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Autumn Is In The Air... So Is Influenza

By Mary Burkart, RN, ICP Nurse Coordinator

The leaves are starting to change colors. Morning air is cool & crisp. Football fans are sporting their team colors. Autumn is here! Unfortunately, autumn is the harbinger of flu season.

Influenza is a respiratory-borne viral illness causing acute symptoms in a variety of people. The very young and elderly are most at risk, as are those with chronic illnesses. Caregivers in the long-term care industry are very in-tune to the fragile health of many of our residents and want to protect them by preventing additional illnesses.

Since the 2012-2013 Influenza vaccine is available from many manufacturers now, the Centers for Disease Control (CDC) recommend administering flu vaccines (flu shots), even before the flu season historically begins (October). It can take up to 2 weeks to gain full antibody protection from the flu vaccine.

The World Health Organization (WHO) & CDC work with organizations around the world to determine the best combination of strains for the annual vaccine. The 2012-2013 vaccine contains different strains than last year due to antigen shift, the frequent mutation of the influenza virus.

Since the early 1980's, flu vaccines have been trivalent-meaning they contain 3 components. On February 23, 2012 the WHO recommended that the Northern Hemisphere's 2012-2013 seasonal influenza vaccine be made from the following three vaccine viruses:

- an A/California/7/2009 (H1N1)pdm09-like virus;
- an A/Victoria/361/2011 (H3N2)-like virus;
- a B/Wisconsin/1/2010-like virus (from the B/Yamagata lineage of viruses).

While the H1N1 virus used to make the 2012-2013 flu vaccine is the same virus that was included in the 2011-2012 vaccine, the recommended influenza H3N2 and B vaccine viruses are different from those in the 2011-2012 influenza vaccine for the Northern Hemisphere. (http://www.cdc.gov/flu/about/season/vaccine-selection.htm)

In the US, the Food & Drug Administration (FDA) determines which viruses will be used in the US-licensed vaccine and informs the manufacturers of that decision.

WHO & CDC, along with other world organizations, are very adept at predicting which strains of the flu virus are most likely to spread. Eighteen of the last Twenty-two annual influenza vaccinations have corresponded to the spreading strains.

WHO & CDC recommend vaccinating everyone six months of age & over, especially those with chronic illnesses such as diabetes, COPD, asthma, cardiovascular disease, cerebral vascular disease, etc. and anyone living with or caring for those at high risk. An annual vaccine is required to provide protection from the currently spreading strains. It's also shown that antibody protection declines over a period of time.

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Unnecessary Drugs: Part 2:
Situations in which an unnecessary drug citation could be given:

This article will incorporate 2 examples for each component of the unnecessary drug definition

There must be a diagnosis / reason for use in the clinical record:

a) Flomax is prescribed in an elderly female resident. Flomax is an alpha blocker whose primary use is in helping with urinary flow in men with BPH. Only men get BPH. This is a potential red flag during the survey process. There is some limited off label use of Flomax for bladder outlet obstruction, and in the case of kidney stones. It might be prescribed off label for this indication in women. For Flomax to be used in a women there would need to be evidence of bladder outlet obstruction or kidney stones, without this documented, Flomax could be considered an unnecessary drug.

b) 82 year old female admitted from hospital after bowel surgery. Sliding scale insulin is ordered with finger sticks AC and HS. There is not a diagnosis of diabetes, and the resident is not receiving any steroid therapy. Finger sticks are consistently below threshold for administration of the insulin; again, there is no diagnosis of diabetes or insulin resistance. Often in hospitals, tight glycemic control is used to help decrease infections and help with healing. In this case the order was not discontinued at discharge. Whether the insulin is administered or not, a supportive diagnosis is needed, and should be requested of the physician, or the order should be discontinued.

Hospitals often add insulin, GI stress ulcer protection (pepcid, prilosec, etc), DVT prophylaxis (with sq heparin or lovenox) as part of hospital protocols. Close attention should be given with medication reconciliation on admission to facilities to eliminate medications that were added during the hospitalization for acute treatment that may not be needed long term. If there is not a new diagnosis at discharge, and the medication was not listed as a home medication prior to hospitalization, thought should be given as to the need for continued therapy, or a diagnosis should be obtained for continued use.

There must be adequate monitoring in place for the drug (labs, assessments, side effects)

Something as simple as checking pulse and blood pressure on a regular basis can help meet these criteria for some medications. Lab monitoring (as recommended by prescribing guidelines) should be employed when appropriate, AIMS / DISCUS assessments can help to monitor for side effects from antipsychotics. A sleep log could be helpful in evaluating hypnotic usage (and the need to continue therapy).

a) Amiodarone is ordered for a resident with atrial fibrillation. Amiodarone can be an effective therapy to manage difficult arrhythmias; however it does come with a host of potential problems. Monitoring is critical and important to long term use. Recommended monitoring includes regular ECG, watching for lethargy, edema of the hands / feet, pulmonary function tests, potassium and magnesium levels, and TSH being among the most important items to monitor. Failure to monitor adequately offers many opportunities for an unnecessary drug citation with this medication!

b) The antipsychotic Zyprexa (Olanzepine) is ordered for treatment of schizophrenia. Monitoring needed to prevent an unnecessary drug citation in this case would need to include a yearly lipid panel, a yearly fasting blood sugar reading, and AIMS assessment (to monitor for EPS) at a minimum. Missing any one of these monitoring tools could lead to an unnecessary drug citation.

