Warfarin (Coumadin) Step-by-Step Counseling Guide

UCONN HEALTH

Version 2 (Last Update 11/15/2016)

Table of Contents

Appendix

Overview

Part of UConn Health's mission is to help patients achieve and maintain healthy lives and restore wellness and health to a maximum attainable level. In order for the hospital to maximize reimbursement, the hospital must adequately practice a variety of evidence-based, scientifically researched standards of care. These practices are reported and tracked by The Centers of Medicare and Medicaid (CMS), and are commonly known as *core measures.* One of the many core measures related to pharmacy calls for warfarin counseling to any patient actively on warfarin therapy. As part of the core measures for this initiative, compliance issues, dietary advice, follow-up monitoring of their INR and the potential for adverse drug reactions and interactions must be addressed with the patient. This is where you come in! Below is a step-by-step guide to warfarin counseling, specific to UConn Health Pharmacy.

How-to Prepare and Counsel

1) Refer to preceptor for a daily printout of patients actively on warfarin therapy. Below is a sample of what the print out looks like. The first column, NRS station, tells you where the patient is located in the hospital. For example, patients AM and AC are located on intermediate (INT) on the 2nd floor in University Tower (North or South Location), while HZ, NM and CL are on the medical unit (MED) in University Tower on the 3rd floor. Patient MM is on the oncology unit (ONC) on the 6th floor and patient RM is on the surgical unit (SURG) on the 5th floor. We do not typically counsel patients in the ICU (HT1) as it may be difficult for them to effectively communicate however, these patients may still be evaluated as they may be a border from a non-ICU service. Patients on MS are from CHMC and should not require counseling. Patients on PSY may be able to be counseled but may require checking with your preceptor.

NRS STATION (patient location)	PT NAME	PAT NUM	PTMEDREC	GENERIC NAME
HT2S (INT)	Patient AM	XXXX6	XXXX0	WARFARIN DAILY DOSE CALL H.O.*
HT2N	Patient AC	XXXX6	XXXX0	WARFARIN DAILY DOSE CALL H.O.*
HT1S (ICU)	Patient ET	XXXX6	XXXX0	WARFARIN DAILY DOSE CALL H.O.*
HT3S	Patient HZ	XXXX6	XXXX0	WARFARIN DAILY DOSE CALL H.O.*
HT3N	Patient NM	XXXX6	XXXX0	WARFARIN DAILY DOSE CALL H.O.*
HT3N	Patient CL	XXXX6	XXXX0	WARFARIN DAILY DOSE CALL H.O.*
MS	Patient TV	XXXX6	XXXX0	WARFARIN DAILY DOSE CALL H.O.*
HT6S	Patient MM	XXXX6	XXXX0	WARFARIN DAILY DOSE CALL H.O.*
HT5S	Patient RM	XXXX6	XXXX0	WARFARIN DAILY DOSE CALL H.O.*

2) Print out copies of "A Patient's Guide to Warfarin (Coumadin)." These are handouts you will be reviewing with patients and must be given to the patient. Become familiar with it! Below is a link to access the handout (see primary handout link on the below page):

   http://health.uconn.edu/pharmacy/patient-education/warfarin-anticoagulation/

3) Before heading off to the patient's room, there are a few things to keep in mind. You may not be able to counsel everyone on their warfarin medication and, therefore, need to prioritize those you see first. This can be done by reviewing patient care documentation in LCR as described below. You want to target those patients whom you suspect will be ready for discharge within the upcoming day as opposed to those who may have a lengthy stay ahead of them; those can be counseled another day. You also want to gain insight about the patient's social history, i.e. what is the patient's living situation? Are they at a nursing home, senior housing facility or living at home with a caregiver such as a spouse, son or daughter? This information is useful to know beforehand, and can help you more appropriately address their ability to maintain monthly INR checks and adherence to therapy. You will also want to know the sensory and cognitive function of the patient to determine how receptive they will be to counseling. You may also encounter a patient that primarily communicates in a language other than English. For these patients, interpreter services are available. Please work with your preceptor for assistance. Lastly, you want to know what the patient's indication for receiving warfarin is, i.e. Afib, DVT, PE, or surgical procedure so you can determine what their INR goal is and answer any clinical questions they may have.

