FAMILY TOOL

Medication Change Questions for Families

A plain-language question guide for understanding an authorized medication change and how it will reach the facility process. It is not a medication recommendation and must not be used to change treatment independently.

HOW TO USE	Mark each item Yes, No, Not Applicable, or Needs Follow-up in your working copy. Add evidence, an owner, and a recheck for every gap. Do not use this public blank template to transmit resident information.

Understand the change

- [ ] What medication changed, and what exactly is different about dose, route, timing, or instructions?
- [ ] Was a medication started, stopped, held, resumed, or replaced?
- [ ] What is the reason for the change?
- [ ] When should the change begin, and is there a planned stop or review date?
- [ ] Which treating provider authorized the change?

Understand monitoring and follow-up

- [ ] What response or improvement is expected?
- [ ] What side effects, condition changes, or warning signs should authorized staff and family watch for?
- [ ] Is any blood pressure, blood sugar, lab, weight, intake, behavior, or other ordered monitoring needed?
- [ ] Who reviews the result and when?
- [ ] What should happen if the medication is unavailable, refused, held, late, or missed?

Verify facility implementation

- [ ] Who received the new order at the facility?
- [ ] Has the current medication record been updated and the prior instruction removed or superseded?
- [ ] Does the pharmacy or medication supply match the current order?
- [ ] Do all shifts that must act know about the change?
- [ ] Is an open issue visible until the medication is available and the change is implemented?
- [ ] Who will confirm completion to the family or authorized representative?

Keep the boundary clear

- [ ] Do not stop, start, hold, or change a medication based on this worksheet.
- [ ] Direct clinical questions to an appropriate facility clinician and the treating provider.
- [ ] Use emergency services when the resident's condition requires emergency care.
- [ ] Do not place a resident name, medication list, diagnosis, or record into a public web form.

Working notes

Use a secure facility or family working copy when recording any resident-specific details. Keep the public blank tool free of identifying information.

Date of conversation	
Person / role contacted	
What changed	
Why it changed	
Start / stop timing	
Monitoring and warning questions	
Facility confirmation	
Open follow-up	

Action and verification log

Action / control	Owner	Due	Evidence / result

Scope disclaimer

This tool is a general process-control aid. It does not replace emergency care, treating-clinician judgment, legal advice, or facility-specific regulatory review. It does not establish a treating relationship or guarantee compliance or outcomes. Use authorized secure methods for resident-identifying information and records.

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