Achieving Quality Now

This meeting will be recorded and will be available at www.fmda.org/journalclub.php

FMDA Journal Club

June 22, 2022
Lynn D'Avico, PharmD, CPh; and Amina Dubuisson, DNP, MBA/HCM, RN, LNHA, CDP – Special Guests
Diane Sanders-Cepeda, DO, CMD – Host


CNA Week
June 16-22
I'm Still Standing
NAHCA
The CNA Association | www.NAHCACNA.org

National Nursing Home Challenges

- Staffing Crisis
- Infection Control & Antibiotic Stewardship
- Readmissions & Preventable Hospitalizations
- Psychotropic Stewardship

Florida Focus

- 46 – Number of Hospitalization per 1000 long-stay resident days
- 46 – RN Turnover during past year
- 33 - % of short stay residents who newly received an antipsychotic medication
- 37 - % of long stay residents who received an antipsychotic medication

Ongoing Challenges for Florida

Reducing Emergency Department visits

Readmissions

Infections

How do we Achieve Quality Now?

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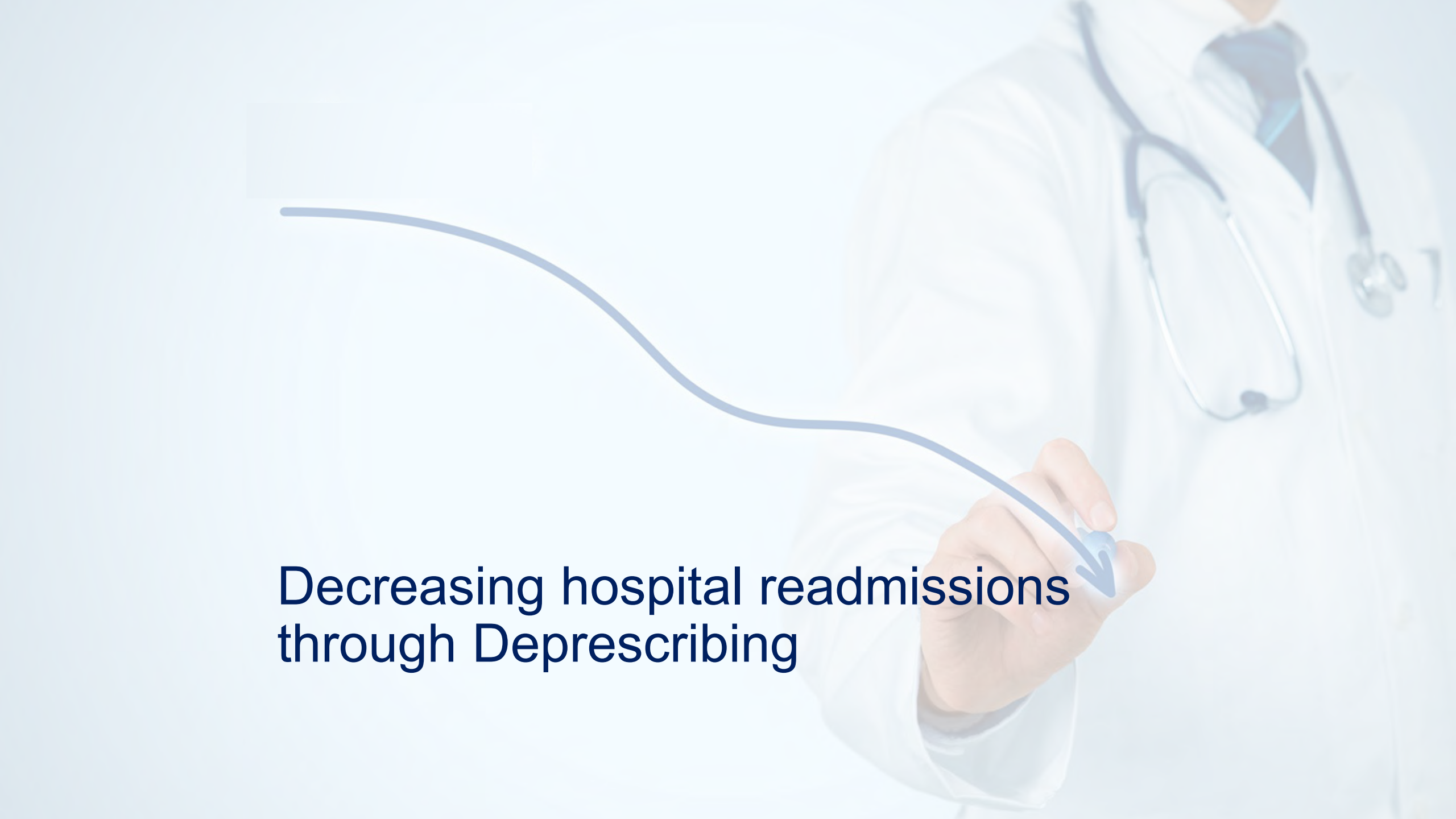
Vice President of Clinical Services, Ventura Services Florida



Decreasing hospital readmissions through Deprescribing

Reported clinical outcomes of deprescribing are:

Decrease:

-Drug-related problems
-Mortality
-Hospital readmissions
-Falls

Increase:

-Quality of Life
-Functional Status

Impact of Deprescribing Interventions in Older Hospitalized Patients on Prescribing and Clinical Outcomes: A Systematic Review of Randomized Trials

