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Royal London Hospital – High Intensity User team

Care Plan and Emergency Pain Protocol

Name: *** NHS: DOB:**

This plan is not a substitute for routine care or clinical judgment. It is the responsibility of the medical team to decide whether it is appropriate to follow this guidance in the context of the presenting situation. The content of this plan has been discussed with Mr * and he will be sent a copy. Please do not share, copy and paste into discharge plans or forward on to others without the explicit consent of our service.*

Brief Overview:

Mr ***** is a 27 year old man with a diagnosis of Functional Gastrointestinal Pain, who can experience intense pain on a daily basis. This pain is usually in his abdomen and at times in his rectal area. Additionally, ***can also experience periods of vomiting when in pain. ***** initially tries to manage his pain at home, but when he feels unable to do so and the pain escalates, he attends A & E. ***** usually calls an ambulance to convey him to A&E, he often does not request this attends his home as he is concerned about how this will affect his relationship with his mum. **** has also in the past used aliases with the LAS.

***** is open to the High Intensity Users Team (HIUT), as he has been attending the Royal London Hospital A&E department for several years on a very regular basis and he has attended approximately 83 times in the last 12 months.

Growing up, **** experienced interrupted attachments with caregivers and he was also involved in traumatic and violent situations as a teenager, which he understandably found disturbing. ***** may have been left feeling uncontained with difficult emotions in relation to these experiences, as he felt that his caregivers were not always available or able to help him process them. Some of these ways of experiencing others may be played out in his current interactions with health professionals, as ***** has described that he has at times felt unsupported, labelled and not taken seriously when suffering from pain and that he has often found visiting A & E an embarrassing and overwhelming experience.

***** had briefly engaged with psychology sessions in the HIUT and he had been able to reflect to an extent on possible links between his emotional and physical pain, on the impact of chronic pain on his life and on finding ways to manage his pain outside of using emergency services. However, he understandably found talking about his feelings challenging and eventually stopped attending. It appears that **** may continue to struggle to develop a psychological understanding of his problems and may hope that there is a purely medical explanation for his pain that will somehow provide a concrete solution to his condition. ****** is not currently engaged in any form of psychological therapy.

RE: Gastroenterology opinion:

****** was discharged by the RLH gastroenterology team on the 27th May 2021, although he did not attend his final appointment. The gastroenterology team concluded that ***** has a diagnosis of 'Functional Abdominal Pain' and that despite multiple investigations there were no 'structural of functional abnormalities' that could explain his episodes of pain. Additionally, the gastro team also expressed concerns that ****** use of opioid medications, including those prescribed in A+E - were likely contributing towards his pain and making his condition worse. (please see end of this plan for full copy of gastroenterology discharge letter)

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Meeting with *** – 22.07.2021:**

On the 22.07.21 ***** attended a meeting with A+E Consultant Alex Alexiou and Paul Fuller from the High Intensity User Team. The meeting was held to explain to ****** the that the view of the A+E MDT was that it was now necessary to support ****** to stop his use of IV Morphine in A+E. It was explained to ***** that his IV morphine use is now at a frequency where he is likely to be dependant on this as a means to address his pain and emotional distress. Additionally, it was explained to ***** that his use of IV morphine is likely to be causing him harm, and contributing towards his severe constipation and abdominal pains; both of which are primary reasons for his A+E attendances. ***** expressed that he was frightened about this, felt that he may not be able to manage his pain effectively and that this would have a significant impact on his mental and physical health. He was reassured that the plan is not to withdraw care and the A+E will continue to support him when he attends but using IV morphine will no longer be the treatment protocol. ***** has acknowledged this but did not agree with this approach.

****** 'Coordinate My Care Plan' was also discussed in this meeting and the current recommendation of giving IV morphine with the LAS will now be withdrawn. ****** has consented for a basic Coordinate My Care plan to remain on the system, although without treatment guidance.

For further information re this review – please read Dr Alex Alexiou entry on CRS – 22.07.2021

Ethics Opinion:

An opinion was sought regarding this change of pain management from the Barts Ethics Panel – summary below, full info copied at end of plan;

'In this case where the patient has an addiction and is accessing health care services to sustain their addiction, we have a moral and ethical duty to address this problem. You might even conclude that by continuing to give the patient opiates as requested solely for his drug dependency we are acting unethically.'

On the back of the above meeting and following multiple MDT discussions the following plan has been developed for when *** attends A+E:**

Guidance and treatment plan for A+E attendances (as agreed with ED Consultant team):

- ***** should be assessed by an ED consultant or senior SpR (ST6) on arrival, ideally accompanied by a member of nursing staff.
- ****** should no longer receive opiates within the Emergency Dept.**
- ****** should have any alternative pathology ruled out after an assessment, outside of his typical presentation.
- **Consider alternatives such as IV Paracetamol, NSAIDS** – further analgesia is also being explored – please document any relevant info and updates to the relative efficacy of any pain medicines administered. This plan can then be updated accordingly.
- **If pain level cannot be managed in A+E – consider an admission for further review and consideration of pain management.** If he is admitted, clear communication between the ED department and the inpatient ward should ensure that his **medication protocol in the ED is also followed in the** ward (i.e. ***** should no longer receive opiates).

