**APMS Frequently Asked Questions**

Pain management is usually one of the top issues on a patient’s mind during his or her hospitalization. The APMS Service provides not only procedural interventions that help with pain management, but also valuable input and expertise in pharmacologic management of patients. We want to be a valuable asset to the hospital and our surgical colleagues in this regard. There is a current effort in many areas of medicine to standardize care since that has been shown to improve outcomes. Because there is a constantly changing group of staff and residents rotating on the service, this handout is intended to answer some commonly asked questions and standardize our approach to patient care on the APMS Service.

**What comprises the APMS Service?**

The APMS Service has 2 distinct but interrelated entities: the APMS team and the PMT team. Both teams are consulting services. The APMS team is what we usually refer to as “APMS”. It is the resident team with direct physician oversight that provides not only procedural pain management interventions, but also serves as a consulting service for complicated pain management patients. The PMT team is a nursing team that follows PCA patients in the hospital and serves as a pain management liaison and resource team for uncomplicated pain management patients. Because the nursing team has indirect (rather than direct) physician oversight, nurses can make recommendations to the primary team, but the primary team staff must accept and write orders.

**What is expected in preparation for a day on APMS?**

The evening before rotating on APMS, residents should review the schedule to identify first-start epidurals and notify staff of those epidurals with a phone call, similar to the night-before phone call for any other room assignment. The check-out can be as simple as "we have 3 first starts - a thoracic for a Whipple, a thoracic for a VATS, and a lumbar for a bilateral knee..."  This ensures that the APMS resident has thought about the appropriate block for the specific procedure and that staff has a heads-up the evening before so that they can arrive early.

**What is expected the morning you are assigned to APMS?**

APMS residents should arrive between 6 and 6:15 to pre-op the first starts and be ready to start the first epidural at 6:30 when staff arrives.

**What is expected prior to each procedure?**

The resident is responsible for calling staff and discussing each procedure prior to starting a block or epidural. The nurses can occasionally send the page, but the resident will be responsible for talking to the staff about it.  It is not sufficient to send a page like, "block in PACU bay 6" with no call back number.  It is not acceptable to start a procedure unless there has been discussion with the staff about that particular procedure and staff has arrived at the bedside or given specific instructions to proceed in his or her absence.

**What is expected with documentation of a procedure?**

The EPIC instruction sheet should be followed (see separate link) in order to make sure everything is done correctly.

**What is expected from overnight APMS coverage?**

Every patient must be added to the list and patients added to the list overnight *must have verbal hand-off* between the call resident and the day team.

**What is expected regarding thoracic epidurals for rib fractures?**

Thoracic epidurals for rib fractures (patients not coming to the OR) need to be seen, evaluated, consented (if they are a candidate for regional), and a note written (whether they are a candidate for regional or not) when the consult is placed. The catheter of choice should be placed if at all possible at the time the patient is seen. If the overnight staff is uncomfortable or unable to place the epidural, the patient needs to be placed on the APMS list and *verbal checkout* needs to take place with the morning APMS team. According to the institution guidelines (see separate link), the catheter is to be placed after morning first starts and before morning rounds begin. If the patient is not a candidate for regional or otherwise refuses, a consult note needs to be completed to that effect and recommendations should be made to optimize pharmacologic management of pain.

**What is expected regarding consults?**

Consults that appear on the list prior to morning rounds are reviewed by the rounding APMS nurse to determine the level of complexity. The PMT (nursing team) will see less complicated patients. If the nurse determines that a patient is too complex for the PMT team, the patient must be seen by the resident team and APMS staff for that day. It is inappropriate for a resident on service to dispute the level of complexity of a patient in order to keep it from coming onto the APMS list. Patients should not be passed back to the nursing team unless the patient has been stabilized, the daytime APMS staff physician determines that it should be seen by the nursing team, and there has been communication between staff and the nursing team regarding continued management. Any consult that is seen after regular daytime rounds should be added to the list for the day team to see for at least one additional day in follow-up.

For consults placed after 3:30, patients should be seen as soon as manpower allows and staffed by the staff covering APMS, unless staff specifically declines seeing the patient. In that case, the resident seeing the patient is to complete the consult note, add the patient to the APMS list, *and give verbal checkout* to the morning APMS team.

**What is the APMS policy regarding consults for Schedule II prescriptions?**

According to the Medical Staff Executive Committee Statement, it is inappropriate for a primary team to consult APMS for Schedule II prescriptions. If the APMS team has been following a patient and managing complicated pain issues (as opposed to a stable patient on home Schedule II drugs), then the APMS staff can write discharge prescriptions (at his or her discretion) if he or she has a Schedule II prescription pad. However, the primary team staff or another physician in that same department is ultimately responsible for Schedule II prescribing for patients on his or her service, not the APMS staff.

**What is the APMS policy regarding IV acetaminophen?**

APMS is authorized to prescribe IV acetaminophen in a selected patient population. Those patients must be NPO, have poorly controlled pain or prohibitive adverse effects from opioid escalation, and exhaustion of other adjuncts in the attempt to control pain. We have a very short leash in this regard, so please don’t abuse this. We are currently approved for an average of 1 patient per week.