Self-Check Tool: Opioid Prescribing

Initial assessment by: _____

Date: _____

In consultation with: _____

_____

_____

Date of previous assessment: _____

This self-check tool is intended to help acute care organizations evaluate and improve the safety of opioid prescribing. Although some questions may be answered by referring to written policies and procedures, automated or triggered electronic reports, manual or electronic chart review, departmental logs or reports, or other records, others may call for methods such as observation, surveys, or interviews with providers, staff, or patients.

General Opioid Safety Practices

	Yes	No	N/I*	N/A	Comments
1. Do the organization's leaders, senior administrators, and managers demonstrate a commitment to:					
a. medication safety and opioid safety by setting goals?	☐	☐	☐	☐	
b. modeling expectations?	☐	☐	☐	☐	
c. allocating appropriate resources for goal achievement?	☐	☐	☐	☐	
2. Is prescribing data shared regularly with prescribers, comparing prescribing patterns to their peers and benchmarks?	☐	☐	☐	☐	

Patient Assessment

3. Are all hospitalized patients comprehensively assessed for pain and risk factors for opioid-related adverse events:

* N/I stands for "Needs Improvement"

	Yes	No	N/I*	N/A	Comments
a. before admission, whenever possible?	☐	☐	☐	☐	
b. on admission?	☐	☐	☐	☐	
c. at discharge?	☐	☐	☐	☐	
3. Has the organization clearly defined expectations for checking available prescription drug monitoring programs (PDMPs) before ordering opioids?	☐	☐	☐	☐	
4. For patients who are already taking opioids, does medication reconciliation include determining not just what medications have been prescribed for patients but also a clinical determination of right drug and right dose?	☐	☐	☐	☐	
5. Is a daily MME calculation completed to assess the overdose risk? (MME=Morphine Milliequivalent Estimate)	☐	☐	☐	☐	
6. Does patient assessment include evaluation of risk factors for opioid-related adverse events, including older age, obstructive sleep apnea (OSA), kidney or liver impairment, and opioid allergies or sensitivities?	☐	☐	☐	☐	
7. Does the patient assessment include consideration of the patient's past or family history of alcohol or drug abuse prior to prescribing medications?	☐	☐	☐	☐	

8. When assessing patients' pain, do clinicians consider:

	Yes	No	N/I*	N/A	Comments
a. the location, onset, frequency, nature (e.g., dull, shooting), and intensity of pain?	☐	☐	☐	☐	
b. the impact of pain on issues such as function, sleep, and emotional distress?	☐	☐	☐	☐	
c. factors that make the pain better or worse or treatments that have worked for the patient in the past?	☐	☐	☐	☐	
9. Does your EHR have a tool to aid assessment and documentation of patient conditions, risk factors, and history related to the use of opioids?	☐	☐	☐	☐	

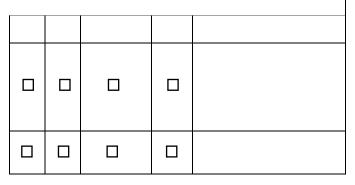|	Yes	No	N/I*	N/A	Comments
10. When a patient is identified as being at high risk for opioid-related adverse events, is that risk effectively communicated across the continuum of care?	☐	☐	☐	☐	

Patient Education

	Yes	No	N/I*	N/A	Comments
11. Do clinicians ask patients about their expectations regarding pain, goals for pain management (including functional goals, not just goals regarding pain intensity), and preferences?	☐	☐	☐	☐	
12. Are alternative pain management programs discussed/shared?	☐	☐	☐	☐	

13. Do clinicians educate patients and family members about:

	Yes	No	N/I*	N/A	Comments
a. pain management?	☐	☐	☐	☐	
b. the patient's risk for opioid-related adverse events?	☐	☐	☐	☐	
c. potential risks and benefits of opioid use in the hospital?	☐	☐	☐	☐	
d. how to safely use patient-controlled analgesia (PCA), if prescribed?	☐	☐	☐	☐	
e. potential risks of addiction / physical dependance / withdrawal?	☐	☐	☐	☐	
f. safe and secure storage of opioids in the home?	☐	☐	☐	☐	
g. how to safety dispose of any unused medication?	☐	☐	☐	☐	
h. risk factors in the home, including drug dependent family members and family history of addiction?	☐	☐	☐	☐	

