GLADYS RICHARDS

(1)

9.4.13

Bhogal – No ques

Green

Use of oramorph at Gosport before she went back to Haslar? – Moaning not screaming. Nurse wld want to relieve it? understandable dem. misread as pain? Haslar discharge said 2 co-cod as req'd. Not on anything else at Has. You start with something diff from Oramorph.

~~Last~~

Haloperidol? Meant for sychzo's not for a good night's sleep. I'm not an expert on Halop. I know more about it than Dr Banks. Halop cld well have contrib'd to fall in Gosport.

Nurse Code A found no injury? Not thorough enough!

Mrs R delty'd at admission to H? Can't remember who made the comment.

Was she unconscious on morning of 18/8 ?

Prof Fenners Report – he reviewed blood results no evid of delyd on adm to H? Yes (evasive remarks)

17.8.98 – Re-adm to G – Criticism of Couchman – she responded? At request of my sister. It took 1/2 hr after adm for her to get attention. My sister had to instruct Couchman.

18.8.98 – Start of diamorphine? Started earlier on 17.8 I saw 2 injections of diam given. My sister saw this. Syringe driver started on 18/8. Once she had oramorph she settled on 17/8. I'd refused diamorph at that stage. This was before Dr B

NO injections until 18/8? No, she had diam on 17/8, 2 injections.

When syr. driver started, in severe pain? No she was unconscious. She was unconscious in the

(3)

Unable to swallow when syr. driver started?
No I don't agree. No evid of haematoma. Never opened her eyes ~~after con~~ again after coming out of X-ray.
When s.d started, it didn't control her pain? How can you tell someone's in pain if they're unconscious.

O'Brien

Mehigan – no sign of a haematoma?
Coroner – wld it show? Not rec.

Green

We'd seen her walking with zimmer before being 1st t'fered from H.
Was she v.v. dependent (H notes say this)?
Only 10 days after op.
Zero on Bartell scale? Yes.
Did you help her use commode on 1st day back at H? V. little she cld do on her own at ~~t~~ that time.
RGN shld be able to tell diff between agitation and pain.
~~Staff at their wit's end~~
Bleed told ~~her~~ you about Oram on 11/8? No.
On 12/8 spoke to Joyce & made sure she didn't
Dose shld have been given 2.5 of Oram but they were giving her 10.
Morph wldn't have contrib'd to fall? She was having other things as well.

O'B

G ? Ans. Don't know why they wanted to keep her off her feet in Haslar.

Code A recollections ?

Delay in diagnosis, Code A explanation of her examination on the floor, no sign of dislocation - clin signs not always clear straight away ? Yes.

Later B examined her on bed & found dislocated - Did delay make any diff ? Treatment cld have come quicker with early diagnosis.

X-ray on 14 ? Heard noise, assumed she was in pain even tho' unconsc. you can make a noise because you're in pain.

Blood results show no dehyd ? Yes but she hadn't had a normal amount of fluid. Nothing on nowish. charts to show she'd had anything to drink.

Screaming on 17/8 on Mrs O'B's arrival ? That was due to pain. Told Couchman that.

Pain remained hard to control ? Yes. She had injections that day - even tho' not on chart ~~she~~ I saw the injections given.

(3)

Despite Oram, pain was barely relieved? Yes.
I didn't know about pureed food, only saw whole food. She was swallowing OK at Haslar that morning. I don't agree she didn't swallow on 17/8. On 18/8 she didn't swallow because she was sedated. Even then she could swallow from the sponge we cleaned her mouth with.

6 doses of Oram - 1.00 on 17 to 04.30 on the 18/8.
But still in pain on 18? Didn't show any sign of pain because of Oram. She'd had 45 mg in this period.

7 hr gap between last Oram & syr. drive? Chart may not have recorded injections. How did she have been given medicines by mouth on 18 if she didn't swallow.
Breakthru' pain whilst on syr. drive? No noise to show she was pain after that, deeply unconscious & for the rest of her life.

