App. A. 14.3.7
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COMPLAINT MADE BY MRS. L. LACK RE. STANDARDS OF CARE FOR HER LATE MOTHER MRS. GLADYS RICHARDS WHILST A PATIENT ON DAEDALUS WARD - G.W.M.H FROM 11.08.98. TO 14.08.98. AND 17.08.98. TO 21.08.98.

1. At what time did Mrs. RICHARDS fall?

Answer - 1330 hours on 13.08.98.

This is in conflict with the medical records - no definite time could be given. Where was she sitting - in her room or in the patients lounge. Her room has a glass window onto the corridor would have meant immediate attention. The room was opposite the reception/nursing desk.

2. Who attended to her?

Answer - S/N Jenny BREWER and H.C.S.W. COOK

If Dr BARTON was in the hospital at the time of the fall why didn't she examine my mother?

3. Who moved her and how?

Answer - S/N Jenny BREWER and H.C.S.W. COOK using a hoist.

A fall from a chair after a hip operation (new hip) should have led to a thorough examination (without clothes) in a prone position.

4. No direct questions asked. Statement only. There is some question regarding accuracy of this statement:-

Response (a) There was only one trained nurse on duty after 3.30 pm and prior to this the second Staff Nurse was completing consultant round. Therefore would not have been available to speak to Mrs. LACK (she states several trained nurses). Trained staff confirmed they would not have said it was Mrs. RICHARDS' dementia causing her to cry out; she had been given medication prescribed by Dr. BARTON who was present on the Ward just after Mrs. RICHARDS' fall. She was not given the stronger medication because Mrs. LACK had previously requested that it was not to be administered as it made her Mother very drowsy.

Mrs LACK informed me she had spoken to several nurses and Mrs Karen REED who saw my mother shortly after fall (but was not informed of fall) also spoke to staff. I was not in Gosport at time of fall but have since heard staff (nursing staff) say my mother called out 'due to dementia'. Mrs LACK had queried medication because within 24 hours of admission my mother was so 'zonked out' rehabilitation re walking.

S/N BREWER did see Mrs. LACK and gave her full details of the fall and the following actions that had been taken (statement by S/N BREWER attached)

See attached sheet

5. Why the delay in x-raying Mrs. RICHARDS?

Answer - Mrs. LACK was telephoned and informed once dislocation was suspected and informed of the Doctor's advice, to which she agreed. This included not transferring her Mother immediately to Haslar.

I understand Mrs LACK was informed by telephone at night. No doubt she was in an extremely upset state at the time and took the doctor's advice. She telephoned me and was very upset at the time.

6. Why no medical examination? Why no x-ray? Why no transfer?

Answer - Duty Doctor was given the full facts of the situation including Mrs. RICHARDS' diagnosis and her age. He stated he felt it would be too traumatic to transfer to Haslar for x-ray at that time of the evening and the journey could cause considerable distress. He advised medication, i.e. Oramorphine (strong pain relief) and to arrange for x-ray the following morning. S/N BREWER agreed with this as did Mrs. LACK when she was informed.

Not acceptable. Mrs RICHARDS' diagnosis prior to 2nd fall despite her age was that she was healthy enough to be considered for rehabilitation (Dr at Haslar report). Oramorphine was strong enough to make Mrs RICHARDS' oblivious of trauma to transfer to Haslar. In view of stated policy did they expect my mother to die in the night at Gosport which would avoided questions being asked.

Why no x-ray?
X-ray at G.W.M.H. only operational up to 5.00 pm Monday to Friday.

X-ray could have been carried out between fall at 1330 & 5pm due to the great distress portrayed by my mother & witnessed by Mrs K REED & Mrs LACK.

Why no transfer?
As above.

I fail to understand why trauma in transfer to Haslar at night would have been any greater than trauma the next morning except it was probably more 'convenient' for staff at G.W.M.H. irrespective of duty of care to the patient & the possibility that the fall trauma & pain could have finished her off before the morning.

7. When returned from Haslar from the ambulance, was Mrs. RICHARDS' position not checked?

Answer - Her position was checked by an H.C.S.W. who immediately went to find a trained nurse and asked her to look at the position of Mrs. RICHARDS' leg. Due to the considerable noise Mrs. RICHARDS was making and, being untrained, she decided not to attempt to move Mrs. RICHARDS herself.

I believe the H.C.S.W was Linda - who has since 'discussed' the situation with me. The trained nurse obviously took no notice of the request - it was only after my arrival with Mrs LACK at approx. 12.20 that I asked the nursing attendant, who was attempting to feed lunch to my mother, to get a qualified nurse. I then pulled back the sheet & saw my mother's position in the bed. She was lying on the injured hip.

8 (a) How was Mrs. RICHARDS brought from Haslar Hospital?

Answer - By ambulance and two crew. She was not escorted by a Nurse, this would have been the responsibility of Haslar Hospital to arrange.

This turned out to be on a sheet not a stretcher. We already knew she came by ambulance & we had suggested that she should be accompanied by Mrs LACK. I heard the telephone call to Haslar. We were informed it was not necessary. She was obviously considered fit enough by Haslar. There were witnesses in Haslar (Ward) who saw my mother leave the ward perfectly all right, I was informed of this by Mrs LACK.

(b) When did she start to show pain? What caused it?

