TJ1

Culturally tailored Islamic dietary guidance for patients with Chronic Kidney Disease

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

Introduction
Chronic Kidney Disease (CKD) disproportionately affects people from ethnically diverse backgrounds. Conventional renal dietary resources often lack cultural and spiritual relevance, creating barriers to engagement and adherence. Many resources overlook the religious practices and cultural needs of Muslim patients, including guidance during Ramadan and the role of Prophetic (Sunnah) foods. To address this gap, a patient information leaflet (PIL) was developed that integrates renal dietetic principles with Islamic teachings. The project was designed as a co-produced service development initiative, grounded in equity, diversity, and inclusion (EDI) principles, to promote health equity in renal dietary education.

Methods
The project was undertaken in 2025 using a community-based participatory research approach, with patient and public involvement at every stage. Two Muslim Specialist Renal Dietitians led the work with support from a Kidney Dietitian Specialist Group (KDSG). The development process began by identifying unmet dietary and religious needs through patient feedback and clinical observations. Renal dietary restrictions related to potassium, phosphate, sodium, and fluid were mapped against Islamic practices and commonly consumed Sunnah foods, using guidance from the Quran, hadith, and NICE NG203 guidance. Draft content was developed in collaboration with patients, community representatives, dietitians, and faith leaders to ensure both medical accuracy and cultural relevance. The leaflet's language and format were refined in stages based on patient and MDT feedback to make it clear, accessible, and culturally sensitive. The PIL was then tested in one-to-one consultations with Muslim patients with CKD to assess acceptability, relevance, and usefulness before wider distribution.

Results
The co-produced PIL provides faith-sensitive dietary guidance that addresses renal restrictions while contextualising them within Islamic teachings. It includes practical advice on fasting during Ramadan and guidance on Sunnah foods such as dates, honey, barley, and black seeds, with clear renal-specific recommendations. The tone of the resource is affirming and incorporates Islamic etiquette such as moderation, intention, and gratitude. Patients reported that the inclusion of Islamic references increased trust in dietary advice, reduced uncertainty around fasting, and improved confidence in applying recommendations. They felt acknowledged and respected in their religious identity. Dietitians reported greater confidence in supporting Muslim patients, and Multi-Disciplinary Teams (MDT) found the resource a valuable tool for enhancing cultural competence.

Discussion

This project demonstrates how a collaborative, patient-focused approach can produce culturally relevant dietary resources that meet the needs of underserved groups. The Islamic renal PIL shows that aligning medical advice with religious beliefs can improve engagement, trust, and adherence. The approach is transferable and could be adapted for other under-represented populations, translated into different languages, and incorporated into group education. Framing this work within an EDI and health inequalities agenda highlights the role of culturally tailored resources in delivering equitable, patient-centred renal care.

TJ2

Ten-year trends (2012-2022) in obesity prevalence in patients receiving haemodialysis and peritoneal dialysis: an exploratory analysis

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

Introduction

Over 1 in 4 UK adults live with obesity. For those with kidney failure, obesity can impede optimal kidney care including limiting access to kidney transplantation. Obesity is common in patients with kidney disease with global estimates suggesting it impacts 25-50% of individuals. However, limited data are available in the UK on obesity prevalence or obesity trends in people receiving dialysis. The aim of this audit was to evaluate the 10-year trends in obesity prevalence in people receiving dialysis in a large inner city teaching hospital.

Methods

A retrospective audit was conducted of data collected prospectively between January 2012 to December 2022. Adults receiving haemodialysis (HD) and peritoneal dialysis (PD) were included. Body-mass index, based on dry weight, was recorded during the Renal Dietitians' annual nutritional assessments. Linear regression determined trends in the proportion of patients with obesity (defined as a BMI of ≥30kg/m2). Data is not included from 2020 influenced by the COVID-19 pandemic.

Results

Data represented 499 patients on haemodialysis in 2012, progressively increasing to 740 patients in 2022. 131 patients receiving peritoneal dialysis were included in the 2012 audit, with 106 in 2022. In 2022, 25.2% of adults in this haemodialysis cohort lived with obesity. This proportion has remained statistically stable over the last 10 years (slope 0.2%/year; 95% confidence interval -0.46-0.43). The proportion of people living with obesity on peritoneal dialysis in 2022 was 21%. Some annual fluctuation in the data was seen and the observed slope was negative; however, this finding was not statistically significant (slope -0.45%/year; 95% confidence interval -1.5-0.61) (see figure 1).

