Goals of Education

- Raise awareness of the current culture and **practice drift** surrounding opioid administration at our hospital
- Standardize and retain nursing scope of practice as it pertains to this initiative
- Improve practice to optimize patient safety and reduce diversion risk
- Provide tools to help nursing navigate the grey areas of pain management

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Administration Accuracy of as Needed Oral Opioids: Comparison of Combined Versus Separate Range Orders

Darcy Matthews, PharmD., Karen M. Whalen, BS Pharm, BCPS, Christine Rahme, PharmD., BCPS

- Darcy Matthews, Pharm D PGY-1 Pharmacy Resident conducted a study to determine if administration accuracy is influenced by how an oral opioid range order is written
- These results have been shared with several groups including: Pain Committee and CORE
- Based upon the results, unanimous feedback from the Pain Committee and CORE, and a call to action from nursing leadership, an educational initiative is required **to correct the identified practice drift**

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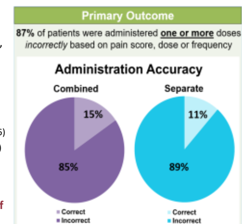
Opioid Administration Research Study

Study Methods

- 100 med-surg patients with range orders for oxycodone, oxycodone/APAP or hydrocodone/APAP were reviewed
  - Combined example
    - Percocet 5/325mg 1-2 tablets Q4H prn for moderate pain (4-6), severe pain (7-10)
  - Separate example
    - Percocet 5/325mg 1 tablet Q4H prn for moderate pain (4-6)
    - Percocet 5/325mg 2 tablets Q4H prn for severe pain (7-10)

Study Results

- *Accuracy did not differ based on order style*
- **87% of patients were administered at least one dose of opioid incorrectly based on the pain score, dose or frequency written on the order**



*Study approved by SJH IRB

1 Opioid Administration Research Study

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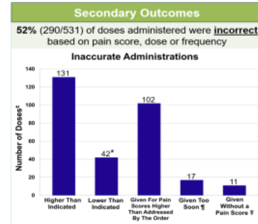
- **52% (290/531) of all doses evaluated for accuracy were <u>incorrect</u> based on the order**
- Most common *<u>drift in practice</u>* is administering a dose designated for a higher pain score when the patient reported a lower pain score
- The second most common drift in practice is administering an oral opioid when an IV opioid is indicated based on the reported pain score and orders
  - **Example:** A patient reports a pain score of 9. Instead of giving fentanyl IVP for severe pain (7-10), the nurse gives Percocet which is written for moderate pain (4-6)



In all of the scenarios of inaccurate administration, the oral opioid administration falls outside of the order parameters

2 Nursing Scope of Practice

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<u>NY State Education Law, Article 139</u>:

"The practice of the profession of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential health problems through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and well-being, and <u>executing medical regimens prescribed by a licensed physician, dentist or other licensed health care provider</u>".

- An example of the most common **drift in practice**:
  - The orders are Oxycodone 5mg Q4H prn moderate pain (4-6) and Oxycodone 10mg Q4H prn severe pain (7-10)
  - The patient's reported pain score is a 4 and he/she asks for Oxycodone 10mg
  - The nurse gives Oxycodone 10mg, **based on the patient's request**, without calling the prescriber to get a new order

The nurse is functioning out of his/her scope of practice because the order is not being executed as written

This is also interpreted as prescribing, which is beyond the scope of the nurse

2 Next Steps

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Orders must be followed as written or modified to meet patient's needs

- *If the previous scenario sounds familiar to you, what should your next steps be?*

1. Review and discuss pain management with your patient
   - What is working for them and what is not
   - Type of pain/source of pain (surgical, acute, chronic)
   - Evaluate patient's understanding and expectations of pain management
2. Assess if pain medications are appropriate
3. Ask about non-opioid options that have worked for them in the past (NSAID, Tylenol)
4. Review non-pharmacological interventions for your patient and implement them
5. Call provider to discuss pain management plan and have order changed, if applicable

