Opioids for acute pain management policy

V1.0

17 January 2017
Summary.

Intravenous opioids can be effective for the rapid control of acute pain, and for titration of opioid dosing.

Intravenous opioids should not usually be used when pain is persistent and on-going.

**Inpatients should not be administered opioids by bolus intravenous injection for more than 48 hours**, except in exceptional circumstances:

- New painful condition arising requiring re-titration of opiate levels, or
- Administration via PCA device, or
- Specifically sanctioned by the patient’s consultant, or
- Specifically sanctioned by a pain consultant, or
- Specifically sanctioned by MDT Management Plan

When on-going opioid therapy is considered appropriate after 48 hours of admission, these should be administered by a route other than intermittent intravenous bolus. Examples include oral, transcutaneous (patch), intramuscular, subcutaneous infusion or IV PCA administration.
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1. **Introduction**

1.1. Opioid medications provide pain relief that is rapid and profound.

1.2. Opioid medications have a number of properties that renders their use problematic:
   - Euphoria or other positive psychological effects
   - Tolerance – diminishing effect of subsequent doses
   - Dependence – unpleasant withdrawal symptoms as drug effect wears off
   These definitions are expanded in appendix 6.

1.3. These properties are more marked in preparations that provide rapid onset and offset of drug effect. Regarding common routes of administration, from the most rapid:
   - Intravenous administration has rapid onset and offset. (Transmucosal administration (eg sublingual fentanyl) and inhaled administration is also rapid in onset and offset). Time to peak effect typically 4-10 minutes.
   - Intramuscular administration is less rapid
   - Oral Instant Release (IR) formulations
   - Oral Sustained Release (SR; MR) formulations
   - Transcutaneous patch is least rapid – time to peak (plateau) effect 8-16 hours

1.4. Administration of intravenous opioids puts patients at risk of requesting more opioids for the management of their mood, or for relief from withdrawal symptoms

1.5. By 48 hours after admission, the patient’s pain level and the patient’s opioid level should be ascertained and steady

1.6. By 48 hours, the detrimental effect of intravenous opioids (above) exceeds any beneficial effects.

1.7. Except in rare circumstances, patients should not receive intravenous opioids after 48 hours. Examples of such circumstances:
   - New painful condition arising requiring re-titration of opiate levels,
   - Administration via PCA device,
   - Specifically sanctioned by the patient’s consultant,
   - Specifically sanctioned by a pain consultant, or
   - Specifically sanctioned by MDT Management Plan

1.8. Where a specific management plan has been made regarding an individual patient, that plan will supersede this policy

2. **Purpose of this Policy/Procedure**

2.1. To control the risk of patients developing or maintaining inappropriate dependence on opiates, or inappropriately high doses of opiates, while maintaining the use of opioids for their valuable effect of controlling pain.
2.2. To provide clarity for doctors and for patients that the provision of opioids by intravenous bolus dosing should cease within 48 hours of admission, except in specific rare circumstances

3. Scope
3.1. This policy applies to all patients in RCHT hospitals, and to all RCHT staff.

4. Definitions / Glossary

**Addiction** is a primary, chronic, neurobiological disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving.

**Opioid drugs** are derived from the opium poppy, or are synthetic versions of such drugs. Opioids available for intravenous use include morphine, oxycodone, pethidine, fentanyl and alfentanil.

**Physical dependence** is a state of being that is manifested by a drug class specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist.

**Tolerance** is the body's physical adaptation to a drug: greater amounts of the drug are required over time to achieve the initial effect as the body "gets used to" and adapts to the intake.

**Pseudo addiction** is a term which has been used to describe patient behaviors that may occur when pain is undertreated. Patients with unrelieved pain may become focused on obtaining medications, may "clock watch," and may otherwise seem inappropriately "drug seeking." Even such behaviors as illicit drug use and deception can occur in the patient's efforts to obtain relief. Pseudo addiction can be distinguished from true addiction in that the behaviors resolve when pain is effectively treated.

5. Ownership and Responsibilities

5.1. This policy was developed by the RCHT pain service in consultation with the Abdominal Pain MDT group.

5.2. Consultants are responsible for ensuring enforcement of the policy, and for formulating plans for patients that they feel should be exceptions to the policy.

5.3. All doctors are responsible for ensuring that prescribing of opioids conforms to this policy and for feeding back issues pertaining to the use of the policy.

5.4. Nursing staff are responsible for notifying doctors in cases where prescription of opioids does not conform to this policy. Nurses are not required to refuse to dispense prescribed medication where the prescription does not conform to this policy.

5.5.
5.6. **Role of the Managers**

Line managers hold no specific responsibility with regard to these guidelines.

5.7. **Role of the Abdominal Pain MDT Group/Committee and the Pain Service**

The pain service will collate reports of issues with and exceptions from this policy. Where necessary, these will be discussed with the Abdominal Pain MDT group, with members of the Pain Team or with appropriate individuals.

