

TL1

Developmental outcomes in offspring of mothers with kidney disease survey.

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

Introduction

Long-term impact of maternal kidney disease on childhood development is unknown. We undertook a parent reported questionnaire exploring child development in offspring of women with kidney disease during pregnancy and compared to national data.

Methods

UK National Registry of Rare Kidney Diseases (RaDaR) female participants were invited to complete the online Fertility, Reproductive health, Educational and Developmental Attainments in offspring (FREDA) Survey from Aug-Oct 2024 hosted on Jisc survey platform. This included questions on menstrual and menopausal symptoms along with health outcomes in their surviving offspring. Offspring health related quality of life was assessed through the validated Pediatric Quality of Life Inventory (PedsQL 4.0) Generic Core scale.

Results

Response rate was 2096/8485(24.7%) of which 753/2096(36%) reported at least one child aged 2-25yrs(n=1,258). Respondents were majority white 680/745(91.3%). 296/753(39%) had at least one child with a medical, developmental or behavioural condition. 316/753(42%) had worried about at least one of their children's future health. 113/1258(9%) of children had received special educational needs (SEN) support. Diagnosis of autism spectrum disorder (ASD) was reported in 95/1258(7%) and attention deficit hyperactivity disorder (ADHD) in 57/1258(5%) (22 both ASD and ADHD). PedsQL 4.0 Generic Cores Scales mean total summary score was 82.11 (SD 16.47) which is consistent with a previously published mean score of 81.08 (SD 13.07) in a school population without chronic health conditions age 5-18yrs (n=2318). Only extreme prematurity (Gestation <28 weeks) significantly impacted PedsQL total mean score in our cohort (coefficient -31.610 [95% CI -45.998 to -17.222] p<0.001) in multivariate analysis including birthweight, CKD stage, sex, renal disease group and gestational age.

Discussion

To our knowledge this questionnaire provides information from the largest cohort of offspring outcomes after pregnancy with kidney disease. Consistent with previous qualitative studies, mothers with kidney disease during pregnancy worry about their children's future health and own kidney disease impact. The proportion of children of mothers with kidney disease requiring SEN support was lower than UK general population (13%) and rates of ASD/ADHD diagnoses were comparable but reporting bias and digital exclusion may contribute to findings. There were low numbers of participants of non-white ethnicities; however, the cohort reflects demographics of UK Kidney patients (UK Renal

Registry 2020). Gestational age was the only factor significantly associated with lower HRQOL scores in a multivariable regression model, with most significant effect seen in the <28w group. Prospective research is needed to understand other longer term health risks to offspring including cardio-renal disease, but our findings suggest that women with kidney disease can be reassured that their offspring do not appear to have worse developmental outcomes than the general population.

TL2

Implementing the Professional Nurse Advocate Role in Independent Dialysis Services: A Staff-Led Approach to Wellbeing and Development

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

Introduction

The Professional Nurse Advocate (PNA) role is now well established across the National Health Service (NHS), having been introduced in March 2021 in response to the COVID-19 pandemic. The pandemic had a profound and detrimental impact on the nursing profession, highlighting the need for staff support and the promotion of wellbeing.

A PNA is a registered nurse who has completed a Level 7 accredited university course based on the A-EQUIP model, which encompasses:

- Formative – Education and development
- Normative – Monitoring, evaluation, and quality control
- Restorative – Clinical supervision
- Personal Action for Quality Improvement

This model supports nurses in maintaining professional standards, improving practice, and enhancing personal wellbeing through structured reflection and supervision.

As an independent dialysis organisation working in partnership with NHS trusts—with 30 clinics across England and over 740 staff, more than 600 of whom work in clinical roles—we were keen to explore access to this invaluable training to better support our teams and, in turn, our patients.

Methods

A staff member was identified who demonstrated the skills and attributes necessary to complete the training and foster a positive culture, particularly in delivering the restorative element of the role. Contact was made with the local NHS PNA team, and confirmation was received that, as an independent provider delivering care to NHS-funded patients, our staff were eligible to access the training.

