NHS Greater Glasgow & Clyde
Mental Health Partnership
Safer Use of Medicines Group

Safer Use of Opioids

The purpose of this guidance is to make staff aware of best practice in the use of opioids.

Opioids are a group of drugs primarily used to treat moderate or severe pain in either acute or palliative circumstances. Examples in common use include

- Diamorphine (also used in acute cardiac/ MI pain for therapeutic purposes)
- Dihydrocodeine injection
- Morphine
- Fentanyl
- Buprenorphine
- Oxycodone
- Methadone (more frequently used as a substitute for illicit opioid use. Detailed guidance on this use can be found in GGC Medicines Adult Therapeutics Handbook)

This is not an exhaustive list. A full list can be found in the BNF.

Used inappropriately these drugs have resulted in patient harm including death. It is important therefore that they are prescribed, dispensed and administered safely. This is especially true in mental health settings where use can be infrequent.

Guidance

1. **General points (**Source: NHS GG&C SUM group Organisational learning report 2009)

    - **Confirm recent opioid dose –** including formulation and frequency of administration, plus any other analgesics. Be alert for any anomalies such as unexpected dose increases or mix-up between modified release and ordinary-release preparations.

    - **Where the dose is to be increased, confirm the calculated dose increase is safe for the patient – check if in doubt.** E.g. for oral morphine or oxycodone in an adult patient, not normally more than 50% higher than the previous dose.

    - **Be familiar with the medicine being prescribed, dispensed or administered** – including usual starting dose, frequency of administration, standard dosage increments, symptoms of overdose & common side-effects.

    - **There is a difference in bioavailability if changing from oral morphine to the parenteral route.** If changing from oral morphine to intramuscular or subcutaneous morphine, the equivalent parenteral dose over 24 hours is half the total 24 hour oral dose. For diamorphine IM or SC, the dose over 24 hours is a third of the total daily oral morphine dose. **Further advice can be found in the Prescribing in Palliative care section of the BNF, GGC Medicines Adult Therapeutics Handbook or Scottish Palliative Care Guidelines**

2. **Prescribing.**

    Out with medical emergencies opioids (such as acute Myocardial Infarction/ Congestive Cardiac Failure) should be prescribed as part of a clear treatment plan. For pain management this should generally be part of a stepped approach as

describe in the W.H.O pain ladder, this is for the management of acute or cancer pain and palliative care, it is not appropriate for use in chronic non-malignant pain. Further advice on pain management can be obtained from local palliative care services or GGC guideline for opioid use in chronic non-malignant pain. Doses should start low and be increased incrementally until pain control is achieved. In substance misuse treatment should be part of a plan supported by Addiction Services.

Care should be taken to clearly distinguish between different formulations of the same drug e.g. Shortec (ordinary release oxycodone) & Oxypro (modified release oxycodone)

3. Administration.

- Staff administering opioids should have knowledge of the usual dose range and common side effects of these drugs. The BNF will provide basic information and further information may be obtained from pharmacy as necessary.
- Where possible administration of opioids should be undertaken by two members of staff. This allows for all aspects of the process to be cross-checked.
- There are frequent incident reports involving controlled drug patches e.g. fentanyl. Most often the reports detail incidents where patches are no longer in situ when the time comes to change them. It is recommended that services adopt a standard process of checking that patches are in situ at every shift change.

4. Storage and record keeping.

Most of the drugs listed above are controlled drugs and are subject to the storage and record keeping requirements of the relevant national legislation (for advice on this contact pharmacy). As mentioned above use of these drugs in a mental health setting is infrequent. Consequently, it is expected that most mental health wards would not routinely keeps these as stock items. A limited number of wards may keep a small stock for urgent access out of hours.

5. Signs of overdose.

Overdose with opioids can lead to fatal respiratory depression. Other signs include drowsiness and slurred speech. Where patients are newly prescribed opioids or are on high doses it would be prudent to consider monitoring respiratory function e.g. number, depth and O_2 saturation. There is guidance in GGC Medicines Adult Therapeutics Handbook on the reversal of opioid induced respiratory depression).

MHP Safer Use of Medicines Group

June 2023