Approaches to managing older people using opiates and their risk of dependence

Ian Hamilton, Gerri Kaufman

Abstract
There is little doubt that opiates have transformed healthcare, particularly in relation to pain management. However, many patients prescribed this type of drug develop problems such as dependency. Although we do not know how many older people have developed such problems due to opiate use we know that some will. It is important for nurses to understand the context in which opiates are used, as well as the specific needs of older people and how to respond to them.

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Keywords
controlled drugs, medicines, older people, polypharmacy

Aim and intended learning outcomes
The aim of this article is to help you consider and understand the risks associated with opiate use by older people.

After reading this article and completing the time out activities, you should be able to:

» Discuss why it is difficult to know how many older people have developed problems with opiates.

» Describe the risks of using opiates and the features of withdrawal.

» Outline who is at risk of developing dependence and some reasons why.

» Describe what you need to consider when interacting with someone with cognitive impairment who is using opiates.

» Summarise the two main intervention approaches with an older person who uses opiates.

Relevance to the Code
Nurses are encouraged to apply the four themes of The Code (Nursing and Midwifery Council (NMC) 2018) to their professional practice. These themes are: prioritise people, practise effectively, preserve safety, and promote professionalism and trust. This article relates to the Code in the following ways:

» Promote professionalism and trust: some nurses may hold strong views about people who misuse drugs, but the Code requires them to refrain from expressing their personal beliefs, including political, religious or moral beliefs, to people inappropriately.

» Preserve safety: the Code requires nurses to keep to appropriate guidelines when giving advice on the use of controlled drugs and recording the prescribing, supplying, dispensing or administering of controlled drugs.

Introduction
The medicinal properties of opiates have probably been known for thousands of years, but it was not until the 1850s that they were formally adopted as drugs (Brownstein 1993). Their analgesic properties to manage moderate-to-severe pain, and for a variety of health problems ranging from postoperative pain to musculoskeletal conditions, made sure their use became widespread. However, their potential to manage pain was also accompanied by problems, such as physical and psychological dependency. The World Health Organization (2019) defines dependence as: ‘A strong desire or sense of compulsion to take the substance.’

The term opiate covers a range of substances including prescribed medicines, such as morphine, fentanyl or oxycodone, with which healthcare professionals are familiar. Heroin
is from the same group or class of drugs, and the main difference between a prescribed opiate and illegally obtained heroin is likely to be the quality control measures used in its manufacture and supply. Heroin can vary in quality and purity, which makes dosing difficult and increases the risk of overdose (Compton et al 2016).

There are also synthetic opiates, such as tramadol, that do not contain morphine – a naturally occurring compound derived from the opium poppy – but have a similar mode of action. Like natural opiates, synthetic opiates, or opioids, can provide pain relief, and lead to dependency and misuse.

Although older people are not immune to drug dependency, it is usually associated with younger people (Beynon et al 2010). For example, the Home Office (2017) crime survey, the largest and most influential survey of drug use in England and Wales, collects no information on anyone aged 60. Nevertheless, other sources, such as specialist drug treatment activity information, provide some insight into trends in older people who have problems with drugs like opiates. The most recent report on drug treatment shows that people with opiate problems tend to be older, with a mean age of 40 years, than those in treatment for problems with other drugs, with a mean age of 34 (Public Health England 2018).

Mortality rates are elevated in older people who use opiates compared with their peers in the general population. Although the proportion of older people in the UK is growing, the proportion of older people developing problems with drugs is higher than this broader population growth (Royal College of Psychiatrists (RCPsych) 2018).

Record numbers of people in the UK and US are dying as a result of opiate use. All healthcare professionals, including nurses, should consider the risks of using these drugs and what they can do to minimise potential harm (Office for National Statistics 2018, National Institute on Drug Abuse 2019).

### Risks

Several risks are associated with opiate use and withdrawal, and are summarised in Box 1. Opiate tolerance can develop quickly so, although the initial dose may be effective, dosages will probably have to be increased over time and increasing opiate dosages increases the risk of an adverse reaction to the drug. Receptors become more sensitive to this class of drugs with age so the reaction to administering an opiate or changing its dose may be more marked in an older person (Darke 2014). The starting dose should be titrated with care, and any future adjustments assessed and monitored.

