

ISMP Canada Safety Bulletin

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Safer Decisions Save Lives: Key Opioid Prescribing Messages for Community Practitioners

- *Do not prescribe potent opioids for minor pain.*
- *Chronic opioid therapy should be reserved for chronic pain that impairs daily function and has not responded to non-opioid treatments.*
- *If opioid therapy is chosen, it should be treated as a therapeutic trial. Prepare patients for the possibility that therapy will be discontinued if it is ineffective or there is evidence of harm.*
- *Educate patients about opioid-associated harm and prevention of overdose.*
- *Understand how to recognize opioid use disorder and how to initiate or refer a patient for treatment.*

In fall 2015, ISMP Canada brought together a panel of opioid experts from across Canada to identify prescribing and management practices likely to result in better opioid prescribing in the community, especially for treatment of chronic noncancer pain. The panel identified a number of themes on opioid prescribing and management, which were further refined into key opioid prescribing messages.* Although the practices described in these messages will be particularly helpful to community prescribers, their relevance extends to all healthcare providers in

the community, as well as regulatory colleges, legislators, and the general public.

Selection of Patients for Opioid Therapy

Do not prescribe potent opioids for patients with minor pain.

Potent opioids (e.g., morphine, oxycodone, hydromorphone) are not needed for treatment of minor pain (e.g., pain resulting from musculoskeletal injuries, minor surgery, or dental work), and their use in this context can delay a patient's return to work. These drugs are suitable for pain associated with major trauma (e.g., fractures, major surgery), but should not be prescribed for longer than the expected recovery time (usually less than 1-2 weeks). Emergency, urgent care, and walk-in clinic physicians should prescribe quantities that will last only a few days, until patients can be seen by their regular physician.

Reserve opioids for patients with severe, chronic noncancer pain that impairs daily function.

Opioids should be considered only after adequate trials of all non-opioid treatments that are appropriate for the underlying condition. Do not prescribe opioids

* This bulletin is not intended to be comprehensive and must be evaluated in the context of professional standards, regulations, and expectations. Not all evidence, knowledge, or advice may have been available or taken into account when this document was prepared, and not all possible practices informing opioid prescribing may have been considered or presented. The opinions, principles, guidelines, practices, and advice outlined in this document are not necessarily those of the project participants, the partnering organizations, or Health Canada, which funded the project.

for fibromyalgia, headache, or low back pain. There is no compelling evidence of effectiveness in these situations, the pain relief will be minimal, and any benefits are typically outweighed by side effects and risk of harm.

Prescribe opioids with caution for patients at high risk of addiction.

There are 2 major risk factors for opioid addiction:

- current or past history of alcohol or substance use disorder
- current or past history of a psychiatric disorder (including anxiety, depression, and post-traumatic stress disorder)

Do not prescribe potent opioids for high-risk patients unless they have a pain condition that interferes with daily life and has not responded to a full trial of all major pain treatments (e.g., nonsteroidal anti-inflammatory agents, antidepressants, anticonvulsants, physiotherapy and other nonpharmacologic therapies). In cases where opioids are to be prescribed for high-risk patients, avoid hydromorphone, fentanyl, and oxycodone; dispense small quantities at frequent intervals (rather than larger amounts at extended intervals); order regular urine drug screens to identify use of nonprescribed opioids, benzodiazepines, or other drugs; and educate patients and families about overdose and harm prevention.

Opioid Selection and Dosage

Treat all opioid prescribing as a therapeutic trial.

There have been no long-term (> 1 year) controlled trials of the effectiveness of opioids, and cohort studies have indicated that patients receiving long-term opioid therapy have worse pain and function outcomes than patients with similar pain conditions who are not taking opioids. Therefore, the opioid should be tapered and discontinued if it does not significantly improve pain and function at a dose of 50 mg MED[†] or if the patient experiences fatigue, sedation, or other side effects.

[†] MED = morphine equivalents/day, also known as morphine milligram equivalents (MME)/day. This is the total amount of opioid consumed in a 24-hour period, converted to the morphine-equivalent daily dose in milligrams. Potency ratios: morphine = 1, oxycodone = 1.5, hydromorphone = 5 (available from http://nationalpaincentre.mcmaster.ca/opioid/cgop_b_app_b08.html).¹

Start with weak opioids first.

Weak opioids include codeine, tramadol products, and transdermal buprenorphine. Switch to a potent opioid only if the weak opioid is ineffective. If a potent opioid is needed, use low doses of a short-acting formulation for initial titration. Avoid fentanyl. Do not prescribe benzodiazepines concurrently with opioids.

Recommend the lowest possible dose for the shortest possible time.

Low doses and slow dose titration are appropriate for all patients, but are especially important for those at risk for opioid-induced falls, sedation, and other harms. Risk factors for opioid-induced falls, sedation, and other harms include advanced age, concomitant benzodiazepine or other sedating medications, alcohol use, sleep apnea, and impairment of renal, hepatic, or respiratory function. Do not prescribe opioids for nighttime use by elderly patients who are at high risk for falls.

