

# The ElderLaw Report

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HARRY S. MARGOLIS, ESQ., EDITOR

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## RESPONDING TO OVERMEDICATION OF NURSING HOME RESIDENTS: USING THE NEW OBRA RULES

By Ron M. Landsman

Walk into some nursing homes and you sense a pervasive, disoriented passivity among the residents. They always seem groggy, unfocused, slovenly, inactive, and unresponsive in the extreme. But in other nursing homes, residents are more alert, responsive to those who walk through the halls and talk to them or those who merely pass them by.

The difference may stem from the use of powerful psychotropic drugs on elderly, demented patients. Because of their dementia, they may have lost many familiar social skills, impulse controls, or the ability to understand the consequences of mild physical interaction. They may be, or at least may have been at some time, aggressive, abusive, physically assertive to the point of striking others, or they are otherwise difficult to handle. But now they are none of those things. They sit, drooling, moaning, eyes out of focus, unable to control any of their basic bodily functions, unable to provide any self-care.

Inappropriate medication of nursing home residents—and all overmedication is inappropriate—is at least common. It may be rampant. While the research is not extensive, and the scientific research system leans toward finding overmedication, the findings of inappropriate use of psychotropic drugs in general and antipsychotic drugs in particular are reasonably clear. Congressional hearings on nursing home problems produced substantial additional testimony about problems of medication for elderly patients. Fine points about the degree of excessive use aside, anyone who works with the elderly will regularly see cases of excessive and inappropriate use of psychoactive drugs.

Based on its hearings, Congress prescribed new, specific rules about when psychoactive drugs may be used on nursing home residents. These rules, with

regulatory implementation by the Health Care Financing Administration, provide substantial new tools for the advocate to prevent or relieve the excessive medication of wards, clients, and clients' relatives.

### *The Prototypical Problem*

Florence Atkinson (not her real name), a ward of mine, was an 82-year-old woman who had lived alone and in increasing isolation since the death of her husband some years earlier. She was argumentative at the beginning of any encounter with another person, and with little provocation would become verbally abusive. But my experience was that she would become engaging, almost charming, with a little attention and appreciation. She required nursing home care because of increasing physical and mental disabilities culminating in a fall and broken hip.

The nursing home where she was first admitted, unwilling to devote the staff time needed to work through her anger, quickly got her physician to prescribe Haldol. He agreed to discontinue its use when questioned about it. She has since been transferred to another nursing home, where no psychoactive medication of any kind has been required.

This use of a powerful antipsychotic drug to control the behavior of a nonpsychotic elderly person whose difficult behavior is the product of dementia reflects at least four distinct problems.

First, the appropriateness of drug therapy needs to be considered. At any dosage level, powerful psychotropic drugs are not a suitable treatment for dementia-induced behavior problems short of direct and real threats to the physical safety of the patient or others. Such "treatment" for verbal abuse, no matter how severe, is

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not for the patient's benefit but for the staff or others.

Moreover, drugs mask symptoms that reflect an unmet need or unsolved problem. Once the symptom is masked (or obliterated) it is difficult or impossible to get to the underlying problem, whose solution would eliminate the symptom. Such underlying problems are not necessarily more costly to solve in the long run. The apparently inexpensive solution of drugging a patient invariably leads to more demands on staff time than the attentive, sensitive solution to the real problem.

The second problem involves the inappropriate selection of Haldol from among those drugs in its class. Haldol is a neuroleptic, somewhat more commonly called an antipsychotic, and is among those neuroleptics that have powerful extrapyramidal effects (see page 5), some irreversible. While none of the drugs in this group is attractive, others are more appropriate for elderly patients because their extrapyramidal side effects are less severe.

The third problem lies in the use of "PRN" orders, which means "as needed." The individual who determines need is a nurse, whose training about the proper use of psychoactive drugs is limited and whose self-interest in controlling a difficult patient is at odds with the patient's needs. In lawyer's parlance, there has been a delegation of decision-making about drug administration to someone neither trained nor positioned to make the best decision for the patient.

