CKD Stewardship:

A Hospital-Based Program to Improve Chronic Kidney Disease Detection, Management, and Education

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CKD Stewardship co-ordinator, Sydney Local Health District

Mind the Gap

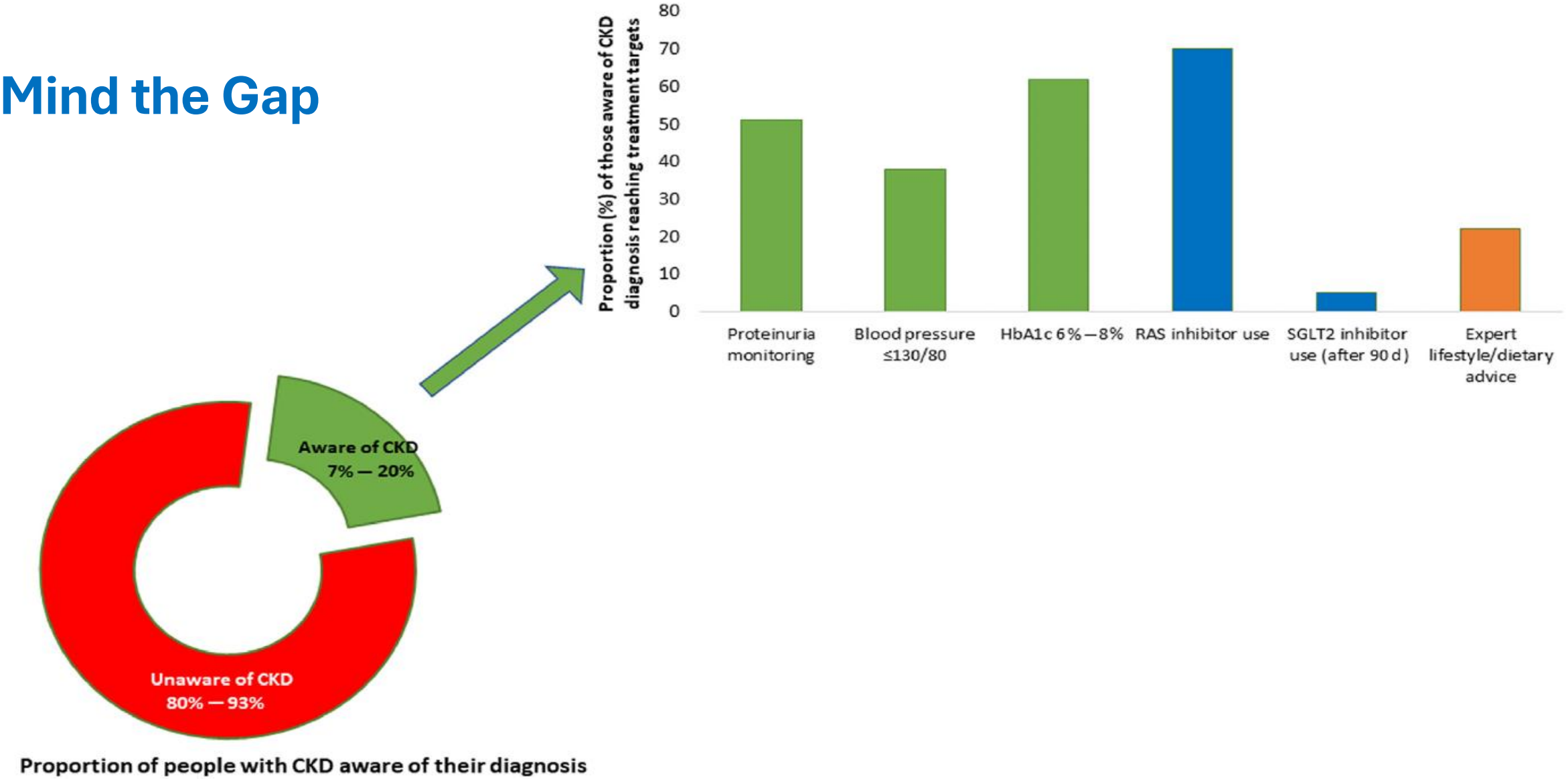


Figure 2 | Proportion of people with chronic kidney disease (CKD) who are aware of their diagnosis and are receiving appropriate guideline-recommended care. The proportion of people with CKD who are aware of their diagnosis varies globally, with rates ranging

