The Pharmacological Management of Cancer Pain in Adults

Clinical Audit Tool

2015

PALLIATIVE CARE

This clinical audit tool accompanies the clinical guideline: ‘Pharmacological Management of Cancer Pain

This tool is a support tool for clinical audit based on the NCEC guideline. It is not NCEC guidance.

The audit could be carried out in any service where specialist or non-specialist healthcare professionals prescribe medications for the management of cancer pain. For example, GP practices, pharmacies and

The audit should involve clinical and non-clinical stakeholders, which may include medical staff of all grades, nurses, GPs, pharmacists, clinical audit staff and patients. Further information about patient and public involvement in clinical audit is available on the HSE website.

The audit standards are based on the Pharmacological Management of Cancer Pain in Adults NCEC National Clinical Guideline No. 9. In developing this tool consideration has been given to the clinical issues covered by the guideline and the potential challenges of data collection. There may be other

To ask a question about this clinical audit tool, or to provide feedback to help inform the development of future tools, please email the National Clinical Programme for Palliative Care at

in Adults’ Issue date: 2015

Standard	Guidance Reference
PRINCIPLES OF PAIN MANAGEMENT	
1. Cancer pain management plans should address the physical, psychosocial, emotional and spiritual domains of patient care. Addressing the physical aspects of cancer pain alone is insufficient. See data collection form question b	1
2. Patients should be given appropriate information about their pain, and pain management, and be encouraged to participate in their treatment plan. See data collection form question c	2
3. Systematic assessment of cancer pain including physical, psychological, and spiritual domains is essential. The patient should be the prime assessor of his or her pain. See data collection form question a	3
4. Cancer patients should have their pain managed in accordance with the WHO Cancer Pain Relief guidance. See data collection form question d	6
OPIOIDS	
Weak opioids	
5. Weak opioids may be used in the treatment of mild to moderate pain, in conjunction with a non-opioid analgesic. Unless specific patient-related issues exist, codeine and codeine/paracetamol combinations should be used in cancer pain management in preference to tramadol or tapentadol. See data collection form question d	7
Choice of opioid	
6. Oral morphine sulphate, hydromorphone and oxycodone may be used as first line treatment in the management of moderate to severe cancer pain. Consider using opioids with the lowest acquisition cost when all other considerations are equal. See data collection form question d	8.1
7. The oral route should be used for administration of opioids, if practical and feasible. If a patient is unable to take oral opioids, a number of alternative application routes exist, such as subcutaneous, intravenous, transmucosal, transdermal, topical and spinal routes. See data collection form question e	9

8. Use of the transdermal route is suitable for patients who have **stable** pain. Patients should be titrated to adequate pain relief with oral or parenteral opioid pain medications prior to the initiation of transdermal patches. Medication for breakthrough pain should also be prescribed. See data collection form question f	14
Dosing Regimen	
9. When starting treatment with strong opioids, offer patients with advanced and progressive disease regular oral sustained-release or oral immediate-release morphine (depending on patient preference), with rescue doses of oral immediate-release morphine for breakthrough pain. See data collection form question g	9,10,11
Opioid side effects	
10. It is important to anticipate and monitor patients for opioid side-effects and manage these at the earliest opportunity to prevent unnecessary morbidity. See data collection form question h	17.1
11. Opioid rotation should be performed where pain is poorly controlled, or side-effects are intolerable. See data collection form question i	20
12. Evidence-based dose conversion ratios should be applied, taking into account individual patient factors. Pain control should be assessed regularly and doses titrated as required. See data collection form question j	21
3. NON-OPIOID PHARMACOLOGICAL MANAGEMENT	
Adjuvant analgesics	
13. In patients with cancer-related neuropathic pain, anti-epileptic and antidepressant medications should be considered, with careful monitoring of side effects. See data collection form question k	32
14. Bisphosphonates should be considered as part of a therapeutic regime for the treatment of cancer pain associated with bone metastases; however, there is insufficient evidence to recommend them as first line therapy. See data collection form question l	33
Specialist input	
15. Methadone may be used for the treatment of moderate or severe cancer pain. Methadone use is only advised through the guidance of specialist palliative care professionals. See data collection form question m	8.3 8.4
16. Available evidence is of low quality and thus only weak recommendations for use of spinal opioids alone or in combination with other drugs can be made. Administering opioids and other medications via spinal delivery systems requires the input of an appropriately qualified specialist. See data collection form question n	15
4. RENAL IMPAIRMENT	

17. In renal impairment, all opioids should be used with caution, and with consideration of reduced doses and/or frequency of administration. Specialist advice should be sought in moderate to severe renal impairment. The presence of renal impairment should not be a reason to delay the use of an opioid for those with cancer pain, when needed. Close monitoring of pain and for signs of opioid toxicity is required. Alfentanil and fentanyl are the safest opioids of choice in patients with stages 4 or 5 kidney disease (estimated glomerular filtration rate <30 ml/ min/1.73 m2). Paracetamol is considered the non-opioid analgesic of choice for mild-to-moderate pain in chronic kidney disease patients. Adjuvant analgesics may require dose adjustment in patients with renal impairment. See data collection form question o	38
5. HEPATIC IMPAIRMENT	
18. In advanced liver disease: Opioids should be used with caution in patients with advanced liver disease. Dosage recommendation should be patient specific and specialist advice sought. The transdermal route should be avoided, as drug absorption can be variable and unpredictable. Sustained release preparation should be avoided. See data collection form question p	39

Exceptions	Definitions
None	Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage. Pain is an experience that affects, and is affected by, both the mind and the body. It involves the perception of a painful stimulus by the nervous system and the reaction of a person to this. Pain is what the experiencing person says it is, existing whenever (s)he says it does
Patients with reduced level of consciousness. Patients receiving follow up assessment (as this question is most relevant to the contact where analgesics are first prescribed).	Good communication between healthcare professionals and patients is essential. It should be supported by evidence-based written information tailored to the patients needs. Treatment and care, and the information patients are given about it, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English.
Patients with reduced level of consciousness	
None	
Patients with severe pain.	None
Documented contraindications to morphine sulphate, hydromorphone and oxycodone use	None
None	

