indicates a genuine shift in clinical behaviour. Improved uACR testing also enables better risk stratification using tools such as the Kidney Failure Risk Equation (KFRE). Earlier identification and risk stratification support timely medicines optimisation, particularly the initiation of ACE-inhibitors, ARBs, and SGLT2-inhibitors in higher-risk patients.

These findings reinforce the importance of prioritising CKD screening in primary care education and suggest that simple, engaging training formats can be effective across multidisciplinary teams.

Further work

Following staff training, it became clear that improving test uptake also requires public engagement. To support sustainable change, targeted CKD education sessions are being developed for community groups, alongside continued staff training focused on risk factors and screening pathways.

TC2

Undergraduate teaching provision in organ donation and transplantation across uk medical schools: a national cross-sectional survey of educators (U-TEACH-ODT)

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TUESDAY - Moderated Poster Session, HALL Q, March 10, 2026, 16:00 - 17:00

Introduction

Organ donation and transplantation (ODT) is a critical health system function, yet undergraduate teaching provision across UK medical schools remains poorly characterised. The most substantive evidence comes from nearly 20 years ago and revealed striking heterogeneity, limited structured exposure, and lack of compulsory teaching. Given increasing demand for transplantation and ongoing organ shortages, there is an urgent need to map current ODT curricular provision, assessment, and barriers to delivery.

Methods

U-TEACH-ODT is a national cross-sectional online survey targeting deans and senior curriculum/assessment leads from all 44 UK medical schools. Only one authoritative response per institution will be sought to ensure accuracy, with up to three senior leads contacted if needed. The questionnaire, developed with input from educators, clinicians, and recipients, captures curricular coverage, hours, assessment, proportion of students with structured exposure, perceived barriers and facilitators, and readiness to expand provision. Analyses will compare provision by transplant-centre affiliation, course structure, and region, and will be triangulated against student-reported data from the parallel U-KNOW-RT survey. The study has been prospectively preregistered on the Open Science Framework (DOI: 10.17605/OSF.IO/38W5N).

Results

The survey will be administered in September 2025. Results are outstanding at the time of abstract submission. Data analysis is expected to commence in November 2025.

Discussion

This study will provide the first UK-wide mapping of ODT teaching provision in nearly two decades, forming one half of a coordinated national programme alongside the U-KNOW-RT student survey. By capturing the perspectives of curriculum leads and triangulating these with student-reported experiences, it will reveal not only the extent of current provision but also areas of misalignment between what educators report delivering and what students experience. Such evidence is critical to addressing inequities between schools, identifying barriers to structured exposure, and highlighting innovations that can be scaled nationally. Importantly, this educator survey complements the student dataset to create a comprehensive national picture of ODT education. Together, these parallel studies will provide the empirical foundation for developing a standardised national ODT teaching module. Embedding such a module would ensure that all UK graduates achieve core literacy

in donation and transplantation, supporting GMC Outcomes for Graduates, improving donor identification, and strengthening transplant pathways. By aligning with national priorities and international recommendations, this work has the potential to influence curriculum, shape policy, and prepare the next generation of doctors to deliver equitable, high-quality transplant care across the NHS.

TC3

Establishing a peer-support network for early-career doctors with an interest in nephrology.

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Background:
Renal medicine is a highly-rewarding specialty. However, limited early clinical exposure, perceived complexity of specialty, and lack of access to role models have been identified as the primary barriers to doctors choosing a career in nephrology.

We developed the UK Kidney Starter Network to address these barriers; a free, peer-facilitated support network for early-career doctors and students with an interest in renal medicine.

Method:
Initially branded as "The UK Kidney Association (UKKA) Renal Starter Club", the network was launched in July 2022 and runs closely with the annual UKKA Taster Day and Crash courses. By joining a national mailing list run by the UKKA, members have access to free quarterly email newsletters, in addition to personalised advice and guidance. Newsletters are used to advertise kidney educational and training events and conferences, triaged to be appropriate to the needs of early-career doctors. Founders work to achieve discounted prices for members at such events.

In 2025, the group was re-branded as "The UK Kidney Starter Network" and launched across social media networks; Instagram, Facebook and LinkedIn.