Answer - Ambulance Crew commented to nursing staff she began screaming as soon as she was put into the ambulance and continued throughout the journey and on Daedalus Ward. The cause of the pain cannot be confirmed but we do know Haslar Hospital were unable to provide an appropriate canvas to transport Mrs. RICHARDS on. Two sheets were used instead. This did mean Mrs. RICHARDS' limb was not supported as well as it would have been on a canvas when moved from bed to trolley to ambulance to trolley to bed on Daedalus Ward. This **may** have caused the pain.

(c) Request to see x-rays denied?

Answer - This was a decision made by individual radiologist. The Ward Staff are unable to influence their decisions. The x-rays Mrs. LACK refers to did not come back to the Ward, they were seen in the Department by the Doctor and Consultant Radiologist.

Mrs LACK did not originally ask to see the x-rays with ward staff. I witnessed her ask staff at the x-ray department. The Doctor & Consultant Radiologist could have told us the result of the x-ray then. It had nothing to do with the ward staff.

(d) Decision made to do nothing but allow Mrs. RICHARDS to die pain-free?

Answer - Dr. BARTON did see Mrs. LACK and involve her in the decision making process. Due to Mrs. RICHARDS' age she would not be able to have surgical intervention for the Haematoma as this would involve general anaesthetic. Therefore, the priority was to keep her pain-free and allow a peaceful death with dignity.

This is totally incorrect. My sister and I saw Dr BARTON together on the Monday evening only because I saw her pass my mothers room & we both went out into the corridor to speak to her. We were not told then of the haemotoma. Dr BARTON said a decision would be made in the morning & she was informed by Mrs LACK that Haslar would have her back straight away.

TRIVIAL CONCERNS RE CLOTHING/LAUNDRY

1 Clothing sent for marking despite CASH's name on all items of clothing?

Answer - All patients/relatives are informed on admission that to safeguard their belongings, clothing is marked with the name of the Ward. This includes clothing of patients whose relatives agree to do the laundry. This decision has been made on Daedalus Ward following several complaints from patients/relatives whose clothing was sent off to the Hospital Laundry by mistake and often never seen again.

This does not make sense. All my mothers clothes were marked as she had been in a nursing home before hospitalisation. My sister visited every day & did her laundry while in Haslar and informed ward staff she would do the same at Gosport. There was no need for the ward name. My mother was in a single room.

Obviously, while Mrs. RICHARDS' clothing had been sent for marking she was given hospital clothing to wear. This should have only been for a day or two. Unfortunately, unbeknown to Ward Staff, G.W.M.H.'s Laundry Marker had broken down so Mrs. RICHARDS' clothing was sent to St. Mary's Hospital for marking. The Ward were not informed of this and, due to Mrs. LACK'S stress at this time, a taxi was authorised to go and collect the clothing and return it to Daedalus Ward.

A taxi was authorised after I had made my feelings known & my sister volunteered to send a taxi at her own expense. At first we were told that the clothes would be back in a day or two and I informed the receptionist my mother was dying now.

2. I have not been able to confirm if any Staff Nurse made any comment regarding getting Mrs. RICHARDS' up when she was so obviously near to death. I would find difficulty in believing any member of staff, either trained or untrained, would make such a comment.

I would find it difficult to believe as well but it did happen.

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 would 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 a 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 hoist. Code A *had been concerned at Mrs RICHARDS distress when she saw her in the afternoon & 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 lay on the floor until she was found at 1330 & where 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 & 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.

Code A *had visited my mother in the afternoon.* Code A *is an ex-Haslar nurse (orthopaedic ward). Why wasn't she informed of the fall. She was aware of my mothers distress & 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. RICHARD'S 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? Why didn't Dr BARTON examine her on the consultants round at 2pm.

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 mothers pain was recognised & 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 & continued to do so until after the x-ray despite pain medication. She was coherent & 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 & 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 & myself arrived at 12.15 & the pillow was only placed there on my sisters instruction to the nurse (COUCHMAN). HCSW 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 & 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 & 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 & my conversation with Philip he later came into the room (my sister was present) to give diamorphine. I objected strongly & said I would not agree to diamorphine until a decision had been made the following morning. I said & I quote "Are we talking about euphanasia because I will not agree to euphanasia". Philip then left the room & came back with an alternative pain killer.

All trained staff interviewed were very aware that Mrs. LACK and her sister, Mrs. McKENZIE 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 her 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 unaware that I did not agree with my sister regarding my mothers 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 mothers fall so I had no connection with making the nursing of Mrs RICHARDS difficult at times on the example given.
I am appalled at the comments regarding mouth care. We were present when a nurse tried to take out my mothers dentures without success. My sister then tried & 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.

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? See additional note.
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 & 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 & the door closed. I told the kitchen orderly to get out as my mother was dying (about 7pm) & 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 & her door open - opposite the desk. The nursing staff had been warned 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 & 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 & Mrs RICHARDS zonked up with tranquillisers would not of 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 & myself. The nurse came after we demanded it. If she came at BALDACHINO's request prior to our arrival she did nothing. When she did come at approx. 12.20 my sister instructed her & helped change my mothers 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 & conflicting. We were not told after the x-ray only next morning by Philip, we were informed nothing could be done & 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 of this nature.

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 & had nothing to do with the trauma my mother might have as stated by Dr BARTON & 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".