PainWeek®

The Curbside Consult in Pain Management

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Disclosure

Learning Objectives

- At the end of this fabulous presentation, the participant will be able to:
  - Define what is meant by a “curbside consult.”
  - Describe the components of the communication model known as “SBAR.”
  - Describe the five components of the “One Minute Preceptor.”

A moment's insight is sometimes worth a life's experience.

Oliver Wendell Holmes, The Professor at the Breakfast Table, Ch. 10

We can have in life but one great experience at best, and the secret of life is to reproduce that experience as often as possible.

Oscar Wilde, The Picture of Dorian Gray, Ch. 17

What is a curbside consultation?

- "An informal process whereby a physician [HCP] obtains information or advice from another physician [HCP] to assist in the management of a particular patient."

Kuo D, et al. JAMA 1998;280:905-9.

Where do “curbside” consults occur?

- Hallways
- Cocktail parties
- Weddings
- Parking lots
- The restroom
- The internet!

Why hospitalists seek curbside consults from specialists

- Confirm what they already know
- Get quick answer to a question
- Continue their medical education
- Determine if a formal consultation is called for
- Negotiate an appropriate course of treatment for a particular patient

Perley CM. J Med Library Asso 2006; 94:137-144.

Why hospitalists seek curbside consults from specialists

- Spread the emotional risk during a difficult case
- Create or sustain camaraderie with physician colleagues
- Find like thinkers among their physician colleagues
- Monitor their own knowledge
- Obtain help to get out of a difficult situation

Perley CM. J Med Library Asso 2006; 94:137-144.

Primary Care Physicians vs. Medical Subspecialists

- Participation in a curbside consult (CC) the previous week
  - PCP – 70.4%
  - Medical subspecialists – 87.5%
- During previous week
  - PCP obtained 3.2 CC
  - Medical subspecialists received 3.6 CC requests

Kuo D, et al. JAMA 1998;280:905-9.

Primary Care Physicians vs. Medical Subspecialists

- CC essential to maintain good MD relationships
  - PCP 38.6%
  - Medical subspecialists
    - 77.2%

Kuo D, et al. JAMA 1998;280:905-9.

Primary Care Physicians vs. Medical Subspecialists

- Insufficient information provided
  - PCP – 49.8%
  - Medical subspecialists – 80.2%
- Important clinical detail was not described
  - PCP – 43.5%
  - Medical subspecialists – 77.6%

Kuo D, et al. JAMA 1998;280:905-9.

Curbside Consult Risks

- Liability risks to attendant and consultant parties
- Respect the boundary between an informal and formal consult

Rules of the Road with CC

- Use common sense
- Consider documenting what you say

subject date

6·26·08

① Kathy [redacted]
wei fx → diarrhea 443·883·1139
Tincture opium if no opiod tx

② Nancy [redacted] - ref LRK
617·899·3676

③ Linda [redacted] ·0953

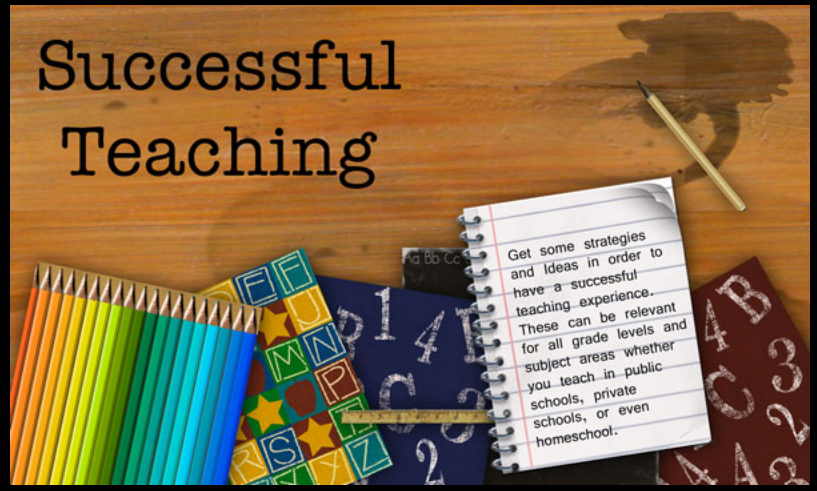
④ Diane [redacted] - 69 yo ♀ uterine → brr
TDF 75, MSC 30 q12h, MSIR 10 (S)
110 lb. 443·945·2325
Rec: MSIR 10 q12 & MSIR 10-20 q hr prn
(12 hrs. p dc TDF)

