Field Fisher Waterhouse

FFW/62/03

GENERAL MEDICAL COUNCIL

-and-

DR JANE BARTON

PANEL BUNDLE
PATIENT

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PANEL BUNDLE
PATIENT

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GMC and Dr Jane Barton
Generic Report on Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital

This report is provided for the General Medical Council at the request of Field Fisher Waterhouse solicitors. It covers principles of medical care and matters specific to Gosport Memorial Hospital and relates to separate individual reports provided on eleven patients.

Declaration of interest in matters relating to Gosport War Memorial Hospital

1. I previously provided a report dated 12 December 2001, at the request of Hampshire Constabulary to examine the clinical notes of five patients treated at Gosport War Memorial Hospital and comment on a number of issues relating to patient management and clinical practices at the hospital. I have reviewed and refer to this report in reference to five patients I have been asked to provide reports on to the General Medical Council. I have not changed the views or opinions I expressed in that report. There are some typographical errors in that report that I have corrected in the relevant supplementary patient reports. I have also referred to additional information in some of the relevant supplementary patient reports.

2. I was a member of the Medical Case Note Review Team that supported the Commission for Health Improvement investigation of Gosport War Memorial Hospital (http://www.cqc.org.uk/_db/_documents/04005353.pdf).

Principles of Medical Care

3. **Pain Relief**
   Pain is a common health problem faced by older people and relief of pain is one of the most important duties of a doctor. Pain may be defined as *"an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage"*. [1] Pain is usually grouped into 4 main classes: nocioceptive, neuropathic, undetermined and psychological. These are usually managed in different ways. Nocioceptive pain such as due to arthritis is generally treated with analgesics. Neuropathic pain due to the nervous system is treated with anti-depressants and/or anticonvulsants. Pain of unclear or undetermined origin is treated with these and other approaches and psychological pain due to sanitization of conversion disorders with psychological approaches.

4. The principles of treatment of acute pain are to determine the underlying cause from history examination and appropriate investigation and to then treat the underlying cause and give adequate pain relief. The nature of the underlying cause and the severity of pain reported by the patient would influence the decision whether to start with a mild analgesic or proceed to use a more potent drug. Because the response to analgesia is unpredictable and there is a risk, particularly in older people, of drug toxicity the general approach of starting low and progressively increasing the dose and potency of drugs used is followed in older people. However to avoid patients remaining in pain with inadequate analgesia good management of severe pain requires the use of as required (prn) drugs in addition to regular drug doses and the re-evaluation of patients. Increases in drug dose or substitution

of a more powerful analgesic is required if analgesia is not achieved. If patients experience adverse effects a reduction in dose or change in drug is required.

5. The management of chronic pain is more complex and requires a consideration of potential long-term adverse effects of drugs and consideration of risks of addiction and the use of other psychological interventional approaches. [1]

6. Good basic principles to follow are to keep drug regimens simple, to reassess patients frequently and recognise that drug doses need to be individualised and that in some patients large doses may be required. There have been concerns that older people may be denied adequate analgesia because of undue concerns about adverse effects from moderate and potent analgesics.

7. The analgesic ladder is a commonly used framework for using analgesic drugs. Drugs are grouped into 3 main classes related to the severity of pain for which they are suitable to be prescribed. For mild pain non-opioid analgesics such as aspirin, paracetamol and ibuprofen are recommended. If these are ineffective or if the patient has more severe pain more potent anti-inflammatory drugs, such as diclofenac or naproxen, or mild opioids (codeine or dihydrocodeine) should be given in combination with paracetamol. For patients who are in severe pain or fail to achieve pain control on drugs for moderate pain more potent opioids (morphine, diamorphine) are recommended.

8. In the majority of patients with acute pain initial treatment would therefore be with drugs from the first two steps of the analgesic ladder (mild or moderate pain) with initial use of opioids only in patients with very severe pain (such as a fractured limb) or in patients who have failed to respond to appropriate doses of drugs used for moderate pain. In addition other therapies particularly anti-depressants and anti-epileptic drugs are used in patients with severe or chronic pain.

9. The most important aspect of good pain management is regular review of the patient and identification of adverse effects. Initial use of potent opioid drugs carries a risk particularly in older people of adverse effects with respiratory depression, hypotension, constipation, drowsiness, nausea and vomiting which could be avoided if pain is controlled with mild or moderate analgesics.

Use of opioid medication

10. The most commonly prescribed opioid is morphine and unless patients are unable to swallow initial dosing should be orally. The British National Formulary[2] states that morphine should be given regularly every 4 hours orally with an initial dose of 5-10mg. In frail elderly patients a starting dose of 5mg is preferred. The BNF states *"to reduce doses recommended in elderly or debilitated patients".* If pain relief is not obtained or is not sustained for 4 hours dose is usually increased by 50%. When pain is controlled it is common practice to switch patients to an oral sustained release preparation to reduce the frequency with which patients need to take medication. Laxatives such as senna or lactulose should be commenced to avoid constipation when morphine or other potent opioids are prescribed, nausea and vomiting should be treated with metoclopramide or haloperidol as required.

11. The parenteral route and that is the administration of opioids by intramuscular intravenous or percutaneous injection is used where more rapid pain relief is required or patients are

unable to swallow as is commonly the case in patients who are receiving palliative care and deteriorating. The parenteral route is also used if bowel obstruction is present and absorption may be impaired or if patients express the desire not to take the medication. Diamorphine is the preferred opioid to use for injection[3] because it is more soluble than morphine and can be given in a smaller volume. The equivalent intramuscular or subcutaneous dose is approximately one third of the oral dose of morphine.

12. Syringe drivers are used to give a continuous subcutaneous infusion of a drug or drugs. This avoids the problems of repeated intramuscular or subcutaneous injections which can be a source of discomfort in older cachectic (frail, thin, muscle wasted) patients. The BNF confirms that indications for use of the parenteral route are patients unable to take medicines by mouth because of nausea and vomiting, drowsiness or coma, bowel obstruction and if the patient does not wish to take regular medication by mouth. Incorrect use of syringe drivers are common cause of drug errors therefore it is important that staff using syringe drivers are appropriately trained and the rate settings on syringe drivers are clearly identified and differentiated[2].

13. The BNF reports a number of potential problems with syringe drivers. If an infusion runs too quickly patients may experience considerable toxicity and adverse effects. If an infusion runs too slowly patients will not receive adequate analgesia. There may also be injection site reactions. Infusions can run too quickly if the rate setting is set incorrectly, or drug calculations have been incorrectly performed. Infusions can run too slowly if the start button has not been used correctly, the batteries run out or there are problems with the syringe driver or cannula connections. Use of a syringe driver is an important clinical decision and the reasons why this is done should always be clearly documented in the medical records.

14. The British National Formulary provides clear advice on the process of administering equivalent doses of orally administered morphine and parentrally administered diamorphine[2]. There are situations where it is appropriate to administer sedative drugs in conjunction with opioid analgesics. However in these circumstances close monitoring is required. Failing to adequately monitor patient may result in life-threatening respiratory depression.

Issues in elderly patients

15. It is well described that older individuals are more sensitive to opioid drugs and older individuals clear the drug less rapidly from the body and studies suggest the duration of pain relief is 50% more in individuals over the age of 70 compared to those under the age of 30 years. It is usual to start with 5 mg rather than 10mg initial oral dose of morphine in frail older people. If an older individual is in considerable acute severe pain or is not frail and above average height and weight is not necessarily unreasonable to start with 10mg dose but patients need to be closely monitored.

16. In the chapter on pain relief in 'Drugs and the Older Person;' Crome writes on the treatment of acute pain; *'Treat the underlying cause and give adequate pain relief. The nature of the painful condition, the response of the patients and the presence of comorbidity will dictate whether to start with a mild analgesic of or to go immediately to a more potent drug. In order to avoid the situation that patients remain in pain, "starting low" must be followed by regular re-evaluation with, if necessary, frequent increases in drug dose. The usual method of*

prescribing morphine for chronic pain is to start with standard oral morphine in a dose of 5-10mg every four hours. The dose should be halved in frail older people.

17. The British National Formulary states in the 'Prescribing for the Elderly' section: *'The ageing nervous system shows increased susceptibility to many commonly used drugs, such as opioid analgesics, benzodiazepines, antipsychotics and anti parkinsonian drugs, all of which must be used with caution' (BNF 36 1998 page 15).*

Medical Assessment

18. Doctors have a responsibility to provide good standards of care. GMC guidelines on good medical practice (1995) state; *Patients are entitled to good standards of practice and care from their doctors. Essential elements of this are professional competence, good relationships with patients and colleagues and observance of professional ethical obligations."* The section on good clinical care states;

"You must take suitable and prompt action when necessary. This must include:

- *An adequate assessment of the patient's condition based on the history and clinical signs including, where necessary, an appropriate examination*
- *providing or arranging investigations or treatment where necessary*
- *Referring the patient to another practitioner, when indicated*

In providing care you must:

- *recognise the limits of your professional competence*
- *be willing to consult colleagues*
- *be competent when making diagnoses and when giving or arranging treatment*
- *keep clear, accurate, and contemporaneous patient records which report the relevant clinical findings the decisions made, information given to patients and any drugs or other treatment prescribed*
- *keep colleagues informed when sharing the care of patients*
- *pay due regard to efficacy and the use of resources*
- *prescribe only the treatment, drugs, or appliances that serve patients' needs*

The 1995 GMC Guidelines state in the section on delegating care to non-medical staff and students *"You may delegate medical care to nurses and other health care staff who are not registered medical practitioners if you believe it is best for the patient. But you must be sure that the person to whom you delegate is competent to undertake the procedure or therapy involved. When delegating care or treatment, you must always pass on enough information about the patient and the treatment needed. You will still be responsible for managing the patient's care."*

19. The 1995 GMC Guidelines state in the section on arranging cover *"You must be satisfied that, when you are off duty, suitable arrangements are made for your patients' medical care. These arrangements should include effective handover procedures and clear communication between doctors.'* The 1998 GMC Guidelines on Good Medical Practice which replaced the 1995 guidelines in July 1998 did not change any of the above recommendations.

20. There are important reasons why good medical practice places these responsibilities on doctors. Failing to undertake an adequate assessment of the patient's condition means that an inaccurate diagnosis may be made and inappropriate treatment given. Similarly failing to recognise limits of professional competence results in patients are put at risk from

potentially incompetent treatment decisions. Failure to keep clear, accurate and contemporaneous patient records means there is no clear information in the notes concerning the patient's condition for other health professionals to refer to and appropriately base their care. If there are no entries in the medical notes that record the thinking, diagnosis and treatment plan put in place at the time, the doctor relies entirely on their memory for making future treatment decisions and for justifying treatment decisions if these are challenged at a future date. Failure to record any adverse effects of treatment means there is no record in the notes for health care professionals to avoid re-providing this treatment.

