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

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Disclosures

• Lindsey Whitlatch RN BSN
  – Has disclosed that she has no conflict of interest

• 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
https://www.youtube.com/watch?v=lw-yuS-fk9g&context=C3e282f3ADOEgsToPDskI70XpQHjnUc-fC19dO2ljq&utm_source=newsletter12212011&utm_medium=email&utm_campaign=askher.
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, 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.*

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

- No Past Month Illicit Drug Use: 240.6 Million People (89.9%)
- Past Month Illicit Drug Use: 27.1 Million People (10.1%)

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 NSDUH 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.
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

3.8 Million Current Misusers of Prescription Pain Relievers (59.3%)
2.6 Million Current Misusers of Prescription Psychotherapeutics Excluding Prescription Pain Relievers (40.7%)

6.4 Million Current Misusers of Prescription Psychotherapeutics

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

<table>
<thead>
<tr>
<th>Drug Type</th>
<th>12 or Older</th>
<th>12 to 17</th>
<th>18 to 25</th>
<th>26 or Older</th>
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</thead>
<tbody>
<tr>
<td>Pain Relievers</td>
<td>1.4</td>
<td>1.1</td>
<td>1.3</td>
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<tr>
<td>Tranquilizers</td>
<td>0.7</td>
<td>0.7</td>
<td>0.6</td>
<td>0.5</td>
</tr>
<tr>
<td>Stimulants</td>
<td>0.5</td>
<td>0.5</td>
<td>0.4</td>
<td></td>
</tr>
<tr>
<td>Sedatives</td>
<td>0.2</td>
<td>0.1</td>
<td>0.2</td>
<td></td>
</tr>
</tbody>
</table>

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

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 (29%), 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

Opioid use can turn deadly

https://www.youtube.com/watch?v=j-9Z0pXbtvI.
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

Warren Rivera
Published: May 2, 2017

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

Date Posted: Wednesday, February 1st, 2017

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, 2011-2015*

*Source: Ohio Department of Health, Bureau of Vital Statistics; Analysis by OHIO Injury Prevention Program; U.S. Census Bureau (population estimates).
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

Ohio residents story

Face the Facts: Opiates in Ohio

Gov. Kasich's message to prescribers

Opioid Prescribing Guidelines

Many opioid addicts were first exposed to these drugs through prescriptions for legitimate pain issues. Health care providers can play a critical role for their patients by adopting consensus-based opioid prescribing guidelines.

Multiple state health care organizations and interested professionals have developed these resources to assist prescribers in making safe choices for their patients. The three sets of guidelines on this page can be used by supplement and not replace the prescriber’s clinical judgment.

ACGOA Prescription Guidelines Fact Sheet
ACGOA Prescription Guidelines Summary
Guidelines Development Partner Organizations

Acute pain management

The Ohio Guideline for the Management of Acute Pain Outside of Emergency Departments provides a general approach in the outpatient management of acute pain.

Chronic, non-terminal pain

The Ohio Guidelines for Prescribing Opioids for

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.

FAQ: New Limits on Prescription Opiates for Acute Pain

Updated 4/3/2017

On Thursday, March 30th, Governor Kasich, Board President, Michael Moné, and leaders of the Medical, Nursing and Dental Boards announced new limits on prescription opiate.

The limits, which must be adopted through administrative rule by each Board, will place limits on the use of opiates for the treatment of acute pain. Based on data from the Ohio Automated Rx Reporting System (OARRS), it is estimated that the common sense parameters would result in a reduction of 1.9 million opiate doses once the new rules are in effect.

The new limits are NOT currently effective and must be adopted by the Boards through the administrative rules process. The Boards are expected to adopt the rules by May 12, 2017.
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 getting them from their 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.

*exclude Hem/Onc Clinics, Pain Service, H11A, H12A/B, Apheresis, BMT Clinic, Aim Team and Palliative Care, Complex Care Clinic, South High PC
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
OpioidSafety 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.

