26th ASPMN National Conference
It’s All about Safety When Delivering
Pain Management:
Current Tools, Techniques and Trends

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Conflict of Interest Disclosure

• Conflict of Interest
  Author: Linda Vanni
  Advisory Board, Collegium
  Editorial Board, DSI
  Speaker Bureau, The Medicine Shop

A conflict of interest is a particular financial or non-financial circumstance that might compromise, or appear to compromise, professional judgment. Anything that fits this should be included. Examples are owning stock in a company whose product is being evaluated, being a consultant or employee of a company whose product is being evaluated, etc.


Objectives

• Identify issues and trends that impact the ability to deliver safe pain management
• Describe tactics that facilitate safe pain management
• Discuss current and future trends related to safe pain management
How did this all happen?

- 1996 APS president’s speech about the need to have pain assessed with the same zeal as vital signs. Ortho third highest prescribers of opioids, dentists
  - Let’s talk about hoarding
- Management pain = prescribe opioids
- Things got out of hand
- 76 Million opioid scripts written in 1991
- 219 Million opioid scripts written in 2011
- The jump from legal to illicit use
Where did the hysteria come from?

- Started with illicit diversion of lawfully prescribed medications and subsequent use by opioid-naïve individuals or by desperate people with addictive disease who will do anything to get as high as they can.
- Most physicians in trouble from prescribing are in trouble due to inadequate documentation.
Soaring Rates of Opioid Addiction Challenge Hospitalist

- Medscape, 3/14/2016
- Increase in patients with addictive disease being admitted
- Two choices when admitted:
  - Get medical treatment and go through withdrawal
  - Leave before getting treatment
- Two main treatments for withdrawal:
  - Methadone
  - Clonidine

U.S. Medical Groups Fighting Prescription Opioid Abuse, MPR, July 30, 2015

- Alliance of 27 major U.S. medical organizations
- AMA – 44 people dying each day from overdoses
- Encouraging use of prescription monitoring programs
- Improve physician education on safe, effective, and evidence-based prescribing
- New web page
- National campaign to increase MD awareness
AAOS: Orthopaedic Surgeons Can Help Stem Opioid Epidemic

- October 16, 2015
- Ortho surgeons third highest prescribers among physicians in the US
- Limit the volume of opioids prescribed
- Multi-modal practice plans
- Coordinating opioid prescriber
- Restricting long acting opioids for cancer related pain
- Refer to Pain Centers

New Flashes

- Doctors Urge CMS, Joint Commission to Rethink Pain Treatment to Help Stem Opioid Epidemic
  May 5, 2016  By: Elizabeth Eaken Zhani, Media Relations Manager, H&HN, April 15, 2016
- Cigna Plans to Cut Opioid Use Among U.S. Customers by 25% By Reuters Staff, May 19, 2016

Pregnancy Issues

- USA Today, 4/30/12
  Number of drug addicted newborns soars
  JAMA – 3.4 out of every 1,000 births born in 2009 suffered from some type of narcotic withdrawal
  U of M – 13,539 infants per year or one drug dependent baby born every hour
  Treating drug dependent babies under Medicaid costs 720 million in 2009
  Most common drugs – hydrocodone/acetaminophen (Vicodin) and oxycodone ER (Oxycontin)
Changing Winds
- CDC, national health risk, prescription abuse
- Are all of years of work to control pain utilizing opioids coming to an end?
- Will there be limits on how much can be prescribed?
- Who can have it?
- Are long term opioids safe to use??
- How long is too long?
- What else can we use to control the pain?
- Always linking pain management to function

More Changes
- Decreasing inpatient length of stay and shift to outpatient emphasis
- Getting patients OOB, early, POD #0
- Decreased reimbursement, equals less resources
- Lengthening life expectancy, sometimes with chronic pain
- Wider economic gap
- Aging population working and living longer, need to function
- Patients with more comorbidities
- Increase in cancer survivorship, living with chronic pain

The Scope of the Survivor Issue
- 66% of 11.7 million people living with a diagnosed cancer in the US at the beginning of 2007, are expected to still be alive at least 5 years after their cancer diagnosis.
- By the year 2020, it is estimated that there will be 18.1 million survivors at an annual cost of $157.77 billion.
- As of January 2012, 13.7 million cancer survivors.
Societal changes

