



PHARMACY NEWSCAPSULE

DEPARTMENT OF HEALTH SERVICES / DIVISION OF QUALITY ASSURANCE

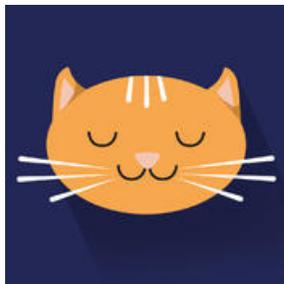
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Douglas Englebert, R.Ph. • 608-266-5388 • douglas.Englebert@dhs.wisconsin.gov

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APP FOR THAT



The Power Nap APP

Everyone has a need for a power nap every now and then. This app sets a 30-minute nap alarm. It has restful nap background sounds (think beach!) and restful waking alarms. If you are a power-napper, this app's for you!

GRADUAL DOSE REDUCTIONS (GDR) AND RESIDENT RIGHTS

Nursing home federal regulations require dose reductions for antipsychotic medications, unless clinically contraindicated. Clinically contraindicated, as defined by the Centers for Medicare and Medicaid Services (CMS) includes:

The GDR may be considered clinically contraindicated if:

- *The resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility; and*
- *The physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or increase distressed behavior.*

In Wisconsin, residents have the right to refuse medications, treatment, and care. And, per Wis. Stat. § 50.08, in instances where antipsychotic medications are used for residents with dementia, written informed consent is required. See: <https://docs.legis.wisconsin.gov/statutes/statutes/50/i/08>

Occasionally, when a facility is requesting a dose reduction for an antipsychotic that is not clinically contraindicated, the resident or his/her family may refuse to reduce the dose.

(continued)

When the facility fails to follow through on the dose reduction, even under the direction of the resident or appropriate party, that facility is still at risk of violating federal law and may be issued a citation.

A dose reduction is based on clinical reasoning. In some cases, there is harm or potential harm occurring to residents from the antipsychotic and reducing the dose is needed to review effectiveness and safety of that medication. When the care team, including the physician, decides to complete a dose reduction, refusal of that reduction by the resident or family of the resident is not valid clinical justification for failing to reduce the medication.

It is appropriate to note that the family or resident may have a valid justification to refuse the reduction of the dose and the care team should take that information into consideration. However, when that refusal is not based on a clinical rationale, the facility needs to complete the dose reduction even under the protestation of the resident or family.

There are ways to complete the dose reduction and address concerns the resident or family may have. For example, if dose reduction in the past caused negative side effects, considering what those side effects were and a different management of the effects may alleviate the concern over the change. For example, a slower dose reduction can be utilized on subsequent attempts.

To avoid dose reduction refusals, communication is vital. During the written consent process, the antipsychotic treatment plan should be discussed. This includes the dose range, the expected time frames for dose changes, and evaluations of medication effectiveness. The discussion should also include when and why the drug may be reduced or eliminated.

Surveyors who see residents with dementia who have been prescribed antipsychotic medications and have not had a dose reduction, and the facility rationale is that the resident refuses the reduction, must investigate that rationale. Facilities that have not addressed dose reduction based solely on a resident refusal are at risk for a citation.

IMMUNIZATION GUIDES

As the saying goes, “Prevention is the best medicine!”

Immunizations are one of the most convenient and safest preventive care measures available. However, pneumococcal vaccines and the new clinical standards can be confusing.

Immunization Action Coalition (IAC) now has two newly updated “pocket guides” for pneumococcal (both PCV13 and PPSV23) and zoster vaccines. These laminated, pocket-sized (3¾” x 6¾”) cards provide frontline health care professionals (not for distribution to patients) with quick reference information highlighting:

- Indications and contraindications for each vaccine
- Targeted populations to be vaccinated
- Vaccine administration details
- Talking points for discussions with patients

To view and request the IAC pocket guides, visit <http://www.immunize.org/pocketguides/>.



What are the requirements for medication aides in nursing homes?

Medication aides are nurse aides who have taken a state-approved medication aide course or who have tested out of the medication aide course. The Nurse Aide Registry will indicate if a nurse aide is also a medication aide. To maintain status as a medication aide, the nurse aide certification must be kept up to date. Additionally, they must complete four hours of medication-related in-service and work 100 hours as a medication aide each calendar year. A medication aide must maintain records of the last three calendar years to show they completed the required in-service and work hours.

When a medication aide has not completed the required in-service or work hours, they are required to contact the Division of Quality Assurance (DQA) to bring their status back into compliance. Individuals who have not met the requirements and contacted DQA may have a letter in their file in lieu of records of hours and in-service.

When possible, surveyors should observe a medication aide pass medications as part of the medication pass task. In addition, a medication aide should be selected as part of the personnel review. Surveyors should check the Pearson VUE registry to note medication aide status and then request verification for the three years of work and in-service records or a letter from DQA.

Nursing students or nursing graduates who are not licensed may pass medications if they are a nurse aide on the registry and the facility has evidence that they are (1) currently enrolled or a graduate of nursing school and (2) have successfully completed a medication administration class that would typically include pharmacology and nursing skills courses. When a nursing student drops out of the nursing program or graduates, they are able to continue to administer medication for one year; thereafter, they must take the medication aide exam to be placed on the Nurse Aide Registry.



Is a physician order required for a resident in a nursing home to self-administer a medication?

There is no federal or state law that requires a physician order for a resident of a nursing home to self-administer medications. Some facilities will use a physician order as a means to document that a medication self-administration assessment was completed, but it is not required.



A community-based residential facility (CBRF) that we just surveyed does not have an RN and they had a medication that was not packaged in unit-of-use packaging. The facility indicated that their pharmacy said the medication could not be repackaged. Is it ok for the facility to do that?

In a CBRF, if there is no registered nurse who meets the criteria for supervision, medications need to be packaged in unit-of-use packaging. However, there are some medications that cannot be packaged in unit-of-use. For example, inhalers typically come in a multi-dose package and cannot be repackaged. There are a few oral medications that, for various reasons, must remain in the manufacturer's container. If a CBRF has information from the pharmacy specific to the medication in question and has trained staff how to administer the medication, including selecting the correct dose and storing the medication, the facility can be considered compliant.