Following a successful university application, the staff member completed the 10-week training programme. To determine next steps, we distributed an anonymous 8-question survey to all staff (approximately 740) to assess:

- Awareness of the PNA role
- Understanding of Restorative Clinical Supervision
- Interest in personal and professional development

- Perceived need for wellbeing support

Results

- Total respondents: 114 (15.4% response rate).
- Clinical staff among respondents: 88%
- Awareness of PNA role: 40%
- Awareness of Restorative Clinical Supervision: 25%
- Staff identifying a need to improve wellbeing: 85%
- Interest in discussing personal/professional development with someone:
 - Yes: 57%
 - Maybe: 39%

Discussion

These findings highlight a clear need to educate our workforce on the PNA role and the benefits it offers—not only to individuals, but also to the wider organisation and our patients. While the response rate was modest, the data provides valuable insight into staff perceptions and priorities.

Key themes emerging from the feedback include:

- A strong desire for wellbeing support
- Limited awareness of structured clinical supervision
- Openness to development conversations

To begin raising awareness, we will:

- Utilise our weekly virtual education sessions as a platform for engagement
- Publish an article in the upcoming national newsletter
- Include the PNA in area and national team calls to promote the role and its impact

We will also review the qualitative feedback to identify recurring concerns and recommend targeted actions to address them.

Next Steps

- Repeat the staff survey in 6–12 months to assess changes in awareness and engagement
- Review the results of the annual staff survey (My Opinion Counts)
- Track participation in restorative supervision sessions
- Evaluate impact on staff wellbeing and retention metrics
- Explore the potential for training additional PNAs across the organisation.

TL3

Obecabtagene autoleucel, a CD19-targeting autologous chimeric antigen receptor (CAR) T-cell therapy, in patients with severe, refractory systemic lupus erythematosus (srSLE): Phase I CARLYSLE preliminary results

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

Introduction:

Patients with srSLE have limited remaining treatment options and represent a population with an unmet need. CD19 CAR Ts have potential for deep depletion of the B-cell lineage, including plasmablasts. Obecabtagene autoleucel (obe-cel) is an autologous CD19-directed CAR T with a fast off-rate binding domain designed to reduce immunotoxicity, approved in adult relapsed/refractory B-cell acute lymphoblastic leukemia. We report initial safety and preliminary efficacy results from the single-arm, open-label, dose-finding, Phase I CARLYSLE study (NCT06333483).

Methods:

Eligible patients (12–65 years old) had an SLE diagnosis based on the 2019 EULAR/ACR criteria and a ≥ 8 -point SLEDAI-2K score at screening with ≥ 1 major SLE-related organ involvement, and were refractory to multiple prior standard-of-care SLE medications. Immunosuppressants were tapered off prior to apheresis. Following lymphodepletion with fludarabine ($3 \times 25 \text{ mg/m}^2$) and cyclophosphamide ($1 \times 1,000 \text{ mg/m}^2$), obe-cel was administered as a single starting flat dose of 50×10^6 ($\pm 20\%$) CAR T-cells. Primary endpoints: incidence of dose limiting toxicities (DLTs) within 28 days of infusion; frequency of adverse events. Secondary endpoints included: SLEDAI-2K; PGA; pharmacokinetics (PK); autoantibody and biomarker levels over time.

Results:

As of 17 March 2025, seven patients had been enrolled and six had been infused with obe-cel, with up to 8 months of follow up. At baseline, all infused patients had severe, refractory, active SLE (SLEDAI-2K score range: 15–28). All infused patients had class III or IV lupus nephritis; four also had class V. Four patients had elevated serum creatinine and an estimated glomerular filtration rate of $< 60 \text{ mL/min/1.73m}^2$; six patients had elevated

