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OPT

Opioid prescribing toolkit

A systematic approach to introducing concepts of opioid stewardship in acute settings

Queensland Government

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- The ED-Opioid Study Team (Royal Brisbane and Women's Hospital)
- The Surgical-Opioid Study Team (Royal Brisbane and Women's Hospital)
- Metro North Design.

TOOLKIT SUPPORT

For editable versions of the intervention resources, advice about implementation or assistance with any questions, please contact us:

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CONTENTS

INTRODUCTION

The rapid rise in the rates of opioid prescribing in the United States (US) since 1990s and its associated harm have been described as an epidemic. Opioids were identified as having caused or contributed to 33,000 drug overdose deaths within the US during 2015, with approximately half involving prescription opioids. In addition, a relationship between opioid prescribing and the use of illicit opioids has been reported.

A number of studies have demonstrated similar trends in opioid prescribing (see figure 1) and associated harms in Australia, although not yet to the extent seen in the US. One study demonstrated a fourfold increase in Pharmaceutical Benefits Scheme (PBS) opioid prescriptions in Australia between 1990 and 2012.

Amid reports of increased opioid prescribing trends and opioid-related deaths in the US there is growing concern that Australia may be following a similar pattern. While evidence from Australia indicates a problem, detailed reports such as those available in the US are not yet available. Even within the US there is substantial variation in rates of opioid prescribing; for example, a sixfold difference in prescribing between highest prescribing counties and the lowest. Similar variations may be present between States and Territories in Australia, as well as areas within individual States.

The reasons for increasing use of opioids are multifactorial and include; an ageing population, increased prevalence of chronic pain and inclusion of opioids in the PBS.

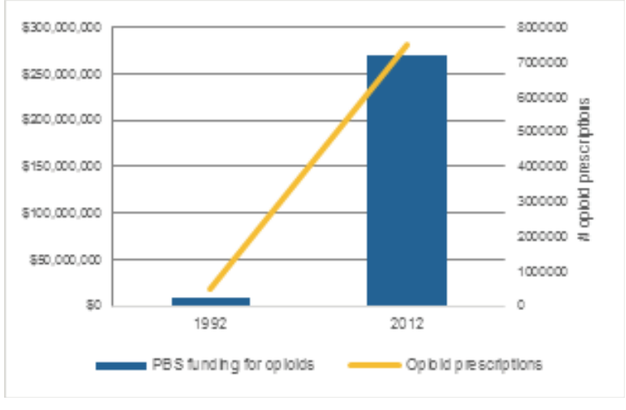
Appropriate prescribing of opioids is a balance between pain management and the risk of medication related harm. Rigorous quality improvement (QI) activites can be used to reduce the likelihood of adverse patient outcomes. Several practice improvement initiatives at the Royal Brisbane and Women's Hospital (RBWH) have successfully reduced the quantity of opioids prescribed at the point of discharge from hospital, with the focus primarily on prescribing of oxycodone. These initiatives have also resulted in improved communication to both patients and general practitioners. Additionally, the inclusion of a de-escalation plan in the discharge summary will ensure patients are not re-prescribed opioids inappropriately. This work has paved the way for an opioid stewardship program at our facility (RBWH).

The Opioid Prescribing Toolkit (OPT) was developed to provide information on how to use utilise the tools developed and tested in RBWH projects in other clinical settings across Queensland. OPT combines methods from quality improvement and implementation sciences and includes instruction on pre-implementation planning strategies and evaluation tools. Whilst OPT is based on improving oxycodone prescribing, it can be adapted for all opioid prescribing. The OPT can be used to facilitate the introduction of concepts of an opioid stewardship program in acute hospital setting.

SUMMARY

- There is a rise of both opioid use and associated harms in Australia.
- Appropriate prescribing of opioids is a balance between pain management and the risk of medication related harm.
- Rigorous quality improvement will reduce the likelihood of adverse patient outcomes.
- This is a step-by-step guide to implementing a quality improvement initiative to improve patient outcomes.

