

Administration of opioids to adult patients in the acute hospital setting

Key Points

- **This guideline is for use in adult patients only.**
- Opioids are powerful pain-relieving medications with potentially dangerous side effects
- Intravenous administration carries the highest risk of complication but by any route these drugs have the potential to cause harm.
- Staff administering opioids should be competent to do so.
- The care environment of the patient receiving opioids should enable close monitoring with early recognition and prompt treatment of side effects.
- The patient's co-morbidities such as renal impairment must be considered when prescribing opioids.
- Safe stewardship of opioids must be observed to reduce the potential of diversion, misuse, dependence, or addiction.
- Opioids are controlled drugs and should be stored and disposed of in accordance with policies and regulations.
- **The use of opioids in Palliative care to manage chronic malignant pain may differ. See the [Frimley ICS Adult Palliative Care Symptom Control Guidelines](#) on the guidelines site.**

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This is a controlled document. If you are using a printed copy, check it against the guidelines site to ensure you are using the latest edition.

Abbreviations

BD	Twice a day
ED	Emergency Department
EPR	Electronic Patient Record (In FHFT this is EPIC)
FHFT	Frimley Health NHS Foundation Trust
FPH	Frimley Park Hospital
GP	General Practitioner
GIRFT	Get It Right First Time (Guidelines)
HWD	Heatherwood Hospital
HWPH	Heatherwood and Wexham Park Hospitals
i.e.	that is
ICU	Intensive Care Unit
IM	Intramuscular
IV	Intravenous
MAR	Medications Administration Record
NNP	Night Nurse Practitioner
PCA	Patient Controlled Analgesia
PACU	Post Anaesthetic Care Unit
PO	by mouth
PRN	as required
QDS	Four times a day
RR	Respiratory rate
RMO	Resident Medical Officer
SpO2	Oxygen saturation
TDS	Three times a day
WPH	Wexham Park Hospital

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1. Introduction

Opioids are powerful pain-relieving medications and may be useful in the management of severe acute pain when given by competent health care professionals. The following points should be remembered¹:

- Opioids are very good analgesics for acute pain and for pain at the end of life but there is little evidence that they are helpful for long term pain.
- A small proportion of people may obtain good pain relief with opioids in the long-term if the dose can be kept low and especially if their use is intermittent (however it is difficult to identify these people at the point of opioid initiation).
- The risk of harm increases substantially at doses above an oral morphine equivalent of 90mg/day, but there is no increased benefit. Tapering or stopping high dose opioids needs careful planning and collaboration.
- If a patient has pain that remains severe despite opioid treatment it means they are not working and should be stopped, even if no other treatment is available.
- Chronic pain is very complex and if patients have refractory and disabling symptoms, particularly if they are on high opioid doses, a very detailed assessment of the many emotional influences on their pain experience is essential.

2. How do opioids work?

Opioids bind to receptors in the brain, spinal cord, and periphery, and can be administered systemically or locally (e.g., intrathecal, intra-articular). Opioid medications can have a similar effect to the body's own naturally produced endorphins. They act on the opioid receptors in the body to produce a feeling of well-being and comfort. While opioids are conventionally regarded as acting on opioid receptors, some opioids achieve analgesic effects by additional mechanisms or via alternate interactions with opioid receptors. The first of this class to be labelled as an "atypical opioid" was tramadol with its effects on noradrenergic and serotonergic inhibitory systems on top of a weak opioid receptor-agonism².

3. How might opioids be given³?

Opioids are available in a variety of formulations and can be given via a variety of routes. By whichever route they are given all opioids have the same side effects- see table 1. Patients should be closely observed for side effects, and these should be managed proactively.

Opioid therapy should be streamlined with just a single formulation given regularly and a single formulation as required.

High dose opioid ampoules such as morphine sulfate 30mg/ml and oxycodone 50 mg/ml should not be routinely stocked in clinical areas. They are for palliative care use only and should not be in general circulation. Any excess supply remaining after palliative care use should be returned to pharmacy.

Consideration of the patient's co-morbidities must be made when prescribing opioids. For example: opioid doses will need reducing in those with renal impairment.

Table 1: Side effects of opioids

Side effect	Management
Sedation	Observe closely, reduce opioid
Respiratory depression	Naloxone if RR $\leq$ 8/min (see Naloxone guideline)
Nausea & vomiting	Antiemetics
Dizziness	Reduce opioid, care when mobilising
Urinary retention	Bladder scan and catheter if required
Pruritus (itching)	Reduce or switch opioid.
Constipation	Aperients
Dependence	Lowest dose for shortest time
Tolerance	Opioid switching
Addiction	High quality stewardship and prescribing
Impaired immune system	Switch and taper
Reduction in sex hormones	Taper
Hyperalgesia (increased sensitivity to pain)	Taper

There is growing opinion⁴ that the description of opioids as ‘weak’ or ‘strong’ is misleading as potential harm through opioid misuse is intrinsic to all opioids, whether weak or strong⁵. Despite that, this is how opioids continue to be described.

