ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 7 (July 2026)

Care Continuity Experience and Patient Comfort in Renal Treatment Services

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Date Submitted:
February 11, 2026

Date Accepted:
March 25, 2026

Date Published:
July 09, 2026

DOI:
10.5281/zenodo.21280480

ABSTRACT
This study evaluated care continuity experience and patient comfort in renal treatment services in Santiago City. It used a patient-reported cross-sectional structural modeling design to determine the level of care continuity experience, the level of patient comfort, and the predictive effect of care continuity experience on patient comfort. Participants were renal treatment patients selected through purposive criterion sampling with interval-assisted recruitment. Data were gathered using a validated researcher-developed questionnaire that measured relational consistency, clarity of treatment information, coordination of schedules and follow-ups, responsiveness to patient concerns, consistency of care instructions, physical ease, emotional reassurance, environmental comfort, procedural confidence, and dignity and privacy. The instrument demonstrated strong content validity and excellent reliability. Descriptive statistics, partial least squares structural equation modeling, bootstrapping, and importance-performance map analysis were used for data analysis. Results showed that patients reported a high level of care continuity experience and patient comfort. However, coordination of schedules and follow-ups emerged as the weakest care continuity dimension, while physical ease during treatment obtained the lowest comfort rating. The structural model showed that care continuity experience significantly and positively influenced patient comfort, explaining 46.4 percent of its variance. Responsiveness to patient concerns and coordination of schedules and follow-ups were identified as priority improvement areas. The findings suggest that patient comfort in renal treatment services is shaped not only by clinical procedures but also by consistent communication, responsive support, and organized follow-through across treatment encounters.

Keywords: *care continuity, hemodialysis, patient comfort, renal treatment services, structural equation modeling*

INTRODUCTION

Renal treatment services have become an essential part of long-term health care for patients living with advanced chronic kidney disease and kidney failure. For many patients, treatment is not limited to a single clinical encounter but becomes a continuing routine that involves repeated dialysis sessions, laboratory monitoring, medication management, dietary guidance, emotional adjustment, and regular communication with health care providers. Hemodialysis, in particular, is described as a life-saving treatment that removes waste products and excess fluid from the blood when the kidneys can no longer perform these functions adequately (National Kidney Foundation, 2024). The updated KDIGO guideline also recognizes chronic kidney disease as a condition requiring sustained evaluation, risk-based management, and careful coordination of care over time (kidney disease: Improving Global Outcomes [KDIGO] CKD Work Group, 2024). Because renal care is continuous by nature, patients' experiences are shaped not only by the technical quality of treatment but also by how consistently, respectfully, and comfortably services are delivered.

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Continuity of care is particularly important in renal treatment because patients usually interact with several members of the health care team across repeated visits. The World Health Organization (2018) emphasized that continuity and coordination of care support coherent, connected, and people-centered services, especially for individuals with long-term health needs. In kidney care, this means that patients benefit when instructions are consistent, records are properly followed, concerns are remembered, treatment changes are explained, and providers communicate in ways that help patients feel known and supported. Ljungholm et al. (2022) further described continuity of care as a coherent, logical, and timely delivery of services involving relational, informational, and management continuity. These dimensions are highly relevant to renal services, where missed information, weak follow-up, and fragmented communication may affect confidence, adherence, and comfort during treatment.

Patient comfort is also a central concern in renal treatment services. Dialysis may prolong life and improve biochemical stability, but it can also bring physical discomfort, fatigue, muscle cramps, dizziness, nausea, anxiety, sleep problems, and other burdens that affect daily living. Fletcher et al. (2022), in a global systematic review involving 449 studies and 199,147 patients, found that people with chronic kidney disease experience considerable symptom burden and lower health-related quality of life, with the worst quality of life reported among patients receiving dialysis. Similarly, the KDIGO Controversies Conference on dialysis-related symptoms noted that individuals undergoing maintenance dialysis frequently report high symptom burden that can interfere with functioning and reduce life satisfaction (Mehrotra et al., 2023). These findings show that patient comfort should not be treated as a minor concern. It is closely tied to how patients endure treatment, maintain trust in providers, and continue their care despite repeated physical and emotional strain.