urinary protein-creatinine ratio. Patients were refractory to B-cell targeting agents and immunosuppressants (median: 5 prior medicines; range: 5–6). No DLTs or immune effector cell-associated neurotoxicity syndrome (ICANS) were observed. Three patients experienced Grade 1 cytokine release syndrome (CRS) with no Grade ≥ 2 CRS. Transient or manageable hypertension was observed in five patients and all patients had transient Grade ≥ 3 neutropenia. Infections were transient and manageable; no life-threatening infections were observed. A ≥ 10 point reduction in SLEDAI-2K scores was seen in the four patients who had ≥ 3 months of follow up and all non-renal manifestations completely resolved within 3 months. Steroid doses were tapered to ≤ 10 mg/day post obe-cel infusion; no other SLE medications were administered. Three of six patients had a complete renal response (CRR) at last follow-up, one at Month 1 (M1) and two at M3. Complement C3 normalized and anti-double-stranded DNA antibody decreased in all six patients by M1 compared with baseline levels. PK data indicated robust CAR T-cell expansion; peak expansion was reached at a median of 10 days. Three patients had ongoing CAR T-cell persistence at last follow-up.

Conclusion:

Initial findings from the ongoing CARLYSLE study of obe-cel in srSLE show a manageable safety profile, with no DLTs, ICANS or Grade ≥ 2 CRS. SLEDAI-2K score reduction and clinical benefit were observed in all patients, including three patients who had a CRR. Despite the short follow up and small number of patients, initial findings are promising; further research is warranted. Updated data will be presented at the conference.

TL4

Assessing and improving documentation of advanced kidney care decisions in a centre using the novel “options clinic” model

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

Introduction

Patients approaching renal failure should be supported to make decisions about renal replacement therapy (RRT) in an advanced kidney care (AKC) clinic. Our centre uses a unique AKC model, named the “options clinic”. Patients are assessed by a team with a subspecialty interest in AKC, focusing on the RRT decision only. It is multidisciplinary, comprising reviews by a nephrologist, dietician, education nurse and a nurse performing frailty and symptom assessments. We believe this targeted approach facilitates effective patient education and empowers decision making. However, reviewing its impact is impeded by inconsistent documentation of RRT decisions. This could lead to missed information in the acute setting, potentially reducing concordance between RRT modalities selected and received. Our project aims to standardise the documentation of RRT decisions in the electronic record.

Methods

The team: three resident doctors, one consultant nephrologist.

Baseline data was collected from a random sample of 70 patients from the database who had commenced RRT. Exclusion criteria were patients: i) who did not start RRT, including those choosing conservative management; ii) new to renal services <90 days prior to starting RRT; iii) who started RRT acutely and subsequently recovered renal function or died that admission; and iv) in the Prepare for Kidney Care Trial. We assessed the electronic record for all data.

The Primary Outcome Measure was whether the RRT decision was documented in the agreed location. If not, we documented where it was located. Other Outcome Measures included: 1) options clinic attendance; 2) whether an RRT decision had been made (including dialysis decisions to bridge to transplantation); and 3) whether the patient received their chosen RRT modality.

We are using the PLAN-DO-STUDY-ACT model. Our intervention will include a departmental meeting presentation, distribution of educational posters to relevant staff, and posters displayed in appropriate offices.

Progress over time will be measured by auditing another patient sample in January 2026. Results will be included in the poster.

Results

3 of the 70 patients met exclusion criteria. Of the remaining 67, 60 (89.6%) had a documented RRT decision. 33 (49.3%) had attended options clinic.

Only 3.3% of decisions were documented in the appropriate location. 86.7% were documented in dedicated education screens. Transplant and dialysis decisions were typically documented in separate, although consistent, places. The remaining 10% were documented in the patient summary, under transplant status or in clinic letters.

65.7% of patients received their chosen RRT as their first therapy; this includes receiving their chosen dialysis modality as a bridge to transplantation.

Discussion

Although most patients have been supported to decide on their preferred RRT modality, decision documentation is inconsistent and unreliable. We have developed an educational intervention to standardise documentation and will audit another patient sample to assess its success and fine-tune our approach. We will include our intervention in departmental inductions and provide annual refreshers to staff to ensure improvement is sustained. Project limitations include the small sample size and the exclusion of patients choosing conservative management due to the difficulty of defining when they reached end-stage renal failure.

