College of Pharmacists of Manitoba

From the Script to the Medical Examiner: Resources for Pharmacist Intervention

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Presenter Disclosure

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No conflicts of interest to declare

Learning Objectives

- Discuss the benefits of the Office of the Chief Medical Examiner (OCME) and its impact on health care practices in Manitoba
- Illustrate the importance of CPhM involvement with the OCME and reflect on the impact of information gathered
- Assess the influence of the Medical Examiner (ME) learnings on policies and regulations thus far
- Analyze a case study and apply learnings to daily practice
- Identify and examine the several resources available for best practices

Part 1

CPhM and the Adult Inquest Review Committee (AIRC)

What is the OCME and the AIRC?

- Office of the Chief Medical Examiner (OCME)
  - The Chief Medical Examiner has the responsibility for the investigation of all unexpected and violent deaths occurring in the Province.

- The OCME has three review committees, meeting monthly:
  - The Children's Inquest Review Committee (CIRC)
  - The Adult Inquest Review Committee (AIRC)
  - The Geriatric Inquest Review Committee (GIRC)

Deaths that Require an Inquiry

- Within 24 hrs after seeking admission to a hospital
- Contagious disease
- In a prescribed type facility or institution or in prescribed circumstances
- During or 10 days after an invasive procedure or under anesthesia
- During, following, or relating to pregnancy
- Child
- Suddenly or unexpectedly
- While in the custody of a peace officer or due to use of force
- Accident
- Poisoning
- While being imprisoned or detained in a correctional facility, jail or a penitentiary
- Homicide or suicide
- While being a resident at a facility under the MHA or a development centre under the VPLMDA
- Contracting a disease or condition, injury, or exposure to toxic substance at work place

Benefits of an Audit Committee

Audit Committee

Systemic Collection of Data

Identify trends

No death is "swept under the rug"

Ensure individuals receive the care they are entitled to

Recommendations that lead to changes in practice and policy making

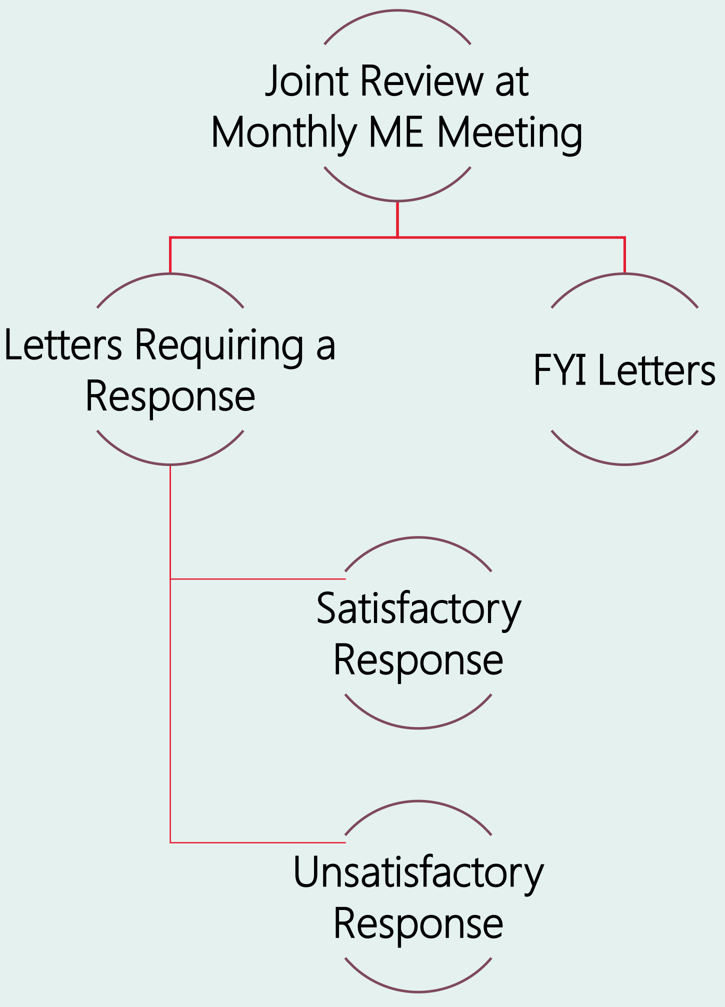
Interprofessional and multidisciplinary involvement leading to collaboration and information

The Importance of CPhM Involvement

CPhM's Mission Statement:

"To protect the health and well-being of the public by ensuring and promoting safe, patient-centred, and progressive pharmacy practice in collaboration with other health-care providers"

CPhM Review of OCME Deaths



CPhM Review of OCME Deaths
Joint Review at Monthly Meetings

- Collaborative reviews: CPSM Medical Consultant & CPhM staff pharmacist
- All deaths involving prescription medications undergo detailed review:
  - Deceased patient's DPIN history
  - Toxicology report
  - Autopsy report
  - Photographs of prescription bottles (if available)

CPhM Review of OCME Deaths
Letters Requiring a Response to CPhM

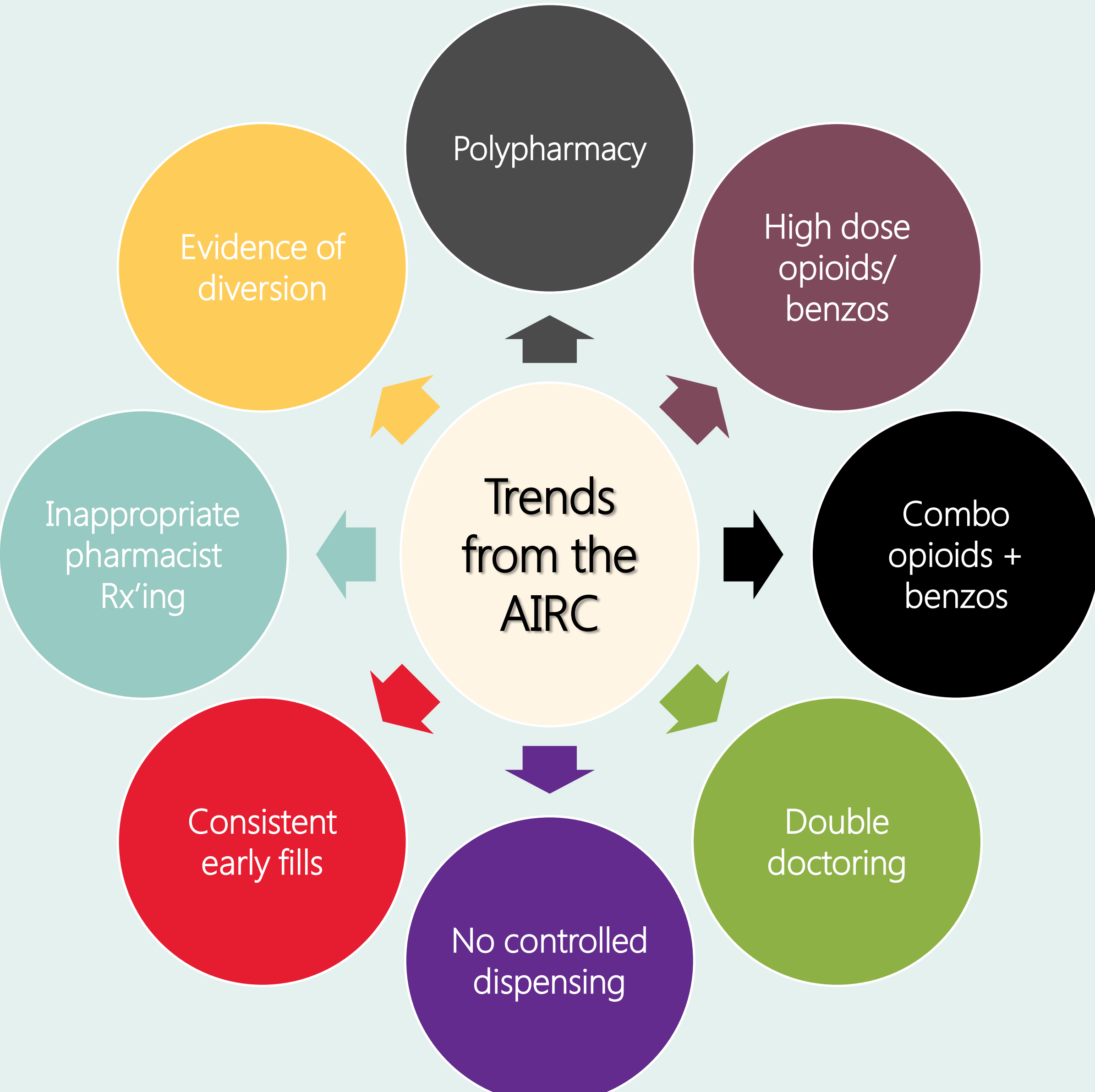
Pharmacy managers asked to respond with the following:

1) Overview of the care provided to the patient
2) Copies of Rxs, including any notes and pharmacist interventions
3) Operational changes and policies instituted to prevent similar situations in the future
4) Additional education undertaken by pharmacy staff
5) Documentation of recommendations/collaboration with prescriber(s)

