

Recharge Renal Reconciliation: Barriers and Enablers for Improving Accuracy of Medication Histories.

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Background:

The renal Outpatient Clinic Letter (OPCL) is an important document and is referred to by clinicians for completing patients' medication histories.

People with chronic kidney disease are admitted to hospital more frequently than the general population (1) and have high rates of polypharmacy (2). It is therefore critical that the medication list within the OPCL is kept accurate and up to date. However, it is not known whether these lists are reconciled adequately following an inpatient admission.

Aim/Objectives:

To assess the accuracy of medication reconciliation at the first renal clinic review following an hospital admission and to analyse and report potential contributing factors for discrepancies.

Methodology:

- A retrospective audit from October to December 2019 aiming to identify discrepancies between the medication list on discharge and in the OPCL.
- Inclusion criteria: follow up in the Renal Outpatient Clinic (OPC) within three months post discharge with a medication list in their OPCL.
- Exclusion criteria: Transferred to another hospital on discharge or readmitted to hospital before their next OPC appointment.
- Discrepancy contributing factors were identified and analysed according to themes.

Results:

- A total of 131 patients identified, with 50 of these patients meeting the inclusion criteria.
- Of these 50 patients, 48% were on dialysis and 16% have had a kidney transplant and were of an average age of 66.7±14.9 years old and prescribed an average of 11.1±4.13 regular medications.
- Thirty-two patients (64%) had at least one (mean 1.77±1.55) medication discrepancy (Fig. 1) of which the most common recorded were omitted drug and wrong dose.
- The main source of discrepancies was attributed to a direct import of the medicine list from the OPCL prior to the inpatient stay (Fig. 2).

