Opioid Nursing Home Adverse Drug Event CHECKLIST

Resident ID Number: ____________________ Resident Name: ______________________________________

Admission Date: _________________________ Resident Age: ______________

Discharge Date: _________________________ Date: ____

CHANGE IN MENTAL STATUS/DELIRIUM RELATED TO OPIOID USE

Risk Factors:

- ☐ PRN or routine use of opioid medication
- ☐ Opioid naiveté (someone who has not been taking opioids)
- ☐ Opioids used in combination with sedatives or other opioids
- ☐ History of opioid abuse
- ☐ Opioid tolerance
- ☐ Severe pain
- ☐ Low fluid intake/dehydration
- ☐ Low body weight
- ☐ History of head injury, traumatic brain injury, or seizures

Signs & Symptoms:

- ☐ Falls
- ☐ Hallucinations
- ☐ Delusions
- ☐ Disorientation or confusion
- ☐ Light-headedness, dizziness or vertigo
- ☐ Lethargy or somnolence
- ☐ Agitation
- ☐ Anxiety
- ☐ Unresponsiveness
- ☐ Decreased
  - o BP
  - o Pulse
  - o Pulse oximetry
  - o Respirations

Clinical Interventions:

- ☐ Administration of Narcan
- ☐ Transfer to hospital
- ☐ Call to physician regarding the new onset of relevant signs or symptoms
- ☐ Abrupt stop order for medication

Probing Questions:

- Is there an assessment and determination of pain etiology?
- Does the resident's pain management regime address the underlying etiology?
- For a change in mental status, is there evidence the physician evaluated the underlying cause, including medications?
- Is there evidence of a system for ensuring that residents are routinely assessed for pain, including monitoring for the effectiveness of pain relief and medication side effects (e.g., over-sedation)?
- If receiving PRN routinely, is there consideration for the timing of administration of the PRN?
- Can staff describe signs/symptoms of over-sedation?
- Is there evidence of a system for ensuring "hand-off" communication includes the resident's pain status and time of last dose?
- Do the resident, family and direct caregivers know signs and symptoms of over-sedation and steps to take if noted (e.g., alert the nurse)?
- Is there evidence the facility implements nonpharmacological pain management approaches?
- Is there a system to ensure extended-release formulations are delivered correctly (e.g., medications not crushed)?

PROLONGED CONSTIPATION, ILEUS OR IMPACTION RELATED TO OPIOID MEDICATION USE

Risk Factors:

- ☐ Opioid medication use (routine or PRN)
- ☐ Uncontrolled pain
- ☐ Recent abdominal surgery
- ☐ Advanced age
- ☐ Diagnosis of dementia, Parkinson's, multiple sclerosis, or quadriplegia
- ☐ Low fluid intake or dehydration
- ☐ Decreased mobility

Signs & Symptoms:

- ☐ Constipation (lack of bowel movement for three or more days or straining to move bowels regardless of frequency)
- ☐ Bloating or abdominal distension
- ☐ Abdominal pain
- ☐ Headaches associated with symptoms above
- ☐ Diarrhea or leaking stool
- ☐ Decreased bowel sounds
- ☐ Nausea/vomiting
- ☐ Decreased or absent ability to urinate
- ☐ Rapid heartbeat
- ☐ Sweating
- ☐ Fever
- ☐ Low or elevated BP

Clinical Interventions:

- ☐ New orders for laxatives, stool softeners, suppositories and/or enemas
- ☐ New order for abdominal x-rays
- ☐ Transfer to hospital

Probing Questions:

- Is there evidence of a bowel regimen in place, such as routine orders for stool softener/laxative?
- For residents with risk factors for constipation, does the care plan reflect interdisciplinary monitoring for signs/symptoms of constipation and an interdisciplinary plan to prevent it, including dietary management?
- Is fluid intake monitored?
- Are residents/families taught signs/symptoms of constipation and the importance of reporting them?
- Are bowel movements (frequency and size) monitored routinely by nursing staff?
- Is bowel status routinely addressed by the physician?
- Upon the initiation of opioids, did the prescriber acknowledge the increased risk of constipation and adjust the plan of care as indicated?
- Is there a protocol in place to address constipation (e.g., a process to provide routine or standing order bowel medications when a resident hasn't had a bowel movement)? If so, is the staff aware of and compliant with the protocol?
- Does the clinical record reflect that the dietician was made aware of an opioid being ordered so that nutritional approaches to prevent constipation could be considered?
- Is there evidence of a system for ensuring that residents are routinely assessed for pain, including monitoring for the effectiveness of pain relief and medication side effects (e.g., constipation)?
- Is there evidence that the facility implements non-pharmacological pain management approaches?

Source:

1. Adverse Drug Event Trigger Tool: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/Downloads/Adverse-Drug-Event-Trigger-Tool.pdf

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