2026 Annual PADONA Conference

DEPRESCRIBING MEDICATIONS IN LONG-TERM CARE FACILITIES

PADONA
PENNSYLVANIA ASSOCIATION OF DIRECTORS OF NURSING ADMINISTRATION

Deprescribing Medications in LTCF

Presented to:

2026 PADONA 38th Annual Conference

Hershey, PA

March 2026

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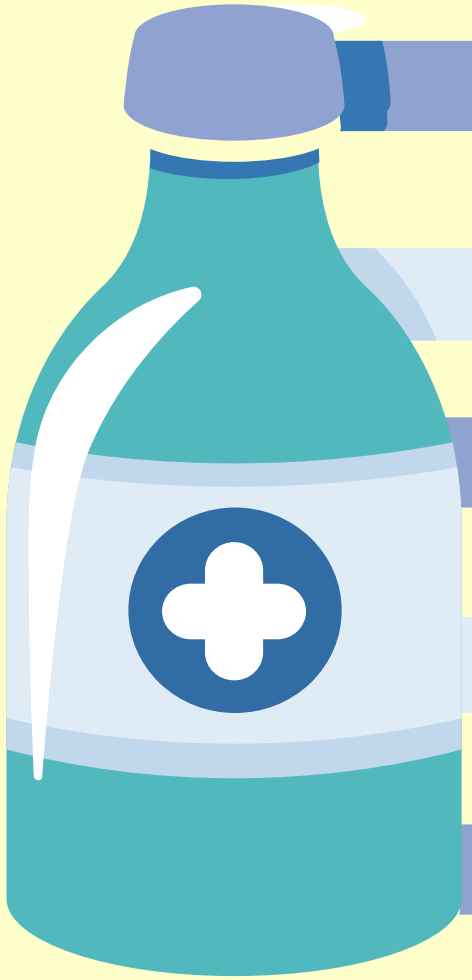
Learning Objectives

By the end of this presentation, participants will be able to:

1. **Apply evidence-based deprescribing frameworks within the long-term care setting** using Beers Criteria, STOPP/START, resident goals of care, prognosis, and CMS regulatory expectations.
2. **Select and safely deintensify high-risk medications commonly overused in LTCF residents** (e.g., antipsychotics, benzodiazepines, antihyperglycemics, opioids, and anticholinergics) while minimizing withdrawal, symptom relapse, and adverse events.
3. **Implement interdisciplinary deprescribing workflows in LTCFs** that integrate nursing assessment, pharmacist drug regimen review, medical oversight, and documentation to improve resident safety, survey outcomes, and quality metrics.

Prescription Drug Use Statistics



Up to 91% Of LTCF residents take **5 or more** prescription drugs

~77% Of LTCF residents are prescribed at least one **potentially inappropriate** medication

5 million Older adults sought **medical attention** for ADEs in 2018

$62 billion In **preventable hospitalizations** over 10 years

150,000 **Premature deaths** expected in the next 10 years due to adverse drug effects

Polypharmacy

Typically defined as ≥ 5 prescription medications

Correlates

With an increased risk of falls, a major driver of morbidity

200%

Increase in polypharmacy over 20 years

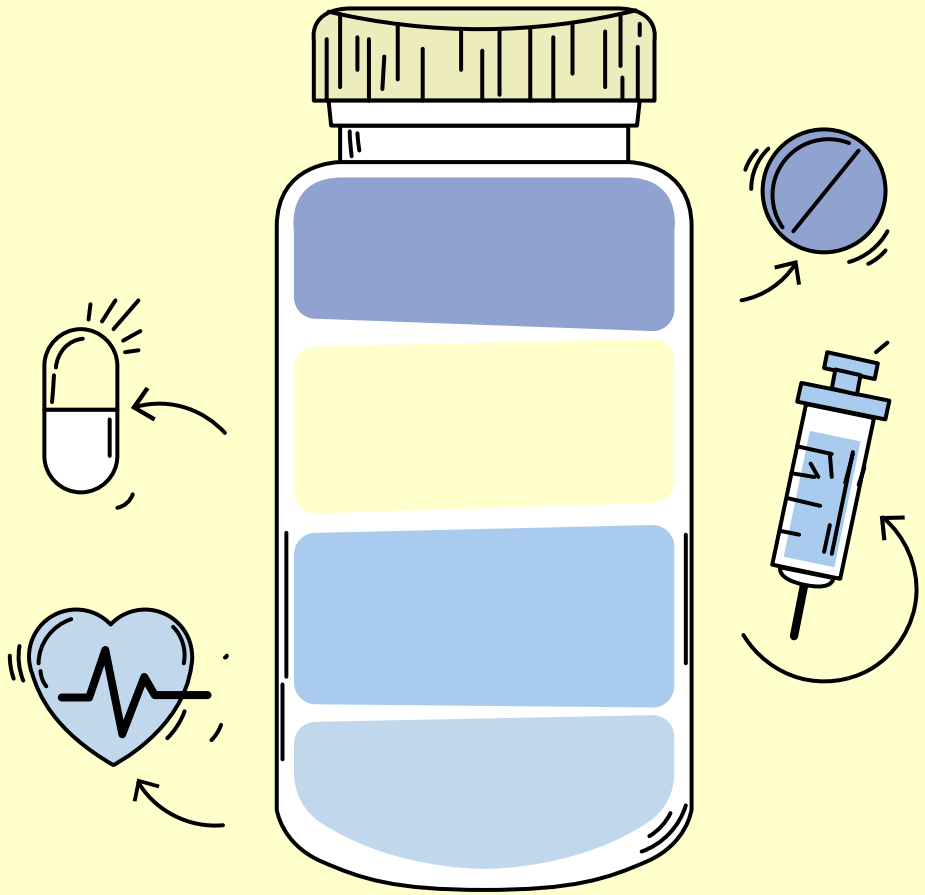
Over 2x risk

Of older patients experiencing delirium with polypharmacy

The Role of Deprescribing

Definition

The planned and supervised process of **reducing** the dose or **stopping** of **medications** that might be causing **harm, or no longer be of benefit**



> 50 %

Of older patients take 5 or more medications

1 in 5

Of these medications are potentially inappropriate

↑ risk of...

