

Peer Support Specialist Incorporation into Collaborative Patient Centered Care

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PROBLEM INTRODUCTION



Peer support specialists (PSS) can deliver recovery care to those suffering with mental health and substance abuse issues



Peer support workers have lived through mental health or substance abuse challenges of their own, which is crucial in personalizing care to patients' needs and preferences.



The purpose of the project was to improve the referral process and increase the number of referrals to the in-house PSS at a health clinic that focuses on Veteran's Affairs.

LITERATURE REVIEW

Roles of PSS

- Lead wellness groups
- Case manager
- Recommend housing
- Recommend jobs
- Health coach
- Accompany patients to appointments
- Serve as emotional support

(Burnell, Needs, & Gordon, 2017)

PSS assist primary care and mental health providers by:

- Supplement the work especially in times of shortage
- improve patient-centeredness, enhance treatment
- improve social functioning
- assist patients in achieving a better quality of life

(Shepardson et al., 2019)

Utilization of PSS:

- Bridge the gap between mental health providers and patients with pragmatic familiarity and understanding of the recovery process at its rudimentary level
- Ultimately complementing the work of mental health professionals

(Azevedo et al., 2020).

Mental health recovery orientation with peer support services can:

- fostered empowerment
- encourage confidence
- afford the patient a higher level of functioning

(Resnick & Rosenheck, 2018)

Health teams with PSS experienced:

- improved outcomes for patients with substance abuse
- reduced relapse rates
- increased treatment retention and adherence
- enhanced motivation

(Possemato et al., 2018)

PROJECT METHODS

Design

- Quality improvement project to improve referral process to the PSS
- Setting: Midwest Department of Veteran's Affairs clinic
- Aim: To increase the number of patients who see the PSS through education provided by the clinical staff

Implementation

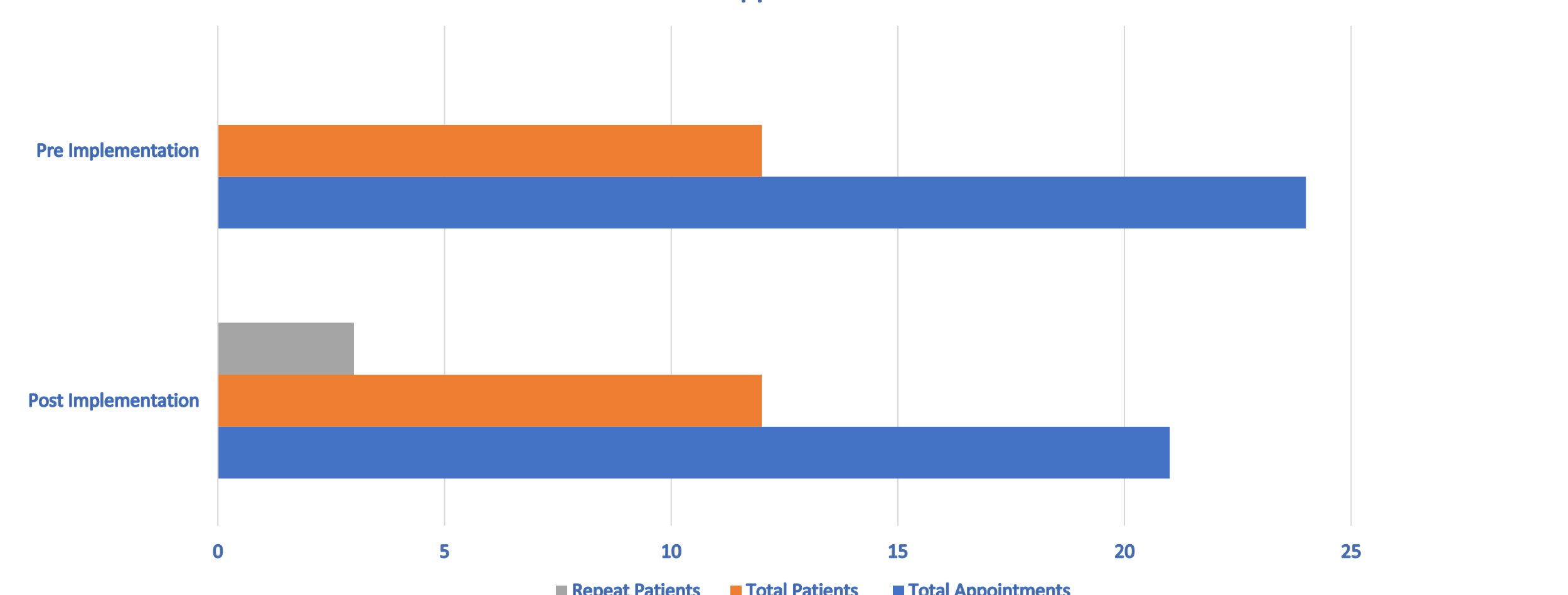
- A PSS receives referral from the provider or nursing staff
- An educational handout created for staff about the PSS's role
- Educational sessions provided to assist clinic staff in identifying patients eligible for PSS services
- If patient qualified for services and was agreeable, the provider was notified and gave a warm handoff to the PSS

Evaluation

- Data from May and June 2021 to determine the number of referrals pre implementation
- Project Implementation: July and August 2021.
- Data number of referrals two-months post intervention
- A meeting with clinic staff, providers and the PSS was held to allow qualitative feedback

EVALUATION

Pre and Post Implementation of Peer Support Educational Handout and Associated Total Patient Appointments

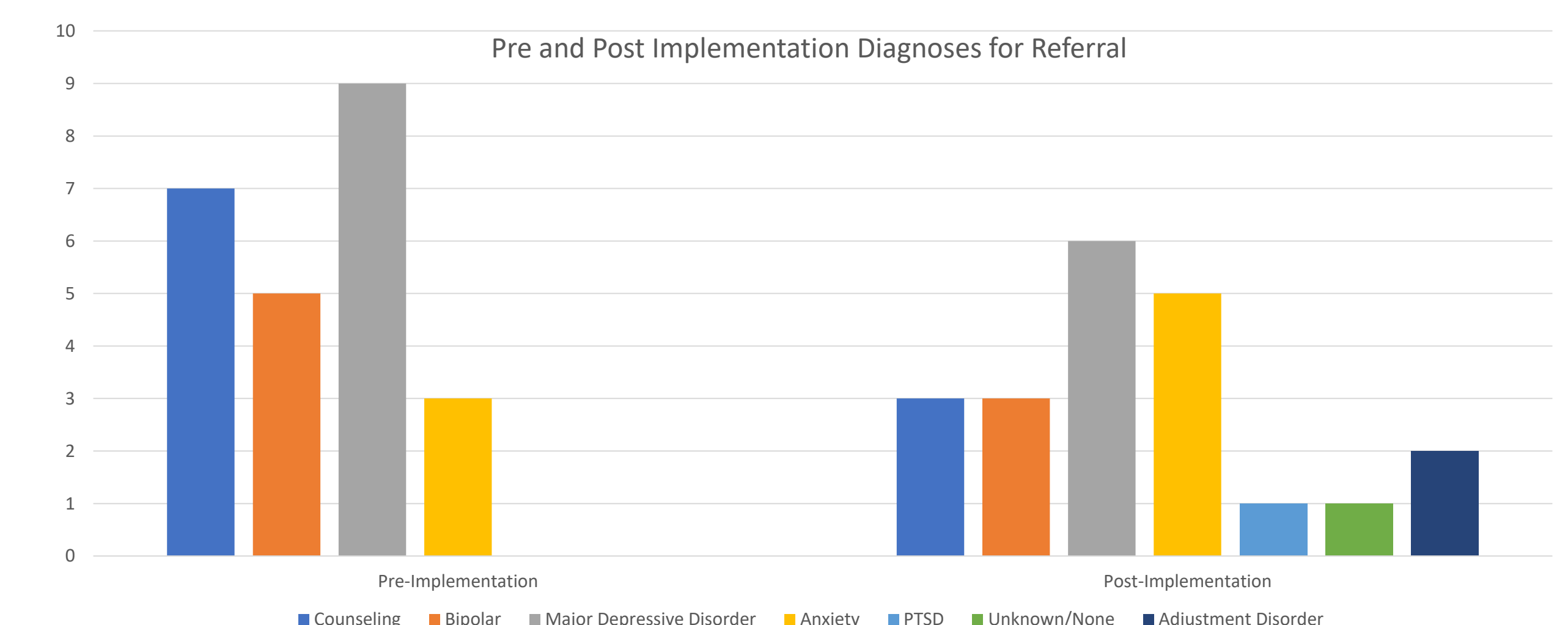


- 24 patient visits pre-implementation and 21 total visits post- implementation
- The same number of patients, 12, were seen both pre and post implementation
- Lack of protocol on when to refer to Peer Support vs. Primary Care Mental Health Integration (PCMHI)
- Clinic staff indicated a better understanding of the PSS role and the services they provide
- Clinic staff reported a better understanding of the referral process

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IMPACT ON PRACTICE

- Clinical staff at this Veteran's Affairs clinic have a better understanding of the services that the PSS provides
- This project can help to identify the role of the PSS and clarify the confusion on when to refer to the PSS or a PCMHI
- Clarification between the two roles will help to establish a better referral system and ensure the correct and most appropriate referral is placed



CONCLUSIONS

PSS continue to act as an additional mental health resource for the primary care provider

PSS have experience supporting a wide variety of mental health disorders and should continue to be utilized for these patients

Long term impact could involve an increase of referrals and the use of PSS over all disciplines of health care

In the setting of the VA, defining the role of the PSS and other mental health specialist (PCMHI) to ensure the correct referral is placed and the proper expertise is used

Better recognition and diagnosing tools for mental health disorders; as well as enhanced methods of treatment and the incorporation of collaborative care with other mental health professionals

ACKNOWLEDGEMENTS



VA

U.S. Department
of Veterans Affairs

Implementation of a Tele-Triage Protocol in an Emergency Department Setting

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PROBLEM INTRODUCTION

- Nationwide, the volume of emergency department (ED) visits has steadily increased over the last several decades (Joshi et al., 2019).
- This increase in volume frequently causes ED crowding and delays in patient evaluation and treatment, which is associated with poor patient outcomes (Rademacher et al., 2019).
- In an effort to decrease door-to-provider (DTP) wait times, an ED in central Illinois initiated a tele-triage process utilizing on-call nurse practitioners and physician assistants.
- Prior to this implementation, no guidelines existed regarding the activation and use of tele-triage medical screening exams at the ED for patients in the waiting room
- A protocol was developed to guide the tele-triage process and to train ED staff on how to implement tele-triage protocol.

LITERATURE REVIEW

- Tele-triage in the ED decreases DTP times and reduces the number of patients who leave without being seen (LWBS) (Izzy et al., 2018; Rademacher et al., 2019).
- Overcrowding of EDs linked to decreased quality of care, negative patient experiences, and exceedingly long door-to-provider times, it also leads to long wait times resulting in patients who leave without being seen (LWBS) (Rademacher et al., 2019; Joshi et al., 2019).
- A study by Rademacher et al. (2019) evaluated tele-screening of patients versus their previous in-person screening and LWBS patient numbers decreased from 25.1% to 4.5%.
- Implementing tele-triage will decrease door-to-provider wait times and decrease the providers and patients' risk to exposure as well as decrease the number of patients who leave without being seen.