As older people are often excluded from clinical trials of interventions or prescribing regimens, evidence for the effects of opiates tends to be gathered from younger adults who process the drug in a significantly different way (Avorn and Shrank 2008). Younger adults are less likely than their older peers to have physical or psychological co-morbidities that affect their ability to seek treatment or benefit from specific interventions.

Opiates are often associated with physical dependence, but there is also a risk of psychological dependence. The psychological desire to repeat the feeling that opiates give can develop quickly as an individual becomes preoccupied with thinking about the drug. This preoccupation is referred to as salience, or wanting more (Adinoff 2004). The journey from initiation to dependence can happen quickly as the initial pleasure of taking opiates becomes a physical and psychological compulsion. The desire to feel good changes

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**Box 1. Effects and risks associated with opiate use and withdrawal**

<table>
<thead>
<tr>
<th>Physical</th>
<th>Psychological</th>
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<tbody>
<tr>
<td>Constipation</td>
<td>Compulsion to take opiate</td>
</tr>
<tr>
<td>Hypoxia</td>
<td></td>
</tr>
<tr>
<td>Nausea</td>
<td>Developing tolerance</td>
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<tr>
<td>Overdose</td>
<td></td>
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<tr>
<td>Symptoms of withdrawal</td>
<td></td>
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<tr>
<td>Developing tolerance</td>
<td></td>
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<tr>
<td>Vomiting</td>
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<table>
<thead>
<tr>
<th>Withdrawal</th>
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<tbody>
<tr>
<td>Agitation</td>
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<tr>
<td>Craving</td>
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<td>Insomnia</td>
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<td>Irritability</td>
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<tr>
<td>Loss of appetite</td>
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<tr>
<td>Low mood</td>
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<tr>
<td>Muscle cramps</td>
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<tr>
<td>Yawning</td>
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</table>

(DrugWise 2017)
to a need to avoid unpleasant physical and psychological withdrawal symptoms (Farrell 1994). However, the risk of dependency should not prevent the use of opiates where the benefits outweigh the risks, such as in palliative care (Gallagher and Rosenthal 2008).

**Who is at risk of dependence?**
Anyone exposed to opiates is at risk of developing problems such as dependency. Unlike many other types of drugs with which men are more likely than women to develop problems, women are as likely as men to develop opiate analgesic dependence (OAD). One report suggests that women aged between 30-50 are at risk, particularly if they have chronic back pain, low mood, are unemployed, and have family or friends who rely on them (Shapiro 2015).

A history of drug misuse is also an indication that current opiate use could develop into dependency (Miech et al 2015, Dowell et al 2016). People with mental health problems, such as anxiety and depression, are known to be at increased risk of dependency. These individuals may have used opiates to self-medicate for low mood or symptoms of anxiety (Varga and Parrish 2015).

The following factors are associated with patients who are at risk of developing OAD (Shapiro 2015):
- Over 55 years of age with depression, diabetes or long-term pain.
- Predominant co-morbidities, including depression and a history of misuse of alcohol or drugs.
- Chronic opioid therapy – 4-10% of patients on this therapy have OAD.
- Increasing frequency of GP prescriptions, unwillingness to reduce dosage or number of drugs taken and rigid medication regimens.

The amount of time between initiating drug use and developing a problem is more rapid for women than for men, a phenomenon known as ‘telescoping’ (Haas and Peters 2000). Women also enter specialist drug treatment with more severe psychological, physical and social problems than men. These are important factors to consider when assessing and interacting with female patients (Hamilton 2017).

**TIME OUT 2**

**Drug history**
Considering the risks outlined do you take a drug history when you assess patients? Are there other questions or areas that you should explore with patients and carers in light of these risks?

The term ‘older age’ usually applies to people in their sixties, but many people who develop serious problems with opiates do not reach this age, and die in their forties or fifties (Hamilton and Stevens 2017). For this group older age applies to people aged 40 or more.

Over the past decade, there was a significant rise in deaths due to drugs, mainly opiates and benzodiazepines, and a significant rise in treatment presentations to specialist drug services in England (Figure 1). This rise has been against a backdrop of a fall in the number of people accessing treatment generally and falling use of opiates in the population as a whole, making the rise in this age group more significant. This growing patient population presents several challenges. For example, people in this group do not necessarily only have problems with opiates, but also have a range of complex mental and physical health problems (Public Health England 2016), which means that they could present to a range of services outside traditional older people’s services.

