Gosport Briefing – Q&As

Lack of adequate monitoring of prescribing practices

What was the role of the nurses?
Registered nurses are regulated by the NMC. Code of professional conduct emphasises that nurses are accountable for their own clinical practice & should act in the best interest of the patient – this could include challenging prescriptions.

What do the tables in the report prove?
The tables demonstrate that the trust did have adequate, contemporary data which, if it had been reviewed, could have led to questions being asked about levels of prescribing.

Tables also highlight that prescribing of diamorphine, haloperidol and midazolam was at a peak in 1998/99, after which it declined.

What steps have the UKCC/NMC taken?
The regulatory bodies are currently reviewing whether there should be any action against individual practitioners.

Why is the prescribing of diamorphine so high on the GP ward?
CHI does have concerns regarding recent prescribing and has recommended that the trust examine why this has occurred.

Are the pharmacy staff to blame?
An adequate pharmacy system to review relevant data could have raised questions around the level of prescribing. CHI has recommended that trust pharmacy arrangements are reviewed as a priority.

Why were such strong drugs administered automatically?
There appears to have been insufficient total patient assessments in 1998, which led to some patients not receiving the rehabilitation they had been admitted for.

Was there a culture of euthanasia?
CHI has serious concerns regarding the use of medicines on these wards in 1998 but is unable to determine whether this contributed to the death of any patients. It is not in CHIs statutory remit to look at the care provided to individual patients.

Why do you think prescribing was so high in 1998?

There were insufficient guidelines in place on the wards to ensure appropriate pain relief for patients who had not been admitted for palliative care. CHI has concluded that good policies to support good prescribing are now in place on the wards.

How many patients are now being left in pain?
CHI has looked at a total of 15 anonymised records and found two instances where patients may have experienced unnecessary pain. The PCT will address this important issue in there review of prescribing.

What should pharmacy staff have done?
Pharmacy staff, who were not employed by the trust, but provide the service under a contract could have used their own data to identify high levels of prescribing of these pain relieving and sedative medicines.

Why was the combination of drugs inappropriate?
CHI has taken the advice of clinical experts in this field in reaching our conclusions. We would have to check any more technical questions relating to medicines with our experts before giving you a complete reply.

Is this another Shipman?
CHI is unable to determine whether any patients have died. The trust have taken significant steps, confirmed by CHI, to ensure that all prescribing of pain relief is now within acceptable parameters.

Lack of supervision & appraisal systems for isolated individuals

Was the clinical assistant the "isolated individual"?
Many doctors in community hospitals could be regarded as isolated, this is why it is important that such practitioner operate in a multi-disciplinary team working and have access to appropriate professional support

Are they still working at the hospital? As clinical assistant? Admitting patients to the GP ward?
Day to day medical support has been provided by a full time staff grade doctor since September 2000.

Should clinical assistants be working on hospital wards?
GPs are valuable members of the workforce of many community hospitals and are essential to the delivery of good quality patient care. All PCTs should ensure that these doctors are fully integrated into both the

formulation and delivery of policies which determine how care is given on the wards. PCTs must take steps to ensure that clinical assistants are adequately supervised and appraised.

Was there a consultant responsible for this supervision? Are they to blame? Have they been referred to the GMC? Are they still working at the hospital?
Dryad and Daedalus are consultant led wards.
Clinical assistant contracts state that consultants were responsible for supervision.
The GMC are reviewing whether any action should be taken under their fitness to practice procedures.
The wards are fully staffed with all levels of medical staff.

Lack of total patient assessment & unfulfilled raised expectations

Were the wrong patients being admitted? Why?
There is some evidence to suggest that the GWMH were admitting patients with increasingly complex care needs.
The trust did take some steps to address the higher dependency of patients.

Were patients being admitted from Portsmouth NHS (acute) trust? CHI gave it a bad cgr - it also is a no star trust? Was this part of the problem?
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General

Why are your recommendations addressed to 2 PCTs?
Following the dissolution of Portsmouth Healthcare NHS Trust in April this year, responsibility for services for older people and the management of the Gosport Memorial Hospital were divided between 2 local PCTs.

How many patients died?
CHI doesn't have a statutory responsibility to investigate the care of any individual patients and cannot therefore answer the question.

How long was this going on for - your investigation only began in 1998?
Concerns were raised with CHI regarding care from 1998, this was chosen as the start point for the investigation.

Why has the police investigation stopped?

This was a decision made by the CPS, CHI cannot comment further.

Will the police investigation reopen as a result of your report?
This is a matter for the police.

Has the CE been made redundant in the PCT reorganisation?
This is a matter for local employers.

The Medical Director is a geriatrician – should he have done more? Was he to blame?
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What are the main lessons to be learnt by PCTs?
To ensure appropriate supervision for clinicians & good monitoring systems for prescribing.