21. A medical assessment is generally performed in any patient admitted to hospital shortly after their arrival on a ward. In most cases unless clerical and nursing staff record patient details and nursing assessments before a patient is seen by a doctor. Medical assessment of a patient on arrival to a hospital ward to review their history and current problems, perform a physical examination, arrange any appropriate investigations and prescribe necessary drug and other treatments. This baseline assessment is important in establishing a diagnosis, and implementing an appropriate management plan. It also provides a baseline assessment against which future symptoms and problems can be assessed.

22. A medical assessment is required when a patient is transferred from one hospital to another for a number of reasons. The patient may develop new problems during transfer. The referring hospital may not have recorded or transferred all necessary information. For older patients transferring from an acute ward to a rehabilitation or continuing care environment a medical assessment is important to confirm they are medically stable and appropriate to stay in a ward environment where there is a lower level of medical and other support services.

23. It is important that the results of an initial medical assessment are recorded in the notes are available for other medical and health care staff to refer to if a patient has new symptoms or problems. On call doctors are called to assess patients and information on their baseline function active problems and level of intervention agreed to be appropriate, is important in helping staff to make appropriate decisions about treatment.

24. A general principle well recognised in medical practice is that if a doctor does not record the results of a history or clinical examination they undertake the assumption is that no such assessment was undertaken. Given the busy nature and multiple patient contacts doctors have, retrospective recall by doctors of the details of the assessment that they took in an individual patients in the absence of a record in the medical notes, either by themselves or another member of the medical team is unlikely to be reliable.

25. GMC guidance in 1995 and 1998 emphasised the importance that doctors recognise limits of their professional competence and be willing to consult colleagues. This is a particularly important for doctors who are trainees or non-specialists working under the supervision of a consultant specialist as was the case with Dr Barton a general practitioner acting as a clinical assistant. In a setting such as Gosport War Memorial Hospital it would be appropriate to discuss and seek advice from the responsible consultant for any patient where the management plan was unclear, where there were complex or difficult management issues where diagnosis or treatment was not clear-cut it would have also been appropriate to seek advice and discuss with the responsible consultants any major change in a patient's medical status particularly if there was unexpected deterioration. If a patient had not been

identified and admitted for palliative terminal care I would consider it important any decision about palliative care was discussed with the responsible consultant.

26. When patients deteriorate in a setting such as Gosport War Memorial Hospital where modern diagnostic services and specialist advice is not easily available it may be necessary for patients to return to the main district general hospital for further assessment. It would be appropriate and expected for a clinical assistant to discuss this with the responsible consultant or another consultant who was acting on behalf of the responsible consultant if he/she was not available.

Medical records and Drug Prescription Charts

27. As previously mentioned GMC guidance places clear emphasis on importance of keeping clear, accurate and contemporaneous patient records. Failing to follow this approach results in the problems already outlined in section 6.

28. Drug charts play and important role in treatment prescribed by doctors the details of the drug dose and time and route through the drug should be administered. It is important that drug charts are clearly completed by medical staff as drugs are generally given by nursing staff who need to be able to clearly identify the drug dose, date and time that drugs should be administered to patients.

29. Many drugs are prescribed at a fixed dose on a regular basis. Sometimes drugs are prescribed as a single dose or written on "as required" basis (often referred to as PRN *pro re nata* meaning as necessary). The administration of drug therapy is recorded in a column on the drug chart relating to a specific day and time usually the initialled signature of the member of nursing staff responsible for administering the medication. Treatment instructions may be given to discontinue treatment on a certain date. This is commonly the case for antibiotic prescriptions. If a drug is discontinued the prescription has a line put through and the date of discontinuation inserted along the initials of the doctor making this treatment change.

30. When drugs are prescribed on an "as required" basis nursing staff are able to use their judgement as to when the drug needs to be administered to the patient and to decide on an appropriate dose if there is a range of doses written. It is common for patients to be written up for a range of opiate doses when requiring potent analgesia. This allows a member of nursing staff to adjust the dose according to a response from previous doses. Usually the range of doses prescribed is small for example 5-10mg of morphine or 2.5mg of diamorphine. If a large dose range is written for a PRN drug there is a risk, unless the drugs are being administered according to a clear protocol understood by all nursing staff, that a patient may be administered an inappropriately high dose of opiate which could lead to respiratory depression, coma and in some cases death.

Standards and Guidelines

31. The British National Formulary is the main reference text doctors should generally refer to in obtaining information about drugs they prescribe to ensure an appropriate drug is chosen for the condition being treated and is given at the correct dose. The BNF has a section on analgesics (4.7 BNF 36,September) with a section on the use of opioid analgesics. This states that a reduced dose is recommended in elderly or debilitated patients. Side effects are listed including respiratory depression, confusion and drowsiness. Recommended doses for

individual drugs are listed. The BNF also contains sections on prescribing in the elderly and the use of syringe drivers in palliative care (see sections 8 and 9 of this report).

32. I have also seen The Palliative care Handbook produced by Portsmouth Healthcare NHS Trust known as the Wessex Protocols, produced to help GPs and other healthcare professionals in managing problems in specialist care. The general principles of symptom management in this document (page 4) state *'Accurate and full assessment is essential for both diagnosis and treatment', 'Be careful that drug side effects to not become worse than the original problem'* and *'continually reassess'*. The WHO analgesic ladder is described. In the use of morphine the recommend starting with a low dose and increase by 30-50% increments each day until pain is controlled or side effects prevent any further increase. In an older patient an appropriate low dose would be 5 mg morphine.

33. The 'Wessex Protocols' recommend that prn doses are prescribed at the same dose as the 4 hourly dose and repeated as often as necessary (hourly if necessary) for breakthrough pain and to review every 24 hours. A syringe drive is recommended when oral administration is not possible because of dysphagia, vomiting or weakness and the conversion of oral morphine to subcutaneous diamorphine should be one third to one half of the morphine dose i.e. a 24 hour oral dose of 30 mg morphine should be replaced with a 10-15 mg diamorphine infusion over 24hr.

34. In the management of anxiety, diazepam is recommended and if a patient is unable to swallow midazolam 10-20mg per 24 hours by continuous subcutaneous infusion. Opioids are not recommended as a treatment for anxiety. For terminal restlessness drug therapy with diazepam (20-60mg per 24 hours orally or rectally), midazolam (10-60mg per 24 hours orally or by subcutaneous infusion) are recommended as possible treatment options.

Matters specific to Gosport War Memorial Hospital

'Clinical Assistant' Position

35. Clinical assistant posts are non-training service, usually part time posts established by hospitals generally undertaken by general practitioners. Theses posts generally work a number of half days (often referred to as sessions) and the person reports to a consultant responsible for the care of the patients. The job description (undated) for the post of clinical assistant to the Geriatric Division in Gosport that was undertaken by Dr Barton states *' This is a new post of 5 sessions a week worked flexibly to provide a 24 hour Medical cover to the Long stay patients in Gosport. The patients are slow stream or slow stream rehabilitation but holiday relief and shared care patients are admitted.'*

36. How many hours Dr Barton should have worked on the ward during the usual working week Monday – Friday 8am -5pm is unclear. I would estimate out of ours calls to the wards would not account for more than 4 hours time in a working week on average so it might be reasonably expected that Dr Barton in her position as Clinical Assistant was present on the wards for 16 hours a week i.e. about 3 hours per day.

37. The job description suggests the post had responsibility for 11 patients at Gosport War Memorial Hospital, 12 patients at Northcott Annexe and 23 patients at Redclyffe Annexe. However the Commission for Healthcare Improvement report states that in Dr Barton had responsibility for Dryad (20 beds) and Daedalus (24 beds) wards. In 1997/8 there were 169 finished consultant episodes (which equates to admissions) for these wards and in 1998/99

197 finished consultant episodes[5]. Therefore on average Dr Barton would have 3-4 newly admitted patients each week to assess. As many of the patients would be stable continuing care or 'slow stream' rehabilitation patients I would consider this was adequate time to assess new patients (which should take 30-40 minutes per patient to conduct a comprehensive medical assessment) and assess any deterioration or major problems in existing patients, to document such assessments in the medical notes and attend a weekly consultant ward round. It would be insufficient time to see all patients every day or document every contact with patients and relatives.

38. The Duties described include *'To visit the units on a regular basis and to be available 'on call' as necessary. To ensure that all new patients are seen promptly after admission. To be responsible for the day to day Medical management of the patients. To be responsible for the writing up of the initial case notes and to ensure that follow up notes are kept up to date. To take part in weekly consultant rounds. To prescribe, as required, drugs for the patients under the care of the consultant Physicians in Geriatric Medicine. To provide clinical advice and professional support to other members of the caring team.'* The job description states that the sessions may be split between two separate general Practitioners, ideally from the same Practice.

39. Clinical assistants are usually not required to have any specialist training in the specialty they are working in. Many Clinical Assistants would not have had specialist training as a trainee in the area of practice they work in as a general practitioner. My understanding is that Dr Barton had received no specialist training or qualifications in Geriatric Medicine such as the Diploma in Geriatric Medicine that some general practitioners take. Because of the lack of specialist training it is important that they seek advice from Consultant colleagues for any aspect of patient care where they lack specialist expertise or where decisions might be seen to be contentious with patients, relatives or other health care professionals.

Continuing Care, Slow Stream Rehabilitation and Palliative Care at Gosport War Memorial Hospital

40. There appears to have been some lack of clarity of the role of the wards at Gosport War Memorial Hospital. Although the wards were continuing care wards in practice patients who required a period of rehabilitation or further assessment prior or returning to their own home or entering residential or nursing home care were admitted to these wards. Transcribed interviews with nursing staff suggest there may have been insufficient rehabilitation and nursing staff to adequately meet the needs of such patients at all times.

41. A further problem is that having two different groups of elderly patients in the wards, those requiring continuing medical and nursing care with others requiring rehabilitation patients, may lead to confusion amongst staff about the management of individual patients unless patient management plans are very clearly understood by all staff. For some of the patients transferred to Gosport War Memorial Hospital it appears to have been unclear to all staff whether individual patients were for continuing care or a period of rehabilitation. Most elderly care services in the 1990s separated out continuing care from rehabilitation beds and often changed continuing care wards into rehabilitation wards and this process appears to have been eventually completed after 2000 at Gosport War Memorial Hospital.

42. Palliative care is a very important aspect of management in frail older people who develop acute illness they are unlikely to survive or have progressive disabling disease. By definition patients in NHS continuing care beds are very dependent and are expected to die on the ward. A significant number of older frail patients in rehabilitation beds will deteriorate and

palliation of symptoms prior to death will be necessary. There is no generally agreed definition of palliative care but palliative care is not confined to end-of life care. NICE has defined palliative care as *'the holistic care of patients with advanced progressive illness. Management of pain and other symptoms and provision of psychological, social and spiritual support is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families'.* Many frail older people require and benefit from such an approach.

43. In many frail older patients receiving palliative care a decision will have been made to limit the extent of other medical interventions, for example surgery, ventilation, and antibiotics. However treatment of active medical problems is compatible and often appropriate in patients receiving palliative care. Prediction of death in frail older people is difficult. Experienced clinicians recognise that patients may die and deteriorate more quickly than anticipated or alternatively that patients who are deteriorating may improve. For these reasons management plans need to be reviewed if a patients' condition changes significantly.

