Opioids

Scope: Unless otherwise stated, these items pertain to opioids (including in combination with other analgesics) used for any indication **EXCEPT** moderate sedation, that are administered by any route **EXCEPT** neuraxial, including: oral, IV, IM, subcutaneous, transdermal, sublingual, buccal/transmucosal, and intranasal.

Self-Assessment Items

A	There has been no activity to implement this item.
B	This item has been formally discussed and considered, but it has not been implemented.
C	This item has been partially implemented for some or all patients, orders, drugs, or staff.
D	This item is fully implemented for some patients, orders, drugs, or staff.
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		A	B	C	D	E
General Items						
Protocols, Guidelines, and Order Sets						
1	Standard protocols and/or guidelines for adults exist and are used to guide practitioners when opioids are prescribed, prepared, dispensed, and administered, and when patients are monitored. ***Scoring guideline:*** *Choose Not Applicable only if your facility does not provide care to adults.*	NOT APPLICABLE				
2	Standard protocols and/or guidelines for neonates and pediatric patients exist and are used to guide practitioners when opioids are prescribed, prepared, dispensed, and administered, and when patients are monitored. ***Scoring guideline:*** *Choose Not Applicable only if your facility does not provide care to neonates or pediatric patients.*	NOT APPLICABLE				
3	One or more protocols and/or guidelines associated with opioid use contain the following content: (score each item individually)					
a	The use of specific opioids, including dosing guidelines that differentiate between the management of **OPIOID-NAÏVE**, **OPIOID-TOLERANT**, and **HIGH-RISK PATIENTS**; and conditions that require dose adjustments					
b	The management of patients with **ABERRANT DRUG-RELATED BEHAVIORS**					
c	Administration of adjuvant agents (e.g., nonsteroidal anti-inflammatory agents, gabapentin, clo**NID**ine, dexmedetomidine) to reduce opioid use					
d	Tapering and discontinuing opioids to avoid withdrawal symptoms					
e	Avoiding concomitant use of other opioids/sedating agents (or adjusting doses if administered concomitantly)					
f	Equianalgesic dose conversion between different opioids and/or routes of administration					
g	Monitoring requirements, including the frequency, intensity, duration, and methods of monitoring based on patients' individual risk factors, response to therapy, and pharmacologic regimen					
h	Management of potentially serious adverse effects such as respiratory depression, inadequate oxygenation/ventilation, unintended advancing sedation, and allergic reaction					

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4	Any opioid equianalgesic dosing chart(s) relied upon by the facility has been reviewed and approved by a pain management specialist and/or an appropriate committee (e.g., **PHARMACY AND THERAPEUTICS**).					
5	Inpatient opioid standard order sets for neonates and pediatric patients provide fixed weight-based doses that require only the input of the patient's weight in metric units to determine the dose. ***Scoring guideline:*** *Choose Not Applicable only if your facility does not provide care to neonates or pediatric patients in an inpatient setting.*					
		NOT APPLICABLE				
Patient Assessment						
6	Before prescribing an opioid, a standard process based on established definitions is used to determine if a patient is **OPIOID-NAÏVE** or **OPIOID-TOLERANT**, and if the patient is a **HIGH-RISK PATIENT** or exhibits **ABERRANT DRUG-RELATED BEHAVIORS**; **and** this information is documented in a designated location in the medical record and used to establish a monitoring plan for the patient.					
7	The facility uses a validated, standardized sedation scale (e.g., Pasero Opioid-Induced Sedation Scale [POSS]) to guide the assessment and early detection of unintended advancing sedation during opioid therapy.					
8	Upon admission or patient encounter, practitioners ask alert and oriented patients with a recent history of pain whether they are wearing an opioid transdermal patch or implanted drug delivery system; **or** they complete a skin examination of patients who are unresponsive, confused, or exhibiting **ABERRANT DRUG-RELATED BEHAVIORS** to detect a patch or implanted drug delivery system.					
Products Used						
9	Concentrations of continuous IV opioid infusions for adult patients are standardized per drug to a single usual concentration (e.g., for **OPIOID-NAÏVE PATIENTS**) and a single high concentration (e.g., for certain **OPIOID-TOLERANT PATIENTS**). ***Scoring guideline:*** *Choose Not Applicable only if your facility does not provide care to adults receiving continuous IV infusions.*					
		NOT APPLICABLE				
10	Concentrations of continuous IV opioid infusions for neonates and pediatric patients are standardized per drug to a single usual concentration (e.g., for **OPIOID-NAÏVE PATIENTS**) and a single high concentration (e.g., for certain **OPIOID-TOLERANT PATIENTS**). ***Scoring guideline:*** *Choose Not Applicable only if your facility does not provide care to neonates or pediatric patients receiving continuous IV infusions.*					
		NOT APPLICABLE				
11a	Opium tincture is not on the formulary and/or is not available in the facility, even in the pharmacy.					
OR	OR					
11b	If opium tincture is on the formulary and/or is available anywhere in the facility, paregoric is not available anywhere, even in the pharmacy.					
Prescribing						
12	When initiating orders for opioids, computer order entry systems default to the lowest initial starting dose and frequency, and alert practitioners when a dose adjustment is required due to age, renal or liver impairment, or when patients are prescribed other sedating medications.					

