September 2015

ICP Consultant Connection

ICP, Inc. • Tiffin, Ohio • Mason, Ohio • Sharpsville, Pennsylvania

Partnership to Improve Dementia Care in Nursing Homes:

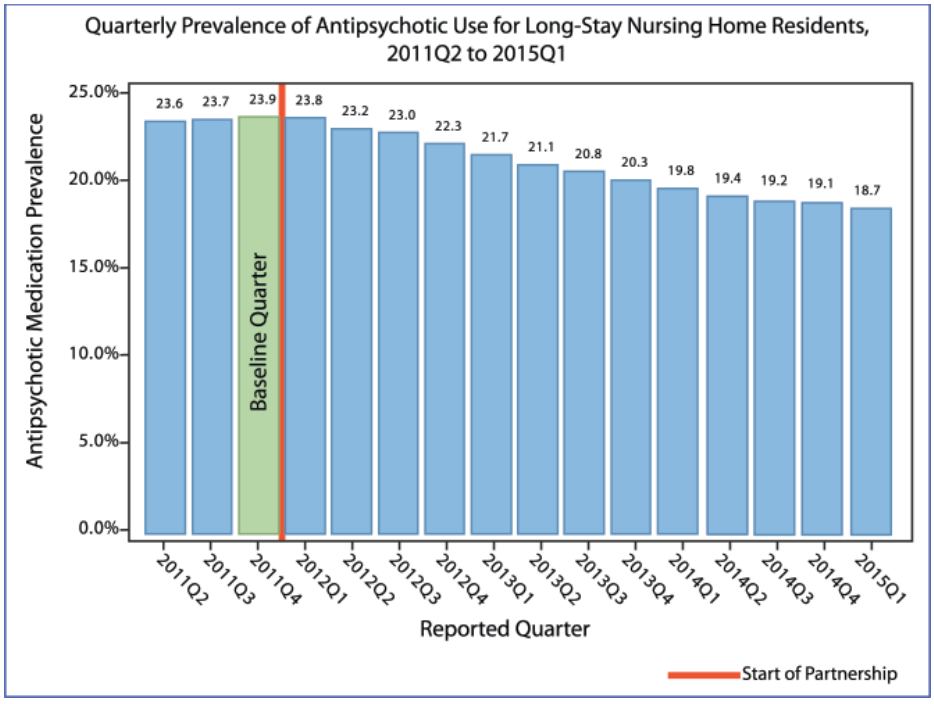
Antipsychotic Drug use in Nursing Homes Trend Update

Todd Harris RPh, CGP, Director of Consulting Pharmacy and the National Partnership to Improve Dementia Care August 2015 News Release

In 2012, CMS launched the National Partnership to Improve Dementia Care in Nursing Homes with the mission to improve quality of care for nursing home residents living with dementia. This Partnership, that includes federal and state agencies, nursing homes, pharmacy providers, advocacy groups and caregivers, continues to focus on the delivery of health care that is person-centered, comprehensive and interdisciplinary, in addition to protecting residents from being prescribed antipsychotic medications unless there is a valid, clinical indication and a systematic process to evaluate each individual.

CMS is tracking the progress of the Partnership by reviewing publicly reported measures. The official measure of the Partnership is the percentage of long-stay nursing home residents who are receiving an antipsychotic medication, excluding those residents diagnosed with schizophrenia, Huntington's Disease or Tourette's Syndrome. In 2011Q4 23.9% of long-stay nursing home residents were receiving an antipsychotic medication; since then there has been a decrease of 21.7% to a national prevalence of 18.7% in 2015Q1. Success has varied by state and CMS region, with some states and regions having seen a reduction of greater than 20%. A three-quarter measure is posted to the Nursing Home Compare website at www.medicare.gov/nursinghomecompare. The long-stay measure on Nursing Home Compare, is the exact same measure as below, except each facility's score is averaged over the last three quarters in order to give consumers information on the past history of each facility. For more information on the National Partnership to Improve Dementia Care, please see https://www.nhqualitycampaign.org/dementiaCare.aspx.

Antipsychotic use has long been a primary focus of ICP consultants to ensure that medications are being used appropriately and at the lowest effective dose. ICP pharmacists have been able to make a large impact on our facilities' overall antipsychotic use through education, procedure changes within the facility, and intervention documentation. Many of our facilities have been able to significantly reduce their prevalence of antipsychotic use - over 65% in some cases. This focus has become even more important recently since each facility's antipsychotic use is now part of their quality measures and their 5-Star rating. As CMS continues to evaluate antipsychotic use and revises regulations, our consultants will continue to work with our customers to help them meet their goals.