Advise patients about opioid-related harms and prevention of overdose.

Use patient-specific handouts, such as [Opioid Pain Medicines—Information for Patients and Families](#), to support discussion of the following issues of concern:

- impairment of ability to drive or operate machinery, especially after initiation of an opioid or after an increase in dose
- avoidance of the combination of opioids with alcohol, benzodiazepines, or illicit drugs
- the need to alert family members and friends to the initiation of opioid treatment, as well as the symptoms and signs of opioid toxicity
- the requirement for secure storage of opioids, especially if children or young adults live in the same house as the patient
- the requirement to not share opioids with others or take opioids from others
- the method for obtaining naloxone from community naloxone programs or pharmacies, where available

Keep the dose below 50 mg MED.

Most patients respond well to doses of 50 mg MED or less. For patients receiving opioid doses above 90-120 mg MED, strongly consider requesting a second opinion from another healthcare provider, and advise these patients to get a naloxone kit from the pharmacy, where available. The risk of overdose and the inherent risk of addiction increase steeply at higher doses.

Tapering Opioids

Taper the opioid dose when necessary.

Taper the dose in the following situations:

- patient has experienced no improvement in function with opioid therapy
- patient is experiencing opioid-induced sedation, depression, fatigue, sleep disturbance, or other harm
- there is a concern that the patient is experiencing opioid-induced hyperalgesia
- there is a concern that the patient may have an opioid use disorder

Consider tapering for any patients who are receiving doses above 50 MED, particularly those whose doses are over 200 MED. Many patients on higher doses will actually experience improvements in their pain, mood, and function when their dose is lowered.

Taper doses by no more than 10% of the total daily dose every 1-4 weeks. Whenever possible, use scheduled rather than as needed (PRN) doses. Dispense small quantities frequently (as often as daily), depending on the patient's adherence to the tapering schedule.

For patients who are taking high doses, do not stop the opioids suddenly.

Abrupt cessation may cause patients who are taking high doses to go into severe withdrawal. This may lead them to seek other sources of opioids, which puts them at risk of overdose and other harms.

Opioid Use Disorder: Diagnosis and Management

Know how to diagnose opioid use disorder.

The clinical features of opioid use disorder include requirement for higher doses than expected for an underlying pain condition, resistance to tapering despite poor analgesic response, alarming behaviours (e.g., patient frequently runs out early; patient accesses opioids from other sources; patient snorts, crushes, or injects oral opioids), poor psychosocial function and mood, and binge use with frequent withdrawal symptoms.

If the diagnosis is unclear, prescribers should:

- closely monitor the patient with frequent visits and urine drug screens (at least every 2 weeks)
- dispense opioids frequently (1-7 times weekly) in small quantities
- closely monitor the patient's pain and function
- refer patients to and/or seek a consult (by phone or email) with an addiction physician

If the patient has an opioid use disorder, develop and discuss the treatment plan with the patient.

Include the following messaging in your discussion of the treatment plan:

- options for initiation of buprenorphine or referral to an addiction specialist
- anticipated benefits of the treatment plan, including reduction of pain, prevention of overdose, and improvement in mood, energy level, and function

For most patients with opioid use disorder, initiate buprenorphine or refer the patient to an addiction physician for buprenorphine or methadone treatment.

Both buprenorphine and methadone have been shown to dramatically reduce opioid use, crime, and overdose. Buprenorphine can be safely prescribed and managed by family physicians.

If the patient refuses the treatment plan, and will not attend an addiction clinic, then taper the dose over 1-3 months, with frequent dispensing (as often as

daily). Continue to offer primary care, unless the patient has been abusive to office staff or other patients.

Educate patients with opioid use disorder about overdose and harm prevention.

All patients on opioids should be educated about overdose and harm prevention, in particular those with opioid use disorder. Several key points should be addressed:

For all patients taking illicit opioids or high doses of prescription opioids:

- Obtain a take-home naloxone kit. In many regions of the country, these kits are available at no cost and without a prescription, through naloxone programs or pharmacies.
- Avoid taking benzodiazepines or alcohol at the same time as the opioid.
- Use a lower dose if the opioid has not been taken for several days or more. Patients on prescribed opioids should contact their doctor for guidance.

For patients who misuse opioids (e.g., inject, crush or snort opioids, or acquire opioids from non-medical sources):

- Never use opioids alone and avoid taking benzodiazepines or alcohol at the same time as an opioid. If available, use opioids at a safe injection site.
- Give naloxone if a friend may have overdosed on opioids and call 911. Never leave the friend alone to “sleep it off”.
- Use pharmaceutical opioids obtained by prescription rather than illicit opioids obtained from other sources. Caution patients that opioids obtained from other sources may contain fentanyl and that other dangerous adulterants are often added to heroin, morphine, oxycodone, and even to cocaine or crystal methamphetamine. This further increases the risk for overdose and death, even for heavy and experienced users.