PROJECT METHODS

Team creates protocol and educates staff on protocol

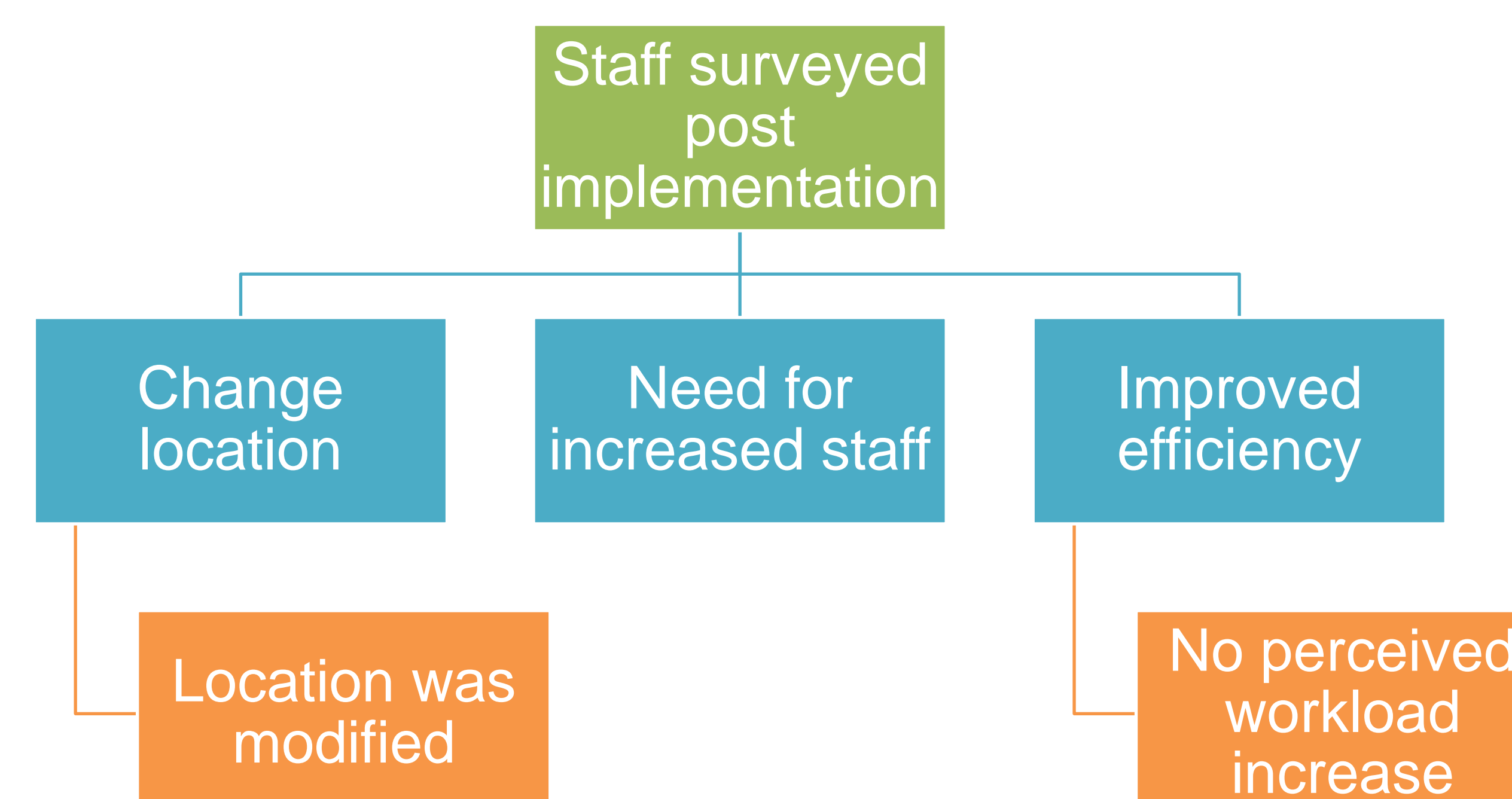
Retrospective data collected Jan. through May 2020 and average DTP, LWBS, and duration of ED visit

Four-week tele-triage protocol piloted in June and July 2021

Data collected on DTP, LWBS, and duration of ED visit for 4-week pilot collection

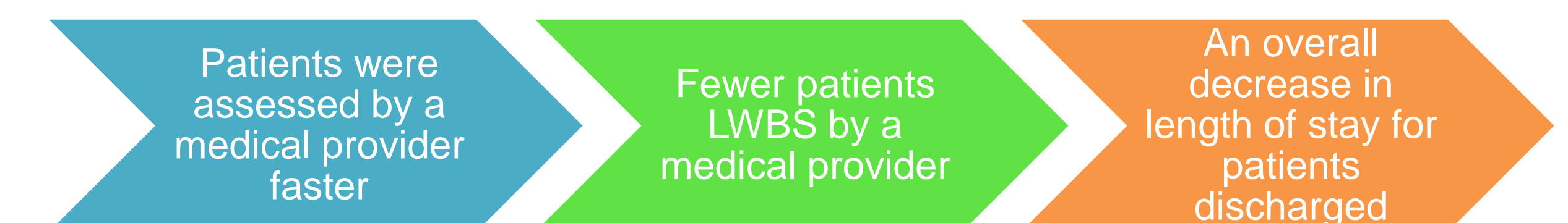
EVALUATION

	Average Door to Provider Time	Average Overall Length of Stay	Percentage of Patients Who Left Without Being Seen
Prior to Project Implementation	20 minutes	178 minutes	3%
During Implementation	17.37 minutes	146.95 minutes	2.96%



IMPACT ON PRACTICE

- Increased use of tele-triage protocol = faster patient evaluation by a medical provider



- Expansion:
 - implementing the tele-triage protocol in other EDs and giving tele-triage providers the ability to not only assess but discharge when appropriate

CONCLUSIONS

- Overall successful implementation of the tele-triage protocol
- Decrease in DTP for patients, overall length of stay and percentage of patients who LWBS
- A limitation faced during implementation was staffing shortages which resulted in inability to activate the protocol on several occasions
- Recommendation from ED staff was to move the tele-triage process to private room with one nurse technician assisting in tele-triage protocol

Acknowledgements

We would like to thank Dr. Sobczak and Dr. Schmidt for their guidance throughout the project. We would also like to thank all at Envision and St. John's Hospital Emergency Department.

Establishing A Neonatal PICC Line Team

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PROBLEM INTRODUCTION

Infants admitted to the NICU have a plethora of diagnoses. The nature of these disease processes usually precludes enteral feedings. Providing the infant with appropriate nutrition and hydration is a priority; this usually requires central venous access. Peripherally Inserted Central Catheters (PICCs) allow for a reliable route of administration for total parenteral nutrition and medications.

Due to various factors, a proposal was made to begin a nurse-led neonatal PICC line team to allow for timelier placement of PICC lines and, ultimately, better care for the neonatal population at the hospital.

LITERATURE REVIEW

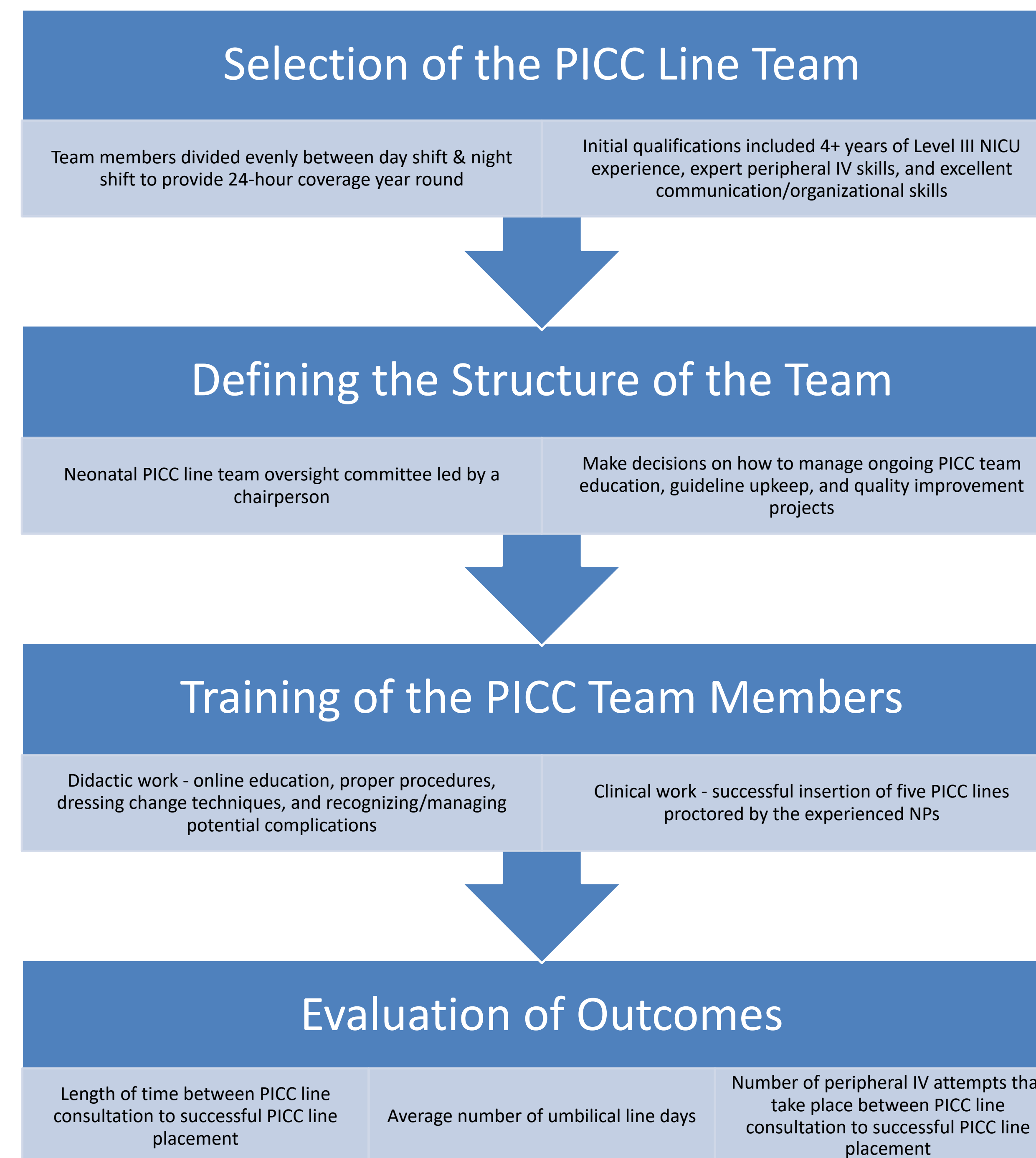
The placement of PICC lines in neonates has been found to be safe, with significantly fewer complications and infections than with surgically placed central venous catheters (CVS).