Figure 1 PBS data 1992 and 2012

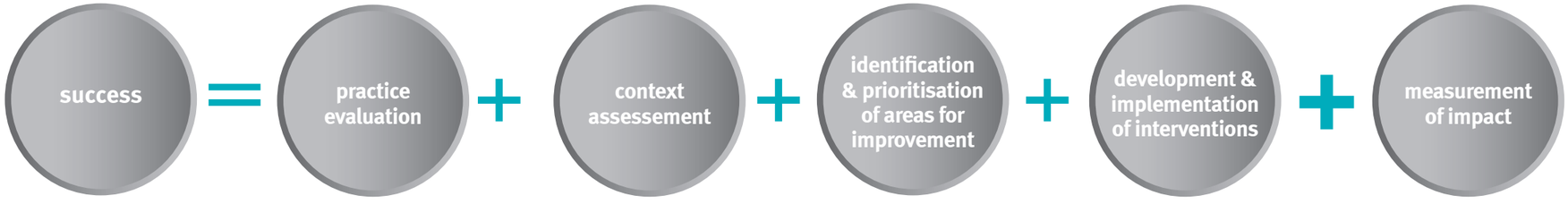


OVERVIEW OF THE OPT MODEL

The OPT is focused on judicious prescribing of oxycodone during and on discharge from an acute hospital setting. The toolkit can be adapted to various clinical settings to improve prescribing of specific opioids or all opioids.

It is anticipated this quality improvement initiative will lead to:

1. improved appropriateness of opioid prescribing;
2. improved education for patients, including the use of simple analgesics and aperients; and
3. improved communication to General Practitioners (GPs).



THE INNOVATION

The opioid prescribing intervention described in OPT may not be the right fit for your setting in its current form. We encourage you to consider the different components of the OPT intervention and how it can best be adapted for your setting. The OPT intervention includes 'core components', which are the essential elements of the intervention, and the 'adaptable periphery' which are the adaptable elements that you can modify to suit your setting.

Opioid stewardship is a co-ordinated approach to ensuring the appropriate use of opioids – delivering adequate analgesia to patients whilst minimising harm by monitoring, evaluating, and improving practice.

Core components	Adaptable periphery
Key stakeholder agreement (including Senior Medical Officers) of opioid prescribing guidelines	**Content** The content of the guidelines is adaptable – the core requirement is that these are based on current best practice and that there is key stakeholder agreement. Ensure an assessment of appropriateness is included in the guidelines. For example, in a surgical setting this may be as simple as stating that all patients discharged on a oxycodone must have had at least one dose in the previous 24 hours. If not, approval from a senior clinician is required.
Evaluation and feedback • Baseline • Ongoing	**Sample size, timing, individual vs. group feedback** Evaluation may be large scale, e.g. organisation wide, or small, e.g. one clinical area on a given day. Evaluation should be conducted at baseline and after implementation.
Staff education	**Content and method of delivery** Education can be delivered to large groups, small groups, or one on one. Ensure it is relevant for the audience by using scenarios and local data.
Patient education	**Content and method of delivery** Patient education may be delivered in a variety of ways, consider your resources and patient profile. We have developed a brochure that contains an individualised pain management plan.

NAVIGATING THE TOOLKIT

The toolkit provides:

1. An overview of the OPT model
2. Steps to implement an opioid prescribing improvement project in your local clinical setting
3. Adaptable resources
   - Project Plan
   - Data Collection Tool
   - Ethics Exemption Request Letter
   - Opioid Prescribing Guidelines
   - Staff Education and Communication Materials
   - Patient Information Brochure

Your opioid prescribing improvement team

Your opioid prescribing improvement team should consist at a minimum:

- A senior physician with a special interest in pain management;
- Junior prescriber(s);
- A clinical pharmacist;
- Representation from nursing;
- Representation from physiotherapy.

The role of the physician champion is to influence change from the top as well as provide education and feedback to staff. In addition they can help identify processes or practices that are counteractive to achieving the goal.

The junior prescribers can be involved throughout the project including data collection, analysis, development and delivery of education, and development of guidelines.

The pharmacist should be involved in all aspects of the initiative including data collection, analysis, development and delivery of education, and development of guidelines.

Nursing and physiotherapy representatives can provide specialist input to development of guidelines and education.

