Eastern Health

Guideline

Title

Acute Pain Management and Analgesic Discharge Guideline

1. Sponsorship

Executive Sponsor (Title)	Chief Medical Officer
Director Sponsor (Title)	Chief Medical Officer
Coordinating Author (Name and Title)	Jeremy Szmerling, Analgesic Stewardship Pharmacist

2. Commissioning

2.1 Commissioning *(completed by Author in consultation with Sponsors listed above)*		
2.1.1 Is this guideline new ?	Yes ☐ Go to 2.1.4 No ☒ Objectify no: 3497 Go to 2.1.2	
2.1.2 Will this guideline, help EH achieve a desired outcome / is it still required?	Yes ☒ go to 2.1.3 No ☐ Detail reason for proposed decommissioning: _____	
2.1.3 Summarise reason for review and changes made:	• Change to executive and director sponsor in line with other medication/clinical related guidelines • Change to EH logos • Release of a national standard through the Australian Commission on Safety and Quality in Health Care • Recent Implemetation of Analgesic Stewardship Service at Eastern Health	
2.1.4 Purpose of guideline,	To provide a guideline for the management of pain in order to ensure consistency of practice and patient safety.	
2.1.5 Scope	EH-Wide ☒ Program-specific ☐ Directorate specific ☐	Corporate Procedure ☐
2.1.6 Are there existing policy documents relevant to this topic? (If yes, consider if can be incorporated into existing document)	Yes ☒ Clinical Governance Policy #2081 No ☐	
2.1.7 With which EH Standard would this guideline?	Pain Management and Evaluation Standard #2386 Medication Management and Safety Standard #2325 Medication Prescribing guideline #129 Medication Administration Guideline #813 Medication Dispensing Guideline #2026	
Will development or revision of this Guideline, procedure or Protocol impact on the Medical Record – Electronic or Paper?	☐ Yes - Electronic Medical Record - Refer to the EMR Clinical Practice Change & Optimisation Guideline* ☐ Yes – Paper Medical Record – Refer to the Clinical Document Approval Guideline* *Wherever possible, EMR change requests and revised Clinical	

	Documents are to be submitted for approval at the same time as the Guideline ☒ No
2.1.8 Who will be consulted (stakeholders)?	ASPPPA Quality and Safety Committee SWMMS Quality and Safety Committee Nursing & Midwifery Professional Council Pharmacy Quality and Safety Committee Analgesic Stewardship Committee Medication Management Clinical Governance Committee Acute Pain Services (Annie Williams, Clinical Nurse Consultant) Anaesthetics (Gordon Mar, Staff Anaesthetist, APS Portfolio)
2.1.9 Which committees are required to endorse this guideline?	Analgesic Stewardship Committee Medication Management Clinical Governance Committee
2.1.10 Which committee will approve this guideline,?	CPC
2.2 Commissioning committee approval to develop/review guideline/procedure/protocol *(completed by committee Secretary or delegate)*	
Approval to proceed with development/review **or** to decommission (delete one) Yes☒ No ☐ Reason (if no): Date Commissioned: 12/10/21 Name of committee that approved/disapproved commissioning: CPC	

Title

Acute Pain Management and Analgesic Discharge Guideline

1. **Context**

This guideline is to:

- Provide a summary of management of acute pain in the adult population at Eastern Health and outline an approach to treating acute pain using a multimodal analgesic approach based on the WHO analgesic ladder.
- Support clinicians support transfer of care patients discharged with opioid analgesics at Eastern Health. The guideline is for use for clinicians to wean and cease analgesics, provide guidance on required documentation to be provided to patients or carers and clinical handover documentation to be provided to general practitioners or other primary care clinicians.

2. **Definition of terms**

APS – Acute Pain Service
NSAID – Non-steroidal anti-inflammatory
PRN – as needed
Clinician – Any health professional registered with the Australian Health Practitioner Regulation Agency
OMEDD – oral morphine equivalent daily dose
FAS – Functional Activity Score
PPI – Proton Pump Inhibitor
PO – for oral administration
SL – for sublingual administration
SC/subcut – for subcutaneous administration
IV – for intravenous administration
BD – twice a day

TDS – three times per day
QID – four times per day

3. **Name of Standard to which Guideline, Procedure or Protocol relates**

Medication Management Standard (2325)

4. **Processes**

Contents

Principles of pain management

Performing a comprehensive pain assessment

Obtain basic elements of the patient's pain history including:

- Onset and timing of pain(s)
- Locations of pains(s) and radiation
- Description of pain(s) to determine type of pain (nociceptive, neuropathic, or mixed) and cause of pain
- Severity of pain(s) and impact of pain on function/activities (refer to Appendix 1 for pain assessment and Functional Activity Score)
- Aggravating factors
- Relieving factors
- Associated symptoms
- Impact of pain
- Current and prior treatments for pain
- Relevant medical +/- surgical history
- Other patient factors which includes the psycho-social aspects like beliefs, expectations, coping skills and mood disorders like anxiety and depression

