The Way UP:
How Four Cross-Cutting Strategies Can Reduce Harm Across the Board

American Hospital Association

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Today's Agenda

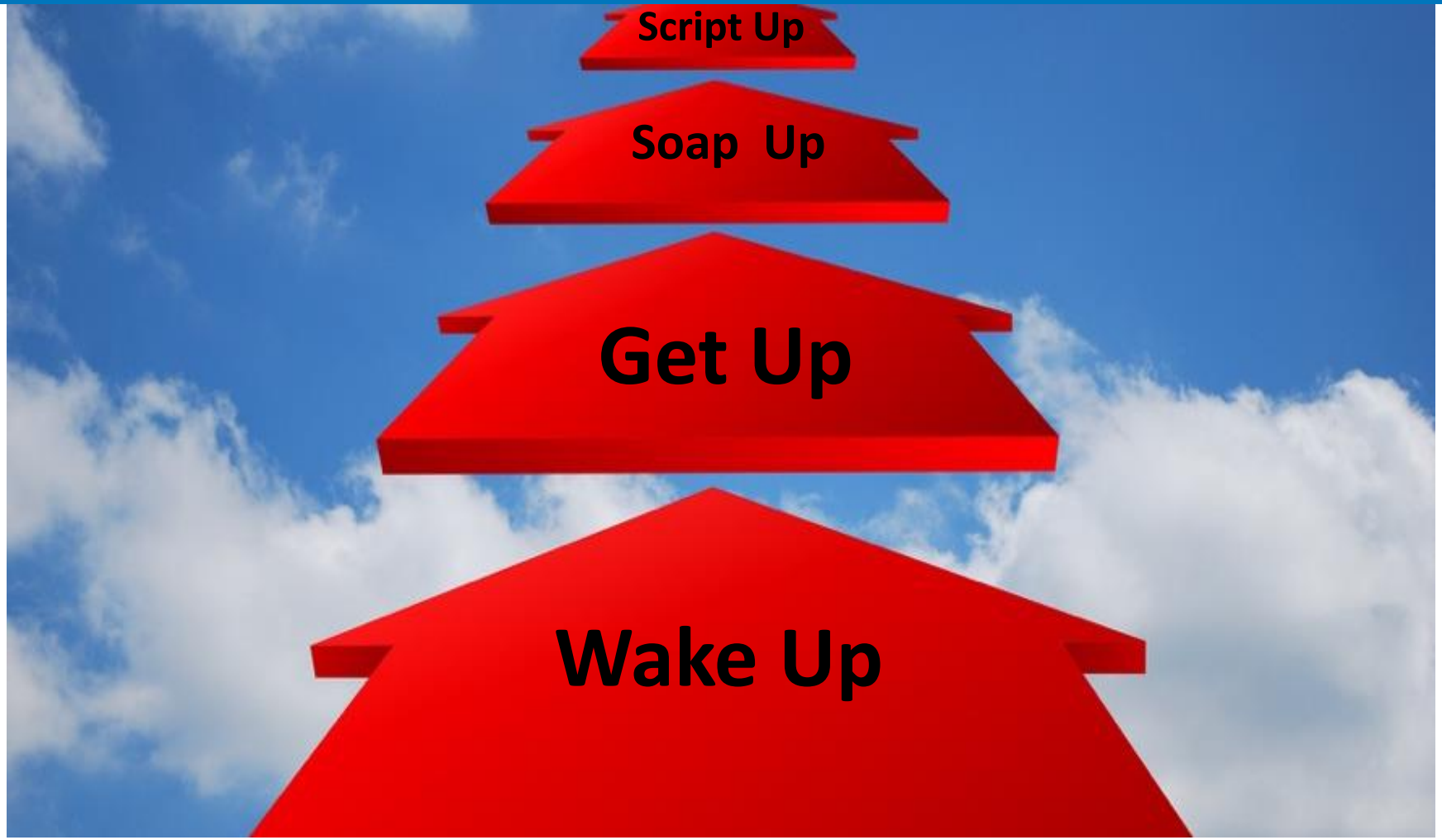
- 11:30 – 11:35: Welcome & Introductions
  - Nikki Medalen & Jean Roland, Quality Health Associates of North Dakota
- 11:35 – 12:10: WAKE UP!
  - Steve Tremain, MD, Cynosure Health
- 12:10 – 12:25: Open Discussion
- 12:25-12:30: Wrap Up and Next Steps
  - Nikki and Jean

Poll #1

Who is in the Audience?

1. Quality leader
2. Administrator
3. Physician
4. Staff nurse
5. Pharmacist
6. Other

A Fresh Approach to Harm Reduction



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Questions to Run On

- How can we better engage front-line caregivers without creating additional burdens?
- What could introducing a simple, cross-cutting set of practices accomplish with your hospitals?
- How can you deploy a program like the UP Campaign with your hospitals and strengthen front-line engagement?

Why the "UP" Campaign?