LOOK FOR THIS SYMBOL TO FIND ADAPTABLE RESOURCES

The implementation processes

Plan

Assess baseline practice
Context assessment
Adapt innovation as appropriate
Determine implementation strategies

Implement

Implement innovation

Evaluate

Were the resources adequate to make the desired changes in practice?

Continuous quality improvement

Engage

Implementation leaders
Opinion leaders
Champions

EMERGENCY DEPARTMENT EXPERIENCE – ED-OPIOID

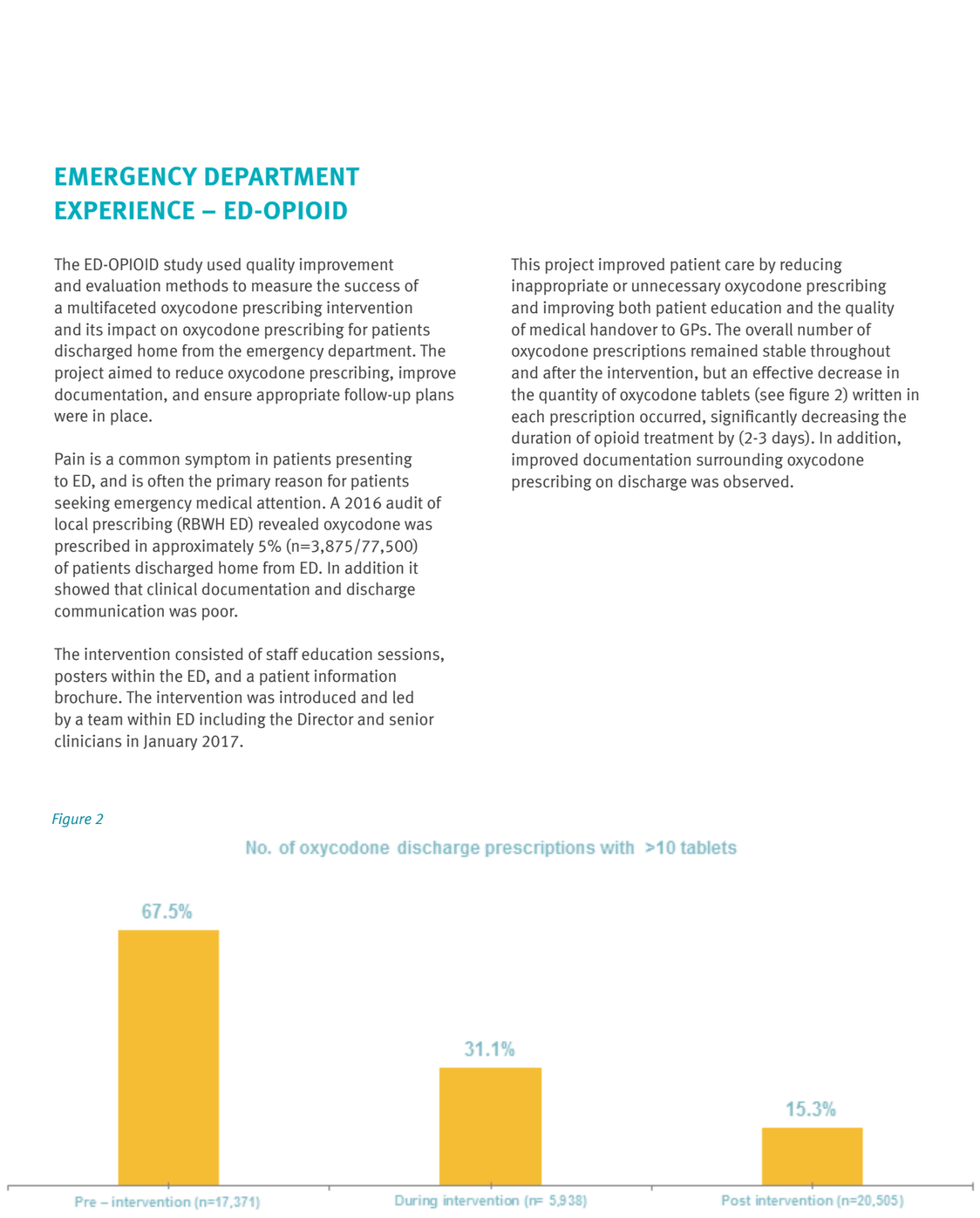
The ED-OPIOID study used quality improvement and evaluation methods to measure the success of a multifaceted oxycodone prescribing intervention and its impact on oxycodone prescribing for patients discharged home from the emergency department. The project aimed to reduce oxycodone prescribing, improve documentation, and ensure appropriate follow-up plans were in place.

