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Claim Review

Communication Chaos at Transition of Care

An elderly diabetic patient with dementia is discharged from a hospital to a senior living memory care unit with orders for duplicative doses of diabetes medication leading to severe hypoglycemia, seizures and death.

SPECIALTY	ALLEGATION	PATIENT SAFETY & RISK MANAGEMENT FOCUS
⁄ Psychiatry ⁄ Hospitalist/hospital ⁄ Senior living/ memory care	⁄ Improper treatment and monitoring of diabetes and medication error resulting in death	⁄ Breakdowns in communication at transitions of care ⁄ Medication reconciliation

Breakdowns in communication between a hospital and post-acute care center at transition of care are a frequent cause of patient injury.

Facts of case

Family members found a 75-year-old woman with a history of diabetes and dementia on the floor of her bedroom in an agitated state after an apparent fall. Her family called an ambulance, and she was transferred to the local hospital emergency department (ED) for evaluation. While in the ED, she became combative, exhibited paranoia and was admitted to the psychiatric unit for treatment.

A hospitalist performed the admitting history and physical and wrote admission orders for insulin, as well as orders for glucose monitoring four times a day. The attending psychiatrist wrote orders for Haldol®, Zyprexa and trazodone. In consultation with her family, court commitment proceedings were initiated because an assessment indicated she would be unable to return home due to her paranoia, dementia and cognitive decline.

After four weeks of hospitalization, while waiting on the commitment proceedings, the insulin was discontinued, and an oral antidiabetic medication was added by the hospitalist. After six weeks of hospitalization, her family was able to find her a room in a senior living memory care unit. The discharge summary listed two oral antidiabetic medications, daily glucose monitoring, as well as Haldol and Risperdal®. The discharge summary was electronically signed by the psychiatric attending physician.

Five days after admission to the memory care unit, she was observed exhibiting jerky movements and was unable to hold herself upright in a chair. The care team notified the nurse practitioner on call, and a telephone order was received to adjust her Haldol dosage. Late the next day, she was found unresponsive in her room and EMS was called. She was severely hypoglycemic and was transferred by ambulance to the ED where she was intubated and admitted to the intensive care unit. An MRI showed an ischemic stroke

and her EEG was minimally responsive. Her family elected to have her extubated with palliative comfort care only. She died two weeks later due to an anoxic brain injury from prolonged hypoglycemia and an acute ischemic stroke.

Her family filed a malpractice claim against the psychiatrist and the senior living center alleging improper treatment and monitoring of diabetes and medication errors.

Disposition of case

The malpractice case was settled against the hospital and senior living center.

Patient safety and risk management perspective

The investigation into this case revealed that the woman was receiving two antidiabetic medications in error after being admitted to the memory care unit. She was taking metformin prior to discharge from the hospital, but the discharge orders included both metformin and glimepiride. The root cause analysis could not pinpoint why the glimepiride was listed on the electronic discharge summary and transfer orders.

Because the psychiatrist was listed as the prescribing physician on the discharge summary, the family filed a claim of negligence against him for the medication error. The psychiatrist testified that psychiatric attending physicians manage only the mental health medications and the hospitalists manage the medical condition medications. However, because the patient was on a psychiatric unit, the EHR-generated discharge summary listed the psychiatrist as prescribing the discharge medications. The investigation also revealed some confusion about whether the woman was to have glucose monitoring. The transfer orders included daily glucose monitoring but the memory care admitting nurse did not transcribe those orders onto the care plan.

The experts who reviewed this case were critical of the hospital and psychiatric unit for not having a reliable process to reconcile medications prescribed by multiple clinicians at the time of discharge. The senior living memory care center was criticized for not reconciling transfer medications, not questioning the double antidiabetic medication orders, not recognizing hypoglycemia, and not performing glucose checks as ordered that could have identified the low glucose level before it became severe.

Risk and resident safety solutions

Breakdowns in communication between a hospital and post-acute care center at transition of care are a frequent cause of patient injury, including readmission to the hospital, permanent disability and death.

In our analysis of Constellation professional liability claims involving skilled nursing, assisted living and independent living facilities asserted from 2010 to 2015, improper management of treatment and improper resident monitoring were the second and third most common and costly claims and together represent one-third of all the claims in the analysis. The contributing factors to these claims involved errors in clinical judgment (critical thinking skills), improper monitoring of resident physiologic status, and breakdowns in communication among the care team concerning the resident's condition.

Readmission quality measures for post-acute providers (skilled nursing and home health care) are now in effect. CMS's Skilled Nursing Facility Readmission Measure now affects post-acute provider compliance and business outcomes.

Skilled nursing, senior living, home health and related organizations should have reliable processes to reconcile and communicate medications at transitions of care. The process should include clarification of questionable orders and review for potentially harmful medication interactions or contraindications. Using a team approach and including a pharmacist on the team enables the team to competently evaluate admission, discharge, and transfer medication orders to prevent injury and malpractice claims. Post-acute care organizations should also have a reliable process to identify an acute change of condition in a patient/resident and promptly notify the attending clinician.

Questions for senior leaders

The following questions may help identify the next steps to take to enhance patient/resident safety and minimize risk:

- ☐ Does your organization have a reliable medication reconciliation process, including a pharmacist on the care team?
- ☐ Do you provide education and training to boost care team member critical thinking skills, monitoring skills and recognition of an acute change in condition?
- ☐ Does your organization provide education and training on the use of team communication tools such as SBAR or IPASS?

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