MDS Alert

Resident Assessment: When Evaluating ADL Decline, Don't Overlook This Potential Culprit

If you don't catch this medication issue, surveyors probably will.

The reason for a resident's ADL decline might be as close as Section O or the medication administration record. So before deciding whether to proceed with rehab, take a look whether any of these medications might be taking a toll on the person's functional status.

Top on the list: Drugs that can cause ADL decline include ones that depress the CNS, including anxiolytics, antipsychotics, and hypnotics, says **Tom Snader, PharmD**, **CPG**, with TCS Pharmacy Consultants in North Wales, Penn.

Residents treated with antipsychotics experience statistically significantly higher rates of decline in activities of daily living, including the late-loss ADLs, according to research by the New York Association of Homes & Services for the Aging. And that's after risk adjusting for other resident characteristics related to functional decline and falls, says **Christie Teigland, PhD**, at NYAHSA, who helped lead the research effort."Anticholinergics as a group can also cause confusion when given in a dose that causes side effects -- [and] the confusion can affect ADLs," adds Snader. Muscle relaxants can also cause ADL problems, he adds. Also look for:

• **Pain medication.** Opioids primarily can lead to ADL decline if they cause sedation. "But if the medication relieves pain without sedation, a person's ADLs may actually improve," Snader says.

• **Certain anti-hypertensive medications.** The less cardio-selective beta blockers, such as propranolol, sometimes lead to complaints about weakness and fatigue, whereas ACE inhibitors and angiotensin receptor blockers (ARBs) don't tend to have that effect, Snader counsels. But clonidine and other alpha blockers can cause weakness because they have a CNS effect, he adds.

Beware: A recent study showed that residents receiving both a drug for dementia and an anticholinergic medication for bladder incontinence didn't fare as well functionally as those receiving the dementia medication alone, says **Susan Scanland, MSN, GNP-BC,** principal of Geriscan Geriatric Consulting in Clarks Summit, Pa. Those in the top quartile of ADL function who were taking a cholinesterase inhibitor for dementia and oxybutynin or tolterodine for incontinence had a 50 percent greater rate of quarterly ADL decline than those taking only the cholinesterase inhibitor, according to the study reported in the Journal of the American Geriatrics Society (May 2008).

Managing the Problem

If the person on an antipsychotic doesn't show behavioral improvement -- or he is declining functionally or cognitively -- stop the medication and look at other ways to manage the behaviors, advises Teigland. Better yet, before starting an antipsychotic, do a root-cause analysis of what's causing the behavior and intervene with nonpharmacological interventions. Staff can use many such approaches, including behavioral management, activities, music therapy, a trial of pain medication --" even encouraging the resident to take naps, Teigland says.

Heads up: Antipsychotics as potential chemical restraints are on the OIG's radar screen -- see page 153 for details.

As for essential medications that you think may be causing ADL decline, the prescriber could reduce the dose to see if that helps improve the resident's functional status without sacrificing the medication's therapeutic effect, Snader suggests. What if you can't reduce the dosage of a necessary med? The prescriber can work with the consultant pharmacist to replace the med with another equally or more effective medication that doesn't have the same potential to compromise ADLs, Snader says.

CPT® 2023 American Medical Association. All rights reserved.

Codify BY AAPC

Example: The prescriber could substitute an ACE inhibitor or a less offensive beta blocker for a problematic beta blocker, he says.

CPT® 2023 American Medical Association. All rights reserved.