TL5

Evaluating the introduction of a nephrology-led renal stone clinic

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

Introduction

Thirteen percent of people will be diagnosed with kidney stones in their lifetime. Alongside surgical options for renal stones, such as ureteroscopy, lithotripsy and percutaneous nephrolithotomy, there has been increasing emphasis on the importance of preventative treatments. The aim of this research was to evaluate outcomes of a new nephrology-led clinic, which focused on optimising preventative measures, to reduce patients' risk of renal stone recurrence.

Methods

Our clinic was established in November 2022. Patients are referred to the clinic by their urologist if 24-hour urine collection identifies metabolic abnormalities. In clinic, patients' urinalysis and risk factors are reviewed, along with stone analysis from renal calculi. Patients are referred for genetic testing if indicated. All patients receive advice about dietary modifications and optimising fluid intake. Barring any contraindications, patients with hypercalciuria are offered a thiazide-like diuretic to reduce this, and those with uric acid or cystine stones, or hypocitraturia, are offered potassium citrate for urine alkalinisation.

Results

Sixty patients were reviewed between November 2022 and August 2025. Mean age was 48 years and 65% were male. Fifty-nine underwent 24-hour urine analysis, with 28 (47.5%) diagnosed with hypercalciuria and 20 (33.9%) with hypocitraturia. Three patients were diagnosed with autosomal recessive cystinuria following genetic testing. Other diagnoses made in clinic include hyperparathyroidism and sarcoidosis. One patient was referred to a tertiary centre for advice due to ongoing high stone burden.

Twenty-four patients were recommended potassium citrate. Of the 21 patients who started it, 17 continued it. Two patients stopped due to diarrhoea, one opted to switch to an alternative treatment and one died of an unrelated cause. Of those who continued it, eight had 24-hour urinary citrate rechecked, with 7/8 (87.5%) showing an increase. Nine have had urinary pH rechecked, with 5/9 (55.6%) showing an increase. Nine have had repeat imaging of their urinary tract, with 5/9 (55.6%) showing stable stone burden and 4/9 (44.4%) showing no stones.

Nineteen patients were recommended indapamide, a thiazide-like diuretic. Of the 15 patients who started it, 13 patients continued it. One patient stopped due to poor compliance and one switched to bendroflumethiazide due to high stone burden, to allow further uptitration. One patient dose-reduced due to lightheadedness. Of those still taking indapamide, five have had 24-hour urinary calcium rechecked, with 5/5 (100.0%) having normalised. Seven have had repeat imaging of their urinary tract, with 4/7 (57.1%) showing

stable stone burden, 1/7 (14.3%) showing improved stone burden and 2/7 (28.6%) showing no stones.

Discussion

We successfully introduced a nephrology-led clinic aimed at reducing patients' risk of renal stone recurrence. Of the 60 patients seen so far, 47 (78.3%) were recommended some form of treatment. Potassium citrate (24/60, 40.0%) and thiazide-like diuretics (19/60, 31.7%) were the most common interventions. Potassium citrate effectively improved urinary citrate and pH, but diarrhoea was a frequent side effect. Indapamide effectively reduced urinary calcium levels and was generally well-tolerated. Stone burden did not increase on repeat urinary tract imaging for any patient taking either of these two interventions.

TL6

Learning from Deaths: The Impact of Themed Mortality Review Meetings, Comprehensive Clinical Case Reviews after Death and Integrated Frailty Services

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

Introduction

The management of end-of-life care in patients with multiple comorbidities and significant frailty is a complex and multifaceted challenge. This quality improvement project evaluates the impact of introducing themed mortality review meetings involving the whole multidisciplinary team (MDT), the circulation of comprehensive clinical case reviews after death, promoting frailty services, and consultant-led board rounds on the quality of end-of-life care. The focus is on key parameters such as Treatment Escalation Plan (TEP) decisions, frailty input, and palliative care involvement over time.

