PHARMACY NEWSCAPSULE

NOVEMBER DECEMBER
20 18

DEPARTMENT OF HEALTH SERVICES/DIVISION OF QUALITY ASSURANCE
Douglas Englebert, R. PH. 608-266-5388 douglas.englebert@dhs.wisconsin.gov

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HOSPICE AND DRUG DISPOSAL

December 1, 2018, marks the one year anniversary of the laws allowing hospice staff to transfer controlled substances from deceased individuals to drug disposal programs. As a reminder, the rules are as follows:

- *450.115(1)(am) "Hospice worker" means a person who is employed by a hospice, as defined in s. 50.90(1).*
- *450.115(3)(d) A personal representative, trustee, or an adult beneficiary, as defined in s. 701.1102(1m), of an estate or trust may grant written authorization to a hospice worker for the disposal of a controlled substance that belongs to the estate or trust.*
- *450.115(4)(a) The authorization describes with reasonable specificity each prescription drug or controlled substance that is to be disposed of.*
- *450.115(4)(b) The authorization is in the physical possession of the person authorized to dispose of the prescription drug or controlled substance and each prescription drug or controlled substance described in the authorization is, within 24 hours after the authorization, signed by the person granting the authorization, transferred to a drug disposal program under s.165.65 or otherwise lawfully disposed of.*
- *450.115(4)(c) The authorization and each prescription drug or controlled substance to be disposed of were obtained without consideration.*

What does this mean in practice? A hospice worker can obtain an authorization that describes in detail the drugs that need to be disposed. The hospice worker needs to bring the drugs to a disposal program within 24 hours of receiving the signed authorization from the deceased individual's personal representative.

PERSONAL CARE AGENCY (PCA) AND MEDICATION SET UP

A surveyor asked the following questions: *Personal care workers (PCWs) in a personal care agency cannot set meds up—correct? However, PCWs can give medications if the nurse sets the medications up in a pill box or if the member asks the PCW to get the pills out of the pill bottles for them. They can do that—correct? Do they have to go through any state-approved training?*

Wisconsin Admin. Code chs. DHS 105 and DHS 107 regulate PCAs. DHS 105 sets the provider certification requirements for PCAs. The general requirements require that a registered nurse supervisor provide written instructions regarding the services to be performed by the PCW. A PCW is required to perform the tasks assigned by the registered nurse supervisor. Any duty assigned to the PCW must have evidence of training and documentation of demonstrated ability supervised by the registered nurse.

DHS 107 sets the reimbursement requirements for personal care services. Medication set up, medication administration, and medication assistance is not a covered service. Medication set up, medication administration, and medication assistance would be a service delegated by an RN and, in order for this service to be covered, there would need to be a prior authorization.

To answer the question: Yes, medication set up, medication administration, and medication assistance could all be done by a PCW. However, the RN must delegate these tasks. The RN must follow N6 of the nurse practice act and must follow DHS 105 related to training, return demonstration, plan of care, and documented instructions for the PCW. For the service to be paid for under Medicaid, the service would also need to have a prior authorization.

ANTICOAGULANTS

Novel or Direct Oral Anticoagulant (NOAC/DOAC) Monitoring

Over the last few years there have been many new anticoagulant medications approved for use. There are some recent studies in individuals over 80 years of age that may increase the presence of these medications in many of the facilities that you survey.

One of the most considerable differences between warfarin and the novel or direct oral anticoagulants (NOAC/DOACs) is the elimination of international normalized ratio (INR) monitoring. Because the NOAC/DOACs work further down in the coagulation cascade and have a much faster onset of action, the need for close monitoring of prothrombin time is eliminated. Although lab monitoring may be eliminated, monitoring for signs or symptoms of bleeding is imperative to avoid negative outcomes. When facility staff communicate concerns about residents—especially falls, it is important that the physician is aware that these medications are being used, as the recommendations or orders that the physician may provide will change with that information.

