

# One Size Does Not Fit All: Opioid Dose Range Orders

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**WITH THE INTRODUCTION** of The Joint Commission (TJC) pain assessment standards 14 years ago, hospitals nationwide implemented initiatives to improve pain management.<sup>1</sup> The ongoing evaluation of pain management practices by TJC and Centers for Medicare and Medicaid (CMS) surveyors during hospital accreditation visits not only continues to fuel attempts to improve the way pain is managed in hospitals, but also has introduced unexpected and concerning consequences. The combination of a focus on reducing undertreated pain, obtaining pain intensity ratings as the primary (and sometimes only) method of pain assessment, and the prevalence of opioid-only pain treatment plans has resulted in an increase in life-threatening opioid-related adverse events.<sup>2-6</sup>

In 2012, TJC published a sentinel event alert presenting concerns related to opioid administration in hospitals.<sup>7</sup> Based on its 2004 to 2011 database of reported opioid-related sentinel events, 47% of the reported events were the result of wrong dose, 29% from improper monitoring, and 11% owing to other factors such as excessive dosing, medication interactions, and adverse effects.<sup>7</sup> Research has also shown that opioid-related adverse effects occur most frequently in patients receiving higher doses of opioids and that these events result in increased hospital length of stay and cost of care.<sup>8-10</sup>

A new concern for health care providers is the inclusion of the patient's perception of pain control during hospitalization as one of the indicators used

to determine global patient satisfaction with the hospital experience in the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, which is distributed to patients after discharge<sup>11</sup> (Table 1). As part of the Affordable Care Act, the HCAHPS survey scores are publicly available and linked to hospital reimbursement for care.<sup>12</sup> This action has led to even more aggressive pain treatment with opioids in an attempt to improve patient satisfaction. As the patient's primary pain managers, nurses feel responsible for the HCAHPS scores related to pain control and thus, indirectly, for hospital reimbursement. They often describe feeling tremendous pressure to control pain and are compelled to administer high opioid doses in an effort to achieve a favorable HCAHPS score (Table 1: "...did staff do all they could...?").

It is important to note that although research has shown a correlation between patient perception of pain control and global satisfaction with hospital stay,<sup>13</sup> there is no evidence that higher opioid doses improve the patient's perception of either of these measures. All health care providers must remember that the ultimate quality indicator for most patients is to experience an uneventful hospital stay and expeditious discharge.

## Improving Safety and Effectiveness of Pain Management

There are a number of actions hospitals can take to improve the safety and effectiveness of pain management. These actions may help to improve the patient's perception of pain control and ultimately global satisfaction with the hospital experience. An important first step is to form a multidisciplinary task force with instructions to evaluate current pain management practices. This begins by asking the following questions:

- Are practices in place that help to identify and monitor patients at high risk for opioid-induced respiratory depression?

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*Conflict of interest: Chris Pasero is a member of the speaker bureau for Cadence Pharmaceuticals and Cumberland Pharmaceuticals.*

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1089-9472/\$36.00

<http://dx.doi.org/10.1016/j.jopan.2014.03.004>

**Table 1. HCAHPS Survey Pain Control Questions**

During this hospital stay, how often was your pain well controlled?

- Never
- Sometimes
- Usually
- Always

During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?

- Never
- Sometimes
- Usually
- Always

HCAHPS, Hospital Consumer Assessment of Healthcare Providers and Systems.

- Do prescribers use a multimodal analgesia approach that seeks to administer the lowest effective opioid dose or to avoid opioids altogether in all patients with pain?
- Are dangerous practices, such as order sets that link pain intensity to opioid dose, in place that discourage nurses from considering multiple patient and iatrogenic factors before the administration of an opioid dose?
- Are patients and families educated about the importance of achieving both effective and safe pain control?

### Identify, Monitor, and Control Risk

It is imperative for members of the health care team to appreciate that all patients are at risk for opioid-induced respiratory depression<sup>14</sup>; however, a number of patient characteristics and iatrogenic practices have been identified that further elevate risk for patients during opioid administration<sup>7,15,16</sup> (Table 2). As with other medication prescribing, it is essential to identify patients who have high risk factors before the prescription and administration of an opioid.

Careful review of the patient's general state of health, current medication use, and pertinent laboratory and radiology findings as well as talking with patients and their families about risk (eg, patient functionality or smoking habits) can help to identify high-risk patient factors.<sup>15</sup> Asking patients if anyone has ever told them they snore or pause in

**Table 2. Risk Factors for Opioid-Induced Respiratory Depression\***

- Age >55 y
- Obesity (eg, body mass index >30 kg/m<sup>2</sup>)
- Untreated obstructive sleep apnea
- History of snoring or witnessed apnea
- Excessive daytime sleepiness
- Retrognathia
- Neck circumference >17.5
- Preexisting pulmonary/cardiac disease or dysfunction, for example, chronic obstructive pulmonary disease and congestive heart failure
- Major organ failure (albumin level <30 g/L and/or blood urea nitrogen >30 mg/dL)
- Dependent functional status (unable to walk four blocks or two sets of stairs or requiring assistance with ambulation)
- Smoker (>20 pack-years)
- American Society of Anesthesiologists patient status classification 3 to 5
- Increased opioid dose requirement
- Opioid-naïve patients who require a high dose of opioid in short period of time, for example, 10 mg IV morphine or equivalent in postanesthesia care unit (PACU)
- Opioid-tolerant patients who are given a significant amount of opioid in addition to their usual amount, such as the patient who takes an opioid analgesic before surgery for persistent pain and receives several IV opioid bolus doses in the PACU followed by high-dose IV patient-controlled analgesia (PCA) for ongoing acute postoperative pain
- First 24 h of opioid therapy (eg, first 24 h after surgery is a high-risk period for surgical patients)
- Pain is controlled after a period of poor control
- Prolonged surgery (>2 h)
- Thoracic and other large incisions that may interfere with adequate ventilation
- Concomitant administration of sedating agents, such as benzodiazepines or antihistamines
- Large single-bolus techniques, for example, single-injection neuraxial morphine
- Continuous opioid infusion in opioid-naïve patients, for example, IV PCA with basal rate
- Naloxone administration: Patients who are given naloxone for clinically significant respiratory depression are at risk for repeated respiratory depression

IV, intravenous.

\*Patient may have one or more of the following to be considered high risk. Modified and used with permission from Pasero et al,<sup>16</sup> Copyright 2011.

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