CHAPTER 12

FEDERAL INDICATORS AFFECTING THE DRUG REGIMEN REVIEW
OVERVIEW OF FEDERAL INDICATORS USED IN PERFORMING A DRUG REGIMEN REVIEW

I. Omnibus Budget Reconciliation Act (OBRA 1990) includes the “Nursing Home Standards Reform Act”. These laws are still in effect and are addressed by CMS through the Federal Interpretive Guidelines. These guidelines have evolved over the years each time raising the contributions and responsibilities of the Consultant Pharmacist

1. 1974 – Drug Regimen Review was mandated
2. 1982 – The Initial Federal Indicators were created
3. 1992 – The Unnecessary Drug were created
4. 1999 – The Quality Indicators & Beers Criteria were created
5. 2006 – Major re-write of the MRR and Unnecessary Medication Guidelines

II. Summary Of Federal Indicators Affecting The Drug Regimen Review

1. F329 – Drug Therapy Guidelines for Unnecessary Medications
2. F428 – Drug Therapy Guidelines for Medication Regimen Review
3. F425 – Pharmacy Services (if services are affecting the intended outcome)
4. F309 – Quality of Care (Pain management)

III. Unnecessary Medications (Ftag 329)

1. General. Each resident’s drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:
   (i) In excessive dose (including duplicate therapy); or
   (ii) For excessive duration; or
   (iii) Without adequate monitoring; or
   (iv) Without adequate indications for its use; or
   (v) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or
   (vi) Any combinations of the reasons above.

2. Antipsychotic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that:
   (i) Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and
   (ii) Residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

INTENT: §483.25(l) Unnecessary drugs The intent of this requirement is that each resident’s entire drug/medication regimen be managed and monitored to achieve the following goals:
• The medication regimen helps promote or maintain the resident’s highest practicable mental, physical, and psychosocial well-being, as identified by the resident and/or representative(s) in collaboration with the attending physician and facility staff;
• Each resident receives only those medications, in doses and for the duration clinically indicated to treat the resident’s assessed condition(s);
• Non-pharmacological interventions (such as behavioral interventions) are considered and used when indicated, instead of, or in addition to, medication;
• Clinically significant adverse consequences are minimized; and
• The potential contribution of the medication regimen to an unanticipated decline or newly emerging or worsening symptom is recognized and evaluated, and the regimen is modified when appropriate.

3. Monitoring for Efficacy and Adverse Consequences (Excerpts from F329)

The information gathered during the initial and ongoing evaluations is essential to:

• Incorporate into a comprehensive care plan that reflects appropriate medication related goals and parameters for monitoring the resident’s condition, including the likely medication effects and potential for adverse consequences. Examples of this information may include the FDA boxed warnings or adverse consequences that may be rare, but have sudden onset or that may be irreversible. If the facility has established protocols for monitoring specific medications and the protocols are accessible for staff use, the care plan may refer staff to these protocols;

• Optimize the therapeutic benefit of medication therapy and minimize or prevent potential adverse consequences;

• Establish parameters for evaluating the ongoing need for the medication; and

• Verify or differentiate the underlying diagnoses or other underlying causes of signs and symptoms.

The key objectives for monitoring the use of medications are to track progress towards the therapeutic goal(s) and to detect the emergence or presence of any adverse consequences.

4. Determining the frequency of monitoring (Excerpts from F329)

The frequency and duration of monitoring needed to identify therapeutic effectiveness and adverse consequences will depend on factors such as clinical standards of practice, facility policies and procedures, manufacturer’s specifications, and the resident’s clinical condition.

Monitoring involves three aspects:
• Periodic planned evaluation of progress toward the therapeutic goals;
• Continued vigilance for adverse consequences; and
• Evaluation of identified adverse consequences.
5. Duration (Excerpts from F329)

Many conditions require treatment for extended periods, while others may resolve and no longer require medication therapy.

6. Tapering of a Medication Dose/Gradual Dose Reduction (GDR) (Excerpts from F329)

The requirements underlying this guidance emphasize the importance of seeking an appropriate dose and duration for each medication and minimizing the risk of adverse consequences. The purpose of tapering a medication is to find an optimal dose or to determine whether continued use of the medication is benefiting the resident.

7. F329 incorporates 9 common conditions and offers tools for monitoring and reference sources for standards of care. These conditions include:

- Diabetes
- Dementia (including Alzheimer’s)
- Behavioral Symptoms associated with Dementia
- Functional Decline
- Delirium
- Bipolar Disorder
- Pain
- Depression
- Abnormal Movements

8. F329 reviews 70 common therapeutic classes of drugs used in geriatrics. This review includes:

- The drug’s indication
- Methods for monitoring the drug
- Common Drug Interactions
- Adverse consequences of therapy
- Identifies exemptions to the monitoring

9. The Use Of Antipsychotics (Ftag 329)

1. There must be a supporting diagnosis justifying the use of the antipsychotic

2. The facility must identify “target behaviors” (ex. striking out) that will be monitored every shift to determine if the drug is effective. This is most frequently done using a “Behavior Intervention Flow Record (see page 12.9)
   Ideally, target behaviors should decrease if the drug and dose are appropriate.
Antipsychotics (continued)

3. The dose of the antipsychotic should not exceed a daily maximum dose (defined in FTAG 329) unless the prescriber can justify the need for higher doses (based on objective data) and he/she addresses the risk vs benefit of the higher dose.

4. The patient must be monitored on a daily basis for non-movement side effects such as drowsiness, drooling, constipation etc.

5. The patient must be assessed at least every 6 months for movement side effects. The most common instrument used in LTC is the AIMS review (Abnormal involuntary movement scale). Movement disorders may include extrapyramidal symptoms (EPS) akathesia, dystonias and pseudo-parkinsonian movements) which may be an early indication of tardive dyskinesia.

*6. Within the first year in which a resident is admitted on an antipsychotic medication or after the facility has initiated an antipsychotic medication, the facility must attempt a gradual dosage reduction (GDR) in two separate quarters (with at least one month between the attempts), unless clinically contraindicated.

*7. After the first year, a GDR must be attempted annually, unless clinically contraindicated.

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

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

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

   - The continued use is in accordance with relevant current standards of practice and the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident’s function or cause psychiatric instability by exacerbating an underlying psychiatric disorder, or
The resident’s target symptoms returned or worsened after the most recent attempt at a GDR within the facility and the physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident’s function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder.

10. Sedative Hypnotics (Ftag 329)

1. Evidence must exist that other possible reasons (caffeine use, depression, pain, noise etc) have been ruled out prior to using a hypnotic

2. For as long as a resident remains on a sedative/hypnotic that is used routinely during the previous quarter, the facility should attempt to taper the medication at least quarterly.

* 3 Before one can conclude that tapering is clinically contraindicated for the remainder of that year, tapering must have been attempted during the previous three quarters.

