**Ontario consensus guidelines on opioid-prescribing in Emergency Departments**

Input from addiction specialists, pain specialists, primary care experts, public health experts, and LHIN leads for Emergency Medicine

**INTENDED AUDIENCE**

LHIN Emergency Medicine Leads, Emergency Department physicians practicing in Ontario

**PURPOSE**

Ontario needs a consistent and persistent approach to prevent opioid-related harms in the community. A policy for safer prescribing of opioids in the Emergency Department helps to enable adherence to best practice and empowers physicians to prescribe appropriately.¹

**BACKGROUND**

As rates of physician prescriptions for opioids have increased, so too have morbidity and mortality for prescription opioid-related deaths.² A significant proportion of opioids used for non-medical purposes are obtained legally through physicians.²⁻⁴ This is startling, considering Canada has the second highest opioid prescribing rates per capita, and no other province or territory dispenses opioids at a higher rate than Ontario.⁵ From 2006-2013 there was a nearly 250% increase in the number of emergency department (ED) visits in Ontario related to withdrawal, overdose, intoxication, harmful use, and other opioid-related diagnoses.⁶ Thus, few groups of professionals, if any, understand the magnitude of this problem better than Emergency Department physicians.

Patients frequently request opioid prescriptions from ED physicians. From one perspective, providing adequate pain management has become an increasingly important goal of emergency care. However, safer prescribing practices are difficult in the ED environment where there is limited continuity of care and poor access to a patient’s past medical files or medication history. The CMPA regularly receives calls from physicians expressing discomfort with the challenges associated with this group of patients, such as risk of addiction, overdose and diversion. The CMPA reminds physicians that they retain professional responsibility for every prescription they write⁷. As per the CPSO prescribing policy, physicians have no obligation to prescribe any drug if they do not feel it is clinically appropriate.⁸ Furthermore, as the misuse of prescription drugs is a serious and growing public health problem, ED physicians have a duty to reduce or impede this diversion. A reduction in a region’s community prescribed opioid load can decrease diversion of prescription opioids within the community and thereby minimize the risk opioids impose on the population.⁹

Long term opioid use should be initiated through a care provider that can build a relationship with the patient, assess for risk of addition with the help of the Opioid Risk Tool and Opioid Manager (Appendix A), monitor the use through urine screening and regular visits, establish goals, and routinely reassess the pain problem⁹. It is recommended that the patient and physician sign a treatment agreement (Appendix B), which typically includes a statement that the patient will not seek opioid prescriptions from other physicians, particularly in the ED.¹⁰ In the context of the acute-care setting these patients are better served by having proper referrals and follow-ups arranged.

Undoubtedly, there are scenarios in which prescribing opioids are part of good clinical care, and the CPSO recommends that physicians do not adopt a blanket “no narcotics” policy.⁹ In the acute setting the benefits of prescribing opioids must be prudently weighed against their risks. Prior to initiating opioid therapy comprehensive screening for potential addiction or misuse is critical, and limits must be set for dosing and dispensing.

Emergency physicians have an opportunity to show leadership in this opioid epidemic through the development and implementation of a policy that can be later adopted by urgent care, walk-in clinics, and many other outpatient settings. The following recommendations are intended for patients who state that they have chronic pain who
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Input from addiction specialists, pain specialists, primary care experts, public health experts, and LHIN leads for Emergency Medicine present to the ED. They are not meant for patients who are undergoing palliative care, nor those with an acute painful illness or injury. They do not replace clinical judgment in the appropriate care of patients.

KEY RECOMMENDATIONS

1) Non-opioid options are first-line for all patients with pain. These include but are not limited to non-pharmacological interventions, NSAIDs, acetaminophen, local anesthetics, and other recommendations outlined in the Canadian Neuropathic Pain Guidelines.11
   - ED physicians can play an important role in promoting non-opioid based care by explaining to patients that there is no evidence for the use of opioid in chronic pain, and that it can cause serious and dose-dependent harm that can be fatal.

2) If an ED physician decides to prescribe opioids, they must comply with CPSO regulations regarding prescription writing and patient identification; as well as the Narcotics Safety and Awareness Act. Patients must be able to prove their identity.

