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Long-Term Care Survey Alert

MEDICATION MANAGEMENT: Sidestep Unnecessary Drugs And F329 Tags

Get your interdisciplinary team marching to this best-practice regimen.

When prescribing medications, less can definitely be better -- especially considering that the more meds a resident takes, the greater his chance of having a serious adverse drug reaction (ADR). And with the revised F329 (unnecessary medications) tag in play starting Dec. 18, you can bet surveyors will be weighing the benefits and risks of a resident's medication regimen and looking for undetected ADRs.

There's a balancing act between prescribing needed medications for residents and getting up to nine or more medications where you are virtually guaranteed of having at least one ADR, said **Matthew Wayne, MD, CMD** in a presentation at the March 2006 **American Medical Directors Association** annual meeting in Dallas.

The problem: If the prescribing clinician follows published clinical practice guidelines for optimally treating heart disease, hypertension, diabetes, osteoporosis, Alzheimer's disease, etc., a resident with a number of those health conditions can end up on a dozen or more medications, cautioned Wayne. Also, when residents go to the hospital, they may come back on additional medications prescribed by acute-care physicians, which can add to the medication tally -- and the risk for ADRs.

Communication is key: Identify the treatment goals for the resident by having a "dialogue" with him and his family and potentially with colleagues in other settings, Wayne suggested to AMDA conferees.

Identify your end points for a medication: Is the end point resolution of infection, improved respiratory status or increased longevity, as examples? Wayne asked. When giving pain medication at the end of life, pain relief is the end point, he said. If the goal is secondary prevention of disease, take a look at the data for a particular drug, he advised. Look to see how many people you have to treat for how long to prevent a negative outcome, such as cardiovascular death. And consider how many of those people would develop ADRs.

Follow These Additional Steps

Doing a carefully documented risk-benefit analysis to justify each prescribed medication will take you a long way toward ensuring appropriate drug therapy. These key steps will also help:

• **Analyze the resident's problem so you don't just treat the symptoms,** advised Wayne. For example, the nurse calls to report that Mrs. Smith is having chest pain, so the physician prescribes a nitrate over the phone when the resident may really just have chest muscle strain, Wayne noted. That kind of practice can cause a resident to end up on a number of unnecessary meds over time, if the physician doesn't follow up.

• **Don't fall for the prescribing cascade.** Consider any symptom in an elderly patient as a potential ADR until proven otherwise, emphasized Wayne, noting that axiom is on the cover of the AMDA medication management toolkit. If a symptom is really an ADR, the answer may be to eliminate or change medication -- not add more, he warned. The list of potential ADRs runs long and includes new or worsening urinary incontinence, mental status change, lethargy, constipation or diarrhea, anorexia and extrapyramidal effects leading to falls, etc.

Example: A resident starts falling after he starts taking an antipsychotic. The revised F329 guidance "puts the burden on the facilities to evaluate whether the antipsychotic has caused or worsened a gait problem that may be causing the person to fall -- and intervene accordingly," says **Nancy Shellhorse,** an attorney in private practice in Austin, TX.

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Tip: Engage all disciplines in residents' medication-related issues so they can detect and report problems. As part of therapy evaluations, for example, physical therapist **Shehla Rooney** looks up each patient's medications to know the side effects, adverse reactions, peak effects of various medications and their impact on the person's tolerance for and progress in therapy. For example, "digitalis toxicity can cause visual disturbances or benzodiazepines can cause muscle weakness" -- and opiates can result in orthostatic hypotension and seizures," says Rooney, principal of **Premier Therapy Solutions** in Cookeville, TN.

• **Start with a low dose and go slow.** But re-evaluate and increase the dose, if necessary, Wayne advised. That way, you lessen the risk of ADRs due to a higher dose that you then have trouble differentiating from new medical symptoms.

• **Be aware of potentially inappropriate combinations of medications with disease states,** advised Wayne. Common examples including NSAIDs with congestive heart failure or peptic ulcer disease, he said. Other combos of drugs and diseases that spell potential trouble: asthma and beta blockers, and constipation and an anticholinergic drug.

Prescribing tip: "Patients with Lewy body dementia and others who cannot tolerate anticholinergic effects, including those with Parkinson's disease, should take quetiapine (Seroquel) if they need an antipsychotic medication," advises **Stephen Feldman, Pharm, FASCP,** president and CEO of the **ICPS Group** in Boston, MA.

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