Discussion

These findings reveal that in 2022, 1 in 4 patients in this haemodialysis cohort, and more than 1 in 5 patients in this peritoneal dialysis cohort, lived with obesity. These figures are consistent with, or greater than, the obesity levels observed locally in the London region (21%, Health Survey for England, 2024). Non-significant changes in the proportion of patients with obesity receiving dialysis were observed in this data. This contrasts with a slight rise in proportion living with obesity over the past decade nationally. The high rates of obesity observed in this population highlights the need for access to appropriate obesity interventions to prevent the potential negative impact of this modifiable health inequality on optimal kidney care.

TJ3

Enhancing patient care via nutrition training for the renal care team

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

Introduction
Chronic kidney disease (CKD) is a progressive condition affecting more than 10% of the UK population and is associated with multiple co-morbidities. Specialist kidney dietitians provide complex, individualised dietary advice to slow disease progression and manage complications. In addition to dietitians, the renal care team (RCT) is well placed to support patients with dietary advice. However, research shows 58% of non-dietetic renal healthcare professionals provided dietary advice to patients, without appropriate training. This can lead to dietary misinformation, unnecessary restrictions, and poorer health outcomes. Within our trust the RCT had not previously received structured training in renal nutrition. Furthermore, patient feedback identified a need to improve staff knowledge to ensure safe, consistent dietary messaging.

Methods
A training programme was developed using current renal nutritional guidelines, and trust protocols. Content focused on key areas of renal nutrition, including the causes and dietary management of hyperkalaemia, hyperphosphataemia, undernutrition, fluid and salt balance, glycaemic control, texture-modified diets, and oral nutritional supplements. The programme included a PowerPoint presentation, an interactive quiz and nutritional supplement tasting to enhance participant engagement. Senior RCT members were invited by email to enrol themselves and junior staff into preset sessions. A link to electronic pre and post training questionnaires were provided. Questionnaires contained open text boxes, closed questions and Likert scale from 0 (“not confident”) to 5 (“very confident”). Pre-training questionnaires assessed existing practice and confidence levels, while post-training questionnaires evaluated impact. Data from both questionnaires was analysed using Microsoft Office Excel to assess changes in knowledge and perceived usefulness of training. Results were fed back during local clinical governance and staff meetings.

Results
Thirty-seven RCT members (95% registered nurses) and six trainee dietitians attended the training. Pre-training questionnaires (n=43) revealed 90% of participants had given dietary advice to patients, with 35% scoring themselves a 4 or 5 out of 5 in confidence in giving dietary advice (Figure 1). Additionally, 22.5% of attendees scored their understanding of kidney nutrition a 4 or 5 out of 5.
Post-training questionnaires (n=29) revealed improved confidence with providing dietary advice (Figure 1), with participants highlighting the interactive quiz as particularly engaging. Furthermore, 100% found the session useful for their job role and 97% (n=28) advised the training programme would be valuable to new starters.

Discussion

The training programme improved the RCTs confidence with giving dietary advice and was positively received by the RCT. Unexpected benefits included enhanced rapport between the RCT and the kidney dietitians.
Challenges identified included staff fatigue and reduced engagement among ward staff and senior doctors. To maximise participation, further discussions with senior RCT members will be required. Providing protected continuing professional development time may also be necessary, alongside establishing regular annual training dates. Review of dietary misinformation from the patient's perspective, will help to determine wider impacts of this training programme. In addition, training could be essential to reduce dietary misinformation and ensure patients with CKD receive accurate, safe, and consistent dietary guidance.

TJ4

Lost in Translation: Gaps in Online Dietary Guidance for Patients with Chronic Kidney Disease

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

Introduction:
Dietary management is a cornerstone of chronic kidney disease (CKD) and haemodialysis care, influencing electrolyte balance, cardiovascular outcomes, and overall quality of life. Patients increasingly seek dietary information online, yet the accuracy, completeness, and guideline alignment of these resources remain unclear. Misleading or incomplete advice can contribute to confusion, non-adherence, and suboptimal clinical outcomes. To date, there has been no systematic assessment of UK-focused online dietary resources for CKD and dialysis patients. This study aimed to evaluate the quality, readability, and guideline alignment of first-page Google search results for renal diet information.

