College of Registered Nurses of Manitoba

RN(NP) Opioid Prescribing to Treat Non-Cancer Pain

Practice Direction

The College of Registered Nurses of Manitoba (the College) Council must, by regulation, establish standards of practice to regulate the quality of practice of registered nurses (RNs).

The Council approves practice directions which are written statements to enhance, explain, add or guide RNs with respect to matters described in the College of Registered Nurses General Regulations or any other matter relevant to registered nursing practice. Compliance with practice directions are required; these expectations also serve as a legal reference to describe reasonable and prudent nursing practice.

It is the responsibility of all registered nurse (nurse practitioner)s in Manitoba to understand all practice expectations and be accountable to apply them to their own nursing practice, regardless of roles or practice settings. Responsibility is the duty to satisfactorily complete your obligations. Accountability means being capable to explain why you did or did not meet these expectations.

The policies of employers do not relieve individual RN(NP)s of accountability for their own actions or the primary obligation to meet practice directions. An employer's policies should not require an RN(NP) to practise in a manner that violates practice directions.

Introduction

This practice direction outlines the practice expectations for all registered nurse (nurse practitioners), RN(NP), in relation to prescribing opioids to treat non-cancer pain.

The practice expectations for opioid prescribing are embedded in the Practice Direction: Practice Expectations for RN(NP)s and modelled on standards by the College of Physicians and Surgeons of Manitoba to ensure an evidence-informed client-centered approach that maximizes safety.

This practice direction will be updated from time to time as new evidence emerges.

Only RN(NP)s who have completed the necessary requirements may prescribe opioids. Find information regarding the process to gain and maintain authority for Prescribing Controlled Drugs and Substances on the CRNM website.

Purpose

To set practice expectations for RN(NP)s for acute or continued opioid prescribing to treat non-cancer pain.

Scope

This practice direction includes all prescribing of opioids to treat non-cancer pain.

It excludes the treatment of active cancer pain, palliative care, end-of-life care, opioid replacement therapy, and substance use disorder. For these excluded areas RN(NP)s are expected to apply the Practice Expectations for RN(NP)s and up-to-date, evidence-informed guidelines and standards.

Definitions

Milligrams morphine equivalent (MME): the conversion of an opioid dose to the equal or equivalent morphine dose using a conversion ratio. Also referred to as morphine milligram equivalent.

Drug program information network (DPIN): an electronic, on-line, point-of-sale drug system linking all community pharmacies (but not pharmacies in hospitals or nursing homes/personal care homes) to capture information about all Manitoba residents. DPIN is maintained by the Government of Manitoba.

Opioid: a broad group of drugs that interact with opioid receptors used for treating moderate to severe pain as well as coughing and diarrhea. E.g. heroin, fentanyl, morphine, codeine.

Practice Expectations

RN(NP)s must practice in a manner consistent with provincial and federal legislation, all CRNM practice directions and the Code of Ethics. This includes federal and provincial controlled substances laws, regulations and rules. The practice expectations listed below are specific to opioid prescribing and must be implemented in conjunction with all other practice expectations and requirements.

Acute Pain or Post-Operative Analgesia Client

For clients with acute pain or who require post-operative analgesia, the RN(NP) is expected to:

a) Prescribe the lowest effective dose of immediate release preparations limited to what the client will need before community follow-up will be resumed (E.g. three days or less will often be sufficient; more than seven days will rarely be needed; but in exceptional circumstances, up to one month).

b) When discharging clients from acute-care settings, or post-operatively, prescribe only the quantities of opioids that the client will need before community follow-up will be resumed, or in accordance with the expected course of the illness where follow-up is not anticipated.

c) Prior to continued opioid prescribing beyond 30 days, consult with other health-care providers if the client's acute pain does not resolve within an expected time-frame given the etiology for the client's acute pain.

d) Assess for the client's risk of opioid misuse and substance abuse history, optimizing non-opioid treatment options if appropriate. Note that much acute and post-operative pain can be managed with non-steroidal anti-inflammatories and acetaminophen alone or in combination.

e) Discuss the risks of opioids with the client (e.g. side effects; physical dependence; crime (being targeted for their medication); addiction, overdose resulting in death; risks of failure to store opioids safely, including diversion and death; risks of consuming alcohol or other sedating substances with opioids simultaneously; risks of operating a motor vehicle or heavy machinery, safety-sensitive occupational risks, and child and elder care responsibilities).

