PRIVATE AND CONFIDENTIAL
Ms Stella Galea
Case Manager, Professional Conduct
UKCC
23 Portland Terrace
LONDON
W1B 1PZ

Our ref: ET/DB
Your ref: PPC/SG/10347
Date: 27 July, 2001
Ext: 4353

Dear Galea

Gosport War Memorial Hospital

Further to your letter and our recent discussion regarding a Police investigation into the events surrounding the death of Mrs Gladys Richards, I am enclosing the following information:

1. Paperwork associated with the original complaint. This commences with a copy of a letter from Code A Mrs Richards' daughter, (Appendix A), the Trust's investigation report (Appendix B), and a letter from the Chief Executive to Code A Mrs Richards' family did not pursue this complaint further within the NHS complaints procedure.

2. Some time after this initial complaint, the Trust received a telephone call from the Police, requesting a written report about the death of Mrs Richards. The Police would not inform us what specific aspects they were investigating, a situation that applied until a short time ago. At no stage were individual nurses mentioned but it became clear from the line of questioning that the Police were interested in the morphine prescription. We provided the information shown in Appendix B.

3. Gosport War Memorial is a Community Hospital in which medical care is shared between GPs and Consultants. In order to help control the pain of patients, a practice had existed that led to broad prescribing of analgesics. The nurses only administered the lowest dose to Mrs Richards and did not, in our view, contravene Trust policies. However, in order to protect nurses and patients more fully, the Trust has implemented new policies and practice guidelines (Appendix C).

Continued / page 2

The Police investigation is now complete and the three nurses you refer to in your letter have received letters from the Police informing them that they are no longer part of any Police investigation. The Trust has been informed by the Police that the C.P.S. have decided that there is insufficient evidence to proceed with a charge of unlawful killing. The nurses concerned have experienced an extremely traumatic three year period and have all suffered personally. I am anxious to stress that the Trust has never received a complaint in relation to the three nurses mentioned in your letter (in all 19 nurses were interviewed as part of this process) and I am concerned about the consequences of another investigation, as they are the kind of committed nurses we want to try to retain in the health service. In consequence, I truly hope that the UKCC is able to offer an early decision in respect of further steps or required information.

Yours sincerely

Code A

Dr Eileen Thomas
Nursing Director

Silent copies: Mr Ian Piper
Mrs Lesley Humphrey
Dr Ian Reid

APPENDIX A

Code A

MM/BM/YJM

22nd September, 1998

4378

Dear Code A

I am writing further to my letter of 25th August, 1998 now that I have received the report from Mrs. Hutchings, who has been investigating all the matters you raised concerning the care provided for your mother, Mrs. G. Richards, prior to her death on Friday, 21st August, 1998.

I should like to reiterate how very sorry I am that your grief has been compounded by so many concerns, but that you for having taken the trouble to write, as this has resulted in a very thorough investigation, and given us the chance to explain and/or apologise for the problems you identified. It has also meant that staff have reviewed procedures and improvements are being implemented as a result.

I should like to respond to each of the points you made, using the numbering system from your notes.

1. At what time did Mrs. Richards fall?
   She fell at 1330 on Thursday, 13th August, 1998 although there was no witness to the fall.

2. Who attended her?
   She was attended by Staff Nurse Jenny Brewer and Health Care Support Worker Code A

3. Who moved her and how?
   Both members of staff did, using a hoist.

4. After the fall
Your mother had been given medicationi presecribed by Dr. Barton, who was present on the ward just after her fall. I understand that it was not your wish for your mother to be given stronger medication because it made her drowsy.

5. Why was there such a delay in dealing with the consequences of the fall?
With the benefit of hindsight it is possible to assume that your mother's dislocation could have been identified much earlier and we can now only apologise for that delay if that was the case. It is notoriously difficult to establish degrees of pain or discomfort in dementia sufferers, but staff now recognise that more attention should have been paid to your mother's signs of discomfort, and your own expressed concerns about that.

6. Why no x-ray? Why no transfer?
These delays were a direct result of the failure to identify a problem earlier in the day - because the x-ray department at Gosport War Memorial Hospital only operates from 9 a.m. to 5 p.m. I understand that you did appreciate this when it was discussed with you on the Thursday evening, and agreed with the advice that it would be best to defer a transfer to Haslar until an x-ray based diagnosis had been made. The transfer to Haslar was organised as soon as possible after the situation had been confirmed by x-ray, on the morning of Friday, 14th August, 1998. It is a matter of great regret that this delay occurred, and we accept and apologise for the fact that the standard of care fell below that which we aim to provide.

7. Why when she was returned to bed from the ambulance was her position not checked?
When your mother arrived on the ward two health care support workers saw her into bed and then went to inform Staff Nurse Couchman that your mother had arrived. They had realised there was a problem and that professional advice was needed. Staff Nurse Couchman came and checked her position, and I believe you assisted her in straightening your mother's leg and placing a pillow between her legs.

8. (a) How was she brought from Haslar?
She was brought by an ambulance with two crew.

(b) Was there an escort/anyone in the back with her?
There was no nurse escort - this would have been arranged by Haslar had it been thought necessary.

(c) When did she start to show pain and what caused it?
The ambulance crew commented that she showed signs of being in pain as she was put into the ambulance. The cause of the pain has not been specifically identified.

(d) Why was my request to see the x-rays denied?
The x-rays were seen in the x-ray department by the doctor and the consultant radiologist. The decision to keep x-rays in the department and not to send them to the ward rests with the consultant radiologist, not the ward staff, and your request may not have been relayed to the department.

(e) Decision to do nothing but provide pain relief?
Dr,. Barton felt that the family had been involved at this stage as she discussed the situation fully with you. She made sure you were aware that the surgical intervention necessary for the haematoma would have required a general anaesthetic and clearly your mother was not well enough for such a procedure to be undertaken. Therefore, the priority, and only realistic option, was to keep her pain-free and allow her to die peacefully, with dignity.

9. Clothing sent for marking despite being named already
As a result of previous problems the ward have adopted the practice of marking all patients clothing with the ward name - a procedure designed to help, which on this occasion, did the absolute opposite. The laundry marker at Gosport War Memorial Hospital had broken down, so your mother's clothes were sent to St. Mary's Hospital and meanwhile she was given hospital clothing. In attempting to meet your completely reasonable request for her own clothes to be returned, a taxi was authorised which in the event brought the clothes back - still only bearing your mother's name. Whilst, as you say, this was a trivial problem on the scale of the real issues, it was a quite ridiculous consequence of a well-intentioned policy which served to cause unlooked for stress. The process is being reviewed as a result of your complaint.

All the staff concerned with the care of your mother were deeply saddened at her experience, and sincere apologise are proffered to you and your sister for the problems which occurred, and the failure of the service to meet your very reasonable expectations. The only constructive aspect I can identify is that lessons have been learned and the experience will benefit future patients, although I fully appreciate that such benefits have little relevance to yourselves.

You may be aware that your sister, **Code A** has telephoned Mrs. Hutchings as she wishes to see this correspondence. I am writing to her to confirm that it is personal to you, although, of course, I hope that you will feel able to share it with her. If you unable to do this then she will need to raise a complaint of her own.

/continued - page 4

Should you wish to pursue the matter further my secretary would be very happy to arrange a meeting with Mrs. Barbara Robinson, Hospital Manager, at your convenience and I would be grateful if you could contact her on 01705 894378 within one month should you wish this.

Thank you once again for writing so comprehensively of your concerns.

Yours sincerely,

Max Millett
Chief Executive

Silent copy to: Mrs. B. Robinson
Mr. W. Hooper

(1)

(1)

Ref Gladys Richards DOB 13 4 98
Died 21.8.98 JRH.

Tuesday 11th Aug. Admitted from Haslar. Able to walk - painful
Wednesday 12. Dementia mis-read. Diamorphine given - (knocked off) so no fluids etc could be given. Thought her anxiousness was Pain!
No Analgesia necessary

THURSday 13 Aug.

Seen to be in pain by Grandaughter Code A 1.30 - 2.15pm
Brought to ward staffs attention. Thought to be dementia, A
Code A brought to the attention of the staff that Mum had
Mother showing with pain, great pain in her hip (For your info she is a qualified Nurse) LL.

(1) At what time did Mrs Richards fall?
(2) Who attended to her.
(3) who moved her and how.
(4) I arrived and saw my mother was in pain. Anxious expression, weeping - calling out. I spoke to several trained and untrained staff. I was told - there is nothing wrong - it's her dementia. I was then told she had fallen from her chair. I asked had she seen a Doctor? Could she be Xrayed? At supper time while my mother was quiet and I was teaspooning her some soup I was asked "Do you think your Mother is in pain?" by RGN doing the drug round. "Not at the moment while I'm feeding her" I said "Well you said she was in pain". "Yes" I said "she has been very uncomfortable since I got here". "Do you think she has done some damage?" "No" she only fell on her bottom from the chair" I stayed till 7.45pm My mother was in distress throgout.

At 9.30pm. I received a phone call from the ward. "When we put your Mother to bed she was in great pain and she may have done something. The Doctor feels its too late to send her to Haslar and our Xray unit is closed. We will give her oramorph for the night to keep her pain free and Xray here in the morning."

