

Modernizing Opioid Management

How 1 hospice saved 1.4 million milligrams of morphine while improving pain management

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Providence Hospice of Seattle

Abstract

Many hospice patients either know someone who struggles with substance use disorder or has had a personal struggle with substance use disorder. In 2018, Providence Hospice of Seattle (PHOS) had done approximately 3,000 admissions. Those in Seattle had a comfort kit containing 600mg of morphine or morphine equivalent delivered to their home. The Hospice Clinical Pharmacist and Hospice Physicians prescribed the comfort kits based on a documented history and physical and rarely included an assessment of the patient by the prescribing provider. The comfort kit opioids were not prescribed for a current symptom but were prescribed for symptoms that might occur in the future. Many opioids were wasted at the time of death, though we had no process for measuring exactly how much. Additionally, PHOS did not have any formal drug diversion assessment. "Narcotic Contracts" were put in place once there was proof of diversion, however clinicians often had suspicions well before they were put in place and long after opioids had gone missing. Half of the complex case reviews in Seattle were related to opioid misuse or diversion. PHOS implemented a comprehensive Opioid Modernization Program that resulted in far fewer opioids entering the community without affecting quality of pain management.

Introduction

A Needs Assessment was initiated after our internal Hospice Clinical Pharmacist mentioned a concern about opioid prescribing practices and overall management of chronic non-cancer pain. The needs assessment included discussions with our partners, review of medical journals and collaboration with our pharmacy. What we found was a need to modernize our opioid program.

In alignment with our mission of "...serving all, especially the poor and vulnerable", it was important that we created safe processes that manage their symptoms for all patients and provide excellent end-of-life care, including patients with substance use disorder.

Methodology

Modernizing our Opioid Management

Changed our processes to add and refresh several tools including:

- Opioid Risk Tool (ORT) for all Patients
- Care Plans
- Safety Agreements for All Patients
- Symptom Management Algorithms
- Provider Information Booklet for business development use
- Workout with targeted education materials for staff
- Education materials for Business Development Liaisons
- Updated default admission e-kit template and a specialized e-kit template for Dementia and Parkinson's

Change Management

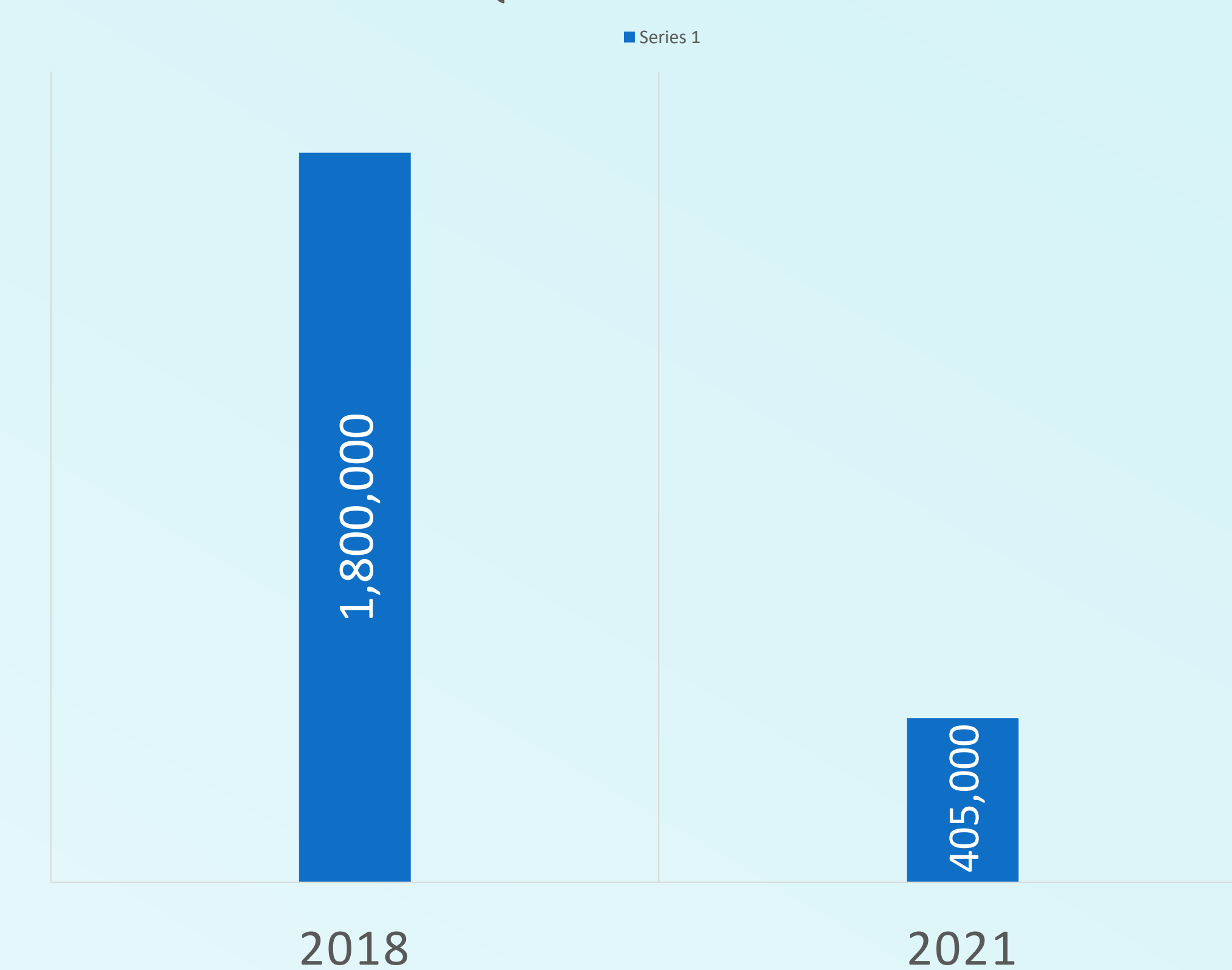
To create the culture change without our ministry, an all-day workout for all staff was done to refresh and update to the new processes. All clinical and some non-clinical staff were included.

Time	Agenda Topic	Outcome
8:30 am	Breakfast and Sign In	Provided
9:00 am	Reflection	Inspiration
9:05am	Caregiver Introductions	Meet & Greet, case for change
9:35 am	Workshop Introduction	Describe context, case for change
10:05 am	Break	
10:20 am	Opioid Risk Tool and Safety Plans	Support a culture of safety and high reliability
11:20 am	Emergency Kit Update	Provide rationale, Support a culture of safety and high reliability
12:05 pm	Lunch	Provided
12:35 pm	Delirium Management	Improve symptom management
1:10 pm	Pain Management	Improve symptom management
2:25 pm	Break	
2:40 pm	Symptom Management Case Study Review Opioid Risk Tool Skills Practice	Develop Competency
3:40 pm	Medication Disposal	Provide rationale, Support a culture of safety and high reliability
4:00 pm	Recap of day	Reinforce

Results

This change process resulted in **1.4 million** milligrams **less** of morphine equivalents entering the community without adversely affecting the quality of pain management.