Initial Trial for Non-Acute Non-Cancer Pain in Opioid Naïve Clients Prescribed up to 50 MME/Day

To determine if a trial of opioids is clinically appropriate for treatment of non-cancer pain for an opioid naïve client, and prior to prescribing opioids, the RN(NP) is expected to:

a) Conduct and document a comprehensive history and physical examination, including:

- i. Pain condition, general medical condition, current medication, opioid use history, psychiatric status, substance abuse history, trauma, psychosocial history, and previous non-pharmacological treatment;
- ii. Client's risk for opioid misuse, abuse, or diversion. Consider use of appropriate screening tools such as those listed in the Opioids Manager to determine the client's risk for addiction to opioids;
- iii. Acquisition and review of applicable health care records; and
- iv. Prior to continued opioid prescribing beyond 30 days, consult with other health-care providers if the client's acute pain does not resolve within an expected time-frame given the etiology for the client's acute pain.

b) Optimize available non-opioid treatment options, including non-opioid pharmacotherapy and non-pharmacological treatment modalities, including considering psychology, psychiatry, sports medicine, physiotherapy, occupational therapy, kinesiology, chiropractic, and dietary.

c) Review the client's current and past medications utilizing Drug Programs Information Network (DPIN) or the electronic health record (eChart). If DPIN or eChart access is unavailable, consult with a pharmacist to obtain DPIN. If no access is available to DPIN, eChart, or a pharmacist, then a maximum three-day prescription can be written to permit such access.

d) Only start with a trial of opioids as a therapeutic trial of less than three months. If therapeutic goals are not met or the harms outweigh the benefits, then discontinue opioids as a slow taper.

e) Always use caution and prescribe the lowest effective dosage of opioid medication. Titrate the dosage gradually, with frequent tolerability checks and clinical reassessments. Monitor opioid effectiveness until optimal dosage is attained, subject to documentation of the following:

- i. Maximum three months prescription, but never authorize the dispensing of more than a one-month supply of any opioid unless the client is in remote communities or travelling where the dispensing may be considered for up to three months.
- ii. Recording all dosages clearly in the client's health care record.

f) Client re-assessment, including assessment of benefits and risks to the client for both pain and function, according to the following time-frames: at least twice in the first month, monthly for the next two months, thereafter at least every three months. For clients in remote communities reassess as frequently as possible if not able to achieve the above.

g) Taper benzodiazepine(s) slowly to the lowest functional dose, or zero if possible, if a client on existing long-term prescribed benzodiazepine(s) requires an opioid trial (either prior to or concurrently). Excluding acute and time-limited indications, do not initiate treatment with benzodiazepines in combination with long-term opioid therapy, except in limited and exceptional circumstances.

h) Document in the client's record the discussion with the client of the following:

- i. Treatment goals including specific and realistic goals of reduced pain severity (not elimination of pain), and improved physical, psychological, social and functional states.
- ii.Non-pharmacological therapy and non-opioid analgesics are preferred for chronic non-cancer pain;
- iii.Potential benefit of long term opioid treatment is modest;
- iv. Risks of side effects, physical dependence, crime (being targeted for their medication); risks of addiction, and overdose resulting in death; risks of failure to store opioids safely, including diversion and death; risks of consuming alcohol or other sedating substances with opioids simultaneously; risks of operating a motor vehicle or heavy machinery, safety-sensitive occupational risks, and child and elder care responsibilities;
- v. Circumstances under which to seek help and where to obtain help if required;
- vi. The end of treatment, including decreasing dosages and returning unused opioids to a pharmacy for safe disposal; and
- vii. Which health care provider(s) will be providing

refill prescription for the client and which health care provider(s) will be following up and prescribing refill prescriptions if the usual health care provider(s) is not available.

i) Require baseline urine drug testing prior to initiating an opioid trial, and require random and/or periodic urine drug testing on an annual basis, or more frequently if there are concerns. When ordering a urine drug screen, ask clients about all medications/drugs recently taken, and be aware of resources to assist assessment for potential false positive or false negative results.

Note that urine drug screens are a tool to:

i. Set a baseline measure of substance use that may help assess risk for addiction, and
ii. Monitor on an ongoing basis, the client's use of prescribed opioids.

j) Not prescribe opioids for clients with an active substance use disorder (excluding nicotine) without considering first obtaining guidance (by telephone is permitted) from a health care prescriber specializing in addiction.

Clients Currently Prescribed between 50 and 90 MME per Day

An RN(NP) that has prescribed or is considering prescribing a client between 50 and 90 MME per day, is expected to:

a) Maintain vigilance for potential diversion and other substances of concern by:

i. Verifying the client's current and past medications utilizing DPIN or eChart at least every three months. If DPIN or eChart access is unavailable, consult with a pharmacist to obtain DPIN (or contact the other prescriber of these drugs, if there is one). If no access to DPIN, eChart, or pharmacist, a maximum three-day prescription can be written to permit such access.

b) Order an initial urine drug screen if one was not done in the past year, and at least yearly thereafter. Note that urine drug screens are a tool to:

i. Set a baseline measure of substance use that may help assess risk for addiction, and
ii. Monitor on an ongoing bases, the client's use of prescribed opioids.

c) Document a comprehensive history and physical examination, if a current history and physical examination is not available, including:

i. Pain condition, general medical condition, current medication, opioid use history, psychiatric status, substance abuse history, psychosocial history, and previous non-pharmacological treatments and therapies.
ii. Assessment of the client's risk for opioid misuse, abuse, or diversion. Use appropriate screening tools to determine the client's risk for opioid addiction.
iii. Comprehensive reassessment of i and ii as necessary based on client's current condition and at least yearly.

d) Always use caution and prescribe the lowest effective dosage of opioid medication. Titrate the dosage gradually, with frequent tolerance checks and clinical reassessment. Monitor opioid effectiveness until optimal dosage is attained, subject to, and documenting, the following:

i. A careful reassessment of the dose is required including discussion and documentation of specific and realistic goals of reduced pain severity (not elimination of pain), and improved physical, psychological, and social functioning.
ii. Careful reassessment of evidence of individual benefits and risks when considering increasing dosage to more than 50 MME per day.
iii. Prescriptions may be written for a maximum of up to three months, but never authorize the dispensing of more than a one-month supply of any opioid. For clients in remote communities, the dispensing may be for up to three months. For clients travelling, the dispensing may be for up to three months, if the client has been on a stable long-term prescription.
iv. Recording of all dosages clearly in the client's health care record.

e) Taper benzodiazepine(s) slowly to the lowest functional dose, or zero if possible, if a client on existing long-term prescribed benzodiazepine(s) is concurrently taking long- term opiates. Excluding acute and time-limited indications, do not initiate treatment with benzodiazepines in combination with long-term opioid therapy, except in limited and exceptional circumstances, which are documented.

f) Once again, consider optimizing available non-opioid treatment options, including non-opioid pharmacotherapy and non-pharmacological treatment modalities, including considering psychology, psychiatry, sports medicine, physiotherapy, occupational therapy, kinesiology, chiropractic, and dietary.

Clients Prescribed More Than 90 MME per Day

An RN(NP) that has prescribed or is considering prescribing a client more than 90 MME per day, is expected to:

a) Perform each of the practice expectations in the above section "Clients Currently Prescribed between 50 and 90 MME per Day."

b) Not abruptly discontinue medications– "Bridging" prescriptions during assessment of the client is acceptable to avoid dangers of withdrawal.

c) Determine the lowest effective dose of opioid needed to achieve and/or maintain the goals of reduced pain severity (not elimination of pain), and improved physical, psychological, and social functioning, and consider a trial of slow tapering of the opioids. When tapering, if the client has a substantial increase in pain and decrease in function that persists more than one month after a dose reduction, tapering may be undertaken more slowly, paused or potentially abandoned in such clients.

d) Consult with an appropriate specialist and/or multidisciplinary program (including these possibilities: practice colleague, pain clinic, psychiatry, psychology, addiction specialist, sports medicine, pharmacist, physiotherapist, kinesiologist, chiropractor, occupational therapist, dietitian, if available) when the client receives a 90 MME dose daily for longer than 90 days or the client experiences serious challenges in tapering off opioids, or if opioid use disorder is suspected.

e) If the client is on 90 MME per day or less, and there is documented benefit to the client, then continue the treatment. See ensuing section "Continued Prescribing of Opioids for Clients with Non-Cancer Pain."

f) Except in circumstances of exceptional need and clearly documented benefit, restrict prescription to no more than 90 MME per day. A second opinion of another prescriber must be sought if considering escalating doses in excess of 90 MME per day.

Clients New to an RN(NP)'s Practice and Already Taking Opioids for a Significant Time-Period

For clients who are new to a RN(NP)'s practice and who have been taking opioids for a significant period of time (approximately six weeks or more), the RN(NP) is expected to:

a) Maintain vigilance for potential diversion and other substances of concern by verifying the current opioid prescription by:

i. Obtaining collateral information from both the previous prescriber(s) and dispensing pharmacy(s) confirming the clinical indication and current opioid dosage;

ii. Reviewing the client's current and past medications utilizing DPIN or eChart. If DPIN or eChart access is unavailable, consult with a pharmacist to obtain DPIN, (or contact the prescribing doctor). If no access to DPIN, eChart, or a pharmacist, then a maximum three-day prescription may be written to permit such access; and

iii. Ordering an initial urine drug screen. Note that urine drug screens are a tool to set a baseline measure of substance use that may help assess risk for addiction, and to monitor on an ongoing bases, the client's use of prescribed opioids prescribed.

b) Conduct and document a comprehensive history and physical examination including,

i. Pain condition, general medical condition, current medication, opioid use history, psychiatric status, substance abuse history, trauma, and psychosocial history, and previous non-pharmacological treatment and therapies;

ii. Assessing the client's risk for opioid misuse, abuse, or diversion and consider appropriate screening tools to determine the client's risk for addiction to opioids;

iii. Obtaining applicable health care records; and

iv. Verifying the client's identity.