Setting realistic expectations around pain

- Expect some pain especially after surgery
- Use of pre-emptive pain medication for incidental/procedural pain
- Goal is to improve function

Non-pharmacological treatment

- Non-pharmacological treatment of pain should always be considered first line:
  - Physical therapy (splinting, dressings, positioning, plaster cast)
  - Physiotherapy exercises +/- Occupational Therapy
  - Psychological approaches (relaxation, education)

Pharmacological Pain Management:

The pharmacological management of acute pain is based on the WHO analgesic ladder. The key principle is to use a *multimodal approach*. The goal of analgesia is to improve **FUNCTION**.

General principles for **opioids**

- Effective in acute pain; ***not*** **in chronic non-cancer pain**
- Use lower doses in the elderly/frail
- Only use **one strong opioid at a time**
- Start with PRN and **limit use of slow-release opioids** to short term use for prolonged painful situations such as major surgery or multi-trauma patients
- **Prescribe regular laxatives and antiemetics**

Pharmacological Management of Acute Pain

- Goal is to improve function
- Start treatment appropriate for the reported severity of pain
- **Aim for pain scores of ≤ 4 & Functional Activity Scores of A or B**

Attachment 1. WHO Pain Ladder

Mild Pain Pain Score 1-3 FAS A	**Moderate Pain** Pain Score 4-7 FAS B	**Severe Pain** Pain Score 8-10 FAS C
Non-pharmacological Approaches **AND/OR** Paracetamol 1g PO QID **AND/OR** NSAID (±PPI) Short Course Celecoxib 200mg BD or Ibuprofen 400mg TDS for 3 days *Consider all precautions, contraindications and side effects*	As for Step 1 **AND** Tramadol immediate release 50-100mg PO or IV QID PRN *Halve the dose in the elderly and specify max dose per 24 hours* *Consider all precautions, contraindications and side effects*	As for Step 2 **AND** Oxycodone immediate release < 70 years old: 5mg every 4-6 hours PRN *Halve the dose in the elderly and specify max dose per 24 hours* *Consider all precautions, contraindications and side effects* ***REFER TO APS to consider SC/IV/SL options***

Considerations for Paracetamol:

- The maximum dose of paracetamol should be reduced in the following patients:
  - frail, elderly or fasting patients reduce to a Maximum of 3g/24hours
  - >33kg and ≤50kg; dose at 15mg/kg up to 4 times per day, Maximum of 3g/24hours
  - In patients with chronic or compensated active hepatic disease, Gilbert's syndrome (familial hyper-bilirubinaemia), chronic malnutrition and dehydration, reduce the dose to a Maximum of 2g/24hours
- Paracetamol-opioid combinations should be avoided, they do not improve analgesia and contribute to a number of opioid related adverse effects.

Considerations for NSAIDs:

- Post gastrointestinal/colorectal surgery confirm with relevant surgical team for appropriateness
- Adverse effects can be significant and include renal impairment, an increased risk of gastrointestinal and surgical haemorrhage, and may worsen heart failure and increase the risk of myocardial infarction and stroke.
- Please review the need for any NSAID after 3 days

- Parecoxib is restricted to use in the Operating Theatre and by the APS ONLY in selected ward patients (For palliative care use, please see policy 2149 on objectify). Please refer such patients to APS for review. It is APS practice to wait at least 12 hours after parecoxib dose before next NSAID dose.

Considerations for Oral Opioids

- For tramadol avoid in >75 years old, history/risk seizures, hyperbaric or risk of serotonin toxicity (See attachment 2 for a list of drugs that may contribute to serotonin toxicity)
- Can also consider Tapentadol immediate release (< 70 years: 50mg every 3 hours) but as per EH formulary use is restricted to APS so will need to refer.

Considerations for SC/IV opioids

- All patients receiving parenteral opioids on the ward must adhere to the Eastern Health PCA clinical practice guideline (Number 868)
- Sublingual and subcutaneous opioids should not be administered concurrently with immediate release oral opioids.
- Medication Choices:
  - Morphine 2.5-5mg subcut up to 4-hourly PRN; OR
  - Fentanyl 25mcg subcut up to 4-hourly PRN (**Fentanyl is ONLY to be prescribed in critical care areas (ED/ICU/PACU/Renal/Haem/Onc)**; OR
  - Buprenorphine 200mcg sublingual up to 4-hourly PRN (Restricted to use by APS)

Other considerations:

- Opioid Tolerant Patients – advice should be obtained from the APS
  - Baseline level of regular pre-admission opioid analgesia prescribed as background analgesia (including sustained release opioids), unless there are reasons to lower this (e.g. patient is acutely unwell or sedated).
  - Always consult SafeScript when assessing patients who are on opioids.
  - Additional doses of opioids for breakthrough pain may be needed and these are titrated depending on patient requirements, surgical indications and disease progression.
  - If your patient presents with a history of opioid diversion or any aberrant behaviours, refer them to the Addiction Medicine service. Alternatively, contact DACAS – 24-hour Clinical Advisory Service on 1800 812 804
- Reversal
  - Naloxone injection is available in all clinical areas on Full and Basic Resuscitation Trolleys to reverse the action of opioids. Naloxone is also available as a nasal spray on the PBS for high risk patients on discharge from hospital. For more information, please contact the ward pharmacist for advice.
- Renal Impairment (see Attachment 3. Renal Pain management guideline)
- Obstetric Patients (see Attachment 4. Obstetric Analgesia)
- Aperients: All patients who are prescribed opioids should also be prescribed aperients.
  - The following aperients are suggested;
    - **Coloxyl and Senna® 2 tablets BD/PRN**
    - **Lactulose 20mL BD/PRN**
    - **Macrogol (Movicol®) 1 sachet BD/PRN**

Referral to Acute Pain Service (APS)

The APS can be contacted via switchboard at BHH, MH and AH

Patient Factors

- Patient's with an OMEDD > 60mg/day
- Patients prescribed multiple opioids
- All patients with severe pain and pain that is difficult to control
- Patients with persistent or neuropathic pain

Surgical Factors

- Painful procedures- thoracotomy, joint arthroplasty, laparotomy
- Prolonged fasting post-surgery- acute abdomen, oesophagectomy

Anaesthetic Factors

- Anaesthetic technique- epidural, perineural catheters, PCA
- Ketamine infusion

Assessment of analgesic side effects and review of analgesia

Assessment of potential side effects of analgesics

Assessment should include:

- Sedation score
- Respiratory Rate
- Oxygen saturation (Sp02)

All patients receiving opioids or sedative agents should have their sedation score and respiratory rate assessed and documented regularly on EMR interactive document.

**Escalate care per METCALL or clinical review criteria.

Opioid analgesic weaning and cessation

General principles for weaning and ceasing analgesics

- If applicable, de-escalate analgesics per the Acute Pain Service (APS) plan outlined in the medical notes.
- Weaning and cessation of analgesic should follow a multimodal analgesia and opioid-sparing strategy to minimise overall opioid analgesic use.
- Consider the individual patient's characteristics such as age, weight, hepatic and renal function, allergies, other health conditions, other medicines prescribed and patient's opioid status.
- Wean and cease one, at most two, analgesics at a time
- In acute on chronic pain aim to wean and/or cease analgesics to baseline medications and/or doses before discharge
- If weaning and cessation cannot be completed in hospital, then provide a medication management plan on discharge

Criteria to commence de-escalation of analgesics

Patients who meet ALL of the following criteria:

- Nil further surgery or painful intervention (e.g. theatre, dressing or VAC change) in the short-term
- Functional activity score (FAS) A or B, refer to Appendix 1 for definition
- Limited use of PRN analgesia (i.e. < 4 doses in the preceding 24 hours)
- No reports of uncontrolled pain in the preceding 24 hours (i.e. pain score < 8 and FAS A/B)

