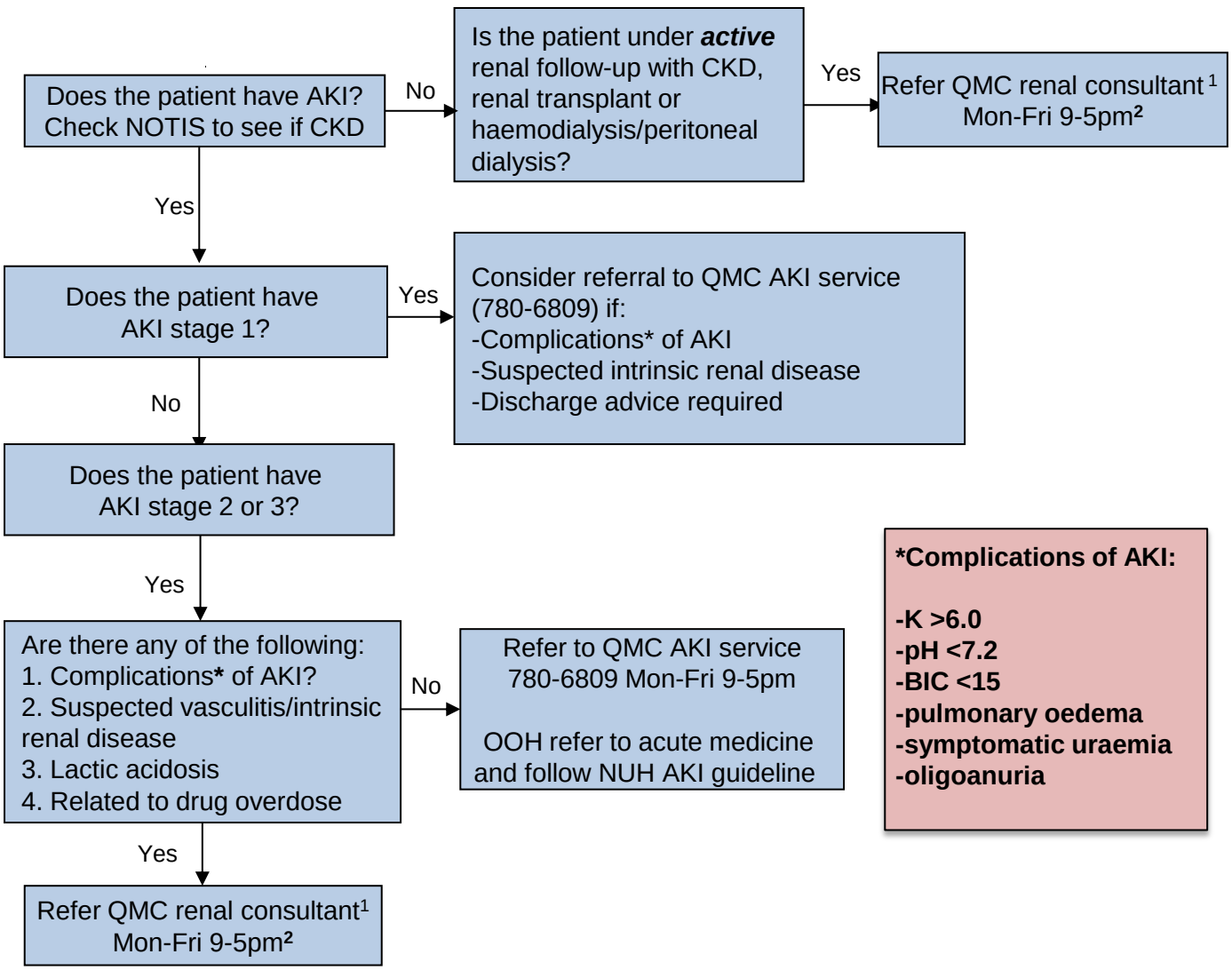
QMC Emergency Admissions Renal Patient Pathway

The following describes patient flow and referral pathway for patients with acute kidney injury and non-AKI patients (CKD, renal transplants, haemodialysis & peritoneal dialysis) who are known to nephrology:

For all patient with confirmed AKI: *Please follow NUH AKI guidelines*
(http://nuhnet/nuh_documents/Guidelines/Trust%20Wide/Trust%20Wide/1719.pdf)

1. **Assess fluid status: rehydrate when necessary**
2. **Urinalysis**
3. **Review drugs, dosage and omit/stop nephrotoxic drugs**
4. **Exclude obstruction**
5. **Treat sepsis (follow sepsis bundle)**
6. **Repeat renal function within 24hrs**



