7. Uncontrolled pain emerging care bundle

7.1. Background

Patients in acute settings frequently report uncontrolled pain.[7] Such pain can negatively affect a patient's health care experience and lead to poor clinical outcomes.[8] Additional efforts are needed to address uncontrolled pain.[9]

7.1.1. Care bundle elements

The elements in this care bundle seek to reduce uncontrolled pain in patients to whom opioids are prescribed and administered (Table 7.1.1).

Table 7.1.1: Care bundle elements for uncontrolled pain

Element	Care bundle elements – uncontrolled pain
One *See 7.2*	Provide patients/consumers and families/whānau with information about opioid use for optimum pain management, in formats appropriate to their needs.
Two *See 7.3*	When prescribing and administering opioids, use pain medication dosing guidelines to determine the appropriate route of administration and to optimise pain management.
Three *See 7.4*	Monitor and document pain behaviours/indicators, and effectiveness of any actions taken, using evidence-based guidelines and methods.

[7] E Manias, T Bucknall, M Bott. 2005. Nurses' strategies for managing pain in the postoperative setting. *Pain Management Nursing* 6: 18–29.

[8] F Perkins, H Kehlet. 2000. Chronic pain as an outcome of surgery. *Anesthesiology* 93: 1123–33.

[9] J Apfelbaum, C Chen, S Mehta, T Gan. 2003. Postoperative pain experience: results from a national survey to suggest postoperative pain continues to be undermanaged. *Anesthesia & Analgesia* 97: 534–40.

Four *See 7.5*	Offer regular analgesia and, where pain is not relieved, offer additional analgesia (with attention to patient safety as well as comfort).
Five *See 7.6*	Regularly educate staff about pain management and opioid use. Education includes assessment of knowledge and skills, educational intervention/s and reassessment.

7.1.2 Outcome measure for uncontrolled pain

Table 7.1.2 describes the outcome measure for use with the care bundle designed to reduce uncontrolled pain.

Table 7.1.2: Uncontrolled pain care bundle outcome measure

Measure	Formula	Operational definitions	Exclusions	Population
Percentage of patients prescribed an opioid that have uncontrolled pain	**Numerator:** Total number of patients prescribed an opioid that have uncontrolled pain **Denominator:** Total number of patients who have an opioid prescribed	**Uncontrolled pain**: ≥2 consecutive pain scores of ≥7/10 (or ≥3/5) in 24 hours **Opioid:** All opioids (strong and weak, including but not limited to: morphine, oxycodone, fentanyl, pethidine, methadone, tramadol, dihydrocodeine, codeine); includes regular and/or PRN opioids **Prescribed:** In practice, authorised an order to supply or administer a substance used or capable of being used to prevent, treat or palliate a disease, or the symptoms or effects of a disease for the purpose of clinical treatment of a patient under the authorising person's care	Nil	Age 12 years and over admitted to a hospital inpatient area

7.2. Element One

Provide patients/consumers and families/whānau with information about opioid use for optimum pain management, in formats appropriate to their needs.

7.2.1. Background

Patients report that they are often not given adequate information about pain control measures despite wanting to be informed.[10] Generally, patient-focused interventions that engage patients actively in their care can have a beneficial effect on patient experience and health status; this includes the use of written materials to improve health literacy.[11] Data on the effectiveness of patient education in pain management is limited. However, given that research shows patient attitudes and beliefs modify their pain perceptions and analgesic requirements, patient and carer education can positively influence the outcome of acute pain management.[12]

7.2.2. Provide information to patients/consumers and families/whānau about opioid use

In an effort to reduce uncontrolled pain and improve patient experience, teams involved in the safe use of opioids national collaborative focused on improving health literacy and supporting patient self-management (Table 7.2.2).

[10] D Taylor, S Loh, K Mulligan, et al. 2010. Management of acute postoperative pain in Australian hospitals: room for improvement. *Journal of the Australasian Association for Quality in Health Care* 20: 29–36.

[11] A Coulter, J Ellins. 2007. Effectiveness of strategies for informing, educating, and involving patients. *British Medical Journal* 335: 24–27.

[12] Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists. 2013. *Guidelines on Acute Pain Management*. Melbourne: Australian and New Zealand College of Anaesthetists.

