

# PREVENTING ADVERSE DRUG EVENTS

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(ADE)

ADVERSE DRUG EVENTS *CHANGE PACKAGE*



## ACKNOWLEDGEMENTS

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## How to Use this Change Package

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This change package is intended for hospitals participating in the Hospital Improvement Innovation Network (HIIN) project led by the Centers for Medicare & Medicaid Services (CMS) and Partnership for Patients (PPF); it is meant to be a tool to help you make patient care safer and improve care transitions. This change package is a summary of themes from the successful practices of high performing health organizations across the country. It was developed through clinical practice sharing, organization site visits and subject matter expert contributions. This change package includes a menu of strategies, change concepts, and specific actionable items that any hospital can implement based on need or for purposes of improving patient quality of life and care. This change package is intended to be complementary to literature reviews and other evidence-based tools and resources.

## PART 1: AEA DEFINITION AND SCOPE

**CURRENT DEFINITION:** An Adverse Drug Event (ADE) is an injury to a patient resulting from a medication intervention, which can occur in any health care setting.<sup>1</sup> The Office of Disease Prevention and Health Promotion (ODPHP) released The National Action Plan for ADE Prevention (ADE Action Plan) in October 2014. The report focused efforts on the group of ADEs that are common, clinically significant, preventable, and measurable. The three initial targets of the ADE Action Plan are:

- > Anticoagulants (primary ADE of concern: bleeding)
- > Diabetes agents (primary ADE of concern: hypoglycemia)
- > Opioids (primary ADE of concern: accidental overdoses/over-sedation/respiratory depression).<sup>2</sup>

This revised Preventing Adverse Drug Events (ADE) Change Package published by HRET acknowledges the evolution of science and the following key revisions:

- > Added opioid driver for monitoring Emergency Department opioid prescribing patterns.
- > Added the Chart Review Process Improvement Discovery Tools for each of insulin, warfarin, and opioids to aid hospitals in finding themes of process failures.

Similarly, The Institute of Safe Medication Practice (ISMP) annually defines several medication classifications, including insulin, anticoagulants, and opioids that are considered to be 'high alert medications' (HAMs).<sup>3</sup> The Joint Commission describes HAMs as those more likely to be associated with harm than other drugs—as they cause harm more frequently, the harm they produce is likely to be more serious, and they have the highest risk of causing injury when misused.<sup>4</sup> Examples of ADEs related to HAMs include common side effects such as high International Normalized Ratios (INRs), moderate over-sedation, and hypoglycemia.

Adverse drug events frequently occur among outpatients as well. Shehab et. al. recently reviewed nationally representative surveillance data and found an estimated four (4) ED visits for adverse drug events occurred per 1,000 individuals annually, and among older adults (aged ≥65 years), anticoagulants, antidiabetic agents, and opioid analgesics were implicated in approximately 60 percent of ED visits for adverse drug events.<sup>5</sup>

Consistent with the national focus and priorities, this change package addresses the HRET HIIN ADE subtopics of:<sup>6</sup>

- > Excessive Anticoagulation with Warfarin
- > Hypoglycemia in Inpatients Receiving Insulin
- > Adverse Drug Events Due to Opioids

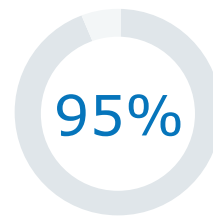
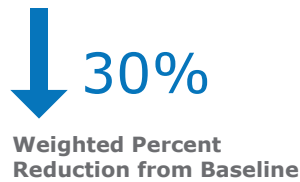
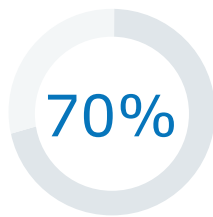
# Magnitude of the Problem and Why This Matters

A study of Medicare beneficiaries by the U.S. Department of Health and Human Services (DHHS) found that 30 percent of inpatients experienced an ADE in 2011.<sup>7</sup> The Agency for Healthcare Research and Quality (AHRQ) estimated that drug-related adverse events occurred in nearly 1.9 million inpatient stays, which include events ranging from when little to no harm is caused to events that result in death.<sup>8</sup> Additionally, studies show that elderly patients<sup>9</sup> and patients prescribed a greater number of medications<sup>10,11</sup> are at increased risk for ADEs.

Most importantly, there is strong evidence that ADEs are preventable. In 2015, the Agency for Healthcare Research and Quality reported that nationwide, from 2010-2014, ADEs were reduced by 16.3 percent, from 49.5 events per 1,000 hospital discharges to 41.4 events,<sup>12</sup> partially as a result of participation by hospitals in the Hospital Engagement Network initiatives.

## > HEN 1.0 Progress:

- Through the work of the AHA/HRET Hospital Engagement Network, from 2011 through 2014, over 1,400 hospitals worked to prevent and reduce adverse drug events. Six of the 31 states participating reduced adverse drug events harm by 40 percent. Under this initiative, 8,155 ADEs were prevented and an estimated \$24,465,000 was saved.



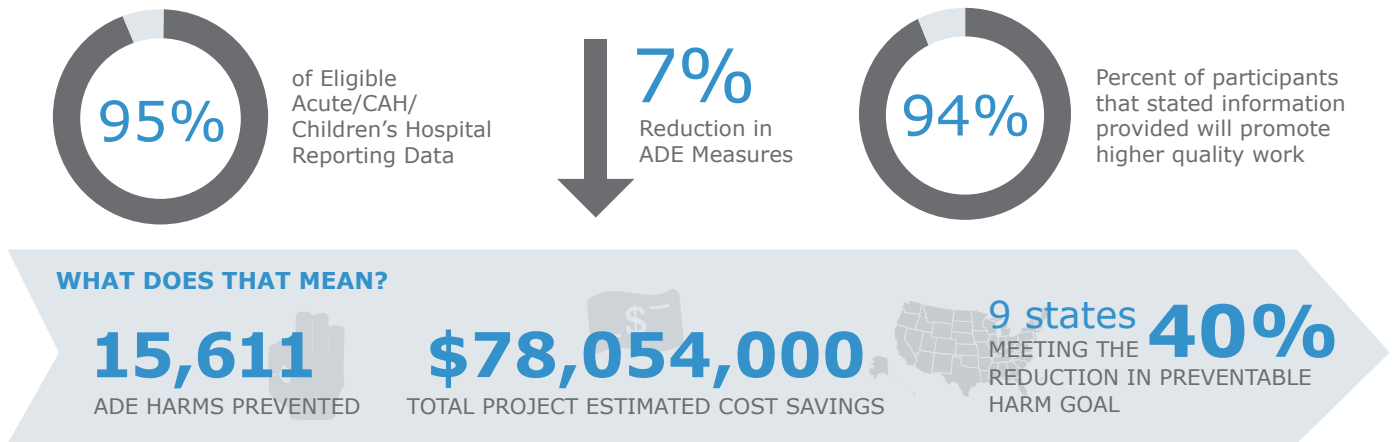
"Chance The Information Will Improve My Effectiveness/Results"

**WHAT DOES THAT MEAN?**

<b>8,155</b> ADEs PREVENTED	<b>\$24,625,000</b> TOTAL PROJECT ESTIMATED COST SAVING	<b>40%</b> 6 states MEETING THE REDUCTION GOAL
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> HEN 2.0 Progress:

- Through the work of the AHA/HRET Hospital Engagement Network 2.0, from September 2015 through September 2016, over 1,500 hospitals worked to prevent and reduce adverse drug events. Nine of the 34 states participating reduced adverse drug events harm by 40 percent. Under this initiative, 15,611 ADEs were prevented and an estimated \$78,054,000 was saved.