Results:
189 members are currently subscribed to the mailing list, representing an 18% increase since 2024. Peak sign-up rates occur in January and July, coinciding with the Renal Taster Day and Crash Course events. Average email open-rate is 80%, and click-through rate is 12%.

A survey of mailing list members suggested key demands were "suggestions for kidney-related audit / quality improvement projects" (82.4%), "information about upcoming courses, conferences and events" (76.5%) and "clinical fellow job advertisements" (52.9%).

Members heard about the network through the Renal Taster event (29.4%), word-of-mouth (17.6%), training programme administrators (17.6%) and social media (11.8%).

Discussion:
The surging membership of The UK Kidney Starter Network demonstrates the demand for peer-led support of early-career nephrologists. However, the translational benefit of

network membership into successful higher specialty applications remains uncertain. Previous mailing list feedback survey had limited responses. We anticipate expansion onto social media platforms will provide greater data analytics to measure engagement and guide future content creation.

Scope for future growth includes increasing awareness among senior colleagues and training programme directors, use of this platform to advertise clinical fellow posts and academic opportunities. An expansion of the events programme is planned, to include an interview course, and annual networking event. To ensure succession over coming years, expansion of the committee will also be required.

Acknowledgements:
We would like to thank the UKKA for their ongoing secretariat support of the UK Kidney Starter Network.

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TC4

Delivering a national simulation training day for newly appointed renal registrars

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Introduction

Simulation-based education (SBE) is a well-evidenced teaching modality. A network of Scottish educators engaged in renal SBE recognised the need to formalise SBE for renal higher specialty trainees. A national training day aiming to prepare new renal registrars was designed and delivered twice in separate training years.

Methods

Renal trainees new to the renal training programme were invited to participate in a free-of-charge one-day course. Faculty included renal consultants, senior registrars, advanced nurse practitioners and staff nurses. A flipped classroom approach was utilised to enable high-level discussion and appraise non-technical skills. The course composed of three workshops in its first iteration – high acuity clinical scenarios, on-call referral telephone scenarios and non-tunnelled central venous catheter (TCVC) insertion mastery. The second iteration replaced the TCVC mastery with additional immersive high acuity scenarios after course feedback. Faculty and participant evaluation was sought through anonymous pre and post-course questionnaires.

Results

Thirteen participants have attended the course, with a heterogenous range of prior experience in renal medicine, ranging from 2-36 months. Although most indicated prior experience of assessing unwell patients with renal disease, only 66.7% felt prepared to lead cardiopulmonary resuscitation in haemodialysis patients and 33.3% felt prepared to manage life-threatening access complications. Prior to the course 58.3% of participants felt confident providing renal advice for patients in a remote location, 75% felt confident to risk assess patients referred by telephone and 66.7% felt confident to determine stability for dialysis.

All participants rated the session as extremely relevant in their development as a renal registrar. After the course, 100% of participants either strongly agreed or agreed that they felt prepared to lead the resuscitation of patients undergoing dialysis in cardiac arrest, manage life-threatening dialysis access complications and risk assess unwell patients referred by telephone. The majority of participants strongly agreed or agreed they felt confident providing advice for patients in a remote location (91.7%) and 83.3% of

participants strongly agreed or agreed they felt confident assessing the stability of patients in receiving dialysis.

The immersive high-acuity scenarios were rated as very realistic. Positive comments included: quality of scenarios, inclusion of a physical dialysis machine, the safe and supportive learning environment with multi-professional faculty, and available faculty expertise. All participants rated the on-call phone scenarios as very or somewhat realistic. Positive comments included: creation of a high-fidelity on-call phone experience with common challenges, good human factor scenarios and tailoring of simulation scenarios to an appropriate stage for higher specialty trainees.

There were mixed opinions regarding the usefulness of the NTCVC mastery session in the first course iteration given previous levels of prior experience (some participants already being independent with the procedure).

Conclusion

The initial iterations of the national renal simulation training day have had favourable evaluation which has provided evidence as a ‘proof-of-concept’. The course is currently unfunded and reliant on faculty enthusiasm and goodwill therefore its sustainability is fragile. The ambitions of the programme are to develop sustainable funding models and faculty development, and expand the involvement of non-medical members of the multi-professional team.