- Increases impact on harm reduction
- Generates momentum in your organization
- Focuses support from leadership
- Engages front line staff
  - connects the dots
  - creates a vision
- Applies throughout organization
- Simplifies patient safety implementation
- Help patients recover **faster** and with **fewer** complications

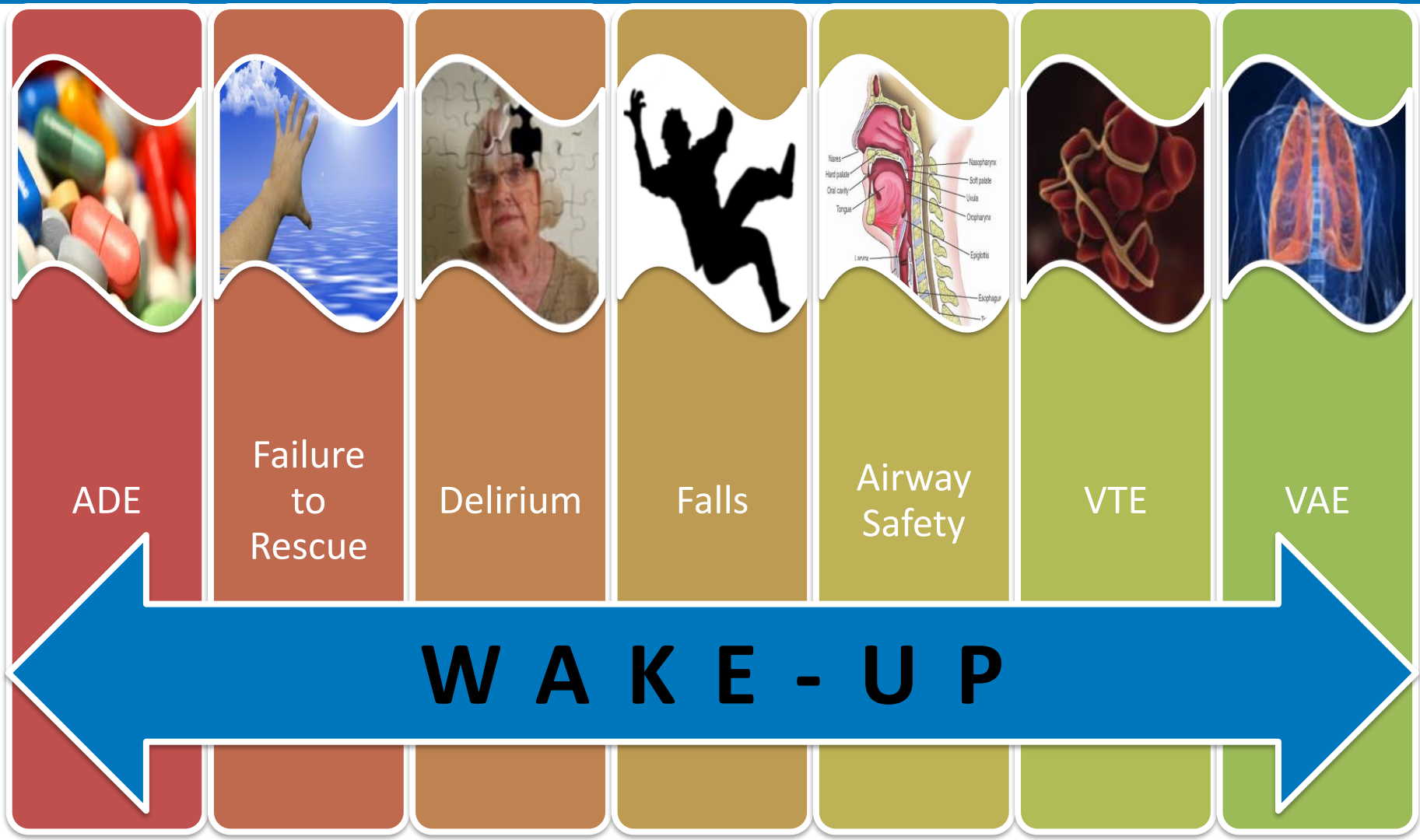
Goal: engage front-line staff and leaders and to increase critical thinking skills.

Can we streamline and simplify making it easier for front-line staff and still improve safety?

Objectives

- Outline the UP Campaign crosscutting interventions
- Develop messaging for the UP Campaign for your facility
- Identify essential next steps for WAKE-UP, GET-UP, SOAP-UP and SCRIPT-UP

