# SESLHD GUIDELINE COVER SHEET

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# Safe Use of Opioids

# Section 1 – Background

Pain is one of the most common reasons adults seek medical care and is a common experience for hospitalised patients. It interferes with many daily activities. One of the goals of pain management is to reduce the effect of pain on function and quality of life. Safe alleviation of pain is important role for doctors, nurses, pharmacists and allied health staff.

Opioid should only be considered for patients with chronic non-cancer pain once non-pharmacological therapies and non-opioid medicines have been optimised.

## What are opioid medicines?

Opioid medicines principally act on opioid receptors in the central nervous system and gastrointestinal system, producing effects including analgesia, respiratory depression, sedation and constipation. Opioid medicines are frequently used to treat moderate to severe pain.

The Australian Medicines Handbook (AMH) provides a summary of the available Opioid Formulations.

| Drug | Oral | | | Injection | Other |
|---|---|---|---|---|---|
| | conventional | controlled release | buccal or sublingual | | |
| buprenorphine | | | tablet | IV, IM | patch |
| codeine | tablet, liquid | | | | |
| fentanyl | | | lozenge, tablet | IV, SC, epidural, intrathecal | intranasal solution, patch |
| hydromorphone | tablet, liquid | tablet | | IV, SC, IM | |
| methadone | tablet, liquid | | | SC, IM | |
| morphine | tablet, liquid | tablet, capsule | | IV, SC, IM, epidural, intrathecal | |
| oxycodone | tablet, capsule, liquid | tablet | | IV, SC | suppository |
| pethidine | | | | IV, SC, IM, epidural | *not listed on Formulary* |
| tapentadol | tablet | tablet | | | |
| tramadol | capsule, liquid | tablet | | IV, IM | |

Opioids present a unique challenge to prescribers. Despite these medicines having an important therapeutic role to play in the management of acute and cancer-related pain, existing evidence is insufficient to support the efficacy and safety of opioid therapy in chronic non-cancer pain.

Opioids also carry well-established risks of dependency and tolerance, and high doses can lead to significant harm, particularly at > 100 mg oral morphine equivalent daily dosage (oMEDD). In addition, the prescription of opioid medicines carries societal risks such as misuse and diversion, making it a public health concern in Australia.

## Risk of Harm from opioid medicine

Errors involving opioids can include:

- Administration of an incorrect formulation. For example, administration of a short-acting formulation when a long-acting formulation was intended (and vice versa).
- Failure to adjust an opioid dose according to patient factors. For example, pain assessment, biochemistry, renal function, age, opioid tolerance and drug interactions with other medicines.
- Dose calculation errors when transitioning between different opioid medicines, formulations or routes of administration.
- Inappropriate use of opioid patches, including the use of fentanyl patches for patients with acute pain who are not opioid tolerant. Other errors involving opioid patches include prescribing and applying patches at the incorrect time interval, cutting or only partially applying patches and failing to remove a patch before applying a new patch.

In addition, the prescribing of opioid analgesia for patients discharged from hospital needs to be undertaken with caution due to the risk of dependency, adverse effects, interactions with other drugs (central nervous system depressants, in particular benzodiazepines, gabapentinoids, and alcohol), cognitive and driving impairment, and falls. There is a correlation between an increase in opioid prescribing for acute conditions on discharge from hospital and opioid-related harm including dependence, injury, overdose, antisocial behaviour and death in the community.

## Section 2 – Purpose of this Guideline

This document outlines the minimum actions required to mitigate risks associated with opioid use while in hospital and on discharge.

It does NOT contain detailed clinical guidance on therapeutic use of opioids. There are a number of specialty services available across SESLHD which can provide expert guidance on the use of opioids, including the Acute Pain Services, Sub-Acute Pain Services, Chronic Pain Services and Addiction medicine.

This document does NOT cover specific requirements for treatment of opioid dependence. For clinical guidance and policy direction for opioid dependence treatment in NSW, refer to:

- NSW Health Policy on Management of Opioid Dependent Persons admitted to Hospitals in NSW.
- NSW Health Clinical Guidelines on Treatment of Opioid Dependence.
- NSW Health Clinical guidelines for use of depot buprenorphine in the treatment of opioid dependence.
- Local protocols.

# Section 3 – Definitions

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| Equianalgesic | Refers to different opioids providing similar analgesic effect at consensus opioid equivalent doses |
| Opioid naïve | Not having previously been exposed to opioids |
| Tolerance | Tolerance refers to the progressive decrease in analgesic effect for the same dose of opioid, or the need for progressively larger doses to maintain the same effect |
| Cross tolerance | Cross tolerance describes the extent to which tolerance to one opioid agent confers a degree of tolerance to a different opioid agent. Consideration of cross tolerance is required to determine safe and appropriate doses when switching opioids in an opioid-tolerant patient. |
| Opioid Induced Hyperalgesia (OIH) | Paradoxical increase in pain when given opioids |
| Opioid Induced Ventilatory Impairment (OIVI) | Decreased respiratory rate &/or tidal volume, +/- increased sedation, +/- upper airway obstruction |
| Persistent Post operative (post discharge) Opioid Use (PPOU) | continuation of opioids prescribed for postoperative pain for longer than 90 days after surgery |
| Modified release (MR) | Drug products that alter the timing and/or the rate of release of the drug substance. MR products are also referred to as controlled release, slow release; extended release, long acting and sustained release. These include oral products, transdermal patches and long acting injections. |
| Immediate release (IR) | Drug products, which are formulated to release the active drug immediately after administration formulated to release the active drug immediately after oral administration |

# Section 4 – Responsibilities

### 4.1 Employees (Registered Nurses, Registered Midwives, Enrolled Nurse without notation, Pharmacy and Medical Staff) are responsible for:

- Ensuring that the correct policy and procedure are adhered to in accordance to legislative requirements on the use of opioids within the SESLHD.

### 4.2 Line Managers are responsible for:

- Ensuring that staff adhere to the correct policy and procedures in accordance to legislative requirements on the use of opioids within the SESLHD.

### 4.3 District Managers/ Service Managers are responsible for:

- Monitoring policy adherence and allocate resources accordingly to facilitate compliance.