> HIIN Reduction Goals:

- Reduce the incidence of harm due to adverse drug events by 20 percent by September 27, 2018.

## PART 2: MEASUREMENT

A key component to making patient care safer in your hospital is to track your progress toward improvement. This section outlines the nationally-recognized process and outcome measures that you will be collecting and submitting data for as part of the HRET HIIN. Collecting these monthly data points at your hospital will guide your quality improvement efforts as part of the Plan-Do-Study-Act (PDSA) process. Tracking your data in this manner will provide valuable information needed to study your data across time and help determine the impact of your improvement initiatives on reducing patient harm. Furthermore, collecting data for these standardized metrics will allow the HRET HIIN to aggregate, analyze, and report progress toward reaching the project's 20/12 reduction goals across all Adverse Event Areas (AEAs) by September 27, 2018.

## Nationally Recognized Measures: Process and Outcome

Please download and reference the encyclopedia of measures (EOM) on the HRET HIIN website for additional measure specifications and for any updates after publication at: [http://www.hret-hiin.org/data/hiin\\_eom\\_core\\_eval\\_and\\_add\\_req\\_topics.pdf](http://www.hret-hiin.org/data/hiin_eom_core_eval_and_add_req_topics.pdf)

### > HIIN Evaluation Measure

- Excessive Anticoagulation with Warfarin-Inpatients
- Hypoglycemia in Inpatients Receiving Insulin
- Adverse Drug Events Due to Opioids

### > Suggested Process Measures

- Hypoglycemia Monitoring: percentage of patients on insulin whose blood sugars registered <80 mg/dl to <70mg/dl at least once
- Opioid Risk Assessment: percentage of patients receiving opioids who receive an opioid risk assessment prior to first opioid dose
- Formal Assessment During Opioid Therapy: percentage of patients receiving opioids who regularly receive a formal assessment (e.g., Pasero Opioid-Induced Sedation Scale (POSS) or Richmond Agitation Sedation Scale (RASS) during therapy)
- Measure a sample of patients on warfarin and determine the percent in which documentation exists as to the patient's likelihood to participate in appropriate follow-up care, likelihood of drug-drug interactions, and the likelihood of diet-drug interactions.

## PART 3: APPROACHING YOUR AEA

### > Suggested Bundles and Toolkits: **Warfarin**

- Anticoagulation Agent Adverse Drug Event Gap Analysis. Retrieved at: <http://www.mnhospitals.org/Portals/0/Documents/ptsafety/ade/Medication-Safety-Gap-Analysis-Anticoagulation-Agent.pdf>

### > Suggested Bundles and Toolkits: **Insulin**

- Hypoglycemia Agent Adverse Drug Event Gap Analysis. Retrieved at: <http://www.mnhospitals.org/Portals/0/Documents/ptsafety/ade/Medication-Safety-Gap-Analysis-Hypoglycemic.pdf>
- Reduce Adverse Drug Events Involving Insulin, Institute for Healthcare Improvement. Retrieved at: <http://www.ihl.org/resources/Pages/Changes/ReduceAdverseDrugEventsInvolvingInsulin.aspx>
- Society of Hospital Medicine Glucose Control Implementation Toolkit. Retrieved at: [https://www.hospitalmedicine.org/Web/Quality\\_Innovation/Implementation\\_Toolkits/Glycemic\\_Control/Web/Quality\\_\\_\\_Innovation/Implementation\\_Toolkit/Glycemic/Overview.aspx](https://www.hospitalmedicine.org/Web/Quality_Innovation/Implementation_Toolkits/Glycemic_Control/Web/Quality___Innovation/Implementation_Toolkit/Glycemic/Overview.aspx)

> Suggested Bundles and Toolkits: **Opioids**

- Opioid Adverse Drug Event Prevention Gap Analysis. Retrieved at: <http://www.mnhospitals.org/Portals/0/Documents/ptsafety/ade/Medication-Safety-Gap-Analysis-Opioid.pdf>
- Pennsylvania Patient Safety Authority Opioid Tools. Retrieved at: <http://patientsafetyauthority.org/EducationalTools/PatientSafetyTools/opioids/Pages/home.aspx>

> Suggested Bundles and Toolkits: **Broadly applicable**

- ISMP Guidelines for Safe Order Sets. Retrieved at: <http://www.ismp.org/tools/guidelines/StandardOrderSets.asp>
- AHA/HRET HEN 2.0 Adverse Drug Event Change Package. Retrieved at [http://www.hret-hen.org/topics/ade/HRETHEN\\_ChangePackage\\_ADE.pdf](http://www.hret-hen.org/topics/ade/HRETHEN_ChangePackage_ADE.pdf)

> For key tools and resources related to preventing and reducing ADEs, visit <http://www.hret-hiin.org/topics/ade/index.shtml>

## Investigate Your Problem and Implement Best Practices

**DRIVER DIAGRAMS:** A driver diagram visually demonstrates the causal relationship between your change ideas, secondary drivers, primary drivers, and your overall aim. A description of each of these components is outlined in the table below. This change package reviews the components of the driver diagram to help you and your care team identify potential change ideas to implement at your facility and to show how this quality improvement tool can be used by your team to tackle new process problems.

AIM	PRIMARY DRIVER	SECONDARY DRIVER	Change Idea
		SECONDARY DRIVER	Change Idea
	PRIMARY DRIVER	SECONDARY DRIVER	Change Idea

**AIM:** A clearly articulated goal or objective describing the desired outcome. It should be specific, measurable, and time-bound.

