Analgesia Guidelines – A guide to prescribing oxycodone (Endone®) on discharge

This document is intended to provide general advice on prescribing oxycodone on discharge

General Principles

Aim

Analgesia in hospital should be individualised as multiple factors can influence analgesia requirements. The purpose of this document is to aid a junior prescriber when considering discharging a patient on oxycodone (endone) therapy. In addition, it will assist pharmacists in assessing safety and appropriateness of opioids when providing a clinical review.

Consider the following when assessing the need for pharmacotherapy for acute pain relief on discharge:

- Assess the patient for individualised care (age, weight, operation, type of pain, GIT/liver/Renal function social habits, severity of pain, functional score, pain expectations, treatment and rehabilitation goals).
  - Use functional activity score (FAS) and pain scores in guiding the appropriate starting point and de/escalation for managing the patient's acute pain.
  - Consider and address underlying conditions that may cause or worsen pain on discharge. E.g. trauma/surgery, increased activity post discharge
  - Conversely, expect acute pain and analgesia requirements to decrease daily
- Assess current treatment and, efficacy as well as past treatments and their side effects.
  - Consider non-pharmacological approaches such as physiotherapy, RICE, massage, heat packs
- Identify early patients who would need further input from specialist teams e.g. by the Persistent Pain Service or Palliative Care
  - If patient takes regular opioids or is on an opioid replacement program, continue therapy and seek advice.
- Opioids should be used in combination with simple analgesia.
- Develop a pain management action plan including a de-escalation strategy post discharge.
  Ensure you document this:
  in the clinical notes
  the discharge summary to the general practitioner
  the patient's individualised patient information brochure.

Assessing and Managing Pain:

Pain score is useful in tracking pain and the functional activity score is useful for making decisions on treatment of pain. It is important to asses pain scores at rest and dynamic (cough, physio, activities that can get them home). ***Aim is to have a patient unrestricted by pain.***

Pain score:

Mild Pain (Pain score: 1–4)

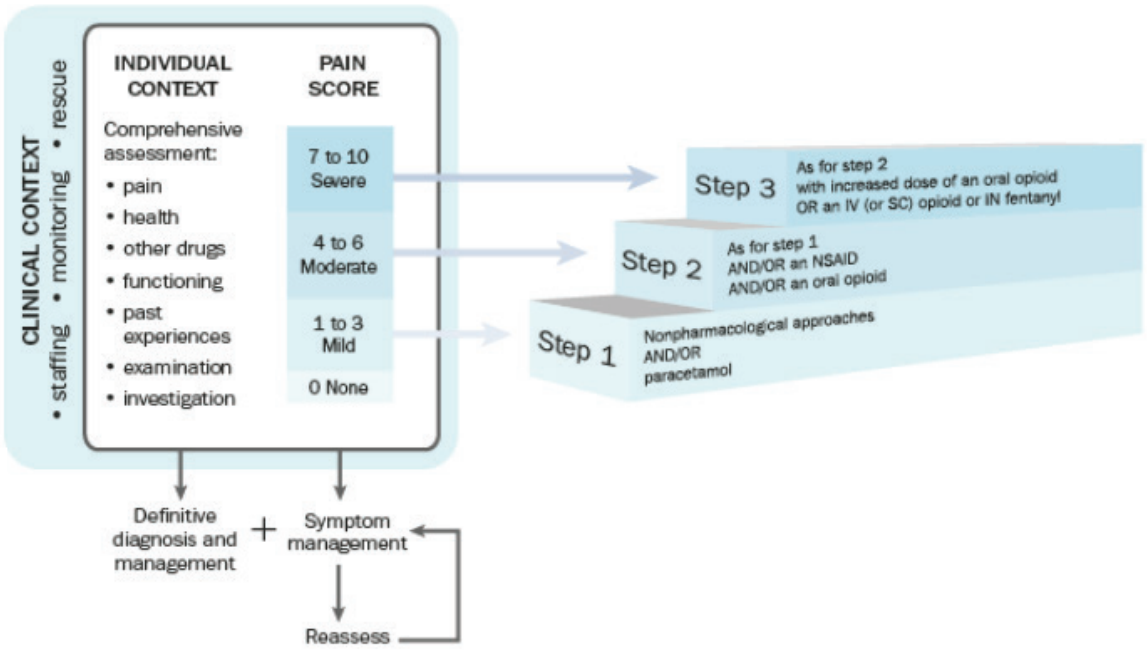
Moderate Pain (Pain score: 5–7)

