APPLIED OPIOID STEWARDSHIP

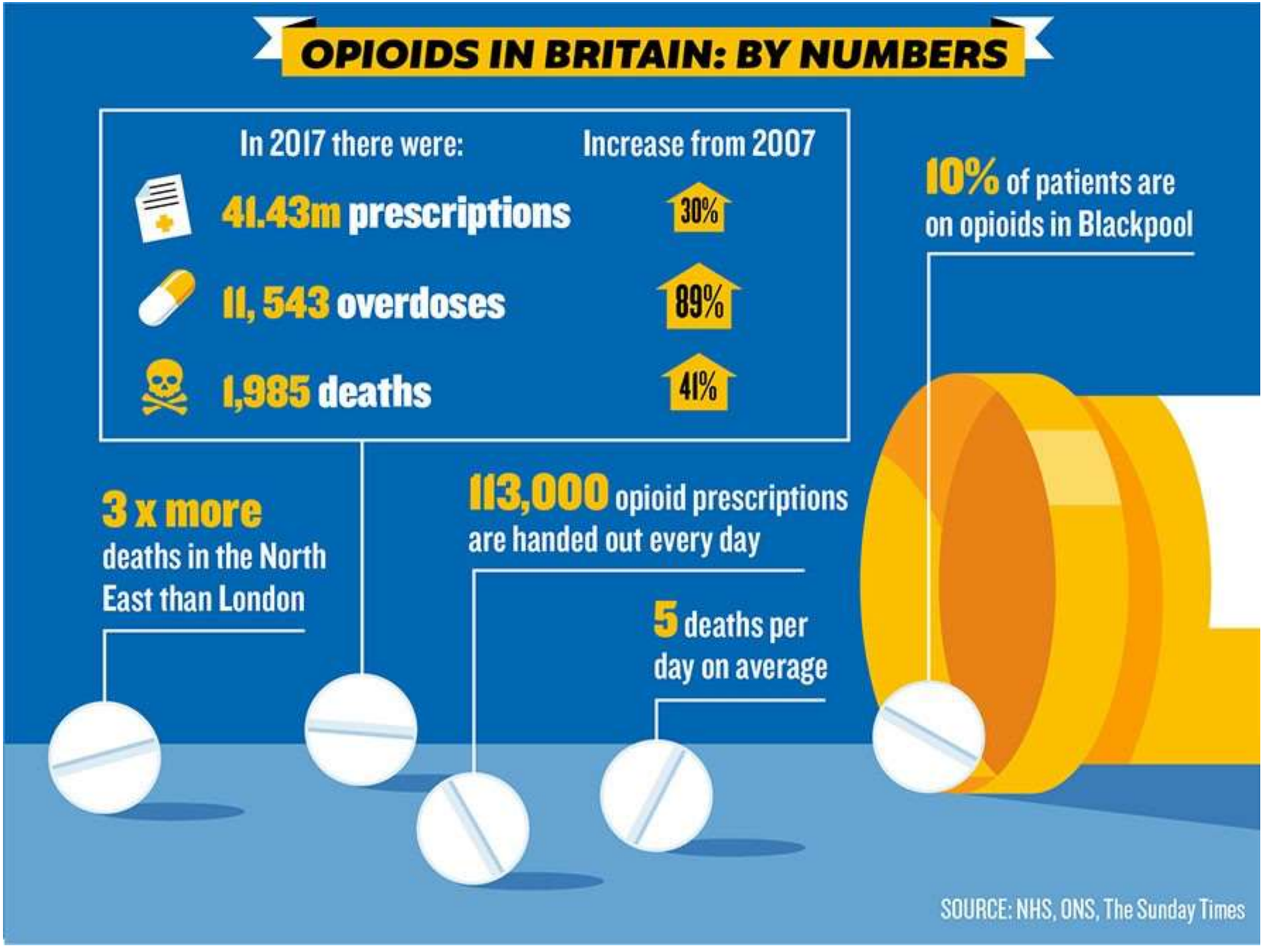
NEW ARTHROPLASTY ANALGESIA PROTOCOL AT NORTHUMBRIA

AGENDA

Why is the arthroplasty protocol being changed?

How is it being changed?

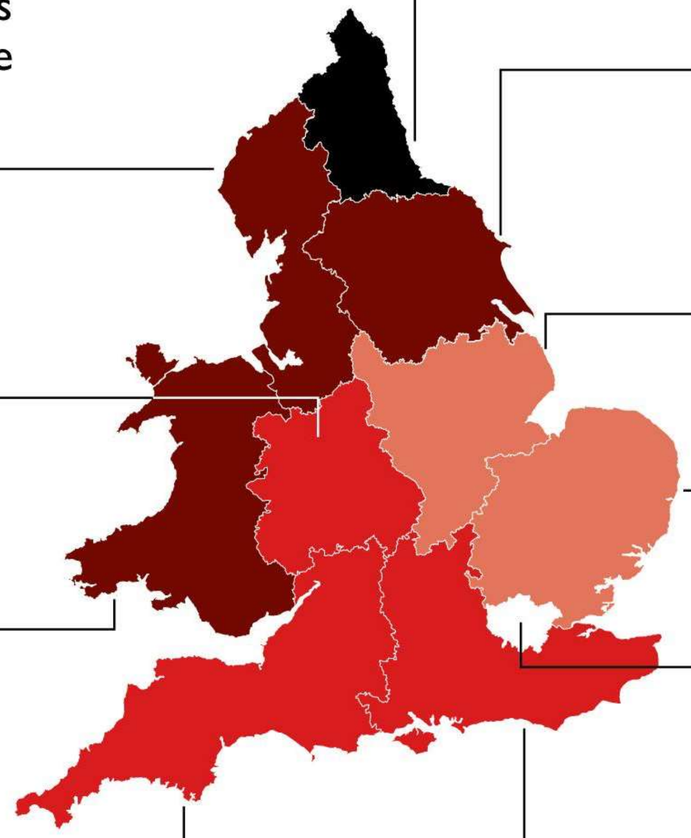
What data has been collected?


OPIOIDS IN BRITAIN: BY NUMBERS
In 2017 there were:
Increase from 2007
41.43m prescriptions
30%
11,543 overdoses
89%
1,985 deaths
41%
10% of patients are on opioids in Blackpool
3 x more deaths in the North East than London
113,000 opioid prescriptions are handed out every day
5 deaths per day on average
SOURCE: NHS, ONS, The Sunday Times

OPIOID DEATHS BY REGION

The death rate* in the northeast of England is more than three times higher than in London

*Number of deaths per 100,000 people



Northeast
6.2

Yorkshire and the Humber
4.2

East Midlands
2.6

East
2.7

London
1.8

Southeast
3

Northwest
4.8

West Midlands
3.2

Wales
4.9

Southwest
3

Drug Safety Update

MHRA

Latest advice for medicines users

The monthly newsletter from the Medicines and Healthcare products Regulatory Agency and its independent advisor the Commission on Human Medicines

Volume 14 Issue 2 September 2020

Contents

Opioids: risk of dependence and addiction page 2

You can find the latest version of this guidance on our website at **www.gmc-uk.org/guidance**

General Medical Council

Good practice in prescribing and managing medicines and devices

You are responsible for the prescriptions that you sign. You must only prescribe medicine when you have adequate knowledge of your patient's health. And you must be satisfied that the medicine serves your patient's need.

This guidance came into effect on 5 April 2021.

Download the guidance

Controlled drugs and other medicines where additional safeguards are needed

59 Some categories of medicine may pose particular risks of serious harm or may be associated with overuse, misuse or addiction. When prescribing, you should follow relevant clinical guidance, such as drug safety updates on the risk of dependence and addiction associated with opioids.[17]

15 You should take account of the clinical guidelines published by:

- **a** National Institute for Health and Care Excellence (England)
- **b** Department for Health, Social Services and Public Safety (Northern Ireland)
- **c** Healthcare Improvement Scotland (including the Scottish Medicines Consortium and Scottish Intercollegiate Guidelines Network) (Scotland)
- **d** All-Wales Medicines Strategy Group (Wales)
- **e** medical royal colleges and other authoritative sources of specialty specific clinical guidelines.

