Case Study 4 – Gladys Richards summary

Patient story

In 1998, Gladys Richards was aged 91 and was resident in a nursing home. By February 1998, she had been diagnosed with severe dementia. In May, Mrs Richards was described as *"withdrawn and anxious at times"* but as being settled most of the time. Mrs Richards wore pads for incontinence, had hearing difficulties, required help with washing and dressing and needed encouragement and help to eat. She would usually sleep through the night but at times would get up and wander. Mrs Richards' daughters and granddaughter were heavily involved in her day-to-day care and visited her daily at the nursing home. By July, Mrs Richards had a six-month history of falls at the nursing home and her daughters were unhappy with the care she was receiving.

On 29 July, Mrs Richards fell and fractured her right neck of femur. She was admitted to the Royal Hospital Haslar ('Haslar Hospital'), where she underwent a partial hip replacement. On 11 August, Mrs Richards was admitted to Gosport War Memorial Hospital ('the hospital') for rehabilitation. On 13 August, Mrs Richards fell and dislocated her right hip. On 14 August, she was transferred to Haslar Hospital where the dislocation was treated. On 17 August, Mrs Richards returned to Gosport War Memorial Hospital where she remained until she died on 21 August.

Care received

Following surgery at Haslar Hospital, Mrs Richards was able to move her left leg quite freely, appeared to have a little discomfort on passive movement of the right hip, and had been sitting out in a chair. On 5 August 1998, Dr Richard Ian Reid concluded that *"despite her dementia she should be given the opportunity to try to re-mobilise"* and confirmed that he would arrange Mrs Richards' transfer to Gosport War Memorial Hospital.

Mrs Richards was transferred on 11 August. She was now fully weight bearing; however, she was walking with the aid of two nurses and a Zimmer frame. Mrs Richards needed total care with washing and dressing, eating and drinking. She had a soft diet and enjoyed a cup of tea. Mrs Richards was occasionally incontinent; if she was fidgety and agitated it meant she wanted the toilet. Her recommended drug treatment on transfer to the hospital was haloperidol suspension, lactulose and co-codamol.

Dr Jane Barton saw Mrs Richards on her admission to the hospital. She noted that Mrs Richards had been transferred for continuing care and was a frail, demented lady. Dr Barton wrote in the records: *"not obviously in pain please make comfortable … I am happy for nursing staff to confirm death."*

Dr Barton wrote a prescription for morphine oral solution 2.5–5 ml (5–10 mg morphine) every four hours as required, and diamorphine 20–200 mg, hyoscine 200–800 micrograms and midazolam 20–80 mg to be administered by subcutaneous infusion over 24 hours. On 12 August, Dr Barton wrote further prescriptions for morphine oral solution 2.5–5 ml (5–10 mg morphine) every four hours and 5 ml (10 mg morphine) in the evening as required. Three doses of morphine oral solution 10 mg were administered to Mrs Richards on 11 and 12 August. On the evening of 12 August, Mrs Richards was drowsy, had difficulty settling for the night and was agitated, shouting and crying but did not seem to be in pain.

In relation to the prescriptions, Dr Barton stated in an interview with Hampshire Constabulary in July 2000:

> "[Mrs Richards] was pleasant and co-operative on arrival and did not appear to be in pain. Later … [she] was screaming … In my opinion it was caused by pain … Given my assessment that she was in pain I wrote a prescription for a number of drugs on 11th August, including oral morphine solution and diamorphine."

During the 2009 General Medical Council (GMC) Fitness to Practise (FtP) hearing, Dr Barton stated:

> "The snapshot view that I gained … was that she was not obviously in pain; but [given her recent surgery] I was minded to make available to the nurses a small dose of oral opiate in order to make her comfortable during that time … I felt [her] general outlook was poor. She was quite possibly going to need end of life care sooner rather than later."