c) Always use caution and prescribe the lowest effective dosage of opioid medication. Titrate the dosage gradually, with frequent tolerance checks and clinical reassessment. Monitor opioid effectiveness until optimal dosage is attained, subject to, and documenting the following:

i. Carefully reassess evidence of individual benefits and risks when considering increasing dosage to more than 50 MME per day.

ii. If the client is on more than 90 MME per day, careful reassessment of the dose is required

including discussion and documentation of specific and realistic goals of reduced pain severity (not elimination of pain), and improved physical, psychological, and social functioning. To determine the lowest effective dose of opioid needed to achieve and/or maintain these goals, consider a trial of slow tapering of the opioids. When tapering, if the client has a substantial increase in pain and decrease in function that persists more than one month after a dose reduction, then tapering may be undertaken more slowly, paused, or potentially abandoned in such clients.

iii. In those rare circumstances where tapering is not appropriate, if the client is on 90 MME per day or more, and there is documented benefit to the client, then continue the treatment. See ensuing section "Continued Prescribing of Opioids for Clients with Non-Cancer Pain."

iv. Medications must not be abruptly discontinued – "bridging" prescriptions during assessment of the client is entirely acceptable to avoid dangers of withdrawal.

v. Prescriptions may be written for a maximum of up to three months, but never authorize the dispensing of more than a one-month supply of any opioid. For clients in remote communities, the dispensing may be for up to three months. For clients travelling, the dispensing may be up to three months, if the client has been on a stable long-term prescription.

vi. All dosages must be recorded clearly in the client's health care record.

d) Taper benzodiazepine(s) slowly to the lowest functional dose, or zero if possible, if a client on existing long-term prescribed benzodiazepine(s) is concurrently taking long-term opiates. Excluding acute and time-limited indications, do not initiate a new benzodiazepine(s) prescription in combination with long-term opioids except in limited and exceptional circumstances, which are documented.

e) Consult with an appropriate specialist and/or multidisciplinary program (including these possibilities: practice colleague, pain clinic, psychiatry, psychology, addiction specialist, sports medicine, pharmacist, physiotherapist, kinesiologist, chiropractor, occupational therapist, dietitian, practice colleague, if available) when the client receives a 90 MME dose daily for longer than 90 days or the client experiences serious challenges in tapering off opioids or if opioid use disorder is suspected.

Adolescent Clients

The concern of opioid use in adolescents parallels adults. There are additional vulnerabilities (including concern that dependency develops more quickly in adolescents) which adds to the need for considering alternate treatments to opioids.

For RN(NP)s treating adolescent clients with acute pain or post-operative analgesia, the RN(NP) is expected to:

a) Attempt, with caution, to adapt the above section "Acute Pain or Post-Operative Analgesia Client" to prescribing for adolescents.

b) Prescribe dosages of opioid that are reduced in proportion to the body mass and development stage of the adolescent.

For the RN(NP)'s adolescent clients for whom opioids are being prescribed (excluding acute pain or post-operative analgesia) the RN(NP) is expected to:

a) Attempt, with caution, to adapt the above sections to prescribing for adolescents while adapting dosages to the body mass and development stage of the adolescent.

b) Utilize non-steroidal anti-inflammatory medication and acetaminophen, or other alternate medication, unless otherwise contraindicated, prior to prescribing opioids.

c) Prior to prescribing opioids, obtain informed consent from the client or the client's substitute decision maker, where applicable based on client's decision-making capacity.

d) Prescribe dosages of opioids that are reduced in proportion to the body mass and development stage of the adolescent.

Continued Prescribing of Opioids for Clients with Non-Cancer Pain

Continued prescribing of opioids for clients with non-cancer pain applying the practice expectations in the above sections must only occur if there is documentation of:

a) Measurable clinical improvement in pain, function, and quality of life evaluations and

b) Maintenance of a satisfactory level of improvements in these parameters, which outweighs the risks of continued opioid treatment.

c) Continuing to prescribe opioids, even the same dose of opioids, solely on the basis that they have been prescribed previously is not acceptable.

Resources

National Pain Centre at McMaster University (2017). *The Opioid Manager, a tool designed to support healthcare providers in prescribing and managing opioids for clients with chronic non-cancer pain.*

University of Toronto (2016). *Navigating Opioids Infographic.*

References

Canadian Nurses Association (2017). *2017 Edition Code of Ethics for Registered Nurses.*

College of Physicians and Surgeons of Manitoba (2019). *Standards of Practice of Medicine. Schedule L – Prescribing Opioids.*

College of Registered Nurses of Manitoba (2018). *Practice Direction: Practice Expectations for RN(NP)s.*

National Pain Centre at McMaster University (2017). *The 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain*

Published: 03/2020

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