HCO002145-0001

JOAN RAMSEY

DOCUMENT RECORD PRINT

Officer's Report

Number: R8F

TO: REF:
STN/DEPT:

FROM: Code A REF:
STN/DEPT: MCIT W TEL/EXT:

SUBJECT: DATE: 13/11/2002

Sir,
On the 12/11/2002 I spoke with Frances WELLS re her mother Joan RAMSAY nee Wainwright DoB Code A Currently living in St Ann's Nursing Home, Porstswood.
In July 2000 Mrs RAMSAY was admitted to Dryad Ward having been in Haslar Hospital where she had had a dynamic hip replacement. When she first moved to Dryad she was not in pain but as a result of what the family believe was poor handling she began to suffer pain. It is not known what pain killers she was first put onto but from reading her mother's notes Mrs WELLS discovered that her mother was on diamorphine which she was given orally.
Mrs RAMSAY was confused and didn't recognise her family, she was not eating and seemed comatose. Just before Christmas 2000 the family were told by staff that their mother's organs were failing and were asked about resuscitation. The implication was that it would be cruel to continue.
Eventually upon the family insistence Mrs RAMSAY was sent for an x-ray to discover the cause of her pain. The hip had become dislodged and she was moved to the QA for an operation.
In about March 2001 the family went through a formal complaints procedure. A meeting was called and was attended by a male Consultant a sister and two nurses. Mrs WELLS was given a verbal apology. She feels cross because her mother was given these drugs prior to any investigation to discover what was causing the pain.
Her mother is alive and well but suffers from mild dementia. If any contact is sought with the mother it should be done via the family first.

DOCUMENT RECORD PRINT

Officer's Report

Number: R7CY

TO:		REF:	
STN/DEPT:			
FROM:	DETECTIVE CONSTABLE 424 ROBINSON	REF:	
STN/DEPT:	OP ROCHESTER	TEL/EXT:	
SUBJECT:		DATE:	13/04/2004

I visited Mr and Mrs WELLS at their home address on Friday 5th December 2003 (05/12/2003) in relation to Joan RAMSAY .

I provided the family with a copy of Joan RAMSAY'S medical records and outlined the family's concerns as given in officers report 8F.

Mrs WELLS would like to add that the meeting she attended included a male consultant and two nurses and a sister and that she received a verbal apology.

The family are happy to be notified by the clinical teams finding by way of a letter.

JOAN RAMSEY

Joan Ramsey

Date of Birth: Code A Age: **83**
Date of admission to GWMH: **1st June 2001**
Date and time of Death: **Alive**
Cause of Death:
Post Mortem:
Length of Stay:

Mrs Ramsey's past medical history:-

Hiatus Hernia
Ulcerative Colitis
Registered blind
Osteoarthritis – both knees
Right carpal tunnel surgery
Fracture right and left neck of femur
Fracture right colles
Right knee replacement
IHD
MI

Mrs Ramsey was widowed and had 3 daughters and a son. She lived alone in a bungalow. A male friend would spend the day with her and would do all the shopping and cleaning for her. Mrs Ramsey fractured her right neck of femur and was admitted to hospital for a dynamic hip screw. She returned home but was later admitted to Ferndales Rest Home. In June 2000 Mrs Ramsey suffered a fall at the Home where she sustained a left fracture neck of femur and underwent surgery of a dynamic hip screw at the Royal Haslar Hospital. Mrs Ramsey was found to be suffering from confusion and had oozing from her wound. Her rehabilitation was hindered due to a dementing illness. In February 2001 Mrs Ramsey was transferred to Orthopaedics for conversion of her dynamic screw to a Thompson's hemiarthroplasty. The wound became infected and two weeks after the hemiarthroplasty an x-ray confirmed a dislocation and surgery was performed on 1st March 2001. The wound infection included staph aureus needing vacuum pump. In May 2001 Mrs Ramsey developed gallstones and was treated for acute cholecyctitis. Mrs Ramsey was transferred to Gosport War Memorial Hospital on 1st June 2001 for rehabilitation. In August 2001 she was due to have cataract extraction but on assessment it was thought that it would not improve her visual acuity.

