Code A

Our reference: MM
Your reference:
Date: 27th March, 2002
Extension: 4378

Dear Code A

Thank you for your letter received here on the 7th March 2002. I have discussed the questions you raised with Dr Ian Reid (the Medical Director) and Fiona Cameron (the General Manager for services in Fareham and Gosport). The following are their comments on the issues you raise.

Training – attitudes in caring for dying patients and their relatives/bereavement counselling

Identification of training needs among all staff takes place via an appraisal system during which individual training needs are identified and planned.

In relation to junior doctors, there is a requirement for them to acquire appropriate skills and attitudes toward dying patients and in particular skills in breaking bad news to both patients and their relatives. The junior doctor's educational supervisor is responsible for monitoring and reviewing this training.

Around a third of qualified staff at Gosport War Memorial Hospital have received training in 'care of the dying patient and their relatives', ' loss and bereavement', and the local hospice training programme. Each of the wards has identified what skills its workforce needs to deliver appropriate care. This is then translated into development plans for individual nurses.

Nutrition and Hydration

Where dying patients are capable of expressing their wishes and are mentally competent to do so, these wishes in relation to eating and drinking would be respected. In the event that patients are unable to make these decisions for themselves, nursing, medical and other staff have a legal duty to act in the patient's best interest. The view as to what constitutes the patient's 'best interests' should be formulated as a result of consideration of a number of factors. These would include ascertaining where possible what the patient's view would have been if they had been able to provide it, any previously expressed views of the patient, the view of the relatives, the patient's present condition and prognosis. This would be coupled with a view as to whether providing hydration was likely to increase suffering.

The decision to hydrate is always based on the individual patient, taking into account the above considerations. Where a decision to hydrate is made, the method used will also be based on the individual patient's condition and tolerance to, for instance, a 'subcutaneous infusion'.

Monitoring pain, blood pressure etc.

The Trust has introduced a policy on 'the assessment and management of pain'. This policy clearly identifies the information which needs to be recorded in order to appropriately manage an individual patient with pain. In relation to other records of vital signs, these would be monitored in specific circumstances, for example where a patient's condition deteriorated unexpectedly. It should be noted that the recording of blood pressure can be distressing to some patients and should only be undertaken where there is a clear clinical rationale.

In addition to the training already referred to, all of the qualified staff at Gosport War Memorial Hospital have undertaken the ALERT (Acute Life Threatening Events – Recognition and Treatment) course. This course is specifically designed to provide nursing staff with the skills to identify the signs of acute life threatening events, to instigate appropriate monitoring and actions. Recording of vital signs is an integral part of this.

Side Effects of Drugs

The potential for drugs to cause side effects or a change in the patient's condition should always be considered by the prescriber and those administering medicines to patients have a responsibility to make themselves aware of known side effects. The decision to prescribe a particular medication will be made by the doctor taking into account his/her assessment of the patient, reference to appropriate medication information, and previous history where this is available. Prescription of any treatment is a clinical decision and clinicians should always make an assessment of the patient, appropriate evidence and past history.

Keeping up to date with research on medication

The British National Formulary is the main way clinical staff keep up to date. This is published twice a year, and each doctor is issued with the latest version. In addition a copy is provided for each ward so that nursing staff have access to it should they have any queries (e.g. during a ward round) or concerns.

Where does the buck stop?

Where a patient is admitted under the care of a consultant, overall responsibility for that care lies with the named consultant. However individual practitioners are accountable for their own practice in line with the professional code of practice.

All consultant appointments are made on the recommendations of an advisory appointments committee whose membership is determined by a statutory NHS circular. The role of the appointment committee, with representation from the appropriate Royal College and University as well as local consultants and the Trust Board, is to ensure firstly that only suitably qualified candidates are invited to interview and secondly that from those who meet this criteria only the best candidate is appointed.

I hope these comments are of some help.

