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When opioid analgesia kills

This summer we received a report from the Department of Health and Social Services (MSSS) on the use of opioids in hospitals,[1] produced by a task force assigned by the Minister to analyze the high number of deaths related to the use of opioid analgesics.

The Coroner's office investigated 12 deaths that occurred between 1995 and 2006 from respiratory depression following the parenteral administration of opioid analgesics. According to Coroner Jacques Ramsay, these twelve deaths were just "the tip of the iceberg."[2]

Coroners sounded the alarm and their comments received wide media coverage last winter, in particular following the report on the investigation into the death of well-known entertainment figure Paul Buisson. The man, age 41, was hospitalized on April 18, 2005 for renal colic, and died the next morning of cardiorespiratory failure. Although he had been given morphine, Gravol and Dilaudid, Mr. Buisson was left unmonitored between 2:30 and 6:10 a.m. The Coroner concluded that his death could have been prevented.

The coroners did not mince their words in criticizing the inadequate monitoring of the patients involved: "I find it absurd that a nurse with 30 years' experience could not tell the difference between deep sleep and a coma," stated coroner Luc Malouin,[3] concerning the death of Shirley Gagnon. Jacques Ramsay, for his part, declared that there was insufficient emphasis on the need for monitoring of patients who are given narcotics. The MSSS expert task force came to the same conclusion.

Monitoring and responsibility

I was very disturbed to read in a newspaper that a nurse could think that a snoring patient was "sleeping well" and required no monitoring. I shudder when I see headlines like "Nurses make mistakes"[4] or "Coroner hears about inadequate work by nursing staff."[5] Such articles, pointing to the incompetence of certain nurses, damage the public perception of our profession and the public sense of safety. But aside from public disgrace, the more serious aspect is that young people, with no major health problems, died prematurely as a result of these professional failings: Valérie Trudeau, age 16, mononucleosis; Isabel Perreault, age 28, a minor motorcycle accident; Patricia Covelli, age 33, abdominal pain; Mark Di Salva, age 31, colic; Alain Olivier, age 48, orthopedic surgery; Paul Buisson…

According to the MSSS report, "Monitoring is pivotal. Although there may have been failures at other points in the healthcare process, had there been proper monitoring, timely adjustments and intervention might have saved lives."[6] In fact, according to the authors, monitoring was the main problem identified in most of the cases studied–eight out of twelve. The

1. Ministère de la Santé et des Services sociaux, *Les accidents évitables dans la prestation des soins de santé : utilisation des opiacés en milieu hospitalier*, final report of the task force analyzing deaths linked to the use of opioid analgesics, Quebec City, MSSS – Direction générale de la coordination, du financement et de l'équipement, 2006.
2. Caroline Touzin, "La pointe de l'iceberg," *La Presse*, March 30, 2006, p. A-5.
3. Guy Benjamin, "Le travail inadéquat du personnel infirmier détaillé devant le coroner," *Le Soleil*, February 2, 2006, p. A-7.
4. Katia Bussière, "Lacunes dans le travail des infirmières," *Le Journal de Québec*, February 2, 2006, p. 10.
5. Guy Benjamin, *op. cit.*
6. Ministère de la Santé et des Services sociaux, *op. cit.*

other crucial aspects examined were initial pain assessment, prescription of medication, administration of medication and intervention to deal with problems.

I will take this opportunity to remind you that assessing the physical and mental condition of a symptomatic person and clinical monitoring (including monitoring and adjusting the therapeutic nursing plan) are the very foundations of our field of practice. With the introduction of collective prescriptions (Bill 90[7]) allowing nurses to initiate or adjust medication depending on a patient's symptoms, nurses are more than ever responsible for the safe and optimal use of medication.

Our profession is involved in all phases of the phamacotherapeutic process. The MSSS task force pointed out a number of failings in the parenteral administration of opioid analgesics. The initial pain assessment was not done rigorously using the appropriate tools, clienteles at risk were not immediately identified and errors in administration led to overdoses. Doctors, too, were singled out for failings in making prescriptions, in particular for overprescribing Dilaudid and underestimating the potentiating effects of a number of drugs.

The OIIQ is aware of the risks involved in the use of opioids, and reminds its members of the importance of respecting standard nursing practices in this area. Back in November 2004, *Perspective infirmière* published a scientific article on this subject[8] and the Order issued a statement on clinical monitoring of clients receiving drugs with a depressant effect on the central nervous system (CNS). The publication was sent to all directors of nursing (DNs) and councils of nurses (CNs), and was placed on our Website as well. This winter I once again wrote to DNs on this subject, asking them to ensure that nurses have the necessary knowledge and skills to properly monitor their patients.

In some hospitals, DNs have put together teams of nurses with expertise in monitoring acute or chronic pain. Some nurses have even promoted the concept of "pain-free hospitals." All health-care institutions should appoint experienced clinical nurses to improve practices in this area and oversee professional development.

I am sure that some of you are thinking that I am placing too much emphasis on competence, that I am forgetting about the shortage of nurses, work overloads, overtime, inexperienced candidates for the profession of nursing and budget problems, and that I should go easier on you. In some cases the context may be somewhat to blame, it is true, but the overall problem seems to be nurses' competence and training. Enough excuses: we must work to correct the situation starting from initial training and in professional development programs. This question of competence must be a priority for all CNs.

"Nothing can justify this kind of situation, particularly not staff shortages. It is more a matter of incompetence and poor organization of healthcare," wrote Jean-Robert Sansfaçon[9] in Le Devoir. In his editorial he added that the multidisciplinary approach and information sharing could improve health care and monitoring and that the quality of care must be a priority. There is no doubt that training is rudimentary in ensuring quality of care. In fact, the MSSS report stresses that "everyone agrees that professional training is an essential strategy in proper pain relief in healthcare institutions. Professional development modules in this area, reflecting advances in treatment, must be developed."[10]

Consequently, the MSSS will be inviting CMDPs,[11] CNs and DNs of healthcare institutions to come up with protocols for the parenteral administration of opioids, and professional development programs. For our part, we must step up our efforts to make colleges and universities aware that their initial training programs have to cover aspects relating to systematic patient monitoring following the administration of opioids and to pharmacotherapy in general. ●

Gyslaine Desrosiers
President

7. *Act to amend the Professional Code and other legislative provisions as regards the health sector* (S.Q. 2002, c. 33).
8. Céline Gélinas, "Prévenir la dépression respiratoire liée à certains médicaments," *Perspective infirmière*, Vol. 2, No. 2, November/December 2004, p. 23-27.
9. Jean-Robert Sansfaçon, "Erreur inexcusable," *Le Devoir*, March 31, 2006, p. A-8.
10. Ministère de la Santé et des Services sociaux, *op. cit.*
11. Councils of physicians, dentists and pharmacists.