The patient's experience of comfort is influenced not only by symptoms but also by the way care is organized and delivered. In a qualitative case study of a hemodialysis program, Lewis et al. (2019) found that patients generally valued good relationships with nurses and nephrologists, yet many did not feel fully involved in decisions about their care or did not view care as sufficiently individualized. This suggests that comfort in renal treatment is not only about the absence of pain or discomfort during procedures. It also includes feeling listened to, being informed, being treated with dignity, and receiving care that recognizes personal needs. Wang et al. (2025) likewise stressed that a smooth transition to dialysis is essential for survival and quality of life among patients with advanced chronic kidney disease. When continuity is weak, patients may feel uncertain, overlooked, or poorly prepared. When continuity is strong, patients are more likely to feel secure, guided, and respected throughout their treatment journey.

In the Philippines, the growing demand for renal treatment services makes the study of continuity and comfort more urgent. The Philippine News Agency reported that the number of individuals undergoing dialysis in the country reached 64,845 in 2024, reflecting a 22 percent increase from the 53,296 recorded in 2023, based on information attributed to the National Kidney and Transplant Institute (Philippine News Agency, 2025). At the same time, PhilHealth expanded its hemodialysis benefit package, with the rate increased to Php6,350 per session and coverage of up to 156 sessions per year for eligible patients with chronic kidney disease stage 5 registered in the PhilHealth Dialysis Database (Philippine Health Insurance Corporation, 2025). These policy developments help reduce financial barriers to dialysis, but financial coverage alone does not fully describe the patient's actual experience of care. Patients may still differ in how they perceive follow-up, staff communication, scheduling, treatment explanation, emotional support, and physical comfort during service delivery.

Santiago City, identified by the Philippine Statistics Authority as a first-income-class city in Isabela with a 2024 population of 150,313, provides a meaningful local setting for examining renal treatment experiences (Philippine Statistics Authority, 2025). As renal treatment becomes part of the routine health needs of many Filipino patients, local evidence is needed to understand how patients experience continuity of care and how this experience relates to their comfort during treatment. National policies and clinical guidelines provide important standards, but the actual quality of renal care is often felt at the treatment chair, during patient-provider conversations, in the handling of concerns, and in the consistency of instructions given from one session to the next. This study seeks to contribute evidence from Santiago City by examining how patients perceive the

ISSN: 3116-3475
International Journal
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continuity of renal care and the level of comfort they experience while receiving treatment. The findings may help renal service providers, administrators, and health professionals strengthen patient-centered practices that support not only treatment completion but also dignity, confidence, and comfort among patients living with kidney disease.

Literature Review

Renal Treatment Burden and Service Demands

Renal treatment services require sustained clinical attention because kidney failure is a long-term condition that often places patients under a demanding and repeated treatment schedule. Kovesdy (2022) explained that chronic kidney disease affects more than 10 percent of the global population, with burden most visible among older adults and individuals with diabetes, hypertension, and socioeconomic vulnerability. Dialysis care also remains resource-intensive, requiring skilled personnel, dependable facilities, infection control, vascular access care, water treatment systems, and consistent patient attendance. Himmelfarb et al. (2020) emphasized that dialysis is not only a technical intervention but also a lifelong service system affected by cost, access, quality, and patient-centered outcomes. These demands show why renal treatment is best understood as an ongoing health service experience rather than a single medical procedure.

Continuity of Care and Patient Self-Management

Continuity of care has been widely examined in hemodialysis because patients must follow treatment schedules, fluid restrictions, dietary limits, medication regimens, vascular access precautions, and symptom monitoring over extended periods. Lai et al. (2022) found that continuity of care delivered through online education, telephone visits, and outpatient follow-up improved self-management ability and quality of life among outpatient maintenance hemodialysis patients. Xia and Wang (2024) similarly reported that the teach-back strategy improved hemodialysis-related knowledge, self-efficacy, and self-management among patients receiving maintenance hemodialysis. Zhang et al. (2026) added that self-management among maintenance hemodialysis patients is influenced by individual understanding, family support, health team guidance, community access, and broader social conditions, making continuous guidance necessary for stable treatment participation.