Anaesthesia 2020 doi:10.1111/anae.15262

Guidelines

An international multidisciplinary consensus statement on the prevention of opioid-related harm in adult surgical patients

N. Levy,[1] **J. Quinlan,**[2] **K. El-Boghdadly,**[3,4] **W. J. Fawcett,**[5] **V. Agarwal,**[6] **R. B. Bastable,**[7] **F. J. Cox,**[8] **H. D. de Boer,**[9] **S. C. Dowdy,**[10] **K. Hattingh,**[11] **R. D. Knaggs,**[12] **E. R. Mariano,**[13,14] **P. Pelosi,**[15,16] **M. J. Scott,**[17] **D. N. Lobo**[18,19] and **P. E. Macintyre**[20]

Surgery and Opioids:
Best Practice Guidelines 2021

FACULTY OF PAIN MEDICINE of the Royal College of Anaesthetists

RCoA Royal College of Anaesthetists

RCGP Royal College of General Practitioners

Royal College of Surgeons of England ADVANCING SURGICAL CARE

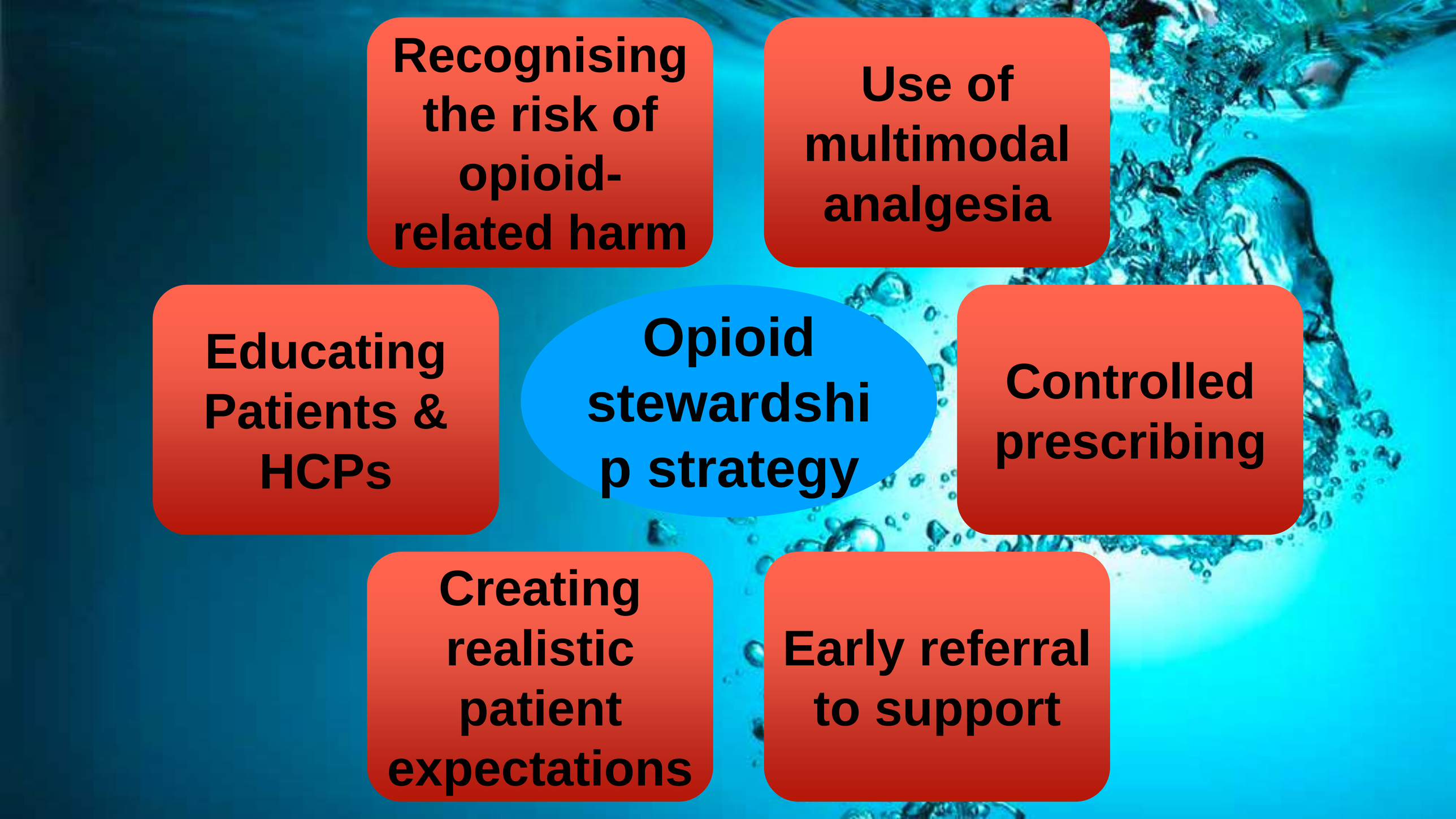
Royal College of Nursing

THE BRITISH PAIN SOCIETY EXPERTISE WHERE IT MATTERS

Centre for Perioperative Care

Endorsed by ROYAL PHARMACEUTICAL SOCIETY

March 2021


Recognising the risk of opioid-related harm
Use of multimodal analgesia
Educating Patients & HCPs
Opioid stewardship strategy
Controlled prescribing
Creating realistic patient expectations
Early referral to support

EARLY REFERRAL FOR SUPPORT

PRE-OPERATIVE OPIOIDS MANAGEMENT : PILOT quality improvement project

Decision made to list patient for surgery

Screening questionnaire to calculate current opioid usage (convert to morphine milligram equivalents (MME) per day) and ascertain opioid dependence

- Less than 50 MME/day → Provide general advice on pre-op pain management
- Takes more than one opioid drug (but combined total less than 120mg MME/day)
- Between 50 mg and 119mg MME/day
- Takes equal to or more than 120mg MME/day

→ Refer to Pharmacy for further triage. Send patient details to Pharmacy pre-assessment inbox

Pharmacy POAC technician reviews inbox Mon to Fri and triages according to daily morphine intake and GP practice

- **Less than 120mg MME/day (incl. multiple opioids)** → Telephone counselling on risks of opioids Send PIL (electronic or paper) → Consider referral (if MME above 50 or symptoms of dependence) to Community pharmacist for additional education and on discharge via DMS
- **120mg or more MME/day: outside PCN location** → Telephone counselling on risks of opioids Send PIL (electronic or paper) → Consider referral (if MME above 50 or symptoms of dependence) to Community pharmacist for additional education and on discharge via DMS
- **120mg or more MME/day: within PCN location** → Consent to refer to relevant PCN pharmacist for additional counselling and de-escalation support

  Supply PIL (electronic or paper) → PCN pharmacist supports de-escalation pre-op and post-op FUP for continued de-

SURGICAL INTERVENTION
Opioids commenced / pre-operative doses adjusted for acute pain management
Patient provided with pain management plan on discharge
Counselled on safe opioid use, risks and de-escalation

