

Acute Kidney Injury Care In The Oncology Population - A Novel Venture

Background

Onco-nephrology is certainly an evolving novel speciality worldwide. The advent of daily acute medical presence at The Christie Hospital has significantly transformed the way oncology patients are assessed and treated at the point of entry. As a direct consequence of this novel remodelling of service provision and care, multiple quality improvement initiatives have been spearheaded to address previously unconsidered clinical challenges. One such demand is acute kidney injury risk mitigation and early targeted intervention in patients receiving various systemic anticancer treatment modalities with or without radiotherapy for a wide range of cancers.

Methods

A series of work streams have been developed over 18 months to tackle the emerging issues surrounding AKI key performance indicators. The current drive is focussing upon refinement of our risk assessment tool/care bundle and its application within our clinical electronic patient records. Moreover, as part of a holistic patient safety thermometer, implementation of live AKI dashboards on our wards is gaining momentum through our business intelligence group. A range of initiatives across the trust have led to practical changes in the way AKI is both perceived and handled by clinical and non clinical staff. These include amongst others, an AKI triage tool for acute oncology nurses receiving hotline referrals, a comprehensive AKI guideline document, patient information leaflet and numerous education presentations across the trust.

Results

AKI e-alert data has suggested an overall downward trend for AKI stage 1 and relatively static figures for stages 2 & 3 (graphs to be included). Consistent data collection has been erratic and painstakingly slow. Furthermore, measuring mortality is precarious due to confounding factors such as advanced cancer and concomitant acute illnesses. Notwithstanding this, morbidity related to AKI can be measured in terms of prolonged length of stay and immediate complications such as the need for escalation of medical care including critical care admission. We anticipate that such data shall be readily available at our fingertips once electronic data records are fully functional.

Discussion

A significant aspect of our work targets robust medicines optimisation at the front door as a key measure to prevent AKI. In addition, undoubtedly prompt relaying of AKI episodes to primary care will form part of the first line defence for patients in preventing AKI in the community. Given the multifactorial nature of AKI in patients receiving anticancer treatment, in tandem with comprehensive pre-emptive strategies, our efforts have been focussing on meticulous fluid management and early involvement of acute physicians and a renal specialist.

Conclusion

Delivering systemic anticancer therapy is fraught with potential deleterious renal sequelae. This, coupled with an ageing population, increasing medical complexity and concomitant use of potentially renal hazardous medications means that not only physicians, but rather all staff involved in delivering clinical care to oncology patients need to be acutely aware of the emerging 'red flag'

features for developing AKI. Our experience thus far, has seen a true culture shift in attitudes towards AKI in a tertiary standalone cancer institute, however more promisingly the will to embed processes in order to affect a sustained and permanent improvement in clinical outcomes for cancer sufferers. To this end, we have applied for the AQUA AKI programme in 2017, in order to critically appraise our current systems.

If our work is accepted for a poster presentation, we expect to have collected further data to show graphically.

Best wishes

Dr Tamer Al-Sayed

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