(5) This was an avoidable delay. Why? Any lay person could have seen she was hurt - by the angle of her leg & thigh LL

FRIDAY 14th. I arrived as she was taken to Xray

(2)

She was deeply under with oramorph.
She was xrayed. The movement caused pain and I stayed with her to comfort her.
We returned to the ward. I was called in to the office by Philip - ward manager and DR Barton to be told - "Your worst fears of last night appear to be true. We have rung Hasler and they have accepted her back."
We arrived at Hasler late morning - mid day. She was expected. The consultant was bleeped. He saw Hollie in Casualty immediately. He then saw me. He showed me the Xrays and position of limb - which I had seen in G.W.H - 24 hrs from accident to admission and second emergency operation. Why? why no examination? why no xray? why no transfer?
(6)
She arrived at Hasler and within 1hr had a manipulation to put the hip back in the socket. From then she was pain free.
She did not regain consciousness fm 1am (15th) on Sat 15th due to amount of analgesia required for the procedure. She was then catheterised so that there was no need to use slipper pan. She had a drip as she had had NIL BY MOUTH since before Xrays on 14th.
She remained pain free in full length leg splint. both legs level and straight - shown to me by consultant. No analgesia was required - she was able to use a commode for the toilet and weight bear for transfer. She ate and drank and the drip was removed and her fluid balance was acceptable.
She progressed on Sunday and was easily manageable. She was seen early on Monday 17th when transfer back was recommended. I rang Hasler at 8.30am to be told she would be going A.M. I asked if I should come & pack & accompany her and they said "No need

(3)

she is fine". I went to G.W.H about 10.45am and was told the ambulance was due about midday I arrived back. at 12.15 mid day
On entering through the swing doors to the ward I heard my Mother screaming. On arrival to the room a care assistant said. "You try feeding her I can't do it she is screaming all the time". My Mother had a starving anxious expression She was gripping her RV thigh op site tightly. She uttered the words Do Something Do something the pain the pain - don't just stand there - I don't understand it the pain the pain sharp sharp — this is some adventure. A SRN came into the room at all the noise I moved the sheet and said look at the awful position she is in, she was lying awkwardly towards the left side with the full length splint not straight and the hips uneven. She cried in pain. I said to the RGN "can we please move her" We moved in together with our arms together under her lower back and the other around her thighs we placed her squarely on her buttocks and within minutes she stopped the screaming

(7) Why when returned to bed from the ambulance was her position not checked.?
why was the source of pain not sought?
From 1pm onwards the Charge Nurse Manager frequently checked my Mother. He acknowledged our concern. He acknowledged her obvious pain. We asked for X rays We asked what had happened between leaving Haslar & arrival into her bed at G.W.H. It was acknowledged that "Something" had happened

(4)

The charge nurse was concerned for her pain and analgesia was given 3 times between her admission & 6pm.

Phillips ward manager agreed she needed Xray to establish if damage had been done as head occurred to the hip.

Xray Dept refused forms signed PP for the DR who was unavailable.

An appointment for Xray was made for 3.45pm as the DR called was expected at about 3.15pm The charge Nurse did all he could to expidite this - keeping us informed and constantly checking Mothers obvious severe pain. He administered pain relief in readiness for the Xrays. He was courteous and attentive at all Times.

DR Barton arrived and we left the room as asked She examined my Mother. She stated she did not think there was hip dislocation but the Xray would go ahead. A review would be held later when Xrays had been seen

We went to Xray. My mother was in pain despite her pain relief. I was not allowed in with her as I was the previous week. I could hear her wailing through the doors while the Xray plates were put in place. We returned to the ward. We were told there was no dislocation but obviously something had happened. We were told she would be given Oramorph for the pain & fully through the night for pain relief and reviewed in the morning.

On Tues 18 we arrived on the ward and were told she had had a peaceful night We were told that she had a massive haematoma causing pain at the Op site

(3)

and the plan of management was to use a syringe driver to ensure she was pain free and she would not suffer when she was washed - moved or changed should all become inconvenient.

The outcome of the use of a syringe driver was explained to us fully. We agreed.

A little later DR Barton appeared and confirmed that a haematoma was present and that this was the kindest way to treat her. She also stated "and the next thing will be a chest infection". Totally insensitive to those already in the first stages of bereavement.

Because the syringe driver was essential for having the right of analgesia for pain - my mother of course would not now regain consciousness, speak, open her eyes to see us, or hear anything anymore. To us Mother as we know her is already gone.

(8) How was she brought from Hadar? Was there an escort? Was anyone in the back with her? At what time did she start to show pain? What caused it? I request again to see the last X-rays. Who decisions were made to do nothing but allow to die pain free.

Answers to the numbered questions are sought in detail.

Trivial things added to our trauma. Her clothing already each's name tabs marked. - had all gone the day after last admission for marking - despite my agreeing to do the washing daily.

Asking continually, to insisting today that Mother be allowed to wear her own clothes has resulted in them being brought by Taxi from Sx Mays 8 days later - still unmarked and all totally unnecessary. - as was a staff Nurse yesterday asking to take her day clothes away - "because we get them up here you know". Our reply was - Just look at her - she will not be getting up anywhere.

The contents and events in this report were in the majority witnessed by my elder sister

Code A

Code A

COMPLAINT MADE BY Code A RE STANDARDS OF CARE FOR HER LATE MOTHER MRS. GLADYS RICHARDS WHILST A PATIENT ON DAEDALUS WARD - G.W.M.H. FROM 11.08.98 TO 14.08.98 AND 17.08.98 TO 21.08.98

1. At what time did Mrs. Richards fall?
   Answer - 1330 hours on 13.08.98.

2. Who attended to her?
   Answer - S/N Jenny Brewer and H.C.S.W. Code A

3. Who moved her and how?
   Answer - S/N Jenny Brewer and H.C.S.W. Code A using a hoist.

4. No direct questions asked. Statement only. There is some question regarding accuracy of this statement:-

   Response (a) There was only one trained nurse on duty after 3.30 p.m. and prior to this the second Staff Nurse was completing consultant round. There fore would not have been available to speak to Code A (she states several trained nurses). Trained staff confirmed they would not have said it was Mrs. Richards dementia causing her to cry out; she had been given medication prescribed by Dr. Barton who was present on the Ward just after Mrs. Richards' fall. She was not given the stronger medication because Code A had previously requested that it was not to be administered as it made her Mother very drowsy.

   S/N Brewer did see Code A and gave her full details of the fall and the following actions that had been taken (statement by S/N Brewer attached).

5. Why the delay in x-raying Mrs. Richards?
   Answer - Code A was telephoned and informed once dislocation was suspected and informed of the Doctor's advise, to which she agreed. This included not transferring her Mother immediately to Haslar.

6. Why no medical examination? Why no x-ray? Why no transfer?
   Answer - Duty Doctor was given the full facts of the situation including Mrs. Richards' diagnosis and her age. He stated he felt it would be too traumatic to transfer to Haslar for x-ray at that time of the evening and the journey could cause considerable distress. He advised medication, i.e. Oramorphine (strong pain relief) and to arrange for x-ray the following morning. S/N Brewer agreed with this as did Code A when she was informed.

   Why no x-ray?
   X-ray at G.W.M.H only operational up to 5.00 p.m. Monday to Friday.

   Why no transfer?
   As above.

7. When returned from Haslar from the ambulance, was Mrs. Richards' position not checked?
   Answer - Her position was checked by an H.C.S.W. who immediately went to find a trained nurse and asked her to look at the position of Mrs. Richards' leg. Due to the considerable noise Mrs. Richards was making and, being untrained, she decided not to attempt to move Mrs. Richards herself.

8 (a) How was Mrs. Richards brought from Haslar Hospital?
Answer - By ambulance and two crew. She was not escorted by a Nurse, this would have been the responsibility of Haslar Hospital to arrange.

(b) When did she start to show pain? What caused it?
Answer - Ambulance Crew commented to nursing staff she began screaming as soon as she was put into the ambulance and continued throughout the journey and on Daedalus Ward. The cause of the pain cannot be confirmed, but we do know Haslar Hospital were unable to provide an appropriate canvas to transport Mrs. Richards on. Two sheets were used instead. This did mean Mrs. Richards' limb was not supported as well as it would have been on a canvas when moved from bed to trolley to ambulance to trolley to bed on Daedalus Ward. This **may** have caused the pain.

8 (c) Request to see x-rays denied?
Answer - This was a decision made by individual radiologist. The Ward Staff are unable to influence their decisions. The x-rays Code A refers to did not come back to the Ward, they were seen in the Department by the Doctor and Consultant Radiologist.

8 (d) Decision made to do nothing but allow Mrs. Richards to die pain-free?
Answer - Dr. Barton did see Code A and involve her in the decision making process. Due to Mrs. Richards' age she would not be able to have surgical intervention for the Haematoma as this would involve general anaesthetic. Therefore, the priority was to keep her pain-free and allow a peaceful death with dignity.

TRIVIAL CONCERNS RE CLOTHING/LAUNDRY

1. Clothing sent for marking despite Cash's name on all items of clothing?
   Answer - All patients/relatives are informed on admission that to safeguard their belongings, clothing is marked with the name of the Ward. This includes clothing of patients whose relatives agree to do the laundry. This decision has been made on Daedalus Ward following several complaints from patients/relatives whose clothing was sent off to the Hospital Laundry by mistake and often never seen again.

Obviously, while Mrs. Richards' clothing had been sent for marking she was given hospital clothing to wear. This should have only been for a day or two. Unfortunately, unbeknown to Ward Staff, G.W.M.H.'s Laundry Marker had broken down so Mrs. Richards' clothing was sent to St. Mary's Hospital for marking. The Ward were not informed of this and, due to Code A stress at this time, a taxi was authorised to goand collect the clothing and return it to Daedalus Ward.

