

Complex Case: Skilled Nursing Care

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Relevant Financial Relationship Disclosure

No one in control of the content of this activity has a relevant financial relationship (RFR) with an ineligible company.

As defined by the Standards of Integrity and Independence in Accredited Continuing Education definition of ineligible company. All relevant financial relationships have been mitigated prior to the CPE activity.

Learning Objectives

- Interpret results of screening and assessments in the management of the geriatric patient.
- Select the appropriate treatment and monitoring for a complex patient-case with multiple conditions, including:
 - Anemia
 - Anxiety
 - Deep vein thrombosis (DVT) prophylaxis
 - Osteoporosis
 - Pain management
 - Syndrome of inappropriate antidiuretic hormone (SIADH)
 - Falls
 - Constipation
- Explain the need for continuity of treatment and communication across the spectrum of services and during transitions between care settings.
- Identify potential medication-related causes of declining physical and cognitive function.

Learning Objectives (cont.)

- Select methods to facilitate medication reconciliation during transitions of care.
- Summarize limitations of biomedical information for the care of older adults.
- Apply outcomes of investigations to optimize care of older adults.
- Develop strategies to prevent or resolve iatrogenic conditions.
- Identify elder abuse/neglect (e.g., physical, psychological, and financial).
- Identify resources to assist in prevention, reporting, and treatment of elder abuse/neglect.

Premise

- You are a clinical geriatric pharmacy specialist who practices at Oak Springs, a 30-bed skilled nursing facility (SNF). You have a great working relationship with the physicians and therapists at Oak Springs and are an integral member of the healthcare team.
- As the pharmacist, you are responsible for evaluating and monitoring every patient's therapy at the facility.
- Upon admission to the facility, a complete medication reconciliation and review must be performed, in addition to monthly chart reviews.
- You are responsible for providing comprehensive drug therapy management and education for all patients residing in the SNF.

Skilled Nursing Care Case - RH

- CC: “I am here to get better and go home. I would like to go home as soon as possible!”
- RH is a 77-year-old Native American female patient who is being admitted to Oak Springs SNF for an inpatient rehabilitation program physical therapy (PT) and occupational therapy (OT).
- RH is status-post day 5 for an open reduction internal fixation (ORIF) to her right hip after she suffered a fall. She had a somewhat complicated hospital stay and is recovering from delirium and pneumonia. Upon discharge assessment from the hospital, she was deemed to be a high fall risk and not safe to go home at this time.

Skilled Nursing Care Case – RH (cont.)

- At hospital discharge, she was assessed and determined to be weight bearing as tolerated (WBAT) to her right lower extremity. Per her daughter, RH was completely independent of all ADLs and IADLs prior to her fall and cared for her 7-year-old great granddaughter during the day.
- Subacute rehabilitation/SNF recommended at least 4 weeks of therapy with re-assessment at that time. She plans on being discharged back home with her family.

Skilled Nursing Care Case – RH (cont.)

- PMH
 - Anxiety
 - Hypertension
 - Hyperlipidemia
 - Type 2 diabetes mellitus
 - Osteoarthritis
 - ORIF R hip (five days ago)

Skilled Nursing Care Case – RH (cont.)

- Medications (upon hospital discharge)
 - Acetaminophen 650 mg orally every 6 hours
 - Alprazolam 0.25 mg orally twice daily*
 - Aspirin (enteric coated) 81 mg orally once daily*
 - Carvedilol 6.25 mg orally twice daily with meals*
 - Ceftriaxone 2 g IV every 24 hours for one more dose
 - Cetirizine 10 mg orally once daily*
 - Citalopram 10 mg orally once daily
 - Glipizide 5 mg orally twice daily with meals*
 - Enoxaparin 40 mg subcutaneously once daily
 - Famotidine 20 mg orally twice daily
 - Lisinopril 40 mg orally once daily*
 - Oxycodone 5 mg orally every 6 hours as needed for moderate to severe pain
 - Senna 8.6 mg orally once daily
 - Simvastatin 20 mg orally daily at bedtime*
 - Extended-release verapamil 240 mg orally daily at bedtime*
 - Quetiapine 12.5 mg orally as needed for agitation

*denotes home medications

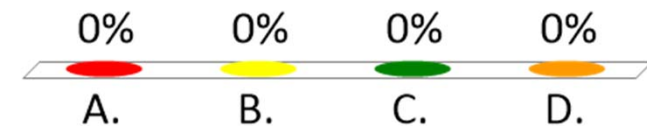
Medication Reconciliation

- Upon admission to the SNF, you are required to conduct a patient assessment and medication reconciliation.

Question 1:

During RH's transition of care medication reconciliation, which of the following medications should be addressed due to lack of indication and/or necessity?

- A. Aspirin, citalopram, famotidine
- B. Citalopram, famotidine, quetiapine
- C. Aspirin, famotidine, quetiapine
- D. Aspirin, citalopram, quetiapine



Causes and Consequences of Poor Medication Reconciliation

- Causes of medication discrepancies and errors
 - Rushed decision making
 - Problematic timing of discharges
 - Poor communication
 - System-generated vs. patient-generated
 - Intentional vs. unintentional
- Common discrepancies
 - Incorrect indication, no monitoring parameters, omissions, incorrect dose, incorrect frequency, duplications, interactions, need to continue/stop dates
- Consequences
 - Inappropriate medications, prescribing cascade, lack of indicated use, delays in care, increased expenditures

Tong M, et al. *J Gerontol Nurs*. 2017; 43(4):9-14.

Gadbois EA, et al. *J Gen Intern Med*. 2019; 34(1):102-9.

Johnson A, et al. *J Am Pharm Assoc*. 2015; 55(2):e264-74.

Manias E, et al. *Res Social Adm Pharm*. 2015; 11(3):442-7.

Comprehensive Medication Reconciliation

- Should be proactive, not retrospective
- Most recent medication list does not always mean the best possible comprehensive medication history
 - Systematic approach → records, discharge list, prescription containers, patient/caregiver interview
 - Open communication and an interdisciplinary “handoff”
 - Access to prescriber with knowledge of patient
 - Involve patient and family/caregiver, such as new patient orientation
 - Electronic medication reconciliation tools

King BJ, et al. *J Am Geriatr Soc*. 2013; 61(7):1095-102.

Gadbois EA, et al. *J Gen Intern Med*. 2019; 34(1):102-9.

Manias E, et al. *Res Social Adm Pharm*. 2015; 11(3):442-7.

Medication Reconciliation Resources

- ASHP Medication Reconciliation Guidance for Pharmacists
 - Obtain medication history, conduct medication reconciliation, and contact prescribers for recommendations
- Guidelines for Admission Medication Regimen Review (aMRR) in the Nursing Facility Setting – ASCP
 - Should be performed as close to actual admission as possible
 - 4 step process:
 - Obtain necessary information/records for review
 - Clinical review process
 - Communication of irregularities from review
 - Documentation of review

Guidelines for Admission Medication Regimen Review in the Nursing Facility Setting.
https://cdn.vmw.com/www.ascp.com/resource/collection/28D69F2D-18D9-4EF8-A086-675AB7E4ECD8/ASCP_Admission_MRR_Guidance_Final_BOD.pdf
(accessed 2021 Sept 13).

ASHP Medication Reconciliation Guidance Document for Pharmacists.
<https://www.ashp.org/-/media/assets/pharmacy-practice/resource-centers/ambulatory-care/medication-reconciliation-guidance-document-for-pharmacists.ashx?la=en&hash=8E66CC1F528D577B650D3B19F4A2EE310E68A75B>. (accessed 2021 Sept 13).