3) Before initiating opioid therapy, all patients should be assessed for opioid misuse or addiction risk using targeted history or validated screening tools, such as the Opioid Risk Tool and Opioid Manager (Appendix A).10 If an addiction problem is identified, ED departments should perform brief interventions or make appropriate referrals for patients to have chemical dependency assessments.12
   - Alternatively, the single question “How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons?” (with an answer of one or more considered positive) may be preferable in the ED. This single question was found to be 100% sensitive and 73.5% specific for the detection of a drug use disorder compared with a standardized diagnostic interview.13

4) Opioid prescriptions will be written for the least potent opioid, with the lowest possible effective dose, and a limited period of time until follow-up with a long term care provider can be arranged.
   - ED physicians should prescribe no more than a short course of opioid analgesics. The New York guideline states that most patients require no more than three days, and the Washington State guidelines suggest a maximum of 30 tablets.14-15

5) ED physicians should take the following precautions when prescribing opioid analgesics:
   - Avoid long-acting or extended-release opioid analgesics
   - Avoid intravenous or intramuscular opioids.
   - Avoid prescribing to patients currently taking benzodiazepines.
   - Avoid prescribing to patients currently taking opioids.

6) Prescriptions for opioid medications that have been lost, stolen or destroyed should NOT be refilled.
   - If the circumstances seem compelling consider obtaining collateral information such as by contacting the pharmacist and/or primary care provider.
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7) Emergency Departments should endeavour to maintain a list of clinics, practitioners, and services for appropriate referrals and follow-up for patients with chronic pain or addiction needs. This list should include chronic pain specialists, physiotherapists/occupational therapists (particularly those who accept ODSP clients), addiction and mental health services, methadone or buprenorphine/naloxone providers, harm reduction groups, and inner-city health organizations.

8) All patients receiving an opioid prescription should be provided information in the form of verbal and/or written instruction (Sample, Appendix C) regarding the risks of overdose and dependence, safe storage (preferably locked) and proper disposal (leftover pills should be returned to the pharmacy for appropriate disposal). Contact information for mental health and addictions services should be included if an addiction problem is identified.

9) When prescribing opioids in the Emergency Department or as the result of post-operative pain treatment, follow-up visits with the family care provider should be encouraged for good continuity of care, for managing opioid reduction and for alternative pain management.

10) Signs should be posted in waiting areas with a simple summary of the department’s opioid prescribing policy (Sample, Appendix D).

These guidelines were adapted from the New York City Emergency Department Discharge Opioid Prescribing Guidelines Available at http://www.nyc.gov/html/doh/html/hcp/drug-opioid-guidelines.shtml

Presently, the Narcotic Monitoring System (NMS) put in place provincially does not actually prevent double doctoring, since it does not provide any real-time feedback to prescribers. Therefore, we will continue to advocate for real-time access to NMS data for all ED and urgent care centers in Ontario.

KEY RESOURCES

1) Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain http://nationalpaincentre.mcmaster.ca/opioid
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Appendix A: Opioid Manager
Appendix B: Opioid Medication Treatment Agreement
Appendix C: Patient Information Handout
Appendix D: Waiting Room Policy Poster

REFERENCES:

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Appendix A: Opioid Manager
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Appendix B: Opioid Medication Treatment Agreement

**Sample Opioid Medication Treatment Agreement**

I understand that I am receiving opioid medication from Dr. ____________ to treat my pain condition. I agree to the following:

1. I will not seek opioid medications from another physician. Only Dr. ____________ will prescribe opioids for me.
2. I will not take opioid medications in larger amounts or more frequently than is prescribed by Dr. ____________.
3. I will not give or sell my medication to anyone else, including family members; nor will I accept any opioid medication from anyone else.
4. I will not use over-the-counter opioid medications such as 222s and Tylenol® No. 1.
5. I understand that if my prescription runs out early for any reason (for example, if I lose the medication, or take more than prescribed), Dr. ____________ will not prescribe extra medications for me; I will have to wait until the next prescription is due.
6. I will fill my prescriptions at one pharmacy of my choice; pharmacy name:

                     
7. I will store my medication in a secured location.

I understand that if I break these conditions, Dr. ____________ may choose to cease writing opioid prescriptions for me.