EDUCATING THE TEAM

MR Opioids
Pain Assessment

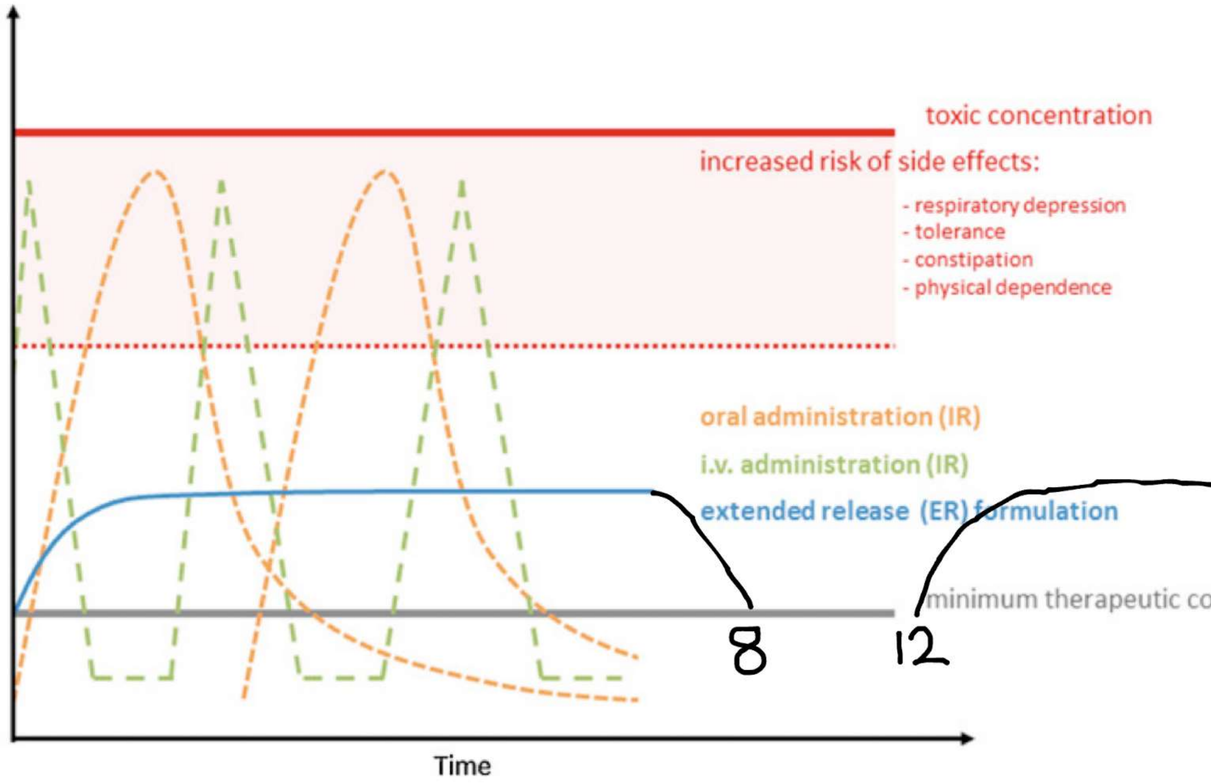
MR OPIOIDS

WHY THEY JUST DON'T MAKE SENSE

Majority of patients Oxycontin has a profile of less than 8 hours

Window of no opioid leads to dose escalation

There is no evidence for Oxycontin's use in fast track surgery



PAIN ASSESSMENT

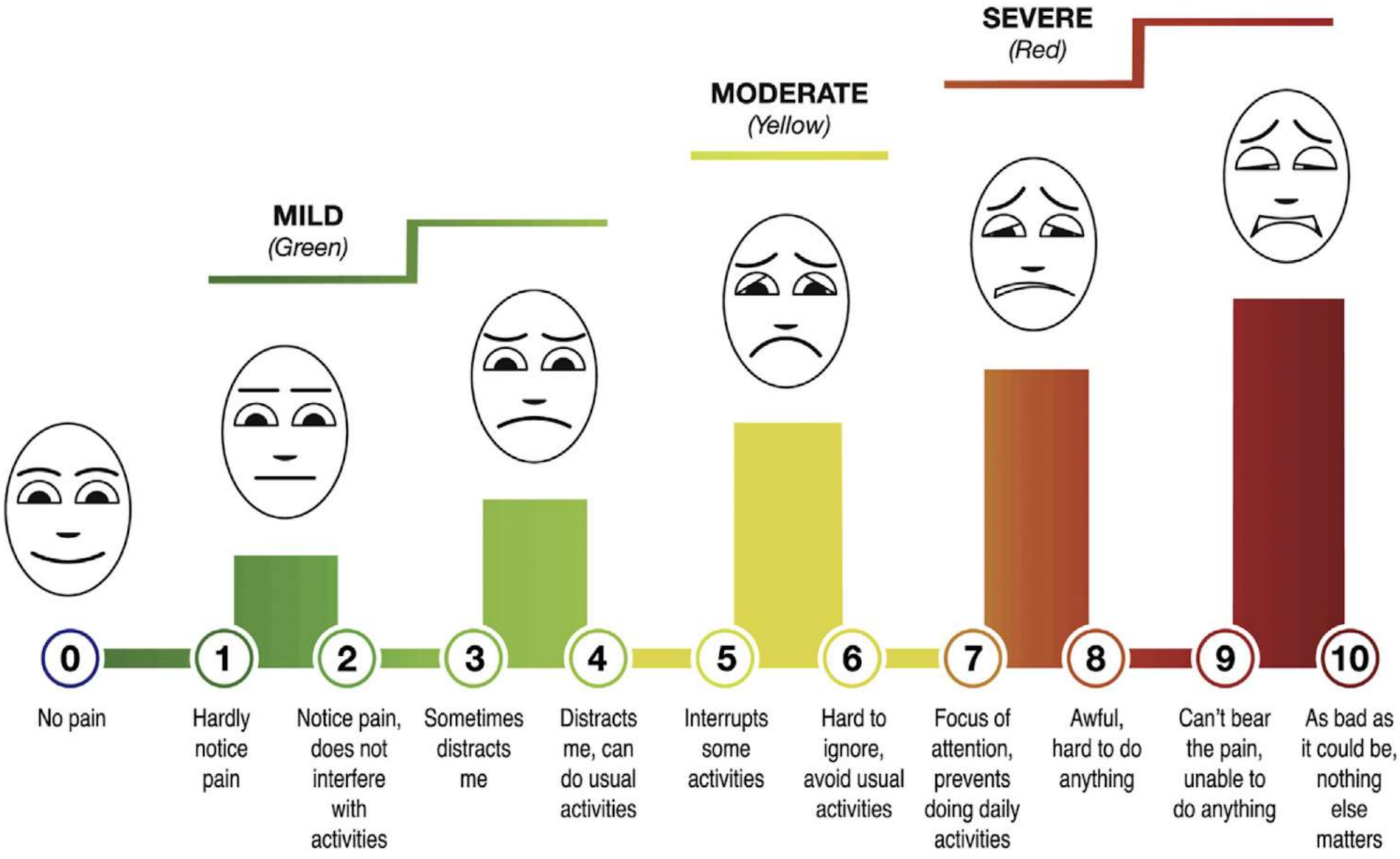
RECOVERY & RESTORATION OF FUNCTION

Box 1: Functional Activity Scale

A No limitation: the patient is able to undertake the activity without limitation due to pain;

B Mild limitation: the patient is able to undertake the activity, but experiences moderate to severe pain;

C Significant limitation: the patient is unable to complete the activity due to pain or pain treatment-related adverse effects.


SEVERE
(Red)
MODERATE
(Yellow)
MILD
(Green)
0
1
2
3
4
5
6
7
8
9
10
No pain
Hardly notice pain
Notice pain, does not interfere with activities
Sometimes distracts me
Distracts me, can do usual activities
Interrupts some activities
Hard to ignore, avoid usual activities
Focus of attention, prevents doing daily activities
Awful, hard to do anything
Can't bear the pain, unable to do anything
As bad as it could be, nothing else matters

