Advance Practice Nurse's Role to Improve Care Transitions through **Advanced Directive Discussions** and **Medication Reconciliation**

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PURPOSE

- Enhanced team-based communication of medication reconciliation and Advanced directive (AD) or Goals of Care (GOC) needs/ discrepancies within a quality improvement project. IMPACT sought to improve transitions of care from hospital to skilled nursing facility (SNF) and reduce 30-day hospital readmissions for Medicare recipients.
- Advance Practice Registered Nurses (APRNs) served as transition advocates. They collaborated and communicated critical information on advanced directives and medication reconciliation to discharging hospital team and admitting SNF staff, and brought the patient perspective to transitional paperwork.

RATIONALE

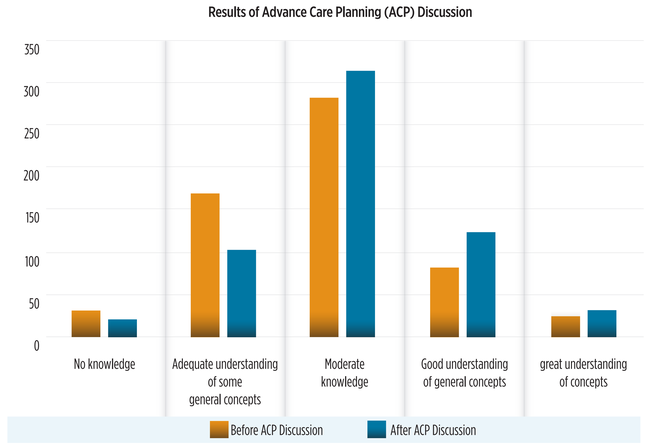
- Nationally, nearly 1 in 5 of over 13 billion Medicare recipients hospitalized annually are readmitted within 30 days of discharge. (1)
- About half of adults experience a medical error after hospital discharge, and 19%-23% suffer an adverse event, most commonly an adverse drug event. (5)
- Hospital readmissions place emotional and physical burdens on patients and families (3)
- Unclear AD/GOC plans and polypharmacy are contributing factors (4)
- Advance directives prepared too early and without a mechanism to refresh them may lead to a medical error. (6)
- Practitioners recognize grave inadequacies in older-adult transfers but often do not take action. (2)
- Poor communication between providers is a key barrier to safe effective transitions for patients from hospital to SNF. (5)

INTERVENTION

- QI project conducted January 2013-April 2015 enrolled 1246 unique Medicare beneficiaries
- Transition APRNs communicated with patients, family, medical team, pharmacists, social workers, case managers, palliative care team and SNF to:
  - **Assess** patient knowledge of Advanced directives
  - **Initiate** goals of care discussion
  - **Interview** patients for a self-assessment of previous knowledge regarding advanced directives and code status
  - **Reconcile** home and discharge medications and track findings
  - **Communicated** critical "just-in-time" information about medications and goals of care to treatment team, patient/ families and SNF staff

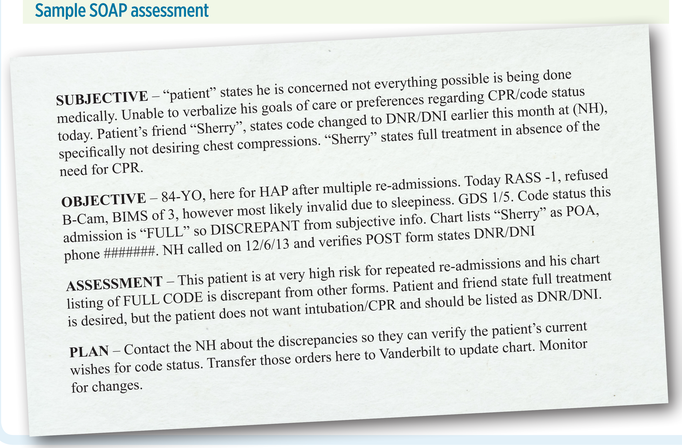
OUTCOMES

Increased patient reported knowledge of Advanced care planning issues [N=585]



33.50% reporting no or adequate knowledge reduced to 21% with no or adequate knowledge in one discussion. Uncovered existing confusion and miscommunication regarding documented code status, advanced directives, end of life preferences discrepancies.

Sample SOAP assessment



SUBJECTIVE – "patient" states he is concerned not everything possible is being done medically. Unable to verbalize his goals of care or preferences regarding CPR/code status today. Patient's friend "Sherry", states code changed to DNR/DNI earlier this month at (NH), specifically not desiring chest compressions. "Sherry" states full treatment in absence of the need for CPR.

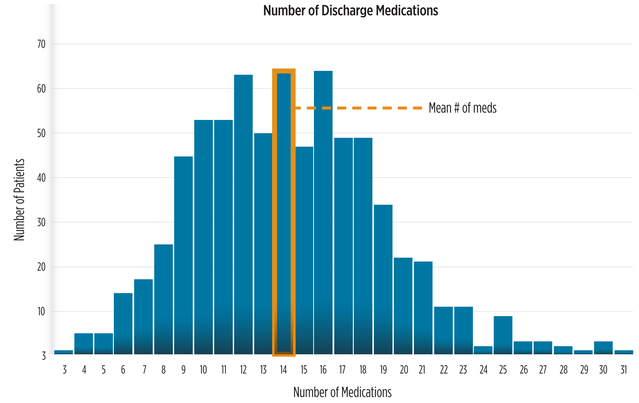
OBJECTIVE – 84-YO, here for HAP after multiple re-admissions. Today RASS -1, refused B-Cam, BIMS of 3, however most likely invalid due to sleepiness. GDS 1/5. Code status this admission is "FULL" so DISCREPANT from subjective info. Chart lists "Sherry" as POA, phone #######. NH called on 12/6/13 and verifies POST form states DNR/DNI

ASSESSMENT – This patient is at very high risk for repeated re-admissions and his chart listing of FULL CODE is discrepant from other forms. Patient and friend state full treatment is desired, but the patient does not want intubation/CPR and should be listed as DNR/DNI.