6. **Standards and practice**

See appendices 3 to 6:
- Opiate dependency risk tool
- Compassionate refusal – ethics
- Conversion tables for equivalent opiate doses
- Opioid management plan bundle

7. **Dissemination and Implementation**

7.1. This policy will be available on: RCHT Document library

7.2. The policy was highlighted at the Grand Round on 14/03/16

7.3. This policy will be disseminated via the various teaching commitments of the pain team. It will also be communicated by consultant to consultant communication, for dissemination among clinical teams. Exceptions to the policy will result in communication to the medical team responsible for the exception.

8. **Monitoring compliance and effectiveness**

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Patients that continue to use intravenous opiates 48 hours after admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead</td>
<td>Dr Keith Mitchell</td>
</tr>
<tr>
<td>Tool</td>
<td>MAXIMS alert generated daily specifying all patients using intravenous opioids for more than 2 days</td>
</tr>
<tr>
<td>Frequency</td>
<td>A report will be generated of: Exceptions to the policy Issues arising from the use of the policy The frequency will be monthly, reducing over time as indicated</td>
</tr>
<tr>
<td>Reporting arrangements</td>
<td>The monthly report will be discussed as a standing agenda item on The pain team acute pain meeting The abdominal pain MDT group</td>
</tr>
<tr>
<td>Acting on</td>
<td>Required changes to policy and/or practice will be discussed in the</td>
</tr>
<tr>
<td>Change in practice and lessons to be shared</td>
<td>Practice change will be recommended to staff by members of the pain team during their hospital rounds. Individual or group emails will be sent to individuals or groups, as appropriate. Pharmacists will be made aware of the policy and will be encouraged to discuss it with ward staff and patients.</td>
</tr>
</tbody>
</table>

9. **Updating and Review**

The document will be reviewed as laid out in part 7, and will be updated as required in accordance with standard RCHT procedure.

10. **Equality and Diversity**

This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Diversity & Human Rights Policy' or the Equality and Diversity website.

Royal Cornwall Hospitals NHS Trust is committed to a Policy of Equal Opportunities in employment. The aim of this policy is to ensure that no job applicant or employee receives less favourable treatment because of their race, colour, nationality, ethnic or national origin, or on the grounds of their age, gender, gender reassignment, marital status, domestic circumstances, disability, HIV status, sexual orientation, religion, belief, political affiliation or trade union membership, social or employment status or is disadvantaged by conditions or requirements which are not justified by the job to be done. This policy concerns all aspects of employment for existing staff and potential employees.

10.1. **Equality Impact Assessment**

10.2. All public bodies have a statutory obligation to undertake Equality Impact Assessments on all policy documents. This must be undertaken by the author using the agreed Equality Impact Assessment Template. The completed assessment is to be added to the end of the policy document as an appendix prior to it being ratified.

10.3. The Initial Equality Impact Assessment Screening Form is at Appendix 2.
# Appendix 1. Governance Information

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Opioids for acute pain management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>19 August 2016</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>17 January 2017</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>17 January 2020</td>
</tr>
<tr>
<td>responsible (author/owner):</td>
<td></td>
</tr>
<tr>
<td>Contact details:</td>
<td>01872 321180</td>
</tr>
<tr>
<td>Brief summary of contents</td>
<td>Intravenous opioids can be effective for the rapid control of acute pain, and for titration of opioid dosing. This policy provides guidance on the use of intravenous opioids.</td>
</tr>
<tr>
<td>Suggested Keywords:</td>
<td>Pain morphine intravenous acute</td>
</tr>
<tr>
<td>Target Audience</td>
<td>RCHT</td>
</tr>
<tr>
<td>Executive Director responsible</td>
<td>Medical Director</td>
</tr>
<tr>
<td>for Policy:</td>
<td></td>
</tr>
<tr>
<td>Date revised:</td>
<td>June 2016</td>
</tr>
<tr>
<td>This document replaces (exact</td>
<td>New document</td>
</tr>
<tr>
<td>title of previous version):</td>
<td></td>
</tr>
<tr>
<td>Approval route (names of</td>
<td>Medical Services Governance Board</td>
</tr>
<tr>
<td>committees)/consultation:</td>
<td></td>
</tr>
<tr>
<td>Divisional Manager confirming</td>
<td>Sheena Wallace</td>
</tr>
<tr>
<td>approval processes:</td>
<td>Medical Services Associate Director</td>
</tr>
<tr>
<td>Name and Post Title of additional signatories</td>
<td>Not required</td>
</tr>
<tr>
<td>Name and Signature of</td>
<td>{Original Copy Signed}</td>
</tr>
<tr>
<td>Divisional/Directorate</td>
<td>Steve Creely</td>
</tr>
<tr>
<td>Governance Lead confirming</td>
<td>Clinical Director for Specialty Medicine</td>
</tr>
<tr>
<td>approval by specialty and</td>
<td></td>
</tr>
<tr>
<td>divisional management meetings</td>
<td></td>
</tr>
<tr>
<td>Signature of Executive Director</td>
<td>{Original Copy Signed}</td>
</tr>
<tr>
<td>giving approval</td>
<td></td>
</tr>
<tr>
<td>Publication Location (refer to</td>
<td>Internet &amp; Intranet</td>
</tr>
<tr>
<td>Policy on Policies – Approvals</td>
<td>✓</td>
</tr>
<tr>
<td>and Ratification):</td>
<td>Intranet Only</td>
</tr>
<tr>
<td>Document Library Folder/Sub</td>
<td>Royal Cornwall Hospital Trust / Clinical / Pain</td>
</tr>
<tr>
<td>Folder:</td>
<td></td>
</tr>
</tbody>
</table>
Links to key external standards

