WC1

Improving the Delivery of Education Sessions to Advanced Kidney Care (AKC) Outpatients

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WEDNESDAY - Moderated Poster Session, HALL Q, March 11, 2026, 13:45 - 14:45

Introduction

Patient education is vital for patient-centred care and better outcomes. However, it faces challenges such as low health literacy, limited information access, poor engagement, and lack of awareness around chronic kidney disease (CKD) . Approximately 61% of working-age adults in England struggle to understand and use health information . Addressing these barriers is essential to improve patient experience and health results. The Advanced Kidney Care (AKC) nursing team our Trust delivers patient education sessions every 3-4 months across two units. The sessions offer information on CKD causes, treatment, renal replacement therapies, maximum conservative management, lifestyle changes and support services through face-to-face chats with members of the AKC and wider renal team, kidney patients and representatives of different support services. Feedback is collected after each session to identify barriers and areas of improvement to enhance the delivery of future sessions.

Methods

A quality improvement (QI) approach with plan-do-study-act (PDSA) cycles has facilitated the identification of needs and experience of those attending the sessions to implement changes. Two forms have been used to collect information from February 2024 until June 2025. The first one is an attendance list completed by the AKC nursing team, which tracks who attended, reasons for non-attendance, and other potential barriers that may have previously gone unaddressed. The second one is a patient feedback questionnaire that assesses the patient experience, the quality of information provided and the level of health literacy of the patients through a Single Item Literacy Screener (SILS) from the NHS Health Literacy Toolkit. These forms provide valuable insights to improve session delivery and ensure that educational support is accessible and effective for all patients. The forms are dynamic and have been constantly modified after each session to improve the quality of the information gathered. The results analysed will refer to the feedback obtained from the session held in June 2025.

Results

The results from the attendance list showed that out of 41 invited, 24 attended (58.5%), with non-attendance mainly attributed to “distance related issues” (52.9%), followed by “feeling unwell” and “forgetfulness” at 23.5% respectively. All attendees were satisfied or very satisfied. 64.7% had high health literacy, while 17.6% had good, and 17.6% had poor skills. Regarding communication, 80% felt they were spoken to in a way they could understand, and none found the information unhelpful. Respondents found it most helpful hearing from other patients, observing dialysis equipment, dietary advice, and learning about conservative management. The least helpful were low sound volume and bright lighting affecting screen visibility.

Discussion

The patient feedback showed high satisfaction levels, with most attendees reporting strong health literacy. Areas for improvement include addressing audio volume and lighting issues. Innovative actions will be implemented including offering online streaming of future sessions for those digitally excluded, and providing call or text reminders. These measures aim to enhance the overall delivery of education, ensuring it is accessible, engaging, and tailored to patients’ needs.

WC2

The depiction of frailty in patient decision aids supporting dialysis and conservative kidney management decision making

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Background

Frailty, characterised by an increased rate of physiological decline, is common in individuals with chronic kidney disease and becomes more prevalent as the disease progresses. Frailty carries an increased risk of adverse events and hospitalization, poor prognosis and decreased quality of life. People with higher levels of functional impairment appear less likely to experience a prolongation of life with dialysis, and frailty may modify the burdens associated with kidney replacement therapy. Despite its clinical significance, frailty assessments are not routinely conducted in advanced kidney care settings, and little is known about how such assessments inform shared decision-making about dialysis and conservative kidney management. Patient decision aids are evidence-based resources designed to help people make decisions about their health. Their effectiveness hinges on the inclusion of clinical and person-centred aspects that people need to inform their decisions. These may be absent when aids are developed without considering factors such as frailty, which influence the outcomes and lived experiences of treatment and care.

Methods

We undertook a qualitative document analysis of international patient decision aids designed for people with kidney failure making decisions about dialysis and conservative kidney management. Resources were discovered through a literature search, grey literature search, snowball searching, and contact with experts in the field. Analysis focused on how frailty was defined, described, and contextualized within each resource. Coding was informed by existing frailty and shared decision-making frameworks and included language used to describe frailty, its role in prognostication, and whether it was framed as a factor influencing treatment suitability or patient values.

Results

We found 23 patient decision aids. Thirteen were (57%) publicly available, eight (35%) had been developed since 2020, seven (30%) were developed in the United States. Frailty was inconsistently and inadequately depicted across patient decision aids. Few resources named or conceptualised frailty. Some used euphemistic or vague terms such as “poor mobility” or “physical ability,” failing to capture the multidimensional nature of lived experience, which includes emotional vulnerability and social isolation. When mentioned, frailty was often narrowly framed as a physical barrier to dialysis and implicitly linked to conservative kidney management. Two decision aids included a self-assessment of functional status; none used validated frailty assessments, or encouraged users to discuss frailty with their healthcare team. This lack of actionable guidance highlights a critical gap in supporting genuine shared decision-making.

