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Patient Safety Tip of the Week

April 19, 2022 Nursing Home Serendipity

Years ago, we encountered a serendipitous phenomenon in a nursing home. The nursing home, which had been running high rates of patient falls, suddenly had a dramatic drop in patient falls. It turned out that, due to a contractual issue, the consulting psychiatrist at the nursing home had ceased coming to the nursing home. As a result, a whole host of psychoactive medications had not been renewed on many patients. While the fall rates decreased, there did not appear to be any significant increase in other unwanted events. That led to the nursing home eventually re-evaluating the need for these medications on each patient and an overall reduction in the use of psychoactive medications in this patient population. The fall rate remained low.

We don't recommend such a cataclysmic cessation of medications in nursing homes, but this occurrence was a valuable lesson in deprescribing.

Now, a new set of circumstances led to another valuable lesson. At the height of the COVID-19 pandemic, a large nursing home chain implemented a policy to temporarily hold potentially unnecessary medications. And,it turned out to be a good study on deprescribing.

McConeghy et al. (McConeghy 2022) describe the early months of the COVID-19 pandemic and challenges facing nursing homes (implementation of new quarantine and isolation practices, procurement, and use of personal protective equipment; daily symptom and exposure screens for staff and residents; adaptation of complex testing protocols; and clinical management of acutely ill residents. This occurred in the setting of staffing shortages due to staff illness and quarantine, disruption of supply chains for PPE and testing supplies, and a health system in crisis.

At that time, "crisis standards" wee proposed by long-term care experts (Wright 2021, Brandt 2020) in order to conserve critical nursing resources and PPE, and to limit exposure risk for residents by reducing unnecessary contact. One of the recommendations was to review medication regimens to identify medications that were of minimal clinical benefit and that could be either temporarily held or permanently discontinued. One large multistate long-term care provider implemented the "nonessential medication on hold" (NEMOH) policy. Nonessential medications were placed on a hold for a period of time, then providers could choose to restart or discontinue them. In essence, this became a deprescribing initiative. "Nonessential" medications in this population included: multivitamins, other vitamin supplements, herbal/naturopathic/homeopathic supplements,

cranberry extract, antihistamines, decongestants, fish oil, probiotics, docusate, statins and all hyperlipidemia drugs, histamine-2 receptor agonists, and proton pump inhibitors. Prescribers were notified of the list of medications to be placed on hold and could override or 'opt-out' of individual hold orders. Every 2 weeks during the hold policy, the hold orders were reassessed by the prescribers and the facility's medical leadership (i.e., medical director).

The study population included 5126 residents in 64 nursing homes. Sixty-three percent (3247) of these residents with eligible medication(s) had at least one medication held during NEMOH. Overall, 5297 of 12,837 (41%) eligible medications were held. Of these held medications, 2897 (54%) were permanently discontinued at the end of the NEMOH period. In total, 23% of the original 12,837 nonessential medications identified at the beginning of the NEMOH period were discontinued.

There were some differences between residents whose medications were permanently discontinued and those who restarted at the end of the hold period. Residents with discontinued medications had more functional dependence, and were more likely to have do-not-resuscitate and do-not-hospitalize orders. Residents with discontinued medications were also more likely than those with restarted medications to be in smaller facilities and less likely to employ advanced practice clinicians.

Multivitamins, H2 receptor antagonists (H2RA's), antihistamines, statins, proton pump inhibitors (PPIs), and probiotics were the most commonly held, whereas other vitamin supplements, cranberry extracts, docusate, fish oil, and the miscellaneous 'other' category were less likely to be held. Among the most prevalent held medications (statins, PPI's, and multivitamins, the discontinuation incidences were 45.5%, 57.7%, 52.6% respectively.

Residents taking nonessential medications had these medications held for a median of 60 days, and when the hold policy was lifted, 54% of held medications were discontinued. The authors conclude that, although the policy was not originally envisioned as such, it became a relatively successful ad hoc deprescribing initiative. They suggest that the NEMOH policy acted as a "nudge" for uptake of deprescribing, but with lower stakes for unenthusiastic providers and residents. "In essence, we enacted a 'trial' deprescribing period of 60 days, and if the resident and prescribers agreed, this led to discontinuation of 54% of the held medications (22% of all eligible 'nonessential' medications)."

Nudges can be surprisingly powerful tools. We discussed "nudges" in our July 7, 2009 Patient Safety Tip of the Week "Nudge: Small Changes, Big Impacts". McConeghy et al. suggest that the NEMOH policy gave providers a set of cognitive clues (a "nudge") that they should consider deprescribing while also providing them a clear pathway through which they could implement the deprescribing.

