Investigation in to the Portsmouth Healthcare NHS Trust Gosport War Memorial Hospital

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The report followed police investigations made between 1998-2001 into the potential unlawful killing of a patient in 1998.

Key Conclusions (see executive summary)

- There were insufficient local prescribing guidelines in place the prescription of powerful pain relieving and sedative medicines.
- The lack of rigorous, routine review of pharmacy data led to high levels of prescribing on wards caring for old people not being questioned.
- Absence of adequate trust wide supervision and appraisal systems.
- Lack of thorough multidisciplinary total patient assessment to determine care needs on admission.

Terms of Reference – pg 1

- The investigation looked at whether since 1998 there has been a failure of trust systems to ensure good quality patient care.

Investigation Process

Consisted of 5 interrelated parts:

1. Review and analysis of a range of documents specific to the care of older people (Appendix A)
2. Analysis of views received from 36 patients, relatives and friends (Appendix B)
3. A 5 day visit by the CHI investigation team to the hospital (Appendix C lists the staff interviewed)
4. Interviews with relevant agencies and other NHS organisations (Appendix D for list)
5. An independent review of clinical and nursing notes taken from a sample of patients who died on the three elderly care wards between August 2001-January 2002.

Background to the investigation

September 1998 – police were contacted regarding the death of a 91 yr old patient in August 1998 with allegations that this patient had been unlawfully killed. — Gillian McKenzie – Daughter

September 1998- November 1998 – investigation conducted by the police, the police sought expert advice.

November 1998- Documents referred to the CPS.

December 1998 – Police made the trust aware of potential issues regarding diamorphine usage.

March 1999 – CPS stated that there was insufficient evidence to prosecute and staff for manslaughter or any other offence.

August 2001 – Following a further police investigation, CPS advised that there was insufficient evidence to provide a realistic prospect of a conviction against any member of staff.

→ media coverage.

March 2001 – 11 other families raised concerns about the circumstances of their relative's deaths. Police referred 4 of these deaths for expert opinion.

December 2001 – Two expert reports received and made available to CHI.

February 2002 – Police decided that a more intense police investigation was not an appropriate cause of action.
Trust sent copies of expert's reports.

Action taken by the Health Authority

June 2001 – The Health Authority reviewed the prescribing practice of 1 local GP.

July 2001 – Chief Executive of the Health Authority asked CHI for advise in obtaining a source of expertise in order to re-establish public confidence in the services for older people in Gosport.

February 2002 – Following receipt of the police expert witnesses reports in February 2002, the health authority sought local changes in relation to the prescription of certain painkillers and sedatives.

Arrangement for the prescription, administration, review and recording of medicines:

Police inquiry and expert witness reports:

- Police expert witnesses reviewed the care of 5 patients who died in 1998, made general comments (see page 12)
- CHI requested a breakdown from the trust of usage of diamorphine, haloperidol (sedative) and midazolam (sedative)

Assessment and Management of Pain

- In 1998 the trust did not have a policy for the assessment and management of pain, one was introduced in April 2001, it is due for review in 2003.
- CHI has also seen evidence of pain management cycle chart and an 'analgesic ladder'.
- Wessex Guidelines – booklet called 'Palliative Care Handbook Guidelines on Clinical Management.

Prescription writing policy.

- Introduced in March 1998.

Administration of Medicines

- Guidance for staff on providing syringe drivers is contained in the trust's policy for assessment and management of pain.
- Information form the trusts shows very little training was given on syringe driving.

Structure of Pharmacy

- Totally inadequate training for non-pharmacy staff.

Key Findings:

1. CHI serious concerns about the quantity, combination, lack of review and anticipatory prescribing of medicines prescribed to older people on the **Dryad** and **Deadalus Wards** in 1998.
2. CHI is unable to determine whether the level prescribing contributing to the deaths of any patients but recognises that if adequate checking mechanism had existed the level of prescribing would have been questioned.
3. The use of diamorphine, midazolam and haloperidol has declined in recent years. → has been very high
4. Pharmacy support in 2002 was inadequate.

Recommendations:

1. Fareham and Gosport PCT must ensure that a system is in place to review and monitor the prescribing off all medicines on wards for older people.
2. East Hampshire PCT and Fareham and Gosport PCT should review all local prescribing guidelines, should review the provision of pharmacy services to the three wards, must ensure that all relevant staff are trained in prescription, review and recording for medicines for older people.

Quality of care and the patient experience.

Patient Experience:

1. CHI examines the experience of older patient admitted to Gosport War Memorial Hospital between 1998-2001 – this was conducted by, stakeholders invited to make contact with CHI, police wrote to relatives who expressed concerns. Secondly a number of observation visits were made in January 2002. — unannounced generally at night.

Stakeholders Views

- Concern made by relatives regarding the lack of nutrition and fluids as patients neared the ends of their lives.
- Continence management. → catheter used for 'convenance'
- The use of pain relieving medicines and the use of syringe drivers to administer them.
- Concern regarding the dressing of the patients. → not wearing their own clothes.
- Comments on the attitudes of staff varied from very positive to less positive.

CHI Observation work

- CHI observed a range of good patient experiences but recognises that this is only a snap shot.
- Ward environment (pg 24)
- Communication with patient's, relatives and carers
- Support towards the end of life, - staff spoke of the difficulty in managing patient and relative expectations following discharge from the acute section.

Key Findings

1. Relatives had serious concerns regarding the care of their relatives.
2. CHI had no specific concerns relating to the standard if nursing care provided.
3. Inability of any ward staff to carry out swallowing assessments.

Recommendations

1. All patient complaints should be used at ward level to improve patient care.
2. Ensure staff are appropriately trained to carry out swallowing assessments.
3. Ensure local continence management, nutrition management and hydration practises are in line with national standards.
4. Use PALS to consider improvement of communication with older patients, their relatives and carers.

Staffing arrangements and responsibility for patient care

Medical Responsibility

- All patients admitted under the care of a consultant.
- Consultants undertake a weekly ward round with a staff grade doctor.

Lessons learned from Complaints

129 complaints have been made regarding the provision of elderly medicine since April 2001.
10 complaints made surrounding the care and treatment of patients on Dryad, Daedalus and Sultan wards between 1998-2002.

External review of complaints:

- 1 complaint was referred to the Health Services Commissioner in May 2000, found the

Trust learning regarding prescribing.

- Action was taken to develop and improve trust policies around prescribing and pain management.

Key findings.

1. The trust should have responded earlier to concerns regarding the level of sedation, which it was aware of in late 1998.
2. Portsmouth Healthcare NHS Trust did effect changes in patient care over time because of patient complaints, but there was no evidence to suggest that these changes have been monitored and reviewed adequately.
3. Delay of finalising the protocol relating to the prescription of diamorphine by syringe driver was unacceptable.
4. There has not been comprehensive training of staff dealing with complaints and communicating with patient's/carers.

Recommendations.

1. Department of Health should work with the Association of Police Officers and CHI to develop a protocol for sharing information regarding patient safety and potential systems within the NHS ASAP.
2. Should ensure that complaints are monitored under new PCT arrangements.
3. Need to ensure staff working on the 3 wards have received training regarding customer care and complaints.

Clinical Governance – it is about making sure that health services have systems in place to provide patients with high standards of care. (see pg 39-42)