2. I have not been able to confirm if any Staff Nurse made any comment regarding getting Mrs. Richards up when she was so obviously near to death. I would find difficulty in believing any member of staff, either trained or untrained, would make such a comment.

Investigation of Complaint made by Code A
Re: Standard of Care Received by her late Mother - Mrs Gladys Richards whilst Patient on Daedalus Ward Gosport War Memorial Hospital

Complaint made verbally to Lesley Humphrey - Director of Quality followed by written notes of events forwarded to myself on 21st August 1998.

Following discussion with Mr Bill Hooper - I was asked to commence investigation on 24th August 1998.

Commissioning Officer - Mr W Hooper
Investigating Officer - Mrs Sue Hutchings

Investigation commenced: 24th August 1998
Investigation completed: 11th September 1998

1. Background
2. Analysis of Events
3. Conclusion
4. Recommendations
5. Statements taken during the investigation
   - 5.1 S.N Margaret Couchman - September 3rd 1998
   - 5.2 S.N Jenny Brewer - September 3rd 1998
   - 5.3 Clinical Manager Philip Beed - September 8th 1998
   - 5.4 E.N Monica Pulford - September 8th 1998
   - 5.5 S.N Christine Joice - September 9th 1998
   - 5.6 HCSW Code A - September 10th 1998 (telephone statement) – withdrawn JM

Other Documents

6. Accident Report Form
7. Riddor Form
8. Code A Notes

1. Background

Mrs Gladys Richards
D.O.B. 13.4.07
Died 21.8.98

Mrs Richards was admitted to Daedalus Ward Gosport War Memorial Hospital from Haslar Hospital on Tuesday 11th August 1998 following hemi-anthroplasty for fracture Rt neck of femur; this had been sustained as a result of a fall while Mrs Richards was a resident at Glen Heather's Nursing Home. Mrs Richards did suffer from degree of dementia but was walking with the aid of a zimmer frame and 2 nurses pain free; not requiring any analgesia when she was discharged from Haslar.

Wednesday 12th August 1998. Code A felt her Mother's dementia was mis-read by nursing staff - although Code A stated her Mother was able to communicate when she needed to go to the toilet, or when she was in pain. For some reason (not made clear to Code A) her Mother was given oramorphine - which caused Mrs Richards to become very drowsy and unable to take any fluids. At this point Code A suggested to nursing staff, she thought her Mother was in pain - but was told it was her dementia that was causing her Mother to cry and scream. On 13th August 1998 about 5 pm Code A was informed by Staff Nurse - her Mother had fallen earlier in the day.

It was a further 24 hours before diagnosis of dislocation of Rt hip was confirmed.

Code A has raised the following questions, which the investigation will focus on:-

1. At what time did Mrs Richards fall?

2. Who attended to her?

3. Who moved her and how?

4. Mrs Richards in pain, anxious, crying - calling out - told by trained and untrained staff "nothing wrong" - why?

5. Avoidable delay in being seen by Doctor and X-Ray ordered - why?

6. Why not transferred sooner?

7. Transfer back from Haslar to Gosport War Memorial Hospital? - leg not positioned correctly - not checked by trained nurse - source of pain not identified?

8a. Was there a nurse escort from Haslar - was anyone accompanying Mrs Richards in the back of the ambulance.

8b. When did Mrs Richards begin to show signs of being in pain and what caused it?

9. Why was Code A not allowed to see X-Rays and not involved in making decision "to do nothing" - allowed to die pain-free.

10a. Mrs Richards personal clothing - identified by cash's name tags all sent for "marking" day after 1st admission - despite Code A agreeing to do the washing daily - why?

10b. No clothes sent with Mrs Richards to Haslar.

10c. Following Code A insistence on her Mother wearing her own clothes and asking where they were, discovered they were at Laundry at St Mary's Hospital - returned to Daedalus - once taxi was ordered by nursing staff - still unmarked - why?

ANALYSIS OF EVENTS

Mrs. Gladys Richards was a frail, 91 year old with dementia who had sustained a fracture of her right neck of femur whilst resident in a Nursing Home. She had surgical repair at Haslar Hospital. Despite her age and confused mental state Mrs. Richards made a good recovery and the medical team at G.W.M.H. agreed to accept Mrs. Richards to give her the opportunity for mobilisation. The transfer to Daedalus Ward was arranged and took place on **11.08.98.**

On arrival to Daedalus Ward, Mrs. Richards was quiet and accompanied by her daughter, Code A She was admitted by Enrolled Nurse Pulford and Code A was seen and told of the plan for managing her mother whilst on Daedalus. Mrs. Richards was also seen by Dr. Barton and medication was prescribed.

Wednesday 12th August, 1998.

S/N Joice was on a late shift. She went into Mrs. Richards room and became concerned because Mrs. Richards looked poorly. She was very drowsy and pale in colour although sitting in a chair. When Code A visited later that afternoon she also became very concerned about her mother's drowsy condition. She was informed of the medication her mother had been given. Mrs. Richards was transferred back to bed by use of a hoist. This did cause Mrs. Richards to wake up and cry out. She settled and was fed her supper by Code A

Thursday a.m. 13th August, 1998.

The Ward was very busy with general activities plus two admissions expected and two discharges. Staffing levels were low although the Clinical Manager had taken some steps to ensure adequate level. There was only one trained nurse on until 12.15 p.m. and after 3.30 p.m. with Consultants round due at 2.00 p.m.

Mrs. Richards had been got up earlier in the morning and sat in a chair in her room. After lunch, approximately 13.30 hours, an H.C.S.W. found Mrs. Richards on the floor by her chair. S/N Brewer was informed and she immediately attended to Mrs. Richards. She checked for any injuries. At this point she did not feel any had been sustained so authorised Mrs. Richrds to be put back into a safer chair using a hoist.

Code A was due to visit that afternoon so S/N Brewer made the decision to see her rather than telephone her regarding her mother's fall, particularly as she did not appear to be suffering from any injuries. It was 6.30 p.m. when S/N Brewer spoke to Code A and informed her of the fall, explaining she did not know how she fell but reassured Code A she had checked her mother before moving her. At this point S/N Brewer asked Code A if she thought her mother to be in pain. Code A did not feel she was as she was eating her tea.

At 7.45 p.m. S/N Brewer commenced putting Mrs. Richards to bed. Once in a lying position she could see Mrs. Richards (right) hip was internally rotated. The Duty Doctor was called immediately and informed of the problem, patients age and dementia. The Duty Doctor felt it would be too traumatic to transfer Mrs. Richards overnight, but to give pain relief and arrange x-ray at G.W.M.H. the following morning and to contact him if any further problems arose.

Code A was telephoned as soon as the pain relief had been administered (approximately 8.30 p.m.) and informed of the current situation and Doctor's advice. S/N Brewer asked if she was satisfied with this to which Code A replied "Yes" and thanked S/N Brewer. Mrs. Richards slept well that night.

Friday 8.00 a.m. 14th August, 1998

Dr. Barton visited the Ward and completed X-Ray Request Form. Mrs. Richards was taken to X-ray Department about 10.45 a.m. accompanied by Code A X-ray confirmed dislocation of (right) hip. Code A was seen by Dr. Barton and Philip Beed, Clinical Manager, and informed. Arrangements made for transfer to Accident and Emergency, Haslar. Mrs. Richards was given pain relief prior to transfer and was accompanied by H.C.S.W. in the ambulance (Code A followed in her car). Mrs. Richards remained at Haslar for 48 hours and arrangements were made to transfer back to Daedalus Ward on 17.08.98.

Monday 11.45 a.m. 17th August, 1998

Mrs. Richards arrived on Daedalus Ward. Mainline Ambulance Crew, but no nurse escort. Transport was arranged by Haslar who telephoned Daedalus and apologised they could not find a canvas to put Mrs. Richards on, i.e. canvas would have two poles inserted to lift patient. Instead they used two sheets to lift Mrs. Richards who was crying and screaming, which apparently had started in the ambulance and continued for some time after her arrival.

Two H.C.S.W.'s supervised Mrs. Richards being put into bed. The ambulance man stated he had been given strict instructions from Haslar that Mrs. Richards was to be kept flat - in bed she was given two pillows only and a pillow between her leg. H.C.S.W. Code A was very concerned regarding the position of (right) leg. She was afraid to straighten it because of the noise Mrs.Richards was making so went to find a trained nurse and seek her advice. At that point Code A arrived. S/N Couchman walked into the room and pulled back the covers and realised the leg was not positioned correctly. Code A offered to assist S/N Couchman and between them re-positioned Mrs. Richards who then stopped screaming.

Mrs. Richards became agitated again a little later. Code A requested her mother be x-rayed again. Dr. Barton was contacted and agreed . S/N Couchman was asked to complete X-ray Request Form and p.p. it. Unfortunately, X-ray Department refused to accept the form and insisted a Doctor's signature had to be on the form. Surgery was contacted and Duty Doctor signed the form and faxed to G.W.M.H. All of this did cause delay.

Mrs. Richards was x-rayed at 15.45 hours. Films were seen by Consultant Radiologist who confirmed no further dislocation. Dr. Barton was informed and discussion took place with Clinical Manager and both Mrs. Richards's daughters who were informed a haematoma had developed at the site of manipulation, i.e. (right) hip and, in medical opinion, the best treatment would be to keep her pain free. The use of a syringe driver was discussed fully. Both daughters agreed to this course of action. From 18th August - 21st August Mrs. Richards condition deteriorated and she died at 8.20 p.m. on the 21st August. Both daughters were present.