Related Documents: https://www.fpm.ac.uk/faculty-of-pain-medicine/opioids-aware

Training Need Identified? Yes.

Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 Jun 10</td>
<td>V1.0</td>
<td>Initial Issue</td>
<td>Keith Mitchell Consultant Pain Management</td>
</tr>
</tbody>
</table>

All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry.

This document is only valid on the day of printing

Controlled Document
This document has been created following the Royal Cornwall Hospitals NHS Trust Policy on Document Production. It should not be altered in any way without the express permission of the author or their Line Manager.
### Appendix 2. Initial Equality Impact Assessment Form

<table>
<thead>
<tr>
<th>Name of the strategy / policy / proposal / service function to be assessed (hereafter referred to as policy) (Provide brief description):</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Policy Aim</strong>* Who is the strategy / policy / proposal / service function aimed at?</td>
</tr>
<tr>
<td>Patients admitted to hospital that have pain sufficient to require the administration of strong opioid drugs intravenously; doctors prescribing opioids to these patients.</td>
</tr>
<tr>
<td>2. <strong>Policy Objectives</strong>*</td>
</tr>
<tr>
<td>Reduce the number of patients developing dependence on opioids; Reduce the number and duration of admissions of patients that report to hospital regularly for the acquisition of pain relief;</td>
</tr>
<tr>
<td>3. <strong>Policy – intended Outcomes</strong>*</td>
</tr>
<tr>
<td>Above</td>
</tr>
<tr>
<td>4. <strong>How will you measure the outcome?</strong></td>
</tr>
<tr>
<td>Reports of patients reporting regularly to RCHT for pain relief are maintained by the Abdominal Pain MDT group.</td>
</tr>
<tr>
<td>5. <strong>Who is intended to benefit from the policy?</strong></td>
</tr>
<tr>
<td>Patients will benefit as they are less likely to be drawn into a pattern of opioid dependence and associated behaviours RCHT will benefit from a reduction in bed-days utilised by patients with long-term pain problems Staff will benefit from a reduction in conflict and uncertainty regarding the provision of intravenous opioids</td>
</tr>
<tr>
<td>6a) <strong>Is consultation required with the workforce, equality groups, local interest groups etc. around this policy?</strong></td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>b) <strong>If yes, have these groups been consulted?</strong></td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>C) <strong>Please list any groups who have been consulted about this procedure.</strong></td>
</tr>
<tr>
<td>The document has been formulated following MDT discussion involving a general practitioner, a psychiatrist, a pain clinician and a gastroenterologist. The policy has been discussed with multiple physicians at grand round and selected surgical consultants</td>
</tr>
<tr>
<td>7. <strong>The Impact</strong></td>
</tr>
<tr>
<td>Please complete the following table.</td>
</tr>
<tr>
<td>Are there concerns that the policy could have differential impact on:</td>
</tr>
<tr>
<td>Equality Strands:</td>
</tr>
</tbody>
</table>

Opioids for acute pain management policy
### Opioids for acute pain management policy

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>x</td>
</tr>
<tr>
<td><strong>Sex</strong> (male, female, trans-gender / gender reassignment)</td>
<td>x</td>
</tr>
<tr>
<td><strong>Race / Ethnic communities /groups</strong></td>
<td>x</td>
</tr>
<tr>
<td><strong>Disability</strong> - Learning disability, physical disability, sensory impairment and mental health problems</td>
<td>x</td>
</tr>
<tr>
<td><strong>Religion / other beliefs</strong></td>
<td>x</td>
</tr>
<tr>
<td><strong>Marriage and civil partnership</strong></td>
<td>x</td>
</tr>
<tr>
<td><strong>Pregnancy and maternity</strong></td>
<td>x</td>
</tr>
<tr>
<td><strong>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</strong></td>
<td>x</td>
</tr>
</tbody>
</table>

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:

- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation - this **excludes any policies** which have been identified as not requiring consultation.  **or**
- Major service redesign or development

8. Please indicate if a full equality analysis is recommended.  
   - Yes  
   - No  

9. If you are not recommending a Full Impact assessment please explain why.

Signature of policy developer / lead manager / director  
Date of completion and submission

Names and signatures of members carrying out the Screening Assessment  
1.  
2.  