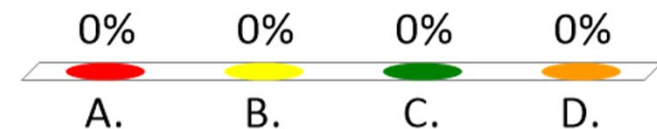
Osteoporosis

- Based on her clinical presentation, RH meets the criteria to start pharmacotherapy for osteoporosis. After your initial assessment and review of RH at the SNF, you decide to recommend an agent.

Question 2:

In addition to initiating a calcium/vitamin D supplement, which of the following is the most clinically appropriate treatment option for RH's osteoporosis?

- A. Alendronate 35 mg orally weekly
- B. Calcitonin 200 IU, 1 spray in one nare intranasally daily, alternating nostrils daily
- C. Ibandronate 150 mg orally weekly
- D. Zoledronic acid 5 mg intravenously over 15 minutes every year



Osteoporosis

- Tools for assessment
 - Central dual-energy X-ray absorptiometry (DXA)
 - T-score, Z-score, bone mineral density (BMD)
 - Fracture risk assessment tool (FRAX®)
- Initiation of pharmacological treatment
 - Central DXA
 - T-score ≤ -2.5 in lumbar spine, femoral neck, or total hip
 - T-score between -1 and -2.5 **AND** FRAX® 10-year all major osteoporosis-related fracture probability $\geq 20\%$ **OR** FRAX® 10-year hip fracture probability $\geq 3\%$ in U.S.
 - Non-traumatic fragility fracture of hip or spine

Camacho PM, et al. *Endocr Pract.* 2020; 26(5):564-70.

Cosman F, et al. *Osteoporos Int.* 2014; 25(10):2359-81.

Eastell R, et al. *J Clin Endocrinol Metab.* 2019; 104(5):1595-1622.

Bisphosphonates

	Alendronate	Risedronate	Ibandronate	Zoledronic acid
Dosage forms	Oral only (vitamin D combo, effervescent tablet)	Oral only (delayed release, calcium carbonate combo)	Oral; intravenous injection	Intravenous infusion only
Prevention dose available?	Yes	Yes	Yes	Yes
Evidence in:				
-Vertebral fx	Yes	Yes	Yes	Yes
-Nonvertebral fx	Yes	Yes	No	Yes
-Hip fx	Yes	Yes	No	Yes
-Glucocorticoid-induced osteoporosis	Yes	Yes	No	Yes
Recommended for men?	Yes	Yes	No	Yes

Nayak S, et al. *J Am Geriatr Soc.* 2017; 65(3):490-5.

Camacho PM, et al. *Endocr Pract.* 2020; 26(5):564-70.

Cosman F, et al. *Osteoporos Int.* 2014; 25(10):2359-81.

Crandall CJ, et al. *Ann Intern Med.* 2014; 161(10):711-23.

Eastell R, et al. *J Clin Endocrinol Metab.* 2019; 104(5):1595-1622.

Clinical Guidelines Committee of the American College of Physicians. *Ann Intern Med.* 2017; 166(11):818-39.

Bisphosphonates

- Bisphosphonate cautions/safety
 - Avoid in: poor renal function ($\text{GFR} \leq 30\text{-}35 \text{ mL/min}$), hypocalcemia, active upper GI disease or esophageal abnormality (oral version only), inability to follow administration instructions, shortened life expectancy
 - Common side effects: upper GI irritation, bone/joint pain
 - Potentially severe but rare side effects: atypical femur fractures (AFF), osteonecrosis of the jaw (ONJ), atrial fibrillation

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Clinical Guidelines Committee of the American College of Physicians. *Ann Intern Med.* 2017; 166(11):818-39.

Other Medication Options

	Classification	Route of Administration	Demonstrated Fracture Risk Reduction	Recommended for Men
Antiresorptive Agents				
Denosumab	Monoclonal antibody - RANKL/RANKL inhibitor*	Subcutaneous injection	Vertebral, hip, nonvertebral	Yes
Raloxifene	Estrogen agonist/antagonist	Oral	Vertebral only	No
Calcitonin	Calcium metabolism modifier	Intranasal spray; subcutaneous injection	Vertebral only	No

*RANKL = receptor activator of nuclear factor kappa-B ligand

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National Osteoporosis Foundation. Clinician's Guide to Prevention and Treatment of Osteoporosis. 2014.

Clinical Guidelines Committee of the American College of Physicians. *Ann Intern Med.* 2017; 166(11):818-39.

Other Medication Options

	Classification	Route of Administration	Demonstrated Fracture Risk Reduction	Recommended for Men
Anabolic Agents				
Teriparatide	Parathyroid hormone analog	Subcutaneous injection	Vertebral, nonvertebral (including hip)	Yes
Abaloparatide	Parathyroid hormone analog	Subcutaneous injection	Vertebral, nonvertebral (including hip)	No (pending)
Antiresorptive/Anabolic Agent				
Romosozumab	Monoclonal antibody - inhibits sclerostin	Subcutaneous injection	Vertebral, nonvertebral (including hip)	No

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Camacho PM, et al. *Endocr Pract.* 2020; 26(5):564-70.

Crandall CJ, et al. *Ann Intern Med.* 2014; 161(10):711-23.

Eastell R, et al. *J Clin Endocrinol Metab.* 2019; 104(5):1595-1622.

National Osteoporosis Foundation. Clinician's Guide to Prevention and Treatment of Osteoporosis. 2014.

Clinical Guidelines Committee of the American College of Physicians. *Ann Intern Med.* 2017; 166(11):818-39.

Osteoporosis Last-Line Therapies

- Hormonal products
 - Estrogen and conjugated estrogen/bazedoxifene
 - Variety of dosage formulations, preparations, and regimens
 - Evidence for *prevention* of vertebral and hip fractures in postmenopausal women
 - Woman's Health Initiative Investigators (2002)
 - Increased risk of MI, stroke, invasive breast cancer, thrombotic events
- Do not recommend combination therapy at this time

Camacho PM, et al. *Endocr Pract.* 2020; 26(5):564-70.

Cosman F, et al. *Osteoporos Int.* 2014; 25(10):2359-81.

Eastell R, et al. *J Clin Endocrinol Metab.* 2019; 104(5):1595-1622.

Clinical Guidelines Committee of the American College of Physicians. *Ann Intern Med.* 2017; 166(11):818-39.

Rossouw JE, et al; Writing Group for the Women's Health Initiative Investigators. *JAMA.* 2002; 288(3):321-33.

Calcium and Vitamin D

- Elemental calcium: carbonate (40%) & citrate (21%)
 - RDA: 1000-1200 mg/day
 - Dietary intake must be factored in
- Vitamin D: ergocalciferol (D₂) & cholecalciferol (D₃)
 - RDA: 1000 IU/day (25 mcg), up to 4000 IU/day (100 mcg)
 - Additional supplementation needed for vitamin D insufficient or deficient patients

Camacho PM, et al. *Endocr Pract.* 2020; 26(5):564-70.

Cosman F, et al. *Osteoporos Int.* 2014; 25(10):2359-81.

Eastell R, et al. *J Clin Endocrinol Metab.* 2019; 104(5):1595-1622.

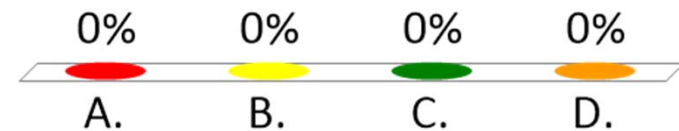
Postmenopausal Osteoporosis – Stepwise Approach

- Correct calcium/vitamin D deficiencies and any causes of secondary osteoporosis
- Lifestyle/non-pharmacological methods and fall prevention
- High risk/no prior fractures
 - Alendronate, denosumab, risedronate, zoledronic acid
 - Alternative: ibandronate, raloxifene
- Very high risk/prior fractures
 - Abaloparatide, teriparatide, denosumab, romosozumab, zoledronic acid
 - Alternative: alendronate, risedronate

Question 3:

If RH is sent out to a local breast health center for a central dual energy X-ray absorptiometry (DXA) today prior to starting her new pharmacotherapy for osteoporosis, how soon would RH need to have another DXA scan performed to assess response to treatment for her osteoporosis?