Severe Pain (Pain score: 8–10).

Functional Activity Score – can be used to make decisions:

A. ***No limitation*** – Patients activity is unrestricted by pain
B. ***Mild limitation*** – Patients activity is mildly restricted
C. ***Severe limitation*** – Patients activity is severely limited by pain.

Deciding where to start when prescribing analgesics for new-onset acute pain (Therapeutic Guidelines 2018)



Determining the quantity of oxycodone to be prescribed on discharge:

1. Patients with acute pain (for example, 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 advice from your team or the Acute Pain Service.
2. Check for previous side effects or allergies to pain medication.
3. Review patient's use of PRN opioid over the 24-48 hours prior to discharge.
   - Check For APMS patients, review APMS continuation plan which can be found on either in the medical notes or in the Acute Pain Management Service (APMS) continuation plan
   - Ensure dose and frequency of the opioid is appropriate at point of discharge. Only prescribe the number of doses you think the patient reqires to cover the anticipated duration of treatment not necessarily the PBS quantity.
   - Do not prescribe oxycodone on discharge if the patient did not require opioid analgesia as an inpatient, unless specifically requested by a senior medical officer. Discharge prescription dose should not exceed the actual total daily dose administered prior to discharge.
   - Using regular paracetamol reduces opioid requirements by up to 30%. Limit duration of regular Paracetamol to five days and NSAIDs to three days, and then prescribe PRN. Include laxative advice and consider the need for antiemetic in some patients.
   - Slow release (SR) opioids* should NOT be routinely prescribed on discharge
4. If there is a concern that a patient is or has been opioid dependent, or is usually prescribed opioids in the community, Medications Regulation and Quality's '13S8INFO' information line (137846) can be contacted 8am to 8pm 7 days a week.
5. Queensland Health AODS provide an Alcohol & Drug Clinical Advice Service from 8am-11pm (ADCAS) 7 days per week, tel 1800 290 928.

Prescribing Slow Release (SR) opioids on discharge

"Slow release (SR) opioids* should NOT be routinely prescribed on discharge

UNLESS:

– Advice has been obtained from senior medical staff, the Acute Pain Management Service or the Chronic Pain Service.

OR

– Patients are continuing an unchanged dose of a SR opioid that was initiated prior to admission to hospital, and there is a genuine need for extra supply which cannot be obtained from the patient's usual or authorised prescriber.

If a prescription for SR opioids is provided:

– Provide a quantity sufficient to cover the anticipated duration of treatment, not necessarily the PBS quantity.

– Specific advice for the patient's GP or authorised prescriber to review ongoing requirements after this time should be recorded in the discharge summary.

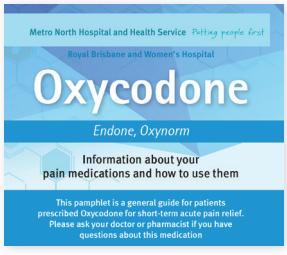
Special Considerations for Use of NSAIDS – Contraindications

- Renal impairment (creatinine › 150micromol/L OR eGFR less than 50mL/min).
- Patients receiving concomitant nephrotoxic drugs such as gentamicin or high dose diuretics – except on specialist advice.
- Active GI disease (e.g. reflux or peptic ulcer).
- Previous known hypersensitivity to NSAIDs including aspirin (this includes those in whom asthma, angioedema, urticaria or rhinitis have been precipitated by either aspirin or an NSAID). Nasal polyps are a marker for hypersensitivity.
- Severe asthmatics (e.g. Steroid dependent or those with atopic symptoms or nasal polyps).
- Haemorrhagic diathesis/current anticoagulant use.
- In the elderly due to increased susceptibility to the adverse effects of NSAIDs alternative agents should be tried. If NSAID therapy is required, a very low dose of a short acting NSAID for 3 days should be employed and the patient monitored for symptoms of gastro-intestinal bleeding, renal and cardiac compromise.

