GUIDING PRINCIPLES RELATED TO OPIOID USE IN NURSING HOMES

GENERAL CONCEPTS

What should our practitioners and staff know about the reasons for concern about opioids and their use in managing pain?

- The United States has a major problem with overuse, abuse, and death related to opioids.
- Although the United States has only about 5 percent of the world’s population, it consumes a disproportionately large percentage of the world’s opioids.
- Opioid-related issues are relevant across the health care system, including—but not limited to—long-term and postacute care settings.
- Long-term and postacute care facilities often admit individuals with pain and/or who have short-term or long-term opioid prescriptions.
- We all have a responsibility to help address the problem, by how we provide direct patient care and by improving our systems and processes and influencing others.
- We should recognize that there are many other significant opioid-related issues besides addiction.
- We are responsible collectively for reviewing whether we are managing pain and using opioids properly in our facility.
- We are responsible to know who is ordering opioids in our facility, as well as whether they have the knowledge and skill to do so appropriately.
- We should use the authoritative information that is available about pain, pain management, and opioid prescribing for pain.
- We should identify and disseminate valid references related to pain management.

What principles should we follow about pain management generally and the use of opioids specifically to manage pain?

- We can potentially manage pain safely and appropriately in our facility.
- We should acknowledge, review, and address all relevant issues related to opioids.
- We should commit to a disciplined, systematic approach to pain management.
- We should recognize that prescribing any medications, including opioids, safely and effectively requires significant knowledge and skill.
- We should ensure that opioids are prescribed, administered, and monitored in accordance with recommendations for their safe and effective use.
- We should recognize that while opioids can be useful for certain situations, they are often not indicated or are ineffective in treating various kinds of pain and painful conditions.
- We should recognize that even when opioids are indicated, they may be ineffective or they may cause significant adverse consequences.
- We should recognize that pain is rarely if ever an isolated issue; instead, we should manage it in the context of other conditions and symptoms.
- We should always consider pain medications in light of the patient’s total medication regimen and their overall status.
- We recognize that appropriate opioid indications and prescribing to manage severe or intractable pain due to underlying causes such as metastatic cancer may not be identical to those for managing acute pain and chronic non-cancer-related pain.

What should the staff and practitioners do to define pain-related issues and identify underlying causes, before or soon after prescribing opioids?

- We recognize that pain is a symptom with diverse causes.
- We should follow the care delivery process steps faithfully in managing pain.
- Once we recognize that pain is—or might be—present, the interprofessional team, including medical practitioners, should help clarify pain symptoms and identify causes.
- We should seek enough details of pain, including a description of its nature (sharp, stabbing, dull, aching, shooting, etc.) as well as location, intensity, and other factors (localized, generalized, things that make it better or worse, etc.) in order to help us understand the problem and identify how to manage it—regardless of whether opioids are indicated.
- We should monitor results closely and adjust interventions prudently.
- We recognize that documentation, description, and reporting of pain symptoms needs more details than just a number and a general body location (for example, “hurts all over,” “complains of leg pain,” “abdominal pain is 7 out of 10,” etc.).
- We recognize that details are needed to help distinguish causes; for example, osteoarthritis or tendinitis can be distinguished from other causes of joint or extremity pain, and commonly respond to non-opioid medication or other interventions and opioids are generally not indicated as first-line treatment.

What can we assume about opioids that were started elsewhere?

- In many cases, we may not know much about why opioids were started by someone else, who ordered them, what causes were identified, what else was tried, what adverse consequences may have resulted, or what to do next.
- When patients are admitted from elsewhere (hospital, community, etc.), we should gather more information to determine whether their current treatment is still appropriate and is not problematic or presenting a significant risk.
- We recognize that when treatment started elsewhere does not seem to be effective or may be causing complications, we should evaluate its continued relevance.
- There is ample evidence that even when opioids are warranted initially as analgesics, they often can be switched subsequently to non-opioid analgesics or other interventions that are equally or more effective.
What should our staff and practitioners know and do in order to manage pain safely and effectively?