- A. 4 weeks
- B. 6 months
- C. 2 years
- D. 10 years



Monitoring - Osteoporosis

- Central DXA
- Biochemical markers of bone turnover
 - Resorption marker: serum C-terminal telopeptide (CTX)
 - Formation marker: serum carboxy-terminal propeptide of type 1 collagen (P1NP)
- Annual height changes

Adler RA, et al. *J Bone Miner Res.* 2016; 31(10):1910.

Camacho PM, et al. *Endocr Pract.* 2020; 26(5):564-70.

Cosman F, et al. *Osteoporos Int.* 2014; 25(10):2359-81.

Eastell R, et al. *J Clin Endocrinol Metab.* 2019; 104(5):1595-1622.

Clinical Guidelines Committee of the American College of Physicians. *Ann Intern Med.* 2017; 166(11):818-39.

Duration of Therapy - Osteoporosis

- Bisphosphonate holidays
 - Based on FLEX and HORIZON extension studies
 - Low likelihood of fracture: oral bisphosphonate for at least 5 years or IV bisphosphonate for at least 3 years
 - High likelihood of fracture: oral bisphosphonate for 6 to 10 years or IV bisphosphonate for at least 6 years
 - Duration of holiday: based on individual patient factors
- Romosozumab
 - Bone-forming effect declines after one year
- Parathyroid hormone analogs
 - Maximum of 2 years of therapy
 - Abaloparatide: US Boxed Warning for osteosarcoma

Seton M. *Arthritis Rheumatol.* 2017; 69(3):494-8.

Adler RA, et al. *J Bone Miner Res.* 2016; 31(10):1910.

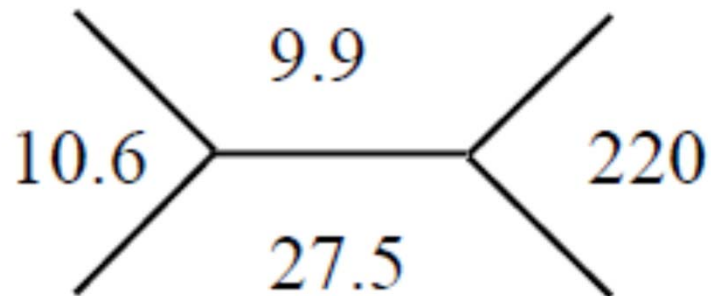
Camacho PM, et al. *Endocr Pract.* 2020; 26(5):564-70.

Diab DL, et al. *Ther Adv Musculoskelet Dis.* 2013; 5(3):107-11.

Eastell R, et al. *J Clin Endocrinol Metab.* 2019; 104(5):1595-1622.

Anemia

- Your review of RH's admission labs reveals the following:



RBC: 4.01

MCV: 104.5

MCH: 32.1

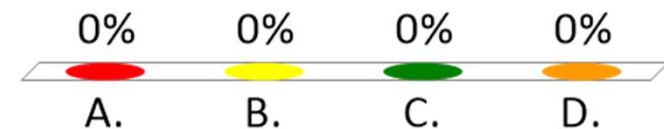
MCHC: 34.4

RDW: 13.0

Question 4:

Based on these results, including decreased hemoglobin (Hgb) and hematocrit (Hct) and elevated mean corpuscular volume (MCV), what would be the most appropriate next step to address her anemia?

- A. Administer epoetin alfa to stimulate erythropoiesis
- B. Measure serum vitamin B12 level to check for pernicious anemia
- C. Obtain a fecal occult blood test to rule out a gastrointestinal bleed
- D. Start ferrous sulfate and check iron panel in three months



Anemia

- Public health crisis
 - Minor problem with major implications
- Contributing factors
 - Age-related changes
 - Gender differences
 - Racial differences
 - Medications
- Common presentations of anemia in older adults
 - Deficiency-related anemias, anemias of chronic disease, unexplained anemia

Lanier JB, et al. *Am Fam Physician*. 2018; 98(7):437-42.

Goodnough LT, et al. *Am J Hematol*. 2014; 89(1):88-96.

Pang WW, et al. *Curr Opin Hematol*. 2012; 19(3):133-40.

Lam S, et al. Chapter 16. Anemia and Preventive Therapy. *Fundamentals of Geriatric Pharmacotherapy*. 2nd ed; 2015:480-8.

Iron-Deficiency Anemia

- Causes: blood loss, atrophic gastritis, low iron intake
- Gold standard: bone marrow aspirate stain or response to trial of iron
 - Clinical definition: ↓ Hgb/Hct, ↓ MCV, ↓ serum iron, ↓ ferritin, ↑ total iron binding capacity (TIBC), ↓ transferrin saturation (TSAT)

Lanier JB, et al. *Am Fam Physician*. 2018; 98(7):437-42.

Pang WW, et al. *Curr Opin Hematol*. 2012; 19(3):133-40.

Lam S, et al. Chapter 16. Anemia and Preventive Therapy. *Fundamentals of Geriatric Pharmacotherapy*. 2nd ed; 2015:480-8.

Iron-Deficiency Anemia (cont.)

- Treatment: iron supplementation
 - If a suspected bleed, need to find the source of the bleed first
 - Oral preferred over intravenous route unless ESRD
 - Low doses (≤ 325 mg orally daily or every other day dosing)
 - Empty stomach vs. with meals
 - Ferrous vs. ferric oral iron formulations
 - Improved absorption with co-medications to decrease gastric pH
 - Vitamin C, fruit juices
 - Continued 3 months after iron deficiency corrected

Lanier JB, et al. *Am Fam Physician*. 2018; 98(7):437-42.

Pang WW, et al. *Curr Opin Hematol*. 2012; 19(3):133-40.

Hallberg L, et al. *Hum Nutr Appl Nutr*. 1986; 40(2):97-113.

Lam S, et al. Chapter 16. Anemia and Preventive Therapy. *Fundamentals of Geriatric Pharmacotherapy*. 2nd ed; 2015:480-8.

Nutrient-Deficiency Anemia

- Clinical definition: ↓ Hgb/Hct, ↑ MCV,
- Vitamin B₁₂ deficiency
 - Elevated levels of methylmalonic acid (MMA) and homocysteine
 - Pernicious anemia, atrophic gastritis, dietary deficiency, GI compromise, drug-induced
 - Treatment: vitamin B₁₂ supplementation
 - Administered via oral, IM, or deep subQ routes
 - Lifelong therapy
 - Watch for neurological manifestations

Lane LA, et al. *Ann Pharmacol*. 2002;36:1268-72.

Lanier JB, et al. *Am Fam Physician*. 2018; 98(7):437-42.

Pang WW, et al. *Curr Opin Hematol*. 2012; 19(3):133-40.

Lam S, et al. Chapter 16. Anemia and Preventive Therapy. *Fundamentals of Geriatric Pharmacotherapy*. 2nd ed; 2015:480-8.

Nutrient-Deficiency Anemia (cont.)

- Folate deficiency
 - Alcoholism, drug-induced, low dietary intake
 - Treatment: folic acid supplementation
 - PO preferred over parenteral route
 - Duration of therapy depends on cause
- If patient has both nutrient-deficiency anemias, treat vitamin B₁₂ deficiency prior to treating folate deficiency

Lanier JB, et al. *Am Fam Physician*. 2018; 98(7):437-42.

Pang WW, et al. *Curr Opin Hematol*. 2012; 19(3):133-40.

