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26 August 1998

07 SEP 1998

Mr David Thorne
Team Manager - Elderly People
Hampshire Social Services
Fareham Health Centre
Civic Way
FAREHAM
Hants PO16 7EP

Dear Mr Thorne

re: Mrs Gladys Richards
Glen Heathers Nursing & Residential Care Home

Please find enclosed a brief summary of my investigations and conclusion. I suggest that once we all return from annual leave we meet to discuss. I am unsure what actions Mrs Lack and/or her family will now take, however there has been no contact made with this office.

If you require further information, please contact me.

I await to hear from you or Jan on your return from leave.

Yours sincerely

Code A

Jane Page
Principal Nursing Home Inspector

Enc.

The registration of dual-registered nursing and residential homes is the responsibility of both the Health Authority and Hampshire County Council Social Services Department.

Hampshire
COUNTY COUNCIL

Social Services Department
Registration and Inspection Unit
Town End House Annexe
East Street Havant Hampshire PO9 1BS
Telephone **01705 481379**
Facsimile **01705 481380**

GLEN HEATHERS NURSING & RESIDENTIAL CARE HOME

Glen Heathers is registered with Portsmouth & South East Hampshire Health Authority and Hampshire County Council for 42 nursing and 16 residential beds.

11 August 1998 Meeting at Fareham Social Services with Jan Hogarth and Dave Thorne regarding Mrs Gladys Richards, a patient at Glen Heathers who recently sustained a fractured femur following a fall at the home. Relatives had raised concerns in respect of care and medication.

11 August 1998, 2.30 pm Unannounced visit to the home, meeting held with Mr J Perkins (Registered Manager/Nurse in Charge) and Mr Andrew Chamberlain (General Manager, Glen Care Homes). Mrs M Gill, RGN, was also involved during the visit,

The home was made aware of the concerns and requested not to make contact with the relatives.

I requested to see all records relating to Mrs Richards' stay in the home and these were made available to me.

Copies of records taken:-

- All daily medication records.
- Accident Procedure.
- Daily statements from 2.1.98 - 31.7.98.
- Resident Assessment form.
- Written statements by 4 members of staff.
- Written statements from Consultant to Glen Care regarding meeting held with Mrs Richards' relatives held on 4.8.98.
- Various assessments, Waterlow etc.
- Nursing interventions via Care Plans.
- GP visits.

Medication Records

Records demonstrate that sedation was given as prescribed by the GP, and examples of half doses being given when Mrs Richards appeared drowsy.

Care Plans

Identify all needs; that Mrs Richards wanders and is at risk. Record relatives' involvement in a change of room, from 1st floor to ground floor.

Records record that relatives want to be responsible for Mrs Richards' care.

[redacted]Statements

Give a chronological sequence of all events day and night. All records signed and dated.

On 11 August 1998 the accident book was seen. I identified that Mrs Richards has had 17 falls since 29.1.98. All details were recorded and appropriate action taken. These records cross reference to daily statements. Mr Perkins oversees all entries regularly.

Staff confirmed that Mrs Richards used to hide her hearing aid in unusual places and that Mrs Lack had discussed many issues with them but would only voice her opinion, not actually complain.

A meeting was held at Glen Heathers between the Director of Nursing for Glen Care Homes and Mrs Lack and her daughter on 4 August 1998 to discuss their concerns. The written statement states that the family accepted that Mrs Richards' care needs had changed and they would consider placing her in a more appropriate environment possibly one of Glen Care Homes' other homes. A further meeting was offered and this was declined.

19 August 1998

Telephone conversation with Dr Bassett, GP to Mrs Richards. He confirmed he had no reason to have concerns about the care Mrs Richards received. He was satisfied that medication was administered appropriately. He felt that the relatives may have had difficulty in accepting their mother's deteriorating health.

Dr Bassett also confirmed that Dr Banks visited and medication was appropriate.

During my discussion with Mrs Gill, RGN, I was informed that the relative, Mrs Lack, has spoken to care staff since Mrs Richards' accident and made them aware of the record she has maintained for the last 3 months.

Conclusion

From the written records obtained and discussions held, I can find no evidence to substantiate that Mrs Richards did not receive appropriate care and medication,

I was informed on 24.8.98 that Mrs Richards has since died following a fall at Gosport War Memorial Hospital. Mrs Lack has approached the home asking for all nursing and medical notes. The home are currently seeking advice although I have advised them that all records must be kept in accordance with the Regulations.

Jane Page
Principal Nursing Home Inspector