Fareham and Gosport NHS
Primary Care Trust

Review of Diamorphine Prescribing at Gosport War Memorial Hospital

March 2003

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Background and Introduction

A CHI investigation was undertaken at Gosport War Memorial Hospital in 2001 as a result of concerns expressed by the police and others around the care and treatment of frail older people within the hospital. The investigation reviewed the existing systems to ensure good quality patient care. CHI identified a number of factors, which contributed to a failure of such systems. The factors included:

- Insufficient prescribing guidelines governing the prescribing of powerful pain relieving and sedative medicines
- The lack of rigorous, routine review of pharmacy data

Recommendation 5 of the CHI report covered the routine review and monitoring of all prescribing on the wards caring for older patients. CHI recommended that the work should include a review of recent diamorphine prescribing on Sultan ward. The PCT CHI implementation team decided to extend the review to cover Daedalus and Dryad wards.

Methodology

The Trust's Pharmacy Clinical Governance Group established the process for this review and acted as the steering group during the review being carried out.

It was agreed to review all patients who had been given Diamorphine either orally or using a syringe driver on Sultan, Dryad and Daedalus wards at Gosport War Memorial Hospital from May 2001. This date was appropriate as it coincided with the launch of the Trust's amended Pain Management Policy (Appendix A).

Controlled Drug Books (CDs) are kept on all wards to ensure appropriate use of specific medications. The CD Books were reviewed for Sultan, Dryad and Daedalus wards to obtain names of patients who had been prescribed Diamorphine.

Due to the current investigations being carried out regarding issues at Gosport War Memorial Hospital, not all CD Books were available and therefore some patients were not included in the Peer Review Process.

Notes were obtained from Gosport War Memorial, Queen Alexandra Hospital and Royal Hospital Haslar Medical Records Departments.

The casenote review was carried out by the Trust's Medical Director over 2 days in March 2003.

Results

25 sets of medical records were reviewed for patients who had been given Diamorphine on Sultan, Daedalus and Dryad wards.

Sultan	19/25	(76%)
Dryad	5/25	(20%)
Daedalus	1/25	(4%)

The Peer Review focused on 4 elements:

- Documentation of pain
- Appropriate Starting Dose
- Appropriate increase in dose (where applicable)
- Syringe Driver Indication documented (where syringe driver used)

The peer review included cross referencing medical and nursing notes along with prescription charts, information documented within the Controlled Drug Books, the Syringe Driver Record Chart and the Syringe Driver Variable Dose Prescription sheet.

1. Documentation of Pain/Reason for Prescribing of Diamorphine

- 20/25 (80%) patients had pain indicated within the medical or nursing notes.

Of the remaining 5 (20%):

- 2 (8%) had no medical records available for the dates during which Diamorphine was prescribed.
- 1 (4%) had no indication of pain in either nursing or medical notes.
- 1 (4%) had a record of 'vomiting' but no clear level of pain was indicated
- 1 (4%) had no clear medical record of being distressed/in pain.

Further Information

- 4/5 (80%) of these patients were on Sultan ward
- 1/5 (20%) patient was on Daedalus ward.
- All patients on Dryad ward had clear documentation of pain/reason for prescribing of Diamorphine.

Comment:

Although the level of pain is documented through the patients' notes, there is no pain assessment tool used by any of the three wards reviewed. An analgesic pain ladder is available on the wards; this defines process rather than assessment. However, once patients receive their prescribed Diamorphine via syringe driver, regular pain scores are undertaken.

2. Appropriate Starting Dose

- 21/25 (84%) of patients had an appropriate starting dose

Of the remaining 4 (16%):

- 2 (8%) patients were started on 15mg over 24 hours. However the reviewer questioned whether 10mg may have been a more suitable starting dose.
- 1 (4%) patient had no 'trial dose' of Diamorphine but was given 20mg over 24 hours which was felt to be inappropriate by the reviewer.
- 1 (4%) patient had no information within their notes to ascertain whether the starting dose was appropriate.

Further Information:

- 2 (50%) of these patients were on Sultan ward
- 1 (25%) patient was on Dryad ward
- 1 (25%) patient was on Daedalus ward.

3. Appropriate Increase/Decrease in Dose

10 patients had an increase/decrease in their dose of Diamorphine.

- 8 (80%) patients had appropriate increase/decrease in their dose of Diamporphine based on the medical/nursing record.

Of the remaining 2 (20%)

- 1 (10%) patient had an increase from 20mg over 24 hours to 30mg over 24 hours and no reason documented. This patient had a further increase to 50mg over 24 hours with no reason given, although during this time the records indicate that the patient was "bubbly".
- 1 (10%) patient had been given 30mg over 24 hours which was then increased to 50mg over 24 hours the following day with no reason documented.