USE OF **MULTIMODAL** PAIN CONTROL

NSAIDs
Cryocuff
Tailored plan

MMA

WORKS BETTER TOGETHER

Regional techniques

Cryotherapy

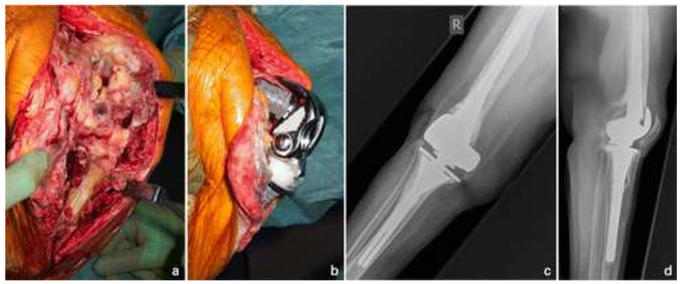
NSAIDs

Dexamethasone

Opioids

Poor candidates for fast-track status

FIG. 2 | Ecoflac® plus – Ibuprofen B. Braun, 400 mg / 100 ml



MMA

WORKS BETTER TOGETHER

Regional techniques

Cryotherapy

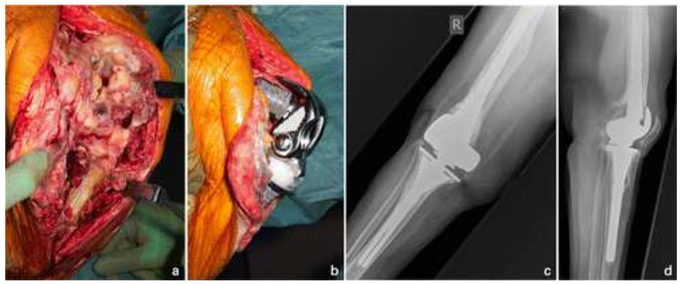
NSAIDs

Dexamethasone

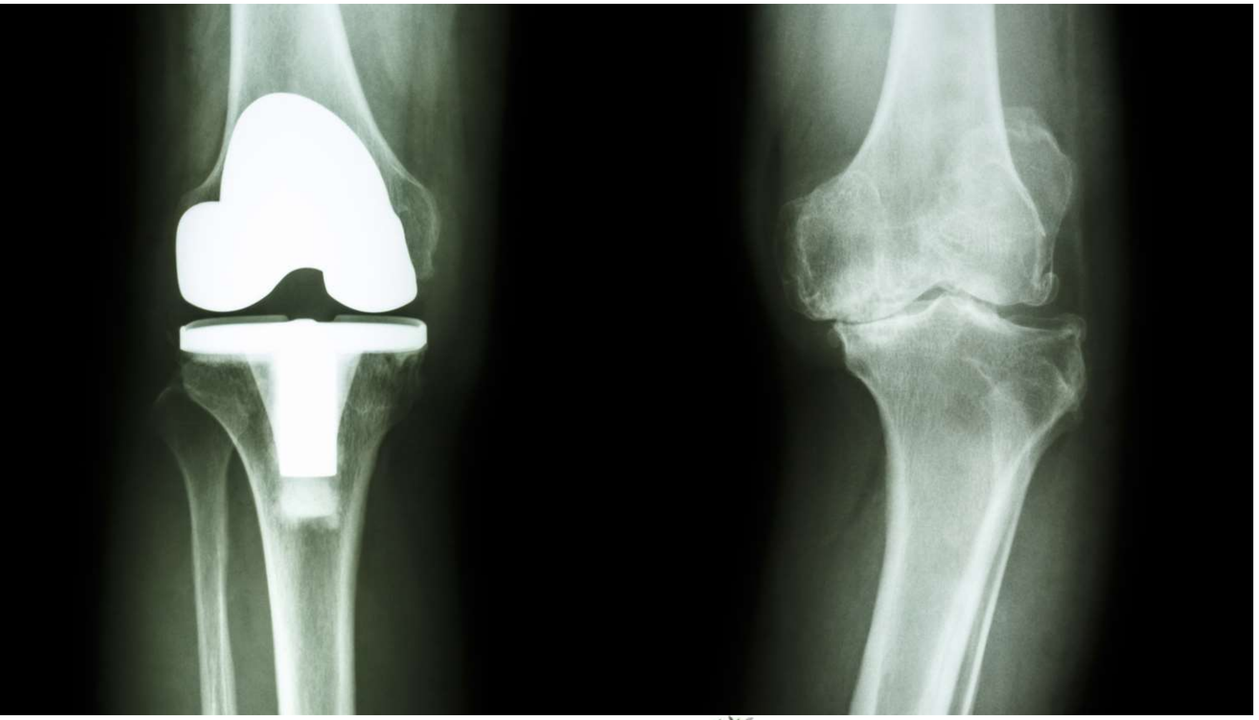
Opioids

Poor candidates for fast-track status

FIG. 2 | Ecoflac® plus – Ibuprofen B. Braun, 400 mg / 100 ml



CREATING REALISTIC PATIENT EXPECTATIONS



Faculty of Pain Medicine
College of Anaesthesiologists of Ireland

THE BRITISH PAIN SOCIETY
EXPERTISE WHERE IT MATTERS

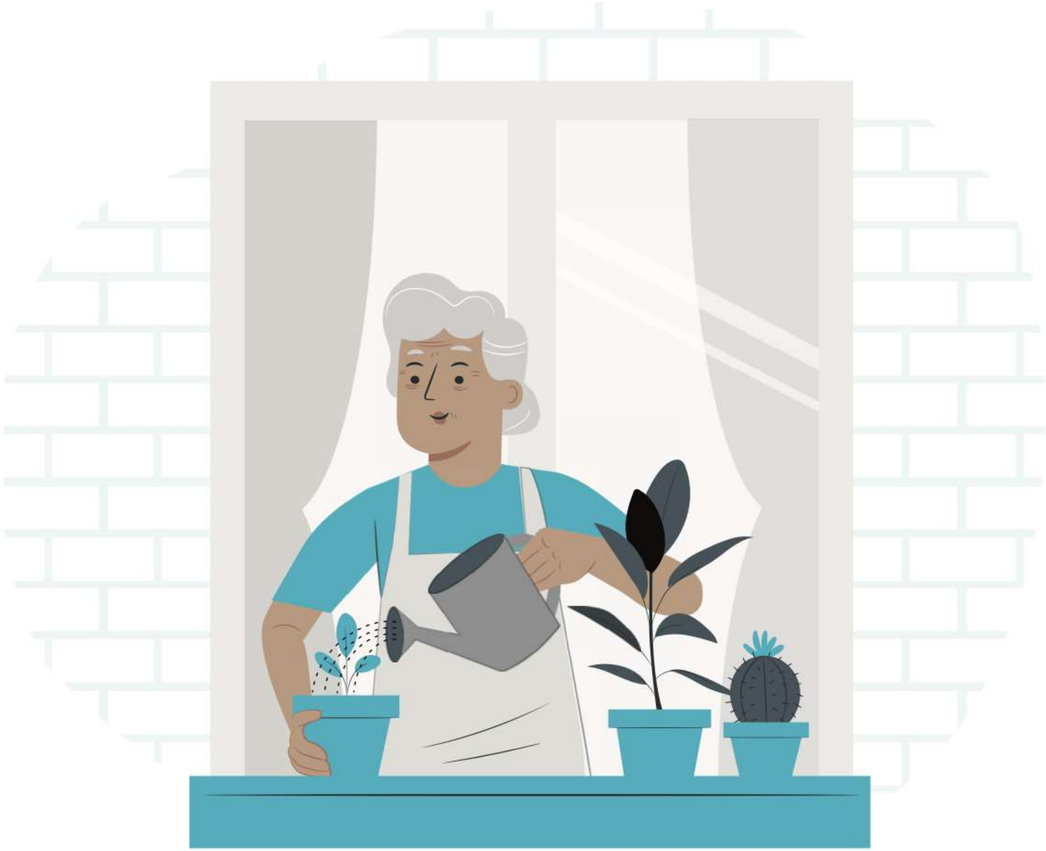
LiveWell with pain

Pain Nurse Network

IrishPainSociety

FACULTY OF PAIN MEDICINE
of the Royal College of Anaesthetists

Thanks to Louise Trewern of the British Pain Society's Patient Voice Committee, for her valuable input to the development of this booklet. Booklet design: Andrassy Media. Version 1, June 2022



Managing pain after your surgery

This leaflet explains what you can do to prepare for going home after surgery and to help your recovery. It describes the medicines used to reduce pain, and how to use them safely while you recover.

RECOGNISING THE RISK OF OPIOID-RELATED HARM

Persistent postoperative opioid use
Opioid-induced ventilatory impairment
Opioid diversion
Driving under the influence of prescription opioid

