CARING FOR OVERFLOW PATIENTS IN THE PACU

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Objective

• Describe 2 nurse competencies essential in the care of the overflow patient.
Changing Face of Healthcare

• Older & sicker
• >’ing co-morbidities
• Non-existent preventative care
• Access to healthcare-delays in diagnosis
• ED visits
• $$$ deductibles delaying surgery
• Less elective surgery
• Or “elective” surgery on ill, elderly
• Hospitals reducing cost by reducing workforce
“Over-flow”

- Patients have met d/c criteria but no inpt bed
- Surgical and non-surgical patients admitted to ASU when no inpatient bed is available
- Critically ill patients, surgical and/or medical, admitted to PACU when the ICU is full or cannot take the patient
- Some define overflow as any pt who should be somewhere else
Put Anything you Can in the Unit*

- ICU beds are closed d/t lack of ICU RNs
- ER is backed up: pre-op pt sent to PACU
- Pt in a procedural area had severe allergic reaction d/t dye and will need close observation and monitoring
- Cath lab holding area nurse is due to go home and last case not ready to be d/c
- Pt codes, ICU too busy: pt comes to PACU

* Quoted from Kim Litwack
Challenges

• OR flow
• Space
• Staffing and staffing ratios
• Competency: RN & MD
• Equipment/supplies
• Visitors
• Patient satisfaction- or not
• Nurse satisfaction- or not
• Physician management of the critically ill
• And..........................
What is a Critical Care Patient?

- Higher level of care
- Intubated, lined, pressors
- Hemodynamically unstable
- Potential for decompensation
- Community hospital vs Academic Medical Ctr
What is a Critical Care Patient?

- Per CMS:

  Critical care is defined as a physician’s (or physicians’) direct delivery of medical care for a critically ill or critically injured patient. A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient’s condition.

  Critical care involves high complexity decision making to assess, manipulate, and support vital system functions to treat single, or multiple, vital organ system failure;
ASPN Standards/ICU Overflow

• Primary responsibility for Phase I: provide optimal standard of care to postanesthesia pt; maintain OR flow
• Appropriate staffing; staffing for ICU pt same as ICU guidelines
• Phase I is critical care unit/similar nurse competencies
• Ensure best environment for pt
• Medical management of pt established
ASPN Standards/ICU Overflow

• Primary responsibility for Phase I: provide optimal standard of care to postanesthesia pt; maintain OR flow

• *But*
  – While caring for complex, unstable CC pt ???
  – ASPAN recommended staffing ratio: 2:1 for unstable pt
ASPAN Standards/ICU Overflow

• Appropriate staffing; staffing for ICU pt same as ICU guidelines

• But
  – Most CC areas are 1:2 except for devices, etc.
  – Unlikely assign 2 fresh postops to same nurse
  – Very difficult for PACU mixing Phase I pt, weaning, titrating drips
  – Standards: Immediate Phase I: 1:1 until critical elements met
    • How to align w/ also caring for CC pt?
ASPAN Standards/ICU Overflow

• Phase I is critical care unit/similar nurse competencies

• True
  – Ventilator management
  – Telemetry
  – Invasive monitoring
  – Vasopressor/vasoactive medications AND titration guidelines
  – Critical values and management
Ventilator Management

• Advanced airway management
• Modes of ventilation
• Ventilator safety: alarms, settings
• Standard of care: confirmation of ETT, securement, oral hygiene, VAP, documentation
• Abg interpretation
• Sedation & sedation strategies
• Weaning if applicable
Telemetry

• Of course
• ? Same capabilities
  – ST segment
  – QTc, etc
  – Alarms
  – Documentation platform
Invasive Monitoring

- Arterial lines - most definitely
  - Alarm limits
  - Documentation platform
- CVP - most definitely
  - Standards- CLABSI, dressing
- PA line - ??
- Continuous CO - unlikely
Critical Care Medications

- CC med test- orientation/annually
- Titration guidelines
- Are they ordered and by whom?
- Protocolized order sets
- Documentation
- Accessibility/pharmacy
Critical Values & Management

- CC admit orders
  - Elyte replacement
  - Fluid goals and management
- Same capability in PACU
- Critical values- to whom?
Achieving/Maintaining Competency

• CC orientation
• CC med test
• ICU shadow
• Focused PACU pt assignments (over-flow)
• Challenges
  – Need to orient to PACU
  – Length of orientation
  – Low volume/high risk patients
  – Resources
Achieving/Maintaining Competency

• On-going
  – Annual skills fair
  – Annual competence assessment
  – Annual learning requirements
    • Compared to CC nurses???

