CLINICAL AUDIT

Reviewing **patients using opioid medicines long-term** for non-cancer pain

July 2023

bpac nz
better medicine

Audit focus

This audit helps primary care health professionals optimise the management of patients prescribed opioid medicines in their practice. The aim is to ensure that patients who have been using these medicines long-term for the treatment of non-cancer pain have their medicine regimen regularly reviewed, in order to determine if ongoing use is appropriate; withdrawal can be discussed with patients for whom ongoing use is not indicated. Patients using these medicines for the management of pain associated with cancer or other palliative care conditions are not covered by this audit. Clinicians could also use the audit to assess other medicines used long-term for the management of chronic pain, such as gabapentin.

Background

Strong opioid medicines are recommended at Step Three of the **World Health Organisation pain ladder**, and are typically reserved for the treatment of severe acute pain or moderate to severe chronic pain, depending on a patient's response to other analgesics. There are few situations when a strong opioid would be initiated for acute pain in primary care. More common scenarios for general practitioners are renewing a prescription of a strong opioid medicine for patients discharged from hospital, renewing prescriptions of strong opioids for patients with chronic pain managed in primary care or initiating or renewing prescriptions of weaker opioids such as tramadol or codeine.

Opioid medicines are potentially addictive. Dispensing data from New Zealand show that between 2017 and 2021, almost one-fifth of the population received an opioid medicine each year. Discussions regarding addiction to opioid medicines are often focused on strong opioids such as oxycodone, however, the same prescribing cautions should be applied to weaker opioids, such as tramadol, to minimise the risk of inappropriate use. Dispensing data from New Zealand show that while weaker opioid use declined slightly between 2017 and 2020, there was an increase in dispensings in 2021.[1]

For further information on New Zealand trends in opioid use, see: **bpac.org.nz/2022/opioids.aspx**

Patients using opioid medicines should be encouraged to adopt and continue with non-pharmacological approaches to managing pain, such as exercise, physiotherapy and relaxation/behavioural techniques. Clinicians can consider the use of multimodal analgesia, such as using paracetamol in combination with an opioid medicine, in order to reduce the dose of opioid medicines required and therefore reduce a patient's risk of adverse effects, as well as provide analgesia when the opioid medicine is withdrawn.

Clinical guidelines recommend that patients should be reviewed within one to four weeks of initiating an opioid medicine or increasing dose, as patients can become dependent as early as one month after initiating opioid medicines.[2, 3] For patients using these medicines long-term, review on a three-monthly basis is recommended (or more often if required).[3] Reviewing patients using opioids long-term can ensure that the medicines and doses they are prescribed are still appropriate for their underlying condition and degree of pain they experience, as well as allowing the opportunity to assess for the development of potential adverse effects.

Withdrawing patients who have become dependent on opioid medicines can be a difficult process, particularly if this is being managed in primary care without the patient having access to additional support from addiction services or a pain clinic in secondary care. The focus of this audit is on identifying patients who are using opioids long-term and ensuring they are reviewed. Withdrawing patients from opioid medicines is not included in the audit process.

For further information on withdrawing patients who are dependent on opioid medicines, see: **bpac.org.nz/BPJ/2014/October/opioid-addiction.aspx**

Audit Plan

Summary

This audit identifies patients who have been prescribed an opioid medicine for three months or more in order to assess whether the choice of medicine(s) and doses remain appropriate.[4]

1. Pharmaceutical Claims Collection, Ministry of Health, 2022.
2. Manchikanti L, Kaye AM, Knezevic NN, et al. Responsible, safe, and effective prescription of opioids for chronic non-cancer pain: American Society of Interventional Pain Physicians (ASIPP) guidelines. Pain Physician 2017;20:S3–92
3. Centers for Disease Control and Prevention. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2022. Available from: https://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm (Accessed May, 2023).
4. If this audit is used to identify patients taking other analgesic medicines long-term, such as gabapentin, clinicians can choose a timeframe appropriate for the medicine in question

Recommended audit standards

Ideally, all patients who have been taking an opioid medicine for the management of non-cancer pain for three months or more should have a documented discussion in their notes about the intended duration of opioid medicine use and a plan for withdrawal. This could also include whether the addition of another analgesic medicine is appropriate in order to reduce the dose of opioid medicine(s) required or whether switching to another analgesic medicine is appropriate. If there is no documented evidence of a discussion, the patient should be flagged for review.