4. Syringe Driver Indicated

22 patients received Diamorphine via a Syringe Driver.

- 18/22 (82%) patients had clearly defined reasons for use of a syringe driver

Of the remaining 4 (18%):

- 1 patient had 'no pain' documented within their notes but was then commenced on a syringe driver.
- 1 patient had no medical records available within the notes
- 1 patient had no reason documented for starting on a syringe driver
- 1 patient was still taking oral medication when started on a syringe driver.

Comment:

1 patient who was put onto a syringe driver had a pain score of 0 (no pain)

General Information

- 1 set of prescription charts were "barely legible".
- On 1 occasion, there was no record on the Prescription Chart of Diamorphine being prescribed although the patient was given 15mg.
- 1 patient had medical records missing for the dates reviewed.
- There was a mistake in recording as time was not signed on the prescription chart
- On 2 occasions, 1 patient was given 110mg of Diamorphine which appeared on the syringe Driver Record Chart but not on the Prescription Chart. On one occasion, this same patient was given Diamorphine, documented on the Prescription Chart but not on the Syringe Driver Record Chart.
- 1 patient had 2.5mg of Diamorphine given on 3 occasions with no reasons given in the medical records. This same patient had no indication in their nursing or medical records of pain or distress before commencing Diamorphine.

It was the opinion of the reviewer that the nursing records were complete and contained relevant information pertaining to the nursing aspects of patient care.

Further work is currently being undertaken to review the quality and legibility of Prescription Charts.

Recommendations

1. Fareham & Gosport PCT to adopt pan PCT pain assessment/recording tool for use with controlled drugs.

2. Fareham & Gosport PCT to develop guidelines for use of tool – mandatory where opiates are concerned.

3. Distribute Pain Management Policy and analgesic ladder (revised April 2003) to wards/consultants/GPs - Bed fund.

4. Engage GPs (Bed Fund/clinical assistants) by:

   a) sharing results of audit with GP group
   b) write to bed fund GPs with précis of audit results and recommendations

5. Audit use of Pain Assessment tool to ensure reasons for changes in dose are recorded.

6. Share results of prescription quality and legibility.

Appendix 1
Pain Management Policy

PORTSMOUTH HEALTHCARE NHS TRUST
CORPORATE POLICY

POLICY FOR ASSESSMENT AND MANAGEMENT OF PAIN

BACKGROUND

Despite dramatic advances in pain control over the past 20 years, many patients in both hospital and community continue to suffer unrelieved pain and up to three-quarters of patients experience moderate to severe pain whilst in hospital. Pain control in hospital has long been documented as ineffective and problematic. Effective problem - solving skills and interventions which reflect the multidimensional nature of pain are required for effective pain management and there needs to be a logical link between the assessment of the problem and the desired outcome.

1. PURPOSE

This policy identifies mechanisms to ensure that all patients/clients have early and effective management of their pain and or distress .

2. SCOPE

This policy provides a framework for all staff working within the Trust who are involved in direct and indirect care. All individual guidelines, protocols and procedures to support the policy must have been approved by the appropriate professional group.

3. RESPONSIBILITY

It is the responsibility of all professionals and support staff involved directly and indirectly in care to ensure that patients/clients

- have their pain and distress, initially assessed and ongoing care planned effectively with timely review dates.
- are informed through discussion of the proposed ongoing care and any need for mechanical intervention

3.1 All professionals are responsible for:

- assessment
- planning
- implementation of action plans
- evaluation
- clear documentation
- liaison with the multiprofessional team

Nurses are also specifically responsible for the:

- administration of the prescribed medication

Medical and Dental staff are also specifically responsible for:

- appropriate prescribing of medication
- clear unambiguous completion of prescription sheet

PAM's are specifically responsible for:

- prescription of therapies
- providing appropriate aids

Service lead groups are responsible for:

- ensuring that the pain management standards are implemented in every clinical setting
- ensuring that the necessary resources and equipment is available
- ensuring that systems are in place to determine and access appropriate training and that qualified nurses can evidence their competencies
- ensuring that standards are being maintained by regular audit and monitoring

4. REQUIREMENTS

4.1 Pain Assessment

All patients/clients who complain of or appear to be in pain must have an initial assessment to establish the type/ types of pain their experiencing.