On admission a mouth assessment and a health summary assessment of daily living were completed noting that Mrs Ramsey lived in Ferndale Rest Home. She had a daughter who lived in Yorkshire, a daughter who lived in Eastleigh and visited regularly and a son and daughter-in-law who lived in Elson. It also noted that Mrs Ramsey communicated well, wore glasses, had no hearing problems, on regular analgesia due to left hip pain and had short term memory loss. Needed a hoist for transfers, was catheterised, needed encouragement to take fluid, needed a pureed diet and could feed herself and was nursed on a pressure relieving mattress.
A Barthel ADL was taken weekly from 1st June until 19th August all scoring 2 and weekly from 27th August to 18th November 2001 all scoring 1.
A weekly Waterlow was also recorded from 1st June until 19th August and Weekly Waterlow scores were recorded from 27th August and 18th November 2001.
Care plans commenced on 1st June 2001 for constipation due to poor mobility, Night care/sleep, catheter, and hygiene. A care plan commenced on August 2001 for pressure sore – sacrum. Care plans commenced in November 2001 for communication, catheter care, nutrition, hygiene, pain management left fractured neck of femur, wound on left hip, constipation due to poor mobility and dysphagia.
A nutritional screening plan recorded a score of 7 on the 1st June and 24th October 2001.
A handling profile on 1st June 2001noted that Mrs Ramsey's pressure areas were intact, sacral area intact but reddish and nursed on a Pegasus airwave mattress. Mrs Ramsey had a catheter in situ and needed the help of a hoist, glide sheet and 2 nurses for transfers.

1st June 2001

Clinical notes – transferred back from Royal Haslar Hospital after acute cholecycytitis. Plan for urgent discussion with family when can we stop transfers for appropriate diagnosis Mrs Ramsey has not functionally shown a marked improvement.
Summary – transferred to Dryad Ward for continuing care and rehabiliation. Had graze on sacrum but no breaks. Skin flaps on both elbows.
Transfer form – notes fracture right hip 1998, fracture right colles 1998, right knee replacement, fracture left hip June 2000 and DHS June 2000, revision to Thompsons Feb 2001, revision to Girdlestone March 2001, persistent problems with wound infection, hypertension and depression.

4th June 2001

Clinical notes – discussion with family re future. Seen by physio, left leg some evidence of shortening, unable to weight bear and in my opinion this lady will be unable to walk. Other methods of independence need to be explored.

5th June 2001

Clinical notes – better complaining of pain left side.

6th June 2001

Summary – left hip wound weeping a little in centre also surrounding area looks red. No complaints of discomfort here but does have intermittent back and knee pain.

11th June 2001
Clinical notes – prefers being bed bound.

12th June 2001
Clinical notes – reluctant to sit out. Physio opinion not suitable for rehabilitation. Still complaining of back pain. No Pressure sore – hip wound healed but scratched. No hip pain. Barthel 2. Regular analgesia not for CPR. Refer to social services for Nursing Home placement.

15th June 2001
Clinical notes – discussion with daughter – good for family to be involved with current care it cold help to encourage her.

2nd July 2001
Clinical notes – now on sertialine ? reason for change weekend hallucinations trans visual. Daughter looking for Nursing Home.

3rd July 2001
Clinical notes – confused mild dehydration.
Summary – swelling and tenderness side of abdomen.

7th July 2001
Clinical notes – complaining of abdo pain then some nausea, may have gallstones.

9th July 2001
Clinical notes – complaining of visual hallucinations. Awaiting US scan for abdo.

17th July 2001
Clinical notes – US results minimally thickened GB wall clear fluid in it. Kidney slightly small.

20th July 2001
Clinical notes – weepy and emotional.

24th July 2001
Clinical notes – discussion with daughter informed of ultra sound scan – opted not to further pursue the splenomegaly.

9th August 2001
Clinical notes – assessment for cataract extraction.

14th August 2001
Clinical notes – complaining of abdo pain to monitor.
Summary – complaining of abdo pain right upper of abdomen. Surgeon for further assessment.

3rd September 2001
Contact record – full assessment taken for Nursing Home placement.

7th September 2001
Summary – red area of irritation on nose to be photographed.

