Streamlining the Process of Recapitulation of Physician Orders: The 45-Day Collaborative Recap

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

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BACKGROUND

Is the monthly recapitulation of physician orders just a "necessary evil" or is this inefficient, human-error prone process an opportunity to improve interdisciplinary collaboration in resident care?

Edgemoor is a 192 bed distinct part SNF with six 32-bed neighborhoods. Residents average more than nine medications daily. We had a monthly recapitulation system where physician orders were reprinted by the pharmacy and checked, updated, signed and converted to medication and treatment sheets by nursing prior to the physician visit. Analysis showed that recapitulation time was associated with multiple medication errors and was a source of tension and highly time consuming for nursing.

We wondered…
Can we make it "leaner"?
Can we make the whole process relevant and useful to resident care?
Can we do the recap less often?

Edgemoor DPSNF ♦ Santee, California

PROCESS OF QUALITY IMPROVEMENT

1. Audits of the recap procedure, staff observations and interviews identified significant problems.
2. Problems were initially identified in 2010 with small fixes attempted but none successful. Interdisciplinary Team comprised of the clerks, nurses, pharmacy staff and physician mapped current process identifying areas of redundancy, frustrations, inefficiency and proposed trial of in-person recaps.
3. A pilot project set up all in one hour, face-to-face recap.
4. The process was brought to other neighborhoods and extended to a 45-day cycle. The MAR and treatment sheets were printed on legal paper. Later, we enhanced the process by including the pharmacist who completed Medication Regimen Review directly with the physicians, approximately every quarter.

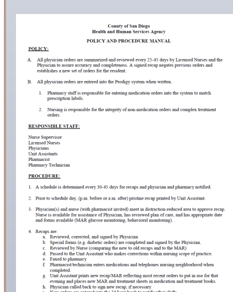
RESULTS

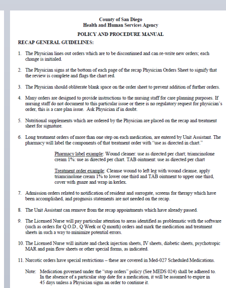
- The 45-day recap process reduced the number of recaps from 12 to 8 annually (30% reduction)
- Staff time for checking, interruptions and use of paper was also reduced.
- Staff savings was used to provide a dedicated nurse and clerk familiar with the resident.
- Errors were significantly reduced. In 2011, pre-intervention, we had 12 recap errors. In 2012, post intervention, we had 0 recap errors.
- Inclusion of the consultant pharmacist enhanced collaboration and nearly eliminated pharmacy review. Involved staff were uniformly positive about the change.

PROBLEMS IDENTIFIED

- Printed in advance, the recapitulations had to be checked and rechecked over three weeks with all new orders added both to the recap and the new MAR, prior to MD signature. Many times, monthly orders were put into place without MD review.
- The recaps and MAR had many handwritten corrections for changes which were hard to read, not dated or initialed and out-of-order, prompting errors.
- Physicians noted recaps might not be "ready" to sign when they were available and nurses noted that they didn't know when the MD came and always had to have the recaps ready. Some physicians made many changes, others just signed. Some physicians came at off-hours, when there was no clerk.
- Items necessary for recap review not consistently available.
- Night nursing staff not transcribing orders or checking.
- Recap schedule was not coordinated with cycle fill schedule.
- Workload varied from 60 to zero recaps daily.
- Recapitulation time was associated with a high error rate. Everyone felt that since there were so many checks, someone else would be finding errors.
- Multiple interruptions of nursing staff by physicians who asked questions at recap times (*Are they still using this prn? What is their blood pressure? Can you tell me about their diabetic control?*) The nurse present may not know the information or the MD needs, which caused irritation, interruptions and poor care.
- Physicians received pharmacy intervention requests separate from their function of reviewing the resident care orders and found it more convenient to ignore or provide insufficient explanation in response to pharmacy reviews.
- Physician orders had redundancies--items that should be removed, care planning issues, inconsistencies in the way orders were written which made the papers longer, more confusing and risky for errors.
- Special "diabetic" orders/MAR were confusing if not implemented on the first of the month.
- Time and staff intensive.
- 30-day recap schedule didn't coincide with 60-day regulatory note schedule.

POLICY & PROCEDURE





Acknowledgement is made to Noel Avilucea for her contribution in designing the poster.

BRIEF SUMMARY OF RECAP PROCESS

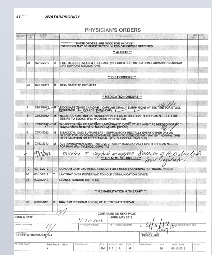
1. The day prior to meeting, all recapitulations are printed but the MAR is not.
2. First thing in the morning, the physician and nurse familiar with the resident plus the pharmacist meet together face-to-face for an hour.
3. When completed, the recaps are faxed to pharmacy for checking within 4 hours, the pharmacy approves the recaps and authorizes printing of the MAR.
4. MAR is printed by noon. The familiar RN checks the MAR with the recap and implements new orders.

Previous processes (Staggered 30 day)	Current processes (45 day collaborative)
12 recaps annually	8 recaps annually
Physicians work alone	Physicians work together allows collegiality, questions and suggestions
Inconsistencies in language on capacity, therapeutic leave, bowel programs, care planning type orders, closer observation, etc.	Alignment of language and procedures with consistency in language throughout the facility; new initiatives could be implemented quickly with 100% change at one time
Peer review accomplished in isolation with physician reviewing records and filling out a form	Physician peer review occurs face to face with questions and collaboration about difficult cases
Pharmacy review reviewed in isolation, separate from record and often physician refused to honor recommendations or did not provide explanation to pharmacist	Pharmacy review contemporaneous with review of orders, permits more ready changes or more conversations, witnessed by other MDs about justifying treatment (and often sensitive proposals for alternatives), minimal pharmacy review outside the recap.
MAR begins with handwriting and as orders added, gets more and more full	MAR and recaps begin without handwriting and so accumulate less "add-ons"
Use of stickies to communicate--they fall off, cannot tell who wrote them, could be ignored	No more stickies.
Physicians constantly interrupting nurses for information when nurse is not always familiar with the patient and has other tasks. easily distracted in process of reviewing so may sign without really checking	Nurse who reviews and checks has only this task and is the most familiar with resident minimize interruptions with copies of all records at fingertips all accomplished in quiet space separate from patient care interruptions
Estimated/average staff time per recap: MD: 30 seconds to 10 minutes Unit secretary: 4 minutes LN: 20 minutes Consulting pharmacist: N/A 1-3 interruptions of staff work	Estimated/average staff time per recap: MD: 30 seconds to 10 minutes Unit secretary: 4 minutes LN: 4 minutes Consulting pharmacist: 2 minutes Dedicated staff to answer questions
Cross-coverage troubling as physicians not familiar with each other's patients	Enhanced cross coverage as physicians more comfortable working together permitting others to sign their recaps and make changes resulted in improved care practices.
MD, pharmacist and nurse worked in isolation	Building physician collaboration with nurse and pharmacy
Pharmacy audits results not available at time of physician decision-making	Audits can be conducted collaboratively with education. "We now must have informed consent for the dose of antipsychotics--let's check the charts as we go through to make sure we have that."
Many complaints	Received positively by every member of the IDT
Unpredictable workload	Predictable workload allows planning
Agency staff unfamiliar with process	No agency staff

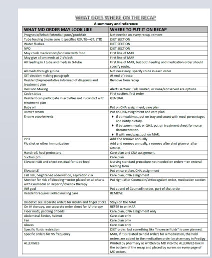
OTHER INITIATIVES LINKED TO RECAP PROCESS

- Standardization of "what goes where on recap."
- Permission for pharmacy to change timing of medications per manufacturer's guidelines through telephone order and collaboration with nurses (e.g. statins at 5 p.m., Coumadin at 5 p.m.).
- Elimination of unneeded prns and establishing procedure to differentiate prns that the resident was attached to (written as "indefinite" and justified even if not used) and those which could be discontinued.
- Establishing standard bowel management program that made physiological sense.
- Stating decision-making capacity in simple terminology.
- Standardization of high risk orders regarding levels of observation.
- Initiation of standard order for those who lack decision making capacity and have no identified surrogate (HSC 1418).
- Eliminating orders designed for nursing instruction and care plan that don't require a physician order (e.g. wedges, hand rolls, therapeutic leave, checking and monitoring).
- Implementing informed consent for psychotropics including antipsychotic dose.

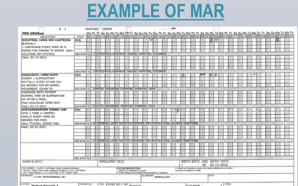
EXAMPLE OF PHYSICIAN ORDERS



STAFF GUIDELINE ON WHAT GOES WHERE ON A RECAP



EXAMPLE OF MAR



CONCLUSION

A 45-day recap process offers substantial efficiencies in time and energy and improved care and interdisciplinary collaboration.