Table4

ID
1
PMH
1966 - Insulin dependent diabetes (elsewhere in records diabetes indicated as dating from 1957) 1982 – retinopathy 1986 – vitreous haemorrhage 1987 – L vitrectomy. Registered blind
final illness
Was admitted to QAH on 3.11.93. Unconscious on admission, but becoming responsive on 4.11.93. 10.11.93 – flaccid R side; comprehending and using full sentences; poor swallowing – NG feeding. Received cefuroxime for a urinary tract infection. In view of continued dense hemiplegia, transferred to a long stay bed on Daedalus ward.
drugs1
Was written up by Dr Barton for diamorphine 40mg sc in 24hrs, hyosine 400mcg sc in 24hrs and midadazolam 20mg sc in 24hrs (i.e. by syringe driver) dated 23.11.93 (i.e.on day of admission). These drugs were not started until 25.11.93. Also written up for oxycodone supps, although none were administered, and actrapid (last dose 26.11.93)
comment1
The patient was certainly disabled by a major stroke; she had received some rehabilitation/physiotherapy in QAH, and an early death was not recorded as expected by QAH staff. It is worrying that Dr Barton concluded on first seeing the patient that a prescription for diamorphine by syringe driver would shortly be needed (23.11.93). The source of pain is not clear, and not treated by QAH staff - no mild analgesia was given. A

ID
2
PMH
1999 – attending Dolphin Day Hospital; loss of confidence following a fall and fractured pubic ramus, atrial fibrillation and urinary problems. Has osteoarthritis of thoracic spine, diverticular disease, deafness.
final illness
Admitted Queen Alexandra Hospital (QAH) 12.11.99 with vomiting, dehydration, poor mobility (secondary to a bimalleolar fracture of L ankle, in plaster cast). An abdominal X ray showed dilated small and large bowels, the initial diagnosis was constipation, and IV fluids were commenced. By 13.11.99, the diagnosis was given as obstruction 2will need laparotomy. The symptoms tended to remit and return, by 19.11.99 she was a little
drugs1
Diamorphine 20-80 mg sc written up 6.12.99, started 22.12.99 Hyoscine 200-800ug written up 6.12.99, not started. Midazolam 20-80mg written up 6.12.99, started 22.12.99. Oramorph written up 19.12.99 5-10 mg
comment1
This case has been managed appropriately in GWMH. An alternative, more aggressive form of management was ruled out when the patient was undergoing specialist assessment in QAH. The patient was under the care of doctors other than Dr Barton in GWMH.

ID
3
PMH
Hypertension 1990 Anxiety/depression from 1966 Uterine bladder prolapse 1982 2000 – admitted Haslar – metastatic squamous carcinoma, primary unknown. Confirmed histologically
final illness
9.2.2000 Admitted from A3 Haslar for palliative care. Grade 2 pressure sore on sacrum, catheterised. Assessed on admission by a doctor other than Dr Barton.- 'very anxious about being in hospital where husband died, we need to pull out stops re getting her home if possible' JAB 16.2.2000 – assessed by OT
drugs1
Oramorph recorded 21.2.2000 5-10 mg 4 hrly, started 22.12. Diamorphine sc 20-80mg in 24 hrs and hyoscine 200-800ug in 24hrs both written up 21.2.2000. Diamorphine started 23.2.2000. Other drugs were used but are not detailed as they were not opiates (EG, GTN, ranitidine).
comment1
The patient's care was appropriate; there are excellent features – a detailed assessment by a specialist, and detailed discussion with a son, OT assessment; decisions on management were appropriate. The early writing up (but not administration) of sc opiates occurs again.

ID
4
PMH
Admitted QAH 11.2.1997 L hemiplegia. Also NIDDM & hypertension. CT scan on 12.2.1997 showed large intracerebral haemorrhage; transferred to Wessex Neurosurgical Centre for angiography and exclusion of aneurysms. Barthel 2, PEG tube; will need slow rehabilitation, but 'very young'.
final illness
9.4.1997 – transferred to Daedalus Ward, GWMH, for rehabilitation. 10.4.1997 – referral to speech therapist to assess swallow JAB. 15.5.1997 – still MRSA + (S/B consultant [I think], & reviewed by consultant every few weeks. 10.7.97 – lack of progress discussed with wife;
drugs1
The drug chart was usually completed by Dr Barton. Oramorph was started at an early stage (December 1997) and continued, MST also being used from 1997; eventually replaced by diamorphine by syringe driver. There is a large number of drug charts and the pattern is difficult to disentangle, but it appears that MST was used regularly, with oramorph for break through pain
comment1
The patient was very severely disabled by the stroke, and no real improvement occurred. The MRSA infection was treated repeatedly in an effort to eradicate it, although this proved very difficult. Patients with this degree of dependency and illness do develop pain, but the factors leading to the initiation of opiate medications are not described in detail. The patient was so far as I can determine from the hand written

ID
6
PMH
1999 – fall ?secondary to an MI. Admitted Haslar, fracture R neck of femur – R hemiarthroplasty. Kingsclere rehab- Barthel 2, some dementia and stubborn, so rehabilitation problematic. Transferred to Dryad for long term care, ? eventual nursing home.
final illness
Final illness 10.2.99 – referred to Dr Banks by Dr Beasely for assessment. 5 further record entries indicating reluctant to take food, fluids or drugs; Dr Reid attended on several occasions
drugs1
The oramorph and diamorphine (& midazolam & hyoscine) were written up by Dr Barton, although there is no related entry in the records. Oramorph 16.3.99, 5mgs. Diamorphine 20-200mg in 24 hrs writeen up (date of writing up not clear). Started 18.3.99, 20mgs, rising to 30mgs on 22.3.99. Medazolam started 18.3.99, 20mgs, rising to 30mgs on 22.3.99
comment1
The absence of detailed information about the reasons for commencing opiates makes this case difficult to assess. However, the patient was managed by doctors other than Dr Barton, and deterioration was noted before the opiates were commenced. Therefore, it is probable that care was appropriate, although the completeness of records is unsatisfactory.

ID
7
PMH
Deaf mute 1982 – carcinoma penis 1995 – aortic valve replacement 2.2.99 – admitted CAH, fractured malleolus, aspiration pneumonia, fracture tibia, PEG feeding – swallowing
final illness
15.3.99 – transferred to Daedalus ward for continuing care. Assessed on admission by Dr Barton. History noted, for 'slow rehabilitation; please make comfortable, I am happy for nursing staff to confirm death. JAB' Seen by another doctor 15.3.99 and 29.3.99, with some improvements in pressure areas noted. No major new problems. 2.4.99 – died 23.40
drugs1
Oramorph written up by Dr Barton 15.3.99 PRN basis. Doses given from 2.4.99. Diamorphine 20-200, hyoscine 200-800, medazolam 20-80 all sc, started 2.4.99 (written up by a doctor other than JAB).
comment1
Little is recorded about the last few days of the illness; the reasons for the commencement of opiates is not clear. The patient was clearly ill and frail, but the precise nature of the terminal events are difficult to determine from the records.

ID
8
PMH
Few details Admitted Haslar 14.6.999.
final illness
20.7.99 – transferred to Dryad ward continuing care, 28.7.99 – on diamorphine, hyoscine and cyclizine; pain well controlled, mass now growing thru chest wall. Dr Reid. 29.7.99 – 17.45 died carcinoma lung following haemotemesis. Assessed by Dr Barton on admission, writing rather difficult to read
drugs1
Diamorphine, hyoscine & cyclizine initiated by Dr Barton, 22.7.99. This date does not match the date in the record continuation chart – but the diamorphine was IM injection 22-27, and sc thereafter. Medazolam 29.7.99. Oramorph from 21.7.99.
comment1
Management appears to have been appropriate. The records were not fully legible, and not a full record of clinical decisions.

ID
9
PMH
1995 – depression, chest infection, NIDDM, poor short term memory, transferred to a rest home. Admitted QAH 28.6.199 fracture R femur – dynamic hip screw; difficult to mobilise, poor fluid intake, catheterised; for transfer to GWMH. Dementia – difficult to understand
final illness
21.7.99 – admitted to Dryad ward from QAH. Assessed by Dr Barton – dementia, fractured hip, past TIAs noted. Barthel 2. 'Please get to know. Please make comfortable. I am happy for nursing staff to confirm death.' JAB 27.7.99 – walks with 2. Needs help with washing and dressing. JAB
drugs1
Oramorph 5mg started 1.8.99; diamorphine (20mg & 30 mg) sc and medazolam 20 mg & 30 mg sc 3.8.99, hyoscine 4.8.99.
comment1
A patient with multiple problems, and was difficult to mobilise. The outcome would not be unexpected, although the precise cause of death is rather unclear. Management appear generally appropriate, although the records are not detailed.

ID
10
PMH
Few details available from records
final illness
Admitted 11.10.99 from Mulberry B. Ca lung, shakey and jaundiced on admission, complained of pain, poor mobility – needs help with transfers and feeding (nursing notes) 11.10.99 – assessed by Dr barton. Transfer to Dryad ward continuing care. Also past history of ca prostate although PSA was recently? normal. Recent deterioration in general condition. 'Plan Get to know, make
drugs1
Oramorph 5-10mg as required from 11.10.99; diamorphine 20-200mg 11.10.99 – started 12.10.99 20 mgs, 30 mgs on 113.10.99. Also hyoscine 4oougs, medazolam 20-40 mgs12 & 13th. Sc.
comment1
The patient had advanced terminal disease, and was managed appropriately.

ID
11
PMH
Past carcinoma larynx, 2 CVAs, atrial fibrillation, dementia, gout, angina, arthritis. Two admissions in 1999 for chest problems and poor mobility – transferred to GWMH after assessment by consultant physician in geriatrics (Dr Reid).
final illness
5.11.99 Admitted Dryad, assessed by dr Barton 'Barthel ?4' 'Plan Get to know. In view of PMH of recurrent SOB, aspiration and Ca Larynx, not for resuscitation, heroics (I think this is the word, but not clearly written). Please make comfortable. I am happy for nursing staff to confirm death' JAB 9.11.99 Seen SLT – advice re feeding
drugs1
Oramorph as required was written up 5.11.99, although none was given. Diamorphine in N saline written up 9.11.99, 3 doses given. Diamorphine sc 20 mg on 10.11, and 40mg twice on 11.11.99. Also hyoscine 400ug one dose and medazolam 20 mg one dose, 40 mg two doses given (over 2 days).
comment1
The reason for the deterioration before death is unclear. The use of an alternative to nebulised diamorphine might have been considered. No investigation is reported. The decision against 'heroics' appears to have been followed. This may have been a reasonable decision since the patient did have significant disability. However the original reason for admission was to see if he could be mobilised sufficiently to return home (Dr

ID
12
PMH
1996 – DU Admitted QAH with dehydration, diarrhoea and vomiting; dementia, needs two to transfer, gross lower limb oedema, abdominal aortic aneurysm, left parotitis.
final illness
Transferred to Daedalus for a period of assessment and to consider options for discharge. 31.3.99 – assessed by Dr Barton. History noted 'Plan get to know, make comfortable, I am happy for nursing staff to confirm death. JAB' 6.4.99 – deterioration over weekend on ss analgesia, more comfortable, and has visited. Please make
drugs1
The nursing notes indicate that codydramol was refused on 1.4.99. Oramorph 5-10mg was started 31.3.99 (Dr Barton prescribed) diamorphine 4.4.99 20mg/day, rising to 40mg/day by 7.4.99 Hyoscine 4.4.99, and medazolam 4.4.99 20mg/day.
comment1
The patient was a frail lady with poor mobility and some dementia, although she did not have a specific terminal disease such as cancer. The reasons why her condition deteriorated are uncertain, and were not investigated. It should be noted that she was originally admitted for assessment.

ID
13
PMH
Past history of DU, depression, angina, psoriasis, osteoporsis. 25.5.99 admitted Haslar, fractured neck of femur – right hemiarthroplasty; has confusion and dementia (Alzheimer's); requires help with washing & dressing, 2 nurses for transfers. Very frail, transfer to GWMH to 'see how she gets on' (Dr Tandy, consultant geriatrician). Medications on transfer were: nitrazepine
final illness
11.6.99 Nurses record notes she was tearful and in pain when moved, on admission. Started on Fentanyl patch and oral oramorph – settled and slept long periods. 13.6.99 – nurses note in considerable pain when moved, crying out; unable to swallow oramorph – syringe driver commenced
drugs1
Oramorph written up and started 11.6.99, but on as required basis. Fentanyl written up 11.6.99, regular dose. Diamorphine 13.6.99 30mg, 14.6 x2, 16.6 30mg, x2; medazolam 10-30mgs from 14.6.9. Also hyoscine from 15.6.99.
comment1
The patient was disabled, and in pain. Alternative medication would have included not opiate analgesia, supplemented by intermittent use of opiates if necessary when pain was severe. The commencement of regular opiates at an early stage suggests an early acceptance of impending death.

ID
14
PMH
Recent admissions for chest infections (QAH); breast cancer with fungating mass left breast; past bilateral hip replacements, confused. CT scan did not show metastases (?cerebrals can)
final illness
14.5.99 - Transferred to Daedalus, assessed by Dr Barton 'Please make comfortable .... Adequate pain relief. I am happy for nursing staff to confirm death. JAB' 27.5.99 – seen by Dr Dubaois, oncology. The ulcer had reduced in size since megesterol had been started. 28.5.99 – 'not comfortable on MST 30mg. Suggest Fentanyl analgesia. Please make comfortable. JAB'
drugs1
Oramorph prescribed (JAB) 14.5.99 for use as required. Also written up for diamorphone, hyoscine & medazolam as required, but not given. Fentanyl 28.5.99, MST 20mg 14.5.99, 30 mg 21.5.99.
comment1
This patient did have advanced breast cancer, and was frail. Management was appropriate.

