Inpatient Management of Potential Opioid Abuse and Diversion

Goal
Identify hospitalized patients who have or are at risk of aberrant medication behaviors (i.e. “cheeking” pills or diverting medications) so all team members can be made aware and appropriate interventions can be implemented. It is a guidance document only, and is intended to increase patient safety and not to limit patient care.

Key Aspects of Care
- Patients who have a history of drug abuse in the community may be considered for Level 1 interventions when appropriate to reduce risk of inpatient abuse or diversion.
- Level 2 interventions are intended for patients who demonstrate drug abuse or diversion while hospitalized. When “At Risk for Abuse of Opiates” is added to the problem list, it will trigger a BPA on subsequent hospitalizations.

Risk Factors for Inpatient Aberrant Behaviors

Note: The risk factors outlined below are not an exhaustive list and only intended to supplement clinical judgment/suspicion as well as OARRS report information.

Physical Findings
- Track marks
- Acute diagnosis for drug abuse (e.g., Endocarditis or Superficial abscesses)
- Nasal septum atrophy
- Symptoms of withdrawal

History of
- IV drug use in past 90-days
- Recent prescription opioid abuse
- Other drug abuse

Behaviors
- Report of controlled substance use inconsistent with prior documentation in the medical record or with Ohio Automated Rx Reporting System (OARRS).
- Double-doctoring or prescription shopping.
  - Received opioid prescriptions from ≥ 5 clinicians in past 90-days.
- Use of pain medications without a prescription in past 90-days.
- Violation of Patients Leaving Units Policy.
- Excessive fixation on medication administration:
  - Keeping track of time.
  - Continuously asking for additional medication.
  - Demanding a certain route of medication administration.
  - Claim to be allergic to all medications other than one requested.
  - Rapidly escalating controlled substance dose requirements

Laboratory Findings
- Toxicology Screen Urine – UDRG on admission confirms presence of illicit drugs.
  - See Appendix A for additional guidance on potential urinary analytes.

Identified Inpatient Abuse or Diversion
Signs of potential drug abuse or diversion occurring during hospitalization include the following:
- Tampering with needle box or pain pumps (IV settings).
- Tampering with his/her IV access.
- Suspicion of visitor supplying drugs of abuse.
- Witnessed diversion or “cheeking” of pain medication
- Abusing non-hospital administered opiates or other drugs while admitted
- Unexplained altered mental status
- Leaving floor without RN approval
- UDRG during hospitalization confirms presence of illicit or non-prescribed medication (see Appendix A)

Level 1 Interventions
- Level 1 interventions are preliminary preventative interventions that may be considered if there is risk for potential aberrant behaviors:

<table>
<thead>
<tr>
<th>Level 1 Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinician converts pills to liquid or RN to crush pills</td>
</tr>
<tr>
<td>See Appendix B for formulary options for opioids</td>
</tr>
<tr>
<td>RN directly observes the patient taking and swallowing medication with possible oral check</td>
</tr>
<tr>
<td>Additional toxicology screens as indicated</td>
</tr>
<tr>
<td>Identification of a prescribing clinician that can be contacted prior to discharge or taper</td>
</tr>
<tr>
<td>Social Work consult for addiction, if appropriate</td>
</tr>
<tr>
<td>See Appendix C – At Risk Population Leaving the Unit Algorithm</td>
</tr>
</tbody>
</table>
Level 2 Interventions

- Level 2 interventions are recommended if there is high clinical suspicion or documentation of drug abuse or diversion that occurred while hospitalized.

Level 2 Interventions

- In order to appropriately monitor these patients on subsequent hospitalizations, add “At Risk for Abuse of Opiates” to the problem list (ICD-10 code Z91.89).
- In the Overview section, narrate the witnessed or suspected behavior and the date of the event.
- You may choose to click off the “Share w/Pt” box if desired.
- Addition of this problem to the problem list will trigger BPA on future hospitalizations.
- Preliminary interventions, if not already done,
- Removal of needle box and room check to ensure all controlled substances are properly secured.
- Security search of room/belongings.
- Patient room moved closer to nurse’s station and door left open.
- Application of tamper prevention seals on all IV ports.
- Limit visitors and off unit privileges. Please refer to Appendix C and Patients Leaving Units Policy for further guidance.
- Use Inpatient Opioid Treatment Agreement if opioids are to be continued.
- Consider sitter.
- Standardization of interventions once drug diversion behaviors have been suspected or documented:
  - Multidisciplinary meeting to establish agreed upon plan of care.
  - Documentation of agreed upon plan of care including patient specific goals and interventions.
- Multidisciplinary communication of plan of care with patient/patient family including:
  - Verbalization of expectations of behavior including what is and what is not permissible.
  - Consequences of unacceptable behaviors or actions.