**PRIMARY DRIVER:** System components or factors that contribute directly to achieving the aim.

**SECONDARY DRIVER:** Action, interventions, or lower-level components necessary to achieve the primary driver.

**CHANGE IDEAS:** Specific change ideas which will support or achieve the secondary driver.



# Drivers in This Change Package

**REDUCE ADES DUE TO INSULIN, WARFARIN, AND OPIOIDS  
 BY 20 PERCENT BY SEPTEMBER 27, 2018.**

ENGAGE PATIENTS AND FAMILIES	EDUCATE PATIENTS AND FAMILIES REGARDING THE RISKS AND BENEFITS OF INSULIN, WARFARIN, AND OPIOIDS	Change Idea
	EDUCATE AND PARTNER WITH PATIENTS TO INCREASE SELF-MANAGEMENT	Change Idea
FIND AND USE DATA TO DRIVE IMPROVEMENT	USE HIGH PROBABILITY LOGIC; DON'T SPEND HOURS VERIFYING THE CAUSE OF EVERY EVENT	Change Idea
	REVIEW DATA FOR THEMES OF FAILURE AND SUCCESS	Change Idea
	MAKE THE DATA VISIBLE	Change Idea
STANDARDIZE THE WORK: INSULIN	TARGET 140-180MG/DL GLUCOSE RANGE, NOT NORMOGLYCEMIA	Change Idea
	IDENTIFY ALL CRITICALLY ILL PATIENTS WITH SEVERE HYPERGLYCEMIA AND TREAT WITH INTRAVENOUS INSULIN INFUSION	Change Idea
	USE BASAL BOLUS CORRECTION INSULIN ON ALL PATIENTS PRESCRIBED INSULIN IN HOSPITALS	Change Idea
	ELIMINATE SLIDING SCALE INSULIN AS THE SOLE MEANS OF GLYCEMIC CONTROL	Change Idea
	ADJUST THE INSULIN REGIMEN AFTER A SINGLE EPISODE OF HYPOGLYCEMIA (GLUCOSE <70 MG/DL)	Change Idea
	COORDINATE MEALS AND INSULIN ADMINISTRATION TIMES	Change Idea
	USE MANUAL OR ELECTRONIC ALERTS TO NOTIFY STAFF OF EVERY PATIENT WITH A PRIOR EPISODE OF HYPOGLYCEMIA IN THE CURRENT (OR PREVIOUS) HOSPITALIZATION	Change Idea
	TRUST WELL-CONTROLLED DIABETIC PATIENTS, ESPECIALLY TYPE 1 DIABETIC PATIENTS, TO MANAGE THEIR INSULIN PUMP AS INPATIENTS	Change Idea

**REDUCE ADES DUE TO INSULIN, WARFARIN, AND OPIOIDS BY  
20 PERCENT BY SEPTEMBER 27, 2018. (continued)**

STANDARDIZE THE WORK: WARFARIN	HAVE THE PHARMACY TRACK AND TREND ALL INRS	Change Idea
	OBTAIN AN INR BEFORE THE FIRST INPATIENT DOSE, EVEN ON OUTPATIENTS ON CHRONIC WARFARIN	Change Idea
	OBTAIN DAILY INRS ON ALL PATIENTS RECEIVING WARFARIN, EVEN IF THE PATIENT HAS BEEN ON CHRONIC OUTPATIENT WARFARIN	Change Idea
	CONSIDER NON-WARFARIN ORAL ANTICOAGULANTS IN PATIENTS IN WHOM INRS MAY BE OR ARE DIFFICULT TO CONTROL	Change Idea
STANDARDIZE THE WORK: OPIOIDS	USE CROSS-CUTTING APPROACHES SUCH AS WAKE UP TO AVOID OPIOID HARM	Change Idea
	USE STRUCTURED APPROACHES TO MANAGE DOSING SAFELY	Change Idea
	USE AVAILABLE TOOLS TO IDENTIFY PATIENTS AT HIGHER RISK OF HARM BEFORE DOSING	Change Idea
	USE AVAILABLE TOOLS AND TECHNOLOGY ON PATIENTS RECEIVING OPIOIDS	Change Idea
	AVOID LAYERING OF MULTIPLE OPIOIDS OR LAYERING OTHER RESPIRATORY DEPRESSANTS (E.G., BENZODIAZEPINES, HYPNOTICS, MUSCLE RELAXANTS, AND ANTIHISTAMINES) WITH AN OPIOID	Change Idea
	MONITOR INDIVIDUAL PHYSICIAN OPIOID PRESCRIBING HABITS AND PROVIDE FEEDBACK	Change Idea

Primary Driver:

ENGAGE PATIENTS AND FAMILIES

By engaging patients and families in the care team, providers can further pursue the most effective paths of treatment, particularly once aware of the patient’s home life and any relevant socio-economic situations. Furthermore, when providers recognize the family as a partner, the family becomes available to assist the care team with a patient’s compliance with the treatment regimen, monitoring for side effects and enacting necessary lifestyle changes.

Ask patients:

“What matters to you?” in addition to “What’s the matter?”

Secondary Driver > EDUCATE PATIENTS AND FAMILIES REGARDING THE RISKS AND BENEFITS OF INSULIN, WARFARIN, AND OPIOIDS.

Insulin, warfarin, and opioids have high risk-benefit ratios. Providing information to patients and families that appropriately balance both risks and benefits helps all involved arrive at the best path of treatment for each individual patient.

Change Ideas

> Insulin specific:

- Inform patients that glucose targets in the hospital may be higher than what they have been taught by their doctor. This is because it is easier to become hypoglycemic in the hospital.
• Inform patients not to self-medicate while in the hospital, unless their doctor has specifically written that order and the nurse and pharmacist are aware.

> Warfarin specific:

- Inform patients and families that anticoagulants like warfarin can help prevent life threatening blood clots in hospitalized patients and that compliance with dietary instructions are important in maintaining proper drug levels and clotting times.

> Opioid specific:

- Educate patients and families about the danger of pain relievers and that hospital staff may instead choose to employ non-pharmacological methods of pain and anxiety management to manage the patient's pain instead of opioids, when appropriate.
• Educate patients that zero pain is not the goal; rather, decreased pain that allows for improved function is the goal.

> Broadly applicable:

- Educate patients and families about the importance of keeping potentially harmful medications secured from small children and other vulnerable individuals.

Suggested Process Measures for Your Test of Change

- Percent of patients and families/caregivers who, when surveyed, can correctly state the risks, benefits, and alternatives to the suggested medications in their own words.
• Percent of patients who opt for a different option given the explanation of risks/benefits.

Secondary Driver > EDUCATE AND PARTNER WITH PATIENTS TO INCREASE SELF-MANAGEMENT.

Self-management is effective when patients and families are educated about and involved in both medication management and treatment both throughout their hospitalization and after discharge. Patients with increased self-management skills have been shown to have lower readmission rates.<sup>13</sup>

Change Ideas

> Insulin specific:

- Educate patients and families regarding hypoglycemia rescue protocols. Use “teach-back” to check their understanding.
• Listen to the patient. Experienced diabetics in good control know how their glucose levels react to certain foods. Many count carbs and know how much bolus or correction insulin is needed.



- Allow hospitalized patients to perform self-management when safe and appropriate.

**> Warfarin specific:**

- Ensure that patients and families thoroughly understand and can keep appointments for follow-up laboratory appointments for INR testing at regular intervals.
- If patients and families are unable to comply with discharge and follow-up instructions, work with community resources to arrange transportation or consider alternate medications.
- Work with the patient and family to obtain a complete listing of all medications, including herbals and over-the-counter medications, so that drug interactions can be minimized or avoided.
- Ensure patients have full understanding of any new dietary restrictions to help avoid drug-food interactions.
- Recognize that some patients may not be suited for safe warfarin therapy and explore alternative options.

**> Opioid specific:**

- Educate patients and families regarding potentially lethal layering effects of multiple opioids or a single opioid combined with a hypnotic, anxiolytic, muscle relaxant, antihistamine, and/or alcohol.
- Educate patients and families about the availability of naloxone and its potential lifesaving effects.
- Educate patients regarding the potentially lethal effects of failure to dispose of fentanyl patches properly.
- Inform families that they can help manage a patient's pain and anxiety by adjusting environmental factors such as lowering bright lights, decreasing noise levels, and achieving optimal room temperature, as well as being empathetic.

