Worcestershire Acute Hospitals NHS Trust

Oral Analgesia Guideline for Hip and Femoral Fracture patients

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

Introduction
A recommended analgesia regime for fractured neck of femur patients at WHAT
Keywords: Fractured Neck of Femur Analgesia, Oxycodone, Pain, Hip fracture, NOF

This guideline is for use by the following staff groups:

- Emergency Medicine
- Trauma and Orthopaedics
- Anaesthetics and Acute Pain
- Orthogeriatrics

Lead Clinician(s)
Dr Joanna Mackie, Consultant Anaesthetist and Anaesthetic Lead for Hip Fracture Pathway
Tracey Dennehy
Lead Practitioner Trauma and Orthopaedics

Approved by Anaesthetic Governance on:

Approved at Trauma and Orthopaedic Governance 25th June 2025

Approved by Medicines Safety Committee on: 9th July 2025
Where medicines are inc Revalued in document.

Review Date: 9th July 2028
This is the most current document and should be used until a revised version is in place

Key amendments to this guideline

Date	Amendment	Approved by:

Introduction

Existing analgesia recommendations for fracture neck of femur patients at WAHT are out of date and no longer best practice. Local audit data also highlights inadequate analgesia sited as the reason for poor day 1 mobility rates, this proposed regime follows best practice with evidence from NICE, RCoA, AAGBI and The Faculty of Pain Medicine.

Unless contraindicated, all Fracture Neck of Femur patients will follow this analgesia regime from time of arrival in the emergency department or point of diagnosis.

The Existing Neck of Femur pathway suggests prescribing Paracetamol, Codeine Phosphate and Oral Morphine. Codeine Phosphate is well recognised to be detrimental in this elderly population. Morphine metabolites are excreted renally, of which a significant proportion of this patient cohort have renal impairment and therefore a risk of accumulation. Less than 15% of an Oxycodone dose is excreted in the kidneys making it more suitable for older adults. There is less nausea and vomiting associated with Oxycodone than Morphine. Modified Release drugs should be avoided in favour of Immediate Release preparations.

Medication Related Procedure

Inclusion Criteria for Oxycodone regimen:

- All suspected or confirmed fracture NOF patients unless they meet any exclusion criteria

Exclusion Criteria for Oxycodone regimen:

- Patient on pre-admission regular long-acting opiates
- Allergy
- See cautions and contraindications below

Patients attending hospital with a suspected or confirmed Fracture Neck of Femur, and meet the inclusion criteria, are prescribed Oxycodone as follows:

Oxycodone 1mg/ml Oral Solution 2.5mg TDS @ 06:00, 14:00 and 22:00
(to be prescribed on the regular section of Prescription Chart)

And

Oxycodone 1mg/ml Oral Solution 2.5mg TDS when required not within 4 hours of a previous dose *(to be prescribed on the PRN section of Prescription Chart)*

Initial Maximum Oxycodone Dose (both Regular and PRN) = 15mg in 24 hours / 2.5mg Six Times per 24-hour period.

1. If patients are already on Modified Release / Long-Acting Opiates prior to admission, suggest continue with the addition of PRN Oramorph. However, patients on long-term opioids need additional scrutiny and senior review, therefore please refer these patients to an appropriate senior member of the clinical team for pain management and consider referring to the acute pain team.
    - Other sedating drugs can lead to sedation, which may affect the ability to perform skilled tasks
2. Cautions:
    - Pancreatitis, toxic psychosis, chronic constipation
3. Contraindications:
    - Allergy: Suggest Oral Morphine as an alternative if unable to receive Oxycodone, dosing as per clinician's judgement
    - Acute abdomen, cor pulmonale, delayed gastric emptying: Consider analgesia via a different route, including Sub-Cutaneous
4. Drug Interactions:

- Oxycodone has the potential to interact with a variety of drug classes, as per the BNF:
    . Atazanavir ↑ exposure to Oxycodone . Adjust dose
    . Buprenorphine ↑ risk of opiate withdrawal when given with Oxycodone .
    . **Clarithromycin** ↑ exposure to Oxycodone. Monitor and adjust dose.
    . Clozapine can cause constipation, as can Oxycodone; concurrent use might increase the risk of developing intestinal obstruction. Caution
    . Cobicistat ↑ exposure to Oxycodone. Monitor and adjust dose
    . Darunavir ↑ exposure to Oxycodone. Monitor and adjust dose
    . Fosamprenavir ↑ exposure to Oxycodone. Monitor and adjust dose
    . Idelalisib ↑ exposure to Oxycodone. Monitor and adjust dose
    . Isocarboxazid ↑ the risk of CNS excitation or depression. Avoid
    . Itraconazole ↑ exposure to Oxycodone. Monitor and adjust dose
    . Ketoconazole ↑ exposure to Oxycodone. Monitor and adjust dose
    . Iopinavir ↑ exposure to Oxycodone. Monitor and adjust dose
    . Nalmefene is predicted to ↓ efficacy of Oxycodone . Avoid
    . Naltrexone is predicted to ↓ efficacy of Oxycodone. Avoid
    . Ozanimod ↑ risk of adverse effects
    . Pentazocine ↑ risk of opiate withdrawal when given with Oxycodone
    . Phenelzine ↑ risk of CNS excitation or depression. Avoid
    . Ritonavir ↑ exposure to Oxycodone. Monitor and adjust dose
    . Tranylcypromine + Oxycodone ↑ risk of CNS excitation or depression. Avoid
    . Voriconazole ↑ exposure to Oxycodone. Monitor and adjust dose

In addition:

1. In conjunction with the prescription of Oxycodone, if no contraindications, please prescribe:
    - Regular Oral Paracetamol 1g QDS, if over 50kg
        - If less than 50kg, reduce Oral dose of Paracetamol as follows:
            - Weight <40kg: 500mg QDS
            - Weight 41kg to 49kg: 500mg to 1g TDS
        - Reserve IV Paracetamol route if unable to be administered or absorbed Orally

    - If less than 50kg, reduce dose to 15mg/kg QDS
  - Regular Oral Laxatives:
    - Macrogol Sachet 1 sachet BD
    - Senna 15mg ON
  - PRN Antiemetic's:
    - Ondansetron 4mg TDS PO/IV
    - Prochlorperazine Buccal 6mg BD (avoid in patients with Parkinson's disease)
- PRN Naloxone: 100-200 micrograms Intravenously is to be prescribed PRN in case of respiratory depression (as per guideline – pre printed on surgical chart)
  - See the BNF on the use of Naloxone for complete or partial reversal of central nervous system depression and respiratory depression, caused by natural or synthetic opioids in adult patient.

2. Oral Oxycodone Solution Immediate Release 1mg/ml will be ordered from pharmacy using the CD Requisition Book.
3. If a pre-operative patient remains in pain despite regular Oxycodone and Paracetamol, a repeat Fascia Iliaca Block should be performed by ED or T&O if not within 6 hours of the previous block.
4. If a post-operative patient remains in pain despite regular Oxycodone and Paracetamol, consider increasing the regular dose of Oxycodone Oral Solution to 5mg. Advice can be sought from the Trauma and Orthopaedic Team, the Orthogeriatrician, the Acute Pain Team and/or the Anaesthetic Team.
5. Oxycodone prescriptions will be reviewed daily by the Trauma and Orthopaedic Teams. Day 3 post-operatively the regular prescription will be reviewed with a view to reduce / wean off the regular doses. If patients are comfortable on regular doses of Oxycodone, mobilising and complying with physiotherapy, and not requiring additional PRN analgesia, then regular doses can be stopped, with PRN Oxycodone remaining available whilst on the acute ward.
6. If complex analgesic regime already in place, the pain team can be contacted for advice.
7. If the patient is for conservative management, contact the Duty Anaesthetist to discuss the need for a Femoral Nerve Catheter.
8. Analgesia suitable for discharge to community hospital: Regular paracetamol and PRN oxycodone or codeine 15-30mgs (and laxatives)
9. Analgesia suitable for discharge home: Regular paracetamol and PRN codeine 15-30mgs (and laxatives).

Training

A prescribing protocol has been produced and attached with this form. This will be in poster format in prescribing areas and attached to all NOF booklets.

Specific communications to be sent out to highlight the change via email and raised at departmental meetings, NOF MDT, nursing handovers etc.

All prescribing of Oxycodone remains within BNF limits.

