Dorothy Stanford
Code A
Age 78

Admitted to GWMH 23.11.93
Admitted from Anne Ward, QAH

Usual address: Egremont Rest Home

PMH
1966 - Insulin dependent diabetes (elsewhere in records diabetes indicated as dating from 1957)
1982 – retinopathy
1986 – vitreous haemorrhage
1987 – L vitrectomy, Registered blind
1992 – totally blind
1993 – note from QAH indicates: L CVA – R hemiplegia; discharged to GWMH with nasogastric tube; unable to maintain activities of daily living, has had variable conscious level, now answers simple questions. Blood sugar being monitored. Catheterised, needs occasional enema.

Final illness

Was admitted to QAH on 3.11.93. Unconscious on admission, but becoming responsive on 4.11.93. 10.11.93 – flaccid R side; comprehending and using full sentences; poor swallowing – NG feeding. Received cefuroxime for a urinary tract infection. In view of continued dense hemiplegia, transferred to a long stay bed on Daedalus ward.

On admission to GWMH 23.11.93, Dr Barton records the above history; she says 'now very poorly', notes a temperature, and says 'needs analgesia', although no details of why or any pain; pain noted in QAH notes. A note dated 24.11.93 reports some general improvement, and that the daughter agrees to discontinue artificial feeds and not use antibiotics. This decision is also noted in the nursing records.

25.11.93 'not eating or drinking, still on sliding scale insulin, daughter aware' (JAB)
26.11.93 'further deterioration on sc analgesia, daughter here' JAB
27.11.93 died 5.45. pronounced dead by sister I Goldsmith.

Nursing records indicate the nasogastric tube was removed 23.11.93. The patient had a little porridge, and the notes indicate that liquids cause coughing. Blood sugars were checked until 24.11.93.

Drugs

Was written up by Dr Barton for diamorphine 40mg sc in 24hrs, hyosine 400mcg sc in 24hrs and midadazolam 20mg sc in 24hrs (i.e. by syringe driver) dated 23.11.93 (i.e.on day of admission). These drugs were not started until 25.11.93. Also written up

for oxycodone supps, although none were administered, and actrapid (last dose 26.11.93).

Comment
The patient was certainly disabled by a major stroke; she had received some rehabilitation/physiotherapy in QAH, and an early death was not recorded as expected by QAH staff. It is worrying that Dr Barton concluded on first seeing the patient that a prescription for diamorphine by syringe driver would shortly be needed (23.11.93). The source of pain is not clear, and not noted by QAH staff; no mild analgesia was given. A discussion with the patient's daughter does appear to have taken place, and this seems to have been followed by a policy of no active treatment – indeed, diamorphine was commenced. These actions suggest that an active and optimistic policy towards rehabilitation was not followed.

Margaret Sutton

Code A
Date of death 25.12.99
Age 90

Gender female

PMH
1999 – attending Dolphin Day Hospital; loss of confidence following a fall and fractured pubic ramus, atrial fibrillation and urinary problems.
Has osteoarthritis of thoracic spine, diverticular disease, deafness.

Final illness
Admitted Queen Alexandra Hospital (QAH) 12.11.99 with vomiting, dehydration, poor mobility (secondary to a bimalleolar fracture of L ankle, in plaster cast). An abdominal X ray showed dilated small and large bowels, the initial diagnosis was constipation, and IV fluids were commenced. By 13.11.99, the diagnosis was given as obstruction ?will need laparotomy. The symptoms tended to remit and return, by 19.11.99 she was a little improved, but it was decided that she would not survive laparotomy. Made 'not for resuscitation', after discussion with the patient's niece. Referred to elderly care team, 23.11.99 (still not opening bowels or passing flatus). On IV fluids.

Elderly care assessment – Barthel 1/20, in need of ongoing specialist input, so in need of continuing care.

Transferred 29.11.99 to Daedalus continuing care bed. Noted to be incontinent of faeces, gross oedema, catheterised, abdomen not distended. 'Overall prognosis poor' (signature not clear, not JAB).

20.12.99 'Deteriorated over week end, generally poorly, pain in chest, oramorph given with good relief, please make comfortable. I am happy for staff to confirm death. JAB'

20.12.99 – seen by another doctor (not clear who); pain confirmed, continue oramorph, nephew is aware she is dying.

