

## December 16, 2024 Weekly Clinical Update

Last week, the current and new regulations were provided related to Discharge Summaries because multiple facilities are being cited for lack of any or incomplete Discharge Summaries. That subject leads to the component of the Discharge Summary of Medication Reconciliation.

Recently Proactive LTC Consulting posted an excellent article written by Angie Hamer, RN, RAC-CT, Senior Consultant (<https://proactiveltcexperts.com/medication-reconciliation-who-what-when-why-and-how/>) on Medication Reconciliation.

The reason Medication Reconciliation is so important is to reduce medication errors, which often occur during a resident's transition or transfer to change in level of care including discharge. Residents are vulnerable to poly-pharmacy, both prescribed by a practitioner, multiple practitioners that fail to coordinate with other practitioners, or, most importantly, over-the-counter or herbals that are administered unbeknownst to any practitioners.

“Medication Reconciliation” is a systematic review of a resident's complete medication regimen that includes prescribed and over-the-counter drugs, nutritional supplements, vitamins, herbal and homeopathic biologicals, and other specific treatments such as TPN and oxygen supplementation and breathing treatments. The goal for Medication Reconciliation process is the “identify and resolve clinically significant issues like duplicate therapies, adverse drug interactions, improper dosages or medications without a clear indication for use.”

Medication Reconciliation should be performed and documented:

- At admission
- Throughout the stay (most facilities have Consultant Pharmacy (CP) Medication Reconciliation during monthly CP Medication Regimen Reviews AND each time the primary care provider certifies all physician orders)
- At discharge: “A recorded medication list is provided to subsequent care providers to facilitate a smooth transition and avoid errors.”

Steps for Medication Reconciliation include:

1. Conduct a comprehensive drug regimen review
  - a. Review clinical records, transfer documents, discharge summaries
  - b. Discuss medication details with practitioners/extenders, residents/representatives
2. Identify clinically significant issues
  - a. Allergies or adverse or history of adverse reactions

- b. Incorrect dosages or frequencies or excessive or prolonged orders or use
  - c. Serious potential drug interactions including drug-drug, drug-food, drug-indication/diagnoses
  - d. Omission of necessary medications or inclusion of unnecessary medications
3. Provide current reconciled medication list at discharge
- a. Include active, medications that have been “held” or discontinued with detailed information
  - b. Ensure list is customized to resident’s specific needs and subsequent care requirements
4. Educate and train staff
- a. Train and ensure competency on proper medication administration and monitoring for adverse effects
  - b. In-service staff on the facility’s systems, policies, procedures and protocols to evaluate and address medication issues
  - c. In-service staff on “who, what, when, why and how” the Medication Reconciliation is completed