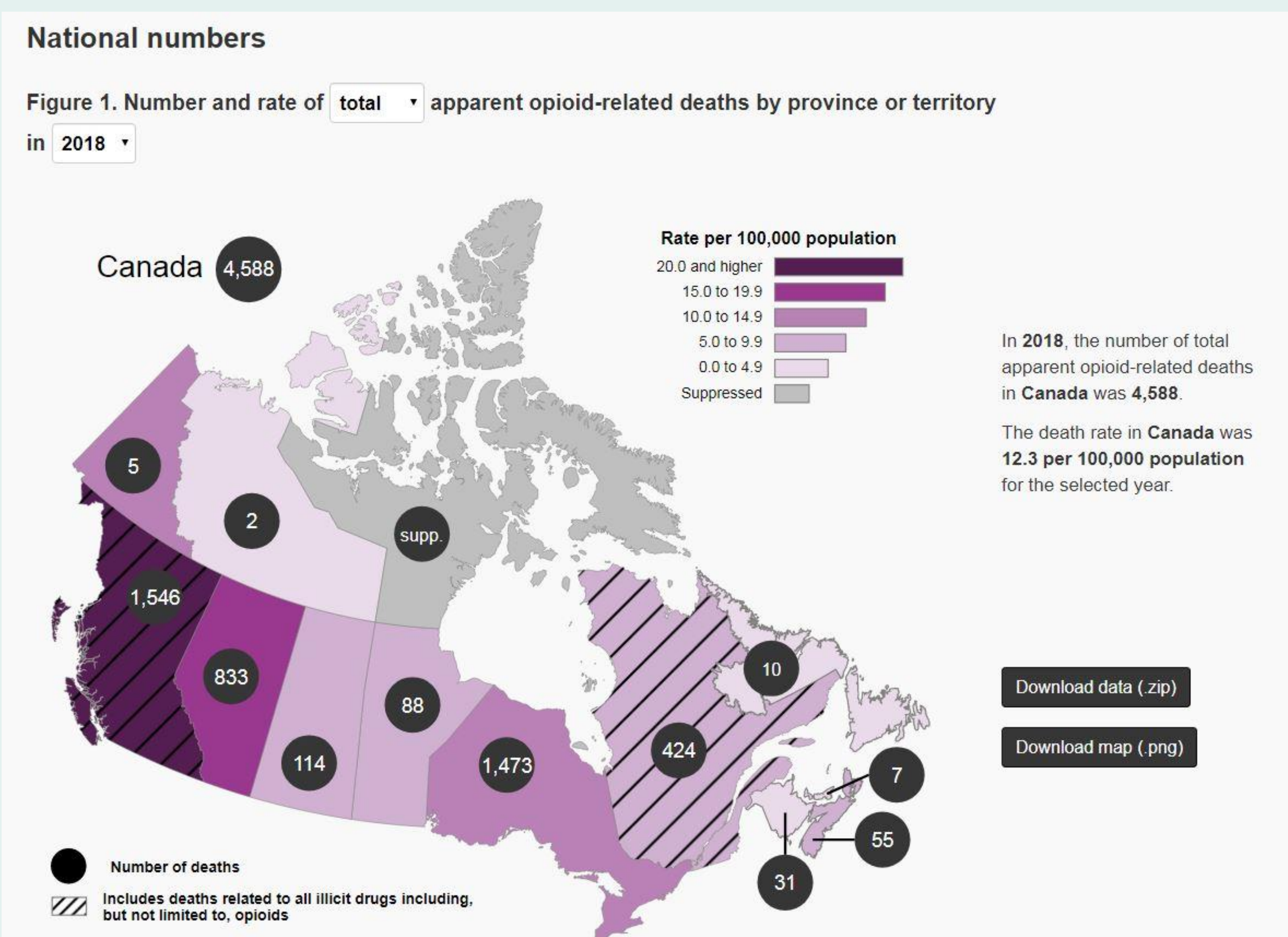
Part 2

Trends and Numbers

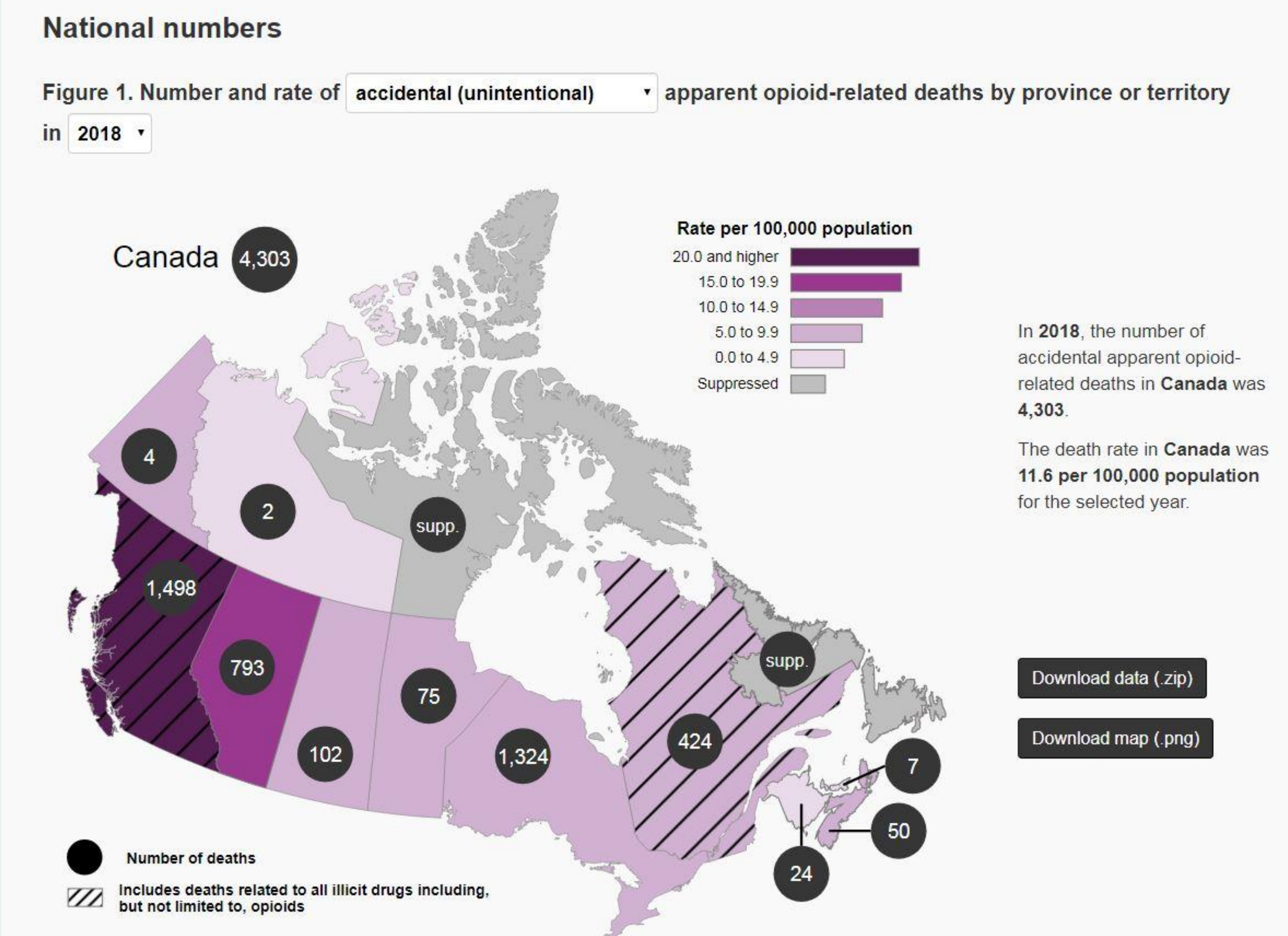
Trends and Areas of Concern Seen from ME Files



Opioid Related Deaths Across Canada



Opioid Related Deaths Across Canada



ISMP Infographic on Navigating Opioids for Chronic Pain

- Divides the risk into 4 categories:
  - 0 – 50 MED
  - 50 – 100 MED
  - 100 – 200 MED
  - >200 MED

*MED = Morphine Equivalents per Day

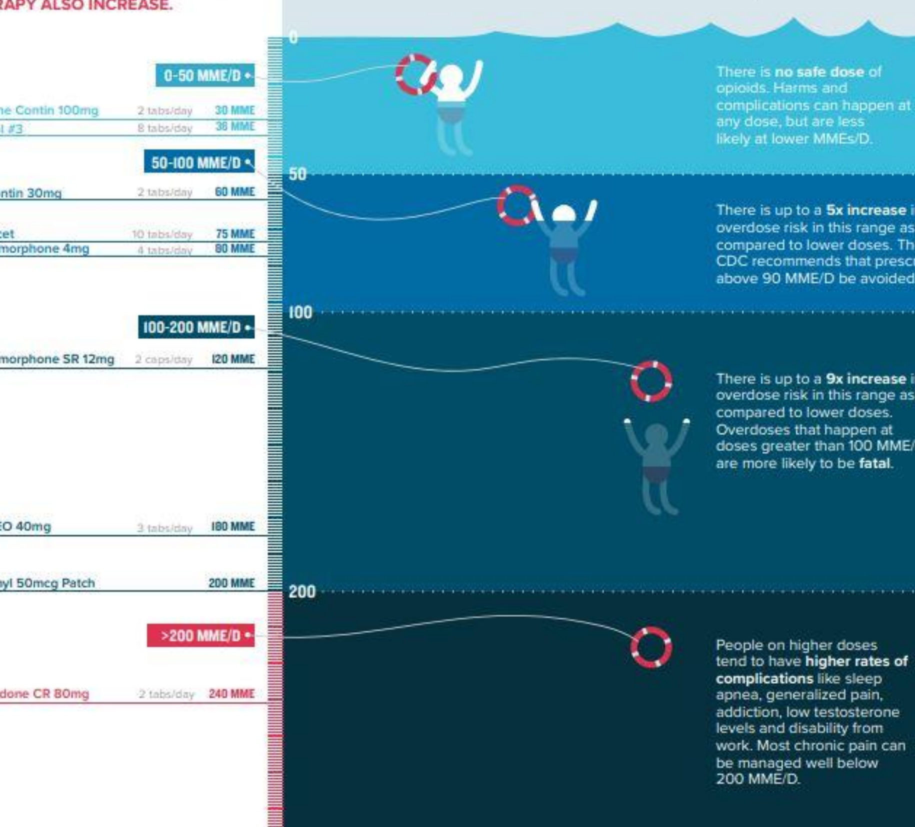
https://www.ismp-canada.org/download/OpioidStewardship/navigating-opioids-11x17-canada.pdf

FOR CHRONIC PAIN

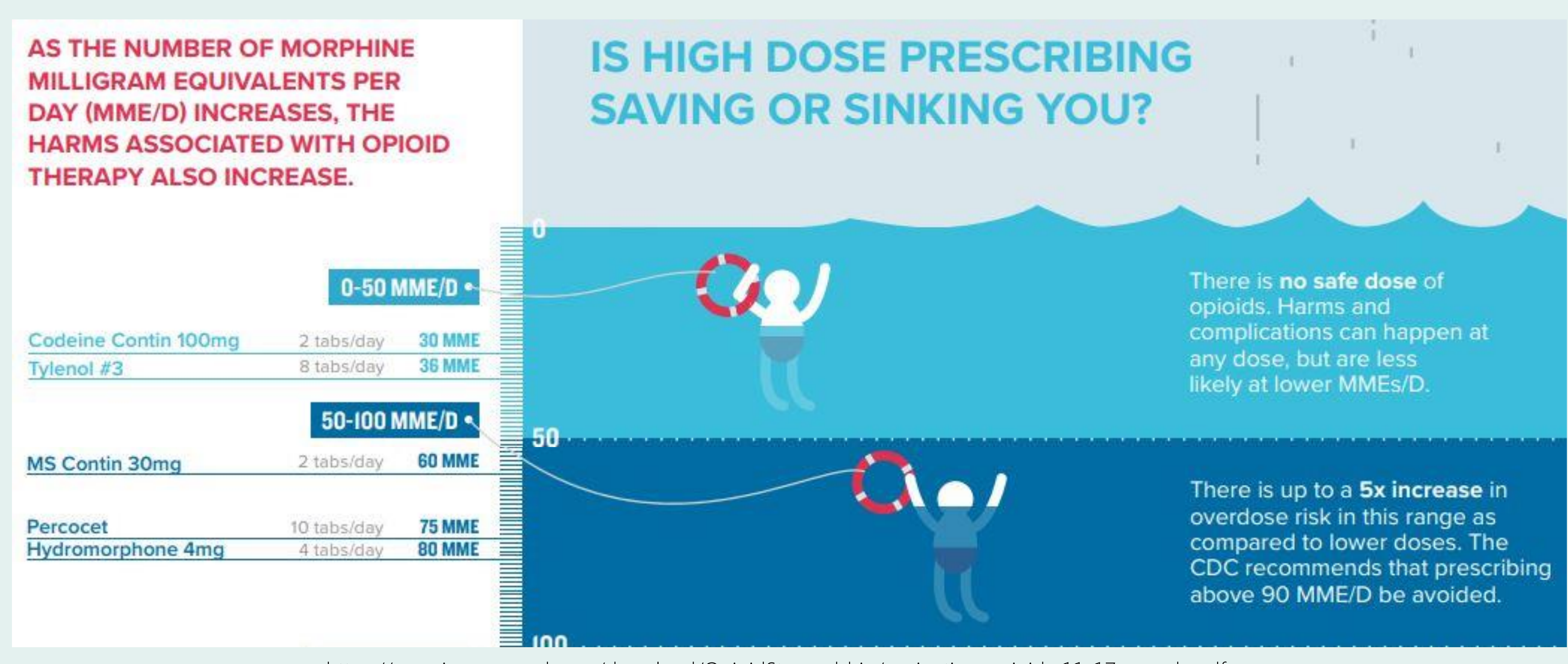
Sometimes the best of intentions lead to devastating consequences. Canada and the U.S. are the two highest consumers of prescription opioids even though we don't have good evidence that they are effective for chronic pain. Since there are many different opioids used for the same purpose, we use **morphine equivalence** to compare how strong they are.

AS THE NUMBER OF MORPHINE MILLIGRAM EQUIVALENTS PER DAY (MME/D) INCREASES, THE HARMS ASSOCIATED WITH OPIOID THERAPY ALSO INCREASE.

IS HIGH DOSE PRESCRIBING SAVING OR SINKING YOU?



ISMP Infographic on Navigating Opioids for Chronic Pain



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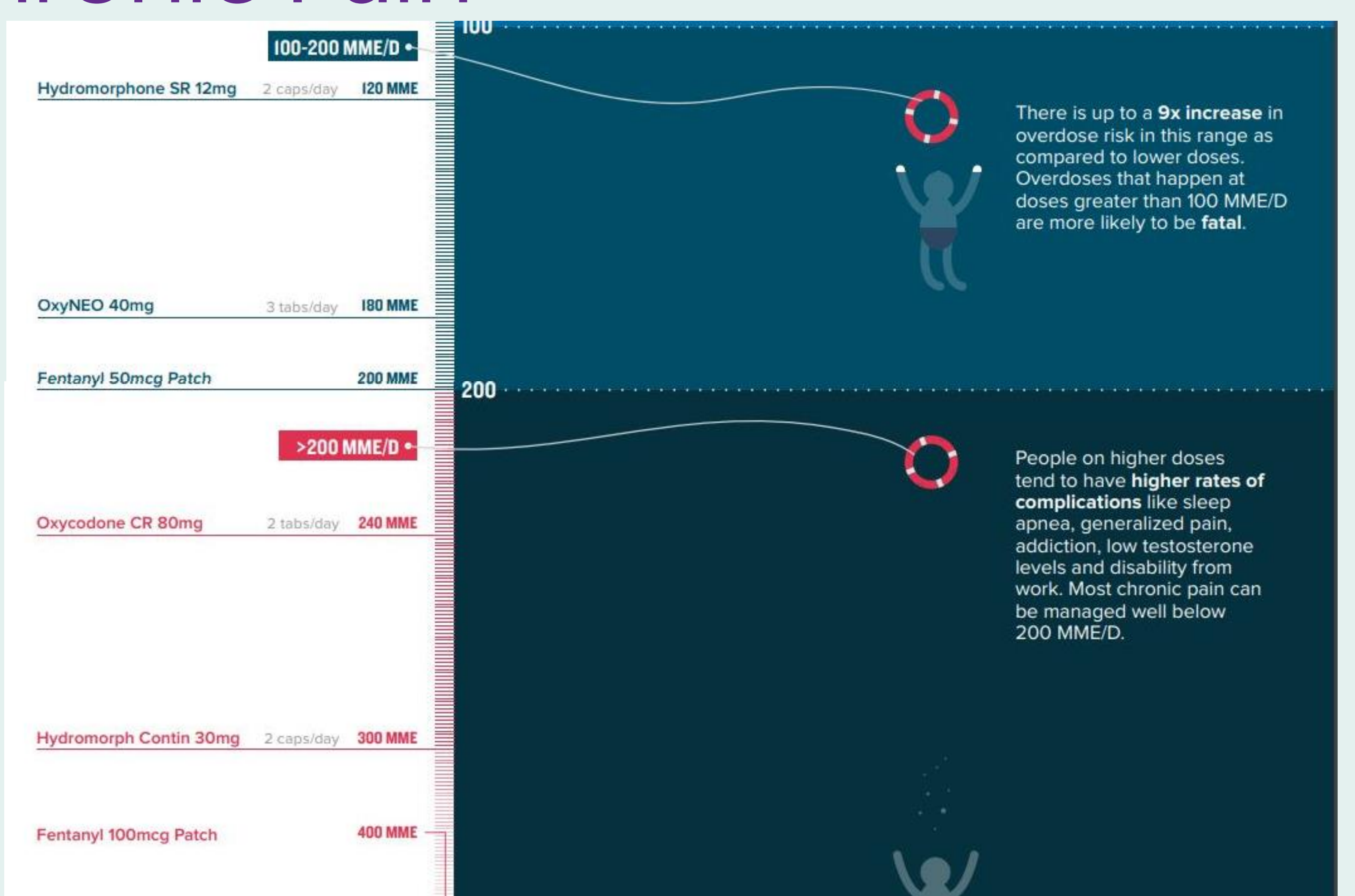
ISMP Infographic on Navigating Opioids for Chronic Pain



https://www.ismp-canada.org/download/OpioidStewardship/navigating-opioids-11x17-canada.pdf

Responsibilities of a Pharmacist Pharmaceutical Regulations

M3P dispensing requirements

78(1) A drug listed in the M3P schedule must not be dispensed unless

(a) a prescription that complies with section 77 is dated by the authorized practitioner within three days before the day it is presented at the pharmacy for filling;

(b) the member doing the final check has taken reasonable steps to ensure patient safety under section 83; and

(c) the prescription and patient information is entered in DPIN, subject to a patient's direction under subsection (3).

Ensuring patient safety

83 Subject to any practice directions, a member must review each prescription and the patient's record and take appropriate action if necessary with respect to

(a) appropriateness of drug therapy;

(b) drug interactions;

(c) allergies, adverse drug reactions and intolerances;

(d) therapeutic duplication;

(e) correct dosage, route, frequency and duration of administration and dosage form;

(f) contraindicated drugs;

(g) any other error in the prescription or potential drug therapy problem not mentioned in clauses (a) to (f);

(h) a drug prescribed by a practitioner outside his or her authorized scope of practice; or

(i) a drug that has not been prescribed consistent with standards of care and patient safety.

Responsibilities of a Pharmacist Ensuring Patient Safety Practice Direction

2.4 The appropriate action to a drug related problem may include one or more of the following, conducted in collaboration with the patient, and the prescriber, where appropriate:

- 2.4.1 gathering additional information from the patient, the patient's health record, the patient's designate or another health care professional;
- 2.4.2 implementing a plan to monitor the drug related problem and to follow up when required;
- 2.4.3 assessing the patient's understanding and willingness of involvement in the plan and its outcomes;
- 2.4.4 reducing the drug related problem by adapting a prescription as described under the Regulations to *The Pharmaceutical Act*, Section 68(3);
- 2.4.5 accessing available lab values or ordering specific laboratory tests in consultation with the prescriber;
- 2.4.6 advising the patient, and the prescriber, where appropriate, about the drug related problem and discuss an alternative action, where appropriate;
- 2.4.7 entering into a patient-care relationship with another health care professional to manage the patient's drug therapy;
- 2.4.8 refusing to dispense or sell the drug or product to the patient; or
- 2.4.9 reporting an adverse reaction to the Canadian Adverse Drug Reaction Monitoring Program.

2.5 Documentation

If the licensed pharmacist has determined that an actual or potential drug related problem exists, the appropriate action(s) taken should be documented in the patient's health record.

Responsibilities of a Pharmacist
Patient Counselling Practice Direction

Required elements of the dialogue when a drug is dispensed or sold to a patient for the first time

2.12 The dialogue under 2.2.1 and 2.2.2 must:

- 2.12.1 confirm the identity of the patient,
- 2.12.2 identify the name and strength of the drug being dispensed,
- 2.12.3 identify the purpose of the drug,
- 2.12.4 provide directions for use of the drug including the frequency, duration and route of therapy,
- 2.12.5 identify the importance of compliance and the procedure if a dose is missed,
- 2.12.6 discuss common adverse effects, drug and food interactions and therapeutic contraindications that may be encountered, including their avoidance , and the actions required if they occur,
- 2.12.7 discuss activities to avoid,
- 2.12.8 discuss storage requirements,
- 2.12.9 provide prescription refill information,
- 2.12.10 provide information regarding how to monitor response to therapy,
- 2.12.11 provide information regarding expected therapeutic outcomes,
- 2.12.12 provide information regarding when to seek medical attention, and
- 2.12.13 provide other information unique to the specific drug or patient.

A licensed pharmacist, an academic registrant, student (while under direct supervision) or an intern must use reasonable means to comply with the provision of the information listed 2.12.1 through 2.12.13 for patients or their representatives who have language or communication difficulties.

2.13 If a drug-therapy problem is identified during the patient counselling, a licensed pharmacist, academic registrant, or intern must take appropriate action to resolve the problem.

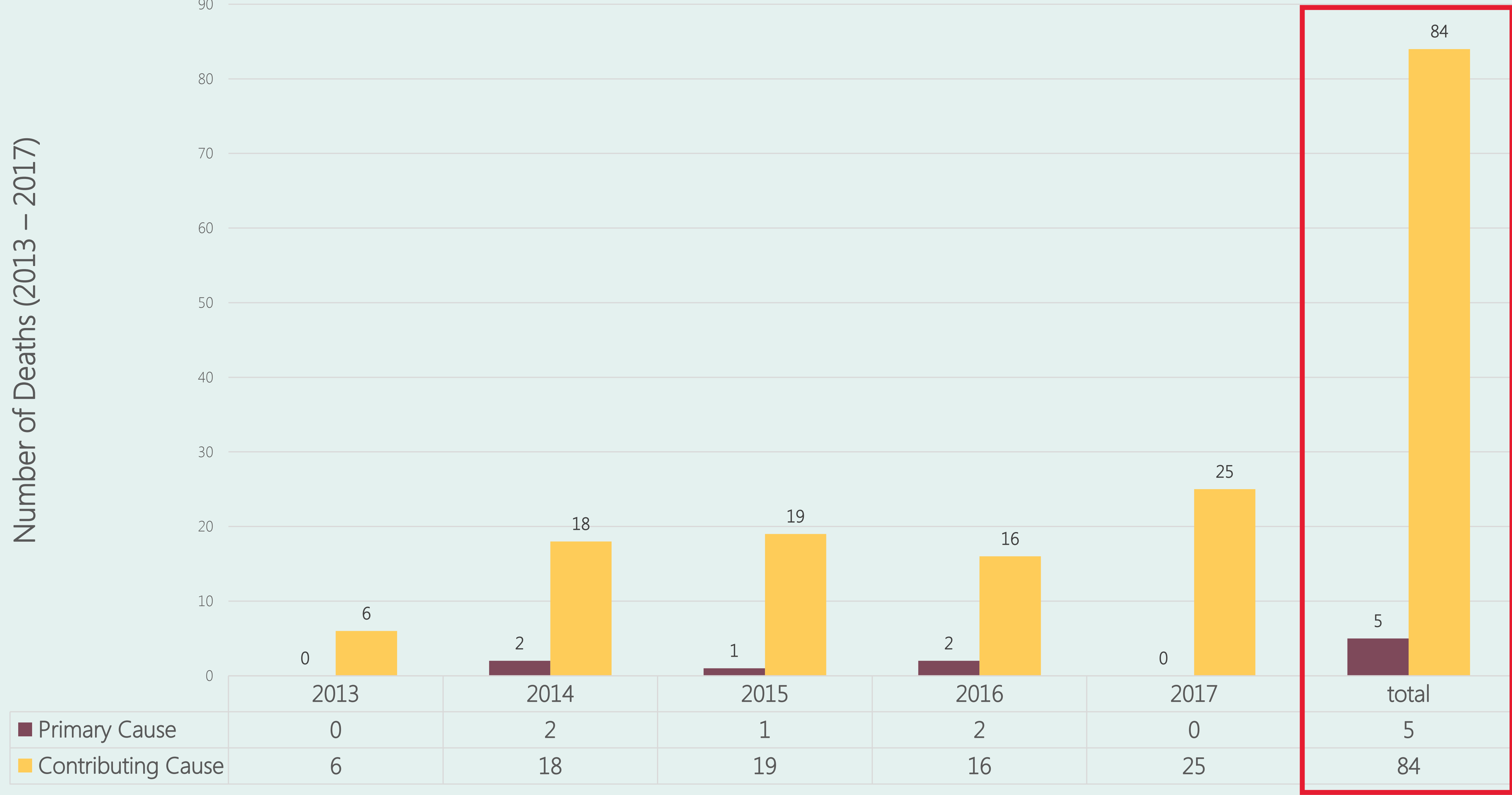
Rights of a Pharmacist
Termination of Patient Relationship

Providing Direction: Termination of patient relationship *by the licenced pharmacist*

2.2 A licenced pharmacist must carefully consider any decision to discontinue care and use reasonable efforts[1] to resolve any issues affecting the relationship with the patient prior to any final decision to terminating the relationship. If a licenced pharmacist is uncertain whether or not it is professionally acceptable to end a pharmacist-patient relationship, they are advised to seek additional professional advice.

Influence of the ME learnings on CPhM Policies and Regulations thus far…

- Exempted Codeine Practice Direction
- Dimenhydrinate/ Diphenhydramine Consultation
- CPhM Quality Assurance Processes
  - Education
  - Informs Standards of Practice, etc.


Diphenhydramine/Dimenhydrinate Primary vs. Contributing Cause of Death (2013 - 2017)
Number of Deaths (2013 – 2017)
90
80
70
60
50
40
30
20
10
0
0
6
2
18
1
19
2
16
0
25
5
84
2013
2014
2015
2016
2017
total
Primary Cause
0
2
1
2
0
5
Contributing Cause
6
18
19
16
25
84

Presenter Disclosure

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No conflicts of interest to declare

Part 3

Case Study and Discussion

Case Study: DN

- 52-year-old female found dead in her home on August 21, 2015
- No evidence of foul play or suicide note was at the scene
- Empty bottles of quetiapine
- PMH: depression, alcohol abuse and smoking, regularly used prescribed opiates for arthritis pain, an episode of “substance intoxication” in November 2014, insomnia, and regularly used OTC acetaminophen products.
- Autopsy: cause of death was determined to be probable cardiac arrhythmia, and mixed drug intoxication was a contributing factor

DPIN History

- **Date of Death**: August 21, 2015

Generic Name	Date Dispensed	Strength	Quantity	Days	Prescriber	Pharmacy
Acetaminophen/ codeine/caffeine	Aug 18, 2015 Jul 25, 2015 Jun 30, 2015 June 5, 2015 May 12, 2015 Apr 19 , 2015 Mar 22, 2015 Feb 26, 2015	300/30/ 15 mg	240	30	Dr. Vee	XYZ Pharmacy
Citalopram	Aug 13, 2015 Jul 11, 2015	20 mg	60	30	Dr. Vee	XYZ Pharmacy
Esomeprazole	Aug 13, 2015 Jul 11, 2015 Jun 10, 2015	40 mg	60	30	Dr. Vee	XYZ Pharmacy
Amitriptyline	Jun 10, 2015 Jun 10, 2015 May 8, 2015 May 8, 2015 Apr 9, 2015 Apr 9, 2015 Mar 10, 2015 Mar 10, 2015 Feb 9, 2015 Feb 9, 2015	50mg 25mg 50mg 25mg 50mg 25mg 50mg 25mg 50mg 25mg	30	30	Dr. Vee	XYZ Pharmacy

Toxicology Report: DN

Drug	Level (ng/mL)	Therapeutic Range, if applicable (ng/mL)
Amitriptyline Nortriptyline Total	523 104∞ 627*ǂ	 75-200
Codeine (free)	400*	10-100
Morphine (free)	15	10-80
Diphenhydramine≈	1540*	14-112
Quetiapine	2439*	100-1000

- *Indicates drugs that were above the therapeutic range
- ǂ Tricyclic antidepressants undergo post-mortem redistribution and levels may be slightly elevated in the toxicology report
- ∞ Nortriptyline is an active metabolite of amitriptyline
- ≈Diphenhydramine is the primary constituent of dimenhydrinate

Discussion

1) Controlled Dispensing
   - Consistent requests for early refills

Generic Name	Date Dispensed	Strength	Quantity	Days	Prescriber	Pharmacy
Acetaminophen/ codeine/caffeine	Aug 18, 2015 Jul 25, 2015 Jun 30, 2015 June 5, 2015 May 12, 2015 Apr 19 , 2015 Mar 22, 2015 Feb 26, 2015	300/30/ 15 mg	240	30	Dr. Vee	XYZ Pharmacy

Discussion

2) Diverted medications

- Quetiapine on scene never prescribed
- Alerting pharmacies involved

Generic Name	Date Dispensed	Strength	Quantity	Days	Prescriber	Pharmacy
Acetaminophen/ codeine/caffeine	Aug 18, 2015 Jul 25, 2015 Jun 30, 2015 June 5, 2015 May 12, 2015 Apr 19 , 2015 Mar 22, 2015 Feb 26, 2015	300/30/ 15 mg	240	30	Dr. Vee	XYZ Pharmacy
Citalopram	Aug 13, 2015 Jul 11, 2015	20 mg	60	30	Dr. Vee	XYZ Pharmacy
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Discussion

3) Stockpiling

- Amitriptyline discontinued July 11, 2015
- **Date of Death:** August 21, 2015

Generic Name	Date Dispensed	Strength	Quantity	Days	Prescriber	Pharmacy
Citalopram	Aug 13, 2015 Jul 11, 2015	20 mg	60	30	Dr. Vee	XYZ Pharmacy
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Discussion

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Morphine (free)	15	10-80
Diphenhydramine	1540*	14-112
Quetiapine	2439*	100-1000

4) OTC medications
- Supratherapeutic levels of DPH/DMH
- Abuse commonly cited in literature
- Strategies to prevent misuse:
  1. Track and record all purchases
  2. Keep DPH/DMH stock BTC
  3. 10-30 tabs > 100 tabs
  4. If kept OTC, stock only a limited number of packages
  5. Ensure OTC products within the direct line of sight of a pharmacist
  6. Always inquire about OTC drug use

Take Home Message

- Beware of a “typical” combination of drugs

Part 4

Resources for Pharmacist Intervention

Resources for Pharmacist Intervention

1. Canadian Guidelines for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain (CNCP)
2. Center for Effective Practice (CEP)
   a) Opioid Management of Chronic Non-Cancer Pain Tool
   b) Opioid Tapering Template
   c) Managing Benzodiazepine Use in Older Adults
3. CDC Guidelines for Prescribing Opioids for Chronic Pain
4. NAPRA Pharmacist's Virtual Communication Toolkit
5. CPSM Prescribing Opioids Guidelines

#1: 2017 Canadian Guidelines for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain (CNCP)

- Guidelines
- Opioid Manager

The 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain

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National pain center

#1: 2017 Canadian Guidelines for Safe and Effective Use of Opioids for CNCP

- Guidelines
  - Recommendation highlights

Recommendations 6 and 7: For patients with chronic noncancer pain who are beginning long term opioid therapy

Strong Recommendation

Recommendation 6: We recommend restricting the prescribed dose to less 90mg morphine equivalents daily rather than no upper limit or a higher limit on dosing

Some patients may gain important benefit at a dose of more than 90mg morphine equivalents daily. Referral to a colleague for a second opinion regarding the possibility of increasing the dose to more than 90mg morphine equivalents daily may therefore be warranted in some individuals.

Weak Recommendation

Recommendation 7: For patients with chronic noncancer pain who are beginning opioid therapy, we suggest restricting the prescribed dose to less than 50mg morphine equivalents daily.

The weak recommendation to restrict the prescribed dose to less than 50mg morphine equivalents daily acknowledges that there are likely to be some patients who would be ready to accept the increased risks associated with a dose higher than 50mg in order to potentially achieve improved pain control.

#1: 2017 Canadian Guidelines for Safe and Effective Use of Opioids for CNCP

- Guidelines
  - Recommendation highlights

Recommendation 9: For patients with chronic noncancer pain who are currently using 90mg morphine equivalents of opioids per day or more

Weak Recommendation

We suggest tapering opioids to the lowest effective dose, potentially including discontinuation, rather than making no change in opioid therapy.

Some patients are likely to experience significant increase in pain or decrease in function that persists for more than one month after a small dose reduction; tapering may be paused and potentially abandoned in such patients.

Recommendation 10: For patients with chronic noncancer pain who are using opioids and experiencing serious challenges in tapering

Strong Recommendation

We recommend a formal multidisciplinary program.

Recognizing the cost of formal multidisciplinary opioid reduction programs and their current limited availability/capacity, an alternative is a coordinated multidisciplinary collaboration that includes several health professionals whom physicians can access according to their availability (possibilities include, but are not limited to, a primary care physician, a nurse, a pharmacist, a physical therapist, a chiropractor, a kinesiologist, an occupational therapist, an addiction specialist, a psychiatrist, and a psychologist).

