AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

Clinical Care Standards

INFORMATION
for health service organisations

Opioid Analgesic Stewardship in Acute Pain

Clinical Care Standard

The *Opioid Analgesic Stewardship in Acute Pain Clinical Care Standard* is relevant in all acute healthcare settings where care is provided for patients with acute pain. It may also apply in other specialist services which provide care within the scope of this standard.

This clinical care standard contains nine quality statements describing the key components of care that patients of all ages can expect when they are prescribed opioid analgesics for acute pain in acute care settings. It covers patients presenting with acute pain to the emergency department (ED) or following surgery, up to and including discharge from hospital.

It includes a set of indicators to support health service organisations to monitor how well they are implementing the care recommended in this clinical care standard and are intended to support local quality improvement activities.

The definitions required to collect and calculate indicator data are specified online: **meteor.aihw.gov.au/content/index.phtml/itemId/755544**.

1 Patient information and shared decision making

The nonpharmacological and pharmacological options for managing acute pain are discussed with a patient and their carer in a way that they can understand, and that leads to a shared understanding of the decision to use an opioid analgesic or other treatment(s).

Ensure systems are in place for clinicians to provide patients, their family or carers, with culturally appropriate information and advice on acute pain treatment options.

Provide high quality written patient materials and resources for use by clinicians and patients that have been developed in partnership with consumers, and meet the diverse needs of people who access services.

Ensure processes are in place so that information is communicated to the patient about their treatment options and medication management or pain management plan, including at transitions of care (such as on transfer in or discharge from hospital).

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Where opioid analgesics are prescribed, ensure systems are in place so that clinicians discuss with patients and their family or carers the need to take the medicine as prescribed, the expected duration of treatment, any potential adverse effects and interactions with existing medicines and when their treatment requires review. Ensure systems are in place so that, on discharge, clinicians discuss with patients and their family or carers the possibility of harm if they give opioid analgesics to other people, and the safe storage and disposal of opioid analgesics.

Monitor patient understanding of information provided for acute pain treatment and evidence of shared decision making – for example, through patient surveys, patient-reported experience measures and patient-reported outcome measures.

There is no indicator.

2 Acute pain assessment

Analgesic prescribing in a patient with acute pain is guided by its expected severity and assessment of patient-reported pain intensity and the impact of pain on the patient's function.

Ensure appropriate evidence-based tools to assess patient function and pain are available, and that processes and policies support their use to assess and document acute pain, before clinicians prescribe appropriate analgesia.

Indicator 2a: Proportion of patients who received opioid analgesics who had pain and functional assessments prior to being prescribed opioid analgesics and had the outcomes of the assessments documented in their medical record.

3 Risk–benefit analysis

Whenever an opioid analgesic is considered for a patient with acute pain, their risk of opioid-related harm is assessed. An opioid analgesic may be prescribed when other analgesics are not clinically feasible or sufficient, and the potential benefits outweigh the potential harms.

Ensure systems are in place for clinicians to assess, and document avoidable, modifiable risk factors before a decision is made to prescribe an opioid analgesic.

Ensure systems are in place for clinicians to establish a patient's opioid status before prescribing opioid analgesics to treat the patient's acute pain.

Ensure policies and processes are in place to provide clinicians with access to appropriate tools, such as real time prescription monitoring (where available) or the Prescription Shopping Program, to identify and assess patients at risk of harm from CNS depressants before opioid analgesics are given or prescribed to treat the patient's acute pain.

Indicator 3a: Proportion of patients who separated from hospital with a supply or prescription of opioid analgesics where a Real Time Prescription Monitoring program or a prescription shopping program was checked prior to separation.

Indicator 3b: Proportion of patients who were prescribed opioid analgesics who were co-prescribed central nervous system depressant medicines while in hospital.

4 Pathways of care

A patient with acute pain prescribed an opioid analgesic who is at increased risk of opioid-related harm is appropriately managed in conjunction with a locally approved pathway to mitigate the potential for harm.

Ensure there is a locally approved policy which defines the clinical pathways for hospitalised patients who are identified to be at increased risk of opioid-related harm. The pathways should enable clinicians to refer and escalate care of patients at increased risk of opioid-related harm to access support services, including specialist services for paediatrics, pain management, drug and alcohol, clinical pharmacy and allied health.

Ensure systems are in place to inform patients why they are being referred to a pathway and the plan for their ongoing clinical management.

Ensure clinicians are trained how to access the pathways, and that workforce proficiency is maintained.

