**Patients with Diabetes receiving Haemodialysis – are they being over-medicated? The Joint British Diabetes Societies for Inpatient Care: Management of adults with Diabetes on the Haemodialysis Unit (2016)** identified that intensive glycaemic management of patients with diabetes receiving Haemodialysis can increased the risk of mortality when compared to that of the non - Chronic Kidney Disease population. It recognises that hospital Haemodialysis patients with Diabetes are a vulnerable high risk group for adverse cardiovascular incidences resulting in the principal cause of mortality for this population. Within this guidance it is recommendedthat the HbA1c target for this group be relaxed from HbA1c 48mmols-59mmols to HbA1C 58-68mmols this is hoped to lower mortality from increased cardiovascular risk factors and reduce incidences of hypoglycaemia. In response to this document a Diabetes Specialist Nurse joined the monthly Renal Quality Assurance meetings, reviewing Haemodialysis patients with Diabetes. This group comprised of a Renal Consultant, a Renal/Diabetes Specialist Nurse, a Haemodialysis nurse and two Renal Dietitians. The focus of the group was to review our population of Haemodialysis patients with Diabetes current HbA1c level, Diabetes medication, nutritional intake and medical condition. In those patients whose Hba1c was <58mmols we clarified whether they were on insulin, oral hypoglycaemic agents, mixed therapy or diet alone. This paper reports on our assessment and intervention on this group of Haemodialysis patients with Diabetes.

The review indicated whether Diabetes medications needed to be adjusted / stopped. This was then undertaken systematically. The patient’s response to change in therapy was assessed by reviewing the patient’s current blood glucose trends and the latest HbA1c levels and was refined accordingly.

The difficulties encountered when attempting to modify medications were interesting and some of which can be reviewed via case studies. For example some patients were very hesitant to reduce or stop insulin or to reduce or to stop oral hypoglycaemic agents. Over a 6-9 month period the patients were reassured by member of the working group regarding the safety of the treatment plan and close monitoring of patient blood glucose as well as Hba1c levels were maintained throughout. Patients, for whom medication was reduced, reported feeling better with a perceived improvement in their quality of life. Patients who were taken off Diabetes therapies, although some initially hesitant, did benefit from this course of action and were pleased by this change in management and lifestyle.

This collaborative multidisciplinary approach of reviewing our Haemodialysis/Diabetes population proved to be excellent for individual professional development. Each team member benefitted from peer support, helping improve specialist clinical knowledge and expertise. An important additional acknowledgement and outcome has to be the significant cost saving in the modification of Diabetes Therapies during this process. Above all however the concluding outcome is an improvement in the overall care of this fragile group, a decreased incidence and risk of hypoglycaemia for our patients and an improved clinical working confidence for Healthcare Professionals caring for this particular group of patients.