PORTSMOUTH HealthCare NHS TRUST

# FAX

Please telephone if any page is missing or indistinct

To:

Date: 23/12/98

For the attention of: LESLEY HUMPHREY

Fax No: 293437

No of pages including this sheet: 9.

From: Department of Medicine for Elderly People
Queen Alexandra Hospital
Cosham
PORTSMOUTH
PO6 3LY

Tel: 01705 - ~~286000~~ 200381

**This facsimile is intended only for the individual or entity to whom it is addressed, if you have received it in error, please destroy the original and telephone 01705 - 286919 or 286920 immediately.**

CONFIDENTIAL.

From: Athena Lord

**DEPARTMENT OF MEDICINE FOR ELDERLY PEOPLE**

**Queen Alexandra Hospital**
Cosham, Portsmouth, Hampshire, PO6 3LY
Tel: 01705 822444 Fax: 01705 200381

## Re- late Gladys Richards - DOB 13/04/07

I am writing this in response to Lesley Humphrey's written request on 17th December 1998. I am the Consultant of Daedalus ward to which Mrs. Richards was admitted as a patient for NHS Continuing Care. She had been assessed at Haslar by Dr. Ian Reid who had also spoken to her 2 daughters. (Letter attached - *Note 1*). My wards rounds for the Continuing Care patients in Gosport are fortnightly on Mondays as I cover both Daedalus and Dryad wards. I was on Study leave on the 17th and 18th August 98. During her 2 short stays on Daedalus Ward (11/8 to 14./8 and 17/8 to 21/8) I did not attend to Mrs. Richards at all, nor did I have any contact with her daughters and hence the comments made are from what I have gathered from her medical, psychiatry and nursing notes, Sue Hutchings report, the sequence of events as documented by Code A Code A (Mrs. Richards' daughter) and from discussions with Philip Beed (Charge Nurse, Daedalus) and Dr. Jane Barton (Clinical Assistant). I have not had access to the Haslar records. The written complaint from Code A the documentation of the investigations and Sue Hutchings report of 11/9/98 were first made available to me on the 17th December 98.

In brief the sequence of events that affected Mrs. Gladys Richards -
30/7/98 - fall in Nursing Home, admitted to Halsar where she underwent a right hemiarthroplasty
11/8/98 - admitted to NHS Continuing Care Daedalus ward, GWMH - able to mobilise with frame and 2 persons
13/8/98 - fall on ward
14/8/98 - right hip x-rayed and subsequent transfer back to Haslar arranged. The same day s Closed hip relocation of right hip hemiarthroplasty was carried out under IV sedation. Nursing transfer letter states "rather unresponsive following the sedation"
17/8/98 - returned to Daedalus ward. On admission in pain and distress and was screaming loudly. She was given 5mg of Oramorph at 1 p.m. after discussion with a daughter who was present. A further Xray was arranged the same day and a dislocation excluded. This is also confirmed in the Radiologist's report.
18/8/98 - decision made following discussion with both daughters to commence a syringe driver containing Diamorphine. Mrs. Richards had required 45 mg Oramorph in a 24 hour period but seemed to be in considerable pain, discomfort and distress. This was reviewed and renewed daily till Mrs. Richards passed away on 21/8.

I have itemised my comments as follows:

1) **Use of Diamorphine via a Syringe Driver**
All the documentation available supports the fact that Mrs. Richards was in very severe pain and distress, screaming loudly on return to Daedalus ward on 17/8. An X-Ray that same day excluded a 2nd dislocation (confirmed by Radiologist's report) and it was decided by the medical and nursing staff that good pain control would be the aim of management.

As Mrs. Richards was demented, her pain control was discussed with one of her daughters who agreed that Oramorph (the oral liquid preparation of Morphine) was

given. This has a short action and needs to be administered 4 hourly for adequate pain control. Inspite of a substantial dose a day later, pain and distress was still a problem. Adequate nursing care was difficult to provide.