22.12.99 further deterioration oral morphine analagesia started 2 days ago, now very comfortable and at peace. Please use sc analgesia if clinically necessary. JAB

24.12.99 Further deterioration. Family coming in today I will see if appropriate. JAB

25.12.99 23.30 died peacefully Death confirmed by Catherine Marjory, RGN

Drugs

Diamorphine 20-80 mg sc written up 6.12.99, started 22.12.99 Hyoscine 200-800ug written up 6.12.99, not started. Midazolam 20-80mg written up 6.12.99, started 22.12.99. Oramorph written up 19.12.99 5-10 mg

Comment
This case has been managed appropriately in GWMH. An alternative, more aggressive form of management was ruled out when the patient was undergoing specialist assessment in QAH. The patient was under the care of doctors other than Dr Barton in GWMH.

Betty Brown

Code A
Age 79

PMH

Hypertension 1990
Anxiety/depression from 1966
Uterine bladder prolapse 1982
2000 – admitted Haslar – metastatic squamous carcinoma, primary unknown. Confirmed histologically through liver biopsy. Gone down hill on the ward (says consultant geriatrician), had DVT, needs 2 to stand, not possible to manage at home.

Final illness
9.2.2000 Admitted from A3 Haslar for palliative care. Grade 2 pressure sore on sacrum, catheterised. Assessed on admission by a doctor other than Dr Barton.- 'very anxious about being in hospital where husband died, we need to pull out stops re getting her home if possible' JAB
16.2.2000 – assessed by OT
21.2.2000 – commenced oramorph for liver pain; warfarin stopped (nurse notes)
21.2.2000 – s/b Dr Lord. No definite evidence of DVT; necrotic mass on CT scan and definite liver mets. Diclofenac +/- oramorph for liver capsule pain. Pt aware of cancer…prognosis poor' Son seen and reasons for stopping warfarin & nifedipine explained. Brief discussion with son on use of morphine. Son agrees that discharge home not practical.

23.2.2000 – syringe driver commenced.
28.2.2000 – 01.15 died. There are no record entries by a doctor between 21.2 and 28.2.2000.

Drugs
Oramorph recorded 21.2.2000 5-10 mg 4 hrly, started 22.12. Diamorphine sc 20-80mg in 24 hrs and hyoscine 200-800ug in 24hrs both written up 21.2.2000. Diamorphine started 23.2.2000. Other drugs were used but are not detailed as they were not opiates (EG, GTN, ranitidine).

Comment
The patient's care was appropriate; there are excellent features – a detailed assessment by a specialist, and detailed discussion with a son, OT assessment; decisions on management were appropriate. The early writing up (but not administration) of sc opiates occurs again.

Norman Willis

Code A
Date of birth: 28.8.1929

Male

PMH
Admitted QAH 11.2.1997 L hemiplegia. Also NIDDM & hypertension. CT scan on 12.2.1997 showed large intracerebral haemorrhage; transferred to Wessex Neurosurgical Centre for angiography and exclusion of aneurysms. Barthel 2, PEG tube; will need slow rehabilitation, but 'very young'.

Final illness
9.4.1997 – transferred to Daedalus Ward, GWMH, for rehabilitation.
10.4.1997 – referral to speech therapist to assess swallow JAB.
15.5.1997 – still MRSA + (S/B consultant [I think], & reviewed by consultant every few weeks.
10.7.97 – lack of progress, discussed with wife;
26.1.98 – Barthel 1. Problem with pain when MST withdrawn – pain L shoulder
9.2.98 – too dependent for nursing home
24.8.98 – epididymo-orchitis
24.9.98 – pemphigoid
5.10.98 – 'prognosis poor' (specialist I think, not Dr Barton).
23.10.98 – started insulin (diabetes worse since steroids started)
8.2.99 – markedly worse last 2 weeks, in pain, crying out, not taking oral medication – diamorphine sc 250mg; wife aware he is dying. (not Dr Barton)
11.2.99 – bronchopneumonia noted
16.2.199 6.10 died

Drugs
The drug chart was usually completed by Dr Barton. Oramorph was started at an early stage (December 1997) and continued, MST also being used from 1997; eventually replaced by diamorphine by syringe driver. There is a large number of drug charts and

the pattern is difficult to disentangle, but it appears that MST was used regularly, with oramorph for break through pain.

Comment
The patient was very severely disabled by the stroke, and no real improvement occurred. The MRSA infection was treated repeatedly in an effort to eradicate it, although this proved very difficult. Patients with this degree of dependency and illness do develop pain, but the factors leading to the initiation of opiate medication are not described in detail. The patient was, as far as I can determine from the handwritten records, regularly assessed and managed by a senior doctor.

Margaret Burt

Date of birth Code A

PMH

1999 – fall ?secondary to an MI. Admitted Haslar, fracture R neck of femur – R hemiarthroplasty.
Kingsclere rehab- Barthel 2, some dementia and stubborn, so rehabilitation problematic. Transferred to Dryad for long term care, ? eventual nursing home.