•Authors
•Authors and affiliations
•Janani Thillainadesan

Drugs & Aging
April 2018, Volume 35, Issue 4, pp 303–319| Cite as

Challenges to deprescribing

Guidelines are published to START medications

New disease conditions require newer and more expensive options

Pharmaceutical Industry does not fund deprescribing

Prescribers are concerned with legal implications

Specialists (psychiatry) are reimbursed per resident/regimen

Addressing polypharmacy

WHO: Prevalence of inappropriate meds 11.5%-62.5%

Polypharmacy is major problem in the elderly

- Greater risk of ADRs
- May lead to “prescribing cascades”
- Symptoms of polypharmacy confused with “aging”:
  - Tiredness, sleepiness, insomnia, constipation, diarrhea, confusion

Polypharmacy → decreases quality of life and unnecessary expense

LONG TERM CARE CMS: “Unnecessary Medication”

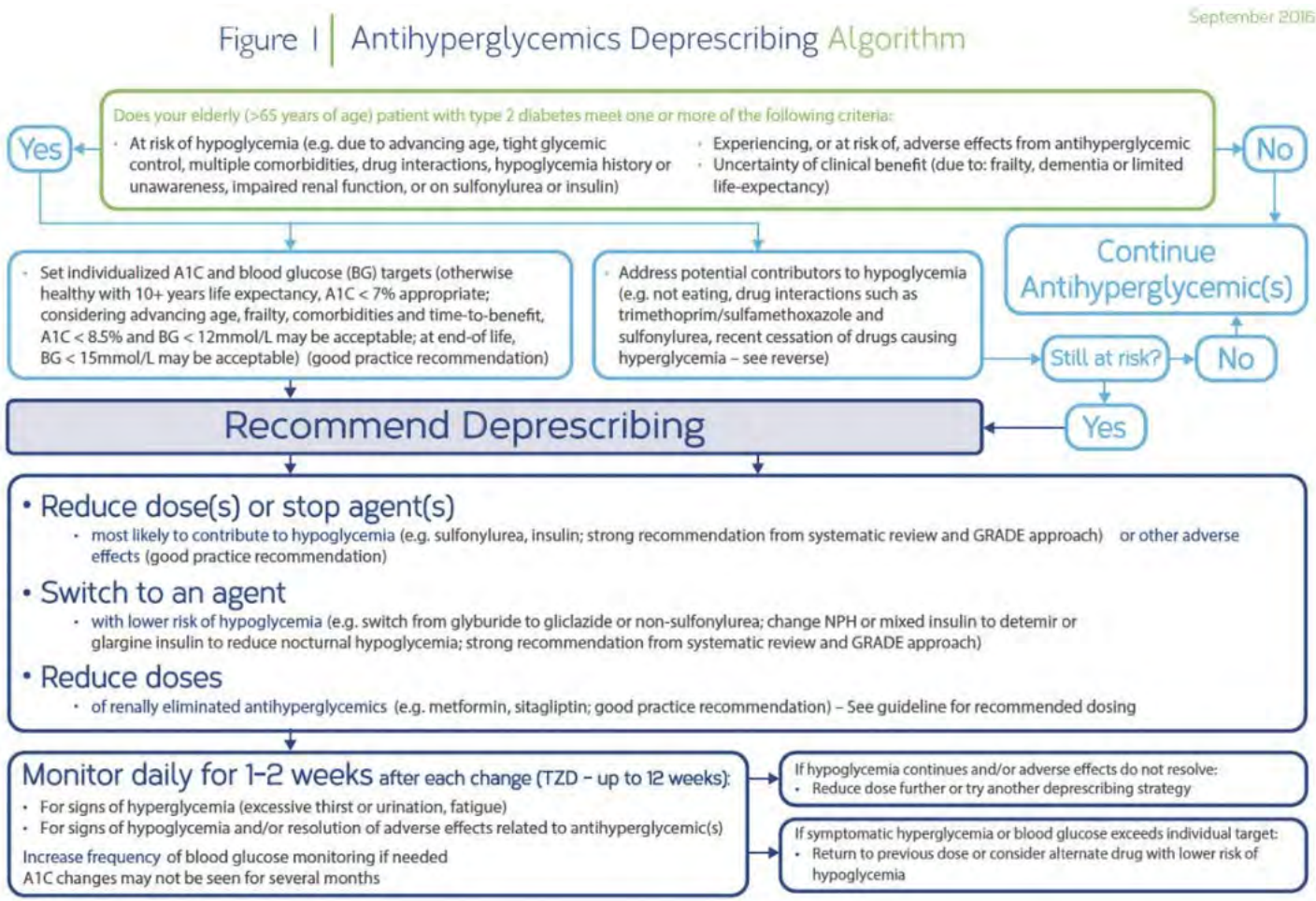


Figure 1 | Antihyperglycemics Deprescribing Algorithm
September 2016
Does your elderly (>65 years of age) patient with type 2 diabetes meet one or more of the following criteria:
At risk of hypoglycemia (e.g. due to advancing age, tight glycemic control, multiple comorbidities, drug interactions, hypoglycemia history or unawareness, impaired renal function, or on sulfonylurea or insulin)
Experiencing, or at risk of, adverse effects from antihyperglycemic
Uncertainty of clinical benefit (due to: frailty, dementia or limited life-expectancy)
Yes
No
Set individualized A1C and blood glucose (BG) targets (otherwise healthy with 10+ years life expectancy, A1C < 7% appropriate; considering advancing age, frailty, comorbidities and time-to-benefit, A1C < 8.5% and BG < 12mmol/L may be acceptable; at end-of life, BG < 15mmol/L may be acceptable) (good practice recommendation)
Address potential contributors to hypoglycemia (e.g. not eating, drug interactions such as trimethoprim/sulfamethoxazole and sulfonylurea, recent cessation of drugs causing hyperglycemia – see reverse)
Continue Antihyperglycemic(s)
Still at risk?
No
Yes
Recommend Deprescribing
• Reduce dose(s) or stop agent(s)
most likely to contribute to hypoglycemia (e.g. sulfonylurea, insulin; strong recommendation from systematic review and GRADE approach) or other adverse effects (good practice recommendation)
• Switch to an agent
with lower risk of hypoglycemia (e.g. switch from glyburide to gliclazide or non-sulfonylurea; change NPH or mixed insulin to detemir or glargine insulin to reduce nocturnal hypoglycemia; strong recommendation from systematic review and GRADE approach)
• Reduce doses
of renally eliminated antihyperglycemics (e.g. metformin, sitagliptin; good practice recommendation) – See guideline for recommended dosing
Monitor daily for 1-2 weeks after each change (TZD – up to 12 weeks):
For signs of hyperglycemia (excessive thirst or urination, fatigue)
For signs of hypoglycemia and/or resolution of adverse effects related to antihyperglycemic(s)
Increase frequency of blood glucose monitoring if needed
A1C changes may not be seen for several months
If hypoglycemia continues and/or adverse effects do not resolve:
Reduce dose further or try another deprescribing strategy
If symptomatic hyperglycemia or blood glucose exceeds individual target:
Return to previous dose or consider alternate drug with lower risk of hypoglycemia

