

[§484.55(c) ... The comprehensive assessment must accurately reflect the patient's status, and must include, at a minimum, the following information:]

(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.

Interpretive Guidelines §484.55(c)(5)

The patient's clinical record should identify all medications that the patient is taking, both prescription and non-prescription *(e.g., over-the-counter drugs, herbal remedies, and other alternative treatments that could affect drug therapy)*, as well as *the dose, route, frequency, or time of administration when indicated on the prescription or order*. The skilled professional *performing the comprehensive assessment* should consider, and the clinical record should document, that the skilled professional considered each medication the patient is currently taking for possible side effects and the list of medications in its entirety for possible drug interactions. *Each agency must determine the capabilities of current staff members to perform comprehensive assessments, considering professional standards or practice acts specific to the State. No specific discipline is identified as exclusively able to perform the medication review. However, only Registered Nurses (RNs), Physical Therapists (PTs), Occupational Therapists (OTs) and Speech-Language Pathologists (SLPs) are qualified to perform comprehensive assessments (see also §484.55(b)). While only the assessing clinician is responsible for accurately completing and signing a comprehensive assessment, the agency may develop a policy where clinicians may collaborate to collect data for all OASIS items. For example, to assess potential side effects and drug interactions, the agency may wish to have RNs or practical (vocational) nurses, as defined in §484.115, review the medication lists.*

HHA should have policies that guide staff in the event there is a concern identified with a patient's medication that should be reported to the physician *or allowed practitioner*.

Survey Procedures §484.55(c)(5)

Through home visit observation and record review, confirm the medications the patient identifies they are taking against the medical record documentation to verify that the HHA identified all medications, both prescription and non-prescription.