- We need our opioid prescribers to assess and document details about pain, diagnose causes and contributing factors to the extent possible (including medications that can directly or indirectly cause pain), evaluate and manage pain in the proper context, evaluate responses to treatment, and prescribe medications safely and effectively.
- We need our staff and practitioners to establish or affirm correct diagnoses and indications for opioids, to the greatest possible extent, prior to or soon after prescribing opioids and periodically thereafter.
- We need our staff and practitioners to perform a meaningful patient assessment, document enough details of pain, and have a substantive discussion to support the initiation and ongoing use of opioids to manage pain.
- We need our staff and practitioners to help us confirm or refute assumptions or impressions that someone may be having pain or needs opioids; for example, when a patient is being treated with opioids based primarily on restlessness or grimacing.
- We cannot just assume that medications are indefinitely indicated or necessary in the doses for which they have been prescribed to date, just because symptoms diminish in someone receiving opioids.

ASSESSMENT AND CAUSE IDENTIFICATION

How much should we try to validate what patients tell us about their pain?

- We recognize that all symptoms—including pain—are subjective to some extent.
- We acknowledge that trying to objectively validate symptoms (including pain), to the greatest extent possible, is a basic principle of all clinical practice.
- We recognize that people have different ways of experiencing and describing pain; for example, some individuals minimize even severe pain while others describe pain as severe and excruciating despite little or no objective evidence.
- We acknowledge that patients have diverse ways of reporting symptoms and are not all equally reliable historians.
- When it is unclear whether a patient is having pain (for example, when cognitively impaired), or when the nature and severity of pain are unclear, our staff and practitioners should try to validate initial assumptions or tentative conclusions (for example, that restlessness is being caused by pain).
- While we should always take patient requests into account, we acknowledge that there are limits to how much medical practitioners should order medications—especially, opioids—based solely or primarily on patient or family requests, without additional validation.

What should staff and practitioners do to validate and manage a patient’s nonspecific symptoms that might reflect pain?
- We acknowledge the need for a systematic effort to identify if nonverbal symptoms reflect pain, including an effort to rule out other explanations for the symptom.
- We recognize that even when nonverbal expressions such as grimacing and restlessness probably reflect pain, opioids may not be indicated or beneficial.
- We recognize the need to consider whether any apparent decrease in nonspecific or nonverbal symptoms is actually due to pain reduction or to undesirable side effects of opioids such as sedation or apathy.
- Even when a patient with non-specific symptoms appears to respond successfully to opioids, our staff and practitioners should reevaluate periodically whether an opioid continues to be indicated or needed over time.

**TREATMENT**

*What should the staff and practitioners consider in deciding whether to initiate, increase doses, or add opioids for pain?*

- We should base decisions to add opioids to a regimen or to increase current opioid doses on a reasonably detailed discussion and analysis of the patient.
- While we recognize that opioids can sometimes be helpful and effective, there are also many situations for which they are not indicated or not helpful.
- We acknowledge that one possible reason why a patient may not get much relief on a given opioid regimen is that opioids are not indicated or are ineffective for their pain, or because the underlying cause has not been identified, or because a different approach to the situation is needed.
- In order to justify giving more of a current opioid regimen, we need to identify at least partial effectiveness of the current treatment without excessive side effects.
- If an increase in opioids by phone or remote ordering does not materially improve symptoms without causing undue side effects, we expect our medical practitioners and staff to assess the situation in more detail before increasing doses or adding more medications.
- We acknowledge that moderate to severe pain does not always require or benefit from opioids. Even when opioids are indicated, non-opioid medications and nonpharmacological interventions may sometimes help reduce the doses, frequency, or duration of opioid treatment.