ID
15
PMH
1997 – leg ulcer 1995 – postmenopausal bleed 1972 – L hemiplegia 4.5.99 – admitted after a fall, swollen right hand, oedema & left leg ulcer; Confused
final illness
17.5.99. Transferred to Dryad continuing care. Assessed by Dr Barton. Poor mobility & leg ulcer; newly diagnosed diabetes mellitus. Plan: stop antibiotics, monitor diabetes, assess mobility, talk to family. 5 - 6 consultations with another doctor – improved mobility 28.6.99 – deteriorated, dependant, agitated ?UTI
drugs1
Oramorph as required written up by JAB 18.5.99, started 27.6.99. Diamorphine 20mg/day sc 2.7, 3.7, 40mg 4.7. also hyoscine 400-800ug and midazolam 20-40 mgs.
comment1
The reason for the patient's deterioration is not clear, but this course of illness is not uncommon in an old person with multiple conditions. Management was essentially conservative, and the deterioration of 28.6.99 was not investigated in depth. This was probably a reasonable plan.

ID
16
PMH
1983 – fractured R femur 1985 – fracture R humeral head 1988 – cataract extraction 1992 – pernicious anaemia
final illness
Admitted GWMH with postural hypotension, depression & falls, 7.5.98. Also poor mobility, urinary incontinence. Not confused. Admitted following assessment by Dr Lord in patient's sheltered accommodation. 7.5.98 – nursing notes record bruising R shoulder, constipated 8.5.98 – commenced on regular oramorph
drugs1
Coproxamol given 7.5.98; Oramorph 5-10mgs, then diamorphine sc 40mg over 24hrs set up 9.5.98, with hyoscine and medazolam.
comment1
The records do not fully disclose the reasons for the clinical decisions that were made. The resort to opiates appears to have been rapid, and the patient deteriorated quickly after starting oramorph.

ID
17
PMH
TIA Alzheimer's Admitted to QA 16.3.98 following recent TIA and general deterioration – reduced mobility, incontinent, more anxious, pain that cannot be localised. No real change in her condition. CT scan indefinite, but possibility of a
final illness
26.3.98 – assessment by Dr Barton. 'Plan get to know, see family, TLC. JAB'5.5.98 – 'further deterioration in overall condition, can't swallow medication, therefore now for sc analgesia make comfortable JAB' 5.5.98 Dr Banks reviewed – now on driver, not swallowing, seems very settled non-rousable. The nursing notes confirm death on 6.5.98, 0.40
drugs1
Diamorphine 40mg 5.5.98 one dose only, with midazolam 40mg; fentanyl 25mg patch 3.5 confirmed.
comment1
Dr Barton's remark prior to starting fentanyl is worrying. The patient then declined further, and was started on sc diamorphine – but there was no specific diagnosis before this series of events was put in train.

ID
18
PMH
1.2.1998 – brain stem stroke, atrial fibrillation; assessed by Dr Tandy, consultant physician in geriatrics, and transfer to Gosport Slow Stream Stroke (Daedauls) arranged.
final illness
16.2.1998 – assessed by Dr Barton. Catheterised, transfer with 2. Barthel 2. 'Plan get to know. Family ... well, religious and feel that no active intervention should be considered. They are very keen for her to go to Tudor Lodge Annexe ....physio and OT see and reassess. I am happy for nursing staff to confirm death. JAB' 17.2.98 – seen by speech and language therapist
drugs1
Oramorph 23.2 10\mg x 2, 24.2 10mg x2.Diamorphine 20mg 24.2, 30mg at 18.30 on 24.2. Also hyoscine and midazolam.
comment1
Management was appropriate – the patient was quite disabled, developed a chest infection, and treatment decisions were carefully discussed with the family.

ID
19
PMH
Past total hip replacement L 1997 - # L hip, DHS, developed pulmonary embolus OA knees and hips CVAs x2
final illness
Admitted QAH – idiopathic megacolon, persistent diarrhoea, poor mobility, pressure sore, congestive cardiac failure, COPD. Kingsclere suggested for rehabilitation. 29.5.98 - Transferred to Dryad ward. Assessed by Dr Barton. 'daughter lives in Devon. In previous interview knows poor prognosis. Not for resuscitation or transfer to acute ward. Please make comfortable. I am happy
drugs1
Written up for as required oramorph, but none given. Diamorphine sc 20mg rising to 40mg/day started 31.5.98, with hyoscine and midazolam as usual.
comment1
The medical records do not contain information to enable a conclusion to be reached about the indications for sc diamorphine. The patient had been ill for a prolonged period, and curative treatment had been ruled out. Attempts at rehabilitation had not been successful. However, the record of care should have been more complete

ID
20
PMH
Senile dementia from 1996 Hemiarthroplasty 24.10.97, post op dysrhythmias
final illness
3.11.97 – transferred from Haslar to Dryad, assessed by Dr Barton. Despite recent operation, extremely mobile. Dr Banks (??) asked for advice. 6.11.97 – seen by Dr Banks. Sedation medication discussed and continued. Continued to be managed on the ward, falls, confusion, referred OT and discharge to nursing home
drugs1
Fentanyl was started by Dr Barton 21.4.98 25ug. Diamorphine, midazolam & hyoscine appear to have been written up 14.2.98, although not commenced until 15.7.98 The daily dose of diamorphine was 60mg.
comment1
It is worrying that sc analgesia should be written up on an as required basis so early. Again, the medication is written up by Dr Barton. However, care appears to have been reasonable. The reason for starting fentanyl is not fully explained.