None	
Patients with incident pain only	
None	
Selected patients who are actively dying where it is considered more appropriate to manage side effects by prescription of additional medications rather than opioid rotate.	
None	
Documented contraindications to anti-epileptic and antidepressant medications; patients without neuropathic pain	
Patients without bone metastases	
Patients who are not receiving methadone	
Patients who are not receiving spinal opioids	

Patients with normal renal function	
Patients with normal hepatic function	

Audit Data for ‘The Pharmacological Manageme

			Question a
Audit ID	Age	Sex	Did patients with new episode of pain have the following components of a comprehensive pain assessment completed within 24 hours of initial contact? Rate compliance on a score of 0-8, giving one point for each component assessed.
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Yes			
No			
Total			0
Percentage			0%

Demographics

Age range:	0 - 0

Male	0
Female	0

nt of Cancer Pain in Adults' clinical audit

Question b		
For patients who were noted to have emotional, social or spiritual distress that contributed to their pain experience:Did the cancer pain management plan include plans for addressing those elements of distress?	For patients who were started o	
	To take opioids for background and breakthrough pain	Side effects and signs of toxicity?

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Question c		
n opioids, at time of initiation of opioids, was the patient told:		
Safe storage?	Follow-up and further prescribing?	Information on who to contact out of hours?

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Question d (i)		
For patients who were noted to have pain, answer one of the foll		
Did patients who reported pain as ‘mild’ have an order made for step 1 analgesic within 24 hours of contact?	Did patients who reported pain as ‘moderate’ have an order made for step 2 analgesic within 24 hours of contact?	Did patients who reported pain as ‘severe’ have an order for step 3 analgesics within 24 hours of contact?

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	Question d (ii)	Question e
owing:	For patients who had consecutive pain reports of poorly controlled pain, were increases of opioid dose or additional analgesic added within 24 hours?	For patients who were prescribed opioids, was the oral route used for analgesia, if practical and feasible?
Did patients who were unable to self-report but who had pain behaviors documented have an order for appropriate analgesic within 24 hrs of contact?		

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Question f		Question g
Was the patient receiving a transdermal opioid?	If yes- was the patient experiencing stable pain at time of prescription of transdermal opioid?	For patients with background pain and for whom treatment with strong opioids was started, were both regular and breakthrough doses of opioids prescribed?

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Question h (i)	Question h (ii)	Question i
Did patients with an opioid order have an existing bowel regimen in place or a new order for a bowel regimen initiated within 24 hours of an opioid order?	Were patients who were prescribed an opioid monitored at contact with a focused assessment with the following analgesic-induced side effects? Rate compliance on a score of 0-4, giving one point for each component assessed.	For patients with poorly controlled pain, or where side-effects are intolerable, was opioid rotation performed?

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Question j	Question k	Question l
For patients who underwent opioid rotation, was an evidence-based conversion ratio that took into account individual patient factors applied?	For patients with cancer-related neuropathic pain, were anti-epileptic and antidepressants considered as part of the management plan?	For patients with cancer bone pain, were bisphosphonates prescribed as part of the management plan?

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Question m	Question n	Question o (i)
For patients receiving methadone for pain management, was this under the guidance of the specialist palliative care team?	For patients receiving spinal opioids for pain management, was this under the guidance of specialist practitioners (anaesthetic or specialist palliative care team)?	For patients with kidney failure stages 4 or 5 was specialist advice sought to guide analgesic prescribing (renal or specialist palliative care team)?

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Question o (ii)	Question o (iii)	Question p
If opioids were prescribed for patients with kidney disease stages 4 or 5, was consideration given to using fentanyl/ alfentanil as opioid of choice?	For patients with chronic kidney disease stages 4 or 5 receiving adjuvant medications, was dose adjustment considered?	For patients with moderate to severe hepatic impairment, was specialist advice sought to guide analgesic prescribing (liver or specialist palliative care team)?

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Audit Title

The Pharmacological Management of Cancer Pain in Adults

Aim

Audit Criteria

Sample

Results

Audit N=

Criteria	Audit results
PRINCIPLES OF PAIN MANAGEMENT	
1. Cancer pain management plans should address the physical, psychosocial, emotional and spiritual domains of patient care. Addressing the physical aspects of cancer pain alone is insufficient.	0%
2. Patients should be given appropriate information about their pain, and pain management, and be encouraged to participate in their treatment plan.	0%
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4. Cancer patients should have their pain managed in accordance with the WHO Cancer Pain Relief guidance.	0%
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	0%
Choice of opioid	
6. Oral morphine sulphate, hydromorphone and oxycodone may be used as first line treatment in the management of moderate to severe cancer pain. Consider using opioids with the lowest acquisition cost when all other considerations are equal.	0%
	0%
Opioids: Route of administration	
7. The oral route should be used for administration of opioids, if practical and feasible. If a patient is unable to take oral opioids, a number of alternative application routes exist, such as subcutaneous, intravenous, transmucosal, transdermal, topical and spinal routes.	0%
8. Use of the transdermal route is suitable for patients who have **stable** pain. Patients should be titrated to adequate pain relief with oral or parenteral opioid pain medications prior to the initiation of transdermal patches.	0%

Opioids: Dosing regimen	
9. When starting treatment with strong opioids, offer patients with advanced and progressive disease regular oral sustained-release or oral immediate-release morphine (depending on patient preference), with rescue doses of oral immediate-release morphine for breakthrough pain.	0%
Opioid side effects	
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Charts

