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Stop the Rash...Preventing IAD

By Irene Sours, RN, WCC

Incontinence-associated dermatitis (IAD) is a prevalent complication of incontinence that compromises skin integrity, predisposes to cutaneous infection, and increases pressure ulcer risk. IAD is an inflammation of the skin as a result of chronic or repeated exposure to urine or feces. Reported IAD incidence rates in long-term care settings vary from 3.4% to 25% and up to 65% in the presence of double incontinence, urine and stool.

Clinical manifestations includes erythema, edema, maceration, denudation, papular/vesicular formations, erosion of the epidermis and/or dermis, poorly demarcated borders, flaking, crust formation, weeping, development of secondary cutaneous infection and sensations of tenderness, pain burning and itching. Complications occurring form IAD is bacterial (appearing as red scaling areas) or fungal infection (appearing as discreet satellite lesions), pressure ulcers, and severe pain. IAD is not confined to areas over bony prominences. It is usually diffuse, found in skin folds and often falls with the confinement area of a containment garment if worn.

IAD may be due to any combination of the following: increased pH, duration and frequency of moisture exposure, mechanical chafing, cutaneous infection, and presence of other irritants or allergens, degree of chemical/enzymatic activity, co-morbidities, age, nutritional status, cleansing method, and use of occlusive containment devices. The severity of IAD is dependent upon the concentration of the irritant, the degree of skin sensitization and specific microflora present. Skin is normally acidic, with a pH range of 5.5 to 5.9. When feces and urine are mixed together, bacteria in the feces convert urea in the urine to ammonia, which make the skin more alkaline.

Management Considerations of Incontinence-Associated Dermatitis

- Minimize incontinence with scheduled toileting programs.
- Consider using drug therapy to control noninfectious diarrhea.
- Use skin care products that cleanse, moisturize, and protect. Most "pH balanced" (5.0-5.9) perineal skin cleansers are designed to maintain the acid mantle of skin.
- Avoid soap because it is alkaline and causes skin irritation.

- Skin should be cleansed gently avoiding friction and patted dry.
- A variety of skin protectant products are available to shield the skin from moisture, urine and feces. Some skin protectants contain active ingredients designed to promote wound healing (Balsam-Peru, castor oil, trypsin ointment, antifungal, antibacterial agent).
- Barrier pastes should be applied in a thick a layer following each incontinence episode while barrier creams, ointments and sprays may be applied in a thinner layer and be effective. Follow manufactures recommendations.
- Some manufacturers of barrier pastes advice not to remove barrier pastes entirely during cleansing but leave a thin coat and reapply. If needed, mineral oil is a gentle and effective method for removing ointments or pastes.
- Evaluate for use of absorptive products that wick urine and liquid stool away from the skin. Consider using briefs when out of bed and disposable under pads when in bed to minimize moisture and heat trapping.
- Ensure adequate nutrition, hydration, oxygenation and reduce pressure.
- Treat fungal infections with topical antifungal powder or cream.
- Treat bacterial infections with organism specific antibiotic.
- Consider use of devices for incontinence such as fecal containment devices.
- Clean intermittent catheterization.
- Consult wound certified nurse.

Upon admission it is importance to evaluate residents for incontinence and interventions are implemented immediately. Provide supplies at the bedside of each at-risk resident who is incontinent. This provides the staff with the supplies that they need to immediately clean, dry, and protect the resident skin after each episode of incontinence. Provide under-pads that pull the moisture away from the skin and limit the use of disposable briefs or containment garments if at all possible. Provide pre-moistened, disposable barrier wipes to help cleanse, moisturize, deodorize, and protect resident from perineal dermatitis due to incontinence. Being proactive can reduce incidents of incontinence associated dermatitis within your facility.

Feel free to discuss bowel and bladder protocols, as well as cleansing and moisturizing skin routines with your ICP Nurse Consultant at any time.

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Unnecessary Drugs Part 3: Avoiding Citations

Appropriate effective medication regimens are the desired goal for every resident requiring medication therapy. Some words of wisdom from this consultant pharmacist with 24 years of experience... Document, monitor, adjust, document, monitor, adjust, and document some more, then continue to monitor and adjust! As our bodies age and diseases present themselves, our ability to metabolize drugs changes, our ability to tolerate physiologic stress diminishes, and our medication therapy needs to change and adjust too. Optimal therapy offers the desired response without the presence of untoward side effects. Drug interactions while often present, are most often are clinically insignificant. ... But this does not mean that just because the interaction has been dormant for the last 10 years does not mean that the addition of yet another agent is safe. Just because mom has been taking drug x for the last 25 years without any problems does not mean it is safe and the best drug today. Status quo is not the answer.

