The Opioid Epidemic: Improving Opioid Safety for Patients through Prescriber, Patient & Family Education

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Disclosures

• Sharon Wrona DNP, RN-BC, PNP, PMHS, AP-PMN
  – Awarded Cardinal Health Generation RX grant for *Reduction of Opioids Prescribed for Pediatric Patients and Improving Opioid Safety Education*
  – Has disclosed that she has no other conflict of interest
Objectives

• The learner will be able to list the statistics on opioid misuse and abuse in the US.

• The learner will identify the new 2018 Joint Commission standard on pain management that impact opioid safety.

• The learner will be able to identify opportunities to place in practice to improve safe opioid prescribing and education for patients
Opioid Epidemic

• According to the CDC, the number of opioid prescriptions sold within the United States has quadrupled since 1999, yet the amount of pain American’s report has not significantly improved.

• The number of Hydrocodone and Oxycodone prescriptions are increasing at a dramatic rate. The U.S. is currently the largest consumer in the world, accounting for nearly 100% of Hydrocodone prescriptions (National Institute on Drug Abuse, 2014).

• The total number of opioid prescriptions throughout the United States would be enough to give every American adult 1 bottle of opioids.
Prescription trends vary by state

2014 Opioid prescribing rates in the continental United States for Medicare - CMS
National Survey on Drug Use and Health - 2015

• Prescription Drug Misuse
  – Any way not directed by a doctor(prescriber), including use without a prescription of one’s own; use in greater amounts, more often, or longer than told to take a drug, or use in any other way not directed by a doctor(prescriber).

• Currently ~ 3.8 million people ages 12 yr. or older misuse pain medications
  – 1.4% population

SAMHSA (2016) Key substance use and mental health indicators in the US: Results form the 2015 National Survey on Drug Use and Health
National Survey on Drug Use and Health - 2016

Figure 1. Numbers of Past Month Illicit Drug Users among People Aged 12 or Older: 2015

Note: Estimated numbers of people refer to people aged 12 or older in the civilian, noninstitutionalized population in the United States. The numbers do not sum to the total population of the United States because the population for NSSUH does not include people aged 11 years old or younger, people with no fixed household address (e.g., homeless or transient people not in shelters), active-duty military personnel, and residents of institutional group quarters, such as correctional facilities, nursing homes, mental institutions, and long-term care hospitals.

Note: The estimated numbers of current users of different illicit drugs are not mutually exclusive because people could have used more than one type of illicit drug in the past month.

SAMHSA (2016) Key substance use and mental health indicators in the US: Results form the 2015 National Survey on Drug Use and Health
National Survey on Drug Use and Health - 2016

Figure 2. Past Month Illicit Drug Use among People Aged 12 or Older, by Age Group: Percentages, 2015

Figure 35. Pain Reliever Use Disorder in the Past Year among People Aged 12 or Older, by Age Group: Percentages, 2015

SAMHSA (2016) Key substance use and mental health indicators in the US: Results from the 2015 National Survey on Drug Use and Health
National Survey on Drug Use and Health - 2016

Figure 5. Misuse of Prescription Pain Relievers and Other Prescription Psychotherapeutics among People Aged 12 or Older Who Were Current Misusers of Any Prescription Psychotherapeutics: 2015

Figure 6. Past Month Misuse of Prescription Pain Relievers, Tranquilizers, Stimulants, and Sedatives among People Aged 12 or Older, by Age Group: Percentages, 2015

SAMHSA (2016) Key substance use and mental health indicators in the US: Results from the 2015 National Survey on Drug Use and Health
National Survey on Drug Use and Health - 2016

Figure 60. Past Year Illicit Drug Use among Youths Aged 12 to 17, by Past Year Major Depressive Episode Status: Percentages, 2015

Figure 62. Past Year Substance Use Disorder (SUD), Major Depressive Episode (MDE), MDE with Severe Impairment, Co-Occurring SUD and MDE, and Co-Occurring SUD and MDE with Severe Impairment among Youths Aged 12 to 17: Percentages, 2015

SAMHSA (2016) Key substance use and mental health indicators in the US: Results form the 2015 National Survey on Drug Use and Health
Pain relief

There is a mismatch between the amount of opioids needed to treat pediatric acute pain, with children using less than 50% of prescribed opioids.

- The leading sources of prescription opioids among adolescent nonmedical users are from their peers and from their own previous prescription opioids.
- Leftover prescription opioids from previous prescriptions account for a substantial source of nonmedical use of prescription opioids among high school seniors.
- 8 out of 10 adolescents who report misusing prescription opioids report that their access to these drugs comes from leftover prescriptions from friends and family members.

U.S. Poison Control Centers Receive 32 Calls a Day About Children Exposed to Prescription Opioids

Researchers calling for changes to prescribing practices, increased education about safe storage at home

Columbus, OH - 3/20/2017

A new study published online today by Pediatrics and conducted by the Center for Injury Research and Policy and the Central Ohio Poison Center at Nationwide Children’s Hospital found that there were more than 188,000 calls to US Poison Control Centers for pediatric exposure to opioids from January 2000 through December 2015, averaging 32 calls a day or one every 45 minutes.

The good news is that thanks to recognition of the problem and efforts from many organizations, the number and rate of exposures to most opioids has been steadily decreasing since 2009. One notable exception is buprenorphine, a medication primarily used to treat people for addiction to heroin and other opioids. While exposures to most other opioids have declined, pediatric buprenorphine exposures continue to climb, which is concerning given that almost half (47%) result in admission to a health care facility.

“As physicians, we need to find a balance between making sure that we are helping our patients manage their pain, and making sure we don’t prescribe more or stronger medication than they need,” said Gary Smith, MD, DrPH, the senior author of the study and director of the Center for Injury Research and Policy at Nationwide Children’s Hospital. “While overall rates of exposure to opioids among children are going down, they are still too high. We need to continue to examine our prescription practices and to increase education to parents about safe ways to store these medications at home to keep them out of the hands of children.”

Overall, most of the exposures occurred among children younger than five years of age (60%) followed by teenagers (30%). The medications leading to the most calls were hydrocodone (20%), oxycodone (18%), and codeine (17%). The reason for and the severity of the exposure varied by age.

Among younger children (0-5 years), most opioid exposures occurred at home and were managed there without serious medical outcome. Most were unintentional non-therapeutic exposures likely caused by exploratory behaviors.
Normal Teen to Heroin Addict
How Does it Happen?
Tyler’s light

Tyler Wayne Campbell

May 25, 1988 – July

Have a Vision, Believe in Yourself, Trust in God, Dare to be

Opioid use can turn deadly

https://www.youtube.com/watch?v=j-9Z0pXbtvl.
Opioid RX Laws across the US

CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016

Recommendations and Reports / March 18, 2016 / 65(1);1–49

Summary

This guideline provides recommendations for primary care clinicians who are prescribing opioids for chronic pain outside of active cancer treatment, palliative care, and end-of-life care. The guideline addresses 1) when to initiate or continue opioids for chronic pain; 2) opioid selection, dosage, duration, follow-up, and discontinuation; and 3) assessing risk and addressing harms of opioid use. CDC developed the guideline using the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) framework, and recommendations are made on the basis of a systematic review of the scientific evidence while considering benefits and harms, values and preferences, and resource allocation. CDC obtained input from experts, stakeholders, the public, peer reviewers, and a federally chartered advisory committee. It is important that patients receive appropriate pain treatment with careful consideration of the benefits and risks of treatment options.

