WELCOME AND INTRODUCTIONS

Raahat Ansari, Program Manager, HRET | 11:00 – 11:05
WEBINAR PLATFORM QUICK REFERENCE

Mute your computer audio →

Today’s Presentation

Chat with the Group

Download today’s slides and resources
## AGENDA FOR TODAY

<table>
<thead>
<tr>
<th>Time</th>
<th>Session Title</th>
<th>Description</th>
<th>Facilitators</th>
</tr>
</thead>
<tbody>
<tr>
<td>11:00-11:05 a.m.</td>
<td>Welcome and Introductions</td>
<td>Open and housekeeping information, including review of relevant HRET HEN resources, change packages and Listserv®.</td>
<td>Raahat Ansari, Program Manager, HRET</td>
</tr>
<tr>
<td>11:05-11:10 a.m.</td>
<td>The “UP” Campaign: WAKE UP</td>
<td>Introducing the “UP” campaign and the role of crosscutting interventions in reducing multiple hospital-acquired conditions (HACs). Shifting focus from many interventions to a few with far-reaching impact.</td>
<td>Maryanne Whitney, RN, CNS, MSN, and Steve Tremain, MD, FACPE, Improvement Advisors, Cynosure Health</td>
</tr>
<tr>
<td>11:10-11:25 a.m.</td>
<td>Sedation: Too Much Temptation?</td>
<td>Didactic discussion of the risks of over-sedation in ICU and non-ICU patients and how over-sedation places patients at risk for multiple HACs. Best practices for sedation and barriers to change and how to overcome them will also be discussed.</td>
<td>Heidi Engel, PT, DPT, Physical Therapist, Member, ICU Liberation Committee, University of California, San Francisco</td>
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<tr>
<td>11:25-11:35 a.m.</td>
<td>Hospital Story</td>
<td>Sharing about their implementation of crosscutting intervention.</td>
<td>Christine Gibbs, RN, MSN, Manager, MICU, Health First Cape Canaveral Hospital, Kathleen McLaughlin, RN, CCRN, Assistant Manager, MICU, Health First Palm Bay Hospital, Florida</td>
</tr>
<tr>
<td>11:35-11:50 a.m.</td>
<td>Implementing the POSS</td>
<td>Successful implementation strategies to reduce over-sedation by implementation of the Pasero Opioid-Induced Sedation Scale (POSS).</td>
<td>Paula Kobelt, MSN, RN-BC, Outcomes Manager, Pain Management and Complementary Therapies, Ohio Health Grant Medical Center, Columbus, Ohio</td>
</tr>
<tr>
<td>11:50-11:55 a.m.</td>
<td>Discussion</td>
<td>Facilitated questions and chat.</td>
<td>Maryanne Whitney and Steve Tremain</td>
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<tr>
<td>11:55 a.m.-12 p.m.</td>
<td>Bringing it Home</td>
<td>Close and reminders about next steps and upcoming “UP” webinars.</td>
<td>Raahat Ansari</td>
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</tbody>
</table>
THE "UP" CAMPAIGN: WAKE UP

Maryanne Whitney, RN, CNS, MSN & Steve Tremain, MD, FACPE Improvement Advisors, Cynosure Health | 11:05 – 11:10
Topic Fatigue?
Rejuvenate with the UP Campaign!
“UP” the targets
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
#1 OPIOID AND SEDATION MANAGEMENT

ADE  FTR  Delirium  Falls  AS  VTE  VAE

WAKE - UP
<table>
<thead>
<tr>
<th>W</th>
<th>Warn Yourself: This is high risk.</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Assess: Use tools (STOP BANG, POSS, RASS, PA-PSA).</td>
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<tr>
<td>K</td>
<td>Know: Your drugs, your patient.</td>
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<tr>
<td>E</td>
<td>Engage: Patients and families to set realistic pain expectations, use of non-sedating analgesics, risks of opioids.</td>
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<tr>
<td>U</td>
<td>Utilize: Dose limits, layering limits, soft and hard stops.</td>
</tr>
<tr>
<td>P</td>
<td>Protect: The patient...our ultimate job.</td>
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</tbody>
</table>
#2 EARLY PROGRESSIVE MOBILITY