Table 2: Oral weak opioids

Name	Dose	Frequency	Comments
Codeine	30 to 60 mg	QDS	Maximum 240 mg in 24 hours
Dihydrocodeine	30 to 60 mg	QDS	Maximum 240 mg in 24 hours
Tramadol	50 to 100 mg	QDS	Maximum 400 mg in 24 hours

Table 3: Oral strong opioids

Name	Frequency/minimum interval	Comments
Morphine sulfate oral solution IR (e.g. Oramorph)	PRN max. 2 hourly	Interval may be adjusted in palliative care
Morphine sulfate IR tablet (e.g. Sevredol)	PRN max. 2 hourly	Interval may be adjusted in palliative care
Oxycodone IR liquid (e.g. OxyNorm, Shortec)	PRN max. 4 hourly	Interval may be adjusted in palliative care. Note 1.5 times as potent as oral IR morphine
Morphine sulfate MR (e.g. MST, Zomorph)	12 hourly	Do not crush or break tablets, Capsules may be opened and sprinkled on food.
Oxycodone MR (e.g. OxyContin, Longtec)	12 hourly	Do not crush or break tablets

Immediate release (IR) opioids are not normally prescribed for regular administration.

Modified release (MR) opioids are not normally prescribed for PRN administration.

Oxycodone MR has a biphasic action and approximately 30% of the dose is released immediately in the first 30-40 minutes after ingestion, therefore IR opioids should not be given within 1 hour of oxycodone MR administration.

Table 4: Transdermal opioids

Drug	Comments
Fentanyl	Range of sizes 12 to 100 micrograms/hour (applied every 3 days or 72 hours)
Buprenorphine	Range of sizes 5 to 70 micrograms per hour (patches 30 micrograms and below are applied every 7 days. Those above 35 micrograms an hour are applied every 4 days)

Table 5: Intravenous strong opioids
(These can usually be given by IM or SC as an alternative to IV)

Name	Comments
Tramadol	Dose as for oral
Morphine sulfate injection	May also be used in continuous intravenous infusion, PCA and syringe pumps delivering continuous subcutaneous infusions
Oxycodone injection	May also be used in continuous intravenous infusion, PCA and syringe pumps delivering continuous subcutaneous infusions.
Fentanyl	Used only in ED, Theatres, endoscopy, PACU and ICU
Alfentanil	Used only in ED, Theatres, endoscopy and ICU or in Palliative Care
Remifentanyl	Used only in Theatres, PACU, ICU and Maternity delivery suite.
Diamorphine	Used in ED and, very rarely, in Palliative Care

4. Intravenous opioids

These should be **titrated to pain** in **small increments** considering frailty, renal, hepatic, and respiratory function. Patients should be closely observed, and side effects recognised and treated. If patient with acute pain requires frequent IV titration or frequent IM injections and cannot tolerate oral opioids, then PCA should be considered. (A separate guideline is available for PCA.)

IV opioid titration for adult inpatients (with normal renal function) in severe acute pain

- Draw up 10mg morphine sulfate or oxycodone immediate release in a 10 ml syringe and add 9mls 0.9% sodium chloride to a total volume of 10mls (1mg morphine or oxycodone per ml).
- Consider need for antiemetic, ensure naloxone is to hand.
- Record Observations: RR, SaO₂, Pulse, BP, pain score, sedation score.
- If RR>10/min, BP>100mmHg systolic, sedation score $\leq$ 1: Administer 2mg morphine or oxycodone IV push over 30 seconds and flush cannula with 5mls 0.9% sodium chloride or suitable IV clear fluid.
- Wait 3 minutes then, if patient's condition unchanged, give another 2mg morphine or oxycodone IV.
- Check and record observations every 5 minutes.
- Continue titration every 3 to 5 minutes until the patient is comfortable or until side effects prevent further administration. **The peak effect of IV morphine or oxycodone boluses may be 15 to 20 minutes after injection.**
- If more than 20mg IV morphine or oxycodone required in a single episode, consult a senior doctor.
- Give naloxone 100 to 400 micrograms IV or IM if RR $\leq$ 8/min (2222: NEWS call for all patients given naloxone, titrate dose of naloxone to response- see Trust guidance).
- **Once IV opioid titration is complete, document the amount given in MAR.**
- Make and prescribe an onward plan for patient's analgesia (consult senior doctor, Pain Team or on-call anaesthetist if necessary). Document titration and plan in EPR.
- Ensure ward nurses are able to continue to observe patient and record observations every 30 minutes for 1 hour after titration. They should also action any onward plan.

CAUTION: IF THE PATIENT IS OLDER, FRAIL AND/OR HAS IMPAIRED RENAL, HEPATIC OR RESPIRATORY FUNCTION, SEEK SENIOR ADVICE. Older people and/or those with frailty require significantly less opioid to achieve the same level of analgesia, initial doses should be reduced to 25-50% of the doses used in young healthy people.

Ensure dose of titration is recorded in controlled drug register and any unused medication is discarded with a witness and recorded accurately.