Table 7.2.2: Purpose, change ideas and lessons learned in relation to improving health literacy and supporting patient self-management

What	How	Lessons learned

Provide patient-centric education using standardised information for consistent messaging	• Provide information in a simple, visually appealing, easy-to-read format.
	• Use a process for staff to routinely converse with patients about their pain.
	
	Resource produced during the collaborative:
	
	Waitemata DHB Patient Information Leaflet
	
	Consider equity and cultural appropriateness.
		• Following co-design principles in developing resources (where patients/consumer advocates partnered with clinical staff – interdisciplinary team) resulted in more useful resources.
		• Challenges were to:
		  ○ present sometimes technically complex language in a simple-to-understand format
		  ○ distribute the completed resource
		  ○ make staff conversations part of routine care
		  ○ measure improvement in patient experience.

Empower patients to 'speak up' when in pain or if experiencing adverse drug events to help with timely management of pain and adverse drug events	• Use a message to give patients 'permission' to ask for help: 'Please let staff know if you are in pain. No matter how busy we seem, you are important to us.'	• Barriers that patients reported included: not wanting to bother busy staff, fear of opioid addiction, expectation that negative experiences are a natural part of disease and recovery processes, and poor understanding of the benefit of or need for analgesics.

7.2.3. Measurement to support Element One

Table 7.2.3 describes the process measure for use with Element One in the uncontrolled pain care bundle.

Table 7.2.3: Process measure for Element One in the uncontrolled pain care bundle

Measure	Formula	Operational definition	Exclusion	Population
Percentage of patients/consumers and families/ whānau provided with information  *When providing patients with information, document in the clinical record:* ***what was given, who got it, who gave it and when.***	**Numerator:** Total number of patients/consumers and families/whānau who received information **Denominator:** Total number of patients who have an opioid prescribed	**Family/whānau:** Includes any family member, friend or caregiver who is supporting the patient during their inpatient stay; the information is provided so the support person can help the patient to: 1) identify/report any opioid-related harms; 2) self-manage those harms if they occur; and 3) optimise pain management by encouraging use of different analgesia options when appropriate **Information:** Explanation about what opioids are, the different types of opioids, their use as analgesics and side effects **In formats appropriate to their needs:** Information needs to be tailored to the patient to optimise their understanding. Information should be provided to patients in a format that suits their level of literacy and preference, such as patient leaflet, one-on-one discussion or video **Opioid:** All opioids (strong and weak, including but not limited to: morphine,	The patient is not in a state to receive or understand the information and the family/whānau is unavailable	Age 12 years and over admitted to a hospital inpatient area, or their support person

Measure	Formula	Operational definition	Exclusion	Population
		oxycodone, fentanyl, pethidine, methadone, tramadol, dihydrocodeine, codeine); includes regular and/or PRN opioids **Prescribed:** In practice, authorised an order to supply or administer a substance used or capable of being used to prevent, treat or palliate a disease, or the symptoms or effects of a disease for the purpose of clinical treatment of a patient under the authorising person's care  ***Consider equity and cultural appropriateness.***		

7.2.4. Template

Refer to Appendix 1 for the measurement template to use with this care bundle.

7.2.5. Tips

- ✓ Develop a reliable process for providing information to patients/consumers and families/whānau.
- ✓ When developing patient information, please refer to the Ministry of Health's guide to developing health information resources, www.health.govt.nz/publication/rauemi-atawhai-guide-developing-health-education-resources-new-zealand.

7.3. Element Two

When prescribing and administering opioids, use pain medication dosing guidelines to determine the appropriate route of administration and to optimise pain management.

7.3.1. Background

Effective treatment of acute pain is a fundamental component of quality patient care.[13] Guidelines to enhance patient outcomes and standardise analgesic techniques and choice of equipment may lead to consistency of practice. This can potentially improve patient safety and analgesic efficacy. These guidelines should be evidence-based wherever possible.[14]

7.3.2. Use appropriate opioid dose and route

In an effort to reduce uncontrolled pain and improve patient experience, teams involved in the safe use of opioids national collaborative focused on improving opioid prescribing (most appropriate dose and route of administration) (Table 7.3.2).

