GMC – v – DR JANE BARTON

COMMISSION FOR HEALTHCARE IMPROVEMENT

SUMMARY OF INVESTIGATION

1. Report of the investigation by the Commission for Healthcare Improvement entitled: "Portsmouth Healthcare NHS Trust at Gosport Ware Memorial Hospital," July 2002.

2. Executive summary (report p.vii):

    - CHI investigation followed police investigations between 1998 and 2001. The police informed CHI of its concerns in August 2001 and provided much of the information considered by CHI.

    - CHI conducted a review of the systems in place – it had no remit to investigate the circumstances of any particular death or the conduct of any individual.

    - CHI concluded that there was a failure in the systems: Insufficient local prescribing guidelines re powerful pain relieving and sedative medicines; lack of rigorous routine review of pharmacy data; absence of supervision and appraisal systems; lack of thorough multidisciplinary patient assessment to determine care needs on admission.

    - CHI concluded that by the time of the report, adequate provision was in place to deal with these criticisms.

3. Key findings (report p.viii-xi):

    - There was lack of clarity amongst all groups of staff and stakeholders about the focus of care for older people and therefore the aim of the care provided (chapter 3).

    - CHI has serious concerns regarding the quantity, combination, lack of review and anticipatory prescribing of medicines prescribed to older people on Dryad and Daedalus wards in 1998. A protocol existed in 1998 for palliative care prescribing referred to as the "Wessex Protocols." This was inappropriately applied to patients admitted for rehabilitation (chapter 4).

    - Portsmouth Healthcare NHS Trust did not have any systems in place to monitor and appraise the performance of clinical assistants. There were no arrangements in place for the adequate supervision of the clinical assistant working on Daedalus and Dryad wards (chapter 6).

4. Terms of reference (report p1-3):

    - CHI launched the investigation into the management, provision and quality of healthcare for which Portsmouth Healthcare NHS Trust was responsible at GWMH on 22nd October 2001.

- The investigation looked at whether, since 1998, there had been a failure of trust systems to ensure good quality patient care, focussing on the following elements within services for older people (inter alia):

  - Staffing and accountability arrangements.
  - Guidelines and practices in place to ensure good quality care.
  - Arrangements for the prescription, administration, review and recording of drugs.
  - Arrangements to support patients and their relatives and carers towards the end of the patient's life.
  - Supervision and training arrangements in place to enable staff to provide effective care.

- The investigation took account of expert witness reports forwarded by the police.

- 59 staff from all groups involved in the care and treatment of older people at the hospital and trust managers were interviewed.

- An independent review of the notes in relation to 15 patients who died on Daedalus, Dryad and Sultan wards between August 2001 and January 2002 took place (Prof Ford was involved in the review).

5. Chapter 3: National and local context. Relevant points:

   - July 2000: NHS publication "Dignity, security and independence in old age" outlines the government's plans for the care of older people. The national service framework for older people was published in March 2001.

   - This chapter gives a summary of the local services available in the few years up to 2002. It details the beds available on the wards in question. It says little about the period 1998-1999.

   - In relation to terminology (3.16): "CHI found considerable confusion about the terminology describing the various levels of care for older people in written information and in interviews with staff. For example, the terms stroke rehab, slow stream rehab, very slow stream rehab, intermediate and continuing care were all used. CHI was not aware of any common local definition for these terms in use at the trust or any national definitions. CHI stakeholder work confirmed that this confusion extended to patients and relatives in terms of their expectations of the type of care received."

   - From key findings: "There was a lack of clarity amongst all groups of staff and stakeholders about the focus of care for older people and therefore the aim of the care provided. This confusion had been communicated to patients and relatives, which had led to expectations of rehabilitation that had not been fulfilled."

6. Chapter 4: Arrangements for the prescription, administration, review and recording of medicines. Relevant points:

- CHI's terms of reference were informed by expert reports commissioned by the police into the deaths of five patients in 1998. However, "CHI has relied on its own independent scrutiny of data and information gathered during the investigation to reach the conclusions in this chapter" (4.2).

- CHI obtained a breakdown from the trust of the usage of diamorphine, midazolam and haloperidol on Daedalus, Dryad and Sultan wards. This data did not show the amounts administered to individual patients. Appendix I is a breakdown of the medicines issued to each ward (4.3).

- CHI shared the experts' view that the use and combination of these drugs in 1998 was excessive and outside normal practice (4.4).

