Notes review 2

Amelia Harfield

Date of birth: Code A
Date of death: 18.11.95

Female

PMH
Previous TIAs
Hiatus hernia
Retinal haemorrhage
Ischaemic heart disease

Final Illness
Nursing record:
Transferred from Guernsey Ward (?QAH) 9.11.95 following L CVA with R hemiparesis on 7.10.95, stroke extended 10.10.95
16.11.95 – extension to stroke. Dr Barton assessed, family aware, 5 mg oramorph given
18.11.95 distressed, vomiting. Syringe driver with diamorphine 40mg. Midazolam & hyoscine. Died 21.30
8.11.95 – poor progress in QAH, haematemesis, occasionally confused, transfer to Dryad long term care arranged.
9.11.95 – admitted to Daedalus (in fact). Assessed by Dr Barton – needs help with feeding, Barthel 2, 'in view of prognosis no heroics. Reassess (??). I am happy for nursing staff to confirm death. JAB'
18.11.95 – sticky L eye. … confused, irritable, very weak but still coping with oral treatment. Cont (another Dr, not clear who)
18.11.95 – died at 21.30.
The records confirm assessments and intervention by physiotherapy.

Drugs
Oramorph written up by Dr Barton 16.11.95, 5mg given, 16-17.11, several doses.
Diamorphine 40-80mg, midazolam 20-80, hyoscine 200ug written up on PRN basis (date of writing not indicated, no box on the form for the date). Administered once, 18.11.95, sc.

Comment
Clearly the patient has major problems following a stroke that extended at least once. The medical notes in GWMH are an inadequate record of the management of the final illness. The pattern of resort to opiates at an early stage is apparent again.

Euphemia Skeens

Date of birth: Code A
Date of death: 24.10.1995

Female

PMH
?past problem with alcohol; little else.
Admitted to QAH with R CVA; needing assistance to carry out all activities of daily living, including feeding; has to be hoisted out of bed. L arm and leg weak. Slightly chesty when transferred to GWMH, but not for antibiotics at that stage. Pain relief was paracetamol in QAH. Transferred to Gosport 20.10.95.

Final illness
20.10.95 – assessed in Gosport by a doctor (not Dr Barton).'Alert, well orientated. Dense L hemiparesis, restless, can't get comfortable. Plan: get to know, add night sedation – temazepam 10-20 mg nocte, coproxamol for discomfort.
23.10.95 – 'unable to transfer – needs a hoist, unable to feed or dress, now incontinent, Barthel 3, mental state strange JAB'
23.10.95 - ?Dr Lord. Dense L stoke and neglect. Plan – stop vitamins, PT & ST to see please.
24.10.95 – seen by speech therapist. Chesty.
25.10.95 – 'I need to see Mrs Skeens son & nok re further management … deterioration quite chesty today JAB'
26.10.95 – 'condition deteriorating, difficulty swallowing, restless …. ?needs opiates ? no antibiotics. I am happy for nursing staff to confirm death. Interview with son. Fully in understanding of mother's condition and happy with management JAB'
29.10.95 – died 10.40 (confirmed by nurse as usual).
Nursing records indicate that the syringe driver was started 28.10.95 – 'distressed and restless'. The oral oramorph was started 26.10.95 – restless and distressed, pain L arm.

Drugs
Oramorph 5-10mgs written up by Dr Barton, regular doses 26.10.95 – 29.10.95; diamorphine sc 40-80 mg 28-29.10.95, with hyoscine and midazolam.

Comment
A patient who suffered a dense stroke, admitted for long term care and rehabilitation, who was started on opiates when a problem arose.