Luyckx et al., KI , 2024



CKD Stewardship:

Virtual detection of admitted patients with stages 3b-5 CKD who are not already known to a kidney specialist

How the program works

Virtual detection of all admitted patients with stage 3b - 5 CKD not known to a kidney specialist

Find

- eGFR<45ml/min
- Not known to a kidney specialist

Tell

- The inpatient team
- The patient
- The GP

Act

- Patient asks for kidney health check
  GP to perform kidney health check

Refer

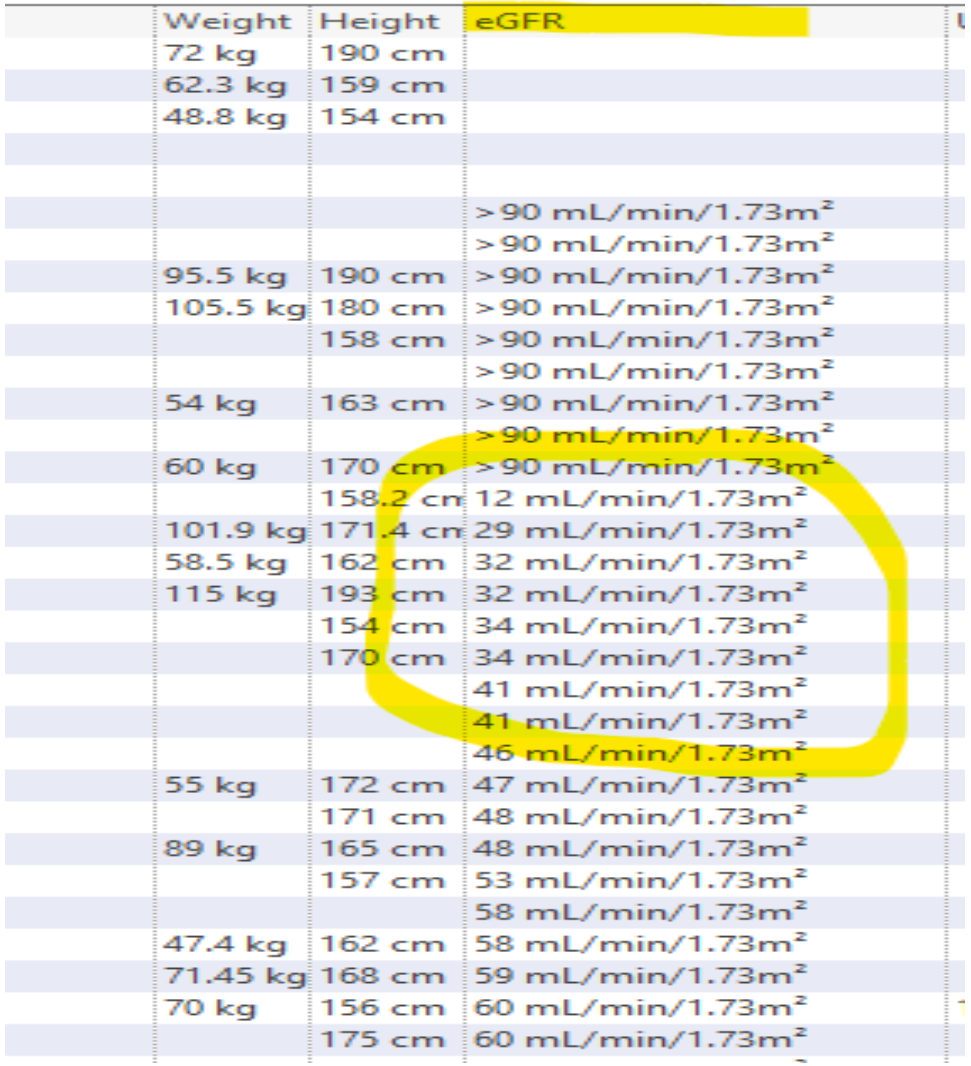
- Nephrology outpatients

Find

Admitted patients with an eGFR < 45

Exclusion criteria:

- Admitted under renal team
- Renal consult
- Age >80yrs
- Age <18yrs
- Palliative care involvement
- Poor prognosis
- Nursing home resident
- Pregnant
- Clear AKI eGFR >60 3 mths or >90 in 6 mths
- Advanced Dementia
- Died
- Already > 2 CKD-S interventions in 12mths



