CE

Safe Opioid Prescribing for Adults by Nurse Practitioners: Part 2. Implementing and Managing Treatment

Randall Steven Hudspeth, PhD, CNS/CNP

ABSTRACT

Opioid use for treating pain is based on a thorough pain-focused history and assessment and begins as a trial. It continues with ongoing monitoring using intermittent risk assessments, urine drug tests, prescription drug monitoring reports, informed consents, and patient provider agreements. These inform providers and patients about treatment choices, responsibilities of each person, and consequences that could result if misuse occurs. Nurse practitioners have a professional responsibility to follow state and national guidelines and to be aware of best practices 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

Randall Steven Hudspeth, PhD, CNP, FAANP, is a practice consultant at RHudspeth Consulting in Boise, ID, and can be reached at raning2@msn.com. In compliance with national ethical guidelines, the author reports no relationships with business or industry that would pose a conflict of interest.

Part 1 of this 2 article series focused on the techniques that a certified nurse practitioner (CNP) should use during the history and assessment phases when information is gathered leading to a decision whether or not to treat a patient with opioids.[1] Based on this information and the results from an opioid risk assessment tool and a urine drug test (UDT), a decision is then made regarding

This CE learning activity is designed to augment the knowledge, skills, and attitudes of nurse practitioners and assist in their understanding of prescribing and treatment of patients requiring opioids.

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.

The author, reviewers, editors, and nurse planners all report no financial relationships that would pose a conflict of interest.
The author do not present any off-label or non-FDA-approved recommendations for treatment.

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further treatment and what that treatment and its parameters should be.

Part 2 focuses on implementing treatment and managing ongoing care. It further provides CNPs with an overview of the current nationally vetted pain management and opioid prescribing standards. Best practice techniques and recommendations based on practice experiences are presented so that the CNP can assimilate them into practice, resulting in safe opioid prescribing as well as protecting their own practice should they become the subject of a regulatory investigation.

USING NATIONAL STANDARDS: IMPLEMENTING TREATMENT WITH OPIOIDS

Decisions to implement treatment with opioids are major junctures in the therapeutic continuum. They rely on assessments that the patient is willing to comply with treatment parameters, and they imply a provider commitment based on pain education and experience.[2,3] Having an abuse history or scoring high risk on a formal misuse risk assessment tool does not prohibit treatment with opioids. It does indicate that closer monitoring is necessary for patient and public safety and that a referral to a pain or addiction specialist should be considered. In patients with a history of substance abuse or those having a psychiatric comorbidity, it becomes especially important for the CNP to consider referring the patient to an expert for treatment, and a decision to refer or not to refer needs to be fully explained in the documentation.[4,5]

When a thorough history and assessment are complete and the decision to proceed with treatment using an opioid trial is made, both the informed consent and the patient and provider agreement (PPA) should be completed before the initial prescription is issued.[6-8] The first step in implementing treatment is completing an informed consent signed by both the patient, or guardian or authorized representative, and the provider. The informed consent identifies the opioid to be prescribed, its potential benefits against risks, and the functional goals of treatment. Opioid treatment benefits include obtaining a level of analgesia so that activities of daily living can be maintained and in some cases advanced to a level that might not otherwise have been tolerable. The risks can be many and include overdose; life-threatening respiratory depression; developing physical dependence or tolerance; drug interactions; the risk of neonatal withdrawal syndrome if the patient is pregnant; inadvertent ingestion by children or others; and drug misuse or abuse by the patient, household contacts, or friends. Because there can be varying benefits and risks with different medicines, a best practice is to specify the medication and update the informed consent when there is a medication change or a rotation to a different medication family.[6]

After an informed consent is completed, establish a PPA. PPAs were formerly referred to as treatment contracts, and they are different documents than informed consents.[7] The PPA is signed by both the patient and provider. Sometimes a family member or other responsible person who will have monitoring or administration responsibility in the home setting must also sign the PPA. As a means of patient education, the PPA informs the patient and family about responsibilities, risks, and expected behaviors and identifies consequences for noncompliance. Importantly, the PPA also gives the provider an exit strategy should stopping treatment become necessary.[7,8]

National recommendations for PPA content are that patients will only use 1 pain medication prescriber, will only use 1 pharmacy, will safeguard medications at home in secure or locked cabinets, will not share medications, will comply with ongoing monitoring requirements such as random UDT and pill counts, and will notify the pain management provider if there are treatments by other providers or emergency department visits for pain-related issues. Template PPAs are available from professional organizations, but many providers use individualized forms developed by their legal counsels that are based on elements of the template PPAs.[7]

The initial opioid prescription should be considered as a trial for a specified time period and should have established guidelines and treatment goals.[5,9] Decision considerations include the potential benefits being likely to outweigh the risks, the probability exists that longer-term opioid use will be necessary, the pain is defined as acute short-term or as chronic long-term, and no alternative therapy has been successful or is as likely to improve functional status as an opioid trial.[10] Because misuse, divergence, and overdose have been