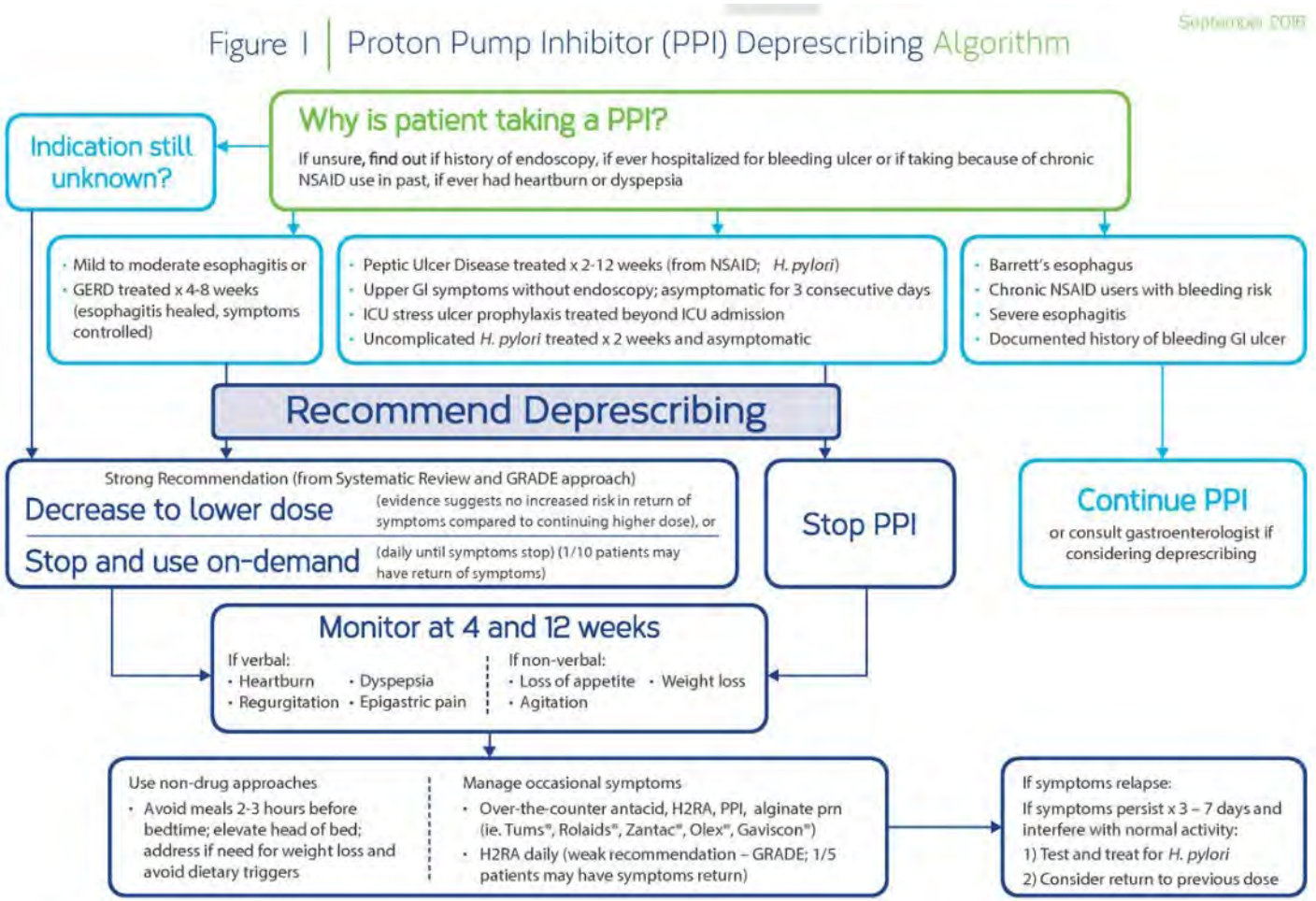
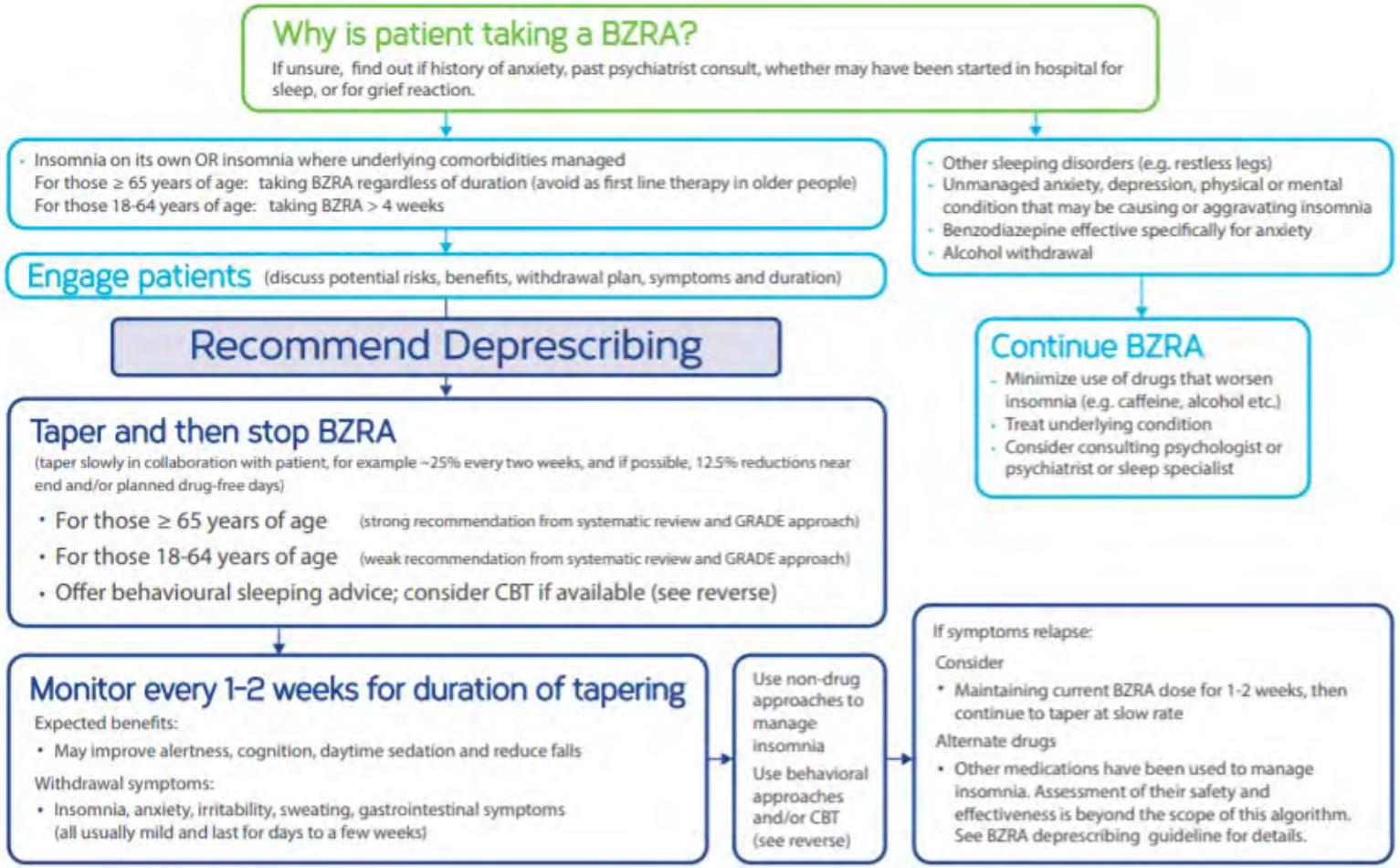
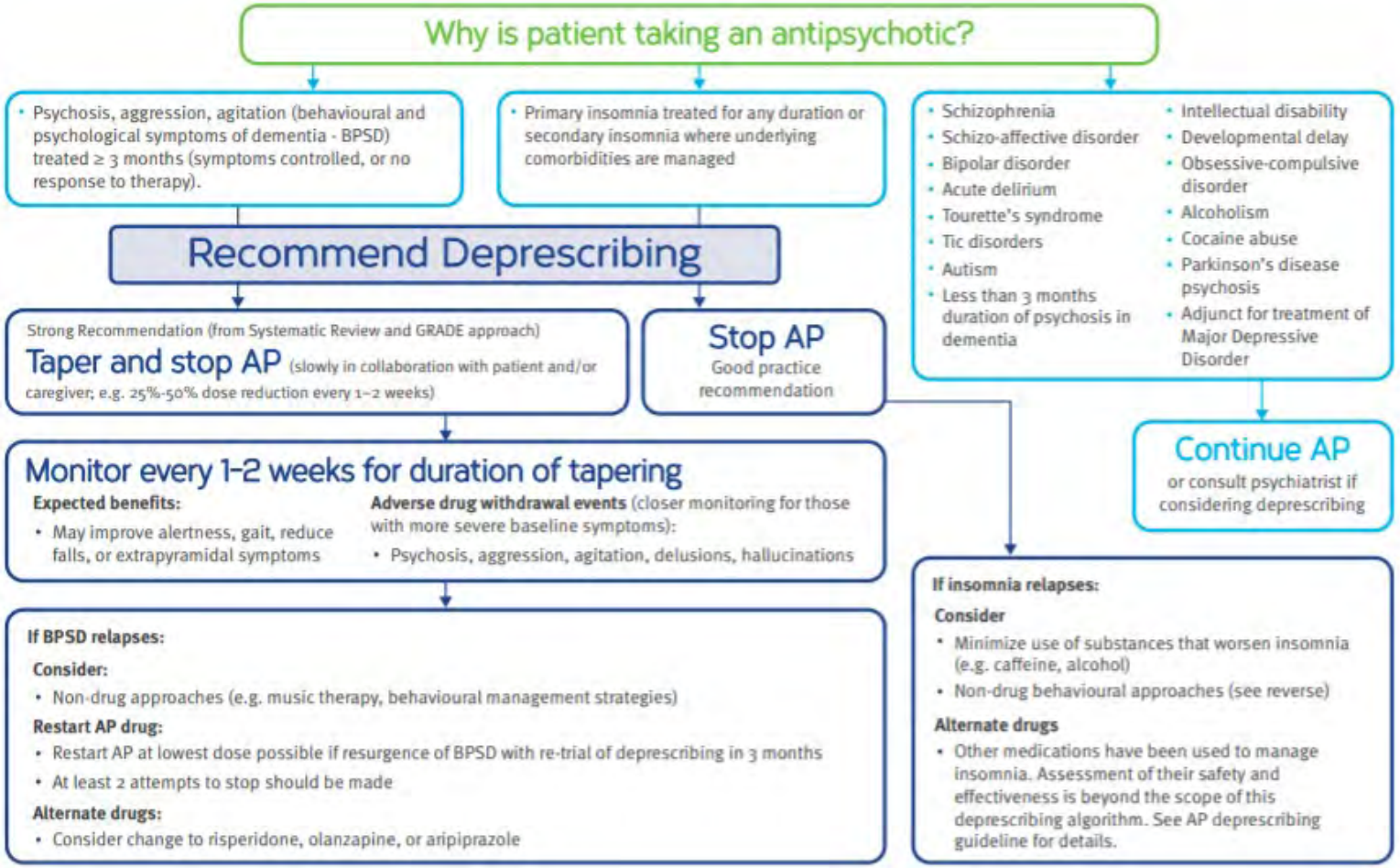