Conclusion

Frailty is underrepresented and often reductively framed in patient decision aids for advanced chronic kidney disease, limiting their capacity to support individualised decisions for older adults and those with multiple comorbidities. Improving the representation of frailty is essential to support shared decision-making, future planning and align care with patient goals. To achieve this, developers should consider patients - including those with lived experience of frailty - as co-designers to ensure language about frailty is acceptable, comprehensible and framed as a crucial factor in understanding how an individual might experience a treatment pathway.

WC3

Online information on kidney disease and haemodialysis: a gap analysis of first-page Google search results

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WEDNESDAY - Moderated Poster Session, HALL Q, March 11, 2026, 13:45 - 14:45

Introduction:
Chronic kidney disease (CKD) affects approximately 10% of adults in the UK, with haemodialysis representing a life-sustaining therapy. Increasingly, patients seek health information online prior to clinic visits; surveys suggest up to 70% of UK patients use the internet to research their condition. While online resources may support self-management, misinformation or incomplete guidance could influence adherence, decision-making, and clinical outcomes. Despite the widespread use of online resources, no UK-focused analysis has systematically assessed whether first-page Google results provide content that is accurate, comprehensive, and aligned with NICE and KDIGO recommendations.

Methods:
In August 2025, a structured Google UK search was conducted using the terms “kidney disease” and “haemodialysis.” The first five results per search and all results appearing on the first page, totaling ten unique websites, were reviewed. Two independent reviewers screened each website, and content was coded across seven domains: definitions, treatment options, procedural detail, complications, guideline alignment, emerging therapies, and health equity. Adequacy was benchmarked against NICE guidance on CKD, dialysis, and transplantation, as well as KDIGO recommendations. Discrepancies between reviewers were resolved by consensus.

Results:
The ten websites analysed included NHS (n=3), Wikipedia (n=1), Mayo Clinic (n=2), Patient.info (n=1), Health.com (n=1), VerywellHealth (n=1), and other educational platforms (n=1). All sources provided accessible definitions of CKD, differentiation between haemodialysis and peritoneal dialysis, and general procedural information regarding vascular access and dietary advice. However, only two websites (20%) explicitly referenced NICE or KDIGO recommendations. None of the websites included details on the molecular mechanisms of renal injury or progression. Emerging therapies such as SGLT2 inhibitors or novel dialyser technologies were not mentioned on any site, and transplantation was referenced on only one website. Eight of ten sites described common complications such as cramps, hypotension, or fatigue, but none addressed dialysis-related amyloidosis, infection risk, or the heightened cardiovascular mortality associated with haemodialysis. None of the websites reported survival data, quality-of-life outcomes, or patient-reported experience measures. Only one website (10%) acknowledged accessibility challenges including low health literacy, language barriers, or socioeconomic inequalities.

Discussion:

First-page Google results for CKD and haemodialysis provide information that is generally accessible but frequently superficial, incompletely aligned with national and international guidance, and deficient in coverage of complications, outcomes, and emerging therapies. The lack of consideration for health equity further risks widening digital health disparities. This analysis underscores the urgent need for evidence-aligned, patient-friendly, co-designed online educational resources to ensure that widely accessible information reflects contemporary best practice and supports informed decision-making in CKD and dialysis care.

WC4

Assessing the Readability of the Kidney Patient Reported Experience Measure (PREM)

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Background: Chronic kidney disease (CKD) is known to disproportionately affect groups with lower educational attainment. Experiences are often shaped by wider social determinants of health that impact on access to screening services and prevention/intervention. Given this, it is essential that measures, such as the annual Kidney Patient Reported Experience Measure (PREM), are widely accessible to ensure equity of voices heard.
Kidney PREM captures patient experience across 13 themes of experience, such as access to kidney team, support, communication and patient information. In addition, patients are asked to rate their overall experience and for any additional comments. Since its inception in 2016, its findings have supported kidney centres across the UK to identify service improvements.
To ensure equity of access to the English language version of the Kidney PREM, this study aimed to systematically assess its readability. By measuring this, we aimed to evaluate whether the PREM is suitably designed to support comprehension and useability for the UK-based CKD population.

