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Infective endocarditis (IE) is one such life-threatening infection resulting from electronic medical record identified patients with ICD-10 codes for both January 1, 2016 to December 31, 2018. A list generated from the chart review of adult SUD patients with infective endocarditis. This Institutional Review Board (IRB) approved study is a retrospective functioning and mental, physical, social, emotional, or spiritual well-being. Trauma results from an event, series of events, or set of circumstances this is SAMHSA defines trauma as: "Individual failure to meet major responsibilities at work, school, or home" (SAMHSA, 2019a, line 28). “Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home” (SAMHSA, 2019b, par. 4). People with SUD are at a higher risk for infections from unsafe injection practices.

Infective endocarditis (IE) is one such life-threatening infection resulting from IV drug use. People with SUD and IE require hospitalization and long-term antibiotics. There are limited publications about the care of hospitalized patients both with SUD and IE.

Two studies from research hospitals located in Massachusetts and Oregon support a need for a systematic team-based care model (Rosenthal, et al., 2019b, para. 4). People with SUD are at a higher risk for infections from unsafe injection practices.

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), an estimated 312,000 people in Oregon are diagnosed with Substance Use Disorder (SUD)(2019a, line 28). “Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home” (SAMHSA, 2019b, para. 4). People with SUD are at a higher risk for infections from unsafe injection practices.

A total of 25 patients (88%) had a urine toxicology screen on admission. None of the patients in the study received services from abusers provider or addition-specific team while at PSVMC. Only 8 (28%) of patients were discharged on MAT with Suboxone or methadone. Additionally, 0 (0 %) of the sample size went to inpatient substance abuse rehabilitation centers.

Fourteen patients (48%) discharged home, which included personal home, friend or family home, or shelter. 7 (24%) were discharged to Skilled Nursing Facilities, 6 (21%) were unhoused, 2 (7%) died. Of the 29 patients, 5 (21%) left against medical advice regardless of discharge location.

Readmission was defined as a readmit to any Providence facility within a six-month window following the discharge. Forty-three (14%) patients were readmitted.

This study identifies gaps in admission screening, in-hospital treatment for drug use, and discharge planning related to SUD patients admitted with IE.

Not every patient had a urine toxicology screen on admission. In addition, no current screening tool, risk assessment, or model of care existed for this population. During their stay no pathway bundle existed. No substance use physician was available to prescribe a medicated assisted treatment (MAT) or facilitate a treatment plan upon discharge. Gaps in discharge also included no patients discharging to an in-patient drug rehab center.

This study supports the need to improve care for this vulnerable population by developing a systematic team-based care model. Recommendations to improve care would be to collaborate with our interdisciplinary team to create a care pathway bundle for patients diagnosed with SUD and IE. This pathway bundle will include standard care practices written into policy that will use a screening tool for identifying these patients, TIC education for caregivers, a patient agreement upon admission, urinalysis screen upon admission, consultation with a substance abuse physician, and close follow up with social work.

Limitations for this study include a small sample size of 29 patients and the chart review process. The study population was found using ICD 10 Codes in the electronic medical record. As a result the study population may underestimate the number of patients with SUD and IE. Missed opportunities include the inability to include social work in reviewing the study population and lack of post-hospital follow-up data. We were also unable to collaborate follow-up care, as many patients did not have strong follow-up care documentation. The study only followed our patients for 6 months post discharge. Despite the limitations this study does provide information that can be used for initiating interventions for this population.

Further research will need to be done once a Standard of Care is implemented. The research and data would suggest that a best practice standardized approach with an additions team is warranted, and that addicted patients be treated by this team.


References