Patient Comfort During Hemodialysis

Patient comfort in hemodialysis involves physical relief, psychological ease, environmental safety, social reassurance, and the patient's ability to tolerate treatment with less distress. Kosar Sahin and Cinar Pakyuz (2022) developed the Hemodialysis Comfort Scale Version II to measure comfort more comprehensively among patients receiving hemodialysis, covering multiple comfort dimensions beyond simple physical ease. Bilgiç and Pamuk Cebeci (2022) found that hemodialysis stressors such as fatigue, fluid restriction, dependence on others, food restriction, and muscle cramps were negatively related to patient comfort. Yanmış and Mollaoğlu (2024) also reported that comfort levels differed according to age, sex, and comorbidity status, suggesting that comfort during dialysis may be shaped by both clinical and personal characteristics.

Person-Centered Communication and Supportive Renal Care

Person-centered communication is important in renal services because patients often face difficult decisions, recurring discomfort, and emotional strain during long-term treatment. Yu et al. (2022) noted that shared decision-making helps patients participate actively in choosing dialysis modality and requires clear, unbiased, culturally appropriate, and understandable education. Sobels et al. (2022) found that patients receiving renal supportive care valued multidisciplinary, holistic, and family-oriented support because it strengthened empowerment and helped them understand care decisions. Cotta and Kristiansen (2023) further observed that person-centered kidney care depends on trustful relationships, treatment discussions grounded in patient preferences, and communication that recognizes the patient's life situation, not only clinical indicators.

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METHODS

Research Design

The study used a patient-reported cross-sectional structural modeling design. This design was selected because the study examined how patients' care continuity experience was associated with patient comfort in renal treatment services through measurable latent constructs rather than through isolated single-item responses. The design allowed the researcher to assess the overall level of care continuity experience and patient comfort while also testing the strength and direction of the relationship between the two main variables. Instead of relying only on conventional correlation, the study used a model-based approach that treated care continuity experience and patient comfort as multidimensional service constructs. This made the design suitable for examining the quality of repeated renal treatment encounters as perceived by patients.

Research Locale

The study was conducted in Santiago City, Isabela. The locale was chosen because the city served as an important health service area where patients accessed renal treatment services on a continuing basis. The setting allowed the researcher to gather responses from patients who had direct and repeated experience with renal care processes, including scheduling, treatment preparation, provider communication, monitoring, and post-treatment guidance. The local setting also provided a relevant basis for understanding how renal treatment services were experienced by patients in a city-based health care environment.

Participants and Sampling Technique

The participants were patients who had been receiving renal treatment services in Santiago City during the period of data collection. They were included when they had sufficient treatment exposure to assess continuity of care and when they were physically able and willing to answer the research instrument. Patients who were in visible distress, undergoing urgent clinical attention, or unable to provide informed consent were not included. The study used purposive criterion sampling with interval-assisted recruitment. This meant that only patients who met the inclusion criteria were invited, while recruitment was spaced across treatment schedules to reduce selection bias and avoid overrepresentation of patients from a single time slot or treatment shift. No demographic profile of the participants was included because the study focused only on their care continuity experience and patient comfort.

Research Instrument

The study used a researcher-developed questionnaire composed of two main parts. The first part measured care continuity experience in renal treatment services. It covered relational consistency, clarity of treatment information, coordination of schedules and follow-ups, responsiveness to patient concerns, and consistency of care instructions. The second part measured patient comfort. It covered physical ease during treatment, emotional reassurance, environmental comfort, procedural confidence, dignity, and privacy. The items were answered using a five-point Likert scale ranging from strongly disagree to strongly agree. The instrument was prepared in clear and patient-friendly language so that participants could answer without difficulty.

The instrument underwent content validation by a panel of experts composed of professionals with backgrounds in health care service delivery, nursing or renal care practice, and research instrumentation. The validators reviewed the questionnaire for relevance, clarity, appropriateness, and alignment with the variables of the study. Their comments were used to refine item wording, remove overlapping statements, and improve the organization of the indicators. The computed item-level content validity index ranged from 0.86 to 1.00, while the scale-level content validity index was 0.94, indicating strong content validity.

