# Qsource Nursing Home Collaborative

## Antipsychotic and Opioid Medications Toolkit

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# F 757 Unnecessary Drugs 483.45(d)
# F758 Unnecessary Psychotropic Drugs 483.45 (c)(3)(e)
Effective 11-28-2017

## Intent of Regulations F757 and 758

- Each resident's entire drug/medication regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical and psychosocial well-being;
- The facility implements gradual dose reductions (GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and
- PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.

The regulations related to psychotropic medications include additional required regulations:

- Only giving psychotropic medications that are necessary to treat a specific diagnosed and documented condition;
- Implementing GDR and other non-pharamacological interventions for residents who receive psychotropic medication, unless contraindicated;
- Limiting the timeframe for PRN psychotropic medications, which are not antipsychotic medications, to 14 days, unless a longer timeframe is deemed appropriate by the attending physician; and
- Limiting PRN psychotropics which are antipsychotic medications to 14 days and not entering a new order without first evaluating the resident.

| Type of PRN Order | Time Limitation | Exception | Required Actions |
|---|---|---|---|
| PRN orders for psychotropic medications, excluding antipsychotics. | 14 Days | Order may be extended beyond 14 days if the attending physician or prescribing practitioner believes it is appropriate to extend the order. | Attending physician or prescribing practitioner should document the rationale for the extended time period in the medical record and indicate a specific duration. |
| PRN orders for antipsychotic medications only. | 14 Days | None. | If the attending physician or prescribing practitioner wishes to write a new order for the PRN antipsychotic the attending physician or prescribing practitioner must first evaluate the resident to determine if the new order for the PRN antipsychotic is appropriate. |



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# F 757 Unnecessary Drugs 483.45(d)
# F758 Unnecessary Psychotropic Drugs 483.45 (c)(3)(e)
Effective 11-28-2017

Keep in mind that the required evaluation of a resident, prior to writing a new PRN order for an antipsychotic includes the attending physician or prescribing practitioner directly examining the resident and assessing the current condition and progress to determine if the PRN antipsychotic medication is still needed. Both the physician's and practitioner's evaluation should be entered into the medical record.

## Tapering Medication

Time frames and duration of attempts to taper any medications must be consistent with accepted standards of practice and depends on the medication, the underlying causes of symptoms, individual risk factors and pharmacologic characteristics of the medication.

Close monitoring and documentation of medications during tapering should occur to minimize or prevent withdrawal symptoms or other adverse consequences; documentation should include any noted side effects and changes in behaviors.

## Dose Reduction

- GDR should occur within the first year for a resident admitted with a psychotropic medication.
- Or, after the prescribing practitioner has initiated a psychotropic medication, the facility attempts a GDR in two separate quarters (with at least one month between attempts), unless clinically contraindicated.

Remember that if the resident with dementia is receiving a psychotropic medication(s), the GDR may be considered clinically contraindicated for reasons that include, but are not limited to:

- the resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility; and;
- the physician has documented the clinical rationale for why any additional attempted dose reduction at that time would likely impair the resident's function or result in an increase in distressed behavior(s).

## Schizophrenia Diagnosis

Diagnoses of Schizophrenia in long term care facilities must be documented in the medical record prior to physicians and/or prescribing practitioners writing orders for psychotropic medications. If the resident is admitted from the hospital with psychotropic medication orders, check for the appropriate diagnosis paperwork. In other words, facilities cannot make an attempt to make the orders fit the diagnosis.

*Adapted from the "State Operations Manual, Appendix PP - Guidance to Surveyors for Long Term Care Facilities"*

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# Tab One
## Policy & Procedures

# Pain Medication Administration Policy

## POLICY:

It is the policy of this facility that pain medications will be administered per physician order and to provide comfort for the resident.

## GUIDANCE:

1. The pain management program is based on a facility-wide commitment to resident care and comfort.
2. Pain Management is defined as the process of alleviating the resident's pain to a level that is acceptable to the resident and is based on his/her clinical condition and goals.
3. Residents are not at risk for addiction to narcotic analgesics if used as prescribed for moderate to severe pain.
4. Staff will be observant for physiologic and behavioral (non-verbal) signs of pain: (non-licensed staff are expected to report to the nurse if resident exhibits pain)
    a. Verbal expressions such as groaning, crying, yelling;
    b. Facial expressions such as grimacing, frowning, clenching of the jaw;
    c. Behaviors, such as resisting care, irritability, depression, decreased participation in usual activities;
    d. Limitations in his/her level of activity due to the presence of pain;
    e. Guarding, rubbing or favoring a particular part of the body;
    f. Difficulty eating or loss of appetite; and
    g. Insomnia.
5. It is important to recognize cognitive, cultural, familial or gender specific influences on the resident's ability or willingness to verbalize pain. For example, some cultures value stoicism and a high threshold for pain which may influence a resident's willingness to report pain or accept pain relieving interventions.
6. Acute pain should be assessed every 60 minutes after the onset and reassessed as indicated after analgesic relief is obtained.
7. The pain assessment consists of gathering both subjective and objective data.
8. The nurse will use the Pain Assessment tool to determine the severity of the pain scale 0-10 for residents who are cognitively intact.
    a. For residents who are cognitively impaired, the use of the Pain Intensity scale with word modifiers will be utilized.
9. Attempt non-medication interventions (such as repositioning, warm or cold compresses) to determine if the pain can be relieved and document what interventions, if any, were used. This step should be taken prior to giving an analgesic as appropriate.
10. Administer pain medication per physician order.
11. Document the pain medication administered; the location and severity of the pain described by the resident; any non-medication interventions attempted; side effects of the medication; and results of the medication administered.

*Note: If pain is anticipated prior to a treatment (such as wound care treatments); pain medication may need to be given to alleviate pain during the procedure.*

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# Controlled Substances

## Policy Statement

The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications.

## Policy Interpretation and Implementation

1. Only authorized licensed nursing and/or pharmacy personnel have access to controlled drugs maintained on premises.

2. Personnel who are authorized to handle controlled substances are approved by the Director of Nursing Services.

3. Controlled substances are stored in the medication room in a locked container, separate from containers for any non-controlled medications.

4. Access to controlled medications remains locked at all times and access is recorded.

5. The Director of Nursing Services maintains a list of personnel who have access to medication storage areas and controlled substance containers.

6. Keys to controlled substance containers are kept on a single key ring separate from any other keys.

7. The Charge Nurse on duty maintains the keys to controlled substance containers. The Director of Nursing Services maintains a set of back-up keys for all medication storage areas including keys to controlled substance containers.

8. Controlled substances are reconciled upon receipt, administration, disposition, and at the end of each shift.

9. **Upon Receipt**:
   a. The nurse receiving the medication and the individual delivering the medication verify the name, dose and quantity of each controlled substance being delivered.
   b. Both individuals sign the controlled substance record of receipt.
   c. An individual resident controlled substance record is made for each resident who is receiving a controlled substance. The record contains:
      (1) name of the resident;
      (2) name and strength of the medication;
      (3) quantity received;
      (4) number on hand;
      (5) name of physician;
      (6) prescription number;
      (7) name of issuing pharmacy; and
      (8) date and time received.
   d. Controlled medications that are designated for emergency or on hand supply are recorded as such.

10. **Upon Administration**:
    a. The nurse administering the medication is responsible for recording:
       (1) name of the resident receiving the medication;

*continues on next page*

(2) name, strength and dose of the medication;
(3) time of administration;
(4) method of administration;
(5) quantity of the medication remaining; and
(6) signature of nurse administering medication.

11. **Upon Disposition**:
    a. Unless otherwise instructed by the Director of Nursing Services, when a resident refuses a non-unit dose medication (or it is not given), or a resident receives partial tablets or single dose ampules (or it is not given), the medication may not be returned to the container.
    b. Medications that are opened and subsequently not given (refused or only partly administered) are destroyed. Waste and/or disposal of controlled medication are done in the presence of the nurse and a witness who also signs the disposition sheet.
    c. Medications returned to the pharmacy are recorded and signed by the Director of Nursing (or designee) and the receiving pharmacy.

12. **At the End of Each Shift**:
    a. Controlled medications are counted at the end of each shift. The nurse coming on duty and the nurse going off duty determine the count together.
    b. Any discrepancies in the controlled substance count are documented and reported to the Director of Nursing Services immediately.
    c. The Director of Nursing Services investigates all discrepancies in controlled medication reconciliation to determine the cause and identify any responsible parties, and reports the findings to the Administrator.
    d. The Director of Nursing Services consults with the provider pharmacy and the Administrator to determine whether further legal action is indicated.

13. In the event there is concern about controlled substances being discharged with the resident and/or resident's representative, the Attending Physician may choose not to discharge the resident with those medications.

14. Policies and procedures for monitoring controlled medications to prevent loss, diversion or accidental exposure are periodically reviewed and updated by the Director of Nursing Services and the Consultant Pharmacist.

| References | |
|---|---|
| **OBRA Regulatory Reference Numbers** | §483.45(h) Storage of Drugs and Biologicals |
| **Survey Tag Numbers** | F761 |
| **Other References** | |
| **Related Documents** | Controlled Drug Record (MP5201)<br>Discarding and Destroying Medications<br>Individual Resident's Controlled Substance Record (MP5211)<br>Shift Verification of Controlled Substances Count (MP5212) |
| **Version** | 1.3 (H5MAPL0155) |

# Adverse Events/Consequences of Medication-Related Problems/Errors

## POLICY:

The facility evaluates medication usage to prevent and detect adverse events and medication related problems such as adverse drug reactions (ADRs), side effects and medication errors.

Adverse events/consequences, including medication errors, will be reported to the attending physician and responsible party.

## PROCEDURE:

1. Residents receiving any medication that has a potential for an adverse event/consequence will be monitored to ensure that any such events/consequences are promptly identified and reported.
2. An 'adverse event/consequence' is defined as an unpleasant symptom that is due to or associated with a medication, such as an impairment or decline in an individual's mental or physical condition or functional or psychosocial status. An adverse event/consequence may include:
    a. Adverse drug reaction;
    b. Side effect;
    c. Medication-medication interaction;
    d. Medication-food interaction;
    e. Medication errors.
3. An 'adverse drug reaction' (ADR), a form of adverse consequence is defined as a secondary and usually undesirable effect of a drug and is different from the therapeutic and helpful effects of the drug. An ADR is any noxious and unintended response to a drug and occurs for prophylaxis, diagnosis, or therapy.
4. Any signs and symptoms that may be related to medications will be reported to the DON/charge nurse promptly. The DON/charge nurse will notify the attending physician of the findings. As necessary, the DON/charge nurse may also contact the consultant pharmacist for help in determining whether adverse consequences might be present.
5. The pharmacist is responsible for reviewing the resident's medication regimen monthly to help identify and report irregularities associated with the use of medications.
6. The DON/nurse and/or physician will document information about the symptoms in the resident's clinical record.
7. The administrator will be informed of the event and will report the findings and outcome of the adverse event to the Quality Assurance and Quality Improvement (QAPI) Committee at the next scheduled meeting. If the administrator feels the QAPI Committee should be informed of the event in advance of the scheduled QAPI meeting, an ad hoc committee may be assembled for review of the event.

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# Behavior Management Policy

## POLICY:

It is the policy of this facility that Residents with a need to address behavioral health will receive services, receive trauma-related care and services from a clinician who has expertise and knowledge of this type of service and referrals will be made to provide appropriate interventions to establish a plan of treatment.

Behaviors/mood indicators may adversely affect the well-being of the Resident, other Residents, staff or visitors. This could include physical behavioral symptoms directed toward others, verbal behavioral symptoms directed toward others, other behavioral symptoms not directed toward others, rejection of care and wandering, and mood indicators.

## PROTOCOL:

1. For Residents who do not have a documented psychiatric mood disorder diagnosis, if a behavior occurs, there will be documentation of its possible cause based on the circumstances surrounding the occurrence or from individual histories.
2. Staff training related to behavioral health will be held to assure that competency and skill sets are appropriate to care for those Residents who have a psychiatric diagnosis, including dementia, history of trauma or post-traumatic stress disorder.
3. Residents who display a mental disorder or psychosocial adjustment difficulty, or who have a history of trauma or post-traumatic stress disorder, will receive appropriate treatment to address the issues to allow him/her the highest level of mental and psychosocial well-being.
4. All recommendations related to Pre-Admission Screening and Resident Review (PASRR) process will be reviewed with recommendations implemented and care planned. If the recommended intervention is not implemented, documentation of the rationale will be documented in the Resident's record.
5. If a new mental health diagnosis or a suspected mental health condition occurs after admission, the pre-screening agency will be contacted to initiate a new PASRR.

## PROCEDURE:

1. A behavior assessment will occur on all new admissions related to known/identified behaviors and/or the use of psychotropic medications to treat certain conditions.
2. All new behavior incidents/mood symptoms or new psychotropic medication orders will be referred to Social Services for completion of the assessment process.
3. For Residents who have been identified as having on-going behaviors/mood alterations, a behavior tracking may be needed for all observed issues. Nurses should be informed when staff have witnessed an on-going or chronic symptom that may require tracking. Any staff member may communicate with the nurse if a behavior/mood alteration is observed.
4. Social Services Director will use behavior documentation to guide in interdisciplinary team (IDT) discussion regarding Residents with symptoms and the effectiveness of interventions.
5. If behavior/mood interventions were not effective, the IDT will review and determine if new interventions should be initiated.
6. Social Services Director will communicate recommended interventions to all staff via the care plan.



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7. If the Resident has not had behaviors noted for three months, or at IDT direction, the Resident can be discontinued from the behavior monitoring program and the care plan will be updated to reflect the change.
8. If the Resident has no identified behaviors but continues a psychotropic medication for a psychiatric diagnosis, such as schizophrenia, major depression, bipolar disorder, etc, the physician should document the rationale to continue the medication.
9. Interventions to manage behaviors will never be used for disciplinary purposes, for the convenience of staff, or as a substitute for an active treatment program.
10. At least quarterly Interdisciplinary meetings will be held to discuss all Residents on the behavior management program as well as those Residents receiving psychotropic medication who may be due for reduction. During the meeting, behavior tracking and care plans will be reviewed. Interventions will be discussed and changed if necessary. Meeting minutes will be documented by IDT.
11. Gradual dose reduction (GDR) tacking will also be reviewed at the quarterly behavior management meeting.

**Interventions That Can Be Used:**

- Distraction
- Activity involvement
- Redirection
- Assess basic needs (toileting, hunger, thirst)
- Assess for discomfort
- New caregiver
- Assess for underlying medical causes
- Specified resident-centered interventions
- Supervised therapeutic environment
- Use of drug management will only be considered if all additional less restrictive interventions have been tried and failed

**Interventions That Will Not Be Used:**

- Restraints
- Involuntary seclusion
- Application of painful or noxious stimuli
- Timeout rooms with negative reinforcement

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# Behavior Management Plan

**Plan:**

This facility will address behavioral health of residents and ensure the following services:

- Trauma-informed care and services
- Appropriate care interventions to address behaviors
- Appropriate care and treatment

Behaviors/mood indicators may adversely affect the well-being of the resident, other residents, staff, or visitors. They could include physical behavior symptoms directed toward others, verbal behavioral symptoms directed toward others, other behavioral symptoms not directed toward others, rejection of care and wandering, and mood indicators.

**Protocol:**

1. For residents who do not have a documented psychiatric mood disorder diagnosis, if a behavior occurs there should be documentation of its possible causes based on the circumstances surrounding the occurrence or as noted from individual histories.
2. Staff training related to behavioral health will be completed to ensure that competency and skill sets are appropriate to care for those residents who have a psychiatric diagnosis, including dementia, history of trauma or post-traumatic stress disorder.
3. Residents who display a mental disorder or psychosocial adjustment difficulty, or who have a history of trauma or post-traumatic stress disorder and/or substance use disorder, will receive appropriate treatment to address the issues and allow him/her to achieve the highest level of mental and psychosocial well-being.
    a. Residents who are identified may need different activities than other nursing home residents. The activity director will participate in the interdisciplinary team (IDT) meetings to better provide appropriate activities for these residents. Care plans will reflect the various activities planned for the residents.
4. All recommendations related to the Pre-Admission Screening and Resident Review (PASRR) process will be reviewed with recommendations implemented and care planned. If the recommended interventions are not implemented, documentation of the rationale will be documented in the resident's medical record.
5. If a new mental health diagnosis or a suspected mental health condition occurs after admission, the pre-screening agency will be contacted to initiate a new PASRR.

**Procedure:**

- A behavior assessment will occur on all new admissions related to known/identified behaviors and/or if the use of a psychotropic medication to treat certain related conditions has been ordered.
- All new behavior incidents/mood symptoms or new psychotropic medication orders will be referred to Social Services for completion of the assessment process.

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- For residents who have been identified as having ongoing behaviors/mood alterations, behavior tracking should be utilized for all observed issues. Nurses should be informed when staff have witnessed an on-going or chronic symptom(s) that may require tracking. Any staff member may/should communicate the behavior/mood observed.
- The Social Service Director will use behavior documentation to guide an IDT discussion regarding residents with symptoms and the effectiveness of interventions.
- If behavior/mood interventions are not effective, the IDT will review and determine if a new intervention should be initiated. This discussion could occur with a quality assurance and performance improvement (QAPI) meeting as well.
- Social Services Director will communicate recommended interventions to all staff via communication and the updated care plan.
- If the resident has displayed behaviors noted for three months, or at IDT direction, the resident should be considered for discontinuation of the medication and the behavior monitoring program. Update the care plan to document the change.
- If the resident has not had behaviors but has continued a psychotropic medication for a documented psychiatric diagnosis, such as Schizophrenia, Major Depression, or Bipolar Disorder, the physician should document the rationale to continue the medication. If a failed gradual dose reduction (GDR) has been attempted on the medication, that rationale should also be documented. The facility will continue to track GDR recommendations and outcomes.
- Interventions to manage behaviors will never be used for disciplinary purposes, for the convenience of the staff, or as a substitute for an active treatment program.
- At least quarterly IDT meetings will be held to discuss all residents on the Behavior Management Program as well as those residents receiving psychotropic medication who may be due for a GDR consideration. During the meeting, behavior tracking and care plans will be reviewed and updated as appropriate. Interventions will be discussed and changed as necessary. The meeting will be documented in IDT notes.
- GDRs will also be reviewed at the quarterly Behavior Management Meeting.

**Interventions that can be utilized include:**

- Distraction
- Activity involvement
- Redirection
- Assess basic needs (toileting, hunger, thirst)
- Assess for pain
- New caregiver
- Assess for underlying medical cause
- Supervised therapeutic environment
- Specific resident centered interventions
- Use of drug management will only be considered if all additional less restrictive interventions have been tried but failed

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# Behavioral Health Services

## Policy Statement

The facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care.

## Policy Interpretation and Implementation

1. Behavioral health services are provided to residents as needed as part of the interdisciplinary, person-centered approach to care.

2. Residents who exhibit signs of emotional/psychosocial distress receive services and support that address their individual needs and goals for care.

3. Residents who do not display symptoms of, or have not been diagnosed with, mental, psychiatric, psychosocial adjustment, substance abuse or post-traumatic stress disorder(s) will not develop behavioral disturbances that cannot be attributed to a specific clinical condition that makes the pattern unavoidable.

4. Staff must promote dignity, autonomy, privacy, socialization and safety as appropriate for each resident and are trained in ways to support residents in distress.

5. Staff training regarding behavioral health services includes, but is not limited to:
   a. Recognizing changes in behavior that indicate psychological distress;
   b. Implementing care plan interventions that are relevant to the resident's diagnosis and appropriate to his or her needs;
   c. Monitoring care plan interventions and reporting changes in condition; and
   d. Protocols and guidelines related to the treatment of mental disorders, psychosocial adjustment difficulties, history of trauma and post-traumatic stress disorder.

6. Behavioral health services are provided by staff who are qualified and competent in behavioral health and trauma-informed care.

7. Staff are scheduled in sufficient numbers to manage resident needs throughout the day, evening and night.

| References | |
|---|---|
| **OBRA Regulatory Reference Numbers** | 483.40 Behavioral Health Services |
| **Survey Tag Numbers** | F740; F741; F742; F743 |
| **Other References** | |
| **Related Documents** | Behavioral Assessment, Intervention and Monitoring |
| **Version** | 1.0 (H5MAPL1461) |

# Psychotropic Medications Policy and Procedure

## POLICY:

It is the policy of this facility that psychotropic medications will be administered per physician order and to provide comfort for the resident.

