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| Analgesic StewardshipProgramAdaptable Program Plan Template  |
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Department of Health

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## Version Control

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| **Version** | **Date** | **Author** | **Comments** |
| 1.0 |  |  |  |
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## Glossary

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| **Acronym** | **Definition** |
| AGS | Analgesic Stewardship |

#  Background

## **1.1** **Background**

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| Opioid analgesics are a high-risk medicine [ACSQHC, 2021a]. Across the world, there is growing recognition of the impact health service-initiated opioids have on suboptimal patient outcomes after discharge. In one Australian study, three quarters of opioid-naïve patients admitted to a major metropolitan health service were discharged from hospital with an opioid. [Bui, 2021] The drivers behind poor patient outcomes (such as opioid dependence, abuse, or overdose) post discharge are becoming more apparent, with the duration of opioid analgesic use, rather than the dosage, considered more strongly related to ultimate misuse in the early postoperative period. [Brat, 2018]Despite recognising the high burden of prescribing, in 2018 less than 5% of Australian hospitals reported having a formal program to manage opioid prescribing. [SHPA, 2018] Analgesic Stewardship programs facilitate the appropriate use and review of analgesics to optimise patient outcomes and reduce the potential for analgesic-related harm. [ACSQHC, 2021b] Like other stewardship programs, an Analgesic Stewardship program includes structured approaches to governance and accountability, policy, education, monitoring and improvement activities. [Bui, 2021] The benefits of Analgesic Stewardship programs include reducing the incidence/potential for opioid related harm and reducing healthcare and economic costs associated with inappropriate opioid analgesic use. [ACSQHC, 2021b]The Australian Commission on Safety and Quality in Health Care launched the Opioid Analgesic Stewardship in Acute Pain Clinical Care Standard (the Standard) in April 2022 that described the key components of care that patients can expect when they are prescribed opioid analgesics for acute pain in acute care settings. It contains quality statements describing the care that should be provided and a set of indicators to support monitoring and quality improvement. A formal analgesic stewardship program provides consistent leadership and oversight for appropriate opioid use to support organisational compliance with the Standard and ensure better patient outcomes. |

#  Program aim

## Program aim

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| *Example: What is the overall aim of the Analgesic Stewardship Program?* |

## Program objective(s)

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|  *Example: What are specific and measurable goals that will be achieved by the program?* |

# Program approach

## Program scope

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|  *Example: Which areas will be targeted or governed by the program?* |

## Key milestones

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| **Stage / Phase** | **Milestones**  | **Activities / Dependencies** | **Timeframe** |
| **PLANNING/DESIGN** | Program Start | Program Lead confirmed |  |
| Research ethics for future publication(s) | Ethics application and research proposal completedSubmission of program lead information |  |
| Core elements of AGS planning | Planning of program team, including membership of an Analgesic Stewardship Committee (or component of an existing Committee) and nomination of at least one medical, pharmacy and nursing Analgesic Stewardship champion Measurement and reporting of agreed baseline analgesic stewardship KPIs to the Analgesic Stewardship Committee and hospital executiveDevelopment or endorsement of patient education materialsDevelopment or endorsement of clinician education materials Development or endorsement of organisational guideline/policy for opioid prescribing at discharge |  |
| Clinical Champion | Appoint medical champion for program |  |
| Intervention and scope planning | Determine potential interventions to address required practice changes indicated by baseline KPI measures Determine scope of interventions (eg. specific ward such as orthopaedics, surgical interns) |  |
| Point Prevalence Audit (PPA) of analgesic use | Planning, testing and conducting PPA across surgical units. Provides a snapshot of current analgesic prescribing practices to identify areas for improvement.  |  |
| Implement core elements | Establish regular Analgesic Stewardship Committee meeting schedule |  |
| Implement discharge guidelines, including promotion strategy |  |
| Establish schedule for planned clinician education |  |
| Implement patient communication resources, including promotion strategy |  |
| Establish schedule for regular monitoring of KPIs (presentation of PPA, reporting indicators) |  |
| Implement interventions | Proposed model/interventions accepted by key stakeholdersImplementation team identified and Plan-Do-Study-Act (PDSA) cycles commencing  |  |
| Qualitative / quantitative data obtained | Collection of intervention outcome measures using identified data sources |  |
| **MONITORING & REVIEW** | Evaluation of model of care  | Data collected and analysed with evaluation report |  |
| Progress reports | Progress reports to committee |  |
| **SUSTAINABILITY** | Sustainability plan | Development of sustainability plan |  |

