Optimizing Medication Safety 3.1 Draft 4Sep2018

Client:_____ Location:_____

A. ASSESSMENT

1. Demographics

a. Allergies (push/pull from EHR)

b. Active Diagnoses (push/pull from EHR)

Date of Birth:_____(DD/MM/YYYY) Age_____

Most Recent Weight:_____ Scale:_____ Date:_____

Most Recent Height:_____ Method:_____ Date:_____

2. Signs and Symptoms

A. If this is an emergency, take immediate action and notify **PRESCRIBER**.

B. Assessment of possible anti-infective related adverse event observed (select all that apply):

a) ☐ Anaphylaxis
b) ☐ Arrhythmias
c) ☐ Gastrointestinal event
d)☐ Blood disorder
e)☐ Liver disorder
f) ☐ Muscle Pain/Weakness/Myositis
g)☐ Neurological event
h)☐ Renal event
i) ☐ Skin reaction
j) ☐ Other

Only the corresponding section will present to the nurse to provide details of the ADE.

A. Anaphylaxis (Compared to baseline; check all that you observe.)

☐ hives, wheel and flare ☐ labored breathing ☐ shortness of breath ☐ BP< 90/60 mmHg
☐ other

Provide details (including onset of ADE relative to drug administration, actions taken):

Date Observed _____

Client:_____ Location:_____

B. Arrhythmias (Compared to baseline; check all that you observe.)

☐ Fast heart rate ☐ Low blood pressure ☐ unconscious ☐ QTc interval > 500 msec
☐ Palpitations ☐ Dizziness ☐ Syncope (fainting) ☐ other

Provide details (including onset of ADE relative to drug administration, actions taken):

Date Observed _____

C. Gastrointestinal Event (Compared to baseline; check all that you observe.)

☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Abdominal tenderness/pain
☐ Distended abdomen ☐ Increased bowel sounds ☐ Infectious diarrhea (*C. difficile)*
☐ Other

Provide details:

Date Observed _____

D. Blood Disorder (Compared to baseline; check all that you observe.)

☐ Fatigue ☐ Bleeding ☐ Delayed clotting ☐ Bruising
☐ other

Provide details:

Date Observed _____

E. Liver Disorder (Compared to baseline; check all that you observe.)

☐ Abdominal tenderness/pain ☐ Nausea/vomiting ☐ Decreased appetite
☐ Yellow skin or eyes ☐ other

Provide details:

Date Observed _____

F. Muscle Pain/Weakness/Myositis (Compared to baseline; check all that you observe.)

☐ Muscle pain ☐ Muscle weakness ☐ other

Provide details:

Date Observed _____

Client:_____ Location:_____

G. Neurological (Compared to baseline; check all that you observe.)

- ☐ 1. Dizziness
- ☐ 2. Confusion
- ☐ 3. Decreased Consciousness
- ☐ 4. Delirium
- ☐ 5. Delusions
- ☐ 6. Hallucinations
- ☐ 7. Spasmodic jerky muscle movements (myoclonus)
- ☐ 8. Peripheral numbness & tingling
- ☐ 9. Seizure(s)
- ☐ 10. Other _____

Provide details:

Date Observed _____

H. Renal Event (Compared to baseline; check all that you observe.)

☐ Decreased urine output ☐ Painful urination ☐ Blood in urine ☐ other

Provide details:

Date Observed _____

I. Skin (Compared to baseline; check all that you observe.)

☐ Rash ☐ Hives/wheel/flare ☐ Erythema (skin redness) ☐ other

Provide details:

Date Observed _____

J. Other Event

Provide details:

Date Observed _____

Client:_____ Location:_____

3. Laboratory Values

A. Current laboratory values (related to ADE):

☐ 1. Serum creatinine Date Obtained _____
☐ 2. WBC Date Obtained _____
☐ 3. Hemoglobin Date Obtained _____
☐ 4. Total bilirubin Date Obtained _____
☐ 5. AST/ALT Date Obtained _____
☐ 6. Platelets Date Obtained _____
☐ 7. Creatinine phosphokinase (CPK) Date Obtained _____
☐ 8. *C. difficile* PCR Date Obtained _____
☐ 9. Other Date Obtained _____