Figure 1 | Proton Pump Inhibitor (PPI) Deprescribing Algorithm
September 2018
Why is patient taking a PPI?
If unsure, find out if history of endoscopy, if ever hospitalized for bleeding ulcer or if taking because of chronic NSAID use in past, if ever had heartburn or dyspepsia
Indication still unknown?
• Mild to moderate esophagitis or
• GERD treated x 4-8 weeks (esophagitis healed, symptoms controlled)
• Peptic Ulcer Disease treated x 2-12 weeks (from NSAID; H. pylori)
• Upper GI symptoms without endoscopy; asymptomatic for 3 consecutive days
• ICU stress ulcer prophylaxis treated beyond ICU admission
• Uncomplicated H. pylori treated x 2 weeks and asymptomatic
• Barrett's esophagus
• Chronic NSAID users with bleeding risk
• Severe esophagitis
• Documented history of bleeding GI ulcer
Recommend Deprescribing
Strong Recommendation (from Systematic Review and GRADE approach)
Decrease to lower dose (evidence suggests no increased risk in return of symptoms compared to continuing higher dose), or
Stop and use on-demand (daily until symptoms stop) (1/10 patients may have return of symptoms)
Stop PPI
Continue PPI
or consult gastroenterologist if considering deprescribing
Monitor at 4 and 12 weeks
If verbal:
• Heartburn • Dyspepsia
• Regurgitation • Epigastric pain
If non-verbal:
• Loss of appetite • Weight loss
• Agitation
Use non-drug approaches
• Avoid meals 2-3 hours before bedtime; elevate head of bed; address if need for weight loss and avoid dietary triggers
Manage occasional symptoms
• Over-the-counter antacid, H2RA, PPI, alginate prn (ie. Tums®, Rolaids®, Zantac®, Olex®, Gaviscon®)
• H2RA daily (weak recommendation – GRADE; 1/5 patients may have symptoms return)
If symptoms relapse:
If symptoms persist x 3 – 7 days and interfere with normal activity:
1) Test and treat for H. pylori
2) Consider return to previous dose