5. Treatment of opioid overdose

- Rapid diagnosis and treatment with naloxone is key as well as treatment for any other substances taken at the same time such as alcohol, paracetamol, and recreational drugs.
- Remember the half-life of naloxone is usually shorter than the opioid taken which means repeated doses of naloxone or an infusion are likely to be required.
- Patients need to be closely observed in an appropriate clinical environment by competent staff.
- Refer to and follow Trust guidelines on opioid overdose.
- Accidental overdose in palliative care patients should be carefully managed to avoid re-emergence of pain.
- Ensure onward care environment when moving from ED is adequate to ensure close observation.

6. Recognition of patients on high dose prescription opioids

Ideally, patients should be screened for chronic pain and opioid use when seen in any encounter. This should include recording the Oral Morphine Equivalent per 24 hours (OME) of prescribed opioids. This is especially important preoperatively. Patients may need a programme of support and advice to optimise management of preoperative pain including opioid prescribing, psychological preparation, and education / expectation management. It may be necessary to refer the patient to a pain specialist for consideration of the feasibility of opioid tapering.

What is equal to what dose of oral morphine table^{3.6}.

Drug	Equivalent to
Tramadol capsules/soluble tablets 100mg	Morphine sulfate oral solution 10mg
Codeine phosphate tablets/syrup 60mg	Morphine sulfate oral solution 6mg
Buprenorphine SL tablet 200 micrograms	Morphine sulfate oral solution 20 mg
Oxycodone Immediate Release capsules/liquid 6.6mg/approx. 5mg	Morphine sulfate oral solution 10mg
Oxycodone Modified Release tablets 10mg	Morphine sulfate Modified Release 15mg
Tapentadol Modified Release tablets 50mg	Morphine sulfate Modified Release 20mg
Tapentadol Immediate Release tablets 50mg	Morphine sulfate oral solution 20mg
Morphine 10mg IV/IM/SC	Morphine sulfate oral solution 30mg

Note the above is for acute and chronic pain. Palliative care guidelines use a 2:1 conversion for IV to oral rather than a 3:1.

Transdermal opioids: Approximate equivalence with oral morphine

Oral morphine equivalent (mg/24 hours)	Transdermal buprenorphine (micrograms/hour)	Transdermal fentanyl (micrograms/hour)
12	5	
24	10	
30	20	12
60		25
84	35	
120		50
126	52.5	
168	70	
180		75
240		100

7. Patients on Opioid Substitution Therapy (OST)

Patients who are receiving substance misuse treatment may be on long-acting opioids, such as methadone or high dose buprenorphine (e.g., Subutex). If they are hospitalised acutely, their opioid requirement may change depending on nature of illness or trauma, and the following points should be considered:

- Doses of methadone or buprenorphine should be confirmed with their substance misuse programme/provider.
- Pain will need to be managed and opioid requirements may rise. One would normally avoid the use of other modified release opioids, and instead, use immediate release preparations as required.
- Early advice from pharmacy and or Inpatient Pain Team may be required.
- Methadone can be a very good painkiller, and with the involvement of the substance misuse team it may be possible to increase the dose and divide it into a BD dosing regimen (as opposed to the usual once daily substance misuse dose) to improve analgesia. (Note Palliative Care team would not manipulate methadone in this way).

See Appendix 1.

8. Patients with chronic pain

Patient with chronic pain can sometimes be on very unusual analgesic regimens when they present to acute hospital care. Usual practice would be to continue their usual regimen whilst an inpatient (unless contraindicated or unsafe). Additional immediate release opioids, as part of a multimodal regimen, could be used to manage additional acute pain needs. Any escalation to existing modified release preparations should be avoided or only undertaken after specialist advice from the Inpatient Pain Team/Palliative Care Team or Pharmacy.

If a patient has an opioid patch and is going for surgery, the patch should be left in place and the anaesthetist informed. Diathermy plates and blood pressure cuffs should not be placed over opioid patches and care should be taken not to artificially heat the patch in any other way as this may increase release of the medication.

9. Older patients and/or those with frailty

Please consult Trust guidance for managing acute pain in this group of patients. It is suggested that the wise clinician uses the smallest amount of opioid possible in this group of patients and reviews the patient before adding more. 'Start low- go slow'.

10. Patients with reduced renal function

Morphine accumulates in patients whose renal function is impaired. Oxycodone is slightly less burdensome on the kidneys. Buprenorphine (sublingual) or fentanyl (IV in anaesthetic areas or buccal/sublingual for malignant pain) may be worth considering for patients with renal failure and acute or chronic pain. Please seek specialist advice from pharmacist or pain team and consult the Trust guidelines and renal drug handbook⁷

11. Special considerations in the Emergency Department

Recognition and alleviation of pain should be a priority when treating the ill and injured. Patients with moderate and severe pain should receive adequate analgesia within 15 minutes of arrival. Patients in severe pain should be transferred to an area where they can receive appropriate intravenous, inhaled or rectal analgesia within 15 minutes of arrival. Patients in severe pain should have the effectiveness of analgesia re-evaluated within 15 minutes of receiving the first dose of analgesia.⁸

Prescribe an immediate-release opioid formulation at lowest appropriate dose, for a limited duration, for use only when required. Avoid modified-release formulation of opioids analgesics unless in exceptional circumstances, e.g., pre-existing regular use of opioids.