MORPHINE EQUIVALENTS PRESCRIBED IN E-KITS



Safe Opioid Management



Conclusion

The ORT has provided an effective tool for assessing risk. Care Plans addressing each stratified score provide individualized care to all. Algorithms give providers and nurses a tool for standardized pain management. Safety agreements on admission outline expectations of both the patient and hospice agency. Appropriate prescribing amounts and safe disposal reduces the potential for misuse within the community.

Our approach to change management resulted in quick and successful adoption of our modernized processes.

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Name/Credentials

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Organization Name

Providence Hospice of Seattle

Introduction/Background

Many hospice patients either know someone who struggles with substance use disorder or has had a personal struggle with substance use disorder. In 2018, Providence Hospice of Seattle (PHOS) had done approximately 3,000 admissions. Those in Seattle had a comfort kit containing 600mg of morphine or morphine equivalent delivered to their home. The Hospice Clinical Pharmacist and Hospice Physicians prescribed the comfort kits based on a documented history and physical and rarely included an assessment of the patient by the prescribing provider. The comfort kit opioids were not prescribed for a current symptom but were prescribed for symptoms that might occur in the future. Many opioids were wasted at the time of death, though we had no process for measuring exactly how much. Additionally, PHOS did not have any formal drug diversion assessment. "Narcotic Contracts" were put in place once there was proof of diversion, however clinicians often had suspicions well before they were put in place and long after opioids had gone missing. Half of the complex case reviews in Seattle were related to opioid misuse or diversion.

A team was created to develop a best practice for opioid prescribing. The project began with a review of current risk assessments and recommendations by the National Hospice and Palliative Care Organization (NHPCO) and other state hospice organizations. The team reviewed papers from the Journal of Hospice and Palliative Nursing, The Journal of Pain Management, The Journal of Palliative Medicine, and did an epub search. After reviewing articles testing the validity of different risk tools, the Nursing Process was utilized to determine interventions based on the assessed risk. "Narcotic contracts" were replaced with Safety Agreements for every patient at the time of admission to hospice. The agency's controlled substance policy was updated, and training developed for proactive symptom management and safe disposal of opioids. The plan was initially implemented as a paper process with the intention of 'hardwiring' once it was validated to improve outcomes. Within six months of implementation, patient pain and symptom management scores improved. With this evidence that the process was effective, electronic forms and care plans were optimized in our EMR. The PHOS Pharmacist estimates PHOS put 1,000,000 fewer milligrams of morphine into the community.

Methods

A Needs Assessment was initiated after our internal Hospice Clinical Pharmacist mentioned a concern about opioid prescribing practices and overall management of chronic non-cancer pain. The needs assessment included discussions with our partners, review of medical journals and collaboration with our pharmacy. What we found was a need to modernize our opioid program.

In alignment with our mission of “...serving all, especially the poor and vulnerable”, it was important that we created safe processes that manage their symptoms for all patients and provide excellent end-of-life care, including patients with substance use disorder.

An overall new opioid process was implemented. This included the

- Opioid Risk Tool (ORT) for all Patients
- Care Plans
- Safety Agreements for All Patients
- Symptom Management Algorithms
- Provider Information Booklet for business development use
- Workout with targeted education materials for staff (nurses, chaplains, social workers, providers, HHAs)
- Education materials for Business Development Liaisons
- Updated default admission e-kit template and a specialized e-kit template for Dementia and Parkinson's

An all-day training for all staff was scheduled to learn the new process and refresh on symptom management. We worked with our business development department to communicate the changes we would be implementing with referring providers in the community.

Outcomes

Within six months of implementation, we estimate having put 1.4 fewer milligrams of morphine equivalents into our community without any adverse outcomes to pain management scores. Staff have expressed relief with a formal process to assess, intervene and

Implications for Practice

By reviewing all pillars of opioid management including the assessment, prescribing and management of opioid use, we can continue to provide excellent symptom management to all who need end of life care. This process also provides layers of safety to our prescribers, nurses, and communities. The ORT allows us to assess all patient for risk of abuse, while care plans lead interventions for safety. All patients now sign a Safety Plan with responsibilities for patients and Hospice. The success of the change management workout led to quick adoption and ongoing process improvement.

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Dear Colleague;

The opioid crisis has impacted all aspects of our community. Hospice programs routinely prescribe opiates to ease certain symptoms of serious illness and end of life. We remain fiercely committed to superb symptom management for our patients, and are equally committed to minimizing risk to the community. Keeping with these tenets, we recently completed a comprehensive review of our prescribing practices. This packet is to inform you of changes we have made to our medication protocols.

1. Hospices have traditionally provided a “comfort kit” of medications for each patient when they are admitted to services. The purpose of this kit is to provide medications for urgent symptoms at end of life. We will continue this practice, but are revising the quantity of medications in this kit and renaming it “E-kit”.
2. The E-kit will be individualized for each patient. Most will continue to include medications for pain, shortness of breath, secretions, fever and constipation. Medications for anxiety and/or delirium and nausea will be determined on a case by case basis. The interdisciplinary team will work closely with the patient, family and attending for on-going symptom management. Adjustments can be made to the E-kit at any time by the attending or hospice provider as appropriate. Please see our FAQ for further details.
4. Patients will be screened at admission with the Opioid Risk Tool, in line with current practice recommendations from AAHPM and NHPCO. The results of the ORT will allow us to develop an individualized safety plan for the patient and may affect the contents of the comfort kit.
5. Internally, we’ve adopted a new methadone protocol, broadened our use of the Prescription Monitoring Program and written a new Drug Disposal Policy.

This packet includes details of our new E-kit contents and directions, some symptom management algorithms we’ve developed, and our patient safety contract. We offer them for your interest and for use in your own practice as you see fit.

Thank you for your confidence in partnering with Providence Hospice of Seattle in caring for the most vulnerable among us. We welcome any comments or concerns you may have about any of these policies. My contact information is included below.

Sincerely,

A handwritten signature in blue ink that reads "Bruce Smith MD".

Bruce C. Smith, MD, MACP, HMDC
Medical Director, Providence Hospice of Seattle
206-320-4000
Bruce.Smith2@providence.org

Compassion | Dignity | Justice | Excellence | Integrity

Our Mission As expressions of God’s healing love, witnessed through the ministry of Jesus, we are steadfast in serving all, especially those who are poor and vulnerable.

