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Submission to the Opioid Analgesic Stewardship in Acute Pain Clinical Care Standard Consultation – September 2021

The Australasian College for Emergency Medicine (ACEM, the College) welcomes the opportunity to provide this submission to the Australian Commission on Safety and Quality in Health Care on their draft Standard on opioid analgesic stewardship in acute pain clinical care.

ACEM is responsible for the training of emergency physicians and the advancement of professional standards in emergency medicine in Australia and Aotearoa New Zealand. As the peak professional organisation for emergency medicine, ACEM has a vital interest in ensuring that the highest standards of medical care are provided for all patients presenting to an emergency department (ED).

ACEM recognises that EDs play a critical role in both prescribing opioids appropriately for acute pain as well as stemming their supply and overprescribing, given that they are often prescribed on discharge from the ED. Regulatory changes were implemented by the Therapeutic Goods Administration (TGA) in 2020 to prompt prescribers to reflect on their opioid prescribing practice and ensure that prior to initiating or continuing to prescribe an opioid, they consider whether patients will benefit from opioid treatment and how to manage risks and harms.[1] Specific to the ED context, ACEM recommends that timely and accessible referral pathways to chronic pain services should also be available to refer patients for comprehensive pain management in patients with ongoing complex pain management issues.[2]

The College commends the work of the Commission in developing the draft Standard. ACEM is supportive of proposals that put the health and wellbeing of the Australian population first. ACEM is supportive of the draft Standard; the principles and quality standards of which are sound and well intentioned.

While the Commission have developed a draft Standard that puts patients first, the College recognises that there are a number of barriers and challenges that currently exist in EDs that may prevent our members from being able to achieve elements of the Standard. In order to fully achieve the goals of the draft Standard, EDs nationwide require better resourcing. Adding further workload that includes risk assessments, pain assessments, associated documentation and conversations about alternate therapies without significantly augmenting staffing and relevant technological aids, is likely to add significant strain to the workloads of many ED staff, who are already experiencing overwhelming pressure.

The College does not seek to derail or detract from the work of the Commission by highlighting where barriers and challenges to the successful implementation of the draft Standard exist but instead, to engage and collaborate with all relevant stakeholders to provide better and safer care nationwide.

The College has set out its comments relating to each of the quality statements below:

1. Patient information and shared decision making

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

ACEM supports a public health campaign to educate patients on the use of opioids and the common misconceptions that are associated with them. This could include factsheets that can be handed out at the point of prescription in the ED on the use, risks, and common side-effects of opioids.

While ED clinicians will always aim to discuss with patients and/or their carers the options for managing acute pain in a culturally safe way, on occasion they may not have the capacity to do so fully and the discussion may be truncated. The barriers to full discussion are increasing patient numbers in health systems that have not received a reciprocal level of staff and infrastructural investment, which results in overcrowded EDs and access block.[3]

While ACEM recommends that clinicians and patients consider referrals of patients with complex pain needs to chronic pain services where available, expanded discussions about managing acute pain would be facilitated with additional staff recruited specifically for this purpose, acknowledging that recruitment outside of metropolitan areas may be difficult. This may be a task that ED-based pharmacists could assist with, rather than the responsibility lying solely with clinicians. Greater numbers of pharmacists based in EDs will enable better shared decision-making across a range of medication-related issues and free up time for ED clinicians.

2. Acute pain assessment

Analgesic prescribing in a patient with acute pain is guided by an assessment of both function and pain intensity.

Emergency clinicians already prescribe opioids for patients with acute pain based on assessment of both functionality and pain intensity.

3. Risk assessment

A patient with acute pain is assessed for risk of opioid-related harm whenever an opioid analgesic is considered. An opioid analgesic can be used if the potential benefit outweighs the potential harm.

ACEM fully supports the ethos of this quality statement, which is consistent with diligent practice, however, the reality of daily emergency medicine practice requires regular and rapid prescription and administration of intravenous opioids such as (but not limited to) Morphine and Fentanyl, given by nurses, often under delegated standing orders for a wide variety of injury and illness in well validated circumstances, including for (but not limited to) major trauma. For example, chest injury, significant fractures/dislocations, acute abdominal pain.