ID
21
PMH
1998 – joint pains, seen by rheumatologist, ? CREST syndrome 5.8.98 - # left neck of femur – hemiarthroplasty; slow recovery exacerbated by angina and breathlessness. Also leg ulcers and reduced hearing. Transferred to continuing care – frail and quite unwell.
final illness
19.8.98 – admitted Dryad ward, assessed by Dr Barton. Catheterised, Barthel 6. transfers with 2. 'get to know. … rehabilitation. I am happy for nursing staff to confirm death JAB'. 21.8.98 – died peacefully at 18.25. The nursing records note: 19.8.98 11.50 c/o chest pain Oramorph given. Dr informed. Pain only relieved for a
drugs1
Oramorph was written up by Dr Barton on 18.8.98 on an as required basis, doses being given 18th and 19th. Diamorphine was written up as a regular prescription, although the date it was written up is not given. The first does was 20mg, on 19th. Doses increased to 40mg then 60 mg (one dose on 21st).
comment1
Oramorph appears to be written up for use as required for most patients on admission. The patient does not appear to have had a medical assessment prior to the commencement of opiates. The episode of chest pain was not investigated, and no clear diagnosis is recorded in the records. Whilst a myocardial infarction or pulmonary embolus are possibilities, the features recorded by the nurses are not typical, and not sufficient to

ID
22
PMH
Osteoarthritis COAD Angina July 1998 # L tib & fib – plating; determined to become independent again, s/b Dr Reid, transfer to GWMH
final illness
6.8.98 – assessed by Dr Knapman on admission. Continue medication 10.8.98 & 24.8.98 – s/b speech and language therapist 1.9.98 – variable swallowing problem, restless, obsessed with passing urine, catheter considered. 'I suggest adequate analgesia and ?heavily sedated and I need to see family JAB'
drugs1
MST was being prescribed during a hospital admission in 1996 As usual, Dr Barton has written up oramorph as required on each new drug chart. MST 60mg bd was written up (a form may be missing, the start is 11.9.98). Diamorphine, hyoscine and midazolam were written up in December, doses of diamorphine being 80mg – 160mg, rising over 5 days
comment1
Dr Lord was trying to mobilise the patient and organise discharge to a nursing home. The reason for the deterioration in health status in December is not clear, and there was a quick resort to sc analgesia – initiated by Dr Barton. Mrs Leek had certainly suffered many problems, and was making only slow progress, but whether a more careful assessment (or a record of a careful assessment) before use of a syringe driver

ID
23
PMH
Previous TIAs Hiatus hernia Retinal haemorrhage Ischaemic heart disease
final illness
Nursing record: Transferred from Guernsey Ward (?QAH) 9.11.95 following L CVA with R hemiparesis on 7.10.95, stroke extended 10.10.95 16.11.95 – extension to stroke, Dr Barton assessed, family aware, 5 mg oramorph given
drugs1
Oramorph written up by Dr Barton 16.11.95, 5mg given, 16-17.11, several doses. Diamorphine 40-80mg, midazolam 20-80, hyoscine 200ug written up on PRN basis (date of writing not indicated, no box on the form for the date). Administered once, 18.11.95, sc.
comment1
Clearly the patient has major problems following a stroke that extended at least once. The medical notes in GWMH are an inadequate record of the management of the final illness. The pattern of resort to opiates at an early stage is apparent again.

ID
24
PMH
?past problem with alcohol; little else. Admitted to QAH with R CVA; needing assistance to carry out all activities of daily living, including feeding; has to be hoisted out of bed. L arm and leg weak. Slightly chesty when transferred to GWMH, but not for antibiotics at that stage. Pain relief was paracetamol in QAH. Transferred to Gosport 20.10.95
final illness
20.10.95 – assessed in Gosport by a doctor (not Dr Barton).'Alert, well orientated. Dense L hemiparesis, restless, can't get comfortable. Plan: get to know, add night sedation – temazepam 10-20 mg nocte, coproxamol for discomfort. 23.10.95 – 'unable to transfer – needs a hoist, unable to feed or dress, now incontinent. Barthel 2, mental
drugs1
Oramorph 5-10mgs written up by Dr Barton, regular doses 26.10.95 – 29.10.95; diamorphine sc 40-80 mg 28-29.10.95, with hyoscine and midazolam.
comment1
A patient who suffered a dense stroke, admitted for long term care and rehabilitation, who was started on opiates when a problem arose.

ID
25
PMH
Parkinsons Hyperthyroidism dementia – diagnosis 1989 Admitted to QAH following fall – knocked over by another resident – # pubic ramus/acetabulum
final illness
Nursing records: Transferred from Anne Ward. 30.12.95 – appears to be in pain on slightest movement. Only on co-codamol. S/b Dr Knapman, oramorph 10mg 4 hrly started. 2.1.96 seen by Dr Barton syringe driver commenced. 3.1.95 – analgesia and midazolam increased as appears still in pain. Nephew seen by Dr Barton. Still signs of pain and agitation 4.1.95, diamorphine 120mg. Continued to deteriorate until death
drugs1
Had received pethidine in QAH for pain, but this had been stopped before transfer (probably around 17.12.95, although difficult to read writing). Oramorph was written up by Dr Knapman 30.12.95, doses being given until 7.1.96. Diamorphine 40-80mg written up by Dr Barton 2.1.95, with midazolam 120-140mg 4.1.96
comment1
Pain control clearly was a problem for this patient. However, there does not appear to have been a comprehensive assessment of the reasons for the pain, nor an attempt to use drugs other than opiates. Once the decision to start opiates was made, followed by transfer to a syringe driver, a decision that the patient is dying might be informed. The patient did have dementia, but the records do not note a detailed

ID

26

PMH

Chronic depression;
Assessed on Mulberry A by Dr Lord – Barthel 0, completely dependent, catheterised, eating little, hypoproteinaemic, for transfer to Dryad. Pressure areas poor.

final illness

5.1.96 – assessed on admission by Dr Barton. Immobility & depression
9.1.96 – 'painful R hand held in flexion, try … (illegible). Also increasing anxiety and agitation ?insufficient …(illegible). ?needs opiates JAB'
10.1.96 – seen by another doctor, most of entry is difficult to read TLC

drugs1

Diamorphine 80-120mg 11.1.96, Dr Barton, with hyoscine & midazolam. Oramorph written up by Dr Barton 11.96, given until 15.1.96

comment1

Another very ill elderly patient. Opiates were initiated when a problem arose. It is not entirely clear what the problem was, but death followed.

ID

27

PMH

L hemiparesis 1993
1996 – another small stroke
4.2.96 - # L neck of femur – repair; assessed by Dr Logan, consultant geriatrician; sacral and heel sores, flexion deformities due to rheumatoid, in pain so started on regular morphine, relatives informed that no

final illness

5.3.96 – assessed on admission by Dr Barton. Condition was clearly poor 'black heels'. 'All nursing care. I am happy for nursing staff to confirm death. I will see relatives as soon as possible JAB'
6.3.96 – 'less well, needs sc adequate analgesia I will speak to relatives JAB'
7.3.96 – 'now having 200mg diamorphine. Very comfortable' (JAB)

drugs1

No drug chart

comment1

A very frail patient – opiates would have been appropriate.