---

Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead, c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa, Truro, Cornwall, TR1 3HD

A summary of the results will be published on the Trust’s web site.

Signed ____________________  
Date ____________________
Appendix 3. Opiate dependency risk tool

Where there is a concern that patient may be at high risk of dependency, the following tool may be used:

<table>
<thead>
<tr>
<th>Mark each box that applies</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Family hx of substance abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Illegal Drugs</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>2. Personal hx of substance abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Illegal Drugs</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>3. Personal hx of substance abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>4. Hx of preadolescent sexual abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>5. Psychologic disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ADD, OCD, bipolar, schizophrenia</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Depression</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Scoring totals:

0-3 Low Risk, 4-7 Moderate Risk, ≥8 High Risk
Appendix 4. Compassionate refusal, ethics

International Narcotics Control Board (INCP):
Protecting the wellbeing of the individual and society is the purpose of prohibiting the non-medical use of drugs, which is certainly not an attempt to limit human rights. The prevention of drug abuse problems by means of national and international control and demand reduction activities can be regarded as a basic human right of the individual and society.

Appendix 5. Conversion tables for equivalent opiate doses

Conversion charts (approx)

<table>
<thead>
<tr>
<th>Analgesic</th>
<th>Route</th>
<th>Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codeine</td>
<td>PO</td>
<td>100 mg</td>
</tr>
<tr>
<td>Diamorphine</td>
<td>IM, IV, SC</td>
<td>3 mg</td>
</tr>
<tr>
<td>Dihydrocodeine</td>
<td>PO</td>
<td>100 mg</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>PO</td>
<td>2 mg</td>
</tr>
<tr>
<td>Morphine</td>
<td>PO</td>
<td>10 mg</td>
</tr>
<tr>
<td>Morphine</td>
<td>IM, IV, SC</td>
<td>5 mg</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>PO</td>
<td>6.6 mg</td>
</tr>
<tr>
<td>Tramadol</td>
<td>PO</td>
<td>100 mg</td>
</tr>
</tbody>
</table>

PO = by mouth; IM = intramuscular, IV = intravenous, SC = subcutaneous

Parenteral route

The equivalent parenteral dose of morphine (subcutaneous, intramuscular, or intravenous) is about half of the oral dose. If the patient becomes unable to swallow, generally morphine is administered as a continuous subcutaneous infusion (for details, see Continuous Subcutaneous Infusions). Diamorphine is sometimes preferred, because being more soluble, it can be given in a smaller volume. The equivalent subcutaneous dose of diamorphine is about one-third of the oral dose of morphine.
This document describes a plan for the management of opioid analgesics agreed between:

Clinician ___________________________ Job title _________________ and

Patient

The aim of this document bundle is for patients and clinicians to have a clear understanding of the possible benefits and the potential pitfalls of long-term opioid usage. Patients starting an Opioid Management Plan should be given the entire bundle. Only the last part - Treatment Agreement - should be saved for GP and hospital records. There are 4 parts:

Opioids for Pain Management – Patient Information is a patient information leaflet describing what opioid analgesics are, when they are used, realistic expectations of benefit and details of the significant risks associated with long term use.

Opioid Management - Prescriber Information is advice primarily designed to educate prescribers but is also appropriate to give to patients.

Weaning Opioids – Advice for patients. There is a sister document: "Weaning Opioids – Advice to GP's" also available.

Opioid Management Plan - Treatment Agreement. This is signed by the patient and prescriber. It outlines terms and conditions to be satisfied for opioid treatment to continue. The clinician provides a brief clinical summary plus details of present analgesic use and suggestions for the future. If new drugs are started it will describe dose ranges that should not be exceeded. It will also give advice on when to try reducing the dose and how to achieve discontinuation if possible.

The completed management plan should be given / sent to the patient. Copies of the completed Treatment Agreement section should be kept in the GP patient records, and sent to The Pain Clinic, RCHT. From here, the treatment agreement will be scanned and uploaded to MAXIMS.

This document has been written by the multi-disciplinary pain management group of RCH with input from the pain team, liaison psychiatry, gastroenterology, clinical health psychology and primary care. It is endorsed by Kernow LMC Version1 - January 2017

Opioids for acute pain management policy
Opioids for Pain Management – Patient Information

What are opioids?
Opioids are a family of strong pain killers, which includes morphine, diamorphine (heroin), fentanyl, codeine, tramadol and others. They are not suitable for all types of pain. The aim of opioid treatment is to reduce the pain so that you can do more of your daily activities, not to take away the pain completely. They should not be used in isolation but with other pain relieving medications and in combination with other activities such as exercise and distraction. Opioids should be taken with the close guidance of a healthcare professional. Care must be taken to use only the prescribed dose and to keep these medications away from children.

