Department of Anaesthesia and Pain Medicine

Acknowledgements

Prof Stephan Schug, HOD Pain Service RPH

Penny Tuffin, Senior Clinical Pharmacist RPH/FSH

Department of Anaesthesia and Pain Medicine

A Brief look at what the Pain Service offers at RPH

- Consultative service (We need to be invited to review)
- Providing Specialist Medical advice and support to Primary teams
- Professor Schug HOD and 10 Consultants and a Pain Fellow
- Close liaison with Regional Anaesthesia/Analgesia Service Cross Pollination
- Pain Medicine Centre Outpatients setting
- 1 CNC and 4 CN's specialising in Pain Medicine 3.4FTE
- Provide Education both in the hospital setting and outside of the hospital
- Sets Safe protocols incorporating Evidence based practice
- Recommended Guidelines for safe practice
- Nursing Practice Standards for Pain

Department of Anaesthesia and Pain Medicine

Rationale For Post-Operative Discharge Analgesia Guidelines

- No Real Guidelines for pharmacists and medical teams to follow
- Complex patients with Multi-injuries with Multi modal Analgesic approach
- Demand for Earlier discharge whilst still on multi-modal approach

Department of Anaesthesia and Pain Medicine

Rationale For Post-Operative Discharge Analgesia Guidelines continued

- To prevent re-admission due to inappropriate discharge planning of analgesia
- To prevent unnecessary long-term development of Chronic pain
- To prevent long term use of inappropriate analgesia increasing dependency/addiction issues

Department of Anaesthesia and Pain Medicine

Where do the Guidelines fit in with other documentation at RPH in the discharge planning

- Review of the Post-Operative guidelines
- Acute Pain service Considerations (Lanyard) inc: Pain Pathway. (What to do before you contact the pain service).
- Discharge Letter to Patient, GP and retained in integrated medical notes.

Department of Anaesthesia and Pain Medicine
Further Developments

- Requirement for guidelines for all patients hospital wide not just Post-operative guidelines

PAIN Pathway

P **aracetamol**
PO 1 g qid

A **nti-inflammatory** medication
celecoxib PO 100-200 mg bd

I **mmediate Release** (IR) Opioids
1st line tramadol 50-100 mg prn 1hrly
2nd line oxycodone 5-10 mg prn 1hrly

N **o improvement**
Seek advice from Acute Pain Service:
page 6450 WSC / 7235 SPC
or by eConsult

N.B The above medications and doses are a guide only. Always consider individual patient factors.

Acute Pain Service
(APS) Considerations

A ssessment of pain
Appropriate Administration of Analgesia for Active Function

P re-existing analgesics are Prescribed and given for Pre-existing Pain conditions (including Preoperatively)

S eek advice from APS if:

- PAIN Pathway followed and pain not relieved
- Complex pain issues are present:
  - neuropathic pain
  - chronic pain
  - opioid tolerance
  - major psychosocial issues

RPH M130909001

Government of **Western Australia**
Department of **Health**
South Metropolitan Health Service

Royal Perth Hospital

Post - Operative Inpatients Discharge Analgesia Guidelines

When prescribing analgesia for discharge consider:

1. Patient's clinical status
   - Age, renal and hepatic function, co-morbidities
2. Type of surgery and expected recovery pathway
   - Expected timeline of recovery
   - Need for rehabilitation and the likelihood of associated pain
   - Acute pain will diminish as the patient recovers
3. Analgesia required over the 24-48 hours pre-discharge
4. The risk of opioid misuse or unnecessary long term use
5. Pre-existing analgesia for long-term pain management prior to hospital admission

General recommendations:

DO prescribe:

1. regular paracetamol to all patients
2. celecoxib to continue course initiated in hospital to a maximum of 7 days
3. small quantities (up to 20 capsules) of tramadol 4 hourly prn for patients who need them
4. rarely - small quantities (up to 20 capsules) of oxycodone IR 4 hourly prn for patients who have demonstrated higher analgesic requirements on the ward

DO NOT prescribe without seeking advice/authorisation from Acute Pain Service:

1. pregabalin, gabapentin, duloxetine or tricyclic antidepressants
2. sustained release opioids (including tramadol and tapentadol)
3. immediate release opioids (excluding tramadol and oxycodone)
4. ketamine lozenges or wafers

DO provide:

1. information to patients regarding expected duration of pain and how to take analgesia
2. instructions to visit GP if pain not resolving

DO ASK for advice and a discharge plan from APS if patient:

1. has continued to require high doses of opioids post-operatively
2. is still requiring slow release opioids or medications for neuropathic pain at time of discharge
3. may require ongoing pain management post-discharge
4. is a Registered Opioid Addict or on CPOP program.To check call Health Dept on (08) 9222 4424. (prescribers only)

Examples of recommended post-operative discharge analgesia

Example 1: The 'average' post-op patient

fentanyl PCA	ceased when oral intake possible
paracetamol 1g PO/IV qid *tramadol 50-100 mg PO/IV 1 hourly prn*	continue until discharge
celecoxib 100-200 mg bd	from when able to take orally for 5-7 days
oxycodone 5-10 mg 1 hourly prn	from when PCA ceased

Discharge home with:

1. paracetamol 1 g qid for at least 5 days (x 50 tablets)
2. celecoxib for remainder of 5 to 7 days (or longer if requested by surgeon)
3. tramadol 50 mg 4 hourly prn
   - (x20) if being sent home sooner than 24 hours since PCA ceased
   - (x20) if needed ≥ 2 doses in last 24 hours with PCA ceased
   - (x10) if needed 1-2 doses in last 24 hours with PCA ceased
4. oxycodone 5 mg 4 hourly prn
   - (x20) if needed ≥ 5 doses in last 24 hours with PCA ceased
   - (x10) if needed 2-4 doses in last 24 hours with PCA ceased
5. Instructions to see GP if pain not resolving

Example 2: The 'non complex' post-op patient

fentanyl PCA	ceased when oral intake possible
paracetamol 1g PO/IV qid *tramadol 50-100 mg PO/IV 1 hourly prn*	continue until discharge

Discharge home with:

1. paracetamol 1 g qid for at least 3-4 days (x 30 tablets)
2. tramadol 50 mg 4 hourly prn
   - (x20) if being sent home sooner than 24 hours since PCA ceased
   - (x20) if needed > 2 doses in last 24 hours with PCA ceased
   - (x10) if needed 1-2 doses in last 24 hours with PCA ceased
   - no tramadol if no tramadol requirement in last 24 hours with PCA ceased
3. Instructions to see GP if pain not resolving

Please contact the APS Registrar (pager 6450) if you have queries regarding these guidelines.