Clinical Guideline No.: CG096

Clinical Guideline for Prescribing Opioids on Discharge

Version No.: 2.0
Approval date: 20/10/20

Government of South Australia
SA Health

Contents

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1. Introduction

This guideline aims to support safe prescribing of opioid medicines on discharge from SA public hospitals and health services, including emergency departments and day surgery units.

2. Background

Opioids are high risk medicines, harm caused by opioids is well known. In 2018 opioids were involved in 57.8% of all unintentional drug deaths in Australia[1]. The number of unintentional drug-induced deaths involving opioids has nearly trebled in the last 12 years (2006-2018)[3]. During this same period deaths involving oxycodone / morphine / codeine increased by 89%[1], and deaths involving fentanyl / pethidine / tramadol increased by almost 1,500%[1].

Opioid prescribing rates continue to increase in Australia in line with prescribing rates seen internationally. In 2016-2017 approximately three million Australians were prescribed at least one opioid (PBS/RPBS) [2]. The most common dispensed was oxycodone (5.7 million prescriptions to 1.3 million people) [2].

South Australia remains the second highest ranked state for number of PBS/RPBS prescriptions dispensed for opioid medicines per 100,000 population (age-sex standardised) with an increase of 4.7%, close to the national average of 4.8%[3].

The consequences from the increased prescribing rates have been associated with increases in opioid-related harm, including re-admission to hospital, addiction, unintended overdose and death.

Hospital-initiated opioids, most often acute pain management, have been identified as a key risk for ongoing and inappropriate use. A greater amount of initial opioid exposure (i.e. higher total dose) is associated with both greater risk of long-term use, and greater risk of overdose. Opioids should be prescribed only when necessary, in the lowest effective dose, and for the shortest duration required[4]. Excessive prescribing of opioids frequently results in quantities of leftover opioid medicines in the community, which are available for diversion and inappropriate use.

3. Definitions

Authorised prescriber means: the prescriber must have an authority to prescribe or supply a drug of dependence for a patient for regular treatment for more than 2 months. Treatment provided by other prescribers must be taken into account when calculating the 2 month period. The two month period applies to the individual consumer and should treatment have commenced with a prior authorised prescriber the duration of therapy should be considered within the context of the two month period.

EXEMPTIONS:

- Patients aged ≥ 70 years (unless the drug is pethidine or dextromoramide)
- Patient's life expectancy is 12 months or less

- Treatment of a current inpatient of a hospital / correctional institution where the prescriber has notified the '*authorised prescriber'* or where an *'authorised prescriber'* does not exist.

Immediate release (IR) means; drug products, which are formulated to release the active drug immediately after administration formulated to release the active drug immediately after oral administration

MATOD means; medication assisted treatment for opioid dependence, which is an opioid substitution program.

Modified release (MR) means; 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.

SLS means: the Safety Learning System is the application that enables all SA Health services to record, manage, investigate and analyse patient and worker incidents as well as consumer feedback. It is also used for capturing information about security services and to record formal notifications such as those for coronial matters or medical malpractice.

4. Principles of the standards

National Safety and Quality Health Service (NSQHS) Standards

Clinical Governance Standard

Standard 1 aims to ensure there are systems in place within health service organisations to maintain and improve the reliability, safety and quality of health care.

Partnering with consumers standard

Standard 2 aims to create health service organisations in which there are mutually beneficial outcomes by having:

- Consumers as partners in planning, design, delivery, measurement and evaluation of systems and services

- Patients as partners in their own care, to the extent that they choose.

The Partnering with Consumers Standard recognises the importance of involving patients in their own care and providing clear communication to patients.

Medication Safety Standard

Standard 4 aims to ensure:

- Clinicians safely prescribe, dispense and administer appropriate medicines, and monitor medicine use; and

- Consumers are informed about medicines, and understand their own medicine needs and risks.

Communicating Safety Standard

Standard 6 aims to ensure timely, purpose-driven and effective communication and documentation that support continuous, coordinated and safe care for patients.

Aged Care Quality Standards

Standard 7 aims to ensure clinicians are sufficient, skilled and qualified to provide safe, respectful and quality care and services.

Standard 8 aims to ensure systems are in place for the delivery of safe and quality care and services

5. General

The use of opioids in the management of acute pain and non-cancer chronic pain should only be considered when first line management with non-opioid medicines such as paracetamol and non-steroidal anti-inflammatories (if not contraindicated) and non-pharmacological therapies (e.g. physiotherapy) have been optimised and have failed or are likely to fail to provide adequate pain relief.

Early effective management of acute pain is critical to reducing morbidity and preventing the development of chronic pain, particularly in the post-operative period and immediately following discharge from hospital. Immediate-release (IR) opioids such as oxycodone are commonly used in this situation and recommended in preference to slow-release opioid formulations. When opioid medications are required to manage acute pain the lowest effective dose should be prescribed.

5.1. Determining appropriateness to prescribe opioids on discharge

Prior to prescribing opioids 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[5].