Methods

A retrospective review of patient records was conducted, focusing on deaths that occurred between December 2024 to March 2025 and May 2025 to August 2025. Data were extracted from patient records, including TEP decisions, frailty assessments, and palliative care involvement.

Interventions: The introduction of themed mortality review meetings, comprehensive clinical case reviews after death, further promotion of frailty services and encouragement of consultant-led board rounds.

Assessment of impact: comparing the timing and consistency of TEP decisions, the recognition and management of frailty and the integration of palliative care input between the two periods.

Results

The analysis revealed several key trends and improvements over time. During the period from December 2024 to March 2025, TEP decisions were often delayed, frailty was recognised but not always acted upon promptly, and palliative care input was recommended but not always timely. Following the implementation of the interventions listed above, there was a notable improvement in the timing and consistency of TEP decisions. The recognition and documentation of frailty became more systematic, and palliative care involvement became more integrated into patient care, facilitating calm end-of-life care in a greater proportion of patients.

Discussion

The introduction of themed mortality review meetings involving members across the MDT and the circulation of comprehensive clinical case reviews after death highlighted learning points and generated a number of quality improvement projects. Providing a forum for MDT based discussion, allowed for subtle culture shifts around TEP discussions. In conjunction with increasing the visibility of the newly created frailty service, this has contributed to significant improvements in the early recognition of frailty, earlier and more consistent TEP decisions, proactive management of frailty, and timely integration of palliative care input. The findings highlight the importance of a collaborative and systematic approach to delivering both appropriate and compassionate care to a complex, multi-comorbid, older patient cohort. This quality improvement initiative underscores the need for ongoing education and training for healthcare professionals, as well as the importance of involving patients and their families in care planning and decision-making processes both in the inpatient and outpatient settings. Future work will focus on further refining these interventions and exploring their long-term impact on patient outcomes and healthcare resource utilisation.

TL7

A retrospective analysis of outcomes in an advanced kidney care clinic – a single centre 20 year experience

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

INTRODUCTION

To improve management of patients with worsening kidney function approaching end stage, we established the advanced kidney care clinic (AKC) in our unit in 2002 with a protocolised referral at eGFR 20mls/min (reduced to 18mls/min in 2017 to manage patient numbers). We present our results from this service

METHODS

All patients coded for having attended the AKC since 2002 were included for analysis (n=11855, 64% male). The downloaded dataset included demographic data, treatment choice, treatment outcome and survival; we report preliminary analysis (with AI-assisted code generation). We have compared outcomes in different age groups and over sequential 5-year periods.

RESULTS

Demographics – Numbers reviewed in the clinic rose from 190 in 2005 to 656 in 2015, after which we reduced the protocolised eGFR for referral from 20 to 18mls/min; currently there are 650 patients under review. Median age has remained around 70 years old (IQR 47-93), but compares with 40 (33-46) in 1986, to 60 (46-71) in 2000 from historical data in our unit before establishing the AKC.

Treatment choice/received - First modality was pre-emptive transplant for 10% of teenagers, 9% of 20-29yrs, 6% of 30-39yrs, 5% of 40-49yrs, 4% of 50-59yrs, 2% of 60-69yrs, <1% of over 70's

Median prevalent patients with a recorded treatment decision increased from 34 in 2006-10, to 126 in 2011-15, 156 in 2016-20 and 180 in 2021-25. Percentage choosing each modality has changed little from 2005-2025 – HD 56 to 54%, PD 15% to 12%; we offered a conservative management (CM) option from 2007 and percentages have remained stable at 29 to 27% since establishment, ranging from 2% of >50's to 19% of >70's and 42% of >80's. There has been a rise in "Undecided" (despite education) from 0% to 11%, especially in patients >70 years old.

Across all age groups and all eras, despite multiple initiatives, the proportion of people choosing PD who failed to received it as first modality remained ~35%.

