Royal Cornwall Hospitals
NHS Trust

Opioids for Acute Pain Management Policy

V3.0

June 2023

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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Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation

The Trust has a duty under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team

Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

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 (e.g. 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.

1.9. This version supersedes any previous versions of this document.

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

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 behaviours 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 behaviours 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 behaviours 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 behaviours 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. Communication with the pain team regarding exceptions is encouraged.

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.

- Lead executive: Medical Director.
- *Lead professional*: Dr Keith Mitchell.
- Nursing lead: Sarah Medlicott.
- Pharmacy lead: Lorraine Moore.

5.5. Role of the Managers

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

5.6. Role of the Pain Service

The pain service will collate reports of issues with and exceptions from this policy. Where necessary, these will be discussed 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

7. Dissemination and Implementation

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

7.2. 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

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Patients that continue to use intravenous opiates 48 hours after admission.
Lead	Dr Keith Mitchell
Tool	Intravenous morphine bolus prescription defaults to 48-hour prescription. MAXIMS alert generated daily specifying all patients using intravenous opioids for more than 2 days. Opioid Trust Analysis generated quarterly and published via RADAR.
Frequency	Daily and quarterly, as above.
Reporting arrangements	The quarterly report will be discussed as required on the pain team acute pain meeting and/or the pain team MDT meeting.
Acting on recommendations and Lead(s)	Required changes to policy and/or practice will be discussed in the above meetings. Appropriate action will be taken in accordance with those discussions.

Information Category	Detail of process and methodology for monitoring compliance
Change in practice and lessons to be shared	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

9. Updating and Review

The document will be reviewed and updated as required in accordance with standard RCHT procedure.

10. Equality and Diversity

10.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the Equality Diversity And Inclusion Policy or the Equality and Diversity website.

10.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Opioids for Acute Pain Management Policy V3.0
This document replaces (exact title of previous version):	Opioids for Acute Pain Management Policy V2.0
Date Issued/Approved:	23 February 2023
Date Valid From:	March 2023
Date Valid To:	March 2026
Directorate / Department responsible (author/owner):	Keith Mitchell. Consultant, Pain Management.
Contact details:	01872 252792
Brief summary of contents:	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.
Suggested Keywords:	Pain morphine intravenous acute
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Medical Services Governance Board
General Manager confirming approval processes:	Doug Riley
Name of Governance Lead confirming approval by specialty and care group management meetings:	James Masters
Links to key external standards:	None
Related Documents:	https://www.fpm.ac.uk/opioids-aware Opioids for Acute Pain Management Policy V3.0
Training Need Identified?	Yes.

Information Category	Detailed Information
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical / Pain

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
17 January 2017	V1.0	Initial Issue	Keith Mitchell Consultant Pain Management
17 October 2019	V2.0	Reviewed - no changes made to policy; Appendix 6 updated. Updated to latest trust template.	Keith Mitchell Consultant Pain Management
23 February 2023	V3.0	Appendices 6 onward deleted and replaced with link to document quoted. References to Abdominal pain MDT removed as that MDT is no longer operational. Minor updates and corrections.	Keith Mitchell Consultant Pain Management

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Opioids for Acute Pain Management Policy V3.0
Directorate and service area:	Pain Service, ACCT
Is this a new or existing Policy?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Keith Mitchell, Consultant Pain Management
Contact details:	01872 252792

Information Category	Detailed Information
Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	Patients admitted to hospital that have pain sufficient to require the administration of strong opioid drugs intravenously and doctors prescribing opioids to these patients.
Policy Objectives	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.
Policy Intended Outcomes	Above
How will you measure each outcome?	Reports of patients reporting regularly to RCHT for pain relief are maintained by the Abdominal Pain MDT group.
Who is intended to benefit from the policy?	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

Information Category	Detailed Information
	regarding the provision of intravenous opioids.
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** 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
6c. What was the outcome of the consultation?	Agreed.
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff or patient surveys:** No

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	

Protected Characteristic	(Yes or No)	Rationale
Religion or belief	No	
Marriage and civil partnership	No	
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Keith Mitchell, Consultant Pain Management

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis

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:

Mark each box that applies	Female	Male
1. Family hx of substance abuse		
Alcohol	☐ 1	☐ 3
Illegal Drugs	☐ 2	☐ 3
Prescription drugs	☐ 4	☐ 4
2. Personal hx of substance abuse		
Alcohol	☐ 3	☐ 3
Illegal Drugs	☐ 4	☐ 4
Prescription drugs	☐ 5	☐ 5
3. Personal hx of substance abuse	☐ 1	☐ 1
4. Hx of preadolescent sexual abuse	☐ 3	☐ 0
5. Psychologic disease		
ADD, OCD, bipolar, schizophrenia	☐ 2	☐ 2
Depression	☐ 1	☐ 1
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.

Brewley-Taylor, D. R. (2005). Emerging contradictions between the United Nations drug control system and the core values of the United Nations. International Journal of Drug Policy, 16, 423–431.)

Appendix 5. Conversion tables for equivalent opiate doses

Conversion charts (approx.)

Transdermal opioids:	Approximate equivalence with Oral Morphine										
Oral morphine equivalent (mg/24 hours)	10	15	30	45	60	90	120	180	270	360	
Transdermal Buprenorphine (µg/hr)	5		10	20	35		52	70			
Transdermal Fentanyl (µg/hr)				12		25		50	75	100	

This is only an approximate guide (doses may not correspond with those given in clinical practice); patients should be carefully monitored after any change in medication and dose titration may be required

Analgesic	Route	Dose
Codeine	PO	100 mg
Diamorphine	IM, IV, SC	3 mg
Dihydrocodeine	PO	100 mg
Hydromorphone	PO	2 mg
Morphine	PO	10 mg
Morphine	IM, IV, SC	5 mg
Oxycodone	PO	6.6 mg
Tramadol	PO	100 mg

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.