## GUIDANCE:

It is the policy of this facility to:

1. Ensure each Resident receives the appropriate assessment and intervention prior to the initiation of psychotropic medication to attain and maintain the highest practicable level of function.
2. Residents who have not used psychotropic medications are not given these medications unless it is necessary to treat a specific condition as diagnosed and documented in the clinical record.
3. Ensure each Resident receiving psychotropic medication is monitored, evaluated, and assessed for reduction opportunities on an ongoing basis.
4. A physician order specifying medications, dose, route, and frequency will be obtained prior to the administration of psychotropic medication.
5. The Resident's medical record must show documentation of adequate indications for psychotropic medication use and the diagnosed condition for which the medication is prescribed. Diagnosis alone does not necessarily warrant the use of psychotropic medications. Psychotropic medication may be indicated if:
    a. Behavioral symptoms present a danger to the resident or others;
    b. There are expressions or indications of distress that are significant to the resident after the interdisciplinary team (IDT) has first identified and addressed any medical, physical, psychological causes, and/or social environmental triggers;
    c. If not clinically contraindicated, multiple non-pharmacological approaches have been attempted, but did not relieve the symptoms which are presenting a danger or significant distress and/or;
    d. Gradual dose reduction (GDR) was attempted but clinical symptoms returned.

If psychotropic medications are prescribed, documentation must clearly show the indication for the psychotropic medication, the multiple attempts to implement care planned, non-pharmacological approaches, and ongoing evaluation of the effectiveness of these interventions.

6. The Resident and/or Resident Representative will be informed prior to the initiation of psychotropic medication. Permission given by or a request made by the Resident and/or Representative does not serve as a sole justification for the medication itself.
7. New admissions admitted to the facility on psychotropic medications will be evaluated by the attending physician in collaboration with the consultant pharmacist to determine the indication for the psychotropic medication and to consider if the medication can be reduced or discontinued upon admission or soon after admission.
8. Prior to the initiation of psychotropic medication or the increase of existing psychotropic medications, the IDT should assess the Resident to rule out possible causes (environmental stressors, psychosocial stressors, treatable medical conditions) and behavioral interventions should be attempted with the response to these interventions documented in the clinical record.
9. Behavior tracking monitoring will be completed and documented for Residents receiving medication to treat behavioral symptoms.
10. All Residents receiving psychotropic medications will be monitored for side effects and appropriate action will be taken upon identification of side effects.
11. All Residents receiving psychotropic medications will have an interdisciplinary plan of care that addresses side effects, potential problems, goals of therapy and behavioral interventions.



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12. GDRs will be completed in accordance with the Centers for Medicare & Medicaid Services (CMS) guidelines. Guidance is as follows: Within the first year in which the Resident is admitted on a psychotropic medication or after the prescribing practitioner has initiated a psychotropic medication, the facility must attempt a GDR in two separate quarters (with at least one month between attempts), unless clinically contraindicated. After the first year, a GDR must be attempted annually, unless clinically contraindicated.
    a. For a resident who is receiving a psychotropic medication to treat expressions or indications of distress related to dementia, the GDR may be considered clinically contraindicated for reasons that include but are not limited to:
        i. The Resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility and;
        ii. The physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the Resident's function or increase distressed behavior.
    b. For any individual who is receiving a psychotropic medication to treat a disorder other than 'expressions or indications of distress' related to dementia (schizophrenia, bipolar disorder, mania, depression with psychotic features, or any other medical conditions, other than dementia), which may cause psychosis, the GDR may be considered clinically contraindicated for reasons that include, but are not limited to:
        i. The continued use is in accordance with the relevant current standards of practice and the physician has documented the clinical rationale for why the attempted dose reduction would be likely to impair the Resident's function or exacerbate an underlying medical or psychiatric disorder; or
        ii. The Resident's target symptom returned or worsened after the most recent attempt at a GDR in the facility and the physician documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the Resident's function or exacerbate an underlying medical or psychotic disorder.
13. Residents do not receive psychotropic drugs pursuant to pro re nata (PRN) orders unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical records; and
    a. A PRN order for psychotropic drugs to include the following classifications: antidepressants, sedative/hypnotics and anti-anxiety are limited to 14 days. If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he/she should document their rationale in the resident's medical record and indicate the duration of the PRN order.
    b. PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. The required evaluation of a resident before the writing of a new PRN order for an anti-psychotic medication is still needed. As part of the evaluation, the attending physician or prescribing practitioner should, at a minimum, determine and document the following in the resident's medical record: *is the antipsychotic medication still needed on a PRN basis? *What is the benefit of the medication to the resident? *Have the resident's expressions or indications of distress improved because of the PRN medication?

Note: A report of the Resident's condition from the facility staff to the attending physician or prescribing practitioner does not constitute an evaluation.

Monitoring and accurate documentation of the Resident's response to any medication(s) is essential to evaluate the ongoing benefits as well as risks of various medications. Monitoring should also include evaluation of the effectiveness on non-pharmacological approaches, such as prior to administering PRN medications.

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# Antipsychotic Medication Use

## Policy Statement

Antipsychotic medications may be considered for residents with dementia but only after medical, physical, functional, psychological, emotional psychiatric, social and environmental causes of behavioral symptoms have been identified and addressed.

Antipsychotic medications will be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and re-review.

## Policy Interpretation and Implementation

1. Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective.

2. The Attending Physician and other staff will gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others.

3. The Attending Physician will identify, evaluate and document, with input from other disciplines and consultants as needed, symptoms that may warrant the use of antipsychotic medications.

4. The Attending Physician and facility staff will identify acute psychiatric episodes, and will differentiate them from enduring psychiatric conditions.

5. Residents who are admitted from the community or transferred from a hospital and who are already receiving antipsychotic medications will be evaluated for the appropriateness and indications for use. The interdisciplinary team will:
   a. Complete PASRR screening (preadmission screening for mentally ill and intellectually disabled individuals), if appropriate; or
   b. Re-evaluate the use of the antipsychotic medication at the time of admission and/or within two weeks (at the initial MDS assessment) to consider whether or not the medication can be reduced, tapered, or discontinued.
   c. Based on assessing the resident's symptoms and overall situation, the Physician will determine whether to continue, adjust, or stop existing antipsychotic medication.

6. Diagnosis of a specific condition for which antipsychotic medications are necessary to treat will be based on a comprehensive assessment of the resident.

7. Antipsychotic medications shall generally be used only for the following conditions/diagnoses as documented in the record, consistent with the definition(s) in the Diagnostic and Statistical Manual of Mental Disorders (current or subsequent editions):
   a. Schizophrenia;
   b. Schizo-affective disorder;
   c. Schizophreniform disorder;
   d. Delusional disorder;
   e. Mood disorders (e.g. bipolar disorder, depression with psychotic features, and treatment refractory major depression);
   f. Psychosis in the absence of dementia;
   g. Medical illnesses with psychotic symptoms and/or treatment-related psychosis or mania (e.g., high-dose steroids);

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h. Tourette's Disorder;
i. Huntington Disease;
j. Hiccups (not induced by other medications); or
k. Nausea and vomiting associated with cancer or chemotherapy.

8. Diagnoses alone do not warrant the use of antipsychotic medication. In addition to the above criteria, antipsychotic medications will generally only be considered if the following conditions are also met:
   a. The behavioral symptoms present a danger to the resident or others; AND:
      (1) The symptoms are identified as being due to mania or psychosis (such as auditory, visual, or other hallucinations; delusions, paranoia or grandiosity); or
      (2) Behavioral interventions have been attempted and included in the plan of care, except in an emergency (see below).

9. In the case of an emergency situation (that is, an acute onset or exacerbation of symptoms or immediate threat to the health or safety of a resident or others) related to one or more of the above conditions or diagnoses, the use of antipsychotic medications must meet following additional requirements:
   a. The acute treatment period is limited to seven days or less; and
   b. A clinician in conjunction with the interdisciplinary team must evaluate and document the situation within 7 days, to identify and address any contributing and underlying causes of the acute psychiatric condition and verify the continuing need for antipsychotic medication; and
   c. Pertinent non-pharmacological interventions must be attempted, unless contraindicated, and documented following the resolution of the acute psychiatric situation.

10. For enduring psychiatric conditions, antipsychotic medications will not be used unless behavioral symptoms are:
    a. Not due to a medical condition or problem (e.g., headache or joint pain, fluid or electrolyte imbalance, pneumonia, hypoxia, unrecognized hearing or visual impairment, medication side effect, or polypharmacy) that can be expected to improve or resolve as the underlying condition is treated or the offending medication(s) are discontinued; and
    b. Persistent or likely to reoccur without continued treatment; and
    c. Not sufficiently relieved by non-pharmacological interventions; and
    d. Not due to environmental stressors (e.g., alteration in the resident's customary location or daily routine, unfamiliar care provider, hunger or thirst, excessive noise for that individual, inadequate or inappropriate staff response, physical barriers) that can be addressed to improve the psychotic symptoms or maintain safety; and
    e. Not due to psychological stressors (e.g., loneliness, taunting, abuse), or anxiety or fear stemming from misunderstanding related to his or her cognitive impairment (e.g., the mistaken belief that this is not where he/she lives or inability to find his or her clothes or glasses) that can be expected to improve or resolve as the situation is addressed.

11. Antipsychotic medications will not be used if the only symptoms are one or more of the following:
    a. Wandering;
    b. Poor self-care;
    c. Restlessness;
    d. Impaired memory;
    e. Mild anxiety;
    f. Insomnia;
    g. Inattention or indifference to surroundings;
    h. Sadness or crying alone that is not related to depression or other psychiatric disorders;
    i. Fidgeting;
    j. Nervousness; or
    k. Uncooperativeness.

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12. All antipsychotic medications will be used within the dosage guidelines listed in F329, or clinical justification will be documented for dosages that exceed the listed guidelines for more than 48 hours.

13. Residents will not receive PRN doses of psychotropic medications unless that medication is necessary to treat a specific condition that is documented in the clinical record.

14. The need to continue PRN orders for psychotropic medications beyond 14 days requires that the practitioner document the rationale for the extended order. The duration of the PRN order will be indicated in the order.

15. PRN orders for antipsychotic medications will not be renewed beyond 14 days unless the healthcare practitioner has evaluated the resident for the appropriateness of that medication.

16. The staff will observe, document, and report to the Attending Physician information regarding the effectiveness of any interventions, including antipsychotic medications.

17. Nursing staff shall monitor for and report any of the following side effects and adverse consequences of antipsychotic medications to the Attending Physician:
    a. General/anticholinergic: constipation, blurred vision, dry mouth, urinary retention, sedation;
    b. Cardiovascular: orthostatic hypotension, arrhythmias;
    c. Metabolic: increase in total cholesterol/triglycerides, unstable or poorly controlled blood sugar, weight gain; or
    d. Neurologic: Akathisia, dystonia, extrapyramidal effects, akinesia; or tardive dyskinesia, stroke or TIA.

18. The Physician shall respond appropriately by changing or stopping problematic doses or medications, or clearly documenting (based on assessing the situation) why the benefits of the medication outweigh the risks or suspected or confirmed adverse consequences.

| References | |
|---|---|
| **OBRA Regulatory Reference Numbers** | §483.45(c) Drug Regimen Review.; §483.45(d) Unnecessary Drugs-General.; §483.45(e) Psychotropic Drugs. |
| **Survey Tag Numbers** | F756; F757; F758 |
| **Other References** | FDA Black Box Warnings for Antipsychotic Medications at http://www.fda.gov/drugs/default.htm |
| **Related Documents** | Tapering Medications and Gradual Drug Dose Reduction |
| **Version** | 1.2 (H5MAPL0062) |

# Behavioral Assessment, Intervention and Monitoring

## Policy Statement

1. The facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care.

2. Behavioral symptoms will be identified using facility-approved behavioral screening tools and the comprehensive assessment.

3. Residents who do not display symptoms of, or have not been diagnosed with, mental, psychiatric, psychosocial adjustment, substance abuse or post-traumatic stress disorder(s) will not develop behavioral disturbances that cannot be attributed to a specific clinical condition that makes the pattern unavoidable.

4. Behavioral health services will be provided by qualified staff who have the competencies and skills necessary to provide appropriate services to the residents.

5. Residents will have minimal complications associated with the management of altered or impaired behavior.

6. The facility will comply with regulatory requirements related to the use of medications to manage behavioral changes.

## Policy Interpretation and Implementation

**General Guidelines**

1. "Behavior" is the response of an individual to a wide variety of factors. These factors may include medical, physical, functional, psychosocial, emotional, psychiatric, or environmental causes.
   a. Behavior is regulated by the brain and is influenced by past experiences, personality traits, environment, and interactions with other people.
   b. Behavior can be a way for an individual in distress to communicate unmet needs, indicate discomfort, or express thoughts that cannot be articulated.

2. "Behavioral or Psychological Symptoms of Dementia (BPSD)" describes behavioral symptoms in individuals with dementia that cannot be attributed to a specific medical or psychiatric cause.
   a. Appropriate assessment and treatment of behavioral symptoms requires differentiating between behavioral symptoms that can be managed by treating underlying factors, and those that cannot.

3. Current guidelines recommend the use of non-pharmacological interventions for BPSD.

**Assessment**

1. As part of the initial assessment, the nursing staff and Attending Physician will identify individuals with a history of impaired cognition, altered behavior, substance use disorder, or mental disorder.
   a. All residents will receive a Level I PASARR screen prior to admission.
   b. If the level I screen indicates that the individual may meet the criteria for a mental disorder, intellectual disability or related condition he or she will be referred to the state PASARR representative for the Level II (evaluation and determination) screening process.
   c. The Level II evaluation report will be used when conducting the resident assessment and developing the care plan.

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2. As part of the comprehensive assessment, staff will evaluate, based on input from the resident, family and caregivers, review of medical record and general observations:
   a. The resident's usual patterns of cognition, mood and behavior;
   b. The resident's usual method of communicating things like pain, hunger, thirst, and other physical discomforts;
   c. The resident's typical or past responses to stress, fatigue, fear, anxiety, frustration and other triggers; and
   d. The resident's previous patterns of coping with stress, anxiety, and depression.

3. The nursing staff will identify, document, and inform the physician about specific details regarding changes in an individual's mental status, behavior, and cognition, including:
   a. Onset, duration, intensity and frequency of behavioral symptoms;
   b. Any recent precipitating or relevant factors or environmental triggers (e.g., medication changes, infection, recent transfer from hospital); and
   c. Appearance and alertness of the resident and related observations.

4. New onset or changes in behavior will be documented regardless of the degree of risk to the resident or others.

5. New onset or changes in behavior that indicate newly evident or possible serious mental disorder, intellectual disability, or a related disorder will be referred for a PASARR Level II evaluation.

6. Current Level II residents will be referred for an additional PASARR Level II evaluation upon a significant change in status assessment.

**Cause Identification**

1. The interdisciplinary team will *thoroughly evaluate* new or changing behavioral symptoms in order to identify underlying causes and address any modifiable factors that may have contributed to the resident's change in condition, including:
   a. Physical or medical changes (for example):
      (1) Infection;
      (2) Dehydration;
      (3) Pain or discomfort;
      (4) Constipation;
      (5) Change related to medications; and/or
      (6) Worsening of or complications related to other conditions.
   b. Emotional, psychiatric and/or psychological stressors (for example):
      (1) Depression;
      (2) Boredom;
      (3) Loneliness;
      (4) Anxiety; and/or
      (5) Fear.
   c. Functional, social or environmental factors (for example):
      (1) Alteration in routine;
      (2) Change in caregivers;
      (3) Sleep disturbances;
      (4) Decline in ability to perform self-care or tasks that he or she could previously complete without help;
      (5) Poor or excessive lighting;
      (6) Noise; and/or
      (7) Uncomfortable temperatures.

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**Management**

1. The interdisciplinary team will evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident, and develop a plan of care accordingly. Safety strategies will be implemented immediately if necessary to protect the resident and others from harm.
   a. Atypical behavior will be differentiated from behavior that is dangerous or problematic for the resident(s) or staff, or behavior that signals underlying distress.
   b. If the behavior is atypical but not problematic or dangerous and the resident does not appear to be in distress, then the IDT will monitor for changes but not necessarily intervene to "normalize" the behavior.

2. The care plan will incorporate findings from the comprehensive assessment and PASARR Level II determinations (as appropriate), and be consistent with current standards of practice.

3. The resident and family or representative will be involved in the development and implementation of the care plan. Resident and family involvement, or attempts to include the resident and family in care planning and treatment, will be documented.

4. The resident and family/representatives will be informed of the resident's condition as well as the potential risks and benefits or proposed interventions.

5. The resident and/or resident surrogate will have the right to refuse treatment.

6. If the resident lacks decision-making capacity and does not have effective family support, the IDT will contact social services to provide assistance to the resident.

7. Interventions will be individualized and part of an overall care environment that supports physical, functional and psychosocial needs, and strives to understand, prevent or relieve the resident's distress or loss of abilities.

8. Interventions and approaches will be based on a detailed assessment of physical, psychological and behavioral symptoms and their underlying causes, as well as the potential situational and environmental reasons for the behavior. The care plan will include, as a minimum:
   a. A description of the behavioral symptoms, including:
      (1) Frequency;
      (2) Intensity;
      (3) Duration;
      (4) Outcomes;
      (5) Location;
      (6) Environment; and
      (7) Precipitating factors or situations.
   b. Targeted and individualized interventions for the behavioral and/or psychosocial symptoms;
   c. The rationale for the interventions and approaches;
   d. Specific and measurable goals for targeted behaviors; and
   e. How the staff will monitor for effectiveness of the interventions.

9. Non-pharmacologic approaches will be utilized to the extent possible to avoid or reduce the use of antipsychotic medications to manage behavioral symptoms.

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10. When medications are prescribed for behavioral symptoms, documentation will include:
    a. Rationale for use;
    b. Potential underlying causes of the behavior;
    c. Other approaches and interventions tried prior to the use of antipsychotic medications;
    d. Potential risks and benefits of medications as discussed with the resident and/or family;
    e. Specific target behaviors and expected outcomes;
    f. Dosage;
    g. Duration;
    h. Monitoring for efficacy and adverse consequences; and
    i. Plans (if applicable) for gradual dose reduction.

11. The Director of Nursing, or designee, will evaluate whether the staffing needs have changed based on acuity of the residents and their plans of care. Additional staff and/or staff training will be provided if it determined that the needs of the residents cannot be met with the current level of staff or staff training.

**Monitoring**

1. If the resident is being treated for altered behavior or mood, the IDT will seek and document any improvements or worsening in the individual's behavior, mood, and function.

2. The IDT will monitor the progress of individuals with impaired cognition and behavior until stable. New or emergent symptoms will be documented and reported.

3. Interventions will be adjusted based on the impact on behavior and other symptoms, including any adverse consequences related to treatment.

4. If antipsychotic medications are used to treat behavioral symptoms, the IDT will monitor their indication and implement a gradual dose reduction, or document why this cannot or should not be done (for example, recurrence of psychotic symptoms after several previous attempts to taper medications).
    a. The IDT will monitor for side effects and complications related to psychoactive medications; for example, lethargy, abnormal involuntary movements, anorexia, or recurrent falling.
    b. If such symptoms are identified, and some medication is still needed, the IDT will adjust the current regimen to try to minimize side effects while maintaining therapeutic effectiveness.

5. If any devices (restraints) are prescribed, the IDT will monitor the situation to ensure that they are beneficial to the individual (for example, enhancing function and improving symptoms) and are not causing complications or disabling the individual.
    a. This will be done frequently when such devices are first employed and regularly thereafter for as long as they are used.
    b. Over time, the staff will reduce the use or remove such devices, or will document why such attempts are not feasible.

