Patient Safety in Transitions of Care

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Objectives

- Describe the importance of communication and documentation in the transitions of care process.
- Evaluate strategies for medication reconciliation and communication of further treatment to ensure the patient's understanding at a transition of care.
- Analyze existing workflows for potential gaps in communicating test results and needed follow-up for patients.

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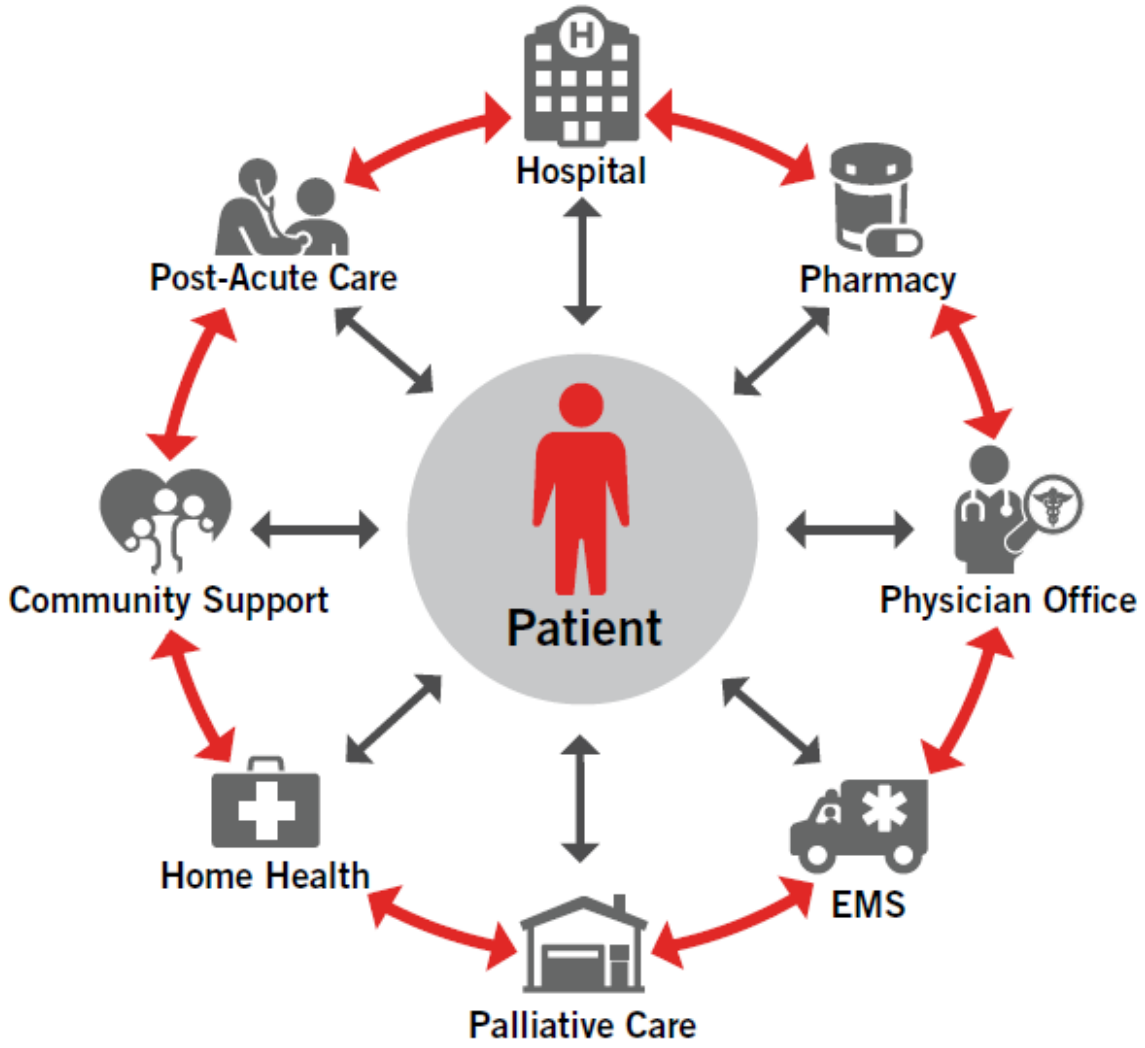
Care Transitions Defined



Graphic taken from Coverys' Care Transitions Through the Lens of Malpractice Claims, 2021

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Why Are Care Transitions So Risky?