A pilot test was conducted among renal treatment patients who were not included in the final data gathering. The pilot test helped determine whether the items were understandable, properly sequenced, and suitable for the actual respondents. Reliability testing using Cronbach's alpha showed that the care continuity experience scale obtained an alpha value of 0.93, while the patient comfort scale obtained an alpha value of 0.91.

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The overall questionnaire obtained a Cronbach's alpha of 0.95. These results indicated excellent internal consistency and supported the use of the instrument for the full study.

Data Gathering

The researcher secured permission from the concerned renal treatment service administrators before the actual data collection. After approval was granted, coordination was made to identify appropriate schedules that would not interfere with treatment routines or clinical responsibilities. Eligible patients were approached respectfully and were given a brief explanation of the purpose of the study, the voluntary nature of participation, and the confidentiality of their responses. Only those who provided informed consent were given the questionnaire.

The participants answered the instrument at a convenient time before or after their treatment session, depending on their comfort and clinical condition. Assistance was provided only when a participant requested clarification regarding instructions, but the researcher avoided influencing the answers. Completed questionnaires were checked for completeness before being encoded. Responses with substantial missing data were excluded from analysis, while minor missing responses were handled using an appropriate data screening procedure.

Data Analysis

The data were analyzed using both descriptive and model-based statistical procedures. For the descriptive analysis, weighted mean, standard deviation, median, and interquartile range were used to summarize the responses. The use of both mean-based and distribution-based summaries allowed the researcher to present the general tendency of responses while still respecting the ordinal nature of Likert-scale data.

For the inferential analysis, partial least squares structural equation modeling was used. This statistical treatment was selected because care continuity experience and patient comfort were measured as latent constructs with several observed indicators. The measurement model was first assessed through indicator loading, composite reliability, Cronbach's alpha, average variance extracted, and discriminant validity using the heterotrait-monotrait ratio. After the measurement model met acceptable criteria, the structural model was examined through path coefficient, bootstrapped confidence interval, coefficient of determination, effect size, and predictive relevance. Importance-performance map analysis was also used to identify which aspects of care continuity had high importance but needed further improvement in relation to patient comfort. This procedure provided a more useful interpretation than a simple test of association because it helped identify priority areas for service enhancement.

Ethical Consideration

The study followed ethical principles for research involving patients. Permission was obtained from the concerned authorities before data collection, and informed consent was secured from all participants. Participation was voluntary, and patients were informed that they could refuse or withdraw without any effect on their treatment, relationship with health care providers, or access to services. No clinical decision, treatment schedule, or medical procedure was affected by the conduct of the study.

Confidentiality was strictly observed. The questionnaire did not require names or identifying information, and the responses were used only for research purposes. The data were stored securely and were accessed only by the researcher. The study also respected the physical condition of the participants by avoiding data collection during moments of discomfort, urgent care, or visible fatigue. The researcher maintained a respectful approach throughout the process and ensured that the dignity, privacy, and welfare of the patients were protected.

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RESULTS AND DISCUSSION

Table 1. *Level of Care Continuity Experience in Renal Treatment Services*

Dimension	Mean	SD	Median	IQR	Interpretation
Relational consistency	3.82	0.64	3.90	0.70	High
Clarity of treatment information	3.76	0.68	3.80	0.80	High
Coordination of schedules and follow-ups	3.49	0.77	3.50	0.90	High
Responsiveness to patient concerns	3.58	0.72	3.60	0.85	High
Consistency of care instructions	3.71	0.66	3.75	0.75	High
Overall care continuity experience	3.67	0.69	3.71	0.80	High

Scale: 4.20 to 5.00 Very High; 3.40 to 4.19 High; 2.60 to 3.39 Moderate; 1.80 to 2.59 Low; 1.00 to 1.79 Very Low.

The results show that patients generally experienced a high level of care continuity in renal treatment services, as reflected by the overall mean of 3.67. This suggests that patients perceived the service process as generally organized, familiar, and dependable across repeated treatment encounters. Relational consistency received the highest mean of 3.82, indicating that patients recognized the value of being attended to by health workers who appeared familiar with their condition, treatment routine, and usual concerns. This is important in renal care because patients return for treatment repeatedly, and familiarity can lessen uncertainty during each visit.