Rhoda Marshall

Date of birth: **Code A**
Date of death: 7.1.96

Female

PMH
Parkinsons
Hyperthyroidism
dementia – diagnosis 1989
Admitted to QAH following fall – knocked over by another resident - # pubic ramus/acetabulum

Final illness
Nursing records: Transferred from Anne Ward. 30.12.95 – appears to be in pain on slightest movement. Only on co-codamol. S/b Dr Knapman, oramorph 10mg 4 hrly started. 2.1.96 seen by Dr Barton syringe driver commenced. 3.1.95 – analgesia and midazolam increased as appears still in pain. Nephew seen by Dr Barton. Still signs of pain and agitation 4.1.95. diamorphine 120mg. Continued to deteriorate until death, 1430, 7.1.96.
Medical notes:
29.12.95 – transfer from Anne Ward – assessed by a doctor (not Dr Barton). In need of long term rehabilitation; needs increased pain relief.
30.12.95 – 'pain control inadequate FOR ORAMORPH 10MG/5ML 4 hourly. Knapman'
2.1.96 – not well in herself. Not feeding well now seems in pain all the time needs sc analgesia. JAB'
7.1.96 – 15.10 RIP

Drugs
Had received pethidine in QAH for pain, but this had been stopped before transfer (probably around 17.12.95, although difficult to read writing).
Oramorph was written up by Dr Knapman 30.12.95, doses being given until 7.1.96.
Diamorphine 40-80mg written up by Dr Barton 2.1.95, with midazolam, 120-140mg 4.1.96.

Comment
Pain control clearly was a problem for this patient. However, there does not appear to have been a comprehensive assessment of the reasons for the pain, nor an attempt to use drugs other than opiates. Once the decision to start opiates was made, followed by transfer to a syringe driver, a decision that the patient is dying might be inferred. The patient did have dementia, but the records do not note a detailed consideration of the alternative management possibilities.

Leslie Pittock

Date of birth: Code A
Date of death: 24.1.96

Male

PMH
Chronic depression;
Assessed on Mulberry A by Dr Lord – Barthel 0, completely dependent, catheterised, eating little, hypoproteinaemic, for transfer to Dryad. Pressure areas poor.

Final illness
5.1.96 – assessed on admission by Dr Barton. Immobility & depression
9.1.96 – 'painful R hand held in flexion, try … (illegible). Also increasing anxiety and agitation ?insufficient …(illegible). ?needs opiates JAB'
10.1.96 – seen by another doctor, most of entry is difficult to read TLC

18.1.96 – 'further deterioration sc analgesia continues, difficulty controlling symptoms, try nozinan JAB'
20.1.96 – has been unsettled on haloperidol in syringe driver – discontinue change to higher dose of nozinan (verbal order)
21.1.96 – much more settled (another doctor)
24.1.96 – died 1.45

Drugs
Diamorphine 80-120mg 11.1.96, Dr Barton, with hyoscine & midazolam. Oramorph written up by Dr Barton 11.96, given until 15.1.96

Comment
Another very ill elderly patient. Opiates were initiated when a problem arose. It is not entirely clear what the problem was, but death followed.

Gladys Hill

Date of birth: Code A
Date of death: 9.3.1996

Female

PMH
L hemiparesis 1993
1996 – another small stroke
4.2.96 - # L neck of femur – repair; assessed by Dr Logan, consultant geriatrician; sacral and heel sores, flexion deformities due to rheumatoid, in pain so started on regular morphine, relatives informed that no prospect of rehabilitation and unlikely to leave hospital. Transfer from Haslar to GWMH.

Final illness
5.3.96 – assessed on admission by Dr Barton. Condition was clearly poor 'black heels'. 'All nursing care. I am happy for nursing staff to confirm death. I will see relatives as soon as possible JAB'
6.3.96 – 'less well, needs sc adequate analgesia I will speak to relatives JAB'
7.3.96 – 'now having 200mg diamorphine. Very comfortable' (JAB)
9.3.96 – 'morphine increased to 250mg very poorly JAB'
9.3.95 – died 21.45.
Nursing notes confirm patient's frail condition and pain, and continued pain despite oramorph.

Drugs
No drug chart

Comment
A very frail patient – opiates would have been appropriate.

Vera Bover

Date of birth: Code A
Date of death 25.3.1996

Female

PMH
CCF
Hypothyroid
Ischaemic heart disease – angina, hypertension
1995 - anterospetal myocardial infarct – VSD
admitted 29.2.96 – leg oedema, weeping fluid (notes say 'not for 555' i.e. not for resuscitation). In need of long term care – transferred to Dryad ward.