Pain is a common symptom in patients presenting to ED, and is often the primary reason for patients seeking emergency medical attention. A 2016 audit of local prescribing (RBWH ED) revealed oxycodone was prescribed in approximately 5% (n=3,875/77,500) of patients discharged home from ED. In addition it showed that clinical documentation and discharge communication was poor.

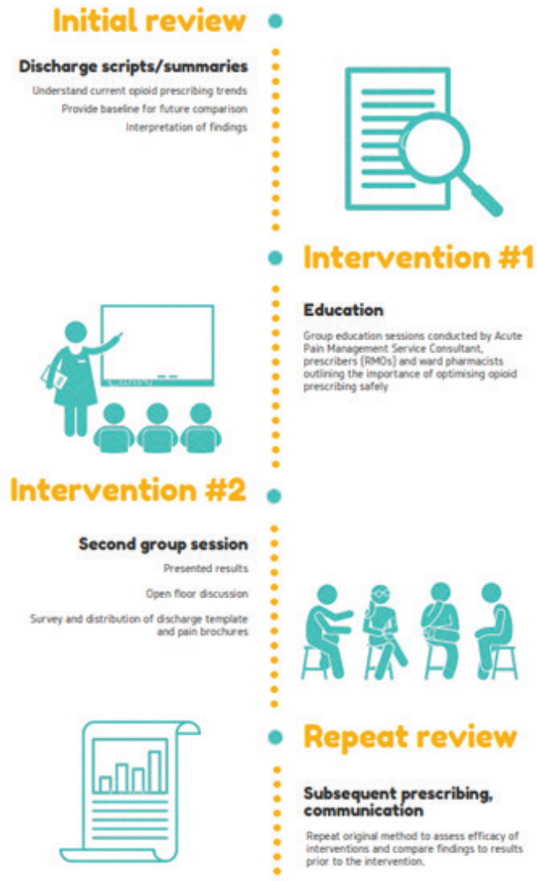
The intervention consisted of staff education sessions, posters within the ED, and a patient information brochure. The intervention was introduced and led by a team within ED including the Director and senior clinicians in January 2017.

This project improved patient care by reducing inappropriate or unnecessary oxycodone prescribing and improving both patient education and the quality of medical handover to GPs. The overall number of oxycodone prescriptions remained stable throughout and after the intervention, but an effective decrease in the quantity of oxycodone tablets (see figure 2) written in each prescription occurred, significantly decreasing the duration of opioid treatment by (2-3 days). In addition, improved documentation surrounding oxycodone prescribing on discharge was observed.

Figure 2



SURGERY EXPERIENCE – SURGERY-OPIOID



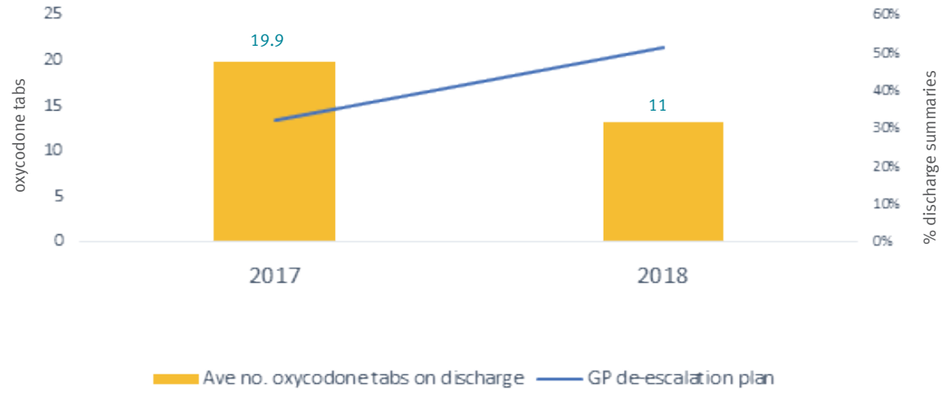
Like the ED OPIOID study, the Surgery-Opioid study used quality improvement and evaluation methods to measure the success of a multifaceted oxycodone prescribing intervention and its impact on oxycodone prescribing for patients discharged home after an acute surgical admission. The project aimed to optimise oxycodone prescribing, improve patient education (especially to promote simple analgesia) and improve discharge communication by including a de-escalation plan.