Patients who receive parenteral opioids should be closely observed for side effects, especially sedation and respiratory depression, **FOR A MINIMUM OF 30 MINUTES** after their last IV opioid dose. **Patients should not be transferred out of ED during this time period, unless clinical circumstances dictate otherwise (e.g., immediate need for radiology/cath lab) and/or they are being transferred to a high dependency area.** In such situations, patients **should be escorted with SpO2 and end-tidal CO2 monitoring and by staff who are competent to recognise and deal with opioid toxicity.**

Review pain management strategies regularly and adjust as function and pain intensity change. Document the outcome of the review and cessation plan. **Cease opioid if pain is not responsive to opioids.**

Safety considerations when giving opioid analgesia:

- Codeine Phosphate is available in oral preparations, 30-60mg qds is a typical adult dose. However, consider lower doses in the older patient or those with frailty. Codeine prescribed in combination with paracetamol is significantly more effective than codeine when prescribed alone.⁹
- Morphine is available as oral, intravenous, intra-muscular and subcutaneous preparations. Due to its relatively slow onset of action, the oral preparation is not recommended for acute pain control in the ED unless the patient is already taking the drug. Morphine 0.1-0.2mg/kg IV is a typical adult dose. However, a titrated dose to provide the desired response is recommended; consider lower doses in the elderly. Use with caution if the patient is at-risk of depression of airway, breathing or circulation.
- It should be noted that the use of opioids in abdominal pain does not hinder the diagnostic process¹⁰
- Opioid seeking behaviour is not uncommon in Emergency Departments. This is not only in those with active abuse but also in those with chronic pain disorders. However, if after assessment an opioid is deemed necessary, do not withhold appropriate treatment, but be aware of possible signs of dependency, such as repeat attendances, asking for treatment by different doctors, and 'losing' prescriptions etc. Emergency Departments are unlikely to start a patient's opioid addiction but can help to cultivate it. If there is a possibility of abuse, patients discharged with opioid prescriptions should have no more than 48-72hrs worth of medication prescribed.⁸

Patients who have ingested alcohol and/or prescription medication and/or recreational drugs, or those who have required naloxone (especially a naloxone infusion) will need their onward care environment selecting carefully. It may be necessary to arrange transfer to a high dependency care area to ensure appropriate monitoring and ongoing care. Transfer of these patients should be made with an appropriately competent staff member as an escort.

12. Opioids in Pregnancy and when breast feeding

Opioids readily cross the placenta, therefore if used during pregnancy neonates may become dependent and experience neonatal abstinence syndrome at birth. Extra vigilance is required, and appropriate treatment should be made available. Foetal movements may be reduced in response to opioids¹¹, and women should be warned about this and told to escalate concerns to their midwife.

If opioids need to be used while breast feeding, advice can be obtained from the Specialist Pharmacy Service: www.sps.nhs.uk who recommend dihydrocodeine, tramadol or morphine providing infant is healthy and full-term. The metabolites of opioids are excreted in breast milk and therefore those who are breast feeding may be advised to avoid taking opioids while feeding or 'pump and dump' the milk.

13. Using opioids after surgery

Some areas utilise GIRFT protocols which include modified release opioids for a fixed timespan after surgery. However, where possible, the International Consensus Statement¹² on opioids should be followed:

1. All patients undergoing surgery should be assumed to be at risk of developing persistent postoperative opioid use and opioid-induced ventilatory impairment. They may need interventions to mitigate those risks.
2. 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, both in hospital and after discharge.
3. Provision of opioid analgesia should be guided by functional outcomes, rather than unidimensional pain scores alone.
4. Multimodal analgesia should be optimised, and patients educated about the use of non-pharmacological and non-opioid analgesia to reduce the amount and duration of opioids required to restore function.
5. Long-acting opioids should not be used routinely for acute postoperative pain.
6. 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.
7. Automated post-discharge repeat prescriptions for opioids should be avoided. Perform a patient review if more opioids are requested.
8. Hospitals should have strategies to mitigate the occurrence of opioid-induced ventilatory impairment. Specifically, all inpatients receiving postoperative opioids must have their level of sedation assessed at appropriate and repeated intervals.
9. Modifiable factors that have been identified as increasing the risk of opioid-induced ventilatory impairment and persistent postoperative opioid use should be addressed. These factors include medicines with sedative properties, long-acting opioids, and reliance on unidimensional pain scores alone to guide prescribing and titration.
10. Patients should be advised on safe storage and disposal of unused opioids and directed to avoid opioid diversion to other individuals (e.g. sharing with friends and family).

14. Care in and discharge from PACU

Orders in EPIC are available for fentanyl, morphine and oxycodone intravenous titrations.