Weight	Height	eGFR
72 kg	190 cm	
62.3 kg	159 cm	
48.8 kg	154 cm	
		>90 mL/min/1.73m²
		>90 mL/min/1.73m²
95.5 kg	190 cm	>90 mL/min/1.73m²
105.5 kg	180 cm	>90 mL/min/1.73m²
	158 cm	>90 mL/min/1.73m²
		>90 mL/min/1.73m²
54 kg	163 cm	>90 mL/min/1.73m²
		>90 mL/min/1.73m²
60 kg	170 cm	>90 mL/min/1.73m²
	158.2 cm	12 mL/min/1.73m²
101.9 kg	171.4 cm	29 mL/min/1.73m²
58.5 kg	162 cm	32 mL/min/1.73m²
115 kg	193 cm	32 mL/min/1.73m²
	154 cm	34 mL/min/1.73m²
	170 cm	34 mL/min/1.73m²
		41 mL/min/1.73m²
		41 mL/min/1.73m²
		46 mL/min/1.73m²
55 kg	172 cm	47 mL/min/1.73m²
	171 cm	48 mL/min/1.73m²
89 kg	165 cm	48 mL/min/1.73m²
	157 cm	53 mL/min/1.73m²
		58 mL/min/1.73m²
47.4 kg	162 cm	58 mL/min/1.73m²
71.45 kg	168 cm	59 mL/min/1.73m²
70 kg	156 cm	60 mL/min/1.73m²
	175 cm	60 mL/min/1.73m²

Renal CKD Stewardship Note

Renal CKD Stewardship Note:

Medical Progress Note
CKD stewardship
Saunders (Nephrologist)
Please note, this is a file review only and not a formal renal consult
This patient has been identified via CKD Stewardship

Diagnosis: Possible Stage 3b/4 CKD

Is the patient on current Guideline Directed Medical Therapy for CKD (as per KDIGO guidelines)
Statin: Yes/No/not appropriate
ACEI/ARB: no
SGLT2i: no
Finerenone (if diabetic): no - note on spironolactone
GLP1-ra (if diabetic): no
Urine ACR result: unknown

Suggest: (JMOs: please copy this note into discharge summary)
Please review medications as per eGFR - note metformin should be reduced when eGFR <30
Consider CKD medical therapies as above if clinically appropriate
Please send urine ACR (microalbumin/creatinine ratio random)
Please include diagnosis of **possible Stage 3b/4 CKD** (dpending on d/c summary) in the discharge summary (in issues list and past medical history)
Please request patient see their GP for Kidney Health Check (EUC, Urine Acr, BP) on discharge

We will send the GP a specific discharge summary with suggested guideline management
The Kidney CNC will see the patient to discuss long term kidney health

Tell

Patient and GP

CKD STEWARDSHIP

Kidney Disease Awareness

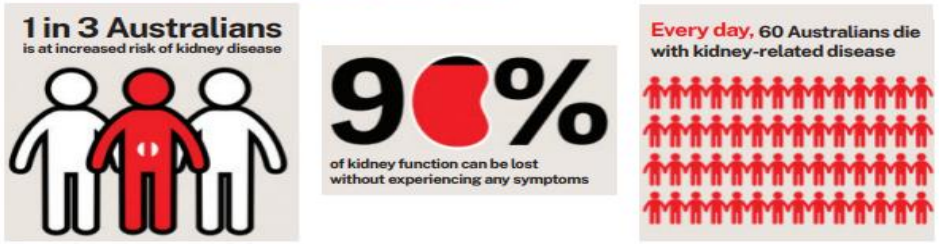
Dear

DRAFT

The blood tests in the hospital show that you might have a problem with your kidneys. To make sure, we want you to do blood and urine tests again with your GP when you're feeling better and out of hospital. Sometimes, things can get better when you're well.

If you do have kidney problems, it's important to know early. There are good treatments available now that can help stop or delay things from getting worse. We'll also send the test results and a letter to your GP so they know what's going on.

CKD Stewardship Team
CKD-Stewardship@health.nsw.gov.au



For more information, visit Kidney Health Australia kidney.org.au/your-kidneys

Or scan the QR code

Act early. Speak to your GP.

NSW Health Sydney Local Health District

Dear Colleague,

Your patient _____ has been identified as possibly having **Chronic Kidney Disease (CKD)** during their recent hospital admission. Optimal medical management can slow progression by up to 50%.

