AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

Clinical Care Standards

Opioid Analgesic Stewardship in Acute Pain

Clinical Care Standard – Acute care edition

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The *Opioid Analgesic Stewardship in Acute Pain Clinical Care Standard* has been endorsed by the following organisations:

Australasian College for Emergency Medicine

ASCEPT

AUSTRALASIAN SOCIETY OF CLINICAL AND EXPERIMENTAL PHARMACOLOGISTS AND TOXICOLOGISTS

australian college of nurse practitioners

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Opioid Analgesic Stewardship in Acute Pain Clinical Care Standard (acute care edition)

Quality statements

1 **Patient information and shared decision making**

The nonpharmacological and pharmacological options for managing acute pain are discussed with a patient and their carer in a way that they can understand, and that leads to a shared understanding of the decision to use an opioid analgesic or other treatment(s).

2 **Acute pain assessment**

Analgesic prescribing for a patient with acute pain is guided by its expected severity and assessment of patient-reported pain intensity and the impact of pain on the patient's function.

3 **Risk–benefit analysis**

Whenever an opioid analgesic is considered for a patient with acute pain, their risk of opioid-related harm is assessed. An opioid analgesic may be prescribed when other analgesics are not clinically feasible or sufficient, and the potential benefits outweigh the potential harms.

4 **Pathways of care**

A patient with acute pain prescribed an opioid analgesic who is at increased risk of opioid-related harm is appropriately managed in conjunction with a locally approved pathway to mitigate the potential for harm.

5 **Appropriate opioid analgesic prescribing**

If an opioid analgesic is considered appropriate for an opioid-naïve patient with acute pain, use an immediate-release formulation at the lowest appropriate dose, for a limited duration, in line with best practice guidelines. Modified-release opioid analgesics cannot be safely or rapidly titrated and their use in acute pain should be exceptional and not routine. The patient is supported to cease any opioid analgesic use as their function and pain improve.

6 **Monitoring and management of opioid analgesic adverse effects**

When an opioid analgesic is prescribed, supplied or administered for a patient with acute pain, adverse effects are monitored and managed. The patient and carer are made aware of potential adverse effects and signs of overdose, including respiratory depression.

7 **Documentation**

When a patient with acute pain is prescribed, supplied or administered an opioid analgesic, the intended duration of therapy, and the review and referral plan are documented in the patient's healthcare record. The cause of the pain for which the opioid analgesic is prescribed is documented, including on the inpatient prescription.

8 **Review of therapy**

During hospital care, a patient prescribed an opioid analgesic for acute pain is assessed regularly to determine their response to therapy and whether an opioid analgesic is effective and appropriate for their stage of care.

9 **Transfer of care**

Planning for appropriate analgesic use at the transfer of care begins when a patient is started on an opioid analgesic during their hospital visit, according to an agreed opioid analgesic weaning and cessation protocol. The number of days' supply of an opioid analgesic on discharge is based on multiple factors, including the expected course of the patient's condition, appropriate arrangements for follow-up and opioid analgesic use in the last 24 hours before discharge.

Indicators for local monitoring

The following indicators will support health service organisations to monitor how well they are implementing the care recommended in this clinical care standard and are intended to support local quality improvement activities. The indicators are numbered to align with the relevant quality statements.

2 Acute pain assessment

Indicator 2a: Proportion of patients who received opioid analgesics who had pain and functional assessments prior to being prescribed opioid analgesics.

3 Risk assessment

Indicator 3a: Proportion of patients separated from hospital with a supply or prescription of opioid analgesics where a Real Time Prescription Monitoring program or prescription shopping program was checked prior to separation.

Indicator 3b: Proportion of patients who were newly prescribed opioid analgesics who were co-prescribed CNS depressant medicines while in hospital.

4 Pathways of care

Indicator 4a: Evidence of a locally approved policy that defines the process for managing admitted patients identified as being at increased risk of opioid-related harm who are prescribed an opioid analgesic. The policy should specify:

- Process for identifying patients who may be at risk of opioid-related harm
- Local pathways for managing patients identified at increased risk of opioid-related harm
- Systems to inform patients why they are being referred to a pathway and the plan for their ongoing clinical management
- Process for clinicians to refer patients to appropriate support services and escalate care to specialist services
- Process to ensure clinicians are competent in the use of the policy
- Process to assess adherence to the policy.

5 Appropriate opioid analgesic prescribing

Indicator 5a: Proportion of patients separated from hospital with a supply or prescription of opioid analgesics who also received a supply or prescription of paracetamol and non-steroidal anti-inflammatory medicines.

Indicator 5b: Proportion of opioid-naïve surgical patients separated from hospital with a supply or prescription of opioid analgesics where the supply or prescription was for a modified-release formulation.

6 Monitoring and management of opioid analgesic adverse effects

Indicator 6a: Proportion of admitted patients who received opioid analgesics who were administered naloxone for respiratory depression.

Indicator 6b: Proportion of admitted patients who received opioid analgesics who also received laxatives to prevent opioid-related constipation.

7 Documentation

Indicator 7a: Proportion of admitted patients who received opioid analgesics where the intended number of days of treatment was documented in their medical record.

8 Review of therapy

Indicator 8a: Proportion of overnight admitted patients separated from hospital with a supply or prescription of opioid analgesics that exceeded the opioid analgesic inpatient dose given during the 24 hours prior to separation.

9 Transfer of care

Indicator 9a: Evidence of a locally approved policy to support the transfer of care of patients who separate from hospital with a supply or prescription of opioid analgesics. The policy should specify the:

- Organisation's opioid analgesic weaning and cessation protocol
- Process for referral to specialist services, if required
- Required documentation to be provided to the patient or carer
- Required clinical handover documentation to be provided to the general practitioner
- Process to ensure the workforce is competent in the use of the policy
- Process to assess adherence to the policy.

Indicator 9b: Proportion of admitted patients separated from hospital with a supply or prescription of opioid analgesics where the supply or prescription exceeded seven days of treatment.

Indicator 9c: Proportion of patients separated from the ED with a supply or prescription of opioid analgesics where the supply or prescription exceeded three days of treatment.

Indicator 9d: Proportion of patients separated from hospital with a supply or prescription of opioid analgesics whose medication management plan was given to the patient or carer on separation.

Indicator 9e: Proportion of patients separated from hospital with a supply or prescription of opioid analgesics whose medication management plan was sent to the general practitioner on separation.

The definitions required to collect and calculate indicator data are specified online at **meteor.aihw.gov.au/content/index.phtml/itemId/755544**. More information about indicators and other quality improvement measures is provided in **Appendix B**.

Clinical care standards

Clinical care standards aim to support the delivery of evidence-based clinical care and promote shared decision making between patients, carers and clinicians. They aim to ensure patients receive best practice care for a specific clinical condition or procedure, regardless of where they are treated in Australia.

A clinical care standard contains a small number of quality statements that provide guidance to clinicians and health service managers on delivering appropriate care. Indicators are included for some quality statements to assist health service organisations monitor how well they are implementing the care recommended in the clinical care standard.

A clinical care standard differs from a clinical practice guideline. Rather than describing all the components of care for a specific clinical condition or procedure, a clinical care standard focuses on key areas of care where the need for quality improvement is greatest.

Clinical care standards aim to improve healthcare outcomes by describing key components of appropriate care, enabling:

- Patients and the community to understand the care that is recommended and their healthcare choices
- Clinicians to provide best practice care
- Health service organisations to monitor their performance and make improvements in the care they provide.

Clinical care standards are developed by the Australian Commission on Safety and Quality in Health Care (the Commission), an Australian Government agency that leads and coordinates national improvements in the safety and quality of health care, based on the best available evidence. By working in partnership with the Australian Government, states and territories, the private sector, clinical experts, and patients and carers, the Commission aims to ensure that the health system is better informed, supported and organised to deliver safe and high-quality care.

See the **clinical care standards website** for more information about the standards.

About the Opioid Analgesic Stewardship in Acute Pain Clinical Care Standard

Context

Priority actions to reduce medication-related harm from high-risk medicines, including opioid analgesics, were identified in Australia's response to the ***World Health Organization Global Patient Safety Challenge – Medication without harm*** (2020). One of the identified priority actions was developing a national guideline for peri-surgical management of high-risk medicines, including the:

- Quantity prescribed on hospital discharge
- Duration of therapy post discharge
- Introduction of de-escalation plans as part of the hospital discharge summary, where appropriate.

Following a public consultation on prescription opioids in 2018, the Therapeutic Goods Administration (TGA) established the Opioid Regulatory Advisory Group to provide independent, expert advice to review proposed options for a regulatory response to opioid use and misuse in Australia. As a result, several **opioid analgesic regulatory changes** were implemented in June 2020.

In April 2020, the TGA engaged the Commission to develop a framework for a National Opioid Analgesic Stewardship program, and an accompanying clinical care standard, which together support the opioid analgesic regulatory changes. The aim of the TGA regulatory changes, the National Opioid Analgesics Stewardship program and the accompanying clinical care standard is to minimise the risk of harm associated with opioid analgesic use.

This clinical care standard describes the key components of care that patients can expect when they are prescribed opioid analgesics for acute pain in acute care settings.

Goal

To ensure the appropriate use and review of opioid analgesics for the management of acute pain to optimise patient outcomes and reduce the potential for opioid-related harm.

Scope

This clinical care standard relates to the care of people of all ages with acute pain for whom opioid analgesics may be considered or prescribed.
It covers patients presenting with acute pain to the emergency department (ED) or following surgery, up to and including, discharge from hospital.

It includes care provided by relevant members of the interdisciplinary team, such as specialist services for paediatrics, acute pain services, drug and alcohol services, clinical pharmacy services and allied health services.

What is not covered

This clinical care standard does not cover:

- Management of the following pain conditions with opioid analgesics
  - chronic non-cancer pain
  - cancer pain
  - pain in palliative care
  - labour and delivery pain
- Management or treatment of opioid use disorders
- Patients presenting to emergency services or hospital ED
  - with major acute trauma, including burns
  - who are as assessed to be in category 1, 2 or 3 of the **Australasian Triage Scale**.

Healthcare settings

This standard applies to care provided in the following care settings:

- All hospital settings, including public and private hospitals, subacute facilities, and outpatient and day procedure services
- Emergency services, including ambulance services.

In this document, the term 'clinician' refers to all types of healthcare providers who deliver direct clinical care to patients, including:

- Doctors
- Dentists
- Nurses
- Midwives
- Pharmacists
- Nurse practitioners
- Aboriginal and Torres Strait Islander health workers or practitioners
- Podiatrists endorsed for scheduled medicines
- Paramedics
- Allied health practitioners.

Not all quality statements within this clinical care standard will be applicable to every healthcare service or clinical unit. Healthcare services should consider their individual circumstances in determining how to apply the statement.

Implementation should consider the context in which care is provided, and local variation and the quality improvement priorities of the individual healthcare services. In rural and remote settings, different strategies may be needed to implement the standard, such as hub-and-spoke models integrating larger and smaller health services and using telehealth consultations.

Evidence that underpins this clinical care standard

Key sources that underpin the *Opioid Analgesic Stewardship in Acute Pain Clinical Care Standard* are current clinical guidelines including:

- ***Therapeutic Guidelines: Pain and analgesia***[1]
- ***Acute Pain Management: Scientific Evidence (5th edition)* (2020)**.[2]

Supporting documents

Supporting documents for this clinical care standard are available on the **Commission's website**.

Supporting documents include information for:

- Consumers
- Clinicians
- Health service organisations.

How to use this clinical care standard

The quality statements describe the expected standard for key components of patient care. By describing what each statement means, they support:

- **Patients** to know what care may be offered by their healthcare system, and to make informed treatment decisions in partnership with their clinician
- **Clinicians** to make decisions about appropriate care
- **Health service organisations** to understand the policies, procedures and organisational factors that can enable the delivery of high-quality care.

This clinical care standard should be implemented as part of an overall approach to safety and quality, incorporating the following principles and standards.

General principles of care

When applying the information contained in a clinical care standard, clinicians are advised to use their clinical judgement and to consider the individual patient's circumstances, in consultation with the patient, or their support people.