How effective are opioids for pain relief?

Acute (recent onset) pain: Opioids work well for acute pain such as post-operative pain or cancer related pain in combination with other analgesics because it is mainly due to tissue damage. We would expect acute pain to settle within 3 months.

Chronic (long term) pain: - not very effective. Chronic pain isn’t usually due to tissue damage, and it is rare to completely relieve it with medications. The aim of treatment is to reduce pain enough to allow you to get on with your life. On average opioids will only help about 1 in 5 people and even then pain levels are generally only reduced by about 30%. This is why we give a trial of treatment and only continue the drug if there is clear benefit.

Are there any side effects?
Opioids have many unwanted side effects. The most common include, but are not limited to: dizziness, sickness, sleepiness, confusion, itching, alteration in mood, reduced sexual drive, weight gain, opioid-induced hyperalgesia (increased pain), opioid-induced bowel dysfunction which includes; narcotic bowel syndrome, nausea, vomiting, abdominal pain and constipation. Too much can lead to reduced breathing, unconsciousness and death. There is a full list of known side effects described in the information leaflet that comes with your medication. Besides pain relief, opioids may have other effects such as euphoria (feeling good/high for a while) or dissociation (emotional numbing). These are followed by a period of “coming down” and worsening pain as the drug levels fall. If this low is managed by increasing the dose of opioid, then escalation, tolerance and increased dependence will follow.

Can I still drive?
The law in the UK currently allows you to drive if you are taking prescribed opioid medicines and are taking them according to the prescription. You should not drive if you have changed your dose or if you feel that your judgment is impaired. You are responsible for making sure you are fit to drive.

Can I drink alcohol?
Alcohol and opioids together cause sleepiness and poor concentration. Avoid alcohol completely when you first start on opioids, when your dose has just been increased or if you drive or operate machinery. When you get on a steady dose of opioid, you may be able to tolerate modest amounts of alcohol.
**Are opioids addictive?**
Physical dependence and/or tolerance can occur with the use of opioid medications.

**Tolerance** is an inevitable physiological process defined by the gradual loss of effect over time as your body gets used to the drug.

**Dependence** means that you may experience withdrawal symptoms if the drug is suddenly stopped; therefore the drug is gradually reduced to prevent this. This is a physiological process, which can be very uncomfortable but is not life threatening. Most people develop dependence if using opioids continuously for more than a few weeks.

**Addiction** is a form of psychological dependence with extreme patterns of behaviour associated with obtaining and consuming the drug. If it is felt that this is happening, the opioid will be gradually withdrawn.

**Abuse** is a term that means that the drug is not being used in a responsible way. If this is suspected, the prescribed opioid will be gradually withdrawn.

**What is an opioid management plan?**
This is a plan of care regarding the prescription of opioid analgesics. It provides patients with information to allow an informed decision regarding commencement or continuation of the drugs and stipulates goals, sets out realistic expectations and responsibilities for both patients and clinicians to minimise risk. Your GP will be responsible for on-going prescribing of your opioids and they will be responsible for ensuring the terms of this agreement are being met. Where a patient management plan is used, this leaflet forms the patient information section of that plan.

**What if I decide to stop taking opioids?**
Stopping opioids may lead to withdrawal symptoms, which are not dangerous but can be very unpleasant. Reduce the dose gradually. Ask your GP for advice, or for a copy of the leaflet *Weaning opioids – advice for patients*.

**Further information for patients**

- British Pain Society  
  [https://www.britishpainsociety.org/](https://www.britishpainsociety.org/)

- Opioids aware section “information for patients”  
  [https://www.fpm.ac.uk/faculty-of-pain-medicine/opioids-aware](https://www.fpm.ac.uk/faculty-of-pain-medicine/opioids-aware)

- Self-management strategies can be found at  
  [http://www.paintoolkit.org/tools](http://www.paintoolkit.org/tools)

- Patient information on Narcotic Bowel Syndrome:  

- Drug driving  
  [https://www.gov.uk/drug-driving-law](https://www.gov.uk/drug-driving-law)
Opioid Management - Prescriber Information

Treating chronic pain is complex and challenging - only 5% of sufferers are pain free at 5 years. Chronic pain does not emanate from tissue damage alone (if at all) but is also a product of altered CNS architecture, thoughts, emotions, understanding of the meaning of pain, previous experience of pain and a representation of their current distress.

Strong opioids are dangerous drugs that are often prescribed and monitored poorly, resulting in preventable sickness, unnecessary long term prescribing and occasionally deaths.

