Huddle Dialog: Opioid Administration Education Initiative

For those of you who have not heard, there has been significant discussion throughout the hospital about the pharmacy research conducted by Darcy Matthews, PharmD.

Darcy set out to determine if administration accuracy is influenced by how an oral opioid range order is written.

Of 100 patients included, **only 13** patients reviewed were administered all opioid doses **correctly** based on the order.

87% of patients were administered at least one dose of opioid **incorrectly** based on the pain score, dose or frequency written on the order

52% (290/531) of all doses evaluated for accuracy were incorrect based on the order.

The most common reason for inaccuracy was the administration of the dose designated for a higher pain score when the patient reported a lower pain score.

For Example: Two Percocet are administered for a reported pain score of 5 but the order indicates only 1 Percocet is due prn moderate pain (4-6).

The second most common reason was administering an oral opioid when an IV opioid was indicated based on the pain score and orders.

An example of this scenario would be: your patient reports a pain score of 9 and there is an order for Percocet for moderate pain (4-6) and fentanyl for severe pain (7-10). When the Percocet is administered instead of the fentanyl, this is an inaccurate administration.

In all of the scenarios of inaccurate administration (2 main examples provided), the oral opioid **administration falls outside of the order parameters.**

The only areas excluded from the study were the critical care and observation units. **However, the identified issues occurred house wide on all shifts.**

Each time an opioid dose is administered without following the order, as written by the provider, the nurse is practicing outside their scope.

Based upon the data, unanimous feedback from the Pain Committee and CORE and a call to action from Leadership, an educational initiative is required to correct the identified practice drift.

In the spirit of patient safety, best practice and diversion avoidance, we all must take responsibility for this drift in practice and hold each other accountable moving forward now that we are aware of it.

A subcommittee of nurses and pharmacists have collaborated to create a new health stream, which is now available online. It serves as a refresher on expectations of best practice and includes a tool kit to help nursing navigate some of the gray areas of pain management.

Please feel free to reach out to Darcy for more information or with any questions that you have!

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