# Section 5 – Principles for Safe Prescribing of Opioids

## Summary

A judicious approach in considering opioid therapy and choosing an appropriate opioid is needed.

Opioids should only be used for the shortest time and at the lowest dose possible; titrated to functional and analgesic end points. Consider a multimodal approach with non-opioid medication *(e.g. paracetamol, NSAIDs)*, nerve blocks, psychological and/or behavioural strategies.

Opioids should not be considered first-line or routine therapy for chronic pain outside of active cancer, palliative, or end-of-life care, given their small to moderate short-term benefits, uncertain long-term benefits, and potential for serious harms.

Long-term opioid use often begins with treatment of acute pain.

It is important to ensure that patients/carers are provided with education regarding the safe and optimal use of opioids that have been prescribed:

The patient's family or carer should be advised to alert the patient's nurse if they have concerns about a change in the patient's condition, including an unexpected increase in sedation, or other adverse effects associated with opioid medicines.

For more detailed information about the assessment and management of pain refer to Therapeutic Guidelines Pain and Analgesia Handbook available via CIAP.

## 5.1 Suitability of opioids for different types of pain

### 5.1.1 Acute Pain

- Opioids can have a clear role in severe, acute pain. Analgesic requirements and duration of need will vary depending on the cause and trajectory of the individual's acute pain. In most settings, a prescription of 3 days or less is recommended, and more than 7 days is rarely required.
- Short-acting, when required, immediate-release opioids are preferred in the management of acute pain.
- Multi-modal analgesia (*e.g. paracetamol, NSAIDS and other adjuvants*) is recommended when managing acute pain.
- Start low and go slow in children, older people and those on other psychoactive medication *(e.g. benzodiazepines, etc.).*

### 5.1.2 Cancer pain and Palliative care at end-of-life

- Confirm the patient's current pain management regimen with a reliable source.
- Discuss complex cases with an Oncologist, Palliative Care or Pain Medicine physician.

### 5.1.3 Chronic non-cancer pain (CNCP)

- The general consensus is that for most patients with chronic non-cancer pain opioid do not provide clinically important improvement in pain or function compared to placebo. Despite this many patients are taking maintenance opioids.
- oMEDD should be calculated for all patients prescribed opioids for CNCP to illustrate the dose dependent risk of harm:
    - **Green light:** oMEDD ≤ 40 mg considered acceptable with less risk of adverse effects
    - **Amber light:** oMEDD 40-99 mg **WARNING** likely increased risk of adverse effects

- **Red light: HIGH RISK** for adverse events and consultation with a specialist pain medicine physician is recommended
  - oMEDD ≥ 100 mg
  - Patients > 65 years with oMEDD ≥ 30 mg
  - Adults patients weighing < 50 kg with chronic medical illness and oMEDD > 1.2 mg/kg/day

- Differentiate between a flare up of chronic pain and increased pain associated with a new injury or condition (acute pain component).
  - Do not initiate or increase opioids for a flare up of chronic pain, unless advised by a pain specialist.
  - If a new acute pain problem develops in a person on long-term opioids, tolerance may require titration to higher opioid doses or opioid rotation.
  - Deprescribing to baseline dose should follow as the acute problem settles.

## 5.2 Prescribing opioid medicines

### 5.2.1 Special Populations

Paediatrics:

Opioid use in children is usually initiated or recommended by specialists. Neonates and infants up to approximately 12 months are more susceptible to respiratory depression associated with opioid use. Children with obstructive sleep apnoea (e.g. associated with obesity or tonsillar hypertrophy) have increased risk of respiratory depression. Start with a low dose and titrate to effect.

Breastfeeding:

Codeine should be avoided-an infant death has occurred (see TGA Safety review: Codeine use in children and ultra-rapid metabolisers). Occasional doses of other opioids are safe but use repeated doses with caution, especially if infant is preterm or <4 weeks old. The infant should be monitored for sedation and other adverse effects.

Elderly:

There is an increased risk of adverse effects including cognitive impairment, sedation, respiratory depression and falls. Use a lower initial dose (e.g. 25–50% of usual adult dose) and titrate to effects.

Patients with a history of opioid dependence:

People with current or past problems of opioid dependence are at higher risk of serious harm from treatment with opioid analgesics. SafeScript NSW is a real time prescription monitoring system which provides access to real-time information about a patient's prescription history for certain high-risk medicines.

Principles for prescribing in this patient population are outlined in the *Information for health professionals: Pain management in patients with a history of opioid dependence;* available on the Safer use of opioids, Victorian Department of Health website. SESLHD Drug and Alcohol Services can also be contacted for consultation and advice.

### 5.2.2 Precautions

Gastrointestinal

Use opioids with caution in patients with ileus; consider parenteral route of administration as oral absorption may be minimal. Opioids may cause spasm of sphincter of Oddi. Seek specialist surgical opinion for patients with bowel obstruction.

Respiratory

Use opioids with extreme caution in patients with respiratory depression, severe obstructive airways disease, at risk of upper airways obstruction (e.g. sleep apnoea), asthma or decreased respiratory reserve as they may depress respiration, decrease the cough reflex and dry secretions. However, morphine is used in some forms of dyspnoea.

Renal

Because active/toxic metabolites accumulate in renal impairment, avoid use of codeine and pethidine; use lower doses of hydromorphone, morphine and tramadol with extreme caution. Alternatively, use an opioid such as oxycodone or tapentadol (both with appropriate dose adjustment) or fentanyl.

Hepatic

Dose adjustment may be required in hepatic impairment. Reduce dose and titrate carefully in severe hepatic disease as may precipitate coma. Oral naloxone-containing preparations (*e.g. Targin*®) should be avoided because patients may have unrecognised portal hypertension, which makes them more susceptible to the adverse effects of these drugs.

Drug Interactions

Opioids have overlapping toxicities such as sedation in patients also taking other CNS depressants such as psychotropic agents. Fentanyl, tramadol and tapentadol can contribute to serotonin toxicity and may interact with SSRIs and SNRIs lowering the seizure threshold.

### 5.2.3 Continuing an opioid on admission

For patients taking an opioid medicine(s) prior to admission, the dose should be confirmed with a reliable source such as the patient's community pharmacist, general practitioner or other medical speciality, SafeScript NSW or My Health Record prior to prescribing.