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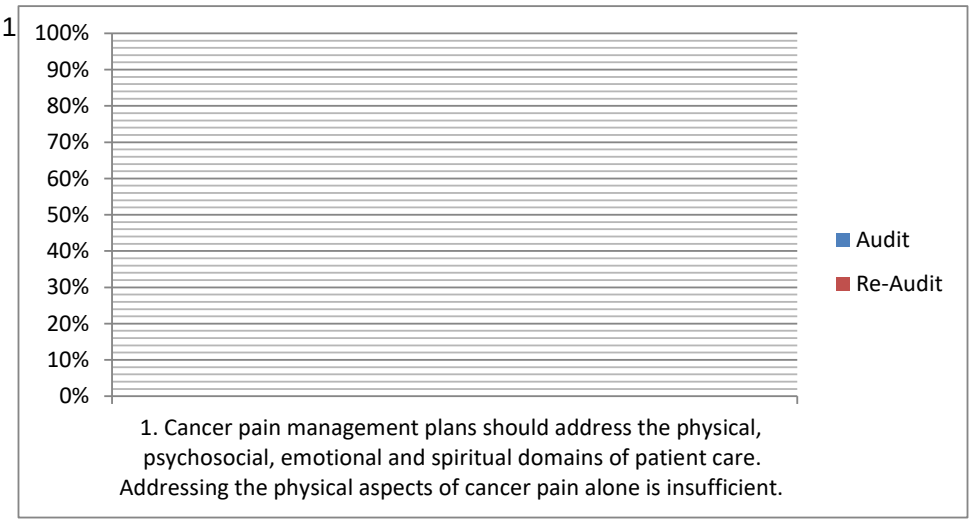
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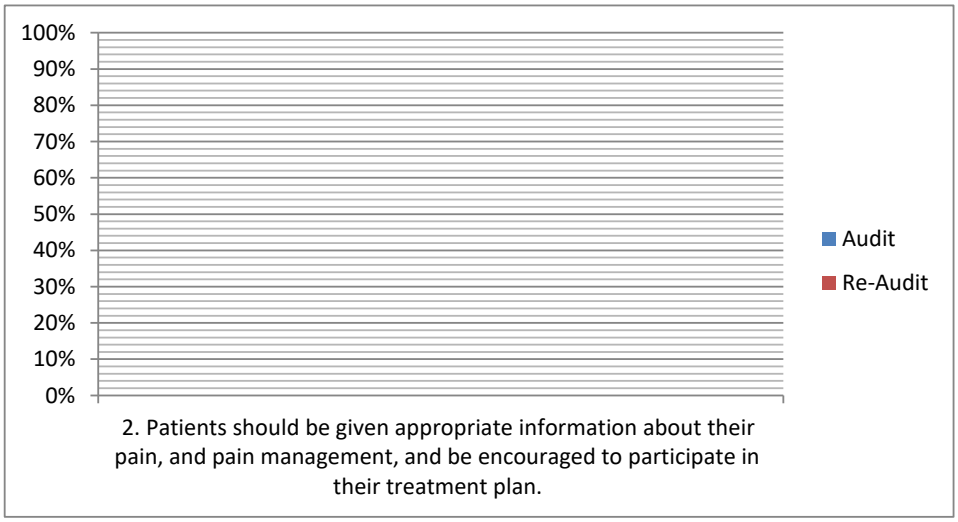
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2. Patients should be given appropriate information about their pain, and pain management, and be encouraged to participate in their treatment plan.

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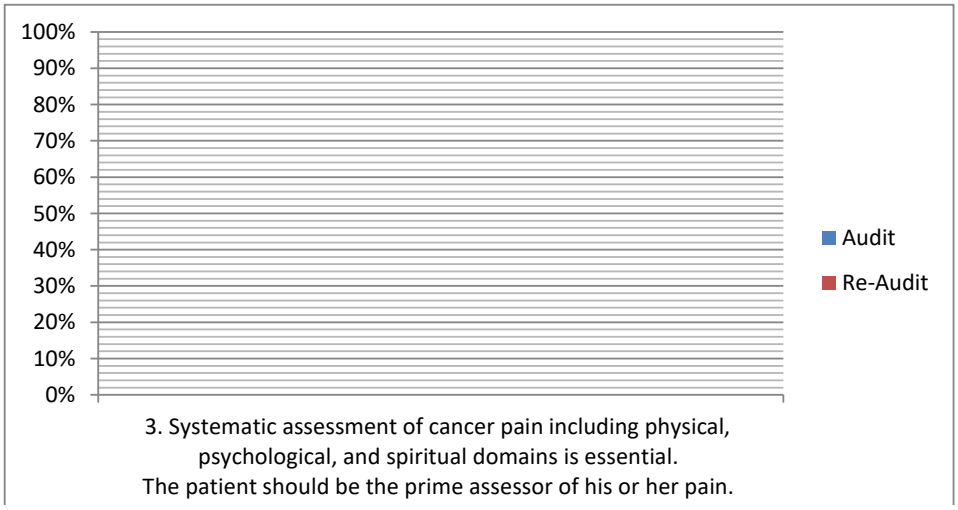
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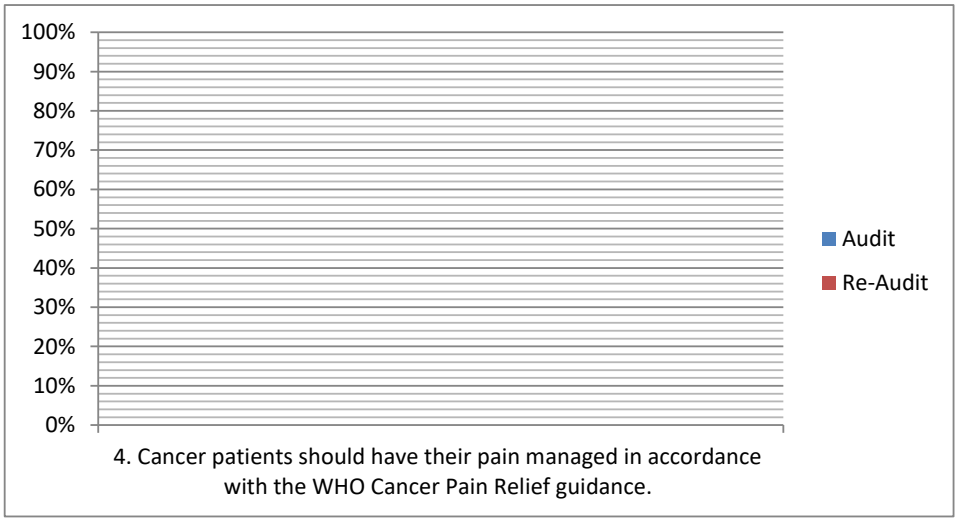

