the Remedi Pulse

MED PASS / MEDICATION STORAGE

Remedi SeniorCare EDUCATION Rx

A CLINICAL AND REGULATORY UPDATE FROM REMEDI SENIORCARE

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Survey Solutions

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

The Medication Pass: Can We do Better? (part 2)

Building on information presented in the June issue of the *Pulse*, we now look at two common misconceptions that can lead to the erroneous citing of medication errors.

TIMING OF ADMINISTRATION

Perhaps no aspect of the medication pass gets as much attention, from both surveyors and staff, as the actual timing of medication administration. Ask any nurse when it's acceptable to administer a medication scheduled for 10 a.m. and the universal response will be "anytime between 9 a.m. and 11 a.m." I was taught this "one hour before / one hour after" concept in nursing school some 30 years ago and it remains entrenched in nursing practice today.

Strict adherence to this golden hour "rule" can, however, lead to the inappropriate citing of timing errors. For example, an order is written as follows: "Digoxin 0.125 milligrams po once per day." The order is transcribed onto the medication administration record and the drug is scheduled to be administered daily at 10 a.m. During the medication pass, the surveyor observes that a clinically stable resident receives her Digoxin at 11:50 a.m. You're now the surveyor … do you cite this as a medication error? According to CMS guidance to surveyors at F332, you should not.

The guidance instructs surveyors to "… Count a wrong time error if the medication is administered 60 minutes earlier or later than its scheduled time of administration, **BUT ONLY IF THAT WRONG TIME ERROR CAN CAUSE THE RESIDENT DISCOMFORT OR JEOPARDIZE THE RESIDENT'S HEALTH AND SAFETY** [bold type included in original text]. Counting a medication with a long half-life (e.g., digoxin) as a wrong time error when it is 15 minutes late is improper because this medication has a long half-life (beyond 24 hours) and 15 minutes has no significant impact on the resident. The same is true for many other wrong time errors."[1] This approach requires surveyors to look beyond the arbitrary one hour time

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FOR MORE INFORMATION
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Taking a Breath: Understanding Inhalers

Prepared by: Sarah Brett, Pharm.D., Clinical Consultant Pharmacist

Asthma and chronic obstructive pulmonary disease (COPD) are both common respiratory disorders that affect many of the residents for whom we care. Many therapies used to treat these conditions require use of one of numerous inhaler devices available. Effectively administering medications using each drug-delivery system is essential to ensure optimal maintenance and treatment. Understanding proper inhaler technique can also help in recognizing when a device may no longer be an effective delivery system for a resident, and prompt a review to determine if there is a more appropriate choice.

Although there are many different inhaler therapies available, they can be classified as either pressurized metered dose (pMDI), dry powder (DPI), or soft mist inhalers. Each class has very similar key points for administration technique.

PRESSURIZED METERED-DOSE INHALERS (PMDI)

- Are the most familiar, and include devices that contain the propellant hydrofluoroalkane (HFA)
- Commonly used with a spacer to help assist in coordination of delivery
- Considered lower-resistance devices
- More appropriate in times of acute exacerbations when a patient may not be able to generate adequate inspiratory flow necessary for the use of alternate devices
- Prime before initial use by shaking the device and spraying four pumps into the air
- For daily use, pMDIs are shaken and residents should be instructed to exhale completely, then wrap lips around mouthpiece, inhale a slow deep breath, remove device from mouth, and hold breath for as long as they can comfortably, or up to 10 seconds
- Examples:
  - ProAir, Proventil, Ventolin, Xopenex, Advair HFA, Dulera, Symbicort HFA, Flovent HFA, Asmanex HFA, Serevent HFA

DRY POWDER INHALERS (DPI)

- Available in several different device styles that might be very familiar to both nurses and residents
  - The unit dose system utilizes a capsule containing the drug in powder form along with a corresponding specialized delivery device
  - Multiple doses within the device are delivered once the dose is triggered and the device is activated, such as in a Diskus® or Turbuhaler®
- Do not utilize a propellant or require as vigilant coordination between actuation of the device and inhalation
  - Rely on the quick, deep breath of the resident in order to aerosolize the drug for delivery
  - If a resident is not able to generate adequate inspiratory flow, the drug may not be delivered optimally via a DPI - this should be brought to the attention of the resident's care team
- Require more attentive handling once the dose is loaded and the device is activated in order to avoid displacing the medication
  - For the unit dose systems, there should be a noticeable whirring noise upon inhalation --an absence of this noise may be an indication of inadequate inspiratory flow, or that the capsule in the chamber needs to be loosened
  - It is important not to pierce the capsule in the chamber of these devices more than once in order to avoid degrading the gelatin capsule and allowing it to pass through the screen to the resident's airway
- Examples:
  - Spiriva HandiHaler, Arcapta Neohaler, Foradil Aerolizer, Flovent Diskus, Serevent Diskus, Advair Diskus, Breo Ellipta, Incruse Ellipta, Anoro Ellipta, Arnuity Ellipta, Asmanex Twisthaler, Pulmicort Flexhaler, Tudorza Pressair

