Transform AKC-
For the best patient experience

Advanced Kidney care in practice – webinar 14 Oct 2025
Transform AKC 1 year on….

Pilot site unit name:
University Hospital Crosshouse, Kilmarnock

Tricia Sutherland – AKC Nurse Specialist

KQIP
Kidney Quality Improvement Partnership

Area for improvement

Year 1 Project aim:

Record Clinical Frailty Scale (CFS) for >90% patients known to the AKC Service in NHS Ayrshire & Arran with eGFR < 20, by 31st December 2025

Year 2 Project aim:

The impact of recording the CFS score RRT decision making & Tx suitability

Frailty:

- High prevalence of frailty in advanced kidney disease, increases as kidney function falls

- Frailty in advanced kidney disease is associated with significant increased risk of adverse outcomes- mortality, hospitalisation, falls and institutionalisation; risk increases with worsening frailty

- Standard treatment options/ targets in CKD provide less benefit and may cause harm in elderly patients with frailty, includes dialysis and transplantation

Rockwood Clinical Frailty Scale

Clinical Frailty Scale*

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 **Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 **Managing Well** – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 **Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 **Mildly Frail** – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 **Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. **Terminally Ill** - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

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KQIP Kidney Quality Improvement Partnership

Learning so far – what we have done

Frailty education & training

Kings Health Partners – Learning Hub/platform –

- Kidney Supportive Care & ACP, 2 x e-learning modules, free to enroll
- Takes approx. 90 mins to complete
- Modules also look at frailty, CFS, frailty management, frailty case scenarios, symptom control, quality of life and data on survival

British Geriatric Society - Frailty Hub

- Articles, national guidelines and best practice relevant to frailty, education & training resources
- elearning for Health (ELFH) for excellence in frailty identification, assessment and personalised care

