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Editorial

Nursing Education Special Edition

FROM THE EDITOR

Abdulrazak Abyad
MD, MPH, AGSF, AFCHS
(Chief Editor)

This is the last issue this year and the issue is rich with continuous education activities and videos.

A paper from Abu Dhabi report on a survey of continuous nursing education (CNE). CNE consists of educational activities which serve to maintain, develop or increase the knowledge, skills, and professional performance and relationships that a physician or dentist uses to provide services for patients, the public and the profession. CNE ultimately manifests as better patient care and better patient outcomes. In an attempt to assess the needs for professional development of the medical, dental practitioners and nursing staff a survey was conducted by means of a Questionnaire by the Department of Primary Health Care at the General Authority for Health Services for the Emirate of Abu Dhabi. 465 questionnaires were included in the study out of 600 hundreds distributed. The response rate was 77 percent. The distribution of the samples by regions were: 42.0% Island Region, 29.5% Middle Region, 27.4% Eastern Region and 0.2% Western. The mean age of the study population was 42years (SD 9.70) The mean of the number of years since graduation was 18 years (mean =8.46, SD=9.16). The authors concluded that in order to upgrade the skills of nurses in primary health care there is a need to initiate the Primary Care Nursing Education Initiative PCNEI.

A paper from Jordan looked at the use of seclusion in psychiatric setting. The author stressed that every challenge in this world should be managed by appropriate ways to maintain the balance of life, this ways should prioritized according to the nature of the challenge; medication and therapy used to treat mentally ill patients, on the same time seclusion is the last choice to control the aggressive behaviors among those patients, but if the seclusion chosen; the health care providers should follow special rules before, during and after implementation.

In addition there is a CNE cases focusing on Palliative Care Nursing and on pain relief in terminal breast cancer. Further more there are two educational videos that have been posted online to supplement this learning:
Sub cutaneous fluid injection in Palliative Care and Use of a Syringe driver

Editorial office:
Abyad Medical Center &
Middle East Longevity Institute
Azmi Street, Abdo Center
PO BOX 618
Tripoli, Lebanon
P + (961) 6 443684
F + (961) 6 443685
E aabyad@cyberia.net.lb
Publishing Office:
medi+WORLD International
Australia
W www.me-jn.com

CME NEEDS ASSESSMENT: NATIONAL MODEL - NURSES CME

Abdulrazak Abyad
Ninette Banday

Correspondence:
Dr Abdulrazak Abyad
Email: aabyad@cyberia.net.lb

Abstract

This CME Needs Assessment paper was written to provide analysis on a particular regional country's <<the country>> proposed CME in Nursing program and can be used as a national model.

In this new millennium most nations, both developed and developing are actively reviewing national health policies and strategies as well as health delivery systems. The over-riding imperative in all cases is to deliver quality nursing care in a cost efficient manner while addressing issues of access and equity.

The provision of health services in <<the country>> is divided into federal, local and private sectors. The Health Authority, and the local government agency is responsible for the provision of integrated, comprehensive, and quality of health services for its population.

Introduction

The vision of <<the country>> is "To Provide World Class Healthcare." One of the first steps to achieve this vision is to start comprehensive educational programs to improve the skills of the primary health care team as Primary Health Care is essentially the first level of contact of the patient with the health care system. The suggested programs include the following:

- Interdisciplinary Primary Care Training Program. To assist medical centers in organizing their delivery of care around the of primary care principals.
- Primary Care Physician Education Initiative (PCPEI). The goals of the educational intervention are to better prepare current physicians to deliver care under this new paradigm.

Need Assessment Survey

In order to develop a comprehensive educational program for the health care team there is a need to carry extensive need assessment the first step in planning an educational activity. In an attempt to assess the needs for professional development of the medical, dental practitioners and nursing staff a survey was conducted by means of a Questionnaire (APPENDIX 1) by<<the country>>. The report takes into account a wide section of the various medical, dental and nursing staff. The wide range of topics that were covered in the survey is also well elaborated in the report included the following

Results of Survey

Demographic Data

465 questionnaires were included in the study out of 600 hundreds distributed. The exclusion criteria were that either the questionnaire was not returned or was incomplete. The response rate was 77 percent.

CME Topics for Nurses

The results for the CME topics for the nurses are presented in the Tables 30 and 31. Clinical Practice Guide of Emergency Care, Professional Accountability & Legal Liability for Nurses, Medication Adherence in Children

with Asthma/Diabetes, infection control and immunization were some of the topics that received high ratings for the need for CME activities.

Format of CME

The response rate for the monthly activity was the highest with Hands - workshops.

Recommendations

It is clear that looking at tables in the report that the respondents rated the importance of topics according to their level of knowledge. It is an important concept that revealed that the less knowledge they have about a topic was reflected by less score on rate of importance. Therefore in planning CME programs this should be taken into account.

Assessment Strategies

In the implementation of any CME activities assessment strategies is critical to judge the success of such a program. For example communication skills learning must be both formative and summative. The knowledge, skills, and attitudes to be assessed must be made explicit to both learners and teachers alike. Potential evaluators include local experts, course faculty, simulated and real patients, peers, and the learners themselves. Formative assessment should occur throughout the communication skills curriculum and is intended to shape and improve future behaviors. Assessment of communication skills must include direct observation of performance. Evaluation of setting a therapeutic environment, gathering data and providing information and closure must be included. Evaluation of advanced skills, including use of interpreters, providing bad news and promoting behavior change should be done as well. Criteria should match the novice level of the end of second year student, who should be able to identify the critical issues for effective communication and perform the skills under straightforward circumstances.

It will be as well a good idea to create a department of Family Medicine under the umbrella of <<the country>> that help coordinate the implementation of the different educational program, in addition to conducting a number of ongoing research and academic activities.

Conclusions

Quality CME can enhance the knowledge base and practice skills of the participating health care provider and is increasingly used as part of the credentialing and reappointment process. Continuing Medical Education is important not only as a requirement for practice, but as means for the profession to achieve one of its primary goals: QUALITY PATIENT CARE.

CME really is about changing behavior through education- about doing something different, doing it better." It is critical to look at CME and CPD in the mentality of 21st century. We attempted to clearly present: that the patient's concerns, values and outcomes must be the center of care; that partnering with an activated patient is essential; that self-awareness is essential in being an effective physician; that improving the process of care and health outcomes is the physician's responsibility and requires a systems approach.

Quality CME can enhance the knowledge base and practice skills of the participating health care provider and is increasingly used as part of the credentialing and reappointment process. Continuing Medical Education is important not only as a requirement for practice, but as means for the profession to achieve one of its primary goals: QUALITY PATIENT CARE.

Introduction to Project

In this new millennium most nations, both developed and developing are actively reviewing national health policies and strategies as well as health delivery systems. The over-riding imperative in all cases is to deliver quality health care in a cost efficient manner while addressing issues of access and equity.

By centering the focus of the program on the patient, rather than who provides the functions and services, we are best able to define our primary care program as the provision of integrated, accessible, cost-effective health care, wellness and preventative services through interdisciplinary teams. These teams are accountable for addressing the healthcare needs of their patients; developing a sustained partnership with their patients and practicing in the larger context of family and community.

Need Assessment

All health care disciplines share a common and primary commitment to serving the patient and working toward the ideal of health for all. While each discipline has its own focus, the scope of health care mandates that health professionals work collaboratively and with other related disciplines. Collaboration emanates from an understanding and appreciation of the roles and contributions that each discipline brings to the 'delivery of care experience'. Such professional socialization and ability to work together is the result of shared educational and practice experiences.