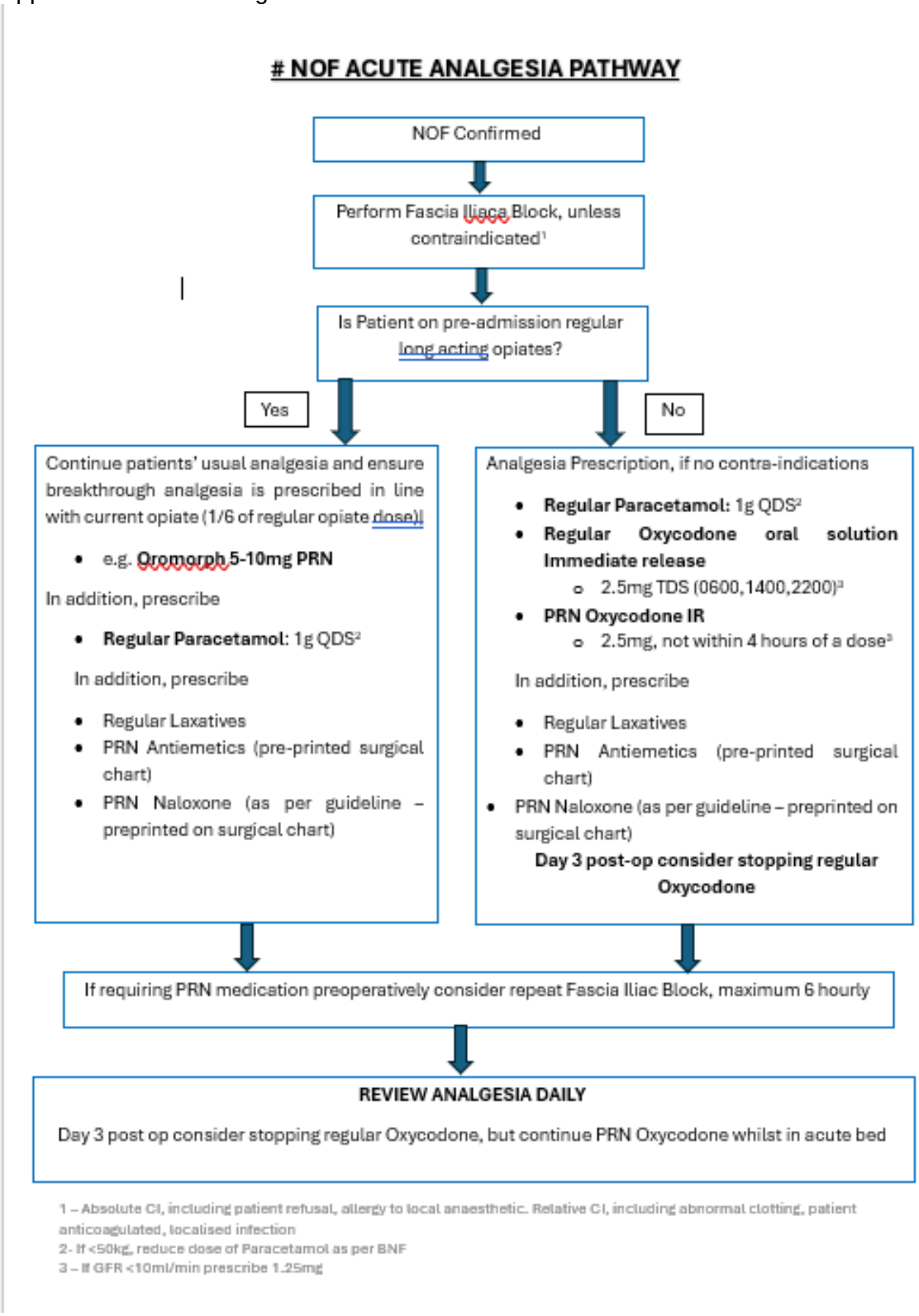
Junior doctors (T&O, ED and Anesthetics) will be taught at each induction / rotation.

