London Acute Kidney Injury Network

NHS
London
Strategic Clinical Networks

Quality Standard

Version 1.0 (2015)

Supporting the delivery of equitable, high quality AKI care through collaboration

www.londonaki.net

@LondonAKI

Overview

The management of acute kidney injury has been the subject of a number of initiatives, standards and directives.

- London AKI Network has identified a need to support implementation teams with clear guidance on current quality standards. These standards apply to organisations (that is, levels of implementation, systems and processes that should be in place) as well as at patient level (what represents quality AKI patient care).

- The London AKI Network quality standard aims to unify these standards in one place. This dovetails with other key products:

    - The London AKI manual, which synthesises clinical guidance (including the National Institute for Clinical Excellence Clinical Guideline 169) into accessible patient pathways.

    - The London AKI Academy educational resources

    - A suite of quality improvement tools that we are signposting through collaboration with the UCL Partners AKI quality improvement collaborative.

    - The London AKI implementation toolkit

- In unison we believe these integrated, locally endorsed resources provide a framework of meaningful support for front-line improvements in AKI care in London.

- This unified standard incorporates key National standards including the 2009 report of the National Confidential Enquiry into Patient Outcome and Death *'Adding Insult to Injury. A review of the care of patients who died in hospital with a primary diagnosis of acute kidney injury (acute renal failure)'* the National Institute for Clinical Excellence (NICE) *Quality Standard 76* and the NHS England June 2014 Stage 3 National Patient Safety Alert *'Standardising the early identification of Acute Kidney Injury'*.

- The content of this standard has been ratified by the London AKI Network board, which has multidisciplinary representation from across London.

- We are supporting this standard with two additional resources: (a) a London AKI Network Audit tool, designed to support teams in undertaking audits at patient level of AKI care and (b) an organisational checklist such that local clinical teams leads and medical directors can assess levels of compliance and implementation at organisational level.

- On November 17th, 2015 at our pan-London sharing best practice event we launched our second survey to assess levels of organisational implementation across London. This self-assessment questionnaire has been sent to all Chief Executive Officers of London Acute Trusts. *In 20, on review of the results of this survey, the network will recognise exemplar sites that have high levels of implementation and are actively engaged in efforts to improve the care of AKI patients.*

Section A: Organisational Standards

Standard 1:

All acute Trusts should have a Trust AKI lead with appropriate support to enable compliance with standards and improvement in AKI care. Such Trust AKI leads should be in contact with London AKI Network (London Renal Strategic Clinical Network) such that they can access National and regional updates and share best practice.

Source: London AKI Network

Standard 2:

All Trusts should be compliant with the June 2014 NHS England Stage 3 directive National Patient Safety Alert 'Standardising the early identification of acute kidney injury'. All laboratory information management systems (LIMS) used in the trust to measure serum creatinine should run the National AKI detection algorithm. 'Tests results' generated by this detection algorithm should be sent to local patient management systems. This data should also be sent to the UK Renal Registry in line with Registry requirements.

Source: NHS England Stage 3 National Patient Safety Alert 'Standardising the early identification of acute kidney injury'. June 2014.

Resources:

'Think Kidneys' Acute Kidney Injury Warning Algorithm Best Practice Guidance. https://www.thinkkidneys.nhs.uk/wp-content/uploads/2014/12/AKI-Warning-Algorithm-Best-Practice-Guidance-final-publication-0112141.pdf

'Think Kidneys' Transmitting AKI Warning Stage Data to the UK Renal Registry. https://www.thinkkidneys.nhs.uk/wp-content/uploads/2015/01/Transmitting-AKI-Warning-Stage-Data-to-the-UK-Renal-Registry-v10.pdf

'Think Kidneys' Top Tips for Best Practice in AKI Reporting. https://www.thinkkidneys.nhs.uk/wp-content/uploads/2015/08/Top-Tips-For-Best-Practice-in-AKI-Reporting.pdf

Section A: Organisational Standards

Standard 3:

Trusts should have systems in place such that patients admitted as an emergency should have urea and electrolytes checked on admission and at appropriate frequency thereafter.

Source: NCEPOD "Adding Insult to Injury". A review of the care of patients who died in hospital with a primary diagnosis of acute kidney injury (acute renal failure). 2009.

Standard 4:

Trusts should have implemented NICE Clinical Guideline 50 'Acute Illness in Adults in Hospital: recognising and responding to deterioration'. In particular all acute patients should have admission physiological observations performed and a written physiological monitoring plan made, taking into account the degree of illness and risk of deterioration.

Source: NCEPOD "Adding insult to Injury". A review of the care of patients who died in hospital with a primary diagnosis of acute kidney injury (acute renal failure). 2009.

