In 2001 the Joint Commission developed pain management standards. These standards require organizations to:

- Recognize the right of patients to appropriate assessment and management of pain
- Screen patients for pain during their initial assessment, and when clinically required during ongoing, periodic reassessments
- Educate patients suffering from pain and their families about pain management

In 2012 the Joint Commission issued a Sentinel Event alert. This alert urged hospitals to take specific measures to help avoid serious complications and even deaths from the use of opioids.
Adverse Events Associated With Opioid Use

- According to the Joint Commission 2012 Sentinel Event
  - Some of the causes of adverse events include
    - Lack of knowledge about potency differences among opioids
    - Improper prescribing and administration of multiple opioids and modalities of opioid administration i.e.
      - Oral
      - Parenteral
      - Transdermal patches
    - Inadequate monitoring of patients on opioids

Serious Complications From Use of Opioids

- According to the Joint Commission 2012 Sentinel Event
  - Of the opioid related adverse drug events, including deaths that occurred in hospitals and were reported:
    - 47% were wrong dose medication errors
    - 29% were related to improper monitoring of the patients
    - 11% were related to other factors including:
      - Excessive dosing
      - Medication interactions
      - Adverse drug reactions
Sedatives and Opioids

- Sedatives and Opioids
  - Are cited by the Joint Commission as High Alert Medication
    - High-alert medications are drugs that bear a heightened risk of causing significant patient harm when they are used in error.

Objectives

- To provide guidelines for:
  - Pain assessment in the adult and elderly
  - Treatment modalities of pain
  - Monitoring for dosages above maximum
  - Documenting and proper waste of controlled substances
- To discuss:
  - The unique physiology that could put adult and elderly patients at risk when receiving analgesics
  - The use and management of HYDROmorphone (Dilaudid) in pain management
What is Pain

- Pain is:
  - A subjective, complex response.
  - An unpleasant sensory and emotional experience associated with actual or potential tissue damage.
  - Defined as a multidimensional, subjective experience with sensory, cognitive and emotional dimensions.
  - Whatever and whenever the patient says it is.
  - Always subjective
    - Patient’s self report of pain is the single most reliable indicator of pain.

Goal of Effective Pain Management

- When administering opioids to a patient their pain will be reduced to an acceptable range without the effects of sedation.
Pain Assessment

- Pain is a subjective experience – it is whatever the patient says it is.
- A patient’s report of pain should be taken at face value without regard for whether the patient “looks like” or “acts like” he/she is in pain.
- Keep in mind the cultural variations in the meaning of pain and the way pain is expressed and reported.
- Use a reliable, valid pain assessment scale.
- In populations that are confused or nonverbal observe for indications of pain such as:
  - Restlessness
  - Groaning
  - Rubbing
  - Moving
  - Vocalizations
  - Grimacing

Pain Rating Scale

- Pain Ruler - Zero to Ten
  - 0 means - NO pain
  - 10 means - the worst possible pain the patient can imagine
- Includes a visual 0-10 scale with associated descriptive words and the Wong-Baker Faces Scale
  - 0 = smiling
  - 10 = crying
- Available in different languages
- Can be used for:
  - Children as young as 3
  - Patients who have limited English skills
  - Patients that are cognitively impaired
Patient Education on Pain Management

- The patient and family/caretaker will be instructed on how to use the pain scale utilized by LCMH.
- The Fact sheet “Our Commitment to Your Pain Relief”, included in the “Patient Guide” is given to every patient on admit.
- This fact sheet explains:
  - LCMH’s philosophy on pain relief
  - How the patient should rate their pain
  - What the patient can expect from the staff at LCMH
  - How the patient can help us treat their pain
- Krames book “Understanding Your Pain” are available on all units.

Barriers to Pain Management

- **Underassessment**
  - Major cause of inadequate pain management
  - Clinician’s personal feelings about pain and pain management.
  - Inadequate history on admission
  - Infants or the elderly who are unable to verbalize their pain.
  - Adults with cognitive or emotional disorders
  - Patients who are seriously ill or intubated.
- **Language and communication barriers:**
  - Hard of hearing
  - Visually impaired
  - Cultural issues
  - Fear of addiction
Responsibilities in Overcoming the Barriers

- Take a thorough and adequate history.
- Realize and accept the patient's self-report of pain.
- Develop an understanding of pain research and management of pain.
- Utilize appropriate pain assessment tools for the age of the patient.
- Utilize pain tools that those of a different language can understand.
- Utilize appropriate tools that address those who are hard of hearing or visually impaired.
- Rely on physiological signs only when the patient is unable to self-report.

The Different Types of Pain

- Nociceptive Pain
- Neuropathic Pain
- Psychogenic Pain
- Unspecified Pain
Nociceptive Pain

- **Nociceptive pain**
  - Associated with stimulation of peripheral or visceral receptors.
  - This type of pain usually responds to conventional analgesic drugs.
  - Included in this category:
    - **Chronic pain**
      - Lasts beyond the normal healing period of 3-6 months
      - Long term functional deficits can be observed in this patient
      - This type of pain is usually associated with a chronic disease process
    - **Acute pain**
      - May result from illness, trauma or tissue damage
      - Usually associated with autonomic symptoms such as tachycardia and/or diaphoresis
      - Expected that acute pain will subside with the healing process


Neuropathic Pain

- **Neuropathic pain**
  - Involves pathology to the peripheral or central nervous system.
  - Typically this pain follows the neural pathways and does not respond well to traditional analgesics.
  - Examples of this type of pain:
    - Postherpetic neuropathy
    - Phantom pain
    - Post-stroke pain
    - Diabetic neuropathy

Psychogenic Pain

- **Psychogenic pain**
  - This pain is entirely related to a psychological disorder with no evidence of a physiological cause.
  - Psychiatric interventions are needed
  - Traditional pain management interventions are not effective

Unspecified Pain

- **Unspecified Pain**
  - The cause of this type of pain is usually not identified.
  - Headaches of an unknown cause would come under this category.
Physiological Effects of Pain

- Pain leads to anxiety and stress.
- Catecholamines are released when pain is experienced leading to:
  - Tachycardia
  - Increased blood pressure
  - Increased oxygen consumption
  - Decreased gastrointestinal motility
- Activation of the sympathetic system can lead to:
  - Hypercoagulopathy
    - Putting the patient at risk for:
      - VTE's
      - Pulmonary emboli
      - Myocardial infarction
- Neuroendocrine response
  - Precipitates an increase of adrenocorticotrophic hormone (ACTH) and cortisol levels
  - Leading to a compromised immune system

(Rothman, 2006)

Unrelieved Pain

- In the elderly population unrelieved pain can lead to numerous factors that can interfere with normal daily activities including:
  - Impaired pulmonary function
  - Impaired GI function
  - Poor immune system response
  - Lack of mobility
  - Delayed healing
  - The inability to sleep or concentrate
  - Depression
  - Decreased activity
  - Deconditioning and gait disturbances
    - Which can cause injuries from falls

(Hanks-Bell, Halvey & Paice, 2004)
Treatment/Documentation for Pain Management

- All patients are assessed for the presence, absence and history of pain
- Initial history includes a comprehensive pain assessment
  - Intensity
    - (0-10) scale rating given by the patient
  - History
    - When the pain began
    - How long does it last
    - Does it come and go
  - Quality
    - Include a description of the pain
      - Ache
      - Burning
      - Throbbing
      - Sharp
      - Soreness
  - Location
    - Where is the pain
    - Is it localized
    - Does it radiate
  - Aggravating & Alleviation factors
    - Does anything make the pain worse
    - Does anything make the pain better
  - Associated signs and symptoms
    - Nausea
    - Fatigue
  - Impact on functional ability
    - Does it affect their ability
      - To sleep
      - To socialize
      - To concentrate
  - Methods of pain management
    - Helpful/unhelpful
      - What are they currently taking or doing to relieve the pain
  - Patient's personal goal for pain relief
    - (0-10 scale)
    - Cannot promise a 0 only the lowest possible

Acronym to Aid in Obtaining a Pain History

- L = the exact LOCATION of the pain and whether or not it radiates
- O = OTHER ASSOCIATED SYMPTOMS
  - Such as
    - Nausea
    - Numbness
    - Weakness
- C = CHARACTER of the pain
  - Throbbing
  - Sharp
  - Dull
  - Burning
- A = AGGRAVATING OR ALLEVIATING factors
  - What makes it better or worse
- T = TIMING of the pain
  - When did it start
  - How long does it last
  - Is it constant or intermittent
- E = ENVIRONMENT
  - Where the pain occurs
    - While working
    - While at home
    - With ADLs
When to Document Pain Intensity and Relief

