The Pharmacological Management of Cancer Pain in Adults

Clinical Audit Tool

2015

PALLIATIVE CARE

This clinical audit tool accompanies the *Pharmacological Management of Cancer Pain in Adults NCEC National Clinical Guideline No. 9.*

Issue date: 2015

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

This document can be used as a starting point for a local clinical audit project that **aims** to improve the information and support given to adults with advanced and progressive disease offered strong opioids for pain control. It contains:

- Clinical audit standards,
- A data collection form,
- An action plan template.

The audit standards and data collection form can be adapted to focus on a smaller part of the tool or expanded to include other local priorities.

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 oncology or general medical wards.

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 recommendations within the guideline suitable for the development of audit standards or an audit project.

A **baseline assessment tool** is also available. This can help to compare practice with the guideline's recommendations and prioritise implementation activity, including clinical audit.

The audit standards in this document include a reference to the guideline **recommendation numbers**. Exceptions not explicitly referred to in the guideline can be added locally, for example, patients declining treatment.

The National Clinical Programme for Palliative Care recommends **compliance** of 100%. If this is not achievable an interim local target could be set, although 100% should remain the ultimate aim.

A **data collection form** should be completed for each patient. There is a section for demographic information that can be completed if this information is essential to the project. Patient identifiable information should never be recorded.

In the case of recommendation 2, the patient records are unlikely to explicitly record all communication with the patient. Therefore, rather than collecting data from patient records the form should be completed by the healthcare professional either during or shortly after their contact with the patient. The audit is intended to help healthcare professionals (or groups of healthcare professionals) to reflect on their own practice and make any identified improvements.

Following the audit, the **action plan template** can be used to develop and implement an action plan to take forward any recommendations made.

Re-audit is a key part of the clinical audit cycle, required to demonstrate that improvement has been achieved and sustained. Once a re-audit has been completed, organisations can submit case reports to the National Clinical Programme for Palliative Care so that they can be used to share the experience of putting guidance into practice.

For **further information** about clinical audit refer to a local clinical audit professional in your own organisation or the Quality and Patient Safety Clinical Audit webpage

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 clinicalprogramme@rcpi.ie

Standards for the Pharmacological Management of Cancer Pain in Adults

Standard	Guidance reference	Exceptions	Definitions
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	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
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	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.
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.	3	Patients with reduced level of consciousness	

Standard	Guidance reference	Exceptions	Definitions
See data collection form question a			
4. Cancer patients should have their pain managed in accordance with the WHO Cancer Pain Relief guidance. See data collection form question d	6	None	

OPIOIDS			
Weak opioids			
5. Weak opioids maybe 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 and tapentadol. See data collection form question d	7	Patients with severe pain.	None
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	Documented contraindications to morphine sulphate, hydromorphone and oxycodone use	None
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. See data collection form question e	9	None	
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	None	
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	Patients with incident pain only	
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	None	
11. Opioid rotation should be performed where pain is poorly controlled, or side-effects are intolerable. See data collection form question i	20	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.	
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	None	
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	Documented contraindications to anti-epileptic and antidepressant medications; patients without neuropathic pain	
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	Patients without bone metastases	
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	Patients who are not receiving methadone	
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	Patients who are not receiving spinal opioids	
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 m^2). 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.	38	Patients with normal renal function	

See data collection form question o			
4. 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	Patients with normal hepatic function	

Data collection form for 'The Pharmacological Management of Cancer Pain in Adults' clinical audit

The patient records are unlikely to explicitly record all communication with the patient. Therefore, rather than collecting data from patient records the form should be completed by the healthcare professional either during or shortly after their contact with the patient.

Audit ID:	Sex:	Age:

The audit ID should be an anonymous code. Patient identifiable information should never be recorded.

No	Question	Yes	No	NA/Notes
Communication				
a.	Did patients with new episode of pain have the following components of a comprehensive pain assessment completed within 24 hours of initial contact? *Appropriately tailored assessment should be conducted on individuals who have impaired consciousness or cognition.* *Guidance recommendation 3* • Pain intensity • Pain location • Pain quality • Pain duration/pattern • Impact of pain on function • Things that make pain better • Things that make pain worse • Presence of anxiety, depression or spiritual distress Rate compliance on a score of 0-8, giving one point for each component assessed.			
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? *Guidance recommendation 1*			
c.	For patients who were started on opioids, at time of initiation of opioids, was the patient told: • To take opioids for background and breakthrough pain, addressing: - How, when and how often to take them? - How long pain relief should last? • Side effects and signs of toxicity? • Safe storage?			