**> Broadly applicable:**

- Provide patient education in the primary language, at the appropriate literacy level, and using the patient's preferred learning method. Doing so has been shown to improve health outcomes.<sup>14</sup>
- Use "teach-back" to verify understanding.

**Suggested Process Measures for Your Test of Change**

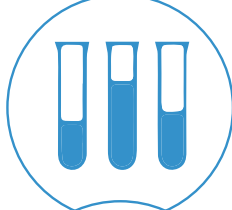
- Percent of patients discharged on insulin, warfarin, or opioids who successfully performed a "teach-back" during discharge medication counseling.
- Percent of patients discharged on hypoglycemic agents who are also discharged with concentrated glucose solution as a home rescue agent.
- Percent of patients discharged on a fentanyl patch who, through "teach-back", demonstrated understanding of the potentially fatal effect of this medication on children and the need to properly secure and dispose of these patches.
- Percent of patients discharged on opioids who required treatment in the emergency department due to an opioid ADE at home.

**Hardwire the Process**

Patient and family engagement must become part of standard workflow. Capture complete social history, a complete list of prescribed, herbal, and over-the-counter medications and personal preferences through conversations with the patient and family or caregiver. Provide opportunity for meaningful discussion of risks, benefits, and alternatives. Institute teach-back at discharge. Anticipate what might go wrong that would lead to an ADE at home.

## Primary Driver:

### FIND AND USE THE DATA TO DRIVE IMPROVEMENT



## Secondary Driver > USE HIGH PROBABILITY LOGIC; REASONABLY LIMIT TIME SPENT VERIFYING THE CAUSE OF THE EVENT.

While there can be several causes leading to severe hypoglycemia, excessively elevated INRs, or need for naloxone administration, experience in the typical hospital shows that 90-95 percent of these situations are due to very limited causes. Verifying each and every cause is time consuming and contributes little to improvement efforts. Resist the temptation to seek “perfect data.” If you can avoid opening that chart you will save precious time for other improvement activities. Read below to find easy ways to identify numerators and denominators, and therefore rates.

### Change Ideas

#### > Insulin specific:

- It is uncommon for a patient to develop severe hypoglycemia and not be on a diabetic medication. In fact, typically these patients are on insulin, with or without an oral hypoglycemic agent. Rare causes of severe hypoglycemia include taking quinine while in kidney failure, excessive and prolonged alcohol intake without food, severe hepatic failure, long term starvation, insulinomas, or rare hormonal deficiencies that are usually diagnosed in childhood.<sup>15</sup>
- To find the numerator the HIIN-ADE-1b measure, run reports on point of care glucose testing or create simple data collection tools on the unit to find glucoses below the threshold of severe hypoglycemia (e.g., <50 mg/dl).
- To find the denominator of this measure, run a pharmacy report to capture all those on insulin.

#### > Warfarin specific:

- It is uncommon for a patient to develop a very high (e.g., >5) INR and not be on warfarin. While liver disease, bleeding disorders, Vitamin K deficiency, and disseminated intravascular coagulation can all elevate the INR,<sup>16</sup> excessive INRs are most commonly due to warfarin since the number of patients on warfarin dwarfs these other uncommon causes of an excessively high INR.
- To find the numerator of the HIIN-ADE-1a measure, run reports to find all INRs above your set threshold.
- To find the denominator of this measure, run a pharmacy report to capture those on warfarin.

#### > Opioid specific:

- The primary use of naloxone is to reverse the effects of opioids.<sup>17</sup> Therefore, naloxone use can serve as a proxy for an ADE due to opioids. While naloxone is sometimes used to treat opioid-induced nausea and pruritis,<sup>18</sup> most physicians do not prescribe naloxone for these indications.
- Verify that typical practice patterns in your organization do not use naloxone for nausea or pruritis. Ask the nurses on surgery, obstetrics, or chemotherapy units about naloxone use.
- To find the numerator of the HIIN-ADE-1c measure, run reports from automated drug cabinets or pharmacy to find all naloxone administrations.
- To find the denominator of this measure, run a pharmacy report to capture those patients on opioids.

### Suggested Process Measures for Your Test of Change

- Sample 10-20 of each of these events. Validate that the low glucose, high INR, or naloxone administration were due to insulin, warfarin, and opioids respectfully. If you have high concordance (>90 percent), then you know that, with confidence, you can proceed without further verification.

## Secondary Driver > REVIEW DATA FOR THEMES OF FAILURE AND SUCCESS.

Look at 10-20 charts of each type of event and identify the most common causes in your institution.

### Change Ideas

#### > Insulin specific:

- What themes did you find? Common causes include an unexpected and sudden situation where the patient cannot eat or drink, or is not allowed to; poor appetite; lack of coordination of insulin administration and meal delivery; or recurrent hypoglycemic events, possibly due to targeting too low of a blood glucose.

#### > Warfarin specific:

- What themes did you find? Common causes include no INR prior to warfarin administration or too rapid warfarin loading.

#### > Opioid specific:

- What themes did you find? Common causes include the lack of assessment of the patient before each dose; excessive dosing for the elderly and frail; routine use of reversal agents in procedural areas or the operating room; or concomitant administration of benzodiazepines, hypnotics, muscle relaxants, or antihistamines.

### Suggested Process Measures for Your Test of Change

- In what percent of charts were you able to find a cause of the event?

## Secondary Driver > MAKE THE DATA VISIBLE.

Engage all staff necessary to improvement by visibly displaying the data. Data often starts a conversation. Discuss it during shift huddles, staff meetings, physician meetings, and board meetings. Display it in your lobby! Your patients know your organization is not perfect. Engage them and harvest their improvement ideas.

### Change Ideas

#### > Insulin specific:

- Segment the data and use run charts to display the rates and most common causes of severe hypoglycemia by unit and prescriber.

#### > Warfarin specific:

- Use run charts to display the rates of excessive INRs and most common causes.
- In medical staff meetings, show the rates by physician.
- Compare physician-driven high INRs with those that occur through the pharmacy-managed warfarin program.

#### > Opioid specific:

- Use run charts to display the rates and most common causes of naloxone use by unit and prescriber.
- Be sure to show the data from ambulatory procedure areas and crosswalk the need for naloxone with the interval between sedation dosing.

### Suggested Process Measures for Your Test of Change

- What percent of your units display ADE rates and causes?
- In what percent of your physician meetings is ADE data shown and discussed? What percent of these discussions conclude with action steps?



Primary Driver:

STANDARDIZE THE WORK: INSULIN

Hardwire the Process

Be efficient with data. It is easy to get mired in it. Set a timer. Spend no more than 15-20 minutes in the chart exploring the record looking for causes. Resist the temptation to be distracted by other events you come across.

Be effective with data. Constantly display actionable data (e.g., run charts, control charts) and analyze the data with all involved parties. Make sure every agenda includes ample time for this event, whether a stand-up meeting or a traditional one. Put data high on the agenda, not at the end.