Audit Data

Eligible patients

All patients who have been prescribed an opioid medicine for three months or more 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 PMS. The notes of identified patients will need to be reviewed in order to ascertain the clinical indication for opioid prescription; patients using opioid medicines to manage pain associated with cancer or another palliative care condition can be excluded from the audit.

Sample size

A sample size of 30 patients is sufficient for the purpose of the audit. However, it is recommended that all eligible patients using opioid medicines long-term for the management of non-cancer pain are subsequently reviewed.

Criteria for a positive outcome

A positive result is achieved if a patient who has been prescribed an opioid medicine for three months or more has a documented discussion in their notes regarding their pain management plan. This discussion could include the expected duration of use of opioid medicines, the use of other analgesics which could be used in combination with opioids to help patients manage their pain, non-pharmacological strategies for pain management and whether withdrawing from an opioid medicine is appropriate or has been attempted.

During the review, clinicians can consider factors such as:

- Has the patient's underlying condition changed, e.g. is a greater or lesser extent of pain relief required?
- Is the prescribed opioid medicine still the most appropriate choice?
- Should doses be adjusted or other non-opioid analgesics initiated?
- Should the patient be referred for additional support for non-pharmacological pain management, e.g. to a physiotherapist?
- Does the patient require assistance from addiction services?

Data analysis

Use the sheet provided to record your data. The percentage achievement can be calculated by dividing the total number of patients currently prescribed an opioid medicine for the management of non-cancer pain relief for three months by the number of patients who have a documented pain management plan discussion in their notes.

Using clinical audits for improving practice and patient outcomes

Clinical audits can be an important tool to identify where gaps exist between expected and actual performance. Once completed, they can provide ideas on how to change practice and improve patient outcomes. General practitioners are encouraged to discuss the suitability and relevance of their proposed audit with their practice or peer group prior to commencement to ensure the relevance of the audit. Outcomes of the audit should also be discussed with the practice or peer group; this may be recorded as a learning activity reflection if suitable.

The Plan, Do, Study, Act (PDSA) model is recommended by the Royal New Zealand College of General Practitioners (RNZCGP) as a framework for assessing whether a clinical audit is relevant to your practice. This model has been widely used in healthcare settings since 2000. It consists of two parts, the framework and the PDSA cycle itself, as shown in Figure 1.

1. The framework

This consists of three questions that help define the "what" and "how" of an improvement project (in this case an audit). The questions are:

- "What are we trying to accomplish?" – the aim
- "How will we know that a change is an improvement?" – what measures of success will be used?
- "What changes can we make that will result in improvement?" – the concept to be tested

2. The PDSA cycle

This is often referred to as the "engine" for creating, testing and carrying out the proposed changes. More than one cycle

is usually required; each one is intended to be short, rapid and frequent, with the results used to inform and refine the next. This allows an ongoing process of continuous learning and improvement.

Each PDSA cycle includes four stages:

- **P**lan – decide what the change to be tested is and how this will be done
- **D**o – carry out the plan and collect the data
- **S**tudy – analyse the data, assess the impact of the change and reflect on what was learned
- **A**ct – plan the next cycle or implement the changes from your plan