Methods:
A structured review of the first 10 Google UK search results for “kidney diet” and “dialysis diet” was conducted in July 2025. Websites were independently assessed by two clinicians with nephrology and renal dietetics expertise. Content was evaluated across six domains: protein, potassium, phosphate, sodium, fluid management, and micronutrients/vitamins. Readability was assessed using the Flesch–Kincaid grade. Guideline concordance was benchmarked against NICE CKD guidance and Kidney Disease Outcomes Quality Initiative (KDOQI) nutrition recommendations. The proportion of sites referencing evidence-based guidelines, including stage-specific and dialysis-specific recommendations, was recorded. Discrepancies were resolved by consensus.

Results:
Twelve unique websites were analysed, including NHS (3), National Kidney Foundation (1), Mayo Clinic (2), Healthline (2), Medical News Today (1), and patient blogs (3). Sodium restriction was mentioned in 85% (n=10/12) of sites, protein in 60% (n=7/12), potassium in 45% (n=5/12), phosphate in 30% (n=4/12), and fluid management in 25% (n=3/12). None addressed all six domains. Only 3/12 (25%) explicitly referenced NICE or KDOQI guidelines. Dialysis-specific protein recommendations were correctly represented in 2/7 sites discussing protein. Readability scores averaged Flesch–Kincaid grade 11.2 (range 9–13), exceeding recommended patient education levels. Only 2/12 (17%) offered culturally adapted dietary advice, and no sites included practical tools such as meal plans or calculators.

Discussion:
Online dietary information for CKD and haemodialysis patients is widely accessible but frequently incomplete, poorly referenced, and challenging to read. Critical gaps include phosphate and potassium guidance, dialysis-specific protein requirements, micronutrient supplementation, and culturally relevant content. These deficiencies risk misinformation, patient anxiety, and non-adherence. This analysis highlights the urgent need for evidence-

based, patient-friendly, culturally sensitive online dietary resources to support safe and informed self-management in kidney disease.

TJ5

Intradialytic Parenteral Nutrition: a survey exploring UK practice and dietitians' views

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

Background: Intradialytic Parenteral Nutrition (IDPN) is a supplementary form of nutrition in people undergoing haemodialysis treatment. It is used to reduce the risk of protein-energy wasting which is known to be associated with higher risk of adverse events including mortality. UK clinical practice guidelines suggest IDPN may be considered when oral or enteral intake is inadequate. However, there is a lack of evidence demonstrating its effectiveness. Whilst small observational studies and trials have demonstrated potential benefits associated with IDPN use, the largest randomised controlled trial (n=186) in the past 20 years did not show any improvement in nutritional parameters or mortality rate with the use of IDPN.

The aim of this survey was to identify IDPN usage across UK renal centres including perceived facilitators and barriers.

Methods: A survey, targeted at kidney dietitians, was developed to capture IDPN use within UK renal centres, including: i) use of guidelines for commencing IDPN ii) auditing practices iii) perceived facilitators and barriers of using IDPN. The survey was distributed electronically via the BDA Kidney Dietitian Specialist Group (KDSG) in April 2025.
Results:

- 26 responses were received from 20 of the 67 adult renal centres in the UK (30% of UK renal centres represented).
- 13 of 20 centres (65%) use IDPN.
- 12 of 13 (92%) follow IDPN guidelines (local or from another Trust) alongside multidisciplinary team (MDT) assessment and 1 of 13 (8%) use MDT assessment without a guideline.
- The majority of centres using IDPN (12/13, 92%) do not audit the effectiveness.
- 11 of 13 (85%) reported support from doctors and the MDT, and 9 of 13 (69%) reported experienced colleagues and local clinical guidelines, facilitated the use of IDPN in their Trust.
- Of the centres not using IDPN, the barriers were reported as the lack of evidence (6 of 7, 86%) following by inadequate staff training and cost of IDPN (5 of 7, 71%).

