Royal United Hospitals Bath
NHS Foundation Trust

Report to:	Public Board of Directors	Agenda item:	11
Date of Meeting:	25 July 2018		

Title of Report:	Gosport Hospital Report & RUH Assurance
Status:	For Information
Board Sponsor:	Dr Bernie Marden, Medical Director
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Appendices	Appendix 1: Learning from Recent Opioid Incidents Safety Bulletin

1. Executive Summary of the Report

The Gosport Independent Panel was set up to address concerns raised by families over a number of years about the initial care of their relatives in Gosport War Memorial Hospital and the subsequent investigations into their deaths.

The report identified a number of findings and these can be found via https://www.gosportpanel.independent.gov.uk/

Within this report the following is raised: "The families, and indeed the nation as a whole, are entitled to ask how these events could have happened; how the hospital dismissed the nurses' concerns and subsequently took no action; how the healthcare organisations failed to intervene; how the professional regulators allowed matters to continue; how the police failed to get to the bottom of what had happened; and whether what happened is to be explained as a conspiracy or in some other way".

The problems are centred on prescribing practices and so this RUH report to Board of Directors is describing how we are able to gain assurances that we do not have a culture of inappropriate prescribing and use of opioids and other sedating medications in palliative care or indeed more generally. The other matters extend beyond the scope of this document and as assurance is offered on the matter of prescribing then the other issues haven't come under consideration, as this has not given rise to concerns in any of these areas.

2. Recommendations (Note, Approve, Discuss)

Board of Directors are asked to note the assurance provided against the findings in relation to prescribing practices raised following the events at Gosport hospital in relation to opioid use.

3. Legal / Regulatory Implications

N/A

4. Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)

N/A

5.	Resources Implications (Financial / staffing)
N/A	

6.	Equality and Diversity
N/A	

7.	References to previous reports
Not previously raised	

8.	Freedom of Information
Public	

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Opioid Assurance

The recent events reported about opioid use at Gosport Hospital have given rise to concern throughout the health community. The following summary highlights the situation at the RUH in terms of the Gosport findings in addition to general assurance about opioid prescribing.

Key Findings in the Report

Finding One: Opioid usage without appropriate clinical indication

Pharmacists review opioid prescribing as part of their daily clinical check. In addition they check the hospital prescribing against the original GP prescribing before admission to ensure that the doses are accurate and whether or not the patient is opiate naive.

There are guidelines for the management of pain on the intranet in the form of an analgesic pain ladder for Adults and Children. Clinical indication is not a mandatory field on ePMA as this would add significant time to the prescribing process.

Junior doctors receive specific training on opioid prescribing by the Chief Pharmacist within 6 weeks of their appointment. There is also further training by the palliative care team.

Finding Two: Anticipatory prescribing with a wide range of doses

This referred mainly to syringe drivers with huge doses and ranges permitted for nurses to use. It is not possible to prescribe this way on the ePMA system and all syringe drivers have to be re-prescribed every 24 hours. However we do have as required prescribing at the RUH for pain relief and for end of life care. The doses and ranges used however are much lower than anything prescribed in Gosport. Nurses can administer a dose range of opioids in accordance with patient response. The doses prescribed are of the order of 2.5-10mg IV, SC or oral morphine in contrast with doses of diamorphine between 20 and 200mg (equivalent to 30-300mg morphine) ranges prescribed at Gosport.

It is worth noting that we have seen an increase in opioid incidents reported on datix. (See appendix 1) Some of these were around as required doses.

Finding Three: Continuous opioid usage for patients admitted for rehabilitation or respite care

This anticipatory prescribing is not carried out at the RUH

Finding Four: Continuous opioids starting at inappropriately high doses.

The guidelines used within the RUH (analgesic ladder) including end of life recommend starting at low doses and titrating upwards. Pharmacists review opioid prescribing as part of the daily clinical check.

A review of all as required prescribing of morphine within the past week (oral, SC and IV) indicated that only two prescriptions were in excess of 20mg morphine.

Finding Five: Opioids combined with other drugs in high doses

This related to syringe drivers with high doses of both diamorphine and midazolam and hyoscine in the same pump. Prescribing of syringe drivers at the RUH is used in palliative care and there are very robust guidelines in place and support from Dorothy House Palliative care team. Doses used at the RUH always start with a lower dose and any increase in dose is managed carefully.

There were also errors reported in the Gosport enquiry due to incorrect use of Graseby 16, 16a and 26 syringe pumps. The RUH MEMS department has confirmed that the RUH has not had these pumps since 2009. The model used at the RUH is McKinley T34 (now known as CME). The purchasing department has also been asked to make sure that there were no random purchases without MEMS knowledge. Finally as a precaution, a check was carried out at Dorothy House Hospice and there are no Graseby pumps remaining there.

Finding Six: Few patients survived long after starting continuous opioids.

There were no serious untoward incidents involving opioids during the past 12 months. Additionally all deaths occurring at the RUH are now screened as part of the Learning from Deaths process and this adds a significant additional opportunity to monitor for patterns of different circumstances that would give the Divisional Risk teams an early insight into the possibility of over use of opioids or other sedating medications causing early death.