No	Question	Yes	No	NA/Notes
	• Follow-up and further prescribing? • Information on who to contact out of hours? *Documentation should include ALL the components for patients who are conscious and cognitively intact in the community setting; appropriately tailored assessment should be conducted on individuals in the community who have impaired consciousness or cognition.* *Documentation on side effects, safe storage, follow up and out of hours follow up may be omitted in the in-patient setting where patients are conscious and cognitively intact; appropriately tailored assessment should be conducted on individuals who have impaired consciousness or cognition.* *Guidance recommendation 2*			
d (i)	For patients who were noted to have pain, answer one of the following: • 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? • 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? *Guidance recommendation 6, 7, 8*			
d (ii)	For patients who had consecutive pain reports of poorly controlled pain, were increases of opioid dose or additional analgesic added within 24 hours? *Guidance recommendations 6, 8*			
e.	For patients who were prescribed opioids, was the oral route used for analgesia, if practical and feasible? *Guidance recommendations 9*			
f.	Was the patient receiving a transdermal opioid? If yes- was the patient experiencing stable pain at time of prescription of transdermal opioid? *Guidance recommendations 14*			
g.	For patients with background pain and for whom treatment with strong opioids was started, were both regular and breakthrough doses of opioids prescribed? *Guidance recommendations 9,10,11*			

No	Question	Yes	No	NA/Notes
h. (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? *Guidance recommendation 17.1*			
h (ii).	Were patients who were prescribed an opioid monitored at contact with a focused assessment with the following analgesic-induced side effects? • Sedation • Nausea and vomiting • Constipation • Delirium Rate compliance on a score of 0-4, giving one point for each component assessed. *Guidance recommendation 17.1*			
i	For patients with poorly controlled pain, or where side-effects are intolerable, was opioid rotation performed? *Guidance recommendation 20,*			
j.	For patients who underwent opioid rotation, was an evidence-based conversion ratio that took into account individual patient factors applied? *Guidance recommendation 21*			
k.	For patients with cancer-related neuropathic pain, were anti-epileptic and antidepressants considered as part of the management plan? *Guidance recommendation 32*			
l.	For patients with cancer bone pain, were bisphosphonates prescribed as part of the management plan? *Guidance recommendation 33*			
m.	For patients receiving methadone for pain management, was this under the guidance of the specialist palliative care team? *Guidance recommendation 8.4*			
n.	For patients receiving spinal opioids for pain management, was this under the guidance of specialist practitioners (anaesthetic or specialist palliative care team)? *Guidance recommendation 15*			
o (i)	For patients with kidney failure stages 4 or 5 was specialist advice sought to guide analgesic prescribing (renal or specialist palliative care team)? *Guidance recommendation 38*			
o (ii)	If opioids were prescribed for patients with kidney disease stages 4 or 5, was consideration given to using fentanyl/ alfentanil as opioid of choice? *Guidance recommendation 38*			

No	Question	Yes	No	NA/Notes
o(iii)	For patients with chronic kidney disease stages 4 or 5 receiving adjuvant medications, was dose adjustment considered? *Guidance recommendation 38*			
p	For patients with moderate to severe hepatic impairment, was specialist advice sought to guide analgesic prescribing (liver or specialist palliative care team)? *Guidance recommendation 39*			

Action plan for ‘The Pharmacological Management of Cancer Pain in Adults’ clinical audit

KEY (Change status)
1 Recommendation agreed but not yet actioned
2 Action in progress
3 Recommendation fully implemented
4 Recommendation never actioned (please state reasons)
5 Other (please provide supporting information)

Action plan lead	Name:	Title:	Contact:

The ‘Actions required’ should specifically state what needs to be done to achieve the recommendation. All updates to the action plan should be included in the ‘Comments’ section.

Recommendation	**Actions required** (specify ‘None’, if none required)	**Action by date**	**Person responsible**	**Comments/action status** (Provide examples of action in progress, changes in practices, problems encountered in facilitating change, reasons why recommendation has not been actioned etc)	**Change stage** (see Key)

When making improvements to practice, organisations may like to use the tools developed by the Palliative Care Clinical Programme to help improve palliative care practice.