MODULE 3: TREATMENT MONITORING AND UNSUPERVISED DOSING

Indicators of best practice

1. Regular clinical review based on treatment needs (by prescriber, nurse or allied health)
2. Regular medical review based on treatment needs
3. Reviewed at least every 3 months (following induction)
4. There is evidence of multidisciplinary team involvement in patient care, including regular contact with dosing points, and other treatment providers e.g. medical practitioners, case workers and pharmacists
5. When switching therapies, followed guideline recommendations for doses
6. Acted on evidence of intoxication, or missed doses to ensure safety
7. Unsupervised (takeaway) doses prescribed in accordance with guideline recommendations* and regularly reviewed to ensure continued safety
8. Tailored and coordinated psychosocial support including interventions to address use of other drugs and alcohol, and/or mental health problems if applicable
9. Discussed long-term goals of OTP and provided information and planning if goal is to withdraw from OTP
10. Cessation of OAT involved psychosocial support, gradual reduction in dose and continuing support, noting the risk of relapse or overdose
11. Regular discussions concerning safety, including driving safety and secure storage of any unsupervised doses and responding to an overdose

*variations must be clinically justified and documented in patient notes

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. Only one results sheet is required per self-audit cycle.
- Complete a follow up self-audit to measure the impacts of your action plan.

Module 3: Treatment monitoring and unsupervised dosing

Complete the questions based on patient records once a relatively stable dose has been achieved (usually after 3 months). This module focusses on ongoing treatment monitoring, prescriber reviews, and prescribing of unsupervised doses.

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

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

Auditor name/s: _____

3.1 According to clinical complexity, this patient has:

- ☐ High treatment needs ***[go to 3.2]***
- ☐ Moderate treatment needs ***[go to 3.3]***
- ☐ Low treatment needs ***[go to 3.4]***

3.2 You consider this patient to have high treatment need. Documented reviews included:

3.2.1 Clinical review at least once a month	☐ Yes	☐ No
3.2.2 Medical review at least every 2 months	☐ Yes	☐ No
3.2.3 Comprehensive treatment review at least every 3 months ***[go to 3.5]***	☐ Yes	☐ No

3.3 You consider this patient to have moderate treatment needs. Documented reviews included:

3.3.1 Clinical review at least every 2 months	☐ Yes	☐ No
3.3.2 Medical review at least every 3 months	☐ Yes	☐ No
3.3.3 Comprehensive treatment review at least every 6 months ***[go to 3.5]***	☐ Yes	☐ No

3.4 You consider this patient to have low treatment needs. Documented reviews included:

3.4.1 Clinical review at least every 3 months	☐ Yes	☐ No
3.4.2 Medical review at least every 6 months	☐ Yes	☐ No
3.4.3 Comprehensive treatment review at least every 6 months ***[go to 3.5]***	☐ Yes	☐ No

3.5 During reviews, is there documented discussions about the patient's long-term goals, including providing advice if the patient's goal is to withdraw from OTP?

☐ Yes ☐ No

3.6 The following multidisciplinary team members were engaged proactively in coordinating patient care:

3.6.1 Nurse practitioners / Clinical Nurse Consultants	☐ Yes	☐ No	☐ N/A
3.6.2 Dosing point / pharmacy	☐ Yes	☐ No	☐ N/A
3.6.3 Other medical practitioners involved in the care of the patient, eg, GP and specialist	☐ Yes	☐ No	☐ N/A
3.6.4 Allied health services	☐ Yes	☐ No	☐ N/A

3.7 Is there evidence of assessment and coordination of psychosocial support to address the individual needs of the patient?

☐ Yes ☐ No ☐ N/A

3.8 If transferred between methadone, s/l buprenorphine and depot buprenorphine, was it done in accordance with NSW OAT clinical guidelines?

