



Pharmacy Newscapsule

Wisconsin Department of Health Services
Division of Quality Assurance

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Antipsychotic Use for Residents with Terminal Restlessness

Due to CMS-led changes, antipsychotic drug data is now being used to calculate nursing home Star ratings. Typically, the lower use of antipsychotics will help a facility obtain a better score. In most instances this is a good thing; however, this also may lead a facility to avoid the use of antipsychotic medications when it may, in fact, be the best choice for a resident.

Terminal Restlessness, which is defined as agitated delirium with cognitive impairment, may occur in hospice patients living in long-term care facilities who are in the final 24-72 hours of their life. In many cases, the use of antipsychotic medications may be the best treatment option.

As surveyors, our role is to ensure that the care residents are receiving meet their needs and is appropriately evaluated.

Terminal restlessness may include many forms of physical behavior, including thrashing, agitation, involuntary muscle twitching or jerks, fidgeting, tossing and turning, and yelling or moaning that may cause distress to the resident or the resident's family.

Prior to treatment of terminal agitation or restlessness, the resident must be assessed to identify and treat reversible side-effects that are caused by the restlessness. Tools available to evaluate delirium are the Confusion Assessment Method, Delirium Rating Scale, Delirium Symptom Interview, and Memorial Delirium Assessment Scale.

Examples of reversible side-effects caused by terminal restlessness include pain or discomfort, urinary retention, constipation and fecal impaction, the use of drugs that lower seizure threshold (opioids, neuroleptics, antiemetics, antidepressants and antihistamines), fear, anxiety, and emotional or spiritual turmoil.

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There is an APP for That!

Simplenote™

There are many note-taking apps. In fact, the Notes app preloaded on your Iphone may work just fine for you. On the other hand, there are other extremely advanced apps for note-taking, but with so many features, some feel those just add more clutter and are difficult to use.

Simplenote™ is just like it sounds --- it has a lot of the simplicity of the general notes app, yet has additional advanced features to be used as well. In addition, Simplenote™ can be synced to other devices to allow you to transfer material from one device to another, should you find that necessary.

I use the app to track ideas I have or summaries of meetings I attend. The search feature allows me to recall those items when I need them.

If the patient is in true terminal restlessness, i.e., the last 24-72 hours of life, treating multiple-infective and metabolic causes is often futile. It is recommended that treatment strategies for end-of-life scenarios be individualized to include identification of underlying causes, ranking the distress, assessing interventions to correct the cause in context with quality of life (QOL) issues, advantages/disadvantages of the intervention versus no intervention and discussing treatment options with the patient and patient's family.

Standard treatments of terminal restlessness include environmental manipulations (reorientation, limiting staff changes, visits by family, reducing noise stimulation), which have not been formally evaluated, and psychotropic medication(s). Psychotropic medications such as benzodiazepines or antipsychotics are not always required and will depend on the cause and presentation of the restlessness. Selection of or need of psychotropic medication is based on the assessment of the type of delirium presented (hyperactive, hypoactive, mixed), and the wishes of a patient and the patient's family.

As a surveyor you are looking to determine if the assessments, communication, and monitoring of treatment are being implemented.

Informed Consent: Is Verbal Consent Allowed?

Nursing homes, hospitals and in some cases Community Based Residential Facilities (CBRFs) may be required to obtain consent to administer psychotropic medications. Wisconsin Admin. Code ch. DHS 94 and Wis. Stat. § 50.08 address requirements for informed consent. The following regulations specifically apply to verbal consent provisions:

Wis. Stat. § 50.08(4)

(a) A nursing home is not required to obtain written informed consent before administering a psychotropic medication to a resident under sub. (3) if all of the following apply:

- 1. The resident is not the subject of a court order to administer psychotropic medications under s. 55.14.*
- 2. There is an emergency in which a resident is at significant risk of physical or emotional harm or the resident puts others at significant risk of physical harm and in which time and distance preclude obtaining written informed consent before administering psychotropic medication.*
- 3. A physician has determined that the resident or others will be harmed if the psychotropic medication is not administered before written informed consent is obtained.*

(b) If par. (a) applies, the nursing home shall obtain oral consent from the resident or, if the resident is incapacitated, a person acting on behalf of the resident, before administering the psychotropic medication, except as provided in par. (c). The oral consent shall be entered in the resident's medical record. The oral consent shall be valid for 10 days, after which time the nursing home may not continue to administer the psychotropic medication unless it has obtained written informed consent under sub. (3).