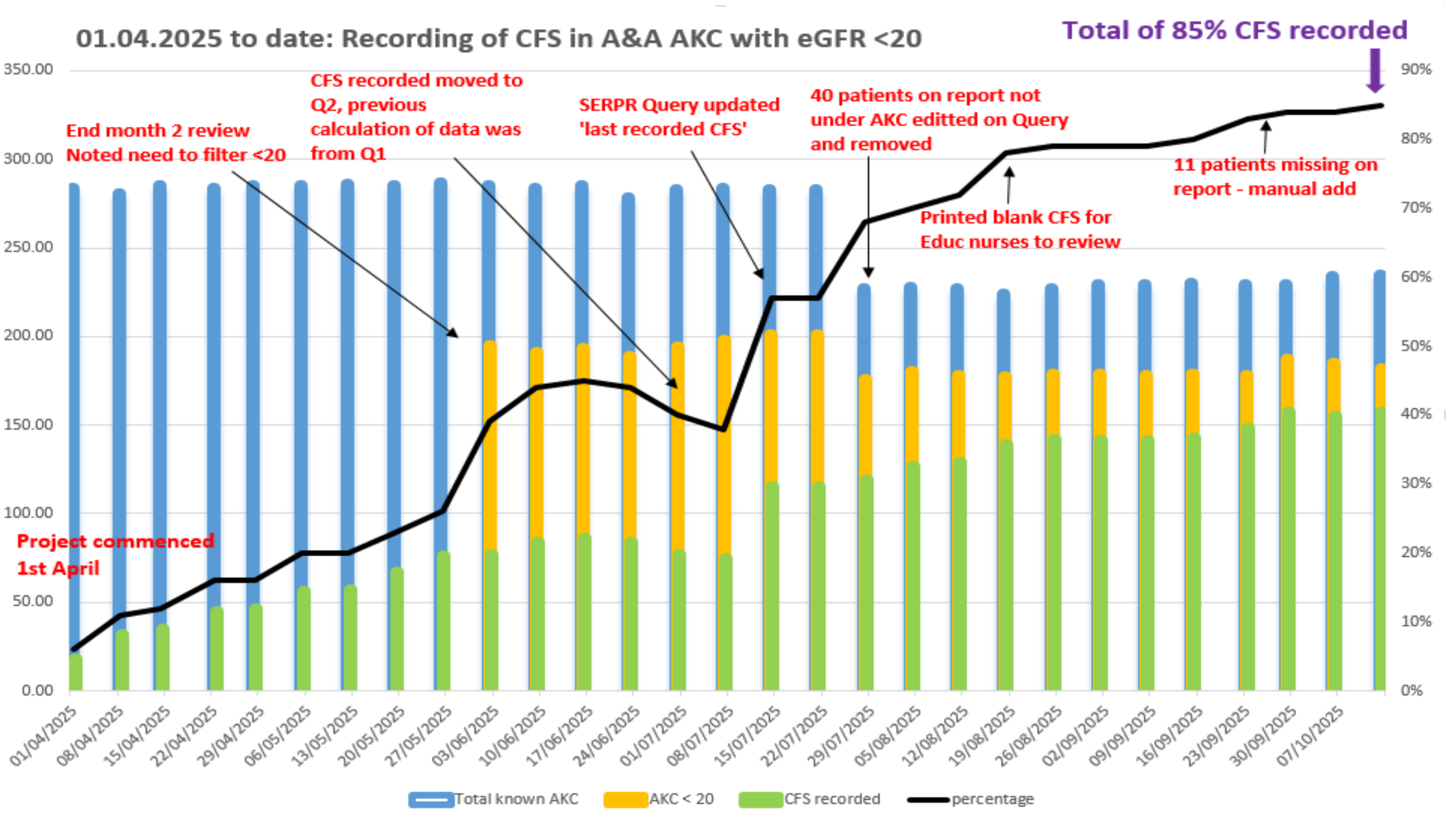
Learning so far…

- Stakeholders
- ‘Re-brand’ now AKC nurses, AKC service, AKC clinic (AKCC)
- Clarify roles to optimise expertise- Data collection, Education/training, Patient engagement, Clinical, IT, Quality Improvement,
- AKC nurses to assess and record CFS
- Record serial CFS and standardise recording of treatment decisions
- Local networking – Acute Frailty Unit, Staying Ahead of the Curve Team, Intermediate Care Teams, Geriatrician, NHS Ayrshire & Arran Frailty Service

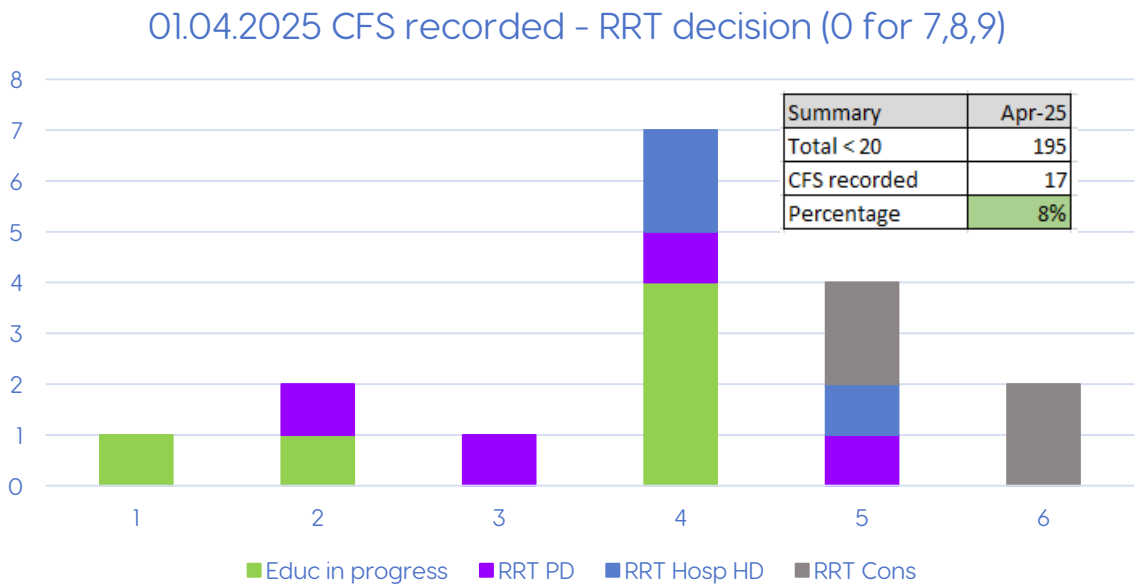
Learning so far...