Secondary Driver > TARGET 140-180 MG/DL GLUCOSE RANGE, NOT NORMOGLYCEMIA.

In 2009, the NICE-SUGAR STUDY revealed that targeting normoglycemia in ill patients was risky. In fact the authors concluded that, "our trial showed that a blood glucose target of less than 180 mg per deciliter resulted in lower mortality than a target of 81 to 108 mg per deciliter. On the basis of our results, we do not recommend use of the lower target in critically ill adults."<sup>19</sup>

The American Diabetes Association (ADA), in its 2018 Standards of Medical Care in Diabetes, acknowledges this and similar studies, and recommends a target glucose of 140-180 mg/dL in the hospitalized patient. Since some literature reports a modest reduction in surgical site infections with lower targets, the ADA finds target glucose of 110-140 mg/dL is acceptable, provided that hypoglycemia can be avoided.<sup>20</sup>

Change Ideas

- > Discuss with your physicians, pharmacists, nurses, and dieticians. Are they up to date?
- > Review your orders sets. Do they support overly aggressive management? Do they need to be altered?
- > Review order entry alerts. At what glucose level do they fire?

Suggested Process Measures for Your Test of Change

- In your random sample of cases with severe hypoglycemia, what percent appeared to have aggressive glucose management? What percent had more than one event?

Secondary Driver > IDENTIFY ALL CRITICALLY ILL PATIENTS WITH SEVERE HYPERGLYCEMIA AND TREAT WITH INTRAVENOUS INSULIN INFUSION.

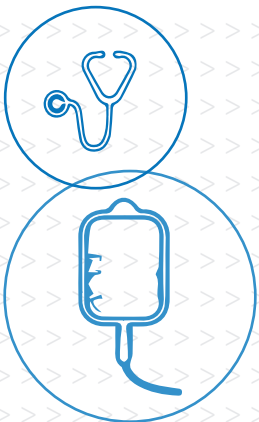
Several authors and the ADA recommend that critically ill patients with glucose levels greater than 180 mg/dL be managed with insulin drips.<sup>21</sup> This is not limited to diabetics, and many ill patients may have glucose intolerance, insulin resistance, or have undiagnosed diabetes.

Change Ideas

- > Reach out to others and obtain insulin drip protocols.
- > Find a champion physician and nurse in the intensive care unit who can, working with pharmacy, test an insulin drip protocol on one patient.
- > If already using insulin drips at times, explore the barriers to spread so that every eligible patient receives optimal care.

Suggested Process Measures for Your Test of Change

- The percent of critically ill patients with two or more glucose readings greater than 180 mg/dL that were subsequently treated with insulin drips.





**Secondary Driver > USE BASAL BOLUS CORRECTION INSULIN ON ALL PATIENTS RECEIVING INSULIN.**

All patients with adequate oral intake should be managed with a combination of basal + bolus (meals) + correction. All patients with who are NPO should be managed with a combination of basal + correction. The use of correction only (also called sliding scale insulin) causes wide variations in glucose levels, sometimes called the "roller-coaster effect."

**Change Ideas**

- > Look to see if you have standard insulin orders that allow for patient variation.
- > Ask the nurses about how much physician variation in insulin orders exists on their unit.

**Suggested Process Measures for Your Test of Change**

- The percent of patients on insulin who are eating that have basal + bolus + correction insulin orders.
- The percent of patients on insulin who are NPO that have basal + correction insulin orders.
- The number of various kinds of correction orders that you can find. As standardization occurs this number should decrease.

**Secondary Driver > ELIMINATE "SLIDING SCALE INSULIN" AS THE SOLE MEANS OF GLYCEMIC CONTROL.**

As noted above, sliding scale insulin as the sole means of glycemic control can lead to great variation and increased risks of severe hyperglycemia and hypoglycemia. The ADA recommends that all patients on insulin receive basal insulin + correction.<sup>22,23</sup>

**Change Ideas**

- > Look at your charts and talk to the nurses. Are physicians using "sliding scale insulin" alone? If so how much variability do you see in glycemic control in those patients treated with sliding scale insulin alone?

**Suggested Process Measures for Your Test of Change**

- The number of patients treated with sliding scale insulin alone in the last month.

**Secondary Driver > ALTER THE INSULIN REGIMEN AFTER A SINGLE EPISODE OF HYPOGLYCEMIA (GLUCOSE <70 MG/DL).**

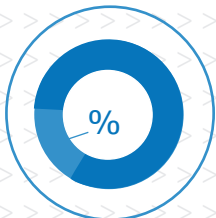
Current standards strongly recommend a change in insulin orders after a single hypoglycemia episode (blood glucose less than 70 mg/dL). Patients who have hypoglycemia events in the hospital are more likely to have additional hypoglycemia or severe hypoglycemic events.<sup>24</sup>

**Change Ideas**

- > Survey your physician and nursing staff to assess their understanding of the seriousness of an inpatient hypoglycemia event and subsequent risk of additional events.
- > Develop scripts for nurses to use to contact physicians for order changes.
- > Role play scripting with nurse and physician champions.

**Suggested Process Measures for Your Test of Change**

- Determine the percent of patients who experience a hypoglycemia event that have their insulin orders altered in response to the event.







### **Secondary Driver > COORDINATE MEALS AND INSULIN.**

Modern short acting insulin can reduce glucose levels in a few minutes. Often nurses give insulin at meal time, but the meal has not arrived to the patient. When short acting insulins are given, glucose levels can plummet before the meal arrives.

#### **Change Ideas**

- > Verify that the meal has arrived and that the patient has an appetite before administering meal based bolus short acting insulin.

#### **Suggested Process Measures for Your Test of Change**

- Monitor a sample. Measure the percent of patients who receive their insulin within ten minutes of eating.

### **Secondary Driver > USE MANUAL OR ELECTRONIC ALERTS TO NOTIFY STAFF OF EVERY PATIENT WITH A PRIOR EPISODE OF HYPOGLYCEMIA IN THE CURRENT (OR PREVIOUS) HOSPITALIZATION.**

#### **Change Ideas**

- > During shift change huddles, report any patient who had a hypoglycemic event on the prior shift, and if and how the insulin orders were changed in response to that event.

#### **Suggested Process Measures for Your Test of Change**

- Compare the rate of recurrent hypoglycemic events in patients whose initial events were reported at shift change versus those whose initial events were not reported.

### **Secondary Driver > TRUST WELL CONTROLLED DIABETICS, ESPECIALLY TYPE I'S, TO MANAGE THEIR INSULIN PUMP AS INPATIENTS.**

Well-controlled diabetics, especially Type I diabetics on insulin pumps with cutaneous glucose monitors, have deep experience managing their glucose levels in a variety of situations. Under certain circumstances these patients can be allowed to manage their insulin safely with supervision. Patients meeting the following criteria should be considered:

1. Have cognitive and physical skills needed to successfully self-administer insulin
2. Maintain adequate oral intake
3. Be proficient in carbohydrate estimation
4. Use multiple daily insulin injections or continuous subcutaneous insulin infusion pump therapy
5. Have stable insulin requirements
6. Understand sick-day management

#### **Change Ideas**

- > Assess your policies and procedures. How can they be updated to allow for self-management?
- > Find a qualified candidate. Test it once. Debrief. Learn. Try it again.