Final illness
10.2.99 – referred to Dr Banks by Dr Beasely for assessment.
5 further record entries indicating reluctant to take food, fluids or drugs; Dr Reid attended on several occasions.
15.3.99 – sips of water only, comfortable, skin intact Barthel 5 for TLC
16.3.99 - social services assessment – has deteriorated in past few days so placement will not be pursued at present. Daughters returning to UK.
22.3.99 – died (no record entries between 16.3 and death).
Nursing records indicate syringe driver started 18.3.99 – complaining of severe generalised pains, refusing oral oramorph; syringe driver started after discussion with daughter.

Drugs
The oramorph and diamorphine (& midazolam & hyoscine) were written up by Dr Barton, although there is no related entry in the records. Oramorph 16.3.99, 5mgs. Diamorphine 20-200mg in 24 hrs writeen up (date of writing up not clear). Started 18.3.99, 20mgs, rising to 30mgs on 22.3.99. Medazolam started 18.3.99, 20mgs, rising to 30mgs on ?22.3.99.

Comment
The absence of detailed information about the reasons for commencing opiates makes this case difficult to assess. However, the patient was managed by doctors other than Dr Barton, and deterioration was noted before the opiates were commenced. Therefore, it is probable that care was appropriate, although the completeness of records is unsatisfactory.

Alexander Hobbins

Date of birth: Code A
Date of death: 3.4.1999
Male

PMH
Deaf mute
1982 – carcinoma penis
1995 – aortic valve replacement
3.2.99 – admitted QAH, fractured malleolus, aspiration pneumonia, fracture tibia, PEG feeding – swallowing disorder, wt fell to <6 stone; fall – fracture R femur, Denham pin. 'probably has a progressive neurological disease of uncertain etiology which might worsen'.

Final illness
15.3.99 – transferred to Daedalus ward for continuing care. Assessed on admission by Dr Barton. History noted, for 'slow rehabilitation; please make comfortable, I am happy for nursing staff to confirm death. JAB' Seen by another doctor 15.3.99 and 29.3.99, with some improvements in pressure areas noted. No major new problems.
3.4.99 – died 23.40.

Drugs
Oramorph written up by Dr Barton 15.3.99 PRN basis. Doses given from 2.4.99.
Diamorphine 20-200, hyoscine 200-800, medazolam 20-80 all sc, started 2.4.99 (written up by a doctor other than JAB).

Comment
Little is recorded about the last few days of the illness; the reasons for the commencement of opiates is not clear. The patient was clearly ill and frail, but the precise nature of the terminal events are difficult to determine from the records.

Arthur Betsworth

Date of birth: Code A
Date of death: 29.7.99

Male

PMH
Few details
Admitted Haslar 14.6.999.

Final illness
20.7.99 – transferred to Dryad ward continuing care, carcinoma lung following haematemesis. Assessed by Dr Barton on admission, writing rather difficult to read.
26.7.99 – nebulised – helped cough
28.7.99 – 'further deterioration start sc hyoscine & midazolam; change over from fantanyl to sc diamorphine' JAB

28.7.99 – on diamorphine, hyoscine and cyclizine; pain well controlled, mass now growing thru chest wall. Dr Reid.
29.7.99 – 17.45 died

Drugs
Diamorphine, hyoscine & cyclizine initiated by Dr Barton, 22.7.99. This date does not match the date in the record continuation chart – but the diamorphine was IM injection 22-27, and sc thereafter. Medazolam 29.7.99. Oramorph from 21.7.99.

Comment
Management appears to have been appropriate. The records were not fully legible, and not a full record of clinical decisions.

Eva King

Date of birth: Code A
Date of death: 5.8.1999

Female

PMH

1995 – depression, chest infection, NIDDM, poor short term memory, transferred to a rest home.
Admitted QAH 28.6.199 fracture R femur – dynamic hip screw; difficult to mobilise, poor fluid intake, catheterised; for transfer to GWMH. Dementia – difficult to understand

Final illness
21.7.99 – admitted to Dryad ward from QAH. Assessed by Dr Barton – dementia, fractured hip, past TIAs noted. Barthel 2. 'Please get to know. Please make comfortable. I am happy for nursing staff to confirm death.' JAB
27.7.79 – walks with 2. Needs help with washing and dressing JAB
28.7.99 – fairly advanced dementia. Aim to mobilise further – another doctor ?Dr Reid
2.8.99 – needs feeding now, not being mobilised ?vaginal bleeding for 3-4 days. MSU no growth. Rubbing L side at times as if in pain – relieved by ORAMORPH. For PV / PR. PV (by Dr Barton) – NAD. Treat for UTI. [another doctor, not sure who]
Nursing notes report sore vulva 1.8.99.
3.8.99 – marked deterioration over night. No further bleeding but uncomfortable despite oramorph. Please make comfortable (JAB)
4.8.99 sc analgesia commenced now ..(illegible). Use hyoscine (illegible) JAB Nurses notes confirm pain – groaning on turning.
5.8.99 – died 3.30.