In fact, most physicians know as little as nursing home nurses about the fine points of psychotropic drugs. To continue the legal analogy, elder law lawyers have a powerful tool in the broad form durable power of attorney, but because of the many legal and practical limitations, its use requires great care, care that many general practitioners do not know to exercise. Drugs in the hands of general practitioner physicians present the same problem: a powerful tool that easily can cause more problems than it solves if not properly used, and which is best left to experts. But just as any lawyer can pull a one-page power of attorney off the shelf and fill it out for a client, so any physician can prescribe powerful psychoactive drugs for a patient.

Finally, there is the problem of dosage levels. Beginning around age 50, people metabolize drugs more slowly, and the impact of the same dose becomes greater. This process advances with age. Dosage levels for the sick or frail elderly should be far lower than for healthy middle-aged adults.

### Requirements of OBRA

Congress' reform of nursing home rules in 1987 [Omnibus Budget Reconciliation Act of 1987 (OBRA), Pub. L. No. 100-203], with implementing regulations to take effect later this year, provides advocates with some extremely useful tools for confronting the problems of patients like Florence Atkinson. At the outset, however, I should note that all of these standards and requirements carry, at least at the first level, only administrative and not private enforcement

mechanisms. Nonetheless, the aggressive advocate should be able to use them to protect a nursing home resident from oppressive medication.

OBRA as enacted prohibits the use of psychotropic drugs absent a physician's order, but further requires that they be used "only as part of a [care] plan designed to eliminate or modify the symptoms for which the drugs are prescribed," and requires annual psychopharmacological reviews by an independent consultant to determine the appropriateness of the drug plan. 42 U.S.C. §1396r(c)(1)(D). This is a particular aspect of the more general right "to be free from ... chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms." The only permissible purpose of a chemical restraint is to "ensure the physical safety of the resident or other residents," and only on a physician's order specifying the duration and circumstance of the restraint. 42 U.S.C.A. §1396r(c)(1)(A)(ii).

That care plan is required more generally to provide for the "highest practicable physical, mental, and psychosocial functioning" of the resident. 42 U.S.C. §1396r(b)(2). It should be based on a multidisciplinary assessment of the resident. The "highest practicable functioning" provides a somewhat objective standard against which to measure the utility and role of a drug treatment.

Moreover, residents are entitled to participate in and be fully informed about the details of their care and treatment and any proposed changes, 42 U.S.C.A. §1396r(c)(1)(A)(i), and, where not competent, to be represented "by the person appointed under State law to act on the resident's behalf." 42 U.S.C.A. §1396r(c)(1)(C).

Implementing regulations become effective October 1, 1990 (unless changed pursuant to an outstanding notice-comment period), and they provide substantial opportunities for advocates. Nursing homes are required to provide patients who are on antipsychotic drugs with gradual dose reductions or drug holidays to determine reliably whether continued medication is required. Moreover, residents who

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### For More Information

*The following organizations can provide guidance on how to evaluate and respond to specific cases of overmedication of nursing home residents:*

**American Society for Consultant Pharmacists**  
2300 9th Street South  
Arlington, VA 22204  
(703) 920-8492

**National Coalition for Nursing Home Reform**  
1424 16th Street, N.W.—Suite L2  
Washington, D.C. 20036  
(202) 797-0657

have not used antipsychotic drugs may not be given them unless it is "necessary to treat a specific condition," and even then only if "[b]ased on a comprehensive assessment of a resident." 42 C.F.R. Part 483.25 (published in 54 Fed. Reg. 5363, Feb. 2, 1989).

According to Barbara Frank of the National Citizen's Coalition for Nursing Home Reform, this latter requirement precludes physicians from prescribing an antipsychotic based on a nurse's report of difficult behavior—or even the physician's own observation—but would require a comprehensive social, physical, medical, and psychological assessment before deciding to use such drugs. Note, however, that the limitation in the regulations is only to antipsychotic drugs, whereas the statute refers more broadly to all "psychopharmacologic" drugs.

