

AKI Shared Learning using Process Mapping and Fishbone Diagrams

At the national RCGP Shared Learning Event (2018), delegates worked in small multidisciplinary groups. Half the delegates on each table undertook [process mapping](#) to explore Post-AKI care whilst the other half generated learning about response to AKI Warning Stage Test Results through use of the [fishbone diagram exercise](#). Learning generated was then fed back to the other half of the table followed by wider discussion with delegates across all the tables. This exercise was facilitated by Dr Joanna Bircher, GP and RCGP QI Lead, responsible for developing the [Quality Improvement Guide for General Practice](#). Learning from this QI Event was also [captured](#) by GP and medical artist, Dr Morium Howlader.

Post-AKI care – Process mapping

Key learning identified through the process mapping exercise included:

Table A

Attendees on table: 3 GPs, 1 AKI Nurse Specialist, 1 Consultant Clinical Scientist, 2 Secondary Care Nephrology Consultants

Attendees undertaking process mapping: 2GP's and 1 AKI Nurse Specialist

- Any stage is an opportunity for things to go wrong
- The two practices that the GP's were based both had different process in place, as a group they decided to use the process from one practice, where one person (admin) co-ordinates who is responsible for what. Right person for the right job? Question was asked, what happens when this person is off? Answer: Other staff will pick it up.
- How many patients know they have AKI? If patients know they are more likely to engage with clinicians (GP's). If patients are aware prior to discharge from secondary care, they are more likely to seek GP follow up themselves.
- Sometimes when patients are given a leaflet in hospital about AKI, when they are discharged they just leave it behind and not take it with them (example from hospital)

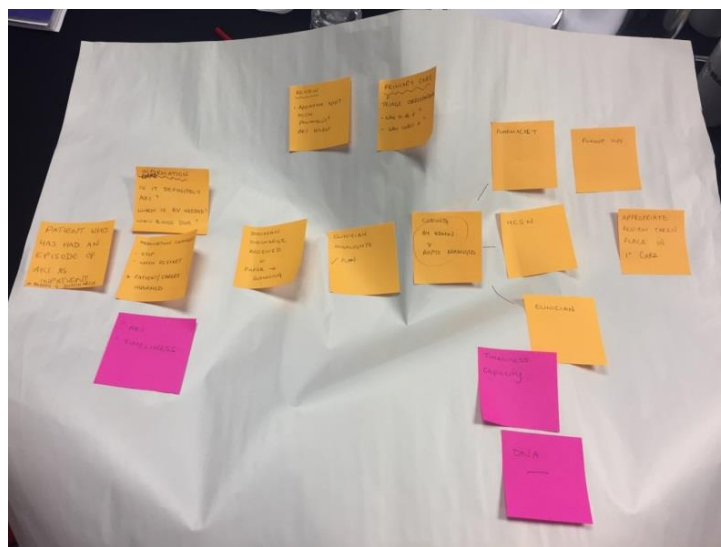


Table B

There was a mixture of primary and secondary care and QI people working on this exercise. There was discussion around how much detail to add, e.g. the need for a “comprehensive” discharge letter or even a discharge plan (rather than just a discharge letter/summary) to indicate the need for detail of the AKI episode including creatinine values and blood pressure on discharge.

The discussion then focused on who needs to know:

- Family and/or Carers informed
- District Nursing teams (it was suggested that Nurses on ward to coordinate ongoing care)
- Social Care
- Community Pharmacy if they use Dossette medicine boxes

It was noted that it is difficult to explain AKI to patients, one attendee referring to a video or animation they had seen of a patient saying “I’ve not had not had any injuries or falls so how can my kidneys be injured?” There was a comment that patient information / education should be done by secondary care – its introduction being seen as too late by time of the GP review.

The next step on the process map was around timeliness of discharge information, with some examples where the letters are posted, and hand-written leading to problems with delays and illegibility.

Coding was discussed – who does it? GP or receptionist/ other? And if not, as the GP how do you know if GP needs to see the patient or perhaps a pharmacist if available in the practice?

Wider delegate discussion

Process mapping feedback from the room:

- Need to empower patients and their families with knowledge.
- Heavily reliant on lots of systems, different failures across different systems.
- Communication issues
- Why don’t we have AKI discharge nurses who contribute towards the discharge summaries?
- There is not a repeatable patient journey across different areas. Lots of hand-offs with no-one to follow the patient across boundaries as there would be with other diagnoses e.g. AMI

Recognition and responding to AKI Warning Stage Test Results – using the Fishbone Diagram
 Resonating with a Safety-I perspective, in multidisciplinary groups, the fishbone diagram exercise focused on understanding reasons leading to failure to respond to an AKI Warning Stage Test Result.

