Iowa Center for Home Care

Medication Management Clinical Record Review

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Purpose: Use this Record Review for a focused audit or integrate into your regular reviews. Specific questions can be used for monitoring if your QI plan is focused on a specific topic. This can also be used for joint competency visits. Form may be modified to fit agency needs.

Best Practices or Care Behaviors	*Clinical Record Number*	*Clinical Record Number*	*Clinical Record Number*	*Clinical Record Number*	*Clinical Record Number*	Total (# checked)
RECONCILIATION						
1. **Verify:** At SOC/ROC, does the clinician obtain a complete list of current medications, including prescription and non-prescription (OTC), administered by any route?						
2. **Validate:** At SOC/ROC, discharge and following any physician encounter, does the clinician review and indicate if medications are to be continued, doses altered, temporarily held, or discontinued?.						
3. Validate: At SOC/ROC, does the clinician observe how the patient takes medications, including reading labels, opening bottles, manipulating pills (prior answering M2020)?						
4. **Clarify:** At SOC/ROC or following any medical encounter, does the clinician compare current medications to discharge summary sheets, new prescriptions, or changes from medical encounter?						
5. **Clarify:** At SOC/ROC, does the clinician contact the patient's primary physician to confirm the current medication list and reconcile discrepancies (as applicable) (M2000 & M2004)?						
6. **Clarify:** If the patient has multiple physicians, does the clinician communicate to each physician the list of patient's current medications (as applicable)?						
7. During transfers to emergent care or hospitalization, was the reason for hospitalization related to medication management issues (e.g. M2310 or M2430 – Response 1 and/or clinical documentation to indicate cause/issue)?						
MEDICATION ADHERENCE						
8. At SOC/ROC, did the clinician assess patient adherence with the medication regimen and, if appropriate, note any reasons for non-adherence to the medication regimen?						

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9. For patients with >8 medications, were interventions conducted to simplify a complex med regimen (remove/discard old/expired meds, use single pharmacy, non-drug alternatives, coordinate doses with established daily routine, sustained-release alternatives, substitute/discontinue cautionary meds, or decrease multiple meds for single condition)?						
10. If a patient required assistance with medication preparation or administration, did the clinician collaborate with patient/family on system(s) to improve medication accuracy and adherence (e.g. pill planner, drug diary, electronic dispenser, medication aids, large-print labels, easy-open bottle tops)?						
11. At SOC/ROC, does the clinician assess and request for appropriate referrals? • PT - functional impairment, especially ambulation and transfers • OT - fine motor, vision, literacy or cognitive deficits • SLP - cognitive or swallowing deficits • MSW - inability to obtain or pay for medications or unable to manage medications and no available caregiver						
MEDICATION KNOWLEDGE						
12. At SOC/ROC, after any medical encounters, and intermittently during the episode as applicable, does the patient verbalize and demonstrate how they take their medications and their schedule (e.g. using teach-back method)?						
13. For therapy only cases, does the therapist provide and document medication education, request nurse consultation, or obtain a nursing referral?						
14. Does any patient identified at high risk for medication-related problems have additional strategies of front-loading visits, phone monitoring, and/or reminder/cueing strategies?						
15. At SOC/ROC, does clinician complete high-risk drug education and, as applicable, provide additional follow-up on subsequent visits (refer to agency policy on list of high-risk drugs)?						

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Aspects of Care Delivery Needing Modification:

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