Discussion: The majority of responding centres reported the use of local guidelines on IDPN prescribing; there is an absence of national guidance. Whilst comparing guideline criteria was beyond the scope of the survey, national clinical guidelines are considered to improve patient outcomes and cost-effectiveness. Limited evidence was identified as the biggest barrier to not using IDPN; a finding supported in existing literature. KDOQI guidelines have recommended adequately powered and long-term clinical trials to evaluate the

independent effects of IDPN compared with oral nutritional supplementation on nutritional status, morbidity, mortality, and quality of life.

Conclusion: The majority of UK renal centres are currently using IDPN despite an absence of data to prove clinical benefits. A national guideline would help support consistent national practices; achieving this would in turn offer scope to undertake a national clinical audit to help evidence the effectiveness of IDPN.

TJ6

Optimizing Hyperkalaemia Management in Haemodialysis: The Role of Potassium Binders and Dietetic Involvement

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

Background:
Hyperkalaemia is a common, potentially life-threatening complication in chronic kidney disease (CKD) due to reduced renal potassium excretion. The European Resuscitation Council classifies hyperkalaemia as mild (5.5–5.9 mmol/l), moderate (6.0–6.4 mmol/l), or severe (≥6.5 mmol/l) pre haemodialysis (HD). Management typically involves a combination of dietary intervention and potassium-lowering medication. NICE guidelines recommend dietary advice in conjunction with pharmacological treatment, with patiromer or sodium zirconium cyclosilicate (SZC) permitted in the UK only when persistent hyperkalaemia is confirmed at potassium ≥6.0 mmol/l.
Methods:
A retrospective audit was undertaken across six HD units in May 2025. Of 1,400 patients, 39 were prescribed potassium binders. Data were collected and analysed from two electronic record systems. Key variables included:

- Serum potassium at dietetic referral and following dietetic review.
- Potassium at initiation of a binder and six months later, with assessment of whether the target (<6.0 mmol/l) was achieved.
- An awareness of what confounding factors such as dialysis adequacy (Kt/V), use of renin–angiotensin–aldosterone system (RAAS) inhibitors, and other medications influencing potassium.

Results:
Dietitian referral was documented for 80% of patients prior to binder initiation; 77% were identified through dietetic screening and 23% referred by the wider MDT.

- Mean serum potassium at referral was 6.52 mmol/L.
- Following initial dietetic intervention, potassium decreased to 5.44 mmol/L, with 29 patients (75%) achieving <6.0 mmol/L.
- A discussion between the consultant and dietitian at binder initiation was documented in 53% of cases.
- Binders were initiated at a mean potassium of 6.8 mmol/L, which reduced to 5.8 mmol/L at six months, with 23 patients (59%) maintaining potassium <6.0 mmol/L.
- Prescription length varied, and medications often remained on drug lists despite uncertainty about dispensing or adherence.
- Binder review within six months occurred in only 42.3% of patients.
- SZC was the most frequently prescribed agent (n=34), yielding a mean final potassium of 5.40 mmol/L with 55.9% achieving control. Patiromer (n=4) produced a lower mean final potassium of 4.75 mmol/L, with 60% achieving control.

Discussion and Conclusion:
Potassium binders effectively reduced serum potassium, yet sustained control was achieved in only 59% of patients after six months, reflecting challenges with adherence, monitoring,

prescription continuity, or binder efficacy. Dietitian involvement was associated with marked early improvements, reinforcing the importance of dietary support. However, the rebound in potassium highlights the need for structured follow-up, repeated reinforcement, and consideration of patient health literacy to support long-term behaviour change.
Documentation was suboptimal, with only 53% of cases recording consultant–dietitian discussions and fewer than half of patients reviewed within six months of binder initiation. This highlights the need for clearer pathways, local standards, and robust multidisciplinary collaboration.
Overall, the audit demonstrates that potassium control in dialysis patients is improved by integrated dietary and pharmacological management, but optimisation requires structured follow-up, consistent documentation, and stronger MDT communication.

TJ7

Exploring the use of GLP-1 and GIP/GLP-1 medications in people on renal replacement therapy, an observational cohort study.

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

Background:
Excess body weight can limit access to kidney transplantation, with a Body Mass Index (BMI) ≥ 37 kg/m² used as a local threshold for eligibility. GLP-1 and GLP-1/GIP receptor agonists are increasingly prescribed to support weight loss in patients with chronic kidney disease (CKD). However, without appropriate nutrition counselling, these medications may contribute to malnutrition and sarcopenia—both common in this population. Their use in the local renal replacement therapy (RRT) population was not well understood.