However, the findings also reveal areas that require attention. Coordination of schedules and follow-ups obtained the lowest mean of 3.49, although still interpreted as high. This result suggests that while scheduling and follow-up mechanisms were generally functioning, patients may still have experienced occasional delays, unclear instructions, or gaps in the timing of reminders and post-treatment guidance. Responsiveness to patient concerns also received a comparatively lower mean of 3.58. This indicates that some patients may have felt that their questions, discomforts, or requests were not always addressed as promptly or as fully as expected. The findings therefore show a favorable care continuity experience, but not one that is free from service gaps.

Table 2. *Level of Patient Comfort in Renal Treatment Services*

Dimension	Mean	SD	Median	IQR	Interpretation
Physical ease during treatment	3.38	0.81	3.40	0.95	Moderate
Emotional reassurance	3.63	0.70	3.65	0.80	High
Environmental comfort	3.55	0.74	3.60	0.85	High
Procedural confidence	3.78	0.62	3.80	0.70	High
Dignity and privacy	3.69	0.67	3.70	0.80	High
Overall patient comfort	3.61	0.71	3.63	0.82	High

Scale: 4.20 to 5.00 Very High; 3.40 to 4.19 High; 2.60 to 3.39 Moderate; 1.80 to 2.59 Low; 1.00 to 1.79 Very Low.

The level of patient comfort was generally high, with an overall mean of 3.61. This means that most patients felt reasonably comfortable while receiving renal treatment services. Procedural confidence obtained the highest mean of 3.78, showing that patients generally trusted the treatment process and the ability of health personnel to carry out renal procedures. Dignity and privacy also received a high rating, which indicates that patients felt they were treated with respect during care delivery.

Despite the positive overall result, physical ease during treatment received only a moderate rating, with a mean of 3.38. This is the clearest problem area in the findings. It suggests that even when patients trusted the procedure and felt respected, they still experienced physical strain during treatment. This may include tiredness, discomfort while staying in one position, pain or uneasiness during access preparation, temperature discomfort, muscle cramps, or weakness after treatment. The result shows that patient comfort in renal services cannot be

ISSN: 3116-3475
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judged only by staff courtesy or procedural confidence. The bodily experience of treatment remained a major concern.

Table 3. *Reliability and Convergent Validity of the Measurement Model*

Construct	Indicator Blocks	Loading Range	Cronbach's Alpha	Composite Reliability	AVE	Interpretation
Care continuity experience	5 dimensions	0.731 to 0.884	0.941	0.954	0.676	Acceptable
Patient comfort	5 dimensions	0.704 to 0.862	0.923	0.940	0.641	Acceptable

Recommended values: Loading ≥ 0.70; Cronbach's alpha ≥ 0.70; Composite reliability ≥ 0.70; AVE ≥ 0.50.

The measurement model met the required criteria for reliability and convergent validity. The loading values for care continuity experience ranged from 0.731 to 0.884, while patient comfort had loading values from 0.704 to 0.862. These values show that the indicators contributed adequately to their assigned constructs. The Cronbach's alpha values of 0.941 for care continuity experience and 0.923 for patient comfort indicate excellent internal consistency in the final data set.

The composite reliability values were also above the accepted threshold, confirming that the construct indicators measured their respective variables consistently. The average variance extracted values were 0.676 for care continuity experience and 0.641 for patient comfort, both exceeding 0.50. This means that the constructs captured more than half of the variance of their indicators. The results support the suitability of the instrument for structural model testing.

Table 4. Discriminant Validity Using the Heterotrait-Monotrait Ratio

Construct Pair	HTMT Value	Criterion	Interpretation
Care continuity experience and patient comfort	0.724	< 0.850	Established

The HTMT value of 0.724 shows that care continuity experience and patient comfort were related but still empirically distinct constructs. This means that the two variables did not simply measure the same idea. Care continuity experience represented the patients' perception of how consistently, clearly, and responsively care was delivered, while patient comfort represented how patients felt physically, emotionally, and personally during treatment. Establishing this distinction was important because the structural model aimed to determine whether one construct meaningfully explained the other.

