

Communication & Reporting

General Discussion:

Communicating and reporting changes to a resident's prescribing practitioner related to health and medication is critical. Reports to a resident's prescribing practitioner, as well as to the resident's guardian or designated representative could include a change in condition, medication error, adverse reaction, medication dosage change, etc. Failure to communicate and report may compromise a resident's health, safety or welfare, and could result in negative outcome to the resident.

Relevant regulations:

ADC:

Standard I.F.(3) If staff administer participants' medications, the following conditions must be met:

- (a) A written order from the prescribing practitioner must be in the record.
- (b) A listing of current medications with the dosage, frequency, and route of administration must be in the record.
- (d) Non-licensed staff must consult with the prescribing practitioner or pharmacist about each medication to be administered.
- (e) Written information describing side effects and adverse reactions of each medication must be kept in the participant's record.

FAMILY ADC:

Standard I.D.(3) If staff administer participants' medications, the following conditions must be met:

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AFH:

DHS 88.07(2)(b)5. Monitoring resident health by observing and documenting changes in each resident's health and referring a resident to health care providers when necessary.

DHS 88.07(2)(b)6. Notifying the placing agency, if any, and guardian, if any, of any significant changes in a resident's medical condition, including any life-threatening, disabling or serious illness, any illness lasting more than 3 days, an injury sustained by the resident, medical treatment needed by the resident or the resident's absence from the home for more than 24 hours.

DHS 88.07(3)(c) If the licensee or service provider assists a resident with a prescription medication, the licensee or service provider shall help the resident securely store the medication, take the correct dosage at the correct time and communicate effectively with his or her physician.

RCAC:

Although there is no specific regulation related to communication and reporting, you should consider best practices for communication and reporting to protect the health, safety and welfare of the tenants.

CBRF:

DHS 83.12(5)(a) The CBRF shall immediately notify the resident's legal representative and the resident's physician when there is an incident or injury to the resident or a significant change in the resident's physical or mental condition.

DHS 83.37(1)(a) There shall be a written practitioner's order in the resident's record for any prescription medication, over-the-counter medication or dietary supplements administered to a resident.

DHS 83.37(1)(e)1. If residents' medications are administered by a CBRF employee, the CBRF shall arrange for a pharmacist or a physician to review each resident's medication regimen. This review shall occur within 30 days before or 30 days after the resident's admission, whenever there is a significant change in medication, and at least every 12 months.

DHS 83.37(1)(e)2. At least annually, the CBRF shall have a physician, pharmacist, or registered nurse conduct an on-site review of the CBRF's medication administration and medication storage systems.

DHS 83.37(1)(e)3. The CBRF shall obtain a written report of findings under [subds. 1.](#) and [2.](#), and address any irregularities for appropriate action. When the review is done by someone other than the prescribing practitioner, the prescribing practitioner shall receive a copy of the report when there are irregularities identified with the resident's medication regimen, which may need physician involvement to address.

DHS 83.37(1)(f)1. When an employee of the CBRF administers a resident's medication, the CBRF shall provide a list of the resident's current medications to all practitioners. If this information is not provided before a prescription is written, the CBRF shall update the resident's primary practitioner or pharmacist before the administration of any new medication.

DHS 83.37(1)(f)2. When a resident self administers medications, the CBRF shall provide a list of the resident's current medications for the resident to provide to all practitioners.

DHS 83.37(1)(k)2. The CBRF shall report all errors in the administration of medication and any adverse drug reactions to a licensed practitioner, supervising nurse or pharmacist immediately. Unless otherwise directed by the prescribing practitioner, the CBRF shall report to the prescribing practitioner, supervising nurse or pharmacist as soon as possible after the resident refuses a medication for 2 consecutive days.

DHS 83.37(1)(L) The CBRF shall make available written information to resident care staff on the purpose and side effects of medications taken by residents.

Relevant DQA Memos:

[BQA Memo 04-026 Physician's Orders and Medications](#)

[DQA Memo 07-018 Self-Report/Facility Reporting Requirements, Including Adult-at-Risk Reporting Requirements](#)

Other Resources:

[DSL MEMO SERIES 2001-32 – Revised Death Reporting Form DSL-2470](#)

Best Practice, Tools & Forms:

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