All trained staff interviewed were very aware that Code A and her sister, Code A did not agree between themselves regarding their mother's care, particularly about pain control. This did make the nursing of Mrs. Richards difficult at times, i.e. she was not returned to bed following her fall on 13.08.98 as Code A had complained previously she felt her mother was on her bed too much and this would not help with rehabilitation.

During her last day of life Nursing Staff were prevented from removing Mrs. Richards dentures as part of mouth care as the daughters said they were not to remove them.

Nursing staff reluctantly accepted this, although in hindsight agree they should have tried harder to persuade the daughters it was in their Mother's best interest to remove the teeth for cleaning.

Sadly, Mrs. Richards's death was not as Code A had hoped it would be. She felt the use of the syringe driver made her mother become unconscious and she did not say her "goodbye", although both she and her sister were with their mother almost continuously day and night during Mrs. Richards last few days. Nursing staff tried not to be obtrusive.

CONCLUSION

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

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

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

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

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

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

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

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

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

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

RECOMMENDED ACTION PLAN (to be agreed with Service Manager)

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

2. Review nursing records and documentation.

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

4. Review marking of clothing "policy".

Code A

11/9/98

Daedalus Ward Action Plan
(in response to investigation re. Mrs. G. Richards)

1. Transfer of patients

Existing ward policy on transfer of patients allows a degree of discretion as to whether or not to transfer a patient if their condition changes. The purpose of this is to save patients and relatives the distress of transfer to a busy acute facility if contra-indicated by their overall condition and prognosis.

The following guidelines will now form part of the policy:

Where it is clearly evident, or highly probable, that an injury has been sustained, for which acute treatment is required and applicable, the patient will be transferred.

The patient and/or relatives are to be involved in deciding whether or not transfer is applicable, ensuring they are aware of the options and their consequences, with the aim of having their informed agreement for whatever decision is taken.

2. Marking of Clothing

Losses of personal clothing are inevitable when clothing is not marked, is upsetting for relatives, and takes up valuable nursing time (inevitably detracting from patient care).

An insistence that all personal clothing is marked has significantly reduced incidence of loss, but still poses some difficulty owing to the time lag required for initial marking.

An information leaflet (copy attached) advises patients and relatives of our personal clothing policy. Included in this is the option for relatives to mark clothing themselves if they wish to do so, which may be quicker than our own marking facilities.

Individual laundry bags are to be purchased for laundry being taken home (as soon as a suitable supplier can be found). These will be hung on patients wardrobes, making it easier for staff to identify when clothing is being washed at home, and allowing relatives to easily locate patients dirty laundry.

A lost laundry book will be used as a central reference of missing clothing. This will save time and effort in handling lost clothing complaints and be a more efficient means of trying to trace the items.

3. Nursing Records & Documentation

A programme of education on nursing documentation will take place on the ward involving all qualified and non qualified staff, relevant to their specific needs.

Internal audit of nursing documentation will take place at regular intervals, and involve all qualified staff, to identify areas of weakness, and consider developments and improvements.

4. Availability & Use of Bank Staff

Activity levels, combined with vacancies, long term sick leave and annual leave, made the period in question busy and stressful for qualified staff. Using qualified bank staff was not an option, as the reality is that contacting those on the bank list invariably draws a negative response.

This is a great pity as it is an option that the ward would and could have used, particularly as the budget existed to do so.

The recommendation is that the hospital seeks to recruit qualified nurses to the bank, who are available to work, and inducts them appropriately.

Daedalus Ward

Patient Information

Clothing

Patients on Daedalus Ward are encouraged to wear their own clothing if they wish to do so. Nursing staff will be happy to advise you on what type of clothing is most appropriate, this is particularly relevant if you intend buying any new items of clothing.

As an alternative to your own clothing the ward has a good stock of clean presentable clothing which patients may use.

If you are wearing your own clothing you may wish to send it home for laundering, in which case it will be left in the bottom of your wardrobe, or you may wish to use the hospitals laundry facilities.

Whether your laundry is being done at home or in the hospital, it is **absolutely essential** that it is properly marked. This can be done by the hospital laundry, and usually takes 3-4 working days (sometimes a little longer), or you can arrange for a relative to mark it.

Marking needs to be on a secure label, with a proper laundry marker, and must contain the following information:

Surname
Daedalus 05
GWMH

You should be aware that due to the high volume of laundry handled by the ward and hospital, clothing does periodically go missing. Provided it is properly marked it will usually reappear.

If you think some clothing has gone missing please inform a member of staff, who will record the details in our laundry book, and ask the laundry room staff to look out for the item.

APPENDIX B

CONFIDENTIAL

MM/LH/YJM

Detective Constable Madeson,
Gosport Police Station,
South Street,
GOSPORT. PO12 1ES

19th January, 1999

4378

Dear Detective Constable Madeson,

Mrs. Gladys Richards (deceased)

Further to your telephone conversation with Mrs. Lesley Humphrey, Quality Manager, please find enclosed a written report from Dr. A. Lord, Consultant Geriatrician, explaining the care provided to Mrs. Richards prior to her death. You will see from Dr. Lord's report that the use of a syringe-driver was discussed with Mrs. Richards' daughters, [Code A] and [Code A] The administration of intravenous fluids was not raised by either daughter prior to Mrs. Richards' death, or in the subsequent formal complaint. The care provided was appropriate for Mrs. Richards' needs.

Strictly speaking the complaint was never formally concluded. Our offer to meet with both daughters to discuss their concerns was accepted and arrangements were made for this to take place on 29th October, 1998. [Code A] then advised us that this date was not convenient and volunteered to agree a suitable date with her sister and inform us accordingly. This action was agreed on 30th September, 1998; we heard nothing further until your call to Mrs. Humphrey on 11th December, 1998.

I hope these details help with your investigation. Please contact Mrs. Humphrey if we can be of any further assistance.

Yours sincerely,

Max Millett
Chief Executive

Silent copy to: Mrs. N. Pendleton (to share with Dr. A. Lord), Dr. J. Barton, and Mr. W. Hooper

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

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

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

I have itemised my comments as follows:

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

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

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

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

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

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

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

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

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

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

Code A

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

TC1 Daedalus Ward 11.8.98

PORTSMOUTH
HealthCare
NHS
TRUST

NOTE 1

DR R I REID, FRCP
CONSULTANT GERIATRICIAN

Elderly Medicine
Queen Alexandra Hospital
Cosham
Portsmouth PO6 3LY

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

RIR/BJG/WVTQ130407

5th August 1998

Surgeon Commander M Scott
The Royal Hospital Haslar
Gosport
Hants

Dear Surgeon Commander Scott

RE: WARD VISIT - E6 WARD HASLAR
Gladys RICHARDS - DOB 13.04.07
HA: GLENHEATHERS NURSING HOME, LEE-ON-SOLENT, HANTS

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

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

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

contd.....

Gladys ,RICHARDS

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

Yours sincerely

DR R I REID, FRCP
Consultant Physician in Geriatrics

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

22nd December 98.

Dear Lesley,

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

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

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

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

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

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

Sincerely,

Code A

Althea Lord
Consultant Geriatrician

copies:
Barbara Robinson
Bill Hooper
Nicky Pendleton

NOTE 2

CONCLUSION

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

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

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

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

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

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

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

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

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

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

RECOMMENDED ACTION PLAN (to be agreed with Service Manager)

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

2. Review nursing records and documentation.

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

4. Review marking of clothing "policy".

Code A

11/9/98

NOTE 3

URGENT - FOR THE NOTICE OF ALL MEDICAL AND NURSING STAFF

DAEDALUS AND DRYAD WARDS
GOSPORT WAR MEMORIAL HOSPITAL

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

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

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

Code A

Dr. Althea Lord
Consultant Geriatrician
20.12.98.

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

APPENDIX C

POLICY NO: CLN/P2

CLINICAL POLICY

PRESCRIPTION WRITING POLICY

THIS IS A JOINT POLICY WITH PORTSMOUTH HOSPITAL TRUST

APPROVED BY THE MEDICAL DIRECTORS OF BOTH TRUSTS AND THE FORMULARY AND MEDICINES GROUP

84

Approved by the Medical Directors of both Trusts and Formulary & Medicines Group March 1998

JOINT TRUST POLICY

PRESCRIPTION WRITING

1.0 PURPOSE

1.1 The primary purpose of this policy is to have an agreed, consistent, safe and professional standard of prescription writing across both Trusts.

1.2 The Policy should also be used for:

a) Teaching or reminding prescribers of the standards expected.
b) Auditing prescriptions and assessing risk management.
c) Resolving prescription writing queries.

2.0 SCOPE

This policy covers all prescriptions written by doctors and nurses, but excludes some specific issues which are handled separately:

b) Pre-printed Prescriptions (individual directorate policies in force).
c) Intravenous Drugs (see Administration of Intravenous Drugs Policy).
d) Self Medication (see separate guidance document in this compendium).

3.0 RESPONSIBILITIES

3.1 It is the responsibility of every member of staff involved in the medication process to acquaint themselves with this policy.

3.2 It is the responsibility of consultants, senior nurse managers and the pharmacy manager to ensure that their staff are aware of the policy.