   Guide to obtaining patient information from LCR:

   - Click on "Admission#" and enter the patient's number (PAT_NUM on the form)
   - Click on the patient's name
   - Go to "DISPLAY Patient Care Documentation"
     - Then go to "All Nsg Documentation This Adm"
     - Look at where the patient is from and if they can perform ADLs to gain an understanding of the patient's home environment
     - Look to see if the patient speaks English and if they are ready to learn to evaluate the patient's education needs (*see Interpreter Service section*)
     - Then go to "Addnl Shift Assessments"
       - Then go to "patient/family"

        - Read patient history to better understand the patient's willingness to receive counseling
- Go to "Notes"
    - Check if there are any notes from neuro, case management, or dietary
        - use these notes to gain more information about the patient's cognitive status, their ability to understand counseling, where they will be going once they are discharged (home, STR, SNF), and if they have been seen by dietary
    - Review ambulatory care notes and discharge summaries to assess patient history
- Go to write orders/current orders
    - Look at PMH to find patient's diagnosis/indication for warfarin therapy

4) You are now ready to counsel your patient! Check the census board on the unit to double check the patient's location (if available). Hospital rooms contain on patient per room.

5) Before walking into a patient's room, you want to be sure to sanitize your hands with the foam hand sanitizer located outside the patient's room. Do this afterwards as well. **Remember, foam in, foam out!** Also, it is important to be aware of any contact precautions prior to entering the room. If there is a sign hanging, please don the proper protective garb.

6) Use the acronym **AIDET** to professionally encounter and counsel your patient:

AIDET
By using AIDET when we communicate with a patient, the patient is being told who you are, why you are in their room, and what will be happening. This decreases patient anxiety and increases patient satisfaction.

A	Acknowledge
I	Introduce
D	Duration
E	Explanation
T	Thank You

- Acknowledge
    - Greet the patient with their name and a smile. This provides a personal connection with the patient.
        - "Good morning/afternoon Ms. Patient."
    - Acknowledge the patient's right to privacy and consider all interactions with patients to be confidential

- Introduce
    - Tell the patient who you are and how you are going to help them.
        - "My name is_____, and I am a pharmacy student working with the pharmacist to assist your team in caring for you."
- Duration
    - Give the patient an estimate of the time it will take to complete the discussion. This is part of setting expectations for the patient so that they are aware at all times why you are in the room and what will happen.
        - "I would like to discuss the medications you take at home. This will take approximately 15 minutes of your time. Is now a good time to discuss this?"
- Explanation
    - Explain what you are going to do for the patient. Ask if they have any questions or concerns.
        - "We want to be sure we have the correct information about your home medications so the correct medications can be ordered for you while you are in the hospital. "
- Thank you
    - Thank the patient for choosing out hospital to receive their care. Ask the patient if there is anything else you can do for them before you leave. Take time to "manage up" the current area, colleagues, and physician to reinforce the team atmosphere to the patient and increase the patient's confidence level in the care they are receiving here at our hospital.
        - "Thank you Ms. Patient for your time and for selecting our hospital. Is there anything I can do for you? You are in excellent hands here in the [Emergency Department]. Have a good day."

7) You can also use the acronym PHARM to ensure a successful patient encounter:

5 Things to do with Every Patient

P	Privacy • Treat all interactions with patients as confidential • "May I come in? I am closing the door/pulling the curtain closed for your privacy" • "Are you comfortable discussing your medications while others are in the room with us?"
H	Hand hygiene • Use antibacterial gel to clean hands for patients protection before and after entering a patient's room
A	AIDET (Acknowledge, introduce, duration, explain, thank) • Framework on how to communicate with patients and families to ease nervousness and anxiousness
R	Right patient: Use two identifiers to ensure correct patient information • Patient name and date of birth
M	Medication questions and manage up • "Do you have any questions for me?" • "You will receive excellent care while you are here- the staff is great."

Tips

Some counseling tips and tricks:

- Some patients refer to warfarin as warfarin, others as Coumadin®. Keep this in mind and use both names in the beginning of your session to ensure the patient knows what medication you are talking about.