- MM
- Dementia
- Increase in lack of Resources
- Opioidphobia now?
  - Lack of availability
  - Lack of resources
  - Prescriptions before discharge

Increase in Chronic Diseases

- ESRD
- COPD
- CV Disease
- DM
- OSA
- Chronic Pain
Patient Satisfaction

- New Reimbursement Guidelines, effective 2013, related to patient satisfaction and pain management, outcome driven, HCAHPS
  - Removing the questions from Value Based Purchasing
  - A Change in the wording
  - Is it linked to over prescribing?
- Realistic expectations from the beginning
- Sitting down with the patient
- Use the term “side effects” when teaching patient’s about medications
- Be a patient advocate
- If pt on long acting pain meds at home and these meds are ordered, wake the patient up to give nighttime dose

Research, Standards and Guidelines for Safe Clinical Practice

- Evidence-based practice
- American Pain Society guidelines
- Numerous guidelines for special populations and conditions
- Joint Commission pain standards
- CDC Guidelines
- National Pain Strategy

The Joint Commission Alert #49

- 08/08/2012
- Sentinel Event Alert Issue 49: Safe use of opioids in hospitals
  Sentinel Event Alert Issue 49: Safe use of opioids in hospitals Although hospital patients may need the strong pain relief that only opioids can provide, The Joint Commission urges hospitals to take specific steps to prevent serious complications or even deaths from opioid use. Although hospital patients may need the strong pain relief that only opioids can provide, The Joint Commission urges hospitals to take specific steps to prevent serious complications or even deaths from opioid use
Hydromorphone Guidelines

- Guidelines utilize range dosing for hydromorphone based on patient’s tolerance or naïveté to opioids.
- New range, opioid naïve – 0.2 mg – 1 mg starting and 0.5 mg starting for opioid tolerant
- Monitoring and reversal of opioid administration described in detail.
- Resources for pain management support is detailed.
- All about 1=7

1 Home Run (1 mg. IVP hydromorphone) equals =

7 pts-Touch Down (7 mgs. IVP morphine)
## Assessment

- Allergies
- Obesity and advanced age
- Opioid naïve versus opioid tolerant
- Previously effective pain medications
- Underlying medical conditions
- Sleep apnea/CPAP?/obese/neck circumference?
- Multiple surgeries
- Current medications (excellent clue)
- Red flag medications

## Head’s Up

- Pre-surgical screening
- Stop Bang

**What Do You Do if OSA is Suspected: STOP-BANG**

<table>
<thead>
<tr>
<th>STOP Questionnaire</th>
<th>BANG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Snoring</td>
<td>BMI &gt; 35</td>
</tr>
<tr>
<td>Tiredness</td>
<td>Age &gt; 50</td>
</tr>
<tr>
<td>Obstructive Sleep Apnea</td>
<td>Neck circumference &gt; 40 cm</td>
</tr>
<tr>
<td>Stop Breathing</td>
<td>(&gt;15.7&quot;)</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>Gender male</td>
</tr>
</tbody>
</table>

High risk: Yes to ≥3 items → Refer for sleep testing

## Assessment

- History of Issues
  - Are we getting an accurate history of issues?
    - What is the multiplier?
    - Benzodiazepines
  - Alcohol
  - Tobacco
  - Illicit drugs
  - Herbals
  - Medical Marijuana
  - Suboxone/Subutex
Special Considerations in the Elderly

- Opioid naïve?
- Examine pain management techniques used prior to admission
- Avoiding Morphine in patient with low GFR
- Decreasing sleep medications
- Avoiding diphenhydramine (Benadryl) and other sedating agents
- Increasing ROM
- Early Mobility
- Caution when using blocks
- Obesity
- Sleep apnea?
- The BEERS List

American Geriatrics Society
BEERS Criteria-2012

- Mark Beers M.D., 1991
- Evidence-based, graded tool
- Assists health care providers in improving medication safety in the geriatric patient
Michigan Automated Prescription System (MAPS)

• Replaces Official Prescription Program effective 1/1/03.
• Requires electronic reporting of all controlled substances in Schedules 2 thru 5 by pharmacies.
• Serialized (OPP) forms no longer required.
• Any healthcare provider with DEA # can have access to site, http://sso.state.mi.us/