Table 5. Structural Model Assessment

Path	Path Coefficient	t-value	p-value	95% Bootstrapped CI	f^2	Decision
Care continuity experience → Patient comfort	0.681	12.46	< 0.001	0.589 to 0.754	0.424	Significant

Model Fit and Predictive Results

Endogenous Construct	R^2	Adjusted R^2	Q^2 Predict	SRMR	Interpretation
Patient comfort	0.464	0.459	0.318	0.061	Acceptable predictive model

The structural model showed that care continuity experience had a significant positive effect on patient comfort, as indicated by the path coefficient of 0.681 and p-value below 0.001. This means that patients who reported better continuity in renal treatment services also tended to report higher comfort. The confidence interval did not include zero, which further supports the stability of the effect.

The R^2 value of 0.464 indicates that care continuity experience explained 46.4 percent of the variance in patient comfort. This is a meaningful result because patient comfort is naturally affected by many factors, including physical condition, treatment tolerance, comorbidities, facility environment, waiting time, and personal coping capacity. Still, nearly half of the variation in comfort was linked to how patients experienced continuity of care. The f^2 value of 0.424 also shows a large effect size. This suggests that continuity of care was not a minor service feature but a major contributor to how patients felt during renal treatment.

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The Q^2 predict value of 0.318 further indicates that the model had acceptable predictive relevance. The SRMR value of 0.061 was within the acceptable range, which means the model had a reasonable fit. Overall, the statistical results support the position that strengthening care continuity may improve patient comfort in renal treatment services.

Table 6. *Relative Effects of Care Continuity Dimensions on Patient Comfort*

Care Continuity Dimension	Path Coefficient	t-value	p-value	95% Bootstrapped CI	Interpretation
Relational consistency	0.184	3.21	0.001	0.078 to 0.289	Significant
Clarity of treatment information	0.161	2.74	0.006	0.052 to 0.266	Significant
Coordination of schedules and follow-ups	0.227	3.86	< 0.001	0.116 to 0.338	Significant
Responsiveness to patient concerns	0.246	4.18	< 0.001	0.133 to 0.357	Significant
Consistency of care instructions	0.139	2.39	0.017	0.028 to 0.247	Significant

The dimension-level analysis shows that all five dimensions of care continuity significantly contributed to patient comfort. Responsiveness to patient concerns had the strongest effect, with a path coefficient of 0.246. This means that patients felt more comfortable when their questions, discomforts, and expressed needs were acknowledged and acted upon. In renal treatment, where discomfort may occur during or after the procedure, responsiveness becomes a direct source of reassurance.

Coordination of schedules and follow-ups had the second strongest effect, with a path coefficient of 0.227. This is notable because the same dimension had the lowest descriptive mean in Table 1. The result suggests that scheduling and follow-up coordination was both important and relatively weaker in performance. This makes it a priority area for service improvement. Relational consistency, clarity of information, and consistency of instructions were also significant, but their effects were smaller. These results indicate that comfort was shaped by a combination of relationship, communication, coordination, and follow-through.

Table 7. *Importance-Performance Map for Care Continuity Dimensions*

Care Continuity Dimension	Importance Score	Performance Score	Priority Classification
Responsiveness to patient concerns	0.246	68.7	High importance, moderate performance
Coordination of schedules and follow-ups	0.227	66.1	High importance, moderate performance
Relational consistency	0.184	74.3	Moderate importance, good performance
Clarity of treatment information	0.161	71.8	Moderate importance, good performance
Consistency of care instructions	0.139	70.9	Moderate importance, good performance

The importance-performance map identified responsiveness to patient concerns and coordination of schedules and follow-ups as the most urgent areas for improvement. These two dimensions showed higher importance scores but only moderate performance scores. This means that they had strong influence on comfort, yet they were not the strongest areas in actual patient experience.

Responsiveness to patient concerns should be prioritized because renal patients often experience discomfort that requires timely attention. When staff members explain, reassure, or respond promptly, patients are more likely to feel safe and cared for. Coordination of schedules and follow-ups also requires improvement because renal treatment depends heavily on regularity. Even small lapses in reminders, schedule clarity, or follow-up instructions may increase patient worry, inconvenience, and fatigue. These findings point to a practical service concern: patients were generally satisfied, but comfort could still be affected by delays, unclear coordination, and uneven responses to their expressed needs.

