REPORT FOR THE GENERAL MEDICAL COUNCIL ON ASPECTS OF CARE AT GOSPORT WAR MEMORIAL HOSPITAL

Instructions

To prepare a generic report for the General Medical Council covering principles of medical care and matters specific to the Gosport War Memorial Hospital in relation to the individual cases and separate individual reports that have been provided to the GMC.

1. Principles of Medical Care

1.1 Pain Relief

Pain is a complex phenomena that is a subjective, personal experience, only known to the person who suffers. Experience of pain may occur at several levels:

- Sensory dimension, the intensity, location and character.
- The affective dimension; the emotional component of pain and how it is perceived.
- Impact; disabling effect of the pain on the person's ability to function and participate in society.

1.1.1 Analgesic Ladder for pain

The relief of pain is therefore part of a comprehensive pattern of care. However, whatever the cause or the effect on the patient the Analgesic Ladder has for many years been the main stay of the approach to analgesia [1, 2]. It is a very simple concept that the choice of drug should be based on the severity of the pain not the stage of the disease. Drugs should be given at standard doses, at regular intervals in a step wise fashion. Thus for mild pain, non-opioid analgesics such as Paracetamol or a non-steroidal anti-inflammatory agent (e.g. Diclofenac) is used. If this non-opioid is not effective or the patient is in moderate pain, a moderate opioid (e.g. Codeine or Dihydrocodeine, often in combination with a non-opioid drug, such as Paracetamol with Codeine in Co-Codamol) is used. If the patient is in severe pain or the pain has not settled or the pain management for moderate pain has not worked, strong opioid analgesia (e.g. morphine) should be used ideally on an oral basis in the first instance.

1.1.2 Assessment of pain

Comprehensive assessment of pain involves:

a) Direct enquiry or observation for signs of pain. It is important to use alternative descriptions such as sore, hurting or aching. Patients with severe cognitive impairment, communication difficulties or language or cultural barriers present further complexities. There may be other observational signs associated with pain including crying, distress, aggression, moaning, calling out, pacing, rocking, various facial expressions and autonomic changes such as sweating, altered breathing patterns and tachycardia.

b) A description of the pain in terms of its sensory and affective and impact should be obtained and high quality services will often use a standardised scale to assist in assessment.

c) A full physical examination should then be undertaken to identify the cause of the pain.

d) Where a cause can be identified the cause should be treated and if it is not identifiable then it is appropriate to treat the symptoms.

e) The patient should then be reassessed to evaluate the effects of treatment.

1.1.3 Principles of administration of pain relief

This involves the Analgesic Ladder. As well as:

- Using the oral route if possible.
- Providing therapeutic doses of an analgesia regularly.
- Titrating the dose of the drug to the individual's analgesic requirement.
- Providing effective analgesia for breakthrough pain.
- Assessing pain control regularly.
- Assessing and treating the psychosocial dimensions of chronic pain.
- Paying attention to bowel function in particular use of laxatives with opioids.
- Providing appropriate adjuvant therapy (e.g. Bisphosphonates for bone pain, Tricyclic Antidepressants for neuropathic pain, non-steroidals for inflammatory pain).
- Keeping the patient and family fully informed.

1.1.4 Use of opioids

In a patient starting at level 3 of the analgesic ladder for the first time a dose of 5 – 10 mgs, four hourly, of Morphine is usual, given orally. Also prescribe Morphine at one sixth of the 24 hour dose for breakthrough or incidental pain.

- Titrate the dose against the individual's level of pain and side effect profile.
- When indicated, increase the dose by 20 - 50%, or by the amount of breakthrough Morphine used in the previous 24 hours.
- When pain is controlled convert to a sustained release formulation in an equivalent dose.
- Prescribe a regular laxative unless contraindicated.
- For injection Diamorphine is preferred as it is more soluble and can be given in smaller volume. In converting an oral dose of Morphine to a subcutaneous dose of Diamorphine, the BNF states that the equivalent intramuscular or subcutaneous dose of Diamorphine is approximately a third of the oral dose [3]. However, the Wessex Protocol states "conversion from oral Morphine to subcutaneous Diamorphine (total daily dose) varies between 2:1 and 3:1 allowing some flexibility depending on the requirement for increased or decreased opioid effect".