There must not be side effects present which cause harm or additional drugs to be added to medication regimen

a) Elavil (amitriptyline) 100mg hs is ordered on admission, family reports it is used for sleep. Within the first week of admission, miralax and docusate are ordered for constipation, the following week senna is added along with ditropan as occasional incontinence had developed. There are now 3 new medications added to the regimen in 2 weeks, all of which are caused by side effects of amitriptyline. On inquiry by a consultant pharmacist, it turned out that the amitriptyline was only used PRN at home, and with daily use significant side effects developed. Monitoring bowel movements is one way that medications with potent anticholinergic side effects (dry eyes, dry mouth, urinary retention, and constipation) can be monitored. The above combination of medications now includes 4 unnecessary drugs!

b) Chantix is ordered in a schizophrenic resident with severe pulmonary disease. The pulmonologist refuses to continue treatment if the resident does not quit smoking. After starting Chantix, the resident continues to smoke 8 cigarettes daily, and has increased agitation leading to increasing doses of psychoactive medications. Chantix in this case is an unnecessary drug because it is causing psychiatric instability due to a drug interaction, excess caffeine exposure (not to mention a lack of efficacy). Monitoring behavioral / mood changes, particularly in a person with psychiatric illness is paramount during Chantix use, side effects can be magnified due to excess nicotine exposure if smoking continues during Chantix therapy (beyond the starter pack).

The dose should be in an acceptable range (neither too high nor too low)

a) Seroquel was originally ordered for delirium during an acute medical illness in the hospital. On admission to a long term care facility, the Seroquel was continued at 100mg hs. Over the course of the next 10 months, Seroquel was successfully reduced to 25mg 3 times per week. Continuing Seroquel at this dose (despite the fact that gradual dose reductions have been completed successfully) presents as a potentially unnecessary drug because there is not a dosing regimen in literature to support using the medication 3 times per week. In this case, the dose is too low, and the medications could be considered unnecessary. It would be acceptable to use this dose with a stop date in a titration to D/C the medications, however in the absence of this plan, it could be considered unnecessary.

b) Pepcid 40mg bid is ordered for GERD in an 88 yof who also has dementia with behavioral disturbance. Estimated creatinine clearance in this case was 21ml/min. Dosing guidelines for pepcid recommend decreasing the dose by 50% or increasing the interval to every 36-48 hours. The recommended dose for GERD is 20mg bid, reduced by 50% due to renal dysfunction reduces the dose to 10mg bid or 20mg once daily. Continuing long term at 40mg bid could lead to a survey citation for excessive dose. Higher doses in the frail elderly can increase behavioral disturbances, and if present in this case could lead to a second citation under unnecessary drugs due to the presence of side effects. If symptoms cannot be controlled with the lower dose, alternate therapy should be considered (prilosec or another proton pump inhibitor for example)

There must not be duplications of therapy (2 drugs with the same mechanism of action)

This part of the definition can get tricky, and the pharmacy can be helpful in evaluating this. The same class of medications does not necessarily mean the same mechanism of action. This is another opportunity to pay careful attention to medication reconciliation during transitions in care settings. Hospitals often use therapeutic substitutions causing duplicate therapy on discharge.

a) Bumex 2mg bid and Lasix 40mg at lunch are ordered for edema. Bumex and Lasix are both loop diuretics and there is no reason to use them together. In this case, if bumex is not effective in producing adequate diuresis, then the dose should be increased, or a second diuretic with a different mechanism of action should be ordered to replace the Lasix.
b) Flomax is ordered for BPH in an 89 yom during a recent hospitalization. On arrival at a LTC facility, orders were written to continue home medications per medication list. Hytrin 1mg hs was added to regimen. Hytrin is listed as an antihypertensive agent, however it can also be used for BPH symptoms, and at the dose and regimen ordered, it was ordered for BPH. Both medications are alpha blockers, and this would be considered a duplication of therapy. If Hytrin was ordered for hypertension, it would also work for BPH and in that case the Flomax could be discontinued.