Aim:
To explore local use of GLP-1 and GLP-1/GIP medications in individuals receiving haemodialysis (HD) or peritoneal dialysis (PD), and assess their impact on BMI, transplant eligibility, and nutritional support.

Method:
A retrospective review of the Proton renal IT system was conducted in September 2025. Patients on HD or PD with GLP-1 or GLP-1/GIP medications listed in their records were identified. Data collected included demographics, diabetes status, BMI and weight at medication start date compared to current weight, use of multivitamins or nutritional supplements, and transplant eligibility based on BMI < 37 kg/m². Descriptive statistics were used.

Results:
Forty patients were identified (60% male, mean age 60 years). Thirty-five were on HD (3.1% of 1117 patients on HD) and five on PD (2.6% of 191 patients on PD). Type 2 diabetes was present in 80% of HD patients and all PD patients. Semaglutide injection was the most prescribed medication (28%), followed by Tirzepatide (23%), Semaglutide tablets (20%), Liraglutide (17%), and Dulaglutide (12%).
Among 33 patients with complete baseline BMI data, the mean starting BMI was 37.9 kg/m² (SD = 6.8) and ranged between 28.2 - 55.4kg/m2. At the time of data collection (September 2025), 25/40 (63%) were still on medication with a median duration of 10 months (range 2-69 months). Of 23 with complete data, 12 (52%) had reduced their BMI, with a median weight loss of 9% (range 2.1–19%). Of the 15 who discontinued treatment, 11 had complete data, and 7 (64%) showed BMI reduction, with a median weight loss of 9.9% (range 1.1–14%). 9/40 (23%) were prescribed multivitamins and 2/40 (5%) oral nutritional supplements. Transplant eligibility improved from 18/33 (55%) at baseline to 23/33 (70%) at follow-up.

Discussion

GLP-1 and GLP-1/GIP use in RRT patients showed promising weight loss, with five more patients meeting transplant criteria. Incomplete data limited analysis. Non-response or side effects may explain lack of weight loss in some, but this information was not accessible. Despite data showing the presence of nutritional support measures, other dietetic activity was not captured. Structured weight loss interventions have been shown to improve outcomes (White et al., 2024).

Conclusion:
GLP-1 and GLP-1/GIP medications are being used in the local RRT population, with over half of the patients showing meaningful weight loss and increases in transplant eligibility. Better integration of dietetic care may enhance outcomes, both in terms of weight loss but also nutritional adequacy.

TJ8

Case report: Dietetic management of a twin pregnancy on haemodialysis

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

Introduction:
Pregnancy on haemodialysis is uncommon, even more to see twin pregnancies and is challenging for both mothers due to long hours of dialysis and medical professionals due to depletion of nutrients and higher risks of complications.

The main precautions that must be taken with pregnant women on dialysis are the maintenance of low levels of pre-dialysis urea, management of renal anaemia, strict blood pressure control alongside care to avoid infections, nutritional deficits, changes in phosphorus-calcium metabolism and electrolyte fluctuations.

This was the first presentation of a female with identical twin pregnancy on dialysis to our unit. The aim of dietetic treatment: to maintain nutritional status/muscle mass and to correct any micronutrient deficiencies.

Methods:
A retrospective analysis of clinical notes of a pregnant patient with twins using electronic hospital notes.

Results:
Dietetic consultation started at 19 weeks' gestation and routine reviews every two weeks until delivery at 33 weeks.

Energy intake of (30-40kcals/kg) ideal body weight (IBW) +300kcals/d from 12+/40 gestation was advised.

Goal protein intake of (1.1-1.4g/kg) IBW was initially advised and increased to 1.8g/kg IBW and build up in dialysis frequency due to increased protein losses during intensive dialysis.

Oral nutritional supplements Renapro shot and Fortisip Compact Protein were offered if the patient was unable to meet protein requirements.

Omega-3 fats were encouraged (walnuts/oily fish). The patient did not like oily fish but was taking Pregnacare Max daily supplementation (contains 300mg) docosahexaenoic acid, to support foetal brain development. NHS pregnancy food safety advice given.