I also need to inform you that Portsmouth HealthCare Trust is dissolving on 31st March 2002 as part of the government's NHS reforms. Responsibility for Gosport War Memorial Hospital passes to the Fareham and Gosport Primary Care Trust from 1st April 2002 - address as follows:

Unit 180, Fareham Reach
166 Fareham Road
Gosport. PO13 0FH
Telephone: 01329 229432

It's chief executive is Mr. Ian Piper, and any further correspondence should be addressed to him.

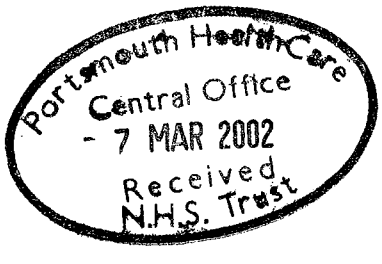
With best wishes,

Yours sincerely,

Max Millett
Chief Executive

Code A

Without Prejudice



Max Millett
Chief Executive
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Dear Mr Millett,

Thank you for your very prompt response to my telephone queries regarding palliative care drugs written up in advance for rehabilitation patients.

The policies now in place have my full approval and have partly made the long haul worthwhile. Something positive has resulted from the death of my mother and other tragedies, together with the previous directive issued in December 1998 concerning falls and X-rays.

I find it difficult to understand how these policies were not in place as a norm and how it has taken so long for the very serious defects in procedures to come to light. I accept there are not many patients who have daughter/daughters with 40 years nursing experience and/or a serious interest in law, brain functions, psychiatric/psychological illness, counselling bereavement and personnel management!

1. I still have some queries however and would appreciate your assurance that other aspects of care have been dealt with. I recall at the AGM the Annual Report indicated that training was to be given to staff concerning their attitude to the dying and next of kin – bereavement counselling commences long before death. I queried at the AGM did this include members of the medical profession as Doctors in general are the worst culprits of insensitivity.?

2. Has anything been done about record keeping concerning nutrition/fluid levels to ensure dehydration is avoided within a short time after admission? My mother was dehydrated by the time she was referred back to Haslar. Are the BMA recommendations in operation regarding hydration drips for the dying?

3. Are records in place when assessing pain ie. Blood pressure, pulse rate, temperature etc? There were no records on my mother's file.

4. Are the side effects of drugs prescribed ie. Dizziness, fainting, confusion, heart failure, renal failure etc known and taken into consideration by medical/nursing

staff and the appropriate observation and action taken.? Is the dose appropriate to age and symptoms? Oramorph is not appropriate on admission when two letters indicated my mother had little pain 3 days after the operation and was fully weight bearing and walking with a zimmer on admission at the Gosport War Memorial Hospital 11th August. Do Doctors actually refer to letters before writing up palliative care drugs and the indication to nursing staff 'I am quite happy for nursing staff to confirm death' for a rehabilitation patient?

5. Does anyone keep up to date with research into the effects of neuroleptic and tricylic, anti-depressant drugs on the brain.? Many of your dementia patients from Nursing Homes are probably suffering from Tardive Dementia, Tardive Akathisia, Tardive Dyskinesia etc and more of the same drugs do not help. (Dr. Peter Breggin "Toxic Psychiatry"). Haloperidol is not appropriate for noisy patients if you do not know why the patient is noisy and certainly not for agitated patients who want to go to the toilet.

6. Where does the buck stop? I would assume the consultant in charge of elderly wards, including Mulberry, bears some responsibility. What are the qualifications, credentials needed and are they rigorously checked before appointment.? (I comment as an ex Personnel Officer with many years experience in recruitment of staff who could effect the quality of life for others.)

7. Having had some personal experience (albeit in the 60's) of the 'acceptable' qualifications in both law and medicine whilst living in Asia (tea-plantation), I am also aware of the culture and attitude to the elderly and dying. I hope you can reassure me that the questions raised in my mind are totally unfounded.

You commented in a telephone call that I was a lady with a mission. No I am not – merely and old Old Roedeanian of a bygone era when honesty and integrity were of value and "those to whom much is given, much is expected in the service and support of others".

Yours sincerely,

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