Why is patient taking a BZRA?
If unsure, find out if history of anxiety, past psychiatrist consult, whether may have been started in hospital for sleep, or for grief reaction.
Insomnia on its own OR insomnia where underlying comorbidities managed
For those ≥ 65 years of age: taking BZRA regardless of duration (avoid as first line therapy in older people)
For those 18-64 years of age: taking BZRA > 4 weeks
Other sleeping disorders (e.g. restless legs)
Unmanaged anxiety, depression, physical or mental condition that may be causing or aggravating insomnia
Benzodiazepine effective specifically for anxiety
Alcohol withdrawal
Engage patients (discuss potential risks, benefits, withdrawal plan, symptoms and duration)
Recommend Deprescribing
Continue BZRA
Minimize use of drugs that worsen insomnia (e.g. caffeine, alcohol etc.)
Treat underlying condition
Consider consulting psychologist or psychiatrist or sleep specialist
Taper and then stop BZRA
(taper slowly in collaboration with patient, for example ~25% every two weeks, and if possible, 12.5% reductions near end and/or planned drug-free days)
For those ≥ 65 years of age (strong recommendation from systematic review and GRADE approach)
For those 18-64 years of age (weak recommendation from systematic review and GRADE approach)
Offer behavioural sleeping advice; consider CBT if available (see reverse)
Monitor every 1-2 weeks for duration of tapering
Expected benefits:
May improve alertness, cognition, daytime sedation and reduce falls
Withdrawal symptoms:
Insomnia, anxiety, irritability, sweating, gastrointestinal symptoms (all usually mild and last for days to a few weeks)
Use non-drug approaches to manage insomnia
Use behavioral approaches and/or CBT (see reverse)
If symptoms relapse:
Consider
Maintaining current BZRA dose for 1-2 weeks, then continue to taper at slow rate
Alternate drugs
Other medications have been used to manage insomnia. Assessment of their safety and effectiveness is beyond the scope of this algorithm. See BZRA deprescribing guideline for details.


Why is patient taking an antipsychotic?
Psychosis, aggression, agitation (behavioural and psychological symptoms of dementia - BPSD) treated ≥ 3 months (symptoms controlled, or no response to therapy).
Primary insomnia treated for any duration or secondary insomnia where underlying comorbidities are managed
Schizophrenia
Schizo-affective disorder
Bipolar disorder
Acute delirium
Tourette's syndrome
Tic disorders
Autism
Less than 3 months duration of psychosis in dementia
Intellectual disability
Developmental delay
Obsessive-compulsive disorder
Alcoholism
Cocaine abuse
Parkinson's disease psychosis
Adjunct for treatment of Major Depressive Disorder
Recommend Deprescribing
Strong Recommendation (from Systematic Review and GRADE approach)
Taper and stop AP (slowly in collaboration with patient and/or caregiver; e.g. 25%-50% dose reduction every 1–2 weeks)
Stop AP
Good practice recommendation
Continue AP
or consult psychiatrist if considering deprescribing
Monitor every 1-2 weeks for duration of tapering
Expected benefits:
May improve alertness, gait, reduce falls, or extrapyramidal symptoms
Adverse drug withdrawal events (closer monitoring for those with more severe baseline symptoms):
Psychosis, aggression, agitation, delusions, hallucinations
If BPSD relapses:
Consider:
Non-drug approaches (e.g. music therapy, behavioural management strategies)
Restart AP drug:
Restart AP at lowest dose possible if resurgence of BPSD with re-trial of deprescribing in 3 months
At least 2 attempts to stop should be made
Alternate drugs:
Consider change to risperidone, olanzapine, or aripiprazole
If insomnia relapses:
Consider
Minimize use of substances that worsen insomnia (e.g. caffeine, alcohol)
Non-drug behavioural approaches (see reverse)
Alternate drugs
Other medications have been used to manage insomnia. Assessment of their safety and effectiveness is beyond the scope of this deprescribing algorithm. See AP deprescribing guideline for details.

STATEMENT OF LEADERSHIP COMMITMENT FOR PSYCHOTROPIC STEWARDSHIP IN A SKILLED NURSING FACILITY

INSERT FACILITY NAME commits to the reduction of psychotropic use in our facility. Facility leadership, INSERT ADMINISTRATOR AND DIRECTOR OF NURSING, is committed to embracing and adhering to CMS guidelines and regulations for reduction of Psychotropics in Nursing Homes. The seven pillars for psychotropic stewardship include leadership commitment, accountability, drug action, expertise, tracking, reporting, and education.

Our administration has identified a Psychotropic Stewardship Committee Leadership Team. Our Psychotropic Stewardship leadership team includes a physician/physician assistant or nurse practitioner, a nurse, and a pharmacist working in collaboration as appropriate by facility resources and/or structure. This team will meet at least quarterly as applicable.

1) Our Psychotropic Stewardship psychiatrist/representative is: INSERT PSYCHIATRIST/REPRESENTATIVE FULL NAME AND TITLE
2) Our Psychotropic Stewardship prescriber/nurse practitioner is: INSERT PRESCRIBER/NURSE PRACTITIONER FULL NAME AND TITLE HERE
3) Our Psychotropic Stewardship nurse is: INSERT NURSE'S FULL NAME AND TITLE
4) Our Psychotropic Stewardship social worker/MDS coordinator: INSERT SOCIAL WORKER/MDS COORDINATOR FULL NAME AND TITLE
5) Our Psychotropic Stewardship pharmacist : INSERT PHARMACIST'S FULL NAME AND TITLE

STATEMENT OF COMMITMENT

1) We, the administration, are committed to supporting efforts that reduce psychotropic use in our facility. (Leadership Commitment Pillar)
    - Despite the facility's lowering trends of in-house psychotropic medication use in the facility, CMS goals are requiring additional psychotropic reductions.
2) We understand that psychotropic reduction is an interdisciplinary activity that improves the selection of a psychotropic therapy (correct drug, dose, duration, and ordered only when necessary).
    - Implementing adequate follow up (behavior monitoring) after prescribing of psychotropic medications to determine if orders can be changed, reduced, or discontinued.
3) We will include psychotropic stewardship-related duties in position descriptions for the psychiatrist, clinical nurse leads, and consultant pharmacists. (Accountability Pillar)
4) We will communicate with nursing staff and prescribing clinicians the facility's expectations about use of psychotropics and the monitoring and enforcement of gradual dose reduction Guidelines. (Action Pillar)
5) We will assist our prescribers, nurses, and our consultant pharmacists in developing psychotropic use guidelines/regulations that ensure the appropriateness (drug, dose and duration of therapy) of any new psychotropic agent ordered. We will attempt to reach out to clinicians with psychiatric expertise in the LTC community.(Drug Expertise Pillar)
6) We will work with our prescribers, nurses and our consultant pharmacist to create a system that monitors and shares reports regarding psychotropic medication use (consumption) in the facility. (Tracking and Reporting Pillar)
7) We commit to creating a culture, through messaging, education, and encouraging improvement, which promotes psychotropic stewardship within our facility. (Education Pillar)

_____ _____
Medical Director/ Administrator (Printed Name and Signature) Date

_____ _____
Director of Nursing (Printed Name and Signature) Date

_____ _____
Facility's Lead AMS Champion (Printed Name and Signature) Date

TO: [INSERT RELEVANT STAFF NAMES]

FROM: PSYCHOTROPIC STEWARDSHIP PROGRAM TEAM

RE: [FACILITY NAME] PSYCHOTROPIC STEWARDSHIP PROGRAM INTERVENTION

DATE: [INSERT DATE]

Psychotropic Medications are among the most commonly prescribed pharmaceuticals in long-term care settings, yet reports indicate that a high proportion of psychotropic medication prescriptions are unnecessary. The adverse consequences of unnecessary psychotropic medication use include adverse drug reactions or interactions, and greatly increased costs. CMS characterizes psychotropic medication overuse as "one of the country's most pressing public health challenge." Overutilization of prescribing practices by clinicians and inappropriate use of, psychotropic medications are believed to be the primary contributors to this problem. As a result of the above complexities, nursing homes are increasingly recognized as over users of psychotropic medications.

