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December 2018 ~ Resource #341217

Opioid Stewardship Checklist

Long-term opioid use, which is associated with the development of opioid use disorder, overdose, and other risks, often begins with opioid use for acute pain.[3] Use this checklist to improve opioid use at your institution and help meet Joint Commission standards for pain assessment and management (https://www.jointcommission.org/assets/1/18/R3_Report_Issue_11_Pain_Assessment_8_25_17_FINAL.pdf). See our toolbox, *Appropriate Opioid Use*, for more information on the topics mentioned below, and patient education resources.

☐ **Set expectations. Ensure prescribers and patients are on the same page regarding opioid risks and benefits.**

- Disseminate key points about opioid risks and benefits:
  - Tolerable pain and improved function are the goals, not complete pain relief.[1,3]
  - Opioids are not always the more effective agents; for renal colic, post-op pain, and soft tissue injuries, non-opioids are just as effective.[1] Our chart, *Analgesics for Acute Pain*, has additional information on non-opioid options (e.g., NSAIDs, local anesthetics, ketamine).
  - Long-term opioid use has not been proven to improve pain or function.[3]
- Educate patients about post-op pain **before** surgery.[2]
- Use shared decision-making when prescribing opioids, incorporating expectation-setting and opioid education. Most patients will forgo an opioid prescription when given information on opioid risks.[2]

☐ **Employ organizational strategies that minimize unnecessary opioid prescribing.**

- Designate a leader or team responsible for pain management, safe opioid prescribing, and performance improvement.[5]
- Have policies and procedures that promote review of high-risk opioid prescriptions (e.g., high-dose, long-acting agent, fentanyl patch) by a pharmacist or pain specialist.[6,10]
- Have systems in place for prospectively identifying patients with risk factors for opioid-induced respiratory depression (e.g., elderly, sleep apnea, benzo use, renal or hepatic insufficiency).[6]
- Provide staff with educational resources to improve pain management and safe opioid use.[5]
- Facilitate access to applicable prescription drug monitoring program(s) (e.g., put a link on the electronic health record home page).[5]
- Change paper or electronic order sets so that non-opioids and opioids by non-IV routes are the default options.[2,8]
- Ensure post-discharge follow-up (e.g., nurse telephone call) to alleviate prescriber concerns about untreated pain.[2]
- Make non-pharmacologic pain treatment options available (e.g., physical therapy), and promote enhanced recovery after surgery protocols.[5,11]
- Ensure that prescribers have access to pain specialists for complex patients (e.g., patients with opioid use disorder, patients with sleep apnea).[5]
- Monitor for possible indicators of unsafe opioid use in the hospital setting (e.g., track adverse effects, naloxone use, doses prescribed, and duration of use).[5]

More. . .

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☐ **If an opioid is appropriate, prescribe safely.**

- Check the prescription drug monitoring program for evidence of misuse, and consider use of an opioid abuse risk stratification tool (e.g., Opioid Risk Tool).[6]
- Use the oral route when possible.[1] Write orders that specify use of the oral route unless the patient is NPO or vomiting.[7]
- Do not prescribe long-acting opioids or fentanyl patches for acute pain.[1,6]
- Use caution when converting from one opioid to another, or from parenteral to the oral route.[3] See our chart, *Equianalgesic Dosing of Opioids for Pain Management*, for help.
- Use a low dose, and combine with non-opioids.[1]
- If using patient-controlled analgesia, omit the basal rate for opioid-naive patients, and use a lockout of 10 min.[6] Transition to oral as-needed analgesics as soon as the patient is tolerating oral fluids and advancing diet.[6]

☐ **Promote opioid safety at transitions of care. At ADMISSION:**

- Train nurses to examine the patients for opioid patches (i.e., fentanyl, buprenorphine) on admission.[6] After confirming that the patient has been using correctly, replace it and date the new patch.[6]
- Get an **accurate** med list, including all opioids that the patient is **taking**, to determine baseline opioid requirements. Sources of information include family members, the outpatient prescriber(s) and pharmacy, and prescription drug monitoring program(s). Keep in mind that the patient may be taking more or less of what has been prescribed.[6]
- Identify chronic opioid users who are being tapered, and help them continue their opioid taper in the hospital.
- Identify patients taking **meds for opioid dependence**; there are special considerations for acute pain treatment in these patients. Also, do not rely solely on patient report of methadone dose; confirm with patient's opioid treatment program and notify them of the admission.[9] **Patients can usually continue their buprenorphine or methadone during hospitalization**, even if they are receiving other opioids.[9]

☐ **Promote opioid safety at transitions of care. At DISCHARGE**:

- Review inpatient opioid use and assess the need for a discharge opioid prescription.
- Limit discharge opioid quantities for acute pain. Most patients will end up not taking more than a few pills, and will have leftovers.[2] Twenty pills are more than plenty for post-op pain after many common surgical procedures.[4]
- Advise patients of opioid side effects (e.g., respiratory depression; effects on driving, interactions with central nervous system depressants [e.g., alcohol, benzodiazepines], tolerance, physical dependence, withdrawal, constipation, nausea).[3]
- Educate patients and caregivers on proper opioid use, storage, and disposal.[5] Provide a timeline for tapering-off opioids, or back to baseline opioid use for patients taking chronic opioids.[6]
- Before discharge, identify and communicate with the provider who will be managing the patient's pain and prescribing opioids.[6] This might be the patient's primary care provider, or a pain specialist, depending on patient needs and the comfort level of the primary care provider.[6]
- Prescribe naloxone for patients at risk of overdose. See our chart, *Naloxone for Opioid Overdose (FAQs)* for help.

More. . .

- If needed, refer patients for opioid dependence treatment.[5] Hospital leadership should keep abreast of community resources.[5]
- For patients admitted on **meds for opioid dependence**, before discharge, contact outpatient prescriber to discuss: (1) meds received during hospitalization, (2) meds that will be prescribed at discharge, (3) any dosage change in their opioid dependence med, and (4) strategy for restarting opioid dependence med if it was held. Experts recommend that buprenorphine be restarted before discharge, when possible.[9]

More. . .

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