The “opioids aware” section of the Faculty of Pain Medicine website gives well designed advice for prescribers and for patients. Here are their golden rules regarding opioids in non-cancer pain:

1. Opioids are very good analgesics for acute pain and for pain at the end of life but there is very little evidence that they are helpful for long term pain

2. A small proportion of people may obtain good pain relief with opioids in the long-term if the dose can be kept low and especially if their use is intermittent. However it is difficult to identify these people at the point of opioid initiation

3. The risk of harm increases substantially and there is no increased benefit at doses above an oral morphine equivalent of 120mg / day

4. If a patient is using opioids but is still in pain, the opioids are not effective and should be discontinued, even if no other treatment is available

5. Chronic pain is very complex and if patients have refractory and disabling symptoms, particularly if they are on a high opioid doses, a very detailed assessment of the many emotional influence on their pain is essential [usually via the pain clinic]

- Usually GPs will provide long-term prescriptions for these medications as long as they improve symptoms and function
- We suggest that this agreement is placed in a noticeable position in the electronic patient record
- Medication reviews should be regular to optimise doses and to intermittently taper and sometimes cease the drugs to inform on the need for continued therapy
- Remember the pain team has information on analgesics, pain interventions, neuropathic prescribing and referral information on the Referral Management Service website / pain management
**Weaning opioids – Advice for patients**

If pain remains severe despite taking opioids, it is probable that the opioids are not helping at all and you would feel better and avoid the associated risks if you reduced or stopped them. Read the leaflet that comes with the medication (or consult the internet) for the long list of negative effects of taking opioids.

We now know that when long-term opioids are used to treat long-term pain, there can be benefit for the first few weeks of treatment, but this benefit then tails off. For the majority, opioids provide little or no pain relief in the long term, and lead to an overall reduction in their quality of life.

Most people that have been on opioids for more than a few days will experience side effects when they reduce the dose. Side effects vary in their intensity and unpleasantness. Side effects generally reduce after 3 days and are mostly gone after a week.

**What are the symptoms of opioid withdrawal?**

Pain is often the first. This may be general muscle and joint pain or an increase in the patient’s painful condition. Many people take these “withdrawal pains” as a sign that the opioids had been working and need to be continued (or even increased) – they are not. It can be tough getting through this time but it’s worth it.

Other side effects of withdrawal are rather like severe flu, and may include

- Sweats, chills, “goose flesh”
- Abdominal cramps, diarrhoea
- Anxiety, insomnia, fatigue, malaise

Not everyone experiences these symptoms, but you are more likely to if you stop your opioids suddenly or reduce the dose very quickly. If you do experience severe symptoms you may need to reduce the dose more slowly. Some people occasionally need medication to control the effects of opioid withdrawal.

**But my opioids were recommended and prescribed by a doctor!**

The evidence regarding the use of long-term opioids has changed in recent years. It has become clear that in the past, doctors over-estimated the effectiveness of opioids, and under-estimated the problems associated with their use.

**How can opioids be withdrawn?**

The most suitable withdrawal schedule varies widely, depending on the individual, their circumstances, the drug dose and how long the drugs have been taken. Try the suggestion below, and adapt it as required.

Work out a **reduction dose** – the amount by which your daily dose will be reduced. A suggestion is approximately 10% of your current daily total opioid dose. It may be necessary to first change your opioid(s) to a drug or a schedule that allows this reduction, then to reduce using the new drug. Your doctor can help you with this. The pain clinic can advise. The reduction figure of 10% is only a rough guide – it may not be possible or practical to do this as tablets only come in certain sizes.
Reduce your daily intake by the reduction dose. If you possibly can, maintain this lower dose for 2 weeks. If after that time your symptoms are no worse than when you were on the higher dose, then you are ready to make your next reduction.

Reduce by the reduction dose again. Repeat the process ten times and your wean is complete.

You may find that withdrawal symptoms become more prominent as you near the end of the wean. This is normal, and is not a sign that the wean shouldn’t continue. Make the dose reduction smaller, and keep going if you can.

**What if withdrawal effects are intolerable?**

First, try reducing in smaller steps, or prolong the period between reductions. Consider non-medical strategies – distraction and self-reward can be very effective. If this proves inadequate, your doctor might have some medication that lessens the side effects. There are organisations that help patients that are struggling to wean opioids or other medications – see your GP for details. (some information is outlined in the document “Weaning Opioids – advice to GP’s”)

**I’ve weaned, and I’ve still got pain. Now what?**

Once you have been off opioids for a few weeks, or at least on a lower dose, consider two questions:

- Has my quality of life gone up or down as a result of the wean? Why?
- Has my pain increased, decreased or remained the same?

If you are not happy with the end result of weaning, speak to your doctor about your experience to discuss what to do now. Suggestions include:

- Consider taking short-acting opioids instead. These should be taken only to treat exacerbations (worsening) of your pain, or before doing activity that you can’t manage without them. Evidence suggests that the less often opioids are used, the more effective they are. They should not be taken more than once or twice a day.
- Consider alternative pain relief. Sometimes a referral to another practitioner, such as a physiotherapist or pain clinician, might be appropriate.
- Occasionally it might be appropriate to reinstate your opioids. This is rare – the majority of people feel and function better after weaning. If you and your GP do decide to go back to opioids, do so gradually in order to stave off the inevitable tolerance and reduction in benefit.