Before we educate on clinical scenarios…

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The following slides review common examples of practice drift and ways to ensure that nurses practice within their scope

- As a nurse, you bring *<u>invaluable</u>* insight into your patient's pain management. We hope the following slides give you the tools you need to help actively participate in pain medication optimization for those you care for!
- **When reviewing the clinical scenarios, please remember:**
  - There are multiple ways to change pain regimens to optimize therapy, these scenarios just give an example of changes that can be made
  - It is **NOT** the nurses responsibility to know exactly how to "fix" the orders, it is your responsibility to <u>ALERT</u> the provider to the mismatch between your patient's needs and the current orders
  - With the information you provide, the prescribers will decide how to optimize the regimen

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3a Tool Kit: Clinical Scenario #1

Example: My patient is reporting a pain score of 5, however, he is unable to get out of bed without grimacing, is sweating and is not talking due to pain. It is known that the patient has been under reporting their pain, despite education. Previous nurses have been administering Oxycodone 10mg, which has provided adequate pain relief.

- **Patient orders:** APAP 650mg for mild pain (1-3), Oxycodone 5mg for moderate pain (4-6), Oxycodone 10mg for severe pain (7-10)
- The nurse uses clinical judgement and decides that the patient should receive Oxycodone 10mg for a moderate pain score, but only has an order that allows administration of Oxycodone 10mg for severe pain

What should you do?

- **PAUSE!** ***You can not administer a medication without an order that supports your administration***
- Contact the provider and describe to them your clinical scenario, then, ask him/her to optimize the pain regimen
  - The provider may choose to do several things with the information you have presented:
    1. Modify the pain scale on your existing order
       - **In this example:** Modify the Oxycodone 10mg order to be given for moderate (4-6) *or* severe pain (7-10)
    2. Change the dose or frequency on an existing order
    3. Discontinue pain orders that are not appropriate for the patient
       - **In this example:** Discontinue Oxycodone 5mg for moderate pain (4-6)
    4. Customize pain scales for your patient to allow for a more broad, or narrow, range for administration

An order from an MD/CA is REQUIRED for all medication changes

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3a Tool Kit: Clinical Scenario #2

Example: My patient is reporting a pain score of 9, however, he is not interested in receiving IV pain medications and wants to receive an oral medication.

- **Patient orders:** APAP 650mg for mild pain (1-3), Oxycodone 5mg for moderate pain (4-6), Fentanyl 25mcg IVP for severe pain (7-10)
- Based on discussions with the patient about pain management, the nurse wants to administer Oxycodone 5mg to treat his pain, but only has Fentanyl IVP ordered for severe pain

What should you do?

- **PAUSE!** ***You can not administer a medication without an order that supports your administration***
- Contact the provider and describe to them your clinical scenario, then, ask him/her to optimize the pain regimen
  - The provider may choose to do several things with the information you have presented:
    1. Modify the pain scale on your existing order
       - **In this example:** Modify the Oxycodone 5mg order to be given for moderate (4-6) *or* severe pain (7-10)
    2. Change the dose or frequency on an existing order
    3. Discontinue pain orders that are not appropriate for the patient
       - **In this example:** Discontinue Fentanyl 25mcg for severe pain (7-10)
    4. Customize pain scales for your patient to allow for a more broad, or narrow, range for administration

In this example – *the provider may also opt to leave the Fentanyl 25mcg IVP active on the profile,* ***but modify the administration instructions*** *to include "for severe pain (7-10) that is unrelieved by oral options"*

An order from an MD/CA is REQUIRED for all medication changes

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3a Tool Kit: Clinical Scenario #3

Example: My patient's pain has responded well to non-opioid options, even when they report moderate pain scores (4-6). They have been refusing opioids for moderate pain (4-6) because they feel as though their pain is adequately managed with acetaminophen. Additionally, a previous nurse administered Oxycodone 5mg for a pain score of 9, which adequately treated the patient's pain. They are now reporting a pain score of 6.

