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Pain, Pills, and Best Practices: Optimizing Opioid Use in Long-Term Care to Eliminate Survey Pains

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When discussing the opioid crisis and the prevalence of opioids across the long-term care industry, we need to look back at when it started and the journey up to today. The opioid crisis has three distinct stages:

1. The first occurred in the 1990s when there was a rise in prescription opioid overdose deaths starting in 1999.
2. The second happened around 2010 when heroin overdose deaths increased due to patients being unable to get opioid prescriptions or needing something more to reduce the pain or meet their drug needs.
3. The third was noted when there was an increase in synthetic opioid overdose deaths starting in 2013 as a result of illicit drugs were being cut with fentanyl to increase volume and addiction properties.

So where are we today?

- 1 out of 4 patients misuse their prescription in some way (not in the manner prescribed).
- 4 out of 5 heroin users (80%) started with misusing the opioid therapy they were on.
- In 2018, geriatric patients demonstrated an increased rate of 12% of opioid overdose deaths.
- Over 40 states reported increases in opioid fatalities in 2021 according to the AMA.

When we look specifically at long-term care opioid use prevalence, we find that 1 out of 3 residents were prescribed opioids for under 30 days and 1/7, or 15.5%, of residents were prescribed opioids long term or greater than 120 days. While these opioid prescriptions may be appropriate, it is important to remember that the elderly are predisposed to accumulative pain, and many have co-morbidities that might place them at more risk.

Top Risks of Opioids

Some of the biggest risks senior face are the side effects that can occur. There are four common areas that are affected:

- The GI tract with symptoms of nausea, vomiting and constipation
- Neurological symptoms of drowsiness, dizziness and cognitive impairment, which places the resident at risk of falling and increased poor decision making
- Autonomic showing symptoms of bladder dysfunction (retention) and dry mouth
- The cutaneous symptoms of itching and increased sweating

In addition, there are some rarer side effects of respiratory, depression, and death as well as complications such as greater tolerance, physical dependence, and addiction. Surveyors are not only looking for these to be care planned and anticipated, but that the nurses are knowledgeable and can recognize these adverse events.

Survey Ramifications of Inappropriate Opioid and Pain Med Use

There are many federal regulations and associated deficiency F-Tags that can be related to pain management and opioid use.

- F-552 – Resident Rights – Right to be Informed/Make Treatment Decisions, which involves shared clinical decision making and informed consent.
- F-602 – Freedom from Abuse, Neglect and Exploitation – Free from Misappropriation/Exploitation (drug diversion would be misappropriation of personal property).
- F-608 - Freedom from Abuse, Neglect and Exploitation – Reporting of Reasonable Suspicion of a Crime (requires reporting drug diversion to the proper authorities).
- F-656 – Comprehensive Resident Centered Care Plan – Develop/Implement Comprehensive Care Plan, for which surveyors look for informed decision making and non-pharmacological interventions.
- F-697 – Quality of care – Pain Management, which focuses on providing pain management according to best standards of practice, non-pharmacological interventions, and documenting what was used as well as the outcome and need for other interventions if necessary.
- F-755 – Pharmacy Services – Pharmacy Services/Procedures/Pharmacist/Records, which specifies oversight of systems to ensure accountability, including controllable substances, and policies and procedures related to controllable substances. Having first doses available for new prescriptions or a way to obtain them without missing any doses is important to providing quality of care. Also, the reconciliation of liquid medications needs to be monitored. This can also trigger F-759 and F-760 medication error tags if the amounts are wrong.

- F-756 – Pharmacy Services – Drug Regimen Review (DRR), Report Irregularities, Act On, which includes assessing opioid therapies and the monitoring and reporting of irregularities and diversion by the pharmacist.
- F-757 Pharmacy Services – Drug Regimen is Free from Unnecessary Drugs, which includes monitoring of drugs by the consulting pharmacist and nursing staff to ensure that excessive doses or durations don't occur as well as preventing and recognizing adverse consequences as quickly as possible. Surveyors are also looking at the psychotropic medications to ensure they are used appropriately.
- F-760 – Significant Medication Errors, which is intended to prevent wrong doses, including when measuring liquids such as morphine sulfate for administration. One thing to mention in this context is the need to be aware if a resident is opioid naïve versus opioid tolerant. An opioid naïve resident is one who has not received opioids in the past 30 days. For this type of resident, it is important to have on hand an antidote agent. An opioid tolerant resident is one who takes opioids on a regular basis, even daily, and can require higher doses to get the relief they need. With these residents, you need to be aware of possible drug interactions that might require an antidote as well. There should be a policy and procedure for the use of the antidote.

