# Transitioning an adolescent receiving haemodialysis and awaiting a kidney transplantation

Evelina London

Arran Wheatley

Renal Transition Clinical Nurse Specialist

EWOPA, Valencia 25/09/2024

# Introduction

- What is transition?
- NICE guidelines
- Transitional tools- Ready, Steady, Go

# Aims of an effective transition

- Better engagement
- Adopt positive health behaviours
- Better long term health outcomes
- Benefit to both individual and NHS

# Why is a good transition important?

- Challenging developmental period
- High levels of anxiety and feeling under prepared
- Benefits of early support

# Examples of current transition models

- Use of transitional tools eg Ready, Steady Go
- Dedicated Young Adult Clinics speciality specific
- Dedicated transition clinics for all YP
- YP only dialysis sessions
- Alternate appointments paed and adult

## Start early

- Health education and promotion of autonomy should be addressed at every appointment
- Encourage child to complete part of appointment alone
- Document readiness and issues to still be addressed, refer on to other services

## Education & Independence

- What are my medication doses / frequencies? What are they for?
- When do I need to contact my team, who is in my team?
- What is the long term prognosis? What can affect this?
- How can I share decision making with my team
- How can I manage my condition more independently?

## Introduction to adults

- Start at 16 years old
- What are my choices for adult care?
- Discuss differences in paed and adult services
- Have I visited and met the team?
- Have I had initial appointment with adults?

## Point of transfer

- Date agreed for transfer
- Prepare comprehensive transfer document in timely manner
- Offer opportunities to join appointments to ensure detailed transfer
- Arrange staggered transition period

## After transfer

- Paediatric team should be contactable and willing to support adult providers
- Do not discharge until YP and both teams are happy

# Case Study

- 16 year old on Haemodialysis, RK
- Need for a transition plan
- RK would go to satellite unit A if still on HD and renal centre B if transplanted
- Nearest satellite unit managed by renal centre which doesn't support in-house transplantation
- Nearest renal centre doesn't have YA support/services
- Transition would involve 4 different teams across 4 sites and 3 hospital trusts

# Challenges of effective transition in our dialysis cohort

- Unknown modality
- Unknown team
- Differences in adult dialysis units
- Appropriateness of alternate appointments
- Adult DDKT lists
- YA support

# Strategies tried

- Parallel transition plans
- Manage expectations of differences between adults & paediatrics
- Support paeds teams to take step back
- Advocate for YP

# What we have learnt

- Multi professional approach
- Development of good relationships with adult teams
- Early planning for DDKT list
- Realistic expectations
- YP feedback

# How can we improve this for YP?

- Investment from adult team
- Empowering our 16-18 year olds
- Any ideas???

# References and acknowledgements

Renal team at Evelina London

-SN Atinuke Ademefun Senior Dialysis Nurse and rest of dialysis nursing team

-SN Kate Mythen, Paediatric Recipient Transplant coordinator

-Prof Manish Sinha, Paediatric Dialysis Consultant

• Colver A, Rapely T, Parr JR et al. 2020. Facilitating transition of young people with long-term health conditions from children's to adults' healthcare services – implications of a 5-year research programme. Clinical. Medicine (London). 20(1): 74–80

• Campbell F, Biggs K, Aldiss SK, O'Neill PM, Clowes M, McDonagh J, While A, Gibson F. Transition of care for adolescents from paediatric services to adult health services. Cochrane Database Syst Rev. 2016 Apr 29;4

• Crawford K, Wilson C, Low JK, Manias E, Williams A. Transitioning adolescents to adult nephrology care: a systematic review of the experiences of adolescents, parents, and health professionals. Pediatr Nephrol. 2020 Apr;35(4):555-567