**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
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.

Zero Hero “Wingman”


- 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

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

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

**GOAL:** Improvement of function to baseline as opposed to complete resolution of pain

### OPTIONS

**NON-PHARMACOLOGIC TREATMENT**
1. Ice, heat, positioning, bracing, wrapping, splints, stretching
2. Massage therapy, tactile stimulation, acupuncture/acupressure, chiropractic adjustment, osteopathic neuromusculoskeletal medicine
3. Biofeedback
4. Directed exercise such as physical therapy

**NON-OPIOID PHARMACOLOGIC TREATMENT**
1. Somatic (Sharp or Stabbing)
   - First Line: Acetaminophen, NSAIDs, Corticosteroids
   - Alternatives: Gabapentin/pregabalin, skeletal muscle relaxants, SSRIs/SNRIs/TCA’s
2. Visceral (Ache or Pressure)
   - First Line: Acetaminophen, NSAIDs, Corticosteroids
   - Alternatives: SNRIs/TCA’s
3. Neuropathic (Burning or Tingling)
   - First Line: Gabapentin/pregabalin/TCA’s/SNRIs
   - Alternatives: Anti-epileptics, baclofen, SSRIs, topical lidocaine, block

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

### Table: Opioid Pharmacologic Treatment

<table>
<thead>
<tr>
<th>Opioid Pharmacologic Treatment</th>
<th>Acute outside ED</th>
<th>Emergency/UC</th>
<th>Chronic - Non terminal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complete risk screening (e.g., age, pregnancy, high risk psychosocial environment, personal/family history of substance use disorder)</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Checking OARIS for patients who will receive</td>
<td>Mandatory if &gt; 7 days</td>
<td>Consider contacting other provider if being prescribed opioids</td>
<td>Recommended each visit - mandated every 90 days</td>
</tr>
<tr>
<td>Review Minor Opioid Consent with parent and patient</td>
<td>Mandatory if not for surgery</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Consider Urine Drug Screen</td>
<td>If positive risk screen</td>
<td>If positive risk screen</td>
<td>Initially if positive risk screen and at least yearly</td>
</tr>
<tr>
<td>Avoid prescribing long acting opioids</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Use caution when prescribing opioids with patients on benzodiazepines and sedatives, hypnotics or patient know to use alcohol or illegal substances</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Provide the patient with the least potent opioid to effectively manage pain</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Prescribe the minimum quantity needed with no refills</td>
<td>Consider limiting to a 3 day supply</td>
<td>Limit to 3 day supply</td>
<td>x</td>
</tr>
<tr>
<td>Consider Opioid Agreement with patient and family</td>
<td>If more than on script given</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Remind that it is unsafe and unwise to give away or sell their opioids</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
</tbody>
</table>

**TRANSITION**

- Discuss how to safely and effectively wean patient off opioid medication
- Coordinate care and communication of complex patients with other clinicians

**SECURE and DISPOSAL**

- Give Opioid Safety Helping Hand
- Discuss proper storage and disposal of opioid medications. Discuss “Seeker” - relatives, friends, neighbors, etc.

**FOLLOW up visit**

- Ask how many medications used to script
- Ask about disposal of unused medications
- Review Goal of Improving Function and pain tolerance progress
- It pain resolves, reassess
- Pain, consider standardized tool for assessment
- Treatment method
- Context and reason for continued pain
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).

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name</td>
<td></td>
</tr>
<tr>
<td>Date of birth</td>
<td></td>
</tr>
<tr>
<td>Prescription name &amp; quantity</td>
<td></td>
</tr>
<tr>
<td>Number of refills</td>
<td></td>
</tr>
<tr>
<td>The prescribed drug is a controlled substance containing an opioid. This means the medication has been identified by the United States Drug Enforcement Administration as having a potential for abuse, dependence or misuse. I certify that I have discussed the following with the minor patient and the patient’s parent, guardian or authorized adult:</td>
<td></td>
</tr>
<tr>
<td>(a) The risks of addiction and overdose associated with a controlled substance containing an opioid;</td>
<td></td>
</tr>
<tr>
<td>(b) The increased risk of addiction to controlled substances of individuals suffering from both mental and substance abuse disorders;</td>
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</tr>
<tr>
<td>(c) The dangers of taking controlled substances containing opioids with benzodiazepines, alcohol or other central nervous system depressants;</td>
<td></td>
</tr>
<tr>
<td>(d) Any other information in the patient counseling information section of the labeling for the medication required by Federal law.</td>
<td></td>
</tr>
<tr>
<td>Signature of prescriber</td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td></td>
</tr>
<tr>
<td>Parent/Guardian</td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td></td>
</tr>
<tr>
<td>Adult Authorized to Consent to Minor’s Treatment*</td>
<td>Date</td>
</tr>
</tbody>
</table>

*An adult to whom a minor’s parent or guardian has given written authorization to consent to the minor’s medical treatment. The prescription must be limited to not more than a single 72-hour supply. If the person consenting to treatment is an adult authorized to consent to a minor’s treatment, see Section 3719.031, Ohio Revised Code.

