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Receiver

Code A

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Indexer

Agenda for Med / Prescrib Comm.

Portsmouth HealthCare NHS Trust
MEMORANDUM

From: Dr Ian Reid

To: See Distribution

Ref: g:/memo/diamorph.doc

cc: [redacted]

15 December 1999

RE : Memorandum for the Protocol for Prescription and Administration of Diamorphine by Subcutaneous Infusion,

I enclose a draft protocol along with a blank infusion and pain control chart and a 'completed' Diamorphine infusion and pain control chart.

I should be very grateful for your comments.

Yours sincerely

Code A

Dr Ian Reid
Medical Director

DISTRIBUTION:
Dr Jane Barton - Clinical Assistant - Gosport War Memorial
Sister J. Hamblin - Dryad Ward - Gosport War Memorial
Dr Althea Lord - Consultant Geriatrician - QAH

PROTOCOL FOR PRESCRIPTION AND ADMINISTRATION OF DIAMORPHINE BY SUBCUTANEOUS INFUSION

INTRODUCTION

In community hospitals, particularly at weekends and bank holidays, medical cover is provided on an emergency call out basis.

This can lead to a situation whereby patients who are experiencing increasing pain may not be able to have their pain control needs immediately met. To overcome this and also to give guidance to nurses who may be unsure as to how much analgesia (diamorphine) to administer within a variable dose prescription.

DOSAGE

Guidance from the palliative care service indicates that if pain has not been controlled in the previous 24 hours by 'Xmg' of diamorphine, then up to double the dose should be administered the following day, i.e. up to 2x 'Xmg' should be given.

PAIN CONTROL CHART

It is suggested that a pain control chart (see appendix) should be completed on a four hourly basis for all patients receiving a diamorphine infusion.

PRESCRIPTION

Diamorphine may be written up as a variable dose to allow doubling on up to two successive days, e.g. 10-40 mg, 20-80 mg, 60-240 mg or similar. The reason for prescribing should be recorded in the medical notes.

ADMINISTRATION

If pain has been adequately controlled within the previous 24 hours, the nurse should administer a similar dose of diamorphine over the next 24 hours.

If the previous 24 hour dose has made the patient unduly drowsy etc., the nurse should use his/her discretion as to whether the dose to be administered for the next 24 hours can/should be reduced, within the prescribed dosage regime. If the minimum dose appears to have made the patient too drowsy, the on-call doctor should be contacted.

If the patient's pain has not been controlled, the nurse should use his/her discretion as to the dose to be given within the next 24 hours, i.e. he or she may administer up to double the previous 24 hours dose.

INFORMATION TO PATIENTS and RELATIVES

Where patients are mentally capable of receiving such information, they must be told that an infusion of a painkiller (diamorphine) is being started and that the dose will be adjusted if necessary to allow them to be as comfortable as possible without being unduly sedated.

When patients are unable to understand such information, by reason of either their physical or mental status, the decision that diamorphine is being, or about to be, administered, should be communicated to their next-of-kin/relatives, again indicating that the aim is to make the patient as comfortable as possible and that the dose will be adjusted to keep the patient as comfortable as possible without being unduly sedated. If relatives express concern about the administration of diamorphine, despite the above discussion, the medical staff should be informed and the medical staff should make every effort to discuss the administration of diamorphine with the patient's next-of-kin/family. A resume of the discussion should be recorded in the patient's notes.

DIAMORPHINE INFUSION AND PAIN CONTROL CHART

DATE						
DOSE						
TIME INFUSION STARTED	0 hours					
PAIN CONTROLLED YES/NO	+4 hours					
	+8 hours					
	+12 hours					
	+16 hours					
	+20 hours					
	+24 hours					
NO. OF TOP UP DOSES OF DIAMORPHINE						
TOTAL DOSE 'TOP UPS' IN 24 HOURS						
COMMENTS						

DIAMORPHINE INFUSION AND PAIN CONTROL CHART

DATE		29/9	30/9	1/10	2/10	3/10
DOSE		10 mg	20 mg	40 mg	80 mg	80 mg
TIME INFUSION STARTED	0 hours	1400	1400	1400	1400	1400
PAIN CONTROLLED YES/NO	+4 hours (1800)	Y	Y	N	Y	
	+8 hours (2200)	Y	Y	N	Y	
	+12 hours (0200)	N	Y	Y	Y	
	+16 hours (0600)	N	N	Y	Y	
	+20 hours (1000)	N	Y	N	Y	
	+24 hours (1400)	N	Y	Y	Y	
NO. OF TOP UP DOSES OF DIAMORPHINE		3	1	3	0	
TOTAL DOSE 'TOP UPS' IN 24 HOURS		10 mg	5 mg	20 mg	0 mg	
COMMENTS						

PORTSMOUTH HealthCare NHS TRUST

MEDICINE & PRESCRIBING COMMITTEE

MINUTES OF THE MEETING HELD 3RD FEBRUARY 2000
Meetings Room, Elderly Medicine Dept, QAH

Present

Ann Dalby (for Barbara Robinson)
Ann Dowd
Mary Mottram (for Mary Bosworth)
Ian Reid (Chair)
Paula Diaper
Michael Drake (for Diane Wilson)
Sarah Randall
Lindy Thorpe (for Paula Turvey)

In attendance:
Jill Mellar, Secretary

ACTION

3. **Protocol for Prescription and Administration of Diamorphine by Subcutaneous Infusion**

Dr Reid reported that the protocol was produced as a result of a complaint and is currently being piloted on Dryad Ward at Gosport War Memorial Hospital. Feedback so far has been positive with the main concern over the layout as the comments section is too small.

