Mrs. G. Mackenzie,

Code A

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

Dear Mrs Mackenzie,

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

Mr M Millett
Chief Executive
Trust Central Office
St James' Hospital
Locksway Road
Portsmouth

22 March 2002

RIR/cmp

Dear Max

Re: Mrs McKenzie's Letter

I have responded to the points as enumerated in Mrs McKenzie's letter. Please feel free to alter, delete etc. as you wish.

1. The Trust has received very few complaints about the attitudes of medical staffing to the dying and the next of kin? No complaints about this have been received since ----------?

   If such a complaint were to be received the complaint would be fully investigated and appropriate action taken.

   All consultant medical staff in the Trust (and the NHS) have an annual appraisal and if any further training issues were identified these would be included in the individual's annual personal development plan. The personal development plan would be reviewed at least at the next appraisal, or earlier if there were serious concerns.

   It is a requirement of junior medical staff training that they should acquire skills in attitudes towards the dying, breaking bad news etc., and this is formally reviewed by their educational supervisor.

2. Yes to record keeping.
   What BMA recommendations?!

   When dying patients are capable of expressing their wishes and are mentally competent to do so, their wishes as to hydration, feeding etc. would be respected.

   When dying patients are incapable of making such decisions the staff (medical, nursing and others) have a legal duty to act in the patient's best interests. The view as to what constitutes "best interests" should be formulated as a result of consideration of a number

of factors and actions – ascertaining what the patient's views might have been had they been capable of giving these, any previously expressed wishes of the patient, the views of relatives, the patient's condition at the time, the patient's prognosis and whether it was felt that the patient was suffering as a result of being unable to take fluids etc. The decision whether or not to hydrate would be an individual one taking all of the above and any other appropriate considerations into account. In the situation where it was felt that hydration was appropriate, hydration would be provided according to the Trust's protocol (I assume one exists i.e. a policy for subcutaneous fluids). (I think it is important to get across the message that all dying patients should not be automatically hydrated).

3. A copy of the pain assessment chart is included and this shows the observations which should be made relating to the assessment of pain. It would be expected that in any patient whose condition deteriorated unexpectedly, pulse, BP and temperature would be measured and recorded. It should be pointed out that BP measurement can be distressing to some patients and that clinical measurement should only be undertaken if there were a clear rationale or protocol which indicated this was good practice, or if there was a change in the patient's condition.

4. The potential for drugs to cause side effects or a change in the patient's condition should be considered by medical, nursing and other therapy staff.

   Doctors should refer to all appropriate available information as well as to the results of their own assessment of the patient before making any clinical decision.

5. No further comment to make.

6. For patients admitted under the care of a consultant, the "buck" stops with that named consultant.

   All consultant appointments are made on the recommendations of an advisory appointments committee whose membership is determined by a statutory NHS circular. The appointment committee includes local management and consultant representatives as well as a representative from the appropriate Royal College (from another NHS region) and the University. The role of the committee is firstly to ensure that only suitably qualified and trained candidates are considered and secondly that from these the best candidate is appointed.

I hope the above is enough to enable you to pen a satisfactory response. Please get in touch with me by Friday (22nd March) if you would like any further information or clarification as I shall be on leave the following week.

Yours sincerely

Dr R I Reid
Medical Director