Use of Drug Charts in the Gosport War Memorial Hospital

44. The drug charts in use in Gosport War Memorial Hospital have a format used in most hospitals with a section for drugs given as a single dose, a section for regular drug prescriptions, a section for 'prn' drugs to be taken as required and a section for prescribing of infusions and fluid management. Drug therapy for the patients under the care of Consultant Geriatricians at Gosport War Memorial Hospital would usually be written up by Dr Barton in her role as Clinical Assistant and sometimes by one of the consultant physicians with patients on the wards.

45. A legal prescription requires a clear written record usually placed in a drug chart of the drug dose (usually in mg or other units), frequency (e.g. once, twice daily) and route of administration (oral, intramuscular etc), start and end date to be written with the signature and date of the prescribing doctor. The responsibility for the appropriateness, accuracy and legibility of a prescription lies with the prescribing doctor. When a drug is discontinued the doctor must draw a line through the prescription and sign their initials and date. The drug chart must have the name and hospital number of the patient inserted.

46. The term 'written up' indicates that a drug prescription has been written by a doctor in the notes. The term 'prescribed' means that the drug involved has been written in the drug chart and should be given to the patient as instructed; this may be a drug administered once, regularly or 'as required' where the drug is administered by the nursing staff is specific symptoms are present. A prescription is usually made by the writing up of a prescription by the responsible doctor or sometimes by a verbal order taken by a member of nursing staff. The term administered means that a drug has been given to the patient. This might be through oral, intravenous, intramuscular injection or infusion or other routes of administration.

47. It is the responsibility of registered nursing staff to administer prescribed drugs according to the instructions written in the drug chart. Registered nursing staff work within a code of professional practice and are expected to carry out administration of medicines to certain standards. Nurses are required to act in the best interest of their patients and this may require nursing staff to challenge prescribing decisions by medical staff.

48. As required or prn prescriptions are usually expected to include a specific instruction by doctors as to the circumstances under which the prescribed drug should be administered including how frequently the drug may be administered e.g. paracetamol up to 4g /24 hours. A prn prescription of GTN might include an instruction 'for angina' or for chest pain'. Prn prescriptions do not always include instructions for drugs which have a good safety profile where it would be expected nursing staff would understand the circumstances under which drugs should be administered e.g. senna or paracetamol where it would be expected nursing staff would understand that the drugs are indicated for constipation and mild pain respectively.

49. It is important that prn "as required" prescriptions for controlled drugs, such as opioids, and other drugs with potentially severe adverse effects, such as midazolam and haloperidol, include clear instructions of the circumstances under which the drugs should be administered. This can be done through the prescriber writing instructions such as 'for severe pain' for diamorphine or by nurses using an agreed protocols or policies for the drugs or the symptoms being managed. There were no unit policies or protocols for the use of opioids and other drugs or the management of pain in the late 1990s at Gosport War Memorial Hospital. Staff at the hospital did refer to the 'Wessex protocols' but these did not appear to be followed in all patients.

50. It is possible Dr Barton trusted nursing staff to know the circumstances under which prescriptions for morphine, diamorphine and midazolam were appropriately administered and the appropriate dose that should be used. However this appears not to have been clear to nursing staff in some patients. For example patient F was prescribed prn morphine without any instructions that this was for pain. Patient F was then administered oral morphine for anxiety and distress when not in pain by nursing staff when this is not an appropriate indication.

51. If wide dose ranges are prescribe for prn drugs there needs to be clear instructions or a policy in place to ensure an appropriate starting dose is commenced by nursing staff. In many patients prn prescriptions of diamorphine and midazolam were very wide e.g. 20-200 mg/24 hr and 20-80mg/24hr. Without clear instructions in the medical notes and drug chart or a policy in place which details appropriate staring dose there is a risk that patients will be administered an inappropriately high dose of a prn drug by nursing staff.

52. Out of hours or when Dr Barton was on leave, other general practitioners covering the hospital would be expected to write up any drugs required out of hours. It is not clear how often on call doctors visited the wards out of hours and in some cases drugs were prescribed by a 'verbal order'. In such a system the nurse writes down the drug prescribed over the phone by the doctor and this is usually confirmed by a second nurse to reduce the chances of any error on the drug or dose prescribed. The potential problem with 'verbal orders' for drug prescriptions is that they involve the prescription of a drug for a problem that may not have been assessed by a doctor taking a history, examining and investigating the patient where this might be required.

53. Review of the notes and interviews suggest that 'anticipatory prescribing' was undertaken where drugs were prescribed for problems that patients might develop. This is sometimes done to avoid the need for a doctor to come to a ward out of hours to prescribe for a simple complaint that does not require urgent medical evaluation.

54. It was common practice in many wards in the 1980s and 1990s for mild analgesics such as paracetamol, laxatives and hypnotic drugs such as temazepam. In recent years anticipatory prescribing of hypnotic drugs in patients who are not already receiving them is now not advised because of the risk of patients developing long term dependence on benzodiazepines as these may be continued after discharge. Because the use of benzodiazepines in older people is associated with falls and hip fracture, and may produce confusion and cognitive impairment, many geriatricians avoid and limit the use of benzodiazepines in older people.

55. Anticipatory prescribing of powerful opioids and sedatives in patients who do not require them when assessed is potentially highly dangerous as the prescribing of such drugs requires careful evaluation of the patient because of the risk of serious adverse effects such as respiratory depression and coma.

56. In the late 1990s the General Medical Council had not produced guidance on prescribing. However Good Practice in Prescribing Medicines was published by the GMC in 2006 and the principles applied in the 1990s. The Guidance refers to the importance of ensuring familiarity with guidance published in the BNF, the need to be in possession of or take an adequate history from the patient, to reach agreement with the patient on the use of any proposed medication, establishing the patient's priorities, preference and concerns, to satisfy oneself that the patient has been given appropriate information in a way they can understand about drug therapy. The guidance also states that doses should be prescribed appropriate for the patient and their condition and that there must be a clear, accurate, legible and contemporaneous record of all medicines prescribed.

57. **Declaration**

a) I understand that my overriding duty is to the panel, both in preparing reports and in giving oral evidence. I have complied and will continue to comply with that duty.
b) I have set out in my report what I understand from those instructing me to the questions in respect of which my opinions as an expert are required.
c) I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters which I regard as relevant to the opinions I have expressed.
d) I have drawn to the attention of the court all matters, of which I am aware which might adversely affect my opinion.
e) Wherever I have no personal knowledge, I have indicated the source of factual information.
f) I have not included anything in this report which has been suggested to me by anyone, including the lawyers instructing me without forming my own independent view of the matter.
g) Where, in my view, there is a range of reasonable opinion, I have indicated the extent of that range in the report.
h) At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I subsequently consider that the report requires correction or qualification.
i) I understand that the report will be the evidence that I will give under oath, subject to any correction or qualification I may make before swearing to its veracity.
j) I have included in this and the supplementary reports a statement setting out the substance of al acts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.
k) I have read and understood the Civil Procedure Rules Part 35 –Experts and Assessors.

Statement of Truth

I confirm insofar as the facts stated in my report are within my own knowledge I have made clear which they are and I believe them to be true, and the opinions I have expressed represent my true and complete professional opinion.

Code A

Gary A Ford

References

1. Drugs in the Older Population. Edited Crome & Ford. Imperial College Press. 2000; 580-600.
2. British National Formulary 36 1998 page 11
3. British National Formulary 36 1998 page 11
4. British National Formulary 36 1998 page 14
5. Commission for Healthcare Improvement Investigation of Portsmouth Healthcare NHS Trust at Gosport War Memorial Hospital. July 2002

APPENDIX To Generic Report (GMC and Dr Barton)

Professor Gary A Ford, FRCP

Pharmacology of Opioid, Sedative, Neuroleptic and Anticholinergic Drugs

Opioid Drugs

Morphine

Morphine is a potent opioid analgesic considered by many to be the 'drug of choice' for the control of acute pain (Therapeutic Drugs Dollery). It is generally considered the drug of choice for oral treatment of severe pain. Oral solutions are commonly used. A frequently prescribed preparation in the UK is 'Oramorph' which is provided as a 10mg/5ml solution. Oral sustained release preparations of morphine are prescribed once the morphine dose that a patient requires is established to reduce the need to take frequent 4 hourly doses of morphine.

Recommended starting dosage regimens of morphine for a fit adult of 70kg are for intravenous bolus dosing 2.5mg every 5 min until analgesia achieved with monitoring of the duration of pain and dosing interval, or a loading dose of 5-15mg over 30min then 2.5mg-5mg every hour. Further information on the use of morphine is provided in my Generic Report. The main therapeutic indications for morphine and other opioid drugs are the control of moderate to severe pain, use as a premedication, sedation of patients where both pain relief and sedation are required, and relief of severe breathlessness in patient with terminal respiratory disease. The major adverse effects of morphine and other opioid drugs are nausea and vomiting and in larger doses hypotension (low blood pressure) and respiratory depression. Other common side-effects include palpitations, hallucinations, vertigo, mood changes, dizziness, confusion, drowsiness, sleep disturbance, headache, urinary retention and pruritus (itching).

A standard reference text recommends *"morphine doses should be reduced in elderly patients and titrated to provide optimal pain relief with minimal side effects"*. Morphine can be used for sedation where short term sedation and pain relief are indicated.

Diamorphine

Diamorphine is also a potent opioid drug. It is more soluble than morphine and is preferred for use in palliative care or other situations where patients are unable to swallow because effective doses can be injected intramuscularly or subcutaneously in smaller volumes. This is particularly advantageous in patients who are emaciated with little muscle mass. Diamorphine is rapidly converted to morphine and therefore has almost identical therapeutic and adverse effects. Diamorphine may be mixed with haloperidol, hyoscine, levomepromazine, midazolam when administered subcutaneously.

Fentanyl

Fentanyl is very potent opioid analgesic available as a transdermal patch. The '25' patch releases 25microg/hr which is equivalent to 90mg morphine administered over a 24 hour period. The transdermal route is useful in patients who are unable to swallow and may be better tolerated than subcutaneous administration of diamorphine in agitated or restless patients who may not accept injections or remove infusion needles. Because fentanyl is very potent if can produce profound respiratory depression. It is commonly used in anaesthetic practice as a premedication and as total intravenous anaesthesia. As for other opioid drugs older people are more sensitive to the effects of fentanyl.

Sedative and Hypnotic Drugs

Chlormethiazole (Clomethiazole)
Chlormethiazole is a hypnotic drug that has sedative, tranquillizing and anti-convulsant effects. It is sometimes prescribed as a hypnotic drug for older people but its use for this indication has decreased in the last 20 years. In general most guidelines advise to avoid the use of hypnotic drugs in the elderly because of the risk of producing ataxia (unsteadiness and poor coordination), confusion and falls. It is also used to control symptoms of alcohol withdrawal.