Falls, adverse drug events, reduced cognitive/functional outcomes, increased hospitalizations, and death

↓ medications

Allows for greater optimization of patient care

Benefits of Deprescribing

DECREASE

Medication errors

IMPROVE

Patient adherence by reducing pill burden

REDUCE

Risk of potentially serious adverse effects (falls, fractures, etc.)

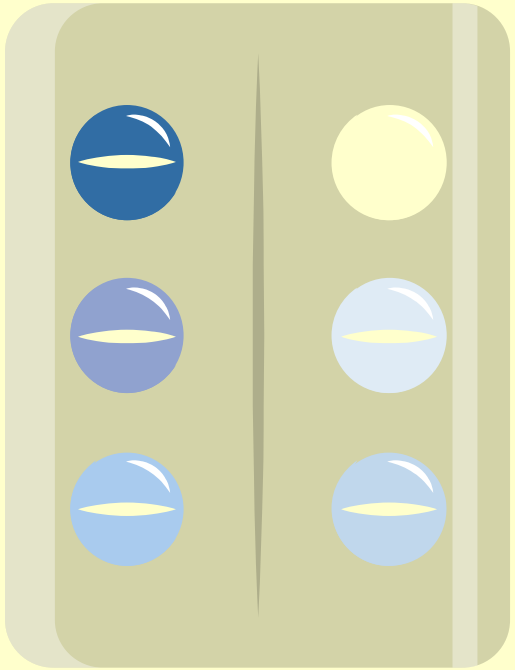
INCREASE

Patient engagement in medication management

MAINTAIN

Or improve quality of life

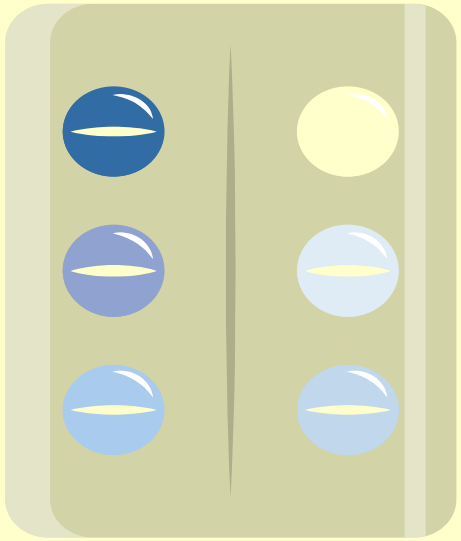
When to Consider Deprescribing



- When medications have no clear indication
- Inappropriate medication for geriatric patients
- Adverse drug events (ADE)
- Medication non-adherence
- Patient preference
- Palliative care/ end of life

Deprescribing Success Rates in Literature

Study conducted over 5 months by Geriatric fellows from August 2018 to January 2019 with 393 total encounters