- **Patient orders:** APAP 650mg for mild pain (1-3), Oxycodone 5mg for moderate pain (4-6), Oxycodone 10mg for severe pain (7-10)
- The nurse uses clinical judgement and decides that she would like to give acetaminophen for moderate pain, but only has an order for Oxycodone 5mg for moderate pain

What should you do?

- **PAUSE!** ***You can not administer a medication without an order that supports your administration***
- Contact the provider and describe to them your clinical scenario, then, ask him/her to optimize the pain regimen
  - The provider may choose to do several things with the information you have presented:
    1. **Modify** the pain scale on your existing order
       - **In this example:** Modify the Oxycodone 5mg order to be given severe pain (7-10) instead of moderate
       - **In this example:** Modify the Acetaminophen order to be given for mild (1-3) *or* moderate pain (4-6)
    2. Change the dose or frequency on an existing order
    3. **Discontinue** pain orders that are not appropriate for the patient
       - **In this example:** Discontinue Oxycodone 10mg for severe pain (7-10)
    4. Customize pain scales for your patient to allow for a more broad, or narrow, range for administration

An order from an MD/CA is REQUIRED for all medication changes

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3a Tool Kit: Clinical Scenario #4

Did you know that pain scales can be ***personalized*** *for your patient versus using the standard Moderate (4-6) and Severe pain (7-10) scales??*

This technique may be helpful to optimize pain management in patients that do not fit the "mold"

Example: My patient is consistently having adequate pain relief when I administer Oxycodone 5mg for a pain score of 4 or 5, but has INADEQUATE results when Oxycodone 5mg is administered for a pain score of 6. He is currently due for a dose of oxycodone and is reporting a pain score of 6.

- **Patient orders:** APAP 650mg for mild pain (1-3), Oxycodone 5mg for moderate pain (4-6), Oxycodone 10mg for severe pain (7-10)
- The nurse uses clinical judgement and decides that the patient should receive Oxycodone 10mg for a pain score of 6, but only has an order that allows her to administer Oxycodone 5mg

What should you do?

- **PAUSE!** ***You can not administer a medication without an order that supports your administration***
- Contact the provider and describe to them your clinical scenario, then, ask him/her to optimize the pain regimen
  - The provider may choose to do several things with the information you have presented:
    1. Modify the pain scale on your existing order
    2. Change the dose or frequency on an existing order
    3. Discontinue pain orders that are not appropriate for the patient
    4. **Customize** pain scales for your patient to allow for a more broad, or narrow, range for administration
       - **In this example:** Modify the oxycodone 5mg order to be given for a **pain score of** 4-5
       - **In this example:** Modify the oxycodone 10mg order to be given for **pain score of** 6-10

This practice will not likely be common, however, some patients may benefit from this customization of their pain regimen!

This method is not intended for a patient who has inadequately treated pain once or twice with the current orders (that may be due to a recent procedure or activity)

3a Tool Kit: How to Modify an Order in EPIC

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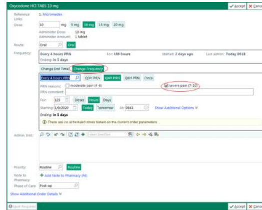
To MODIFY an existing order in EPIC *after an order is obtained (in the event that the Provider is unable to access Epic at that time)*:

1. Select the medication in the order screen
2. Click on 'Modify', the order will open (screen shot)
3. Click on 'Change Frequency', circled in red
4. Check, or uncheck, the PRN reason field as appropriate for your new order

If you are creating a CUSTOM pain range – please ensure that both PRN reasons are UNCHECKED, then type in the comment section what the custom pain score is

- example: PRN comment = "for **pain score** of 4-7"

5. Click accept at bottom of window



The pharmacy team is always here to help walk you through how to modify orders if you need help!