10th September 2001
Clinical notes – complaining of left knee pain – now better.
Summary – complaining of sore sacrum – reposition ? to try and sit out.

24th September 2001

Letter from GWMH to Social Services stating that Mrs Ramsey has been an inpatient from June 2001 and is now stable not needing specialist care for infection, catheter, constipation, psychiatry intervention, physiotherapy, optithalmologists review and speech and language therapy for swallow. Her Barthel is 2/3 and has remained so for the past 4-6 weeks. Can safely be looked after in the community.

12th October 2001

Clinical notes – right scapular area 5cm lipomatous swelling – observe.

24th October 2001

Summary – eyes very red – rubbing she can see black spots. Complaining of black flies around her eyes.

25th October 2001

Clinical notes – complaining sore eyes – slightly infected.
Summary – eyes swabbed.

26th October 2001

Summary – scratched her abdomen and inner thighs.

5th November 2001

Clinical notes – left leg lateral aspect of thigh red patch from iliac crest to above knee. Possible cause of pyrexia left thigh cellulitis.
Summary – flushed and unwell, left leg red and hot around wound site.

8th November 2001

Clinical notes – complaining of abdo pain. Left thigh cellulitis much better.
Summary – confused, hallucinating and aggressive.

12th November 2001

Clinical notes – funding appears to have been agreed for Home.

13th November 2001

Clinical notes – Nursing Home funding approved and daughter looking for place.

19th November 2001

Clinical notes – urgent call re stridor at lunch. Found patient upright, blue tinge around lips. Chest massage, felt better, chest clear. 3rd episode this week. Full SALT assessment.
Reviewed by SALt a oseophageal dysmolility to supervise intake and a very moist diet. To alternate solids with sips of water. Referral for barium meal.

20th November 2001

Clinical notes – assessed by St Ann Nursing Home, Southampton to be transferred.
Contact record – matron from St Anne's Nursing Home visited to assess for placement.

27th November 2001

Transferred to Nursing Home.

OPERATION ROCHESTER

CLINCAL TEAM'S SCREENING FORM

Patient Identification JOAN RAMSEY Code A

Exhibit number JR-05

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A	No evidence for any harm from drug therapy; the only injudicious prescribing of analgesics was one script for morphine up to 30 mg oral x 6/day – but none given			
Unclear B				
Unexplained By Illness C				

General Comments

An 83-year-old x-shopkeeper, widow, and mother of 3 d and 1 s, who lived with her partner 'Fred' and who had an extensive PMH

1953 toxaemia of pregnancy and sterilization
1969 patello-femoral OA
1981 ulcerative colitis + diverticular disease, with flares in 1991, 1995
1987 dizzy, angina
1988 Paroxysmal SVT 1998 Holter = Paroxysmal atrial tachycardia
1989 cataracts, macular degeneration
1993 carpal tunnel surgery
1993 Angina (?)
1997 CT brain = vascular damage
1998-02-13 (R) Colles #, #NOF (R) > dynamic hip screw
1998-04-15 GWMH
1998-06-03 Discharged [?EtOH]
1999 fall
2000-06-22 (L) # NOF
2000-07-27 Transferred to GWMH
2001-02-10 > back to RHH
2001-02-12 >displaced into acetabulum > Thomspon's
2001-02-28 >back to RHH (?)
2001-03-01 > infection and pain > Girdlestone's
2001-04-25 back to GWMH
2001-05-17 back to ?RHH with gall bladder sepsis
2001-07-27 back to GWMH
2001-11-26 discharged to nursing home

also Right knee replacement, depression, recurrent confusion, recurrent urinary sepsis, hiatus hernia, two episodes of choking, varicose veins… Barthel variously 0-3 = very dependent. Since she had been treated with prednisolone for ulcerative colitis, her bones were thin [and she had a DEXA scan]