Going back to the unnecessary drug definition... even if all of the components of the unnecessary drug definition are met on paper, it is possible that a change in resident status could change the appropriateness of therapy. For example... JD has diabetes, HTN, CHF, and dementia with agitation (which is treated with an atypical antipsychotic with a clinical contraindication to attempt further reductions documented). JD suffers a stroke and is paralyzed and no longer can strike out at staff during care. The atypical antipsychotic needs to be addressed despite past failures because it was being used for behavioral disturbances which are no longer present due to a change in status. Similarly after the stroke JD is eating very little and his blood sugars are dropping, of course his insulin dose will be lowered, or perhaps there is a change in cardiac function requiring a change in cardiac medications... the underlying theme... document, monitor, adjust, and repeat as needed.

As noted in part 2 of this series, a common area related to medication related problems arise in changes in level of care... from home to the hospital... to home health... to the hospital... to LTC... or where ever in between... Medication errors and miscommunication of information can and do happen under these circumstances. Assuming that a medication listed as a home medication is actually being used regularly is a mistake. Verification with the community pharmacist can help determine compliance prior to admission and alert the facility of high risk medications which may not have been used regularly at home. More people than not, don't keep a current and accurate medication list. Verification of medication use prior to administration on a routine basis in a LTC facility is critical... in this case, ask questions, document, monitor, adjust, and repeat as needed!

On admission to a LTC facility, a good H&P from the home primary care physician is critical in evaluation of medications for appropriate use. The LTC medical director will not know why drug x is used (particularly if it is being used off label, or has several indications for use). The history is the only way to get this information. Many drugs are started during hospitalization as part of written protocols, and often some of these drugs get ordered at discharge from the hospital. Knowing the hospital protocols will help in evaluation of some of the medications (such as the need for drugs like pepcid or prilosec, sliding scale insulin in a non diabetic or heparin /lovenox in a non surgical patient). Addressing medications not listed as home medications prior to ordering them from the pharmacy can prevent unnecessary costs, decrease drug interactions, and prevent unnecessary drugs from being used. Ask questions, document, monitor, adjust, and repeat as necessary! (This is an underlying theme!)

Monitoring medications with lab tests, nursing assessments, etc play an important role in prevention of unnecessary drug citations. There used to be a document called "Appendix N" which outlined some basic monitoring parameters. Appendix N was created sometime before a lot of today's nursing staff was born. CMS eliminated Appendix N from the documents available to surveyors about 8 years ago because it was so outdated and did not contain any drugs that came to the market in the last 20 years. Without that document, there is little specific guidance for nursing staff. Look to the consultant pharmacist for guidance in the necessary monitoring for medications.

Lastly, it is worthy to mention the Beer's criteria drugs which have been well documented as problematic medications in the older adult. They are so problematic, that CMS incorporated the entire criteria into the survey process with specific guidance for surveyors as to what to look for in persons receiving these medications. Focus on monitoring of the most problematic medications in the older person is a great place to start in identification of medications related problems... ask questions, document, monitor, and adjust!

Zostavax: The Shingle Vaccine

Shingles is a painful infection that is commonly seen among the elderly. It initially presents initially with pain down one side of the body or face. This pain progresses into a red rash that develops into blisters. The blisters proceed to break open and dry into a crust, which usually falls off in two to three weeks. The shingles virus generally infects one nerve. Shingles is caused by the varicella-zoster virus, the same virus that causes chicken pox in children and young adults. Because shingles is caused by a virus, typical antibiotics used against bacterial infections will be of no benefit to treat the outbreak. The only treatments available are antivirals such as acyclovir or valacyclovir. The pain associated with shingles is caused by inflammation of the nerves and it is not muscular or skeletal in nature. Because of this, typical pain relievers, including over the counter medications and narcotic pain relievers may not be effective. Gabapentin is sometimes prescribed for the pain associated with shingles because it relieves nerve associated pain.

While the initial outbreak of shingles is painful and debilitating, the most serious result is the possibly of postherpetic neuralgia. Postherpetic neuralgia is a condition in which the pain associated with the shingles outbreak continues after the rash and blisters have resolved. This pain can range from mild discomfort to severe and debilitating pain. Treatment usually consists of gabapentin. This is more common in the elderly, which is why shingles prevention is important as opposed to treating patients once they have already developed the disease.