Recommendations

1. Please re-check the creatinine (eGFR) and urine albumin:creatinine ratio (ACR) three months apart to confirm the diagnosis.
2. Please code the CKD in your practice software

Yellow Clinical Action Plan*
eGFR >60ml/min/1.73m² with albuminuria >30mg/mmol OR
eGFR 49-59ml/min/1.73m² with NO albuminuria
1. Review every 12 months: blood pressure, weight, smoking, CV risk
2. Reassess Urine ACR, eGFR, lipids and HbA1c (if diabetic)

Orange Clinical Action Plan*
eGFR 30-59mL/min/1.73m² with albuminuria >30mg/mmol OR
eGFR 30-44ml/min with NO albuminuria
1. Review every 3-6 months: blood pressure, weight, smoking, CV risk
2. Reassess Urine ACR, eGFR, lipids, HbA1c (if diabetic), EUC
3. Consider ACEi or ARB for hypertension first line therapy
4. Statin therapy
5. Consider SGLT2i if albuminuria >30mg/mmol (even in non-diabetics)

When to refer to nephrology*
1. Persistent Urine ACR >30mg/mmol regardless of eGFR
2. If confirmed Stage 4 (eGFR <30ml/min) or 5 (eGFR<15ml/min) of any cause
3. Sustained decrease in eGFR of 25% or more within 12 months
4. Sustained decrease in eGFR of 15ml/min/year
5. CKD with resistant hypertension despite at least three antihypertensives

HealthPathways Sydney link

*Action Plans and referral guideline adapted from Kidney Health Australia CKD management handbook for health professionals, 2020. https://kidney.org.au/health-professionals/ckd-management-handbook

We hope that you find this information useful.

CKD Stewardship Team,
SLHD-CKDStewardship@health.nsw.gov.au

CKD Stewardship Team - Nephrologists: Dr Lucy Wynter, Dr John Saunders
Clinical Nurse Consultants: Rowena Monteverde, Lisa Tienstra

"Yeah, [I was happy to discuss kidney health with the nurse] cos I don't know anything about them, really." (Male, 78)

"She was helpful and good to know someone came around and sorted of cared about it that sort of thing..." (Male, 72)

"I didn't know that there was a problem with my kidneys really until I think she might have told me or maybe it was the doctor…apparently they aren't working as well as they could, now I'm on this tablet called Forxiga" (Female, 73)

Tell


Kidney disease
EDUCATION SESSION
CKD STEWARDSHIP
CKD STEWARDSHIP

Act

Perform a Kidney Health Check
Prescribe Guideline Directed Medical Therapy

The Kidney Health Check

Targeted detection of CKD occurs via Kidney Health Checks for patients at increased risk. The Kidney Health Check involves the following:



Blood pressure check
Consider ambulatory blood pressure (ABP) monitoring or home BP monitoring in addition to in-clinic readings.



Urine test
Albumin/creatinine ratio (ACR) to check for albuminuria.



Blood test
eGFR calculated from serum creatinine.

Refer

To a Kidney Specialist (If required)

