the Remedi Pulse

DEPRESCRIBING TO TREAT POLYPHARMACY AND NOTABLE BEERS LIST UPDATE

Remedi SeniorCare EDUCATION Rx

A CLINICAL AND REGULATORY UPDATE FROM REMEDI SENIORCARE

2019 VOLUME 2

Survey Solutions

with William Vaughan, BSN, RN
VP of Education & Clinical Affairs

Casting a Wide Regulatory Net: Professional Standards of Quality

Reviewing the 2019 update to the *American Geriatrics Society's Beers Criteria for Potentially Inappropriate Medication Use in Older Adults* caused me to reflect on the role of such publications in the nursing home survey process. The Beers Criteria, first published in 1991 and widely considered an essential geriatric clinical resource, is referenced in the CMS Guidance to Surveyors under F758 (Unnecessary Drugs) and F759 (Psychotropic Drugs). CMS notes that the Beers Criteria "provides information on safely prescribing medications for older adults," along with a standard disclaimer that "references to non-CMS sources do not constitute or imply endorsement of these organizations or their programs." Despite that caveat, CMS clearly believes there is value in providing the Beers Criteria to surveyors, presumably to be used in determining compliance with federal regulations.

So how do standards, published by organizations outside of CMS, gain traction in the survey process? The answer can be found at F658 (Comprehensive Care Plans), which reads in part "The services provided or arranged by the facility … must meet professional standards of quality." Professional standards of quality are then broadly defined in the associated Guidance to Surveyors:

"Professional standards of quality" means that care and services are provided according to accepted standards of clinical practice. Standards may apply to care provided by a particular clinical discipline or in a specific clinical situation or setting. Standards regarding quality care practices may be published by a professional organization, licensing board, accreditation body or other regulatory agency. Recommended practices to achieve desired resident outcomes may

continued on page 4

FOR MORE INFORMATION
RemediRx.com

EDITORIAL STAFF

JENNIFER HARDESTY Pharm.D., FASCP
Chief Clinical Officer
Jennifer.Hardesty@RemediRx.com

ERIN FOTI, Pharm.D., BCGP
Director of Consulting Services
Erin.Foti@RemediRx.com

REBECCA OGDEN BSN, RN, CRNI
Corporate Account Manager
Rebecca.Ogden@RemediRx.com

Please do not hesitate to contact your Remedi Consultant Pharmacist or Account Manager if you have any questions or concerns.

CMS notes that the Beers Criteria "provides information on safely prescribing medications for older adults."

The Battle Against Polypharmacy

Presented by: Erin M. Foti, Pharm.D., BCGP, Director of Consulting Services

With the average life span reaching into the seventies and eighties, now more than ever we are treating residents with multiple comorbidities and numerous medications. Therapeutic polypharmacy is a term used when a resident is prescribed multiple medications that are clearly warranted to treat his/her various conditions.

Polypharmacy is generally defined as "the use of more medications than are clinically indicated, or when a medication regimen contains at least one unnecessary drug." In long-term care, polypharmacy comes with its own F-tag, F757. F757 states that each resident's drug regimen must be free from unnecessary drugs. This may include, but not be limited to, drugs used with:

- excessive dose
- excessive duration
- inadequate monitoring
- no indication for use
- in the presence of drug-related side effects

Health care providers should aim to systematically reduce polypharmacy on a routine basis.

- The first step is to ensure all of a resident's medications are documented, including any over-the-counter or herbal/alternative products. If a resident sees more than one prescriber, this list should be shared among the various providers in order to avoid unnecessary prescribing and duplication of therapy.
- Secondly, medications should be matched to known conditions or diagnoses of the individual, and excess medications should be discontinued.
- Next, any medication that is causing the individual side effects, is ineffective, or does not have a clear benefit, should be stopped.
- Finally, careful thought and consideration should be given before a new medication is initiated. Health care providers should review alternative forms of treatment, such as non-pharmacological interventions, prior to initiating medication management.

