# IIIB2: MEDICATION MANAGEMENT

## Policy

In order to optimize the therapeutic benefit of medication therapy and minimize or prevent potential adverse consequences, facility staff, the attending physician/prescriber, and the consultant pharmacist perform ongoing monitoring for appropriate, effective, and safe medication use. When selecting medications and non-pharmacological interventions, members of the interdisciplinary team participate in the care process to identify, assess, address, advocate for, monitor, and communicate the resident's needs and changes in condition.

## Procedures

A. The interdisciplinary team reviews the resident's medication regimen for efficacy and actual or potential medication-related problems **[on an ongoing basis/quarterly]**. (See Appendix 5: MEDICATION ISSUES OF PARTICULAR RELEVANCE IN OLDER ADULTS for specific guidance.)

1) When possible, non-pharmacologic interventions are considered before initiating a new medication.

2) The resident is evaluated before initiating, withdrawing, or withholding medication(s), or using non-pharmacologic approaches.

a. The extent of the evaluation will vary according to the resident's current condition, but may include:

1. An appropriately detailed evaluation of mental, physical, psychosocial, and functional status, including comorbid conditions and pertinent psychiatric symptoms and diagnoses, and a description of resident complaints, symptoms, and signs (including the onset, scope, frequency, intensity, precipitating factors, and other important features).
2. Resident's goals and preferences.
3. Allergies to medications and foods and potential for medication interactions.
4. History of prior and current medications and non-pharmacological interventions (including therapeutic effectiveness and any adverse consequences).
5. Recognition of the need for end-of-life or palliative care.
6. Refusal of care and treatment, including the basis for declining it, and the identification of pertinent alternatives.

3) Information gathered during the initial and ongoing evaluations are incorporated into a comprehensive care plan that reflects appropriate medication-related goals and parameters for monitoring the resident's condition and ongoing need for the medication(s), including, but not limited to, what is monitored, who will be responsible for monitoring, and how often and when a re-evaluation is necessary.

a. The care planning team defines quantitative and qualitative monitoring parameters using a variety of resources, including Appendix 5: MEDICATION ISSUES OF PARTICULAR RELEVANCE IN OLDER ADULTS and Appendix 12: TOOLS FOR MONITORING MEDICATIONS IN LONG-TERM CARE RESIDENTS, manufacturers' package inserts and box warnings; facility policies and procedures; pharmacists; clinical practice guidelines or clinical standards of practice; medication references; and clinical studies or evidence-based review articles that are published in medical and/or pharmacy journals.

4) The resident's medication regimen is evaluated when one or more of the following occur. When there is a significant negative change from baseline (designated with an asterisk*), medications should be ruled out as a cause in accordance with the policy on adverse consequence detection and prevention (See IIIB3: PREVENTING AND DETECTING ADVERSE CONSEQUENCES AND MEDICATION ERRORS).
   a. Admission or re-admission.
   b. A clinically significant change in condition/status.*
   c. A new, persistent, or recurrent clinically significant symptom or problem.*
   d. An unexplained decline in function or cognition.*
   e. A worsening of an existing problem or condition.*
   f. A new or worsening psychiatric manifestation or distressed behavior.*
   g. A new medication order or renewal of orders.
   h. Significant changes in diet that may affect medication absorption.
   i. An irregularity identified in the pharmacist's monthly medication regimen review (MRR).
   j. A medication error, e.g., wrong medication or expired medication.*

5) When a resident receives a new medication, the medication order is evaluated for the following:
   a. The dose, route of administration, duration, and monitoring are in agreement with current clinical practice, clinical guidelines, and/or manufacturer's specifications for use.
   b. A written diagnosis, an indication, and/or documented objective findings support each medication.
   c. The resident has no known allergies to the medication.
   d. The resident is not taking other medications, nutritional supplements, including herbal products, or foods that would be incompatible with the prescribed medication.
   e. The resident does not have a condition, history, or sensitivity that would preclude the use of the medication.
   f. The prescriber documents the clinical rationale in the resident's **[active record]** for using a medication outside these stated guidelines.