This clinical care standard aligns with key principles that are the foundation for achieving safe, high-quality care including:

- Person-centred care and shared decision making
- Informed consent
- Cultural safety for Aboriginal and Torres Strait Islander people.

For more information and additional Commission resources, see **Appendix A**.

Measurement for quality improvement

Measurement is a key component of quality improvement processes. The Commission has developed a set of indicators to support clinicians and health services organisations to monitor how well they are implementing the care recommended in this clinical care standard. The indicators are intended to support local quality improvement activities. No benchmarks are set for these indicators.

The indicators are listed with the relevant quality statements. The definitions required to collect and calculate indicator data are available online at **meteor.aihw.gov.au/content/index.phtml/itemid/755544**. More information about indicators and other quality improvement measures is in Appendix B.

Information on other quality measures including patient-reported outcome measures and patient experience measures is in Appendix C.

Meeting the requirements of national standards and accreditation

Implementing this clinical care standard as part of a quality improvement activity can help health services meet the requirements of the National Safety and Quality Health Service (NSQHS) Standards (second edition).

More information about clinical care standards and the NSQHS Standards is in **Appendix D**.

Background: Opioid Analgesic Stewardship in Acute Pain

Opioid analgesics have established efficacy for managing acute pain. However, careful assessment and management are required to deliver the benefits of prescribing opioid analgesics while minimising the possibility of harms, including respiratory depression, misuse, dependence and overdose.

Opioid use, potential harms and misuse

Opioid analgesics are high-risk medicines, widely used in hospitals and primary care to manage pain. Current guidelines and advice support the use of immediate-release opioid analgesics for short-term use in acute pain at the lowest dose, for the shortest duration to minimise harm associated with opioid analgesics.[1-3] There is no evidence to support the use of modified-release opioid analgesics for acute pain, and evidence is emerging that suggests that their use is problematic. For example, modified-release opioid analgesics are associated with increased risk of opioid-related harm and complications following surgery.[3,4] Over time, there has been an increase in the use of opioid analgesics to treat chronic non-cancer pain, despite the lack of evidence to support this.[5] This may begin with inappropriate use in acute non-cancer pain.

The ***Third Australian Atlas of Healthcare Variation (2018)*** found that, between 2013–14 and 2016–17, the rate of opioid analgesic dispensing per 100,000 people increased by 5% nationally. The magnitude of variation in dispensing rates increased as well, from 4.8-fold to 5.1-fold. The first ***Atlas of Healthcare Variation (2013)*** reported that dispensing rates were highest in areas of low socioeconomic status and lower in areas of increasing socioeconomic status. Dispensing rates tended to be higher in inner and outer regional areas than in major cities or remote areas.

A report[6] on national data and trends on opioid use and harms in Australia found that every day there were nearly 150 hospitalisations and 14 emergency department (ED) presentations involving opioid harm, and three drug-induced deaths involving opioid use. In 2016–17, 3.1 million people had one or more prescriptions dispensed for opioids (most commonly for oxycodone). About 715,000 people used over-the-counter codeine products and prescription opioid analgesics for illicit or non-medical purposes, while about 40,000 people used heroin.

Australia's Annual Overdose Report 2020 identified that 900 deaths were attributed to unintentional overdose of opioids in 2018, representing a 9% increase since 2014. Between 2014 and 2018, pharmaceutical opioids were the most common type of opioids associated with unintentional deaths.

Priorities for addressing inappropriate opioid analgesic use

Prescribing opioid analgesics in hospital settings has been identified as a key risk area for initiating treatment with, and ongoing use of, opioids.[6] EDs and surgical services have been identified as common sources of opioid analgesic prescriptions.[7-9] Up to 70% of Australian hospitals report sending patients home with powerful opioid analgesics 'just-in-case'.[10] In Australia, it has been reported that more than one in every 13 people who start weak opioid analgesics (such as codeine) transition to strong opioids (such as morphine).[11]

Persistent postoperative opioid analgesic use (PPOU) is defined as patients taking any opioids prescribed for postoperative pain for longer than 90 days after surgery.[4] In Australia, PPOU is reported to occur in 3.9–23.6% of patients undergoing surgery.[12,13] The duration (number of days) of the first opioid analgesic prescription, rather than the dosage, is more strongly related to misuse in the early postoperative period, with each refill and week of opioid analgesic prescription associated with a large increase in opioid misuse among opioid-naïve patients.[14]

Australia's response to the World Health Organization Global Patient Safety Challenge – *Medication without harm*[15] – proposed priority actions to reduce harm from high-risk medicines. Actions included increasing early career prescriber competency with high-risk medicines, especially among junior clinicians in the acute hospital sector.

A United Kingdom study of primary care patients reported that opioid analgesic prescribing factors, such as high morphine milligram equivalent dose per day at initiation and concurrent use of gabapentinoids, were associated with longer-term opioid use. In addition, the study reported that the following were associated with long-term opioid use[16]:

- Older age
- Social deprivation
- Comorbidities such as fibromyalgia, rheumatological conditions and recent major surgery
- History of substance abuse, alcohol abuse and self-harm/suicide.

Better stewardship of opioid analgesics could reduce quantities of opioid analgesics prescribed for acute pain and the possibility of harm from opioid analgesics. The Therapeutic Goods Administration (TGA) regulatory reforms[17] for smaller pack sizes support prescribing smaller quantities to manage pain for 72 hours. Small pack sizes of some opioid analgesics are now listed on the Pharmaceutical Benefits Scheme.

Opioid analgesic adverse effects

Due to the distribution of opioid receptors throughout the body, opioid analgesics may produce a broad spectrum of adverse effects. These include dysphoria, euphoria, sedation, respiratory depression, constipation, suppression of endocrine systems, cardiovascular disorders, convulsions, nausea and vomiting. In some cases, opioid-induced hyperalgesia or pain caused by a stimulus that does not normally elicit pain has been reported.[18] Long-term use of opioid analgesics can produce persistent use, tolerance, addiction and lead to diversion.

Respiratory depression, which is more completely described by the term opioid-induced ventilatory impairment (OIVI), is a serious and potentially life-threatening adverse effect of opioid analgesic use.[19,20] The risk of respiratory depression (OIVI) is higher in older patients, patients prescribed continuous infusions or more than one opioid analgesic or formulation, patients prescribed modified-release opioid analgesics, those who are co-prescribed sedatives, and those who are ineffectively monitored for OIVI.[1] Respiratory depression (OIVI) is more likely to occur in the first 24 hours after surgery.[1,20]

Importantly, many patients who experience harm from respiratory depression (OIVI) have no identifiable comorbidities that predict an increased risk of OIVI.[21-23] The Australian and New Zealand College of Anaesthetists Faculty of Pain Medicine ***Statement on Principles for Identifying and Preventing Opioid-Induced Ventilatory Impairment (OIVI)***[24] advise that significant OIVI is almost always accompanied by excessive sedation. The statement, currently under revision to reflect TGA regulatory changes, includes an example of a commonly used sedation scoring system. It also recommends regular assessment of patient sedation levels in the acute setting when an opioid analgesic is administered for acute pain. Australian research has identified that using a sedation score is a more reliable clinical indicator of early respiratory depression (OIVI) than a decrease in respiratory rate.[20,25]

Opioid analgesic stewardship

Opioid analgesic stewardship involves supervising or taking care of opioid analgesics, and applies a systematic approach to optimising the use of opioid analgesics. This extends to appropriate and safe use of opioid analgesics, with effective monitoring and surveillance.[26]

The benefits of opioid analgesic stewardship programs include:

- Ensuring appropriate dose and duration of opioid analgesics
- Reducing inappropriate opioid analgesic use
- Limiting use of modified-release opioid analgesics for acute pain, so they are used only in exceptional circumstances and not routinely
- Reducing incidence/potential for opioid-related harm
- Reducing healthcare and economic costs associated with inappropriate opioid analgesic use.

Factors that increase harm from opioid analgesics include:

- Prescribing opioid analgesics unnecessarily, when nonpharmacological analgesia, paracetamol, non-steroidal anti-inflammatories or other opioid-sparing strategies may be appropriate
- Prescribing opioid analgesics to patients with identified risk factors, including patients taking benzodiazepines or other sedative hypnotics, barbiturates or gabapentinoids, and non-opioid naïve patients
- Prescribing opioid analgesics without appropriate monitoring and managing opioid analgesic adverse effects
- Prescribing opioid analgesics without review of therapy to determine the patient's response to therapy
- Routine prescribing of modified-release opioid analgesics for acute pain
- Inappropriate prescribing of high doses of opioid analgesics
- Prescribing inappropriate dose and quantities of opioid analgesics on discharge from hospital
- Not assessing and considering patient possession of existing opioid analgesics on discharge from hospital
- Prescribing opioid analgesics for longer duration than required by not providing a weaning and cessation plan
- Patients not taking opioid analgesics as prescribed by their clinician
- Patients not correctly storing opioid analgesics and not correctly disposing of unused opioid analgesics.

1 Quality statement 1 – Patient information and shared decision making

The nonpharmacological and pharmacological options for managing acute pain are discussed with a patient and their carer in a way that they can understand, and that leads to a shared understanding of the decision to use an opioid analgesic or other treatment(s).

Purpose

To inform patients, and their family or carer, about the potential benefits and harms of acute pain treatment options so that they can participate in decision-making about their treatment with their clinician. This may or may not include opioid analgesics.

What the quality statement means

For consumers

Acute pain is pain that lasts for a few moments, days or weeks. If you have acute pain, your clinician will explain your treatment options. These may include medicines and other treatments. The aim of these medicines and other treatments is to reduce your pain levels to allow you to undertake your regular day-to-day activities. They may not take away all your pain.

Your clinician will explain the possible benefits and harms (the good and bad things that might happen) of the different options. This can help you and your clinician decide how to manage your pain.

Opioid analgesic medicines (pain relief medicines commonly known as opioids) are one option, but they can have serious adverse effects. Your clinician may suggest trying other options first. Other options include non-opioid medicines, and other treatments such as heat packs, ice packs, exercise or physiotherapy. You and your clinician might decide that a combination of two or more treatments is best for you.

If you decide on a medicine, your clinician will give you instructions about what you need to do, especially if you will use the medicine after leaving hospital. It is important that you follow these instructions correctly to get the most benefit. Talk to your clinician if you are not sure what to do, or if you have questions about:

- How many times a day to take the medicine and if the medicine should be taken with food
- Whether the medicine will affect other medicines you use
- What the adverse effects are and how to manage them.

If you are prescribed an opioid, only use the medicine for the reason it is prescribed, and do not give this medicine to other people, such as friends and family. Opioid analgesic medicines can make you sleepy. If you are prescribed an opioid analgesic do not drink alcohol or drive. Check with your clinician about what other medicines you can safely take, including sleep medicines, so you don't have any negative interactions with the opioid medicine.

For clinicians

Discuss the patient's expected recovery, and the potential benefits and harms of acute pain treatment options, with them or their carer. Tailor the options to the patient's acute pain in line with a stepwise approach when providing treatment options, which may or may not result in prescribing opioid analgesics. This discussion should consider the patient's preferences and needs, and any cultural and linguistic matters.

Inform the patient of suitable treatment options to help with symptoms, including paracetamol and non-steroidal anti-inflammatories, and nonpharmacological treatments such as splinting, heat packs, ice packs, physiotherapy and exercise.

If opioid analgesics are considered appropriate, discuss with the patient the importance of using opioid analgesics as prescribed, how to take them and for how long, potential opioid analgesic adverse effects and interactions with existing medicines, and when the treatment will be reviewed.

If opioid analgesics are supplied or prescribed on discharge, discuss how to safely store opioid analgesics and dispose of unused opioid analgesics by returning to the patient's local community pharmacy.

Provide culturally and linguistically appropriate written information and resources to the patient about their treatment options and their analgesic treatment. When a patient is unable to receive information or participate in treatment decisions, provide information to the patient's family or carer and offer them the opportunity to participate in decisions, if appropriate.

