PAIN CONTROL NEWSLETTER

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4867 Sunset Blvd. Los Angeles, CA 90027
E-mail address: *LAMC PRN_Pain Team-KPSC-LAMC*

EPIDURAL PAIN MANAGEMENT

By Jennifer Chai, MSN, RN, CNS

Upon discharge all Kaiser Permanente's hospitalized patients receive the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. Of the HCAHPS survey's 27 questions, three are clustered as a Pain Composite to inquire about patient's care experience during their hospitalization. Majority of patients can tell us their pain level with some exceptions. Careful consideration of multicultural aspects must be incorporated into Nursing Process as defined in the California Board of Registered Nursing (BRN) Scope of Practice. Thus, the importance of promptly addressing patient's perception of pain cannot be overstated.

The previous issue of Pain Resource Nurse (PRN) newsletter discussed various modalities and equianalgesia. This issue discusses epidural analgesia (LAMC Epidural Infusion Policy#5174). For example, epidural catheter placement is common in Labor & Delivery units and in orthopedic unit for joint surgeries. Epidural analgesia is gaining more popularity among patients as it provides better pain management. Subsequently, we may see wider application of epidural analgesia. It is incumbent upon us to be familiar and proficient in the care management of patients with epidural catheters.

Dr. Eddie Chen, Anesthesiologist, stated in his inservice that most of the epidural catheter placements for joint surgeries are similar to L & D, e.g., in Lumbar 3-4, or Lumbar 4-5. The blockade may cover up to T10 even for joint cases. He discussed nursing responsibilities at handoff to ensure patient safety. The catheter site and connection must be assessed at the beginning of each shift and documented. The RN tightens any loose connection but must STAT page anesthesia for dislodged catheter. Once the patient arrives on the floor from PACU, the RN assesses the patient every two hours and documents findings for the entire duration of the epidural therapy:
(Refer to Table 1 on page 2)

RNs must pay attention to the administration instructions in eMAR precisely. Assessments per policy include monitoring patients for excessive blockade, e.g., respiratory rate <10, or excessive sedation level. In those situations, the RN must stop the infusion immediately, stimulate the patient, and provide O2 via mask or Ambu bag and STAT page the anesthesiologist on duty. The RN also may administer antidote or reversal agent as ordered and. Following the parameters set in the MD order for hypotensive patient, RN provide will provide fluid volume support (e.g., LR IV). Equally important to note is that while on epidural therapy, patients are NOT candidates for anticoagulation therapy.

The City of Hope has recently implemented wider use of epidural therapy for their patients. It also has a Standardized Protocol (SP) for RNs to initiate and manage potential toxic effects of a local anesthetic used in combination for epidural (bupivacaine toxicity) with "lipid rescue". This lipid in "lipid rescue" is the same lipid we hang with TPN. At this time, the anesthesia department at LAMC handles lipid rescue cases. With wider utilization of epidural analgesia and expertise that comes with experience, we can envision a SP for RNs to initiate lipid rescue in the future.

QUESTION:

How do you perform Independent Double Check with High Alert Medication?

a. One RN verifies the order in the computer while the other RN checks the pump in patient's room
b. One checks/reads aloud the order and settings while the second RN validates it
c. One RN checks orders and settings, then the other RN verifies the orders and settings in patient's room.