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| References | |
|---|---|
| **OBRA Regulatory Reference Numbers** | §483.10(e) Respect and Dignity.; §483.12(a) The facility must-;§483.20(b) Comprehensive Assessments; §483.20(e) Coordination; §483.25(k) Pain Management.; 483.40 Behavioral Health Services; 483.40(b)(3); §483.45(d) Unnecessary Drugs-General.; §483.45(e) Psychotropic Drugs. |
| **Survey Tag Numbers** | F604; F605; F636; F644; F697; F740; F744; F757; F758 |
| **Other References** | |
| **Related Documents** | Antipsychotic Medication<br>Behavioral Health Services<br>Use of Restraints<br>Admission Criteria |
| **Version** | 2.1 (H5MAPL0971) |

# Tapering Medications and Gradual Drug Dose Reduction

## Policy Statement

1. After medications are ordered for a resident, the staff and practitioner shall seek an appropriate dose and duration for each medication that also minimizes the risk of adverse consequences.

2. All medications shall be considered for possible tapering. Tapering that is applicable to antipsychotic medications shall be referred to as gradual dose reduction.

3. Residents who use antipsychotic drugs shall receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

## Policy Interpretation and Implementation

1. Periodically, the staff and practitioner will review the continued relevance of each resident's medications.

2. The Attending Physician and staff will identify target symptoms for which a resident is receiving various medications. The staff will monitor for improvement in those target symptoms, and provide the Physician with that information.

3. The staff and practitioner will consider tapering of medications as one approach to finding an optimal dose or determining whether continued use of a medication is benefiting the resident.

4. The staff and practitioner will consider tapering under certain circumstances, including when:

a. The resident's clinical condition has improved or stabilized;

b. The underlying causes of the original target symptoms have resolved;

c. Non-pharmacological interventions, including behavioral interventions, have been effective in reducing symptoms; or

d. A resident's condition has not responded to treatment or has declined despite treatment.

5. The Physician will review periodically whether current medications are still necessary in their current doses; for example, whether an individual's conditions or risk factors are sufficiently prominent or enduring that they require medication therapy to continue in the current dose, or whether those conditions and risks could potentially be equally well managed or controlled without certain medications, or with a lower dose.

6. The Physician will order appropriate tapering of medications, as indicated.

7. The time frames and duration of tapering attempts should be based on relevant factors including other medications that the resident is taking, underlying causes of symptoms, individual risk factors, and pharmacologic characteristics of the medications. Some medications (e.g., antidepressants, sedative/hypnotics, opioids) may need more gradual tapering in order to minimize withdrawal symptoms or other adverse consequences.

8. When a medication is tapered or stopped, the staff will closely monitor the resident and will inform the Physician if there is a return or worsening of symptoms.

9. When a medication is tapered or stopped, the staff and practitioner shall document the rationale for any decisions to restart a medication or reverse a dose reduction; for example, because of a return of clinically significant symptoms.

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10. Residents who use antipsychotic drugs shall receive gradual dose reductions, unless clinically contraindicated, in an effort to discontinue the use of such drugs. Pertinent behavioral interventions will also be attempted. (*Behavioral interventions* refer to non-pharmacological attempts to influence an individual's behavior, including environmental alterations and staff approaches to care.)

11. Within the first year after a resident is admitted on an antipsychotic medication or after the resident has been started on an antipsychotic medication, the staff and practitioner shall attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, the facility shall attempt a GDR at least annually, unless clinically contraindicated.

12. For any individual who is receiving an antipsychotic medication to treat behavioral symptoms related to dementia, the GDR may be considered clinically contraindicated if:

a. The resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility; and

b. The physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or increase distressed behavior.

13. For any individual who is receiving an antipsychotic medication to treat a psychiatric disorder other than behavioral symptoms related to dementia (for example, schizophrenia, bipolar mania, or depression with psychotic features), the GDR may be considered contraindicated, if:

a. The continued use is in accordance with relevant current standards of practice and the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying psychiatric disorder; or

b. The resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility and the physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder.

14. Attempted tapering of sedatives and hypnotics shall be considered as a way to demonstrate whether the resident is benefiting from a medication or might benefit from a lower or less frequent dose. Tapering shall be done consistent with the following:

a. For as long as a resident remains on a sedative/hypnotic that is used routinely and beyond the manufacturer's recommendations for duration of use, the physician shall attempt to taper the medication at least quarterly unless clinically contraindicated. Clinically contraindicated means:

    (1) The continued use is in accordance with relevant current standards of practice and the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder; or

    (2) The resident's target symptoms returned or worsened after the most recent attempt at tapering the dose within the facility and the physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder.

15. Attempted tapering of psychopharmacologic medications other than antipsychotics or sedatives and hypnotics shall be considered as a way to demonstrate whether the resident is benefiting from a medication or might benefit from a lower or less frequent dose. Tapering shall be done consistent with the following:

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a. 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 will attempt to

taper the medication during at least two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, tapering will be attempted at least annually, unless clinically contraindicated. The tapering may be considered clinically contraindicated, if:

(1) The continued use is in accordance with relevant current standards of practice and the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder; or

(2) The resident's target symptoms returned or worsened after the most recent attempt at tapering the dose within the facility and the physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder.



| References | |
|---|---|
| **OBRA Regulatory Reference Numbers** | §483.45(c) Drug Regimen Review.; §483.45(d) Unnecessary Drugs-General.; §483.45(e) Psychotropic Drugs. |
| **Survey Tag Numbers** | F756; F757; F758 |
| **Other References** | |
| **Related Documents** | Antipsychotic Medication Use |
| **Version** | 1.1 (H5MAPL0226) |

# Tab Two
## Assessments

# Pain Assessment and Management Program (PAMP) Implementation

## Skilled Nursing Facility (SNF) PAMP Assessment

Facility Name: _____ CCN: _____

Assessment Date: _____ Completed by: _____

*Work with your interdisciplinary leadership team to complete the following assessment. Each item relates to PAMP elements that should be in place for a successful PAMP in your facility. The PAMP assessment is supported by published evidence and best practices including but not limited to the Centers for Disease Control and Prevention (CDC), Department of Health and Human Services (HHS), the Joint Commission, National Quality Forum (NQF), Institute for Healthcare Improvement (IHI), and state government recommendations. Select one of the implementation status options on the right for each assessment item. Once this form is complete, please go online and enter your answers.*

| Assessment Items | Not Implemented/No Plan | Plan to Implement/No Start Date Set | Plant to Implement/Start Date Set | In Place Less than Six Months | In Place Six Months or More |
|---|---|---|---|---|---|
| **Commitment** | | | | | |
| 1. A facility-wide leadership team is in place with representatives from various departments and disciplines – including administrators, nursing, activities, social services, and medical director – who are responsible for pain management and safe opioid practices. [i] | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. The medical director/nurse practitioner/physician assistant of your facility are required to review the Prescription Drug Monitoring Program (PDMP) database prior to prescribing or renewing opioids. [ii] | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. Your facility uses screening tools to identify residents who are or may have been at risk for opioid use disorder (OUD). [iii] | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Action** | | | | | |
| 4. Your facility has defined criteria to screen, assess, and reassess pain that is consistent with the patient's age, condition, and ability to understand. [iv] | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5. Your facility reassesses/responds to the resident's pain through the following:<br>a. Evaluation and documentation of response(s) to pain intervention(s). | ☐ | ☐ | ☐ | ☐ | ☐ |

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| Assessment Items | Not Implemented/No Plan | Plan to Implement/No Start Date Set | Plant to Implement/Start Date Set | In Place Less than Six Months | In Place Six Months or More |
|---|---|---|---|---|---|
| b. Progress toward pain management goals including functional ability. | ☐ | ☐ | ☐ | ☐ | ☐ |
| c. Side effects of treatment. | ☐ | ☐ | ☐ | ☐ | ☐ |
| d. Risk factors for adverse events caused by the treatment. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 6. Your facility offers residents nonpharmacological ways to manage their pain. [v] | ☐ | ☐ | ☐ | ☐ | ☐ |
| 7. When opioids are used, your facility combines them with nonpharmacologic and nonopioid therapies (e.g., massage, acupuncture, mindfulness, hypnosis, music therapy, or cognitive behavioral therapy). [vi] | ☐ | ☐ | ☐ | ☐ | ☐ |
| 8. Your facility consistently refers residents to clinics that offer medication-assisted treatment (MAT) in combination with behavioral therapies for OUD. [vii] | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Track and Report** | | | | | |
| 9. Your facility tracks opioid usage in some way (e.g., performance improvement project [PIP], on Quality Assurance & Performance Improvement [QAPI] agenda, written or electronic dashboard, pharmacy reports, prescriber reports reflecting morphine milligram equivalent [MME] prescribed, electronic health record [EHR] alerts, and concomitant prescribing of benzodiazepines and opioids). [viii] | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Education and Expertise** | | | | | |
| 10. Your facility provides staff and providers with ongoing education to improve:<br>a. Pain assessment | ☐ | ☐ | ☐ | ☐ | ☐ |
| b. Pain management | ☐ | ☐ | ☐ | ☐ | ☐ |
| c. The safe use of opioids based upon clinical need. | ☐ | ☐ | ☐ | ☐ | ☐ |
| d. Naloxone administration [ix] | ☐ | ☐ | ☐ | ☐ | ☐ |
| 11. Your facility provides education regarding pain management, pain treatment plans, and the safe use of opioid medications to residents, families, and caregivers. [x] | ☐ | ☐ | ☐ | ☐ | ☐ |

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## Open Response

1. What do you believe is going well in your organization related to opioid stewardship (please provide any tools you are using)?

2. What are some of the barriers you are facing with your opioid stewardship?

3. What are your organizational goals surrounding opioid stewardship?

i. **Rationale:** The long-term care setting is an expanding sector of health care, serving populations with diverse and complex pain management needs including post-acute, long-term care needs, and recovery after an opioid-related hospitalization. Opioids are one of the leading causes of preventable ADEs in SNFs. Inconsistent evaluation of pain treatment effectiveness, including opioid treatment by prescribers, has been identified as an issue by Joint Commission stakeholders and in current literature. This inconsistency in the quality-of-care calls for the medical director's oversight of pain management and responsible opioid prescribing.

**Reference:** *https://www.jointcommission.org/assets/1/18/3_21_Pain_standards_NCC_12_21_18_FINAL.pdf
https://store.qualityforum.org/products/national-quality-partners-playbook%E2%84%A2-opioid-stewardship

ii. **Rationale:** Clinicians should review the patient's history of controlled substance prescriptions through PDMP review to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. EHRs should integrate PDMPs to eliminate barriers to accessing PDMP data, especially when these data points are mandated.

**Reference:** https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6501e1.pdf
https://www.hhs.gov/sites/default/files/pain-mgmt-best-practices-draft-final-report-05062019.pdf

iii. **Rationale:** Risk stratification can aid in determining appropriate treatments for the best clinical outcomes.

**Reference:** https://www.hhs.gov/sites/default/files/pain-mgmt-best-practices-draft-final-report-05062019.pdf
*https://store.qualityforum.org/products/national-quality-partners-playbook%E2%84%A2-opioid-stewardship
*https://www.mbc.ca.gov/Licensees/Prescribing/Pain_Guidelines.pdf

iv. **Rationale:** Current literature stresses the importance of an evidence-based approach to pain assessment and reassessment, which includes assessing how pain affects the patient's function. The organization has flexibility in choosing screening and assessment tools. Ideally, the tools will meet the needs of the patient population. For example, chronic pain generally requires more extensive patient/resident assessment, including various domains of physical and functional impairment. Unidimensional reassessment based on pain intensity rating alone is inadequate.

**Reference:** *https://www.jointcommission.org/assets/1/18/3_21_Pain_standards_NCC_12_21_18_FINAL.pdf
https://geriatricpain.org/clinicians/pain-assessment-information
https://www.azdhs.gov/documents/audiences/clinicians/clinical-guidelines-recommendations/prescribing-guidelines/az-opioid-prescribing-guidelines.pdf

v. **Rationale:** Alternatives to Opioids (ALTO) is an evidence-based, multi-modal, nonopioid approach for the management of acute and chronic pain for specific conditions as well as opioid addiction and abuse. Nonpharmacologic and nonopioid therapies are preferred for chronic pain. Although specific evidence on the effectiveness of nonpharmacologic therapies in long-term care populations is still needed, existing evidence suggests that nonpharmacologic therapies can be effective in managing acute and chronic pain among older adults. The leadership team should work with clinician leaders to determine which nonpharmacologic therapies should be available.

**Reference:** *https://www.jointcommission.org/assets/1/18/3_21_Pain_standards_NCC_12_21_18_FINAL.pdf
https://geriatricpain.org/pain-management-interventions
https://cha.com/opioid-safety/colorado-alto-project/

vi. **Rationale:** Nonpharmacologic and nonopioid therapies are preferred for chronic pain.

**Reference:** https://www.cdc.gov/drugoverdose/pdf/prescribing/CDC-DUIP-QualityImprovementAndCareCoordination-508.pdf
https://www.azdhs.gov/documents/audiences/clinicians/clinical-guidelines-recommendations/prescribing-guidelines/az-opioid-prescribing-guidelines.pdf
*https://www.mbc.ca.gov/licensees/prescribing/pain_guidelines.pdf
*https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/SACB/CDPH%20Document%20Library/Prescription%20Drug%20Overdose%20Program/PrescribingGuidelines4.26. 17Compliant.pdf

vii. **Rationale:** Referral to specialty substance use disorder treatment is recommended for patients with substance use disorder. Access to substance use disorder treatment is variable, and decisions about treatment referrals should take local resources and patient preferences into account.

**Reference:** https://store.samhsa.gov/product/Advisory-Sublingual-and-Transmucosal-Buprenorphine-for-Opioid-Use-Disorder-/SMA16-4938?referer=from_search_result

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*https://www.azdhs.gov/documents/audiences/clinicians/clinical-guidelines-recommendations/prescribing-guidelines/hospital-discharge-opioids.pdf https://www.chcf.org/collection/medication-assisted-treatment-for-opioid-use-disorder/

viii. **Rationale:** Opioids are one of the leading causes of preventable ADEs in long-term care facilities. Analysis of data related to adverse events and development of prevention strategies are necessary to increase quality and safety of patient/resident care. Dashboards measure the extent to which providers adhere to policies and allow providers to see how their patients and their implementation of specific clinical practices compare to their colleagues. EHR templates and fields should be incorporated in the clinical workflow and auto-populated to the extent possible to facilitate consistent use and to support standards of practice.

**Reference:** https://www.cdc.gov/drugoverdose/pdf/prescribing/CDC-DUIP-QualityImprovementAndCareCoordination-508.pdf
https://www.healthit.gov/sites/default/files/2018-12/CDSSession.pdf
*https://www.jointcommission.org/assets/1/18/3_21_Pain_standards_NCC_12_21_18_FINAL.pdf
https://www.azdhs.gov/documents/audiences/clinicians/clinical-guidelines-recommendations/prescribing-guidelines/hospital-discharge-opioids.pdf
*https://www.mbc.ca.gov/licensees/prescribing/pain_guidelines.pdf
*https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/SACB/CDPH%20Document%20Library/Prescription%20Drug%20Overdose%20Program/PrescribingGuidelines4.26. 17Compliant.pdf

ix. **Rationale:** A high proportion of patients and residents in long-term care facilities experience pain, and many have comorbid conditions such as cognitive impairment and disability that make the task of pain management especially difficult. The organization can increase staff and practitioner competence in pain management by providing access to evidence-based educational resources.

**Reference:** *https://www.jointcommission.org/assets/1/18/3_21_Pain_standards_NCC_12_21_18_FINAL.pdf
*https://store.qualityforum.org/products/national-quality-partners-playbook%E2%84%A2-opioid-stewardship
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4057040/pdf/nihms585966.pdf
https://www.azdhs.gov/documents/audiences/clinicians/clinical-guidelines-recommendations/prescribing-guidelines/az-opioid-prescribing-guidelines.pdf
*https://www.mbc.ca.gov/licensees/prescribing/pain_guidelines.pdf
*https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/SACB/CDPH%20Document%20Library/Prescription%20Drug%20Overdose%20Program/PrescribingGuidelines4.26. 17Compliant.pdf

x. **Rationale:** Patient involvement in pain management planning involves information sharing and collaboration between the patient and the care team, allows the team to clarify objectives, and guides the patient in a manner that can increase treatment adherence. It is important to identify domains of function or quality of life issues that the patient/resident values and prioritize improvement in these areas to increase satisfaction with treatment progress.

**Reference:** *https://www.jointcommission.org/assets/1/18/3_21_Pain_standards_NCC_12_21_18_FINAL.pdf
*https://store.qualityforum.org/products/national-quality-partners-playbook%E2%84%A2-opioid-stewardship
https://www.azdhs.gov/documents/audiences/clinicians/clinical-guidelines-recommendations/prescribing-guidelines/az-opioid-prescribing-guidelines.pdf
*https://www.mbc.ca.gov/licensees/prescribing/pain_guidelines.pdf
*https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/SACB/CDPH%20Document%20Library/Prescription%20Drug%20Overdose%20Program/PrescribingGuidelines4.26. 17Compliant.pdf

# Pain Assessment and Documentation Tool

## Introduction

**The Pain Assessment and Documentation Tool (PADT) is a two-sided chart note designed to be easily included in a patient's medical record and to facilitate ongoing evaluation of patient pain and documentation of pain management. The PADT is intended to be administered by a clinician and includes sections to assess pain-related outcomes in four areas: analgesia, activities of daily living, adverse events (i.e., side effects), and aberrant drug-related behavior.**

# Progress Note
## Pain Assessment and Documentation Tool (PADT™)

**Patient Name:** _____ **Record #:**_____

**Assessment Date:** _____

**Patient Stamp Here**

**Current Analgesic Regimen**

| Drug Name | Strength (eg, mg) | Frequency | Maximum Total Daily Dose |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**The PADT is a clinician-directed interview; that is, the clinician asks the questions, and the clinician records the responses. The Analgesia, Activities of Daily Living, and Adverse Events sections may be completed by the physician, nurse practitioner, physician assistant, or nurse. The Potential Aberrant Drug-Related Behavior and Assessment sections must be completed by the physician. Ask the patient the questions below, except as noted.**

### Analgesia

**If zero indicates "no pain" and ten indicates "pain as bad as it can be," on a scale of 0 to 10, what is your level of pain for the following questions?**

**1. What was your pain level on average during the past week? (Please circle the appropriate number)**

**No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it can be**

**2. What was your pain level at its worst during the past week?**

**No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it can be**

**3. What percentage of your pain has been relieved during the past week? (Write in a percentage between 0% and 100%.)**

**_____**

**4. Is the amount of pain relief you are now obtaining from your current pain reliever(s) enough to make a real difference in your life?**

☐ **Yes** ☐ **No**

**5. Query to clinician: Is the patient's pain relief clinically significant?**

☐ **Yes** ☐ **No** ☐ **Unsure**

### Activities of Daily Living

**Please indicate whether the patient's functioning with the current pain reliever(s) is Better, the Same, or Worse since the patient's last assessment with the PADT.* (Please check the box for Better, Same, or Worse for each item below.)**

| | Better | Same | Worse |
|---|---|---|---|
| **1. Physical functioning** | ☐ | ☐ | ☐ |
| **2. Family relationships** | ☐ | ☐ | ☐ |
| **3. Social relationships** | ☐ | ☐ | ☐ |
| **4. Mood** | ☐ | ☐ | ☐ |
| **5. Sleep patterns** | ☐ | ☐ | ☐ |
| **6. Overall functioning** | ☐ | ☐ | ☐ |

***If the patient is receiving his or her first PADT assessment, the clinician should compare the patient's functional status with other reports from the last office visit.**



(Continued on reverse side)

# Progress Note

## Pain Assessment and Documentation Tool (PADT™)

### Adverse Events

**1. Is patient experiencing any side effects from current pain reliever?** ☐ Yes ☐ No

**Ask patient about potential side effects:**

| | None | Mild | Moderate | Severe |
|---|---|---|---|---|
| a. Nausea | ☐ | ☐ | ☐ | ☐ |
| b. Vomiting | ☐ | ☐ | ☐ | ☐ |
| c. Constipation | ☐ | ☐ | ☐ | ☐ |
| d. Itching | ☐ | ☐ | ☐ | ☐ |
| e. Mental cloudiness | ☐ | ☐ | ☐ | ☐ |
| f. Sweating | ☐ | ☐ | ☐ | ☐ |
| g. Fatigue | ☐ | ☐ | ☐ | ☐ |
| h. Drowsiness | ☐ | ☐ | ☐ | ☐ |
| i. Other_____ | | ☐ | ☐ | ☐ |
| j. Other_____ | | ☐ | ☐ | ☐ |