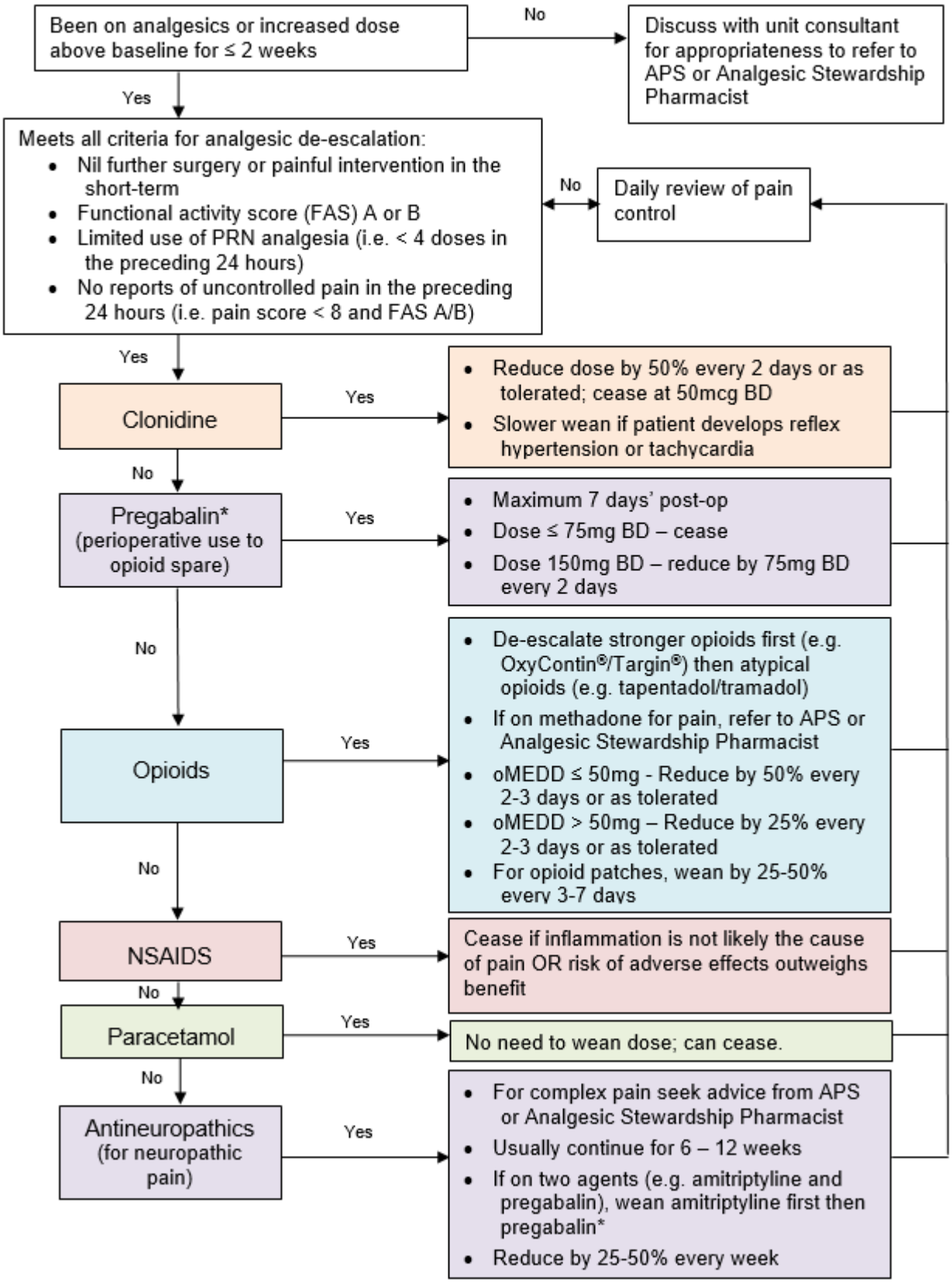
De-escalating analgesics in those treated for ≤ 2 weeks

Aim to de-escalate analgesics prior to discharge. The order and rate of de-escalation for analgesics may be adjusted based on the patient's type of pain, response, side effects and risk of adverse effects.

Attachment 5. Flowchart for de-escalation of analgesics in those treated for ≤ 2 weeks

Flowchart – De-escalating analgesics in those treated for ≤ 2 weeks

Aim to de-escalate analgesics prior to discharge. The order and rate of de-escalation for analgesics may be adjusted based on the patient's type of pain, response, side effects and risk of adverse effects.



** On de-escalation of high doses and from prolonged use, monitor for seizures and withdrawal symptoms*

Discharge of patients on analgesics

Paracetamol and NSAIDs

- Use the smallest dose for the shortest time and consider risks.
- 5 to 7 days' supply is usually adequate.
- Consider using a proton pump inhibitor in patients who must have a NSAID but are at risk of GI adverse effects.

Opioid analgesics

- Where possible, wean patients from opioids prior to discharge. If this is not possible, a documented medication management plan for opioid analgesic weaning and cessation and/or follow-up and information for the GP is required.
- Prescribing of opioid analgesics at discharge should be guided by the assessment of the patient's functional activity and pain scores and the amount of opioid analgesic use in the period up to 24-hour period before discharge, using an OMEDD.

Supply of opioid analgesics at discharge

- Strong opioids are not recommended for routine prescription on discharge, particularly in opioid naïve patients. This can be dangerous or even fatal.
- If opioids need to be prescribed on discharge, they should be prescribed at the **lowest appropriate dose** and for the **shortest time**. It is recommended that if a patient requires greater than 3-day supply, they are reviewed by their GP prior to continuation of opioid therapy.
- If a patient is discharged with an opioid analgesic, the quantity should be for up to a **maximum of seven days' treatment** to reduce and stop the opioid analgesic
- The quantity of supply should take into account the day of discharge and when the patient can reasonably be expected to access primary care and other healthcare services post-discharge
- For patients who live in locations with limited access to prescribers and pharmacies, consider their individual circumstances and expected course of their condition
- Prescribing of **modified-release opioid analgesics** should be limited for acute pain to specific circumstances, and for as shorter duration as possible, before ceasing opioid analgesics or changing to an immediate release opioid analgesic if required.