All members of the healthcare team must be vigilant to avoid what is known as the prescribing cascade. This is the term used to describe when one drug is added in order to treat the side effect of another, such as prescribing an overactive bladder medication for someone on a diuretic. The principle of "any new symptom should be considered drug-related until proven otherwise" is wise advice that if given thoughtful consideration, can limit the prescribing cascade.

A helpful tool to guide clinicians in making the best therapeutic choices for residents is the Beers Criteria, updated in January of 2019. The Beers Criteria is intended for use in adults over 65 years old, and applies to all healthcare settings, with the exception of hospice and palliative care. The Criteria provides a review of medications that are preferred or should be avoided in the elderly, with a goal of improving drug selection, providing education, reducing side effects, and serving as a reference for evaluating care in older adults. The Criteria should be used as a guide for caution and not an absolute contraindication when making a drug selection, as each selection should be resident specific.

Prescribers, pharmacists, and nurses all play an important role when it comes to methodically reviewing medication regimens and ensuring that our aging population receives the most ideal therapeutic approach. By avoiding potentially inappropriate medications and removing unnecessary medications, we can improve resident safety, clinical outcomes, and increase our residents' overall quality of life.

see chart on page 3

Remedi Superstar Nurse

TERRI MCCAHILL, LPN

Metron of Cedar Springs, Cedar Springs, MI

CONGRATULATIONS to Terri McCahill, LPN, at Metron of Cedar Springs, Cedar Springs, MI for being chosen as the REMEDI Superstar nurse. Terri's Director of Nursing, Welarchie "Lanie" Sosnowski, BSN, CRRN, RN-BC submitted her nomination. Per Lanie, "Terri has worked at Metron of Cedar Springs for 23 years. She started as a floor nurse, then worked as a unit manager for 22 years, and presently is the unit manager in the long-term care east/west hall. Terri is very dependable, accomplishes her tasks in a timely manner, and ensures that the residents' needs are met. She is a team player, has a great relationship with our staff, and is an effective mentor. Terri leads by example and follows policy and regulation. She goes above and beyond her normal duties, arrives to work early, and helps the staff nurses accomplish their tasks."

Email your Superstar Nurse nomination(s) to Rebecca.Ogden@RemediRx.com

Notable Changes or Removals for the Most Recent Beers Criteria Update

Medication/Drug Class	Updated Change	Additional Comments
H2 blockers (Famoditine/ Ranitidine)	Removed from “avoid” list in residents with dementia or cognitive impairment	• Evidence weak for cognitive effects • Remain on the list to “avoid” in delirium • PPI drugs discouraged in the absence of indications, needed therapy option
SNRIs (Cymbalta/ Effexor)	Added to “avoid” list in residents with a history of falls or fracture	• May be the choice to use based on potential benefits and lack of availability of safer alternatives
Nuplazid (Pimavanserin)	Added as preferred agent with Quetiapine and Clozapine for Parkinson’s psychosis	• Aripiprazole removed
Digoxin	Clarified as “avoid” in first line therapy for Atrial Fib and heart failure	• Avoid doses > 0.125 mg/day
Reglan (Metoclopramide)	Clarified duration	• Avoid, unless for gastroparesis, with duration not to exceed 12 weeks
Amaryl (Glimepiride)	Added to list of sulfonylureas that may cause prolonged hypoglycemia	• Added in addition to Glyburide
Ultram (Tramadol)	Added to list of drugs associated with hyponatremia or SIADH	• Certain chemotherapeutic agents removed from this list due to low utilization
Nuedexta (Dextromethorphan/ Quinidine)	Added to “use with caution” list	• Limited efficacy, potential to increase the risk for falls and drug interactions
Bactrim (Sulfamethoxazole/ Trimethoprim)	Use with caution in residents with reduced renal function and taking an ACE inhibitor or ARB	• Increased risk of hyperkalemia
Opioids	Drug interaction with Benzodiazepines	• Increased risk of overdose • Avoid
Opioids	Drug interaction with Gabapentin, Lyrica	• Increased risk of sedation, respiratory depression, death • Avoid; exception during the transition between therapies or reducing opioid use - use with caution

Survey Solutions

continued from page 1

reference sources for standards of practice include:

- Current manuals or textbooks on nursing, social work, physical therapy, etc.
- Standards published by professional organizations such as the American Dietetic Association, American Medical Association, American Medical Directors Association, American Nurses Association, National Association of Activity Professionals, National Association of Social Work, etc.
- Clinical practice guidelines published by the Agency for Healthcare Research and Quality.
- Current professional journal articles.