Nurses working outside older people’s services should be aware of these patients’ needs and know how to treat the complex co-morbidities with which they present. Multimorbidity is the existence of two or more long-term conditions and is common in older people (Masnoon et al 2017). One or more medicines may be used to treat each condition, therefore polypharmacy or the use of multiple medicines is also common in the older population (Masnoon et al 2017).

In developed countries, about 30% of patients aged 65 years or over are prescribed five or more drugs (Scott et al 2015), but some patients may be exposed to ‘major’ or

**Figure 1.** Trends in age group 40 and older for opiate use and treatment presentations

(Adapted from Public Health England 2018)
Older people with polypharmacy who conceal the use of opiates may be at risk of an unidentified drug-drug interaction. When caring for patients taking multiple drugs, healthcare professionals should be vigilant about the potential for drug-drug interactions and make no assumptions about the medicines being taken. The British National Formulary (BNF Publications 2019) provides a helpful summary of enhanced interactions.

The incidence of ADRs increases when multiple drugs are taken (Anathhanam et al 2012). An ADR is defined as an unwanted or harmful reaction experienced after taking a drug or combination of drugs under normal conditions of use (Greener 2014).

ADRs can be classified as type A or type B. Type A reactions are exaggerations of a drug’s normal actions when the medicine is given at the recommended therapeutic dose (Greener 2014). Postural hypotension in a patient taking medication for raised blood pressure is an example of a type A ADR. This type is associated with high morbidity but low mortality and accounts for about 95% of ADRs that result in hospital admissions in the UK (Pirmohamed et al 2004). Greater sensitivity to drugs in older people predisposes them to a risk of type A ADRs. If the use of opiates is concealed, adverse effects may be interpreted as a new condition and further medicines may be prescribed inappropriately. This is known as incremental prescribing or the ‘prescribing cascade’ (Duerden et al 2013).

Type B ADRs are bizarre drug effects not linked to the known pharmacology of a drug (Greener 2014). Examples of type B reactions include anaphylaxis with penicillin, or skin rashes with antibiotics (Greener 2014). Type B reactions are less common than type A and associated with low morbidity but high mortality (Pirmohamed et al 1998). Reducing the number of drugs a patient takes is an important intervention to minimise the risk of ADRs (Anathhanam et al 2012).

Assessment
Starting a conversation with anyone about drug use can be difficult because it may be an activity they have concealed from everyone they know. People can also feel a sense of shame in relation to their drug use. Older people are no different from any other age group when it comes to the stigma they have experienced about their use of drugs, and they may anticipate being judged by healthcare workers when they share their personal stories (RCPsych 2013). It is important to remember that each person has a personal and often painful story to tell.

Developing a rapport with patients will increase the chance of them being willing to share their stories. This requires healthcare workers to be warm, honest, open, able to listen, empathic and non-judgemental. Although these skills can seem fundamental or be taken for granted, nurses can spend their careers honing and improving their ability to use them effectively.

The specific health needs of older people with drug misuse and dependence are highlighted in UK guidelines (Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group 2017) (Box 2).

There are some fundamentals to consider when assessing a person’s use of drugs. Where there is polypharmacy, obtaining a full list of substances, including how they are used and in what quantities, is a good start. A more thorough assessment includes the route of drug consumption and a detailed history of drug use.

Predicting who is at risk of developing opiate dependency is difficult because no single factor is reliable (Turk et al 2008). Nurses can consider exploring a patient’s current and past use of opiates, and other drugs, at initial assessment or when reviewing a patient’s care. Many people are introduced to opiates after surgery or as a way of managing pain (Higgins et al 2018), and it is worth considering whether patients on repeat prescriptions for opiates have had them reviewed recently. Some healthcare professionals are reluctant to discuss repeat prescriptions for opiates with patients, who can perceive such consultations as challenging.

A range of assessment instruments are available, including the Addiction Severity Index (McLellan et al 1980) and the Drug Use Disorders Identification Test: Extended
Housing or financial problems can develop with dwindling resources. Increased cardiovascular disease risk due to alcohol, smoking and lifestyle. Risk of drug-drug interactions, which may increase or decrease HIV infection. Family breakdown/relationship problems. Hepatic damage due to hepatitis B or C infection or excess alcohol use, venous damage and/or arterial damage. Alcohol or drug withdrawal syndromes may be more severe and increased risk of falls, sedation, cognitive impairment and road traffic accidents. Age-related disorders common in the older population, including chronic pain, hypertension, diabetes, cognitive impairment and chronic airways disease. Increased sensitivity to alcohol or drugs or prescription medications. Alcohol or drug withdrawal syndromes may be more severe and prolonged. Housing or financial problems can develop with dwindling resources or increased care costs.

**Cognitive function**

Opiates are known to impair cognitive function, particularly memory, reaction time and information-processing capacity (Schiltenwolf et al 2014). Nurses should consider individual cognitive function, including the ability to problem-solve, recall past and more recent events, and concentration. This is important, not only at the assessment stage, but as nurses work with patients to change their relationship with substances. In practical terms it means thinking about the pace of a conversation, which may have to be adjusted to the person’s ability to concentrate or retain information. Summarising or repeating points, and checking the patient’s understanding of important parts of the conversation, can be helpful.

The components of cognitive function not only vary by individual, but are likely to vary over time in the individual. Assessment of cognitive function should not be viewed as a one-off activity, but an ongoing and repeated part of assessment that informs the type and pace of an intervention.

There are ways of establishing a patient’s history and current use of opiates when they are unable to recall these details. With the patient’s consent, the healthcare worker can speak to family, friends and other professionals who are or have been in contact with the patient. The patient’s notes might yield relevant detail about opiate use, including previous treatment attempts and their outcomes.

**Interventions**

In general there are two ways to think about the aim of an intervention for an older person who has a problem with opiates. The first is to reduce the potential for harm, which could include changing the way opiates are sourced and used. For example, helping them to move from an illicit or deceptive source, such as buying drugs on the internet or through a dealer, to prescription of a substitute drug, such as methadone, that can then be supplied and monitored in a more organised way. This ensures the quality and dose of the opiate are known, and therefore relied on, and ensures the patient is not using a drug of variable quality and strength that could be contaminated with other chemicals.

**Box 2. Special health needs of older people with substance use problems**

<table>
<thead>
<tr>
<th>Complications related to a long history of drug and alcohol use</th>
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<tbody>
<tr>
<td>Hepatic damage due to hepatitis B or C infection or excess alcohol use, or a combination of both</td>
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<tr>
<td>HIV infection</td>
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<tr>
<td>Chronic airways disease from smoking tobacco or from inhaling drugs or tuberculosis</td>
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<tr>
<td>Increased cardiovascular disease risk due to alcohol, smoking and lifestyle</td>
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<tr>
<td>Venous damage and/or arterial damage</td>
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<tr>
<td>Past cardiac valve destruction</td>
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<tr>
<td>Poor dental health</td>
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<tr>
<td>Family breakdown/relationship problems</td>
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<tr>
<td>Mobility problems consequent on groin injecting</td>
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<tr>
<td>Traumatic injuries due to falls, accidents or assaults</td>
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<tr>
<td>Ongoing risk of overdose</td>
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<tr>
<td>Impaired immunity</td>
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<tr>
<td>Increased risk of cancer</td>
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<tr>
<td>Chronic pain</td>
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<tr>
<td>Impaired mental health with increased risk of self-harm and suicide</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Polypharmacy</th>
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<tbody>
<tr>
<td>Increased risk of falls, sedation, cognitive impairment and road traffic accidents when sedating medicines, such as benzodiazepines, hypnotics, antipsychotics, antihistamines, anticholinergics or other opioids, are prescribed</td>
<td></td>
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<tr>
<td>Risk of drug-drug interactions, which may increase or decrease methadone levels and to a lesser extent buprenorphine</td>
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</tr>
<tr>
<td>Risk of QT interval prolongation when methadone is co-prescribed with a range of medications, including antipsychotics, tricyclic antidepressants, citalopram and erythromycin</td>
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</table>

<table>
<thead>
<tr>
<th>Normal ageing process</th>
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</thead>
<tbody>
<tr>
<td>Increased sensitivity to alcohol or drugs or prescription medications</td>
<td></td>
</tr>
<tr>
<td>Age-related disorders common in the older population, including chronic pain, hypertension, diabetes, cognitive impairment and chronic airways disease</td>
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<tr>
<td>Loneliness, boredom and mental health problems in some who become isolated with age</td>
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<tr>
<td>Alcohol or drug withdrawal syndromes may be more severe and prolonged</td>
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<tr>
<td>Housing or financial problems can develop with dwindling resources or increased care costs</td>
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</table>

(Adapted from Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group 2017)
The Leeds Dependence Questionnaire (LDQ) is derived from a psychological understanding of the nature of dependence and is therefore suitable for measuring dependence during periods of substance use or abstinence. The LDQ is an indicator of how addicted a person is and therefore how difficult it will be to achieve a positive outcome. For help-seeking populations, the LDQ is a reasonable proxy for substance use, but for people who are socially quite stable, employed and have functional families, heavy drinking or other drug use is less well correlated with dependence.