TC5

Development of a Regional Renal MDT Simulation course using co-production methodology with Patients

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Introduction

This project was to develop multi-disciplinary renal associated high-fidelity simulation sessions involving nursing, medical, pharmacy and other allied health profession staff. The main objective was to use patients as equal partners in the development. There was a mixture of acute kidney injury, chronic kidney disease, dialysis and transplantation associated cases exploring emergency skills, communication and human factors as well as considering cultural and behavioural differences in our patient population. The project was funded by the East of England Renal Network.

Method

The courses were full day with the aim to deliver 8 in the financial year. Each simulation session involved a 20 minute scenario followed by a 40 minute debrief when topics can be explored in depth. The course was advertised to all Renal units within the East of England.

The project focused on using patients as equal partners in the development of the simulation scenarios and involving them during the simulation days. There was an initial discussion forum with patient group (LAKPA- Lister Area Kidney Patient Association) to discuss what are the main issues that they have faced, and how we can create simulation scenarios to mimic this.

Likewise a patient or relative was also present as part of the faculty to share their experiences, thoughts and ideas on the day.

There was on-going help from LAKPA for advertising the sessions and recruitment of patients

Results

We have successfully run 6 simulations days so far and we are planning to complete the final 2 in this calendar year. The feedback has been very positive. We were able to ensure that a patient representative was present during every simulation day so far and the insights they have brought has been remarkable. Please see table one for the quantitative participant feedback. The scores are out of 10.

Qualitative feedback from participants:

- Deep discussions
- Whole experience was filled with so much knowledge. I am leaving this session with a different outlook on kidney care.
- ***was excellent. Having a patient attend is very beneficial.
- Nice to have patient perspective
- Having a transplant patient was very helpful

Conclusion

By involving LAKPA and considering cultural differences in our renal population, there was an opportunity for significant learning from simulating these cases. We were able to discuss important topics in the debrief, including cultural choices regarding DNACPR and language barriers in understanding dialysis. We believe it is vital that patients are including in the development and running of such educational events to ensure that learning is complete and worthwhile.

TC6

Educational strategies to improve the management of CKD in Primary Care

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INTRODUCTION
The management of earlier stages of chronic kidney disease (CKD) is often made more complex due to lack of clinical confidence of healthcare professionals. Alongside limited knowledge, access to support tools, competing priorities and reduced clinical confidence are all barriers faced by healthcare professionals working in primary care when diagnosing and managing people living with CKD.
In a bid to improve the management, a London based nephrology unit and integrated care board (ICB) collaborated to improve understanding and upskill clinicians in identifying, coding, and managing people living with CKD stages 1-5.

METHOD
Various members within the nephrology service were job planned to support and integrate care between primary and secondary care.

The development of one single referral form
A single point of access means reduction workload in primary care. Referring clinicians are provided advice and guidance on the management of their patient, or the patient may be accepted into a nephrology clinic (community-based CKD service or appropriate secondary care clinic e.g. diagnostics, lupus etc). The consultant-led triage service of these referrals is also used to provide brief targeted education on CKD.

Development of a detailed CKD pathway
As patients with long term conditions are routinely looked after by non-medical healthcare professionals in primary care (mainly nurses and pharmacists), the CKD pathway was updated to provide the relevant support tools required by all teams to aid identification, diagnosis, and management of CKD within GP practices. The pathway was built in consultation with relevant stakeholders.

An education programme to support CKD management in primary care
Nephrology have teamed up with the ICB's training hub and medications advisers to provide structural education sessions to primary care. The format of these sessions ranges from webinars, interactive Q&A sessions and presentations delivered either online or in person. The sessions are tailored to the needs of the audience to get maximum engagement.

An education programme to support patients newly diagnosed with CKD

Monthly webinars are also run by the members of the CKD team aimed at patients newly diagnosed with CKD to empower them on how to live well with CKD. The times of the sessions are varied to enable attendance by patients/ carers. Anyone can attend as long as they have been made aware of their diagnosis.

