Health
Hunter New England
Local Health District

Opioid prescribing in the hospital setting

Health Professional Resources
November 2020

A Hunter New England Clinical Guideline

Introduction

Evidence supports:

1. Opioid prescription in cancer pain, palliative or comfort care and within a pharmacotherapy management program for opioid dependency/addiction
2. Time-limited opioid prescribing in acute pain
3. De-prescribing opioids in chronic non-cancer pain (CNCP) due to lack of efficacy and risk of harm.
4. Increased risk of harm when opioids are combined with benzodiazepines or other psychoactive drugs

Practical strategies include:

1. Routine use of opioid prescribing boundaries
2. Communication with GP at hospital discharge about opioid dose, intended duration of use and weaning plan
3. Seeking appropriate specialist advice when considering opioid prescription for CNCP or when recommending de-prescribing in a long term &/or high dose opioid use CNCP patient
4. Having a conversation about de-prescribing with people on maintenance opioids for CNCP

Assessment

1. **Multidimensional pain assessment:**
    a. Screen for red flags then broaden the approach
    b. Consider using brief questionnaires (e.g. Orebro 10, Brief Pain Inventory or ultra-brief PEG - Pain Enjoyment General activity).
    c. Multidimensional assessment for all types of pain leads to broad-based treatment, addressing biomedical and psychosocial aspects along with physical activity and nutrition

2. **Risk assessment for opioid misuse:**
    a. A drug and alcohol history and/or Opioid Risk Tool screening quantifies risk of misuse.
    b. Contact Australian Prescription Shopping Information Service on 1800 631 181 for “at-risk” patients

General treatment considerations

1. **Opioid prescribing boundaries:**
    a. **ED presentations**
        - avoid prescribing opioids unless clear evidence of acute injury/condition
        - avoid prescribing opioids for exacerbations of CNCP or uncomplicated opioid withdrawal symptoms
        - do not replace lost prescriptions/medications
        - limit number of opioid doses prescribed
        - communicate with GP
    b. **During hospital stay:**
        - multiple teams may contribute to prescribing boundaries (Pain Services, Drug and Alcohol, Consultation Liaison Psychiatry). Clear communication is required
        - the treating team/admitting medical officer remains the final authority
    c. **At discharge:**
        - Communicate with GP about discharge opioid medication and a plan for tapering
        - ask about unused medication stocks at home
        - if opioids have been commenced or changed in hospital a limited discharge supply can be provided (maximum: 3 days for acute pain; 7 days for cancer pain, palliative care or delayed GP access)
        - amount supplied should take into account the amount of opioid used in the previous 24 hours
        - discuss opioid risks including driving impairment and need for secure storage at home

2. **Monitoring opioid therapy:**
    a. Use 5 A's: **A**nalgesia, **A**ctivity, **A**dverse effects, **A**ffect and **A**berrant behaviour.
    b. Opioid prescription is directed to achieve the functional goals (e.g. deep breathing or walking), not pain relief alone

3. **Opioid de-prescribing:**
    a. Discuss the possibility of de-prescribing with any person on opioids for CNCP presenting to the hospital system. Consider referral to a pain service or suggest the GP considers referring
    b. In de-prescribing long-term opioids the standard approach is co-ordinated by the GP often with specialist pain medicine physician support. One strategy is to reduce the daily dose by 10-25% of the initial dose every month. This aims at cessation in 3-9 months and allows time to develop active self-management strategies
    c. Patient fear of medication reduction should be addressed to assist progress. Consider offering weaning support from a Pain Service, GP or practice nurse as appropriate and available
    d. De-prescribe faster if dangerous side effects, opioid misuse or after treatment of acute pain

e. If dependency/addiction is the primary problem then consider opioid maintenance supported by an Addiction Medicine service

4. **Opioid rotation:**
    a. Opioid rotation may be considered to treat tolerance, adverse effects or reduce total daily dose
    b. Rotation involves changing to another opioid typically at 50% of the equivalent dose
    c. Seek advice from a pain, addiction or palliative medicine physician

Specific treatment considerations

Acute pain (<3 months duration)

1. Opioids can have a clear role in acute pain. In most acute settings, cease opioids **within 1 week**
2. In complex cases wean and cease opioids **within 90 days**
3. Titrate opioids to functional and analgesic end points
4. Short-acting opioids are preferred
5. *Start low and go slow* in children, older people and those on other psychoactive medication
6. Consider concurrent / multimodal approach also with non-opioid medication, nerve blocks, psychological/behavioural strategies
7. 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. De-prescribing should follow as the acute problem settles
8. Communicate with GP at discharge about opioids dispensed, intended duration and a de-prescribing plan

Cancer pain and / or palliative care

1. Confirm current doses with prescriber or pharmacy prior to charting.
2. When prescribing opioids in this group, carefully balance benefit with adverse effects
3. Short and/or long acting agents can be titrated to functional and analgesic end points

Opioid dependency/addiction

1. Communicate with opioid prescriber and/or Drug and Alcohol team and/or dosing pharmacy/clinic
2. Do not give additional opioids for pain unless there is a new injury or condition
3. The systematic use of prescribing boundaries is particularly important in this context
4. Confirm, in writing, usual dose, last dose and take-away doses prior to prescribing in inpatient setting
5. Approval to prescribe a drug of addiction for a drug dependent person must be obtained from NSW Ministry of Health (Complete Form 1 Application for Authority to Prescribe a Drug of Addiction) unless the patient is an inpatient in which case opioids can be prescribed for up to 14 days
6. A person on an authorised opioid maintenance program for dependency can be prescribed supplementary opioids for a new acute condition while in hospital. Any supplementary opioids

must be ceased prior to hospital discharge.

Chronic non-cancer pain (≥3 months duration)

1. Current scientific evidence does not support initiating or continuing opioid therapy
2. There are many people on maintenance opioids for CNCP despite the lack of evidence. The standard treatment in this situation is de-prescribing
3. A Traffic Light system can be used to illustrate the dose dependent risk of harm
    - oMEDD **40mg or less** considered acceptable (green light) with less risk of adverse effects
    - oMEDD **40-99mg** is a warning (amber light) zone with increased risk of adverse effects
    - oMEDD **100mg or greater** is high risk (red light) for adverse events and consultation with a specialist pain medicine physician is recommended
4. 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
5. Consider developing an individualised pain recovery plan for frequent presenters to the hospital system
6. Approval to continuously prescribe a drug of addiction for more than 2 months must be obtained from NSW Ministry of Health for prescription of certain opioids, including buprenorphine (except transdermal), hydromorphone, methadone or any injectable form, (Form 1 Application for Authority to Prescribe a Drug of Addiction)
7. Older people are at greater risk of opioid adverse effects including cognitive impairment and falls. Opioid prescription for older persons experiencing CNCP is not recommended outside the palliative phase

Consultation

Discuss proposed variations from the above recommendations with a pain, addiction or palliative medicine physician.

Endorsement

This clinical guideline was endorsed in 2020 by members of the Hunter New England Local Health District Anaesthesia and Pain Clinical Stream.