Document in the patient's healthcare record what information was conveyed to the patient, including the provision of written information such as a consumer medicines information sheet, the **Pharmaceutical Society of Australia's Opioid Medicines fact sheet,** information about safe storage and disposal, and the outcome of the shared decision making process. Outcomes of shared decision making should be documented wherever possible, including in the medication management plan and clinical handover summary.

For health service organisations

Ensure systems are in place for clinicians to provide patients, and their family or carers, with culturally appropriate information and advice on acute pain treatment options.

Provide high-quality written patient materials and resources for use by clinicians and patients that have been developed in partnership with consumers, and meet the diverse needs of people who access your services.

Ensure processes are in place so that information is communicated to the patient about their treatment options and medication management or pain management plan, including at transitions of care (such as on transfer in, or discharge from, hospital).

Where opioid analgesics are prescribed, ensure systems are in place so that clinicians discuss with patients and their family or carers the need to take the medicine as prescribed, the expected duration of treatment, any potential adverse effects and interactions with existing medicines, and when their treatment requires review. Ensure systems are in place so that, on discharge, clinicians discuss with patients and their family or carers the possibility of harm if they give opioid analgesics to other people, and the safe storage and disposal of opioid analgesics.

Monitor patient understanding of information provided for acute pain treatment and evidence of shared decision making – for example, through patient surveys, and patient-reported experience measures. See **Appendix C** for more information.

Related resources

- Clinical Excellence Commission NSW. ***Managing Side Effects of Opioid Medicines in Hospital: Information for patients, families and carers***
- Choosing Wisely. ***Patient Guide to Managing Pain and Opioid Medicines***
- SA Health. ***Oxycodone for Short-Term Management of Acute Pain***
- SA Health. ***Information for Paediatric Patients, and Their Carer, Given Opioids for Short-Term Treatment of Acute Pain***
- SA Health. ***Going Home After Having Been Given a Medicine That Can Make You Sleepy***
- WA Health. ***Pain Relief Medications Following Surgery and Injury: Information for patients preparing for discharge***
- TGA. ***Return Your Unused Opioids – Resource Kit***
- ***Return Unwanted Medicines***
- Pharmaceutical Society of Australia. ***Opioid Medicines Fact Sheet for Patients, Families and Carers***.

2 Quality statement 2 – Acute pain assessment

Analgesic prescribing for a patient with acute pain is guided by its expected severity and assessment of patient-reported pain intensity and the impact of pain on the patient's function.

Purpose

To ensure the impact of acute pain on the patient's function is considered together with pain scores, to guide the appropriate choice of analgesia.

What the quality statement means

For consumers

Being in acute pain can interfere with your ability to participate in your regular day-to-day activities. It is important for your clinician to understand how your acute pain is affecting your ability to function, as well as how much pain you are feeling. This can help them to provide the most appropriate treatment. The treatment may not completely stop your pain. The aim of treatment is to reduce your pain to a level that allows you to return to your regular day-to-day activities.

Your clinician will ask you questions about how your pain is interfering with your ability to function normally and carry out activities. They may also ask you questions about how you are coping with your pain. For example, whether the pain is affecting your sleep, or your ability to carry out regular activities. There are several measurement tools to score your pain and your function, and your clinician will use the ones that best suit your needs when they assess your acute pain.

For clinicians

When treating a patient with acute pain, assess the patient's functional activity using an evidence-based assessment tool before prescribing an opioid analgesic. The results of the functional assessment should be considered together with patient's pain scores in discussion with the patient to guide appropriate treatment. The outcome of the assessments should be documented in the patient's medical record.

Consider the clinical context – such as intensive care or ward – and the patient context including developmental, cognitive, emotional, language and cultural factors, to assist in choosing an appropriate pain assessment tool for acute pain.[2] For example, verbal pain descriptors may be a better choice of pain measurement tool than numerical rating scales for some Aboriginal and Torres Strait Islander people.[27]

Validated tools for measuring pain in neonates, infants and children are available, and the appropriate tool should be selected based on the child's age and developmental stage.[2]

For health service organisations

Ensure appropriate evidence-based tools to assess patient function and pain are available, and that processes and policies support their use to assess and document acute pain before clinicians prescribe appropriate analgesia.

Related resources

Several evidence-based tools for assessing pain and function are available.

Functional Activity Scale[2,4,28]

A. No limitation: the patient can undertake the activity without limitation due to pain (pain-intensity score is typically 0–3)
B. Mild limitation: the patient can undertake the activity, but experiences moderate to severe pain (pain-intensity score is typically 4–10)
C. Significant limitation: the patient cannot complete the activity due to pain or pain treatment-related adverse effects independent of pain-intensity scores.

Pain scoring systems

- **Wong-Baker FACES Pain Rating Scale** and **Multi-Language Wong-Baker FACES Pain Rating Scale**
- **Multi-language International Association for the Study of Pain Faces Pain Scale Revised**.

Pain scoring systems for paediatric patients

A summary of validated tools for measuring pain in paediatric patients is in *Acute Pain Management: Scientific Evidence (5th edition)* (2020)[2]:

- Table 10.1 Acute pain-intensity measurement tools – neonates
- Table 10.2 Composite scales for infants and children
- Table 10.3 Self-report tools for children
- Table 10.4 Sample of observational pain assessment scales for intellectually disabled children.

Pain scoring systems for cognitively impaired patients

A summary of tools for measuring pain in patients with dementia can be found in *Acute Pain Management: Scientific Evidence (5th edition)* (2020)[2], including:

- Faces Pain Scale
- **Abbey Pain Scale**
- **Pain Assessment in Advanced Dementia (PAINAD)**
- **Pain Assessment Checklist for Seniors with Limited Ability to Communicate**
- Mobilization–Observation–Behaviour–Intensity–Dementia Pain Scale (MOBID).

Other resources include:

- Doloplus-2, which is a behavioural pain assessment scale for older people who present with verbal communication disorders
- Pain Assessment Checklist for Seniors with Limited Ability to Communicate (PACSLAC)
- Royal Children's Hospital, Melbourne, Clinical Guidelines (Nursing). *Pain Assessment and Measurement*.

Indicator for local monitoring

Indicator 2a: Proportion of patients who received opioid analgesics who had pain and functional assessments prior to being prescribed opioid analgesics.

METeOR link: **meteor.aihw.gov.au/content/index.phtml/itemId/755547**

More information about the indicator and the definitions needed to collect and calculate indicator data can be found in the above METeOR link.

3

Quality statement 3 – Risk–benefit analysis

Whenever an opioid analgesic is considered for a patient with acute pain, their risk of opioid-related harm is assessed. An opioid analgesic may be prescribed when other analgesics are not clinically feasible or sufficient, and the potential benefits outweigh the potential harms.

Purpose

To ensure that analgesia is optimised, and that the appropriate assessment of risk factors is completed and documented to identify the need for specific risk-modification strategies.

What the quality statement means

For consumers

If you have acute pain and might benefit from an opioid analgesic medicine, your clinician will ask questions to consider the benefits for you and to check your risk of harm from using these medicines. They will ask what pain medicines you are already taking or have used before. Sometimes an opioid analgesic may not be prescribed, because it is not the best medicine to treat your acute pain or there is a possibility of serious harm from the medicine. Opioid-related harm ranges from less serious effects such as nausea and vomiting, itchiness and constipation, through to severe problems such as an inability to stay awake or difficulty in breathing, which may be life-threatening. Long-term harms include dependence and addiction.

Before a surgical procedure, your clinician will ask you questions to determine your risk of harm if opioid analgesics are prescribed after your surgery. Some medicines increase the risk of side effects of opioid analgesics. It may be necessary for you and your clinician to consider reducing or stopping these medicines if opioid analgesics may be required.

If your surgery is planned (elective) and you are already taking opioid analgesics, your clinician may advise reducing your opioid analgesic dose in the lead up to the surgery. This can improve your recovery and increase the options available for managing your pain after surgery.

For clinicians

Identify and document avoidable, modifiable risks of harm if opioid analgesics are prescribed for a patient with acute pain, using appropriate assessment tools where possible.

Patients from some vulnerable groups may be at increased risk of opioid analgesic-related harm. These include older people, infants and children, pregnant and breastfeeding patients, patients with a disability, patients with unstable adverse social circumstances, patients with psychological comorbidities, and patients with substance use disorders.[2]

Patients cannot be reliably assessed for risk of respiratory depression (OIVI). Older age is one risk factor commonly reported as being associated with an increased risk of respiratory depression (OIVI). Follow best practice recommendations for appropriate doses of immediate-release opioid analgesics in older people, such as *Therapeutic Guidelines* and *Acute Pain Management: Scientific Evidence (5th edition)* (2020).[2]

Other risk factors include chronic opioid analgesic use, chronic sleep-disordered breathing, chronic obstructive pulmonary disease, diabetes, hypertension, hepatic or renal impairment, neurological diseases and obesity.[2]

Modifiable, avoidable risk factors for sedation and respiratory depression (OIVI) include[2]:

- Use of more than one opioid analgesic at a time
- Use of modified-release oral and transdermal opioid analgesics
- Use of continuous opioid analgesic infusions
- Continued administration of opioid analgesics to treat pain that is not responding to opioid analgesics
- Co-administration of central nervous system (CNS) depressants such as benzodiazepines and other sedative hypnotics, barbiturates, gabapentinoids, alcohol and recreational drugs.

Establish the patient's opioid status and existing opioid analgesics in their possession before prescribing opioid analgesics for acute pain. Access Real Time Prescription Monitoring tools or the **Prescription Shopping Program** to obtain information on use of other medicines that cause sedation and respiratory depression (OIVI), to inform shared decision making before giving or prescribing opioid analgesics.

For non-opioid naïve patients taking opioid analgesics prior to a planned or elective surgery or procedure, if time allows, slowly reduce opioid analgesics[29] according to recommendations outlined in the current best practice guidelines. For patients identified to be at increased risk of opioid-related nausea and vomiting after surgery, consider opioid-sparing treatments or alternatives to opioid analgesics to manage their acute pain.

For health service organisations

Ensure systems are in place for clinicians to assess and document avoidable, modifiable risk factors before a decision is made to prescribe an opioid analgesic.

Ensure systems are in place for clinicians to establish a patient's opioid status before prescribing opioid analgesics to treat the patient's acute pain.

Ensure policies and processes are in place to provide clinicians with access to appropriate tools, such as a real time prescription monitoring system (where available) or the Prescription Shopping Program, to identify and assess patients at risk of harm from CNS depressants before opioid analgesics are given or prescribed to treat the patient's acute pain.

Related resources

Real time prescription monitoring systems:

- QScript (Queensland)
- SafeScript NSW (New South Wales)
- SafeScript (Victoria)
- Canberra Script (Australian Capital Territory)
- DORA (Tasmania)
- ScriptCheck (South Australia)
- Electronic Recording and Reporting of Controlled Drugs (Western Australia).

The system of **Real Time Prescription Monitoring (RTPM)**, on which the state and territory systems are based, is designed to monitor the prescribing and dispensing of controlled medicines with the aim of reducing their misuse in Australia.

Services Australia provides a **Prescription Shopping Program** for prescribers of PBS medicines to make informed decisions for patients who may get more PBS subsidised medicines than they need.

Indicators for local monitoring

Indicator 3a: Proportion of patients separated from hospital with a supply or prescription of opioid analgesics where a Real Time Prescription Monitoring program or prescription shopping program was checked prior to separation.

METeOR link: **meteor.aihw.gov.au/content/index.phtml/itemId/755550**

Indicator 3b: Proportion of patients who were newly prescribed opioid analgesics who were co-prescribed CNS depressant medicines while in hospital.

METeOR link: **meteor.aihw.gov.au/content/index.phtml/itemId/755552**

More information about the indicators and the definitions needed to collect and calculate indicator data can be found in the above METeOR links.

4 Quality statement 4 – Pathways of care

A patient with acute pain prescribed an opioid analgesic who is at increased risk of opioid-related harm is appropriately managed in conjunction with a locally approved pathway to mitigate the potential for harm.

Purpose

To ensure that patients presenting with acute pain who are prescribed an opioid analgesic have access to a pathway of care to mitigate the risk of opioid-related harm, if required. This includes referral to appropriate support services, escalation of care to specialist services for paediatrics, pain management, drug and alcohol services, clinical pharmacy and allied health.

