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Healthcare professionals' views on opioid stewardship interventions in postoperative, opioid-naive patients: a qualitative service evaluation

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Introduction: Overuse of opioids has led to an opioid crisis.12 Opioid stewardship interventions have been developed in some countries. However, there are currently no uniform guidelines that can be used to implement opioid stewardship interventions in the United Kingdom. Prescribing opioids postoperatively is a key risk area of opioid use.12 To the best of our knowledge, no previous study has explored healthcare professionals’ (HCPs’) views on opioid stewardship interventions in postoperative, opioid-naive patients.

Aim: To explore hospital HCPs’ views on opioid stewardship interventions for postoperative patients who were not taking opioids before surgery.

Methods: Semi-structured interviews were conducted with pharmacists, doctors, and nurses in one National Health Service hospital trust as a service evaluation. Participants were recruited through purposive sampling and asked about their opinions on opioid stewardship interventions in postoperative, opioid-naive patients. Interviews were audio-recorded and transcribed verbatim. Data were analysed using inductive thematic analysis.

Results: Interviews were conducted with 3 doctors, 3 nurses and 4 pharmacists of diverse grades. All participants were involved in clinical opioid practice, with 9 responsible for elective surgery and 1 for trauma surgery. The main themes identified were HCPs’ knowledge and attitudes, decision-making processes, communication with patients, and discharge management.

In terms of HCPs’ knowledge and attitudes, most participants were unaware of opioid stewardship. However, during the interviews, the pharmacists used their knowledge of antimicrobial stewardship to help them conceptualise opioid stewardship. Most participants were unaware of the risks associated with opioid-naive patients. Although many available resources about opioid stewardship were identified by participants, they suggested that these were not used in practice.

Decision-making processes for opioid prescribing were reported as being heavily reliant on individual clinical judgment due to the absence of standardised guidelines. In addition, decisions were primarily made by anaesthetists rather than by the ward staff responsible for postoperative care. Shared decision-making with patients was limited, primarily occurring postoperatively.

Time limitations, complex medical information, and patients’ lack of knowledge about opioids were reported to hinder effective communication and information exchange between HCPs and patients. HCPs reported giving patients information verbally, with minimal use of educational materials.

In terms of discharge management, HCPs stressed the importance of providing clear and comprehensive information. After patients were discharged from the hospital, HCPs had no further contact with them or the primary healthcare system, leaving follow-up to GPs.

Conclusion: To the best of our knowledge, this is the first study to explore HCPs’ knowledge in postoperative opioid stewardship practice. Our findings suggest that although pharmacists have some knowledge of the concept of stewardship generally, many HCPs are unaware of opioid-naive patients’ risks, suggesting that more training...
may be needed. We identified the underutilisation of available resources and reliance on clinical judgment due to the lack of guidelines. Limited shared decision-making and communication challenges were also identified. This study was limited to a small number of participants in one hospital trust, which may compromise the generalisability and representativeness of our findings. Further work should include anaesthetists and other specialists, as well as patients and carers.

References