In order to develop a comprehensive educational program for physicians, dentists, nurses and the rest of the health care team there is a need to carry extensive need assessment. Needs assessment is the first step in planning an educational activity. Identification of needs provides the basis for writing activity objectives. Many sources may be used to establish needs. Physician needs may be determined through prior activity evaluations and/or surveys of individual needs. New advances in a clinical treatment may be identified as an area in which

further education is needed. Needs assessment data may be drawn from surveys (on-site, email, Web site), focus groups, expert consensus, faculty perception, formal or informal requests from physicians, analyses of previous evaluations, epidemiological data, environmental scans including literature search/review, and quality assurance/ improvement data (e.g., gaps between practice guidelines and practice performance, patient safety/institutional error data, and information from external entities such as licensing boards or certifying agencies, etc.).

It might seem self evident that the need to learn should underpin any educational system. Indeed, the literature suggests that, at least in relation to continuing professional development, learning is more likely to lead to change in practice when needs assessment has been conducted, the education is linked to practice, personal incentive drives the educational effort, and there is some reinforcement of the learning. On the other hand, basing learning in a profession entirely on the assessment of needs is a dangerous and limiting tactic. So a balance must be struck.

The definition of Need

As in most areas of education, for many years there has been intense debate about the definition, purpose, validity, and methods of learning needs assessment. It might be to help curriculum planning, diagnose individual problems, assess student learning, demonstrate accountability, improve practice and safety, or offer individual feedback and educational intervention. Published classifications include felt needs (what people say they need), expressed needs (expressed in action) normative needs (defined by experts), and comparative needs (group comparison). Other distinctions include individual versus organizational or group needs, clinical versus administrative needs, and subjective versus objectively measured needs. The defined purpose of the needs assessment should determine the methods used and the use made of the findings.

Exclusive reliance on formal needs assessment in educational planning could render education an instrumental and narrow process rather than a creative, professional one.

Methods of needs assessment

Although the literature generally reports only on the more formal methods of needs assessment, doctors use a wide range of informal ways of identifying learning needs as part of their ordinary practice. These should not be undervalued simply because they do not resemble research. Questionnaires and structured interviews seem to be the most commonly reported methods of needs assessment, but such methods are also used for evaluation, assessment, management, education, and now appraisal and revalidation.

Learning for needs

The main purpose of needs assessment must be to help educational planning, but this must not lead to too narrow a vision of learning. Learning in a profession is unlike any other kind of learning.

Thus, educational planning on the basis of identified needs faces real challenges in making learning appropriate to and integrated with professional style and practice. The first step is to recognize the need of learning that are a part of daily professional life in medicine and to formalize, highlight, and use these as the basis of future recorded needs assessment and subsequent planning and action, as well as integrating them with more formal methods of needs assessment to form a routine part of training, learning, and improving practice.

Methodology

Quality health care for patients is supported by maintenance and enhancement of clinical, management and personal skills. The knowledge and skills of practitioners require refreshment, and good professional attitudes need to be fostered through the process of continuing professional development. In an attempt to assess the needs for professional development of the medical, dental practitioners and nursing staff a survey was conducted by means of a Questionnaire (APPENDIX 1) by<<the country>>. This report takes into account a wide section of the various medical, dental and nursing staff. The purposes of the review, therefore were to:

- Determine the area of professional development
- Help the primary care physician, dentists, and nurses meet the challenge of changes in the structure and delivery of patient care.
- Encourage more reflection on practice and learning needs, including more forward planning; and
- Make the educational methods used in practice more effective

The topics that were covered in the survey included the following

CME Topics for Nurses

- Special Nursing Topics
- Medical Topics

Format of CME

Timing of the CME

Type of Activities

Self Study

Results

The results of the survey is presented in five parts, demographic data, physicians, dental, nurses CME and preferences. Statistical analysis was done using SPSS statistical package. The tables below represent a summary of the data collected.

CME Topics for Nurses

Ratings for the CME topics for the nurses was also rated in the same format as the physicians. The results are presented in the Tables 30 and 31.

Table 1: Special Nursing Topics

	Topics	Rating of Importance		Knowledge Level		Recommended CME	
		Mean	SD	Mean	SD	Mean	SD
1	Supervision/Management	3.35	1.51	2.83	1.07	3.43	1.48
2	Terminal Care	2.68	1.48	2.59	1.17	3.03	1.44
3	Assessment Strategies	3.49	1.52	3.18	1.02	3.44	1.43
4	The Ethics of Nursing Practice	3.62	1.56	3.63	1.08	3.37	1.51
5	Professional Accountability & Legal Liability for Nurses	4.03	1.28	3.33	1.11	3.78	1.37
6	Child Abuse - Know it When You See It	3.64	1.40	2.75	1.0	3.74	1.21
7	Holistic Nursing Practice: A Whole Perspective	3.36	1.46	2.89	1.11	3.69	1.24
8	Leadership/Management	3.61	1.44	3.15	1.18	3.48	1.46
9	Lab Tests and Interpreting Reports	3.65	1.46	2.82	.97	3.68	1.23
10	Nursing Fundamentals	3.90	1.51	3.85	1.07	3.66	1.35
11	Nursing Management	3.82	1.51	3.58	.94	3.85	1.31
12	Strategies to Promote Medication Adherence in Children With Asthma/Diabetes	4.18	1.19	3.09	1.11	4.11	1.21
13	Psycho-Social Aspects of Nursing	3.76	1.32	2.98	1.11	3.87	1.30
14	Substance Abuse: What You Should Know	3.73	1.37	2.80	1.0	3.67	1.33
15	SIDS - Sleeping Interventions to Deter SIDS	3.09	1.55	2.33	1.07	3.58	1.32
16	Infection Control	4.00	1.52	3.77	.95	3.74	1.50
17	Domestic Violence	3.02	1.418	2.57	.98	3.05	1.35
18	Delegation: A Step Toward Empowerment	3.09	1.51	2.70	1.05	3.30	1.23
19	Clinical Practice Guide of Emergency Care	4.37	1.19	3.41	1.02	4.34	1.09

Table 2: Medical Topics

Topics		Rating of Importance		Knowledge Level		Recommended CME	
		Mean	SD	Mean	SD	Mean	SD
1	Diabetes Mellitus	4.04	1.42	3.70	.81	3.81	1.42
2	Obesity	3.74	1.48	3.32	.93	3.46	1.47
3	Osteoporosis	3.93	1.34	2.80	.95	3.91	1.26
4	Hyperlipedemia	4.05	1.18	2.65	.91	3.90	1.25
5	Chest Pain – CAD	4.46	1.05	3.28	.96	4.28	1.15
6	Hypertension	4.15	1.42	3.71	.92	4.12	1.24
7	Cardiac Rehabilitation	4.22	1.16	2.80	1.02	4.21	1.11
8	Abdominal pain	4.10	1.16	3.27	.96	3.86	1.20
9	Asthma	3.93	1.50	3.70	1.02	3.86	1.30
10	Tuberculosis	3.89	1.22	3.03	1.07	3.82	1.23
11	Convulsions/ Epilepsy	4.13	1.16	3.12	.88	4.12	1.16
12	Cellulitis	3.73	1.15	2.67	.98	3.71	1.27
13	Infection Control	4.47	.95	3.63	.92	4.01	1.21
14	Normal growth and development	3.81	1.39	3.44	.96	3.46	1.23
15	Nutrition	3.84	1.44	3.51	.93	3.66	1.26
16	Immunizations	4.39	.99	3.59	1.12	3.89	1.32

It is clear from the above table that the level of knowledge of the nursing staff in the medical topic is low which reflect the lack of any CME program for the nursing staff.

