Authorized Agent Controlled Analgesia: Update on 2013 Position Statement

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Conflict of Interest Disclosure

• Conflicts of Interest for ALL listed contributors:
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Objectives

• Describe the ASPMN AACA position statement and the supporting literature
• Differentiate between the responsibilities for nurses, prescribers, organizations and authorized agents
• Identify strategies for successful implementation
History of AACA Position Paper

• 2002-2004
  – Institute for Safe Medication Practice (ISMP) published precautions and advised “PCA-only for patients”
  – Joint Commission reported on PCA errors and included steps that should be taken to prevent unauthorized use of PCA
• 2005-2006 ASPMN task force developed first position paper –published in 2007
• 2010-2012 ASPMN task force to review and update the initial position paper – published 2013

PCA Therapy & PCA by Proxy

• PCA considered safe: overly sedated patient will drop PCA button, preventing delivery of more opioid doses.
• PCA by Proxy: dose delivery by anyone other than patient. Term in literature describing both authorized and unauthorized dosing

What are the alerts really saying?

• Intention of the alerts were to warn only against unauthorized use of PCA.
• Analgesic infusion pumps are often used for alternative analgesic therapies and the term PCA pump is a misnomer.
What is the answer?

There is a need to distinguish between unauthorized and authorized dose activation of analgesic infusion pumps (ASPMN, 2007).

Unauthorized Activation of the Analgesic Pump

Anytime anyone other than the patient presses the “PCA” button during PCA therapy.

But what about when it’s authorized? Is that PCA?

A rose by any other name would smell just as sweet….?

“PCA by Proxy” = Confusion
Clarifying the Issue

- Use terminology/definitions that are clear and accurately reflect the practice (ASPMN, 2007)
  - Authorized Agent Controlled Analgesia
  - Designated Agent Controlled Analgesia
  - Nurse Activated Dosing
  - Caregiver Activated Dosing

Authorized Agent Controlled Analgesia: AACA

- Term accurately reflects the desired and safe practice
- Provide pain management to patients
  - Vulnerable for under-treatment
  - Unable to speak for themselves and unable to self-administer medication
  - With a caregiver who can be educated to assist with dosing (Nurse caregiver or family member)

2013 ASPMN Position Statement

- Continues to support use of AACA, not Unauthorized caregiver pump activation
- Purpose: to provide timely and effective pain management and promote equitable care
- Conditions:
  - clear procedures related to patient/AACA selection
  - Assessment requirements
  - Caregiver education
AACA-supporting literature

• 2007 Position paper cited a limited number of studies that examined the use of AACA, almost exclusively in the pediatric patient population.
• 2013 Position Statement cites 6 studies related to use of AACA in the pediatric patient population, one in developmentally disabled.

2013 Literature Review

• No difference in complications between PCA and AACA in pediatric oncology patients. AACA use increased from 11.6% to 49.7% from 2005-2011. (Anghelescu et al., 2011)
• Low occurrence of adverse events requiring intervention in both PCA and AACA groups, but AACA required more intense interventions. (Voepel-Lewis et al., 2008)

Literature Review

• Czarnecki et al. reported low rate of A/Es with AACA in developmentally disabled (2008) and among infants and preschoolers (2011). Recommend diligent patient assessment (including vital signs, sedation level, electronic monitoring as indicated, and hourly documentation of injections and attempts), medication management, and caregiver education.
Literature Review

• Although the incidence of S/E is low with AACA, the rate is slightly higher than with PCA. AACA patients have more co-morbidities. (Krane, 2008).
• No reports of “PCA by Proxy” related adverse events by TJC or ISMP since the introduction of the 2005 position statement.

Gaps in Literature

• Lack of well designed, large RCTs
• Lack of studies among adults, the elderly
• Lack of studies re: patient/family/staff satisfaction
• Lack of studies comparing efficacy of AACA to IV prn, continuous infusions
• Lack of uniform vocabulary

AACA Practice Guideline

• Individualized to the unique needs of the patient
• Standards and safe practice for PCA therapy in place
• Additional responsibilities
  – Nurses
  – Prescriber
  – Organization
  – Authorized agent
### Who would benefit from AACA?

- Patients with cognitive or physical limitation that prevent them from self administration of analgesics.
- Each patient must be carefully assessed for appropriateness of AACA modality.
- The AACA plan of care must be individualized for each patient.
- If at any point, the patient’s status changes and the patient is able to self administer analgesics, AACA must be discontinued, and an alternative plan must be developed.

### The Case for AACA: Related Factors

- The ability of nurses to assess their patients’ pain
- The ability of family members to assess their loved one’s pain
- The ability of family members to deliver highly technological care

### When is AACA an appropriate option?

- Assessment of the patient indicates the “need”—not simply the “want”
- Limited acceptable alternatives
- Availability of authorized agents
Criteria for Authorized Agent Selection - Nurse Controlled

- Nurse who understands PCA/AACA process and concepts
- Nurse recognizes benefit of AACA
- Patient care assignment facilitates frequent assessment/intervention by assigned nurse

Criteria for Authorized Agent Selection - Family Controlled

- Parent, spouse/significant other, care giver who can be with the patient the majority of the time.
- Willingness to participate in delivery of analgesia.
- Understands key concepts and the assessment process.
- Availability of respite: a secondary and possibly a tertiary pain manager.