#### **Suggested Process Measures for Your Test of Change**

- Measure the number of patients admitted with insulin pumps in a 30-day period.
- In a sample of 10, count how many would meet the characteristics.

#### **Hardwire the Process**

On admission, capture the six key criteria listed above in all diabetics regarding appropriateness of self-management in the hospitals.

## Primary Driver:

### STANDARDIZE THE WORK: WARFARIN



#### **Secondary Driver > HAVE THE PHARMACY TRACK AND TREND ALL INRS.**

Pharmacy management of warfarin is increasingly common and results in equal, and at times better, control.<sup>26,27</sup> Allowing for increased pharmacy participation using proven algorithms, either alone or in partnership with physicians, can reduce high INRs.

#### **Change Ideas**

- > Identify champion pharmacists and physicians willing to try pharmacist-driven warfarin management.
- > Train champion pharmacists with warfarin management training modules/programs.<sup>28</sup>
- > Have pharmacists manage warfarin with physicians as partners.

#### **Suggested Process Measures for Your Test of Change**

- Percent of pharmacist warfarin management recommendations accepted by physicians.
- Compare in-range INRs in pharmacist warfarin management versus physician warfarin management.

#### **Secondary Driver > OBTAIN AN INR BEFORE THE FIRST INPATIENT DOSE, EVEN ON OUTPATIENTS IN CHRONIC WARFARIN.**

Since warfarin effectiveness can vary based on albumin levels, diet, and medications, even patients who have been stable on outpatient warfarin can have altered INRs on admission. Both patients who are new to warfarin and those who have been taking it should have an INR ordered and reviewed before given the first inpatient dose.<sup>29</sup>

#### **Change Ideas**

- > Set a hard stop at the time of the first inpatient warfarin dose administration to require verification and acknowledgement of INR upon admission.
- > Confirm all medications on admission, transfer, and discharge to minimize drug-drug interactions that would affect INR levels.

#### **Suggested Process Measures for Your Test of Change**

- Sample 20 recent patients given inpatient warfarin. Measure the percent that had an INR performed before the first inpatient warfarin dose.

#### **Secondary Driver > OBTAIN DAILY INRS ON ALL PATIENTS ON WARFARIN, EVEN IF THE PATIENTS HAVE BEEN ON CHRONIC OUTPATIENT WARFARIN.**

A common failure point in inpatient warfarin management is failure to obtain a daily INR.<sup>30</sup>

#### **Change Ideas**

- > Include daily INR testing in warfarin order sets.
- > Implement real time alerts to the physician-pharmacist team whenever an INR is trending above 3.5.
- > Use a protocol to discontinue or restart warfarin peri-operatively.

#### **Suggested Process Measures for Your Test of Change**

- Sample 20 recent patients given inpatient warfarin. Measure the percent that had a daily INR performed.



**Secondary Driver > CONSIDER NON-WARFARIN ORAL ANTICOAGULANTS IN PATIENTS IN WHOM INRS MAY BE OR ARE DIFFICULT TO CONTROL.**

Warfarin is not appropriate for some patients, especially those with the inability to undergo regular laboratory testing. Furthermore, patients on other medications that may interfere with or potentiate warfarin’s effect, and those with irregular diets may be prone to lability in their INR results.

**Change Ideas**

- > Implement a screening tool to assess patient specific risks for warfarin that include those relating to: ability to follow up, manage medications, and stabilize diet.
- > Perform automatic nutrition consults for all patients on warfarin to avoid drug-food interactions.

**Suggested Process Measures for Your Test of Change**

- Measure a sample of patients on warfarin and determine the percent in which documentation exists as to the patient’s likelihood to participate in appropriate follow up care, likelihood of drug-drug interactions and the likelihood of diet-drug interactions.

**Hardwire the Process**

Implement order sets for warfarin that include INRs before first dose, daily INRs, and risk profiles. Standardize peri-operative management of warfarin by using protocols.

**Primary Driver:**  
**STANDARDIZE THE WORK: OPIOIDS**

**Secondary Driver > USE CROSS-CUTTING APPROACHES SUCH AS “WAKE UP” TO AVOID OPIOID HARM (SEE APPENDIX II).**

Over-sedation is a common adverse drug event that can lead to the most serious complications: coma, ICU care, and death or disability. In addition, over-sedation leads to reduced mobility, resulting in increased falls, pneumonia, and venous thromboembolic disease. Structured opioid and sedation management can decrease harm in the following topics: ADE, failure to rescue, delirium, falls, airway safety, venous thromboembolism, and ventilator associated events.

**Change Ideas**

- > Implement "WAKE UP" in the post-op surgical units to prevent harm from over-sedation.

**Suggested Process Measures for Your Test of Change**

- Sample the rate of patient acknowledged adequate pain relief versus rate of over-sedation (e.g., naloxone use, enhanced monitoring, held doses).
- Compliance with sedation assessment tools prior to opioid administration.

**Secondary Driver > USE STRUCTURED APPROACHES TO MANAGE DOSING SAFELY.**

Structured approaches can reduce error. Hospitals have used several of these to prevent over-sedation.

**Change Ideas**

- > Limit dosage strengths available in floor stock and automated drug cabinets.
- > Use protocols and tables for equi-analgesic transition from one opioid to another.
- > Set alerts for hydromorphone doses based on patient risk of over-sedation.

- > Assess the patient's opioid history to determine if the patient is opioid naïve (less than 60 mg morphine equivalence per day for the last seven days) or opioid tolerant (greater than or equal to 60 mg morphine equivalence per day for the last seven days).<sup>31</sup>
- > Implement standard processes for opioid ordering to prevent duplicate layered opioids or opioids with benzodiazepines, hypnotics, muscle relaxants, or antihistamines.
- > Only allow basal patient controlled analgesia in patients who are opioid tolerant.<sup>32</sup>
- > Develop protocols to manage fentanyl patches to prevent overdose.

#### Suggested Process Measures for Your Test of Change

- Measure the percent of patients for whom opioid tolerance or intolerance is documented.
- Of those noted to be tolerant, measure the percent that meet established opioid tolerance criteria.
- Count number of patients over the age of 65 who receive more than 1 mcg of hydromorphone in a dose.

#### Secondary Driver > USE AVAILABLE TOOLS TO IDENTIFY PATIENTS AT HIGHER RISK BEFORE DOSING.

Risk varies due to age, illness, opioid tolerance/intolerance, obesity, and other factors. Using standard tools to assess each patient's risk before the first dose can lead to safer opioid administration.

#### Change Ideas

- > Use the "STOP BANG" checklist on each patient to identify risk of airway obstruction during sedation or opioid administration.<sup>33,34</sup>
- > Assess the current awareness of opioid risk among your health care professionals using the Pennsylvania Opioid Knowledge Self Assessment tool.<sup>35</sup>

#### Suggested Process Measures for Your Test of Change

- Measure the percent of patients who receive a "STOP BANG" assessment prior to first sedation dose.
- Assess the level of opioid knowledge in your physicians, pharmacists and nurses.

