the Remedi Pulse

EVOLVING ANTICOAGULANT RISK

A CLINICAL AND REGULATORY UPDATE FROM REMEDI SENIORCARE

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Survey Solutions

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

A New Paradigm: Implement Your Plan of Correction Before Immediate Jeopardy is Cited

Immediate jeopardy (IJ) is the highest severity level at which a federal deficiency can be cited during a nursing home survey. CMS views immediate jeopardy as "a crisis situation in which the health and safety of individual(s) are at risk." As such, surveyors must notify providers once they determine that an IJ exists, and they cannot leave the facility until an acceptable plan of correction is developed and implemented. IJ level deficiencies typically result in the threat of termination from the Medicare/Medicaid programs and trigger the imposition of significant civil monetary penalties. In calendar year 2015, of the approximately 105,000 deficiencies written nationwide, 1,725 were cited at an immediate jeopardy level.

During my career at the Maryland state survey agency, I was involved either as a surveyor or chief nurse in the issuance of numerous IJ deficiencies. The mismanagement of high risk medications, specifically anticoagulants, figured prominently in these cases. Providers would, understandably, bring tremendous resources to bear on correcting IJ deficiencies. It was clear to me that had just a portion of those resources been available on an on-going basis, many and perhaps most of the deficiencies would never have been cited. Below are several common and successful approaches I observed in plans of corrections written to address IJ level deficiencies related to anticoagulants:

STAFFING: There is a fundamental relationship between staffing and regulatory compliance. While the number of staff present on any particular shift is an important metric, the quality and capabilities of that staff are equally important. And given that many medications, including anticoagulants, are administered by unlicensed individuals (e.g., medicine

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MODERNIZING OLD PRESCRIBING HABITS IN ANTICOAGULATION

Prepared by Janelle Massaro, Pharm.D., Consultant Pharmacist

Anticoagulants are used with great regularity in long-term facilities, as anticoagulation therapy is common to prevent or treat thrombo-embolic events after joint replacements, CVA, DVT/PE, or atrial fibrillation (AF). Approved in 1954, the vitamin K antagonist, warfarin, has been the mainstay of anticoagulation therapy for many years. In more recent times, a flood of newer, more targeted medications in the marketplace have added to the arsenal of treatment options available to clinicians. As the treatment options expand and patients are changed to alternative agents, clinicians must be aware of the most appropriate way to transition from one anticoagulant to another.

There are several major classes of anticoagulants available:

- Low Molecular Weight Heparins (LMWHs): Lovenox (enoxaparin) and Fragmin (dalteparin)
- Indirect Factor Xa Inhibitors: Arixtra (fondaparinux)
- Direct Factor Xa Inhibitors: Xarelto (rivaroxaban), Eliquis (apixaban), Savaysa (edoxaban)
- Direct Thrombin Inhibitors: Pradaxa (dabigatran)

Residents may be admitted from an acute care setting with orders for Heparin at prophylaxis doses of 5,000 units SQ BID to TID for 10-14 days or enoxaparin 40 mg SQ QD for DVT/PE for 10-35 days post-op[3]. In many cases, anticoagulation therapy stops after this point, but the question arises on how and what to transition with when using anticoagulation for treatment rather than prophylaxis. It is important to recognize the differences between medications in a class when switching. Differences include frequency of dosing, renal dosing, and drug interactions. The attached table[1] serves as a guide to assist in deciding which medication option is available and how to transition to long-term anticoagulation (AC) therapy.

Converting from	Converting to	Recommendations
Warfarin	Xarelto**	• D/C warfarin, start when INR < 3
	Savaysa**	• D/C warfarin, start when INR < 2
	Eliquis**	• D/C warfarin, start when INR < 2.5
	Pradaxa**	• D/C warfarin, start when INR < 2
Non-warfarin containing oral AC	Xarelto*	• Give 0-2 hours prior to next evening dose of other AC, d/c other AC
	Eliquis, Savaysa	• Give dose at next scheduled time of other discontinued AC
LMWH (enoxaparin)	Savaysa	• D/C enoxaparin, give at next scheduled dose of enoxaparin

Converting from	Converting to	Recommendations
Xarelto	Coumadin	• No clinical data, may d/c oral AC, start parenteral AC and warfarin at next scheduled dose of Xarelto
Eliquis	Coumadin	• Eliquis affects INR, may use same method for transitioning as Xarelto, d/c parenteral AC when INR in therapeutic range
Savaysa	Coumadin	• Current dose 60 mg: reduce to 30 mg, start warfarin • Current dose 30 mg: reduce to 15 mg, start warfarin • Monitor INR weekly, may d/c Savaysa when INR ≥ 2
Pradaxa	Coumadin	• CrCl ≥ 50 mL/min, start warfarin 3 days before d/c • Pradaxa CrCl 30-50 mL/min, start warfarin 2 days before d/c Pradaxa • CrCl 15-30 mL/min, start warfarin 1 day before d/c Pradaxa

Dosing considerations:
*Xarelto is recommended to be given in the evening with food (15,20 mg doses), 10 mg without regards to meals.
**renally dosed medication

Now that it has been shown how to transition residents from one anticoagulant to another, the question arises, what are the benefits or differences between them? In the previous publication of *The Pulse*, April 2016, the article "How Cheap Drugs Can Get Expensive" is a great example. Warfarin is a commonly used, inexpensive medication to manage multiple medical issues, but it comes at a cost:

- Numerous drug and food interactions
- Requires multiple blood draws (increasing risk for missed INRs)
- Timely communication of INRs to prescribers
- Medication errors due to constantly changing orders

The newer oral AC agents do not require significant lab monitoring; therefore reducing risk for missed lab draws, fewer drug interactions, no lab reporting to prescribers, and statistically significantly less risk for major bleeding with Eliquis (not a class benefit)[3]. But they too come with a cost - a financial cost as well as minimal antidotes for bleeding (Praxbind is available in acute care settings to reverse Pradaxa). It is important to assess the patient as a whole and decide which anticoagulant option best suits their needs.

