safety IN PRACTICE

General Practice Opioids Clinical Module 2019-20

Every patient, every time

AUCKLAND DISTRICT HEALTH BOARD Te Toka Tumai

Waitematā District Health Board

Best Care for Everyone

ALLIANCE HEALTH+ Inspiring Health Transformation

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comprehensive care

National Hauora Coalition

ProCare

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Contents

Section 1: Introduction

1.1 Background

A key aim of the Safety in Practice programme is to reduce the harm experienced by patients from medication use. Adverse events related to medications are a significant cause of patient morbidity and mortality, and a source of substantial costs for both organisations and patients.[1,2]

The Institute for Healthcare Improvement (IHI) classes opioids as one of four groups of medicines (along with anticoagulants, insulin and sedatives) that cause harm to patients even when used as intended. Harms associated with opioid therapy include tolerance, hyperalgesia[3], iatrogenic addiction, drug diversion and aberrant drug-related behaviours.[4] A 2013 review noted increases in opioid use for back pain and other chronic musculoskeletal conditions, leading to prescription opioid addiction and fatal overdose.[5]

Nearly half of all referrals to Auckland Opioid Treatment Services for opioid addiction originate from pain relief started in the acute setting with oral medication.[6] Advice outlined in a Goodfellow 'Gem' July 2018 indicates that, "*long term use often starts with acute pain so prescribe the lowest effective dose of short acting opioid – 3 days or less will often be sufficient and more than 7 days is rarely needed*".[7] A 2017 study of medication-related harm in New Zealand hospitals indicated that of the top 10 medicines implicated in harm, opioid medications featured five times. Of the individual medicines, morphine caused 16% of harm, and other opioids (fentanyl, oxycodone, codeine and tramadol) account for 14%. Together opioids account for 30% of harm and are implicated in 3 of the most commonly reported harms; constipation, nausea/vomiting and delirium/confusion/over-sedation.[8]

This module helps practices review the rigor of their processes for prescribing and reviewing patients who have been prescribed an opioid for acute pain management (started within the last 3 months), and does not include those prescribed in a palliative care setting or for chronic pain.

1.2 Aim

100% of opioid* prescribing initiated for acute pain relief will follow a safe, standardised process by 2020.

*Includes any medication containing: codeine, dihydrocodeine, fentanyl, morphine, oxycodone pethidine and tramadol

1.3 Equity

Reducing inequalities in outcomes between Māori and other high needs groups compared to the general population is a priority at all levels of the health system, including Auckland and Wāitemata DHBs.[9]

While Safety in Practice is not a programme specifically focused on equity issues, it is well recognised that for those groups who are already experiencing poorer health outcomes, the very reasons that contribute to this also could make them more at risk of errors, oversights, miscommunications and receiving care that is less able to meet their needs. Working on communication, safe monitoring and prescribing to improve patient safety overall would be expected to have particular benefit for reducing risk for these groups, which would contribute to reducing inequity.

In the audit practices will report the ethnicity of each patient.

Practices can focus on specific groups using an equity lens.

Some examples might be:

- In using the information from the audits in your practice, focus as a priority on Māori and other high needs patients. Both Dr Info and Mohio both allow either selection by Māori, or by high needs, or ordering them according to ethnicity.
- Specifically seeking input from patients from these groups on their experience of the practice's opioid management processes, and how they might be improved from the patient interaction point of view.

