Bulletin for Community Pharmacists and Pharmacy Technicians:

Updated Opioids Aware Dose Guidance

Source: Faculty of Pain Medicine, Royal College of Anaesthetists
Full guidance: https://www.fpm.ac.uk/opioids-aware
Scope: Applies to opioid use ***excluding*** **sickle cell disease, palliative care, and end-of-life care**.

Key Update: Revised Oral Morphine Equivalent dose (OME) thresholds for opioid use excluding sickle cell disease, palliative care, and end-of-life care

- The recommended **oral morphine equivalent (OME)** threshold for opioid use **excluding sickle cell disease, palliative care, and end-of-life care** has been **reduced from 120mg to 90mg/day**, with an **ideal target of 50mg/day**. These are more clearly designated as guidance and exceptions may be clinically appropriate
- The guidance now emphasises that **doses above 90mg OME/day rarely provide additional benefit** for chronic non-cancer pain **excluding sickle cell disease, palliative care, and end-of-life care,** and significantly increases the risk of harm.
- Pharmacists are encouraged to **flag patients not in the excluded groups who are approaching or exceeding 90–120 mg OME/day** for clinical review and to highlight or discuss with the prescriber before further dose escalation, unless clearly justified.

Other Important Changes

- **Stronger expectation of regular review:** Opioid therapy should be reassessed routinely for functional benefit, adverse effects, and signs of dependence.
- **Clearer direction to avoid escalation:** Dose increases should not be routine; pharmacists should be alert to rapid titration, early supply requests, or lack of functional improvement.
- **Reinforced shared decision-making:** Patients should be supported to understand realistic expectations, risks of long-term opioid use, and non-pharmacological alternatives.

- **Safeguarding:** New information on safeguarding considerations when prescribing strong opioids, especially in vulnerable populations.
- **Terminology:** Clarity on the use of terminologies when describing opioids
- **Updated patient information section** Updates to content, language and format and updated patient information leaflets.

Opioids Aware is a continually updated document that evolves as new evidence emerges

- A useful patient centred resource in this arena is the Live Well with Pain website which hosts useful resources and patient information. Of specific note is the patient leaflet Living with persistent pain- where do medicines fit in?
- The Flippin' Pain website also contains many helpful resources.
- A review of pain medication may include the following points/considerations:
    - Opportunity to talk about how you are getting on with your medication
    - Any concerns taking your medicine
    - What to do if you forget to take your regular medicines
    - Is the medicine and dose still right for your condition, taking into account any co morbidities?
    - If medication is not effective, or no longer required, then discuss stopping.
    - Opportunity to talk about side effects and ask questions
    - Shared decision making and plan what medication to take if for flares- consider lower maintenance dose

Implications for Community Pharmacy

- Integrate the revised OME thresholds into clinical checks for all chronic opioid prescriptions **excluding sickle cell disease, palliative care, and end-of-life care**.
- Prompt prescribers when doses approach high-risk levels or when therapy appears ineffective.
- Provide consistent, evidence-based messaging to patients about safe opioid use.
- Document interventions as part of routine clinical governance.
- A recent Coroner's report and article has highlighted the importance of regular review and dose reduction in people using opioids for non-cancer pain.

Counselling on Paediatric and Liquid Medicines

We have recently received reports where parents and carers misunderstood the **volume of liquid medication** to administer, resulting in **incorrect doses being given**. Clear, practical counselling at the point of supply is therefore essential.

Prescribers will be reminded to reinforce dosing instructions when issuing small-volume liquid medicines. However, they will not have access to the medication pack or an oral syringe during the consultation, so **community pharmacy counselling remains essential**.

Key actions for community pharmacies

- Provide **verbal counselling** for all paediatric and liquid medicines, especially where doses are small or unusual (e.g., <1 millilitre).
- **Demonstrate the exact volume** using an oral syringe or dosing device whenever possible.
- **Check** that parents/carers understand:
    - the prescribed dose
    - the correct measuring device
    - how to draw up and administer the volume
    - the dosing frequency and duration
- Supply an **appropriate oral syringe** and ensure it matches the dose volume.
- **Encourage** parents/carers to repeat back the instructions to confirm understanding (TeachBack).

Your support is vital in preventing medication errors and ensuring safe, effective treatment for children and young people. Thank you for continuing to provide high-quality counselling and patient-centred care.