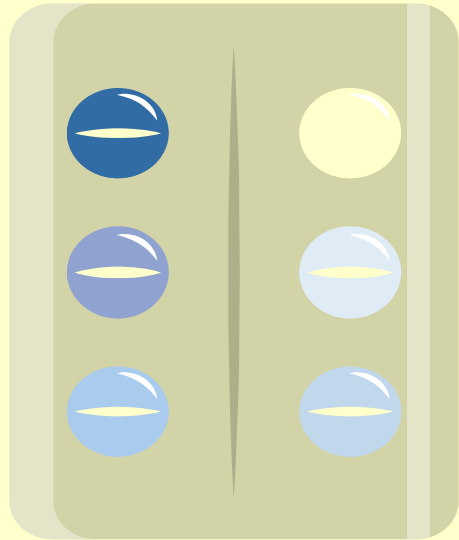


LTC success rate of **96.9%**

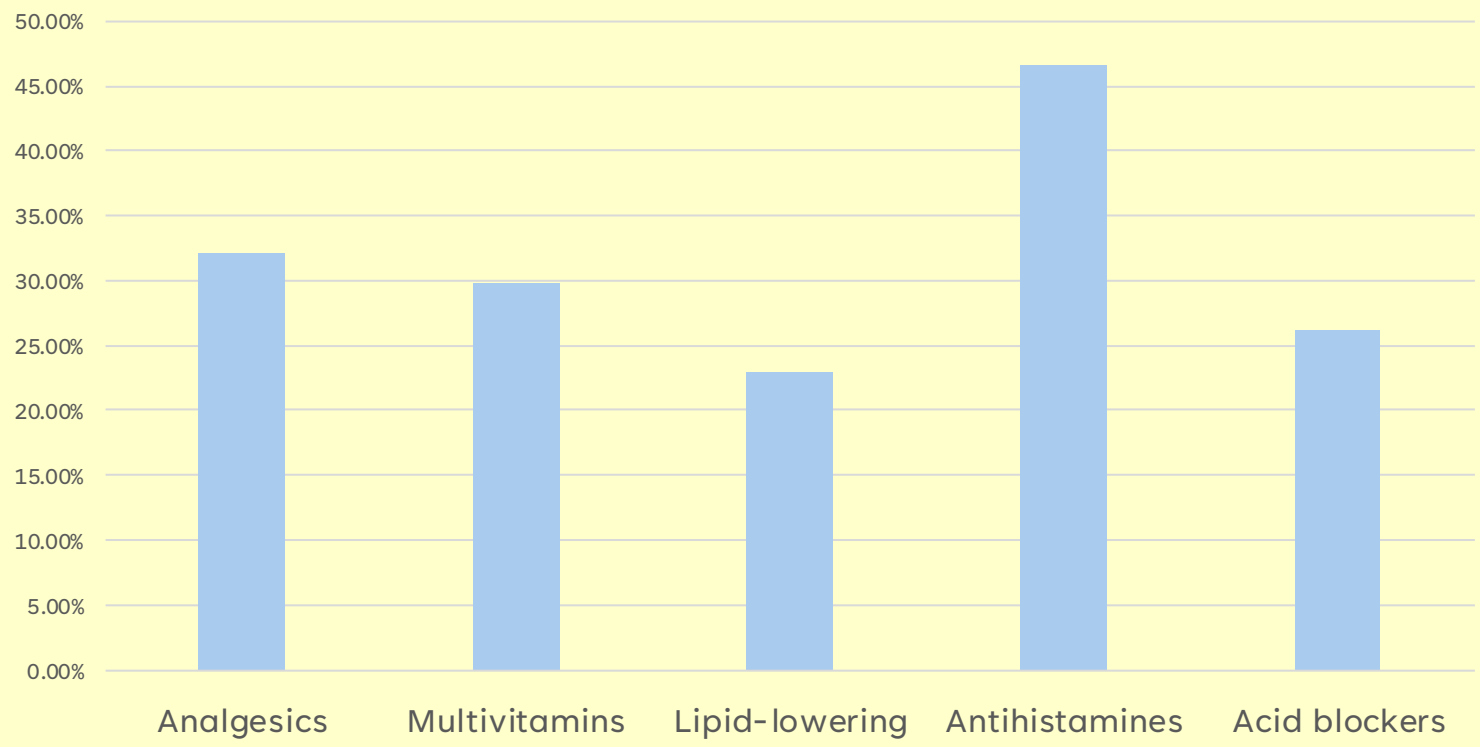
Total encounters success rate of **90.1%**

1.4 medications deprescribed per encounter in LTC

1.0 medication deprescribed per encounter in outpatient clinic



Deprescribing Success Rates in Literature



Steps for Deprescribing

1. Identify potentially inappropriate medications
2. Determine if the medication dosage can be reduced or if the medication can be stopped
3. Plan tapering
4. Monitor for discontinuation symptoms or the need to restart
5. Document outcomes

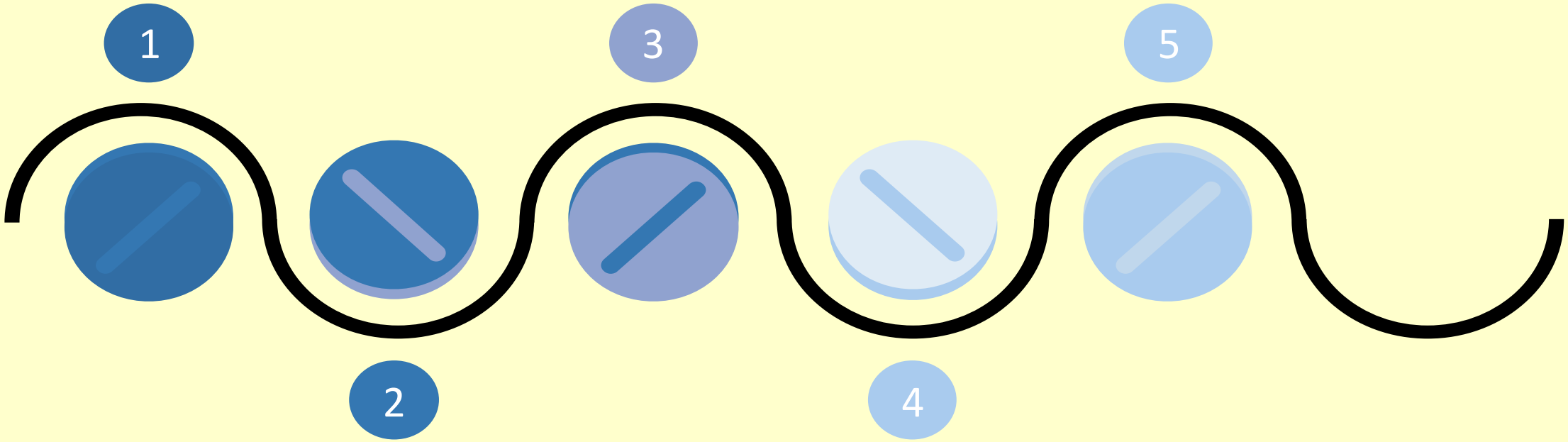
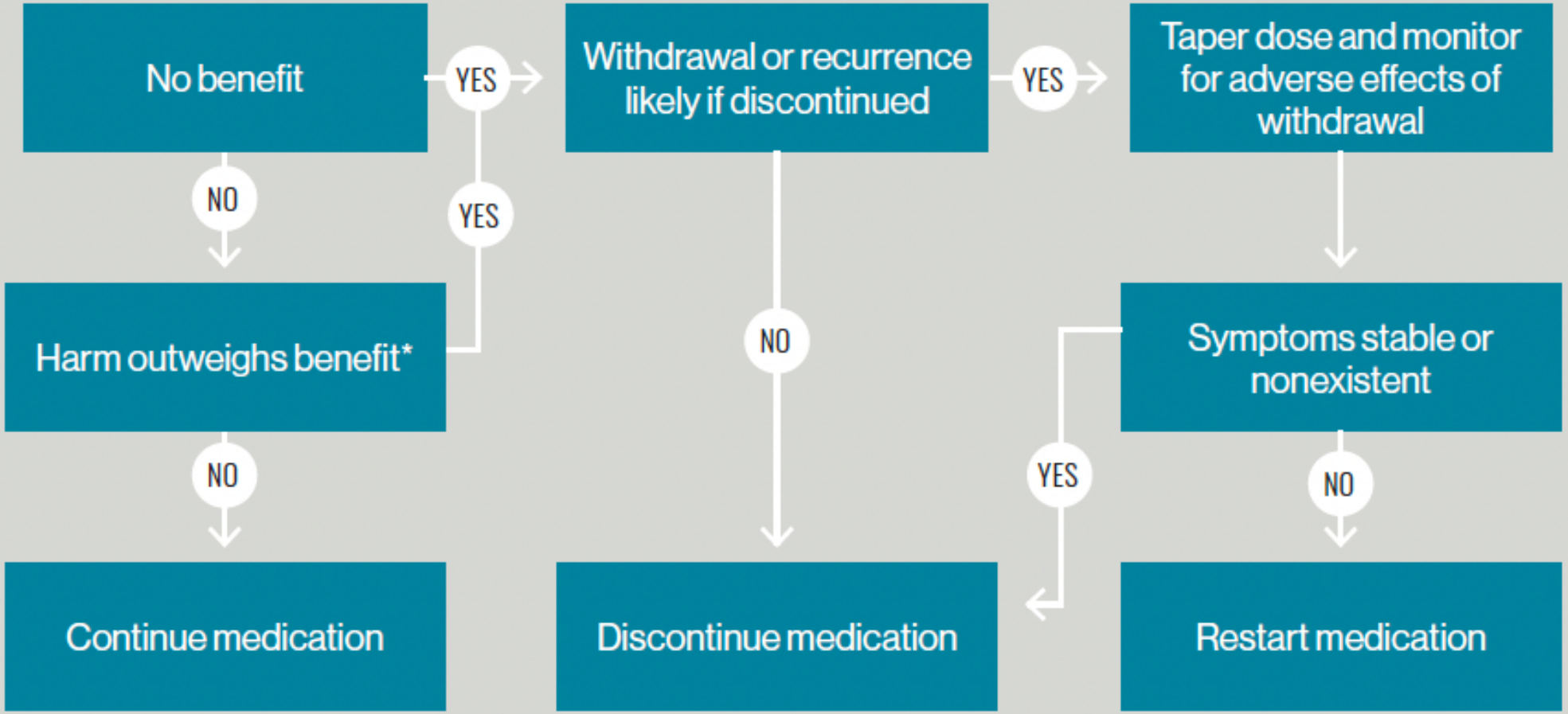