- There was a marked decline in the use of these three drugs in recent years (up to 2002) (4.5).

- In 1998, the trust did not have a policy for the assessment and management of pain. This was introduced in April 2001. The purpose of the policy document was to identify mechanisms to ensure that all patients had early and effective management of pain or distress. It included the following points: The prescription must be written by medical staff following the diagnosis of type(s) of pain and be appropriate in the circumstances of the patient; if the drugs are to be administered by syringe driver, the rationale for this decision must be clearly documented; all prescriptions for drugs via syringe driver must be written on a prescription sheet designed for this purpose (4.6).

- Some nursing staff told CHI that since the introduction of the policy, it took longer for some patients to become pain-free and medical staff were apprehensive about prescribing diamorphine (4.8).

- Many staff spoke of the "Wessex Protocols" – a booklet entitled "Palliative care handbook guidelines on clinical management" drawn up by Portsmouth Healthcare NHS Trust, the Portsmouth Hospitals NHS Trust and a local hospice, in association with the Wessex palliative care units. These guidelines were in place in 1998 (4.9). They are comprehensive and contain detail in line with the BNF on the use and dosage of medicines commonly used in palliative care. The guidelines are not designed for a rehabilitation environment (4.10).

- Verbal prescriptions: A prescription-writing policy was produced jointly with the Portsmouth Hospitals NHS Trust in March 1998. It has a section on verbal prescription orders, including telephone orders, in line with UKCC guidelines. CHI understood that such arrangements are common practice in GP-led wards and work well on Sultan ward, with arrangements in place for GPs to sign the prescription within 12 hours (4.12, 4.13).

- Information provided by the trust indicated only two qualified nurses from Sultan ward had taken part in a syringe driver course in 1999. Five had also completed a drug competencies course. No qualified nurses from Dryad or Daedalus wards had completed either course between 1998 and 2001 (4.16).

- Review of medicines: CHI recommended that a process should be found to ensure that effective and regular reviews of patient medication take place by senior clinicians and pharmacy staff (4.19).

- Pharmacy: Pharmacy training for non-pharmacy staff was described as "totally inadequate" and not taken seriously. Nobody knew of any training offered to clinical assistants (4.21). There were no systems in place in 1998 for the routine review of pharmacy data which could have alerted the trust to any unusual or excessive patterns of prescribing, although the prescribing data was available for analysis (4.22).

- Additional key findings:

  - Point 3: The usage of diamorphine, midazolam and haloperidol had declined in recent years, reinforced by trust staff interviewed by CHI and by CHI's own review of recent case notes. Nursing staff interviewed confirmed the decreased use of both diamorphine and the use of syringe drivers since 1998.
  - Point 5: CHI welcomed the introduction and adherence to policies regarding the prescription, administration, review and recording of medicines. Anticipatory prescribing was no longer evident on these wards.
  - Point 6: CHI found little evidence to suggest that thorough individual total patient assessments were being made by multidisciplinary teams in 1998. This approach to care had been developed in the years up to 2002.
  - Point 7: Pharmacy support to the wards in 1998 was inadequate. A system should have been in place to review and monitor prescribing at ward level.

7. Chapter 6: Staffing arrangements and responsibility for patient care. Relevant points:

- The lead consultant was not responsible for the clinical practice of individual doctors (6.2).

- Until July 2000, a clinical assistant provided additional medical support (then replaced by a staff grade doctor). In 2002, two consultants undertook a weekly ward round with the staff grade doctor. In 1998, there was a fortnightly ward round on Daedalus ward. On Dryad, ward rounds were scheduled fortnightly, though occurred less frequently (6.3).

- The staff grade post is a pivotal, potentially isolated post. In 2001, the trust identified the risk of professional isolation and lack of support at GWMH as a reason not to appoint a locum consultant (6.4).

- Clinical assistants work as part of a consultant-led team and have the same responsibilities as hospital doctors to prescribe medication, write in the medical record and complete death certificates. Clinical assistants should be accountable to a named consultant (6.6).

- From 1994 until the resignation of the post-holder in July 2000, a clinical assistant was employed for five sessions at the GWMH. The job description clearly stated that the clinical assistant was accountable to named consultant physicians in geriatric medicine (6.7).