* 4. For the use of sedative/hypnotics, clinically contraindicated means that the physician has documented the clinical rationale for why any additional attempted tapering at that time would be likely to impair the resident’s function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder.

* These are 2006 changes in the interpretive guidelines

11. Considerations Specific to Psychopharmacological Medications (Other Than Antipsychotics and Sedative/Hypnotics).

1. This includes: Anticonvulsants
   Tranquilizers
   Mood Stabilizers
   Psychoactive Drugs
   Anti-Alzheimers Drugs (Cholinesterase Inhibitors)

   (NOTE: Anticonvulsants & Mood stabilizers are only considered Psychopharmacologic medications if they are used for behaviors)

2. During the first year in which a resident is admitted on a psychopharmacological medication (other than an antipsychotic or a sedative/hypnotic), or after the facility has initiated such medication, the facility should attempt to taper the medication during at least two separate quarters (with at least one month between the attempts), unless clinically contraindicated.

3. After the first year, a tapering should be attempted annually, unless clinically contraindicated. The tapering may be considered clinically contraindicated, if:
• The resident’s target symptoms returned or worsened after the most recent attempt at a tapering within the facility; and
• The physician has documented the clinical rationale for why any additional attempted tapering at that time would be likely to impair the resident’s function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder.

12. The Use Of Tranquilizers (Ftag 329)

1. There must be a supporting diagnosis for the use of all routine tranquilizer drugs. There should be evidence in the chart that environmental reasons for a patient’s anxiety or distress have been ruled out.

2. Long acting benzodiazepines (i.e. Chlordiazepoxide, Diazepam) should not be used in the elderly unless there is evidence that a short acting drug is ineffective.

3. The dose of all benzodiazepines should not exceed the maximum daily dose as defined in F329 unless there is justification in the chart for a higher dose.

* 4. During the first year in which a resident is admitted on a psychopharmacological medication (other than an antipsychotic or a sedative/hypnotic), or after the facility has initiated such medication, the facility should attempt to taper the medication during at least two separate quarters (with at least one month between the attempts), unless clinically contraindicated.

* 5. After the first year, a tapering should be attempted annually, unless clinically contraindicated.

* 6. The tapering may be considered clinically contraindicated, if:
   • The resident’s target symptoms returned or worsened after the most recent attempt at a tapering within the facility; and
   • The physician has documented the clinical rationale for why any additional attempted tapering at that time would be likely to impair the resident’s function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder.

7. The patient should be monitored every shift for side effects from the medication. This is most frequently done using a “Behavior Intervention Flow Record (see page 12.10)

8. Duplication of benzodiazepines should be avoided. The use of a daily tranquilizer and a benzodiazepine sleeper many be considered duplicate therapy.
13. Antidepressants (Ftag 329)

1. There must be a supporting diagnosis for the use of an antidepressant drugs. There should be evidence in the chart that environmental reasons for a patient’s depression have been ruled out.

2. Older tri-cyclic antidepressants are not considered appropriate drugs in the elderly because of the high likelihood of anti-cholinergic side effects.

3. The federal guidelines do not require a “Behavior Intervention Flow Record (see page 12.10) be used to monitor antidepressant therapy. However, there should be evidence in the chart that the drug has improved the depression and side effects are not an issue.

4. Tri-cyclic antidepressants may be appropriate when used to treat neuropathic pain.

5. It may be appropriate to discontinue an antidepressant if the patient is stable and has not shown signs of depression in more than 6 months.

14. Alzheimers Treatments

1. These products may lose their effectiveness if they are discontinued during the course of therapy. Therefore, it may not be appropriate to attempt dosage reductions on these medication to prove effectiveness.

2. The consultant should have literature available during the survey (or in the patient’s chart) that would justify not attempting dosage reductions.

3. The prescriber should document in the chart why it is inappropriate to attempt dosage reductions.

4. There may be a time when the dementia has progressed to the point to the drug is no longer providing benefit. When this happens, discontinuation may be appropriate.
1. §483.60(c) Drug Regimen Review

(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

(2) The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.

2. INTENT (F428) 42 CFR 483.60(c)(1)(2) Medication Regimen Review

The intent of this requirement is that the facility maintains the resident’s highest practicable level of functioning and prevents or minimizes adverse consequences related to medication therapy to the extent possible, by providing:

- A licensed pharmacist’s review of each resident’s regimen of medications at least monthly; or a more frequent review of the regimen depending upon the resident’s condition and the risks or adverse consequences related to current medication(s);

- The identification and reporting of irregularities to the attending physician and the director of nursing; and

- Action taken in response to the irregularities identified.

- The facility must have policies and procedures to obtain a consultant pharmacist review on any new admission or resident who experiences adverse effects BETWEEN scheduled consultant visits.

3. CMS Definitions 2006 (see F425 in Section II of this manual for a complete list of definitions)

1. Irregularity - refers to any event that is inconsistent with usual, proper, accepted, or right approaches to providing pharmaceutical services (see definition in F425), or that impedes or interferes with achieving the intended outcomes of those services.

2. Medication Regimen Review (MRR) - is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences associated with medication. The review includes preventing, identifying, reporting, and resolving medication-related problems, medication errors, or other irregularities, and collaborating with other members of the interdisciplinary team.
3. **Monitoring** - is the ongoing collection and analysis of information (such as observations and diagnostic test results) and comparison to baseline data in order to:
   • Ascertain the individual’s response to treatment and care, including progress or lack of progress toward a therapeutic goal;
   • Detect any complications or adverse consequences of the condition or of the treatments; and
   • Support decisions about modifying, discontinuing, or continuing any interventions.

IV. **F425 – Pharmacy Services (if services are affecting the intended outcome)**

F425 (Pharmacy services) will be discussed in following chapters. In general, if the level of pharmacy services does not meet the needs of the resident the consultant pharmacist MUST address this deficiency in their monthly consultant reviews.

Examples:
- A pain medication has been ordered but has not been delivered by the pharmacy before the medication needs pain management.
- A resident is admitted late in the evening and medications are unavailable in the facility for the morning med pass.
- The time between the drug being ordered and the scheduled time of delivery results in missed doses. This is especially true for Antibiotics and Pain Medications.
- The Emergency Kit does not contain medications frequently ordered in the facility resulting in delays in initiating therapy.