What the quality statement means

For consumers

If your clinician has identified you as having an increased risk of harm from opioid analgesics, your clinician may refer you to other hospital-based support services. These may include specialist services for children and adolescents, pain management, drug and alcohol, clinical pharmacy and allied health to help manage your acute pain and the risk of possible harm.

For clinicians

Manage and refer patients identified at increased risk of opioid-related harm according to a defined clinical pathway for appropriate support services. This includes escalation of care to specialist services for paediatrics, pain management, drug and alcohol, clinical pharmacy and allied health.

Inform the patient why they are being referred. Provide information about the care to which they are being referred according to the pathway. Advise the patient of your role in the patient's continuing care.

For health service organisations

Ensure there is a locally approved policy that defines the clinical pathways for hospitalised patients who are identified to be at increased risk of opioid-related harm. The pathways should enable clinicians to refer and escalate care of patients at increased risk of opioid-related harm to access support services, including specialist services for paediatrics, pain management, drug and alcohol, clinical pharmacy and allied health.

Ensure systems are in place to inform patients why they are being referred to a pathway and the plan for their ongoing clinical management.

Ensure clinicians are trained on how to access the pathways and that workforce proficiency is maintained.

Related resources

Drug and alcohol services

- Drug and Alcohol Specialist Advisory Service for New South Wales and ACT health professionals
- Drug and Alcohol Clinical Advisory Services (DACAS) for Victoria, Tasmania and Northern Territory health professionals
- Drug and Alcohol Clinical Advisory Services (DACAS) for South Australia health professionals.

Indicator for local monitoring

Indicator 4a: Evidence of a locally approved policy that defines the process for managing admitted patients identified as being at increased risk of opioid-related harm who are prescribed an opioid analgesic. The policy should specify:

- Process for identifying patients who may be at risk of opioid-related harm
- Local pathways for managing patients identified at increased risk of opioid-related harm
- Systems to inform patients why they are being referred to a pathway and the plan for their ongoing clinical management
- Process for clinicians to refer patients to appropriate support services and escalate care to specialist services
- Process to ensure clinicians are competent in the use of the policy
- Process to assess adherence to the policy.

METeOR link: **meteor.aihw.gov.au/content/index.phtml/itemId/755556**

More information about the indicator and the definitions needed to collect and calculate indicator data can be found in the above METeOR link.

5

Quality statement 5 – Appropriate opioid analgesic prescribing

If an opioid analgesic is considered appropriate for an opioid-naïve patient with acute pain, use an immediate-release formulation at the lowest appropriate dose, for a limited duration, and prescribe in line with best practice guidelines. Modified-release opioid analgesics cannot be safely or rapidly titrated and their use in acute pain should be exceptional and not routine. The patient is supported to cease any opioid analgesic use as their function and pain improve.

Purpose

To ensure that appropriate opioid analgesic treatment is prescribed, supplied or administered for acute pain in a way to limit the dose and duration of opioid analgesic use.

To ensure that the patient is supported to reduce the dose of all opioid analgesics and cease their use as function and pain improve.

What the quality statement means

For consumers

If you are prescribed an opioid analgesic medicine for acute pain, your clinician will prescribe the lowest dose needed to reduce your pain. The dose will be in line with accepted guidelines.

Taking opioid analgesic medicines for longer than required to manage your acute pain can lead to the medicine becoming less effective and cause harm. Your clinician will discuss with you how to reduce your use of opioid analgesic medicine. As a first step, this might include reducing the dose while you continue to use other medicines to manage your pain. For example, your clinician might advise taking paracetamol and anti-inflammatories while reducing the dose of the opioid analgesic for acute pain. Treatments such as heat packs, ice packs, exercise and physiotherapy may also be recommended to manage your pain.

As your pain and function improve, it may be appropriate to stop using, or change how you use the opioid analgesic medicine. For example, in hospital, changing from an injection or an infusion into the bloodstream through one of your veins to a medicine you take by mouth, or by reducing the dose and how often you take the medicine. In some cases, you can just stop the medicine as your pain improves. Your clinician will talk to you about how long you will need to take this medicine after you leave hospital.

For clinicians

Consider Pharmaceutical Benefits Scheme requirements for drugs of addiction, state and territory regulations, and best practice guidelines when prescribing opioid analgesics.

If an opioid analgesic is required for acute pain in an opioid-naïve patient, follow best practice guidelines. Use immediate-release formulations at the lowest appropriate dose and for the shortest appropriate duration. Consider strategies to minimise overall opioid analgesic use.

Consider the individual patient's characteristics such as age, weight, hepatic and renal function, allergies, and other health conditions such as obstructive sleep apnoea. Consider the patient's opioid status and other medicines prescribed. Use paracetamol and anti-inflammatories to reduce the dose of opioid analgesic for acute pain. Consider whether the patient has a life-limiting illness and whether they are in the care of a palliative care team.

An opioid analgesic weaning and cessation plan is particularly important for patients prescribed opioid analgesics because long-term opioid use often starts with using opioid analgesics for acute pain. Opioid analgesic dose reduction should start as soon as possible, and can usually start one to two days after major surgery or trauma.[1] In general, opioid analgesics should be discontinued before paracetamol and non-steroidal anti-inflammatories are discontinued.[1]

Define an opioid analgesic weaning and cessation plan guided by assessing the patient's functional activity and pain scores, the amount of opioid analgesic used in each 24-hour period and the duration of therapy. For example, if discontinuing opioid analgesics that were prescribed for a short duration and used for less than 10 days, doses can be reduced quickly. This also applies when discontinuing immediate-release opioids prescribed for acute pain in patients who are also on long-term opioid analgesic therapy.[1] Discuss, and agree to, the weaning and cessation plan with the patient.

There is no evidence to support the use of modified-release opioid analgesics for acute pain. Some emerging evidence shows that their use is problematic. For example, modified-release opioid analgesics following surgery are associated with increased risk of opioid-related harm and complications.[3,4] The Therapeutic Goods Administration (TGA) states that modified-release products should only be used where the pain is opioid-responsive and the patient requires daily, continuous, long-term treatment. Long-term treatment does not align with the definition of acute pain. The TGA also states that modified-release opioids are not indicated to treat chronic non-cancer pain (other than in exceptional circumstances) or for 'as-needed' pain relief.[17]

For health service organisations

Ensure systems are in place for clinicians to be able to access best practice guidelines for appropriate prescribing of opioid analgesics for acute pain.

Ensure processes and systems are in place to alert clinicians to limit the duration of therapy for opioid analgesics and plan to reduce their use.

Ensure policies, procedures and systems are in place for clinicians to supply or prescribe paracetamol and anti-inflammatories alongside opioid analgesics.

Ensure policy and procedures are in place to prevent the prescribing of modified-release opioid analgesics for routine management of acute pain.

Related resources

Guidelines

- ***WHO Analgesic Ladder (revised) (2020)***[30]
- Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists. ***Opioid Dose Equivalence Calculation Table***
- ***Acute Pain Management: Scientific Evidence (5th edition)*** (2020)
- ***Therapeutic Guidelines: Pain and analgesia***
- ANZCA ***Guideline on Acute Pain Management***
- ANZCA ***Position Statement on the Use of Slow-Release Opioid Preparations in the Treatment of Acute Pain***
- PROSPECT. ***Better Postoperative Pain Management Guidelines***.

Paediatric guidelines

- Children's Hospital Westmead. ***Pain Management – CHW: Practice guideline***
- Royal Children's Hospital, Melbourne, Clinical Guidelines (Nursing). ***Pain Assessment and Measurement***
- Royal Children's Hospital, Melbourne, Clinical Guidelines (Nursing). ***Management of the Paediatric Patient Receiving Opioids***
- South Australian Paediatric Clinical Practice Guidelines. ***Acute Pain Management and Opioid Safety in Children***
- Perth Children's Hospital. ***Analgesia*** (ED guidelines)
- Perth Children's Hospital. ***Analgesia Emergency Department Guidelines***.

Reducing guidelines

- Primary Health Tasmania. ***A Guide to Deprescribing Opioids***.

Indicators for local monitoring

Indicator 5a: Proportion of patients separated from hospital with a supply or prescription of opioid analgesics who also received a supply or prescription of paracetamol and non-steroidal anti-inflammatory medicines.

METeOR link: **meteor.aihw.gov.au/content/index.phtml/itemId/755558**

Indicator 5b: Proportion of opioid-naïve surgical patients separated from hospital with a supply or prescription of opioid analgesics where the supply or prescription was for a modified-release formulation.

METeOR link: **meteor.aihw.gov.au/content/index.phtml/itemId/755561**

More information about the indicators and the definitions needed to collect and calculate indicator data can be found in the above METeOR links.

6 Quality statement 6 – Monitoring and management of opioid analgesic adverse effects

When an opioid analgesic is prescribed, supplied or administered for a patient with acute pain, adverse effects are monitored and managed. The patient and carer are made aware of potential adverse effects and signs of overdose, including respiratory depression.

Purpose

To ensure patients with acute pain who are prescribed, supplied or administered opioid analgesics are monitored for adverse effects such as nausea, constipation, sedation, and signs of overdose, including respiratory depression (OIVI) and are managed appropriately.

What the quality statement means

For consumers

If you are prescribed or given an opioid analgesic for acute pain, your clinician should regularly check for harmful effects and adjust your treatment when necessary. Harmful effects from opioid analgesics include nausea, constipation, itchiness, drowsiness and slowed breathing.

Your clinician will monitor adverse effects by regularly checking your breathing, how drowsy you are and how often you are going to the toilet.

Opioid analgesics can sometimes slow down your breathing to dangerously low levels. Becoming very sleepy after having an opioid analgesic can be a sign your breathing is too slow. When you first start an opioid analgesic, starting with a smaller dose will reduce drowsiness, have less effects on your breathing, and be safer for you. If you do become very sleepy after taking your opioid analgesic medicine, do not take any more opioid analgesics unless you are completely awake. Your clinician will monitor your breathing and adjust your treatment if necessary, such as lowering the dose. Talk to your clinician if you have concerns about sleepiness or your breathing.

Your clinician will prescribe laxatives to prevent or treat constipation. If required your clinician will prescribe appropriate treatments for nausea and vomiting, or itchiness.

For clinicians

If opioid analgesics are prescribed, regularly monitor the patient for adverse effects in line with current best practice guidelines.[1] The frequency of patient monitoring will be influenced by the hospital setting, pain severity, age and comorbidities, and the dose and route of administration of the opioid analgesic. Develop appropriate management strategies for the adverse effects, including adjustments to the dose, route of administration, formulation and type of opioid analgesic.

Prescribe appropriate treatments to prevent and manage opioid analgesic–induced adverse effects: laxatives to prevent or treat constipation, and appropriate treatments for nausea and vomiting, and itchiness.

Patient sedation levels should be monitored and the results documented in the monitoring chart in the patient medical record. Excess sedation is a reliable indicator of respiratory depression (OIVI).[2,20,24] Patients with excess sedation (such as a score of greater than 1) should be managed by de-escalating the opioid analgesic dose and continued monitoring. Withhold all opioids until the patient is awake. If more analgesia is needed, a smaller dose should be given regardless of pain score. Monitoring sedation should always be paired with appropriate opioid analgesic prescription and dose adjustment. Excess sedation may require escalation of care, according to locally approved protocols. Consider the administration of naloxone to reverse respiratory depression (OIVI), according to a locally approved protocol.

CNS depressants such as benzodiazepines or other sedative hypnotics, barbiturates, and gabapentinoids increase the risk of excess sedation. These medicines should be avoided and patients taking these medicines should be subject to increased monitoring.

Patient cohorts at risk of excess sedation and respiratory depression (OIVI) include people who take opioid analgesics chronically; and patients with sleep-disordered breathing, chronic obstructive pulmonary disease, diabetes, hypertension, hepatic and renal impairment, neurological diseases and obesity. Patients with these comorbidities should be subject to increased monitoring.