### Guidelines

Finally, the proposed regulations come with guidelines—hotly contested, watered down, but still valuable—to be used by surveyors of state licensing agencies who monitor nursing home compliance with regulations and law. After listing 18 antipsychotic drugs, the guidelines note specific conditions for which these drugs may be used. In addition to a number of recognized disorders (e.g., schizophrenia, acute psychotic episodes), they include organic brain conditions "including dementia" but only if with "associated psychotic and/or agitated features defined" as specific behaviors "objectively (e.g., biting, kicking, and scratching) documented" and that make the residents "[p]resent danger" to themselves or others (including staff) or "[a]ctually interfere with staff's ability to provide care." (The inclusion of staff would appear to be problematic, given the statute's restriction of chemical restraints to protecting the physical safety of the patient or other residents.) Antipsychotic drugs may also be prescribed for psychotic symptoms but only if symptoms "cause the resident frightful distress" (emphasis in original). There follows a long list of 15 precluded bases for the use of antipsychotics, including wandering, agitation, and other common symptoms of nursing home residents, and "[a]ny indication for which the order is on an 'as needed' (PRN) basis."

Surveyors are instructed to issue a negative finding if "only one resident" is getting an antipsychotic drug without the required diagnosis or behavior. The nursing home is required to work with the physician to plan "immediate gradual dose reduction" (emphasis in original).

The guidelines also require that absent at least one effort at gradual dose reduction, drug holiday, or behavioral programming for each resident receiving antipsychotic drugs, there must be a negative finding.

### An Action Plan

The requirements of OBRA provide advocates with a number of arguments to prevent or terminate inappropriate use of antipsychotic drugs. As to other drugs (see page 4),

the arguments are less compelling, given the regulations, but the same procedures, albeit with less powerful arguments, would be appropriate.

In any case, the advocate's task, either with the existing care staff or independent consultants, is to determine whether any drug therapy, or what drug therapy, is appropriate. As outlined by Ms. Frank of the Citizen's Coalition, the advocate should keep the following factual standards or questions in mind:

**1. Risk/benefit analysis.** What are the benefits of the drug and what are the potential burdens? What specific needs are being met? The nursing home is required to maximize each resident's potential and minimize injury or damage; how are those goals being achieved?

**2. Best of alternative options.** What are the other means by which to achieve the appropriate result? What are their relative risks and benefits? The extent to which extremely simple solutions—for example, walking with the wandering patient, sitting with an agitated patient for a few minutes, installing nonconstraining barriers—solve problems is striking.

**3. Close analysis of impact.** Is the drug working at all? Has its effectiveness been closely assessed? Should it be altered?

With these criteria in mind, the advocate then should take the following steps.

First, review with the attending physician in detail the need for and consequences of use of the drug. It may be necessary (and effective) to inform the physician of side effects. Inquire what the physician knows about side effects, dosage levels (and specifically whether the age of the resident has been taken into account), alternative drugs, and alternative nondrug therapies. In my experience, the inquiry alone will induce most physicians to rewrite their orders.

Second, the physician may be amenable to advice from someone more expert and so may welcome a referral to a geriatric specialist, psychiatrist, a community mental health clinic, or a psychopharmacologist.

Third, absent physician cooperation, an appropriate next step is to hire another physician. Protocol among physicians, however, may make it difficult or impossible to secure another physician.

Fourth, raise the question of compliance with OBRA requirements with the appropriate nursing home staff. You might begin with the medical director, who as another physician may be in the best position practically to secure a different treatment. The director of nursing may also be brought in, not least because it is his or her staff who is required to monitor resident response and to function as the first line of compliance, so to speak, in terms of bases for treatment.

When all else fails, of course, the administrator should be advised that the facility appears not to be in compliance with OBRA requirements. Among the issues to raise, as noted, are whether the drug treatment is justified by symptoms of

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sufficient seriousness, as set out in the guidelines, whether there is a care plan with which it complies, and whether that plan achieves the resident's highest functioning. Additional issues are whether there has been an annual psychopharmacological review and compliance with quality assurance requirements.

Fifth, advocates—including lawyers—should invoke the assistance of nursing home ombudsmen, who monitor the performance and respond to complaints of every nursing home receiving Medicare or Medicaid benefits. While no panacea, they may be able to effect results, given their long-term relationship with nursing homes that advocates new to the scene do not have. They are also extremely knowledgeable about rights and procedures.

