MEDICATION RECONCILIATION FOR HAEMODIALYSIS OUTPATIENTS

Cross references	Medication reconciliation and use of medication management plans SGSHHS ClBR
1. Purpose	To ensure the continuity of intended medications for haemodialysis outpatients attending St George Hospital Haemodialysis Unit

2. Process

Background

Medication reconciliation: a formal process of verifying and clarifying a patient' intended medication regimen at each transfer of care. In the case of haemodialysis patients it provides for continuity of intended medications between multiple providers e.g. nephrologist, GP and other specialists as well as patient initiated non prescriptions medications.

Medication reconciliation is required for all patients who are admitted to the hospital for greater than 24 hours. There are a number of aspects of medication reconciliation which can be applied to the ongoing case management of patients attending 4 West for haemodialysis. This WPI provides guidelines for primary nurses in medication reconciliation.

2.1 When to perform reconciliation

Medication reconciliation should be performed:

1. For all patients commencing chronic dialysis treatments and is the responsibility of the allocated primary nurse;
2. On an ongoing basis especially following a nephrologist or GP visit

Evidence that the medication check has occurred:

- Notation on the patient orientation checklist.
- Recording of all medications on the 4 west medication form
- Where there is a discrepancy this should be documented in the patient's haemodialysis file/RISC data base.

2.2 Where should the medication information come from?

It is advised to use two sources to confirm the accuracy of the information:

- A recent discharge letter (within 6 months)
- Medical Director
- Patient/carer
- Patient can be asked to bring their medications with them to dialysis
- Residential age care staff (copy of the medication chart)
- GP
- Community pharmacist

2.3 Important considerations

It is important to set up communication channels between the patient/carer. Inform them of the importance of letting the nurses know if they have been for a recent appointment or if they have been prescribed a new medication.

If there are any discrepancies identified with medications please advise the patient, GP and nephrologist as indicated. It may be necessary to organise a Home Medicines Review or in some instances the patient may require an alternative method of medication administration such as a Webster pack. Note the situation, action and outcome within the patient file/RISC data base.

3. Network file	Haemodialysis
4. External references / further reading	
5. Specialty/department committee approval	Renal Department Haemodialysis Committee
6. Department head approval	Professor Mark Brown or Assoc. Prof. Ivor Katz
7. Executive sponsor approval – NCD or CGM	E. Child A/NCD - Medicine

Revision and Approval History

Date published	Revision number	Author (Position)	Date revision due
July 2015	1	Tracey Blow, Nurse Unit Manager	July 2018

WPI Criteria	Yes	No
Contains ward/unit/department specific instructions only	x	
Description of process is straight forward and without variables. **NOT a WPI** if dependent on various decision making pathways **e.g.** if something is A do B and if C do D	x	
Process is free from complex clinical decision making	x	
Process is free from medications	x	
Process is free from high risk invasive procedures	x	
Document will be located on the ward/unit/department dedicated intranet page	x	
Document will be listed in a local register by custodian responsible for facilitating WPI review every 3 years	x	
Department head will approve the document and nursing co-director or clinical group manager will be the executive sponsor	x	
If **NO** to any of the criteria ↓ **NOT a WPI** – progress to clinical business rule (CIBR) development		