Transform AKC-
For the best patient experience

Summit Update

Pilot site unit name: Kilmarnock

Area for improvement

(& why are you focussing on that?)

Project aim:

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

PubMed®

frailty

Search

Advanced Create alert Create RSS

User Guide

Save Email Send to

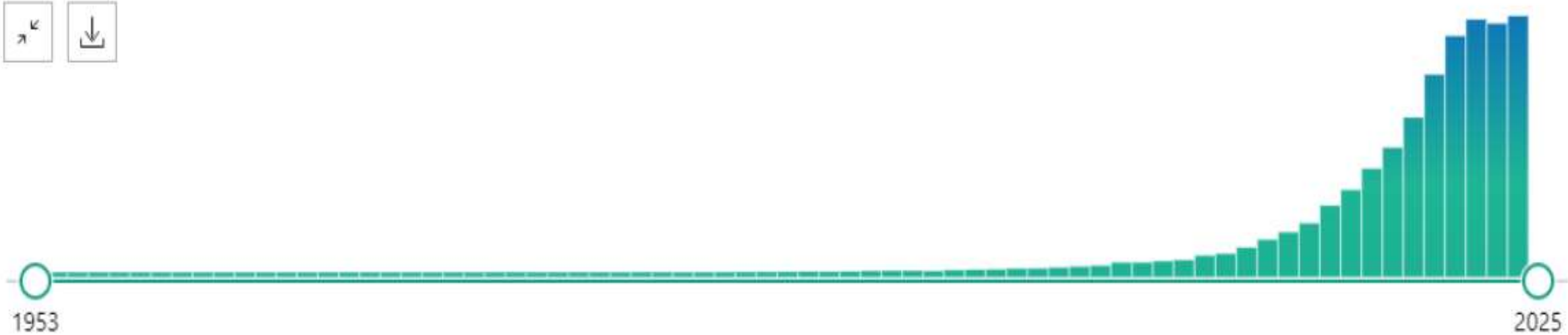
Sort by: Best match

Display options

RESULTS BY YEAR

33,501 results

Page 1 of 3,351



Area for improvement

(& why are you focussing on that?)

Frailty:

- Frailty is dynamic and most commonly follows a downward trajectory in people with advanced kidney disease
- Frailty may respond to intervention
- Frailty is not routinely assessed in AKC
- AKC- frailty info may inform shared decision making, support treatment choices/ transitions

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.

DALHOUSIE UNIVERSITY *Inspiring Minds*

KQIP Kidney Quality Improvement Partnership

Learning so far...

(About systems, stakeholders, patients, from the process map)

- Systems:
  - Secure database, record serial CFS and standardise recording of treatment decisions, run report weekly and evaluate monthly
  - Core clinical team to assess and record CFS, AKC nursing team
  - Less than 6% of patients known to AKC have CFS recorded, Feb 2025

- Stakeholders:
  - Patients and their families
  - Renal multi-disciplinary team, nursing and medical staff, hospital management
  - Clarify roles to optimise expertise- IT, Research and Development, Quality Improvement, Clinical

Learning so far...

(About systems, stakeholders, patients, from the process map)

- Patients:
  - Plan significant patient involvement, Patient Focus Group to include AKC, Renal Supportive Care (RSC), haemodialysis, peritoneal dialysis and transplant patients, and their families
  - Patient Support and Advocacy Officer, Kidney Care UK

Taking action: what we have done

(This is what we are going to start doing, ie training needs for team & this is how we are going to measure it).

- AKC service- 'Re-brand' staff and service: AKC/ Advanced Kidney Care Nurse, Team and Service

- Frailty education to Renal Supportive Care Working Group, and Renal team

- Education and training about frailty- core AKC nursing team, 1st Feb 2025:
  - Ottawa Hospital Research Institute- Rockwood Scale Training module
  - British Geriatric Society- eLearning course
  - NHS Specialist Clinical Frailty Network- Training module

Taking action: what we have done

(This is what we are going to start doing, ie training needs for team & this is how we are going to measure it).

- Communication with wider health and social care services:
    - Ayrshire and Arran website- updated information about renal services which includes AKC webpage
    - Social media- Ayrshire and Arran Renal Services
    - 'Networking' with local Frailty Network, Care of the Elderly Teams
- QI Project Flow Diagram:

Kilmarnock: 2025 Plan

Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	June 2025
Monthly pilot site working group meetings (OLG)					
Virtual QI Training for pilot sites Identify area for improvement Measurement	F2F QI support visits by Ranjit Aim & Scope System: SERPR Stakeholder Analysis 18 & 25th MDTs	F2F national Transform AKC Summit (Birmingham) Pilots to present projects	MDT regroup after Summit Evaluate edits / agree as MDT prior to commencing Aim 1st April commence Website / social media updates	Nurses Training complete in CFS F2F educ/HV assess pts & record in EPR Run weekly reports / Evaluate monthly	Plan for first 3 / 6 / 9 month review **3 month aim to have > 30 % AKC patients with CFS recorded** MDT 10th
Initial Planning of local Project	Project Planning Stakeholder engagement	Network with pilot sites and national CFS experts	Time to launch	PDSA	MDT Evaluation
Engage local Transform AKC patient focus group					

Kilmarnock: 2025 Plan

July 2025 → Aug 2025 → Sept 2025 → Oct 2025 → Nov 2025 → Dec 2025

Monthly pilot site working group meetings (OLG)

July 2025	Aug 2025	Sept 2025	Oct 2025	Nov 2025	Dec 2025
Evaluate / support local engaged patients Plan meeting Aim Local website complete	Engage stake holders MDT panned local T.AKC update 26th Share data / PSDA outcomes	Plan for 2nd evaluation at 6 months **6 month aim to have > 60 % AKC patients with CFS recorded**	Use EPR to evaluate CFS in relation to: Decision making RRT modality Trajectory CFS: 6-9 ? Trigger tool	Engage stake holders MDT panned local T.AKC update 25th Share data / PSDA outcomes	Plan for 3rd evaluation at 9 months **9 month aim to have > 90 % AKC patients with CFS recorded**
Engage / feedback	Keep MDT informed in progress	Network with pilot sites and national CFS experts	Start 'what to do with data?'	MDT support re next steps	Plan for 2026 …

Engage local Transform AKC patient focus group

KQIP
Kidney Quality Improvement Partnership

Patient education

(any changes made to patient education since 3 Dec event)

- Review of all written educational information provided for patients and carers-Ayrshire and Arran AKC and Renal Supportive Care leaflets, and Kidney Care UK material
- Frailty: ageing with kidney problems leaflet, Kidney Care UK
- Information letter regarding frailty assessment in AKC- in progress
- Renal services information, including AKC, update on Ayrshire and Arran website and social media to improve patient and public access to information