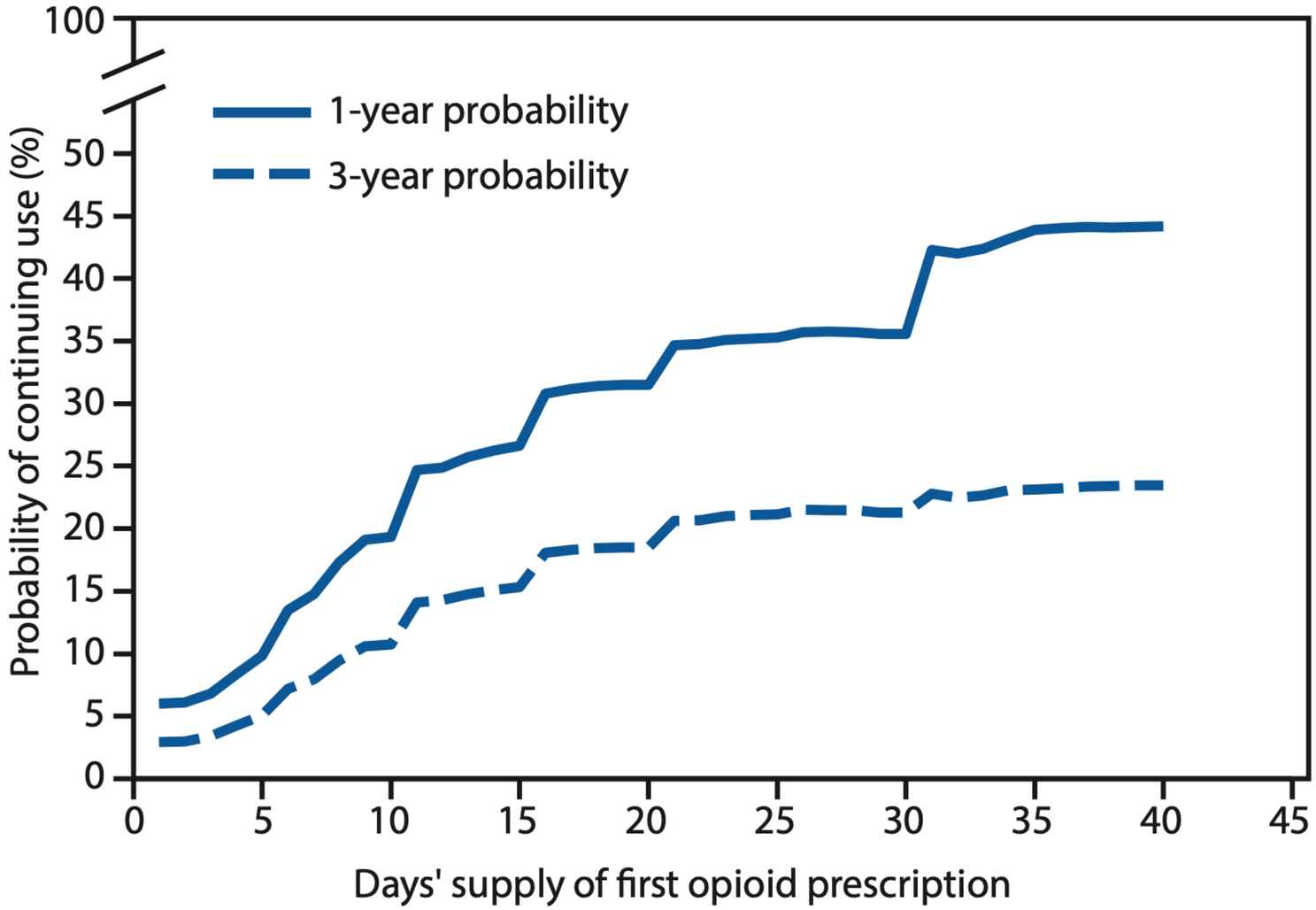
PERSISTENT POSTOPERATIVE OPIOID USE

RECOGNISE THE ROLE WE PLAY

5% risk

Major drivers:

1. MR
2. > 5 days supply
3. Repeat prescriptions



OPIOID-INDUCED VENTILATORY IMPAIRMENT

NOT JUST RESPIRATORY DEPRESSION

Triad

Airway muscle tone

Depression of arousal centres

Respiratory depression

This is what causes death

Sedation is the earliest indictor

87%

of patients who came to harm from OIVI did so on the first day or night after surgery

0 – Wide awake

1 – Easy to rouse (and can stay awake)

2 – Easy to rouse but unable to remain awake

3 – Difficult to rouse

A score of 2 is taken to indicate early OIVI and, therefore, the aim should be to titrate an opioid so that a patient's sedation score is always less than 2

50%

Of those obtaining opioids for nonmedical use are able to source them from family and friends