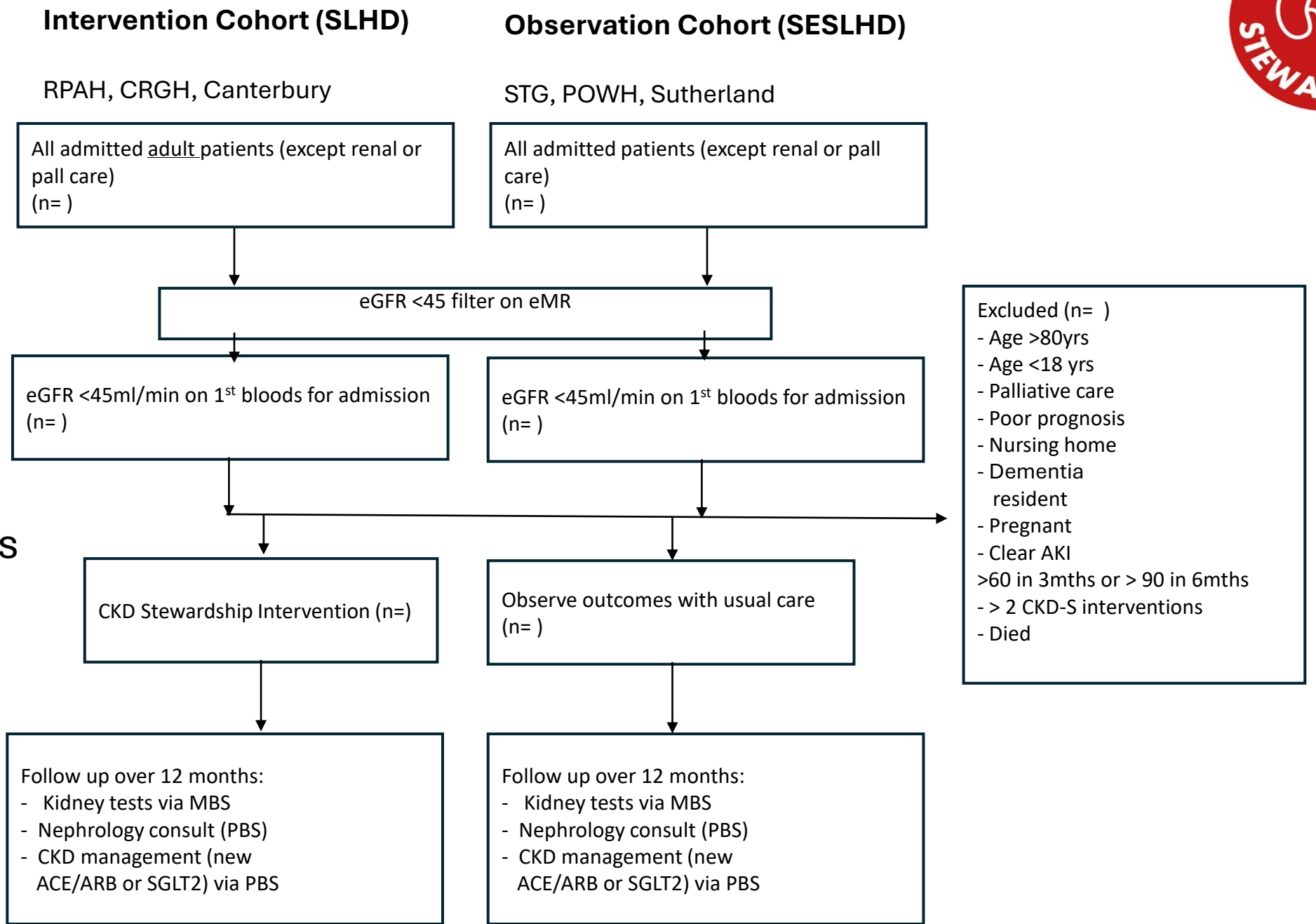
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CKD Stewardship Prospective Cohort Study