Our Values Compassion Dignity Justice Excellence Integrity

Our Vision Health for a Better World

Our Promise “Know me, care for me, ease my way”



Some tools you will find in this booklet:

Frequently asked questions about the changes we are making to emergency kits

Symptom Management Algorithms

- Non-Cancer Pain Management
- Cancer Pain Management
- Dyspnea
- Delirium
- Anxiety
- Dementia Behaviors
- Nausea and Vomiting
- Insomnia
- Constipation
- Diarrhea
- Pruritus
- PCA Infusions

Opioid Risk Tool

Opioid Risk Care Plans

Medication Disposal Policy

Opioid Safety Agreement we go over with all patients

Medication Safety Plan

Providence Hospice works with your attending provider to manage medications to safely control symptoms of your illness to ensure quality of life. Some of the medications Hospice provides have the potential to be abused and/or taken by others for their own use. The federal and state government regulate how controlled substances (such as Morphine, Fentanyl, Oxycodone, etc.) are made, prescribed and dispensed.

Due to these regulations and for safety, your Hospice team including your attending provider need to create a plan to address your safety. The intent of this plan is to ensure:

1. Your symptoms are controlled, managed and continually assessed by the Hospice team.
2. You, your family and caregivers feel confident in the safe management of your medications.
3. Your controlled medications are monitored to avoid any concerns in the future.

The purpose of this agreement is to protect you and your caregiver(s) responsibility in managing controlled substances prescribed to you while under the care of Providence Hospice.

I agree to the following:

1. I will provide direct, open, honest and respectful communication about this plan.
2. I will take my medications as prescribed.
3. I will notify hospice prior to taking any medications in the E-Kit. Medications will not be reordered without prior authorization.
4. I will not share, sell, or otherwise permit others to have access to these medications.
5. I will provide all of my medications to the Hospice RN during visits to review.
6. I will inform hospice of any new medications/medical conditions/adverse effects.
7. I will keep these medications out of reach of children and/or pets.
8. I agree that medications may not be replaced if they are lost, or destroyed.
9. If medications are stolen, I will complete a police report and provide a case number.
10. Any medical treatment is initially a trial and that continued prescription is contingent on evidence of benefit.
11. Any unused medications will be disposed of according to the Hospice Policy for disposal of unused medication.
12. For my own safety I should avoid using street drugs (ex. as cocaine, heroin) while using controlled substances.
13. It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribed by this provider or referral for further specialty assessment.

Your Hospice team agrees to the following:

1. To provide direct, open, honest and respectful communication about this plan, and provide education on your medications to you, your family and caregivers.
2. To request refills of your medications when needed as ordered by your medical provider.
3. A nurse will visit at least every 14 days to assess your symptom management and medication supply.
4. A nurse will count the medications and review any use of PRN (as needed) medications.
5. Work with you on addressing any safety concerns regarding the safety of your medications.
6. Offer emotional support and referral to additional community resources if needed.
7. Prescriptions may be issued early if the provider or patient will be out of town when a refill is due. These prescriptions will contain instructions to the pharmacist that they not be filled prior to the appropriate date.

Providence Hospice is committed to your symptom management, quality of life, and safety. This plan is intended to help you and your Hospice team feel confident in providing this for you.

Reviewed with patient by:

Clinician name: _____ Clinician signature: _____

Your signature acknowledges agreement to this plan:

Patient name: _____ Patient/Surrogate Decision Maker signature: _____

Date Signed: _____ Sign two copies. One for the patient and one for Hospice

Opioid Care Plans



<u>Problem</u>	<u>Goal</u>	<u>Intervention</u>
Low risk for opioid diversion	Provide for adequate symptom management while safely prescribing opioids	<ul style="list-style-type: none"> ◇ Continue monitoring safe use of opioids ◇ Narcotic counts at every routine visit and as needed ◇ Safe Storage ◇ Review safety plan PRN
Moderate risk for opioid diversion	Provide for adequate symptom management while safely prescribing opioids	<ul style="list-style-type: none"> ◇ Narcotic counts at every visit ◇ Up to 2 weeks maximum supply ◇ Minimize use of benzodiazepines, consider alternatives such as antidepressants, anxiolytics - If currently on benzodiazepines, remove lorazepam from the emergency kit ◇ Assess and address associated mental health issues ◇ IDT Review with the Hospice Physician & RpH ~ CCR if needed
High risk for opioid diversion	Provide for adequate symptom management while safely prescribing opioids	<ul style="list-style-type: none"> ◇ Emphasize safety ◇ Express concerns explicitly ◇ Limit supply to 1 week or less with signature upon receipt ◇ Frequent evaluations ◇ Complex Case Review ◇ Identify family member to control opioid administration. ◇ Consider the use of: <ul style="list-style-type: none"> ⇒ Urine drug screen ⇒ Long-acting opioids without short-acting breakthrough opioids
Patient currently abusing or non-compliant with established opioid safety plan	Provide for adequate symptom management while safely prescribing opioids	<ul style="list-style-type: none"> ◇ Inform the patient & Family that the plan has been violated and that the hospice must evaluate other options ◇ Complex Case Review ◇ Do not dispense an emergency kit ◇ Identify safety issue, consider family meeting ◇ Identify reasons for ongoing opioid use ◇ Safety Plan Options ◇ Prevent abuser's access to opioids ◇ Admit patient to controlled environment ◇ Reduce limited supply further ◇ Single reliable person to administer opioids ◇ Ethics consult ◇ Hospice will no longer manage/supply opioids ◇ Add Naloxone ◇ Refer to Hospice discharge policy if staff safety is a concern ◇ Contact law enforcement and/or adult or child protective services
Long Term Chronic Pain already on opioids	Provide for adequate symptom management while safely prescribing opioids	<ul style="list-style-type: none"> ◇ Discuss in IDT plan for pain management
Homeless or in an unsafe environment	Provide for adequate symptom management while safely prescribing opioids	<ul style="list-style-type: none"> ◇ Discuss with patient/family and hospice physician about emergency kit delivery ◇ Discuss in IDT plan for pain management ◇ Hold Emergency Kit
Abuser involved in caregiving	Provide for adequate symptom management while safely prescribing opioids	<ul style="list-style-type: none"> ◇ Emphasize safety for identified individual ◇ Deny access to individual ◇ Install lock box



Hospice Comfort Kit/Emergency Kit

Changes Fact Sheet

Evaluation of current practice:

- Comfort kits sent to all patients upon admission without formal assessment of opioid abuse/diversion risk
- Medications are often used for ongoing symptom management, not just end-of-life emergencies
- Many drug-drug interactions and duplicate therapy interactions arise due to use of comfort kit medications

Concerns with current practice:

- Abuse/diversion in light of the opioid crisis
- Safety of the patients without an appropriate risk for abuse assessment
- Waste of unused medications by many patients
- Liability for prescribers
- Lack of clarity for clinicians, patients, families

