**Preventing Opioid Abuse: The Role of the Nurse**

By David Griffiths, Nurses Service Organization

Opioids have become a leading cause of unintentional injury death in Washington, even more than motor vehicle accidents or firearm fatalities, according to 2016 state data. Nationwide, the Centers for Disease Control and Prevention (CDC) reports that overdose deaths related to prescription opioids have quadrupled since 1999. Nurses can play an important role in reducing these deaths, as well as addiction problems, through their assessments and monitoring of patients.

The depth and breadth of prescription opioid abuse is far-reaching. A 2016 study published in the *Journal of the American Medical Association (JAMA)* by Baker and colleagues notes that there is significant variability in the amount of opioids prescribed. The most commonly dispensed opioid was hydrocodone (78 percent), followed by oxycodone (15.4 percent).

Every day, more than 1,000 people are treated in emergency departments for misusing one of these prescription opioids. In 2014, almost 2 million people in the United States abused or were dependent on prescription opioids. At least half of all opioid overdose deaths involve a prescription opioid and strike a wide adult population, with prescription opioid overdose rates between 1999 and 2014 highest among people age 25 to 54, according to the CDC.

But there may be a course correction underway. A 2015 study in the *American Journal of Preventive Medicine* reported a decrease in the rate of prescribing opioids (- 5.7 percent), perhaps indicating that more healthcare providers are becoming aware of the addiction issue.

At the same time, it’s important for nurses to be well aware of steps they can take to help protect themselves from possible legal action stemming from opioids.

Assess the patient carefully

Pain medication should be matched to the individual patient’s needs. This begins with a detailed medical history, including a list of currently prescribed and past medications. Ask about a history of substance use or substance use disorders in the patient and the patient’s family. If opioids are being considered, assess the patient’s psychiatric status.

A physical exam should also be completed, keeping in mind signs and symptoms of possible substance abuse, such as advanced periodontitis, traumatic lesions, and poor oral hygiene. If patients are already being managed for chronic pain, the nurse should consult with the appropriate provider.

Screen and refer patients

One model for follow-up of possible substance abuse is Screening, Brief Intervention, and Referral to Treatment (SBIRT) from the Substance Abuse and Mental Health Services Administration. SBIRT is a method for ensuring that people with substance use disorders and those at risk for developing these disorders receive the help they need.

Nurses also can help detect patients with substance misuse with the National Institute on Drug Abuse Quick Screen (NIDA). If a substance use disorder is suspected, the nurse should remain nonjudgmental while referring patients for further evaluation and treatment, so they receive the care they need.

Nurses need to closely monitor patient use of controlled drugs to avoid overdependence or potential addiction, and refer chronic pain patients to a pain management center or specialist. Be sure to document the referral in the patient’s health record. Nurses also should consider referral for patients who seek opioids beyond when they are likely to be needed.

Apply evidence-based pain management

To provide optimal patient care, as well as to protect themselves from legal action, nurses should practice evidence-based pain management. That includes considering non-steroidal anti-inflammatory drugs (NSAIDs), such as ibuprofen, as first-line pain medication.

NSAIDs have been shown to be at least as effective (if not more so) than opioids for managing pain, particularly in combination with acetaminophen. Before patients begin taking NSAIDs, verify that they are not taking other anticoagulants, including aspirin, and check for hepatic or renal impairment.

Nurses should complete continuing education courses in pain management, and document they did so, which can provide evidence of their knowledge in event of legal action.

Educate patients

Nurses have an opportunity to educate patients about the role of pain medication in their care. This education should include pain medication options and the reasons why non-opioids are preferred.

Verbal and written instructions after the procedure need to contain name of drug, dosage, adverse effects, how long the drug should be taken, and how to store it. Results from a 2016 survey published in *JAMA Internal Medicine* found that more than half (61 percent) of those no long taking opioid medication keep it for future use, so patients need to be told to dispose of unused drugs and how to do so. Patients can search for places that collect controlled substance drugs through the Drug Enforcement Administration at www.deadiversion.usdoj.gov.

The same survey found that about 20 percent shared the opioid with another person, so education material should mention not to do this. Nurses should also discuss the perils of driving or undertaking complex tasks while taking an opioid. Document in the patient’s health record that this information was provided and the patient acknowledged receipt and understanding. An office visit can also provide the opportunity for nurses to address opioid abuse on a larger scale.

Below are some considerations for the use of pain medication in patients:

* Use non-steroidal anti-inflammatory drugs (NSAIDs) as the first option. Consider a selective NSAID to avoid increased risk of bleeding. Know that using acetaminophen in combination with NSAID may have a synergistic effect in pain relief. (Do not exceed 3,000 mg/day in adults.)7
* Provide patient education
* Document patient communications, education, and referrals in the health record

Nurses who assess and monitor patients for treatment of pain are encouraged to be mindful of and have respect for their inherent abuse potential. Doing so helps protect patients from harm and nurses from potential liability.

***About the author***

*David Griffiths is senior vice president of program management for Nurses Service Organization (NSO), where he develops strategy and oversees execution of all new business acquisition and customer retention for the group’s allied healthcare professional liability insurance programs. With more than 15 years of experience in the risk management industry, he leads a team covering account management, marketing and risk management services. More at* [*www.nso.com*](http://www.nso.com)*.*

This risk management information was provided by Nurses Service Organization (NSO), the nation's largest provider of nurses’ professional liability insurance coverage for over 650,000 nurses since 1976. INS endorses the individual professional liability insurance policy administered through NSO and underwritten by American Casualty Company of Reading, Pennsylvania, a CNA company. Reproduction without permission of the publisher is prohibited. For questions, send an e-mail to [service@nso.com](mailto:service@nso.com) or call 1-800-247-1500. [www.nso.com](http://www.nso.com).

This article is provided for general informational purposes only and is not intended to provide individualized business, risk management or legal advice.  It is not intended to be a substitute for any professional standards, guidelines or workplace policies related to the subject matter.

**Resources**

1. Governor Jay Inslee. Opioid Epidemic Policy Brief, 2016. <http://www.governor.wa.gov/sites/default/files/exe_order/OpioidEpidemic.pdf>
2. Baker JA, Avorn J, Levin R, Bateman BT. Opioid prescribing after surgical extraction of teeth in Medicaid patients, 2000-2010. *JAMA.* 2016;315(15)1653-1654.
3. Centers for Disease Control and Prevention. Prescription opioid overdose data. 2016. [www.cdc.gov/drugoverdose/data/overdose.html](http://www.cdc.gov/drugoverdose/data/overdose.html).
4. Kennedy-Hendricks A, Gielen A, McDonald E, et al. Medication sharing, storage, and disposal practices for opioid medications among US adults. *JAMA Int Med*. June 13, 2016.
5. MCauley JL, Leite RS, Melvin CL, Fillingim RB, Brady KT. Opioid prescribing practices and risk mitigation strategy implementation: identification of potential targets for provider-level intervention. *Substance Abuse.* 2016;37(1):9-14.
6. Levy B, et al. “Trends in opioid analgesic – prescribing rates by specialty, U.S., 2007-2012.” Am J Prev Med 2015; 49(3): 409-413.
7. Substance Abuse and Mental Health Services Administration. Screening, brief intervention, and referral to treatment (SBIRT). 2016. [www.samhsa.gov/sbirt](http://www.samhsa.gov/sbirt).
8. Thorson D, Biewen P. Bonte B, et al. Acute pain assessment and opioid prescribing protocol. Institute for Clinical Systems Improvement. 2014. https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm