Notes review 3

Florence Birkenhead

Date of birth: Code A
Date of death: 26.9.1988

Female

PMH
Abdominal surgery, nature unclear

Final illness
Nursing notes
Admitted Redclyffe, 19.2.88; confused & disorientated; can walk with one nurse
Nursing record over ensuing months documents confusion and agitation, levels varying
Nurses note 11.9.88 – drowsy all day, haloperidol omitted. 12.9.88 – s/b Dr Barton co-trimoxazole for 5 days. 13.9.88 deteriorating, being nursed in bed. Sore on sacrum, taking little fluid.; 19.9.88 general condition continues to deteriorate; 25.9.88 – continues to deteriorate; 26.9.88 died 16.30
Letter feb 1988 confirms assessment by physician, dementia , drug induced Parkinsonism (on thrioridazine)
Medical notes – 6.2.88 – thioridazine stopped – orphenadrine; 9.2.88 ?MI, worsening dementia, drug induced Parkinsons – transferred to Gosport
The records in Redclyffe have few entries, document confusion, a fall 4.3.88, they do not document the deterioration before death, the only relevant entry being confirmation of death on 26.9.88. Appears to have been returned to thioridazine during May 88, and switched to haloperidol later.

Drugs
Haloperidol signed by Dr Barton, starting in June

Comment
No opiates were used. The patient clearly had advanced dementia with confusion and agitation. The records relating to the final illness are very limited, and it is difficult to come to a conclusion about the management at that time, although there were no matters of concern recorded.

Francis Ayers

Date of birth: Code A
Date of death:

Male

PMH
COPD
CCF
angina
Osteroarthiritis – fixed flexion of hips
Transfused 3 units blood, 29.7.88
Confusion – on haloperidol
1987 – heamaturia
1985 – back pain to legs

Final illness
Acute admission 13.6.88 – shortness of breath, swollen legs, immobility, marked CCF & COAD. Anaemia (iron deficient)
Became confused.
27.6.88 – admission assessment by Dr Barton – admitted for long stay care – plan: all nursing care, aperients, (illegible); developed haematuria, transferred to B4 (acute hospital); constipation treated and returned to Gosport. 29.8.88 – pain at night, temgesic 1 nocte (signature not clear);
30.8.88 – Dr Knapman – still leg pain, temgesic 4 hrly; subsequently also given largactil, and co-dydramol.
16.11.88 – 'further deterioration, periods of Cheyne Stokes when asleep. Quite alert when awake Chest … large rales. JAB' Nurses notes indicate MST 20mg ordered by Dr Barton; MST given from 6.11.88 or earlier.
19.11.88 – continues to deteriorate, very chesty; given diamorphine 10mg IM 4-5 hrly. Signature not clear. Dr Beasley according to nurses notes
20.11.88 – died 3.30, confirmed by nurse
The nursing records indicate that he was virtually confined to bed from July, and had pain (initially given co-proxamol), and had antibiotics for urine infections. The notes indicate that he was very dependent, and becoming increasingly dependent. MST was started 26.9.88 following assessment by Dr Barton and another doctor (unclear who). Pain continued to be a variable problem.

Drugs
Dr Barton prescribed buprenorphine 2.9.88, although does not appear to have been was given at this point, but was given 21.10.88 [nursing notes indicate started 26.8.88]; MST 10mg was prescribed 26.9.88, although it is not clear whether it was administered at this point. It was given from 4.10.88. Diamorphine 10mg IM prescribed by Dr Beasley, 19.11.88, 3 doses given before death.

Comment
A very dependent patient, who gradually became worse despite treatment. Management appears appropriate.

Edith Smith

Date of birth: **Code A**
Date of death: 1.9.89

Female

PMH
1985 # hip L
Deteriorating senile dementia
Feb 1988 – stroke, unable to walk
Immobility – seen by geriatrician for shared care (inpatient/home care alternating)

Final illness
15.7.88 – admission assessment by Dr Barton – Plan: melolin to sore areas, assess bowel function & catheter, all nursing care.
Readmission in ?October
Another admission 30.12.88 – assessed by Dr Barton on admission; not oriented
Several further shared care admissions
6.10.89 – admitted for shared care 'continue all nursing care JAB'
27.10.89 – 2 seizures this pm, R side of face floppy, CVA diagnosed by dr Beasley. 'No resuscitation'
3.11.89 'deceased peacefully 12.25pm for burial JABarton'
The nursing notes indicated 29.10.89 – Cheyne Stokes respiration, appears to be deteriorating; 2.11.89 appears in pain when moved atropine and diamorphine 10mg IM given 4-6 hrly; syringe driver started with 40mg diamorphine.