1.4 Measures and Rationale

Measure 1 Is there a clear indication within the problem list for an opioid to be used?
Rationale • It is sound clinical practice that the indication for stronger pain relief is clearly recorded and apparent for other clinicians such as locums who might need to follow the patient up. This facilitates dose adjustment or appropriate targeted questioning at review, with clearer expectations about likely patient progress and a plan. • For any medication with risk of harm, it is important to have clear documentation from a medico-legal point of view, around clinical reasoning and justification for management.
Sources • BPAC Analgesic Update March 2018 https://bpac.org.nz/report/snippet/analgesic-update.aspx • BPAC Feb 2018: When to consider strong opioids for patients with acute pain https://bpac.org.nz/2018/opioids.aspx
Measure 2 Is there evidence that a pain score has been used prior to the current prescription of an opioid?
Rationale • Using a pain score provides a baseline that allows comparison at review. It also provides clinical evidence to support the use an opioid, which may be indicated for severe pain. • Using a pain score that includes a functional component (see resources section) helps to standardize understanding between patients and clinicians about what the score means
Sources As above
Measure 3 Is there evidence that paracetamol and/or NSAID have been prescribed concurrently with the opioid?
Rationale • Multi-modal analgesia (concurrent use of analgesics with different modes of action) utilising the analgesic ladder can improve analgesic effectiveness, reduce the dose of opioids if these are prescribed, reduce adverse effects and minimise the length of time that patients require opioids.
Sources • BPAC Analgesic Update March 2018 https://bpac.org.nz/report/snippet/analgesic-update.aspx • BPAC Feb 2018: When to consider strong opioids for patients with acute pain https://bpac.org.nz/2018/opioids.aspx • BPAC Issue 18: WHO Analgesic Ladder: which weak opioid to use at step two? https://bpac.org.nz/BPJ/2008/December/docs/bpj18_who_ladder_pages_20-23.pdf

Measure 4 Is the duration of treatment with the opioid 10 days OR LESS?
Rationale • Long term use often starts with acute pain. Prescribe the lowest effective dose of short acting – 3 days or less will often be sufficient and more than 7 days rarely needed. • Up to 10 days allows some clinician discretion depending on the situation. This would be an expected MAXIMUM given without the patient being clinically reviewed.
Sources • Goodfellow Gems https://www.goodfellowunit.org/gems/guidelines-prescribing-opioids-chronic-non-malignant-pain
Measure 5 If this is NOT their first opioid prescription in the last month, is there documented evidence that the patient was asked about side effects of the opioid?
Rationale • Patients should be reviewed for common side effects to allow for medication adjustment, mitigation of side effects and the prevention of other more serious complications such as constipation and over-sedation. • Discussing side effects as part of an analgesia plan improves compliance. • Different people metabolise opioids at different rates which influences the effectiveness and risk of side effects for different people. Monitoring therefore needs to be individualised.
Sources • BPAC Feb 2018: The principles of managing acute pain in primary care https://bpac.org.nz/2018/acute-pain.aspx • BPAC Feb 2018: Prescribing tramadol appropriately https://bpac.org.nz/2018/tramadol.aspx
Measure 6 Has the patient been given a written patient information guide on the opioid within the last month?
Rationale • A written patient information guide assists patients to understand their medicine regimen. This can help to minimise medication errors and optimise pain management. • Patient understanding and awareness of the common potential side effects and how to mitigate against them is important for therapeutic effectiveness and compliance.
Sources • BPAC Feb 2018: The principles of managing acute pain in primary care https://bpac.org.nz/2018/acute-pain.aspx

Section 2: Instructions

2.1 Collect your baseline data

2.1.1 Identify patients

On the day of the data collection each month, run the query related to your module, available to download from http://www.safetyinpractice.co.nz in the Resources section.
Refer to "Finding your patients" document on website.

Remember you are looking to identify patients who have only recently been initiated on an opioid medication, so you need to exclude patients who are receiving this medicine for palliative care, or for chronic pain management (longer than 1 month).

2.1.2 Randomise

From the list generated in step 2.1.1 it is essential to **RANDOMLY SELECT** your sample of 10 patients to audit. An online random number generator can be used. Note Safety in Practice does not endorse advertising associated with such tools.

2.1.3 Audit

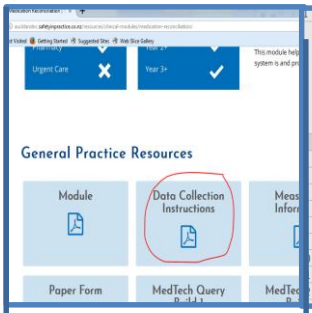
Review each of your 10 selected records against the following criteria. You can use the Paper Form provided on the resources section of our website to keep track or simply enter records directly onto the audit spread sheet.

