Table 2: Recognising and Responding to Acute Kidney Injury for Adults in Mental Health facilities

"Think" Cause	"Think" Medication#	"Think" Fluids	"Think" Review¥
History of acute Illness? • Think Sepsis – check temperature • Think Hypotension – check pulse and BP Intrinsic kidney disease? (E.g. vasculitis) • Think Urinalysis Urinary tract obstruction?	Any medication which could **exacerbate** AKI? Consider withholding: • NSAIDs • Diuretics • Antihypertensive medication Any medication which may **accumulate** and cause harm during AKI? Any **new** medication that may **cause** AKI?(E.g. drug induced tubulo-interstitial nephritis - **Lithium**)	What is the patient's volume status? If hypovolemia present: • When did patient last pass urine? • Can the patient increase fluid intake? • Is transfer for IV fluid replacement and monitoring required? Does the patient have and/or need carer support?	Does the patient need transfer to medical unit? If not, when will you review? Have you ensured handover?¥

*Refer to main guidance document – Guidance for mental health professionals on the management of acute kidney injury

Refer to medicines optimisation toolkit for primary care http://www.thinkkidneys.nhs.uk/aki/medicines-optimisation-for-aki

¥ Refer to overarching principles in communication of diagnostic test results https://www.england.nhs.uk/patientsafety/discharge

The table is a guide to support recognition and response to AKI in mental health facilities

The table does not apply to children and young people (<18 years) or patients receiving end of life care

Adapted from Primary Care guidelines