Opioid Stewardship

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Aims

• Guidelines have been developed to assist prescribers for safe and effective use of opioids.
• There is a growing concern around use of opioids for chronic non cancer pain and their risks.
• If opioids are being used in the chronic non cancer patients then we need to ensure we are following guidelines to the best of our ability with patient safety at the forefront for decision making.
The case for change

• During COVID, a number of patients have required scripts for narcotics
• Cross coverage means that prescribing has highlighted variation in practices
• A common theme is poor patient compliance with renewals
• Guidelines exist around prescription of opioids; we want to ensure we are meeting these guidelines
Aim Statement & Outcome Measure

• We want to compare our opioid prescribing practices against known guidelines from Health Quality Ontario

• Number of charts compliant with the guidelines
• Number with opioid contracts
• Number with in date (12 month) opioid contracts
• Number with opioids Greater than 90mg Morphine equivalents
Results

Charts reviewed- 100 within 2-week period
23 Opioid prescriptions

- Number of charts compliant with the guidelines- 0
- Number with opioid contracts- 1
- Number within date (12 month) opioid contracts- 0
- Number with opioids Greater than 90mg Morphine equivalents – 2
- Number with opioids greater than 50mg Morphine equivalents - 6
Results

Fishbone Diagram for Opioid Contract QI

- **Process**
  - Lack of written procedure
  - Unknown results of outcomes when using opioid contracts
  - Opioid contracts being made readily available to shadow charts

- **Materials**
  - Opioid contracts within clinic
  - Ease of access to necessary contract
  - All team members being aware of location

- **Clinicians**
  - Routine
  - Not common practice among other team members
  - Background knowledge for reasoning of contract

- **Time Constraints**
  - For clinicians
  - For RNs/RPNs in clinic
  - For patients coming to clinic

- **Environment**
  - Lack of knowledge re: location of contracts
  - No process written guiding team members
  - No reminders

- **Lack of Opioid Contracts for Patients Receiving Opioids**
## Results

### Driver Diagram for Opioid Contract QI

<table>
<thead>
<tr>
<th>Aim</th>
<th>Primary Drivers</th>
<th>Secondary Drivers</th>
<th>Change Ideas</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% of patient’s at the Chronic Pain Clinic who are being provided with Opioid Prescriptions will have an opioid contract by January 1, 2021</td>
<td>Meet Current Recommendations for Clinician prescribing opioids for patients</td>
<td>Review Current recommendations for opioid contracts</td>
<td>Make available in clinic</td>
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<td></td>
<td></td>
<td>Review current contract being used in CPC</td>
<td>Email out to all prescribers</td>
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<td></td>
<td></td>
<td>Ensure Contracts are readily available to all prescribers</td>
<td>Ensure location is known</td>
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<td>Train RNs/RPNs to check shadow chart for opioid contracts</td>
<td>Do this with new hires and remind current employees</td>
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<td>Clinicians check for contract when filling in opioid renewals</td>
<td>Remind clinicians</td>
</tr>
<tr>
<td>Reduce potential for Opioid Errors and Abuse/Increase compliance and understanding around expectations</td>
<td>Review contracts/expectations with clients</td>
<td>Do this at every appointment and with all renewals</td>
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<tr>
<td></td>
<td></td>
<td>Review MeQ recommendations prior to scripts/renewals</td>
<td>Do this at every appointment and with all renewals</td>
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<td>Have an exit strategy for all individuals receiving opioids – discuss with patient</td>
<td>Make exit strategy part of clinician plan when implementing opioids</td>
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<td>Increase communication around questions pertaining to opioids</td>
<td>Discuss contract in detail with patient and offer opportunities to ask questions</td>
<td>Do this with every contract</td>
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<td>Review reasoning for contract and evidence behind it</td>
<td>Offer opportunities for review of evidence</td>
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<tr>
<td>Review individuals on long term use of opioids and make a plan moving forward re: prescriptions (continue? Wean? Etc.)</td>
<td>Identify those patients who have been receiving opioids long term</td>
<td>Once identified, review pain status and doses</td>
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<td>If patient is stable at current dose discuss with PCP taking over the prescription</td>
<td>Communicate this plan with PCP</td>
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<td>If no change to function or pain, consider wean</td>
<td>Discuss evidence for wean with patient</td>
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<td>Consider hyperalgesia</td>
<td>Discuss with patient</td>
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<tr>
<td>Steps in the Process</td>
<td>Failure Mode (What could go wrong?)</td>
<td>Failure Causes (Why would the failure happen?)</td>
<td>Failure Effects (What would be the consequences of the failure?)</td>
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<td>Orders are written for Opioids - new med - and a contract is written at the same time</td>
<td>A contract is not written at the time of a new prescription for opioids</td>
<td>It may be forgotten to fill in the opioid contract with the patient</td>
<td>A contract is not filled out when needed</td>
</tr>
<tr>
<td>Renewal for opioids is prescribed and contract is reviewed at the same time</td>
<td>A contract is not reviewed at the time of renewal</td>
<td>It may be forgotten to review a previous opioid contract with medication renewal</td>
<td>A review of the contract is not completed</td>
</tr>
<tr>
<td>Opioid contracts are written into policy for all patients receiving opioids</td>
<td>If not in policy/procedure guidelines it may be missed/forgotten</td>
<td>There is no written policy or procedure to complete the opioid contract</td>
<td>Policy and procedure act as a reminder and incentive – if there isn’t one then less likely to be done</td>
</tr>
<tr>
<td>All clinicians are required to fill in opioid contracts</td>
<td>A clinician is not required to fill in the opioid contract therefore it may</td>
<td>If not required then takes away incentive /</td>
<td>Opioid contracts may be missed on many</td>
</tr>
</tbody>
</table>