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Dispensing						
13	Commercially available opioid IV infusions or prefilled syringes/bags/cassettes for IV PCA are used whenever available; **and** pharmacy prepares and dispenses any IV and PCA opioid infusions that are not commercially available for individual patients as prescribed. ***Scoring guideline:*** *Choose Not Applicable only if patients in your facility never receive IV or PCA opioid infusions.*	NOT APPLICABLE				
Administration						
FAQ 14	If multiple choices for pain therapy have been prescribed, practitioners are provided with standard guidance (beyond individual judgment) for selecting which medication and dose should be administered and how often, based on the patient's pain assessment and functional status (not pain intensity score alone) to prevent dangerous **DOSE STACKING** and respiratory depression.					
15	For patients receiving IV opioids, nurses communicate the patients' opioid status (**OPIOID-NAÏVE** or **OPIOID-TOLERANT**); recent pain assessment, sedation score, and medications administered; and risk factors for unintended advancing sedation and respiratory depression, during change-of-shift report and across all patient transitions in care. ***Scoring guideline:*** *Choose Not Applicable only if patients in your facility never receive IV opioids or patient care never transitions between shifts, practitioners, or settings.*	NOT APPLICABLE				
16	IV push doses of opioids in commercially available or pharmacy-prepared prefilled syringes are not further diluted. ***Note:*** *Drug references may mention possible dilution to facilitate slow titration of the dose during administration. However, dilution should not occur unless recommended by the manufacturer or supported by evidence in peer-reviewed literature, and approved by the facility.* ***Scoring guideline:*** *Choose Not Applicable only if patients never receive IV push doses of opioids in your facility.*	NOT APPLICABLE				
FAQ 17	IV push doses of opioids are never diluted by drawing up the contents into a commercially labeled, prefilled flush syringe of 0.9% sodium chloride. ***Scoring guideline:*** *Choose Not Applicable only if patients never receive IV push doses of opioids in your facility.*	NOT APPLICABLE				
Patient Monitoring						
18	Continuous pulse oximetry is used to monitor all patients receiving continuous IV opioids (including PCA with or without a **BASAL INFUSION**) for indications other than palliative/end-of-life care. ***Scoring guideline:*** *Choose Not Applicable only if patients never receive continuous IV opioids in your facility.*	NOT APPLICABLE				
19	A reliable method of measuring the adequacy of ventilation and airflow (e.g., capnography) is used to monitor all patients receiving supplemental oxygen and continuous IV opioids (including PCA with or without a **BASAL INFUSION**) for indications other than palliative/end-of-life care. ***Scoring guideline:*** *Choose Not Applicable only if patients never receive continuous IV opioids in your facility.*	NOT APPLICABLE				
20	Alarms for pulse oximetry and/or capnography are set to minimize the risk of missing significant respiratory depression as well as minimizing nuisance alarms; **and** these alarms reach the responsible nurse promptly (e.g., via text message).					