This guideline is intended to improve communication between clinicians and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder, overdose, and death. CDC has provided a checklist for prescribing opioids for chronic pain (http://stacks.cdc.gov/view/cdc/38025) as well as a website (http://www.cdc.gov/drugoverdose/prescribingresources.html) with additional tools to guide clinicians in implementing the

State Opioid Laws & Prescribing Limits

State Legislations That Currently Limit Opioids

Legislators are taking notice of the opiate epidemic in the United States and are huddling to create new laws to limit opioid prescriptions. Some states that have already enacted legislation to limit opioid prescriptions are:

• Connecticut
• Maine
• Rhode Island
• Virginia

New Protections for Safe Prescribing of Opiates

Data Posted: Wednesday, February 1st, 2017
Categories: Department of State

DOVER – Continuing efforts to curb the abuse of opiate pain medication in Delaware, the state agency charged with regulating medical practice and drug prescription recently unveiled rules that will help doctors and pharmacists more closely monitor and control the use of opiates by patients under their care.

The new requirements contain expanded procedures related to prescribing opiates for acute episodes as well as for chronic, long-term pain management. Some components are at the discretion of the prescribing provider while other requirements are situation-based.
Ohio Opioid Epidemic

Ohio Drug Overdose Data by County

Figure 10. Average Age-Adjusted Unintentional Drug Overdose Death Rate Per 100,000 Population, by County, Ohio Residents, 2010-2015

Figure 5. Number of Unintentional Overdose Involving Selected Drugs, by Year, Ohio, 2000-2015

* Prescription opioids not including fentanyl; fentanyl was not captured in the data prior to 2007 as denoted by the dashed line.

Source: Ohio Department of Health, Bureau of Vital Statistics; Analysis Conducted by ODH Injury Prevention Program.

Multiple drugs are usually involved in overdose deaths. Individual deaths may be reported in more than one category.
Ohio lawmakers push opioid prescription restrictions, online addiction counseling

COLUMBUS, Ohio -- Prescription painkillers are responsible for the largest number of opioid overdoses in Ohio, and state lawmakers want to further restrict prescribing the highly-addictive pills.

GOP lawmakers introduced companion bills in the House and Senate that would adopt national opioid prescribing guidelines, set dosage limits for opioids prescribed by dentists and primary care doctors and make addiction education and counseling available online.
In the news.....

Physician's Murder Highlights Risk of Saying 'No to Opioids

The late Todd Graham, MD, in South Bend, Indiana, was primarily a physiatrist, and devoted only a small portion of his practice to pain management. According to his best friend, Dr. Graham was trying to phase out pain management completely because of how the opioid abuse epidemic had changed that field over the years.

"Patients have become more difficult," said A. J. Mencias, MD, in an interview with Medscape Medical News. "A lot of them don't react so well when you deny them opioid painkillers."

Sometimes relatives of pain patients who hear the word 'no' don't react so well either, which happened to Dr. Graham, a popular 56-year-old physician. He was shot to death on July 26 by the husband of a patient whose request for opioid painkillers he denied earlier that day. The patient's husband, Michael Jarvis, then took his own life.

Dr. Graham's murder highlights the risk for physical violence faced by pain-management physicians, particularly as they and others come under increasing pressure to avoid prescribing opioids for chronic pain. The extent of

DEA Proposes Significant Cuts to Opioid Production in 2018

Anita Ault
August 10, 2017

The US Drug Enforcement Administration (DEA) is proposing to significantly reduce the amount of opioids produced in 2018.

The proposal to cut opioid production by 20%, published in the Federal Register on August 7, comes on the heels of a 25% or more reduction in opioid production in 2017.

Each year, the DEA proposes and then enforces production quotas as a means of controlling diversion of scheduled substances. It assesses what it thinks is needed in medicine, science, research, and industry. The agency is proposing a reduction in 2018 of more commonly prescribed Schedule II opioid painkillers, including oxycodone, hydrocodone, oxymorphone, hydromorphone, morphine, codeine, meperidine, and fentanyl. Citing sales figures from IMS Health, the DEA says demand for these prescription products has declined.
2018 Joint Commission Pain Management Standards

• Standard LD.04.03.13
  – Pain assessment and pain management, including safe opioid prescribing, is identified as an organizational priority for the hospital.
    • The hospital has a leader or leadership team that is responsible for pain management and safe opioid prescribing and develops and monitors performance improvement activities.
    • The hospital provides nonpharmacologic pain treatment modalities.
    • The hospital provides staff and licensed independent practitioners with educational resources and programs to improve pain assessment, pain management, and the safe use of opioid medications based on the identified needs of its patient population.
2018 Joint Commission Pain Management Standards

• Standard LD.04.03.13 – continued
  • The hospital provides information to staff and licensed independent practitioners on available services for consultation and referral of patients with complex pain management needs.
  • The hospital identifies opioid treatment programs that can be used for patient referrals.
  • The hospital facilitates practitioner and pharmacist access to the Prescription Drug Monitoring Program databases.
2018 Joint Commission Pain Management Standards

• Standard PC.01.02.07
  – The hospital assesses and manages the patient’s pain and minimizes the risks associated with treatment.
    • The hospital involves patients in the pain management treatment planning process through the following
      – Providing education on pain management, treatment options, and safe use of opioid and non-opioid medications when prescribed.
    • The hospital educates the patient and family on discharge plans related to pain management including the following:
      – Safe use, storage, and disposal of opioids when prescribed
2018 Joint Commission Pain Management Standards

• Standard PI.02.01.01
  – The hospital compiles and analyzes data.
    • The hospital analyzes data collected on pain assessment and pain management to identify areas that need change to increase safety and quality for patients.
    • The hospital monitors the use of opioids to determine if they are being used safely (for example, the tracking of adverse events such as respiratory depression, naloxone use, and the duration and dose of opioid prescriptions).
Opioid Safety Initiative Journey
Why This Project?

• 1 in 5 high school students report lifetime misuse of prescription opioids.

• 70% of misused opioids are from a friend or relative or gotten from own prescriptions.

• In 2015, > 40 people died each day in the U.S. from Rx opioids misuse.
Why This Project at NCH?

We are contributing to the opioid epidemic in our communities

• < 25% of Prescribers and Nurses at NCH discuss locking up and disposal of opioids

• **No** formal process for opioid safety education

• Post op appendectomy patients reported using only ~ **3 doses (30%)** of home going opioid prescribed for pain
# Opioid Safety Task Force

- ED/UC
- ENT
- Gen Surgery
- Heme/Onc
- Neurology
- Orthopedics
- Pain Service
- Palliative Care
- Pharmacy
- Primary Care
- Rheumatology
- Sports Medicine
- Urology
- Chief Residents
- Community Education
- Marketing
- QI

Journey to Best Outcomes
NCH Opioid Safety Initiatives

Nationwide Children’s Hospital started an Opioid Safety Task Force in January 2016 to look at ways we can improve opioid prescribing and education at NCH. The area of focus for the task force are:

• Prescribing practices
  – Do our patients need as much medication as we are prescribing them?
• Improve Education about pain management and opioid use
  – Prescribers
  – Nurses
  – Patients and families
• Opportunities to educate about safe storing and disposal of medications (including opioid)
NCH Opioid Safety Initiative

NCH prescribing practices over a 12 month period were reviewed.

For each home going script (inpatient and outpatient) there was an average of 25 doses ordered per prescription.
NCH Opioid Safety Initiative

The top opioid prescriptions were from H5A&B and H10B.