Lam S, et al. Chapter 16. Anemia and Preventive Therapy. *Fundamentals of Geriatric Pharmacotherapy*. 2nd ed; 2015:480-8.

Anemia of Chronic Disease & Unexplained Anemia

- Anemia of chronic kidney disease (CKD)
 - Reduced erythropoietin production
 - Treatment: parenteral iron supplementation + erythropoietic-stimulating agents (ESA) for Hgb < 10 g/dL
- Anemia of inflammation
 - Elevated inflammatory cytokines, ± low serum iron
 - Treatment: treat underlying cause if possible, iron supplementation if low iron indexes, ± ESA

Weiss G, et al. *Blood*. 2019; 133(1):40-50.

Makipour S, et al. *Semin Hematol*. 2008; 45(4):250-4.

Lanier JB, et al. *Am Fam Physician*. 2018; 98(7):437-42.

Goodnough LT, et al. *Am J Hematol*. 2014; 89(1):88-96.

Pang WW, et al. *Curr Opin Hematol*. 2012; 19(3):133-40.

Lam S, et al. Chapter 16. Anemia and Preventive Therapy. *Fundamentals of Geriatric Pharmacotherapy*. 2nd ed; 2015:480-8.

Anemia of Chronic Disease & Unexplained Anemia (cont.)

- Myelodysplasia/hematologic malignancy
 - Bone marrow failure disorder
 - Treatment: bone marrow transplant, \pm ESA, blood transfusions, cancer treatments
- Unexplained anemia in older adults/senile anemia
 - “Waste-basket” diagnosis, stem cell aging, hormone imbalances
 - Treatment: treat underlying cause if possible, \pm ESA, supportive care/non-pharmacological interventions
 - Usually fail iron therapy

Makipour S, et al. *Semin Hematol*. 2008; 45(4):250-4.

Lanier JB, et al. *Am Fam Physician*. 2018; 98(7):437-42.

Goodnough LT, et al. *Am J Hematol*. 2014; 89(1):88-96.

Pang WW, et al. *Curr Opin Hematol*. 2012; 19(3):133-40.

Lam S, et al. Chapter 16. Anemia and Preventive Therapy. *Fundamentals of Geriatric Pharmacotherapy*. 2nd ed; 2015:480-8.

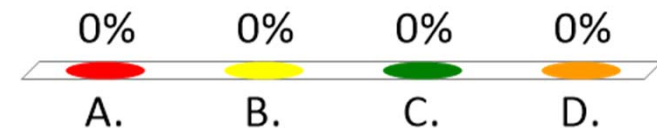
Osteoarthritis/Pain

After several days at the facility, RH is complaining of pain when she attends physical therapy in the mornings and afternoons, and this sometimes limits her ability to fully participate in her sessions. She is using as needed (PRN) oxycodone 5 mg orally once daily to help alleviate this pain after her therapy sessions, as well as her scheduled acetaminophen. She states that she took over-the-counter ibuprofen at home in the past and that can help her pain at times.

Question 5:

Which of the following is a US Boxed Warning associated with the use of nonsteroidal anti-inflammatory drugs (NSAIDs)?

- A. Increased risk of cardiovascular events
- B. Increased risk of suicidal ideations
- C. Increased risk of life-threatening serious rashes
- D. Increased risk of addiction, abuse, and misuse



Assessment - Pain

- Nociceptive vs. neuropathic vs. mixed
 - “PQRST” question approach
- Complete physical and neurological examination
 - Patient’s report is vital (pain diaries)
- Assessment tools
 - Visual Rating Scale, Numerical Rating Scale, Verbal Descriptor Scale, FACES Rating Scale
 - McGill Pain Questionnaire, Brief Pain Inventory
 - Severe cognitive impairment: PAIN-AD, behavioral changes in patient, nonverbal cues

Kaye AD, et al. *Ochsner J.* 2010; 10(3):179-87.

Davis MP, et al. *Drugs Aging.* 2003; 20(1):23-57.

American Geriatrics Society. Pharmacological management of persistent pain in older persons. 2009; 10:1062-83.

Pain Treatment - Non-Pharmacologic Options

- Physical & occupational therapy
- Exercise
- Patient and caregiver education
- Weight reduction (if overweight)
- Assistive devices
 - Footwear and other structural modifications
- Transcutaneous electric nerve stimulation (TENS)
- Hot/cold modalities
- Massage/acupuncture
- Informal cognitive strategies
 - Social gatherings, visiting family/friends, music, prayer, humor, meditation, relaxation

Kaye AD, et al. *Ochsner J*. 2010; 10(3):179-87.

Davis MP, et al. *Drugs Aging*. 2003; 20(1):23-57.

Dowell D, et al. *MMWR Recomm Rep*. 2016; 65:1-49.

Kolasinski SL, et al. *Arthritis Rheumatol*. 2020; 72(2):220-33.

American Geriatrics Society. Pharmacological management of persistent pain in older persons. 2009; 10:1062-83.

Hix M. Chapter 14. Pain and Sensory Disorders. *Fundamentals of Geriatric Pharmacotherapy*. 2nd ed; 2015:424-30.

Pain Treatment - Non-Opioid Analgesics

- Topical agents
 - Capsaicin, topical NSAIDs, lidocaine
- Acetaminophen (APAP)
- NSAIDs
 - COX-2 inhibitors
- Corticosteroids
 - Oral and intra-articular (IA) injections
- Other adjunct options
 - IA hyaluronic acid, skeletal muscle relaxants, serotonin-norepinephrine reuptake inhibitor (SNRIs), anticonvulsants, cannabinoids

Ali A, et al. *Cureus*. 2018; 10(9): e3293.

Kaye AD, et al. *Ochsner J*. 2010; 10(3):179-87.

Davis MP, et al. *Drugs Aging*. 2003; 20(1):23-57.

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Hix M. Chapter 14. Pain and Sensory Disorders. *Fundamentals of Geriatric Pharmacotherapy*. 2nd ed; 2015:424-30.

Pain Treatment - Opioids Analgesics (Selected List)

- Tramadol
- Hydrocodone
- Codeine (in form of APAP/codeine)
- Morphine
- Oxycodone
- Methadone
- Fentanyl
- Hydromorphone

Kaye AD, et al. *Ochsner J.* 2010; 10(3):179-87.

Davis MP, et al. *Drugs Aging.* 2003; 20(1):23-57.

Dowell D, et al. *MMWR Recomm Rep.* 2016; 65:1-49.

Kolasinski SL, et al. *Arthritis Rheumatol.* 2020; 72(2):220-33.

American Geriatrics Society. Pharmacological management of persistent pain in older persons. 2009; 10:1062-83.

Hix M. Chapter 14. Pain and Sensory Disorders. *Fundamentals of Geriatric Pharmacotherapy.* 2nd ed; 2015:424-30.

Monitoring/Cautions - Pain

- Adverse reactions/side effects
 - Age-related changes
 - Multiple dosage forms available → oral route usually preferred
 - NSAIDs
 - US Boxed Warnings for increased CV events and GI bleeds/ulcers
 - Caution in renal insufficiency
 - Opioids
 - Gain tolerance vs. persistent side effects
 - Long-term consequences of opioid therapy

Ali A, et al. *Cureus*. 2018; 10(9): e3293.

Kaye AD, et al. *Ochsner J*. 2010; 10(3):179-87.

Davis MP, et al. *Drugs Aging*. 2003; 20(1):23-57.

Dowell D, et al. *MMWR Recomm Rep*. 2016; 65:1-49.

American Geriatrics Society. Pharmacological management of persistent pain in older persons. 2009; 10:1062-83.

