VOLUME 2 | ISSUE 8

Safety Matters Newsletter HSHS WWD

May 25, 2017

Teamwork, Follow through and Communication to Prevent Complications from Medications

What happened?

Situation:

A patient was re-admitted to the hospital for weakness and multiple falls. During this admission it was discovered the patient had lung injury possibly secondary to amiodarone toxicity.

Background:

The patient was placed on amiodarone with a dose of 400 mg three times a day during a hospital admission four months prior to the readmission. This dosage was continued throughout that hospital stay; the patient was discharged and continued on the same dose until readmission to the hospital four months later. The continued use of amiodarone may have contributed to the lung injury.

What went wrong?

Assessment:

The amiodarone dosage was not tapered after discharge. The discharging provider intended the dose be addressed at the clinic follow up appointment scheduled one week after discharge, but the dose was not addressed at that time. The patient had three ER visits, the first 6 days after discharge and two just before second hospitalization three months later. The high amiodarone dose was not addressed. The dose adjustment was missed at the patient's subsequent clinic appointment as well. These missed opportunities are a classic example of the "Swiss Cheese Model" of system failure.

Amiodarone has several potentially fatal toxicities. According to the Food & Drug Administration, an important toxicity is pulmonary (hypersensitivity pneumonitis or interstitial/alveolar pneumonitis). This has occurred as clinically manifested disease at rates as high as 17 percent in patients with ventricular arrhythmias given doses of around 400 mg daily. Pulmonary toxicity is fatal about 10 percent of the time.

What are we doing?

Recommendation:

Certain medications have a higher risk of serious side effects or complications. When prescribing these types of medications, it is important to make sure that patient follow up is appropriate and completed.

The WWD Readmission Steering Committee is creating a discharge summary template in Epic which contains evidence-based information. This will standardize the information included on the discharge summary and help ensure all pertinent information is included. The template has been created and is currently being tested. The template for discharge summary will be built and loaded into Epic Production as soon as testing is complete.

Every person on the care team (inpatient care, outpatient care, nursing, pharmacy, providers) has a role to be situationally aware and to speak up when something does not seem to be quite right. Speaking up for safety can be the change that closes the hole in one of those slices of Swiss cheese, stopping that failure from occurring.

Contact SafetyMatters@hshs.org with questions or feedback