#### Secondary Driver > USE STANDARD VALIDATED TOOLS AND TECHNOLOGY ON PATIENTS RECEIVING OPIOIDS.

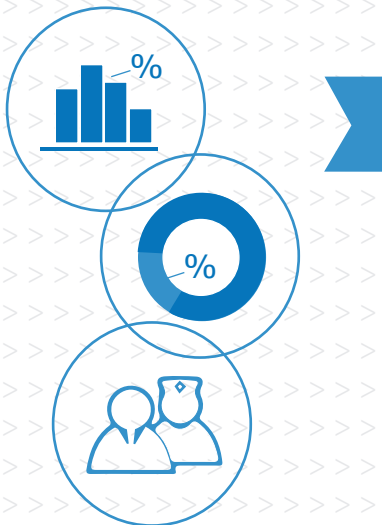
Standard, validated tools exist for assessing patients' response to opioid administration both after each dose and before the subsequent dose. End tidal capnography, the most accurate indicator of adequate respirations, alerts caregivers should respirations be suppressed and carbon dioxide levels rise.

#### Change Ideas

- > Use the Pasero Opioid-Induced Sedation Scale (POSS) on all patients receiving opioids in the peri-operative period and on the general medical/surgical units<sup>36</sup> (See Appendix III).
- > Use the Richmond Agitation Sedation Scale (RASS) on all intensive care unit patients<sup>37</sup> (See Appendix IV).
- > Use end tidal capnography in patients requiring more than pre-defined threshold opioid doses, or in those at risk for over-sedation as defined by risk assessment tools.<sup>35</sup>

#### Suggested Process Measures for Your Test of Change

- Percent of patients receiving opioids monitored by the POSS or RASS.



**Secondary Driver > AVOID LAYERING OF MULTIPLE OPIOIDS OR LAYERING OTHER RESPIRATORY DEPRESSANTS (E.G., BENZODIAZEPINES, HYPNOTICS, MUSCLE RELAXANTS, AND ANTIHISTAMINES) WITH AN OPIOID.**

Layering can occur in two forms: when a patient has multiple active opioid orders or when other respiratory depressants are added to opioids. These combinations can lead to respiratory depression.

**Change Ideas**

- > Implement patient specific, not physician specific order sets.
- > Develop opioid order sets based on risk stratification of over-sedation.
- > Offer non-opioid alternative analgesia and build the options into order sets.
- > If two opioids are ordered for different levels of pain, clearly define which opioid is to be used for each pain level, along with the minimum interval between doses when transitioning to higher opioid potency.
- > Disallow orders for prn benzodiazepines in patients on opioids unless they have been regularly taking benzodiazepines.
- > Disallow hypnotics, muscle relaxants, and antihistamines in patients on opioids.

**Suggested Process Measures for Your Test of Change**

- Review over-sedation events and determine the percent in which the patient had received opioids plus benzodiazepines, hypnotics, muscle relaxants, or antihistamines.
- Assess a sample of opioids orders and count the occurrences when multiple providers are writing concurrent opioid orders on the same patient.

**Hardwire the Process**

Require an opioid risk assessment prior to the first dose. Implement and require the use of opioid safe order sets. Assess every patient administered opioids before and after every dose per the POSS or RASS protocol.

**Secondary Driver > MONITOR INDIVIDUAL PHYSICIAN OPIOID PRESCRIBING HABITS AND PROVIDE FEEDBACK.**

A new and important focus is emerging which looks at the opioid prescribing habits of inpatient, emergency, and outpatient physicians. High opioid prescribers are more likely to find their patients still on opioids one year after the first prescription. A study by the Centers for Disease Control and Prevention (CDC) reveals that patients who receive an initial prescription supplying more than 4-5 days of opioids or who receive any refills are also most likely to remain on opioids long-term. Furthermore, another study showed that most physicians underestimate their opioid prescribing practices. Opioid prescribing can be substantially reduced while still effectively managing pain.

**Change Ideas**

- > Monitor individual physician opioid prescribing patterns for patients discharged from the hospital, outpatient procedure areas, and the Emergency Department (ED) and provide targeted educational feedback.
- > Engage your ED leaders to provide greater use opioid alternatives in the ED.

**Suggested Process Measures for Your Test of Change**

- Percentage of patients discharged from hospital, ED, or outpatient procedural areas with prescriptions for opioids.
- Percentage of patients in the ED who receive opioid alternatives with or without opioids versus those who receive opioids only.
- Percentage of high prescribers who reduce their opioid prescriptions to the mean.



## PDSA In Action | Tips on How to Use the Model for Improvement

**Choice of Tests and Interventions for ADE Reduction:** There are interventions that can be effective in reducing the risks of ADEs. Improvement teams should begin their efforts by reviewing recent events to better understand what the greatest needs are in their facility. Suggested tests of change include:

- > Pharmacy track and trend daily INRs of the next ten patients started on warfarin, with daily feedback to physicians.
- > Nurse-physician dyad trial of nurse scripts to notify the physician of a hypoglycemia event and request new insulin orders.
- > Trial the use of the Pasero Opioid-Induced Sedation Scale with one or two nurses in the post-op surgery unit.

IMPLEMENT SMALL TESTS OF CHANGE		Implement the Sepsis Bundle
<b>PLAN</b>	Design a small pilot on a unit where a nurse champion and physician champion can trial scripting for nurse notification of the physician and request for new insulin orders.	
<b>DO</b>	Keep the scale of an initial test small. Allow the nurse-physician dyad time to trial several scripts over the phone in simulated events. Test those perceived to be the best with a few other physicians and nurses.	
<b>STUDY</b>	Analyze the results of testing and disseminate successful processes and changes to the executive leadership and the larger institution.	
<b>ACT</b>	Continue to monitor the effectiveness of these processes and make necessary periodic revisions to enhance performance.	

### Potential Barriers

- > Physicians may resist using standard orders, believing they represent cookbook medicine. Educating physicians regarding the proven value of standard order sets in reducing errors can mitigate this resistance and increase adoption. Presenting the options for customization and opt-out for patients with special needs can promote acceptance.
- > Physicians may be cautious about supporting protocols implemented by pharmacists, nurses, or nurse practitioners. Some physicians may be unaware of the positive safety records and advantages of these approaches. Education about the advantages of such protocols, inclusion of physicians in the protocol development process, and data capture within your organization of small samples showing superiority or lack of inferiority can help breakthrough this barrier.
- > The technology to install dosage and multiple (duplicative) therapy alerts may not be available at every facility.

## Enlist administrative leadership as sponsors to help remove or mitigate barriers

- > Executive, clinical, and human resource leaders must lead the effort to prevent and reduce errors. Leaders who employ blame and shame when dealing with errors are likely to decrease their staff's willingness to report an error from which they could learn. It is critical that an organization's senior management, team leaders, human resources department, and legal staff understand this new culture of safety approach.
- > Senior physician, nurse, and pharmacy management will be critical players in promoting the success of new innovations such as those noted above. Some improvement efforts may be initially perceived as new and unfamiliar, or burdensome.
- > Physician leadership will be the key to success. The literature cited in this change package provides a basis for engaging physician leaders in change.