THIS AGREEMENT MADE the ____ day of ____________, 20__.

_________________________  __________________________
Patient Signature           Physician Signature

— adapted from the Canadian Guideline for Safe and Effective Use of Opioids in Chronic Non-Cancer Pain
Opioid Treatment Agreement Information

Opioids are an important part of a comprehensive pain treatment program. Ideally, a treatment agreement should be discussed prior to initiation of a long term opioid trial after evaluation of opioid risk with your patient. Opioid treatment agreements may not be necessary for all long-term opioid patients, however, they should be considered for those patients at high risk of misuse or abuse.

The purpose of a treatment agreement is to:
- Promote communication between the physician and patient.
- Improve patient safety.
- Clarify possible prescribing issues and how they will be managed.
- Avoid misunderstandings.
- Improve practice efficiency.
- Assist the physician in dealing with aberrant behaviours.

The sample treatment agreement provided can be modified to reflect physician prescribing practices and individual patient circumstances. Some options to consider if appropriate are:

1. I may be required to have part-fills of my prescriptions to improve safety.
2. I may be required to do urine drug screening and/or blood testing as part of my medication management.
3. I will not use any mood-altering drugs or medications while being prescribed opioids.
4. I agree to participate in other treatment modalities recommended by Dr. ________________.
5. For my opioid trial to be a success, I would like to achieve:

<table>
<thead>
<tr>
<th>Pain (0-10)</th>
<th>Now</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Setting realistic treatment goals with your patient is important and this can be incorporated in your treatment agreement to guide care. Physicians should have firm boundaries around opioid prescribing in their practices. Physicians should be consistent but exercise judgement for unusual circumstances. Repeated aberrant behaviour is more worrisome than a one-time situation with a reasonable explanation.

It is important to ensure informed consent prior to initiating long-term opioid therapy. A discussion about potential benefits, side effects, complications, and risks is important to have with your patient. Setting realistic goals with your patient about pain reduction and/or functional improvement can be helpful to determine optimal dose and manage expectations. Patient educational materials are provided in the Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain in Appendix B-4.

For more information about the Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain go to: http://nationalpaincentre.mcmaster.ca/opioid/.
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Appendix C: Patient Information Handout

Messages for Patients Taking Opioids

Note: Opioids are a group of similar medications that are used to help with pain — there is more than one type of opioid and they have different names for example, Percocet®, OxyContin®, Tylenol® No. 2, Tramace®.

1. Opioids are used to improve your ability to be active and reduce pain.
   - You and your doctor will set goals and ensure the medication is effective in achieving the goals, e.g. improving your ability to do the things you did before pain prevented you.
   - If you seem to benefit from the pain medication, your doctor will see you for follow-up visits to assess pain relief, any adverse effects, and your ability to meet your set activity goals.

2. There are side effects from opioids, but they can be mostly controlled with increasing your dose slowly.
   - Common side effects include:
     - nausea (28% of patients report it), constipation (26%),
     - drowsiness (24%), dizziness (18%), dry-skin/itching (15%), and
     - vomiting (15%).
   - Side effects can be minimized by slowly increasing the dose of the drug and by using anti-nausea drugs and bowel stimulants.

3. Your doctor will ask you questions and discuss any concerns with you about your possibility of developing addiction.
   - Addiction means that a person uses the drug to “get high,” and cannot control the urge to take the drug.
   - Most patients do not “get high” from taking opioids, and addiction is unlikely if your risk for addiction is low: those at greatest risk have a history of addiction with alcohol or other drugs.