4. Cancer patients should have their pain managed in accordance with the WHO Cancer Pain Relief guidance.

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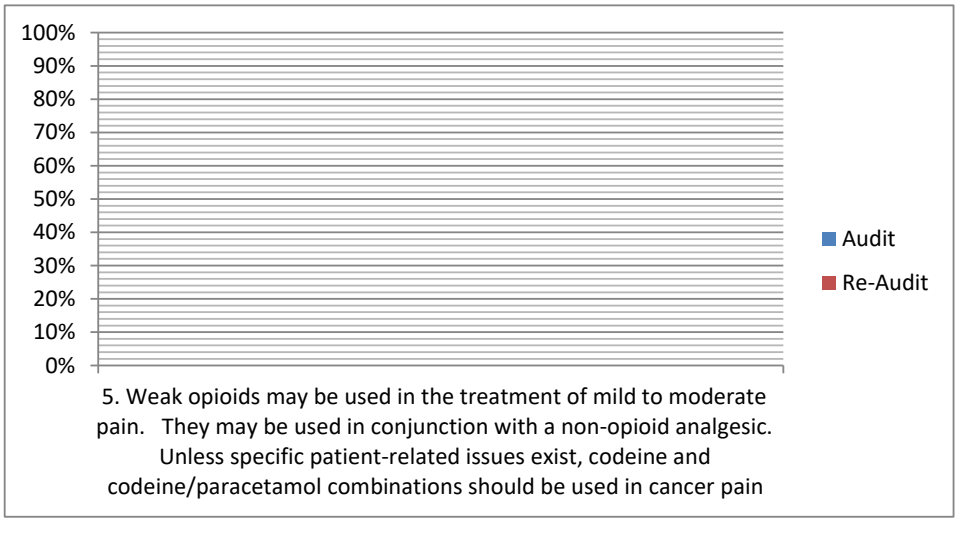

5. Weak opioids may be used in the treatment of mild to moderate pain. They may be used in conjunction with a non-opioid analgesic. Unless specific patient-related issues exist, codeine and codeine/paracetamol combinations should be used in cancer pain

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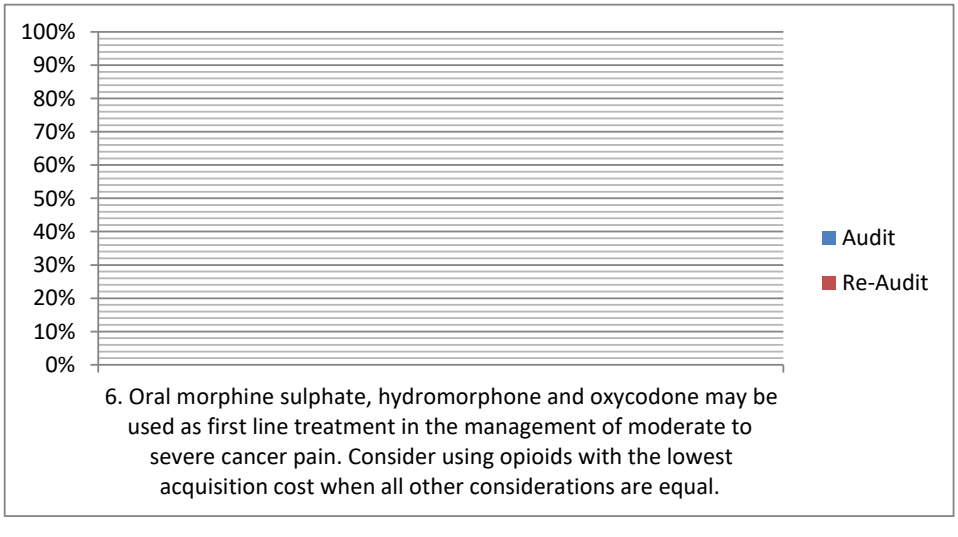

6. Oral morphine sulphate, hydromorphone and oxycodone may be used as first line treatment in the management of moderate to severe cancer pain. Consider using opioids with the lowest acquisition cost when all other considerations are equal.