Table 7.3.2: Purpose, change ideas and lessons learned in relation to improving prescribing

What	How	Lessons learned
Provide staff with standardised guideline (appropriate dose and route)	• Develop and produce local Acute Pain Opioid Prescribing Guidelines. • Disseminate the guidelines and continue to evaluate their efficacy.	• Sometimes staff chose the lower end of the guidelines' prescribed dose when a dose on the higher end of the dosing range would have been more appropriate. This may have been due to lack of opioid knowledge.

[13] Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists. 2013. *Guidelines on Acute Pain Management.* Melbourne: Australian and New Zealand College of Anaesthetists.

[14] SA Schug, GM Palmer, DA Scott, et al. 2015. *Acute Pain Management: Scientific Evidence, Fourth Edition 2015*. Melbourne: Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine.

	• Deliver key messages in an easily accessible, easy-to-use format – for example, on a lanyard.	• The guidelines may have supported an increase in the mean oral morphine dose and a reduction in the use and dose of intravenous morphine. • Anecdotally prescribers, nurses and physiotherapists have found the guidelines useful for more appropriate opioid dose selection.

7.3.3. Measurement to support Element Two

Table 7.3.3 describes the process measure for use with Element Two in the uncontrolled pain care bundle.

Table 7.3.3: Process measure for Element Two in the uncontrolled pain care bundle

Measure	Formula	Operational definition	Exclusion	Population
Percentage of opioid prescriptions that have been prescribed according to the relevant dosing guideline	**Numerator:** Total number of opioid prescriptions that have been prescribed according to the relevant guideline for the specific indication **Denominator:** Total number of opioid prescriptions	**Prescribing**: In practice, authorising an order to supply or administer a substance used or capable of being used to prevent, treat or palliate a disease, or the symptoms or effects of a disease for the purpose of clinical treatment of a patient under the authorising person's care **Administering:** Giving a medicine to a patient; this includes self-administration by the patient **Opioids:** All opioids (strong and weak, including but not limited to: morphine, oxycodone, fentanyl, pethidine, methadone,	A patient with a clinical condition not explicitly covered by the guidelines	Age 12 years and over admitted to a hospital inpatient area

Measure	Formula	Operational definition	Exclusion	Population
		tramadol, dihydrocodeine, codeine); includes regular and/or PRN opioids **Pain medication:** Specifically, opioids **Dosing guidelines:** An approved document that includes information on the appropriate dose, route of administration, frequency and anticipated duration of treatment for different indications **Optimise pain management:** Make a patient's experience of pain a favourable one, including their prior expectation, their actual pain and their ability to function at a level that would be expected in their situation without adverse effects		

7.3.4. Template

Refer to Appendix 1 for the measurement template to use with this care bundle.

7.3.5. Tip

✓ Make guidelines accessible and user friendly for the doctors and nurses who use them.

7.4. Element Three

Monitor and document pain behaviours/indicators, and effectiveness of any actions taken, using evidence-based guidelines and methods.

7.4.1. Background

Reliable and accurate assessment of acute pain is necessary for safe and effective pain management. Assessing and measuring pain is fundamental to the process of diagnosing the cause of a patient's pain, selecting an appropriate analgesic therapy and evaluating then modifying that therapy according to the individual patient's response.[15] Assessing pain both at rest and when the patient is mobile is important. Visual analogue scales are one method of assessing pain and are most useful in the acute pain setting, but other pain indicators are also important, particularly in patients with cognitive impairment or in non-acute pain.[16] Effective management of acute pain depends on formal protocols and guidelines covering acute pain management that are relevant to each institution, as well as on formal quality assurance programmes to regularly evaluate its effectiveness.[17]

7.4.2. Monitor and document pain behaviours/indicators

In an effort to reduce uncontrolled pain and improve patient experience, teams focused on improving the routine monitoring of pain and complications, and improving the documentation of pain behaviours/indicators (Table 7.4.2). The teams were working on acute pain management. Management of chronic and other types of pain would require different indicators.

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[15] SA Schug, GM Palmer, DA Scott, et al. 2015. *Acute Pain Management: Scientific Evidence, Fourth Edition 2015.* Melbourne: Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine.

[16] H Breivik, HC Borchgrevink, SM Allen, et al. 2008. Assessment of pain. *British Journal of Anaesthesia* 10: 17–24.

[17] Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists. 2013. *Guidelines on Acute Pain Management*. Melbourne: Australian and New Zealand College of Anaesthetists.