### Potential Aberrant Drug-Related Behavior

**This section must be completed by the physician**

***Please check any of the following items that you discovered during your interactions with the patient. Please note that some of these are directly observable (eg, appears intoxicated), while others may require more active listening and/or probing. Use the "Assessment" section below to note additional details.***

- ☐ Purposeful over-sedation
- ☐ Negative mood change
- ☐ Appears intoxicated
- ☐ Increasingly unkempt or impaired
- ☐ Involvement in car or other accident
- ☐ Requests frequent early renewals
- ☐ Increased dose without authorization
- ☐ Reports lost or stolen prescriptions
- ☐ Attempts to obtain prescriptions from other doctors
- ☐ Changes route of administration
- ☐ Uses pain medication in response to situational stressor
- ☐ Insists on certain medications by name
- ☐ Contact with street drug culture
- ☐ Abusing alcohol or illicit drugs
- ☐ Hoarding (ie, stockpiling) of medication
- ☐ Arrested by police
- ☐ Victim of abuse
- ☐ Other: _____

_____

_____

**2. Patient's overall severity of side effects?**

☐ None ☐ Mild ☐ Moderate ☐ Severe

**Assessment: (This section must be completed by the physician.)**

**Is your overall impression that this patient is benefiting (eg, benefits, such as pain relief, outweigh side effects) from opioid therapy?** ☐ Yes ☐ No ☐ Unsure

**Comments:** _____

_____

### Specific Analgesic Plan:

**Comments:**_____

- ☐ Continue present regimen
- ☐ Adjust dose of present analgesic
- ☐ Switch analgesics
- ☐ Add/Adjust concomitant therapy
- ☐ Discontinue/taper off opioid therapy

**Date:**_____ **Physician Signature:** _____

**Provided as a service to the medical community by Janssen Pharmaceutica Products, L.P.**

# PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE: _____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
*(use "✓" to indicate your answer)*

| | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| **1.** Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| **2.** Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| **3.** Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| **4.** Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| **5.** Poor appetite or overeating | 0 | 1 | 2 | 3 |
| **6.** Feeling bad about yourself—or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| **7.** Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| **8.** Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| **9.** Thoughts that you would be better off dead, or of hurting yourself | 0 | 1 | 2 | 3 |
| add columns | | + | + | |

*(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).* TOTAL:

**10.** If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____



A2663B 10-04-2005

# PHQ-9 Patient Depression Questionnaire

**For initial diagnosis:**

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

***Consider Major Depressive Disorder***

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

***Consider Other Depressive Disorder***

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

**Note:** Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.
Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

**To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:**

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

**Scoring: add up all checked boxes on PHQ-9**

**For every** ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

**Interpretation of Total Score**

| | **Depression Severity** |
|---|---|
| 1-4 | Minimal depression |
| 5-9 | Mild depression |
| 10-14 | Moderate depression |
| 15-19 | Moderately severe depression |
| 20-27 | Severe depression |



A2662B 10-04-2005

# Pain Assessment in Advanced Dementia Scale (PAINAD)

## Instructions

Observe the patient for five minutes before scoring his or her behaviors. Score the behaviors according to the following chart. Definitions of each item are provided on the following page. The patient can be observed under different conditions (e.g., at rest, during a pleasant activity, during caregiving, after the administration of pain medication).

| Behavior | 0 | 1 | 2 | Score |
|---|---|---|---|---|
| Breathing (independent of vocalization) | Normal | • Occasional labored breathing<br>• Short period of hyperventilation | • Noisy, labored breathing<br>• Long period of hyperventilation<br>• Cheyne-Stokes respirations | |
| Negative vocalization | None | • Occasional moan or groan<br>• Low-level speech with a negative or disapproving quality | • Repeated troubled calling out<br>• Loud moaning or groaning<br>• Crying | |
| Facial expression | Smiling or inexpressive | • Sad<br>• Frightened<br>• Frown | • Facial grimacing | |
| Body language | Relaxed | • Tense<br>• Distressed pacing<br>• Fidgeting | • Rigid<br>• Fists clenched<br>• Knees pulled up<br>• Pulling or pushing away<br>• Striking out | |
| Consolability | No need to console | Distracted or reassured by voice or touch | Unable to console, distract, or reassure | |
| | | | **TOTAL SCORE** | |

## Scoring

The total score ranges from 0-10 points. A possible interpretation of the scores is: 1-3=mild pain; 4-6=moderate pain; 7-10=severe pain. These ranges are based on a standard 0-10 scale of pain but have not been substantiated in the literature for this tool.

## Source

Warden V, Hurley AC, Volicer L. Development and psychometric evaluation of the Pain Assessment in Advanced Dementia (PAINAD) scale. J Am Med Dir Assoc. 2003;4(1):9-15.

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# PAINAD Item Definitions

(Warden et al., 2003)

## Breathing

1. Normal breathing is characterized by effortless, quiet, rhythmic (smooth) respirations.
2. Occasional labored breathing is characterized by episodic bursts of harsh, difficult, or wearing respirations.
3. Short period of hyperventilation is characterized by intervals of rapid, deep breaths lasting a short period of time.
4. Noisy labored breathing is characterized by negative-sounding respirations on inspiration or expiration. They may be loud, gurgling, wheezing. They appear strenuous or wearing.
5. Long period of hyperventilation is characterized by an excessive rate and depth of respirations lasting a considerable time.
6. Cheyne-Stokes respirations are characterized by rhythmic waxing and waning of breathing from very deep to shallow respirations with periods of apnea (cessation of breathing).

## Negative Vocalization

1. None is characterized by speech or vocalization that has a neutral or pleasant quality.
2. Occasional moan or groan is characterized by mournful or murmuring sounds, wails, or laments. Groaning is characterized by louder than usual inarticulate involuntary sounds, often abruptly beginning and ending.
3. Low level speech with a negative or disapproving quality is characterized by muttering, mumbling, whining, grumbling, or swearing in a low volume with a complaining, sarcastic, or caustic tone.
4. Repeated troubled calling out is characterized by phrases or words being used over and over in a tone that suggests anxiety, uneasiness, or distress.
5. Loud moaning or groaning is characterized by mournful or murmuring sounds, wails, or laments in much louder than usual volume. Loud groaning is characterized by louder than usual inarticulate involuntary sounds, often abruptly beginning and ending.
6. Crying is characterized by an utterance of emotion accompanied by tears. There may be sobbing or quiet weeping.

## Facial Expression

1. Smiling or inexpressive. Smiling is characterized by upturned corners of the mouth, brightening of the eyes, and a look of pleasure or contentment. Inexpressive refers to a neutral, at ease, relaxed, or blank look.
2. Sad is characterized by an unhappy, lonesome, sorrowful, or dejected look. There may be tears in the eyes.
3. Frightened is characterized by a look of fear, alarm, or heightened anxiety. Eyes appear wide open.
4. Frown is characterized by a downward turn of the corners of the mouth. Increased facial wrinkling in the forehead and around the mouth may appear.
5. Facial grimacing is characterized by a distorted, distressed look. The brow is more wrinkled, as is the area around the mouth. Eyes may be squeezed shut.

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**Body Language**

1. Relaxed is characterized by a calm, restful, mellow appearance. The person seems to be taking it easy.
2. Tense is characterized by a strained, apprehensive, or worried appearance. The jaw may be clenched. (Exclude any contractures.)
3. Distressed pacing is characterized by activity that seems unsettled. There may be a fearful, worried, or disturbed element present. The rate may be faster or slower.
4. Fidgeting is characterized by restless movement. Squirming about or wiggling in the chair may occur. The person might be hitching a chair across the room. Repetitive touching, tugging, or rubbing body parts can also be observed.
5. Rigid is characterized by stiffening of the body. The arms and/or legs are tight and inflexible. The trunk may appear straight and unyielding. (Exclude any contractures.)
6. Fists clenched is characterized by tightly closed hands. They may be opened and closed repeatedly or held tightly shut.
7. Knees pulled up is characterized by flexing the legs and drawing the knees up toward the chest. An overall troubled appearance. (Exclude any contractures.)
8. Pulling or pushing away is characterized by resistiveness upon approach or to care. The person is trying to escape by yanking or wrenching him- or herself free or shoving you away.
9. Striking out is characterized by hitting, kicking, grabbing, punching, biting, or other form of personal assault.

**Consolability**

1. No need to console is characterized by a sense of well-being. The person appears content.
2. Distracted or reassured by voice or touch is characterized by a disruption in the behavior when the person is spoken to or touched. The behavior stops during the period of interaction, with no indication that the person is at all distressed.
3. Unable to console, distract, or reassure is characterized by the inability to soothe the person or stop a behavior with words or actions. No amount of comforting, verbal or physical, will alleviate the behavior.

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# Adverse Drug Event Trigger Tool

## Intended Use of This Tool:

This tool is intended to assist surveyors to identify:

1. The extent to which facilities have identified resident-specific risk factors for adverse drug events,
2. The extent to which facilities developed and implemented systems and processes to minimize risks associated with medications that are known to be high-risk and problem-prone, and
3. When a preventable adverse event has occurred and evaluate if the nursing home identified the issue and responded appropriately to mitigate harm to the individual and prevent recurrence.

## Definition:

- **Adverse Event:** An untoward, undesirable, and usually unanticipated event that causes death, serious injury, harm, or the risk thereof.
- **Adverse Drug Event:** An injury resulting from drug-related medical interventions.
- **Adverse Drug Reaction:** Harm directly caused by a drug at normal doses.
- **Anticholinergic Effects:** Physical symptoms resulting from drugs that counter the action of acetylcholine including increased blood pressure, respiratory distress, clumsiness/unsteadiness, bloating/constipation/ileus, nausea/vomiting, dry mouth, delirium, drowsiness/lethargy/fatigue, urinary retention, hallucinations, memory problems, and blurred vision.
- **Prescribing Cascade:** Adverse reaction to one drug that goes unrecognized or is misinterpreted resulting in the prescriber inappropriately prescribing a subsequent drug to treat the signs/symptoms of the adverse reaction.
- **Polypharmacy:** Multiple definitions exist, but most include reference to drugs without indication and the number of medications used (e.g., more than 10).
- **Risk Factor:** Issue or condition that increases the potential for an adverse event to occur. Risk factors include resident level issues such as medications prescribed, age, and concurrent conditions as well as system level issues such as lack of staff knowledge related to high-risk medications and unclear protocols to address lab results.

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| **Adverse Drug Event (ADE)** | **Risk Factors -** These increase the potential for ADEs. Multiple factors increase risk. | **Triggers: Signs and Symptoms (S/S) -** Any of these may indicate an ADE may have occurred. | **Triggers: Clinical Interventions -** These actions may indicate an ADE occurred. | **Surveyor Probes -** These questions are designed to assist in the investigation. A negative answer does not necessarily indicate noncompliance. |
|---|---|---|---|---|
| Change in mental status/delirium related to opioid use | • PRN or routine use of opioid medication<br>• Opioid naiveté (someone who has not been taking opioids)<br>• Opioids used in combination with sedatives or other opioids<br>• History of opioid abuse<br>• Opioid tolerance<br>• Severe pain<br>• Low fluid intake/dehydration<br>• Low body weight<br>• History of head injury, traumatic brain injury, or seizures | • Falls<br>• Hallucinations<br>• Delusions<br>• Disorientation or confusion<br>• Light-headedness, dizziness, or vertigo<br>• Lethargy or somnolence<br>• Agitation<br>• Anxiety<br>• Unresponsiveness<br>• Decreased<br>  ○ BP<br>  ○ Pulse<br>  ○ Pulse oximetry<br>  ○ Respirations | • Administration of Narcan<br>• Transfer to hospital<br>• Call to physician regarding new onset of relevant signs or symptoms<br>• Abrupt stop order for medication | • Is there an assessment and determination of pain etiology?<br>• Does the resident's pain management regimen address the underlying etiology?<br>• For a change in mental status, is there evidence that the physician conducted an evaluation of the underlying cause, including medications?<br>• Is there evidence of a system for ensuring that residents are routinely assessed for pain, including monitoring for effectiveness of pain relief and side effects of medication (e.g., over-sedation)?<br>• Is there consideration for the timing of administration of the PRN?<br>• Can staff describe signs/symptoms of over-sedation?<br>• Is there evidence of a system for ensuring "hand off" communication includes the resident's pain status and time of last dose?<br>• Do the resident, family, and direct caregivers know signs and symptoms of over-sedation and steps to take if noted (e.g., alert the nurse)?<br>• Is there evidence the facility implements non-pharmacological pain management approaches?<br>• Is there a system to ensure extended-release formulations are delivered correctly (e.g., medications not crushed)? |

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| Change in mental status/delirium related to psychotropic medication use (including antipsychotics, antidepressants, anxiolytics, and hypnotics) | • PRN or routine use of psychotropic medication<br>• Use of more than one psychotropic medication including more than one drug from the same class or different classes<br>• Advanced age<br>• Polypharmacy | • Falls<br>• Confusion<br>• Sedation<br>• Cardiac arrhythmias<br>• Orthostatic hypotension<br>• Destabilized blood sugar<br>• Akathisia<br>• Parkinsonism<br>• Anticholinergic effects | • Transfer to hospital<br>• Call to physician regarding new onset of relevant signs or symptoms<br>• New order for restraint<br>• Abrupt stop order for medication | • Does the medical record include consistent documentation of clinical indication, e.g., do physician notes, care plan, and tracking sheets all address the same indication?<br>• If receiving PRN and routinely, is there consideration for the timing of administration of the PRN?<br>• Is there evidence of a system for ensuring the resident is routinely assessed for effectiveness of the medication and signs/symptoms of adverse drug reactions/events?<br>• Is there a system for monitoring for involuntary movements?<br>• Is there evidence that the facility has attempted gradual dose reduction or rationale documented if not attempted?<br>• Is there evidence the facility implements non-pharmacological approaches and interdisciplinary management of the condition that the medication targets?<br>• Is there evidence in the medical record that the resident or representative were involved in decisions related to medication use?<br>• Is there a system to ensure extended-release formulations are delivered correctly (e.g., medications not crushed)? |
| Hypoglycemia related to use of anti-diabetic medication | • Insulin use<br>• Sliding scale insulin use<br>• Oral hypoglycemic medication use<br>• Decrease in oral intake while taking anti-diabetic medication | • Hypoglycemia (e.g., <50 mg/dl)<br>• Falls<br>• Headache<br>• Shakiness, nervousness, anxiety<br>• Sweating, chills, clamminess<br>• Irritability, impatience<br>• Change in mental status<br>• Emotional changes | • Stat administration of Glucagon or IV dextrose<br>• Administration of orange juice or other high sugar food or fluids in response to blood sugar reading or symptoms | • Does the care plan reflect interdisciplinary monitoring for:<br>  ○ Signs/symptoms of hypoglycemic episodes?<br>  ○ Changes in oral intake?<br>• Is there evidence blood glucose testing and insulin administration are coordinated with meals?<br>• Is there evidence the facility has addressed any pharmacy recommendations?<br>• If sliding scale insulin is used, does the medical record contain documentation of risk vs. benefits? Clinical rationale?<br>• If an EHR is used, are finger stick glucose testing results incorporated into it? |

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| Hypoglycemia related to use of anti-diabetic medication (cont.) | | • (including new anger, sadness, stubbornness)<br>• Lightheadedness, dizziness<br>• Hunger<br>• Nausea<br>• Complaints of blurred or impaired vision<br>• Tingling or numbness in lips and/or tongue<br>• Weakness, fatigue, or somnolence<br>• Incoordination<br>• Seizures<br>• Unconsciousness<br>• Rapid heartbeat | • Transfer to hospital | • Is there evidence that finger stick glucose results are routinely reviewed for effectiveness as part of the care plan?<br>• Is there evidence that the facility routinely educates caregivers on risk factors and symptoms/signs of hypoglycemia?<br>• Is the resident and family educated regarding the signs and symptoms of hypoglycemia and regarding the resident's diabetes management plan<br>• Does the facility have low blood sugar protocols in place?<br>• Is there a system to ensure lab results, including finger stick blood glucose results, are appropriately communicated to the physician and the dietician including when panic values are obtained?<br>• Is there evidence that glucose monitoring equipment is maintained and that staff technique meets standards of practice. |
| Ketoacidosis related to insulin therapy | • Diabetic residents with concurrent illnesses<br>• Infection<br>• Diabetic residents with consistently high blood glucose levels<br>• Episodes of high physical and/or emotional stress or trauma<br>• A diabetic resident that frequently declines antidiabetic medications or consumes foods not included in diet | • Nausea/vomiting<br>• Abdominal pain<br>• Weakness/fatigue<br>• Shortness of breath<br>• Fruity-scented breath<br>• Confusion<br>• Rapid respirations<br>• Elevated temperature | • Stat order for lab testing including to evaluate blood sugar and fluid and electrolyte status<br>• Stat order for insulin<br>• New order for and administration of IV fluids<br>• Transfer to hospital | • Is there evidence of a system for routine monitoring of blood sugar?<br>• If the resident refuses antidiabetic medication or consumes foods not included in usual/planned diet, is there evidence of an interdisciplinary plan to address refusals that includes the prescriber and the family, as appropriate?<br>• For residents with risk factors for ketoacidosis, does the care plan reflect multi-disciplinary monitoring for signs/symptoms of ketoacidosis?<br>• Is there evidence that the facility routinely educates caregivers on risk factors and symptoms/signs of ketoacidosis?<br>• Does the facility have elevated blood sugar protocols in place?<br>• If sliding scale insulin is used, does the medical record contain documentation of risk vs. benefits? Clinical rationale?<br>• Is there a system to ensure lab results, including finger stick results, are appropriately |

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| Ketoacidosis related to insulin therapy (cont.) | | | | communicated to the physician and the dietician including when panic values are obtained? |
| Bleeding related to antithrombotic medication use | • Anticoagulant, antiplatelet, or thrombolytic medication use<br>• Concurrent use of more than one antithrombotic medication (e.g., use of aspirin while on anticoagulants)<br>• History of stroke or GI bleed<br>• NSAID medication use while on anticoagulants<br>• Antibiotics use while on anticoagulants<br>• Amiodarone use while on anticoagulants<br>• Dietary changes affecting vitamin K intake (e.g., dark leafy greens) | • Elevated PT/INR, PTT<br>• Low platelet count<br>• Bruising<br>• Nosebleeds<br>• Bleeding gums<br>• Prolonged bleeding from wound, IV, or surgical sites<br>• Blood in urine, feces, or vomit<br>• Coughing up blood<br>• Abrupt onset hypotension | • Stat order for PT/INR, PTT, platelet count, or CBC<br>• Abrupt stop order for medication<br>• Administration of Vitamin K<br>• Transfer to hospital | • Does the medical record include documentation of clinical indication?<br>• Is there evidence the facility routinely monitors lab results of all residents on<br>• anticoagulant/antiplatelet therapy?<br>• Is there a system to ensure lab results, including PT/INRs, are appropriately communicated to the physician including when panic values are obtained?<br>• Is there evidence that the facility educates caregivers on risk factors and symptoms and signs that may be indicative of excessive bleeding due to antithrombotic medications?<br>• Are residents/families educated regarding the risks associated with antithrombotic medication use and the signs and symptoms of excessive bleeding?<br>• Is there evidence of system to alert prescribers and nursing staff when anticoagulants are combined with other drugs which increase the risk of bleeding?<br>• Does the resident's dietary plan include recognition of foods that interact with antithrombotic medications (e.g., is there a plan to ensure consistent intake of foods and beverages rich in Vitamin K for residents on warfarin)? |