Drugs
Oramorph 5mg started 1.8.99; diamorphine (20mg & 30 mg) sc and medazolam 20 mg & 30 mg sc 3.8.99, hyoscine 4.8.99.

Comment
A patient with multiple problems, and was difficult to mobilise. The outcome would not be unexpected, although the precise cause of death is rather unclear. Management appear generally appropriate, although the records are not detailed.

Lawrence Racey

Date of birth: Code A
Date of death: 13.10.99
Male

PMH
Few details available from records

Final illness
Admitted 11.10.99 from Mulberry B. Ca lung, shakey and jaundiced on admission, complained of pain, poor mobility – needs help with transfers and feeding (nursing notes)
11.10.99 – assessed by Dr barton. Transfer to Dryad ward continuing care. Also past history of ca prostate although PSA was recently? normal. Recent deterioration in general condition. 'Plan Get to know, make comfortable, needs palliative care only. I am happy for nursing staff to confirm death' JAB
12.10.99 – wife and BIL seen. Made aware of general condition. Agreed that … not appropriate and that he is to be made comfortable. Oramorph commenced but in view of … may need sc analgesia soon' JAB
13.10.99 – condition deteriorated throughout the day, died peacefully at 16.35 (nurse).

Drugs
Oramorph 5-10mg as required from 11.10.99; diamorphine 20-200mg 11.10.99 – started 12.10.99 20 mgs, 30 mgs on 113.10.99. Also hyoscine 4oougs, medazolam 20-40 mgs12 & 13th. Sc.

Comment
The patient had advanced terminal disease, and was managed appropriately.

Frank Horn

Date of birth: Code A
Date of death:
Male

PMH
Past carcinoma larynx, 2 CVAs, atrial fibrillation, dementia, gout, angina, arthritis. Two admissions in 1999 for chest problems and poor mobility – transferred to GWMH after assessment by consultant physician in geriatrics (Dr Reid).

Final illness
5.11.99 Admitted Dryad, assessed by dr Barton 'Barthel ?4' 'Plan Get to know. In view of PMH of recurrent SOB, aspiration and Ca Larynx, not for resuscitation,

heroics (I think this is the word, but not clearly written). Please make comfortable. I am happy for nursing staff to confirm death' JAB
9.11.99 - Seen SLT – advice re feeding
10.11.99 – 'marked deterioration over last 24 hrs. persistent cough relieved by nebulised diamorphine in N/saline. Daughter to be seen. Sc analgesia is now appropriate + neb if required'. JAB The nursing notes do not provide much information about the nature of the deterioration or reason for sc analgesia. The only notes indicates 'Distressed with coughing fit about 0500. Diamorphine 10mg/2mls normal saline nebuliser given at 05.35.'
11.11.99 – 'further deterioration. Comfortable on sc analgesia. I will see daughter today. I am happy for nursing staff to confirm death. JAB' The nursing notes indicate that he was distressed when being attended.
12.11.98 – died at 4.30.

Drugs
Oramorph as required was written up 5.11.99, although none was given. Diamorphine in N saline written up 9.11.99, 3 doses given. Diamorphine sc 20 mg on 10.11, and 40mg twice on 11.11.99. Also hyoscine 400ug one dose and medazolam 20 mg one dose, 40 mg two doses given (over 2 days).

Comment
The reason for the deterioration before death is unclear. The use of an alternative to nebulised diamorphine might have been considered. No investigation is reported. The decision against 'heroics' appears to have been followed. This may have been a reasonable decision since the patient did have significant disability. However, the original reason for admission was to see if he could be mobilised sufficiently to return home (Dr Reid). It is reasonable to conclude, therefore, that fairly rapid deterioration and death were not expected.

Vera Miller

Date of birth: Code A
Date of death: 8.4.1999

Female

PMH
1996 – DU
Admitted QAH with dehydration, diarrhoea and vomiting; dementia, needs two to transfer, gross lower limb oedema, abdominal aortic aneurysm, left parotitis.

