

ConfidentialREPORT OF A VISIT TO REDCLIFFE ANNEXE, GOSPORT WAR MEMORIAL HOSPITALAT 21.30 HOURS ON THURSDAY 31 OCTOBER 1991BYGERARDINE M. WHITNEY, COMMUNITY TUTOR, CONTINUING EDUCATIONPurpose 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 Tubbritt wrote to Evans the producers of Diamorphine and received literature and a video - Making Pain Management More Effective.

5. Staff Tubbritt is undertaking a literature on Pain and Pain Control.

Code A

Signed:

..... Time: 23.35 hours

G M Whitney
Community Tutor, Continuing Education

Date: 31 October 1991