Falls  PrU  Delirium  CAUTI  VAE  VTE  Readmissions

GET UP
<table>
<thead>
<tr>
<th>G</th>
<th>Go: Determine the resources in your institution and how you will implement a mobility program.</th>
</tr>
</thead>
<tbody>
<tr>
<td>E</td>
<td>Evaluate (Patient Capabilities): On which scale/tool/evaluation method will you standardize?</td>
</tr>
<tr>
<td>T</td>
<td>Team up for progressive mobility: Rehab, nursing and respiratory join to implement the mobility plan.</td>
</tr>
<tr>
<td>U</td>
<td>Unite: Engage patients, families and friends in mobility progression.</td>
</tr>
<tr>
<td>P</td>
<td>Promote progress: Measure and report unit mobility performance.</td>
</tr>
</tbody>
</table>
#3 HAND HYGIENE

- **CDI**
- **CAUTI**
- **SSI**
- **VAE**
- **CLABSI**
- **Sepsis**

**SOAP - UP**

**ATTENTION! I HAVE A CENTRAL LINE**
<table>
<thead>
<tr>
<th>S</th>
<th>Scrub: For 20 seconds with the right product. Remember soap for <em>C. diff.</em></th>
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</thead>
<tbody>
<tr>
<td>O</td>
<td>Own: Your role in preventing HAIs.</td>
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<tr>
<td>A</td>
<td>Address: Immediately intervene if breach is observed.</td>
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<tr>
<td>P</td>
<td>Place: Hand hygiene products in strategic locations.</td>
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<tr>
<td>U</td>
<td>Update: Hand hygiene products and policies as needed to promote adherence.</td>
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<tr>
<td>P</td>
<td>Protect: Patient and families; get them involved.</td>
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</table>
SEDATION: TOO MUCH TEMPTATION?

Heidi Engel, PT, DPT, UCSF | 11:10 – 11:25
# IMPROVE PATIENT COMFORT, SAFETY, AND OUTCOMES

<table>
<thead>
<tr>
<th>PAD SYMPTOMS</th>
<th>ASSESSMENT AND MONITORING TOOLS</th>
<th>CARE IMPROVEMENT ABCDEF BUNDLE</th>
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<tbody>
<tr>
<td><strong>P</strong>AIN</td>
<td><strong>NRS:</strong> Numeric Rating Scale</td>
<td><strong>A</strong>ssess, Prevent and Manage Pain</td>
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<td><strong>BPS:</strong> Behavioral Pain Scale</td>
<td><strong>B</strong>oth Spontaneous Awakening Trials and Spontaneous Breathing Trials</td>
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<td><strong>CPOT:</strong> Critical Care Pain</td>
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<td>Observation Tool</td>
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<tr>
<td><strong>A</strong>GITATION</td>
<td><strong>RASS:</strong> Richmond Agitation Sedation Scale</td>
<td><strong>C</strong>hoice of Sedation</td>
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<td></td>
<td><strong>SAS:</strong> Sedation Agitation Scale</td>
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<tr>
<td><strong>D</strong>ELIRIUM</td>
<td><strong>CAM-ICU:</strong> Confusion Assessment Method for ICU</td>
<td><strong>E</strong>arly Mobility and <strong>E</strong>xercise</td>
</tr>
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<td></td>
<td><strong>ICDSC:</strong> Intensive Care Delirium Screening Checklist</td>
<td><strong>F</strong>amily Engagement and Empowerment</td>
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</table>
GOALS OF ICU SEDATION

• Calm; assess and treat for pain first
• Comfort; assess and treat for pain and dyspnea first
• Communicate; see whether patient is able to communicate clearly
• Reduce anxiety and agitation
• Facilitate mechanical ventilation
• Decrease traumatic memory of ICU stay and procedures
“When am I going to walk? I walked yesterday. It’s better than just being in the chair. I feel better when I am walking.”
AVOID CHEMICAL RESTRAINTS AND FEEL THE WEIGHT OF CRITICAL ILLNESS WELL BEYOND SURVIVAL
SCCM PAIN CARE BUNDLE

Assess

- Assess pain ≥ 4x/shift and PRN
- Significant pain with NRS >3, BPS >5, or CPOT>2

Treat

- Treat pain within 30 minutes of detecting significant pain and reassess:
  - Non-pharmacological treatment (e.g., relaxation)
  - Pharmacological treatment

Prevent

- Administer pre-procedural analgesia and/or non-pharmacological interventions
- Treat pain first, then sedate

All ICU patients should be routinely assessed for:
- **Pain** (Likert self-report, or BPS/CPOT non-self-report)
- **Agitation/depth of sedation** (RASS/SAS)
- **Delirium** (CAM-ICU/ICDSC)

Important factors influence the choice and dose of analgesia and sedative medications.