Even if a case has been documented effectively by the nursing home staff, it may still be possible to frame the issue favorably for the next step. Notwithstanding prior drug reviews or holidays, for example, evidence of new cause for one would shift the burden back to the nursing home. Similarly, observing the patient and reporting either adverse

side effects or the absence of justifying symptoms should validate a finding that further review is required.

Sixth, absent satisfaction within the nursing home, the advocate can turn first to the state licensing agency whose surveyors are required to implement the regulations pursuant to the guidelines, quoted above. In addition, the Health Care Financing Administration maintains its own compliance staff, which is available for investigating serious complaints independent of state licensing agencies.

### Conclusion

OBRA's requirements are sufficiently concrete to enable thoughtful, persistent advocates to prevent or end inappropriate drug use. The care plan requirements and the underlying medical and regulatory standards are sufficiently clear to enable advocates broad opportunity for ameliorating the conditions of many residents.

*Ron M. Landsman practices elder law in greater Washington, D.C., and is based in Bethesda, Maryland. He is a founding member of the National Academy of Elder Law Attorneys.*

## A PSYCHOACTIVE DRUG PRIMER

Many drugs with psychoactive properties are used appropriately to treat psychological symptoms ranging from delusions and hallucinations to depression, pain, Parkinson's type symptoms, anxiety, stress, and nausea, among others. In addition, many standard drugs are used to treat strictly medical conditions that have psychoactive side effects. The problem of difficult behavior among demented elderly patients invites misuse of many psychoactive drugs. Dr. Peter Cimboric, a psychologist at Catholic University in Washington, D.C., reviewed some of the more widely used drugs and their problems. His comments are summarized briefly here.

The three most commonly encountered classes of psychoactive drugs used on elderly nursing home patients are neuroleptics (antipsychotics), antianxiety/hypnotic agents, and antidepressants. While it is useful to review these drugs in detail, two extremely important first principles to appreciate in the use of psychoactive drugs, especially with the elderly, involve polypharmacy and side effects.

### The Problem of Polypharmacy

Symptoms that appear to be psychiatric or emotional in nature are often caused by drugs being used to treat organic illness. Lowering the levels of these other drugs or changing them will quickly clear up the undesired psychiatric symptoms. This is the first line of attack on apparent psychiatric problems. The problem of polypharmacy is especially widespread among the elderly because of the far greater frequency of medical problems, for which the drugs have been prescribed, and also because of the failure of physicians

to appreciate that elderly patients almost always require drugs in significantly lower dosage levels than do other younger adult patients.

### The Role of Side Effects

For all of these drugs, prescription (within the right class of drugs) is by shotgun. There is no research or chemical basis for knowing in advance which drugs will work on which patients. Where the positive effects are not known in advance, the proper method for selection is from the reverse end, by selecting to avoid adverse side effects. If the drug with the expected most minimal (in the jargon of the trade, tolerable) side effect is effective, then its use might be continued; if it does not work well enough, then drugs with the next least adverse side effects should be tried, and so forth.

Once all alternatives have been excluded, these drugs may be indicated if used and monitored properly. The key element in safe and effective use is in monitoring the symptoms and side effects. The physician should require—and in any event the nursing home staff should insist on providing—careful and detailed reports of the resident's response. Dosage level and, perhaps, the drug selected should be changed and experimented with until adequate symptom control with minimal adverse side effects is achieved.

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### Antipsychotics

As the name suggests, these drugs are used for the treatment of schizophrenia and other severe psychotic disorders. All of the antipsychotics have one or both of two sets of side effects, anticholinergic or extrapyramidal. "Anticholinergic" means the drug works against acetylcholine, one of 35 known neurotransmitters, itself with numerous functions in the body, both in the brain and elsewhere. "Extrapyramidal" means the drug affects certain identified brain cells.

Ironically—and dangerously—in each case the side effects can look like the very symptoms attempting to be treated. Inexperienced physicians or the nurses on whom they rely may thus incorrectly conclude that further drug treatment and higher dosages are called for when that is the worst thing to do, and where the opposite approach—reduction or elimination—is the medically appropriate course.