There are ten items scored 0-3. A score of:

- Below 10 = low dependence
- 10-22 = medium dependence
- Above 22 = high dependence

(Raistrick et al 1994)

<table>
<thead>
<tr>
<th>Question</th>
<th>Never</th>
<th>Sometimes</th>
<th>Often</th>
<th>Nearly always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you find yourself thinking about when you will next be able to have another drink or take more drugs?</td>
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<tr>
<td>Is drinking or taking drugs more important than anything else you might do during the day?</td>
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<td>Do you feel that your need for drink or drugs is too strong to control?</td>
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<tr>
<td>Do you plan your days around getting and taking drink or drugs?</td>
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<tr>
<td>Do you drink or take drugs in a particular way to increase the effect it gives you?</td>
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<tr>
<td>Do you drink or take drugs morning, afternoon and evening?</td>
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<tr>
<td>Do you feel you have to carry on drinking or taking drugs once you have started?</td>
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<tr>
<td>Is getting an effect more important than the particular drink or drug you use?</td>
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<td></td>
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</tr>
<tr>
<td>Do you want to take more drink or drugs when the effects start to wear off?</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Do you find it difficult to cope with life without drink or drugs?</td>
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</tbody>
</table>

Here are some questions about the importance of alcohol or other drugs in your life. Think about the main substance you have been using over the past four weeks and tick the answer closest to how you see yourself.
Other components of this harm-reduction approach can include needle exchange schemes, which provide the patient with a supply of sterile and effective needles and syringes, to minimise the risk of contracting blood-borne infections, such as HIV or hepatitis C (Beynon et al 2010).

The second general approach is to encourage abstinence. As with harm reduction, this can involve prescribing a substitute drug, such as methadone, but with a negotiated gradual reduction in its dosage until the patient is prepared physically and psychologically for abstinence.

The journey from point of engagement to recovery is unlikely to be smooth and straightforward. There is a high probability that the patient will find the pace of drug substitution and dosage reduction too fast, and may relapse to taking the original drug. This should not be viewed negatively because relapse or non-concordance with prescribing regimens is the norm, as has been observed with a range of health problems outside addiction (Sellman 2010).

Deprescribing or rationalising a prescription regimen can be a way of minimising harm and can be the first step in a recovery journey. Deprescribing can be defined as a ‘process of withdrawal or dose reduction of medications which are considered inappropriate in an individual’ (Reeve et al 2017). The deprescribing process is a patient-centred process that forms part of the good prescribing continuum (Cadogan et al 2016). It comprises five steps that are required for the safe and effective cessation of medication (Box 3) (Reeve et al 2014).

Deprescribing provides opportunities to start conversations with the patient about drug use, and following the deprescribing steps ensures a thorough assessment of all the medicines the patient is taking. Tapering of dependency-forming medications, such as opiates, should be undertaken carefully and, ideally, the reducing dosage should be agreed between prescriber and patient. Minimising physical and psychological discomfort from opiate withdrawal optimises concordance.

Although there is emerging evidence of the effectiveness of deprescribing techniques (Reeve et al 2017), it is not known if these are transferrable to older people who use opiates as well as other medication and drugs, such as alcohol, cannabis and tobacco. However, growing evidence of the benefits and safety of deprescribing strengthens the case for greater integration of the process into clinical practice (Reeve et al 2017).

Irrespective of the intervention the therapist or healthcare worker offers, they can help patients reduce the amount of drugs they take, or abstain altogether (Miller and Moyers 2015). Qualities such as honesty, warmth and empathy are critical in ensuring the relationship between healthcare worker and patient is positive and respectful.

