APPENDIX F

Report of the Gosport Investigation Medical Notes Review Group

Purpose

CHI undertook a review of anonymised medical notes of a random selection of 15 patients who had died between 1st August 2001 and 31st January 2002 on either Daedalus, Dryad or Sultan wards at the Gosport War Memorial Hospital.

CHI's intention for this piece of work was to determine whether the policies and systems put in place by the Portsmouth Healthcare NHS Trust since the events of 1998, to address prescribing practices at the trust are being implemented and are impacting on the quality of care patients are now receiving. CHI's review also considered the nursing notes for each patient and looked at the quality of nursing care as documented in the notes. Finally, the review considered whether the cause of death recorded in the notes was appropriate.

Methodology

The group received 15 sets of anonymised medical notes from the trust which related to the last admission of 15 patients. Five patients were randomly selected from each of the following wards; Daedalus, Dryad and Sultan. A total of 49 patients had died whilst on these wards during the sample timeframe.

Findings

Use of Medicines

Prescription

The group considered that the volume and combination of medicines used was appropriate for this group of patients and was in line with accepted good practice and British National Formulary guidelines. Once only, PRN and syringe driver prescribing was acceptable. There was no evidence of anticipatory prescribing.

The case notes suggested that the use of the "analgesic ladder" to incrementally increase and decrease pain relief in accordance to need was being followed. The group saw no evidence to suggested that patients had been prescribed large amounts of pain relief such as diamorphine, on admission where this was not necessary. Cocodamol had been prescribed in a number of cases as an

initial analgesic, with progression to alternative medicines as and when more pain relief was needed. The use of the "analgesic ladder" was less evident in Sultan ward.

However, in two cases, the group saw evidence of unacceptable breakthrough pain, with 6 hourly rather than 4 hourly prescriptions, which could have allowed this to happen. There was also some evidence of the simultaneous prescribing of cocodamol and fentanyl, which was not thought by the group to be the most effective combination of medicines.

Administration
Syringe drivers had been used to deliver medication to six of the patients reviewed. Appropriate use of syringe drivers was observed, with discussions with families prior to this documented.

Appropriate administration of medicines by nursing staff was evident. Telephone prescriptions issued over the telephone by GPs on Sultan ward were appropriately signed.

Review and recording of medicines
Evidence of consistent review of medication was seen, with evidence to suggest that patients and relatives were involved in helping to determine levels of pain. Nursing staff had appropriately administered medicines in line with medical staff prescriptions. Prescription sheets had been completed adequately on all three wards. Generally, record keeping around prescribing was clear and consistent, though this was not as clear on Sultan ward.

The Use and Application of the Trust's policies on the Assessment & Management of Pain, Prescription Writing and Administration of IV Drugs

The group agreed that these Trust policies were being adhered to, based on the medical notes reviewed.

Quality of Nursing Care Towards the End of Life

The team found a consistently reasonable standard of care given to all patients they reviewed. The quality of nursing notes was adequate, though patchy. There was some evidence to suggest a task orientated approach to care with an over emphasis on the completion of individual tasks, such as the completion of multiple

(bowel? Sheets – Maureen – was this the form they were endlessly completing?) rather than on the holistic care of the patient. The team saw some very good, detailed care plans and as well as a number of cases were no clear agreed care plan was evident.

The team was concerned that swallowing assessments for patients with dysphasia had been delayed over a weekend due to the working hours of the speech and language therapist. Nurses could be trained to undertake this role in order not to compromise patient nutrition. Despite this, generally the trust's policies regarding fluid and nutrition were being adhered to, though a number of patients had only been weighed once on admission.

There was evidence of therapy input, though this had not always been incorporated into care plans and did not always appear comprehensive.

Some pressure sore prevention issues were identified.. Maureen – could you help here??

There was thorough, documented evidence to suggest that comprehensive discussions were held with relatives and patients towards the end of the patient's life. The decision of families regarding DNR were clearly stated in the medical record.

Recorded Cause of Death

The group found no cause for concerns regarding any of the stated causes of death.

General Comments

Admission Criteria

The team considered that the admission criteria for both Daedalus and Dryad wards was being adhered to. However there were examples of patients admitted to Sultan ward who were more dependent than the admission criteria stipulates. There is also an issue regarding patients who initially meet the admission criteria for Sultan ward who then develop complications and become more acutely sick.

Elderly Medicine Consultant Input and Access to Specialist Advice

Patients on Dadalus and Dryad wards received regular, documented review by consultant staff. There was clear

evidence of specialist input, from mental health physicians and medical staff from the acute sector.

Out of Hours

There was little evidence of out of hours input into the care of patients reviewed by CHI, though the team formed the view that this had been appropriate and would indicate that the general management of patients during regular hours was therefore opf a good standard.