Midazolam
Midazolam is a benzodiazepine. It is used as a hypnotic, preoperative medication, sedation for procedures such as dentistry and gastrointestinal endoscopy, long-term sedation and induction of general anaesthesia. It is not licensed for subcutaneous use, but is described in the British National Formulary prescribing in palliative care section as 'suitable for a very restless patient' it is given in a subcutaneous infusion dose of 20-100mg/24hs.

A standard text describes the use of sedation with midazolam in the intensive care unit setting, and states, *"sedation is most commonly met by a combination of a benzodiazepine and an opioid, and midazolam has generally replaced diazepam in this respect"*. It goes on to state, *"in critically ill patients, prolonged sedation may follow the use of midazolam infusions as a result of delayed administration"*. Potentially life-threatening adverse effects are described, *"Midazolam can cause dose-related CNS depression, respiratory and cardiovascular depression. There is a wide variation in susceptibility to its effects, the elderly being particularly sensitive. Respiratory depression, respiratory arrest, hypotension and even death have been reported following its use usually during conscious sedation. The elderly are listed as a high-risk group; the elderly are particularly sensitive to midazolam. The dose should be reduced and the drug given slowly intravenously in a diluted form until the desired response is achieved"*. In drug interactions the following is stated: *"midazolam will also potentiate the central depressant effects of opioids, barbiturates, and other sedatives and anaesthetics, and profound and prolonged respiratory depression might result"*.

Neuroleptic (Antipsychotic) Drugs

Thioridazine
Thioridazine is a phenothiazine antipsychotic drug that was previously widely used in the treatment of schizophrenia and psychosis. Because of cardiac toxicity the drug was restricted in use in 2000 and eventually withdrawn from the market in 2005. Before 2000 thioridazine was very commonly prescribed to treat agitation and restlessness in older people with dementia. Typical doses used were 50-100mg/day in older people. Common side effects are drowsiness, dizziness, fatigue, and vertigo

Haloperidol
Haloperidol is a butyrophenone antipsychotic drug with less sedative and fewer anticholinergic effects than other antipsychotic drugs such as levomepromazine and chlorpromazine. It has more extrapyramiodal side-effects and may casue parkinsonion symptoms, restlessness (akathisia) and involuntary movements (dystonia or tardive dyskinesia). Haloperidol causes less hypotension than other chlorpromazine and is therefore often used for the treatment of agitation and restlessness in older people. The usual oral dose used for treatment of restlessness

and agitation in the elderly is 0.5-1.5mg daily. When administered as a subcutaneous infusion a dose of 5.15mg/24hr is usually prescribed.

Levomepromazine (Nozinan)

Levomepromazine is a phenothiazine anti-psychotic drug with pronounced sedative effects. It is mainly prescribed in the management of schizophrenia but is also used as an adjunctive treatment in palliative care for the management of restlessness and distress. When used by intramuscular injection a dose of 12.5-25mg is recommended. When used as a subcutaneous infusion a starting dose of 5mg/24hours is recommended although doses up to 200mg/24hours may be required to achieve sedation in some patients. Levomepromazine can cause skin irritation when infused subcutaneously.

Anticholinergic Drugs

Hyoscine

The British National Formulary describes hyoscine hydrobromide as an antagonist (blocking drug) of acetylcholine. It reduces salivary and respiratory secretions and provides a degree of amnesia, sedation and antiemesis (antinausea). In some patients, especially the elderly, hyoscine may cause the central anticholinergic syndrome (excitement, ataxia, hallucinations, behavioural abnormalities, and drowsiness).

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CHAPTER 22

Pain Relief

P. Crome

Introduction

Persistent or recurrent pain is probably the commonest health problem faced by older people. Pain varies in location, nature, frequency and severity and there are numerous underlying causes. Clearly, the prognosis varies too, related to the aetiology. Inadequately treated acute pain, for example after surgery, results in increased morbidity through immobility leading to deep venous thrombosis, chest infections and delayed return of normal bowel function. Additionally, chronic and recurrent pain is important because it is associated with mental and sleep disturbances, decreased functioning and mobility and increased risk of hospitalisation. There are a large number of analgesic drugs available for physicians to prescribe and treatment strategies have been developed for conditions such as arthritis and the pain of cancer. However, it is the general experience that effective management with complete remission of symptoms and without drug side-effects often proves elusive. It is certainly the view of patients that pain is poorly managed.[1] This chapter summarises present knowledge about pain and its treatment in older people.

Epidemiology

A recent community study provides important information on the prevalence, location, temporal pattern and severity of pain.

Table 22.1. Percentage prevalence of pain and persistent pain* in 741 community dwelling subjects over 65

Location	Pain	Persistent pain
Head	5.1	1.5
Face	0.4	0
Neck	11.6	4.7
Back	29.6	12
Limb joints	44.5	19.4
Chest	2.4	0.7
Abdomen	5.1	1.9
Limb except joints	17.3	10.4

*Defined as pain daily for six months or more.

Adapted from Brochet *et al.*[2]

In a French study of community-living older people aged over 65, over 70% of the 741 subjects surveyed complained of pain, most commonly in the limb joints and back (see Table 22.1).[2] Almost a third of the sample complained of pain each day for more than six months. The prevalence of persistent pain was higher in the older cohorts. Thus, 49% of women and 35% of men over 84 complained of persistent pain compared to 33% and 20% of women and men aged 68–74. This high prevalence of arthritis has been confirmed in the U.K. One study reported that arthritis affected 40% and 54% of men and women respectively aged 65–74 years with slightly higher rates of 44% and 66% for men and women aged 75 or more.[3] The effect of this increased prevalence of pain on self-perceived health status may be less marked. In the Tipping the Balance Study, the SF-36 domain bodily pain score was only slightly lower (more pain) in the

80–89 year old group compared to the 70–79 age group[4] indicating that the impact of pain continues to increase into extreme old age.

Types of Pain

Pain may be defined as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage".[5] Patients use a wide range of adjectives to describe pain. These include sharp, burning, throbbing, aching and crushing. The meanings patients ascribe to these terms varies and other communication difficulties such as dysphasia or cognitive impairment may make it difficult for the physician to fully appreciate the sufferers' experiences. The use of visual aids to aid assessment of severity is used in a growing number of centres. Examples of such aids include visual analogue scales on which severity of pain is graded from "no pain" to "worse possible pain" or showing patients a series of faces ranging from a happy smiling face to one contorted with pain and asking the patient to point to the one that best shows how they feel.

Pains may be grouped into four main classes (nocioceptive, neuropathic, undetermined and psychological) which are usually managed in different ways (Table 22.2).

Pain and Old Age

The traditional view has been that older people are more stoical about pain and complain less. Studies of experimental pain produced by such stimuli as thermal radiant heat, electric shock or pressure on the Achilles Tendon have produced contradictory results; some suggest that older persons tolerance is higher whilst others show no age effect.[7–8] These studies have focussed largely and not surprisingly on superficial pain. Further criticisms

Table 22.2. Classification of pain by pathophysiological process and principal treatment modality

Type of pain	Causes	Principal treatments
Nocioceptive	Arthritis, visceral pain, ulceration, limb ischaemia	Analgesics
Neuropathic	Trigeminal neuralgia, postherpetic neuralgia, painful neuropathies, phantom limb	Antidepressants/anti-convulsants
Undetermined	Headaches, migraine	Various
Psychological	Somatisation disorder Hysterical reaction	Psychological approaches

Adapted from AGS[6]

of this area include the absence of longitudinal studies, the large number of methods used to study pain and variability of end-points that were employed. Harkins' overall conclusion was that superficial pain is not altered in old age however deep pain appears to be less frequent and less intense in a number of acute conditions.[8] The evidence for the latter is based on the phenomenon of silent myocardial infarction[9] or silent perforated peptic ulcer[10] in which the older patient presents with atypical features such as fatigue and immobility rather than with pain. However, patient selection for these studies may have affected the results and whilst clinicians should always be aware of atypical presentation, classical presentation is still more common. Denial of pain may have other causes. Interestingly, Barsky *et al.* in their review of this subject do not present any evidence of age being a factor.[11] However it is doubtful whether these differences have any influence on treatment strategies which depend on the titration of analgesic dose and dosing interval against clinical symptoms.

Pain in Nursing Home and Cognitively Impaired Patients

The assessment and treatment of pain in patients in nursing homes deserves special consideration. This group of older people has the highest prevalence of pain (several studies reporting rates over 50%), the highest rates of co-morbidity, the highest levels of dependency and the highest rates of cognitive impairment due to dementia or sequelae of stroke. Assessment and management therefore pose particular problems. However, they do also have the potential advantage that they are observed 24 hours a day by nursing staff. Their general frailty may make investigation of underlying causes difficult. Important points in management include treating all co-morbid conditions as optimally as possible. For example, pain from an enlarged liver will respond to treatment for the heart failure producing hepatomegaly. Depression should be treated and patients should be encouraged to be as independent as possible. Exercise programmes should become standard.[12,13] This subject has been reviewed elsewhere by Ferrell[14] and Pamelee.[15–16] The latter author makes the point that there is good evidence that the expression of pain by cognitively impaired individuals should be regarded as valid and should not be dismissed.[15] Whenever possible clues should be sought from observations of staff and relatives, for example, groaning on moving. Within the limits imposed by the patient's condition and co-operation relevant investigations should be undertaken (simple X-rays, ultrasound). In addition to the obvious discomfort caused to the sufferer, families and friends may also be extremely distressed by the observation of such behaviour. Patients with dementia may enter a terminal phase. Such patients should be managed along the general lines established for palliative care in cancer.

The Treatment of Pain

Acute Pain

The basic principals are relatively simple. Treat the underlying cause, (e.g., antibiotics for infection, fixation for fracture) and give adequate pain relief. The nature of the painful condition, the response of the patient and the presence of co-morbidity will dictate whether to start with a mild analgesic or to go immediately to a more potent drug. In view of the uncertainty of response and the fact that drug toxicity may occur unpredictably might suggest that the general rule "start low, go slow" should remain. In order to avoid the situation that patients remain in pain, "starting low" must be followed by regular re-evaluation with, if necessary, frequent increases in drug dose.

Chronic Pain

The management of chronic pain differs from that of acute pain in that a range of additional issues may emerge and always need to be considered. The basic principle is, however, similar — accurate diagnosis and adequate analgesic drugs. However, in all cases of chronic pain, particularly those in which the cause is not adequately diagnosed or when the severity of pain and disability seems greater than the underlying disease process would suggest, the following points should always be considered:

- disease modification (e.g., second-line drugs for arthritis),
- concerns about long-term as opposed to acute side-effects of drugs,
- risk of addiction,
- life-style coping strategies (e.g., behavioural-cognitive therapy),
- psychiatry co-morbidity (e.g., depression),
- interventional treatments (e.g., nerve blocks etc.).