• Michigan Automated Prescription System (MAPS)
  – A report supplied by the State of Michigan of scheduled medications, prescribers, pharmacies, payment type, doses and quantities of medications prescribed to the patient over the past year
  – All prescribers have the ability to generate a report on a patient under their direct care
  – This is considered confidential information and is not to be placed in the patient's chart
  – Content of the MAPS report may be written or dictated within the patient's medical record
  – The interpretation of this report is crucial in determining safe pain management practice
  – Access MAPS by using this link: https://sso.state.mi.us/
  – Register to create an initial user name and password
  – This allows for immediate report results

Link to MAPS
Respiratory Depression

- How frequent is it?
- First sign of trouble
- Careful of combinations
- IM injections result in less potential for respiratory depression, true or false
Let’s talk Sedation

- RASS – scale created, reliable and valid for measurement of purposeful induced sedation.
- Aldrete (I & II) – utilized in recovery room areas for measurement of recovering from anesthesia.
- CPOT – utilized for patient unable to give self report of pain.
- Pasero Opioid Sedation Scale (POSS) – reliable and valid for use in patients receiving opioid therapy for pain.

Pasero Opioid-induced Sedation Scale (POSS)

- 0 = Sleep, easy to arouse acceptable; no action necessary; may increase opioid dose if needed
- 1 = Awake and alert acceptable; no action necessary; may increase opioid dose if needed
- 2 = Slightly drowsy, easily aroused acceptable; no action necessary; may increase opioid dose if needed
- 3 = Frequently drowsy, arousable, drifts off to sleep during conversation unacceptable; monitor respiratory status and sedation level closely until sedation level is stable at less than 3 and respiratory status is satisfactory; decrease opioid dose 25% to 50% or notify prescriber or anesthesiologist for orders; consider administering a non-sedating, opioid-sparing nonopioid, such as acetaminophen or a NSAID, if not contraindicated
- 4 = Somnolent, minimal or no response to physical stimulation unacceptable; stop opioid; consider administering naloxone; notify prescriber or anesthesiologist; monitor respiratory status and sedation level closely until sedation level is stable at less than 3 and respiratory status is satisfactory

Michigan Opioid Safety Score
Who is monitoring respirations?

- Team members
- Accurate patient history
- Snoring
- 02 sat
- EtC02 Monitoring – Alarm Fatigue?

Use of Technology

EtC02 Monitoring

- Is it going to be the gold standard?
- Does it have to be done on everyone?
- Special 02 cannula—uncomfortable for patient?
- How does it differ from pulse oximetry?
- Do we have a false sense of security with pulse ox, especially when the patient is on supplemental 02?
- Expense???
Smart Pumps

Intrathecal Devices

Electronic Schedule II Prescribing
Electronic Medical Record
Poly-Sedative Alert

BENZODIAZEPINES

“Poly Sedative Drug Alert”

eCare Business Requirements
Add Poly Sedative Drug Alert

Purpose: To Notify prescribers/nursing staff of patients receiving multiple sedating agents within a defined time period

Outcome: Patient Safety

Metric: Monitor SafeR System Med Errors/events

Rule Specifications

• Requirement:
  - If the patient has had a combination of 2 or more of the medications from the identified list administered or has continuously received in a defined rolling time period, an alert will trigger to nursing when attempting to administer a medication (from the MAW) in the identified list.
  OR
  - If the patient has had a combination of 2 or more of the medications from the identified list administered or has continuously received in a defined rolling time period, an alert will trigger to provider when attempting to order an additional medication from the identified list.

• Exclusions:
  - Critical Care areas/locations (see slide #3)
  - Hospice patient type
  - Active CIWA Protocol order
  - Active CIWA Power Plan
  - PACU (PACU synonym drugs)
Critical Care locations to exclude from alert:

<table>
<thead>
<tr>
<th>Location</th>
<th>Location</th>
<th>Location</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac/Critical Care (ICU, PCCU, Ph)</td>
<td>Spec. Care (ICU)</td>
<td>ICU (ICU)</td>
<td>ICU (ICU)</td>
</tr>
<tr>
<td>Intensive Care Unit (ICU, PCCU, Ph)</td>
<td>3 F 4 5</td>
<td>ICU (ICU)</td>
<td>ICU (ICU)</td>
</tr>
<tr>
<td>Neonatal Intensive Care Unit (NICU, PCCU, Ph)</td>
<td>4 NICU 5</td>
<td>NICU 5</td>
<td>NICU 5</td>
</tr>
</tbody>
</table>