⑤ Linda [redacted] 0953
82 yo hip pain, possible fx
MSO4 + sulfa allergy??
fam ≠ oxy
MSC 90 q12
Rox 3x30
dexamem 8 q12
Trilisate 750 qs → D/C

180
90
270 ÷6 = MSIR 40q4

Rules of the Road with CC

- Keep the conversation general and brief
- *CC are safer when used for educational purposes!*



Agenda/Objectives

- Presenting a patient (for CC or orders)
  - Communicate necessary information
  - Include all IMPORTANT clinical detail
  - Do not include extraneous information
- Responding to queries and recognizing the "teachable moment."
- What to do with that "teachable moment" when you find it!

I have this case…

- A 31 year old woman, with an 8 year h/o leukemia
- She is the sweetest thing; she's a CCU nurse, and is one semester away from her master's degree
- She just got married six months ago. She told me "My husband is the best man on earth. He married me knowing I was dying."
- She has the worst pain I've ever seen in my career, and we've tried *everything*.
- Oh, yeah, she has mets to the meninges.
- She on a hydromorphone infusion, and I can't get her pain under control. Any thoughts?

Did this accounting…

1. Communicate all necessary information?
2. Include all important clinical details?
3. Include extraneous information?

How could I have done a better job presenting this patient?

JCAHO Sentinel Events

- Communication failures are associated with untoward events
  - 65% of sentinel events
  - 90% root cause analyses
- National Patient Safety Goal 2E
  - Clear, concise and thorough communication of pertinent clinical information
  - Improved patient safety and clinical outcomes

Haig KM et al. Joint Commission Journal on Quality and Patient Safety 2006;32:167-175

Differences in Communication Styles

- Nurses – descriptive and detailed
- Physicians – use brief statements, summarizing salient patient information
  - Bullet points
  - Headlines
- Communication styles, training, gender, cultural differences, prior relationships, hierarchy, past experience

Let’s call the doctor

https://www.youtube.com/watch?v=T9D3h3DFd1c

What makes you CRAZY in this clip…

https://www.youtube.com/watch?v=tM1CKK0MOoo

SBAR Model

- Dr. Michael Leonard, physician leader for patient safety at Kaiser Permanente (Denver)
  - Introduced a model of structured communication that helps clinicians have a shared mental model for the patient's clinical condition
- An effective tool for all types of communication handoffs
  - S – Situation
  - B – Background
  - A – Assessment
  - R – Recommendation

SBAR Model

- Situation – the problem
- Background – brief, related, to the point
- Assessment – what you found, what you think
- Recommendation – what you want

Prior to Contacting Clinician

- Assess patient, review chart
- Make sure you have all relevant clinical information
- Know admitting diagnosis, date of admission, patient's age
- Current medications, lab results

S - Situation

- State what is happening at the present time that has warranted the SBAR communication.
- Identify yourself, your title, your agency/employer
- "I am calling about [patient's name]…
- I'm calling because [patient's name] is [what is going on now]

S - Situation

- “Hello, this is Lynn McPherson, the clinical pharmacist at University Ambulatory Care.
- I am calling about your patient Mr. Jones, who is experiencing increased pain in his feet.”

B - Background

- Explain circumstances leading up this situation. Put the situation in context for the reader/listener.
- State the admission diagnosis, patient's age, date of admission.
- State the pertinent medical history/clinical information.
- Brief synopsis of the treatment to date.

B - Background

- Medical history/clinical information may include:
  - Current medications, IV fluids, labs
  - Allergies
  - Vital signs
  - Code status
  - HPI (symptom analysis)

Symptom Analysis

- P (palliative/precipitating/previous therapy)
- Q (quality)
- R (region/radiating)
- S (site/severity)
- T (temporal)
- U (YOU - associated symptoms)

B - Background

- “Mr. Jones is a 72 year old man with an 18 year history of type 2 diabetes. He also has a history of depression and hypertension.
- His A1c has fallen from 9.2 to 7.8 with the addition of sitagliptin to his regimen of metformin and glipizide.
- He continues to complain of pain in both feet on the bottoms and the tops. He complains of numbness and tingling in his feet, and occasional burning.

B - Background

- On physical exam he shows decreased sensation to monofilament testing, ankle and knee jerks, decreased two point discrimination and vibratory sensation.
- He rates the pain as a best of 4, a worst of 8, and an average of 6. Pain prevents him from getting a good night's rest.
- On his last clinic visit he wanted to try ibuprofen, and unsurprisingly, this did not reduce the pain."

