

# VNAA Blueprint for Excellence

PATHWAY TO BEST PRACTICES

## Clinical Training: Medication Reconciliation

VNAA Best Practice for  
Home Health



# Learning Objectives

- To understand why medication reconciliation is important to providing quality care
- To understand the three step process for improving medication reconciliation
- Identification of barriers patients may have when taking medications and ways to overcome them



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# Why is medication reconciliation so important?

- The number one problem in treating illnesses is patients' failure to take prescribed medications correctly, regardless of age
- In the U.S., 50-70% of patients do not take medications properly
- 10% of hospital admissions relate to taking meds properly, 23% of all nursing home admissions

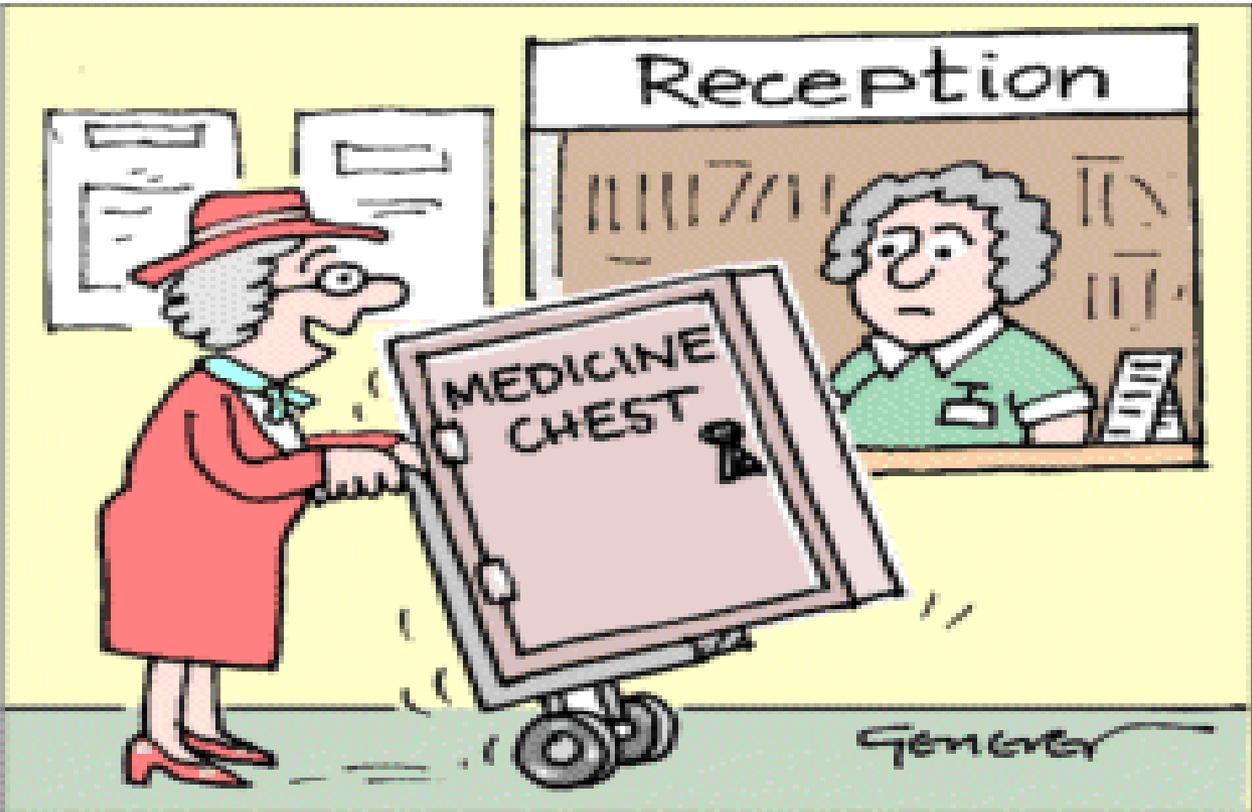


# Statistics

- 22% take less than what is prescribed
- 12% do not fill their prescription at all
- 12% do not take the medication at all after buying the prescription
- 29% stop taking the medication before it runs out
- 12 - 20% take other people's medication



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# Medication reconciliation

- Takes on new importance as an increasing number of patients are prescribed multiple medications by multiple physicians



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Medication Reconciliation\* is the process of identifying the most accurate list of all medications a patient is actually taking — including name, dosage, frequency, and route. The information is then used to determine which medications the patient should be taking per physician orders.

- The Medication Reconciliation process for home care has three basic steps:
  1. Verify - Collect an accurate medication list
  2. Clarify - Clarify any questions about drug/dose/frequency
  3. Reconcile - Communicate with physician about any identified medication questions or concerns

\*Adapted from the Institute for Healthcare Improvement



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# Step 1: Verify

Collect a COMPLETE list of ALL medications that the patient is currently taking. This includes:

- Prescription medications
- OTC medications, i.e., aspirin, acetaminophen, NSAIDs, Benadryl for sleep
- Culturally-based home remedies, such as:
  - Ginseng (for physical and mental performance, infection resistance)
  - Chamomile tea (for sleep/anxiety)
- OTC herbal products, such as:
  - St. John's Wort (for depression, stress, anxiety)
  - Senna (for constipation)
  - Black Cohosh (for menopause symptoms)
- Dietary supplements such as Calcium (to prevent osteoporosis)
- Vitamins such as Niacin, Vitamin E, Vitamin D



# Step 1: Verify

- It is important to specifically ask about the use of non-prescription medications and preparations – patients often do not consider things such as vitamins “medications” and will not volunteer that they are taking them
- Other tips for obtaining more complete medication lists at the start of home care:
  - Tell the patient/family BEFORE the first visit to collect all of the patient’s medications and have them ready for the nurse to see.
  - Ask the patient what help they think they might need in managing their medications.



