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Number 1;

To review the Admission Process, particularly when it is known a Patient has suffered multiple falls.

It is difficult to review this process when the terms of reference do not make it clear which admission process. There are in fact three different ones.

1- Admission process for Step Down Patients from Surgical Wards Acute Hospitals. This is covered by strict Criteria a copy of which is attached to this report. At the present time the form that is completed for Patients awaiting transfer to Sultan Ward is under review / redesign following a critical incident. These Patients awaiting transfer from the Acute Hospitals are always discussed with the GP concerned and should a GP decide that the Patient required care in an Acute Unit, transfer back would be automatic to the care of the Consultant whose care he/she was under before admission to GWMH.

2- Admission process for Patients coming into Sultan Ward direct from Home / Community via the Patients own GP. Again there are strictly laid down criteria – the GP's are aware that Sultan Ward is not an appropriate place for acutely ill Patients / Patients requiring IV. Therapy / complex procedures / complex dressings, and the GP's are aware they are responsible for the Medical cover for these Patients, admission is arranged directly with the Ward by the GP concerned, should the Patients condition change significantly the GP will arrange transfer to Acute unit with transport

3- The documentary process of admission to Sultan Ward is started by the Nursing staff, the process is the same for all Patients:

- The patient is welcomed to the ward, and either helped into bed or chair, the layout of the ward is explained, where the toilets are, what times meals are, the patient is observed by the nurse completing the admission forms / she/he will spend some time talking to the patient / patients own medication is taken from the patient to a place of safety / if coming from another unit, notes are also collected from the patient. Once settled the patient is provided with food / drink if it is required.

- The GP is notified that the Patient has arrived on the ward and is asked to attend to clerk the patient in and if the patient shows obvious signs of injury the GP will be asked to attend ASAP.

- The patient has a name band attached to the wrist / the general information sheet is completed / care being taken to get contact numbers from relatives before they leave, an information leaflet about the ward is also given the relatives / friends at this time.

- If it is known that the Patient has suffered falls prior to admission a careful history Re the falls is taken from the patient / relatives / ambulance crew.

- The whole of the patients body / skin integrity is checked, and a Body Chart noting any bruising / lacerations / obvious bony injury etc is commenced, if there is any pain or obvious injury the patient is not mobilised until seen by the GP – X-rays may be arranged at GWMH.

- All basic observations such as TPR / BP / Urinalysis / are done and charted. / ADL sheets are completed / Care plans are individualised and started / Waterlow score – depending on the total – patient may need to be nursed on a special mattress / Barthel score / lifting and handling profile may be commenced but not completed at this time / a nutritional screen is completed and depending on the result a food/fluid chart could be commenced. / If pressure sores are present these must be documented on admission.

- If the patient has previous hospital notes these are requested from medical records.

- **A Documentation Audit is being done at present and depending on the results, some of the forms in use at present may well change.**

- The admission process is lengthy – very time consuming – but so important that it cannot be rushed. Staff need time to talk and observe patients – staff in general are concerned when they have admissions that they in effect are removed from the ward in general for a time and if the staffing levels are low this puts other staff under more pressure.

- A good example of this, is one of the incidents documented in Mr. G. Code A complaint letter, it occurred on the 30th January. On that day there were already 23 high dependency patients on the ward, and only two trained nurses and two HCSW's on duty on the am shift and the same level of staff on the pm shift, they had an admission on the ward during that morning which in effect reduced the trained staff to one for a considerable time, thus putting other members of staff under more pressure. The incident occurred late morning / lunchtime.

Number 2:

Evaluate the Quality of Recorded Communication with Relatives and the Multi-professional Team.

The quality of the recorded communications in so far as it is recorded is good, concise, and easy to read on the whole with not too many abbreviations. Most entries give a clear picture of the communication / interaction / episode.

All except one entry is signed and dated, and only four out of a total of eighteen entries have no time recorded.

The problem arises with what is not recorded, there is no record good or bad of the incidents on the 30th – 31st January 2002, no record of the vomiting incident or the patient being moved to a single room, because of this, the whole record of this patients admission to Sultan Ward is incomplete.

Number 3 and 4

3- Discuss and evaluate the Medical and Nursing management of a Patient whose condition deteriorates.

4- Assess the Medical and Nursing Care of Patients with Hydration need.

I feel unable to discuss and evaluate number 3 and 4. I do not feel I have the knowledge to do this.

The deterioration of Code A condition and his hydration needs have been addressed in the report of my investigation.

Number 5

I was asked to identify "How do Staff Ensure the Dignity of Patients.

I interviewed 8 members of Sultan Ward Staff – some alone, others in Groups.

All staff interviewed were quite sure about how they ensure the dignity and privacy of the Patients in their care.

