Emergency Medicine Policy:
Appropriate Use of Opioid Medication in Emergency Medicine at NorthShore

We have put together a policy in Emergency Medicine at NorthShore based on national guidelines that protects our patients from opioid complications: This is not a substitute for clinical judgement.

- WE NEVER FILL- **LOST**, **STOLEN**, or **DESTROYED** prescriptions
- We never initiate long acting opioids (including methadone and fentanyl): Exception to Methadone: Police bring in patient for 1 dose
- If opioids are prescribed, it is for a maximum of **3 days (Approx. 17 pills)**

Examples of Conditions where other medications that do not have sedating issues or any other significant long term complications like opioids should be utilized:

- Lacerations
- Soft tissue injuries
- Ankle sprains
- Fibromyalgia
- Low back pain
- Tooth pain
- Migraines

Conditions that may require opioids medications include:

- Renal colic
- Fractures
- Diverticulitis
- Burns
- Abscess
- Cancer pain

We Do Not Treat Chronic Pain
Definition of Chronic Pain:

- A patient seen in the ED one previous time within the last month for the same medical issues or complaint

OR

- A patient given a narcotic prescription by a provider in the last month for chronic medical issues identified in the patient's chart (headaches, abdominal pain, back pain, fibromyalgia, etc.)

Other Treatment Options in place of opioids (Benzodiazepines are not indicated for pain)

- Lidocaine patches
- Headache Options:
    1. Haldol(haloperidol) 2.5mg IV with Benadryl(diphenhydramine) 25mg IV piggyback over 20 minutes or oral Benadryl (diphenhydramine) 25mg
    2. Intranasal Lidocaine by Atomizer
        a. 1cc of 4% Lidocaine atomized in each nostril
- General Pain Option:
    1. Intranasal Ketamine by Atomizer
        a. Initial: 0.7mg/kg intranasal + 0.25mg/kg intranasal x 1 after 10-15 mins PRN
        MAX➔Total Dose: 1mg/kg