PROBARI

Detecting Patient Care 'Landmines'

A guide with real examples to show the importance of looking beyond the discharge medication list

Search for incorrect orders on the discharge medication list

- **Readmission medication orders based off of outdated/inaccurate 'home medication' list**
  - **Example:** Long stay resident on an antipsychotic had several dose reductions while in facility but following brief hospitalization resident returned with order to continue medication at older high dose due to facility med orders not being updated in hospital records
- **Discharge summary medication list not updated to reflect med changes documented in the discharge provider note**
  - **Example:** A new admission was started on an anticoagulant for treatment of a blood clot; the discharge provider note states to use for a 4 week duration and then stop, however the discharge med list does not reflect a stop date for the anticoagulant medication.

Double-check the lack of or inappropriate indications on the discharge medication list

- **No alert or instructions when medications ordered for off-label use**
  - **Example:** A patient with Huntington's disease was receiving low-dose Lithium as off-label treatment to slow progression of neurological symptoms but also required other psychotropic medications due to mental health issues. On admission the Lithium order was entered with indication of mood stabilization and the provider subsequently increased dose to higher therapeutic dose in response to behavioral expressions following admission.
- **Incorrect indication for discharge medication order**
  - **Example:** A resident with severe lymphedema was admitted on diuretic to reduce lower extremity swelling which was reviewed with the facility physician and the medication was discontinued due to diuretic not being an effective or approved treatment for lymphedema and has potential for negative resident outcomes such as kidney damage, dehydration, etc.

Scan for medication allergy inaccuracies

- **Allergies added per residents report due to side effects that are common with use**
  - **Example:** A resident with several risk factors for infection was admitted with multiple listed antibiotic allergies on the Discharge Summary. On further discussion with the resident it was determined that the reactions experienced by the resident were common side effects from use such as nausea and/or diarrhea
- **Missing or no allergies on the admission records**
  - **Example:** Allergy list discrepancies can easily exist between different hospital health system EHRs so it is important to verify the allergies with the patient or responsible party to identify any allergies that were not entered into transferring hospital's patient record. Many times we have found through our IHIE access that there are missed allergies from previous hospitalizations in different acute care settings.