4.1.1 Systems must be in place to ensure that:-

- all qualified nursing and medical staff have the required skill to undertake pain assessments and manage pain effectively.
- a local 'agreed' pain assessment method is implemented.
- a local 'agreed' documentation method is implemented
- all staff have the required training to implement and monitor the 'pain standards'

4.1.2 All professional staff are required to:-

- exercise professional judgement, knowledge and skill
- be guided by verbal and non verbal indicators from the patient/client/ re intensity of pain
- be guided by carer/relatives if appropriate
- document site and character of the pain
- share information with the care team to enable a multiprofessional approach to the management of the patient/client
- plan on going care where possible with the patient , documenting clear evaluation dates and times
- ensure documented evidence supports the continuity of patient care and clinical practice

4.2 Prescribing

A clear unambiguous prescription must be written by medical staff following diagnosis of the type/types of pain.

- The prescription must be appropriate given the current circumstances of the patient/client
- If the prescription states that the medication is to be administered by continuous infusion (syringe driver) the rationale for this decision must be clearly documented

N.B (**The continuous infusion route is not more effective than the oral route)**

- All prescriptions for drugs administered via a syringe driver must by written on a prescription sheet designed for this purpose
- Systems must be in place to ensure staff have the access to appropriate medication guidance and the analgesic ladder.
- Systems must be in place to ensure staff have the skill to implement the above

5. AUDIT/CLINICAL GOVERNANCE

The systems in place to support this policy should be subject to an annual audit based on the requirements of this policy and should feature in annual clinical governance plans and reports

This policy is supported by the following documents

- **Syringe driver variable dose prescription chart**
- **Syringe driver check list**
- **Pain management cycle**
- **Pain management standards**

POLICY PRODUCED BY: Wendy Inkster
POLICY PRODUCED: April 2001
APPROVED BY TRUST BOARD:
REVIEW DATE: May 2003

SYRINGE DRIVER VARIABLE DOSE PRESECRIPTION

Name	Date of Birth	Ward / Address	Hospital No	Allergies and Drug Sensitivities
DRUG 1 (approved name)				**Special Instructions for analgesics** (to include strategy for dose increases, and additional PRN doses, changes in patient condition)
Dose per 24 hours	Route		Max. dose per 24hr not to exceed.	• If breakthrough pain occurs, a PRN dose of ....mg can be given every ....hours
To be diluted in	Start date		Pharm	• If PRN dose does not control pain, increase subsequent PRN dose(s) to ....mg every ......hours to the maximum dose written on this prescription
Signature of Prescriber			Date	• If pain is controlled with **Drug 1** as prescribed and no additional PRN doses have been required, repeat the **<u>same</u>** daily dose on the following day.
DRUG 2 (approved name)			Pharm	• If pain has only been controlled with the addition of PRN doses, add total PRN doses given in previous 24 hours to the dose given in syringe driver in the previous 24hours, rounded up to the nearest 5mg but only up to maximum dose written on this prescription.
Dose per 24 hours	Route		Start date	• PRN doses may only continue to be administered as prescribed if dose does not exceed the maximum variable- dose prescription
Signature of Prescriber			Date	• If the patient/clients pain or anxiety is not controlled within the above parameters or there are concerns about sedation level or overdose, a medical review must be requested and or specialist medical advice be sought
DRUG 3 (approved name)			Pharm	
Dose per 24 hours	Route		Start date	
Signature of Prescriber			Date	Signature of Prescriber Date

PORTSMOUTH HEALTHCARE NHS TRUST - SYRINGE DRIVER RECORD CHART.

NURSES: This chart <u>must</u> be completed on setting up the syringe driver and at least every shift change.

PATIENT NAME **NHS/HOSP NO.** **WARD/ADDRESS** **DATE**

PATIENT																							
Pain level																							
Sedation level																							
Respiratory rate																							
Infusion site																							
*PRN doses administered (mg)																							
SYRINGE DRIVER	**SYRINGE DRIVER MODEL =** **SERIAL NUMBER =**																						
Light flashing Yes or No																							
Rate set @ (state mm/24hr or 1hr)																							
millimetres of fluid remaining																							
Syringe secure Yes or No																							
Connections secure Yes or No																							
Clarity of fluid in syringe																							

Signature of checking nurse																						

All PRN doses given must

be recorded and signed for

Pain level			Sedation level		Respiratory rate	
No pain		1	Aw ake	1	9 - 24 / min	1
Acceptable pain		2	Dozing intermitently	2	Less than 9 / min	2
Unacceptable pain		3	Difficult to awaken	3	More than 25 /min	3
if 3 take & record action			if 3 take & record action		if 2 or 3 enter on sheet	

Enter all concerns and action taken in progress sheet.

