Case Study – Gladys Richards

Summary of hospital admission

- In 1998, Gladys Richards was aged 91 and was resident in a nursing home.
- On 29 July, she fell and fractured her right neck of femur. She was admitted to the Royal Hospital Haslar ('Haslar Hospital'), where she underwent a right cemented hemiarthroplasty (partial hip replacement).
- On 11 August, she was admitted to Gosport War Memorial Hospital for rehabilitation.
- On 13 August, she fell at Gosport War Memorial Hospital and dislocated her right hip.
- On 14 August, she was transferred to Haslar Hospital where the dislocation was treated.
- On 17 August, she returned to Gosport War Memorial Hospital.
- On 21 August, Mrs Richards died.

Background, care and treatment

On 4 February 1998, Mrs Richards was assessed by Dr Victoria Banks, a psychiatrist specialising in old age. Dr Banks confirmed that Mrs Richards was *"cognitively … obviously severely impaired"*. However, she was not found to be depressed. Dr Banks's view was that Mrs Richards had *"severe dementia with end stage illness"*. She prescribed a regimen of haloperidol, trazodone and lavender oil, with the possibility of utilising other drugs in the future. By May 1998, Mrs Richards was described by staff at the nursing home as *"withdrawn and anxious at times"* but as being settled most of the time due to her new drug regimen. Mrs Richards wore pads for incontinence, required help with washing and dressing and also needed encouragement and help to eat. She would usually sleep through the night but would get up and wander at times. Mrs Richards' daughters and granddaughter were heavily involved in her day-to-day care and would visit her at the nursing home daily. The records indicate that Mrs Richards had hearing difficulties and had been awaiting new hearing aids. Records confirm that by the time of her admission to Haslar Hospital, Mrs Richards had a six-month history of falls, the last fall resulting in her fractured neck of femur on 29 July.

On 29 July, Mrs Richards was admitted to Haslar Hospital where she underwent a right cemented hemiarthroplasty (partial hip replacement).

On 5 August, Dr Richard Ian Reid assessed Mrs Richards at Haslar Hospital. He noted:

> "[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 V Banks who presumably felt that 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 … and has not spoken to them for six to seven months. Her mobility has also deteriorated during that time and when unsupervised she has a tendency to get up and fall … I believe that she is usually continent of urine but has occasional episodes of faecel incontinence. Since her operation she has

> been catheterized … [she] has been noisy at times … she has been continued on Haloperidol, her Trazodone has been omitted. According to her daughters … she has been much brighter mentally and has been speaking to them at times."

Dr Reid also noted:

> "Mrs Richards was confused and unable to give any coherent history … She was pleasantly cooperative [and] 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 have a little discomfort on passive movement of the right hip … [and] has been sitting out in a chair … despite her dementia she should be given the opportunity to try to re-mobilise."

Dr Reid confirmed that he would arrange Mrs Richards' transfer to Gosport War Memorial Hospital and noted that her daughters were unhappy with the care she had received at the nursing home.

On 11 August, Mrs Richards was discharged from Haslar Hospital and her recommended drug treatment was *"Haloperidol Suspension, Lactulose and Co-codamol"*, all of which were to be taken orally. The discharge letter from Haslar Hospital to Gosport War Memorial Hospital stated: *"[Mrs Richards] had a right cemented semi-arthroplasty and she is now fully weight bearing. Walking with the aid of two nurses and a Zimmer."* The letter advised that Mrs Richards:

> "… needed total care with washing and dressing, eating and drinking … daughters are extremely devoted and like to come in and come in and feed her at meal times … Mrs Richards has a soft diet and enjoys a cup of tea … [is] continent [and] when she becomes fidgety and agitated it means she wants the toilet, occasionally continent at night but usually wakes … Occasionally says recognizable words but not very often."

On admission to Gosport War Memorial Hospital on 11 August, Mrs Richards was assessed by Dr Barton who recorded in the clinical notes: *"transfer to Daedalus Ward for continuing care … impression frail demented lady not obviously in pain please make comfortable. Transfers with hoist, usually continent, needs help with ADL, Bartel 2. 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) four hourly 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.

The records confirm that morphine oral solution 10 mg was administered to Mrs Richards on 11 August at 14:15 and 23:45. The drug charts also confirm that haloperidol was administered to Mrs Richards on 11 August at 18:00.