RESULTS

Local reporting data shows an improvement in number of patients coded with CKD from 2.89% (September 2024) to 3.03% (July 2025), closing the gap to national average (4.4%). Since the launch of the education sessions, an increase in the number of patients started on standard of care including statins ACEi/ ARBs and SGLT2i in primary care (figure 1) is noted.

LIMITATIONS

At present, we cannot calculate the proportion of patients coded with CKD that attended the webinars. This is mainly because presenters are bound by strict GDPR rules meaning attendees are anonymised and prior registration is not enabled.

CONCLUSION

The interventions were formalised by January 2025. While more work is needed, initial data demonstrates promising improvement CKD management within this London-based ICB.

TC7

Development of an Educational Tool to Support Training in Cardiorenal Metabolic Care within Harrow Primary Care Networks

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TUESDAY - Moderated Poster Session, HALL Q, March 10, 2026, 16:00 - 17:00

Introduction:
Cardiorenal metabolic (CRM) disease represents a convergence of obesity, diabetes, chronic kidney disease and cardiovascular disease, driving high morbidity and premature mortality. Addressing these conditions requires workforce development to enable holistic, preventative care across primary and secondary care. As part of the Harrow CRM Hub project, an educational framework was developed to train clinicians and wider staff working with people with CRM to deliver effective care.

Methods:
The design was undertaken by a multidisciplinary group comprising primary care clinicians, speciality clinicians and CRM project managers. The group mapped existing CRM-related resources across national and regional programmes and assessed them against the requirements of a comprehensive CRM training hub suitable for a range of primary care team members. The team used this to develop a bespoke educational.
The development process was iterative, involving multiple revisions and piloting with clinicians. Content was structured around three domains:
1. "Why" - understanding population needs and burden of CRM disease
2. "How" - operational delivery of the CRM pathway at primary care level
3. "Me" - developing personalised, patient-centred care skills

The tool combined evidence-based content with case studies, practical resources, and a tiered training framework (1) healthcare assistants and practice nurses; 2) non-prescribing clinicians; 3) prescribers and specialists.
Results:
The final training package included:
- Core slide set introducing CRM, its epidemiology, and clinical interactions.
- Resources focussed on prevention, early identification, and personalised lifestyle care planning.
- Practical resources, including case scenarios and EMIS templates.
- A tiered training framework specifying essential knowledge and skills for different roles.

Feedback from pilot sessions highlighted several strengths: clarity in presenting CRM as a single, integrated condition rather than siloed diseases; improved staff confidence in lifestyle medicine and health coaching; and increased understanding of personalised care approaches. Clinicians valued the structured format and local relevance, while non-clinical

staff appreciated accessible materials to support patient engagement. Suggested refinements included simplification of some modules and the addition of visual summaries to aid rapid learning.

Discussion:

The development of a CRM educational tool has addressed a gap in available training for integrated, multidisciplinary management. By bringing together expertise from primary and secondary care and embedding iterative feedback, the tool ensures relevance and usability across diverse primary care teams. It is designed to support sustainability of the CRM pathway by equipping staff with the knowledge, skills, and confidence to deliver proactive, patient-centred care. Next steps include formal rollout across Harrow and making the module freely available to support wider adoption and develop patient education materials about CRM. Formal evaluation of its impact on staff knowledge, confidence, and patient outcomes will be essential to inform scale-up of the CRM model.

Conclusion:

A bespoke educational resource for CRM hubs was developed through a collaborative, multidisciplinary process. The tool provides a structured, locally relevant framework for training staff across primary care in the delivery of CRM pathways. Wider implementation and formal evaluation of its impact on staff knowledge, confidence, and outcomes will be the next step in supporting scale-up of the CRM model.

TC8

Supervising non-medical prescribing students: Student's feedback

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TUESDAY - Moderated Poster Session, HALL Q, March 10, 2026, 16:00 - 17:00

Renal units have many non-medical prescribers (NMP), in various roles who will have been trained to the standards as set out by the Royal pharmaceutical society competency framework, (2021). A Designated Prescribing Practitioner's (DPP) role is to assess a NMP student's ability ensuring they have shown evidence that they meet the competencies. The DPP is accountable for the final sign off for the NMP student. Designated Prescribing Supervisors (DPS) provide direct supervision and guidance for the NMP student to be supported to achieve the standards.
According to RPS (2019) both DPP and DPS need to demonstrate characteristics such as professional skills and knowledge as well as teaching and training skills prior to taking on the role. They are expected to work in partnership with the student, prioritising patient care and develop within the role. They also have to provide a good learning environment and governance guidance.
It is essential the DPP and the DPS work with the NMP student to provide supportive learning opportunities to allow them to develop and learn, to achieve competence to prescribe within their clinical role.
Whilst there was guidance of what a DPP and DPS should provide there was no formalised feedback system in place.