V. **F309 – Quality of Care (Pain management)**

1. **Synopsis of Regulation (Tag F309)** The resident must receive and the facility must provide the necessary care and services to attain or maintain his/her highest practicable level of physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

2. **Criteria for Compliance with F309 for a Resident with Pain or the Potential for Pain** For a resident with pain or the potential for pain (such as pain related to treatments), the facility is in compliance with F309 Quality of Care as it relates to the recognition and management of pain, if each resident has received and the facility has provided the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care i.e., the facility:
   • Recognized and evaluated the resident who experienced pain to determine (to the extent possible) causes and characteristics of the pain, as well as factors influencing the pain;
• Developed and implemented interventions for pain management for a resident experiencing pain, consistent with the resident’s goals, risks, and current standards of practice; or has provided a clinically pertinent rationale why they did not do so;

• Recognized and provided measures to minimize or prevent pain for situations where pain could be anticipated;

• Monitored the effects of interventions and modified the approaches as indicated; and

• Communicated with the health care practitioner when a resident was having pain that was not adequately managed or was having a suspected or confirmed adverse consequence related to the treatment.

The expectation is the Consultant Pharmacist will be involved in the selection of pain medication and the assessment of therapy to ensure that the medication is controlling the pain.
AIMS TEST

POLICY:

It is the policy of this facility that all residents receiving antipsychotic drugs shall be monitored for extrapyramidal symptoms.

METHODS:

1. All residents admitted to this facility with orders for antipsychotic medications shall receive an AIMS test (abnormal involuntary movement scale test) within 7 days of admission.

2. All residents receiving initial orders of antipsychotic medications while in the facility shall receive an AIMS test within 7 days of the initial order.

3. All residents receiving antipsychotic medications shall receive AIMS test every six months while receiving these drugs.

4. All AIMS tests shall be conducted by the charge nurse or their designee. These tests shall include the name of the resident and the date the test was conducted.

5. All AIMS tests shall be reviewed by the physician, signed and dated.

6. Any significant change in ratings shall be identified and reported to the physician.

7. This test shall remain a part of the chart.
# ABNORMAL INVOLUNTARY MOVEMENT SCALE (AIMS)

INSTRUCTIONS: Complete examination procedure before making ratings. While conducting the examination, have resident sit in a firm chair without arms. For all MOVEMENT ratings (sections A, B, and C) rate highest severity observed. Circle only one code for each evaluation.

<table>
<thead>
<tr>
<th>SCORING CODES:</th>
<th>0 = None</th>
<th>1 = Minimal/Normal</th>
<th>2 = Mild</th>
<th>3 = Moderate</th>
<th>4 = Severe</th>
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## SECTION A: FACIAL AND ORAL MOVEMENTS

1. MUSCLES OF FACIAL EXPRESSION
   - e.g., movements of forehead, eyebrows, periorbital area, cheeks; include involuntary (e.g., jerking, grimacing)
   - 0 1 2 3 4 0 1 2 3 4 0 1 2 3 4 0 1 2 3 4

2. LIPS AND PERIORAL AREA
   - e.g., puckering, pouting, smacking
   - 0 1 2 3 4 0 1 2 3 4 0 1 2 3 4 0 1 2 3 4

3. JAW
   - e.g., clenching, chewing, mouth opening, lateral movement
   - 0 1 2 3 4 0 1 2 3 4 0 1 2 3 4 0 1 2 3 4

4. TONGUE
   - Rate only increase in movement both in and out of mouth, NOT inability to sustain movement.
   - 0 1 2 3 4 0 1 2 3 4 0 1 2 3 4 0 1 2 3 4

## SECTION B: EXTREMITY MOVEMENTS

5. UPPER (ARMS, WRISTS, HANDS, FINGERS)
   - Include chronic movements (i.e., rapid, objectively purposeless, irregular, spontaneous), athetoid movements (i.e., slow, irregular, complex, serpentine). Do NOT include tremor (i.e., repetitive, regular, rhythmic)
   - 0 1 2 3 4 0 1 2 3 4 0 1 2 3 4 0 1 2 3 4

6. LOWER (LEGS, KNEES, ANKLES, TOES)
   - e.g., lateral knee movement, foot tapping, heel dropping, foot scurrying, inversion and eversion of foot
   - 0 1 2 3 4 0 1 2 3 4 0 1 2 3 4 0 1 2 3 4

## SECTION C: TRUNK MOVEMENTS

7. NECK, SHOULDERS, HIPS
   - e.g., rocking, twisting, squirming, pelvic gyrations
   - 0 1 2 3 4 0 1 2 3 4 0 1 2 3 4 0 1 2 3 4

## SECTION D: GLOBAL JUDGMENTS

8. SEVERITY OF ABNORMAL MOVEMENTS
   - 0 1 2 3 4 0 1 2 3 4 0 1 2 3 4 0 1 2 3 4

9. INCAPACITATION DUE TO ABNORMAL MOVEMENTS
   - 0 1 2 3 4 0 1 2 3 4 0 1 2 3 4 0 1 2 3 4

10. RESIDENT AWARENESS OF ABNORMAL MOVEMENTS
    - Rate only patient's report
    - 0 = No awareness
    - 1 = Aware, no distress
    - 2 = Aware, mild distress
    - 3 = Aware, moderate distress
    - 4 = Aware, severe distress

## SECTION E: DENTAL STATUS

11. CURRENT PROBLEMS WITH TEETH AND/OR DENTURES
    - 0 = No
    - 1 = Yes

12. DOES RESIDENT USUALLY WEAR DENTURES?
    - 0 = No
    - 1 = Yes

## EVALUATOR SIGNATURES

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NAME——Last
First
Middle
ABDOMINAL PHYSICIAN
Chart No.

12.13
### Dyskinesia Identification System - Condensed User Scale (DISCUS)

- **Current Psychotropics/Anticholinergic and Total MG/Day:**
  - (See instructions on other side)

### Scoring
- 6: NOT PRESENT (movements not observed or some movements observed but not considered abnormal)
- 5: MINIMAL (movements are difficult to detect but occur only once or twice in a short non-repetitive manner)
- 4: MODERATE (movements occur frequently and are easy to detect)
- 3: SEVERE (movements occur without control and are easy to detect)
- NA: NOT ASSESSED (an assessment for an item is not done (or not done)

### Assessment DISCUS Item Score (Enter Score Code for Each Item)

#### FACE
1. Tics
2. Grimaces

#### EYES
3. Blinking

#### ORAL
4. Chewing/Lip Smacking
5. Puckering/Sucking/Thrusting Lower Lip

#### LINGUAL
6. Tongue Thrusting/Tongue in Cheek
7. Tonic Tongue
8. Tongue Tremor
9. Atypical/Myokymic/Lateral Tongue

#### HEAD/NECK/TRUNK
10. Retrocollis/Torticollis
11. Shoulder/Hip Toning

#### UPPER LIMB
12. Atypical/Myokymic/Finger-Wrist-Arm
13. Pill Rolling

#### LOWER LIMB
14. Ankle Flexion/Foot Tapping
15. Toe Movement

#### TOTAL SCORE
(Score items 1 - 15 only)

### Comments/Others

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(This form is most often used in the ICF-DD facility)
### Behavior/Intervention Monthly Flow Record