*Why should we look at the entire drug regimen when prescribing for pain?*

- We recognize that opioids have significant effects and side effects on the central nervous system and the body as a whole.
- We understand that many other categories of medications can interact with opioids to cause or contribute to significant and possibly severe side effects and other complications.
- We expect our staff and practitioners to monitor closely patients receiving opioids for clinically significant side effects, interactions, and complications.
- We expect our staff and practitioners to seek, identify, and address potential side effects and complications (including psychiatric, neurological, and behavioral) from opioids—
alone or in combination with other medications.

What risks and adverse consequences of opioids should we consider when they are used to treat pain?
- We need our staff and practitioners to consider possible interactions and adverse consequences in anyone who has a significant unresolved symptom or an acute change of condition while receiving opioids.
- We realize that potential adverse consequences related to opioids go well beyond commonly discussed ones such as constipation, addiction, and respiratory depression. Among other things, they may include significant psychiatric and behavioral issues, falls, dizziness, confusion, urinary retention, abdominal pain, disorientation, impaired function, apathy, lethargy, anorexia/weight loss, and death.
- We recognize that the adverse consequences of opioids (up to and including death) are often exacerbated in combination with medications in many other classes, including (but not limited to) antiepileptic medications, muscle relaxants, benzodiazepines, antidepressants, other opioids, antipsychotic medications, tramadol, and anticholinergic medications.

How should we manage PRN opioids for pain?
- We should expect our staff and practitioners to order and use PRN analgesics—including opioids—judiciously and appropriately, based on enough assessment to demonstrate that the medication is pertinent and effective over time.
- When multiple PRN options are available for a given patient, we recognize that the only way to know which PRN medication to give is to do an adequately detailed assessment of the patient.
- We realize that there are several reasons why a patient may request PRN analgesics frequently, including ineffective or insufficient standing doses or an overall pain treatment regimen that is ineffective or otherwise needs to be modified.
- We expect our staff and practitioners to not simply switch PRN opioids to a standing dose, or add more PRN opioids, until they review the current situation including the patient’s current pattern of PRN analgesic use.

What should staff and practitioners do when patients or families request opioids generally, or specific opioids, to manage pain?
- We encourage and expect our staff, patients, and families to report pain symptoms objectively and in detail.
- We recognize that patients and/or families may request or demand opioids generally or specific ones, and may sometimes threaten the facility or intimidate the staff and practitioners if they do not get what they ask for.
- We need to try to validate the appropriateness of a patient’s specific treatment requests, especially if pain is not adequately relieved despite being on opioids or they are
requesting more opioids despite increases or are unwilling to reconsider current approaches.

- While staff may inform a practitioner of a request by a patient or family for a specific analgesic, staff should not suggest orders for opioids or additional doses of opioids. Instead, they should provide objective detail that helps the practitioner define the problem and the correct treatment.

- We acknowledge that opioids should not be prescribed or dispensed based primarily or solely on patient or family demand, but rather on a clear and sufficiently detailed evaluation of patient-specific information, appropriate indications, and the lowest possible effective frequency, dose, and duration.

- We recognize that patients and families do not necessarily understand the care process, opioid indications, medication risks and adverse consequences, or the need to seek pain details and underlying causes of symptoms.

- We acknowledge that good customer service and patient-centered care do not mean simply giving patients whatever they ask for or agreeing to their requests and demands without further exploration.

- We expect our staff and practitioners to question or challenge patients and families when they ask for—or insist upon—certain medications that are not indicated or are potentially problematic, including opioids, or if they refuse to consider pertinent alternatives.

- We recognize that opioids should be carefully prescribed and dispensed on a very limited basis upon discharge from the facility (e.g., no more than a 10-14-day supply) and only to those with a clear need based on a pertinent evaluation at or near the time of discharge.

- We recognize that studies have shown that opioids that are prescribed for patients on discharge often go unused and are likely to be stolen.