Final illness
Transferred to Daedalus for a period of assessment and to consider options for discharge.
31.3.99 – assessed by Dr Barton. History noted 'Plan get to know, make comfortable, I am happy for nursing staff to confirm death. JAB'
6.4.99 – deterioration over weekend on sc analgesia more comfortable … and has visited. Please make comfortable 20mg/diamorphine/medazolam chesty For burial JAB'.
8.4.99 00.45 died

The nursing notes indicate that on 4.4.99, had been eating and drinking only a little, refusing medication, extremities cold; her daughter was contacted and was aware that the 'outlook was probably not good'. The daughter visited as is recorded as agreeing that force feeding would not be indicated. The use of the syringe driver was explained. Later on 4.4., the patient was noted to have pain on movement, had vomited and was distressed. Sc analgesia was commenced.

Drugs
The nursing notes indicate that codydramol was refused on 1.4.99. Oramorph 5-10mg was started 31.3.99 (Dr Barton prescribed) diamorphine 4.4.99 20mg/day, rising to 40mg/day by 7.4.99 Hyoscine 4.4.99, and medazolam 4.4.99 20mg/day.

Comment
The patient was a frail lady with poor mobility and some dementia, although she did not have a specific terminal disease such as cancer. The reasons why her condition deteriorated are uncertain, and were not investigated. It should be noted that she was originally admitted for assessment.

Margaret Benford

Date of birth: Code A
Date of death: 16.6.199

Female

PMH
Past history of DU, depression, angina, psoriasis, osteoporsis.
25.5.99 admitted Haslar, fractured neck of femur – right hemiarthroplasty; has confusion and dementia (Alzheimer's); requires help with washing & dressing, 2 nurses for transfers. Very frail, transfer to GWMH to 'see how she gets on' (Dr Tandy, consultant geriatrician). Medications on transfer were: nitrazapine, trazadone, risperidone, lactulose.

Final illness
11.6.99 Nurses record notes she was tearful and in pain when moved, on admission. Started on Fentanyl patch and oral oramorph – settled and slept long periods.
13.6.99 – nurses note in considerable pain when moved, crying out; unable to swallow oramorph – syringe driver commenced.
11.6.99 – Dr Barton assessed, transfer to Dryad ward continuing care. 'immobile in pain' Barthel 0. 'Plan Get to know make comfortable. I am happy for nursing staff to confirm death JAB.'
13.11.99 'Fentanyl commenced on arrival sc analgesia commenced needs medazolam also. Family need to be seen JAB'
14.6.99 – another doctor, in pain when being moved, poor oral intake, on diamorphine and medazolam
16.6.99 died 17.25.

Drugs
Oramorph written up and started 11.6.99, but on as required basis. Fentanyl written up 11.6.99, regular dose. Diamorphine 13.6.99 30mg, 14.6 x2, 16.6 30mg, x2; medazolam 10-30mgs from 14.6.9. Also hyoscine from 15.6.99.

Comment
The patient was disabled, and in pain. Alternative medication would have included not opiate analgesia, supplemented by intermittent use of opiates if necessary when pain was severe. The commencement of regular opiates at an early stage suggests an early acceptance of impending death.

Edna Hillyer

Date of birth: Code A
Date of death:

Female

PMH

Recent admissions for chest infections (QAH); breast cancer with fungating mass left breast; past bilateral hip replacements, confused. CT scan did not show metastases (?cerebrals can)

Final illness
14.5.99 - Transferred to Daedalus, assessed by Dr Barton 'Please make comfortable .... Adequate pain relief. I am happy for nursing staff to confirm death. JAB'
27.5.99 – seen by Dr Dubaois, oncology. The ulcer had reduced in size since megesterol had been started.
28.5.99 – 'not comfortable on MST 30mg. Suggest Fentanyl analgesia. Please make comfortable JAB'
7.6.99 – seen by another doctor – deterioration noted 'unlikely to survive for long'. (?Dr Lord)
14.6.99 – Seen again by the other doctor – ct Fentanyl, keep comfortable, if she dies, nursing staff please confirm
16.6.99 – 'further deterioration. Need sc analgesia ... (illegible) JAB'
16.6.99 – died 21.15

Drugs
Oramorph prescribed (JAB) 14.5.99 for use as required. Also written up for diamorphone, hyoscine & medazolam as required, but not given. Fentanyl 28.5.99, MST 20mg 14.5.99, 30 mg 21.5.99.

Comment
This patient did have advanced breast cancer, and was frail. Management was appropriate.

Ruth Marshall

Date of birth: Code A

Date of death: 5.7.1999

Female

PMH
1997 – leg ulcer
1995 – postmenopausal bleed
1972 – L hemiplegia
4.5.99 – admitted after a fall, swollen right hand, oedema & left leg ulcer; Confused.