Supply of immediate release opioid analgesic at discharge

If immediate release opioid analgesics are required at discharge

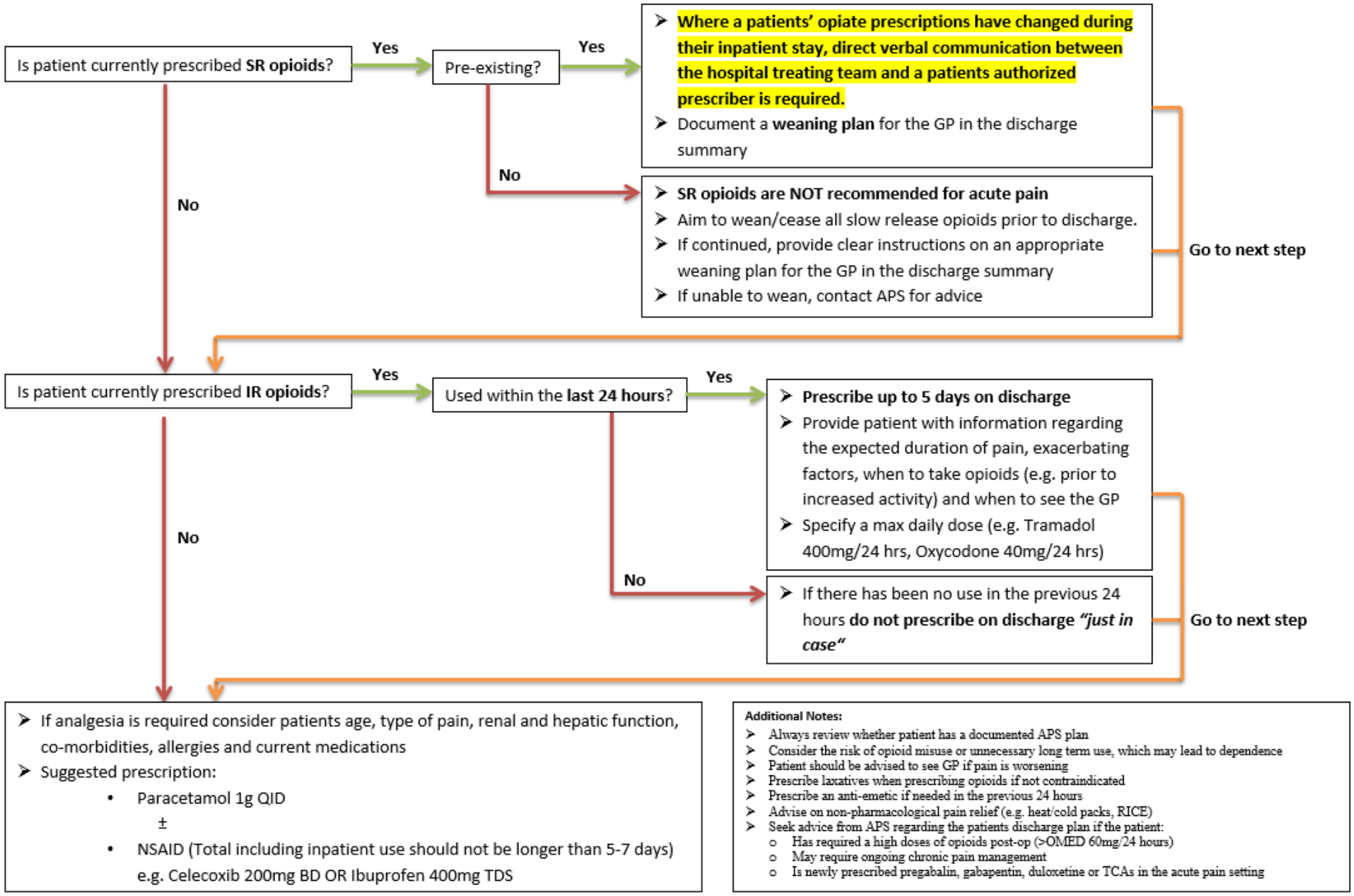
- Prescribe necessary quantities, **NOT** full packs
- Assess number of PRNs doses in **last 24 hours** to guide quantities
- Prescribe at the lowest appropriate dose for the shortest time, a **maximum of 3-5 days'** supply is recommended

E.g. If a patient has used TWO 5mg doses of Oxycodone in the last 24hours, a maximum of 10 tablets supply should be prescribed. (2 tablets x 5 days= 10 tablets)

SafeScript

Clinicians should obtain and check information from SafeScript to identify and assess patients at risk of harm including their opioid status and existing opioid analgesics in their possession, prior to the supply or prescription of opioid analgesics.