**Behavior:** Biting

**Intervention Codes** (see Care Plan)
1. Communicate
2. On 1:1 basis
3. Refer to nurse's notes
4. Activity
5. Return to room (temperature)
6. Toilet
7. Backup

**Outcome Codes**
- 1: Improved
- 2: Unchanged
- 3: Worsened

**Side Effects**
- A.
- B.
- C.

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**Behavior:** Kicking

**Intervention Codes** (see Care Plan)
1. Communicate
2. On 1:1 basis
3. Refer to nurse's notes
4. Activity
5. Return to room (temperature)
6. Toilet
7. Backup

**Outcome Codes**
- 1: Improved
- 2: Unchanged
- 3: Worsened

**Side Effects**
- A.
- B.
- C.

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**Sample Facility**

**Physician:** Adams, Gus

**Room:**

**Diagnosis:** Biting/Kicking 2nd to

**ICD9:** 1215

**Strength:**

**Diagnosis:**

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**NOTE:**
- Enter the intervention codes and side effects codes with initials for each shift. See the back of the form for a list of behaviors and potential side effects.
- Enter the number of episodes per shift with initials.
- Enter the number of behavior episodes per day with initials.
- Enter the number of behavior episodes per week with initials.
- Enter the number of behavior episodes per month with initials.

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**Other:**

**Diagnosis:**

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**Nurse Reviewer:**

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**References:**
NURSING HOME

SAMPLE POLICY & METHODS

BEDTIME SEDATIVE/HYPNOTIC MEDICATION

POLICY:

It is the policy of this facility that bedtime medications given for sleep shall be made available to our residents as ordered by the physician and shall not be administered inappropriately.

METHODS:

1. Unless otherwise ordered by the physician, **no sleep medication shall be given before the hour of 10 PM.**

2. Each sleeping medication administered shall clearly state the events that necessitated giving the medication after 10 PM including what non-medication interventions were utilized to aid the resident in going to sleep.

3. Orders from the physician for times prior to 10 PM shall clearly designate the time the medication should be given (i.e., 7:00 PM) or at the time requested by the resident.
Center for Clinical Standards and Quality/ Survey & Certification Group

Ref: S&C: 13-02-NH
DATE: November 2, 2012

TO: State Survey Agency Directors

FROM: Director Survey and Certification Group

SUBJECT: Nursing Homes - Clarification of Guidance related to Medication Errors and Pharmacy Services

Memorandum Summary

We are providing clarification on three specific topics related to medication errors and pharmacy services:

- **Medication Errors**: Potential medication errors related to medication administration via feeding tube and administration timing for metered dose inhalers and proton pump inhibitors and survey implications.

- **Medication Administration Practices**: The practice of “borrowing” medications and issues related to diversion, control, reconciliation and disposal of medications, including Fentanyl patches.

- **Medication Regimen Reviews for Stays under 30 days and/or Changes in Condition**: The need for pharmacist medication regimen reviews when a resident experiences a change in condition and/or for residents admitted for less than 30 days.

Background

Medications are an integral part of the care provided to nursing home residents. They are administered to achieve positive outcomes, such as curing an illness, diagnosing a disease or a condition, modifying a disease process, reducing or eliminating symptoms, or preventing a disease or symptom. However, any medication or combination of medications may result in adverse consequences. Therefore residents must only receive medications when there are clear clinical indications and when the potential benefits outweigh the risks.

To improve the review of the requirements regarding medications and pharmacy services, the Centers for Medicare & Medicaid Services (CMS) implemented revised interpretive guidance for tag F329- Unnecessary medications and for Pharmacy services at F425, F428, and F431 on
December 18, 2006. Since the 2006 guidance release, we have received several requests for clarifications regarding:

- Medication errors;
- Medication administration practices; and
- Medication regimen reviews for stays under 30 days and changes in resident condition.

I. Medication errors

*Administration of Medications via a Feeding Tube (collectively refers to Nasoenteric i.e. nasogastric or nasointestinal, or Gastrostomy tubes)*

Surveyors have identified problems regarding safe administration of medications via a feeding tube (such as incorrectly crushing timeReleased oral medications) or not flushing the tube before, in between and after administration of a medication. In accordance with F425- Pharmacy Services, the facility, in consultation with the pharmacist, must provide procedures for the accurate administration of all medications. The procedures must reflect current standards of practice, including but not limited to: types of medications that may be safely administered via a feeding tube; appropriate dosage forms; techniques to monitor and verify that the feeding tube is in the right location (e.g., stomach or small intestine, depending on the tube) before administering medications; preparing drugs for enteral administration, administering drugs separately, diluting drugs as appropriate, and flushing the feeding tube before, between, and after drug administration; and that medications with known incompatibilities must not be given at the same time.

Survey Implications:

Refer to F322- Nasogastric Tubes, if placement of the feeding tube is not checked prior to medication administration. For a resident who requires fluid regulation, the physician’s order should include the amount of water to be used for the flushing and administration of medications.

For administering medications via tube feeding, the standard of practice is to administer each medication separately and flush the tubing between each medication. An exception would be if there is a physician’s order that specifies a different flush schedule for an individual resident, for example because of a fluid restriction. Failure to flush before and in between each medication administration is considered a single medication error and would be included in the calculation for medication errors exceeding 5 percent. If noncompliance with the administration of medication(s) via a feeding tube has been identified at F332- Medication Errors, additional requirements should be investigated such as F425- Pharmacy Services to assure that the facility has policies for administration of medications via feeding tube that meet current standards of practice.

Also consider F520 - Quality Assessment and Assurance (QAA), in order to determine whether the QAA committee monitors for safe medication administration practices including the administration of medications via feeding tubes in order to assure that facility policy and
standards of practice are implemented. The committee and the medical director and pharmacist are expected to be involved in the oversight of safe medication administration practices.

- **Metered Dose Inhalers (MDIs)**

Updates in asthma and chronic obstructive pulmonary disease (COPD) practice guidelines have prompted us to clarify the use of metered dose inhalers to administer medications, and more specifically the timing between puffs. If more than one (1) puff is required, (whether the same medication or a different medication), current guidelines, and/or manufacturer product information indicate there should be a waiting time of approximately one (1) minute between puffs except for short acting beta agonists such as albuterol, where a shorter wait time of 15-30 seconds is acceptable.\(^2\) Ensuring that a device is administered correctly is vital to optimizing inhalation therapy. Numerous educational resources on the storage and administration of various inhalation therapies (e.g., diskus, nebulizer, MDI) are available. Some examples include:

- http://www.aafa-md.org/thumbdrive.htm (under pharmacy file-handouts);
- You Tube Video: http://www.youtube.com/watch?v=Z_95ni8DJwU

**Survey Implications:**

If surveyors identify concerns related to the administration of medications at F332- Medication Errors, then additional requirements may also be considered and investigated such as F425- Pharmacy Services.