Opioid Prescribing at the RUH and Assurance

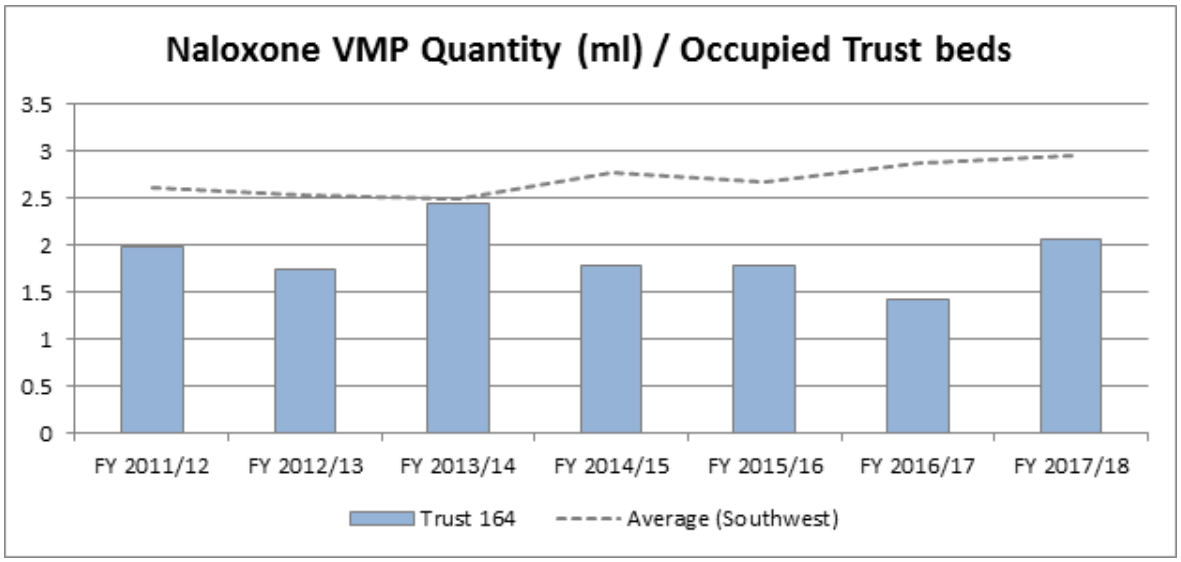
The Medicines Advisory Group reviews reported datix incidents regularly and high risk medicines including opioids are included in the workplan. The last review

indicated an increase in the number of incidents and a bulletin was circulated widely to doctors nurses and pharmacists to share the learning.

The Chief Pharmacist provides quarterly reports to the local intelligence network of all reported datix incidents re controlled drugs. There have been no concerns raised at that meeting about the level of reporting.

Controlled drugs are strictly controlled at ward level requiring two signatures for administration.

A proxy measure for overuse of opioids is the use of naloxone to reverse the effects of opioids. The graph below shows that the RUH is below the regional average



Conclusions

There is significant assurance that the prescribing of opioids in the RUH occurs within a framework of robust clinical governance. There are up to date and regularly reviewed guidelines, close monitoring of compliance, support from pharmacists and the palliative care team, and regular training. There is a strong pattern of incident reporting supporting the assertion that there is a robust culture of risk awareness. A feature of the problems at Gosport was a poor safety culture where inter-professional working was characterised by difficulties with raising concerns and bullying. The RUH has a well-established Freedom to Speak Up Guardian and in addition the multidisciplinary work of the Palliative Care team was highlighted as outstanding in the most recently published CQC report.

It is recommended that Board of Directors receives this report and takes assurance that the combination of Medicines Management and good

interdisciplinary working at the RUH make the occurrence of a pattern of significantly poor practice as was evident in Gosport extremely unlikely.

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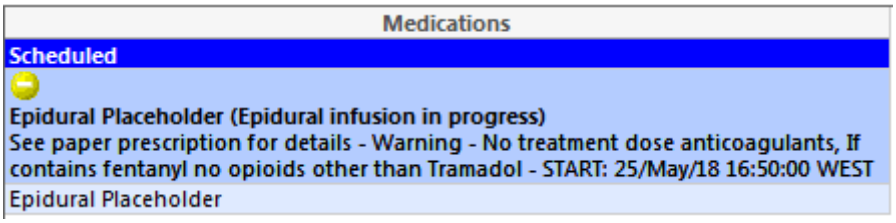
Learning from Recent Opioid Incidents

Over the last 6 months we have seen an increase in Datix incidents involving opioids. Please share this bulletin among staff in your areas for learning.

Prescribing and Administration Errors

- There have been a number of incidents where a patient had a PCA or opiate-containing epidural running AND was prescribed and administered additional opioid. Always check the full drug chart before administering opioids. No opiate other than tramadol may be co-administered with a PCA or opiate-containing epidural. Prescribers should add an Epidural placeholder to the drug chart on ePMA to alert to the presence of an epidural (search for Epidural):



- An elderly patient in severe pain received 25mg intravenous morphine in divided doses over 5 hours, and became opioid-toxic requiring naloxone. Remember to allow enough time between doses to assess patient response, particularly in opioid-naïve, elderly or renally impaired patients
- We have seen a number of wrong dose administration errors, particularly involving “when required” (PRN) opioids. Remember controlled drugs require a double check, and both checkers must review the prescription independently and fully

Documentation Errors

- There have been a number of incidents of poor documentation in CD registers and on ePMA. If an administered dose is not signed for there is a risk of duplication and patient harm
- Controlled drug stock levels must be checked daily and any discrepancies must be reported to the ward pharmacist and investigated promptly

For more information see: Medicines Code – Controlled drugs policy & procedure.

Written by Fiona Turnbull, Lead Pharmacist Medication Safety & Governance, May 2018. Approved by Medicines Advisory Group and Acute Pain Team.