

# PHARMACY NEWSCAPSULE

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Wisconsin Department of Health Services  
Division of Quality Assurance  
**Sept-Oct 2008**

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## **GDR/Tapering Review**    By Doug Englebert, R.Ph.

Let's look at two scenarios that have previously been discussed in this newsletter.

### **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 in 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 quarter requirement. After the first attempted dose reduction, the second dosage reduction must be attempted in the last quarter of the year with at least the month separation from the last attempt. The second attempted dose reduction *can* be avoided via clinical contraindication. Clinical contraindication can be evidence of the first failed dosage reduction and clinical rationale provided by the physician.

In scenario one, we will make a small change and indicate that the resident with dementia had symptoms of psychosis including harmful hallucinations. The antipsychotic medication in this case was for the psychosis and, now, the resident has been on a stable dose for nine months. Would a dose reduction be required? It may be required and it may not. For example, if the antipsychotic medication worked, was not causing side effects, and the physician rationale was that the resident experienced psychosis related to a medication side effect, then at nine months it is likely that the side effect may no longer be present and an attempted dose reduction may be appropriate. However, if the rationale is that the psychosis was related to underlying major depression, holding off on a dose reduction of the antipsychotic may be appropriate at nine months. In summary, for new onset mental illness in a resident with dementia, continuing the

medication may sometimes make sense. In other cases, continuing the medication is not appropriate.

### Scenario Two

The resident has **schizophrenia** and has been on the same dose of risperidone for 8 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 happen in month eight or nine in order to meet the quarter requirement. However, this first dosage reduction **can** be avoided by providing clinical rationale along with support of clinical standards of practice **as to why** the dosage reduction would not be in the resident's best interest.

Now, change scenario two to someone with bipolar disorder who is stable on a dose of 4 mg of risperdal. The person is responding to the risperdal and is tolerating side effects. In this case, the physician may decide that the risperdal at 4 mg will be used for the maintenance dose, which will be continued for longer than the 9-12 months when the survey guidance would direct a surveyor to ask questions about a dose reduction. In this case, if a facility can show (1) that the risperdal has been effective, (2) that the resident has tolerated side effects, and (3) that the physician indicates that they plan to continue with the current maintenance dose until the next exacerbation of mania, then these reasons can be acceptable clinical contraindication to a dose reduction.

These scenarios represent individuals who have mental illness. Each resident and each mental illness is unique. For many residents and for various types of mental illness, treatment with an antipsychotic drug may need to continue at current stable doses beyond the 9-12 month interval for a dose reduction. If facilities have evidence showing (1) that the medication is working, (2) that side effects are being monitored and tolerated, and (3) that the physician has provided rationale and support including acceptable standards of practice for longer term treatment for the mental illness, then a dose reduction would be clinically contraindicated (not required).

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## New Medications

Brand Name	Generic Name	Use
Cleviprex	Clevidipine	Injectable medication for hypertension.
Nplate	Romiplostim	For idiopathic thrombocytopenic purpura.
Xenazine	Tetrabenazine	Medication for treating involuntary movement of Huntington's disease.
Prandimet	Metformin/repaglinide	Combination medication for treating type two diabetes.

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

The last issue of this newsletter shared the guidance available in the State Operations Manual defining symptomatic and asymptomatic urinary tract infections. There is other guidance that also addresses UTI treatment that you should know about.

All standards are consistent in indicating that asymptomatic bacteruria should not be treated with antibiotics. On an individual basis, however, there are different considerations for defining a symptomatic urinary tract infection. For example, some individuals may be immunocompromised and a UTI is more critical to these individuals.

In general, providers should be creating procedures to assess residents with potential urinary tract infections. Those procedures should include the information that will be provided to physicians when staff calls to consult with the physician about a resident's change in condition.