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21	Prior to any opioid administration, a nurse performs an assessment of the patient (e.g., vital signs, pain assessment using the facility's pain assessment scale) and verifies when the last dose of an opioid and/or other sedating agent was taken or administered to ensure the time interval between doses is appropriate.					
22	Following the administration of intermittent opioid doses, nurses perform a post-administration assessment within the facility-designated timeframe of respirations (i.e., quality of respirations, respiratory effort, rate, rhythm), circulation (i.e., heart rate, blood pressure), sedation (using the facility's sedation scale), and pain (using the facility's pain assessment scale[s]).					
23	During the administration of continuous IV opioids, nurses perform an assessment of the following within the facility-designated timeframe: (score each item individually) ***Scoring guideline:*** *Choose Not Applicable for items* ***a*** *through* ***e*** *only if patients never receive continuous IV opioids in your facility.*					
a	Respiration (i.e., quality of respirations, respiratory effort, rate, rhythm, breath sounds)					
		NOT APPLICABLE				
b	Oxygenation (i.e., pulse oximetry) and/or ventilation (i.e., capnography)					
		NOT APPLICABLE				
c	Circulation (i.e., heart rate, blood pressure)					
		NOT APPLICABLE				
d	Sedation (using the facility's sedation scale)					
		NOT APPLICABLE				
e	Pain (using the facility's pain assessment scale[s])					
		NOT APPLICABLE				
24	Predefined discharge/transfer criteria for adults, neonates, and/or pediatric patients exist to make clear the minimum amount of time that a patient must be monitored after receiving opioids, and the level of alertness and respiratory adequacy required to be discharged from the facility or transferred from the procedural/operative area.					
Storage						
Scoring guideline for this section: *Choose Not Applicable only if the products listed in the items are not available in your facility.*						
25	Immediate-release and extended-release formulations of the same opioid are stored separately in the pharmacy (e.g., different bins, drawers, or cabinets that are physically separated) and in patient care areas (e.g., separate locked, lidded compartments in ADCs).					
		NOT APPLICABLE				

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26	Highly concentrated and usual-strength formulations of the same opioid are stored separately in the pharmacy (e.g., different bins, drawers, or cabinets that are physically separated) and in patient care areas (e.g., separate locked, lidded compartments in ADCs).	NOT APPLICABLE				
27	Highly concentrated oral liquid and **PARENTERAL** opioids are only stored in the pharmacy and in certain patient care units (in unit doses only) where significant chronic, cancer, or end-of-life pain is treated; these products are not stocked in the emergency department.	NOT APPLICABLE				
28	Morphine and **HYDRO**morphone are not stored right next to each other in the pharmacy and/or in patient care areas.	NOT APPLICABLE				
29	Outside of the pharmacy, morphine and **HYDRO**morphone are stocked in different strengths (e.g., 1 mg/mL prefilled syringes of **HYDRO**morphone; 2 mg/mL prefilled syringes of morphine).	NOT APPLICABLE				
Expression of Drug Names						
30	The abbreviations MSO_4 for morphine and $MgSO_4$ for magnesium sulfate (which could be confused with each other), and DTO for deodorized tincture of opium (which could be mistaken as diluted opium tincture), are never used when expressing the drug names in computer order entry systems, order sets, protocols, guidelines, MARs/eMARs, ADC screens, infusion pump screens, drug storage bins, pharmacy labels and/or **AUTOMATED SYSTEM LABELS**, and any other format used to communicate the drug in the facility.					
Product Differentiation						
FAQ 31	**TALL MAN LETTERING** with bolded text for the unique letter characters of look-alike opioid drug names (e.g., **HYDRO**morphone and morphine, oxy**CODONE** and Oxy**CONTIN**) is used when displaying the names in computer order entry systems, order sets, protocols, guidelines, MARs/eMARs, ADC screens, infusion pump screens, drug storage bins, and pharmacy labels and/or **AUTOMATED SYSTEM LABELS**.					
32	An auxiliary label noting its concentrated strength is affixed to nonstandard or highly concentrated opioid products that are dispensed from the pharmacy.					
Reversal Agents						
33	Guidelines exist to **RESCUE** a patient with unintended advancing sedation and/or respiratory depression during opioid therapy, and, if labor and delivery services are provided, for a neonate with severe respiratory depression whose mother received an opioid within hours of delivery.					
34	Resuscitation equipment, supplemental oxygen, and naloxone are readily accessible wherever opioids are administered; **and** the naloxone is accompanied by a clear indication for when it should be used, directions for preparation and administration near the point of use, and a protocol or coupled order set that permits emergency administration.					
35	Patients who receive naloxone are monitored for signs of resedation and respiratory depression for at least 90 minutes after administration of the reversal agent.					

