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Fentanyl Alert

Since its release in 1990, the fentanyl (Duragesic®) patch has often been in the pharmacy news. Accidental overdose caused by concurrent fever, heating pad use or failure to remove patches when applying new ones, top the list of headline grabbers.

The latest incident is tragically ironic. A two-year old boy died of a fentanyl overdose after returning from a nursing home! His family was visiting his great-grandmother and the boy appeared to have placed a patch inside his mouth.

Upon investigation, fentanyl patches were found in trash pails, on the floor, stuck to bed railings and in other unsecured patient areas throughout the facility. ISMP has issued a warning regarding proper disposal of fentanyl. Patches should always be folded over onto themselves (so no drug imbedded adhesive is exposed) immediately after they are removed. They should then be transported immediately to a secure area, such as a double-locked narcotic cabinet or Stericycle disposal unit. Some facilities have used patches affixed to 8 ½ X 11 sheets (with resident name and date) as proof of proper removal. Sharps containers are not intended for medication disposal and flushing used patches down the toilet (recommended by the FDA) can cause plumbing calamities, so these are not viable options.

Children and pets are frequent visitors to LTC and retirement facilities. Ensure patches are properly disposed of and that dropped tablets or capsules are immediately removed from the floor so a repeat of this tragedy does not occur.

Beers List

In 1991, Dr. Mark Beers, created a list of medications that were potentially hazardous in the elderly. The list has had a tremendous impact on prescribing, and a third update was released recently by the *American Geriatric Society*.

Listed entries are supported by both quality of evidence and strength of recommendation notations. Some of the more significant recommendations include: avoiding sliding scale insulin as it increases the likelihood of hypoglycemia, without improvement in glucose control; avoiding benzodiazepines for the treatment of insomnia, agitation or delirium and avoiding amiodarone and other drugs used for rhythm control as first line agents, as they cause more problems than drugs used for rate control (e.g. B-blockers, Ca channel blockers).

Our consultants had already been making many of these recommendations. They will now reference the *List* directly, because its format is so precise and efficient.

Skin Stuff

We had a wonderful conference day on May 2nd. The presentations kicked off with an entertaining, informative session from Eva Borland of Smith & Nephew.

She started by discussing the staging and treatment of skin tears. The use of steri-strips was discouraged, because they can damage the skin when removed. RNAO Best Practice Guidelines indicate that they should be avoided. Regardless of the dressing product used, great care must be exercised upon removal. She gave a great removal tip. An arrow indicating the direction to be peeled should be drawn on the dressing!

Another pointer that surprised the attendees was the volume of saline required to cleanse a wound. A minimum volume of 100 ml is to be used in most cases. All instruments, dressings and solutions used must be sterile to avoid contamination of the wound.

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