- CHI was not aware of any trust systems in place to monitor or appraise the performance of clinical assistants in 1998. This lack of monitoring was still common practice within the NHS. The consultants admitting patients to Dryad and Daedalus wards, to whom the clinical assistant was accountable, had no system for supervising the practice of the clinical assistant, including any review of prescribing. CHI found no evidence of any formal lines of communication regarding policy development, guidelines and workload. Staff interviewed commented on the long working hours of the clinical assistant, in excess of the five contracted sessions (6.8, reflected in key finding 1).

- The H-grade senior nurse coordinator post, appointed in November 2000, was a specific trust response to an acknowledged lack of nursing leadership at the GWMH (6.19).

8. Chapter 7: Lessons learnt from the complaints. Relevant points:

- CHI learned that external clinical advice sought by Portsmouth Healthcare NHS Trust in September 1999, during the course of a complaint resolution, suggested that the prescribing of diamorphine with dose ranges from 20mg to 200mg a day was poor practice and "could indeed lead to a serious problem." This comment was made by the external clinical assessor in regard to a patient given doses ranging from 20mg to 40mg per day (7.8).

- Portsmouth Healthcare NHS Trust correspondence suggested that there was an agreed protocol for prescription of diamorphine by syringe driver with doses of 20-200mg per day. CHI understood this to refer to the Wessex Protocols (7.9).

- A draft protocol for the prescription and administration of diamorphine by syringe driver was piloted on Dryad Ward in 1999 and discussed in committee meetings in 2000. The guidance was incorporated into the policy for the assessment and management of pain in April 2001 (7.10).

- Action taken by the trust since 1998 included:

  - An increase in the frequency of consultant ward rounds on Daedalus ward, from fortnightly to weekly, from February 1999.
  - The appointment of a full time staff grade doctor in September 2000 following the resignation of the clinical assistant.
  - Piloting pain management charts and prescribing guidance, after April 2001 (7.11).

9. Possibly significant documents reviewed by CHI:

- Portsmouth Healthcare NHS Trust Annual Reports, 1998/9 – 2000/1.

- "Improving quality – steps towards a first class service," Portsmouth Healthcare NHS Trust, September 1998.
- "Wessex palliative care handbook: guidelines on clinical management," 4th edition.
- "Compendium of drug therapy guidelines," Portsmouth Healthcare NHS Trust, Portsmouth Hospitals NHS Trust, 1998.
- "Draft protocol for prescription and administration of diamorphine by subcutaneous infusion," medical director, Portsmouth Healthcare NHS Trust, 15th December 1999.
- "Administration of controlled drugs – the checking role for support workers: guidance note for ward/clinical managers," Portsmouth Healthcare NHS Trust, February 1997.
- "Summary medicines use 1997/1998 to 2000/2001 for wards Dryad, Daedalus and Sultan," Portsmouth Hospitals NHS Trust pharmacy service, April 2002.
- "Clinical nursing development, promoting the best practice in Portsmouth healthcare," Portsmouth Healthcare NHS Trust, January 1998.
- "An evaluation of clinical supervision activity in nursing throughout Portsmouth Healthcare NHS Trust," Portsmouth Healthcare NHS Trust, December 1999.
- Anonymised correspondence on complaints relating to GWMH since 1998.
- "Learning from experience: action from complaints and patient based incidents, 1998-2001," Portsmouth Healthcare NHS Trust.
- Job description: Lead consultant, department of medicine for elderly people, February 1999.
- Job description: Clinical assistant, April 1988.
- Job description: Service manager, grade H, August 2000.
- Job description: Full time staff grade physician, July 2000.
- "Medical accountability structure for GWMH," undated.
- "Supervision arrangement consultant timetable at GWMH 1998-2001," Portsmouth Healthcare NHS Trust.
- Competence record and development for qualified nurses 1998-2001, Sultan, Dryad and Daedalus wards.
- Expert reports of Prof Livesley (9/11/00), Prof Ford (12/12/01) and Dr Mundy (18/10/01).

10. Appendix B: Views from patients and relatives/friends:

- Number of responses to CHI were summarised. The general nature of the responses were summarised. There were some positive experiences. There were many complaints about the level of communication.

- An area of concern was: "Arrangements for the prescription, administration, review and recording of medicines. The majority of concerns were around the prescribing of diamorphine. Others centred on those authorised to prescribe the medication to the patient and how this was communicated to the relatives/carer" (point viii).