Sedation and Factors Nurses Consider When Making Decisions to Medicate for Pain in the PACU

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Disclosures

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Presentation Objectives

- Background & Significance of Opioid-Induced Sedation
- Discuss Qualitative Study entitled, "The Common Meanings and Shared Practices of Sedation Assessment in the Context of Managing Patients with an Opioid: A Phenomenological Study"
- Discuss Relevance to Practice, Next Steps, and Invite Feedback by ASPMN members

The Challenges of Managing Acute Pain

- "Just as we now know (the) earth is not flat, we know that pain is not a vital sign. Let's remove that from the lexicon," James Milam, MD, an AMA delegate said in MedPage Today. "Whatever it's going to take to no longer include pain as a vital sign ... Let's just get rid of the whole concept and try to move on." – June 2016
Sedation as a concept

- Classified as intentional or incidental
- Level of Consciousness or Arousalility

Purpose

- To understand the common meanings of sedation and shared practices in the context of post-operative pain management in expert nurses during pain management with opioids.
- To describe the practical knowledge used by expert post-anesthetic care unit (PACU) nurses in managing pain while avoiding side effects such as over-medication and opioid-induced respiratory depression

Methodology

- Purposive Sample - Expert Registered Nurse (RN) that had worked for at least 7 years and has worked in the PACU for a time of greater than 6 months within the organization
- Tri-site, suburban Canadian healthcare organization
- Face to face interview conducted (n=20)
- All data transcripts were reviewed by the interpretive team consisting of an expert in methodology, an expert in clinical content, and 2 graduate nursing students trained in Hermeneutics with experiences working in the PACU
- Modified Seven-Stage Hermeneutic Process from Diekelman, Allen, and Tanner (1989)
Philosophical Underpinnings

- Patricia Benner’s Novice to Expert Nursing Theory (1984)
  - Stages of nursing in terms of competence, experience, skill and knowledge
  - Focuses on the richness of knowledge embedded in expert clinical practice

Sample Demographics

<table>
<thead>
<tr>
<th>Sample Demographics</th>
<th>Mean</th>
<th>SD</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>54</td>
<td>9.46</td>
<td>31-66</td>
</tr>
<tr>
<td>Years of Experience</td>
<td>30</td>
<td>10.86</td>
<td>10-45</td>
</tr>
<tr>
<td>Years of PACU Experience</td>
<td>10</td>
<td>9.14</td>
<td>1-43</td>
</tr>
</tbody>
</table>

Education Preparation

- Diploma: 50%
- Bachelor: 30%
- Masters: 20%

Recognizing Every Patient is Different

- Recognizing every patient responds differently
- Recognizing every patient has a different history
- Recognizing every patient has different expectations
Recognizing that every patient is different.

- “So everybody’s receptors are different so maybe one drug might not work for another patient versus another one and the drugs work differently on each receptor” (P20)
- “So, everybody – everybody is different. They present differently, and then there’s different personalities as well where you know somebody is having pain, but they’re being very stoic, ... they look like they’re trying to relax, they have their eyes closed, and are laying very still, but they don’t – they look very tense, ... I think you need a different approach” (P11).

Walking a Fine Line

- Balancing comfort and alertness
- Practicing watching and waiting
- Prioritizing pain management
- Anticipating that things can go bad in a split second

- ... I’m heading into respiratory territory or possible because you’re always afraid too when…they’re not showing anything [pain relief] and all of a sudden you hit that high level of medication, all of a sudden boom, respiratory depression, respiratory arrest (P2).
- He did keep breathing, surprisingly. (laughing) because we gave him one hell of a load. I remember looking at X[nother nurse] and going oh my god, how much more morphine can we give this man, because and I mean he had so much pain right, and he really legitimately had so much pain. ... we really couldn’t give him more without admitting him to a unit or someplace where he, ...he’d be monitored for his breathing (P3).
Engaging in Iterative Knowing

- Tuning into a patient based on ongoing experience
- Identifying the picture of pain and sedation
- Adapting practices based on wisdom and gut feeling

Engaging in Iterative Knowing

- “It’s great to be able to tune into a patient that’s not quite there because they’re sedated, but at the same time you feel like you’re able to sense what they’re feeling and what they’re doing, it’s great to be an advocate for a patient, I really like that” (P19).
- “He was a young guy, he had an ankle fracture, … the one OR, brought the patient out, he was just beyond any kind of pain scale available … We were just playing catch up the entire time, he honestly thought that he had woke up during his surgery and that they were still cutting and doing the procedure. He was like just that you know, going to meet my maker kind of looking at it like, his eyes were bulging, heart rate was through the roof, blood pressure wasn’t too bad, but he was just you know, gasping, and just fear, just panic on his face. … but he was in so much pain that he thought for sure something horrible was happening to him” (P11).

