SHPA's response to the draft Opioid Analgesic Stewardship in Acute Pain Clinical Care Standard

Quality Statement 1: Patient information and shared decision making

1. Does the quality statement adequately describe the quality of care that should be provided to those patients presenting to the Emergency Department (ED) and to post-surgical hospital inpatients and day patients with acute pain who require opioid analgesics?

Yes.

2. How could the quality statement be improved?

The Society of Hospital Pharmacists of Australia (SHPA) supports the involvement of the patient and carer in making decisions about their treatment, highlighting the key role of clinical pharmacists in providing tailored medication education to patients through verbal medication counselling and consumer medication information (CMI) leaflets.

Quality Statement 2: Acute pain assessment

3. Does the quality statement adequately describe the quality of care that should be provided to those patients presenting to the Emergency Department (ED) and to post-surgical hospital inpatients and day patients with acute pain who require opioid analgesics?

Yes.

4. How could the quality statement be improved?

N/A

Quality Statement 3: Risk assessment

5. Does the quality statement adequately describe the quality of care that should be provided to those patients presenting to the Emergency Department (ED) and to post-surgical hospital inpatients and day patients with acute pain who require opioid analgesics?

Yes.

6. How could the quality statement be improved?

SHPA believes the assessment for risk of opioid-related harm should include the patient's prior and current use of opioids, both prescription and illicit, as prior use can be considered a risk factor and should be recognised when determining future treatment options.

7. Do you agree that the indicators capture information that can be used locally to support clinical quality improvement activities?

Indicator 3a: Strongly agree

Indicator 3b: Strongly agree

8. If you disagree, please briefly explain why, suggest how the indicators can be improved, or provide alternative indicators.

The Society of Hospital Pharmacists of Australia
PO Box 1774 Collingwood Victoria 3066 Australia
(03) 9486 0177 | shpa.org.au | shpa@shpa.org.au | ABN: 54 004 553 806

Whilst we strongly agree with the proposed indicators, SHPA notes that not all jurisdictions have access to a Real-Time Prescription Monitoring (RTPM) program. This could be a barrier to capturing important data used to inform clinical quality improvement activities. SHPA recommends the implementation of a National RTPM system to support safe use of opioids especially during high-risk transitions of care between health settings.

SHPA would also like to note that not all hospital pharmacy departments are staffed outside of the usual business hours, this therefore impacts on the ability to obtain an accurate and thorough medication history detailing prior and current opioid use. SHPA's Medication Safety position statement [1] recommends seven-day, extended hours access to clinical pharmacy services in all health settings where medications are being used, to facilitate the safe and judicious use of medications.

Quality Statement 4: Pathways of care

9. Does the quality statement adequately describe the quality of care that should be provided to those patients presenting to the Emergency Department (ED) and to post-surgical hospital inpatients and day patients with acute pain who require opioid analgesics?

Yes.

10. How could the quality statement be improved?

SHPA welcomes the inclusion of clinical pharmacists as part of the pathway of care, highlighting the multidisciplinary approach required to mitigate opioid-related harm. Opioid Stewardship Pharmacists (OSP) who are clinical pharmacist with expertise in pain and analgesia management, aim to mitigate harm associated with opioids prescribed in hospital by impacting on the overall patient journey at four main intervention points:

- collaborating with prescribers
- managing the supply of opioids on discharge
- increasing patient education
- sharing of information with primary care providers

There are high levels of interest in opioid/analgesic stewardship programs in public hospital settings however, although models are being implemented in various hospitals, a critical mass has not been reached.

The majority of public hospitals require additional funding to invest in opioid/analgesic stewardship programs, this funding is difficult to secure in a highly competitive environment. This is particularly the case in states who are non-signatories to the Public Hospital Pharmaceutical Reform Agreements who have lower pharmacy workforce capacities. The inclusion of opioid/analgesic stewardship in the NSQHS standards is imperative to ensuring broader adoption.

11. Do you agree that the indicator captures information that can be used locally to support clinical quality improvement activities?

Indicator 4: Strongly agree

12. If you disagree, please briefly explain why, suggest how the indicator can be improved, or provide alternative indicators?

N/A

Quality Statement 5: Appropriate opioid analgesic prescribing

13. Does the quality statement adequately describe the quality of care that should be provided to those patients presenting to the Emergency Department (ED) and to post-surgical hospital inpatients and day patients with acute pain who require opioid analgesics?

Yes

14. How could the quality statement be improved?

In the section 'For Clinicians', SHPA supports highlighting the key role of a clinical pharmacist in advising on most appropriate treatment as well as prompting review of opioids prior to discharge, as well as side effect management (opioid-induced constipation, ability to operate machinery or drive).

