Safe Op
Optimizing Pain Prescribing

Optimizing Perioperative Opioid Prescribing
for Acute Pain

CORE PRINCIPLES

- Multimodal analgesia first — opioids only for breakthrough pain
- Lowest effective dose · shortest duration · short-acting formulations
- Individualized care with ongoing assessment & patient education
- Return unused opioids to pharmacy
- Refer persistent pain beyond expected recovery to specialist

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Clinical Recommendations at a Glance

1 Preoperative Risk Assessment

Screen for risk factors for persistent postoperative opioid use: procedures with nerve injury risk, anxiety/depression/PTSD/pain catastrophizing, chronic pain under medical supervision, substance use history (tobacco, alcohol, cannabis), risk-modifying medications, and younger age (<35). Consider preoperative pain consultation for high-risk patients to develop a tailored perioperative plan.

2 Multimodal Analgesia First

Default to NSAIDs (naproxen 500 mg BID or ibuprofen 400 mg QID) + acetaminophen (1 g PO TID–QID) for up to 14 days. Prescribe opioids only for breakthrough pain at the lowest effective dose, shortest duration, short-acting formulations. Patients not requiring opioids in the last 24 h of admission, or who prefer not to use opioids, should not receive an opioid prescription at discharge.

3 Evidence-Based Opioid Quantity Limits

Base quantity on expected functional recovery:

Recovery	Timeline	Tablets
Rapid	< 2 weeks	**0 – 12**
Moderate	2 – 4 weeks	**0 – 30**
Long-term	> 4 weeks	**0 – 60 (part-fill)**

Prescriptions should be time-limited (e.g., 14-day expiry) and written at discharge — not pre-operatively.

4 Follow-Up, Patient Education & Safe Disposal

Assess pain and function at follow-up; do not auto-renew opioid prescriptions. Educate patients on realistic pain goals, safe use, tapering, storage, and return of unused opioids to pharmacy. Refer persistent pain beyond expected recovery to a transitional/chronic pain clinic. Refer unsafe use concerns to pain/addictions services.

5 Institutional Policies & Staff Training

Hospitals should implement and maintain evidence-based perioperative pain management policies. Provide ongoing education for all perioperative staff — surgeons, anesthesiologists, nurses, pharmacists, and allied health professionals — on opioid prescribing guidelines, multimodal analgesia, and opioid-sparing strategies.

UNIVERSITY OF TORONTO
Centre for the Study of Pain

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Detailed Clinical Recommendations

Optimizing Perioperative Opioid Prescribing for Acute Pain

PREOPERATIVE RISK ASSESSMENT 1

1.1 — Screen all surgical patients for:

- Nerve injury procedures
- Anxiety / Depression / PTSD
- Pain catastrophizing
- Chronic pain (supervised)
- Substance use history
- Risk-modifying medications
- Age < 35 (contextual)

1.2 — High-risk patients

Consider preoperative pain consultation where available to develop a tailored perioperative pain management plan aimed at reducing opioid use.

MULTIMODAL ANALGESIA 2a

2.1 — First-line therapy

Pharmacological (NSAIDs, acetaminophen, regional anesthesia) and/or non-pharmacological (physiotherapy, ice/heat, elevation, breathing, meditation) approaches should be used first.

2.1.4 — Standard discharge analgesia (unless contraindicated)

Acetaminophen 1 g PO TID to QID × 14 days

NSAIDS (e.g. naproxen 500 mg PO BID or ibuprofen 400 mg PO QID) × 14 days

2.1.2/2.1.3 — Opioid-free discharge

Patients not requiring opioids in the last 24 h of admission, or who prefer not to use opioids, should not receive an opioid prescription at discharge.

OPIOID PRESCRIBING LIMITS 2b

2.2 — If opioids are indicated

Prescribe only for breakthrough pain. Written at discharge (not pre-operatively). Time-limited with expiry aligned to expected recovery (e.g., 14 days). Use same opioid as received in hospital. Avoid combination opioid–non-opioid products.

2.3 — Quantity by recovery trajectory

Recovery	Timeline	Tablets
Rapid	< 2 weeks	**0 – 12**
Moderate	2 – 4 weeks	**0 – 30**
Long-term	> 4 weeks	**0 – 60 (part-fill)**

2.3.5 — Preferred agents (lowest potency, short-acting)

- Morphine 5 mg
- Hydromorphone 1 mg
- Tramadol 50 mg
- Oxycodone 5 mg

FOLLOW-UP & ONGOING ASSESSMENT 3

3.1 — Follow-up assessment

Ask about postoperative pain and opioid use at follow-up. Instruct patients to return unused opioids to their local pharmacy.

3.2 — No automatic refills

Repeat prescriptions should not be routine or automated. Additional opioids should only be prescribed after reassessment of pain, function, and risk factors by a healthcare professional.

3.3 — Persistent pain referral

If pain persists beyond the expected functional recovery period (with complications excluded), refer to a transitional/chronic pain clinic.

3.4 — Unsafe use

If unsafe opioid use or harm is suspected, assess in person and consider referral to pain and/or addictions services.

PATIENT EDUCATION 4

4.1 — Pre- & post-operative education

Provide written and verbal information on:

- Realistic pain goals
- Functional expectation recovery
- Multimodal options
- Drug interactions (e.g., alcohol)
- Overdose & dependence risks
- Safe use & tapering
- Risk factors for OUD

4.2 — Responsibility & contact

Inform patients of who manages their postoperative pain (surgeon, primary care, pain team) and who to contact for refills, inadequate pain control, or follow-up.

4.3 — Safe storage & disposal

Provide written and verbal information on safe storage (locked, out of reach of children/pets) and disposal (return to pharmacy — do not flush or discard in trash).

POLICIES & STAFF TRAINING 5

5.1 — Institutional policies

Hospitals should implement and maintain policies that support safe, evidence-based perioperative pain management and opioid prescribing practices. Policies should be regularly reviewed and updated in line with emerging evidence and national guidelines.

5.2 — Staff education & training

Appropriate education and training should be provided for all perioperative staff — including surgeons, anesthesiologists, nurses, pharmacists, and allied health professionals — on opioid prescribing policies, multimodal analgesia, and opioid-sparing pain management strategies.

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SafeOp Optimizing Pain Prescribing

Developed through a national working committee process, including Delphi rounds and expert workshops. Builds on the 2020 Clarke & Hance SafeOp Consensus Statement (Canadian Journal of Pain, 2020;4(1):67–85).