A - Assessment

- Analysis and considerations of options.
- What you found or think is going on
- “I believe the patient is experiencing [insert your impression]…or
- I have no idea what is causing this.”

A - Assessment

- “I believe Mr. Jones is experiencing painful diabetic neuropathy in both feet.”

R - Recommendation

- Recommend what action you would like to occur.
- “I believe the patient should be referred for [whatever you think]
- I recommend beginning antibiotic therapy.
- I recommend changing the analgesic regimen to [new regimen].”

R - Recommendation

- “I recommend we discontinue the ibuprofen and begin an agent shown to be effective in treating painful diabetic neuropathy.
- Mr. Jones tells me he would also welcome a therapeutic intervention for his depression, so I recommend we begin duloxetine 20 mg po qd (Duloxetine) which will likely be beneficial for both the depression and neuropathic pain.
- We can titrate the duloxetine to 60 mg over the next week or two
- What do you think of this plan?”

Play it again Sam!

Let’s try it again Pharmacist John…

https://www.youtube.com/watch?v=fsazEArBy2g

Back at the ranch…

- Situation
- “Hello, this is Lynn McPherson, the clinical pharmacist. I’m calling about HJ, who is experiencing a severe pain crisis.”

Back at the ranch…

- Background
- “HJ is a 31 year old woman with an 8 year history of leukemia, diagnosed with meningeal mets about 3 months ago. She was managed at home on methadone for pain until ten days ago, at which time her pain significantly escalated and she was admitted to the inpatient unit…”
- “…Her pain is in her head (literally), and she describes two different pains. The persistent pain she describes as though her head is in a vice, and she rates it as an 8 consistently…”

Back at the ranch…

- Background
- "…The second pain is a superimposed pain in her head that occurs without warning and escalates to a "42" out of 10 within minutes. She says it feels like someone is sawing in and out of her head when this pain occurs, which generally lasts about an hour…"
- "…There are no predictors of this pain, although it does seem to be present frequently on awakening from sleep (although it happens while awake as well)…"

Back at the ranch…

- Background
- "…When admitted she was switched to a hydromorphone infusion, which is currently running at 30 mg/hour, with a 7.5 mg bolus every 15 minutes, and an order for a clinician-activated bolus of 7.5 mg as well. She also is receiving midazolam at 6 mg/hour…"
- "…Yesterday we tried a lidocaine challenge of 100 mg, which had absolutely no impact on her pain. The hydromorphone has been increased to 35 mg/hour with a 10 mg bolus, and the midazolam has been increased to 8 mg/hour."

Back at the ranch…

- Assessment
- “To be honest, I’m not sure what is causing this horrendous pain or how to control it.
- Increases in hydromorphone have a marginal effect.
- This could be hyperalgesia or tolerance to the opioid.”

Back at the ranch…

- Recommendation
- "I would like to recommend instituting a ketamine infusion, starting at 10 mg/hour.
- It can be increased to 15 mg/hour in 6 hours, and increased by 5 mg/hour every 6 hours as needed until pain is controlled, but short of psychotomimetic adverse effects…"
- "Just to be safe, we should reduce the hydromorphone infusion to 35 mg/hour and reduce the midazolam to 6 mg/hour.
- What do you think of this plan?"

Meanwhile….back at the unit

- HJ was started on ketamine at 5:30 pm Monday evening as requested; the hydromorphone and midazolam were decreased slightly.
- Patient's persistent pain continued, but the thunderclap headache did not recur that evening or during the night.

Meanwhile….back at the unit

- The next morning she had increased pain, so the ketamine was increased, as was the hydromorphone and midazolam.
- During the week, the ketamine was increased to 20 mg/hour, and hydromorphone was increased to 40 mg/hour and midazolam to 8 mg/hour.
- Pain ranged from 0-4, and NO thunderclap headaches.
- The following Saturday morning, the nurse contacted the clinical pharmacist to report that HJ had slightly increased pain, especially when she tried to sit upright.
- The pharmacist recommended a bolus of hydromorphone and an increase in the ketamine dose.

Meanwhile….back at the unit

- Nurse Betty agreed that she would contact the prescriber to get this order. She also stated…
- “What side effects should I be looking for with this keta….keta….keta stuff?”

Let's Make This Moment a Teachable Moment.

The One Minute Preceptor

1. Get a commitment
2. Probe for supporting evidence
3. Reinforce what was done well
4. Give guidance about errors/omissions
5. Teach a general principle

Let’s take a look…

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