RE-TYPED ANALYSIS WITH COMMENTS

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.**

See letter from Haslar, Dr Reed, who considered she was fit enough for rehabilitation. Yes, she was confused. I could allege this was not helped by the drugs given.

On arrival to Daedalus Ward, Mrs. RICHARDS was quiet and accompanied by her daughter, Mrs. LACK. She was admitted by Enrolled Nurse PULFORD and Mrs. LACK 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.

I understand Mrs Lack emphasised that medication which 'zonked her out' did not aid rehabilitation nor did it enable her to eat or drink. After transfer to Gosport her fluid balance was not right on return to Haslar after the fall 2-3 days later.

Wednesday 12th August, 1998

S/N JOICE was on 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 Mrs. LACK 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 Mrs. LACK.

Mrs Richards had already been lifted from the fall by joist. Mrs Karen Reed had been concerned at Mrs Richard's distress when she saw her in the afternoon and reported it. She was not informed of the fall. Mrs Lack on being informed by Mrs Reed visited our mother. She was not informed of the fall only later after feeding supper.

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.

How long did my mother lie on the floor until she was found at 13.30 and when was she found?

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. RICHARDS to be put back into a safer chair using a hoist.

At what time did Mrs Richards have lunch and who fed her (Staff shortages). Since when is a Nurse qualified to examine a fully clothed hip when the Consultants were doing their rounds. Did she supervise the lifting or merely authorise it?

Mrs. LACK 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 Mrs. LACK and informed her of the fall, explaining she did not know how she fell but reassured Mrs. LACK she had checked her mother before moving her. At this point S/N BREWER asked Mrs. LACK if she thought her mother to be in pain. Mrs. LACK did not feel she was as she was eating her tea.

Mrs. Reed had visited my mother in the afternoon. Mrs Reed is an ex Haslar Nurse (orthopaedic ward why wasn't she informed of the fall? She was aware of my mother's distress and informed Nursing Staff.

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, patient's 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.

Mrs. Richards was lying on the floor after the fall – why did it take so long for a proper examination? And why didn't Dr. Barton examine her on the Consultants round at 2 p.m.

Mrs. LACK 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 Mrs. LACK replied, "Yes," and thanked S/N BREWER. Mrs. RICHARDS slept well that night.

Mrs Lack can answer this better than I can when my sister telephoned me she was very upset but in a way relieved that at last my mother's pain was recognised and not merely pushed aside as Dementia.

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 Mrs. LACK. X-ray confirmed dislocation of (right) hip. Mrs LACK 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 (Mrs. LACK 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.

Screaming when we arrived at 12.15. She was screaming and continued to do so until after the X-ray despite pain medication. She was coherent and continually told me 'to do something' even when I held her hand as we went down to X-ray department.

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. BALDACCHINO 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 Mrs. LACK and Mrs. MACKENZIE arrived. S/N COUCHMAN walked into the room and pulled back the covers and realised the leg was not positioned correctly. Mrs. LACK offered to assist S/N COUCHMAN and between them re-positioned Mrs RICHARDS who then stopped screaming.

This is not correct. There was no pillow between her legs when Mrs Lack and myself arrived at 12.15 and the pillow was only placed there on my Sister's instruction to the Nurse (Couchman). H.C.S.W. Baldacchino is 'Linda' previously referred to by me.

Mrs. RICHARDS became agitated again a little later. Mrs. LACK 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.

Not correct. We requested X-rays. Philip was the Nurse concerned. He informed us his signature had not been accepted and he was unable to contact a Doctor as there was a meeting going on. He later informed us Dr. Barton was due at about 3.30. Dr. Barton then examined my mother and agreed an X-ray.

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' 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.

Not correct. See previous paragraphs. After the X-ray and my conversation with Philip he later came into the room (my sister was present) to give diamorphine. I objected strongly and said I would not agree to diamorphine until a decision had been made the following morning. I said and I quote 'Are we talking about euthanasia because I will not agree to euthanasia". Philip then left the room and came back with an alternative pain killer.

All trained staff interviewed were very aware that Mrs LACK and her sister, Mrs. MACKENZI 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 Mrs. LACK had complained

previously she felt her mother was on her bed too much and this would not help with rehabilitation.
This was when she was 'zonked out'.
During the 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.

I am at a loss at these comments. I was that I did not agree with my sister 'regarding my mother's care particularly about pain control'. We were both fully in agreement that the Nursing care left a lot to be desired. I was not at Gosport at the time of my mother's fall so I had no connection with making the nursing of Mrs. Richards difficult at times or the example given.

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.

Why? I am appalled at the comments regarding mouth care. We were present when a Nurse tried to take out my mother's dentures without success. My sister then tried and my mother bit her! This may have been just a reflex action but it certainly did not take place on the last day of her life. At the time of the 'biting' my sister did say 'leave them in' as it seemed to us pointless to distress my mother further.
If my mother was so close to dying I fail to understand why it was "in her best interests to have her teeth cleaned."

Sadly, Mrs. RICHARDS' death was not as Mrs. LACK 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.

We were "continuously" with my mother night and day. I slept there by her bedside from Tuesday night until she died on Friday. Nursing staff were not obtrusive but what a pity communication was so poor that a kitchen orderly burst in to find out why I had not taken supper off the trolley although the curtain was drawn and the door closed. I told the kitchen orderly to get out as my mother was dying (about 7 p.m.) and she then proceeded to tell me I would have to have supper as I had paid for it. I will not put into writing what I said but she did leave the room.

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 re-occurrence. 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. Mrs. LACK stayed with her mother until early evening and was asked if she felt her mother to be in pain. Mrs. LACK did not feel her mother was. Mrs. LACK was then asked if she would like her mother to be put to bed. She replied, "No rush."

Why wasn't there a witness – with a window onto the corridor and her door open – opposite the desk. The Nursing staff had been worried that my mother would attempt to walk to the lavatory if she could not get assistance – why wasn't a table put in front of her from the outset. It is obvious that patient care did suffer.

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.

See previous comments re. examination on the floor or rather inadequate examination.

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

Pretty obvious when she fell and made worse by the hoist. A hoist was used on many occasions at Haslar – it didn't dislocate the new hip.

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' dementia, would she have been aware of the time?

I agree with this and Mrs. Richards zonked up with tranquillisers would not 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.

Why did Gosport accept Mrs. Richards on arrival. She left the ward at Haslar pain free. She should have been sent back to Haslar immediately.

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.

It was noted by Mrs Lack and myself the Nurse came after we demanded it, if she came at Baldacchino's request prior to our arrival she did nothing. When she did come at approx. 12.20 my sister instructed her and helped change my mother's position with a pillow between her legs.

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.

Unacceptable and conflicting. We were not told after the x-ray only next morning by Philip. We were informed nothing could be done and the impression given that death was imminent.

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.

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.)

   This clearly indicates that it was "policy" not to transfer patients outside working hours and had nothing to do with the trauma my mother might have as stated by Dr. Barton and the Nursing staff on more than one occasion.

2. Review nursing records and documentation.

   Nursing and medical records were abysmal.

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

4. Review marking of clothing "policy".