3b Tool Kit: Multimodal Pain Approach

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- **Multimodal analgesia** is a pharmacologic method of pain management which combines various groups of medications for pain relief
- Keep in mind, patients may benefit from around the clock, multimodal pain medications

Drug Group	Examples
Tylenol	acetaminophen
NSAIDS	ibuprofen, ketorolac, naproxen, celecoxib
Topical Medications	lidocaine patches, capsaicin cream, methylsalicylate/menthol cream
Muscle Relaxants	methocarbamol, metaxalone, cyclobenzaprine, tizanidine, baclofen
Gabapentinoids	gabapentin & pregabalin

3b Tool Kit: Alternative Pain Approach

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- Ask your patient "what helps them with pain at home?"
- Don't be afraid to have family or patients involved in their pain therapy

Ice/Heat	Walking	Consult to Music Services
Elevation of Affected Site	Healing Touch	Volunteer Visit
Pet Therapy	Music Channel (85,86)	Aromatherapy

3c Tool Kit: Patient Education

Understanding the Pain Scale

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1. Discuss patient understanding of the scale
2. Assess their pain using the numeric and functional scale
   - Remember, the numeric pain scale can have mixed results and be subjective
   - Pain can be difficult for a patient to quantify→ use the functional pain scale to clarify the patient's pain level
3. Discuss the type of pain they're having: Surgical, Acute, Chronic
4. Discuss their pain management expectations
   - Risk/Benefit of opioids
   - The goal is to treat pain, but not impair ADLs
5. Educate patients on how the medications work, how quickly they work (pharmacokinetics) and possible side effects they may experience

Functional Pain Scale

0-1	**No Pain to Minimal** My pain is hardly noticeable
2-3	**Mild to Uncomfortable** My pain bothers me but I can ignore it most of the time. Pain does not prevent activities
4-5	**Moderate to Distracting** I think about my pain most of the time; I cannot do some activities.
6-7	**Distressing to Unmanageable** I think about my pain all the time; it keeps me from doing most activities, but can use phone, watch TV, or read
8-9	**Intense to Severe** My pain is all I can think about; I can barely talk or move; I cannot use phone, watch TV, or read
10	**Worst Pain Possible** Unbearable Unable to verbally communicate because of pain

3d Tool Kit: Opioid Pharmacological Information

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Drug	Onset (IV)	Onset (PO)	Half-life	Typical Duration	Pearls
Morphine	5-10 min	~ 30 min (peak ~1hr)	2-4 hr	3-5 hr	Avoid in renal impairment
HYDROmorphone	5 min (peak 10 -20 min)	15-30 min (peak 30 - 60 min)	2-3 hr	3 -4 hr	1mg IV hydromorphone is equal to 7mg IV morphine
Fentanyl IV	Almost Immediate (max – several min)	n/a	3-4 hr	1-2 hr	Short acting
Oxycodone	n/a	10-15 min (peak 1.2-1.9 hr)	3-4 hr	3-6 hr	Available with or without APAP
Hydrocodone	n/a	10-20 min (peak ~1 hr)	3-4.5 hr	4-6 hr	Only available in combination with APAP
Tramadol	n/a	60 min (peak 2 – 3 hr)	6-8 hr	4-6 hr	Needs to be dose adjusted based on renal function
Tapentadol	n/a	30-45 min (peak 1.25 hr)	4 hr	2-4 hr	Expensive

- How patients handle opioids in their system and what dose to start ***will vary*** depending on:
  - Age, sex, body weight
  - Renal and hepatic function
  - Previous exposure to opioids
- Oral Route is typically preferred and lasts longer than IV route
- Monitor for over sedation, respiratory depression, constipation and confusion
- Don't always jump to IV opioids when oral opioids aren't working
  - Remember the **Multi-Modal** approach to pain management is usually the most successful and safest

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Thank you!

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.

Appendix

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