Identifying the Picture of Sedation

<table>
<thead>
<tr>
<th>A Patient who is arousable to...</th>
<th>A Patient who is somnolent to...</th>
<th>A Patient who is oversized to...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waking up to voice, spontaneously</td>
<td>Unable to follow commands</td>
<td>You’re holding their airway open for help</td>
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<tr>
<td>Open eyes, focus on you</td>
<td>Able to follow commands</td>
<td>BP, HR could be low, RR low</td>
</tr>
<tr>
<td>Can cough and protect their own airway</td>
<td>Waking up to physical stimulus</td>
<td>Not able to stay awake</td>
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<tr>
<td>Breathing and responsiveness</td>
<td>Not able to stay awake</td>
<td>Possibly not maintaining an oxygen saturation while awake</td>
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<tr>
<td>Spontaneous movement</td>
<td>Not able to stay awake</td>
<td>Not able to stay awake</td>
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<tr>
<td>Follow a conversation, answering simple questions, engaging in interaction</td>
<td>Not able to stay awake</td>
<td>Not able to stay awake</td>
</tr>
<tr>
<td>Able to push the call bell for help if needed</td>
<td>Not able to stay awake</td>
<td>Not able to rouse or rouse with great difficulty to painful stimuli</td>
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<tr>
<td>They’re hard to wake up (don’t respond to voice)</td>
<td>Not able to stay awake</td>
<td>If they do rouse to deep stimuli, it isn’t for long</td>
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<tr>
<td>Waking up to physical stimulus</td>
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Looking beyond and anticipating

- Looking at the whole patient beyond the assessment and monitors
- Personalizing discharge criteria to meet the patient’s safety needs
- Always thinking forward and anticipating the next steps for that patient

“Because you look at a monitor, and then look at your patient, and you see the rate is 22, and you look over, and it’s kind of an irregular 22, or a gasping 22. It makes it a very different rate, or shallow 22. Breathing will probably be the biggest thing that I would watch. Is it regular? Are they taking big size in between? Is it very shallow? and that sort of thing” (P11).

“...you would have that forward thinking, hopefully to know what to do next and to know when you should notify when you need help, when it’s beyond your scope of practice and you need someone to say, yes go ahead, or no, we should do this ... you know where you’ve done as much as you can and now, or when the patient’s in danger or before the patient gets to danger, I think you need to have that forward thinking to know when you should be notifying somebody that there’s a potential issue here” (P14).

Constitutive pattern: Interpreting sedation by integrating practical understandings and anticipating beyond.

- Nurses are constantly surveying and tuning into their patients, integrating verbal and non-verbal cues into their assessments.
- They base their interventions on what they iteratively have learned to walk a fine line as a way to balance alertness and comfort while prioritizing pain management.
- “Pain and sedation are the two things that you’re focused on all the time” (P18).
- Nurses interpret sedation outside of, but inclusive of, the framework of arousability identifying a picture of pain that they initially report in their stories, incorporating observational data such as: behavioral cues, skin color, hemodynamic stability, respiratory stability, movement, ability to interact and safety into what sedation means for their patients.
Participant checking regarding themes and pattern

- The themes and pattern interpreted from the interviews was sent out to the participants to validate the findings.
- “Agree with what you’ve outlined here and incorporate these guidelines in my nursing practice” (P2).
- “Looks great to me!... I like the attributes & themes you’ve identified. ...As you’ve mentioned, balancing analgesia & sedation is imperative ...Anticipation is a great heading and essential in PACU” (P18).

Implications of Findings

- This study has further developed the understanding of sedation to include the components of:
  - arousability
  - hemodynamic and respiratory stability
  - mobility/motor function
  - ability to interact
  - safety
- Introducing these components of sedation into sedation scales currently in practice will expand the expert nurses knowledge into novice nurses training, while improving the scales sensitivity and specificity for the detection of advancing sedation in the hospitalized patient.

Questions to ASPMN Members

- How do you define sedation within your practices?
- Which sedation scales are you using?
- Are you finding any gaps with scale use within your practice?
References


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