May 27 2002

INVESTIGATION AT GOSPORT WAR MEMORIAL HOSPITAL

EXECUTIVE SUMMARY

CHI has undertaken this investigation as a result of concerns expressed by the police and others around the care and treatment of frail older people provided by Portsmouth Healthcare NHS Trust at Gosport War Memorial Hospital. This follows a number of police investigations between 1998 and 2001 into the potential unlawful killing of a patient in 1998. As part of their investigations, the police commissioned expert medical opinion, which was made available to CHI, relating to a total of five patient deaths in 1998. In February 2002, the police decided not to proceed with further investigations.

Based on information gathered during their investigations, the police were sufficiently concerned about the care of older people at Gosport War Memorial Hospital to share their concerns with CHI in August 2001.

Key findings

In reaching the conclusions in this report, CHI has addressed whether, since 1998, there had been a failure of trust systems to ensure good quality patient care.

CHI believes that the use of diamorphine and the combination of medicines with a sedative effect administered to patients in 1998 was excessive and outside of accepted practice. There were no trust policies in place to ensure the correct use of an 'analgesic ladder' and some **[or was it all???]** patients had been administered strong opiate analgesia on admission. There had been a practice of anticipatory prescribing of high dose ranges of medicines, with nursing staff being given the discretion to administer as required.

Portsmouth Healthcare NHS Trust failed to act on the triggers provided in 1998 by a police investigation, a pattern of patient complaints and the trust's own pharmacy data to undertake an immediate review of prescribing practice on the wards caring for older people.

Portsmouth Healthcare NHS Trust has, since 2001, a policy i relating to the assessment of pain. This includes guidance on appropriate prescribing. Following a review of the case notes of patients in late 2001 and early 2002, CHI believes that appropriate prescribing is now being undertaken and anticipatory prescribing is no longer happening. The trusts own review ?????

CHI found no trust system for reviewing the performance of clinical assistants and unsatisfactory supervision arrangements. CHI understands that appraisal systems for GPs acting as clinical assistants are still in their infancy within the NHS but considers that the concerns around prescribing on these wards were significant enough to have initiated such a review of practice.

There was confusion at both ward and senior management level, echoed nationally, around the terminology and expectations of the range of care offered to older people.

CHI found a well structured and motivated senior managerial team that demonstrated a strong emphasis on staff welfare and development. Good, patient quality based local performance review mechanisms were in place throughout the trust. The principles of clinical governance and reflective nursing practice had been developed to deliver improved patient care.

Recommendations

Kellie to add

[the recommendations need to be added to the exec summary grouped by organisation aimed toward.]