Opioid Prescribing in Palliative Head and Neck Cancer Patients

Dr Greig Torpey [1] *Dr Fiona Finlay* [1,2]
[1] NHS Greater Glasgow and Clyde
[2] University of Glasgow

Abbreviated abstract: An overview of the impact that a hospital palliative care team have in ensuring adequate opioid analgesic pain control in twenty palliative head and neck cancer patients.
Using a gold standard of prescribing guided by SPCG, it determined that ward-based doctors achieved 20% adequate analgesia, and the palliative care team improved this to 45%.
It will highlight common pitfalls and describe a range of proposed interventions aiming to improve prescribing by both groups, leading to improved pain control.

Related publications:

– *NHS Scotland*, Scottish Palliative Care Guidelines – Choosing and Changing Opioids (2019)

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G.torpey@nhs.net - 1

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Previous work and challenge

There is limited literature addressing the accuracy of opioid prescribing in palliative care patients in general, however there are clear Scottish Palliative Care guidelines describing the current best practice for choosing and changing opioids.

Palliative head and neck cancer patients regularly require complex pain management, including opioids, however it was unclear whether the patients were receiving the best possible care.

The ear, nose and throat team at the QEUH in Glasgow sees a disproportionately large number of palliative patients compared to many hospitals, and this gives an excellent opportunity to analyse and improve our prescribing.

If we can achieve adequate opioid analgesia at the earliest possible opportunity, then in theory patients should receive better care earlier in their disease.

Approach and Methods

This audit looked at the number of patients receiving adequate analgesia (simple analgesia and opioids) as per our gold standard, initially that prescribed by the ward-based doctors and then after the hospital palliative care team had reviewed them.

Patients included in the data were those with MDT determined head and neck cancer, who had subsequently been referred to the hospital palliative care team.

Following specific, strict guidelines drafted from the Scottish Palliative Care Guidelines, the appropriateness of the prescribing was then determined. This included

- Whether pain level was documented in the notes
- If the opioid was suitable for the eGFR
- If the as required dosing was a suitable ratio to the regular dose
- If there was a maximum as required dose in 24 hours before further medical review
- If the route was appropriate to the patient.

Results and Conclusions

There was room for significant improvement from the ward- based doctors prescribing practice, with only 20% of patients audited achieving the gold standard, and was suboptimal by the hospital palliative care team, where the they only achieved 45% of patients attaining the gold standard.

Proposed Interventions:

- Opioid prescribing teaching to all ward-based doctors at the start of their rotation
- Enabling nursing stuff to recognise poor prescribing through education, and then empowering them to highlight this to medical staff
- Creating a checklist to be used by ward-based doctors for patients with terminal head and neck cancer, in advance of palliative care team review.

Key Take-Home Message: In order to achieve gold-standard opioid prescribing in >90% of patients, both ward-based doctors and the hospital palliative care team must work together, receive suitable education, and utilise novel ideas to attempt to improve prescribing.

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G.torpey@nhs.net - 4

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