

# Pharmacy NewsCapsule

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## Inappropriate Use of Hand Sanitizer By Doug Englebert, R.Ph.

Over the last couple of years there have been ongoing discussions of the appropriate placement of hand sanitizer containers in the health care environment, and how and when they can be used. Now there are actual reports of an additional issue--ingestion of alcohol hand sanitizers. This may sound like an unusual occurrence, but it has happened and can be dangerous if it results in alcohol poisoning.

Hand sanitizer can contain significant amounts of alcohol. For example, some contain upwards of 62% ethanol, or more, by volume. In comparison, liquors like vodka are usually 50% alcohol by volume. As a result, there have been reports of individuals with alcohol addictions drinking hand sanitizers as a substitute for an alcoholic drink. This is similar to reports of individuals with alcohol dependency ingesting mouth washes and other products with high alcohol contents.

The concern with the ingestion of hand sanitizers is that it can quickly turn into a case of alcohol poisoning. In some unfortunate situations, when hand sanitizers contain isopropyl alcohol, ingestion of just 200 ml can be fatal; because it depresses the central nervous system and the heart. Even more significant is that ingestion of small volumes of 1-2 ounces of the sanitizer can be lethal to children.

Fortunately, most hand sanitizers have an unpleasant taste, so ingestion should not be commonplace. However, the large number of hand sanitizers in various health care environments, combined with the conditions of some individual residents or patients, may lead to ingestion of this product. Individuals at risk may include people with alcohol abuse or dependence, or those with certain types of mental illness who may have ingested inappropriate items in the past. Health care facilities or programs that work with individuals with these characteristics must consider the use of hand-sanitizer safety measures.

Please keep in mind that hand sanitizers play a very important role in preventing the spread of infection, and patient/resident safety needs to be balanced against the need for infection control measures.



## New Drugs

Brand Name	Generic Name	Use
Alli	orlistat	Over-the-counter formulation of Xenical for weight loss
Amrix	cyclobenzaprine	New extended-release, once-daily muscle relaxant.
Flector	diclofenac	NSAID patch for acute pain due to strains, sprains, and contusions.
FluMist	influenza vaccine, live	New REFRIGERATED formulation. To be available for the 2007-2008 influenza season.
Lialda	mesalamine	New once-daily oral tablets for ulcerative colitis.

## Insulin Update By Doug Englebert, R.Ph.

The last few years have seen the introduction of a flurry of new products to the insulin environment. In addition to enhanced traditional insulin, there are now “add on” products that must be considered. The introduction of these new products has raised questions related to standards of practice for storage, preparation, administration, and monitoring. A resource table has been created summarizing some of the common questions and providing useful information for State survey staff and health care providers. The table is attached to this newsletter and will also be available on an OQA web site. The web site link will be provided to you in a future publication.

Some unusual questions have been posed concerning the dropping of a vial of insulin, putting insulin into the pneumatic tube system for delivery, or mixing uncommon combinations. In these cases, answers can often be inferred from the information in the resource table. For example, when preparing insulin for administration, the insulin vial should not be shaken; but instead, the vial should be rolled. The reason for rolling rather than shaking is that shaking can destroy the insulin, often causing bubbling or foaming of the insulin. Incidents like dropping the vial or sending the insulin through the pneumatic tube system can have the effect of shaking and should, therefore, be avoided. If a surveyor observes a vial being dropped; the expectation will be that facility staff should inspect the vial to assure it has not cracked or broken, and that the insulin has not been shaken to the point where the insulin may have been destroyed.

In situations where insulin is being mixed in unusual combinations in the same syringe, caregivers should take special precautions. Facility staff who have to mix different types of insulin should have information to confirm the propriety of the mixture. An order for an “unusual mixture” is often an indication to check the medication order. For example, a mixture of two rapid-acting insulins would appear to be an inappropriate clinical practice, and a thorough check of the order may indicate that it was actually for a medium-acting and rapid-acting insulin. This type of error can easily occur, because insulins tend to have similar sounding names and spelling. For example, Humalog, Humulin N, and Humulin R all look and sound alike and could cause confusion, which can lead to mixture errors.

# Nursing Home Guidance Update

By Doug Englebert, R.Ph.

## Gradual Dose Reduction or Tapering Scenarios

Following are scenarios that provide some general guidance for medication dose reduction or tapering, based on the new Centers for Medicare and Medicaid Services (CMS) guidance that went into effect on December 18, 2006. The scenarios listed below are only examples of what may occur and are intended to provide guidance for the investigation of, and compliance with, F329—Unnecessary Drugs. Real situations involving individual residents identified during survey may have different characteristics and complexities that can affect compliance with F329.