Fig. 1: Rate of Discrepancies Amongst Patients

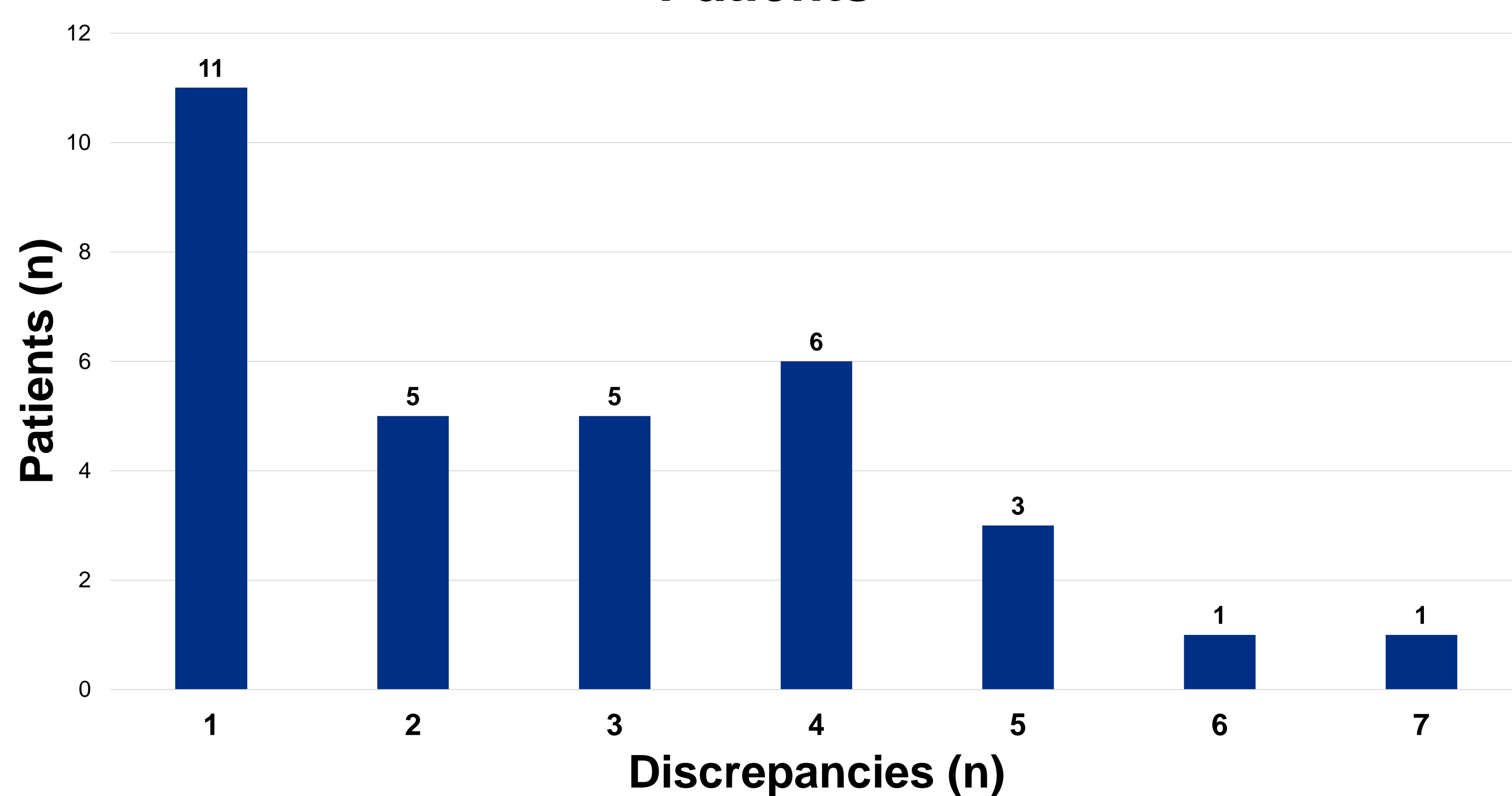


Fig. 2: Sources of Medication Discrepancies

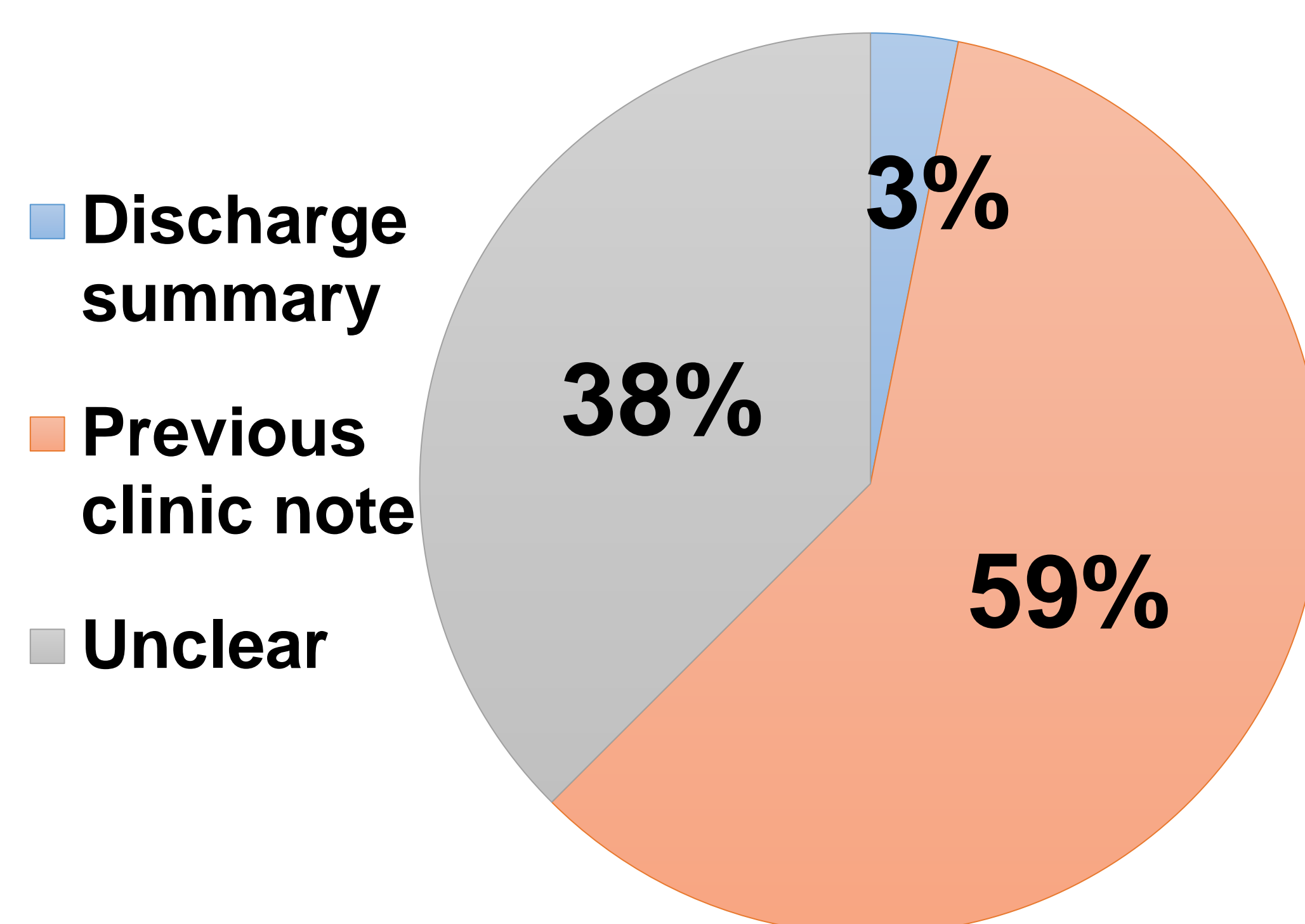


Table: 1 Examples of Discrepancies

Patient demographic	Discrepancies
A 68-year-old male, with CKD stage 5, on haemodialysis	i. Aspirin 100 mg daily, not documented (new medication on discharge) ii. Lantus (insulin glargine) 12 units in the morning, not documented (new medication on discharge) iii. Perindopril 5 mg daily instead of 2.5 mg daily (decreased on discharge) iv. Amlodipine 5 mg daily, documented. Ceased on discharge.

Discussion:

Discrepancies in the OPCL medication list frequently occur due to incomplete medication reconciliation. Introduction of medication reconciliation by an outpatient pharmacist as well as improved integration of inpatient and outpatient patient information systems are proposed solutions.

A limitation was that the source of 38% of discrepancies were unclear. As it was a retrospective audit it could not be determined if this documentation was accurate. Nonetheless a large proportion were easily attributed to previous clinic lists.

References:

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2. Schmidt IM, Hübner S, Nadal J, Stephanie T, et al. Patterns of medication use and the burden of polypharmacy in patients with chronic kidney disease: the German Chronic Kidney Disease study. Clinical Kidney Journal. Volume 12, Issue 5, October 2019, Pages 663–672, <https://doi.org/10.1093/ckj/sfz046>

