

Perception and Practice Among Emergency Medicine Health Care Providers Regarding Discharging Patients After Opioid Administration

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ABSTRACT

Purpose: This study aimed to determine the current attitudes, perceptions, and practices of emergency medicine providers and nurses (RNs) regarding the discharge of adult patients from the emergency department (ED) after administration of opioid analgesics.

Methods: A cross-sectional survey was administered at 3 hospital sites with a combined annual ED census of >180,000 visits per year. All 59 attending emergency physicians (EPs), 233 RNs, and 23 advanced practice clinicians (APCs) who worked at these sites were eligible to participate.

Findings: Thirty-five EPs (59.3%), 88 RNs (37.8%), and 14 APCs (60.9%) completed the survey for an overall response rate of 51.75%. Most respondents were female (95 [69.9%]). The factor ranked most important to consider when discharging a patient from the ED after administration of opioids was the patient's functional status and vital signs (median, 2.00; interquartile range, 2.00–3.50). More RNs (84 [96.6%]) than EPs (29 [82.9%]) reported that developing an ED policy or guideline for safe discharge after administration of opioids is important to clinical practice ($P = 0.02$). Only 8 physicians (23.5%) reported that they did not prescribe intramuscular morphine, and 15 (42.9%) reported that they did not prescribe intramuscular hydromorphone. EPs (7 [20.0%]) and RNs (3 [3.4%]) differed in regard to whether they were aware if any patients to whom they administered an opioid had experienced an adverse drug-related event ($P = 0.01$). Most EPs (24 [68.6%]) and RNs (54 [61.4%]) believed that the decision for patient discharge should be left to both the emergency medicine provider and the RN.

Implications: Most study participants believed that developing a policy or guideline for safe discharge after administration of opioids in the ED is important to clinical practice. Only a few physicians reported that they did not prescribe intramuscular hydromorphone or morphine. Most participants believed the discharge decision after administration of opioids in the ED should be primarily determined by both the emergency medicine provider and the RN. (*Clin Ther.* 2018;■:■■■–■■■) © 2018 Elsevier HS Journals, Inc. All rights reserved.

Key words: analgesics, opiate, opioid, safe discharge.

INTRODUCTION

In the United States, approximately 105 people die of drug exposures on a daily basis.¹ More than 2 million emergency department (ED) visits annually result from drug misuse and abuse.¹ Drug-related deaths due to prescription analgesics such as opioids have now surpassed trauma as the leading cause of injury deaths.² In 2012, a total of 2937 cases of fatal poisonings were reported to the National Poison Data System; the primary substance implicated was a pharmaceutical.³ Of these, abused prescription drugs, primarily opioids, were implicated, including methadone, oxycodone, acetaminophen/hydrocodone,

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morphine, fentanyl, tramadol, and oxycodone/acetaminophen.³ Even worse, the drug-related death rates are increasing; they have nearly quadrupled since 1999.⁴

According to the Agency for Healthcare Research and Quality, the problem has become much broader, with hospitalizations increasing among middle-aged and older age groups.⁵ In addition, there has been a significant increase in both pain-related US ED visits and prescriptions for opioid analgesics during the past decade.⁶ Between 2001 and 2010, Mazer-Amirshahi et al⁶ noted hydromorphone and oxycodone had the greatest increase in ED administration, and oxycodone and hydrocodone had the largest increases in discharge prescriptions. Interestingly, there was no difference in discharge prescriptions for nonopioid analgesics during the same period.⁶ In a recent study of 27,516 ED patient visits during a single week across the country, 17% of discharged patients were prescribed opioid pain relievers.⁷

Coupled with these increases in prescription use and misuse, iatrogenic injury due to opioid analgesic administration in the ED has recently been examined. In 2015, Beaudoin et al⁸ identified 73 ED patients in 2 urban academic EDs in which naloxone administration was required because of iatrogenic overdose after opioid administration. Patient-, provider-, and systems-based risk factors included chronic medical conditions; failure to adjust dosing in the elderly, and renal and hepatic impairment; multiple doses and routes of administration; co-administration of sedatives; problems with patient hand-offs; consideration of patient sex; and pharmacy error.⁸ In 2012, the Joint Commission recommended initiating policies and procedures for reducing adverse events with opioids for inpatients, yet interestingly it failed to specifically address the subset of patients who receive opioids in the ED and are then discharged.⁹

Intriguingly, the postanesthesia care unit has similar features to the ED in terms of treating acute pain with subsequent discharge, along with the potential for opioid-associated adverse drug events. General guidelines and recommendations for discharge of the postoperative patient after opioid administration have existed for the postanesthesia care unit, unlike the ED, by groups, including the American Society of Perianesthetic Nurses ([Appendix I](#)) and the American Society of Anesthesiologists.¹⁰ The American Society

of Perianesthetic Nurses has recommended a more specific time frame by which to discharge the postoperative patient based on pharmacokinetic parameters.¹⁰ The American Society of Anesthesiologists has not recommended a mandatory observation period after medication administration but instead has recommended that “patients should be observed until they are no longer at risk for cardiorespiratory depression and discharge criteria should be designed to minimize the risk of central nervous system or cardiorespiratory depression after discharge.”¹¹ Clearly, both organizations addressed the issue of patient discharge after opioid administration, albeit in a slightly different manner.

Other often overlooked yet significant problems associated with patients receiving opioid medications in the ED and subsequently being discharged (with or without prescriptions) include falls and impairment while performing complex motor tasks.¹² McIntosh and Leffler¹³ noted that 7% of patients who received opioid analgesics after discharge from the ED “drove a vehicle while under the influence of the drug.” In addition, sex-specific guidelines for patient discharge have not been developed, a particular gap in the scientific literature because sex-specific differences in drug offloading (eg, males have a more rapid onset and offset of morphine than females) have been documented.¹⁴

Regarding these clear deficiencies in the ED discharge process after opioid administration, Wolf et al¹⁵ recently published a survey of emergency nurses (RNs) that revealed the perception that determination of readiness for discharge after a patient has received Schedule II or III narcotics in the ED is largely left up to the nursing staff. Participants suggested that development of policies and checklists to assist in decision making related to discharge readiness would be useful for both RNs and patients.¹⁵

We hypothesized that there would be significant variability among perceptions and practices regarding discharging ED patients after opioid administration among emergency medicine (EM) clinical care providers. This study aimed to determine the current attitudes, perceptions, and practices of attending emergency physicians (EPs), physician assistants (PAs), nurse practitioners (CRNPs), and RNs regarding the discharge of adult patients after administration of opioid analgesics.

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