### Anticholinergic Effects

Among other effects, antipsychotic drugs cause dehydration of hollow organs, including the brain, lungs, and heart. One result is dementia-like symptoms, such as confusion, disorientation, poor concentration, and loss of memory function. Another is dizziness, most sharply experienced when the resident stands up quickly, causing falls and hip fractures; this risk is substantial and itself warrants avoiding these drugs. The most commonly used brands are Mellaril and Thorazine (chlorpromazine). The latter also contributes to liver function problems, and so is particularly inappropriate for use on the elderly.

### Extrapyramidal Effects

These are all problems of movement, such as Tardive Dyskinesia (involuntary movements of the mouth, tongue, and limbs; sometimes irreversible), a movement disorder called akathisia, Parkinsonianism, and acute dystonic reaction (profound muscle spasms). The most commonly used drug brands that are particularly problematic for this kind of side effect are Haldol, Stelazine, and Navane. The involuntary movement symptoms caused by these drugs are easily interpreted as agitation.

This is not to say that these drugs should never be used, only that use should be limited to absolute necessity, where a resident is unable to control his or her behavior and is a physical threat to himself or herself or others. Use in other circumstances, for example for a resident who is verbally abusive, is not for that resident's welfare. They should never be used prophylactically but only as a last resort.

### Antianxiety/Hypnotic Agents

Most antianxiety or antihypnotic drugs (the latter for sleep difficulties) are of the class known as benzodiazapines; these drugs are used for calming down agitated patients. A less frequently encountered class used to treat anxiety or sleep difficulties—but with even less defensible rationale for their use—are barbiturates and a chemically closely related class,

carbamates.

Some of the more common benzodiazapines are well known indeed: Valium, Librium, Dalmane, Serax, Xanax, and Ativan. Chemically, they function much like alcohol in their effect on the central nervous system but, to their credit, without alcohol's adverse effect on the liver. The symptoms of overdose are thus much like those of alcohol—slurred speech, motor coordination problems, confusion, impaired judgment, and a "drunk" feeling. Their major problem, in addition to causing oversedation, is that they are addictive.

Barbiturates and carbamates are severely addictive and more toxic, so that overdoses are life-threatening where overdoses of benzodiazapines usually are not. Among the most familiar of the former two classes are Equanil, Miltown, Seconal, and Nembutal. There is no reason now to use any of these drugs with elderly patients, given newer, less addictive, safer drugs to control the same symptoms.

Of those now available, Buspar is a new and quite effective drug with a long-delayed onset of action of more than seven days; it is also not addictive and so has no abuse potential, based on current research. To be sure, it has not been out long enough to identify all of the problems, but so far it has a very benign profile. By contrast, most other antianxiety drugs take effect in an hour or so. But given their addictive character, they should only be used after nondrug therapies have been attempted.

The appropriate use of benzodiazapines is either for an individual with chronic, debilitating, long-term anxiety, where the patient initiates a request for the drug, or for short-term, situation-specific circumstances—for example, a high-anxiety incident such as a necessary trip outside the nursing home. Overuse, as always, should be avoided.

Anxiety may particularly be a problem of polypharmacy. Anxiety is also susceptible to a wide array of other treatments; for example, it can often be treated effectively with increasing social contacts or exercise (include walking). Even such simple remedies as warm milk can be effective.

### Antidepressants

As a group these drugs usually have no extrapyramidal side effects, but most have anticholinergic side effects (the most anticholinergic being Elavil and Tofranil or SK Pramirine, which should thus be avoided), and the last being Norpramin or Pertofrane, Prozac, and Desyrel. Their other major drawback is that most are cardiotoxic, and so can cause damage to heart tissue or function, particularly in overdose. Some may also be quite sedating, like Elavil, Tofranil, and Sinequan. As with most other drugs, these effects are most noticeable and thus most dangerous with elderly patients, and require particularly careful monitoring. The elderly are also quite susceptible to these sedating effects.

These drugs can be useful for stroke patients, who typically suffer quite severe depression in the wake of the condition, and might also be used with those who have already indicated a positive response to antidepressant medication.

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