Method

A feedback form was devised using open and closed questions assessing the general expectations. In order to receive honest feedback, students sent this feedback to a collator and had the option of keeping the feedback anonymous.
A pilot form was completed by 10 students and specific feedback requested about the ease of use and time taken to complete. The form was adjusted and digitalised and sent to all 37 students completing the course in the trust in the summer of 2024.

Results

10 out of 37 forms were returned with one having no comment about their DPS.
1 out of the 10 did not want their feedback shared with their mentors.
Common themes were similar for the DPS and DPP which described them to be approachable, supportive, flexible and generous with their time. However, one comment said they gave no praise or support.
Anecdotal praise was given for the form "much more meaningful (feedback). Thank you" And "I am not sure I would have known about a negative situation without it".

Discussion

In order to improve, feedback needs to be given. This form allows the NMP students a way to deliver this in structured way, which allows the NMP lead to have a greater understanding of the students experience and if needed, the option to investigate further.

Most students were complimentary of their DPS and DPP and were happy for this feedback to be shared.
The benefit for the DPP/ DPS is they have formal feedback to assist with appraisals or if needed for revalidation and are able to improve their practice as a result.
This was the first time this form was used and further data will be available following this year's cohort responses.

TC9
BUILD

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TUESDAY - Moderated Poster Session, HALL Q, March 10, 2026, 16:00 - 17:00

B.U.I.L.D your skills in Peritoneal Dialysis

A well-debated concern is how to keep inpatient staff competent and confident in providing peritoneal dialysis (PD). This challenge is intensified by the high turnover of staff and low admission rates for PD patients, which can lead to reduced competencies and confidence among the inpatient team.

To address this issue, we implemented a targeted educational program aimed at empowering ward staff to deliver high-quality care to patients receiving peritoneal dialysis. The B.U.I.L.D. training model included a study day on peritoneal dialysis for all participating ward nurses, the participating nurses were all band 6 nurses, as this was deemed to be the group most likely to encounter and direct care and treatment plans for patients receiving peritoneal dialysis whether on the ward as an inpatient or providing support out of hours to patients at home on peritoneal dialysis.

The nurses followed a two-week schedule of practical and theoretical experiences within the PD department. Each participant received an educational pack holding competencies categorised as essential or desirable based on the nurse's grade and experience in the department, supported by research & evidence-based methodologies.

The B.U.I.L.D. training model stands for:

- B: Bag Exchange
- U: Urgent Start
- I: Injecting
- L: Line Change
- D: Dressing

To assess the training's effectiveness, we conducted pre- and post-questionnaires to evaluate competencies and the overall impact of the B.U.I.L.D. model. We are confident that this approach did streamline training and enhance the care provided to both inpatients and outpatients receiving peritoneal dialysis, improving patient experience.

Patient feedback highlighted how well the inpatient nurses were able to troubleshoot issues related to peritoneal dialysis. The most significant improvement was seen when the peritoneal dialysis team was reduced, allowing inpatient nurses to rotate into the PD department and provide comprehensive coverage and support across all areas.

The final stage will be to convert the training from Face to face simulation to virtual reality simulation using headsets to enable immersive and engaging learning to suit the different development needs and provide flexibility for inpatient staff, as time to develop and educate becomes an ever increasing challenge within our work place. This will hopefully provide safe repeated practice of procedures and so embed good Peritoneal dialysis practice for all staff that will in turn provide an enhanced patient experience and allow staff to keep up to date and feel confident when caring for an inpatient receiving peritoneal dialysis, and reduce the time needed to allocate training areas, teams and equipment for practical work stations and study days in these challenging times.