> *A geriatric pearl of wisdom: When you see changes in residents, look at their medications first. The change in condition should be considered a drug side effect until proven otherwise. This will assist in preventing some of these F-Tags.*

Person-Centered Standards of Practice for Pain Management

There were 1,200 deficiencies issued for F-552 from 2019-2022 according to the *data.cms.gov* site, so we'll focus primarily on that tag here.

When reviewing F-552 – Resident Rights – Right to be Informed/ Make Treatment Decisions, it is very clear what is expected: that a professional staff member inform the resident and other responsible persons regarding the new treatment or care, identifies the risks and benefits and alternative therapy, and allows the resident to choose. To meet the informed decision-making regulation, some of the items to review include:

- Risks such as falls, GI issues such as constipation and sedation, and polypharmacy and drug-drug interaction potential
- Benefits like pain control, enhanced therapy, and better quality of life
- Alternative treatments that are non-opioid medications as well as non-pharmacological interventions such as meditation, psychology interventions, guided imagery, cognitive behavior treatment, physical therapy, TENs units, and acupuncture to name a few. The pharmacist can assist the nurse in this discussion by providing non-opioid alternatives and discussing starting doses and titration prior to the resident discussion. Surveyors are looking for non-pharmacological interventions to be care planned and used.

While it is essential to ensure the resident and others are included in care decision making, you may face some challenges when implementing a process, including:

- Identifying which staff are competent to provide this information
- Determining how much information is enough for the decision-making process
- Deciding what to do if the surrogate decision maker isn't available and the resident is not able to make decisions alone
- Knowing what and how much to document to ensure that this topic is well covered

Solutions to these issues require the participation of many staff and should not rest on the DON's shoulders alone. While the facility needs to have robust policies and procedures to address these challenges, the consulting pharmacist and medical director must help to set them up. Prioritizing the drugs that have the highest risk first and then working on other drugs can make this process more feasible.

> *A geriatric pearl of wisdom: Start low and go slow when adding medications to the elderly. That way, it's easier to reduce or remove a medication if adverse drug events occur.*

Survey Issues Regarding Pain During the Pandemic (2021-2022)

- Medication Availability: Chronic pain medications were unavailable (lack of prescription from MD) x 3 days = resident complained of withdrawal symptoms to surveyor
- Lack of follow up when interventions were ineffective: No notification with pain ranging from 2 hours–11 days
- Lack of non-pharmacological interventions: Professional standards
- Use of PRN instead of routine medication regimen: "Why do I have to be in pain to get medication?"
- Failure to follow graduated orders: complex mild, moderate, and severe dosing

Red Flags Regarding Diversion

The process of receiving, storing, administrating, and destroying medications is quite complex, and diversion can occur at any point. Generally, the staff involved in all of these steps are potentially capable of the diversion; usually, it is the least suspicious person.

Frequent issues in nursing homes where diversion/misuse has occurred include:

- Lost/spilled/accidentally thrown away drugs
- Count discrepancies
- Drug not providing the expected benefit
- Conflicting stories

What to look for if you suspect diversion:

- Emergency Medication Supply
  - Quantity limits and resupply frequency
  - Numerous overrides
  - Inventory discrepancies
- Tampering with a medication supply
  - Replacing tablets or liquids
  - Removal of liquid from a sealed bottle
  - Placement of medications on a resident
- Lack of compliance with workflow and processes
  - Leaving medications unattended
  - Distraction from tasks
  - Failure to document
  - Inaccurate waste records
- Medication supply/documentation sheets unaccounted for
- Prescription forgery

Ten to 15% of all healthcare workers have a substance abuse issue. Unfortunately, the outcome of diversion in nursing homes is harm – to the healthcare worker personally and professionally and also to the residents who are hurt through misappropriation of drugs, lack of drugs to relieve their pain, or substituted medications that caused harm by providing no relief. Some ways to prevent or lessen the risk of diversion include having:

- Substantial policies and procedures regarding receipt of received controlled substances
- Accurate logs with the logs being monitored frequently
- Double locks and two people signing off of all logs and dispensing of controlled substances
- Destruction policies and procedures designed to safeguard the residents and staff and follow state guidelines

Avoiding Risk for Residents and Facilities

The opioid epidemic is enduring, and geriatric long-term care residents are at a disproportionately high risk for pain disorders, exposure to opioid medications, and poor outcomes due to profound ADE profiles for this class of drugs. While opioids have a veritable and warranted place in pharmacotherapy, it's crucial to ensure your policies and practices are effective to ensure the health and safety of your residents as well as your compliance. Numerous F-Tags are citable in relation to pain management and opioid use, and the right standards of practice are vital to avoiding a deficiency.