Opioid Stewardship for non-medical prescribers

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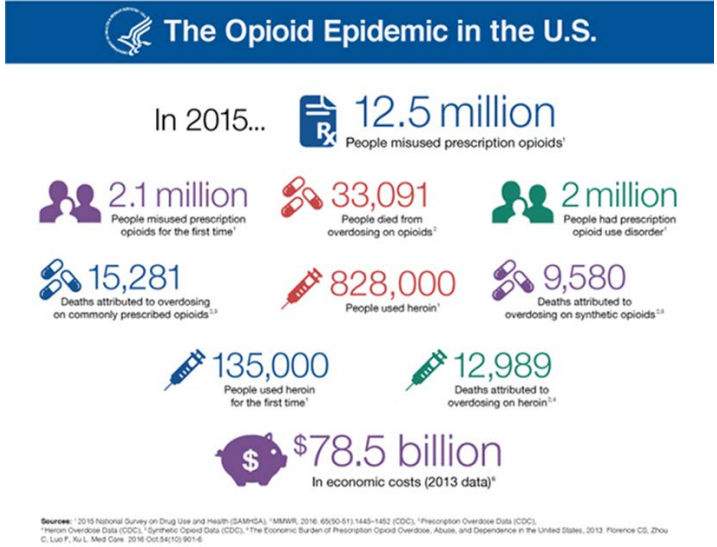

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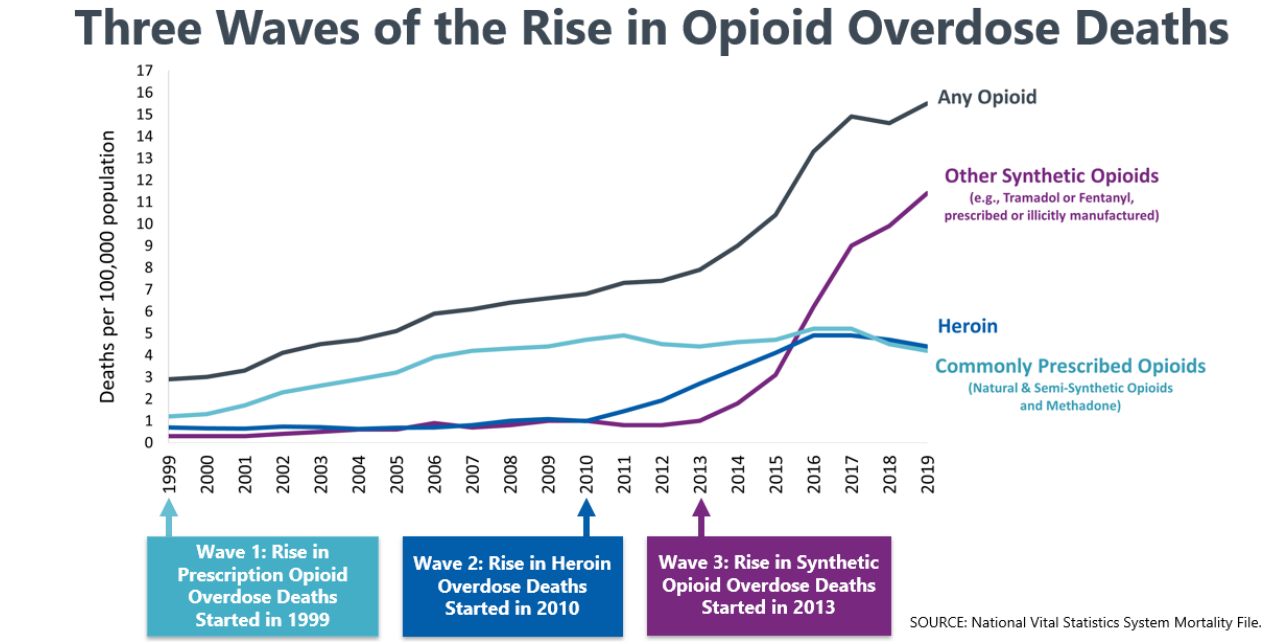
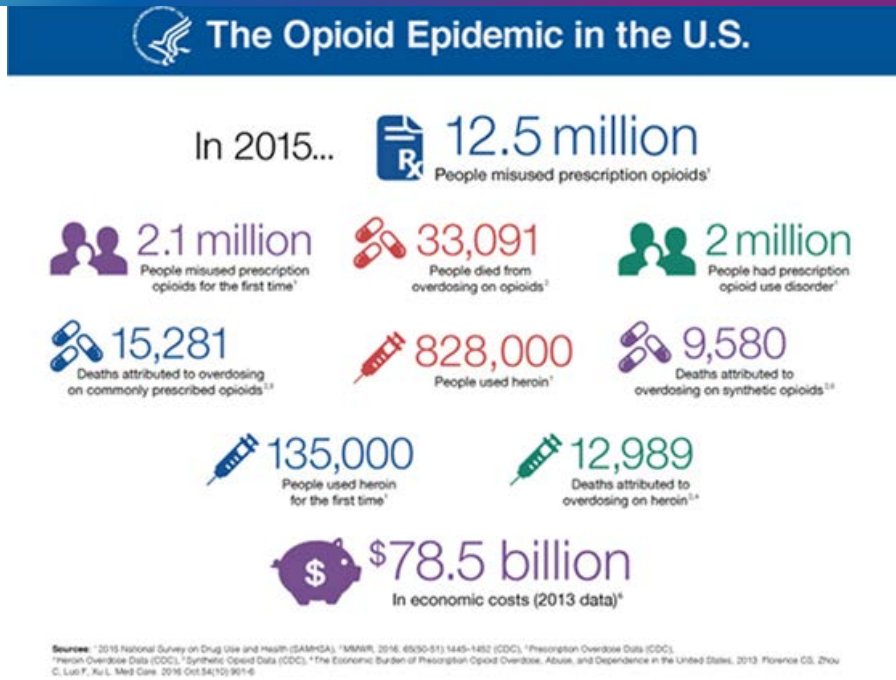
- Define NMP prescribing roles
- Define opioid stewardship
- Discuss ORADEs and the need for opioid stewardship
- Discuss drivers for opioid use and misuse
- Discuss new international , MHRA and GMC guidance
- Discuss components of opioid stewardship





Non-medical Prescribers

- either
- Independent or
- Supplementary prescribers

Overview

A range of non-medical healthcare professionals can prescribe medicines for patients as either Independent c Supplementary Prescribers.

Independent prescribers are practitioners responsible and accountable for the assessment of patients with previously undiagnosed or diagnosed conditions and for decisions about the clinical management required, including prescribing. They are recommended to prescribe generically, except where this would not be clinical appropriate or where there is no approved non-proprietary name.

Supplementary prescribing is a partnership between an independent prescriber (a doctor or a dentist) and a supplementary prescriber to implement an agreed Clinical Management Plan for an individual patient with th patient's agreement.

Independent and Supplementary Prescribers are identified by an annotation next to their name in the relevan professional register.

Information and guidance on non-medical prescribing is available on the Department of Health website at www.dh.gov.uk/health/2012/04/prescribing-change.

For information on the mixing of medicines by Independent and Supplementary Prescribers, see *Mixing of medicines prior to administration in clinical practice: medical and non-medical prescribing*, National Prescribing Centre, May 2010 (available at www.gov.uk/government/publications/mixing-of-medicines-prior-to-administration-in-clinical-practice-medical-and-non-medical-prescribing).

For information on the supply and administration of medicines to groups of patients using Patient Group Directions see Guidance on prescribing.

In order to protect patient safety, the initial prescribing and supply of medicines prescribed should normally remain separate functions performed by separate healthcare professionals.

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Opioid Stewardship

ISMP definition

- Opioid Stewardship may be described as coordinated interventions designed to improve, monitor, and evaluate the use of opioids in order to support and protect human health.

Co-ordinated Safe disposal

- Education of HCPs
- Education of Patients
- Leaflets
- Facilities

Opioid Stewardship are coordinated interventions designed to improve human health.