Pain - Guidance for Treatment in Older Adults

- American Geriatrics Society (AGS) Step-wise Approach
 - Start with APAP ± NSAIDs/COX-2 inhibitor with opioids reserved for moderate to severe pain that leads to functional impairment and/or diminished quality of life
 - Continuous pain treated with around-the-clock, long-acting medications
- 2019 ACR/Arthritis Foundation Guidelines for Management of Osteoarthritis of the Hand, Hip, and Knee
 - Strong recommendations for oral NSAIDs with conditional recommendations for APAP, tramadol, and duloxetine

Ali A, et al. *Cureus*. 2018; 10(9): e3293.

Kaye AD, et al. *Ochsner J*. 2010; 10(3):179-87.

Davis MP, et al. *Drugs Aging*. 2003; 20(1):23-57.

Kolasinski SL, et al. *Arthritis Rheumatol*. 2020; 72(2):220-33

American Geriatrics Society. Pharmacological management of persistent pain in older persons. 2009; 10:1062-83.

Pain - Guidance for Treatment in Older Adults (cont.)

- CDC Guideline for Prescribing Opioids for Chronic Pain
 - Start with immediate-release opioids and avoid long-acting agents, methadone, and transdermal fentanyl
- 2019 AGS Beers Criteria – Table 5
 - Avoid opioids and certain combinations
 - Benzodiazepines
 - Gabapentin, pregabalin

Ali A, et al. *Cureus*. 2018; 10(9): e3293.

Kaye AD, et al. *Ochsner J*. 2010; 10(3):179-87.

Davis MP, et al. *Drugs Aging*. 2003; 20(1):23-57.

Dowell D, et al. *MMWR Recomm Rep*. 2016; 65:1-49.

American Geriatrics Society. Pharmacological management of persistent pain in older persons. 2009; 10:1062-83.

Constipation

After changing RH's pain medication regimen, it is noted that RH has decreased bowel sounds and complains of some bloating. Nursing reports her last bowel movement (last night) was large and hard. RH is complaining of increased straining during bowel movements.

Question 6:

Which of the following would be an appropriate bowel regimen for RH?

- A. Magnesium hydroxide (400 mg/5 mL) 15 mL orally every 4 hours
- B. Mineral oil 45 mL orally daily at bedtime
- C. Lubiprostone 24 mcg orally twice daily
- D. Polyethylene glycol 3350 17 g in 8 oz of water orally once daily



Constipation

- High prevalence in older adults
 - Comorbidities, medications, functional status, age-related changes
 - Symptom diagnosis vs. Rome IV criteria
- Primary constipation
 - Slow-transit constipation
 - Defecation disorders
 - Constipation-predominant irritable bowel syndrome (IBS)

Gallagher PF, et al. *Drugs Aging*. 2008; 25(10):807-21.

Gallegos-Orozco JF, et al. *Am J Gastroenterol*. 2012; 107(1):18-25.

Ford AC et al; Task Force on the Management of Functional Bowel Disorders. *Am J Gastroenterol*. 2014; 109 Suppl 1:S2-26.

Secondary Constipation

- Medical disorders/diseases
 - GI, neurological, cardiac, endocrine/metabolic
- Medications
 - Analgesics, antacids, anticholinergics, antidepressants, calcium channel blockers, diuretics, anticonvulsants, calcium, iron
- Lifestyle issues
 - Sedentary, dehydration, diet, ignoring the urge to defecate, travel

Wald A. *JAMA*. 2016; 315(2):185-91.

Gallagher PF, et al. *Drugs Aging*. 2008; 25(10):807-21.

Gallegos-Orozco JF, et al. *Am J Gastroenterol*. 2012; 107(1):18-25.

Constipation Treatment

- Non-pharmacologic therapy
 - Address any secondary causes
 - Optimize medications and treatment of disease states
 - Diet/hydration
 - Exercise
 - Biofeedback
 - Positioning during defecation

Wald A. *JAMA*. 2016; 315(2):185-91.

Gallagher PF, et al. *Drugs Aging*. 2008; 25(10):807-21.

Mounsey A, et al. *Am Fam Physician*. 2015; 92(6):500-4.

Gallegos-Orozco JF, et al. *Am J Gastroenterol*. 2012; 107(1):18-25.

Ford AC et al; Task Force on the Management of Functional Bowel Disorders. *Am J Gastroenterol*. 2014; 109 Suppl 1:S2-26.

Constipation Treatment (cont.)

- Stool softeners
 - Docusate calcium, docusate sodium
 - Increased risk of fecal incontinence, especially if used alone
- Laxatives
 - Preferred: osmotic laxatives (e.g., polyethylene glycol), stimulant laxatives (e.g., senna, bisacodyl)
 - Caution using bulk-forming agents (e.g., psyllium) due to risk of impaction
- Prokinetic agents
- Enemas/suppositories

Wald A. *JAMA*. 2016; 315(2):185-91.

Gallagher PF, et al. *Drugs Aging*. 2008; 25(10):807-21.

Mounsey A, et al. *Am Fam Physician*. 2015; 92(6):500-4.

Gallegos-Orozco JF, et al. *Am J Gastroenterol*. 2012; 107(1):18-25.

Ford AC et al; Task Force on the Management of Functional Bowel Disorders. *Am J Gastroenterol*. 2014; 109 Suppl 1:S2-26.

Opioid-Induced Constipation

Non-pharmacologic changes: increase water and fiber intake,
increase exercise/active lifestyle

Laxatives (osmotic, stimulant/stool softener, lubricant)

BFI \geq 30 points after ~1 week of opioid treatment

BFI < 30 points after ~1 week of opioid treatment

Naldemedine

Naloxegol

Methylnatrexone

Continue current treatment

Reassess every 2 weeks

BFI: Bowel Function Index

Wald A. *JAMA*. 2016; 315(2):185-91.

Davis MP, et al. *Drugs Aging*. 2003; 20(1):23-57.

Crockett SD, et al. *Gastroenterology*. 2019; 156(1):218-26.

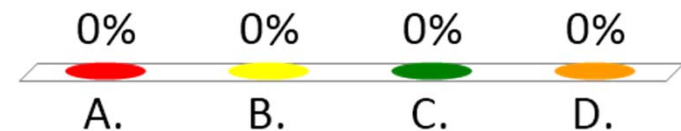
Deep Vein Thrombosis (DVT) Prophylaxis

RH has been at your facility for one week now. She continues to progress in therapy WBAT with her right lower extremity. During your weekly interdisciplinary meeting, it is mentioned that RH continues on enoxaparin for deep venous thrombosis (DVT) prophylaxis at the facility since her hip fracture repair surgery at the hospital.

Question 7:

What is the minimum recommended duration of DVT prophylaxis for RH?

- A. 7 days
- B. 14 days
- C. 6 weeks
- D. 6 months



DVT Prophylaxis

- American College of Chest Physicians (ACCP) guidelines
 - Total hip arthroplasty (THA), total knee arthroplasty (TKA), and hip fracture surgery (HFS): minimum 10-14 days with extended thromboprophylaxis in outpatient period for up to 35 days
- Scottish Intercollegiate Guidelines Network (SIGN) guidelines
 - THA and TKA: extended thromboprophylaxis preferred but no specifics given
 - HFS: 4 weeks
- American Association of Orthopaedic Surgery (AAOS) guidelines
 - THA, TKA, and HFS: up to physician's discretion
- National Institute for Health and Clinical Excellence (NICE) guidelines
 - TKA: ≥ 14 days
 - THA: >14 days for newer agents
 - HFS: 1 month

Guyatt GH, et al. *Chest*. 2012; 141(2 Suppl):7S-47S.
Fleivas DA, et al. *EFORT Open Rev*. 2018; 3(4):136-48.
Falck-Ytter Y, et al. *Chest*. 2012; 141(2 Suppl):e278S-325S.