- Use open ended questions

- Keep your message short and simple

- Our nutrition staff at the hospital also provides some dietary education to patients on warfarin. If the patient mentions someone came by to speak to them about their warfarin it may have been the nutrition staff.

- If a patient is close to being discharged, check to see if their discharge medications still includes warfarin. Some patient may have only been on warfarin for their hospital stay and therefore do not require counseling. This information can be obtained in LCR or the

patient's chart.

- Another source of information is the Med-History Technicians. They can tell you a wealth of information relating to the patient's home medications, including if the patient has been on warfarin prior to admission or the home medications (if reviewed already).

- Be sure to verify the patient's date of birth before each counseling session. This is also a good way to gauge a patient's cognitive function and their ability to understand any information you present.

- Here are a few points to make sure you review:
    - What warfarin does
    - Reason for taking warfarin
    - Blood test for checking warfarin is called an INR
    - Target INR is…(insert patient's INR)
    - How to take warfarin
    - Possible side effects of warfarin (i.e. bleeding)
    - Review of possible drug interaction with warfarin (both prescription and OTC)
    - Who should the patient call if any questions

Interpreter Services

Providing language assistance to limited English proficiency (LEP) and deaf and hard of hearing patients is MANDATED by multiple state and federal statutes. These governances consistently reaffirm that accurate, effective communication between patients and clinicians is the most essential component of the healthcare encounter.

Joint Commission Requirements:

- Effective communication with patients in a language the patient understands;
- Consideration of patients' cultural and spiritual values within their treatment;
- Provision of patient education materials in a language the patient understands;
- A written statement of patient rights in a manner they understand;
- Collection and documentation of each patients' preferred language.
- Qualification of interpreters through proficiency assessment, training, education and experience.

The Joint Commission defines a qualified interpreter as one who (students are not qualified interpreters):

- Has been assessed for their fluency in both languages
- Is proficient in the skills and ethics of interpreting
- Is knowledgeable about specialized medical terms and concepts

Bilingual staff is **prohibited** from interpreting for patients unless they have been deemed qualified by the Interpreter Services Office. Family or friends are not permitted to interpret for patients except when requested by the patient, after signing a waiver. The use of minors to interpret is strictly prohibited, under any circumstances.

LEP patients MUST be offered language assistance at no cost for services provided. Staff should never say to patients: "An interpreter is not available."

The following policies have been adapted to comply with federal, state and Joint Commission regulations and must be read prior to counseling is done at UConn Health (click on the links):

Interpreters/Linguistic Access for Persons with Limited English Proficiency (HAM #08-007)

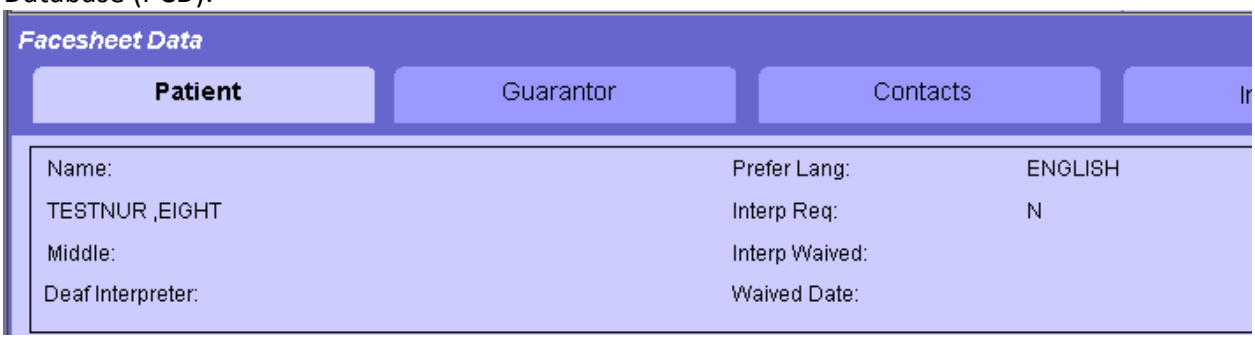
Effective Communication with Deaf and Hard of Hearing Patients (Policy 2016-04)

Patients' Facesheets (front of chart) are printed with:

1. Preferred Language
2. Interpreter Required
3. Interpreter Waived
4. Date Waived

These fields are also in CPOE/LCR in the Facesheet Data and within Nursing Admission

Database (PCD).



