Opioid Practice Self-Assessment

Instructions

The **Opioid Practice Self-Assessment**, was developed based on good opioid practices identified from the **Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain**, and well-established medication safety self-assessments from Institute for Safe Medication Practices (ISMP) Canada.

This practice questionnaire is designed to:

- Heighten awareness of the distinguishing characteristics of safe opioid practice;
- Create a new baseline of practitioner efforts to enhance the safety of opioid use; and
- Assist practitioners to evaluate their efforts over time.

The practice questionnaire is divided into 7 key practices that influence safe opioid use. Each key practice is defined by a core distinguishing characteristics of safe opioid practice. Representative practice questionnaire items are provided to help prescribers to evaluate their success with each of the core distinguishing characteristics.

The practice questionnaire items in this document are not intended to represent a minimum standard of practice and should not be considered as such. No practice should expect to score "perfect" on all aspects of the questionnaire. In In fact, some of the practice questionnaire criteria represent innovative practices and system enhancements that are not widely implemented in practices today. However, their value in reducing errors is grounded in research and expert analysis of medication errors and opioid management. Opioid Practice Self-Assessment findings are intended for internal use and become more useful as repeat assessments are performed to see where improvements have been achieved over time and where challenges remain.

Instructions for Conducting the Practice Questionnaire

1. Set aside an appropriate time to complete the questionnaire. It is expected that completing the practice questionnaire should take between 60 and 90 minutes.
2. Sole practitioners may be able to complete the questionnaire by themselves, although may request or need feedback from clerical or nursing staff to adequately answer questions.
3. Practitioners in a group practice may perform the questionnaire with feedback from other group members.
4. Other staff members who may have knowledge of the opioid practices should also be involved in the questionnaire (e.g., clinic nurse, social worker, pharmacist, receptionist).
5. It is helpful to have access to some representative patient charts or the electronic medical record available to review the procedures and processes in place for opioid management.
6. Complete or discuss each practice questionnaire item and evaluate the practice's current success in implementing the item.

As necessary, investigate and verify the level of implementation for each item with other members of the practice and/or staff outside the assessment team.

Possible responses:

A There has been no activity to implement this item
- This process, procedure, or element of practice is not performed in this practice

B This item has been formally discussed and considered but not implemented
- This process, procedure, or element of practice has been contemplated or discussed but is not performed in this practice

C This item has been partially implemented
- An aspect of the process, procedure, or element of practice is performed in this practice e.g., pain duration and type is collected and documented systematically, but not pain intensity

D This item is fully implemented in some cases
- This process, procedure, or element of practice is performed fully in some but not all patients, or by some but not all practitioners in this practice

E This item is fully implemented throughout the organization
- This process, procedure, or element of practice is performed by all practitioners to all patients in this practice

8. Please enter your responses into the online form. You may print a copy of the practice questionnaire for reference as you prepare your responses.

Some helpful definitions

Structured process

"A **structured process** is in place to collect and document the patient's allergies and associated reactions**"**

"A **structured process** is in place to document the opioid initiation plan.

a. starting dose,
b. formulation (liquid/tablet etc),
c. duration before dose adjustment"

A structured process refers to a process, method, or procedure that is consistent, systematic, and applicable to all suitable patients or clinical scenarios. It may refer to a location on a paper chart, an electronic medical record template, a practice pattern, or any other interaction between a patient and an element of the practice. It must be consistent for all applicable patients and for all applicable health care practitioners. It may be part of an explicit practice policy or it may be an habitual manner of practice.

Examples:

- Requiring every new patient to fill out a form that lists their allergies is a **structured process** to collect allergy information.
- Having this allergy information always displayed in a consistent location on the demographic screen of the electronic medical record is a **structured process** for displaying allergy information.

- Asking patients about allergies at every visit is a **structured process** for updating allergy information.
- Only renewing opioid medications in 28 day intervals is a **structured process** to limit the amount of opioid prescribed and to encourage patient follow up.
- Using two part carbon copy prescription pads is a **structured process** to document prescriptions and to reduce the risk of prescription forgery or manipulation

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For the following questions, please answer each question according to the legend below:

A = No activity to implement
B = formally considered, but not implemented
C = partially implemented in some areas
D = fully implemented in some areas
E = full implemented throughout