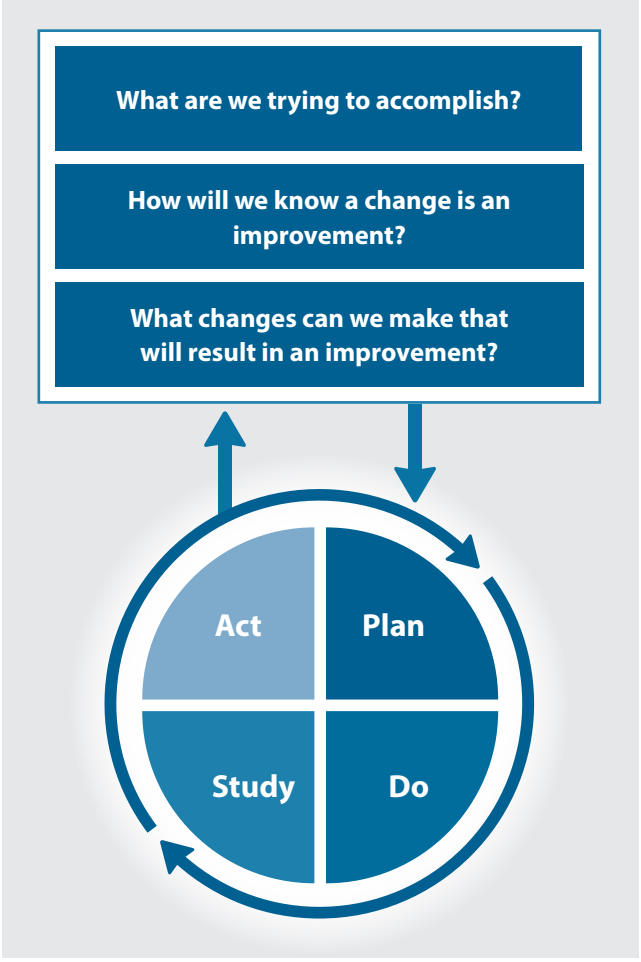

Figure 1. The PDSA model for improvement.

Source: Plan, Do, Study, Act (PDSA) cycles and the model for improvement

Claiming credits for Te Whanake CPD programme requirements

Practice or clinical audits are useful tools for improving clinical practice and credits 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. A minimum of 12 credits is required in the Patient Outcomes category over a triennium (three years).

Any data driven activity that assesses the outcomes and quality of general practice work can be used to gain credits in the Patient Outcomes learning category. Under the refreshed Te Whanake CPD programme, audits are not compulsory and the RNZCGP also no longer requires that clinical audits are approved prior to use. The college recommends the PDSA format for developing and checking the relevance of a clinical audit.

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

If a clinical audit is completed as part of Te Whanake requirements, the RNZCGP continues to encourage that evidence of participation in the audit be attached to your recorded activity. Evidence can include:

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

N.B. Audits can also be completed by other health professionals working in primary care (particularly prescribers), if relevant. Check with your accrediting authority as to documentation requirements.

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

bpacnz
PO Box 6032, Dunedin
Phone 03 477 5418
contact@bpac.org.nz

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www.bpac.org.nz/audits

Data sheet – cycle 1 Reviewing patients using opioid medicines long-term for non-cancer pain

Patient prescribed an opioid medicine for the management of non-cancer pain for three months or more	**Patient has a documented pain management plan discussion in their notes***	
Patient	YES	NO
1		
2		
3		
4		
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10		
11		
12		
13		
14		
15		
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Data Summary	**/ 30**	
Percent of patients with pain management plan discussion in their notes	**%**	

* Patients without a documented discussion in their notes should be flagged for review

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

Data sheet – cycle 2 Reviewing patients using opioid medicines long-term for non-cancer pain

Patient prescribed an opioid medicine for the management of non-cancer pain for three months or more	**Patient has a documented pain management plan discussion in their notes***	
Patient	YES	NO
1		
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11		
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Data Summary	**/ 30**	
Percent of patients with pain management plan discussion in their notes	**%**	

* Patients without a documented discussion in their notes should be flagged for review

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

SUMMARY SHEET
Audit of medical practice (CQI activity)

Topic:

Reviewing patients using opioid medicines long-term for non-cancer pain

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.

ACTION: Describe how these improvements will be implemented.

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

SECOND CYCLE

DATA: Date of data collection:

CHECK: Describe any areas targeted for improvement as a result of analysing the data collected.

ACTION: Describe how these improvements will be implemented.

MONITOR: Describe how well the process is working.

COMMENTS:

DECEMBER 2016