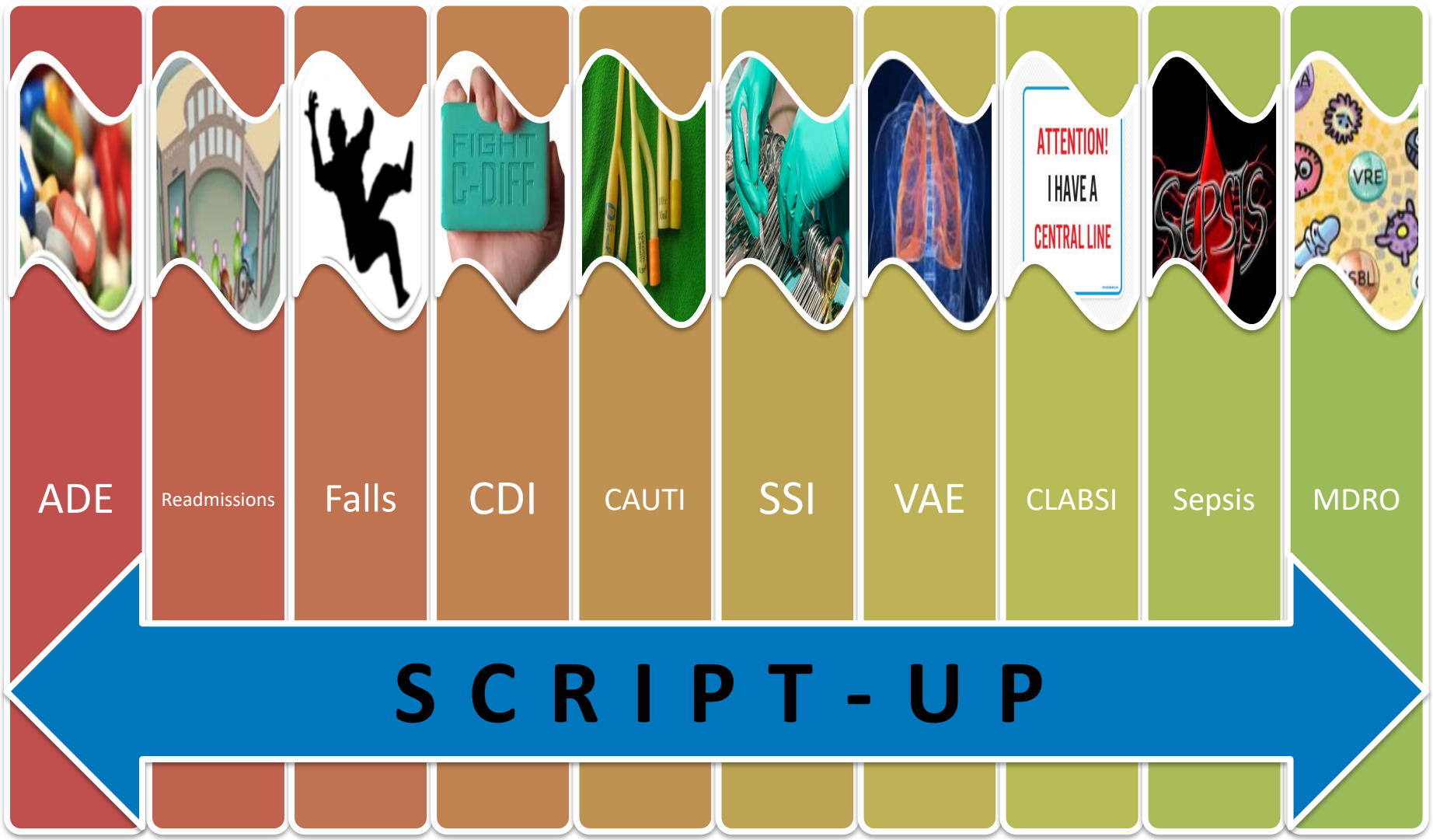
1 Opioid & Sedation Management



2 Early Progressive Mobility

3 Hand Hygiene

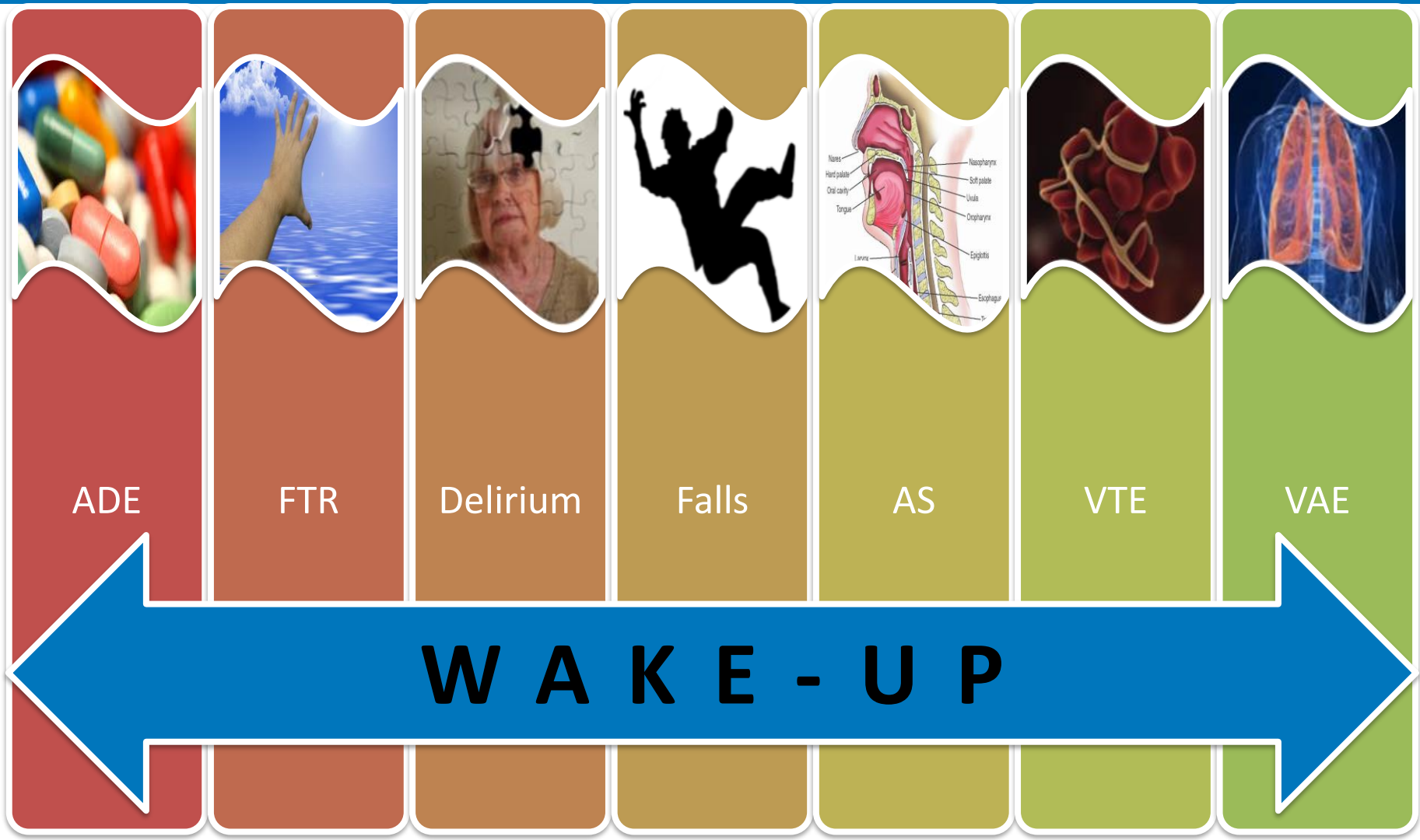
#4 Optimize Medications



FOUNDATIONAL QUESTIONS:

1. Is my patient awake enough to get up?
2. Have I protected my patient from infections?