Monitoring of Outcomes

We will audit the implementation fully, looking at accuracy of prescriptions, time to analgesia, duration of regular analgesia, along with any complications. We already discuss this at our quarterly NOF Governance meeting

Appendices

Appendix 1 – NOF Analgesia Flow Chart



Monitoring

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the Policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: (Responsible for also ensuring actions are developed to address any areas of non-compliance)	Frequency of reporting:
	WHAT?	HOW?	WHEN?	WHO?	WHERE?	WHEN?
P1	These are the 'key' parts of the process that we are relying on to manage risk. We may not be able to monitor every part of the process, but we MUST monitor the key elements, otherwise we won't know whether we are keeping patients, visitors and/or staff safe.	What are we going to do to make sure the key parts of the process we have identified are being followed? (Some techniques to consider are; audits, spot-checks, analysis of incident trends, monitoring of attendance at training.)	Be realistic. Set achievable frequencies. Use terms such as '10 times a year' instead of 'monthly'.	Who is responsible for the check? Is it listed in the 'duties' section of the Policy? Is it in the job description?	Who will receive the monitoring results? Where this is a committee the committee's specific responsibility for monitoring the process must be described within its terms of reference.	Use terms such as '10 times a year' instead of 'monthly'.

References

1. Prescribing Opioids to Older Adults: A Guide to Choosing and Switching Among Them Marc Ginsburg, RN, MScN, NP; Shawna Silver, MD, PEng; Hershl Berman, MD, FRCPC DISCLOSURES Geriatrics and Aging. 2009;12(1):48-52.
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4. https://bmcanesthesiol.biomedcentral.com/articles/10.1186/s12871-018-0583-8
5. SPC Oxycodone Hydrochloride 5mg/5ml Oral Solution - Summary of Product Characteristics (SmPC) - (emc) (medicines.org.uk)
6. The Centre for Perioperative Care, The Royal College of Anaesthetists and The Faculty of Pain Medicine released a position statement on Modified Release Opioids: https://cpoc.org.uk/sites/cpoc/files/documents/2023-05/CPOC%20MR%20Opioid%20statement.pdf
7. Faculty of Pain Medicine of The Royal College of Anaesthetists (2021) Surgery and Opioids Best Practice Guidelines surgery-and-opioids-2021_4.pdf (fpm.ac.uk)
8. NHS Lanarkshire Guideline For The Anaesthetic Management Of Hip Fractures In The Frail Elderly Patient BACKGROUND (scot.nhs.uk

Contribution List

This key document has been circulated to the following individuals for consultation:

Designation
Tracey Dennehy, Lead Practitioner Trauma & Orthopedics.
Dr Elma Wong, Consultant Anaesthetist and Lead for Acute Pain,
Dr Catherine Jackson: Consultant Geriatrician and Clinical Lead
Dr Susan Powell Consultant Geriatrician
Dr Christina Harris Community Clinical Lead

This key document has been circulated to the chair(s) of the following committee's / groups for comments:

Committee
Trauma and Orthopaedic Governance
Medicines Safety Committee

Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and included as an appendix to key document when submitted to the appropriate committee for consideration and approval.

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form

Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust	✓	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	

Details of individuals completing this assessment	Name	Job title	e-mail contact
Date assessment completed			

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	Title: Oral analgesia for Hip and Femoral Fracture Patients			
What is the aim, purpose and/or intended outcomes of this Activity?				
Who will be affected by the development & implementation of this activity?	❑ x ❑ ❑	Service User Patient Carers Visitors	x ❑ ❑ ❑	Staff Communities Other _____
Is this:	❑ Review of an existing activity X New activity ❑ Planning to withdraw or reduce a service, activity or presence?			

What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	
Summary of relevant findings	

Section 3
Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age		x		
Disability		x		
Gender Reassignment		x		
Marriage & Civil Partnerships		x		
Pregnancy & Maternity		x		
Race including Traveling Communities		x		
Religion & Belief		x		
Sex		x		
Sexual Orientation		x		

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)		x		
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)		x		

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
		.		
How will you monitor these actions?				
When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)				

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	Tracey Dennehy
Date signed	
Comments:	
Signature of person the Leader Person for this activity	
Date signed	
Comments:	

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	no
2.	Does the implementation of this document require additional revenue	no
3.	Does the implementation of this document require additional manpower	no
4.	Does the implementation of this document release any manpower costs through a change in practice	no
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	no
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval.