

Opioid Analgesic Stewardship in Acute Pain

Clinical Care Standard

The goal of the *Opioid Analgesic Stewardship in Acute Pain Clinical Care Standard* is to ensure the appropriate use and review of opioid analgesics for the management of acute pain, optimise patient outcomes and reduce the potential for opioid-related harm.

1 Patient information and shared decision making

The nonpharmacological and pharmacological options for managing acute pain are discussed with a patient and their carer in a way that they can understand, and that leads to a shared understanding of the decision to use an opioid analgesic or other treatment(s).

Discuss the patient's expected recovery and the potential benefits and harms of acute pain treatment options, with them or their carer. Tailor the options to the patient's acute pain in line with a step-wise approach when providing treatment options, which may or may not result in prescribing opioid analgesics. This discussion should consider the patient's preferences and needs, and any cultural and linguistic matters.

Inform the patient of suitable treatment options to help with symptoms, including paracetamol and non-steroidal anti-inflammatories, and nonpharmacological treatments such as splinting, heat packs, ice packs, physiotherapy and exercise.

If opioid analgesics are considered appropriate, discuss with the patient the importance of using opioid analgesics as prescribed, how to take them and for how long, potential opioid analgesic adverse effects and interactions with existing medicines, and when the treatment will be reviewed.

If opioid analgesics are supplied or prescribed on discharge discuss how to safely store opioid analgesics and dispose of unused opioid analgesics by returning to the patient's local community pharmacy.

Provide culturally and linguistically appropriate written information and resources to the patient about their treatment options and their analgesic treatment. When a patient is unable to receive information or participate in treatment decisions, provide information to the patient's family or carer and offer them the opportunity to participate in decisions, if appropriate.

Document in the patient's healthcare record what information was conveyed to the patient, including the provision of written information such as a consumer medicine information sheet, the Pharmaceutical Society of Australia's fact sheet on [Opioid medicines](#), information about safe storage and disposal and the outcome of the shared decision making process. Outcomes of shared decision making should be documented wherever possible including in the medication management plan and clinical handover summary.

2 Acute pain assessment

Analgesic prescribing in a patient with acute pain is guided by its expected severity and assessment of patient-reported pain intensity and the impact of pain on the patient's function.

When treating a patient with acute pain, assess the patient's functional activity using an evidence-based assessment tool before prescribing an opioid analgesic. The results of the functional assessment should be considered together with patient's pain scores in discussion with the patient to guide appropriate treatment. The outcome of the assessments should be documented in the patient's medical record.

Consider the clinical context – such as intensive care or ward – and the patient context including developmental, cognitive, emotional, language and cultural factors, to assist in choosing an appropriate pain assessment tool for acute pain.¹ For example, verbal pain descriptors may be a better choice of pain measurement tool than numerical rating scales for some Aboriginal and Torres Strait Islander people.²

Validated tools for measuring pain in neonates, infants and children are available, and the appropriate tool should be selected based on the child's age and developmental stage.¹

3 Risk–benefit analysis

Whenever an opioid analgesic is considered for a patient with acute pain, their risk of opioid-related harm is assessed. An opioid analgesic may be prescribed when other analgesics are not clinically feasible or sufficient, and the potential benefits outweigh the potential harms.

Identify and document avoidable, modifiable risks of harm if opioid analgesics are prescribed for a patient with acute pain, using appropriate assessment tools where possible.

Patients from some vulnerable groups may be at increased risk of opioid analgesic-related harm. These include older people, infants and children, pregnant and breastfeeding patients, patients with a disability, patients with unstable adverse social circumstances, patients with psychological comorbidities, and patients with substance use disorders.¹

Patients cannot be reliably assessed for risk of respiratory depression, which is more completely described by the term opioid-induced ventilatory impairment (OIVI). Older age is one risk factor commonly reported as being associated with an increased risk of respiratory depression (OIVI). Follow best practice recommendations for appropriate doses of immediate release opioid analgesics in older people, such as *Therapeutic Guidelines and Acute Pain Management: Scientific Evidence (5th Edition)* (2020).