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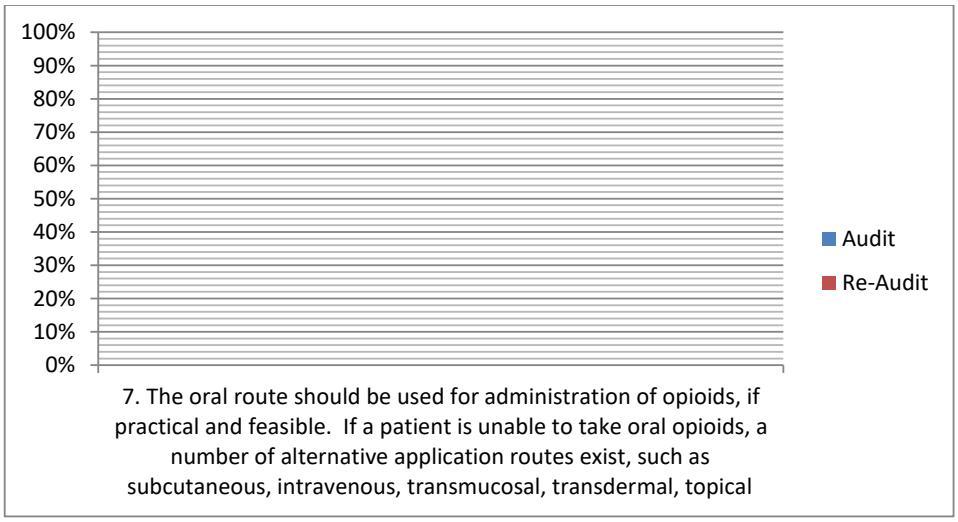
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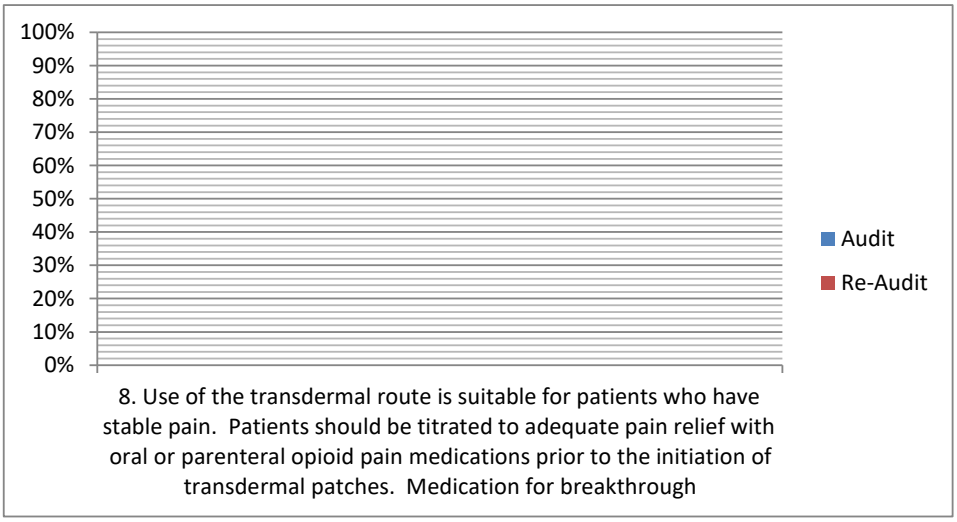
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8. Use of the transdermal route is suitable for patients who have stable pain. Patients should be titrated to adequate pain relief with oral or parenteral opioid pain medications prior to the initiation of transdermal patches. Medication for breakthrough

