Background

• In 2008, The Joint Commission issued a Sentinel Event Alert warning for an increase in patient accidental deaths and overdoses associated with anticoagulants.

• These untoward events can be prevented with increased communication between healthcare providers and patients.

• This evolved into a National Patient Safety Goal which focuses on reducing the harms of anticoagulation medication.

• Anticoagulants contribute to an increase in major bleeding risk of 0.3-0.5% and intracranial hemorrhage of 0.2% annually (Majeed & Schulman, 2013).

• Anticoagulant use coupled with increased fall risk:
  - Annually, one third of all older adults ages 65 or older sustain a fall (CDC, 2014).
  - Among older adults, falls are the leading cause of both fatal and nonfatal injuries (CDC, 2014).

• Complications are largely due to lack of patient knowledge and poor compliance (Hua, et al., 2011).

• Our medical center identified the need to improve our compliance with providing education to our patients regarding the harms associated with anticoagulant therapy, and identified innovative ways to provide this education with our new technology.

Purpose

The purpose of our initiative is to:

• Protect the safety of our patients by improving our compliance with informing patients about the harms associated with their anticoagulation therapy.

• Utilize technology to help guide staff nurses to provide patient education in compliance with regulatory standards.

Methods

• March ‘13: Explored the education options available in our new Electronic Health Record (EHR) for anticoagulation patient education
  - Developed education with screen shots as reference materials for staff

• April ‘13: Trained staff in using our new evidence-based patient education templates in our EHR which included required teaching points for anticoagulation patient education

• June ‘13: Requested a monthly report from our EHR (Epic) to monitor compliance

• August ‘13: Built report; capturing 100% of patients discharged on Warfarin and Enoxaparin

• September ‘13: Changed the monitoring report build to capture 100% of our patients discharged on all anticoagulants and tracked our progress for providing patients the necessary education.
  - Reported compliance by unit-level detail

• October ‘13: Nurse Educators partnered with Nursing Quality Specialists and staff nurses to increase staff awareness about the NPSG by rounding on patient care units to educate staff on NPSG requirements and documentation requirements

• Question regarding anticoagulation patient education added to our internal Mock Joint Commission Tracer Tool

• December ‘13: Best Practice Advisory (BPA) went live in Epic to help facilitate a reminder for staff to complete the education and documentation

Results

• Within five months of implementing these innovative steps to improve upon anticoagulation patient education, our compliance with providing the education according to the National Patient Safety Goal increased from 49% to 90%, and has remained above 97% to date.

• Providing a streamlined process that utilized existing tools available in the EHR, helped to ensure the practice of anticoagulation patient education could be carried out and monitored across settings.

• Transparency in reporting outcomes, and accountability for practice at the unit level was helpful to drive change and reach improvements.

Discussion

• The innovative use of technology can help staff to be more adept to protect the safety of patients by improving compliance with informing them about the harms associated with their anticoagulation therapy.

• The use of EHR technology can help to streamline the process for monitoring and tracking organizational progress towards National Patient Safety Goals.

Conclusions

• The purpose of our initiative is to:
  - Protect the safety of our patients by improving our compliance with informing patients about the harms associated with their anticoagulation therapy.
  - Utilize technology to help guide staff nurses to provide patient education in compliance with regulatory standards.

References:

