



MONTANA STATE HOSPITAL POLICY AND PROCEDURE

PAIN ASSESSMENT, MANAGEMENT AND THE SAFE USE OF OPIOIDS

Effective Date: January 31, 2019

Policy: TX-35

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V. PURPOSE:

- A. To assess and manage a patient's pain while minimizing risks associated with treatment.
- B. To minimize the risk of adverse events, abuse and addiction, evidence-based prescribing practices are to be used when treating acute and chronic pain with opioids.

VI. POLICY:

- A. Pain assessment and management, including safe opioid prescribing, is an organizational priority.
- B. The Licensed Independent Practitioner is actively involved in pain assessment, multimodal pain management and safe opioid prescribing.
- C. The hospital utilizes a pain management program which defines a process for the safe assessment and management of pain including the safe use of opioids.
- D. The patient's right to pain management is respected.
- E. Pain assessments are consistent with the scope of care, treatment and services provided, and the patient's condition.
- F. Assessment methods used are consistent with the patient's age, condition, and ability to understand.
- G. Reassessment criteria are used to evaluate and respond to the patient's pain.
- H. Risk reduction strategies include, but are not limited to, staff education, training and competency assessment; use of evidence-based clinical guidelines/protocol/order sets; implementation of opioid-specific high-risk/high alert medication safeguards; requirements for second level review; evaluation of morphine milligram equivalents (MME), standardized tools for screening patients for risk factors; patient/family education.
- I. Opioid-related incidents are tracked and analyzed for quality assurance performance improvement.

VII. DEFINITIONS: None.

VIII. RESPONSIBILITIES:

- A. The Hospital's pain management program will be responsible for pain management and safe opioid prescribing including the development and monitoring of performance improvement activities.
- B. Pain assessment and management, including safe opioid prescribing, is an organizational priority.

- C. **All Staff Responsibility:**
1. Supporting the use of non-pharmacological treatment modalities as treatment options.
 2. Providing 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 the its patient population.
 3. Providing information to staff and licensed independent practitioners on available services for consultation and referral of patients with complex pain management needs.
 4. Facilitating practitioner and pharmacist access to the Prescription Drug Monitoring Program (PDMP) database(s).
- D. **Licensed Independent Practitioner Responsibilities:** The licensed independent practitioner is actively involved in pain assessment, pain management, and safe opioid prescribing to include:
1. Participating in the establishment of protocols and quality metrics (structure, process, outcomes).
 2. Determining duration of opioid pain management therapy with a stop date ≤ 30 days.
 - a. See Patient Assessment/Monitoring of Opioid Therapy.
 3. Specify specific etiology of pain (e.g., “Lower back pain” and not “generalized pain”).
- E. **Pharmacy Responsibilities:** The pharmacist’s role is integrated into a system-wide pain assessment and management plan.
1. Verify each analgesic order has associated indication for specific etiology of pain.
 2. Determine if each admitted patient is opioid tolerant or naïve by means of Montana Prescription Drug Registry (MRDR).
 3. Communicate with staff and licensed independent practitioners regarding opioid analgesic therapies and potential alternatives.
 4. Ensuring each opioid medication order has stop date ≤ 30 days after the written date of order.
 5. Opioid use is monitored to determine if they are being utilized safely.
- F. **Nursing Responsibilities:**
1. Nurses are responsible for managing pain, notifying providers of changes to the patient and documenting on the Pain Flow Sheet form.
 2. MSH nursing staff will follow the **MSH Nursing Procedure: *Vital Signs and Pain Assessment*** for patients receiving opioid pain management therapy.

IX. PROCEDURE:

- A. To minimize the risk of adverse events, abuse and addiction, evidence-based prescribing practices are to be used when treating acute and chronic pain with opioids.
- B. The patient’s pain is treated, or the patient is referred for treatment.