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Staff Competency and Education						
36	Educational programs for all practitioners who care for patients receiving opioids are delivered at least every year around the following content: (score each item individually)					
a	Definition and differences in the management of **OPIOID-NAÏVE**, **OPIOID-TOLERANT**, and **HIGH-RISK PATIENTS**					
b	Opioid conversions and how to use any tools provided by the facility					
c	Appropriate starting doses and the danger of rapid dose escalation					
d	Indications for extended-release and long-acting opioids, associated risks, and education on the requirements of the US Food and Drug Administration *Extended-Release and Long-Acting (ER/LA) Opioid Analgesics Risk Evaluation and Mitigation Strategy (REMS)*					
e	Risk of initiating transdermal fenta**NYL** patches in **OPIOID-NAÏVE PATIENTS**					
f	Clinical and technological (e.g., capnography) monitoring requirements					
g	Sedation as the first sign of respiratory depression					
Patient Education (Includes Caregiver Education When Appropriate)						
37	Patients discharged on opioids are provided with verbal and up-to-date written information at an appropriate reading level and in their preferred language about pain management and safe use of opioid medications, including the following: (score each item individually)					
a	The impact of opioid therapy on psychomotor and cognitive function (which may affect ambulation, work, driving)					
b	Effect of taking too much opioid medication and when/who to call for medical attention					
c	Avoidance of other central nervous system depressants (including alcohol and over-the-counter or illicit drugs)					
d	Not sharing opioids with others					
e	Secure storage and disposal, including drug take-back programs available in the community					
f	How to obtain naloxone from a retail pharmacy if the patient has risk factors for opioid overdose					
Specific Opioids or Modes of Delivery						
Combination Opioids with Acetaminophen						
38	Computer order entry systems alert practitioners if the prescribed medication(s) could exceed the maximum safe daily dose of acetaminophen for adults, neonates, and pediatric patients, considering all possible scheduled and "PRN" doses of acetaminophen-containing medications.					

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		A	B	C	D	E
39	Patients who are prescribed an opioid with acetaminophen to take at home are educated about the amount of acetaminophen in each tablet; the **MAXIMUM** (single) **DOSE**; how many doses they can take each day; and to avoid taking other prescription and nonprescription acetaminophen/medications that contain acetaminophen.					
Extended-Release, Long-Acting, and High-Dose Opioids						
40	A process is in place (e.g., alert requesting confirmation during order entry) to verify that the patient is **OPIOID-TOLERANT** with chronic pain before dispensing extended-release and long-acting opioids that are indicated only for these patients (e.g., extended-release oxy**CODONE** [80 mg or higher doses], extended-release **HYDRO**morphone, extended-release morphine [100 mg or 200 mg tablets], fenta**NYL** transdermal patches).					
41	A process is in place (e.g., alert requesting confirmation during order entry) to verify that the patient is **OPIOID-TOLERANT** with chronic pain before dispensing high-dose opioids indicated only for breakthrough pain in **OPIOID-TOLERANT PATIENTS** (e.g., certain forms of fenta**NYL** [Actiq, Fentora, Lazanda, Subsys, Abstral]).					
Patient-Controlled Analgesia (PCA)						
Scoring guideline for this section: *Choose Not Applicable only if patients in your facility never receive opioid PCA.*						
42	Patient selection criteria have been established and are followed for PCA therapy, which exclude patients who cannot control medication delivery themselves due to their level of consciousness, physiological condition, or limited cognitive ability and comprehension.					NOT APPLICABLE
43	PCA is initially prescribed using a standard order set. ***Exception:*** *Excludes dose changes based on the patient's response after implementation of PCA.*					NOT APPLICABLE
44	Order sets for PCA include: recommended initial and **MAXIMUM DOSES** (bolus and demand) and a lockout interval based on whether the patient is **OPIOID-NAÏVE** or **OPIOID-TOLERANT**, and/or a **HIGH-RISK PATIENT**; monitoring guidelines; and an order for naloxone to reverse respiratory depression, including directions for use.					NOT APPLICABLE
45	PCA **BASAL INFUSIONS** are not used initially in **OPIOID-NAÏVE PATIENTS**.					NOT APPLICABLE
46	Patients, family members, and visitors are educated about the dangers of any individual other than the patient activating the PCA button to deliver a medication dose (i.e., PCA by proxy); **and** a warning label, "**FOR PATIENT USE ONLY**," appears on the cord or activation button for PCA.					NOT APPLICABLE