Indicator 4a: Evidence of a locally approved policy that defines the process for managing admitted patients identified as being at increased risk of opioid-related harm who are prescribed an opioid analgesic. The policy should specify:

- Process for identifying patients who are at risk of opioid-related harm
- Local pathways for managing patients identified at increased risk of opioid-related harm
- Systems to inform patients of why they are being referred to a pathway and the plan for their ongoing clinical management
- Process for clinicians to refer patients to appropriate support services and escalate care to specialist services
- Process to ensure clinicians are competent in the use of the pathway
- Process to assess adherence to the pathway.

5 Appropriate opioid analgesic prescribing

If an opioid analgesic is considered appropriate for an opioid-naive patient with acute pain, use an immediate release formulation at the lowest appropriate dose, for a limited duration, and prescribe in line with best practice guidelines. Modified release opioid analgesics cannot be safely or rapidly titrated and their use in acute pain should be exceptional and not routine. The patient is supported to cease any opioid analgesic use as their function and pain improve.

Ensure systems are in place for clinicians to be able to access best practice guidelines for appropriate prescribing of opioid analgesics for acute pain.

Ensure processes and systems are in place to alert clinicians to limit the duration of therapy for opioid analgesics and to plan to reduce their use.

Ensure policies, procedures and systems are in place for clinicians to supply or prescribe paracetamol and anti-inflammatories alongside opioid analgesics.

Ensure policy and procedures are in place to prevent the prescribing of modified-release opioid analgesics for routine management of acute pain.

Indicator 5a: Proportion of patients who separated from hospital with a supply or prescription of opioid analgesics who also received a supply or prescription of paracetamol and non-steroidal anti-inflammatory medicines.

Indicator 5b: Proportion of opioid naïve surgical patients admitted for surgery who separated from hospital with a supply or prescription of opioid analgesics where the supply or prescription was for a modified-release formulation.

6 Monitoring and management of opioid analgesic adverse effects

When an opioid analgesic is prescribed, supplied or administered for a patient with acute pain, adverse effects are monitored and managed. The patient and carer are made aware of potential adverse effects and signs of overdose, including respiratory depression.

Ensure systems and protocols are in place for clinicians to monitor and manage opioid analgesic adverse effects such as nausea, constipation, sedation, and signs of overdose including respiratory depression (OIVI). Ensure monitoring of sedation levels and appropriate action when sedation levels increase. Ensure all clinicians are aware of these systems and protocols.

Ensure protocols are in place to escalate care. Ensure all clinicians are aware of these protocols.

Where electronic healthcare records are in place, consider incorporating PowerPlans, flags and reminders of opioid analgesic adverse effects into the record management system.

Indicator 6a: Proportion of admitted patients who received opioid analgesics who were administered naloxone for respiratory depression.

Indicator 6b: Proportion of admitted patients who received opioid analgesics who also received prophylactic laxatives to prevent opioid constipation.

7 Documentation

When a patient with acute pain is prescribed, supplied or administered an opioid analgesic, the intended duration of therapy, and the review and referral plan are documented in the patient's healthcare record. The cause of the pain for which the opioid analgesic is prescribed is documented, including on the inpatient prescription.

Ensure a system is in place for clinicians to document the intended duration (number of days), the weaning and cessation plan, and the review and referral plan for opioid analgesics in the patient's healthcare record.

Ensure a system is in place for clinicians to document the cause of pain for which the opioid analgesic is prescribed, including on the inpatient prescription.

Where electronic healthcare records are being used, incorporate flags and reminders into the record management system to support documentation in all relevant fields or consider making them mandatory fields.

Indicator 7a: Proportion of admitted patients who received opioid analgesics where the intended number of days of treatment was documented in their medical record.

8 Review of therapy

During hospital care, a patient prescribed an opioid analgesic for acute pain is assessed regularly to determine their response to therapy and whether an opioid analgesic is effective and appropriate for their stage of care.

Ensure systems are in place for clinicians to regularly review the effectiveness, appropriateness and ongoing need for opioid analgesics according to the patient's stage of care. In hospital, this includes ceasing opioid analgesics when no longer necessary, and reviewing regularly from the first prescription. Ensure oMEDD calculator is available for clinicians to determine the appropriate daily dose of opioid analgesic.

Include systems to ensure that review of opioid analgesics occurs immediately before the patient leaves the hospital.

Ensure referral and escalation of care processes are in place to support clinicians when a patient's acute pain does not respond to opioid analgesic therapy. This may include referral to other hospital-based support services including escalation to specialist services for paediatrics, pain management, drug and alcohol, clinical pharmacy, and allied health.