Documentation and Communication

- Standardized place to document in medical record such as social history section and discharge summary.
  - Please see Documentation (Electronic) of the Nursing Process in IHIS.

Pain Management (History of Opioid Abuse)

- Patients with a history of opioid abuse may require—and should receive—opioids when clinically indicated. These patients may require higher doses due to opioid tolerance.
- Change IV medications to oral as soon as medically indicated.
  - Consider use of oral liquid or crushed tablets to prevent diversion or hoarding.
- Avoid administering prn and scheduled pain medications at the same time.
  - Avoid prescribing benzodiazepines and diphenhydramine with opioids.
  - In select circumstances (e.g. patients previously appropriately prescribed and taking long-acting opioids), a combination of prn and scheduled dosing may be appropriate.
- Employ non-pharmacological comfort measures such as:
  - Repositioning.
  - Heating or cooling.
  - Distraction.
- Employ non-opioid pharmacologic therapies as appropriate.
  - Examples include:
    - Acetaminophen.
    - Nonsteroidal anti-inflammatories.
- For additional information on pain management please see OSUWMC Pain Management and OSUWMC Pain Management (Nursing) Policy.

Discharge Planning

- Review OARRS report prior to patient discharge if prescribing opiates.
- Identify prescribing physician that can be contacted prior to patient discharge.
- Consider prescription to only include pain medication up through the patient’s next appointment OR
- Consider discharge prescriptions with instructions to taper opioids off or to pre-hospitalization dose OR
- Consider NOT discharging the patient on controlled substances.
- Patient education:
- Risk of sharing needles and injecting.
- Community support networks.
- Consider pain contract.
- Consider risk – benefit of discharging with chronic IV access devices.
Resources

- IHIS Tip Sheet: Opioid Ordering Restrictions for Acute Pain
- IHIS Tip Sheet: Best Practice Advisory (BPA) for Patients At Risk for Opioid Abuse

Order Set

- OSU IP GEN: Medication Misuse Management [4624]

References


Guideline Authors

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Guideline Approved


Disclaimer: Clinical practice guidelines and algorithms at The Ohio State University Wexner Medical Center (OSUWMC) are standards that are intended to provide general guidance to clinicians. Patient choice and clinician judgment must remain central to the selection of diagnostic tests and therapy. OSUWMC’s guidelines and algorithms are reviewed periodically for consistency with new evidence; however, new developments may not be represented.

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Appendix A
Table 1. Potential Urinary Analytes for Patients Taking Opioids*