3.3 SHARED CARE. The legal responsibility for prescribing lies with the doctor who signs the prescription.

4.0 REQUIREMENTS FOR PRESCRIPTION WRITING.

4.1 GENERAL REQUIREMENTS

Prescriptions should be written legibly and in ink and should state the following:

a) Name of the patient

b) Age of the patient.

c) Generic name of the medicine.
This should be written clearly and not abbreviated. The trade name may be used for multi-ingredient products not given a title by the BNF. The trade name must be used for cyclosporin, lithium and theophylline, because the various brands differ in bioavailability.

d) The dose. In particular:

- The unnecessary use of decimal points should be avoided (eg 3mg not 3.0mg).
- Quantities less than 1gram should be written in milligrams (eg 500mg not 0.5g).
- Quantities less than 1 milligram should be written in micrograms (eg 500micrograms not 0.5mg).
- When decimal points are unavoidable a zero should be written in front when there are no other figures (eg 0.5ml not .5ml).
- For liquid oral medicines other than laxatives, the dose should be prescribed by weight (eg milligrams) not volume (ie mL).
- For mixed compound preparations which come as a single dose, the number of tablets should be stated (eg co-proxamol).
- The words: micrograms, nanograms, units must not be abbreviated.

e) Route of Administration.
For inhaled medicines the device should also be stated.

f) Frequency of Administration.
In the case of preparations to be taken 'as required' a minimum dose interval should be specified, and an indication if not obvious. Although directions should preferably be in English without abbreviation the following Latin abbreviations are allowed:

b.d.	=	twice daily
o.d.	=	every day
o.m. or mane	=	in the morning
o.n. or nocte	=	at night
p.r.n.	=	when required
q.d.s.	=	four times daily
stat	=	immediately
t.d.s.	=	three times daily

g) Quantity to be Supplied.
Outpatients - minimum normally 14 days and maximum normally 28 days (or sufficient to complete a course of treatment).
TTOs - 7 days or sufficient to complete a course of treatment.

h) Signature of the Prescriber.

i) Date

4.2 INPATIENT PRESCRIPTIONS (Additional Requirements)

a) Ward.

b) Consultant's name.

c) Patient's Identification Number.

d) The Drug Allergies and Sensitivities section should be completed. State "not known" if this is the case.

e) The patient's weight for all children. For adults only where doses are weight related (eg chemotherapy).

f) Times of administration for regular and once only drug therapy.

4.2.1 Changing Drug Doses

When a dose must be changed, the Trusts encourage doctors to completely rewrite the prescription to avoid misinterpretation. However, it is acceptable to make one dose change, provided the new dose is clear, the old one has been clearly deleted, and the prescriber both signs and dates the change.

4.2.2 Stopping a Drug

When a drug is discontinued the prescription should be deleted with a large 'Z', countersigned and dated by the doctor.

4.2.3 Dose Withheld by Doctor

The dose administration box should be filled with an 'X' and countersigned. The reason for the decision should be documented in the medical record.

4.2.4 Dose Missed or Refused

In the Hospitals' Trust, the dose administration box should be filled with the appropriate code number or abbreviation as follows:

1 or "refused"	-	Patient refused dose
2 or "NBM"	-	Nil by mouth
3 or "N/S"	-	No Stock - drug unavailable
4 or "absent"		Patient not on ward
5 or "iv"	-	IV therapy precludes a dose
0	-	Other reason specify in nursing notes.

For Healthcare Trust prescriptions, nurses can either write 'X' in the box and give the reason in the Exceptions to Prescribed Orders Sections, or follow the convention above.

4.3 MEDICINES ADMINISTERED AT NURSES' DISCRETION

a) Directorates specify the medicines involved in any given clinical area.

b) Prescriptions should be in the "once only" section of the prescription chart.

c) Prescriptions must carry the nurse's signature and status and not "nurse prescribed".

d) The same nurse must sign for administration in the "given by" column.

e) Medicines which require administration on a frequent basis, should be referred to a doctor for prescribing.

4.4 CONTROLLED DRUGS FOR TTOs AND OUTPATIENTS

The following are additional requirements for controlled drug prescriptions.

a) The prescription must be written in the **doctor's own handwriting** including **the name and address of the patient.** Addressographs are not acceptable.

b) The **form** must be stated (eg, tabs, elixir, Inj etc.), irrespective of whether it is implicit in the proprietary name (eg MST).

c) The **strength** must be stated where appropriate. This is not necessary where only one strength exists (eg Diconal), but is required where the dose is not the same as the strength. (See example A below).

d) The **total quantity of the preparation** (eg number of tablets, millilitres, or number of dose units) should be written in both **words and figures.**

e) The **dose and frequency** must be stated.

Example A	Example B
Morphine Sulphate M/R Tablets 40 mg bd Supply 14 (fourteen) 10mg tabs and 14 (fourteen) 30mg tabs	Morphine Sulphate Elixir 10mg in 5mls 15mls six times per day Supply 250ml (Two hundred and fifty ml)

4.5 VERBAL ORDERS

a) Telephone orders for single doses of drugs can be accepted by a registered nurse or midwife if the doctor is unable to attend the ward.

b) The prescription must be timed, dated and signed by the person taking the message, and endorsed "verbal order".

c) The doctor's name should be recorded, and the doctor should sign the prescription within 12 hours.

d) Pharmacists operate under a separate protocol (in this compendium).

CLN/P3

PORTSMOUTH HEALTHCARE NHS TRUST
CORPORATE POLICY

POLICY FOR ASSESSMENT AND MANAGEMENT OF PAIN

BACKGROUND

Despite dramatic advances in pain control over the past 20 years, many patients in both hospital and community continue to suffer unrelieved pain and up to three-quarters of patients experience moderate to severe pain whilst in hospital. Pain control in hospital has long been documented as ineffective and problematic. Effective problem - solving skills and interventions which reflect the multidimensional nature of pain are required for effective pain management and there needs to be a logical link between the assessment of the problem and the desired outcome.

1. PURPOSE

This policy identifies mechanisms to ensure that all patients/clients have early and effective management of their pain and or distress .

2. SCOPE

This policy provides a framework for all staff working within the Trust who are involved in direct and indirect care. All individual guidelines, protocols and procedures to support the policy must have been approved by the appropriate professional group.

3. RESPONSIBILITY

It is the responsibility of all professionals and support staff involved directly and indirectly in care to ensure that patients/clients

- have their pain and distress, initially assessed and ongoing care planned effectively with timely review dates.
- are informed through discussion of the proposed ongoing care and any need for mechanical intervention

3.1 All professionals are responsible for:

- assessment
- planning
- implementation of action plans
- evaluation
- clear documentation
- liaison with the multiprofessional team

Nurses are also specifically responsible for the:

- administration of the prescribed medication

Medical and Dental staff are also specifically responsible for:

- appropriate prescribing of medication
- clear unambiguous completion of prescription sheet

PAM's are specifically responsible for:

- prescription of therapies
- providing appropriate aids

Service lead groups are responsible for:

- ensuring that the pain management standards are implemented in every clinical setting
- ensuring that the necessary resources and equipment is available
- ensuring that systems are in place to determine and access appropriate training and that qualified nurses can evidence their competencies
- ensuring that standards are being maintained by regular audit and monitoring

4. REQUIREMENTS

4.1 Pain Assessment

All patients/clients who complain of or appear to be in pain must have an initial assessment to establish the type/ types of pain their experiencing.

4.1.1 Systems must be in place to ensure that:-

- all qualified nursing and medical staff have the required skill to undertake pain assessments and manage pain effectively.
- a local 'agreed' pain assessment method is implemented.
- a local 'agreed' documentation method is implemented
- all staff have the required training to implement and monitor the 'pain standards'

4.1.2 All professional staff are required to:-

- exercise professional judgement, knowledge and skill
- be guided by verbal and non verbal indicators from the patient/client/ re intensity of pain
- be guided by carer/relatives if appropriate
- document site and character of the pain
- share information with the care team to enable a multiprofessional approach to the management of the patient/client
- plan on going care where possible with the patient , documenting clear evaluation dates and times
- ensure documented evidence supports the continuity of patient care and clinical practice

4.2 Prescribing

A clear unambiguous prescription must be written by medical staff following diagnosis of the type/types of pain.

- The prescription must be appropriate given the current circumstances of the patient/client
- If the prescription states that the medication is to be administered by continuous infusion (syringe driver) the rationale for this decision must be clearly documented
  N.B (**The continuous infusion route is not more effective than the oral route)**
- All prescriptions for drugs administered via a syringe driver must by written on a prescription sheet designed for this purpose
- Systems must be in place to ensure staff have the access to appropriate medication guidance and the analgesic ladder.
- Systems must be in place to ensure staff have the skill to implement the above

5. AUDIT/CLINICAL GOVERNANCE

The systems in place to support this policy should be subject to an annual audit based on the requirements of this policy and should feature in annual clinical governance plans and reports

This policy is supported by the following documents

- **Syringe driver variable dose prescription chart**
- **Syringe driver check list**
- **Pain management cycle**
- **Pain management standards**

POLICY PRODUCED BY: Wendy Inkster
POLICY PRODUCED: April 2001
APPROVED BY TRUST BOARD:
REVIEW DATE: May 2003