Nurses’ Role

- Knowledge and skill related to PCA therapy
- Participate in identifying and educating agent
- Assess and document ability of agent
- Assess pain relief and unintended sedation and respiratory distress
- Document patient response, agent’s care and opioid use
- Intervene and stop AACA if necessary
Prescriber’s Role

- Collaborate with nursing staff to determine the need and appropriateness of AACA
- Assess risks and benefits of AACA, including understanding of principle of “double effect”
- Individualize AACA prescription based on patient’s history, medical condition, and concomitant meds
- Re-evaluate need for AACA and reinforce education of caregiver

Organization

- Sound multidisciplinary policy and procedure
  - Prescribing and administering AACA
  - Notification and documentation of care
- Provide education
  - Materials for agent
  - Staff education related to policy and therapy
- Provide ongoing evaluation
  - Outcomes
  - Adverse events

How is ACCA care notification made?

- Unique order set
- Signage-chart, bed, pump, wristband
- Hand-off reports
- Plan of care
- Profiles on AACA delivery device
NURSE CONTROLLED ANALGESIA

ONLY PRIMARY NURSE MAY ACTIVATE DOSING BUTTON
ALL OTHERS: DO NOT ACTIVATE DOSING BUTTON

Education Strategies

- Verbal Instruction
- Demonstration, return demonstration
- Teach-back method
- Written instructions
- Timely review

Authorized Agent’s Role

- Participate in learning
  - Indications for pump activation, patient assessment
  - Action of opioids and operation of the pump
  - Signs of over sedation and respiratory depression
  - When to notify the nurse
  - Not to push the demand button when patient is asleep
- Follow instruction
- Notify Nurse
- Agree not to reprogram or violate the infusion system
Implementation: Success

• Example......

• Effective strategies were:
  – Multidisciplinary team
  – Patient-family centered care committee

Implementation: Your stories

• Who participated in writing the policy for AACA?
• What were the drivers for AACA in your organization?
• What education do you provide for your nursing staff and others related to AACA (RN and Family)
• What specific modifications do you make for AACA?

Implementation Challenges: An example

• Father watches his son, too young to push a PCA button for analgesia, cry, moan and say Owie. NCA is ordered, but the nurse does not immediately respond to his call light and he pushes the button.
  – Authorized or unauthorized?
  – What do you say?
  – What do you do?
Implementation Challenges: Your stories

- What strategies have you used to get staff/administrative support?
- What evaluation mechanisms do you have in place?
- How might you have implemented AACA differently?
- What have you learned along the way?

Authorized Agent in a General Care Setting

The Patient with a Cognitive Limitation

The Patient with a Cognitive Limitation: BF – male age 83

- Immediately post op for spinal fusion
- History of mild dementia.
- Moans spontaneously at times and cries when knees/legs manipulated
- Oriented to person but not place or time
- Unable to understand the relationship between pressing the dosing button, receiving analgesic medication, and pain relief
Possible Treatment Modalities

• Oral analgesics
• Intermittent IM/SQ injections
• Continuous intravenous infusion
• Intermittent intravenous boluses
• Nurse Controlled Analgesia

Patient’s Prescription

• Nurse Controlled Analgesia:
  – Intermittent nurse-activated doses delivered based on
    • Behavioral signs
    • Principle of Assume Pain Present (APP)
• Nurse appropriately assessed patient’s sedation level and respiratory rate prior to dose delivery

Authorized Agent in a General Care/ Step Down Setting

The Patient with a Physical Limitation
The Patient with a Physical Limitation:
JL- female age 37

- 70% BSA 2nd and 3rd degree burns, including both hands and fingers.
- Care includes frequent debridement and grafting of hands and fingers
- Cannot activate analgesic infusion pump dosing button
- Occupational therapy attempt at alternative apparatus unsuccessful

Possible Treatment Modalities

- Oral analgesics
- Intermittent IM/SQ injections
- Continuous Intravenous Infusion
- Intermittent Intravenous boluses
- AACA: Nurse Controlled Analgesia

Patient’s Prescription

- Nurse Controlled Analgesia with a background continuous infusion
- Nurse-activated doses delivered based on patient request or agreement
- In addition, nurse appropriately assessed patient’s pain score, quality, and patient’s sedation level and respiratory rate prior to activating dose
- Once status appropriate, background opioid changed to oral sustained-release medication
Authorized Agent in a Pediatric Setting
The Pediatric Patient with End of Life Pain

The Pediatric patient with EOL Pain
BT – male age 13
• Stage IV Rhabdomyosarcoma, dx 10mo ago.
• Only child of a divorced couple. Mother is primary caregiver, on family medical leave.
• BT and his mother well known to oncology and pain service
• Abdominal pain significantly worsening in past week
• Spiking fevers, nausea, vomiting, deteriorating mental status
• Sepsis workup underway, Temp 103

Patient Prescription
• Family (mother) controlled analgesia with Nurse Controlled Analgesia for respite when agreed upon need.
  – Continuous infusion with demand doses
  – Activate dose when behavioral signs of pain present
  – Notify nurse of change in condition and slow respirations
Few things we do for patients are more fundamental to the quality of life than relieving pain.

Dunwoody, CJ. Patient-Controlled Analgesia: Rationales, Attributes, and Essential Factors. ONJ. 1987,6(5),31-36.