

# RIGHT TRAINING, RIGHT CARE



Improving CRRT Delivery in Adult Critical Care

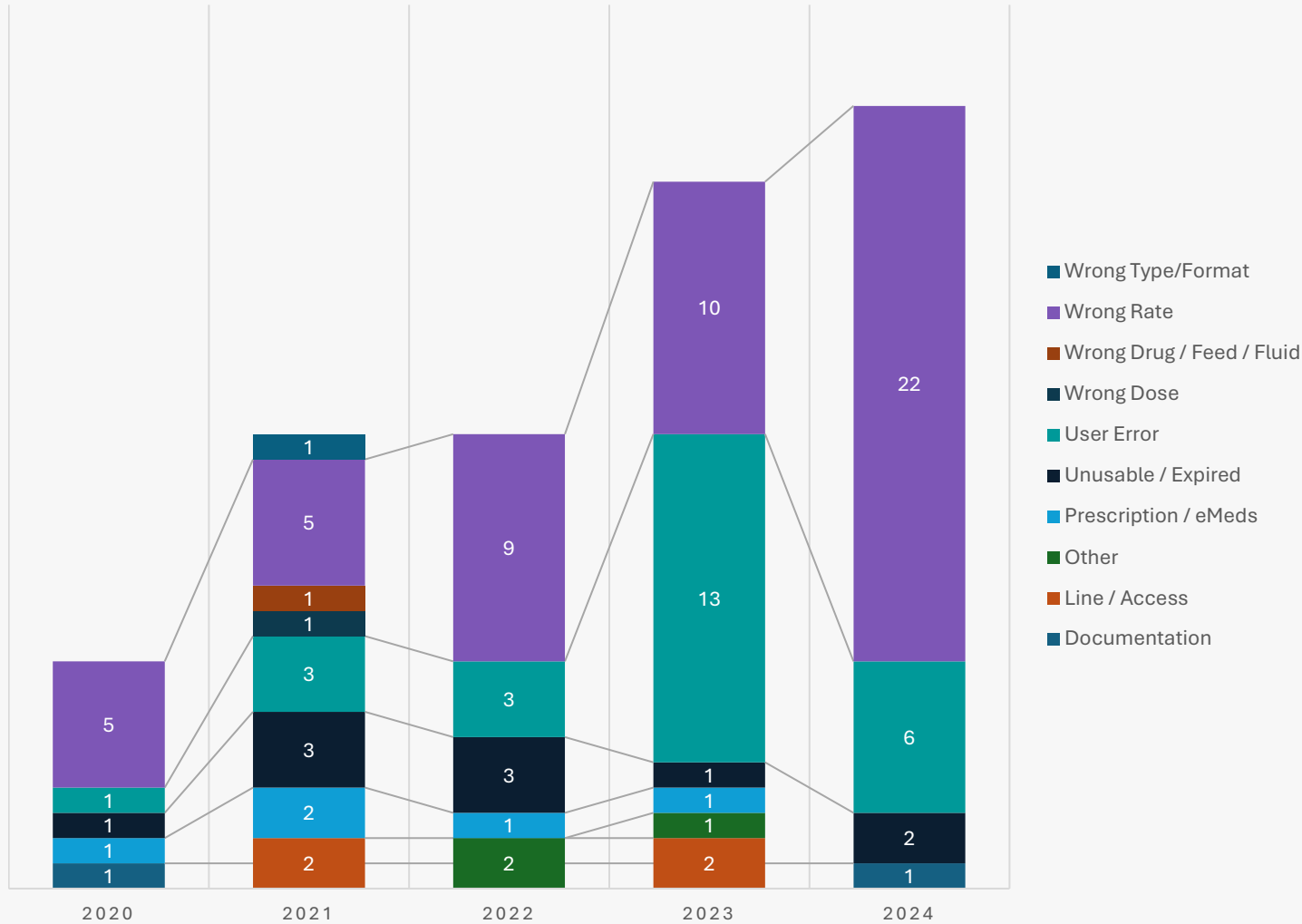
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The Leeds  
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# THE CHALLENGE

