OASIS Alert

Outcomes: Don't Just Review Medications -- Take Action

Use this tool to protect your patient and your agency.

If you don't do a complete medication review in your OASIS assessment -- including identifying and resolving medication errors -- you not only risk survey deficiencies, but also can endanger your patient's life.

Many transitions to home care are unplanned, unanticipated, occur on nights, weekends or late Friday afternoon and do not involve clinicians familiar with the patient, experts point out. The lack of coordination in the transition process can lead to medication errors that result in adverse events, rehospitalizations and even death.

Home health patients are especially likely to experience medication problems because they may have multiple chronic conditions, cognitive problems, several sources of prescriptions, multiple informal caregivers or perhaps live alone, experts say.

Examine Your Work Flow

What do you do with the medication list you make for each patient during assessment? Home health agencies often are not aware of what the work flow process is within the agency and how they can improve it, says **Risa Hayes**, a quality improvement coach with the Tran-sitions in Care program at the **Colorado Foundation for Medical Care** in Englewood, CO. "Often the clinician makes a list of medications but doesn't resolve the problems the list identifies," she tells **Eli**.

Watch for: Four common medication errors identified in a survey of nearly 7,000 home care patients by researchers at **Vanderbilt University** were: unnecessary therapeutic du-plication; cardiovascular medication problems; falls and confusion related to psychotropic drug problems and problems with non-steroidal anti-inflammatory drugs.

New Tool Highlights Medication Problem Resolution

In a current **Centers for Medicare & Medicaid Services-**funded pilot project, participants use the "Medication Discrepancy Tool" to reconcile medication problems they identify, Hayes says (for a copy of the tool, see p. 37). The tool at least provides a standard way of capturing the data and may help agencies standardize the process for following up on medication discrepancies, she suggests.

The **University of Colorado** Care Tran-sitions program developed the MDT with a grant from the **John A. Hartford Foundation**, UC's Dr. **Eric Coleman** tells **Eli**. HHAs can use the MDT to identify and characterize medication discrepancies.

The tool is designed to prevent problems rather than to follow up on adverse events, Hayes adds. It encourages resolution of a problem by identifying action steps after helping the clinician pinpoint the causes of the problem and contributing factors. "Every clinician we've talked to has loved the Medication Discrepancy Tool," Hayes reports.

How To Use The Tool

Once you identify a medication discrepancy, you address that with a separate MDT form. A discrepancy can include

problems such as inaccurate medication information, no information about changed or discontinued medications or patient problems in taking the medication. Determine whether the discrepancy is "patient level" such as the patient didn't fill the prescription or is having side effects from the medicine, or "practitioner/health system level" such as incorrect dosage or duplication. The clinician then records the actions she or the patient takes to resolve the problem.

Scenario: On admission, the patient tells you he is taking his cholesterol-lowering medication every morning at breakfast just like he's supposed to. Later when you ask him to tell you what he's eating, he says he has a big glass of grapefruit juice every morning. It's clear he doesn't understand the interaction you are aware of between grapefruit and his medication.

What to do: As you go through these steps, follow along using the form on p. 37:

1. Once you identify this problem, note it on the MDT form.

2. Then check off the causes and contributing factors. Perhaps under Patient Level you mark "Non-intentional non-adherence i.e. knowledge deficit." Under System Level, you might check "Conflicting information from different informational sources," if the pill bottle mentions the need to avoid grapefruit, but the discharge instructions don't. Or perhaps "Dis-charge instructions incomplete/inaccurate/ illegible" better defines the cause.

3. Finally, under "Resolution," you would record the action you have taken. such as "Addressed performance/knowledge deficit." You might also mark "Provided resource information to facilitate adherence," if the patient wanted to see information in writing before he gave up his favorite juice.

Note: For a copy of the MDT, email marianc@eliresearch.com, with "MDT" in the subject line.