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| Thrombo-embolism related to anticoagulant medication use | • Anticoagulant medication used;<br>• Prolonged immobility<br>• Recent major surgery<br>• Prior history of venous thromboembolic events<br>• Consistently sub-therapeutic PT/INR | • Pain or tenderness and swelling of upper or lower extremity<br>• Increased warmth, edema and/or erythema of affected extremity<br>• Unexplained shortness of breath<br>• Chest pain<br>• Coughing<br>• Hemoptysis<br>• Feelings of anxiety or dread | • Stat order for PT/INR<br>• Stat chest x-ray,<br>• Transfer to hospital | • Is there evidence the facility routinely monitors lab results of all residents on anticoagulant/antiplatelet therapy?<br>• Is there a system to ensure lab results, including PT/INRs, are appropriately communicated to the physician including when sub-therapeutic values are obtained?<br>• Is there evidence that the facility educates caregivers on risk factors and symptoms and signs that may be indicative of thrombo-embolism? |
| Prolonged constipation, ileus, or impaction related to opioid medication use | • Opioid medication use (routine or PRN)<br>• Uncontrolled pain<br>• Recent abdominal surgery<br>• Advanced age<br>• Diagnosis of dementia, Parkinson's, multiple sclerosis, or quadriplegia<br>• Low fluid intake or dehydration<br>• Decreased mobility | • Constipation (lack of bowel movement for three or more days or straining to move bowels regardless of frequency)<br>• Bloating or abdominal distension<br>• Abdominal pain<br>• Headaches associated with symptoms above<br>• Diarrhea or leaking stool<br>• Decreased bowel sounds<br>• Nausea/vomiting<br>• Decreased or absent ability to urinate<br>• Rapid heartbeat<br>• Sweating<br>• Fever<br>• Low or elevated BP | • New orders for laxative, stool softeners, suppositories and/or enemas<br>• New order for abdominal x-rays<br>• Transfer to hospital | • Is there evidence of a bowel regimen in place such as routine orders for stool softener/laxative?<br>• For residents with risk factors for constipation, does the care plan reflect interdisciplinary monitoring for signs/symptoms of constipation and an interdisciplinary plan to prevent it including dietary management?<br>• Is fluid intake monitored?<br>• Are residents/families taught signs/symptoms of constipation and the importance of reporting them?<br>• Are bowel movements (frequency and size) monitored routinely by nursing staff?<br>• Is bowel status routinely addressed by the physician?<br>• Upon the initiation of opioids, did the prescriber acknowledge the increased of risk of constipation and adjust the plan of care as indicated?<br>• Is there a protocol in place to address constipation (e.g., a process to provide routine or standing order bowel medications when a resident hasn't had a bowel movement)? If so, is the staff aware of and compliant with the protocol? |

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| Prolonged constipation, ileus, or impaction related to opioid medication use (cont.) | | | | • Does the clinical record reflect that the dietician was made aware of an opioid being ordered so that nutritional approaches to prevent constipation could be considered?<br>• Is there evidence of a system for ensuring that residents are routinely assessed for pain, including monitoring for effectiveness of pain relief and side effects of medication (e.g., constipation)?<br>• Is there evidence that the facility implements non-pharmacological pain management approaches? |
| Electrolyte imbalance (including dehydration and acute kidney injury) related to diuretic use | • Use of diuretics<br>• Advanced age<br>• Dependence in ADLs – especially eating<br>• Diagnosis of dementia<br>• Fluid restrictions<br>• Recent diarrhea or vomiting<br>• Hot weather or other trigger for increased fluid needs<br>• Use of medical devices that increase fluid needs (e.g., air-fluidized mattresses) | • Abnormal electrolytes<br>• Dry skin and mucous membranes including cracked lips<br>• Poor skin turgor<br>• Thirst<br>• Confusion<br>• Concentrated urine and/or decreased output<br>• Lethargy<br>• Elevated temperature<br>• Low BP with increase in pulse<br>• Weight loss | • Abrupt stop order for diuretic medication<br>• New order for labs<br>• New order for and administration of IV fluids<br>• Transfer to hospital | • For residents with risk factors for dehydration, does the care plan reflect interdisciplinary approaches for prevention including:<br>  ○ Monitoring for signs and symptoms of dehydration, and<br>  ○ Observation/documentation of consumption of liquids?<br>• Is there evidence of a system for timely identification of residents with risk factors for dehydration?<br>• Does the facility have protocols for:<br>  ○ Hydration?<br>  ○ Monitoring intake and output?<br>  ○ Dehydration risk assessment?<br>  ○ Fluid intake assessment?<br>• Does every resident have access to fluids?<br>• Are protocols in place to ensure hydration during extreme heat?<br>• Are care plan approaches to ensure adequate hydration resident-specific and known to staff caring for the resident?<br>• Are residents provided with the assistance they need to drink, including between meals? |

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| Drug toxicity related to acetaminophen | • Concurrent routine and PRN orders for acetaminophen and medications containing acetaminophen<br>• Failure to have a maximum daily dose of acetaminophen order or protocol in place<br>• Maximum daily dose of acetaminophen routinely nears or exceeds 4 gm<br>• Uncontrolled pain<br>• Residents with liver damage<br>• Residents that consume three or more alcoholic drinks per day | • Elevated liver function tests<br>• Fatigue or weakness<br>• Abdominal pain<br>• Loss of appetite<br>• Jaundice, including yellowing of sclera<br>• Itching<br>• Bruising<br>• Confusion<br>• Edema/ascites | • Abrupt stop of all acetaminophen products<br>• Transfer to hospital<br>• New order for liver function tests<br>• New order for N-acetylcysteine | • Is there evidence of a system for ensuring residents with orders for routine or PRN acetaminophen do not receive more than 4 grams in a 24-hour period?<br>• Is there evidence of a system to ensure that medications that contain acetaminophen are flagged to alert medication nurses that the resident has more than one medication containing acetaminophen ordered?<br>• Is there evidence of a system to ensure changes in condition are identified, assessed, including an assessment of medications, and communicated to the physician promptly?<br>• Is there evidence that the facility implements non-pharmacological pain management approaches?<br>• Is there evidence of a system for ensuring that residents are routinely assessed for pain, including monitoring for effectiveness of pain relief and side effects of medication?<br>• Is there a system to ensure extended-release formulations are delivered correctly (e.g., medications not crushed)? |
| Drug toxicity related to digoxin | • Advanced age<br>• Hypokalemia<br>• Hypomagnesaemia<br>• Hypothyroidism<br>• Decreased renal function<br>• Drugs that impair renal function<br>• Drugs that cause hypokalemia | • Elevated digoxin level<br>• Abnormal electrolytes<br>• Lethargy, drowsiness, fatigue<br>• Neuralgia<br>• Headache<br>• Dizziness<br>• Confusion<br>• Hallucinations<br>• Seizures<br>• Visual disturbances (e.g., yellow-green distortion, snowy vision, photophobia)<br>• Anorexia, weight loss<br>• Nausea/vomiting<br>• Abdominal pain | • New order for and administration of IV fluids<br>• Transfer to hospital<br>• New order for and administration of activated charcoal<br>• New order for and administration of digoxin-specific | • Does the care plan reflect interdisciplinary monitoring for signs/symptoms of digoxin toxicity?<br>• Is apical pulse prior to administration of digoxin with the drug held when pulse rate <60 bpm (unless other parameters are set by the physician)?<br>• Is there evidence of a system to ensure changes in condition are identified and assessed promptly, including an assessment of medications?<br>• Is there evidence of a system for routine monitoring of renal function and serum medication concentration level?<br>• Is there a system to ensure lab results are appropriately communicated to the physician including when panic values are obtained? |

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| Drug toxicity related to digoxin (cont.) | | • Diarrhea<br>• Palpitations<br>• Shortness of breath<br>• Syncope<br>• Lower extremity edema<br>• Irregular or slow heart rate<br>• Irregular respirations | antibody (e.g., Digibind)<br>• Abrupt stop order for medication | |
| Drug toxicity related to levothyroxine | • History of thyrotoxicosis<br>• Advanced age<br>• Cardiac arrhythmias | • Abnormal thyroid studies, including TSH<br>• Headache<br>• Leg cramps<br>• Tremors<br>• Heat intolerance<br>• Increased sweating<br>• Diarrhea<br>• Nervousness or irritability<br>• Chest pain<br>• Shortness of breath<br>• Rapid or pounding heartbeat<br>• Insomnia | • Abrupt stop order for medication<br>• Transfer to hospital | • Is there evidence of a system to ensure changes in condition are identified and assessed promptly, including an assessment of medications?<br>• Is there evidence of a system for ensuring lab tests to monitor thyroid functions are ordered and drawn?<br>• Is there a system to ensure lab results are appropriately communicated to the physician including when panic values are obtained?<br>• For residents with risk factors for drug toxicity related to levothyroxine use, does the care plan reflect interdisciplinary monitoring for signs/symptoms of adverse drug reactions to levothyroxine? |
| Drug toxicity related to angiotensin-converting enzyme (ACE) inhibitors | • Renal artery stenosis<br>• Impaired renal function<br>• Aortic valve stenosis/cardiac outflow obstruction<br>• Congestive Heart Failure<br>• Dehydration<br>• History of hypersensitivity to ACE inhibitors<br>• Concurrent use with:<br>  ○ Diuretics<br>  ○ NSAIDs<br>  ○ Anticoagulants<br>  ○ Cyclosporine | **Hyperkalemia S/S**<br>• Elevated potassium levels<br>• Fatigue<br>• Weakness<br>• Dizziness, syncope<br>• Headaches<br>• Slow, weak, or irregular pulse<br>• Nausea<br>• Abnormal heart rhythm/ECG abnormalities | • Transfer to hospital<br>• Stat order for lab work<br>• Abrupt stop order for medication<br>For hyperkalmeia may also see:<br>• Stat order for IV calcium<br>• Stat order for Kayexalate<br>• New order for diuretics | • Is there evidence of a system to ensure changes in condition are identified and assessed promptly, including an assessment of medications?<br>• Is there evidence of a system for ensuring serum potassium, BUN, and creatinine levels are drawn routinely?<br>• Is there a system to ensure lab results are appropriately communicated to the physician including when panic values are obtained?<br>• For residents with risk factors for drug toxicity related to ACE inhibitor use, does the care plan reflect interdisciplinary monitoring for signs/symptoms of adverse drug reactions to ACE Inhibitors? |

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| Drug toxicity related to angiotensin-converting enzyme (ACE) inhibitors (cont.) | ○ Potassium supplements | **Angioedema S/S**<br>• Swelling of soft tissues<br>• Shortness of breath<br>• Wheezing<br>• Persistent non-productive cough<br><br>**Acute Kidney Failure S/S**<br>• Elevated BUN/creatinine Reduced/absent urine output<br>• Swelling of feet/legs<br>• Nausea/vomiting<br>• Anorexia<br>• Flank pain | | |
| Drug toxicity related to phenytoin | • Advanced age<br>• Liver impairment<br>• Kidney impairment | • Severe mental status or mood changes<br>• Changes in gait, balance, or coordination<br>• Drowsiness<br>• Loss of consciousness<br>• Uncontrollable eye movements<br>• Uncontrollable shaking/jerking motions<br>• Slow/slurred speech<br>• Nausea/vomiting;<br>• Decreased respirations | • Stat drug levels and CBC ordered<br>• Abnormal therapeutic drug levels<br>• Abrupt stop order for medication<br>• Transfer to hospital | • Is there evidence in the medical record for clinical indication?<br>• Is there evidence of a system for ensuring therapeutic drug levels are drawn routinely?<br>• Is there a system to ensure lab results are appropriately communicated to the physician including when panic values are obtained?<br>• Is there evidence of a system to ensure changes in condition are identified and assessed promptly, including an assessment of medications?<br>• For residents with risk factors for drug toxicity related to phenytoin use, does the care plan reflect interdisciplinary monitoring for signs/symptoms of adverse drug reactions to phenytoin?<br>• Is there a system to ensure extended-release formulations are delivered correctly (e.g., medications not crushed)? |

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| Drug toxicity related to lithium | • Advanced age<br>• History of lithium toxicity<br>• Kidney impairment<br>• Hypothyroidism<br>• Decreased PO intake<br>• Dehydration<br>• Concurrent administration of:<br>  ○ Diuretics<br>  ○ ACE inhibitors<br>  ○ NSAIDS<br>  ○ Neuroleptics<br>  ○ Antiepileptics<br>  ○ Calcium antagonists | • Elevated serum lithium level<br>• Elevated serum sodium level<br>• Diarrhea<br>• Nausea/vomiting<br>• Weakness/dizziness<br>• Stomach pain<br>• Hand tremors or muscle twitches<br>• Slurred speech<br>• Abnormal ECG<br>• Incoordination<br>• Uncontrollable eye movements<br>• Seizures<br>• Coma | • Stat order for ECG<br>• Stat order for drug level<br>• Stat order for IV hydration<br>• Transfer to hospital | • Is there evidence in the medical record for clinical indication?<br>• Is there evidence of a system for ensuring therapeutic drug levels are drawn routinely?<br>• Is there a system to ensure lab results are appropriately communicated to the physician including when panic values are obtained?<br>• Is there evidence of a system to ensure changes in condition are identified and assessed promptly, including an assessment of medications?<br>• For residents with risk factors for drug toxicity related to lithium use, does the care plan reflect interdisciplinary monitoring for signs/symptoms of adverse drug reactions to lithium?<br>• Is there a system to ensure extended-release formulations are delivered correctly (e.g., medications not crushed)? |
| Drug toxicity related to valproic acid | • Existing liver disease<br>• Impaired renal function<br>• Concurrent administration:<br>  ○ Antidepressants<br>  ○ Benzodiazepines<br>  ○ Antibiotics | • Loss of appetite,<br>• Nausea/vomiting<br>• Confusion<br>• Dizziness<br>• Lethargy<br>• Numbness, tingling, weakness, or involuntary muscle twitching,<br>• Increased heart rate<br>• Decreased respirations | • Stat order for drug level (VPA)<br>• Order for brain CT (looking for edema)<br>• Order for ECG<br>• Administration of Narcan, L-carnitine, or activated charcoal | • Is there evidence of a system for ensuring therapeutic drug levels are drawn routinely?<br>• Is there a system to ensure lab results are appropriately communicated to the physician including when panic values are obtained?<br>• Is there evidence of a system to ensure changes in condition are identified and assessed promptly, including an assessment of medications?<br>• For residents with risk factors for drug toxicity related to valproic acid use, does the care plan reflect interdisciplinary monitoring for signs/symptoms of adverse drug reactions to valproic acid?<br>• Is there a system to ensure extended-release formulations are delivered correctly (e.g., medications not crushed)? |

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| Drug toxicity related to antibiotics | • History of renal disease/insufficiency<br>• Concurrent administration with:<br>  ○ Medications that raise PT/INR or PTT<br>  ○ Phenytoin<br>  ○ Other antibiotics | • Elevated kidney function tests<br>• Elevated liver function tests<br>• Elevated serum potassium<br>• Decrease in platelets<br>• Nausea/vomiting<br>• Diarrhea<br>• Loss of appetite<br>• Flushing of skin<br>• Lethargy<br>• Dizziness<br>• Hearing loss<br>• Rash<br>• Seizures<br>• Ventricular arrhythmias<br>• Peripheral neuropathy<br>• Esophagitis<br>• Symptoms of hypoglycemia<br>• Phlebitis | • Orders for abrupt discontinuation of medication<br>• ECG order<br>• Order for Stat lab work | • Is there evidence in the medical record for clinical indication?<br>• Is the order time limited?<br>• Does the care plan and/or medication administration record (MAR) reflect special instructions related to antibiotic administration such as taking with food or water, infusing IV antibiotic over certain time period, monitoring of drug levels and other labs (as appropriate)?<br>• Is there evidence of a system to ensure changes in condition are identified and assessed promptly, including an assessment of medications?<br>• Is there a system to ensure lab results are appropriately communicated to the physician including when panic values are obtained?<br>• For residents with liver or kidney disease, is there evidence of additional monitoring to ensure antibiotics do not adversely affect kidney or liver function, i.e., additional lab work, monitoring intake/output?<br>• Is there evidence of a system to evaluate appropriate use of antibiotics, i.e. an antibiotic stewardship program?<br>• For residents with risk factors for drug toxicity related to antibiotic use, does the care plan reflect interdisciplinary monitoring for signs/symptoms of adverse drug reactions to antibiotics?<br>• Is there a system to ensure that dietary adjustments are made if needed when antibiotics are ordered?<br>• Is there a system to ensure antibiotics are not given in conjunction with medications that impact their absorption (e.g., Milk of Magnesia)? |

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| Altered cardiac output related to cardiac medications (blood pressure medications, beta blockers) | • Advanced age<br>• History of heart attack, arrhythmia, cardiomyopathies, or CHF | • Fainting<br>• Falls<br>• Elevation/drop in BP<br>• Bradycardia<br>• Dizziness<br>• Light-headedness<br>• Nausea<br>• Sweating<br>• Weakness/fatigue<br>• Visual disturbances<br>• Clamminess<br>• Loss of consciousness | • Abrupt stop of medication<br>• IV fluids<br>• Transfer to hospital | • Is there evidence of a system to ensure changes in condition are identified and assessed promptly, including an assessment of medications?<br>• For residents with risk factors for altered cardiac input related to cardiac medications, does the care plan reflect interdisciplinary monitoring for signs/symptoms of altered cardiac output?<br>• Is there a system to ensure routine monitoring of cardiac status for residents receiving blood pressure medications (e.g., blood pressure monitoring)? |

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# Tab Three

## Interventions



Quality Improvement Organizations
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# Considerations for Opioid and Psychotropic Use in Long-term Care

## Pain Management Principles

- Assess the type of pain the patient is experiencing.
- Establish clear and specific treatment goals before starting pain management.
- Initiate and optimize non-pharmacologic therapies first. Should be tailored to patient-specific needs.
- Add non-opioid therapies with a preference for scheduled over as needed administration.
- Opioid therapies should only be considered when other therapies are not providing adequate control and only when benefits for both pain and function outweigh risks.
- Co-prescription of opiates and benzodiazepines should be avoided.
- Evaluate benefits and harms within 1-4 weeks of starting opioid therapy and every 3 months thereafter.

## Psychotropic Medications

- Antidepressants
- Antipsychotics
- Anxiolytics
- Hypnotics
- Mood stabilizers

## Best Practices

- Antidepressants and Mood Stabilizers
    - May be helpful for patients with depression, anxiety, and other mood conditions
    - Risks and benefits must be assessed as side effects may be more impactful in this patient population
- Anxiolytics and Hypnotics
    - High risk medications with pronounced side effects in long term care patients
        - Cognitive impairment, delirium, dementia, falls risk, respiratory depression, sedation, decreased sleep quality
    - Consider alternatives to benzodiazepines (alprazolam, lorazepam, diazepam) for anxiety, including non-pharmacological interventions, antidepressants, etc.
    - Address sleep hygiene and alternatives to hypnotics
- Antipsychotics
    - In long term care patients, risks of prolonged use of antipsychotics often outweigh the benefits
    - Focused efforts on reducing inappropriate use in this population
    - Only patients with correctly documented diagnosis for use (by appropriate provider) should have orders for antipsychotics
        - Off-label uses are not appropriate in most circumstances
    - Evaluate individualized benefit and risk assessment
    - Assess transitions of care, polypharmacy, and adverse drug effects frequently

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AAPACN
AMERICAN ASSOCIATION OF POST-ACUTE CARE NURSING

# Non-Pharmacological Interventions for Pain Management

## Target Audience

Nurses

## Learning Objectives

This learning activity should enable you to:

- Summarize potential risks associated with pain medications
- Identify non-pharmacological interventions for pain management

### *What Does It Mean to You to Be Comfortable?*

Different people may have different answers to this question. To one person it may mean not having a worry in the world, while to another it could mean just being free from a nagging backache. Residents, too, may differ in their views of what it means to be comfortable. However, one thing that they all probably would agree on is that if they are having pain, they are not comfortable! Helping residents to relieve pain and to be comfortable are important nursing care measures. Most residents would put these measures at the top of the list of what is important to them. As a nursing caregiver, you need to know how to help residents relieve pain and be as comfortable as possible.

## Pain Medications

Often, when people have pain, they first think of taking a medication to relieve it. Television and magazine ads regularly highlight the many medications available for headaches, aching joints, and other discomforts, so it is no surprise that people reach for a medication when they need to relieve pain. Pain medications are useful. However, for people who are old or who must take them regularly, these medications can cause problems.

Even though there are risks associated with medications, they are not necessarily bad. Medications do have a place in pain control and can help residents achieve a high quality of life. However, because medications carry risks, they should be used carefully and only when there are no other ways to control pain.

### *Older Bodies React to Medication Differently*

As people age, their bodies handle medications differently. In older people, medications take longer to be absorbed and to travel through the body. The reduced function of some of the body's organs in late life slow down the process of eliminating the medication from the bloodstream. As a result, medications stay in the bloodstream longer and can build up to dangerous levels that can cause complications.

