Codify
BY AAPC

Long-Term Care Survey Alert

Quality of Care: Snooze On Hypnotic Use And You Will Lose On Your Next Survey

Follow this QA checklist to avoid a rude awakening.

The answer to why a resident may not be sleeping -- or why he's falling or more confused than usual -- may be close as your MAR. So take a look before surveyors beat you to the peek.

For example, certain medications can cause insomnia where dose adjustments or switching to a different med could eliminate the need for a sleep aid. And hypnotics and other sleep aids can cause a number of adverse drug reactions or negative outcomes, such as falls, pressure ulcers, cognitive changes and other problems.

Use this checklist of questions to assess each resident taking a sleep aid to see if you need to make changes to his medication regimen or care plan.

Is the resident who is complaining of insomnia receiving a stimulating medication? Prescribing pills to treat ills that are really side effects of medications can get your facility in hot water with surveyors if you haven't identified that's what you're doing -- and have a rationale for why it's the best alternative.

Proactive strategy: Identify drugs that can cause insomnia and see if the physician can make adjustments that sidestep the need for a sleep aid. Decongestants can cause insomnia, as can theophylline, says **Carla Saxton, PharmD**, with the **American Society of Consultant Pharmacists.** "If changing the time for administering theophylline does not ease the insomnia, the physician might consider using another medication," she says.

Steroids can also cause central nervous system stimulation. "The residents and facility staff should understand that the stimulation is a side effect so they don't think the person has some other problem keeping him awake," says Saxton.

"Oral steroids should be used in the smallest possible dose and for the shortest possible time," Saxton advises. If the patient has to take long-term steroids for rheumatoid arthritis or respiratory conditions and has insomnia, the care plan should include good sleep hygiene measures, she adds.

An antidepressant can "cause somnolence or insomnia, depending on how the individual responds," says **Kyle Copeland, PharmD**, with **Covenant Health** in Knoxville, TN. So if a resident starts complaining he can't sleep after starting antidepressant therapy, talk to the physician and consulting pharmacist about the issue.

Tip: Reducing or eliminating caffeine intake, if the resident agrees, may cure a case of insomnia, not to mention urinary frequency or incontinence that can cause nighttime awakening.

Have you done and documented a solid assessment to determine other causes of insomnia? Ask the person why he thinks he can't sleep. Is the person in pain at night, lonely, frightened -- or sleeping too much during the day? (For an in-depth look at how to use the MDS to ferret out causes of insomnia, see "Don't Let Surveyors Accuse You Of Being Asleep At The Assessment Wheel," in the March 2006 MDS Alert. For ordering information, see the advertisement at the end of this issue.)

With any new onset of insomnia, look for pain, depression, a recent loss or infection, suggests **Reta Underwood**, a survey consultant in Buckner, KY.

CPT® 2023 American Medical Association. All rights reserved.

Is the resident receiving the recommended dose of a hypnotic for the geriatric population? "Elderly people receiving a hypnotic should generally receive about half the recommended dosage for younger adults," says Copeland. For example, an elderly person would normally receive 5 mg of Ambien rather than 10 mg, he says.

Could the person's sleep aid be causing or aggravating other clinical issues? Sleep aids can cause urinary incontinence, falls, confusion and short-term memory loss. A person in a drug-induced sleep won't move as much during the night, which could lead to skin breakdown.

A hypnotic that causes the resident to be groggy in the morning can also affect her meal and fluid intake in the morning, which is usually nursing home residents' best meal, cautions **Cheryl Connors, RDCD**, dietitian for **Sunshine Terrace**, a nursing facility in Logan, UT.

Avoid This Vicious Cycle

Is a resident coming off a sleep med experiencing rebound insomnia that causes the physician to restart a sleep aid? If so, the person may never get off his sleep med.

Solution: Teach the resident or his family that his insomnia could worsen for a time after discontinuing a hypnotic agent. Ideally, the physician should ease the person off the medication slowly, says Jones. And the care plan should include sleep hygiene measures designed to promote sleep, such as hot milk near bedtime, a change in light patterns, etc. Tips: Consider implementing a sleep health program that includes the nurse, pharmacist, physician and dietitian, suggests Jones. The team can investigate whether a resident's lack of sleep could be due to a physical problem, pain, transition into the nursing home -- or the side effect of another drug, he adds.

Patients with persistent insomnia who don't respond to sleep hygiene and other nursing interventions may benefit from a Part B-covered sleep study or evaluation, says Underwood.

CPT® 2023 American Medical Association. All rights reserved.