6) As needed (PRN) orders include an indication for use.
    a. If the PRN medication is used to modify behavior, the indication(s) for use is clearly defined in objective terms, e.g., what specific symptom(s) is being addressed.
    b. The resident is monitored for the effectiveness of the medication or possible adverse consequence. Results are documented in the resident's active record.

7) When a resident receives medications from the same class or with similar therapeutic effects (duplicate therapy), the clinical rationale and benefit are documented in the resident's **[active record]**.

8) The medication regimen is re-evaluated **[periodically/every quarter]** to determine whether prolonged or indefinite use of a medication is indicated.
    a. Prescribers, facility staff, and consultants document progress towards, maintenance of, or regression from therapeutic goals.
    b. If the resident's condition has not responded to treatment or has declined despite treatment, the resident is evaluated to determine whether the medication should be discontinued or the dosing should be altered.

9) When a resident's clinical condition has improved or stabilized, the underlying causes of the original target symptoms have resolved, and/or non-pharmacological interventions, including behavioral interventions, have been effective in reducing the symptoms, the resident is evaluated for the appropriateness of a taper or gradual dose reduction (GDR) of the medication.

B. If a medication seems unnecessary or harmful to the resident, the **[Director of Nursing, consultant pharmacist]** requests the prescriber to evaluate the resident for the continued need for the medication and/or to consider tapering the medication. If the prescriber deems the medication necessary, a documented clinical rationale for the benefit of, or necessity for, the medication is documented in the resident's **[active record]**.

C. When other organizations perform medication therapy management services, e.g., Medicare Prescription Drug Plans (PDPs), the consultant pharmacist evaluates the recommendation for applicability to the long-term care resident.

NOTE: The above procedures are applicable to any therapeutic monitoring. Following includes a specific section on monitoring psychotropic medications. However, many other drug classes may deserve special monitoring.

**Antipsychotics.** If a resident is admitted on an antipsychotic medication or the facility initiates antipsychotic therapy, the facility must attempt a GDR in two separate quarters (with at least one month between the attempts) within the first year, unless clinically contraindicated. After the first year, a GDR must be attempted annually, unless clinically contraindicated.

1. A GDR is considered clinically contraindicated if:
    a) Target symptoms returned or worsened after the most recent attempt at a GDR and the physician documents the clinical rationale for why any additional attempted dose reductions would likely impair the resident's function, increase distressed behavior, or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder. –OR–
    b) The continued use is in accordance with relevant current standard of practice and the physician documents the clinical rationale for why any additional attempted dose reductions would likely impair the resident's function, increase distressed behavior, or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder.

**Sedatives/Hypnotics.** A GDR is attempted quarterly for residents receiving sedatives/hypnotics that are used routinely and beyond the manufacturer's recommendations for duration of use, unless clinically contraindicated.

1. A GDR is considered clinically contraindicated if:
    a) Target symptoms returned or worsened after most recent attempt at GDR and the physician documents the clinical rationale for why any additional attempt to taper would likely impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder. –OR—
    b) The continued use is in accordance with relevant current standard of practice and the physician documents the clinical rationale for why any additional attempted dose reductions would likely impair the resident's function, increase distressed behavior, or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder.

**Other Psychopharmacologic Medications*.** During the first year in which a resident is admitted on a psychopharmacological medication (other than an antipsychotic or a sedative/hypnotic), or after the facility has initiated such medication, the facility attempts a GDR during at least two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, a tapering should be attempted annually, unless clinically contraindicated.

1. The GDR is considered clinically contraindicated if:
    a) Target symptoms returned or worsened after the most recent attempt at a GDR and the physician documents

the clinical rationale for why any additional attempted dose reductions would likely impair the resident's function, increase distressed behavior, or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder. –OR--

b) The continued use is in accordance with relevant current standard of practice and the physician documents the clinical rationale for why any additional attempted dose reductions would likely impair the resident's function, increase distressed behavior, or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder.

*Psychopharmacologic medication is defined by the Centers for Medicare & Medicaid Services [42 CFR §483.25(l) Unnecessary Medications (F329)] as: "any medication used for managing behavior, stabilizing mood, or treating psychiatric disorders."