Order and Order Set Search						
PACU						
Order Sets, Panels, & Pathways						
Phase of C...	Name	Dose	Freq...	Disp...	Ref	End...
	Adult Anaesthesia Postprocedure Orders					
	Adult Anaesthesia THR/TKR/UKR - GIRFT Postprocedure Orders					

During Visit Drugs					
Name	Default Dose	Default Route	Default Frequency	Phase of Care	Pref List
Fentanyl injection 10 micrograms/mL (PACU/ICU/Pain Nurses only)	10-25 microgra...	Intravenous	As needed		FHFT RX INPATIENT...
morphine sulfate injection 1 mg/mL (PACU/ICU/Pain Nurses only)	2 mg	Intravenous	Every 5 min PRN		FHFT RX INPATIENT...
oxycodone injection 1 mg/mL (PACU/ICU/Pain Nurses only)	2 mg	Intravenous	Every 5 min PRN		FHFT RX INPATIENT...

Note: the maximum cumulative amount of fentanyl in a titration episode is 100 micrograms, morphine 20mg, oxycodone 20 mg. If more is required, medical advice must be sought.

Ensure dose of titration is recorded in controlled drug register and any unused medication is discarded with a witness and recorded accurately.

See Appendix 2 for suggested fentanyl bolus protocol.

Patients who have had IV opioid titration in the PACU area should not be discharged from PACU unless cardiovascularly stable, comfortable and with a respiratory rate of 10 breaths per minute or more. Generally, this means that **patients should not leave PACU until at least 30 minutes after their last IV opioid bolus.**

15. Switching opioids

The FPM, 2022¹ give this advice:

- Switching from one opioid to another should only be recommended or supervised by a healthcare practitioner with adequate competence and sufficient experience. If uncertain, ask for advice from a more experienced practitioner.
- Opioid rotation or switching may be considered if a patient obtains pain relief with one opioid but is suffering severe adverse effects.
- When converting from one opioid to another, the initial dose depends on the relative potency of the two drugs and route of administration.
- An individualised approach is necessary.
- Conversion factors are an approximate guide only because comprehensive data are lacking and there is significant inter-individual variation.
- In most cases, when switching between different opioids, the calculated dose-equivalent must be reduced to ensure safety. The starting point for dose reduction from the calculated equi-analgesic dose is around 25-50%.
- A dose reduction of at least 50% is recommended when switching at high doses (e.g. oral morphine or equivalent doses of 500mg/24 hours or more), in older patients or those with frailty, or because of intolerable undesirable effects.
- The half-life and time to onset of action of the two drugs need to be considered when converting so that the patient does not experience breakthrough pain or receive too much opioid during the conversion period.

- Once the conversion has occurred, the dose of new opioid should be titrated carefully according to individual response and the patient monitored closely for side effects and efficacy, especially when switching at high doses.
- Withdrawal symptoms (e.g. sweating, yawning and abdominal cramps, restlessness, anxiety) occur if an opioid is stopped/dose reduced abruptly.

16. Tapering opioids

When pain is unresponsive to opioids patients should not continue with this therapy. Chronic pain and neuropathic pain are generally unresponsive to opioids. Tapering of opioids needs to be done slowly at an individualised pace for the patient. The patient and their GP may require ongoing support from the pain clinic.

17. Discharging patients on opioids

- Patients should always be discharged with the medication they require to be comfortable and recover.
- If a new opioid therapy was started in hospital, it is vital that this is explained in the discharge summary and to the patient /carers.
- Ideally patients should be tapered off unnecessary opioids before they are discharged but discharge should not be delayed by this.
- If it is necessary to discharge the patient on a temporary dose of an immediate release opioid, such as morphine sulfate oral solution, then the expectation should be set with the patient that this is not to become a permanent medication for them, and it will need to be tapered off after a short period of time. In this instance a limited amount should be prescribed (maximum 2 weeks only).
- If there is a possibility of abuse, any patient discharged with opioid TTOs should be prescribed and dispensed with no more than 48-72hrs worth of medication⁸.

18. Opioid stewardship

Safe and effective management of opioids is everyone's responsibility. All staff should adhere to the Trust's Medicines Policy and the law surrounding controlled drugs¹³. The Trust's accountable officer for controlled drugs is the Chief Pharmacist. Levy et al in their article on the UK recommendations on opioid stewardship¹⁴ describe:

Opioids were prescribed to roughly 5% of the UK population in 2015. Between 1998 and 2016, opioid prescriptions increased by 34% in England, and the total oral morphine equivalence dose increased by 127% to 431 000 mg/1000 population/year. A recent UK study found that 14.6% of people given opioids for the first time became long term opioid users within a year.

In response to this healthcare crisis, the UK Medicines and Healthcare Products Regulatory Agency (MHRA) has issued recommendations¹⁵ that before prescribing opioids, clinicians must discuss the risks and features of tolerance, dependence, and addiction with patients, and jointly agree a treatment strategy and plan for the end of treatment. The UK General Medical Council¹⁶ advises that clinicians should comply with MHRA recommendations along with other guidance, making compliance a professional duty. The MHRA has produced a safety leaflet on opioid medicines to help patients and their families reduce the risk of harm¹⁷ - see appendix 3.