Final illness
17.5.99. Transferred to Dryad continuing care. Assessed by Dr Barton. Poor mobility & leg ulcer; newly diagnosed diabetes mellitus. Plan: stop antibiotics, monitor diabetes, assess mobility, talk to family.
5 - 6 consultations with another doctor – improved mobility
28.6.99 – deteriorated, dependent, agitated ?UTI
30.6.99 – 'dreadful night restless, agitated hallucinating try risperidone 0.5mg JAB'
30.6.99 – consultation about toothache
1.7.99 – calmer on risperidone, antibiotic changed. 'Please make comfortable. I am happy for nursing staff to confirm death JAB'
2.7.99 – 'needs sc analgesia with cyclizine try and continue antibiotics son needs to be made aware of poor prognosis JAB'
5.7.99 – unconscious bubbling respirations dying Dr Reid
5.7.99 – died 16.15.

Drugs
Oramorph as required written up by JAB 18.5.99, started 27.6.99. Diamorphine 20mg/day sc 2.7, 3.7, 40mg 4.7. also hyoscine 400-800ug and midazolam 20-40 mgs.

Comment
The reason for the patient's deterioration is not clear, but this course of illness is not uncommon in an old person with multiple conditions. Management was essentially conservative, and the deterioration of 28.6.99 was not investigated in depth. This was probably a reasonable plan.

Catherina Askew

Date of birth: **Code A**
Date of death:

PMH
1983 – fractured R femur
1985 – fracture R humeral head
1988 – cataract extraction
1993 – pernicious anaemia
1994 – fractured R femur
thyroidectomy
chronic renal failure
1996 – acute confusional state due to UTI

Final illness
Admitted GWMH with postural hypotension, depression & falls, 7.5.98. Also poor mobility, urinary incontinence. Not confused. Admitted following assessment by Dr Lord in patient's sheltered accommodation.
7.5.98 – nursing notes record bruising R shoulder, constipated
8.5.98 – commenced on regular oramorph
9.5.98 – very sleepy, bubbly breathing (nurses' records); 23.30 deteriorating, syringe driver set up, diamorphine 40mg.
Doctor's notes:
7.5.98 – assessed by Dr Barton; management plan not recorded
10.5.98 – died at 12.25.

Drugs
Coproxamol given 7.5.98; Oramorph 5-10mgs, then diamorphine sc 40mg over 24hrs set up 9.5.98, with hyoscine and medazolam.

Comment
The records do not fully disclose the reasons for the clinical decisions that were made. The resort to opiates appears to have been rapid, and the patient deteriorated quickly after starting oramorph.

Phyllis Horne

Date of birth: Code A
Date of death: 6.5.1998

Female

PMH
TIA
Alzheimer's
Admitted to QA 16.3.98 following recent TIA and general deterioration – reduced mobility, incontinent, more anxious, pain that cannot be localised. No real change in her condition, CT scan indefinite, but possibility of a posterior fossa lesion. Transferred to GWMH.

Final illness
26.3.98 – assessment by Dr Barton. 'Plan get to know, see family, TLC. JAB'
27.3.98 – 'beginning to wake up, not eating and drinking. I am happy for nursing staff to confirm death. JAG'
30.3.98 – seen by Dr Lord. Functionally very dependent.. Barthel 0. Situation discussed with daughter in law.
27.4.98 – Dr Lord. Confused with some rigidity. Given haloperidol for agitation. Referred to Dr Banks for advice
27.4.98 – discussed with Dr Banks – medication altered, prognosis is poor.
3.5.98 – 'frightened agitated appears in pain suggest transdermal analgesia despite no obvious clinical justification!! Dr Lord to countersign. I am happy for nursing staff to confirm death. JAB'

5.5.98 – 'further deterioration in overall condition, can't swallow medication, therefore now for sc analgesia make comfortable JAB'
5.5.98 Dr Banks reviewed – now on driver, not swallowing, seems very settled non-rousable.
The nursing notes confirm death on 6.5.98, 9.40.

Drugs
Diamorphine 40mg 5.5.98 one dose only, with midazolam 40mg; fentanyl 25mg patch 3.5 confirmed.

Comment
Dr Barton's remark prior to starting fentanyl is worrying. The patient then declined further, and was started on sc diamorphine – but there was no specific diagnosis before this series of events was put in train.

Doris Feben

Date of birth: Code A
Date of death 25.2.1998
Female

PMH
1.2.1998 – brain stem stroke, atrial fibrillation; assessed by Dr Tandy, consultant physician in geriatrics, and transfer to Gosport Slow Stream Stroke (Daedauls) arranged.

