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Fareham and Gosport Primary Care Trust
Investigation – Sultan Ward – GWMH
Patient Relatives Complaint Re: Mr. A. E. Duggan.

Summary of Findings:

Code A declined to meet with me before he has seen the formal response from the Trust to his complaint letter; I have therefore answered all of his complaints in depth. Some of these could have been resolved by that meeting, some were more relevant to Dr. Grocock than to the staff on Sultan ward, I will refer to Dr. Grocock's letter when necessary.

A- Code A states that there appears to have been no examination of his "Fathers injuries" as a result of his falls prior to admission.

Code A was examined at home following these falls, on at least 3 - 4 occasions by 999 Ambulance Paramedics who had been called to the house by Code A wife, to lift him up off the floor and put him back into bed – on no occasion was any injury found.
He was seen at home on the 22 Jan 02. by a Doctor from Health-call who diagnosed a viral chest infection but no other injuries.
He was seen at home on the 24 Jan 02 by Dr. Grocock, who started him on Antibiotics but found no other injuries, except he had "gone off his legs."
He was admitted to Sultan Ward on the 25 Jan 02 after M Code A n contacted his GP to say he had fallen, but again had no apparent injuries – Code A asked that he be admitted to GWMH and not Q.A.H.
A 999-ambulance paramedic crew brought him to the ward – again no injuries were noted.
The Staff Nurse who admitted Code A to the ward did a full body / skin integrity check and found "some bruising in various stages of healing " on his trunk / arms / legs / feet none of it gross or indicative of bony injury. There was no broken skin / lacerations and the patient was not complaining of any pain.
Following this examination by the nurse Dr. Grocock arrived to clerk the Patient in, he found no sign of injury, after being checked by 8-9 different trained staff and in the absence of any apparent injuries no specific investigations were undertaken.

No injuries were found during Code A s admission to GWMH.
Bruising to the areas already described was the only injury noted during the Autopsy following Mr. Code A death.

B-Several times in the letter there is reference to the "Liver Disease Plan" Constructed by a Health-call Doctor.

There is in fact no such thing as the "Liver Disease Plan" it is a grammatical error, the nurse writing the report inadvertently left off a full stop after the following:
S/B (seen by) Dr. Lynch? Felt patient looked jaundiced.? Liver disease.
Plan (doctors often write this it means –" this is what we'll do") Await blood results
ECG.
C x-ray
Continue Antibiotics
The Doctor concerned was Dr. Sheila Lynch one of Dr. Grocock's partner's not a Health-call doctor.

All of the investigations requested by Dr. Lynch were in fact completed on the 28 Jan all of the results are attached to this report.

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C- Liver Scan Result

The liver scan was reported on the day it was done. 31st January 2002. The findings were:

- Very difficult scan – when I asked the staff in x-ray what this meant, I was told it meant it was difficult to visualise the liver etc. for any number of reasons – the usual one being the size and shape of the patients abdomen.
- There was no obvious liver disease seen
- Ascites was noted – but not described as large amounts.
- Gall Bladder was not identified
- Common Bile Duct was not dilated
- Right Kidney – no obstruction
- Left Kidney – not seen
- Bladder – distended

Apart from the ascites the scan was NAD. (Nothing abnormal detected)

Dr. Matthias Koslowski stated in the Autopsy report dated the 8th Feb.2002 that the Ultrasound of the abdomen revealed mild ascites but was otherwise unremarkable.

D-On the 31 January 2002 – Code A and his wife saw what they thought was very concentrated urine in their Fathers urine drainage bag - I assume they thought it was because he was dehydrated, in fact it was **Choluria.**

This is a well-documented condition that occurs when a patient has an excess of the bile pigment Bilirubin in the blood.

Normally there is 3 – 20 umol/L present in the blood, when the level rises to 20 – 30 umol/L visible jaundice appears, the skin and eyes show a yellow discolouration. The urine becomes very dark brown or even dark orange, in fact dark sherry coloured.