## Step 2: Clarify

- Clarify medication names, doses, frequencies, and to identify combinations that may be contraindicated or medications that seem to be inappropriate
- In the Clarify step, a key goal is to identify potentially serious drug-drug interactions or therapeutic duplication within the patient's medication list
- Therapeutic duplication is present when the patient's medications include two or more medications from the same chemical family or therapeutic class
- A possibility for drug-drug interaction (DDI) is present when the patient's medications include two or more medications with the potential to interact negatively with one another



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The following table lists the severity levels as defined by First Data Bank:

Significance	Description
1	Contraindicated Drug Combination — Level 1 indicates that the drug combination is clearly contraindicated and should not be administered to the same patient. Manufacturer labelling to this effect is sufficient to support including a drug combination in this severity level.
2	Severe <b>Interaction</b> — Level 2 indicates that the drug combination can produce serious effects in most patients. However, the medications can be monitored and/or the agent(s) titrated, to minimize the risk of <b>adverse</b> effects. The drug combination may be absolutely contraindicated in some but not all patients. Information to identify such patients is provided in the DDIM monograph. Drugs that must never be administered simultaneously, but can be given on an alternating schedule, are also specified in the DDIM monograph. Required action may include discontinuing one or both agents, or adjusting dosage, altering of administration scheduling, or monitoring the patient.
3	Moderate <b>Interaction</b> — Level 3 indicates that the clinician should assess the patient's individual characteristics and take appropriate action. Required action may include discontinuing one or both medications, adjusting dosage, modifying administration scheduling, or monitoring the patient.
9	Undetermined Severity-Alternative Therapy <b>Interaction</b> — Level 9 indicates that the drug combination involves agents classified by First DataBank as alternative therapy. <b>Interaction</b> is possible, but the severity level does not specify the potential severity of the <b>interaction</b> . Required action may include discontinuing one or both medications, adjusting dosage, modifying administration scheduling, or monitoring the patient.



## Step 2: Clarify

- Besides looking for therapeutic duplication and drug-drug interactions, the reconciliation process should identify any potentially *inappropriate* medications. Certain medications should generally be avoided in older persons – although a physician may decide that their use for an individual patient's specific clinical circumstance is appropriate. One such list of medications is called the Beers Criteria.



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## Step 3: Reconcile

- Reconcile the medications with the physician
- If the patient's medication list is free from therapeutic duplication, potentially inappropriate medications, and no dose, route or frequency questions have been identified, the completed medication list can be entered in section 10 on the HCFA Form 485 and sent to the physician for verification and signature
- If a question or potential problem has been identified, the nurse (or therapist) is responsible for ensuring that these are reported to the physician, and for obtaining clarification or revised orders



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# Facilitating physician response

- Clinicians are trained to write care plans more narrative in nature. Physicians however are trained to use “headlines” or bullet points notations. As a result there are different approaches when communicating.



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# SBAR

- SBAR is a communication model that is easy to remember, adaptable to the situation, painless to learn and most importantly, effective.
  - **S**ituation - What is happening with the patient?
  - **B**ackground- What is the clinical background?
  - **A**ssessment- What do I think the problem is?
  - **R**ecommendation- What would I recommend?



# Adherence and medication management

- To improve the patient's management of complicated medication regimens, home health agency staff need to understand what gets in the way of adherence and understanding
- Assessment needs to be more than the ability to take medications



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# Adherence vs. Persistence

- Adherence: the extent to which a person takes medications as prescribed
- Persistence: the ability of a person to continue to take medications for the intended course of therapy



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# Factors contributing to adherence

- Health literacy: Failure to understand directions on the label
- Regimen complexity
- Dosing frequency more often than twice a day
- Remembering doses and refills
- Fear of side effects; 45% people do not take their meds because of the side effects
- I feel okay now, why should I take it?
- Cost



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# Health literacy

- Health literacy is the ability to read, understand and act on health information in order to make appropriate health decisions. Poor health literacy results in medication errors, impaired ability to remember and follow treatment recommendations, and reduced ability to navigate within the health care system.



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# Health literacy

- Older adults with low health literacy may have trouble reading health information material, following prevention instructions, understanding basic medical instructions, and adhering to medication regimens. A study of patients aged 60 years and older at two public hospitals found that 81% could not read and understand basic materials such as prescription labels.
- [Foundation: Health Literacy - YouTube](#)



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# Conclusion

- "Medicine used to be simple, ineffective and relatively safe."
- "Now it is complex, effective, and potentially dangerous."
- Sir Cyril Chantler



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