• CC Standards of care
  – Available
  – PACU RNs knowledgeable
? Hiring Strategies

• CC patient challenges
• Unable to fully meet competencies
• ? Restrict hire to RNs w/ critical care experience
  – Inherent anticipatory knowledge of pending doom
  – Daily care of patients w/ vents, lines, meds
    • BUT need to ensure on-going competence
Medical Management Established

• Per Leapfrog

**ICU Physician Staffing (IPS)**

A growing body of scientific evidence suggests that quality of care in hospital ICUs is strongly influenced by:
(i) whether “intensivists” are providing care; and (ii) how

Hospitals fulfilling the IPS Standard will operate adult or pediatric general medical and/or surgical ICUs and neuro ICUs that are managed or co-managed by intensivists who:

1. Are present during daytime hours and provide clinical care exclusively in the ICU; and,
2. When not present on site or via telemedicine, returns notification alerts at least 95% of the time, (i) within five minutes and (ii) arranges for a physician, physician assistant, nurse practitioner, or a FCCS-certified nurse to reach ICU patients within five minutes.
Medical Management Established

• CC patient in PACU- MD responsible??
  – Anesthesia - ? CC competent
  – Surgical resident
  – Hospital medicine- not CC competent
  – Intensivist
  – PACU nurse
Black Hole

• Pt accepted in ICU, remains in PACU
• Which MD is responsible?
ASPAN Standards/ICU Overflow

• Ensure best environment for pt
• What defines best??
  – Anesthesia- airway management
  – Nursing- MD management, RN competency
  – Charge Nurse(s)- patient/OR flow
  – Surgeon- anywhere
  – Patient- most competent staff to provide expert care
  – Family- able to visit
Additional Challenges

• Monitoring capabilities
• Documentation/EHR
• Visitation guidelines
• Equipment/supplies
• Resources
Monitoring

• Same/comparable to ICU
• PetCo2, pressure lines, ICP
Documentation

- MUST have ability to view/access all orders
- CC admit orders vs Surgical orders
- MUST have ability to document same as ICU
  - Assessment fields
  - Same language/"within normal limits"
  - Same/similar plan of care
  - VS- same parameters, ability
- Challenges
  - Context
  - Paper vs Electronic
Case Study

• Pt s/p extensive spinal cord instrumentation, fusion- long OR case, GA
• Arrives in PACU, intubated & sedated on propofol
• Able to follow commands, moving UE only
• Chest x-ray done per DOS
• 1 hour stay, transferred to ICU
• Thoughts??
Case Study cont.

- Arrival in ICU - team assesses pt - not moving BLE
- Immediate flat plate AP/lat spine films, which were on the immediate p-op orders
- Emergent MRI
- Return to OR following AM
  - Spinal cord transected by screw
- Papaplegic, sacral decubitus, mult ops, rehab-hosp-rehab-hosp
- Lost job, home, $$$$$
Key Issues

• Why can’t the pt just go directly to the ICU?
  – ICU RN competency in postanesthesia care
  – Staffing
  – Anesthesia preference

• Transport risks of the critically ill
  – Hypoxemia/hypoxia
  – Unplanned extubation
  – Equipment failure
  – Loss of IV access
  – Physiologic deterioration of pt
Visitation

• Overflow patients deserve same visitation as would be provided/available in intended destination CC/MS

• Families may have been told ICU destination
  – Concerned d/t change in plan

• PACUs not equipped for extended visits, ON families
Equipment/Supplies/Resources

- Pressure lines etc
- Pharmacy - CC meds
- Pharmacy oversight/rounding
- Case management/social work (available in CC)
Case Study

• 86 yo male, HM, fx hip
• S/b anesthesia AM of surgery
  – Hct low- needs blood
  – << BP- needs blood +/- fluid
  – Check e-lytes
  – Expects HM to “optimize” pt
• Arrives pre-op holding late afternoon
  – Received 1 unit of blood, no fluid, no repeat labs
Case Study

• OR ~ moderately stable
• Neo at end, not sig. EBL
• Discussion ? ICU-
• Phone call by ortho- pt “intubated”
  – ICU can take pt later, not now
  – Plan PACU
• Extubated, BP <<<<‘ing
Case Study