Panel comments – Box 1

- The Panel notes the anticipatory prescribing of morphine oral solution.
- The Panel notes the anticipatory prescribing of diamorphine, hyoscine and midazolam in high and very wide dose ranges.
- The Panel has not found any document in the clinical records to show that morphine oral solution, diamorphine, midazolam and hyoscine were clinically indicated on 11 August.
- The Panel has not found any document in the clinical records to confirm Dr Barton's rationale for prescribing morphine oral solution, diamorphine, midazolam and hyoscine on 11 August.
- It is not clear from the clinical records why, having noted Mrs Richards as *"not obviously in pain"*, Dr Barton prescribed morphine oral solution and diamorphine.

- It was usual in the health service to use *"TLC"* (tender loving care) or *"make comfortable"* as euphemisms for patients who were to be treated palliatively.
- It is not clear from the medical records why Dr Barton requested that Mrs Richards be *"made comfortable"* and why Dr Barton 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 … re-mobilise"*.

In relation to her note *"happy for nursing staff to confirm death"*, Dr Barton stated during an interview with Hampshire Constabulary in July 2000:

> "[Mrs Richards] was probably near to death, in terms of weeks and months from her dementia before the hip fracture supervened. Given her transfer from nursing home to acute hospital and then to continuing care and the fact that she had recently undergone major surgery; in addition to her general frailty and dementia, 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."

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

> "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."

In her police interview, in relation to the prescription of morphine oral solution and diamorphine on 11 August, Dr Barton stated:

> "[Mrs Richards] was pleasant and co-operative on arrival and did not appear to be in pain. Later her pain relief and sedation became a problem. She was screaming. This can be a symptom of dementia but could also be caused by pain. In my opinion it was caused by pain as it was not controlled by Haloperidol alone. Screaming caused by dementia is frequently controlled by this sedative. Given my assessment that she was in pain I wrote a prescription for a number of drugs on 11th August, including [morphine oral solution] and Diamorphine."

During the FtP hearing, Dr Barton stated:

> "The snapshot view that I gained of that patient when I examined her on the bed that afternoon was that she was not obviously in pain; but I knew perfectly well that she had just had a transfer from another hospital, she had not long had fairly major surgery and she was very frail anyway. She was going to be very uncomfortable for the first few days and I was minded to make available to the nurses a small dose of oral opiate in order to make her comfortable during that time not to be administered regularly but at their discretion if they felt she needed it."

In relation to the prescription of diamorphine, Dr Barton said:

> "Because I felt that this lady her outlook on the background of her very severe dementia … and the major surgery, that her general outlook was poor. She was quite possibly going to need end of life care sooner rather than later."

Dr Barton went on to state that post-operative analgesia was often inadequate and she would have expected Mrs Richards to still be in pain when she was transferred to Gosport War Memorial Hospital.