Non-pharmacologic strategies play an important role when managing pain and agitation.
POTENTIAL HARMs RESULTING FROM AN ICU STAY

• Weakness
• Delirium and cognitive changes
• Loss of endurance
• Psychological trauma
• Loss of income and ability to engage in previous activity or work
THE IMPACT OF IMMOBILITY

The duration of bed rest during critical illness was consistently associated with weakness throughout 24-month follow-up.


Based on available evidence, early exercise/PT seems to be the only treatment yet shown to improve long-term physical function of ICU survivors.

DIRECTLY RELATED TO AMOUNT OF TIME IN BED

• Bed rest was associated with loss of strength 4-5 percent per week in healthy, well-nourished subjects

• Acute skeletal muscle wasting in critical illness – via u/s of quad cross section areas – lose 18 percent in 10 days
  – Pt w/single organ failure muscle wasting starts as early as day 3 (2%) by days 7 (3%)
  – Pt w/multi-organ fail wasting at day 3 (9%) day 7 (16%)
  – Bottom line: Early and rapid muscle wasting over first week
SIDE EFFECTS OF BED REST

• Muscle strength in a healthy person can decrease 1.3% to 3% for every day spent on bedrest.¹
• Effects are more profound in older people and in those with critical illness.²
• A new study suggests that 3% to 11% strength loss occurs for every day in bed in an ICU setting.³
  – Age and days on bedrest are independent predictors of worsening function.

POTENTIAL COGNITIVE AND PSYCHOLOGICAL HARM

- Delirium
  - “Although estimates differ, it appears that at least 1 in 3 survivors of critical illness will experience long-term cognitive impairment of a severity consistent with mild to moderate dementia.”
  - [www.icudelirium.org](http://www.icudelirium.org), US Department of Veterans Affairs

- Post Traumatic Stress Disorder (PTSD)
  - Risk factors: pre-ICU anxiety or psychological history, length of mechanical ventilation required, type of sedation used

COGNITIVE CHANGES RELATED TO ICU STAY

• 25 to 40 percent of patients with new onset cognitive changes
  — Impaired learning and short term memory
  — Executive function
  — Attention

• **Contributing Factors:** Hypoxemia, variable glucose control, delirium, sepsis

RECOGNIZING DELIRIUM

• Most often it is hypoactive delirium
• Inattentive and disorganized thinking
• CAM ICU Tests for Delirium, Target Richmond Agitation-Sedation Scale (RASS) vs Actual RASS
• Don’t rely on assumptions
• Profound long-term implications

CAN WE DO BETTER?

“There appears to be significant potential for harm arising from the traditional ICU culture of patient immobility and an often excessive or unnecessary use of sedation.”

ABSOLUTE CONTRAINDICATIONS TO PROGRESSIVE MOBILITY IN ICU

- Patients on neuromuscular blockade
- Hemodynamic instability requiring escalating dose or multiple vasopressors
- Significant oxygenation dysfunction requiring high level of oxygen
- Unstable fractures
- Cerebral edema with uncontrolled intracranial pressure
- Active bleeding
- Intra-aortic balloon pump in femoral artery
- Pacer dependent with transvenous temporary pacemaker
- ECMO with femoral cannulation
- Femoral arterial sheath
- Open chest/open abdomen
FACILITATORS OF MOBILITY

• Adequate staffing
• Dedicated ICU PT/OT
• Cooperation, flexibility, collaboration of staff
• Multi-discipline rounding
• A mobility protocol to make new mobility behaviors routine
• Hemodynamic stability of patient addressed specifically to facilitate mobility
• Awake and alert patient: target RASS 0 to -1 achieved