19. Where to get help

- Pharmacy
- The Trust's Inpatient/Acute Pain Teams. and Palliative Care Team are all available to support staff in caring for patients and to support patients. Consults can be ordered via EPIC but for more immediate advice and support bleep or phone them.
- Critical Care Outreach Team
- RMO at Heatherwood Hospital
- The Outpatient Chronic Pain Team can be contacted via their admin team email fhft.pain.clinic@nhs.net or by phoning x134201 option 4 option 4.

At Frimley Park Hospital

- **Inpatient Pain Team** via EPIC or on Bleep **5252** or **X134571** (Monday – Saturday 08.30-16.30)
 - Out of hours contact on-call anaesthetist on Bleep **5002** (escalate to On-call consultant anaesthetist via switchboard if no response)
- Inpatient Palliative Care Team Bleep **5799** or **X136755** (Monday to Sunday 08:30-16:30)
 - Out of hours doctors may contact Consultant on call via switchboard.
- **Critical Care Outreach Nurse Practitioner** on Bleep **5467**
- **Night Nurse Practitioner (NNP)** on Bleep **5454**

At Heatherwood* and Wexham Park Hospitals

- **Inpatient Pain Team WPH** via EPIC or on Bleep **4820** or **X154435** (Monday – Friday 08.30-16.30)
 - Out of hours contact on-call anaesthetist on **07768463877** (escalate to on-call consultant anaesthetist via switchboard if no response)
- **Inpatient Pain Nurse HWD** via EPIC or **07776633562** (Tuesday to Saturday 08:30-14:30/16:30) or contact WPH team as above
- **Inpatient Palliative Care Team X154789 or mobile 07766367058** (Monday to Sunday 08:30-16:30)
 - Out of hours doctors may contact On Call Consultant on call via switchboard.
- **Critical Care Outreach Nurse Practitioner** on Bleep **4186**
- **Clinical Site Manager** Bleep through switchboard

***Note:** at HWD, Farnham and Heathlands the palliative care service is provided via the FPH team.

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Appendix 1: Pain management in those with substance misuse¹

Inadequate acute pain management increases likelihood of:

- delayed recovery
- relapse to addiction
- recourse to illicit drug use

Risks to acute pain management in current opioid addicts include:

- Self-discharge because of poor analgesia
- Self-medication
- Sedation/overdose when tolerance to opioids is uncertain and when patients are using additional centrally active medications
- Diversion and misuse of drugs prescribed for acute pain

Principles of good pain management are underpinned by:

- Empathic communication with the patient and reassurance that pain will be managed optimally
- Comprehensive assessment including physical and emotional comorbidities
- **Liaison with other healthcare providers and those supporting the patient**
- **Objective confirmation of substance misuse**
- Prompt provision of appropriate opioid therapy to avoid withdrawal
- Assessment and management of anxiety
- Use of multimodal analgesia including analgesic drugs of different classes, local anaesthesia, and general measures to minimise pain
- Clear plan for dose tapering as acute pain subsides

Acute pain management in patients receiving opioid substitution therapy (OST)

- Patients need on-going reassurance that their pain will be assessed and managed appropriately
- OST used to attenuate opioid withdrawal does not provide analgesia for acute pain
- The existing opioid substitution regimen should be continued
- Opioids for analgesia need to be prescribe in addition to the patient's maintenance regimen
- The patient on substitution therapy is likely to be tolerant to the effects of opioids, so may need larger than usual doses
- Patients may have increased pain sensitivity associated with their prolonged exposure to opioids
- Communication with other members of healthcare team including drug services and the patient's GP must be maintained

For patients on methadone:

- Split the dose and administer twice or three times daily
- Titrate additional analgesia to effect

For patients on buprenorphine:

- Split the dose and administer twice or three times daily
- Titrate additional analgesia or
- Discontinue and provide alternative analgesia
- Change to methadone

Acute pain management in patients in recovery from opioid addiction: important considerations

- Risk of relapse may occur both with use of opioids **AND** under-treatment of pain
- Use non-opioid interventions where possible
- Careful explanation of the risks and benefits of the proposed treatment plan should be discussed with the patient
- Anxiety should be assessed and managed, if necessary, with medication
- Patients may have strongly held beliefs regarding opioid therapy, and these should be respected

