

### Opioid Stewardship Program Purpose

Through collaboration and evidence-informed practices, our purpose is to lead a coordinated, province-wide effort to promote:

- appropriate use of opioids
- improve patient outcomes
- reduce opioid-related harms such as overdose and opioid use disorder

*“Opioid Stewardship is often described as coordinated interventions designed to improve, monitor, and evaluate the use of opioids in order to support and protect human health.”*  
- Institute for Safe Medication Practices (ISMP)

### Opioid Stewardship Principles

#### **1 Patient-centered, trauma-informed, equitable care**

Provide compassionate, patient-centred care that recognizes the impact of colonialism, racism, discrimination, trauma, and social determinants of health. Promote equitable access to safe and effective pain &/or opioid use disorder management.

Key ideas:

- shared decision-making
- culturally safe care
- reduce stigma towards individuals with pain and/or substance use disorders
- consider patient values, goals, and lived experience
- avoid undertreatment of pain or opioid withdrawal

#### **2 Multimodal Pain Management**

Offer multimodal analgesia, through the use of a variety of non-pharmacological and pharmacological therapies, for the treatment of pain. An evidence-based, multimodal approach to pain improves overall outcomes, including patient pain management and functional status, while reducing opioid utilization and associated harms.

Encourage:

- optimization of non-pharmacologic therapies such as physiotherapy, mindfulness, CBT, etc.
- optimization of non-opioid medications as appropriate to pain type and stage
- maintain multimodal analgesia approaches should opioid therapy be required

#### **3 Evidence-Based Opioid Prescribing**

Prescribing that aligns with the best available clinical evidence and established guidelines to ensure safe, appropriate, and effective pain management.

Examples:

- use opioids only when benefits outweigh risks

- follow evidence-based prescribing recommendations and guidelines
- appropriate formulation, route, dosing, frequency
- lowest effective dose for the shortest period of time
- avoidance of high-risk combinations (e.g., opioids and benzodiazepines)
- regular reassessment of therapy

#### **4 Risk Assessment and Prevention of Opioid-Related Harm**

Identify individuals at risk of opioid-related harm:

- patient risk factors such as substance use disorder, mental health disorder, respiratory or renal disease
- medication risk factors such as concurrent CNS depressants, high MEDD, modified-release opioids

Focus on preventing and/or reducing opioid-related harms such as:

- toxicity and overdose
- long-term side effects such as immune suppression, suppression of HPA axis, and increased fracture risk
- continued opioid use and long-term dependence
- opioid use disorder

#### **5 Interdisciplinary Collaboration**

Encourage organizational and external collaboration to improve and promote stewardship activities.

May include, but not limited to:

- pharmacists
- nurses
- physicians
- physiotherapists
- pain and addiction medicine specialists
- mental health professionals
- First Nations and Métis Health
- non-clinician support such as data analysts and specialists
- organizational leadership

#### **6 Education and Capacity Building**

Promote ongoing education for health care providers to support safe, effective, and evidence-based prescribing for the management of pain and opioid use disorder. Through sustained and ongoing education, Opioid Stewardship Program can increase capacity, competency, and confidence in other health care providers and their patients.

Education should include, but not limited to:

- safe opioid prescribing
- multimodal pain management
- opioid use disorder treatment and withdrawal management
- concurrent opioid use disorder and pain
- risk assessment for opioid-related harms
- stigma-informed care

### 7 Standardized Policies and Order Sets

Implement standardized policies, procedures, and Order Sets to improve consistency in evidence-based practice, assessment, and prescribing. Ensure policies do not stigmatize or restrict access for patients.

Examples:

- Medication Management, Controlled Substances, Harm Reduction policies and procedures
- Opioid Range Order policy
- Automatic Stop Order policy
- Guideline for Opioid Ordering on Order Sets
- Order Sets promoting opioid prescribing guidelines (e.g., Total Knee or Total Hip Arthroplasty Post-Operative Orders)

### 8 Data-Driven Quality Improvement

The Opioid Stewardship Program uses data to monitor opioid prescribing and utilization, identify opportunities to improve safety, and guide quality improvement initiatives. As a learning health system, the program continuously evaluates outcomes and integrates evidence and feedback to refine practices and reduce opioid-related harm.

## Opioid Prescribing Guidelines

To align with National and International Opioid Guidelines and best practices, the Opioid Stewardship Program **strongly recommends** the following guidelines:<sup>1-12</sup>

1. Optimize non-opioid analgesics prior to initiating opioids for pain management
2. Avoid initiating modified-release opioids for acute or subacute pain
3. Avoid the use of codeine and combination-codeine products
4. Avoid the use of tramadol and combination-tramadol products
5. All opioid orders should be written in route-specific dosing, as oral and parenteral formulations are not equivalent (e.g., HYDROmorphine 1-2 mg PO q4hprn or HYDROmorphine 0.5-1 mg IV q2hprn)
6. Oral route preferred for opioid and non-opioid analgesia when appropriate (e.g., tolerating oral or nasogastric medications & nutrition, functioning GIT)
7. Avoid ordering and coadministration of multiple opioid therapies for most patients, (e.g., morphine and HYDROmorphine) with the exception of fentanyl, methadone, and buprenorphine
8. Use extreme caution when prescribing opioids and CNS depressants concurrently (e.g., opioids and benzodiazepines)
9. Offer opioid agonist therapy (OAT) to all individuals with opioid use disorder, utilizing approved Order Sets and/or consult specialist as needed
10. Provide access to appropriate opioid withdrawal symptom management to all at-risk individuals
11. All individuals in health care facilities with an opioid order, scheduled or PRN, should have a naloxone PRN order
12. Individuals with prescription opioids of 50 MEDD or greater and/or those living with a history of substance use disorder should have access to Take Home Naloxone Kit

**Additionally, we recommend: review, apply, and/or utilize Order Sets, Policies, Procedures, and specialized services (e.g., addiction medicine, acute pain service), as appropriate.**

## Acronyms and Definitions

MEDD = morphine equivalent daily dose

PRN = as-needed dose

Multimodal Analgesia or Treatment = The concurrent use of separate therapeutic interventions with different mechanisms of action aimed at different pain mechanisms.

Pain Stages:

- Acute: sudden, short-term; generally resolves once underlying issue heals
- Subacute: longer lasting than acute; often considered transitional phase, lasting 6 weeks to 3 months
- Recurrent: irregular intervals, episodic pain; often due to long-term condition
- Chronic: persists for more than 3 months

Pain Types and Characteristics:

- Nociceptive: non-nerve tissue damage
- Neuropathic: lesion or damage to nervous system
- Nociplastic: pain from altered somatosensory signaling, despite no clear evidence of actual or threatened tissue damage
- Mixed: has at least two of nociceptive, neuropathic, and nociplastic pain
- Sensitization: Increased responsiveness of neurons to their normal or subthreshold afferent input.  
Note: Central sensitization, change in function of central neurons only. Peripheral sensitization, neurons in the periphery affected due to stimulation of their receptive fields.

## References

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