Even if the Centers for Medicare & Medicaid Services didn’t have a monthly medication regimen review (MRR) requirement for residents of skilled nursing facilities, having a periodic review of each resident’s medications in a focused, methodical way invariably results in better care for the residents we serve.

The heightened awareness of the increased risks for adverse drug events (ADEs), prescribing cascades, falls, and hospitalizations has caused concern about the use of potentially problematic or unnecessary combinations of drugs in our senior population (P.A. Rochon, “Drug Prescribing for Older Adults,” UpToDate, Apr. 26, 2021, https://bit.ly/38DDGzY). The Centers for Disease Control and Prevention estimates the number of emergency department visits related to ADEs to be at more than 1.3 million annually (Medication Safety Program, “Medication Safety—An Assessment That Should Occur at Facility Admission” that pharmacists perform with a critical eye for all possibilities associated with medications. Not only does the review encompass a snapshot of the medication list, it also allows the pharmacist to review key nursing, dietary, and therapeutic activities, rehabilitation progress, and medical notes. The pharmacist can then provide a recommendation for optimizing key medication regimens or for suggested clinical monitoring such as laboratory work.

Drugs that are high-risk medications or cited as potentially inappropriate medications (see the American Geriatrics Society’s Beers Criteria: https://bit.ly/33hWPpP) are a high priority for falls risk mitigation strategies. Nursing and risk management team members also may call on pharmacists to review medications at a fall, including recommendations on medication adjustment or additional interventions such as orthostatic blood pressure recordings or fingerstick monitoring, as indicated (see Figure 1 for a sample template note).

MRR Recommendations
Pharmacists’ MRR recommendations tend to have some core elements of Situation, Background, Assessment, Recommendation.
pharmacist. In addition, the pharmacy’s that is reviewed at least annually for minimum laboratory test frequency measures that the manufacturers panel, comprehensive metabolic panel, look for the basics — basic metabolic change as the resident ages. Pharmacists adjustment based on therapeutic levels that can be considered clinically significant, can be considered clinically significant.

1. Recommending laboratory testing and clinical monitoring. Most drugs are affected by a resident’s ability to metabolize them; many medications require adjustment based on therapeutic levels and hepatic and renal function, which change as the resident ages. Pharmacists look for the basics — basic metabolic panel, comprehensive metabolic panel, liver, and thyroid — and for any drug level measures that the manufacturers recommend having performed “periodically.” The facility should have a policy for minimum laboratory test frequencies that is reviewed at least annually by the medical director and consultant pharmacist. In addition, the pharmacist will review provider notes to ensure acknowledgment of results requested but not performed (laboratory test refusal, quantity insufficient to test, results not found in electronic health records [EHR] or chart) or results outside the normal ranges. Providers are encouraged to comment on all outlier results with a relevant progress note.

2. Requesting a medication be reduced, tapered, or discontinued. Quite often there are opportunities to simplify the number of drugs in a regimen or to reduce dosages or frequencies; these would include both routinely scheduled and as-needed (PRN) medications. Enrollment in hospice benefits or a palliative care regime is also a key opportunity for modifications. Pharmacists review the monitoring data provided in the EHR or chart/medication record for clinical parameters — including blood pressure, heart rate, fingerstick monitoring results, and the medication administration record — to identify medications that are being refused, held, or not administered due to lack of demand. This focused time spent reviewing may not be a priority for the provider, so these specific pharmacist recommendations should prompt a more in-depth probe into the resident’s status.

3. Identifying concerns related to electronic order entry and acknowledgement. Such concerns may include clarification of directions, scheduling of administration times, monitoring protocols, missing stop dates, and any auxiliary warnings related to a drug prescription order. Any of these data entry points can be considered clinically significant and require time-sensitive attention for correction and error avoidance.

4. Simplifying regimens with multiple drugs in the same category; avoiding the prescribing cascade; using shared decision-making to promote medication regimen optimization. Avoiding therapeutic duplications, adding a drug to counteract side effects of a drug, and encouraging resident engagement are all relevant strategies that pharmacists should highlight and call to a provider’s attention. The adoption of shared decision-making as a strategy for having informative discussions with patients and caregivers that lead to medication reductions has become a more accepted intervention.

5. Addressing the elephant in the room: the gradual dose reduction (GDR). With GDR for any psychotropic medication, it’s best to acknowledge that we should avoid the statement “We can’t reduce!” More and more evidence points to GDR as a successful medication discontinuation strategy. Reducing psychotropics in conjunction with programming and nonpharmaceutical interventions promotes the resident’s best quality of life. It also addresses the facility’s need to maintain an active program for monitoring where the facility compares with national and state benchmarks as an indicator of quality (see F758 on psychotropic drugs: https://go.cms.gov/3JEz5Ub).

Robert C. Accetta, RPh, is a board-certified geriatric pharmacist and the president/owner of Rivercare Consulting, LLC, a care strategy and consulting business for care organizations.

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The overall goal of this course is to provide Advanced Practice Nurses with knowledge necessary to provide high quality dementia care management.

The Fundamentals of Dementia Care Management

The 22 modules in this curriculum are divided into 6-units and offers 8.5 Nursing Continuing Professional Development Contact Hours:

Unit A - Introduction to Dementia Care Management
Unit B - Integration into Health System and Community
Unit C - Essential Skills for DCSs
Unit D - Initial Assessment and Care Planning
Unit E - Ongoing Co-Management
Unit F - Caregiver Training and Support

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This workshop covers the topics listed below and offers 6.5 Nursing Continuing Professional Development Contact Hours which includes 1.5 hrs. of pharmacology credit:

• Background and Models of Dementia Care
• Advanced Practice Nurses as Gerontological Specialists and Dementia Care Specialists
• Management of Neuropsychiatric Symptoms
• Caregivers as part of the team
• Advanced Care Planning

To access the course visit gapna.org/dcs

This educational activity is jointly provided by Anthony J. Jannetti, Inc. [AJJ] and the Gerontological Advanced Practice Nurse Association (GAPNA).

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