1.1.5 Syringe Drivers

Syringe drivers allow a continuous subcutaneous infusion which can provide good control of symptoms with little discomfort or inconvenience to the patient. Indications include:

- Patient unable to take medicines by mouth for example due to vomiting or coma.
- There is malignant bowel obstruction where further surgery is not possible.
- Where the patient does not wish to take a regular medication by mouth.
- The Wessex Protocol also states "the last 24 / 48 hours of life".

The most common causes of problems with syringe drivers are putting the wrong dosage in the driver, problems with the driver either going too fast or too slow and poor training of staff.

1.1.6 Opioid toxicity and side effects

a) Drowsiness and sedation. Most commonly within the first few days of opioid usage. Severe overdosage may lead to coma and slowing of respiration to the point of respiratory failure.

b) Nausea and vomiting. Nausea is particularly common in those taking oral Morphine. It can be helped with the co-prescription of either Metoclopramide or Haloperidol.

c) Constipation. Develops in almost all patients who should be treated routinely with laxatives.

d) A dry mouth is often troublesome.

Individuals can vary enormously in their tolerability of Opioids. Opioid toxicity may also present as agitation, hallucinations, increased confusion leading to interpretation as uncontrolled pain, and when further opioids are given leading to sedation, lack of fluid intake and further toxicity. This syndrome is sometimes misdiagnosed as terminal agitation.[4]

Patients with both renal impairment and hepatic impairment are both extremely sensitive to opioids.

1.1.7 The use of Midazolam with Diamorphine

Research has shown that a high proportion of patients are distressed in the last week of life. Agitation and restlessness is particularly common. In a terminally restless patient there should be a proper attempt to determine the etiology of the distress. Where this is pain, appropriate analgesia is the first approach. However, if this does not relieve the agitation and distress it is appropriate to add further drugs to manage the symptoms of terminal restlessness. Haloperidol is particularly helpful in cases of agitation, and Midazolam for restlessness. Both can be put subcutaneously in a syringe

driver and can be mixed with Diamorphine where required. Midazolam also has the advantage that it raises the seizure threshold. The BNF[3] states that it should be given in a dose of 20 – 100 mgs per 24 hours, the Wessex Protocol state 10 – 100 mgs per 24 hours[2] although others believe that in older people a lower dose of 5 – 20 mgs per 24 hours is normally sufficient[5]. Thus pain by itself is not a reason to add Midazolam. If excessive doses of Midazolam are used with excessive doses of opioid analgesia it would significantly increase the risk of over sedation, respiratory failure, coma and potentially hasten death.

1.1.8 Principles of prescribing in old age

The British National Formulary[3] sets out important issues around old people particularly the very old and frail.

a) Appropriate prescribing to people receiving multiple drugs - this greatly increases the risks of drug interactions, adverse interactions and poor compliance.
b) Forms of medication in the frail - an older patient may have difficulty swallowing and there may be problems with fluid intake.
c) Manifestations of disease – problems of normal age may be mistaken to disease such as age related muscle weakness being confused with neurological disease.
d) Sensitivity – the nervous system of older people is particularly sensitive to many commonly used drugs and the BNF mentions opioid analgesics and Benzodiazepines (such as Midazolam).
e) Pharmacokinetics – the most important affects of age is the reduction in renal clearance and therefore atoxic drug metabolites may accumulate with greater preponderancy with adverse effects. Liver metabolism of some drugs is also reduced in old age.

The key principles are:

- Use as few drugs as possible, use dosages substantially lower than for younger patients, often 50% of adult dose, review regularly, simplify regimes, explain clearly. Doctors should use the BNF to check dosages and drug interactions.

2. Medical Assessment and Records

2.1 Assessment and Records

Doctors have a responsibility to make the care of the patient their first concern. The attributes of good clinical care are set out in the GMC's document Good Medical Practice[6]. This states that good clinical care must include:

- Adequate assessment of the patient's condition based on the history and clinical signs including, where necessary, an appropriate examination.
- Providing or arranging investigations or treatments where necessary.
- Referring the patient to another practitioner, when indicated.