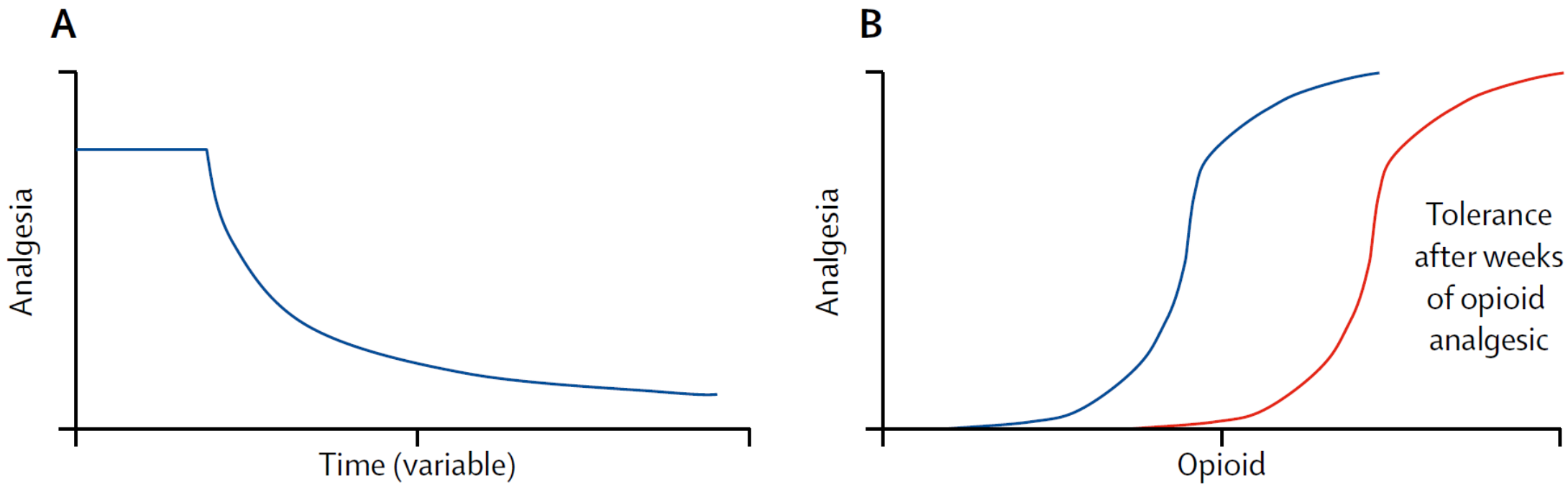
Pain relief has 4 vital functions

1. Humanitarian
2. Attenuate stress response
3. Promote function
4. Promote recovery and return to optimal health

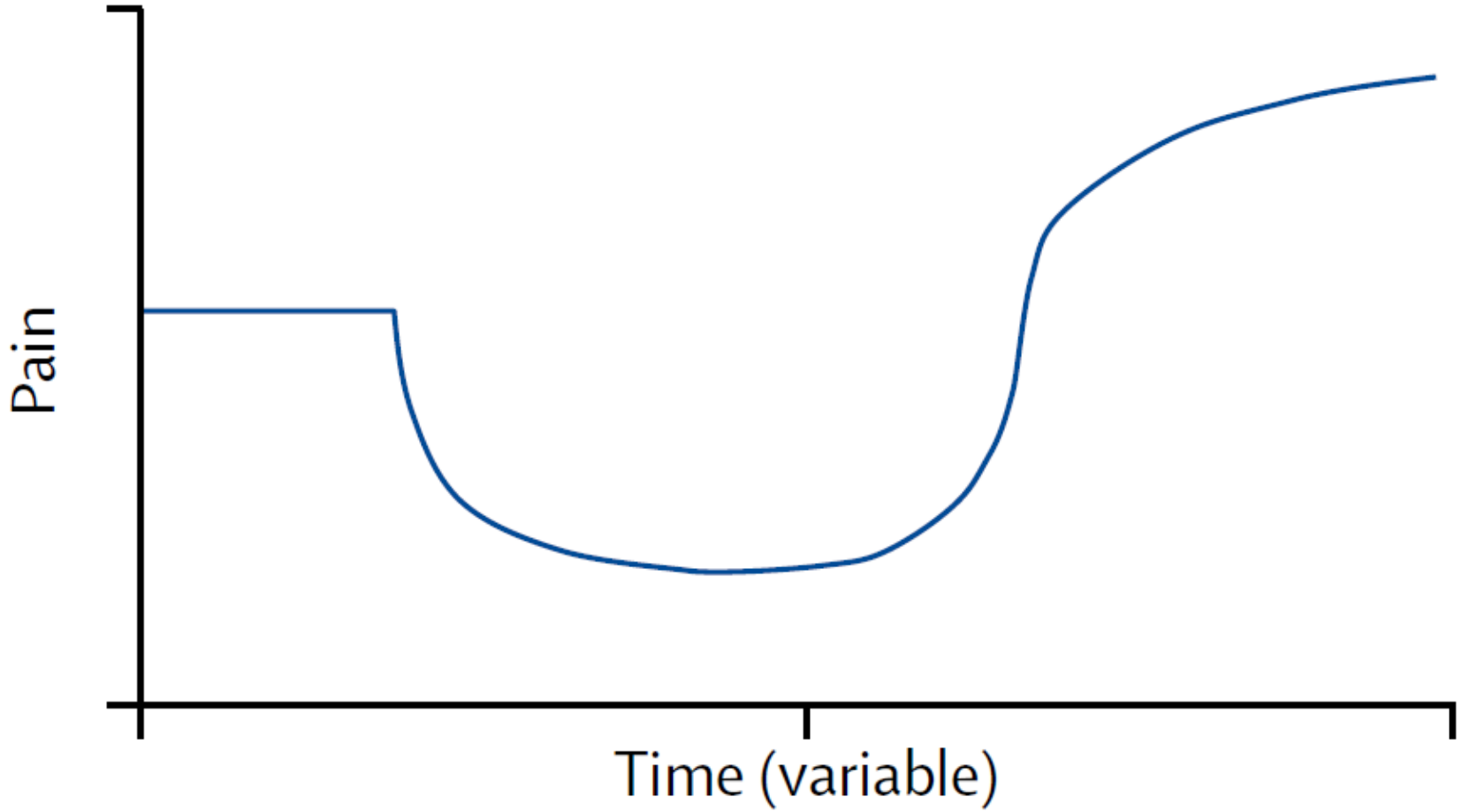
Opioid Stewardship are coordinated interventions designed to monitor, and evaluate the use of opioids in order to support and protect human health.

- Has the patient got opioid resistant pain ?
- Is the patient developing tolerance?
- Is the patient developing opioid induced hyperalgesia?
- Do the opioids need deprescribing ?
- Does the patients have ORADEs

Tolerance to opioid analgesia



Opioid induced hyperalgesia



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Inpatient opioid-related adverse drug events (ORADEs)

JAMA Surgery | Original Investigation

Association of Opioid-Related Adverse Drug Events With Clinical and Cost Outcomes Among Surgical Patients in a Large Integrated Health Care Delivery System

Shahid Shafi, MD, MBA, MPH; Ashley W. Collinsworth, ScD, MPH; Laurel A. Copeland, PhD; Gerald O. Ogola, PhD, MPH, MS; Taoran Qiu, MS; Maria Kouznetsova, PhD, MPH; I-Chia Liao, MPH; Natalie Mears, BA; An T. Pham, PharmD, MBA; George J. Wan, PhD, MPH; Andrew L. Masica, MD, MSCI

ORADE Descriptions	Severity
Respiratory	
Pulmonary congestion & hypostasis	Mild
Pulmonary insufficiency following surgery and trauma Respiratory complications Other pulmonary insufficiency, not elsewhere classified	Moderate
Bradypnea	Moderate
Acute respiratory failure	Severe
Hypoxemia Hypoxia	Moderate
Mechanical ventilator	Severe
Central Nervous System	
Delirium Altered mental status Confusion – classified otherwise	Moderate
Nervousness	Mild
Dizziness/vertigo	Mild
Gastrointestinal	
Dry mouth	Mild
Paralytic ileus Postoperative ileus	Moderate
Constipation Constipation - narcotic	Mild
Nausea/vomiting following GI surgery Nausea/vomiting	Moderate
Opioid Antagonist	
Naloxone Naloxegol Methylnaltrexone	Moderate
Other Adverse Events	
Dermatitis/Pruritus	Mild
Bradycardia, postoperative	Moderate
Fall from bed Other accidental fall Accidental fall (not specified)	Moderate
Drugs causing adverse events in therapeutic use	Mild

Impact of inpatient opioid-related adverse drug events

Table 2. Risk-Adjusted Clinical and Cost Outcome Estimates for Patients With and Without ORADEs[a]

Outcome	Value (95% CI)[b]		Difference
	ORADE	No ORADE	
Inpatient mortality, %	3.0 (2.8-3.3)	0.1 (0.1-0.2)	2.9
Discharge to another care facility, %[c]	20.0 (19.5-20.6)	10.4 (10.2-10.6)	9.6
LOS, d	6.8 (6.7-6.8)	5.2 (5.1-5.3)	1.6
Cost of hospitalization, $[d]	25 599 (24 974-26 104)	17 374 (17 191-17 547)	8225
30-d Readmission, %	8.9 (8.5-9.4)	7.1 (7.0-7.3)	1.8

ORADEs in the Community

- Social impact
- Financial impact on the person, the family and the community
- Opioid use disorder
- Opioid diversion
- Drug driving
- Death from opioid induced ventilatory impairment
- Transition to illicit opioid use

THE OPIOID EPIDEMIC BY THE NUMBERS

130+
People died every day from opioid-related drug overdoses[3]
(estimated)

10.3 m
People misused prescription opioids in 2018[1]

47,600
People died from overdosing on opioids[2]

2.0 million
People had an opioid use disorder in 2018[1]

808,000
People used heroin in 2018[1]

81,000
People used heroin for the first time[1]

2 million
People misused prescription opioids for the first time[1]

15,349
Deaths attributed to overdosing on heroin (in 12-month period ending February 2019)[2]

32,656
Deaths attributed to overdosing on synthetic opioids other than methadone (in 12-month period ending February 2019)[2]

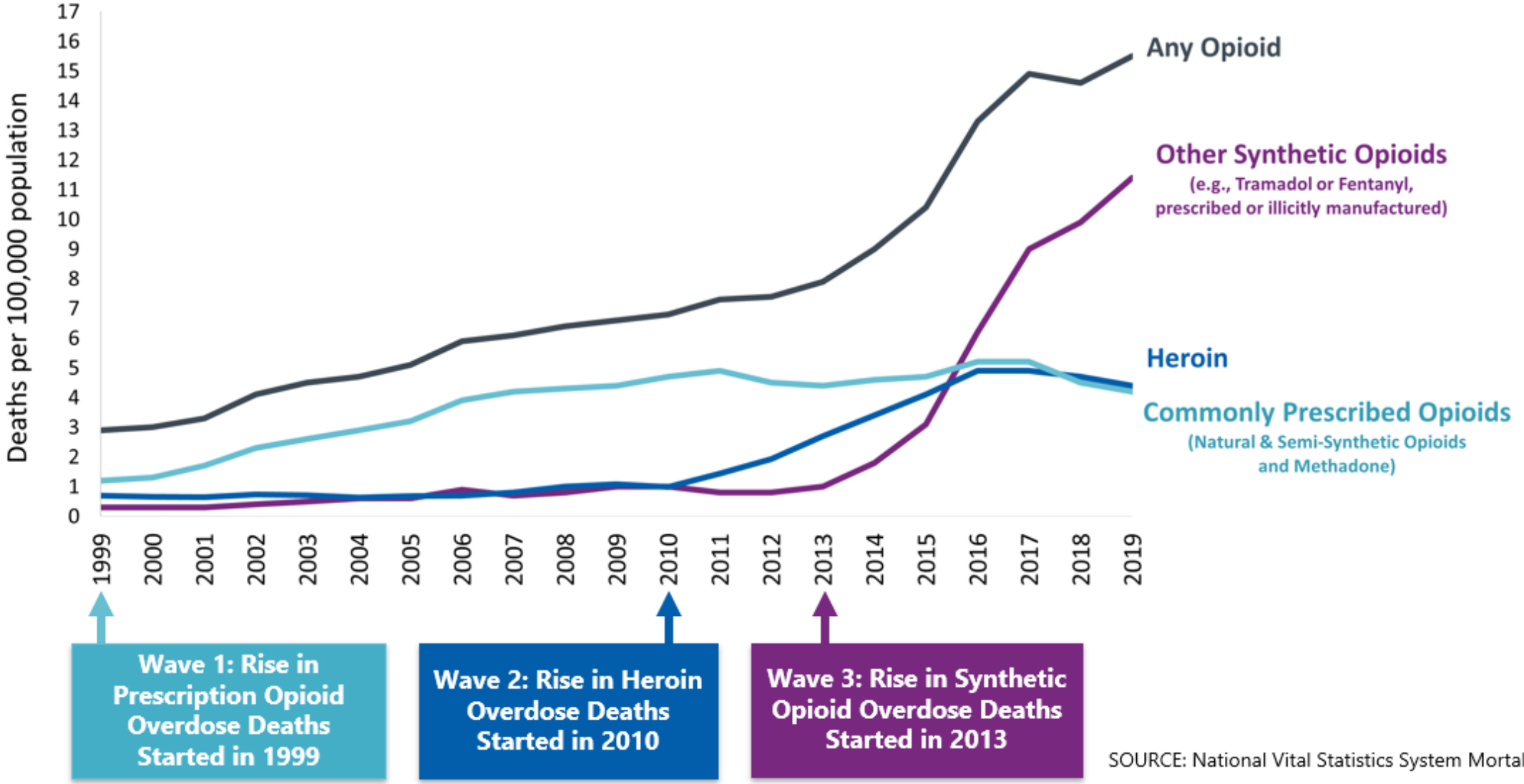
SOURCES

1. 2019 National Survey on Drug Use and Health. Mortality in the United States, 2018
2. NCHS Data Brief No. 329, November 2018
3. NCHS, National Vital Statistics System. Estimates for 2018 and 2019 are based on provisional data.

HHS.GOV/OPIOIDS

Opioid use and misuse- the other epidemic

Three Waves of the Rise in Opioid Overdose Deaths



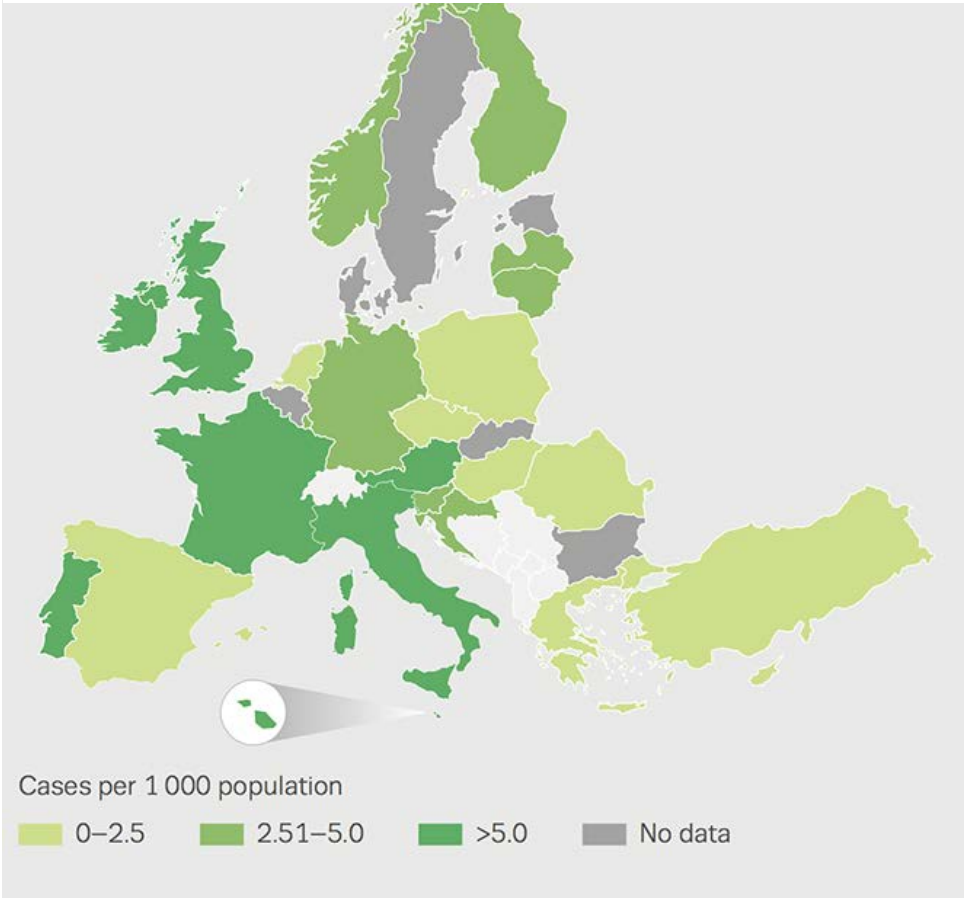
SOURCE: National Vital Statistics System Mortality File.

