June - July 2014

ICP Consultant Connection

Institutional Care Pharmacy • Tiffin, Ohio • Mason, Ohio • Sharpsville, Pennsylvania

Silent Stealers of Sight

Vision loss among the elderly is a major health problem. Approximately one person in three has some form of vision-reducing eye disease by the age of 65. The most common cause of vision loss among the elderly is age-related macular degeneration, glaucoma, cataract and diabetic retinopathy. These diagnoses have been referred as "silent stealers of sight" because they progress so gradually that they are frequently unnoticed until vision loss has become severe. Like so many medical conditions, early detection is key to effective treatment.

Four leading eye diseases:

- Macular degeneration, or age-related macular degeneration (AMD), is a leading cause of vision loss in Americans 60 and older. AMD affects the macula, the part of the eye that allows seeing fine detail and is characterized by the loss of central vision.
  There are two types: wet and dry. Wet AMD happens when abnormal blood vessels grow under the macula. These new blood vessels often leak blood and fluid. Wet AMD damages the macula quickly. Blurred vision is a common early symptom. Dry AMD happens when the light-sensitive cells in the macula slowly break down. A common early symptom is that straight lines appear crooked. Risk factors include smoking, excessive sunlight exposure and family history.
- Cataract is a common cause of vision impairment among the elderly, but surgery is often effective in restoring vision. Cataract is the 5th most common chronic condition in adults over age 75. Resident with visually significant cataracts may complain of blurred vision or glare. Cataract progression is typically slow, with gradual loss of vision over months to years. Exposure to ultraviolet light may contribute to the progression of cataract formation.
- Diabetic retinopathy is the most common diabetic eye disease and a leading cause of vision loss and blindness in American adults age 65 and older. Diabetic retinopathy may be classified as early or advanced depending on the symptoms. Symptoms may include the following: spots or dark strings floating (floaters), blurred vision, fluctuating vision, dark or empty areas in their vision, vision loss and difficulty with color perception. Diabetic retinopathy usually effects both eyes.
- Glaucoma is a potentially serious form of eye disease. The majority of cases of glaucoma are open angle glaucoma (95%). Increased intraocular pressure leads to atrophy and cupping of the optic nerve head causing visual field deficits that can progress to blindness. Vision changes include loss of peripheral vision, intolerance to glare, decreased perception of contrast and decreased ability to adapt to the dark.

Safety is a major concern for or elderly residents in our facilities with vision impairment. Low vision loss can affect resident quality of life if interventions are not implemented.

Nursing care strategies include the following:

- Avoid disruption in the management of chronic eye conditions by obtaining past history and assuring continuation of ongoing regimens, such as eye drops for glaucoma.
- Encourage the use of good lighting in resident rooms. Avoid glare whenever possible.
- Encourage the use of the resident's eyeglasses. Have family provide lighted magnification if needed (these are the large magnifiers with a light attached).
- Add contrast to the fixtures in the room if light switches blend into the wall or faucets blend into the sink.
- Encourage annual eye exams either with Optometrist or Ophthalmologist.
- Annual dilated exam for resident with diabetes and hypertension by ophthalmologist.
- Notify the primary care provider of any acute change in vision:
  - Sudden hazy or blurred vision
  - Double vision
  - Seeing flashes of light
  - Seeing halos around lights
  - Unusual, even painful, sensitivity to light or glare
  - Changes in the color of the iris
  - Sudden development of persistent floaters
  - Recurrent pain in or around the eye

Vision loss threatens older adults' independence and quality of life. By being aware, the interdisciplinary team can be proactive in helping individual residents with vision problems live a safe and productive life in our facilities.

References: http://consultgerirn.org/topics/sensory_changes/want_to_know_more#item_2
Treating Low Vision by Eleanor Faye, MD, FACS http://www.todaysgeriatricmedicine.com/news/ex_071310_shtml
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Docusate Sodium

Docusate sodium has found its way onto a number of constipation protocols in hospital and palliative care settings alike, even with a lack of supportive statistical evidence. Three recent articles have researched whether this medication is truly beneficial to the patient or just adding to their pill burden.

