Long-Term Care Survey Alert

Medication Management: Target The Top 4 Reasons Facilities Get Tagged For Antipsychotic Meds

Expect surveyors to be paying closer attention to use of these drugs ... here's why.

Crack down on use of antipsychotic medications in your facility before surveyors beat you to the draw and leave you holding a handful of F tags.

Beware: Tougher draft survey guidelines for unnecessary drugs (F329-F331) are now making the rounds (see, "Survey Guidance", this issue). That means a preemptive strategy is your best bet for surviving heightened survey scrutiny coming down the pike.

Use this four-point checklist to see if any of these common problems are at play in your facility - and, if so, give them top billing in your QA committee.

1. The facility fails to follow and document the OBRA-mandated re-quirements to show the antipsychotic drug therapy is medically necessary.

The regulations allow nursing facilities to give residents antipsychotic drugs to treat a number of conditions, including schizophrenia and psychotic mood disorders, Huntington's disease and Tourette's disorder. On the list is organic mental syndromes (which the DSM-IV now calls delirium, dementia and amnestic and other cognitive disorders) with associated psychotic and/or agitated behaviors.

To see the list of diagnoses and other requirements, review the State Operations Manual at www.cms.hhs.gov/manuals/107_som/som107ap_pp_guidelines_ltcf.pdf.

Make sure the physician or treating clinician documents one of the designated diagnoses in the medical record - and record it in Section I of the MDS, including the specific ICD-9 code, if needed, in Section I3, advises **Christine Twombly, RNAC**, a consultant with **Reingruber & Co.** in St. Petersburg, FL.

Remember OBRA: The facility can only use antipsychotic meds to treat dementia-related psychosis or behaviors if the symptoms are causing the person functional impairment or distress, endangering him or others, or interfering with essential care. And even then, the physician should not automatically order an antipsychotic.

The regulations require staff to do an assessment/analysis to figure out the underlying causes of a resident's dementia-related behavior, says **Sam Kidder, PharmD**, in Silver Spring, MD. "You can do that by tracking and documenting when the behavior occurs, what's going on, and any antecedents, etc.," he says.

"Just as the nurse wouldn't expect a physician to order an antihypertensive medication for a patient without documented blood pressure readings, the nurse shouldn't expect to obtain an order for a psychoactive drug without careful documentation and analysis of the resident's behaviors," Kidder cautions.

"Yet physicians are often quick to write such prescriptions, which can get the facility into survey problems," Kidder notes. For example, if a resident strikes at staff who provide care, try to figure out why he is doing that, Kidder suggests. "Is he in pain, paranoid, hallucinating, not fully awake when they put the blood pressure cuff on his arm? Does he have periods of low oxygenation where he becomes confused or delirious?" Kidder asks.

2. Residents are experiencing over sedation or serious adverse effects typically associated with

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antipsychotic drugs.

Facilities that tend to get cited at F329 or F330 or for chemical restraints (F222) have patients on higher-than-average dosages of antipsychotic drugs and haven't addressed adverse effects, such as Parkinson's type symptoms, falls and/or precipitous loss of ADL functioning, comments **Lori Daiello, PharmD**, a consultant in Orlando, FL.

Further, if surveyors see a resident slumped in his wheelchair throughout the survey, they may question what's going on, even if the resident is on an acceptable dose of a neuroleptic - and the facility has gone through the OBRA ropes to document the medical rationale for the drug, experts caution.

"You have to look at the effect of the drug on that individual resident and his ability to interact and engage in the facility," says Daiello.

3.The facility appears to be prescribing an antipsychotic to treat behaviors that are bothering the staff rather than the resident.

The most common example occurs when a resident screams or calls out repeatedly, but doesn't appear distressed or functionally impaired by the behavior. As a long-term care ombudsman, Kidder encountered a situation where a frail resident was calling out "help me, help" to the point that the behavior drove even stress-resistant staff nuts.

But the behavior wasn't bothering the resident a bit - in fact, she enjoyed the attention it brought her, Kidder relates.

Nevertheless, the physician prescribed a psychoactive medication in an average dose for the resident to be administered daily after lunch, which completely zonked her out, due to her small size. This situation is ripe for an F tag, caution survey experts.

Use a behavioral management approach: Address chronic calling- out behavior by doing a careful assessment to determine its cause, Kidder advises. "Geropsychiatrists will say they don't know why people with dementia call out like that, but in this case, the woman would quit calling out if you went in to see her."

Using a behavioral management approach, staff would pay attention to the resident when she wasn't calling out, but not respond immediately when she began the behavior, says Kidder. "Then increase the interval of time before you respond to the calling out," as long as you know the resident is safe. "Getting other residents to interact with the resident more can help, too," he adds, "but their attention shouldn't be contingent on her not calling out."

4. The medical record lacks clear documentation as to why the prescribing clinician has decided not to attempt a gradual dose reduction in a particular case.

The regulations require facilities to assure residents taking antipsychotics receive a gradual dose reduction and behavioral interventions in an effort to discontinue the med - unless clinically contraindicated.

(New draft survey interpretive guidelines suggest dose reduction may be successful for residents with dementia-related psychotic symptoms after four to six months of treatment.)

In fact, the existing regs say facilities should attempt gradual dosage reductions and behavioral interventions twice for residents with organic mental syndromes to see if the person's psychotic/behavioral symptoms resurface.

Yet the physician does not have to attempt dosage reduction even once if he believes it's a bad idea. What might be a good rationale or contraindication to not reducing the antipsychotic medication?

One example would be "a resident who had shown violent tendencies related to delusions," says Daiello. "Or a person with severe agitation who has shown a marked improvement in the quality of his life and functional status while on a low dose of an antipsychotic" might be another example, she adds.

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The regulation also doesn't say how much to reduce the dosage, so the facility can attempt micro-reductions and look at the impact on the resident's behavior, Daiello adds.

Documentation tip: Recognizing that an antipsychotic reduction can be a serious mistake for certain residents, **Royal Manor Healthcare** uses a specific form to document contraindications for dose reductions (see form "Clip 'N Save", this issue). The form might, for example, let a new attending physician know not to change a drug regimen that's worked well for a patient with schizophrenia for years without significant adverse effects, according to **Treva Boydelatour, RN, LNC**, corporate compliance nurse with the Middlebrook Heights, OH-based nursing facility organization.

Hit a Home Run With Surveyors

If you take the following steps, surveyors shouldn't accuse your facility of using a chemical restraint or unnecessary drug, according tos **Adam Rosenblatt, MD**, a geropsychiatrist at **Johns Hopkins Medical Center**.

1. assess and document the behaviors to look for patterns, and attempt to improve the behaviors with environmental and interpersonal strategies;
2. ensure that the physicians always document their rationale for selecting the drug to treat identified behavioral or psychotic symptoms;
3. show that the physician started the drug at a low dose and increased it to a therapeutic level; and
4. illustrate that the resident's behavior improved and he appears to be tolerating the drug well.

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