Table 7.4.2: Purpose, change ideas and lessons learned in relation to improving routine monitoring and documentation

What	How	Lessons learned

Improve routine monitoring for pain and effectiveness of any treatment provided to reduce pain	• Emphasise the importance of routine pain assessment and documentation through a combination of approaches to increase awareness and provide reminders, such as:
	  ○ senior leaders, management staff, ward champions and pain team going on walk-a-rounds
	  ○ actively asking ward staff about pain management and progress
	  ○ providing dedicated ward space to show and regularly feed back audit results and ideas being tested.
	• Introduce nursing champions to help drive behaviour.
	• Identify senior nursing staff to champion the new process so that the change idea is sustainable.
		• By actively asking ward staff about pain management and progress, senior leadership and management staff showed their interest and emphasised the project's importance.
		• Having dedicated ward space to show and regularly feed back audit results and ideas being tested helped ward staff to keep aware of what was being done and to recognise and appreciate the value of their work.
		• Anecdotal evidence suggests that, even though pain was being routinely monitored and care was not compromised, staff did not always document it. However, knowing that pain scores were being audited, staff retrospectively documented scores, some of which may not necessarily be the actual score.
		• Nursing champions can drive change in behaviour.
		• Good communication and awareness were necessary for the champions to work effectively.
		• Administration time was not allocated and should be considered in the future.
		• This change idea generated a lot of discussion among the nursing staff and consequently they became more engaged.

What	How	Lessons learned
Reassess and document pain scores at 60 minutes after administration of opioids	• Use hourly rounding to introduce a structured and visible framework to support reassessment of pain. • Standardise documentation on the adult observation chart to show trending and visibility. • Use an hourly rounding snapshot survey with a mix of validated questions, including observational and direct questions.	• Nurses surveyed agreed that intentional rounding helped with reassessment and documentation.

7.4.3. Measurement to support Element Three

Table 7.4.3 describes the process measure for use with Element Three in the uncontrolled pain care bundle.

Table 7.4.3: Process measure for Element Three in the uncontrolled pain care bundle

Measure	Formula	Operational definition	Exclusion	Population
Percentage of patients prescribed an opioid who have had pain behaviours/indicators monitored and documented	**Numerator:** Total number of patients prescribed an opioid who have had pain behaviours/indicators documented according to local guidelines and methods	**Monitor pain behaviours/indicators:** Assess or measure pain behaviours and indicators; the type and frequency of measurement should be based on local guidelines that are evidence-based; these may include: distorted movement, affective distress, facial/audible expressions, seeking help; verbal feedback from patients	Nil	Age 12 years and over admitted to a hospital inpatient area

Measure	Formula	Operational definition	Exclusion	Population
	Denominator: Total number of patients that have had an opioid prescribed	(that inform a functional pain score or equivalent) or non-verbal cues **Document pain behaviours/indicators:** Record pain behaviours/indicators in clinical documentation, or another approved inpatient record **Monitor and document effectiveness of any actions taken:** Monitor and document relevant clinical signs and symptoms that measure the impact of any therapeutic intervention used to manage uncontrolled pain (eg, monitor and document response to administered top-up analgesia) **Evidence-based guidelines and methods:** These include the use of monitoring protocols with adequate reliability as well as electronic and template-based methods of capturing uncontrolled pain history. A guideline or method (therapeutic intervention) that is supported by evidence which could be based on local expert opinion (lower-grade evidence) or, ideally, published literature (higher-grade evidence) **Opioid:** All opioids (strong and weak, including but not limited to: morphine, oxycodone, fentanyl, pethidine, methadone, tramadol,		

Measure	Formula	Operational definition	Exclusion	Population
		dihydrocodeine, codeine); includes regular and/or PRN opioids		

7.4.4. Template

Refer to Appendix 1 for the measurement template to use with this care bundle.

7.4.5. Tip

✓ Automated vital signs monitoring system and clinical decision support algorithms may support and enhance clinical practices.

7.5. Element Four

Offer regular analgesia and, where pain is not relieved, offer additional analgesia (with attention to patient safety as well as comfort).