Drugs triggering rule

All drugs listed below, except for Ambien, Ativan, Benadryl, Codeine, Codeine, Dilaudid, Flexeril, Haldol, Methadone, Morphine, Norco, Oxycodone, Restoril, Robaxin, Trazodone, Valium, and Xanax, trigger within rolling 12 hour/Fentanyl Patch 72 hour PCA and epidural "continuous" administration. See Excel spreadsheet with Drug Category Exclusions.
Poly Sedative Drug Rule Logic-
Administration

1. Medication scanned to be administered from identified list
   AND
2. 2 of the medications in the identified list have been administered or
   continuously received in the defined time frame

   ✓ YES - Create the alert message to nursing – triggers administration alert
     window
   ✓ NO – Do not alert: MAW would display admin window

PCA- how would we make sure this triggers (continuously running)

**************This patient has had 2 or more medications that have known************
sedative effects administered within the last 12 hours.

DON'T: NO alerts for dose failure, has had 2 or more medications that have
sedative effects administered within the last 12 hours

Alert –Order Alert Window

DO you want to order anyway?

- Yes (takes prescriber back to order entry
  screen)
- No (takes prescriber back to order entry
  screen)

Include dose, route and orderable name of medications
in determined timeframe

72 for fentanyl/patch/12 for all others
Poly Sedative Drug Rule Logic-Order Entry

1. Provider or Nursing (VOTO) selects individual orderable from identified list (from order entry screen)

   AND

2. 2 of the medications in the identified list has been administered or continuously received in the defined time period

   ✓ YES - Create the alert message to provider – triggers ordering alert window
   ✓ NO – Do not alert – continue with order entry process

   Nursing will not get if initiating power plan

Alert – Nursing Alert Window

*************** This patient has had 2 or more medications that have known sedative effects administered within the last 12 hours. ***************

DO you want to administer anyway?
 o Yes  (takes back to POSS form for documentation of sedation level)
 o No ( Cancels and takes back to MAR)

Include dose, route and orderable name of medications in determined timeframe
72 for fentanyl patch/12 for all others

Serotonin Syndrome Drug/Drug Interaction
Pyxis Alert

• “Too Close” concept for opioid administration
  – 59 minutes IV
  – 119 minutes Oral

Q-T Prolongation Drug/Drug Interaction

Hydromorphone Guidelines

• Hydromorphone guidelines approved by Medical Executive Committee on 1/17/12.
• Guidelines utilize range dosing for hydromorphone based on patient’s tolerance or naïveté to opioids.
• New range, opioid naïve – 0.2 mg – 1 mg starting and 0.5 mg starting for opioid tolerant
• Monitoring and reversal of opioid administration described in detail.
• Resources for pain management support is detailed.
Hydromorphone Ordering

Sentri 7

Fentanyl Safety

- Policy
- Not for Acute
- Oh that PACU! A little of this, a little of that
- EMR Patch check
- Not for Psych ISMP
- Lozenge = Troche
- PCA and IV on the regular units?
methadone

FDA Indications: Severe pain, narcotic detoxification, and temporary maintenance of narcotic addiction. Off label pediatric use.

- Cost
- morphine Allergy
- Neuropathy Pain
- morphine adverse effects
- Pain refractory to other opioids
- Uncontrolled pain

Reference: Adapted from Am Family Physician, 71(7), 2005

methadone

- Inexpensive
- Accumulates with repeated dosing
  - 85% protein bound, caution cachetic patient
  - Slowly released up to 10 days after dose increase
- Available in 10 mg tablet or oral solution, use of 40 mg diskette no longer available for pain mgt use
- Patient may be subjected to scrutiny, stigma & misconceptions
methadone (Dolophine)

- Synthetic opioid agonist
- Has been available since 1940s; synthesized during WWII when MSO$_4$ was in short supply
- Structurally unique - unlike morphine and meperidine
- Metabolized in liver; CYP450; 2B6, 2C19, 3A4 (primary), 2C9, 2D6 (minor substrate)
- May interact differently with mu opioid receptors

Current Practice is Trial and Error

50% of Beta Blockers work the first time.
60% of Depressed patients do not respond fully to the first prescribed Medication.

Methadone represents less than 5% of all opioid prescriptions, but is responsible for a third of the deaths.