The issues relating to drugs are discussed below but detailed discussion of non-pharmacological issues is outside the scope of this chapter. Many patients will benefit from multi-disciplinary assessment in pain clinics.[17]

Pharmacological Approaches

The basic principles of drug therapy are to keep drug regimens simple, to prevent side-effects, to reassess frequently, to recognise that dosage needs to be individualised and that large doses may be required. Although there is wisdom in the standard aphorism "start low and go slow" it should not be so low and so slow that the patient gets no pain relief. This is important because of the evidence that the elderly are denied analgesics when younger patients are given them.[18]

The Analgesic Ladder

There are a large number of analgesic drugs. They can be grouped into three main classes according to the severity of pain for which they are suitable to be prescribed. In practice, one can suffice with a relatively small formulary of drugs. Table 22.3 lists those drugs which are available in our hospital grouped by type of pain for which they might be used. The drugs for mild pain (aspirin, ibuprofen and paracetamol) are generally regarded as being equipotent and, in the U.K. are available for over the counter sale without prescription. Morphine is generally regarded as the drug of choice for severe pain. The use of drugs between these two poles of efficacy is more problematic in that their potential usefulness is often hampered by unacceptable side-effects.

Paracetamol (acetaminophem)

This is the safest analgesic drug being virtually devoid of side-effects at standard therapeutic doses. There is some evidence that

Table 22.3. Analgesic drugs available in North Staffordshire Hospital

For mild pain	Aspirin Paracetamol Ibuprofen
For moderate pain	Combination analgesics: Co-codamol 8/500 (codeine 8 mg, paracetamol 500 mg) Co-proxamol 32.5/325 (dextropropoxypehene 32.5 mg, paracetamol 325 mg) Non-steroidal anti-inflammatory drugs Diclofenac, indomethacin, naproxen
Opioid	Codeine Diamorphine Dihydrocodeine Morphine Pethidine
Adjuvant therapy	Amitriptyline Carbamazepine Valproate

prolonged therapeutic dosage might increase renal impairment but this is not proven. The only significant toxicity is hepatic and renal failure following acute overdosage. A number of studies have shown no clinically relevant difference in pharmacokinetics between young and elderly subjects.[19–22] Wynne *et al.* investigated the drug's pharmacokinetics in both healthy and frail older subjects.[23] Half-life was not prolonged in the fit elderly group but was in the frail group when compared to healthy young subjects (mean values 123, 144 and 226 minutes respectively). Clearance was reduced by approximately 50% in the frail older group compared to the young healthy subjects. Clearance for the fit elderly fell mid-way between these two groups. Thus although the pharmacokinetics of paracetamol do show some significant alterations in old age they are probably of insufficient size to warrant routine dosage reduction, except possibly in frail older

subjects. Hepatotoxicity in this group with usual dosing has not been reported.

Aspirin

Acetyl-salicylic acid or aspirin as it is usually referred to in the U.K. has anti-inflammatory and antipyretic actions as well as being a widely used analgesic. Its major role now is as an anti-platelet drug in the secondary prevention of cardio-vascular and cerebro-vascular disease (see Chapters 11 and 15). Its principal disadvantage is that it causes gastric erosions and may precipitate haemorrhage and perforation. Aspirin is rapidly absorbed undergoing hydrolysis both in the gut wall and liver. Further hydrolysis occurs in the blood by red cell esterase. Its metabolite, salicylic acid undergoes conjugation and oxidation before excretion. There have been several studies examining the influence of age on the drug's pharmacokinetics. Although statistically significant changes in some pharmacokinetic measurements have been shown after oral administration of aspirin, these are regarded as being not of sufficient magnitude to justify dosage alteration.[24–25] It is not clearly stated in the above two papers whether the elderly subjects were fit or frail. The influence of frailty on pharmacokinetics is potentially important (see Chapter 4). The influence of frailty of aspirin esterase has subsequently been investigated. Williams *et al.* found that plasma esterase activity was reduced in frail elderly subjects compared healthy elderly subjects.[26] This was investigated further by Summerbell *et al.* who concluded that the impaired aspirin metabolism in frail elderly people was the consequence of a reduction in quantity of the esterase.[27]

Enteric-coated aspirin may reduce side-effects but with in at least one brand, clear absorption profiles were not observed.[28] In practice no dosage reduction is necessary in older people. It is suitable as an alternative to paracetamol in those already taking

the drug as prophylaxis for vascular disease and in those small number of patients who can not tolerate paracetamol. It should be avoided in those with upper gastro-intestinal pathology because of the increased risk of bleeding[29] and in those who have shown other sensitivities to the drug (e.g., asthma).

The prostaglandin analogue misoprostol, histamine$_2$-receptor antagonists and proton-pump antagonists have been shown to reduce gastro-intestinal toxicity from aspirin and other non-steroidal anti-inflammatory drugs in a variety of clinical and experimental situations. However, it is yet clear whether one or other of these classes of drugs should be co-prescribed routinely to elderly patients when they are receiving long-term analgesic treatment with aspirin. This is the subject of a Cochrane Collaboration review.[30]

Ibuprofen and the Non-steroidal Anti-inflammatory Drugs

Ibuprofen is a non-steroidal inflammatory drug that is believed to act by inhibiting the enzyme cyclo-oxygenase and reducing the production of prostaglandins. The principal side-effect is upper gastro-intestinal erosion leading to haemorrhage and perforation. There is good evidence that ibuprofen is the least damaging in this respect and it may be the most effective of the simple analgesics for acute pain.[31] There are a wide range of other often over-looked side-effects including salt and water retention, hypertension and renal failure. The other drugs of this class are more potent, but also produce more side-effects. They have their major role in the treatment of arthritis and discussed in more detail in Chapter 21.

Combination Analgesics

The use of analgesic combinations containing two drugs acting through different pharmacological mechanisms offers theoretical

advantages of greater pain relief without the disadvantage of side-effects. A large number of combinations of simple analgesics such as aspirin and paracetamol with low dose or low potency narcotic drugs are available both as over the counter and prescription only medication. de Craen *et al.* concluded in their systematic review of codeine-paracetamol combinations, used principally in the post-operative situation, that the analgesic advantage of the combination over paracetamol alone was small.[32] Side-effects were higher with the combination following multiple dosing (pooled rate ratio 2.5, 95% CI 1.5–4.2) but not statistically significant after single doses. There is no information about the effect of age on this interaction. Codeine combinations can lead to constipation whilst those containing dextropropoxyphene are a commonly involved in deliberate self-harm. Overdoses of co-proxamol (paracetamol and dextropropoxyphene) are particularly difficult to manage. Not only is there the problem of early toxicity from the opioid component but also a delayed risk of paracetamol hepatoxicity. This combination is extremely popular and well tolerated as an analgesic despite there being a lack of good evidence of superior efficacy compared to paracetamol alone. There is little information about the use of the drug in older patients but its elimination half-life is significantly prolonged in older people. The half-life of its major metabolite nor-dextropropoxyphene is prolonged even more and in many patients had not reached steady-state plasma concentrations even after several days treatment.[33]

Opioid or Narcotic Analgesics[34]

These exert their analgesic effects through central nervous system opioid receptors. Most of the commonly used drugs (morphine, codeine, dextropropoxyphene) are agonists exerting their principal therapeutic action through the μ_1 opioid receptor. Other generally less potent opioids have partial agonist or agonist-antagonist

Table 22.4. Adverse effects of opioid drugs

Respiratory system	Respiratory depression (reduced respiratory rate, tidal volume) Hypoxia and hypercapnoea Cough suppression
Cardiovascular system	Hypotension Bradycardia (vagal effect)
Gastro-intestinal system	Reduced oesophageal pressure — incresed reflux Delayed gastric emptying and gastro-intestinal motility *Constipation Abdominal pain
Central nervous system	Tolerance *Drowsiness Coma Seizures Movement disorders *Nausea and vomiting Pupillary constriction *Confusion Hallucinations
Urinary system	Retention of urine

*Common

activity (e.g., buprenorphine, pentazocine). These latter drugs tend not to be so useful in older people because of their dysphoric side-effects. The range of recognised side-effects of opioids is quite considerable and these are listed in Table 22.4.

Since narcotic analgesics are one of the principal drugs of addiction, there is obvious concern that by giving these drugs to patients they will become dependent. However there is little evidence that therapeutic administration of narcotic drugs produces addiction. For example, Porter and Jick[35] reported that only four of 11,882 patients who were prescribed a narcotic

analgesics during their hospital stay developed evidence of addiction. However, dependency is a real, albeit uncommon occurrence and it is wise to exercise some precautions in prescribing. Special care needs to be taken over decision to prescribe opioids to patients with pre-existing psychiatric disease, alcoholism or those with a personality disorders.

Morphine

Morphine is by far the most commonly used opioid and may be prescribed both orally and parenterally. It is metabolised in the liver to glucuronides, morphine-6-glucuronide, being the major active metabolite. The excretion of this metabolite is dependent on renal function which is relatively reduced in older people. Baillie *et al.* reported that morphine clearance was reduced by a third following intravenous administration. The areas under the plasma concentration time curve were greater following both morphine slow-release and elixir preparations.[36] Sear *et al.* found that the area under the plasma concentration time curve for morphine-6-glucuronide was similar in elderly and middle aged patients undergoing surgery although the clearance of the parent compound was reduced.[37] If clearance was reduced one might expect less of the glucuronide to be formed. The observation that the area under the plasma concentration time curve was not in fact reduced suggests that clearance of the metabolite is also reduced. The greater pharmacodynamic effect reported below may therefore be due to relative accumulation of morphine-6-glucuronide.

The evidence suggests that older people require a smaller initial dose of the drug but subsequent doses should be guided by response. Bellville *et al.* reviewed 712 patients who received either morphine or pentazocine commented that age had an effect independent of operation site, height and weight and hospital.[38] In another study, Kaiko found that for a given dose

of morphine both the duration of pain relief and the quantity of pain relief were approximately 50% more in patients aged 70–89 than those aged 18–29.[39] Studies on the pharmacokinetics of the drug mentioned above are compatible with these observations.

Morphine has the advantage of being available in a number of formulations including oral solutions and various sustained release preparations. The conversion dose for oral to parenteral morphine is three to one. It may also be used in more sophisticated ways for example by patient controlled infusion. Thus Egbert *et al.* reported a clinical trial of patient controlled intravenous morphine compared to standard intra-muscular morphine in a group of frail elderly surgical patients.[40] They found that, not only was pain better controlled when given by the self-administered route, but that post-operative confusion and pulmonary complications were reduced. Morphine is also commonly given by sub-cutaneous infusion via a syringe driver to patients who cannot swallow and who are terminally ill.

Pethidine

Pethidine (meperidine in U.S.A.) is converted to an active metabolite nor-pethidine which acts predominately on the μ-receptors. Accumulation can occur with dysphoric neuropsychiatric symptoms and seizures. It has a short duration of action that makes it unsuitable as an analgesic for anything other than pain of brief duration. It is therefore now used to a much lesser degree in the management of chronic pain and should be avoided in older people.

Prescribing Guidelines

The usual method of prescribing morphine for chronic pain is to start with standard oral morphine (tablet or liquid) in a dose of 5–10 mg every four hours. This dose should be halved in frail

older people. In addition further doses should be given if breakthrough pain occurs. Patients should then be switched to a twice daily sustained-release preparation (e.g., MST) with additional doses of 1/6 the total daily dose for breakthrough pain. At the same time laxatives (e.g., senna and lactulose or codanthramer) should be started to avoid constipation. Nausea and vomiting should be treated with regular metoclopramide or haloperidol.