See the Start Talking! website for tips on talking to kids about drugs: StartTalking.ohio.gov
exclude Hem/Onc Clinics, Pain Service, H11A, H12A/B, Apheresis, BMT Clinic, Aim Team and Palliative Care, Complex Care Clinic, South High PC

Ped Surg reduces opioid rx from 10 to 5 doses

OARRS e-mail to prescribers

Rule from Gov. Kasich

Presentation – PGR and SGR

Opioid Safety Website go-live

Med Stat practice tool published

Avg doses/Rx/mo
Baseline Average
Baseline Period
Control Limits
Goal(s)

# of home going opioid Rx per month
863 783 957 921 954 1,024 1,044 899 900 781 1,000 818 860 919 919 930 951 997 1,005 829 834 833 833 835 838 863 905 923

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

• For patients who will be on opioid for more than a short period of time the prescriber most likely will have the patient and family sign an opioid agreement.

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

<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>Complete SOAPP-14 Questionnaire</td>
<td>Date Opioid Bundle Components</td>
<td>HIGH</td>
<td>High Risk Surveillance Freq. Vists: Min monthly UDS monthly OARRS: Every Script Pill Count: Monthly Peds QL: q visit</td>
<td>Major Violation</td>
</tr>
<tr>
<td>Urine Drug Screen</td>
<td>Patient Information, Age, MAR</td>
<td></td>
<td></td>
<td>- Impaired - Negative UDS</td>
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<tr>
<td>OARRS Review</td>
<td>SOAPP Score and Risk</td>
<td></td>
<td></td>
<td>- UDS positive for illicit substances or non-prescribed schedule II meds</td>
</tr>
<tr>
<td>Pill/Patch Count</td>
<td>UDS date and results</td>
<td></td>
<td></td>
<td>- Other opioid prescriber</td>
</tr>
<tr>
<td>Let’s Start Talking Minor Consent</td>
<td>Pill Count/Early Refill Request</td>
<td></td>
<td></td>
<td>- Concerning behaviors around scheduled II meds</td>
</tr>
<tr>
<td>Opioid Agreement</td>
<td>Compliance with non-opioid tx</td>
<td></td>
<td></td>
<td>- Non-compliant with non-opioid tx/referred (≥2 times)</td>
</tr>
<tr>
<td>PedsQL</td>
<td>Peds QL Self Report</td>
<td>MODERATE</td>
<td>Moderate Risk Surveillance Freq. Vists: Min q month UDS q 90 days OARRS: Every Script Pill Count: q 90 days Peds QL: q visit</td>
<td>Major Violation</td>
</tr>
<tr>
<td></td>
<td>Minor Consent: Opioid Agreement</td>
<td></td>
<td></td>
<td>- 1. Verbal Warning</td>
</tr>
<tr>
<td></td>
<td>Minor/Major Violations</td>
<td></td>
<td></td>
<td>- 3. Pain Managed in Clinic</td>
</tr>
<tr>
<td></td>
<td>Opioid Safety Education with Lock Box</td>
<td>LOW</td>
<td>Low Risk Surveillance Freq. Vists: Min q 90 days UDS Annually OARRS: Every Script Pill Count: Annually Peds QL: q visit</td>
<td>Minor Violation</td>
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<td>- 5. Addiction Treatment</td>
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<td>- Failure to bring pill bottle/old patches to visit</td>
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<td>- Call early for refill or run out early</td>
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<td>- Missed/cancels appointments (≥2 times)</td>
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<td>- Failure to provide urine specimen</td>
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<td></td>
<td></td>
<td>- Non-compliant with non-opioid tx/referred (≥2 times)</td>
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<td></td>
<td>Consider Increasing Risk Level</td>
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<td>1. Verbal Warning</td>
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<td></td>
<td>2. Alternative Pain Management</td>
</tr>
</tbody>
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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. SOAPP-14
2. DARRS
3. Minor Consent
4. PedSQL Completed
5. UDS completed
6. Opioid Agreement if more than 1 month

