Complete each field below to assess your organization’s commitment to preventing opioid ADEs. Download the [Plan-Do-Study-Act Worksheet](https://hqin.org/resource/plan-do-study-act-worksheet/) to assist in your improvement efforts.

| **What are your program strengths?** | | | |
| --- | --- | --- | --- |
| **What areas need improvement?** | | | |
| **Are you willing to commit to implementing or reviewing your existing huddle process**  **with direct care staff?** | | | |
| **Question**  ***(Check the “Y” and/or “NI” box(es) to designate***  ***Yes and if the area Needs Improvement)*** | **Y** | **NI** | **Comments** |
| Is there an assessment and determination of pain etiology? |  |  |  |
| Does the resident’s pain management regime address the underlying etiology? |  |  |  |
| For a change in mental status is there evidence that a physician conducted an evaluation of the underlying cause, including medications? |  |  |  |
| Is there a system for ensuring that residents are routinely assessed for pain, including monitoring for effectiveness or pain relief and side effects of medication (e.g., over-sedation, constipation)? |  |  |  |
| If receiving PRN and routinely, is there consideration for the timing of administration of the PRN? |  |  |  |
| Can staff describe signs/symptoms of over sedation? |  |  |  |
| Is there a system for ensuring “hand off” communication that includes the resident’s pain status and time of last dose? |  |  |  |
| Do the resident, family, and direct caregivers know signs and symptoms of over-sedation and steps to take if noted (e.g., alert the nurse)? |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Question**  ***(Check the “Y” and/or “NI” box(es) to designate***  ***Yes and if the area Needs Improvement)*** | **Y** | **NI** | **Comments** |
| Do staff implement and document non-pharmacological pain management approaches consistently including prior to administering a prn? |  |  |  |
| Is there a system to ensure extended-release formulations are delivered correctly (e.g., medications not crushed)? |  |  |  |
| Is a bowel regimen in place such as routine orders for stool softener/laxative? |  |  |  |
| For residents with risk factors for constipation does the care plan reflect interdisciplinary monitoring for signs and symptoms of constipation and a plan to prevent it including dietary management? |  |  |  |
| Is fluid intake monitored? |  |  |  |
| Are residents/families taught signs/symptoms of constipation and the importance of reporting them? |  |  |  |
| Are bowel movements (frequency and size) monitored routinely by nursing staff? |  |  |  |
| Is bowel status routinely addressed by the physician? |  |  |  |
| Upon initiation of opioids, does the prescriber acknowledge the increased risk of constipation and adjust the plan of care as indicated? |  |  |  |
| Is there a protocol in place to address constipation (e.g., a process to provide routine or standing order bowel medications when a resident hasn’t had a bowel movement? If so, are staff aware of and compliant with the protocol? |  |  |  |
| Does the clinical record reflect the dietician was made aware of an opioid being ordered so that nutritional approaches to prevent constipation could be considered? |  |  |  |

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