PURPOSE:

To reduce preventable harm to Manitoba Renal Program (MRP) clients by developing medication reconciliation processes at each healthcare transition point.

DEFINITIONS:

1. **Medication Reconciliation**
   The process for generating a comprehensive list of all medications the client has been taking at healthcare transition points.

2. **Best Possible Medication History (BPMH)**
   Includes the drug name, dose, route and frequency of prescription medications, non-prescription medications, vitamins, and supplements.
   The health care practitioner must use at least two information sources to collect the BPMH. The two sources may include:
   - Client Bubble pack
   - Family/Caregiver Medication vials
   - Client medication list
   - Community pharmacy
   - DPIN Medication Administration Record (MAR)
   - Electronic Patient Record
   The Renal Medication Flow Sheet represents the client's BPMH.

3. **Health Care Practitioner**
   Includes nursing staff, medical staff, pharmacists, and pharmacy technicians.

4. **Health Care Transition Points**
   These include beginning of service and periodically thereafter, upon transfer, and on referral.

POLICY:

1. **In Centre Hemodialysis:**
   Medication reconciliation is performed within 2 weeks of initiating dialysis, every 6 – 12 months following initiation of dialysis, with each transfer, and on referral.

   *Home Dialysis (home hemodialysis and peritoneal dialysis) and Manitoba Local Centres:*
   Medication reconciliation is performed at each Interdisciplinary Clinic visit.

   *Stages 4 and 5 Chronic Kidney Disease (clients not on dialysis):*
   Medication reconciliation performed at each Interdisciplinary Renal Health Clinic visit.

2. Medication reconciliation is a shared responsibility involving the client and one or more health care practitioners.
RATIONALE FOR SELECTION OF TARGET MRP CLIENTS:

**Dialysis:**
These clients are prescribed an average of 12 different medications and are at high risk of medication errors during health care transition points.

**Stages 4 and 5 Chronic Kidney Disease (CKD):**
These clients are also prescribed many medications as a result of complications of their chronic kidney disease and are seen frequently by the Interdisciplinary team at the Renal Health Clinics.

**Stages 1 to 3 CKD:**
These clients are not included in the MRP Medication Reconciliation process as they are usually not seen by the interdisciplinary team and are not prescribed a high number of medications by the nephrologist. However, more complicated clients in this category may be referred by their nephrologist to be seen by the interdisciplinary team and would then have medication reconciliation performed as described under Stage 4 and 5 CKD.

GUIDELINES:

1. Medication Reconciliation at the Beginning of Service

**In-Centre Hemodialysis:**
The BPMH is collected within two (2) weeks of initiating dialysis. The BPMH is documented on the Physician Order sheet or MRP Outpatient Prescription and transcribed to the Renal Medication Flow Sheet. Documentation follows the MRP Standard 60.10.05 Renal Medication Flow Sheet available at: http://www.kidneyhealth.ca/wp/wp-content/uploads/pdfs/P&P/P&P_60.10.05.pdf

**Home Dialysis (home hemodialysis and peritoneal dialysis) and Manitoba Local Centres:**
The BPMH is collected during training for home hemodialysis or peritoneal dialysis. Manitoba Local Centres have their BPMH collected during the assessment visit. Documentation follows the MRP Standard 60.10.05 Renal Medication Flow Sheet available at: http://www.kidneyhealth.ca/wp/wp-content/uploads/pdfs/P&P/P&P_60.10.05.pdf

**Stages 4 and 5 CKD:**
The BPMH is collected at the first Interdisciplinary Renal Health Clinic visit. The BPMH is documented on the Physician Order sheet or MRP Outpatient Prescription and transcribed to the Renal Medication Flow Sheet. Documentation follows the MRP Standard 60.10.05 Renal Medication Flow Sheet available at: http://www.kidneyhealth.ca/wp/wp-content/uploads/pdfs/P&P/P&P_60.10.05.pdf

2. Periodic Medication Reconciliation

**In-Centre Hemodialysis:**
A BPMH is completed every 6-12 months by the renal pharmacist. A Case Summary is completed by the nephrologist every 12 months. The pharmacist 12 month BPMH is typically coordinated with the nephrologist Case Summary.

Clients are also asked to inform the dialysis unit of any new medications or changes to their medications that are prescribed outside of the dialysis unit. The Renal Medication Flow Sheet is updated with the new medication information.

Changes to medications are provided to the client’s primary care provider and other specialists in the yearly Case Summary.

**Home Dialysis (home hemodialysis and peritoneal dialysis) and Manitoba Local Centres:**
A BPMH is completed at the beginning of every Interdisciplinary Clinic visit by the pharmacist or nurse. The Renal Medication Flow Sheet is updated with the new medication information.

Changes to medications are provided to the client’s primary care provider and other specialists in the form of a dictated letter after the clinic by the nephrologist and in the yearly Case Summary.

**Stages 4 and 5 CKD:**
A BPMH is completed at the beginning of every Interdisciplinary Clinic visit by the pharmacist or nurse and documented on the Renal Medication Flow Sheet.
Changes to medications are provided to the client’s primary care provider and other specialists in the form of a dictated letter by the nephrologist.

3. Client Communication

   a) Medication Cards

**In-Centre Hemodialysis:**
A medication card in either electronic or written format with the current BPMH and any changes to the medications is provided to clients initiating dialysis and during their periodic medication reconciliation by the renal pharmacist or pharmacy technician. The Manitoba Renal Program Medication Card is recommended (Appendix B 60.40.09).