In order to upgrade the skills of nurses in primary health care there is a need to initiate the Primary Care Nursing Education Initiative PCNEI. The goals of the PCNEI are to :

• Provide Lifelong Learning opportunities for professional nurses regarding the latest developments, concepts, and research in advanced nursing practice and the profession of nursing.

• Increase awareness in the nursing community of current health care trends and practice issues.

• Collaborate with other health care professionals to provide educational opportunities for nurses and other members of the health care team.

It is important to show commitment from the authority to professional development support for nurses, for example:

• Professional continuing education opportunities available and supported;

• Resource support for advanced education in nursing, including RN-to-BSN completion programs and graduate degree programs;

• Preceptorships, organized orientation programs, re-tooling or refresher programs, residency programs, internships, or other educational programs available and encouraged;

• Incentive programs for registered nursing education for interested licensed practical nurses and non-nurse health care personnel;

• Long-term career support program targeted to specific populations of nurses, such as older individuals, home care or operating room nurses, or nurses from diverse ethnic backgrounds;

• Specialty certification and advanced credentials are encouraged, promoted, and recognized;

• APNs, nurse researchers, and nurse educators are employed and utilized in leadership roles to support clinical nursing practice; and

• Linkages are developed between health care institutions and baccalaureate/graduate schools of nursing to provide support for continuing education, collaborative research, and clinical educational affiliations.

• What resources are committed to the ongoing professional development of nurses, i.e. tuition, continuing education, and certification?

• How much is budgeted annually per staff nurse for attendance at professional development activities?

• Do you provide tuition reimbursement for nursing course work completed towards obtaining the next higher degree?

In this era of increasing health care workforce shortages, there is an ever expanding need for high-quality professional nursing care due largely to changes in the socio-demographics of the population and in the health care system itself. There is a critical need for PCNEI to fully utilize the knowledge and skills of professional nurses and to ensure their continuous professional development, and promote excellence in lifelong learning for all health care providers. In today's challenging healthcare environment, nurses committed to professional continuing education for nurses help maintain the standards of nursing practice and improve the health of the public.

Adult Learning Principles

In addition to being "champions," teachers need to employ principles of adult learning in their approach to teaching these topics. The knowledge base for any of these topics is changing every day with the information and technology explosion that has occurred in the last quarter-century. Genetics is a perfect example of a topic subject to rapid, ongoing revision based upon new research findings. Physicians must learn how to identify their own learning needs and address these needs effectively, in order to keep up with the ever-advancing knowledge base in most of these topic areas.

Self-Awareness

In addition to fostering an enthusiastic approach to lifelong learning, the instructional method must encourage physicians to reflect upon their own lives in relationship to the topic. The topic of geriatrics, for example, emphasizes many issues that every student will face, through the aging of parents and themselves. Substance abuse, end-of-life, and other topics often elicit strong emotions within students, as physicians remember past experiences or recognize ongoing struggles within their own lives. Teachers must create environments that are safe enough to foster trust and intimacy, and yet challenge physicians to reflect upon their own experience of life, as they develop a basic level of mastery in these special topic areas

Format of CME

Attempt was made to establish the most suitable timings and frequency of the CME activities.

The ratings adopted were :

1 being least appropriate, 5 most appropriate. The results are presented in the following tables and the need for a monthly activity was rated highest 3.95 with Hands- on Training.

Table 3: Timing of CME

	Timing of the CME	Rating	
		Mean	SD
1	Weekly at night	2.42	1.52
2	Half day in the weekend on weekly basis	2.48	1.49
3	Bi-weekly	2.61	1.55
4	Monthly	3.95	1.38
5	Once yearly (Conference)	2.75	1.72
6	Others	2.03	1.60

Table 4: Type of Activities

Type of activities		Rating	
		Mean	SD
1	Classic lectures	3.41	1.49
2	Workshops	3.91	1.38
3	Hand on Training	3.96	1.29
4	Conferences	3.55	1.32
5	Journal Club	2.82	1.48
6	Others	1.85	1.37

Table 5: Self Study Methods

Self Study		Rating	
		Mean	SD
1	Videotapes	3.39	1.45
2	Monographs	2.52	1.26
3	Journals	3.64	1.38
4	Internet	3.58	1.43
5	CD	3.55	1.48
6	Others	2.03	1.49

Interactive formats are not inherently beneficial nor always produce change. Some formats may be more conducive to specific changes in behavior and some to support. Group dynamics, facilitation, personal agendas, and internal and external influences contribute to the complexity of the format. In general, the focus was on choice of CME as opposed to other elements of the learning cycle. This approach has been documented previously and reflects the traditional approach to learning. It is well established that CME should follow the principles of androgogy - adult, self-directed learning. The term 'androgogy' has been coined to describe the learning culture appropriate to adult education . Whereas the term 'pedagogy' describes the teacher-centred approach to the education of children, androgogy 'recognises education to be a dynamic lifelong process' that 'is learner-orientated'. This is grounded in experiential learning - identifying and addressing needs and applying learning with continuing reflection.

CME & CPD for Nurses

The response of the nursing team to the survey was significant, it reveals the high lack of CME activities for nurses at the Emirate level. There is a great need to devise a comprehensive CME program to improve the skills of the nursing team within primary health care

Because the health care system is evolving and changing rapidly, continuous efforts to survey nurses and employers to identify content and skills needed for educational programs in nursing are essential. In Nursing learning is a life long process and continuing education is an integral part of professional development. While graduate and undergraduate education lead to formal academic degrees, continuing professional education consists of those learning activities intended to build upon the educational and experiential basis of nurses.

Changes in the social, political, economic and technological environments impact on the environment for health and health care and on professional practice. These changes provide challenges and opportunities for the nursing profession to develop and support effective CME program. The work environment for the practice of nursing has long been cited as one of the most demanding across all types of work settings. Nurses provide the vast majority of patient care in hospitals, nursing homes, ambulatory care sites, and other health care settings. The first objective of the professional practice environment for nurses is to put the patient first. Nurses and health care organizations must focus on patient safety and care quality and always ask the question, "What is best for our patients?"

In recent years a variety of factors have converged to challenge the work environments of contemporary nurses. Rapid advances in biomedical science, improved disease prevention and management, integration of new clinical care technologies, and shifts in care delivery to a broad array of clinical sites have contributed to the rapidly increasing need for well-educated, experienced

nurses. Additionally, population demographics are changing as the public ages in growing numbers and becomes increasingly diverse in culture and language. Exacerbating the challenges to the work environment for nursing practice is the nationwide shortage of nurses and other allied health professionals.

Conclusion

CME really is about changing behavior through education-about doing something different, doing it better." The bottom line of CME in the past has been the activities we produced-how many, how much they cost, how many people came. In essence, CME was more activity-oriented than learner-oriented. "Not only do you have to focus on the learner," "you have to focus on the learner in the context in which they are learning, which is the healthcare environment where they practice medicine." The aim of the proposal is to 'to provide leadership in the delivery of high quality education, for the primary care team, in the context of a caring and vibrant academic environment'

It is critical to look at CME and CPD in the mentality of 21st century. We attempted to clearly present: that the patient's concerns, values and outcomes must be the center of care; that partnering with an activated patient is essential; that self-awareness is essential in being an effective physician; that improving the process of care and health outcomes is the physician's responsibility and requires a systems approach.

