No one at the nursing facility could ever remember seeing so much blood. Every discussion thereafter seemed to revisit how horrified everyone was when Mary had to be sent to the emergency department (ED). The quality committee asked the facility’s medical director to learn how this unfortunate occurrence could have been avoided and ensure that it would never recur. The resulting investigation found:

Mary, 87, had been living independently at her own home since the death of her husband nearly 10 years ago. Although she had been diagnosed with stable hypertension and elevated cholesterol, she was doing well under the care of her family physician. Three years ago, she had had a transient ischemic episode with a brief hospitalization under the care of a neurologist. No further symptoms were evident thereafter.

Four months ago, Mary had an episode of chest pain without myocardial injury. Evaluation revealed coronary artery obstruction, for which she underwent percutaneous placement of a coronary artery stent.

Back home one evening, Mary took her beloved dog for a walk. Almost back at her house, Mary’s legs became entangled with the leash. Neighbors found her lying at the base of her front porch steps in pain. Medical transport arrived and took her to the ED of the local hospital. There she was diagnosed with a left hip fracture. As her family doctor did not render care in the hospital, she was admitted by the hospitalist on call. She was evaluated and cleared for surgery by her usual cardiologist.

Prior to the open reduction, internal fixation operation to repair the fracture, her aspirin and clopidogrel were stopped to reduce the chance of bleeding. Postoperatively, enoxaparin and warfarin were initiated for prophylaxis.

A smooth postoperative course ensued. As there were no contraindications to transfer, plans were made to transfer Mary to a local skilled nursing facility (SNF) for therapy.

While she was still in the hospital on the day of her transfer (after orders had been already transmitted to the SNF), the cardiologist stopped by to see Mary. Although she was doing well in cardiovascular function, the cardiologist noted that her clopidogrel had not been resumed. He handwrote this drug on the discharge orders to maintain protection of the stent.

At the SNF, the admitting nurse believed the clopidogrel had already been approved by the nursing home’s on-call physician, with other admission orders, so she added clopidogrel to the medication administration record for Mary.

Mary asked her SNF nurse about medications she was to receive, noting that her usual aspirin was not mentioned, insisted that her neurologist be called about it. When reached, the neurologist confirmed the history of a prior transient ischemic episode and indicated that Mary should be on aspirin (325 mg) daily. He did not ask about other medications Mary was taking.

The on-call SNF physician was told of the neurologist’s insistence on the aspirin and approved it without asking what other medications were being administered.

Caring Transitions
By James Lett II, MD, CMD

One Resident, Two Bad Transitions, Many Lessons
With that, Mary was simultaneously, and precariously, on enoxaparin, warfarin, clopidogrel, and aspirin. Fortunately, it seemed, an International Normalized Ratio (INR) test had been ordered for 2 days after her admission to the SNF.

But on that day, Mary had a change in cognition. Although a nurse and a covering physician felt it was probably due to her narcotic pain drugs, Mary’s family asked that she be sent to the ED for evaluation. Since the SNF’s only copy machine was locked in the vacationing director of nurse’s office, no list of current medications was sent to the ED.

The ED physician initiated the standard protocol established for an alteration in mental status. Mary’s evaluation was unremarkable except for leukocyte esterase and a few white blood cells in her urine (but no nitrite). Nevertheless, she was diagnosed with a “urinary tract infection” and returned to the SNF on antibiotics that were ultimately unnecessary.

A prescription for sulfamethoxazole-trimethoprim came with her from the ED, and the SNF’s on-call physician approved it without any discussion of Mary’s current medications. That specific antibiotic is known for a dangerous interaction with warfarin, but the physician never asked and was never told about Mary’s use of this drug. The sulfamethoxazole-trimethoprim was initiated from the facility emergency box.

Another unforeseen consequence of the day at the ED was that the scheduled INR was not done because Mary was gone when the laboratory phlebotomist came through. Two nights later, Mary passed her first black stool just before bedtime, according to a later review of the nursing notes. As her vital signs were stable and Mary appeared fine, nursing decided to only monitor her, and the physician was not notified. By morning, she had passed three more black stools and had begun vomiting bright red blood. Her pulse rose and her blood pressure fell dramatically.

By the time a covering physician was reached, an ambulance had been called and had already arrived on site. The flashing lights, sirens, and presence of copious blood completed a scene that no one at the SNF that evening has been able to forget.

The medical director’s assessment found several points at which this catastrophic intersection of four anti-thrombotic medications, warfarin, and sulfamethoxazole-trimethoprim—which nearly cost Mary her life—could have been avoided. The evaluation highlighted a number of problematic issues:

▶ As in most bad patient transitions, Mary’s two disastrous episodes featured communications gone awry between caregivers and a lack of true medication reconciliation.

▶ The facility should have had policies and procedures and a standard transfer form covering information the SNF must send with any transitioning resident, particularly one going to the ED. (A template for such a policy and appropriate sample forms are available in the AMDA clinical practice guideline “Transitions of Care in the Long-Term Care Continuum” at www.amda.com/tools/clinical/toccpg.pdf.)

▶ At each clinical interaction concerning Mary’s care, significant patient information, particularly regarding medications, was omitted. The facility should have had a standardized communication script such as a Situation-Background-Assessment-Recommendation (SBAR) to ensure adequate information during patient-care calls. (An SBAR tool for transitions is available at http://interact2.net/tools_v3.aspx.)

▶ The attending physician was not notified when laboratory work—the INR—was missed. The facility should have had a policy that missed laboratory work is reported to the attending physician and will be performed at the next possible opportunity, unless the physician wishes to order it done sooner.

▶ There was no real-time physician or staff interaction with the consultant pharmacist or the dispensing pharmacy to review Mary’s drug regimen for potentially dangerous interactions. The facility should have had a policy and procedure for the consultant pharmacist or pharmacy vendor to contact the facility when multiple medications in one therapeutic category are ordered (in this case, enoxaparin, warfarin, aspirin, and clopidogrel).

The facility’s quality committee adopted the recommendations, to be implemented immediately.

A past AMDA president, Dr. Lett chaired the AMDA workgroup that created the clinical practice guideline “Care Transitions in the Long-Term Care Continuum” and currently is chairman of the AMDA Transitions of Care Committee. You can comment on this and other columns at www.caringfortheages.com under “Views.”