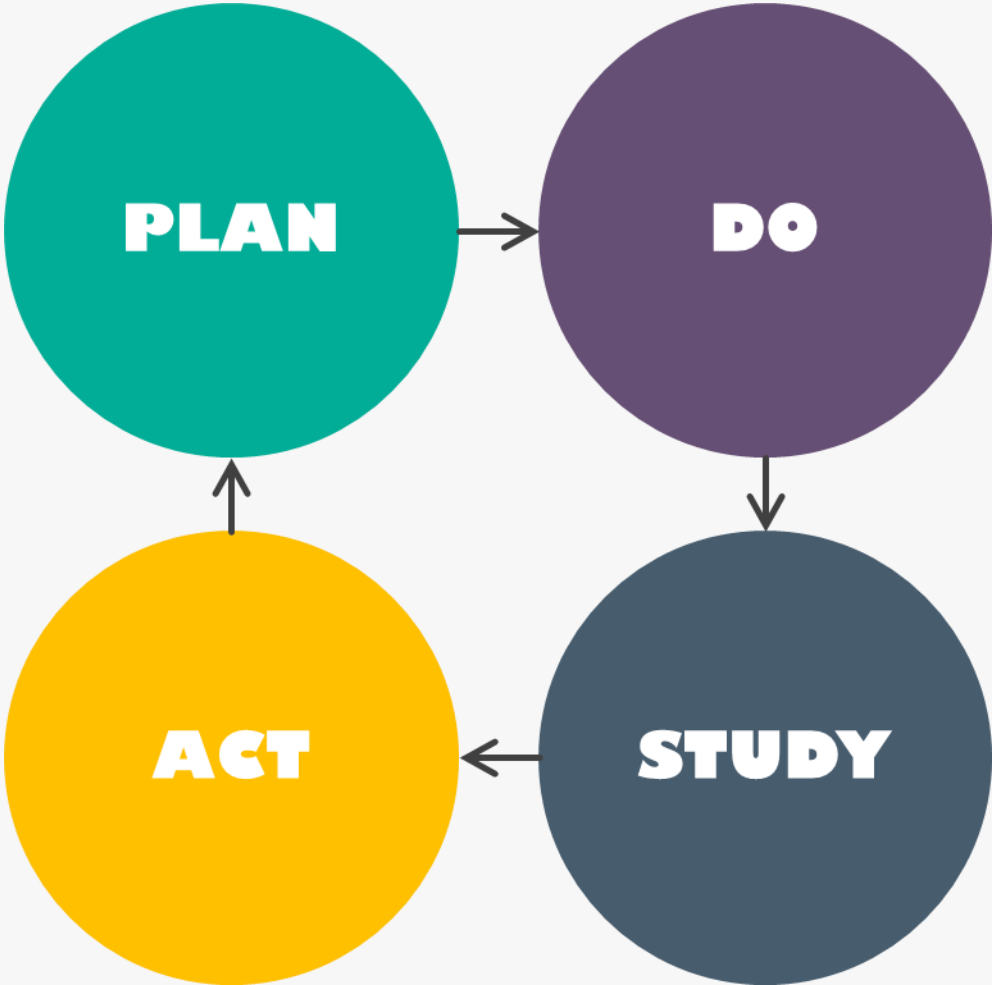
NUMBER OF INCIDENTS BY TYPE AND YEAR



# THE AIM

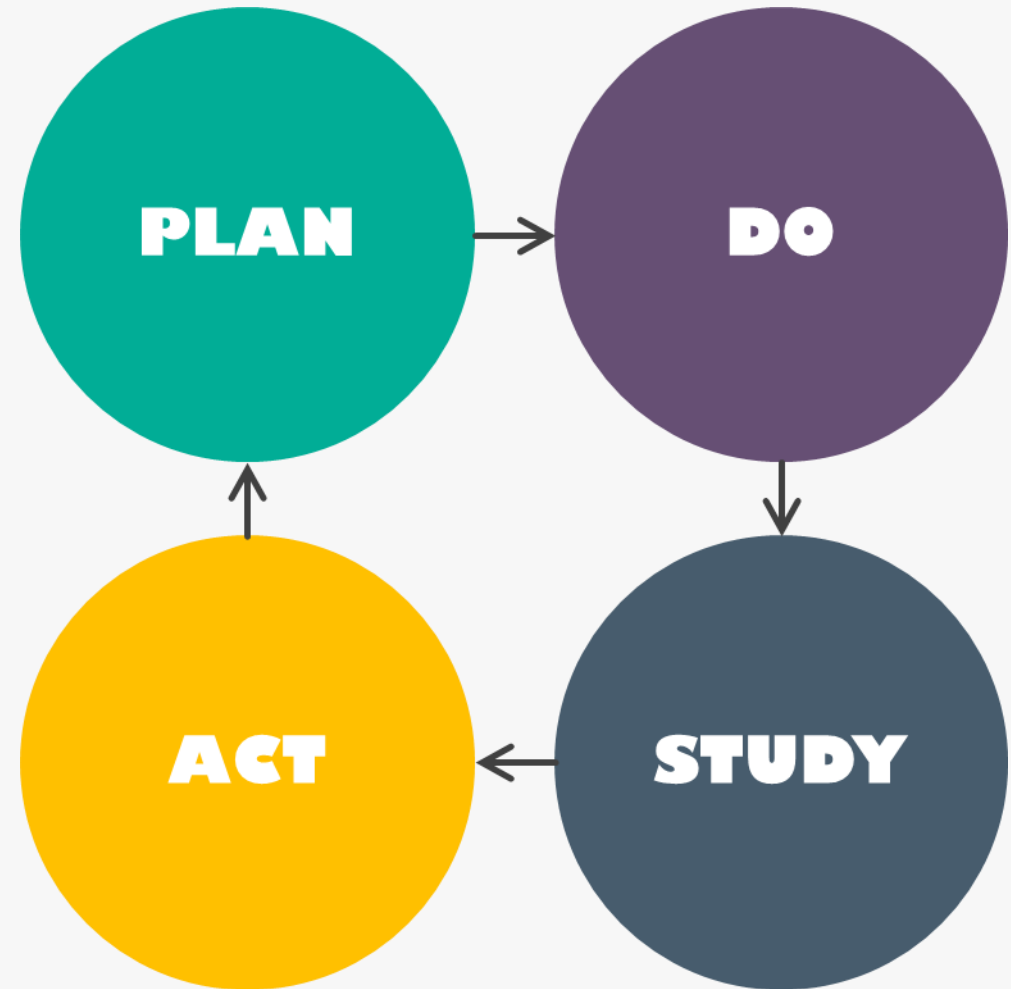
Improve safety, consistency,  
and cost-effectiveness  
of CRRT





# THE APPROACH

- Incident-informed problem identification
- Co-designed interventions
- Incremental testing and refinement
- Continuous feedback and governance review



# STAKEHOLDERS

- Quality & Education team
- Renal Group leads
- Key trainers & Champions
- Frontline critical care nurses
- Governance forum



# STAGE ONE

## PLAN

- Incidents linked to knowledge gaps & low confidence
- Existing training generic and infrequent
- Training compliance was low

## DO

- Moodle pre-learning
- Practical hands-on sessions
- Protocol-aligned, scenario-based study day
- Supervised troubleshooting

## STUDY

- Feedback showed improved understanding
- Staff requested more practical time

## ACT

- Practical training extended
- (4 → 7 hours)

# STAGE TWO

## PLAN

- Variable competency assessment across units
- Inconsistent expectations and sign-off
- The competency framework was basic

## DO

- CSU-wide CRRT competency framework
- Clear knowledge & skills criteria
- Create an initial version

## STUDY

- Test it with experts and real users
- Collect feedback
- Improve it
- Repeat the cycle

## ACT

- Improved clarity and consistency
- Positive frontline feedback
- Some feedback on language used
- Change some formats