- Arrives PACU ~ 19:30
- VS: 90/68 (cuff), 100 ST, spont breathing
  - Dusky, minimally arousable
- 3 ORs running – anesthesia not available
- Labs sent - electrolyte derangements
- HM - pt too sick and planned for ICU
- Transferred to unit ` 21:30
- Codes ~ 1 hour after arrival to ICU
Process Improvement

• M&M, RCA, department meeting
• Discuss pt disposition @ start of case
  – Difficult/impossible to obtain CC bed @ short notice
• Change CC language from “we don’t have a bed”
  – “we don’t have a nurse”
• Collect data
• On-going meetings, discussions
Process Improvement

• Anesthesia rounds daily @ 8, 15, 21 and prn
• Active involvement in evaluating pts who should be moved to higher level of care
• More focused attention by anesthesia on critical nature of patients and need for ICU
  — “they look fine now but……”
Strategies

• How we communicate:
  – We can’t take that pt
  – Pt is too sick
  – We don’t have enough staff
  – We’re too busy
  – WAAAAAAAAAHH
Skilled Communication Strategies

• Is there anyone who is sick or on the “table” that we don’t know about & can expect?
• Per the ASPAN Standards, the recommended staffing for our PACU at this time, based on who we have and who we expect is........
• I see that this pt is on a levo gtt. Please complete the Vasoactive Orders so that we can titrate this med accordingly
Strategies

• Regular communication w/ anesthesia attending or “floor runner”
  – End of the case is NOT time to debate pt destination
• Collaborate with ICU nursing leadership
  – Teach classes to nsg staff on post anesthesia nursing & care
• Collaborate w/ intensivists
• Be at the table, not behind the door
  – Ensure PACU nsg leadership member of critical care comm., nsg meetings
  – Invite ICU nsg leadership to join in OR huddles
Strategies

• Critically ill pt require same standard of care as they would receive in ICU
  – 24 hour MD management
• If attending service is not 24 hour- incentive to send directly to ICU
  – Add language to OR schedule that pt will require ICU bed postop to alert staff
• Be EXTREMELY clear on which MD is managing the pt
  – Pt accepted in SICU- they are
  – But according to the SICU, you are
  – No, I’m not. Call them
Black Hole

• Pediatric pt arrives s/p crani, develops Sz
  – N/S attending not available, had “signed off” to neurology attending
  – Neurology fellow unaware of pt – told RNs to cont to try to contact N/S
  – Anesthesia in OR- not available
  – Family not allowed to visit d/t critical events
  – Brain damage
Effective Communication

• Skilled communication
  – Order sets: “pt on _____ service, attending__
  – Prior to arrival in PACU maybe
  – Hand-off from surgical resident
  – Hand-off from anesthesia- what is their role?
  – Who will we be contacting
  – Who will be updating the family
Med-Surg Overflow

- Delays in transfer (staffing, occupancy, snow)
- Volume
- Planned 23 obs unit
- Unplanned admission (post-op, post procedure)
ASPAN Standards

• Primary responsibility optimal care of PACU pt
  – Maintain OR flow
• Adequate staffing
• OR- if unable to enter PACU same standard of care as Phase I PACU
• Overflow patients- same standard of care as inpatient med-surg units
• Appropriate competencies
Challenges

• Family visitation
• Ability to safely ambulate
• Communal bathroom or none???
• Dietary/food service
• Phones
• Privacy
• NOISE
• Transitioning care from Phase I to med-surg
Same Standard of Care

• Documentation
• EHR/orders/phases of care
• Competencies
• Medication management
  – Supplies
  – Pharmacy oversight
Med-Surg Nursing Care

• Care of the suicide pt
• Restraints
• Delirium assessment
• NICHE/older adult
• CAUTI
• Discharge process POD #1
  – f/u appt, teaching, supplies
• Competencies, forms, paperwork, EMR- oh my

..........................
Patient Experience

• Do we welcome them even when we may not want them?
• Do we reassure families that we are competent?
• Do we ever say that the only reason the pt is here is due to poor staffing?
• Does our attitude affect the pt?
Nurse Experience

• Do they have the resources to do their job safely?

• Do they have the documented competency?
  – Is it current? Annual?

• When they are uncomfortable, what are their resources and do they know them?

• If they want more knowledge, how do you provide it?
Final Thoughts

• Overflow is challenging on many levels
• Examine volume, workflow
• Identify resources
  – RRN
• Ensure competency
• CC- partner with CC colleagues
  – Orientation
  – Skills fairs
• Collect data, data, data
• Document adverse events early and often