McDiarmid et al. (2017) found that when a member of the nurse-led team places a PICC, the patient receives all the advantages of a PICC line with a very low risk of complications.

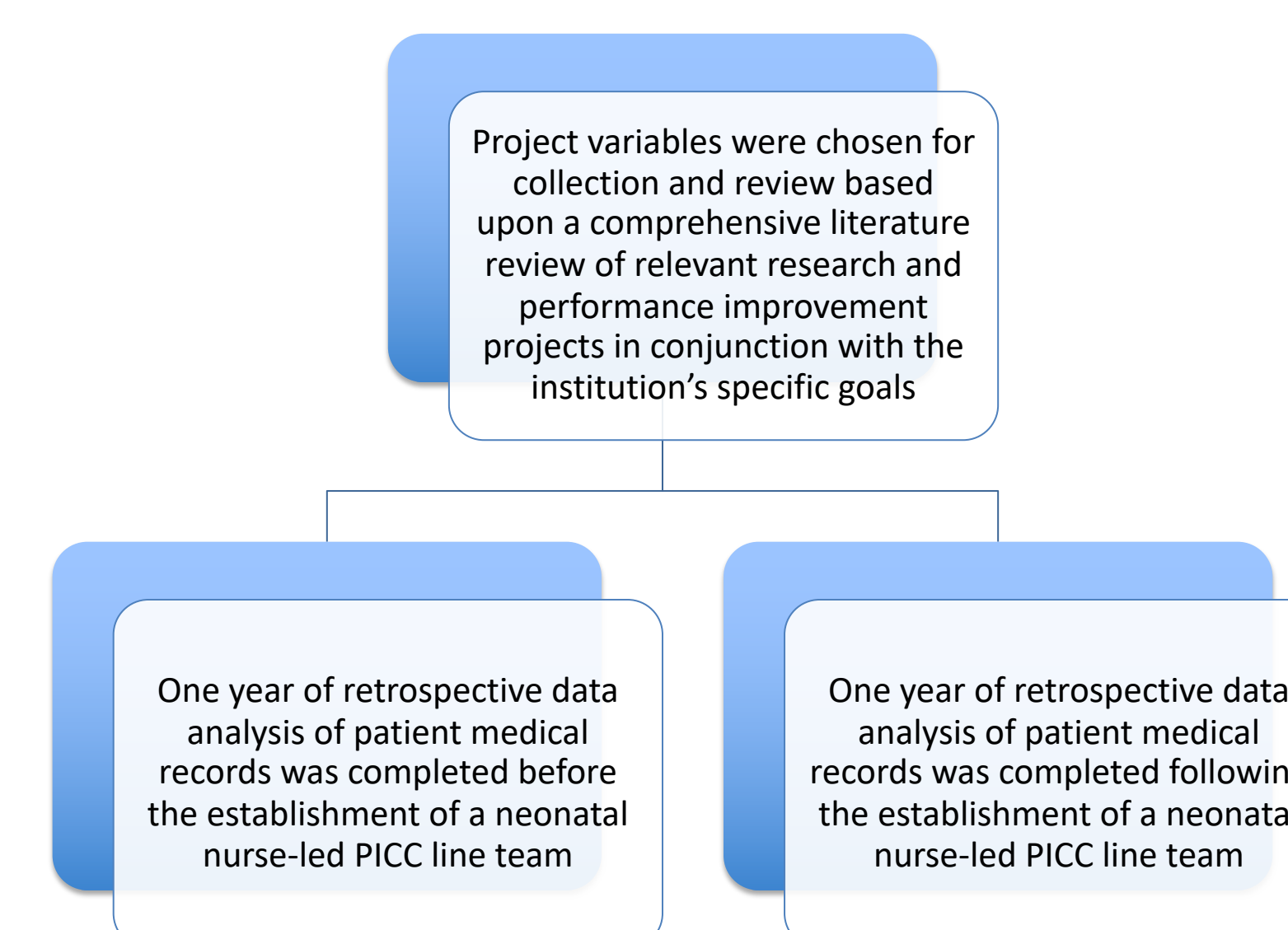
Krein et al. (2015) suggested that the increasing utilization of PICC lines in the NICU can be attributed to nurses' ability to safely and cost-effectively insert PICC lines after receiving additional training. Thus, PICC teams have become an extremely vital part of the health care team.