A review of recently cited deficiencies under F658 provides insight into how surveyors are interpreting this regulation.

- A nursing assistant failed to follow the care plan while transferring a resident to bed, twisting her knee resulting in immediate complaints of pain. The resident's leg was not assessed until 24 hours later, at which time she was sent to the hospital and diagnosed with multiple fractures of her right leg. In the deficiency, the surveyor referenced a chapter on pain management from a textbook entitled *Fundamentals of Nursing Practice* as the professional standard that was not met.
- An immediate jeopardy deficiency was cited at a nursing home where staff failed to respond appropriately to high and low blood glucose readings. As an example, a diabetic resident was admitted to the hospital in a hyperosmolar state after the nursing staff failed to notify the physician for 24 hours of multiple blood glucose readings great than 600 mg/dL. When interviewed by the surveyor, the staff stated they did not notify the physician because "there were no parameters to do so." No specific source referencing the standard of practice that was not met was included in the deficiency.
- During observation of the medication pass, the surveyor noted that the nursing staff did not wash their hands or use an alcohol-based hand sanitizer in between contact with multiple residents. The surveyor referenced the *CDC Guidelines for Hand Hygiene in Healthcare Settings* as the professional standard that was not met.
- A facility was cited for failure to provide CPR to a resident who orally and in his advance directive requested the intervention. The American Heart Association's guidelines for CPR were referenced as the professional standard that was not met.
- To promote person-centered care, a nursing facility liberalized their medication pass times which allowed for 4 hour blocks of time in which to administer selected medications. The surveyors then cited the facility for this practice, erroneously noting that "… professional standards do not allow the nursing staff a window of 3-4 hours as identified on the medication pass times form … professional standards only allow 1 hour before or one hour after the scheduled time for the medication administration … if the medication was administered outside of the two-hour window, of one hour before or one hour after, then a medication error was made." To support the surveyors' conclusions, the deficiency contained a reference to an Institute for Safe Medication Practices (ISMP) document from 2011 entitled "Guidelines for Timely Administration of Scheduled Medications (Acute)[1]". This document addressed medication management in the *acute care* setting and was written five years before the person-centered "mega rule" was implemented. The surveyors were also apparently unaware of the admonition in the Guidance to Surveyors under F759 (Medication Error Rate) to "Count a wrong time error if the medication is administered 60 or more minutes earlier or later than its scheduled time of administration, but only if that wrong time error can cause the resident discomfort or jeopardize the resident's health and safety. Counting a medication with a long half-life (e.g., digoxin) as a wrong time error when it is 15 minutes late is improper because this medication has a long half-life (beyond 24 hours) and 15 minutes has no significant impact on the resident. The same is true for many other wrong time errors." It's unclear if the facility disputed this deficiency, but it would have been our strong recommendation to challenge the citation.

Nursing facilities should care for their residents using evidence-based practices, many of which can be found in publications referenced in the Guidance to Surveyors under F658. With the implementation of QAPI regulations less than six months away, facilities should consider incorporating a periodic review of such publications in their QAPI plan. As evidenced by the deficiencies noted above, in practice, these publications ultimately have the force of regulations.

[1]https://www.ismp.org/guidelines/timely-administration-scheduled-medications-acute

Note: Bill was a surveyor with the Maryland State Survey Agency from 1988 until 2001. He became Chief Nurse of the agency in 2001 and remained in that position until joining Remedi SeniorCare in 2013.