Standard 5:

Every hospital should have a written guideline on the prevention, detection and management of acute kidney injury. This should include clear guidance as to how the three clinical areas where patients with AKI are treated (critical care unit, the renal unit and the non- specialist ward) interact to ensure delivery of high quality, clinically appropriate care for patients with AKI. Implementation should be supported with staff education and awareness.

Source: NCEPOD "Adding Insult to Injury". A review of the care of patients who died in hospital with a primary diagnosis of acute kidney injury (acute renal failure). 2009.

Source: London AKI Network.

Resources:

NICE Clinical Guideline 50. https://www.nice.org.uk/guidance/cg50

London AKI Network regionally agreed guidelines and pathways (synthesising national guidance).
http://www.londonaki.net/clinical
http://www.londonaki.net/downloads/LondonAKInetwork-Manual.pdf

Section A: Organisational Standards

Standard 6:

All acute admitting hospitals should have appropriate levels of access to nephrology advisory and liaison services as well as clear arrangements with a sub-regional renal unit for the transfer of patients for tertiary AKI services.

Source: NCEPOD "Adding Insult to Injury". A review of the care of patients who died in hospital with a primary diagnosis of acute kidney injury (acute renal failure). 2009.

Source: London AKI Network.

Standard 7:

All acute admitting hospitals should have access to a renal imaging service 24 hours a day including the weekends. Appropriate arrangements must be in place to provide emergency relief of obstruction with appropriate urological or interventional radiology access. Where emergency cover is not provided onsite clear network arrangements must be in place.

Source: NCEPOD "Adding insult to Injury". A review of the care of patients who died in hospital with a primary diagnosis of acute kidney injury (acute renal failure). 2009.

Source: London AKI Network.

Resources:

London AKI Network regionally agreed guidelines and pathways (synthesising national guidance).
http://www.londonaki.net/downloads/LondonAKInetwork-ReferralFromWard.pdf
http://www.londonaki.net/downloads/LondonAKInetwork-TransferFromWardToKidneyUnit.pdf
http://www.londonaki.net/downloads/LondonAKInetwork-ReferralFromCriticalCareToNephrology.pdf
http://www.londonaki.net/downloads/LondonAKInetwork-TransferFromCriticalCareToUnit.pdf

Section A: Organisational Standards

Standard 8:

All level 3 units should have the ability to deliver renal replacement therapy; and where appropriate these patients should receive clinical input from a nephrologist.

Source: NCEPOD "Adding Insult to Injury". A review of the care of patients who died in hospital with a primary diagnosis of acute kidney injury (acute renal failure). 2009.

Standard 9:

There should be sufficient critical care and renal beds to allow rapid step up in care if appropriate. Transfer may be required for acute renal support, monitoring, other organ support, diagnostics or specialist therapy.

Source: NCEPOD "Adding insult to Injury". A review of the care of patients who died in hospital with a primary diagnosis of acute kidney injury (acute renal failure). 2009.

Source: London AKI Network.

Resources:

London AKI Network regionally agreed guidelines and pathways (synthesising national guidance). http://www.londonaki.net/downloads/LondonAKInetwork-ReferralFromWard.pdf

Section B:
Direct Patient Care Standards

These standards relate to direct patient care and are derived entirely from ***National Institute for Clinical Excellence Quality Standard 76.*** *Our intention here is to highlight the presence of this standard and place it in the context of other local and NHS guidance, including organisational standards mapped in Section A.*

Further information relating to this quality standard is available here: http://www.nice.org.uk/guidance/qs76

NICE provide not only advice on these quality strategies but potential measurement strategies for quality improvement initiatives targeting these standards.

Standard 1:

People who are at risk of acute kidney injury are made aware of the potential causes.

Rationale: Many people who develop acute kidney injury are not aware of the potential causes and how to prevent it. Acute kidney injury can be prevented by educating people about the risks and how to stop it from developing. Better education delivered in primary care settings, outpatient settings and on discharge from hospital will help to reduce the number of people developing acute kidney injury outside hospital and the number being admitted to hospital with the condition.

Source: NICE Quality Standard 76.

