



Merseyside and Cheshire Palliative Care Network Audit Group

***PRESCRIBING OF TRANSDERMAL OPIOIDS IN  
PALLIATIVE CARE PATIENTS***



**Please complete a separate audit form for each patient seen within your branch of the service who is prescribed transdermal opioids for the period 01/10/2009 – 01/04/2010. The form can be completed electronically or by hand.**

**ICN:**                    **Setting:** Hospice Inpatient  Hospice OPD  Hospice Day Care   
Hospital Inpatient  Hospital OPD  Community

**Date of Assessment**                    **Sex:** Male  Female  **D.O.B.**                    **Diagnosis**

**1. Which Transdermal Opioid is the patient currently prescribed?**

FENTANYL  Dose

BUPRENORPHINE (BUTRANS)  Dose

BUPRENORPHINE (TRANSTEC)  Dose

**2a. Was this the patient's initially prescribed dose?** Yes  No  Don't Know

**2b. If No, what was the initially prescribed dose?** Not known/available

**2c. If known what was the date of the initial prescription?**

**Comments**

**3. Who was the original prescriber?** General Practitioner  Hospital Doctor

Palliative Care Specialist  Not Known  Other  (Please state)

**4. How would you classify the patient's pain?**

Pain related to cancer  Non-malignant pain  Not Clear

**Comments**

**5. Was the patient prescribed an opioid analgesic prior to commencement of the transdermal opioid?**

Yes  Go to question 6

No  Go to question 7

Don't know  Go to question 7

**Comments**

**6. What was the formulation and dose of opioid prescribed immediately prior to commencement of the transdermal opioid?**

Name of Strong Opioid

Name of Weak Opioid

Dose of Strong Opioid

Dose of Weak Opioid

**7a Does the patient have breakthrough medication prescribed?** Yes  No

**7b. If yes what medication is prescribed?**

**7c. What dose is prescribed?**

**8. Is there a documented reason recorded in the patient's case notes for the use of a transdermal opioid?**

Yes  No  **If yes please state**

**9. Does the patient have any of the following? (Please tick all that apply)**

Difficulty/Unable to swallow  Difficulty with compliance of oral medications

Persistent Nausea and/or Vomiting  Gastrointestinal Obstruction

Renal dysfunction  (If yes see question 10) Documented Intolerance of other opioids

Problematic Constipation  Stable pain  Comments

**10. If renal dysfunction was a contributing reason for prescription of the transdermal opioid please indicate the most recent biochemistry**

Urea Potassium Creatinine e GFR (if known)

**11. Did the patient experience any side effects/incidents relating to the prescribing of a transdermal opioid?**

Yes  No  **If yes please state**

**12. Is it documented that the patient received any counselling/education regarding the use of transdermal opioids prior to the initial prescription?**

Yes  No  Don't Know  **If yes please state by whom?**

**13. Following your initial assessment please state what the palliative care team chose to do with the transdermal opioid and why?**

**Thank you for taking the time to complete this form. Please return completed forms to: Dr Graham Whyte, StR Palliative Medicine, Aintree Palliative Care Team, University Hospital Aintree, Lower Lane, Liverpool, L9 7AL or electronically to [graham.whyte2@nhs.net](mailto:graham.whyte2@nhs.net)**