Care Planning

14. During the patient's hospital stay:

	Yes	No	N/I*	N/A	Comments
a. do clinicians adjust therapy as needed in preparation for discharge (e.g., by tapering opioid therapy, by transitioning to other routes of administration or modalities)?	☐	☐	☐	☐	
b. coordinate with outpatient prescribers as needed?	☐	☐	☐	☐	

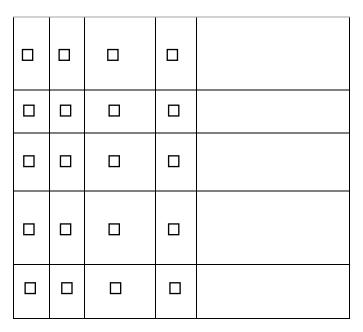|	Yes	No	N/I*	N/A	Comments
15. Has the organization evaluated the MME of opioid medications that are prescribed for patients at discharge for several common conditions?	☐	☐	☐	☐	

16. At discharge, do staff discuss with patients and families:

	Yes	No	N/I*	N/A	Comments
a. the plan of care for pain management?	☐	☐	☐	☐	
b. how and when to take prescribed medications?	☐	☐	☐	☐	
c. the importance of avoiding other substances (e.g., nonprescription medications, alcohol) while taking opioids without first checking with the physician or pharmacist?	☐	☐	☐	☐	
d. medication side effects?	☐	☐	☐	☐	
e. activities of daily living that could exacerbate pain and corresponding mitigation strategies?	☐	☐	☐	☐	
f. medication storage and disposal or take-back?	☐	☐	☐	☐	
17. Do clinicians consider prescribing naloxone at discharge to patients at risk for life-threatening respiratory depression, prescribed >= 50 MME per day or overdose?	☐	☐	☐	☐	

Therapy Selection and Dosing

	Yes	No	N/I*	N/A	Comments
18. Do prescribers have easy access to relevant clinical nationally accepted Standards of Care and institutional guidelines for pain management?	☐	☐	☐	☐	
19. Is clinical decision support consistent with those guidelines?	☐	☐	☐	☐	
20. Has the organization limited the variety and standardized the options for opioid therapy in their formulary?	☐	☐	☐	☐	
21. Does the organization have a pharmacist review the standardized options at regular intervals to ensure any appropriate updates are included?	☐	☐	☐	☐	
22. Does the organization educate prescribers and offer clinical tools to support safe selection and dosing of	☐	☐	☐	☐	

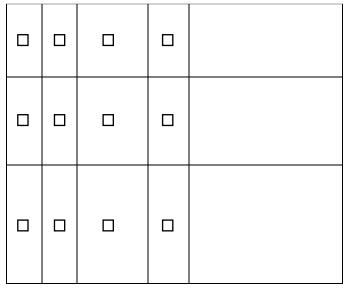|	Yes	No	N/I*	N/A	Comments
opioid therapy, such as clinical decision support alerts and population-specific institutional guidelines approved by the medical staff?					
23. Does the organization routinely evaluate opioid policies and order sets to help ensure that orders are written clearly and unambiguously	☐	☐	☐	☐	
24. Are validated opioid conversion tools (e.g., equianalgesic dosing calculators or tables) readily available to prescribers?	☐	☐	☐	☐	
25. Has the organization implemented strategies to address confusion regarding appropriate dosing of hydromorphone, such as					
a. addressing hydromorphone dosing in the formulary,	☐	☐	☐	☐	
b. institutional guidelines, and order sets;	☐	☐	☐	☐	
c. considering the availability and locations of product options in automated dispensing cabinets;	☐	☐	☐	☐	
d. monitoring for inappropriate prescribing; and	☐	☐	☐	☐	
e. providing education and coaching?	☐	☐	☐	☐	