STANDARDS

Portsmouth HeathCare NHS Trust

Nursing Standard: 1
Topic: Pain Management
Sub topic: Assessment

Standard Statement: The patient/client has an initial assessment of their pain

Structure	Process	Outcome
S1 A registered nurse or competent support worker in learning disabilities is identified as responsible for the patient/client on each shift	The identified nurse / competent support worker: Follows the pain assessment process of the pain management cycle and gathers information	O1 *The patients/client pain has been identified*
S2 Pain assessment method is agreed	P1 *Asks the patient/client about: Where the pain is: What it feels like; What increases it: What relieves it Observes for non verbal indicators Psychological and social state should be considered including anxiety, depression and patients/clients beliefs about pain*	*O2 Factors which influence the pain have been recognised*
S3 Documentation method is agreed	*P2 Record the results of the pain assessment on the agreed documentation*	*O3 The patient / client has*
	P3 Action plans as per pain management cycle Identifying the need for	*a) been given the prescribed PRN medication*
S4 Documentation is available : i.e. Medical, psychological and socio-economic histories	*a) prescribed PRN medication or*	*b) been referred to the relevant medical team*
	b) referral to the medical team or	
	c) alternate complementary intervention	

STANDARDS

Portsmouth HeathCare NHS Trust

Audit form 1
Audit objective: to establish if the patient client has had an initial assessment made of the pain
Time frame: to be determined locally
Sample: representative number of both nurse and patients / clients
Auditors: to be determined locally
Date:

Target group	Code	Method	Audit Criteria
Nurse	*S1*	*Ask & check records*	*Is there a registered nurse / competent support worker (learning disabilities) identified as responsible for the patient/ client on each shift?*
	S2	*Ask & check records*	*Is there an agreed pain assessment method?*
	S3	*Ask & check records*	*Is there an agreed pain documentation method?*
Nurse	*P1*	*Ask & check records*	*Is the pain management cycle chart available?*
			If appropriate:
			a) have non verbal indicators been considered
			b) have psychological and social state been considered
			c) have relatives involvement been considered
	P2	*Check records*	*Is the pain assessment recorded on the agreed documentation?*
	O2	*Ask & check records*	*Is there evidence that factors influencing pain have been recognised?*
	O3	*Check records*	*a) Have any prescribed medication or complementary alternative been given?*
			b) Have any medical referrals been timely?

STANDARDS

Portsmouth HeathCare NHS Trust

Nursing Standard: 2
Topic: Pain Management
Sub topic Action Plan

Standard Statement: An action plan is devised, using the information gained from the assessment which reflects effective management of the pain.

Structure	Process	Outcome
S1 A registered nurse will be available to administer the patients /clients prescribed medication. In learning disabilities a registered nurse will be available to authorise a competent support worker to administer the patients /clients prescribed medication.	*The identified nurse:* Follows The Pain Management Cycle Chart *P1 Monitors the effects of the prescribed medication 30 /60 minutes post administration. If good effect reassess at 60 minutes and within 3 hours*	*O1 The patient / client would communicate and / or show non verbal indications of a reduction in their pain* *O2 The patient / client would communicate and / or show non verbal indications of no reduction in their pain*
S2 Information regarding the WHO Analgesic Ladder is available *S3 Patients / clients start at the step of the WHO Analgesic Ladder appropriate for their severity of pain*	*P2 Ask patient / client about the effect observe for non verbal indicators*	
	P2 Record the medication effect after each reassessment in the patients / clients documentation *P3 Ensure that all prescribed analgesia is administered at the correct time*	*O3 Records would show the effects of the prescribed and administered medication*
	P3 Identifies the patient / client who needs further medical review	*O4 The patient / client has been refereed to the relevant medical team for further review*

STANDARDS

Portsmouth HeathCare NHS Trust

Audit form 2
Audit objective: to establish if the patient / client has had an action plan devised
Time frame: to be determined locally
Sample: representative number of both nurse and patients / clients
Auditors: to be determined locally
Date:

Target group	Code	Method	Audit Criteria
Nurse	*S1*	*Ask & check records*	*Has a registered nurse or in learning disabilities competent support worker administered the patients / clients prescribed medication?*
	S2	*Ask & observe*	*Is there an WHO Analgesic Ladder available?*
	S3	*Ask & check records*	*Do patients / clients commence on the step of the Analgesic Ladder appropriate for their severity of pain?*
Nurse	*P1*	*Ask & check records*	*Is there evidence that the effects of the prescribed medication has been assessed 30 / 60 minutes and again within 3 hours post administration?*
	O3	*Check records*	*Has the effects of the prescribed medication been recorded on the agreed documentation?*
	O3	*Check records*	*Have referrals to relevant medical teams been timely?*

STANDARDS

Portsmouth HeathCare NHS Trust

Nursing Standard 3
Topic: Pain Management
Sub Topic: Care Issues

Standard Statement: A plan of care is devised which meets the individual requirements of the patient /client in order to effective manage their pain.

Structure	Process	Outcome
S1 Information is available about *a) the patients / clients health status* *b) the pain assessment (NB Standard 1)* *c) the action plan (NB Standard 2)* *S2 The patient / client where ever possible should be given information about the pain management and be encouraged to take an active role in their pain management* *S3 Communication systems with family and friends are in place where relevant*	*P1 The registered nurse with the patient / client or relevant others devise a plan of care which:* *P2 Incorporates information from the initial assessment* *P3 Incorporates information from other members of the multidisciplinary team* *P4 Defines the goals of the care* *P5 Patients / clients receiving an opioid should have possible side effects managed effectively.* *a) Constipation:* *access to regular prophylactic laxatives* *b) Nausea & vomiting:* *assess need for a short term antiemetic.* *c) Sedation:* *d) Dry Mouth :* *Good oral hygiene*	*O1 The patient /client receives the planned care.* *O2 The care plan is evaluated regularly as specified within it.* *O3 Evidence where possible of patient / client participation in their pain management*

STANDARDS

Portsmouth HeathCare NHS Trust

Audit form 3
Audit objective: to establish if a plan of care is devised which meets the individuals requirements of the patient / client
Time frame: to be determined locally
Sample: representative number of both nurse and patients / clients
Auditors: to be determined locally
Date:

Target group	Code	Method	Audit Criteria
Nurse	*S1*	*Ask & observe*	*Is information available about:* *a) health status* *b) pain assessment* *c) an action plan*
	S2	*Ask & observe*	*Where ever possible has the patient / client been encouraged to take an active role in their pain management?*
	S3	*Ask & observe*	*Is there an established system for communicating with family and friends of the patient / client?*
	P1	*Ask, observe & check records*	*a) Is there a plan of care for the patient / client?* *b) Has it been devised by the nurse with the patient / client or relevant others?*
	P2		*Does it: Incorporate information from the initial assessment?*
	P3		*Incorporate information from members of the multidisciplinary team?*
	P4		*Defines the goals of the care?*
	P5		*If the patient / client is receiving an opioid have predictable side effects been considered and managed accordingly?*
Nurse / Patient /Client	*O1*	*Ask & check records*	*Has the patients / clients received the planned care and participated in their pain management?*

STANDARDS

Portsmouth HeathCare NHS Trust

Nursing Standard 4
Topic: Pain Management
Sub topic Organisational Issues

Standard Statement: The clinical teams work towards ensuring that the organisation of staff is responsive to, and meets the individual requirements of, the patient / client in order to effective manage their pain.

Structure	Process	Outcome
S1 All staff understand their responsibilities in accordance to the policy for assessment and management of pain	*P1 The Clinical Area / House Manager meets with the clinical team initially to agree the local pain assessment and documentation methods then meets on a regular review basis*	*O1 Recorded agreed local Pain Assessment and Pain Documentation methods.*
S2 Policies are available for the administration of medicines and for IV Therapy	*P2 The Clinical Area / House Manager and individual practitioners should ensure they have the required skills to undertake a pain assessment and for the effective ongoing management.*	*O2 Evidenced competence of all appropriate team members*
S3 Systems are in place to ensure that nursing staff have the required skill to undertake a pain assessment and for effective ongoing pain management.	*P3 The clinical team follow the pain management cycle chart and are guided by using the WHO Analgesic Ladder*	
S4 Systems are in place to ensure a local agreed pain assessment method and documentation method is implemented.	*P4 The clinical team have a working knowledge of the communication systems established with other specialist departments*	
S5 Communication systems are established for consultation with other specialist departments.		

STANDARDS

Portsmouth HeathCare NHS Trust

Audit form 4

Audit objective: to establish if the clinical team work ensuring that the organisation of staff is responsive to and meets the individual requirements of the patient / client in order to effective manage their pain