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[5].

5.1.1. Patients with acute pain

It may be appropriate to prescribe immediate-release (IR) opioids on discharge for some patients for short-term, acute pain management.

5.1.2. Patients with chronic cancer/non-cancer pain

MR opioids

- MR opioids should not be prescribed on discharge for patients taking long-term opioids prior to hospital admission unless:
  - There is a genuine need for extra supply which cannot be obtained from the patient's usual or authorised prescriber; or

- Where requirements have changed during their hospital stay, e.g. dose change.

- Any changes to the patient's MR opioid doses should only be made after discussion with the patient's usual or authorised prescriber.

IR opioids

- The aim would be to minimise the need for any IR opioid and have the patient discharged with their MR opioid only. However if additional IR opioids are needed on discharge, these should only be prescribed after discussion with the patient's usual or authorised prescriber.

5.1.3. Patients in opioid substitution programs and/or dependent on non-prescribed controlled drugs

- Prescribing opioids is restricted for patients:
  - Prescribed opioids as part of their treatment of opioid dependence, e.g. in a MATOD program; or
  - Dependent on non-prescribed pharmaceutical opioids, illicit opioids (e.g. heroin) and amphetamines.
- In all cases opioids for discharge should only be prescribed after discussion with the usual or authorised prescriber.
- For patients participating in a MATOD program, prior to discharge contact the:
  - Patient's usual or authorised prescriber; and
  - Community pharmacy/centre where the patient usually obtains their MATOD medications.
- If a supply of opioids for short-term management of acute pain is needed (the aim would usually be to cease all non-MATOD opioids before discharge) there are two options:
  - A temporary increase in the patient's MATOD medication may be possible, but only after discussion with the patient's usual or authorised prescriber ; OR
  - If IR opioids are required on discharge (e.g. post-operative acute pain) contact any of the services listed below for advice on whether a limited supply may be prescribed.
- Advice can be obtained from the:
  - Drug and Alcohol Consultation Liaison Service (DACLS) if available in the hospital
  - Hospital's Acute Pain Service (APS)
  - Patient's authorised prescriber

- Telephone-based Drug and Alcohol Clinical Advisory Service (DACAS), on 7087 1742

5.2. Determining the Quantity of Opioid to be Prescribed

5.2.1. Patients with acute pain

Review patient's use of 'prn' opioid over the 24 hours prior to discharge:

- 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 point of discharge:

  - 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):

    - Divide total daily dose by 6 to obtain the maximum 4 hourly dose to be prescribed.

    - Order a dose range so that lower doses can be taken; order 4 hourly prn.

    - If the calculated maximum single dose is 20mg or more, seek advice before prescribing.

  - Consider a quantity appropriate to patient's requirements at the point of discharge based on dose, expected duration and dose tapering plans.

  - PBS prescriptions can be for any quantity up to the stated maximum. It is not necessary to prescribe the maximum quantity if a lesser quantity is sufficient for the patient's needs.

- The decision to prescribe IR opioids for short-term management of acute pain after discharge should be based primarily on an assessment of the patient's functional activity rather than pain scores alone.

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

5.2.2. 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 or authorised prescriber has been contacted by the medical officer regarding details of the supply.

5.2.3. Patients in an opioid substitution program and/or dependent on non-prescribed controlled drugs

- Where immediate-release opioids appear to be required on discharge, e.g. postoperative acute pain, contact DACLS, the Acute Pain Service or equivalent who will advise whether a limited supply may be prescribed (see section 5.1.3 above for details).

- For patients participating in an opioid substitution (MATOD) program:

  > Prescribe as per specialist advice from DACLS and/or APS and with the agreement of the patient's usual or authorised prescriber.

  > The community pharmacy/centre where the patient usually obtains their supply must be advised.

5.3. How to Write a Legal Discharge Prescription for Opioid Medications

Most opioids are classified as Drugs of Dependence due to their high potential for misuse, abuse and dependence. Drugs of Dependence are subject to specific requirements under the controlled substances legislation, relating to prescribing, supply, storage and transport.

Specific requirements exist for the use of opioids in patients with a known or suspected history of drug dependence and for the treatment of drug dependence.

The prescription and supply of drugs of dependence in South Australia is regulated under the Controlled Substances Act 1984 and Controlled Substances (Poisons) Regulations 2011.

All prescribers in South Australia must comply with this legislation as well as any SA Health policies, local guidelines and PBS criteria (for PBS prescriptions) when writing discharge prescriptions for opioid medicines.

5.4. Electronic Medication Record Systems

Electronic medication record systems (EMR), e.g. EMR & PAS (Sunrise EMR), should assist prescribers with their clinical decisions to support safe and appropriate prescribing of opioids. For example in the case of oral immediate release opioids that can be used in the short term treatment of acute pain, EMR systems should not include a default quantity for discharge/out-patient prescriptions. In these cases, the quantity should appear as zero for the prescriber to adjust, as the appropriate quantity may be less than the PBS quantity.