Comment
A frail, elderly and demented lady who had a stroke during a shared care admission. Management appears appropriate; the prescription charts are not available, but diamorphine was given before death to relieve pain.

Emma Bird

Date of birth: Code A
Date of death: 27.10.89

Female

PMH
1981 – excision of ganglion

Final illness
Nursing notes indicate admitted 31.7.86, from Anne ward, QAH, doubly incontinent, oedematous feet; 26.10.89 - in pain when moved, diamorphine 40mg in syringe driver, died 27.10.89.
11.7.86 – admitted QAH, dementia, mild CCF, immobility; physiotherapy not effective, transferred to GWMH.
The medical notes have entries in GWMH from 4.8.86; entries are infrequent, and document oedema and weight. The writing is difficult to read, by a doctor other than Dr Barton until September 1988.
4.10.89 – 'recent deterioration all round. Frail not eating chokes easily may need pain relief' (JAB)
26.10.89 – 'syringe driver commenced JAB'
27.10.89 'deceased 2.50 am JAB'

Drugs
The drug chart was not available on the microfiche copy of the records.

Comment
The medical records are very brief, and it is not possible to be clear about the nature of the final illness. The patient was clearly highly dependent.

Winifred Pacey

Date of birth: Code A
Date of birth: 22.10.89

Female

PMH
1979 – mild monoplegia
BCC L cheek, 1983
1987 - # L radius
1989 – subarachnoid haemorrhage – severe impairment, no response to pain or communication

Final illness
transferred from QAH following subrachnoid, 20.9.89. Heavily dependent on nursing care, in bed. Nursing notes indicate that the condition deteriorated 22.10.89, death at 2.30
20.9.89 – admitted GWMH, assessed by Dr Barton; now responds to voice, but unable to communicate. Plan continue feeding, watch pressure areas. JAB
21.9.89 – discussion with family; aware of poor prognosis but wish all .. measures to continue.
22.10.89 – pronounced dead 2.30hrs by nurse.

Drugs
Drug chart not available

Comment
A patient who had a severe stroke, with major residual disability. The records indicate that she deteriorated – but the nature of this is unclear. She does not appear to have received opiates.

Ivy Attwood

Date of birth Code A
Date of death; 7.6.89

Female

PMH
April 89 – stroke, L hemiplegia; was dementing prior to stroke; recovery slow, intensive physio requested by GP

Final illness
Slow response to physio – for slow stream stroke 11.5.89
15.5.89 – admission for long term care; assessed by JAB – 'Plan all nursing care'
16.5.89 – 'further deterioration overnight, episode reduced tone L arm unresponsive needs catheter, continue nursing care JAB'
23.5.89 – illegible entry, a doctor other than Dr Barton
6.6.89 – 'deteriorated over last couple of days chest ratly start diamorphine/atropine JAB'
7.6.89 – 'died 9.25 am for cremation JAB'
The nursing notes indicate – 3.6.89 in considerable pain when moved IM diamorphine 10mg given stat 4.10 pm much more settled.

Drugs
No drug chart

Comment
The notes are limited, and do not provide a full account of the final illness. However, the patient appears to have had a severe stroke and was not improving. The deterioration appears to have been associated with chest symptoms.

Kathleen Smith

Date of birth Code A
Date of death 30. 9. 1990

Female

PMH
Epilepsy
Spastic quadriplegia, in need of full nursing care
In long term care

Final illness
Transferred to Redclyffe, 19.6.86
The nursing notes record use of a syringe driver 26.9.90; unable to take fluids, restless; 29.9.90 s/b Dr barton – on diamorphine 100 mgm, hyoscine; 30.9.90 continued to deteriorate, died …
10.10.89 – pains in knee .., then no entries in medical record until:
26.9.90 – 'deterioration in general state over last few days; athetoid movements; vomiting & not taking fluids distressed. Plan start syringe driver, diamorphine, … hyoscine if required JAB'
30.9.90 – condition continued to deteriorate, death confirmed by nursing staff.

Drugs
No drug chart

Comment
A highly disabled younger patient. The notes are very limited, and the nature of the final illness is obscure. The justification for the decision to initiate diamorphine is not detailed, although some deterioration and distress is recorded.