Final illness
13.3.96 – assessed by Dr Barton. 'Plan gentle mobilisation ..illegible JAB'
15.3.96 – 'illegible R leg looking inflamed' (JAB)
20.3.96 – Dr Tandy (I think, writing not clear). Oedema worse, daughter feels mother has had enough. Oramorph started.
25.3.96 – 'called to see, death confirmed 15.10. JAB'
The nursing notes confirm deteriorating condition and difficulty tolerating oral medication, 21.3.96

Drugs
Oramorph was written up 12.3.96, by a doctor other than Dr Barton, but none is recorded as given. Dr Barton also wrote up oramorph 13.3.96 PRN, none recorded as given, but also wrote up a regular dose, and two doses given 20/21.3.96. Diamorphine sc commenced 21.3.96 40mg/24hrs plus hyoscine & midazolam. Fentanyl 25ug patch used 21.3.96.

Comment
A patient with advanced and irremediable illness. A considered decision was taken that aggressive treatment would not have been appropriate. Management was appropriate.

Frederick Johnson

Date of birth: Code A
Date of death: 31.3.96

Male

PMH
Admitted from Sultan ward for long term care, 9.5.94; very deaf, poor sight; uco Dr Tandy. First admitted 1993, probably had had a myocardial infarct; poor mobility, urinary incontinence; seen by Dr Severs, long term care bed arranged 'may get him to nursing home standard but no more'

Final illness
Nursing notes
26.3.96 – very frail
29.3.96 nursing notes indicate oramorph commenced by Dr Barton
9.5.94 – 98 yr old transferred to Redclyffe Annexe today from Sultan Dr Lord assessed.
18.7.94 – 'step son killed in RTA last week. Illegible but coping JAB'
various minor problems, generally appears to be declining in health
15.3.96 – 'not so well today. Heavy head cold. Chest occ wheeze. Not for heroics resusc or antibiotics. I happy for nursing staff to confirm death JAB'
29.3.96 – 'further deterioration. Uncomfortable coughing to have a tiny dose of oramorph regularly JAB'
31.3.96 – died 20.00

Drugs
Diamorphine sc 10-??mg written up by Dr Barton, 23.3.96, given 30.3.96 with midazolam & hyoscine. Oramorph written up 23.3.96 and given for 5 days. Sc diamorphine was written up by Dr Barton 20.2.95 as an as required prescription although none was given at this stage.

Comment
A conservative approach would have been justified in a very old and frail patient. The management in this case was probably appropriate. A more intensive treatment of the chest infection might have been attempted, although given the general state of health, it is unlikely that this would have made any difference.

Kathleen Duffin

Date of birth: Code A
Date of death: 20.9.96

Female

PMH
Chorea
R CVA 12.8.1996

Final illness
Nursing notes:
2.9.96 – admitted from Haslar; dense Lt hemiplegia, catheterised, speech impaired, fed via naso-gastric tube, Barthel 0.
17.9.96 – quite distressed, pulling out naso-gastric tube. Dr Barton informed – to discuss with Mr Duffin. 'He agrees to her feed being discontinued and for her to be made comfortable. Has agreed to syringe driver, set up diamorphine 60mg'
20.9.96 – 5.40 died
Assessed by Dr Logan in Haslar – too frail and stroke too severe to respond favourably to formal rehabilitation – for a continuing care bed.
2.9.96 – assessed on admission by Dr Barton.
9.9.96 – seen by ? Dr Lord – R basal ganglion haemorrhage, chorea affects R arm & leg when awake; new stroke; prognosis v poor. Discussed with husband, was not

mobile prior to stroke. Informed she may not survive. Not for antibiotics if pyrexial; for oramorph / diamorphine if distressed. If deteriorates, NG tub not to be replaced if family agree.
17.9.96 – 'Mrs Duffin's general condition has deteriorated over the last week. She is restless, irritable and uncomfortable. With the agreement of her husband we will discontinue feeding and commence sc analgesia all nursing care. I am happy for nursing staff to confirm death. JAB'
20.9.96 – died 5.40.

Drugs
Diamorphine 40-200mg sc written up Dr Barton 2.9.96. Started 17..9.96. Also midazolam and hyoscine.

