10-27-25 Weekly Clinical Update

The October 17th issue of McKnights LTC Clinical Daily News (https://www.mcknights.com/news/study-nearly-two-thirds-of-nursing-home-residents-were-exposed-to-med-combos-linked-to-potential-drug-drug-interactions/?utm_source=marketing&utm_medium=email&utm_campaign=58NWLTR_MLT_CLINICAL_10%2F20%2F2025&hmEmail=7n8%2FnCqJ2EkZVo%2BD7NdkWt9Sz%2By1cfMN&sha256email=fbf33a7d51f2b4dc43206e4af9c3d189a41c798606a36c9ae3a3324420aa90e5&elqTrack=True) had an interesting article titled, "Study: Nearly two-thirds of nursing home residents were exposed to med combos linked to potential drug-drug interactions". Polypharmacy has long been an issue for seniors…so much so that CMS used to include 9+ meds as a quality indicator. A past-president of the Kansas Medical Directors Association, spoke often about the dangers of polypharmacy and told providers that "if a resident takes 5 or meds, there is a 100% of drug-drug interactions". In this world of elder care, who takes 5 meds? No one…15 or 25 is more realistic. The McKnights article stated, "The 12 most common DDIs involved central nervous system (CNS)-active drugs, anticholinergics, antihypertensives, opioids and diuretics. The DDI (Drug-drug interaction) with the longest median exposure duration (81 days) was concurrent use of acetylcholinesterase inhibitors and heart rate-reducing drugs. Using three or more CNS-active drugs was the most prevalent DDI, observed in 27.1% of all residents." The article cited an article in the Journal of the American Geriatrics Society. (https://agsjournals.onlinelibrary.wiley.com/doi/10.1111/jgs.70175#xd_co_f=MjNlNWE0ZTUtYjNjMS00NzE4LWFlZmItYjgzYzAzMjM3Mjlk~)

The risks of polypharmacy are obvious: adverse drug events; drug-drug interactions when the drugs counteract or amplify each other leading to unintended consequences; prescribing cascades which implies that side effects from 1 drug may be misinterpreted as a new condition, prompting additions medication orders; cognitive impairment and falls; and increased risk for ER visits &/or hospitalization.

So what is the role of the facility in solving these risks? After all, nurses or management don't write med orders…only the physician can write a med order. This is sometimes cited by facility staff. But the facility is responsible for the overall care of each and every resident being cared for. So here are some strategies for safer medication management:

- Routine medication reviews specific to polypharmacy and/or drug-drug interactions
    - Add polypharmacy to Weekly Risk meetings using tools like the Beers Criteria to flag meds
- Deprescribing protocols including systematic taper or DC meds protocols that are not longer providing the desired medication effects

    - Prioritize resident-centered goals over disease/condition-specific targets
- Staff training on recognition of side effects and advocacy for medication adjustments
- Technology integration with the use of dashboards to track polypharmacy trends and flagging of high-risk residents and potential for drug-drug potential interactions (PCC features facility notification of potential drug-drug interactions and the facility is responsible for notification of the ordering practitioner of those potential interactions)
- Family & resident engagement by involvement of resident and family members in medication decisions
    - Provide clear explanations of risks, benefits, and potential drug-drug interactions to support informed consent

By aligning medication practices with resident goals and clinical best practices, nursing facilities can enhance safety, reduce costs, and improve quality of life…that's our job…right?