- **Proton Pump Inhibitors (PPI)**

This clarification provides surveyors directions for further investigation if they have identified concerns related to the circumstances and timing of PPI administration. Section 483.60(a), Pharmacy Services, requires the facility to establish procedures that assure the accurate administration of medications to meet the needs of each resident. The facility must have policies that address the timing for medications that are required to be administered with regard to food intake (for example, with food or on an empty stomach). PPIs, such as lansoprazole (Prevacid) and omeprazole (Prilosec), are routinely used in nursing home settings. For optimal therapeutic benefit, most PPIs should be administered on an empty stomach, ideally 30-60 minutes before meals. The rationale is that in order for the medication to provide the maximum benefit it needs to be present in the system before food activates the acid pumps so that the peak concentration of the PPI will coincide with maximal acid secretion.\(^3\) Some residents may report benefits of this medication being administered outside the 30-60 minutes prior to a meal and this needs to be determined and documented to justify the continued administration times.

As with any class of medication, it is important to identify the indication for use as well as continued need to ensure appropriate use. This is particularly important with new resident admissions, since many patients are placed on a PPI after an acute care stay, but may not require long-term therapy with these agents. The Food and Drug Administration requires adding information to the PPI prescription label as well as to the over the counter (OTC) PPIs. They
noted that patients who take higher doses and/or remain on PPIs longer (at least one year) were reported to have a higher incidence of hip, wrist or spine fractures. This warning, as well as the increased risk for infections such as pneumonia and *Clostridium difficile*, reinforces the importance of evaluating each resident for continued medication use.

Survey Implications:

If concerns related to the administration of medications have been identified at F332- Medication Errors, then additional requirements may also be considered and investigated such as F281- Professional Standards of Quality, F329- Unnecessary Medications or F425- Pharmacy Services.

**II. Concerns regarding medication administration practices**

**A. “Borrowing Medications”**

Nurses have reported situations in which a medication is not available in the resident’s supply or in the facility’s emergency medication kit or supply. Nursing staff may then decide to “borrow” medications from another resident’s supply in order to relieve pain or ensure timely administration of an antibiotic or cardiac medication for the benefit of a resident. This practice of borrowing medications from other residents’ supplies is not consistent with professional standards and contributes to medication errors.

If permitted under State law, a contracted pharmacy provider may establish an emergency supply of medications in collaboration with the medical director and the director of nurses. The surveyor should investigate whether policies and procedures are in place for emergency kit use and if they are being implemented. The facility may use an automated medication distribution system and should have procedures for both routine and emergency use of medications.

**Survey Implications:**

The surveyor should interview staff responsible for medication administration in order to determine:

- How they assure each resident has a sufficient supply of their prescribed medications (for example, a resident who is on pain management to assure an adequate supply of medication is available to meet the resident’s needs). At a minimum the system is expected to include a process for the timely ordering and reordering of a medication;
- Who monitors to assure that the medications are delivered when ordered; and
- What they do if a resident’s prescribed medication is not available for administration.

If the staff borrows medications to administer to a resident due to the failure of the staff to order the medication and not following the facility’s system for reordering medications, refer to F281- Professional Standards of Quality.

In addition, interview the pharmacist, director of nurses, and/or medical director as appropriate in order to determine if they have a system in place to assure each resident has a sufficient supply.
of their prescribed medications for timely administration and monitor that the system is followed. (See F425- Pharmacy Services)

Determine whether the nursing staff contacted the prescriber if an ordered medication was not available. Review the resident’s record for documentation regarding the notification and orders from the prescriber on how to address the non-availability of the medication. If the prescriber was not available, determine if the medical director was contacted for orders or further action (See F501- Medical Director, and F514 - Accuracy of medical record.)

Determine whether the QAA committee monitors to assure the timely provision and administration of each resident’s prescribed medications. (See F520 - Quality Assessment and Assurance).

B. Fentanyl Patches

Tag F431- Service Consultation requires a licensed pharmacist, who is employed by or provides services to a facility, to establish a system of records of receipt and disposition of all controlled medications. The system should enable periodic, accurate reconciliation and accounting of all controlled drugs. Fentanyl transdermal patches are a controlled substance commonly used in nursing homes for pain medication. These patches present a unique situation given the multiple boxed warnings, the potential for abuse, misuse and diversion, and the substantial amount of fentanyl remaining in the patch after use. The facility’s policies must address safe and secure storage, limited access and reconciliation of controlled substances in order to minimize loss or diversion, and provide for safe handling, distribution and disposition of the medications.

One benefit of the patch is the continuous delivery of fentanyl over 72 hours. This slow-release of fentanyl from the transdermal reservoir allows for more consistent pain control in patients with chronic pain. This unique delivery system, however, is not impervious to diversion, even after the fentanyl patch has been used, removed and/or disposed. One study determined that even after three days of use, 28 to 84.4% of the original fentanyl dose was still present in the patch. The study noted that the dose remaining in the patch was within the limits of a lethal fentanyl dose.

The remaining fentanyl in a used patch is a potential vehicle of abuse and accidental overdose and warrants implementation of adequate disposal policies. Fentanyl products contain several boxed warnings related to potential abuse, misuse and diversion, and specifically, the contraindication of fentanyl transdermal patch use in individuals who are not opioid tolerant.

Staff should dispose of fentanyl patches in the same manner as wasting of any other controlled substances, particularly because the active ingredient is still accessible. Wasting must involve a secure and safe method, so diversion and/or accidental exposure are minimized. Tag F425 requires the facility’s procedures to address the disposition of all medications. This includes but is not limited to:

- Timely identification and removal of medications from the current supply of medications for disposition;
- Identification of storage method for medications awaiting final disposition;
• Control and accountability of medications awaiting final disposition;
• Documentation of actual disposition for both full dose and any other remaining partial dose; and
• A method of disposition consistent with applicable state and federal requirements, local ordinances, and standards of practice.

Survey Implications:

If surveyors identify misuse or diversion of a controlled substance, they should consider and investigate these requirements:

• F309 - Quality of care, for evidence and/or potential outcomes, such as unrelieved pain. For example, evidence that on a particular shift, or when a particular staff member is working, that the resident’s pain symptoms are not relieved to the extent possible but the pain symptoms are met to the extent possible on other shifts;
• F425 - Pharmacy Services, for policies for safeguarding and access, monitoring, administration, documentation, reconciliation and destruction of controlled substances;
• F431 - Pharmacy service consultation, for drug records and reconciliation of controlled drugs;
• F514 - Clinical Records, accuracy of medical record and for the documentation of the administration of the medication and outcomes; or
• F520 - Quality assessment and assurance, for how the QAA committee monitors the administration, reconciliation and disposition of controlled substances in the facility.