Ensure policy, procedures and systems are in place to support clinicians to change from intravenous to oral opioid analgesics in patients with acute pain. This should include incorporating flags in electronic medication management systems where these are in use.

Indicator 8a: Proportion of overnight admitted patients separated from hospital with a supply or prescription of opioid analgesics that exceeded the opioid analgesic inpatient dose given during the 24 hours prior to separation.

9 Transfer of care

Planning for appropriate analgesic use at the transfer of care begins when a patient is started on an opioid analgesic during their hospital visit, according to an agreed opioid analgesic weaning and cessation protocol. The number of days' supply of an opioid analgesic on discharge is based on multiple factors, including the expected course of the patient's condition, appropriate arrangements for follow up and opioid analgesic use in the last 24 hours before discharge.

Ensure a locally approved policy is in place to support transfer of care of patients discharged from hospital with a supply or prescription for opioid analgesics.

Ensure an opioid analgesic discharge weaning and cessation protocol is available to clinicians and used for patients who are prescribed, supplied or administered an opioid analgesic for acute pain during their hospital stay. The protocol should address the cessation or weaning of opioid analgesics started in hospital and provided or prescribed over more than 24 hours. On hospital discharge, the protocol should outline the elements of a weaning and cessation plan that includes:

- The selection of an appropriate formulation of an opioid analgesic
- For patients in hospital for more than a day, the selection of an opioid analgesic dose on discharge that is based on use in the last 24 hours before discharge, using an oral morphine-equivalent daily dose (oMEDD)
- For patients discharged from day surgery, the selection of an appropriate opioid analgesic appropriate dose based on the expected trajectory of the patient's condition
- An appropriate supply of opioids, considering the day of discharge and when the patient can reasonably be expected to access primary care and other healthcare services post-discharge
- Processes to identify patients who already have opioid analgesics in their possession that may adequately treat their acute pain, and do not require an additional prescription on hospital discharge, and to advise them on the appropriate use of those analgesics

- Prompt communication of a clinical handover summary to the patient's general practitioner that includes
  - the cause of the pain for which the opioid analgesic was prescribed
  - the opioid analgesic dose prescribed or recommended on discharge (which will differ to the inpatient dose)
  - a medication management plan that includes recommendations for reducing and ceasing the opioid analgesic where appropriate
- Provision of written patient information that addresses
  - how many times a day to take, use or apply the medicine, and if the medicine should be taken with food
  - whether the medicine may affect other medicines
  - what the potential adverse effects are, and how to manage them
  - when to seek urgent care for adverse effects of the medicine or lack of pain relief
  - details of how to reduce the medicine and stop the medicine (weaning and cessation plan)
  - how to safely store and dispose of the medicine.

Ensure processes are in place to identify the patient's general practitioner who will continue the patient's care after leaving hospital. If this is not possible, ensure processes are in place to assist the patient access health care after discharge.

Ensure processes are in place to reduce and stop the opioid analgesic by allowing up to a maximum of:

- Three days' opioid analgesic supply to patients discharged from the ED
- Seven days' opioid analgesic supply for patients discharged following a hospital stay.

These processes should allow for exceptions such as the patient's ability to access services in the community and comorbidities.

Indicator 9a: Evidence of a locally approved policy to support transfer of care of patients who separate from hospital with a supply or prescription of opioid analgesics. The protocol should specify the:

- Organisation's opioid analgesic weaning and cessation protocol
- Process for referral to specialist services, if required
- Required documentation to be provided to the patient or carer
- Required clinical handover documentation to be provided to the general practitioner or other primary care clinician
- Process to ensure the workforce is competent in the use the policy
- Process to assess adherence to the policy.

Indicator 9b: Proportion of admitted patients separated from hospital with a supply or prescription of opioid analgesics where the supply or prescription exceeded seven days of treatment.

Indicator 9c: Proportion of patients separated from the ED with a supply or prescription of opioid analgesics where the supply exceeded three days of treatment.

Indicator 9d: Proportion of patients separated from hospital with a supply or prescription of opioid analgesics whose medication management plan was given to the patient or carer on separation.

Indicator 9e: Proportion of patients separated from hospital with a supply or prescription of opioid analgesics whose medication management plan is sent to the primary care clinician on separation.

Questions?

For more information about the clinical care standard, please visit: **safetyandquality.gov.au/ccs**.

You can also contact the Clinical Care Standards project team at: **ccs@safetyandquality.gov.au**.