" The future depends on what we do in the present" Mahatma Ghandi

TC10

Enhancing Health Care Professional Engagement with Kidney PREM Across Yorkshire & Humber

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TUESDAY - Moderated Poster Session, HALL Q, March 10, 2026, 16:00 - 17:00

Introduction

The Kidney Patient Reported Experience Measure (Kidney PREM) is a national survey designed to capture the experiences of people living with kidney disease across the UK. This data is essential for understanding the quality of care from the patient's perspective and identifying areas for improvement.

In 2025, Yorkshire & Humber (Y&H) took a new approach to increase health care professional (HCP) engagement with PREM results. Traditionally shared during a single regional meeting, the strategy was adapted to bring the data directly to local teams, aiming to expose more staff to patient feedback and promote action at the unit level.

Methodology

To implement this approach:

- The Y&H Lead Nurse contacted all regional kidney units to offer department-level presentations of PREM results.
- The Kidney Quality Improvement Partnership (KQIP) Programme Manager (PM) coordinated logistics, scheduling sessions during existing departmental meetings.
- A tailored slide deck and unit-specific PREM posters were developed and presented in each meeting, with materials circulated to all attendees.

This localised method allowed for meaningful conversations around the data within the context of each unit's operational realities.

Results

- Engagement increased significantly - see table 1
- Each unit now has a PREM poster ready to display and use for discussions with patients.
- Key discussions included:
  - Addressing concerns raised by haemodialysis (HD) patients, particularly around communication and care experience.
  - Reinvigorating the Shared HD Care Programme, which had stalled post-pandemic.
  - Exploring ways to involve patient forums, volunteers, and the Kidney Patient Associations (KPAs) in both data collection and dissemination.
  - Engaging transplant clinics and admin staff in PREM promotion to reach a broader patient cohort.

In some settings, there were barriers (e.g., lack of KPA or staff capacity), but plans were initiated to overcome them, such as involving the new Kidney Information Network (KIN) or liaising with volunteer services.

Conclusion

This case study highlights that embedding PREM engagement into local clinical team meetings is a practical and effective strategy. Key outcomes include:

- Significant increase in the number of HCPs exposed to and engaged with PREM data.
- Improved visibility of patient feedback through custom posters and local discussions.
- Greater sense of shared responsibility for data collection and quality improvement.
- A foundation laid for more meaningful improvement initiatives, with the full impact expected to be reflected in 2025 PREM results.

TC11

Supporting dialysis staff through a visual pocket guides: Enhancing onboarding, confidence, and clinical safety.

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TUESDAY - Moderated Poster Session, HALL Q, March 10, 2026, 16:00 - 17:00

Introduction

Starting work in a dialysis unit can be both exciting and overwhelming. Whether newly qualified or transitioning from another clinical area, staff must quickly adapt to a highly specialised and fast-paced environment.

Evidence highlights the need for accessible resources that support staff well-being and reduce the pressures of increasing workloads. Effective onboarding tools are linked to improved staff retention, job satisfaction, and overall patient safety. In particular, concise, portable educational aids have been shown to enhance clinical decision-making, standardise best practices, and reduce anxiety among new practitioners. These tools help foster a sense of preparedness that is critical for success in dialysis care.

Methods

A survey was distributed to 20 dialysis unit staff, including nurses and technicians with a range of experience levels: from less than one month to over ten years. The questionnaire comprised 13 questions designed to gather input on the desired content for an educational resource, as well as preferred formats for information delivery and retention.

Based on survey findings, a prototype pocket guide was developed to support new dialysis staff entering this highly specialised and critically important area of practice. The guide was also intended to serve as a practical refresher for more experienced colleagues.

The prototype guide was distributed to staff members who volunteered to pilot the resource in clinical practice. Informal feedback was collected regarding its usability, relevance, and perceived impact on confidence and workflow.