It also states that in providing care you must:

- Recognise the limits of your professional competence.
- Be willing to consult colleagues.
- Be competent when making diagnoses and when giving or arranging treatment.
- Keep clear, accurate and contemporaneous patient records which report the relevant clinical findings, the decisions made, information given to patients and any drugs or other treatments prescribed.
- Keep colleagues well informed sharing the care of patients.

A failure to meet these standards puts the patient at risk:

- Without assessment there can be no proper treatment and would be a clear failing in duty of care to the patient.
- Without recording assessments there are risks to the patient of:
    - Missing and forgetting important matters.
    - No base line on which to document, understand and assess changes in condition.
    - No information for other members of staff whether medical or other members of the health care team to understand the problems and base their own management upon it.
    - No audit trail when decisions are questioned or challenged.

2.2. Use of Drug Charts

On hospital drug charts there are broadly speaking 4 ways to prescribe a drug each with its own section.

- Drugs may be given as a single dose. This is usually on the front of the chart which should state the dose, the route of administration and the time and date of that administration. It would be normal for the nursing (or medical) staff to give the medication at the time and date specified and if not to make a record of why that failed to happen.

- Drugs may be prescribed on a regular basis at the same time and dosages each day. There is often a column where the timing of dosages should be included. The drugs should always be given by the nursing (or medical) staff at the time and at the dose indicated. If it is not given at the time or dose indicated there should be a record made on the drug chart or in the notes as to why this happened. If the dose and/or the timings of the drugs are to be changed the whole prescription should have a line put through it, it should be dated and initialled and a new regular prescription written up on a different line.

- Many medications are prescribed on an "as required" basis (PRN which abbreviates *pro re nata: 'as the occasion arises; when necessary'*). The nursing staff or sometimes the patient may then use their judgement when these drugs are given. It would be normal to specify the dose and the minimum dose interval. It is common practice to give a small dose range. For example, Paracetamol one or two tablets at 6 hourly PRN. This part of the drug chart is most commonly used for sleeping tablets, mild analgesia, laxatives and anti-emetics, but may be condition specific. For example a small dose range of Diamorphine 2.5-5mg is often written up in patients admitted with acute myocardial infarction or unstable angina. This

reflects the need for rapid analgesia but allows some judgement as to the actual dose required particularly if a previous dose has not worked while further medical attention is obtained. As indicated earlier breakthrough doses of analgesics PRN may also be written up when a regular opioid has been started on the regular side of the drug chart.

- The final part of the drug chart is for infusions and fluid management.

Prescribing requires:

- The drug, the dose, the strength, the route of administration and the frequency to be written up for all prescriptions.
- Avoid multiple route prescribing for a single prescription (e.g. IV and oral).
- When changing the dosage you should draw a line through the prescription, date and initial, and then re-write a new prescription.
- The law for controlled drugs states that a prescription must be signed and dated and must always state:
    - the name and address of the patient
    - the form and strength of the preparation
    - either the total quantity (in both word and figures) of the preparation, or the number (in both words and figures) of dosage units, as appropriate, to be supplied in any other case the total quantity (in both words and figures) of the controlled drug to be supplied.
    - the dose

- In a guideline for responsibility on prescribing [7] the Department of Health has advised that the legal responsibility for prescribing lies with the doctor who signs the prescription.
- It is good practice to review the drug chart of every patient as part of a normal ward round. This would also be the case when new drugs are to be prescribed or there is a change in the patient's condition.

Comment

Where these guidelines and instructions are not followed patient care and safety may be compromised due to:

- Confusion as to whether the drugs are to be given regularly or irregularly.
- Important doses of required drug medication being missed.
- Confusion and misunderstanding over the appropriate dose of drug to use and when it should be used.
- A risk of treating patients symptomatically when medical reassessment of a patient's condition would be more appropriate.