FAQs

Why the name change? *Emergency Kit (E-kit) emphasizes the medications are for end-of-life symptom exacerbations, rather than ongoing symptom management.*

I am concerned that pills will be harder for families to give a patient at end-of-life. It seems like a lot of work to crush. *CA has never used liquid morphine and never had any problems with this. There is risk of drawing up liquid medications incorrectly and making an error.*

Why can't we use haloperidol for agitation any more? *Delirium is a very complicated symptom that could have multiple underlying reversible causes. Use of the medication can impact proper assessment of what is really going on. An order can be obtained for use of haloperidol after assessment and consultation with a provider.*

Will comfort kits still be sent out to all patients on admission? *The vast majority of patients will continue to get an E-kit. Only those at high risk of abuse will not get an E-kit on admission, but will get a comprehensive plan for symptom management.*

I am very concerned about the dosing interval—how will we manage people's symptoms only giving morphine every 4 hours? *These dosages are a starting point for opioid-naïve patients. Providers will be reviewing each patient upon admission for relevant E-kit orders. If a patient is already on opioids, their E-kit will look different. As patients change, dosing can be changed in consultation with providers.*

Do the providers realize this is going to increase their call volume...especially after hours?? *Yes. Hospice Providers are prepared for that. We are also doing a push on proactive symptom management education for all staff to plan ahead for possible crises in the home.*

Hospice Comfort Kit/Emergency Kit

Summary of Changes

Dosing changes with pharmacokinetic rationale

Drug or drug class	Current CK/CCK dosing	Pharmacokinetic rationale for change	New E-kit dosing
Opioids	Every 1 hour prn	Onset 30 minutes, peak response 1 hour, duration 3 hours—longer for many hospice patients with decreased liver/renal function	Not more often than every 4 hours
Lorazepam	Every 1 hour prn	Onset 60-90 minutes, duration 6-8 hours	Not more often than every 4 hours
Haloperidol	Every 1 hour prn	Onset 30-60 minutes, time to peak 2-6 hours, half-life 10-37 hours	Not more often than every 4 hours

To reduce confusion, dosing ranges have been replaced with specific doses. "Not to exceed" comments have also been added to orders. Note that certain patient situations may warrant discussion with provider regarding a dosing frequency change.

Formulation and route changes with safety rationale

Drug	Current CK/CCK formulation and route	Safety rationale for change	New E-Kit route
Morphine sulfate	20mg/ml liquid given PO/SL	Reduce quantities of opioid in the home - currently we provide 600mg/ounce of liquid morphine to all patients. Liquid medications can be difficult to draw up, easy to make dosing errors.	Morphine sulfate immediate release tabs 15mg given PO/PR
Hydromorphone	1mg/ml liquid given PO/SL	Consistency with liquid morphine. Liquid medications can be difficult to draw up, easy to make dosing errors.	Hydromorphone 2mg tabs given PO/PR

Pill crushers will be included with E-kits

Opioid Risk Tool

Opioid Risk Tool (Mark Each Box that Applies)				
Patient and or family unable to complete	<input type="checkbox"/> Yes	If unable stop here		
Immediate Family History of Substance Abuse	Points	Female	Male	
Alcohol	<input type="checkbox"/> Yes <input type="checkbox"/> No		1	3
Illegal drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No		2	3
Rx Drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No		4	4
Personal History of Substance Abuse				
Alcohol	<input type="checkbox"/> Yes <input type="checkbox"/> No		3	3
Illegal drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No		4	4
Rx Drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No		5	5
Age between 16-45 years	<input type="checkbox"/> Yes <input type="checkbox"/> No		1	1
Psychological disease				
ADD, OCD, Bipolar, Schizophrenia	<input type="checkbox"/> Yes <input type="checkbox"/> No		2	2
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No		1	1
Scoring Totals			<=3=low 4-7=moderate 8 or>=High	
Is patient homeless or in an unsafe environment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes: Discuss with patient/family and hospice physician about E-kit delivery. If no safe family member to control opioids, do not dispense E-kit.		
If Moderate Risk is scored complete additional questions:				
How recent is the substance abuse?				
Which substance(s) are being abused?				
How significant is the abuse?				
If High risk is scored complete additional questions:				
Who is abusing substances?				
Is the abuser involved in care giving?	<input type="checkbox"/> Yes <input type="checkbox"/> No			

Anxiety – Assessment

Assessment Guidelines:
 Assess pain level: Acute exacerbation, acute onset of new pain?
 GI/GU: Assess bowels - possible impaction? Nausea? Urinary retention, possible UTI?
 Psych/Social: Depression; Unmet end of life planning, need for social work? Unmet spiritual needs, need for chaplain support? Perform PHQ4, environmental/social triggers, trauma-related
 Medications: Anxiety producing meds (steroids, Ritalin), withdrawal syndromes: caffeine, alcohol, nicotine, illegal substances; paradoxical effects of medications (look at lorazepam in the demented patient)
 Medical: sleep deprivation, metabolic state (liver disease - ammonia level, hypoxia)
 Pre-procedural anxiety? (dressing changes, port access, pleural/peritoneal draining)

Non-Pharmacologic Interventions:

Intervene appropriately based on PHQ4 score, active, empathic listening · Subdued environment/reduce stimulus · Softly lighted surroundings with familiar objects and familiar faces · Conversation with the patient and family should be calm and reassuring · Allow time for patient to talk freely about his/her concerns · Aromatherapy · Relaxation/visualization/distraction · Offer relaxation tapes · Massage · Therapeutic touch · Create simple predictable routines · Favorite music or pets · Patient and family education regarding treatment options, medications and anticipated effects · Offer spiritual support

If effective – continue treatment
 If ineffective consider adding

Anxiety
No contraindications to benzodiazepines:
 Lorazepam* 0.5mg tabs 0.25-2mg (0.5-4 tabs) po/sl/pr q6h pm. Reassess at 1 hour.
 *Use cautiously with elderly and dementia patients

Anxiety
Contraindications to benzodiazepines
 Hydroxyzine HCL 10-25mg po q4h pm

Therapy is ineffective
 Maximize dose of lorazepam or try alternative: clonazepam 0.5-1mg q6h pm or alprazolam 0.25-0.5mg q4h pm

Therapy is effective
 Continue current treatment. May consider a change to long-acting clonazepam 0.5-1mg q6h pm if less dosing frequency is desired

Therapy is effective
 Continue with current therapy. Reassess need, efficacy and tolerability as needed

Therapy is ineffective
 Increase dose of antihistamine, consider anti-psychotics, reevaluate benzodiazepines

Reassess and determine if:
 1. If patient has anxiety with psychosis (hallucinations, delusions) haloperidol 0.5mg 1-2 tabs po/sl/pr q1h pm. Max 4mg/6 hrs.
 2. If > 4 week prognosis consider: Consider SSRI (sertraline 25mg daily starting) SNRI (venlafaxine XR 37.5mg daily) or other medication. Consult hospice provider/pharmacist as needed.