Quality CME can enhance the knowledge base and practice skills of the participating health care provider and is increasingly used as part of the credentialing and reappointment process. Continuing Medical Education is important not only as a requirement for practice, but as means for the profession to achieve one of its primary goals: QUALITY PATIENT CARE. To our patients CME requirements are a commitment made by the medical and dental practitioner to keep our knowledge and skills current.

APPENDIX

SURVEY: CME TOPICS FOR NURSES

Please rate each of the topics below

(a) In order of importance for you to have CME on the topic (1 = least important to 5 = most important)

(b) By rating your own current level of knowledge of the topic. (1 = basic to 5 = highly skilled)

(c) Recommend CME activity on level of priority. (1=least to 5 = highest priority)

	Topics	Rating of Importance		Knowledge Level		Recommended CME	
		Mean	SD	Mean	SD	Mean	SD
1	Supervision/Management	3.35	1.51	2.83	1.07	3.43	1.48
2	Terminal Care	2.68	1.48	2.59	1.17	3.03	1.44
3	Assessment Strategies	3.49	1.52	3.18	1.02	3.44	1.43
4	The Ethics of Nursing Practice	3.62	1.56	3.63	1.08	3.37	1.51
5	Professional Accountability & Legal Liability for Nurses	4.03	1.28	3.33	1.11	3.78	1.37
6	Child Abuse - Know it When You See It	3.64	1.40	2.75	1.0	3.74	1.21
7	Holistic Nursing Practice: A Whole Perspective	3.36	1.46	2.89	1.11	3.69	1.24
8	Leadership/Management	3.61	1.44	3.15	1.18	3.48	1.46
9	Lab Tests and Interpreting Reports	3.65	1.46	2.82	.97	3.68	1.23
10	Nursing Fundamentals	3.90	1.51	3.85	1.07	3.66	1.35
11	Nursing Management	3.82	1.51	3.58	.94	3.85	1.31
12	Strategies to Promote Medication Adherence in Children With Asthma/Diabetes	4.18	1.19	3.09	1.11	4.11	1.21
13	Psycho-Social Aspects of Nursing	3.76	1.32	2.98	1.11	3.87	1.30
14	Substance Abuse: What You Should Know	3.73	1.37	2.80	1.0	3.67	1.33
15	SIDS - Sleeping Interventions to Deter SIDS	3.09	1.55	2.33	1.07	3.58	1.32
16	Infection Control	4.00	1.52	3.77	.95	3.74	1.50
17	Domestic Violence	3.02	1.418	2.57	.98	3.05	1.35
18	Delegation: A Step Toward Empowerment	3.09	1.51	2.70	1.05	3.30	1.23
19	Clinical Practice Guide of Emergency Care	4.37	1.19	3.41	1.02	4.34	1.09

Topics	Rating of importance	Knowledge level	Recommended CME
II. MEDICAL TOPICS			
Diabetes Mellitus			
Obesity			
Osteoporosis			
Hyperlipedemia			
Chest Pain – CAD			
Hypertension			
Cardiac Rehabilitation			
Abdominal pain			
Asthma			
Tuberculosis			
Convulsions/ Epilepsy			
Cellulitis			
Infection Control			
Normal growth and development			
Nutrition			
Immunizations			

Any other skills or topic you feel are important for your academic development:

Personal Information (optional)

Name _____
Degree _____
E-mail _____
Work place _____

Are you willing to help in the teaching process of the CME?

POSITION STATEMENT PAPER ON SECLUSION USAGE AMONG AGGRESSIVE PATIENTS

Qusai Mohammed Harahsheh

Correspondence:
Qusai Mohammed Harahsheh
School of Nursing
The Hashemite University
Email: Qusaimohad@yahoo.com

Abstract

Every challenge in this world should be managed by appropriate ways to maintain the balance of life. These ways should be prioritized according to the nature of the challenge; medication and therapy used to treat mentally ill patients, and at the same time seclusion is the last choice to control the aggressive behaviours among those patients. But if seclusion is chosen, the health care providers should follow special rules before, during and after implementation.

Key words: **Seclusion, Aggressive, patient**

Introduction

In our world there are many problems, diseases, and tragedies. There are wars, stressors, difficulties, responsibilities and tasks, all of them may result in mental disorders within people, as a circle of destructive behaviours images.

On the other hand, there are many solutions, medications, methods, techniques and good people which help in maintaining the balance in this life.

In general, mental illnesses are inability to cope with different stressors which are developed by the environment, both internally or externally. This failure of coping is reflected as incongruent feelings, thoughts and behaviours against norms which are used locally or culturally. At the same time this maladaption interferes with people's function socially, physically and occupationally (Townsend, 2006).

Moreover there are many methods used to control the destructive behaviours. One of the most important methods is seclusion. Seclusion is defined as involuntary or voluntary isolation of patients in a specific room. This room is called a seclusion room. It has many characteristics focusing on a non-stimulating place, It must be locked, supervised via a window and contain safety measurements as a whole (Health Care Commission 2008).

Furthermore seclusion is considered as one of the most important measurements used in close units for mental health patients as a result of aggressive behaviours which may affect health care providers, other patients in the unit and the patient themself. (Happell & Harrow, 2010).

The number of seclusion episodes varied from 3.7 - 110/1000 in patient/days in the USA and the Netherlands and 1.3 - 1517/1000 patient/days in Australia, Belgium (Janssen et al., 2008).

The Mental Health Commission defined seclusion as a place that has a locked door designed in a way which prevented patients from going outside; this person was to stay in this room alone and all the time.

In 1839 the British psychiatrist John Connolly advocated to eliminate seclusion from treatment (Colonize, 2005).

Many centuries previously, seclusion was used as an essential element of treating the acute mentally ill patient. It was used in 1950 when psychotropic agents failed to control aggressive behaviours of patients (Guthrie, 1978).

Furthermore the position statement defined it as a critical issue, with highly commitment to it according to the judgment of professionals and it resulted in best and safe practice. At the same time it described the important conditions, how staff worked with these conditions, which procedures must be used and how staff must apply procedures by specific strategies to implement it in the correct and safe way (Vollmer et al., 2011).

The purpose of this position statement paper is to clarify use of seclusion for mentally ill patients in psychiatric settings, and identify seclusion procedures used by psychiatric nurses in daily practice.

The current author outlines this paper as following; introduction of literature review which is divided into opponent and proponent studies, summary and conclusion of literature,

followed by a position statement which concludes with specific concerns and recommendations related to seclusion and finally a summary and conclusion of the position statement followed by acknowledgment and references.

Literature Review

Introduction

This literature review will explain and clarify the usage of seclusion, effects and reasons of usage among mentally ill patients in the psychiatric settings, and describe the opponent and proponent studies. The author used many online databases such as Science direct, biomed and PubMed, and found a huge number of articles related to seclusion, most of them against seclusion and others in defence of using it among psychiatric patients.

Opponent Studies

During searching in different databases the author found that most articles against the usage of seclusion among psychiatric or mentally ill patients. Many studies concluded that using seclusion is still a large ethical dilemma because it is acting against patient autonomy (Prinsen & Van Delden, 2009); at the same time using seclusion is considered as distractive of patient rights to make personal decisions or choose the preferred way of treatment (FinLex, 2009).

Furthermore people may look at seclusion from a human and ethical dimension; on this point the International Recommendations didn't consider seclusion as a treatment or therapy, and the use of seclusion must be just as an emergency measure and the specialist must use it carefully, on the other hand some studies show that some patients considered seclusion as unnecessary, extra intervention and sometimes it may not have any benefits for them (Soininen et al, 2013).