Fluids for this patient were not restricted as they maintained a large urine output.

Table.1 summarises nutritional biochemistry. Low potassium/ phosphate advice was not needed as electrolytes were within normal ranges and even prone to depletion.

Calcium was provided by dialysate, daily pregnancy supplementation and through diet. Vitamin D was monitored and supplemented with 400IU/day. Magnesium was within normal range at first dietetic assessment and then monitored as dialysis frequency was increased; compared to the increased dietary reference values for pregnancy.

Water-soluble vitamin replacement was commenced after first dietetic assessment and though suggested to renal consultant about doubling Renavit dose as HD was increased to 16hrs/week this did not occur. Folic acid 5mg/day commenced to prevent neural tube defects and high-risk pregnancy support. Zinc was deficient on first assessment and frequently monitored and targeted supplementation to prevent foetal abnormalities. Selenium was measured at the first assessment and was within normal ranges.

Mid upper arm circumferences (MUAC) and handgrip strength (HGS) to monitor protein status due to pregnancy induced weight gains (Table 2). Birth of the identical twins was at 33 weeks' and regular dialysis was no longer needed post-delivery.

Discussion:
Dietetic care is key in supporting the nutritional demands of pregnant women having regular dialysis. Nutrients prone to deficiency were protein, phosphate, potassium and zinc which were monitored and supplemented if necessary. MUAC & HGS measurements showed fat and protein status to guide dietetic assessments. Earlier dietetic intervention would help women to prepare for HD-supported pregnancies and to avoid the risk of nutrient depletion.

TJ9

Beyond the diet sheets! Using educational videos to improve patients' confidence, knowledge and engagement in salt and fluid management.

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

Background: Excess sodium consumption and fluid overload are associated with cardiovascular events, and adverse patient outcomes(1). Despite consistent dietary counselling, many patients receiving maintenance dialysis struggle to successfully manage their salt and fluid intake. Traditional patient dietary education using diet sheets has been increasingly challenging due to poor patient engagement and differing health literacy levels. Videos are increasingly recognised as an educational tool to address wider learning styles and needs, and to engage patients in a more accessible way.

Aim: To investigate the impact of using an in- house produced educational video on patient reported knowledge and confidence, and to explore patients' experience regarding salt and fluid management and education, through a patient questionnaire.

Method: A 6 minute long, subtitled, video about 'Salt and Fluid when receiving Haemodialysis' was created in-house by a Specialist Renal Dietitian. The content was based on key principles in salt and fluid management which are routinely delivered during a standard dietetic counselling.

Long standing dialysis patients with known challenges in managing their salt and fluid were identified by their unit's dietitian using routine clinical parameters, such as NTProBNP and IDWGs. The video was shown to 10 selected patients during their HD session, and the knowledge, confidence and general observations were investigated with the use of specifically designed pre and post video patient questionnaire.

Findings: Most patients had knowledge gaps in the key concepts in salt and fluid management, despite repeated education throughout modalities. Over 90% of the patients found the video easy to follow, understand and agreed that their knowledge and confidence about salt and fluid management increased after watching the video. The visually presented content helped patients to better understand key concepts such as reading food labels, 5g of salt as a household measure and recommended daily fluid allowance. The patients expressed their interest particularly in practical tips to manage their salt and fluid.

The video and questionnaire improved patient engagement dramatically, inspiring discussions and enabling them to self-identify potential dietary changes.

Conclusion: With an ever-increasing haemodialysis population, meeting the gold standard time frame for dietetic education can be very challenging. Delivering timely education on salt and fluid is vital to help to prevent hospital admissions related to fluid overload and optimise long term patient outcomes. The use of videos in delivering introductory concepts on salt and fluid has the potential to provide timely and standardised, widely accessible foundation education for dialysis patients prior to a tailored consultation with specialist dietitian. For patients living with CKD, ongoing care means that key health messages need to be thoughtfully and timely reinforced and shared in a creative way to keep them supported and engaged. Educational videos provide an effective opportunity to reach a wider multicultural audience by combining visual and auditory input to appeal to diverse learners.