It was noted that there may already be other protocols in operation in areas such as The Rowans, Charles Ward at QAH and District Nurses in the Community. It was agreed that in order for one trust-wide document to be produced all practices would need to be "tied up" together. It was agreed that Dr Reid would make contact with The Rowans and Charles Ward and Lindy Thorpe would take the document to the Nursing Advisory Committee to ascertain the views of district nurses. Both to report back at a future meeting. IR/LT

Med file

PORTSMOUTH
HealthCare
NHS
TRUST

Dr H Jones
Consultant in Palliative Medicine
The Rowans
Purbrook Heath Road
Purbrook
Waterlooville

Our ref
g:\ianr\medicine\letters\jones
Your ref

Date
07 February 2000
Ext
6728

Dear Huw

PROTOCOL FOR PRESCRIPTION ADMINISTRATION OF DIAMORPHINE BY SUBCUTANEOUS INFUSION

I enclose a copy of a protocol which I have drafted for use on a rehabilitation and continuing care ward. It was discussed at the last meeting of the Trust's Medicines & Prescribing Committee where there was general agreement that it seemed appropriate and helpful. However, the Committee asked me to contact you to see whether you have any protocols in existence which might give an added dimension to the development of a trust-wide protocol. If you have one I should be very grateful if you would let me have a copy.

Yours sincerely

Code A

Dr R I Reid
Medical Director

Encs.

DEPARTMENT OF MEDICINE FOR ELDERLY PEOPLE

Queen Alexandra Hospital
Cosham, Portsmouth, Hants PO6 3LY
Tel: 023 92822444 Fax: 023 92200381

PROTOCOL FOR PRESCRIPTION AND ADMINISTRATION OF DIAMORPHINE BY SUBCUTANEOUS INFUSION

INTRODUCTION

In community hospitals, particularly at weekends and bank holidays, medical cover is provided on an emergency call out basis.

This can lead to a situation whereby patients who are experiencing increasing pain may not be able to have their pain control needs immediately met. To overcome this and also to give guidance to nurses who may be unsure as to how much analgesia (diamorphine) to administer within a variable dose prescription.

DOSAGE

Guidance from the palliative care service indicates that if pain has not been controlled in the previous 24 hours by 'Xmg' of diamorphine, then up to double the dose should be administered the following day, i.e. up to 2x 'Xmg' should be given.

PAIN CONTROL CHART

It is suggested that a pain control chart (see appendix) should be completed on a four hourly basis for all patients receiving a diamorphine infusion.

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Diamorphine may be written up as a variable dose to allow doubling on up to two successive days, e.g. 10-40 mg, 20-80 mg, 60-240 mg or similar. The reason for prescribing should be recorded in the medical notes.

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DATE		29/9	30/9	1/10	2/10	3/10
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NO. OF TOP UP DOSES OF DIAMORPHINE		3	1	3	0	
TOTAL DOSE 'TOP UPS' IN 24 HOURS		10 mg	5 mg	20 mg	0 mg	
COMMENTS						

MLP file

PORTSMOUTH
HealthCare
NHS
TRUST

Dr Val Vardon
Associate Specialist
Elderly Medicine
QAH

Our ref
g:\ianr\medicine\lttrs\vardon
Your ref

Date
07 February 2000
Ext
6728

Dear Val

PROTOCOL FOR PRESCRIPTION ADMINISTRATION OF DIAMORPHINE BY SUBCUTANEOUS INFUSION

I enclose a copy of a protocol which I have drafted for use on our rehabilitation and continuing care wards. This is currently being piloted on Dryad Ward at Gosport War Memorial Hospital. The Trust's Medicines & Prescribing Committee recently considered the protocol and there was general agreement that it was useful and helpful. However, the Group asked me to contact you and Huw Jones to see whether in your respective areas you are currently using a protocols which could either be incorporated in this draft protocol, or used to reshape this draft protocol, so that a trust-wide protocol could be developed.

If you have such a protocol I should be very grateful if you would let me have a copy.

With many thanks.

Yours sincerely

Code A

Dr R I Reid
Medical Director

Encs.

