**Management of Post-Operative Opioids**

**Background**

The launch of the Faculty of Pain Medicine: Royal College of Anaesthetists Opioid Aware resources (2015) highlighted the economic and health impacts of long term opioid use. The document recommends that opioids are useful in acute pain, but prescribing should be monitored, prescriptions reviewed regularly and where possible reduced or stopped.

As a service we often recommend opioid analgesia for post-operative pain management. However we were unclear what happens with these recommendations after patients are discharged.

**Aim and Objectives**

Our aim was to ensure that post-operative opioids were being effectively managed and tapered in the community. By looking at the information provided to both patients and their General Practitioner, we hoped to identify any missed opportunities to communicate the patient’s analgesic plan.

As a secondary objective we wanted to examine specific specialties, operations and opioids to help target any future educational interventions.

**Methods**

Ethical approval was not required. We used the departmental database to identify patients who had received epidural analgesia for major surgery, as there was potential for them to have ongoing pain and opioid use in the community. We included all patients from the departmental database between 02/01/19 and 14/02/19, leading to a sample size of 50 patients. Patients were then excluded if they had died or had a palliative diagnosis.

Utilising a pro forma, we searched the Trust electronic patient record to establish which patients were discharged with an opioid prescription. Contact was made with these patients via telephone between 46 and 113 days after discharge.

**Main results**

Of the 50 patients 2 were excluded for the above reasons and 32 were discharged on an opioid. Of these only 6 had any information regarding ongoing opioid management on their discharge letter.

We managed to contact 19 of the 32 patients and only 1 reported receiving opioid management advice prior to discharge. 6 (31.6%) of the patients contacted were still using an opioid under the care of their General Practitioner, the most common of which being oxycodone, despite more morphine and codeine being prescribed on discharge.

**Conclusions**

A significant number of patients continued to use opioids after discharge. Communication between the Trust and patients/their General Practitioner was inadequate in relation to opioid reduction. With noticeable anxiety expressed by patients regarding the lack of an analgesic plan on discharge.

These patients were seen by the pain service, who in a separate audit of their patient’s notes found an opioid reduction plan documented in 46 of 63 cases. Our results would suggests that retention of this information by patients after discharge is poor.

We intend to introduce a specific patient information leaflet discussing how to manage post-operative pain and opioids. This will be distributed to all patients who are discharged with opioid analgesia. In addition, we have recently introduced teaching sessions for medical and nursing staff regarding opioid management strategies on discharge and improving the information sent to General Practitioners. We are also proposing a business case for a telephone follow up service.