There is a 20 fold difference in the dosages of warfarin required to achieve therapeutic effect while the plasma concentrations vary 30-50 fold among individuals receiving the same dose.

Methadone is a restricted medication

- Methadone is authorized to be ordered by the following prescribers:
  - Pain specialist, palliative care, or oncology prescriber initiating methadone therapy for pain
  - Any prescriber continuing a patient’s home methadone therapy verified by a methadone clinic
  - Intensivist initiating treatment for weaning of long term opioid infusions
  - Neonatologist for the treatment of neonatal abstinence syndrome
  - Addiction Specialist with Methadone prescribing privileges (Methadone Treatment Provider).
Methadone
Analgesic or Detox Agent

* Incomplete Cross-Tolerance
* Inverse relationship with dosing
* Monitor ekg for QT prolongation

Reference: J Emergency Medicine, 32(3), 2007
Naloxone

- Opioid antagonist
- Not a benign drug
- Dilute one ampule (0.4 mg/ml) with 0.9 NS for total volume of 10 mls = 0.04 mgs/ml
- Administer 2 mls to start
- Caution of short half life of naloxone versus opioid

Reversal Agents

- Are we giving the right reversal agent?
- Rapid Response Team
- Who is monitoring their use?

Pyxis
Pyxis

• Removal of naloxone from Pyxis
  1) Drug being used to counteract over sedation by a narcotic?
     Yes
     No
  2) If patient is over sedated, did you complete a SafeSystem report?
     Yes
     No

Shift to Multi-Modal

Analgesia Ladder

Combination Analgesics Rationale

• Multiple sites of action target multiple pain pathways
• Complementary pharmacokinetic activity
• Potentially synergistic analgesic effect
• Reduced adverse event profile with comparable efficacy

The Shifting Paradigm

- All about multi-modal
  - Scheduled acetaminophen
- Pain Management always linked to function
- Opioid-sparing
- The future of topicals
- Integrative therapies
- Anti-abuse opioids being approved by FDA
- Always keeping it safe

Ortho taking the Lead!

Ortho Power Plan

Pre-op in holding
  - Pregablin (Lyrica), acetaminophen and dexamethasone (Decadron)
  - Block by anesthesia (adductor canal)
In the OR
  - Intra-articular block (by Ortho surgeon)
  - End of case dose of ketorolac (Toradol)
Post-op
  - Aggressive icing
  - OOB and up in chair after arrival to unit with PT or nursing
  - Scheduled acetaminophen, ketorolac
  - Oxycodone oral scheduled, if necessary, hydromorphone IV
  - Less opioids, more multi-modal
  - Discharge POD #1 (?), home on acetaminophen/oxycodone (Percocet)
In the Near Future

• Pre-op genetic testing
• Ortho surgery without opioids?
• Huge influx of patients
• More buprenorphine/naloxone- (Suboxone), buprenorphine (Butrans)
• All about safety

Education all Around

• Physician Modules  APP
• Nursing Education
• State Mandated?
• Incomplete Cross Tolerance
• General Orientation

Key Points

• Safety, Safety and Safety
  * Any doubt, don’t give it, clarify!
  * Know the drug that you are administering
• Patient Advocacy
  * No stereo-typing or biases
• There is always help available
Creating a Culture of Safety

• Daily Safety Huddle
• Close calls/Life Savers
• Therapeutic Duplication
• Event Reporting
  – P & T
  – Pain Advisory

Protecting Your License

• SPMP
• Documentation, Documentation, Documentation
• Electronic Prescribing

Lack of Resources

• Insurance coverage for Abuse deterrent opioids
• Pain Clinics preference for interventional procedures
• Lack of Addiction Specialists
Resources to the Rescue

• In and Out patient Pharmacists
• Pain Services
• Utilize those PRNs
• Pain Advisory Groups
• Safe practice policies
• Security

Other Safety Concerns

• Having their own home medications in the room
• Visitors
• Edibles
The ED
- Non-Use of Opioids
- Quicker Turn Around
- On the look out for Buprenorphine Implants
- Clinical Decision Unit (CDU)

Sending Patients Home
- Weaning protocols
- Home Environment
- Safe Keeping Education
- Safe Disposal
- Referrals
- Communication with Provider
  - Opioid Contract

Got Drugs?
Turn in your unused or expired medication for safe disposal
April 30, 2016
10AM to 2PM
Safety Issues

- Are we dealing with illegal or legal substances? Multi-substances?
- Opioid naïve?
- Are we getting accurate information from the patient, i.e. amount, type of issues?
- Discrimination on our part?
- Ethical treatment?