**Note:** The RPN (Risk Profile Number) is calculated as the product of the Likelihood of Occurrence, Likelihood of Detection, and Severity. Higher RPN values indicate higher risk of failure occurrence.
## Results-FMEA TOP 3 RPN

<table>
<thead>
<tr>
<th>Contracts are being renewed annually and reviewed with clients at each visit – discussing expectations, etc.</th>
<th>Old contracts may be left in chart without being reviewed or updated as needed</th>
<th>A contract may be outdated if not renewed annually</th>
<th>The patient may have an opioid contract that does not apply to them any longer</th>
<th>RNs/RPNs/Clinicians are making sure to check on opioid contracts and that they have been signed within the year</th>
<th>( (8 \times 8 \times 2) = 128 )</th>
<th>Continuing education to discuss evidence for this practice</th>
</tr>
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<td>It may be forgotten to fill in the opioid contract with the patient</td>
<td>A contract is not filled out when needed</td>
<td>Attach opioid contracts to all new patient charts – keep in chart as a reminder if an opioid script is started to fill it out</td>
<td>( (5 \times 7 \times 4) = 140 )</td>
<td>Store opioid contracts in same location as prescription pads</td>
</tr>
<tr>
<td>Administrative staff make sure to pull a chart when there is an opioid specific request for renewal</td>
<td>Shadow charts are not being pulled and therefore the contract is not readily available</td>
<td>The admin staff may not know it is an opioid specific request or may forget to pull the chart</td>
<td>Opioid contracts may be missed on many different patients</td>
<td>Pulling charts for all prescriptions</td>
<td>( (6 \times 8 \times 2) = 96 )</td>
<td>Education on what an opioid is and a list of common prescribed opioids within the clinic</td>
</tr>
</tbody>
</table>
Change Ideas

• Focus on top RPN items
• Create a system to track these individuals
• Prompts on charts
• Enforce accountability for infractions, including limiting or stopping prescriptions
• Send summary sheet/copy of contract with patient for joint accountability
Proposed PDSA #1
The first PDSA was to review the 100 charts and summarize # of patient's receiving opioids – DONE

Plan – start to collect data and create a database (ideas?) for individuals receiving opioids

Do – out of the 100 charts: 62 total had received a prescription; 23 of those scripts were opioids; 1 patient who had an opioid contract but this was done in 2016 by a resident

Study – we predict that the majority of patient's receiving opioids at the CPC will not have a contract in place

Act – let's discuss a plan!
Expected Results/Impact

We are better able to meet requirements for HQO by introducing contracts as a standard within in the Chronic Pain Clinic.

It will be easier for clinicians to monitor and follow up with their patients if contracts are readily available and reviewed.

This keeps both clinician and patient involved and accountable.

Provides an opportunity to review those who have been on opioids long term and to assess whether this is the best treatment option for them moving forward.

Involving everyone in the clinic will help to maintain this standard.
Conclusion

In summary: we have done a review of small sample at the Chronic Pain Clinic and found that there were no up to date opioid contracts for the 23 individuals who had received opioids.

To help meet HQO guidelines for opioid stewardship we are purposing that we ensure we are completing opioid contracts with all individuals receiving opioids moving forward.
Conclusion

Next steps:
- Discuss possible barriers (database; changing routine/practice; buy in from all clinic staff; follow through)

Rollout:
- Update contract and bring into clinic use
- Chart prompt for patients receiving opioids
- Training of all staff
- Follow up sample accountability check
- Record results and disseminate knowledge