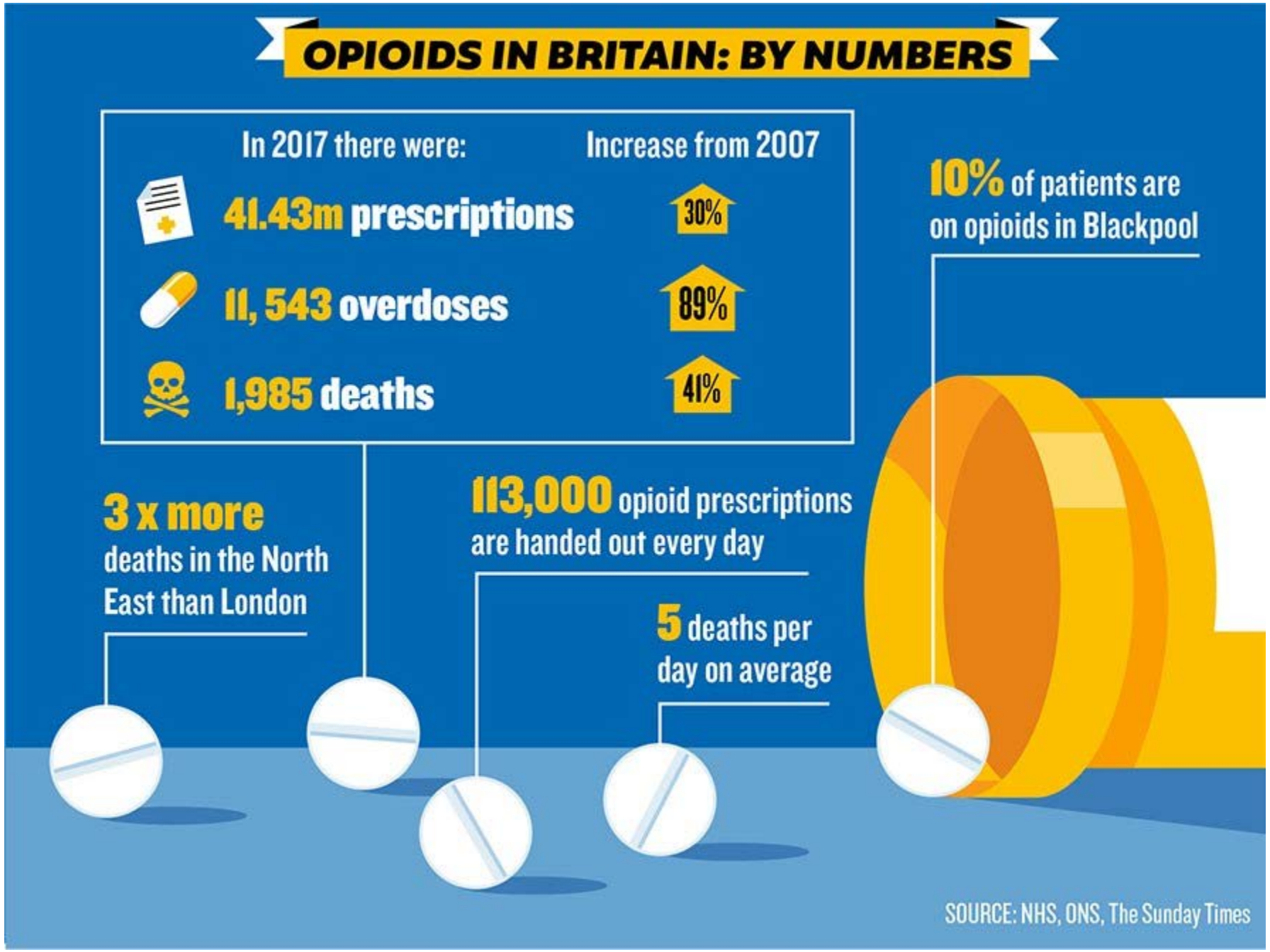
Opioid use and misuse- the other UK epidemic

UK figures

- 5% of the population prescribed opioids in 2015
- 18% in Scotland
- 5% of the population misuse prescription opioids
- 1998 and 2016, opioid prescriptions increasing+++
- Morphine equivalency consumption is now 431 mg per person per year

Prevalence of high risk opioid use in Europe




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 misuse and Opioid diversion

- Opioid mis-use is use without a prescription or use for reasons other than that for which the opioid was prescribed.
- Opioid diversion is the transfer by any means of a legitimately prescribed opioid(s) to a party other than the individual for whom it was originally prescribed

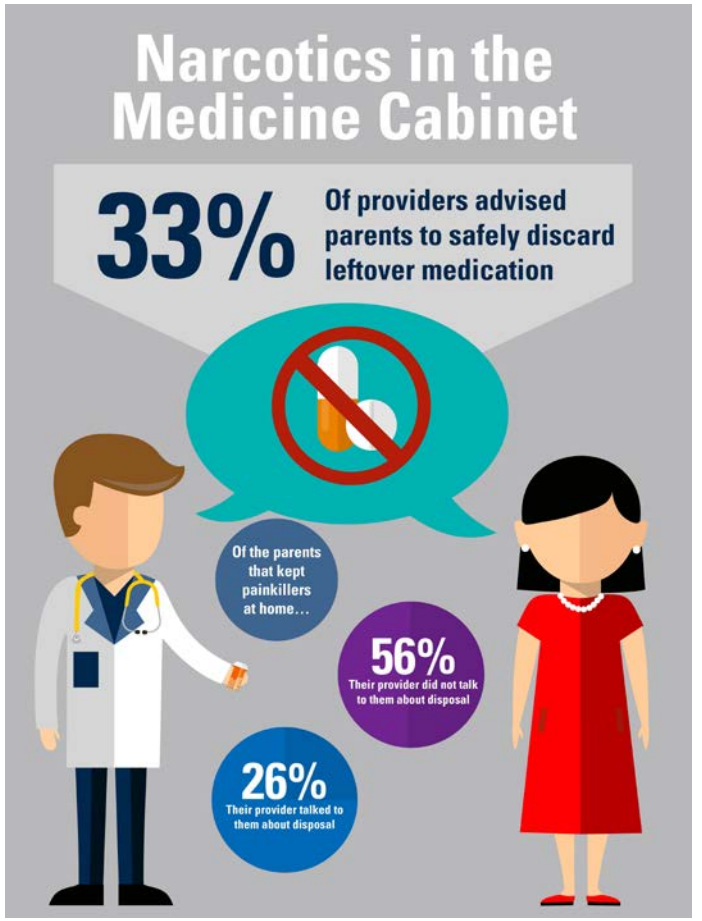
Why does proper opioid disposal matter?

Protecting Family and Friends

2/3 of teens who report prescription abuse get the medicines from friends, family and acquaintances.

1 in 4 teens has misused or abused a prescription drug at least once in their lifetime.[1]

825 children died and 116,000 were treated in the ER for drug poisoning in 2009.[2]



Driving under the influence of prescription opioids

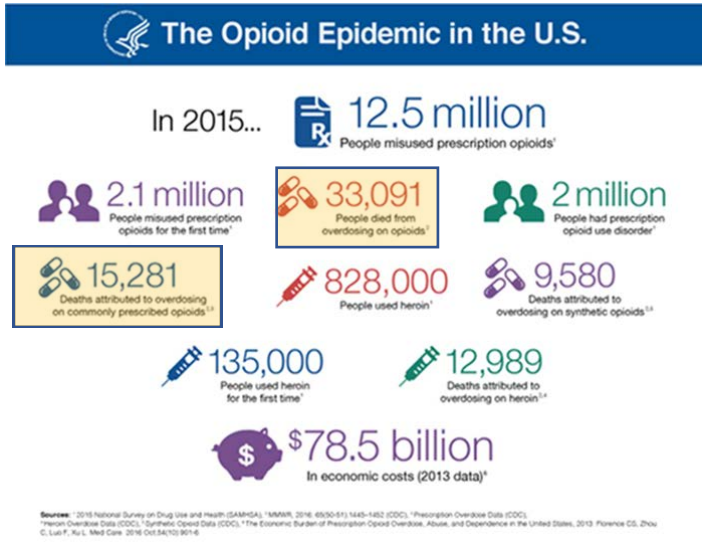
Age and Ageing 2016; **45:** 628–634
doi: 10.1093/ageing/afw115
Published electronically 26 July 2016

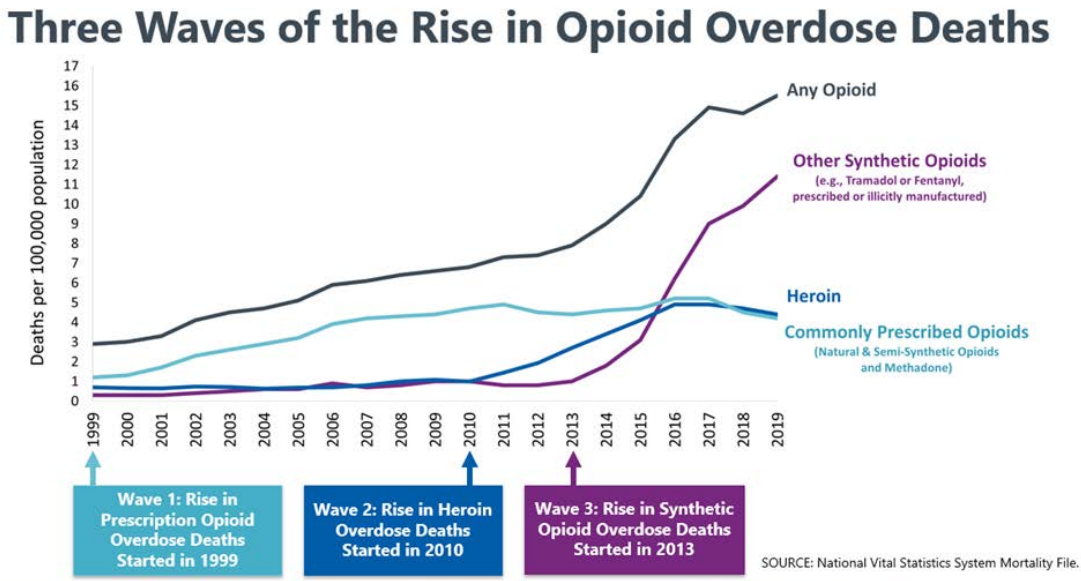
New opioid analgesic use and the risk of injurious single-vehicle crashes in drivers aged 50–80 years: A population-based matched case–control study

- Increased risk of fatal road traffic collisions within 30 days of commencing opioids

Opioid induced ventilatory impairment

- More than just respiratory depression
- Relaxation of upper airway
- Depression of consciousness
- Compounded by other sedatives eg gabapentinoids





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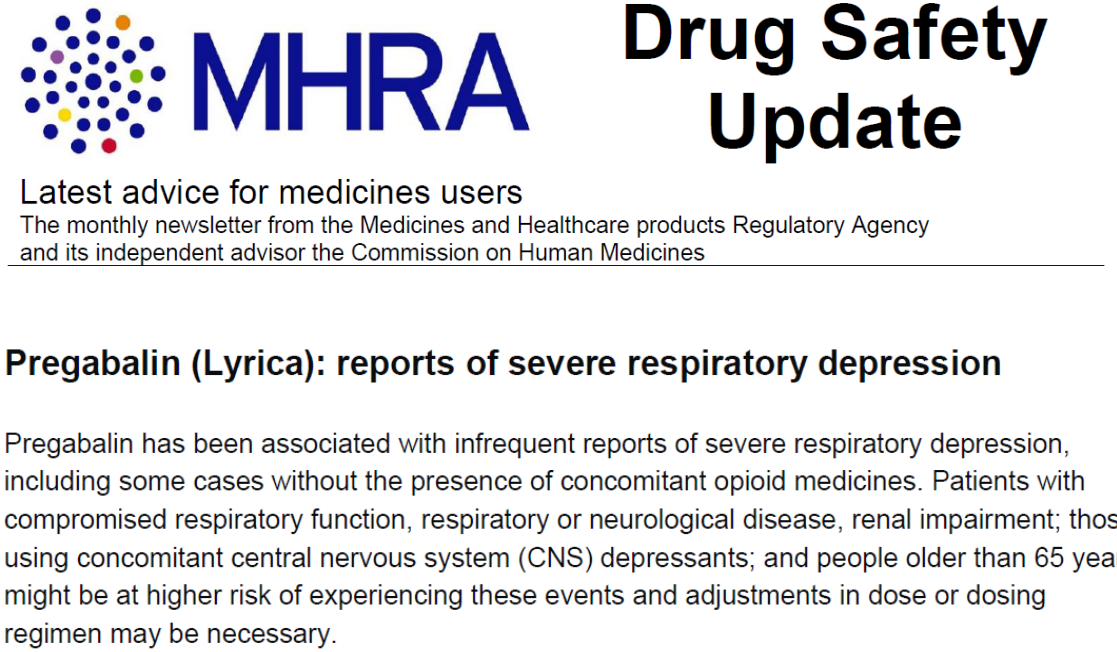

MHRA

Drug Safety Update

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

Pregabalin (Lyrica): reports of severe respiratory depression

Pregabalin has been associated with infrequent reports of severe respiratory depression, including some cases without the presence of concomitant opioid medicines. Patients with compromised respiratory function, respiratory or neurological disease, renal impairment; those using concomitant central nervous system (CNS) depressants; and people older than 65 years might be at higher risk of experiencing these events and adjustments in dose or dosing regimen may be necessary.