Initial patient assessment

	A	B	C	D	E
Core Characteristic #1 – A systematic and formal assessment of the risk and benefits to a patient of instituting opioid therapy is conducted prior to beginning therapy					
When assessing a patient for treatment for chronic non-malignant pain:					
1. A structured process is in place to collect and document: a. pain syndrome: cause, type duration and pattern and intensity i. pain causation ii. pain type (neuropathic, nociceptive or mixture) iii. pain duration iv. initial pain pattern v. initial pain intensity vi. limitations in function or quality of life caused by pain					
b. pre-existing or co-existing conditions i. co-existing medical conditions, ii. psychiatric conditions, and iii. substance use disorders					

	c. pre-existing or co-existing use of sedating licit or illicit substances (history) i. alcohol use ii. cannabis use iii. benzodiazepine use iv. other opioid use (prescribed or OTC) v. street (other illicit) drug use					
	d. indications for opioid prescribing i. documentation that non-opioid management has proven in-adequate for pain control					
	e. contraindications and relative contraindications to opioid prescribing i. screening for absolute contraindications (documented allergy or previous serious side effect to the specific opioid being considered; ii. screening for relative contraindications (co-existing use of drugs with sedating side-effects; conditions for which there is limited evidence of analgesic efficacy; cognitive deficit; advanced age; living alone.)					
2.	A structured process is in place to collect and document the patient's allergies and associated reactions					
3.	A structured process is in place to collect and document the patient's adverse drug reaction history					
4.	A structured process is in place to review current medications (including over-the-counter drugs, vitamins, herbals, recreational drugs, and homeopathic drugs) that the patient has been taking					
5.	A structured process is in place to obtain and evaluate baseline urine drug screen results prior to the first prescription for opioids [optional]					

Initial Treatment plan

	A	B	C	D	E
Core Characteristic #2 – The treatment initiation plan is implemented in a systematic and thorough way					
When prescribing treatment for chronic non-malignant pain:					
1. A structured process is in place to document treatment expectations: a. Treatment goals					
b. Situations that will prompt dose increase or decrease					
c. A written opioid prescription agreement [optional]					
d. Re-assessment intervals					
2. A structured process is in place to document use of analgesic ladder when prescribing for chronic pain					
3. A structured process is in place to document the opioid initiation plan. a. starting dose, b. formulation (liquid/tablet etc), c. duration before dose adjustment;					
4. A structured process is in place to document advice on use of PRN doses					
5. A structured process is in place to document use of adjunctive pain control measures, such as physiotherapy, psychotherapy, and self-help techniques					
6. Rules/guidelines/policies within your organization/practice setting define the timeframe for reviewing patients after initiation					

Patient Monitoring and Reassessment

	A	B	C	D	E
Core Characteristic #3 – Patients are monitored and re-assessed at appropriate intervals in a structured manner to optimize the benefit of opioid therapy while minimizing risks and adverse effects.					
When monitoring a patient on treatment for chronic non-malignant pain: **AND** When adjusting the treatment plan:					
1. At each encounter, a structured process is in place to review any change in medications from the prior encounter					
2. A structured process is in place to collect and document the patient's current pain severity measurement/ results of patient pain self-monitoring and any related changes in function or quality of life					
3. A structured process is in place to collect and document any adverse effects of opioid therapy a. screening for opioid side effects					
b. screening for adverse events, (opioid-related emergency department visits for intoxication or withdrawal, opioid-related trauma, suicide attempts)					
c. screening for opioid dependency/ aberrant drug-related behaviours					
d. documentation of safe home storage of medication					
4. A structured process is in place to document a review of opioid need					
5. A structured process is in place to document the dose adjustment regime and pain monitoring that informs dose adjustment a. intended dose adjustment regime					
b. results of patient pain self-monitoring,					
c. evidence of stepped prescribing approach					
6. Rules/guidelines/policies within your organization/practice setting define the timeframe for repeat urine drug screening [optional]					
7. A structured process is in place to document the current pain management plan (a) prescribing regime,					
(b) review by prescriber,					
(c) adjunctive therapy regime					
8. A structured process is in place to document the indication for PRN doses					
9. A structured process is in place to assess safety to drive					
10. Rules/guidelines/policies within your					

organization/practice setting define the timeframe for review after dose adjustment					
11. Rules/guidelines/policies within your organization/practice setting to ensure continuity of prescriptions and treatment while usual prescriber is absent					
12. A mechanism is in place to ensure the correct interval between opioid prescriptions has elapsed prior to writing the next opioid prescription					
13. A structured process is in place to follow-up with patients who miss their scheduled appointments					
14. There is a process or mechanism to identify and refer patients who may require pain specialist consultation					
15. There is a process or mechanism to identify and refer patients who may require addiction services					
16. There is a process or mechanism to deal with or refer patients who exhibit evidence of diversion or illicit use of prescribed medications					