Unfortunately, the McConeghy study did not include and statistics about unwanted outcomes, patient/family satisfaction, provider satisfaction, or unintended consequences.

Our March 2022 "MedSafer: Glass Half-Empty or Half-Full?" discussed MedSafer, a study (McDonald 2022), on electronic decision support for deprescribing in hospitalized older adults intended to answer the question of whether deprescribing actually translates to fewer adverse drug events (ADE's). The study population was older (≥65 years) hospitalized patients with an expected survival of more than 3 months who were admitted to 1 of 11 acute care hospitals in Canada. So, it was not on nursing home patients. Though it found deprescribing increased from 29.8% in control patients to 55.4% in intervention participants, there was no difference in adverse drug withdrawal events between groups. However, there was no significant difference in the primary outcome, ADE's within 30 days of discharge. The incidence of post-discharge falls did decrease but not statistically significantly. The authors noted that, while the intervention identified numerous deprescribing opportunities, many were for low-risk nonbeneficial polypharmacy (eg, nonstatin cholesterol-lowering medications or stool softeners) rather than for potentially inappropriate medications (PIM's). They suggest that deprescribing these medications is less likely to impact 30-day ADE's. The latter, of course, are the ones held in the McConeghy study. But McDonald et al. point out that deprescribing the "nonessential" medications still has both patient and societal value (avoiding excess cost, waste, pill burden, etc.).

The McConeghy study adds to a growing list of studies on deprescribing and includes a patient population (nursing home residents) in whom the potential benefits of deprescribing may be important. Hopefully, the study can serve as a template for nursing homes to take a stab at a deprescribing program.

Some of our past columns on deprescribing:

- March 4, 2014 "Evidence-Based Prescribing and Deprescribing in the Elderly"
- September 30, 2014 "More on Deprescribing"
- May 2015 "Hospitalization: Missed Opportunity to Deprescribe"
- July 2015 "Tools for Deprescribing"
- April 4, 2017 "Deprescribing in Long-Term Care"
- October 31, 2017 "Target Drugs for Deprescribing"
- January 2018 "What Happens After Delirium?"
- June 2018 "Deprescribing Benzodiazepine Receptor Agonists"
- November 27, 2018 "Focus on Deprescribing"
- March 19, 2019 "Updated Beers Criteria"
- March 10, 2020 "Medication Harm in the Elderly"
- June 2020 "The Antipsychotics in Dementia Conundrum"
- June 29, 2021 "Barriers to Deprescribing"
- September 2021 "A Primer on Deprescribing"
- February 22, 2022 "Medication Reconciliation at ICU Exit"
- March 2022 "MedSafer: Glass Half-Empty or Half-Full?"

Some of our past columns on Beers' List and Inappropriate Prescribing in the Elderly:

- January 15, 2008 "Managing Dangerous Medications in the Elderly
- June 2008 "Potentially Inappropriate Medication Use in Elderly Hospitalized Patients"
- October 19, 2010 "Optimizing Medications in the Elderly"
- September 22, 2009 "Psychotropic Drugs and Falls in the SNF"
- September 2010 "Beers List and CPOE"
- June 21, 2011 "STOPP Using Beers' List?"
- December 2011 "Beers' Criteria Update in the Works"
- May 7, 2013 "Drug Errors in the Home"
- November 12, 2013 "More on Inappropriate Meds in the Elderly"
- January 28, 2014 "Is Polypharmacy Always Bad?"
- March 4, 2014 "Evidence-Based Prescribing and Deprescribing in the Elderly"
- September 30, 2014 "More on Deprescribing"
- February 10, 2015 "The Anticholinergic Burden and Dementia"
- May 2015 "Hospitalization: Missed Opportunity to Deprescribe"
- July 2015 "Tools for Deprescribing"
- November 2015 "Medications Most Likely to Harm the Elderly Are…"
- August 2, 2016 "Drugs in the Elderly: The Goldilocks Story"
- October 31, 2017 "Target Drugs for Deprescribing"
- January 2018 "What Happens After Delirium?"
- May 2018 "Antipsychotic Use in Nursing Homes: Progress or Not?"
- June 2018 "Deprescribing Benzodiazepine Receptor Agonists"
- October 2018 "STOPP/START/STRIP"
- November 27, 2018 "Focus on Deprescribing"
- March 19, 2019 "Updated Beers Criteria"
- March 10, 2020 "Medication Harm in the Elderly"
- June 2020 "The Antipsychotics in Dementia Conundrum"
- February 2021 "Under the Radar: Muscle Relaxant Use"
- April 2021 "Alarming Use of Fall-Prone Medications in 65+ Patients"
- June 29, 2021 "Barriers to Deprescribing"
- September 2021 "A Primer on Deprescribing"

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