Compass SHARP

Compass SHARP in Practice Microlearning Series

COMPASS HEALTHCARE COLLABORATIVE

Sustainable Healthcare Transformation

Module 10: High-Risk Populations (Elderly, Sleep Apnea, Renal Disease)

Welcome to Compass SHARP in Practice, a quick high-yield learning session made for busy healthcare professionals like you. In each episode, our Compass coaches will explore a real-world case, define a clinical goal, and walk through practical strategies to improve care. Whether you're tuning in via video, audio, or reading the summary, we hope to sharpen your skills and build knowledge that helps you better care for your patients.

A Patient Case

Megan is a 77 year old woman with obstructive sleep apnea and chronic kidney disease who undergoes a right knee replacement. Postoperatively, she is prescribed the facility standard of oxycodone with instructions to take 10 milligrams every four hours as needed for pain. After a one day hospital stay, she is discharged home. By her second evening at home, she becomes somnolent, her oxygen saturation drops, and her family is forced to call 911. This scenario is common because standard opioid orders are often applied to patients whose physiology makes them anything but standard. Patients with advanced age, sleep apnea, lung disease, renal or hepatic impairment all have lower metabolism or less physiologic reserve, and therefore greater sensitivity to opioids.

Goal

Our goal in this module is to apply evidence-based strategies to recognize early risk, tailor therapy, and prevent avoidable opioid related harm.

First, assess risk before prescribing. During the preoperative evaluation, flag patients with high-risk features such as advanced age, frailty, sleep apnea, renal or hepatic disease, obesity, or concurrent sedative use. These risks should guide postoperative orders, including lower starting doses, longer dosing intervals, the use of continuous monitoring for sedation and oxygenation when indicated in hospitals or at home, and counseling patients and families about the risks of overusing medications.

Second, use multimodal opioid sparing analgesia. For these patients, every avoided milligram matters. Scheduled acetaminophen, NSAIDs (if safe for the patient), and regional analgesia significantly reduce opioid exposure and related respiratory events. Pain control should focus on comfort and function rather than the complete elimination of pain. Non-pharmacologic approaches such as positioning, ice, or relaxation training should be part of the plan, since they support effective pain management.

Third, implement risk-based monitoring and clear escalation pathways. High-risk patients should never receive opioids without structured sedation scoring and well-defined escalation criteria. Nurses should feel empowered to hold or reduce doses when sedation increases, and protocols should support early activation of rapid response or rescue teams. Families should be coached to withhold medications when sedation or somnolence are present.

Back to the Case

Let's revisit our knee replacement patient.

This time her care plan is tailored from the start. She receives a regional block and scheduled acetaminophen. Her opioid order begins at half the typical dose with clear parameters for sedation monitoring and pulse oximetry overnight. Her family is informed and knows how to safely administer medications at home. She is discharged with a plan that fits her risk level, and her pain is controlled without accidental overuse or overdose. This is what it looks like to move from reaction to prevention.

Takeaways

- Integrate opioid risk screening into the preoperative checklist.
- Build order set prompts that suggest dose reductions or enhanced monitoring for high-risk patients.
- Empower nursing staff and families to act on early warning signs such as increased sedation.
- Share outcome data, including opioid-related rescue calls, to drive improvement and accountability.

Thank You

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Thank you for all you do caring for your patients.