Time frame: to be determined locally

Sample: representative number of both nurse and patients / clients

Auditors: to be determined locally

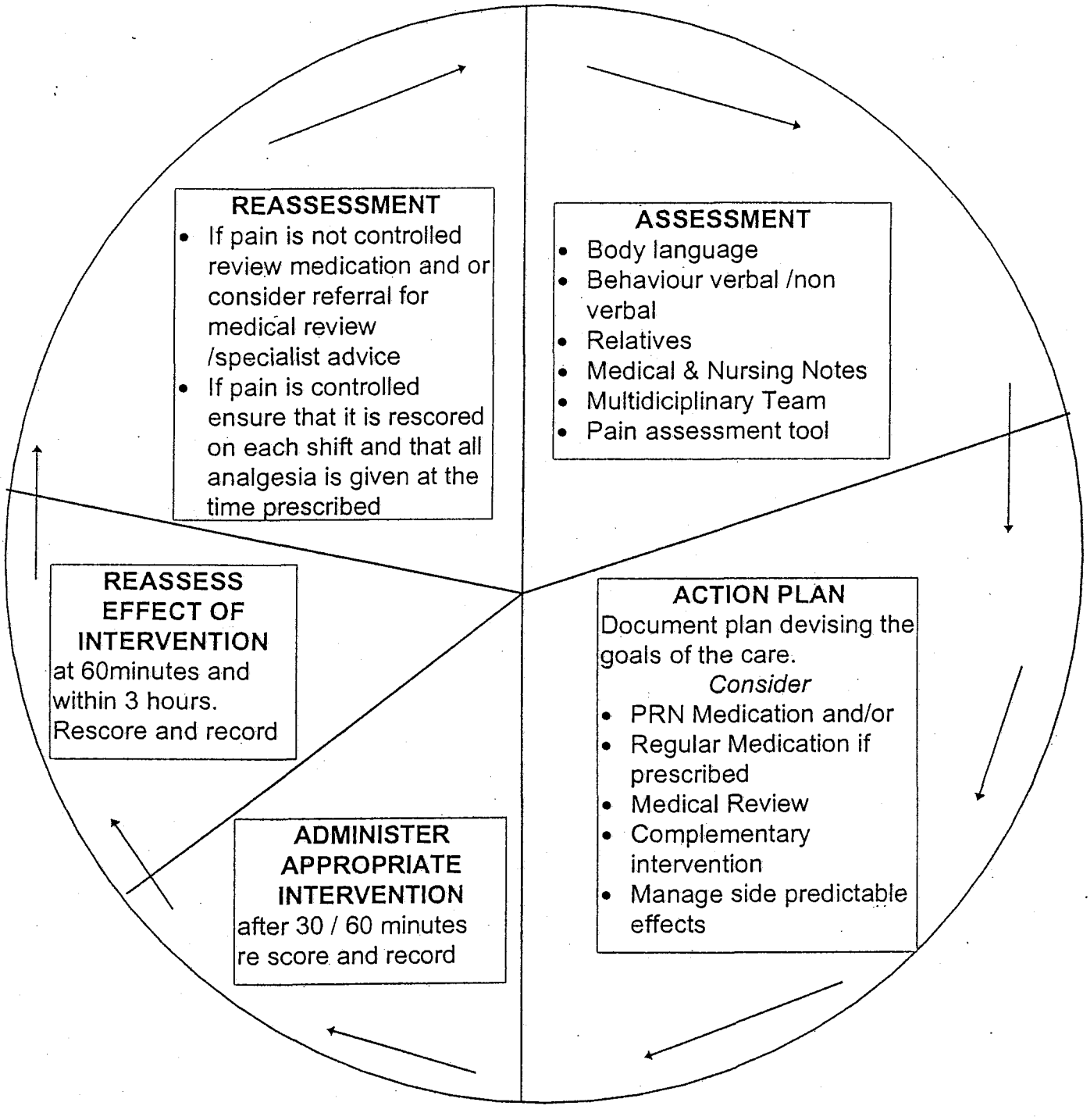
Date:

Target group	Code	Method	Audit Criteria
All staff	*S1*	*Ask*	*Can each members of the multidisciplinary team explain their responsibility in relation to pain management?*
	S2	*Ask & observe*	*Are policies available for the administration of medicines, IV Therapy and assessment and management of pain?*
	S3 *P2* *O2*	*As, observe & check records*	*Is there a system in place to ensure staff have the required skill to undertake a pain assessment and ongoing pain management?*
	S4	*Ask, observe & check records*	*Is there a system in place to ensure staff implement the agreed pain assessment and documentation methods?*
	S5 *P4*	*Ask*	*Is there an established communication system for consultation / advice with specialist departments?* *Do staff know who to contact and how to implement the system?*
Nurse	*P1* *O1*	*Ask & check records*	*Is there evidence of regular review of the agreed pain assessment and documentation methods?*

Portsmouth HealthCare NHS

NHS Trust

PAIN MANAGEMENT CYCLE



PORTSMOUTH HEALTHCARE NHS TRUST - SYRINGE DRIVER RECORD CHART.

NURSES: This chart must be completed on setting up the syringe driver and at least every shift change.

ATIENT NAME | NHS/HOSP NO. | WARD/ADDRESS | DATE

PATIENT																						
ain level																						
edation level																						
espiratory rate																						
ıfusion site																						
PRN doses administered (mg)																						
YRINGE DRIVER	SYRINGE DRIVER MODEL =											SERIAL NUMBER =										
ight flashing Yes or No																						
ate set @ (state mm/24hr or 1hr)																						
illimetres of fluid remaining																						
yringe secure Yes or No																						
Connections secure Yes or No																						
Clarity of fluid in syringe																						
Signature of checking nurse																						

All PRN doses given must be recorded and signed for

Pain level	
No pain	1
Acceptable pain	2
Unacceptable pain	3
If 3 take & record action	

Sedation level	
Awake	1
Dozing intermitently	2
Difficult to awaken	3
If 3 take & record action	

Respiratory rate	
9 - 24 / min	1
Less than 9 / min	2
More than 25 /min	3
If 2or 3 take&record action	

Enter all concerns and action taken in progress sheet.

PORTSMOUTH HEALTHCARE NHS TRUST - SYRINGE DRIVER RECORD CHART.

NURSES: This chart must be completed on setting up the syringe driver and at least every shift change.

PATIENT NAME | NHS/HOSP NO. | WARD/ADDRESS | DATE

PATIENT																						
Pain level																						
Sedation level																						
Respiratory rate																						
Infusion site																						
*PRN doses administered (mg)																						
SYRINGE DRIVER	SYRINGE DRIVER MODEL =												SERIAL NUMBER =									
Light flashing Yes or No																						
Rate set @ (state mm/24hr or 1hr)																						
millimetres of fluid remaining																						
Syringe secure Yes or No																						
Connections secure Yes or No																						
Clarity of fluid in syringe																						
Signature of checking nurse																						

All PRN doses given must be recorded and signed for

Pain level	
No pain	1
Acceptable pain	2
Unacceptable pain	3
If 3 take & record action	

Sedation level	
Awake	1
Dozing intermitently	2
Difficult to awaken	3
if 3 take & record action	

Respiratory rate	
9 - 24 / min	1
Less than 9 / min	2
More than 25 /min	3
If 2or 3 take&record action	

Enter all concerns and action taken in progress sheet.

Portsmouth HealthCare NHS
NHS Trust

SYRINGE DRIVER VARIABLE DOSE PRESCRIPTION

Name	Date of Birth	Ward / Address	Hospital No	Allergies and Drug Sensitivities
FRED SMITH	10/1/00	H20	2999999999	PENICILLIAN

DRUG 1 (approved name)
DIAMORPHINE

Dose per 24 hours	Route	Max. dose per 24hr not to exceed.
20MG	S.C	40MG
To be diluted in	Start date 10/0/00	Pharm

Signature of Prescriber J Bloggs Date 10/0/00

DRUG 2 (approved name)
MIDAZOLAM

Dose per 24 hours	Route	Start date	Pharm
20MG	S.C	10/0/00	

Signature of Prescriber J Bloggs Date 10/0/00

DRUG 3 (approved name)

Dose per 24 hours	Route	Start date	Pharm

Signature of Prescriber Date

Special Instructions for analgesics
(to include strategy for dose increases, and additional PRN doses, changes in patient condition)

- If breakthrough pain occurs, a PRN dose of Diamorphine 2.5 mg can be given every 4 hours
- If PRN dose does not control pain, increase subsequent PRN dose(s) to 5 mg every 4 hours to the maximum dose written on this prescription
- If pain is controlled with **Drug 1** as prescribed and no additional PRN doses have been required, repeat the same daily dose on the following day.
- If pain has only been controlled with the addition of PRN doses, add total PRN doses given in previous 24 hours to the dose given in syringe driver in the previous 24hours, rounded up to the nearest 5mg but only up to maximum dose written on this prescription.
- PRN doses may only continue to be administered as prescribed if dose does not exceed the maximum variable- dose prescription
- If the patient/clients pain or anxiety is not controlled within the above parameters or there are concerns about sedation level or overdose, a medical review must be requested and or specialist medical advice be sought

Signature of Prescriber J Bloggs Date 10/0/00

Portsmouth HealthCare NHS
NHS Trust

SYRINGE DRIVER VARIABLE DOSE PRESCRIPTION

Name	Date of Birth	Ward / Address	Hospital No	Allergies and Drug Sensitivities

DRUG 1 (approved name)			
Dose per 24 hours	Route		Max. dose per 24hr not to exceed.
To be diluted in	Start date		Pharm
Signature of Prescriber			Date
DRUG 2 (approved name)			Pharm
Dose per 24 hours	Route		Start date
Signature of Prescriber			Date
DRUG 3 (approved name)			Pharm
Dose per 24 hours	Route		Start date
Signature of Prescriber			Date

Special Instructions for analgesics
(to include strategy for dose increases, and additional PRN doses, changes in patient condition)

- If breakthrough pain occurs, a PRN dose..... ..... can be given every..... hours
- If PRN dose does not control pain, increase subsequent PRN dose(s) to .... mg every ..... hours to the maximum dose written on this prescription
- If pain is controlled with **Drug 1** as prescribed and no additional PRN doses have been required, repeat the **same** daily dose on the following day.
- If pain has only been controlled with the addition of PRN doses, add total PRN doses given in previous 24 hours to the dose given in syringe driver in the previous 24hours, rounded up to the nearest 5mg but only up to maximum dose written on this prescription.
- PRN doses may only continue to be administered as prescribed if dose does not exceed the maximum variable- dose prescription
- If the patient/clients pain or anxiety is not controlled within the above parameters or there are concerns about sedation level or overdose, a medical review must be requested and or specialist medical advice be sought

Signature of Prescriber Date

ANALGESIA LADDER

- **MILD** ~ Paracetomol. Oral/PR. 1 Gram QDS.
- **MODERATE** ~ Codydramol/Coproxamol/Cocodamol 30/500 ii QDS
- **STRONG** ~ Oral Morphine/Oramorph 4 hourly including 2am dose.
  5mg if Paracetomol previously used.
  10 mg after moderate analgesia.