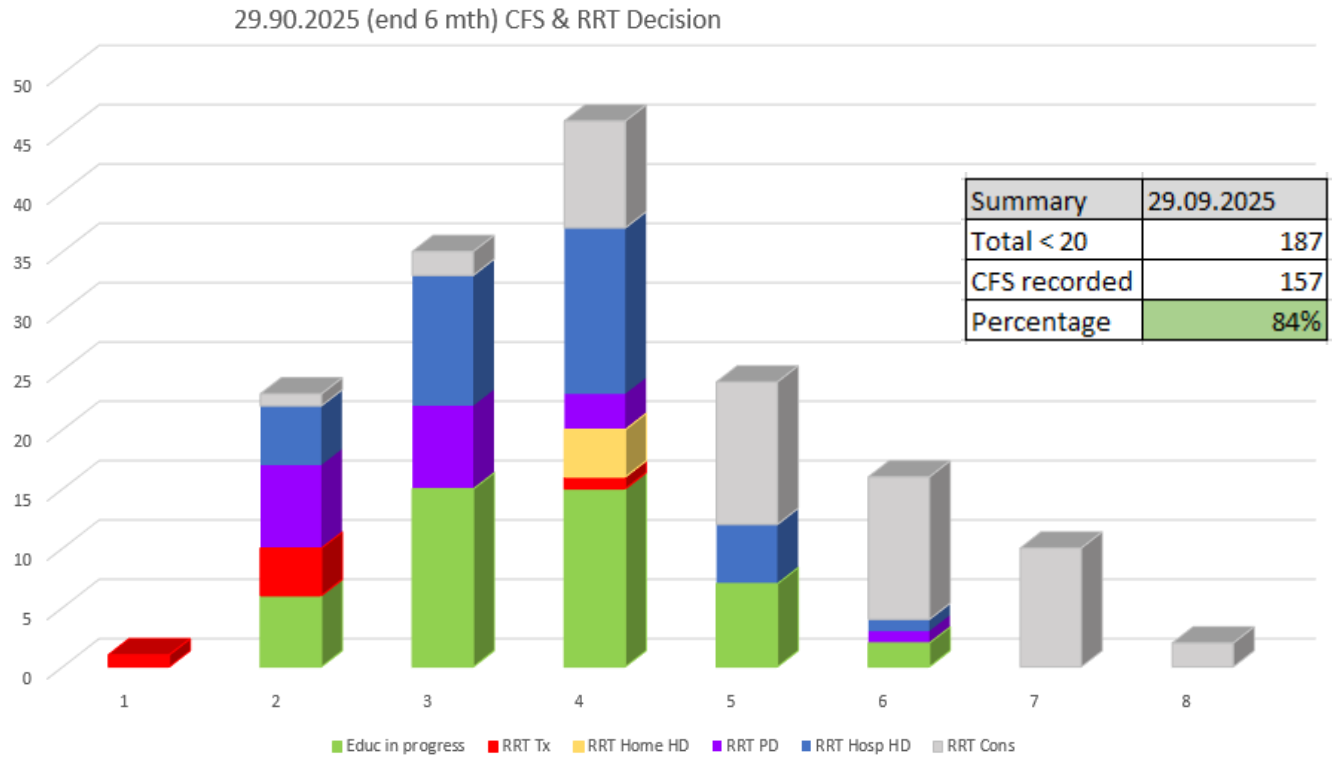
- NHS Ayrshire & Arran website & social media
- Patient engagement
- EPR - SERPR report
- Feb 2025 - less than 6% of those patients known to AKC Service have CFS recorded
- From 1st April - Run report weekly and evaluate monthly
- Review of CFS then the associated RRT choice & transplant status

01.04.2025 to date: Recording of CFS in A&A AKC with eGFR <20



CFS and RRT Decision Making





17 recorded CFS
11 completed education
Tx - No recorded Tx as preferred RRT
CFS 2-5 for PD
CFS 5 & 6 chosen for Conservative Care

157 recorded CFS
112 completed education
Tx – 6 chosen, CFS 4 – assess!
CFS 2-6 – 22 patients have chosen PD & Home HD
CFS 2- 8 - 48 have chosen for Conservative Care

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Other benefits...

- Support meetings with project leads, Rosie & Ranjit monthly
- Pilot sites teams meetings monthly
- Webinars & F2F meetings (Birmingham) throughout year
- Andy Nixon, frailty expert presented to Ayrshire & Arran Renal MDT
- Real AKC Teamwork!

What next ....

- Continue to record CFS
- Develop local patient frailty information leaflet
- Develop holistic frailty assessment
- Remember that frailty can respond to intervention
- Signposting & referrals
- Share progress and learning with renal MDT
- **Can't wait to see how this takes shape into Year 2 of our Transform AKC!**