SOFT MIST INHALERS

- New innovations - becoming more widely utilized drug-delivery systems
- Generate an aerosol without utilizing a propellant or relying on the patient's inspiratory flow
  - A spring forces the solution through a nozzle system that produces the mist
  - Since the mist lasts longer than many pMDIs, there is less concern for problems with coordination of actuation and inhalation
- Require less inhalation effort to deliver the medication to the lower lungs
- Must first be assembled which involves loading the cartridge into the inhaler and writing the discard date of 3 months from when the cartridge is loaded
- Must be primed prior to first use
- Daily use involves turning the clear base, opening the cap, instructing the resident to breathe out completely and then placing lips around mouthpiece, followed by pressing the dose release button as the resident takes a slow deep breath, removing the device from mouth, and having the resident continue to breathe in and hold breath for 10 seconds or as long as comfortable
- Examples:
  - Spiriva Respimat, Stiolto Respimat, Combivent Respimat, Striverdi Respimat

With all of these devices, it is important to remember the fundamental basics that help to ensure appropriate medication administration:

- Label each device when it is opened
- Refer to expiration guidelines to determine a beyond-use date
- pMDIs should be inspected before use and discarded if the count is at zero in order to ensure appropriate dose delivery, even if it still feels full
- Assist residents to rinse their mouth and spit out the water after inhaling a corticosteroid to help prevent oral thrush
- Sequence inhalers so that bronchodilators are administered prior to steroids in order to optimize inhaled steroid therapy

Residents depend on our expertise in properly delivering medications through each of these various types of inhalers.

References:
Capstick TG, Clifton IJ. Inhaler technique and training in people with chronic obstructive pulmonary disease and asthma. Expert Rev Respir Med. 2012 Feb;6(1):91-101; quiz 102-3. doi: 10.1586/ers.11.89. Review. PubMed PMID: 22283582.

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Stop the Madness: Rational Medication Administration Times

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

The seemingly endless medpass cycle-starting early at 6 a.m. and often going until midnight, can be challenging to both residents and staff alike! Numerous medication passes can tie up facility staff, and can adversely affect resident quality of life by producing interruptions of activities and disrupting important sleep time. By promoting a resident-centered, rational medpass schedule, individual preferences and quality of life can be preserved while still achieving good clinical outcomes.

THE EARLY MORNING MEDICATION PASS

Several medications have traditionally been administered very early in the morning. Synthroid, Proton Pump Inhibitors, and Bisphosphonates (alendronate, risedronate), are often scheduled anywhere from 6 a.m. - 8 a.m., but these administration times may require staff to wake a resident early, just to take a medication. For those residents who prefer to sleep in, or are more challenging in the morning - consider these options:

Proton Pump Inhibitors

- Some medications in this class may be given without regard to food (e.g., pantoprazole and rabeprazole)
- For certain residents you may want to consider administering the drug 30-60 minutes prior to lunch or dinner to achieve an empty stomach, as opposed to breakfast
- Give medication with breakfast, but monitor efficacy closely for several weeks

Synthroid

- While Synthroid is best absorbed on an empty stomach, it can be administered any time of day as long as it is given under the same conditions each day
- For example, it can be given with breakfast as long as it is always given with breakfast
- Alternatively, administer Synthroid 30 minutes prior to dinner, or at bedtime to achieve the empty stomach condition

Bisphosphonates

- Medications such as alendronate or risedronate should always be given on an empty stomach in the morning with a full glass of water, the resident sitting upright to avoid adverse GI effects
- Administration time of this class of medication is not flexible; however, an extended-release risedronate (Atelvia) can be given immediately after breakfast
- Change resident to a once-weekly or once-monthly formulation

THE "HEAVY" MEDICATION PASS

The heaviest medication pass of the day is traditionally the time that is assigned to "Once Daily" in your facility. Blood pressure medications, stool softeners, vitamins/minerals, cholesterol medications, antidepressants- most of the "QD" medications are slated for this medpass. Staff often times have so many medications to administer and document that they run behind or may be tempted to take shortcuts; and residents have numerous medications to swallow. Consider "re-balancing" the medpass by doing the following:

- Move vitamin, mineral, and herbal supplements to a medpass later in the day
- Consolidate various vitamin and mineral supplements into a single product
- Administer docusate or other routine bowel medications at a later medpass

LATE NIGHT MEDICATION PASS

As a general rule of thumb, you should re-evaluate the rationale of any routine medication order administered after 9 p.m. In certain circumstances a strict dosing schedule may be required (e.g., Parkinson's Disease, pain management, antibiotics, etc.). A risk-vs.-benefit assessment should be performed for any medication therapy that may interrupt or impede a resident's sleep. Those artificial tears Q2H can wait until morning!

A FINAL NOTE:

If you choose to alter the administration time away from the standard, consider a statement in the resident's record such as, *"I have evaluated the risk-vs.-benefit of administering DRUGXYZ at 6 a.m., and determined resident quality of life may be impacted adversely by waking him/her too early. Please administer the medication at 8 a.m."* By doing what is best for the resident and documenting your rationale, you ensure good clinical care with transparent justification.

Understanding Inhalers (cont'd)

"Respimat Insight." Respimat. Boehringer Ingelheim, n.d. Web. 12 July 2015. <https://www.respimat.com/functions_and_use/howitworks.html>.

"How to Use Inhalers." UPMC. University of Pittsburgh Schools of the Health Sciences, 2011. Web. 12 July 2015. <http://www.upmc.com/patients-visitors/education/breathing/pages/use-inhalers.aspx>.

Nurse of the Month

KATHY WOODINGTON, LPN
St. Mary's Nursing Center, Leonardtown, MD

CONGRATULATIONS to Kathy Woodington, LPN, Charge Nurse at St. Mary's Nursing Center, Leonardtown, MD, for being chosen as the Remedi "Nurse of the Month." Kathy was nominated by her Unit Manager, Carrie Sager, RN. Per Carrie, "Kathy has been a nurse for 35 years and has worked full-time at St. Mary's for 15 years on the night shift while also working as a medical records reviewer part-time. She is extremely thorough in her work and takes pride in all that she does. Kathy is very skilled with the use of My Remedi not only for order entry, but also utilizes a variety of reports available to complete 24-hour checks, verify order completeness, and to do her job effectively and efficiently. She consistently makes positive contributions to the care of all residents, is dedicated to her residents and treats them with the utmost respect. Kathy is a tremendous asset to Unit 2.

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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frame and perform a critical analysis of the entire clinical picture before citing a timing error. Facilities should undertake a similar analysis, if cited, to determine if the deficiency should be disputed.

In 2011, the Institute for Safe Medication Practices examined the issue of medication timing in the acute care setting and came to two important conclusions. It was determined that "relatively few medications truly require exact timing of doses" and that "many nurses reported feeling great pressure to take shortcuts to comply with the [timing] rule, which … led to errors, some harmful." ISMP developed guidelines for the timely administration of medications (http://www.ismp.org/tools/guidelines/acutecare/tasm.pdf) and while they were intended for use in the acute care setting, they certainly contain principles that are applicable to long-term care.

POLICIES AND PROCEDURES

A review of several hundred deficiencies from multiple states cited at F332 (medication error rate > 5%) during 2014 revealed that surveyors often use a facility's own policies and procedures to establish or confirm that a medication error occurred. While examining such documents may have merit in the survey process, non-compliance with a policy or procedure does not in and of itself meet CMS's definition of a medication error. A medication error is the failure to administer medication in accordance with the prescriber's order, the manufacturer's specification, and/or accepted professional standard and principles.[2] Facilities frequently and appropriately develop policies and procedures which exceed regulatory requirements as they strive to deliver exceptional care to their residents. Provider's should consider disputing medication error related deficiencies which are cited based on criteria other than that which is established by CMS.

The timing of medication administration, as is the case with all services provided in a long-term care facility, should be determined based on a resident-centered approach to care.

Note: Bill was a surveyor with the Maryland State Survey Agency from 1988 until 2001. He became Chief Nurse of the agency in 2001 and remained in that position until joining Remedi SeniorCare in 2013.

References:
[1] State Operations Manual: Appendix PP - Guidance to Surveyors for Long-Term Care Facilities: F 332

[2] State Operations Manual: Appendix PP - Guidance to Surveyors for Long-Term Care Facilities: F 332