Strengthening Medication Safety in Long-term Care

Model Policy 4 for Testing

To support LTC Homes in their review and updating of medication management policies

Quarterly Medication Assessments

Purpose:

This policy outlines the process at the Home for completing resident quarterly medication assessments to optimize medication-related outcomes for residents as per *Ontario Regulation 246/22, section 146* which states*:*

"At least quarterly, a documented reassessment of each resident's drug regime."

Scope:

This policy applies to all prescribers, nursing staff, consultant pharmacists, and long-stay residents* admitted to the Home. Residents admitted for short stay or respite care are exempt.

*Where a resident is unable to participate, their Medical Power of Attorney/Caregiver will be consulted.

Overview of Process:

Nursing Staff and/or Pharmacy Service Provider (PSP):

1. Identifies residents for which a quarterly medication assessment is necessary. These should be staggered as much as possible so that all residents do not fall on the same month (i.e., a third of residents fall in month 1, a third in month 2, and a third in month 3 of a quarter).

2. Identifies and confirms with the prescriber the intended date of the medication assessment.
    a. Creates the initial version of quarterly medication assessment on the day of or within a maximum of one week of the quarterly review date. Forms created earlier have a risk of being outdated by the time of the review unless there is a robust process of reconciliation/updating in place until the medication assessment date.

Nursing Staff

1. Reviews the resident chart order sheets the day before the medication assessment to determine if any recent medication changes have occurred. If so, the form is updated and provided to the prescriber.

2. Collates pertinent data that may inform the assessment including:
    a. recent specialist notes,
    b. BP readings,
    c. Blood glucose readings,
    d. Recent lab work
    e. Monitoring information for responsive behaviours
    f. Pharmacy recommendations
    g. Any other information reflecting on the resident clinical status.

3. Assists the prescriber in completing the assessment.

4. Processes the new orders or changes.

Prescriber

1. Identifies and confirms with the Nursing staff or PSP the intended date of the medication assessment.

2. Reviews the medication assessment form in the context of the resident's clinical status, pertinent vitals signs or lab values, goals of care, paying particular attention to potentially inappropriate medications, situations that may indicate potential preventable harm from medications, and other highlighted concerns related to medications.

3. Engages the care team and resident (or POA/Caregiver as applicable) in decision-making accounting for the resident's goals of care.

4. Completes the new orders on assessment form.

5. Ensures appropriate follow-up of changes as necessary (e.g., vital sign monitoring, lab values).

Pharmacy Service Provider (PSP)

1. Where possible, performs a Medication Review[4] in the 2 weeks prior to the medication assessment.

2. Assists the prescriber in completing the assessment.

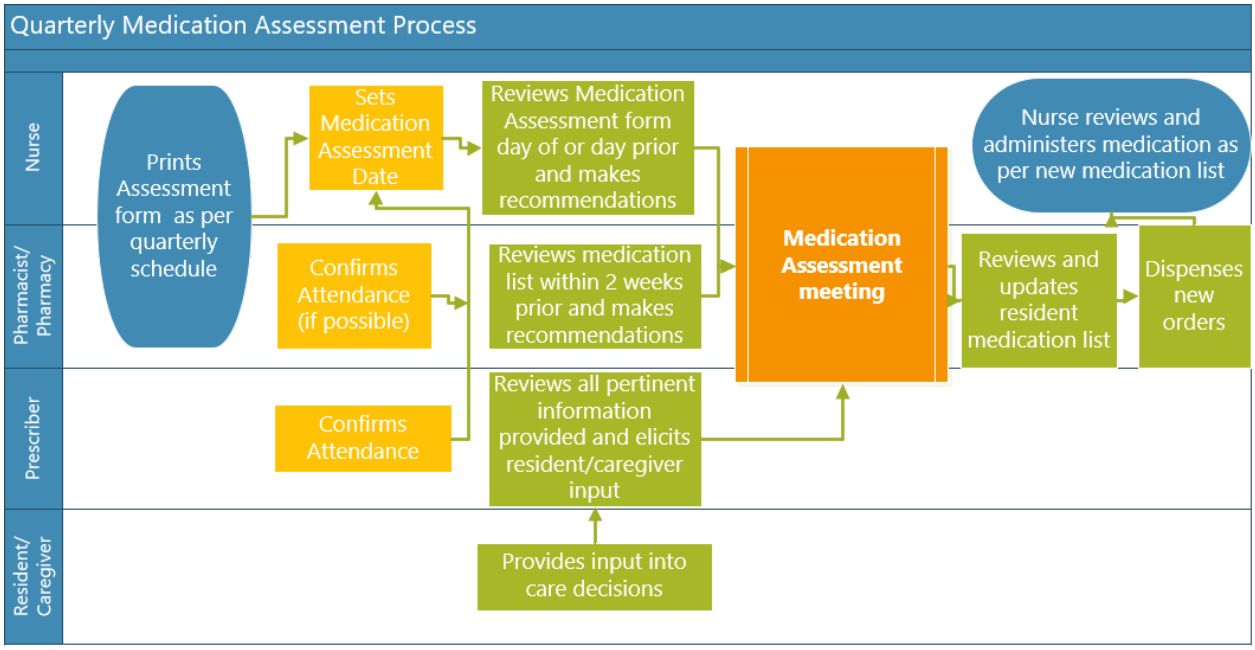
3. Processes the new orders or changes on the assessment form.

4. Assists with ensuring appropriate follow-up of changes as necessary.

Glossary of Key Terms:

Term	Definition
Quarterly medication assessment	A resident's current medication and treatment plan is reviewed, updated if applicable, and information documented on the Quarterly Medication Assessment Form. The review and documentation must include pertinent resident demographics, allergy and sensitivity information, as well as pertinent organ function (e.g., Glomerular Filtration Rate, presence of Liver Disease). Features of a good assessment that are also documented include: • medications that appear on a potentially inappropriate medication list (e.g. Beers List, START STOPP Criteria)[2,3], • recently changed medications, • medications for potential deprescribing, • medications that may benefit from clinical review (i.e., antipsychotics, benzodiazepines, opioids, etc.), • recent use of PRN medications, • pertinent medical information (diet, crushed meds), • an appropriate indication for every medication, • medications as a result of prescribing cascades or those that are causing side effects. The assessment form also acts as an order sheet containing all legal requirements of a prescription – resident information, prescriber signature, date, quantities etc. The date of the previous assessment is noted on the form.

Process Map:



References:

1. *Ontario Regulation 246/22, section 146*
2. *Beer's List of Potentially Harmful Drugs in the Elderly* *https://www.pharmacyquality.com/wp-content/uploads/2019/05/Beers-List-350301.pdf*
3. STOPP/START criteria for potentially inappropriate medications/potential prescribing omissions in older people: *https://pubmed.ncbi.nlm.nih.gov/31790317/*

Revision History:

Revision Number	Effective Date	Reason for Change	Version Number
1			
2			