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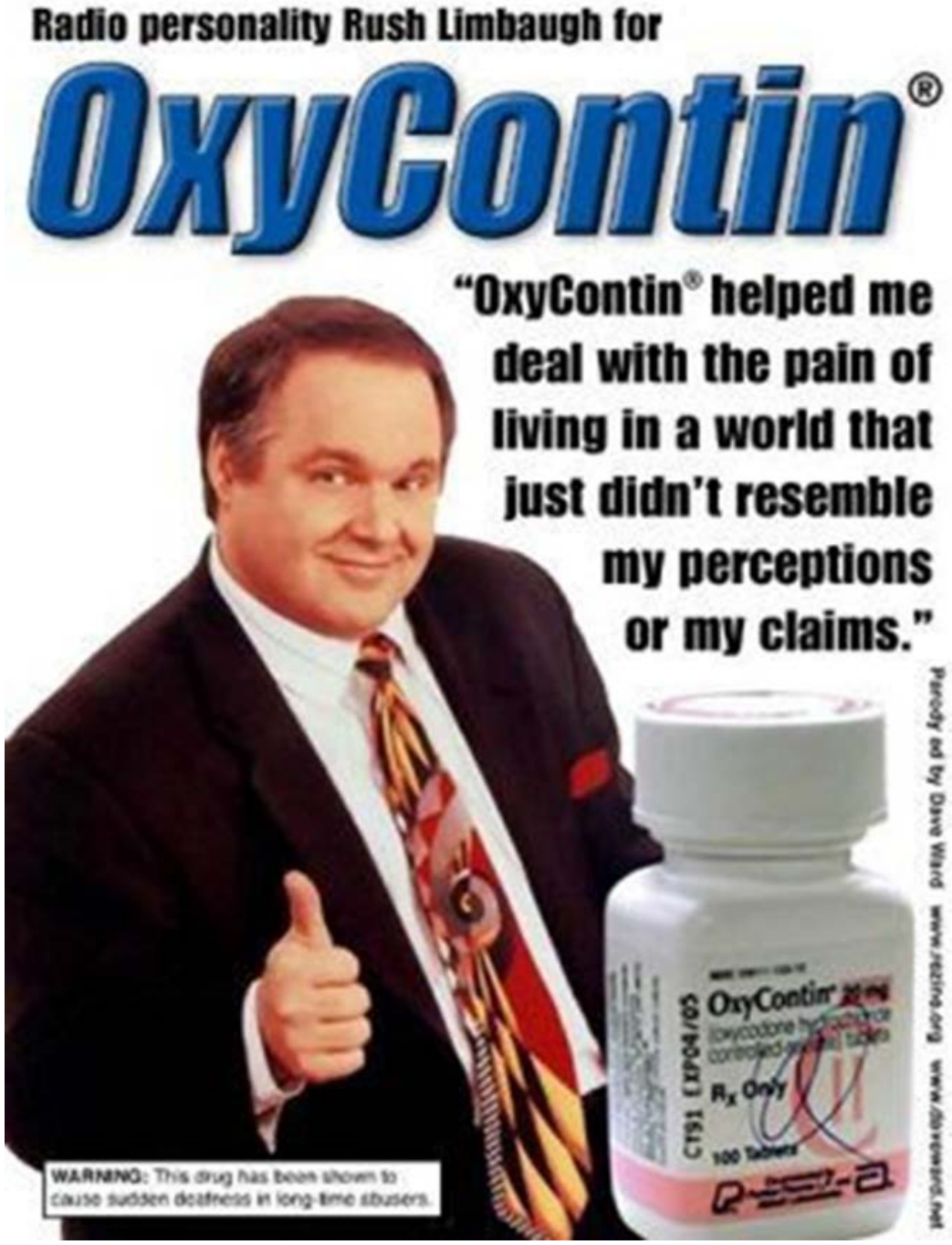
Drivers for opioid use and misuse

CBS NEWS / *June 21, 2018, 7:47 AM*

Purdue Pharma used deceptive sales tactic for OxyContin after settlement, ex-sales rep says



PHARMALOT

Purdue will plead guilty to federal charges, reaches $8.3 billion deal over opioid crisis

By ED SILVERMAN @Pharmalot / OCTOBER 21, 2020

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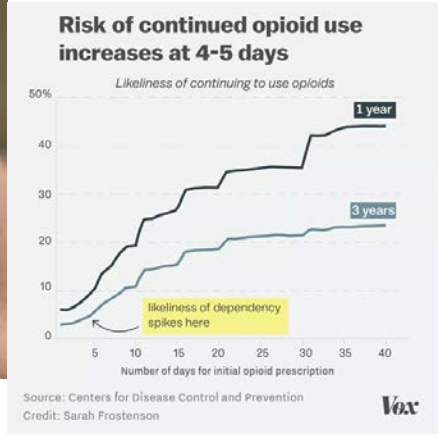

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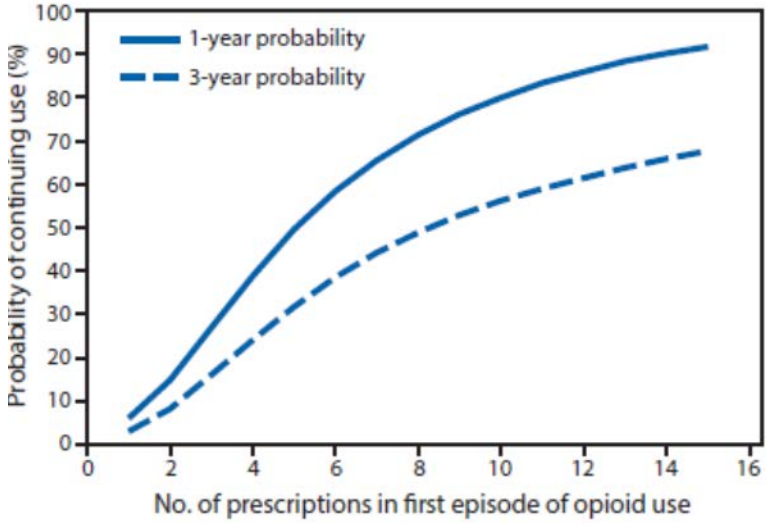

PHARMACOLOGY

- Addictive properties of drugs
- Long-acting preparations
- Compound analgesics

SERVICE UNDER-PROVISION

- Lack of alternative resources/ services to support people with chronic pain
- Lack of recognition of chronic pain as a long-term condition

PERSONAL

- Surgery and exposure to opioids
- Past or current drug or alcohol dependence
- Chronic pain
- Psychological comorbidities including anxiety and catastrophic thinking

HEALTHCARE INITIATIVES

- "Pain as the 5th Vital Sign"
- Titrating opioids to numerical pain scores alone
- Incentivisation e.g. payment by results and payment by patient reported outcome measures

PRESCRIBING

- Poor knowledge about safe opioid stewardship/acute and chronic pain prescribing
- Use of repeat prescriptions
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PHARMACEUTICAL INDUSTRY

- Misbranding
- Aggressive marketing/false claims about addiction
- Sponsoring drug trials designed to demonstrate superiority
- Past involvement with

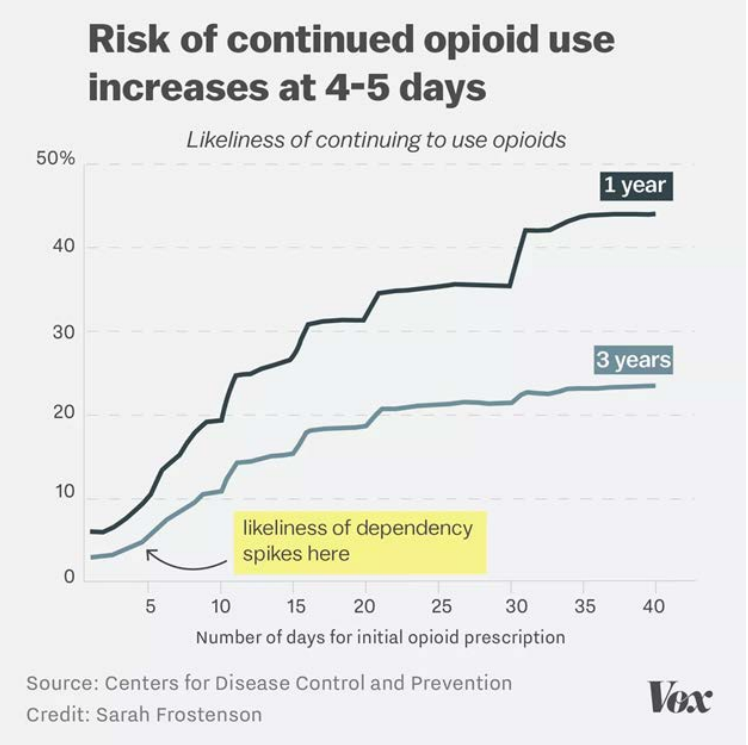
SOCIETY

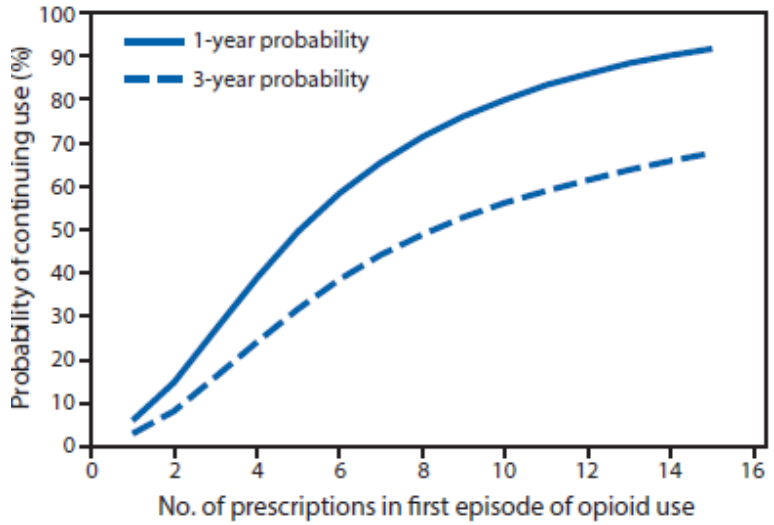
- Opioid diversion
- Lack of safe opioid disposal
- Socio-economic deprivation