To calculate Opiate dose ~
If pain recurs before 4 hours, give an extra 4 hourly dose from the PRN column.
Review the dose daily. Add any PRN doses to the regular prescription, divide 24 hour total by 6 to achieve an effective 4 hourly dose.

WHEN STABLE convert to Morphine Sulphate Sustained Release 12 hourly.

If the patient is dysphagic, vomiting or unconscious give SC Diamorphine at 1/3rd of the 24 hour total oral Morphine dose. (Coproxamol etc. are opiates i.e. ii = 8mg oramorph).

REMEMBER
Give antiemetics for 2-3 days if new to Morphine.
Give aperients when using opiates.
Not ALL pain is Morphine responsive.

- **BONY PAIN: NSAID'S** (Think about renal failure, GI bleeding, heart failure).
- **LIVER PAIN: NSAID'S** or Steroids.
- **NERVE PAIN:** Amitryptline 50-75mg (start at 25mg)
- **CONSTIPATION:** Aperients or enemas.
- **ANGINA: GTN**
- **INCREASED INTRACRANIAL OR SPINAL CORD PRESSURE:**
- Dexamethasone.
- **BEDSORES:** Pressure relief and dressings.
- **PSYCHOLOGICAL DISTRESS:** Listen and explain, offer antidepressants, benzodiazepines.

EVALUATE the effect of the analgesia ~
Within ½ hour (if not effective the patient needs more)
When the next does is due: (is it lasting 4 hours?)
When the patient is moved. (Are they fully pain controlled?)

OBSERVE for any side effects; document and treat accordingly.
If the patient becomes more ill or drowsy with analgesia ~
CHECK THE PUPILS.

If they are normal it is probably the disease progression, if they are pinpoint it could be due to the Morphine.

SOURCES OF ADVICE: Colleagues, Charles Ward, Palliative Care Team, Pharmacy, Pain Clinic, Radiotherapy Department, etc.

STANDARDS

Portsmouth HeathCare NHS Trust

Nursing Standard: 2
Topic: Pain Management
Sub topic Action Plan

Standard Statement: An action plan is devised, using the information gained from the assessment which reflects effective management of the pain.

Structure	Process	Outcome
S1 A registered nurse will be available to administer the patients /clients prescribed medication. In learning disabilities a registered nurse will be available to authorise a competent support worker to administer the patients /clients prescribed medication.	*The identified nurse:* Follows The Pain Management Cycle Chart *P1 Monitors the effects of the prescribed medication 30 /60 minutes post administration. If good effect reassess at 60 minutes and within 3 hours*	*O1 The patient / client would communicate and / or show non verbal indications of a reduction in their pain* *O2 The patient / client would communicate and / or show non verbal indications of no reduction in their pain*
S2 Information regarding the WHO Analgesic Ladder is available *S3 Patients / clients start at the step of the WHO Analgesic Ladder appropriate for their severity of pain*	*P2 Ask patient / client about the effect observe for non verbal indicators*	
	P2 Record the medication effect after each reassessment in the patients / clients documentation *P3 Ensure that all prescribed analgesia is administered at the correct time*	*O3 Records would show the effects of the prescribed and administered medication*
	P3 Identifies the patient / client who needs further medical review	*O4 The patient / client has been refereed to the relevant medical team for further review*

STANDARDS

Portsmouth HeathCare NHS Trust

Audit form 2
Audit objective: to establish if the patient / client has had an action plan devised
Time frame: to be determined locally
Sample: representative number of both nurse and patients / clients
Auditors: to be determined locally
Date:

Target group	Code	Method	Audit Criteria
Nurse	*S1*	*Ask & check records*	*Has a registered nurse or in learning disabilities competent support worker administered the patients / clients prescribed medication?*
	S2	*Ask & observe*	*Is there an WHO Analgesic Ladder available?*
	S3	*Ask & check records*	*Do patients / clients commence on the step of the Analgesic Ladder appropriate for their severity of pain?*
Nurse	*P1*	*Ask & check records*	*Is there evidence that the effects of the prescribed medication has been assessed 30 / 60 minutes and again within 3 hours post administration?*
	O3	*Check records*	*Has the effects of the prescribed medication been recorded on the agreed documentation?*
	O3	*Check records*	*Have referrals to relevant medical teams been timely?*

STANDARDS

Portsmouth HeathCare NHS Trust

Audit form 3
Audit objective: to establish if a plan of care is devised which meets the individuals requirements of the patient / client
Time frame: to be determined locally
Sample: representative number of both nurse and patients / clients
Auditors: to be determined locally
Date:

Target group	Code	Method	Audit Criteria
Nurse	*S1*	*Ask & observe*	*Is information available about:* *a) health status* *b) pain assessment* *c) an action plan*
	S2	*Ask & observe*	*Where ever possible has the patient / client been encouraged to take an active role in their pain management?*
	S3	*Ask & observe*	*Is there an established system for communicating with family and friends of the patient / client?*
	P1	*Ask, observe & check records*	*a) Is there a plan of care for the patient / client?* *b) Has it been devised by the nurse with the patient / client or relevant others?* *Does it: Incorporate information from the initial assessment?*
	P2		*Incorporate information from members of the multidisciplinary team?*
	P3		*Defines the goals of the care?*
	P4		*If the patient / client is receiving an opioid have predictable side effects been considered and managed accordingly?*
	P5		
Nurse / Patient /Client	*O1*	*Ask & check records*	*Has the patients / clients received the planned care and participated in their pain management?*

STANDARDS

Portsmouth HeathCare NHS Trust

Nursing Standard 3
Topic: Pain Management
Sub Topic: Care Issues

Standard Statement: A plan of care is devised which meets the individual requirements of the patient /client in order to effective manage their pain.

Structure	Process	Outcome
S1 Information is available about *a) the patients / clients health status* *b) the pain assessment (NB Standard 1)* *c) the action plan (NB Standard 2)* *S2 The patient / client where ever possible should be given information about the pain management and be encouraged to take an active role in their pain management* *S3 Communication systems with family and friends are in place where relevant*	*P1 The registered nurse with the patient / client or relevant others devise a plan of care which:* *P2 Incorporates information from the initial assessment* *P3 Incorporates information from other members of the multidisciplinary team* *P4 Defines the goals of the care* *P5 Patients / clients receiving an opioid should have possible side effects managed effectively.* *a) Constipation:* *access to regular prophylactic laxatives* *b) Nausea & vomiting:* *assess need for a short term antiemetic.* *c) Sedation:* *d) Dry Mouth :* *Good oral hygiene*	*O1 The patient /client receives the planned care.* *O2 The care plan is evaluated regularly as specified within it.* *O3 Evidence where possible of patient / client participation in their pain management*

STANDARDS

Portsmouth HeathCare NHS Trust

Audit form 4

Audit objective: to establish if the clinical team work ensuring that the organisation of staff is responsive to and meets the individual requirements of the patient / client in order to effective manage their pain

Time frame: to be determined locally

Sample: representative number of both nurse and patients / clients

Auditors: to be determined locally

Date:

Target group	Code	Method	Audit Criteria
All staff	*S1*	*Ask*	*Can each members of the multidisciplinary team explain their responsibility in relation to pain management?*
	S2	*Ask & observe*	*Are policies available for the administration of medicines, IV Therapy and assessment and management of pain?*
	S3 *P2* *O2*	*As, observe & check records*	*Is there a system in place to ensure staff have the required skill to undertake a pain assessment and ongoing pain management?*
	S4	*Ask, observe & check records*	*Is there a system in place to ensure staff implement the agreed pain assessment and documentation methods?*
	S5 *P4*	*Ask*	*Is there an established communication system for consultation / advice with specialist departments?* *Do staff know who to contact and how to implement the system?*
Nurse	*P1* *O1*	*Ask & check records*	*Is there evidence of regular review of the agreed pain assessment and documentation methods?*

STANDARDS

Portsmouth HeathCare NHS Trust

Nursing Standard 4
Topic: Pain Management
Sub topic Organisational Issues

Standard Statement: The clinical teams work towards ensuring that the organisation of staff is responsive to, and meets the individual requirements of, the patient / client in order to effective manage their pain.

Structure	Process	Outcome
S1 All staff understand their responsibilities in accordance to the policy for assessment and management of pain	*P1 The Clinical Area / House Manager meets with the clinical team initially to agree the local pain assessment and documentation methods then meets on a regular review basis*	*O1 Recorded agreed local Pain Assessment and Pain Documentation methods.*
S2 Policies are available for the administration of medicines and for IV Therapy	*P2 The Clinical Area / House Manager and individual practitioners should ensure they have the required skills to undertake a pain assessment and for the effective ongoing management.*	*O2 Evidenced competence of all appropriate team members*
S3 Systems are in place to ensure that nursing staff have the required skill to undertake a pain assessment and for effective ongoing pain management.	*P3 The clinical team follow the pain management cycle chart and are guided by using the WHO Analgesic Ladder*	
S4 Systems are in place to ensure a local agreed pain assessment method and documentation method is implemented.	*P4 The clinical team have a working knowledge of the communication systems established with other specialist departments*	
S5 Communication systems are established for consultation with other specialist departments.		