Conclusion

Opioid prescribing and management in the community are complex issues. This report summarizes key prescribing messages that aim to minimize the use of opioids and reverse their associated harm, as well as to support community prescribers in the treatment of opioid use disorder.

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Reference

1. Appendix B-8-1: Oral opioid analgesic conversion table. In: Canadian guideline for safe and effective use of opioids for chronic non-cancer pain. Hamilton (ON): National Opioid Use Guideline Group (NOUGG); 2010 [cited 2016 Nov 9]. Available from: http://nationalpaincentre.mcmaster.ca/opioid/cgop_b_app_b08.html

Eliminate Dangerous Dose Designations—Use a Leading Zero Before a Decimal

CBC.ca recently reported a [medication incident](#) that resulted in immediate harm and potential long-term complications to a young boy because he ingested a 10-fold overdose of risperidone daily over several months. The intended dose was 0.3 mL daily of risperidone solution but the dose on the prescription was written as “.3 mL daily”. The prescription was dispensed with instructions to give 3 mLs (10 times the intended dose) every day.

ISMP Canada considers lack of a leading zero to be a dangerous dose designation. Use of a trailing zero *after* a decimal can also lead to 10-fold errors. We urge all healthcare providers and electronic prescribing and dispensing system designers to avoid using dangerous dose designations to prevent errors.

See ISMP Canada’s Do Not Use List of Dangerous Abbreviations, Symbols and Dose Designations; available from: www.ismp-canada.org/download/ISMPCanadaListOfDangerousAbbreviations.pdf

Dose Designation	Example	Potential Problem	Correction
Trailing zero	$\mathcal{X}.0$ mg	Decimal point is overlooked resulting in 10-fold dose error.	Never use a zero by itself after a decimal point. Use “ \mathcal{X} mg”.
Lack of leading zero	$.\mathcal{X}$ mg	Decimal point is overlooked resulting in 10-fold dose error.	Always use a zero before a decimal point. Use “0. \mathcal{X} mg”.

Figure 1. Dangerous dose designations from ISMP Canada’s *DO NOT USE Dangerous Abbreviations, Symbols and Dose Designations*

This segment of the bulletin describes a recent SafeMedicationUse.ca publication from ISMP Canada's Consumer Program.

October 2016 - Newsletter

Medications Can Look Like Candy

Some medications look like candy, and some are even made into gummies and lollipops, which can be very appealing to children. Consumers are asked to refer to medications as “medications”, not “candy”—and to help children understand the difference between the two.

SafeMedicationUse.ca received a report about a child who took a parent's Imodium (loperamide) because to the child, it looked and tasted like candy. A package of mint-flavoured, fast-dissolving Imodium was left on a desk at home, and the child ate 4 tablets. When the parents realized what had happened, they took the child to the emergency department where charcoal was given. Fortunately, the child did not suffer any serious harm.

Tips for Practitioners:

- Ask parents and caregivers to refer to medications or natural health products as “medications”, rather than “candy”.
- Educate parents and caregivers about the proper storage of all medications, both prescription and nonprescription, as well as natural health products. Share the newsletter on safe storage:
https://safemedicationuse.ca/newsletter/newsletter_Misconception1Storage.html

Tips to Share with Consumers:

- Never call medication “candy”. If children believe that a medication is a type of candy, they may take it on their own.
- Keep **all** medications and natural health products, out of the reach of children. Do not rely on “child-resistant” caps to keep children safe from medications.
- Contact your doctor or your local [poison control centre](#) for advice if there has been accidental ingestion of medication. Keep the phone number of your local poison control centre in a visible area of the house.

Practitioners are encouraged to share the consumer version of this SafeMedication.ca newsletter with their patients:

[Medications Can Look Like Candy](#)

(https://safemedicationuse.ca/newsletter/newsletter_MedicationsCanLookLikeCandy.html)



Consumers Can Help Prevent
Harmful Medication Incidents

SafeMedicationUse.ca



The Canadian Medication Incident Reporting and Prevention System (CMIRPS) is a collaborative pan-Canadian program of Health Canada, the Canadian Institute for Health Information (CIHI), the Institute for Safe Medication Practices Canada (ISMP Canada) and the Canadian Patient Safety Institute (CPSI). The goal of CMIRPS is to reduce and prevent harmful medication incidents in Canada.



The Healthcare Insurance Reciprocal of Canada (HIROC) provides support for the bulletin and is a member owned expert provider of professional and general liability coverage and risk management support.



The Institute for Safe Medication Practices Canada (ISMP Canada) is an independent national not-for-profit organization committed to the advancement of medication safety in all healthcare settings. ISMP Canada's mandate includes analyzing medication incidents, making recommendations for the prevention of harmful medication incidents, and facilitating quality improvement initiatives.

Report Medication Incidents

(Including near misses)

Online: www.ismp-canada.org/err_index.htm

Phone: 1-866-544-7672

ISMP Canada strives to ensure confidentiality and security of information received, and respects the wishes of the reporter as to the level of detail to be included in publications. Medication Safety bulletins contribute to Global Patient Safety Alerts.

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