William Evans

Date of birth Code A
Date of death 1.5.90

Male

PMH
1923 - appendicectomy
1941 - # L hip
Congestive cardiac failure
Parkinsons
GP Dr Barton
1987 – admitted with poor mobility, back pain, CCF to acute hospital; 16.12.87 episode of loss of consciousness. Attempts to improve mobility not successful, referred to geriatrician.

Final illness
1.3.88 – transferred to GWMH, referral to audiology & urology (catheterised); stricture treated
29.8.88 – admitted long term care, immobile, needs 2 to transfer, rather deaf, oriented to time & place.
6.7.89 'catheter changed size 12 Foley inserted 5ml balloon JAB'
16.8.89 – URTI No fever No signs RS No Rx (another doctor, signature not clear)
21.8.89 – now very chesty Rales ++. Diamorphine IM (I think this is what the writing indicates, & probably Dr Beasley)
11.9.98 – catheter changed
16.1.90 – 'catheter pulled out recatheterised 16/30ml balloon JAB'
18.1.90 –'Mr Evans has deteriorated gradually since Jan and chest infection has not returned previous state of mobility or mentally All nursing care JAB'
30.1.90 – 'further deterioration in condition. Has required one injection of diamorphine 20 Jan (??) relatives informed JAB'
15.3.90 2.45 called to see – cyanosed, very SOB distressed – IV diamorphinem frusemide, aminophylline (?Dr Beasley)
26.4.90 – deteriorated, pyrexial cough rales ++ diamorphine & largactil (signature unclear)
29.4.90 very .... (poorly legible) diamorphine im stat and up to 20 mg prn (signature unclear)
1.5.90 died 6.25 confirmed by nursing staff, and by Dr Barton
Nursing records indicate:
15.3.90 – found cyanosed and distressed
22.3.90 – started on MST 30mg for relief of generalised pain by Dr Barton
chesty 26.4.90, co-trimoxazole & simple linctus given; 28.9.90 chest very moist, agitated at times, chlorpromazine, 29.4.90 still very chesty, diamorphine and atropine

given (Dr Beasley); seen by Dr Barton 30,9.90 – to commence diamorphine by syringe driver.

Drugs
No drug chart

Comment
The nursing records do indicate a steady decline in health and an increase in distress in the months before death; the medical notes do not detail an assessment of this decline, and the decision to start regular opiates is not reported.

Alfred Howes

Date of birth Code A
Date of death 14.1.90

Male

PMH
1988 – acute confusional state, Parkinsons, urinary incontinence, dementia, immobility (hospital admission) – improved
chronic myelocytic leaukaemia
akinetic rigid syndrome

Final illness
Nursing records:
8.1.90 – transferred from QAH
13.1.90 – patient deteriorated. Seen by Dr Beasley – chest infection, no treatment indicated, may have diamorphine if necessary
14.1.90 – discomfort on turning, given IM diamorphine 5mg, 5.00am, died 6.50 am.
Letters indicate was in a rest home, but went down hill after an attack of 'flu'. Sacrum breaking down, incontinence worse, immobile, loss of weight, probable left basal pneumonia – admitted QAH, prognosis 'very grim' (Dr Severs)
9.1.90 – admission assessment by Dr Barton – grossly confused, not responding to simple questions
13.1.90 – sudden deterioration over the morning T 38.2 (axilla) not responding … RS rales ++ Poor quality of life, dementia, therefore no treatment. Relatives to be informed. (not signed, but presumably Dr Beasley).

Drug chart
None available

Comment
An elderly patient with dementia, who had recently deteriorated following an respiratory infection. A decision was taken to not treat a new respiratory infection. Diamorphine was given once. The management may have been appropriate, although a discussion with relatives is not recorded prior to the decision against active treatment.

Hilda Nelson
Date of birth Code A
Date of death 8.8.93

Female

PMH
Angina
NIDDM – diet controlled
1992/3 – syncope & AF; frail, oedema to mid calf
1993 – admitted, ischaemic R big toe; given MST then oramorph; no indication for surgery; 23.7.93 – discussion with daughter – impending gangrene both lower limbs, agree to transfer to Radclyffe, not for 555 (Dr Lord)

Final illness
2.8.93 – assessed by Dr Barton ct MST 30mg bd, keep comfortable
5.8.93 – 'further deterioration in general condition. Further deterioration in general condition. In pain, confused and frightened. Sc analgesia commenced. Family in agreement but will be seen today JAB'
8.8.93 – condition continued to deteriorate died 01.30 confirmed by nursing staff.
The nursing records confirm the commencement of syringe driver 4.8.93

Drugs
Chart confirms MST 30mg, Dr Barton, 27.7.93. Also, diamorphine 40mg in 24 hrs sc written up 27.7.93, (80mg 7.8.93) although not commenced until 4.8.93; also hyoscine and midazolam

Comment
Following specialist assessment, surgery was ruled out; the surgeon had hoped the toe would self-amputate. The nature of the deterioration in the general condition (5.8.93) is not clear; consequently, it is impossible to judge whether the introduction of diamorphine was appropriate; a remedial condition may have been responsible for the deterioration.

Harold Colclough

Date of birth Code A
Date of death 20.12 91

Male

PMH
Angina
COAD

Final illness
Admitted GWMH for investigation of cachexia, 4.4.91; generally slow progress
18.4.91 – chef with excess alcohol consumption, severe COAD with pulmonary hypertension # ribs & sternum, partial flail chest, … on feet, weak, ?cereballar … Try short course of steroids and ventolin via nebuliser. May require long term care (signed

by doctor other than Dr Barton, not clear who). He received a reducing dose of steroids over the following months
12.11.91 – s/b Dr Barton unwell breathless .. for amoxil and reducing dose of prednisolone JAB
10.12.91 ..suggest possible L pelvis met, pain in L groin on standing v sob. I accept that a neoplastic lesion is fairly likely. He refuses … Bloods and chest X`ray ordered. MST has been started (not Dr Barton) [ESR was 54, but raised before; X ray of pelvis 'a metastasis or myelome could produce this appearance but I suppose it could all be tied up in a vicious circle of local porosis, trauma and then further disuse porosis.' ? for scan. Report dated 5.12.91; chest X ray 9.4.91- osteoporosis
16.12.91 'unwell chesty again cotrimoxazole and all nursing care. May need increased analgesics if uncomfortable JAB'
19.12.91 'marked deterioration overnight hypoxic .. confused. Start diamorphine medication wife informed all nursing care JAB
20.12.91 – death confirmed by nursing staff

Drugs
No chart

Comment
Clearly an ill patient, with multiple problems. The notes are thin, and therefore the inpatient care is difficult to follow. The possibility of malignancy does not seem to be strongly supported.

Gertrude Robertson

Date of birth Code A
Date of death 28.4.91

Female

PMH
1975 – pulmonary embolus
1980 – R THR; post op DVT
1988 – infection L foot – sinus opened
hypertension years

Final illness
27.3.91 – assessed at GWMH by Dr Logan following amputations of toes both feet for peripheral vascular disease; warfarin should be stopped because of her general frail state; depression, heart failure, rapid atrial fibrillation, hypothyroidism but myocardium cannot cope with thyroxine. For a long stay bed.
28.3.91 – admitted Redclyffe. 1.4.91 – s/b Dr Barton swelling R wrist. On MST 10mg for pain.
8.4.91 – 'does not seem so well today. Sore throat mouth ulcers seems in pain. Increase MST all nursing care. No antibiotics. JAB'
17.4.91 'very poorly today. Increase diamorphine if necessary. All nursing care JAB'
20.4.91 illegible. Sc diamorphine hyoscine and something else started ?Dr Beasley
21.4.91 – death confirmed ?Dr Beasley.

Drugs
No drug chart

Comment
Again, a patient with advanced and multiple conditions. The final illness is not documented adequately, and it is not possible to judge the appropriateness of management decisions.

Edith Willshire

Date of birth Code A
Date of death 26.6.91

Female

PMH
1942 – pulmonary TB
1983 – hyperosmolar coma
1985 – hypoglycaemic treatment stopped
1989 – falls, reduced mobility
7.6.91 Acute admission pressure sores, immobility, UTI; discharged to Redclyffe. She had been increasingly frail over the preceding 3 weeks, bed-bound on admission

Final illness
14.6.91 – assessed by Dr Barton on transfer to long term care. 'main problem immobility, poor intake and output, heel sores. Previous URTI. All nursing care JAB'

26.6.91 – comfortable night. Died peacefully at 7.30am (nursing staff). Death confirmed 7.45 JAB.

Drugs
The 1991 drug chart was not in the microfiche records.