Nursing Standard: 1
Topic: Pain Management
Sub topic: Assessment

Standard Statement: The patient/client has an initial assessment of their pain

S1 A registered nurse or competent support worker in learning disabilities is identified as responsible for the patient/client on each shift	The identified nurse / competent support worker: Follows the pain assessment process of the pain management cycle and gathers information P1 *Asks the patient/client about: Where the pain is: What it feels like; What increases it: What relieves it Observes for non verbal indicators Psychological and social state should be considered including anxiety, depression and patients/clients beliefs about pain*	O1 *The patients/client pain has been identified*
S2 Pain assessment method is agreed		*O2 Factors which influence the pain have been recognised*
S3 Documentation method is agreed	*P2 Record the results of the pain assessment on the agreed documentation* *P3 Action plans as per pain management cycle Identifying the need for*	*O3 The patient / client has* *a) been given the prescribed PRN medication* *b) been referred to the relevant medical team*
S4 Documentation is available : i.e. Medical, psychological and socio-economic histories	*a) prescribed PRN medication or* *b) referral to the medical team or* *c) alternate complementary intervention*	

Audit form 1
Audit objective: to establish if the patient client has had an initial assessment made of the pain
Time frame: to be determined locally
Sample: representative number of both nurse and patients / clients

Auditors: to be determined locally
Date:

Target group	Code	Method	Audit Criteria
Nurse	*S1*	*Ask & check records*	*Is there a registered nurse / competent support worker (learning disabilities) identified as responsible for the patient/ client on each shift?*
	S2	*Ask & check records*	*Is there an agreed pain assessment method?*
	S3	*Ask & check records*	*Is there an agreed pain documentation method?*
Nurse	*P1*	*Ask & check records*	*Is the pain management cycle chart available?* *If appropriate:* *a) have non verbal indicators been considered* *b) have psychological and social state been considered* *c) have relatives involvement been considered*
	P2	*Check records*	*Is the pain assessment recorded on the agreed documentation?*
	O2	*Ask & check records*	*Is there evidence that factors influencing pain have been recognised?*
	O3	*Check records*	*a) Have any prescribed medication or complementary alternative been given?* *b) Have any medical referrals been timely?*

Nursing Standard: 2
Topic: Pain Management
Sub topic Action Plan

Standard Statement: An action plan is devised, using the information gained from the assessment which reflects effective management of the pain.

Structure	Process	Outcome
S1 A registered nurse will administer the patients /clients prescribed medication. *In learning disabilities a registered nurse will authorise a competent support worker to administer the patients /clients prescribed medication the* *S2 Information regarding the WHO Analgesic Ladder is available* *S3 Patients / clients start at the step of the WHO Analgesic Ladder appropriate for their severity of pain*	*The identified nurse:* Follows The Pain Management Cycle Chart *P1 Monitors the effects of the prescribed medication 30 /60 minutes post administration. If good effect reassess at 60 minutes and within 3 hours* *P2 Ask patient / client about the effect observe for non verbal indicators*	*O1 The patient / client would communicate and / or show non verbal indications of a reduction in their pain* *O2 The patient / client would communicate and / or show non verbal indications of no reduction in their pain*
	P2 Record the medication effect after each reassessment in the patients / clients documentation *P3 Ensure that all prescribed analgesia is administered at the correct time*	*O3 Records would show the effects of the prescribed and administered medication*
	P3 Identifies the patient / client who needs further medical review	*O4 The patient / client has been refereed to the relevant medical team for further review*

Audit form 2

Audit objective: to establish if the patient / client has had an action plan devised
Time frame: to be determined locally
Sample: representative number of both nurse and patients / clients
Auditors: to be determined locally
Date:

Target group	Code	Method	Audit Criteria
Nurse	*S1*	*Ask & check records*	*Has a registered nurse or in learning disabilities competent support worker administered the patients / clients prescribed medication?*
	S2	*Ask & observe*	*Is there an WHO Analgesic Ladder available?*
	S3	*Ask & check records*	*Do patients / clients commence on the step of the Analgesic Ladder appropriate for their severity of pain?*
Nurse	*P1*	*Ask & check records*	*Is there evidence that the effects of the prescribed medication has been assessed 30 / 60 minutes and again within 3 hours post administration?*
	O3	*Check records*	*Has the effects of the prescribed medication been recorded on the agreed documentation?*
	O3	*Check records*	*Have referrals to relevant medical teams been timely?*

Nursing Standard 4
Topic: Pain Management
Sub topic Organisational Issues

Standard Statement: The clinical teams work towards ensuring that the organisation of staff is responsive to, and meets the individual requirements of, the patient / client in order to effective manage their pain.