Drugs and driving: the law

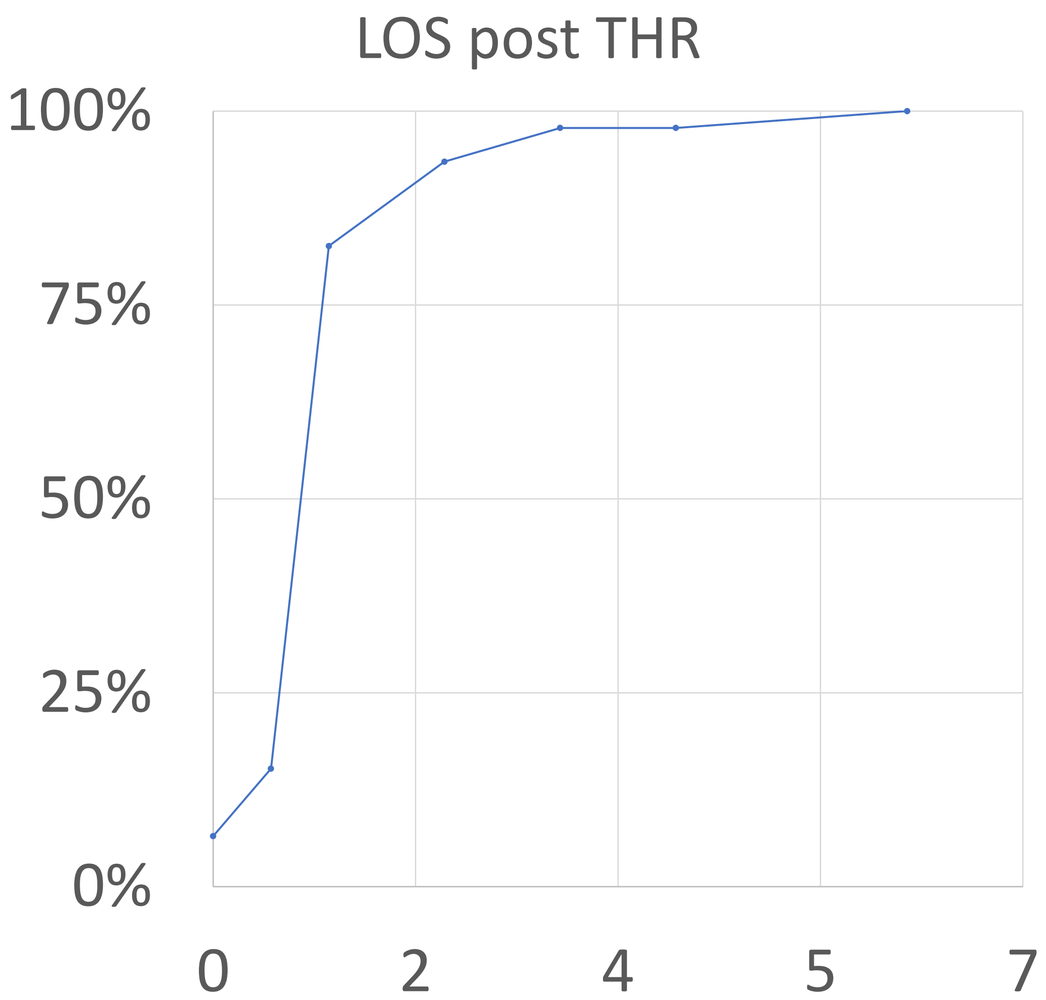
DATA COLLECTION

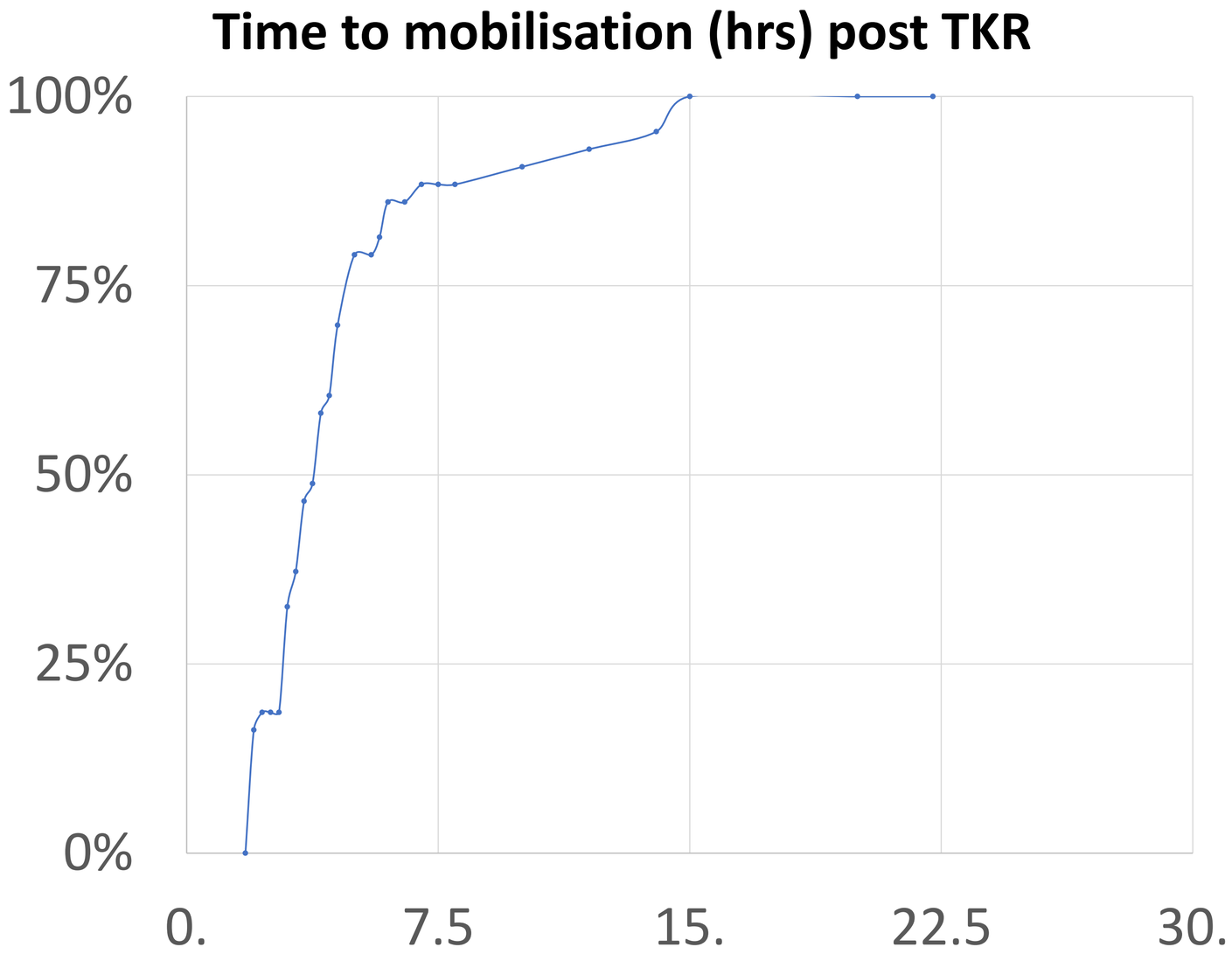
WHAT WILL WE BE MEASURING

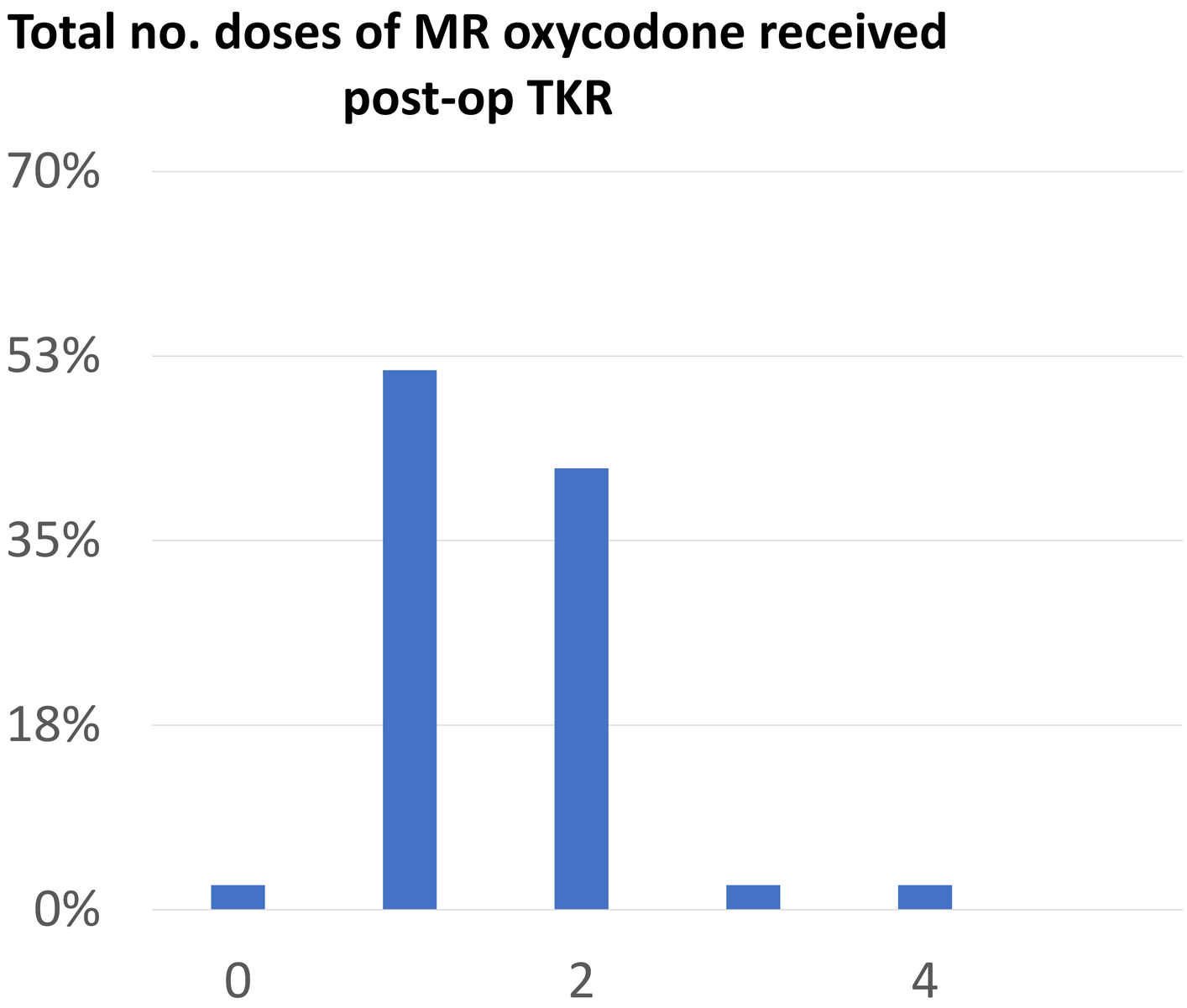
Inpatient pain burden

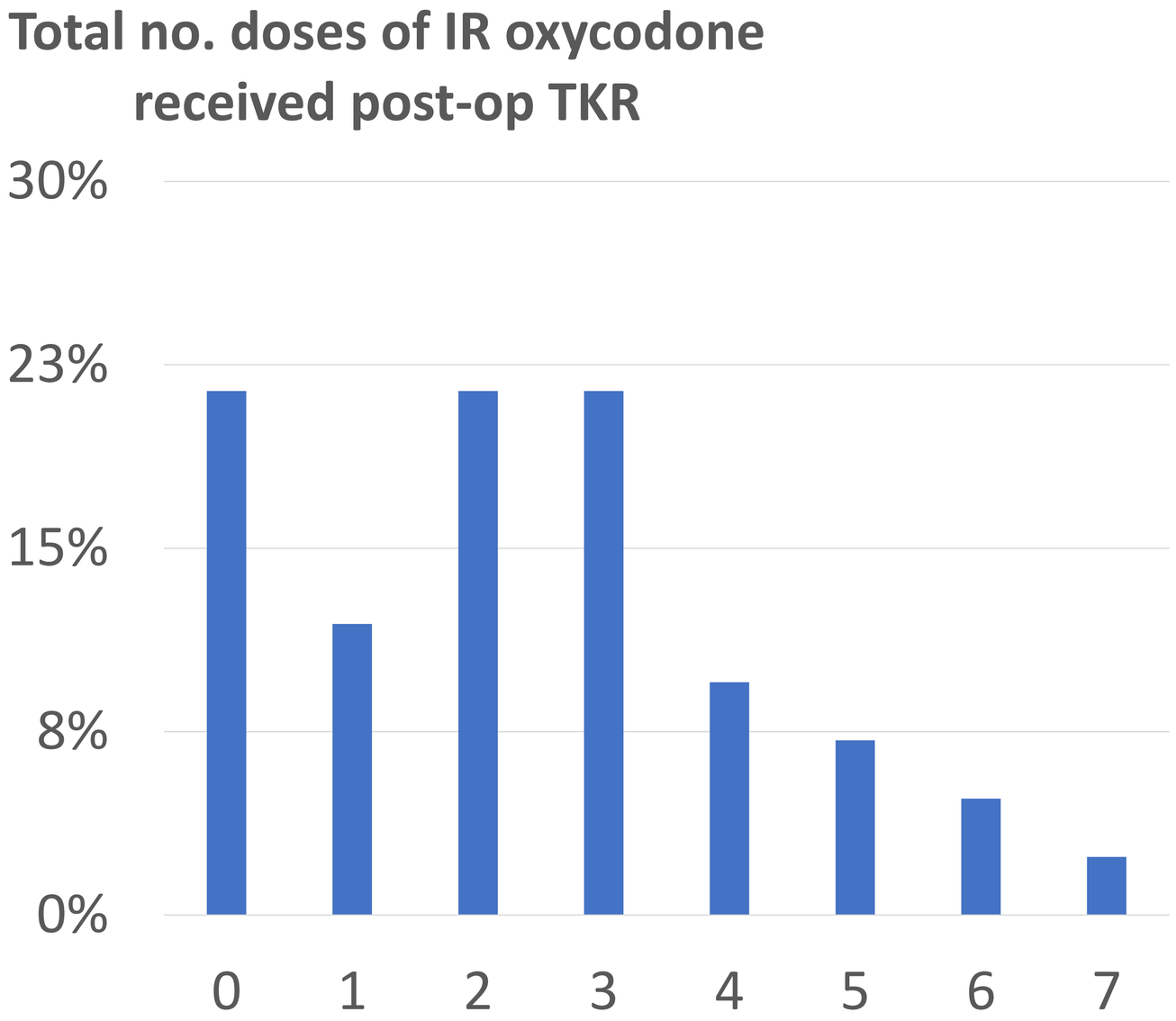
Discharge pain burden

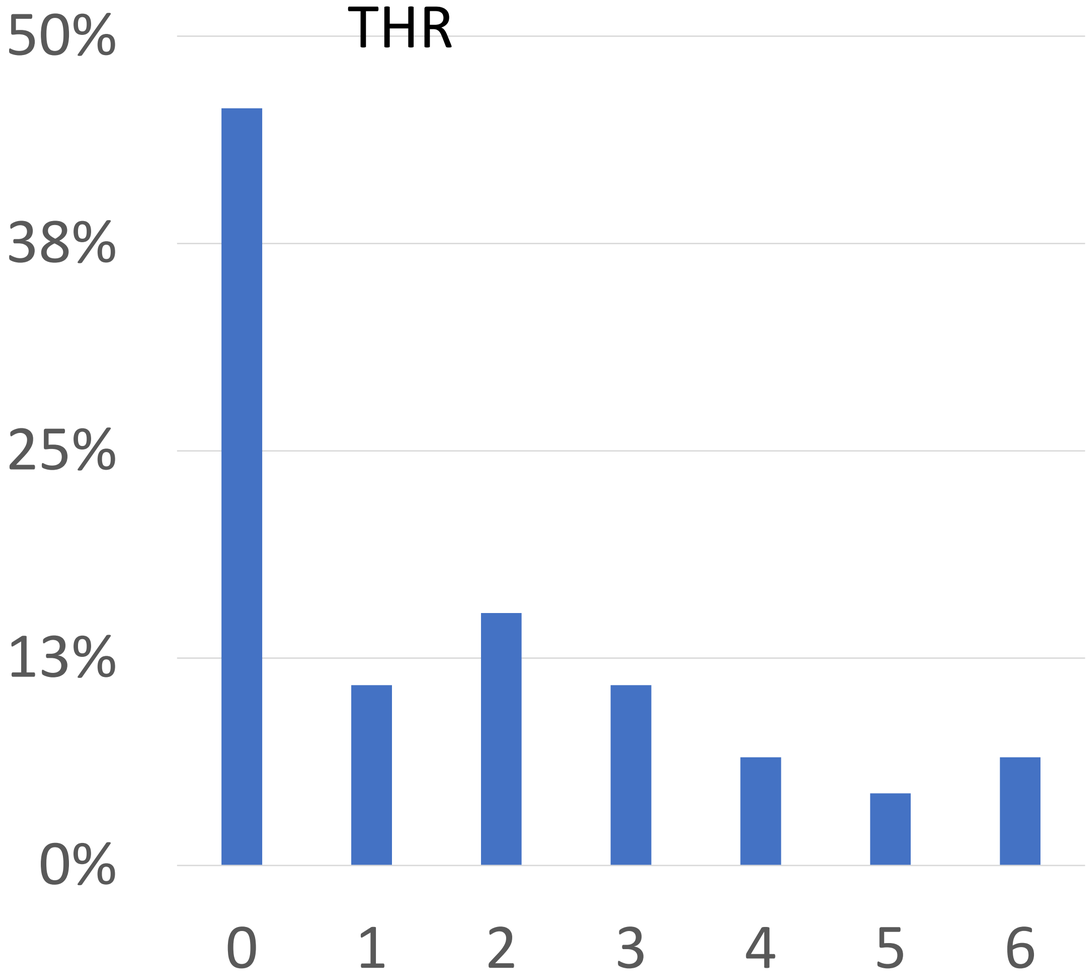
Repeat opioid prescription rate

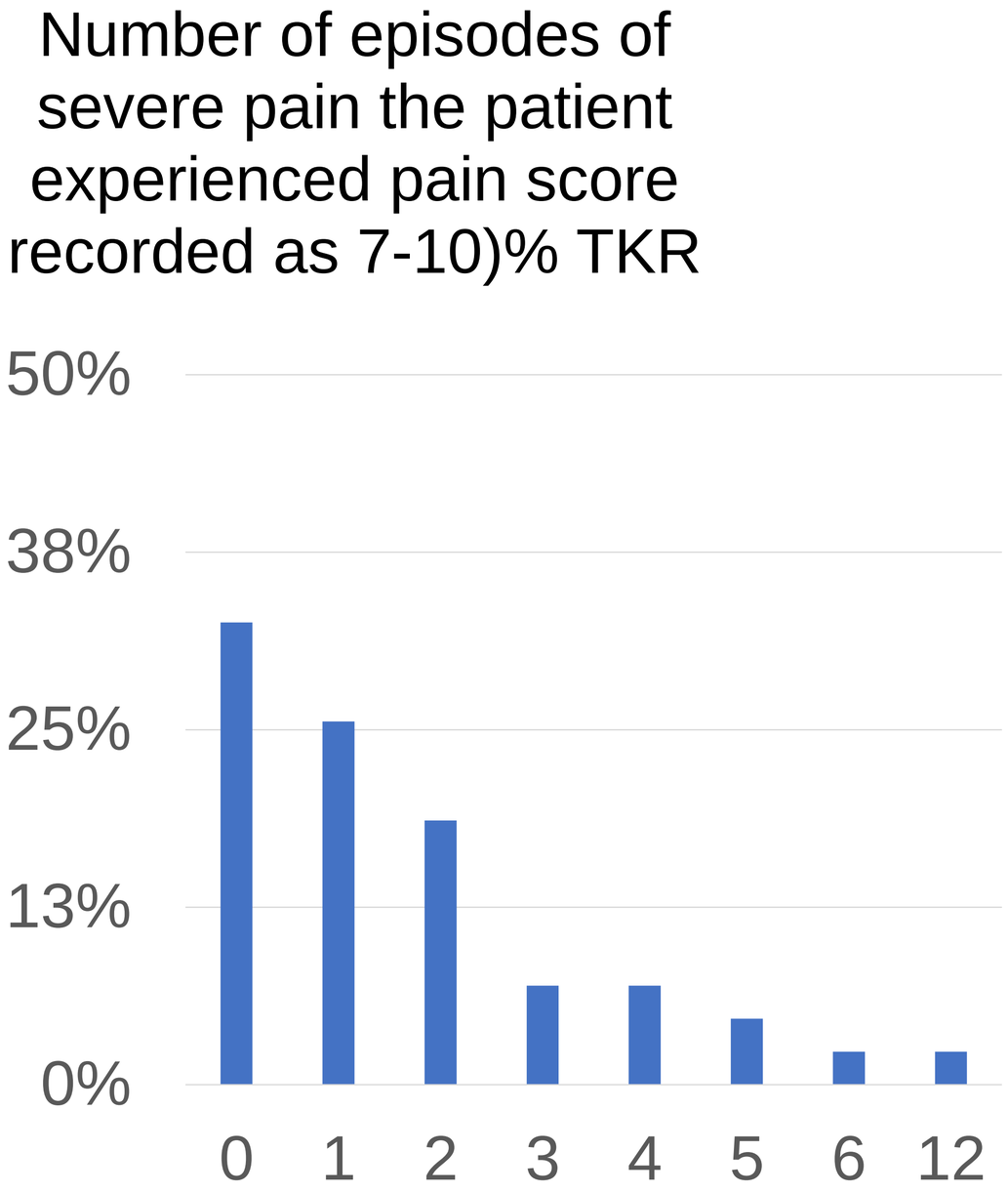

LOS post THR
100%
75%
50%
25%
0%
0
2
4
5
7


Time to mobilisation (hrs) post TKR
100%
75%
50%
25%
0%
0.
7.5
15.
22.5
30.