#1: 2017 Canadian Guidelines for Safe and Effective Use of Opioids for CNCP

- Opioid Manager

Opioid	Dosage forms	Initial dose	Minimum time interval for increase	Suggested dose increase	Maximum dose/day	50 MED	90 MED
Codeine CR	• Tab: 50, 100, 150, 200 mg	• 50 mg q 12 h	• 2 days	• 50 mg/d	• 300 mg q 12 h	• 334 mg/d	• 600 mg/d
Codeine IR	• Tab: 15, 30 mg • Syrup: 5 mg/mL • Elixir: 16 mg/10 mL with Acetaminophen 320 mg • Tab: 8, 15, 30, 60 mg with Acetaminophen 300 mg • Tab: 15, 30 mg with Acetaminophen 325 mg • Tab: 15, 30 mg with Acetylsalicylic acid 375 mg	• 15–30 mg q 4 h prn	• 7 days	• 15–30 mg/d	• 600 mg/d or acetaminophen 4 g/d	• 334 mg/d	• 600 mg/d
Hydromorphone CR, PR	• CR: 3, 4.5, 6, 12, 18, 24, 30 mg • PR: 4, 8, 16, 32 mg	• 3 mg q 12 h, maximum 9 mg/d • 4 mg q 24 h, maximum 8 mg/d	• Minimum 2 days • Minimum 4 days, recommended 14 days	• 3 mg/d • 4 mg/d	• N/A	• 10 mg/d	• 18 mg/d
Hydromorphone IR	• Tab: 1, 2, 4, 8 mg • Syrup: 1 mg/mL	• 1–2 mg q 4–6h prn, maximum 8 mg/d	• 7 days	• 1–2 mg/d	• N/A	• 10 mg/d	• 18 mg/d
Morphine CR, ER	• Tab: 15, 30, 60, 100, 200 mg • Cap (12 h): 10, 15, 30, 60, 100, 200 mg • Cap (24 h): 10, 20, 50, 100 mg	• 10–15 mg q 12 h • 10 mg q 24 h • 10 mg q 24 h	• Minimum 2 days, recommended 14 days	• 5–10 mg/d	• N/A	• 50 mg/d	• 90 mg/d
Morphine IR	• Oral solution: 1, 5, 10, 20, 50 mg/mL • Tab: 5, 10, 20, 25, 30, 50 mg • Cap: 5, 10, 20, 30 mg	• 5–10 mg q 4 h prn, maximum 40 mg/d	• 7 days	• 5–10 mg/d	• N/A	• 50 mg/d	• 90 mg/d
Oxycodone CR with naloxone CR	• Tab: 5/2.5, 10/5, 20/10, 40/20 mg	• 5 mg/2.5 mg q 12 h	• Minimum 1–2 days	• 5/2.5 mg/d	• 80 mg/d oxycodone and 40 mg/d naloxone	• 33 mg/d oxycodone	• 60 mg/d oxycodone
Oxycodone CR	• Tab: 5, 10, 15, 20, 30, 40, 60, 80 mg	• 10 mg q 12 h	• Minimum 2 days, recommended 14 days	• 10 mg/d	• N/A	• 33 mg/d	• 60 mg/d
Oxycodone IR	• Tab: 5, 10, 20 mg • Tab: 5 mg with acetylsalicylic acid or acetaminophen 325 mg • Tab: 2.5 mg with acetaminophen 325 mg	• 5–10 mg q 6 h prn, maximum 30 mg/d • 1–2 tab q 6 h prn • 1–2 tab q 6 h prn	• 7 days	• 5 mg/d	• N/A • Acetaminophen 4 g/d	• 33 mg/d	• 60 mg/d
Tapentadol ER	• Tab: 50, 100, 150, 200, 250 mg	• 50 mg q 12 h	• 3 days	• 50 mg q 12 h	• Not recommended >500 mg/d	• 160 mg/d	• 300 mg/d
Tapentadol IR	• Tab: 50, 75, 100 mg	• 50 mg q 4–6 h prn	• On the first day of dosing, the 2nd dose may be administered 1 hour after the first dose, if adequate pain relief is not attained with the first dose	• 50mg q 4–6 h	• Not recommended daily doses > 700 mg on the first day of therapy and 600 mg on subsequent days	• 160 mg/d	• 300 mg/d
Tramadol CR	• Tab (Zytram XL®): 75, 100, 150, 200, 300, 400 mg • Tab (Tridural®): 100, 200, 300 mg • Tab (Ralivia®): 100, 200, 300 mg • Tab (Durela®): 100, 200, 300 mg	• 150 mg q 24 h • 100 mg q 24 h • 100 mg q 24 h • 100 mg q 24 h	• 7 days • 2 days • 5 days • 5 days	• 75–100 mg q 24 h	• 400 mg/d • 300 mg/d • 300 mg/d • 300 mg/d	• 300 mg/d	• 540 mg/d* • Over maximum dose
Tramadol IR	• Tab: 50 mg • Tab: 37.5 mg with acetaminophen 325 mg	• 25 mg once daily** • 1 tablet q 4–6 h prn	• 4 days • Depends on patient's clinical response	• 25 mg/d • 1–2 tablet(s) q 4–6 h prn	• 400 mg/d • 8 tabs/day or acetaminophen 4 g/d	• 300 mg/d	• 540 mg/d* • Over maximum dose

http://nationalpaincentre.mcmaster.ca/opioidmanager/

#1: 2017 Canadian Guidelines for Safe and Effective Use of Opioids for CNCP

- Opioid Manager

Section C: Maintenance & Monitoring

- This section is intended to support providers with patients continuing opioid therapy.
- Monitor and document a patient's response to the opioid therapy through regularly scheduled appointments.

INITIATION, MAINTENANCE & MONITORING

These are the key elements to document upon initiating a trial of opioid therapy (3–6 month) and on an ongoing basis for monitoring purposes.

See **Appendix B - Initiation, Maintenance & Monitoring Chart** for a fillable version of this table that can be inserted into the patient medical record.

- ☐ Date (patient seen)
- ☐ Opioid prescribed
- ☐ Daily dose
- ☐ Daily morphine equivalent dose
- ☐ Date of new dose to be administered
- ☐ Status of patient goals
- ☐ Pain intensity (Brief Pain Inventory[iv])
- ☐ Functional status changes
- ☐ Adverse effects (e.g. fatal and non-fatal overdose, motor vehicle accident, addiction, sleep apnea, osteoporosis, drowsiness, constipation, dizziness/vertigo, hypogonadism, vomiting, nausea, sexual dysfunction, opioid induced hyperalgesia, dry skin/pruritis)
- ☐ Presence of clinical features of opioid use disorder (see **Clinical Features of Opioid Use Disorder** table)
- ☐ Date and result of last urine drug screening
- ☐ Naloxone prescription written
- ☐ Tapering offered
- ☐ Non-pharmacological therapies being used for pain
- ☐ Non-opioid pharmacotherapy being used for pain

Clinical pearls

- Opioids increase the risk of gastrointestinal adverse events vs. non-opioid therapy alone (64 more events per 1000 patients treated)
- Identify the lowest effective dose for patients continuing opioid therapy

http://nationalpaincentre.mcmaster.ca/opioidmanager/

#1: 2017 Canadian Guidelines for Safe and Effective Use of Opioids for CNCP

- Patients that would benefit most from THN:
  - Receiving >90 MED
  - Past, active, or evolving Opioid Use Disorder
  - Multiple comorbidities (e.g. lung disease, depression) receiving/using a concurrent BZD or a combination of sedative drugs
  - Reduced tolerance (detox, tapering, rotating)

Injected Naloxone

is an antidote for opioids which can include:

Codeine, Demerol, Hydromorphone, Heroin, Oxycodone, Dilaudid, Morphine, Buprenorphine, Fentanyl, Methadone

1 Signs of an Overdose

- Soft/no breath or snoring
- Pinpoint pupils
- Blue lips, nails, or skin
- Cold, clammy skin
- Limp body
- Doesn't respond to shouting

2 Call 911

3 Give Naloxone

Break drug ampoule →

Pull into needle very slowly →

Inject into large muscle

(after **step 4**) If they aren't breathing after 2-3 min, give another dose

4 Check The Person's Breathing

Breathing

Put person in recovery position

- Hand supports head
- Knee stops body from rolling onto stomach

Not Breathing

Push hard and fast in center of chest to the beat of *Stayin' Alive*

Give compressions until help arrives

5 Stay Calm

Don't put them in a bathtub/shower

Don't inject stimulants (ie. meth)

Don't stand them up

Wait for help to arrive

More info:
http://harmreduction.org/issues/overdose-prevention/overview/overdose-basics/
http://www.ccsa.ca/Resource%20Library/CCSA-CCENDU-Take-Home-Naloxone-Canada-2016-en.pdf
http://www.albertahealthservices.ca/info/page12491.aspx
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6423a2.htm

http://www.kellygrindrod.com/resources/

Intranasal Naloxone

is an antidote for opioids which can include:

Codeine, Demerol, Hydromorphone, Heroin, Oxycodone, Dilaudid, Morphine, Buprenorphine, Fentanyl, Methadone

1 Signs of an Overdose

- Soft/no breath or snoring
- Pinpoint pupils
- Blue lips, nails, or skin
- Cold, clammy skin
- Limp body
- Doesn't respond to shouting

2 Call 911

3 Give Naloxone

Peel the package open →

Place your thumb on the plunger →

Press plunger firmly into nostril

(after **step 4**) If they aren't breathing after 2-3 min, give another dose

4 Check The Person's Breathing

Breathing

Put person in recovery position

- Hand supports head
- Knee stops body from rolling onto stomach

Not Breathing

Push hard and fast in center of chest to the beat of *Stayin' Alive*

Give compressions until help arrives

5 Stay Calm

Don't put them in a bathtub/shower

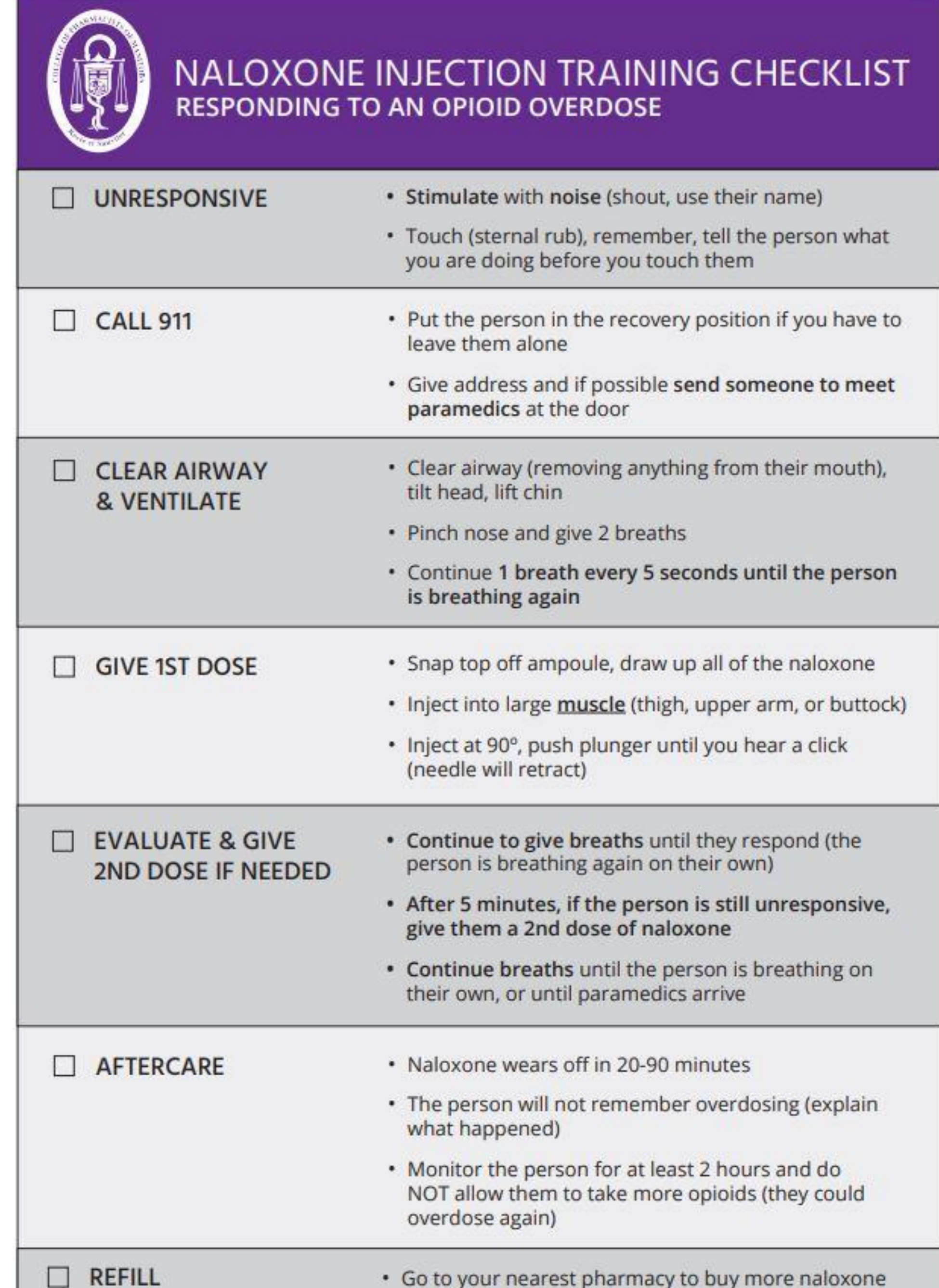
Don't inject stimulants (ie. meth)