We know as a fact from the blood test results received on the 29th Jan. 2002 that the level of bilirubin in Code A 's blood was elevated to **65** and he was beginning to show signs of Jaundice, This prompted his GP to organise the liver scan on the 31st Jan.2002, and his medication was also changed because the liver function test / U/E's / Potassium levels were all abnormal and the blood test were repeated on the 1st Feb. 2002.

Documentary evidence to support the above statements will be included with this report.
All of the above I feel could have been explained to Code A if I had had the opportunity to talk to him before writing this report.

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I will try to answer the other seventeen complaints as concisely as possible:

1- Yes Code A was admitted to the most appropriate hospital
See DR. Grocock's letter.

2- I have answered this Complaint in great detail as A in the summary of findings. See also Dr. Grocock's letter

3- I have answered this complaint in great detail as B in the summary of findings. A raft of investigations was done on the 28th Jan 02
The results of which are all included in this report, the blood tests excluded significant dehydration. See also Dr. Grocock's letter.

4- The nursing Care plans show that Code A received all necessary Nursing Care on the 29 – 30 – 31 Jan. 2002.For instance there are 8 recorded episodes of incontinence of urine recorded between the 29 –31 Jan. 4 of these episodes on the 31 Jan. Between 1600hrs and 2005 Code A was washed changed and clean linen put on his bed 3 times and was given supper at approx. 1730hrs. See also Dr. Grocock's letter

5- Code A had breakfast of cereal with milk / tea and 50mls of Orange juice before being put on "nil by mouth" for 6 hrs as per the written instructions from the x-ray department. He came back to the ward at approx. 1600hrs.and the staff knew from the notes they had made at handover that he was to resume food and fluids on return to the ward. Not all of his fluids are entered on the fluid chart, he was given supper of Soup / egg sandwich / ice cream again it was noted but no amounts filled in. As I have stated in section D above, the patient was incontinent 3 times that evening this is not consistent with dehydration.

6- As I have stated in section 4, Code A was not left un-cared for on the evening of the 31st Jan. He had been washed / changed / his bed changed twice since 1600hrs that day and was washed and changed again when his Son arrived at 2005. On his return from x-ray he was very agitated and did not want any covers on his legs or feet – it is a side effect of Jaundice that affects some patients, their limbs /legs become hypersensitive and they cannot bear any pressure on the limb, not even a blanket. Code A constantly pulled the covers from the bottom of the bed and the trained nurse on duty that night had folded a sheet across his middle to try to preserve his dignity

7- There was never any restriction on the amount of fluids Code A was allowed to have. The staff constantly encouraged him to drink. During his stay on Sultan Ward Code A was seen by three different Doctors, none of whom thought he was dehydrated until the 1st Feb.2002 when his condition was deteriorating prior to transfer.

8- See Dr. Grocock's letter.

9- See Dr. Grocock's letter.

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10- Most of Code A 's fluid input was recorded correctly, from the 25th Jan. the day he was admitted. Code A n's Son was concerned that his Father was not drinking enough, even when the staff made tea and gave it to Code A whilst his Son was present. It is admitted that charts were not always completed properly. This was in some part due to other pressures on the Staff.
There was never any concern about M Code A s output of urine so it was not recorded except as wet pads / beds.

11-There was no deliberate attempt to hide the incident on the 31 Jan 2002. M Code A was understandably upset by his Fathers condition, but he should not have taken his anger out on the staff. He shouted at a very young student nurse, he shouted at the HCSW who went to her aid even when his wife asked him not to he continued, that same HCSW had already washed and changed Mr. Code A twice that evening he also shouted at the trained nurse, there were three out of the four members of staff on duty that night in a very distressed state, they a were all aware that M Code A had been cared for that evening. On that particular day Sultan Ward had 22 High Dependency Patients on the ward and just 2 Trained staff and 2 HCSW's on duty, it had been a very hectic afternoon and evening. The trained nurse involved had had no break and was writing the report of the incident after 9pm when she should have been off duty at 8-30pm. She was tired / stressed and had been subjected to shouting from an angry relative, I think in the circumstances it is no wonder she chose to not record everything that evening. Night staff were informed as she handed over and Sister Ann Haste was informed about the incident the following morning. The nurse did apologise several times to Mr. and Code A she agrees it was not appropriate to speak to them outside the patients room, equally Code A s shouting was also inappropriate and what he did subjected already stressed staff to what amounts to Verbal Abuse.