**Opioid Misuse Risk Level**
- Based on Bundle Data

**Nurse Documents Bundle Components**
- Risk Level based on Electronic Tracking Spreadsheet

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

**PC Follow Up Visits**
- RN Collects Opioid Bundle Information
- Based on Surveillance Plan

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

- Is Patient Still Taking Opioids?
- RN Communicates Visit Frequency and Surveillance Plan
- Based on Patient’s Risk Level to Pt.

**Minor Violation**
- Failure to bring pills/bottle/pouch to visit
- Call early for refill or run out early
- Missed/failed appointments (>2 times)
- Failure to provide urine specimen
- Non-compliant with non-opioid tx/referrals (>2 times)

- Verbal Warning
- Alternative Pain Management
- 2nd Minor Violation

**Major Violation**
- UDS positive for illicit substances
- Nurse Documents Bundle Components

- Opiate Compliance Test Completed
- Test Negative for Rx Opioid
- Stop Rx Opioid
- Offer Alternative Pain Management

- UDS positive for marijuana or non-prescribed schedule II drugs
- DARRS - other opioid prescribed
- Concerning reports from other physicians or pharmacist
- Concerning behavior around scheduled fills
- Non-compliant with non-opioid tx/referrals (>2 times)

- 1st offence Verbal Warning
- Increase Opioid Risk Level
- Consider Alternative Pain Management
- 2nd offence Verbal Warning
- Opioid Taper
- Possible Addiction Treatment Assessment
### Patient Tracking Sheet

**Minor Violation:**
- Failure to bring pill bottle to visit
- Call early for refills or run out early
- Misses/cancels appointments (>2 times)
- Failure to provide urine specimen
- Non-compliant with non-opioid tx 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>SOAP Category</th>
<th>&lt; 12 yo or DD Parent screening</th>
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<td>5</td>
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<td>Moderate</td>
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**Major Violation:**
- Impaired
- UDS positive for illicit substances or non-prescribed schedule II meds
- OARRS - other opioid prescriber
- Concerning reports from other physicians or pharmacist
- Concerning behaviors around scheduled II meds
- Non-compliant with non-opioid tx referrals (>2 times)

<table>
<thead>
<tr>
<th>OARRS Date</th>
<th>OARRS Problem</th>
<th>Pill Count Early Refill Date</th>
<th>Pill Count Early Refill Issues</th>
<th>compliant with non-opioid tx referrals</th>
<th>PedsQL Score Physical</th>
<th>PedsQL Score Psych/Social</th>
<th>PedsQL Score School</th>
<th>PedsQL Score Overall</th>
<th>Minor Consent Date</th>
<th>Opioid Agreement Date</th>
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<td>25</td>
<td>4/26/2016</td>
<td>Moderate</td>
<td>No</td>
<td>Yes</td>
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</tbody>
</table>
Educating parents about possible misuse

RED FLAGS OF MEDICATION ABUSE

RED FLAGS

Signs that your child may be abusing their medication include:

- Most of the time, your child will not openly state that they are abusing their medication, or even if they are, they may not.
- There are many signs that may point toward medication abuse, but many of these signs can also be attributed to being a teenager growing up.
- It's important to understand what may be a warning sign vs. what is normal behavior for your child.
- Some categories of warning signs and examples of each are included below.

Behavioral changes:
- Looked down, secretive behavior.
- Disappearance of friends or family.

Home and/or car signs:
- Smell of car.
- Frustration in your voice.

Mood changes:
- Noisy and emotional.
- Less motivated, uncooperative, isa, or depressed mood.

School or work problems:
- Loss of interest in extracurricular activities or hobbies.
- Failure to fulfill responsibilities.

Hygiene or personal appearance:
- Messy appearance.
- Difficulty going to bed or waking up.

Health problems:
- Unusual tiredness.
- Nausea.

What is Medication Abuse?

Medication abuse occurs when:
- A medication is taken in a higher dose than prescribed by the doctor.
- A medication is not taken as prescribed.

It is important to take the medication exactly as prescribed.