In particular I can find no justification for writing up drugs for a possible syringe driver on a PRN part of a drug chart with a very large dosage range in many cases (20 – 200 mgs of Diamorphine). The reasons for this are:

- A decision to start a syringe driver is an important clinical decision that should always require the patient to be seen and reassessed.
- Syringe driver medication should always be written up on the regular side of the drug chart and the prescription should be re-written each time the dosage is changed.

- It might be appropriate for single PRN doses of an oral or parental opioid to be made available on the PRN side of the drug chart with a very small dosage range in those cases where the medical assessment had already noted pain or other symptoms that might not be managed in a short period of time while awaiting further medical attention. 24 hour medical attention was available for all patients at GWMH.
- There is a theoretical risk that a high and clinically inappropriate dose of drugs could be mistakenly started at any time without further medical review or assessment.

2.3 Limits of clinical competence

The GMC Guidelines above state that in providing care the clinician must:

- Recognise the limits of their professional competence.
- Be willing to consult colleagues.

All patients on Dryad and Daedalus Ward had a named consultant Geriatrician responsible for their care. However, the day to day responsibility was devolved to the clinical assistant, a General Practitioner. There is no doubt that many of the patients had complex multiple pathology and were challenging clinical and management problems. The type of complexity faced in managing older people at GWMH included:

- Being prepared to look for a medical reason for change in status or symptomatology. For example a recent onset of confusion may indicate an undiagnosed and untreated urinary tract infection.
- High technology interventions and diagnostics were not available on the Gosport War Memorial Hospital site. Yet such interventions are often crucial in the modern management of patients. It would have been a significant decision to have to arrange for a patient to return to a DGH for an investigation or in-patient care. Such decisions should normally be subject to discussion between the clinical assistant and the consultant in charge of the patient or the consultant on call.
- In patients with multiple pathology where there has been active treatment so far but a further significant clinical events happens. Whether to continue to actively treat, investigate or to make a decision regarding palliative and terminal care can often be complex and emotional. A multi-disciplinary approach involvement of a senior clinician, usually the consultant in charge of the patient's care, would be normal good practice.

3. Matters specific to the Gosport War Memorial Hospital

3.1. The position of a Clinical Assistant

Clinical assistant posts are part-time hospital posts that were initially intended for GPs who wished to work in hospital and were appointed under paragraph 94 of Terms and Conditions of Service[8]. GP clinical assistants can do no more than 9 notional half days. There are no clearly defined terms and condition of service. The role is a career grade role, not a training role and may be permanent. They are usually responsible to a named consultant. Clinical assistants may have had variable experience before being appointed to a post but there is no minimal standard set. It is the employing

organisation that would be responsible for ensuring any clinical assessment had the appropriate skills and training to undertake the task set out in the job description.

3.2 The Job Description

The job description[9] is undated but confirms that the clinical assistant is responsible for a maximum of 46 patients. The job description makes clear there is:

- There is 24 hour medical cover and to be available on call as necessary.
- To ensure that all new patients are seen promptly after admission.
- To be responsible for writing up the case notes and ensuring that follow up notes are kept up to date and reviewed regularly.
- To take part in the weekly consultant ward round.

However there is no comment on the medical cover to be provided if the post holder is unavailable out of hours or for longer periods of leave such as holiday.

There is some confusion in the job summary as it states that it is to provide 24 hour cover to the long stay patients but then goes on to state that patients are "slow stream" or "slow stream rehabilitation".

References

1. World Health Organisation: Cancer Pain Relief and Palliative Care. WHO, Geneva, 1990.
2. Palliative Care Handbook: Guidelines on Clinical Management. 3rd Edition, Salisbury Palliative Care Services (also known as "Wessex Protocols"), May 1995.
3. British National Formulary.
4. ABC of Palliative Care: Principles of Control of Cancer Pain. BMJ: 332; 1022-1024, 2006.
5. Welsh J, Fallon M, Keeley P W. Chapter 23, Brocklehurst Text Book of Medicine 6th Ed. 2002
6. Good Medical Practice. The GMC, October 1995.
7. DoH Circular EL (91) 127.
8. Terms and Conditions of Service, paragraph 94.
9. Job Description for the post of Clinical Assistant to the Geriatric Division in Gosport War Memorial Hospital.