“I can’t manage to wean these medications unaided”

Ask your GP about sources of help available in your area. Some are listed on this document’s sister leaflet “Weaning opioids – Advice for GP’s”.

Type “weaning opiates” into a search engine to peruse sources available on the internet.

**Information sources**

http://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware

This document has been written by the multi-disciplinary pain management group of RCH with input from the pain team, liaison psychiatry, gastroenterology, clinical health psychology and primary care. It is endorsed by Kernow LMC

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Opioids for acute pain management policy

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Opioid Management Plan: Treatment agreement

Patient Details

Patient Declaration
In signing this agreement, the patient agrees to the following conditions regarding his / her treatment and the prescribing of an opioid medication:

1. I have read and understood the information in the document “Opioid Management Plan”, including sections on patient information, prescriber information and weaning.

2. My GP is responsible for prescribing a safe and effective dose of the opioid medication. My GP will control my dose, perhaps with advice from one or more hospital specialist in a condition relevant to my pain (“relevant specialist”). I will not use an opioid medication other than at the dose prescribed and I will discuss any changes in my dose with my GP.

3. Any evidence of unsafe use such as: drug hoarding, acquisition of any opioid medication or other pain medication from other sources (which includes emergency departments), uncontrolled dose escalation, loss of prescriptions, or failure to follow the agreement may result in termination of the agreement and withdrawal of opioids.

4. I am responsible for the security of my opioid medication at home. Lost, misplaced or stolen medication or prescriptions for opioid medicines may not be replaced. In the event that opioid medication is stolen, this must be reported to the police.

5. I will only obtain my opioid medication from my GP or another doctor specifically authorised by them, or a relevant specialist. I understand that no early prescriptions will be provided.

6. I have read the patient information on this agreement regarding opioid analgesia and I will tell my GP or specialist if I experience on-going/intolerable side effects.

7. As possible dependence is important in the management of my pain, I have informed the clinician signing this contract of any present or past dependence on alcohol or drugs that I may have had, and of any illegal activity related to any drugs (including prescription medications) in which I may have been involved.

8. I am aware that giving my opioid medication to other people is illegal and could be dangerous to them.

9. I understand that if my level of activity has not improved, I do not show a significant reduction in my pain, or if I fail to comply with any of the conditions listed above my opioid prescription may be changed or stopped.

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Opioids for acute pain management policy
Opioid Management Plan: Treatment agreement

Clinicians prescribing an opioid should have plans regarding future provision of the drug. This section allows the clinician to clarify these plans with the patient. Sections may be omitted at the prescriber’s discretion.

Healthcare Professional to complete - Sections may be omitted as appropriate.

Condition(s) being managed with opioids:

Opioids being taken prior to the implementation of this agreement:

New opioids being commenced as this agreement is being implemented:
THIS IS FOR A TRIAL PERIOD DURING WHICH THE PRESCRIBER WILL NEED GOOD EVIDENCE OF IMPROVEMENT IN FUNCTION TO EMBARK ON LONG TERM TREATMENT. (Suggest weak opioid eg codeine or tramadol, not Sustained-Release, or oramorph max 30mg / 24hrs. “As required” (prn) use generally preferable to by-the-clock.)

Period before next mandatory review:
(For new trials or dose adjustments, suggest 4-6 weeks. For long-term prescription, 6 – 12 months)
At the end of the trial period the patient should be reviewed and if function is improved, opioids may be considered in the longer term. Make a longer term plan, including regular (maximum 6 month) reviews. Consider intermittent dose reductions or drug holidays so as to demonstrate that ongoing prescriptions are clinically appropriate and beneficial.

Plan for weaning opioids, if applicable
(If the opioids are not to be weaned to zero, include an acceptable range for the on-going dose of opioids)

Is there a maximum opiate dose above which opioids are not to be escalated in the management of the condition being treated?
(Patients with non-cancer pain should not usually be supplied more that 120mg oral morphine per day, or equivalent. Most patients should receive much less – a ceiling of 60mg per day is generally sensible. Trials of escalation should be reviewed after 4-6 weeks and reversed unless clear improvement in function and/or quality-of-life is perceived.)

Patient and Prescriber Declaration
We have read and understood the information leaflets Opioids for pain management – Patient information, opioid management – prescriber information and Weaning Opioids – Advice for patients
We understand the information in the leaflets, and in this Treatment Agreement
We agree that my opioid medication will be provided as laid out in these documents.

Patient’s signature: __________________________ Date:

Patient’s name: __________________________

Medical practitioner’s signature: __________________________ Date:

Medical practitioner’s name & role: __________________________

The management plan should be given / sent to the patient.
Copies of the completed Treatment Agreement section should be kept in the GP patient records, and sent to The Pain Clinic, RCHT. From here, the treatment agreement will be scanned and uploaded to MAXIMS.

