

Medication Management in Long Term Care (Communication & Treatment)

- Criteria**
- ▶ Change in Condition
OR
 - ▶ First time resident shows up on QI resident level summary with either QI #6, #7, #19, #20, or #21
OR
 - ▶ When family question it
OR
 - ▶ When staff or surveyors, or consultant pharmacist questions it

Medication Review

Yes

YES

Gather Clinical Information

- Areas (Examples)**
- ▶ Current list of medications
 - ▶ Information on each med
 - ↳ Start date & End date
 - ↳ Dosage & frequency
 - ↳ Condition/Diagnosis for med
 - ↳ Who ordered it
 - ↳ If PRN, frequency given
 - ▶ Change +/- in resident since med was initiated, (i.e. cognition/behavior, ADL/functional status, food/fluid intake, bowel)

- DOCUMENTATION**
- ▶ Document in Nurse Notes gathering of data and faxing Info to Dr./APN/PA
 - ▶ Document in Nurses Notes contact with Dr./APN/PA and reasons to change or not change med(s)
 - ▶ Review/update medication sheets
 - ▶ Update care plan where appropriate
 - ▶ Communicate with pharmacy consultant & family

**FAX Information and Contact
Attending Physician**

- Checklist for Nurse to provide to Physician
(HAVE RESIDENT CLINICAL RECORD IN HAND WHEN CALLING PHYSICIAN)**
- ▶ Drug List
 - ▶ Diagnoses, Allergies
 - ▶ Recent B/P, Resp., Temp. & Pulse
 - ▶ Recent Lab values
 - ▶ etc. (comments from resident, family, etc.)

Physician Orders/Changes Received

Facility staff proceeds with Phy. Orders (ex: meds, lab etc)
Staff notifies pharmacy & family of changes
Staff continues to observe, assess and treat based on orders and care plan

Adjust Medication sheets & Care Plan

Notify Dr./APN/PA & family, if medication adjustments affect resident negatively, in order to consider other treatment options