# Measurement plan

## Family of measures / selected indicators from Clinical Care Standards

Define measures that will be used for baseline and ongoing monitoring of the AGS program. Suggested measures are listed below - health services may choose measures depending on local improvement priorities and available resourcing. Monitoring and reporting may be performed more frequently with initial implementation of interventions (e.g. fortnightly) or less frequently for established programs (e.g. quarterly).

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| **Measure type** | **Measure and operational definition** | **Frequency** |
| **Outcome** | % of opioid naïve surgical patients separated from hospital with a supply or prescription of opioid analgesics    | Fortnightly |
| % of opioid naïve surgical patients separated from hospital with a supply or prescription of modified release or long-acting opioid analgesics  | Fortnightly |
| Average quantity of immediate release opioid analgesics that surgical patients separated from hospital with (supply or prescription)  | Fortnightly |
| % overnight admitted surgical patients separated from hospital with a supply or prescription of immediate release opioid analgesics that exceeded the opioid analgesic inpatient dose given during the 24 hours prior to separation  | Fortnightly |
| **Process** | % of surgical medical, nursing and pharmacy staff that have completed education on opioid analgesics in acute settings\*  | Once |
| % of sites with evidence of a locally approved policy to support transfer of care of patients supplied or provided prescription opioid analgesics at discharge  | Once |
| % of sites with evidence of a local Analgesic Stewardship Committee  | Once |
| % of admitted surgical 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.  | Fortnightly |
| % of admitted surgical patients separated from hospital with a supply or prescription of opioid analgesics where the supply or prescription exceeded seven days of treatment.  | Fortnightly |
| % 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.  | Fortnightly |
| **Balancing** | % of surgical 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.   | Fortnightly |
| % of surgical patients separated from hospital with a supply or prescription of opioid analgesics who also received a supply or prescription of gabapentinoids  | Fortnightly |

\* For example, the High Risk Medicines online education module, “Opioid Analgesics in Acute Settings”, available at <https://hrmeducation.health.gov.au/>

# Program organisation

## 5.1 Governance and program management

## Roles and responsibilities

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| --- | --- | --- |
| **Name**  | **Program Role** | **Program Responsibilities** |
|  | Program Lead | Responsible for delivering the program on time and to quality. Ensures risks are managed and issues are resolved. Coordinates the day-to-day delivery of program tasks and activities, reporting requirements and overall program management at the health service. |
|  | Medical Champion | A specialist clinician who provides expert opinion on pain management and can influence analgesic practices for the health service.Provides the Program Lead with clinical support and guidance to identify and deliver AGS initiatives within the scope of the AGS program at the health service. |
|  | Hospital executive sponsor | To provide executive sponsorship to the AGS program and assist in making AGS a strategic goal of the healthcare organisation. |
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## Program Capability

Identify the knowledge and skills of your program team and outline any specific gaps in these skills that will need to be addressed.

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# Stakeholder engagement and communications plan

Identify each stakeholder group and determine objectives, method, frequency and deliverable of the communication plan. For broader stakeholder group, consider the use of social media. Remove / add rows as necessary.