Additional Safety Issues

- Multiple Long Acting Opioids
- Sedating Agents
- Pulse Oximetry versus ETCO2 monitoring
- Watch those interaction warnings — methadone and ondansetron (Zofran)
- Continuous QT interval real time monitoring
- The acetaminophen limits
- Bar coded, smart pumps for PCA and epidural

Acute Pain Management in the patient with active addictive disease or a history of addictive disease
Problem-Solving Concerns About Pain Management

- Pain is multi-focal in nature. Only the patient is able to describe their pain. It is highly individualized.
- Patients receiving the same surgery/procedure can experience different pain levels.
- If the patient’s pain seems out of proportion to what you would expect, you can always consult with pain management.
- Pain is a warning mechanism. A constant complaint of unrelieved pain should be investigated for possible other physiological causes.
- Patients who are sedate on opioid medications should always have their adjuvant therapies maximized. Adjuvant therapies will allow for opioid sparing.
- If a flag appears when ordering a pain medication, evaluate the seriousness of the interaction. The CYP450, subcategory 3A4, maybe involved producing a potentially harmful inhibitor or inducer effect. If unsure of what to do, check the “pharmacy to evaluate” order.

Problem-Solving Concerns About Pain Management (Continued)

The most common problems you may encounter:

- The #1 side effect of pain medication is constipation. All patient receiving opioids should be assessed for bowel function and placed on a bowel regime. This includes both stool softener and laxative, i.e., Senokot S.
- Another common side effect is itching. If patient's itching is uncontrolled, try changing opioids versus adding sedating medications such as benadryl.
- Caution in using sleep medications, benzodiazepines, anti-emetics and muscle relaxants in addition to opioids because of their sedating nature.
- Pain medications should never be given intra-muscular. If no IV access is available opioids may be given subcutaneously.
- If patient is NPO consider use of Patient Controlled Analgesia (PCA).

Suboxone and Butrans

- Buprenorphine/naloxone-Suboxone, Butrans is Buprenorphine.
- Restricted prescribing.
- Antagonist, agonist.
- Should be stopped at least 3-4 days pre-op.
Opioid Tapering Guidelines

• Weaning of post-operative, short acting pain medications
• CDC guidelines for acute pain ???
• Disconnect regarding patient’s ability to obtain post-operative pain medications

Genetic Polymorphism

UGT 1A1; involved in the glucuronidation of morphine, buprenorphine, and nalorphine.
UGT 1A3/1A4; glucuronidation of TCA.
UGT 2B7; glucuronidation of benzodiazepines.
• Genetic polymorphism: population distribution for inheriting liver enzyme activity controlled by a single gene locus.

CYP 2C19 approx. 18% Japanese and African Americans, 3-5% of whites, poor metabolizers with higher plasma conc. of drug substrates.
Ex. Diazepam, imipramine, and phenytin.

CYP2D6 7-10% whites, 1-4% African Americans inherit autosomal recessive allele on chromosome 22 results in poor metabolism with higher plasma conc., prolonged half lives. Ex. Codeine-cannot convert codeine to morphine, paroxetine, venlafaxine, fluoxetine, desipramine, imipramine, nortriptyline and oxycodone.

(Core, 2002), (Cleary & Hogan, 2007)

Caring for the patient with Addictive Disease

• Be a patient advocate, empathy
  – Treating the patient with AD who has pain
  – Treating withdrawal symptoms

• All about safety
  – Your safety
  – The patient’s safety
    • Visitors, substances in room
***FDA Drug Safety Communications
8/2012 Reviewing the safety of codeine administered post-tonsillectomy/adenoidectomy. 2/20/13 Black box warning Issued. Deaths occurred in children ultra-rapid metabolizers with sleep apnea.

What is wrong with this photo?

Caring for the patient with Addictive Disease
• Remember---not being admitted for detox
• On Suboxone?
• Caution with language
• Use multi-modal therapies
• Listen and treat the addictive disease as any other
• Can give info on addiction treatment, but don’t be surprised if the patient is not receptive
  – Example
Thank you very much!

Questions???