Patient education:

It is important that patients and carers are educated regarding the safe and optimal use of Oxycodone.

1. The Patient Information Brochure should be provided to all patients prescribed Oxycodone for ongoing but short-term treatment of acute pain to supplement verbal education.



2. Set the expectation on the trajectory of pain post discharge
3. It is a legal requirement for the prescriber to advise patients of the risks associated with driving or operating machinery whilst taking an opioid.
4. Encourage the patient to see their GP if they continue to Have pain after discharge.
5. Provide advice on simple analgesics and on how to avoid constipation.

Table 2

Essential information for patients prescribed an opioid on discharge from hospital

While taking opioids for continuing pain after discharge patients and their carers should be advised:

- Not to take more medication than prescribed and to take a little less each day
- Not to give their medication to anyone else
- To store their medication in a safe place and out of reach of others
- To see their doctor if strong pain continues
- Not to drive, operate machinery or make important decisions
- Not to take alcohol or sleeping tablets
- If they are sleepy, not to take any more medication until wide awake and then take a smaller dose
- If they are noticed to be very sleepy or having trouble staying awake, the emergency department of their nearest hospital or ambulance should be contacted
- To safely dispose of any medication that they do not use

Based on the information in a printed patient information sheet on the South Australia Health website[151]

Ref - Macintyre P, Huxtable C, Flint S, Dobbin M. Costs and consequences: a review of discharge opioid prescribing for ongoing management of acute pain. Anesthesia and Intensive Care. 2014;42(5):558-574.

Communication to primary care provider:

It is important to communicate details of opioids prescribed to the patient's primary care provider (for example, GP, community pharmacist, Residential Aged Care staff), including:

- Discharge letter which must include information on Oxycodone strength, dose, frequency, quantity and suggested duration of treatment, including plan for de-escalation, other analgesics, and follow up review plan.
- Patient's individualised pain management plan, as per the Patient Information Brochure.

See below for an example of communication on the discharge

"Mr. XX was discharged on Endone 5mg /regular/prn/duration for management of pain. In addition to his Endone we have advised him to take paracetamol regularly until pain resolves and, if indicated, anti-inflammatories for 3-5 days"

We anticipate that the current pain management is sufficient for the type of procedure. If he is to represent with continuing pain please review ongoing need of all agents."

Oxycodone prescribing on discharge from Hospital:

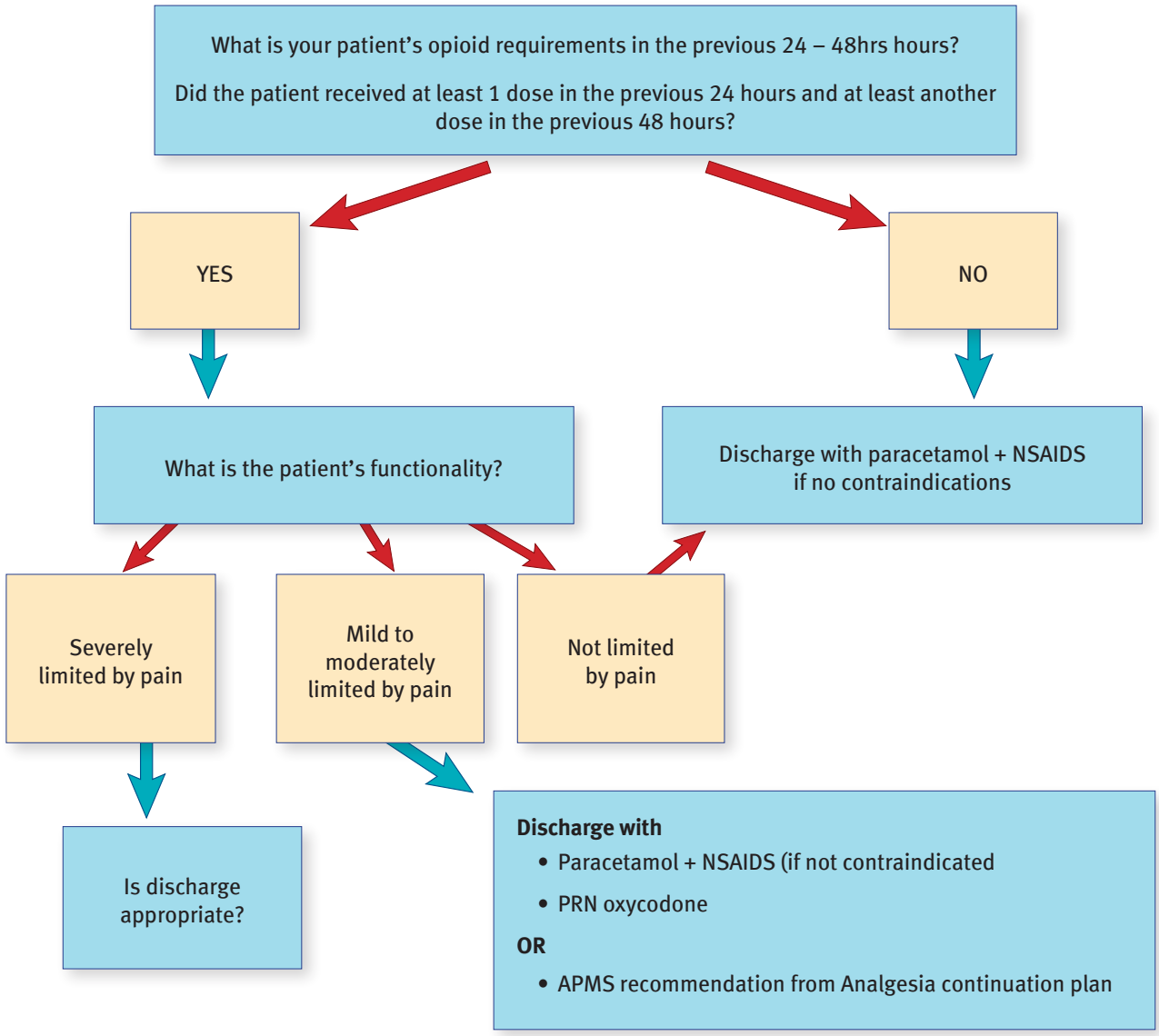
What do I need to include on the prescription?

- Full name, address and date of birth of patient (patient sticky label must be on ALL copies of prescription).
- Generic drug name, form (e.g. tablets, capsules, liquid) and strength.
- Quantity to be dispensed must be written in words and numbers (e.g. '10, ten').
- Dose and hourly frequency, total maximum daily dose, Duration.
- No repeats should be authorised.
- Prescriber name and signature and Prescriber contact details (e.g. pager, speed dial). Prescriber number.
- Date prescription is written.
- Complete allergy/ADR section (e.g. 'nil known') where possible.
- Document any authority approval numbers.

Appendix 1 Oxycodone Prescribing on Discharge

When prescribing oxycodone on discharge

1. Individualise care – Only prescribe the number of doses you think the patient reqires to cover the anticipated duration of treatment not necessarily the PBS quantity.
2. Educate the patient
3. Communicate to the GP.



Advice patient

- Set expectation of pain management - Trajectory of pain post discharge
- Use of simple and multi modal analgesia for opioid sparing effect
- Use of aperients
- How to take analgesia using patient information sheet.

Communicate to GP

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