Ask Dr B
why?

O'B

Jenkins

① Halop at Haslar? - not on daily basis?
Don't believe on daily basis, just as & then. (Shown daily on records)
As req'd records show Halop given frequently in addition? ~~Yes~~. (Record shows this)
Yes, I agree.

② Oramorph (see p. 62) - Diff sections of prescrip sheet. Dr B's prescrip is in the "as req'd" section. "Oram 10mg in 5mls" 2.5 to 5 mls? Prescrip shows Dr B gave nurses leeway.
Look at 2nd column 14/8 - 1st dose top of range, 2nd & 3rd bottom of range.

③ P. 29 - Dr Baton's note for 11/8 - in middle "frail dement, not obv in pain, pl. keep comfortable" only consult round every 2 wks. Dr B there an hr a day, no-one there at night. Dr writing up licence for nurses when Mrs R was in pain. Condition can change rapidly? Yes.

+ If no prescrip for drugs, nurses wld have had to bring a Dr in if Mrs R in pain? Oram for severe pain, you try other things first.

O'B – J

Look at p. 62 – Beed's initials for giving 5 mls at 11.? Only one person recorded, not 2? Yes. Only Oram shown on chart for 14|8 given? Yes.

More pain relief given at H on arrival? At H only knew about what given. (see p. 30) These notes sent to H with a blank ½ page.

Haslar told what she'd had? Yes.

Knowles

10.4.13

(1)

Reid

Jenkins

Daed for rehab, Dr B a clinical assistant there for 1 hr a day? Yes. I wasn't working at G before '99. Dr B went round with consult on weekly round every 2 wks. Dr B assiduous to her duties. Came in twice a day regularly. In her own time. Resp for Daed & Dryad (40 beds total). Only a short time with each patient. Time pressures on her. Notekeeping ... brief by necessity. Seeing patients altho' not always recorded in notes.

Prescip based on initial ass'ment. Prescip in anticipation because no Dr there for most of the day. Same practice at QAH.

Pre-99, anticip prescip but nurses wld talk to Dr before administration of drug? Yes, that's my understanding. Not usual for anticip prescip but the practice at G and consults aware of it? Yes.

Consults did wkly rounds - ~~see~~ wld see every single patient with review of med needs. Consult wld be well aware of patient's prescips. No-one had raised concerns about prescip with Dr B.

Dr Banks letter (p. 679)

End stage D = Unable to care for themselves. Limited appreciation of surroundings. Lengthy sleep.
Next stage of ESD = loss of mobility poss with conseq complics.
Fall can be pre-terminal event resulting in bronchpneu. due to inability to clear secretions.
Can come on in hours, v. quickly.
Stress of injury/surg can take a toll.
Recovery rates for old are v. low.
2nd fall injury/revision - further strain on her.
3rd referral in such circums, prognosis wld become poorer, chances of recovery diminish significantly.

Reid | Knowles

Use of oram on 17/18 Aug.
Admin chart (p.62) - Oral dosage v-a-v subcut, in general terms change wld involve a reduction to 1/3 of oral dosage for subcut.
"Nursing a problem" - Ms R still in great pain after dosage. BNF says in those circums dosage can go up by 50% ∴ 36 mgs - 40 mgs presc ∴ approp and reasonable.

If dosage too high, it will cause sedation & depressed resp. but sometimes nec to relieve suffering.
Survival for 3 or 4 days shows the dosage unlikely to be a factor in her demise.

Mrs O'B

Wld you be sup't she was unconsc. with this dosage? Not approp to admin more if unconscc.
BMA concl on Dr B? Confirmed.

