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Code A

Code A

MM/BM/YJM

1st October, 1999

4378

Dear Code A

I am writing further to my letter of 6th August, 1999 now that I have received the report from Dr. G. Turner, Clinical Director, Elderly Care Services, Southampton. I enclose a copy for your information.

In my letter of 24th June, 1999 I suggested that obtaining a second opinion should be the conclusion of the local resolution of your complaint. You echoed this sentiment in your letter of 19th July, 1999. In view of Dr. Turner's conclusions I assume that you will not wish to pursue the matter further at this level but please contact me within the next month if there are any further steps you would wish me to take.

Yours sincerely,

Max Millett
Chief Executive

Silent copy to: Dr. I. Reid
Mr. W. Hooper
Dr. A. Lord

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16 September 1999

Mr M Millett
Chief Executive
Portsmouth Healthcare NHS Trust
St James Hospital
Portsmouth
PO4 8LD
For the attention of Barbara Melrose Project Officer

Dear Mr Millett

Re: Complaint regarding Code A

Thank you very much for inviting my comments on two aspects of the care of the Code A resulting from Code A I have been through the notes in great detail and am happy to comment on the areas that you requested from my position as Clinical Director of a district Elderly Care Service.

Firstly the use of morphine. In my experience, it is frequently the case that elderly people, when transferred from an acute environment to a rehabilitation unit, become unsettled after transfer. This is partly related to the disruption and the anxiety of the new environment and also undoubtedly partly due to the physical stress of the journey itself. It is noteworthy that when Code A Code A was admitted to the Gosport War Memorial hospital, morphine was not written up straight away but after 24 hours a doctor was asked to assess her because she was in pain which was not controlled by the oral analgesics which had been given to her. These were the same analgesics that she had been given on transfer from Haslar and I think it is probably worth pointing out that Co-codamol is an opiate containing drug. As a result of the concern of the nurses and the doctor who assessed her the day after admission, a very small dose of an oral Morphine preparation was used. In fact, on analysing the drug charts it seems that over the subsequent week to ten days she was actually only given between 10 and 20 mgs of morphine per day. More often than not this was at night in order to help her sleep and was a perfectly appropriate response to the fact that the night nurses often noted that she was very uncomfortable at night. It is not clear exactly from where her pain originated, from her fracture site or from her pressure sores, but there is plainly concern within the nursing notes that she was in discomfort and it is known that the pain from pressure sores can sharply deteriorate when skin separation occurs

In my opinion, the use of morphine is entirely justified in any old person who is in pain. It is an easy drug to use because it is easily administered and more reliably absorbed and therefore much more immediately acting than some of the so called minor analgesics. Because its side effects are well recognised, it is not dangerous if used in appropriate quantities which I believe was the case here, and because it can induce a sense of well being, it often relieves a lot of the anxiety to which I have alluded.

Code A
Sue Palmer

Over the subsequent two weeks her need for pain relief was assessed regularly and she was still only receiving between 10 and 20 mgs Oramorph. On the 23 November Dr Lord's extremely good summary and proposed management plan in the notes makes it quite plain that at that stage the patient was in a very poorly condition, was hardly responding to any questions but was groaning in discomfort when disturbed. She made the then entirely justifiable decision to change the administration of morphine from oral administration to the use of firstly subcutaneous injections which are generally regarded as virtually painless and then subcutaneous infusion.

I suspect that it still may not be clear to Code A how little morphine his mother actually had. Whilst I recognise that as an elderly lady she would be susceptible to the effects of morphine, the small doses that she received until the first record of him becoming concerned on 17 November, would not be sufficient to explain her deteriorating state. Indeed on the 14, 15 and 16 November she received only 10 mgs of morphine at night which is a very tiny dose and is frequently used in many other situations in order to help sleeping. It is usually the case that the first dose of morphine is the most likely to cause drowsiness. He himself noted on 12 November how much brighter she was - even after the first dose of morphine at 14.05.

In summary I therefore believe the use of Morphine was entirely appropriate and that the amounts administered could not be considered excessive. At the time when a decision was made to change her to parenteral administration of the drug as opposed to oral administration, that decision appears to be entirely justified by the excellent documentation in the notes.

The second area for which you have asked my comments is the concern about dehydration. The question of dehydration is a particularly common and worrying one for all small rehabilitation units where patients are often frail and the culture of rehabilitation can sometimes mean that fluid intake is not measured. In this respect I do not believe that the Gosport War Memorial Hospital is any different to any other community rehabilitation unit. The Nursing care plan has recognised that her fluid intake was poor. Indeed this was alluded to by Dr Lord when she originally visited Code A over at Haslar. By the 14 November the nurses had noted that her urine had become rather concentrated and the plan then and on the next day was to encourage fluids although fluid intake was noted still to be poor. It is certainly true that the nurses having failed to increase the patient's fluid intake to appropriate amounts on two successive days might have requested a doctor to consider subcutaneous fluids. However this would only have meant that that request would have been made on 16 November rather than the 17 November when a doctor was asked to see her, at which point of course her son also noticed that she was dry. However I am sure there is not a doctor at Gosport War Memorial Hospital every day, again in common with most other peripheral rehabilitation units, and I feel that there is no evidence presented in the notes which would suggest that fluid being administered by drip from the 16th would have made any difference at all to her outcome. In as much as it is possible to say from the records that I have seen, she continued to receive subcutaneous fluids, at least one litre in 24 hours for the next two to three weeks, which was an appropriate attempt to ensure that any deterioration due to dehydration was corrected and reversed. The fact that she did not improve at all with parenteral rehydration I think also goes to demonstrate the poorly state she was in was not due to fluid depletion.

In summary therefore I believe that the use of analgesia was appropriate both in terms of the type of drug and the amount used, especially in the early stages, and I feel that dehydration was noted by the nurses who took appropriate action in the early stages and there was not an unreasonable delay before starting her on alternative methods of fluid provision once oral rehydration was shown to be unsuccessful. It is very hard for me to criticise these two aspects of the management of this patient.

I hope these comments are helpful. Please let me know if there is anything more I can tell you.

With best wishes.

Code A

Dr Gill Turner
Clinical Services Director
Elderly Care Unit