In relation to the notes she made, Dr Barton also told the police:

> "[Mrs Richards] was probably near to death, in terms of weeks and months from her dementia before the hip fracture supervened. Given [her admission and surgery] I appreciated that there was a possibility that she might die sooner rather than later. This explains my reference at that time to the confirmation of death, if necessary by the nursing staff."

In 2009, Dr Barton told the FtP hearing:

> "That was a routine entry I made into the notes of patients who might at some time in the future die on the ward [so that] … nursing staff … did not have to bring in an out of hours duty doctor to confirm death … it did not signify at that time I felt that she was close to death; it was a fairly routine entry in the notes."

At 13:30 on 13 August, Mrs Richards was found on the floor. No injury was noted at the time. By 19:30 she had pain and morphine oral solution was later administered. No other action was taken in respect of Mrs Richards' condition that evening. The next day, Mrs Richards was still in pain. Morphine oral solution was administered to her and an X-ray revealed that her right hip was dislocated. Following discussion between Dr Barton and the clinician at Haslar Hospital, Mrs Richards was transferred back to Haslar Hospital where the dislocation was treated under sedation. The procedure was uneventful and Mrs Richards remained in Haslar Hospital for two days.

On 17 August, Mrs Richards was transferred back to Gosport War Memorial Hospital. She had been given a canvas knee-immobilising splint which was to stay in place for four weeks. Haslar Hospital advised that Mrs Richards could *"mobilise fully weight bearing"* and that, when she was in bed, it was advisable to encourage abduction by use of pillows or a wedge. Haslar Hospital made it clear that there would be *"no follow up unless complication".* Mrs Richards arrived at Gosport War Memorial Hospital in pain and distress. She had been transferred by the ambulance crew on a sheet rather than on canvas. Mrs Richards was given four doses of morphine oral solution between 13:00 and 20:30.

In the early hours of 18 August, Mrs Richards was still in pain and two further doses of morphine oral solution were administered to her. Dr Barton assessed Mrs Richards in the morning and noted, *"still in great pain, nursing a problem I suggest s.c. diamorphine / haloperidol / midazolam … please make comfortable".* She wrote another prescription for diamorphine 40–200 mg over 24 hours.

In July 2000, Dr Barton told the police that there was a lot of swelling and tenderness around the area of Mrs Richards' prosthesis, that in her assessment Mrs Richards had *"developed a haematoma or a large collection of bruising around the area where the dislocated prosthesis had been lying whilst dislocated",* and that this was in all probability the cause of Mrs Richards' pain. Dr Barton stated her view was that *"this complication would not have been amenable to any surgical intervention"* and that transfer to Haslar Hospital was not in Mrs Richards' best interests.

In 2009, Dr Barton told the FtP hearing:

> "I knew that nothing surgically could have been done for this condition and that it would just have to be allowed to heal in its own time, if her condition permitted and she remained well enough … I did not feel that a transfer back to an acute unit at that point was in [Mrs Richards'] interests. She probably would not have even survived the journey back, so we had to continue on our route of palliative care, becoming terminal care."

On 18 August, at 11:45, the administration of diamorphine 40 mg, haloperidol 5 mg and midazolam 20 mg was commenced by syringe driver. The daily administration of these drugs, plus hyoscine, by syringe driver continued until 21 August, when Mrs Richards died.