FIGURE. Deprescribing Algorithm to Apply in Practice[24]

For each medication, answer the following questions:



*Consideration should be given to medications being used for symptom control, adverse effect mitigation, or as preventive care. If symptoms/adverse effects are stable or nonexistent, an attempt at tapering/discontinuing should be considered. If a medication is for preventive care but the patient has limited life expectancy, consideration should be given to whether harm outweighs benefit.

Categories of Medications for Deprescribing Consideration

- Vitamins (consolidate and standardize)
- Supplements without verified benefit
- Statin medications
- Proton pump inhibitors (PPIs)
- Benzodiazepines

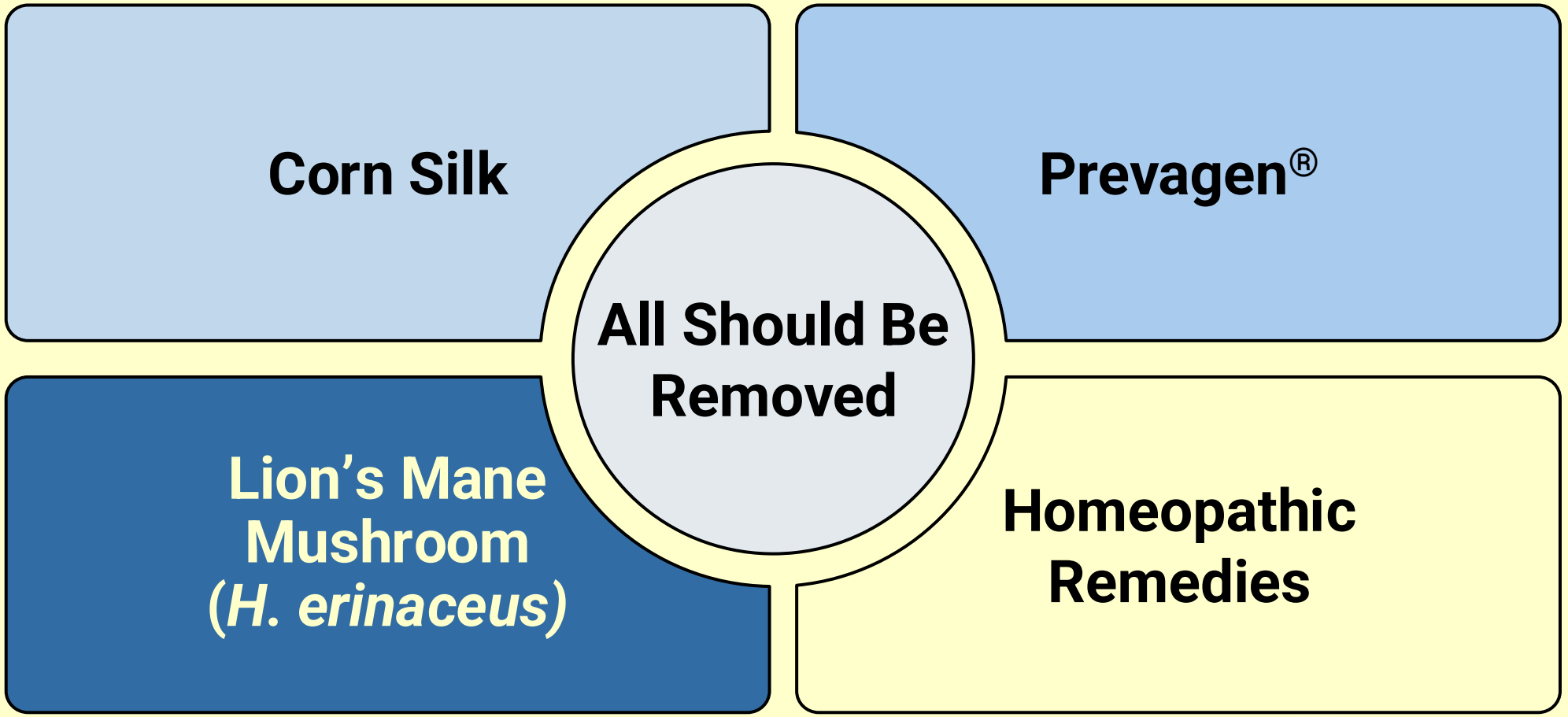
- Antimuscarinics
- Anticholinergics
- Aspirin
- Antipsychotics
- Cholinesterase inhibitors + memantine
- NSAIDS
- Anti-hyperglycemics

