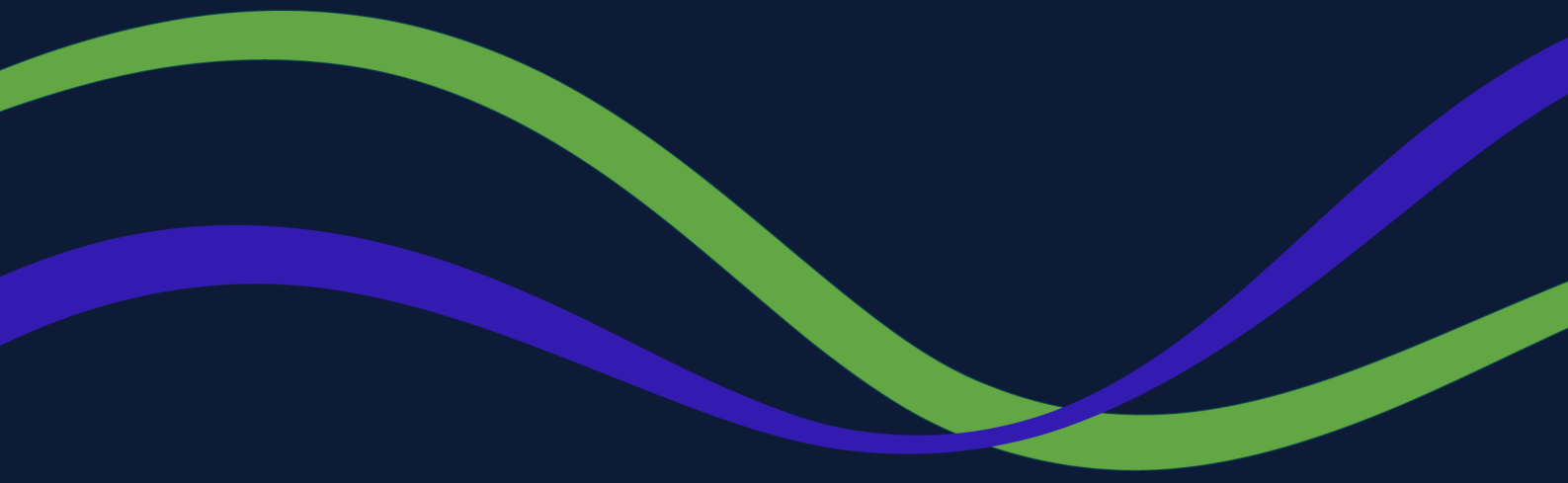
FPM

Faculty of Pain Medicine
ANZCA

Resources for Opioid Stewardship Implementation (ROSI)

Frequently Asked Questions

January 2024



Our hospital does not have an Acute Pain Service (APS). How do we establish an opioid stewardship program?

Opioid stewardship programs do not require large teams. Any interested pharmacist, senior nurse, or doctor can be an opioid stewardship champion and build an opioid stewardship program.

What is the first step when commencing an opioid stewardship program?

Do not prescribe any modified-release opioid preparations for opioid naive patients.

The central goal of any opioid stewardship program is safe and effective opioid prescribing. The prescribing guides included in the ROSI are a simple first step that can help initiate and support the introduction of an opioid stewardship program.

Prescribing guidelines ensure prescribers have ready access to best-practice prescribing for simple analgesics and opioid medications. They can help reduce prescriber errors and ensure appropriate medication inclusion and exclusion. Clinical decision support tools have been demonstrated to decrease variability, improve quality, decrease adverse events, and improve efficiency and costs[1].

Adapt the ROSI prescribing guides to suit local context however do not include any modified release preparations.

How do we engage stakeholders and roll out education?

Presentation at grand rounds, morbidity and mortality meetings and department in-service sessions help facilitate stakeholder education and increase clinician engagement with opioid stewardship programs.

Acute pain service teams should be included as a standing item in Anaesthetic Department M&M meetings. Reports should include rates of respiratory depression, review of adverse events and current prescribing rates.

ROSI guides provide information on compiling reporting rates for all these criteria.

Some clinicians regard that there is no problem with prescribing MR opioids. How do you change ingrained practice?

Strong evidence for altering prescribing habits has been demonstrated by providing individualised feedback to prescribers, known as academic detailing[2].

An informal chat is often the best way to facilitate conversations to address the need for change, challenge long-held beliefs and provide information and evidence on best practice opioid prescribing in acute pain.
Prescribers must be aware that documents, such as the ANZCA **Position statement on acute pain management 2023** and the ACSQH **Opioid Analgesic Stewardship in Acute Pain Clinical Care Standard**, are the current best practice reference documents against which clinicians' practice is measured.

These documents would be used as evidence for minimum safety standards in the event of a critical incident review.

How do you ensure the uptake of resources across all specialties and departments?

- Ensure resources are embedded into all new hospital policy and procedure. documents. Where possible, revise existing documents to include resources.
- Ensure unity across all resources, e.g. prescribing protocols are aligned to lanyard cards.
- Create folders in applications such as HosPortal or other mobile apps to facilitate timely and easy access to protocols and other reference documents.
- Distribute lanyards / prescribing cards to all prescribers on commencement of employment or during orientation.
- Be a constant reminder to clinicians of the need for judicious use of opioids when prescribing and for the consideration of the ongoing need for prescribing when preparing discharge medications.
- Always reference local protocols and other documents (e.g. FPM position statement/CCS) when providing advice or consultation to raise awareness of best practice evidence and recommendations.

What is wrong with a 2-day prescription of a modified-release (MR) opioid?