Results

Among the 20 participants 90% expressed a preference for a pocket guide comprising 10–20 pages. Respondents highlighted the importance of including concise, high-yield content covering:

· Common dialysis complications and corresponding interventions

· Normal laboratory values relevant to dialysis care

· Emergency procedures

· Blood tests and associated vacutainer tube colours

· Cannulation techniques

· Machine troubleshooting guidance

The feedback underscored a strong demand for a compact, easy-to-navigate resource that could support both knowledge retention and confident clinical decision-making during routine and emergency scenarios. According to staff feedback, the pocket guide has been really helpful because it is easy to carry and gives quick, clear and reliable guidance when they need to double-check a haemodialysis procedure or a certain protocol for patient care. Overall, the feedback highlights that the pocket guide enable staff to check procedure and clarify unfamiliar interventions without leaving the patient's side or interrupting workflow.

Conclusion

The pocket guide serves as a practical bridge between initial training and the development of long-term expertise, supporting safe and consistent care delivery in high-pressure dialysis settings. This project highlights the value of visual learning aids and quick-reference tools in easing the transition for new dialysis staff while also reinforcing knowledge among experienced team members.

By incorporating visual elements such as diagrams, colour-coded cues, and concise summaries, the guide makes complex procedures more accessible and memorable. Early feedback suggests these features enhance understanding and knowledge retention, reduce anxiety, and promote greater clinical confidence.

Overall, these findings support the integration of portable, visually engaging educational tools into dialysis unit onboarding programmes, with potential to improve both staff experience and patient outcomes.

TC12

Iterative design of PoCUS training in a developing country

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TUESDAY - Moderated Poster Session, HALL Q, March 10, 2026, 16:00 - 17:00

The swift evolution of Point of care ultrasound (PoCUS) as an imaging modality has transformed bedside diagnostic and decision-making practice across all medical specialties. Nephrologist-operated PoCUS incorporates renal ultrasound for anatomical assessment, volume status assessment through focused lung, cardiac and abdominal vein scans along with real-time ultrasound imaging for improved catheter placement and fistula assessment. The development of these techniques has solidified the role of PoCUS, facilitating patient assessments done non-invasively with precision and timeliness, especially in internal medicine, emergency medicine, critical care and nephrology.

As a portable, increasingly affordable and easy-to-use modality, PoCUS is being widely incorporated into practice, particularly in resource poor settings. The caveat being that well calibrated training resources and certification programmes are crucial to deliver safe and competent practice and guarantee high-quality patient care.

Following the successful delivery of 2 ISN-certified PoCUS courses for nephrology consultants and trainees in Pakistan, we developed, improved and delivered the third PoCUS course this year. The first 2 courses allowed iterative development and created a faculty of mentors who facilitated the 3rd course. The 2025 PoCUS course was the largest of its kind in scope, attendance and logistics. The integration of a more structured and comprehensive procedures logbook, final assessment done digitally to ensure transparency, efficiency and clarity along with a well-designed and executed OSCE style practical examination, done with standardised, calibrated marksheets, set this iteration of the course on a new level of excellence. Along with ISN support, it was also recognised and certified by the College of Physicians and Surgeons of Pakistan (CPSP), the organisation responsible for all postgraduate training in the country. The venue was a tertiary care, centre of excellence in Islamabad, helmed by the president of the Pakistan Society of Nephrology.

With an initial expression of interest from 60+ candidates, a total of 37 students attended the course. 34 candidates (92%) successfully appeared in the final

assessments and passed the course. The criteria to successfully pass the course included mandatory pre-course online lectures (with minimum 60% attendance), completion of a procedures logbook as well as successfully passing both the written MCQ and OSCE style practical assessment. The median pass-mark was 75% in the written examination demonstrating effective consolidation of knowledge. With the large candidate cohort, the OSCE was designed and conducted in 2 carousels running in parallel. Quality assurance and parity was maintained using well-defined, structured marksheets that were pre-agreed and calibrated unanimously with the course faculty. The feedback from the course candidates, organising and teaching faculty as well as the CPSP officials was overwhelmingly positive. Over the 3 courses, 71 candidates passed the PoCUS course and from the high performing candidates, 30 mentors have been credentialed to continue PoCUS training.

The development, availability and accessibility of portable, handheld and affordable ultrasound devices, mandates the need for structured, well designed and quality assured training programmes and accreditation pathways. This is essential for the effective, safe and sustainable deployment and incorporation of PoCUS into clinical practice across all medical specialties.