5.5. Patient Education

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

- It is a legal requirement for the prescriber to advise patients of the risks associated with driving or operating machinery whilst taking an opioid.

- All adult patients (and/or their carers) prescribed IR oxycodone for short-term treatment of acute pain should be provided with the SA Health leaflet Information for patients given oxycodone for short-term treatment of acute pain to supplement verbal education.

- All paediatric patients (and their carers) prescribed IR opioids for short-term treatment of acute pain the SA Health leaflet Information for paediatric patients, and their carers, given opioids for short-term treatment of acute pain should be provided to all paediatric patients to supplement verbal education.

- Other consumer information resources are available from professional bodies and organisations, including online resources from NPS MedicineWise and the Pharmaceutical Society of Australia's Opioid Medicine Fact Sheet.

5.6. Communication to Primary Care Provider

It is important to communicate details of opioids prescribed to the patient's primary care provider, e.g. GP, authorised prescriber, community pharmacist, residential aged care staff, including:

- Discharge letter which must accurately reflect information on opioid dose, frequency and suggested duration of treatment, including plan for dose reduction.

- Patient's pain management plan.

5.7. 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 their carers.

Prescribers should consider prescribing naloxone for patients at risk of an opioid overdose when prescribing opioids on discharge. This includes patients on prescribed opioids, anyone using illicit opioid drugs and also patients participating in an opioid substitution therapy.

6 Safety, quality and risk management

National Standard 1 Clinical Governance	National Standard 2 Partnering with Consumers	National Standard 3 Preventing & Controlling Healthcare-Associated Infection	National Standard 4 Medication Safety	National Standard 5 Comprehensive Care	National Standard 6 Communicating for Safety	National Standard 7 Blood Management	National Standard 8 Recognising & Responding to Acute Deterioration
☒	☐	☐	☒	☐	☒	☐	☐

7 Eligibility criteria

Inclusion:
All SA Health clinical staff, including consultants, students and contractors, involved in the prescribing, dispensing and supplying medicines and providing education about medicines to patients and /or their carers at discharge.

Exclusion: N/A

8 Reference

References

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2. AIHW (Australian Institute of Health and Welfare) 2018. Opioid harm in Australia and comparisons between Australia and Canada. Canberra: AIHW

3. ACSQHC and AIHW (Australian Commission on Safety and Quality in Health Care and Australian Institute of Health and Welfare) 2018. The Third Australian Atlas of Healthcare Variation, Sydney: ACSQHC

4. UpToDate. Prescription of opioids for acute pain. Version 29.0. Accessed online 01/09/2020

5. Macintyre PE, Huxtable CA, Flint SLP, Dobbin MDH. Costs and consequences: a review of discharge opioid prescribing for ongoing management of acute pain. *Anaesth Intensive Care* 2014; 42: 558-574

Resources

SA Health opioids for acute pain resource kit
SA Health Clinical Resources - Opioids
SA Health Clinical Resources - Prescribing Drugs of Dependence
SA Health preventing and responding to adverse effects of opioids - naloxone
PBS revised opioids listings from 1 June 2020
NPS opioid resources
Choosing-Wisely patient guide to managing pain and opioid-medicines
NPS community use of naloxone for opioid overdose

Australian Government take home naloxone pilot - about opioid overdose and adverse reactions

Acknowledgement

The Royal Adelaide Hospital's Opioid Work Party (OWP) developed the initial guideline which was accepted following state-wide consultation by the Quality Use of Medicines SA (QUMSA) working group of the South Australian Medicines Advisory Committee (SAMAC) in 2013.

9 Document Ownership & History

Document developed by: Medicines and Technology Programs, Systems Leadership and Design
File / Objective No.: 2020-06600 | A2080469
Next review due: 01/10/2025
Policy history: Is this a new policy (V1)? **N**
Does this policy amend or update and existing policy? **Y**
If so, which version? 1.4
Does this policy replace another policy with a different title? **N**

ISBN No.: 978-1-76083-315-2

Approval Date	Version	Who approved New/Revised Version	Reason for Change
20/10/20	V2	Skye Jacobi, Acting Deputy Chief Executive, Systems Leadership & Design, Department for Health and Wellbeing	Included section on electronic medication record systems. Updated Section 4 'Principles of the Standards' – included NDIS and Aged Care Standards. Put into the current clinical guideline template. Minor editing and updated references
April 2016	V1.4	SA Health Safety and Quality Strategic Governance Committee	Amended telephone number of DACAS
December 2015	V1.3	SA Health Safety and Quality Strategic Governance Committee	Amended typographical error in Fact Sheet
September 2015	V1.2	SA Health Safety and Quality Strategic Governance Committee	Updated format, Branch name and reference
December 2014	V1.1	SA Health Safety and Quality Strategic Governance Committee	New template, update contact information, and add paediatric information sheet
September 2013	V1	SA Health Safety and Quality Strategic Governance Committee	Original SA Health Safety and Quality Strategic Governance Committee approved version