Therapy is ineffective
Consider consultation with attending, hospice provider, pharmacist consultation

Therapy is effective
 Continue with current therapy. Reassess need, efficacy and tolerability as needed

MSW and CHP interventions concurrently with pharmacologic treatments

E-kit Summary of Changes

Indication changes for haloperidol with rationale

Drug	Current CK/CCK indication	Rationale for change	New E-Kit indication
Haloperidol	Agitation or nausea/vomiting	Delirium is a complex symptom that requires nurse assessment of the multiple possible etiologies, consideration of non-pharm interventions. A nurse may obtain a verbal order from provider to have delirium	Nausea and vomiting* * for patients without Dementia/Parkinsons, not living in a SNF.

E-kit Contents

Abbreviated Standard E-kit Contents

- **Pain or SOB:** Morphine sulfate tabs OR oxycodone tabs OR hydromorphone tabs
- **Anxiety:** Lorazepam tabs
- **Nausea/vomiting:** Haloperidol tabs or haloperidol liquid
- **Secretions:** Hyoscyamine sublingual tabs
- **Pain and Fever:** Acetaminophen suppositories

Type of E-kit	Deviation from Standard E-kit	Rationale
SNF	Haloperidol not included Constipation medication not included	SNFs have strict regulations over the use of psychotropic medication SNFs have their own bowel protocols
Dementia/Parkinsons	Quetiapine tabs for anxiety rather than lorazepam Haloperidol removed	Literature supports avoiding benzodiazepines in dementia patients Haloperidol has been overused for managing dementia behaviors Duplicate therapies with other antipsychotics

To reduce waste and risk of diversion, quantities of all medications have been reduced, unless patient is on TIP protocol.

Non-Cancer Pain Assessment - PQRSTUA

P – precipitating, palliating and previous treatment or therapy (What makes it worse? What makes it better and what have you tried?)
Q – quality (stabbing, shooting, throbbing, aching, gnawing etc.)
R – region and radiation (Where is it and does it move anywhere?)
S – severity (How severe is it? Number scale, faces scale)
T – temporal (What is the time course: constant, intermittent, how many times daily, how long does it last?)
U – Where do U (the patient) want it to be?
A – associated symptoms (What symptoms accompany the pain. Does it affect sleep, mood, relationships?)

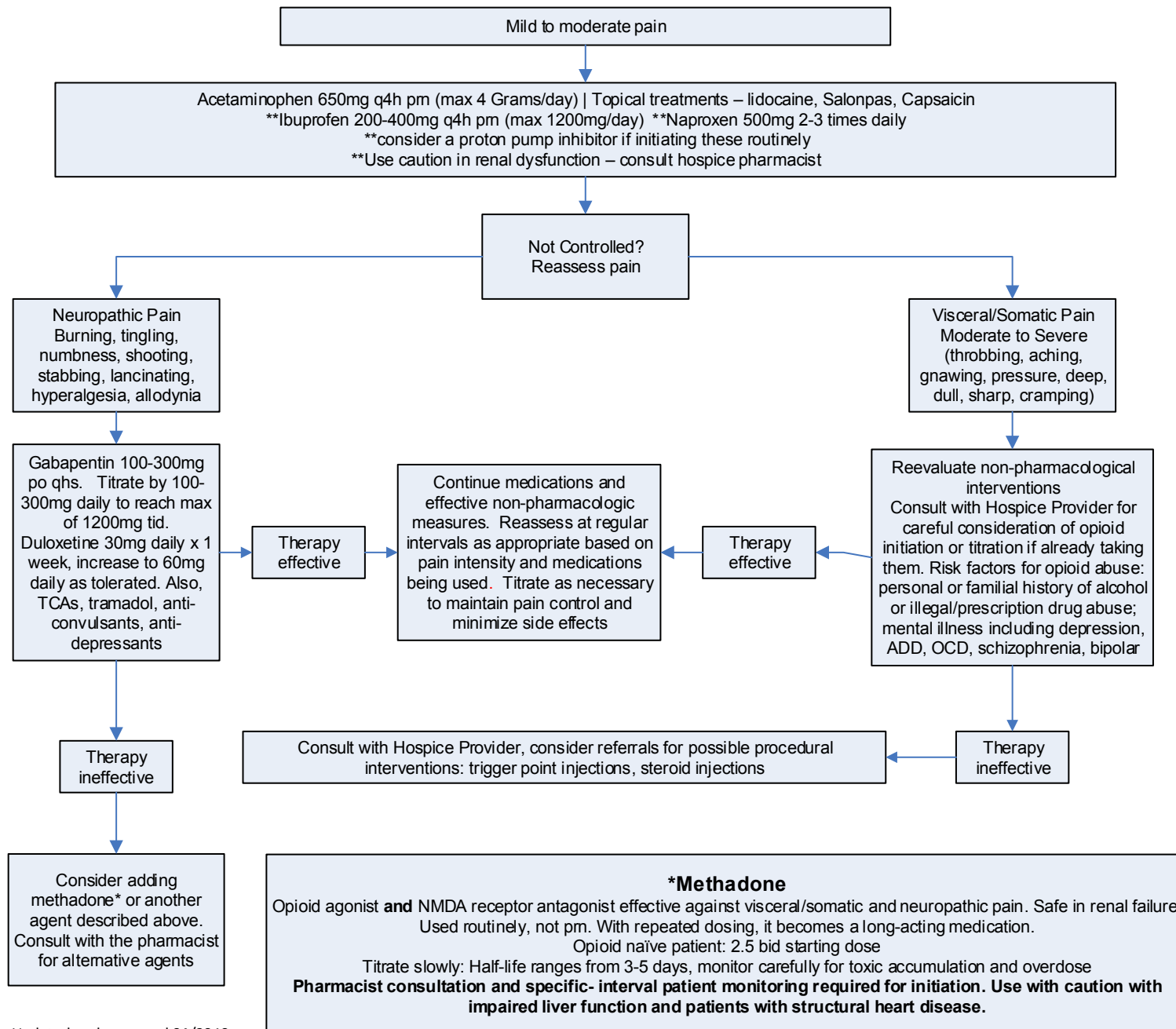
Consider also Total Pain or Existential/Spiritual Pain especially if symptoms seem out of proportion with disease.

For chronic non-cancer pain, non-pharmacologic and non-opioid pharmacologic therapies are preferred.

For patients who come on hospice services with opioids already prescribed for chronic non-cancer pain, consider early in-person evaluation by Hospice Provider and have only one prescribing provider.