4. Opioids can help but they do have risks — these can be managed by working cooperatively with your doctor.
   - Take the medication as your doctor prescribed it.
   - Don’t drive while your dose is being gradually increased or if the medication is making you sleepy or feel confused.
   - Only one doctor should be prescribing opioid medication for you — don’t obtain this medication from another doctor unless both are aware that you have two prescriptions for opioids.
   - Don’t take opioids from someone else or share your medication with others.
   - You may be asked for a urine sample — this will help to show all the drugs you are taking and ensure a combination is not placing you at risk.
   - Your doctor will give you a prescription for the amount of medication that will last until your next appointment — keep your prescription safe and use the medications as instructed — if you run out too soon or lose your prescription your doctor will not likely provide another
   - If you cannot follow these precautions it may not be safe for your doctor to prescribe opioid medication for you.
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5. If you stop taking your medication abruptly, you will experience a withdrawal reaction.
   - Withdrawal symptoms do not mean you are addicted — just that you stopped the drug too quickly — your doctor will direct you on how to slowly stop this medication so you won’t have this experience.
   - Opioid withdrawal symptoms are flu-like, e.g., nausea, diarrhea, and chills.
   - Withdrawal is not dangerous but it can be very uncomfortable.
   - If you interrupt your medication schedule for three days or more for any reason, do not resume taking it without consulting a doctor.

6. Overdose from opioids is uncommon, but you and your family should be aware of the signs.
   - Opioids are safe over the long term, BUT can be dangerous when starting or increasing a dose.
   - Overdose means thinking and breathing slows down — this could result in brain damage, trauma, and death.
   - Mixing opioids with alcohol or sedating drugs such as pills to help anxiety or sleeping, greatly increases the risk of overdose.
   - You and your family should be aware of signs of overdose — contact a doctor if you notice: slurred or drawing speech, becoming upset or crying easily, poor balance or, “nodding off” during conversation or activity.

7. The medication the doctor prescribes for you can be very dangerous to others.
   - Your body will get used to the dose your doctor sets for you but this same dose can be very dangerous to others.
   - You have reached your proper dose slowly, but someone who is not used to the medication could have a serious reaction, including death — don’t give your medication to anyone else — it is illegal and could harm them.
   - Keep your medication securely stored at home — the bathroom medicine cabinet is not a safe place; research has shown that others, particularly teenagers might help themselves to these drugs from friends or relatives.
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Appendix D: Waiting Room Policy Poster

PRESCRIBING OPIOID PAINKILLERS IN THE EMERGENCY DEPARTMENT

People sometimes misuse opioid painkillers, either by taking them in ways they weren’t prescribed or by taking someone else’s prescription. In New York City, one in four overdose deaths involve opioid painkillers. Our emergency department will only provide pain relief options that are safe and appropriate.

FOR YOUR SAFETY, WE DO NOT:

* Prescribe long-acting opioid painkillers.  
  Such as oxycodone (OxyContin®), morphine (MSContin®), fentanyl patches (Duragesic®) or methadone.
* Prescribe more than a short course of opioid painkillers.  
  3 days in most cases.
* Refill lost, stolen or destroyed prescriptions.

Prescription opioid painkillers can be just as dangerous as illegal drugs.

- Opioid painkillers can cause confusion, drowsiness and increased sensitivity to pain.
- People can become dependent on or addicted to opioid painkillers.
- An overdose of opioid painkillers can cause a person to stop breathing and die.

Keep your prescription opioid painkillers safe!

- Keep opioid painkillers in their original labeled containers.
- Keep opioid painkillers out of sight and out of reach of children, preferably in a locked cabinet or on a high shelf.
- Get rid of opioid painkillers you are no longer using by flushing them down the toilet.

Problem with painkillers?  
Help is available — call 1-800-LIFENET

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Notice to Patients

Emergency Department Policy on Opioid Pain Prescriptions

At Guelph General Hospital, we do our best to provide the safest care possible. If you have a pain condition, our Emergency doctors will help you and offer treatment choices. However, they are under no obligation to give opioid prescriptions (strong pain medicines). Those require ongoing monitoring for both safety and effectiveness.

For safety reasons, our doctors will not renew expired or lost opioid prescriptions. If you need ongoing pain management, we ask you to visit your family doctor or specialist. If needed, we can help you find a healthcare provider.

Thank you
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We do not prescribe, renew or replace lost pills of narcotics for chronic conditions.
We do not prescribe medical marijuana or other controlled substances.
Consult your doctor for those prescriptions.

Nous ne prescrivons pas, ne renouvelons pas et ne remplaçons pas de narcotiques utilisés pour une maladie chronique.
Nous ne prescrivons pas non plus de cannabis médical ou de substances contrôlées.
Consultez votre médecin traitant pour obtenir ces médicaments.