- **Pain should be documented:**
  - On admission
  - Routinely with vital signs
  - After any known pain-producing event
  - With each new report of pain
  - After each pain management intervention
    - 30 minutes after IV meds
    - 60 minutes after PO meds
  - Any pain report of >4 requires intervention
    - Pain >4 interferes with ADL's
    - A patient can sleep through pain

The World Health Organization Analgesic Ladder

- When choosing an opioid the World Health Organization recommends using a systematic and graduated approach
- This three-step approach of administering the right drug in the right dose at the right time is inexpensive and 80-90% effective.
- The “analgesic ladder”
  - Starts with non-opioids
  - Then changes to weak opioids and nonsteroidal anti-inflammatory drugs (NSAIDs)
  - Progress to stronger medications as needed
    - Depending on side-effects or ineffectiveness
  - An adjuvant should be used to calm fears and anxieties.
    - An adjuvant is a pharmacological or immunological agent that modifies the effect of other agents
Level 1 of The World Health Organization Analgesic Ladder

- **Level 1**
  - Includes mild to moderate pain
  - Includes a pain rating of 0-3 on a zero to 10 rating scale
  - The WHO recommends nonopioid medications for treatment of pain at this level
    - Acetaminophen (Tylenol)
    - NSAIDs
      - Many older adults have contraindications to NSAIDs and may have comorbidities preventing them from adhering to this approach

Level 2 of The World Health Organization Analgesic Ladder

- **Level 2**
  - Includes persisting pain from level one
  - Includes pain identified by the patient to be a 4-6 rating
  - The WHO recommends a weak opioid to treat this level of pain, or a nonopioid analgesic alone or with an adjuvant
    - Codeine (Tylenol with codeine)
    - Medications that contain:
      - HYDROcodone - (Vicodin)
      - OxyCODONE - (Percocet)
      - Tramadol - (Ultram)
Level 3 of The World Health Organization Analgesic Ladder

- **Level 3**
  - Includes pain identified as severe, a rating of 7-10.
  - Includes pain from a lower level that has not been relieved.
    - Morphine
    - HYDROmorphine (Dilaudid)
    - Sublimaze (Fentanyl)
    - Methadone
    - An adjuvant of a nonopioid may be added if needed

The Elderly: Pain Assessment and Management in a Special Population

- Pain in the elderly has the potential to affect their independence and quality of life.
- Assisting the elderly patient to assess their pain is key to effective pain management.
- The clinician must ensure that the patient is able to comprehend the instructions given.
  - Cognitive deficits may lead to confusion.
  - Hearing difficulties may interfere with comprehension.
  - In the case of converting from one drug to another it is vital that the patient understands that the old drug is not to be used anymore and must be disposed of appropriately.
- Must keep in mind the physiological changes that occur with aging.
- Must reduce the elderly patient’s pain without the patient experiencing the adverse side effects of analgesic.
Key Points to Remember When Setting Up a Pain Relief Plan With the Elderly

- The elderly may have fear in admitting to pain.
- Elderly patients may have visual or auditory impairments that may interfere with pain assessment tools.
- Pain does not decrease with age.
- Pain is not reduced in those who are cognitively impaired.
- Polypharmacology
  - Taking multiple medications can lead to potential drug interactions.

Key Points to Remember When Setting Up a Pain Relief Plan With the Elderly (cont.)

- This population may have numerous comorbidities.
  - Making it difficult to identify an acute process
- Elderly patients have a greater peak and longer duration of action than younger patients.
- Changes in metabolism in the elderly result in slower clearance of the medications.
  - Decreased renal function
  - Decreased liver function
Key Points to Remember When Setting Up a Pain Relief Plan With the Elderly (cont.)

- Side effects of analgesics may be more pronounced in the elderly:
  - Constipation
  - Ileus
  - Urinary retention
  - Nausea
  - Increased confusion

- Analgesic administration in the elderly is complicated by:
  - Chronic disorders
  - Multiple drugs
  - Nutritional alterations
  - Slowed metabolism

Key Points to Remember When Setting Up a Pain Relief Plan With the Elderly (cont.)