Vitamins

Consolidating Vitamins Reduces Medication Errors and the Time Associated with Medication Passes
• Standardize Magnesium supplements: **Mag64®** • Standardize multivitamins: **Therems®-M** • Combine eye vitamins and multivitamins: **PreserVision® AREDS 2 + Multivitamin**

• Vitamin D
  ◦ **Current regimen**: Vitamin D3 2000 units daily
  ◦ **Alternative regimen**: Vitamin D3 50,000 units once or twice monthly if indicated
• Standardize Vitamin D and Calcium doses to reduce confusion when both strengths are not listed on the orders
  ◦ **Calcium +D 600/400**
  ◦ **Calcium +D 500/200**

Supplements Without Verified Benefit

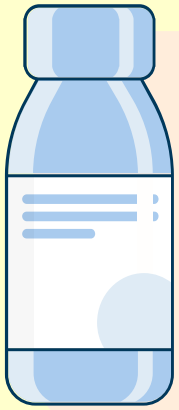


Prevagen®

Not confirmed by additional studies

Manufacturer Claims

The product contains a protein derived from jellyfish that “has been clinically proven to improve memory”

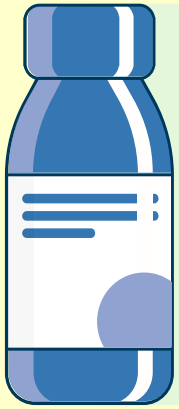


Manufacturer Results

Performed 30+ analyses of the data and came up with 3 results that were statistically significant

Federal Trade Commission

Found that Prevagen® is no more effective than placebo at improving any of the nine cognitive skills including memory



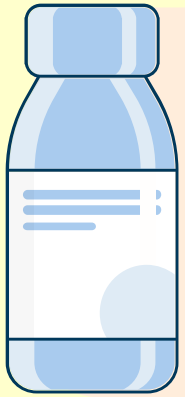
FTC Results

The results failed to show a statistically significant improvement in the treatment group

Homeopathic Remedies

What are They?

Made from a variety of sources such as plants, animals, and minerals

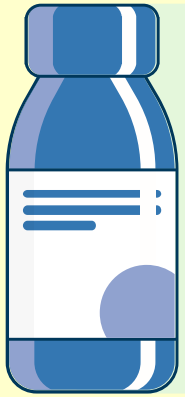


Evidence

Little to support their use as an effective treatment for any specific health condition

Controversial Use

Not possible to scientifically explain how a product can produce any effect if it contains little to no active ingredient



Ingredients

Some products may contain substantial amounts of active ingredients resulting in side effects or drug interactions

Statin Medications

Consider dose or therapy reduction of statin medications

Assess ASCVD risk, life expectancy, and likelihood for adverse effects Adverse effects such as **muscle pain** can affect quality of life

Little evidence regarding the benefit of statins for **primary prevention** in patients **> 75** years of age

The 2019 ACC/ AHA guidelines recommend **continued use** in the geriatric population for **secondary** prevention

10-year ASCVD event risk – valid only for **patients ages 20-79**

Difficult to identify highest risk patients and determine potential benefits

Non-Pharmacologic Recommendations to Reduce ASCVD Risk

Diet intake of vegetables, fruits, legumes, nuts, whole grains, and fish

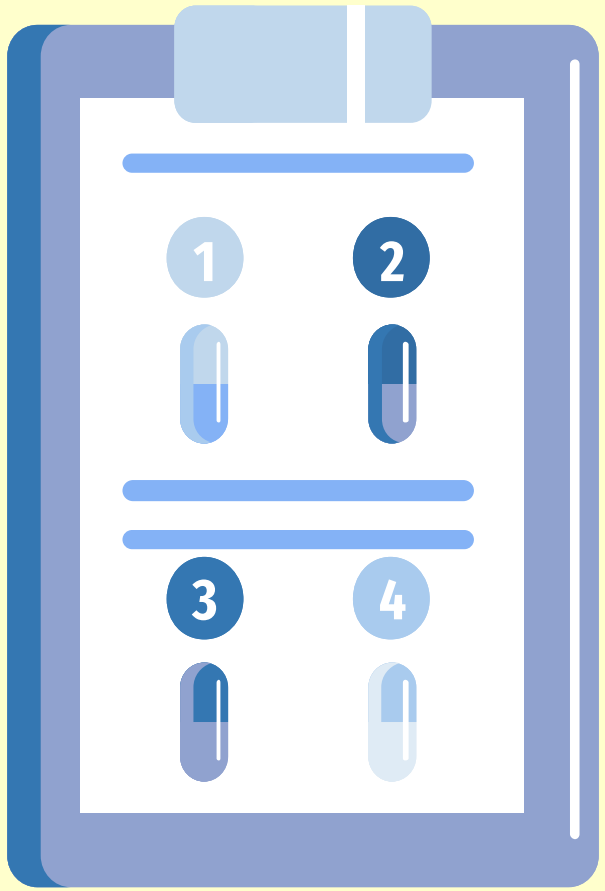
Replace saturated fat with dietary monounsaturated and polyunsaturated fat