Prof Ferner

Green

Effects/side effects of opiates – Wldn't happen unless getting enough to control pain? Not sure. In practice, people poisoned by opiates are unconsc. Pain controlled people often asleep. Varies between individual patients.
Sometimes nec to risk sedation to alleviate pain.
Ethics of Mrs R case – wld it have been approp to leave her in pain rather than risk unconsci.
Circums of start of syr. driver?
Fluid charts from Hastar show she was drinking subst. amounts before return from H.
Nursing records shortly after return to G (p.45)

Evid = no more morph than nec to control pain? Diffic to say. If pain on movement why not pain relief for that specific pain.
Dosage reduced life expectancy.

Ferner / Jenkins

Used to treat patients like her for 30 yrs.
I wld consult dr's, nurses, relatives.
Jnr docs wld make ass'ments themselves.
Heavy reliance on views of others on state of patient? I wld rely on them.
If I dr briefly there, they'd have to be heavily reliant? I imagine so.

- Tolerance of opiates – side effects and patients over time build up tolerance.
Cross tolerance between drugs? Certainly between morph & diamorph.
Greater dose than needed wld give side effects?
Some of side effects with a req'd/justified dose.
- Tol. has a tech meaning? Pain itself is a stimulant.
Resp depression – cough reflex supressed. Pneum commonly develops in this situation.

Why wld
she survive
so long with
this level of
pain relief/sedation?

F | J

~~Keen~~

If this was o'dose, why wasn't death sooner? Subcut slower ~~ed~~ absorb c.f. intravenous. Still resp death, even if not sudden.
It wld take hrs to reach ~~a stable~~ 3–6 hrs to have effect as an o'dose.
~~Wkdz it~~
2 injections by Reed may have raised levels higher.

F | Knowles

Double effect wld have been borne in mind by Dr Reid in his answers today.
She survived for 4 days on this dosage - surprising? If pain & suffering relieved.
Not giving fluids – if someone dying & not in distress, this wld be OK. Treated as terminally ill for last 4 days – was that the correct dosage in that case.

F/O'B†B

I was X-mined on ~~Fs~~ blood test of 29/7 on the basis that test was on 2nd adm on 14/8.

F/Meligan

Sensitwe to morphine? Yes.
11 Aug Dr B note consistent with anticip p'scribing only if anticipating demise. It happened but I can't see any justification for 200 mg of diam subcut at that time (11/8).
Misuse of drugs chart diffic to understand, they're unclear & suboptimal.
Giving discrt to Nurses to give a fatal dose.
Any indic on morning of 18/8 that move to pal. care was justified? No. I'd expect a note to be made at the time as to why.
"Please make comf" on 18/8 cld be euph for terminal care but the phrase also used on 11/8, so cld mean Dr B thought term care approp on 11/8.
Suprised by suggestion she'd been given more morphine than recorded.

F/M

Wld expect records to show what was going on but they don't here.

Giving fent loading morph can produce the sympts that wld give rise to the decis to undertake pal care.

Trazadone can cause sleepiness.

Beed

Meligan

Did you ever feel nurses/dr's cldn't cope with workload? Always busy.
Dr B never complained to me about being overstretched.

If you think drug regime was wrong you cld complain? Yes but I thought Mrs R's regime was appropriate. Drugs/care was subj to joint discussions with nurses/dr's/my manager.

Records shld recall all signifc things. We had record keeping difficulties on the ward at that time. Shortcomings in quality/quantity of Mrs R's records.

level of drugs = Dr B's decis based on feedback from me.

Were you aware family felt over sedated? Don't remember that.

Not on every patients notes for death confirm but on quite a lot, at Dr B's discretion based on ass'ment.

Criteria for putting it on? → Ask Dr B. It was patents whose condit was generally poor.

On 11/8 records, Ms R old swallow.
T'fer letter from Dr Reid – ready for rehabil
that's what she was admitted for.

What kind of chair was she in when she fell?
An upright chair. She got a more upright chair.

17/8

Wasn't there when she was put in bed.
Don't remember if we had pat slides then.
Staff said it was done using a sheet to t'fer from trolley. That wasn't normal, shld have been done with canvas.
Aware Ms OB found her in unsatis position. I didn't see it. I didn't give her an injection, I don't remember / nothing in records to that to indicate that I did that.
Did you give her a 2nd diam injection as well that day? No, If I did it wld be documented. I wldn't have omitted to record that.
Did you have prescribing power to give a PRN diamorph injection? No.

