the Remedi Pulse

Remedi SeniorCare EDUCATION Rx

A CLINICAL AND REGULATORY UPDATE FROM REMEDI SENIORCARE

FEBRUARY 2015

Survey Solutions

with William Vaughan, BSN, RN
VP of Education & Clinical Affairs

From Misappropriation of Property to Actual Harm: The Impact of Drug Diversion on Survey Results

Every year the Gallop organization conducts a poll asking the public to rate the honesty and integrity of various professions… and consistently nurses and pharmacists top the list. The trust placed in nurses and pharmacists is well deserved and earned every day, as they care for people who are often at a vulnerable point in their lives. Drug diversion, however, violates that trust and has serious implications for residents, families, staff, and those who lead long-term care (LTC) facilities.

The November 2014 issue of The Remedi Pulse featured an article by Bethany Schultz, Pharm. D., which provided an excellent overview of the problem of drug diversion in LTC. In this month's issue Dr. Jennifer Hardesty, Remedi's Chief Clinical Officer, shares several concrete approaches to identifying and addressing drug diversion. Leadership in LTC should also be well versed with the regulatory standards that exist related to drug diversion. This overview of the federal nursing home regulations is on point, and while these regulations are specific to nursing homes, several of the concepts discussed are relevant and applicable to assisted living facilities. Please note that many state agencies (Medicaid fraud units, boards of nursing, boards of pharmacies, police, etc.,) have an interest in and authority over individuals who engage in drug diversion, and facilities should work closely with these organizations when such activity is suspected.

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Please do not hesitate to contact your Remedi consultant pharmacist or account manager if you have any questions or concerns.

Drug Diversion Detection and Prevention

Prepared by: Jennifer Hardesty, Pharm.D.,
Chief Clinical Officer

Drug diversion, or the unlawful channeling and/or misuse of regulated pharmaceuticals, occurs in both the general public and healthcare settings alike. Healthcare professionals are not immune to drug abuse and misuse, and professionals such as nurses, pharmacists, physicians, dentists, critical care professionals, and veterinarians are at particularly high risk for diversion of controlled substances due to the relatively common access to controlled substances in the workplace.

Early identification of diversion and abuse, as well as quick interventions, are vital for both patient care concerns and the health care professional's recovery. Facility Management and staff should be aware of behavioral indicators that may point to potential diversion and drug abuse problems:

STAFF BEHAVIORAL INDICATORS:

- Isolates self from others, eats meals alone, avoids staff social events
- Frequent, unexplained disappearances during shift
- Often shows up on days off to finish work or retrieve forgotten items
- Frequently late to work
- Frequently volunteers to work extra shifts
- Volunteers to hold the narcotic keys/perform count
- Frequently spills or wastes narcotics
- Chaotic home/personal life
- Frequent confrontations with other staff members
- Refuses to comply with narcotic diversion investigational procedures
- Implausible excuses for behavior or becomes defensive

RESIDENT CARE INDICATORS:

- Inconsistent/incorrect charting
- Displays inconsistent work quality - times of both high and low efficiency
- Offers to medicate other nurses' patients on a regular basis
- Obtains larger dose of narcotics when the ordered dose is available, documents the remaining amount as wasted
- Requests to care for specific patients or on units with high pain management needs
- His/her patients reveal inconsistent pain scale patterns or complain that narcotics are not effective only on that shift

An ounce of prevention is worth a pound of cure! Staff with access to controlled substance medications should be periodically assessed to ensure that proper procedures addressing controlled substances are being followed.

STAFF DIVERSION PREVENTION – BEST PRACTICES:

- Only remove medications for your assigned patients
- Only remove current dose of medication for your patient
- Properly document medication administration and pain scores
- All wastes of medications must have a documented witness
- Don't be a "virtual witness" to medication wasting or shift-to-shift narcotic count
- Don't loan your ID badge or pass-codes to anyone
- Return unused medications according to procedure
- Report medication discrepancies promptly to administration
- Report attempted inappropriate access to medications to administration
- Report witnessed or suspected medication diversion to administration

If you have questions or would like additional information, please contact your Remedi consultant pharmacist.

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Use of Methadone for Pain

Prepared by: Rob Shulman, BS, R.Ph., CGP, FASCP, Director of Consultant Pharmacy Services

Approved in the US in 1947, methadone was primarily used for opioid withdrawal and long-term addiction from the 1970s until the mid-1990s when it became more popular for use in cancer pain. Today's use goes beyond cancer pain and, due to specific pharmacological properties, is now used for non-cancer pain.

Glutamate is the primary excitatory receptor in the CNS. NMDA is a glutamate receptor that when activated by glutamate causes neurotoxicity, due to over-exciting of the neurons which leads to cell death. Namenda is an NMDA receptor antagonist and thus, slows cell death in Alzheimer's disease. Unlike other opioids, methadone has NMDA receptor antagonist properties (yes, similar to Namenda), which give it a secondary mechanism of action that is very useful for neuropathic pain. Other opioids like morphine, oxycodone, and hydrocodone do not have this property and therefore, have limited efficacy in treating neuropathic pain. Use of high-dose opioids or opioids normally dosed BID being dosed TID are cases where neuropathic pain should be suspected. Methadone is an alternative to traditional opioids in those cases, but use in long-term care (LTC) has been minimal. Contrary to some belief, methadone CAN be prescribed in the LTC setting, if there is a documented pain need. Physicians prescribing methadone should be familiar with using the drug, but do not have to have a specific license to prescribe it for pain. It is a Schedule II narcotic and therefore, like other opioids, needs an appropriate signed prescription prior to dispensing.

