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Mr C West,
District General Manager,
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ROYAL COLLEGE OF NURSING

Dear Chris,

I am seeking your advice on how best to resolve a problem which was brought to my attention in April 1991 but apparently has been present for the last 2 years.

I was contacted by a staff nurse who is currently employed on night duty in Redclyffe Annexe, her concern was that patients within Redclyffe were being prescribed Diamorphine who she felt did not always require it, the outcome being that the patient died. The drug was always being administered via 'syringe drivers'. It is fair to say that this member of staff was speaking on behalf of a group of her colleagues.

On my advice the staff nurse wrote to Isobel Evans, Patient Care Manager putting forward her requirements under the UKCC Code of Professional Conduct. Following this I had a meeting with Isobel Evans Patient Care Manager on the 26th April 1991, the outcome of this was that a 'policy' would be produced to specifically address the prescribing and administration of controlled drugs within Redclyffe. In addition a meeting would be held with the staff and Isobel where they could voice their concerns, this meeting took place on the 11th July 1991 and the minutes circulated, as these give a clear outline of the concerns of the staff I have enclosed a copy for your perusal.

Following the aforesaid meeting two study days on 'Pain Control' were arranged, as you will see from the minutes relating to the meeting of the 11th July 1991 some of the concerns voiced by the staff were that diamorphine was being prescribed for patients who were not in pain. These study days did temporarily alleviate the worries of the staff.

Regrettably the concerns of the staff have once again returned, one of the staff nurses who is currently on an ENB course was talking about this subject to Gerrie Whitney, Community Tutor, Continuing Education. Gerrie visited Redclyffe on the 31st October 1991 and subsequently wrote a report. Copies of her report were circulated to Isobel, Bill Hooper and Sue Frost, as I feel it is pertinent I have obtained Gerrie's permission to enclose a copy.

75 ANNIVERSARY RCN 1916 1991

After receiving this report Isobel responded by sending a 'memo' (copy enclosed) to the trained staff at Redclyffe. As the 'concerns' had now apparently become "allegations" I wrote to Isobel voicing my concern on this point, also that she had to date not produced the policy to which we had agreed in April 1991. I also informed her that it was my view that unless I heard to the contrary a grievance would have to be lodged. To date Isobel has not responded.

I feel the staff have acted professionally and with remarkable restraint considering that it is fair to say that since highlighting their concerns there has been a certain amount of ostracization. After talking to the staff and thinking it through I now feel that a grievance may not completely resolve this issue. I have been told that it is only a small group of night staff who are 'making waves', this could be true as a majority of the day staff have left over the period of 2 years that this situation has been present, whether this was a reason for their leaving I am unsure.

I have various concerns, for the patients and subsequently their relatives, the staff in that they are working in this environment but also that this could be leaked to the media. While none of the staff or myself have any desire whatsoever to use this means there is serious concern from both myself and the staff that someone could actually leak this and I hope you know my feelings about the media and using it as a means of resolving problems. On this basis alone I hope you agree with me in that we have to address this issue urgently.

As I stated at the beginning I am seeking your advice on what I think you will now feel is a difficult problem. I must stress that none of the staff have shown any malice in what they have said and that their only concern is for the patient.

Your comments/advice would be greatly appreciated.

Yours sincerely,

Keith Murray

Branch Convenor

Code A

Confidential

REPORT OF A VISIT TO REDCLIFFE ANNEXE, GOSPORT WAR MEMORIAL HOSPITAL

AT 21.30 HOURS ON THURSDAY 31 OCTOBER 1991

BY

GERARDINE M WHITNEY, COMMUNITY TUTOR, CONTINUING EDUCATION

Purpose of Visit

The visit was in response to a request by Staff Nurse Anita Tubbritt to discuss the issue of anomalies in the administration of drugs.

Present

Staff Nurse Sylvia Giffin
Staff Nurse Anita Tubbritt
Enrolled Nurse Beverly Turnbull
Nursing Auxiliary Agnes Howard (Does not normally work at Redcliffe Annexe)
2 RGN's and 1 EN wished to but were unable to attend the meeting.

Background Information

The staff present presented the Summary of the Meeting held at Redcliffe Annexe on 11 July 1991 - appendix.

Problems Identified on 31 October 1991

1. Staff Nurse Giffin reported that a female patient who was capable of stating when she had pain was prescribed Diamorphine via syringe driver when she was in no obvious pain and had not complained of pain.

2. Staff Nurse Giffin reported that a male patient admitted from St Mary's General Hospital who was recovering from pneumonia, was eating, drinking and communicating, was prescribed 40 mg Diamorphine via a syringe driver together with Hyoscine, dose unknown, over 24 hours. The patient had no obvious signs of pain but had increased bronchial secretions.

3. Staff Nurse Tubbritt reported that on one occasion a syringe driver "ran out" before the prescribed time of 24 hours albeit that the rate of delivery was set at 50 mm per 24 hours.

4. The staff are concerned that Diamorphine is being prescribed indiscriminately without alternative analgesia, night sedation or tranquillisers being considered or prescribed.

5. Nurse Tubbritt reported that a female patient of 92 years awaiting discharge had i.m. 10 mg Diamorphine at 10.40 hours on 20.9.91. and a further i.m. 10 mg Diamorphine at 13.00 hours on 20.9.91. administered for either a manual evacuation of faeces or an enema.

6. There are a number of other incidents which are causing the staff concern but for the purposes of this report are too many to mention. The staff are willing to discuss these incidents.

7. It was reported by Staff Nurse Tubbritt that:

   a) 42 ampoules of Diamorphine 10 mg were used between 20 April 1991 - 15 October 1991.

   b) 57 ampoules of Diamorphine 30 mg were used between 15 April 1991 - 15 October 1991 (24 of the 57 ampoules of Diamorphine 30 mg were administered to one patient, who had no obvious pain, between 9 September 1991 and the 21 September 1991).

   c) 8 ampoules of Diamorphine 100 mg were used between 15 April 1991 - 21 September 1991 (4 of the 8 ampoules of Diamorphine 100 mg were administered to the patient identified in 7b above, between 19 September 1991 and the 21 September 1991).

      Note - This patient had previously been prescribed Oramorph 10 mg in 5 ml oral solution which was administered regularly commencing on 2 July 1991.

      The staff cannot understand why the patient was prescribed Oramorph and Diamorphine.

      When the staff questioned the prescription with Sister they were informed that the patient had pain. The staff recalled having asked the patient on numerous occasions if he had pain, his normal reply was no.

Conclusion

1. The staff are concerned that Diamorphine is being used indiscriminately even though they reported their concerns to their manager on 11 July 1991 (appendix).

2. The staff are concerned that non opioids, or weak opioids are not being considered prior to the use of Diamorphine.

3. The staff have had some training, arranged by the Hospital Manager, namely:

   - The syringe driver and pain control
   - Pain control

4. Staff Nurse Tubritt wrote to Evans the producers of Diamorphine and received literature and a video - Making Pain Management More Effective.