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Narcotic Peel-Offs Galore

The narcotic peel-off label on the back of our narcotic cards is a wonderful convenience. It allows you to peel and stick full narcotic ID and quantity information into your count book. You don't have to spend time writing everything down, potentially omitting information and dealing with legibility issues.

Now that we dispense narcotics on a biweekly basis for most of our homes, more than one peel-off label is required per Rx. Our new labels, set to debut in early September, will have three peel-offs.

I realized there are multiple ways the labels can be deployed, so I polled some of our nurses for ideas. There were two common recommendations. The first was to affix both peel-off #1 to the current page of the *Narcotic Count Book* and peel-off #2 to the next page (if the unit has many narcotics and uses two pages in the count book, peel-off #2 is affixed to the page after the next page). Both peel-offs are affixed at the same time. When the card for the first week is finished or when the nurse reaches the bottom of the count book page, they continue on the next page, where the peel-off is already in place waiting for them.

Option #2 is for the night staff to peel-off the second label the night before the end-of-shift count transitions to the next page in the count book. Both options make good sense and nursing staff and management should discuss which option works best in your home.

The third peel-off can be used for PRNs. In this case, the additional peel-offs would be peeled when it is time to document on a new page in the *Narcotic Count Book*.

Monitoring Drug Induced Excess Sedation

Everyone has been scrambling to complete the ISMP *Medication Safety Self-Assessment* before the September 30th deadline. One survey question that regularly earns a "Not Implemented" response is: "Residents receiving medications known to cause sedation (e.g., opioids, benzodiazepine drugs and, antipsychotics) are monitored through an established process to detect unintended advancing sedation, in particular during medication initiation and after dosing changes".

I've discussed this question with several DOCs. All felt that monitoring for excess sedation per shift for one week at the onset of treatment or when a dose is increased would satisfy the MSSA request and be a good safety measure. Since antipsychotic sedation risk is less than that from the other two groups, and some homes already monitor antipsychotics closely, this group will not be included. Please let the nurses know that eMAR will contain a statement to "Monitor for Unintended Advancing Sedation – re *Drug X*". There should be a corresponding notation in the Progress Notes in response to this message.

Iron Tx – Less is More

Low hemoglobin plus low ferritin and MCV (mean corpuscular RBC volume), often results in an Rx for high dose, high frequency iron (Fe) supplementation. We often see orders for fe fumarate 300mg (100mg elemental Fe!) prescribed TID. Several recent studies (*Lancet Haematology*, *Internal Med J*, etc.) show BID, daily or Q2day administration of various iron doses yield the same increases in hemoglobin and ferritin, however, higher doses cause far more GI upset and constipation. Frequent administration of Fe increases levels of hepcidin, a hormone that reduces Fe absorption. Give less iron for better absorption and GI tolerance. Also, the "old-wive's tale" that vitamin C help with Fe absorption is not true!

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