Documents)
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DEPARTMENT OF MEDICINE FOR ELDERLY PEOPLE

Queen Alexandra Hospital
Cosham, Portsmouth, Hants PO6 3LY
Tel: 023 92822444 Fax: 023 92200381

PROTOCOL FOR PRESCRIPTION AND ADMINISTRATION OF DIAMORPHINE BY SUBCUTANEOUS INFUSION

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	+16 hours (0600)	N	N	Y	Y	
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NO. OF TOP UP DOSES OF DIAMORPHINE		3	1	3	0	
TOTAL DOSE 'TOP UPS' IN 24 HOURS		10 mg	5 mg	20 mg	0 mg	
COMMENTS						

PORTSMOUTH
HealthCare
NHS
TRUST

Dr I Reid
Medical Director
Elderly Medicine
QAH

Our ref
VV/BN
Your ref
g:\ianr\medicine\lttrs\vardon
Date
11 February 2000
Ext
6923

Dear Ian

PROTOCOL FOR PRESCRIPTION ADMINISTRATION OF DIAMORPHINE BY SUBCUTANEOUS INFUSION

On Charles Ward we do not have a protocol for prescription, but use the normal drug prescription chart. The initial diamorphine infusion is written up on the regular medication with a fixed dose, eg 10mg over 24 hours. On the prn column we write down diamorphine subcutaneously with a range of doses, eg 2.5mg – 10mg. If the patient is not pain controlled the stat dose is given and recorded. When the infusion needs to be changed, the dose will be adjusted using the number of stat doses in the previous 24hrs and recorded in red, both on the prn column and on the regular column as + 10mg from prn column for instance in the signing box; so if the pain has not been controlled, the usual increase would be to one and a half times the previous dose or previous dose plus total of stat doses. For instance, in your example, on 30/9 where 20mg had been prescribed and 5mg given as stat, I would have only increased it to 30mg for the next day and similarly from 1/10 – 2/10 40mg + 20mg top up I would have given 60mg on 2/10.

As far as the remarks about drowsiness are concerned it is quite important that the nurses and relatives understand that the patient's condition is likely to make them drowsy if they deteriorate and it is not necessarily the medication that has led to a deterioration in their condition. We usually check the patient's pupils and if they are normal size it is very unlikely that the patient is receiving too much morphine. However, if the pupils are pinpoint, the drowsiness may very well be caused by too much morphine and the dose should be reduced. If they are not pain controlled and with pinpoint pupils, they may need a different kind of analgesic.

Cont/d...

DEPARTMENT OF MEDICINE FOR ELDERLY PEOPLE

Queen Alexandra Hospital
Cosham, Portsmouth, Hants PO6 3LY
Tel: 023 92822444 Fax: 023 92200381

Rhonda Cooper and Wendy Inkster are now putting out the protocol and starting training sessions on pain management and syringe driver protocols for the nurses and I understand these will be available to those in small hospitals as well.

Yours sincerely

Code A

Dr V Vardon
Associate Specialist

PORTSMOUTH
HealthCare
NHS
TRUST

DHJ/JEM

21 February 2000

Dr I Reid
Medical Director
Portsmouth HealthCare HNS Trust
Elderly Medicine
Queen Alexandra Hospital
Cosham
Portsmouth

Our ref

Your ref

Date

Ext

Dear Ian,

RE: Diamorphine Guidelines

Thank you for sending me a copy of these guidelines which I am currently looking at and have also circulated to the team for their collective opinion. One early comment I can make is that I did find them a little confusing, particularly the dose increments recommended which are not those that we would recommend. Also, it is important to contain within these guidelines, conversion factors from other opioids in particular the conversion from oral Morphine to parenteral Diamorphine which is something that few people seem to be aware of. As you will know, 30mg of oral Morphine is equivalent to 10mg of parenteral Diamorphine.

The conversion by many seems to be rather hit and miss and based more on what they think than what they know. I don't doubt that we will make some recommendation for changes of the guidelines, so that this information can be clearer. Our comments will follow very shortly. I hope they are all together when I return from half term, so I will have an opportunity to reply to you then.

Yours sincerely,

Code A

Dr Huw Jones
Consultant in Palliative Medicine

PALLIATIVE CARE

The Rowans
Purbrook Heath Road, Purbrook, Waterlooville PO7 5RU
Tel: 023 9225001 Ext: (answerphone) Fax: 023 92255775
Website: http: ///www.portsmouth.healthcare.org

Medicines and Prescribing Committee Meeting

6th April 2000
12:30 pm
Meetings Room, South Block, QAH

AGENDA

1. Apologies

2. Minutes of previous meeting (3rd February 2000)

3. Matters Arising (not covered by the Agenda below)

4. Protocol for Prescription and Administration of Diamorphine by Subcutaneous Infusion

5. Group protocols for Nurse Administration of Medicines

6. Control of Administration of Medicines Policy (see attached letter)

7. Any other business

on syringe driver control. It was agreed that it would be appropriate to have a Trust wide policy for pain control, but it was recognised that there might be different formularies for use in different parts of the Trust. It was agreed that Wendy should convene a group of appropriate nurses to develop the policy. It was suggested that Althea Lord and Huw Jones should be consulted about the formularies for pain control. Ian Reid agreed to write to Althea and Huw indicating that Wendy Inkster would be contacting them at some stage about this.

ACTION

RIR

3. **Matters Arising not covered in the Agenda below)**

None were raised.

4. **Protocol for Prescription and Administration of Diamorphine by Subcutaneous Infusion**

Wendy Inkster reported that she was engaged in developing nursing policy on pain recognition and pain control and that elderly medicine had developed a policy