Over the phone interpreting for those with LEP can be accessed 24hrs/day through any standard phone or by a direct connection with the dual handset phones, located within each patient care area. Note that any standard phone can be used to access interpreters if needed.

Speak, at a regular pace and volume, directly to the patient- not to the interpreter. The interpreter will convey the speaker's tone and anything else that they hear. Interpreters are bound by a Code of Ethics which includes strict confidentiality of all interpreted communications.

Deaf and hard of hearing patients

- Maintain eye contact with the patient.
- Be aware that Deaf people pick up on very subtle facial and body movements. The "tone of your voice" is determined by your facial expressions.
- Many Deaf people do not read lips at all. This is not a reliable method of communicating as only about 30% of spoken English is visible on the lips. The remainder being guesswork and "fill in the blanks". Consider trying to lip-read the phrases "car accident" or "heart attack" or other undistinguishable words (e.g. shoes, choose, juice).
- American Sign Language has a different syntax and grammar than written or spoken English. Please be advised that how "well" Deaf patients may read and write English is not necessarily an indication of their intelligence.
- VRI-Video Remote Interpreting can be used for deaf patients

The clinician administering medical care is responsible for documenting the presence of a qualified interpreter within the patient record. If a patient has waived services and is using their own interpreter, document person's name and relationship to the patient. When using the VRI or the Voiance telephone interpreters for LEP patients, document the telephone interpreter's ID# in the patient record.

Documentation

8) The last thing that needs to be done is documentation of the encounter. Before heading back to the pharmacy, inform the pharmacist on the unit that the counseling is complete who will then make note of the encounter. There is also a spreadsheet located in the pharmacy to keep account of the encounters so be sure to fill it out daily for each counseling encounter.

9) Lastly, inform your preceptor of all the patient's names you successfully counseled and she will document the session in LCR. Below is an example of what is recorded as part of the patient's profile:

D: Education required for warfarin.

A: Spoke to patient regarding indication for warfarin, how to take Warfarin, drug and food interactions, and monitoring of ADRs. Teaching on warfarin completed with patient. Patient given handout "A Patient's Guide to Warfarin' from JDH Department of pharmacy.

R: Patient confirmed they understood the information provided and left written communication with patient.

The note is in "DAR" form and is documented in the patient care flowchart section in LCR. The "DAR" provides a model for documenting patient care actions. The D stands for data, which contains subjective and/or objective information that supports the stated focus or describes the patient status at the time of an intervention. The A stands for action and contains a description of interventions made to address the patient's status. The R stands for response and describes the patient's response to the intervention.

The clinician administering medical care is responsible for documenting the presence of a qualified interpreter within the patient record. If a patient has waived services and is using their own interpreter, document person's name and relationship to the patient. When using the VRI or the Voiance telephone interpreters for LEP patients, document the telephone interpreter's ID# in the patient record.