The first article written in 2000[1] examined all the published studies that met their criteria of chronically ill or inpatients in a chronic care facility, subject to chronic constipation or had risk factors for constipation. The patients were given oral docusate, and they measured either stool consistency, stool frequency, or the use of other laxatives. Studies written in English or French and published after 1940 were reviewed. Using key words "constipation", "dioctyl", and "docusate" researchers searched a number of databases as well as hand searched through palliative care journals, which yielded only four studies that met all the inclusion criteria. These studies all differed in the setting (hospital, nursing home unit at VA, and retirement center) and study design (randomized double-blind cross-over, randomized unblinded comparative, and time series with randomized single-blind). They also all used varying strengths of docusate (60-240mg QD-BID). However, all studies showed a small trend toward increased frequency and improved stool consistency with docusate compared to placebo. Three of the studies allowed additional laxatives to be used which could have favored the results.

The second study published in 2008[2], compared the effectiveness of a sennoside-based bowel protocols with and without docusate in hospitalized patients with cancer. The patients in each treatment group were comparable in age, gender, and reason for admittance. Overall 80% of these patients were on opioid therapy and 72% were admitted for supportive care. Only 10% in the docusate plus senna group (DS) were opioid naïve, which based on the protocol were started on docusate only, the other 90% were started on the combination which equated to the first step in the senna only group (S). This resulted in the starting dose of senna for the S group being higher overall than the DS group. Patients in the DS group requested more interventions (ie lactulose, enemas) than the S group, however the S group had more diarrhea (8 vs 4), and both groups had 3 patients complain of cramping. The S protocol was shown to be significantly more effective in producing a bowel movement than the DS protocol in supportive care patients, many of which were taking opioids. The amount of senna in each protocol was the same, but the DS group had an extra step before starting the senna. Due to the increased number of pills in the DS group, physicians may have been reluctant to escalate the DS group, which could account for the differences between groups.

The final study published in 2013[3] was a double-blind, placebo controlled trial looking at docusate in hospice patients. Again this study had a docusate and senna group (DS) and a senna and placebo group (S). They were measuring stool frequency, volume, and consistency; as well as patient perception of their bowel movement. Both groups were similar regarding age, gender, diagnosis, MMSE score, daily oral intake, and opioid use. However, the DS group had more people on morphine while the S group had more patients on hydromorphone, but there was no difference in the mean morphine equivalent daily dose between the groups. Results showed no statistically significant difference in the number of bowel movements per day, stool volume or consistency between the two treatment groups. Using the Bristol Stool Form Scale patients in the S group tended to have Type 4 (smooth and soft, like a sausage or snake) and Type 5 (soft blobs with clear-cut edges) while patients in the DS group tended to have Type 3 (sausage, cracks in the surface) and Type 6 (mushy, fluffy pieces with ragged edges). There was no significant difference in the patients' perceptions of the difficulty (amount of straining) or completeness (sense of evacuation) between the two groups.

Docusate is well tolerated with minimal side effects; but it can lead to other problems. These capsules can often be large and doses may require patients to take many capsules multiple times a day, increasing the pill burden on already heavily medicated patients. While the cost of docusate is small (10-16 cents per capsule)[2] the impact it has on the nursing workload can become expensive. This along with the limited data and questionable efficacy should be considered when starting or continuing a compromised patient on docusate. Both of the newer studies included mostly patients who were on chronic opioid medications, which may not be applicable to a regular nursing home patient. Until more studies are conducted, continue using your best clinical judgment to do what is in the best interest of the patient.

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References:

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2. Hawley PH. A Comparison of Sennoside-Based Bowel Protocols with and without Docusate in Hospitalized Patients with Cancer. Journal of Palliative Medicine. 2008;11;4:575-581
3. Tarumi Y, Wilson MP, Szafran O, Spooner GR. Randomized, Double-Blind, Placebo-Controlled Trial of Oral Docusate in the Management of Constipation in Hospice Patients. Journal of Pain and Symptom Management. 2013;45;1:2-13

FDA Warns of Next-Day Impairment with Sleep Aid Lunesta (eszopiclone)

On May 15 the Food and Drug Administration (FDA) warned that the insomnia drug eszopiclone can cause next-day impairment of driving and other activities that require alertness. As a result, the recommended starting dose has been lowered to 1 mg at bedtime. Health care professionals should follow the new dosing recommendations when starting patients on eszopiclone. Patients should continue taking their prescribed dose of eszopiclone and contact their health care professionals to ask about the most appropriate dose for them.

