Visit to Rwanda to support pharmacists and medics training in use of opioids in palliative care

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Global Palliative Care - working towards sustainability

- How the visit came about
- What we did
- The results
- Key points
- Our thoughts and hopes for the future
How did it come about?

- October 2012 presentation of poster at RCGP conference Glasgow – Prof Scott Murray
- November 2013 Victoria and Ruth 2 week THET mentorship visit to Rwamagana
- Introduced to Dr Christian
- September 2014 Dr Christian attends St Christopher's hospice course and visits MSH, Stourbridge
Visit to Mary Stevens Hospice
Stourbridge

• Met with all members of the MDT from CEO to volunteer coordinator

• Sharing of ideas

• Victoria particularly keen for C meet with Julie re NSAIDs prescribing limitations

• Who could have predicted where this would lead ..................................
Initial resistance!
Almost.........................
What happened next

• C introduced us over Skype to Jean Claude K Tayari from the Medical Procurement and Production Division (MPPD) at the Rwanda Biomedical Centre
• He was involved in organising training for pharmacists and medical chief of staffs on the availability of opioid analgesics for pain management other than in peri operative use
• Rwanda had just started to produce its own morphine solution but uptake had been poor
• Data from 2014 showed that 13 out of 18 clinical establishments (district and referral hospitals) had not requested or prescribed morphine
• Those that had used it mainly for peri-operative pain
• All establishments however reported treating cancer patients
• We were invited to go out and help!
Two back to back, three day workshops

- Prepared pre and post course assessments
- Delivered training sessions
- Interactive games with use of everyday objects
- Quizzes
- Case studies in small groups
Liquid strength multi:

- 5mg/15mL gray
- 10mg/1mL red
- 20mg/1mL blue

Dosage: 40mL 2

Multiline casts 4 hours:

- 5mg 4x2 = 15mg x 6
  - 90
- 30mg + 30mg = 60mg

Total = 80
What were our aims?

- TO REDUCE PAIN IN PATIENTS WITH PALLIATIVE CARE NEEDS AND THOSE IN CHRONIC PAIN
- To reduce inequality of morphine usage in Rwanda compared to the rest of the world
- To reduce fear and dispel myths that can prevent opioids from being used
- To promote MDT working
- To give practical support for morphine prescribing
Did we achieve this?

- 63 delegates attended in total
- Case studies and morphine calculation exercises undertaken during the workshop were well received and gave us confidence that the main points were being understood.
- This was supported by analysis of the data we obtained on the pre and post course assessment.
WHEN CAN MORPHINE BE USED?

<table>
<thead>
<tr>
<th></th>
<th>PRE TEST</th>
<th>POST TEST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Only when death</td>
<td>64%</td>
<td>87%</td>
</tr>
<tr>
<td>is imminent (no)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Days (yes)</td>
<td>51%</td>
<td>77%</td>
</tr>
<tr>
<td>Weeks (yes)</td>
<td>47%</td>
<td>83%</td>
</tr>
<tr>
<td>Months (yes)</td>
<td>56%</td>
<td>85%</td>
</tr>
<tr>
<td>Years / indefinitely</td>
<td>47%</td>
<td>93%</td>
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CAN MORPHINE BE USED WITH OTHER MEDICATIONS FOR PAIN

- NSAIDS (YES): Pre: 53%, Post: 98%
- Paracetamol (YES): Pre: 54%, Post: 93%
- Other Opioids (NO): Pre: 73%, Post: 91%
- Amitriptyline (YES): Pre: 37%, Post: 92%
- Dexamethasone (YES): Pre: 46%, Post: 93%
CHANGE IN OPINION FOLLOWING THE WORKSHOP

<table>
<thead>
<tr>
<th>Opinions</th>
<th>Pre Test</th>
<th>Post Test</th>
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</thead>
<tbody>
<tr>
<td>There is no maximum dose of morphine</td>
<td>24%</td>
<td>88%</td>
</tr>
<tr>
<td>Morphine should be prescribed regularly every 4 hours</td>
<td>27%</td>
<td>92%</td>
</tr>
<tr>
<td>You can drive when taking morphine if you do not feel impaired</td>
<td>21%</td>
<td>83%</td>
</tr>
<tr>
<td>Morphine is not effective for all types of pain</td>
<td>16%</td>
<td>73%</td>
</tr>
<tr>
<td>Patients do not die more quickly when prescribed morphine</td>
<td>84%</td>
<td>97%</td>
</tr>
<tr>
<td>Patients prescribed morphine do not have to stay on it forever</td>
<td>55%</td>
<td>82%</td>
</tr>
</tbody>
</table>
Home Visit - Case Study

• During our visit we had the opportunity to visit a patient with the Hospice at Home team.
• Young Gentleman with a Brain tumour
• Symptoms:-
  – significant head pain (especially in the morning)
  – loss of vision (clear exophthalmos)
• When asked the hospice at home team had not considered a trial of corticosteroids for 2 reasons:-
  – no knowledge that it might offer any benefit
  – Patient was struggling to take tablets and dexamethasone only available in 0.5mg strength
Home Visit - Case Study - Outcome

- Advised that dexamethasone tablets would readily dissolve in water and the patient agreed to try a dose of 8mg (16 tablets) daily
- Also advised an increase in the patient's morphine dose from 10mg 4 hourly to 15mg 4 hourly as he was clearly in pain
- Within ten days we were informed that not only was the head pain being successfully managed but also that his vision had improved.
Key points

• All this came about from talking and listening to people (contraception)
• By forming personal links / bonds
• Developing those personal friendships to allow things to happen
• By demonstrating real benefit of MDT working
What we would like to happen next

• To be able to offer practical help and support for individual clinicians and their management of specific patients

• To continue to promote the advantages of MDT working especially by building stronger links between pharmacists and doctors

• To use models we know work – grand rounds and virtual wards
Workshop

Developing the UK primary care virtual ward model for supporting our international partners in clinical management of palliative care patients