Where possible, pharmaceutical review should be completed prior to administration of the first dose of an opioid agent. Specific attention should be paid to:

- Previous adverse effects associated with opioids (including overdose).
- The appropriateness of the opioid agent for the indication
- The dose prescribed in view of the comorbidities and other medications (*particularly other opioids and sedating agents).*

### 5.2.4 Initiating an opioid during admission

The goals of pain treatment are to enhance functioning and reduce suffering and distress, while minimising the risk of adverse effects.

As with any treatment, an initial prescription of opioids should be based on:

- a comprehensive medical assessment
- a diagnosis

- a risk assessment of opioid misuse or opioid related harm (see Appendix A). Prescribers should be aware of the characteristics of each opioid, its accepted indications for use, and its general and specific risks.
- thoughtful consideration of the likely benefits of any opioid medication, as well as alternative nonpharmacological treatments and interventions.
- a management plan derived through shared decision making, where patients and / or carers are fully informed of the benefits, risks and harms associated with opioid medicines. Section 5.7 provides patient information resources which might assist in these conversations.

### 5.2.5 Consider the most appropriate route of administration:

- Intravenous (IV) administration is preferred for acute, severe pain (*e.g. postoperatively*), but is not appropriate for CNCP.
- Oral (PO) administration of opioids is preferred when prompt analgesia is not required (*e.g. postoperatively when analgesia has been established*), provided oral absorption is not impaired. PO administration should be used for ongoing analgesia, irrespective of the route of administration used for initial treatment.
- Subcutaneous (SC) administration is as effective as the IV route. It is used for intermittent doses and infusions of opioids in acute and chronic pain, and end-of-life care.
- Intramuscular (IM) administration is painful and absorption may be erratic. It has no role in cancer pain relief and is becoming less common in managing other types of pain.
- Transdermal patches are not suitable for acute pain because delayed onset and prolonged action make rapid, safe titration impossible.
- Modified-release (MR) opioid products should not generally be used for routine acute pain due to the risk of life-threatening OIVI. Their delayed onset and prolonged duration of action make rapid and safe titration impossible. They should not be used in opioid-naïve patients.
- Intranasal opioids are associated with a high risk of opioid-induced ventilatory impairment and should rarely be used outside critical care areas (*e.g. emergency departments, intensive care units, postoperative recovery units*).

Refer to the NSW Medicines Formulary for medicine (active ingredient/strength/form) specific prescribing restrictions. Initiation and discharge prescriptions for specific opioid products are restricted to prescribers with appropriate qualifications and expertise.

5.3 Prescribing an opioid during admission

### 5.3.1 Fixed Interval Variable Dosing (FIVD)

FIVD is the method by which a medication is ordered by providing a variable dose range rather than one set dose. The dose to be administered is then chosen by the clinician administering the medication.
In response to an adverse event in an opioid-naïve patient who was prescribed HYDROmorphone with an FIVD, the Ministry of Health has recommended that Fixed Interval Variable Dosing (FIVD) medication orders should be avoided. In situations where their use cannot be avoided, specific clinical criteria must be provided to nursing staff to support decisions on dose selection and monitoring. The prescriber is to specify the maximum individual dose, maximum daily dose, hourly frequency for administration and the maximum number of doses or maximum duration of treatment.

### 5.3.2 Product specific prescribing requirements

Overall, there is little clinical evidence to support the systematic choice of one opioid over another, either in terms of efficacy, tolerability, or risk of misuse. Hence a universal recommendation for the choice of opioid cannot be made, since there are a number of drug and patient factors that must be considered. For more detailed information on the selection of an appropriate opioid refer to Therapeutic Guidelines Pain and Analgesia Handbook available via CIAP.

When ordering HYDROmorphone, oromucosal fentanyl, oral IR or MR morphine, and oxycodone products, prescribers in addition to the generic name include the trade name of the product.

For HYDROmorphone prescribing, refer to SESLHDPR/669 - HYDROmorphone in Adult Patients in SESLHD acute care facilities – management of.

### 5.3.3 Concomitant Medications

- Antiemetics - Nausea may occur initially; an antiemetic may be given prophylactically, but use should be reviewed within a few days as nausea often lessens with continued opioid use.
- Laxatives - Little, if any, tolerance to opioid-induced constipation develops. Attention to fluid intake, diet and mobility is required; regular laxative use (*e.g. stimulant laxative and stool softener*) is essential as soon as opioid treatment is started.

## 5.4 Monitoring, dose titration and medication reviews

### 5.4.1 Monitoring

Once initiating opioid therapy, it should be monitored regularly by assessing the following 5 A's:

1. Activity: What progress has been made in the patient's functional goals (*e.g. sitting or standing tolerance, walking ability, ability to perform activities of daily living)*?
2. Analgesia: How does the patient rate the following over 24 hours? Average pain? Worst pain? How much relief have pain medications provided?
3. Adverse effects: Has the patient experienced any adverse effects from medication (*e.g. constipation, nausea, dizziness, drowsiness)*?
4. Aberrant behaviours: has the patient been taking the medicine/s as prescribed? Has the patient exhibited signs of medication abuse/misuse?
5. Affect: Have there been any changes in the way the patient has been feeling?

**Remember that opioid prescription is directed to functional goals (e.g. deep breathing or walking), not pain relief alone.**

### 5.4.2 Opioid Dose Titration

When titrating opioid doses, the adequacy of pain relief must be balanced against the occurrence of adverse effects. The eTG: Pain and Analgesia summarises the principles for opioid dose titration to support safe use of opioid regimens, including when not to give additional opioid doses and when to review the pain management strategy (*e.g. diagnosis and analgesic choice).*

### 5.4.3 Opioid Tapering

Opioid analgesia attenuates with time, while the likelihood of harm persists or increases over time and with increasing doses. Evidence suggests that tapering opioids can improve chronic pain, function and quality of life. The decision to taper opioids requires careful planning, close monitoring and patient-centred engagement. The NPS MedicineWise Opioid Tapering Algorithm, provides a step-wise approach to tapering.