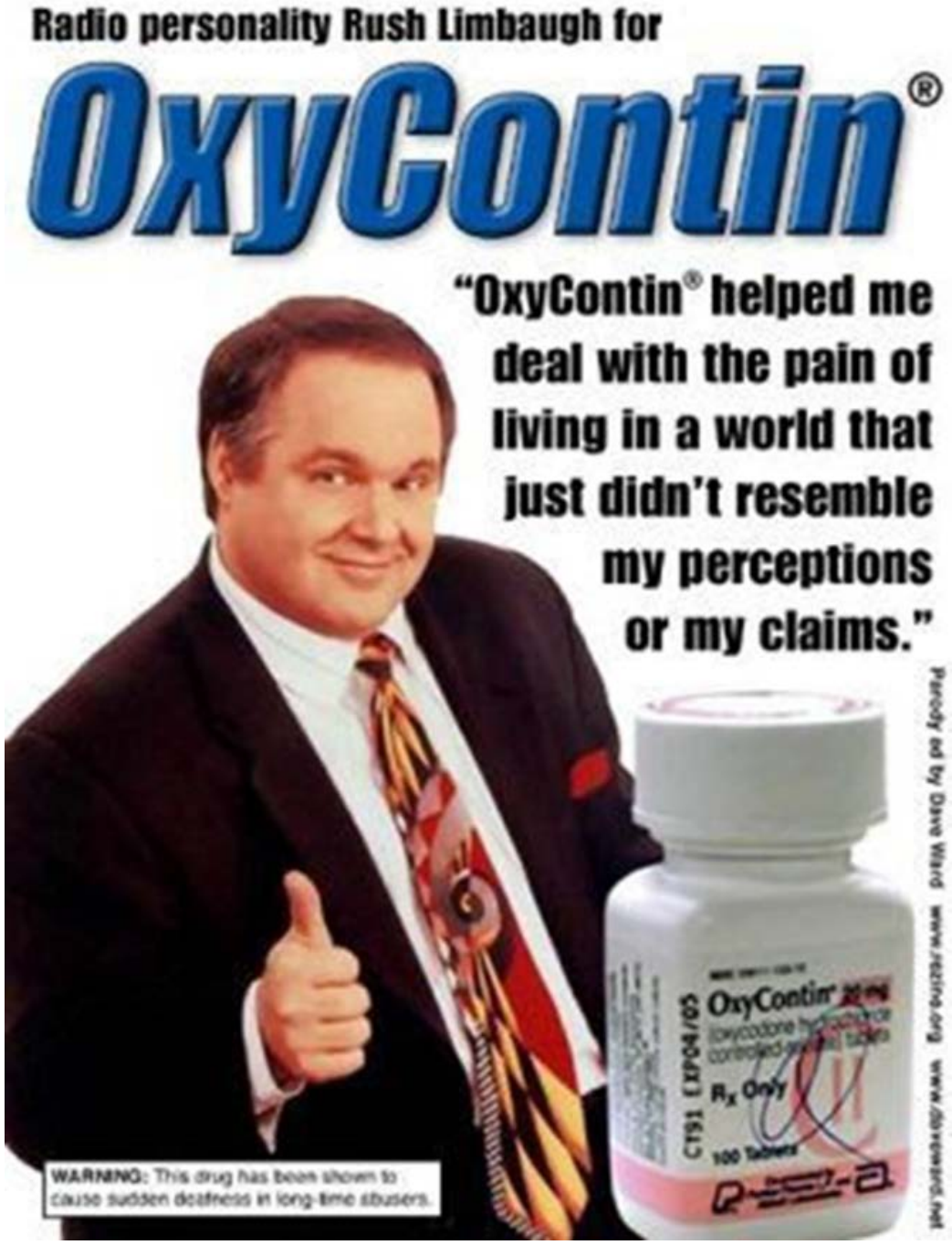
Centers for Disease Control and Prevention
MMWR
Morbidity and Mortality Weekly Report
Weekly / Vol. 66 / No. 10
March 17, 2017

Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015

Anuj Shah[1]; Corey J. Hayes, PharmD[1,2]; Bradley C. Martin, PharmD, PhD[1]







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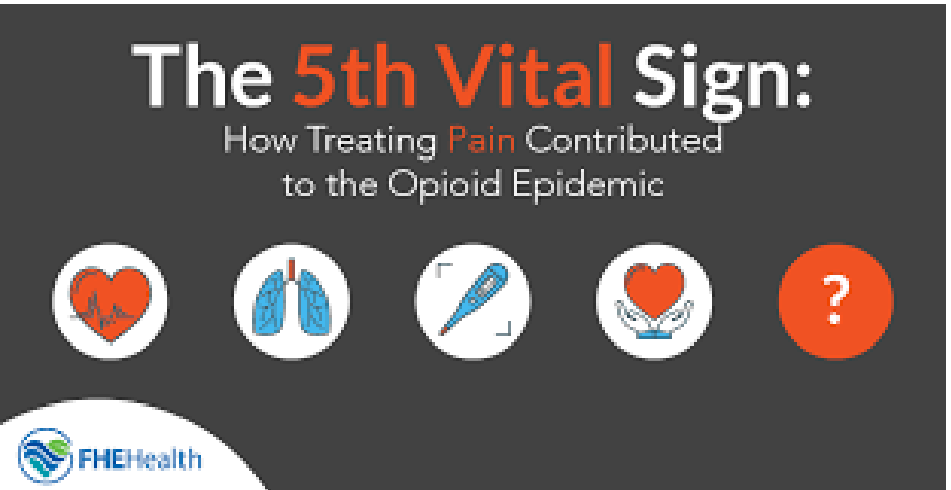

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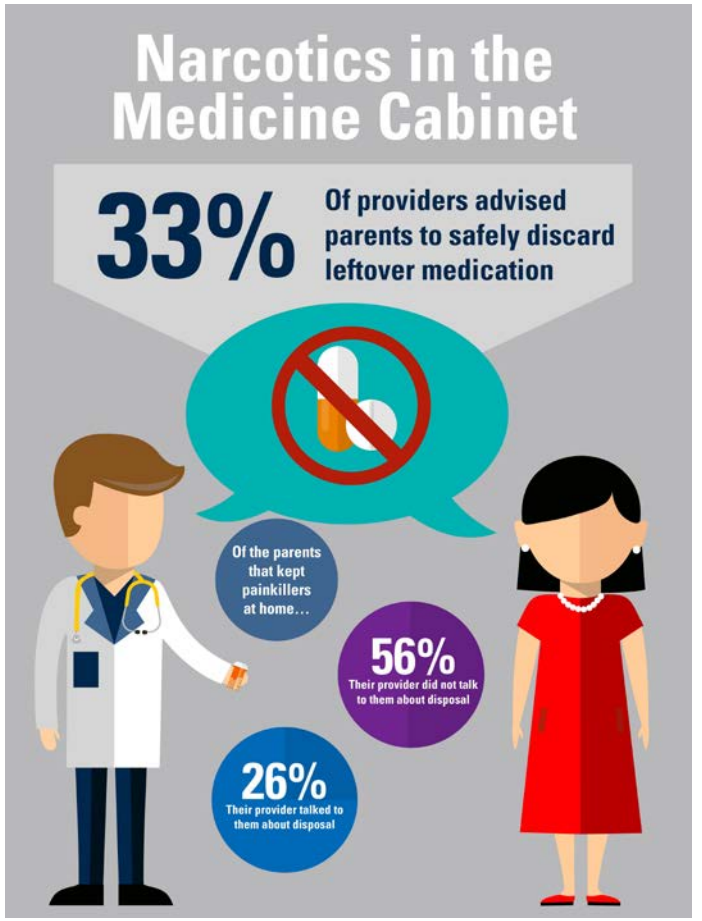

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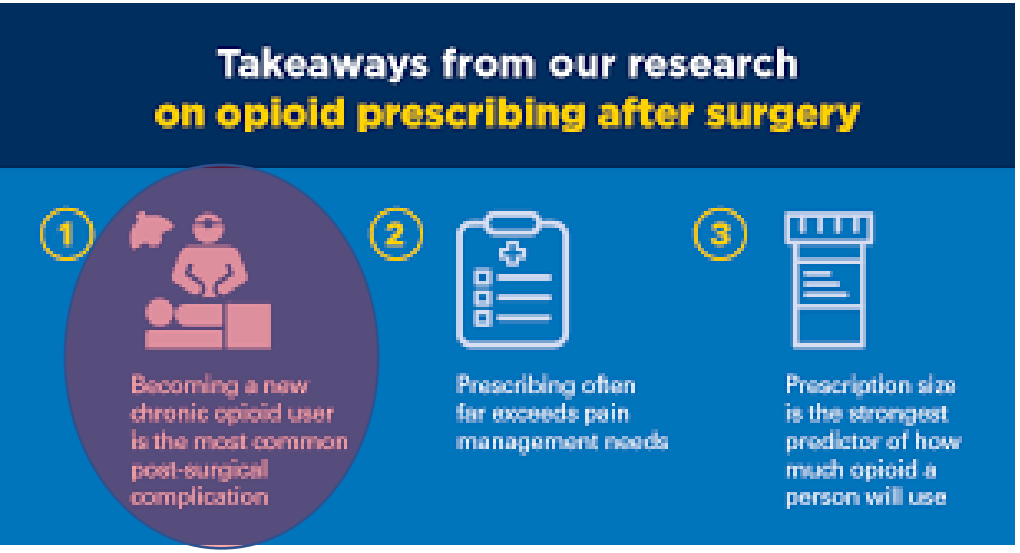

https://ihpi.umich.edu/sites/default/files/2019-02/Opioids_Surg_FINAL_2.22.19.pdf

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Unrealistic expectations

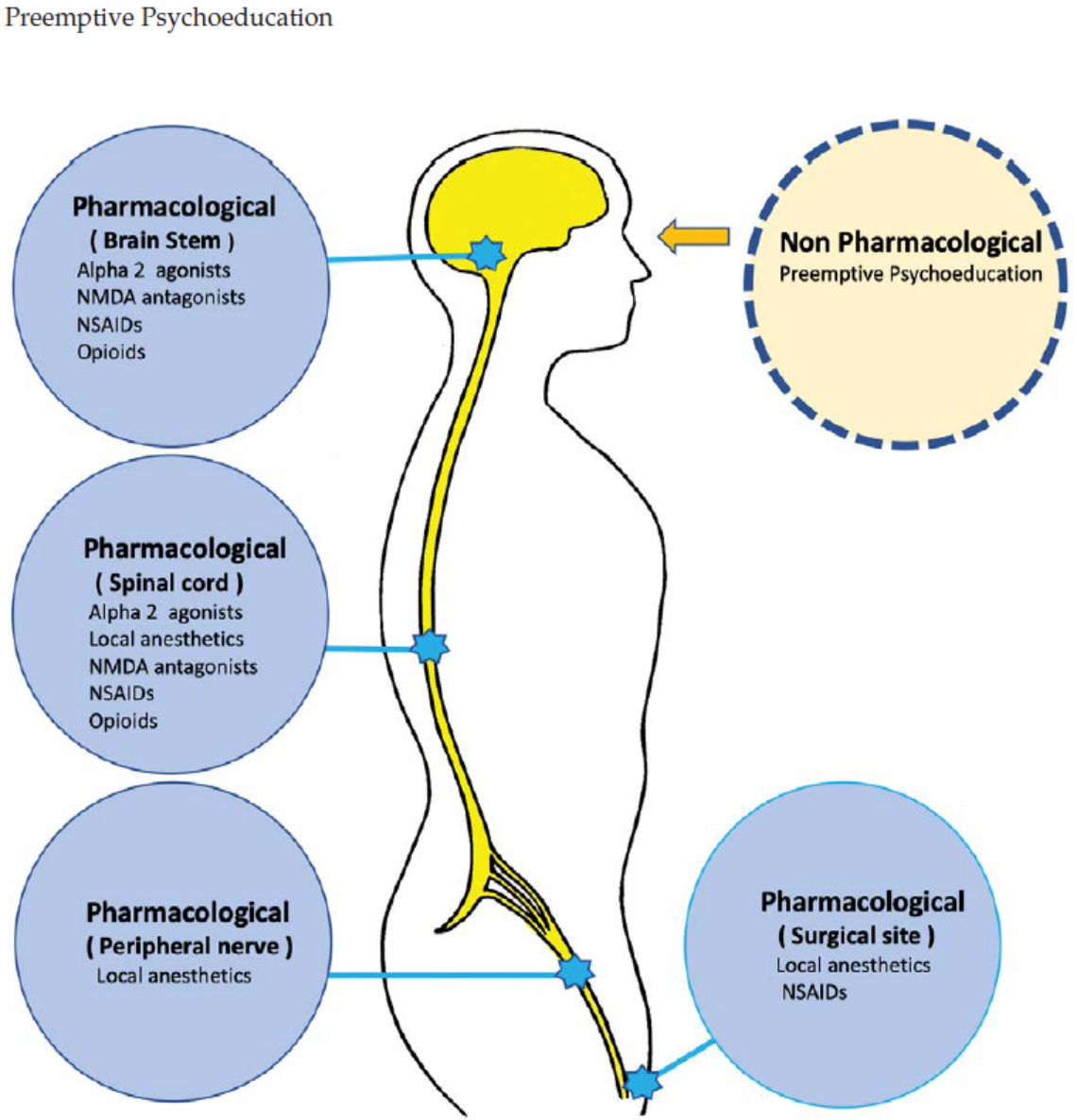

Figure. Schematic diagram of non-pharmacological preemptive pain psychoeducation as a part of multimodal perioperative pain control option. NMDA indicates *N*-methyl-D-aspartate; NSAID, nonsteroidal anti-inflammatory drugs.