At the same time seclusion may cause emotional trauma and distress for patients and staff (Frueh et al., 2005), moreover nursing and medical ethics working together must respect the dignity and the autonomy of the patient by providing choices, not by paternalistic practice (Holmes et al., 2004), and staff in the psychiatric field must not seclude any patient.

On the other hand the basic element in the therapeutic relationship between staff and psychiatric patient is trust, so how can patients trust any person who restricts them in a closed room and restricts their autonomy; from this dimension seclusion is not preferable in the psychiatric setting (Soininen et al., 2013).

Although seclusion is considered as a safety measuret which prevents trauma or injury and is an agitation reducing measure, the practice still lacks the effectiveness and safety for use in this intervention (Bergk et al., 2011). There is not enough evidence about the effectiveness of seclusion and there is no marked in decrease in the distractive or aggression behaviours by seclusion among serious mentally ill patients (Sailas E et al., 2000).

Now, to decrease seclusion use the new science focuses on the alternative measures to reduce using of seclusion in psychiatric settings, but there is insufficient implementation of these measures (Gaskin C et al., 2007) To be more focused on this point it is important to know that use of support, active listening, good communication between staff and psychiatric patient will decrease the seclusion usage to 73% among child units and 47% among adolescents in a psychiatric unit.

Furthermore (Smith et al., 2005), suggest using the psychiatric emergency response team in stressful situations and crises in psychiatric settings. This team is trained, educated, have a therapeutic way of communication and have de-escalating techniques skills. The suggestion is to involve this team to work effectively with aggressive and violent patients without use of seclusion.

Moreover, Scanlan (2009) concluded that providing training strategies during crisis situations, such as de-escalating measures and non-violent interventions are an essential element to decrease using seclusion in any psychiatric unit.

On the other hand Stewart et al, 2010 suggest that use of medication such as atypical antipsychotics play an effective role to decrease use of seclusion.

Regarding quality of life, medical science patient satisfaction and patient quality of life during and after hospitalization the new science starts to apply the concordance term in hospitals which means involve patients in the decision making process to choose the treatment method and take patient opinion before any intervention like seclusion (WHO, 2008).

Furthermore seclusion may act negatively on the caring process; there are many traumas and harmful results for both staff and patients, that have occurred during seclusion interventions (Frueh et al., 2005).

The current author obtained a policy about seclusion from King Abdullah University Hospital, developed in 2013. This policy concluded with a specific concern and recommendation for seclusion. It aimed to provide specific guidelines related to therapeutic use of seclusion for psychiatric patients in any psychiatric setting.

Proponent's Studies

During the searching process the author found a few studies affirming use of seclusion in psychiatric units These articles focused on the time, duration, and goal of using seclusion among psychiatric patients.

The international recommendation considered seclusion as an emergency measure provided to prevent any incidence of violence or injuries for staff and patient. This was from a legal dimension, but not from a humanity dimension. Seclusion may not affect any patient quality of life, but the negative mode is it may decrease the patient's quality of life (Soininen et al., 2013).

(Schreiner et al., 2004) conclude that to keep patients and staff safe at the psychiatric unit, seclusion must be used, and this use depends on empirical knowledge; at the same time if the decision is taken to put any patient in seclusion room it's must depend on objective behaviours.

It is important to know that 33% - 62% of seclusion incidences occurred as a result of actual threatening violence (El-Badri &Mellsop, 2002). For this reason seclusion is used just in an emergency situation (Tardiff & Lion, 2008). Furthermore many countries use seclusion for management of disruptive, aggressive, violent behaviours enacted by psychiatric patients, and this management is considered as the last choice and aimed to protect patient, staff, and other workers' safety (Hoyer G et al., 2002).

Many studies focused on the reason for using seclusion. Some of them concluded that seclusion may be use when a patient developed disorientation or aggression without violent signs or threatening others as a prophylactic measure among psychiatric or mentally ill patients (Kaltia et al., 2003).

Moreover the use of seclusion is accepted when a patient developed aggressive behaviours (Poulsen H et al., 2002).

At the same time, the (MHC, 2011) suggests using seclusion became the cause of 20% psychiatric nurse loss in many areas within the last year as a result of aggressive behaviours and shortage of staff.

On the other hand (O'Hagen et al., 2007) shows agreement with seclusion intervention for an immediate debriefing technique but it must be followed by formal incident of debriefing intervention.

Summary and Conclusion

On review of the literature studies the highest number of studies in this literature were against use of seclusion among psychiatric patients. A few studies defended use seclusion because of safety for patient and staff; in general seclusion usage is still an ethical dilemma.

On one hand patients have right of autonomy, safety, and self-determining. Seclusion contravenes all of their rights. Studies have shown that seclusion cannot solve the problem completely and health care providers can use other measurements such as medication, communication skills, and decreasing this technique. This measurement is to protect patient rights and enhance patient quality of life.

On the other hand, a few studies defend the use of seclusion because of it protects staff and patients from aggressive behaviours and violence which are developed by psychiatric patients who have disorientation and aggression signs.

Finally the new science is focused on providing training and courses for staff who are working in the psychiatric field to enhance their ability to use other measurements with psychiatric patients, especially with aggressive and violent patients, to decrease seclusion usage in psychiatric settings.

Position Statement

The current author strongly agrees with using seclusion procedure for psychiatric patients just in highly stressful situations to protect patients and staff and the medical global message is to enhance patient quality of life and prevent harm during and after hospitalization especially when in the psychiatric field we have many other choices rather than seclusion, such as medication, communication skills, verbal-de-escalating technique and many other methods.

The author has developed this position statement with policy developed by King Abdullah University Hospital. This position statement summarizes specific concerns and recommendations for seclusion usage, that must be applied by all health care providers and especially in psychiatric settings.

The following list of major concerns and recommendations:

- Try restrictive practice (Seclusion) as a last choice for safety precaution and to prevent harm.
- Educate all health care providers especially psychiatric nurses about communication skills and de-escalating technique.
- Provide pharmacological courses for psychiatric patients focused on atypical antipsychotic medication to use it for patients rather than seclusion.
- Educate staff on how to develop a trusting relationship with psychiatric patients.
- Develop a special team in every psychiatric setting such as psychiatric emergency response team characterized by the ability to communicate on therapeutic ways and effectively with aggressive patients. Manage the stressful situations without any physical activity, highly trained in verbal de-escalating technique, Ability to work effectively with aggressive and violent patients.
- Start applying the concordance term in psychiatric settings.
- Solve the shortage of staff in psychiatric settings by enhancing the job satisfaction for them, especially salary and working hours issues.
- Provide courses related to signs of agitation and aggressive behaviours of patients to take the correct precautions from the health care providers.
- Human being rights and patient dignity should be protected by nurses all the time, especially during seclusion.
- The seclusion room should be used after an assessment of the needs of the patient and staff.
- Acceptable reasons for seclusion :

(1) To prevent physical injury.

(2) To decrease stimulation for the patient.

(3) To prevent major damage to the unit.