12- None of the staff interviewed had any recollection of Code A expressing his concerns. They were all aware that his Fathers condition was changing. His Barthel Score was updated on the 31 Jan. to record this. With the best will in the world and with / low staffing levels / high bed occupancy / and just human nature it is not always possible to record everything.

13- It is not normal practice to raise beds to prevent patients getting back into bed. On occasions it is used to try and reverse sleeping patterns – not to make a quieter night for the night staff. Other patients in the environment have to be considered and it is not always possible to give a patient a single room. Other patients had expressed anger at Code A n the 4-bedded room, from the 25th Jan. to the 30th Jan. when he was moved to a single room, he had been constantly in and out of bed all night, keeping everyone awake, he would then get into bed and sleep during the day. Mr. D Code A could also have fallen and injured himself he was in and out of bed so often. The cot sides were used in conjunction with Trust Guidelines, he was on a profile bed and the sides are an integral part of the bed. At this stage Code A was for rehabilitation and mobilisation. He was moved to the other Team and a single room after the vomiting incident and because of the other patients, one of whom was Palliative Care and very poorly. It also gave Code A more privacy, as he did not like the covers on his legs.

14-The 30th Jan. was again a very busy shift. Patients were being admitted, there were 4-5 palliative care patients and a very disruptive patient from Collingwood on the ward, they had 24 high dependency patients and again only 2 trained staff and 2 HCSW's on duty on the am and pm shifts. So the patients came first and the record keeping second. The sister in charge dealt with the patient and Code A and is very concerned about what has been documented in the complaint letter, and what was actually said by her. She actually said "that this could be a virus as there has been one going around" At no time was it stated or inferred that Code A was or could have been infectious, he was being nursed on an open ward with no precautions. Code A s chair had been pulled forward out of position so he could see out of the window to try to motivate him.

15- As stated in answer to question 14 at no time was it said or inferred that Mr. Duggan was infectious.

16- GWMH has a laundry facility to deal with personal items from Continuing Care Patients only. Very rarely if ever do patients on Sultan Ward have no one to do their laundry. On the rare occasion that it does happen the staff go cap in hand to the laundry lady who will usually help out, if not patients are given some of the ward stock of clothes, these are marked to go to the main laundry. Patients and Relatives are informed of this on page 4 of the ward leaflet, there is also information about a private laundry facility on the wall by the nurse's station. The clothes were wet as the staff had as usual sluiced all the solid food / vomit from the pyjama jacket. In all the Acute Hospitals all patients are expected to make arrangements for their own personal laundry to be done.

17- The Staff on Sultan Ward are all distressed by this complaint even the Staff who were not involved in Code A care.
They all regret the distress the family are feeling and they would not wish this to happen to anyone. In an ideal world every patient coming into hospital has the right to be treated with dignity and a right to privacy. This is what the Staff on Sultan Ward aim to provide for all patients.

Staff were stretched to the limit physically and mentally, they all believe they gave Code A the care he was entitled to and did their best to protect his privacy and dignity.

In mitigation it is a fact that during the period of time Code A was a patient on the ward from the 25th Jan to the 1st Feb 2002 the ward was full of high dependency patients and for a variety of reasons Staffing levels were very low. Staff Rotas and the Bed Occupancy form for that month are included in the documents attached to this report.

It is interesting to note that an **Incident form number 28679** was completed by a staff nurse on Sultan Ward on Sunday the **13th January 2002**, stating that there were only three members of staff on duty on that late shift, which was too little to care for 22 – 24 high dependency patients, and she thought all that had affected patients, this was just two weeks before Code A admission to the ward, they were also holding the hospital bleep and were expected that evening to make the soup for the patients evening meal. A copy of that incident form is included with the documents attached to this report.

I think this illustrates what the staff said when interviewed, they really were stressed and under pressure. It also came at a time when all staff were still feeling threatened by the CHI investigation.