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| **Stakeholder Group** | **Objective of communication / stakeholder needs** | **Method of communication** | **Frequency / date** | **Responsibility** | **Outcome** |
| *Program Team* | *Decision making and program design*  | *Meetings / emails* | *Fortnightly in planning stage* | *Program Lead* | *Schedule of meetings developed**Documented meeting minutes*  |
| *Analgesic Stewardship Committee* | *Guide program interventions* | *Meetings / emails* | *Monthly* | *Program Lead* | *Terms of Reference endorsed* |
| *Pharmacy Department* |  |  |  |  |  |
| *Surgical Services* |  |  |  |  |  |
| *Emergency Services* |  |  |  |  |  |
| *Acute Pain Services* |  |  |  |  |  |
| *Clinicians* |  |  |  |  |  |
| *Patients* |  | *Face-to-face conversation with clinicians**Patient information brochures* | *Daily* | *Clinicians involved in care* |  |
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# Risk management / Risk Register Log

Consider key risks to the successful delivery of the program such as recruitment, key person dependency, staff capability, relocations, IT support, partnership etc. Add rows where necessary. See appendix for risk assessment criteria. Remove / add rows as necessary.

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| **Risk**  | **Description** | **Mitigation Strategy** | **Likelihood** | **Consequence** | **Risk Rating** | **Action** | **Status** |
| *Unable to engage with [stakeholder/s]* | *Key features of the program unable to be progressed or agreed upon* | *Ensure regular discussion and communication to establish responsibilities and commitment* | *Possible* | *Major* | High |  | Addressed |
| COVID restrictions | Key features of the program unable to be progressed or agreed upon | Ensure discussion and contingency plan | Unlikely | Major | High |  |  |
| Local approval processes for resources (eg. Guidelines) | Unable to implement core element relating to patient and clinician education | Use versions approved by Analgesic Stewardship Committee | Possible | Moderate | Medium |  |  |
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# Appendices

## Risk assessment criteria

SCV has provided risk assessment criteria below.

### 8.1 Consequence criteria

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| **Scale** | **Program Budget** | **Program Milestones** | **Program Outcomes** | **Program Quality** |
| **Catastrophic** | >10% budget impact requiringrevision to program plan andadditional funding required | Significant impact – need to reschedule program significantly. | Inability to achieve key programbenefits with significant impact onprogram success, program/programterminated | Critical quality issues with key deliverable(s), substantial loss of stakeholder confidence |
| **Major** | 5-10% budget impact withadditional funding required to maintain scope, quality andschedule | High impact – need an extension of program timeframes. | Major degradation of key programbenefits with substantial impacton program success | Major quality issues with key deliverable(s), impacting / delaying program |
| **Moderate** | 2-5% budget impact requiringrelease of contingency funding | Medium impact – can be managed in current schedule but significantly reduces buffer time built into schedule. | Impact on the achievement of anumber of key program benefitswith intervention required to meetall program benefits and potentialimpact on program success | Several quality issues with key deliverable(s) |
| **Minor** | > 2% budget impact absorbedwithin existing budget butrequires adjustment to fundingallocation | Small impact – can be managed within current buffer time built into schedule. | Inability to achieve some programbenefits with minimal impact onprogram success | Minor quality issues with key deliverable(s) |
| **Insignificant** | Budget impact easily absorbedwithin existing budget | Insignificant schedule change. | Insignificant benefit impact. | Insignificant impact to the quality of key deliverable(s) |

### Likelihood criteria

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| **Scale** | **Description** |
| Almost Certain | Expected to occur |
| Likely | Will probably occur |
| Possible | Capable of happening |
| Unlikely | Not likely, improbable |
| Rare | Occurring very infrequently |

### Risk rating criteria

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| **Risk Rating Matrix** | **Likelihood Scale** |
| Rare | Unlikely | Possible | Likely | Almost Certain |
| **Consequence** | Catastrophic | High | High | High | High | High |
| Major | Medium | High | High | High | High |
| Moderate | Low | Medium | Medium | High | High |
| Minor | Low | Low | Medium | Medium | Medium |
| Insignificant | Low | Low | Low | Low | Low |

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