Final illness
16.2.1998 – assessed by Dr Barton. Catheterised, transfer with 2. Barthel 2. 'Plan get to know. Family … well, religious and feel that no active intervention should be considered. They are very keen for her to go to Tudor Lodge Annexe ….physio and OT see and reassess. I am happy for nursing staff to confirm death. JAB'
17.2.98 – seen by speech and language therapist
18.2.98 – 'chat to daughter, aware of prognosis, will think about fluid replacement and antibiotics if develops pneumonia. Dr Lord to see family tomorrow JAB'
19.2.98 – s/b Dr Lord. Daughter not keen on sc fluids or antibiotics, therefore not for now.
19.2.98 – dehydration and chest infection, daughter agrees to treatment (Dr Lord).
23.2.98 – deteriorating, bronchopneumonia, not for iv antibiotics. Diamorphine if distressed. Prognosis v poor. (Dr Lord)
24.2.98 – 'further deterioration. Chest rattly, restless, uncomfortable, needs sc analgesia ……. Family aware and hopefully prepared. I am happy for nursing staff to confirm death. JAB'
The nursing notes confirm that the patient was having pain on 24.2.98, and the diamorphine was increased to 30mg
25.2.98 – died at 11.15.

Drugs
Oramorph 23.2 10\mg x 2, 24.2 10mg x2.Diamorphine 20mg 24.2, 30mg at 18.30 on 24.2. Also hyoscine and midazolam.

Comment
Management was appropriate – the patient was quite disabled, developed a chest infection, and treatment decisions were carefully discussed with the family.

Leonard Kelmsley

Date of birth: Code A
Date of death: 3.6.98

Male

PMH
Past total hip replacement L
1997 - # L hip, DHS, developed pulmonary embolus
OA knees and hips
CVAs x2
COPD
Congestive cardiac failure

Final illness
Admitted QAH – idiopathic megacolon, persistent diarrhoea, poor mobility, pressure sore, congestive cardiac failure, COPD. Kingsclere suggested for rehabilitation.
29.5.98 - Transferred to Dryad ward. Assessed by Dr Barton. 'daughter lives in Devon. In previous interview knows poor prognosis. Not for resuscitation or transfer to acute ward. Please make comfortable. I am happy for nursing staff to confirm death. JAB' 'Quick word with daughter. Happy to wait and see how he settles'
3.6.98 – death confirmed at 11.50.

The nursing records indicate on 31.5.98 – general condition poor, in a good deal of pain, syringe driver commenced, diamorphine 20mg.

Drugs
Written up for as required oramorph, but none given. Diamorphine sc 20mg rising to 40mg/day started 31.5.98, with hyoscine and midazolam as usual.

Comment
The medical records do not contain information to enable a conclusion to be reached about the indications for sc diamorphine. The patient had been ill for a prolonged period, and curative treatment had been ruled out. Attempts at rehabilitation had not been successful. However, the record of care should have been more complete.

Kate Coalbran

Date of birth: Code A
Date of death: 19.7.98

Female

PMH
Senile dementia from 1996
Hemiarthroplasty 24.10.97, post op dysrhythmias

Final illness
3.11.97 – transferred from Haslar to Dryad, assessed by Dr Barton. Despite recent operation, extremely mobile. Dr Banks (??) asked for advice.
6.11.97 – seen by Dr Banks. Sedation medication discussed and continued. Continued to be managed on the ward, falls, confusion, referred OT and discharge to nursing home considered. Placement at Beechcroft arranged 16.3.98
27.4.98 – deteriorating, distressed, won't take oral medication, on Fentanyl, comfortable; no longer suitable for discharge to nursing home.(Dr Lord). The nursing notes indicate some deterioration 14.4.98, possibly a CVA; the patient's son is reported as not preferring active treatment. The fentanyl was started after the patient was seen by Dr Barton, but no reason is given for the medication.
8.6.98 – gradual deterioration, calmer with fentanyl (Dr Lord).
15.7.98 – 'deterioration in general condition, very stiff, … to nurse. Diazepam not effected, use midazolam. Son aware of further deterioration. JAB'
17.7.98 – 'further deterioration in general condition. Sc analgesia continues. I am happy for nursing staff to confirm death. JAB'
19.7.98 - died 11.55.

Drugs
Fentanyl was started by Dr Barton 21.4.98 25ug. Diamorphine, midazolam & hyoscine appear to have been written up 14.2.98, although not commenced until 15.7.98 The daily dose of diamorphine was 60mg.