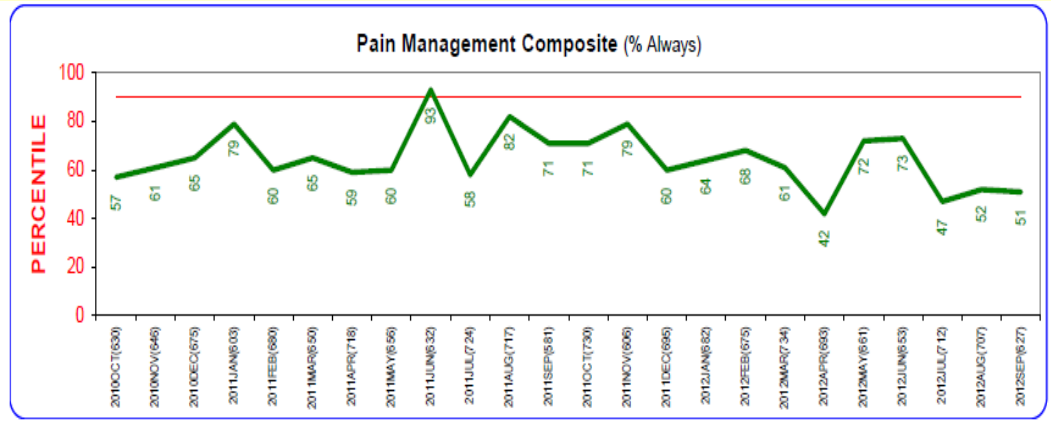
E-mail your response to: ***LAMC PRN_Pain Team-KPSC-LAMC***

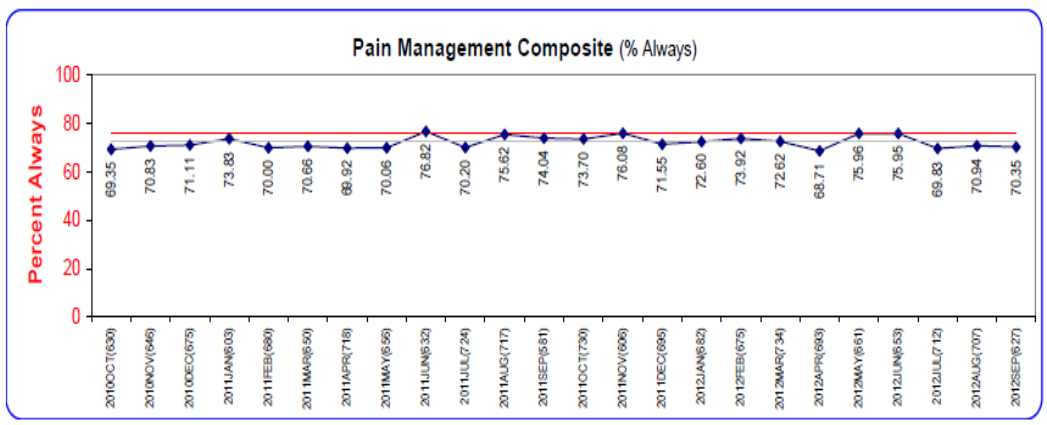
EPIDURAL PAIN MANAGEMENT (CONT'ON)

TABLE 1

▪ Assess and monitor patient every 2 hrs: ▪ Vital signs ▪ Pain level ▪ Sedation level ▪ Neurovascular sensory & movement of lower extremities (hips, legs, & feet)	▪ STAT page Anesthesiologist (# 4111) if: ▪ Respiratory rate <10 (Stop the infusion & O_2 mask PRN) ▪ Pt complains of pain still on epidural ▪ Excessive sedation or unarousable ▪ Give reversal agent as Anesthesia Order ▪ Epidural catheter is accidentally dislodged	▪ Independent Double Check by Two (2) RNs must be documented in eMAR: ▪ Initiating ▪ Hanging a new bag ▪ Changing the dosage ▪ During warm handoff ▪ End of shift & Transfers

HCAHPS Score on Pain Management – LAMC





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Susan Borja, CNC - 7E Days
Jennifer Chai, CNS - MS 4W, 6W, 7E
Diane Co, Interim CE - 6E, 7W
Emma Cuenca, CNS - CSU, CCU, ICSU
Glenda Totten, CNS – Director, Nursing QI
Lita Tsai - Administrative Manager
Joy Ramos, CNC - 6 W Nocs
Ngozi Uwagboi, CNC - 6 E Days

LAMC Pain Champions: All Trained CNCs

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