Appendix I: Counseling Log –Counseled

Patient Name	Admit number	MR Number	Dx	New	Cont Therapy

Appendix II: Counseling Log – Not Counseled

Patient Name	Admit number	MR Number	Dx	New	Cont Therapy	Reason

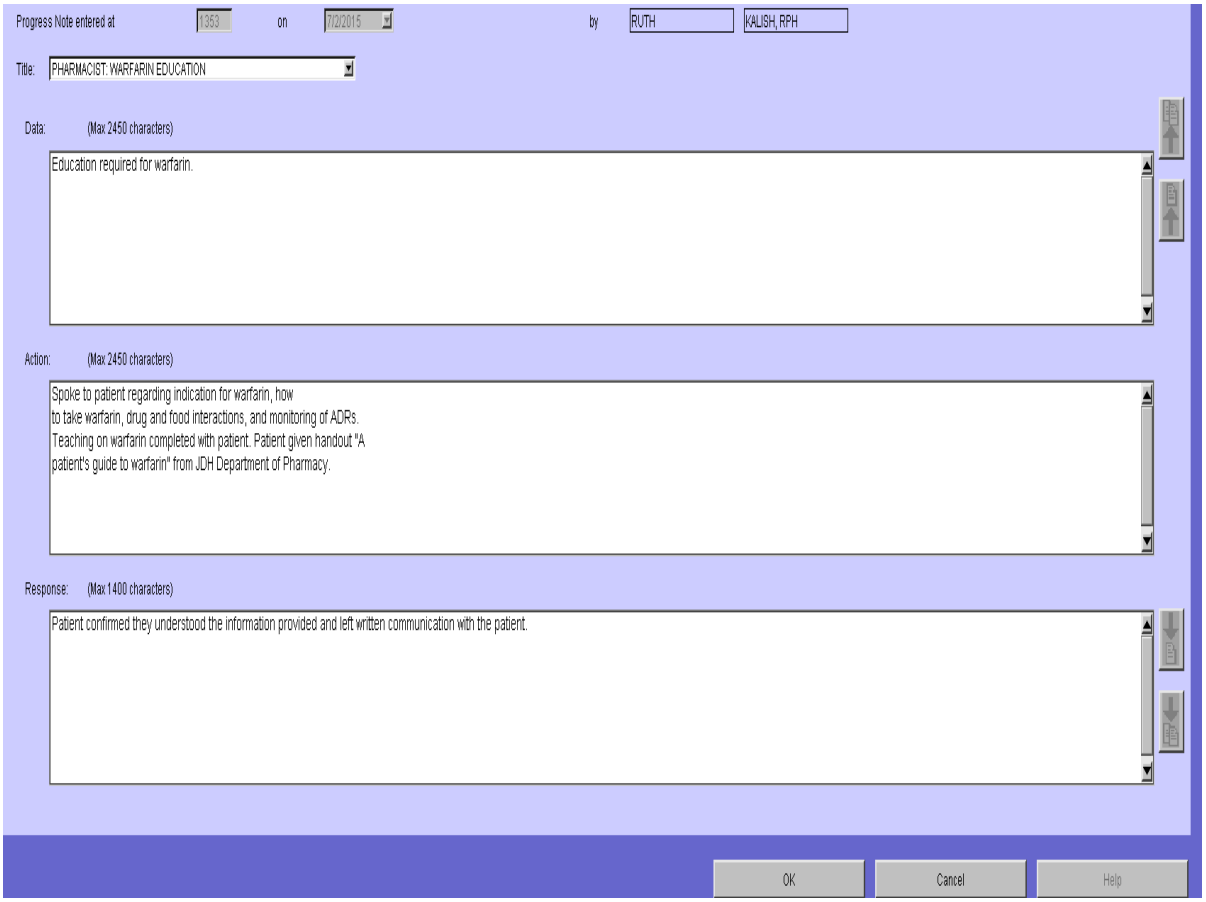
Appendix III: Example of DAR*

D: Education required for warfarin.

A: Spoke to patient regarding indication for warfarin, how to take Warfarin, drug and food interactions, and monitoring of ADRs. Teaching on warfarin completed with patient. Patient given handout "A Patient's Guide to Warfarin' from JDH Department of pharmacy.

R: Patient confirmed they understood the information provided and left written communication with patient.

*Don’t forget to document if interpreter services used within the DAR note



Appendix IV: How to Document

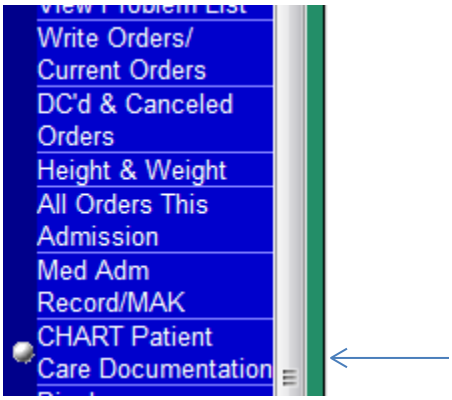
Documenting Warfarin Education

Log-in to LCR/POE

Select Unit from “In-Patients Census”