Comment
It is impossible to determine what occurred in this case.

Frederick Carter

Date of birth Code A
Date of death 2.1.91

Male

PMH
1980 – R hernia repair
1989 – gross congestive cardiac failure, leg ulcers, IHD

Final illness
11.12.90 – admitted long standing CCF, worse – leg ulcers leaking fluid

18.12.90 – s/b specialist, diuretics advised 'If matters do not improve or this proves impossible please let me know' No signature
21.12.90 – Would the geriatric team please be able to Mr Carter over as I cannot see him ever returning to Northcott House.
29.12.90 – short illegible entry by JAB
2.1.91 – died 11.35
The nursing notes indicate that Mr Carter was s/b Dr Barton & catheterised 28.12.90. Also, 2.1.91 – very distressed & agitated this morning, complaining of generalised pain IM diamorphine 10mg given

Drugs
No 1991 drug chart

Comment
Again, exactly what happened is not documented. He was certainly very ill.

Rita Floyd

Date of birth Code A
Date of death 1.2.91

Female

PMH
Admitted to St Mary's 4.10.90 via psychigeriatrics, back pain, unsteadiness, incontinent, confusion

Final illness
Nursing notes
1.11.90 Admitted from B3 St Mary's. Alzheimer's disease
18.1.91 – seen by Dr Barton, unable to take fluids ?further CVA ?TIA In pain when being turned – oramorph 6 hrly. 1.30 s/b Dr barton to commence syringe driver. Diamorphine 40mgs
29.1.91 – s/b Dr Barton & Dr Logan. Care to continue
30.1.91 – condition continues to deteriorate. S/b Dr Barton, diamorphine increased to 80mg. 1.2.91 died 12.40
medical notes
transferred to long stay 1.11.90. assessed by Dr Barton – no problems
22.11.90 – Rita appears to be deteriorating over the last few days. There are no obvious physical signs except a runny nose ?URTI all nursing care. JAB Now thrombophlebitic R leg elevate, support'
28.1.91 – now increased spasm R side and neck. Much weaker ?? further CVA. Start syringe driver. To see family on w/k. all nursing care JAB'
31.1.91 – now very unwell … ++ increase diamorphine and hyoscine JAB
2.1.91 – death confirmed 12.40

Drugs
No chart. Diamorphine was given according to the records

Comment
Care could well have been appropriate, the records do not contain sufficient detail to be clear (gaps between entries, brief entries, no firm diagnoses).

William Chase

Date of birth Code A
Date of death 7.10.92

Male

PMH
1989 Ruptured aortic aneurysm
COAD / asthma
Left hemiparesis
RLL pneumonia
Probable ethanol abuse
April 1992 – s/b physician, deteriorating all round, inpatient rehabilitation; Seen by Dr Lord – patient refused residential care

Final illness
Nursing notes
18.6.92 – transferred to Redclyffe, respite care; readmitted 12.7.92
2.10.92. deteriorated, feels unwell; seen by Dr Lard, oramorph
5.10.92 – a little brighter this afternoon. Continues oramorph
7.10.92 - general condition deteriorated, MST 30 given with difficulty. S/b Dr Barton – syringe driver to be commenced diamorphine 80mgs, hyoscine 400mcgs. Died 9 hrs.
June 1992 – subacute intestinal obstruction, surgery would be high risk (Dr Lord)
2.10.92 – Dr Knapman – c/o L groin pain o/e tender lymph nodes septrin given; diarrheoa bad again, bowel sounds normal
2.10.92, 17.00 Dr Lord. Unwell, flushed, feels hot, more jaundiced. Uncomfortable. 'I feel a bowel cancer is likely with his past history and worsening jaundice but do not feel he is for further investigation. Oramorph to keep comfortable, continue septrin, let family know he is poorly and may not survive.
7.10.92 – 'marked deterioration in last 24 hrs. V restless, cyanosed, Cheyne Stokes. Syringe driver commenced at 12.20. Needs midazolam & hyoscine. Family present and fully informed JAB'

Drugs
No drug chart. Was given opiates

Comment
This patient had several major illnesses, and became ill, frail and jaundiced. Management appears appropriate.