3. Does my patient need any medication changes?

1 Opioid & Sedation Management



Poll #2

Have you ever had a scary over-sedation event at your hospital or another?

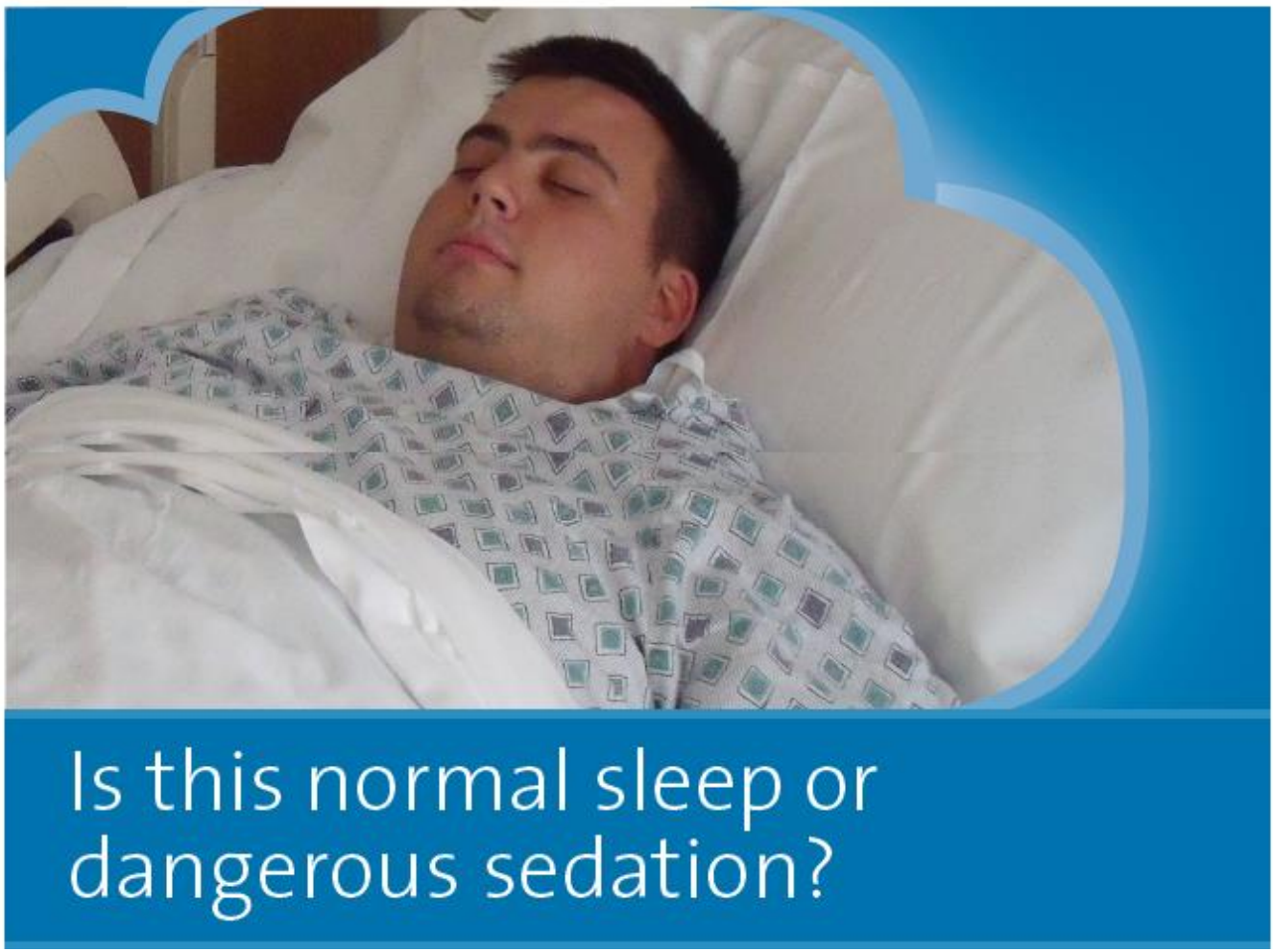
1. Yes, where I work now
2. Yes, where I worked in the past
3. No