For health service organisations

Ensure systems and protocols are in place for clinicians to monitor and manage opioid analgesic adverse effects such as nausea, constipation, sedation, and signs of overdose including respiratory depression (OIVI). Ensure monitoring of sedation levels and appropriate action when sedation levels increase. Ensure all clinicians are aware of these systems and protocols.

Ensure protocols are in place to escalate care. Ensure all clinicians are aware of these protocols.

Where electronic healthcare records are in place, consider incorporating PowerPlans, flags and reminders of opioid analgesic adverse effects into the record management system.

Related resources

Sedation tool

The Australian and New Zealand College of Anaesthetists Statement on principles for identifying and preventing opioid-induced ventilatory impairment (OIVI) in the acute pain setting provides one example of a commonly used sedation scoring system:

Sedation score*	Response
0	Awake, alert
1	Easy to rouse, remains awake
2†	Easy to rouse, unable to remain awake
3	Difficult to rouse

* Note that a sedation score (e.g. 'sedation score less than 2') may be specified in the 'Max dose/24 hrs' in the PRN section of the national inpatient medication chart to indicate the maximum amount to be administered in 24 hours when prescribing opioids.

† A score of 2 is taken to indicate early respiratory depression (OIVI) and therefore the aim should be to titrate an opioid so that a patient's sedation score is always less than 2.

Other tools and guidelines

- Faculty of Pain Medicine, Australian & New Zealand College of Anaesthetists. ***Opioid Dose Equivalence Calculation Table***
- South Australian Paediatric Clinical Practice Guidelines. ***Acute Pain Management and Opioid Safety in Children***
- Clinical Excellence Commission NSW. ***Managing Side Effects of Opioid Medicines in Hospital: Information for patients, families and carers***
- Victorian Quality Council, Victorian Department of Human Services. ***Acute Pain Management Measurement Toolkit***.

Indicators for local monitoring

Indicator 6a: Proportion of admitted patients who received opioid analgesics who were administered naloxone for respiratory depression.

METeOR link: **meteor.aihw.gov.au/content/index.phtml/itemId/755563**

Indicator 6b: Proportion of admitted patients who received opioid analgesics who also received laxatives to prevent opioid-related constipation.

METeOR link: **meteor.aihw.gov.au/content/index.phtml/itemId/755566**

More information about the indicators and the definitions needed to collect and calculate indicator data can be found in the above METeOR links.

7 Quality statement 7 – Documentation

When a patient with acute pain is prescribed, supplied or administered an opioid analgesic, the intended duration of therapy, and the review and referral plan are documented in the patient's healthcare record. The cause of the pain for which the opioid analgesic is prescribed is documented, including on the inpatient prescription.

Purpose

To improve documentation of opioid analgesic therapy to support effective communication among clinicians and patient understanding through the patient's healthcare record and the inpatient prescription. Documentation allows the appropriateness of the prescription to be assessed, and ensures that all clinicians involved in the patient's care have access to consistent and current information.

What the quality statement means

For consumers

Your healthcare record contains information about your opioid analgesic therapy. This includes information on:

- The medicine (active ingredient/s) and dose you have been prescribed
- The cause of the pain for which the opioid analgesic is prescribed
- How long to use them for
- The plan to review your opioid analgesic treatment
- The plan to reduce the opioid analgesic medication, to allow you to stop taking the medicine.

Information in your healthcare record can help different clinicians involved in your care to understand why an opioid analgesic has been prescribed and the plan for your care.

For clinicians

When prescribing opioid analgesics, document the indication, intended duration (number of days), the review and referral plan, and the weaning and cessation plan in the patient's healthcare record. This documentation includes the patient's paper or electronic medical record, the My Health Record system, prescription record, medication chart and medication management plan.

Document the cause of pain for which the opioid analgesic is prescribed, including on the inpatient prescription, to ensure the reason for use of the opioid analgesic is printed on any dispensed opioid analgesic the patient takes with them when they leave hospital.

Document co-prescribed paracetamol, non-steroidal anti-inflammatories or nonpharmacological treatments, in the patient's healthcare record.

For health service organisations

Ensure a system is in place for clinicians to document the intended duration (number of days), the weaning and cessation plan, and the review and referral plan for opioid analgesics in the patient's healthcare record.

Ensure a system is in place for clinicians to document the cause of pain for which the opioid analgesic is prescribed, including on the inpatient prescription.

Where electronic medical records are being used, incorporate flags and reminders into the record management system to support documentation in all relevant fields or consider making them mandatory fields.

Indicator for local monitoring

Indicator 7a: Proportion of admitted patients who received opioid analgesics where the intended number of days of treatment was documented in their medical record.

METeOR link: **meteor.aihw.gov.au/content/index.phtml/itemId/755568**

More information about the indicator and the definitions needed to collect and calculate indicator data can be found in the above METeOR link.

8

Quality statement 8 – Review of therapy

During hospital care, a patient prescribed an opioid analgesic for acute pain is assessed regularly to determine their response to therapy and whether an opioid analgesic is effective and appropriate for their stage of care.

Purpose

To ensure that opioid analgesics prescribed for patients with acute pain are effective and appropriate for the patient's stage of care.

What the quality statement means

For consumers

If you are prescribed an opioid analgesic while in hospital, your clinicians should regularly check that you still need the medicine, that the medicine is helping your pain and that it is the best medicine for you. Your pain and ability to function will be regularly checked, and the amount of opioid analgesic you take will be reduced as your condition improves and your need for pain relief decreases.

If your pain does not improve when you take an opioid analgesic your clinician may change your medicine or refer you to other hospital-based support services. These may include specialist services for children and adolescents, pain management, drug and alcohol, clinical pharmacy, and allied health such as physiotherapy.

For clinicians

When opioid analgesics are prescribed, the effectiveness, appropriateness and ongoing need for opioid analgesic therapy should be regularly reviewed according to the patient's stage of care. If the opioid analgesic is continued, decisions about the appropriate daily dose of opioid analgesic should be based on the oral morphine-equivalent daily dose (oMEDD) given in the past 24 hours.

During their hospital care, a patient prescribed an opioid analgesic for acute pain should have regular assessment of their pain and function. Due to interpatient variability, the timing of regular assessments should be tailored to the needs of the patient considering the patient's sedation scores, physical state, ability to move and engagement with active interventions such as physiotherapy.

Consider alternative pain management for patients whose acute pain does not respond to opioid analgesics. This may include changing the opioid analgesic to a non-opioid medicine, nonpharmacological management or referral to other hospital-based support services. These may include specialist services for paediatrics, pain management, drug and alcohol services, clinical pharmacy, or allied health.

If opioid analgesics are being administered intravenously, consider switching to oral opioid analgesic options as soon as the oral route is available.

Ensure review of opioid analgesic treatment occurs immediately before the patient leaves the hospital. The aim of opioid analgesic therapy should be to manage the patient's acute pain with an opioid analgesic for the shortest duration possible.

For health service organisations

Ensure systems are in place for clinicians to regularly review the effectiveness, appropriateness and ongoing need for opioid analgesics according to the patient's stage of care. In hospital, this includes ceasing opioid analgesics when no longer necessary and reviewing regularly from the first prescription. Ensure an oMEDD calculator is available for clinicians to determine the appropriate daily dose of opioid analgesic.

Include systems to ensure that review of opioid analgesics occurs immediately before the patient leaves the hospital.

Ensure referral and escalation of care processes are in place to support clinicians when a patient's acute pain does not respond to opioid analgesic therapy. This may include referral to other hospital-based support services, including escalation to specialist services for paediatrics, pain management, drug and alcohol, clinical pharmacy and allied health.

Ensure policy, procedures and systems are in place to support clinicians to change from intravenous to oral opioid analgesics in patients with acute pain. This should include incorporating flags in electronic medication management systems where these are in use.

Indicator for local monitoring

Indicator 8a: Proportion of overnight admitted patients separated from hospital with a supply or prescription of opioid analgesics that exceeded the opioid analgesic inpatient dose given during the 24 hours prior to separation.

METeOR link: **meteor.aihw.gov.au/content/index.phtml/itemId/755570**

More information about the indicator and the definitions needed to collect and calculate indicator data can be found in the above METeOR link.

Quality statement 9 – Transfer of care

Planning for appropriate analgesic use at the transfer of care begins when a patient is started on an opioid analgesic during their hospital visit, according to an agreed opioid analgesic weaning and cessation protocol. The number of days' supply of an opioid analgesic on discharge is based on multiple factors, including the expected course of the patient's condition, appropriate arrangements for follow-up and opioid analgesic use in the last 24 hours before discharge.

Purpose

To ensure appropriate opioid analgesic prescribing on discharge and communication with the patient's ongoing clinicians and carers when an opioid is considered necessary for a patient with acute pain. Appropriate opioid analgesic prescribing on discharge balances adequate pain relief with reducing the risk of prolonged opioid analgesic use and reducing community reservoirs of unused opioid analgesics.

What the quality statement means

For consumers

It is important that you know how to safely manage your pain when you leave hospital. Not everyone who receives opioid analgesics while in hospital will need to take them when they leave. In some cases, the pain can be managed with other medicines or techniques.

If an opioid analgesic is prescribed for you, the dose will help you to manage your pain and get back to your regular day-to-day activities. The amount you receive will be based on several things. Your clinician will consider your expected recovery along with the amount of pain relief you needed while you were in hospital. You should be advised to reduce your dose of opioid analgesic as your pain and ability to function improve.

The amount of opioid analgesic medicine you receive will be individualised to your needs. To reduce the risk of harm, there are limits on the amounts of opioid analgesics hospitals can provide:

- If you are seen in the emergency department (ED), the most that can be supplied is three days of treatment
- If you have been admitted to hospital, the amount of opioid analgesics you are given will be based on your pain relief needs in the last 24 hours you were in hospital. The most that can be supplied is seven days of treatment.

The aim is to help with your pain and give you time to visit your general practitioner where your care will be reviewed.

If you leave hospital on a weekend, live far from medical support or if your pain is expected to continue for longer, your clinician will talk to you when you are leaving hospital about the appropriate amount of opioid analgesic for your circumstances.

To ensure your care is continued, you will be advised to consult your general practitioner for follow-up after you leave hospital. If you do not have a general practitioner, your clinician will advise you on how to access care after you leave hospital.

You will be given a medication management plan describing why you were prescribed the opioid analgesic and how to reduce and stop taking this medicine. The plan to reduce and stop your opioid analgesic will be provided to your general practitioner. This is to make sure that you use these medicines for as short a time as possible, as long-term use of opioid analgesics can cause serious health and social issues. The medication management plan will include information on:

- How many times a day to take, use or apply the medicine, and if the medicine should be taken with food
- Whether the medicine will affect other medicines you use
- What the potential adverse effects are and how to manage them
- When to seek urgent care for adverse effects of the medicine or if the medicine is not helping with the pain
- How to reduce the medicine, to allow you to stop taking the medicine (weaning and cessation plan)
- How to safely store and dispose of the medicine.

If you already have opioid analgesics at home that can treat your acute pain, you may not be prescribed additional opioid analgesics when you leave hospital.

Your clinician will ask you for the details of your general practitioner to ensure your care is continued when you leave hospital. Information will be provided to them about the care you received in hospital, including the medicines you received in hospital and when you left hospital.

For clinicians

Plan for appropriate opioid analgesic use at the transfer of care when a patient is first prescribed, supplied or administered an opioid analgesic for acute pain during their hospital visit/stay. Follow an opioid analgesic weaning and cessation protocol to start weaning and cessation of opioid analgesics during their hospital stay/visit guided by assessing the patient's functional activity and pain scores. As part of the medication management plan provided to the patient, their carer and the patient's general practitioner on discharge, the weaning and cessation plan for opioid analgesics should include:

- The appropriate formulation of an opioid analgesic to provide or prescribe
- The appropriate oral morphine-equivalent daily dose (oMEDD) on discharge, which is based on the total oMEDD given in the last 24 hours before discharge
- For patients discharged from day surgery, the appropriate opioid analgesic number of days' supply based on the expected trajectory of the patient's condition
- The appropriate opioid analgesic number of days' supply, considering the day of discharge and when the patient can reasonably be expected to access primary care and other healthcare services post-discharge
- Identification of the patient who already has opioid analgesics in their possession that may adequately treat their acute pain and does not require additional prescription on hospital discharge, and advice on the appropriate use of those opioid analgesics
- Identification of the patient's general practitioner who will continue the patient's care after leaving hospital. If this is not possible, develop a plan to assist the patient access health care after discharge.