Gordon Lee

Date of birth Code A
Date of death 25.12.92

Male

PMH
1989 – acute retention; not a suitable candidate for surgery
CVA 26.11.92
Admitted Haslar, poor fluid intake and immobility; transferred to GWMH

Final illness
17.12.92 – assessed by Dr Barton. 'all nursing care. May need antidepressant and analgesia as necessary JAB'
21.12.92 'all broken areas seen .. .. all dressed and noted. Now on oramorph 8 hourly at present. Fluid intake much better. Catheter draining better. JAB'
23.12.92 – 'remains poorly. Poor fluid intake. Still in pain when handled. Increase oramorph to 4hrly
24.12.92 pm all nursing care. Will need sc analgesia now. V. bubbly and poorly. JAB'
25.12.92 – '0500 vital signs disappeared. For cremation. JAB'
Nursing records brief – the patient was cold on arrival, wearing only a nightgown, wrapped in a blanket.

Drugs
No drug chart

Comment
Very few details in the records. The patient had suffered a significant stroke, although its extent was not documented on admission to GWMH. Received opiates when deteriorated.

Dorothy Flynn

Date of birth Code A
Date of death 21.2.93

Female

PMH
1971 - PMB
1992 – investigation of weight loss and SOB – pulmonary fibrosis

Final illness
18.2.93 – seen in Dr Lord's outpatients, and admitted directly – frail, losing weight, poor mobility, mild cyanosis, breathless, exhausted
18.2.93 – chest X ray moderate R pneumothorax, pulmonary fibrosis
had improved a little when seen on the ward by dr Lord
19.2.93 – 'condition isq – JAB'
21.2.93 – nauseous today ? cause. Might be dihydrocodeine leave off pro tem ..Dr Lord. Then I think it is Dr Knapman's writing, details not clear – looks as though oxycodone and IM diamorphine 10mg were given. Died at 5.30. Nursing notes confirm Dr Knapman

Drugs
No drug chart

Comment
Clearly a very ill patient; it is not clear what happened to lead to death.

Isabella Harman

Date of birth Code A
Date of death 2.3.93

Female

PMH
1992 - ?perforated peptic ulcer, too infirm for surgery. Discharged home in weak condition

Final illness
26.2.93 - Admitted to Redclyffe following domiciliary visit – intra-abdominal event, extensive OA, infected pressure sores, hypoproteinaemic oedema, incontinent. Dr Lord informed son that 'she is gravely ill and unlikely to recover'.
27.2.93 - s/b Dr Barton. Massive sacral sore 'pain relief important. To see son on Monday JAB'
1.3.93 – Dr Lord discussed with son best place for her care – home or in hospital.
2.3.93 – died. 'Seen after death by me JAB'
Nursing notes confirm severity of illness and use of oramorph.

Drugs
No drug chart

Comment
The patient was probably terminally ill on admission, and management was appropriate.

George Hardie

Date of birth Code A
Date of death 15.3.93

Male

PMH
1991 – TURP for adenecarcinoma
1993 – L hemiplegia; CT scan ?bleeding into a tumour R basal ganglia
wheelchair bound prior to admission to Redclyffe

Final illness
Transferred to Redclyffe 28.1.93
S/b Dr Barton, 10.3.93. CVA, old ng prostate with ?? into tumour.

11.3.93 s/b Dr Lord. Chest infection; discussed with daughter. Trial of antibiotics for 24 hrs, if no improvement, stop. Keep comfortable with diamorphine. 'She will contact daughter in Scotland and is aware he is dying'
12.3.93 – 'sc analgesia is available if felt appropriate. For regular oramorph pro tem. JAB'
25.3.93 – 'now on syringe driver very poorly. Daughter and granddaughter with him JAB'
15.3.93 – 'time of death 10.05 JAB'
The nursing notes confirm syringe driver with diamorphine 40mg started 12.3.93, plus midazolam & hyoscine.

Drugs
No chart, but received opiates

Comment
Appears to have had a cerebral tumour at the root of the CVA; management appears reasonable.

Barbara Dunce

Date of birth Code A
Date of death 24.3.93

Female

PMH
Hypertension
diabetes
1986 – L hemiparesis
7.2.93 – R hemiparesis (confirmed by CT)

Final illness
10.3.93 - Admitted to Redclyffe for rehabilitation after stroke. S/b Dr Barton at admission – 'all nursing care and relatives informed JAB'
15.3.93 – s/b Dr Lord. Not communicating, taking pureed diet, v frail, catheterised, sacral ulcer with black patch, heel ulcer L. ct actrapid sc; oramorph before dressings, NSAID elixir.
24.3.93 – 'marked deterioration since yesterday. Sc analgesia commenced pm. Husband seen but remains unrealistic about prognosis. All nursing care. JAB Death confirmed 09.20. JAB'

Drugs
Diamorphine 40mg sc written up 10.3.93, started 23.3.93, with hyoscine & midazolam (by Dr Barton). Oramorph written up 15.3.93, 5mg 4 hrly, by Dr Barton, 4 doses daily given15.3.93 onwards (was this before dressings?).

