Over time, long-term care (LTC) regulations have intensified to the point of surpassing the regulations of nuclear power plants (American Society of Consultant Pharmacists, 2006). The medication regimen review (MRR) is important to provide safe and effective LTC patient care. The MRR has undergone significant changes since the first set of guidelines was developed in 1967 and the founding father, George F. Archambault, coined the term consultant pharmacist (American Society of Consultant Pharmacists, 2007). The purpose of this editorial is to review the goals of the MRR and identify means to strengthen the mandated process.

The main focus of the LTC consultant pharmacist is to review medication regimens for facility residents. MRR is required every 30 days or more frequently, as defined by federal regulations (Centers for Medicare & Medicaid Services [CMS], 2011). The MRR is a retrospective review that provides information and recommendations to nurses, primary care providers, and facility administration. Attention is concentrated on the identification of unnecessary medications, potentially duplicate therapy, or inappropriate medications (e.g., Beer’s Criteria [American Geriatrics Society, 2012]), as well as necessary monitoring parameters (e.g., laboratory tests, blood pressure, blood sugar). Follow up for resultant actions from recommendations is also required.

The MRR is complex and requires communication with the facility staff and ideally also with the patient or family member(s) to determine the appropriate medication regimen. One of the many regulations, referred to as Tag F329, requires interdisciplinary team involvement and pertains to unnecessary drugs being taken by the patient (CMS, 2006). An example of F329 is as follows:

An LTC patient is admitted to the hospital with an infection (e.g., pneumonia, septic urinary tract infection), develops delirium, and is then placed on an antipsychotic medication. The infection is treated and resolves. The patient returns to the facility on the antipsychotic medication with an unknown or inappropriate indication. Each LTC resident’s medication must have a reason for use or diagnosis. The consultant pharmacist reviewing the medications and charts for residents is especially vigilant for an accurate diagnosis. If the diagnosis is not in the chart, collaboration with the nurse is necessary to

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Building Rapport with the Consultant Pharmacist
Several ways to improve communication may be as easy as being respectful, building rapport and professional relationships, and treating others as you would like to be treated.

The consultant pharmacist can assist in the regulatory process by identifying variances and reporting them to the director of nursing and the administrator. If needed, the identified issue should be placed on the agenda for review by the LTC facility’s quality assurance committee. By proactively raising awareness and attending to the potential problem through quality assurance committees, facilities are better able to answer the questions and concerns of regulators and meet the intent of the regulations—quality care. Other areas in which the consultant pharmacist may participate in regard to the MRR and quality are medication cart audits (e.g., expired medications, appropriate labeling and storage) and medication pass observations for safety and efficiency.

Effective communication regarding the MRR can increase the quality of life of older adults at an LTC facility; however, time and workloads are challenges. For nurses, the demands of patient care, documentation, coordination of care, delegation of care, administration of medication, provision of treatment, and meeting attendance may make the prospect of adding an additional task to perform—including a recommendation made by a consultant pharmacist—overwhelming, especially if there is no explanation or discussion with staff. For the LTC consultant pharmacist, the demands are intense as well, with the need to review a large number of charts per day; juggle regulations; and complete emergent, mandated medication reviews and generation of reports for the director of nursing and administration. Although computer programs and often stable medication regimens may assist the consultant pharmacist in completing the work, the volume can be tremendous.

Several ways to improve communication may be as easy as being respectful, building rapport and professional relationships, and treating others as you would like to be treated. For example, “When you have a minute, would you please review this? The number where I can be reached is attached; please call me if you have any questions.” Building rapport and professional relationships with the staff does not take much time and builds trust among colleagues. Calling them by name, asking how their day is going prior to asking them to fax a request to the physician, asking them if they have any questions before you leave for the day, or dropping off a bag of candy or goodies occasionally is a way to connect and are examples of practical ways to work together. Finally, it is important for the consultant pharmacist and the nursing staff to communicate the results of the MRR. Outcomes that have a positive effect on quality of life, function, and care delivery processes help reinforce the power of teamwork. There are many demands on us as health care providers. Working as a team will help us achieve the end goal: striving to provide the best quality of life possible for our patients while their care is in our hands.

REFERENCES


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