- Chronic pain versus acute pain
  - The elderly population may experience pain from chronic conditions.
    - It is the clinician’s responsibility to assist the elderly in differentiating a chronic condition from an acute condition.
Physiological Changes That Affect Treatment Modalities In the Elderly

- Changes in metabolism in the elderly result in slower clearance of medications.
- Decreased renal and liver function from the normal aging process:
  - Can result in retention of metabolites from medications that are normally excreted by the body.
  - The glomerular filtration rate is estimated to decrease about 1% per year after the age of 40.
  - A lower glomerular filtration rate will have an effect on those drugs that are eliminated through the kidneys.

- With aging the central nervous system has an increase in sensitivity requiring lower doses of opioids.
- Slower metabolism in the elderly puts them at risk for the side effects of analgesics leading to:
  - Constipation
  - Ileus
  - Urinary retention
  - Nausea
  - Increased confusion
  - Hypotension
  - Dizziness
- It is important to remember that the above side effects can occur in post-operative patients regardless of age.
Physiological Changes That Affect Treatment Modalities In the Elderly (cont.)

- Because of the decreased body mass in the elderly:
  - They do not absorb IM or subcutaneous medications as well as they did when they were younger.
  - The aging effects on the GI system slow the absorption of medication given orally.

Remember With Administration of Opioids to the Elderly:

- Opioids having long half-lives can result in toxicity in the elderly.
- Ask yourself what else is the patient receiving that could potentiate the action of the opioid.
- Avoid IM as a route of administration.
  - Elderly have poor intramuscular absorption of medications.
  - Explain the treatment plan to the patient and the family.

Because of the physiological changes that occur in the elderly a basic standard was developed in the administration of opioids in this population:

**Start Low and Go Slow!**
Things to Remember With Administration of Opioids to the Elderly

- **Prior to medication administration document:**
  - Respiratory Rate
  - Pulse
  - Blood Pressure
  - Level of Consciousness
  - Pain Level

- **If a dose range has been ordered:**
  - Start with the lower dose
  - Gradually increase the dose if pain is unrelieved
  - Monitor for side effects

Things to Remember With Administration of Opioids to the Elderly (cont.)

- Use round-the-clock administration of the medication, not PRN.
- Monitor the patient for respiratory depression.
- Have Naloxone (Narcan) readily available.
- Anticipate, prevent and treat adverse effects.
- Observe the patient for side effects of:
  - Constipation
  - Urinary retention
  - Ileus
  - Hypotension
  - Confusion

- If dosing around the clock patients should be on a scheduled stimulant laxative to prevent constipation
  - Example: Senna-S
### Commonly Used Opioids

<table>
<thead>
<tr>
<th>Opioid</th>
<th>Important Points</th>
<th>Indications</th>
<th>Contraindications/ Cautions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codeine</td>
<td>Metabolized to Morphine</td>
<td>Mild Pain</td>
<td></td>
</tr>
<tr>
<td>Morphine</td>
<td>Renally cleared metabolites</td>
<td>Moderate to severe pain</td>
<td>Avoid in patients with decreased creatinine clearance</td>
</tr>
<tr>
<td>HYDROMorphone</td>
<td>Renally cleared metabolites</td>
<td>Older adults who require parenteral opioids</td>
<td>Avoid in patients with decreased creatinine clearance</td>
</tr>
<tr>
<td>(Dilaudid)</td>
<td>Much more potent than Morphine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OxyCODONE</td>
<td>No renally cleared metabolites</td>
<td></td>
<td>Patients with reduced creatinine clearance who can take oral medication</td>
</tr>
<tr>
<td>(Percocet)</td>
<td>Very potent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sublimaze</td>
<td>Takes up to 48 hours to achieve steady state</td>
<td>Patients with stable opioid requirements</td>
<td>Patients with fluctuating pain levels</td>
</tr>
<tr>
<td>(Fentanyl)</td>
<td>Can be a good choice in many older adults</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meperidine</td>
<td>Renally cleared metabolite</td>
<td>Contraindicated for treatment of pain</td>
<td>High risk of seizures</td>
</tr>
<tr>
<td>(Demerol)</td>
<td>Long metabolite half-life</td>
<td></td>
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</tr>
</tbody>
</table>