Attachment 6. Algorithm for Opioid Prescribing on Discharge



Documentation for patients and carers

Patients or carers should receive written patient information and medication management plan that includes recommendations for reducing and cease opioid analgesics where appropriate. The medication management plan should be developed in discussion and agreeance with the patient or carer.

Patients should be provided a copy of the relevant short term pain relief plan, either in the form of a patient leaflet, patient friendly medication management plan or as part of the discharge summary medication management plan.

Clinical Handover

Clinicians should ensure there is prompt communication of a clinical handover to the patient's general practitioner or other primary care clinician that includes

- Cause of the pain for which the opioid analgesic was prescribed
- Medication management plan that includes recommendations for reducing and ceasing the opioid analgesic appropriate. **Where a patients' opiate prescriptions have changed during their inpatient stay direct verbal communication between the hospital treating team and a patients authorized prescriber is required.**

This should be documented in the medical discharge summary.

A recommended example medication management plan is shown below in the box – replace information in brackets with information specific to the patient and ensure plan matches discharge script/summary.

[INSERT PATIENT] was discharged on [**INSERT OPIOID DRUG**, STRENGTH, DOSE, REG/PRN, DURATION and QUANTITY; repeat if multiple opioids] for **short term** management of **acute** pain.

We have also advised/provided [**INSERT NSAID DRUG**, STRENGTH, DOSE, REG/PRN] for **[3-5] days**.

In addition to [INSERT DRUG/s NOTED ABOVE] we have advised the patient to **take paracetamol regularly** until their pain resolves.

We anticipate this analgesia medication plan will be sufficient. However, the patient may require your clinical review for ongoing management of pain. Opioids can normally be discontinued 7 to 10 days after surgery. Complex patients may require titration and cessation over a longer period.

Referral to specialist services

For patients with pain post discharge that require support services and aids and equipment to manage safety post discharge, consider referrals to allied health services

Patients 'at risk' of chronic pain issues who may be amenable and agreeable to further assessment or management can be referred to a chronic pain management service for follow up post discharge.

Where patients have a component of opioid dependence, comorbid addiction to other drugs or are otherwise at a high risk of medication related aberrance they can be referred to Eastern Health addiction medicine services (Turning Point Eastern Treatment Services) which includes consultancy, assessment and treatment outpatient clinics such as the PJC based pain and opioid dependence clinic. Alternatively for specialist advice you can contact DACAS – 24-hour Clinical Advisory Service on 1800 812 804

Scope

For use within Eastern Health for adult patients with acute (or acute on chronic) non-cancer pain

5. Tools & Techniques

See Appendix 1

6. Level of Supporting Evidence Available

Level 4 - Expert opinion

7. References

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8. **Development History**

Version Number	Date Created	Review Date
1	June 2020	June 2022
2	January 2022	June 2024

9. **Attachments**

Attachment 1. WHO Pain Ladder
Attachment 2. Drugs that may contribute to serotonin toxicity
Attachment 3. Renal Pain management guideline
Attachment 4. Obstetric Analgesia
Attachment 5. Flowchart for de-escalation of analgesics in those treated for ≤ 2 weeks
Attachment 6. Algorithm for Opioid Prescribing on Discharge

Development / Review (complete this section after development/review, prior to approval)

Key external information sources consulted: Legislation ☐ External benchmarks ☐ External standards ☒ Risk Register Item ☐ Other ☐ Provide specific details: Safer Care Victoria Analgesic Stewardship Service Pilot Program Documentation Alfred Health Pain Management Guidelines Australian Commission on Safety and Quality in Healthcare Opioid Analgesic Stewardship in Acute Pain Clinical Care Standard – Consultation Draft	
Key Stakeholders consulted in development/review *eg. IPAC, OHS, Support Services, ICT, Residential Care, Legal Counsel.*	Title/Name: ASPPPA Quality and Safety Committee SWMMS Quality and Safety Committee Nursing & Midwifery Professional Council Pharmacy Quality and Safety Committee Analgesic Stewardship Committee Medication Management Clinical Governance Committee Acute Pain Services (Annie Williams, Clinical Nurse Consultant) Anaesthetics (Gordon Mar, Staff Anaesthetist, APS Portfolio)
Consumer consulted	Yes ☒ No ☐
Has development or revision of this Guideline, Procedure or Protocol impacted on the Medical Record – Electronic or Paper?	☐ Yes - Electronic Medical Record - Refer to the EMR Clinical Practice Change & Optimisation Guideline* ☐ Yes – Paper Medical Record – Refer to the Clinical Document Approval Guideline* *Wherever possible, EMR change requests and revised Clinical Documents are to be submitted for approval at the same time as the standard ☒ No
Implementation plan developed and attached?	Yes –Guideline/Procedure/Protocol is new or significantly revised ☐ No –Guideline/Procedure/Protocol has undergone only a minor revision ☒
Policy documents to be removed following approval	Document Numbers & Titles
Further comments/notes	
Key search words	Acute Pain, Opoid, Opioids, Analgesia, Pain Management, Pain