Duration of DVT Prophylaxis

- Wells *et al.* (2010)
 - Extended-duration (> 14 days) associated with lower incidence venous thromboembolism (VTE) and lower bleeding events in THA and TKA
- Forster *et al.* (2016)
 - Extended-duration (> 14 days) recommended for THA but not enough evidence to assess for TKA or HFS
- Additional considerations
 - Age, type of procedure, comorbidities, functional status/frailty, fall risk, co-medications

Wells PS, et al. *Am J Manag Care.* 2010; 16(11):857-63.

Forster R, et al. *Cochrane Database Syst Rev.* 2016; 3:CD004179.

2019 American Geriatrics Society Beers Criteria® Update Expert Panel. *J Am Geriatr Soc.* 2019; 67(4):674-94.

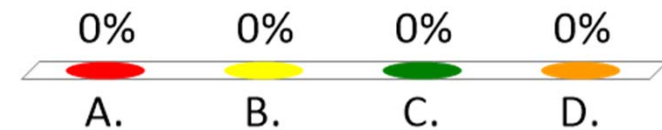
Anxiety

- RH has been at the facility for about four weeks and you are conducting the monthly chart review. She has been slowly progressing in therapy and is doing well. It is determined that RH would benefit from two more weeks of therapy services before being discharged home.
- During a recent chat with the social worker, RH stated her anxiety is better controlled than it was before her hospitalization, she is becoming more confident as she improves in therapy, and she is looking forward to going home soon.

Question 8:

Since RH seems to be responding well to her selective serotonin reuptake inhibitor (SSRI) therapy, what would be the most clinically appropriate next step in addressing her anxiety?

- A. Slowly taper down the dose of alprazolam by no more than 25% every 1-2 weeks until medication is discontinued
- B. Discontinue alprazolam immediately to prevent any further potential side effects from benzodiazepine use
- C. Change alprazolam to a longer-acting benzodiazepine, such as diazepam, to prevent withdrawal and then slowly taper the dosage before discontinuing the medication
- D. Switch alprazolam to lorazepam since it is a preferred benzodiazepine in the older adult population and continue medication



Anxiety

- First-line pharmacotherapy includes SSRIs and SNRIs
- Buspirone
- Can initiate benzodiazepine bridge for 2-6 weeks during initiation of antidepressant
 - Lorazepam (0.5-2 mg/day)
 - Oxazepam (10-30 mg/day)

Flint AJ. *Drugs Aging*. 2005; 22(2):101-14.

Subramanyam AA, et al. *Indian J Psychiatry*. 2018; 60(Suppl 3):S371-82.

Mathys M, Belgeri MT. Chapter 13. Psychiatric Issues. *Fundamentals of Geriatric Pharmacotherapy*. 2nd ed; 2015:385-92.

Monitoring - Anxiety

- Adverse reactions/side effects of agent
 - SSRIs: electrolytes, extrapyramidal symptoms, increased bleeding risk, serotonin syndrome, fractures, sexual disturbances, weight fluctuations, sleep abnormalities, GI issues, falls
 - SNRIs: similar to SSRIs, elevated blood pressure, giddiness, insomnia
 - Benzodiazepines: falls, sedation, respiratory depression, cognitive impairment, abuse/dependence, paradoxical agitation
- Duration of antidepressant therapy: at least one year
 - Some may need lifelong therapy

Flint AJ. *Drugs Aging*. 2005; 22(2):101-14.

Subramanyam AA, et al. *Indian J Psychiatry*. 2018; 60(Suppl 3):S371-82.

Mathys M, Belgeri MT. Chapter 13. Psychiatric Issues. *Fundamentals of Geriatric Pharmacotherapy*. 2nd ed; 2015:385-92.

Benzodiazepine Taper

- Reassess by 4-6 weeks of therapy
- Switch patients on multiple benzodiazepines to one drug
- Outcomes have not been shown to improve if switch from one benzodiazepine to another
 - Can consider switching to long half-life drug (clonazepam)
- Use scheduled rather than PRN doses
- Tannenbaum *et al.* (2014) – EMPOWER trial

Flint AJ. *Drugs Aging*. 2005; 22(2):101-14.

Tannenbaum C, et al. *JAMA Intern Med*. 2014; 174(6):890-8.

Subramanyam AA, et al. *Indian J Psychiatry*. 2018; 60(Suppl 3):S371-82.

Centre for Effective Practice – Ontario College of Family Physicians. Management of benzodiazepines in older adults.

https://cep.health/media/uploaded/CEP_Benzodiazapine_2019.pdf (accessed 2021 Oct 4).

National Center for PTSD – US Department of Veteran Affairs. Effective treatments for PTSD: helping patients taper from benzodiazepines.

https://www.va.gov/painmanagement/docs/OSI_6_Toolkit_Taper_Benzodiazepines_Clinicians.pdf (accessed 2021 Oct 4).

Benzodiazepine Taper (cont.)

- Recommended taper: decrease by 25% of dose every 1-2 weeks until at 20% of original dose then a slower taper of 12.5% every 2 weeks near the end
 - Alternate strategies: change to once-daily medication and taper over 4 weeks or decrease by 10% every 1-2 weeks
 - Slow tapers have been found to be more successful than fast ones
- Caution/obstacle: withdrawal symptoms
 - Can consider adding anticonvulsant for high dose withdrawal
 - Go slowly at end of taper to prevent symptoms
- Some may need to continue benzodiazepine lifelong if taper fails

Flint AJ. Drugs Aging. 2005; 22(2):101-14.

Subramanyam AA, et al. Indian J Psychiatry. 2018; 60(Suppl 3):S371-82.

Centre for Effective Practice – Ontario College of Family Physicians. Management of benzodiazepines in older adults.
https://cep.health/media/uploaded/CEP_Benzodiazapine_2019.pdf (accessed 2021 Oct 4).

National Center for PTSD – US Department of Veteran Affairs. Effective treatments for PTSD: helping patients taper from benzodiazepines.
https://www.va.gov/painmanagement/docs/OSI_6_Toolkit_Taper_Benzodiazepines_Clinicians.pdf (accessed 2021 Oct 4).

Iatrogenic Conditions - SIADH

- Several days later, the nurses note RH has been a little sluggish and during the weekly interdisciplinary SNF meeting, the therapist states RH's gait has been more unsteady than past weeks
- The physician draws labs to look for abnormalities or infection – resulting labs include:

127	98	18	100
4.0	28	1.1	

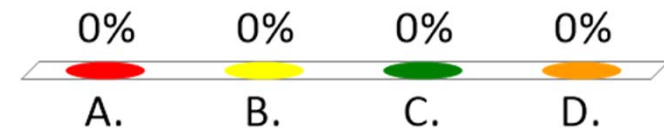
6	11.2	247
	32.3	

TSH: 3.32 uIU/mL

Question 9:

Which of the following medications is most likely contributing to RH's hyponatremia?

- A. Cetirizine
- B. Citalopram
- C. Glipizide
- D. Verapamil



Hyponatremia

- Age-related changes
- Hypervolemic vs. hypovolemic vs. euvoletic
- SIADH: antidiuretic hormone (ADH)-induced retention of ingested or infused water
 - Serum Na < 135 mEq/L
 - Serum osmolality < 280 mOsm/kg
 - Urine Na > 20 mEq/L
 - Urine osmolality > 150 mOsm/kg

Rottmann CN. *Am J Nurs.* 2007; 107(1):51-8.

Filippatos, et al. *Clin Interv Aging.* 2017; 12:1957-65.

Cuesta M, et al. *Best Pract Res Clin Endocrinol Metab.* 2016; 30(2):175-87.