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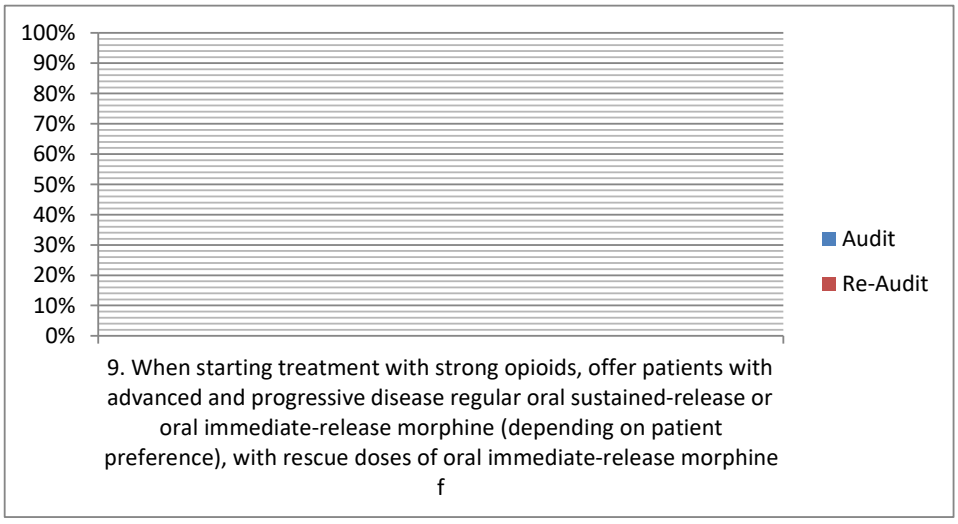
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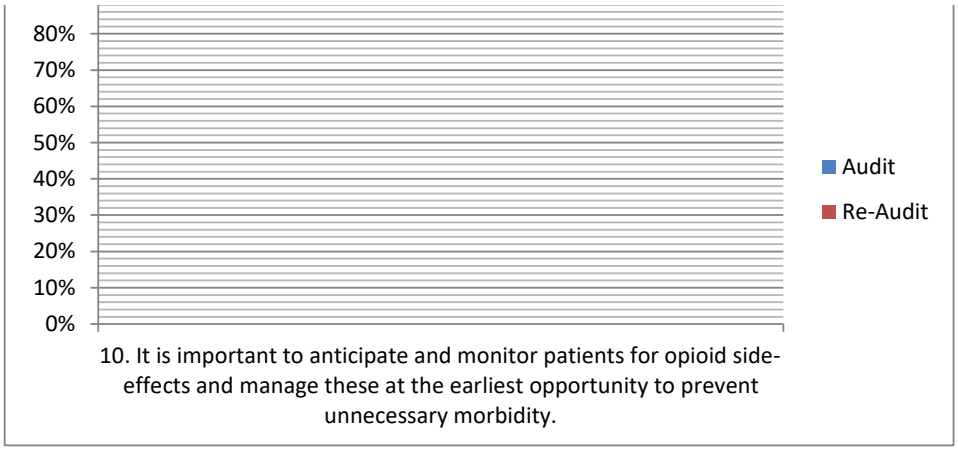
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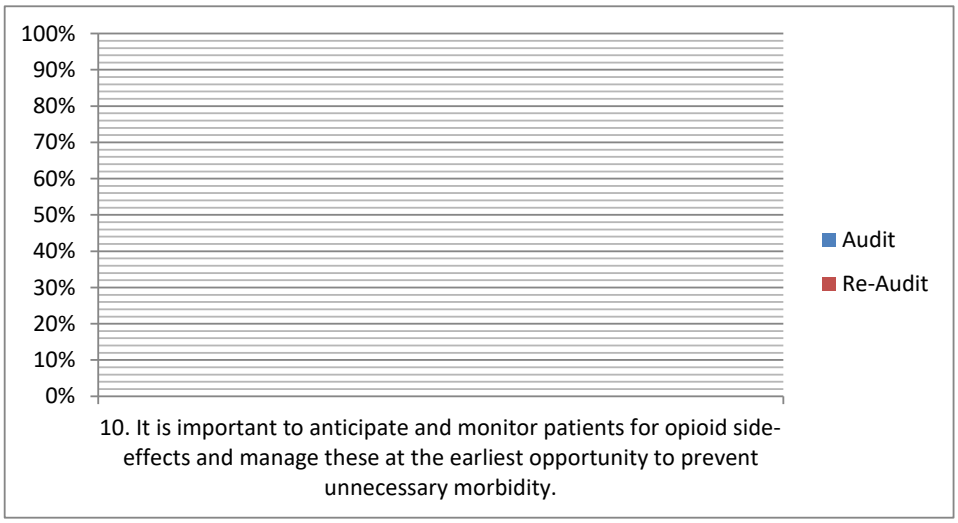
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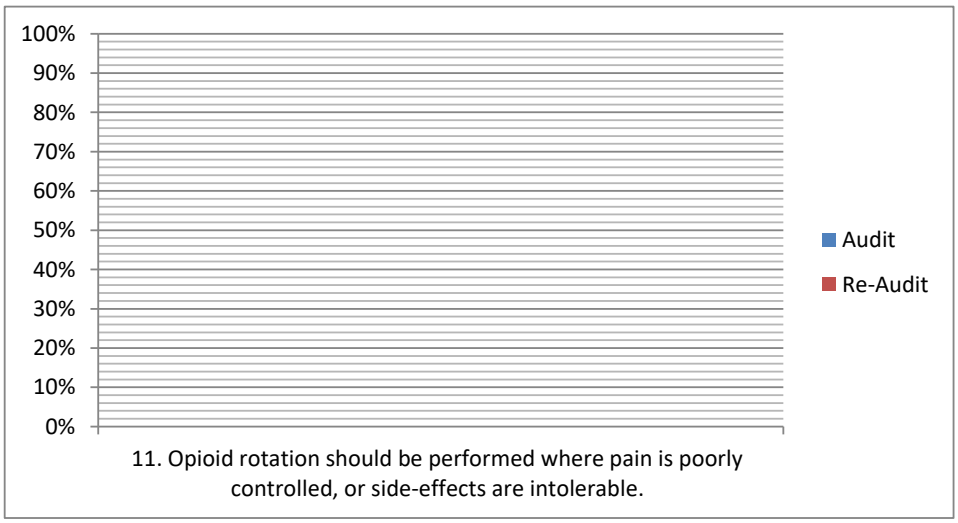
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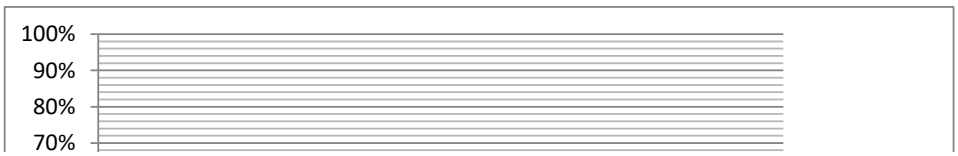
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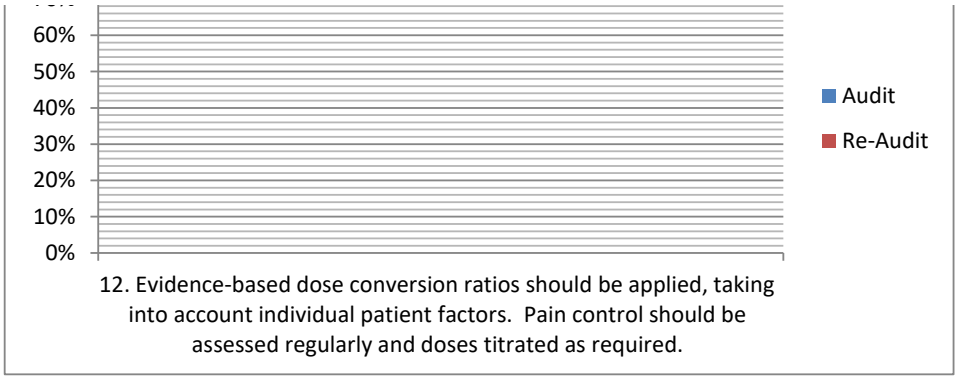

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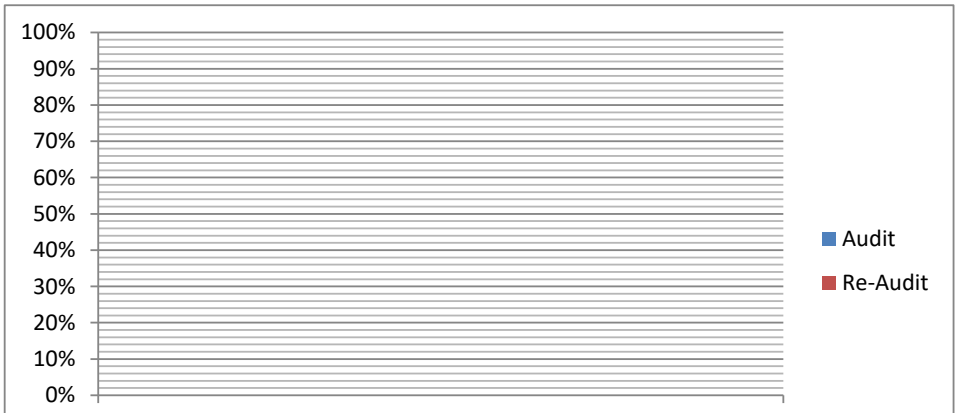