2.1.3.1 Measures & guidance

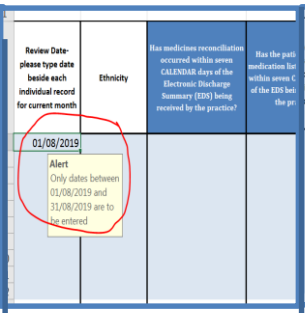
Measure 1 Is there a clear indication within the problem list for an opioid to be used?
Guidance There needs to be clear indication within the clinical record that would be apparent to a non-attendant clinician, of the underlying clinical problem for which the opioid is being prescribed. Record YES if this is apparent. Record NO if this is not clearly recorded.
Measure 2 Is there evidence that a pain score has been used prior to the current prescription of an opioid?
Guidance Record YES if this is clearly recorded. Record NO if this is not clearly recorded.
Measure 3 Is there evidence that paracetamol and/or an NSAID have been prescribed concurrently with the opioid?
Guidance This could be evidenced by co-prescription, or documentation of concurrent medications in the record. Record YES if this is clearly recorded. Record NO if this is not clearly recorded.
Measure 4 Is the duration of treatment with the opioid 10 days OR LESS?
Guidance Check against prescriptions issued. Record YES if the prescription duration is for 10 days or less Record NO if it is for longer than 10 days. NB the 10 days is for the dosage per day as prescribed, or if it is not clearly specified i.e. prn, then at the maximum dose.
Measure 5 If this is NOT their first opioid prescription in the last month, is there documented evidence that the patient was asked about side effects of the opioid?
Guidance Record YES if this is clearly documented. Record NO if this is not clearly recorded. Record N/A if this was their first prescription in the last month.
Measure 6 Has the patient been given a written patient information guide on the opioid within the last month?
Guidance Record YES if it is clear what written information about the opioid was given Record NO if this is not recorded.

2.1.4 Complete the spreadsheet

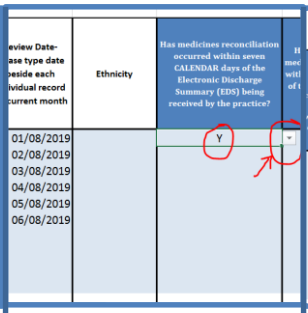
Tip: Your first set of data is relating to the month of August so this is due on September 10th. For this data set record "August" in the first column.



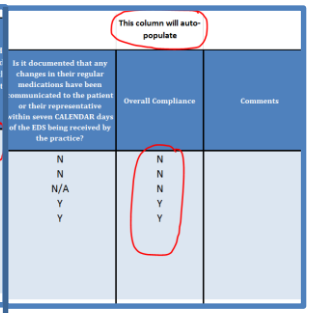
Download the spread sheet for your module in the Resources section of www.safetyinpractice.co.nz



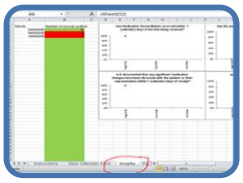
Record the month **the data relates** to in a DD/MM/YY format in the left column (Alert boxes in yellow will guide you). For your first data set collected in September this is 1/8/18



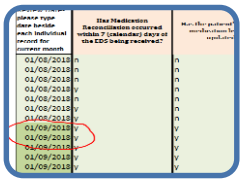
Mark Y, N or N/A by clicking on the dropdown menu, against for each measure and each patient according to your findings in the previous section.



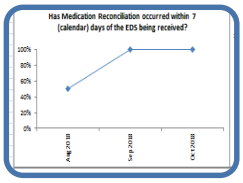
The final measure "Overall compliance" will auto-populate.



Graphs will be automatically generated in the next tab in the spreadsheet.



Next month add your data to the same spreadsheet.



This means you can track your progress over time.

Tip: Please don't audit more than 10 patient for a given month or add or remove rows from the spread-sheet as this will disrupt the formulas and cause the graphs to break.