Endorsement and Approval

Endorsement by relevant committee (*completed by committee secretary or delegate)*		
Name(s) of Endorsing Committee(s) *e.g. Quality & Safety Committee, CPC, Clinical Risk Governance Committee.*	Conditions of endorsement	Date Endorsed dd/mm/yy
Medication Management Clinical Risk Governance Committee		4/5/22
		/ /
Approval by relevant committee *(completed by committee secretary or delegate)*		
Approved for		1 Year (Extreme Risk) ☒ 2 Years (High Risk) ☐

		3 Years (Moderate or Low Risk) ☐
Alignment of Guideline, Procedure or Protocol		Date approved dd/mm/yy
EH-Wide	Clinical Practice Committee	☒ 15 / 01 / 21
Program or Directorate-specific	Program Quality & Safety Committee *Specify:*	☐ / /
Corporate Procedure	Executive Committee	☐ / /
	Board/Board Committee	☐ / /
	Date of next review: *Please notify coordinating author and Manager Clinical Governance of approval*	**15/1/2024**

Publishing

Date approval notified to Manager Clinical Governance *(completed by Manager Clinical Governance)*	
Date forwarded to policy administrator *(completed by QPI Executive Assistant)*	
Date published on Objectify *(completed by publishing administrator)*	

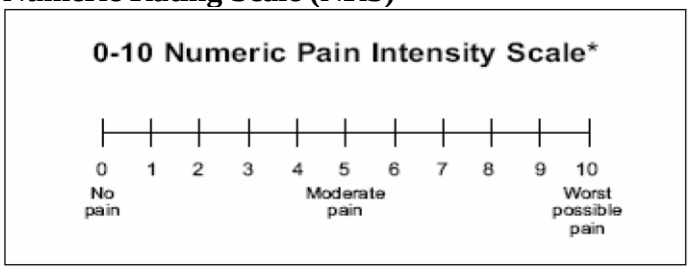
Appendix 1. Comprehensive Pain Assessment Including Pain Assessment Tools

Comprehensive Pain Assessment Including Pain Assessment Tools
Obtain basic elements of the patient's pain history including:
Primary site of pain and any radiation
Conditions associated with the onset of pain
Character of the pain – nociceptive or neuropathic, somatic or visceral, or combinations thereof
Intensity of the pain
Associated symptoms e.g. nausea, vomiting, sweating
The pains effects on the patient's function, measured by the Functional Activity Score (FAS)
Current and prior treatments for pain
Relevant medical and surgical history
Other patient factors, which includes the psycho-social aspects like beliefs, expectations, coping skills and mood disorders like anxiety and depression

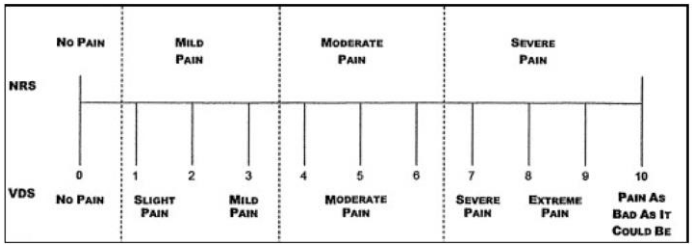
A full pain history should be obtained from the patient as part of their initial assessment and thereafter should be obtained;
As part of routine observations
Pre- and post- administration of analgesia
Within 60 minutes of administration of oral analgesia
More frequently if alternate route of administration
If patient is experiencing pain

FUNCTIONAL ASSESSMENT
The more the pain is interfering with a patient's ability to function e.g. deep breath, cough, mobilise, the more likely they will have complications like chest infections or deep vein thrombosis (DVT). The goal of pain management should be to improve patient's functional ability and in turn to reduce the risk of complications.
The ability to function with pain can be graded by using the Functional Activity Score (FAS).
FAS A — no limitation; the patient is able to undertake the activity without limitation due to pain (pain intensity score is typically 0 to 3);
FAS B — mild limitation; the patient is able to undertake the activity but experiences moderate to severe pain (pain intensity score is typically 4 to 7);
FAS C — severe limitation; the patient is unable to complete the activity due to pain, or analgesic-related side effects (pain intensity score is 8-10)

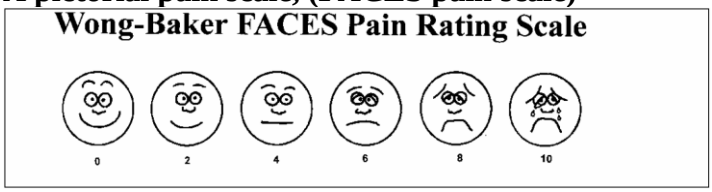
UNIDIMENSIONAL PAIN ASSESSMENT TOOLS FOR THOSE WHO CAN SELF-REPORT
Examples include:
Numeric Rating Scale (NRS)