Atypical Pain

A number of pharmacological agents have been used in the treatment of atypical and neuropathic pains. Many of these diseases have their peak frequencies in later life but there is a paucity of information about the influence of age as an independent factor in determining treatment choice and response.

Antidepressants

Patients with chronic pain may become depressed and it is often difficult to disentangle somatic complaints may be part of depressive symptomatology. Differentiation of cause and effect may be difficult. Antidepressants such as amitriptyline may be useful in chronic pain even when there is little evidence of depression. Support for this view comes from an open study of different treatment approaches to post-herpetic neuralgia. The antidepressants amitriptyline and nortriptyline were reported as useful in 60% of these patients who as a group were not depressed as judged by the Beck Depressive Inventory.[41] On the other hand carbamazepine and other anti-convulsants were not helpful. Antidepressants have been shown to be more effective than carbamazepine in central post-stroke pain.[42] This beneficial effect can be achieved at doses lower than would be given for the treatment of depression.

A meta-analysis of 39 placebo-controlled studies confirmed the efficacy of antidepressants. They calculated that the average chronic pain patient had less pain than three quarters of the patients who had been treated with placebo.[43] The benefits of antidepressants in neuropathic pain have also been demonstrated in a systematic review.[44] Some of these drugs (principally the tricyclic antidepressants) are dangerous in overdose and the risk of suicide must always be assessed before they are prescribed.

Carbamazepine

This has a long-standing role in the treatment of trigeminal neuralgia but is now being used in other neuropathic condition.[45] Carbamazepine response may fluctuate but this is not related with plasma drug concentrations.[46] The relationship between the underlying cause of this condition which may be due to vascular compression[47] and the modes of action of drugs which ameliorate it are not clear. Phenytoin and baclofen may be effective if carbamazpine fails. The mode of action of carbamazepine in trigeminal neuralgia is not certain. Meta-analysis of the effects of carbamazepine and other anticonvulsants has found benefit from these drugs in a number of painful conditions.[48]

Pain Clinics

The management of chronic persistent pain is probably best undertaken by a multi-disciplinary pain clinic employing a variety of non-pharmacological approaches. The effectiveness of such an approach in older people has been reported by Helme *et al.*[17] They found that of their cohort 72% had less pain, 53% reported being more active and in 65% mood was improved. Only 4% reported no improvement at all. These clinics use many other techniques. Behavioural-cognitive therapy is based on a detailed understanding of the psycho-social context in which the

individual's pain is experienced. Then a range of specific strategies are devised, for example, stressor situations can be managed by, for example, avoidance, thus controlling pain and improving quality of life.[49] Physical treatments include heat, cold, massage, aromatherapy and TENS. Again there is a paucity of randomised controlled data about the efficacy of these modes of therapy in old people.

Conclusions

Pain, both acute and chronic is a common problem in older people. As in so many field of geriatric medicine there is paucity of information about the differences in approach that are required to produce optimal benefit. Indeed in one recent review of treating acute pain in hospital, the only comment made about older people related to co-existing illnesses and differences in drug handling.[31] The key practice points are to ask about pain specifically for most patients have more pain then they report, to give adequate doses of effective drugs at regular intervals. Frail older people should be started on reduced doses of opioids but otherwise healthy older people should receive standard doses.

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GMC and Dr Jane Barton
Supplementary Report to
Generic Report on Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital

Professor Gary A Ford, FRCP
Consultant Physician

22 May 2009

GMC and Dr Jane Barton
Generic Report on Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital

1. This report is supplementary to my previous report dated 21 April 2009 and is made for the purpose of correcting drafting errors. All page number references in the report refer to the -123- format.

2. Introductory paragraph line 3 '..relates to separate individual reports provided on eleven patients' corrected to '...relates to separate individual reports provided on twelve patients.'.

3. Section 1 line 6 'There are some typographical errors...' changed to 'There are some typographical and minor factual errors...'

   Section 3 line 9 '... due to sanitization of conversion disorders..' corrected to '.. due to somatisation or conversion disorders..'.

   Section 11 line 1 'The parenteral route and that is the administration..' corrected to 'The parenteral route which is the administration...'

   Section 20 line 4 ' ..results in patients are put at risk..' corrected to 'results in patients being put at risk ...'.

   Section 23 line 1 ' .. are recorded in the notes are available..' corrected to ' .. are recorded in the notes and are available..;'.

   Section 29 line 8 ' .. inserted along the initials of the doctor..' corrected to '..inserted along with the initials of the doctor..'.

   Section 30 line 6 ' ..5-10mg of morphine or 2.5mg of diamorphine.' changed to '.. 5-10 mg of morphine or 2.5-5mg of diamorphine.'

   Section 32 line 2'. 'Wessex Protocols, produced to help GPs and ...' corrected to ' Wessex Protocols, to help general practitioners..'.

   Section 32 line 7. '...the use of morphine the recommend starting...' corrected to '.. the use of morphine they recommend starting...'.

   Section 33 line 4. '....weakness and the conversion of oral ....' Changed to '..weakness. The document recommends the conversion of oral...'.

   Section 35 line 1 'Clinical assistant posts are non-training service, usually part time posts established by hospitals generally undertaken by general practitioners. Theses posts..' corrected to "Clinical assistant posts are non-training service, usually part time, posts established by hospitals and are generally undertaken by general practitioners. These posts..'.

   Section 39 line 6. '.... it is important that they seek advice....' corrected to '... it is important that clinical assistants seek advice...'.

Section 46 line 4 '..where the drug is administered by the nursing staff is specific symptoms are present.' corrected to ' .. where the drug is administered by the nursing staff if specific symptoms are present.'

Section 50 line 6 ' ...when this is not an appropriate indication.' corrected to ' ...when this was not an appropriate indication.'

Section 51 line 1. 'If wide dose ranges are prescribe for prn drugs there needs to be...' corrected to 'If wide dose ranges are prescribed for prn drugs there need to be...'

Section 51 line 5 '....or a policy in place which details appropriate staring dose...' corrected to ' .. or a policy in place which details an appropriate starting dose...'.

Section 52 line 6 '...the chances of any error on the drug or dose prescribed.' Corrected to ' ... the chances of any error in the drug or dose prescribed.'

Section 54 line 2 '.... paracetamol, laxatives and hypnotic drugs such as temazepam.' Changed to '...paracetamol, laxatives and hypnotic drugs such as temazepam to be prescribed routinely on a prn basis for patients'.

4. I understand my duties as an expert, as set out at paragraph 57 of my Generic Report.

I believe that the facts I have stated in this report are true and that the opinions I have expressed are correct.

Code A

.....

GARY A FORD

Generic

GMC – v – DR JANE BARTON

CHRONOLOGY: PATIENT C – EVA PAGE

Date of Birth: Code A

Date:	Event:	Source:	Page(s):	Comments:
30/4/97	Admitted to Queen Alexandra Hospital, following a collapse. Diagnosed with a reversible ischaemic neurological deficit. Commenced on aspirin. Discharged back to residential home on 7/5/97.	Correspondence Discharge summary Nursing notes Clinical notes	52-57 58 136-139 160-165	
6/2/98	Admitted to Queen Alexandra Hospital, Department of Medicine for Elderly People. Diagnosis includes probable carcinoma of the bronchus and depression.	Spell summary Patient profile Care plan Nursing notes X-ray report Clinical notes	202 207 228 232 290 296	

19/2/98	Transferred to Charles Ward, Queen Alexandra Hospital, under Dr Lord.	Transfer form Spell summary Care plan Nursing notes Clinical notes	196 198 218-230 235 302	
27/2/98	Transferred to Dryad Ward, GWMH. Reviewed by Dr Barton.	General information Significant events Nursing care plan Spell summary Clinical notes	166, 169 170 174-192 194 304	
	Drug charts indicate: • Oramorph: Dr Barton prescribes 2.5ml (5mg) PRN. • Thioridazine: Dr Barton prescribes 25mg PRN. • Dr Barton also prescribes digoxin, frusemide, ramipril, sotalol, sertraline and lactulose.	Drug charts	272	

28/2/98	Drug charts indicate: • Oramorph: 5mg administered at 16.20. • Thioridazine: 25mg administered at 13.00. Further unclear dose then prescribed. • Heminevrin: Unclear dose prescribed. Administered at 22.00.	Significant events Nursing care plan Drug charts	170 174-192 272, 274, 276	
1/3/98	Drug charts indicate: • Thioridizine: Two doses administered. • Heminevrin: One dose administered, then discontinued.	Nursing care plan Drug charts	181 276	
2/3/98	Seen by Dr Barton. Reviewed by Dr Lord.	Significant events Clinical notes	170 305	

	Drug charts/nursing notes indicate: • Fentanyl: Dr Barton prescribes Fentanyl 25 patch x 5 days PRN. Patch administered at 08.00. • Diamorphine: Dr Barton prescribes 5mg. Administered at 08.00 and 15.00. • Thioridizine: One dose administered, then discontinued.	Significant events Drug charts	170 272, 276	
Undated	Drug charts indicate: • Diamorphine: Dr Barton prescribes 20-200mg/24hrs (in daily review prescriptions, marked "PRN") by subcutaneous infusion. • Midazolam: Dr Barton prescribes 20-80mg/24hrs (in daily review prescriptions, marked "PRN") by subcutaneous infusion. • Hyoscine: Dr Barton prescribes 200-800µg/24hrs (in daily review prescriptions, marked "PRN") by subcutaneous infusion.	Drug charts	278	
3/3/98	Drug charts indicate: • Diamorphine: 20mg/24hrs administered from 10.50. • Midazolam: 20mg/24hrs administered from 10.50.	Drug charts	278	

	Death recorded at 21.30.	Significant events Nursing care plan Clinical notes	171 181 306	

