ENSURING MEDICATION CONTINUITY
Nephrophiles, LLC
Santa Fe, NM

Contact Information
Robert Kossmann, MD
1650 Hospital Drive, Suite 200
Santa Fe, NM
505-982-4276
RJKNEPH@aol.com

Category:	Medication Errors and Omissions
Type of Facility:	Private Nephrology Practice
Number of Patients:	180
Number of Physicians:	4

Background
Nephrophiles, LLC is a private nephrology practice that coordinates care with three Fresenius Medical Care dialysis facilities in the Santa Fe region. In 2006, Nephrophiles developed a new policy to address the gaps in communication between the local hospital and dialysis facilities. They realized that patients being discharged from the hospital to the dialysis units, either as new starts on dialysis or returning chronic hemodialysis patients, were not always getting appropriate labs, prescription changes, medications or medication changes and were concerned about the quality and safety for patients. To address this, Nephrophiles developed the Discharge Instructions template tool. The tool meets the need for clear communication from the discharging physician to the outpatient dialysis units for appropriate orders for ongoing outpatient dialysis and reduces the risk the patient will not get the treatment needed and prescribed. To ensure that everyone at the facility was aware of and using the tool, they involved both RN staff and MDs in the discussions of the indication for the development and use of the tool.

Policies implemented:
A patient coming from the hospital cannot receive outpatient HD treatment unless the Discharge Instruction tool or a telephone order is received FIRST.

As a result of implementing use of the Discharge Instructions tool, Nephrophiles found the patients were receiving more timely draws of Hgb after returning to the outpatient HD unit from the hospital. Additionally, there was greater attention to dry weight change needs, medication changes, and antibiotics than there had been prior to use of the form.

Recommendations:
Nephrophiles recommends that facilities looking to address medication errors and omissions confer with colleagues and RN staff to establish whether there's a need to implement use of a standardized tool, or if another mechanism is in place already that satisfies this need. If not, they recommend the facilities consider adopting this very simple tool to improve patient safety.