CLINICAL AUDIT

Appropriate prescribing of **Oxycodone for non-cancer pain** in general practice

Valid to January 2028

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Background

Oxycodone is a strong opioid that milligram for milligram is approximately twice as potent as morphine. It is indicated for the treatment of moderate to severe pain, when morphine is not tolerated, and all other options have been considered (including non-opioid analgesics and weaker opioids options). Between 2017 and 2021, the number of patients prescribed oxycodone in New Zealand increased from 5.0 per 1000 people to 5.8 per 1000 people.[1] Previous data highlighted that the majority of people dispensed oxycodone in New Zealand are initiated on this medicine outside of general practice, i.e. by a doctor in secondary care, however, general practitioners continue to initiate almost one-quarter of prescriptions and continue oxycodone in 17% of people initiated in secondary care.[2] Clinicians are urged to assess whether the initiation or continuation of oxycodone is appropriate for each specific clinical situation, before writing a prescription. N.B. This audit is aimed at examining unnecessary oxycodone prescribing and does not include use of oxycodone in patients with cancer or another terminal condition, where other factors are involved in clinical decision-making.

Morphine is the preferred first-line option for the treatment of acute and chronic moderate to severe non-cancer pain, if a strong opioid is indicated. When compared to morphine, oxycodone:

- Has no better analgesic efficacy
- Has a similar adverse effect profile
- Has more addictive potential
- Is significantly more expensive

Fentanyl or methadone are safer options in patients with renal impairment, who require a strong opioid, because they have no clinically significant active metabolites (unlike morphine and, to a lesser extent, oxycodone). In many cases, however, morphine can still be safely used in patients with renal impairment, if it is dosed appropriately. Discussion with a nephrologist is recommended in patients with eGFR < 30 mL/min/1.73m^2.

For further information, see "Oxycodone: how did we get here and how do we fix it?", BPJ 62 (July, 2014): **www.bpac.org.nz/BPJ/2014/July/oxycodone.aspx**

1. Ministry of Health. Pharmaceutical Claims Collection. 2022.
2. Ministry of Health. Pharmaceutical Claims Collection. 2017.

Recommendations

Oxycodone should only be prescribed for the treatment of moderate to severe non-cancer pain in patients who are intolerant to morphine and when a strong opioid is the best option. When considering initiation of oxycodone, always ask yourself if you would use morphine for this patient. If the answer is no then do not prescribe oxycodone. Oxycodone should not be prescribed when a weaker opioid, e.g. codeine, dihydrocodeine or tramadol, would be more appropriate.

Remember that: 5 mg oxycodone is approximately equivalent to 10 mg morphine, 50 – 100 mg tramadol, 100mg dihydrocodeine or 100 mg codeine.

Audit plan

This audit aims to help you identify patients who have been prescribed oxycodone (excluding those with cancer or another terminal condition) and then to consider whether or not this was the most appropriate analgesic medicine.

The recommended steps for completing the audit are:

1. Identify all patients currently prescribed oxycodone
2. Assess whether they meet the indications for oxycodone treatment (below)
3. Where appropriate, switch the patient to another treatment or taper their dose

Indications

Although there are exceptions to every rule, in the majority of cases, oxycodone should only be prescribed if the patient:

- Is intolerant or allergic to morphine and;
- Has moderate to severe pain and;
- There has been an adequate trial of other treatments which have been unable to control the pain

In most cases, oxycodone should be a short-term treatment only and analgesia should be tapered as pain levels decrease. The dose of oxycodone can be stopped or slowly reduced and, where required, the patient can be switched to a weaker opioid and/or paracetamol.

N.B. Tapering or ceasing analgesia is unlikely to be appropriate for patients with cancer pain (or other palliative care conditions requiring ongoing pain relief), therefore this audit is restricted to patients using oxycodone for non-cancer /non-palliative care pain.

Criteria for a positive result

Any patient currently being treated with oxycodone should have the following recorded in their notes:

- The indication for treatment with a strong opioid (exclude those being treated for cancer pain)
- The reason why morphine was not an appropriate treatment
- The recommended plan for reducing the dose, ceasing treatment and/or switching to another analgesic as required

And if the patient does not meet the required indications

- A note to recall/review the patient, to assess pain, and to taper the dose or switch to another analgesic

Audit standards

By the second data cycle of this audit, 90% of the patients who have been prescribed oxycodone in the previous 12 months should meet the required indications (i.e. moderate to severe non-cancer pain requiring a strong opioid, intolerance or allergy to morphine and a tapering plan in place).

Data

Eligible people

All patients who have received a prescription for oxycodone to manage non-cancer pain in the previous 12 months are eligible for this audit.

Identifying patients

You will need to have a system in place that allows you to identify eligible patients. Many practices will be able to identify patients by running a 'query' through their practice management software.

Once a patient has been identified, assess whether the indication for analgesia warrants treatment with a strong opioid and if there is a record of an intolerance or allergy to morphine. Check whether there has been a recent assessment of the severity of the patient's pain and a plan for tapering analgesia. Also consider whether the patient has had an adequate trial of other treatments.

