OASIS Alert

Quality Improvement: USE THESE 4 STEPS TO MINIMIZE ADVERSE DRUG REACTIONS

Following these steps will make M2010 and M2015 easier to answer.

Here's the most important question to ask yourself about each of the patient's medications: "Is there a good reason for not stopping this medicine?"

Two new OASIS C process measures will appear on Home Health Compare. M2010 (Patient/Caregiver high-risk drug education) asks if at start of care (SOC) and resumption of care (ROC) you provided instruction to the patient/caregiver about special precautions for all high-risk medications, and how and when to report problems that may occur.

M2015 (Patient/Caregiver drug education intervention) asks if, since the previous OASIS assessment, agency staff or another health care provider instructed the patient/caregiver to monitor the effectiveness of the drug therapy, drug reactions, and side effects, and how and when to report problems that may occur. But before you begin instructing the patient, ask yourself if the patient needs all the medications you've recorded on the list of current medications.

Uncover Serious Issue: Failure to Discontinue Unnecessary Medication

Overmedication is a common problem for elderly patients with multiple co-morbidities, experts agree. "If a person takes nine or more meds, he's statistically 100 percent certain to have an adverse drug reaction," cautions **Russell Jenkins**, an internist and a board member of the **Institute for Safe Medication Practices**.

Your first line of defense is a good medication review. Careful and thorough consideration of a patient's medications can prevent falls, loss of appetite, confusion, hospitalization, and even death. Experts suggest these key strategies:

1. Review medications on admission and periodically. The clinician should ask if there's a good reason for not stopping each medication, advised physician **Matthew Wayne**, in a presentation at the March 2009 **American Medical Directors Association** meeting.

And even if the drugs all have appropriate indications, look to see "whether the aggregate of the medications is causing nausea or drug-drug interactions," advises Baltimore, Md.-based physician **Harold Bob**. Medication-related nausea or gastrointestinal distress can lead to appetite loss -- a key factor in triggering a downward spiral, Bob cautions. That's especially true for people with dementia, he adds.

2. Focus on 'high alert' medications.

Pay special attention to whether patients really need what's known as "high alert" medications. By definition, those medications pose a higher risk of patient harm if an error occurs, says Jenkins. The list includes anticoagulants, antipsychotics, diuretics, and anti-epileptics.

Tip: "Ask whether an elderly patient really needs to be on warfarin or low molecular weight heparin," Jenkins suggests. He reports seeing patients who remain on a blood thinner for inappropriate lengths of time because no one thought to take the person off it. For example,the patient may have started taking heparin to help prevent deep-vein thrombosis due to hip surgery, he says. "Yet the prophylaxis has a limited time period for clinical effectiveness -- usually three months."

You may also find a patient is on a medication due to an exacerbation of congestive heart failure or seizures that long ago resolved, he adds.

3. Prune the PRNs. When "pruning" or trimming potentially inappropriate medications, look closely at PRN (as needed) medication use, advises **Susan Scanland**, a geropsychiatric nurse practitioner in Clarks Summit, Pa.

Also make sure PRN medication orders don't get carried on forever. Ask if the patient has used the PRN medication within the last two months. "If a patient doesn't need a PRN for two months but then suddenly does, you'd want to know what's going on," adds Jenkins.

4. Follow the evidence for treating psych and behavioral problems. For example, less medication may sometimes be better in treating patients with psychiatric illnesses. One study funded by the **National Institutes of Health** found that adding an antidepressant on top of a mood stabilizer to treat depression in people with bipolar disorder had as much effect as a sugar pill (New England Journal of Medicine,March 28, 2007).

In other cases, the right combination of medications can stave off the need for additional psychoactive meds. Research shows that usingantidepressant therapy to treat depression to remission, and dementia medication (such as cholinesterase inhibitor plus Namenda starting in the middle stages of Alzheimer's) can decrease the need for antipsychotics or antianxiety agents, says Scanland.

If the patient is taking antipsychotics "off label" to treat dementia-related behavioral symptoms, make sure to monitor whether the medication is helping the patient. Patients treated with antipsychotics not only don't improve but are often worse after the first year of treatment, according to research by the **New York Association of Homes & Services for the Aging**, says **Christie Teigland,** one of the researchers. "So, the [medications] don't work in most cases. Behavioral approaches do work and they work much faster."