(c) If par. (a) applies, the resident is incapacitated, and the nursing home has made a good faith effort to obtain oral consent, under par. (b), of a person acting on behalf of the resident but has been unable to contact such a person, the nursing home may

administer the psychotropic medication to the resident for up to 24 hours before obtaining consent under par. (a) or sub. (3).

DHS 94.03 (2m) *In emergency situations or where time and distance requirements preclude obtaining written consent before beginning treatment and a determination is made that harm will come to the patient if treatment is not initiated before written consent is obtained, informed consent for treatment may be temporarily obtained by telephone from the parent of a minor patient or the guardian of a patient. Oral consent shall be documented in the patient's record, along with details of the information verbally explained to the parent or guardian about the proposed treatment. Verbal consent shall be valid for a period of 10 days, during which time informed consent shall be obtained in writing.*

There are also provisions for verbal consent. For nursing homes, when consent is required and verbal consent is used, the nursing home must show that (1) the resident does not have a court order, (2) the situation is an emergency, and (3) the physician has determined that delaying treatment due to the lack of consent will harm the resident or others.

In other entities such as hospitals and CBRFs, when DHS 94 applies, verbal consent is allowed in emergency situations or when time and/or distance are a problem and there is risk of harm to the patient or resident.

Facilities need to be aware of these provisions and adopt procedures that will ensure compliance. As surveyors, you will be looking to see that procedures are developed and implemented consistently.

Additional information on consents can be found at the following web pages:

- Nursing Home Consent Requirements Including FAQ
<https://www.dhs.wisconsin.gov/regulations/nh/infconsent-psychotropic.htm>
<https://www.dhs.wisconsin.gov/publications/p0/p00336.pdf>
- Informed Consent/Client Rights
<https://www.dhs.wisconsin.gov/clientrights/informedconsent.htm>
- Informed Consent Forms
<https://www.dhs.wisconsin.gov/forms/medbrandname.htm>

Note the forms are used for multiple provider types and therefore not all are required for nursing homes. Please use the publications link above to determine when use of a form is needed in a nursing home.



Consultant Corner

by Doug Englebert, R.Ph.

- 1. A CBRF employee called yesterday indicating they are having problems with a physician not signing orders but, instead, they were having the nurse E-sign the orders. Consequently, the orders were returned to the facility looking like the nurse had ordered them, rather than the physician. Would this be acceptable?**

The following DQA memo addresses electronic health records and requirements which apply to physician orders: <https://www.dhs.wisconsin.gov/dqa/memos/13-011.pdf>

Many times when providers ask this question they are referring to prescription medication orders. In these cases, pharmacies must follow both federal and state laws in relation to signatures and electronic prescriptions. Electronic prescription orders are intended to be computer-to-computer communication and the systems have security and other measures to ensure a proper electronic signature. In some cases, facilities with electronic records are printing those records to be used in other facilities; for example, a physician clinic enters an electronic prescription but prints out a copy to send to the CBRF. An electronic prescription signature, when printed out, will not have the typical physician signature on it.

So what is required? Let's assume we are in a world without computers. In that world, a nurse may prepare a written prescription for a blood pressure medication, put the physician name on it, and sign his/her own name (nurse). That is a legal prescription for the pharmacy; however, for some provider types (CBRF), the regulation may say that the practitioner must sign the order. In that case, the nurse's signature is not okay.

Returning to the original question, the first consideration should be whether the e-signature was sent from one computer to another computer or if it is an electronic order that was printed then given to the provider. The second consideration is to determine what the order was written for. And, the final consideration is to determine what the regulations state (for the provider type in question) regarding the physician's order. These three considerations are a good start to determine if the order and signature you are looking at is valid.

- 2. Can nursing home, CBRF, and AFH return unused controlled substances to the pharmacy if they are still in the original packaging? If not, are they responsible for the destruction?**

In general, nursing homes, CBRFs, and AFHs are not considered DEA registrants. Non-DEA registrants are not allowed to return unused controlled substances to the pharmacy; therefore, the answer to the above question is "no" – nursing homes, CBRFs and AFHs may not return unused controlled substances to the pharmacy. For more information see the federal DEA rule: <http://www.deadiversion.usdoj.gov/faq/general.htm#t-3>