Don't stand them up

Wait for help to arrive

More info:
http://harmreduction.org/issues/overdose-prevention/overview/overdose-basics/
http://www.ccsa.ca/Resource%20Library/CCSA-CCENDU-Take-Home-Naloxone-Canada-2016-en.pdf
http://www.albertahealthservices.ca/info/page12491.aspx
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6423a2.htm

https://uwaterloo.ca/pharmacy/naloxone-and-opioid-crisis-resources



NALOXONE INJECTION TRAINING CHECKLIST
RESPONDING TO AN OPIOID OVERDOSE

Step	Actions
☐ UNRESPONSIVE	• **Stimulate** with **noise** (shout, use their name) • Touch (sternal rub), remember, tell the person what you are doing before you touch them
☐ CALL 911	• Put the person in the recovery position if you have to leave them alone • Give address and if possible **send someone to meet paramedics** at the door
☐ CLEAR AIRWAY & VENTILATE	• Clear airway (removing anything from their mouth), tilt head, lift chin • Pinch nose and give 2 breaths • Continue **1 breath every 5 seconds until the person is breathing again**
☐ GIVE 1ST DOSE	• Snap top off ampoule, draw up all of the naloxone • Inject into large **muscle** (thigh, upper arm, or buttock) • Inject at 90°, push plunger until you hear a click (needle will retract)
☐ EVALUATE & GIVE 2ND DOSE IF NEEDED	• **Continue to give breaths** until they respond (the person is breathing again on their own) • **After 5 minutes, if the person is still unresponsive, give them a 2nd dose of naloxone** • **Continue breaths** until the person is breathing on their own, or until paramedics arrive
☐ AFTERCARE	• Naloxone wears off in 20-90 minutes • The person will not remember overdosing (explain what happened) • Monitor the person for at least 2 hours and do NOT allow them to take more opioids (they could overdose again)
☐ REFILL	• Go to your nearest pharmacy to buy more naloxone

College of Pharmacists of Manitoba | February 8, 2017

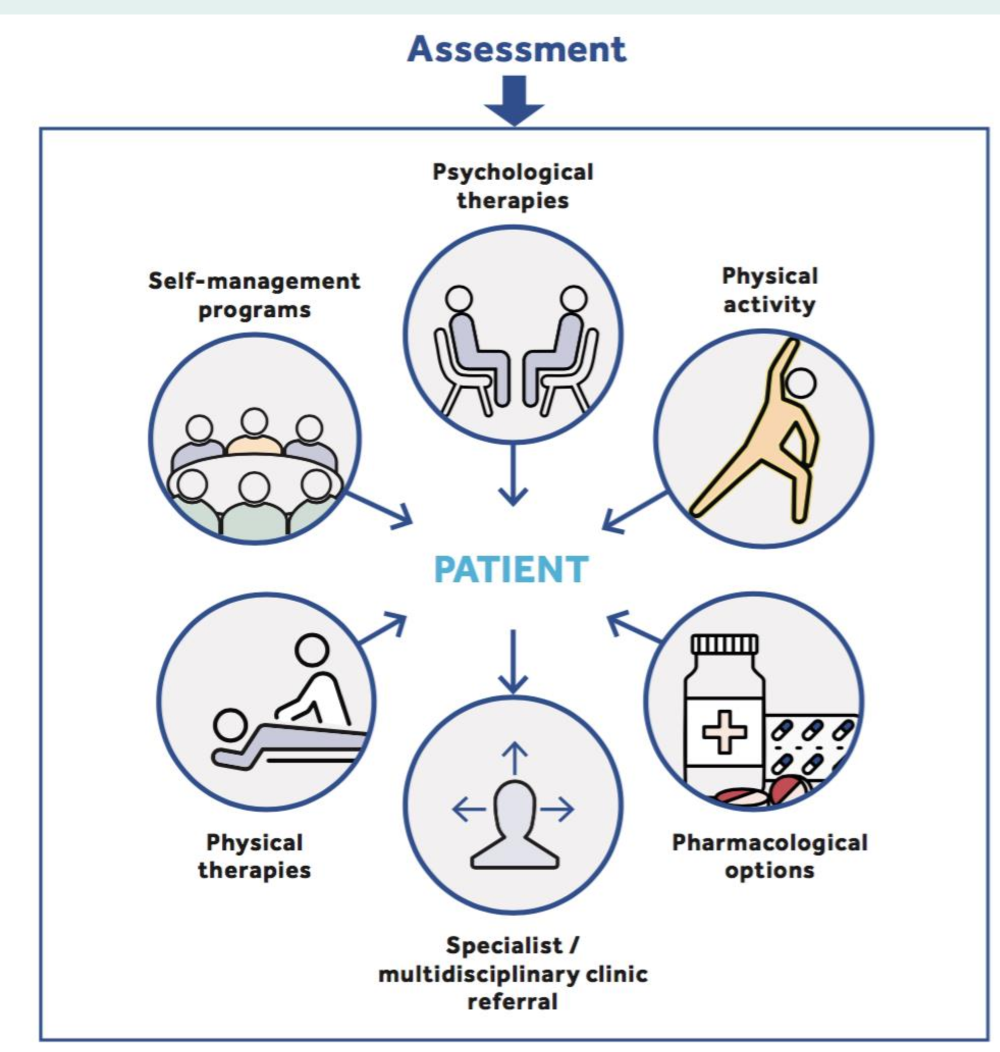
https://www.cphm.ca/uploaded/web/Legislation/Guidelines/Naloxone/Checklist%20for%20Naloxone%20Injection%20Training_MB.pdf

#2: Center for Effective Practice (CEP)

a) Management of Chronic Non-Cancer Pain Tool
b) Opioid Tapering Template
c) Managing Benzodiazepine Use in Older Adults

#2: Center for Effective Practice (CEP)

a) Management of Chronic Non-Cancer Pain (CNCP) Tool



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#2: Center for Effective Practice (CEP)

a) Management of Chronic Non-Cancer Pain Tool

https://cep.health/media/uploaded/20180628-CNCP-Rev-4.0FINAL.pdf

1. Baseline assessment	
Assessment parameter	**Factors to consider**[2,3,5]
Pain condition	☐ Identify pain diagnoses, e.g. osteoarthritis, fibromyalgia or neuropathic pain ☐ If suspected Complex Regional Pain Syndrome (CRPS)[i], consider urgent referral ☐ Assess biomedical yellow flags (see Yellow Flags table below) ☐ Pain: Brief Pain Inventory (BPI)[ii]: • Intensity • Character • Duration • Exacerbating and alleviating factors • Systemic symptoms ☐ Past investigations/consultations ☐ Response to current/past treatments (consider whether trial was long enough to evaluate efficacy/side effects) ☐ Past medical history ☐ Current medications (including prescription, non-prescription, and natural products)
Functional and social history	☐ Assess functional status and impairment (e.g. BPI) ☐ Psychosocial history: living arrangements, family/social support, family obligations, work status, sleep, relationships ☐ Assess social yellow flags (see Yellow Flags table below)
Mental health	☐ Current and past psychiatric history (e.g. depression PHQ-9[iii], anxiety GAD-7[iv], PTSD) ☐ Family psychiatric history ☐ Assess psychological yellow flags (see Yellow Flags table below)
Substance use history & opioid risk assessment	☐ Review history of substance use, abuse, and addiction (start with family history then personal history): ☐ Alcohol, cannabis, prescription medications, illicit drugs ☐ Attendance at an addiction treatment program ☐ If on opioids, review for the presence of any opioid use disorder features. May use Opioid Risk Tool[v], however, it has insufficient accuracy for risk stratification[2,6] ☐ Use urine drug testing before starting opioid therapy. Consider annual urine drug testing (or more often, as appropriate) for the use of opioid medication and/or illicit drugs[2]
Physical examination	☐ Document relevant physical examination based on diagnosed pain condition(s)

#2: Center for Effective Practice (CEP)

a) Management of Chronic Non-Cancer Pain Tool

YELLOW FLAGS[1]	
Assess the following to identify patients with CNCP who are at risk for poor outcomes:	
Biomedical	• Severe pain or increased disability at presentation • Previous significant pain episodes • Multi-site pain • Non-organic signs • Iatrogenic factors
Psychological	• Belief that pain indicates harm • Expectation that passive rather than active treatments are most helpful • Fear-avoidance behaviour • Catastrophic thinking • Poor problem-solving ability • Passive coping strategies • Atypical health beliefs • Psychosomatic perceptions • High levels of distress
Social	• Low expectations of return to work • Lack of confidence in performing work activities • Heavier workload • Low levels of control over rate of workload • Poor work relationships • Social dysfunction/isolation • Medico-legal issues

https://cep.health/media/uploaded/20180628-CNCP-Rev-4.0FINAL.pdf

#2: Center for Effective Practice (CEP)

a) Management of Chronic Non-Cancer Pain Tool

- Additional red flags:
  - Forged/altered RXs
  - Opioid/Benzodiazepine/sedative RXs from outside the immediate geographic area
  - Cash payments
  - Inconsistent/early refills
  - Multiple prescribers

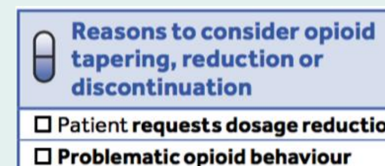
3. Clinical features of Opioid Use Disorder[8]

Indicator	Examples
Altering the route of delivery	• Injecting, biting or crushing oral formulations
Accessing opioids from other sources	• Taking the drug from friends or relatives • Purchasing the drug from the 'street' • Double-doctoring
Unsanctioned use	• Multiple unauthorized dose escalations • Binge use rather than scheduled use
Drug seeking	• Recurrent prescription losses • Aggressive complaining about the need for higher doses • Harassing medical office staff for faxed scripts or 'fit-in' appointments • Nothing else 'works'
Repeated withdrawal symptoms	• Marked dysphoria, myalgia, gastrointestinal symptoms, cravings
Accompanying conditions	• Currently addicted to alcohol, cocaine, cannabis, or other drugs • Underlying mood or anxiety disorders are not responsive to treatment
Social features	• Deteriorating or poor social function • Concern expressed by family members
Views on the opioid medication	• Sometimes acknowledges being addicted • Strong resistance to tapering or switching opioids • May admit to mood-leveling effect • May acknowledge distressing withdrawal symptoms

https://cep.health/media/uploaded/20180628-CNCP-Rev-4.0FINAL.pdf

#2: Center for Effective Practice (CEP)

b) Opioid Tapering Tool



- ☐ Patient **requests dosage reduction**
- ☐ **Problematic opioid behaviour** (e.g. diversion, altering the route of delivery, accessing opioids from other sources)
- ☐ Clear evidence of **opioid use disorder (OUD)**

Tapering **alone** is not likely an effective treatment for OUD. It may require further assessment and possible consultation to identify the optimal therapeutic options.

- ☐ **Adverse effects:**
  - ☐ Experiences **overdose** or early warning signs for **overdose risk** (e.g. confusion, sedation, slurred speech)
  - ☐ Medical **complications** (e.g. sleep apnea, hyperalgesia and withdrawal mediated pain)
  - ☐ Adverse effects **impair functioning** below baseline level
  - ☐ Patient does not tolerate adverse effects
- ☐ Opioid dosages >90 MED[1]
- ☐ Opioid dosages **>50 MED without benefit** in improving pain and/or function
- ☐ Opioid is **combined with benzodiazepines**[3]
- ☐ Other:

Provide information about why a taper might be needed:

- "Chronic pain is a complex disease and opioids alone cannot adequately address all of your pain-related needs."
- "I think it is time to consider the opioid dose you are on and its risk of harm. The risk of overdose and the risk of dying from overdose go up as the dose goes up."
- "Did you know that most of the evidence showing benefits from opioid use for chronic non-cancer pain supports relatively low doses (less than 100 MED)?"[1,2]
- "In some people, opioids can make their pain worse rather than better. Hyperalgesia resulting from an opioid is when the opioid makes one more sensitive to pain instead of less."

