PHARMACY NEWSCAPSULE

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IN THIS ISSUE

App for That! 1
Nursing Home GDR.....1
Medication Repackage.....2
Medication Error.....4

App For That!

Every issue we feature an app that you may find useful. Send us your favorite apps that you use for your work and personal lives We will highlight these apps in the newsletter so that we can all learn from each other.

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Nursing Home Gradual Dose Reductions

by Doug Englebert, R.Ph.

The following is a scenario that provides some general guidance for medication dose reduction or tapering, based on the Centers for Medicare and Medicaid Services (CMS) guidance. The scenarios listed below are only examples of what may occur and are intended to provide guidance for the investigation of and compliance with F758 - Unnecessary Drugs. Real situations involving individual residents identified during survey may have different characteristics and complexities that can affect compliance with F758.

Scenario: A 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 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, constitutes evidence of clinical contraindication.

The key components in this example:

- Antipsychotic treating behaviors of dementia.
- Has been on same continuous dose for nine months or longer.

Clinical Contraindication key components:

- Evidence that the first reduction failed. Often, if a resident has been on the antipsychotic medication, they may experience some withdrawal symptoms. A true failure is if the resident's harmful, persistent, clearly documented behavior returns. Other symptoms of withdrawal do not count as a dose reduction failure.
- Clinical rationale: First and foremost, rationale shows the drug has worked where persistent harmful behavior is no longer occurring. Second, rationale shows the underlying causes of the persistent harmful behavior are likely still present, such as underlying stage of dementia has not changed.

Gradual dose reduction requirements for antipsychotics in dementia really present a bare minimum and extended period for review. Clinically, if a resident is started on an antipsychotic medication within a facility, within four to eight weeks there should be an evaluation of effectiveness to determine if medication is still needed. For residents admitted to a facility already on an antipsychotic, this scenario needs immediate evaluation within 14 days to truly determine the reason for the medication and what should be monitored. If no reason can be identified the medication should consider a dose reduction immediately.

Adult Family Home-Medication Packaging

Q: Can an adult family home accept medications packaged by the managed care nurse? This example is specific to lorazepam oral liquid. The pharmacy indicated they could only dispense the medication in the original multidose bottle with the calibrated dropper. The managed care nurse and the physician assistant did not want the resident to have more than 5 doses available in the adult family home, so the managed care nurse picked up the pharmacy bottle and repackaged the oral liquid in syringes. The syringes were placed in a bag and a label placed on the bag. Can the adult family home use these?

A: Adult family home rules are very specific that prescription medications must remain in the packaging provided by the pharmacy.

Wis. Admin. Code § DHS 88.07(3) Prescription medications.

(a) Every prescription medication shall be securely stored, shall remain in its original container as received from the pharmacy and be stored as specified by the pharmacist.

For these reasons the adult family home would not be able to accept the medications.

Regardless of the regulations this practice is concerning. The medication guidelines for oral liquid lorazepam requires the medication to be dispensed in the original manufacturer container with the calibrated dropper. Once that medication is open the product is good for 90 days. The nurse when repackaging the medication did not follow these manufacturer guidelines. Therefore, it is unknown how long the lorazepam is good for and if it would cause any problems.

In some cases, medications may be able to be repackaged based on studies and manufacturer guidance that may not be present in the package insert labeling. Pharmacists when repackaging medication rely on these studies and other references when deciding to repackage medication and what beyond use date (expiration date) they may assign to the medication.

Another issue with the practice used by the nurse in this instance is the choice of syringe used. Was this an oral syringe? Was it plastic or glass? Some medications have compatibility issues with plastic or glass, so the choice of the syringe is important. The choice of an oral syringe is also important. There have been cases when oral medication is placed in the wrong type of syringe and then the person administering meds placed a needle on the syringe and injected oral medication incorrectly.

Lastly, the practice the nurse used related to labeling is also troubling. Each oral syringe prepared should have an individual label on it. There are standards of practice for pharmacies that may include putting the name of the drug, strength, lot number, beyond use date on each syringe. In addition, a warning label like "for oral use only" may be placed on the syringe.

Bottom line is repackaging of medications carry a lot of responsibility and consideration that requires expertise in the area. If regulations allow repackaging and providers choose to repackage medications, providers should be consulting with experts to ensure the medications are provided in a safe manner.

A Medication Error Occurred…Now What?

This article is not intended to be an editorial but rather is a compilation of events, observations and considerations when dealing with medication errors.

The definition of a medication error can often be defined differently from facility to facility. Some facilities consider it a medication error if an error occurred in the system but was caught before it reached the resident or patient. Some facilities define medication errors as only those that reach the patient. Each facility type may have regulations or surveyor guidelines that define medication errors. For example, in nursing homes, in the medication pass task a medication error is defined as administration errors that reach the resident. For surveyors, there is some regulation that can be cited for actual medication errors that reach the patient.

What about medication errors that do not reach the patient? Facilities should be actively monitoring these types of errors through quality assurance (QA) processes. Part of the QA process should be to monitor national and local communications like sentinel reporting and medication error databases. Sentinel reports can be an outside source that a facility can use to identify a potential weakness within their own facility. When asking about facility QA programs, surveyors should look to see if part of that program is medication error prevention.

Another important consideration for surveyors is the facility's reaction to medication errors. Facility staff that does not take immediate action after determining a significant medication error runs the risk of receiving more severe citations. For example, a significant medication error occurs, and staff fail to call the physician for direction and/or the staff fail to monitor the person or send them to another facility, like an emergency room, where the person could be adequately monitored.

Surveyors should focus their investigation on gathering facts about the significance of the medication error and what the facility response to that error was. Response to medication errors includes the immediate support that needs to be provided to the person, but it should also include the evaluation and implementation of changes in the facility's medication system to prevent similar errors from occurring in the future. Surveyors typically focus on gathering evidence regarding why the error occurred and what action was taken by the facility. This is very appropriate; however, surveyors, if possible, should also investigate what the facility did or did not do as far as addressing potential systems problems such as quality assurance interventions.