## 5.5 Converting between different opioids and formulations

Opioids differ in potency, adverse effects, pharmacokinetics and formulation. It may be necessary to change to another opioid medicine, formulation, dose or route due to:

- Difficulties swallowing
- Intolerable adverse effects
- Inadequate response despite dose escalation (*note: wait appropriate time for full effect before making changes)*
- A change in the patient's clinical condition *(e.g. worsening renal or hepatic function).*
- Drug interactions

Tolerance to opioids develops with continued use of a specific opioid. When changing opioids, the tolerance does not predictably continue with the new agent. The calculated equianalgesic dose of the new opioid should be reduced by 25 to 50% to prevent adverse effects. Ensure an adequate breakthrough regimen is prescribed when switching between opioids.

**Practice Points**

- Ensure converted dose includes dose reduction for incomplete cross tolerance.
- There is significant inter/intra-patient variability in response to different opioid drugs.
- Patient should be closely monitored after switching opioids or changing the dose. The dose or drug should be revised as necessary.
- When prescribing the dose of new agent, be aware of the available strengths of the intended medicine to ensure the dose can be administered (*round down dose if necessary).*

### 5.5.1 Opioid Calculator

There are many calculators available to determine the equianalgesic dose of opioids.

The Faculty of Pain Medicine (FPM) produces the Opioid Dose Equivalence Calculation Table which is intended for comparison of different opioids and opioid formulations in individual patients or in patient cohorts.

The SESLHD Quality Use of Medicines Committee (QUMC) recommends the use of the eviQ Opioid Conversion Calculator where a change in opioid, dose or route is required. The following details are required to use the eviQ Opioid Conversion Calculator;

- patient's age (calculator can only be used for patients > 12 years)
- patient's total dose of regular opioid therapy in 24 hours
- patient's total dose of breakthrough opioid therapy in 24 hours, if any

- opioid the patient is converting from and to

### 5.5.2 Opioids NOT included in the eviQ Opioid Conversion Calculator

- Codeine combination products containing paracetamol, aspirin or ibuprofen - *There is no evidence that low dose codeine in combination with these non-opioids have any benefits over the non-opioid alone.*
- Tapentadol - *alternative sources note that 100 mg of PO tapentadol is equivalent to ≈ 20 – 30 mg PO morphine.*
- Buprenorphine transdermal patches – *the calculator will only allow conversion FROM a buprenorphine patch and not TO a patch as there is limited evidence about, and experience of its use compared to other opioids.*
- Methadone – *dose conversion to: from other opioids and methadone is complex; consultation with pain management specialists familiar with methadone use is recommended.*
- Fentanyl lozenges – *there is no dose equivalence between fentanyl lozenges and other opioid formulations. The optimal dose cannot be predicted by the dose of regular opioid or previous breakthrough opioid. It should be individually titrated by starting at the lowest dose (200 micrograms). The NSW TAG Fentanyl Oromucosal Formulation Advisory provides information on rapid-acting and sublingual formulations of fentanyl.*

Given the complexity of converting these opioids, clinicians are encouraged to seek assistance from pain specialists (*e.g. Acute Pain Services, Sub-Acute Pain Services, Chronic Pain Services and Addiction Medicine*).

## 5.6 Opioids for pain management on discharge

### 5.6.1 Determining appropriateness to prescribe opioids on discharge

Prior to prescribing opioids on discharge a pharmaceutical review should be completed where possible. SafeScript NSW may assist by providing access to real-time information about a patient's prescription history for certain high-risk medicines, including opioids and benzodiazepines. For management of acute pain post-discharge a full review of the severity of pain and current opioid requirements should be considered by the prescriber.

An assessment of pain severity is best guided by its impact on patient function rather than actual pain score ratings alone. Other factors to consider include the choice and formulation of the opioid, duration of treatment, how soon after discharge a patient can visit their primary health care professional, and the need for providing the patient with advice and information on managing their pain. Review Acute Pain Service (APS) documented plan, if present.

An assessment should be made of possible risks of diversion or misuse.

- Patients must be instructed on the expected duration of pain and analgesic requirements (including maximum daily doses, possible adverse effects and a detailed opioid weaning plan where required).

Patient with acute pain: It may be appropriate to prescribe immediate-release (IR) opioids on discharge for some patients for short-term, acute pain management.
MR opioids should not be routinely prescribed for acute pain and should never be started to facilitate a rapid discharge. If MR opioids are in use at the time of discharge, patients must have a clearly documented plan to wean the opioids and suitable follow up should be arranged to ensure prolonged use does not occur.

Patients with chronic cancer / non-cancer pain: Modified-release (MR) opioids should not be prescribed at discharge for patients taking long-term opioid prior to hospital admission, unless there is a genuine need for extra supply which cannot be obtained from the patient's usual prescriber or where requirements have changed during their hospital stay *(e.g. dose changes).* Any changes to the patient's MR opioid doses should only be made after discussion with the patient's usual prescriber.
The aim would be to return the patient to their baseline MR opioid only and minimise the need for any IR opioid. However if additional IR opioids are needed on discharge, these should only be prescribed after discussion with the patient's usual or authorised prescriber.

Patients in opioid substitution programs: Generally, a person on an authorised opioid substitution program for dependence must have supplementary opioids ceased prior to hospital discharge. If supplementary opioids are required to be continued on discharge it MUST be communicated to the patient's primary care provider to apply for authorisation [Application for Authority to Prescribe a S8 Drug of Addiction - Pain Management]

### 5.6.2 Determining the quantity of opioids to be prescribed

Patients with acute pain: Review patient's use of 'prn' opioid over the 24 hours prior to discharge.

Note: Patients with acute pain (*e.g. postoperative or post-trauma pain)* whose opioid requirements are high or have not reduced during their admission, may not yet be appropriate for discharge. Seek review and advice from the hospital's Acute Pain Service.

Ensure dose and frequency of the opioid are appropriate at the point of discharge:

- Consider the patient's expected pain over the next 3 to 5 days.

- Discharge prescription dose should not exceed the actual dose administered to the patient prior to discharge.
- **DO NOT** base discharge prescription on initial inpatient opioid dose range and frequency. Calculate requirement from patient's use over the **immediate** preceding 24 hour period.