- Nursing note must be written every two hours, date, time of violence and any destructive behaviours from patient and any order taken from the doctor.
- Continuous monitoring and observation should be done by staff after any violent behaviour.
- Medication meals, fluids must be given to patient carefully.
- Maintain personal hygiene twice daily and clothing if needed, toileting every two hours during day time and four hours during night time, if patient uncooperative use a bedpan.
- Educate nurses, unqualified personnel and family caregivers on the appropriate use of seclusion, and on the alternatives to these restrictive interventions.
- Assess patient status pre seclusion usage, talking with patient, going to other calm area, explore the problem and try to solve it before using seclusion.
- Ethical consideration to clarify when, where and how patients are to be secluded and monitored during seclusion.
- Seclusion needs doctor assessment before applying, then doctor order and charted in medical record date and time of seclusion
- If seclusion order obtained, charge nurse and nursing supervisor must be informed.
- If seclusion applied, family and care giver should be informed as soon as possible.
- Seclusion should be applied by a qualified staff nurse.
- Seclusion ends when a doctor orders it after assessing patient behaviour status and decide there is no dangerous behaviours toward self or others.

Summary and Conclusion

The purpose of this position statement paper was to clarify using of seclusion for mentally ill patient among the psychiatric settings, and identify seclusion procedures used by psychiatric nurses in daily practice.

Seclusion is considered as a last choice to control aggressive behaviour, to maintain a safe environment and prevent harm for patient themself, staff, and others, and other interventions must be used first; if medication and other techniques are not effective then seclusion can be used.

If seclusion is ordered for use, psychiatric nurses must implement the concerns and special considerations mentioned previously.

Despite seclusion affecting patient autonomy and contravening human rights, the main goal in the psychiatric setting as a priority is to enhance safety precautions and prevent harm of self and others and enhance quality of life.

As reviewed, literature studies found that most studies are against using seclusion and to reduce this practice and enhance patient quality of life by using another proper way to reduce and avoid seclusion.

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CNE : PAIN RELIEF AND PATIENT CARE IN A TERMINAL BREAST CANCER PATIENT

CME Authors:

Dr Bambi Ward
Emeritus Professor Neil Carson

To complement this CNE case 2 videos have been placed online as follows:

Nursing videos:

• Subcutaneous Fluid Administration

• How to use a syringe driver

See: http://www.mejfm.com/MEQUIP/Video%20Library.htm

Case Presentation

Mrs Green is a fifty year old married lady who has a twenty five year old son. She is a former nurse with a passionate interest in complementary and alternative therapies. She writes books and poems and runs a meditation group from her secluded home in the mountains. She lives with her husband, who works full time as an architect, and her two cats.

Mrs Green was diagnosed with breast cancer six years ago. She elected to have alternative treatments in Mexico, as well as a short course of radiotherapy and chemotherapy. She declined surgery.

Mrs Green telephones and requests a home nursing visit. She tells you her right hip has been painful for one week.

There has been no history of trauma to Mrs Green's hip. When the pain has been particularly bad, she has taken paracetamol tablets once or twice a day and they helped relieve the pain.

Her dctor arranges an X-ray of her right hip. The X-ray findings were normal.

Question 1:

How should Mrs Green be managed?

Select one or more of the following:

1. Mrs Green should have a bone scan
2. Commence Mrs Green on a non-steroidal anti-inflammatory drug
3. Advise Mrs Green to take paracetamol 500mg 1-2 tablets 4 hourly when needed for pain until further review

(Answers and feedback are on next page)

Answers and feedback for Question 1

1. Mrs Green should have a bone scan

The authors agree

Given her history of breast cancer, bony metastases are the likely cause of her hip pain.

A bone scan is the most appropriate way of diagnosing bony secondaries.

2. Commence Mrs Green on a non-steroidal anti-inflammatory drug

The authors agree

A non-steroidal anti-inflammatory drug,(NSAID) such as Naproxen 500mg bd or Ibuprofen 400 mg tds is considered to be the initial treatment of choice for bony metastases.

Since you suspect bony metastases, it is worth prescribing an NSAID while waiting for the bone scan result, providing there are no contraindications. (eg history of peptic ulcer).

3. Advise Mrs Green to take paracetamol 500mg 1-2 tablets 4 hourly when needed for pain until further review

The authors disagree

It is not appropriate to prescribe analgesics for cancer pain on a purely 'as needed' basis. If a non-steroidal anti-inflammatory drug is contraindicated, then one or two 500mg tablets of paracetamol should be prescribed regularly, ie. 4 hourly, in order to prevent pain. (Maximum dosage is 8 tablets per day).

Further history

Given that Mrs Green's pain has responded to prn doses of paracetamol, it is likely that 4 hourly paracetamol would control her pain. If 4 hourly paracetamol does not control her pain, then Mrs Green needs to be told to report this to her doctor or visiting nurse.

If Mrs Green's pain is not well controlled, initiate an opioid, such as morphine or oxycodone, rather than codeine. Morphine and oxycodone are much more flexible than codeine in terms of dose escalation.

Once the cause of the pain is established, appropriate adjuvant analgesics (eg. corticosteroids) and other modalities (eg. radiotherapy) should be considered.

The bone scan confirms an isolated metastasis in Mrs. Green's right hip.

Important aspects of breaking bad news include:

- Delivering bad news face to face in a quiet, private place.
- Giving patients the option of having a 'significant other' person present.
- Ensuring the consultation is unhurried, uninterrupted and of sufficient length.
- Sitting at the patient's level.
- Maintaining eye contact.
- Giving information in lay terms, rather than using medical jargon.
- Giving the patient permission to express their feelings.
- Using silence, where appropriate, to facilitate this process.
- Reinforcing information delivered verbally by handing patient written information -whenever possible. (It is not unusual for shocked or distressed patients to forget much of what has been said to them by their doctor).
- Supporting the patient and reassuring them, when appropriate.
- Promoting patient confidence by informing them they will receive the best treatment possible.
- Ensuring the patient has the opportunity to have all their questions answered.
- Using the word 'cancer' directly.

Remember patients usually prefer to be given bad news by a familiar doctor with whom they have a good rapport.

The National Breast Cancer Centre (NBCC) has produced a summary of psychosocial clinical practice guidelines, providing information, support and counselling for women with breast cancer. A comprehensive list of breast cancer resources can be obtained by visiting www.nbcc.org.au.

Imagine you are Mrs Greens' Doctor...

Question 2

Which of the following statements about morphine are true?

Select one or more of the following

1. Cancer patients commonly develop rapid tolerance to the analgesic effect of morphine.
2. There is a ceiling dose for morphine given to patients with cancer pain.
3. Oral morphine causes significant respiratory depression in the majority of cancer patients.
4. Morphine use in cancer patients carries a high risk of psychological dependence.
5. Under dosing with morphine is the main reason cancer patients suffer unrelieved pain.

Answers and feedback are on the next page

Answers and feedback for Question 2

1. Cancer patients commonly develop rapid tolerance to the analgesic effect of morphine.

The authors disagree.

Increases in opioid doses in palliative care patients are probably due either to increasing nociceptive pain signals due to disease progression and/or tolerance. Tolerance is a pharmacodynamic property in which an increase in dose is required to produce the same level of effect. Some degree of tolerance probably occurs in most patients who receive opioids during the course of a terminal illness, so the therapeutic index may decrease. However this tends to be a gradual process rather than a rapid one. Tolerance is not considered to be a barrier to the provision of adequate analgesia.

2. There is a ceiling dose for morphine given to patients with cancer pain.

The authors disagree.

There is no ceiling dose for morphine in the management of cancer pain. The individual patient's analgesic needs should determine the way in which the morphine dose is titrated. The correct morphine dose is one that results in pain control without the presence of intolerable side effects. It is also important not to continue escalating the dose of morphine if the response is minimal or short term. In such cases, a different approach to pain management is required, ie. the use of other analgesic drug classes, route changes, interventions (eg. neurolysis) or treatment of the underlying disease.

3. Oral morphine causes significant respiratory depression in the majority of cancer patients.

The authors disagree.

In practice, significant respiratory depression is uncommon in patients where the morphine dose is gradually titrated according to individual needs. Respiratory pain can be reversed by giving naloxone, but this may precipitate severe pain.

Exceptions include:

- patients at risk of respiratory failure from other causes
- patients with impaired renal function
- opioid naïve patients
- patients receiving an excessive dose of morphine and/or too often
- patients who have had a procedure (eg. nerve block) to acutely relieve their pain.

4. Morphine use in cancer patients carries a high risk of psychological dependence.

The authors disagree.

As the risk of psychological dependence in cancer patients taking morphine is extremely low, fear of addiction should not be a reason to delay prescribing it. One needs to bear in mind that the majority of cancer patients will remain on a regular opioid until they die, so the issue of addiction does not arise. If the drug needs to be ceased, this can be done gradually (e.g. reducing the amount by 20-25% per day) so that effects of psychological dependence are avoided or minimised.

Exception: A small number of patients with a past history of drug abuse or psychiatric illness.

5. Under dosing with morphine is the main reason cancer patients suffer unrelieved pain.

The authors agree.

Unfortunately a varying degree of apprehension or reticence about using opioid drugs still exists amongst some doctors and patients. Doctors who still believe some or all of the common morphine myths may be reluctant to prescribe adequate doses.

Morphine, used appropriately, does not hasten death.

Morphine myths continued...

Question 3.

Which of the following statements about morphine are true?

Select one or more of the following

1. The early use of morphine for cancer patients reduces the likelihood of it being useful later.
2. A withdrawal syndrome is difficult to avoid if the dose of morphine is gradually reduced before complete cessation.
3. Severe pain requires parenteral morphine, even if a patient can swallow
4. Morphine should be given on an ‘as required’ basis in chronic cancer pain.
5. Patients do not become tolerant to the sedative effects of morphine when it is used to treat chronic cancer pain.

Answers and feedback are on the next page

Answers and feedbak to Question 3

1. The early use of morphine for cancer patients reduces the likelihood of it being useful later.

The authors disagree.

Morphine has a wide therapeutic range, so it can be titrated according to the need of each individual patient.

There are many cancer patients who take morphine for several years before their death. The dose of morphine is simply increased as/if required.

2. A withdrawal syndrome is difficult to avoid if the dose of morphine is gradually reduced before complete cessation.

The authors disagree.

The main reason for ceasing morphine in a cancer patient would be that pain relief had been successfully achieved by another treatment, eg. surgery or radiotherapy. If the patient's dose of morphine was gradually reduced by 20-25% per day, then withdrawal symptoms should be minimised or avoided.

3. Severe pain requires parenteral morphine, even if a patient can swallow

The authors disagree.

Analgesics should be prescribed orally whenever possible.

Oral morphine is as effective in providing analgesia as the equivalent dose of parenteral morphine. (The oral to parenteral conversion ratio for morphine is 3:1).

4. Morphine should be given on an 'as required' basis in chronic cancer pain.

The authors disagree.

To effectively prevent pain, analgesia is best given regularly rather than as required.

Analgesia also needs to be prescribed on as as needed (prn) basis for breakthrough or incident pain eg. prior to showering.

5. Patients do not become tolerant to the sedative effects of morphine when it is used to treat chronic cancer pain.

The authors disagree.

It is not unusual for patients to feel drowsy during the first few days of commencing morphine, however the drowsiness is generally mild and tends to settle within several days.

Further Information

In order to facilitate compliance, it is important patients be informed of this side effect. They should also be assured the drowsiness is likely to improve in 2-5 days and it is worth perservering with the treatment.

In summary, it is essential the treating doctor dispels any myths their patient may have regarding the taking of morphine. It is also important to emphasise that patients can live for a long time while taking morphine, and how it can improve quality of life by providing good pain control.

Further history

Mrs Green agrees to commence oral morphine after her concerns have been addressed. She also continues to take Naproxen tablets, 500mg bd.

Question 4

Given that Mrs Green is "opioid naive" (is not currently taking any opioids), what dose of morphine mixture (immediate release morphine = IRM) should be prescribed for the next 24 hours, and how often should it be administered? ***Consider your answer before checking below***

Answer 4

Morphine mixture 5 - 10 mg 4 hourly

10mg morphine mixture is the usual starting dose for a 50 year old opioid naive patient.

Morphine mixture is available in the following strengths: 1mg/ml., 5mg/ml., 10mg/ml, 20 mg/ml and 40 mg/ml.

Effective management of cancer pain involves giving analgesia at regular intervals rather than when required.

The aim is to prevent the pain recurring before the next dose of analgesia is taken.

Question 5

Which of the following is/are TRUE of the dose of morphine mixture in an opioid naive patient?

An elevated creatinine of 300 mmol/L would not alter my starting dose of morphine.

Consider your answer before checking below

Answer

The statement is FALSE.

The major metabolites of morphine are dependent on renal excretion. Therefore a patient with impaired renal excretion needs a lower starting dose of morphine than a patient with normally functioning kidneys.

It is appropriate to initiate a lower than usual dose of morphine mixture eg. 2.5 - 5 mg 4 hourly for a frail 75 year old lady.

Consider your answer before checking below

Answer

This statement is TRUE.

Start with a lower dose in an elderly and/or frail patient. The major metabolites of morphine are dependent on renal excretion. An elderly frail patient is more likely to experience side-effects such as confusion or drowsiness if they are commenced on the standard morphine dose. Reasons for this could include renal impairment, low body weight and multiple drug interactions

It is appropriate to make the same percentage increase in the daily dosage of morphine mixture in a frail 75-year-old patient as for a 50-year-old patient.

Consider your answer before checking below

Answer

This statement is FALSE.

Increasing the dose of regular 4 hourly morphine mixture slowly and gradually by approximately 30% rather then the usual 50% is appropriate in managing a frail and/or elderly patient's pain. The major metabolites of morphine are dependant on renal excretion. An elderly, frail patient is more likely to experience side effects such as confusion or drowsiness if the regular dose of morphine is increased too quickly. Reasons for this could include renal impairment, low body weight and multiple drug interactions.

Question 6

What dose of morphine mixture prn (if any) should be prescribed for Mrs Green's breakthrough pain on the day that you initiate regular morphine mixture ?

Consider your answer before checking below

Answer 6

Morphine mixture 5 mg orally pm for extra pain

The goal of treatment is to achieve the best possible pain control.

It is therefore necessary to prescribe a breakthrough dose of morphine to supplement the regular 4 hourly dose in case the patient experiences pain between the regular doses of morphine. This breakthrough dose is prescribed prn and is an important strategy in managing pain. It enables a more rapid attainment of an effective dose of morphine and is important in managing incident pain eg. prior to showering. It is also likely to save you from being telephoned in the middle of the night by a palliative care nurse requesting a prn morphine order.

Some palliative care doctors choose to initiate oral morphine in opioid naive patients using sustained release preparations such as Kapanol or MS Contin.

Question 7

What dose of sustained release morphine should be prescribed for Mrs Green?

Fill in the blanks in the sentence below:

Consider your answer before checking below

Sustained release morphine ..... mg bd or ..... mg daily.

Answer 7

Available sustained release of morphine are:

* kapanol 10, 20, 50, 100 mg capsules daily or bd.

* Ms contin 5, 10, 30, 60, 100, 200 mg tablets bd.

* Ms mono 30, 60, 90, 120 mg capsules daily

The standard starting dose of sustained release morphine for opiod naive patients is generally considered to be 20 mg bd or 40 mg daily.

Question 8

What dose of morphine mixture prn (if any) would you prescribe for breakthrough pain if you planned to initiate sustained release morphine in the form of Kapanol 20mg bd or 40 mg daily?

Consider your answer before checking below

Answer 8

Morphine mixture 5 mg orally prn for extra pain.

It is essential to prescribe a top-up dose of morphine mixture to supplement the regular dose of sustained release preparations of morphine. The goal of treatment is to achieve the best possible pain control. It is therefore essential to prescribe a breakthrough dose of morphine mixture to supplement the regular 4 hourly dose in case the patient experiences pain between the regular doses of morphine. This breakthrough dose is prescribed prn and is an important strategy in managing uncontrolled pain.

Question 9

In the past, Mrs Green has experienced nausea from both pethidine (given during labour) and panadeine forte, prescribed for the pain of impacted wisdom teeth many years ago.

Should a regular anti-emetic be prescribed for Mrs Green when morphine mixture is initiated? (Yes or No)

Consider your answer before checking below

Answer and feeback to Question 9 is on the next page

Answer 9

Yes author agrees

Given her past history of anusea from two different opiods, it would be appropriate to prescribe a regular prophylactic anti - emetic when morphine was initiated. Example of anti - emitic include: - maxolon (metoclopramide) 10 mg tablets qid - stemetil (prochlorperazine) 5 mg tablets tds or qid - Haloperidol 0.5 mg - 1 tablet tds.

The anti - emetic can be discontinued after 5 to 7 days, as the vomitingg centre is likely to have settled by then.

Question 10

Should Mrs Green be prescribed a prophylactic laxative? (Yes or No)

Consider your answer before checking below

Answer 10

Yes author agrees

The aim of prescribing a laxative with opioids is to prevent the almost universal predictable side affect of constipation. Examples of prophylactic laxative are: -

Coloxyl with senna 1- 2 tablets daily, up to tds, or

Lactulose or sorbitol 20 mls daily up to tds.

Further history

Mrs Green is commenced on 10mg morphine mixture 4 hourly (at 0630, 1030, 1430 and 1830). She is also ordered a double dose at 2230 with the aim of keeping her pain free overnight. She also takes four top up doses of 5mg morphine mixture over 24 hours.

Question 11

If after 24 hours, Mrs Green's pain had improved by about 50%, how much morphine would you provide over the next 24 hours? (include your dose of morphine mixture prn).

Consider your answer before checking below

Answer 11

15 mg morphine mixture 4 hourly (at 0630, 1030, 1430 & 1830) and 30 mg at 2230, plus morphione mixture 5 mg prn.

Mrs Green took 80 mg morphine over the previous 24 hours (10+10+10+10 +20+5+5+5+5). It is usual to increase the regular 4 hourly dose of morphine by 30 - 50% depending on clinical observation, breakthrough requirements , incident pain and physiological parameters such as renal function.

Recommended dose escalations for regular 4 hourly morphine mixture are as follows:

5mg 10mg

10mg 15mg

15mg 20mg

20mg 30mg

The breakthrough range for morphine mixture 2-4 hourly prn is usually 30-50% of the regular hourly dose.

Question 12

Some patients who are prescribed regular 4 hourly morphine mixture may not understand the concept of top-up/ breakthrough doses. This means they do not take any top-up doses, and their pain remains poorly controlled.

If Mrs Green was such a patient, what dose of morphine should be ordered for her over the next 24 hours if the original regular dose was 10mg morphine mixture 4 hourly?

Consider your answer before checkingon the next page

Answer 12

15 mg 4 hourly, that is a 30 - 50% dose increase.

Recommended dose escalations for regular 4 hourly morphine mixture are as follows:

5mg 10mg

10mg 15mg

15mg 20mg

20mg 30mg

Question 13

If Mrs Green's pain was well controlled on the original

total daily dose of 80mg immediate release morphine mixture, what dose of sustained release morphine mixture should you convert her to?

Consider your answer before checking below

Answer 13

The total daily dose is 80 mg. So give kapanol 80 mg (10 + 20 + 50 capsules) daily or MS contin 40 mgbd (10 + 30 mg tablets).

Do **not** mix Kapanol and MS Contin as they have different pharmacokinetic profiles.

Do **not** forget to continue the 5mg top-ups of morphine mixture prn.

Question 14

Mrs Green is having a total daily morphine dose of 80mg.

What should be the equivalent dose of morphine if it was given as a continuous subcutaneous infusion?

Consider your answer before checking below

Answer 14

Given that Mrs Green's total daily dose of oral morphine is 80 mg and the oral bio-availability of morphine is effectively 30%, devide 80 by 3 = 27 mg per 24 hours in a syringe driver. This dose would then be rounded up to 30 mg per 24 hours. Some palliative care units divide the total daily dose of oral morphine by 2, rather than 3 when calculating an equivalent continuous subcutaneous infusion dose of morphine.

Further history

On the last day of her two-week radiotherapy course, Mrs Green becomes progressively drowsy and is mildly nauseated on Kapanol 80mg daily. She is no longer on an anti-emetic.

Physical examinationreveals the following sign:-

Right hip pain virtually gone.

Small pupils.

Decreased respiratory rate

Question 15

What is the likely explanation for these physical findings?

Consider your answer before checkingon the next page

Answer 15

Mrs Green has symptoms of a morphine overdose, her daily morphine requirement has reduced, because of the palliative radiotherapy's analgesic effect. The radiation response usually takes 2 - 3 weeks to occur.

Action: Mrs Green's daily dose of morphine is reduced, and her daily dose of morphine stabilises on Kapanol 20mg bd.

Lesson: The dose of morphine does not necessarily need to be increased. Regular review of morphine doses is important, especially in patrients who receive palliative radiotherapy.

See video of Use of a Syringe driver: http://www.mejfm.com/MEQUIP/Video%20Library.htm

Further Information

Let us assume Mrs Green's pain is well controlled with morphine. However she subsequently develops intractable nausea, confusion and drowsiness. Her symptoms are assessed as being opioid related, after excluding other causes. (ie. brain metastases, hypercalcaemia and renal failure).

There are three different management options:

- Reduce the dose of morphine
- Change the route of morphine (eg. from oral to continuous subcutaneous infusion
- Change morphine to a different opioid (opioid substitution)

Option one is likely to result in a return of Mrs Green's pain. She is not keen to have a syringe driver at this stage, and you elect to do an opioid substitution. This involves changing a patient with unacceptable, refractory adverse effects of one opioid to a different opioid. The aim of this is to improve any adverse side effect(s) while maintaining an equivalent dose of analgesia.

Reference: Ashby M.A., Martin P., Jackson K.A. Opioid substitution to reduce adverse effects in cancer pain management. MJA 1999: 70: 68-71.

Question 16

What analgesic could be used as an alternative to morphine, and in what form should it be administered ?

How do you convert the dose of Kapanol 20mg bd to the new analgesic?

Consider your answer before checking below

Answer 16

Oxycodone would be an appropriate alternative to morphine. Oxycodone is available in a sustained release formulation called oxycontin in the form of 10 mg, 20 mg, 40 mg, 80 mg tablets, given bd. The conversion ratio of morphine to oxycodone is 1 : 1. Therefore kapanol 40 mg bd could be changed to oxycontin 40 mg bd.

END OF CASE