

PROCESS FOR MEDICATION RECONCILIATION FOR THERAPY ONLY

PURPOSE:

To ensure proper medication reconciliation for therapy only patients

PROCESS:

- **Gather Medication information**—Physical Therapy or Speech Therapy performs the start of care (SOC) visit and views and records the list of all prescription and over-the-counter medication that a patient/caregiver reports they are currently taking.
- **Determine Medication knowledge and adherence**--At the SOC visit, the therapist will assess patient/caregiver knowledge and level of independence with medication regime. Consider asking the following:
 - “Where do you store your medications?”
 - “Please show me all of your medications whether you are currently taking them or not.”
 - “Tell me which meds you are currently taking and what each of your medications is for”
 - “Tell me how you remember to take your meds”
 - “Are there certain meds that you have trouble remembering to take?”
 - “If yes, what do you do to try to remember to take those meds?”
 - “What would you do if you thought you were having a side effect from a medication?”
 - “How do you obtain or purchase your medications?”
 - “What do you do if you have trouble affording or getting your medications?”
- Compare all current medications to the referral list of medications (if interagency referral, generally this would be to the W-10) and note any discrepancies.
- **Follow up with Nursing:**
 - The therapist will alert the Clinical Supervisor or RN designee with findings (*agency to determine time frame*).
 - The Clinical Supervisor or RN designee will
 - Review medication list to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and nonadherence with drug therapy.
 - Notify the physician of discrepancies to determine any further orders or changes to the plan of care.
 - Follow up with patient based on findings, educate on medication regime and/or consider referral to nursing as appropriate.
 - Document all findings, interventions and patient response in patient record.
 - Update therapy.

- Refer for nursing medication management visit as warranted based on educational needs and complexities of medication regime
- **Medication changes during episode:**
 - If the patient reports a medication change at the time of a therapy visit and the medication bottle is in the home, the therapist may enter the medication into the patient's medication list and run the drug to drug interaction.
 - The therapist will alert the clinical supervisor or RN designee to the new medication and any interactions noted.
 - If new medication reported or ordered by a physician, the therapist will contact Clinical Supervisor or RN designee to approve the verbal order.

*****NOTE: Per CT practitioner's unit, therapy disciplines are not allowed to take medication orders from a physician. *****

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