Contents

FDA Strengthens Warning That Non-Aspirin NSAIDs Can Cause Heart Attacks or Strokes

Source: FDA; July 9, 2015.

Changes Apply To Both Prescription and Over The Counter Drugs

The FDA is strengthening an existing label warning that non-aspirin nonsteroidal anti-inflammatory drugs (NSAIDs) increase the chance of a heart attack or stroke. Based on a review of new safety information, the agency is requiring updates to the drug labels of all prescription NSAIDs.

NSAIDs are widely used to treat pain and fever from many different long- and short-term medical conditions, such as arthritis, menstrual cramps, headaches, colds, and the flu. Examples include ibuprofen, naproxen, diclofenac, and celecoxib.

The risk of heart attack and stroke with NSAIDs, either of which can lead to death, was first described in 2005 in the Boxed Warning and Warnings and Precautions sections of the prescription drug labels. Since then, the FDA has reviewed new safety information on prescription and non-prescription NSAIDs, including observational studies, a large combined analysis of clinical trials, and other scientific publications. These studies were also discussed at a joint meeting of the FDA's Arthritis Advisory Committee and the Drug Safety and Risk Management Advisory Committee, held in February 2014.

Based on the FDA's review and the advisory committees' recommendations, prescription NSAID labels will be revised to reflect the following information:

- The risk of heart attack or stroke can occur as early as the first weeks of using an NSAID. The risk may increase with longer use of the NSAID.
- The risk appears greater at higher doses.
- It was previously thought that all NSAIDs may have a similar risk. Newer information makes it less clear that the risk for heart attack or stroke is similar for all NSAIDs; however, this newer information is not sufficient for the FDA to determine that the risk of any particular NSAID is definitely higher or lower than that of any other particular NSAID.
- NSAIDs can increase the risk of heart attack or stroke in patients with or without heart disease or risk factors for heart disease. A large number of studies support this finding, with varying estimates of how much the risk is increased, depending on the drugs and the doses studied.
- In general, patients with heart disease or risk factors for it have a greater likelihood of heart attack or stroke after NSAID use than have patients without these risk factors because they have a higher risk at baseline.
- Patients treated with NSAIDs after a first heart attack were more likely to die during the first year after the heart attack compared with patients who were not treated with NSAIDs after their first heart attack.
- There is also an increased risk of heart failure with NSAID use

The FDA will request similar updates to the existing heart attack and stroke risk information in the Drug Facts labels of over-the-counter non-aspirin NSAIDs. In addition, the format and language contained throughout the labels of prescription NSAIDs will be updated to reflect the newest information available about the NSAID class.

At risk: Obstructive sleep apnea patients

From The Joint Commission Quick Safety – Issue Fourteen, June 2015

Obstructive sleep apnea (OSA) is a common sleep-related breathing disorder characterized by repetitive, periodic, partial or complete obstruction of the upper airway during sleep, with periods of breathing cessation lasting for more than 10 seconds. OSA occurs in both adults and children, and patients with OSA can experience complications when receiving sedatives, such as opioid analgesia or general anesthesia. These medications "diminish the protective arousal reflex triggered by bouts of hypoxia, thereby increasing the risk of prolonged periods of apnea and respiratory arrest." Sedatives and narcotics can decrease pharyngeal muscle tone, "which can worsen existing OSA and increase upper airway resistance."[1]

The Joint Commission has received 61 sentinel event reports in which the patient was diagnosed with or suspected of having OSA. OSA may have been a contributing factor in some of these cases, however, the nature of OSA presents difficulties in directly associating OSA with the patient's death or injury. OSA is associated with numerous comorbidities, such as diabetes, hypertension, stroke, heart failure and coronary artery disease.[1] The risk factors for OSA are included in the box at the right.