Comment
Presumably the opiates were to give relief of pain caused by the pressure sores. This would have been reasonable. The nature of the deterioration on 24.3.93 is not described.

Harry Dumbleton

Date of birth Code A
Date of death 12. 6. 93

Male

PMH
Appendicectomy
Repair, bilateral inguinal hernia, 1979
Dilation of urethral stricture, 1987
Atherosclerotic Parkinsons with dementia
Glaucoma
?epilepsy. Deteriorating condition during admission to QAH following falls – barthel 0, doubly incontinent, variable abilities. Remaining in bed for own safety. Discharged to long stay bed.

Final illness
25.5.93 – admitted to Gosport, assessed by Dr Barton. Not feeding himself, awaiting bed in Portsmouth
28.3.93 – had several minor and one major fit yesterday ?missed a dose of phenytoin on Wednesday. Check phenytoin level. JAB
28.5.93 insertion fine 11 catheter
4.6.93 – short entry by Dr Barton, not legible.
7.6.95 Dr Lord. Physically and verbally aggressive today. Settled now. Not mobile, hoist for transfers, eating and drinking well. To stay in Gosport.
11.6.93 – 'has deteriorated markedly over last couple of days. Great difficulty swallowing … to talk to relatives and start sc analgesia. JAB'
Nursing notes ; 11.6.93 – becoming very chesty, great difficulty in swallowing rather distressed`at times. Seen by Dr Barton – for syringe driver after discussing it with Mrs Dumbleton. Contacted Mrs Dumbleton and son, they agree. SC diamorphine 40mg, hyoscine 400 mcgs, midazolam 20mgs

Drugs
No chart

Comment
Certainly a severely ill and dependent patient. The features of the deterioration, its cause and how its management was considered is not detailed in the medical notes. No pain is documented ('distress' in nursing notes).

Edith Foale

Date of birth Code A
Date of death 5.7.93

Female

PMH
1988 # R femur - hemiarthroplasty, mild dementia, UTI, hypothyroidism. Fallback syndrome

Final illness
Nursing notes record 17.6.93 in discomfort when being turned, on oramorph
20.6.93 distress still, syringe driver commenced 40mg diamorphine
21.6.93 generalised pain, especially when being turned – syringe driver
28.6.93 remains stiff and agitated on turning. Diamorphine increased to 80mg
5.7.93 further deterioration over night. Died 9.50
medical notes – 16.11.92 90yr old lady with known dementia & difficulty walking admitted from home following CVA. For nursing care and assessment of whether she will be able to return home (note by ?consultant).
23.11.92 – drowsy, chesty 'I am happy to transfer her to Redclyffe Annexe for long stay, although I feel she may not survive long' dr Lord
24.11.92 – assessed by Dr Barton 'All nursing care. Difficult informing husband as no phone JAB'
20.4.93 – pain on movement, difficulty persuading her to take tablets – oxycodone suppose (JAB)
26.4.93 – comfortable on oxycodone, totally dependent, continue Dr Lord
18.6.93 – 'has deteriorated markedly over last 4 weeks. Now on oramorph 20mg 4 hrly. Sc analgesia w/a if necessary Husband well aware of deterioration JAB'
21.6.93 'syringe driver started yesterday. Comfortable night, no problems. JAB'
21.6.93 – Dr Lord. Comfortable on sc diamorphine via syringe driver. Husband content that she is dying – ct. tlc.
2.7.93 – 'further deterioration. Remains on syringe driver … all nursing care. Husband well aware.' 5.7.93 – 'death confirmed JAB'

Drugs
Chart records DF118 elixir written up by Dr Barton as required 10.12.92, and paracetamol, and regular diclofenac suppositories. Diamorphine 40mg sc written up 21.6.93, 80mg 28.6.93, plus midazolam, hyoscine. Oramorph as required 28.4.93. Oxycodone 6.4.93.

Comment
It would appear that the CVA was quite severe, although details are not clear. An elderly patient with multiple problems.