

Long Term Care for the Elderly

The Role for Pharmacists

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Consultant pharmacy represents a branch of the profession that has almost become synonymous with nursing homes in the USA. This is largely due to the legal framework that surrounds nursing home care in the USA and the requirement for pharmacy review of medication in this setting. However, consultant pharmacy has been in existence for almost 30 years and had its roots in community practice; today, a consultant pharmacist is defined as a practitioner who provides services to long-term care facilities on a contractual basis. This paper provides an overview of this type of pharmacy practice, the current delivery of consultant pharmacy services in the USA and lessons for the international pharmacy profession.

Development of consultant pharmacy in the USA

Consultant pharmacy developed from community pharmacy practice. Those based in community practice were providing a medication supply service to nursing homes with a number of these practitioners providing a more advanced service than basic dispensing. Legislation in the mid-1960's sought to improve the quality of nursing home care, but perhaps the most important development in nursing home regulation and legislation was the publication of the Institute of Medicine's (IOM) report on improving the quality of care in nursing homes in 1986¹.

One of the key recommendations from the report was that: "each resident is to receive high-quality care to meet individual physical, mental and psychosocial needs. The care should be designed to maintain or improve the residents' physical, mental, and emotional well-being".¹

The Omnibus Budget Reconciliation Act of 1987 (OBRA 87)

Following the IOM report, legislation was enacted within the USA to improve care in nursing homes - the Nursing Home Reform Act which was embedded in the Omnibus Budget Reconciliation Act of 1987 (OBRA 87)² - and was implemented in October 1991.

As a first step to improve the quality of care in nursing homes, attempts have been made through the OBRA regulations to undertake a comprehensive assessment of the residents' needs, encompassing the following areas:

- Medically defined conditions and prior medical history
- Medical status measurement
- Functional status
- Sensory and physical impairments
- Nutritional status and requirements

- Special treatments or procedures
- Psychosocial status
- Discharge potential
- Dental condition
- Activities potential
- Rehabilitation potential
- Cognitive status
- Drug therapy

Such assessments must be carried out on patients no later than 14 days after admission, following a significant change in the resident's physical or mental condition and at least once every 12 months, with a partial reassessment every quarter.

As a means to assist in this standardisation of care, it was necessary to develop an instrument which could be used in the collection of patient data. The Resident Assessment Instrument (RAI) was produced by a research consortium in conjunction with the federal organisation that oversees the US government's health programmes—the Health Care Financing Agency (HCFA)³. It includes a set of central assessment items known as the Minimum Data Set (MDS) and 18 Resident Assessment Protocols (RAPs).

In terms of prescribing, the MDS contains a domain which embraces medication use; this specifically relates to the following elements:

- the number of medications used in the previous 7 days
- if any new medications had been initiated in the previous 90 days
- the number of days during which the resident had received injections of any kind in the previous 7 days
- the number of days (during the last 7 days) the resident received an antipsychotic, anxiolytic, antidepressant, hypnotic or diuretic medication.

Drug Regimen Review (DRR) is the means by which drug therapy in patients is evaluated in most long-term care facilities. Such reviews, under

current legislation, are carried out on a monthly or quarterly basis by a consultant pharmacist.

The DRR should include at least an evaluation of the appropriateness of, and response to, each patient's drug therapy. The pharmacist must report any irregularities to the attending doctor and director of nursing.

Thus, specific justification is required in relation to prescribing of psychoactive drugs. The regulations state that "the resident has the right to be free from any chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms". Further regulations provide specific guidance on the use of unnecessary drugs and antipsychotic drugs.

Table I
Long-acting benzodiazepines which should not be used in nursing home residents according to HCFA regulations³

- Flurazepam
- Chlordiazepoxide
- Clorazepate
- Diazepam
- Clonazepam
- Quazepam
- Halzepam

An unnecessary drug is broadly defined as a drug that is used in excessive dose, for excessive duration, without adequate indications for its use or in the presence of adverse consequences which indicate the dose should be reduced or discontinued. For example, it is stated that specified long-acting benzodiazepines should not be used in residents unless an attempt with a shorter-acting drug has failed; these long-acting agents are listed in Table I.

However, exceptions to these guidelines are made in the case of diazepam being used for neuromuscular disorders or when long-acting benzodiazepines are being used to withdraw patients from shorter-acting drugs. Further guidance is given in relation to the use of short-acting

benzodiazepines and other anxiolytic/sedative drugs, drugs for sleep induction (largely hypnotics) and miscellaneous agents such as barbiturates.