Comment
It is worrying that sc analgesia should be written up on an as required basis so early. Again, the medication is written up by Dr Barton. However, care appears to have been reasonable. The reason for starting fentanyl is not fully explained.

Ruby Lake

Date of birth: Code A
Date of death: 21.8.98.

Female

PMH
1998 – joint pains, seen by rheumatologist, ? CREST syndrome
5.8.98 - # left neck of femur – hemiarthroplasty; slow recovery exacerbated by angina and breathlessness. Also leg ulcers and reduced hearing. Transferred to continuing care – frail and quite unwell.

Final illness
19.8.98 – admitted Dryad ward, assessed by Dr Barton. Catheterised, Barthel 6. transfers with 2. 'get to know. … rehabilitation. I am happy for nursing staff to confirm death JAB'.
21.8.98 – died peacefully at 18.25.

The nursing records note: 19.8.98 11.50 c/o chest pain Oramorph given, Dr informed. Pain only relieved for a short period, very anxious. Diamorphine 20mg midazolam 20mg commenced in syringe driver.
20.8.98 condition appears to have deteriorated overnight. Diamorphine 20mg, hyoscine & midazolam continues. Continued to deteriorate, chest bubbly.

Drugs
Oramorph was written up by Dr Barton on 18.8.98 on an as required basis, doses being given 18th and 19th. Diamorphine was written up as a regular prescription, although the date it was written up is not given. The first does was 20mg, on 19th. Doses increased to 40mg then 60 mg (one dose on 21st).

Comment
Oramorph appears to be written up for use as required for most patients on admission. The patient does not appear to have had a medical assessment prior to the commencement of opiates. The episode of chest pain was not investigated, and no clear diagnosis is recorded in the records. Whilst a myocardial infarction or pulmonary embolus are possibilities, the features recorded by the nurses are not typical, and not sufficient to reach a conclusion. Another, more minor, condition might have been responsible (the patient was known to have had angina).

Mabel Leek

Date of birth: Code A
Date of death: 18.12.1998

Female

PMH
Osteoarthritis
COAD
Angina
July 1998 - # L tib & fib – plating; determined to become independent again, s/b Dr Reid, transfer to GWMH for rehabilitation.

Final illness
6.8.98 – assessed by Dr Knapman on admission. Continue medication
10.8.98 & 24.8.98 – s/b speech and language therapist
1.9.98 – variable swallowing problem, restless, obsessed with passing urine, catheter considered. 'I suggest adequate analgesia and …?heavily sedated and I need to see family JAB'
14.9.98 – Dr Lord; not mobile; to mobilise when plaster of paris removed. Discussed with relative – concerned about recent confusion, reduce impramine and ?stop.
28.9.98 – Dr Lord. Tenosynovitis R, stop imipramine, try diclofenac
5.10.98 – Dr Lord Patient confused and wheeling herself into corridor. Cannot be reasoned with '(on long term MST)'

13.10.98 – 'patient complaining bitterly about pain in heel inside plaster cast. In view of increased swelling of foot and postponement of fracture clinic appt needs to be seen soon. JAB'

26.10.98 – Dr Lord. POP removed. On MST 70 bd.
9.11.98 – Dr Lord, cellulites L heel – flucloxacillin
23.11.98 – Dr Lord – ulcer smaller; to go to nursing home in new year.
7.12.98 – Dr Lord, Barthel 4/20, ulcer sloughing with some necrotic tissue. Pain better, less drowsy, ct same dose MST
14.12.98 – 'Poppy has deteriorated over weekend, pain relief is a problem. I suggest starts sc analgesia and please make comfortable. I am happy for nursing staff to confirm death. JAB'
15.12.98 – 'further deterioration. On sc analgesia – comfortable. Family aware. JAB'
18.12.98 – died 17.15.
The nursing notes indicate that the patient was unresponsive on 14.12.98, but in pain when moved; seen by Dr Barton, syringe driver commenced.
The MST appears to have been started 8.8.98 by Dr Peters – having breakthrough pain.

Drugs
MST was being prescribed during a hospital admission in 1996
As usual, Dr Barton has written up oramorph as required on each new drug chart.
MST 60mg bd was written up (a form may be missing, the start is 11.9.98).
Diamorphine, hyoscine and midazolam were written up in December, doses of diamorphine being 80mg – 160mg, rising over 5 days.

Comment
Dr Lord was trying to mobilise the patient and organise discharge to a nursing home. The reason for the deterioration in health status in December is not clear, and there was a quick resort to sc analgesia – initiated by Dr Barton. Mrs Leek had certainly suffered many problems, and was making only slow progress, but whether a more careful assessment (or a record of a careful assessment) before use of a syringe driver would have been helpful.