**Home Dialysis (home hemodialysis and peritoneal dialysis) and Manitoba Local Centres:**
A medication card in either electronic or written format with the current BPMH and any changes to the medications is provided to clients during home dialysis training or the Local Centres permanent assessment. The card will be updated periodically at their interdisciplinary clinic visits by the renal pharmacist or pharmacy technician. The Manitoba Renal Program Medication Card is recommended (Appendix B 60.40.09).

**Stages 4 and 5 CKD:**
Clients will be given a copy of the Manitoba Renal Program Medication Card (Appendix B 60.40.09) at their first interdisciplinary clinic visit. Clients or their caregivers will be asked to complete the medication card and bring it to their Renal Health Clinic visits so that it can be reviewed and updated.

   b) Changes to Medications

**In-Centre Hemodialysis:**
The MRP Medication Change Form (Appendix A 60.40.09) is provided to the client for changes made to medications in the hemodialysis unit. The hemodialysis nurse or pharmacist reviews this form with the client and documents that it was provided to the client on the outpatient prescription.

**Home Dialysis (home hemodialysis and peritoneal dialysis) and Manitoba Local Centres:**
Clients attending a clinic will be informed of any medication changes during the clinic visit and an outpatient prescription will either be provided to the client or faxed to their community pharmacy.

Clients who are not attending a clinic when a medication change is made will receive a phone call from a dialysis nurse letting them know of the change and which pharmacy the prescription was sent to. The dialysis nurse will document that they client was contacted on the outpatient prescription.

**Stages 4 and 5 CKD:**
Clients attending a clinic will be informed of any medication changes during the clinic visit and an outpatient prescription will either be provided to the client or faxed to their community pharmacy.

Clients who are not attending a clinic when a medication change is made will receive a phone call from the Renal Health Clinic nurse letting them know of the change and which pharmacy the prescription was sent to. The Renal Health Clinic nurse will document that they client was contacted on the outpatient prescription.

4. Medication Reconciliation on Transfer

   a) Permanent Transfer of Dialysis Clients (Hemodialysis & Peritoneal Dialysis) between MRP sites:

The “Transfer Checklist for dialysis patients transferring between Winnipeg units or sites” is located in 60.30.19 Protocol for Transfer of Patients between Dialysis Units and / or Sites within the Manitoba Renal Program: [http://www.kidneyhealth.ca/wp/wp-content/uploads/pdfs/P&P/P&P_60.30.19_Protocol%20_Transfer.pdf](http://www.kidneyhealth.ca/wp/wp-content/uploads/pdfs/P&P/P&P_60.30.19_Protocol%20_Transfer.pdf)

The transferring hemodialysis unit provides the current medication list and the Medication Administration Record for PRNs and single dose medications administered within the last month, to the receiving dialysis unit as per the checklist.

A health care practitioner from the receiving dialysis unit performs a BPMH with the client within 2 weeks of the transfer. This list is reconciled against the medication information documented on the transferring Renal Medication Flowsheet and the transferring MAR. The most up-to-date medications list is generated, documented on the Renal Medication Flowsheet and appropriate modifications to medication orders are made.
b) Transfer of clients to Home Dialysis (home hemodialysis or peritoneal dialysis) or Manitoba Local Centres:

A BPMH is performed and documented as outlined in “1. Medication Reconciliation at the Beginning of Service”.

c) Transfer of clients to and from Long-Term Care Facilities:

In-Centre Hemodialysis:
Any changes made to a resident’s medications are communicated using the reciprocal Manitoba Renal Program and Long Term Care Communication Record (WRHA Form# W-00273, WR-16, CL0065-5). The documentation standard for the Manitoba Renal Program & Long Term Care Communication Record is available online at: http://home.wrha.mb.ca/hinfo/guidelines_other.php

Home Dialysis (home hemodialysis and peritoneal dialysis) and Manitoba Local Centres:
The long-term care facility sends a copy of the client’s Medication Administration Record (MAR). Medications changes are written on an outpatient prescription and provided to the long-term care facility and pharmacy.

Stages 4 and 5 CKD:
The long-term care facility sends a copy of the client’s Medication Administration Record (MAR). Medications changes are written on an outpatient prescription and provided to the long-term care facility and pharmacy.

d) Discharge of clients from an acute care facility after an inpatient admission:

A client’s medications are reconciled within two (2) weeks of discharge from hospital. Various information sources are used to determine the most up-to-date medication list and for assessing individual medications. Completion of a Discharge Medication Reconciliation/Prescription Order is encouraged to communicate medication information to the next provider(s) of care. Any changes in the client’s medication are documented on the Renal Medication Flowsheet and physician orders written as appropriate.

5. Medication Reconciliation on Referral (to another setting, service, service provider, or level of care outside the MRP)

The client’s Renal Medication Flowsheet and the most recent Case Summary are provided. In addition, 60.40.06 Guidelines for Managing Hospitalized Hemodialysis Patients (http://www.kidneyhealth.ca/wp/wp-content/uploads/pdfs/P&P/P&P_medadmintimes.pdf) provides further guidance to hospital-based healthcare practitioners on medications and medication reconciliation.

REFERENCES:

Accreditation Canada. Ambulatory Care Services Required Organizational Practices 8.3, 8.4, and 12.2.


REVIEWED BY:
Beatrice Patton, B.Sc.(Pharm), WRHA Patient Safety Pharmacist