For IR oxycodone (*preferred option for ongoing treatment of acute pain*):

1. Divide total daily dose by 6 to obtain the maximum 4 hourly dose to be prescribed.
    a. *If the calculated maximum single dose is ≥ 20 mg, seek advice before prescribing.*
2. Order a dose range so that lower doses can be taken; order 4 hourly prn.
3. Prescribe only 4 – 20 tablets based on anticipated requirements.

Patients with chronic cancer / non-cancer pain: In situations where there is a genuine need for extra supply that cannot be obtained with a prescription from the usual or authorised prescriber, ensure the usual authorised prescriber has been contacted by the medical officer regarding details of the supply.

### 5.6.3 Documenting the patient's Pain Management Plan

It is important to communicate details of opioids prescribed to the patient and/or carer, as well as the patient's primary care provider. This will help to minimise the risk of OIVI, Persistent Post-operative/Post-discharge Opioid Use (PPOU), and opioid misuse & diversion. The discharge letter must accurately reflect information on the opioid dose frequency and suggested duration of treatment, including a plan for dose reduction, where appropriate. Ideally, this is incorporated into the patient's Pain Management Plan documented in the discharge letter.
Recommend using the eMR Discharge Pain Medication Plan template created using the auto-text template by entering


into the discharge summary document.

**Discharge Pain Medication Plan**

The following plan has been discussed with <<name of patient/carer>> and should be supplemented with non-medicated options for managing pain where clinically appropriate.

This patient has been prescribed opioid(s) for pain management on discharge (refer to 'Medication being taken on discharge' section).

<<name of opioid(s)>> should be reduced over the next <<number of days>> days or sooner, with a plan to cease.

We anticipate this discharge pain medication plan will be sufficient, however, the patient may require your clinical review for ongoing management of pain. Opioids can normally be discontinued 7 to 10 days after surgery/acute injury. Complex or opioid-dependent patients may require titration and cessation over a longer period.

Follow-up appointments have been scheduled with <<name of doctor/clinic/service>> at <<date/time>>.

If pain deteriorates or persists longer than expected, the patient may need to be referred to the primary admitting team.

## 5.7 Patient education on opioid medicines and adverse effects

### 5.7.1 Patient Education

It is essential that patients/carers are fully informed of the benefits, risks and harms of opioid medicines and that they provided with education regarding the safe and optimal use of the opioid/s that have been prescribed.

- Patients should be instructed on the safe disposal of any unused opioid medicines (including verbal and written information for used patches – this is included in the Consumer Medicines Information).
- Patients and/or carers must be provided with appropriate advice on sedation and fitness to drive or operate machinery (when applicable), see NSW Health Driving Safety and Medicines Patient Information.
- Patients at risk of overdose should be considered for naloxone and an opioid safety plan, see Monash Maximising Opioid Safety Patient Leaflet.
- Consumer Medicines Information should be provided with medication (including when medication is supplied from the Emergency Department).
- See Section 9 for additional Patient Friendly Opioid Resources.

### 5.7.2 Preventing and responding to adverse effects of opioids

Naloxone

Deaths from accidental opioid overdose can be prevented by naloxone. Healthcare professionals should identify patients at risk of opioid overdose or adverse reaction and be actively involved in the provision of brief training and facilitation of naloxone supply to patients and/or carers. See Section 9 for Patient Friendly Opioid Resources, or contact SESLHD Drug and Alcohol Services, Toxicology or Pharmacy for further information.

Populations where take-home naloxone supply should be considered in the hospital setting include:

- people who present with an episode of severe opioid toxicity (*e.g. someone being treated for opioid toxicity in an emergency department)*
- people who inject opioids (*e.g. people who inject opioids may have a hospital admission for injection-related conditions, such as an abscess, or conditions unrelated to injecting opioids)*
- people prescribed opioid substitution therapy (*e.g. people prescribed methadone or buprenorphine-naloxone or buprenorphine depot*)
- people prescribed opioids for chronic pain, who have relevant opioid-related risk factors - see list below (*e.g. through outpatient pain clinics)*
- people who are opioid-naïve, with opioid-related risk factors - see list below and are prescribed strong opioids for pain (*e.g. post-surgical discharge supply of strong opioids for a patient with chronic obstructive pulmonary disease or sleep apnoea)*
- family, carers or peers of any of the above groups

Among those prescribed opioids for pain, the following factors are associated with increased risk of opioid-related mortality, suggesting take-home naloxone should be offered:

- taking a high opioid dose (> 50 mg of oral morphine equivalent daily dosage)
- taking concurrent sedatives (*e.g. benzodiazepines*)
- other concurrent substance use (*including alcohol use*)
- other comorbidities (*e.g. respiratory conditions, liver or kidney disease, mental health conditions such as depression)*

Naloxone may be used for reversal of acute respiratory depression from opioids but care should be taken in patients on chronic opioids or receiving opioids for palliation as a pain crisis may be precipitated.

### 5.7.3 Allergy & Adverse Drug Reaction (ADR) documentation

The American Society of Health-System Pharmacists (ASHP) defines an ADR as "any unexpected, unintended, undesired, or excessive response to a drug that:

- requires discontinuing the drug (therapeutic or diagnostic)
- requires changing the drug therapy
- requires modifying the dose (except for minor dosage adjustments)
- necessitates admission to a hospital
- prolongs stay in a healthcare facility
- necessitates supportive treatment
- significantly complicates diagnosis
- negatively affects prognosis or
- results in temporary or permanent harm, disability, or death."

The ASHP definition includes allergic reactions (an immunologic hypersensitivity response to a drug) and idiosyncratic reactions (an abnormal response to a drug that is specific to an individual).

**The treating clinician is responsible for determining whether an ADR is clinically important.**

The nature and response of the ADR should be accurately communicated to the patient and/or carer and other health care professionals, including the patient's general practitioner and community pharmacist, at discharge.

Documentation of new ADR/allergies should include, as a minimum:

- generic name of the medication and brand name where relevant
- type of reaction
- how the reaction was managed
- how long after exposure to the medicine the reaction developed
- reaction progress, including efficacy of treatment, re-challenge, desensitization, etc.