Using opioids to treat acute pain in surgical setting is appropriate, but needs to be tailored to individual's pain requirements. Baseline audits of discharge prescribing in 2015 and 2017 indicated a practice of defaulting to the PBS quantity of 20 oxycodone tablets on discharge prescription. The study also showed suboptimal communication of a pain management plan to the general practitioner. This may result in inadvertent continuation of oxycodone in the community.

The practice evaluation, development and delivery of the intervention and subsequent re-evaluation was undertaken by a team that included the Lead for Acute Pain Services and prescribers within surgery.

The Surgery-Opioid intervention was successful in improving patient care by reducing inappropriate or unnecessary oxycodone prescribing, improving patient education and improving the quality of medical handover to General Practitioners (see figure 3).

Figure 3



OPT CHECKLIST

PLAN

- ❑ Form a team
- ❑ Assess baseline practices
- ❑ Undertake context assessment
- ❑ Adapt intervention to local context
- ❑ Determine implementation strategies
- ❑ Document project plan
- ❑ Consider ethics requirements

ENGAGE

- ❑ Stakeholder identification and analysis
- ❑ Develop communication plan
- ❑ Stakeholder engagement

IMPLEMENT

- ❑ Implement as per project plan

EVALUATE

- ❑ Re-evaluate practice (PDSA cycles)
- ❑ Implement strategies for continuous monitoring, evaluation and improvement
- ❑ Disseminate findings

THE OPT TEAM IS HERE TO HELP!

CONTACT US IF YOU NEED ASSISTANCE

PLAN

FORM AN INTERDISCIPLINARY TEAM WITH A COMMON GOAL

Successful quality improvement initiatives require engaging stakeholders, in depth process analysis and redesign. By definition, this is a team-based activity. Improvement design and implementation are much more likely to be successful if frontline staff, those who live with care processes every day, are involved from the beginning.

Your implementation team will also need a champion to drive change. Ideally, a good champion would be a well-respected individual, typically a clinician, who is passionate about quality improvement and can articulate why it is important to reduce potential opioid-related harm in your institution.

ASSESS BASELINE PRACTICES

An understanding of current practices will assist in identifying gaps as well as provide a baseline for comparison. See below an example of a data collection tool and project plan that can be adapted for both pre and post implementation evaluations.

CONTEXT ASSESSMENT

Undertake an assessment to understand key barriers and facilitators that may impact your ability to successfully implement an opioid prescribing improvement project. You may choose to use the Health services Implementation Project Context Assessment Tool, which we have outlined on the following page and included in the online resources.

Some considerations when you are undertaking a Context Assessment:

LOCAL SETTING

What is the culture of the ward or clinical area? Is there a desire for change? Is improving opioid prescribing considered a priority? Have previous similar change efforts been successful? Do you have leadership engagement and support? Are there adequate resources to deliver the intervention?

UNSURE WHAT YOU NEED? CONTACT THE OPT TEAM FOR ASSISTANCE. WE CAN HELP YOU TO TAILOR THE PROJECT TO MATCH THE RESOU RCES YOU HAVE AVAILABLE IN YOUR LOCAL SETTING.

INDIVIDUALS INVOLVED - RECIPIENTS

You will need to determine what is required for effective behaviour change. Consider prescribers' attitudes toward the intervention, their knowledge of the 'local' problem and evidence for best practice, as well as individual motivations and learning styles.

ADAPT INNOVATION FOR YOUR SETTING

Refine the innovation to facilitate success in your setting. Consider the results of your baseline assessment and context assessment, including the inner and outer setting and the characteristics of the individuals involved. Develop local resources.