If someone is in considerable pain after having received regular Oramorph then the next step up the anaelgesic ladder is Diamorphine. The syringe driver was chosen as it delivers a continuous dose of Diamorphine over a 24 hour period, and hence 4 hourly injections are not required. It was also possible to add in Haloperidol 5 mg/24hours into the syringe driver. Mrs. Richards had been on this prior to her initial admission to Haslar. This was to treat agitation which had been a problem in the Nursing Home and occasionally at night on Daedalus Ward. Due to her underlying dementia, and inability to communicate fully, her distress could have been due to an element of anxiety and hence Midazolam was added to the syringe driver as an anxiolytic.

The above anaelgesia and sedation was considered necessary for Mrs. Richards to keep her comfortable and aimed at addressing pain, anxiety and agitation.

**2) Decision not to start intravenous fluids.**

Having established with Mrs. Richards daughters that she required opiates for pain control, we were now in the situation of providing palliative care. Basic nursing care, including mouth care was not possible as Mrs. Richards could not understand and comply with requests and was also in considerable distress. In this instance parenteral fluids are often not used as they do not siginificantly alter the outcome. If this is necessary in order to keep the mouth dry and skin hydrated, it is done by the subcutaneous route only on NHS continuing care wards. Patients requiring intravenous fluids would need to be transferred to an acute bed at Haslar or QA. Mrs. Richards was 91 years of age, frail, confused and had been twice to Halsar for surgical procedures and hence a 3rd transfer back for intravenous fluids only would not have been appropriate. I do not feel that the lack of intravenous fluids for the 4 days that Mrs. Richards was on a syringe driver significantly altered the outcome.

The concern about the lack of intravenous fluids was not raised by either daughter on Daedalus ward prior to her death and isn't included in Code A written comments/questions.

**3) What was agreed with Code A and Code A**

The administration of the 1st dose of Oramorph on 17/8 was discussed and agreed with a daughter prior to it being administered. Consent was obtained for the doses to be repeated to ensure adequate anaelgesia.. The administration of subcutaneous morphine via a syringe driver was discussed on 18/8 and agreed by both daughters. Both these discussions were carried out by C/N Philip Beed.

Code A

Dr.A.Lord, Consultant Geriatrician
22/12/98

PORTSMOUTH
HealthCare
NHS
TRUST

NOTE 1

DR R I REID, FRCP
CONSULTANT GERIATRICIAN

Elderly Medicine
Queen Alexandra Hospital
Cosham
Portsmouth PO6 3LY

Tel: 01705 822444
Extension: 6920
Direct Line: 01705 286920
Fax: 01705 200381

RIR/BJG/WVTQ130407

5th August 1998

Surgeon Commander M Scott
The Royal Hospital Haslar
Gosport
Hants

Dear Surgeon Commander Scott

**RE: WARD VISIT - E6 WARD HASLAR**
**Gladys RICHARDS - Code A**
**HA: Code A**

Thank you for referring Mrs Richards whom I saw on Ward E6 at Haslar Hospital on 3rd August.

Fortunately two of her daughters were present when I visited so I was able to obtain information from them, about Mrs Richards pre-morbid health. It would appear that Mrs Richards has been confused for some years but was mobile in her nursing home until around Christmas 1997 when she sustained a fall. She started to become increasingly noisy. She was seen by Dr Banks whom presumably felt she was depressed as well as suffering from a dementing illness. She has been on treatment with Haloperidol and Trazodone. According to her daughters she has been "knocked off" by this medication for months and has not spoken to them for some six to seven months. Her mobility has also deteriorated during that time and when unsupervised she has a tendency to get up and fall. In the last such incident she sustained a fracture to the neck of her right femur, for which she has had a hemi-arthroplasty. I believe that she is usually continent of urine but has had occasional episodes of faecal incontinence.

Since her operation she has been catheterised. She has had occasional faecal incontinence and has been noisy at times. She has been continued on Haloperidol, her Trazodone has been omitted. According to her daughters it would seem that since her Trazodone has been omitted she has been much brighter mentally and has been speaking to them at times.

contd.....