- **Avoid using Entonox -** ***** is aware of the harmful effects of repeated Entonox use but continues to request this. There have been 3 known events of ***** moving to areas of A+E unseen and taking Entonox without this being prescribed. Any incidents should be recorded on Datix and escalated for consideration of appropriate response
- Ask ***** instead to take deep breaths and exhale – it will help release the air and pain in the stomach. If he struggles with this give him an unattached mouthpiece. Sucking on the mouthpiece is the same action as the deep breathing exercise for anxiety.
- When **** is distressed and in pain, he can present as quite challenging in his behaviour and this has been known to impact on other patients and the department in general. This change in pain management is likely to be extremely difficult for ****** and he will require a great deal of support and input to manage his distress in an appropriate manner. Staff should look to escalate early and seek additional support from senior staff and potentially security as required.
- ****** should be requested to remain in his cubicle, rather than move around the department as he has often been noted to do when he feels his needs are not being met.
- If ****** reports he is feeling suicidal or depressed – he should be referred to the MH Liaison Team – ******* has been given the contact information for the Tower Hamlets 24 hour Crisis line – 0800 073 0003
- The RLH Drug and Alcohol Team – have kindly agreed to contact ****** w/c 26.07.2021 – to offer support and to assess if an opiate substitute medication is indicated.

Ongoing plan:

- ***** has been advised to engage with the RLH drug and alcohol team with a view to exploring his complex relationship with opiate medicines further and with a possible view to starting an opioid replacement therapy. In the meeting on the 21.07 he agreed for the DALT team to make contact with him to discuss this further.
- ****** GP has referred him to the chronic pain team for further support and possible recommendations of pain management and psychological input.
- Ongoing liaison with the LAS to review how this new plan impacts on ***** care and treatment with crews responding to him in the community. Guidance and opinion for LAS pain management response will also be sought
- MDT meeting to held regularly to discuss the impact and progress of this plan – first meeting to be held W/C 09/08/21.
- Following above MDT, contact will be made with ***** (Paul or Alex) to communicate any changes to the plan and to give ***** an opportunity to discuss his care experience since the change of plan. Regular contact will be made with ****** as he continues to adjust to this new approach.
- ****** to remain under the RLH High Intensity User Team – who will continue to offer support to ***** and the ED team.
- Support to be provided to A+E team when impact of this new plan has been further understood.

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Patient Involvement in care plan – Care plan and pain protocol discussed at length with ***** in meeting on the 21.07.2021 – **** will be send a copy.

Care plan completed by: Paul Fuller, Senior Nurse Practitioner and Dr Christina Katsakou, Clinical Psychologist – HIUT, RLH A+E Consultant, Dr. Alex Alexiou

Copies to: GP, Barts Health Hospitals, East London Foundation Trust

Care plan signed off by MDT:

Care Plan review date:

Royal London Hospital - High Intensity User Team

elt-tr.rlhfrequentattenders@nhs.net

Copy of Gastro Discharge letter – 27.05.2021 – Dr Peter Byrne

Dear *******

We are sorry that you did not attend your review appointment with us. But not surprised in the context of what has been happening in recent years. This letter is a discharge letter to summarise what has happened and direct you on the next best steps.

You have been attending this hospital and Gastroenterology for many years, latterly with high frequency visits to ED. Dr Byrne first met you in October 2018 on the Gastro ward and wrote: "He has been investigated by my gastroenterology colleagues and there are no structural or functional abnormalities that would explain his condition (vomiting). Very helpfully he told me today that he is 100% certain that he will never smoke cannabis again." However, you continued to smoke cannabis (as now) and your difficulties progressed from vomiting to intermittent abdominal pain. You missed the clinic appointment with us for the following month, as you do multiple clinic appointments with physicians and psychologists - however your A&E attendances continued to increase. These contacts are documented on your medical records.

Our discharge diagnosis is that you have a functional abdominal pain syndrome that is made WORSE by opioids (oromorph, injected morphine) and cannabis. You do NOT have SMA syndrome or any structural problem with your stomach, small or large bowels. Your anorectal physiology is unremarkable - you do not need surgery or further interventions.

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We recommend referral to a Pain Clinic that specialises in psychosocial interventions for chronic primary pain and will support you to get off opioids. There are considerable risks (not least death by respiratory depression / stopping breathing due to toxic doses) if you continue to take these at the doses you have been getting. We sincerely hope you go on to accept psychological support and go forward to live the life you want to lead. Good luck with all of this.

Copy of Ethics Panel advice, kindly provided by Dr Ian Morrison - 20.07.2021:

Dear Mischa and Amy

A clinician is not mandated to give treatment that is requested by a patient or family if the clinician believes it is not in the patient's best interest.

In this case where the patient has an addiction and is accessing health care services to sustain their addiction, we have a moral and ethical duty to address this problem. You might even conclude that by continuing to give the patient opiates as requested solely for his drug dependency we are acting unethically.

As has been already outlined, we should invite the patient to participate in a multidisciplinary meeting and endeavour to draw up a treatment contract.

As part of the contract an initial assessment by a physician might be offered , as this would allow any relevant investigations to exclude or confirm relevant pathology. This then allows colleagues to proceed with confidence when assessing the patient in the future knowing that significant pathology has been excluded.

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We should also engage with the drug and alcohol dependency and chronic pain teams to draw up a therapeutic pathway for the patient's day to day care. This should include attendance to ED and what treatment might be offered.

In terms of ED, if the patient attends a senior should assess the patient and based on clinical findings treat appropriately. If there is no acute pathology then we should follow the prearranged therapeutic pathway to manage the patient's opiate dependence.

The key will be consistency and the multidisciplinary team supporting one another.

I would suggest regular meetings to review engagement and issues we encounter, with minutes kept that are saved to the patient's CRS record.

It is highly likely the patient will not engage but that does not preclude us moving forward.

So finally, to answer your original question, it is not unethical to withhold opiates or any medication that we believe is harmful or unnecessary, provided we undertake an assessment of the patient's needs, offer safe alternatives and clearly document our reasoning.

I am very happy to chat face to face or support any of the team as needed

BW

Ian