

# The GeriJournal



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## **Narcotic Legislation**

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The Narcotics Safety and Awareness Act (NSAA) came into effect on November 1<sup>st</sup>. The NSAA legislation was designed to provide better accountability at all levels where narcotics are handled. Prescribers, pharmacists and those picking up or receiving delivery of narcotics are all impacted in some way.

The NSAA mandates that prescribers include their College ID# (CPSO) and a patient identification number, most often the Health Card number, on all orders for prescription narcotic and controlled medications. Included in this list are benzodiazepines, such as lorazepam and clonazepam, as well as phenobarbital, Ritalin®, testosterone derivatives and tramadol.

The legislation stipulates that an approved form of identification be provided when these drugs are received. It has been suggested that the current combination of a facility staff signature on the delivery manifest and a proper *Drug Record Book* entry will

satisfy MOHLTC. This remains to be confirmed. With regard to the prescriptions themselves, most facilities affix resident labels from Point Click Care or MED e-care to their physician order sheets. These labels already include the Health Card number and the CPSO number can be added fairly easily.

The NSAA has generated a fair bit of discussion and excitement. Retail pharmacy was the intended target, but if the legislation is interpreted literally, it could be a burden for non-hospital health care facilities, especially with regard to receiving delivery of narcotics. Talks between OLTC, CPSO, OPA and MOHLTC are ongoing and hopefully current procedures will be deemed acceptable.

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## **Take BP Meds at Night**

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Do you work evenings? If so, you may want to stop reading now. A randomized study comparing morning versus evening administration of blood pressure (BP) drugs was recently completed. Patients were followed for roughly five years. One group of the 661 subjects was asked to take all of their BP medications in the morning. In the other group, at least one of the BP meds was to be taken at bedtime.

Remarkably, cardiac events (MI, CHF, angina, stroke, etc.) occurred less than 1/3 as often

in the group that took one BP drug at bedtime. Cardiac deaths were similarly reduced.

All subjects in the trial had chronic kidney disease (CKD) and hypertension. Ambulatory (24-hour) BP was measured annually and shortly after dosage changes. Nocturnal BP was lower in the bedtime group, but overall BP control was also significantly better.

There are several possible reasons for this unexpected benefit. Albumin loss via the urine is an indicator of kidney damage. CKD patients taking protective drugs, such as Diovan®, retain more albumin with HS administration. Also, BP naturally dips at night. “Non-dippers” encounter more CV problems. Those in the HS group would have the advantage of being “dippers”.

The composition of this study group is not unlike that of our LTC population. Changing the administration time of one or more BP meds may be worth considering in some of our residents. Those with cardiac concerns like angina or CHF are most likely to benefit.

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## **Plavix/Pradox**

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Pradox® and Plavix® have been confused due to the similarity of their names and strengths (75 mg). Precautions such as using generic format (clopidogrel, dabigatran) are recommended to prevent error.