4. Current anti-infectives resident is receiving (anti-infective may have been started in the hospital):

Brand Name	Generic Name	Start Date	Stop Date

5. Discussion with Prescriber

Recommendation to the Prescriber:

☐ Discontinue suspected anti-infective ☐ Replace with alternative medication ☐ Change dose/ frequency/route of administration ☐ other

☐ No further action at this time

Provide details, including follow-up plan (if applicable):

B. INTERVENTION

1. Suspected Anti-infective _____

2. Course of Action and Follow-up

☐ Discontinue suspected medication _____
☐ Replace with alternative medication _____
☐ Change dose/frequency/route of administration _____

☐ Other_____
☐ No further action at this time

Provide details, including follow-up plan (if applicable):

C. ADDITIONAL REVIEW AND EVALUATION

1. Estimated Creatinine Clearance _____ mL/min Date _____

2. Other Possible Adverse Anti-infective Events

A. Evaluate if the resident has experienced an anti-infective related ADE:

☐ 1. Anti-infective-anticoagulant drug interaction

Document interacting anti-infective(s) and if appropriate action(s) have been taken to address interaction:

Active anticoagulant (select all that apply):

- ☐ warfarin (Coumadin)
- ☐ rivaroxaban (Xarelto)
- ☐ apixaban (Eliquis)
- ☐ edoxaban (Savaysa)
- ☐ dabigatran (Pradaxa)

☐ 2. Multi-drug resistant organism (MDRO) infection(s)

Identify type of multi-drug resistant (MDRO) infection(s):

- ☐ methicillin-resistant *S. aureus* (MRSA)
- ☐ vancomycin-resistant *Enterococci* (VRE)
- ☐ carbapenem-resistant *Enterobacteriaceae* (CRE)
- ☐ MDR *Acinetobacter*
- ☐ MDR *Pseudomonas*
- ☐ Extended spectrum beta-lactamase (ESBL) producing *Enterobacteriaceae*
- ☐ other _____

How many anti-infectives has the resident received in the last 90 days?

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ other

Provide details of anti-infectives (i.e., dose, duration, frequency, indication, start and end dates):

Date Observed _____

☐ 3. *C. difficile* infectious diarrhea
(Compared to baseline; check all that you observe.)

☐ diarrhea ☐ abdominal pain ☐ increased bowel sounds
☐ *C. difficile* PCR_____ date _____
Provide details:

Date Observed _____

☐ 4. Other
Provide details:

Date Observed _____ Suspected Anti-infective _____

3. Category of Possible Anti-infective Adverse Drug Event

☐ Allergy
☐ Anticipated/Expected/Dose-related
☐ Idiosyncratic/Unanticipated/Unpredictable

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4. Event Outcome (Hartwig Severity Assessment Scale)

☐ Level 1. Resolved, no residual harm. No change in treatment was needed.

☐ Level 2. Resolved with suspected anti-infective held, discontinued or otherwise changed.

☐ Level 3. Resolved with suspected anti-infective held, discontinued or otherwise changed AND/OR an antidote or other treatment was required.

☐ Level 4. Any Level 3 ADE which causes hospitalization or increases length of stay by at least 1 day.

☐ Level 5. Any Level 4 ADE which requires intensive medical care.

☐ Level 6. The ADE caused permanent harm to the resident.

☐ Level 7. The ADE either directly or indirectly led to the death of the resident.

Client:_____ Location:_____

Resulting Severity of the ADE

- ☐ A. Mild Event: Levels 1 and 2
- ☐ B. Moderate Event: Levels 3 and 4
- ☐ C. Severe Event: Levels 5, 6 and 7

5. EMR Documentation

☐ This adverse event should be documented in the resident's medical record to help avoid future exposure and adverse events.

Hartwig SC, Siegel J, Schneider PJ. Preventability and severity assessment in reporting adverse drug reactions. Am J Hosp Pharm 1992; 49: 2229–2231.