Comment
This patient was severely ill, had undergone specialist assessment, and the management plan was discussed with the family. Management was appropriate.

Alexander Gardener

Date of birth: **Code A**
Date of death 24.10.1996

Male

PMH
Severe mitral stenosis and mild mitral regurgitation (1994)
Pernicious anaemia
1989 – MI
1993 – MI
TIA – 1987
1994 – TURP

Final illness
Admitted from St Christophers (GWMH more accessible for wife); had a series of major problems during an acute admission initiated by a UTI;
15.10.96 – assessed by Dr Knapman on admission – multiple problems, continue previous treatment
16.10.96 – seen by Dr Barton. Transfer with 2 .. incontinent of urine and faeces, ..alter and orientated, main problem immobility, past Mis and aortic stenosis, Barthel 4. 'Plan get to know, check FBC .. etc, assess mobility, build bridges with wife JAB'
16.10.96 – seen by another Dr – for assessment of mobility. Lungs clear continue medication
24.10.96 – asked to see, suddenly deteriorated, vomited x1. writing not clear death confirmed 21.45. Signature difficult to interpret - Doctor uncertain
Nursing notes:
16.10.96 – seen by Dr Qureshi for further assessment; appears to be in pain with back. To be seen by Dr Barton re pain control in am. Wife visited
19.10.96 – commenced oramorph for pain control. Some vomiting is recorded.
24.10.96 – found to have vomited when checked for settling for the night, extremely dyspnoeic and distressed. BP unobtainable, pulse irregular, level of consciousness

rapidly deteriorated, unresponsive. Dr Peters visited, conscious level further decline, respirations very few, Certified dead 21.40. A blood test indicated high serum potassium and high urea, 16.10.96 (the results may indicate some dehydration, but they are probably not significant). Glucose was 7.2 on 21.10.96, and Hb was 11.9.

Drugs
Diamorphine 10mg 4 hrly PRN written up by Dr Barton (no date), but none given. Oramorph also written up by Dr Barton 18.10.96, given once on that date, and regularly until 24.10.96.

Comment
The records contain very little information about the reasons for starting opiate medication. Death was sudden, the cause being uncertain. However, the patient had advanced ishaemic heart disease and was very dependent.

Florence Deacon

Date of birth: Code A
Date of death: 14.11.96

Female

PMH
Dementia
Arthritis
Vertebrobasilar insufficiency
Deafness
11.10.96 – admitted QA, multi infarct dementia, poor mobility; bed sores, incontinent, wheezy

Final illness
16.10.96 – assessed by Dr Barton. transferred Dryad ward; Barthel 1. dementia, immobility. 'plan get to know, assess mobility, watch bowels JAB'
16.10.96 – seen by Dr Lord? For bronchodilator and treatment for skin sores
18.10.96 – Dr Barton reports discussion with daughter and grand daughter. Mother's health has deteriorated in past 3 years. The writing is not entirely legible, but the conclusion is 'make comfortable no heroics/resusc I am happy for nursing staff to confirm death JAB'
30.10.96 – breathing has improved, eating better, generally improved, wheezing continues – try salbutamol (?Dr Lord). The nursing notes indicate use of nebulised salbutamol to good effect on 10.11.96, although problems continued and oxygen was used.
12.11.96 – 'generalized exp wheeze not responding to above. Try pednisolone 20 mg daily. Start oramorph inform family JAB' ' Further (illegible) collapse at approx 10.45 now moribund. Sc analgesia commenced now comfortable, family aware JAB'
13.11.96 – comfortable, not distressed (another doctor)
3.40 'life signs extinct JAB'
The nursing records confirm deterioration on 12.11.96, but do not record administration of oramorph (frusemide was given).

Drugs
She had been receiving salbutamol orally before transfer. Oramorph was written up by Dr Barton on as required basis, and one dose was given (5mg), and regularly 11-12.11.96, 4 doses. Salbutamol via nebuliser written up by Dr Barton 8-12th November 3-4 per day. Diamorphine sc was written up PRN 20-100mg 12, 13, 14.11.96, with midazolam & hyoscine.