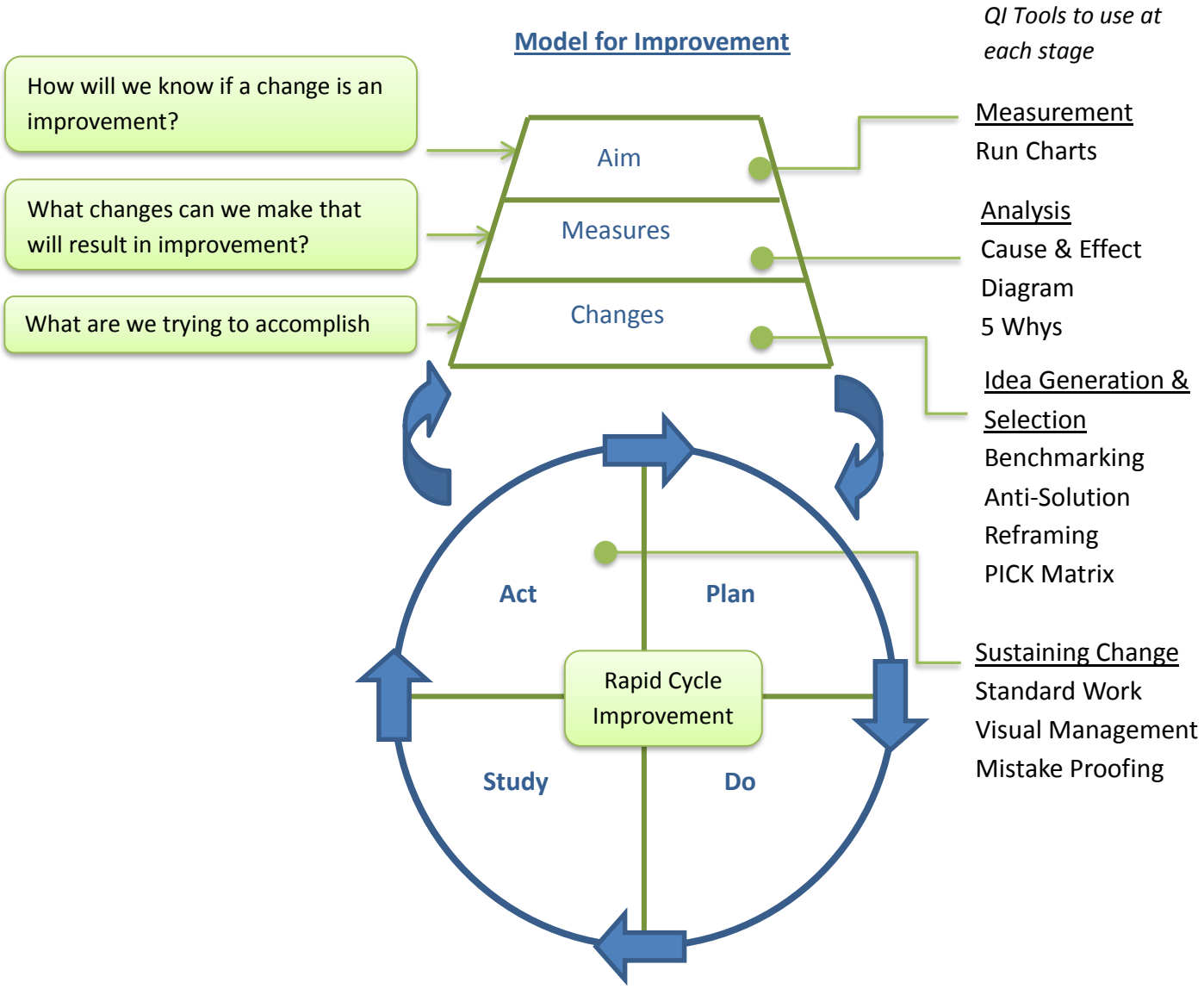
2.1.5 Submit

Submit your data by sending the complete spreadsheet on the 10th of each month to audit@safetyinpractice.co.nz AND your PHO facilitator.

You should SAVE the spread sheet somewhere and then next month add the new data to this same spread sheet. Repeat the process each month.

