LESSONS FROM ACUTE KIDNEY INJURY

INTRODUCTION

"AKI is associated with poor patient outcomes"

"AKI is common & a powerful marker for high risk"

"This a one year PCN AKI quality improvement project
This is the learning & diagnostic phase of the project"

AKI can be used at a low to learn how to improve safety and quality of care for patients with complex health & care needs.

WORK TO DATE & CHALLENGES AHEAD

The "think kidneys" AKI programme is a fantastically ambitious programme aiming to change the outcomes of AKI in England.

"But... the commonest cause of readmission after AKI medications are stopped is pulmonary oedema"

This highlights the need to communicate when to restart medication!

The drugs usually stopped are ACEi/ARBi/metformin... but often many other drugs can accumulate!

Jick day rules are controversial... there's little evidence

Read isn't open article before implementing jick day rules in your area

Challenges: we need to avoid alert fatigue! There is complex social science behind this!
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QUALITY IMPROVEMENT IN AKI: UNDERSTANDING THE PROBLEM

There are different sorts of problems faced in QI...

Complicated Problems v2 Complex Problems

Trying to launch a space rocket. The components are 'complicated', but you can learn these components...

...like raising a child! There's all sort of factors involved.

Aki is a Complex Problem!

We are all here today to get a shared understanding of a problem, and how we can come together to solve these problems!

To tackle it we must take account the local context; one size will not fit all.

Context is the soil for your ideas!
LESSONS FROM...

ACUTE KIDNEY INJURY

CASE PRESENTATION

DR ALISON RIMMER
BURY GP

EXAMPLE OF AKI RESULT PASSED ONTO OCH DOCTOR
UNABLE TO GET AN ANSWER ON THE PHONE...
THIS PATIENT IS KNOWN TO OFTEN NOT ANSWER...

WITH NO CLINICAL CONTEXT +

USING ENRICHED SUMMARY CARE RECORDS IS VITAL

EXAMPLE OF A PATIENT ADMITTED WITH ‘AKI’
Cr 382 ...... DISCHARGED 390 !
BASELINE Cr USUALLY 350-400 !

EXAMPLE OF A FARMER
Cr 850 !
BASELINE BLOOD 1 YEAR AGO
DIFFICULT TO PREDICT PRE-TEST PROBABILITY

OR

AKI

CKD

???

IT'S NOT ALWAYS POSSIBLE TO SAY !

DR HELEN FINNAMORE
GPST SEDGEFIELD

DR DUNCAN HILL
GP, MANCHESTER

HOSPITAL DISCHARGE SUMMARY

AKI MENTIONED
BUT NOT CODED...

MEDICATIONS STopped
‘GP TO FOLLOW UP’
‘NEW’ MEDICATION PRESCRIBED...
BUT NOT DISPENSED

PRACTICE PHARMACIST TO REVIEW MEDS

GP PRACTICE...
NO PLAN FOR AKI DISCHARGE
POOR CODING
LACK OF STRUCTURE FOR COMMUNITY FOLLOW UP

BOOK PATIENTS FOR 1 WEEK F/U
FOR BP + BLOOD
GP APPT WITH RESULTS

PROVIDE SICK DAY RULES CARD

IMPROVE WORKFLOW
CODING TEAM
LESSONS FROM
ACUTE KIDNEY INJURY
UNDERSTANDING THE PROBLEM
ROUND TABLE DISCUSSIONS

DR. JOANNA BIRCHER
LEAD FOR QUALITY IMPROVEMENT,
PARKER & QUALITY CCC

RESPONDING TO AKI WARNING STAGE
TEST RESULTS USING A ‘FISH BONE’ EXERCISE

EXAMPLE

POST AKI CARE USING PROCESS MAPPING
LESSONS FROM... ACUTE KIDNEY INJURIES

JO WOONEY - PROGRAMME MANAGER
DETERIORATING PATIENT, KSSAHIN

CARE-FLOW CONNECT
REDUCES NUMBERS OF HANDBOVERS

STAGE 3 AKI
SENT TO ALL TEAM MEMBERS WITHIN A GROUP
CHECK IF TASK HAS BEEN ACTIONED

?INCLUDE PRIMARY CARE IN THE FUTURE
ALLOW INTERACTIONS BETWEEN SERVICES
TONY TETLOW
CONSULTANT CLINICAL SCIENTIST
TAMESIDE HOSPITAL TO ROLL OUT AKI ALERTS!