<table>
<thead>
<tr>
<th>Drug</th>
<th>Urinary Analytes</th>
<th>Additional Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heroin (diacetylmorphine)</td>
<td>• Codeine</td>
<td>• Heroin has a very short presence in urine (6-8 hours)</td>
</tr>
<tr>
<td></td>
<td>• Morphine</td>
<td>• Careful analysis is important</td>
</tr>
<tr>
<td></td>
<td>• 6-monoacetylmorphine</td>
<td></td>
</tr>
<tr>
<td>Codeine</td>
<td>• Codeine</td>
<td>• Morphine is a metabolite of codeine</td>
</tr>
<tr>
<td></td>
<td>• Morphine</td>
<td>• Hydrocodone is a minor metabolite of codeine</td>
</tr>
<tr>
<td></td>
<td>• Hydrocodone</td>
<td>• Consider Heroin as a potential source for unexpected presence</td>
</tr>
<tr>
<td>Morphine</td>
<td>• Morphine</td>
<td>• Hydromorphone is a minor metabolite of morphine</td>
</tr>
<tr>
<td></td>
<td>• Hydromorphone</td>
<td>• Codeine is present as an impurity in commercially manufactured morphine</td>
</tr>
<tr>
<td></td>
<td>• Codeine</td>
<td>• Consider Heroin as a potential source for unexpected presence</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>• Hydrocodone</td>
<td>• Hydromorphone is a metabolite of hydrocodone</td>
</tr>
<tr>
<td></td>
<td>• Hydromorphone</td>
<td>• 6-hydrocodol is a metabolite of hydrocodone and the stereoisomer of dihydrocodeine</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>• Hydromorphone</td>
<td></td>
</tr>
<tr>
<td>Oxycodone</td>
<td>• Oxycodone</td>
<td>• Oxymorphone is a metabolite of oxycodone</td>
</tr>
<tr>
<td></td>
<td>• Oxymorphone</td>
<td>• Hydrocodone is a potential impurity in commercially manufactured oxycodone preparations</td>
</tr>
<tr>
<td>Oxymorphone</td>
<td>• Oxymorphone</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Oxycodone</td>
<td>• Oxymorphone is a potential impurity in commercially manufactured oxymorphone preparations</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>• Norfentanyl</td>
<td>• Norfentanyl is a metabolite of fentanyl</td>
</tr>
<tr>
<td></td>
<td>• Fentanyl</td>
<td>• False negatives are possible with fentanyl when tested by UDRG (LC/MS/MS) at OSU labs.</td>
</tr>
<tr>
<td>Methadone</td>
<td>• Methadone</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Methadone metabolites</td>
<td></td>
</tr>
<tr>
<td>Buprenorphine</td>
<td>• Buprenorphine</td>
<td>• Buprenorphine unlikely to be detected by typical UDRG (LC/MS/MS) at OSU Lab due to high lowest limits of detection</td>
</tr>
<tr>
<td></td>
<td>• Norbuprenorphine</td>
<td>• Order “Buprenorphine, Urine Screen” for unexpected result and/or to ensure accurate compliance testing</td>
</tr>
</tbody>
</table>

NOTE: If questions regarding interpretation of results, please consider consult to pharmacist

Table 2. Urinary Analytes for Patients Taking Benzodiazepines*

<table>
<thead>
<tr>
<th>Drug</th>
<th>Urinary Analytes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lorazepam</td>
<td>• Lorazepam</td>
</tr>
<tr>
<td>Alprazolam</td>
<td>• Alprazolam</td>
</tr>
<tr>
<td>Diazepam</td>
<td>• Diazepam</td>
</tr>
<tr>
<td></td>
<td>• Nordiazepam</td>
</tr>
<tr>
<td></td>
<td>• Temazepam</td>
</tr>
<tr>
<td></td>
<td>• Oxazepam</td>
</tr>
<tr>
<td>Clonazepam</td>
<td>• Clonazepam</td>
</tr>
<tr>
<td></td>
<td>• 7-Aminoclonazepam</td>
</tr>
<tr>
<td>Temazepam</td>
<td>• Temazepam</td>
</tr>
<tr>
<td></td>
<td>• Oxazepam</td>
</tr>
<tr>
<td>Oxazepam</td>
<td>• Oxazepam</td>
</tr>
<tr>
<td>Triazolam</td>
<td>• Triazolam</td>
</tr>
<tr>
<td>idazolam</td>
<td>• Midazolam</td>
</tr>
</tbody>
</table>

*Adapted from *Dominion Diagnostics: Urinary Analytes for Patients Taking Opiate-based Medication.*
Appendix B

