UK Kidney Association

Ten primary care priorities for adults with AKI

Practical follow-up that focuses on risk, recovery, and the whole person

Recovery doesn't stop at discharge. These priorities support safer follow-up after AKI — guided by kidney recovery, comorbidity, and clinical context.

1. Understand the AKI

- Cause(s), AKI stage, recovery status
- Baseline vs discharge creatinine
- Share understanding with patient/carers

2. Treat the person, not the blood test

- Interpret creatinine changes in clinical and social context.
- Consider:
  - symptoms, haemodynamics & volume status
  - medicines
  - comorbidities
  - cognition, dependence, and carer/social support

3. Treat handover as safety-critical

Clarify if missing:

✓ AKI stage & cause
✓ Recovery trajectory
✓ Baseline + discharge creatinine
✓ Medicines stopped/changed (and why)

Ambiguity → prompt follow-up.

4. Identify who needs earlier or closer review

Arrange earlier, tailored follow-up for people with:

- heart failure or poor kidney recovery
- chronic kidney disease
- diabetes, hypertension, or cardiovascular disease
- frailty, multimorbidity, cognitive impairment, or social vulnerability

5. Make AKI visible

Code and flag AKI to support:

- Safer prescribing
- Targeted recall
- Earlier escalation during future illness

6. Review medicines

Revisit changes made during AKI:

- Avoid unnecessary long-term stopping
- Consider BP, volume, kidney recovery, goals of care
- Clearly document decisions not to restart
- Optimise cardio-kidney-metabolic therapies

Failure to restart indicated drugs causes avoidable harm.

7. Actively review RAAS inhibitors

ACEi / ARB and SGLT2i should usually be restarted, unless contraindicated.

Benefit especially important for:

- heart failure
- prior myocardial infarction
- albuminuric chronic kidney disease

8. Assess volume status carefully, especially in heart failure

AKI + HF = high readmission risk

- Treat congestion even if creatinine rises
- Reduce diuretics only if hypovolaemia
- Liaise early with HF services if prognostic meds stopped or reduced

Advanced illness and end-of-life care

- Prioritise symptom control over prognostic treatment.
- Titrate diuretics to relieve distress from fluid overload.

9. Match monitoring to risk

- Repeat creatinine/eGFR as clinically indicated
- Align with LTC reviews where possible

Higher progression risk with:

- Severe/prolonged AKI
- Incomplete recovery
- CKD or CKD risk factors

Consider nephrology if recovery incomplete or eGFR <30

10. Check for persistent kidney damage

At ~3 months:

- Measure urine ACR and eGFR
- If abnormal → code CKD, explain to patient, manage long term risk

Visit the UK AKI Guide for more information, available at ukkidney.org

The table is a guide to support recognition and response to AKI in primary care, but clinical judgement must take precedence.
The table does not apply to children and young people (<18 years) or patients receiving end of life care.

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