Dm
upto
250mgm

ID
28
PMH
CCF Hypothyroid Ischaemic heart disease – angina, hypertension 1995 – anteroseptal myocardial infarct – VSD
final illness
13.3.96 – assessed by Dr Barton. 'Plan gentle mobilisation ..illegible JAB' 15.3.96 – 'illegible R leg looking inflamed' (JAB) 20.3.96 – Dr Tandy (I think, writing not clear). Oedema worse, daughter feels mother has had enough. Oramorph started
drugs1
Oramorph was written up 12.3.96, by a doctor other than Dr Barton, but none is recorded as given. Dr Barton also wrote up oramorph 13.3.96 PRN, none recorded as given, but also wrote up a regular dose, and two doses given 20/21.3.96. Diamorphine sc commenced 21.3.96 40mg/24hrs plus hyoscine & midazolam. Fentanyl 25ug patch used 21.3.96
comment1
A patient with advanced and irremediable illness. A considered decision was taken that aggressive treatment would not have been appropriate. Management was appropriate.

ID
29
PMH
Admitted from Sultan ward for long term care, 9.5.94; very deaf, poor sight; uco Dr Tandy. First admitted 1993, probably had had a myocardial infarct; poor mobility, urinary incontinence; seen by Dr Severs, long term care bed arranged 'may get him to nursing home standard but no more'
final illness
Nursing notes 26.3.96 – very frail 29.3.96 nursing notes indicate oramorph commenced by Dr Barton 9.5.94 – 98 yr old transferred to Radcliffe Annexe today from Sultan Dr Lord assessed
drugs1
Diamorphine sc 10-??mg written up by Dr Barton, 23.3.96, given 30.3.96 with midazolam & hyoscine. Oramorph written up 23.3.96 and given for 5 days. Sc diamorphine was written up by Dr Barton 20.2.95 as an as required prescription although none was given at this stage.
comment1
A conservative approach would have been justified in a very old and frail patient. The management in this case was probably appropriate. A more intensive treatment of the chest infection might have been attempted, although given the general state of health, it is unlikely that this would have made any difference.

ID
30
PMH
Chorea R CVA 12.8.1996
final illness
Nursing notes: 2.9.96 – admitted from Haslar; dense Lt hemiplegia, catheterised, speech impaired, fed via naso-gastric tube, Barthel 0. 17.9.96 – quite distressed, pulling out naso-gastric tube. Dr Barton informed – to discuss with Mr Duffin. 'He
drugs1
Diamorphine 40-200mg sc written up Dr Barton 2.9.96. Started 17..9.96. Also midazolam and hyoscine.
comment1
This patient was severely ill, had undergone specialist assessment, and the management plan was discussed with the family. Management was appropriate.

ID
31
PMH
Severe mitral stenosis and mild mitral regurgitation (1994) Pernicious anaemia 1989 – MI 1993 – MI
final illness
Admitted from St Christophers (GWMH more accessible for wife); had a series of major problems during an acute admission initiated by a UTI; 15.10.96 – assessed by Dr Knapman on admission – multiple problems, continue previous treatment 16.10.96 – seen by Dr Barton. Transfer with 2 – incontinent of urine and faeces – alter and orientated, main
drugs1
Diamorphine 10mg 4 hrly PRN written up by Dr Barton (no date), but none given. Oramorph also written up by Dr Barton 18.10.96, given once on that date, and regularly until 24.10.96.
comment1
The records contain very little information about the reasons for starting opiate medication. Death was sudden, the cause being uncertain. However, the patient had advanced ishaemic heart disease and was very dependent.

ID

32

PMH

Dementia
Arthritis
Vertebrobasilar insufficiency
Deafness

final illness

16.10.96 – assessed by Dr Barton. transferred Dryad ward; Barthel 1. dementia, immobility. 'plan get to know, assess mobility, watch bowels JAB'
16.10.96 – seen by Dr Lord? For bronchodilator and treatment for skin sores
18.10.96 – Dr Barton reports discussion with daughter and grand daughter. Mother's health has deteriorated

drugs1

She had been receiving salbutamol orally before transfer. Oramorph was written up by Dr Barton on as required basis, and one dose was given (5mg), and regularly 11-12.11.96, 4 doses. Salbutamol via nebuliser written up by Dr Barton 8-12th November 3-4 per day. Diamorphine sc was written up PRN 20-100mg 12, 13, 14.11.96 with midazolam & hyoscine

comment1

The patient had multiple problems, included advanced dementia. It had been agreed that aggressive treatment would not be indicated. The use of morphine in the presence of wheeze might be questioned, although this might have been a reasonable choice at some point. It is not clear whether the opiates were [illegible] when death had become imminent and inevitable, or whether opiates had been used before this point

ID

33

PMH

20.3.99 # neck of femur, DHS R in QAH.
Advanced dementia
Assessed by geriatric specialist 14.4.97 – has deteriorated, not suitable for nursing home. ?urinary retention and pleural effusion (not confirmed on chest X-ray)

final illness

16.5.97 – assessed by Weeks (?physio) has rehabilitation potential
19.5.97 – much the same – for Gym, continue sit/stand activities
3.6.97 – unwell not for Gym
4.6.97 – died

drugs1

Coproxamol was used for a short period, and the patient was taking diazepam, paracetamol, chlormethiazole. Diamorphine sc 4.6.97 20mg used, with hyoscine & midazolam. Oramorph 5mg used once, 4.6.97.

comment1

The patient was highly dependent and had dementia and immobility. Dr Barton decide that active treatment was not indicated when he became more unwell – 'I think Basil should be made comfortable'.

I think X should be made comfortable. No aggressive treatment

ID
34
PMH
NIDDM on diet Atrial fibrillation 1981 – partial gastrectomy 1989 – polymyalgia
final illness
3.6.97 - Admitted from FI ward QA, nursing notes indicate failed to settle 0200, restless and agitated midazolam 20mg given via syringe driver over 24hrs. Needs assistance with all aspects of daily living. 4.6.97 – condition appears to have deteriorated over night – remains restless. Seen by Dr Barton, syringe driver charged with diamorphine 20mg, Midazolam 40mg
drugs1
Diamorphine sc 20-100 mg 4.6.97 written up by Dr Barton, 20mg given; also hyoscine and midazolam.
comment1
The reason for the deterioration of the elderly and frail lady after admission to GWMH is obscure, and little effort was devoted to investigation.

ID
35
PMH
Alpha 1 antitrypsin deficiency _ airways obstruction & emphysema 1981 - Ca prostate 1982 – epileptic fit Frontal lobe tumour
final illness
5.3.97 – assessed on Dryad by a doctor other than Dr Barton. Management was discussed with the patient's daughter. 19.3.97 – improved, no specialist medical or nursing needs, may consider placement. (not Dr Barton) 2.4.97 – starting to deteriorate – diazepam & oramorph (not Dr Barton)
drugs1
Oramorph written up by Dr Barton as required, one dose given, date not legible; then regular oramorph 5mg three daily and 10mg at night from 2.4.97. Diamorphine sc , fentanyl, hyoscine and medazolam written up by Dr Barton, although none administered. The diamorphine and midazolam that was given was written up by another doctor, presumably Dr Davies, 5.4.97
comment1
Dr Barton writes prescriptions in advance as is often the case. The care of the patient was, however, appropriate.