Methods

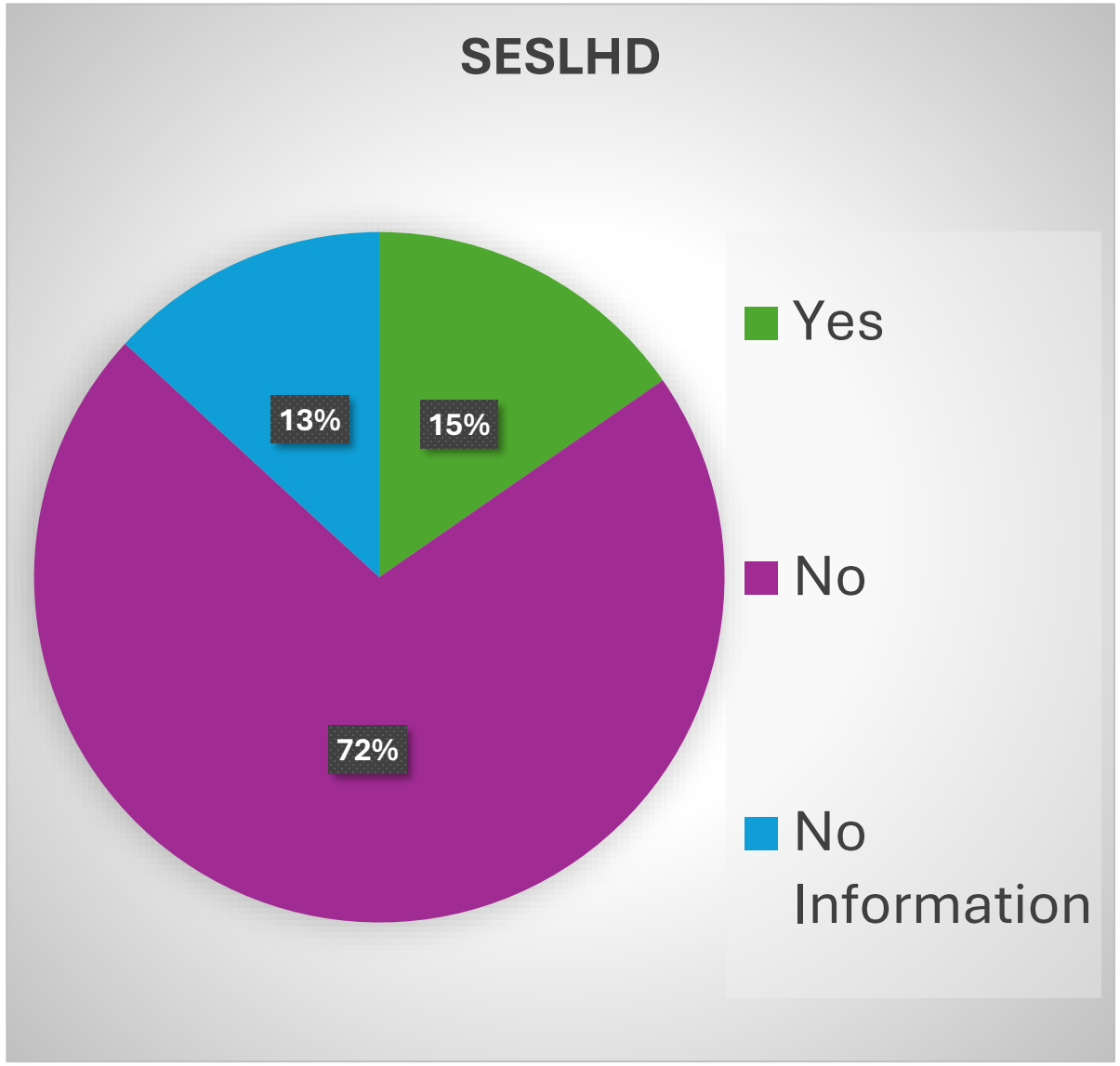
- Comparing usual care (SESLHD) with usual care plus CKD Stewardship