Outcomes – Death before treatment (excluding CM) occurred in 6% of 20-29yrs, 13% of 30-39yrs, 12% of 40-49yrs, 19% of 50-59yrs, 24% of 60-69yrs, 36% of 70-79yrs and 42% of 80-89yrs and 54% of over 90's. Including CM, 35% of >60's, 51% of >70's and 84% of >80's die without RRT. From first AKC appointment, median survival for >60's patients who survived

to receive dialysis was 1850 days, for CM 1105 days; >70's dialysis 1727 days, CM 1035 days; >80's dialysis 1385, CM 860 days.

CONCLUSIONS

Expansion in AKC has been largely driven by protocol-driven referrals of septuagenarians and older; the most common outcome in these patients is death before active treatment regardless of preferred treatment. We believe the increasing number of patients undecided on preferred treatment results from increasing complexity of the case mix seen in the service. We believe these data demonstrate that in many cases of people with advanced CKD, their other medical problems are more likely to influence their outcome, especially at older ages. We believe that future planning of AKCs should take account of this.

TL8

Stone-specific risk factors for renal impairment in kidney stone disease – a retrospective analysis of 920 patients

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

Introduction: Kidney stone disease is a common, highly recurrent condition with a recognised association to Chronic Kidney Disease (CKD), in addition to some of its main risk factors – including hypertension, diabetes and metabolic syndrome. The pathophysiology of the causal link is complex and likely depends on stone type, the presence of recurrent stone events and urological treatment intervention. However, few studies have evaluated other stone-specific factors, such as stone type and size, for their predictive value in CKD and its progression.

Methods: The records of 920 patients who underwent ureteroscopy, lithotripsy or percutaneous nephrolithotomy for stones from January 2018 to October 2022 were examined. Patients were divided in subgroups based on stone type, history of previous intervention and size of largest stone on imaging. The groups were analysed for age, gender, ethnicity, intervention performed, diagnosis of diabetes mellitus and prescription of antihypertensive agents. The mean estimated Glomerula Filtration Rate (eGFR) at the time of intervention, the proportion of patients with eGFR<60ml/min/1.73m², and the odds of recovering eGFR to ≥60ml/min/1.73m² were compared between the groups.

Results: The patients had a mean age of 50.0 years (Standard Deviation (SD): 14.6), were predominantly male (61.7%) and of White ethnicity (51.7%), with the remainder being Asian (30.4%) and Black (8.3%). The majority (81.2%) underwent ureteroscopy. 35.2% had a history of previous intervention, which was defined here as recurrent disease. The mean BMI was 28.8kg/cm² (SD: 6.2), 24.2% had diabetes and 31.1% were prescribed at least one antihypertensive agent. The mean eGFR was 73.8ml/min/1.73m² (SD: 16.8). Stone analysis was available for 601 patients; 68.7% of those were Calcium Oxalate (CaOx) stone formers (SFs) and 33.9% were Calcium Phosphate (CaP) SFs. Compared to CaP SFs, CaOx SFs had similar mean eGFR at baseline and similar rates of eGFR<60ml/min/1.73m² but were significantly less likely to recover eGFR to >60ml/min/1.73m² on follow-up (OR 0.18, 95% CI: 0.064-0.543). Compared to non-recurrent SFs, recurrent SFs were older (52.5 ±14.5 vs. 48.6±14.5 years, p<0.01), more likely to be diabetic (29.6% vs. 21.0%, p<0.01) and to be on antihypertensive treatment (36.4 vs. 27.9%, p<0.01). There was a small but significant difference in their mean eGFRs at the point of intervention (75.0 ±16.8 vs. 71.5 ±16.6 ml/min/1.73m² respectively, p<0.01), but no significant difference in rates of eGFR<60ml/min/1.73m² (16.9% vs. 22.2%, p=0.054) nor odds of recovery (OR 1.06, 95% CI: 0.506-2.214). Stone size was not associated with lower eGFR at baseline, nor odds of recovery (OR 1.058, 95% CI: 0.506-2.214) when comparing the first with the fifth quintile of size of largest stone.