Decis to instit pall. care –
Last night staff oram at 4.30 – it had been diffic to rouse her / gwo it.

"Please keep comf" = move to pal. care. Indic's patient was to going to die.

Large doses of morph cause rsp. depression / heavy sedation.

Why didn't you re-ass^{t} drug regime? Mrs R had entered pall. stage we weren't expecting any change in her care.

Did you discuss progressive use of morph with Dr B? We started at a relatively low dose.

Factors influenced Dr B's decis & your advice to her? Patients condit over last 24 hrs and then. Her pain was local & generalised.

Told family haem. That's what Dr Peters said she had.

No written record of haem? I was told at time.

There was no surface bruising.

I don't remember her coming back from H in a splint.

(4)

On 11/8 or 17/8 I read the discharge letters. I don't recall 4 week splint being mentioned.
Who met her on 11 or 17? On 11 don't know. On 17 2 healthcare assistants met her.

B/O'B

17/8 - You told Mrs McK that you'd give her an injection to make her more comfortable? I don't remember. I didn't say anything about an injection of diamorph.
Remember being told about H offer of re-adm? Don't remember that. I don't recall Dr B's reply. Vaguely recall Dr B said she wldn't survive further surgery. Orum 4 hrly + review in morning? That fits with what occured.

45 mgs given by a.m. of 18/8 & was unconscious by then & remained so until went on syr. driver. Yet still decis made? Yes.
~~I saw~~ I don't remember giving her any injection on 17/8. If I'd given one, it wld be recorded. I wouldn't have done it w'out recording it.
Check 11/8 prescrip. to give diamorph do you think that's right? It was a syr. driver prescrip. Not a PRN injection prescrip.

17/8 - Alleg of injections - Mrs O'B spoke saying he was busy - was that why he didn't record/remember.

If was a controled drug, I'd need a presip (5) + I'd record it.

Is dementia a mental health problem? Yes. Higher level of drugs given to them than patients without m.h. problems.

1st Adm 11/8

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she was put in room to right of nursing office.

- I recall Mrs O'B being there.

[redacted]

Did you feel she was in so much pain she needed Oram on 1st afternoon, 2 hrs after OB left? Yes

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17/8

- 45 mg ⟶ ~~00~~ 04.00 ? Correct.

Not eating, drinking – due to sedation? May have had an effect on that. Don't remember me being unconscious.

No further med 04.30 ⟶ until s.d? Yes

Diff between sleeping/unconscious? Yes, didn't drink if unconscious.

B/ Jenkins

1998 — Nursing for 18 yrs then.
Ward Man from early '98 — was it under doctored? Yes. I remember Dr B being replaced by full time Dr in 2000 - for 2 wards + day hosp.
In 98 Dr there for small part of day. Consult = Dr Lord, round once a week, 1/2 ward each time.
Nurses wld need to be in reg contact with Dr B. Patient care discussed with her even when in own surgery.
Came in for max 1 hr start of each workday. Usually left at 9.00.
Wld come back in to see t'fered patients, usually at lunchtime.
Relatives ~~used~~ did come at any time.
Treating patients on both wards.
Wld discuss concerns with Dr B.
Had good working relat. with B.

Patients not always t'fered without full records. Patients from H often not in condit we hoped / not as described in letter.

Patients often took a step back due to effects of transfer. (7)

Patic if elderly or confused.

Expectations of relatives — Did rel's find it frustrating not to have Dr to speak to? Sometimes but Dr B good.

Hopes of rels re: rehab? Often didn't be met due to condition of patient. They found it diffic to accept.

Diff's in opinion between daughters.

'Happy to confirm death' sometimes written in for v. elderly/frail patients by Dr B on 1st adm.

Barthel 2/3 = No indep movement.