Ensure patients have clear expectations of tapering:

- "Some patients suffering with pain do better if they reduce their use of opioids."
- "Dose reduction or discontinuation of opioids frequently improves function, quality of life and pain control. This may take some time, and your pain may briefly get worse at first."

Address discrepancies between the patient's goals and their current pain management:

- "I want to make sure your pain management is as safe as possible and I want to get you back to your regular activities."

Adjust to any resistance to opioid reduction by reframing the conversation:

- "Opioids can have an effect on your central nervous system – they may be causing fatigue or lessening your ability to do daily activities. It is common to see one's alertness and function level go down when the opioid dose goes up."
- "Sounds like your pain has not improved even with the high dose you have been trying. It may be time to consider a lower dose."

https://cep.health/media/uploaded/20180305-Opioid-Tapering-Tool-Fillable.pdf

#2: Center for Effective Practice (CEP)

b) Opioid Tapering Tool

Section B: How to taper, reduce, or discontinue

For those on a higher dose and/or longer term opioids there is an increased potential for more challenges to tapering, including withdrawal symptoms.

General approach

- **Establish the opioid formulation to be used for tapering**
  - Switching from immediate release to controlled release opioids on a fixed dosing schedule may assist some patients in adhering to the withdrawal plan[1]
- **Establish the dosing interval**
  - Scheduled doses are preferred over PRN doses (to help with better pain control and withdrawal)
  - Keep the dosing interval constant (e.g. bid)
- **Establish the rate of taper based on patient health, preference and other circumstances**

  Individualize tapering schedule – there is insufficient evidence to recommend for or against specific tapering strategies and schedules[1,2]

  ☐ Slow taper should be followed unless otherwise indicated (e.g. patient preference)

  ☐ Rapid taper over 2–3 weeks

CAUTION: Reducing the dose immediately or rapidly over a few days/weeks, may result in severe withdrawal symptoms and is best carried out in a medically-supervised withdrawal centre.[1]

Example of slow taper

Current opioid: Morphine SR 120mg bid

Decrease Morphine SR by 15 mg

Weeks	Dose
Weeks 1 & 2	Morphine SR 105mg qam and 120mg qhs
Weeks 3 & 4	Morphine SR 105mg bid
Weeks 5 & 6	Morphine SR 90mg qam and 105mg qhs
Weeks 7 & 8	Morphine SR 90mg bid
Weeks 9 &10	Morphine SR 75mg qam and 90mg qhs
Weeks 11 & 12	Morphine SR 75mg bid
Weeks 13 & 14	Morphine SR 60mg qam and 75mg qhs
Weeks 15 & 16	Morphine SR 60mg bid
Weeks 17 & 18	Morphine SR 45mg qam and 60mg qhs
Weeks 19 & 20	Morphine SR 45mg bid

Continue until the lowest effective dose is found for the patient.

Example of rapid taper

Current opioid: Morphine SR 120mg bid

Decrease Morphine SR 120mg bid to 90mg bid x 3 days, then 60mg bid x 3 days, then 30mg bid x 3 days, then 15mg bid x 3 days, then 15mg qhs x 3 days, then stop

Other methods used to reduce dose, taper or discontinue:

- Switch current opioid to another opioid and reduce MED by 25% to 50% – see Opioid Manager Appendix C - Switching Opioids
- Switch to opioid agonist therapy such as buprenorphine-naloxone or methadone. If unfamiliar with protocol, clinicians should consult with someone knowledgeable with buprenorphine-naloxone use.[1] Online courses are available for providers to learn more about buprenorphine-naloxone use.

https://cep.health/media/uploaded/20180305-Opioid-Tapering-Tool-Fillable.pdf

#2: Center for Effective Practice (CEP)

c) Managing Benzodiazepine Use in Older Adults

Talking points

Ask patients what they take the benzodiazepine for

"What concerns did you originally start the benzodiazepine for? Have the concerns that led to your initial benzodiazepine prescription changed?"[10]

Highlight the benefits versus risks of benzodiazepine use for older adults

"Although benzodiazepines sometimes offer small benefits in the short term, they stop working and become harder to wean from over time. Despite this, the serious side effects of taking benzodiazepines remain, such as cognitive impairment, delirium, falls, fractures and increased risk of motor vehicle accidents."[7]

"To maintain your independence, it is important to reduce or remove any medications that increase your risk of cognitive impairment, delirium, falls, fractures and motor vehicle accidents."[7]

"While taking a benzodiazepine you have an increased risk of side effects:[11]

- 5 times higher risk of memory and concentration problems
- 4 times higher risk of daytime fatigue
- 2 times higher risk of falls and fractures (hip, wrist)
- 2 times higher risk of experiencing a motor vehicle accident"

"The benzodiazepine may cause problems with your memory and concentration which could result in an assessment of your driving privileges."[9]

https://cep.health/media/uploaded/CEP_BenzodiazapineTool_2019.pdf

#2: Center for Effective Practice (CEP)

c) Managing Benzodiazepine Use in Older Adults

SECTION C: Starting and continuing benzodiazepines (continued)

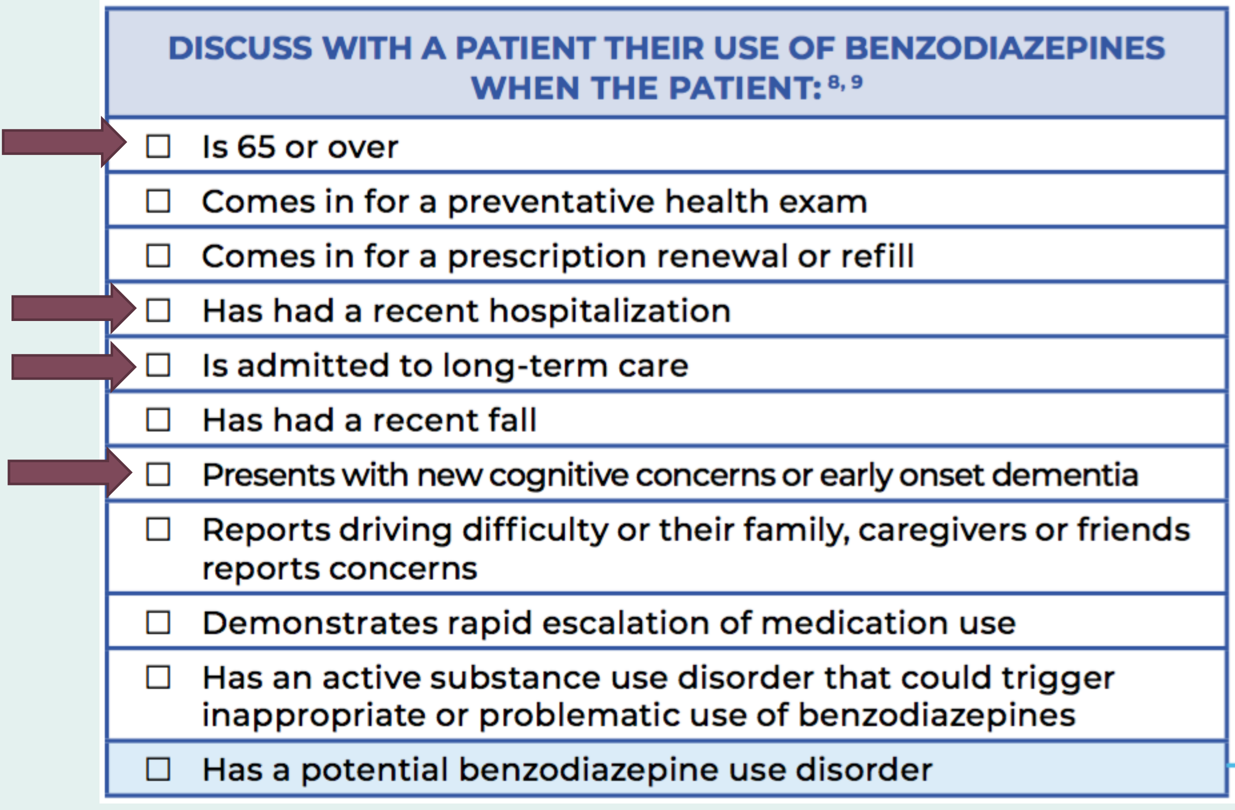
	BENZODIAZEPINES AVAILABLE IN ONTARIO [7, 21, 30, 31]				
	Benzodiazepine		Formulations	Approximate equivalent oral dose (mg)*	Half-life (hours)**
LONG-ACTING	Chlordiazepoxide	Capsule	**5 mg, 10 mg, 25 mg**	10	100
	Clorazepate	Capsule	**3.75 mg, 7.5 mg, 15 mg**	7.5	100
	Diazepam	Tablet	**2 mg^, 5 mg^, 10 mg^**	5	100
	Flurazepam	Capsule	**15 mg, 30 mg**	15	100
INTERMEDIATE-ACTING	Alprazolam	Tablet	**0.25 mg^, 0.5 mg^**, 1 mg^, 2 mg	0.5	12–15
	Bromazepam	Tablet	**1.5 mg^, 3 mg^, 6 mg^**	3	8–30
	Clobazam	Tablet	**10 mg^**	10	10–46
	Clonazepam	Tablet	0.25 mg, **0.5 mg^**, 1 mg, **2 mg^**	0.25	20–80
	Lorazepam	Tablet	**0.5 mg, 1 mg^, 2 mg^**	1	10–20
	Nitrazepam	Tablet	**5 mg^, 10 mg^**	5	16–55
	Oxazepam	Tablet	**10 mg^, 15 mg^, 30 mg^**	15	5–15
	Temazepam	Capsule	**15 mg, 30 mg**	15	10–20
SHORT-ACTING	Triazolam	Tablet	**0.125 mg^, 0.25 mg^**	0.25	1.5–5

^ Scored * Equivalent to 5mg diazepam ** Parent compound and active metabolite **Bolded** = covered by the Ontario Drug Benefit [30]

https://cep.health/media/uploaded/CEP_BenzodiazapineTool_2019.pdf

#2: Center for Effective Practice (CEP)

c) Managing Benzodiazepine Use in Older Adults



DISCUSS WITH A PATIENT THEIR USE OF BENZODIAZEPINES WHEN THE PATIENT: [8, 9]
☐ Is 65 or over
☐ Comes in for a preventative health exam
☐ Comes in for a prescription renewal or refill
☐ Has had a recent hospitalization
☐ Is admitted to long-term care
☐ Has had a recent fall
☐ Presents with new cognitive concerns or early onset dementia
☐ Reports driving difficulty or their family, caregivers or friends reports concerns
☐ Demonstrates rapid escalation of medication use
☐ Has an active substance use disorder that could trigger inappropriate or problematic use of benzodiazepines
☐ Has a potential benzodiazepine use disorder

https://cep.health/media/uploaded/CEP_BenzodiazapineTool_2019.pdf

#2: Center for Effective Practice (CEP)

c) Managing Benzodiazepine Use in Older Adults

SECTION B: Discontinuing benzodiazepines (continued)