ID
36
PMH
1977 - # R hip 1993 – haematemsis – oesophageal ulcer 1995 – Epilepsy secondary to CVA Congestive cardiac failure
final illness
25.2.97 – transferred to Dryad ward. For TLC (signature not clear) 27.2.97 – 'family need to be seen on WE. Make comfortable. I am happy for nursing staff to confirm death JAB' 5.3.97 – comfortable, pain free. On diamorphine/midazolam (?Dr Hutchinson)
drugs1
Diamorphine sc 40-200mg, hyoscine, midazolam all signed by Dr Barton. Treatment started 5.3.97. Oramorph signed by Dr Barton started 4.3.97
comment1
This elderly patient was severely ill. Management appears reasonable, although more details should have been recorded in the notes.

ID
37
PMH
NIDDM 1995 – cellulites 1996 – L hemiparesis AF
final illness
25.1.96 – transferred to Daedalus; assessed by Dr Barton. 'main problem mobility' Barthel 0-1. short term memory gone. 29.1.96- seen by Dr Lord. 12.2.96 – seen by Dr Lord, if Barthel 4 or better, for nursing home, if not, for long stay
drugs1
Diamorphine 40-200mg, midazolam & hyoscine written up by Dr Barton on the early drug charts routinely for as required use, but not used until 3.3.97, 20-40 mg of diamorphine in 24hrs.
comment1
Management was appropriate.

ID
38
PMH
1996 - L shoulder hemiarthroplasty following #, recovering reasonably well January 1997. NIDDM (diet) Renal failure L radial nerve palsy
final illness
Prolonged stay in acute hospital following shoulder surgery, numerous problems, prognosis regarded as poor. 18.2.97 – urea 47.4, creatinine 548, Na 164
drugs1
Oramorph PRN written by Dr Barton, not given. Regular treatment prescribed 20.2.97 2 doses given. Diamorphine sc 40-200mg with midazolam & hyoscine written up by Dr Barton, used for 1 day only.
comment1
The patient had received intensive inpatient treatment over a long period of time, and was severely ill. The management in GWMH was appropriate, although the records were not completed.

ID
39
PMH
1988 – ca cervix, radiation therapy 1993 - depression cystectomy Carotid artery stenosis
final illness
13.1.97 – transferred to Daedalus ward. Assessed by Dr Lord, ct NG feeding; speech and physio therapy, prognosis poor. 20.1.97 – pulled out tube, actrapid started. See family ?PEG. 22.1.97 – cough, erythromycin
drugs1
Oramorph written up by Dr Barton PRN as usual, none given, otherwise no opiates.
comment1
Management was appropriate.

ID
40
PMH
Seen by Dr Hutchinson, consultant geriatrician, in Haslar – dense L hemiparesis, urinary incontinence, dysarthria, LVF/AF, left arm embolus, deranged LFTs, sodium 123. Put on list for slow stream stroke rehab at Gosport
final illness
27.1.97 – assessed on admission, not by Dr Barton, handwriting not recognised. Continue warfarin 31.7.97 – 'sat out yesterday requires help to feed and dress, ... doubly incontinent, Barthel 0, daughter to ..??? JAB' 3.2.97 – seen by Dr Lord, stop heminevrin. Long discussion with daughter: agree that warfarin is
drugs1
Oramorph written up by Dr Barton started ?3-4/2/97, 2-3 doses; diamorphine sc 40-200 mg started 9.2.97, with hyoscine and midazolam, for one dose.
comment1
The indications for active treatment were reviewed by a specialist; the patient started opiates soon after.

ID
41
PMH
Pacemaker 1994 - Vascular dementia deaf 1997 – admitted QA, generally unwell, difficulty feeding, transferred to Dryad
final illness
Nursing notes: 22.9.97 – admitted from QAH 29.9.97 – relatives seen by DR Lord – distressed by the information on poor prognosis, told staff would try as long as they could
drugs1
Oramorph written up by Dr Barton, not used. Diamorphine sc injection – not used; diamorphine sc 20-200mg written up one dose given, also midazolam & hyoscine (Dr Barton). Fentanyl started 30.9.97, Dr Barton.
comment1
Again, medical notes incomplete. In view of the advanced dementia, active treatment would have been inappropriate, although whether opiates were required is difficult to judge.

ID
42
PMH
MS from 1950s. Long resident in continuing care 1993 – admission to GWMH for holiday care, then several admissions during year for respite, deteriorated at admission Feb 1994 – not discharged – accepting of long stay by May 1994
final illness
drugs1
Oramorph written up by Dr Barton from June 97, 5mg x3 in the day, 10mg at night, with dose increasing. Diamorphine sc also written up by Dr Barton, and Fentanyl
comment1
The patient received palliative care. A specialised neurology unit might have been a more appropriate placement. However, the patient had very advanced MS and more active treatment would not have been appropriate.

ID
43
PMH
1995 - Acute on chronic renal failure NIDDM Old CVA 1992 Glaucoma I
final illness
9.12.97 – (nursing notes) Admitted – catheterised, pain in legs ?neuropathy, reduced mobility, renal problems, pressure areas, NIDDM, given oramorph for pain. Medical notes: 9.12.97 – admitted to Daedalus; assessed on admission by Dr Knapman – at treatment
drugs1
Oramorph by Dr Barton, used 4 hourly; also diamorphine sc 20-200mg 10.12.97, 2 does used, with hyoscine and midazolam
comment1
A seriously ill patient with multiple difficult and deteriorating problems. The decision to begin sc diamorphine is not discussed in the medical notes. Management may have been appropriate, but alternative options are not recorded as considered.

ID
44
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 – c/b Dr Barton co trimoxazole for 5 days
drugs1
Haloperidol signed by Dr Barton, starting in June
comment1
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.

ID
45
PMH
COPD CCF angina Osteoarthritis – fixed flexion of hips
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
drugs1
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, 10.11.88, 2 doses given before death
comment1
A very dependent patient, who gradually became worse despite treatment. Management appears appropriate.

ID
46
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 20.12.88 – assessed by Dr Barton on admission: not oriented
drugs1
2.11.89 appears in pain when moved atropine and diamorphine 10mg IM given 4-6 hrly; syringe driver started with 40mg diamorphine
comment1
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.

no prediy and opiate

ID
47
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
drugs1
The drug chart was not available on the microfiche copy of the records.
comment1
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.

ID
48
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
drugs1
Drug chart not available
comment1
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.

ID
49
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'
drugs1
No drug chart
comment1
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.

ID

50

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:

drugs1

No drug chart

comment1

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.

ID

51

PMH

1923 - appendicectomy
1941 - # L hip
Congestive cardiac failure
Parkinsons

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)

drugs1

No drug chart

comment1

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.

