# Lessons learned tackling high opioid prescribing

As a practice of 10 000 patients, we identified all patients who were prescribed opioid-based analgesia at daily doses greater than 120 mg. In total, 35 patients were identified and we have spent the last 12 months reducing these doses down to below 120 mg. So far, 29 of the patients have reduced below 120 mg daily morphine (one patient left the surgery, one died, and one was removed due to unacceptable behaviour unrelated to reducing their opioids). The remaining three patients are all expected to reduce below 120 mg in the next 3 months.

Lessons we have learned from the project are as follows:

## POTENCY OF DIFFERENT OPIOIDS

As clinicians, we had limited awareness of the different potency of some opioids, specifically oxycodone and fentanyl. Very high daily morphine doses were found in these groups (highest doses were 480 mg daily morphine for oxycodone and 404 mg daily morphine for fentanyl). There were also a number of patients on more than one type of opioid.

## TEAM WORKING

It was important that all clinicians were fully supportive of the project and felt confident enough to discuss reductions and not to give additional or early prescriptions.

## ENGAGEMENT

Patients were understandably reluctant to talk about their opioids and it took considerable effort to get these patients to engage with the surgery. Initially all of the patients were written to and invited in to talk about their prescriptions. After a 1-month interval, the majority of these patients were telephoned and invited in. We also put notes on each patient's prescription and, for patients who failed to respond to our attempts at contact, we gradually reduced down their prescription volume from 1 month to 2 weekly then finally to weekly until contact was made.

## PATIENT DISCUSSIONS

Each patient was given a specific appointment to talk exclusively about their opioids. Written information was offered to patients about the risks of high-dose opioids and a discussion was had with each patient, ultimately informing them that the surgery needed to reduce their daily morphine dose down to below 120 mg for safety reasons. Each patient was advised that their prescription was to be gradually reduced every 3 months. Some patients were initially very upset about talk of reducing their opioids, but making it clear that we were not going to completely stop these medications and that we were only reducing doses down to safer recommended doses helped patients to engage. Each patient was offered a referral to the local pain management team and, in those who were very anxious or upset, this offered confirmation and reassurance that a reduction was advised.

## MONITORING OF PRESCRIPTIONS

All of the patients chose to reduce their opioids using their current formulation of medication. All of the identified patients had their analgesia on their repeat medication lists limited to 1 month at a time, with an interval lock to prevent early ordering. Each patient was aware that early medication requests would not be issued. One lead GP checked all of the 35 patients identified monthly to ensure reductions were happening. The next review date was written on each prescription next to the dose.

## FOLLOW-UP

The did-not-attend (DNA) rate for follow-up appointments and for those choosing to attend the pain service was high. We felt that some patients used a referral to secondary care as a way of delaying the initiation of a reduction. Each of these DNAs was followed up on the telephone by the lead GP, who reduced the strength of medications down when required. This reinforced that a reduction in strength of opioids was going to be continued as planned and it encouraged the patients to be actively involved.

## IMPACT ON PAIN

Very few patients reported any increase in their pain. As doses were reduced, the majority of patients felt considerably better and were happy that their doses were reduced. A small number of patients chose to completely come off their opioids as the reductions highlighted how little analgesic benefit some patients were obtaining from their opioids.

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## ISSUES

Patients on fentanyl patches appeared to find their reductions the most challenging, in part due to the wide range of predicted opioid dose with each patch and the limited patch strength.

## PREVENTION

As a practice, we are now mindful of setting an upper dose with opioids in chronic pain and decline to increase doses above 120 mg daily morphine. All patients who join the surgery on high doses of opioids are brought in for review and a gradual reduction in these doses discussed and implemented.

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