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Opioids for acute pain management policy
**Weaning opioids – Advice for GPs**

The patient leaflet "Weaning opioids" is designed to advise both patients and GP's. This section is designed to augment a GP's reading of the leaflet, not replace it.

Consider using the opioid agreement plan within the Opioid Management Plan Bundle. This lays out the issues surrounding opioids and documents agreement of the weaning process.

A drug wean should be considered a one-way process. Pick a target opioid dose. This may be zero. It may be a dose that you and the patient can agree upon as a reasonable, achievable dose. For patients on very high doses, the "generally accepted maximum" of 120mg Oral Morphine Equivalents (that's about 37mcg/hr fentanyl) might be appropriate. A wean can be paused but should not be reversed except in exceptional circumstances.

**Further notes on weaning**

The leaflet reflects standard advice from the CDC\(^1\) and FPM\(^2\). Find the nearest dose that you can to 10% of the patient’s daily opioid intake, and reduce by that. Repeat every 2 weeks. The reduction becomes a larger proportion of the dose that the patient is taking as their dose reduces. This is why patients may run into difficulty as they reach lower doses. Explain, encourage and if necessary, slow down!

There are a variety of weaning strategies published. Feel free to vary from the above if the patient requests or if you consider it appropriate. A much faster wean is tolerated by many, who may want to get it over with!

Simple ways of reducing by 10% include the use of zomorph 10mg tablets, or appropriate volumes of oramorph.

**Example:** Patient has a 75mcg patch, and takes on average 30mg oramorph per day on top. This is the oral morphine equivalent of 300mg per day of morphine (conversion table, reference below)

Suggested reduction step: 20mg (30mg is difficult to implement). Suggested method:

Convert Fentanyl to zomorph 280mg per day – 140mg bd, with oramorph on top – allow some increase to allow for variability in conversion.

Wait a week to settle.

Reduce daily intake by 20mg zomorph (ie to 130mg bd). Maintain oramorph.

Repeat every 2 weeks.

It is perfectly valid to use reducing doses of fentanyl. The patches can be cut from corner to corner to halve the dose.

**To wean or not to wean?**

Factors in deciding whether to wean opioids, and how far to reduce the dose, include:

- Evidence that opioids are not helping – patient's complaints of pain; patient's function; reports from patient's family or associates
- Risk of side effects or complications of opioids
- Risk of drug theft or diversion
- Patient's ability to cope with the effects of dose reduction
- Risk of patient procuring more dangerous opioids from alternative sources

**Other considerations before starting a wean:**

Encourage patient preparations. These include timing of weaning steps, distraction strategies, social support, help in reducing temptation to relapse.
Consider and agree GP or other healthcare support and monitoring during the wean

**What if the patient isn't keen?**
GMC guidance is that doctors have to act in patients best interests – this may involve reducing an opiate script against their wishes.
Document your reasons for embarking on an enforced wean, and on your attempts to gain patient agreement. A documented MDT discussion is advisable. Consider contacting secondary care (such as the pain clinic) for advice.
A suggested strategy for an enforced wean:
Pick a reduction dose (eg 10%)
Inform the patient that you will reduce their prescription by that amount every month. They can decide at what point during the month they wish to reduce their intake, but need to be ready for the lower dose when they collect their repeat
Make sure you implement the dose reductions!
You will need to ensure that the patient is not inadvertently prescribed opioids by colleagues by appropriate communication within the practice, with locum services and if necessary emergency services.

**Sources of assistance**
ADDACTION may be helpful in providing a key-worker, group work or additional information. Patient has to agree to the referral and be in need of additional psychological support. Single point of contact 0333 2000 325.
Cornwall Neighbourhood for Change helps clients to reduce prescription drugs. web: cn4c.org.uk.
Tel: 07500 885325 or 01209 310610

**Pharmacological assistance**
Drugs given to assist weaning can themselves be weaned after each step reduction in opioid, or maintained throughout the weaning period.
Clonidine (adrenergic α2 agonist) 100mcg 6° prn may lessen anxiety, sweats and chills.
Lofexidine 200mcg 6° prn (then titrated prn) - similar to clonidine; may cause less hypotension
Gabapentin 300mg tds may reduce anxiety and pains
(Both Clonidine and Gabapentin should be started and reduced gradually, by a tablet every 2 days.)
Diazepam 2mg tds for agitation
Loperamide 2mg may reduce diarrhea
Buscopan – 10mg tds for abdominal cramps
Quinine 200mg 12° prn for generalized cramps
Paracetamol or NSAIDS (eg ibuprofen) may reduce muscle and joint pains

Dose Conversion: Search for “Opioid conversion”, or visit for example
http://opioidcalculator.practicalpainmanagement.com/

Guidance on weaning from major professional organisations:
https://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware

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