In the latter case, it is stated that the initiation of drugs such as amobarbital and secobarbital should not occur in any dose for any resident. Those patients already receiving these drugs should undergo a gradual dose reduction programme.

The regulations provide a wealth of information on the effective use of antipsychotic drugs. Guidance on drug dosage levels and monitoring for antipsychotic side-effects is given. It is specifically stated that, based on a comprehensive assessment of a resident, the facility must ensure that

Table IIa
Medical conditions in which antipsychotic agents may be used as specifically governed by OBRA 87 regulations²

Antipsychotic drugs should not be used unless the clinical record documents that the resident has one or more of the following "specific conditions"

- Schizophrenia
- Schizo-affective disorder
- Delusional disorder
- Psychotic mood disorders (including mania and depression with psychotic features)
- Acute psychotic episodes
- Brief reactive psychosis
- Schizophreniform disorder
- Atypical psychosis
- Tourette's disorder
- Huntington's disease
- Organic mental syndromes (called delirium, dementia and amnesic and other cognitive disorders by DSM-IV*) with associated psychotic and/or agitated behaviours.

* Diagnostic and Statistical Manual of Mental Disorders, fourth edition.

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 those who receive these drugs, should also undergo gradual dose reductions and behavioural interventions (unless clinically contra-indicated) in an effort to discontinue these drugs; the medical conditions of note are detailed in Tables IIa and IIb. The aim of this particular regulation is that the use of psychoactive medication must be justified and documented. Therefore, it is permissible to prescribe in apparent contravention of the legislation provided clinical justification is given.

Lessons for the international pharmacy profession

Clearly, the provision of pharmaceutical services to nursing homes and other long-term care environments in the USA is markedly different to that in other parts of the world. Consultant pharmacy is generally perceived as a clinical speciality, and remuneration for

Table IIb

Medical conditions in which antipsychotic agents should not be used as specifically governed by OBRA 87 regulations²

Antipsychotics should not be used if one or more of the following is/are the only indication

- Wandering
- Poor self care
- Restlessness
- Impaired memory
- Anxiety
- Depression
- Insomnia
- Unsociability
- Indifference to surroundings
- Fidgeting
- Nervousness
- Uncooperativeness
- Agitated behaviours which do not represent danger to the resident or others

services is very different to other national health systems. Perhaps most importantly, many countries do not have a legislative system in place which demands medication review by a pharmacist and justification of prescribing decisions.

Because of these pronounced differences, the import of a consultant pharmacy model into other countries requires considerable discussion and debate. Under the current United Kingdom system, the community pharmacist's involvement in clinical activities to nursing homes is limited to medication supply.

There is also the potential conflict of interest in that pharmacists are currently the main providers of medication to homes; as they are remunerated for the number of items they dispense, there is little incentive to rationalise medication. The current payment available to pharmacists providing advice to homes would not compensate for losses incurred through a reduction in dispensing.

It is also important to consider those who work within the nursing home sector. Although the pharmacy profession may view an extension of services and responsibility to be highly desirable, the views of nursing home managers and other health care professionals who work within this environment should also be sought. A recent survey carried out in all nursing and residential homes in Northern Ireland indicated that staff in these homes were highly supportive of further staff training by pharmacists in the recognition of medication-related problems, additional advice and guidance on missed doses and a pharmacist review of patient medication records to assess drug-drug interactions and possible adverse drug reactions⁴.

Long-term care for the elderly is becoming a major issue within UK health policy. The Royal College of Physicians has commended the role of community pharmacists in medicines'

management as part of its report on "Medication for Older People"⁵ and considers that the profession can contribute to the care of nursing home residents.

Most recently, the UK Department of Health has issued a document entitled "Care Homes for Older People. National Minimum Standards"⁶. This outlines national minimum standards expected under the Care Standard Act 2000 and one such standard states that the registered manager of a home should seek information and advice from a pharmacist regarding medicines policies within the home and medicines dispensed for individuals within the home.

The increasing elderly population represents major challenges for health care professionals in the new millennium and pharmacy is no exception. Pharmacists need to examine what they currently do within long term care and expand their services accordingly.

The American model is something from which we can learn, and perhaps by selecting those elements which are most adaptable to the other healthcare systems, we can start to move some way towards a more holistic approach of care to a highly vulnerable patient group. ★

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