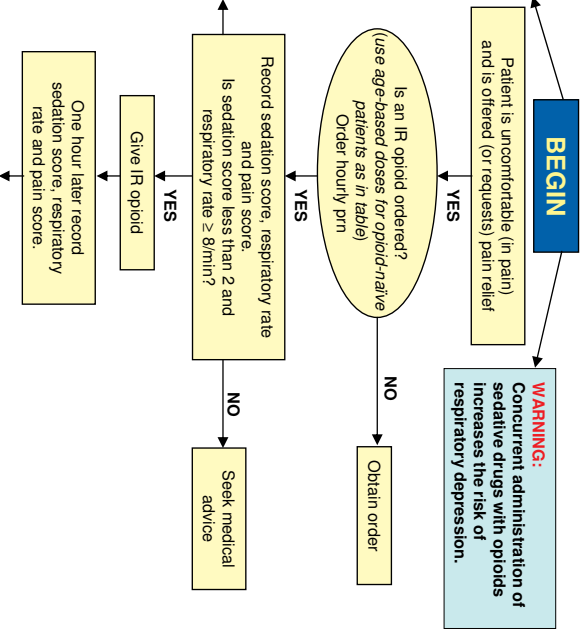


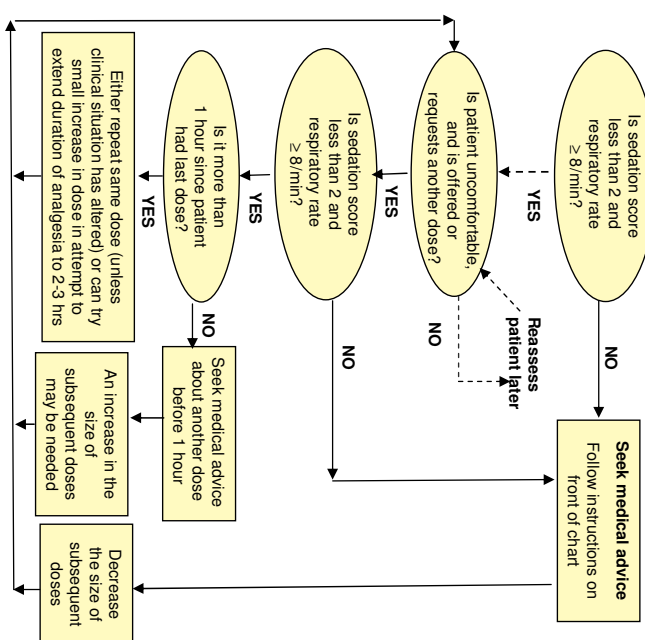
CALHN Guidelines
INTERMITTENT IMMEDIATE-RELEASE (IR) ORAL OR
SUBCUTANEOUS OPIOID ADMINISTRATION
 For Acute Pain Management

- Check for prior administration of opioids and commence hourly observations.
- If oral or subcut opioid has been preceded by an IV opioid, continue to record hourly observations for 6 hours after last dose.
- Provide a summary of total opioid dose administered to patient in the preceding 12 hours at handover of patient to another clinical care area.
- If a change is made from one IR opioid to another, or to the route of administration, ensure that at least 1 hour has elapsed since the last dose of IR opioid



WARNING:
 Concurrent administration of sedative drugs with opioids increases the risk of respiratory depression.

Advice can be obtained from:
 • Pharmacy Department OR
 • Acute Pain Service (if protocol appears not to be effective or patient is excessively sedated)



AGE-BASED IMMEDIATE - RELEASE OPIOID DOSES FOR ACUTE PAIN MANAGEMENT

The doses below are suggested initial doses only for opioid-naïve inpatients with moderate to severe acute pain.
 • Lower opioid doses are more appropriate in patients with less pain and/or if treatment is not initial.
 • Opioid-tolerant patients (patients taking opioids long-term) may require higher doses.
 • Consideration should be given to dosage amendment in differing clinical situations.

Age (yrs)	Subcut MORPHINE or OXYCODONE (mg) *	Subcut FENTANYL (microg) *	Oral OXYCODONE (mg) *
< 15		seek advice	
15 – 39	7.5 – 12.5	100 – 200	10 – 25
40 – 59	5 – 10	75 – 150	10 – 20
60 – 69	2.5 – 7.5	40 – 100	5 – 15
70 – 85	2.5 – 5	40 – 75	5 – 10
> 85	2 – 3	30 – 50	2.5 – 5

Recommended dose interval: 1 hourly prn* ↓ dose if pain not severe

Contact WCH Drug Information Centre or WCH Department of Anaesthesia for advice on opioid doses for children <15 years

• Order recommended dose of immediate - release opioid hourly prn (Note: this is for inpatients only; suggest 4 hourly prn otherwise).
 • Suggest start in middle of dose range.
 • Doses may be given hourly if needed but frequency of subsequent doses will depend on response to previous dose; can increase dose given in attempt to extend duration of analgesia to 2-3 h or more as long as sedation score is less than 2.
 • Upper limit of dose range can be increased if analgesia is inadequate, sedation score is less than 2 and respiratory rate greater than 7 breaths/min (first check that doses are correct/ have been given).
 • Oxycodone and fentanyl can be given to patients with renal impairment.
 • Note that the equianalgesic dose (same analgesic efficacy) for subcut oxycodone is equal to that of subcut morphine but is half the oral oxycodone dose. That is 10 mg subcut oxycodone = 10 mg subcut morphine = 20 mg oral oxycodone.
 • If a decision is made to give subcut fentanyl note that 10 mg morphine = 150 microg fentanyl. Note also that 150 microg fentanyl = 3 mL, which is a large volume for subcut injection, and can be very painful unless given slowly.
 • Some patients may require a prescription for oral oxycodone at discharge.
 • If patient was already taking long-term opioids on admission or has a history of substance abuse this may not be appropriate – seek advice.

IMPORTANT NOTES
 • Slow-release (SR) opioids such as Oxycotin, MS Contin and Kapanol, as well as fentanyl or buprenorphine patches, are not suitable or safe for management of acute pain.
 • At some hospitals patients can only be commenced on SR opioids and fentanyl or buprenorphine patches by the Pain Management Unit, Acute Pain Service, Cancer Centre, Spinal Injury Unit & also Consultant General Physicians and Geriatricians for prescription for patients with malignancy. Check hospital Formulary.

MONITORING OF THERAPY IS ESSENTIAL IF OPIOIDS ARE TO BE TITRATED SAFELY FOR EACH PATIENT

CALHN
 RAH TQEH
IMMEDIATE-RELEASE 'PRN' ORAL AND SUBCUTANEOUS OPIOID ORDERS FOR MANAGEMENT OF ACUTE PAIN

PATIENT LABEL
 Unit Record No.: _____
 Surname: _____
 Given Names: _____
 Date of Birth: _____ Sex: _____

OPIOID ORDERS:

1. If the patient is drinking, an oral opioid is usually given.
2. Usually order **EITHER oral OR subcut** (note that doses are different for each route of administration).
3. Refer to guidelines (see back of this form) for age-based doses in opioid-naïve patients; **DO NOT** use trailing zeros (e.g. 5 mg and not 5.0 mg); Order dose as mg or microgram.
4. There must be an interval of at least one hour between doses, regardless of route of administration.

<ol style="list-style-type: none"> 1. ORAL OPIOID (name): 2. DOSE RANGE: <i>Sign & date any change.</i> to 3. DOSE INTERVAL: hourly PRN (providing sedation score < 2) 	<ol style="list-style-type: none"> 1. SUBCUT OPIOID (name): 2. DOSE RANGE: <i>Sign & date any change.</i> to 3. DOSE INTERVAL: hourly PRN (providing sedation score < 2)
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Place label on the PRN section of the NIMC MR 90.0
For All PRN opioid orders see MR98.9

TREATMENT OF SIDE EFFECTS:

RESPIRATORY DEPRESSION (EXCESSIVE SEDATION):

1. If sedation score = 2 (indicates respiratory depression):
 - a. medical review required within 30 mins
 - b. do not give any more opioid until sedation score < 2
 - c. do hourly sedation scores until sedation score < 2 for at least 2 hours
 - d. reduce size of subsequent doses (e.g. half the dose)
2. If sedation score = 3 (indicates severe respiratory depression irrespective of respiratory rate) OR sedation score = 2 and respiratory rate ≤ 7 breaths/min:
 - a. initiate MER call
 - b. give 100 microgram NALOXONE IV stat. Repeat 2 minutely PRN up to a total of 400 microgram (if no IV access, give 400 microgram NALOXONE subcut or IM)
 - c. do hourly sedation scores until sedation score < 2 for at least 2 hours

NAUSEA AND VOMITING:
 Refer to hospital protocols

SIGNATURE OF MEDICAL OFFICER:..... Date:.....
 (Print name.....) Designation..... Contact No.....

Cease above orders:
 Signature of MO..... Date:..... Time:..... Contact No.....

IMMEDIATE-RELEASE 'PRN' ORAL AND SUBCUTANEOUS OPIOID ORDERS MR 98.9

GENERAL ORDERS:

1. Supplemental oxygen (2 to 4 L/min nasal specs) may be advisable in some patients, e.g. after major surgery or trauma.
2. Note that administration of other systemic opioids or sedatives (including antihistamines) will increase the risk of respiratory depression.
3. Naloxone must be immediately available.
4. Many patients will not ask for pain relief, therefore analgesia should be offered hourly until comfortable and then at least 4 hourly, with concurrent monitoring and documentation of pain and sedation scores.
5. *Monitoring requirements: see overleaf.*
6. For inadequate analgesia or other problems related to the analgesia, contact the medical officer. Patients with two consecutive pain scores at rest > 7 and/or FAS = C must be reviewed by a doctor.
7. If respiratory rate is 8-10/min, no action is required as long as sedation score is < 2. If sedation score is 2 or 3, follow instructions below.