Order Sets

	Yes	No	N/I*	N/A	Comments
26. Do order sets include options for nonpharmacologic pain management and nonopioid pain medications when appropriate?	☐	☐	☐	☐	
27. Do order sets list criteria for adjusting the dose based on kidney impairment or age or contain an order for consultation (e.g., with pharmacy) for such adjustments?	☐	☐	☐	☐	
28. Do order sets indicate monitoring modalities that should be used (e.g., specific sedation scale, daily MME monitoring, specific continuous monitoring modality) and the drugs needed to reverse oversedation (e.g., naloxone)?	☐	☐	☐	☐	

	Yes	No	N/I*	N/A	Comments

PRN (As Needed) Therapy and Range Orders

	Yes	No	N/I*	N/A	Comments
29. If the organization has determined that range orders are acceptable, do pain assessment policies and the electronic health record list both subjective measures (e.g., pain intensity) and objective measures (e.g., patient age, comorbidities, response to previous treatments, use of other sedating medications, sedation level, respiratory status, and daily MME level) for prescribers and nurses to consider before they prescribe or administer opioids?	☐	☐	☐	☐	

Clinical Decision Support

	Yes	No	N/I*	N/A	Comments
30. Is the patient's opioid-naïve or opioid-tolerant status clearly visible to users in the patient's chart, during ordering, and during pharmacist review?	☐	☐	☐	☐	

31. Does the clinical decision support system flag:

	Yes	No	N/I*	N/A	Comments
a. factors that put patients at particularly high risk for opioid-related adverse events (e.g., OSA, kidney or liver impairment, older age)?	☐	☐	☐	☐	
b. duplicate opioid therapy?	☐	☐	☐	☐	
c. ordering of long-acting opioids for acute pain?	☐	☐	☐	☐	
d. ordering of PCA basal infusion rates?	☐	☐	☐	☐	
e. ordering of opioids to which the patient has documented allergies or sensitivities?	☐	☐	☐	☐	
f. potentially dangerous medication interactions (e.g., opioids and benzodiazepines)?	☐	☐	☐	☐	
g. doses of opioids and acetaminophen that exceed predetermined maximums?	☐	☐	☐	☐	
h. daily MME doses > 90?	☐	☐	☐	☐	

	Yes	No	N/I*	N/A	Comments

Order Review and Consultation

32. Does the organization promote consultation with pharmacists or specialists when:

	Yes	No	N/I*	N/A	Comments
a. switching opioids?	☐	☐	☐	☐	
b. changing the route of administration?	☐	☐	☐	☐	
c. prescribing for patients with impaired kidney or liver function?	☐	☐	☐	☐	
d. treating patients with complex pain needs (e.g., acute on chronic pain, pain that is difficult to control)?	☐	☐	☐	☐	
e. treating patients with substance use disorder?	☐	☐	☐	☐	
f. treating patients who are currently taking buprenorphine or methadone (for treatment of a substance use disorder or for chronic pain management)?	☐	☐	☐	☐	
g. treating patients with implanted medication delivery systems?	☐	☐	☐	☐	
h. pharmacist consultation with MME daily dosing >90?	☐	☐	☐	☐	

Following are some of the sources used to develop the questions in this tool. This list is not comprehensive.

American Society of Anesthesiologists:

Practice guidelines for acute pain management in the perioperative setting: an updated report by the American Society of Anesthesiologists Task Force on Acute Pain Management. Anesthesiology 2012 Feb;116(2):248-73. http://www.asahq.org/~/media/Sites/ASAHQ/Files/Public/Resources/standards-guidelines/practice-guidelines-for-acute-pain-management-in-the-perioperative-setting.pdf PubMed: https://www.ncbi.nlm.nih.gov/pubmed/22227789

Practice guidelines for the perioperative management of patients with obstructive sleep apnea: an updated report by the American Society of Anesthesiologists Task Force on Perioperative Management of Patients with Obstructive Sleep Apnea. Anesthesiology 2014 Feb;120(2):268-86. http://www.asahq.org/~/media/Sites/ASAHQ/Files/Public/Resources/standards-guidelines/practice-guidelines-for-the-perioperative-management-of-patients-with-obstructive-sleep-apnea.pdf PubMed: https://www.ncbi.nlm.nih.gov/pubmed/24346178