Structure	Process	Outcome
S1 All staff understand their responsibilities in accordance to the policy for assessment and management of pain *S2 Policies are available for the administration of medicines and for IV Therapy* *S3 Systems are in place to ensure that nursing staff have the required skill to undertake a pain assessment and for effective ongoing pain management.* *S4 Systems are in place to ensure a local agreed pain assessment method and documentation method is implemented.* *S5 Communication systems are established for consultation with other specialist departments.*	*P1 The Clinical Area / House Manager meets with the clinical team initially to agree the local pain assessment and documentation methods then meets on a regular review basis* *P2 The Clinical Area / House Manager and individual practitioners should ensure they have the required skills to undertake a pain assessment and for the effective ongoing management.* *P3 The clinical team follow the pain management cycle chart and are guided by using the WHO Analgesic Ladder* *P4 The clinical team have a working knowledge of the communication systems established with other specialist departments*	*O1 Recorded agreed local Pain Assessment and Pain Documentation methods.* *O2 Evidenced competence of all appropriate team members*

Audit form 4
Audit objective: to establish if the clinical team work ensuring that the organisation of staff is responsive to and meets the individual requirements of the patient / client in order to effective manage their pain
Time frame: to be determined locally
Sample: representative number of both nurse and patients / clients
Auditors: to be determined locally
Date:

Target group	Code	Method	Audit Criteria
All staff	*S1*	*Ask*	*Can each members of the multidisciplinary team explain their responsibility in relation to pain management?*
	S2	*Ask & observe*	*Are policies available for the administration of medicines, IV Therapy and assessment and management of pain?*
	S3 *P2* *O2*	*As, observe & check records*	*Is there a system in place to ensure staff have the required skill to undertake a pain assessment and ongoing pain management?*
	S4	*Ask, observe & check records*	*Is there a system in place to ensure staff implement the agreed pain assessment and documentation methods?*
	S5 *P4*	*Ask*	*Is there an established communication system for consultation / advice with specialist departments?* *Do staff know who to contact and how to implement the system?*
Nurse	*P1* *O1*	*Ask & check records*	*Is there evidence of regular review of the agreed pain assessment and documentation methods?*

Nursing Standard 3
Topic: Pain Management
Sub Topic: Care Issues

Standard Statement: A plan of care is devised which meets the individual requirements of the patient /client in order to effective manage their pain.

Structure	Process	Outcome
S1 Information is available about a) the patients / clients health status b) the pain assessment (NB Standard 1) c) the action plan (NB Standard 2) *S2 The patient / client where ever possible should be given information about the pain management and be encouraged to take an active role in their pain management* *S3 Communication systems with family and friends are in place where relevant*	*P1 The registered nurse with the patient / client or relevant others devise a plan of care which:* *P2 Incorporates information from the initial assessment* *P3 Incorporates information from other members of the multidisciplinary team* *P4 Defines the goals of the care* *P5 Patients / clients receiving an opioid should have possible side effects managed effectively. a) Constipation: access to regular prophylactic laxatives b) Nausea & vomiting: assess need for a short term antiemetic. c) Sedation: d) Dry Mouth : Good oral hygiene*	*O1 The patient /client receives the planned care.* *O2 The care plan is evaluated regularly as specified within it.* *O3 Evidence where possible of patient / client participation in their pain management*

Audit form 3
Audit objective: to establish if a plan of care is devised which meets the individuals requirements of the patient / client
Time frame: to be determined locally
Sample: representative number of both nurse and patients / clients
Auditors: to be determined locally
Date:

Target group	Code	Method	Audit Criteria
Nurse	*S1*	*Ask & observe*	*Is information available about:* *a) health status* *b) pain assessment* *c) an action plan*
	S2	*Ask & observe*	*Where ever possible has the patient / client been encouraged to take an active role in their pain management?*
	S3	*Ask & observe*	*Is there an established system for communicating with family and friends of the patient / client?*
	P1	*Ask, observe & check records*	*a) Is there a plan of care for the patient / client?* *b) Has it been devised by the nurse with the patient / client or relevant others?* *Does it: Incorporate information from the initial assessment?*
	P2		*Incorporate information from members of the multidisciplinary team?*
	P3		*Defines the goals of the care?*
	P4 *P5*		*If the patient / client is receiving an opioid have predictable side effects been considered and managed accordingly?*
Nurse / Patient /Client	*O1*	*Ask & check records*	*Has the patients / clients received the planned care and participated in their pain management?*

PAIN MANAGEMENT CYCLE