DETERMINE IMPLEMENTATION STRATEGIES

Implementation strategies are methods or techniques used to enhance the adoption, implementation and sustainability of an intervention. It is necessary to develop strategies to overcome barriers and enable efficient and effective implementation. Implementation strategies should address the specific factors that have been identified in your assessment of the intervention, setting, and individuals.

Implementation strategies can include:

- Education
- Providing manuals and factsheets
- Employing forcing functions (e.g. approval processes)
- Audit and feedback

There is no 'one-size-fits-all' approach; you need to be adaptive and use different strategies to respond to challenges and facilitate implementation in your unique environment.

RESOURCES FOR PLANNING

PROJECT PLAN

CONTEXT ASSESSMENT TOOL

DATA COLLECTION TOOL

SIMPLE ETHICS LETTER

PLANNING FOR SUCCESSFUL IMPLEMENTATION

Without effective implementation, even well planned interventions can be rendered ineffective. Implementation success results from taking an evidence-based intervention and implementing it effectively using strategies appropriate for the specific setting.

While you are planning your project, it is important to consider some key barriers and facilitators that may impact your ability to successfully implement an opioid prescribing intervention. This can be done by undertaking a context assessment such as the Health services Implementation Project Context Assessment Tool (HIPCAT). The context assessment is comprised of seven domains which may influence implementation:

Figure 2 Effective Implementation

1. **Innovation:** The change in practice or process that will be implemented. An innovation is generally made up of core components which are the essential elements of the innovation, and the adaptable periphery which are the adaptable elements that can be modified to the local setting.

2. **Outer context:** The economic, political and social context in which the organisation resides. Generally in health services implementation this is the wider health system.

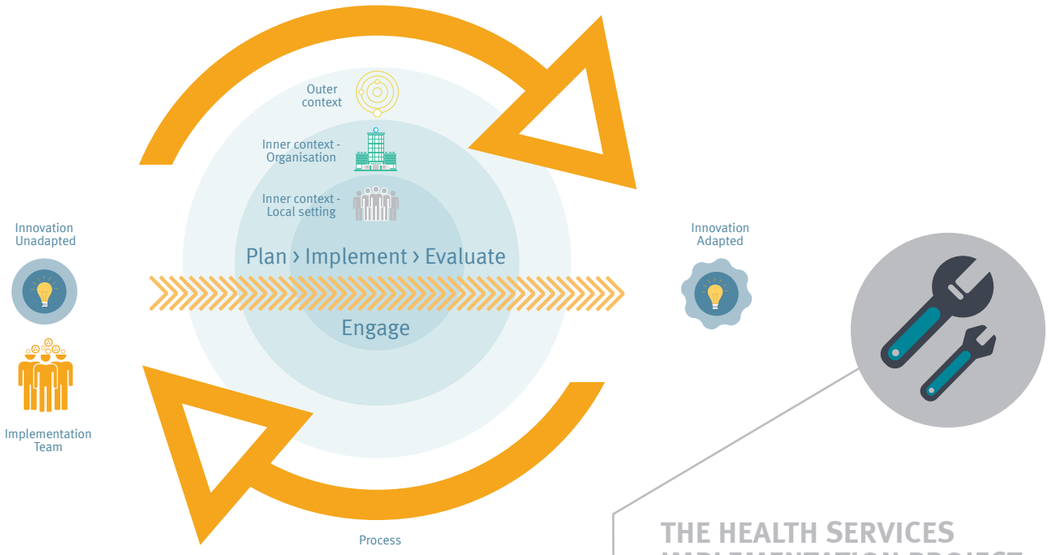
3. **Inner context – organisation:** The structural, political and cultural contexts through which the implementation process will proceed at an organisational level. This may be a hospital, health service or private organisation.

4. **Inner context – local setting:** The structural, political and cultural contexts through which your implementation process will proceed at a local level. Essentially, this is where the innovation will be delivered. This may be a ward, department or specific clinical area.

5. **Individuals involved – recipients:** The people who are affected by and influence implementation within the local setting. This domain considers the impact individuals and teams have in supporting or resisting change.