ID
52
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
drugs1
None available
comment1
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

ID
53
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; 22.7.93
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
drugs1
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
comment1
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

ID
54
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
drugs1
No chart
comment1
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.

ID
55
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 Redcliffe, 1.4.91 – c/h Dr Barton swelling R wrist. On MST 10mg for pain
drugs1
No drug chart
comment1
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.

ID
56
PMH
1942 – pulmonary TB 1983 – hyperosmolar coma 1985 – hypoglycaemic treatment stopped 1989 – falls, reduced mobility
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
drugs1
Drugs The 1991 drug chart was not in the microfiche records
comment1
It is impossible to determine what occurred in this case.

ID
57
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 ever as I cannot see him ever returning to
drugs1
No 1991 drug chart
comment1
Again, exactly what happened is not documented. He was certainly very ill.

ID
58
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 e/h Dr barton to commence syringe driver. Diamorphine 40mgs
drugs1
No chart. Diamorphine was given according to the records
comment1
Care could well have been appropriate, the records do not contain sufficient detail to be clear (gaps between entries, brief entries, no firm diagnoses).

ID
59
PMH
1989 Ruptured aortic aneurysm COAD / asthma Left hemiparesis Bilat. pneumonia
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
drugs1
No drug chart. Was given opiates
comment1
This patient had several major illnesses, and became ill, frail and jaundiced. Management appears appropriate.

ID
60
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'
drugs1
No drug chart
comment1
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.

ID
61
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
drugs1
No drug chart
comment1
Clearly a very ill patient; it is not clear what happened to lead to death

ID
62
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'.
drugs1
No drug chart
comment1
The patient was probably terminally ill on admission, and management was appropriate.

ID
63
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
drugs1
No chart, but received opiates
comment1
Appears to have had a cerebral tumour at the root of the CVA; management appears reasonable.

ID
64
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, at actrapid sc; oramorph before dressings, NSAID elixir
drugs1
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?).
comment1
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.

ID
65
PMH
Appendicectomy Repair, bilateral inguinal hernia, 1979 Dilation of urethral stricture, 1987 Atherosclerotic Parkinsons with dementia
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
drugs1
No chart
comment1
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).

ID
66
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
drugs1
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.
comment1
It would appear that the CVA was quite severe, although details are not clear. An elderly patient with multiple problems.

ID
67
PMH
MI, 1989 Mitral, tricuspid and aortic regurgitation 1992 – admitted for control of increasing cardiac failure; followed up by Dr Lord in Outpatients, gradually getting worse during 1992/3
final illness
Admitted for treatment of CCF, sacral sore, incontinence, increased dependency, Daedalus ward 8.6, after assessment by Dr Lord 8.6.93 assessed on admission by Dr Barton 17.6.93 c/h Dr Lord. CCF not under control – metolazone
drugs1
Oramorph written up by Dr Barton as required, not given. Diamorphine 40mg sc, Dr Barton, 21.7.93, one dose given, with hyoscine, midazolam
comment1
A frail man, getting gradually worse; the reason for the decline in the few days before death is not clear.

ID
68
PMH
March 1993 – pre-renal failure, fall. UTI, old MI, pressure sores Dementia Breast lump, Barthel 3, depression – admitted Phillips ward
final illness
Nurses notes; Admitted from F4 12.11.93. ?CI, confused.; 16.11.93, not for active treatment, to be referred to Redclyffe; 19.11.93 s/b Dr Lord, transfer to Gosport tomorrow. . 22.11.93 admitted from Phillip ward. 26.11.93 consistently refused medication, extremely agitated and distressed, pain all over. Discussion between Dr Barton and nursing staff concluded that analgesics via syringe driver would be best. Mrs Shea
drugs1
Diamorphine 40mg sc one dose 26.11.93, written up 22.11.93 (on admission), plus hyoscine and midazolam.
comment1
A patient with advanced illness; active treatment was ruled out.

ID
69
PMH
1983 – OA hip, cerebral atherosclerosis 1988 – poor hearing 1992 – shared care admissions to Redclyffe dementia
final illness
1993 – gangrene due to arterial disease – MST; letter from Dr Lord explaining that amputation would be difficult, does not expect patient to survive long. 15.12.93 –'transferred to long stay Daedalus. Very poorly gangrenous foot grazed sacrum very deaf BO today all nursing care if cannot cope with oral fluids may need sc analgesia IAB'
drugs1
Oramorph 10mg 4 daily, 20mg at night Dr Barton, 15-19.12; diamorphine 80mg sc 20.12, with midazolam and hyoscine; 40mg with hyoscine & midazolam sc 18-19.12.93
comment1
Severely ill; management appears appropriate.

ID
70
PMH
1994 - #Rnof -hemiarthroplasty December 1994 #ribs following fall, chest infection, Parkinson's?, AF, transferred to Daedalus for rehabilitation
final illness
8.12.94 admitted GWMH, assessed by Dr Barton 9.12.94 – n incontinent, needs a catheter, not eating or drinking illegible analgesia, 10.12.94 may need sc fluids JAB 11.12.94 – pyrexial refusing to take medication. Comfortable, no pain. Looks as though she has had enough
drugs1
Oxycodone suppose, Dr Barton, bd, written up 9.2.94, started 11.12.94. Also diamorphine sc 40 mg written up 10.12.94, given 13.12.94 once, with hyoscine & midazolam
comment1
A highly dependent patient, who deteriorated.

ID
71
PMH
1994 – incontinence 1994 - arthritis
final illness
Admitted to redclyffe long standing dementia treated at Knowle hospital, ?CVA, dementia, sacral pressure sore, 14.9.94 14.9.94 – 'transferred to Redclyffe annexe long stay pleasantly demented, hasn't ... yet, recognises Lynne, catheterised 1.9.94 incontinent small sore on sacrum small blister on heel, needs hoist to transfer, IAB'
drugs1
Written up for diamorphine sc 40mg on 16.9.94 by Dr Barton, given 9.10.94 with midazolam & hyoscine. Also written up for oramorph
comment1
The records are limited. The events that precipitated death are rather unclear.

ID
72
PMH
1994 – admitted with confusional state, dementing process since February 1994 1994 – collapse ? cause, # nof 'unlikely to rehabilitate and I will put her on the long stay list'. Had arthroplasty
final illness
13.9.94 – 'transferred to Edclyffe Annexe # R neck of femur 28.8.94 sacral pressure sore catheterised notes not available all nursing care JAB' 5.10.94 gradual deterioration over last few days sc analgesia commenced yesterday died 13.10 for burial JAB'
drugs1
Oramorph written up 25.9.94, given 25-5.10.94; diamorphine written up 30.9.94, 40mg given 5.10.94
comment1
A very elderly and dependent patient who had a fractured hip, the advisability of surgery was debated; she deteriorated after transfer to Redclyffe.