Other risk factors include chronic opioid analgesic use, chronic sleep-disordered breathing, chronic obstructive pulmonary disease, diabetes, hypertension, hepatic or renal impairment, neurological diseases, and obesity.¹

Modifiable, avoidable risk factors for sedation and respiratory depression (OIVI) include¹:

- Use of more than one opioid analgesic at a time
- Use of modified release oral and transdermal opioid analgesics
- Use of continuous opioid analgesic infusions
- Continued administration of opioid analgesics to treat pain that is not responding to opioid analgesics
- Co-administration of central nervous system (CNS) depressants such as benzodiazepines and other sedative hypnotics, barbiturates, gabapentinoids, alcohol and recreational drugs
- Establish the patient's opioid status and existing opioid analgesics in their possession before prescribing opioid analgesics for acute pain. Access Real Time Prescription Monitoring tools, or the [Prescription Shopping Program](#) to obtain information on use of other medicines that cause sedation and respiratory depression (OIVI), to inform shared decision making before giving or prescribing opioid analgesics.

For non-opioid naïve patients taking opioid analgesics prior to a planned or elective surgery or procedure, if time allows, slowly reduce opioid analgesics³ according to recommendations outlined in the current best practice guidelines.

For patients identified to be at increased risk of opioid-related nausea and vomiting after surgery, consider opioid-sparing treatments or alternatives to opioid analgesics to manage their acute pain.

4 Pathway of care

A patient with acute pain prescribed an opioid analgesic who is at increased risk of opioid-related harm is appropriately managed in conjunction with a locally approved pathway to mitigate the potential for harm.

Manage and refer patients identified at increased risk of opioid-related harm according to a defined clinical pathway for appropriate support services. This includes escalation of care to specialist services for paediatrics, pain management, drug and alcohol, clinical pharmacy and allied health.

Inform the patient why they are being referred. Provide information about the care to which they are being referred according to the pathway. Advise the patient of your role in the patient's continuing care.

5 Appropriate opioid analgesic prescribing

If an opioid analgesic is considered appropriate for an opioid-naïve patient with acute pain, use an immediate release formulation at the lowest appropriate dose, for a limited duration, and prescribe in line with best practice guidelines. Modified release opioid analgesics cannot be safely or rapidly titrated and their use in acute pain should be exceptional and not routine. The patient is supported to cease any opioid analgesic use as their function and pain improve.

Consider Pharmaceutical Benefits Scheme requirements for drugs of addiction, state and territory regulations, and best practice guidelines when prescribing opioid analgesics.

If an opioid analgesic is required for acute pain in an opioid naïve patient, follow best practice guidelines. Use immediate-release formulations at the lowest appropriate dose and for the shortest appropriate duration. Consider strategies to minimise overall opioid analgesic use.

Consider the individual patient's characteristics such as age, weight, hepatic and renal function, allergies, and other health conditions such as obstructive sleep apnoea. Consider the patient's opioid-status, and other medicines prescribed. Use paracetamol and anti-inflammatories to reduce the dose of opioid analgesic for acute pain. Consider whether the patient has a life limiting illness and whether they are in the care of a palliative care team.

An opioid analgesic weaning and cessation plan is particularly important for patients prescribed opioid analgesics because long-term opioid use often starts with using opioid analgesics for acute pain. Opioid analgesic dose reduction should commence as soon as possible, and can usually start one to two days after major surgery or trauma.⁴ In general, opioid analgesics should be discontinued before paracetamol and NSAIDs are discontinued.⁴

Define an opioid analgesic weaning and cessation plan guided by assessing the patient's functional activity and pain scores, the amount of opioid analgesic used in each 24 hour period and the duration of therapy. For example, if discontinuing opioid analgesics prescribed for a short duration and used for less than 10 days, doses can be reduced quickly. This also applies when discontinuing immediate release opioids prescribed for acute pain in patients who are also on long-term opioid analgesic therapy.⁴ Discuss, and agree to, the weaning and cessation plan with the patient.