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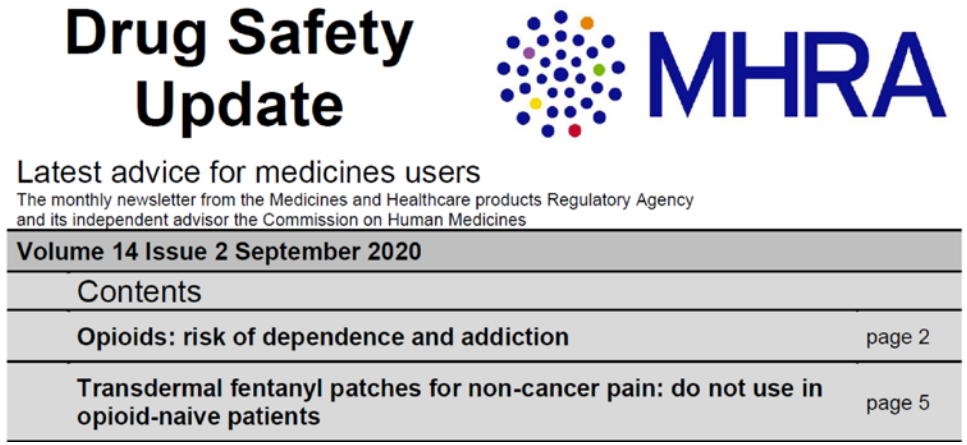


International consensus recommendation

International consensus recommendation

- Pre-operative weaning of opioids where possible
- Realistic expectations

International consensus recommendation

- Function should be used to guide opioid administration

Functional Pain Score

A — no limitation	the patient is able to undertake the activity without limitation due to pain (pain intensity score is typically zero to three);
B — mild limitation	the patient is able to undertake the activity but experiences moderate to severe pain (pain intensity score is typically four to ten); and
C — significant limitation	the patient is unable to complete the activity due to pain, or pain treatment-related adverse effects, independent of pain intensity scores.

International consensus recommendation

- Long-acting opioids should **not** routinely be used for acute postoperative pain.

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

All patients undergoing surgery should be assumed to be at risk of developing persistent postoperative opioid use and opioid-induced ventilatory impairment.

Consider optimising management of pre-operative pain and psychological risk factors before surgery, including weaning of opioids where possible. Ensure realistic expectations of postoperative pain control.

Functional outcomes should guide provision of opioid analgesia, rather than unidimensional pain scores alone.

Multimodal analgesia should be optimised and patients educated about the use of non-pharmacological and non-opioid analgesia.

Long-acting opioids should not be used routinely for acute postoperative pain.

A patient-centred approach should be used to limit the number of tablets and the duration of usual discharge opioid prescriptions, typically to less than a week.

Automated post-discharge repeat prescriptions for opioids should be avoided. Perform a patient review if more opioids are requested.

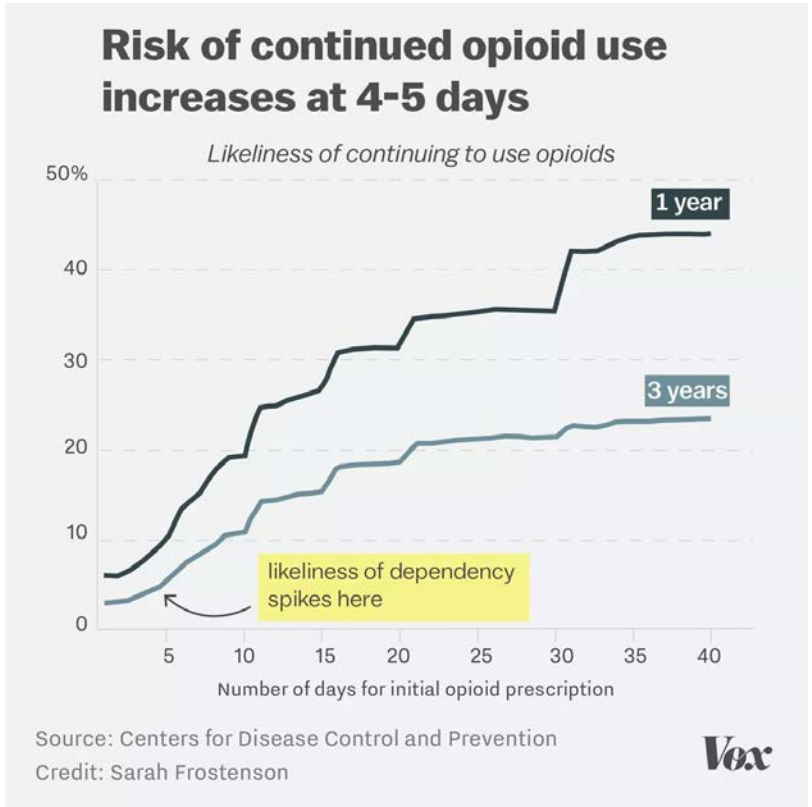
Hospitals should have strategies to mitigate the occurrence of opioid-induced ventilatory impairment.

Modifiable factors that have been identified as increasing the risk of opioid-induced ventilatory impairment and persistent postoperative opioid use should be addressed.

Patients should be advised on safe storage and disposal of unused opioids and directed to avoid opioid diversion to other individuals.

International consensus recommendation

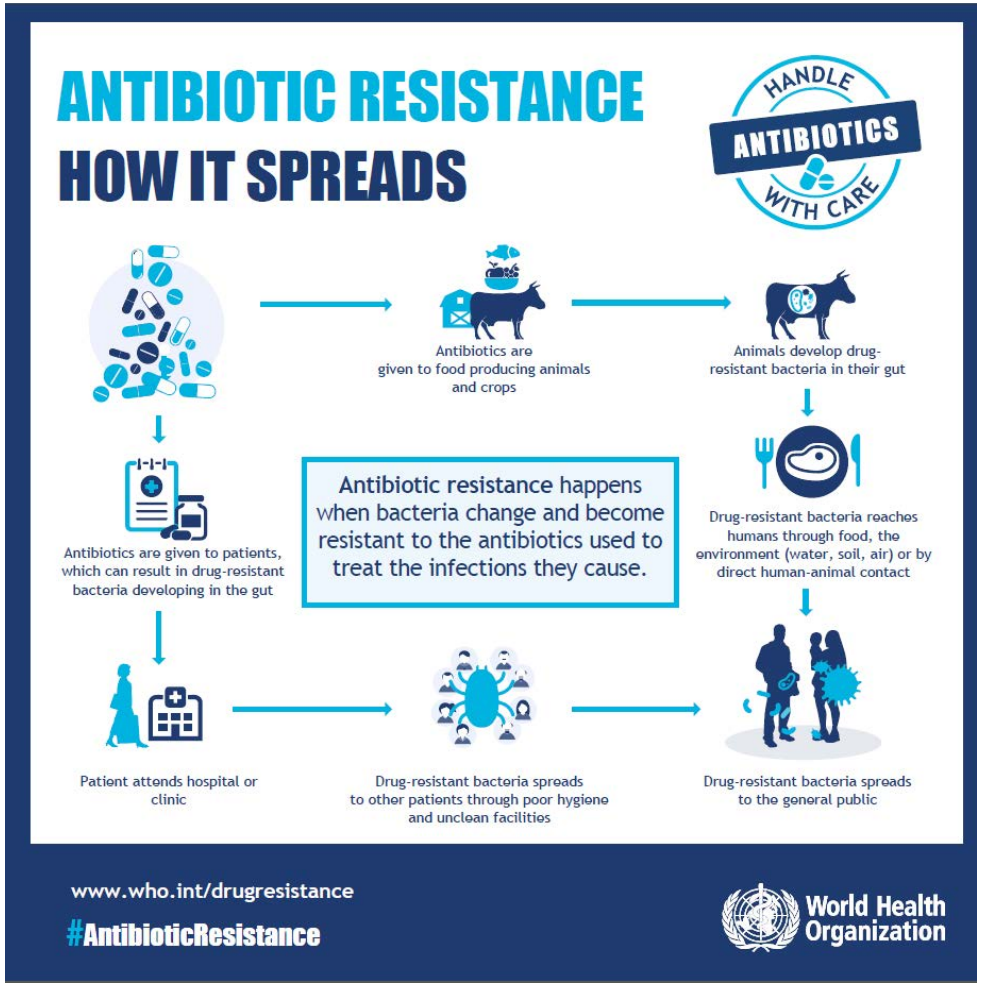
- Limit the number of tablets and the duration of opioid prescriptions, typically to less than a week.



For acute pain, prescriptions should only be for the expected duration of pain severe enough to need opioids. **Three days or less** is often enough; more than seven days is rarely needed.

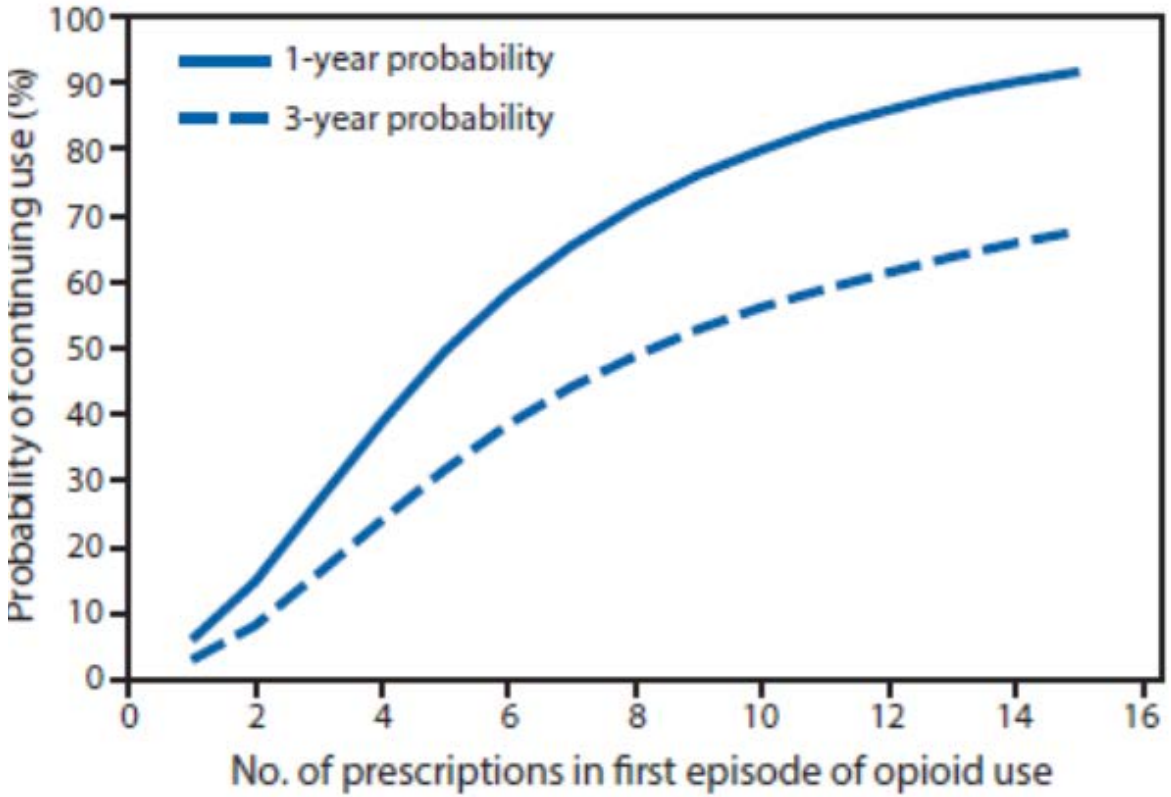
Antibiotic and Opioid stewardship

- Consider them both as courses
- With an end date of treatment



International consensus recommendation

- Avoid repeat prescriptions of opioids



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

All patients undergoing surgery should be assumed to be at risk of developing persistent postoperative opioid use and opioid-induced ventilatory impairment.