Please ensure all data sent to Safety in Practice is anonymised

2.2 Creating Change – Using the Model for Improvement



Before you start:

- Bring together your team – this is the group that will work with you to plan and carry out the test of change
- Select the process you wish to change

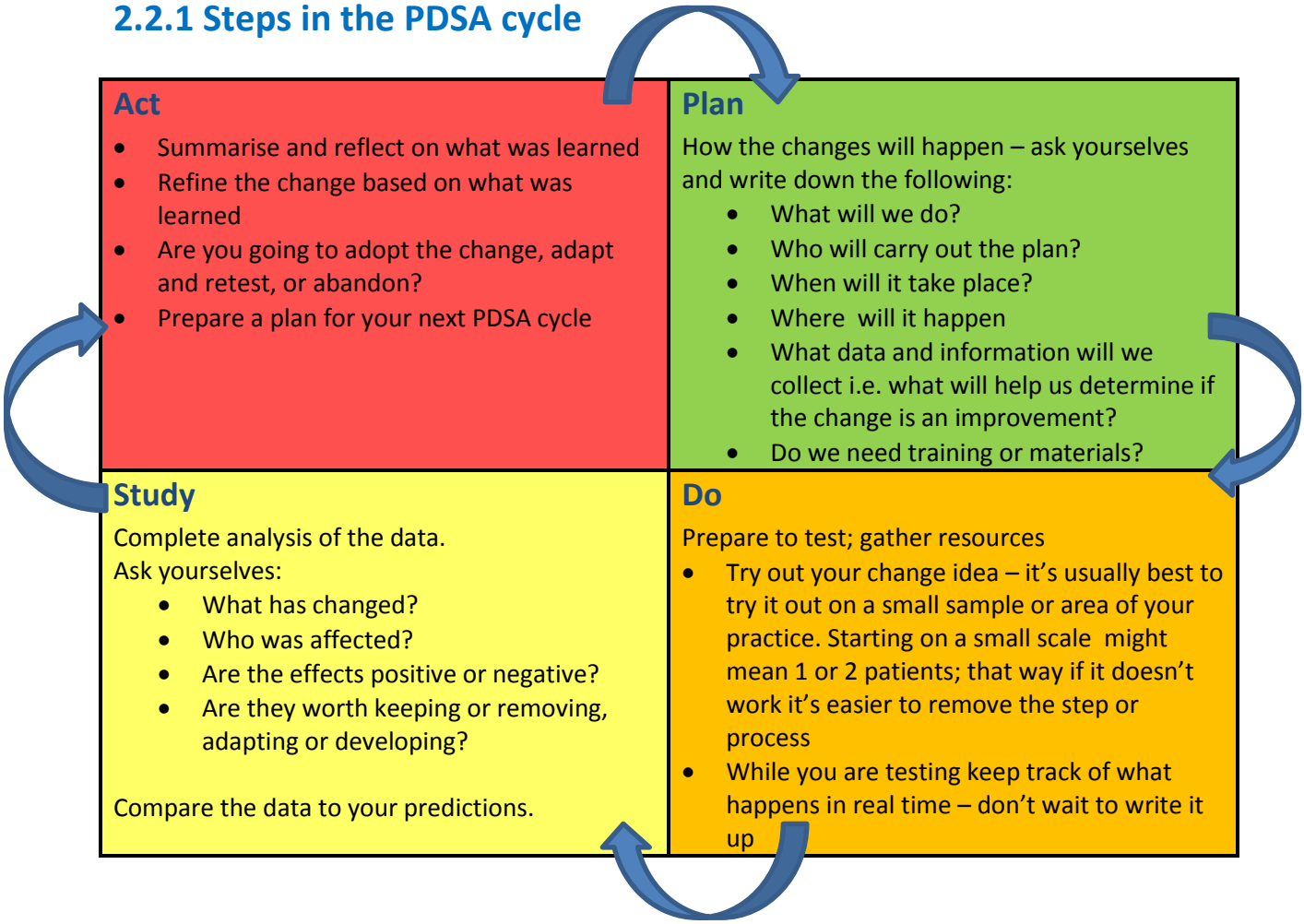
As a team answer the 3 questions above:

1. Aim: *What are we trying to accomplish? (write an objective for this PDSA cycle)*
2. Measure: *How will we know if a change is an improvement?*
3. Changes: *What changes can we make that will result in improvement?*

The following QI techniques will help you engage your team at every step:

- Meeting Facilitation Tips
- Silent Brainstorming
- Post-it Note Brainstorming
- Dot Voting