**MONITORING**

*What should be monitored and documented regarding a patient who is receiving opioids?*

- Our staff and practitioners should monitor both effectiveness and possible adverse consequences related to analgesic treatment.

- We want our staff and practitioners to discuss in adequate detail patients with pain receiving analgesics (including opioids) in order to understand whether the treatment—including the medication regimen—continues to be relevant, safe, and effective.

- We acknowledge that as a patient's condition and medication regimen changes, medications that were effective previously may become less effective, while those that were not problematic previously may subsequently interact with other medications in the patient’s regimen or cause adverse consequences.

- We want our staff and practitioners to identify and document enough details in the medical record to enable pertinent decisions about new or continued opioid ordering and use.

- We expect our staff and practitioners to be aware of, monitor for, and address identified or likely adverse consequences of opioids, either alone or in combination with other medications.
What should we do about ordering and giving PRN opioid analgesics?

- We acknowledge that PRN opioids need the same careful prescribing parameters for judicious use as other potentially problematic medications such as psychopharmacological medications.
- We expect PRN analgesics to be ordered and given appropriately and safely, based on enough detail in the orders and care plan to target the use and minimize problematic use.
- We expect our staff to obtain enough objective detail about a patient’s pain to validate the need for giving PRN doses, based on a relevant plan for each patient.
- We expect our staff and practitioners to review carefully situations where staff are giving PRN doses of opioids or other potent and higher-risk analgesics frequently or continuously.
- We do not want our staff and practitioners to switch to standing doses of opioids for occasional or intermittent pain when PRN medication is needed only occasionally, primarily or solely based on regulatory and survey considerations.
- Even when standing and PRN orders for opioids are indicated, we recognize that nonpharmacological interventions and non-opioid analgesics may be helpful adjunctive treatment.
- The decision about whether to give a PRN opioid dose needs substantially more assessment details than just the numeric pain scale results.
- We do not want nurses to give the most potent opioid analgesic available from among several options just because it is easier than doing an adequate assessment at the time of an interim dose.
- Before raising the dose and the frequency of a given opioid or adding more opioids, or switching from PRN to standing doses of opioids, we expect the medical practitioners and staff to identify whether and to what extent opioids have been effective and are still indicated.

What do we do if we think that a patient is drug seeking or has a drug dependency or abuse problem?

- We can anticipate that some patients in nursing homes may seek drugs or may be addicted to or dependent on opioids, regardless of whether or not they are in pain.
- We should use available resources, such as a state or regional Health Information Exchange, to identify whether other providers have prescribed opioids for a patient.
- We acknowledge that there are some reliable clues to drug seeking behavior and we expect the staff and practitioners to seek, document, and address clues to opioid seeking, dependency, and addiction.
- When patients show a number of clues that suggest that they may be drug seeking, we expect our staff and practitioners to take it seriously, clarify whether the patient may be seeking medication due to dependency in addition to, or instead of pain; and set appropriate limits for prescribing opioids for the patient.
- We recognize that it is imprudent to continue to prescribe unnecessary or inappropriate opioids and other medications based on patient or family threats or intimidation, or primarily or solely based on regulatory and survey considerations.
**GENERAL PROCESSES AND OVERSIGHT**

*What limits should we place on those who prescribe opioids?*

- We should be aware of whether our prescribers have basic competencies related to pain management and opioid prescribing, and limit those with insufficient knowledge and skills.
- We should check that practitioners with limited knowledge and skill about prescribing opioids either do not do so, or have a medical practitioner who is familiar with opioid prescribing guide them and review their orders.

*How should the staff and practitioners utilize and interact with other advisors and consultants such as consultant pharmacists, pain consultants, and pain clinics when opioids are involved?*

| - We realize that pain consultants and pain clinics often evaluate patients in an artificial setting — their office or clinic — and not in the context of the patient’s everyday activities. |
| - We realize that we should use pain consultants sparingly, should provide them with ample objective details (e.g., the patient’s daily function, pain patterns, drug seeking efforts, or significant adverse consequences while taking opioids), and should coordinate any analgesic recommendations from a clinic or consultant with the rest of the patient’s medication regimen. |
| - We cannot depend primarily or solely on a consultant pharmacist to identify serious issues related to opioids or assume that everything is OK if the consultant pharmacist does not find any. |
| - We recognize that only some hospice patients have pain that warrants the use of opioids. |
| - We recognize that giving opioids is not necessarily more compassionate than giving non-opioid medications or nonpharmacological interventions that result in adequate pain management. |
| - We realize that medication-related adverse consequences can be unnecessarily debilitating in hospice patients, and should be minimized, sought, and addressed unless the care plan has identified that the desired goal is pain relief regardless of any adverse consequences. |
| - We expect our hospice providers to prescribe opioids judiciously, manage pain in the proper context, and coordinate care and prescribing with the staff, the patient, the patient’s other primary practitioners, and in light of the entire medication regimen. |
| - We expect our primary care practitioners and staff to remain involved in managing patients with pain, even when hospice or other consultants are involved. |
| - We expect our staff and practitioners to speak up and assert themselves when necessary with outside and internal pain consultants and opioid prescribers, especially when pain symptoms continue despite opioid administration or despite increasing doses, when adverse consequences occur, or when patients may be drug seeking. |

*What should practitioners and staff do to try to minimize opioid diversion and to be vigilant for it*
in their facilities?

- We recognize that we need an organized and assertive effort to oversee opioid use in our facility and to prevent and identify diversion.
- We acknowledge that drug diversion is a continuing and substantial problem in healthcare facilities such as nursing homes.
- We expect our prescribers, staff, and management to be alert to issues of diversion, theft, and illicit use of opioids in the facility.
- We realize that the effort to address drug diversion risks should include accountability for the prescribing, administration, documentation and storage of opioids.

How should our facility oversee and review its pain management approaches, including the use of opioids to treat pain?

- Our facility needs to systematically review clinical practices and processes related to pain management and opioid use, and may need to question and intervene in specific cases.
- Our facility should establish and apply meaningful policies, protocols, oversight, monitoring, and control of opioids.
- Our facility should encourage everyone to speak up about concerns related to pain management; for example, use of specific analgesics despite warnings, interactions, or complications or patients who are declining or not improving as anticipated while on opioid analgesics.
- Our facility should devote a meaningful segment of its quality improvement activities to the many issues surrounding pain management and opioid prescribing and use.
- Our medical practitioners and the medical director must be an integral part of the oversight process, along with facility management and other clinical leadership—well beyond just reviewing quality measures related to pain.
- We expect our facility leadership to establish the right mindset and implement appropriate protocols for the prescribing, administration, monitoring, and control of high risk, potentially life-threatening medications.

How should our facility address pain issues in light of nursing home regulations and surveyor scrutiny?

- We are aware that many nursing home staff and medical practitioners cite nursing home regulations, the survey process, fear of deficiencies, and concerns about performance on quality measures as a rationale for the quantity, frequency, doses, and types of opioids that are given to patients for pain.
- We do not agree that giving opioids by itself is necessarily evidence of doing the right thing regarding pain management or of meeting regulatory requirements.
- We realize that we have a responsibility to have enough detailed information and documentation so that surveyors can see clearly how the staff and practitioners manage a patient’s pain, how they have decided on someone’s current analgesic regimen, how they decide that a patient needs opioid analgesics, how goals for pain relief are identified, and how
they monitor appropriately for effectiveness and adverse consequences related to pain management.

- We expect surveyors to conduct fair and objective assessments of individuals with pain and the management of pain, to request and to review additional evidence and to look at the whole picture before drawing conclusions related to patient complaints and concerns.

- In reviewing quality measures related to pain, we should consider pain management processes and practices and consider whether we are using analgesics safely and effectively; that is, how we get our results is as important as the outcomes.