Discussion: Our study suggests that diabetes and hypertension are associated with increased risk of stone disease recurrence and lends support to the hypothesis that stone type may be of predictive value when considering the risk of progression to CKD. Neither recurrence status, nor stone size was significantly associated with renal impairment.

TL9

Real-world insights into nurse-led management of CKD-associated pruritus in the UK: Results from an online survey

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

Introduction:

Chronic Kidney Disease-associated Pruritus (CKD-aP) represents a prevalent condition among individuals with end-stage kidney disease (ESKD) who receive haemodialysis (HD). Approximately 80% experience this condition, with nearly 40% suffering from itching that ranges from moderate to severe in intensity. While exact prevalence data for the UK are limited, global studies provide these estimates.

After dialysis is optimised, additional treatments may be used to manage symptoms. In dialysis centres, the nephrology multidisciplinary team (MDT), especially nurses, play a key role in identifying and managing CKD-aP. However, awareness and management approaches vary widely. To understand these differences and improve care, an online survey was conducted among kidney dialysis nurses across the UK, with the primary objective to explore current CKD-aP care practices, including screening and diagnosis methods, treatment approaches, and opportunities for improvement.

Methods:

A quantitative online survey was completed by 103 kidney dialysis nurses across the UK via Microsoft Forms. Ethical exemption was obtained from Salus Institutional Review Board.

Results:

Nurses demonstrated strong awareness of CKD-aP, with over 95% rating screening as important. Most recognised the condition's impact on health-related quality of life, particularly itch, sleep disturbance, work or school, and emotional wellbeing. However, routine screening is inconsistent: informal conversations predominate, and 99/103 nurses reported not using formal scales consistently, despite most finding them helpful. Documentation and consultant involvement are variable. Treatments vary, with creams and antihistamines being widely used for mild CKD-aP, whilst advanced therapies (e.g., gabapentin, phototherapy) are less commonly applied, despite a specific therapy option, such as difelikefalin being available for moderate/severe CKD-aP.

Key barriers to effective screening included limited awareness within healthcare teams (75/103), patient non-reporting (72/103), lack of standardised tools (66/103), perceived limited treatment options (53/103) and time constraints (38/103). Despite these, 98% of nurses supported regular screening for CKD-aP, and 97% believed it would improve patient care. Expected benefits of regular and standardised screening included reduced itch intensity (91/103), improved sleep (90/103), fewer physical signs of scratching (85/103), improved depression (78/103), improved quality of life (77/103), increased diagnosis (76/103), and reduced impact on work or school (54/103) (see Figure 1).

Figure 1. Expected impact of regular and standardised CKD-aP screening on patients

Discussion:

With appropriate support and resources, there is a significant opportunity to translate motivation into action, standardising care and improving outcomes for patients with CKD-aP.

TL10

5 Years activity in a Renal Day Case unit.

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

Introduction:

Renal Day Case (RDC) provides care for outpatients in a tertiary renal centre covering a large geographical area. RDC provides an opportunity for early reviews, monitoring of patients post kidney transplant, procedures and intravenous infusions with the aim to reduce admissions and additional pressures on the acute medical ward. RDC also allows research to be carried out in a clinical setting. The purpose of this audit was to review the activity of the RDC unit over the past 5 years.

Methods:

Data was manually collected on a daily basis over the last 5 years regarding the patient's need for attendance and outcome.

Results:

Yearly attendance increased by 19% from 2339 patients in 2021 to 2917 in 2024 with the average attendance increasing from 200 patients per month in 2021 to 243 patients per month in 2024. The Hepatitis B vaccination clinic was launched in 2022 following a shift from primary care providing this service. This has provided more than 500 vaccinations over 3 years.

The number of infusions performed in RDC has increased by 54% in 4 years. Many infusions are offered on RDC including monofer, rituximab and cyclophosphamide as well as research medications. Interestingly there has been a reduction in cyclophosphamide over the last 4 years and an increase in rituximab highlighting a potential change in practice. 107 patients were admitted via the Renal day case unit in 2024, a 58% rise from 62 patients in 2022, potentially indicating the complexity of the patients being reviewed has increased.

88.8 % of renal kidney biopsies, central venous catheters (CVC) insertions/removals and peritoneal dialysis (PD) catheter insertions/removals are performed in the procedure room in RDC rather than interventional radiology. The number of biopsies has increased from 105 in 2021 to 182 in 2024. The insertion of medical PD catheters has also increased from 15 to 31 per year. Pleasingly the number of CVC 's inserted has decreased from 164 temporary and 113 tunnelled per year in 2021 to 105 and 107 respectively in 2024, this has to be due to more patients starting haemodialysis (HD) with permanent access as the total number of HD patients has increased year on year.

A recent addition to the data collection was the number of reviews performed. This is either by the renal ACP or renal registrar. 928 patients were reviewed over the last 12 months therefore reducing the burden on other services.

Discussion:

From the data provided there remains an increasing need for the RDC to review and provide treatment for the ambulatory patients in a timely manner as an alternative to admission or outpatient clinics. The unit has initiated new pathways such as the hepatitis B vaccination programme to adapt to the demands needs of the renal service as well as being used as a clinical facility for research.

Conclusion:

Further work should be carried out to the cost effectiveness of the service and to look for opportunities to increase patient numbers further to relieve pressures on other assessment areas.

TL12

Embedding infection prevention behaviours through experiential learning in dialysis: outcomes from a multi-centre quality improvement initiative

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

Introduction

Healthcare-associated infections (HCAIs) present a persistent threat to patient safety, particularly within haemodialysis units, where patients are exposed to frequent vascular access and close clinical contact. Despite established guidelines, compliance with infection prevention practices such as hand hygiene remains suboptimal. This quality improvement initiative aimed to enhance infection prevention behaviours through a structured, week-long experiential learning programme delivered consistently across all dialysis clinics within a large national network in England.

Methods

A five-day Infection Prevention and Control (IPC) Week was implemented simultaneously across 29 geographically dispersed dialysis clinics covering the whole of England. The programme was designed to be reproducible and accessible for every site, ensuring equity of delivery despite differences in clinic size, workforce, and workload. Daily themes included hand hygiene, personal protective equipment (PPE), cleaning and disinfection, respiratory etiquette, sharps safety, and shared haemodialysis care. Activities combined presentations, practical demonstrations (e.g. ultraviolet light assessments of hand hygiene), audits, and interactive challenges. Engagement was monitored through attendance logs, feedback surveys, and observational data. Knowledge acquisition was self-assessed via post-event surveys. Patients were also encouraged to participate in selected activities.

Results

Staff engagement was high, with 100% of respondents reporting some level of participation; 56% felt highly engaged. Learning preferences were split, with 41% favouring presentations and 47% preferring practical activities. Importantly, 53% of staff reported involving patients in IPC-related education during the week. Feedback demonstrated a perceived improvement in IPC knowledge and confidence in applying infection prevention measures. Observational audits revealed greater attention to hand hygiene and PPE technique in participating units post-intervention. Delivering the initiative across a wide geographical area highlighted differences in engagement between clinics, but overall demonstrated the feasibility of implementing a national-scale quality improvement project.

Discussion

This initiative demonstrated that experiential learning fosters engagement and improves infection prevention knowledge and behaviours in dialysis settings. Crucially, the design and delivery model ensured that all 29 clinics across England were included, overcoming geographical and operational challenges to create a unified programme. The consistent

national approach reinforced infection prevention as a shared responsibility while allowing clinics to adapt activities to their own local context. Standardising future audits through a digital clinical audit tool may strengthen ongoing compliance monitoring and sustain improvements. This model shows how coordinated, large-scale quality improvement programmes can embed infection prevention behaviours and promote a culture of patient safety across dispersed dialysis services.