2.2.1 Steps in the PDSA cycle



2.1.2 Change ideas

The following ideas have been tested and implemented in previous SiP teams

Clinical processes	• Update of locum and registrar orientation document • Updating and circulating opioid prescribing policy amongst clinicians at the practice • Ensure whole practice team are familiar with handling of controlled drugs and prescribing processes. • Controlled drug prescriptions to be scanned into patient notes to ensure audit trail • New controlled drug prescription pads received, continue to be documented in numerical sequence in controlled drugs register • Explore possibility of coding for opioid prescribing
Team and clinician engagement	• Agreement together for max of 10 days on script • Education through Goodfellow Webinar on acute pain management viewed by all clinicians https://www.goodfellowunit.org/events/pharmacological-management-acute-pain • Clinical champion address 'outliers' individually
Pain scores	• Explore and agree on pain score system to be used – ideally one which has a functional component to it See Analgesia in Adults with Acute Pain section in https://aucklandregion.healthpathways.org.nz/
Recording of side effects	• Keyword prompt for side effects to document
Patient advice	• Standardised handouts for patients – use of resources on www.saferx.co.nz or www.healthnavigator.org.nz • Keywords to record patient information • Embed information into PMS document including SafeRX documents

2.1.3 Previous teams' experiences

Benefits	Challenges
•Reassurance that staff are following the process •Clearer team roles •Involving reception admin in an area not thought to concern them has benefits for the whole practice •Reduction in opioid induced side effects •Process helps towards Cornerstone accreditation •Reduction in amount of opioids prescribed	•Time consuming •Getting agreement from all team members •Buy-in from doctors •Patients not keen on other adjuvant treatments •Adjusting measures to what is relevant to that clinic

Section 3: Resources

3.1 MOPs & Cornerstone

The Opioid Management Audit is not specifically endorsed by the RNZCGP for Maintenance of Professional Standards but individuals can write this up as an audit for quality improvement for MOPS outlining what they have done, their findings and what they have done to further improve processes.
The audits and PDSA cycles can be used for Cornerstone / Foundation standards as a Quality Improvement activity.

3.2 Connections to other parts of Safety in Practice programme

Pharmacy

Opioids Module
Pharmacies also have a specific module that looks at their processes around patient education for patients prescribed an opioid.

AIM: All patients receiving prescribed opioids will receive education about the medicine at time of medicine collection. (ie codeine, dihydrocodeine, fentanyl, morphine, oxycodone, pethidine, tramadol) by June 2020.

Process Measures
Is there evidence the patient was informed how to use the medicine?
Is there evidence there was a discussion about possible side effects?
Is there evidence the patient was informed about interactions with other substances that can increase the risk of sedation?
Is there evidence the patient was informed when to seek advice relating to alarm symptoms?
Is there evidence the patient was offered written information about their medicine?
Outcome Measures
Was the patient able to correctly describe (dose and frequency) how to use their medicine?
Was the patient able to identify a possible side effect of their medicine?
Was the patient able to identify who to ask for help with their medicines?

If you work with a pharmacy in your area that might be interested, feel free to direct them to the website or to contact us at info@safetyinpractice.co.nz

3.3 Additional Resource

Resources – general

- 'Acute lower back pain in adults'
https://aucklandregion.healthpathways.org.nz/index.htm
- Analgesia in adults with acute pain
https://aucklandregion.healthpathways.org.nz/71935.htm
- BPAC Feb 2018: The principles of managing acute pain in primary care
https://bpac.org.nz/2018/acute-pain.aspx
- BPAC Feb 2018: Prescribing tramadol appropriately
https://bpac.org.nz/2018/tramadol.aspx
- BPAC Feb 2018: When to consider strong opioids for patients with acute pain
https://bpac.org.nz/2018/opioids.aspx
- BPAC Feb 2018: When to consider strong opioids for patients with acute pain
https://bpac.org.nz/2018/opioids.aspx

Pain score (incorporating functional component)

Rating	Pain level
0	**No pain**
1 to 3	**Mild pain** (nagging, annoying, interferes little with *ADLs)
4 to 6	**Moderate pain** (interferes slightly with ADLs)
7 to 10	**Severe pain** (disabling, unable to perform ADLs)
	*ADLs is the abbreviation for activities of daily living

Source – Auckland Regional Health Pathways - Analgesia in Adults with Acute Pain

Example of specific patient information given out along with guide:

MORPHINE
PATIENT INFORMATION GUIDE

Never give your medicines to others even if their symptoms are the same as yours.