- They make sure patients feel respected – that they are looked after in a caring respectful manner.
- Ensure Patients are informed – have all the information they need.
- Give Patients time to consider what they want to do.
- Talk to Patients as adults – one to one – not as children.
- They try to ensure Patients are exposed as little as possible.
- Ensure they use the Patients screens – Sultan Ward has recently had Privacy Curtains fitted across door-ways in Bathrooms / shower rooms and across the door-ways of the single rooms to stop inadvertent exposure of Patients, thus ensuring their dignity.
- They ask how the Patient wants to be addressed, formally or by their first names – this should be recorded on admission.
- They do not discuss Patients within earshot of others
- They do not leave Patients Documentation around where anyone can read it – this includes care plans.
- Make sure that patients have their own clothes / night wear and are not dressed in someone else's clothes.
- When a Patient is catheterised – they try to make sure the drainage bag is tucked out of sight when the Patient is out of bed – also that it is emptied regularly.
- Several of the Staff were concerned that occasionally nurses and other staff were guilty of stereotyping elderly people:
    - Re; deafness – voices are raised – assuming they don't understand.
    - Talking condescendingly to Patients / treating them as children
    - Almost "Americanising our way of speech" There has been a lot in the nursing press recently.
    - Crossing over certain Boundaries – Familiarity being one – calling Patients by Slang Words – love – darling – etc.
    - Staff were concerned that Student Nurses coming onto the ward automatically call Patients by their first names.

Number 6:

To review and evaluate the content of the nursing record for the period of admission to transfer.

I looked first at the completed ADL sheets.

Some were partially individualised, night staff had used the ADL / Sleeping sheet to record the patients sleeping patterns nightly, plus his medication, Temperature, incontinence of urine.

There is no separate Nursing Care Plan for Number 5 – ADL / Sleeping. All other ADL Sheets has a corresponding Nursing Care Plan.

There is an entry, dated and signed for each day of the patients admission, most of it is task orientated but they do record the care given to the patient on a daily basis, albeit not in great detail.

Some entries are very sparse, and give only an outline of the care given, others are more explicit.

Again entries of the 30th – 31st January 2002 do not record either of the incidents complained about, except to date and time the episodes of urinary incontinence on the evening of the 31st January 2002.

No Care Plan records any vomiting episodes during the patient's admission.

The pressure of Time / staffing levels / level of dependency of patients / and the number of patients on the ward must have some bearing on what was recorded.

Number 7:

Identify and Review the Decision Making Process for Transferring an Acutely Ill Patient to an Acute Hospital:

1- Sudden onset of Acute Illness – the laid down process is very clear

If a patient suddenly collapses / has chest pain / ?CVA / any symptoms that are acute and could become life threatening any member of staff on duty can start the process without a Doctor being present.

All staff receive annual CPR training / update
All Bleep Holders also receive ALERT training.

- The Medical Emergency Team is called to the ward by dialling **6666** on any phone– this call goes to the "Red Phone" – whoever answer's that phone sets the system moving – during the day it will be the switchboard staff at night the staff on Daedalus ward.

- Staff calling for help tell the person on the phone the nature of the problem and where the emergency is and that is all they do – they then return to help with the situation and the patient.

- The person answering the phone passes the message to the porters and the hospital bleep holder – Then dials **999** for a paramedic ambulance to attend , and fills in the log by the phone.

- The patients GP / out of hours Deputy is informed that there is an emergency and asked to attend as soon as possible.

- The patient's relatives are informed that there is an emergency.

- The patient is transferred if necessary to a place of safety by **999** Ambulance ie: A/E Department, Queen Alexandra Hospital.

2- For set down patients the emergency process is the same – but the Criteria says they should be readmitted under the Consultant whose care they were under before transfer to GWMH. **Transfer back should be immediate.**

3- For Patients whose condition deteriorates slowly / insidiously over a period of days the staff would bring to the GP's attention any concerns they have / or members of the multidisciplinary team may have Re the Patients condition. The GP can then if considered necessary arrange for the Patient to be transferred via A/E or direct to a ward at the acute unit. Transport would be arranged for the patient, the patients relatives would be informed before transfer.

Day and Night Staff on the wards have all been involved in exercises to test the process – All seemed confident that they understood the process and that it would work.

Number 8

Was it reasonable for the Patient?

a- To be Admitted to Sultan Ward Initially

b- Should the decision to Transfer the Patient have been made earlier.

A- **Yes** it was reasonable to admit the Patient to Sultan Ward. The Patient had a chest infection that was being treated by antibiotics, but he had gone "Off his Legs" at home and kept falling. Mr. Code A Wife had had to call a 999 ambulance 3-4 times just to lift him back into bed. At this stage there was no indication that he was developing Jaundice, or any other serious condition His Wife requested that he be admitted to Gosport War Memorial Hospital. He was for rehabilitation and Mobilisation and then discharge home.

B- **No** the decision to transfer should not have been made earlier. From the 25th – 27th January Code A showed some improvement. It was not until the 28th Jan. that it was suspected he was developing Jaundice. At this stage he was still eating and drinking albeit small amounts. A whole raft of investigations were initiated on the 28th Jan. and Physiotherapy was organised for the 30th Jan. Following the receipt of the blood results on the 29th Jan. Dr Grocock changed Code A 's medication as the results showed abnormal liver function / low potassium, he also organised that the blood tests be repeated on Friday 1st Jan. and prior to that to have a Liver Ultrasound Scan on the 31st Jan. It was following this Ultrasound Scan that Code A 's condition became much worse, he was transferred the following day to Anne Ward, Queen Alexandra Hospital Cosham.