The duration of therapy should be acceptable (not excessive)

Medications ordered to manage acute illness often get ordered without a stop date, in which case the orders continue indefinitely in the LTC setting. Using stop dates helps significantly in decreasing excessive duration medications.

a) Claritin 10mg daily is added to a medication regimen for allergic rhinitis during hay fever season. Claritin should be discontinued after the first hard frost when the dust / pollen have diminished. Continuing indefinitely is unnecessary in this case.
b) Heparin 5000 units sq every 8 hours was ordered at hospital discharge without a stop date. 3 weeks into the LTC stay, the consultant pharmacist questions the need for long term DVT prophylaxis in a resident who is ambulating to physical therapy sessions. If long term anticoagulation is needed, oral therapy should be recommended unless there are contraindications to such therapy.

For residents receiving psychotropic drugs for behavioral disturbances associated with dementia, an attempt to reduce / discontinue the psychotropics are attempted unless clinically contraindicated.

This part of the definition is a little less cloudy; however it still raises questions in some cases. Dose reductions must be attempted unless clinically contraindicated.

a) JD is a 92 year old male with end stage Parkinson's disease with dementia. Seroquel 25mg tid is ordered for hallucinations related to the Parkinson's disease (hallucinations are well known to occur in Parkinson's disease) shortly after admission to a LTC facility. Appropriate monitoring (FBS, Lipids, AIMS assessment) is in place. After 3 months there are still documented hallucinations and the Seroquel dose was increased to 50mg tid . Shortly after the dose increase the hallucinations diminish significantly. After 3 more months the hallucinations are absent. It would be appropriate to attempt to reduce the Seroquel dose in this case. A possible reduction regimen would be to decrease the dose to 50mg bid. If the hallucinations did not return, a second reduction should be attempted in the next couple of months. If at any point the hallucination return, the prior dose would be considered the lowest effective dose at that time. Additional attempts could be attempted again after if a hallucination free period presented clinically again. Attempts at reduction with immediate return of symptoms could be used to document clinical contraindication to further reduction attempts (unless the resident experiences a significant change in status which alters physical symptoms) at which time the reduction process should be attempted again.
b) Ativan 0.5mg tid prn increased agitation / anxiety is ordered in an 88 year old female with end stage dementia and lifelong anxiety disorder (for which she has take Lexapro 10mg daily for years). Nursing and social service documentation has no mention of any episodes of anxiety / agitation. Review of MAR shows 22 doses administered during the previous month. Each dose of medication should be matched with a non pharmacologic intervention attempt prior to use. If the medication is used, the outcome of the intervention should also be documented. Failure to complete the documentation and non pharmacologic interventions attempted could lead to an unnecessary drug citation.

The above examples only scratch the surface of the potential opportunities for unnecessary drug citations. The consultant pharmacist can be a tremendous resource in identification of potential unnecessary drug citations. The drug regimen review recommendations help to document identification of potential problems as well as eliminate problems by prompting changes in therapy and monitoring.

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Influenza

Even in the event the vaccine does not match the strains seen in the community, the flu vaccine offers some protection against the flu.

Flu symptoms appear suddenly. High fever, body aches, fatigue, malaise, cough, and congestion are just a few of the symptoms. Many people describe it as "feeling like I've been run over by a semi". Anti-viral medications can help make the symptoms milder and help you feel better quicker. They can also help prevent complications such as pneumonia.

Other treatments are based on symptoms; antipyretics can help control the high fever; analgesics help with the body aches; frequent rest periods can help the fatigue & malaise; and maintaining good hydration can help thin the mucous, thereby relieving congestion.

Secondary bacterial infections are a serious complication of influenza. As the flu virus weakens the body's defenses, pathogenic bacteria start to multiply. It's not unusual for someone with the flu to later develop pneumonia. The elderly & fragile patients in long-term care may not recover from these illnesses.

MDS 3.0 manual states, "The Influenza season varies annually. Information about current Influenza season can be obtained by accessing the CDC Seasonal Influenza (Flu) website. This website provides information on Influenza activity and has an interactive map that shows geographic spread of Influenza: http://www.cdc.gov/flu/weekly/fluactivitysurv.htm and http://www.cdc.gov/flu/weekly/usmap.htm . Facilities can also contact their local health department website for their local Influenza surveillance information. The Influenza season ends when Influenza is no longer active in your geographic area. Once the influenza vaccination has been administered to a resident for the current influenza season, this value is carried forward until the new influenza season begins." There are no difinitive dates for administering the vaccine, i.e. October 1 to May 1. LTCF's must continue to give flu shots until influenza is no longer active in your geographical area.

While the flu vaccine is the best way to prevent the spread of influenza, other common infection control practices can help as well. Handwashing continues to be vital, especially after coughing, sneezing or blowing a nose. Isolating people who are ill can also help, especially if symptoms seem to be on one particular floor or unit. Asking visitors to wear a mask may also help prevent the spread of the flu. Encourage your residents and staff to get the flu shot and watch for signs of the flu.

The beauty of autumn should be enjoyed by all; so let's prevent the flu!