### Commonly Made Mistakes With HYDROMorphone (Dilaudid)

- **HYDROMorphone (Dilaudid) is ordered in place of Morphine.**
- **HYDROMorphone (Dilaudid):**
  - **Is six times** more potent than Morphine
    - 1mg of HYDROMorphone is = to 6mg of Morphine
  - Starting dose should be 0.2mg – 1mg
Opioid Side Effects

- Sedation
- Nausea and vomiting
- Impaired cognition
- Ileus and constipation
- Myoclonus
  - A quick, involuntary muscle jerk
- Pupillary constriction
- Respiratory depression
- Urinary retention
- Hyperalgesia
  - Occurs when the use of opioids reduces the pain threshold and can manifest as opioid tolerance.
  - Pain can in fact become worse despite an increase in dose or escalation of use.
- Loss of appetite
- Impaired orthostatic tolerance
- Seizures

Hyperalgesia

Opioids Frequently Used For Pain Management

- Morphine
  - Considered the gold standard opioid for pain management.
  - Breaks down to an active metabolite that is excreted in the urine.
  - Should be used with caution in patients with renal dysfunction.
    - Retention of the metabolite can cause adverse side effects
      - Sedation
      - Respiratory depression

Dose:

**Adult maximum starting dose IVP** = 6mg with a peak in 30 minutes

**Geriatric (>65 years of age) maximum starting dose IVP** = 3mg with peak in 30 minutes
Opioids Frequently Used For Pain Management (cont.)

- HYDROMORPHOINE (Dilaudid)
  - SIX TIMES MORE POTENT THAN MORPHINE
  - Metabolite may not be clinically relevant.
    - Therefore a good analgesic for patients with renal dysfunction

Dose:
Adult maximum starting dose IVP = 1mg with peak in 30 minutes
Geriatric (>65 years of age) maximum starting dose IVP = 0.5mg with peak in 30 minutes

---

Opioids Frequently Used For Pain Management (cont.)

- Sublimaze (Fentanyl)
  - Fast acting
  - Short half-life
  - Duration in the elderly can be unpredictable
  - Slow elimination from tissues
    - Watch for adverse effects for up to 12 hours

Dose:
Adult maximum starting dose IVP = 50mcg with peak in 30 minutes
Geriatric (>65 years of age) maximum starting dose IVP = 25mcg with peak in 30 minutes
Opioids Frequently Used For Pain Management (cont.)

- Meperidine (Demerol)
  - Not a preferred medication in the elderly due to potential toxicity from accumulation of the metabolite.
    - Meperidine (half-life 15-20 hours)
  - Can cause seizures in the elderly.
  - Used with patients having allergies to other opioids.
  - Is automatically substituted to Morphine by pharmacy unless one time only dosing.

**Dose:**

*Adult maximum starting dose IVP = 50mg with peak in 30 minutes*

*Geriatric (>65 years of age) maximum starting dose IVP – 25mg with peak in 30 minutes*

---

Initial Assessment – Prior to Narcotic Administration

- Assess and document patients pain score
  - Using the pain scale
- Record baseline
  - Blood pressure
  - Pulse
  - Respiratory rate
  - LOC

***NOTE: DOSAGE IS DEPENDENT ON PATIENT AGE, WEIGHT, MEDICAL CONDITION AND NARCOTIC HISTORY***
Monitoring the Patient After Administration of Opioids

- When administering opioids to the elderly, especially those that do not normally take this type of analgesia, it is important for the nurse to monitor for signs of sedation.
  - A state of sedation usually precedes respiratory depression.

- For patients that are opioid-naïve:
  - Naïve implies that the patient is not already taking opioids
    - Monitoring should be done more frequently during the first 12 to 24 hours they are receiving opioids.
    - A sedation scale should be used.

Monitoring the Patient After Administration of Opioids (cont.)

- Reassessment after medication administration is to include:
  - Sleeping Respiratory Rate (before arousing the patient)
  - Pulse
  - Blood Pressure
  - Level of Consciousness
  - Pain Control
Reassessment After Medication After Administration of Opioids (cont.)

