PORTSMOUTH & SOUTH EAST HAMPSHIRE HEALTH AUTHORITY

COMMUNITY HEALTH CARE SERVICES

PORTSMOUTH CITY DIVISIONAL HEADQUARTERS
NORTHERN PARADE CLINIC
DOYLE AVENUE
PORTSMOUTH
PO2 9NF

Portsmouth Code A

Our ref: GMW/PSE

Your ref:

Please ask for.....

4 November 1991

Mrs. Anita Tubbritt

Code A

Dear Anita

Report of a Visit to Redclyffe Annexe, 31.10.91

Herewith a copy of the above named report. I have given copies of the report to:

Code A Principal Solent School of Health Studies, QAH.

Mr. W. Hooper, General Manager (West) Gosport War Memorial Hospital.

Mrs. I. Evans, Patient Care Manager, Gosport War Memorial Hospital.

Those who were present at the meeting.

I also wish to assure you of my support and help in this matter. Please do not hesitate to contact either Sue Frost or myself if you require any guidance.

Yours sincerely

Code A

Community Tutor, Continuing Education.

ENC.

Confidential

REPORT OF A VISIT TO REDCLIFFE ANNEXE, GOSPORT WAR MEMORIAL HOSPITAL

AT 21.30 HOURS ON THURSDAY 31 OCTOBER 1991

BY

GERARDINE M WHITNEY, COMMUNITY TUTOR, CONTINUING EDUCATION

Purpose of Visit

The visit was in response to a request by Staff Nurse Anita Tubbritt to discuss the issue of anomalies in the administration of drugs.

Present

Staff Nurse Sylvia Giffin
Staff Nurse Anita Tubbritt
Enrolled Nurse Beverly Turnbull
Nursing Auxiliary Agnes Howard (Does not normally work at Redcliffe Annexe)
2 RGN's and 1 EN wished to but were unable to attend the meeting.

Background Information

The staff present presented the Summary of the Meeting held at Redcliffe Annexe on 11 July 1991 - appendix.

Problems Identified on 31 October 1991

1. Staff Nurse Giffin reported that a female patient who was capable of stating when she had pain was prescribed Diamorphine via syringe driver when she was in no obvious pain and had not complained of pain.

2. Staff Nurse Giffin reported that a male patient admitted from St Mary's General Hospital who was recovering from pneumonia, was eating, drinking and communicating, was prescribed 40 mg Diamorphine via a syringe driver together with Hyoscine, dose unknown, over 24 hours. The patient had no obvious signs of pain but had increased bronchial secretions.

3. Staff Nurse Tubbritt reported that on one occasion a syringe driver "ran out" before the prescribed time of 24 hours albeit that the rate of delivery was set at 50 mm per 24 hours.

4. The staff are concerned that Diamorphine is being prescribed indiscriminately without alternative analgesia, night sedation or tranquillisers being considered or prescribed.

5. Nurse Tubbritt reported that a female patient of 92 years awaiting discharge had i.m. 10 mg Diamorphine at 10.40 hours on 20.9.91. and a further i.m. 10 mg Diamorphine at 13.00 hours on 20.9.91. administered for either a manual evacuation of faeces or an enema.

6. There are a number of other incidents which are causing the staff concern but for the purposes of this report are too many to mention. The staff are willing to discuss these incidents.

7. It was reported by Staff Nurse Tubbritt that:

   a) 42 ampoules of Diamorphine 10 mg were used between 20 April 1991 - 15 October 1991.

   b) 57 ampoules of Diamorphine 30 mg were used between 15 April 1991 - 15 October 1991 (24 of the 57 ampoules of Diamorphine 30 mg were administered to one patient, who had no obvious pain, between 9 September 1991 and the 21 September 1991).

   c) 8 ampoules of Diamorphine 100 mg were used between 15 April 1991 - 21 September 1991 (4 of the 8 ampoules of Diamorphine 100 mg were administered to the patient identified in 7b above, between 19 September 1991 and the 21 September 1991).

      Note - This patient had previously been prescribed Oramorph 10 mg in 5 ml oral solution which was administered regularly commencing on 2 July 1991.

      The staff cannot understand why the patient was prescribed Oramorph and Diamorphine.

      When the staff questioned the prescription with Sister they were informed that the patient had pain. The staff recalled having asked the patient on numerous occasions if he had pain, his normal reply was no.

Conclusion

1. The staff are concerned that Diamorphine is being used indiscriminately even though they reported their concerns to their manager on 11 July 1991 (appendix).

2. The staff are concerned that non opioids, or weak opioids are not being considered prior to the use of Diamorphine.

3. The staff have had some training, arranged by the Hospital Manager, namely:

   - The syringe driver and pain control
   - Pain control

4. Staff Nurse Tubritt wrote to Evans the producers of Diamorphine and received literature and a video - Making Pain Management More Effective.