Provide the patient with written information on discharge that addresses:

- How many times a day to take, use or apply the opioid analgesic, and if it should be taken with food
- Whether the opioid analgesic will affect other medicines they use
- What the adverse effects are and how to manage them
- When to seek urgent care for adverse effects of the opioid analgesic or lack of pain relief
- How to reduce the opioid analgesic, to allow the patient to stop taking the opioid analgesic (weaning and cessation plan)
- How to safely store and dispose of the opioid analgesic.

If a patient is discharged from ED with an opioid analgesic, the quantity supplied may be for up to a maximum of three days' treatment.

If a hospital inpatient is discharged with an opioid analgesic, the quantity may be for up to a maximum of seven days' treatment to reduce and stop the medicine.

For patients who live in locations with limited access to prescribers and pharmacies, consider their individual circumstances and expected course of their condition, and provide an appropriate quantity of opioid analgesics that provides analgesia and mitigates the risk of opioid-related harm after discharge.

For health service organisations

Ensure a locally approved policy is in place to support transfer of care of patients discharged from hospital with a supply or prescription for opioid analgesics.

Ensure an opioid analgesic discharge weaning and cessation protocol is available to clinicians and used for patients who are prescribed, supplied or administered an opioid analgesic for acute pain during their hospital stay. The protocol should address the cessation or weaning of opioid analgesics started in hospital and provided or prescribed over more than 24 hours. On hospital discharge, the protocol should outline the elements of a weaning and cessation plan that includes:

- The selection of an appropriate formulation of an opioid analgesic
- For patients in hospital for more than a day, the selection of an opioid analgesic dose on discharge that is based on use in the last 24 hours before discharge, using an oMEDD
- For patients discharged from day surgery, the selection of an appropriate opioid analgesic appropriate dose based on the expected trajectory of the patient's condition
- An appropriate supply of opioids, considering the day of discharge and when the patient can reasonably be expected to access primary care and other healthcare services post-discharge
- Processes to identify patients who already have opioid analgesics in their possession that may adequately treat their acute pain and do not require an additional prescription on hospital discharge, and to advise them on the appropriate use of those analgesics
- Prompt communication of a clinical handover summary to the patient's general practitioner that includes
  - the cause of the pain for which the opioid analgesic was prescribed
  - the opioid analgesic dose prescribed or recommended on discharge (which will differ to the inpatient dose)
  - a medication management plan that includes recommendations for reducing and ceasing the opioid analgesic where appropriate

- Provision of written patient information that addresses
  - how many times a day to take, use or apply the medicine, and if the medicine should be taken with food
  - whether the medicine may affect other medicines
  - what the potential adverse effects are and how to manage them
  - when to seek urgent care for adverse effects of the medicine or lack of pain relief
  - details of how to reduce the medicine and stop the medicine (weaning and cessation plan)
  - how to safely store and dispose of the medicine.

Ensure processes are in place to identify the patient's general practitioner who will continue the patient's care after leaving hospital. If this is not possible, ensure processes are in place to assist the patient access health care after discharge.

Ensure processes are in place to reduce and stop the opioid analgesic by allowing up to a maximum of:

- Three days' opioid analgesic supply to patients discharged from the ED
- Seven days' opioid analgesic supply for patients discharged following a hospital stay.

These processes should allow for exceptions such as the patient's ability to access services in the community and comorbidities.

Related resources

Clinician resources

- SA Health. ***Clinical Guideline for Prescribing Opioids on Discharge***
- WA Health. ***Recommendations for Prescribing Analgesia on Discharge Following Surgery or Acute Injury: Information for health practitioners preparing the patient for discharge***
- Society of Hospital Pharmacists of Australia. ***Take-Home Naloxone in Australian Hospitals***.

Consumer resources

- Clinical Excellence Commission NSW. ***Managing Side Effects of Opioid Medicines in Hospital: Information for patients, families and carers***
- Choosing Wisely. ***Patient Guide to Managing Pain and Opioid Medicines***
- Alfred Health. ***Managing Your Pain After Leaving Hospital***
- SA Health. ***Oxycodone For Short-Term Management of Acute Pain***
- SA Health. ***Information for Paediatric Patients, and Their Carer, Given Opioids for Short-Term Treatment of Acute Pain***
- SA Health. ***Going Home After Having Been Given a Medicine That Can Make You Sleepy***
- WA Health. ***Pain Relief Medications Following Surgery and Injury: Information for patients preparing for discharge***
- TGA. ***Return Your Unused Opioids – Resource Kit***
- Pharmaceutical Society of Australia. ***Opioid Medicines Fact Sheet for Patients, Families and Carers***.

Indicators for local monitoring

Indicator 9a: Evidence of a locally approved policy to support the transfer of care of patients who separate from hospital with a supply or prescription of opioid analgesics. The policy should specify the:

- Organisation's opioid analgesic weaning and cessation protocol
- Process for referral to specialist services, if required
- Required documentation to be provided to the patient or carer
- Required clinical handover documentation to be provided to the general practitioner
- Process to ensure the workforce is competent in the use of the policy
- Process to assess adherence to the policy.

METeOR link: **meteor.aihw.gov.au/content/index.phtml/itemId/755572**

Indicator 9b: Proportion of admitted patients separated from hospital with a supply or prescription of opioid analgesics where the supply or prescription exceeded seven days of treatment.

METeOR link: **meteor.aihw.gov.au/content/index.phtml/itemId/755574**

Indicator 9c: Proportion of patients separated from the ED with a supply or prescription of opioid analgesics where the supply or prescription exceeded three days of treatment.

METeOR link: **meteor.aihw.gov.au/content/index.phtml/itemId/755576**

Indicator 9d: Proportion of patients separated from hospital with a supply or prescription of opioid analgesics whose medication management plan was given to the patient or carer on separation.

METeOR link: **meteor.aihw.gov.au/content/index.phtml/itemId/755578**

Indicator 9e: Proportion of patients separated from hospital with a supply or prescription of opioid analgesics whose medication management plan was sent to the general practitioner on separation.

METeOR link: **meteor.aihw.gov.au/content/index.phtml/itemId/755580**

More information about the indicators and the definitions needed to collect and calculate indicator data can be found in the above METeOR links.

Appendix A:
General principles of care

This clinical care standard aligns with key principles that are the foundation for achieving safe, high-quality care. When implementing this clinical care standard, health services should ensure quality improvement activities support these principles.

Person-centred care

Person-centred care is health care that is respectful of, and responsive to, the preferences, needs and values of patients and consumers.[31,32]

All clinical care standards support the key principles of person-centred care, as does the *Opioid Analgesic Stewardship in Acute Pain Clinical Care Standard*:

- Treating patients with dignity and respect
- Encouraging patient participation in decision making (see 'Shared decision making' below)
- Communicating with patients about their clinical condition and treatment options
- Providing patients with information in a format that they understand and encouraging them to participate in decision-making.

Shared decision making

Shared decision making involves discussion and collaboration between a consumer and their clinician. It is about bringing together the consumer's values, goals and preferences with the best available evidence about benefits, risks and uncertainties of treatment, to reach the most appropriate healthcare decisions for that person.

Involving support people

The **Australian Charter of Healthcare Rights** (second edition) describes the rights that consumers, or someone they care for, can expect when receiving health care.

Patients have the right to involve the people they want in planning and making decisions about their health care and treatment. This could be a family member, carer, friend or a consumer advocate such as a social worker. Many health services employ different types of liaison officers, such as Aboriginal and Torres Strait Islander liaison officers, who can provide patients with advocacy, information and support.

This clinical care standard does not specifically refer to carers and family members, but statements which refer to clinicians' discussions with patients about their care should be understood to include support people if this is what the patient wishes, or a substitute decision-maker if the person is unable to provide their consent.

Informed consent

Informed consent is a person's voluntary and informed decision about a health care treatment, procedure or intervention that is made with adequate knowledge and understanding of the benefits and risks to them, and the alternative options available. See the **Informed Consent in Health Care fact sheet**, developed by the Commission.

Action 2.4 in the National Safety and Quality Health Service (NSQHS) Standards requires health service organisations to ensure that informed consent processes comply with legislation and best practice.[32]

Cultural safety and patient safety

Cultural safety is about overcoming the cultural power imbalances of places, people and policies to contribute to improvements in Aboriginal and Torres Strait Islander health.[33]

The Cultural Respect Framework 2016–2026[34] commits the Australian Government and all states and territories to embed cultural respect principles into their health systems. The framework should be used to develop, implement and evaluate cultural awareness and cultural competency strategies.

Health consumers are safest when clinicians have considered power relations, cultural differences and patients' rights. Part of this process requires clinicians to review their own beliefs and attitudes.[35]

The NSQHS Standards *User Guide for Aboriginal and Torres Strait Islander Health*[35] describes six specific actions that aim to help health services improve the quality of care and health outcomes for Aboriginal and Torres Strait Islander people.[32]

Appendix B:
Indicators to support local monitoring

The Commission has developed a set of indicators to support clinicians and health services in monitoring how well they implement the care described in this clinical care standard. The indicators are a tool to support local quality improvement activities. No benchmarks are set for any indicator.

The process to develop the indicators specified in this document comprised:

- A review of existing Australian and international indicators
- Prioritisation, review and refinement of the indicators in consultation with some members of the topic working group, and some members of the Commission's Medication Safety Oversight Committee.

The underlying data for these indicators are collected from local sources, through prospective data collection or retrospective chart audits or review of policies and protocols.

In this document, the indicator titles and hyperlinks to the specifications are included with the relevant quality statement under the heading 'Indicator(s) for local monitoring'. Full specifications for the *Opioid Analgesic Stewardship in Acute Pain Clinical Care Standard* indicators can be found in the Metadata Online Registry (METeOR) at **meteor.aihw.gov.au/content/index.phtml/itemId/755544**.

METeOR is Australia's web-based repository for national metadata standards for the health, community services and housing assistance sectors. Hosted by the Australian Institute of Health and Welfare, METeOR provides users with online access to a wide range of nationally endorsed data and indicator definitions.

The Commission recommends other quality improvement indicators listed below to support monitoring.

Other Commission-endorsed indicators to support local monitoring

Hospital-acquired complications (optional)

A hospital-acquired complication (HAC) refers to a complication for which clinical risk mitigation strategies may reduce (but not necessarily eliminate) the risk of that complication occurring.[36] The HACs list comprises 16 agreed, high-priority complications for which clinicians, managers and others can work together to address and improve patient care. Each of the HACs has several associated diagnoses and codes, which allow further exploration of the data. Data for HACs are derived from the admitted patient data collection.

The high-priority complication relevant to this clinical care standard is medication complication when the diagnosis is medicine-related respiratory depression. The Commission has developed several resources for clinicians, managers and executives, governing bodies and others that can help them put in place strategies that reduce the occurrence of HACs. These are available on the **Commission's website**.

Appendix C:
Measuring and monitoring patient experiences

Systematic, routine monitoring of patients' experiences of, and outcomes from, health care is an important way to ensure that the patient's perspective drives service improvements and person-centred care. This is the case in all health services.

Patient experience measures

While this clinical care standard does not include indicators specific to measuring patient experiences, the Commission strongly encourages health services to use the Australian Hospital Patient Experience Question Set (AHPEQS). AHPEQS is a 12-question generic patient experience survey that has been validated in both day-only and admitted hospital patients across many clinical settings. The **instrument is available for download** to both private and public sector health services.

Patient-reported outcome measures

In Australia, patient-reported outcome measures (PROMs) are an emerging method of assessing the quality of health care. The Commission is leading a national work program to support the consistent and routine use of PROMs to drive quality improvement.