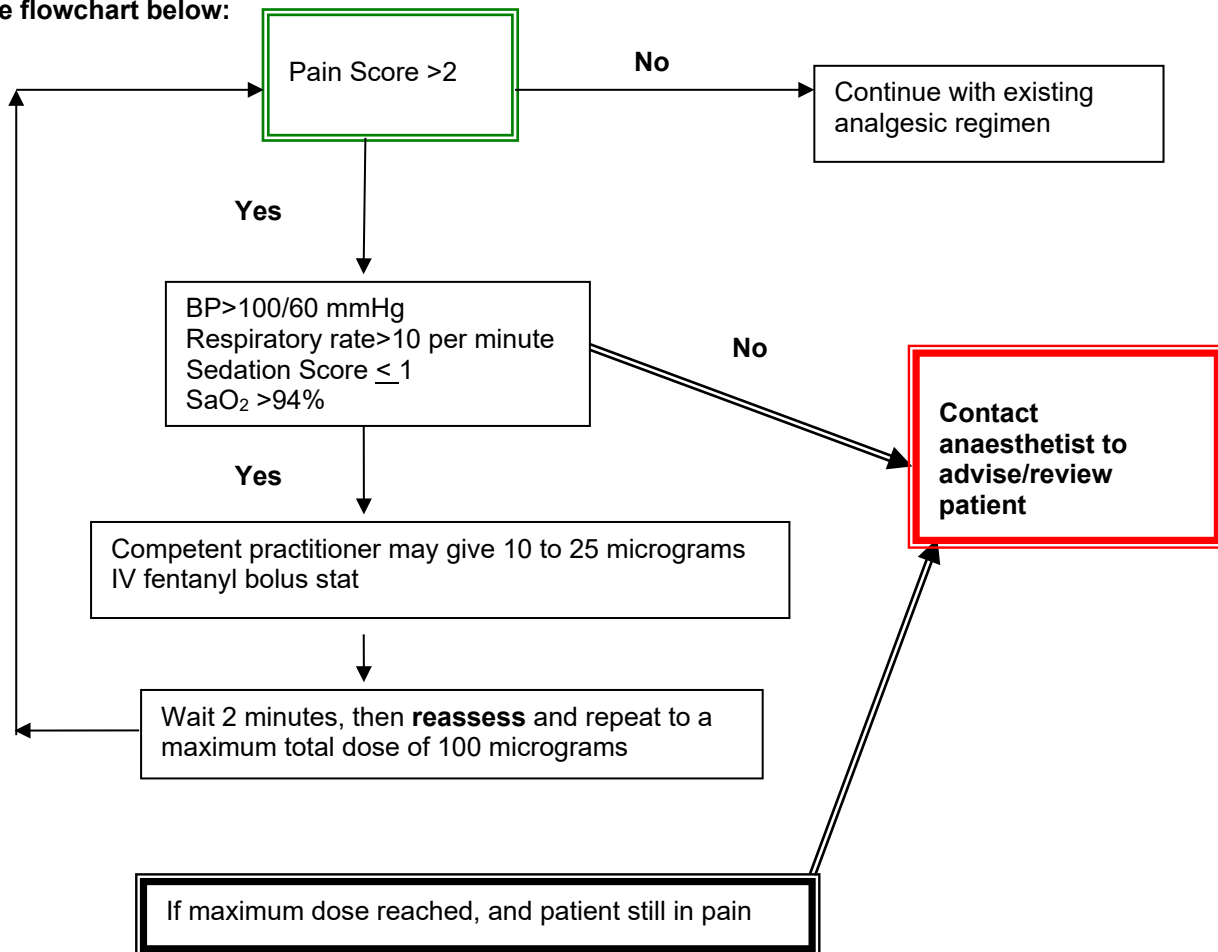
Appendix 2: Protocol for the administration of intravenous fentanyl boluses for analgesia, to adult patients, by competent practitioners in the Post Anaesthetic Care Unit (PACU) and endoscopy.

Fentanyl bolus must be prescribed in the drug MAR by an anaesthetist.

Fentanyl should be prepared as follows:

- 100 micrograms of fentanyl in 2 ml ampoule drawn up in a 2 ml syringe.
- 10 ml syringe with 8mls of 0.9% sodium chloride.
- Add fentanyl to 0.9% sodium chloride.
- Each 1ml contains 10 micrograms of fentanyl.
- Syringe must be labelled.

Use the flowchart below:



Pain Score

- 0 = no pain
- 1 = mild pain
- 2 = moderate pain
- 3 = severe pain
- 4 = worst pain imaginable

Sedation Score

- 0 = none
- 1 = mild (occasionally drowsy, easy to rouse)
- 2 = moderate (frequently drowsy, easy to rouse)
- 3 = severe (somnolent, difficult to rouse)
- S = normal night-time sleep (easy to rouse)

Patient must have onward analgesic plan

Patient must not go to the ward until 30 minutes after last fentanyl bolus

Appendix 3: Patient leaflet: Opioid medicines and the risk of addiction¹⁴.

This safety leaflet is to help support you in using opioid medicines safely. Please keep it in a safe place.

Patients, family, friends, and carers can play an important role in the safe use of these medicines and in reducing the risk of harm. Please share this information with them.

Opioid medicines and the risks

Opioids are a type of medicine that help relieve pain. They are very effective over short periods to relieve moderate to severe pain. They are also sometimes prescribed for long periods to relieve pain in serious conditions. Examples of opioids include codeine (including co-codamol), tramadol, fentanyl, oxycodone and morphine.

Opioids have a serious risk of addiction, especially with long-term use. The person who prescribed an opioid or your pharmacist should explain how long it is safe for you to take your medicine for.