- **Peds Surgery**
  - Ruptured Appy Dx

- **ENT**
  - T & A Dx

- **Orthopedics**
  - Supracondylar fx and spinal fusion Dx
Opioid Safety Taskforce
Prescribing Initiative

Aim
Decrease the NCH wide* average number of opioid doses per home going opioid prescription by 10% from 25 doses to 22.5 doses by 7/31/2017 and sustain for 6 months.

Overall Strategic Goal

Key Drivers
Appropriate prescribing practices
Education of professionals

Interventions
Implement a tracking form or online app for Surgical patients to track doses taken
Review data for doses taken with Surgical physicians
E-prescribe opioids in Epic
Implement a decision tree for pain treatment alternatives
Develop a list of prescription drop box sites

*exclude Hem/Onc Clinics, Pain Service, H11A, H12A/B, Apheresis, BMT Clinic, Aim Team and Palliative Care, Complex Care Clinic, South High PC
Legitimate Opioid Prescription Increases the Risk for Future Opioid Misuse in Some Adolescents – Groenewald & Palermo (2016)

- Clinicians should consider the risk for future opioid misuse when prescribing opioids to adolescents.
- Nurses should educate adolescents and parents about the risk of opioid prescriptions.
- Leftover opioids from legitimate prescriptions are a major source of opioids misuse in adolescents.


- The Ohio Guidelines for Prescribing Opioids for the Management of Acute Pain Outside of the Emergency Departments recommend prescribe the minimum quantity needed with no refills based on each individual patient, rather than a default number of pills.
- The Ohio Guidelines for Emergency and Acute Care Facility Opioid and Other Controlled Substances (OOCS) Prescribing recommend Except in rare circumstances, prescriptions for OOCS should be limited to a three-day supply.
Zero Hero “Wingman”

NCH has taken the GCOAT guidelines to develop guidelines at NCH for pain management.

**Opioid Decision Making Tree**

1. **PAIN ASSESSMENT**
   - Medical history and physical examination
   - Location, intensity, severity, and associated symptoms
   - Quality of pain (omnoloc, visceral or neuropathic)
   - Psychological factors, personal and family history of addiction

   GOFAL: Improvement of function as opposed to complete resolution of pain

2. **DEVELOP PLAN**
   - Educate patient and family and develop goals for treatment
   - Discuss risks/benefits of non-pharmacologic and pharmacologic therapies
   - Set patient expectation for the degree and duration of the pain

**OPTIONS**

**NON-PHARMACOLOGIC TREATMENT**
1. Ice, heat, positioning, bracing, wrapping, splints, stretching
2. Massage therapy, tactile stimulation, acupuncture
3. Neuromodulation by therapist

**NON-OPIOID PHARMACOLOGIC TREATMENT**
1. Somatic (Sharp or Stabbing)
   - First Line: Acetaminophen, NSAIDs, Corticosteroids
   - Alternative: Gabapentinoids/gabapentin, skeletal muscle relaxants, SSRI/SNRIs/TCAs
2. Visceral (Ache or Pressure)
   - First Line: Acetaminophen, NSAIDs, Corticosteroids
   - Alternative: SNRI/TCAs
3. Neuropathic (Burning or Tingling)
   - First Line: Gabapentinoids/gabapentin, TCA/SNRIs

For more information and patient resources regarding safe opioid usage, visit NationwideChildrens.org/Opioid-Safety.
Minor Opioid Consent

• By Law in Ohio it is mandatory to have a Start Talking! Consent Form for Prescribing Opioids to Minors signed for all kids < 18 years of age if opioids prescribed for outpatient use (exclusion for surgery or emergency care).
1/30/2018

*exclude Hem/OncClinics, Pain Service, H11A, H12A/B, Apheresis, BMT Clinic, Aim Team and Palliative Care, Complex Care Clinic, South High PC
Longer Term Opioid Use

Agreement with the patient/family
- Sets limits with controlled substances
- Gives way to document expectations of patient and parent.
- Not a legal binding agreement

Long-Term Controlled Substances Therapy Agreement

This Agreement is designed to set limits around you or your child’s access to controlled substances and to protect our ability to prescribe them to you or your child. This protection requires strict adherence to the terms of this Agreement.

My signature at the bottom of this Agreement indicates the following:

1. I agree that I will obtain all controlled substance prescriptions from the below clinic/team, unless a specific authorization is obtained for an exception.
2. I agree to use the medication as prescribed and will participate in all other treatment options for pain management as recommended by my provider.
3. I understand that no changes in dose or frequency will be made without consultation with the clinic/team.
4. I will not store, sell or otherwise let anyone else take my or my child’s medication.
5. I understand that lost, damaged or destroyed medication will not be replaced.
6. I understand that using prescription medication is legal, and if the team discovers that I have not/have my child’s prescription medication, they will discontinue the prescription and will file a police report.
7. I agree to submit to urine or blood drug screen tests at any time they are requested by the team.
8. I have disclosed any history of substance abuse or family history or concerns for substance abuse to the provider.
9. I understand that taking any medication such as OxyContin, oxycodone, hydrocodone, etc., while on the clinic/team’s treatment plan with the use of opioids may be stopped.
10. I understand that these medications can affect judgment, coordination, concentration or alertness, and that it is not advisable to operate machinery, automobiles or make important decisions when starting or adjusting these medications.
11. I agree to inform the clinic/team about any new medications, medical conditions and any adverse effects that the medication(s) or my child take.
12. I am aware that these medications can cause withdrawal. I will not stop these medications abruptly.
13. I agree to have the original containers of medications available during each office visit for review if requested.
14. I understand that the clinic/team will not provide early prescription refills for missing medications or not taking medications as prescribed.
15. I understand and agree that the clinic/team may discontinue my or my child’s prescription or non-controlled substance with reasonable legal authorities or pharmacies if there are questions regarding the impairment or access to these medications.
16. I understand and agree that prescription renewals will not be given if I do not keep my scheduled home visits.

By signing below I indicate that I understand the above information and agree to follow the medical plan for the use of controlled substances prescribed by the clinic/team. I understand that if I do not abide by the terms of this Agreement, the team may discontinue prescribing the medication in question.

Clinic/Team Name

Patient

Date/Time

Physician

Date/Time

Parent/Guardian

Date/Time

Witness

Date/Time

Adm. Controlled substance agreement as DMMT form

DATE: _____ - _____

WITNESS: _____ - _____
Opioid Safety Taskforce
Prescribing and Education Initiative

**Aim**
Increase the percentage of patients prescribed chronic opioids that are engaged in a formal Opioid Risk Assessment for abuse/diversion from <5% to 75% by 12/31/2017 and sustain for 6 months.