# STAGE THREE

## PLAN

- Recurrent documentation-related incidents
- Cognitive overload in calcium/citrate prescribing

## DO

- Redesigned CRRT prescription charts
- Clearer layout & colour coding

## STUDY

- Improved clarity and usability
- Early reduction in related incidents

## ACT

- Ongoing monitoring and audit

Improved Staff confidence

Clear, standardised definition of CRRT competence

Reduced reliance on informal or assumed competence

Improved transparency of training and sign-off

Improved post training knowledge



Reduced variation in CRRT practice across units and staff groups

Improved clarity of prescriptions and documentation

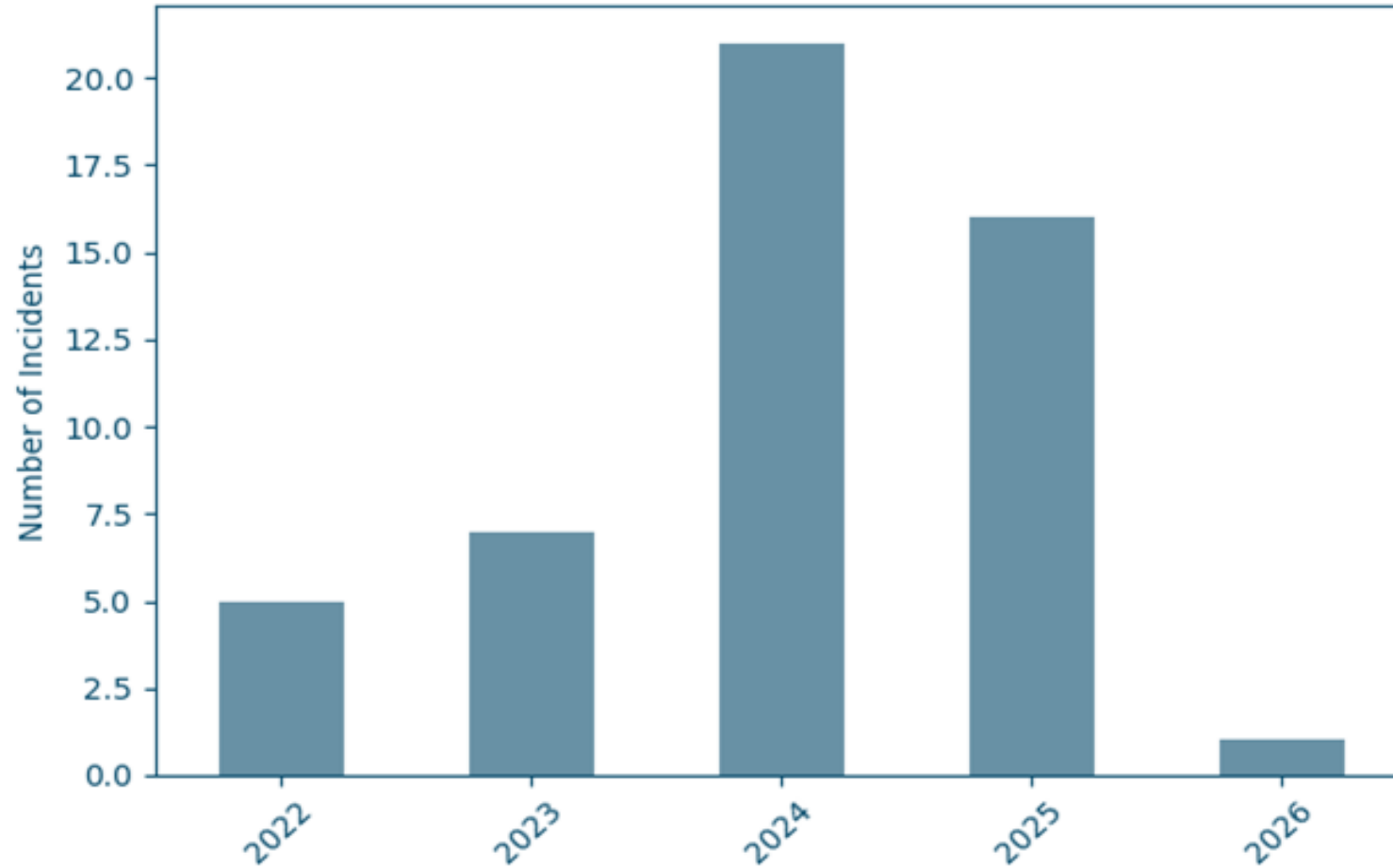
Greater consistency between prescriptions, machine settings, and monitoring

