Many assisted living residents are there because they need help managing their medications, and some senior living providers are moving toward electronic recordkeeping for medication administration in an effort to become more efficient and improve their care continuum partnership profile.

PharmaCare “interfaces” with many eMAR software products and we are able to download the medications into the facility’s database for the assisted living residents. When asking our customers that have transferred to using eMARs they agree that there are certainly considerations and potential hurdles to face, but the outcome is ultimately “worth it.”

Healthcare reform goals include reducing paperwork, administrative costs, and hospital readmissions. Using eMARs can help with this. Electronic recordkeeping can also reduce medical errors and improve quality of care. When assisted living providers begin partnering with electronic recordkeeping for medication administration in an effort to become more efficient and improve their care continuum partnership profile.

Each company considering a transition toward electronic recordkeeping for medication administration in an effort to become more efficient and improve their care continuum partnership profile.

Electronic recordkeeping needs to figure out what it is that they’re looking for as they begin shopping around. Things to consider include:

• Using eMARs requires having computers on each medication cart—primary and backup.
• What are the community’s wireless capabilities, if choosing an Internet-based (versus server-based) system? Are there “dead zones”?
• Is it possible to customize a program to fit a particular community?
• Who will provide both initial and ongoing training (for new hires or software updates)?
• Does the facility want bi-directional information, pharmacy to facility and facility to pharmacy?

When choosing an eMAR software, think about system reliability - how long has it been in use? - along with how quickly it can be implemented, the extent of its mobile access (for tablets or smartphones, for example) and its remote reporting capabilities. Once a system is chosen, there are still more things to consider and do in the days, weeks, and months prior to implementation and roll-out. This includes meeting with the pharmaceutical partner to confirm the process for entering orders into the eMAR database.

There needs to be “buy-in” from the administration down to those who will use it on a daily basis. The eMAR is a tool, but if you’re not using it properly it’s not going to do what it was intended to do. Tools are only as good as the people using them, it’s important to make sure staff understands the goals associated with implementing a system.

— Jill Ashenfelter, RN, CPhT, Assisted Living Account Manager

We are dedicated to serving your facility, its staff, and its residents with the best pharmacy service possible. If you have any questions or concerns, please contact us.

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Amy Sines, PharmD - Clinical Services Manager
Jill Ashenfelter, RN, BC, CPhT - Assisted Living Nurse Mgr
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CLINICAL CORNER - Tramadol CIV

The Drug Enforcement Agency and Department of Justice have decided to place Tramadol into schedule IV of the Controlled Substances Act. The change will become effective for Maryland homes on August 18, 2014. It is already in effect in West Virginia. This scheduling action requires the regulatory controls and administrative, civil, and criminal sanctions applicable to schedule IV controlled substances on persons who handle (manufacture, distribute, dispense, import, engage in research, conduct instructional activities with) or possess or propose to handle tramadol. All LTCF and assisted living facilities will need to obtain an authorized prescription from the physician as you would obtain for other CIV medications (ex: lorazepam, alprazolam, etc). Any questions concerning this new change, please do not hesitate to call.

— Amy Sines, PharmD, Clinical Services Manager
ALTERNATIVE TO ALLERGY SHOTS: Grasitek, Oralair, Ragwitek

Allergy Coverage:
- Grasitek: Timothy grass; the only allergy agent approved for children as young as 5 years old. Should be started at least 12 weeks prior to allergen season.
- Oralair: sweet vernal, orchard, perennial rye, Timothy grass, Kentucky Bluegrass; approved for 10-65 years old. Should be started at least 16 weeks prior to allergen season.
- Ragwitek: short ragweed; approved for 18-65 years old. Should be started at least 12 weeks prior to allergen season.

According to the Centers for Disease Control and Prevention (2012), the national average for hand hygiene compliance among healthcare workers is only approximately 40%. This is a very disturbing statistic considering that hand washing is such a simple procedure to perform. The National Institute of Health has estimated that the annual cost of preventable medical errors is estimated at $17-$29 billion dollars. Healthcare acquired infections (HAIs) are considered preventable medical errors. Every year 2 million patients acquire HAIs annually which is approximately 1 out of every 20 patients. Of these 2 million patients - 90,000 will die!

Clean hands are the single most important factor in reducing the spread of many bacteria and antibiotic resistant strains. Did you know that a single gram of human feces, which is about the weight of a paperclip, can contain one trillion germs? The CDC recommends that healthcare providers should practice hand hygiene at key points in time to disrupt the spread of microorganisms to patients including:

- Before/after patient contact
- Before/after contact with blood, body fluids, or contaminated surfaces (even if gloves are worn)
- Before/after intubation of patient's intact skin (i.e. taking a pulse or blood pressure, physical examinations, lifting the patient in bed)
- Before/after contact with environmental surfaces in the immediate vicinity of patients
- Before invasive procedures
- After removing gloves

The CDC also states that hand washing education in the community:
- Reduces the number of people who get sick with diarrhea by 31%.
- Reduces diarrhea illness in people with weakened immune systems by 38%
- Reduces respiratory illnesses, like colds, in the general population by 21%.

Hand hygiene is a simple thing and it’s the best way to prevent infection and illness. — Karen Metcalfe, RN, BC, LTC Quality Improvement Nurse

Breaking a Costly Cycle – Rehospitalization of Skilled Nursing Patients

There have already been strategies developed to reduce readmission rates in SNF’s. These tools include INTERACT II and LTC Performance Trend Tracker, are already looking at systems and processes to reduce readmission rates. These tools tend to focus on the continuum of care and the transition of care processes. It is a known fact that a smooth and accurate transition in and out of, or between healthcare facilities reduces hospital readmissions. Other suggestions such as the use of nurse practitioners in rates facilities to perform a higher level of patient assessments, access to specialists in the facility, and enhanced quality improvement programs are also being utilized. It will require facilities to begin to look differently at the specialty services they offer, the quality of their staff and the addition of skilled support staff to remain successful – and let us keep in mind, hospitals will be watching very closely. They must learn to evaluate and partner with post-acute care facilities that effectively manage readmissions.

By taking a proactive approach, and starting to look at ways to improve the transition of care in and out of your facility, it will give you the opportunity to improve both patient care, and the relationship with the referring hospital. This will ensure that your facility will continue to be a trusted partner in the region's healthcare.

- Steve Lovrey, PharmD, Director of Pharmacy