6. **Individuals involved – implementation team:** The designated project team responsible for implementing the innovation. For clinical projects, the implementation team should include a clinical champion.

7. **Process:** The process of planning, implementing and evaluating the innovation. Stakeholders should be engaged throughout. The implementation process is not always linear; it is important to continuously evaluate and use different strategies to respond to implementation challenges.



THE HEALTH SERVICES IMPLEMENTATION PROJECT CONTEXT ASSESSMENT TOOL IS AVAILABLE IN THE OPT ONLINE RESOURCES

ENGAGE

Stakeholder engagement is an essential part of the implementation process and should be conducted throughout, from project conception to evaluation and monitoring. Engagement involves attracting and involving individuals in the initiative through communication, education, social marketing and role modelling. Staff resistance or indifference is a common barrier to implementing change. Even the best-planned interventions will fail if the human factors relating to change are not respected and addressed. Whether a change is large or small, you will need to persuade people that it is worthwhile.

Identify and engage key opinion leaders, who are individuals in your clinical area who have formal and informal influence on the attitudes and beliefs of their colleagues. Leverage clinical champions to market and drive the intervention.

RBWH ED Experience

"It was important to continually reinforce our key messages through education, in-services and staff meetings. It was a big effort but getting in front of our teams to discuss the importance of our project was key to our success."

Dr Rina Savage, Emergency Registrar and Chief Investigator, 'ED-OPIOID'

IMPLEMENT

It's time to implement your intervention using the resources and implementation strategies defined in your planning phase.

STAFF EDUCATION

When designing your local education package consider including:

- Description of the problem using local data;
- Description of local initiatives planned or already underway;
- Comparison of local experience with others within your area, the state or in Australia.

Redcliffe Experience

"When I started my role as an Opioid Stewardship Pharmacist, I often wished there were evidence-based tools to help me navigate the quality improvement process so that I could have hit the ground running. OPT provides this step-wise and practical approach to help with the formalities such as the ethics application and protocol, and the resources like patient leaflets to help get the ball rolling in engagement with clinical areas such as the ED. No two hospitals are the same and the approach which promotes assessment of local data, and allows for customisation of educational resources empowers each site to take the lead in improving their opioid prescribing practices without needing to start from scratch."

Benita Suckling, Opioid Stewardship Pharmacist, Redcliffe Hospital

RESOURCES FOR IMPLEMENTATION

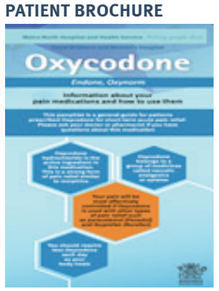
OPIOID PRESCRIBING GUIDELINES FACTSHEET

STAFF EDUCATION

OPIOID PRESCRIBING GUIDELINES POSTER

STAFF POSTER

PATIENT BROCHURE



EVALUATE

Use the same methodology that you used for baseline assessment to re-evaluate practice. Identify areas of high performance and develop strategies to address areas that require further improvements. Ensure wide dissemination of findings.

Re-evaluation can be undertaken at multiple time points and is largely dependent on the resources available and the result you hope to achieve.

RESOURCES FOR EVALUATION

DATA COLLECTION TOOL

THE DATA COLLECTION TOOL THAT WAS USED TO OBTAIN YOUR BASELINE ASSESSMENT SHOULD BE USED AGAIN TO EVALUATE CHANGE.

SUSTAINING CHANGE

Change is not sustained without appropriate monitoring and controls. Before you close your project, identify a process owner who will be responsible for monitoring data on an ongoing basis and undertaking corrective action as required. Improvement is a continuous cycle that requires continuous monitoring and evaluation.

CABOOLTURE EXPERIENCE

"OPT has been a fantastic resource for our opioid stewardship in the Caboolture Emergency Department. We have had excellent support from the research team to structure, maintain and monitor our intervention. They have given us great suggestions and resources for ongoing development of our opioid stewardship program, which has empowered our clinicians to adopt safe and appropriate analgesic prescribing. We hope this will have a positive impact on our community and decrease the harms from such medications."

Dr Jonathan Thompson, Staff Specialist, Emergency Department, Caboolture Hospital

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