***Complications of AKI:**

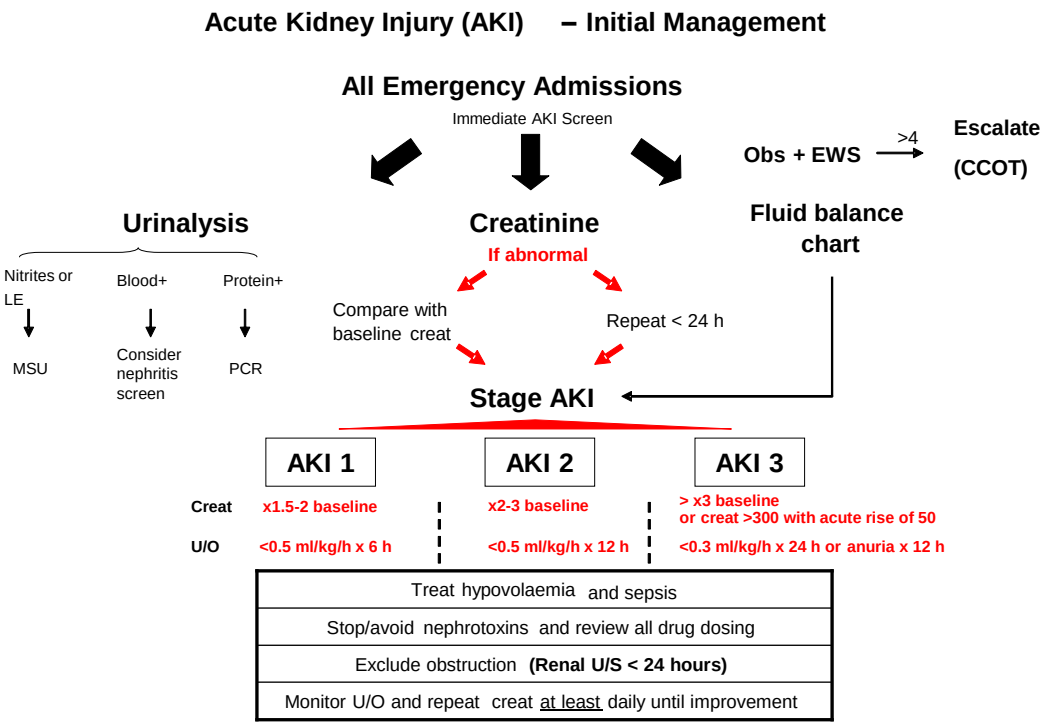
-K >6.0
-pH <7.2
-BIC <15
-pulmonary oedema
-symptomatic uraemia
-oligoanuria

Notes:
[1] Please refer to renal consultant rota on the intranet for QMC cover or via switchboard
[2] For urgent out of hours refer to renal StR/cons on-call at NCH via switchboard
[3] If discharging a patient with AKI stage 1 from ED please ensure this is documented on the discharge summary and appropriate follow-up advice is given to GP

AKI pathway developed by Dr Bisset (Renal Consultant), Dr Coleman (ED Consultant) 11/11/14. review date 11/11/16

KDIGO AKI staging criteria

Stage	SCr criteria	U/O criteria
1	1.5–1.9 x baseline OR ≥26 μmol/L increase	<0.5mL/kg/h for 6–12 h
2	2.0–2.9 x baseline	<0.5mL/kg/h for ≥12 h
3	3.0 x baseline OR Increase in SCr to ≥354 μmol/L OR Initiation of RRT OR In patients <18 years, decrease in eGFR to <35 mL/min per 1.73 m^2	<0.3mL/kg/h for ≥24 h OR anuria for ≥12 h



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Suggestion for inclusion into GP letter:

"Dear Dr,

A patient registered to your practice has been discharged from the ED.

During their assessment is was noted that they may have had either stage 1 AKI, or possibly new found CKD if no recent U&E was available to view:

Urea was:
Creatinine was:
GFR was:

*The last GFR was: on the xx/xx/xxxx
*NO previous GFRs existed on NOTIS

*Delete as appropriate

NICE clinical guideline 182 recommends the following:

In people with a new finding of reduced GFR, repeat the GFR within 2 weeks to exclude causes of acute deterioration of GFR – for example, acute kidney injury, starting new medications

Take the following steps to identify the rate of progression of CKD:
Obtain a minimum of 3 GFR estimations over a period of not less than 90 days.

Monitor people for the development or progression of CKD for at least 2–3 years after acute kidney injury, even if serum creatinine has returned to baseline.

If you have any queries please contact the QMC AKI team (M-F 0900-1700) via the NUH switchboard 0115 9249924"