MODULE 1: ASSESSMENT AND TREATMENT PLANNING

Indicators of best practice

1. Comprehensive assessment of patient undertaken
2. Treatment choice and setting was informed by clinical factors, including patient safety and patient preferences/goals
3. Comprehensive individualised treatment plan developed, in collaboration with the patient
4. Discussed driving risk during induction and stabilisation
5. Discussed risks with using multiple sedating medicines / substances
6. Provided education about minimising risk of overdose and use of take-home naloxone
7. Obtained patient consent after informing the patient of side effects, the risks associated with the OTP and the challenges associated with withdrawal off the OTP.

Notes

- Complete the self-audit for a random 10% sample (or at least 5 patients) being prescribed opioid agonist treatment.
- Use one audit form per patient record.
- Select the most appropriate options on the audit form based on what is **documented** in the patient records.
- Set targets to reach for each indicator (best practice is 100%)
- Calculate the results of the self-audit and develop an action plan to address identified gaps.
- Complete a follow up self-audit to measure the impact of the action plan.

Module 1: Assessment and treatment planning

Complete self-audit questions based on what is documented on the patient records, usually within the first 4 weeks of initiation of treatment. While treatment planning occurs at the start of a therapeutic relationship, it should be undertaken at every opportunity, as patient needs and goals will change during treatment.

Patient initials: _____ Date of Birth: _ _ / _ _ / _ _ _ _

Prescriber name: _____ Audit date: _ _ / _ _ / _ _ _ _

Auditor name/s: _____

1.1 Prior to initiation of treatment, case formulation included documented assessment of:

1.1.1 Reason for presenting	☐ Yes	☐ No	1.1.7 Medication review	☐ Yes	☐ No
1.1.2 Substance use history[A]	☐ Yes	☐ No	1.1.8 Physical state examination[C]	☐ Yes	☐ No
1.1.3 Prior treatments for substance use	☐ Yes	☐ No	1.1.9 Mental state examination[D]	☐ Yes	☐ No
1.1.4 Comorbid medical conditions	☐ Yes	☐ No	1.1.10 Initial treatment plan	☐ Yes	☐ No
1.1.5 Comorbid mental health conditions	☐ Yes	☐ No	1.1.11 Investigations (inc. baseline UDS)	☐ Yes	☐ No
1.1.6 Comorbid psychosocial conditions[B]	☐ Yes	☐ No			

[A] including current substance use, route of administration, and time of last use, and history of harms from substance use including overdoses

[B] including social problems and high-risk behavior

[C] including injection sites, intoxication and withdrawal

[D] including risk of harm to self/others

1.2 Treatment planning considered

1.2.1 Use of other substances, and risks and complications of use (including dependence, overdose, psychosis)	☐ Yes	☐ No	☐ N/A
1.2.2 Medical conditions (e.g. chronic pain, HIV, acute and chronic medical conditions)	☐ Yes	☐ No	☐ N/A
1.2.3 Psychiatric conditions	☐ Yes	☐ No	☐ N/A
1.2.4 Pregnancy	☐ Yes	☐ No	☐ N/A
1.2.5 Cognitive impairment	☐ Yes	☐ No	☐ N/A
1.2.6 Social circumstances[E]	☐ Yes	☐ No	☐ N/A

[E] consider housing, domestic and family violence, family/friends/partner who may be using drugs, children living with them and / or Dept. of Communities and Justice involvement, employment, residential location.

1.3 A detailed treatment plan was:

1.3.1 Documented	☐ Yes	☐ No
1.3.2 Developed in collaboration with the patient	☐ Yes	☐ No

1.4 Documented discussion and review of risks associated with the opioid agonist treatment (OAT) included:

1.4.1 Challenges associated with withdrawing from treatment	☐ Yes	☐ No
1.4.2 Side effects of treatment	☐ Yes	☐ No
1.4.3 Impairment of driving ability during induction or switching treatment	☐ Yes	☐ No

1.5 Education about overdose risk included documented discussions about:

1.5.1 Intentional or accidental use of OAT by a person for whom not prescribed (e.g. children)	☐ Yes	☐ No
1.5.2 Increased risks of overdose following withdrawal	☐ Yes	☐ No
1.5.3 Increased risk of overdose if combining OAT with other sedating substances	☐ Yes	☐ No
1.5.4 When and how to use naloxone and provision of prescription or referral to obtain take home naloxone	☐ Yes	☐ No

1.6 Has patient consent been documented following a discussion about risks and treatment expectations?

☐ Yes ☐ No

Results table (use this template to record results following data collection)							
Indicator	**Meets the indicator if**	**Y/N Pt 1**	**Y/N Pt 2**	**Y/N Pt 3**	**Y/N Pt 4**	**Y/N Pt 5**	**Total Y (%)**
1. Comprehensive assessment of patient undertaken	Q1.1 all 'Yes'						
2. Treatment choice (and setting) was informed by clinical factors, including patient safety and patient preferences/goals	Q1.2 all 'Yes' or 'N/A'						
3. Comprehensive individualised treatment plan developed, in collaboration with the patient	Q1.3 all 'Yes'						
4. Discussed driving risk during induction and stabilisation	Q1.4.3 is 'Yes'						
5. Discussed risks with using multiple sedating medicines / substances	Q1.5.3 is 'Yes'						
6. Provided education about minimising risk of overdose and use of take-home naloxone	Q1.5 all 'Yes'						
7. Obtained patient consent after informing patient of side effects, challenges associated with withdrawal off OTP and risks associated with OTP	Q1.6 is 'Yes'						

Action plan (use this template to plan actions to address gaps and record dates of completion)		
Indicators where less than target 100% achieved	**Planned actions to address gap**	**Date actions completed**

Re-audit: Following action plan completion, conduct another self-audit, eg after 3 months and compare the results.