Panel comments – Box 2

- The Panel has found no documents in the clinical records to confirm that Mrs Richards was screaming as if in pain on 11 or 12 August.
- Dr Barton did not record any of the above views in Mrs Richards' clinical notes at the time of her admission and, given Dr Reid's view that Mrs Richards should be given the opportunity to remobilise, and Haslar Hospital had prescribed co-codamol only, it is not clear to the Panel why Dr Barton did not discuss her views and prognosis with Mrs Richards' consultant or any members of her family.
- At the time of Mrs Richards' admission, guidance from the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) and the Royal College of Nursing (RCN) (see Bibliography) emphasised the requirement for nurses to work in an open and cooperative manner with patients and their families. In this regard, the Panel has seen no documents in the clinical records to confirm that nurses engaged in any adequate end of life care discussion with Mrs Richards' family.
- At the time of Mrs Richards' admission, accountability was an integral part of nursing practice. Nurses were accountable for their actions, and inactions, at all times. The relevant nursing professional codes of conduct and standards required nurses to scrutinise a prescription; question any ambiguity in the prescription; where they believed it necessary, refuse to administer a prescription; and report to an appropriate person or authority any circumstances which could jeopardise the standards of practice or any concern about health services within their employing Health Authority or Trust. The codes and guidance made it clear that to silently tolerate poor standards is to act in a manner contrary to the interests of patients or clients, and contrary to personal professional accountability. The Panel has not seen any document to confirm that nurses treating Mrs Richards challenged the proactive and wide dose range prescriptions of morphine oral solution, diamorphine and midazolam. The Panel has not seen any document to show that nurses consulted the British National Formulary (BNF) guidance or the Wessex guidelines to scrutinise the doses; nor did they question any of the consultants, doctors or the pharmacist at Gosport War Memorial Hospital in respect of the prescription and doses.
- The relevant nursing codes of conduct and standards required nurses to be able to justify and be accountable for any actions taken when administering or overseeing the administration of drugs. The Panel notes that the relevant nursing codes of conduct and standards provided that, when administering or overseeing the administration of drugs, nurses should be able to justify and be accountable for any actions taken.
- The Panel has not seen any document in the clinical records to show the reason or rationale for the decision to commence morphine oral solution on 11 and 12 August, or for the choice of a 10 mg starting dose.
- The Panel has not seen any document in the clinical records to show that nurses consulted the BNF guidance, the Wessex guidelines, any doctor or the pharmacist when commencing the administration of morphine oral solution to Mrs Richards or when choosing a 10 mg starting dose, which was the higher dose on the range prescribed by Dr Barton.
- 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.
- At the time of Mrs Richards' admission, the UKCC guidance required nurses to carry out a comprehensive assessment of the patient's nursing requirements, and devise, implement and keep under review care plans. The UKCC guidance also required nurses to create and maintain medical records in order to provide accurate, current, comprehensive and concise information concerning the condition and care of the patient. Such records would include: details of observations, problems, evidence of care required, action taken, intervention by practitioners, patient responses, factors that appeared to affect the patient, the chronology of events, and reasons for any decision. These records would provide a baseline against which improvement or deterioration could be judged. Among other elements of care, *"Through their role in drug administration nurses are in an ideal position to monitor the drugs progress, reporting responses and side effects"*. In this regard, 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 the patient's needs and contained missing entries for entire days. For example, the 'Personal Hygiene' care plan appeared to be a typed proforma and stated: *"patient is unable to maintain own personal hygiene … ensure patient is clean or comfortable at a level acceptable to him or her".* There was nothing that took account of Mrs Richards' cognitive impairment, capabilities, likes, dislikes and preferences. The Panel found no pain charts or pain management plans in Mrs Richards' medical records. It is not clear to the Panel how Mrs Richards' pain and the effectiveness of analgesia were adequately monitored. The Panel has found no document to confirm that any assessment of Mrs Richards' cognitive impairment was carried out or 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 entries for 13, 14 and 21 August only. Fluid and nutritional intake was an important part of the clinical picture. Morphine oral solution, diamorphine and midazolam could impair the ability to eat and drink.

On 12 August 1998, Dr Barton wrote further prescriptions for morphine oral solution 2.5–5 ml (5–10 mg morphine) four hourly, and 5 ml (10 mg morphine) in the evening as required. The records confirm that morphine oral solution 10 mg was administered to Mrs Richards at 06:15. Nursing notes for the evening of 12 August recorded, at 18:00, *"patient drowsy"* and, at 23:00, that Mrs Richards was having difficulty settling at night and was agitated, shouting and crying but that *"she did not seem to be in pain".* There are no clinical notes on 12 August.

Panel comments – Box 3

- The Panel has not found any document in the medical records to show that morphine oral solution was clinically indicated on 12 August.
- The Panel notes that following the administration of three doses of morphine oral solution 10 mg on 11 and 12 August, Mrs Richards was noted to be *"drowsy".*

On 13 August, the nursing notes record:

> "… found on the floor at 13.30 hours checked for injury none apparent at time hoisted into safer chair. At 19.30 pain rt hip internally rotated. Dr Brigg contacted advised Xray AM and analgesia during the night. Inappropriate to transfer for Xray this PM. Daughter informed."

The drug chart and nursing notes confirm that Mrs Richards was given morphine oral solution at 20:50 and that she *"slept well".* There are no clinical notes on 13 August.

On 14 August, the nursing notes record *"some pain in rt leg?/hip this am"* and that Mrs Richards ate porridge. Dr Barton noted in the clinical records:

> "… sedation/pain relief has been a problem screaming not controlled by Haloperidol … very sensitive to [morphine oral solution]. Fell out of chair last night Right hip shortened and internally rotated daughter aware and not happy please X-ray. Is this lady well enough for another surgical procedure?"

The drug chart confirms that morphine oral solution 5 ml (10 mg) was administered to Mrs Richards at 11:50.

Dr Barton saw Mrs Richards again later that day after the X-ray and contacted Surgeon Commander Spalding at Haslar Hospital. The note records that she relayed Mrs Richards' history of a dislocated hip, sent him Mrs Richards' X-rays and informed him that Mrs Richards had been given morphine oral solution at midday. Later that day, the nursing notes record

that Mrs Richards' hip was dislocated and she was to be transferred to Haslar Hospital *"for reduction under sedation"*.

In the police interview in July 2000, Dr Barton stated: *"Although I was concerned, given Mrs Richards' overall condition and her frailty that she might not be well enough for another surgical procedure, I felt that this clearly would be a matter for assessment by the clinicians at Haslar."*

On the same day, Nurse Philip Beed wrote to Haslar Hospital. He confirmed Mrs Richards' transfer to the accident and emergency department for a reduction of her dislocated hip and that there had been no change in her treatment since her admission to Gosport War Memorial Hospital on 11 August, *"except addition of [morphine oral solution]"*. He confirmed that 10 mg of morphine oral solution had been given to Mrs Richards at 11:50 and that Gosport War Memorial Hospital would be happy to take Mrs Richards back after the reduction.

On 17 August, Mrs Richards was discharged from Haslar Hospital and transferred back to Gosport War Memorial Hospital. The discharge letter confirmed that Mrs Richards *"underwent a closed reduction under IV sedation. The reduction was uneventful. However she was rather unresponsive following the sedation then gradually become more responsive but was unable to pass urine."* Mrs Richards was given 2 mg of midazolam as sedation for the reduction procedure. The letter confirms that Mrs Richards had been catheterised and had been given a canvas knee-immobilising splint *"to discourage any further dislocation"*. The splint was required to stay in place for four weeks. The letter made it clear 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 an abduction wedge.

The nursing notes record that, at 11:48, Mrs Richards had returned to Gosport War Memorial Hospital and was very distressed and appeared to be in pain. The notes record that Mrs Richards had been transferred by the ambulance crew on a sheet and not canvas. The nursing notes record the advice from Haslar Hospital that abduction in bed should be encouraged and specifically the advice from Haslar Hospital that there would be *"no follow up unless complication"*. At 13:05 the Gosport War Memorial Hospital records further note that Mrs Richards was in pain and distress and that *"2.5 mg in 5 ml"* of morphine oral solution was given to her, although the drug charts record the dose given as 2.5 ml (5 mg morphine). The notes record that Mrs Richards' daughter had informed staff that the surgeon had said *"must not be left in pain if dislocation occurs again"*. The note records that Dr Barton was contacted and she ordered that an X-ray be carried out. The nursing record ends: *"PM Hip Xrayed … no dislocation seen … for pain control overnight and review by Dr Barton."*

Mrs Richards was given three 2.5 ml doses of morphine oral solution (5 mg morphine) and one 5 ml dose of morphine oral solution (10 mg morphine) between 13:00 and 20:30 on 17 August.

Dr Barton's untimed clinical note records: *"readmission … from RHH. Closed reduction under IV sedation. Remained unresponsive for some hours. Now appears peaceful. Please continue Haloperidol. Only give [morphine oral solution] if in severe pain."*

In her police interview in July 2000, Dr Barton stated:

> "At the time of her arrival back on the ward Mrs Richards appeared peaceful and not in severe pain. This was however an initial judgement made on an assessment shortly after her arrival on the ward. I was concerned that she should have opiates only if her pain became a problem, and I altered her drug chart accordingly. I was not aware

at that time that she had been having intravenous morphine at [Haslar Hospital] until shortly before her transfer. This would have explained why at this time she appeared to be peaceful and not in pain."

Panel comments – Box 4

- It is not clear to the Panel at what time Dr Barton first saw Mrs Richards on 17 August. However, it is clear from the nursing notes that Mrs Richards arrived on the ward around 11:50 and was in distress and pain and therefore was not peaceful on her arrival at Gosport War Memorial Hospital. It is also clear that Mrs Richards was noted to be in pain and distress again at 13:05 when a dose of morphine oral solution was administered to her. During the FtP hearing Dr Barton confirmed that she must have seen Mrs Richards after she had received this dose of morphine oral solution, that Mrs Richards had not received intravenous morphine at Haslar Hospital, and that this was an error in her police statement.

On 18 August, Mrs Richards was given two 5 ml doses of morphine oral solution (10 mg morphine) between 02:30 and 04:30. Dr Barton later noted, *"still in great pain, nursing a problem I suggest s.c. [subcutaneous] diamorphine / haloperidol / midazolam … please make comfortable"*. The drug charts confirm that Dr Barton wrote another prescription for diamorphine 40–200 mg subcutaneously over 24 hours. In the later police interview, Dr Barton stated that when she examined Mrs Richards there was a lot of swelling and tenderness around the area of the prosthesis. It was her assessment that 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 the pain. Dr Barton confirmed her view 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.