American Society of Anesthesiologists, American Society of Regional Anesthesia and Pain Medicine. Practice guidelines for the prevention, detection, and management of respiratory depression associated with neuraxial opioid administration: an updated report by the American Society of Anesthesiologists Task Force on Neuraxial Opioids and the American Society of Regional Anesthesia and Pain Medicine. Anesthesiology 2016 Mar;124(3):535-52. http://www.asahq.org/~/media/Sites/ASAHQ/Files/Public/Resources/standards-

guidelines/practice-guidelines-for-the-prevention-detection-and-management-of-respiratory-depression.pdf
PubMed: https://www.ncbi.nlm.nih.gov/pubmed/26655725

CDC. About CDC's Opioid Prescribing Guideline. 16 Mar 2023 [cited 21 Aug 2023].
https://www.cdc.gov/opioids/healthcare-professionals/prescribing/guideline/index.html

Chou R, Gordon DB, de Leon-Casasola OA, et al. Management of postoperative pain: a clinical practice
guideline from the American Pain Society, the American Society of Regional Anesthesia and Pain Medicine, and
the American Society of Anesthesiologists' Committee on Regional Anesthesia, Executive Committee, and
Administrative Council. J Pain 2016 Feb;17(2):131-57. http://www.jpain.org/article/S1526-
5900%2815%2900995-5/abstract PubMed: https://www.ncbi.nlm.nih.gov/pubmed/26827847

Drew D, Gordon D, Morgan B, et al. American Society for Pain Management Nursing, American Pain Society. A
position statement on the use of "as-needed" range orders for opioid analgesics in the management of pain.
2018 June [cited 2021 Jun 11]. http://www.aspmn.org/Documents/Position%20Statements/As-
Needed_Range_Orders_for_Opioid_Analgesics_in_the_Management_of_Pain_Consensus_Statement_of_ASP
MN_and_APS.pdf

Institute for Safe Medication Practices:

> ISMP's guidelines for standard order sets. 2010 [cited 2021 Jun 11].
> http://www.ismp.org/tools/guidelines/standardordersets.pdf

Jarzyna D, Jungquist CR, Pasero C, et al. American Society for Pain Management Nursing guidelines on
monitoring for opioid-induced sedation and respiratory depression. Pain Manag Nurs 2011 Sep;12(3):118-
45.e10. http://www.aspmn.org/documents/GuidelinesonMonitoringforOpioid-
InducedSedationandRespiratoryDepression.pdf PubMed: https://www.ncbi.nlm.nih.gov/pubmed/21893302

Joint Commission:

> Prepublication requirements: standards revisions related to pain assessment and management. 2017
> Jun 19 [cited 2021 Jun 11].
> https://www.jointcommission.org/assets/1/18/HAP_Pain_Jan2018_Prepub.pdf

> Safe use of opioids in hospitals. Sentinel Event Alert 2012 Aug 8;(49):1-5.
> https://www.jointcommission.org/sea_issue_49/

Pasero C, Quinlan-Colwell A, Rae D, et al. Prescribing and administering opioid doses based solely on pain
intensity: a position statement by the American Society for Pain Management Nursing. Pain Manag Nurs 2016
Oct;17(5):291-2. http://www.aspmn.org/Documents/Position%20Statements/Dose_Numbers_PP_Final.pdf
PubMed: https://www.ncbi.nlm.nih.gov/pubmed/27663218

Society of Hospital Medicine. Frederickson TW, Gordon DB, De Pinto M, et al., eds. Reducing adverse drug
events related to opioids (RADEO): implementation guide. 2015 [cited 2017 Jun 6].
https://www.hospitalmedicine.org/clinical-topics/opioid-safety/

Action Plan

Assessment Completed By: _____ Date: _____

Question No.	Action Required	Responsibility	Target Date	Action Completed	
				Date	Initials

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				Date	Initials