References:

Prepared by Emily LeDoux PharmD, Candidate 2018
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
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.
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.
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!!!
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

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

- Physician prescribing medication: 76.5%
- Nurse: 92.6%
- Pharmacist: 58.8%
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 Lortab 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 Amazon for as little as $15. Medications can also be locked in an inexpensive tool box with a combination lock to secure.
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.
TRANSITION

Signs of withdrawal may include:

- Hot & cold flashes
- Sweating
- Goosebumps
- Agitation
- Fatigue
- Muscle aches
- Yawning
- Runny nose
- Fast heart rate
- Difficulty sleeping
- Abdominal pain
- Diarrhea
- Nausea
- Vomiting
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.
Treating Pain After Inpatient 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. Parents can also help us understand their 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 younger children, the pain scale uses visual signs to evaluate pain (see chart below).

Subjective pain scales:

Faces: More appropriate for preschool and young school children.

*Show me how you feel by pointing to the face.*

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<td>0</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>No Hurt</td>
<td>Hurts Little</td>
<td>Hurts Little More</td>
<td>Hurts Even More</td>
<td>Hurts Whole Lot</td>
<td>Hurts Worst</td>
</tr>
</tbody>
</table>

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.

What can you do to help?

It is important 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 patient should cough or take a deep breaths 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 books
- Ask about Child Life Services
- Massage therapy, acupuncture, aromatherapy, hypnosis (ask your nurse about these therapies)
- Bring comfort items from home, such as stuffed animals or a music device with headphones
- Ask your nurse if it is safe to place a warm or cold pad on the area that hurts.

Important words to know:

- IV: Directly into the vein
- PO: (By Mouth): Once the patient is able to eat or drink
- Epidural Catheter: A small hollow plastic tube that is injected through and taped to the skin 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 sleepy than on other pain medicines
- PCA (Patient Controlled Analgesia) Pump: A machine with a syringe filled with pain medicine that delivers the medicine through your child’s IV line. It is controlled by your child.
- NCA (Nurse Controlled Analgesia) Pump: A machine with a syringe filled with pain medicine that delivers the medicine through your child’s IV line. It is controlled by your child’s nurse.
- CCA (Caregiver Controlled Analgesia) Pump: A machine with a syringe filled with pain medicine that delivers the medicine through your child’s IV line. It is controlled by the child’s caregiver.
- Basal and Demand Dosage: These terms relate to PCA, NCA and CCA pumps. A basal dose of pain medicine is a constant, set amount of pain medicine that is given to your child through the pump. A demand dose is a set dose of pain medicine that is given 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 block: Involves placement of local anesthetic (numbing medicine) around the nerve(s) to numb them for certain procedures. A single shot usually lasts 12 to 24 hours, which allows the patient to have constant pain relief while still able to move 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 (a hollow plastic tube) that gives a continuous amount of numbing medicine over several days (usually 3 to 5 days) next to the nerves. 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 medicines. Other things to look for after surgery:

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

If your child experiences any of these symptoms, please talk to the child’s nurse or doctor. If your child is prescribed opioids to control pain after surgery, your doctor will also prescribe a medicine for constipation because of the risk of opioids causing constipation. Some medicines for this include stool softeners, Miralax and sometimes semisolids. For small children, 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 opioids (including morphine, hydromorphone and fentanyl). Some medicines that are given by mouth include acetaminophen (Tylenol), dispropfen (Motrin/Advil) or opioids (hydrocodone or oxycodone).

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

Other Medicines:

- Muscle relaxants: May be given for certain surgeries to relieve muscle spasms (many times described as muscle cramps). Muscle spasms are a pain that episodes generally cannot control. It is important not to give muscle relaxants at the same time as opioid pain medicines because of the risk for slowed breathing, unless told otherwise by your doctor.
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.

Parents 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 younger children, the pain scale uses visual signs to evaluate pain (see chart below).

Subjective pain scales:

Faces: More appropriate for preschool and young school children.

Show me how you feel by pointing to the face:

<p>| | | | | | |</p>
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<tr>
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<td>8</td>
<td>10</td>
</tr>
<tr>
<td>NO HURT</td>
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<td>HURTS LITTLE BIT</td>
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<td>HURTS WHOLE LOT</td>
<td>HURTS WORST</td>
</tr>
</tbody>
</table>

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.