All opioids can cause allergic reactions. Codeine and morphine are the main opioids that cause most allergic-type reactions. Although some of the symptoms resemble those of a true allergy, they are in reality symptoms of pseudoallergies caused by endogenous histamine release from the mast cells, which is also considered a pharmacological effect. These symptoms include flushing, itching, sneezing, hives, sweating, exacerbation of asthma, and low blood pressure, and their occurrence depends on the concentration of opioids in the mast cells.

**A true allergy to opioids is rare** and seems to be IgE mediated or T-cell mediated. Symptoms of a true opioid allergy include hives, maculopapular rash, erythema multiforme, pustular rash, severe hypotension, bronchospasm, and angioedema.

# Section 6 – Safe Administration of Opioids

Refer to SESLHD/734 High-Risk Medicines Management for general principles for ensuring the correct administration of high risk medicines.

## 6.1 Second person check

A second person check must be employed when administering opioids in accordance with NSW Health Policy Directive PD2022_032 - Medication Handling.

To be effective, a second person check must be conducted independently by the second person to reduce the risk of bias that occurs when the person preparing and checking the medication is likely to see what they expect to see, even if an error has occurred. Two people are unlikely to make the same mistake if they work independently. If they work together or influence the checking procedure by suggesting what the checker must find, both could follow the same path to error. When performed correctly, independent second person checks have been found to detect 95% of errors (ISMP, 2013).

## 6.2 Product specific administration instructions

### 6.2.1 Transdermal patches

- Confirmation from the prescriber should be sought if multiple patches are required to achieve a prescribed dose.
- Before applying a patch, check that the medicine and strength details are clearly visible on the patch itself
- Write the date of application on the patch using a marker, and record the time of application and site of application on the medication chart.
- Ensure patch is not exposed to temperature extremes.
- Opioid transdermal patches MUST NOT be cut or only partially applied to achieve a smaller dose.
- Record the time of patch removal on the medication order or in the patient's health care record.
- Ensure safe and secure disposal when relevant (e.g. opioid patch).
- Always check for existing patches prior to applying a new patch. (NOTE: the eMEDs system does not have a "patch removal order" for all patches).

### 6.2.2 Modified release (MR) oral medicines

- Never dissolve, divide, chew or crush for administration. MIMS Online offers "Don't Rush to Crush" a comprehensive guide to administering oral medicines to patients who are unable to swallow or have swallowing difficulties. If further advice is required, contact the Pharmacy Department.

### 6.2.3 Opioid infusions

- A rate-limiting device such as an infusion pump must be used for all opioid-containing infusions. Where possible, this should be a 'smart' pump. Dose error reduction software must be turned on and not bypassed.

## 6.3Administration documentation

In accordance with the NSW Health Medication Handling Policy (PD2022_032) the person administering the medication must record the administration in the appropriate section of the patient's medication record. Where applicable, the staff member witnessing the administration must countersign the administration record.

## 6.4 Patient Monitoring

The frequency and type of monitoring will be determined by the individual circumstances. For example:

- in patients on long-term stable therapy routine observations may be sufficient;
- patients on an EOLCP may be excluded from monitoring;
- patients with risk factors for adverse effects or patients taking other medications which may potentiate the sedation and respiratory depressant effects of opioids (e.g. benzodiazepines, antipsychotics etc.) may require increased monitoring.

The Attending Medical Officer and/or Specialist team should specify in the progress notes the specific monitoring requirements for the individual patient.

For all other patients, the following is a guide:

| Mode of administration | Perform and Record | Frequency |
|---|---|---|
| Oral | Sedation score, respiratory rate, pain score | One hour after initial dose (or dose increase) then every four hours if dosing continues |
| Subcutaneous (intermittent dosing) | Sedation score, respiratory rate, pain score | 30 minutes after initial dose (or dose increase) then every four hours if dosing continues |
| Continuous subcutaneous infusion (CSCI) (Palliative Care) | Sedation score, respiratory rate, pain score and as per CSCI Monitoring Chart | 30 minutes after initiation of the infusion (or dose increase) then every four hours |
| Post Anaesthetic Care Unit (Pain Protocol) | Sedation score, respiratory rate, BP, pain score | Every 3 to 5 mins while on protocol |
| Patient Controlled Analgesia (PCA) | Sedation score, respiratory rate, pain score | Every hour for six hours then every two hours for the duration of the PCA |
| Intrathecal Morphine | Sedation score, respiratory rate, pain score | Every hour for 12 hours then every two hours for until 24 hours post administration |
| Epidural fentanyl | Sedation score, respiratory rate, pain score, blood pressure and heart rate | Every hour for 6 hours then then every 2 hours<br><br>Refer to SESLHDPR/324 for further details |

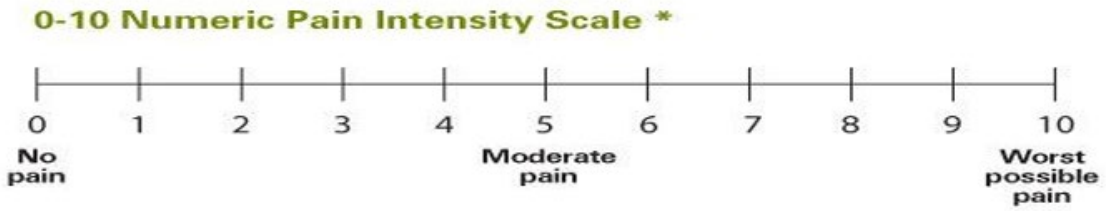
The patient must also be observed the patient for other side effects, e.g. light headedness, visual disturbances, tinnitus, constipation, pruritis, nausea, vomiting. Refer to medical team for review if necessary.

Core observations for all hospital admissions should be performed in accordance with the National Consensus Statement: Essential elements for recognising and responding to acute physiological deterioration.

In addition to core observations, hourly Intentional Patient Rounding by a healthcare team member includes assessment of discomfort including pain and sedation.

A variety of pain measurement tools are available for doctors to use. They include numeric scales, visual analog scales, and verbal rating scales.

