CLINICAL GUIDELINE

Oral immediate release (IR) strong opioid administration, Queen Elizabeth University Hospital

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

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Approval Group:	South Sector Clinical Governance Forum

Important Note:

The Intranet version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

NHS Greater Glasgow & Clyde Queen Elizabeth University Hospital	Pages Effective From	1- 3 January 2023
Acute Pain Service Guidelines (Adult / Surgical) **Oral immediate release (IR) strong opioid administration.**	Review Date	January 2025
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Opioids are very good analgesics for the relief of moderate to severe acute pain; especially when used as part of a multimodal analgesic plan. The first step in relieving acute pain is to undertake an accurate pain assessment. Patients' self-reports are the most reliable indicator of their experiences of pain. Assess pain intensity by using a pain scoring tool, such as the Numerical Rating Scale (0 to 10) or Verbal Descriptor Scale (mild, moderate or severe). If the patient is unable to self-report, a behavioural assessment tool (such as the Abbey Pain Scale) should be used to estimate the presence and severity of their pain.

0	1	2	3	4	5	6	7	8	9	10
Nil	Mild Pain			Moderate Pain			Severe Pain			

It is unrealistic to expect patients will be pain free. The aim of acute pain management is to optimise analgesia to enable functionality and patient comfort. This is the pain level at which the patient can perform activities necessary for recovery, such as deep breathing and mobilising.

To achieve a comfort – functionality balance

Function Score at QEUH

Measurement of pain intensity (0 to 10) is only part of the assessment of pain and efficacy of analgesia. The assessment of functional ability (for example the ability to deep breathe, engage with physiotherapy, mobilise after surgery) gives a good indication of the effectiveness of analgesia.

A	**No limitation, activity unrestricted by pain or settles quickly**
B	**Mild limitation, mild activity restriction**
C	**Moderate limitation, attempts but reluctant to continue because of pain** **SEEK ADVICE**
D	**Severe limitation, unable to or refuses to perform because of pain** **URGENT REVIEW REQUIRED**

The goal of acute pain management is to achieve good functional ability (a Function Score of A or B).

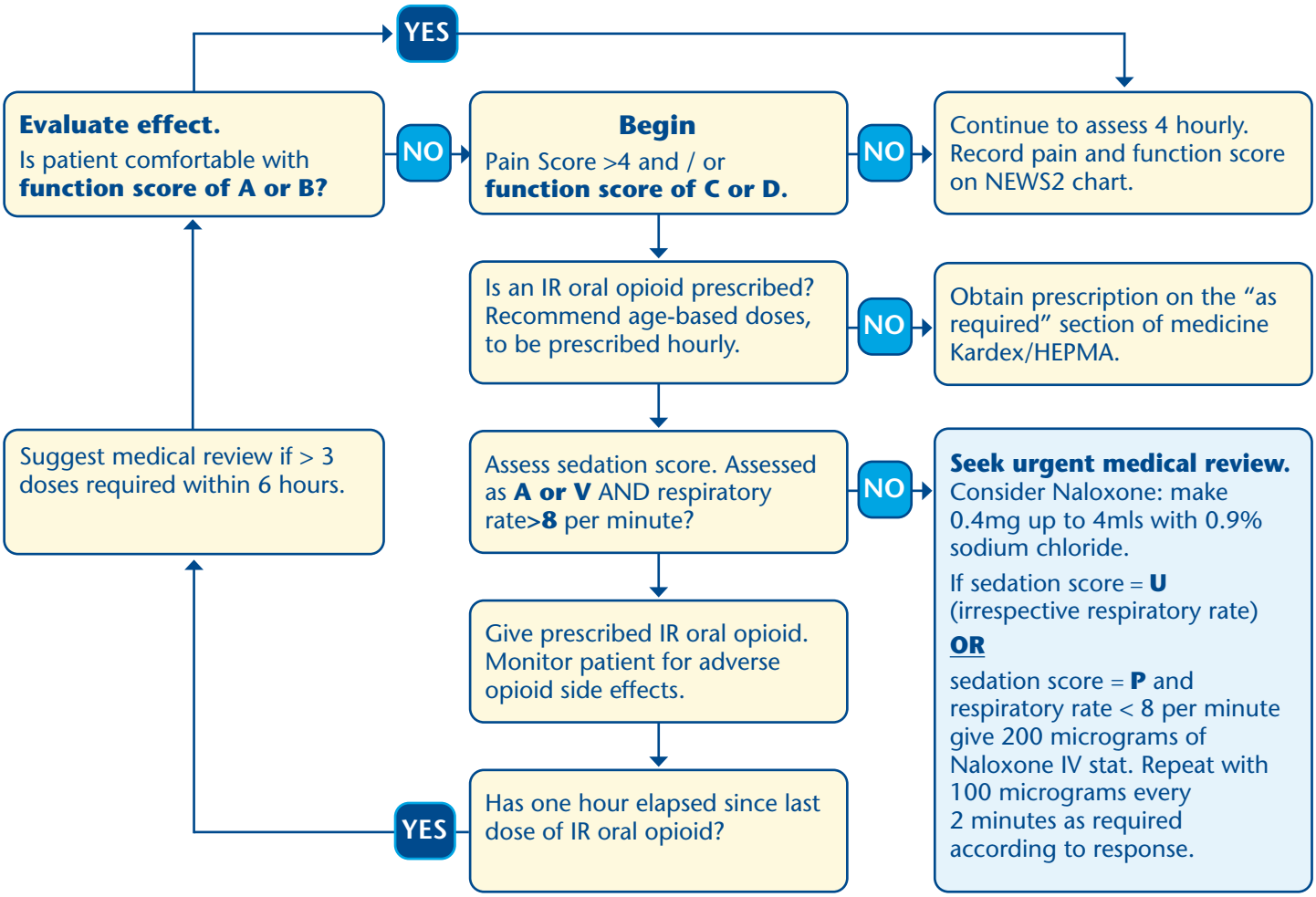
The majority of patients will receive immediate release strong opioid via the oral route. Opioid doses need to be titrated carefully to achieve pain relief to suit each individual patient while minimising unwanted side effects. (Examples of immediate release oral strong opioid in common use at QEUH are Oramorph, Sevredol or Shortec).

It is vital that evaluation of effectiveness of analgesia and monitoring for adverse opioid side effects is carried out. Following below = algorithm for intermittent oral administration (IR) strong opioid.

Age-based immediate release ORAL opioid doses for Acute Pain Management.

Suggested initial doses for opioid-naïve inpatients in moderate to severe acute pain and <u>normal renal / hepatic</u> function.

(IR) MORPHINE: i.e. Oramorph or Sevredol	**(IR) OXYCODONE:** i.e. Shortec
Age: ≤70 years = 10mg	Age: ≤70 years = 5mg
>70 years = 5mg	>70 years = 2.5mg
>80 years = 2.5mg	> 80 = 1 or 2mg



Good Practice Points

- Avoid concurrent administration of sedating medication (e.g. piriton, cyclizine, diazepam) as these may combine to increase risk of respiratory depression.
- Modified release opioids should not routinely be prescribed for the management of acute pain (unless part of a specific Protocol) and should have a planned discontinuation date.
- Monitor closely for opioid toxicity especially frail, low body weight and elderly people.
- As acute pain improves, opioid requirements decrease. Suggest daily review by medical team decreasing frequency and / or dose as acute pain settles.
- Routine discharges home are not expected to require strong opioid. If senior surgical team decide an individual has on-going need, the Acute Pain Team recommends tablet formulation rather than liquid OraMorph.