Access to pain relief for addictions service client
15HDC00563, 30 June 2017

District health board ~ Addictions service ~ Opioid substitution treatment ~ Pain management ~ Addiction ~ Right 4(1)

A man who was on long-term opioid substitution treatment presented to the emergency department at his local hospital after a fall. Following this presentation the man was found to have multiple nodules on his lungs and a lesion on his liver. A consultant physician reviewed the man and recorded an impression of chronic liver disease, hypoxia with suspicions of malignancy, and abdominal lesions and nodes. Further investigations were ordered.

Three days later, the man contacted an addiction clinician at the Addictions Service, and advised that he had been diagnosed with cancer of the liver. The addiction clinician informed the manager at the Addictions Service. The minutes from the Addictions Service's weekly meeting noted that the man was being investigated for liver cancer and was requesting to have his methadone increased when discharged from hospital.

The hospital discharge summary referred to the man's "possible poor prognosis" and included a plan for outpatient follow-up and GP review of the man's abdominal pain and pain relief.

The man presented at the hospital again, reporting shortness of breath and abdominal pain. He was admitted to the medical ward and provided with morphine. The man's admission and pain were reported to the manager at the Addictions Service. The manager told the addiction clinician that she had spoken to an addiction specialist, and that they "should be looking at reducing [the man's] methadone not increasing it". However, the addiction specialist said that he did not discuss the man with the manager at the Addictions Service at that time, and that information was based on a previous discussion.

The man was discharged by a house officer, with a prescription for increased methadone intended for acute pain relief. The man was noted at the time to be in severe pain with a deteriorating clinical condition.

The man presented the house officer's prescription to a pharmacy. Because of the change in methadone dose, the pharmacy called the Addictions Service. The addiction specialist called the house officer to clarify the prescription, and was advised that the methadone was prescribed to help with abdomen pain. The addiction specialist told HDC that the house officer was unaware of the man's current prescription and the DHB policy on prescribing methadone for addiction services clients on discharge. The house officer then cancelled the prescription.

The addiction specialist did not follow up on the prescription when he returned to work the next day.

The man's wife told HDC that over this period the man was in pain, and his condition was deteriorating rapidly.

The man was discussed at the next Addictions Service meeting, at which time it was noted that the man was having an MRI that afternoon. The minutes note that the addiction clinician was "reluctant to increase [the man's] methadone, due to concern he is drug-seeking".

The man underwent the MRI, but it could not be completed because he was unable to lie still owing to pain. This information was relayed by the addiction clinician to the addiction specialist. The addiction specialist said that this was the first indication he had that the man could be requiring methadone for clinical reasons rather than addiction. Responsibility for the man's methadone prescribing was handed over to a palliative care specialist. The man was transferred to hospice care, and passed away shortly afterwards.

Findings

There were a number of missed opportunities for communication about the man's situation, his condition, and his pain relief requirements, as a result of service-based failures attributable to the DHB. The man did not receive the pain relief he should have been able to access. As a result, it was found that the DHB failed to provide services to the man with reasonable care and skill and breached Right 4(1).

Recommendations

It was recommended that the DHB:

a) Develop a process for formal handover of addictions service clients when they move from outpatient to inpatient services and vice versa; conduct an audit to ensure that all interactions with clients are recorded in addictions service records and/or, if relevant, clinical records; and review and revise, as necessary, the position descriptions for addictions service staff referred to within this report, to ensure clarity of role expectations, professional development, and support.
b) Conduct a random audit of hospital discharge summaries over a one-month period to assess compliance with the requirement that hospital discharge summaries be sent to relevant GPs.
c) Provide refresher training for hospital staff on the "Methadone/Buprenorphine (with Naloxone) — Opioid Substitution Therapy for Treatment of Dependence (Addiction)" and "Pain Management — Adults" guidelines.
d) Provide a written apology to the man's family.