PROMs are standardised, validated questionnaires that patients complete, without any input from clinicians. They are often administered at least twice to an individual patient – at baseline and again after an intervention, or at regular intervals during a chronic illness. The information contributed by patients filling out PROM questionnaires can be used to support and monitor the movement of health systems towards person-centred, value-based health care.

PROMs are being used to evaluate healthcare effectiveness at different levels of the health system, from the individual level to service and system levels. There is growing interest across Australia and internationally in the routine interrogation of patient-reported outcome information for evaluation and decision-making activities at levels of the health system beyond the clinical consultation.

Appendix D:
Integration with the National Safety and Quality Health Service Standards

Monitoring the implementation of this clinical care standard will help organisations to meet some of the requirements of the National Safety and Quality Health Service (NSQHS) Standards (second edition).[32]

The NSQHS Standards aim to protect the public from harm and improve the quality of health service provision. They provide a quality assurance mechanism that tests whether relevant systems are in place to ensure that expected standards of safety and quality are met.

Within the NSQHS Standards, the Clinical Governance Standard and the Partnering with Consumers Standard combine to form the clinical governance framework for all health service organisations that applies to all other standards:

- The Clinical Governance Standard aims to ensure that systems are in place within health service organisations to maintain and improve the reliability, safety and quality of health care.
- The Partnering with Consumers Standard aims to ensure that consumers are partners in the design, delivery and evaluation of healthcare systems and services, and that patients are given the opportunity to be partners in their own care, to the extent that they choose.

Action 1.27b, Action 1.28 and Action 4.15

Under the Clinical Governance Standard, health service organisations are expected to support clinicians to use the best available evidence, including clinical care standards (see Action 1.27b), to monitor and respond to unwarranted clinical variation (Action 1.28), and identify high-risk medicines used within the organisation and has a system to store, prescribe, dispense and administer high-risk medicine safely (see Action 4.15).

Health service organisations are expected to implement the NSQHS Standards in a way that suits the clinical services provided and their associated risks.

Information about the NSQHS Standards is available at the **NSQHS Standards website**.

Glossary

Term	Definition
acute care	A short but urgent or severe administration of a clinical service to a hospital-admitted patient during an episode of care.
acute pain	A normal and time-limited response to trauma or other noxious experience, including pain related to medical procedures and acute medical conditions. Acute pain is pain that lasts for a few moments, a few days or a few weeks, but less than three months.
adjuvants	Medicines with analgesic properties, although pain relief is not their primary indication. For example, ketamine, gabapentin, pregabalin, magnesium, lidocaine and dexmedetomidine.
adverse effects	Unintended effects from a medicine, treatment or device.
adverse events	An incident that results, or could have resulted, in harm to a patient or consumer. A near miss is a type of adverse event.[32]
analgesic	Medicine that relieves pain by targeting the cause of pain or by reducing the feeling of pain.
assessment	A clinician's evaluation of a disease or condition, based on the patient's subjective report of the symptoms and course of the illness or condition and the clinician's objective findings. These findings include data obtained through laboratory tests, physical examination and medical history; and information reported by carers, family members and other members of the healthcare team.[32]
audit	A systematic review of clinical care against a predetermined set of criteria.
best practice	When the diagnosis, treatment or care provided is based on the best available evidence, which is used to achieve the best possible outcomes for patient
carer	A person who provides personal care, support and assistance to another individual who needs it because they have a disability, medical condition (including a terminal or chronic illness) or mental illness, or they are frail or aged. An individual is not a carer merely because they are a spouse, de facto partner, parent, child, other relative or guardian of an individual, or live with an individual who requires care. A person is not considered a carer if they are paid, a volunteer for an organisation, or caring as part of a training or education program.[37]
chronic non-cancer pain	Constant daily pain for a period of three months or more in the past six months in the absence of a cancer diagnosis. Also referred to as persistent pain.
clinical decision support tools	Tools that can help clinicians to draw on available evidence when making clinical decisions. These may include decision aids, risk calculators, evidence summaries and question prompt lists.
clinical handover	The transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another clinician or health service organisation temporarily or permanently.

Term	Definition
clinical pharmacist	Specialised pharmacist embedded in medical wards and units who actively optimises appropriate use of medicines, decreases serious adverse effects and improves patient care. If the focus is analgesics, the role may provide clinical care in related services such as acute pain services or pain clinics depending on service capacity.
clinical pharmacy services	A range of activities including medication reconciliation, assessing current medication management, clinical review, therapeutic drug monitoring and managing adverse effects, contributing to the medication management plan, providing medicines information, facilitating the continuity of medication management on discharge or transfer, and participating in interdisciplinary ward rounds and meetings.
clinical practice guidelines	Statements that include recommendations intended to optimise patient care that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options.[38]
clinician	A trained health professional who provides direct clinical care to patients including registered and non-registered practitioners. Clinicians may provide care within a health service organisation as an employee, a contractor or a credentialed healthcare provider, or under other working arrangements. They include nurses, midwives, medical practitioners, allied health professionals and other clinicians who provide health care, and students who provide health care under supervision.
consumer	A person who has used, or may potentially use, health services, or is a carer for a patient using health services. A healthcare consumer may also act as a consumer representative to provide a consumer perspective, contribute consumer experiences, advocate for the interests of current and potential health service users, and take part in decision-making processes.[39]
deprescribing	The process of reducing, leading to the cessation of, medicines. Deprescribing aims to discontinue potentially inappropriate medicines and improve patient outcomes. In this document, the terms weaning, reducing and de-escalation are taken to have the same meaning.
discharge summary	A collection of information about events during care of a patient by a provider or organisation. The document is produced during a patient's stay in hospital as either an admitted or a non-admitted patient, and issued when or after the patient leaves the care of the hospital.
drug and alcohol services	A range of services including early and brief interventions, treatment and extended care services delivered by hospital networks, non-government organisations and other partners.
education	A more formal gaining of theoretical knowledge within an institution over years culminating in a qualification.

Term	Definition
electronic medication management	Can refer to: ■ General practice desktop prescribing systems ■ Hospital clinical information systems that have electronic ordering, decision support systems such as evidence-based order sets, dispensing systems, and ordering and supply solutions ■ Electronic healthcare records, including medication charts, in the acute and primary care sectors.
e-prescribing	Prescriptions that are issued and dispensed using an electronic system, without using a paper-based document at any point.
guidelines	Clinical practice guidelines are systematically developed statements to assist clinician and consumer decisions about appropriate health care for specific circumstances.
healthcare-associated infection	Infections that are acquired in healthcare facilities (nosocomial infections) or that occur because of healthcare interventions (iatrogenic infections). Healthcare-associated infections may manifest after people leave the health service organisation.[40]
healthcare record	A record of the patient's medical history, treatment notes, observations, correspondence, investigations, test results, photographs, prescription records and medication charts for an episode of care.[32]
health service organisation	A separately constituted health service that is responsible for implementing clinical governance, administration and financial management of a service unit or service units providing health care at the direction of the governing body. A service unit involves a group of clinicians and others working in a systematic way to deliver health care to patients. It can be in any location or setting, including pharmacies, clinics, outpatient facilities, hospitals, patients' homes, community settings, practices and clinicians' rooms.[32]
hospital	A licensed facility providing healthcare services to patients for short periods of acute illness, injury or recovery.[41]
hospital admission	The administrative process of becoming a patient in a hospital.
immediate-release opioid analgesics	Medicines formulated to release the full dose of the opioid analgesia immediately after administration, resulting in relatively rapid drug absorption and onset of analgesic effect.
inappropriate prescribing	Using a medicine when there is an equal or more effective and lower risk alternative available, including prescribing nonpharmacological strategies.
informed consent	A process of communication between a patient and clinician about options for treatment, care processes or potential outcomes. This communication results in the patient's authorisation or agreement to undergo a specific intervention or participate in planned care. The communication should ensure that the patient understands the care they will receive, all the available options and the expected outcomes, including success rates and side effects for each option.[42]
intern/junior doctor	A first-year doctor working under supervision to obtain general registration.

Term	Definition
medical practitioner	A medically qualified person whose primary role is the diagnosis and treatment of physical and mental illnesses, disorders and injuries. They include general practitioners, medical specialists, interns and residents.
medical record	See **healthcare record**
medication management plan (MMP)	A continuing plan for the use and management of medicines developed in collaboration with the patient. The MMP records medicines taken before admission and aids medication reconciliation throughout the patient's episode of care. It is a record of patient-specific medication issues, actions taken to resolve issues and medication management goals developed during the episode of care.[43]
medicine	A chemical substance given with the intention of preventing, diagnosing, curing, controlling or alleviating disease, or otherwise improving the physical or mental wellbeing of people. These include prescription, non-prescription, investigational, clinical trial and complementary medicines, regardless of how they are administered.[44]
modified-m-release opioid analgesics	Therapy intended for patients with chronic pain, and for patients who require repeated dosing with immediate-release opioid analgesics (typically dosed twice-daily for 24 hours). Also referred to as slow, controlled or sustained release opioid analgesics.
multidisciplinary team	A team comprising clinicians from several different healthcare disciplines who work together to deliver comprehensive care.
multimodal analgesia	The administration of two or more medicines to provide analgesia, with the aim to improve pain relief while reducing opioid analgesic requirements and opioid-related adverse effects.
non-opioid naïve	Patients taking opioid analgesics before the acute event or surgery.
nurse practitioner	A registered nurse experienced in their clinical specialty, educated at the masters level, and who is endorsed by the Nurses and Midwives Board of Australia to provide patient care in an advanced and extended clinical role, including prescribing medicines.
opiate	Opioids derived from opium or their semisynthetic congeners.
opioid analgesics	Medicines used to achieve analgesia by reducing transmission of nociceptive impulses (by affecting central nervous system mu-opioid receptors) and modulating the descending inhibitory pathways from the brain. Some opioid analgesics (for example, tramadol and tapentadol) also produce analgesia via non-opioid receptors.
opioid naïve	Patients who have not received opioid analgesics in the 30 days before the acute event or surgery.
opioid-related harm	A term covering the broad spectrum of adverse events and harms seen with opioid analgesics, ranging from nausea and vomiting, constipation and pruritus through excess sedation and respiratory depression (opioid-induced ventilator impairment [OIVI]) to persistent postoperative opioid use, opioid dependence and diversion, and driving under the influence of opioid analgesics.

Term	Definition
opioid use disorder	A problematic pattern of opioid use leading to clinically significant impairment or distress within a 12-month period.
oral morphine-equivalent daily dose (oMEDD)	A marker of analgesic potency, allowing comparisons between different opioid analgesics in terms of their ability to produce the same analgesia as would be expected from a given dose of morphine.
pain	An unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage.
patient	A person who is receiving care in a health service organisation.[32]
perioperative	Relating to, or occurring in or around, the time of a surgical procedure.
persistent postoperative opioid use (PPOU)	Patients taking any opioids, prescribed for postoperative pain, for longer than 90 days after surgery.[4]
point of care	The time and location of an interaction between a patient and a clinician for the purpose of delivering care.[32]
policy	A set of principles that reflect the organisation's mission and direction.
postoperative care	Care received following a surgical procedure until a patient's hospital discharge.
primary care clinician	Medical practitioners, dental practitioners, nurse practitioners, Aboriginal and Torres Strait Islander health practitioners and allied health practitioners, who provide first-level healthcare contact with individuals as close as possible to where people live and work.
primary health care	The first level of contact for individuals, families and communities with the national health system. Primary health care is provided as close as possible to where people live and work, and is the first stage of a continuing healthcare process. It covers health promotion, prevention, early intervention, treatment of acute conditions, management of chronic conditions and end-of-life care.
procedure	The set of instructions to make policies and protocols operational, which are specific to an organisation.[32]
quality improvement	The combined efforts of the workforce and others – including consumers, patients and their families/carers, researchers, planners, and educators – to make changes that will lead to better patient health outcomes, better system performance in care and better professional development.[45] Quality improvement activities may be sequential, intermittent or continuous.[32]
registrar	A doctor with at least three years' experience in a public hospital and who supervises more junior doctors and is training to become a specialist.
resident medical officer	A medical officer who has completed internship and registration with the Medical Board of Australia working under the supervision of a specialist in a hospital.