Administration

The administration of these drugs is not complex; however, there are a few key parameters to follow for each drug, which are listed below:

- Pradaxa (dabigatran): Take with a full glass of water, with or without food. Do not crush or chew; swallow whole. Must store in original container; use within four months of opening.
- Xarelto (rivaroxiban): 10 mg tablets may be taken with or without food; 15 mg and 20 mg tablets should be taken with food at approximately the same time each day. Tablets may be crushed and are stable in water or applesauce for up to four hours.
- Eliquis (apixaban): Take with or without food. May crush and suspend tablets in 60 mL D5W for nasogastric tube administration; administer immediately after preparation.
- Savaysa (edoxaban): May be taken with or without food.

Dose Adjustments

Dose adjustments are crucial in certain populations. If a resident has severe renal impairment, the anticoagulant is not excreted from the kidneys as efficiently, causing an increased concentration of drug in the body and increasing risk for bleeds and, even worse, death. Below are considerations for dosing adjustments in each of the available new oral anticoagulants.

- Pradaxa: Renal adjustments, depending on indication and renal function.
- Xarelto: Renal adjustments, depending on indication and renal function.

  Moderate or severe hepatic impairment, or any hepatic disease associated with coagulopathy – Avoid Use.

Geriatrics: No adjustment necessary.

- Eliquis: Renal adjustments, depending on indication, age, body weight, and serum creatinine.
  Severe hepatic impairment: Use not recommended.
- Savaysa: Renal adjustments, depending on indication and renal function.
  Moderate or severe hepatic impairment: Use not recommended. Dose decrease adjustments needed for body weight 60 kg or less.

Monitoring

Monitoring patients who are on NOAC/DOACs is still imperative, even though INRs are no longer needed. Bleeding continues to be a concern in these patients and the following signs and symptoms should be considered when assessing a resident's risks:

- ***Bleeding:*** Bruising, bleeding of the gums when brushing teeth, coughing or vomiting up blood, blood in the urine or stools, black tarry stools, nosebleeds, elevated INR. Stroke: sudden changes in vision, sudden onset of extreme headaches, sudden dizziness, numbness on one side of the body, sudden confusion.
- ***Clotting:*** Increase in swelling of the legs, pain in the calves, shortness of breath, chest pain. Addition of any new medications, whether prescription or over-the-counter, should always be discussed with the resident's physician before administering for the first time, to conclude that a drug interaction is not evident.
- ***Drug Interactions:*** Drug interactions are still a concern with NOAC/DOACs; however, the amount of drug interactions are much less than those with warfarin. Drugs that have a potential for causing a bleed (e.g., such as nonsteroidal anti-inflammatory drugs, antiplatelet agents, and other anticoagulants) should be avoided as this will increase the risk of a bleed if used in combination. P-glycoprotein (P-gp) inducers should also be avoided in combination with the NOACs, as they can decrease the effectiveness of the NOAC and potentially cause clotting.
- ***Special Considerations:*** Reversal Agent: In 2018 a reversal agent was approved. ANDEXXA, coagulation factor Xa (recombinant), inactivated-zhzo is a recombinant modified human Factor Xa (FXa) protein that can be used to treat patients taking rivaroxaban and apixaban, when reversal of anticoagulation is needed due to life-threatening or uncontrolled bleeding. Nursing homes may decide to keep this medication in their emergency kit. If they do they should have procedures and training that indicate they are prepared to administer this medication should an emergency occur.

DIALYSIS AND PHOSPHATE BINDERS

Nursing home and assisted living residents that go to dialysis require significant coordination between the long-term care facility and the dialysis facility. One area that needs to be addressed is the use of phosphate binders. It is sometimes difficult to adhere to the correct use of these medications due to the number of pills, effect on taste, cost, and administration restrictions. Facilities should ensure that residents are being compliant with these medications. If residents refuse the medication, it should be communicated to the dialysis facility. Also, if phosphate levels are high, the dialysis facility should be communicating back to the long-term care facility to ensure that medications are being administered appropriately before making changes.