'Not obv. in pain' = snapshot.

As req'd prescip (p.62) → Discret for nurses.

'SC' in 24 hrs wldn't give auth for intrav hy? No.

Intrav wld have to say so.

Ulcy to give cont'd drugs w'out prescip + writing it up.

(8)

Nurses have prof dolgs re use of controlled drugs. Concerns about use have to be rf'd up chain of command.

Oram has 4 hrs effectiveness - hence 4hr prescip.

Syr Drivers - cld have been used from 11/8 but I'd have discussed with Dr B before/soon after uses.

More than 1 on ward.
Used occasionally for patient? Yes. Patients sometimes died who weren't on them.
Consid'd appropr. where patient in a lot of pain.
Some wld rally on S.D. & later removed - but not terribly usual, not often.

On 18/8 SD because of problems controlling her pain. Present when discussed with daughters. I can't remember if both agreed but I'd have rf'd back if strong disagreement.
Started at 40mg diam (bottom of Dr B's range). Dr B's decis/prescip & discussed by her. I considered it an appropr. dose on my assessment of Mrs R's condit. Appropr. route to give diam - I thought so.

Had deteriorated by 17/8 re-adm. (a)
Hrly monitoring whilst on syr. dr. Approp'ness reconsidered each time.

B | Green

Staffing - Heavy workload on D Ward, we were often stretched. I raised them with managers by regular contact. Not an issue raised when Mrs R on ward.

Drugs on Chart

Hal - for mental health = fairly low dose.
Wld mh probs make any diff for level of morph? Diff patients get diff doses dep. on pain levels.

Bartel (p. 40) completed by nurse on first adm. (look at scores)

Mrs R need 2 people to t'fer. I don't know if we ass'd walking, wldn't do it immed, usually w'in 24hrs.
We cld on own init to instit syr dr. We'd start on lowest altho' discret.

10

B | Green

Any concerns about undue sensitivity due to Oramorph? Yes t'script 92.
Gap in drug record 12/8 - 13/8 due to our concerns about o'dosing.

Discussion of dosages 17 - 18/8 on p. 62.

Diam untrav injections — Procedure for admin described.
No discreps when Mrs R on ward.
Subcut. morph doesn't require swallowing + more continuous effect c.f. Oramorph.
Neither more dangerous than the other.

O'B 2nd call

Green

Other people may have formed a different impression.
No nursing care given on 19/8 other than syr driver reloading

(11)

Litre of fluid on evening of 11/8.
When I arrived on 12/8 she was unconsc.
You did get her co-op better than
nurses? Yes.

Mrs McK (2nd)

Coachman (Difficult for her to understand + answer ques)

c/Meh.

Only dr can prescribe.
We'd speak up if we had reservations about prescrips.

Barton

Meltigan

Used 97 BNF.

Can't judge adeq of cover + workload. We all worked very hard.

Adeq med care given to Mrs R.

I was having continuing refresher training.

Resp for my own continuing educ.

11/8 - H thought she was suitable for t'fer + Dr R thought not dying.

When I saw her she was comfortable & not in pain.

Made avail medic if she shld deteriorate.

I thought she might deteriorate.

I thought w'in wks/months of her death, not nec imminent. Not nec w'in next few hrs or days.

I wrote what I did on all end stage dement. similar cases. I was in an isolated role in a cottage hospital.

Didn't return from H in good condit on 17/8. Procedure a success but ~~the~~ she was badly effected by it.

18/8 - Prescribed syr dr. incl. Diam. (2)
Prescip level was an admin device in case it was ever needed. If I wasn't avail, I didn't want to delay admin of medic. Nurses always started at bottom range dose.