Table A (see diagram)

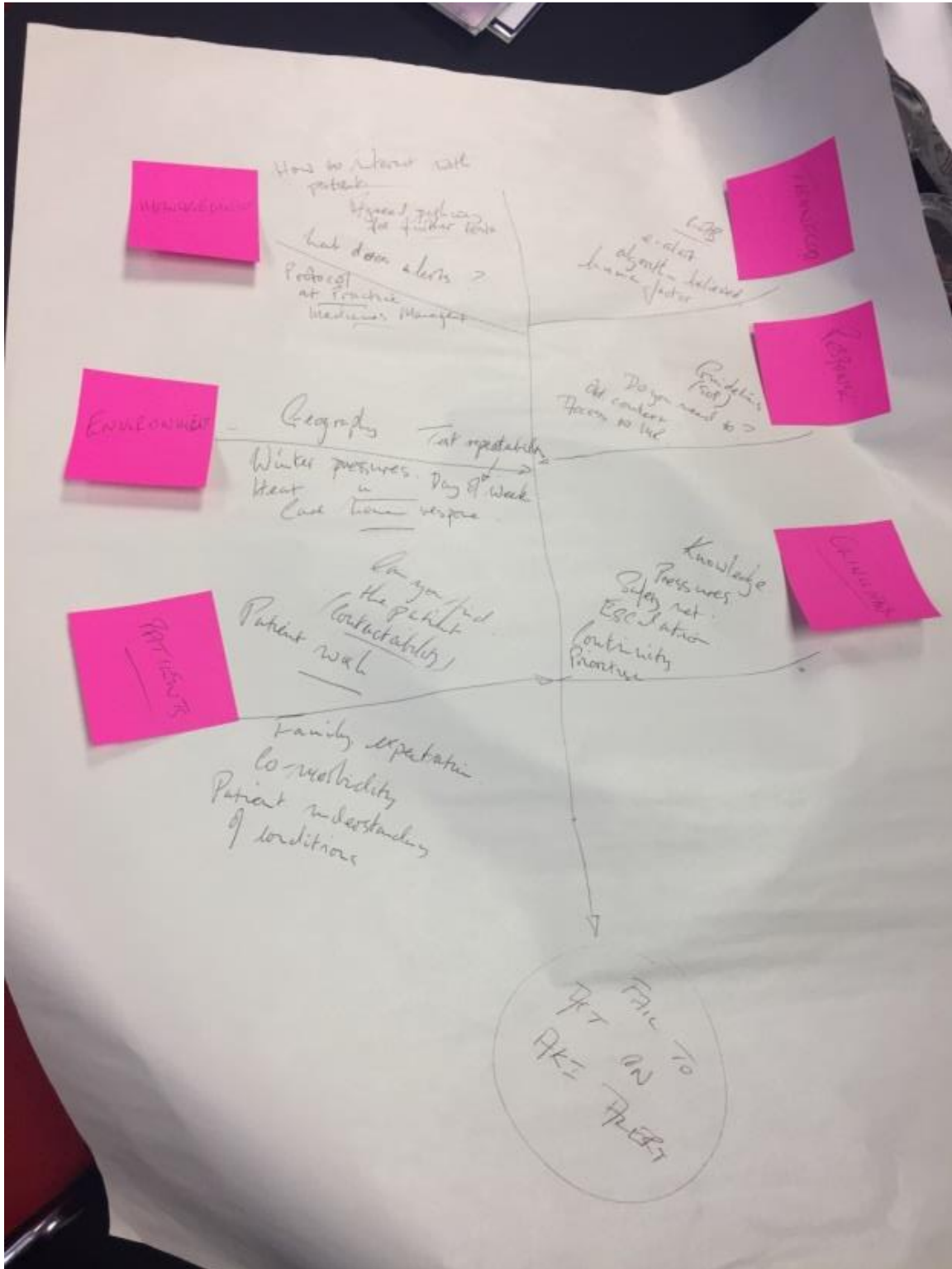


Table B

The main point they chose was the need for ownership, having an identified person responsible for responding to Test Results. It was mentioned that regular staff changes, use of temporary staff and locums make it difficult.

The group then discussed the use of other staff than GPs, e.g. some practices having a pharmacist who can undertake medicine reviews. However, it was noted that the patients may well need to go to see the GP anyway for changed medications unless the pharmacist is able to prescribe – still a burden on GP time.

The possibility of a shared care protocol was discussed as they do for methotrexate or Stroke so that different clinicians can access and influence care plan, bringing together primary, and secondary care and patients. However, this was criticised as putting too much emphasis on kidneys being the problem.

There was a discussion over the lack of evidence for assessing fluid status in primary care to assess dehydration, and the use of urine colour charts in Think Kidneys material.

Wider delegate discussion

Fishbone diagram exercise feedback from the room:

- Systems don't talk to each other (hospital and community systems)
- Need to know why we (GPs) are doing blood tests (home visits), need to be able to explain to patients the reasons why blood tests are being taken.
- Who is taking ownership of dealing with the test results - how are the roles allocated?