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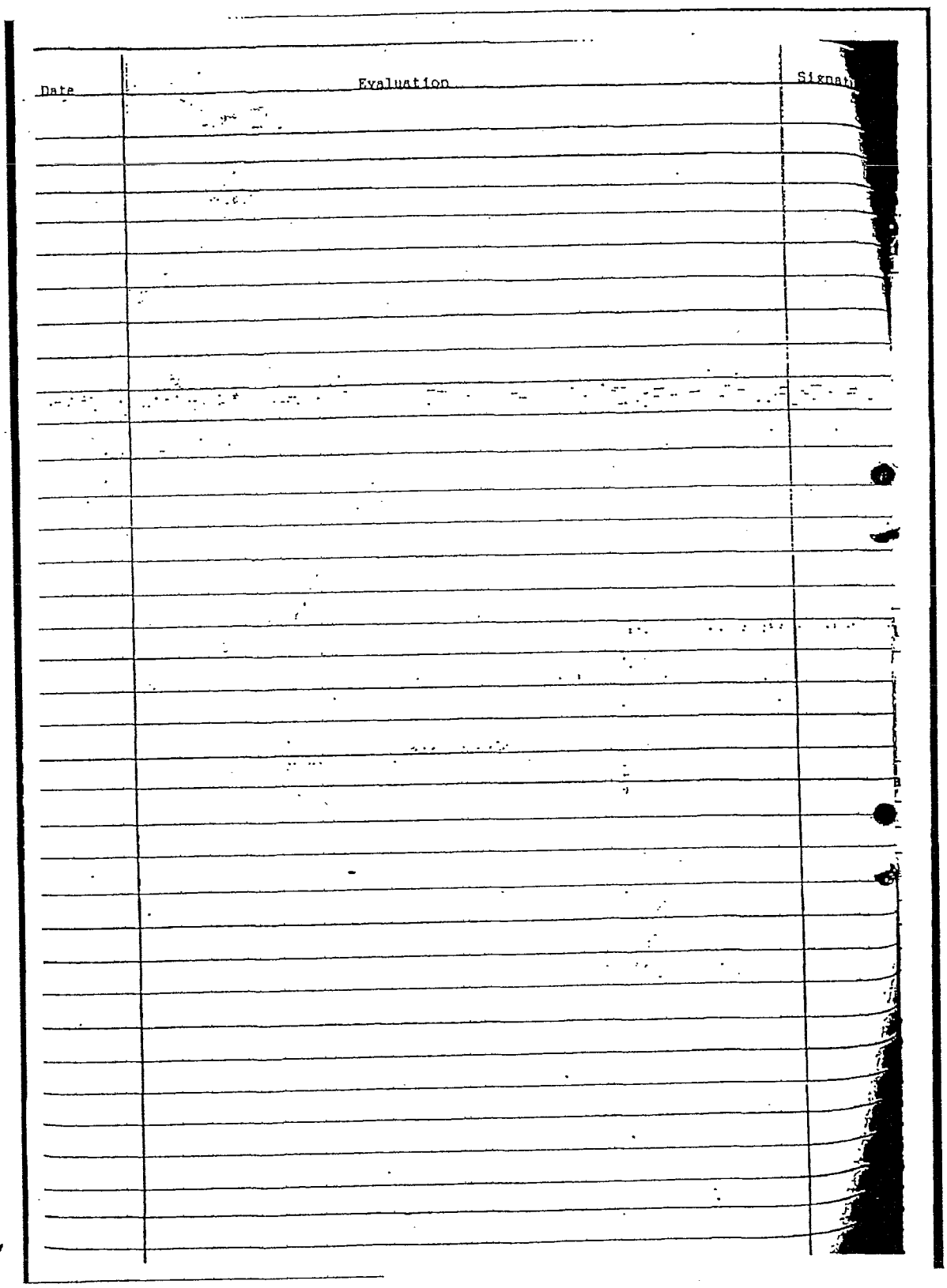
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Code A

Date	Evaluation	Signature

QAH | F1

CONSULTANT AWM

ALLERGIES AND DRUG SENSITIVITIES

None known.

Unit No.

SURNAME (Block letters) PAGE

First Names EVA.

Date of Birth 29/12/10 | Wt.

FIX CONTINUATION MR411 (E) HERE

Date	Time	ONCE ONLY AND PRE-MEDICATION DRUGS	Route	Dose	Signature	Given

AS REQUIRED PRESCRIPTION (Including Post-Operative Drugs valid for 48 hours only)

Administration Record FIX CONTINUATION MR 411 (B) HERE

Prescription	Date	Time	Dose	Given	Date	Time	Dose	Given	Date	Time	Dose	Given	Date	Time	Dose	Given
DRUG (Approved Name)																
Route / Dose / Date / Pharm																
SIGNATURE																
SPECIAL DIRECTIONS																
DRUG (Approved Name)																
Route / Dose / Date / Pharm																
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Route / Dose / Date / Pharm																
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SPECIAL DIRECTIONS																

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WOE 10-0

DATE	NURSING CONTINUATION SHEET	SIGNATURE
	Spoke with MO Greatbatch. Transport booked for pm. Son informed.	
7-5-97	Discharged from ward. ~~Transport~~. TTA's given to her. Nursing home contacted that she was left the ward.	SO

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MR 200

QA HOSPITAL

HISTORY SHEET

UNIT NO S.M.W. M.F.

Name PACE, Eve
(Surname First)

Address

Date of Birth 29.12.9

Family Dr.

DATE	CLINICAL NOTES (Each entry must be signed)
2.5.97	Reviewed again. CT could not be done. Extremely confused, refusing to cooperate. Normally lives in Residential. We are left to with social problems. Needs assessment by the psychogeriatrician Please Refer Dr ASHRAF Cons.
6.5.97	MRC explained that had a stroke comprehension good much less confused. appreciate of transient symptoms unlikely to be a seed in view of rapid recovery

Code A

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Code A

INDEX OF PATIENT'S PROBLEMS

LP8

NAME. EVA PAGE .....D.O.B. 29:12:09..HOSP.NO.....

TEAM. A! TEAM .....DESIGNATED NURSE. LYNNE BARRETT

PATIENT'S PROBLEM/NEEDS.....

.....

	RESOLVED	DATE
1. MOUTH ASSESSMENT		
2. MOVING AND HANDLING PROFILE.		
3. PERSONAL HYGIENE		
4. ELIMINATION - URINARY		
5. ELIMINATION - BOWELS.		
6. SLEEP.		
7.		
8.		
9.		
10.		

NI/NURS/SL-FORM

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PORTSMOUTH HealthCare NHS TRUST

HANDLING PROFILE

Name Eva Page. Date of Birth 29.12.09.
Hosp. No 0579096 Location CHARLES (19/2)
Care Group SW Cooper Weight
Diagnosis Anorexia / ?cu lung

PATIENT/CLIENT RISK FACTORS eg	EFFECTS OF RISK FACTORS ON ABILITIES/HANDLING NEEDS
COMMUNICATION	depressed + introverted
COMPLIANCE	appears to understand
PAIN	No c/o pain
SKIN INTEGRITY	Waterlow 20 lacerations from falls.
CLIENT/CARER PREFERENCE	Skin dry + thin Anxious + afraid
ENVIRONMENTAL RISK FACTORS	
EG. PRESSURE RELIEVING MATTRESSES	Pegasus Bi valve.
ADDITIONAL HANDLING CONSTRAINTS	
EG. IVI, URINARY CATHETER	22/2/98 Indwelling catheter

		RE-EVALUATION
Date of Assessment	19/2/98	
Name of Assessor	S M Cooper	
Signature of Assessor		
Designation of Assessor	RGN.	

PORTSMOUTH HealthCare NHS TRUST

EVALUATION

	EVALUATION		
MOVEMENT	RAG	AT BEST	AT WORST
1.Turning/Rolling	A	Independent	Assistance needed 2 nurses.
2.Up/down Bed	A	Independent.	2 nurses using multiglide and through arm.
3.In to bed	A	Independent.	2 nurses to steady.
4. Out of bed	A	Independent	2 nurses to steady.
5.Sit to Stand/Standing	R	Independent.	2 nurses to steady.
6.On/Off Toilet/Commode	R.	Independent	2 nurses to steady.
7.In/Out of Chair	A	Independent.	2 nurses to steady
8.Walking		Independent.	2 nurses to steady.
9.Bath/Shower	R.	Independent.	2 nurse using bath hoist.
Signature of Assessor	J TURNER		RE-EVALUATION
Print Name			
Designation	HCSW.		
Date of Assessment	7.2.98.		

Red = Much assistance required Amber = Some help Green = Independent

Code A

Code A

Code A

DEPARTMENT OF MEDICINE FOR ELDERLY PEOPLE

NAME..... D.O.B. .....

	Initials							
WATERLOW SCORE - Review weekly Add scores to risk factor	Date							
Build/Weight for Height Average Above average Obese Below average	0 1 2 3							
Continence Complete/Catheterised Occasional incontinence Cath/incontinent of faeces Doubly incontinent	0 1 2 3							
Skin Type - Visual Risk Areas Healthy Tissue paper/dry/ oedematous/clammy Discoloured Broken/spot	0 1 2 3							
Mobility Fully Restless/fidgety Apathetic Restricted Inert/traction Chairbound	0 1 2 3 4 5							
Sex/Age Male Female 14 - 49 50 - 64 65 - 74 75 - 80 81 +	1 2 1 2 3 4 5							
Appetite Average Poor/NG tube Fluids only NBM/Anorexic	0 1 2 3							
Special Risks **Tissue Malnutrition** eg: Terminal cachexia Cardiac failure Peripheral vascular disease Anaemia Smoking	8 5 5 2 1							
Neurological Deficit eg: Diabetes/M.S./C.V.A. Motor/sensory paraplegia	8 - 6							
Major Surgery/Trauma Orthopaedic - below waist Spinal On table more than two hours	5 5							
Medication Steroids, cytotoxics High dose anti-inflammatory	4							
Score								

Score: 10 - at risk 15 - high risk 20 - very high risk

DEPARTMENT OF MEDICINE FOR ELDERLY PEOPLE

CARE PLAN

NAME OF PATIENT HOSPITAL NUMBER QS790 96

DATE	PROBLEM
	DESIRED OUTCOME

	PRESCRIBED CARE	REVIEW	SIGN.

Code A

DEPARTMENT OF MEDICINE FOR ELDERLY PEOPLE

NAME OF PATIENT Eva Paye CARE PLAN

D.O.B. 29-12-09 HOSPITAL NUMBER Q579096

DATE	PROBLEM DIET (2)		
19/2/98	Eva needs encouragement to Eat & Drink... She is dehydrated.		
	DESIRED OUTCOME		
19/2/98	To maintain an adequate Food & Fluid intake.		
	PRESCRIBED CARE	REVIEW	SIGN.
19/2/98	• Help Eva to choose foods that she enjoys from the menu. • Encourage her to drink regularly. • Make sure that she is sitting comfortably & help her with her food if she is unable to manage by herself.	23.2.98	J. Tomkins
23/2/98	Reviewed - continue as above	28.2.98	[signature]

WHL 1517

Code A

Code A

Code A

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Code A

DEPARTMENT OF MEDICINE FOR ELDERLY PEOPLE

NAME OF PATIENT Eva Page CARE PLAN

D.O.B. 29-12-09 HOSPITAL NUMBER Q579096

DATE	PROBLEM	PSYCHOLOGICAL (9)		
19/2/98	Eva is very frightened + needs plenty of reassurance + to see that she has not been left alone.			
19/2/98	DESIRED OUTCOME			
	For Eva to feel settled + not frightened			
	PRESCRIBED CARE		REVIEW	SIGN.
19/2/98	• Explain any procedures or treatments to Eva so that she understands • Give her time to express any fears or worries she may have. • Explain to Eva's family any treatments or procedures necessary + give them time to express any worries they may have. • Explain the philosophy of Charles Ward.		23.2.98	J Tomlinson
25/2/98	Confusion ↑, may require prn midazolam if anxiety ↑ + she becomes very distressed. To be reviewed by Dr Vardon re dose of sedation			R Cooper
25.2.98	Eva has been commenced on Thioridazine to try and alleviate her fears and anxieties. • Continue to assess effectiveness			

WHL 1517

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DEPARTMENT OF MEDICINE FOR ELDERLY PEOPLE

NAME OF PATIENT Eva Page. HOSPITAL NUMBER Q579096

D.O.B. 29-12-09.