Term	Definition
risk assessment	Assessment, analysis and management of risks. It involves recognising which events may lead to harm in the future, and minimising their likelihood and consequence.[46] A process of identifying patients who are at risk of harm or who already have a disease, injury or complication. The assessment requires sufficient knowledge to make a clinical judgement.
risk factor	A characteristic, condition or behaviour that increases the possibility of disease, injury or loss of wellbeing.
scope of practice	The extent of an individual clinician's approved clinical practice within a particular organisation, based on the clinician's skills, knowledge, performance and professional suitability, and the needs and service capability of the organisation.[47]
shared decision making	A consultation process in which a clinician and a patient jointly participate in making a health decision, having discussed the options and their benefits and harms, and having considered the patient's values, preferences and circumstances.[48]
specialist (private or public)	A clinician who has finished their training in one of the medical specialties and has obtained employment, or practises as a specialist. Specialists can be employed on a full-time or part-time basis, and can also see private patients within the terms of their employment arrangements.
staged supply	Refers to arrangements where the pharmacist, usually in response to a request from the prescriber, supplies a medicine to the patient in instalments rather than supplying the full amount prescribed at the outset.
standard	Agreed attributes and processes designed to ensure that a product, service or method will perform consistently at a designated level.
stewardship program	Programs that ensure the best possible use of high-risk medicines such as antimicrobials, anticoagulants and opioid analgesics across a hospital by monitoring their use and coordinating interventions.
surgeon	Doctors who have completed further training in a surgical specialty, recognised by the regulatory authorities of Australian Medical Council, Medical Council of New Zealand and the Australian Health Practitioners Regulatory Agency.
system	The resources, policies, processes and procedures that are organised, integrated, regulated and administered to accomplish a stated goal. A system: ■ Brings together risk management, governance, and operational processes and procedures, including education, training and orientation ■ Deploys an active implementation plan; feedback mechanisms include agreed protocols and guidelines, decision support tools and other resource materials ■ Uses several incentives and sanctions to influence behaviour and encourage compliance with policy, protocol, regulation and procedures ■ The workforce is both a resource in the system and involved in all elements of systems development, implementation, monitoring, improvement and evaluation.[32]

Term	Definition
tolerance	A requirement for increased doses of an opioid to achieve the same analgesic effect.
transitions of care	Situations where all or part of a patient's care is transferred between healthcare locations or clinicians, or levels of care within the same location as the patient's condition and care needs change.
training	The development of knowledge and skills through formal or informal courses and workshops. Usually occurs over weeks or months, and can be delivered in multiple ways, in multiple locations.
visiting medical officer	A general practitioner or specialist clinician in private practice who also provides medical services in a public hospital or health service.
weaning and cessation plan	A plan that specifies dose reductions of opioid analgesic over a defined number of days and requires discontinuation of opioid analgesic by specified day. For opioid analgesic therapy lasting less than seven days, no gradual reduction in dose is necessary as patients are at a lower risk of withdrawal.

References

1. Pain and analgesia [published 2020]. In: Therapeutic Guidelines [digital]. Melbourne: Therapeutic Guidelines Limited; 2021 Mar. Available from: **www.tg.org.au**. (Note: 'eTG complete' is now known as Therapeutic Guidelines online.)
2. Schug S, Palmer G, Scott DA, Alcock M, Halliwell R, Mott J, editors. Acute pain management: scientific evidence. 5th ed. Melbourne: Australian and New Zealand College of Anaesthetists; 2020.
3. Australian and New Zealand College of Anaesthetists. Position statement on the use of slow-release opioid preparations in the treatment of acute pain. Melbourne: ANZCA; 2018.
4. Levy N, Quinlan J, El-Boghdadly K, Fawcett WJ, Agarwal V, Bastable RB, et al. An international multidisciplinary consensus statement on the prevention of opioid-related harm in adult surgical patients. Anaesthesia. 2021 Apr;76(4):520–536.
5. Chou R, Turner JA, Devine EB, Hansen RN, Sullivan SD, Blazina I, et al. The effectiveness and risks of long-term opioid therapy for chronic pain: a systematic review for a National Institutes of Health Pathways to Prevention Workshop. Ann Intern Med. 2015 Feb 17;162(4):276–286.
6. Australian Institute of Health Welfare. Opioid harm in Australia: and comparisons between Australia and Canada. Canberra: AIHW, 2018.
7. Stanley B, Collins LJ, Norman AF, Karro J, Jung M, Bonomo YA. Opioid prescribing in the emergency department of a tertiary hospital: a retrospective audit of hospital discharge data. EMA. 2020 Feb;32(1):33–38.
8. Pouryahya P, Birkett W, Mc RMAD, Louey S, Belhadfa M, Ferdousi S, et al. Oxycodone prescribing in the emergency department during the opioid crisis. EMA. 2020 Dec;32(6):996–1000.
9. Allen ML, Kim CC, Braat S, Jones K, Winter N, Hucker TR, et al. Post-discharge opioid use and handling in surgical patients: A multicentre prospective cohort study. Anaesth Intensive Care. 2020;48(1):36–42.
10. Society of Hospital Pharmacists of Australia. Reducing opioid-related harm: a hospital pharmacy landscape paper. Melbourne: Society of Hospital Pharmacists of Australia, 2018.
11. Lalic S, Ilomäki J, Bell JS, Korhonen MJ, Gisev N. Prevalence and incidence of prescription opioid analgesic use in Australia. Br J Clinic Pharmacol. 2019;85(1):202–215.
12. Roughead EE, Lim R, Ramsay E, Moffat AK, Pratt NL. Persistence with opioids post discharge from hospitalisation for surgery in Australian adults: a retrospective cohort study. BMJ Open. 2019;9(4):e023990.
13. Stark N, Kerr S, Stevens J. Prevalence and predictors of persistent post-surgical opioid use: a prospective observational cohort study. Anaesth Intensive Care. 2017 Nov;45(6): 700–706.
14. Brat GA, Agniel D, Beam A, Yorkgitis B, Bicket M, Homer M, et al. Postsurgical prescriptions for opioid naive patients and association with overdose and misuse: retrospective cohort study. BMJ. 2018;360:j5790.
15. Australian Commission on Safety and Quality in Health Care. Medication without harm – WHO Global Patient Safety Challenge. Australia's response. Sydney: ACSQHC; 2020.
16. Jani M, Birlie Yimer B, Sheppard T, Lunt M, Dixon WG. Time trends and prescribing patterns of opioid drugs in UK primary care patients with non-cancer pain: a retrospective cohort study. PLOS Medicine. 2020;17(10):e1003270.
17. Therapeutic Goods Administration. Prescription opioids: what changes are being made and why. [Internet] Canberra: TGA; 2021 [cited 2021 Nov 24] Available from: **www.tga.gov.au/prescription-opioids-what-changes-are-being-made-and-why**.

18. Cohen B, Ruth L, Preuss C. Opioid analgesics. [Internet] Treasure Island, Florida: StatPearls Publishing; 2021 [cited 2021 Mar 12] Available from: **www.ncbi.nlm.nih.gov/books/NBK459161/**.
19. Bowen J, Levy N, Macintyre P. Opioid-induced ventilatory impairment: current 'track and trigger' tools need to be updated. Anaesthesia. 2020 Dec;75(12):1574–1578.
20. Macintyre PE, Loadsman JA, Scott DA. Opioids, ventilation and acute pain management. Anaesth Intensive Care. 2011 Jul;39(4):545–558.
21. Overdyk F, Dahan A, Roozekrans M, van der Schrier R, Aarts L, Niesters M. Opioid-induced respiratory depression in the acute care setting: a compendium of case reports. Pain Manag. 2014 Jul;4(4):317–325.
22. Lee LA, Caplan RA, Stephens LS, Posner KL, Terman GW, Voepel-Lewis T, et al. Postoperative opioid-induced respiratory depression: a closed claims analysis. Anesthesiology. 2015 Mar;122(3):659–665.
23. Gupta K, Prasad A, Nagappa M, Wong J, Abrahamyan L, Chung FF. Risk factors for opioid-induced respiratory depression and failure to rescue: a review. Cur Opin Anaesthesiol. 2018 Feb;31(1):110–119.
24. Australian and New Zealand College of Anaesthetists. Statement on principles for identifying and preventing opioid-induced ventilatory impairment (OIVI) in the acute pain setting. Melbourne: n.d.
25. Schug S, Palmer G, Scott D, Halliwell R, Trinca J. Acute pain management: scientific evidence. 4th ed. Melbourne: Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists; 2015.
26. Uritsky TJ, Busch ME, Chae SG, Genord C. Opioid stewardship: building on antibiotic stewardship principles. J Pain Pall Care Pharmacother. 2020;34(4):181–183.
27. Fenwick C. Assessing pain across the cultural gap: central Australian Indigenous peoples' pain assessment. Contemp Nurse. 2006 Sep;22(2):218–227.
28. Levy N, Sturgess J, Mills P. 'Pain as the fifth vital sign' and dependence on the 'numerical pain scale' is being abandoned in the US: Why? BJA. 2018 Mar;120(3):435–438.
29. Quinlan J, Levy N, Lobo DN, Macintyre PE. Preoperative opioid use: a modifiable risk factor for poor postoperative outcomes. BJA. 2021;127(3):327–331.
30. Anekar AA, Cascella M. WHO Analgesic Ladder. [Updated 2021 May 18]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2022 Jan. Available from: **www.ncbi.nlm.nih.gov/books/NBK554435/**
31. Australian Commission on Safety and Quality in Health Care. Patient-centred care: improving quality and safety through partnerships with patients and consumers. Sydney: ACSQHC, 2011.
32. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards (second edition). Sydney ACSQHC, 2017.
33. Australian Indigenous Doctors' Association. Cultural safety for Aboriginal And Torres Strait Islander doctors, medical students and patients. Canberra: AIDA; 2017.
34. National Aboriginal and Torres Strait Islander Health Standing Committee of the Australian Health Ministers' Advisory Council. Cultural respect framework 2016–2026 for Aboriginal and Torres Strait Islander health. Canberra: AHMAC, 2016.
35. Australian Commission on Safety and Quality in Health Care. User guide for Aboriginal and Torres Strait Islander health. Sydney: ACSQHC, 2016.
36. Australian Commission on Safety and Quality in Health Care. Hospital-acquired complications information kit. Sydney: ACSQHC, 2018.
37. Social Services Australia. Carer Recognition Act 2010 (No. 123). Canberra: SSA, 2010.
38. Institute of Medicine (US) Committee on Standards for Developing Trustworthy Clinical Practice Guidelines. Clinical practice guidelines we can trust: standards for developing trustworthy clinical practice guidelines. Washington, DC: National Academies Press, 2011.

39. Consumers Health Forum of Australia. About consumer representation. [Internet] Canberra: CHF; 2020 [cited 2022 Jan 18] Available from: **chf.org.au/representation**.

40. National Health and Medical Research Council. Australian guidelines for the prevention and control of infection in healthcare. Canberra: NHMRC, 2019.

41. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards (first edition). Sydney: ACSQHC, 2012.

42. Carey-Hazell K. Improving patient information and decision making. Australian Health Consumer. 2005 Jan;1(2005–2006):21–22.

43. Society of Hospital Pharmacists of Australia. Chapter 4: Medication management plan. J Pharm Pract Res. 2013;43(S2):S20–S22.

44. Australian Pharmaceutical Advisory Council. Guiding principles for medication management in the community. Canberra: APAC, 2006.

45. Batalden PB, Davidoff F. What is 'quality improvement' and how can it transform healthcare? Qual Saf Health Care. 2007 Feb;16(1):2–3.

46. National Patient Safety Agency (UK). Healthcare risk assessment made easy. London: National Health Service, 2007.

47. Australian Commission on Safety and Quality in Health Care. Safety and Quality Improvement Guide Standard 1: Governance for Safety and Quality in Health Service Organisations. Sydney: ACSQHC, 2012.

48. Hoffmann TC, Del Mar CB. Shared decision making: what do clinicians need to know and why should they bother? Med J Aust. 2014 Nov 3;201(9):513–514.

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