PROJECT METHODS

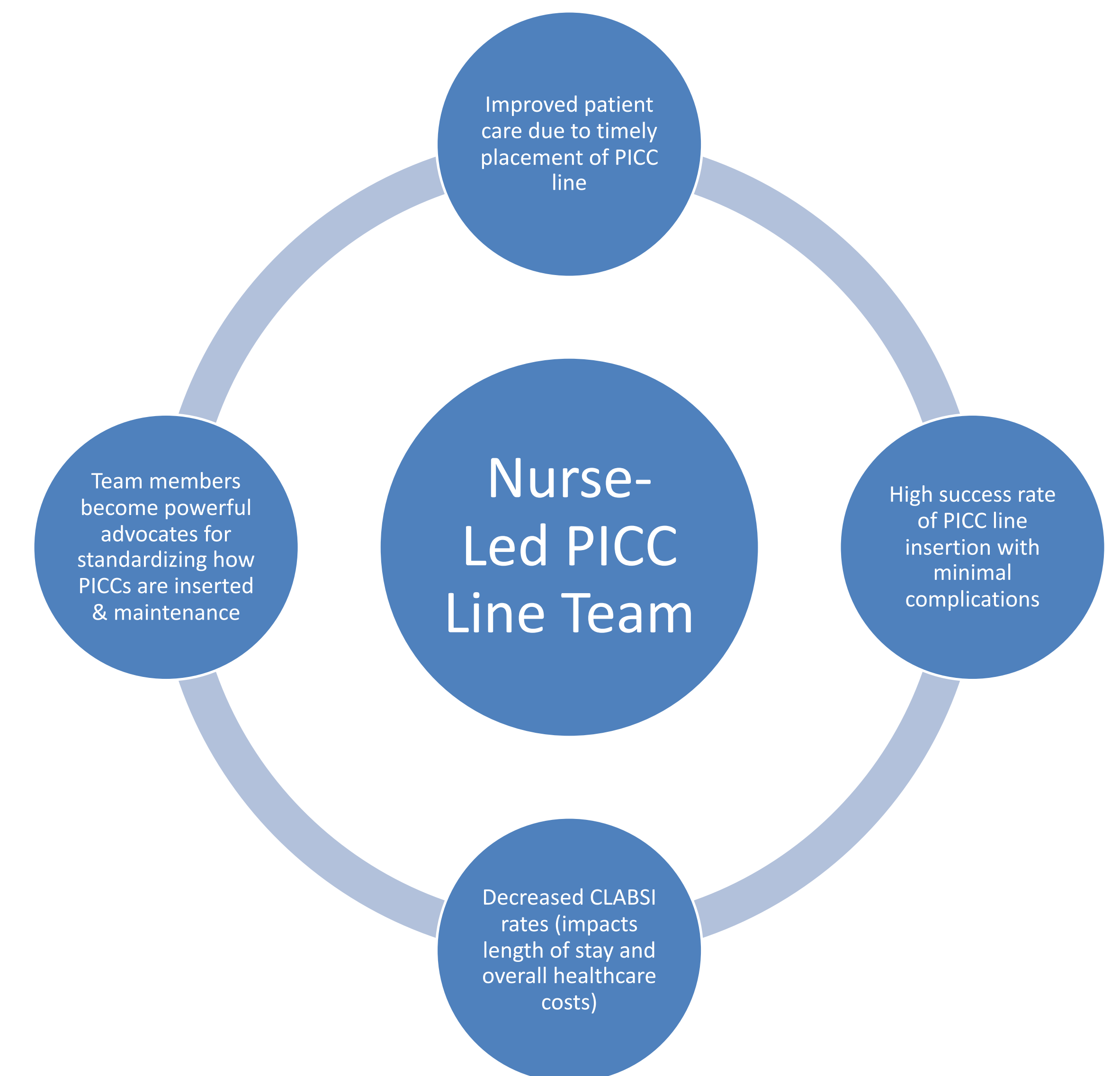


EVALUATION

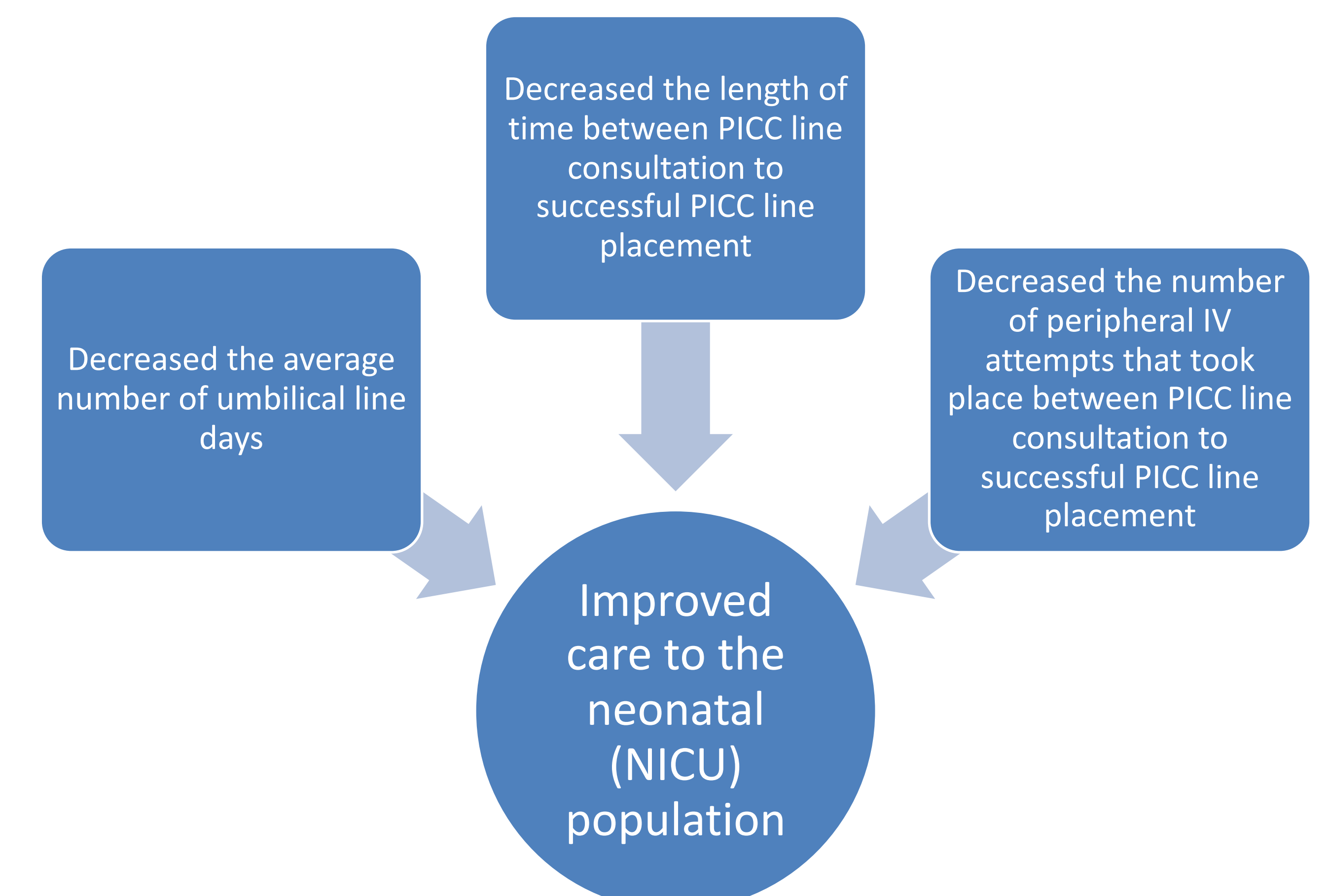


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IMPACT ON PRACTICE



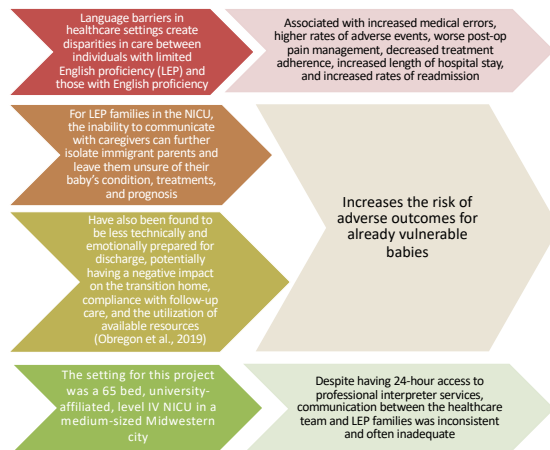
CONCLUSIONS



Improving Healthcare Team Communication with Limited English Proficiency Families in the NICU

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PROBLEM INTRODUCTION



LITERATURE REVIEW

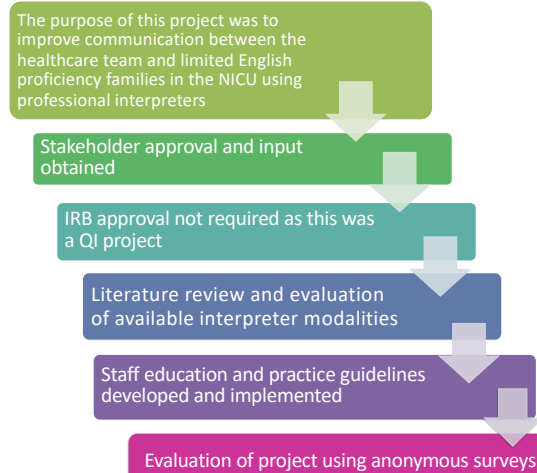
Databases: Academic Scholar Complete, Cumulative Index to Nursing and Allied Health Literature Plus with Full Text (CINAHL), MEDLINE Complete, Google Scholar

Keywords: language barriers, limited English proficiency, safety risks, healthcare, interpreters, video, modalities, NICU, family centered care, education, best practice, practice guidelines, evidence-based practice

Sources published from 2000-2021

1. Professional medical interpreters have been shown to greatly improve parent/staff communication, increase parent satisfaction, and improve quality of care
2. Solid parent-provider communication can result in better health outcomes by increasing parental empowerment and participation in their child's care (Walker-Vischer et al., 2015)
3. Despite the acknowledged advantages of using professional interpreters, even when they are readily available, they are frequently under-utilized
4. Use of ad hoc interpreters should be avoided

PROJECT METHODS



EVALUATION

Post-education surveys revealed that staff found the PowerPoint clear, easy to understand and applicable to the care of NICU patients

5 LEP families identified

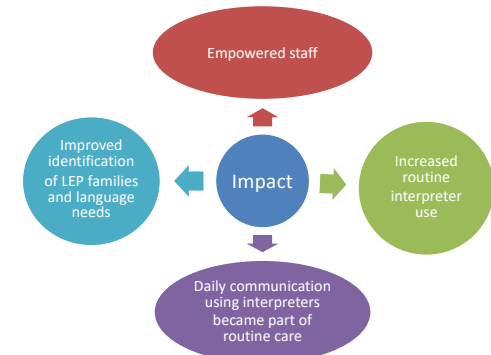
- All language preferences and interpreter needs documented in EMR
- Families with 2 LEP parents updated with interpreters most frequently (every 1-2 days)
- Care conferences scheduled for 2 long-term stays
- Video was most frequently used modality

Barriers to Interpreter Use:

- Family preference (EP parent used as interpreter)
- Time constraints (high census/acuity, staffing shortages)
- Family not present at bedside during rounds
- Unclear rules regarding in-person interpreters
- No interpreter available for preferred language

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CONCLUSIONS

Educational module and clear practice guidelines helped NICU staff understand the importance of identifying LEP families and using professional interpreters

Staff felt empowered to use available modalities, improving routine communication with LEP families

Video remote interpreter service was by far the most popular for its convenience and "personal" factor

Daily communication using professional interpreters and providing true family-centered care to LEP families in the NICU can potentially decrease the risk of adverse outcomes associated with language barriers

Future implications for potential projects:

- Review of available translated materials
- Certification of staff members as interpreters

PROJECT COMPONENTS

Staff Education

- Importance of professional interpreter use
- Strategies for communicating effectively through an interpreter
- Instructions on all three available interpretation modalities (in-person, video, and telephone)



Practice Guidelines

- Identification of LEP families and documentation of language preference and assistance needs in the electronic medical record (EMR)
- Routine communication between LEP families and the medical team using an interpreter.
 - "Orientation" to the NICU at the time of admission
 - Communication during daily bedside rounds
 - Routine multi-disciplinary care conferences

Anticipatory Guidance for Caregivers of Pediatric Patients Ages 0-12 Months

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PROBLEM INTRODUCTION

- The greatest causes of infant death include sudden unexpected death in infancy (SUDI), suffocation, transportation-related injuries, drowning, burns, poisoning, and falls (Borse et al., 2008).
- Anticipatory guidance is defined as proactive counseling for caregivers regarding various aspects of childcare and development (Weber-Gasparoni & Rayes, 2019).
- The purpose of anticipatory guidance is to promote health in the developing child while working to prevent unintentional injury or harm.
- Common topics include but are not limited to nutrition, sleep, safety, immunizations, and developmental milestones.
- This project sought to improve the process and delivery of anticipatory guidance for infants aged 0-12 months at one rural pediatric primary care clinic.

LITERATURE REVIEW

- Anticipatory guidance has multiple benefits: improved parenting and child safety practices, increased child development and decreased maternal stress (Hsu et al., 2018).
- There are various methods of providing anticipatory guidance education to caregivers of children aged 0-12 months, some of which include videos/other electronic materials, written materials, and verbal discussion.
- Various studies have demonstrated benefits in the provision of anticipatory guidance education through the combination of videos, written materials, and verbal discussion (Franz et al., 2018; Hsu et al., 2018; Panza et al., 2020; Paradis et al., 2011).

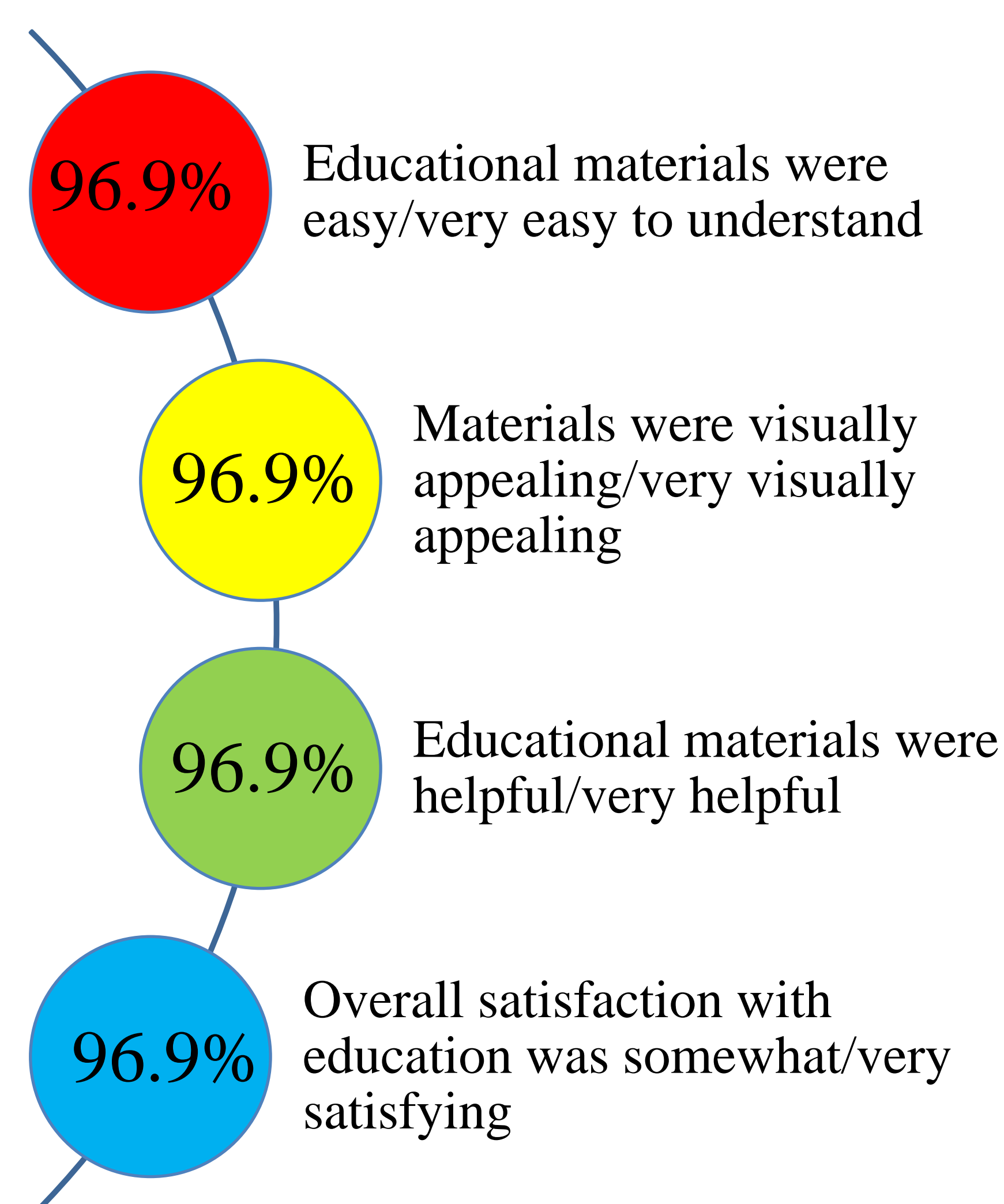
PROJECT METHODS

- Updated written educational materials with most recent recommendations
- Revised design of written educational materials to optimize caregiver engagement
- Created anticipatory guidance educational videos
- Presented videos on clinic tablet to caregivers during each well child visit prior to the provider entering the examination room
- Through these interventions, caregiver education regarding most recent evidence-based anticipatory guidance recommendations was optimized and tailored to the caregiver's current understanding of recommendations