**Conclusion**

There is a tendency to assume drug problems affect mainly younger people, but they affect people of all ages. There are reliable indicators that, as the general population ages, an increasing number of older people are dying prematurely due to opiate use.

Nurses should be aware that the number of older people becoming dependent on opiates is increasing, and consider how they can identify and support these patients. It is likely that a blend of talking treatment and pharmacological management is the optimum approach to reducing dependency and the risk of mortality for this group of patients.

Everyone has the capacity to change, and it is important to maintain an optimistic outlook with older people who rely on opiates. For nurses this approach is aided by qualities such as warmth, empathy and honesty, and the ability to build trust with patients. These skills can take a career to hone and enhance the nurse-patient relationship so that change becomes possible.

**TIME OUT 4**

Healthcare professional attributes

Now that you have read the article think about a patient you have met who was using opiates, and how much information and attention you gave them. Reflect on how you might change your approach the next time you meet such a patient.

<table>
<thead>
<tr>
<th>Box 3. The five-step patient-centred deprescribing process</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step</strong></td>
</tr>
<tr>
<td>1</td>
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<td>2</td>
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<td>3</td>
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<td>4</td>
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<td>5</td>
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</tbody>
</table>

(Reeve et al 2014)
TIME OUT 5

The Code

Nurses are encouraged to apply the four themes of the NMC (2018) Code to their professional practice. Consider how managing older people using opiates and their risk of dependence relates to the Code

TIME OUT 6

Reflection

Now that you have completed the article you might like to write a reflective account as part of your revalidation. Guidelines to help you are at rcni.com/ reflective-account

References


Managing older people using opiates

TEST YOUR KNOWLEDGE BY COMPLETING THIS MULTIPLE-CHOICE QUIZ

1. People in treatment for opiate use have a median age of:
   a) 25
   b) 40
   c) 46
   d) 60

2. A common opiate is:
   a) Fentanyl
   b) Morphine
   c) Oxycodeone
   d) All of the above

3. A physical effect of opiate use is:
   a) Compulsion
   b) Irritability
   c) Nausea
   d) Low mood

4. Which of the following may signify a patient has opiate analgesic dependence?
   a) Infrequent requests for prescriptions
   b) Desire to reduce the number of medications taken
   c) Desire to reduce medication dosage
   d) Rigid medication regimes

5. What percentage of people aged 65 years and older are prescribed five or more drugs?
   a) 10%
   b) 25%
   c) 30%
   d) 50%

6. Which of the following is a potential physical complication related to a long history of drug use in older people?
   a) Boredom
   b) Loneliness
   c) Financial difficulties
   d) Poor dental health

7. Which of the following statements is correct?
   a) Polypharmacy decreases the risk of adverse drug reactions (ADRs)
   b) Type A ADRs are associated with high morbidity and low mortality
   c) Type A ADRs are associated with low morbidity and high mortality
   d) Type B ADRs are more common than Type A

8. A score below 10 on the Leeds Dependence Questionnaire indicates:
   a) Low dependence
   b) Medium dependence
   c) High dependence
   d) Severe dependence

9. An example of a harm reduction intervention is:
   a) Non-concordance with a prescribing regimen
   b) Needle exchange scheme
   c) Buying opiates from a street dealer
   d) Buying opiates from the internet

10. Step 3 of the five-step deprescribing process involves:
    a) Monitoring
    b) Comprehensive medication history
    c) Determining if medication can be stopped
    d) Initiating withdrawal

How to complete this assessment

This multiple-choice quiz will help you test your knowledge. It comprises ten multiple choice questions broadly linked to the previous article. There is one correct answer to each question. You can read the article before answering the questions or attempt the questions first, then read the article and see if you would answer them differently.

You may want to write a reflective account. Visit rcni.com/reflective-account

Go online to complete this multiple-choice quiz and you can save it to your RCNi portfolio to help meet your revalidation requirements.

Go to rcni.com/cpd/test-your-knowledge

The answers to this quiz were compiled by Lisa Berry

This multiple-choice quiz was compiled by Lisa Berry

1. a 2. a 3. c 4. c 5. c 6. c 7. c 8. c 9. b 10. c

This activity has taken me ___ minutes/hours to complete. Now that I have read this article and completed this assessment, I think my knowledge is:

Excellent □ Good □ Satisfactory □ Unsatisfactory □ Poor □

As a result of this I intend to: ________________________________

______________________________

______________________________

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