Total no. doses of MR oxycodone received post-op TKR
70%
53%
35%
18%
0%
0
2
4


Total no. doses of IR oxycodone received post-op TKR
30%
23%
15%
8%
0%
0
1
2
3
4
5
6
7


Number of episodes of severe pain the patient experienced pain score recorded as 7-10)% THR
50%
38%
25%
13%
0%
0
1
2
3
4
5
6


Number of episodes of severe pain the patient experienced pain score recorded as 7-10)% TKR
50%
38%
25%
13%
0%
0
1
2
3
4
5
6
12

TELEPHONE FOLLOW UP

12th January to 20th June 2021

1,319 cases

Question	% of Patients who said YES
Has your pain been well controlled? (n=1304)	90%
Is the pain stopping you from sleeping? (n=1305)	29%
Were you given Oramorph (liquid morphine) to take home? (n=1302)	93%
Have you used the Oramorph? (n=1208)	63%

CONTROLLED PRESCRIBING

MR opioids
Co-analgesics
Advice for GPs

No long-acting (MR) opioids

No co-analgesics

No more than 5 day discharge supply

Pre-op opioid wean

Pre-op information. ‘Recovery & restoration of function’

Multi-modal pain management

Knowledgeable staff

Limit discharge opioids to 5 days, communicate with GP

- 90% of patients used 1-5 doses of strong IR opioid + 1-2 doses of MR Oxy
- 2/3 of patients were using a mixture of other opioids
- 20% receive NSAIDs
- one-third of patients don’t experience any severe pain. 15% of patients experience 4 or more episodes of severe pain

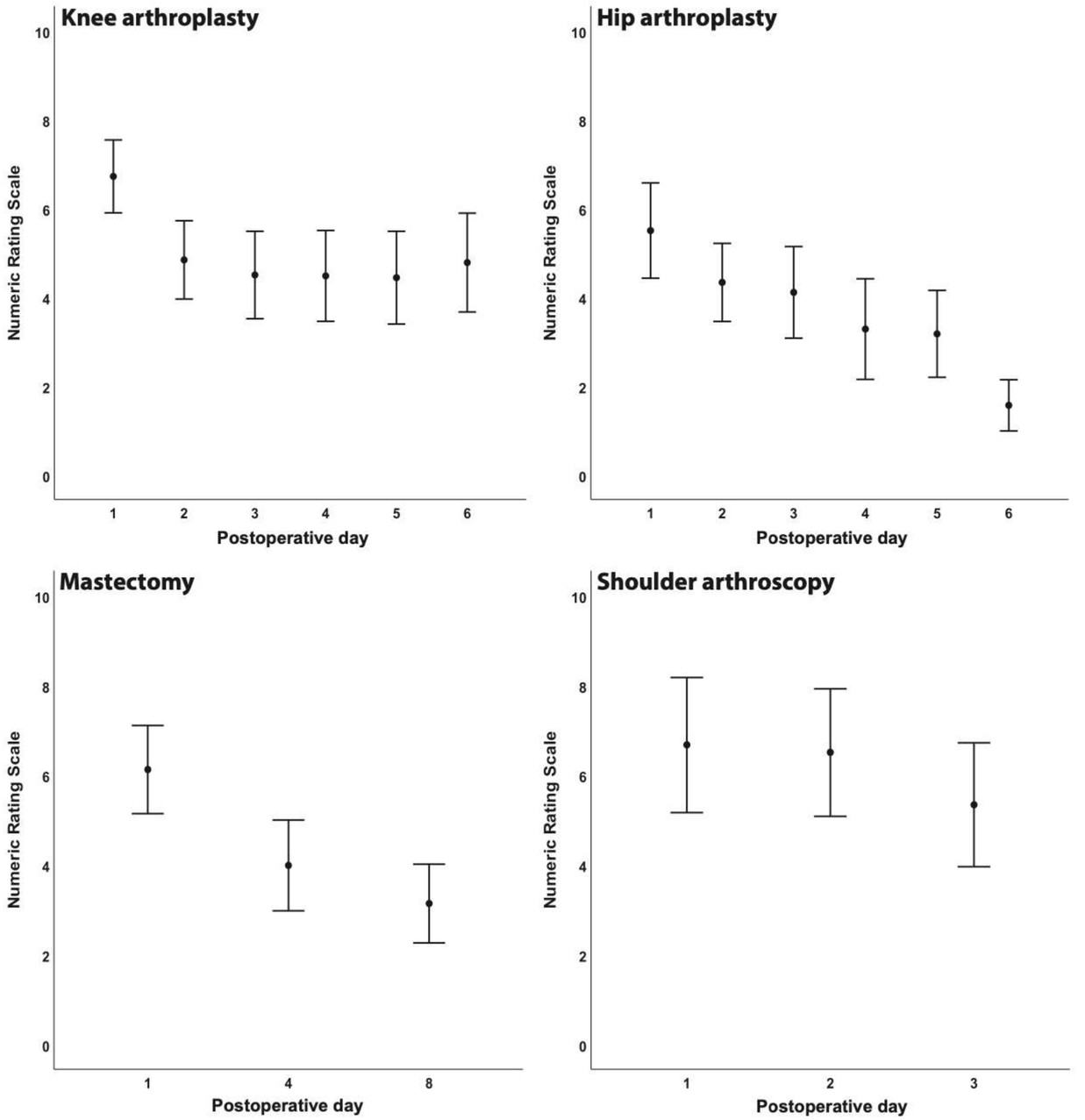


Figure 1 Mean worst pain scores for four surgical procedures: total knee arthroplasty; total hip arthroplasty; mastectomy; and shoulder arthroscopy. Error bars represent 95%CI.

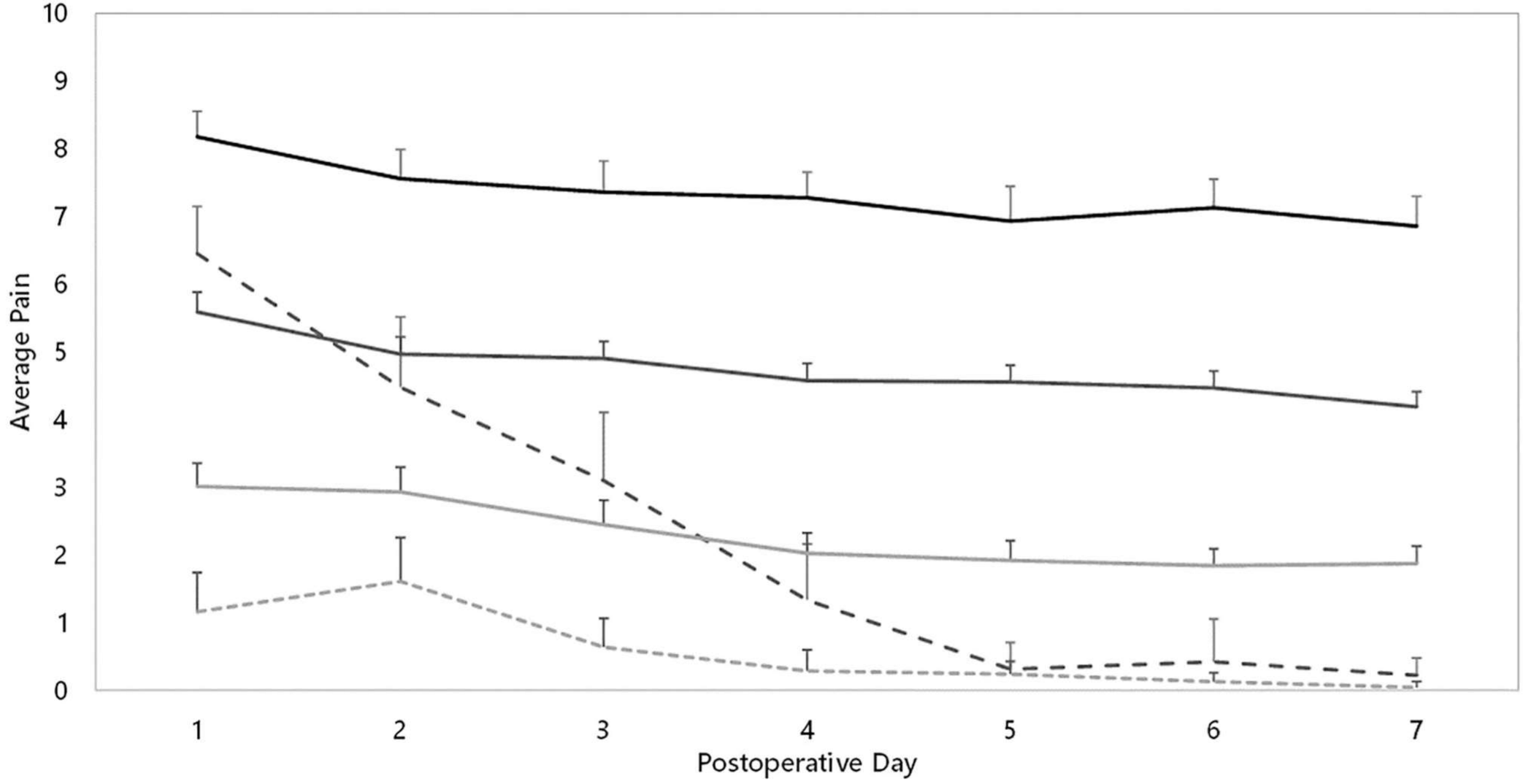


Fig. 3.

Group-based pain trajectories for first 7 days following surgery. Error bars indicate 95%CIs.

	No. of doses	No. Patients	Average no. doses / patient
Paracetamol	806	100	8.06
Ibuprofen	309	65	4.75
Naproxen	21	5	4.2
Codeine	394	84	**4.69**
Tramadol	37	8	4.63
Morphine	110	43	**2.56**
Ondansetron	1	2	0.5