EVALUATION

- Data regarding written and video educational materials were collected from caregivers through the administration of anonymous, voluntary paper surveys with Likert scales
- 32 caregiver surveys were collected - RESULTS:



- Provider perspectives were collected using anonymous, voluntary surveys, utilizing open-ended questions
- A focus group was also held with clinic staff to discuss provider/staff perspectives on the project
- Provider perspectives were similarly positive

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IMPACT ON PRACTICE

Provided new, updated means of caregiver education

Updated hand-out forms for caregivers to take home and utilize later

Opportunity for further development for how anticipatory guidance is provided in the office

CONCLUSIONS

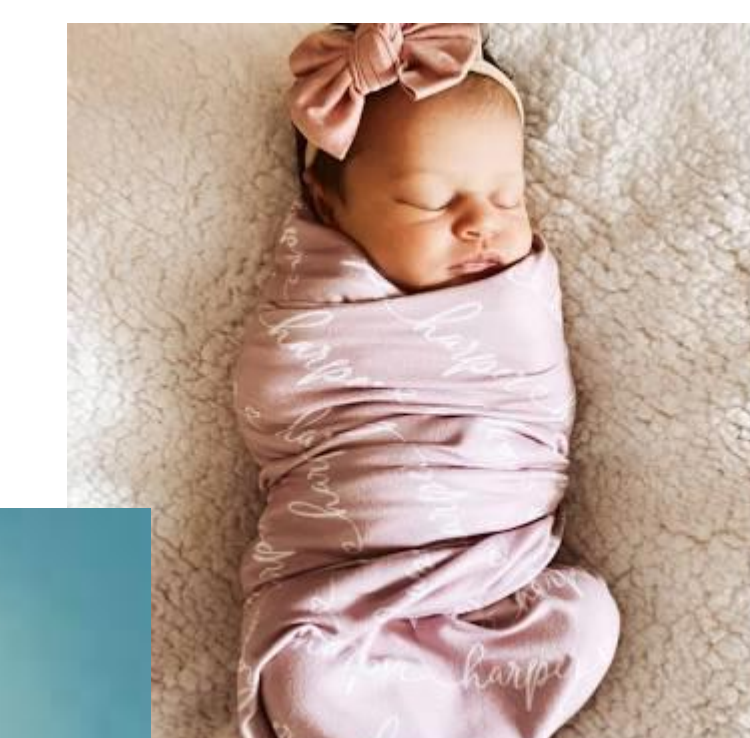
Anticipatory guidance is best received when given in multiple formats

All materials were able to be updated and visually impactful

Caregivers received more individualized education during appointments

Need for funding for rural clinic website updates identified

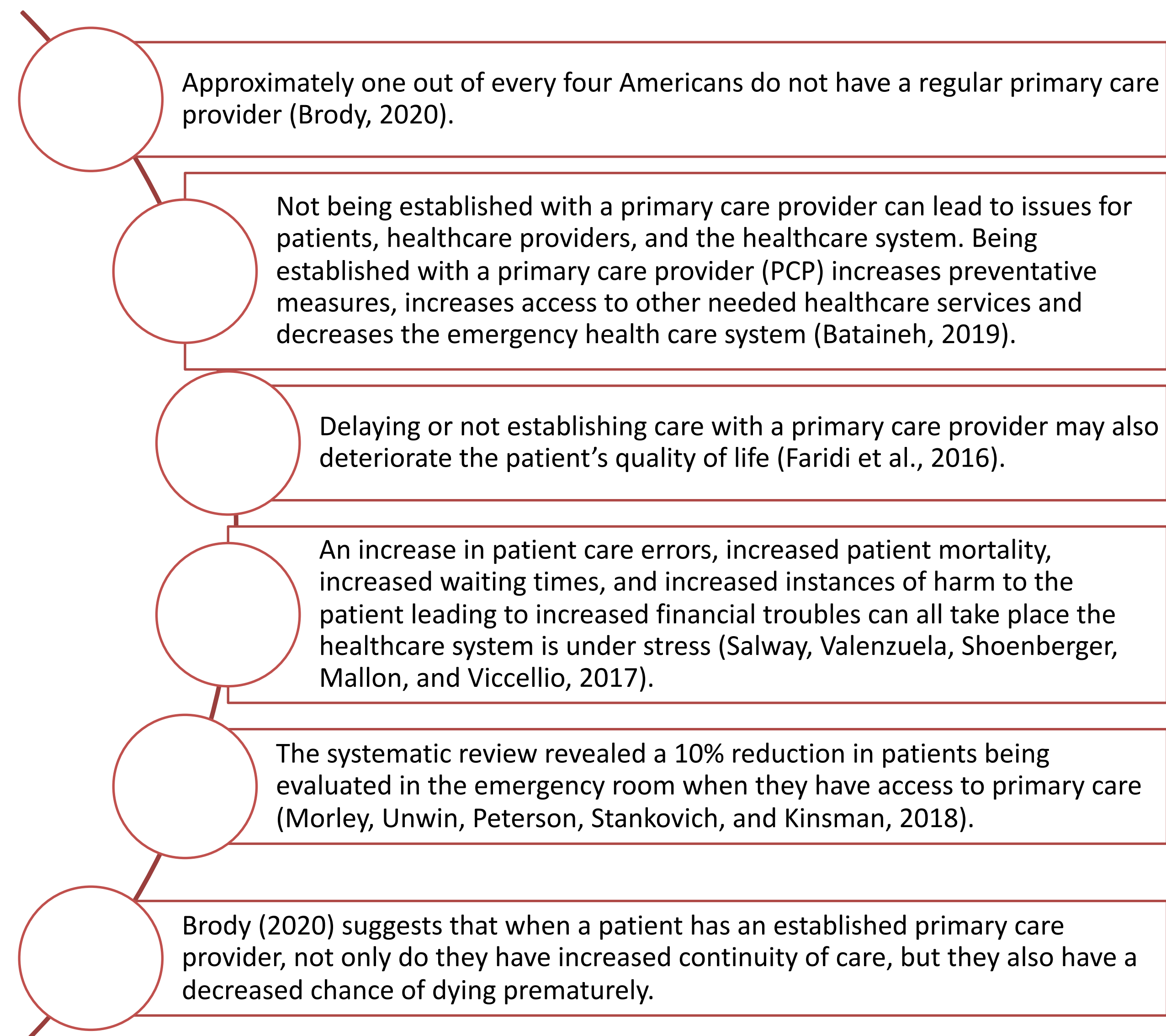
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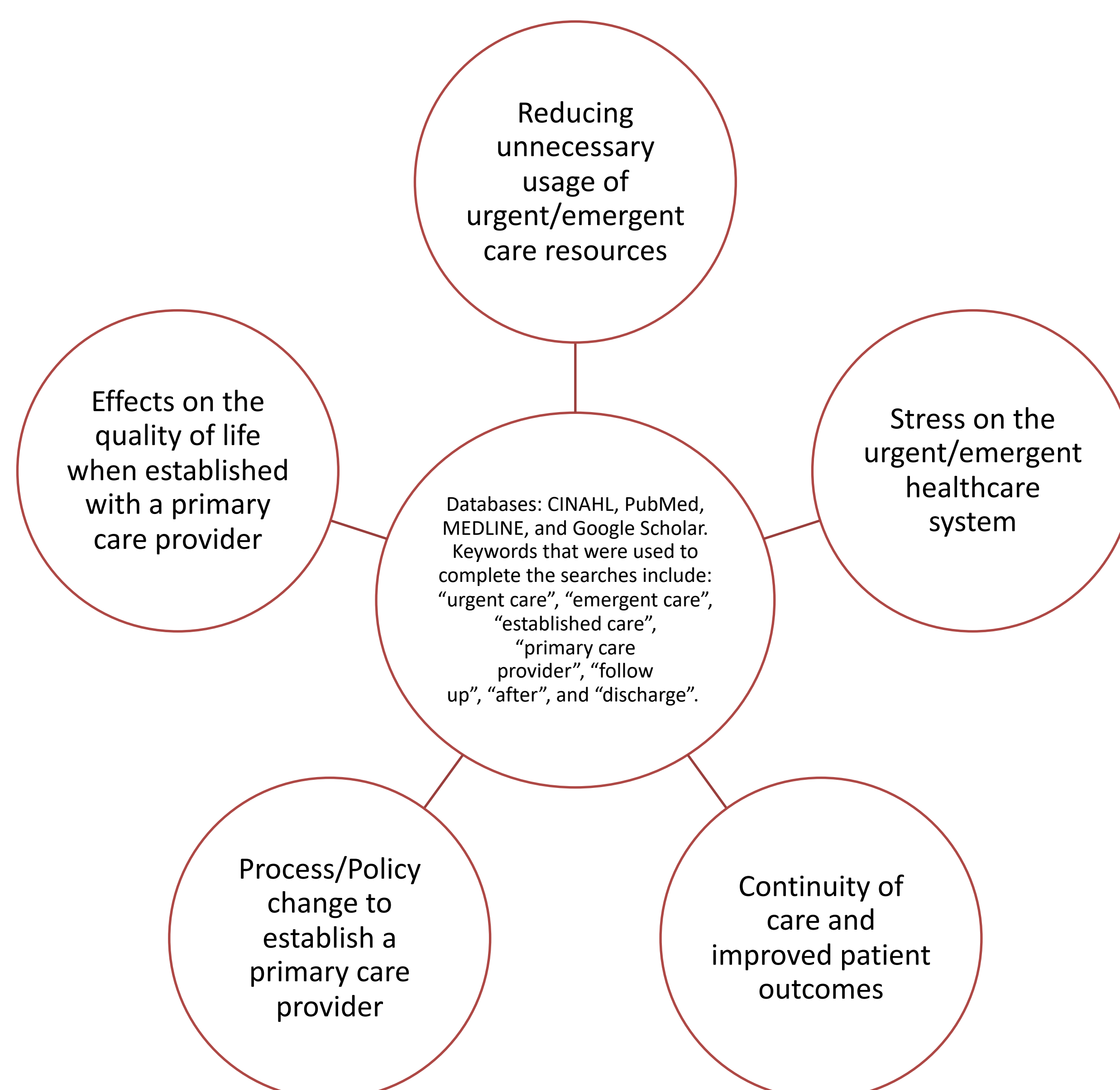
Establishing Care with a Primary Care Provider