Gladys RICHARDS

When I saw Mrs Richards she was clearly confused and unable to give any coherent history. However she was pleasant and cooperative. She was able to move her left leg quite freely and although not able to actively lift her extended right leg from the bed, she appeared to have a little discomfort on passive movement of the right hip. I understand that she has been sitting out in a chair and I think that, despite her dementia, she should be given the opportunity to try to re-mobilise. I will arrange for her transfer to Gosport War Memorial Hospital. I understand that her daughters intend to give up the place in Glenheathers Nursing Home as they have been unhappy with the care, but would be happy to arrange care in another nursing home.

Yours sincerely

DR R I REID, FRCP
Consultant Physician in Geriatrics

cc. Dr J H Bassett
Lee-on-Solent Health Centre
Manor Way
Lee-on-Solent
Hampshire

22nd December 98.

Dear Lesley,

In addition to the 2 pages of the requested report on the late Gladys Richards I have 2 further comments to make, and would value a written reply to these from yourself, Barbara Robinson and Bill Hooper.

1)**"Review agreed 'policy' of medical consultant team not to transfer patients to Accident and Emergency, Haslar outside of working hours (i.e. G.W.M.H. X-Ray Department)"** This statement is taken from Sue Hutchings signed CONCLUSION of 11/9/98. Copy attached - *Note 2.*

This statement is false. I am the sole member of the medical consultant team for NHS Continuing Care at GWMH at present. Neither I or any of my predecessors have recommended such a policy. There is no written policy regarding transfer of patients to A & E at Haslar. If there is one as mentioned I would be grateful for a copy as I have not been able to find one either at QAH or Gosport. It is expected that anyone suspected of a fracture or dislocation is sent to the nearest A & E department and if there is a reason for not doing so this is documented in the notes.

Further I was not consulted about this complaint in August or September. Inspite of a statement that is an insult to my professional integrity I find out by chance on the 18th December - more than 3 months after it was written. Why?

At no point was either myself or the duty Consultant Geriatrician involved in making the decision not to transfer Mrs. Richards to Haslar on the night of 13/8. I attach a Memo (*Note 3*) that has gone out to Daedalus and Dryad wards, Dr. Jane Barton, Dr. A. Knapman so that appropriate action can be taken if similar events occur over the Christmas and New Year weekends. This memo contains temporary guidelines of what should be done in the event of a suspected fracture or dislocation and hasn't been agreed by the medical or nursing staff on Deadalus and Dryad wards yet. I will discuss this further with Mrs. N. Pendleton and Consultant Colleagues so that a suitable policy could be circulated to all NHS Continuing Care Wards of the department.

2) There seems to be discrepancy in the way in which complaints are handled at QAH and GWMH. If there is a compliant on the acute ward at QAH, Nicky Pendleton sends me a copy as soon as it arrives requesting a response and then sends me a copy of the final statement before it is sent out to the complainant. This is not the case in Gosport and I'm writing to request that the system that is and always has been operational in QAH is carried out in Gosport and hope that this will happen with immediate effect.

Sincerely,

Code A

Althea Lord
Consultant Geriatrician

copies:
Barbara Robinson
Bill Hooper
Nicky Pendleton

NOTE 2.

## CONCLUSION

Mrs. Richards did fall from her chair on 13.08.98 but this was not witnessed by anyone. The trained nurse on duty at the time did check her for injuries and there did not appear to be any. Therefore, Mrs. Richards was put into another chair with a table to help prevent reoccurrence. Unfortunately, on that day the Ward was exceptionally busy and low in numbers of trained staff, although patient care did not suffer - only the stress level of the one trained nurse. Code A stayed with her mother until early evening and was asked if she felt her mother to be in pain. Code A did not feel her mother was. Code A was then asked if she would like her mother to be put to bed. She replied "No rush".

Once S/N Brewer put Mrs. Richards on the bed, using a hoist, she noticed the angle of the hip and immediately phoned the Duty Doctor. Medical opinion was not to transfer to x-ray until the following day.

When did dislocation occur, i.e. when she fell? or when hoist was used?- unable to define.

Once x-rays confirmed dislocation, transfer to Accident and Emergency at Haslar was arranged - as appropriate.

In view of Mrs. Richards' previous fracture I feel she should have been transferred to Haslar the night before and that S/N Brewer should have insisted on this when contacting the Duty Doctor. S/N Brewer did agree with the Doctor that transferring Mrs. Richards at that time, i.e. 8.30 p.m. - 9.00 p.m. would have been too traumatic for Mrs. Richards. You could argue, due to Mrs. Richards's dementia, would she have been aware of the time?