A risk assessment is a necessary requirement to establish a patient's analgesic response status in order to determine the type and appropriate dosing of an opioid analgesic that is required. In practice such assessments in the ED are based on issues such as age, co-morbidities, actual or potential neurological, respiratory or renal compromise and are done rapidly according to accepted and validated guidelines. In terms of risks of ongoing opioid use beyond immediate administration, emergency clinicians will be able to perform full and documented risk assessments for all patients who require acute pain management and opioid analgesic prescribing with better resourcing of EDs. A full risk assessment should be standard practice beyond the immediate prescription of intravenous opioids in specific validated circumstances. This is also a task which ED-based pharmacists may be better suited to perform.

Currently, in settings where resources are available, ACEM recommends Screening, Brief Intervention and Referral to Treatment (SBIRT) models to identify, reduce, and prevent problematic use, abuse of, and dependence on alcohol and other drugs.[4] The real time prescription monitoring system is a key facilitator identify patients at risk of opioid harm or misuse. It is excessively cumbersome and impractical to set an expectation that this is checked for every outpatient opioid prescription without systems such as this in place.

In many healthcare settings, prescriptions issued are not electronic, so performing a full risk assessment documented in this manner is not only unrealistic; for many patients it may be impossible. Many healthcare services also lack access to a real time prescription monitoring service and the Prescription Shopping Program. Upgrades to electronic systems may be required in some settings to fully implement this standard.

It is also unclear how data for Indicator 3b would be collected, nor what the optimum value would be. We suggest that a form of electronic audit would be required to make this manageable.

4. Pathway of care

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

Clinicians require an interventional service to which patients identified as dependent on drugs during the screening process, can be referred. This will typically be an alcohol or other drugs (AOD) service, although some clinicians will be able to refer to chronic pain services. Full risk assessments will likely see an increase in the number of patients that rightly, need referrals for AOD treatment. The Standard must take this into account and recommend increased availability of and resources for AOD services.

ACEM recognises that there is presently a limited availability of AOD services particularly out-of-hours and in rural and regional areas, and there is often a significant delay between referral and treatment. ACEM supports initiatives to both expand the availability of community-based AOD services and to embed AOD clinical specialists in Eds to initiate optimal therapy and provide continuity of care as patients transition from ED to AOD specialist management, whether on an outpatient or inpatient basis.

A reality in all EDs is recurrent presentations every day of patients with chronic pain. This group of patients are frequent ED users with complicated physical and psychological healthcare needs and who would benefit enormously from improved access to chronic pain clinic assessments. These patients need carefully planned and documented approaches to either acute exacerbations or flares of their chronic pain, which requires pain service clinics to be appropriately resourced.

5. Appropriate opioid analgesic prescribing

If an opioid analgesic is considered appropriate for an opioid-naive patient with acute pain, use an immediate release formulation at the lowest appropriate dose, for a limited duration, in accordance with Therapeutic Guidelines. If a modified-release opioid analgesic is considered appropriate in specific circumstances, it is used after careful assessment and for a short duration. Support should be provided to the patient to reduce and cease opioid analgesic use as function and pain improve.

Clinicians prescribe opioids for patients with acute pain where appropriate based on assessment of both functionality and pain intensity, with prescriptions issued as a short-term method of pain management. Compared to Therapeutic Guidelines, we have been anecdotally told that ED clinicians will often under-dose patients while in the ED to avoid over-reliance on opioid analgesia. Where opioids are prescribed to discharged patients, they are intended to act as a bridge between discharge and the patient's next GP visit, where they can discuss longer term pain management if still required.

While care, experience and guidelines are required, the immediate prescribing and administration of short-acting (often intravenous) opioids (as described above) for clearly validated reasons in acute pain seen in Ed should be differentiated from any ongoing prescribing of opioids in ED and on discharge, where higher levels of awareness of ongoing issues are required.

Concern has been raised over indicator 5a. As most simple analgesics do not require prescriptions, the indicator is too cumbersome to measure without introducing additional workload for clinicians who will be expected to write unnecessary prescriptions or EDs being expected to provide a supply of medicine that is readily available to patients/consumers in the community.