UNIQUE GOALS FOR PT/OT IN THE ICU

- Pulmonary care
- Cognitive training
- Family engagement
- Identifying patient goals of care
- Acute assessments minute by minute and throughout the day
- Observation of long-term trends
- Keeping circadian cycle normalized
PATIENT AND FAMILY COLLABORATION

Autonomy

Communication

Recognizing the person inside the patient

Connecting to the world outside

Natural light

ICU diaries

Decreasing sense of helplessness
AGITATED WHEN LYING IN BED
RESTRAINED
FULLY ALERT ABLE TO COMMUNICATE
SITTING UP WITH CLIPBOARD
ALLOW YOUR PATIENTS THE
OPPORTUNITY TO SURPRISE YOU, TO
MAINTAIN THEIR DIGNITY, AND TO
RESTORE THEIR LIVES
PASSIVE OUTWARD APPEARANCES
CAN BE HIGHLY MISLEADING
QUESTIONS?

Contact Info:
Heidi Engel, PT, DPT
UCSF Medical Center
Heidi.engel@ucsf.edu
CASE STUDY: HOSPITAL STORY
Christine Gibbs, RN, MSN and Kathleen McLaughlin, RN, CCRN | 11:25 – 11:35
ABOUT US

- Integrated Delivery Network – Four Hospitals - 900 Beds – Health Insurance – Medical Group – Outpatient Services - Serving Space Coast of Florida

- Tertiary Division–
  - Health First’s Holmes Regional Medical Center

- Community Hospital Division–
  - Health First’s Cape Canaveral Hospital
  - Health First’s Palm Bay Hospital
  - Health First’s Viera Hospital
ABOUT US

Health First’s
Cape Canaveral Hospital
Cocoa Beach, FL

Health First’s
Palm Bay Community Hospital
Palm Bay, FL
PREVENTING HARM IN THE ICU

• Using less sedation prevents patient harm
  – Allows for early spontaneous breathing trials resulting in early extubations
  – Decreases ventilator days thus decreased LOS in the ICU
  – Decreases ventilator associated complications, i.e., VAP
  – Decreases patient delirium
  – Decreases patient complications, i.e., hypotension related to sedation
  – Decreases incidence propofol infusion syndrome
CHANGING OUR PROCESS

• Currently we utilize a checklist during change of shift huddle
  – Number of ventilators in the unit
  – Result of previous early morning sedation vacation
  – Is the patient ready for a spontaneous breathing trial as evidenced by:
    • Rapid Shallow Breathing Index (RSBI) < 105
    • Fi02 < 50
    • PEEP < 8
    • Hemodynamically stable
    • Able to follow simple commands
OUR PRIOR PROCESS

• Previously our process was not patient centered
  – Nursing waited for physician to round and initiate the vent weaning process
  – Nursing was not consistent with performing the sedation vacation and sometimes it was not performed by nursing at all during the shift
  – If the patient failed the initial vent weaning another attempt was often times not made for another 24 hours
  – No prior collaboration with respiratory therapy in this process
OUR NEW PROCESS

• Less sedation leads to better outcomes
  – Early morning sedation vacation in collaboration with nursing from both day and night shift during huddle
  – Daily collaboration includes the respiratory therapists
  – Medications are titrated to the Mindful Attention Awareness Scale (MAAS) score
  – Physician order sets for patient sedation dictates desired MAAS score
  – Physicians are now required to utilize specific order sets with parameters as opposed to previous blanket orders “titrate to sedation”
  – Critical Care Observation Tool (CPOT) is utilized with specific goal to titrate and/or administrate opioids/pain medications
BARRIERS AND HOW WE RESOLVED

• What surprised you or came up during the implementation and how did you handle it?
  – Difference of opinion between disciplines on when to start the sedation vacation
  – Initially timing of sedation vacation was not consistent and was based on physician preference
  – Prior to using CPOT nursing questioned if the patient perception of pain was subjective
  – Currently nurses express they have an objective scale to follow and a standardized process
ADVICE FOR OTHERS