Comment
The patient had multiple problems, included advanced dementia. It had been agreed that aggressive treatment would not be indicated. The use of morphine in the presence of wheeze might be questioned, although this might have been a reasonable choice at some point. It is not clear whether the opiates were begun when death had become imminent and inevitable, or whether opiates had been used before this point, making death inevitable.

Basil Taylor

Date of birth: Code A
Date of death: 17.4.1997

Male

PMH
20.3.99 # neck of femur, DHS R in QAH.
Advanced dementia
Assessed by geriatric specialist 14.4.97 – has deteriorated, not suitable for nursing home. ?urinary retention and pleural effusion (not confirmed on chest X ray)
Needs encouragement to eat and drink, very thin, catherised; doubly incontinent

Final illness
16.5.97 – assessed by Weeks (?physio) has rehabilitation potential
19.5.97 – much the same – for Gym, continue sit/stand activities
3.6.97 – unwell not for Gym
4.6.97 – died
The nursing records indicate 'rather chesty' 4.6.97; Seen by Dr Barton, oramorph started. Condition deteriorated by 1700, quite anxious, vomiting, syringe driver commenced.
Medical notes:
17.4.97 – assessed by Dr Barton 'needs all care see how he goes JAB'
21.4.97 – seen by Dr Lord – prognosis poor.
19.5.97 – Barthel 2. stable in last month, refer for nursing home (Dr Lord)
4.6.97 – 'Basil has deteriorated over last few days. Barthel 1. in some pain, chesty I think Basil should be made comfortable. No aggressive treatment. Illegible / sc analgesia. I am happy for nursing staff to confirm death JAB'
4.6.97 – died 17.35

Drugs
Coproxamol was used for a short period, and the patient was taking diazepam, paracetamol, chlormethiazole. Diamorphine sc 4.6.97 20mg used, with hyoscine & midazolam. Oramorph 5mg used once, 4.6.97.

Comment
The patient was highly dependent and had dementia and immobility. Dr Barton decide that active treatment was not indicated when he became more unwell – 'I think Basil should be made comfortable'.

Helena Service

Date of birth: Code A
Date of death:

Female

PMH
NIDDM on diet
Atrial fibrillation
1981 – partial gastrectomy
1989 - polymyalgia
1984 – CVA
1993 – CVA, L sided weakness
1995 – CCF due to mitral regurgitation
1996 - gout
1997 – admitted QAH, Assessed by Geriatric Physician on ward – longstanding cardiac failure, admitted because of breathlessness, confused, and general deterioration. Deaf. Listed for GWMH.

Final illness
3.6.97 - Admitted from FI ward QA, nursing notes indicate failed to settle 0200, restless and agitated midazolam 20mg given via syringe driver over 24hrs. Needs assistance with all aspects of daily living.
4.6.97 – condition appears to have deteriorated over night – remains restless. Seen by Dr Barton, syringe driver charged with diamorphine 20mg. Midazolam 40mg.
Blood test on 4.6.97 indicated low potassium and high urea & creatinine.
5.6.97 – condition continued to deteriorate died 3.45.
medical notes:
3.6.97 – assessed by Dr Barton. 'confused' 'breathless plethoric lady' 'needs palliative care if necessary. I am happy for nursing staff to confirm death JAB'
nurse notes that condition continued to deteriorate, death occurring at 3.45 on 5.6.07

Drugs
Diamorphine sc 20-100 mg 4.6.97 written up by Dr Barton, 20mg given; also hyoscine and midazolam.

Comment
The reason for the deterioration of the elderly and frail lady after admission to GWMH is obscure, and little effort was devoted to investigation.

John Colebrooke

Date of birth: Code A
Date of death: 6.4.97

Male

PMH
Alpha 1 antitrypsin deficiency _ airways obstruction & emphysema
1981 - Ca prostate
1982 – epileptic fit
Frontal lobe tumour
Admitted to Haslar, assessed by geriatric physician – confused, cerebral mets, primary unknown, prostatism. Barthel 7-8/20. For transfer to Dryad.