Reduce amounts of cholesterol and sodium in diet

Minimize intake of processed meats, refined carbohydrates, and sweetened beverages

Avoid the intake of trans fats when possible

Proton Pump Inhibitors (PPIs)



Duration

- Should be used only when there is a specific clinical indication, and at the **lowest effective dose** for the **shortest** period of time

Risks With Long-Term Use

- Higher risk of fractures
- Risk of infections like *C.diff* and pneumonia
- Vitamin B12 deficiency

Alternatives

- Tums®
- Pepcid®
- Use as needed short-term

Non-Pharmacologic Approaches

- Avoid meals 2-3 hours before bedtime
- Elevate head of bed
- Avoid dietary triggers

Benzodiazepines

Recognized as potentially inappropriate medications in older patients due to their safety profile but continue to be commonly prescribed and infrequently discontinued

Side Effects:

- High risk of psychomotor impairment, falls, fractures, and cognitive impairment

Deprescribing:

- Slow taper to avoid withdrawal
- 25% every 2 weeks (~12.5% toward end)

Deprescribing NOT Recommended if:

- Used for severe anxiety or grief → must consult psychiatrist
- Used for acute alcohol withdrawal

Antimuscarinics

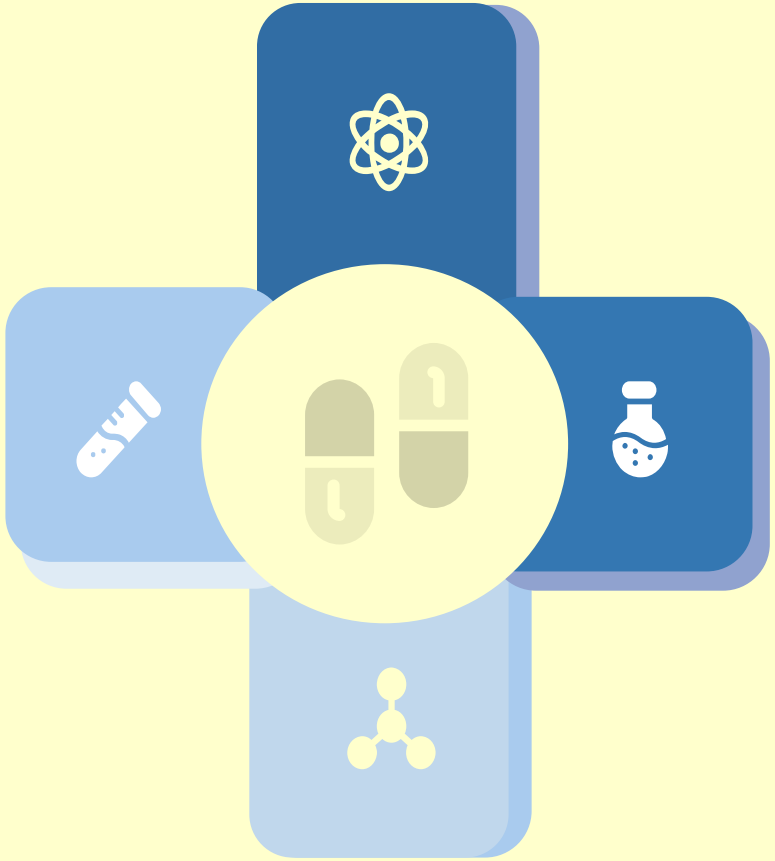
Indication

Routinely used in elderly patients for urinary incontinence

Risks

Anticholinergic side effects:

- Dry mouth
- Blurred vision
- Impaired cognitive performance
- Delirium



Non-Pharmacologic

First-line:

- Behavioral strategies (scheduled voiding)

Drug-Interactions

Many adverse drug-drug interactions

- Directly counteract effects of cholinesterase inhibitors → faster rates of functional decline

Aspirin (ASA)

1

Indication

Secondary prevention for reduction of **cardiovascular events**

2

Risks

Increased bleeding risk with **increasing age**

3

Statistics

50% increase in risk of hemorrhagic stroke and double extracranial bleeding

4

Guidelines

Current guidelines **DO NOT** recommend ASA in patients ≥70 years of age

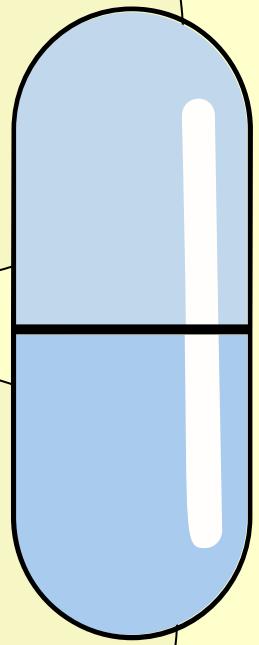
Antipsychotics

Indication

Commonly used to control behavioral and psychological symptoms of dementia (delusions, hallucinations, aggression)