• Share any tips and tricks if you could do it over again
  – Decide on a protocol and pre-determined time prior to implementation of your new process
  – Design a checklist in order to reduce errors caused by lack of information and inconsistent procedures
  – Create a standardized work practice to use during morning and afternoon huddles
WRAP UP AND NEXT STEPS

• **Summary:** ICU has been successful with no VAP in over two years at both Palm Bay and Cape Canaveral Hospitals

• **What are you planning next?** Initiatives to continue reducing our restraint usage as well as Foley catheter days

• **Questions?**

• **Contact Info:**

  Christine Gibbs, MSN, RN  
  Nurse Manager, MICU, Cape Canaveral Hospital  
  christine.gibbs@health-first.org

  Kathleen McLaughlin, RN, CCRN  
  Assistant Nurse Manager, MICU, Palm Bay Hospital  
  kathleen.mclaughlin@health-first.org
IMPLEMENTING THE POSS

Paula Kobelt, MSN, RN-BC, Ohio Health  |  11:35 – 11:50
Implementation of a Standardized Sedation Assessment in the PACU to Prevent Post-Operative Opioid-Induced Respiratory Depression

Paula Kobelt, MSN, RN-BC, Outcomes Manager Pain Management and Therapies
Nurses raised concerns about decreasing Adverse Drug Events (ADEs) associated with opioid administration in the PACU.

Bone and Joint PACU
Providing care for 7,000 patients/year

Main PACU
Providing care for 13,300 patients/year
KEY STEPS FOR SUCCESS

Engage Participate
Evidence Proof
Endure Persist

Success
BACKGROUND

PACU nurses’ challenges:

- Patient safety
- Patient satisfaction
- Pain management
- Expediting recovery
- Without increasing risk for opioid related respiratory depression

Kobelt, Burke, Renker (2014), p. 8
OPIOID RELATED ADEs

47% of the negative outcomes were attributed to wrong dose medication errors

29% to improper monitoring

11% were due to excessive dosing, medication interactions and adverse effects
PACU NURSES

Pasero, C., 2013
GUIDELINES FOR PACU NURSES

STANDARDIZED SEDATION ASSESSMENT

- Detect changes in sedation
- Assist nurse critical decision-making
- Identify discharge status
- Provide standardized handoff information

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

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 primary2 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 naloxone3,4; stay with patient, stimulate, and support respiration as indicated by patient status; call Rapid Response Team (Code Blue) if indicated; notify primary2 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.
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
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• Modified by GMC

• No revisions
INTERVENTION: POSS PROTOCOL

The POSS Protocol included adding the POSS with Interventions to the:

- PACU “every 15 minute” assessments and
- Before and after each opioid administration in addition to a pain intensity rating

For POSS 3 or POSS 4:
- No discharge from PACU and no additional opioids
### Perioperative Flowsheet in Epic

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Value 1</th>
<th>Value 2</th>
<th>Value 3</th>
<th>Value 4</th>
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<td><strong>Oxygen Therapy</strong></td>
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<td>SpO2</td>
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<td>O2 Device</td>
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<td>O2 Flow Rate (L/min)</td>
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<td>Pulse Oximetry Type</td>
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<td>Richmond Agitation Sedation Scale (RASS)</td>
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</tbody>
</table>
When is best time to reassess?

Opioid Dosing Guidelines

Badge Backers

<table>
<thead>
<tr>
<th>Opioids (Mu Agonists)</th>
<th>Route</th>
<th>Onset (min)</th>
<th>Peak (min)</th>
<th>Duration (HOURS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine (Immediate release)</td>
<td>PO</td>
<td>30-60 (PO)</td>
<td>60-90 (PO)</td>
<td>3-6 (PO)</td>
</tr>
<tr>
<td>Morphine</td>
<td>IV</td>
<td>5-10 (IV)</td>
<td>15-30 (IV)</td>
<td>3-4 (IV)</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>IV</td>
<td>1-5 (IV)</td>
<td>3-5 (IV)</td>
<td>0.5-4 (IV)</td>
</tr>
<tr>
<td>Fentanyl Patch Transdermal (TD)</td>
<td>TD</td>
<td>12-16 hrs (TD)</td>
<td>24 hrs (TD)</td>
<td>48-72 (TD)</td>
</tr>
<tr>
<td>Hydromorphone (Dilaudid®)</td>
<td>PO</td>
<td>15-30 (PO)</td>
<td>30-90 (PO)</td>
<td>3-4 (PO)</td>
</tr>
<tr>
<td>Hydromorphone (Dilaudid®)</td>
<td>IV</td>
<td>5 (IV)</td>
<td>10-20 (IV)</td>
<td>3-4 (IV)</td>
</tr>
</tbody>
</table>