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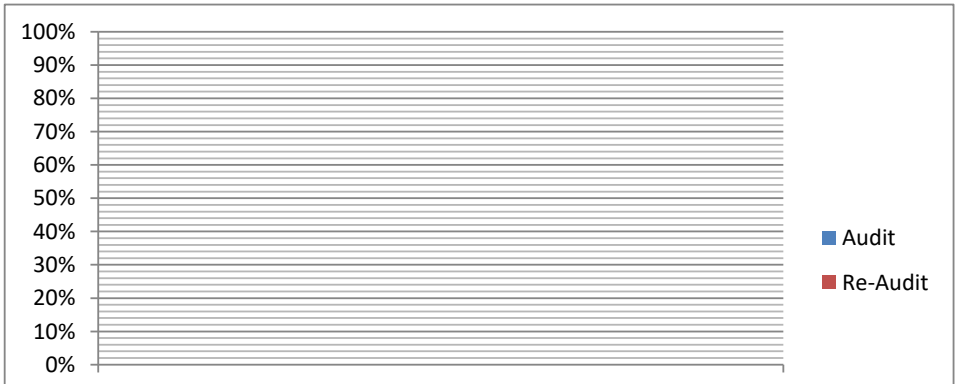

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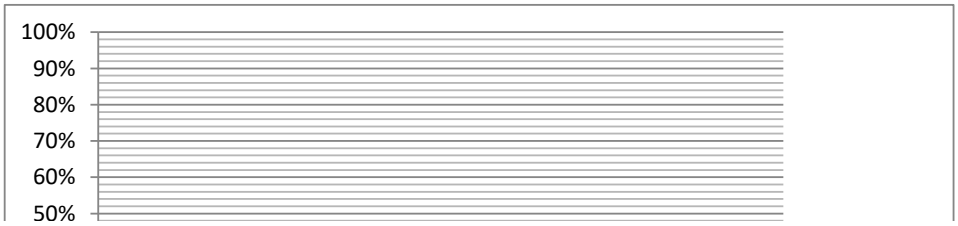

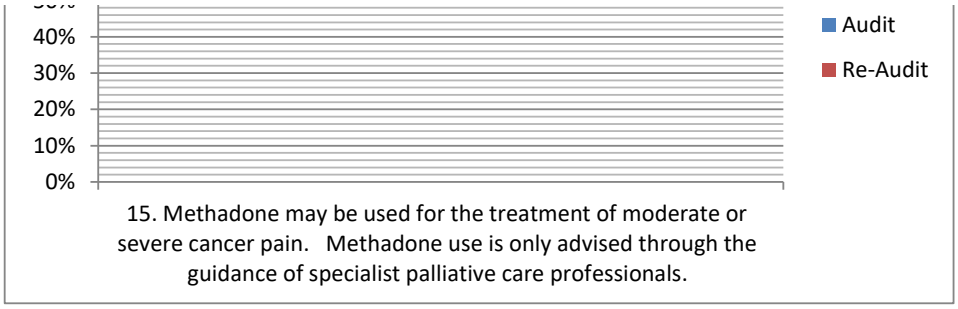

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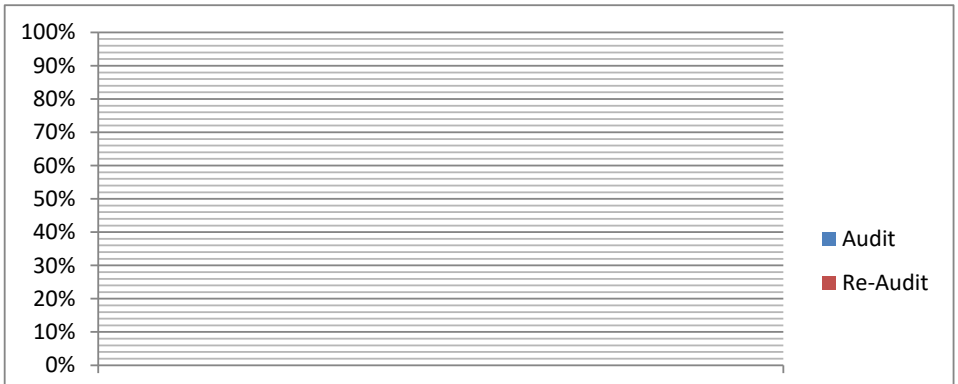

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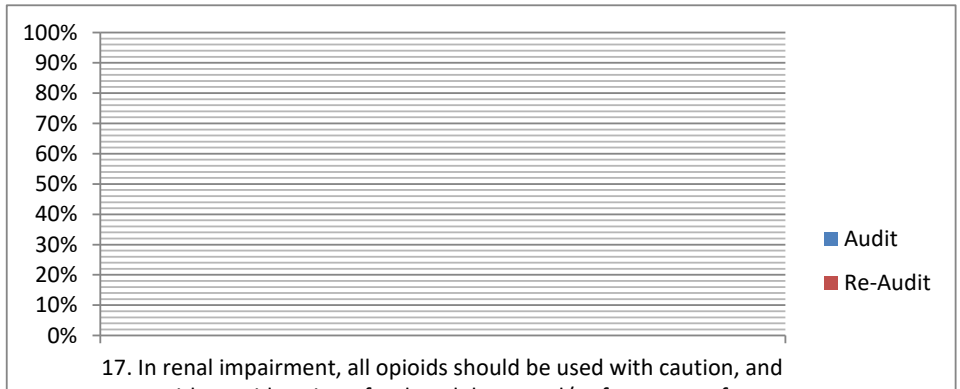