Poll #3

Have you ever personally been involved in a clinical situation where the patient suffered harm, or could have suffered harm from iatrogenic over-sedation?

1. Yes
2. No

Sleep vs Sedation

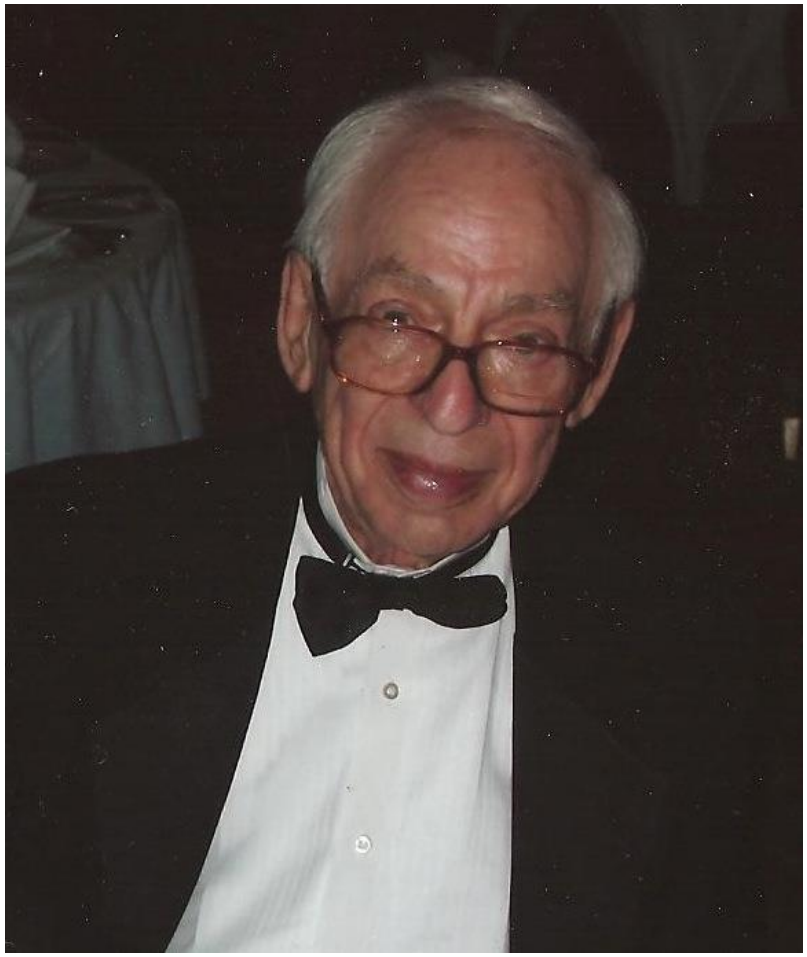


Story #1

Not Just Sedatives and Opioids

- Antihistamines/anticholinergics
- Antipsychotics
- Some antidepressants
- Anti-emetics
- Muscle relaxants

Story #2



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ICU Pitfalls of Sedatives and Analgesics

Sedatives and analgesics may contribute to:

- Increased duration of mechanical ventilation
- Length of intensive care requirement
- Impede neurological examination
- May predispose to delirium

Kollef M, et al. *Chest*. 114:541-548.
Pandharipande et al. *Anesthesiology*. 2006;124:21-26.

Med/Surg Pitfalls of Sedatives and Analgesics

- Over sedation
- Transfer to ICU
- Hypoxic encephalopathy
- Death

Tools That Will Help

- STOP BANG
- POSS: Pasero opioid-Induced Sedation Scale

MUST DO's

WAKE-UP MUST DO's

1. Establish Expectations

2. Pair POSS & Pain

3. Manage with Multiple Modalities

MUST DO #1
Establish Expectations

Goals of Pain Management:

- Relieve suffering
- Achieve early mobilization
- Reduce hospital length of stay

THE GOAL IS NOT ZERO PAIN!

MUST DO #2
Pair POSS & Pain

Just Right!

Over Medicated: Hibernating

Under Medicated: Not Happy

☹#@xx!!