Non-pharmacologic interventions to consider in conjunction with pharmacologic options:

Favorite music and aromas, spiritual care and counseling, distraction, guided imagery/visualization, empathetic listening, heat, cold, position changes, acupuncture, acupressure, massage, etc.



Delirium

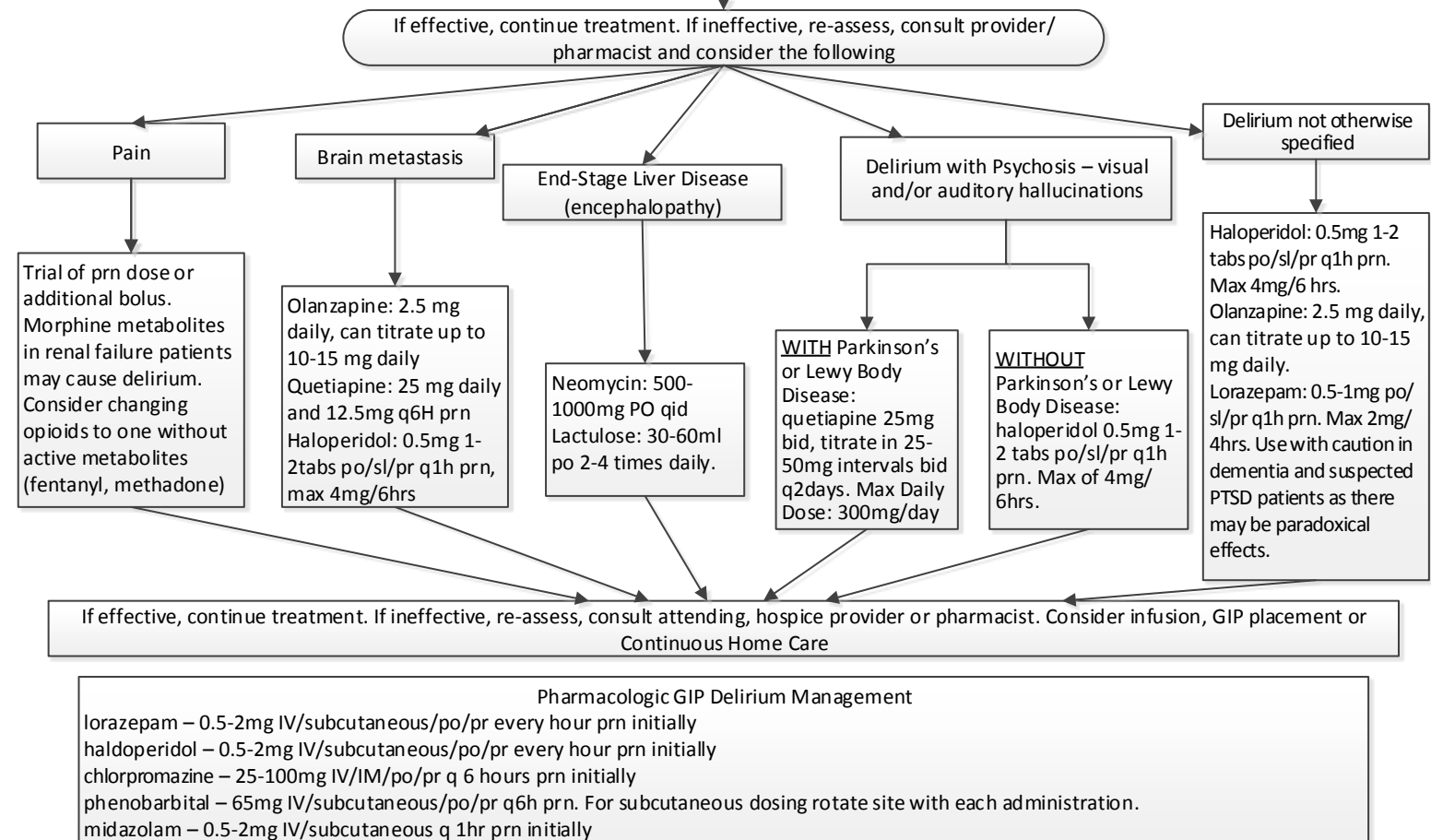
Delirium can be “hyperactive” (agitation) or “hypoactive”. The hallmark of delirium is an **acute** change in the level of arousal; supporting features include altered sleep/wake cycle, mumbling speech, disturbance of memory and attention, perceptual disturbances with delusions and hallucinations. For behaviors that are chronic and dementia-related, see [Management of Behavioral and Psychological Symptoms of Dementia \(BPSD\) Algorithm](#).

