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Pharmacist's Letter
Hospital

Prevent Med Errors at Transitions of Care

Almost half of patients may experience a med error when transferring from the ICU to a non-ICU setting.

Incorporate these strategies to reduce the risk of error.

Stop unnecessary meds. If your EHR allows, sort transfer meds by “order set” to quickly identify meds from ICU sets.

Discontinue antipsychotics started for ICU delirium. Over half of patients have an antipsychotic mistakenly continued at transfer out of the ICU...and after discharge.

Remove pressors and other ICU drips from your patient’s med list...and stop agents left over from mechanical ventilation order sets (sedatives, neuromuscular blocking agents, etc).

Also switch ICU-specific protocols to floor protocols...such as for electrolyte replacement or sliding scale insulin.

Stop stress ulcer prophylaxis. It’s not indicated once ICU patients are stable enough to transfer to the floor...but over one-third of previous ICU patients are discharged on a PPI without an indication.

Reassess VTE prophylaxis. It may need to be stopped in ambulating patients...or added in those with resolving bleeding risks.

Also ask IT if it’s possible to remove “continue all meds” buttons from transfer orders.

Restart necessary meds. Perform med rec at ICU transfer to the floor, even if it was done at admission. About 75% of home meds are stopped on ICU admission. Readdressing may help catch omitted meds.

For example, antiplatelets may be held while ruling out a bleed...or some home oral meds may be held in an NPO patient.

On the other hand, document if a med is intentionally stopped or changed...so it’s not accidentally restarted at discharge.

Double-check dosing. For example, ensure there’s a process to communicate renal adjustments at transfer...and to readjust meds as kidney function changes.

Ensure doses for IV to po switches are correct. For instance, IV doses of levothyroxine are about 50% to 75% of the oral dose.

Use our *Transitions of Care Checklist* for guidance at admission, discharge, and when transferring between facilities.

Key References:

-Tully AP, Hammond DA, Li C, et al. Evaluation of Medication Errors at the Transition of Care From an ICU to Non-ICU Location. Crit Care Med. 2019 Apr;47(4):543-549.
-Rice M, Lear A, Kane-Gill S, et al. Pharmacy Personnel's Involvement in Transitions of Care of Intensive Care Unit Patients: A Systematic Review. J Pharm Pract. 2021 Feb;34(1):117-126.
-Wang Y, Zhang X, Hu X, et al. Evaluation of medication risk at the transition of care: a cross-sectional study of patients from the ICU to the non-ICU setting. BMJ Open. 2022 Apr 15;12(4):e049695.
-Dixit D, Barbarello Andrews L, et al. Descriptive analysis of the unwarranted continuation of antipsychotics for the management of ICU delirium during transitions of care: A multicenter evaluation across New Jersey. Am J Health Syst Pharm. 2021 Jul 22;78(15):1385-1394.
-Palmowski L, von Busch A, Unterberg M, et al. Timely Cessation of Proton Pump Inhibitors in Critically Ill Patients Impacts Morbidity and Mortality: A Propensity Score-Matched Cohort Study. Crit Care Med. 2024 Feb

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