POSS AKA "GOLDILOCKS SCALE"


S- Sleep, easy to arouse


1- awake and alert


2- slightly drowsy


3- frequently drowsy, drifts off to sleep during conversation


4- somnolent, minimal or no response to stimulation

Pasero Opioid-Induced Sedation Scale (POSS) With Interventions*

S = Sleep, easy to arouse

Acceptable; no action necessary; may increase opioid dose if needed

1 = Awake and alert

Acceptable; no action necessary; may increase opioid dose if needed

2 = Slightly drowsy, easily aroused

Acceptable; no action necessary; may increase opioid dose if needed

No discharge from PACU
No additional opioids

3 = Frequently drowsy, arousable, drifts off to sleep during conversation

Unacceptable; monitor respiratory status and sedation level closely until sedation level is stable at less than 3 and respiratory status is satisfactory; decrease opioid dose 25% to 50%[1] or notify primary[2] or anesthesia provider for orders; consider administering a non-sedating, opioid-sparing nonopioid, such as acetaminophen or a NSAID, if not contraindicated; ask patient to take deep breaths every 15-30 minutes.

4 = Somnolent, minimal or no response to verbal and physical stimulation

Unacceptable; stop opioid; consider administering naloxone[3,4]; stay with patient, stimulate, and support respiration as indicated by patient status; call Rapid Response Team (Code Blue) if indicated; notify primary[2] or anesthesia provider; monitor respiratory status and sedation level closely until sedation level is stable at less than 3 and respiratory status is satisfactory.

***Appropriate action is given in italics at each level of sedation.**

[1] If opioid analgesic orders or hospital protocol do not include the expectation that the opioid dose will be decreased if a patient is excessively sedated, such orders should be promptly obtained.

[2] For example, the physician, nurse practitioner, advanced practice nurse, or physician assistant responsible for the pain management prescription.

[3] For adults experiencing respiratory depression give intravenous naloxone very slowly while observing patient response ("titrate to effect"). If sedation and respiratory depression occurs during administration of transdermal fentanyl, remove the patch; if naloxone is necessary, treatment will be needed for a prolonged period, and the typical approach involves a naloxone infusion. Patient must be monitored closely for at least 24 hours after discontinuation of the transdermal fentanyl.

[4] Hospital protocols should include the expectation that a nurse will administer naloxone to any patient suspected of having life-threatening opioid-induced sedation and respiratory depression.

Two Scales are Better than One for Narcotic and Sedation Administration

PAIN ALONE

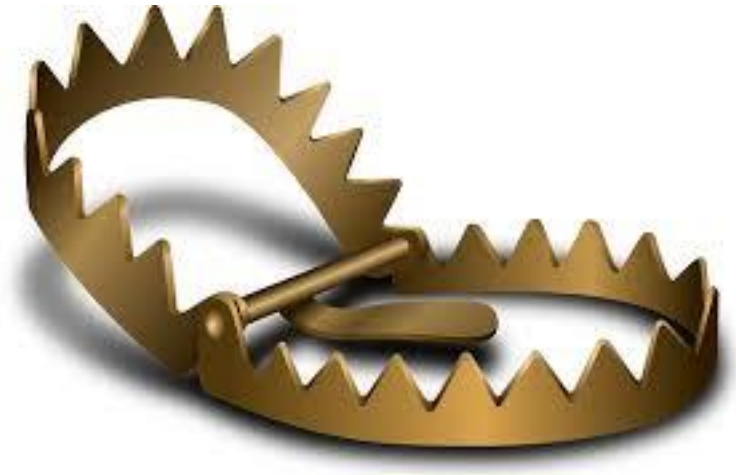
- Risk factors may be absent
- Objective?
- Dosage based on number or range
- Patients and families understand the numeric dosing

PAIN & POSS

- Two scales allow for safer dosing
- High pain scale with high POSS scale – no narcotics
- High pain scale low POSS - med dose