5. Staff Tubbritt is undertaking a literature on Pain and Pain Control.

Signed: Code A ..... Time: 23.35 hours

Date: 31 October 1991

Community Tutor, Continuing Education

Summary of Meeting held at Redclyffe Annexe on 11.7.91

A meeting was arranged for the trained staff at Redclyffe Annexe following concern expressed by some staff at the prescribed treatment for 'Terminal Patients'

Present:- Mrs. Evans
Sister Goldsmith
Sister Hamblin
S/N Giffin
S/N Ryder
S/N Barrett
S/N Williams
S/N Donne
S/N Tubbritt
S/N Barrington
E/N Turnbull

The main area for concern was the use of Diamorphine on patients, all present appeared to accept its use for patients with severe pain, but the majority had some reservations that it was always used appropriately at Redclyffe.

The following concerns were expressed and discussed:-

1. Not all patients given diamorphine have pain.

2. No other forms of analgesia are considered, and the 'sliding scale' for analgesia is never used.

3. The drug regime is used indiscriminately, eachpatients individual needs are not considered, that oral and rectal treatment is never considered.

4. That patients deaths are sometimes hastened unnecessarily.

5. The use of the syringe driver on commencing diamorphine prohibits trained staff from adjusting dose to suit patients needs.

6. That too high a degree of unresponsiveness from the patients was sought at times.

7. That sedative drugs such as Thioridazine would sometimes be more appropriate.

8. That diamorphine was prescribed prior to such procedures such as catheterization* - where dizepam would be just as effective. (& enemas!)

9. That not all staffs views were considered before a decision was made to start patients on diamorphine - it was suggested that weekly 'case conference' sessions could be held to decide on patients complete care.

10. That other similar units did not use diamorphine as extensively.

Mrs. Evans acknowledged the staffs concern on this very emotive subject. She felt the staff had only the patients best interest at heart, but pointed out it was medical practice they were questioning that was not in her power to control. However, she felt that both Dr. Logan and Dr. Barton would consider staffs views so long as they were based on proven facts rather than unqualified statements. Mrs. Evans also pointed out that she was not an expert in this field and was not therefore qualified to condemn nor condone their statements, she did, however, ask them to consider the following in answer to statements made.

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1. That patients suffered distress from other symptons besides pain but also had the right to a peaceful and dignified death. That the majority of patients had complex problems.

2. If 'sliding scale' analgesia was appropriate in these circumstances, particularly when pain was not the primary cause for patient distress. That terminal care should not be confused with care of cancer patients.

3. The appropriateness of oral treatment at this time considering the patients deterioration and possibility of maintaining ability to swallow. The range of drugs available to cover all patients needs in drugs that can be given rectally together with patients ability to retain and absorb product.

4. It was acknowledged that excessive doses or prolonged treatment may be detrimental to patients health but was there any proven evidence to suggest that the small amounts prescribed at Redclyffe over a relatively short period did in fact harm the patients.

5. It could be suggested to Dr. Barton that drugs could be given via a butterfly for the first 24 hrs. to give trained staff the opportunityto regularise dose to suit patient.

6. That treatment sometimes needed regularising as patients condition changed -were staff contributing signs of patients deterioration to effects of drug? Few patients remained aware until the moment of death.

7. What was the evidence to suggest that thioridazine or any other similar drugs would be better.

8. Again, what was the objection to diamorphine being used in this way and how was diazepam better.

9. Mrs. Evans wholly supported any system which allowed all staff to contribute to patients care however, she could not see that weekly meetings were appropriate in this case where immediate action needed to be taken if any action was required at all.

10. What was the evidence to prove that these other units care of the dying was superior to ours,before any change could be taken on this premis it would need to be established that we would be raising our standards to theirs rather than dropping our standards to theirs.

It was evident that no one present had sufficient knowledge to answer these questions with authority, it was therefore decided that before any critisism was made on medical practice we needed to be able to answer the following questions.

- What effect does Diamorphine have on patients.

- Are all the symptons that are being attributed to Diamorphine in fact due to other drugs patients are recieving, or even their medical condition.

- Is it appropriate to give Diamorphine for other distressing symptons other than pain.

- Are there more suitable regimes that we could suggest.

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To try and find the answers to these questions Mrs. Evans would invite Kevin Short to talk to staff on drugs and ask Steve King from Charles Ward Q.A. if he would be prepared to contribute to discussion.

This would take time to arrange meanwhile staff were asked to talk to Dr. Barton if they had any reason for concern on treatment prescribed as she was willing to discuss any aspect of patient treatment with staff.

I hope I have included everyones views in this summary, as we will be using it to plan training needs, please let me know if there is any point I have omitted or you feel needs amending.

IE/LP
16.7.91