- C. Assessment methods used are consistent with the patient's age, condition, and ability to understand.
- D. Opioids are used only when benefits are likely to outweigh risks.
- E. Start with the lowest effective dose of immediate-release opioids. For acute pain, prescribe only the number of days the pain is expected to be severe enough to require opioids.
- F. Medical providers with knowledge of patient pain will assess patient and recommend proper pain relief through medicinal, interventional or diversional means.
- G. The licensed independent practitioner is actively involved in pain assessment, multimodal pain management and safe opioid prescribing.
- H. Pain assessments are consistent with the scope of care, treatment and services provided, and the patient's condition.
- I. Pain assessment shall be conducted before and after each PRN opioid medication is administered. A post-administration assessment shall occur 30-90 minutes after opioid medication is administered. Assessments will be documented on the *MSH Pain Assessment & Opioid Use Tracking* sheet.
- J. Standardized tools are used to screen patients for risk factors associated with over-sedation and respiratory depression.
- K. Pulse oximetry may be used to monitor oxygenation. Pulse oximetry alone is not adequate to assess respiratory depression, especially in patients receiving supplemental oxygen.
- L. Monitoring is individualized according to patient response.
- M. Patients receiving end-of-life/palliative pain management are not subject to specific monitoring parameters and assessment criteria within this policy. Pain management needs in this patient population will be at the discretion of the licensed independent practitioner based on patient needs and disposition.
- N. Reassess benefits and risks if considering dose increases.
- O. Use state-based prescription drug monitoring programs (PDMPs) which help identify patients at risk of addiction or overdose.
- P. Overall pain control and status in patients receiving opioid pain management shall be evaluated/assessed by a licensed independent practitioner at intervals ≤ 30 days in duration.
- Q. To encourage reevaluation/assessment of opioid therapy, opioid pain medication orders shall be written to have a stop date ≤ 30 days after the written order date.
- R. If an individual order for an opioid is lacking a stop date, then the pharmacist on duty shall assign a stop date of 30 days past the written date to the order.
- S. Monthly MAR renewal shall not be considered an evaluation/assessment. Licensed independent practitioners will rewrite orders for specific opioid pain medications on triplicate order sheets if opioid therapy continuation is deemed appropriate.
- T. Flags and alerts are enabled in systems to screen for concomitant use of central nervous system (CNS) depressants (e.g., benzodiazepine, etc.) and other potential drug interactions.
- U. Assessment tools, dose conversion scales, and pain management protocols/order sets are evidence-based.

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- V. For chronic pain morphine milligram equivalents (MME) *may* be used to gauge risk of overdose potential.
- W. Employ a patient evaluation and risk stratification, including assessment of risk for substance abuse, misuse or addiction.
- X. Employ multimodal approaches to pain management; optimizing non-pharmacological and non-opioid therapies and psychotherapeutic co-interventions.

X. REFERENCES:

- A. The Joint Commission Standards LD.04.03.13, RI.01.01.01 EP 8, PC.01.02.07, MS.05.01.01 EP 18, PC.01.02.07, PI.01.01.01 EP 56, PI.02.01.01 EP18-19
- B. CMS Conditions of Participation § 482.23(c)(4), 482.25(b)(6), 482.21, 482.13(b)(1).
- C. Healthcare Facilities Accreditation Program (HFAP) 16.01.01, 16.01.06, 16.01.07, 12.00.01, 25.01.10,15.01.09.
- D. DNV National Integrated Accreditation for Healthcare Organization MM.1, PR.1 SR.11, NS.3, QM.7 SR.7.
- E. *TJC Sentinel Event Alert* Safe Use of Opioids in Hospitals, Issue 49, August 8, 2012 http://www.jointcommission.org/assets/1/18/SEA_49_opioids_8_2_12_final.pdf Accessed August 2017.
- F. *CDC Guidelines for Prescribing Opioids for Chronic Pain – United States 2016, Morbidity and Mortality Weekly Report, March 15, 2016* <http://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm> Accessed August 2017.
- G. *AHRQ: The Effectiveness and Risks of Long-Term Opioid Treatment of Chronic Pain* September 2014 <https://effectivehealthcare.ahrq.gov/topics/chronic-pain-opioid-treatment/research/> Accessed September 2017.
- H. CPS Clinical Pain Management Resources <https://apps.rxresourcesolutions.com/RxIntelnet/content.aspx?objectID=10175> Accessed August 2017.

XI. COLLABORATED WITH: Medical Director, Pharmacy, Director of Nursing.

XII. RESCISSIONS: None, new policy.

XIII. DISTRIBUTION: All hospital policy manuals.

XIV. ANNUAL REVIEW AND AUTHORIZATION: This policy is subject to annual review and authorization for use by either the Administrator or the Medical Director with written documentation of the review per ARM § 37-106-330.

XV. FOLLOW-UP RESPONSIBILITY: Director of Nursing.

XVI. ATTACHMENTS: None.

Signatures:

Kyle Fouts
Interim Hospital Administrator

Thomas Gray, M.D.
Medical Director