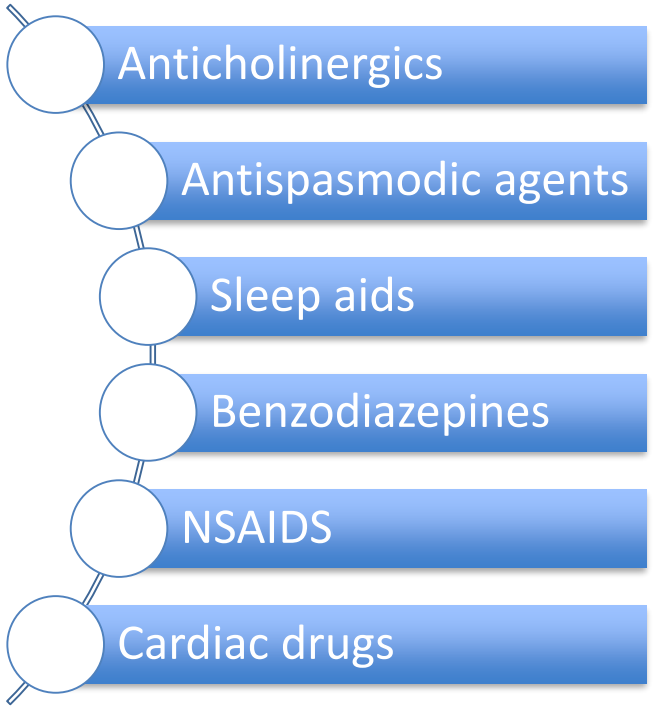
The Traps

- Layering and Stacking
  - Beware of Benzo's
- Beer's List Medications

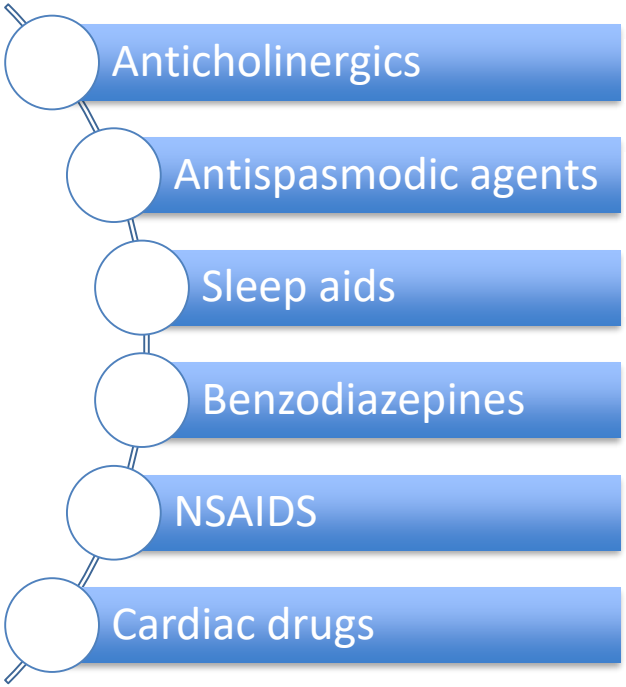


Try to stay away from harmful medications in the elderly

- Flag, stop and replace medications on the Beer's List
- If needed, switch to a safer agent
- If not needed, discontinue medication



Medications to avoid in those over 65yrs



Benadryl®, Phenergan®, Vistaril®

Donnatal®, Bentyl®, Librax®, Probanthine®

Ambien®, Luminal®, Dalmane®, Nembutal®

Ativan®, Valium®, Xanax®, Librium®, Klonopin®

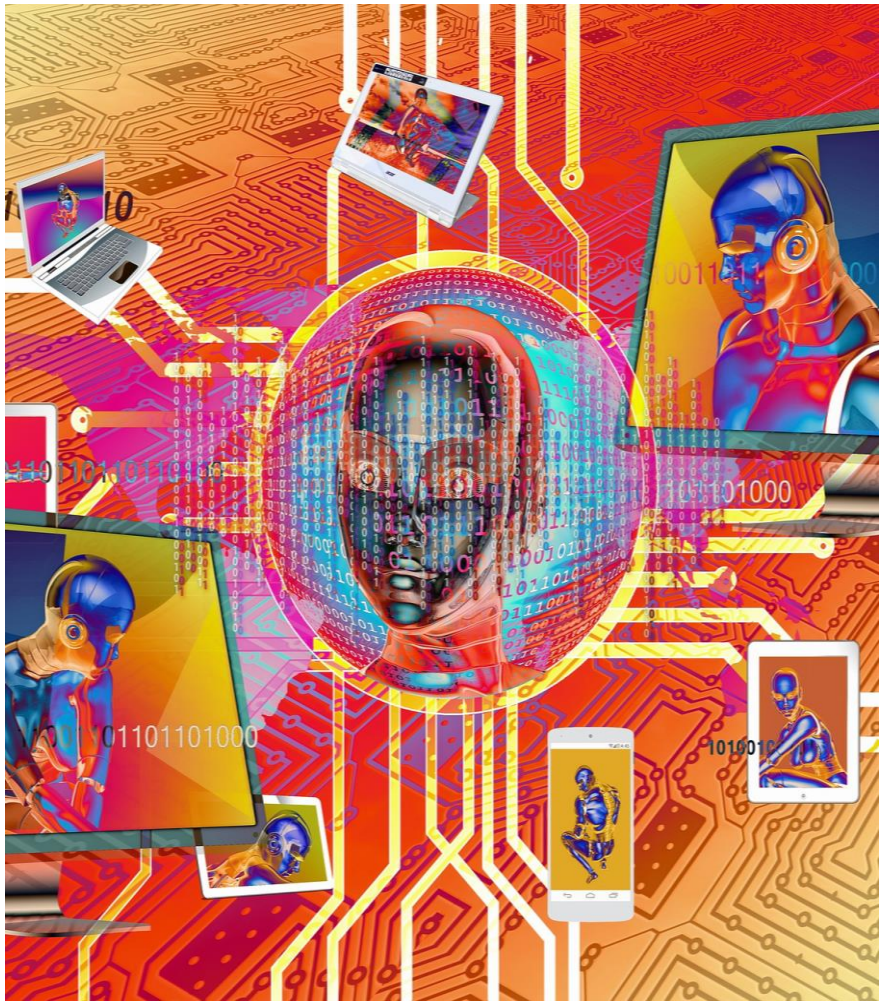
Advil®, Motrin®, Aleve®

Digoxin > 0.125mg/day, Procardia®, Catapres®

MUST DO #3
Multi-Modal Pain Management

Pharmacological and

Non-pharmacological



Multimodal Pain Management

- Combination of opioid and one or more other drugs
  - acetaminophen (Tylenol, others)
  - ibuprofen (Advil, Motrin IB, others)
  - celecoxib (Celebrex)
  - ketamine (Ketalar)
  - gabapentin (Gralise, Neurontin)
- Non-pharmacological interventions

www.mayoclinic.org/pain-medications/art-20046452

Can We Manage Mild to Moderate Pain Adequately Without Medications?