Both the clinical care standards and Faculty of Pain Medicine (FPM) regard that MR opioids should only be prescribed in exceptional circumstances[3,4]. MR opioids should not be initiated within the first 1-2 weeks of the onset of acute pain.

Administration of MR opioids increases the risk of adverse events including increased sedation score, opioid-induced ventilatory impairment (OIVI) and the consequent increased risk of patient harm[4]. The risk of unintentional overdose events has been reported as significantly increased within the first 2 weeks of initiation of a MR formulation[5].

Additionally, evidence suggests that the addition of a MR opioid does not improve pain scores or functional ability as significantly lower peak plasma concentrations are achieved with modified-release medications compared to immediate-release (IR) formulations.[6]

Finally, the risk of persistent post-operative opioid use is increased when patients are commenced on MR opioids.[7] Weaning and ceasing of MR preparations requires increased oversight and monitoring when comparted to IR formulations.[7]

Prescribers in tertiary hospitals, in particular, must be mindful that regional or country patients may not have sufficient or timely access to resources to support opioid use and weaning when they return home. Appropriate oversight may be significantly more challenging in regional and remote locations where timely access to GPs can be difficult. Clear plans and expectations regarding the ongoing need for opioids should be provided to patients prior to discharge. This is much easier to achieve when only immediate-release preparations are prescribed.

When is it appropriate to prescribe modified-release (MR) opioids for acute pain?

A modified-release opioid should not be initiated within the first 1-2 weeks of the onset of acute pain.

In the context of severe and ongoing acute nociception, and in pain that has been demonstrated to be opioid responsive, a time-limited prescription for modified-release atypical opioids may be warranted. However, this must be regarded as an exception rather than routine practice and prescribing in this case must include a plan for review, weaning and ceasing.

My hospital does not support the routine use of atypical opioids; how can we advocate for change?

The ROSI includes a guide to assist with preparing an application to local drug and therapeutics committees to request an expansion to hospital formulary and other local prescribing restrictions. This resource can be adapted for local use.

How many opioids should be supplied on discharge?

Opioids should not be supplied "just in case". Most acute pain lasts 7-10 days, and patients are often more comfortable at home than in hospital.

Prior to recommending any opioid medication for discharge:

- Review opioid requirements for the previous 24-48 hours
- Ask patients how many tablets they think they will require (they will often respond with a smaller number than clinicians would otherwise prescribe and be equally satisfied and comfortable).
- If the patient is from an area where timely access to post discharge GP follow up may be delayed, then the amount of opioid provided for discharge should be sufficient to prevent unintended premature cessation of opioid analgesia.

If an opioid is dispensed on discharge, ensure the patient and GP has received instructions for weaning and ceasing.

How do you communicate weaning strategies with GP?

Instructions for expectations regarding the ongoing use of opioids prescribed in the hospital should be included on all discharge summaries. The Pain Medicine Discharge Plan is a simple, effective and timely way to provide information about in-hospital analgesic prescribing and expectations for ongoing analgesic requirements.

Encourage patients to book appointments with GPs prior to hospital discharge.

For individuals identified as high risk, it may be appropriate for a senior clinician to contact the GP to discuss the expected trajectory for recovery and the ongoing need for opioid prescribing.

How do you obtain local prescribing data and other reporting criteria?

Pharmacy department (eg, opioid stewardship pharmacists) can assist with data collection of local prescribing and dispensing rates.

Quality and risk managers within hospitals can provide information on rates of hospital acquired complication (HAC).

ROSI resources include downloadable quick guides to assist members of the multidisciplinary team to obtain data to provide evidence for the relevant quality statements.

References:

1. HealthIT.gov. Clinical Decision Support. From https://www.healthit.gov/topic/safety/clinical-decision-support Accessed January 2024.
2. Stevens J, et al. A sustainable method to reduce post-operative oxycodone discharge prescribing in a metropolitan tertiary referral hospital. Anaesthesia. 2019;74:292-299.
3. Australian Commission on Safety and Quality in Health Care. Opioid Analgesic Stewardship in Acute Pain Clinical Care Standard. From https://www.safetyandquality.gov.au/publications-and-resources/resource-library/opioid-analgesic-stewardship-acute-pain-clinical-care-standard-2022 Published April 2022. Accessed January 2024.
4. Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine. Position statement on acute pain 2023. From https://www.anzca.edu.au/getattachment/558316c5-ea93-457c-b51f-d57556b0ffa7/PS41-Guideline-on-acute-pain-management Accessed January 2024.
5. Miller M, et al. Prescription Opioid Duration of Action and the Risk of Unintentional Overdose Among Patients Receiving Opioid Therapy. JAMA Intern Med. 2015;175(4):608–615.
6. Gohler K, Brett M. Comparative pharmacokinetics and bioavailability of tapentadol following oral administration of immediate- and prolonged-release formulations. Medicine International Journal of Clinical Pharmacology and Therapeutics. 2013; 51:338-48.
7. Lam T, et al. Comparing opioid types in the persistence of opioid use following surgical admission: a study protocol for a retrospective observational linkage study comparing tapentadol and oxycodone in Australia. BMJ Open 2022;12:e060151.

The Resources for Opioid Stewardship Implementation (ROSI) have been developed by Ms. Bernadette Findlay, Clinical Nurse Consultant, and Associate Professor Jennifer Stevens, Anaesthetist and Pain Medicine Specialist at St. Vincent's Hospital, Sydney, in conjunction with the Faculty of Pain Medicine. Development of the ROSI has been supported by an unrestricted educational grant from CSL Seqirus. CSL Seqirus were not involved in the creation of intellectual property or any other content contained within the ROSI.

ST VINCENT'S HOSPITAL SYDNEY