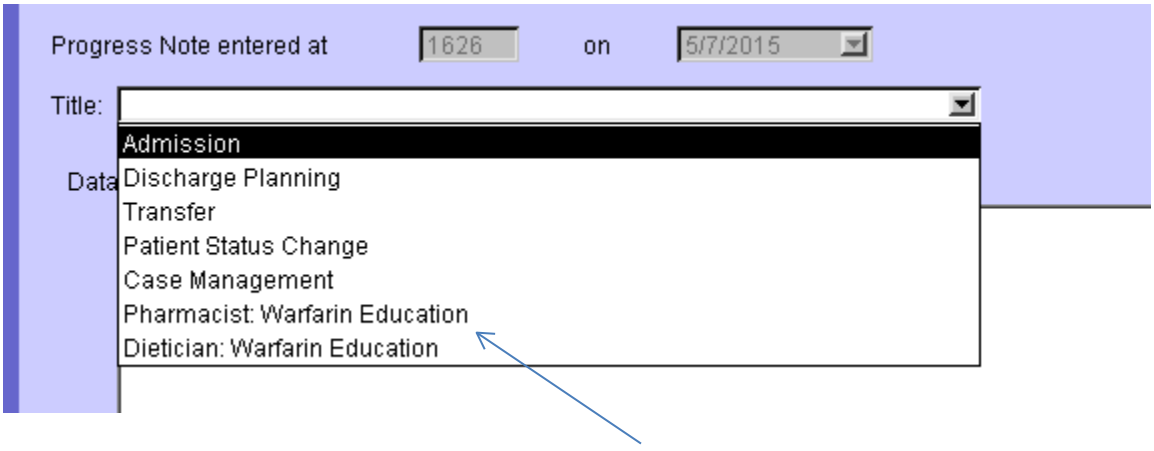
Select patient’s name

Select “Chart Patient Care Documentation”



This will open to Chart Progress notes

Select the title of the note, modify the date and time if you are “back” charting



Complete the 3 sections of the note

Select OK, you are all done. Log-out of LCR/POE.

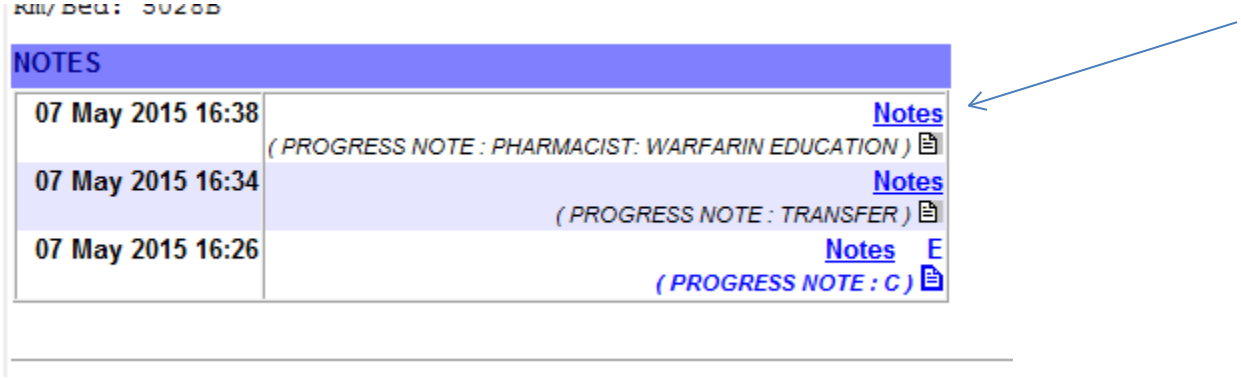
To revise or delete a note select Revise Progress/Care Plan Notes

Select Append text, you will not be able to change the original note only add a clarification to the existing note. Once completed select "Chart"

To delete a note select append text providing reason for deleting note. Select chart. Select the note you want to delete and Revise and then delete note finally select chart. The note will be marked as erroneous and will remain in the chart.

To review the documentation select Display Patient Care Documentation:

Select progress/Care Plan Notes/select the blue NOTES and the note will display



If you are reviewing the note in the same entry session you must hit refresh to the note to apply to the chart.