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The presence of renal impairment shoul

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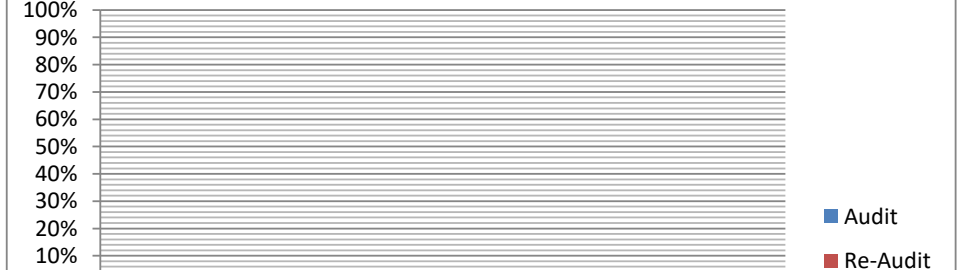

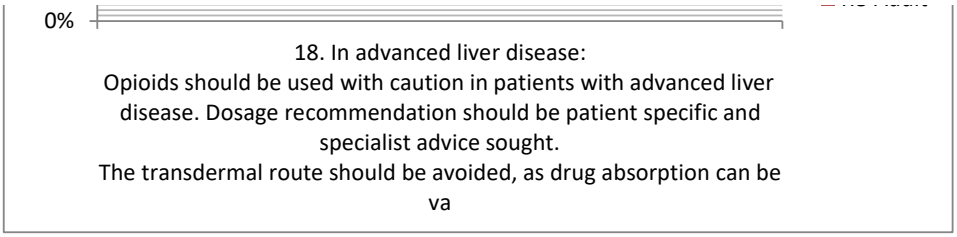
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18. In advanced liver disease:
Opioids should be used with caution in patients with advanced liver disease. Dosage recommendation should be patient specific and specialist advice sought.
The transdermal route should be avoided, as drug absorption can be va

0 **Re-audit N= 0**

	Re-audit results	
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Re-Audit Data for 'The Pharmacological Manage

			Question a
Audit ID	Age	Sex	Did patients with new episode of pain have the following components of a comprehensive pain assessment completed within 24 hours of initial contact? Rate compliance on a score of 0-8, giving one point for each component assessed.
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38			
39			
40			
Yes			
No			
Total			0
Percentage			0%

Demographics

Age range:	0 - 0

Male	0
Female	0

ement of Cancer Pain in Adults' clinical audit

Question b		
For patients who were noted to have emotional, social or spiritual distress that contributed to their pain experience:Did the cancer pain management plan include plans for addressing those elements of distress?	For patients who were started o	
	To take opioids for background and breakthrough pain	Side effects and signs of toxicity?

0	0	0
0	0	0
0	0	0
0%	0%	0%

Question c

ın opioids, at time of initiation of opioids, was the patient told:

Safe storage?	Follow-up and further prescribing?	Information on who to contact out of hours?

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0	0	0
0	0	0
0%	0%	0%

Question d (i)		
For patients who were noted to have pain, answer one of the foll		
Did patients who reported pain as ‘mild’ have an order made for step 1 analgesic within 24 hours of contact?	Did patients who reported pain as ‘moderate’ have an order made for step 2 analgesic within 24 hours of contact?	Did patients who reported pain as ‘severe’ have an order for step 3 analgesics within 24 hours of contact?

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0%	0%	0%

	Question d (ii)	Question e
owing:	For patients who had consecutive pain reports of poorly controlled pain, were increases of opioid dose or additional analgesic added within 24 hours?	For patients who were prescribed opioids, was the oral route used for analgesia, if practical and feasible?
Did patients who were unable to self-report but who had pain behaviors documented have an order for appropriate analgesic within 24 hrs of contact?		

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0%	0%	0%

Question f		Question g
Was the patient receiving a transdermal opioid?	If yes- was the patient experiencing stable pain at time of prescription of transdermal opioid?	For patients with background pain and for whom treatment with strong opioids was started, were both regular and breakthrough doses of opioids prescribed?

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Question h (i)	Question h (ii)	Question i
Did patients with an opioid order have an existing bowel regimen in place or a new order for a bowel regimen initiated within 24 hours of an opioid order?	Were patients who were prescribed an opioid monitored at contact with a focused assessment with the following analgesic-induced side effects? Rate compliance on a score of 0-4, giving one point for each component assessed.	For patients with poorly controlled pain, or where side-effects are intolerable, was opioid rotation performed?

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Question j	Question k	Question l
For patients who underwent opioid rotation, was an evidence-based conversion ratio that took into account individual patient factors applied?	For patients with cancer-related neuropathic pain, were anti-epileptic and antidepressants considered as part of the management plan?	For patients with cancer bone pain, were bisphosphonates prescribed as part of the management plan?

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Question m	Question n	Question o (i)
For patients receiving methadone for pain management, was this under the guidance of the specialist palliative care team?	For patients receiving spinal opioids for pain management, was this under the guidance of specialist practitioners (anaesthetic or specialist palliative care team)?	For patients with kidney failure stages 4 or 5 was specialist advice sought to guide analgesic prescribing (renal or specialist palliative care team)?

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0	0	0
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Question o (ii)	Question o (iii)	Question p
If opioids were prescribed for patients with kidney disease stages 4 or 5, was consideration given to using fentanyl/ alfentanil as opioid of choice?	For patients with chronic kidney disease stages 4 or 5 receiving adjuvant medications, was dose adjustment considered?	For patients with moderate to severe hepatic impairment, was specialist advice sought to guide analgesic prescribing (liver or specialist palliative care team)?

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