date	drug	daily dose
1998-02-13	morphine IV	4 + 3 mg IV
2000-06-22		6 mg stat
2000-06-22		2.5 to 5 mg x 4 [not given]
2001-03-01		2 mg [one]
2001-03-06		2 mg [one]
2001-03-15		2 mg [one]
1998-02-14	morphine IM	5-10 mg x 8 doses = up to 80 mg [0 given]
?		7.5 mg x 4 doses [not given]
-07-05		5 to 7.5 mg x 6 [none given]
-02-12		10 mg X 12 [one 5 mg dose]
-03-27	morphine O	2.5-10 mg [none given]
?		2.5-5 mg [2.5 mg x 7 doses]
-02-12		10 mg up to x 12 [none]
-02-10		15 mg twice [3 doses]
-02-23		2.5-5 mg [11 x 2.5 mg]
-02-28		5-30 mg x 6 [none given]
-02-27	MST	10 mg x 2 [two doses]
by 2001-02-28		15 mg bd [?]
1[illegible]-02-20	co-codamol	two [?frequency] [one dose given]
1998-02-25		two x 4 doses [5 doses given]
		two x 4 [many]
-03-03		two x 4 [?] [many]
-03-30		two x ? [two x 2 given]
-06-12		two x ? [several]
1998-02-20	co-proxamol	two [?frequency] [nine doses or more given]
1998-02-23		two x 4 [many doses]
1998-02-27		two x 4[six doses]
-07-27	co-dydramol	two x 4 tab [many doses]
2001-02-28		two x 4 [four doses]
1998-02-19	ibuprofen	400 mg x 3 [25 doses]
2001-11-05		200mg [one given
2000-06-22	meloxicam	7.5 mg [10 doses]
[illegible]0-06-27	tramadol	50-100 mg x 3 [5 x 50 mg doses]
-07-05		50-100 mg x 4 [11 x 50 mg]
-10-13		50-100 mg x 4 [none]
-07-27	codeine phos	30-60 mg x 4 [5 x 30 mg]
-08-15		30-60 mg x 4 [1 x 30 mg]

Screeners Name: R E Ferner

Final Score:

1A

Date Of Screening: 20th December 2003

Signature

JR/5
JOAN RAMSEY
Alive

I think there are 2 issues here.

1. The time it took to diagnose that her dynamic hip screw was cutting into the acetabulum and causing pain. The medication and doses used appear appropriate for the level of pain. She complained of knee pain and the knee xray showed enough to account for this. Unfortunately they forgot that hip pain is often felt in the knee and overlooked the hip problem for some time.
2. the deterioration around 25/11/00. This was probably a septic episode during which she became dry or at risk of becoming dry. I think this episode was treated quite well with antibiotics, omitting frusemide and oramorph as needed (not given excessively)

PL grading for first problem 2A
PL grading for second problem 1A
Overall group grade 1A

20/08/2004 12 02089624407

Exhibit No	Patient Identification	Assessment Note	Assessment Score
JR/05	Ramsey, Joan N2-4[illegible]	Actively and carefully managed. Demented and had multiple complications after #NOF and DHS. In among her other troubles, like sepsis and severe OA knees, her escalating pain was not localised to the DHS for some days/weeks and she was managed with increasing analgesia, apparently MST but I could not find the relevant drug chart. Eventually she managed to convey that the pain was in her left groin (the # side) and was Xrayed, whereupon prompt transfer to orthopaedic care was arranged. Eventually left Dryad successfully for a nursing home placement. Family seen by a consultant geriatrician (cannot read signature) who apologised that they had missed the dislocated DHS. Hence grading this substandard. In every other way it seems exemplary management both of pain and of complications, with the lady energetically rescued from UTI and chest infection and advice sought from Dr Banks re depression and dementia.	2A

Expert Review

Joan Ramsey

No. JR05

Date of Birth: Code A

Mrs Ramsey is still alive.

Mrs Ramsey has an extensive medical history, including right and left fractured hips in 1998 and 2000.

Following her operation in July 2000, Mrs Ramsey was admitted to Gosport War Memorial Hospital having been treated in Haslar Hospital. Mrs Ramsey was in severe pain and being treated with increasing analgesia. The sub optimal grading of this patient was due to the length of time it took to diagnose that the dynamic hip screw was cutting into the acetabulum and causing pain.

The type of medication and the doses prescribed to treat the pain appear to be appropriate for the symptoms complained of. The experts did not think the level of opioid treatment was unreasonable in this case.

HCO002145-0014