Sample size

The number of eligible patients will vary according to your practice demographic. If you identify a large number of patients, take a random sample of 30 patients whose notes you will audit.

Data analysis

Use the data sheet to record your data and calculate percentages.

Identifying opportunities for Audit of Medical Practice

The first step to improving medical practice is to identify the criteria where gaps exist between expected and actual performance and then to decide how to change practice.

Once a set of priorities for change have been decided on, an action plan should be developed to implement any changes.

Taking action

It may be useful to consider the following points when developing a plan for action (RNZCGP 2002).

Problem solving process

- What is the problem or underlying problem(s)?
- Change it to an aim
- What are the solutions or options?
- What are the barriers?
- How can you overcome them?

Overcoming barriers to promote change

- Identifying barriers can provide a basis for change
- What is achievable – find out what the external pressures on the practice are and discuss ways of dealing with them in the practice setting
- Identify the barriers
- Develop a priority list
- Choose one or two achievable goals

Effective interventions

- No single strategy or intervention is more effective than another, and sometimes a variety of methods are needed to bring about lasting change
- Interventions should be directed at existing barriers or problems, knowledge, skills and attitudes, as well as performance and behaviour

Review

Monitoring change and progress

It is important to review the action plan develop previously against the timeline at regular intervals. It may be helpful to review the following questions:

- Is the process working?
- Are the goals for improvement being achieved?
- Are the goals still appropriate?
- Do you need to develop new tools to achieve the goals you have set?

Following the completion of the first cycle, it is recommended that the doctor completes the first part of the Audit of Medical Practice summary sheet (Appendix 1).

Undertaking a second cycle

In addition to regular reviews of progress with the practice team, a second audit cycle should be completed in order to quantify progress on closing the gaps in performance.

It is recommended that the second cycle be completed within 12 months of completing the first cycle. The second cycle should begin at the data collection stage. Following the completion of the second cycle it is recommended that practices complete the remainder of the Audit of Medical Practice summary sheet.

The Royal New Zealand College of General Practitioners

Claiming credits for Te Whanake CPD programme

This audit has been endorsed by the RNZCGP for CPD purposes for General Practitioners and can be claimed towards the Patient Outcomes (Improving Patient Care and Health Outcomes) learning category of the Te Whanake CPD programme, on a credit per learning hour basis. General practitioners are encouraged to discuss the outcomes of the audit with their peer group or practice; this may also be recorded as a reflection if suitable.

To claim points go to the RNZCGP website: **www.rnzcgp.org.nz**

The RNZCGP encourages that evidence of participation in the audit be attached to your recorded activity. Evidence can include:

- A summary of the data collected
- An Audit of Medical Practice (CQI) Activity summary sheet (Appendix 1 in this audit or available on the RNZCGP website)

The Royal New Zealand College of General Practitioners
Te Whare Tohu Rata o Aotearoa
Endorsed CPD Activity

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PO Box 6032, Dunedin
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bpac nz better medicine

www.bpac.org.nz/audits

Data sheet – cycle 1 Appropriate prescribing of oxycodone for non-cancer pain in general practice

Patients prescribed oxycodone	Moderate to severe pain	Intolerant or allergic to morphine	Plan in place to taper analgesia
Patient	YES/NO	YES/NO	YES/NO
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			
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23			
24			
25			
26			
27			
28			
29			
30			
Total Yes			
% Yes			

Please retain this sheet for your records to provide evidence of participation in this audit.

Data sheet – cycle 2 Appropriate prescribing of oxycodone for non-cancer pain in general practice

Patients prescribed oxycodone	Moderate to severe pain	Intolerant or allergic to morphine	Plan in place to taper analgesia
Patient	YES/NO	YES/NO	YES/NO
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
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21			
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25			
26			
27			
28			
29			
30			
Total Yes			
% Yes			

Please retain this sheet for your records to provide evidence of participation in this audit.

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Te Whare Tohu Rata o Aotearoa

APPENDIX 1

SUMMARY SHEET
Audit of medical practice (CQI activity)

Topic:
Appropriate prescribing of oxycodone for non-cancer pain in general practice

Date:

Activity designed by (name of organisation, if relevant):
Bpac^{nz}

Doctor's name:

Results discussed with peer group or colleagues?
☐ Yes ☐ No

Date:

FIRST CYCLE

DATA: Date of data collection:

CHECK: Describe any areas targeted for improvement as a result of analysing the data collected. (If the findings have any implications for health equity, please include this.)

ACTION: Describe how these improvements will be implemented.

MONITOR: Describe how well the process is working. When will you undertake a second cycle?

AUGUST 2016

SECOND CYCLE

DATA: Date of data collection:

CHECK: Describe any areas targeted for improvement as a result of analysing the data collected. (If the findings have any implications for health equity, please include this.)

ACTION: Describe how these improvements will be implemented.

MONITOR: Describe how well the process is working.

COMMENTS:

AUGUST 2016