INTRODUCTION OF AKI DETECTION SOFTWARE
POSSIBILITIES, STRENGTHS & PITFALLS...
AKA TALES OF A CAUTIOUS BIOCHEMIST

MEALS/DIET CAN IMPACT CRITICITING!
IF STAGE 1 ALERT RAISED...
CONSIDER REPEATING RENAL FUNCTION TESTING!

SOFTWARE ALGORITHM...
- LOOKS FOR CR IN PREVIOUS 7 DAYS... IF NONE...
- PREVIOUS 365 DAYS!
- LOOKS AT THE CHANGE, NOT THE ABSOLUTE VALUE

QUESTIONS AND ANSWERS

- LOT OF MY BLOODS APPEAR RED...
  ...WE PUT COMMENTS UNDER AKI ALERTS

- WHAT ABOUT USING TRAFFIC LIGHT COLOURS?
  THERE IS DIFFICULTY MAKING NEW REFERENCES

- CAN YOU HIGHLIGHT USING A DIFFERENT COLOUR TO HIGHLIGHT...
  10% UK POPULATION COLOUR ILLINOIS
LESSONS FROM...
ACUTE KIDNEY INJURY

IF WE GENERATE LOTS OF AKI ALERTS WITHOUT SUPPORT...
= DISSAPPOINTMENT
= MISINTERPRETATION

IGNORE IT

DEAL WITH IT...

PHONE MEDICAL SPR OR NEPHROLOGIST?

OR

 SECURE EMAIL TO RENAL
ALL CONSULTANTS SIMULTANEOUSLY RECEIVE GP EMAILS

BESPOKE PROMPT SERVICE

INSSTEAD OF
"PLEASE CAN YOU SEE THIS PATIENT IN CLINIC"

WE ARE TRYING TO SUPPORT AKI CARE IN THE COMMUNITY DELIVERED BY PRIMARY CARE TEAMS

ON AVERAGE 1-2 EMAILS ARE GENERATED BY GPs IN PRACTICE IN 5 CCQs

AKI NICE INDICATORS - PILOTING OF INDICATORS

CRAIG GRIEVE - TECHNICAL ADVISOR

EVERYONE IS AWARE OF NICE GUIDELINES, BUT NOT NICE INDICATORS!

UPCOMING NICE AKI INDICATORS (DEVELOPED WITH 'THINK KIDNEYS')

1. AKI REGISTER (PATIENTS 2 AKI IN PRECEDING 12 MONTHS)
2. % MEDICATION REVIEW WITHIN 1 MONTH OF DIAGNOSIS
3. % SERUM CREATININE CHECKS > 3 MONTHS OF DIAGNOSIS
4. % PATIENTS GIVEN WRITTEN INFORMATION 5 WEEKS OF DIAGNOSIS

'PILOT' = TESTING TO ENSURE INDICATORS WORK...
? WORTHY MARKERS OF QUALITY...
... OR JUXT NOISE!
ACUTE KIDNEY INJURY

LESSONS FROM

HOW DO WE MOVE FORWARD?
SETTING CLEAR AIMS & MEASURING IMPROVEMENT

WE WILL BE MAKING AIMS
SOME IS NOT A NUMBER
SOON IS NOT A TIME

WE WANT SPECIFIC MEASURES

Task: On 3 post it notes write an aim
* Be specific as possible
* How would you measure this aim?
* Using outcome & process measures?

WHAT ARE WE TRYING TO IMPROVE?

WE MAKE A LOT OF ASSUMPTIONS ON WHAT WE THINK WILL IMPROVE SOMETHING!

AUDIENCE MEMBER INVITED TO SHARE AIM

MY AIM IS TO IMPROVE PATIENT AND CARER UNDERSTANDING OF AKI...

HOW WILL WE KNOW THAT A CHANGE IS AN IMPROVEMENT?

DR BIRCHER

IS EDUCATION AN AIM?

YES, SO WHEN PATIENTS KNOWS WHEN TO SEEK HELP

OK, SO THE AIM IS TO EDUCATE PATIENTS TO ASK FOR HELP WHEN INDICATED

WHAT CHANGES CAN WE MAKE THAT WILL RESULT IN IMPROVEMENTS?

THIS IS A DIFFERENT WAY OF THINKING...

...DIFFERENCE BETWEEN A CHANGE IDEA & AN AIM