WHY HAVE WE GIVEN YOU THIS GUIDE?
This information is for you to use when taking morphine
Morphine is used for the relief of severe pain
Morphine can cause serious side effects, so it is important you know how to take it safely
Talk to your doctor, pharmacist (chemist) or nurse if you have any questions

SafeRX patient guides

Codeine
http://www.saferx.co.nz/assets/Documents/22ee17a698/codeine-patient-guide.pdf
Oxycodone
http://www.saferx.co.nz/assets/Documents/afbcf75121/Patient_info_oxycodone.pdf
Tramadol
http://www.saferx.co.nz/assets/Documents/7b6c086e7d/tramadol-patient-guide.pdf

Health Navigator

Overview pain relief medicines
https://www.healthnavigator.org.nz/medicines/p/pain-relief-medications/
Codeine
https://www.healthnavigator.org.nz/medicines/c/codeine/
Tramadol
https://www.healthnavigator.org.nz/medicines/t/tramadol/
Morphine
https://www.healthnavigator.org.nz/medicines/m/morphine/
Oxycodone
https://www.healthnavigator.org.nz/medicines/o/oxycodone/

3.4 Glossary

ADE	Adverse Drug Event
ADHB	Auckland District Health Board
Bundle	Each of the areas identified as presenting the highest risk to patients within the community have been developed into modules. Each module is structured to include a change package and a bundle.
CARM	Centre for Adverse Reaction Monitoring New Zealand
Change package	A ccollection of change ideas known to produce a desired outcome in a process or system.
Dr Info	A clinical information platform used by general practices. Data is extracted and analysed from practices PMS'.
IHI	Institute of Healthcare Improvement
HQSC	Health Quality & Safety Commission of New Zealand
Module	A structured way of improving the processes around patient care: a small, straightforward set of evidence-based practices, generally three to five, that, when performed collectively and reliably, have been proven to improve outcomes.
Mohio	A clinical information platform used by general practices. Data is extracted and analysed from practices PMS'.
PMS	Patient management system e.g. MedTech, MyPractice, ToniQ
PHO	Primary health Organisation e.g Auckland, Alliance Health Plus, Comprehensive Care, East Health Trust, Total Healthcare, National Hauora Coalition, Procare
RNZCGP	Royal New Zealand College of General Practitioners
WDHB	Waitemata District Health Board
SIP	Safety in Practice

3.5 References

[1] Stausberg J. International prevalence of adverse drug events in hospitals: an analysis of routine data from England, Germany and the USA. BMC Health Services Research. 2014; 14:125.

[2] Bouvy JC, De Bruin ML, Koopmanschap MA. Epidemiology of adverse drug reactions in Europe: a review of recent observational studies Drug Safety. 2015; 38:437–453.

[3] Chen L, Vo T, Seefield L et al. Lack of correlation between opioid dose adjustment and pain score change in group of chronic pain patients. 2013 *J Pain*Apr;14(4):384-92

[4] Sullivan MD, Von Korff M, Banta-Green C et al. 2010. Problems and concerns of patients receiving chronic opioid therapy for chronic non-cancer pain. *J Pain.*May;149(2):345-53

[5] Korff M.2013.Long-term Use of Opioids for Complex Chronic Pain. *Best Pract Res Clin Rheumatolol* 27(5):663-72

[6] Correspondence and presentation from Dr V McFarlane AOTS 2018.

[7] Goodfellow Gems, July 2018. Available at: https://www.goodfellowunit.org/gems/guidelines-prescribing-opioids-chronic-non-malignant-pain

[8] Robb, G, Loe E, Maharaj A et al. Medication-related patient harm in New Zealand hospitals. New Zealand Medical Journal 2017;130(1460):21-32. Available at: www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2017/vol-130-no-1460-11-august-2017/7328

[9] Waitemata and Auckland DHBs, 2017. 2017/18 Annual Plan. Available at: http://www.waitematadhb.govt.nz/dhb-planning/organisation-wide-planning/annual-plan/