REFERENCES

1. Muller, Allison A. MHA Clinical Spotlight: Anticoagulation. Managed Healthcare Associates. January 2016:19-23.
2. Semla TP, Beizer JL, Higbee MD. Geriatric Dosing Handbook. 18th ed. Hudson, OH: Lexicomp; 2013: 917, 639
3. Eliquis [package insert]. Princeton, NJ: Bristol-Myers Squibb Company; 2015.

Nurse of the Month

TERRI GRIMES, LPN
The Laurels of Steubenville, Steubenville, OH

CONGRATULATIONS to Terri Grimes, LPN, The Laurels of Steubenville, Steubenville, OH, for being chosen as the Remedi Nurse of the Month. Terri was nominated by her administrator, Lori Marsh. Per Lori, "Terri came to work for us in the fall of 2014 with more than 20 years of nursing experience. It is obvious when you work with Terri that she is truly in the healthcare industry, because she cares about people. She consistently makes herself available to assist her fellow nursing staff and the guests. Terri is always smiling and pleasant with all staff members and sensitive to the needs of our guests. She is detail-oriented with her documentation and admission paperwork, and she is a true team player. When new guests arrive, she greets them in a friendly manner and ensures that their dietary orders are correct, and their dietary preferences are granted during mealtimes. Terri always goes above and beyond our expectations and truly exhibits the "Laurel Way." She is very kind and helpful to new nurses and helps teach them the proper way of handling company policies, processes, and systems. Terri's follow-through is amazing regarding her treatments and assessments of the guests. She directs her STNA's in a helpful and professional manner and assists them in caring for our guests as needed. She is gifted in showing empathy toward our guests and their families. Terri is very conscientious in her delivery of care, because she takes a vital interest in the guests and their needs. Terri has a great sense of humor, while upholding a professional demeanor with staff, management, and our entire Laurel team. These are just a few reasons why Terri Grimes deserves to be titled the Remedi Nurse of the Month.

The Remedi "Nurse of the Month" exemplifies excellence in nursing practice. Email your Nurse of the Month nomination(s) to Rebecca.Ogden@RemediRx.com. Nurses Rock!!

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aides), the need for direction and oversight by a RN cannot be overstated. Providing robust and consistent staffing, in all disciplines, is a key factor in preventing significant medication errors.

CHECKS/BALANCES: When cited for anticoagulant errors that often resulted in hospitalizations and occasionally the death of a resident, providers would respond by "beefing up" their medication management practices. More frequent reviews by the consultant pharmacist of all residents receiving anticoagulants, requiring the administration of anticoagulants to be done solely by licensed nursing staff, and even requiring that two licensed nurses check each dose of an anticoagulant prior to administration were practices that resulted in improved resident outcomes. While there are costs associated with each of these practices, they paled in comparison to those related to unnecessary re-hospitalizations and regulatory sanctions.

COMMUNICATION: The disconnect between clinical assessments, laboratory monitoring, and prescriber notification was the genesis for many IJ deficiencies related to anticoagulants. Once cited, providers would begin to document recent, relevant laboratory results (e.g., INR, Hct, etc.) on medication administration records, revamp their EHR to highlight findings related to anticoagulants, and prioritize communication between the facility, pharmacy, and prescriber. These changes translated into improved care of residents and reduced the risk of regulatory non-compliance.

QAPI: Lastly, many deficiencies that would have been cited at an actual harm level were elevated to IJ because the provider failed to recognize the error and take steps to prevent it from re-occurring. For example, a routine INR was obtained on a resident receiving Warfarin and noted to be elevated at 8.90. The prescriber was promptly notified and ordered the Warfarin held and a repeat INR drawn the following day. The nursing staff failed to transcribe either order. The resident continued to receive Warfarin and, unfortunately, fell three days later, subsequently dying from an intracranial bleed. The provider did not conduct a root cause analysis or take any meaningful action to prevent this scenario from repeating itself. Several months later this record was reviewed during the annual survey and resulted in a finding of IJ. While the care of this resident was clearly deficient, a robust and effective QA process could have resulted in the corresponding deficiency being cited at an actual harm rather than an IJ level (and likely lessened the impact on the facility's 5 star rating and decreased the amount of the civil monetary penalty that was imposed).

The regulatory push is on to evaluate how providers are managing high risk medication, with anticoagulants being the "poster child" in this effort. Now is certainly a good time to consider a proactive rather than reactive approach to the oversight of these historically misused medications.

References

[1] State Operations Manual Appendix Q - Guidelines for Determining Immediate Jeopardy

[2] https://data.medicare.gov/