## Change not only the practice, but also the culture

- > To achieve the organization's improvement goals, everyone involved with the care of sepsis patients must be included in the development and implementation of the elements in this bundle. The processes, protocols, and order sets must be carefully scripted and standardized; tested, reviewed, and revised; and, to promote staff awareness and commitment, communicated to all employees by the senior leadership.

# PART 4: CONCLUSION AND ACTION PLANNING

Despite progress over the last few years, adverse drug events still remain the most common of all adverse events with insulin, warfarin, and opioids having the greatest incidence of harm. This change package offers knowledge, strategies, and ideas ready for you to test and implement within your organization.

First, assess your own organization by seeking out your ADEs. Do not rely on occurrence reports as they likely underrepresent the actual occurrence of ADEs. Start by searching for INRs >5, glucoses <50 mg/dL and naloxone use. Once you have identified an area of opportunity, engage the front-line staff by asking their ideas. Then, find physician, nurse, pharmacy, and administrative champions. Finally, start with small, time-limited tests of change. Learn from each of these tests and try again. It is important to make sure the new process is workable before you spread, but do not wait until you have a perfect process.

## PART 5: APPENDICES

### APPENDIX I: ADVERSE DRUG EVENTS (ADE) TOP TEN CHECKLIST

Associated Hospital/Organization: HRET HIIN

Purpose of Tool: A checklist to review current or initiate new interventions to prevent ADEs in your facility

Reference: [www.hret-hiin.org](http://www.hret-hiin.org)

### 2018 Adverse Drug Events (ADE) Top Ten Checklist

1. Standardize concentrations and minimize dosing options where feasible.
2. Set dosing limits for insulin and opioids.
3. Set target glucose levels at 140-180 mg/dL in the hospitalized patient.
4. Eliminate "sliding scale" insulin as the sole method of glycemic management. Manage all patients with basal + bolus + correction if eating, and basal + correction if not.
5. Seek new insulin orders for any patient with a single episode of inpatient hypoglycemia (less than 70 mg/dL).
6. Coordinate meal and insulin times.
7. Implement pharmacist-driven warfarin management.
8. Use standard opioid equi-analgesic conversion tables.
9. Use standard order sets to avoid multiple concurrent prescriptions of opioids and sedatives.
10. Use effective tools to reduce over-sedation from opioids (e.g., risk assessment tools such as "STOP BANG" and sedation assessment tools such as the Richmond Agitation Sedation Scale or the Pasero Opioid-Induced Sedation Scale).



## APPENDIX II: WAKE UP

**Associated Hospital/Organization:** HRET HIIN

**Purpose of Tool:** To provide cross-cutting strategies to reduce opioid harm while simultaneously decreasing the risk of other hospital-acquired conditions.

**Reference:** [www.hret-hiin.org](http://www.hret-hiin.org)

<b>W</b>	<b>Warn Yourself: This is high risk.</b>
<b>A</b>	<b>Assess: Use tools (STOP BANG, POSS, RASS, PA-PSA).</b>
<b>K</b>	<b>Know: Your drugs, your patient.</b>
<b>E</b>	<b>Engage: Patients and families to set realistic pain expectations, use of non-sedating analgesics, risks of opioids.</b>
<b>-</b>	
<b>U</b>	<b>Utilize: Dose limits, layering limits, soft and hard stops.</b>
<b>P</b>	<b>Protect: The patient...our ultimate job.</b>

## APPENDIX III: PASERO OPIOID-INDUCED SEDATION SCALE (POSS)

**Associated Hospital/Organization:** Not applicable

**Purpose of Tool:** To assess sedation levels in patients who are receiving opioids to prevent over-sedation and respiratory depression.

**Reference:** Pasero, Chris. Assessment of sedation during opioid administration for pain management. *Journal of Perianesthesia Nursing*, 24:186-90, 2009. Retrieved at: [http://mghpcs.org/eed\\_portal/Documents/Pain/Assessing\\_opioid\\_induced\\_sedation.pdf](http://mghpcs.org/eed_portal/Documents/Pain/Assessing_opioid_induced_sedation.pdf)

### **Pasero Opioid-induced Sedation Scale (POSS) with Interventions\***

**S = Sleep, easy to arouse**

*Acceptable; no action necessary; may increase opioid dose if needed*

**1 = Awake and alert**

*Acceptable; no action necessary; may increase opioid dose if needed*

**2 = Slightly drowsy, easily aroused**

*Acceptable; no action necessary; may increase opioid dose if needed*

**3 = Frequently drowsy, arousable, drifts off to sleep during conversation**

*Unacceptable; monitor respiratory status and sedation level closely until sedation level is stable at less than 3 and respiratory status is satisfactory; decrease opioid dose 25% to 50% or notify prescriber or anesthesiologist for orders; consider administering a non-sedating, opioid-sparing nonopioid, such as acetaminophen or a NSAID, if not contraindicated.*

**4 = Somnolent, minimal or no response to verbal and physical stimulation**

*Unacceptable; stop opioid; consider administering naloxone; notify prescriber<sup>2</sup> or anesthesiologist; monitor respiratory status and sedation level closely until sedation level is stable at less than 3 and respiratory status is satisfactory.*

\*See appropriate action in italics at each level of sedation.

## APPENDIX IV: RICHMOND AGITATION SEDATION SCALE (RASS)

**Associated Hospital/Organization:** Not applicable

**Purpose of Tool:** To assess the level of consciousness and agitation in Intensive Care Unit patients to guide sedation and assist in communication among care providers.

**Reference:** Curtis N. Sessler, Mark S. Gosnell, Mary Jo Grap, Gretchen M. Brophy, Pan V. O'Neal, Kimberly A. Keane, Eljim P. Tesoro, and R. K. Elswick. "The Richmond Agitation Sedation Scale", American Journal of Respiratory and Critical Care Medicine, Vol. 166:1338-1344, 2002. Retrieved at: <http://www.atsjournals.org/doi/full/10.1164/rccm.2107138#.VwwGDxMrLOS>

+4	<b>COMBATIVE</b>	Combative, violent, immediate danger to staff
+3	<b>VERY AGITATED</b>	Pulls to remove tubes or catheters; aggressive
+2	<b>AGITATED</b>	Frequent non-purposeful movement, fights ventilator
+1	<b>RESTLESS</b>	Anxious, apprehensive, movements not aggressive
0	<b>ALERT &amp; CALM</b>	Spontaneously pays attention to caregiver
-1	<b>DROWSY</b>	Not fully alert, but has sustained awakening to voice (eye opening & contact > 10 seconds)
-2	<b>LIGHT SEDATON</b>	Briefly awakens to voice (eyes open & contact > 10 sec)
-3	<b>MODERATE SEDATION</b>	Movement or eye opening to voice (no eye contact)
-4	<b>DEEP SEDATION</b>	No response to voice, but movement or eye opening to physical stimulation
-5	<b>UNAROUSABLE</b>	No response to voice or physical stimulation

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