What do we do at home?

Comfort measures:

- Pet therapy
- Warm compresses, blankets
- Ice packs
- Extra pillows
- Aromatherapy
- Massage
- Herbal tea
- Stress ball
- Music

Do Comfort Measures Help?

- These modalities can:
  - Reduce anxiety
  - Reduce pain
- Reducing anxiety can reduce pain
- Non-pharmacologic pain reduction methods reduce the need for pain medications

Do Hospitals Offer These?

http://www.hopkinsmedicine.org/the_johns_hopkins_hospital/services_amenities/services/pain-control-comfort-menu.html

Positive Results!

- Pain scores
- Nausea scores
- Anxiety scores….

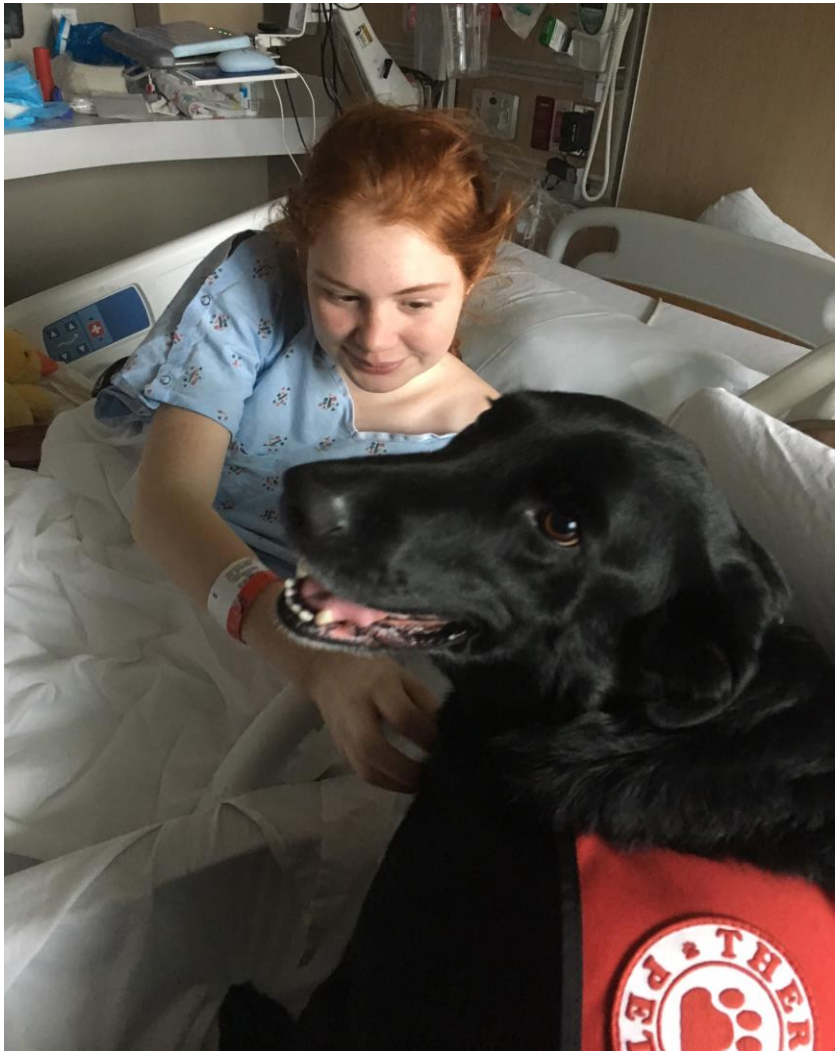
All decreased by more than 50%

NEXT: Looking to see if opioid usage and opioid ADEs are both decreased.

Multi-Modal Case Study

Emma, age 13, had her 3rd surgery for a congenital foot deformity. Pain management was problematic, so both gabapentin and pet therapy were added to lower opioid doses with excellent results, allowing discharge to home 36 hours later.

Emma and Lucy



WAKE UP Check Point

To reduce Adverse Drug Events, Failure to Rescue, Delirium, Falls, Airway Safety, VTE and VAE:

- ✓ Are you using the Pasero Opioid-induced Sedation Scale (POSS) prior to and after opioid administration?
- ✓ Do you offer multimodal pain management; both pharmacologic and non-pharmacologic modalities?
- ✓ Are you setting pain management expectations ("0" is not the goal) prior to admission?
- ✓ Are you asking about comfort level in addition to pain score?
- ✓ Are you using Teach-Back methods with patients and families to enhance their knowledge and assist in setting pain management expectations?

And What About End of Life Care?

- Advanced Directives?
- Palliative Care (formal or informal)?
- Comfort opioids for end of life pain?

Questions and Discussion!

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thanks

Dr. Steve Tremain, Improvement Advisor
Cynosure Health