In addition, if the investigation identifies diversion of a resident’s medication, the surveyor must review for F224- Misappropriation of Resident’s Property. If it is determined that a resident’s medications were diverted for staff use, the State Agency must make referrals to appropriate agencies, such as local law enforcement; Drug Enforcement Administration; State Board of Nursing; State Board of Pharmacy; and possibly the State licensure Board for Nursing Home Administrators.

III. Medication Regimen Reviews for Stays under 30 days and Changes in Condition

Consultation (including medication regimen review) by the pharmacist can promote safe and effective medication use. The regulation at F428 -Medication Regimen Review requires that a licensed pharmacist review each resident’s medication regimen at least once a month.

The facility is expected to have a proactive, systematic and effective approach to monitoring, reporting, and acting upon the effects, risks, and adverse consequences of medications. The pharmacist may need to conduct the medication regimen review more frequently (for example weekly), depending on the resident’s condition and the risks for adverse consequences related to current medications. The requirement for the medication regimen review applies to all residents, including residents receiving respite care, residents at the end of life or who have elected the hospice benefit, residents with an anticipated stay of less than 30 days, or residents who have experienced a change in condition. Complex residents generally benefit from a pharmacist’s review during the transition from hospital to skilled nursing facility. This review may prevent
errors due to drug-drug interactions, omissions, duplication of therapy or miscommunication during the transition from one team of care providers to another.

The current guidance at F425-Pharmacy Services provides examples of how the facility, in collaboration with the pharmacist and medical director, can establish procedures to address medication regimen reviews for residents whose anticipated stay is less than 30 days. According to the guidance, facility procedures are expected to address how and when the need for a consultation will be communicated, how the medication review will be handled if the pharmacist is off-site, how the results or report of the pharmacist’s findings will be communicated to the provider, the expectations for the provider’s response and follow up, and how and where this information will be documented.

Survey Implications:

Both the previous and the current guidance at F428-Medication Regimen Review have identified that the pharmacist may need to review a medication regimen more frequently, depending on the resident’s condition and the risk for adverse consequences associated with the medications. Efforts to prevent medication-related adverse consequences and to recognize existing or emerging complications are a significant focus of clinical care in nursing homes. If there is evidence the pharmacist should have conducted more frequent reviews, surveyors should consider consulting an advanced practitioner, pharmacist or physician at the State Survey Agency or Regional Office to review cases in which this practice may be considered deficient.

If non-compliance has been identified at F428, then additional requirements may also be considered and investigated such as F385-Physician Supervision; F329-Unnecessary Medications; or F501-Medical Director.

For questions on this memorandum, please contact alice.bonner@cms.hhs.gov.

Effective Date: Immediately. This policy should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators within 30 days of this memorandum.

References:

1. http://www.ismp.org/newsletters/acuteCare/articles/20100506.asp 5/06/10


4. a. FDA (Federal Drug Administration) drug safety communication: possible increased risk of fractures of the hip, wrist and spine with the use of proton pump inhibitors.3/23/2011.
MINI-MENTAL STATE EXAMINATION (MMSE)

ORIENTATION

Where are you?
(Ask the general question first, then the specific questions below)

Name this place (building or hospital)
What floor are you on now?
What state are you in?
What county are you in? (If not in a county, score correct if city is correct)
What city are you in (or near) now?

What is the date today?
(Ask the general question first, then the specific questions below)

What year is it?
What season is it?
What month is it?
What is the day of the week?
What is the date today?

REGISTRATION

Name three objects (ball, flag, and tree) and have patient repeat them.
(Say objects at about 1 word per second. If patient misses object, ask him/her to repeat it after you until he/she learns it. Stop at 6 repeats.)

Score 1 for each object correctly repeated
(Max = 3)

ATTENTION AND CALCULATION

Subtract 7s from 100 in a serial fashion to 65.
Alternatively
Ask the subject to spell the word WORLD. Then have the subject spell it backward.

Score 1 for each correct to 65 (Max = 5)
Score 1 for each correctly placed letter

RECALL

Do you recall the names of the three objects?

Score 1 for each recalled
(Max = 3)
**LANGUAGE**

Ask patient to provide names of a watch and pen as you show them to him.

Score 1 for each object correct (Max = 2) □

Repeat "no ifs, ands, or buts." (Only one trial)

Score 1 if correct □

Give patient a piece of plain blank paper and say, "Take the paper in your right hand (1), fold it in half (2), and put it on the floor (3)."

Score 1 for each part done correctly (Max = 3) □

Ask patient to read and perform task written on paper: "Close your eyes."

Score 1 if patient closes eyes. □

Ask patient to write a sentence on a piece of paper.

Score total of 1 if sentence has a subject, object, and verb. (Max = 1) □

**CONSTRUCTION**

Ask patient to copy the design of the interlocking five-sided figures.

![Design of interlocking five-sided figures]

Score 1 if all 10 angles are present and two angles intersect. Ignore tremor and rotation. (Max = 1) □

**TOTAL SCORE**

(Maximum score = 30) □

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GERIATRIC DEPRESSION RATING SCALE, Brink et al., 1982; Yesavage et al., 1983

GERIATRIC DEPRESSION RATING SCALE
Brink et al., 1982; Yesavage et al., 1983 - SHORT version - Sheik et al., 1986
(to be completed by a trained clinician)

DATE: 12/27/2006       TIME (24hr): 10:59

Choose the best answer for how you have felt over the past week:

Yes / No

[ ] [ ] 1. Are you basically satisfied with your life?
[ ] [ ] 2. Have you dropped many of your activities and interests?
[ ] [ ] 3. Do you feel that your life is empty?
[ ] [ ] 4. Do you often get bored?
[ ] [ ] 5. Are you in good spirits most of the time?
[ ] [ ] 6. Are you afraid that something bad is going to happen to you?
[ ] [ ] 7. Do you feel happy most of the time?
[ ] [ ] 8. Do you often feel helpless?
[ ] [ ] 9. Do you prefer to stay at home, rather than going out and doing new things?
[ ] [ ] 10. Do you feel you have more problems with memory than most?
[ ] [ ] 11. Do you think it is wonderful to be alive now
[ ] [ ] 12. Do you feel pretty worthless the way you are now
[ ] [ ] 13. Do you feel full of energy?
[ ] [ ] 14. Do you feel that your situation is hopeless?
[ ] [ ] 15. Do you think that most people are better off than you are?

TOTAL GDS:

(GDS maximum score = 15)

0 - 4 normal, depending on age, education, complaints
5 - 8 mild
9 - 11 moderate
12 - 15 severe

TEXT FOR YOUR RECORDS - click here:  

12.26
NEUROPSYCHIATRIC INVENTORY—NURSING HOME (NPI-NH)

Directions: Read all items from the NPI-NH "Instructions for Administration of the NPI-NH." Mark caregiver’s responses on this worksheet before scoring the frequency, severity, and occupation disruption. See complete structured interview and inventory instructions.

<table>
<thead>
<tr>
<th>A. DELUSIONS: Y N N/A</th>
<th>B. HALLUCINATIONS: Y N N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency _________ Severity _________ Occupational Disruption _________</td>
<td>Frequency _________ Severity _________ Occupational Disruption _________</td>
</tr>
<tr>
<td>□ 1. Fear of harm</td>
<td>□ 1. Hears voices</td>
</tr>
<tr>
<td>□ 2. Fear of theft</td>
<td>□ 2. Talks to people not there</td>
</tr>
<tr>
<td>□ 3. Spousal affair</td>
<td>□ 3. Sees things not there</td>
</tr>
<tr>
<td>□ 4. Phantom boarder</td>
<td>□ 4. Smells things not there</td>
</tr>
<tr>
<td>□ 5. Spouse imposter</td>
<td>□ 5. Feels things not there</td>
</tr>
<tr>
<td>□ 6. House not home</td>
<td>□ 6. Unusual taste sensations</td>
</tr>
<tr>
<td>□ 7. Fear of abandonment</td>
<td>□ 7. Other</td>
</tr>
<tr>
<td>□ 8. Talks to TV, etc.</td>
<td></td>
</tr>
<tr>
<td>□ 9. Other</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C. AGITATION/AGGRESSION: Y N N/A</th>
<th>D. DEPRESSION/DYSPHORIA: Y N N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency _________ Severity _________ Occupational Disruption _________</td>
<td>Frequency _________ Severity _________ Occupational Disruption _________</td>
</tr>
<tr>
<td>□ 1. Upset with caregiver; resists ADL's</td>
<td>□ 1. Tearful and sobbing</td>
</tr>
<tr>
<td>□ 2. Stubbornness</td>
<td>□ 2. States, acts as if sad</td>
</tr>
<tr>
<td>□ 3. Uncooperative; resists help</td>
<td>□ 3. Puts self down, feels like failure</td>
</tr>
<tr>
<td>□ 5. Cursing or shouting angrily</td>
<td>□ 5. Discouraged, no future</td>
</tr>
<tr>
<td>□ 7. Hits, harms others</td>
<td>□ 7. Talks about dying, killing self</td>
</tr>
<tr>
<td>□ 8. Other</td>
<td>□ 8. Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E. ANXIETY: Y N N/A</th>
<th>F. Elation/Euphoria: Y N N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency _________ Severity _________ Occupational Disruption _________</td>
<td>Frequency _________ Severity _________ Occupational Disruption _________</td>
</tr>
<tr>
<td>□ 1. Worries about planned events</td>
<td>□ 1. Feels too good, too happy</td>
</tr>
<tr>
<td>□ 2. Feels shaky, tense</td>
<td>□ 2. Abnormal humor</td>
</tr>
<tr>
<td>□ 3. Sobs, sighs, gasps</td>
<td>□ 3. Childish, laughs inappropriately</td>
</tr>
<tr>
<td>□ 4. Racing heart, “butterflies”</td>
<td>□ 4. Jokes or remarks not funny to others</td>
</tr>
<tr>
<td>□ 5. Phobic avoidance</td>
<td>□ 5. Childish, pranks</td>
</tr>
<tr>
<td>□ 7. Other</td>
<td>□ 7. Other</td>
</tr>
</tbody>
</table>

NPI-NH Page 1
### G. APATHY/INDIFFERENCE: Y N N/A

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Severity</th>
<th>Occupational Disruption</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 1. Less spontaneous or active</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ 2. Less likely to initiate conversation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ 3. Less affectionate, lacking emotions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ 4. Contributes less to household chores</td>
<td></td>
<td></td>
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<tr>
<td>□ 5. Less interested in others</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ 6. Lost interest in friends or family</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ 7. Less enthusiastic about interests</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ 8. Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### H. DISINHIBITION: Y N N/A

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Severity</th>
<th>Occupational Disruption</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 1. Acts impulsively</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ 2. Excessively familiar with strangers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ 3. Insensitive or hurtful remarks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ 4. Crude or sexual remarks</td>
<td></td>
<td></td>
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<tr>
<td>□ 5. Talks openly of private matters</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ 6. Inappropriate touching of others</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ 7. Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### I. IRRITABILITY: Y N N/A

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Severity</th>
<th>Occupational Disruption</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 1. Bad temper, “flies off handle” easily</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ 2. Rapid changes in mood</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ 3. Sudden flashes of anger</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ 4. Impatient, trouble coping with delays</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ 5. Cranky, irritable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ 6. Argues, difficult to get along with</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ 7. Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### J. ABERRANT MOTOR BEHAVIOR: Y N N/A

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Severity</th>
<th>Occupational Disruption</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 1. Paces without purpose</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ 2. Opens or unpacks closets or drawers</td>
<td></td>
<td></td>
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<tr>
<td>□ 3. Repeatedly dresses and undresses</td>
<td></td>
<td></td>
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<tr>
<td>□ 4. Repetitive activities or “habits”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ 5. Handling, picking, wrapping behavior</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ 6. Excessively fidgety</td>
<td></td>
<td></td>
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<tr>
<td>□ 7. Other</td>
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<td></td>
</tr>
</tbody>
</table>

### K. NIGHTTIME BEHAVIORS: Y N N/A

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Severity</th>
<th>Occupational Disruption</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 1. Difficulty falling asleep</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ 2. Up during the night</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ 3. Wanders, paces, inappropriate activity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ 4. Awakens others at night</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ 5. Wakes and dresses to go out at night</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ 6. Early morning awakening</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ 7. Sleeps excessively during the day</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ 8. Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### L. APPETITE/EATING BEHAVIORS: Y N N/A

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Severity</th>
<th>Occupational Disruption</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 1. Loss of appetite</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ 2. Increased appetite</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ 3. Weight loss</td>
<td></td>
<td></td>
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<tr>
<td>□ 4. Weight gain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ 5. Change in eating habits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ 6. Change in food preferences</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ 7. Eating rituals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ 8. Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The NPI and the NPI-NH are copyrighted instruments, and any commercial use must be negotiated with the author. The NPI-NH is a summary of the NPI questions. Reliable administration of the NPI-NH depends on the use of the NPI scale questions available from the author. Contact Jeffrey L. Cummings, MD, Alzheimer's Cooperative Study, Reed Neurological Research Center, UCLA, 710 Westwood Plaza, Los Angeles, CA 90095-1769, USA. Tel: 310-206-5238.

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The page number is NPI-NH Page 2.
CORNELL SCALE FOR DEPRESSION IN DEMENTIA (CSDD)

SCORING SYSTEM

a = unable to evaluate 1 = mild or intermittent
0 = absent 2 = severe

Ratings should be based on symptoms and signs occurring during the week prior to interview. No score should
be given if symptoms result from physical disability or illness.