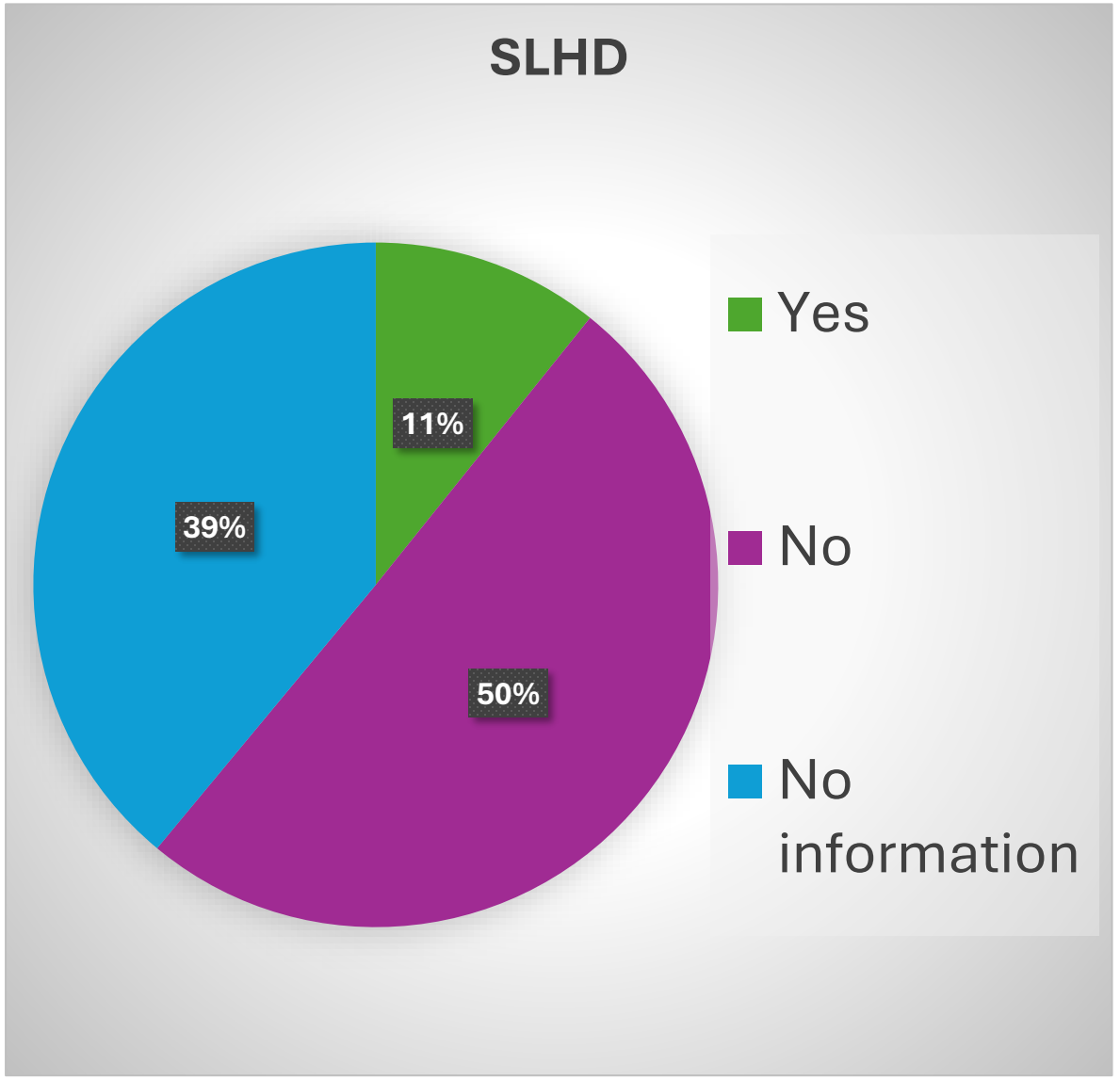


Results … so far

- 11,000 patient files were screened = 12% of admissions.
- 956 included in CKD Stewardship study (SLHD n=483 and SESLHD n=473) (1% of admissions)
- >69% eGFR 30-44
- Nurse education delivered to 78% of patients
- 50% previously unaware of their kidney disease
- CKD documentation increased from 25% on admission to 50% on discharge
- Urine ACR testing increased from 5% on admission to 32% on discharge
- >30 nephrology referrals made

SGLT2I


SESLHD
13%
15%
72%
Yes
No
No Information


SLHD
11%
39%
50%
Yes
No
No information

Sydney Excellence Awards – Highly Commended



Modified CKD-S Radiology outpatients



Next Steps



1. Analyse data: prospective cohort study



2. AIHW linkage to PBS/MBS data (ethics approved)



3. Develop and implement stepped wedge RCT/ within NSW

Interested in CKD Stewardship?

Carmen.Moroney@health.nsw.gov.au

Protocol:

https://bmjopen.bmj.com/content/bmjopen/15/3/e094554.full.pdf



CKD Stewardship Newsletter

Issue: 1 December 2025

Welcome

Welcome to the first edition of the CKD Stewardship (CKD-S) Newsletter. This newsletter will keep you informed about the CKD-S program, its impact, and upcoming initiatives.

What is CKD-S?

CKD-S is a hospital-based program, improving detection, management, and education of people living with chronic kidney disease (CKD).

Developed by kidney specialist Dr Lucy Wynter, the program has been successfully implemented in the Sydney Local Health District (SLHD) since March 2024.

A Message from the CKD-S Founder – Dr Lucy Wynter

Welcome to CKD-S! We are a small but expanding team of kidney nurses and doctors who are passionate about preventing avoidable dialysis. Despite the availability of effective medications such as SGLT2 inhibitors, nsMRAs, GLP-1s, and ACE/ARBs, many eligible patients are still not receiving them — so we decided to act.

Around 12% of hospitalised patients have Stage 3b–5 CKD. CKD-S identifies these patients while they are already in hospital, explains their kidney health, recommends evidence-based treatments, and communicates with their GPs. We use the results in front of us rather than letting them go unaddressed.

In our first 12 months, we identified 500 mid-to-late-stage CKD patients not under renal care. Most were unaware of their diagnosis, and only 9.6% were on optimal therapy. We reviewed them, educated teams, and wrote to their GPs. We want you to join us — together we CAN make a difference.