



Connecticut Emergency Department Opioid Prescribing Guidelines

Patient care goals may be optimized when one medical provider coordinates all prescribed opioids to treat a patient's chronic pain, to the extent possible. The following guidelines are an educational tool to assist emergency medical personnel (EMPs) in addressing the care needs of persons who come to the Emergency Department (ED), and who have a chronic pain condition that may involve the use of opioids.

Specific Considerations for Emergency Departments:

The ED should coordinate the care of patients who frequently visit the ED, using an ED care coordination program, to the extent possible.

ED opioid prescriptions for acute injuries, such as fractures, should be in an amount that will last until the patient is reasonably able to receive follow-up care for the injury. In most cases, this should not exceed thirty (30) pills.

ED patients should be asked about a history of current substance abuse prior to prescribing opioids for acute pain. Opioids should be prescribed with great caution in the context of a substance abuse history.

EMPs generally should not order IV or IM opioids for acute exacerbations of chronic pain.

EMPs generally should not provide replacement prescriptions for controlled substances that were lost, destroyed, or stolen.

EMPs generally should not provide replacement doses for Methadone or Suboxone, but special consideration may be given in the event of natural disasters or other exigent circumstances.

EMPs generally should not prescribe long-acting opioids (e.g. Oxycontin, Fentanyl patches, methadone) for acute pain management.

EMPs should exercise caution when considering prescribing opioids for ED patients in situations in which the identity of the individual cannot be verified.

Specific Legal, Oversight, and Policy Considerations

The Emergency Medical Treatment and Active Labor Act (EMTALA) requires patients who present at the hospital seeking care to be screened for any emergency medical condition. This includes patients who present with reports of pain. If an emergency medical condition is present, EMTALA requires that the patient be stabilized prior to transfer or discharge. EMTALA allows an EMP to use his or her clinical judgment in treating pain, and does not expressly require the use of opioids.

The Joint Commission has various standards and guidelines relating to pain management. Where applicable, the standards that should be considered include: HR.01.04.01, EP 4; MS.03.01.03, EP 2; PC.01.02.01, EP 2; PC.01.02.07, EP 1-4; PC.02.03.01, EP10; PC.03.01.07, EP2; and RI.01.01.01, EP 8.

To the extent that these guidelines are expressly adopted by hospital policy, EMPs should be supported and should not be subject to adverse considerations when following these guidelines.

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Disclaimer: These guidelines are an educational tool. Clinicians should use clinical judgment in making treatment decisions and not base clinical decisions solely on this document. This document does not establish any standard of care. Deviation from it will occur when clinical situations dictate. No legal proceeding, including medical malpractice proceedings or disciplinary hearings, should reference a deviation from any part of this document as constituting a breach of professional conduct.