Causes of Hyponatremia

- Drug-induced causes
 - Diuretics – thiazides, loop
 - Antidepressants (SSRIs, SNRIs), antipsychotics, anticonvulsants, benzodiazepines
 - Antineoplastics, hormones
- Disease/disorder-induced causes
 - Congestive heart failure, cirrhosis, excessive hydration/overload
 - Low sodium intake, CNS disorders, intracranial bleeding, infection (pulmonary), malignancies, hormone deficiencies, symptomatic HIV infection
 - “Tea and toast” hyponatremia

Rottmann CN. *Am J Nurs.* 2007; 107(1):51-8.

Filippatos, et al. *Clin Interv Aging.* 2017; 12:1957-65.

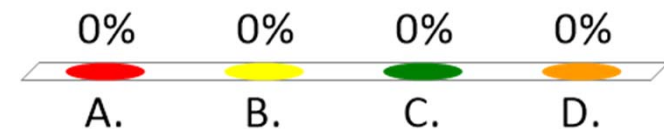
De Picker L, et al. *Psychosomatics.* 2014; 55(6):536-47.

Cuesta M, et al. *Best Pract Res Clin Endocrinol Metab.* 2016 ;30(2):175-87.

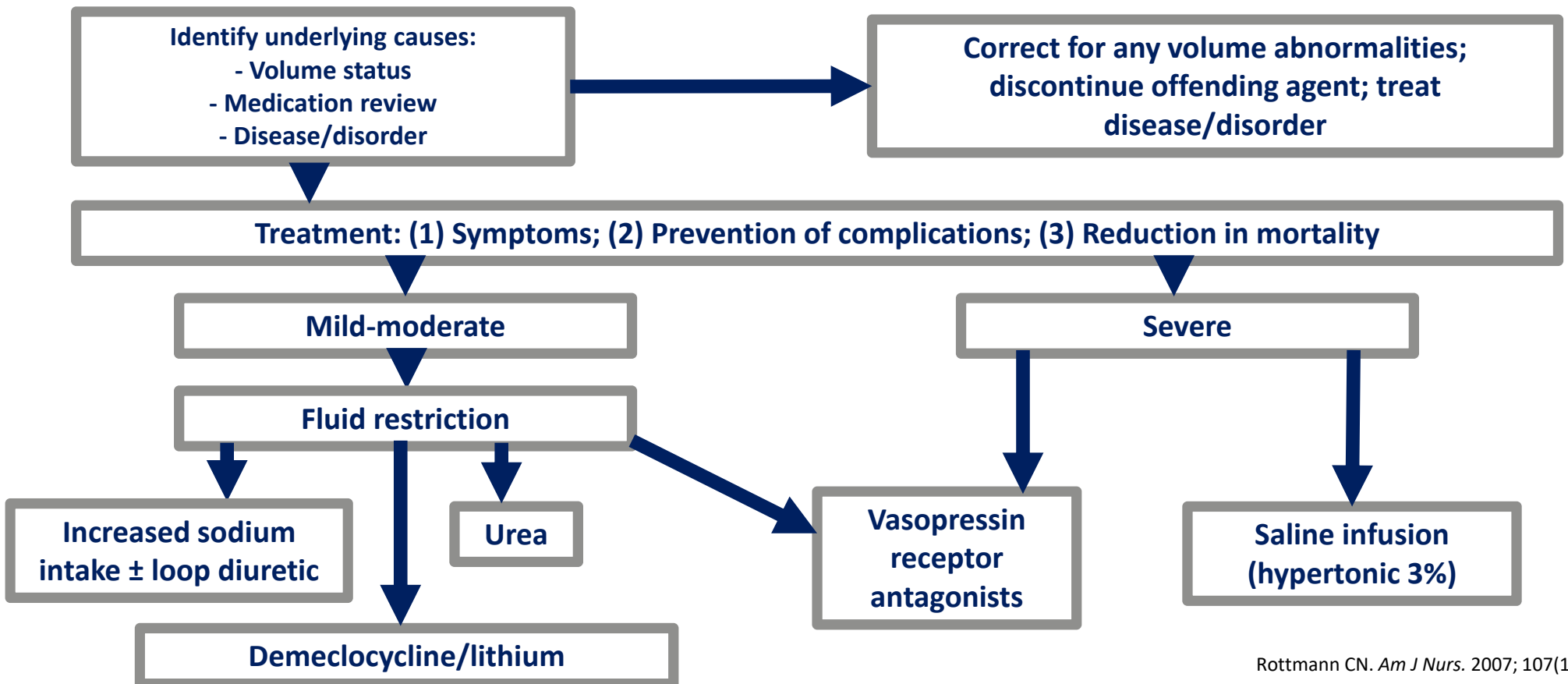
Question 10:

After discontinuing the offending agent, which of the following would be the next appropriate clinical step in addressing RH's SIADH?

- A. Begin tolvaptan 15 mg orally daily for 30 days
- B. Bolus 500-mL IV of hypertonic (3%) saline
- C. Restrict fluid intake to 800-1000 mL daily for 3-5 days
- D. Initiate demeclocycline 600 mg orally twice daily until sodium level within normal limits



SIADH



Rottmann CN. *Am J Nurs.* 2007; 107(1):51-8.

Cuesta M, et al. *Best Pract Res Clin Endocrinol Metab.* 2016; 30(2):175-87.

Antidepressant-Induced SIADH

- Patient risk factors
 - Demographic, comorbidities, medications
- Worst offenders tend to be SSRIs/SNRIs
 - Coupland *et al.* (2011)
- Other antidepressants also carry risks
 - TCAs, mirtazapine, bupropion, MAOIs, trazodone

Coupland CA, et al. *BMJ*. 2011; 343:d4551.

Rottmann CN. *Am J Nurs*. 2007; 107(1):51-8.

Filippatos, et al. *Clin Interv Aging*. 2017; 12:1957-65.

De Picker, et al. *Psychosomatics*. 2014; 55(6):536-47.

Mogi T, et al. *Psychiatry Clin Neurosci*. 2012; 66(1):80.

Antidepressant-Induced SIADH

- Discontinue offending agent
- Avoid re-challenging patient with offending agent
 - Caution switching to another agent in the same class, as well
- Choose agent with lower risk of SIADH
 - Mirtazapine, bupropion, trazodone, TCAs
- Use clinical judgment and close monitoring

Coupland CA, et al. *BMJ*. 2011; 343:d4551.

Rottmann CN. *Am J Nurs*. 2007; 107(1):51-8.

Filippatos, et al. *Clin Interv Aging*. 2017; 12:1957-65.

De Picker, et al. *Psychosomatics*. 2014; 55(6):536-47.

Mogi T, et al. *Psychiatry Clin Neurosci*. 2012; 66(1):80.

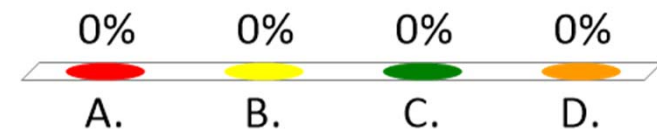
Prevention - Falls

About a week later, RH loses her balance while transferring to the toilet but the occupational therapist was able to catch her and lower her to the ground safely with no issues noted.

Question 11:

What is the most clinically appropriate intervention to help prevent falls for RH in the future when she is back at home?

- A. Encourage use of anti-slip footwear devices at all times
- B. Initiate a calcium supplement to help decrease risk of fractures
- C. Recommend use of an assistive mobility device, such as a cane or walker
- D. Conduct a home hazards assessment by an occupational therapist



Assessment - Falls

During annual assessment, if a patient reports 2 or more falls in the past 6-12 months, any fall resulting in injury, difficulty with balance/gait, or fear of falling – then assess the following areas:

- Syncope
- Gait or mobility problems
- Vision impairment
- Cognitive impairment
- Postural hypotension
- Polypharmacy or high-risk medications
- Environmental hazards
- Vitamin D deficiency

Lee A, et al. *Perm J*. 2013; 17(4):37-9.