**Key Drivers**
- Standardization of opioid misuse/ diversion assessment
- Standardization of opioid care plan and surveillance based on risk stratification
- Education of patients and families on risks for opioid misuse/diversion
- Proper education of practitioners on risk for opioid misuse/diversion

**Interventions**
- Identify opioid misuse assessment tools to globally implement on patients on outpatient opioids
- Develop Opioid Risk Assessment (low, medium, high) in EPIC
- Develop stratified management protocols based on scored risk assessment
- Monitor practitioners’ compliance with opioid risk stratification management protocols
- Develop monitoring tools to track patients who develop opioid misuse
- Educate practitioners, patients and families on risk for opioid misuse for adolescents and young adults and need to screening
- Educate practitioners on risk assessment and risk stratification opioid management and monitoring
# Longer Term Opioid Use

## Pain Clinic Opioid Misuse Project Definitions

<table>
<thead>
<tr>
<th>Opioid Bundle Components</th>
<th>Information to Document on Tracking Spreadsheet</th>
<th>Opioid Risk Level</th>
<th>Opiate Risk Surveillance Plan</th>
<th>Violation Consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date/Opioid Bundle Components</td>
<td>Patient Information, Age, MIN</td>
<td>HIGH</td>
<td>High Risk Surveillance Freq: Min. 3 times UDS monthly</td>
<td>Major Violation</td>
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<td>Urine Drug Screen</td>
<td>Lock Box Give</td>
<td>MODERATE</td>
<td>Moderate Risk Surveillance Freq: Min. 3 times UDS monthly</td>
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<tr>
<td>OARRS Review</td>
<td>SCANN Score and Risk Screening</td>
<td>LOW</td>
<td>Low Risk Surveillance Freq: Min. 3 times UDS monthly</td>
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</tr>
<tr>
<td>Pat/Patch Count</td>
<td>UDS date and results</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Let's Start Talking Minor Consent</td>
<td>Pat/Patch/Early Refill Request</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opioid Agreement</td>
<td>Compliance w/ non-opioid tx</td>
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<td></td>
</tr>
<tr>
<td>Opioid Safety Education with Lock Box</td>
<td>Peds OQ Self Report</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minor Consent &amp; Opioid Agreement</td>
<td>Risk Assessment Category</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peds OQ</td>
<td>Minor/Major Violations</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Major Violation
- UDS positive for Marijuana > 3 times or non-prescribed schedule med.
- Opioid medication in UDS, failure to complete UDS
- OARRS - other opioid prescriber
- Concerning reports from other physicians or pharmacist
- Concerning behaviors around scheduled 3 times
- Non-compliant with non-opioid referrals (1-2 times)

### Minor Violation
- Failure to bring pill bottle/old patches to visit
- Call early for refills or run out early
- Missed/canceled appointments (2 times in 3 months)
- Failure to provide or abnormal UDS
- Non-compliant with non-opioid referrals (2 times in 6 months)

1. Verbal Warning
2. Alternative Pain Management
3. Pain Managed in Clinic
4. Opioid Taper
5. Addiction Treatment

1. Verbal Warning
2. Alternative Pain Management
Longer Term Opioid Use

Preventing Opioid Misuse in the Pain Clinic Patients

Opioid Initially Started:
- Determined Opioid Necessary for Pain Management
- Opioid Bundle Initiated

1. SOAP-L + and Family Rx
2. DARRS
3. Minor Consent
4. PD SSD Complied
5. UDS Complexed
6. Opioid Agreement

Opioid Misuse Risk Level *** Based on Bivariate Data

**Name Documents Bundle Components/Risk Level*** on Electronic Tracing Flowsheet and give to follow up

RN Communicates Visit Frequency and Surveillance Plan Based on Patient's Risk Level to Pt.

RN Collects Opioid Bundle Information Based on Surveillance Plan.

No Patient Risk Level Changed Y

To Patient Still Taking Opioid

No Further Action Required Until Patient Prescribed Opioid.

No Risk Level Change at Opioid Contract Violation or Change in UDS

- Failure to bring pill bottle/pill patches to visit
  - Call early for refill or run out early
- Missed/canceled appointments (2 times in 6 months)
- Failed to provide or abandon opioid UDS
- UDS continued + THC without Rx
- Non-compliant with non-opioid therapies (2 times in 6 months)

Verbal Warning
Alternative Pain Management
Consider Increasing Risk Level for 6 months
2nd Minor Violation

Minor Violation:
- Negative UDS
- UDS Positive for illicit substances

Opiate Compliance Test Completed

Test Negative for Rx Opioid
Stop Rx Opioid
Offer Alternative Pain Management

Major Violation:
- UDS positive for Marijuana > 3 occasions or non-prescribed schedule meds, - opiod medication in UDS, Failure to complete UDS
- DARRS: other opioid prescriber
- Concerning reports from other physicians or pharmacist
- Concerning behaviors around scheduled meds
- Non-compliant with non-opioid therapies (2 times)

1st offense Verbal Warning
Increase Opioid Risk Level
Consider Alternative Pain Management
3rd offense Verbal Warning
Opioid Taper
Possible Addiction Treatment Assessment

PC Follow Up Visits

RN Communicates Visit Frequency and Surveillance Plan Based on Patient’s Risk Level to Pt. and Feudal Data
# Patient Tracking Sheet

## Minor Violation:
- Failure to bring pill bottle to clinic
- Call early for refills or run out early
- Misses/cancels appointments (2 times)
- Failure to provide urine specimen
- Non-compliant with non-opioid referrals (2 times)

<table>
<thead>
<tr>
<th>Date</th>
<th>Patient Name</th>
<th>MRN</th>
<th>Age</th>
<th>Practitioner</th>
<th>Lock Box Given</th>
<th>SOAPP Date</th>
<th>SOAPP-14 Score (0-56)</th>
<th>SOAPP Category</th>
<th>&lt; 12 yo or DD Parent screening</th>
<th>Sexual abuse or Emotion Abuse</th>
<th>Date UDS</th>
<th>UDS results</th>
</tr>
</thead>
</table>

## Major Violation:
- Impaired
- UDS positive for illicit substances or non-prescribed schedule II meds
- DARRS - other opioid prescriber
- Concerning reports from other physicians or pharmacist
- Concerning behaviors around scheduled II meds
- Non-compliant with non-opioid referrals (2 times)

<table>
<thead>
<tr>
<th>OARRS Date</th>
<th>Pill Count Early Refill Date</th>
<th>Pill Count Early Refill Issues</th>
<th>Pill Count Non-opoid Referrals</th>
<th>PedsQOL Score Physical</th>
<th>PedsQOL Score Social</th>
<th>PedsQOL Score School</th>
<th>PedsQOL Score Overall</th>
<th>Minor Concern Date</th>
<th>Opioid Agreement Date</th>
<th>Risk Category</th>
<th>Minor Violation</th>
<th>Major Violation</th>
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<td>No</td>
<td>0</td>
<td>25</td>
<td>50</td>
<td>75</td>
<td>25</td>
<td>4/25/2016</td>
<td>Low</td>
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<td>No</td>
</tr>
</tbody>
</table>
Educating parents about possible misuse

RED FLAGS OF MEDICATION ABUSE

RED FLAGS
Sign that your child may be abusing their medication activities or hobbies, failure to fulfill responsibilities, complaints from teachers or employers, hygiene or appearance problems. Many appearance, dress, diet, and grooming abnormalities, lack of personal hygiene or cleanliness, lack of interest in appearance, and poor hygiene.

WHAT IS MEDICATION ABUSE?
Medication abuse occurs when a medication is taken in a manner different from the way it is intended to be used. It is not in order to feel better, but not in order to get a pleasurable effect. For example, using a pain medication to help feel better.

Abuse Versus Addiction

ABUSE VERSUS ADDICTION
They are not the same.

While abuse of drugs and addiction to drugs are often talked about, they do not describe the same thing. The difference between these two terms is defined by the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM-5). DSM-5 describes drug abuse as having one of the following problems in time occurring:

- **Inability to manage responsibilities at work, school, or home**
- **Legal problems related to behavior**
- **Inability to feel or experience pleasure in normal activities**
- **Repeated use of drugs despite the problems caused by its use**
- **Continued use of drugs despite the harm caused by its use**

Drug addiction includes three or more of the following:

- **Loss of interest in activities that were once enjoyable**
- **Multiple failures stop or reduce use of drug**
- **Behavior that is centered around the purchase, getting, or using a drug**

Medication is an important part of your child's therapy and is often the best tool at decreasing their pain to a tolerable level. Encourage your child to utilize lessons from other therapies, such as psychotherapy or behavioral therapy, to help reduce their path.

Reference:
Nurses Can Make a Difference with our Opioid Epidemic
Opioid Safety Taskforce
Prescribing and Education Initiative

Aim

Increase % of pts d/c from H5A/H5B/H10B Rx opioids that receive opioid safety education from 0% in 10/1/2016 to 50% by 7/31/2017 & then increase to 100% by 1/31/2018 & sustain for 6 mon.

Key Drivers

- Proper education of outpatient pharmacy staff
- Proper education of nurses
- Proper education of practitioners
- Proper education of patients and families
- Communication/documentation between team members

Interventions

- Healthcare Providers will use the Zero Hero “Wingman” approach for opioid safety
- Hospital Opioid Safety Website
- NCH Pharmacy filled script – Pharmacy Provides Opioid Safety Education
- Provide patients and families Helping Hand for opioids safety
- Develop Opioid Safety video to support health literacy needs from Helping Hand.
- Provide link to Opioid Safety Helping Hand in pain management order set and D/C navigator
- Document Opioid Safety provided to patient/family on Discharge Navigator/AVS/Teaching Record

Improve overall education to patients/families on opioid safety
Opioid Safety Education for the Nurse

Online 0.5 CE module created for nurses at NCH
How Nurses Can Help

1. To help decrease the number of excess opioids in our community and ensure safe opioid practices.
   – Nurses can use the *Zero Hero “Wingman”* approach when reviewing opioid prescriptions.
   – Nurses can begin educating patients while in the hospital and at clinic visits.

2. Nurses can help address this significant public health problem by teaching families/patients how to Monitor, Secure, Transition, and Dispose opioid medication.

3. It is essential for nurses to begin educating patients on safe opioid practices as soon as possible in the hospital or at the clinic visit.
Zero Hero “Wingman”

To improve prescribing practices at NCH practitioners are being asked to prescribe the appropriate # of opioids needed for optimal pain management without over prescribing when guidelines suggest less medications.

• After reviewing opioids prescribed in home going Rx the average number of doses prescribed per Rx was 25 doses. The highest areas that Rx’s were being given were on several of the surgical floors at discharge from surgeries such as ruptured appendectomy, fractures, and ENT surgeries.

• These areas are looking at the # of doses given per Rx and calling families to find out how many of the doses were actually given. Using this data will help determine what # of doses may be appropriate for different surgical procedures.
Key educational points to remember for opioid education

1. Monitor
2. Secure
3. Transition
4. Dispose
MONITOR

• Every patient and parents should be instructed on the importance of taking the medication as directed and to try alternative pain management techniques first to reduce the risk of abuse and addiction.

  Alternative pain management techniques include:
  - deep breathing
  - distraction
  - acupuncture/acupressure
  - massage therapy
  - non-opioid medications (acetaminophen, ibuprofen, or other pain medications prescribed by physician)
  - splinting of the incision
  - aromatherapy
  - ice/heat
  - positioning
  - directed exercise such as physical therapy
MONITOR

• It is important to instruct individuals to keep a record of when they take their prescribed opioid medication.
• Due to the increase in opioid abuse in our community it is important to be aware of “seekers”. A seeker is someone looking to steal opioid medications.
  – A “seeker” can be a sibling, relative, friend, neighbor, or a stranger.
MONITOR

- Instruct patients, or parents to discuss with their child, that they should avoid talking or sharing with friends, relatives, etc. what medications they are prescribed.

- It is illegal to share (give) medications that are prescribed with someone else.

- The majority of individuals who use opioids for non-medical reasons report receiving the medication from a family member or friend, not a physician.
SECURE

According to Partnership for Drug-Free Kids, only 20% of prescribers regularly provide education to patients on how to secure & dispose of prescribed controlled substances.

Prescriber Pre-survey NCH

RN pilot sample Inpatient NCH

NCH is not any better….but we can be!!!
SECURE

It is the responsibility of the prescriber, nurse, and pharmacy to ensure patients are properly educated on safe use, storage, and disposal of opioids in order to prevent adverse drug events in patients and others.

RN pilot sample
Inpatient NCH

![Bar chart showing responses on who is responsible for educating about opioid medication.]

Whose responsibility do you feel it is to educate a patient about their opioid medication?

- 76.5% for Physician prescribing medication
- 92.0% for Nurse
- 56.8% for Pharmacist
SECURE

• Medication should always be kept in its original prescription bottle.
  • A second labeled prescription bottle can be provided by the pharmacy if the medication needs to be taken to school.
The leading cause of child poisonings in the United States are related to medications.

- The death rate from unintentional drug overdose in 2014 was 21.4 per 100,000 persons, compared to 18.2 in 2013.

- In 2007, these deaths surpassed motor vehicle accidents as the #1 cause of accidental death.
SECURE

Do you have your medications secured in a locked location?

Don’t be an unintentional drug dealer.
MONITOR & SECURE

During a patient’s 1 month post-op visit for a posterior spinal fusion, the nurse is completing the patient’s medication reconciliation. The nurse asks the patient how often they are taking their hydrocodone with acetaminophen for pain. The patient states they have been out of the medication for 2 weeks even though they were prescribed a one month supply.

• This should raise a red flag to the nurse. The nurse needs to determine how often the medication was taken and if the medication was shared with others. The patient’s mother responds she only gave the patient a total of 3 tablets per day as prescribed. The mother said she kept the medication in her purse where no one else had access.

• The nurse needs to explain the importance of locking all medication in order to prevent the medication from being stolen or accidently ingested by others. A prescription lock box can be purchased on line or at a store for as little as $15. Medications can also be locked in an inexpensive tool box with a combination lock to secure.
TRANSITION

Understanding how to transition off of opioids is something every patient should be educated on.

• Teach the patient and families they should use non-opioid medications such as acetaminophen and Ibuprofen and alternative pain management techniques to help them weaning off of the opioid.

• Often times scheduling and alternating between acetaminophen and ibuprofen every 3-4 hours can eliminate or significantly decrease the amount of opioid pain medication needed.
TRANSITION

- If patients are taking opioids for a longer period of time and the prescribed opioids are less effective for pain management than they were initially, the patient may be developing a tolerance to the medication. It is important to tell patients and families to discuss this with the healthcare provider.

- Be sure to tell patients and families if an opioid medication was needed consistently for more than 7 days and is no longer needed for pain, the patient should follow the recommended weaning schedule provided by their healthcare provider.

  Signs of withdrawal may include:
  - Hot & cold flashes
  - Sweating
  - Goosebumps
  - Agitation
  - Fatigue
  - Muscle aches
  - Yawning
TRANSITION

A nurse is discharging a 9 year old from the hospital following an acute appendectomy. The nurse reviews each prescription with the patient and caregiver. The patient is prescribed hydrocodone q4h prn & ibuprofen q6h prn for pain.

- Parents should be instructed to try to reduce the child’s pain by using a pillow for splinting the incisions, alter patients position, or use distraction methods.
- If pain does not improve, parent can give the child the prescribed dose of ibuprofen first.
- If the child’s pain is not improved after 1-2 hours, parent should give the child the prescribed dose of hydrocodone.
- Patients/caregivers should be instructed to try alternative pain management techniques prior to using an opioid in order to reduce the risk of abuse and addiction.
NCH Post op Pain Handouts

Treating Pain After Inpatient Surgery

NCH Post op Pain Handouts

What can you do to help?
It is important to take deep breaths and cough from time to time to get rid of lung fluid. Bubbling and coughing can be fun and help the lung fluid out. If there is a surgical wound, try splinting the affected area. Splinting is holding a pillow of folded blanket and gently applying pressure over the wound. The patient should cough or take a deep breath during splinting.

Try different positions to decide what is most comfortable. You can make suggestions about positions. It is also important to move while in bed, and walk when allowed to get out of bed.

Stroking your child’s hands, arms, legs or head may be comforting. Small children may be more comfortable when someone holds them.

Try to distract your child from the pain and make him or her as comfortable as possible. Suggestions include:

- Keep the room quiet and dim the lights.
- Play soft music.
- Watch a favorite movie or television show.
- Read books.
- Ask about Child Life Services.
- Manage therapy, acupuncture, aromatherapy, hypnosis (ask your nurse about these therapies).
- Bring comfort items from home, such as stuffed animals or music devices with headsets.
- Ask your nurse if it is safe to place a warm or cold pad on the area that hurts.

Important words to know:
- IV: Intravenously
- PO: By Mouth
- Epidural Catheter: A small hollow plastic tube that is inserted through the skin and a plug or plug is placed in the middle of the back. It delivers pain medicine to your child. If your child has an epidural catheter, he or she will have decreased or no sensation in the lower body but will most likely be less deep sleep or on other pain medicine.
- PCA (Patient Controlled Analgesia Pump): A machine with a syringe filled with pain medicine that delivers this medicine through your child’s IV line. It is controlled by your child.
- NCA (Nurse Controlled Analgesia Pump): A machine filled with pain medicine that delivers this medicine through your child’s IV line. It is controlled by your child’s nurse.
- CCA (Computer Controlled Analgesia Pump): A machine filled with pain medicine that delivers this medicine through your child’s IV line. It is controlled by the child’s computer.

Sedation and Sedation: There are three types to NCA, PCA and CCA pumps. A broad dose of pain medicine is a constant, or set amount of pain medicine that goes to your child through the pump. A demand dose is a set dose of pain medicine that goes to your child when you, the nurse or your child presses the button to deliver pain medicine. There is usually a limit to how many times a demand dose will be delivered over a period of time.

- Nerve Blocks: Involves placement of local anesthetic (numbing medication around the nerve) to numb the area for certain procedures. A single needle is usually instructed 12 to 24 hours, which allows the patient to have constant pain relief while also able to move the legs and begin physical therapy.
- PNC (Peripheral Nerve Catheter): Depending on the type of procedure, your surgeon may choose to place a small catheter (a hollow plastic tube) that gives a continuous amount of numb medicine over several days (usually, 3 to 5 days) once the procedure is over. The catheter can be safely removed by the family at home.

How do patients usually feel after surgery?
Patients may feel tired after surgery. This could be due to stress and side effects of some pain medicines. Other things to look for after surgery:

- Fatigue
- Constipation
- Upset stomach
- Nausea
- Slow breathing

If any of these symptoms occur, or your child experiences any of these symptoms, please talk to the child’s nurse or doctor.

If your child is prescribed disulfiram to control pain after surgery, your child will have a prescribed a medicine for constipation because of the chance of constipation causing constipation. Some medicines for this include stool softeners, Metamucil and sometimes sometimes, Pre seed stools, like docusate sodium. It is important to drink plenty of water.

What medicines are used to control pain?
There are multiple medicines that may be offered to control pain. IV medicines that your doctor might use to control pain include acetaminophen, ketorolac or epidural (including morphine, hydromorphone and fentanyl), which are that are given by mouth include acetaminophen (Tylenol), hydrocodone (Morphine’s/Advil) or epidural (hydrochloride and acetaminophen).

Inpatient post-surgical children begin pain management in the hospital with IV pain medicine. The doctor will decide when it is okay to change from IV medicine to oral pain medicine. It is important to note that these medicines are dosed on your weight, which is why your child does not take more medicine than prescribed and follows the instructions.

Other Medications:
- Muscle relaxants: May be given for certain surgeries to reduce muscle spasm (muscle spasm is a pain that occurs generally caused by muscle weakness). Muscle relaxants are a pain that occurs generally caused by muscle weakness. It is important not to give muscle relaxants at the same time as opioid pain medicines because of the risk for slowed breathing, which is told otherwise by your doctor.

0 Hurt   2 Hurt Little Bit   4 Hurt Even More   6 Hurt Worse Lot   8 Hurt Worst Lot

Older children and adults can rate their pain on a scale of 0 to 10, with 0 being no pain and 10 being the worst pain.
NCH Post op Pain Handouts & Tracking Form

Treating Pain After Outpatient Surgery

Nationwide Children’s Hospital wants to make our patients as comfortable as possible. Having pain is normal after surgery, but there are ways to decrease the pain.

How is pain evaluated?

Sometimes it can be hard to know if pain, anxiety or stress is causing discomfort. Possible signs of pain are crying, facial cues, leg movement and how easily the patient can be comforted. Patients can also help us understand their own child’s needs. Nurses and doctors use guides called pain scales to measure pain. There are different pain scales that can be used based on the patient’s age. For youngsters, the pain scale uses visual signs to evaluate pain (see chart below).

Subjective pain scales:

Faces: Most appropriate for preschool and young school children.

Show me how you feel by painting to the face:

0 2 4 6 8 10

Older children and adults can rate their pain on a scale of 0 (no pain) to 10 (worst pain).

Ways that your child might be given medicine:

- IV Directly into the vein
- PO (by mouth): Once the child is able to eat or drink

What can you do to help?

It is important for your child to take deep breaths and cough from time to time. Blowing bubbles can be fun and help the lungs too. If there is a surgical wound, try splinting the affected area. Splinting is holding a pillow or folded blanket and gently applying pressure over the wound. The child should cough or take a deep breath during splinting. Try different positions to decide what is most comfortable. Your nurse can make suggestions about safe positions. It is also important to move while in bed, and walk when allowed to get out of bed. Stroking your child’s hands, arms, legs or head may be comforting. Small children may be more comfortable when someone holds them.

Try to distract your child from the pain and make him or her as comfortable as possible. Suggestions include:

- Keep the room quiet and dim the lights
- Play soft music
- Watch a favorite movie or television show
- Read book

Important things to know:

- Nerve block: Involves placement of local anesthetics (numbing medicine) around the nerves to numb them during certain procedures. A single dose usually lasts around 12 to 24 hours, which allows the child to have continuous pain relief while still able to move the lower legs and begin physical therapy.
- PNC (Peripheral Nerve Catheter): Depending on the type of procedure, your surgeon may choose to place a small catheter in a hollow plastic tube that gives a continuous amount of medicine over several days (usually 3 to 5 days) next to the nerve. This catheter can be safely removed by the family at home.

How do patients usually feel after surgery?

Patients may feel tired after surgery. This could be due to stress and side effects of some pain medications. Other things to look for after surgery:

- Tired
- Constipation
- Upset stomach
- Rash
- Slow breathing

If your child experiences any of the above, please talk to the child’s nurse or doctor.

What medications are used to control pain?

There are multiple medicines that may be offered to control pain. Opioid medications are given by mouth and generally include acetaminophen (Tylenol), ibuprofen (Motrin/Children’s) or spinals (hydrocodone or morphine).

General post-surgery pain management strategy:

For most children the surgeon will recommend alternating Tylenol and Motrin every three hours for the first two days after surgery. Your child’s surgeon may prescribe an opioid (usually hydrocodone or morphine) which is recommended only in the event of severe pain. These medicines can be used in addition to Tylenol or Motrin, but should only be given if the child is in pain while using the alternating Tylenol and Motrin schedule.

Your child might be prescribed an opioid that is a combination product containing acetaminophen, including hydrocodone/acetaminophen (Narcodol) or oxycodone/acetaminophen (Percocet). For children who are prescribed these opioid pain medications, give this medication in place of the acetaminophen (Tylenol) when needed. This is only necessary if you feel that your child’s pain is uncontrolled on the alternating schedule of Tylenol and Motrin AND you were prescribed a combination opioid medication. In summary, do not give a combination opioid within 4 to 6 hours of giving your child Tylenol.

Many times ketorolac (also known as Toradol), which is an IV medication similar to Motrin, is given during the surgery to help with pain. If this happens, the first dose of Tylenol should not be given until three hours after the ketorolac was given. If ketorolac was not given, the first dose of Tylenol should be given as soon as you are home or as instructed by hospital staff.

48 hours after surgery, Tylenol and Motrin should no longer be given every three hours, and should be only given as needed for pain.

The next page is a chart with all of this information for you to keep track of what medicine was given to your child and when the next dose is due. Your child’s nurse or healthcare provider should discuss this with you prior to leaving the hospital.

It is important to note that these medicines are dosed based on your child’s weight, so make sure to see that your child does not take more medicine than prescribed and that he or she takes the correct medication.

Other Medications:

- Muscle relaxer: May be given for certain surgeries to allow muscle spasm (many times described as muscle cramps, which is a pain that spasms generally cannot control). It is important, unless your doctor tells you not to, to give muscle relaxants at the same time as opioid pain medication because they help to decrease breathing.
- Special diet: Recommended in patients taking opioids because opioids increase the risk of developing constipation. Your doctor may give you instructions or prescribe a stool softener for your child. While your child is taking a stool softener, it is important to make sure that he or she is drinking plenty of fluids to prevent constipation.
# NCH Post op Pain Handouts & Tracking Form

## Pain Medicine Administration Chart

**Tylenol**
- Start time: 3 hours after administration
- O.D.: ______ ml (liquid) or ______ tablet (as needed) every 4 hours
  - "ONLY" give if your child’s pain is still uncontrolled with the use of Tylenol and Motrin

**Motrin**
- Start time: 3 hours after administration
- O.D.: ______ ml (liquid) or ______ tablet (as needed) every 4 hours
  - "ONLY" give if your child’s pain is still uncontrolled with the use of Tylenol and Motrin

**Opioid**
- Start time: 3 hours after administration
- O.D.: ______ ml (liquid) or ______ tablet (as needed) every 4 hours
  - "ONLY" give if your child’s pain is still uncontrolled with the use of Tylenol and Motrin

### Day of Surgery

<table>
<thead>
<tr>
<th>Day of Surgery</th>
<th>Dosage</th>
<th>Check-off</th>
<th>Time Given</th>
<th>Opioid as needed ONLY Drug</th>
</tr>
</thead>
<tbody>
<tr>
<td>2nd Day after Surgery</td>
<td>Tylenol</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3rd Day after Surgery</td>
<td>Motrin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4th Day after Surgery</td>
<td>Opioid</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5th Day after Surgery</td>
<td>Tylenol</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6th Day after Surgery</td>
<td>Motrin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7th Day after Surgery</td>
<td>Opioid</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Next Day After Surgery

<table>
<thead>
<tr>
<th>Day of Surgery</th>
<th>Dosage</th>
<th>Check-off</th>
<th>Time Given</th>
<th>Opioid as needed ONLY Drug</th>
</tr>
</thead>
<tbody>
<tr>
<td>2nd Day after Surgery</td>
<td>Tylenol</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>3rd Day after Surgery</td>
<td>Motrin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4th Day after Surgery</td>
<td>Opioid</td>
<td></td>
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</tr>
<tr>
<td>5th Day after Surgery</td>
<td>Tylenol</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>6th Day after Surgery</td>
<td>Motrin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7th Day after Surgery</td>
<td>Opioid</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*After 48 hours: Stop regular or scheduled Tylenol and Motrin and give either as needed*
DISPOSAL

In many cases, individuals save their opioid medication and will use it for reasons the medication was not prescribed for or to give to others.

- 70% of people who abuse prescription opioids get them free from a relative or friend or by using their own prescription.
DISPOSAL

Educating patients and caregivers on proper medication disposal will help reduce prescription opioid diversion and accidental overdoses.

- **Dispose**
  - When the medicine is no longer needed, read the label or call the pharmacy to find out how to get rid of the leftover medicine.
  - To protect your privacy and prevent illegal refills, remove labels on the medicine container before you throw it out.

- **Talk to your child**
  - When you talk to your child about drug use, include prescription medicines.
  - Talk to your family members, especially teenagers, about the dangers of taking and mixing medicines. Even though medicine is given for health reasons, taking too much or mixing certain medicines with other medicines, can be deadly. If you do not know what the risks are, ask a doctor or pharmacist.
  - Stay calm when discussing issues with your child.
DISPOSAL

• In one recent study, 314 nurses were surveyed on opioid storage and disposal. Only 29% of those nurses knew how to correctly store and dispose of excess opioids.

• In another survey, 275 patients were given an opioid prescription following a procedure, only 58% of the prescribed medication was consumed. Researchers found patients disposed of the unused medication in various ways.
  ▪ 89% of the individuals kept their leftover medication at home
  ▪ 6% threw the medication in the trash
  ▪ 2% flushed the opioids down the toilet
  ▪ < 1% returned medication to the pharmacy
DISPOSAL

• The FDA (food & drug administration) recommends all unused or expired medications be transferred to an authorized collector for disposal, preferably a nearby drug take-back program.

• If there are no drug take-back programs available, the FDA asks that individuals contact their local law enforcement or waste management authorities for official guidelines.

• People can visit www.rxdrugdropbox.org to find a nearby collection location.
DISPOSAL

• There has been some conflicting information on proper opioid disposal. If the medication being disposed can cause serious harm if ingested by a person or pet then the medication is recommended to be flushed according to the FDA. This recommendation is a direct contradiction to the U.S. Environmental Protection Agency’s (EPA) recommendations for disposal. The EPA is concerned if medications are flushed down the toilet our drinking water may become contaminated.

• The two agencies have agreed that potentially dangerous medications, such as opioids, should be crushed and mixed with an unpalatable substance like kitty litter or coffee grounds, then sealed in a plastic container and disposed in the trash.

• If all other disposal methods are unavailable, unused opioids should be flushed down the toilet.
DISPOSAL

• When disposing medication patches (buprenorphine & fentanyl patches)
  – the adhesive side should be folded into itself (medication part should not be exposed) then flushed down the toilet.
• Patches should NEVER be disposed of in the trash due to the risk of accidental exposure.
• NCH has a Helping Hand specific to Fentanyl patches which explains how to use and dispose of the patch.
  – Every patient should be given this helping hand if prescribed a Fentanyl patch.

Changing the patch
  ▪ The patch is usually used for 72 hours (3 days). Then a new one is placed on the skin. Your child’s doctor may have different directions for when to change the fentanyl patch.
  ▪ Patches will be labeled with the drug name and strength. Make sure you have the right strength before application.
  ▪ The new patch goes on a different area of the body. Be sure to remove the old patch before applying a new patch. Do not put the new patch in the same place as the old patch.
  ▪ When you take off an old patch, fold the sticky sides together and flush it down the toilet. Do not throw it away in the garbage can.
  ▪ If the patch falls off, fold the sticky sides together and flush it down the toilet. Do not throw it away in the garbage can. Put on a new patch in a different place on the body.
DISPOSAL

• A 4 year old girl was visiting her grandparents’ home and suddenly became unresponsive and died. The autopsy showed a transdermal Fentanyl patch in her stomach. Apparently, the girl ingested the patch which she found in the trash and ultimately died from a massive Fentanyl overdose (U.S. Food & Drug Administration, 2016).
DISPOSAL

During an 8 year old’s 1 month post-op appointment for a supracondylar fracture, the nurse asks the patient’s father if the child is still requiring his hydrocodone medication for pain. Father stated his son has not needed the medication for 3 weeks.

• The nurse should ask the parent if he knows how to properly dispose of the unused hydrocodone.
• The nurse needs to educate the family that the hydrocodone should not be kept if the patient no longer needs the medication for pain control.
  – Getting rid of the medication will eliminate the risk of accidental overdose or the medication being used for reasons other than its intended use.
• NCH has helping hands with instructions on how to dispose of medications that should be given to family.
Opioid Safety Helping Hand

Important Facts to Know When Taking Opioids

Opioid (OHi pee ame) is the generic word that refers to a whole group of medicines. Opioid medicines are used for pain control. They work best when used with other non-medicine treatments for pain, as combination with acetaminophen and ibuprofen. Some of these are exercise, massage, heat, ice, relaxation techniques, deep breathing, and distraction.

There are 4 important points to remember when your child is taking opioids: Monitor, Secure, Transition, and Dispose.

Monitor

- There are laws that control the possession and use of opioids. Your child's medical provider has ordered this medicine for your child only. They should be taken only as prescribed because they can be harmful and habit-forming. Do not let anyone else take this medicine.
- Know where the medicines are at all times. Keep a count of how much you have so you will always know how much is left.
- There is potential for abuse of these medicines. Opioid medicines should only be used when needed because they can be addictive. Even though this does not happen to everyone, opioid addiction can happen to anyone and can lead to permanent illness, addiction, and even death.
- Be on the lookout for “Seekers” – friends, relatives, neighbors, or strangers – who are looking to steal opioid medicines.
- It is important to keep a record of when the medicine is given. Use a calendar or Helping Hand Hi-V-V-1, Medication Record.

Possible side effects (from most common to least common):

- Constipation - It is recommended your child take medicine to help prevent or treat constipation while taking opioids.
- Nausea or vomiting - Your child may need to take medicine to help control nausea and vomiting.
- Drowsiness - If your child becomes drowsy or sleepy, do not let them drive a bike or operate machinery (such as a lawnmower or car), or take part in any activities where they must stay alert and awake.

https://www.youtube.com/watch?v=jIH0gi92KKA&t
Opioid Safety Education Button in Epic

Ambulatory setting:

Inpatient, ED, Urgent Care, and OR:

We will use this as a way to track usage of this HH and education at NCH. Our Zero Hero goal is 100% of patient and families will receive this helping hand upon discharge if they receive an opioid prescription from NCH.

Nationwide Children's
When your child needs a hospital, everything matters.
Proper education of patients and families

- Helping Hand –
  - Important Facts to Know When Taking Opioids (Monitor, Secure, Transition, Dispose)
  - Opioid Helping Hands
- Educational Handouts
- Educational Videos
  - 700 Children’s Blogs related to opioid safety and pain management
Four Steps for Safe Opioid Usage

**MONITOR**
1. Warn that medications should be taken only as directed by the medical provider or dentist because they can be harmful and habit-forming. Do not let anyone else take this medicine.
2. Take inventory
3. Be on the lookout for “Seekers”

**TRANSITION**
1. The sooner a patient can get on the combination of acetaminophen and ibuprofen and off the opioid medication, the less likely they are to become dependent on opioids.
2. Using a combination of other non-opioid medication and non-medication pain management options are best.

**SECURE**
1. Keep this medicine in a locked cabinet or lock box.
2. Don’t take all opioids when leaving the home, only what is needed while gone.

**DISPOSE**
1. Opioids and other medications should be disposed of when they are no longer needed.
2. Visit www.redpillbox.org to find a nearby collection location.

NationwideChildrens.org/Opioid-Safety.

NCH Outpatient Pharmacies educating patients and families with each opioid script filled in our outpatient pharmacies.
Proper education of patients and families

• Upon return visits to hospital, clinics, or during follow-up phone calls be sure to ask patients and families about opioid use, storage, and disposal of the medications at home.
  – Remember people need to hear things ~ 7 times before they start to become habit
Opioid Safety Education H5A/H5B/H10B

Chart Type: p-Chart (modified)**

- **Helping Hand Go-Live 11/2016**
- **Treating Pain After Surgery Go-Live 11/11/17**
- **Opioid Safety Learning Center Go-Live**
- **Unit Stats Email**

**Date**

- Rate of Education
- Process Stage Mean
- Process Stages
- Control Limits
- Goal(s)

**Control Limits are wider than standard because the number of 0%’s (or 100%’s) is sufficient to skew probabilities. Standard limits would yield false special cause flags.**
2 Year Post Survey Results

How do you determine the quantity of home going opioids to prescribe?

When writing a home going opioid prescription which of the following do you discuss?
2 Year Post Survey Results

When a patient is discharged from the hospital with an opioid prescription, which of the following do you ensure the patient/caregiver understands prior to discharge? (check all that apply)

- Adverse effects
- Benefits and risks
- How to use medication
- How to call local pharmacy
- The importance of measuring the dose
- Proper storage of medication
- Proper disposal of medication
- Waivers and other patient concerns

Has your practice changed with opioid safety education to patients/caregivers in the past year?

- Yes
- No
- Yes but only for patients I am concerned about

Nationwide Children’s
When your child needs a hospital, everything matters.
2 Year Post Survey Results

Prescribers

Are you aware of Opioid Safety Initiatives at Nationwide Children's Hospital?

Nurses

Are you aware of Opioid Safety Initiatives at Nationwide Children's Hospital?
CONCLUSION

Providing patients and caregivers with verbal and written education on safe opioid management will help lower exposure to opioids, prevent abuse, and diversion.

Nurses can make a difference by being the Wingman for prescribers along with educating patients and families on opioid safety.
PCSS-O is a collaborative effort led by American Academy of Addiction Psychiatry (AAAP) in partnership with: Addiction Technology Transfer Center (ATTC), American Academy of Neurology (AAN), American Academy of Pain Medicine (AAPM), American Academy of Pediatrics (AAP), American College of Physicians (ACP), American Dental Association (ADA), American Medical Association (AMA), American Osteopathic Academy of Addiction Medicine (AOAAM), American Psychiatric Association (APA), American Society for Pain Management Nursing (ASPMN), International Nurses Society on Addictions (IntNSA), and Southeast Consortium for Substance Abuse Training (SECSAT).

For more information visit: www.pcss-o.org
For questions email: pcss-o@aaap.org

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