Please note equipotent dose: IV Hydromorphone (Dilaudid®) 1 mg = IV Morphine 6 mg

| Methadone (Dolophine®)                 | PO    | 30-60 (PO)  | 60-120 (PO) | 4-8 (PO)         |
| Hydrocodone (as in Vicodin®, Lortab®) | PO    | 30-60 (PO)  | 60-90 (PO)  | 4-6 (PO)         |
| Oxycodone (as in Percocet®)            | PO    | 30-60 (PO)  | 60-90 (PO)  | 3-4 (PO)         |

<table>
<thead>
<tr>
<th>Agonist-antagonist</th>
<th>Route</th>
<th>Onset (min)</th>
<th>Peak (min)</th>
<th>Duration (HOURS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buprenorphine (Suboxone)</td>
<td>SL</td>
<td>5 (SL)</td>
<td>30-60 (SL)</td>
<td>unknown (SL)</td>
</tr>
</tbody>
</table>

Please note equipotent dose: IV Buprenorphine 1 mg = IV Buprenorphine 2 mg

Opioid Chart

- Reassess the pain intensity and side effects (e.g., sedation) after pharmacological pain management interventions, at an interval dependent on the medication and route of administration (see chart on back).
- Analgesia, in addition to side/adverse effects are more likely to occur at the peak concentration of the medication.
- Side effects of opioids include: sedation, respiratory depression, urinary retention, constipation, nausea and vomiting.
SAFE OPIOID DOSING

Do You Realize?

Approximate Equianalgesic Doses

1 mg IV HYDROMORPHONe (Dilaudid®)

3 Percocet® 5/325 or (15 mg OXYcodone)

6 mg IV Morphine

American Hospital Association®
SLEEP VS SEDATION

Is this normal sleep or dangerous sedation?
Main Peri-Operative Services: PACU
Purposes of the quasi-experimental study were:

- **Patient Outcomes**
  - To measure the efficacy of the POSS use in the PACU for sedation assessment & pain management

- **Communication Survey**
  - To determine if the implementation of the POSS protocol would affect PACU nurses’ confidence with assessing sedation with medication administration, and hand-off communications

Kobelt, Burke, Renker (2014)
DATA COLLECTORS

26 clinical nurses participated in the data collection for the study

- To evaluate the effects of the POSS, data abstracted from 394 medical records in the pre intervention period and 448 medical records from the post intervention period included:

  Time in PACU; amount of opioids administered in PACU; Aldrete, pain rating and POSS scores at discharge from PACU; Naloxone administered; patient demographics.

Kobelt, Burke, Renker (2014)
PACU RNS and post-operative unit nurses were surveyed to assess their insights and views associated with the new POSS protocol in the PACU and effects on quality, safety and hand off communication.

Kobelt, Burke, Renker (2014)
STUDY OUTCOMES

The POSS protocol addressed the need for a standardized sedation assessment without:

- Increasing number of calls to physicians or anesthesia providers. POSS intervention steps facilitated decision making and directed the nurses to take appropriate actions.
- Changing the amount of medications given
- Increasing LOS in the PACU

Kobelt, Burke, Renker (2014)
STUDY OUTCOMES

• PACU nurses reported the use of the POSS increased their confidence in administering opioids to address pain and prevent over-sedation.
• Both PACU and clinical nurses indicated increased quality of pt care related to using the POSS and administering opioids
• PACU and clinical nurses’ comfort communicating handoffs
• Scope of study limited to detect adequate numbers opioid related ADEs to evaluate impact of POSS in preventing respiratory depression.

Kobelt, Burke, Renker (2014), p. 8
STUDY OUTCOMES

- Focusing on safely administering opioids using the POSS did not affect pain intensity ratings at discharge from PACU.

