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P054 -COMPLIANCE OF ACUTE KIDNEY INJURY (AKI) BUNDLE IN PATIENTS ADMITTED WITH AKI STAGE 3

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Introduction:

Acute kidney injury (AKI) is one of the most common complications of in-hospital patients and especially those admitted with critical care illnesses. Up to one in five emergency admissions to hospital are believed to be associated with AKI (Wang, 2012). Depending upon the patient age group, the mortality rates ranges from 30 – 60 % and elderly patients are more susceptible (Hobson, 2009). Up to 100,000 deaths that occur in secondary care may be associated with AKI. However, according to NCEPOD (2009) report, about one third of AKI cases could potentially be prevented and this can reduce the financial cost very significantly.

Aims:

To assess the compliance of AKI bundle in patients admitted to hospital with AKI stage 3 or developed AKI during their stay in hospital.

Methods:

This is a retrospective qualitative audit project. The source of the data was derived from was from the data pooled for AQuA. These are from electronic patient records and was obtained from trust AKI team. Data was stored in password protected trust computer systems. The audit was registered with the trust audit team.

Key clinical issues that will be covered in this audit are,

a) Clinical assessment in the identification of acute kidney injury b) Urinalysis using urine dipstick. c) Radiological imaging of kidneys to investigate for the cause of AKI and to rule out any obstruction. d) Preventing further deterioration of AKI by holding potentially nephrotoxic drugs. e) Involvement of Nephrology specialist service and / or referral of the acutely ill patients to critical care services. f) Repeat renal function test within 24 hours of the first AKI alert.

Inclusion criteria:

Patients above 18 years of age.

Coded with a diagnosis of AKI as per NHS AKI algorithm from October 2017 – March 2018.

Exclusion criteria:

Pregnant patients.

Patients receiving renal replacement therapy.

Patients admitted for palliative care or those who were palliated within 24 hours of admission to hospital.

Patients discharged within 24 hours of hospital admission

Conclusion:

Despite ample knowledge of the biologic basis of AKI, descriptions of the incidence, risk factors, sequelae, and outcomes of AKI remain relatively limited or have been based upon older descriptions without reflecting the most current definitions or practice patterns. We demonstrated that automated data collection does not reflect the compliance of AKI guidelines and needs a clinical validation. Introducing a care bundle which should be made available readily to all the treating physicians. This will be helpful as a simplest way of recalling the line of management including the basic interventions and provided an efficient way of recording these in the notes via the AKI clinical entry on the electronic patient records.