Side Effects

Weight gain, dizziness, falls, cardiovascular adverse events, and death



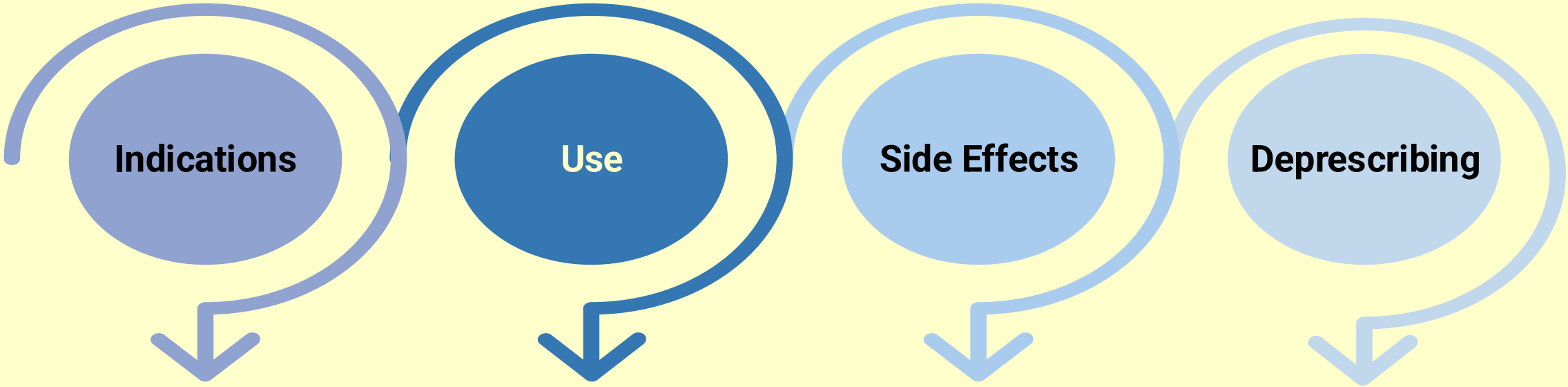
Deprescribing

Guidelines recommend re-evaluation every 3 months to determine the need to continue

Non-pharmacologic Interventions

Cognitive behavioral therapy & environmental interventions

Cholinesterase Inhibitors + Memantine



- **Only indicated** for mild to moderate Alzheimer's disease
- **Minimal benefit** in severe dementia

- Slows progression and provides symptomatic relief
- Very **modest** benefit for cognition and functional status

- Diarrhea, dizziness, confusion, headache, insomnia, agitation, weight loss, and **falls**

- **Stop if** significant decline while on treatment, severe/ end stage dementia, or ADEs
- **Taper** every 4 weeks

Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)

Duration

- Chronic use of all NSAIDS should be **avoided** due to risk of GI bleed
- All NSAIDS should be avoided in patients with stage IV and V chronic kidney disease (CrCl <30mL/min)

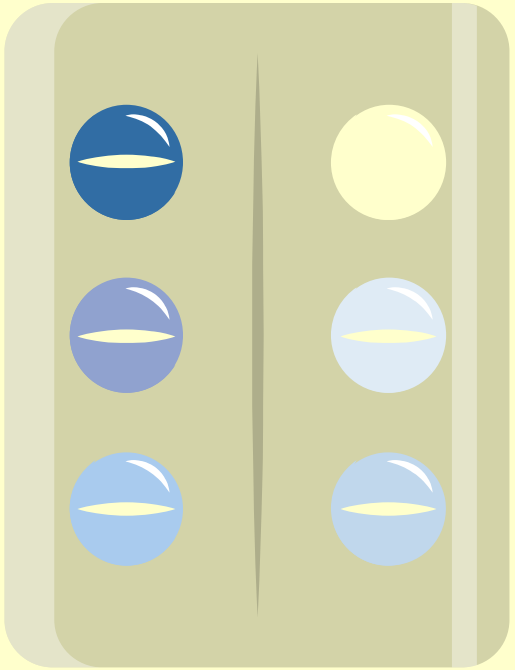
Alternatives

- Acetaminophen (**first-line** agent for mild to moderate chronic pain in the elderly)
- Topical NSAIDs

Risks With Long-Term Use

- Gastrointestinal bleeding
- Nephrotoxicity (damage to kidneys)

Antihyperglycemics in T2DM



Aim
For relaxed, individualized glycemic goals rather than tight control

Prioritize
Avoidance of hypoglycemia and symptomatic hyperglycemia

Stop
Secretagogues- sulfonylureas, meglitinides

Simplify
Insulin regimens- stop sliding scales, reduce basal insulin

Continue
Metformin if eGFR > 30 mL/min

Hold
SGLT2 for poor intake or volume depletion risk

Tools to Assist Providers with Deprescribing

AGS Beers Criteria (American Geriatrics Society) — 2023 update
What: Authoritative list of potentially inappropriate medications (PIMs) for adults ≥65, with cautions, drug–disease interactions, and dose adjustments.
How to use in LTCF: Run medication reviews against Beers lists to flag high-risk meds (e.g., anticholinergics, long-acting benzodiazepines, certain antipsychotics). Use as an initial screen during quarterly or admission med reviews.

Tools to Assist Providers with Deprescribing

STOPP/START criteria (Screening Tool of Older Persons' Prescriptions / Screening Tool to Alert to Right Treatment)
What: Explicit criteria to identify potentially inappropriate prescriptions (STOPP) and potential prescribing omissions (START). Updates provide condition-specific rules.
How to use in LTCF: Use during comprehensive med reviews to both stop harmful meds and identify necessary but missing therapies — helpful when multiple comorbidities make deprescribing nuanced. Consider embedding STOPP/START checks into pharmacist medication review workflows.

