# Long-Term Care Survey Alert

## Medication Management: Sidestep Serious Adverse Drug Events With These Smart Moves

**This package of evidence-based and practical strategies may be just the remedy you're looking for.**

Prevention is always the best medicine, and that's especially true in ensuring a resident's drug regimen itself doesn't cause illness or injury. And focusing on a few areas can go a long way toward accomplishing that goal.

Start by asking the hospital to give you the information required to make safe medication decisions at the get-go. Nursing homes should collaborate with hospitals to develop a communication form to share information about patients transferred between the two settings, advises **Russell Jenkins, MD**, an internist and a board member of the Institute for Safe Medication Practices. Make sure the form includes major diagnoses, a list of the patient's medications, drug allergies -- and when the patient received the last dose of a daily medication, Jenkins says. He finds that when staff don't know the latter information, sometimes they just guess rather than calling the hospital to find out. But "omitting or giving an extra dose of certain medications, such as anticoagulants or anti-epileptics can cause significant adverse drug events."

Red flag the "Big 4": Diabetes mellitus, kidney disease, liver disease, and psychiatric disease are associated with increased medication errors leading to significant patient harm, cautions Jenkins.

**Target Anticholinergic Drugs**

Drugs with anticholinergic properties can cause major problems for elders (see the table on p. 15). As a common example, diphenhydramine (Benadryl), which is the active ingredient in many OTC sleep aids and Tylenol PM, has anticholinergic side effects that can lead to falls, confusion, delirium, constipation, and urinary retention, cautions **Carla Saxton-McSpadden**, a long-term care pharmacist with the American Society for Consultant Pharmacists.

Anticholinergic medications also decrease the effect of an anticholineresterase medication for dementia, cautions **Susan Scanland, MSN, GNP, RN**, president of Geriscan Geriatric Consulting in Clarks Summit, Pa. Yet one study showed that one out of three people with dementia taking such medications were receiving an anticholinergic, she notes (Carnahan RM et al. J Am Geriatr Soci. 2004 Dec: 42(12):2082-7).

Another problem: "Physicians may not realize a combination medication has an anticholinergic medication in it," cautions Jenkins. "Most prescribers know these medications by their trade names which provide almost no indication of what's in the combination medication." A lot of these medications are on the Beers list, he adds -- "for example, ones used to treat non-specific intestinal and stomach cramps often contain an anticholinergic medication." (You can download the Beers list, which provides a rundown of potentially inappropriate meds for elders, at www.dcri.duke.edu/ccge/curtis/beers.html.)

Solution: Have the pharmacist and pharmacy flag medications with an anticholinergic effect. And post the Beers list on the computer screensaver in the nursing station to educate prescribers and nursing staff about inappropriate medications for elders, Scanland suggests.

**Watch for Negative Changes, Falls**

The first three things you think about when a patient develops a new symptom are "medication, medication, medication," says **Daniel Haimowitz, MD, CMD**, in Levittown, Pa.

Psychoactive medications can pave the way for falls. "One study concluded that falls appear directly related to the number of psychoactive medications a person is taking," cautions Scanland.

Important: If a resident appears to have any kind of a reaction to a medication, such as a rash or hypersensitivity, report it to the physician, advises **Robin Bleier, LHRM, FACDONA**, principal of RB Health Partners Inc. in Tarpon Springs, Fla. Also document the reaction and confirm with the physician whether to list the medication as an allergy or sensitivity to avoid giving it in the future. Remember, Bleier emphasizes, "the mild reaction today may be the anaphylaxis of tomorrow."

**Treat Depression, Dementia**

One study showed that discontinuing memantine (Namenda) for Alzheimer's disease caused nursing home residents within 60 days to increase their use of antipsychotics and anxiolytics, cautions Scanland. The residents also lost weight, she adds (Hofbauer RK et al. Poster presentation at American Medical Directors Association 31st annual symposium, March 2008).

Another study: Elders who switched from Lexapro to another SSRI for non-medical reasons ended up on significantly more anxiolytics, antipsychotics, and non-opioid pain medications, cautions Scanland. The patients who made the change also had more behavioral symptoms, says Scanland, referencing the research presented at the International Society for Pharmacoeconomics and Outcomes Research 10th Annual European Congress in October 2007.

Bottom line: "Treating depression to remission (absence of all symptoms) and using the 'gold standard' of combination therapy (a cholinesterase inhibitor plus Namenda) starting in the middle stages of Alzheimer's can decrease the need for antipsychotics or benzodiazepines," says Scanland.