### *Using Many Drugs Increases Risks*

Polypharmacy is common among nursing home residents. Unfortunately, polypharmacy increases the risk for medications to interact with each other. For example, one medication can increase the effects of another medication, or cause a third medication to be less effective. The risk for side effects and complications increases when the number of medications a resident takes increases.

### *Diseases Can Change Medication Actions*

Some diseases can change the way medications behave in the body. For example, kidney disease can slow down the body's ability to eliminate medications. As mentioned earlier, when medications are not eliminated as they normally should be, they can build up to high levels that cause serious complications.

## Nurses' Role in Pain Control

Your efforts can help to better control residents' pain and reduce their need for medications. Let's look at actions that could be helpful.

### *Assessment*

Assessment—the collection of information about a resident—is a very important part of nursing care. Pain control starts with a thorough nursing assessment that will help the physician and entire care team develop a plan of care to manage the resident's pain.

### *Supporting Treatments*

If your feet hurt because you're wearing shoes that are a few sizes too small, you could take a pain pill to numb the pain. However, the wisest action would be to remove the shoes. Likewise, when residents have pain, the best action is to

eliminate the source of the pain, when possible. Pain could be caused by conditions that are treatable. These include infections, medication reactions, poor positioning, and uncontrolled diseases.

After conditions are diagnosed, treatments may be prescribed. By helping residents receive the treatment they need, you can improve their level of comfort.

### *Non-Drug Measures to Control Pain*

Many basic nursing care measures can do wonders to promote residents' comfort. Often, even small actions can have significant impact, such as:

- Helping residents to reposition themselves
- Setting up a food tray and assisting with feeding
- Giving a back rub or massaging the shoulders
- Listening and talking with the resident
- Keeping the environment quiet and pleasant

For many people, gently touching, rubbing, and massaging are comforting. Before rubbing or massaging an area, ask the resident if it is all right to do so. (Not everyone responds favorably to being touched.) If the resident is fine with your doing so, rub or massage the area gently. Using lotion can provide comfort and help to moisten the skin.

For those who believe in God or a higher power, prayer and religious activities are often important. Praying for improved health and freedom from pain is not unusual. If you see a resident praying or are aware of his or her desire to do so, provide privacy. Ask the resident if he or she wants a religious article. If you are comfortable doing so, ask the resident if he or she would like you to pray with or for him or her or sit in silence supporting the resident while they pray. Be sure not to force your faith or religious practices on a resident.

## Non-Drug Therapies for Pain Control

### *Acupuncture*

Acupuncture is a therapy that has been practiced for thousands of years as part of traditional Chinese medicine. It is based on the belief that there are invisible lines of energy running through the body and that when any of these energy lines gets blocked, illness results. To correct the problem, needles are placed at different points along these lines. Acupuncture should only be done by a trained professional.

### *Aromatherapy*

This is a branch of herbal medicine that uses scents from aromatherapy to cause certain reactions in the body. For example, the scents of lavender, rose, and geranium are calming.

### *Chiropractic*

Chiropractic is a therapy based on the belief that health problems are related to the spine getting out of alignment. A chiropractor moves the spine back into place to relieve symptoms. Chiropractic is often used to treat back problems.

### *Guided Imagery*

With Guided Imagery therapy, a person is given suggestions of images to think about, such as a peaceful place or a medication traveling through the body to eliminate pain. The body reacts to this suggestion by calming the person to help relieve pain.

### *Herbal Medicine*

Herbal Medicine is a practice that uses plants to bring about therapeutic results. For example, white willow relieves joint pain, valerian relaxes muscles, and capsicum (chili pepper oil) rubbed on a joint can provide pain relief. Because herbs can have powerful effects and interact with medications, they should only be used under the direction of a professional.

### *Progressive Relaxation*

Progressive Relaxation is a series of exercises in which the person closes the eyes, takes deep breaths, and relaxes different parts of the body to achieve a state of deep relaxation. A caregiver can guide the resident through this; scripted recordings can also be used.

### *Giving a Basic Hand Massage*

Hand massages can be very useful in providing comfort and calming residents. Ask a co-worker to be a partner and practice this simple technique for hand massage. Pour a small amount of lotion onto the palms of your hands and cradle one of the person's palm between your hands. (Hint: scented lotions are pleasant and relaxing to use.) Support the hand and gently stroke from the area of the person's wrist to the fingertips. Using your thumbs, make circular motions from the center of the person's palms toward the edge of the hand. Turn the person's hand over and massage the outer surface

of the hand. With your thumb and index finger, massage each finger, starting at the joint where the finger meets the main part of the hand and working toward the tip. Gently make circular motions with each finger, as though doing range of motion. Finish the massage by holding the person's hand between your hands and gently rubbing and stroking.

## Knowledge Check

### True or False

**1. Pain can only be managed with medication.**

a. True

b. False

**2. An elderly person rarely has side effects from taking pain medication.**

a. True

b. False

**3. The nurse's assessment of a resident's pain is essential to successfully managing it.**

a. True

b. False

**4. Anyone can prescribe and apply herbal remedies to manage a resident's pain.**

a. True

b. False

**5. A basic pain relief intervention can include repositioning and helping a resident move.**

a. True

b. False

**Answers**

1. False, 2. False, 3. True, 4. False, 5. True

## Notes

## Our Mission Statement

Nursing home mission statement here

Nursing home logo here

## How is your pain?

Your comfort is important to your recovery and well-being. You are the most important member of our healthcare team.

We depend on you to describe your pain so we can help you feel better quickly. So tell us about your pain and how you are feeling.

What number best describes your pain on average in the past week?


No Pain — Worst you can imagine

What number best describes how, during the past week, pain has interfered with your enjoyment of life?


No Pain — Complete interference

What number best describes how, during the past week, pain has interfered with your general activity?


Not at all — Complete interference

## Menu of Comfort Items Available

### Sleep

- Warm bath or shower
- Essential oil
- Darkness
- Night light
- Quiet
- Music
- No interruptions
- Herbal tea (resident supplied)
- Snack or sandwich
- Massage (as staffing permits)
- Television
- Sound machine (if available)

### Relaxation

- Soothing sounds recording (if available)
- Stress ball
- Aromatherapy

### Entertainment

- Adult color book
- Book (large print, audio)
- Magazine
- Deck of cards
- Reading visit
- Talking visit

### Feeling Better

- Shampoo
- Scalp massage
- Toothbrush and floss
- Mouthwash
- Prayer (with willing staff member)
- Meditation
- Deep breathing
- Guided imagery
- Sunshine
- Chocolate
- Walking in the hallway
- Gentle stretching

### Comfort

- Warm blanket
- Warm washcloth
- Extra pillows
- Ice pack
- Hand massage
- Neck pillow
- Temperature adjustment
- Lotion
- Lip balm
- Repositioning
- Straightening bed linens

# GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

## IMPROVING PRACTICE THROUGH RECOMMENDATIONS

CDC's *Guideline for Prescribing Opioids for Chronic Pain* is intended to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder and overdose. The Guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.

## DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

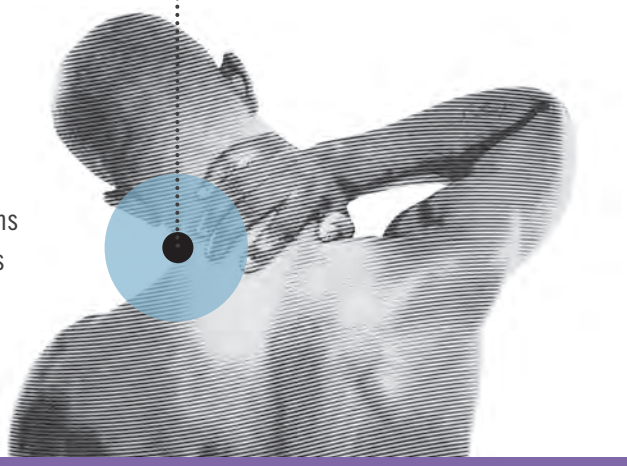
1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

### CLINICAL REMINDERS

- **Opioids are not first-line or routine therapy for chronic pain**
- **Establish and measure goals for pain and function**
- **Discuss benefits and risks and availability of nonopioid therapies with patient**



**U.S. Department of Health and Human Services**
Centers for Disease Control and Prevention

**LEARN MORE** | www.cdc.gov/drugoverdose/prescribing/guideline.html

## OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

### CLINICAL REMINDERS

- Use immediate-release opioids when starting
- Start low and go slow
- When opioids are needed for acute pain, prescribe no more than needed
- Do not prescribe ER/LA opioids for acute pain
- Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue if needed


**4** When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

**5** When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.

**6** Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

**7** Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

## ASSESSING RISK AND ADDRESSING HARMS OF OPIOID USE

**8** Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.

**9** Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

**10** When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

**11** Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

**12** Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

### CLINICAL REMINDERS

- Evaluate risk factors for opioid-related harms
- Check PDMP for high dosages and prescriptions from other providers
- Use urine drug testing to identify prescribed substances and undisclosed use
- Avoid concurrent benzodiazepine and opioid prescribing
- Arrange treatment for opioid use disorder if needed

# Indiana Pain Management Prescribing Final Rule

**Adopted by the Indiana Medical Licensing Board September 25, 2014**

**Summary created by the Indiana State Medical Association - Updated October 25, 2016**

## Background

The Medical Licensing Board of Indiana (MLB) adopted an Emergency Rule on Oct. 24, 2013 that regulates physicians engaged in the practice of pain management prescribing, enforced Dec. 15, 2013, pursuant to Senate Enrolled Act 246. The Final Rule was adopted on Sept. 25, 2014. The Final Rule went into effect Nov. 6, 2014, except drug testing, which went into effect Jan. 1, 2015. Differences between the Emergency Rule and Final Rule are designated with *. The MLB made changes to the Rule effective Sept. 21, 2016.

## The Prescribing Rule

Applies only to the prescribing of opioid-containing controlled substances for pain management.
(See **Definitions** section)

## Exclusions

The rule does not apply to:

1. Patients with a terminal medical condition (Refer to definitions section.)
2. Residents of an Indiana-licensed health facility (as defined by state law)
3. Patients enrolled in an Indiana-licensed hospice program (as defined by state law)
4. Patients enrolled in an inpatient or outpatient palliative care program of an Indiana-licensed hospital or hospice (as defined by state law)

## Thresholds

The rule applies only if a patient has been prescribed any of the following medications, at these doses and durations:

| Drug | Dose | Duration |
|---|---|---|
| *Transdermal opioid patch | Any | >3 consecutive months |
| *Any opiate extended-release medication not in abuse - deterrent form if an FDA-abuse deterrent form is available | Any | Day 1 |
| *Tramadol**<br>(See explanation below.) | >60 mg MED***/day | >3 consecutive months |
| Any other opioid-containing controlled substance | >60 pills/month<br>OR<br>>15 mg MED***/day | >3 consecutive months |

***Tramadol – The rule only applies to tramadol IF it ever becomes a controlled substance under Indiana law, which is anticipated in 2015. Tramadol became a controlled substance at the federal level on Aug. 18, 2014.*

****MED = Morphine-equivalent dose, as determined through use of any accepted conversion table.*



## Patient Assessment

Physicians must perform their own initial evaluations and risk stratifications of patients, including:

1. Appropriately focused history and physical examinations and appropriate tests, as indicated,
2. Documented attempts to obtain and review records from prior providers,
3. Patient-completed pain assessment tools,
4. Assessment of patient's mental health status and risk for substance abuse with valid screening tools, and
5. After initial evaluation, establishment of a working diagnosis and tailored treatment plan to meaningful and functional goals. (Review the plan with the patient occasionally.)

## Non-Opioids

Where medically appropriate, the physician must utilize non-opioid options instead of prescribing opioids.

## Patient Informed Consent

Discuss with the patient:

- Potential risks and benefits of opioid treatment for chronic pain, including the rises and benefit of using an abuse deterrent form (as opposed to a non-abuse deterrent if an abuse-deterrent form is available for the opioid product prescribed to the patient).
- Expectations related to prescription requests
- Proper medication use
- Alternative modalities to opioids for managing pain
- A simple and clear explanation to help patients understand the key elements of their treatment plan
- Counseling for women ages 14 to 55 of child-bearing potential about risk to fetus when a mother has taken chronic opioids during pregnancy (including risk of fetal opioid dependency and neonatal abstinence syndrome)
- Risks of dependency and addiction
- *Safe storage practices for prescribed opioids

**Provide a written warning disclosing the risks associated with taking extended-release medications that are not in an abuse deterrent form (if prescribed)*

## Patient Visits

- No prescribing without periodic scheduled visits
- If medication and treatment plan are stable, face-to-face visits at least once every four months
- If changes are still being made to medication and treatment plan, visits at least every two months until stabilized
- During visits, evaluation of progress, regular compliance with treatment plan and setting clear expectations along the way (e.g., physical therapy, counseling, other treatment)

## INSPECT Reports

At the outset of the treatment plan, and at least annually thereafter, prescribing physician must run an INSPECT report and document in patient's chart whether it is consistent with the physician's knowledge of the patient's controlled substance use history.

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## Drug Monitoring Tests (Effective Jan. 1, 2015)

*At any time the physician determines that it is medically necessary, whether at the outset of the treatment plan, or any time thereafter, a prescribing physician shall perform or order a drug monitoring test that must include a confirmatory test using a method selective enough to differentiate individual drugs within a drug class.

*In determining the medical necessity of a drug monitoring test, the physician shall consider these factors where applicable and reasonably feasible:

1. Whether there is reason to believe a patient is not taking or is diverting the opioids prescribed
2. Whether there has been no appreciable impact on the chronic pain despite being prescribed for a period that would generally have an impact
3. Whether there is reason to believe the patient is taking or using controlled substances other than opioids or other drugs or medications including illicit street drugs that might produce significant polypharmacological effects or have other detrimental interaction effects
4. Whether there is reason to believe patient is taking or using additional opioids not prescribed by any treating physician
5. Attempts by patient to obtain early refills of opioid-containing prescriptions
6. Number of instances when patients allege their prescriptions were lost or stolen
7. INSPECT report provides irregular or inconsistent information
8. Previous drug monitoring tests raised concerns about opioid usage
9. Necessity of verifying the patient no longer has substances in their system that are not appropriate under the treatment plan
10. Patient engages in apparent aberrant behavior or shows apparent intoxication
11. Patient's opioid usage shows an unauthorized dose escalation
12. Patient is reluctant to change medications or is demanding certain medications
13. Patient refuses to participate in or cooperate with a full diagnostic work-up or examination
14. Whether a patient has a history of substance abuse
15. Patient has a health status change (e.g., pregnancy)
16. Co-morbid psychiatric diagnoses
17. Other evidence of chronic opioid use, controlled substance abuse or misuse, illegal drug use or addiction, or medication non-compliance
18. Any other factor the physician believes is relevant to making an informed professional judgment about the medical necessity of a prescription

**Physicians are required to consider all the factors in determining whether to order/perform a drug test. However, once a physician determines that a drug test is medically necessary, any remaining factors (of the 18) that have not yet been considered do not have to be considered.*

## Daily High Dose Threshold

When opioid dose reaches morphine equivalent dose of >60mg/day, a face-to-face review of treatment plan and patient evaluation must be scheduled, including consideration for a specialist referral. If physician elects to continue treating at that level, physician must develop a revised assessment plan for ongoing treatment and document in the chart, including an assessment of increased risk for adverse outcomes.

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## Treatment Agreements*

With patients, review and sign a "Treatment Agreement" that must include (minimum):

1. Goals of the treatment
2. Patient's consent to drug-monitoring testing *when physician determines it is medically necessary
3. Physician's prescribing policies, including:
    a. rule that patient take medication(s) as prescribed
    b. prohibition on sharing medication(s)
4. Requirement that the patient inform the physician:
    a. about any other controlled substances prescribed or taken by the patient;
    b. *if the patient drinks alcohol while taking opioids
5. Permission to conduct random pill counts
6. Reasons the opioid therapy may be changed or discontinued by the physician

**A copy of the signed agreement must be retained in the patient's chart.*

## Key Definitions (not comprehensive)

1. **Chronic Pain**
    a. A state in which pain persists beyond the usual course of an acute disease or healing of an injury or that may or may not be associated with an acute or chronic pathologic process that causes continuous or intermittent pain over months or years.
2. **Terminal**
    a. A condition caused by injury, disease or illness from which, to a reasonable degree of medical certainty:
        i. No recovery is expected.
        ii. Progression to death can be anticipated as an eventual consequence of that condition.

*This is an unofficial summary. A full, official version of the final rule should be consulted for compliance purposes at [https://www.ismanet.org/pdf/legal/IndianaPainManagementPrescribingFinalRuleSummary.pdf](https://www.ismanet.org/pdf/legal/IndianaPainManagementPrescribingFinalRuleSummary.pdf).*

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Pain

# Wong-Baker FACES Pain Rating Scale

Source: Practical Pain Management, Medscape




The Wong-Baker Face Pain Rating Scale is the pain scale most preferred by physicians, parents and children. It proves to be an inexpensive, yet easy to use, pain scale, these factors are important, as measuring pain in children can be extremely difficult.

The scale consists of six faces that range from no pain at all to the worst pain imaginable. The emotional faces range from smiling to grimacing. Children match their level of pain to a face on the scale.

Children rating their pain on the Wong-Baker Faces Pain Rating Scale are better able to communicate their level of pain, as opposed to surveys or other pain scales. A concern arises with children who do not cry with pain or are embarrassed to choose a face with tears. Although no pain-rating scale is efficient for all children, the Wong-Baker Faces Pain Rating Scale seems to work best. Adults with language barriers also benefit from this type of pain

scale. The Wong-Baker Faces Pain Rating Scale has proven to be a valid and reliable pain scale.

TIPS FOR SUCCESS:

# Reducing the Use of Antipsychotic Medications

Antipsychotic medication use in nursing home residents who have dementia has limited effectiveness and causes severe side effects, including low blood pressure, over sedation, increased risk of stroke, diabetes, heart disease, falls and fractures and increased mortality. A key component of state and national initiatives is eliminating the off-label use of antipsychotic medications. How? Through individualized non-pharmacologic interventions that address residents' unmet needs, thereby reducing their distressed behaviors.

## Interventions for Antipsychotic Medications

***Interventions only work if they are individualized for each resident***

- Use a "Behavioral Symptoms Monitoring Sheet" to track behaviors and learn the "unmet need" being communicated. Observe and assess a resident over 48 hours. Do not use an isolated instance. Look for patterns, triggers and unmet needs.
- Meet weekly as an interdisciplinary team to review residents, behaviors and medications. Select one or two residents for gradual dose reduction (GDR). Once resident(s) is stabilized, choose one or two more.
- Make the director of nursing or other nurse leader a gatekeeper for all antipsychotic medications. Structure it so nurses must first check in with the nurse leader before contacting the physician for a new order/dose change. The nurse leader should model how to use non-pharmacologic interventions.
- Include specific interventions for each distressed behavior for suggestions about how to provide comfort and how to understand what the resident needs/wants.
- Make a policy that all new orders for antipsychotic medications have an automatic stop order after 72 hours and cannot be resumed without care team recommendations.
- Use personalized music to engage residents with dementia. Some other non-pharmacologic interventions include aroma and light therapy, food or drink, going outside and/or assessing for pain.
- Ask certified nursing assistants (CNAs) to get information from families, including helpful approaches to comfort/calm the resident. Record and share with unit staff.
- Conduct a stand-up meeting/huddle on the unit after a new distressed behavior. Involve CNAs.
- Create a general toolbox of ideas and non-pharmacologic interventions for staff. Keep handy. Use regularly.
- Meet with families and spend as much time as it takes to educate them about the dangers of and need to eliminate off-label use. Involve them in problem-solving.

## Tips for All Interventions

- Keep a focus on reducing antipsychotic medications. Select one or two residents at a time for a gradual dose reduction (GDR).
- Listen to the resident. Get to know the resident well. Tune into his/her communication style and needs. This is the cornerstone for avoiding antipsychotic medications.
- Organize information in a tracking tool to record all antipsychotic medications, GDRs and results.
- Use strong leadership and establish a gatekeeper who will monitor use and prevent new orders without an appropriate diagnosis. Do not allow a "knee-jerk" reaction of ordering an antipsychotic medication after an isolated behavior.
- Use trial and error when trying different non-pharmacologic interventions. Be sure to include everyone's ideas. Start with the easiest interventions and look for successes to share.
- Establish an automatic process for evaluation and GDR for newly admitted residents who are taking antipsychotic medications.
- Conduct additional activities through one-on-one interactions with a resident. Place resident-specific boxes (e.g., memory box, activity box, life history or career-related activity box) in the resident's room.