Ashley Whitlatch, MSN, APRN, FNP-BC
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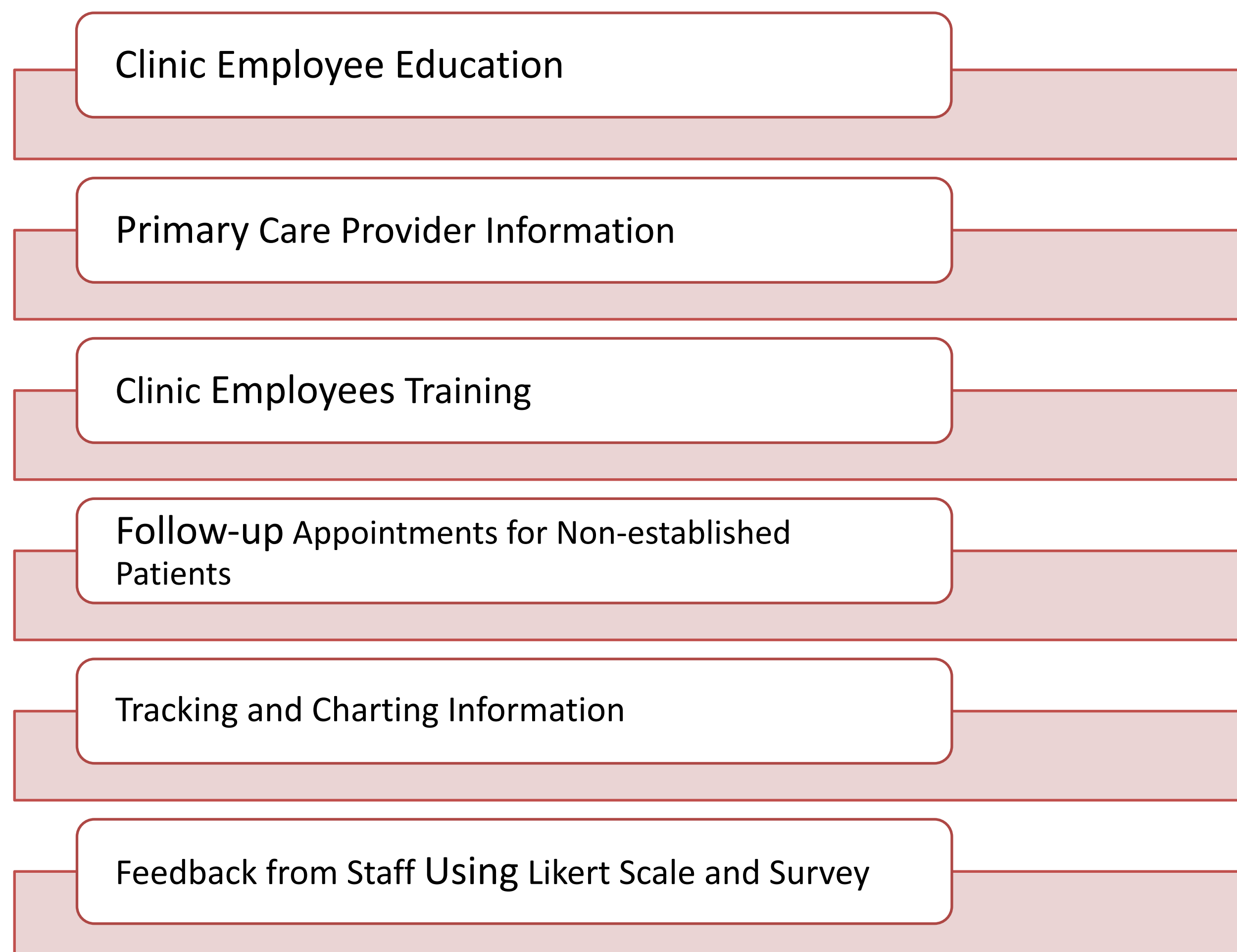
PROBLEM INTRODUCTION