http://www.fda.gov/Drugs/DrugSafety/ucm397260.htm

Appropriate treatments for agitation and restlessness in hospice patients

Restlessness and agitation are common issues for the terminally ill patient. There are many different terms used to describe restlessness such as terminal anguish, terminal delirium, and terminal agitation. The signs and symptoms of restlessness vary from patient to patient. Common signs include mood changes, yelling, shouting, a desire to want to move, and non-purpose motor function. The best way to treat restlessness is to first identify possible physical sources such as pain, constipation, nausea, vomiting, dehydration, metabolic disturbances, withdrawal from nicotine, opioids, or benzodiazepines. Non pharmacological treatments such as cognitive activity, relaxation, breathing exercises, counseling, emotional support, reorientation, and reducing environmental stimuli for restlessness should always be tried first and in conjunction with pharmacological treatment. There are several treatment options for restlessness and agitation once other causes have been ruled out. Treatment options include antipsychotics, benzodiazepines, barbiturates, and opioids. The medication selected should take into account the patient's allergies and medical conditions. Haldol is considered the treatment of choice for restlessness in terminally ill patients showing greater effectiveness with less side effects than many other medications. The minimal dose of haldol should be initiated and titrated to desired effect or until side effects appear. Note that this is only the case for terminal restless associated with the active dying process.

Haldol has a black box warning of increased mortality in patients with dementia related psychosis. Common side effects include extrapyramidal symptoms, tardive dyskinesia, akathisia, insomnia, anxiety, and drowsiness. Olanzapine and risperidone are alternative options of therapy if haldol is contraindicated. These medications also have a black box warning against use in patients with dementia related psychosis. Similar side effects should be monitored for these treatment options. Other treatment options include lorazepam, propofol, and midazolam.

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Healthy Feet Healthy People!

Healthy feet are essential for healthy aging, yet three out of four people develop foot problems as they age

So, why are healthy feet so important?

- Healthy feet allow activity which, as we know, has numerous benefits such as weight loss; maintaining and improving muscle and bone strength; and improving emotional health.
- Healthy feet allow proper foot and body mechanics which help prevent falls in seniors. Falls are a major cause of disability in seniors.
- Proper foot care can alert people to early signs of other more serious health issues such as diabetes or poor circulation, or cancer (irregular moles/growths on bottom of foot).

Many people can manage their own foot care as they age. If physically able to do so, here are some tips to keep your feet healthy:

- Observe feet daily for any open areas, blisters or swelling. Use a mirror to observe if you have difficulty seeing them.
- Wash and dry feet everyday with warm water, especially between the toes.
- Apply moisturizer to the feet each day, but avoid placing in between the toes.
- Wear clean socks, avoiding ridges or elastics at the top which can restrict proper circulation
- Wear comfortable, supportive, properly fitting footwear. If diabetic, check shoes for foreign objects and ensure they fit properly.

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Mission Statement:
ICP is committed to exceeding our customers' and employees' expectations through quality health-care service, continuous education, and effective communication.

Tramadol becomes a Controlled Substance on September 1st

Effective September 1, 2014, tramadol and products containing tramadol will be classified as Schedule IV controlled substances in the state of Ohio, pursuant to Ohio Administrative Code 4729-11-03.

In order to ensure compliance with state and federal controlled substance requirements, the Ohio State Board of Pharmacy advises that health care professionals adhere to the following requirements:

- All prescriptions for tramadol and products containing tramadol must be treated as controlled substance prescriptions on and after September 1, 2014. This means they must be signed by the prescriber or issued verbally by the prescriber or the prescriber's appointed agent.
- Tramadol must be packaged and stored securely as a controlled substance.
- Proof-of-use sheets must be maintained and a physical count of tramadol products must be conducted at each change of shift.

In order to ensure compliance with state and federal controlled substance requirements, the Ohio State Board of Pharmacy encourages all pharmacists to read and follow the D.E.A. requirements for controlled substances before accepting or prescribing tramadol or any other product containing tramadol.

ICP pharmacy is committed to ensuring your organization's compliance with state and federal controlled substance requirements. If you have any questions or need additional assistance, please call contact ICP at 800-228-8278.