15. Do you agree that the indicators capture information that can be used locally to support clinical quality improvement activities?

Indicator 5a: Neither agree or disagree

Indicator 5b: Strongly agree

Indicator 5c: Strongly agree

16. Do you agree that the indicators capture information that can be used locally to support clinical quality improvement activities?

In reference to indicator 5a, while SHPA supports best practice is to include all intended prescribed medications on a discharge prescription, it may not be common practice. Simple analgesia may be advised by the clinician on discharge; however, it may not necessarily be prescribed on the discharge prescription as patients can obtain simple analgesia (e.g. paracetamol) over the counter without a prescription.

Quantity of opioid medicines supplied or prescribed on discharge could also be considered as a quality indicator.

Quality Statement 6: Monitoring and management of opioid analgesic adverse effects

17. Does the quality statement adequately describe the quality of care that should be provided to those patients presenting to the Emergency Department (ED) and to post-surgical hospital inpatients and day patients with acute pain who require opioid analgesics?

Yes

18. How could the quality statement be improved?

In the section 'For Clinicians', SHPA supports highlighting the key role of a clinical pharmacist at all aspects of a patients journey through the hospital by influencing treatment choice at point of prescribing, monitoring for adverse effects during their inpatient stay, as well as providing medication counselling to patients and carers on discharge.

19. Do you agree that the indicators capture information that can be used locally to support clinical quality improvement activities?

Indicator 6a Strongly agree

Indicator 6b Strongly agree

20. If you disagree, please briefly explain why, suggest how the indicators can be improved, or provide alternative indicators

N/A

Quality Statement 7: Documentation

21. Does the quality statement adequately describe the quality of care that should be provided to those patients presenting to the Emergency Department (ED) and to post-surgical hospital inpatients and day patients with acute pain who require opioid analgesics?

Yes

22. How could this quality statement be improved?

In either section 'For Clinicians' or 'For Health Service Organisations', it should be acknowledged that Electronic Medical Record systems and Electronic Prescribing systems used in hospitals, have the capacity to prompt the prescriber and pharmacist to note the indication for opioid analgesic, intended duration of therapy, as well as any management or referral plans.

23. Do you agree that the indicator captures information that can be used locally to support clinical quality improvement activities?

Indicator 7 Agree

24. If you disagree, please briefly explain why, suggest how the indicator can be improved, or provide alternative indicators?

SHPA agrees with indicator 7 in principle, however, to further facilitate this, a clear section to record intended duration of opioids on Medication Management Plans (MMP) would be recommended. To assist in transition of care and facilitate patient safety, a review date could also be documented in the patient's notes or on the medication chart itself at point of prescribing. Electronic Medical Records which are being increasingly used in hospital settings, also have the capacity for MMPs to be more interactive and dynamic for prescribers and pharmacists, enabling more quality and informed clinical review and prescribing. These records would also be able to be shared with community-based clinicians upon discharge.

Quality Statement 8: Review of therapy

25. Does the quality statement adequately describe the quality of care that should be provided to those patients presenting to the Emergency Department (ED) and to post-surgical hospital inpatients and day patients with acute pain who require opioid analgesics?

Yes

26. How could this quality statement be improved?

N/A

27. Do you agree that the indicator captures information that can be used locally to support clinical quality improvement activities?

Indicator 8 Agree

28. If you disagree, please briefly explain why, suggest how the indicator can be improved, or provide alternative indicators?

SHPA agrees with indicator 8 in-principle, however, suggests that the wording is amended. The term 'inconsistent' could also imply reduced or when required dosing which also may be appropriate in regard to the patient's opioid management plan despite not being consistent with the dose in the previous 24 hours. SHPA proposes the following changes to indicator 8 for clarity:

Proportion of patients who separated from hospital with a supply of prescription opioid analgesics that is appropriate in regard to the inpatient doses given during the 24 hours prior to separation.

Quality Statement 9: Transfer of care

29. Does the quality statement adequately describe the quality of care that should be provided to those patients presenting to the Emergency Department (ED) and to post-surgical hospital inpatients and day patients with acute pain who require opioid analgesics?

Yes

30. How could this quality statement be improved?

N/A

31. Do you agree that the indicators capture information that can be used locally to support clinical quality improvement activities?

Indicator 9a Strongly Agree

Indicator 9b Agree

Indicator 9c Agree

Indicator 9d Agree

32. If you disagree, please briefly explain why, suggest how the indicators can be improved, or provide alternative indicators.

In reference to indicator 9c and 9d, SHPA suggest that this indicator is split into two separate indicators to allow comparison between opioid naïve patients and those receiving regular treatment with opioid medicines.

SHPA believe it is important that the MMP is provided to the patient and carers (where appropriate) as well as primary care providers to support seamless transition of care.