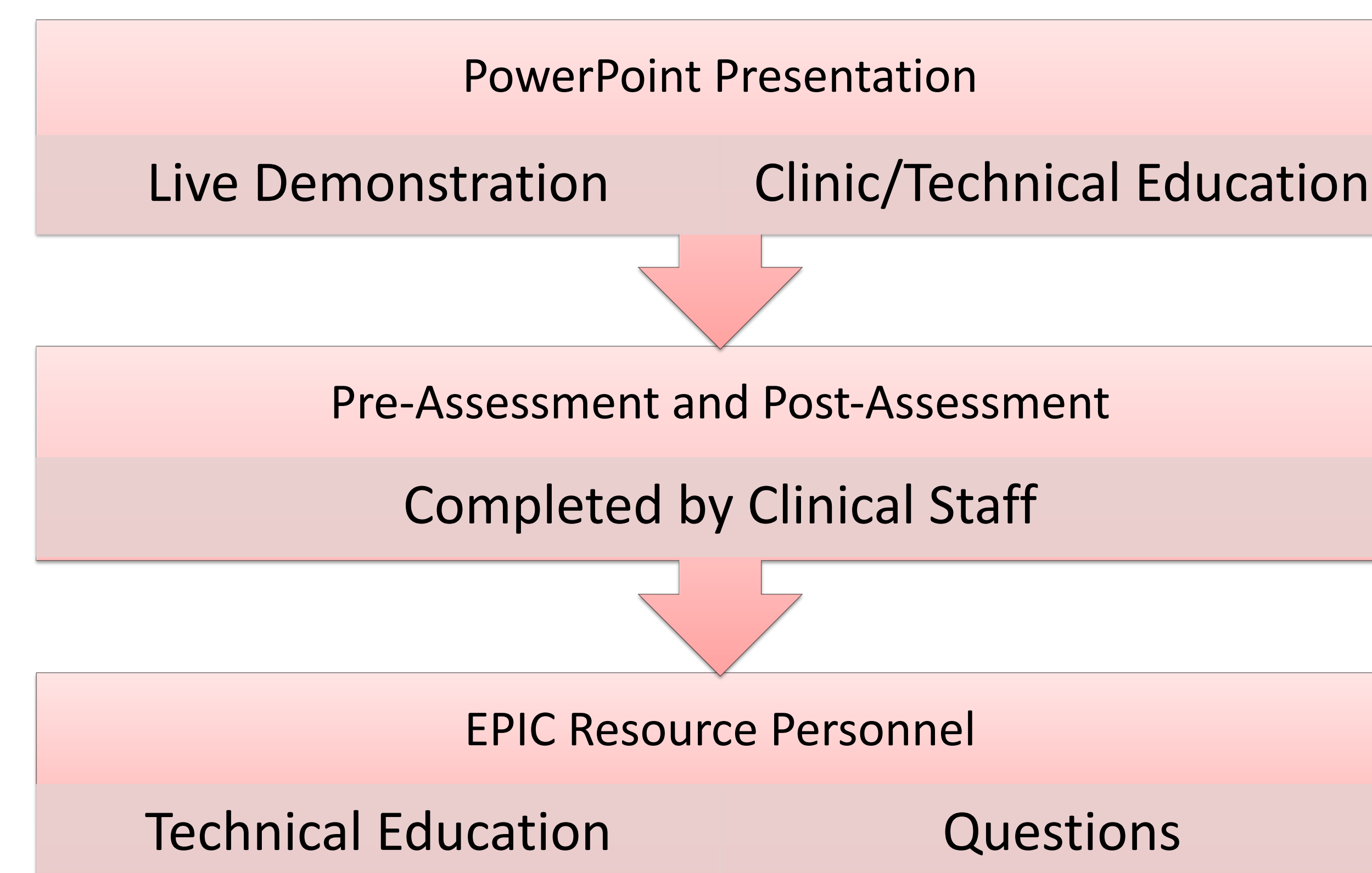
LITERATURE REVIEW



PROJECT METHODS

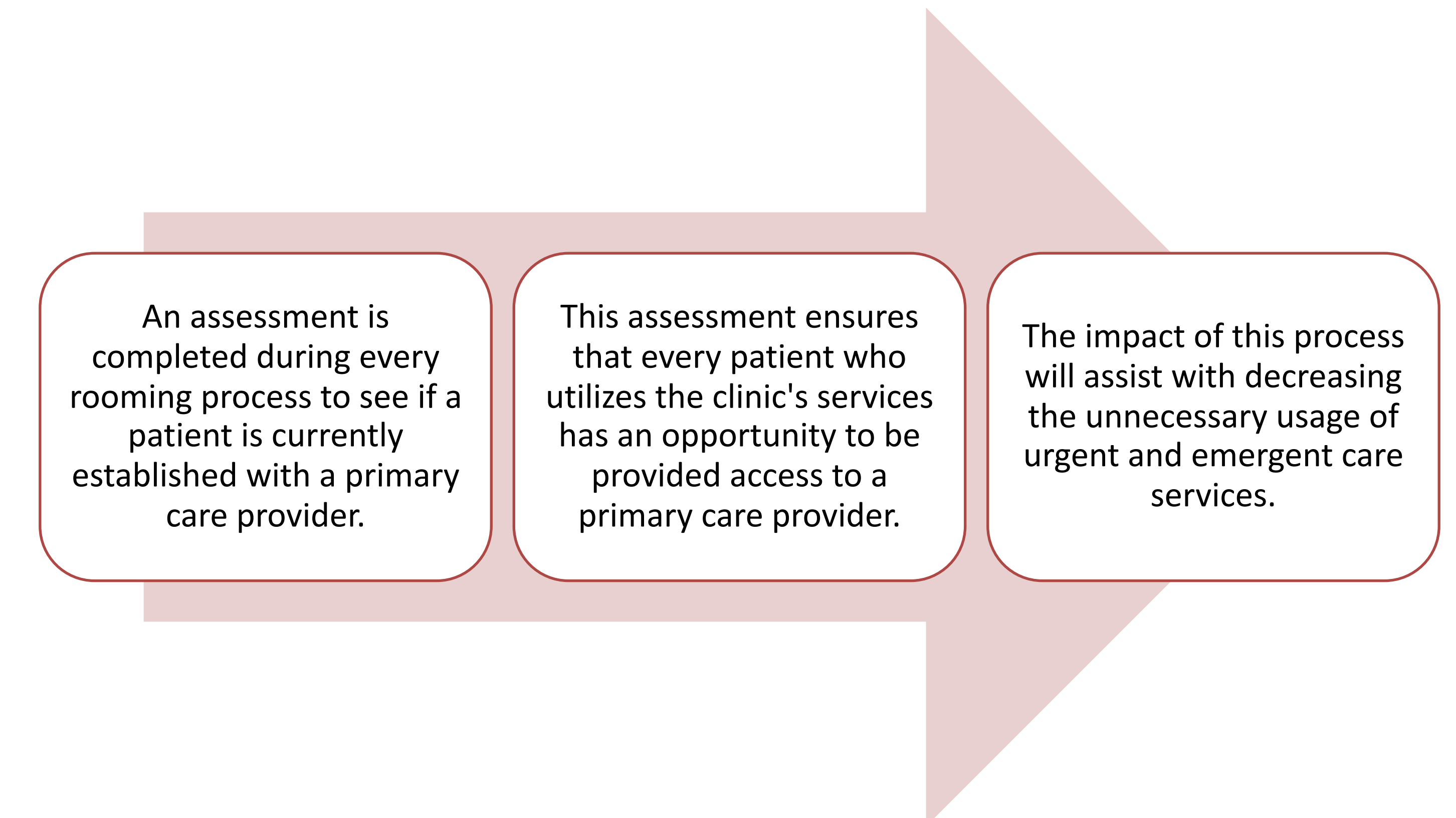


EVALUATION



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CONCLUSIONS

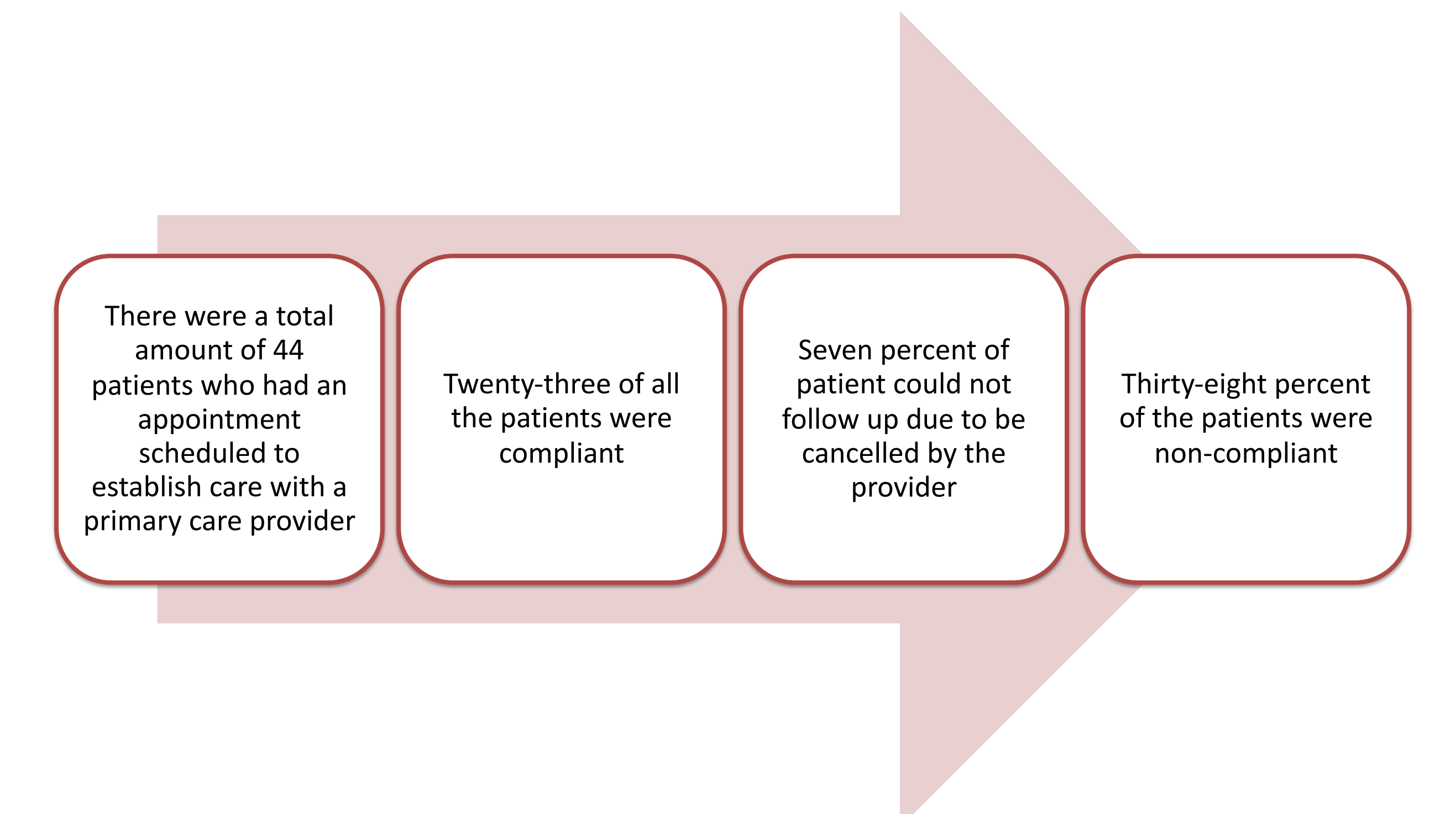


Image from Catalytics, Inc.

ERAS protocols for General Abdominal and Orthopedic Surgery: Preoperative Hydration and Multimodal Management

Kristin Wolff, BSN, SRNA & Sadie Turner, BSN, SRNA
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PROBLEM INTRODUCTION

Introduction to ERAS:

- Evidence-based, patient-centered, interdisciplinary team-developed protocol (AANA, 2017)
- Utilized to decrease the patient's stress response to surgery, maintain preoperative physiologic function, and expedite recovery (AANA, 2017).
- Colorectal ERAS protocols were the first ERAS protocols developed (late 1990s), and today medical centers are currently developing and implementing more ERAS protocols for specific service lines such as general abdominal and orthopedic cases (Heathcote et al., 2019).

ERAS Evidence:

- Current evidence demonstrates that ERAS protocols lead to better patient outcomes, decrease postoperative complications, facilitate recovery, and allow for earlier discharge (AANA, 2017).
- Studies show that one must employ the preoperative, intraoperative, and postoperative components of the ERAS protocols to achieve maximum benefits (Heathcote et al., 2019).

Project Problem:

- A rural hospital in eastern Illinois, Paris Community Hospital (PCH), utilizes some components of the ERAS protocols, mainly the intraoperative portions, but lacks the full utilization.
- The purpose is to identify evidence-based ERAS protocols for general abdominal and orthopedic surgery, with emphasis on preoperative hydration, preoperative multimodal management, and postoperative multimodal pain management.

PROJECT METHODS

Aim

- Educate the healthcare providers in the knowledge deficit areas: perioperative goal-directed fluid management, preoperative and postoperative multimodal analgesic management, and the contraindications to the medications utilized in ERAS protocols.

Implementation

- Educational voiceover PowerPoint and protocol regarding the management of hydration status and multimodal analgesia for general abdominal and orthopedic surgeries.
- In-person presentation at the monthly surgical meeting, giving providers another opportunity to receive the material and ask questions.

UPDATED HYDRATION PROTOCOL

General Abdominal Surgery	Orthopedic Surgery
Preoperative: <ul style="list-style-type: none">• Patients should be euvoletic, with electrolyte excesses or deficits corrected before inducing anesthesia• Clears up to 2 hours before surgery• Light meal until 6 hours before anesthesia induction• Include carbohydrate drink consumed 2-3 hours prior to induction (more studies needed on morbidly obese and GERD)• If diabetic, monitor sugar• Bowel preparation: avoid for colonic surgery, may use for rectal surgery	Preoperative: <ul style="list-style-type: none">• Clears up to 2 hours before surgery• Light meal until 6 hours before anesthesia induction• Include carbohydrate drink consumed 2-3 hours prior to induction (can be added benefit, but further studies are needed)
Intraoperative: <ul style="list-style-type: none">• Use goal-directed fluid therapy (GDFT) utilizing hemodynamic framework• Isotonic crystalloids are appropriate for the treatment of hypovolemia• Colorectal surgery: 1-4 ml/kg/hr to maintain fluid homeostasis, cardiac output, and tissue perfusion	Intraoperative: <ul style="list-style-type: none">• Use goal-directed fluid therapy (GDFT) utilizing hemodynamic framework• Effective fluid management for orthopedic surgeries is focused on avoiding electrolyte imbalances and meeting insensible losses
Postoperative: <ul style="list-style-type: none">• Consume oral fluids as soon as patient is awake and without nausea• Stop IV fluids after oral intake started	Postoperative: <ul style="list-style-type: none">• Consume oral fluids as soon as patient is awake and without nausea• Stop IV fluids after oral intake started

MULTIMODAL ANALGESIA PROTOCOL

GENERAL ABDOMINAL SURGERY

	Preoperative	Intraoperative/Postoperative	Caution
Acetaminophen	-1g IV or PO q6hrs starting within 30min-2hrs preoperatively	-1g IV or PO q6hrs for 7-14 days postop	-Liver dysfunction -Overdose can cause hepatotoxicity, max dose is 4g per day
NSAIDs	-PO NSAID prior to surgery (Nonselective or COX-2 selective dependent on patient risk factors) -Time dosing to achieve optimal pharmacodynamic effect that coincides with surgery onset to maximize multimodal opioid-sparing effect	-Anastomotic leak risk: cautious use is advised in gastrointestinal, colorectal, and bariatric surgeries related to possible deleterious effects on anastomotic healing -Higher rate of anastomotic leakage associated with nonselective NSAIDs -Selective COX-2 inhibitors = same rate of anastomotic leakage as those not taking NSAIDs -More studies required before recommendation from ERAS	-NSAIDs can lead to disadvantages of platelet inhibition, increased bleeding, gastric ulceration, bronchospasm, and renal vasoconstriction
Gabapentinoids	-Pregabalin (Lyrica) dosed 75mg PO q12hrs -Gabapentin 300-600mg q12hrs	-Limited to a single preoperative dose unless indicated for postoperative neuropathic pain to limit the side effects	-Cause increased postoperative sedation, dizziness, visual disturbances, and peripheral edema -Elderly should receive a lower preoperative dose due to increased sedation and respiratory depression -Renally excreted so caution with renal disease and decrease dose.
Corticosteroids	-Dexamethasone 4mg-10mg	-N/A	-Immunosuppression at higher doses -Increased blood glucose levels
Lidocaine/Local Anesthetics	-Spinal/epidural analgesia or TAP blocks	-Mixed results on efficacy but may consider: Lidocaine IV bolus 1-2 mg/kg with induction followed by lidocaine infusion 1-3 mg/kg/hr for 24 hours	-Local anesthetic systemic toxicity (LAST)
Ketamine	-0.1-0.5 mg/kg IV with induction	-0.1-0.3 mg/kg IV q30-60min or 0.1-0.2mg/kg/hr infusion -Can continue infusion for 24-72 hrs postop, but decrease dose to 10mg/hr or less after 24 hrs	-CAD, uncontrolled HTN -Shock/minimal catecholamine stores -Increased ICP, increased IOP, globe injuries -History of psychosis -Hepatic dysfunction, porphyria, recent liver transplant
Dexmedetomidine	-0.5-2mcg/kg IV bolus slow (over 10-20 min)	-0.2-0.7 mcg/kg/hr infusion (primarily only intraoperative)	-Hemodynamically unstable patients- dexmedetomidine may cause bradycardia, hypotension, or transient hypertension -Mixed results if increases or decreases nausea risk- dexmedetomidine may decrease nausea via opioid-sparing -Postoperative sedation

ORTHOPEDIC SURGERY

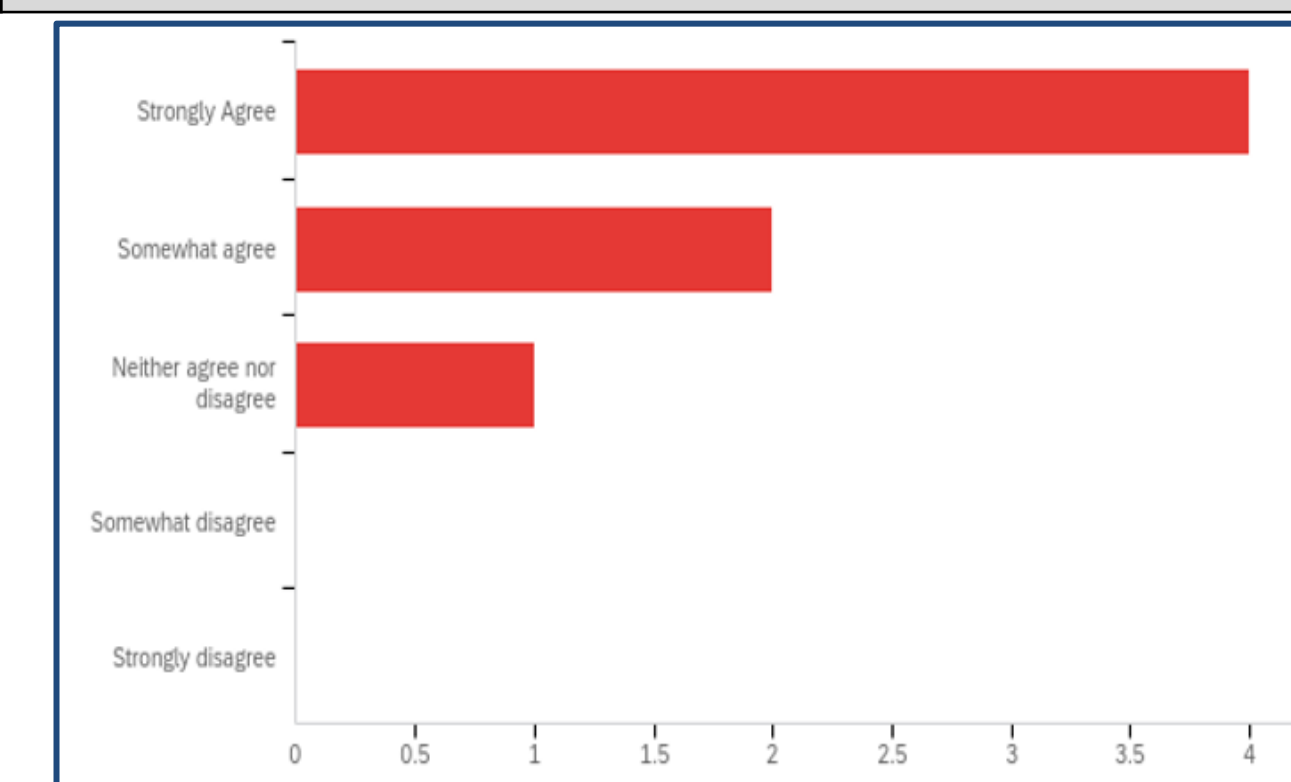
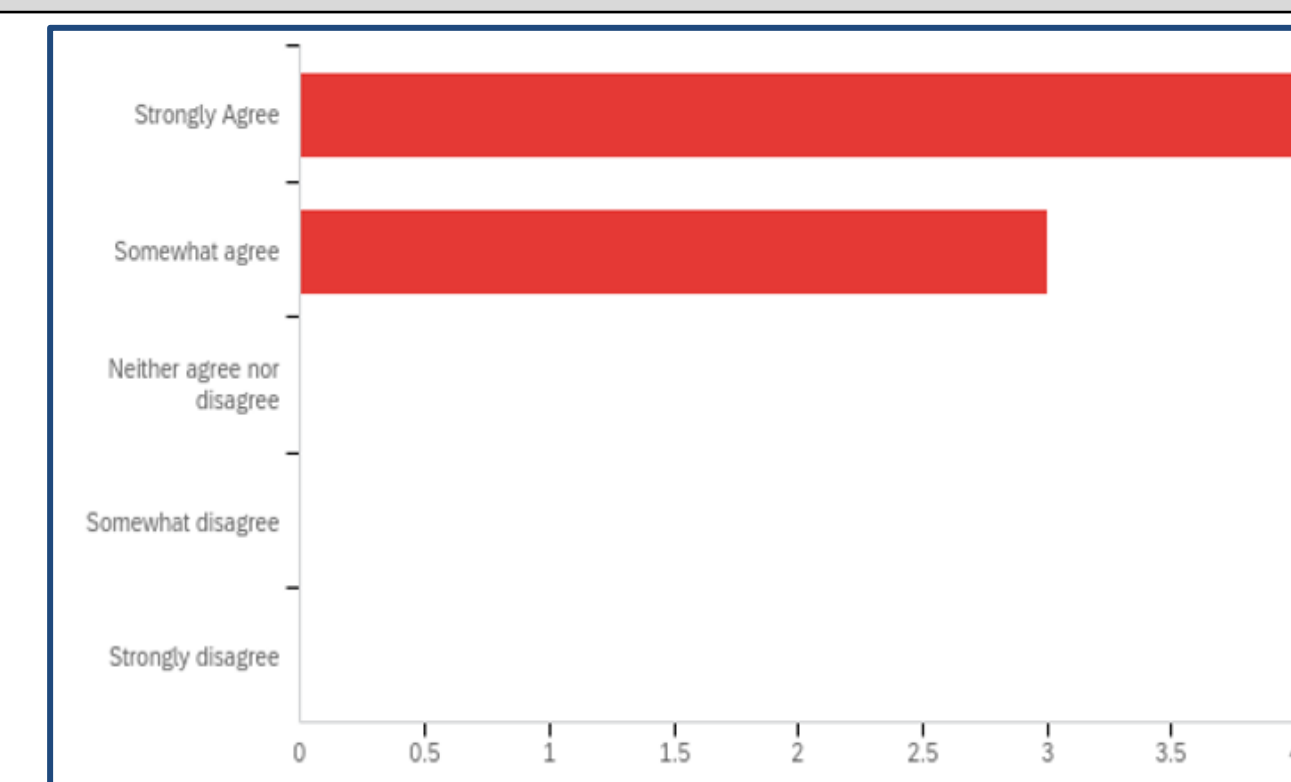
	Preoperative	Intraoperative/Postoperative	Caution
Acetaminophen	-1g IV or PO q6hrs starting within 30min-2hrs preoperatively	-1g IV or PO q6hrs for 7-14 days postop (could continue longer)	-Liver dysfunction -Overdose can cause hepatotoxicity, max dose is 4g per day
NSAIDs	-COX-2 Inhibitor Celecoxib: 400mg an hour before surgery -If available parecoxib, parenteral COX-2 Inhibitor can be utilized	-200mg q12hrs for at least 5 days postoperatively, some studies show celecoxib up to 6 weeks postop is beneficial -Nonselective NSAIDs could be used	-NSAIDs can lead to disadvantages of platelet inhibition, increased bleeding, gastric ulceration, bronchospasm, and renal vasoconstriction
Gabapentinoids	-Pregabalin (Lyrica) dosed 75mg PO q12hrs -Gabapentin 300-600mg q12hrs	-Only take up to day 4	-Cause increased postoperative sedation, dizziness, visual disturbances, and peripheral edema -Elderly should receive a lower preoperative dose due to increased sedation and respiratory depression -Renally excreted so caution with renal disease and decrease dose.
Corticosteroids	-Methylprednisone 125mg OR -Dexamethasone 4mg-10mg (preferably 4mg)	-N/A	-Immunosuppression at higher doses -Increased blood glucose levels
Lidocaine/Local Anesthetics	-Peripheral Nerve Blocks	-Lidocaine IV bolus 1-2 mg/kg with induction -0.1-0.3 mg/kg IV q30-60min or 0.1-0.2mg/kg/hr infusion -Can continue infusion for 24-72 hrs postop, but decrease dose to 10mg/hr or less after 24 hrs -Ortho adjunct example: 1-10mcg/kg/min started during procedure and stopped 48hr postop	-Local anesthetic systemic toxicity (LAST)
Ketamine	-0.1-0.5 mg/kg IV with induction	-0.1-0.3 mg/kg IV q30-60min or 0.1-0.2mg/kg/hr infusion (primarily only intraoperative)	-CAD, uncontrolled HTN -Shock/minimal catecholamine stores -Increased ICP, increased IOP, globe injuries -History of psychosis -Hepatic dysfunction, porphyria, recent liver transplant
Dexmedetomidine	-0.5-2mcg/kg IV bolus slow (over 10-20 min)	-0.2-0.7 mcg/kg/hr infusion (primarily only intraoperative)	-Hemodynamically unstable patients- dexmedetomidine may cause bradycardia, hypotension, or transient hypertension -Mixed results if increases or decreases nausea risk- dexmedetomidine may decrease nausea via opioid-sparing -Postoperative sedation

EVALUATION

Evaluation: post-presentation anonymous survey completed by three anesthesia providers, two surgeons, and two other surgical healthcare workers

All participants agreed that the presentation improved their knowledge regarding perioperative goal-directed fluid management, preoperative and postoperative multi-modal analgesic management, and the contraindications to the medications utilized in ERAS protocols.

Six out of seven participants stated the knowledge gained from the presentation would affect their practice.



IMPACT ON PRACTICE

The number of general abdominal and orthopedic procedures continues to grow. ERAS protocols improve patient satisfaction, decrease surgical complications and decrease costs and hospital length of stay.

Proper preoperative hydration improves patient satisfaction along with having metabolic and clinical benefits.

The project can be sustained by continued use of the protocols and the providers' ability to update the protocol as evidence continues to evolve.

Multimodal analgesia management decreases stress response to surgery and opioid use. With the current opioid epidemic and the multiple adverse effects of opioids, limiting their use has numerous benefits for the patient.

CONCLUSIONS

Continued Research

Utilizing the research methods of this project at facilities across the country would lead to increased utilization of ERAS protocols.

Facilities that do not utilize ERAS protocols must have complete education on what ERAS is and how to utilize ERAS protocols.

Facilities that partially utilize protocols, such as PCH, would benefit from assessing current practices, then education directed at the deficits.

Increasing the use of ERAS protocols can have a powerful impact on current practice.

Limitations

A limitation of this project was the small number of participants. Another limitation of this project was using a convenience sample of participants.

References



LITERATURE REVIEW

Preoperative Hydration

- Preoperative fasting guidelines are consistent for nearly all surgical procedures, allowing patients to drink clear liquids (including carbohydrate drinks) until 2 hours before anesthesia induction and eat a light meal until 6 hours before induction. (Thiele et al., 2016; Gustafsson et al., 2019)
- The ERAS protocols for orthopedic and abdominal general surgical cases include consuming a carbohydrate drink 2-3 hours prior to surgery. (Gustafsson et al., 2019)
- Maintaining a zero-fluid balance is the goal, as fluid excesses and deficits are associated with increased postoperative complications and prolonged hospital stay. (Gustafsson et al., 2019)

Multimodal Analgesia

- The American Society of Enhanced Recovery states that multimodal analgesic strategies should include a minimum of two nonopioid analgesics and an epidural or regional nerve block as appropriate. (Marcotte et al., 2020)
- Utilizing a multimodal approach, including NSAIDs, acetaminophen, gabapentinoids, corticosteroids, lidocaine, NMDA antagonists, and dexmedetomidine, can significantly reduce the opioid requirements of the patient. (Kaye et al., 2019)
- Utilizing multimodal medications optimizes pain control for the patient, reduces the reliance on opioids, and reduces the length of stay. (Frassanito et al., 2020; Feldheiser et al., 2015).

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