To address these issues, [INSERT NAME OF NURSING HOME] has developed a psychotropic stewardship program. Psychotropic stewardship is the act of using psychotropic medications appropriately – that is, using them only when truly required. This program includes tools, policies, and procedures that aim to guide nursing home staff toward more responsible and effective use of psychotropics.

This effort, to be implemented beginning [INSERT DATE], is crucial to improving outcomes for our residents and the nursing home as a whole. Your participation will be essential.

[INSERT NAME AND TITLE OF AUTHORIZING OFFICER]

[INSERT DATE]

POLARIS PHARMACY SERVICES Rx

Psychotropic Report Form For Long Term Care

PSYCHOTROPIC STEWARDSHIP

Resident Name:	
DOB:	

	Pharmacological Screening	Exclusionary Criteria	Intervention
	Must Have: a supervisor/nurse manager must be notified of change request for psych med.		Prior to contacting psych/prescriber to add/increase/change psychotropic medication – first notify supervisor and R/O psych behavior
	❑ Pain ❑ COPD/dyspnea ❑ Infection ❑ Environment/readjustment (e.g. dementia/fear) ❑ Sleep hygiene ❑ Endocrine (e.g. thyroid, diabetes)	Investigate and determine that resident is not experiencing any of the exclusions.	Non pharmacological interventions should be applied.
Behavior Checklist	Anxiety-related	❑ Anxiety ❑ Panic ❑ Phobias ❑ Obsessive compulsive behaviors	0 1 2 3 4 0 1 2 3 4 0 1 2 3 4 0 1 2 3 4
	Mood related	❑ Irritability ❑ Aggression ❑ Hypersexuality	0 1 2 3 4 0 1 2 3 4 0 1 2 3 4
	Depressed mood	❑ Loss of interest/unhappy/underactivity ❑ Appetite ❑ Sleep issues	0 1 2 3 4 0 1 2 3 4 0 1 2 3 4
	Psychotic related	❑ Self talk ❑ Delusions/hallucinosis ❑ History of schizophrenia/Tourette's or Huntington's disease	0 1 2 3 4 0 1 2 3 4 0 1 2 3 4
	Other	❑ Alcohol/drug abuse (new on set or history) ❑ PTSD/trauma	0 1 2 3 4 0 1 2 3 4

Completed by: _____ Date/time: _____

Reviewed by: _____ Date: _____

When using the checklist scale- if resident is determined to be a 0,1 or 2- pharmacological therapy is not recommended.
If resident is determined to be a 3 + 4- may require pharmacological intervention + comprehensive by a clinician/psychiatrist.

PROACTIVE ASSESSMENT

Antipsychotics in Long Term/Short Term Residents

Steps in the Process	Potential Failure Modes	Failure Causes	Failure Effects	Likelihood of Occurrence (1-10)	Likelihood of Detection (1-10)	Severity Score Total of 2 previous columns	Actions to Reduce Failure
New onset or worsening behavior noted in a resident	Nurse fails to implement all possible nonpharmacological interventions	Lack of time	Inappropriate intervention Nurse requests medication increase or initiation to reduce resident behaviors				Training and education of all nurse staff regarding the importance and the need to exhaust all non pharmacological interventions. Become familiar with resident routine and habits, in an attempt to anticipate needs prior to resident becoming increasingly agitated
Nurse calls or speaks to MD/Psych	MD unfamiliar with resident and accepts information provided by nurse/interprets call as a need for med intervention. Physician prescribes an antipsychotic not justified by the behaviors consistent with anxiety most often presented, and fails to attempt a short-term anxiolytic	Inappropriate procedure/lack of appropriate nursing intervention. Physicians avoiding 14 days CMS rule for PRN psychotropic opt for routine medication	Physician is swayed to order a new medication according to information being relayed				Discuss and hold forum with physicians addressing prescribing behaviors and exhausting all alternative treatment methods prior to initiating medicinal treatment for behavior, including sleep logs etc. Redirect staff. Psych eval first.
MD orders new psych eval or antipsychotic prescription	Med is administered even in the absence of behaviors	Physician does not assess whether alternative methods have been attempted,	Treatment can reduce level of function, dependency, or lead to EPS				Educate and reinforce behavior documentation. Initiate stop and re-evaluation dates for all new Rx antipsychotic medications or increased doses
Psych hesitant to change current Rx or go against family/resident request	Failure to justify med use with appropriate rationale	Reduced behaviors due to chemical effects gives the false perception of effectiveness of drug when alt methods may work just as well	Prolonged inappropriate med use leading to F329 citation				Audit conducted and routinely ongoing to ensure justification for medication is supported in MD documentation.

PROACTIVE ASSESSMENT

Antipsychotics in Long Term/Short Term Residents

Steps in the Process	Potential Failure Modes	Failure Causes	Failure Effects	Likelihood of Occurrence (1-10)	Likelihood of Detection (1-10)	Severity Score Total of 2 previous columns	Actions to Reduce Failure
MDS is coded as resident having received antipsychotic in the last 7 days	Coding is completed for use despite need/symptoms	Antipsychotic utilization is never Rx'd PRN unless attempting GDR from a routine Rx, so the tx will always be routine and trigger as multiple doses in 7 days look back period on MDS	Increase in MDS Quality Measure Monthly report for Long and Short-term resident antipsychotic utilization in comparison to state and national triggers				Prevent this with above listed interventions

ANALYSIS

The failure occurs at the point in which the nurse places a call to the physician or approaches the physician to report an increase in resident behaviors without having properly utilized all available nonpharmacological options for redirecting and minimizing resident behaviors. Physician is dependent upon the nurse to communicate all necessary information, and a call or request from the nurse will be answered with treatment orders under the assumption that all else has failed.