DAILY SUMMARY

DATE/ TIME	COMMENT	SIGN
	24.02.98 09-35 contd.)	
	given. (4b) d) Bioclusive applied sacral area.	A Wendell CE
24/2/98	(2) Small meal taken - but no supps.	
1900	Drinks encouraged. (5a) Collect bag emptied.	
	urine very concentrated. (3a) Incontinent of loose	
	faeces. (4) Washed & made comfortable.	L.
	(9a) Eva getting progressively more upset,	
	frightened and agitated. 2.5 mg Midazolam	
	given with little effect.	
nocte	2) Taking fluids well. 3a) Catheter patent	
	and draining well. 3a) Catheter patent and	
	draining well. 3b) faecal leakage x3	
	overnight. Washed and changed as necessary.	
	9) Very unsettled - calling out loudly, and	
	disturbing other patients. Appeared very	
	agitated. Midazolam 2.5mg given at	
	23.15 hours with little effect. Eva remained	
	agitated and noisy. Reassurance given.	
	A further 2.5mg midazolam given at	
	01.45 hours with short term effect only. P Bowley	
07.15.	A little more settled this morning.	
1300	(1a) Asleep for most of the morning.	
	Then alternating with coughing, breathlessness	
	and calling out. (2) No supps taken.	
	but has had some fluids. Likes her	
	H. Protein drinks. (5a) Catheter bag	
	emptied - patent + draining. (3b) Nil form	
	Bowels. (9a) Re-assurance given but Eva	
	as before is frightened - but doesn't	
	know why. (9) No calls or visitors	L.

DEPARTMENT OF MEDICINE FOR ELDERLY PEOPLE

NAME OF PATIENT Eva Page

HOSPITAL NUMBER

DAILY SUMMARY

DATE/ TIME	COMMENT	SIGN
10.15hrs	(2) small amount of ice-cream taken	
	otherwise declined. oral fluids taken.	
	(3a) catheter draining. (3b) abdomen	
	distended ?bowels. PR faeces in rectum	
	[illegible] suppositories administered as agreed.	
V	small constipated result. + fluid.	
	(4) position altered	
	(9) remaining anxious and agitated	
	reassurance offered.	[illegible]
	(4) full wash given, mouthcare	
	declined.	
nocte	Much more settled night. Calling out at	
	times although settled quickly. Thioridazine	
	given as px at 22^00 hrs.	
	3a) Catheter patent but draining only small	
	volumes of urine.	
	Nursed on alternate sides.	
	3b) Continues to leak faecal fluid - Washed and	
	changed as necessary.	[illegible]
26.2.98	(3a) Catheter draining minimal amounts. (3b)	
	leaking faecal fluid - so with Eva's permission	
	rectal examination performed - faecal fluid only.	
	high phosphate enema given - with 1 small amount	
	constipated stool passed. (4) Full wash given by	
	agency nurse Wilde. (4b) Biocclusive remains intact	
	on saccum. (6) Whilst Eva was being assisted	
	to transfer from the commode to a chair by	
	myself and S.N Cooper - she appeared to pass out -	
	returned to bed, where she regained consciousness-	[illegible]
	ness. She is now resting in bed. (9). Eva has been	

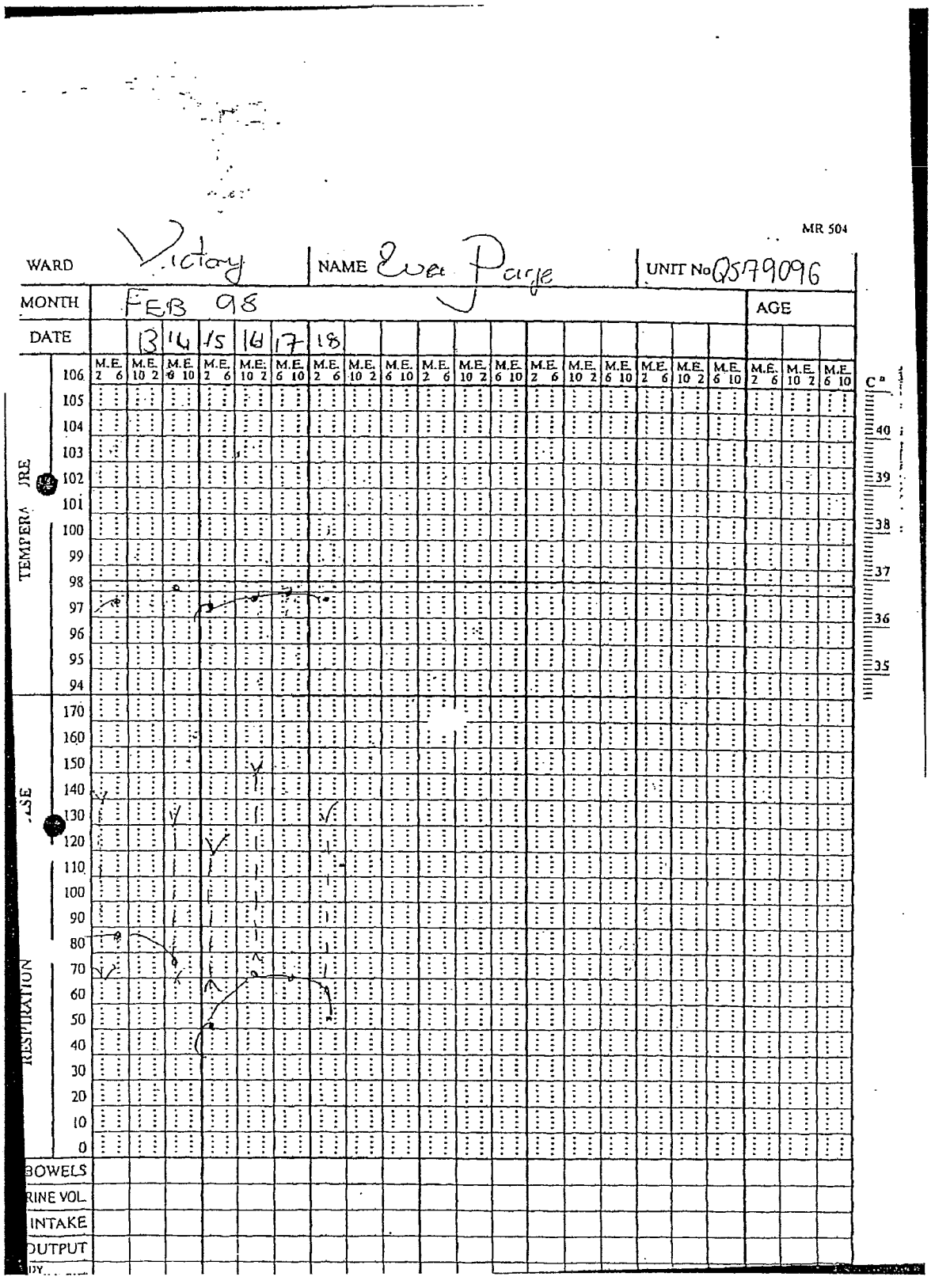
Code A

Code A

Code A

Code A

Code A



MR 504

WARD Victory | NAME Ewa Paige | UNIT No Q5179096

MONTH FEB 98 | AGE

DATE 13 14 15 16 17 18

M.E. 2 6 | M.E. 10 2 | M.E. 6 10

TEMPERATURE 106 105 104 103 102 101 100 99 98 97 96 95 94

PULSE 170 160 150 140 130 120 110 100 90 80

RESPIRATION 70 60 50 40 30 20 10 0

°C 40 39 38 37 36 35

BOWELS

URINE VOL.

INTAKE

OUTPUT

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Patients Property List

Name : D.o.B. Admission Date :

Nightdress	
Pyjamas	
Dressing Gown	
Slippers	
Vest	
Pants	
Socks	
Tights/ Stockings	
Shirt / Blouse	
Trousers	
Jumpers	
Jacket/ Coat	
Skirt	
Dress	

Wash Bag Contents: -

Brush / Comb	Dentures Cleaner
Towel	Denture Pot
Soap	Toothbrush
Flannels	Toothpaste
Electric Shaver	Make Up

Miscellaneous Items : - eg: jewellery

FORMShrubpropfist

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GMC100465-0223

.... HOSPITAL

HISTORY SHEET

Name (Surname First): PAGE, EVA
Address
Date of Birth: 24/12/10
Family Dr.

DATE	CLINICAL NOTES (Each entry must be signed)
6/2/98 1745	GP REFERRAL
	(87) IN RESIDENTIAL HOME
	PC – GENERAL DETERIORATION OVER PAST 5 DAYS
	c/o NAUSEA
	↓ APPETITE
	NOW DEHYDRATED
	Hx of PC – FELT "DEPRESSED" LAST FEW WEEKS
	↑ SLEEP
	↓ MOTIVATION
	LOSS OF APPETITE
	GP PRESCRIBED SERTRALINE on 26/1
	SINCE THEN DEVELOPED NAUSEA ~~[illegible]~~
	PERSISTENTLY
	ALSO SOME VOLUNTARY WITHDRAWAL AS
	"STAFF AT NURSING HOME TREAT HER
	AS IF SHE IS STUPID"
	IS NOW AGREEABLE TO TRY AND TAKE
	↑ FLUIDS / DIETARY SUPPLEMENTS
	PMHx – PAROXYSMAL AF } LONG-STANDING
	CCF
	DHx – RAMIPRIL 5mg OD
	FRUSEMIDE 40mg OD.
	DIGOXIN 125mcg OD
	SOTALOL 40mg BD
	ASPIRIN 75mg OD.
	SERTRALINE 50mg OD
	Nil KNOWN ALLERGIES.

296-

WWG 518

Code A

Code A

Code A

Code A

Code A

Code A

Code A

MR 200

Curr HOSPITAL

HISTORY SHEET

UNIT NO S.M.W. M.F.

Name PAGE EVA
(Surname First)

Address

Date of Birth

Family Dr.

DATE	CLINICAL NOTES (Each entry must be signed)
25/2/98	Confused & some agitation
	towards afternoon → evening.
	Says she's frightened - not
	sure why. Tends to scream
	at night.
	Not in pain.
	- Try HS Thioridazine.
	- Son in Gosport ∴ transfer
	to NHS CC GWMH - 27/2 or
	early next wk.
	- Hemineverin for nocte (If
	Thioridazine not working).
	[signature]
	all other drugs stopped by Dr [illegible]
	Transfer to Dryad Ward Continuing Care
27/2/98	Δ of Ca Bronchus made on CXR on admission 6/2
	Generally unwell off legs, not eating
	Bronchoscopy not done
	PR
	[illegible]
	needs help ē eating & drinking
	needs hoisting
	Barthel 0

WWG 518

Code A

Code A

Death Certificate