Care transitions involve situations where:

- Multiple providers and influencers must collaborate, coordinate, and communicate fully and effectively on behalf of their shared patient.
- Differing cultures (among hospital departments, between different facilities or practices, and between patient and provider) can result in miscommunication with negative consequences.
- Resources can be stretched thin during periods of emergency or high volume and during shift changes.
- Reliance upon electronic medical records can pose complications and increase risk.
- Discharge decisions can be rushed or incomplete.
- The patient's ability to understand the process and treatment, as well as their functional capability, is vital.

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Case 1

An 82-year-old female patient was transferred from an inpatient status to the skilled nursing area of a health center so that she could receive PT, OT, and IV antibiotics. She had a staph infection associated with an internal left knee prosthesis, recent left knee revision with debridement and a chronic left knee replacement joint infection which had developed sinus cavities.

Five days after her admission to skilled nursing it was noted that there were no follow up appointments on her skilled chart. Investigation of her transfer records found two scheduled follow up appointments and weekly lab work orders for a Vancomycin trough, CRP, ESR, and CBC that were to have been completed four days after her admission to the skilled unit.

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Case 1

What went wrong?

The admitting nurse missed the orders for IV antibiotics and labs when the patient was admitted to skilled nursing.

How did this happen?

- Had the admitting nurse not been properly trained in the process of admitting patients to the skilled nursing unit?
- Was the documentation accompanying the patient at their admission to skilled nursing incomplete or confusing?
- What was the understanding of the nursing staff that took care of the patient on Days 1 -4 regarding why the patient was admitted to their unit?
- Was the patient or her family unable to be a part of her care team and question why she was not receiving IV antibiotics?

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What system improvements or staff actions would have prevented the event from occurring?

- Creating a standard process to ensure the transfer of information from an inpatient admission to a skilled nursing admission and/or auditing the process to ensure staff follow the process (e.g., detailed discharge or admission checklist).
- Performing a medication reconciliation at the time of dismissal from the Med/Surg floor and again at admission to the SNF.
- Providing the patient and family education and counseling about the patient's treatment plan (in this case IV meds and PT/OT).

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Case 2

A 35-year-old male, paraplegic secondary to a gun shot wound, had a coccyx wound which had been managed as an outpatient by the clinic for 10 months. This delay was due to a shut down of elective surgeries caused by COVID. The patient was scheduled at the earliest available appointment for a closed flap over the coccyx wound.

The surgeon did not admit the patient post operatively because he had a false understanding of the patient's home resources which would have allowed the patient to remain off the surgical site. The patient should have been on strict bed rest with no weight to coccyx area for a period of time post surgery. This did not occur which resulted in the patient requiring an additional surgery and a longer hospitalization.

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Case 2

What went wrong?

The patient was not admitted to the hospital or transferred to a rehab facility for post op recovery care.

How did this happen?

- There was no recognition by the care team that the patient did not have the resources to allow him to adhere to surgeon's orders for strict bedrest at home post surgery.
- The patient did not disclose to the care team his lack of assistance at home and inability to follow the surgeon's post op orders.

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Case 2

What system improvements or staff actions would have prevented the event from occurring?

- Performing an enhanced assessment, including hospital assessment, comprehensive home assessment, and Social Determinants of Health assessment.
- Providing a written discharge or transition plan at the time of discharge/transition, written at the patient's appropriate literacy level, and assessing the patient's and their identified family caregivers' degree of understanding by having them explain in their own words what was to happen as the patient transitioned to a new care setting.

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Case 3

A 64-year-old man began treatment for Hepatitis C with the medication Mavyret. Six weeks later at a cardiologist's visit he was started on Lipitor to treat his high cholesterol prior to a scheduled procedure.

Two weeks later he contacted his primary care doctor complaining of having problems using his arms and legs. In reviewing his Medication History, it was discovered that he was taking two meds known to have drug-drug interactions causing rhabdomyolysis.

The patient was hospitalized, both drugs were immediately stopped, and patient is currently in rehab. The Hepatitis C treatment outcome may not be successful because of the shortened course of treatment with Mavyret and at this time it is not known how much return to pre-event status his arms and legs will experience.

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Case 3

What went wrong?