Methods: Readability was assessed following the approach of Patalay et al (2018), using four widely recognised formulae: the Flesch-Kincaid Grade Level, the Gunning Fog Index, the Coleman-Liau, and the Dale-Chall Readability Formula. These indices capture distinct linguistic features relevant to comprehension, including word and sentence length, vocabulary familiarity, and jargon use. Each index provides a US grade-level score, translatable into age by adding six years (i.e., grade-level 5 = 10-11 years). Each item was assessed individually using all four formulae, to give four readability scores per item. Scores were averaged at theme level, then across the full PREM, to generate an overall readability level in years.

Results: Preliminary estimates for readability grade of the full Kidney PREM ranged from 8.06 to 9.55, (mean 9.15), equivalent to a reading age of 14-15 years. Within themes, fluid and diet received the youngest readability grade of 6.4 (age 10-11 years), with privacy and dignity receiving the highest readability grade of 13.3 (age 19-20 years).

Discussion: Initial findings demonstrate that the reading age required to access the Kidney PREM is 14 to 15 years. Given that the average reading age in the UK is estimated to be 9-11 years, with a significant proportion of adults who read below this, the findings of this study suggest that the Kidney PREM readability level exceeds much of the UK adult population. Furthermore, readability rates varied widely across the Kidney PREM themes, which may result in unequal representation of experience. However, these methods do not account for all necessary medical terms used in the survey, that many long-term kidney patients will be

well versed in, potentially inflating the reading age required to access the Kidney PREM. Further work is planned aiming to account for this.

Conclusion: Measuring the Kidney PREM readability highlights opportunities to improve accessibility for patients with differing literacy levels. Recommendations, including the support of routine readability tools in the design and production of patient-facing materials and measures, can help to reduce barriers to comprehension and increase patient involvement in feedback, research and improvement initiatives.

WC5

Integration across primary and secondary care: a collaboration to develop, implement and evaluate an interactive educational webinar programme for people living with CKD stages 1-3

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WEDNESDAY - Moderated Poster Session, HALL Q, March 11, 2026, 13:45 - 14:45

INTRODUCTION

To improve outcomes in people with CKD, early patient education is needed to enhance understanding, help identify CKD, prevent/delay progression, and optimise management.

In London and Surrey Heartlands, there was no group education programme for people to ask questions in real time to multi-disciplinary experts.

The London Kidney Network and Kidney Care UK came together to address this unmet need and aimed to:
1. Develop and deliver a high quality, interactive educational webinar programme for people with CKD stages 1-3.
2. Evaluate patient questionnaire results from each webinar to:
a. Improve subsequent sessions.
b. Determine the value of repeating the programme in 2026.

METHODS

We developed:
1. A 70-minute live webinar focused on CKD stages 1-3. Each webinar contained the same educational content, with half the time dedicated to answering participants’ questions via a diverse multi-professional panel (nephrologist, dietitian, pharmacist, nurse).

2. A post-webinar questionnaire (SurveyMonkey) to collect and evaluate feedback from attendees.

A pilot webinar in November 2024 was promoted nationwide, and deemed successful based on feedback from attendees and the support/clinical team. A second and third webinar was delivered via MS-Teams in April and July 2025 (5.30-6.40pm), targeted at London and Surrey Heartlands residents.

We engaged with six ICSs to advertise webinars 2 and 3, and to encourage primary and secondary care to ask patients to register online (demographic questions included).

RESULTS

Across all 3 webinars:

•489 attendees, 64% living in London or Surrey Heartlands, with most from South London.
•Majority of respondents were living with CKD 1-3, aged 55+, and of Black or White ethnicity.

Post-webinar questionnaire response rate was 32%. Key findings below are averages across all 3 webinars (from Table 1) unless stated otherwise:
•91% rated the webinar excellent or good.
•Across April and July, the nurse's talk was deemed most helpful, followed by Q&A session.
•97% rated their CKD knowledge good or very good post webinar, and would recommend it to others.
•90% rated their confidence good or very good post webinar.
•More than 3/4 found it easy to register and join online.
•Free text feedback was also positive, e.g.
"Speaking to a human GP is impossible, so asking questions was helpful."

DISCUSSION

We achieved our aims of developing, delivering and evaluating our webinar programme. Improvements were made in response to feedback, e.g. some attendees found digital technology challenging. Therefore, we provided a written and video guide on joining the webinar. Overall patient feedback was very positive; thus, our webinar will be repeated in 2026 between 5-7pm. Webinars tailored to specific under-served populations may be considered.

Confidence to live well with CKD still needs improving, confirming the need to explore ways to achieve this by engaging with patients. We will ensure greater participation across all ICSs by learning from ICSs with high attendee numbers.

We recommend that all kidney networks consider a similar programme to promote self-management, reduce unwarranted variation of care, and support integration of primary and secondary care. Partnerships with patient charities and across networks will reduce duplication and promote sustainability.

