CE

Safe Opioid Prescribing for Adults by Nurse Practitioners: Part 1. Patient History and Assessment Standards and Techniques

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ABSTRACT

Using an opioid to treat pain is the last component in a sequence of events that are documented and inform the provider and the patient about treatment choices, responsibilities of each person, and consequences that could result if there is misuse. The prescribing process begins with a comprehensive history and multiple assessments that use risk assessment and other tools, urine drug tests, prescription reviews, informed consents, and patient provider agreements. Nurse practitioners have a professional responsibility to follow state and national guidelines for safe opioid prescribing to protect patients, the public and themselves if they become the subject of an investigation.

Keywords: drug abuse, misuse, opioid risk assessment, safe prescribing

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INTRODUCTION

Opioid misuse, divergence, and overdose are public health problems in the United States.[1,2] Increasing numbers of deaths each year are opioid related.[3] Evidence supports that more people use opioids for nonmedical reasons and become addicted.[4] Increasing numbers of patients are seen in emergency departments with some level of opioid misuse.[5] Outpatient clinics report increased numbers of patients seeking pain medications for multiple issues.[6] More hospitals offer inpatient pain services to manage complex patients who are

This CE learning activity is designed to augment the knowledge, skills, and attitudes of nurse practitioners and assist in their understanding of history and assessment of the adult prior to opioid prescribing.

At the conclusion of this activity, the participant will be able to:

A. Describe components implementation/treatment management phases leading to opioid prescribing
B. Discuss nationally vetted standards of care specific to pain management and ongoing opioid prescribing
C. Evaluate ongoing use of pain rating scales, opioid abuse risk assessment tools, urine drug tests, prescription drug monitoring programs, informed consent and patient provider agreements when treating patients with opioids

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The author do not present any off-label or non-FDA-approved recommendations for treatment.

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admitted for surgical or other interventions and who also have substance-abuse issues.

Evidence shows that > 50% of opioid prescriptions are written by primary care providers, including certified nurse practitioners (CNPs).[7] Opioid prescribing is complex and both professional organizations and regulatory authorities have demonstrated interest in formulating prescribing standards and implementing safeguards to protect patients and the public from misuse and adverse outcomes. The purpose of this study is to provide CNPs with an overview of the current nationally vetted pain management and opioid-prescribing standards. A further aim is to present techniques and recommendations based on best practice experiences so that CNPs can assimilate them into practice for safe opioid prescribing and for protection of their own practice should they become the subject of a regulatory investigation. Treating pain patients is separated into 4 processes: (1) obtaining a comprehensive history; (2) using multiple assessment techniques; (3) implementing treatment; and (4) managing ongoing care. This part of the study (Part 1) details obtaining a comprehensive history and using multiple assessment techniques.

Common problems faced by clinicians are limited formal pain management education, a lack of familiarity using opioid misuse risk assessment tools, and a lack of awareness of techniques to mitigate opioid misuse when prescribing.[8] Skill development is sporadic and is often based on the provider's own experiences learned by trial and error or the experiences of peers, who also lack formal pain education. Because this concern was widely identified, national organizations have implemented efforts to develop position papers and formal pain curricula, including the American Society for Pain Management Nursing.[9,10] The National Institutes of Health Pain Consortium has begun a pain curriculum development process utilizing selected centers of excellence.[11] The US Food and Drug Administration's blueprint specific to extended-release and long-acting opioid analgesic management has been developed and implemented to impact provider education.[12]

Being knowledgeable about the nationally vetted standards of care and safeguards for treating patients with opioids is the professional responsibility of the CNPs who prescribe opioids.[13] Treatment begins with a comprehensive patient history that includes information specific to pain. The traditional physical assessment component should also include a pain evaluation. Assessments need to include formal opioid misuse risk tools, reviewing patient-specific profiles from state boards of pharmacy prescription drug monitoring programs (PDMPs), obtaining and assessing past records from other providers, and performing urine drug tests (UDTs). Having referral relationships in place for specialized pain management care of complex patients, whose needs may exceed the experience or comfort level of the provider, all serve to safeguard the patient and the public from harm and to positively impact the reduction of opioid misuse as a national health problem.

BACKGROUND

Understanding basic pain concepts can facilitate more effective patient specific pain management interventions. Clear definitions enhance effective communication between health care workers, patients, regulators, and the public.[14] Addiction fear is concerning to both patients and CNPs and much research about opioid use and its implications was generated over the past 2 decades.[15] An outcome has been clearer definitions and understanding about conditions related to opioid use such as: tolerance; physical dependence; psychological dependence; pseudoaddiction; and addiction.

Tolerance is not addiction. Tolerance exists when the expected and historic response to a drug is no longer achieved at the same dosage levels and increases become necessary. The patient presentation is focused on wanting more drugs because they are not pain-free due to physical adaptation at the current dose level. Health care professionals at all levels commonly see this as drug-seeking behavior.[16]

Physical dependence is a state of adaptation whereby the body functions normally only with the drug and withdrawal is manifested when the drug is removed. Dependent situations can occur with or without an addiction.[17]

Psychological dependence is related to using something because its ingestion becomes associated with the alleviation of mental duress, such as anxiety, depression, or other emotionally uncomfortable