Drug Information

	A	B	C	D	E
Core Characteristic #4 – Prescribers utilize up to date guidelines and protocols, and take advantage of technological safeguards when prescribing opioids					
When prescribing, monitoring and adjusting opioid therapy:					
1. Current protocols guidelines, dosing formulas, maximum dose recommendations for opioids are readily accessible and used by prescribers					
2. A computer system performs dose-range check, and warns prescribers about overdoses when maximum initial dose, escalation, or watchful dose recommendations are exceeded (patients on high dose - over 200mg morphine dose equivalent daily)					
3. A computer system performs dose-range check, and warns prescribers about underdoses when recommended tapering intervals are exceeded					
4. There is a mechanism to ensure usual prescription renewal frequency is not exceeded for either routine or as-needed opioids.					
5. A computer system performs automated drug interaction checks and allergy checks					

Communication of prescriptions and other drug information

	A	B	C	D	E
Core Characteristic #5 Methods of communicating, and prescribing opioid therapy orders are standardized to minimize the risk for error.					
1. Basic information (e.g., prescriber name and registration number, patient name, birth date, patient identifier, prescription date, quantity of medication, length of therapy in number of days) are clear and easily visible on prescriptions					
2. Prescribers enter opioid prescriptions into a computer system					
3. Critical information (e.g., drug, dose, route, total amount to be dispensed, and start and end dates) is displayed in the same sequence using consistent terminology in the opioid prescriptions					
4. All medications are ordered using the generic name of the medication (with the brand/trade name used for differentiation if required)					
5. Look-alike drug names are clearly distinguished in a way that differentiates them (e.g., tall man lettering, use of brand name in parentheses) anywhere drug names are listed					
6. Opioid doses are expressed as mg and never as mL (for liquid preparations)					
7. A list of prohibited error-prone abbreviations (e.g., qd) is established for written and electronic communication of all opioid prescriptions					
8. Trailing zeros are never used after a decimal in a dose expression (e.g., use 10mg NOT 10.0mg)					
9. Leading zeros are always used before a decimal for dose less than 1 (e.g., 0.1mg NOT .1mg)					
10. Writing the total opioid dose for the entire length of the prescription is prohibited (e.g., 1000mg oxycodone over one month)					
11. Steps are taken to round doses of opioid drugs to match commercially available strengths/concentrations when calculating dose requirements, whenever possible.					
12. For intermittent treatment with opioid drugs (i.e., PRN opioids), the quantity of drugs prescribed is the exact quantity required by the patient for a specified timeframe					
13. For intermittent treatment with opioid drugs (i.e., PRN opioids) precise instructions are included in the notation of the prescription (e.g., take one tablet every 4 hours for severe pain) and, where applicable, limitations are also included (e.g., maximum of 3 tablets per 24 hours)					

Competency and Education

	A	B	C	D	E
Core Characteristic #6 – Prescribers engage in maintenance of competency and continuing education events related to opioid prescribing					
1. All prescribers involved in prescribing opioids for chronic non-cancer pain have read and regularly review the current guidelines for safe and effective opioid prescribing					
2. Prescribers incorporate activities related to opioid prescribing in their continuing medication credit requirements					

Patient Education

	A	B	C	D	E
Core Characteristic #7 Patients and/or family/caregivers/legal decision makers are included as active partners in their care, educated about opioid drugs, and are taught ways to prevent medication errors:					
1. Prescribers and other licensed healthcare practitioners educate patients and/or family/caregivers/legal decision makers about recommended pain management alternatives including the general treatment plan prior to the selection of opioid therapy					
2. Before the first opioid prescription, designated licensed health care practitioners provide patients and/or family/caregivers/legal decision makers with information about the drug, general purpose, prescribed dose and duration of therapy, immediate and delayed side effects, and when to seek medical help					
3. A structured process is in place to discuss and document that patient has been given warning(s)/ advice on adverse effects patients being commenced on opioid treatment for chronic non-malignant pain (preferable in writing): a. drowsiness, b. avoidance of other substances with sedation effects, (including alcohol) c. machinery and vehicle driving, d. regime for pain monitoring, e. what to do in event of drowsiness or worsening pain.					
4. Before the first opioid prescription, pre-menopausal female patients are educated about the potential					

	reproductive risks (e.g., neonatal abstinence syndrome) associated with opioid therapy					
5.	Ongoing educational dialogue about the treatment is provided with each subsequent patient encounter to ensure understanding and compliance					
6.	Patients and/or caregivers receive both written and verbal instructions and educational material (in their primary language and comprehension level) to guide medication administration in the home.					
7.	A structured process is in place to measure patient's and/or caregiver's comprehension about the information/instructions that were provided (e.g., teach-back method)					
8.	Patients are educated about personal safety pertaining to the handling, storage, and disposal of opioid drugs					
9.	Patients are educated about the potential for medication errors associated with opioid drug administration					