Residents in skilled nursing facilities (SNFs) often have many medical conditions, and frequently take multiple medications, a situation known as polypharmacy. When a resident receives many different medications, some may be redundant or unnecessary. This increases the likelihood of:

- Adverse drug reactions
- Drug-drug or drug-nutrient interactions
- Potential “prescribing cascade” that occurs when a medication side effect is misinterpreted as a new medical problem or a change in condition, and results in the addition of another medication

Polypharmacy can cause harm to residents and may result in rehospitalization.

The use of multiple drug therapies substantially increases the risk of an adverse drug event. According to a 2014 Office of the Inspector General report, 22% of Medicare beneficiaries admitted to a SNF experienced an adverse event within 35 days of admission, and 37% of those events were related to medications. The consequences can include prolonged stay, permanent harm, need for life-sustaining intervention, or transfer to the hospital. In fact, thirty-five percent of the adverse events resulted in hospitalization.

CMS has determined that adverse events are a significant problem that warrant increased awareness and emphasis on reduction. Starting this summer, CMS will begin pilot testing surveys focused on safety systems in order to enhance surveyors’ skills for identifying preventable adverse events. As the emphasis on preventing events grows and the move toward outcomes-based reimbursement in long term care continues, it is important for facilities to focus on strategies to reduce medication-related adverse events.

Your PharMerica Consultant Pharmacist can provide drug evaluations and recommendations for your residents during regular on-site visits. Between consulting visits, PharMerica’s interim medication regimen review (iMRR) can help evaluate a resident’s change in condition to prevent the addition of unnecessary medications to their regimen. While multiple medications are often needed to manage a resident’s condition, your Consultant Pharmacist can ensure proper medication therapy that will help reduce preventable adverse events, hospital readmission, and costs – while driving better care and outcomes for SNF populations.

Chronic pain is common among older adults, especially those residing in long term care facilities. In fact, it is estimated that 45% to 80% of geriatric residents in nursing homes suffer from chronic pain, and most experience it on a daily basis.

Many factors complicate the management of pain in older adults, including high rates of dementia, sensory impairment, and disability. Consequences of poor pain management include anorexia, anxiety, agitation, behavioral problems, cognitive decline, depression, falls, reduced activity and functional status, delayed healing, and polypharmacy. The result is increased staff burden, and risk for F-Tag citations from CMS.

F309 states that “residents must receive the necessary care and services for the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care.” DEA regulations concerning the dispensing of controlled substances are strictly enforced. For new orders and subsequent resident prescriptions, facilities should focus on compliance in the following key areas:

- **Required elements of valid controlled substance prescriptions**
  - Available at http://www.deadiversion.usdoj.gov/faq/prescriptions.htm
- **Verbal emergency authorization (Schedule II)**
  - Signed valid prescription provided to pharmacy within 72 hours or seven days depending on the state

• Pharmacy must report prescriber to DEA if signed valid prescription is not received in the required time frame
• **Removal of controlled substance from Emergency Drug Kit (EDK)/Automatic Dispensing System (ADS)**
  - Drug order must be NEW (not current order) and meet criteria for an emergency
  - Nurse must verify with the pharmacy that a valid prescription (either faxed or verbal emergency authorization) is received in order for a pharmacist to provide her/him authorization to remove a dose from the EDK/ADS

Facility non-compliance with these requirements and procedures may delay the pharmacy’s ability to dispense necessary medications or slow the process for obtaining an emergency dose. This creates quality of care implications, and places the facility at risk for F425, which states that facilities must provide routine and emergency drugs and biologicals to residents.

To streamline processes and make sure that residents receive necessary therapy, facilities should review or develop procedures for everything from pain assessment and proper treatment to administering doses and assessing the benefits of therapy. Each member of the interdisciplinary team plays an important role in this process and good collaboration will improve resident outcomes and control costs while reducing readmission and minimizing F-Tag risks.
Restless Leg Syndrome (RLS) in the LTC Resident

Restless leg syndrome (RLS) is a neurological movement disorder characterized by throbbing, pulling, creeping, or other unpleasant, even painful, sensations in the legs and an uncontrollable urge to move them to relieve the discomfort. Symptoms occur primarily when a person is relaxing or at rest, and typically increase in severity during the night, which can cause insomnia.