Verbal Descriptor Scale (VDS)



A pictorial pain scale, (FACES pain scale)



BEHAVIOURAL RATING SCALE FOR PATIENTS WHO ARE UNABLE TO SELF-REPORT PAIN

For patients unable to provide a self-report of pain: scored 0–10 clinical observation

Face	**0** Face muscles relaxed	**1** Facial muscle tension, frown, grimace	**2** Frequent to constant frown, clenched jaw	**Face score:**
Restlessness	**0** Quiet, relaxed appearance, normal movement	**1** Occasional restless movement, shifting position	**2** Frequent restless movement may include extremities or head	**Restlessness score:**
Muscle tone*	**0** Normal muscle tone	**1** Increased tone, flexion of fingers and toes	**2** Rigid tone	**Muscle tone score:**
Vocalisation**	**0** No abnormal sounds	**1** Occasional moans, cries, whimpers and grunts	**2** Frequent or continuous moans, cries, whimpers or grunts	**Vocalisation score:**
Consolability	**0** Content, relaxed	**1** Reassured by touch, distractible	**2** Difficult to comfort by touch or talk	**Consolability score:**
Behavioural pain assessment scale total (0–10)				**/10**

* Assess muscle tone in patients with spinal cord lesion or injury at a level above the lesion injury. Assess patients with hemiplegia on the unaffected side.

** This item cannot be measured in patients with artificial airways.

Other recommended observational scales include:

Pain assessment checklist for seniors with limited ability to communicate (PACSLAC)

Pain Assessment in Advanced Dementia (PAINAD)

Abbey pain scale

Appendix 2. Initial Opioid Prescribing Based on Age

Initial Endone® (immediate release oxycodone) dose, 4 hourly PRN*	
Age (years)	**Dose range (mg)**
18 – 39	10 – 15
40 – 59	5 – 15
60 – 69	5 – 10
70 – 79	5
>80	2.5

*Specify maximum dose in 24 hours

Appendix 3. Opioid Dose Equivalence Table

In order to calculate an oral Morphine Equivalent Daily Dose (OMEDD), multiply the current daily opioid dose by the conversion in column 2.
For example, OMEDD of oxycodone 40mg/day = 40 x 1.5 = 60mg/day

Opioid Dose Equivalence Calculation Table			
Current Opioid		**Conversion Factor**	**Proprietary Names**
ORAL PREPARATIONS			
Morphine	mg/day	1	Anamorph, Kapanol (MR), MS Contin (MR), MS Mono (MR), Ordine, Sevredol
Oxycodone	mg/day	1.5	Endone, OxyContin (MR), OxyNorm, Targin (MR)
Hydromorphone	mg/day	5	Dilaudid, Jurnista (MR)
Codeine	mg/day	0.13	Aspalgin, Codalgin, Panadeine, Panadeine Forte, Mersyndol, Nurofen Plus, others
Tramadol	mg/day	0.2	Durotram-XR (MR) , Tramal, Tramadol SR (MR), Zydol, Zydol SR (MR), others
Tapentadol	mg/day	0.3	Palexia-SR (MR), Palexia-IR
SUBLINGUAL PREPARATIONS			
Buprenorphine	mg/day	40	Suboxone, Subutex, Temgesic
TRANSDERMAL PREPARATIONS			
Buprenorphine	mcg/hr	2	Norspan
Fentanyl	mcg/hr	3	Denpax, Durogesic, Dutran, Fenpatch, Fentanyl Sandoz
PARENTERAL PREPARATIONS			
Morphine	mg/day	3	DBL morphine sulphate injection, DBL morphine tartrate injection
Oxycodone	mg/day	3	OxyNorm FI
Hydromorphone	mg/day	15	Dilaudid FI, Dilaudid-HP FI
Fentanyl	mcg/day	0.2	DBL fentanyl injection, Sublimaze

*Adapted from Faculty of Pain Medicine, ANZCA – June 2021
This opioid dose equivalence table is intended for comparison of different opioid and opioid formulations in individual patients or in patient cohorts. Caution is required if opioid dose equivalence tables are used to guide opioid switching, as the administration of a calculated 'equivalent' dose of the replacement opioid may lead to overdosage. It should be noted that there is considerable variability in pharmacokinetics and pharmacodynamics of the different opioids, within and between individual patients. In addition interactions

with non-opioid drugs can strongly influence opioid pharmacokinetics. Modified-release formulations can be sub-classified as delayed- or extended- release. Extended release of a drug can be achieved using sustained- or controlled-release delivery systems. When the opioid regimen includes modified- and immediate-release preparations, both should be included in calculation of the oMEDD.