A drug-drug interaction warning message in the EHR was overridden by both the ordering physician and the pharmacist so that the single dose of Lipitor could be given. The order was not discontinued after the single dose.

How did this happen?

The ordering provider did not enter the order correctly and the patient received not just the one dose of Lipitor but continued the Lipitor as part of his daily medication routine.

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Case 3

What system improvements or staff actions would have prevented the event from occurring?

- Providing training for providers how to order a single dose of a medication in the EHR.
- Performing medication reconciliation at admission and at discharge.
- Reviewing EHR workflows that prompt warnings to verify the warnings' need and removing any extraneous warnings found.
- Strengthening a culture of safety with emphasizing the use of the tool "Validate and Verify" when EHR provides warnings or if something does not seem correct to the staff caring for a patient.

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Medication Reconciliation Strategies

- Study data shows that effective processes can detect and avert most medication discrepancies
  - Obtaining, verifying, and documenting prescriptions
  - Considering pre-admission/home medication list
  - Providing updated medication list and communication on information management
- Medications at Transitions and Clinical Handoffs (MATCH)

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Guiding Principles

- Develop a single medication list shared by all disciplines
- Clearly define roles and responsibilities for each discipline involved in medication reconciliation
- Standardize and simplify the process and eliminate unnecessary redundancies
- Make the right thing to do the easiest thing to do
- Develop effective prompts or reminders for consistent behavior
- Educate patients and their families or caregivers on the process and the important role they have
- Ensure process design meets all local laws or regulatory requirements

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“One Source of Truth”

- All disciplines caring for the patient should be working from the same medication list
- List should be centrally located and easily visible
- Each discipline should have the ability to update the home medications

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Defining Roles & Responsibilities

- What discipline builds the record upon admission? How will information be validated and completed?
- What process steps are needed to perform medication reconciliation on outpatients and inpatients upon admission, transfers, and discharge?
- Team approach with clearly defined roles for each admission point

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Integrating Medication Reconciliation into Existing Workflow

- Prompts to complete required steps: need to occur within the workflow
- Automations can be beneficial here
- Flowchart can then be created based on established workflows
- Designing the process
  - Inpatient Practice Setting
  - Post-Acute Care Settings
  - Medication Reconciliation at admission, transfer, and discharge

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Building a Flowchart Diagram

Admission

- ❑ **Medication History**
  - Who obtains medication history? What is captured? Where is it documented? How do you monitor that it is documented appropriately?
- ❑ **Comparison**
  - Who compares medication orders to histories? When does reconciliation occur? How do you identify which discrepancies require clarification?
- ❑ **Orders**
  - Who places the orders? What is the process? When are ordering decisions documented? How are discrepancies resolved?
- ❑ **Resolution**
  - Who follows up on discrepancies? When does the follow up occur? How do you document outcome of the intervention?

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Building a Flowchart Diagram

Facility Transfer

- **Comparison**
  - Who reconciles upon transfer? What is the process for reconciling orders currently receiving compared to at the new level of care? When does reconciliation occur in preparation for transfer? Where is it documented? How do you monitor that reconciliation is occurring?
- **Orders**
  - Who receives medication orders and updates order for new level of care? When does the review and update occur? How are orders handled for transfer?
- **Resolution**
  - Who follows up on discrepancies? When does the follow-up occur? Where is it documented? How do you monitor discrepancies were resolved?

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Building a Flowchart Diagram

Discharge

- ❑ **Medication Discharge List and Reconciliation**
  - Who reviews, reconciles, and updates in preparation for discharge? What is the process? When does it occur? Where is the complete history documented? How do you monitor that the list is updated and given to the patient with education on the changes? Who communicates with patient and family/caregivers?
- ❑ **Resolution**
  - Who follows up on discrepancies? When does the follow-up occur? Where are discrepancies documented? How do you document the outcome of the intervention? How do you monitor discrepancies were resolved?

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Auditing at Transitions of Care

Data Collection Strategy
Method: (Paper audit form vs. electronic vs. other)
Frequency:
Patients:
Sample Size:
Person Accountable for
Data Collection:
Data Entry:
Plotting on Run Chart:
Other Details:

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Auditing at Transitions of Care

Medication Reconciliation Audit Form

Unit:_____ Manager:_____ Date:_____

Data Collector's Name:_ _____

Introduction:

- The data is to be collected and reported on a _____ basis.
- During each _____, a total of _____ charts should be selected for record review.
- Findings are to be tracked through your own quality process.
- Provide copies of the completed audit form to _____

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Auditing at Transitions of Care

Instructions:

Medication reconciliation is the process of comparing medications the patient has been taking prior to admission/entry to the hospital to the medications the organization is about to provide to identify any unintended discrepancies. If a patient will be provided/given any medications while under our care or prescribed any new drugs to take after their stay, medication reconciliation is required.