Panel comments

11 and 12 August 1998

- Morphine oral solution, and diamorphine, midazolam and hyoscine were prescribed in high and very wide dose ranges.
- The Panel has not found any document in the medical records to show that morphine oral solution, and diamorphine, midazolam and hyoscine were clinically indicated.
- The Panel has not found any document in the medical records to show Dr Barton's rationale for prescribing morphine oral solution, diamorphine, midazolam and hyoscine.
- Dr Barton did not record any of the explanations she gave to Hampshire Constabulary, or the GMC FtP hearing, in Mrs Richards' clinical notes at the time of her assessment.
- It is not clear from the medical records why Dr Barton requested that Mrs Richards be *"made comfortable"* (be treated palliatively) and noted that she was *"happy for nursing staff to confirm death"* in circumstances where Dr Reid had decided Mrs Richards should be given the opportunity to remobilise.
- The Panel has not found any document in the medical records to confirm that Mrs Richards was screaming as if in pain on 11 or 12 August.
- It is not clear to the Panel why Dr Barton did not discuss her differing views and prognosis with the consultants at Gosport War Memorial Hospital and Haslar Hospital, or with any members of Mrs Richards' family.
- The Panel has not seen any document in the medical records to confirm that nurses scrutinised, questioned, challenged or refused to administer the proactive and wide dose range prescriptions of morphine oral solution, diamorphine and midazolam.
- The Panel has not seen any document in the medical records to show the nurses' rationale for administering three doses of morphine oral solution and for choosing a 10 mg starting dose, which was the highest dose in the range prescribed by Dr Barton, on 11 and 12 August.
- The Panel has not seen any document in the medical records to show that nurses consulted the British National Formulary (BNF) guidance, the Wessex guidelines,[4] any doctor or the pharmacist when commencing the administration of morphine oral solution 10 mg.
- The Panel has not seen any document to show that nurses were provided with any written guidance from the doctors, consultants or Portsmouth HealthCare NHS Trust on when to commence the administration of morphine oral solution or the choice of starting dose.

17 to 21 August 1998

- The Haslar Hospital transfer letter stated *"no follow up unless complication".* It is not clear to the Panel why Dr Barton did not consult with the clinicians at Haslar Hospital about Mrs Richards' haematoma, treatment and transfer in light of the apparent complication and having previously decided that consultation with Haslar Hospital was necessary.
- The Panel has seen no record in the clinical notes to suggest that Mrs Richards had a haematoma.
- It is not clear to the Panel why Dr Barton did not investigate the presence and the nature of any haematoma.
- It is not clear to the Panel on what basis Dr Barton determined that any haematoma was not amenable to surgical intervention or any other form of treatment.
- Dr Barton did not record any of the explanations she provided to the police or to the FtP hearing in Mrs Richards' clinical notes at the time of her assessment.
- The Panel has found no document in the medical records to confirm Dr Barton's rationale for increasing the dose range of diamorphine to 40–200 mg.

4 Salisbury Palliative Care Services, 1995. *The Palliative Care Handbook: Guidelines on clinical management*, third edition.

- The administration of diamorphine 40 mg over 24 hours by syringe driver in a patient who had received 45 mg of morphine oral solution in the previous 24 hours constitutes more than double the effective dose of morphine. The Panel can find no justification in the clinical records for this increase in dosage.
- The Panel has not seen any document in the medical records to confirm that nurses scrutinised, questioned, challenged or refused to administer the high and wide dose range prescription of diamorphine.
- The Panel has not seen any document in the medical records to show the nurses' rationale for administering diamorphine 40 mg and midazolam 20 mg.
- The Panel has not seen any document in the medical records to show that nurses consulted the BNF guidance, the Wessex guidelines, any doctor or the pharmacist when commencing the administration of diamorphine, midazolam and hyoscine.
- The Panel has not seen any document to show that nurses were provided with any written guidance from the doctors, consultants or the Trust on when to commence the administration of morphine oral solution or the choice of starting dose.

General comments

- The Panel found a lack of information in Mrs Richards' daily nursing notes. The care plans seen by the Panel were scanty, were not personalised to Mrs Richards' needs and contained missing entries for entire days.
- The Panel has not seen any document in the medical records to confirm that the nurses implemented any form of pain management plan. It is not clear on what basis Mrs Richards' response to analgesia was being assessed and determined.
- The Panel has found no document to confirm that any assessment of Mrs Richards' cognitive impairment was carried out, or that it was the subject of a care plan.
- The Panel has not seen any fluid charts among Mrs Richards' medical records and the nutrition plan was a proforma which contained scanty entries for 13, 14 and 21 August only.
- The Panel has not seen any document in the medical records to show that the nurses took into account the possible side effects of morphine when noting Mrs Richards' condition.