Principal recommendations

All patients admitted as an emergency, regardless of specialty, should have their electrolytes checked routinely on admission and appropriately thereafter. This will prevent the insidious and unrecognised onset of AKI. (Clinical Directors and Medical Directors)

Predictable and avoidable AKI should never occur. For those in-patients who develop AKI there should be both a robust assessment of contributory risk factors and an awareness of the possible complications that may arise. (Clinical Directors and Medical Directors)

All acute admissions should receive adequate senior reviews (with a consultant review within 12 hours of admission as previously recommended by NCEPOD[3]). (Clinical Directors and Medical Directors)

NCEPOD recommends that the guidance for recognising the acutely ill patient (NICE CG 50) is disseminated and implemented. In particular all acute patients should have admission physiological observations performed and a written physiological monitoring plan made, taking into account the degree of illness and risk of deterioration. (Clinical Directors and Medical Directors)

There should be sufficient critical care and renal beds to allow rapid step up in care if appropriate. (Department of Health)

All level 3 units should have the ability to deliver renal replacement therapy; and where appropriate these patients should receive clinical input from a nephrologist. (Clinical Directors and Medical Directors)

All acute admitting hospitals should have access to either onsite nephrologists or a dedicated nephrology service within reasonable distance of the admitting hospital. (Clinical Directors and Medical Directors)

All acute admitting hospitals should have access to a renal ultrasound scanning service 24 hours a day including the weekends and the ability to provide emergency relief of renal obstruction. (Clinical Directors and Medical Directors)