

PHARMACY NEWSCAPSULE

Wisconsin Department of Health Services
Division of Quality Assurance
July-August 2008

Contents in this Issue:

Home Meds

[Medication Monitoring by Lab](#)

[New Drugs](#)

[UTI and Antibiotics](#)

[Consultant Corner](#)

Home Meds By Doug Englebert, R.Ph.

“Home medication” is a phrase with at least two very different meanings or contexts.

One scenario can occur in facilities when patients or residents (who reside in or receive services for an extended period of time) need to leave the facility for some purpose. These leaves may be short---as for lunch or dinner---or for as long as a day or a week. In these situations, facilities often ask how the provision of medications should be handled so that a patient or resident can have medication available during their leave. Some questions that may arise are:

- When a resident/patient is going on pass to home, what is the proper procedure for packing home meds?
- Is this a function a nurse can perform?
- Is the length of the pass relevant?
- Is it a pharmacist function only?”

In general, the preferred method of handling leave medications is to have the pharmacy package the needed supply for the leave. However, from a practical standpoint, because of such things as timing, insurance, other payment issues, and location, this is not always possible. The next best solution is to send the entire supply of pharmacy medications with the patient/resident. In most cases, the medications are appropriately labeled and packaged. This can be a problem if there is a concern about the return of unused medications to the facility after the leave is finished.

In some cases, facility regulations limit who can transfer medications to other types of packaging. For example, in a nursing home medication packaging transfers can only be done by a pharmacist or physician. Therefore, if the resident is going on a leave from the nursing home that extends beyond a single med pass, the facility is required to send the entire supply of medications, have a pharmacist package a leave supply, or have a physician package or delegate the packaging of a leave supply.

For those facilities that have medication transfer restrictions, those regulations need to be adhered to or a waiver must be requested. In some cases, the Division of Quality Assurance has provided guidance on options to repackage medication. For example, please see http://dhs.wisconsin.gov/rl_DSL/Publications/pdfmemos/04-006.pdf

The second connotation of the phrase “home meds” involves a situation in which a resident or patient is admitted with a supply of medication from home that they wish to use or finish in the facility. A common question is “can a facility use medications brought in from home by the resident or patient at the time of admission?”

Occasionally, patients or residents will come to a hospital or nursing home with their own medications that they wish to continue taking or finish using. Facilities often ask if this can be allowed. In most situations the medications can be used. When a facility administers such medications, the facility will have a process and procedure in place to address this situation. For example, when a facility wants to make sure that medications brought in are the correct products, the facility will have a procedure to assure identification. This may mean that a facility only allows the use of medication that comes from home if it is in its original packaging or if it has been identified and verified by a pharmacist.

In general, medications from home can be used when the resident or patient is self administering the medication. In these cases, it may still be necessary to identify the medications and establish processes for self administration that address such issues as storage and documentation.

Medication Monitoring by Lab By Doug Englebort, R.Ph.

Digoxin, phenytoin, theophylline, and other medications are often monitored by “drawing a blood level.” That means that blood is taken from the resident or patient and tested. The result of the test indicates how much medication is in the blood. A number of studies have helped establish blood level references that help clinicians know if a drug is at a level that has been shown to be effective, ineffective, or a cause of side effects.

In our role as surveyors, we determine whether or not a facility is protecting patients or residents with adequate monitoring. The question we ask is: “How often do these blood levels need to be drawn?” In many cases, there may not be a standard of practice. Instead, the need for levels will be patient-or resident-specific and based on responses or changes in condition.

That being said, there are some general guidelines that can be considered. For example, when medication changes are made, or when a medication interaction has a potential to occur, levels may be checked. Often when someone initially starts on a medication, a lab may be drawn frequently to determine if the drug has reached a therapeutic level. Once an individual is stable, some facilities will create policies to conduct levels every six months or annually. In some cases, physicians may also have their own standards for monitoring drug levels. In general, there are very few instances of existing standards that dictate when drug levels should be measured. However, in individual situations, surveyors should expect to see a plan for drug lab monitoring. In some cases, drug levels may not be taken for extended periods and regular drug level testing is replaced by monitoring for symptoms of toxicity. When symptoms of toxicity occur, the facility

will then draw drug levels. Monitoring for symptoms of toxicity is often more effective than monitoring for arbitrary, routine drug levels.