ID
73
PMH
Severe dementing illness fits 1994 – subtrochanteric # r femur - DHS
final illness
September 94 – s/b orthopaedic surgeon, failing to mobilise. Further surgery and even X ray ruled out as would cause distress in view of mental state. 14.9.9.4 – remains poorly .. husband nor accepting needs to be seen pain relief controlled on oramorph JAB'
drugs1
Diamorphine sc 40mg written up Dr Barton 16.9.94, given 29.9.94, also midazolam & hyoscine. Oramorph written up 12.9.94 Dr Barton given from 13.9
comment1
A frail patient, who was not expected to improve following her hip fracture. Management appears appropriate, in general.

ID
74
PMH
1966 – jaundice 1969 –R THR 1978 – hemigastrectomy 1983 – hypertension
final illness
Admitted by Dr Lord to acute ward for investigation; hepatic encephalopathy; ascites and raised INR, not for biopsy at present – cirrhosis ?cause, transferred to GWMH 3.6.94 – transferred to Daedalus, transfers with 2, poor eyesight and hearing, feeding herself, catheterised incontinent of bowels barthel 2 'AB'
drugs1
Diamorphine 40mg sc written up 29.6.94, but not given
comment1
Notes thin, but care appears to have been appropriate.

ID
75
PMH
1993 – progressive CVA
final illness
Nursing notes 13.3.94 is in obvious pain, to commence oramorph at 18.00. Use of syringe driver discussed with daughter and she is in agreement. 14.3.94 – syringe driver commenced 40mg diamorphine Medical notes 26.1.94 Transferred from OA, assessed by Dr Barton; consultations with speech therapist, Dr barton, Dr
drugs1
Oramorph written up 7.3.94, continued until 14th; diamorphine 40 mg sc written up 12.3.94, started 14th, with hyoscine & midazloam.
comment1
Again, notes limited.

ID
76
PMH
Feb 1994 – Thompson arthroplasty for # L hip
final illness
16.2.94 – transferred to Daedalus; seen by Dr Barton. For long stay 28.2.94 ' not doing much at all., legs contracted not weight bear feeds hislef occasionally, incontinent with catheter JAB' 28.2.94 Dr Lord – discussion re family. They had expected intense physio and individual nursing care – but
drugs1
Diamorphine written up 16.1.94, signature \not clear. 2.5-5mg IM as required. Given 2-3 per day
comment1
The reason for starting the syringe driver is not recorded.

ID
77
PMH
PMH 1991 - deafness
final illness
Nursing notes 17.1.94 Transferred from Haslar, #nof, L DHS.Then R CVA 27.12.93, needs help with all ADLs. 20.1.94 general condition deteriorating, in considerable pain – oramorph. 21.1.94 – diamorphine started 17.1.94 assessed by Dr Barton
drugs1
Oramorph written up 19.1.94, given 18??-21st. Diamorphine sc 40 mg written up 21.1.94, started 21.9.94 (Dr Barton). Also hyoscine & midazolam.
comment1
CVA plus # hip – management generally reasonable.

ID
78
PMH
1951 – Fothergills repair 1962 – hypertension 1982 – cholecystectomy 1986 – bladder cancer, alveolitis
final illness
1995 – admitted acutely, haemtemsis & abdo pain – carcinomatosis, primary unknown. Transferred to Daedalus for palliative care. Admitted there 26.1.95 – assessed by Dr Barton 'may need sc analgesia JAB' 30.1.95 s/b Dr Lord. On diamorphine 31.1.95 'family with her. So diamorphine continued. Comfortable. JAB'
drugs1
I could not find the relevant drug chart, but the sequence of events is reasonably clear.
comment1
Appropriate care.

ID
79
PMH
Rheumatic fever Parkinsons 1978 # femur 1992 R CVA 1993
final illness
Nursing records: 22.6.95 admitted from QA 'poorly lady' dense R CVA, L hemiplegia, 'if appears to be in any pain to have oramorph'. 26.6.95 condition poor s/b Dr Barton syringe driver commenced, diamorphine 40mg Medical notes 22.6.95 'transferred to Druid ward long stay care. Dense R eye and L hemi old parkinsons. # ne femur
drugs1
Oramorph 22.6.95, Dr Barton, as required, one dose given on 23.6; diamorphine sc 40mg 22.6.95, given once 26.6.95, with hyoscine, midazolam; also regular paracetamol from 23rd
comment1
Certainly a very disabled patient. It is difficult to judge from the records whether the opiates were begun early – 2 months after the last stroke.

ID
80
PMH
1988 – through knee amputation R Parkinsons
final illness
13.8.93 'transferred to Daedalus for long stay main problems COAD, amputee, Parkinsons disease, bowels x2 today JAB' various entries, then 4.6.95 'new passed urine + clots. Start trimethoprim, push fluids JAB'
drugs1
Oramorph 25.6.95 Dr Barton, one dose given; diamorphine 40mg 28.6.95 one dose, with hyoscine and midazolam
comment1
A long stay patient with extensive disabilities; a decision was taken not to investigate actively a sudden decline in health. This was probably a reasonable decision.

ID
81
PMH
1989 – TIA 1993 - CCF 1994 - Ca l breast AF
final illness
1.12.94 – transferred to long stay Redclyffe – cva .. November, now pressure sores' Barton 22.12.94 – 'chat with next of kin. General feeling that chest infection etc should not be treated. BS consistently low, therefore no oral hypoglycaemics. All nursing care and sc analgesia if indicated. JAB' 17.8.95 R shoulder painful 2/2 X-ray everything otherwise very vague JAB'
drugs1
Diamorphine 40mg written up 8.9.95, 8-11th, 80mg from 12th & 13th, the 120mg to 19.9.95, then 160mg to 25th, with midazolam; oramorph written up 5.12.94, given until 7.9.95. {Diamorphine was also written up as required 13.3.95, but not given]
comment1
Clearly a disabled patient, with multiple problems. The management appears reasonable, although the precise explanation for the terminal deterioration is not clear.

ID
82
PMH
Temporal lobe epilepsy Marked infarct dementia 1980 aortic valve replacement 1993 TURP
final illness
Nursing notes 20.11.95 seen by Dr Barton to commence oramorph 6hrly for relief of neck pain 21.11.95 very chesty condition deteriorating unable to take diet or medication 22.11.95 syringe driver commenced diamorphine 40mg; died 6.15
drugs1
Oramorph written up by Dr Barton 21.11.95, and given; as required had been written 21.8.95, given from 20.11.; diamorphine 40mg with midazolam & hyoscine given 22.11 (date of writing up not on chart as in the PRN section).
comment1
A patient with significant illness, who had had a long inpatient stay; the problem that precipitated the final decline is not clear.