- Reassessment of the patient when the drug is peaking
  - Which is usually 15 – 30 minutes after administration
    - Assess presence or absence of pain
      - Using the pain scale
    - Pain increase or decrease
      - Using the pain scale
    - Mood and functionality
    - Sedation level
    - Side effects
      - Nausea
      - Pruritus Etc.
    - Patient satisfaction with the effects
    - Review of the patient pain goal

Monitoring for Dosages Above Maximum

- Any IV narcotic order exceeding the maximum dose requires initiating and maintaining the following monitoring practices:
  - Vital signs and level of consciousness to be measured and documented prior to medication administration.
  - Reassessment recommended at 15 minute intervals x 4 including:
    - Sleeping Respiratory Rate (before arousing the patient)
    - Pulse
    - Blood Pressure
    - Level of Consciousness
    - Pain Control
  - Pulse oximetry will be measured continuously.
  - Supplemental O2 and emergency equipment should be readily available.
Sedation Scale for Assessing Level of Consciousness

<table>
<thead>
<tr>
<th>Assessing Level of Consciousness</th>
</tr>
</thead>
<tbody>
<tr>
<td>S = Sleeping, but easy to arouse</td>
</tr>
<tr>
<td>1 = Alert and awake</td>
</tr>
<tr>
<td>2 = Resting, slightly drowsy, easily aroused</td>
</tr>
<tr>
<td>3 = Frequently drowsy, difficult to arouse, drifts off to sleep during conversation</td>
</tr>
<tr>
<td>4 = Unarousable, minimal or no response to physical stimulation</td>
</tr>
</tbody>
</table>

Respiratory Depression

- **Respiratory Depression**
  - Occurs in 0.2% of patients receiving opioids
  - Increases with age
  - Increases with higher doses
  - Increases with underlying cardiopulmonary disorders
  - Increases with those receiving supplements along with opioids

- According to LCMH policy
  - Severe Respiratory depression is defined as:
    - A decrease in respiratory rate to less than 10 per minute
    - A marked decline in the level of consciousness
    - An Oxygen saturation of <90%
Emergency Actions to be Initiated With Respiratory Depression

- Emergency actions are to be initiated at this time per LCMH policy:
  - Naloxone (Narcan) dose: 0.2mg IV push every 5 minutes PRN up to 1mg
    - If respiratory rate is < 10/minute
  - Oxygen per nasal cannula
  - Stat arterial blood gases (ABGs)
  - Notify physician in charge immediately

*It is important to remember: These are standing orders and there is no need to call the physician prior to giving the Naloxone. The physician is to be notified after you have given the Naloxone, started the oxygen and obtained stat arterial blood gases.*

Witnessed Waste of Controlled Substances

- Controlled substances need to be administered within 30 minutes from time of removal from ADM
- If the dose is less than the amount vended
  - The excess medication is wasted with a witness at the time of removal from the ADM
- Incremental dosing from a single vial/syringe is only permitted in procedural areas ie. PACU
  - For pain titration every 5 minutes
- No single syringe or vial may be used for longer than sixty minutes at a time
Documenting Waste of Controlled Substances

- Waste of oral medication will be witnessed, crushed and disposed of in the waste container.
- Patches (Fentanyl) are to be witnessed, cut into four (4 pieces) and flushed down the toilet.
- Any unused portion of the controlled substance must be witnessed, discarded and documented appropriately on the medication Automated Distribution Machine or sign out sheet.
- Documentation including signature of both RNs is done on the medication Automated Distribution Machine per PCS Policy 1906.

Controlled Substances

- No one is permitted to store or conceal controlled substances on their own person at any time
  - Beyond those exceptions on the previous slide
- The same RN that vends the controlled substance from the ADM should be the one to administer the medication via electronic bar code scanning
### Controlled Substances

- If epidural infusions or PCA cassettes are not completed:
  - The remaining solution volume must be wasted and witness is documented in the eMAR
  - Disposal must be unrecoverable either down sink drain or toilet (as permitted by the DEA)
  - Return any non-administered controlled substances to the ADM return bin by selecting the name of the drug to be returned; this also cancels the charge
  - Exclusion, drugs with purple sign out sheets returned to specific drawer in ADM

### Controlled Substance, Individual Patient Record

- The Individual Patient Sign Out Sheet is used to account for scheduled substances dispensed to a particular patient.
- Documentation
  - The dose administered must be documented on the MAR
- When the individual controlled substance is completed or when the medication is discontinued send the following to Pharmacy:
  - Accounting sheet
  - Refill order
  - Empty container or any remaining unused medications
References