Other Document Form

Number 190

Title Palliative Care documents and issues raised by Prof

(Include source and any document number if relevant) Livesley 19/5/00

Receivers instructions urgent action Yes / No

Document registered / indexed as indicated

No(s) of actions raised

Statement readers instructions

Indexed as indicated

No(s) of actions raised

Examined - further action to be taken

Further actions no(s)

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

Code A

Pain control in palliative care

Step-by-step approach.

1 Non-opiods (paracetamol)

2 Opiods (codeine) + step 1 drugs

3 Strong opiods (morphine, diamorphine) important to titrate the dose beginning with 2.5-5mgs four hourly. Be careful in those who are opiod naïve. When stabilised then use a modified release preparation (Oramorph SR, MST Continus). Oramorph SR is a tablet, MST Continus can be made up in suspension if tablet swallowing is not possible. Always make a rapid action opiod available for break through pain and at one sixth of the total daily opiod dose.

4 The oral route for drug administration is preferred. Opiods are easily absorbed and not more effective if given parenterally.

Regulations for controlled drugs

There are regulations for the prescription, storage, recording, and destruction of controlled drugs.

Use of unlicensed drugs

Responsibility for use is the clinician's or the pharmacist's rather than the manufacturer.

Additional issues

Did the act or omission of the 'ambulance transport staff' materially contribute to the death of Mrs Richards?

Did the act or omission of Dr B materially contribute to the death of Mrs Richards?

Did the act or omission of the nursing staff materially contribute to the death of Mrs Richards?

Did the act or omission of the pharmacist or pharmacy department materially contribute to the death of Mrs Richards?

Did the act or omission of the hospital materially contribute to the death of Mrs Richards?

Did the act or omission of any other person(s) materially contribute to the death of Mrs Richards?

Did Dr B hasten Mrs Richards' death intentionally?

If intentionally, was this the foreseeable consequence of symptom relief – or was it clinical negligence – or the aggressive practice of palliative care?

If the ~~the~~ aggressive practice of palliative care, was such aggressive palliative care required and/ or appropriate – or could symptom relief have been achieved by other more appropriate means?

Was the death of Mrs Richards a foreseeable or unforeseeable consequence of her treatment?

Why was Code A prescribed on 11th August 1998 and not given? Code A Was its use in this way common practice on the ward and/or in that hospital? What was the pharmacist's responsibility in overseeing drug usage? What is the vicarious responsibility of the hospital in this matter in terms of its clinical governance? [Clinical governance is 'clinical practice delivered to accepted standards that are routinely monitored through clinical audit and clinical risk management and all supported by procedures for adverse outcome reports and their evaluation.]

How many other patients have died under similar circumstances while under the care of Dr B or other doctors at the hospital?

How many cremations have taken place? How many burials have there been and would exhumation(s) be appropriate?

What was the role of the Coroner and/or the Registrar of Births, Marriages, and Deaths in this matter?

Comment

At present I find it difficult to conceive of an innocent explanation for the prescription of the drugs for and the circumstances of their administration to Mrs Richards following her admission to Gosport War Memorial hospital.

What is clinical negligence?

To succeed in a claim of clinical negligence against a doctor, the patient (who becomes a claimant) must prove, on the balance of probabilities, that:

- the doctor owed a duty of care
- there was a breach of that duty
- harm followed as a result (causation is established).

The aims of palliative care remain constant and have been defined as:

'...active total care offered to a patient with a progressive disease and their family when it is recognised that the illness is no longer curable, in order to concentrate on the quality of life and the alleviation of distressing symptoms within a framework of a co-ordinated service. Palliative care neither hastens nor postpones death, it provides relief from pain and other distressing symptoms, integrates the psychological and spiritual aspects of care. In addition it offers a support system to help relatives and friends cope during the patients illness and in bereavement.'[1]

Principles of palliative care[2]

1. Affirms life and regards dying as a normal process

2. Neither hastens nor postpones death

3. Provides relief from pain and other distressing symptoms

4. Integrates psychological, social and spiritual aspects of care so that patients may come to terms with their own death as fully and as constructively as they can

5. Offers a support system to allow patients to live as actively and creatively as possible until death

6. Offers a support system to help families cope during a patient's illness and in bereavement

REFERENCES

1. World Health Organisation Regional Office for Europe: Palliative cancer care-Policy statement based on the recommendations of a WHO Consultation (1989) cited in: Standing Medical Advisory Committee and Standing Nursing and Midwifery Advisory Committee (1992) The principles and provisions of palliative care. Joint report of the Standing Medical Advisory Committee and Standing Nursing and Midwifery Advisory Committee, London.

2. Higginson I. Palliative and terminal care. In: Stevens A, Raftery J. *Health care needs assessment.* (Epidemiology based needs assessment reviews, second series.) Oxford: Radcliffe Medical Press, 1997.