Final illness
5.3.97 – assessed on Dryad by a doctor other than Dr Barton. Management was discussed with the patient's daughter.
19.3.97 – improved, no specialist medical or nursing needs, may consider placement. (not Dr Barton)
3.4.97 – starting to deteriorate – diazepam & oramorph (not Dr Barton)
5.4.97 – not tolerating oral morphine, on 60mg/day. Diamorphine 20mg midazolam 20mg syringe driver (Dr Davies??)
died 2,15, 6.4.97 (nursing notes indicate seen by Dr Barton 4.4.97 – no change in treatment).

Drugs
Oramorph written up by Dr Barton as required, one dose given, date not legible; then regular oramorph 5mg three daily and 10mg at night from 2.4.97. Diamorphine sc , fentanyl, hyoscine and medazolam written up by Dr Barton, although none administered. The diamorphine and midazolam that was given was written up by another doctor, presumanly Dr Davies, 5.4.97.

Comment
Dr Barton writes prescriptions in advance as is often the case. The care of the patient was, however, appropriate.

Kathleen Smith

Date of birth: Code A
Date of death: 7.3.97

Female

PMH
1977 - # R hip

1993 – haematemsis – oesophageal ulcer
1995 – Epilepsy secondary to CVA
Congestive cardiac failure
1996 – L hip replacement after #
1996 – bladder cancer – diathermy
24.1.97 – admitted QAH, chest infection; transferred 12.2.97 to Charles Ward for palliative care

Final illness
25.2.97 – transferred to Dryad ward. For TLC (signature not clear)
27.2.97 – 'family need to be seen on WE. Make comfortable. I am happy for nursing staff to confirm death JAB'
5.3.97 – comfortable, pain free. On diamorphine/midazolam (?Dr Hutchinson)
7.3.97 – died 01.35

Drugs
Diamorphine sc 40-200mg, hyoscine, midazolam all signed by Dr Barton. Treatment started 5.3.97. Oramorph signed by Dr Barton started 4.3.97

Comment
This elderly patient was severely ill. Management appears reasonable, although more details should have been recorded in the notes.

Margaret Mordue

Date of birth: Code A
Date of death:

Female

PMH
NIDDM
1995 – cellulites
1996 – L hemiparesis
AF
CCF
Confusion

Final Illness
25.1.96 – transferred to Daedalus; assessed by Dr Barton. 'main problem mobility' Barthel 0-1. short term memory gone.
29.1.96- seen by Dr Lord.
12.2.96 – seen by Dr Lord, if Barthel 4 or better, for nursing home, if not, for long stay.
25.3.96 – Barthel 3, for long stay (Dr Lord); followed by several entries, generally indicating less well
31.10.96 – 'deteriorating. not needing any analgesia. Make comfortable all nursing care. I am happy for nursing staff to confirm death JAB'
18.11.96 – continues to deteriorate, poor prognosis – Dr Lord

28.2.97 –' Margaret has deteriorated very gradually over the last few weeks. She remains … and is now distressed. She will need analgesia if becomes symptomatic and reluctant to swallow. The family are aware. No … I an happy for nursing staff to confirm death JAB'.
4.3.97 – Margaret has deteriorated further. Sc analgesia commenced yesterday. Family aware. All nursing care. JAB'
4.3.97 – died 2.30 pm.

Drugs
Diamorphine 40-200mg, midazolam & hyoscine written up by Dr Barton on the early drug charts routinely for as required use, but not used until 3.3.97, 20-40 mg of diamorphine in 24hrs.

Comment
Management was appropriate.

Patrick Page

Date of birth: Code A
Date of death: 21.2.97

Male

PMH
1996 - L shoulder hemiarthroplasty following #, recovering reasonably well January 1997.
NIDDM (diet)
Renal failure
L radial nerve palsy
Stroke 1996
1983 – diabetic retinopathy

Final illness
Prolonged stay in acute hospital following shoulder surgery, numerous problems, prognosis regarded as poor.