Proposed indicators:

Indicator 9c

Proportion of opioid naïve patients who separated from hospital with a supply or prescription of opioid analgesics whose medication management plan:

- *Includes the intended number of days that opioid analgesia will be required*
- *Is given to the patient and/or their carer upon separation from hospital*
- *Is sent to the primary care clinician upon separation from hospital*

Indicator 9d

Proportion of patients with regular or chronic use of opioid analgesics, who separated from hospital with a supply or prescription of opioid analgesics whose medication management plan:

- *Includes the intended number of days that opioid analgesia will be required*
- *Is given to the patient and/or their carer upon separation from hospital*
- *Is sent to the primary care clinician upon separation from hospital*

For Consumers

33. Do you have any other comments about the clinical care standard from your experience of being prescribed, dispensed or administered opioid analgesics in hospital to treat acute pain?

N/A

34. Please provide further comments here

N/A

35. Is the consumer guide useful?

N/A

36. Please comment

N/A

For Clinicians

37. The quality statements target areas of care which could benefit from quality improvement. Are there additional aspects of care missing from the quality statements that should be included?

No

38. Please provide further comments here

N/A

39. If implementing this clinical care standard, what would be the implications for your practice?

SHPA recommend that MMPs are pharmacist-led to ensure that indictors stipulated in this clinical care standard are adhered to. Discharge summaries must also have input by clinical pharmacists to ensure an accurate medication summary with consideration of appropriate monitoring and review. This is already embedded into practice in many hospitals around Australia.

A collaborate prescribing model between doctors and pharmacists would further assist in patient safety and transfer of care as well as increasing efficiency. SHPA's position statement on Medication Safety [1] recommends the expansion of Partnered Pharmacist Medication Charting (PPMC) to all Australian hospitals. In the PPMC model, a pharmacist conducts a medication history interview with a patient; partners in the development of a medication plan for that patient with the treating doctor, patient and nurse and then charts the patient's regular medications while the doctor charts any new medications. This would also ensure that opioid analgesics are reviewed or ceased prior to discharge and any ongoing monitoring or management is communicated to the primary care provider.

40. Is the fact sheet for clinicians useful?

Yes

41. Please comment

N/A

For Health Services

42. The quality statements target areas of care which could benefit from quality improvement. Are there additional aspects of care missing from the quality statements that should be included?

No

43. Please provide further comments here

N/A

44. If implementing this clinical care standard, what would be the implications for your health service organisation?

SHPA believes that this clinical care standard is a vital step for patient safety and beneficial to quality improvement around opioid analgesics. SHPA recommends that in order to implement this standard, resourcing and funding of the workforce will need to be considered. SHPA's *Standard of practice in pain management for pharmacy services* advocates for the role of an Analgesic Stewardship Pharmacist, who are essential in further facilitating the implementation of this standard [2].

A pain management pharmacist should preferably be embedded within the pain management multidisciplinary team to consider the effects of comorbidities in patients presenting with pain, as well as the potential for and outcomes of individual and community harm regarding opioid analgesics. The *SHPA's Standard of practice in pain management for pharmacy services* also recommends pain management pharmacist staffing levels for pharmacy services to be 1 FTE pharmacist per 20 beds [2].

45. Is the fact sheet for health services useful?

Yes

46. Please comment

N/A

47. Do you know of any current or planned initiatives that could support the implementation of this clinical care standard?

Increasing the number of states adopting Real-Time Prescription Monitoring (RTPM) programs will assist in preventing opioid related harm as well as establishing opioid use prior to admission. A national RTPM is recommended to provide equity across all states.

48. Do you have any other comments that you would like to make about this clinical care standard?

In reference to page 19, line 20, SHPA believes this resource is the Royal Children's Hospital, Melbourne not Adelaide. In reference to page 30, line 34, SHPA proposes that there should be mention of all sedating medicines, not sedative hypnotics alone.

49. **Organisation:** The Society of Hospital Pharmacists of Australia

50: Role: Policy Analyst

51. Capacity: Organisation representing hospital pharmacists

52. Location: N/A

53. **Base:** N/A

References:

1. The Society of Hospital Pharmacists of Australia (SHPA), Medication safety position statement, Collingwood: The Society of Hospital Pharmacists of Australia; Available from https://www.shpa.org.au/sites/default/files/uploaded-content/website-content/Fact-sheets-position-statements/shpa_medication_safety_position_statement_sep2020.pdf Accessed 5th October 2021

2. Lim, D., Hall, A., Jordan, M., Suckling, B., Tuffin, P.H., Tynan, K., Warrior, N. and Munro, C. (2019), Standard of practice in pain management for pharmacy services. J Pharm Pract Res, 49: 270-284.