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
- May soft music
- Watch a favorite movie or television show
- Read books

Important words to know:

- Nerve block: Involves placement of local anesthetic (numbing medicine) around the nerve to numb them for certain procedures. A single shot 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.
- PNEC (Perioperative 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 numbing 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 medicines.

Other things to look for after surgery:

- Feeding
- Constipation
- Uptown stomach
- Rash
- Faster breathing

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

What medicines are used to control pain?

There are multiple medicines that may be offered to control pain. Outpatient medicines are given by mouth and generally include acetaminophen (Tylenol), ibuprofen (Motrin/Advil) or opioids (hydrocodone or oxycodone).

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 oxycodone) which is recommended only on an as-needed basis. These medicines can be used in addition to Tylenol or Motrin, but they should only be given if your child is still 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 (Norco) or oxycodone/acetaminophen (Percocet). For children who are prescribed these as-needed pain medicines, give this medicine in place of the acetaminophen 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 6 to 8 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.

8 hours after the surgery, Tylenol and Motrin should no longer be given scheduled 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 medicines you have given 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 follows the instructions.

Other Medicines:

- Muscle relaxers: May be given for certain surgeries to relieve muscle spasms (many times described as muscle cramps), which is a pain that opioids generally cannot control. It is important, unless your doctor tells you to, not to give muscle relaxers at the same time as opioid pain medicines because of the risk of slowed breathing.
- Stool softeners: 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 stomach cramping.

NATIONWIDE CHILDREN’S
When your child needs a hospital, everything matters."
# NCH Post op Pain Handouts & Tracking Form

## Pain Medicine Administration Chart

- **Ketorolac was given at if given:**
  - Tylenol start time is (3 hours after Ketorolac):
  - Motrin start time is (3 hours after Tylenol):

**Opioid**

- **Drug Name:**
  - **Dose:** __________ ml (Liquid) OR __________ tablet
  - **AS NEEDED every:** __________ hours

*ONLY give opioids if your child’s pain is still uncontrolled with the rotation of Tylenol and Motrin*

## Post-op Medicine Chart

- Please give __________ mL of Children’s Tylenol (Children’s Acetaminophen 160mg/5 mL)
  - OR
  - Please give __________ tablets of oral Tylenol (Each tablet contains __________ mg of acetaminophen)

- Please give __________ mL of Children’s Motrin (Children’s Ibuprofen 100mg/5 mL)
  - OR
  - Please give __________ tablets of oral Motrin (Each tablet contains __________ mg of ibuprofen)

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</thead>
<tbody>
<tr>
<td>Dose Number</td>
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After 48 hours: Stop regular or scheduled Tylenol and Motrin and give either as needed.

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* NationWide Children’s
* When your child needs a hospital, everything matters.
DISPOSAL

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

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

Educating patients and caregivers on proper medication disposal will help reduce prescription opioid diversion and accidental overdoses.
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 a survey of 275 patients who were given an opioid prescription following a procedure, only 58% of the prescribed medication was consumed. Researchers found patients disposed 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
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.
A 4 year old girl was visiting her grandparents’ home and suddenly become 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.
Important Facts to Know When Taking Opioids

Opioid (OH pee ahd) 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, in 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 Disposal.

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, injury, and even death.
- Be on the lookout for “Seekers” - siblings, relatives, friends, 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 HH-N-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 ride a bike or operate machinery (such as a lawnmower or car), or take part in any activities where they must stay alert and awake.
  - Itchiness
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.
Proper education of patients and families

- Helping Hand –
  - Important Facts to Know When Taking Opioids (Monitor, Secure, Transition, Dispose)
  - Opioid Helping Hands
- Educational Handouts
  - 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.xdrugdropbox.org to find a nearby collection location.

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

NationwideChildrens.org/Opioid-Safety.
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
**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.**

| Pts educated | 85 | 67 | 94 | 68 | 68 | 98 | 63 | 63 | 74 | 53 | 83 | 81 | 67 | 71 | 74 | 68 | 77 | 73 | 68 | 83 | 84 | 62 | 82 | 103 | 80 | 55 | 95 | 85 | 61 | 84 | 10 | 84 | 75 | 78 | 51 | 88 | 61 | 35 | 35 | 52 | 27 |
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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.