6. Monitoring and management of opioid analgesic adverse effects

When an opioid analgesic is prescribed for a patient with acute pain, monitor and manage adverse effects. Ensure the patient and carer are aware of potential significant adverse effects and signs of overdose.

When opioid analgesia is prescribed for patients receiving treatment in the ED, those patients are monitored closely during their ED stay for adverse effects. While very careful thought must go into the effects of any ongoing opioid use when prescribed on discharge from ED, it is unrealistic for ED clinicians to be responsible for the entirety of the monitoring and management of patients who are prescribed opioid analgesia on discharge from the ED. Emergency clinicians need to be very aware of the effects of any opioid analgesia they prescribe including on discharge and these must be clearly communicated to the patient and/or their carers and their primary care doctor (GP). Sufficient advice should be provided to patients and carers to allow such monitoring. Patient information sheets on the use of opioids, the significant adverse side effects, and signs of overdose should be made available in the ED. Patients must refer to these, self-monitor, and either return to the ED or see their GP if there are any adverse effects. The provision of this information should be recorded in the patient's medical record.

7. Documentation

When a patient with acute pain is prescribed 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.

ACEM supports full documentation of patient care. This includes recording of type of therapy, length of therapy and the referral plan in the medical record of a patient. Currently, many EDs particularly in rural and remote areas, do not have the functionality or resources to document electronically the duration of therapy and the review and referral plan when a patient is prescribed an opioid analgesic. While many EDs want to be able to prescribe electronically, prescriptions are still written by hand. Documenting opioid analgesia in this way in the ED would require a fundamental change in the way in which prescriptions are issued. This may require additional staff employed in the ED specifically to document prescriptions or as has been suggested above, a greater presence of ED-based pharmacists to facilitate this standard.

As over-the-counter medications such as paracetamol or ibuprofen require no prescription, in many situations these are only prescribed by letter or oral instruction. Introducing a requirement to electronically document these types of prescriptions would be an unnecessary and overly cumbersome means of tackling the problem of opioid abuse.

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 the patient's stage of care.

Clinicians in the ED currently assess patients prescribed opioid analgesic and review their therapy on an ongoing basis throughout their stay in ED, with an eye on potential issues once they leave ED (admitted, transferred, or discharged).

9. Transfer of care

Planning for appropriate analgesic use at the transfer of care begins when a patient is commenced on an opioid analgesic during their hospital visit, according to an agreed opioid analgesic discharge protocol. Supply of an opioid analgesic is based on the expected course of the patient's condition, arrangements for follow up and opioid analgesic use in the period up to 24 hours before discharge.

The College is supportive of this quality statement, however, in the explanatory text on page 34, it is specified that a supply of up to three days should be supplied. In many situations, a three-day supply will not be sufficient to bridge to the GP or alternative healthcare service. Increasingly, patients find it very difficult to get appointments with these services in a timely manner, which contributes to the over-utilisation of EDs. An alternate statement could be "the quantity supplied should only be for as long as it is predicted to be needed coupled with a review by GP at the earliest date to consider whether the opioids need to be continued. In many instances this will mean 3-5 days supply of treatment."

Thank you again for the opportunity to provide feedback to this consultation. If you require any further information about any of the above issues or if you have any questions about ACEM or our work, please do not hesitate to contact Jesse Dean, General Manager, Policy and Regional Engagement (jesse.dean@acem.org.au; +61 3 9320 0444).

Yours sincerely,

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ACEM President

[1] Therapeutic Goods Association (TGA). Prescription opioids: information for health professionals. Department of Health; 2020. Available from: https://www.tga.gov.au/prescription-opioids-information-health-professionals
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[3] Australasian College for Emergency Medicine (ACEM). Position Statement: Access Block [online]. ACEM, Melbourne: 2021 [accessed 22 September 2021]. Available from: https://acem.org.au/getmedia/c0bf8984-56f3-4b78-8849-442feaca8ca6/S127_v01_Statement_Access_Block_Mar_14.aspx
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