OSA affects approximately one of four adults in the United States. Approximately 90 percent of people go undiagnosed.[2]

A common chronic disorder that requires lifelong care, OSA symptoms include:

- Snoring, restlessness or resuscitative snorts during sleep
- Respiratory efforts during arousals from sleep
- Daytime symptoms due to disrupted sleep, such as sleepiness, fatigue or poor concentration

Risk factors for OSA

- Obesity (BMI>35)
- Male gender
- Advancing age
- Craniofacial or upper airway soft tissue abnormalities
- Smoking
- Congestive heart failure
- Atrial fibrillation
- Nasal congestion
- Menopause
- Family history

Source: Strohl,KP, overview of obstructive sleep apnea in adults. Up To Date, 2015, WoltersKluwer (accessed May 20, 2015)

Staff in The Joint Commission's Division of Healthcare Improvement cites the following concerns regarding OSA:

- Lack of training for health care professionals to screen for and recognize OSA
- Failure to assess patients for OSA
- Lack of guidelines for the care and treatment of individuals at risk for, and those diagnosed with, OSA[1]
- Failure to implement appropriate monitoring of patients with risk factors associated with OSA
- Lack of communication among health care providers regarding patients with OSA or potential risk factors associated with OSA
- Lack of postoperative evaluation and treatment for OSA

Safety Actions to Consider:

- Screen and identify any patient suspected of having OSA. Appropriate screening would minimize the number of undiagnosed patients who present for surgery, and allow them to get the additional care and therapy they may need.
- Evaluate the patient's plan of care to ensure all precautions are taken while in your facility. Some aspects of care to consider include:
  - Assessing the use of sedating medications and narcotics
  - Continuous pulse oximetry monitoring of the patient in an observed environment
  - Use of supplemental oxygen or positive airway pressure device
  - Patient positioning

1. Academic Medical Center | Patient Safety Organization. Patient Safety Alert: Obstructive sleep apnea – management considerations, Issue 19, December 2013
2. Shear TC, et al. Risk of sleep apnea in hospitalized older patients. Journal of Clinical Sleep Medicine, 2014;10(10)

ICP INSTITUTIONAL Care Pharmacy™
1815 West County Road 54 Tiffin, Ohio 44883

PRSRT STD
U.S. POSTAGE
PAID
Tiffin, OH
PERMIT No. 52

LeadingAge™ Ohio

The Advocate of Not-For-Profit Services For Older Ohioans

OHCA / OCAL / OCDD CHAMPION Partners Club Member

Web: www.icppharm.com
email: icp@icppharm.com

Tiffin Main Line: 800.228.8278

Tiffin Pharmacy: 877.447.5539
Fax: 800.325.9826

Business Office: 800.252.1679
Fax: 800.338.8593

Medical Supplies: 877.228.8278
Fax: 800.208.6809

ICP Southern Region: 866.544.5433
Fax: 513.573.9628

PA Pharmacy: 888.203.8965
Fax: 888.431.4924

Pharmacy Services:
Subacute Care
Long Term Care
Assisted Living
Alternative Living
Correctional Facilities

Consulting Services:
Consultant Pharmacists
Nurse Consultants
Respiratory Therapists
Medical Record Experts
Reimbursement Authorities
MDS Specialists
Wound Care Certified Consultants

Additional Services:
Respiratory Equipment and Supplies
Medicare Part B Billing
Inventory Bar Coding Program
Enteral / Nutritional Program
Medical Supplies
Incontinence Products
Wound Care Products

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

National Alert on Potentially Fatal Dosing Due to Measurement Devices

Recently, a fatal event was reported to the Institute for Safe Medication Practices (ISMP) National Medication Errors Reporting Program in which a nurse confused dosing scales printed on a dosing cup. According to this report by the National Alert Network (NAN), the nurse mistook a dosing cup that measured drams for milliliters (mL), resulting in a fatal dose being administered to the patient. Many organizations support the adoption of the metric system for prescribing and dosing of liquid medications; however, it is still commonplace to find that the dosing instruments utilized and available are still using measurements in drams and household measurements (e.g. teaspoon, tablespoon). Drams are no longer widely used by healthcare professionals, and create confusion and potential for error when utilized in any patient setting.

The report advises healthcare professionals to talk with their vendors about the measuring devices available and work towards getting these devices in mL only, as well as recommending the device has the measurement scales printed instead of embossed for easier reading. In addition, the report recommends the use of oral syringes that measure only in mL be used with oral liquid medications whenever possible, to make sure the proper dose is administered. According to a proposed change in United States Pharmacopeial Convention (USP) General Chapter <17>, it will be required to provide the patient or caregiver with an appropriate dosing instrument to accurately measure and administer oral liquid medications. These devices should have graduations that "shall be legible and indelible, and the associated volume markings shall be in metric units and limited to a single measurement scale that corresponds with the dose instructions on the prescription container label.

In order to prevent harm to patients, extra caution should be taken with oral liquid medications to prevent a potential incorrect dosing.

ISMP - Move Toward Full Use of Metric Dosing - http://www.ismp.org/NAN/files/NAN-20150630.pdf