Table 1. OSUWMC Opioids per Formulary

<table>
<thead>
<tr>
<th>Crushable Tablets*</th>
<th>Opioid</th>
<th>Opioid Dose</th>
<th>Morphine Equivalent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hydrocodone w/ Acetaminophen (Norco®)</td>
<td>5 mg w/ acetaminophen</td>
<td>325 mg</td>
<td>5 mg</td>
</tr>
<tr>
<td></td>
<td>7.5 mg w/ acetaminophen</td>
<td>325 mg</td>
<td>7.5 mg</td>
</tr>
<tr>
<td></td>
<td>10 mg w/ acetaminophen</td>
<td>325 mg</td>
<td>10 mg</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>2 mg</td>
<td>10 mg</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4 mg</td>
<td>20 mg</td>
<td></td>
</tr>
<tr>
<td></td>
<td>8 mg</td>
<td>40 mg</td>
<td></td>
</tr>
<tr>
<td>Morphine</td>
<td>15 mg</td>
<td>15 mg</td>
<td></td>
</tr>
<tr>
<td></td>
<td>30 mg</td>
<td>30 mg</td>
<td></td>
</tr>
<tr>
<td>Oxycodone HCl</td>
<td>5 mg</td>
<td>7.5mg</td>
<td></td>
</tr>
<tr>
<td></td>
<td>15 mg</td>
<td>22.5 mg</td>
<td></td>
</tr>
<tr>
<td></td>
<td>20 mg</td>
<td>30 mg</td>
<td></td>
</tr>
<tr>
<td>Oxycodone w/ Acetaminophen (Percocet®)</td>
<td>Oxycodone 5 mg w/ acetaminophen</td>
<td>325 mg</td>
<td>5 mg</td>
</tr>
<tr>
<td>Oral Liquids</td>
<td>Hydromorphone</td>
<td>1 mg/1 ml oral syringe (or 1 mg/mL)</td>
<td>5 mg</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 mg/1 ml oral syringe (or 2 mg/mL)</td>
<td>10 mg</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 mg/1 ml oral syringe (or 4 mg/mL)</td>
<td>20 mg</td>
</tr>
<tr>
<td>Morphine</td>
<td>20 mg/1 ml oral syringe (or 20 mg/mL)</td>
<td>20 mg</td>
<td></td>
</tr>
</tbody>
</table>

*Note: Never crush extended-release preparations

Table 2. Opioid Conversion of Tablets to Oral Liquid Doses

1. Tablets may be crushed or converted to oral liquid formulations.
2. Long acting or sustained release tablets cannot be crushed or converted.
3. Immediate release hydrocodone with acetaminophen, hydromorphone, and morphine tablets should be crushed or converted to an equivalent dose oral liquid.
4. Oxycodone products (with or without acetaminophen) should be crushed or converted to an equivalent dose morphine or hydromorphone oral liquid.*

<table>
<thead>
<tr>
<th>Oxycodone or Oxycodone with Acetaminophen</th>
<th>Morphine Liquid Dose</th>
<th>Hydromorphone Liquid Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 mg</td>
<td>7.5 mg</td>
<td>2 mg</td>
</tr>
<tr>
<td>10 mg</td>
<td>15 mg</td>
<td>3 mg</td>
</tr>
<tr>
<td>15 mg</td>
<td>22.5 mg</td>
<td>5 mg</td>
</tr>
<tr>
<td>30 mg</td>
<td>45 mg</td>
<td>10 mg</td>
</tr>
</tbody>
</table>

*Note: Due to less cost with equivalent efficacy, morphine or hydromorphone liquid are preferred to oxycodone liquid
Appendix C: At-Risk Population Leaving the Unit Algorithm

New Patient Arrives on Unit.
Care Team review Welcome Letter with patient

Is patient at high risk per “Patients Leaving Unit Independently” policy?

No → Patient follows the standard unit policy – no more than 30 minutes off the unit at a time.

Yes → During rounding, remind patient about expectations outlined in Welcome Letter

Does the patient leave the unit?

No → Continue care as usual

Yes →

- Contact the patient on cell phone.
- Attempt to contact the patient’s emergency contact.
- Notify Security to assist locating the patient.
- Notify charge nurse, nurse manager, physician, and appropriate admins.

Does the patient return within an hour?

No → Attending physician shall consider discharge AMA if there are no imminent risks to patient safety.

Yes →

Is the patient high risk due to substance or opioid abuse?

No →

- Hold patient care conference. Review and outline the expectations.
- Patient signs Patient Safety agreement.

Yes →

- Hold patient care conference. Review and outline the expectations.
- Patient signs Patient Safety agreement AND Opioid Safety agreement.

Does the patient comply with the Patient Safety and/or Opioid Safety agreement?

No → Engage Legal, Critical Event Officer, AOC, and Attending Physician to discuss next steps, including:

- Discharge AMA if appropriate.
- Make potential adjustments to plan of care.
- Communicate visitor restrictions.

Yes → Continue care as usual.