There is no evidence to support the use of modified release opioid analgesics for acute pain. Some emerging evidence shows that their use is problematic. For example, modified release opioid analgesics following surgery are associated with increased risk of opioid-related harm and complications.^{5,6} The Therapeutic Goods Administration states that modified release products should only be used where the pain is opioid-responsive and the patient requires daily, continuous, long-term treatment. Long-term treatment does not align with the definition of acute pain. The Therapeutic Goods Administration also states that modified release opioids are not indicated to treat chronic non-cancer pain (other than in exceptional circumstances), or for 'as-needed' pain relief.⁷

6 Monitoring and management of opioid analgesic adverse effects

When an opioid analgesic is prescribed, supplied or administered for a patient with acute pain, adverse effects are monitored and managed. The patient and carer are made aware of potential adverse effects and signs of overdose, including respiratory depression.

If opioid analgesics are prescribed, regularly monitor the patient for adverse effects in line with current best practice guidelines.⁴ The frequency of patient monitoring will be influenced by the hospital setting, pain severity, age and comorbidities, and the dose and route of administration of the opioid analgesic. Develop appropriate management strategies for the adverse effects, including adjustments to the dose, route of administration, formulation, and type of opioid analgesic.

Prescribe appropriate treatments to prevent and manage opioid analgesic-induced adverse effects: laxatives to prevent or treat constipation, and appropriate treatments for nausea and vomiting, and itchiness.

Patient sedation levels should be monitored and the results documented in the monitoring chart in the patient medical record. Excess sedation is a reliable indicator of respiratory depression (OIVI).^{1,8,9} Patients with excess sedation (such as a score of greater than 1) should be managed by de-escalating the opioid analgesic dose and continued monitoring. Withhold all opioids until the patient is awake. If more analgesia is needed, a smaller dose should be given regardless of pain score. Monitoring sedation should always be paired with appropriate opioid analgesic prescription and dose adjustment. Excess sedation may require escalation of care, according to locally approved protocols. Consider the administration of naloxone to reverse respiratory depression (OIVI), according to a locally approved protocol.

CNS depressants such as benzodiazepines or other sedative hypnotics, barbiturates, gabapentinoids increase the risk of excess sedation. These medicines should be avoided and patients taking these medicines should be subject to increased monitoring.

Patient cohorts at risk of excess sedation and respiratory depression (OIVI) include people who take opioid analgesic chronically; and patients with sleep-disordered breathing, chronic obstructive pulmonary disease, diabetes, hypertension, hepatic and renal impairment, neurological diseases, and obesity. Patients with these co-morbidities should be subject to increased monitoring.

7 Documentation

When a patient with acute pain is prescribed, supplied or administered an opioid analgesic, the intended duration of therapy, and the review and referral plan are documented in the patient's healthcare record. The cause of the pain for which the opioid analgesic is prescribed is documented, including on the inpatient prescription.

When prescribing opioid analgesics, document the indication, intended duration (number of days), the review and referral plan, and the weaning and cessation plan, in the patient's healthcare record. This documentation includes the patient's paper or electronic healthcare records, the My Health Record system, prescription record, medication chart and medication management plan.

Document the cause of pain for which the opioid analgesic is prescribed, including on the inpatient prescription, to ensure the reason for use of the opioid analgesic is printed on any dispensed opioid analgesic the patient takes with them when they leave hospital.

Document co-prescribed paracetamol, NSAIDs or non-pharmacological treatments, in the patient's healthcare record.

8 Review of therapy

During hospital care, a patient prescribed an opioid analgesic for acute pain is assessed regularly to determine their response to therapy and whether an opioid analgesic is effective and appropriate for their stage of care.

When opioid analgesics are prescribed the effectiveness, appropriateness and ongoing need for opioid analgesic therapy should be regularly reviewed according to the patient's stage of care. If the opioid analgesic is continued, decisions about the appropriate daily dose of opioid analgesic should be based on the oral morphine-equivalent daily dose (oMEDD) given in the past 24 hours.

