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P271 -What happens to patients who have unplanned dialysis starts due to late decision making or late decision changes after six months?

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Background
The period approaching end stage kidney disease (ESKD) can be a stressful and challenging time for patients; it may be characterised by the provision of large amounts of information by the healthcare team, changes in medication and changes in health state and perception. In addition, patients are asked to make serious and long lasting decisions about their healthcare, which often need to be made some time in advance of dialysis commencement. It is known that some patients struggle to engage with decision making, either failing to make a choice, changing their mind very late, or experiencing changes in their medical status that may render their initial decision inappropriate. It is important to support patients who have had an unplanned start to convert to their preferred modality where possible or to provide definitive vascular access where necessary.

Methods
Data were collected on all patients who started any form of renal replacement therapy (RRT) in 2017, having been known to the renal service at a large tertiary referral unit in a mixed socioeconomic area. Data collected included demographics (age, gender, ethnicity and deprivation as assessed using Index of Multiple Deprivation (IMD) deciles) and modality choice three months prior to RRT start and RRT modality after six months.

Results
171 eligible patients started RRT in the period studied, with 60% being male and 56% of non-white ethnicity. The rate of deprivation was high, with 31% being in the lowest IMD decile. The distribution of modality decisions three months prior to RRT start was: haemodialysis (HD) 46% (n=71), peritoneal dialysis (PD) 41% (n= 70), undecided/not documented 11% (19), conservative care 2% (n=3) and pre-emptive transplant 0.6% (n=1).

Of the patients who had chosen HD, 73% actually started HD with an AVF or AVG, and of the patients who had chosen PD, 77% actually started PD (13 patients were transplanted prior to PD start). The patient who had chosen a pre-emptive transplant was transplanted. 26% of those who made a late decision started PD and 11% started HD with an AVF/AVG, leaving 62% starting HD with a tunnelled catheter.

After six months, 86% of patients who had started HD with an AVF/AVG were still using the same access. 66% of the patients who had chosen PD but started HD on a tunnelled catheter had converted to PD. Of the patients who started HD on a tunnelled catheter, 47% were still using a tunnelled catheter at six months.

Conclusions
In our cohort the absence of timely decision making was associated with not only starting HD using a tunnelled catheter but remaining on the same access for the first six months. Those who had a late modality change also had a higher chance of starting HD with a tunnelled catheter, though some patients then started PD within the following six months. To increase home therapy numbers we need to proactively manage those patients who have unplanned dialysis starts, to ensure that they have the opportunity to use a home therapy or dialyse with definitive vascular access.