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Second Generation Antipsychotics - Better Not Perfect

By now everyone should be aware that surveyors and other healthcare organizations are really targeting those residents receiving antipsychotics. The American Health Care Association and the National Center for Assisted Living have a quality initiative goal of reducing off-label use of antipsychotics by 15% by the end of the year. Their scrutiny of these medications comes with good reason. These medications have many potentially severe adverse effects. However, this article isn't to tell you that antipsychotics should never be used, but it is to make you aware of the differences in adverse effects between the two types of antipsychotics and to bring your attention to some changes in the frequency of monitoring requirements listed in the table below.

Second Generation Antipsychotics (SGAs) have greatly increased our capabilities to care for patients with psychiatric illnesses. SGAs can often allow patients to live a full productive life with as little interference as possible. With the introduction of First Generation Antipsychotics (FGAs) health care professionals were able to treat the positive symptoms of psychosis; however, this came at a great cost with extensive side effects. Even at clinically effective doses FGAs could produce extrapyramidal symptoms such as dystonic reactions, drug-induced parkinsonism, akathisia, and tardive dyskinesia. The extensive side effects of FGAs often led to discontinuation of the treatment due to intolerance of side effects. With the introduction of SGAs an elimination of extrapyramidal symptoms was seen as well as the ability to treat negative symptoms of psychosis such as withdrawal, apathy, and the lack of verbal communication.

The introduction of the SGAs led to higher compliance rates and quality of life. Although the elimination of extrapyramidal symptoms was a huge gain when switching to SGAs they came with metabolic side effects such as dramatic weight gain, diabetes, increased LDL levels, increased triglyceride levels, decreased HDL levels, and diabetic ketoacidosis. While the metabolic side effects are a problem for the entire class often switching between medications in the class may alter the side effect profile for the patient. When switching between SGAs a cross taper should be performed where the original SGA should be gradually discontinued while the SGA is slowly brought to clinical levels. Abrupt discontinuation of Antipsychotics should be avoided.

Due to Second SGAs metabolism side effects creating long lasting cardiovascular effects, close monitoring of the following parameters is suggested:

Measure	Baseline	4-weeks	8-weeks	12-weeks	Annually
Personal/family history of Diabetes and Hyperlipidemia	X				X
Body Mass Index (BMI)	X	X	X	X	X
Waist circumference	X				X
Blood pressure	X			X	X
Fasting blood glucose	X			X	X
Fasting lipid profile	X			X	X

(Magellan Health Services. Second Generation Antipsychotic Tip Sheet. N.p.: Magellan Health Services, 12/11. Essential Tools for Atypical Antipsychotics Monitoring. Independence, Dec. 2011. Web. 19 Sept. 2012.)

These monitoring parameters can be used more frequently in patients who are at higher risk of side effect complications. Increased monitoring is seen at the beginning of a SGA regimen for early detection of side effects. Once a patient is stable on a SGA and is not at risk from the side effects monitoring should be decreased in frequency as seen above.

SGAs are very valuable despite their side effects and need for monitoring. With the use of SGAs expanding the need for appropriate monitoring expands with it. As with all medications, the risks and benefits of therapy should be weighed before making a change to a medication regimen. Increased awareness of SGAs and their possible side effects should lead to an increase in the quality of care and quality of life provided to these patients.

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education, and effective
communication.*

Vaccine - from Page 2

Zostavax is the brand name for the vaccine used to prevent the occurrence of shingles. It is indicated for the prevention of shingles in patients over the age of 50. The Centers for Disease Control (CDC) currently recommends all patients over the age of 60, who have not yet received the zoster vaccine and who are not contraindicated for its use, should receive Zostavax. Patients who would be considered contraindicated include, those who have a decrease immune system, patients receiving immunosuppressant therapy including high dose steroids, or any other patients whose immune system is compromised, such as patients with HIV or leukemia.

Zostavax needs to only be administered one time in patients over 60 years of age. It is injected subcutaneously in the upper deltoid region of the arm. Zostavax should be stored between -58°F to 5°F, meaning it should be kept in the freezer. Zostavax is provided as a powder, meaning it must be reconstituted. The diluent provided should be stored at either room temperature or in the refrigerator. To reconstitute Zostavax, all of the diluent should be brought into a syringe and then injected into the vial of powdered vaccine. The vaccine should then be gently mixed, not shaken, until all the vaccine has been dissolved. The vaccine can then be administered to the patient.

In conclusion, Shingles is an infection caused by the same virus that causes chicken pox. In the elderly it can cause painful postherpetic neuralgia that can be severe and debilitating. Because of this all patients over the age of 60 who are not contraindicated for that administration of Zostavax, should receive the vaccine.

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