WC6

Embedding Women's Health into CKD and Post-Transplant Care: A Quality Improvement Audit

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Title :
Embedding Women's Health into CKD and Post-Transplant Care: Audit for Quality Improvement
Background:
Women with chronic kidney disease (CKD) and kidney transplants face challenges around family planning, contraception, pregnancy, and menopause. It was felt that these care plans are often unmet in repatriated transplant clinics.
Methods:
Retrospective primary and secondary care notes review for women of reproductive age at the time of their kidney transplant 2000-2025 with functioning kidney transplant, if there was evidence of family planning and contraception discussions.
Results:
In the transplant cohort, 75% of women had no documented evidence of family planning or contraception discussions during their CKD or transplant journey.
Interventions:
Clinical Vision e-record: New "Women's Health" tab with prompts for family planning and contraception discussions.
Patient education: Updated CKD packs with Kidney Care UK leaflets on women's health, menopause, contraception, and pregnancy; materials placed in waiting areas to stimulate discussions.
Transplant follow-up: Structured rediscussion about return of menstruation and pregnancy at repatriation clinic, provision of Pregnancy after Kidney Transplant leaflet, and an annual "holistic" transplant clinic to aid focus of non direct transplant graft, wider patient health needs.
Future Plans:
By March 2026, follow-up data will be available to evaluate improvements in documentation and patient engagement during CKD and transplant clinics after embedding these interventions.
Conclusion:
Women's health is not consistently addressed in CKD and transplant clinics. Embedding prompts and holistic review may normalise these conversations and improve patient-centred outcomes.

WC7

An Audit of Lifestyle Advice Given to Patients with Chronic Kidney Disease in Primary Care

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WEDNESDAY - Moderated Poster Session, HALL Q, March 11, 2026, 13:45 - 14:45

Chronic kidney disease (CKD) affects approximately 11% of the global adult population and is associated with increased cardiovascular risk and progression to end-stage renal disease (Lucas & Taal, 2022). Lifestyle modifications, such as dietary changes, smoking cessation, physical activity and weight management are essential to CKD management. National guidelines recommend that patients with CKD receive tailored lifestyle advice as part of their routine primary care management.

A retrospective audit was conducted using EMIS electronic health records. A search was performed to identify audit patients with active CKD stages 1-3. Patient records from the past five years were reviewed for documented lifestyle advice in four categories: alcohol use, smoking cessation, diet and weight management, and overall absence of lifestyle advice.

A total of 276 patients with active chronic kidney disease (CKD) stages 1-3 were identified. Among these, 11% (n = 31) had no recorded alcohol advice, 12% (n = 33) had no recorded smoking cessation advice, and 4% (n = 12) has no documented diet or weight management advice. Notably, 2% (n = 6) of patients had no recorded lifestyle advice in any of these categories.

While most patients had some form of advice recorded, notable gaps remain, particularly in alcohol and smoking cessation guidance. To address this, a targeted SMS message was developed to give specific advice around alcohol, smoking cessation, diet and weight management. This was sent to affected patients to provide relevant lifestyle advice. This audit met its objective by identifying the extent to which lifestyle advice is being documented for patients with CKD in primary care, and a process was introduced to ensure all patients are given relevant advice. A re-audit is planned in 6-12 months to evaluate the effectiveness of this intervention.

Lucas, B. & Taal, M. W., 2022. Epidemiology and causes of chronic kidney disease. Medicine, 51(3), pp. 165-169.

WC8

My kitchen looks like that.

Co-creating dietary education resources through community-based participatory research

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WEDNESDAY - Moderated Poster Session, HALL Q, March 11, 2026, 13:45 - 14:45

Introduction

Chronic kidney disease (CKD) affects ~13% of UK adults, with disproportionately higher prevalence among South Asian and Black African/Caribbean populations (Public Health England, 2018). These groups experience pronounced health inequalities, linked to socioeconomic disadvantage, systemic inequities, and culturally incongruent health resources. Traditional patient education materials often assume high literacy and familiarity with Western cuisine, limiting engagement among ethnically diverse populations (Marmot, 2020; Greenhalgh et al., 2016).

Problem

Written and visual dietary resources are typically Eurocentric and English-language based. Digital platforms such as YouTube and Instagram are increasingly used for health information. Yet CKD-related content rarely addresses non-European cuisines, reflects diverse cultures and is less available in non-English languages, perpetuating exclusion and disengagement (Nutbeam, 2008).

