Emergency Nurses' Perceptions of Discharge Processes for Patients Receiving Schedule II and III Medications for Pain Management in the Emergency Department

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Introduction: There is a lack of evidence-based criteria for the discharge of patients receiving Schedule II and III narcotic medications in the emergency department. The purpose of this study was to understand nurses' perceptions about common practices in the discharge of patients receiving Schedule II and III narcotics in the emergency department in terms of dosage, time, availability of care resources at home, and other discharge criteria.

Methods: A qualitative exploratory design was used. A sample of emergency nurses was recruited from the preregistered attendees of a national conference. Two focus group sessions were held, and audiotaped in their entirety. The audiotapes were transcribed and analyzed for emerging themes by the research team.

Results: Identified themes were Time, Physiologic Considerations, Cognitive Considerations, Safety Considerations, Policies, Evidence, Ethical/Legal Concerns, and Nursing Impact. Participants reported drug-to-discharge times of 0 minutes ("gulp and go") to 240 minutes after administration of Schedule II and III narcotics specifically, and "any medication" generally. The most common reason given for a wait of any kind was to assess patients for a reaction.

Discussion: It is the perception of our respondents that determination of readiness for discharge after a patient has received Schedule II or III narcotics in the emergency department is largely left up to nursing staff. Participants suggest that development of policies and checklists to assist in decision making related to discharge readiness would be useful for both nurses and patients.

Key words: Discharge; Emergency nursing; Clinical decision-making; Policies

Introduction

Although the American College of Emergency Physicians has guidelines on the prescription of Schedule II and III narcotics after discharge,[1] criteria for discharge from the emergency department after these medications are administered are difficult to find. The use of these medications is common; Mazer-Amirshahi et al[2] found a doubling of prescription of opioids in the emergency setting between 2001 and 2010, but only a modest increase in presentations for pain-related complaints. In the same study an increase in opioid use was found for such complaints as headache, abdominal pain, and chest pain. The authors of this study suggest several reasons for the change in prescribing trends, specifically the change in practice guidelines that encourages more aggressive pain management, but also the emphasis on patient experience data that may encourage providers to more quickly prescribe opioids for pain. In the past decade, overdoses from prescription painkillers have resulted in more than 100,000 deaths in the United States.[3] Schedule II and III narcotics are frequently prescribed for use in treating acute pain while a patient is in the emergency department. Schedules II and III are classifications delineated by the Comprehensive Drug Abuse Prevention and Control Act of 1970 and determined by the Drug Enforcement Administration.[4] Classification decisions for specific drugs are based on judgments about the potential for their abuse. Schedule II opioids include morphine, oxymorphone, oxycodone, and oxycodone combination products, as well as

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hydromorphone and fentanyl. Schedule III opioids include combination products, such as hydrocodone (15 mg or less) combined with acetaminophen or ibuprofen, as well as some of the codeine combination products.[4]

A time-unlimited search of PubMed, CINAHL, and Ovid was performed, using the following search terms: "nursing care narcotics emergency department," "discharge after narcotics," "narcotics emergency department," "narcotic discharge guidelines," and "narcotics." There was a dearth of literature on the process or guidelines to discharge patients from the emergency department after receiving Schedule II or III narcotics by any route. Pediatric literature includes recommendations for both the emergency department and the ambulatory surgery setting, mostly in the context of procedure-related pain management and sedation. Discharge criteria are defined by returning to preprocedure baseline in terms of respiratory status, circulation, and level of consciousness, as well as activity level, pain status, and absence of nausea/vomiting. Parents are instructed to monitor their child for problems in respiratory effort, level of consciousness, pain, toleration of fluid/food, activity level, and the operation/procedure site. They are instructed to call emergency medical services if the child has increased work of breathing or apnea, or if they have difficulty waking the child. Parents are told to notify a physician or to go to the nearest emergency room for problems, questions, or concerns related to their child's diagnosis and procedure.[5,6] Hatfield et al[6] also recommend adding a 1-hour stay in the emergency department after administration of medication. Pediatric patients are never discharged alone. No recommendations are given for adult patients in the general literature.

There is a paucity of literature on current discharge practices for adult patients (older than 18 years) who have received Schedule II and III narcotics in the emergency department. Therefore patients may be spending more or less time in the emergency department than they need to, with the attendant safety and throughput issues.

PURPOSE

The purpose of this study was to understand nurses' perceptions about common practices in the discharge of patients receiving Schedule II and III narcotics in the emergency department in terms of dosage, time, availability of care resources at home, and other discharge criteria.

PROTECTION OF HUMAN SUBJECTS

The study was reviewed by the Chesapeake Institutional Review Board and was determined to be exempt from Institutional Review Board oversight.

Methods

The study methodology was a qualitative, exploratory descriptive design using semistructured focus group interviews for data collection.

SAMPLE

A purposive sample of 19 emergency nurses was recruited from a larger group of 848 emergency nurses who preregistered for a US national conference held in March 2014. Participants were placed into 2 separate focus groups for optimal group size.[7]

DATA COLLECTION

Focus group data were used to identify emergency nurses' understanding of the process by which patients who are given Schedule II and III narcotics by oral, intramuscular, and intravenous routes are determined to be ready to be discharged from the emergency department. A semistructured interview format was used to answer the following questions:

1. What are the physiologic criteria that nurses perceive a patient must meet before being discharged from the emergency department?
2. What are some clinical and/or social considerations nurses make before discharge?
3. What resources do emergency nurses believe are necessary to ensure safe discharge for these patients?
4. Do protocols exist to guide decision making? If so, on what are they based?

Focus groups lasted approximately 1 hour and were facilitated by a moderator and a second researcher, who took field notes and audio recorded the discussion of each focus group. The focus group discussions were transcribed in their entirety.

DATA ANALYSIS

The transcribed focus group data were analyzed for common themes by the principle investigator and the other 2 members of the research team individually, and then a second time as a team to determine final categories and themes. A summary of findings and conclusions was presented to the 19 participants for their review and agreement that we had captured their input. There was agreement among the 5 participants who responded that the research team had accurately interpreted their comments and that the overall conclusions reflected their experience.