Consider optimising management of pre-operative pain and psychological risk factors before surgery, including weaning of opioids where possible. Ensure realistic expectations of postoperative pain control.

Functional outcomes should guide provision of opioid analgesia, rather than unidimensional pain scores alone.

Multimodal analgesia should be optimised and patients educated about the use of non-pharmacological and non-opioid analgesia.

Long-acting opioids should not be used routinely for acute postoperative pain.

A patient-centred approach should be used to limit the number of tablets and the duration of usual discharge opioid prescriptions, typically to less than a week.

Automated post-discharge repeat prescriptions for opioids should be avoided. Perform a patient review if more opioids are requested.

Hospitals should have strategies to mitigate the occurrence of opioid-induced ventilatory impairment.

Modifiable factors that have been identified as increasing the risk of opioid-induced ventilatory impairment and persistent postoperative opioid use should be addressed.

Patients should be advised on safe storage and disposal of unused opioids and directed to avoid opioid diversion to other individuals.

International consensus recommendation

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Drug Safety Update

MHRA

Latest advice for medicines users

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Volume 14 Issue 2 September 2020

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MHRA

Advice for healthcare professionals:

- opioid medicines (opioids) provide relief from serious short-term pain; however long-term use in non-cancer pain (longer than 3 months) carries an increased risk of dependence and addiction
- discuss with patients that prolonged use of opioids may lead to drug dependence and addiction, even at therapeutic doses – warnings have been added to the labels (packaging) of UK opioid medicines to support patient awareness
- before starting treatment with opioids, agree with the patient a treatment strategy and plan for end of treatment

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

General Medical Council

THIS GUIDANCE COMES INTO EFFECT ON 5 APRIL 2021

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 comes into effect on 5 April 2021.

Download the guidance

You can download this guidance in English or Welsh

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]

60 If you don't have access to relevant information from the patient's medical records you must not prescribe controlled drugs or medicines that are liable to abuse, overuse or misuse or when there is a risk of addiction and monitoring is important.[18] Exceptions to this are when no other person with access to that information is available to prescribe without unsafe delay and it is necessary to:

- **a** avoid serious deterioration in health or avoid serious harm
- **b** ensure continuity of treatment where a patient is unexpectedly without access to medication for a limited period.

Prescribing at the recommendation of a colleague

76 If you prescribe based on the recommendation of another doctor, nurse or other healthcare professional, you must be satisfied that the prescription is needed, appropriate for the patient and within the limits of your competence.

17 See MHRA safety drug update on opioids and risk of dependence and addiction.

Obtaining a patient's consent

50 You should be proportionate when obtaining a patient's consent. For most prescribing decisions, you can rely on a patient's verbal consent, as long as you are satisfied that they've had the opportunity to consider any relevant information and decided to go ahead. Sometimes a patient's signature is required on a form, for example to comply with an MHRA drug safety alert about a medicine with serious side effects.

NICE National Institute for Health and Care Excellence

NICE guideline

Shared decision making

NICE guideline
Published: 17 June 2021
www.nice.org.uk/guidance/ng197

The BRAN acronym

ChoosingWisely UK

NHS

Make the most of your appointment

It can be a bit daunting having an appointment – but asking your healthcare professional the four **BRAN** questions can help you make the right choice for you.

Benefits

What are the Benefits?

Risks

What are the Risks?

Alternatives

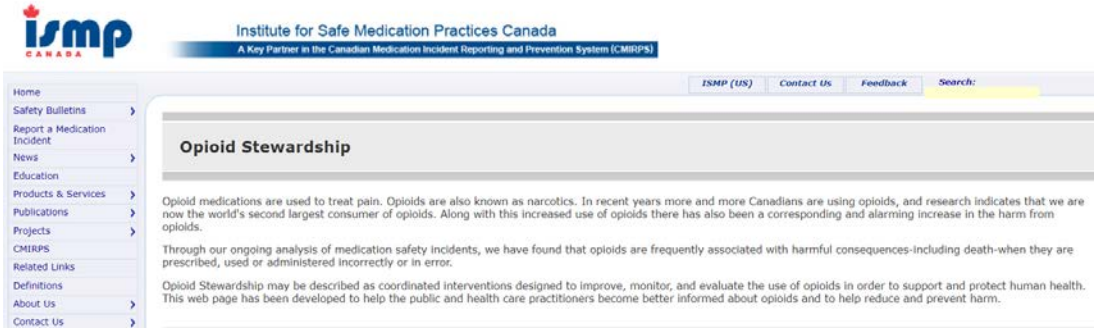
What are the Alternatives?

Nothing

What if I do Nothing?

Aims

- Define NMP prescribing roles
- Define opioid stewardship
- Discuss ORADEs and the need for opioid stewardship
- Discuss drivers for opioid use and misuse
- Discuss new international , MHRA and GMC guidance
- Discuss components of opioid stewardship



Avoiding the known risk factors

- Unrealistic expectations
- Aiming for reduction in unidimensional pain intensity scores
- Use of modified release opioids
- Repeat prescriptions
- Long duration

Components of opioid stewardship

1. Research
2. Education of prescribers
3. Education of Patients and carers
4. Realistic expectations
5. Treat opioid prescriptions for non-cancer pain as a course
6. Avoid repeat prescriptions
7. Avoid co-prescribing with other sedatives
8. Avoid long duration
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12. Avoid opioid diversion
13. Review

Need to implement effective strategies

SOFA

The Society for Opioid Free Anesthesia

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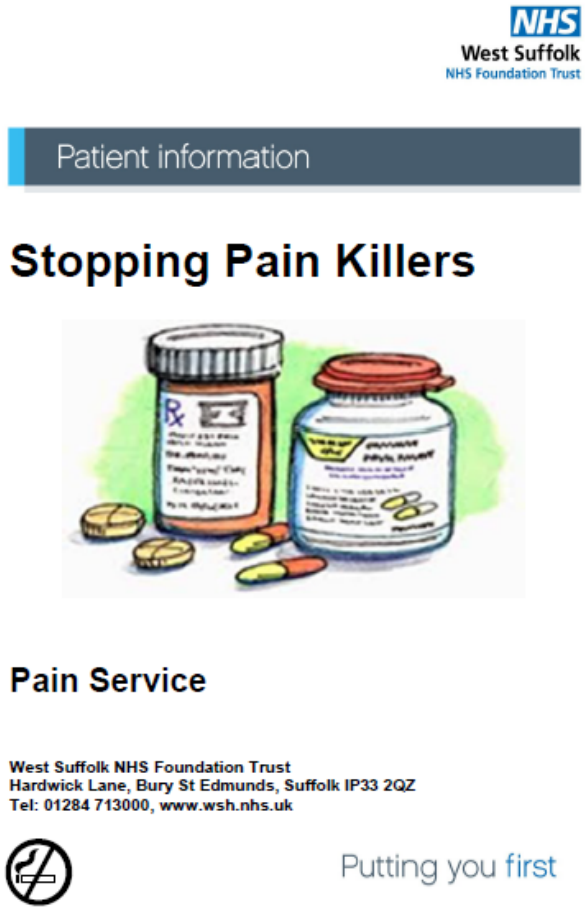
Deprescribing Advice

- Expectation to stop opioids
- How to stop opioids



NHS
West Suffolk
NHS Foundation Trust

Patient information

Stopping Pain Killers

Pain Service

West Suffolk NHS Foundation Trust
Hardwick Lane, Bury St Edmunds, Suffolk IP33 2QZ
Tel: 01284 713000, www.wsh.nhs.uk

Putting you first

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Realistic expectations

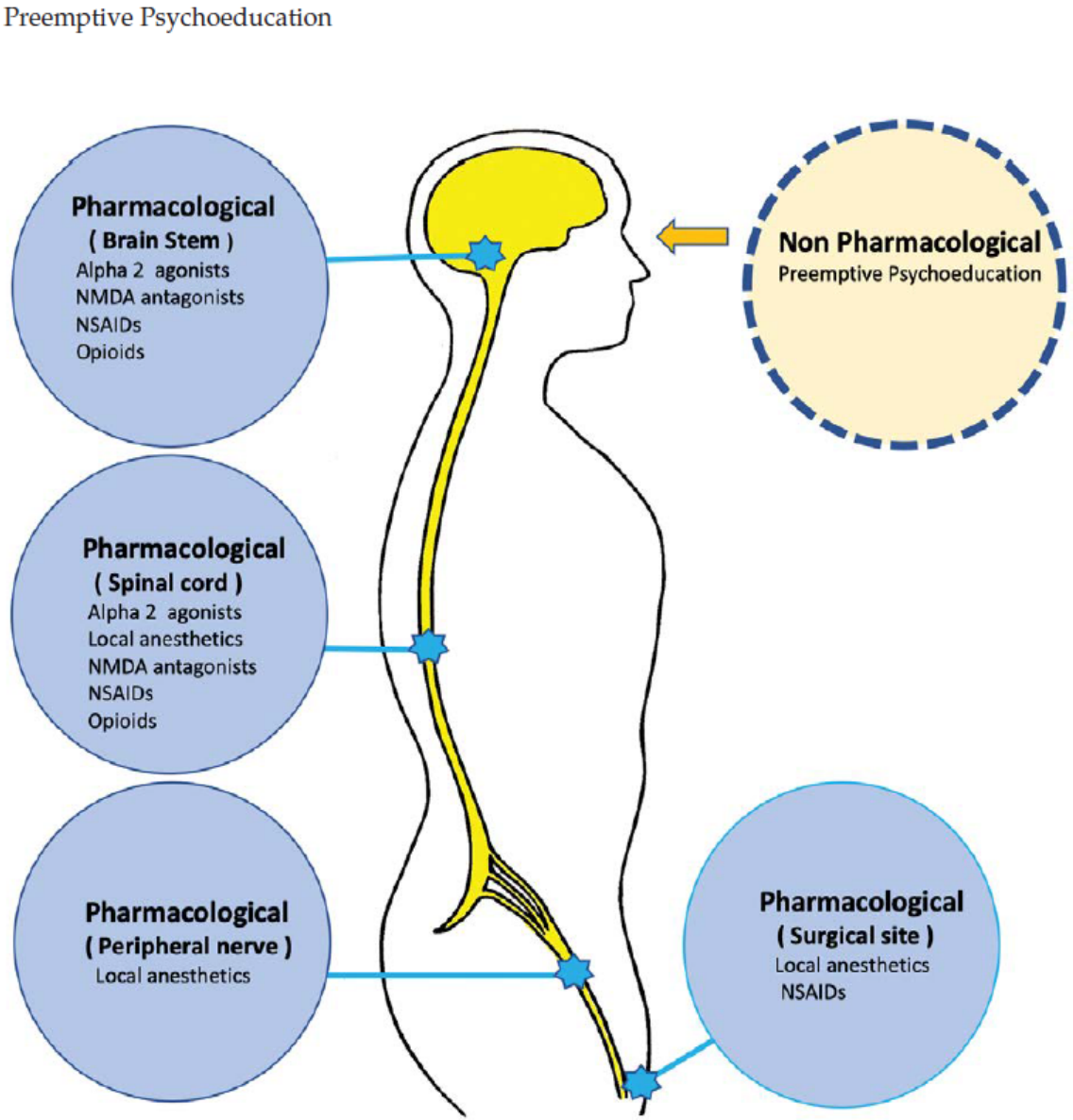

Figure. Schematic diagram of non-pharmacological preemptive pain psychoeducation as a part of multimodal perioperative pain control option. NMDA indicates *N*-methyl-D-aspartate; NSAID, nonsteroidal anti-inflammatory drugs.