Results from many studies and care settings reveal that lack of quality sleep can lead to exhaustion and daytime fatigue, depression, memory impairment, difficulty concentrating and irritability. Since undiagnosed restless leg syndrome can disrupt a resident’s sleep, it is important to identify the symptoms of the condition in order to treat it. Symptoms include:

- A strong urge to move the legs, which often, but not always, occurs with unpleasant feelings in the legs.
- When the disorder is severe, there may be the urge to move the arms.
- Symptoms that start or get worse during periods of inactivity, such as when sitting still or lying down.
- Relief obtained from movement, especially walking.
- Symptoms that begin or worsen in the evening or at night.

The cause of restless leg syndrome is unknown in most people; however, it has been associated with obesity, smoking, iron deficiency/anemia, nerve disease, polyneuropathy, diabetes, poor venous circulation, and kidney failure – conditions routinely experienced by elderly residents. Some common medications prescribed in the LTC setting may possibly cause RLS, including anti-nausea agents (e.g. prochlorperazine or metoclopramide), antipsychotics (e.g. haloperidol or phenothiazine derivatives), antidepressants that increase serotonin, and some cold and allergy medications containing sedating antihistamines.

Diagnosis and treatment of restless leg syndrome can help reduce the effects of sleep disruption, and prevent hospitalizations from falls caused by the tendency to get out of bed at night.

To help relieve symptoms of RLS, facilities should encourage residents to:

- Avoid sitting in one position for too long.
- Get up and move often throughout the day and stretch the legs.
- Avoid foods and drinks that contain caffeine, including coffee, tea, soft drinks, and chocolate.
- Avoid tobacco and alcoholic beverages.

If lifestyle modifications and exercise do not provide relief, treatment with medications such as analgesics, anti-Parkinson’s agents (e.g. ropinirole and pramipexole) or anti-epileptics (e.g. gabapentin) have been found to be effective. To achieve the best outcomes, residents should be frequently observed and accurately assessed with complete documentation of results and possible medication side effects.
SPIRIVA® (tiotropium bromide) is a long-acting inhaled anticholinergic agent for the maintenance treatment of chronic obstructive pulmonary disease (COPD). Traditionally delivered as a dry powder inhalation through the HandiHaler device, it is now also available as SPIRIVA® RESPIMAT®, which delivers a slow-moving mist that helps patients inhale the medication independent of effort.

Both SPIRIVA® HandiHaler® and SPIRIVA® RESPIMAT® are once-daily medications to treat bronchospasm associated with COPD, including chronic bronchitis and emphysema, and to reduce COPD exacerbations. Long-acting anticholinergic agents are considered an appropriate maintenance option for most patients with COPD, according to the 2014 GOLD algorithm for the treatment of COPD. SPIRIVA® is contraindicated in patients with a history of hypersensitivity to tiotropium, ipratropium (atropine derivatives), or any component of either product. SPIRIVA® is not indicated for the initial treatment of acute episodes of bronchospasm (rescue therapy).

SPIRIVA® RESPIMAT® and the SPIRIVA® HandiHaler® are available in a 30-day package size, and the HandiHaler® is also available in a 5-day institutional pack. SPIRIVA® HandiHaler® and SPIRIVA® RESPIMAT® should not be used together.

Prescribers, nurses, and pharmacists need to make sure all orders for SPIRIVA® now specify whether the HandiHaler or the RESPIMAT® should be dispensed. The quantity dispensed for SPIRIVA® HandiHaler® represents the number of capsules (30 or 5), while the quantity for SPIRIVA® RESPIMAT® represents the number of cartridges (1). Both devices require two inhalations once daily:

- **SPIRIVA® HandiHaler®**: 2 inhalations per capsule once daily
- **SPIRIVA® RESPIMAT®**: 2 inhalations once daily


For more information on SPIRIVA, please visit: [www.spiriva.com](http://www.spiriva.com) or contact your Consultant Pharmacist.