Verbal Numerical Rating Score (VNRS)




Faces Pain Scale – Revised (FPS-R)

*In the following instructions, say "hurt" or "pain," whichever seems right for a particular child.*

**"These faces show how much something can hurt. This face** *[point to left-most face]* **shows no pain. The faces show more and more pain** *[point to each from left to right]* **up to this one** *[point to right-most face]* **- it shows very much pain. Point to the face that shows how much you hurt** [right now]**."**

*Score the chosen face **0, 2, 4, 6, 8,** or **10**, counting left to right, so '0' = 'no pain' and '10' = 'very much pain.' Do not use words like 'happy' and 'sad'. This scale is intended to measure how children feel inside, not how their face looks.*



**Sources.** Hicks CL, von Baeyer CL, Spafford P, van Korlaar I, Goodenough B. The Faces Pain Scale – Revised: Toward a common metric in pediatric pain measurement. *Pain* 2001;93:173-183. Bieri D Reeve R, Champion GD, Addicoat L, Ziegler J. The Faces Pain Scale for the self-assessment of the severity of pain experienced by children: Development, initial validation and preliminary investigation for ratio scale properties. *Pain* 1990;41:139-150.

The tool used should be appropriate to the patient's cognitive development, language, culture and preference. For example, faces scales (comprising a series of cartoon faces ranging from a happy face to a very sad/tearful face) are most appropriate for children who may have difficulty translating their pain into a numerical value or a verbal descriptor.

Assessment tools have been developed that attempt to capture a more global picture of a patient's pain experience. They consider multiple dimensions of pain such as the characteristics of pain, the emotional aspects of pain, and functional impairment. More widely known multidimensional scales include the Brief Pain Inventory (a short and long form is available), the McGill Pain Questionnaire, the Behavioural Assessment of Pain Questionnaire, and the Pain Outcomes Questionnaire.

# Section 7 – Reversal of opioid effects

Opioids are the most common cause of drug-related death in Australia. They can cause respiratory depression that is disproportionately severe compared with their sedative effect, especially in children and other opioid-naive people.

First-line treatment for opioid poisoning is support of airway and breathing.

Naloxone is a pure opioid antagonist and can be given to immediately reverse severe adverse effects of opioids, such as sedation and respiratory depression after opioid overdose or intoxication. The aim of naloxone therapy is to reverse hypoventilation and increase the patient's level of consciousness sufficiently to protect their airway.

**Naloxone must be available in patient care areas wherever opioid medicines are used.**

Refer to local facility protocols for details on the administration of naloxone.

# Section 8 – Safe Storage and Supply of Opioids

- Where possible only one strength of an opioid medicine is stored in patient care areas.
- If more than one strength of an opioid medicine is required, strategies are in place to reduce selection error (*e.g. opioid identification chart)*.
- Nursing staff are responsible for checking patient care areas (at least weekly) to identify and remove inappropriately stocked opioid medicines.
- Naloxone injection is available for reversal in all clinical areas where opioids are used.
- Commercially prepared pre-mixed solutions are recommended for use in all clinical areas to reduce the risk of error and contamination associated with manual preparation of opioid syringes/bags (*e.g. opioid PCA syringes).*

## Section 9 – Patient Friendly Opioid Resources

- Managing Pain and Opioid Medicines, NPS MedicineWise
- Information about understanding pain, NPS MedicineWise
- Opioid medicines and chronic non-cancer pain, NPS MedicineWise
- How to use opioid medicines safely, NPS MedicineWise
- Risks of high-dose opioid medicines, NPS MedicineWise
- Managing your pain safely with opioids, Safer use of opioids, Victorian Department of Health
- Acute low back pain – self management diary, Safer use of opioids, Victorian Department of Health
- Advice for common discharge medications, Developed by SGH for SESLHD, including oral opioid medicines, oral hydromorphone, fentanyl & buprenorphine transdermal patches
- 'Point-of-prescribing' leaflets, Developed by SGH for SESLHD, including adjuvant pain medicines, PCA and end-of-life care
- Discharge Analgesia Guidelines (Acute Pain Adult Inpatients), Developed by POWH
- Managing your pain after injury or surgery, Developed by POWH
- Using NYXOID Nasal Spray, YouTube
- Naloxone information for people who are prescribed opioids, YouTube
- Maximising Opioid Safety, Monash University
- Opioid Overdose Response Plan – naloxone nasal spray (Nyxoid®), Penington Institute

## Section 10 – Staff Education

Safe Use of High-Risk Medicines – Safe Use of Opioids; Course Code: 267525641,*Consider the complexity of care that patients require when taking opioid medicines,* HETI

Patient Controlled Analgesia – Adult Pain Management; Course Code: 40063903, *Review the key characteristics of opioids and their role in patient controlled analgesia,* HETI

Safe Use of HYDROmorphone; Course Code: 199776392, *HYDROmorphone is a potent opioid analgesic. It is used to treat moderate to severe, acute or chronic pain,* HETI

Acute Pain Management for Adults; Course Code: 78572002, *Identify patients ta significant risk of opioid related complications. Consider physical, psychological and sociological aspects when determining patient's analgesic requirements,* HETI

Pain Management Hub for health professionals; *Access to all NPS MedicineWise resources focused on pain management,* NPS MedicineWise

# Section 11 – References

1. NSW Ministry of Health Policy Directive PD2024_006 - High-Risk Medicines Management
2. NSW Ministry of Health Policy Directive PD2022_032 - Medication Handling
3. Safety Alert Bulletins (SABS) on high risk drugs, e.g. Safe use of Midazolam SN: 022/09 available from: https://www.health.nsw.gov.au/sabs/Pages/default.aspx as released from time to time
4. NSW Ministry of Health Policy Directive PD2020_047 - Incident Management
5. ACSQHC 2022 - Opioid Analgesic Stewardship in Acute Pain Clinical Care Standard
6. D. Dowell, et al. CDC Clinical Practice Guideline for Prescribing Opioids for Pain – United States, 2022; 71(3);1-95
7. D. Dowell, et al. Prescribing Opioids for Pain, November 3, 2022
8. M. Saljoughian, Opioids: Allergy vs. Pseudoallergy, U.S. Pharmacist, July 20, 2026
9. L. Lee, et al, ASHP Guidelines on Adverse Drug Reaction Monitoring and Reporting, Am J Health-Syst Pharm. 2022;79:e83-89
10. NPS MedicineWise, Pain Management Hub
11. Victorian Department of Health, Safer Use of Opioids
12. ANZCA, Position statement on acute pain management, 2023
13. ACI, Pain Management Network
14. SHPA, Take-home naloxone in Australian hospitals, Version 2, September 2022