During their hospital care, a patient prescribed an opioid analgesic for acute pain should have regular assessment of their pain and function. Due to interpatient variability, the timing of regular assessments should be tailored to the needs of the patient considering the patient's sedation scores, physical state, ability to move and engagement with active interventions such as physiotherapy.

Consider alternative pain management for patients whose acute pain does not respond to opioid analgesics. This may include changing the opioid analgesic to a non-opioid medicine, nonpharmacological management or referral to other hospital-based support services. These may include specialist services for paediatrics, pain management, drug and alcohol services, clinical pharmacy, or allied health.

If opioid analgesics are being administered intravenously, consider switching to oral opioid analgesic options as soon as the oral route is available.

Ensure review of opioid analgesic treatment occurs immediately before the patient leaves the hospital. The aim of opioid analgesic therapy should be to manage the patient's acute pain with an opioid analgesic for the shortest duration possible.

9 Transfer of care

Planning for appropriate analgesic use at the transfer of care begins when a patient is commenced on an opioid analgesic during their hospital visit, according to an agreed opioid analgesic weaning and cessation protocol. The number of days' supply of an opioid analgesic on discharge is based on multiple factors including the expected course of the patient's condition, appropriate arrangements for follow up and opioid analgesic use in the last 24 hours before discharge.

Plan for appropriate opioid analgesic use at the transfer of care when a patient is first prescribed, supplied or administered on an opioid analgesic for acute pain during their hospital visit/stay. Follow an opioid analgesic weaning and cessation protocol to start weaning and cessation of opioid analgesics during their hospital stay/visit by assessing the patient's functional activity and pain scores. As part of the medication management plan provided to the patient, their carer and the patient's general practitioner on discharge, the weaning and cessation plan for opioid analgesics should include:

- The appropriate formulation of an opioid analgesic to provide or prescribe
- The appropriate oral morphine-equivalent daily dose (oMEDD) on discharge, which is based on the total oMEDD given in the last 24 hours before discharge
- For patients discharged from day surgery, the appropriate opioid analgesic number of days' supply based on the expected trajectory of the patient's condition
- The appropriate opioid analgesic number of days' supply, considering the day of discharge and when the patient can reasonably be expected to access primary care and other healthcare services post-discharge
- Identification of the patient who already has opioid analgesics in their possession that may adequately treat their acute pain and does not require additional prescription on hospital discharge, and advice on the appropriate use of those opioid analgesics
- Identification of the patient's general practitioner who will continue the patient's care after leaving hospital. If this is not possible, develop a plan to assist the patient access health care after discharge.

Provide the patient with written information on discharge that addresses:

- How many times a day to take, use or apply the opioid analgesic, and if it should be taken with food
- Whether the opioid analgesic will affect other medicines they use
- What the adverse effects are and how to manage them
- When to seek urgent care for adverse effects of the opioid analgesic or lack of pain relief
- How to reduce the opioid analgesic, to allow the patient to stop taking the opioid analgesic (weaning and cessation plan)
- How to safely store and dispose of the opioid analgesic.

If a patient is discharged from ED with an opioid analgesic, the quantity supplied may be for up to a maximum of three days' treatment.

If a hospital in-patient is discharged with an opioid analgesic, the quantity may be for up to a maximum of seven days' treatment to reduce and stop the medicine.

For patients who live in locations with limited access to prescribers and pharmacies, consider the patients individual circumstances and expected course of their condition, and provide an appropriate quantity of opioid analgesics that provides analgesia and mitigates the risk of opioid-related harm after discharge.

Questions?

For more information about the clinical care standard, please visit: safetyandquality.gov.au/ccs.

You can also contact the Clinical Care Standards project team at: ccs@safetyandquality.gov.au.

References

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The Australian Commission on Safety and Quality in Health Care has produced this clinical care standard to support the delivery of appropriate care for a defined condition. The clinical care standard is based on the best evidence available at the time of development. Healthcare professionals are advised to use clinical discretion and consideration of the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian, when applying information contained within the clinical care standard. Consumers should use the information in the clinical care standard as a guide to inform discussions with their healthcare professional about the applicability of the clinical care standard to their individual condition.

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