For further information on using opioids safely, and a full list of possible side effects, read the Patient Information Leaflet (PIL) that came with your medicine, and keep it handy. PILs for each opioid are also available on the [MHRA's website](#).

Taking opioid medicine safely

Only take the medicine as directed.

- Do not increase the dose or take an extra dose
- Do not take any other medicines that contain opioids to “top up” your pain relief
- Do not take opioid medicines if you are pregnant without health professional advice

Do not do any of these without advice from the person who prescribed the medicine or from a pharmacist. Taking more than you should, can lead to overdose.

Babies born to women who took opioids during pregnancy may need to be carefully monitored for withdrawal effects after birth. Talk to your doctor or midwife if you are worried.

If you have any questions about your opioid medicine or side effects, or if you do not understand how to take your medicine, talk to the person who prescribed your opioid medicine or to a pharmacist. Keep talking to them about your pain – there may be different treatments that can help.

- Do not allow others to take any opioid medicines given to you. Your medicine has been prescribed or specifically recommended for you by your doctor or pharmacist and can be dangerous if taken by other people – it could even cause fatal overdose.
- Always keep medicines out of sight and reach of children.

Signs of addiction and what to do

Addiction can happen gradually. It can make you feel that you are no longer in control of how much medicine you need to take or how often you need to take it. You might feel that you need to carry on taking your medicine, even when it doesn't help to relieve your pain.

If your pain is becoming difficult to manage, talk to your doctor. Your body may have stopped sensing the pain-relieving effect of your opioid. This is called ‘opioid tolerance’. It could be an early warning sign that you are at risk of becoming addicted.

Signs that you may be addicted to opioids include:

- Craving for the medicine
- Feeling that you need to take more medicine than prescribed or as instructed on the pack, even though the medicine is causing unwanted effects on your overall health (for example, some of the withdrawal side effects in the next section)
- Feeling that you need to take additional medicines containing opioids or other pain relief medicines to achieve the same relief

- Taking opioid medicines for reasons other than pain relief: for instance, to ‘stay calm’ or ‘help you sleep’
- Experiencing withdrawal side effects when you stop taking the medicine suddenly (see below).

If you notice any of the above, talk to your doctor or a pharmacist.

Safely stopping opioid medicines

If you have been taking your opioid medicine for a long time, do not stop taking it suddenly because this may cause unpleasant withdrawal side effects. It is important to get the right help and support when you are ready to stop taking your medicine.

Talk to your doctor, nurse, or a pharmacist.

They will be able to help you to come off your opioid medicine slowly to reduce unpleasant withdrawal side effects. Safely coming off opioids can take a long time. Every person is different. Take any unused opioids back to a pharmacy for safe disposal.

Withdrawal side effects may include a combination of the following:

- Shivers
- Diarrhoea
- Difficulty sleeping
- Sweating
- Widespread or increased pain
- Body aches
- Irritability and agitation
- Nausea and vomiting

If you experience any of these talk to the person who prescribed your medicine or a pharmacist.

Effects of taking too much opioid medicine

Taking too much opioid medicine is called an overdose, whether it’s intentional or not. This can be very serious and may cause death.

Some of the signs of an overdose include:

- Confusion or hallucinations
- Slurred speech
- Lips or fingernails are blue or purple
- Poor coordination or balance
- Unresponsive or unconscious
- Heavy or unusual snoring
- Difficulty breathing or no breathing
- Very small pupils in the eyes

Your family, friends, and carers should know these signs so they can take immediate action.

If you think that you or someone else has taken too much of their opioid medicine, dial 999 immediately.

If you experience side effects to your opioid medicines you can report these directly to the Medicines and Healthcare products Regulatory Agency on the [Yellow Card website](#), via the free apps (‘Yellow Card Scheme’ in the Google Play Store or ‘Yellow Card – MHRA’ in the Apple App Store), or by phoning the free phoneline (0800 731 6789).

Full Version Control

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This guideline has been registered with the trust. However, clinical guidelines are guidelines only. The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician. If in doubt, contact a senior colleague or expert. Caution is advised when using guidelines after the review date. This guideline is for use in Frimley Health Trust hospitals only. Any use outside this location will not be supported by the Trust and will be at the risk of the individual using it.

Version History

Version	Date	Guideline Lead(s)	Status	Comment
0.1	07/10/22-01/01/2024	Dr Marcus Peck Karin Cannons	Drafts 0.1-0.6	Drafts sent to all stakeholders and developed with their comments
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1.2	Mar 2026	Karin Cannons	interim	Updating of reference 1 and dose of concern's of harm to 90mg P4

Related Documents

Document Type	Document Name
Policy	Trust Medicines policy
Guidelines	Management of Opioid Induced Respiratory Depression
	PCA for Teenage and Adult Patients
	Frimley ICS Adult Symptom Control Guidelines in Palliative Care
	Opioid pocket card for doctors/prescribers
	Optimising analgesia for adult inpatients with acute pain
	Acute pain in older patients and/or those with frailty
	Opioid induced constipation
	Pain management in adult inpatients following lower limb amputation