AGS/BGS. *J Am Geriatr Soc*. 2011; 59:148-57.

Moylan KC, et al. *Am J Med*. 2007; 120(6):493.e1-6.

Moncada LVV, et al. *Am Fam Physician*. 2017; 96(4):240-7.

Assessment – Falls (cont.)

- Comprehensive physical assessment
 - Vitals/laboratory evaluations
 - Balance
 - Romberg test
 - Gait
 - Timed Up and Go (TUG) Test
- Complete medication review
 - Fall risk medications
 - Selected examples: non-selective medications, anticholinergics, antidiabetics, diuretics, laxatives, opioids, medications that act on the CNS

Lee A, et al. *Perm J*. 2013; 17(4):37-9.

AGS/BGS. *J Am Geriatr Soc*. 2011; 59:148-57.

USPSTF, et al. *JAMA*. 2018; 319(16):1696-1704.

Moylan KC, et al. *Am J Med*. 2007; 120(6):493.e1-6.

Moncada LVV, et al. *Am Fam Physician*. 2017; 96(4):240-7.

Prevention - Falls (Community-Dwelling)

- Exercise program with focus on balance and muscle-strength training
- Multifactorial/multicomponent interventions
 - Minimize high-risk medications and decrease number of medications
 - Treat vision impairment, specifically cataract surgery
 - Manage postural hypotension
 - Address heart rate/rhythm abnormalities with pacemaker placement
 - Ensure appropriate footwear in icy conditions or with disease-specific issues
 - Manage urinary incontinence issues
 - Modify home environment with home hazards assessment done by occupational therapist
 - Provide education and information
- No evidence for support: vitamin D supplementation with no known deficiency, assistive devices, nutritional supplementation, hip protectors

Lee A, et al. *Perm J*. 2013; 17(4):37-9.

AGS/BGS. *J Am Geriatr Soc*. 2011; 59:148-57.

USPSTF, et al. *JAMA*. 2018; 319(16):1696-1704.

Moncada LVV, et al. *Am Fam Physician*. 2017; 96(4):240-7.

Moyer VA; USPSTF. *Ann Intern Med*. 2012; 157(3):197-204.

Karlsson MK, et al. *Scand J Public Health*. 2013; 41(5):442-54.

Prevention - Falls

- Long-term care
 - Multifactorial/multicomponent interventions
 - Exercise programs should be used with caution
 - Vitamin D supplements for proven or suspected insufficiency, patients who have abnormal gait or balance, or those who are otherwise at increased risk for falls
- Cognitive impairment
 - Insufficient evidence

Elder Abuse/Neglect

After 6 weeks at the SNF, RH is walking up to 300 feet with a cane and can dress, bathe, and toilet herself independently. It is determined that RH has progressed back to her baseline and is ready to “graduate” from therapy and be discharged back home with her family.

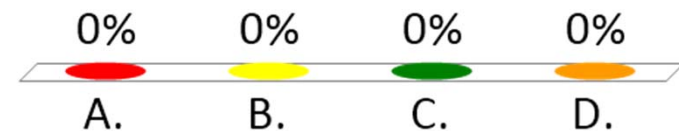
Elder Abuse/Neglect (cont.)

- Upon pre-discharge counseling for her medications, RH expresses some concerns about affording all of her medications once she is back home. She explains “money is tight” since her granddaughter’s husband moved back home with them and he “borrows” money from her often. She quickly excuses the behavior and says he just needs to “let off some steam” since he was laid off his job several months ago. RH explains as the only male in the household it is his obligation to do what he wants with the money and he can get very upset when questioned about it.
- After you and the nurse hear this, you have some concerns about the financial status of RH when she goes back home.

Question 12:

Based on your concerns, what should the next step be for addressing the situation?

- A. Report your findings to the Elder Abuse/Tribal Hotline immediately
- B. Call RH's bank and explain the situation so they can investigate misappropriated funds
- C. Continue to monitor the situation but do not report anything until you have concrete evidence of wrongdoing
- D. Speak directly to her granddaughter's husband about the situation and warn him you may report the situation to the local authorities if this issue continues



Elder Abuse/Neglect

- Neglect
 - Self-neglect: hoarding, personal hygiene, unsanitary conditions, inadequate utilities, house needs repairs
- Abuse
 - Physical, emotional, fiduciary/financial, sexual
- Exploitation
- Abandonment

Fulmer T. *Am J Nurs.* 2008; 108(12):52-9.

Dong X. *Clin Interv Aging.* 2017; 12:949-54.

Conry M. *Consult Pharm.* 2009; 24(4):306-15.

Pickering CE, et al. *Home Healthc Now.* 2016; 34(4):182-8.

Risk Factors for Elder Abuse/Neglect

- Advanced age
- Female
- Low income
- Limited education
- Minority status
- Functional/cognitive impairment
- Social isolation
- Caregiver stress/deficits
- History of family violence/abuse
- Poor family dynamics
- Alcohol/substance abuse in home

Dong X. *Clin Interv Aging*. 2017; 12:949-54.

Conry M. *Consult Pharm*. 2009; 24(4):306-15.

Pickering CE, et al. *Home Healthc Now*. 2016; 34(4):182-8.

Warning Signs of Elder Abuse/Neglect

- Weight loss, poor hygiene
- Unattended medical needs
- Over- or under-medicated
- Sudden changes in financials
- Sudden change in prescription refilling
- Bruises, pressure marks
- Unexplained withdrawal/isolation
- Hypervigilance
- Observation of verbal abuse, belittling, treating like a child
- Older adult not allowed to answer questions or speak

Dong X. *Clin Interv Aging*. 2017; 12:949-54.

Conry M. *Consult Pharm*. 2009; 24(4):306-15.

Pickering CE, et al. *Home Healthc Now*. 2016; 34(4):182-8.

Elder Abuse/Neglect

- Intentional vs. unintentional
 - Cultural differences
- Screening tools
 - Selected examples: Elder Assessment Instrument (EAI), Vulnerability to Abuse Screening Scale (VASS), Brief Abuse Screen for the Elderly (BASE), Texas Self-Neglect Scale
- Challenges for reporting
 - Impact on patient
 - Lack of evidence or proof
 - Fear of getting involved

Fulmer T. *Am J Nurs.* 2008; 108(12):52-9.

Dong X. *Clin Interv Aging.* 2017; 12:949-54.

Conry M. *Consult Pharm.* 2009; 24(4):306-15.

Gallione C. *J Clin Nurs.* 2017; 26(15-16):2154-76.

Brijnath B, et al. *Gerontologist.* 2020; 60(3):472-82.

Pickering CE, et al. *Home Healthc Now.* 2016; 34(4):182-8.

Elder Abuse/Neglect Resources

- Mandatory reporting in most states for most healthcare professionals
 - Need *reasonable* cause, not proof or evidence
 - Confidential, anonymous reporting
- Adult Protective Services (APS)
- National Center on Elder Abuse (NCEA)
 - <https://ncea.acl.gov/>
- National Indigenous Elder Justice Initiative (NIEJI)
 - <https://www.nieji.org/hotlines>

Fulmer T. *Am J Nurs*. 2008; 108(12):52-9.

Conry M. *Consult Pharm*. 2009; 24(4):306-15.

Pickering CE, et al. *Home Healthc Now*. 2016; 34(4):182-8.

NCEA. <https://ncea.acl.gov/> (accessed 2021 Sept 27).

NIEJI. <https://www.nieji.org/hotlines> (accessed 2021 Sept 27).

**"All that is necessary for the
triumph of evil is that good men
do nothing." - Edmund Burke**

Complex Case: Skilled Nursing Care

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