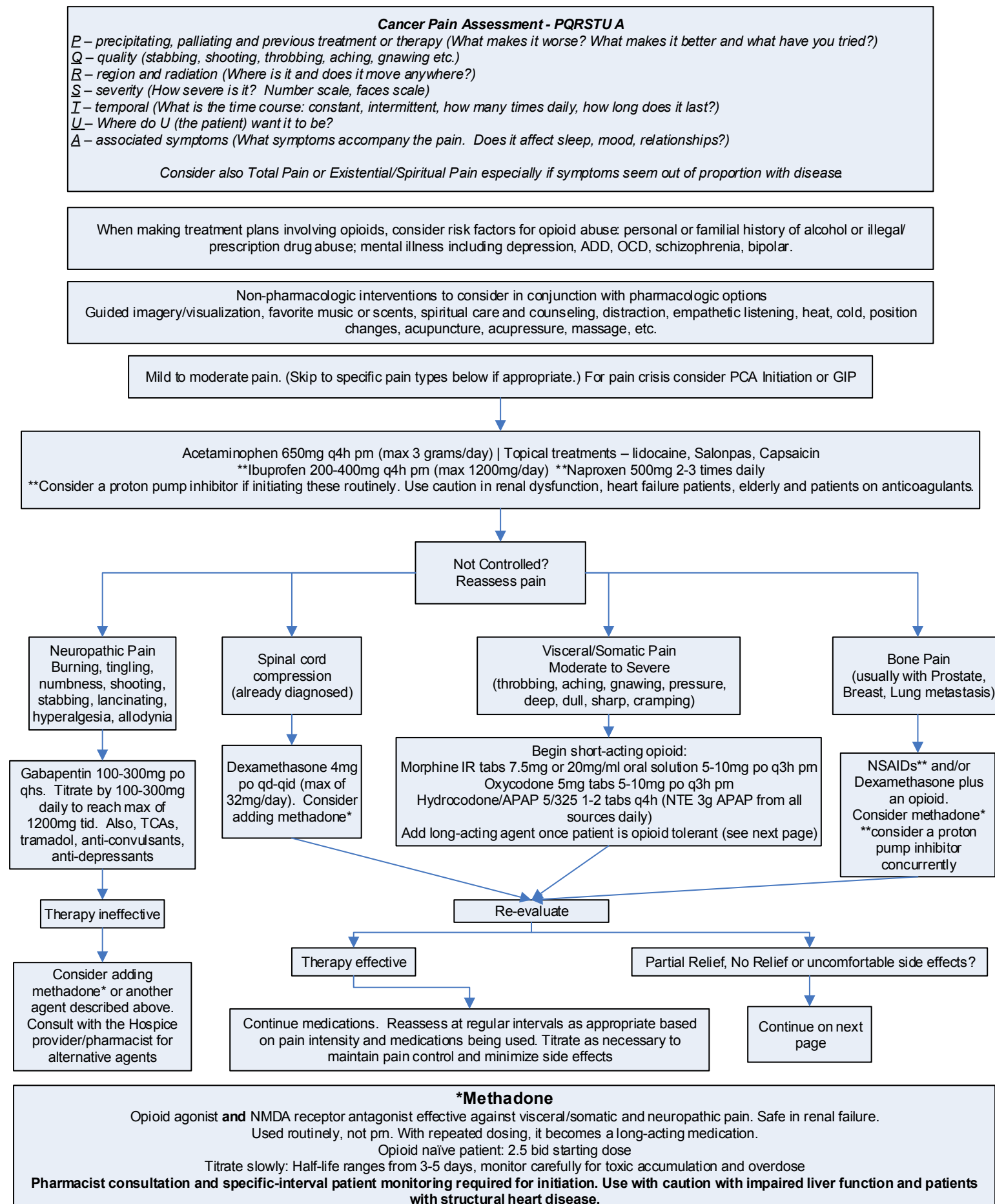
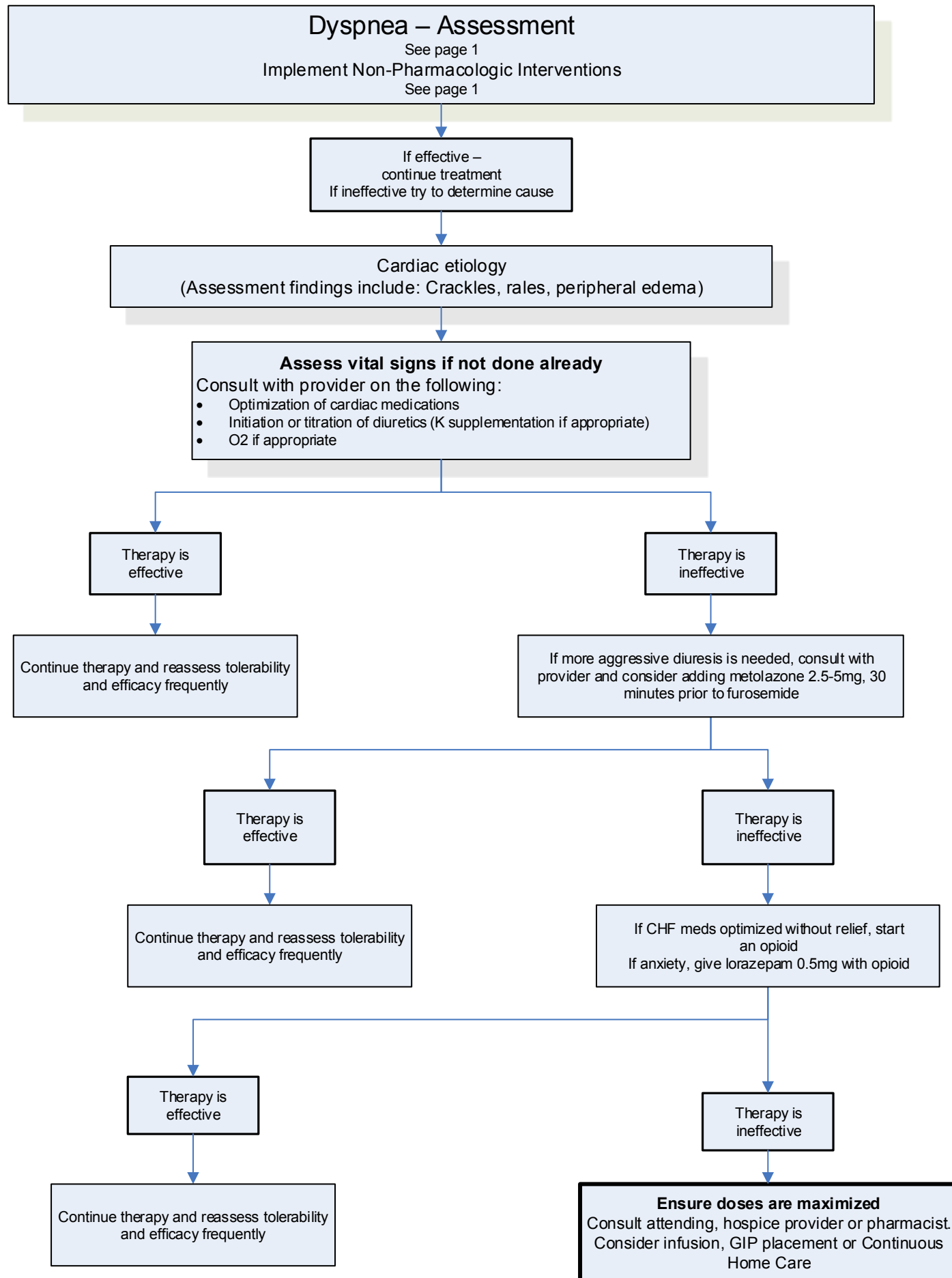
Assessment Guidelines - DELIRIUMS

Drugs: Steroids, stimulants (methylphenidate), opioids, anti-cholinergics; withdrawal from caffeine, nicotine, illegal substances, other CNS active medications, baclofen if stopped abruptly, antidepressants; paradoxical effects from benzodiazepines, phenobarbital
Eyes, Ears, ETOH: Environmental factors such as sound, light, certain individuals or familial/social triggers; withdrawal from alcohol
Low-oxygen states to organs
Infection: UTI
Retention: Urinary retention or constipation
Post-Ictal state
Underhydrated, Undermedicated for pain, **Under-rested**
Metabolic state, Metastasis: Hypercalcemia, hypoxia, hypoglycemia, hypo/hyponatremia, ammonia level in liver patients; possible brain metastasis
Subdural/Stress/Spiritual distress: Behavioral changes can occur up to three days after a fall; consider unmet spiritual needs; PTSD