1. Confirm a medication list was collected from the patient upon arrival to (list must include medication name, dose, route, and frequency).
2. The list must then be available in the patient's chart for the caregiver to review prior to initiating care.
3. Identify that the complete and updated list of medications was then provided to the patient at discharge and discussed within the context of discharge instructions ("resume home meds" is not acceptable).

Medication Reconciliation	**Pt. 1 Y/N**	**Pt. 2 Y/N**	**Pt. 3 Y/N**	**Pt. 4 Y/N**	**Pt. 5 Y/N**
• List of home medications was collected from the patient at the time of arrival, and medication name, dose, route, frequency were documented in the appropriate location of the medical record.					
• List of home medications collected was available for the caregivers to review prior initiating care.					
• Updated medication list was provided to the patient at discharge and discussed in the context of discharge instructions.					

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Auditing at Transitions of Care

If you observe someone NOT doing the right thing, ask the following questions:

1. Is this a supply/logistic issue (can't find forms, pens, etc.)? _____

_____

_____

2. Is this a performance/knowledge/skill issue? _____

_____

_____

3. Is this a human factors (distraction, noise, fatigue) issue?_____

_____

_____

4. Other barriers to compliance? _____

_____

_____

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Auditing at Transitions of Care

Goal: 100% Compliance

Numerator:

- Number of medication lists collected and completed on outpatients requiring medication reconciliation.
- Number of medication lists that were provided back to outpatients in the context of discharge instructions.

Denominator: Number of outpatients requiring medication reconciliation.

The chart below represents an example of an audit reporting chart that could be used to communicate audit reporting results on any given day. The number of charts reviewed will vary depending on the size of your organization.

Audit Reporting Chart

Issue	Compliance Defined as:	Current Compliance as of [insert date]	Action Plan
Medication Reconciliation on Admission	Numerator: # of patients with a home medication list documented and reconciled at admission Denominator: # of patients admitted	GOAL: >90% ACTUAL: [insert current compliance]	Insert plans to close the gap between the actual compliance percentage and the goal
Medication Reconciliation on Transfer	Numerator: # of patients with medications reconciled upon transfer Denominator: # of patients transferred	GOAL: >90% ACTUAL: [insert current compliance]	Insert plans to close the gap between the actual compliance percentage and the goal
Medication List at Discharge	Numerator: # of patients provided an updated home medication list at discharge Denominator: # of patients discharged	GOAL: >90% ACTUAL: [insert current compliance]	Insert plans to close the gap between the actual compliance percentage and the goal

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Identifying & Addressing Challenges

Implementation Challenges	Observations	Proposed Action	Next Steps/Primary Responsibility
Example: Reliance on memory; lack forced function	Physicians are not remembering to place a medication reconciliation order	Design a prompt during the admission ordering phase that creates a forcing function for physicians to complete the medication reconciliation form	Monitor physician compliance for completing the medication reconciliation form

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Communicating Test Results

Closed-loop communication

- ❑ Patient centered definition of diagnostic error
  - Failure to "establish an accurate and timely explanation of the patient's health problem(s)"
  - Failure to "communicate that explanation to the patient" (The Joint Commission, n.d.)
- ❑ Addressing as a system-wide issue
- ❑ *Safety actions to consider*
  1. *Identify workflows*
  2. *Establish consistent processes*
  3. *Notify patients of test results*
  4. *Forward or escalate results*
  5. *Ensure test results are communicated to a back-up provider*
  6. *Optimize HIT to communicate test results*
  7. *Improve/evaluate your organization's patient portal(s)*

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References

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Thank You

"When implemented at the right time and in the right way, care transitions enhance care delivery, improve patient outcomes, and move organizations toward successful attainment of the triple aim: better health, better care, and lower cost through improvement."

From: High-quality Care Transitions Promote Continuity of Care and Safer Discharges, New York State Nurses Association, Vol. 6, Number 2

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