



Medication Management for Patients Residing At Home

Policy:

Community Hospice & Palliative Care health care professionals, in accordance with their scope of practice and law and regulation, provide education and oversight in the management of medications ordered for patients' use at home.

Purpose:

To establish and maintain a safe and effective medication management program for adult patients residing at home.

To comply with all applicable federal, state and local health and safety laws, regulations and codes.

Definitions:

Comfort Kit—a kit containing medications which may be required for a patient's urgent symptom management needs. Medications may be administered from the Comfort Kit only after an order is obtained by the nurse.

First Dose—the initial dose of a medication the patient has not previously used.

Home Medication Administration Record—an accurate list of all medications ordered for the patient's use. This record is maintained in the patient's home to help promote safe administration of medications.

Procedure:

1. A list of allergies and medications that the patient is currently taking is obtained at time of admission to the hospice program and is reviewed and compared with medications being ordered. Any discrepancies are discussed with the patient's physician.
2. The nurse may develop and update information on a Community Hospice & Palliative Care "Home Medication Administration Record", or an equivalent record as provided by the patient/caregiver, that the patient/ caregiver may use to assist them in knowing which medications to take and when to take them.
3. Routinely the medication administration record is reviewed with the patient/caregiver and compared to the list of ordered medications in the hospice electronic medical record (EMR). The nurse revises the medication administration record when necessary and reviews the changes with the patient/caregiver.
4. If provided, the "Comfort Kit" for urgent symptom management needs may be used only after a physician has directed that a medication be given to the patient.
5. The interdisciplinary group (IDG) determines the ability and willingness of the patient/caregiver to accurately and safely use/administer medications. Instruction to the patient/caregiver may include, but not be limited to:
 - an understanding of the appropriate use and purpose of all medications included in the POC
 - how and when to administer medications included in the POC
 - documentation of use/administration of medications



- potential side effects/interactions of medications included in the POC and the importance of reporting any unusual effects
 - emergency response to adverse reactions
 - safe storage of medications
 - proper disposal of used medication patches or syringes, and medication no longer ordered for use
 - an understanding of when to call hospice if difficulties or questions arise regarding the use/administration of medications
6. The nurse may also provide the patient/caregiver with instruction for filling a pill box with regularly scheduled medications up to the next nursing visit. The nurse may assist with filling a pill box and documents this need in the patient's plan of care. The nurse does **not** put any as needed (PRN) medications in the pill box.
 7. During routine visits, the nurse counts any controlled substances and reviews routine and as needed (PRN) medications to determine supply needs and records same in the EMR. The nurse orders medications from the pharmacy according to the patient's supply needs.
 8. Ongoing patient/caregiver teaching of safe and accurate medication use/administration and response to teaching is documented in the patient's clinical record. Identified needs are entered into the patient's plan of care.

Reference: Medicare Regulations Hospice Conditions of Participation (CoPs), March 2, 2016, 42CFR 418.106(a)(1), (c)(1), (d)(1), (e)(2)(i)