Methods

This project employed a Community-Based Participatory Research (CBPR) framework (Israel et al., 2013), to ensure:

Community engagement: Participating patients, families and dietitians represented the communities they live and serve in, creating strong visual symbolism and culturally congruent media.

Shared spaces: Filming in participants’ kitchens created an embodied, relational context in which knowledge, traditions, and culinary skills were shared. The kitchen became a meaningful site for interaction, fostering trust, reciprocity, and cultural affirmation.

Lived experience and community-based solutions: Through selecting well known traditional dishes, this project respected community values and traditions around cooking and food, maintaining familiarity and cultural relevance.

Strengthening of social bonds: Sharing kitchens, foods, recipes, techniques and linguistic terms generated meaningful interpersonal connections that extend beyond typical information transfer, producing lasting collaboration and social capital.

Epistemic equity: Patients contributed their culinary knowledge, linguistic skills, and personal practices, while dietitians provided nutrition expertise. This mutual recognition cultivated co-learning, empowerment, and culturally sensitive adaptations.

Results

This project co-created seven kidney-friendly cooking videos featuring people living with CKD, their families, and dietitians of matched cultural heritage. Traditional recipes were collaboratively adapted to align with potassium-reduction guidance. This community of volunteers subsequently dubbed the videos into multiple languages.

The act of filming and dubbing committed the co-creation process to permanent public record through producing 56 dietary education videos, now uploaded onto Imperial College Healthcare's public facing YouTube channel.

Discussion

This project demonstrated the value and power of CBPR in generating meaningful public health resources that address both informational and cultural gaps in mainstream health literature.

This project demonstrated that:

Social and Epistemic equity through knowledge production and sharing between culinary and nutritional experts can redress structural health inequalities (Ward et al., 2018).

Co-learning and collaborative exchange throughout planning and filming stages helped find culturally embedded solutions to dietary problems.

Relational trust can be built via re-balancing of power, embodied interactions, and shared domestic space.

Community-centred educational spaces such as kitchens create lasting social and cultural value for project participants and recipients alike.

Patient empowerment through normalising traditional cuisines within kidney-friendly adaptations, can reinforce cultural identity while promoting self-efficacy in dietary management.

WC9

The Experiences of Education and Information given to Minority Ethnic Patients Diagnosed with CKD: A Systematic Review

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WEDNESDAY - Moderated Poster Session, HALL Q, March 11, 2026, 13:45 - 14:45

CKD is a life changing diagnosis. Unfortunately, diagnosis is often made during the later stages of the disease particularly for minority ethnic patients. Patient education and information is a fundamental requirement along the CKD pathway to facilitate shared decision making, which in turn enables self-management. To ensure minority ethnic patients have access to the correct support throughout their CKD journey it is a necessity to establish their experiences and perspectives on the information and education the have or are currently receiving.

Search strings were developed for the following databases, and databases were searched from their inception date until 2025: Cochrane, CINHAL, PubMed, MedRxiv, Scopus. Data extraction utilized participant and patient education/information characteristics, plus qualitative study results. The number of studies included was 64, with 14 countries represented in the literature: USA, Australia, Iran, England, Norway, Switzerland, Canada, Denmark, Ireland, Bangladesh, New Zealand, Sri Lanka, India, and Singapore.

There were 10 ethnic groups represented. ESRD represented 52% of the included studies, transplant represented 33%, and stages 1-5 represented 15%. A majority of the literature focused on all types of education (N=13), 3 focused on diet educational tools, 4 focused on e-tools, 1 on social media, 1 on video/film interventions, and 1 on an exercise intervention.

The literature was analysed utilising thematic analysis (Braun and Clarke., 2023). The overarching theme of ‘Mistrust’ was identified, filtering through every aspect of the CKD journey. Further themes identified were intrapersonal and systemic: communication difficulties, lack of cultural congruence, low socio-economic status, and complex medical systems all worked as barriers to patient education. Without trust and good communication patients are not gaining the knowledge required to ask further questions of health professionals that will facilitate shared decision making and self-management of their CKD. Equally low education levels and SES reduce access and understanding of technology where information could be found. Furthermore, the information that is available is tailored to traditional white western patients which has no relevance for minority ethnic patients particularly in terms of diet assistance.

The literature did identify various needs and facilitators for patient education for minority ethnic patients. Culturally and linguistically tailored interventions, peer support, improved communication, and additional consultation time were amongst the most important. It is imperative that future research aims to include minority ethnic patients views and perspectives to enable the development of these important interventions to reduce the disparities seen along the chronic kidney disease pathway. Additionally, the literature had little focus on primary care interventions and awareness which is an important area of focus to enable patients to act prior to diagnosis. The rest of this PhD aims to investigate these areas.