☐ Yes ☐ No ☐ N/A

3.9 Where there was documentation of intoxicated presentations, were there actions taken to ensure safety?

☐ Yes ☐ No ☐ N/A

3.10 Following a risk assessment concerning unsupervised ('take away') doses, including the ability to store doses safely, the patient's risk was documented as:

3.10.1 ☐ High risk ***[go to 3.11]***

3.10.2 ☐ Moderate risk ***[go to 3.12]***

3.10.3 ☐ Low risk ***[go to 3.13]***

3.10.4 ☐ No documented risk ***[go to 3.14]***

3.11 Guidelines recommend no takeaway doses for patients at high risk except in special circumstances. Does the patient record reflect this?

☐ Yes ☐ No ☐ No, but addiction specialist consulted ***[go to 3.14]***

3.12 Guidelines recommend up to 2 unsupervised methadone doses or up to 4 unsupervised buprenorphine / buprenorphine-naloxone doses a week for patients at moderate risk. Does the patient record reflect this?

☐ Yes ☐ No ☐ No, but addiction specialist consulted ***[go to 3.14]***

3.13 Guidelines recommend up to 4 unsupervised doses of methadone or buprenorphine a week, and up to 1-4 weeks of buprenorphine-naloxone for patients at low risk. Does the patient record reflect this?

☐ Yes ☐ No ☐ No, but addiction specialist consulted

3.14 Is there documentation of a structured safety review at least every 3 months and included review of unsupervised dosing arrangements (inc. secure storage), UDS, responding to overdose and driving risk assessment?

☐ Yes ☐ No

3.15 When planning for the cessation of OAT[A], there was documented discussions about:

3.15.1 The process for withdrawal and patient engagement in decision-making	☐ Yes	☐ No	☐ N/A
3.15.2 Gradual dose taper over months, vs rapid reductions (days/weeks) or sudden cessation	☐ Yes	☐ No	☐ N/A
3.15.3 Psychosocial support addressing coping strategies, risk behaviours, support systems	☐ Yes	☐ No	☐ N/A
3.15.4 Regular reviews of progress & plans	☐ Yes	☐ No	☐ N/A
3.15.5 Continuing care / monitoring after ceasing OAT, due to risk of relapse and overdose risk (as tolerance decreases)	☐ Yes	☐ No	☐ N/A

[A] most patients take at least 1-2 years to achieve stability that optimises the chances of successful cessation

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. Regular clinical review based on treatment needs (by prescriber, nurse or allied health)	Q3.2.1, Q3.3.1 or Q3.4.1 is 'Yes'						
2. Regular medical review based on treatment needs	Q3.2.2, Q3.3.2 or Q3.4.2 is 'Yes'						
3. Reviewed at least every 3 months (following induction)	'Yes' to ANY for Q3.2 Q3.3.1 or Q3.3.2 is 'Yes' Q3.4.1 is 'Yes'						
4. There is evidence of multidisciplinary team involvement in patient care, including regular contact with dosing points, and other treatment providers e.g. medical practitioners, case workers and pharmacists	Q3.6 all 'Yes' or 'N/A'						
5. When switching therapies, followed guideline recommendations for doses	Q3.8 is 'Yes' or 'N/A'						
6. Acted on evidence of intoxication, or missed doses to ensure safety	Q3.9 is 'Yes' or 'N/A'						
7. Unsupervised (takeaway) doses prescribed in accordance with guideline recommendations* and regularly reviewed to ensure continued safety	Q3.10.1 or Q3.10.2 or Q3,10.3 AND Q3.11 or Q3.12 or Q3.13 is 'Yes' or 'No, but addiction specialist consulted'						
8. Tailored and coordinated psychosocial support including interventions to address use of other drugs and alcohol, and/or mental health problems if applicable	Q3.7 is 'Yes' or 'N/A'						
9. Discussed long-term goals of OTP and provided information and planning if goal is to withdraw from OTP	Q3.5 is 'Yes'						
10. Cessation of OAT involved psychosocial support, gradual reduction in dose and continuing support, noting the risk of relapse or overdose	Q3.15 all 'Yes' or 'N/A'						
11. Regular discussions concerning safety, including driving safety and secure storage of any unsupervised doses and responding to an overdose	Q3.14 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.