During the FtP hearing, Dr Barton stated:

"[Mrs Richards] was not well enough to return to the acute orthopaedic ward. We knew she had a large haematoma, or bruise, around where the dislocation had been put back. 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."

Panel comments – Box 5

- The Panel notes that Dr Barton did not consult the clinicians at Haslar Hospital about Mrs Richards' haematoma, treatment and transfer, having previously decided that consultation was necessary.
- The Haslar Hospital transfer letter stated *"no follow up unless complication"*. It is not clear to the Panel why Dr Barton did not consult the clinicians at Haslar Hospital in light of the apparent complication.
- 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.
- It is not clear to the Panel why Dr Barton did not record this diagnosis and view in her clinical notes at the time she assessed Mrs Richards. There are also no nursing notes to reflect this diagnosis.

On 18 August, the nursing notes state: *"reviewed by Dr Barton, for pain control via syringe driver"*. The records confirm that at 11:45 the administration of diamorphine 40 mg, haloperidol 5 mg and midazolam 20 mg was commenced by syringe driver.

In the later police interview, Dr Barton confirmed her rationale for prescribing the subcutaneous administration of diamorphine as follows:

> "I explained that it was the most appropriate drug as their mother was not eating or drinking or able to swallow, subcutaneous infusion … was the best way to control her pain … this drug, the dose used and this mode of administration are standard procedures for patients who are in great pain but who cannot take medicines by mouth."

Dr Barton went on to explain that Mrs Richards had not responded to 45 mg of morphine oral solution over the previous 24 hours, so it was necessary to introduce the use of diamorphine.

During the FtP hearing, Dr Barton stated:

> "I calculated the number of doses of [morphine oral solution] she had had in the preceding 24 hours and the conversion for that should have been approximately 20mg, but her pain was not controlled so I was minded to increase it, hence 40mg and agreed that in effect, if the figure with regard to the [morphine oral solution] was a total of 45 in the previous 24 hours."

Dr Barton stated that this was an *"appropriate starting dose for [Mrs Richards'] symptoms"*.

Panel comments – Box 6

- 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.
- The Panel notes that 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 a doubling of the effective dose of morphine. The Panel can find no justification in the clinical records for this increase in dosage.
- As noted above, the Panel has not found any pain management records for Mrs Richards; accordingly, it is not clear on what basis Mrs Richards' response to analgesia was being assessed and determined.
- The Panel has not found any document in the clinical records to show that on 18 August the nurses scrutinised or questioned Dr Barton's prescription of diamorphine and midazolam or refused to administer these drugs.
- It is also not clear from the records on what basis Dr Barton had concluded that Mrs Richards was not eating, drinking or able to swallow. The Panel has not found any fluid charts in the clinical records.

At 20:00, the nursing notes record that Mrs Richards remained peaceful and sleeping but *"reacted to pain when being moved"*. This was noted to be pain in both legs.

Panel comments – Box 7

- In addition to its intended effects, morphine might also have a number of side effects on a patient, including agitation and respiratory depression. The Panel has not seen any document in the clinical records to show that the nurses treating Mrs Richards understood or took into account these possible side effects of morphine when noting Mrs Richards' reaction to being moved. In this regard, the relevant nursing codes of conduct and standards required nurses to take every reasonable opportunity to maintain and improve knowledge and competence, including understanding the substances used when treating a patient.

On 19 August, the nursing notes record that Mrs Richards' grandson wished to speak with Dr Barton or Nurse Beed later that day, and that Mrs Richards' daughter was *"not happy with various aspects of care. Complaint to be handled officially by S Hutchings Nursing Co-ordinator."* The drug chart confirms that diamorphine 40 mg, midazolam 20 mg, haloperidol 5 mg and hyoscine 400 micrograms were administered by syringe driver at 11:20. There are no clinical notes on 19 August.

On 20 August, there are no clinical notes or nursing notes. The drug charts confirm that diamorphine, midazolam, hyoscine and haloperidol continued to be given to Mrs Richards until 21 August.

On 21 August, at 11:55, Dr Barton noted *"much more peaceful, needs Hyoscine for rattily chest"*. At 21:20, Staff Nurse Sylvia Giffin recorded Mrs Richards' death.