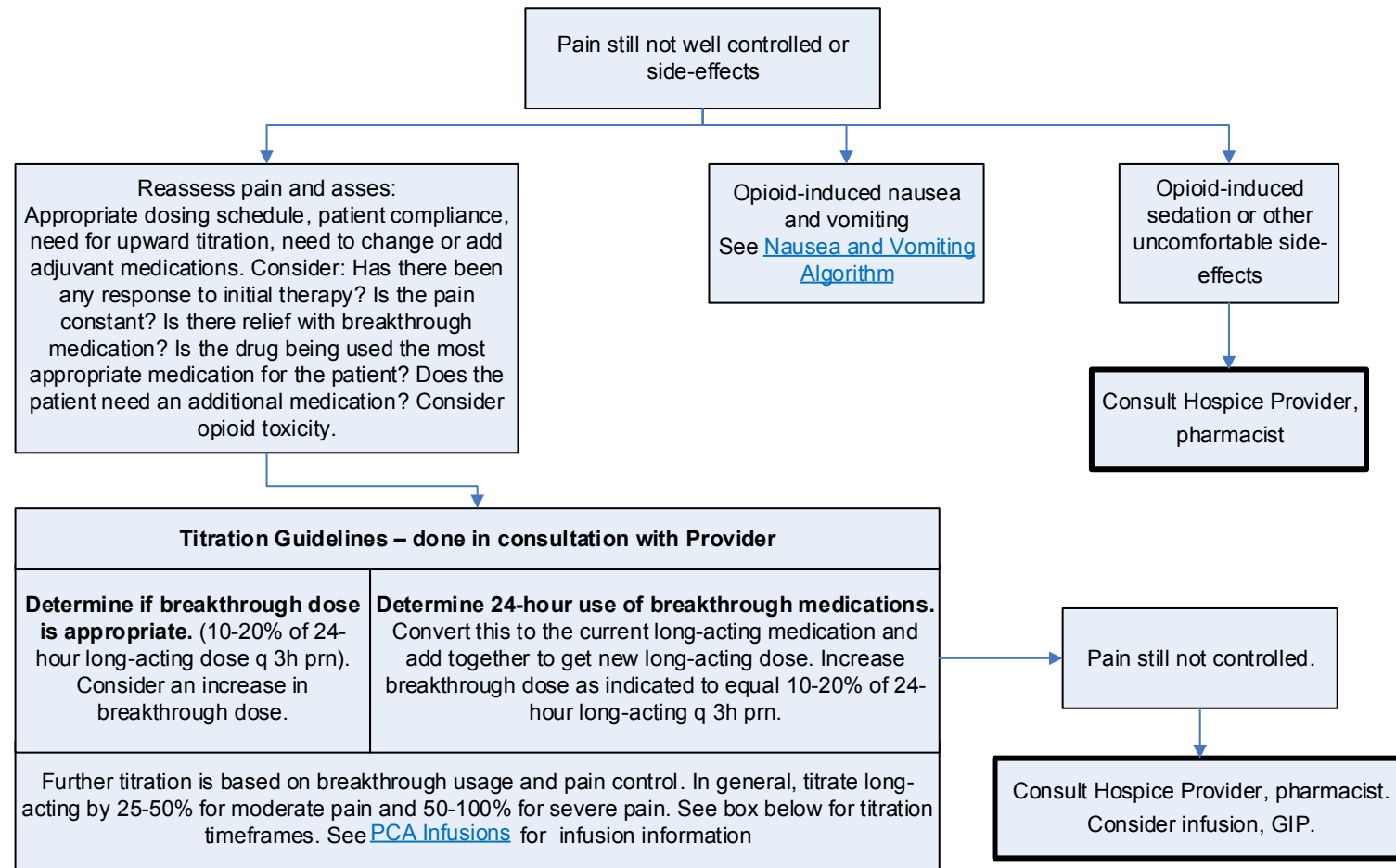
Non-pharmacologic Interventions

Physical	Environmental	Social/spiritual
Position change for comfort Tend to possible GI/GU needs Clear communication with patient before tactile stimuli Move patient slowly Massage/comforting touch	Favorite music, aromas, pets Subdued environment/reduce stimuli Well-lit surroundings Familiar objects and faces Relaxation/visualization/distraction Simple, predictable routines	Active, empathetic listening Calm, reassuring conversation with patient and family Allow time for patient to express concerns Spiritual support Grief counseling/MSW support Education on causes of behavior, possible treatments





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Initiation of long-acting opioids: Consider for patients receiving daily opioids when they become opioid tolerant. The FDA identifies this group as "receiving 60mg of oral morphine daily, at least 30 mg of oral oxycodone daily, or at least 8mg or oral hydromorphone daily or an equianalgesic dose of another opioid for a week or longer."

Long-acting medications include:
MS Contin (morphine extended release, morphine ER, morphine SA, Oramorph) – 15mg, 30mg, 60mg, 100mg tablets
Morphine should be used with caution in end-stage renal disease
Methadone – dose requires pharmacist consultation – 5mg, 10mg tablets; liquid 10mg/ml
Fentanyl transdermal: 12mcg/hr, 25mcg/hr, 50mcg/hr, 75mcg/hr, 100mcg/hr patch. Reserved for patients who cannot swallow, for whom methadone is not appropriate and rectal administration of medication is not an option. Fentanyl may also be used if there is patient/caregiver compliance issues.

Add up the past 24-hour opioid use of breakthrough medications. Divide total daily dose in half or by 3 and round down to get oral long-acting q12h or q8h dose. Calculate the breakthrough dose as 10-20% of total daily long-acting and dose q3h prn.

Titration:
Morphine: May titrate every 1-2 days
Methadone: May titrate ever 5-7 days
Fentanyl patches: May titrate every 3-6 days

Dyspnea – Assessment

Identify underlying diagnoses

General assessment: Lung sounds, respiratory rate, pulse, blood pressure, O2 sat if appropriate, activity level, positioning
Is patient smoking?
Consider other causes*: Anemia, pneumonia, bronchospasm, pulmonary embolism
Assess fluid status: Renal disease? Hepatic disease? Is the patient on tube feedings?
Is there edema, ascites?
History of Cardiac Disease: Are cardiac medications optimized? Presence of chest pain?
Pulmonary conditions and comorbidities: What is baseline pulmonary function? Are current medications optimized? Consider presence of pleural effusion, lung metastases, pneumothorax
Psychosocial: Anxiety/panic attack - see [Anxiety algorithm](#), consider unmet spiritual needs
*Consult with provider to determine next steps keeping in mind patient goals and hospice philosophy

Non-Pharmacologic Interventions:

Raise the head of the bed, reposition patient, place fan in room to re-circulate air, open window, line of sight to open space or window, put a damp cool cloth on face.
Breathing techniques
OT referral for energy conservation, DME by bedside,
Perform pleural/peritoneal drainage procedure if indicated.
See [Anxiety algorithm](#) for related non-pharmacologic interventions