# Section 12 – Version and Approval History

| Date | Version: | Version and approval notes |
|---|---|---|
| October 2022 | DRAFT | Author: Erica Wales, Lead Pharmacist Quality Use of Medicines |
| November 2022 | DRAFT | Draft for comments period. |
| December 2022 | DRAFT | Approved at SESLHD Quality Use of Medicines Committee |
| March 2023 | 1 | Approved by SESLHD Clinical and Quality Council. Published by SESLD Policy team. |
| 1 November 2024 | 1.1 | Amendment to section 5.3.1: Addition of “The prescriber is to specify the maximum individual dose, maximum daily dose, hourly frequency for administration and the maximum number of doses or maximum duration of treatment.” Approved by SESLHD Drug and Therapeutics Committee and Executive Sponsor. Minor formatting updates and internal hyperlinks corrected by SESLHD Policy. |
| 25 March 2025 | 1.2 | Minor review. Links updated and reference to NSW Health Policy Directive PD2024_006 - High-Risk Medication Management Policy. Approved at SESLHD Drug and Therapeutics Committee. |

# Appendix A: Assessments

## Multidimensional pain assessment:

- Screen for red flags (clinical indicators of possible serious underlying conditions requiring further medical intervention) then broaden the approach.
- Consider using brief questionnaires (e.g. Brief Pain Inventory or ultra-brief PEG).
- Multidimensional assessment for all types of pain leads to broad-based treatment addressing biomedical and psychosocial aspects along with physical activity and nutrition.

## Risk assessment for opioid misuse:

- A drug and alcohol history and/or Opioid Risk Tool screening quantifies risk of misuse
- SafeScript NSW is a computer software system that provides prescribers and pharmacists with real-time information about a patient's prescribing and dispensing history for certain high- risk medicines. It is not integrated into local clinical application systems, however NSW Health prescribers and pharmacists can register to enable access to the SafeScript NSW portal using their StaffLink ID and password (Register here). This will provide a history of the patient's high-risk medicines prescribed or dispensed in the community. Use of high dose opioids, multiple prescribers and concurrent prescribing of potentially harmful substances will be highlighted and is useful information prior to prescribing or dispensing within the hospital setting.
- Consider eligibility for Take-home naloxone (see section 5.7.2).

## Patient screening for risk of harm with sanctioned opioid use:

- Screen patients for previous adverse effects prior to prescribing.
- Screen patients for risk factors such as asthma, obstructive sleep apnoea, or patients receiving other medication which can potentiate the effects of opioids such as benzodiazepines.
- Except in palliative care, concomitant use of multiple opioids should be avoided.

# Appendix B: Pain Medicine Plan After Leaving Hospital

Insert hospital logo or your letterhead here

| MRN | | SURNAME | |
|---|---|---|---|
| GIVEN NAME(S) | | | |
| DOB | SEX | AMO | WARD/CLINIC |

(Please enter information or affix Patient Information Label)

## Pain Medicine Plan After Leaving Hospital

**This plan tells you what medicine to take for your pain when you leave hospital and what to do next.**

The medicine has been prescribed for you after your admission on (date)_____for

_____

Please take this plan to show your GP, Dr._____ at your next visit.

☐ It is unlikely that you will need a repeat prescription of any strong pain medicines, unless there is an unexpected change in your recovery.

☐ A further prescription for strong pain medicine will likely be required. Please visit your GP within 3-4 days of your discharge so they can review and prescribe additional medication if required.

Stop Second

| **Regular pain medicine** | **Take these medicines at regular intervals to help with pain** | |
|---|---|---|
| **Paracetamol**<br>500mg tablet | How much:_____ tablets<br>How often: _____times a day<br>Maximum tablets each day: | You will probably need this medicine for: |
| **Anti-inflammatory medicine**<br>Name _____mg tablet | How much: _____tablets<br>How often: _____times a day<br>Maximum tablets each day: | You will probably need this medicine for: |

Stop First

| **Opioids or morphine like medicine** | **These medicines are for strong pain, take if needed.**<br>Take these medicines if pain makes it too hard for you to do things like:<br>Get out of bed, go for a walk, do physiotherapy or other activities that you enjoy. | |
|---|---|---|
| **Tapentadol (50mg tablet)**<br>Brand: Palexia ™IR | How much: _____tablets<br>How often: _____times a day<br>Maximum tablets each day: | You will probably need this medicine for: |
| **Oxycodone 5mg tablet**<br>Brand: Endone™ 5mg | How much:_____ tablets<br>How often:_____times a day<br>Maximum tablets each day: | You will probably need this medicine for: |

**Morphine like pain medicines can cause constipation. If you are constipated you can:**

- **Eat foods with more fibre**
- **Take laxatives. You can get laxatives from supermarkets and pharmacies.**

Brands include Coloxyl with Senna and Movicol. You can ask a pharmacist for more information about laxatives.

**Number of opioid tablets dispensed on discharge** ☐

## Important Points

### Where should I keep my medicine?

Always keep your medicine in a safe place.

Never share your medicine with others.

### What should I do with any medicines I don't need?

Take any unused or unwanted medicines to your local pharmacy for safe disposal.

Do not throw any medicine in the bin, or flush them down the toilet or sink.

### Other things to try which are also helpful for managing pain

- Practise deep breathing exercises
- Go for a gentle walk. Slowly increase how much exercise and activity you do.
- Have a comfortable and well supported position in bed.
- Consider the use of hot or cold packs.
- Psychological and spiritual practices such as mindfulness, prayer, relaxation.
- Distract yourself by watching the TV/ or movie, listen to music, spend time with friends.

**If you have ongoing pain, or pain that is getting worse despite taking the medication as prescribed in this plan**

**OR**

**If you have other signs and symptoms such as a temperature, swelling or redness around a wound contact your doctor.**

Additional instructions or comments:

**Name and designation** _____ **Date** _____

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