## Overcoming Barriers

- Educate staff about the serious side effects of and need to reduce this class of medications. Provide regular support, information and training about dementia and non-pharmacologic interventions.
- Overcome CNA hesitation by regularly asking for their input and giving praise. Follow through on their suggestions.
- Educate physicians about state and national initiatives. Encourage your medical director to discuss these efforts with all prescribers.
- Before a resident is admitted, contact the hospital case manager about an appropriate diagnosis, history of medication use and/or discontinuation of an antipsychotic medication, etc.
- When undergoing a GDR, be prepared and consider the following:
    - Huddle regularly to problem solve together.
    - Recognize early warning signs and share interventions that work best.
    - Learn as much as you can about the resident's preferred routines and create an individualized schedule, if needed.
    - Conduct one-on-one activities.
    - Utilize consistent staff assignment.
    - Consider assigning two staff members to assist during care.
    - Include the family in all care changes and keep them informed of any results.
    - Trial and error are key—along with patience!

For more information, consult the **ACE Best Practices Booket**, which can be found by visiting:

www.mpqhf.org/qio/quality-improvement-tolls-resources/

Then click on **Nursing Home Quality Improvement** and look under QAPI.

Or go directly to this link:

http://mpqhf.org/QIO/wp-content/uploads/2016/03/ACEBestPracticesHandbook-508.pdf



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# Tab Four

## Tools

# Medication Reconciliation Worksheet for Post-Hospital Care

INTERACT®
Version 4.0 Tool

**Part 1:** Hospital Recommended Medications Needing Clarification

| **Medications Recommended by Hospital at Discharge for which Clarification is Needed** | **Clarification Needed*** | **Resolution for Final Medication Orders** *(Continue, Stop, Change)* |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Examples: unclear diagnosis or indication, uncertain dose or route of administration, stop date, hold parameters, lab tests needed for monitoring, dose different than before hospitalization, medication duplication*

**Part 2:** Medications Prior to Hospitalization Needing Clarification

| **Medications Taken Before Hospitalization Not Currently on Hospital-Recommended List** | **Comments** *(e.g. reason for the medication before hospitalization, and reason it was stopped in the hospital, if known)* | **Resolution for Final Medication Orders** *(Continue, Stop, Change)* |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Resident/Patient Name** _____ **Date** _____/_____/_____


*Updated June 2018*

# Instructions for Completing the Medication Reconciliation Worksheet

INTERACT®
Version 4.0 Tool

This Worksheet is intended to be a tool for nursing staff who are involved in reviewing medication orders for residents/patients admitted for post- acute care, with the goal of identifying clarifications and discrepancies that need to be resolved with the resident/patient's primary care clinician. Completing this worksheet will document that you have performed medication reconciliation at transition points of care as required by CMS.

CMS Defines Medication Reconciliation as follows: a process of comparing pre-discharge medications to post-discharge medications by creating an accurate list of both prescription and over the counter medications that includes the drug name, dosage, frequency, route, and indication for use for the purpose of preventing unintended changes or omissions at transition points of care.

**NOTE:** It is best to complete this Worksheet before calling the clinician for initial verification of orders. However, this may not always be possible. In these cases, verify the initial orders and discuss any major issues with the clinician. Then, use this Worksheet to identify clarifications and discrepancies, and resolve them with the responsible primary care clinician as soon as possible

## Part 1

1. Complete the column on the left by carefully reviewing the medications recommended by the hospital at discharge, and listing medications that need clarification.
2. Complete the middle column by noting any issues that need clarification, for example: unclear diagnosis or indication, uncertain dose or route of administration, stop date, hold parameters, lab tests needed for monitoring, dose different than before hospitalization, medication duplication. This requires a discussion with resident and/or caregiver (if they were admitted to the hospital from home), or review of the most recent MAR (for residents/patients who were in the facility before the hospitalization).
3. Complete the section on 'Resolution for Final Medication Orders' by reviewing all clarifications needed with the resident/patient's primary care clinician and obtaining orders for those medications that should be continued, stopped, or changed.

## Part 2

1. Complete the column on the left by carefully reviewing the medications recommended by the hospital at discharge with the resident/patient or resident representative (if they were admitted to the hospital from home), or reviewing the most recent MAR (for residents/patients who were in the facility before the hospitalization) and listing any medications that were taken before hospitalization that are not on the list recommended by the hospital.
2. Complete the middle column by noting the reason for the medication before hospitalization, if known, and the reason it was stopped in the hospital, if known.
3. Complete the section on 'Resolution for Final Medication Orders' by reviewing all clarifications needed with the resident/patient's primary care clinician and getting orders for those medications that should be continued (if any).


*Updated June 2018*

# Prescribing Tips for Pain Management

- Assess the type of pain the patient is experiencing:
  - Acute or chronic
  - Injury-related
  - Neuropathic
- Consider consulting a pain management specialist.
- Clear and specific treatment goals should be established before starting pain management.
- Initiate and optimize non-pharmacologic therapies first. Therapies should be tailored to patient-specific needs.
- Add non-opioid therapies, if necessary, with a preference for scheduled over as needed administration.
- Opioid therapies should only be considered when other therapies are not providing adequate control and only when benefits for BOTH pain and function outweigh risks.
  - Opioids should be started with lowest effective dose of immediate-release medication
  - Avoid long-acting products
  - Avoid doses greater than 90 morphine milligram equivalents (MME) per day
- Co-prescription of opiates and benzodiazepines should be avoided.
- Evaluate benefits and harms within 1-4 weeks of starting opioid therapy and every 3 months thereafter.
  - Should include assessment of opioid use disorder

## Considerations for Opioid Tapering

- Patient requests a dose reduction
- Resolution of condition or injury causing the pain
- Benefits of therapy do not outweigh the harms
- No meaningful improvement (30% or more) in pain or function
- Dose increases above 50 morphine milligram equivalents (MME) per day should be carefully assessed for benefits and risks and consider tapering
- Changes or deterioration in physical, emotional, or social functioning
- Signs of opioid use disorder or dependence

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# Drugs with a High Potential for Severe Outcomes in the Elderly

| Drugs | Comments |
|---|---|
| **Psychotropics** | |
| Amitriptyline (Elavil) | Strongly anticholinergic and sedating |
| Barbiturates | More side effects than most sedative-hypnotic drugs; should not be used except to control seizures (phenobarbital) |
| Long-acting benzodiazepines | Long half-life and, hence, prolonged sedation; associated with an increased incidence of falls and fractures |
| Doxepin (Sinequan) | Strongly anticholinergic and sedating |
| Meprobamate (Miltown) | Highly addictive and sedating |
| **Analgesics** | |
| Meperidine (Demerol) | Not effective when administered orally; metabolite has anticholinergic profile |
| Pentazocine (Talwin) | Confusion and hallucinations more common than with other narcotics |
| **Miscellaneous** | |
| Antispasmodic agents | Highly anticholinergic with associated toxic effects |
| Chlorpropamide (Diabinase) | Serious hypoglycemia possible because of the drug's prolonged half-life |
| Digoxin (Lanoxin) | Decreased renal clearance; doses should rarely exceed 0.125 mg except when treating arrhythmias |
| Ergoloid mesylates (Hydergine) | Generally ineffective for dementia or any other condition |
| Methyldopa (Aldomet) | Causes bradycardia and exacerbates depression |
| Ticlopidine (Ticlid) | More toxic than aspirin |

*Information from Beers M. Explicit criteria for determining potentially inappropriate medication use by the elderly. An update. Arch Intern Med 1997;157:1531–6.*

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# Drugs with a High Potential for Less Severe Outcomes in the Elderly

| Drugs | Comments |
|---|---|
| **Analgesics** | |
| Indomethacin (Indocin) | More central nervous system side effects than any other nonsteroidal anti-inflammatory drug |
| Propoxyphene (Darvon) | Few advantages over acetaminophen and has narcotic side effects |
| **Antihypertensives** | |
| Beta blockers | Can cause problems in patients with asthma or chronic obstructive pulmonary disease; may precipitate syncope because of negative inotropic and chronotropic effects |
| Reserpine* | Can cause depression, sedation, and orthostatic hypotension |
| **Miscellaneous** | |
| Antihistamines† | Highly anticholinergic |
| Cyclandelate (Cyclospasmol) | Generally ineffective for dementia or any other condition |
| Dipyridamole (Persantine) | Frequently causes orthostatic hypotension; of benefit only in patients with artificial heart valves |
| Ergoloid mesylates (Hydergine) | Generally ineffective for dementia or any other condition |
| Muscle relaxants | Increased cholinergic activity, sedation and weakness |
| Trimethobenzamide (Tigan) | Least effective antiemetic and can cause extrapyramidal symptoms |

**—Reserpine is available alone (in generic form) and is also found in combination drugs such as reserpine-trichlormethiazide (Metatensin).*

*†—Over-the-counter and prescription first-generation antihistamines.*

*Information from Beers M. Explicit criteria for determining potentially inappropriate medication use by the elderly. An update. Arch Intern Med 1997;157:1531–6.*

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# Antidepressant Drugs and Dosages Preferred for Use in the Elderly

| Drugs | Geriatric Dosage (mg per day) | | Side Effects | | | |
|---|---|---|---|---|---|---|
| | Starting Dosage | Maintenance Dosage | Sedation | Agitation | Anticholinergic Effects | Orthostatic Hypotension |
| **Tricyclic Antidepressants** | | | | | | |
| Desipramine (Norpramin) | 25 | 50 to 150 | Low | Low | Low | Low |
| Nortriptyline (Pamelor) | 10 to 25 | 40 to 75 | Moderate | - | Low | Low |
| **Selective Serotonin Reuptake Inhibitors** | | | | | | |
| Citalopram (Celexa) | 20 | 20 to 40 | Low | Low | - | - |
| Fluvoxamine (Luvox) | 50 | 50 to 200 | Low | Low | - | - |
| Paroxetine (Paxil) | 10 | 20 to 30 | Low | Low | - | - |
| Sertraline (Zoloft) | 25 to 50 | 50 to 150 | Low | Low | - | - |
| **Miscellaneous** | | | | | | |
| Bupropion (Wellbutrin) | 100 | 100 to 400 | - | Moderate | - | Low |
| Nefazodone (Serzone) | 100 | 100 to 600 | Moderate | - | Low | Low |
| Trazodone (Deyrel) | 25 to 50 | 50 to 300 | High | - | Low | Moderate |
| Venlafaxine (Effexor) | 75 | 75 to 350 | Low | Low | Low | Low |

*- = Very low or insignificant effects*

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# Psychotropic Medication Quick Reference Guide

| ANTIDEPRESSANTS* | |
|---|---|
| **Generic** | **Brand** |
| Imipramine | Tofranil |
| Desipramine | Norpramin |
| Amitriptyline | Elavil |
| Nortriptyline | Pamelor |
| Clomipramine | Anafranil |
| Trazodone | Desyrel |
| Nefazodone | Generic only |
| Fluoxetine | Prozac |
| Bupropion | Wellbutrin, Wellbutrin SR & XL |
| Sertraline | Zoloft |
| Paroxetine | Paxil |
| Venlafaxine | Effexor, Effexor XR |
| Desvenlafaxine | Pristiq, Khedezla |
| Fluvoxamine | Luvox |
| Mirtazapine | Remeron |
| Citalopram | Celexa |
| Escitalopram | Lexapro |
| Duloxetine | Cymbalta, Irenka |
| Vilazodone | Viibryd |
| Vortioxetine | Trintellix |
| Milnacipran | Savella |
| Levomilnacipran | Fetzima |

| ANTIANXIETY AGENTS*** | |
|---|---|
| **Generic** | **Brand** |
| Diazepam | Valium |
| Chlordiazepoxide | Librium |
| Clorazepate | Tranxene |
| Clonazepam | Klonopin |
| Lorazepam | Ativan |
| Alprazolam | Xanax, Xanax XR |
| Buspirone | BuSpar |
| Hydroxyzine | Atarax, Vistaril |
| Clonidine | Catapres |

| ANTIPSYCHOTICS** | |
|---|---|
| **Generic** | **Brand** |
| Chlorpromazine | Generic only |
| Thioridazine | Generic only |
| Clozapine | Clozaril |
| Prochlorperazine | Compazine |
| Perphenazine | Generic only |
| Loxapine | Generic only |
| Trifluoperazine | Generic only |
| Fluoxetine | Generic only |
| Thiothixene | Generic only |
| Haloperidol | Haldol |
| Pimozide | Orap |
| Risperidone | Risperdal |
| Paliperidone | Invega |
| Olanzapine | Zyprexa |
| Ziprasidone | Geodon |
| Iloperidone | Fanapt |
| Asenapine | Saphris |
| Lurasidone | Latuda |
| Aripiprazole | Abilify |
| Cariprazine | Vraylar |
| Pimvanserin | Nuplazid |
| Brexpiprazole | Rexulti |
| Quetiapine | Seroquel |
| Lumateperone | Caplyta |
| Olanzapine/Fluoxetine | Symbyax |

| HYPNOTICS* | |
|---|---|
| **Generic** | **Brand** |
| Temazepam | Restoril |
| Triazolam | Halcion |
| Zolpidem | Ambien, Intermezzo |
| Zaleplon | Sonata |
| Eszopiclone | Lunesta |
| Ramelteon | Rozerem |
| Diphenhydramine | Benadryl |
| Doxepin | Sinequan, Silenor |
| Surovexant | Belsomra |
| Estazolam | Generic only |

***Side effect monitoring is required. **Behavior monitoring, side effect monitoring and quarterly AIMS assessments are required. ***Behavior and side effect monitoring are required.***

*This is a general reference only and the manufacturer's product information should be consulted prior to the prescribing of any medication for any dosage changes or contraindications. References: www.PsyD-fx.com; www.factsandcomparisons.com (accessed March 2021)*

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# Psychotropic Medication Quick Reference Guide

### Common Side Effects of Antidepressant Agents:

- Nausea / diarrhea
- Fatigue
- Dizziness
- Dyspepsia
- Tremors
- Anorexia
- Constipation
- Headache
- Anxiety
- Dry mouth

### Common Side Effects of Antianxiety Agents:

- Dizziness
- Sedation
- Weakness
- Anorexia
- Confusion
- Dysarthria
- Changed appetite

### Common Side Effects of Antipsychotic Agents:

- Movement disorder
- Insomnia/drowsiness
- Weight changes
- Anxiety
- Falls / fractures
- Hypotension

### Common Side Effects of Hypnotic Agents:

- Delirium
- Fractures
- ER visits / hospitalizations
- Memory Impairment Sedation
- Weakness
- Confusion
- Falls
- MVAs
- Dysarthria
- Dizziness
- Anorexia

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# Checklist for the Use of Schizophrenia/Schizoaffective/Schizophreniform Disorder Diagnoses I-6000

**Check-Off List:**

1. Was a diagnosis of Schizophrenia/Schizoaffective/Schizophreniform present upon admission?
   a) If yes, did review of the medical record contain documentation of a comprehensive psychiatric evaluation, completed by a physician that meets professional standards of practice, to assign an active diagnosis of Schizophrenia?
   b) If no, and Schizophrenia diagnosis was added after admission to the facility, medical record must contain documentation of a comprehensive psychiatric evaluation, completed by a physician that meets professional standards of practice, to assign an active diagnosis of Schizophrenia; and supportive documentation of behaviors consistent with Schizophrenia are present for a duration of a minimum of six months prior to the addition of the diagnosis.
2. Was the diagnosis listed on the electronic health record (EHR) diagnosis list?
3. Was the diagnosis coded on the MDS?
4. Within the past sixty (60) days, was a signed physician's progress note with the diagnosis of Schizophrenia/Schizoaffective/Schizophreniform present in the resident's Progress Notes or included in a signed monthly order review, per the requirements of the Resident Assessment Instrument manual? Was diagnosis an active problem within the past seven days of the assessment reference date as evidenced by daily medication?

**Antipsychotic Medication Use for Schizophrenia/Schizoaffective/Schizophreniform Disorder – Clinical Indication, Monitoring and Gradual Dose Reductions:**

1. Does the medical record provide clinical indication for the use of antipsychotic medications (i.e., diagnoses, symptoms such as paranoia/hallucinations/false personal beliefs/disorganized speech/flat affect)?
2. Was supportive documentation present to track active monitoring for adverse drug events related to antipsychotic medications?
3. Is documentation present to indicate that gradual dose reductions were attempted as appropriate for psychotropic medications?

**The above-referenced indicators must be met to support a diagnosis of Schizophrenia/Schizoaffective/Schizophreniform for each resident in your facility.** If the above-referenced indicators are not met, a diagnosis of Schizophrenia/Schizoaffective/Schizophreniform is not appropriate and the physician should be contacted to obtain an appropriate alternative diagnosis.

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# Schizophrenia Diagnosis Audit

Resident Name _____Admit Date_____Auditor Date_____

| Yes | No | Description | Notes/Comments |
|---|---|---|---|
| | | Was the diagnosis of Schizophrenia present on admission? | |
| | | Date of schizophrenia diagnosis. | |
| | | Was the resident receiving antipsychotic medications upon admission to facility? | |
| | | If resident was on an antipsychotic medication upon admission, is there a supporting diagnosis in the medical record? | |
| | | If diagnosis was present on admission to the facility was the PASRR Level II completed upon admission to the facility? | |
| | | Was the resident diagnosed with schizophrenia after admission and/or during the stay at the facility? | |
| | | Did resident have a diagnosis of dementia prior to the signs/symptoms suggestive of schizophrenia? | |
| | | If the diagnosis was made after admission, were antipsychotic medications prescribed just before or right after diagnosis was made? | |
| | | List on blank line below the antipsychotic meds with order dates:<br><br>_____ | |
| | | If the diagnosis was received at the facility, are there persistent behaviors documented, including hallucinations or delusions for a minimum of six months prior to the start of antipsychotic medication(s)? | |
| | | If diagnosis was received after admission to the facility, was there a detailed evaluation/comprehensive evaluation completed by an appropriate practitioner such as a medical doctor or psychiatrist? | |
| | | Is there a person-centered care plan related to schizophrenia diagnosis that addresses moods and behaviors that are documented and tracked? | |
| | | Where are moods/behaviors documented? Enter on blank line below.<br><br>_____ | |
| | | Is schizophrenia coded on the MDS and not present anywhere else in the medical record? | |
| | | If diagnosis is coded on the MDS, is there a signed physician note in the last 60 days? | |
| | | If diagnosis is coded on the MDS, is there documentation of an active problem within the last seven days of the assessment reference date (ARD)? | |

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# Anxiolytic and Sedative Hypnotic Drugs Commonly Used In Elderly

| Drugs | Geriatric Dosage (mg per day)* | | |
|---|---|---|---|
| | Anxiety | Insomnia | Onset of Action |
| **Short-Acting Agents** | | | |
| **Benzodiazepines** | | | |
| Alprazolam (Xanax) | 0.75 | 0.25 | Intermediate |
| Estazolam (Prosom) | 0.5 | 0.5 | Fast |
| Lorazepam (Ativan) | 2 | 1 | Intermediate |
| Oxazepam (Serax) | 30 | 15 | Slow |
| Temazepam (Restoril) | - | 15 | Intermediate |
| Triazolam (Halcion) | - | 0.125 | Fast |
| **Antihistamines** | | | |
| Diphenhydramine (Benadryl) | 50 | 25 | Fast |
| Hydroxyzine (Atarax) | 50 | 50 | Fast |
| **Miscellaneous** | | | |
| Zolpidem (Ambien) | - | 5 | Fast |
| **Long-Acting Agents** | | | |
| **Benzodiazepines** | | | |
| Chlordiazepoxide (Librium) | 20 | 20 | Intermediate |
| Clonazepam (Klonopin) | 1.5 | 1.5 | Intermediate |
| Clorazepate (Tranxene) | 15 | 15 | Fast |
| Diazepam (Valium) | 5 | 5 | Very Fast |
| Flurazepam (Dalmane) | 15 | 15 | Very Fast |
| Halazepam (Paxipam) | 40 | 20 | Slow |
| Prazepam (Centrax) | 15 | 15 | Slow |
| Quazepam (Doral) | 7.5 | 7.5 | Intermediate |

*— = Not indicated.*

**=The dosages given in this table are as established by the Health Care Financing Administration guidelines for fulfilling the requirements of the Omnibus Budget Reconciliation Act (OBRA) of 1987. They are not the maximum dosages. When the OBRA-specified dosage of a drug is exceeded, documentation of necessity is required.*

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# Five Whys Tool for Root Cause Analysis

***Overview:*** Root cause analysis is a structured team process that assists in identifying underlying factors or causes of an event, such as an adverse event or near –miss. Understanding the contributing factors or causes of a system failure can help develop actions that sustain corrections.

The Five Whys is a simple problem-solving technique that helps to get to the root of a problem quickly. The Five Whys strategy involves looking at any problem and drilling down by asking: "Why?" or "What caused this problem?" While you want clear and concise answers, you want to avoid answers that are too simple and overlook important details. Typically, the answer to the first "why" should prompt another "why" and the answer to the second "why" will prompt another and so on; hence the name Five Whys. This technique can help you to quickly determine the root cause of a problem. It's simple, and easy to learn and apply.

***Directions:*** The team conducting this root cause analysis does the following:

- Develops the problem statement. (See Step 1 of Guidance for RCA for additional information on problem statements.) Be clear and specific.
- The team facilitator asks why the problem happened and records the team response. To determine if the response is the root cause of the problem, the facilitator asks the team to consider “If the most recent response were corrected, is it likely the problem would recur?” If the answer is yes, it is likely this is a contributing factor, not a root cause.
- If the answer provided is a contributing factor to the problem, the team keeps asking “Why?” until there is agreement from the team that the root cause has been identified.
- It often takes three to five whys, but it can take more than five! So keep going until the team agrees the root cause has been identified.

**Tips:**

- Include people with personal knowledge of the processes and systems involved in the problem being discussed.
- Note that the Five Whys technique may not always help you to identify the root cause. Another technique you might consider is the fishbone diagram. The fishbone diagram forces you to think broadly across various categories that could be causing or contributing to the problem (See How to Use the Fishbone Tool for Root Cause Analysis tool).

| | |
|---|---|
| ***Problem statement*** | One sentence description of event or problem |
| ***Why?*** ⇨ | |
| ***Why?*** ⇨ | |
| ***Why?*** ⇨ | |
| ***Why?*** ⇨ | |
| ***Why?*** ⇨ | |
| ***Root Cause(s)*** | 1.<br>2.<br>3.<br><br>To validate root causes, ask the following: If you removed this root cause, would this event or problem have been prevented? |

***Example:***
Here is an everyday example of using the Five Whys to determine a root cause:
Problem statement – your car gets a flat tire on your way to work.

1. Why did you get a flat tire?
    - You ran over nails in your garage
2. Why were there nails on the garage floor?
    - The box of nails on the shelf was wet; the box fell apart and nails fell from the box onto the floor.*
3. Why was the box of nails wet?
    - There was a leak in the roof and it rained hard last night. (Root cause=leak in the roof)

*IF YOU STOPPED HERE AND "SOLVED" THE PROBLEM BY SWEEPING UP THE NAILS, YOU WOULD HAVE MISSED THE ROOT CAUSE OF THE PROBLEM.

# Tab Five

## Tracking



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# Pain Management Diary

| Date | Time | Symptom Description | Pain Scale Rating | Location of Pain | Medication and Dosage and/or Non-Medication Interventions | Pain Scale Rating One Hour After Intervention | Side Effects from Medication |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
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| | | | | | | | |

## Pain Intensity Scale (from Pain Assessment Rating Scale Sheet)

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| No Pain | Mild | Mild | Mild | Mild | Moderate | Moderate | Moderate | Severe | Severe | Worst Pain |

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# GDR Worksheet

| Residents Name and Medical Rec Number | Admit Date | Psychotropic Medication | Start Date | Date of Signed Order | Date Progress Note | IDT Review Date | 1st GDR Attempt Date | Failed Y/N | 2nd GDR Attempt Date | Failed Y/N |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | |
| | | | | | | | | | | |
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# Psychotropic Medication Tracking Tool for Nursing Homes
## (Use with Antipsychotic, Antianxiety, and Hypnotic Medications)

| **Resident:** | **Room:** | **Date:** |
|---|---|---|
| Prescribing Clinician: | | |
| Medication: | Dose: | Frequency: |
| Route: | Scheduled or PRN: | |
| Diagnosis/Clinical Rationale: | | |
| Target Behavior(s): | | |
| Target Behavior(s) observed within last seven days: | | |

Document the ongoing progress and/or probable causes of the target behavior(s). Include who was involved, what happened, where, and when it occurred, why it possibly occurred, and how it affected the resident or others:

_____
_____
_____
_____
_____

**Facility Processes**

Is there documentation of an evaluation of possible environmental, medical, physical, emotional, social, functional, or psychiatric causes or triggers of the resident's behavior?

☐ Yes ☐ No

Has pain been considered as a possible cause of behavior?

☐ Yes ☐ No

Has medication been considered as possible cause of behavior?

☐ Yes ☐ No

Are there individualized, person-centered non-medication interventions and therapeutic approaches included in the care plan?

☐ Yes ☐ No

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## Psychotropic Medication Tracking Tool for Nursing Homes
**(Use with Antipsychotic, Antianxiety, and Hypnotic Medications)**

Are these interventions and approaches utilized by the staff?

☐ Yes ☐ No

***If any of the above are answered NO, action is necessary to include these in resident's clinical record.***

Notes on effectiveness or non-medication interventions and therapeutic approaches used:

_____

_____

_____

_____

Is there documentation of risk/benefit discussion with resident or legal representative and interdisciplinary team when obtaining consent before the initiation of medication? (If answered 'No', action is necessary to include this in resident's clinical record.

☐ Yes ☐ No

Describe any observed changes in the frequency/intensity of the primary target behavior(s) after medication was started:

_____

_____

_____

_____

**Clinical Monitoring**

Has the resident experienced adverse effects of functional decline due to medication?

☐ Yes ☐ No

If 'Yes', describe:

_____

_____

_____

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## Psychotropic Medication Tracking Tool for Nursing Homes
### (Use with Antipsychotic, Antianxiety, and Hypnotic Medications)

If started outside facility, is medication still necessary after individual has acclimated to the facility?

☐ Yes ☐ No

Has a gradual dosage reduction (GDR) been attempted in the last 3 months?

☐ Yes ☐ No

If 'Yes', describe outcome of the GDR:

_____

_____

_____

If 'No', is GDR appropriate at this time?

☐ Yes ☐ No

*(NOTE: GDR is recommended every three months when behavior frequency/intensity remains at a manageable level. Consult with prescribing physician)*

If GDR is not appropriate, has physician documented a clinical explanation for maintaining the medication at the current dose?

☐ Yes ☐ No

*(NOTE: for residents with dementia, at least one attempt at GDR should be initiated within the facility unless behaviors are causing severe distress or harm to self or others.)*

Comment:

_____

_____

_____

Signature: _____ Date:_____

*(Name/Title Credentials)*

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# Gradual Dose Reduction Tracking Form

Facility Name: _____ Date: _____

| | |
|---|---|
| **Resident Name:** | **Prescribing Clinician:** |
| **Medication/Dose:** | **Frequency:** |
| **Length of Therapy:** | **Diagnosis:** |
| **Target Behavior(s):** | |

☐ *A) Gradual dose reduction (GDR) must be discussed at this time, and we need to attempt a GDR*
***OR***
☐ *B) Provide documentation that demonstrates continued use is in accordance with current standards of practice and any attempted dose reduction is likely to impair the individual's function OR target symptoms returned or worsened after the most recent attempt at GDR and the physician has documented the clinical rationale for why any additional attempted dose reduction is likely to impair the individual's function or increase distressed behavior.*

**Inter-disciplinary team (IDT) behavior committee has reviewed use of medication. Risk vs. benefit outline:**

_____
_____
_____

☐ **Yes, please taper to the following dose:**

_____
_____
_____

☐ **No, the current medication regimen allows the resident to function at the highest practicable level of wellbeing. Reduction would be distressful to the resident and the behavior could potentially increase and may exacerbate any underlying medical and psychiatric disorder impairing the resident's overall quality of life. It is my professional medical opinion that the benefit of the medication(s) outweighs any side effects/risks involved.**

Comments:

_____

_____

Signature: _____ Date: _____

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# Antipsychotic Admission and Quarterly Review Worksheet

## Tips for Using This Tool:

- This tool can be used to assist Minimum Data Set (MDS) Coordinators in the completion of the CMS MDS, Section N, Medications.
- This tool can also be used in conjunction with the Alliant Health Solutions Antipsychotic Medication Trigger Tool (https://bit.ly/43HZaMC), the Antipsychotic Medication Rounding Tool (https://bit.ly/43JZCKf) and as part of the facility's overall Quality Assurance and Performance Improvement (QAPI) program.
- If this tool is used as a worksheet and not made part of the medical record, retain, and dispose of according to facility document retention and disposal policy.
- This tool can be used as part of a training program for education of clinical staff including MDS Coordinators, admissions, social workers, nurse managers, and front-line staff on the multiple considerations associated with use of an Antipsychotic medication.
- The schedule for use of this tool can be modified to align with facility specific processes and review schedules.

| **Resident Name:** | **Unit:** | **Room:** |
|---|---|---|
| **Admission Date:** | | **Date:** |
| Does the patient/resident have a diagnosis of Schizophrenia, Huntington's Disease or Tourette's Syndrome? | | No ☐ Yes ☐<br>If yes, date of dx: _____<br>Diagnosing Physician: _____ |
| Does the patient/resident have a diagnosis of Psychosis Not Otherwise Specified? | | No ☐ Yes ☐<br>If yes, date of dx: _____<br>Diagnosing Physician: _____ |
| Does the patient/resident have a diagnosis of Dementia with Behaviors? | | No ☐ Yes ☐<br>If yes, date of dx: _____<br>Diagnosing Physician: _____ |
| Does the patient/resident require a Preadmission Screening and Resident Review (PASRR) Level 2 Screen? | | No ☐ Yes ☐<br>If yes, date of dx: _____<br>Diagnosing Physician: _____ |
| Has the patient/resident had an Abnormal Involuntary Movement Scale (AIMS) assessment? | | No ☐ Yes ☐<br>If yes, date of dx: _____<br>Diagnosing Physician: _____ |
| Does the patient/resident have any other diagnosis that has resulted in an order for an anti-anxiolytic, antidepressant, and/or antipsychotic? | | No ☐ Yes ☐<br>If yes, date of dx: _____<br>Diagnosing Physician: _____ |
| Does the patient/resident have ICD10 Codes in the medical record for any of the above diagnoses? | | No ☐ Yes ☐<br>If yes, date of dx: _____<br>Diagnosing Physician: _____ |
| Has the patient/resident had a Psychiatry consult? | | No ☐ Yes ☐<br>If yes, date of dx: _____<br>Diagnosing Physician: _____ |

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List all anxiolytics, antidepressants, and/or antipsychotics that the patient/resident has received within the last seven days:

| Medication | Dose | Frequency | Rationale (signs, symptoms, and diagnosis) | Date of last dose change |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

| | |
|---|---|
| Has the patient/resident had a Gradual Dose Reduction (GDR)? | No ☐ Yes ☐<br>If yes, date GDR initiated: _____<br>Medication: _____<br>Starting Dosage: _____<br>End Dosage: _____ |
| During the GDR, did the patient/resident experience any new onset or change in frequency of signs and/or symptoms of distress? | No ☐ Yes ☐<br>If yes, review care plan to verify updates. |
| Is the patient/resident on any PRN anxiolytic, antidepressant, antipsychotic that should be considered for routine use or discontinuation? | No ☐ Yes ☐<br>If yes, Medication: _____ |
| Should the patient/resident be considered for GDR at this time? | No ☐ Yes ☐<br>If yes, share recommendation for GDR with the interdisciplinary team. |

Notes/Additional Comments:

_____
_____
_____
_____
_____
_____
_____
_____

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# Gradual Dose Reduction (GDR) in Skilled Nursing Facilities: Key Regulatory Concepts

| Antipsychotic GDR Requirements per F758[1] | Potential Clinical Contraindications for GDR[1] |
|---|---|
| **Within the first year**<br>A GDR must be attempted in two separate quarters (with at least one month between attempts), unless clinically contraindicated.<br><br>**After the first year**<br>A GDR must be attempted annually, unless clinically contraindicated. | **Expressions or indications of distress related to dementia**<br>A GDR may be considered clinically contraindicated if the:<br>• Resident's target symptoms returned or worsened after the most recent attempt at a GDR *within the facility*; **AND**<br>• Physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or increase distressed behavior.<br><br>**Psychiatric disorder other than expressions or indications of distress related to dementia (e.g., schizophrenia, bipolar mania, depression with psychotic features)**<br>The GDR may be considered clinically contraindicated, if the:<br>• Continued use is in accordance with relevant current standards of practice **AND** the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or exacerbate an underlying medical or psychiatric disorder; **OR**<br>• Resident's target symptoms returned or worsened after the most recent attempt at a GDR *within the facility* **AND** the physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or exacerbate an underlying medical or psychiatric disorder. |
| **Other Psychotropic GDR Requirements per F758[1] (e.g., anxiolytics, antidepressants, mood stabilizers, sedatives/hypnotics)** | **Potential Clinical Contraindications for GDR[1]** |
| **Within the first year**<br>A GDR must be attempted in two separate quarters (with at least one month between attempts), unless clinically contraindicated.<br><br>**After the first year**<br>A GDR must be attempted annually, unless clinically contraindicated. | The GDR may be considered clinically contraindicated, if the:<br>• Continued use is in accordance with relevant current standards of practice **AND** the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or exacerbate an underlying medical or psychiatric disorder; **OR**<br>• Resident's target symptoms returned or worsened after the most recent attempt at a GDR *within the facility* **AND** the physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or exacerbate an underlying medical or psychiatric disorder. |
| **As Needed (PRN) Antipsychotics and Psychotropics per F758[1]** | **PRN Antipsychotics or Psychotropics[1]: Limitations on Duration** |
| **Antipsychotic orders**: PRN orders for antipsychotics are limited to 14 days. A new order may be written by the physician after directly evaluating the resident and determining whether a new order for up to 14 days is warranted. The physician must document progress toward goals, benefits to the resident, the diagnosed specific condition, **AND** the indication for the PRN medication.<br><br>**Psychotropic (non-antipsychotic) orders**: PRN orders for psychotropic (non-antipsychotic) drugs are limited to 14 days. Orders may be extended beyond the 14 days if the prescriber believes it is appropriate to continue and documents the progress toward goals, benefits to the resident, the specific condition being treated, the rationale for the extended time period, **AND** the specific duration for the PRN order. | |

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# Frequently Asked Questions about Gradual Dose Reduction (GDR) for Psychotropics

**Q What happened to the list of acceptable diagnoses for psychopharmacological agents**

**A** CMS removed the diagnosis list from the State Operations Manual (SOM) and instead relies on individual prescribers to document diagnosis and adequate indication for use. Additionally, psychopharmacological is now referred to as psychotropic.

**Q What happened to Behavioral and psychological symptoms of dementia (BPSD) as a supporting diagnosis?**

**A** BPSD reflects a cluster of symptoms (e.g., agitation, psychosis, anxiety) and is not a diagnosis itself.

**Q Is it true that a diagnosis alone is not sufficient to justify the use of a psychotropic?**

**A** While every medication should have a corresponding diagnosis, additional documentation is required to support continued use. Centers for Medicare & Medicaid Services (CMS) requires that, "The resident's medical record must show documentation of adequate indications for a medication's use and the diagnosed condition for which a medication is prescribed." Indication for use is defined as, "the identified, documented clinical rationale for administering a medication that is based upon an assessment of the resident's condition and therapeutic goals and is consistent with manufacturer's recommendations and/or clinical practice guidelines, clinical standards of practice, medication references, clinical studies or evidence-based review articles that are published in medical and/or pharmacy journals."

**Q Is Compazine (prochlorperazine) included in the restrictions on as needed (PRN) orders?**

**A** Yes. Although commonly used for nausea and vomiting, regardless of how it is being used, prochlorperazine is classified as an antipsychotic and is therefore treated the same as any PRN antipsychotic order.

**Q Are there other times I need to consider a GDR?**

**A** Yes.The SOM states: "After initiating or increasing the dose of a psychotropic medication, the behavioral symptoms must be reevaluated periodically (at least during quarterly care plan review, if not more often) to determine the potential for reducing or discontinuing the dose based on therapeutic goals and any adverse effects or functional impairment." Consideration of a GDR is just one component of the continuous assessment of a resident's wellbeing. Dose changes, functional status changes, suspected adverse events (e.g., falls), changes in expressions or indications of distress are just some of the triggers for reassessment and consideration of GDR.

**Q Where can I find the GDR guidance for Skilled Nursing Facilities?**

**A** State Operations Manual Appendix PP Guidance to Surveyors for Long Term Care Facilities is available at:
https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/nursing-homes.html

**Q Which medications are considered non-antipsychotic psychotropics?**

**A** Below are examples of medications that may be considered non-antipsychotic psychotropics, depending upon how they are being used.

| Non-antipsychotic Psychotropic Medication Examples (generic names, not all inclusive) | | | |
|---|---|---|---|
| **Antianxiety** | **Antidepressant** | **Sedative/Hypnotic** | **Mood Stabilizer** |
| alprazolam | escitalopram | eszopiclone | lamotrigine |
| buspirone | mirtazapine | temazepam | lithium |
| lorazepam | trazodone | zolpidem | valproate, divalproex |

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**Utilize a person-centered, interdisciplinary approach to managing persons on psychotropic medications. Have an established approach to individualize and assess goals of therapy, including gradual dose reduction.**

Gradual dose reduction has been defined as, *"the stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued".*

### Evaluate changes in behavior or mood

Address underlying causes (e.g., pain, boredom) and/or environmental factors (e.g., temperature, noise)

### Monitor behaviors on an ongoing basis

- Is the behavior distressful or does it present potential for harm to the individual or others?
- What non-drug interventions are effective in decreasing the behavior?

### Discuss dose reductions with resident, family, or responsible party

- Review the benefits of dose reduction attempts, emphasize the goals of finding the lowest effective dose and potentially reducing the overall number of medications
- Discuss the plan for dose reductions at appropriate intervals and that careful consideration will be taken before a gradual dose reduction will be performed
- Provide reassurance that doses will be titrated down slowly to avoid withdrawal and there will be ongoing monitoring for symptom recurrence

### Individualize interventions and assess effectiveness

- Use combinations of various techniques throughout the day (e.g., redirection, repositioning, music, games, crafts, socialization, physical activity, family photos, cognitive behavioral therapy)
- Assess effectiveness of non-drug interventions on an ongoing basis

### Monitor and evaluate the resident's response to medication

- Assess the duration, dose, side effects, and/or adverse effects
- Understand that many behavioral symptoms do not respond to treatment with medications (e.g., wandering, yelling)

### Consider a gradual dose reduction

If sustained improvement in behavior or mood, evaluate for a gradual dose reduction while maintaining non-drug interventions

**Ongoing attempts to incorporate nonpharmacologic interventions (e.g., music, redirection, calm environment) while reducing or eliminating the use of medications used to treat emotional or behavioral concerns is a best practice, particularly in those with dementia. Documenting your interventions and their outcomes, based on the ideas listed above, is a valuable step toward appropriate use of these medications.**

**Abbreviations**

| | |
|---|---|
| **GDR** | gradual dose reduction |
| **PRN** | as needed |

**References**


1. 42 CFR 483, Subpart B – Requirements for Long Term Care Facilities
2. CMS FAQ: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/LTC-Survey-FAQs.pdf
3. American Geriatrics Society 2019 updated AGS Beers Criteria. JAGS. 2019
4. American Psychiatric Association. Five things clinicians and patients should question. Choosing Wisely. 2015 Apr.
5. Psychiatric Association practice guideline on the use of antipsychotics to treat agitation or psychosis in patients with dementia. Am J Psychiatry. 2016; 173(5):543-546.