Clearer “standard way” of delivering CRRT across the CSU

## **WHAT'S CHANGED?**

# RESULTS: early impact

CALCIUM CITRATE RELATED CRRY INCIDENTS BY YEAR



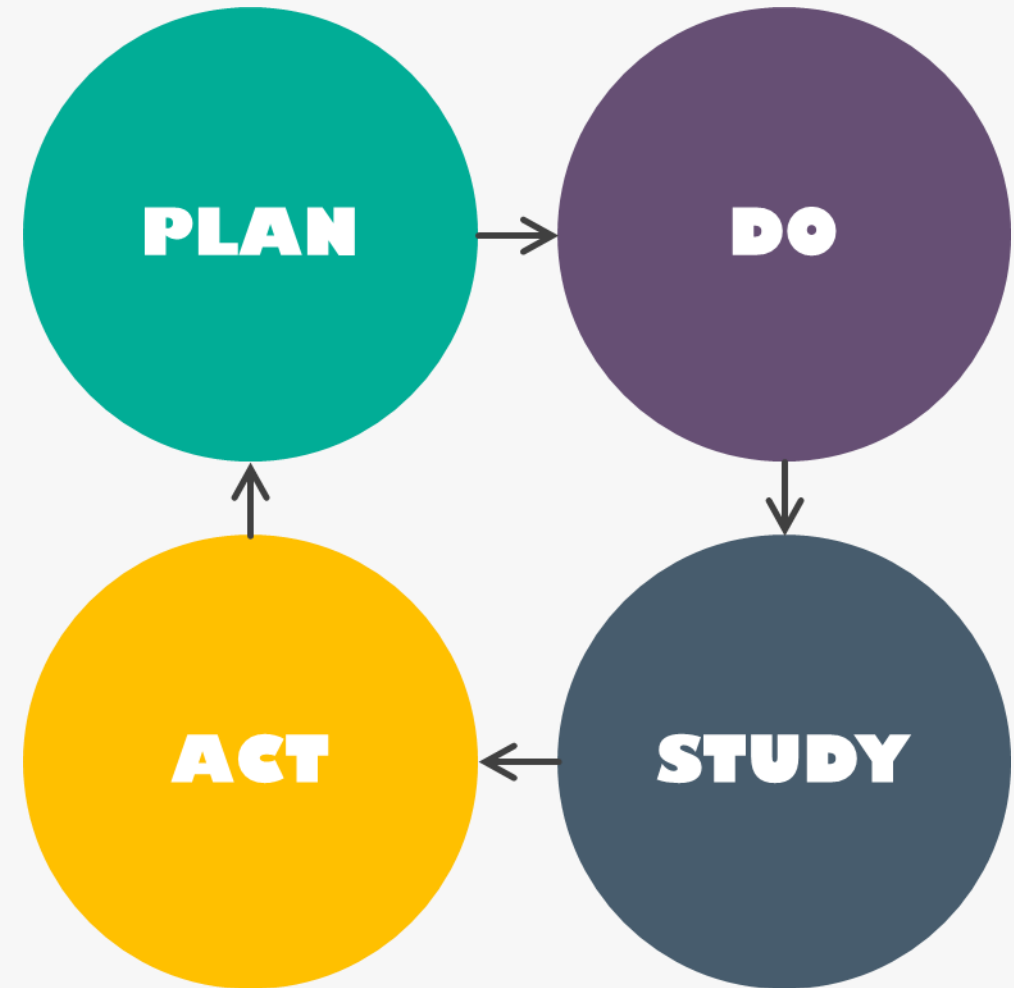
# KEY LEARNING



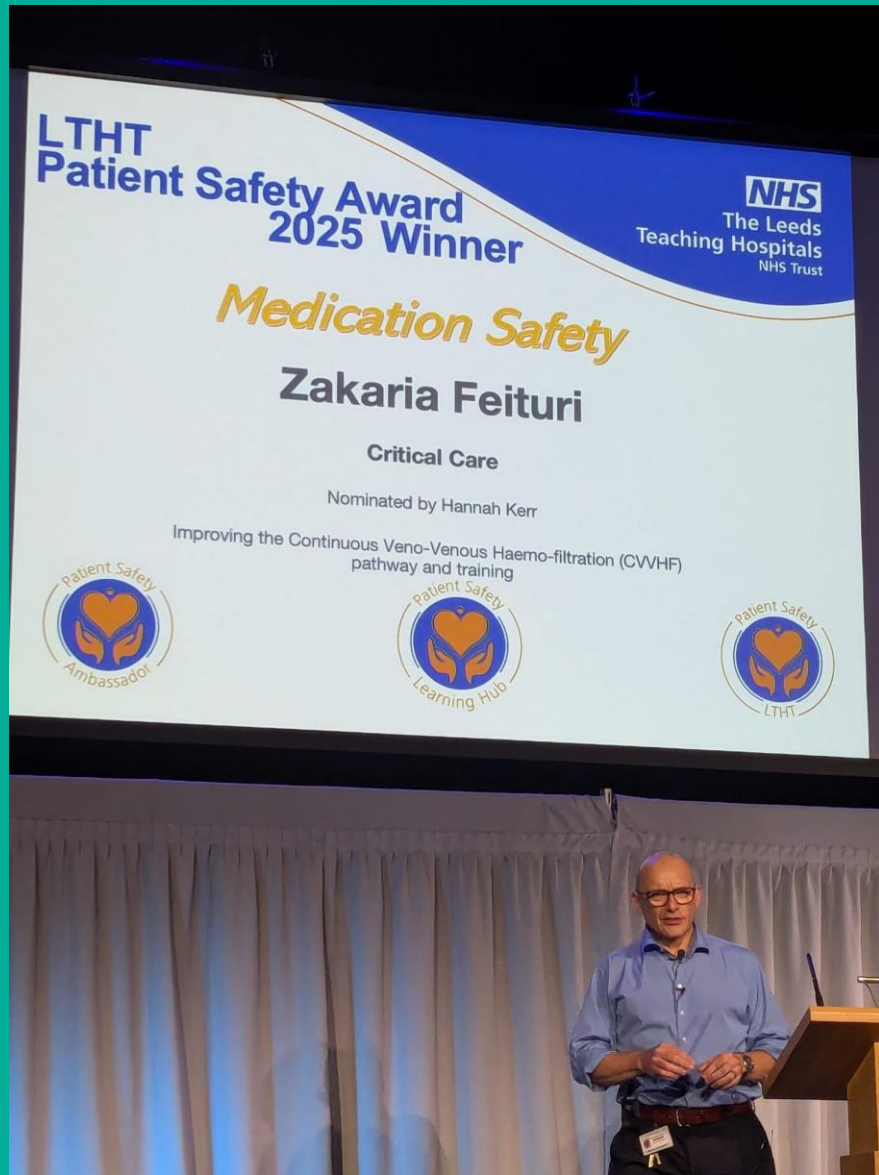
- Education alone is insufficient
- Competency standardisation reduces variation
- System and documentation design matter
- Stakeholder engagement enables sustainability

# NEXT STEPS

- Follow-up audit of CRRT incidents
- Annual refresher training
- Ongoing PDSA cycles
- SOP for incident management
- Potential spread to other high-risk therapies



BEING RECOGNISED  
BY THE TRUST



# THANK YOU

Any Questions?



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