### Scenario One

The nursing home resident has **behaviors of dementia** and has been on the same dose of risperidone for eight months. What are the requirements for a dose reduction? The requirements for dose reduction for this resident include two attempts in the first year, performed over two separate quarters, with at least a month between attempts. This resident will need to have the **first** attempted dose reduction in month eight or nine in order to meet the quarterly requirement. After the first attempted dose reduction, the second dosage reduction must be attempted in the last quarter of the year, with at least a one month separation from the first attempt. The second attempted dose reduction **can** be avoided if there is clinical contraindication. Failure of the first dosage reduction, along with a clinical rationale provided by the physician, constitute evidence of clinical contraindication.

### Scenario Two

The resident has **schizophrenia** and has been on the same dose of risperidone for eight months. What are the requirements for dose reduction? The requirements for dose reduction in this resident include two attempts in the first year, performed in two separate quarters, with at least a month between attempts. This resident's first dosage reduction will need to occur in month eight or nine in order to meet the quarterly requirement. However, this first dosage reduction **can** be avoided by providing a clinical rationale, along with support from clinical standards of practice justifying why the dosage reduction would not be in the resident's best interest.

### Scenario Three

The male resident has been taking citalopram for eight months. He has Alzheimer's and the citalopram was started for **behavior symptoms that were thought to be a result of depression**. The resident had no previous history of depression. What are the requirements for dose reduction? The requirements for dose reduction in this resident include two attempts in the first year, performed in two separate quarters, with at least a month between attempts. However, the first dosage reduction can be avoided by providing a clinical rationale, along with support from clinical standards of practice justifying why the dosage reduction would not be in the resident's best interest. Since this resident has no previous history of depression or confirmed depression, there is no clinical standard of practice to support continued use of citalopram. Therefore, the first attempted dose reduction will need to occur in month eight or nine in order to meet the quarterly requirement. The second dosage reduction must be attempted in the last quarter of the year. The second attempted dose reduction **can** be avoided if there is clinical contraindication. Failure of the first dosage reduction, along with a clinical rationale provided by the physician, constitutes evidence of clinical contraindication.

## Consultant Corner By Doug Englebert, R.Ph.

### 1) **In a nursing home, hospital, or assisted living facility is it permitted for staff to “borrow” medications from one patient/resident to give to another patient/resident?**

“Borrowing,” in this scenario, is defined as follows: Resident A has been prescribed, is dispensed, and is taking the medication omeprazole 20 mg each day for 15 days. It is a Saturday and Resident B has a new medication order to start omeprazole 20 mg each day. The staff in the facility wants to start the medication immediately and do not want to wait for the pharmacy to dispense it, so they “borrow” the medication from Resident A to use for Resident B. When Resident B’s medications then comes from the pharmacy, Resident A’s medication supply is repaid from Resident B’s medication supply.

Regulations do not address this specific scenario. However, there may be general regulations that can be applied, such as medication packaging or labeling requirements, medication transfer requirements, or, in some cases, regulations may simply indicate that staff need to follow standards of practice. In addition to facility regulations, there may be other state and federal regulations that must be followed. For example, if the medication being “borrowed” is a controlled substance, the person implementing the “borrowing” may be violating federal Drug Enforcement Administration regulations concerning controlled substances. One last set of regulations that apply include Medicare or Medicaid reimbursement policies, which may consider this “borrowing” a fraudulent activity based on the circumstances.

Regulations aside, let's look at this scenario of “borrowing.” When a medication is borrowed the medication may not go through the facility medication systems to assure medication allergies, interactions, dose, etc., are checked. In addition, when medications are returned to the supply of the person from which it was borrowed, medication may be placed back into inappropriate packaging that could create additional problems. An example would be if the medications was placed back into the bubble packaging and taped back up. The question of possible tampering may arise when other staff administers the medication at a later time.

One last consideration related to borrowing is the reason for doing it. Often staff borrows medication to make it easier for them to meet their own needs rather than to meet resident or patient needs. The resident’s or patient’s condition or needs may not require the medication to be borrowed for immediate administration. If there are immediate resident/patient needs that are creating a borrowing situation, then the facility needs to look at their contingency supply, 24-hour pharmacy coverage, etc. These system elements/practices should obviate the need for “borrowing.”

In summary, borrowing medications from other patients or residents often results in the violation of regulations or facility policies. Borrowing is a practice that can create safety concerns and put individuals at risk. Therefore, providers should not engage in this practice and should monitor staff to ensure that they do not engage in this activity. If it is determined that staff members in a health care facility are borrowing medications, facility management needs to examine why it is occurring. If there are situations where resident/patient needs are not being met, then facility systems should be revised to eliminate medication borrowing. If a surveyor determines borrowing has occurred, they should investigate the facility’s quality assurance, pharmacy services and standards of practice.