13/8 & 14/8
"Is lady well enough" explained, t'for surgery a morbid factor. Proc had to be done but it wldn't improve her outlook. Enormous conseq damage to surrounding tissue.
She remained unconse. for whole day after the proc.
17/8 Discharge letter from H - ~~not the~~ not the lady I saw. I accept she only had co-cod at Haslar. I got this wrong because of 2nd hand info from nurse, didn't have H notes when I made that statement.
My decis on future care wasn't made on this assump. It wldn't make any diff to my prescribing that I thought she had ~~st~~ had ortow.
Morph.
Don't remember seeing a splint.

By 17~~8~~/8 I thought her death was inevitable & ∴ palliative care from then on.
Before 2nd X-ray.
I don't remember Beed giving an inject. before X-ray. Wldn't have been given without it being recorded.
No morph admin'd was factored into my 18/8 decis, only the Oramorph.
Don't remember Ms O'B saying a consult at Haslar wld accept a return.

~~Rds~~
My ass'ment of 18/8 confirmed that of mine of 17/8.
For Oram, patient still has to be able to swallow.
Didn't check swallowing on 18/8. Not a factor in my syr. dr. decision. She cld still have had Oram that morning pre-syr. dr. if she'd been capable of taking it.
Haem v. signific in decis to go to pall care.
Can't remember if I phys examined her. I got the info from Dr Peters. X-rays never came back from the Ward.

Haems resolve in days/wks, not gen life threatening. It would have resolved for her if she hadn't been dying. Decis made when she came back of 17/8 + lack of further disloc.

Haem caused pain, a major problem of her. Pall care not nec end of life care. In terminal care at the end of her treatment from 18/8 at the time of move to syr. drier.

~~Step~~

Diam = 2x Oram dosage ? Yes. Oram not working so this was a perfectly acceptable step up analgesic ladder.

My note taking was sloppy.

She was peaceful & rousable ~~too~~ after syr. dr. - I was told by nurses.

She stopped passing urine, no diff. Morph goes thru' liver. Quantities of morph in her system not increasing. I didn't think I'd given her too much, based on observs of me and nurses.

inhumane to take diam away in order to assess her.

21/8

Wasn't in hosp when she died.
Bronch was the only reason for her death in my view.
Diam doesn't cause bronchopn.

Barton / O'B

Because of set-up, I had little time to spend with patients.
Wessex Guidelines for wards wher pall care is given.

I didn't see her walk on 11/8. Staff said she needed hoist + 2 people to walk, altho' she was weight bearing.

11/8 - Haslar record = disparity with what she was like when I saw her.

17/8 - T'fering hr back wldn't have altered her management. Complics weren't amenable to surg treatment. She needed palliative care - given when no surg treatment or cure to make her comfortable.

Barton / Green

Only Traz had been stopped at H.

Para 31

Prescip ~~on~~ on p.66. written on 13/8. ~~because~~ because Mrs R was noisy and agitated Oramgwen on 12/8 had worn off.

Don't think 13/8 halop wldn't have had much of an influence on her falling at 13.30

Oramm – smallest dose nec is the appropr. one. If pain breakthru', it wld need to be increased.

Jenkins / B

Morning t'fers usual from H but they didn't always come then. They shld be seen by dr w'in 24 hrs by me or another dr from my practice.

(7)

Often patients worse than describ'd in d'charge letter. Not always as well as letter said they were.

17/8 Readm - We didn't see what Ms O'B said H told her regarding Mrs R's condit.

Oram on 17/8 - R wld have had to have been able to swallow.

Nothing a surg ward cld have done to treat a haem.

Transfer on 17/8 - led to diffics/pain. A further t'fer wld have added / exacerb'd this - totally inapprop.

Oram 04.30 on 18/8 - for it to have been given means she must have swallowed it.

Nursing note of 20.00 contradicts suggestion that she was deeply unconsc. then.

I sat in on morning nursing briefings to get info on patients.

The ward was under-doctored. When I resigned I was replaced by 2 full time docs - then no need for anticip prescribing when dr's available. If dr's there 24/7 no need for my 11/8 instructs.

Review of
level of analgesia?
Wld it be apprpr.
to discontinue analg.
to see how much
pain she's in?