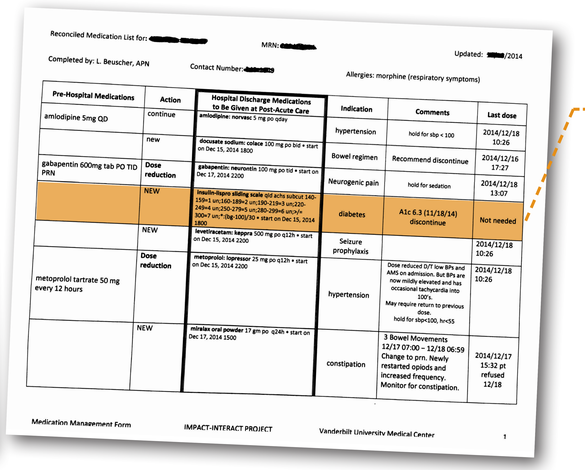
PLAN – Contact the NH about the discrepancies so they can verify the patient's current wishes for code status. Transfer those orders here to Vanderbilt to update chart. Monitor for changes.

Improved accuracy/safety of transitional medication list

Mean Number of discharge medications in validated APRN reconcilliation sample (N=727) = 14.3 (±4.8) (similar to entire sample (N=1246) = 14.3 (±4.9)) ((scatter plot))



Uncovered and communicated discrepancies and inaccuracies in medication lists.



Reconciled Medication List for: [redacted] MRN: [redacted] Updated: [redacted]/2014

Completed by: L. Beuscher, APN Contact Number: [redacted] Allergies: morphine (respiratory symptoms)

Pre-Hospital Medications	Action	Hospital Discharge Medications to Be Given at Post-Acute Care	Indication	Comments	Last dose
amlodipine 5mg QD	continue	amlodipine: norvasc 5 mg po qday	hypertension	hold for sbp < 100	2014/12/18 10:26
	new	docusate sodium: colace 100 mg po bid + start on Dec 15, 2014 1800	Bowel regimen	Recommend discontinue	2014/12/16 17:27
gabapentin 600mg tab PO TID PRN	Dose reduction	gabapentin: neurontin 100 mg po tid + start on Dec 17, 2014 2200	Neurogenic pain	hold for sedation	2014/12/18 13:07
	NEW	insulin-lispro sliding scale qid ac/hs subcut 140-159=1 un;160-189=2 un;190-219=3 un;220-249=4 un;250-279=5 un;280-299=6 un;>300=7 un;* (bg-100)/30 * start on Dec 15, 2014 1800	diabetes	A1c 6.3 (11/18/14) discontinue	Not needed
	NEW	levetiracetam: keppra 500 mg po q12h + start on Dec 15, 2014 2200	Seizure prophylaxis		2014/12/18 10:26
metoprolol tartrate 50 mg every 12 hours	Dose reduction	metoprolol: lopressor 25 mg po q12h + start on Dec 15, 2014 2200	hypertension	Dose reduced D/T low BPs and AMS on admission. But BPs are now mildly elevated and has occasional tachycardia into 100's. May require return to previous dose. hold for sbp<100, hr<55	2014/12/18 10:26
	NEW	miralax oral powder 17 gm po q24h + start on Dec 17, 2014 1500	constipation	3 Bowel Movements 12/17 07:00 – 12/18 06:59 Change to prn. Newly restarted opiods and increased frequency. Monitor for constipation.	2014/12/17 15:32 pt refused 12/18

Medication Management Form IMPACT-INTERACT PROJECT Vanderbilt University Medical Center 1

- NP contacted the discharging medical team for 34.9% (254) of the patients to communicate med concerns prior to discharge.
- 1.1 (±2.0) errors per patient communicated to team.
- 0.5 (±1.5) errors per patient corrected prior to discharge.

OTHER OUTCOMES

Catalyzed systemic change during project

- Two or more sets of medication lists generated in hospital EMR previously, new software created for "one list" model going forward.

Facilitators of communication activated

- New documentation section to improve patient goals of care/advanced directive information
- EMR converted to a single discharge list

APPLICATION TO PRACTICE

- Advance Practice Nurses are well positioned to make a significant contribution to improve patient transitions from hospital to SNF.
- APRNs have a holistic approach, conducive to engaging patients/ families in baseline AD/GOC discussions
- APRNs are uniquely positioned to assess, discover and translate gaps/ errors/potential dangers in transition of medications
- APRNs are recognized by stakeholders as knowledgeable and trusted patient advocates and may be uniquely positioned to overcome barriers to improvement of medication reconciliation and changes to care plans. This is an area for further research.

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