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Development of a Quality Improvement Process Following Evaluation of Patient Outcomes and Nursing Documentation

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Abstract

The release of new opioid treatment guidelines that were published in February 2009 and the implementation of the REMS (Risk Evaluation Mitigation Strategies) have prompted the development of a compliance quality improvement project. Within the practices there are many patient issues that can arise with opioid prescriptions. In order to ensure patient safety and good practice a compliance monitoring program was developed.

Many patient phone calls, lost prescriptions, inappropriate use of medication and other concerns were dealt with on a daily basis. A pilot program was developed to review charts for patient teaching and education. The next step was to develop a one page educational sheet and implement a phone follow-up call to the patient after receiving the prescription. The outcomes that were looked at include the number of phone calls from the patient, lost prescriptions, compliance in taking the medication as directed and any other concerns. In conjunction with this, charts were reviewed for documentation of the elements of Universal Precautions for Pain Management.

This program focused on both Physician and Nursing compliance.

Improvement Plan and Implementation:

During January and February 2010, a teaching/medication guideline sheet was developed to include the following elements: Medication purpose, dosing, side effects, renewals, safe storage, and proper disposal. (see Figure 1)

This sheet was given to patients when they received any prescriptions at their visit. For patients that called in for renewals, they received the teaching sheet/guideline when they picked up the prescription. In order to capture the education, the nursing note was revised. (see Figure 2) This allowed better documentation of nurse's patient teaching about the prescribed medication. A follow-up call was made 5 days after the visit to assess any problems with the medication. (see Figure 3) This process was implemented May 1, 2010.

Implemented a plan with our in-house retail pharmacy in which the prescription is sent to the pharmacy by the staff and the patient has the option to pick up the prescription at the pharmacy or the pharmacy would fed-ex the medication to the patient's home.

No scripts are sent to the patient homes.

Figure 1
Medication Safety Instructions

Figure 2
Nursing Progress Note

Figure 3
Phone Follow-Up

Retrospective Chart Review:

A retrospective chart review from July to December 2009 of 250 charts was completed for current nursing practice for documentation of teaching when prescriptions were given. This project was completed at Lehigh Valley Hospital-Muhlenberg Center for Pain Management. In addition, we were tracking the number of phone calls made by the patient after receiving a prescription about any problems or concerns with the medication.

Out of the 250 charts-100 patients had received prescriptions for opioid medications. 80 charts had no documentation that the patient had any teaching or instructions in regards to the prescribed medication. 20 charts had adequate documentation of teaching about the prescribed medication. In addition, approximately 55 patient phone calls were recorded with problems or concerns about their prescribed medication.

Concurrent chart reviews were completed during February, March, May and June- 33 random charts for compliance in obtaining an opioid agreement and the use of Urine Drug Screens. The patients were on an opioid from a few months to 7 years. Out of the 33 charts there were 6 charts that had an opioid agreement-many that were obtained but never updated on an annual basis. Out of the 6 that had an opioid agreement there was only 1 UDS completed. Many of the charts were lacking in documentation of risk assessments, benefit of current treatment and the 4A's.

Concurrently, a Standard Operating Procedure was developed for Opioid Prescribing to include opioid agreements, outline responsibilities of the staff (physician and nursing), and urine drug screen guidelines. This SOP was implemented as of July 6, 2010.

Evaluation/Outcome:

As of July 15, 2010 approximately 175 patients received the teaching/guideline sheet at each clinic visit. There was an overall improvement in nursing documentation as well as patient compliance with taking the medication as prescribed along with satisfaction with their current treatment.

The pharmacy collaboration overall decreased the number of pharmacies that were being used by the patients, the number of lost prescriptions due to no mailing of prescriptions. The pharmacy was able to monitor if patients went to other physicians/pharmacies for additional medications. It also increased patient satisfaction and compliance. As well decrease nursing time spent on writing/ mailing/ documenting of renewals.

The follow up phone call was difficult to complete. Many times patients were not home or did not return our phone calls. In follow-up at the next visit many patients did not report any major issues with their medication.

Future Processes:

- Revise and update opioid agreements
- Have at least 2 days per month scheduled for UDS days
- Follow-up monitoring of charts to be completed 3 months after implementation of the SOP for the implementation of opioid agreements and the use of UDS in the practice.
- Continue chart reviews for nursing documentation of teaching and patient compliance.