TJ10

Implementing the 2020 KDOQI Nutrition Guidelines for Chronic Kidney Disease: Focus on Protein Restriction in Stages 3–5 Chronic Kidney Disease

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

Introduction: Protein-energy wasting and metabolic complications are prevalent in advanced chronic kidney disease (CKD), making nutritional management a key component of care. The 2020 Kidney Disease Outcomes Quality Initiative (KDOQI) clinical practice guideline recommends protein restriction to 0.55-0.60 g/kg/day in metabolically stable adults with non-dialysis CKD stages 3-5, based on evidence that it reduces the risk of progression to end-stage kidney disease or death (1A), and evidence that it may improve quality of life under close clinical supervision (2C). Despite international endorsement, the extent to which this recommendation has been adopted in UK clinical practice remains unclear. UK guidance does not emphasise strict protein restriction, and real-world adherence to KDOQI targets has not been systematically evaluated. This study aimed to assess national implementation of the KDOQI protein restriction recommendations by surveying renal dietitians across the UK, identifying current practices, perceived barriers, and unmet resource needs.

Methodology: A national, cross-sectional survey was conducted between July and September 2025 to explore current practices and guideline adherence regarding protein restriction in stages 3-5 non-dialysis CKD. The survey was designed by the study team and distributed electronically via the British Dietetic Association (BDA) Kidney Dietitian Specialist Group (KDSG) mailing list, targeting renal dietitians across the UK. Participants provided informed electronic consent, and no identifiable data were collected. Responses were anonymised and processed in line with UK data protection laws. Descriptive statistics were used to analyse the data, with findings summarised using frequencies and proportions. Ethical approval was granted by the Birmingham City University Ethics Committee.

Results: A total of 39 renal dietitians across the UK completed the survey. The majority (62%) were Band 7, with 21% Band 6 and 15% Band 8a or above. Only 2 respondents (5%) reported routinely implementing the KDOQI-recommended protein restriction target of 0.55-0.60 g/kg/day in non-dialysis CKD patients without diabetes. The most common target used was 0.8-1.0 g/kg/day (66%), followed by 0.6-0.8 g/kg/day (26%). While the former aligns with historical UK national recommendations, the latter is consistent with targets recommended by KDOQI 2020 for patients with diabetes and endorsed by the International Society of Renal Nutrition and Metabolism (ISRNM), but remains above the stricter intake advised for those without diabetes. Reported barriers to implementing lower protein targets included limited time for dietary counselling (41%), concerns about patient adherence (38%), and lack of interdisciplinary coordination (13%). Only 23% of respondents

reported access to structured tools or resources to support protein restriction. Respondents were asked to identify factors that could facilitate implementation, with 77% (30/39) indicating a need for patient-friendly materials, such as meal-planning guides, and 13% highlighting the need for additional staff education.

Conclusion: This study demonstrates limited adoption of the KDOQI 2020 protein restriction targets among UK renal dietitians, with only 5% reporting use of the recommended intake for non-dialysis CKD patients without diabetes, highlighting a clear gap between international guidance and real-world UK practice. The barriers identified in this study should be addressed to enable more effective translation of international recommendations into UK clinical settings.

TJ11

Perception of dietitians amongst renal patients receiving haemodialysis: a quality improvement project

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

Introduction:
A patient on dialysis may receive dietary advice or opinions from many different sources including family, friends, other patients on dialysis, a range of healthcare professionals and the internet. This can result in receiving conflicting information which can be overwhelming and mean knowing what to do becomes confusing and promotes anxiety around eating and drinking. Having access to a specialist renal dietitian is essential as they can take a holistic approach in providing individualised dietary advice to optimise a patient's biochemistry, weight, and nutritional status. Their expertise in the field allows them to provide evidence based dietary advice whilst considering the multi-morbidities a person with CKD may have. A literature search was conducted and found a lack of data around the perceived value of a dietitian within the renal speciality.

The aim of this quality improvement project was to collect baseline data of the renal patients' perceptions of the dietitian, with a focus on perceived value and accessibility to dietetic input.

Methods:
All patients that regularly dialyse at a satellite haemodialysis unit were invited to complete a mixed-methods questionnaire, including both quantitative and qualitative questions. Dialysis assistants completed the questionnaire between June and August 2025. Anonymity was ensured to promote honesty and reduce response bias.