Tools to Assist Providers with Deprescribing

Deprescribing.org (Canadian group) — evidence-based deprescribing guidelines & algorithms
What: Practical, class-specific deprescribing algorithms (e.g., benzodiazepines, antipsychotics, proton pump inhibitors, statins for frail older adults), patient pamphlets, decision aids.
How to use in LTCF: Use the stepwise algorithms at the bedside to guide tapering plans, counseling scripts, and to create resident-specific deprescribing care plans. Excellent for pharmacist-physician shared decision making.

What Nursing Staff Can Do to Reduce Polypharmacy & Support Deprescribing

Help recognize, support, and safely monitor medication reduction to improve resident safety and quality of life.

1. Identify Residents at High Risk

Flag and report residents with:

- New **confusion, sedation, dizziness**
- **Falls or near-falls**
- New or worsening **constipation, urinary retention**
- **Poor appetite, weight loss**
- **Functional decline**
- Daytime sleepiness or nighttime agitation
- Residents on:
  - Antipsychotics
  - Benzodiazepines
  - Opioids
  - Anticholinergics
  - PPIs > 8 weeks
  - ≥5–10 total meds

2. Provide Critical Monitoring During Tapers

- **Antipsychotics** → watch for agitation, hallucinations
- **Benzodiazepines** → watch for anxiety, tremor, insomnia
- **Opioids** → watch for pain escalation, withdrawal
- **Antihypertensives** → watch BP, dizziness, falls
- **Diabetes meds** → watch BG and hypoglycemia

3. Communicate Changes

- Immediately report:
  - New behaviors
  - Change in sleep or appetite
  - Pain increase
  - Vitals outside normal range
- Clearly document:
  - Date/time of change
  - Which medication was adjusted
  - Objective vs subjective findings
  - Resident or family concerns
- Use this safety phrase when appropriate: *"Change possibly related to recent medication reduction of _____ on (date)."*

4. Support and Document Non-Drug Alternatives

- **Sleep hygiene** instead of sedatives:
  - Lights down at night
  - Reduce nighttime vitals unless needed
  - Warm drinks, calming routines
- **Pain non-drug measures:**
  - Repositioning
  - Heat/ice
  - Gentle ROM or massage
- **Behavioral supports instead of antipsychotics:**
  - Music therapy
  - Structured daytime activity
  - Consistent caregivers when possible
- **Constipation prevention instead of laxative stacking:**
  - Fluids, fiber, mobility

5. Educate & Reassure Residents and Families

Fear of stopping medications is common.

Nursing can reinforce messages like:

"We're reducing medicines to lower fall and confusion risk."

*"This is a **trial**, and the provider will restart if needed."*

"We are watching closely for any problems."

6. Prevent Automatic Re-Starting of Stopped Meds

Ensure discontinued meds are:

- Removed from MAR
- Removed from emergency kits
- Clarified during transitions of care

If a stopped med is reordered, verify:

"This was intentionally discontinued — confirm restart."

7. Support Admission & Transition Reconciliation

- Identify:
  - PRN meds never used
  - Duplicate drug classes
  - Old hospital-only meds
- Ask: *“Is this still needed here?”*
- Include: *“Candidate for deprescribing?”* as part of (re)admission med review.

8. Participate in Interdisciplinary Deprescribing Rounds

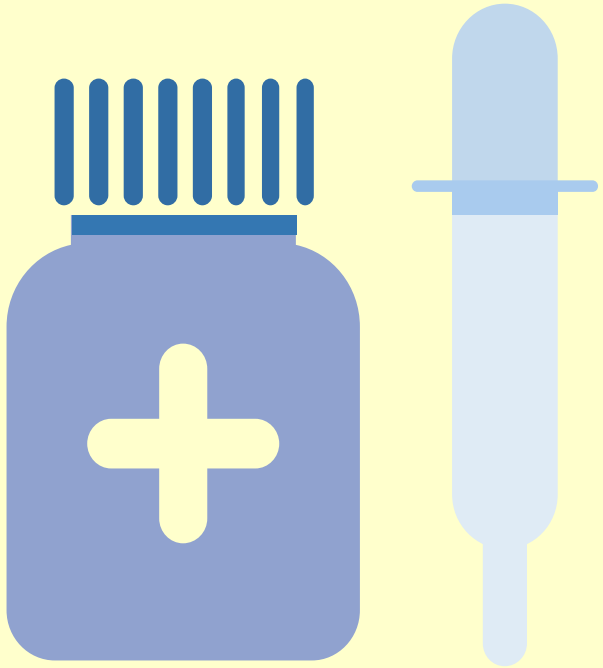
Nursing input is essential during pharmacist/provider reviews. Nurses contribute:

- Behavior patterns by shift
- Actual PRN usage vs MAR orders
- Functional changes
- Sleep and appetite trends
- Family concerns

Assign one nurse per unit to attend quarterly med review or antipsychotic review meetings.

Remember:

Deprescribing is a safety process — not just stopping medications. Nursing monitoring makes it successful.



The Value of a Pharmacist in Deprescribing

Pharmacists bring:

- Expertise in **geriatric pharmacology**
- Knowledge of **drug interactions, renal dosing, and anticholinergic burden**

Proven benefits of pharmacist involvement:

- ↓ Total medication burden
- ↓ Potentially inappropriate medications (Beers Criteria)
- ↓ Falls, hypoglycemia, and adverse drug events
- ↓ Hospital transfers
- ↓ Medication costs

Supports **CMS compliance**:

- F-758 Unnecessary Medications
- F-757 Psychotropic Use
- F-760 Drug Regimen Review

Improves:

- Survey readiness
- Provider efficiency
- Resident alertness & participation in therapy
- Family satisfaction

Pharmacist-led deprescribing = **safer care, better outcomes, and lower cost**

A week's worth of medication for a 92-year old patient, before and after deprescribing.

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Thank You