7.5.1. Background

Pain is a subjective individual experience, affected by psychological and social factors, such as the site and nature of the injury, personality, age, gender, anxiety, understanding and cultural factors. Uncontrolled pain can have harmful physiological, psychological and emotional effects on an individual. Patients should be advised to prevent pain by taking analgesia regularly, rather than waiting for pain to occur and then taking analgesia, as this leads to the individual 'chasing the pain' rather than managing or controlling it.[18]

7.5.2. Provide analgesia in a timely and responsive way

In an effort to reduce uncontrolled pain and improve patient experience, teams focused on improving the routine administration of regularly prescribed analgesia (Table 7.5.2).

[18] J Gregory. 2014. Dealing with acute and chronic pain: part two – management. *Journal of Community Nursing* 28(5): 24–29.

Table 7.5.2: Purpose, change ideas and lessons learned in relation to improving the routine administration of regularly prescribed analgesia

What	How	Lessons learned

Routinely administer analgesia that is prescribed for administration on a regular basis, and provide timely treatment when pain is unrelieved	• Emphasise the importance of administering regularly prescribed analgesia by using a combination of approaches to increase awareness and provide reminders, such as:
	  ○ senior leaders, management staff, ward champions and pain team going on walk-arounds
	  ○ actively asking ward staff about pain management and progress
	  ○ providing dedicated ward space to show and regularly feedback audit results and ideas being tested.
	• Offer additional analgesia when pain unrelieved.
		• By actively asking ward staff about pain management and progress, senior leadership and management staff showed their interest and emphasised the importance of pain management.
		• Having dedicated ward space to show audit results and ideas being tested helped ward staff to keep aware of what people were doing on the project and to recognise and appreciate the value of their work.

7.5.3. Measurement to support Element Four

Table 7.5.3 describes the process measure for use with Element Four in the uncontrolled pain care bundle.

Table 7.5.3: Process measure for Element Four in the uncontrolled pain care bundle

Measure	Formula	Operational definition	Exclusion	Population
Percentage of patients offered regular analgesia, and analgesia when pain is not relieved	**Numerator:** Number of patients offered analgesia when pain met an unrelieved status **Denominator:** All patients prescribed an opioid who have at least one episode of uncontrolled pain	**Offer regular analgesia:** Active methods of engaging patients in discussions about their pain that include offering analgesia for uncontrolled pain **Regular:** No less than the frequency of prescribed regular analgesia **Where pain is not relieved:** A patient's pain is not relieved to the extent set out in the operational definition **Attention to safety and comfort:** Assessing and documenting a patient's comfort after giving analgesia to assure effectiveness and that the patient is safe (for example; respiratory status, sedation level if an opioid has been administered). **Opioid:** All opioids (strong and weak, including but not limited to: morphine, oxycodone, fentanyl, pethidine, methadone, tramadol, dihydrocodeine, codeine); includes regular and/or PRN opioids	Patients who refuse an intervention	Age 12 years and over admitted to a hospital inpatient area

7.5.4. Template

Refer to Appendix 1 for the measurement template to use with this care bundle.

7.5.5. Tip

✓ Automated vital signs monitoring system and electronic clinical decision support algorithms may support and enhance clinical practices.

7.6. Element Five

Regularly educate staff about pain management and opioid use. Education includes assessment of knowledge and skills, educational intervention/s and reassessment.

7.6.1. Background

Effective management of acute pain depends on close liaison with and education and training of all staff.[19] Appropriate education of medical and nursing staff is essential to managing more sophisticated forms of analgesia safely and effectively. Staff education may take several forms; the evidence for any benefit or the best educational technique is inconsistent.[20]

7.6.2. Educate staff about pain management and opioid use

In an effort to reduce uncontrolled pain and improve patient experience, teams focused on educating staff about pain management and opioid use (Table 7.6.2).

[19] Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists. 2013. *Guidelines on Acute Pain Management*. Melbourne: Australian and New Zealand College of Anaesthetists.

[20] SA Schug, GM Palmer, DA Scott, et al. 2015. *Acute Pain Management: Scientific Evidence, Fourth Edition 2015.* Melbourne: Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine.