PLAN

Re-education and re-enforcement to all staff on the use of all non-pharmacological intervention for redirecting and reducing a resident behavior, with a call to the physician for further recommendation only after all non-pharmacological interventions have failed.

Education for all direct care staff on the management of the Elderly with Dementia and psychiatric conditions.

Education and discussion with the physician's and psychiatrist consultants on the requirement for documented rationale for the use of an antipsychotic medication and timeliness or follow up and GDR as appropriate, and in accordance with state and federal regulation

RESULTS

Psychiatric Symptoms and Behavior Checklist

Name: _____

DOB____/____/____

Checklist can be completed by primary care provider, or by caregiver and reviewed by provider

Please mark the list below:

No symptoms--0
Mild symptoms occasionally--1
Mild symptoms some of the time--2
Major symptoms some of the time--3 Major symptoms all of the time--4

Scale

Symptoms and behaviors	BASELINE [1] Mark if usually present	NEW Mark if recent onset	COMMENTS If new onset or increased
Anxiety-related			
Anxiety			
Panic			
Phobias			
Obsessive thoughts			
Compulsive behaviors			
Rituals/routines			
Other			
Mood-related			
Agitation			
Irritability			
Aggression			
Self-injurious behavior			
Depressed mood			
Loss of interest • Unhappy/miserable • Under-activity			
Sleep issues			
Eating pattern			
Appetite			
Weight (provide details)			
Elevated mood			
Intrusiveness			
Hypersexuality			
Other			
Psychotic-related [2]			
Psychotic and psychotic-like symptoms (e.g., self talk, delusions, hallucinations)			
Movement-related			
Catatonia ('stuck')			
Tics			
Stereotypies (repetitive movements or utterances)			
ADHD-related or Mood Disorder			
Inattention			
Hyperactivity			
Impulsivity			
Dementia-related			
Concentration			
Memory			
Other			
Other			
Alcohol misuse			
Drug abuse			
Sexual issues/problems			
Psychosomatic complaints			

[1] Establish usual baseline i.e., behaviors and daily functioning before onset of concerns. [2] Use caution when interpreting psychotic-like symptoms and behaviors in patients with IDD. These may be associated with anxiety (or other circumstances) rather than a psychotic disorder.

NONPHARMACOLOGIC TREATMENT– treatment of underlying medical conditions should always be the first treatment strategy and implemented in all residents with agitation/distress. Whenever possible, these interventions should be selected and tailored to the resident'spreferences, skills and abilities.

Examples of Nonpharmacologic Treatment Categories and Strategies

Sensory	Music therapy, white noise therapy, massage, light therapy, physical touch (with caution in some), tactile stimulation, olfactory stimulation, dolls, pegboards. Reduction of sensory input may be effective (i.e. quiet room, less talk, less touch).
Environmental	Increase in personal space, reduction in disruptive stimuli, special care units, lightning. Positive behavior among caregivers and staff. Plants, pets, magazines, gardening and animal books.
Behavioral	Reinforcement of alternative behaviors, positive reinforcement, behavior modeling, validation therapy, redirection, psychotherapy. Kneeling down to establish eye contact. Use short sentences and give extra time for response. Avoid reality orientation. Increase pleasure activities.
Communication	Awareness of caregiver's nonverbal, verbal and written communication skills. Consistent, individualized caregiver's approach that recognizes the needs of the resident.
Family Support and Education	Offer caregiver classes, provide written materials, refer families and caregivers to local support groups.
Exercise	Encourage physical activities to optimize outcomes.

What is a Gradual Dose Reduction (GDR)?

Gradual dose reductions (GDRs) are a standard practice in nursing homes and in other types of facilities. In a nursing home, government regulations require that certain drugs affecting the brain (such as medications for distressed behaviors, anxiety, sleep, and depression) be assessed for a GDR at regular intervals. Several physicians' groups and the Alzheimer's Association also recommend GDRs. This is a good practice to make sure residents are safe and are taking the lowest possible effective dose of a medication.

Gradually reducing the dose of medications is a way to make sure someone is taking the lowest effective dose. Lower doses have less risk for side effects. Stopping the medication after it has been successfully lowered can tell us if the medication is still needed. This can be a safe practice in nursing homes or other facilities, because staff can watch as these changes are made.

Some Reasons to Lower Doses or to Stop Medications Include:

- ✓ Medications are not able to fix problems such as behaviors caused by unmet needs or a side effect of another medication
- ✓ Use of many medications at the same time can increase side effects and the risk for interactions between them
- ✓ Aging and illness can make medications stay in the body much longer, which increases the risk of side effects
- ✓ People with several different diseases are often more sensitive to medications and have unusual reactions to them (especially older adults)

Medications, aging, and illness can make people more likely to fall, become confused, get infections or have other complications. For this reason, GDRs are important to assess if a medication is being used at the right dose, for the right reason, for the right amount of time. Sometimes medications that worked in the past are no longer the best choice and a change is needed. Sometimes a dose should be lowered, or a medication should be stopped. Several facility team members are involved in determining if a GDR could be tried, such as doctors, nursing staff, consultant pharmacists and others.

The Florida Society For Post-Acute And Long-Term Care Medicine

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POLST FLORIDA
PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT

Best Care Practices
In the Post-Acute & Long-Term Care Continuum

This meeting has been recorded and will be available at www.fmda.org/journalclub.php