Haslar Hospital were responsible for organising transport to transfer Mrs. Richards back to Daedalus Ward. It appears they booked Main Line Ambulance Services who were not happy about transferring Mrs. Richards without a canvas to lie her on. Haslar apologised and gave them two sheets instead. The Ambulance Crew confirmed to the nursing staff that Mrs. Richards began crying/screaming immediately they put her into the ambulance. They were given instructions to keep her flat. This may have been the cause of Mrs. Richards' distress or pain due to the transfer from bed to trolley to bed at Daedalus.

A nurse escort did not accompany Mrs. Richards. Unable to confirm the position Mrs. Richards was in in the ambulance, but once in bed it was noted her leg was not straight but at an angle. This would have caused some considerable discomfort. Once her (right) leg was straightened, within a few minutes of arrival she stopped crying out.

Once further x-rays confirmed no further dislocation, medical, nursing and family were involved in making the decision of how to treat Mrs. Richards - in view of Mrs. Richards age of 91 years. Agreement was made that she must be kept free of pain, therefore syringe driver was put in situ to ensure continual pain relief, the outcome of which was explained fully to both daughters.

Sadly, Mrs. Richards last few days and her death were not how her daughters had hoped her end would be, i.e. she did not regain consciousness and they felt they could not say "goodbye". The nursing staff were very aware of this and tried to involve the family as much as possible. Regarding the "trivia" part of the complaint, i.e. clothing being sent away for marking. It is policy on Daedalus Ward for all patient's clothing to be marked with the Ward name. This decision has been made in the light of complaints from relatives whose clothing has disappeared. This includes clothing of patients whose relatives agree to their laundry. It is a safeguard in case an article of clothing is put into the Hospital Laundry Bag by mistake. Unfortunately, at the time Mrs. Richards was admitted the marking machine at G.W.M.H. was broken so the laundry lady sent it to St. Mary's for marking but failed to inform the Ward of this. Steps have now been taken to ensure Wards are kept informed.

The nursing staff are sorry that this added to the stress the family were already suffering. As a result of this investigation an action plan will be recommended by myself to ensure we reduce the risk of further complaints of this nature.

**RECOMMENDED ACTION PLAN (to be agreed with Service Manager)**

1. Review agreed "policy" of medical consultant team not to transfer patients to Accident and Emergency, Haslar outside of working hours (i.e. G.W.M.H. X-Ray Dept.).

2. Review nursing records and documentation.

3. Further training on records and documentation for all staff.

4. Review marking of clothing "policy".

Code A

11/9/98

NOTE 3

NOTE 3

2

# URGENT - FOR THE NOTICE OF ALL MEDICAL AND NURSING STAFF

## *DAEDALUS AND DRYAD WARDS*
## GOSPORT WAR MEMORIAL HOSPITAL

In the event of a **suspected fracture and/or dislocation** in a patient on the ward the following must be adhered to:

1) Ensure the patient is comfortable and pain free.
2) Call out Dr. Jane Barton or the duty doctor.
3) If after a medical examination a fracture and/or dislocation cannot be confidently excluded an urgent X-Ray must be arranged as soon as is possible. If this is not possible at GWMH, the patient must be transferred to the nearest A&E Department irrespective of the time of day.
4) If for any reason this is not done (eg: in someone who is for palliative care) this must be discussed with the next-of-kin and documented in the medical and nursing notes.
5) If there is any concern about making the right decision the duty Geriatrician should be contacted via QA switchboard.

If there is any problem with carrying this out please let me know.

Code A

Dr. Althea Lord
Consultant Geriatrician
20.12.98.

Circulation:
- Dr. Jane Barton, Clinical Assitant
- Dr. A.Knapman and partners
- Sr. G. Hamblin, Dryad Ward
- Philip Beed, C/N Daedalus Ward
- Lesley Humphrey, Quality Manager, Portsmouth HealthCare Trust

PORTSMOUTH

HealthCare
TRUST