Table 7.6.2: Purpose, change ideas and lessons learned in relation to educating staff about pain management and opioid use

What	How	Lessons learned
Improve staff knowledge	• Design a survey using Survey Monkey[21] to identify gaps in staff knowledge. • Provide short education sessions (15 minutes) at handover. Sessions can take the form of 'myth busters' with multi-choice questions to review commonly or easily misunderstood concepts. Discuss the answers with the group. • Provide staff with education, guidance resources and documentation standards for pain management. • Provide ward education on pain monitoring and life-threatening complications related to the use of intravenous patient-controlled analgesia or patient-controlled epidural analgesia. **Resources produced during the collaborative:** Waitemata DHB Agenda for Pain Study Day Waitemata DHB Pain Study Day Objectives Waitemata DHB e-Learning Module Introduction National Prescribing Service Pain Management Module	• Staff were discussing analgesia more often on the ward. • People needed significant prompting before they completed the survey. • Staff understanding of naloxone use was poorer than expected. Other DHBs conducting the same survey had very similar results, suggesting this finding is likely to be the same for many DHBs in New Zealand. • Staff often learn from experience and from other staff. • The majority of staff stated they would like more education. • Staff responded positively to short, targeted messages. • The sessions generated great discussions. • Student nurses on the wards also attended. • It was difficult to get everyone to attend. • The sessions needed to be repeated several times, which was labour intensive. • The education sessions were fun and interactive and clearly demonstrate the need for an integrated health system where different knowledge and skills come together to make improvements. • Through the process of developing the educational and guidance resource, clinicians from various disciplines had to

[21] www.surveymonkey.com

What	How	Lessons learned
	Waitemata DHB Staff Education Booklet Canterbury DHB Nurse Survey	critically reflect on existing practice and best practice and to recommend pragmatic guidelines (eg, time, resource, value added of suggested monitoring parameters). • The completed resource was particularly useful because, for the first time, the DHB had a single formal guidance resource that provided clear, standardised and practical instructions on pain management. • Developing the resource was complex and resource intensive. • Distributing the completed resource was a challenge. It was published online and printed copies were available. A communication and dissemination plan plus a structured educational programme would have made the resource more visible and led to its wider distribution among staff. • Comparing current knowledge among staff with what ward educators thought they knew provided insight into existing knowledge gaps. • Providing education on routine pain assessment and documentation helped to address and draw attention to what is expected. • The education sessions spurred staff to learn more about general pain management. Subsequently, more staff enrolled in the pre-existing pain management education programmes and online eLearning – pain management platform. • Evidence showed that routine pain monitoring and documentation practices improved significantly.

What	How	Lessons learned
		• Some staff may not have received the education due to differing shifts. Because of staff rotation and changes, education needs to be provided regularly. • To sustain the change idea, repeated reminders may be required.
Develop nursing leadership in ward	• Develop nurse champions. • Buddy experienced nursing staff with a nurse specialist to share learnings about effective pain management, promote the changes tested, raise the profile of pain management and provide support.	• Nursing staff were very receptive to peer buddying. • This change idea to increase individuals' knowledge and understanding was time consuming.

7.6.3. Measurement to support Element Five

Table 7.6.3 describes the process measure for use with Element Five in the uncontrolled pain care bundle.

Table 7.6.3: Process measure for Element Five in the uncontrolled pain care bundle

Measure	Formula	Operational definition	Exclusion	Population
Percentage of staff who had assessment and education completed annually	**Numerator:** Total number of staff on a ward/hospital assessed, provided with an educational intervention, and reassessed for opioid use and pain management (annually) **Denominator:** Total number of permanent staff, and non-permanent staff employed more than 30 days on a ward/hospital	**Regularly:** Annually at a minimum **Staff**: All prescribers, nurses, pharmacists and other allied health professionals involved in the prescribing, dispensing and administration of opioids **Knowledge and skills**: Includes knowledge of opioid use, pain management, related risks and risk reduction strategies and monitoring requirements related to pain **Educational intervention/s**: Electronic, paper-based or other teaching method **Assessment/reassessment:** Electronic or paper-based appraisal of knowledge **Opioid:** All opioids (strong and weak, including but not limited to: morphine, oxycodone, fentanyl, pethidine, methadone, tramadol, dihydrocodeine, codeine); includes regular and/or PRN opioids	Non-permanent staff employed 30 days or less	Permanent staff, and non-permanent staff employed more than 30 days

7.6.4. Template

Refer to Appendix 1 for the measurement template to use with this care bundle.

7.6.5. Tips

✓ Repeat education sessions regularly to sustain results.

7.7. Balancing measures

The suggested balancing measures for this bundle are:

- opioid-induced constipation
- opioid-induced ventilatory impairment.