(1)

Portsmouth HealthCare NHS Trust
MEMORANDUM

Code A

18/12

From
Mrs. L. Humphrey

To
Dr. A. Lord

LH/YJM

17th December, 1998

Mrs. Richards deceased, Gosport War Memorial Hospital, 21st August, 1998

Since our telephone conversation earlier this week, both of Mrs. Richards' daughters (Mrs. Lack and Mrs. McKenzie) have confirmed they are happy for us to release details of her care to the police.

I have not seen Mrs. Richards' notes yet; I understand they are on Dryad Ward.

On reflection, I think the best way forward would be for you, as consultant in charge, to prepare a statement explaining the decision made with regard to Mrs. Richards' care following transfer back from Haslar on 17th August, 1998 - in particular: the use of syringe driver analgesia, the decision not to start intravenous fluids, and what was explained/agreed with Mrs. Lack and Mrs. McKenzie. You will probably want to preface this with a summary of what went before.

Once I have received your statement (and the patient records, please) I will ask our solicitors to comment on the content.

Once we are all comfortable with the statement I will arrange for it to be forwarded to the police, with a covering letter from Max Millett.

Please let me know if I can be of any help in preparing the statement or offer support in any way. I do appreciate how stressful these situations are - all we can do is give an honest and straightforward explanation of what happened.

Thank you for your help.

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Copy to: Mrs. B. Robinson
Mrs. N. Pendleton

Re- late Gladys Richards - DOB Code A

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 Mrs. Lesley Lack (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 Mrs. Lesley Lack, 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 Mrs. Lacks' written comments/questions.

3) What was agreed with Mrs. Lack and Mrs. McKenzie

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.

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

PORTSMOUTH HOSPITALS NHS TRUST

PORTSMOUTH HealthCare TRUST

Portsmouth Hospitals and Portsmouth HealthCare

Compendium of

DRUG THERAPY GUIDELINES 1998

Emily

For ADULT Patients Only

Approved by Elderly Medicine and Formulary & Medicines Group. Updated 1998.

SUBCUTANEOUS FLUID REPLACEMENT

USES

Subcutaneous fluids can be a useful method to correct mild dehydration, eg:
(1) to maintain adequate fluid intake after a stroke until swallowing improves.
(2) in palliative care.

ADVANTAGES

(1) Does not require venous access
(2) Little patient discomfort
(3) Can be used in a restless patient (site beyond the patient's reach)
(4) Useful for overnight rehydration
(5) Can be re-sited by nursing staff

CONTRA-INDICATIONS

(1) Severe dehydration where larger volumes of fluid are required
(2) Bleeding diathesis
(3) Generalised oedema
(4) Skin sepsis

METHOD OF ADMINISTRATION

Clean site with a Medi-swab.
Needle - 19 gauge butterfly.
Site - chest, abdominal wall, sub-scapular, axillary, thigh.
Site and needle must be changed every 48 hours.
Maximum rate of administration - 2 litres in 24 hours.
Hyaluronidase should not routinely be used (see 'Problems' below).

FLUIDS

Sodium chloride 0.9% or glucose 4% with sodium chloride 0.18%.
Dextrose 5% has been used, but is best avoided as it can be irritant.
Potassium chloride may be added, but not more than 20mmol per litre.

PROBLEMS

(1) Fluid not absorbed after the first 24 hours. Hyaluronidase 1500 units injected s.c. at the site (or added to a litre of saline) may help, but it can be painful and is often ineffective. Hyaluronidase must not be used routinely.
(2) Erythema or local skin damage.
(3) Infection (rare).

Jane Marshall, directorate pharmacist, manages this guideline (ext 6632).