.....

New Medications

Brand Name	Generic Name	Use
Durezol	Difluprednate	Corticosteroid for inflammation in the eye.
Entereg	Alvimopan	Opioid antagonist to prevent post op ileus after bowel resection surgery.
Actonel	Risedronate	A new 150 mg tablet to be used once a week.
Aplenzin	Bupropion hydrobromide	New formulation for treating depression.

UTI and Antibiotic: Is the antibiotic unnecessary? By Doug Englebert, R.Ph.

Antibiotics are routinely and appropriately used for urinary tract infections. The thing that needs to be determined is whether a patient or resident actually has a urinary tract infection. Often times the elderly have chronic bacteriuria. The research-based literature suggests treating only symptomatic UTIs with antibiotics. If antibiotics are used when the definition of a symptomatic urinary tract infection is not met, then the use of the antibiotic should be questioned.

What are the criteria for a urinary tract infection? Symptomatic UTIs are based on the following criteria:

People **without** a catheter should have at least three of the following signs and symptoms:

- Fever [increase in temperature of >2 degrees F (1.1 degrees C) or rectal temperature >99.5 degrees F (37.5 degrees C) or single measurement of temperature >100 degrees F (37.8 degrees C)];¹⁴
- New or increased burning pain on urination, frequency, or urgency;
- New flank or suprapubic pain or tenderness;
- Change in character of urine, e.g., new bloody urine, foul smell, or amount of sediment, or as reported by the laboratory (new pyuria or microscopic hematuria); and/or
- Worsening of mental or functional status, e.g., confusion, decreased appetite, unexplained falls, incontinence of recent onset, lethargy, decreased activity.

People **with** a catheter should have at least two of the following signs and symptoms:

- Fever or chills;
- New flank pain or suprapubic pain or tenderness;
- Change in character of urine, e.g., new bloody urine, foul smell, or amount of sediment, or as reported by the laboratory (new pyuria or microscopic hematuria); and/or
- Worsening of mental or functional status. Local findings such as obstruction, leakage, or mucosal trauma (hematuria) may also be present.

Consultant Corner By Doug Englebert, R.Ph.

1) How should nursing home surveyors view nurses leaving the room while the nebulizer is running?

If the nurse or respiratory therapist leaves the room during a nebulizer treatment, then we consider this self administration. That means the facility must do an assessment to determine if the resident can keep the mask, hold the handheld device, etc. If the facility has not done this, then we may cite F179 for self administration. We do not count the nurse leaving the room as a medication error for med pass purposes.

2) Does the facility have to do routine blood pressures for people taking atypical antipsychotics like zyprexa?

Atypical antipsychotics, like other medications, can cause the side effect of orthostasis. Therefore, when the medication is started or changed, blood pressures may be done for a period of time. In some cases, orthostasis may not be of concern, because the person is not ambulatory or because of some other reason. If you do not see blood pressures being done, you should interview nursing staff, the physician, and the consultant pharmacist to determine the reason for this omission.

3) Does the diagnosis for each medication need to be listed on the medication administration record (MAR)?

There is currently no regulation for any facility type that requires a diagnosis to be listed on the MAR for each medication. That being said, many medication errors and adverse events can be avoided when staff clearly understands what the indication is for a medication.

4) A facility indicated there was a drug shortage of fluphenazine. What should we expect facilities to do about these shortages?

Drug shortages occur for many reasons---manufacturers stop making drugs, the FDA shuts down a plant, raw materials become unavailable, etc. Facilities may monitor shortages by using the following website as one resource
http://www.ashp.org/s_ashp/bulletin.asp?id=402&CID=1500&DID=1544&sort=0

As facilities or programs become aware that shortages are occurring, they may need to make arrangement for alternative supplies, or in some cases, alternative medications. Hospitals often , communicate to the physicians through physician committees that a shortage is occurring and any alternatives that can be used. This process can work well in a large multidisciplinary facility. In other, smaller facilities there may be a need to work closely with their pharmacy to proactively observe shortages, develop a plan, and communicate that plan to meet the needs of residents and patients.