ALTERNATIVE RATES FOR TAPERING

- Taper by 10% every 1–2 weeks until 20% of the original dose is reached, then taper by 5% every 2–4 weeks[14]
- For those experiencing severe side effects or severe anxiety, consider a slower taper of 10% every 2 weeks[14]
- For those taking a benzodiazepine for panic disorder, taper the weekly dose by a maximum of 10% per week over a period of 2–4 months
- For those who have been taking a long half-life benzodiazepine for only a short-term (e.g. up to 4 weeks of clorazepate or clonazepam), taper over 1 week
- Alprazolam
  - For doses <4mg/day, taper by no more than 0.5mg every 3 days or no more than 0.25mg every week[14]
  - For doses ≥4mg/day, even slower tapers over 3+ months are required (e.g. 0.5mg every 2–3 weeks, then slow to 0.25mg every 2–3 weeks when at 2mg/day)[14]

TAPERING LONG-ACTING BENZODIAZEPINES

- **Switching to long-acting benzodiazepines for a taper:**
  - Switching to long-acting benzodiazepines may be done (e.g. diazepam, clonazepam), but this has not shown to reduce the incidence of withdrawal symptoms or improve cessation rates more than tapering shorter-acting benzodiazepines[7]
  - Long-acting benzodiazepines do however offer advantages when tapering, including fewer rebound symptoms, constant drug levels and ease of formulation[14, 19, 20]
  - To reduce the severity of withdrawal symptoms, keep a patient on a long-acting benzodiazepine for at least 2 months following a switch (from a short-acting benzodiazepine) and before initiating a taper from the long-acting benzodiazepine[14]
- **To taper long-acting benzodiazepines:**[21]
  - Taper by no more than diazepam 5mg or clonazepam 0.25mg equivalent/week
  - Adjust rate of taper according to patient's symptoms
  - Slow the pace of the taper once the dose is below 20mg of diazepam equivalent (e.g. 1–2 mg/week)
  - Instruct the pharmacist to dispense daily, weekly or every 2 weeks depending on the dose and patient reliability

For additional examples of tapering approaches see The Ashton Manual[iii]

https://cep.health/media/uploaded/CEP_BenzodiazapineTool_2019.pdf

#3: CDC Guidelines for Prescribing Opioids for Chronic Pain

Guideline Resources: Clinical Tools

The Guideline for Prescribing Opioids for Chronic Pain is intended to help providers determine when and how to prescribe opioids for chronic pain, and also how to use nonopioid and nonpharmacologic options that are effective with less risk. The clinical tools below have been developed with you, the primary care provider, in mind, to help you carry out the complex task of balancing pain management with the potential risks that prescription opioids pose.

Talk with Patients

Talk with patients about their pain management options and risks of opioid treatments using Conversation Starters.

Quick Reference for Healthcare Providers

Quick Reference for Healthcare Providers [PDF – 1MB]

Urine Drug Testing

Urine Drug Testing [PDF – 96KB]

Mobile App

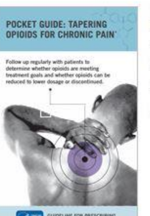
Opioid Prescribing Guideline Mobile App [PDF – 637K]

Guideline Resources: Mobile App

Pharmacists' Brochure

Pharmacists: On the Front Lines [PDF – 1MB]

Pocket Guide: Tapering



Pocket Guide: Tapering Opioids for Chronic Pain [PDF – 2MB]

Fact Sheet

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

Guideline for Prescribing Opioids for Chronic Pain: Recommendations [PDF – 725 KB]

Please note: An erratum has been published for this issue. To view the erratum, please click here.

Centers for Disease Control and Prevention
MMWR
Morbidity and Mortality Weekly Report
Recommendations and Reports / Vol. 65 / No. 1 March 18, 2016

CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016

Continuing Education Examination available at http://www.cdc.gov/mmwr/cme/conted.html.

#4: NAPRA Pharmacist's Virtual Communication Toolkit

Pharmacist's Virtual Communication Toolkit: Engaging in Effective Conversations About Opioids

New information is changing how opioids are being used.

Learn more about the 3 stages for engaging in conversations with your patients including strategies, behaviours and sample dialogue. This virtual toolkit links to a wide range of communication tools for both pharmacists and their patients.

STOP
AND LISTEN

DROP
STIGMA AND TALK ABOUT OPIOIDS

ROLL
WITH RESISTANCE

STOP & LISTEN to your patients. Patients are more likely to engage when you communicate your concern for their wellbeing.

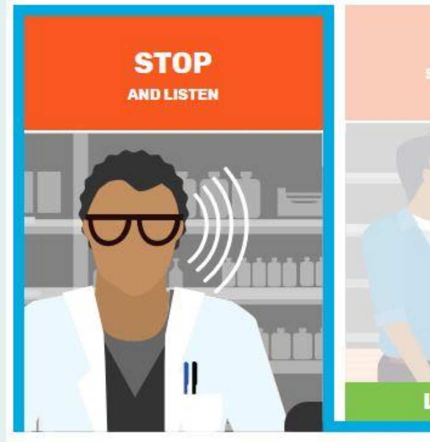
DROP STIGMA AND TALK ABOUT OPIOIDS Avoid assumptions about a patient's pain, life situation or willingness to talk. Share accurate information about opioids.

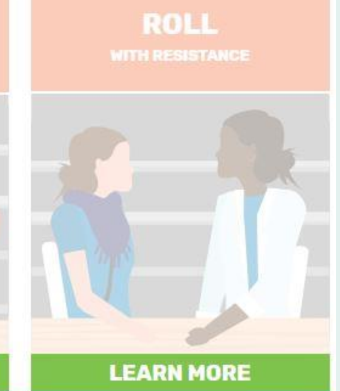
ROLL WITH RESISTANCE and encourage patients to work with you. Focus goals on what the patient wants to improve their quality of life -not only on pain scores.

LEARN MORE | LEARN MORE | LEARN MORE

https://napra.ca/pharmacists-virtual-communication-toolkit-engaging-effective-conversations-about-opioids

#4 : NAPRA Pharmacist Communication Toolkit





STOP & LISTEN to your patients. Patients are more likely to engage when you communicate your concern for their wellbeing.

BUILD TRUST WITH YOUR PATIENTS BY SHOWING THAT YOU CARE ABOUT THEM:

Connect with your patients in a private area.

Strategy	Sample Dialogue
Take a breath and relax your hands to model calmness.[8] Let patients know you have time.	*"I know it looks hectic around here, but I have time to help you with this prescription."*

Be curious, actively listen, and acknowledge patients' experiences with pain or opioids.[9]

Strategy	Sample Dialogue
Use open questions and invitations.	Questions: *"What are you doing for your pain? Where is the pain?"* Invitations: *"**Tell me** what you take." "**Explain** your pills to me." or "**Describe** what you are able to do each day."*
Reflect back both facts and feelings to ensure the patient feels heard and understood.	Fact: *"So, you haven't been able to cook or keep up with the housework. Tell me more."* Feeling: *"You are disappointed about missing the reunion."* Another approach is "Invite Listen and Summarize".[10]
Acknowledging someone's experience with opioids helps to build rapport and does not mean you support misuse of opioids.	*"You are in pain."* *"Many people are afraid reducing opioids will make their pain worse."*
Explore the human side of pain by asking questions outlined in the "ACT-UP" acronym: Activities, Coping, Thinking, Upset, People.[11]	Activities: *"How is your pain affecting your life (i.e. sleep, appetite, physical activities, and relationships)?"* Coping: *"How do you deal/cope with your pain (what makes it better/worse)?"* Think: *"Do you think your pain will ever get better?"* Upset: *"Have you been feeling worried (anxious)/depressed (down, blue)?"* People: *"How do people respond when you have pain?"*

https://napra.ca/pharmacists-virtual-communication-toolkit-engaging-effective-conversations-about-opioids

#5: CPSM Prescribing Opioids Guidelines

Schedule L – Prescribing Opioids

Attached to and forming part of the Standards of Practice of Medicine.

Preamble

This Standard establishes the standard of practice and ethical requirements of all physicians in Manitoba in relation to prescribing opioids. **This Standard excludes the treatment of active cancer pain, palliative care, end-of-life care, opioid replacement therapy, and opioid use disorder.** The purpose of this Standard is to assist members in prescribing opioids for maximum safety. Knowledge of the risk to benefit ratio of prescribing opioids has altered over time, so prescribing opioids must address pain, function, and the addiction. It recognizes that:

- Every member is professionally responsible for each opioid prescription the member provides to the patient.
  water
- In prescribing opioids each member provides their clinical judgment, which is to be that of a physician acting reasonably in the circumstances and is documented.
- Patients living with chronic pain can reasonably expect to experience at best a modest improvement in their pain when treated with opioids. Indiscriminate opioid prescribing is associated with significant patient and societal harms. There is no evidence that long term opioid treatment is indicated or effective for certain medical conditions including chronic headache disorders, fibromyalgia, and axial low back pain.
- There is valuable information available on prescribing opioids and members should educate themselves through available resources. Three valuable resources affirmed by the College as a national consensus, which may change over time as new evidence emerges, are:
  - *The 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain* http://nationalpaincentre.mcmaster.ca/documents/Opioid%20GL%20for%20CMAJ_01may2017.pdf and
  - The *Opioid Manager*, a tool designed to support healthcare providers in prescribing and managing opioids for patients with chronic non-cancer pain, http://nationalpaincentre.mcmaster.ca/opioidmanager/, both published by the National Pain Centre at McMaster University.
  - *Guidelines for Prescribing Opioids for Chronic Pain*, US Centers for Disease Control and Prevention, 2017, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

https://cpsm.mb.ca/cjj39alckF30a/wp-content/uploads/Standards%20of%20Practice/Standards%20of%20Practice%20of%20Medicine.pdf#page=88

Take Home Messages
1. Engage patients in meaningful conversations
2. Use Resources and Information Available
3. Collaborate with prescriber(s) and voice your concerns
4. Employ Additional Risk Mitigation Strategies
5. Always Monitor and Reassess
6. Document Relevant Interactions
UDS and Opioid Contracts
Drug Disposal
Controlled Dispensing
Lockboxes
Suggest Alternatives
Naloxone

References and Additional Reading

We would like to acknowledge the following resources:

- Surveillance of Opioid Misuse and Overdose in Manitoba. Available at: https://www.gov.mb.ca/health/publichealth/surveillance/opioid.html
- National Report: Apparent Opioid-related Deaths in Canada (Sept 2019). Available at: https://health-infobase.canada.ca/datalab/national-surveillance-opioid-mortality.html
- The 2017 Canadian Guidelines for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain. Available at: http://nationalpaincentre.mcmaster.ca/guidelines.html
- Center for Effective Practice, Practice Tools available at: https://cep.health/
- University of Waterloo, Naloxone and Opioid Resources. Available at: https://uwaterloo.ca/pharmacy/naloxone-and-opioid-crisis-resources
- CDC Guidelines for Prescribing Opioids for Chronic Pain, 2016. Available at: https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6501e1.pdf
- CDC Pharmacists: On the Front Lines, Addressing Prescription Opioid Abuse and Overdose. Available at: https://www.cdc.gov/drugoverdose/pdf/pharmacists_brochure-a.pdf
- College of Physicians and Surgeons of Manitoba, Schedule L - Prescribing Opioids Standard of Practice. Available at: https://cpsm.mb.ca/cjj39alckF30a/wp-content/uploads/Standards%20of%20Practice/Standards%20of%20Practice%20of%20Medicine.pdf#page=88
- NAPRA Pharmacist's Virtual Communication Toolkit. Available at: https://napra.ca/pharmacists-virtual-communication-toolkit-engaging-effective-conversations-about-opioids

Questions and Answers