18.2.97 – urea 47.4, creatinine 548, Na 164
Nursing notes:
Transferred from Mary Ward, QAH, fractured shoulder, CVA, very frail
20.2.97 – restless and in pain, seen by Dr Barton – diamorphine 40mg by syringe driver
medical notes
17.2.97 – assessed by Dr Barton on transfer to Dryad. 'get to know, assess renal function, mobilise gently, all nursing care, see family, I am happy for nursing staff to confirm death JAB' Blood results as above.
19.2.97 – assessed by another doctor (?signature). Discussion with brother.

Drugs
Oramorph PRN written by Dr Barton, not given. Regular treatment prescribed 20.2.97 2 doses given. Diamorphine sc 40-200mg with midazolam & hyoscine written up by Dr Barton, used for 1 day only.

Comment
The patient had received intensive inpatient treatment over a long period of time, and was severely ill. The management in GWMH was appropriate, although the records were not completed.

Ivy Mitchell

Date of birth: Code A
Date of death: 12.2.97

Female

PMH
1988 – ca cervix, radiation therapy
1993 - depression
cystectomy
Carotid artery stenosis,
TIAs
1996 – MI
IDDM
LVF
Admitted Haslar dense R hemiparesis and MI; seen by Dr Hutchinson, geriratician – for slow stream stroke when stable. Although prospects for rehabilitation limited.

Final illness
13.1.97 – transferred to Daedalus ward. Assessed by Dr Lord, ct NG feeding; speech and physio therapy, prognosis poor.
20.1.97 – pulled out tube, actrapid started. See family ?PEG.
22.1.97 – cough, erythromycin
22.1.97 – Dr Lord discussed case with daughter; feels her mother has had enough trauma and surgery. Try antiobiotics 1 week, if distressed, oramorph/diamorphine
3.2.97 – brighter
12.2.97 – unwell this evening sweaty and pale, suddenly slumped in bed and died.
None of these record entries were by Dr Barton.

Drugs
Oramorph written up by Dr Barton PRN as usual, none given, otherwise no opiates.

Comment
Management was appropriate.

Queenie Nicholson

Date of birth: Code A
Date of death: 9.2.97

Female

PMH
Seen by Dr Hutchinson, consultant geriatrician, in Haslar – dense L hemiparesis, urinary incontinence, dysarthria, LVF/AF, left arm embolus, deranged LFTs, sodium 123. Put on list for slow stream stroke rehab at Gosport

Final illness
27.1.97 – assessed on admission, not by Dr Barton, handwriting not recognised. Continue warfarin
31.7.97 – 'sat out yesterday requires help to feed and dress, … doubly incontinent, Barthel 0, daughter to ..??? JAB'
3.2.97 – seen by Dr Lord, stop heminevrin. Long discussion with daughter; agree that warfarin is discontinued and aspirin used. Not for antibiotics if pyrexial, if distressed for diamorphine. Not for transfer to QAH or Haslar if acute problems occur as overall prognosis is poor.
5.2.97 – '..does not seem to be in pain …. Use opiates if necessary JAB'.
6.2.97 – 'vaginal bleeding now painful .. is now on opiates .. is deteriorating make comfortable, all nursing care. I am happy for nursing staff to confirm death. JAB'
no further entries.
Nursing notes indicate PV bleeding continuing to 9.2.97

Drugs
Oramorph written up by Dr Barton started ?3-4/2/97, 2-3 doses; diamorphine sc 40-200 mg started 9.2.97, with hyoscine and midazolam, for one dose.

Comment
The indications for active treatment were reviewed by a specialist; the patient started opiates soon after.

John Pimm

Date of death: Code A
Date of death: 27.10.97

Male

PMH
Pacemaker
1994 - Vascular dementia
deaf
1997 – admitted QA, generally unwell, difficulty feeding, transferred to Dryad

Final illness
Nursing notes:
22.9.97 – admitted from QAH
29.9.97 – relatives seen by DR Lord – distressed by the information on poor prognosis, told staff would try as long as they could.
30.9.97 – commenced fentanyl

27.10.97 - died
medical notes:
22.9.97 – assessed by Dr Barton. – CVA, senile dementia, pacemaker, doubly incontinent, Barthel 1, attempt slow stream rehabilitation.
23.9.97 – refusing all medication and fluids. '1 l sc fluids in 24 hrs JAB'
29.9.97 – Dr Lord. Confused, denies pain, Barthel 2. Wife doesn't accept dementia; agreed to stop sc fluids, not for NG feeds, keep comfortable if he deteriorates.
13.10.97 – little change, poor prognosis (Dr Lord)
27.10.97 – 'increasingly poorly over weekend. Wife still insists that improving. No insight into condition. Fantanyl seems to control pain. JAB' died 12.30.