Experience with methadone is critical for proper dosing. It has an extremely long half-life of 8-59 hours. Half-life is the amount of time it takes your body to eliminate half of the drug it was presented. Knowing this, it is easy to see how drug accumulation can occur. In 2006, the FDA issued an advisory warning of increases in life threatening respiratory depression, arrhythmias, and deaths. It was noted that many of these deaths were due to drug interactions and illicit use. Methadone's duration of analgesic action is 4-8 hours, but its peak respiratory depression occurs later, which can be misleading when monitoring for toxicity. The full analgesic effect of methadone is not seen for 3-5 days, so dose titrations should occur no more frequently than weekly. Normal starting dose is 2.5 mg every 8-12 hours. Side effects include those similar to other opioids - nausea, vomiting, constipation, and sedation. One of the areas methadone differs is in its ability to cause bradyarrhythmias due to QT prolongation. So, use with other medications that can cause QT prolongation such as Seroquel, Geodon, clarithromycin, etc., should be avoided. Other serious drug interactions include ketoconazole, carbamazepine, erythromycin, phenytoin, rifampin, and tramadol.

Experience with methadone is critical for proper dosing. It has an extremely long half-life of 8-59 hours.

Methadone is a complex drug that may have an expanded role in the LTC setting if used cautiously and with an experienced hand. Please contact your Remedi SeniorCare consultant pharmacists, should you have questions or need additional information.

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Benzon, et al. Essentials of Pain Medicine. 3rd Ed. Philadelphia. Elsevier. 2011. 91-93.

DePiro et al. Pharmacotherapy: A Pathophysiologic Approach. 8th Ed: New York. McGraw Hill Med. 2011: 1118-19.

Methadone: Wikipedia at http://en.wikipedia.org/wiki/Methadone. Accessed 1-12-15.

Nurse of the Month

CAROLE WRIGHT, RN

Retired Director of Nursing, Eliza Bryant Village, Cleveland, OH

CONGRATULATIONS to Carole Wright, RN, retired Director of Nursing from Eliza Bryant Village in Cleveland, Ohio, for being chosen as the Remedi "Nurse of the Month." Ms Wright was nominated by Arlene Jaroscak, RN, LNHA, Director of Clinical Transitions for Eliza Bryant Village. Per Arlene, "Ms. Wright retired in November, 2014, after 33 years of service at Eliza Bryant Village, serving an underserved population in an inner-city, non-profit, critical access facility. She began her life-long career at Eliza Bryant Village as an STNA. Ms. Wright then became an LPN, MDS Nurse, RN Unit Manager, Assistant DON, Interim DON, and she finished her career as the Director of Nursing for the past eight years. Eliza Bryant Village, as well as the entire nursing facility team, has flourished under Ms. Wright's leadership, as she shared her gifts of service and diplomacy. Thank you, Ms. Carole Wright, for 33 years of service to Eliza Bryant Village."

Remedi acknowledges a "Nurse of the Month" in each of our newsletters. DONs/ADONs/LNHAs, NOW is the time for you to reward the nurse(s) at your facility, who exemplify excellence in nursing practice. The "Nurse of the Month" will receive an award and a certificate of commendation from Remedi. Please submit the following information: nominated nurse's name/title, facility name, state, years at facility, years of experience and why this nurse should be chosen, such as leadership abilities, clinical expertise, teamwork, professional and personal strengths.

Email your Nurse of the Month nomination(s) by the 30th of the month to Rebecca.Ogden@RemediRx.com. Nurses Rock!!

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Federal Nursing Home Regulations:

- F431 in effect requires facilities to acknowledge the issue of drug diversion by developing policies and procedures that will detect and deter related activity. Make sure your pharmacist is actively involved in the development and periodic review of these documents, as this is required by regulation. Inconsistencies between how a pharmacy and nursing home process controlled medications is a red flag to surveyors and when found will prompt an in-depth review.

- Speaking of consistency, surveyors frequently compare the controlled drug log to the individual residents' medication administration record (MAR). If a drug is signed out on the log but not documented as administered to the resident on the MAR, the causes range from poor record keeping to drug diversion. Facilities, from a quality assurance perspective, should routinely review both documents and promptly address any inconsistencies.

- One of the more explicit requirements of F431 reads as follows: "The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs … other drugs subject to abuse…" While the term "permanently affixed" is somewhat open to interpretation, the intent as it relates to preventing drug diversion is clearly to limit one's ability to quickly and easily remove large quantities of controlled drugs from a facility (i.e., as in the case of a free standing narcotic box). Note also the requirement that "other drugs subject to abuse" must be stored in the same fashion as controlled drugs. Facilities, working with their consultant pharmacist and medical director, should review their drug inventory and determine which drugs could potentially fit the definition of "subject to abuse." The National Institute on Drug Abuse maintains statistics that may help facilities identify such drugs at http://www.drugabuse.gov/drugs-abuse/prescription-drugs-cold-medicines

- CMS defines neglect as the "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness" (42 C.F.R. §488.301). The diversion of drugs in a nursing home meets this definition and may also be considered misappropriation of a resident's property. In either case, a facility is required to promptly report the incident to the state survey agency. Learn more at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCLetter05-09.pdf

Successfully addressing drug diversion requires a team effort. The staff at Remedi SeniorCare has the education, experience, and expertise to help you address any related concerns.