A. Mood-Related Signs

1. Anxiety
   anxious expression, ruminations, worrying

2. Sadness
   sad expression, sad voice, tearfulness

3. Lack of reactivity to pleasant events

4. Irritability
   easily annoyed, short-tempered

B. Behavioral Disturbance

5. Agitation
   restlessness, handwringing, hairpuling

6. Retardation
   slow movements, slow speech, slow reactions

7. Multiple physical complaints
   (score 0 if GI symptoms only)

8. Loss of interest
   less involved in usual activities
   (score only if change occurred acutely, i.e., in less than 1 month)

C. Physical Signs

9. Appetite loss
   eating less than usual

10. Weight loss
    (score 2 if greater than 5 lb in 1 month)

11. Lack of energy
    fatigues easily, unable to sustain activities
    (score only if change occurred acutely, i.e., in less than 1 month)

CSDD Page 1
D. Cyclic Functions

12. Diurnal variation of mood
   symptoms worse in the morning
   a 0 1 2

13. Difficulty falling asleep
    later than usual for this individual
    a 0 1 2

14. Multiple awakenings during sleep
    a 0 1 2

15. Early-morning awakening
    earlier than usual for this individual
    a 0 1 2

E. Ideational Disturbance

16. Suicide
    feels life is not worth living, has suicidal wishes, or makes suicide attempt
    a 0 1 2

17. Poor self-esteem
    self-blame, self-deprecation, feelings of failure
    a 0 1 2

18. Pessimism
    anticipation of the worst
    a 0 1 2

19. Mood-congruent delusions
    delusions of poverty, illness, or loss
    a 0 1 2

INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL)

Circle one statement in each category (A–H) that applies to subject.

A. Ability to use telephone
   1. Operates telephone on own initiative—looks up and dials numbers, etc.
   2. Dials a few well-known numbers.
   3. Answers telephone but does not dial.
   4. Does not use telephone at all.

B. Shopping
   1. Takes care of all shopping needs independently.
   2. Shops independently for small purchases.
   3. Needs to be accompanied on any shopping trip.
   4. Completely unable to shop.

C. Food preparation
   1. Plans, prepares, and serves adequate meals independently.
   2. Prepares adequate meals if supplied with ingredients.
   3. Heats and serves prepared meals, or prepares meals but does not maintain adequate diet.
   4. Needs to have meals prepared and served.

D. Housekeeping
   1. Maintains house alone or with occasional assistance (e.g., “heavy work—domestic help”).
   2. Performs light daily tasks such as dishwashing, bedmaking.
   3. Performs light daily tasks but cannot maintain acceptable level of cleanliness.
   5. Does not participate in any housekeeping tasks.
E. Laundry
1. Does personal laundry completely.
2. Launders small items—rinses socks, stockings, etc.
3. All laundry must be done by others.

F. Mode of transportation
1. Travels independently on public transportation or drives own car.
2. Arranges own travel via taxi, but does not otherwise use public transportation.
3. Travels on public transportation when assisted or accompanied by another.
4. Travel limited to taxi or automobile with assistance of another.
5. Does not travel at all.

G. Responsibility for own medications
1. Is responsible for taking medication in correct dosages at correct time.
2. Takes responsibility if medication is prepared in advance in separate dosages.
3. Is not capable of dispensing own medication.

H. Ability to handle finances
1. Manages financial matters independently (budgets, writes checks, pays rent, pays bills, goes to bank); collects and keeps track of income.
2. Manages day-to-day purchases, but needs help with banking, major purchases, etc.
3. Incapable of handling money.

The Purpose Of Pain Scales

These easy-to-use tools offer valuable insight into the experience of pain.

By Rhonda B. Graham
InteliHealth Staff Writer

Pain is best defined as an uncomfortable or unpleasant feeling that tells you something may be wrong in your body. It’s one way your body sends a warning to your brain. The spinal cord and nerves serve as passageways through which pain messages travel to and from your brain and the other parts of your body.

But sometimes it’s difficult to put the pain you feel into words. Telling your doctor where and how long something hurts is only part of the information needed to diagnose your condition and determine your treatment. You need to be able to describe your pain in a way that gives your doctor clues to your state of health.

Pain scales are tools that can help your doctor diagnose or measure your pain’s intensity. In some cases, the information provided can help your doctor choose the best treatment. The most widely used scales are visual, verbal, numerical or some combination of all three forms.

- **Visual.** Visual scales have pictures of human anatomy to help you explain where your pain is located. A popular visual scale — the Wong-Baker Faces Pain Rating Scale — features facial expressions to help you show your doctor how the pain makes you feel. This scale is particularly useful for children, who sometimes don’t have the vocabulary to explain how they feel.

- **Verbal.** Verbal scales contain commonly used words such as "low," "mild" or "excruciating" to help you describe the intensity or severity of your discomfort. Verbal scales are useful because the terminology is relative, and you must focus on the most characteristic quality of your pain.

- **Numerical.** Numerical scales help you to quantify your pain using numbers, sometimes in combination with words.

To be most accurate, pain scales are best used as the pain is occurring. Over time, with treatment, your doctor can use pain scales to record how your pain is changing and to see if treatment is having the intended effect.

If you suffer from chronic pain, print out one of the scales provided to help you describe or rate your discomfort for your doctor. Ask your doctor if he or she prefers one of these pain scales or a different one.

The Wong-Baker Faces Pain Rating Scale

Designed for children aged 3 years and older, the Wong-Baker Faces Pain Rating Scale is also helpful for elderly patients who may be cognitively impaired. It offers a visual description for those who don’t have the verbal skills to explain how their symptoms make them feel.

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To use this scale, your doctor should explain that each face shows how a person in pain is feeling. That is, a person may feel happy because he or she has no pain (hurt), or a person may feel sad because he or she has some or a lot of pain.

- **Face 0** is very happy because he or she doesn't hurt at all.
- **Face 1** hurts just a little bit.
- **Face 2** hurts a little more.
- **Face 3** hurts even more.
- **Face 4** hurts a whole lot.
- **Face 5** hurts as much as you can imagine, although you don't have to be crying to feel this bad.

You should point to each face using the words to describe the pain intensity. You should then choose the face that best describes how you feel.

**A Verbal Pain Scale**

With a verbal scale, you can describe the degree of your discomfort by choosing one of the vertical lines that most corresponds to the intensity of pain you are feeling. This is a good way to explain early postoperative pain, which is expected to diminish over time. Your doctor can use this scale to determine if your recovery is progressing in a positive direction.

**A Numerical Pain Scale**

A numerical pain scale allows you to describe the intensity of your discomfort in numbers ranging from 0 to 10 (or greater, depending on the scale). Rating the intensity of sensation is one way of helping your doctor determine treatment.

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Numerical pain scales may include words or descriptions to better label your symptoms, from feeling no pain to experiencing excruciating pain. Some researchers believe that this type of combination scale may be most sensitive to gender and ethnic differences in describing pain.

Last updated December 06, 2006