Drugs
Oramorph written up by Dr Barton, not used. Diamorphine sc injection – not used; diamorphine sc 20-200mg written up one dose given, also midazolam & hyoscine (Dr Barton). Fentanyl started 30.9.97, Dr Barton.

Comment
Again, medical notes incomplete. In view of the advanced dementia, active treatment would have been inappropriate, although whether opiates were required is difficult to judge.

Pamela Brown

Date of birth: Code A
Date of death: 8.10.97

Female

PMH
MS from 1950s.
Long resident in continuing care
1993 – admission to GWMH for holiday care, then several admissions during year for respite, deteriorated at admission Feb 1994 – not discharged – accepting of long stay by May 1994.
24.7.96 – immobile, not doing much. No problems at the moment (signature not clear).
13.11.96 – trouble feeding, pain generalised, controlled on fentanyl (??Dr)
11.12.96 – on oramorph, so far so good (??Dr)
19.2.97 – no more problems (??Dr)
16.3.97 – abdominal pain ?constipate
18.3.97 severe pain – oramorph to 20mg; constipation managed with picolax
24.3.97 – Dr Lord 'I don't think she is a candidate for acute transfer in the event of intestinal obstruction – not a candidate for surgery'. Continued to be managed conservatively.
9.7.97 – 'see note from AL 24.3.97 .... Not for transfer to acute unit .... I am happy for nursing staff to confirm death. JAB'
18.7.97 – 'Pamela is having difficulty tolerating oramorph and sc analgesia seems excessive. In view of ..of fentanyl, I have .. by MST .... JAB'
23.7.97 – Dr Ashram – subacute obstruction. Not fit for surgery, increase MST.

1.9.97 – Dr Lord Barthel 3, bowels still a major problem; keep comfortable, prognosis poor.
6.10.97 – 'needs sc analgesia. Haolperidol seems to cause skin irritation. Try hyoscine/midazolam/diamorphine. … no active intervention … JAB'
8.10.97 – 15.30 died

Drugs
Oramorph written up by Dr Barton from June 97, 5mg x3 in the day, 10mg at night, with dose increasing. Diamorphine sc also written up by Dr Barton, and Fentanyl

Comment
The patient received palliative care. A specialised neurology unit might have been a more appropriate placement. However, the patient had very advanced MS and more active treatment would not have been appropriate.

Bernard Webb

Date of birth: Code A
Date of death: 14.12.97

Male

PMH
1995 - Acute on chronic renal failure
NIDDM
Old CVA 1992
Glaucoma L
1994 –acute DU
1978 – gout
1970 – hypertension
war wounds
November 1997 – to attend day hospital to improve mobility and be assessed

Final illness
9.12.97 – (nursing notes) Admitted – catheterised, pain in legs ?neuropathy, reduced mobility, renal problems, pressure areas, NIDDM, given oramorph for pain.
Medical notes:
9.12.97 – admitted to Daedalus; assessed on admission by Dr Knapman, ct treatment.
10.12.97 – s/b Dr Barton. Difficult to decipher. See family ?wife at home. Oramorph during night for pain. Make comfortable. I am happy for nursing staff to confirm death. JAB'
14.12.97 - ?LVF Rx frusemide & cefaclor (Dr Knapman).
14.12.97 - 13.15 died.
27.11.97 – urea and creatinine high (as in previous tests)

Drugs
Oramorph by Dr Barton, used 4 hourly; also diamorphine sc 20-200mg 10.12.97, 2 does used, with hyoscine and midazolam

Comment
A seriously ill patient with multiple difficult and deteriorating problems. The decision to begin sc diamorphine is not discussed in the medical notes. Management may have been appropriate, but alternative options are not recorded as considered.