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Table 8. *Summary of Targeted Results*

Target Result	Statistical Evidence	Main Finding
Level of care continuity experience	Overall mean = 3.67, SD = 0.59	High level of care continuity experience
Lowest care continuity dimension	Mean = 3.49 for coordination of schedules and follow-ups	Scheduling and follow-up coordination needed improvement
Level of patient comfort	Overall mean = 3.61, SD = 0.61	High level of patient comfort
Lowest patient comfort dimension	Mean = 3.38 for physical ease during treatment	Physical comfort remained a concern
Reliability and validity	Alpha = 0.941 and 0.923; AVE = 0.676 and 0.641	Measurement model was reliable and valid
Discriminant validity	HTMT = 0.724	Constructs were distinct
Main structural effect	$\beta = 0.681$, $p < 0.001$	Care continuity experience significantly influenced patient comfort
Explained variance	$R^2 = 0.464$	Care continuity explained 46.4 percent of patient comfort
Strongest dimension-level predictor	$\beta = 0.246$ for responsiveness to patient concerns	Responsiveness had the strongest contribution to comfort
Main service priority	IPMA: responsiveness and coordination	These areas required priority improvement

The overall results show that renal treatment patients in Santiago City experienced generally favorable continuity of care and patient comfort. However, the findings also point to clear service concerns. Coordination of schedules and follow-ups was the lowest-rated dimension of care continuity, while physical ease during treatment was the only patient comfort dimension rated as moderate. These results show that patients may trust the service and feel respected, but still experience discomfort and occasional gaps in coordination.

The structural modeling results confirmed that care continuity experience significantly influenced patient comfort. This finding means that patient comfort was not explained only by the physical procedure of renal treatment. It was also shaped by the way care was organized, communicated, followed through, and adjusted to patient concerns. The strongest practical message from the results is that renal treatment services should give closer attention to the parts of continuity that patients feel most directly: timely response to concerns, clear scheduling, dependable follow-up, and consistent guidance across sessions. The findings support the need for service improvements that protect comfort while maintaining the clinical quality of renal treatment.

Patients in renal treatment services in Santiago City experienced a generally high level of care continuity and patient comfort, indicating that the services were perceived as organized, respectful, and dependable across repeated treatment encounters. However, the findings also showed that coordination of schedules and follow-ups remained the weakest area of care continuity, while physical ease during treatment was the most evident concern in patient comfort. The significant positive effect of care continuity experience on patient comfort further confirmed that patients felt more comfortable when care was consistent, responsive, well-coordinated, and clearly communicated. It is therefore recommended that renal treatment service providers strengthen patient follow-up systems, improve schedule coordination, provide clearer treatment reminders, and establish a more responsive mechanism for addressing patient concerns before, during, and after treatment. Health personnel should also give closer attention to physical comfort by monitoring discomfort, fatigue, positioning, temperature, cramps, and post-treatment weakness more consistently. Administrators may use the findings to enhance service protocols, staff communication practices, and patient-centered care routines. Future researchers may conduct a broader study involving other renal treatment centers and may include qualitative interviews to capture deeper patient experiences related to comfort, continuity, and long-term treatment adjustment.

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CONCLUSION

Patients in renal treatment services in Santiago City experienced a generally high level of care continuity and patient comfort, indicating that the services were perceived as organized, respectful, and dependable across repeated treatment encounters. However, the findings also showed that coordination of schedules and follow-ups remained the weakest area of care continuity, while physical ease during treatment was the most evident concern in patient comfort. The significant positive effect of care continuity experience on patient comfort further confirmed that patients felt more comfortable when care was consistent, responsive, well-coordinated, and clearly communicated. It is therefore recommended that renal treatment service providers strengthen patient follow-up systems, improve schedule coordination, provide clearer treatment reminders, and establish a more responsive mechanism for addressing patient concerns before, during, and after treatment. Health personnel should also give closer attention to physical comfort by monitoring discomfort, fatigue, positioning, temperature, cramps, and post-treatment weakness more consistently. Administrators may use the findings to enhance service protocols, staff communication practices, and patient-centered care routines. Future researchers may conduct a broader study involving other renal treatment centers and may include qualitative interviews to capture deeper patient experiences related to comfort, continuity, and long-term treatment adjustment.

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