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Opioid Transdermal System (fentaNYL, buprenorphine)						
47	The fenta**NYL** transdermal patch that delivers 12.5 mcg/hour is expressed as fenta**NYL** transdermal (or **DURAGESIC**) "12" and not "12.5" in orders, computer order entry systems, order sets, protocols, guidelines, MARs/eMARs, ADC screens, drug storage bins, and pharmacy labels and/or **AUTOMATED SYSTEM LABELS**, to prevent confusion with 125 mcg/hour dosing.					
48	The date, time, and anatomical location of an opioid transdermal patch applied to a patient by a practitioner is documented on the patient's MAR/eMAR.					
49	In inpatient settings, at least once per shift, a practitioner verifies that the opioid patch is still in place on the patient's skin in the same anatomical location where it had been documented. ***Scoring guideline:*** *Choose Not Applicable only if your facility does not provide care to inpatients.*					
		NOT APPLICABLE				
50	Practitioners remove any previously applied transdermal opioid patches prior to the application of a new patch and document the patch removal on the patient's MAR/eMAR.					
51	An organizational policy on the proper disposal of opioid patches (e.g., narcotic disposal system containers, containers that deactivate residual drug, flushing down the toilet, not thrown in ordinary trash receptacles) exists and is followed.					
52	Patients being discharged or leaving the facility with a new prescription for an opioid transdermal patch are provided with verbal and up-to-date written information at an appropriate reading level and in their preferred language about: (score each item individually)					
a	How to apply the patch properly					
b	Avoidance of heat exposure (e.g., hot tubs, sun bathing, heating pad over patch)					
c	Removal of the old patch before application of a new patch					
d	Secure storage and disposal of the patches to avoid unintended access by children, pets, and individuals with **ABERRANT DRUG-RELATED BEHAVIORS**					

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Methadone						
Scoring guideline for this section: *Choose Not Applicable only if methadone is never prescribed for patients in your facility.*						
53	Protocols for prescribing methadone to adults and/or children have been established and include the following: (score each item individually)					
a	ECG before treatment and at defined intervals thereafter (based on baseline ECG, high dose, dose changes, drug interactions, other risk factors [e.g., electrolyte abnormalities], patient symptoms)					
		NOT APPLICABLE				
b	Recommended initial **MAXIMUM DOSE** and dose increases					
		NOT APPLICABLE				
c	Assessment and monitoring requirements					
		NOT APPLICABLE				
d	Guidelines for managing pain in patients taking methadone to treat addiction					
		NOT APPLICABLE				
54	Methadone is only prescribed or initiated by practitioners who have substantial experience with its use; are familiar with the drug's risk profile, adverse effects, and pharmacologic properties (e.g., long/variable half-life, interactions, effects on the QTc interval, respiratory depression); **and** they are prepared to educate and closely monitor their patients.					
		NOT APPLICABLE				
55	If an inpatient is being treated for opioid addiction by an approved methadone provider/clinic, the patient's dose is confirmed with the methadone provider and the source is documented prior to the first dose if the drug is continued during hospitalization or long-term care. ***Additional scoring guideline:*** *Choose Not Applicable only if your facility does not provide care to inpatients.*					
		NOT APPLICABLE				
56	Mnemonics in computer order entry systems are configured to prevent confusion between methadone and other drugs that start with "met...," especially those with similar strengths (e.g., methylphenidate).					
		NOT APPLICABLE				

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57	Patients who will be, or are, self-administering methadone at home for chronic pain or addiction treatment are educated about the following: (score each item individually)					
a	Importance of taking the drug exactly as prescribed to avoid a potentially fatal build up in the body					
		NOT APPLICABLE				
b	Plans for monitoring therapy and adjusting doses					
		NOT APPLICABLE				
c	Serious side effects to report to the prescriber					
		NOT APPLICABLE				
d	Risks associated with methadone, including the drug's long/variable half-life, risk of respiratory depression, sudden death (from QTc interval prolongation and arrhythmia), and drug-drug interactions					
		NOT APPLICABLE				
e	Importance of disclosing methadone use to other healthcare providers, including retail pharmacists					
		NOT APPLICABLE				
Opioid Addiction and Abuse						
58	Effective systems are in place to deter and promptly identify drug diversion at any point of opioid use, from procurement to administration and/or wasting of unused drug; **and** an internal group is available to quickly investigate concerns that arise during drug diversion surveillance.					
59	Adequate pain treatment is not withheld from patients with active or previous opioid addiction because of fears of worsening addiction or precipitation of relapse.					
60	Prescribers access data from Prescription Drug Monitoring Programs (PDMPs) to identify past and present opioid prescriptions during the assessment of patients who may require outpatient opioids, and if refills are provided, to determine the safety and appropriateness of the opioid prescriptions.					