Results:
56 patients completed the questionnaire, representing 74% of those invited to participate. 80% of patients could not name a dietitian, however 73% of patients felt they could recognise a dietitian from their uniform. The questionnaire demonstrated that only 30% of patients could correctly recall how recent their last dietetic review was and 30% incorrectly recalled this. However, there was missing information for 39% of the patients. Despite almost a third of patients not recalling the time frame of their last review, 75% of patients did report that they could remember the advice that they were given by the dietitian.

Information gathered showed that half of the patients who participated felt positively, 23% felt neutral, 9% felt negatively and 18% were unsure towards dietetic input. 71% of patients found dietetic advice useful and 77% felt it was realistic. However, 46% of patients felt that they did not need more dietetic input and 29% felt they needed more dietetic advice. 66% of patients knew how to contact the dietitians.

Discussion:

The questionnaire was completed by the majority of renal patients on the satellite unit and highlights the overall positive perception of dietitians, especially in regard to finding the dietary advice given useful and realistic. The responses highlight that more focus is required to ensure patients know how to contact the renal dietetic team. Missing information from the questionnaires was a barrier to gathering comprehensive information around patients remembering the time frame of their last dietetic review. Despite one third of patients stating they could recall previous dietetic advice, the actual details of this advice were not requested in this questionnaire which would be a beneficial next step to verify the accuracy of the patients' dietary recall and how this could be further improved.

TJ12

Evaluating weight changes in new kidney transplant recipients: comparing those with and without dietetic intervention

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

Introduction:
Weight gain is common following kidney transplantation, often due to improved health, increased appetite, fewer dietary restrictions, and certain medications. However, this can elevate the risk of developing new-onset diabetes, heart disease, and metabolic syndrome. Within the transplant multidisciplinary team, the dietitian plays a crucial role by providing tailored nutritional assessments and guidance, focusing primarily on food safety, heart-healthy recommendations, balanced eating, weight management, and nutritional support. In 2023, staffing challenges within the renal dietetic team limited dietetic coverage in kidney transplant clinics, meaning only some patients received dietary advice. Since 2024, regular dietetic support has been provided to all transplant patients. To assess the effects of consistent dietetic support, a retrospective review of weights from transplant recipients was conducted.

Method:
Weights were extracted from nephrology consultant clinic letters. The initial weight was recorded from the first post-transplant clinic letter, and the second weight from the letter closest to six months post-transplant. The timeframe was cross-checked against dietetic records to determine whether the patient had received dietetic intervention. The sample size was based on the total number of new kidney transplants performed in 2023 and 2024. All patients who underwent kidney transplantation and were subsequently transferred back to the primary hospital for follow-up care during this period were included. Recipients were identified using the electronic renal system.

Results:
The sample consisted of 23 patients in 2023 and 24 in 2024. In 2023, 70% of patients received initial advice, compared to 100% in 2024. Cardioprotective advice was provided to 22% in 2023, while 96% received it in 2024. Post-transplant weight changes varied: 82% of patients gained weight in 2023 versus 58% in 2024. No patients maintained a stable weight in 2023, compared to 4% in 2024. Weight loss was observed in 18% of patients in 2023, increasing to 38% in 2024. The average percentage of weight gain in 2023 was 8.7%, corresponding to an average gain of 7.7 kg (range 0.6–14.6 kg). In 2024, the average weight gain was 5.6%, with an average gain of 4 kg (range 1.9–7.4 kg).

Discussion
The comparative data, with similar sample sizes, from 2023 and 2024 suggest a marked improvement in dietetic intervention and advice to post-transplant patients. The increase from 70% to 100% in initial advice, and from 22% to 96% in cardioprotective guidance, highlights a significant enhancement in patient education. Correspondingly, there was a

notable shift in post-transplant weight trends. Although weight gain remained prevalent, its incidence decreased from 82% in 2023 to 58% in 2024, alongside reductions in both the average percentage and kg of weight gained. Importantly, for patients achieving weight loss, this more than doubled, from 18% to 38%, potentially reflecting improved adherence to dietary advice and intervention. Weight change is used as a primary outcome, but other post-transplant health indicators, such as lipid profile, cardiovascular events, quality of life were not evaluated. These findings support the positive impact of dietetic intervention on weight trends post-transplant, further studies could explore the specific factors driving these improvements.