## Medication Reconciliation in Home-Based Care

Patients often have medications changed during care transitions from one care environment and provider to another such as hospital to home. While most changes are planned, unintentional discrepancies can arise due to incomplete medication histories or lack of communication. These errors may result in omitted drugs, duplicated therapies, or incorrect dosages, increasing the risk of adverse drug events.[i]

**<u>What</u> is Medication Reconciliation (MedRec)?**

MedRec is a complex process of reviewing the patient's complete medication regimen, including drug name, dosage, frequency, and route, at the time of a care transition and comparing it with the regimen being considered for the new setting of care. This includes prescription, over the counter (OTC), herbal and nutraceuticals, and recreational medications.[ii]

**<u>Why</u> Medication Reconciliation?**

Medication discrepancies are common during transitions from hospital to home, raising the risk of adverse drug events (ADEs). MedRec is vital for improving drug safety in older adults, but getting an accurate list for home base care patients relies on obtaining recent clinical documentation from hospitals, physicians and from patients or caregivers themselves.[iii]

**<u>When</u> is Medication Reconciliation completed?**

MedRec must be completed at every transition of care. For home-based providers, the process is completed at admission to services and continuously throughout the service period. It is not a one-time event. Optimal practice for safe patient care is MedRec at every nursing visit.[iv]

**<u>Who</u> Can Complete Medication Reconciliation?**

Usually, a registered nurse will complete MedRec in home-based care. Physicians and pharmacists may also complete this function. It is recommended providers check a state's professional practice acts for licensed clinicians to ensure the right discipline is completing MedRec by regulatory requirements.

**Why is this important from a survey perspective?**

- Top survey finding (federal, state and CHAP). Typically found during home visits, record reviews, PAE (occurrences), QAPI and Infection Prevention and Control (Injection and Medication Safety), Medication administration (if applicable).
- High patient health and safety risk and increased potential
- Ensure alignment with physician orders, med profile and clinical documentation, care plan, patient meds and med lists in the home
- Needs to be done on admission as part of comp assessment and updated ongoing (see recommendation below to conduct med rec with each skilled primary care clinician). Other team members can communicate with the primary clinician/IDG.
- Comp assessment federal tags below but medication accuracy is incorporated into many other standards such as care planning, professional management, etc.

Hospice

L530 §418.54(c)(6) Drug profile. A review of all of the patient's prescription and overthe-counter drugs, herbal remedies and other alternative treatments that could affect drug therapy. This includes, but is not limited to, identification of the following: i. Effectiveness of drug therapy ii. Drug side effects iii. Actual or potential drug interactions iv. Duplicate drug therapy v. Drug therapy currently associated with laboratory monitoring.

Home Health:

G536[§484.55(c) … The comprehensive assessment must accurately reflect the patient's status, and must include, at a minimum, the following information:] (5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.

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**The Medication Reconciliation Process**

Provider organizations can design their own MedRec process that dovetails with the state and federal provision of care regulations. The goal is to review the patient's current complete medication regimen. The medication reconciliation steps below provide a comprehensive method for collecting data and determining the accuracy of the medications the patient is (or perhaps is not) taking.[v]

1. To save time, ask the patient to have all their medications readily available at the time of the home visit.
2. Start the process by assessing the patient's/representative's perspectives and goals about their medications.

3. Ask the patient/representative to show you all of their medications, including over-the-counter drugs, herbal drugs, nutraceuticals, supplements, creams, inhalers, and as-needed medications. Ask to see old medication they may have saved as well (antibiotics, narcotics, etc.).
4. Gather information from additional resources, such as hospital discharge paperwork, assisted living facility records, provider records, and the patient's pharmacy as available.
5. Compare each prescription bottle to the medication recorded in the provider record.
6. Look for any high-risk medications, especially those on the American Geriatrics Society Beers Criteria® list, such as opioids, hypoglycemics, and anticoagulants.

   The five lists included in the AGS Beers Criteria® describe medications where the best available evidence suggests they should be:

   - Avoided by most older adults (outside of hospice and palliative care settings);
   - Avoided by older adults with specific health conditions;
   - Used with caution because of the potential for harmful side effects; or
   - Avoided in combination with other treatments because of the risk for harmful "drug-drug" interactions; or
   - Dosed differently or avoided among older adults with reduced kidney function, which impacts how the body processes medicine.[vi]

7. Home Health providers: Use the Outcome and Assessment Information Set (OASIS), to help assess patients' medication management capabilities and to identify patients who might be at increased risk for medication errors.
8. Assess for any medication duplication, drug-to-drug interactions, or drug-to-disease interactions.
9. Ask the patient if they're taking the medication as prescribed. If not, ask them what barriers they're encountering.
10. Ask them how they dispense the medication to themselves (for example, filling a 7-day pill container, taking each dose from the bottle). Work with the patient to find a dispensing method that facilitates adherence.

11. Assess the patient's medication use by asking about each medication's indication and their response to it.
12. Discuss risks, benefits, and side effects of each medication.
13. Discuss safe disposal options with patient/representative/caregiver that are aligned with federal and state regulations for drug disposal in the home.
14. Assess the patient's willingness to take the medication, its affordability, and whether the regimen is realistic. Conclude with a plan that will enable the patient to take medications as prescribed.
15. Assess the patient's ambulatory status and dexterity to determine the need for physical or occupational therapy.
16. Work with a physician and/or pharmacist or a consultant pharmacist to review patients' medication regimens for potential red flags (e.g., drug–drug interactions, polypharmacy, and look-alike/sound-alike products).

Medication management in home-based care is challenging due to unique conditions and patient needs. To lower medication errors and patient harm, organizations should consistently complete MedRecs, educate staff and patients, enhance communication, and address risks or barriers.

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[i] Medication Reconciliation. PSNet [internet]. Rockville (MD): Agency for Healthcare Research and Quality, US Department of Health and Human Services. 2019.
[ii] Medication Reconciliation. PSNet [internet]. Rockville (MD): Agency for Healthcare Research and Quality, US Department of Health and Human Services. 2019.
[iii] Taylor, K. (2021). Geriatric medication reconciliation in the home setting: A patient-centered approach can improve outcomes. *American Nurse Journal*, *16*(7), 14-18.
[iv] Taylor, K. (2021). Geriatric medication reconciliation in the home setting: A patient-centered approach can improve outcomes. *American Nurse Journal*, *16*(7), 14-18.
[v] Taylor, K. (2021). Geriatric medication reconciliation in the home setting: A patient-centered approach can improve outcomes. *American Nurse Journal*, *16*(7), 14-18.
[vi] Fick, D. M. (2023). Many Older Adults Take Multiple Medications; Updated AGS Beers Criteria® Will Help Ensure They Are Appropriate. *Journal of gerontological nursing*, *49*(6).