As a surveyor, if you see antibiotics being used for apparent asymptomatic urinary tract infections, you should be asking questions about the facility's procedures for assessing potential UTIs. In addition to the State Operations Manual, some of the standards that providers may be using to create policies are included in the table that can be accessed at [http://dhs.wisconsin.gov/rl\\_DSL/Publications/utiResChart.pdf](http://dhs.wisconsin.gov/rl_DSL/Publications/utiResChart.pdf)

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

### **1) In an assisted living facility, should the facility contact the doctors and the family about drug alerts and drugs with Black Box Warning?**

In assisted living, as at home, the decision to use prescription medication starts with the physician. When a physician diagnoses an issue and decides to use a drug, he/she has a responsibility to discuss the risks and benefits of that medication with the resident. The pharmacist expands on that discussion by reinforcing the potential for risks of the medication. In addition, the pharmacist provides information regarding proper use, when to contact the physician, etc. This information helps facilities, families, and residents to be aware of the signs and symptoms of problems. The facility, resident, and other members of the care team also have a responsibility to monitor and inform the physician, pharmacist, and appropriate others that the resident may be experiencing side effects or other problems.

As a surveyor, we should be investigating to ensure that the facility is monitoring the drug for effectiveness and communicating issues when the drug does not work or is causing problems. If you are interested in a listing of medications with a black box warning, please see <http://formularyproductions.com/blackbox/>.

### **2) Is a dose reduction required for residents with a diagnosis of diabetic neuropathy and behaviors of dementia who are being treated with only one medication like Cymbalta®?**

For any medication being used for two diagnosed issues (i.e., dementia behaviors and neuropathic pain from diabetes), a dose reduction can be avoided. If the drug works and the person is tolerating any side effects, acceptable justification for skipping a dose reduction could include: the medication is for chronic neuropathic pain and is effective.

3) **Can a physical therapist administer medications as part of iontophoresis? Can the physical therapist delegate the medication administration to a physical therapist aide? What are some of the medication handling issues for iontophoresis?**

Yes, physical therapists---within their scope of training---can administer medications in those procedures in which they have been specifically trained. In addition, the physical therapist can delegate the act of performing iontophoresis and medication administration. However, the physical therapist cannot delegate the assessment process that determines whether or not the patient should receive iontophoresis.

Iontophoresis is transdermal administration of a medication using electricity. In essence, the drug is applied to the skin and then is forced into the skin via electricity. Instructions for application include application to undamaged skin. The skin is to be cleaned, usually, with alcohol. Typically, a drug is added to the electrode pad (e.g., dexamethasone, acetic acid) and the pad applied near the area being treated. The two areas of concern that a surveyor should look at are infection control and medication management.

**Infection Control:** There must be an infection control policy/procedure and you must observe adherence to that procedure. For iontophoresis, that includes hand washing and equipment cleaning. The electrode pads should be used for only one patient or should be sterilized between patients. The American Physical Therapy Association has specific recommendations addressing MRSA and points to the CDC guidelines.

[http://www.apta.org/AM/Template.cfm?Section=Info\\_for\\_Clinicians&CONTENTID=43719&TEMP LATE=/CM/ContentDisplay.cfm](http://www.apta.org/AM/Template.cfm?Section=Info_for_Clinicians&CONTENTID=43719&TEMP LATE=/CM/ContentDisplay.cfm)

**Drug Management:** Typically, injectable medications in multidose vials are used. Sometimes this may be preservative-free medication, as preservatives may interfere with iontophoresis. Physical therapists usually draw up the drug in a nonsterile environment and, therefore, need to have a procedure to handle multidose vials. This would include a procedure to document a medication disposal date and, since the product used in iontophoresis is for topical use, the vial used for that procedure should be labeled or stored in a manner that alerts staff that the dexamethasone remaining in the vial should be used for iontophoresis only---*not* for injection.

Pharmacy standards of practice indicate that multidose vials with preservatives expire within 28 days unless the manufacturer or other data supports some other time frame. If the drug is diluted and placed in non sterile water, etc., that product is no longer considered sterile at 24 hours. If the physical therapist is mixing up solution to store over a period of days, they must have information to indicate that the medication is stable for the time frame they are using.

4) **What is going on with heparin errors?**

Over the last couple years there have been some well publicized medication events involving heparin and infants. These events have typically involved infants receiving high doses of heparin. There are many reasons why this has occurred. Those reasons include inconsistent standards related to dosing in the infant population, heparin labeling, medication storage problems, and medication mixing problems. Some of these problems are potentially exacerbated by shortages of heparin that have occurred due to contaminated product. These shortages may be creating a situation where different concentrations and strengths of heparin are newly available to staff, resulting in mixing errors. The Institute of Safe Medication Practices has developed some resources that facilities can use to begin looking at heparin and other anticoagulants in their facility, to assess their practices, and to address safety concerns. (<http://www.ismp.org>)