- 68.5% vs. 54.6% of pts able to give pain intensity rating at discharge from PACU with use of POSS

Kobelt, Burke, Renker (2014)
Ann Shirk, RN
Main Peri-Operative Services: PACU
POSS

Pasero Opioid-Induced Sedation Scale

nicknamed the “Goldilocks Scale”

because we want to get it ....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
Handoffs

Nurses are confident the patient will do well on the post-op unit following discharge from the PACU.
SUMMARY

This study supports the use of the POSS as a standardized nursing practice for assessing sedation for opioid management in the PACU.

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

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; immediately notify the physician to obtain an order or follow completed pre-printed orders to decrease or hold opioid dose and consider administering a non-sedating, opioid-sparing nonopioid, such as acetaminophen or an NSAID, if not contraindicated.

4 = Somnolent, minimal or no response to verbal or physical stimulation
   - Unacceptable; immediately notify the physician to obtain an order or follow completed pre-printed orders to: stop opioid; consider administering naloxone; 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.


http://dx.doi.org/10.1016/j.jopan.2014.07.003
SUCCESSFUL IMPLEMENTATION

Engage  Participate  Evidence  Proof  Endure  Persist

Success

References can be found at the end of the presentation
QUESTIONS?

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HARDIN MEMORIAL HOSPITAL + MARION GENERAL HOSPITAL + HOMEREACH + OHIOHEALTH NEIGHBORHOOD CARE
WESTERVILLE MEDICAL CAMPUS + 21,000 PHYSICIANS, ASSOCIATES & VOLUNTEERS
REACTION & DISCUSSION

Maryanne Whitney & Steve Tremain | 11:50 – 11:55
BRING IT HOME

Raahat Ansari, Program Manager, HRET | 11:55 – 12:00
PHYSICIAN LEADER ACTION ITEMS

What are you going to do by next Tuesday?
- Find out how your organization is managing ICU sedation: are patients still being “snowed for their own good?” or told to “have nice day?”
- Work with nursing to identify if and how sedation scales such as RASS and POSS are used: Who? Where? When?

What are you going to do in the next month?
- Work with physician and nursing leaders and staff to fully assess sedation and opioid management.
- Develop a plan to implement state of the art policies and procedures for sedation and opioid management throughout the hospital.
PHARMACY LEADER ACTION ITEMS

What are you going to do by next Tuesday?

- Work with nursing to discover how sedation is managed in the ICU and the floor beds.
- Look at order sets to see whether they promote or hinder appropriate sedation.

What are you going to do in the next month?

- Working collaboratively with physicians and nurses, assess medications/doses/intervals/routes commonly used to manage pain and anxiety.
- Develop sedation protocols that prevent over-sedation and promote optimal patient functioning.
UNIT-BASED TEAM ACTION ITEMS

What are you going to do by next Tuesday?

- Reassess how you are managing sedation in the ICU. Are you minimizing it to promote function?
- Reassess how you are managing opioids and other sedatives on the floor. Are you monitoring with a standard tool like the a POSS? Are you layering benzodiazepines on top of opioids?

What are you going to do in the next month?

- Develop or strengthen your sedation and monitoring policies and processes.
- Be diligent about ensuring that the level of sedation is best for the patient!
HOSPITAL LEADERS ACTION ITEMS

What are you going to do by next Tuesday?

- Meet with key staff and review what is happening with sedation in your facility.
- Use leadership walk-rounds to gain deeper understanding of the current state and barriers to change. Talk with staff and families.

What are you going to do in the next month?

- Oversee, support and resource multi-disciplinary efforts to optimize sedation for all patients who may need it.
- Understand yet challenge barriers to change.
What are you going to do by next Tuesday?

- Review a copy of the organization’s sedation and sedation monitoring policies and procedures for both the ICU and the floor beds.
- Speak with patients, families and staff to understand where opportunities for improvement lie.

What are you going to do in the next month?

- Gather stories that illustrate the functional difference between oversedated and optimally sedated/awake patients.
- Get a seat at the table of the multi-disciplinary discussions for policy and procedure changes.
THANK YOU!

Find more information on our website: www.hret-hen.org

Questions/Comments: hen@aha.org
REFERENCES


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