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Opioids must be considered a course of treatment

Drug Safety Update

MHRA

Advice for healthcare professionals:

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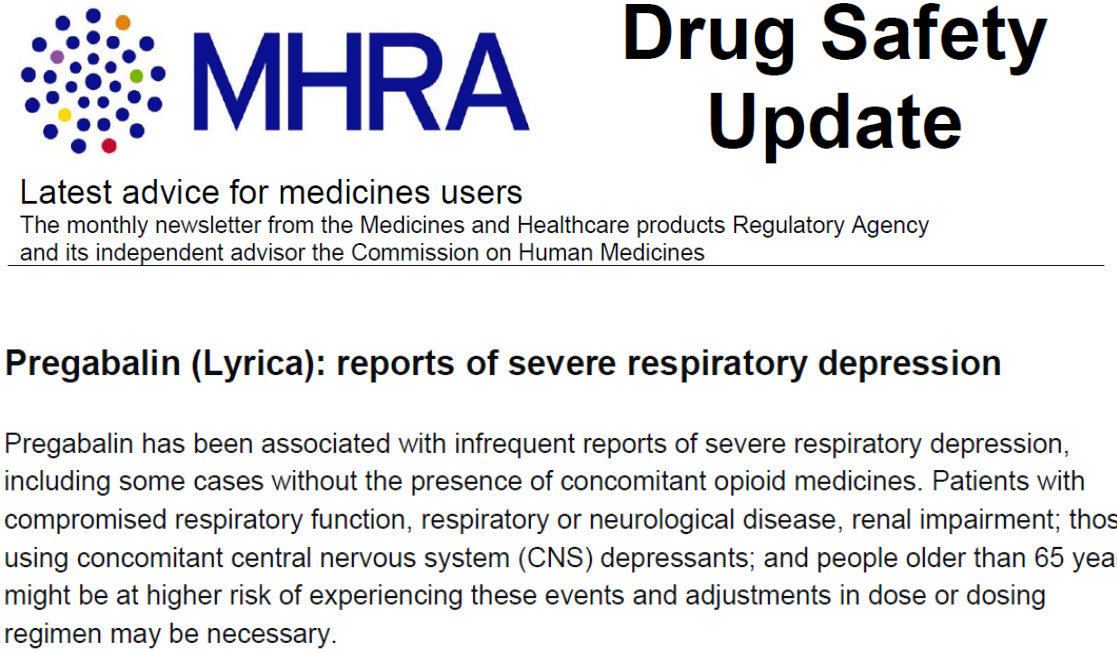
Opioid induced ventilatory impairment

- More than just respiratory depression
- Relaxation of upper airway
- Depression of consciousness
- Compounded by other sedatives eg gabapentinoids



MHRA

Drug Safety Update

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Pregabalin (Lyrica): reports of severe respiratory depression

Pregabalin has been associated with infrequent reports of severe respiratory depression, including some cases without the presence of concomitant opioid medicines. Patients with compromised respiratory function, respiratory or neurological disease, renal impairment; those using concomitant central nervous system (CNS) depressants; and people older than 65 years might be at higher risk of experiencing these events and adjustments in dose or dosing regimen may be necessary.

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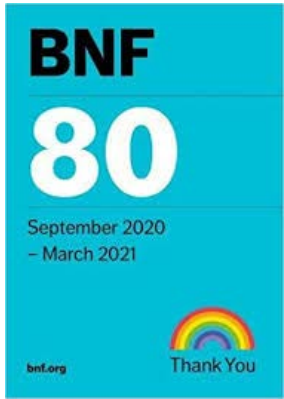
Driving under the influence of prescription opioids

Driving and skilled tasks

Drowsiness may affect performance of skilled tasks (e.g. driving); effects of alcohol enhanced. Driving at the start of therapy with opioid analgesics, and following dose changes, should be avoided.

For information on 2015 legislation regarding driving whilst taking certain controlled drugs, including opioids, see *Drugs and driving* under Guidance on prescribing.



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Preventing harm from opioid diversion

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Safe Disposal

- Patients should be advised on safe disposal of unused opioids and directed to avoid opioid diversion to other individuals

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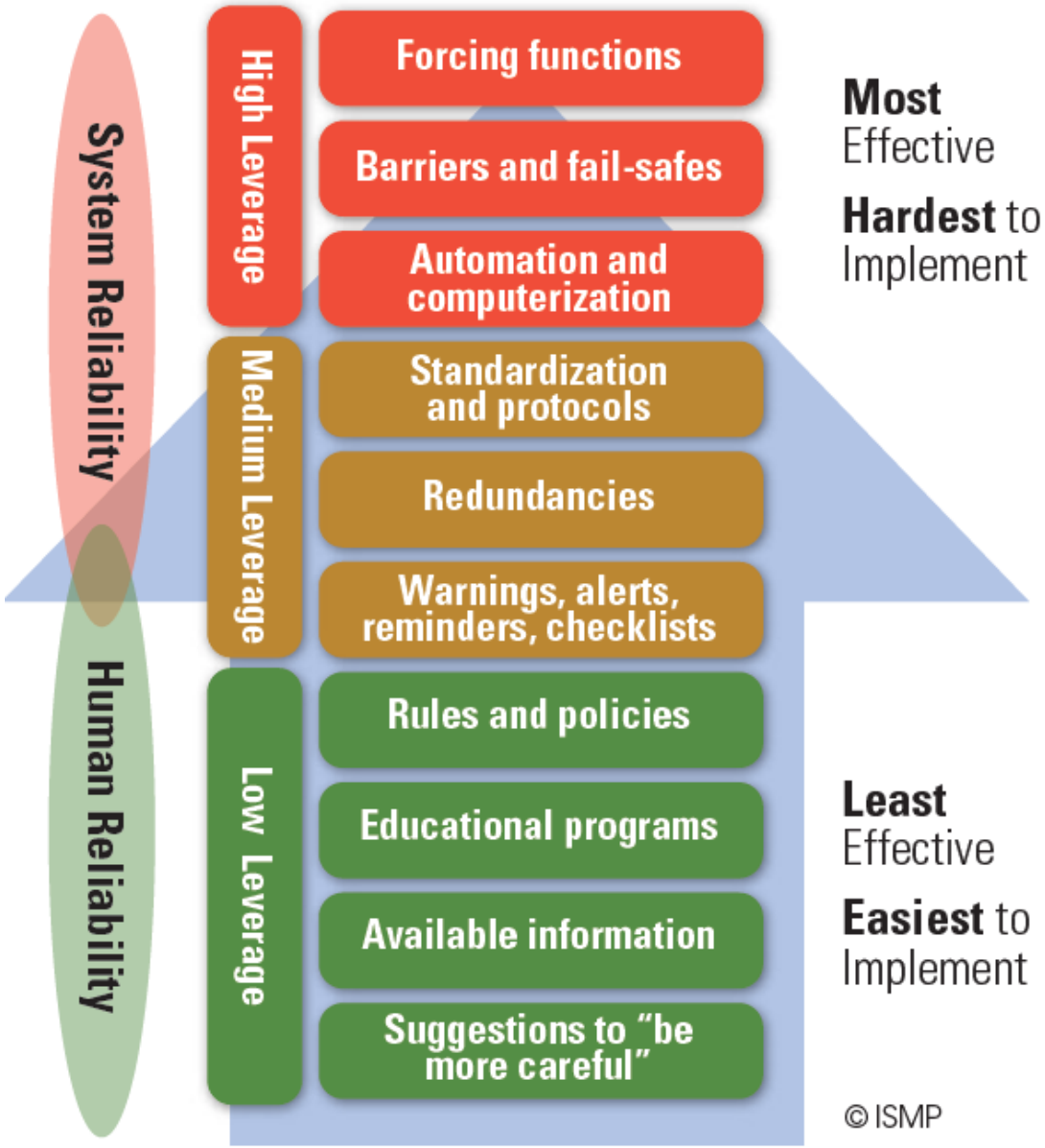
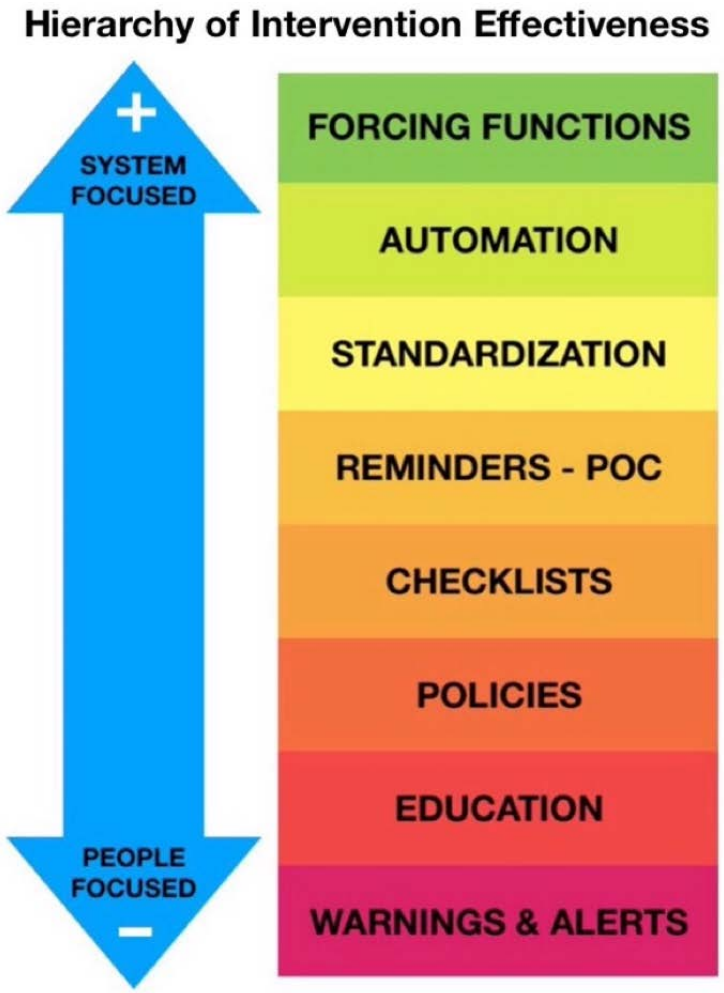
Implementing opioid stewardship



Human factors and forcing functions



forcing function

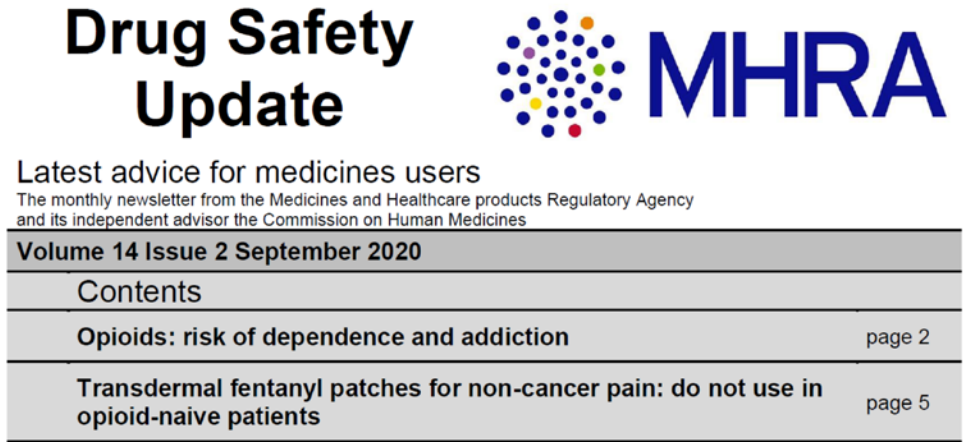
mechanisms built into the workflow to prevent specific errors or reduce their impact

Examples of Human factor engineering in healthcare to reduce errors

- Checklists
- CPOE SYSTEM
  (Computerized physician order entry)
- Color Coding of Medical gasses adaptor
- Barcode medication administration system.
- Forcing functions : Removal of concentrated potassium from general wards

Summary

- Define NMP prescribing roles
- Define opioid stewardship
- Discuss ORADEs and the need for opioid stewardship
- Discuss drivers for opioid use and misuse
- Discuss components of opioid stewardship
- Discuss new international , MHRA and GMC guidance



Take home messages

1. Limit duration and agree end date (course of treatment)
2. No repeat prescriptions and no modified-release opioids
3. Regular assessment
4. Through SDM ensure patients are aware of BRAN
5. Promote safe storage and disposal
6. Avoid drug driving, opioid diversion
7. Work with others