Standard 2:

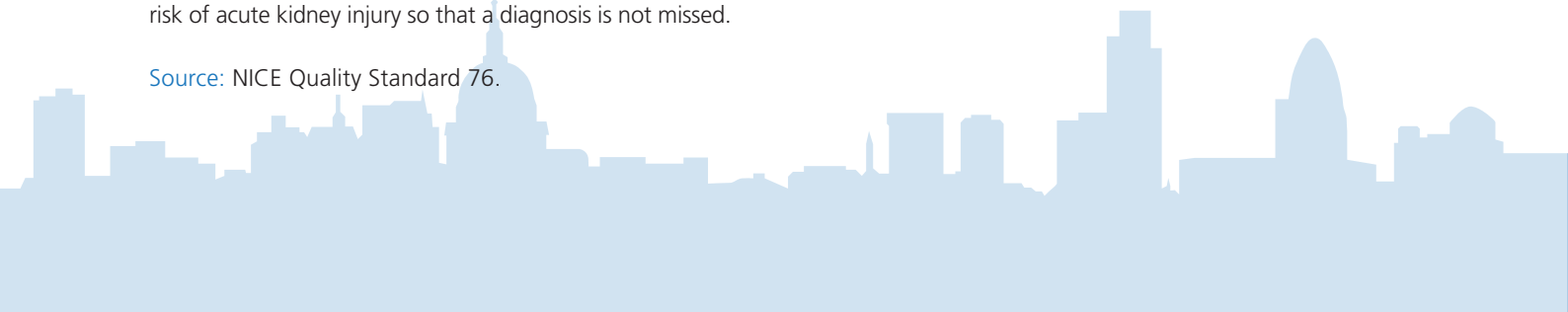
People who present with an illness with no clear acute component and 1 or more indications or risk factors for acute kidney injury are assessed for this condition.

Rationale: People with acute kidney injury may present with no obvious signs or symptoms of this condition in primary or secondary care settings. Early assessment for acute kidney injury when making decisions about treatment for people who are at risk may prevent delays in treating the condition, leading to improved outcomes. It is important for healthcare professionals to be aware of when it is necessary to assess the risk of acute kidney injury so that a diagnosis is not missed.

Source: NICE Quality Standard 76.

Resources:

London AKI Network regionally agreed guidelines and pathways (synthesising national guidance). http://www.londonaki.net/downloads/LondonAKInetwork-RiskPreventionRecognition.pdf



Section B:
Direct Patient Care Standards

Standard 3:

People in hospital who are at risk of acute kidney injury have their serum creatinine level and urine output monitored.

Rationale: Acute kidney injury can be a 'silent' condition with no external signs or symptoms. Because many episodes of acute kidney injury are preventable, identifying people who are at risk and monitoring their clinical condition is important. Changes in serum creatinine level and urine output are indicators of risk, and it is important that these biomarkers are monitored alongside a 'track and trigger' system. Recognising and responding to these changes will ensure appropriate and quick intervention to prevent acute kidney injury developing.

Source: NICE Quality Standard 76.

Standard 4:

People have a urine dipstick test performed as soon as acute kidney injury is suspected or detected.

Rationale: Understanding the cause of acute kidney injury by testing the urine for blood and protein is important for guiding further specialised investigations and appropriate treatments. Urine dipstick testing is a simple, effective and inexpensive diagnostic test to identify underlying conditions that can be treated to either prevent acute kidney injury or reduce its severity, thus avoiding more serious consequences.

Source: NICE Quality Standard 76.

Resources:

London AKI Network regionally agreed guidelines and pathways (synthesising national guidance).
http://www.londonaki.net/downloads/LondonAKInetwork-RiskPreventionRecognition.pdf
http://www.londonaki.net/downloads/LondonAKInetwork-ReferralFromWard.pdf

'Think Kidneys' Acute Kidney Injury Warning Algorithm Best Practice Guidance. https://www.thinkkidneys.nhs.uk/wp-content/uploads/2014/12/AKI-Warning-Algorithm-Best-Practice-Guidance-final-publication-0112141.pdf

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Section B:
Direct Patient Care Standards

Standard 5:

People with acute kidney injury have the management of their condition discussed with a nephrologist as soon as possible, and within 24 hours of detection, if they are at risk of intrinsic renal disease or have stage 3 acute kidney injury or a renal transplant.

Rationale: Input from nephrologists to the management of acute kidney injury is needed as soon as possible for people who are at risk of their condition worsening or of adverse outcomes. This helps to ensure that people get the specialist care they need to help their condition improve and to prevent it from deteriorating further.

Source: NICE Quality Standard 76.

Standard 6:

People with acute kidney injury who meet the criteria for renal replacement therapy are referred immediately to a nephrologist or critical care specialist.

Rationale: It is important to ensure that people with acute kidney injury who need treatment receive it in the right care setting (such as an intensive care unit or renal unit) at the right time, and that delays in treatment that put people at risk are avoided. This can be achieved through immediate referral supported by effective referral and transfer protocols that prioritise people with the greatest need. Prompt treatment offers potential benefits that include preventing further deterioration of renal function, improving chances of renal recovery, shorter hospital stays, lower mortality and better long-term outcomes.

Source: NICE Quality Standard 76.

Resources:

London AKI Network regionally agreed guidelines and pathways (synthesising national guidance).
http://www.londonaki.net/downloads/LondonAKInetwork-ReferralFromWard.pdf

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