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Form MG11(T)

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of: COLLINS, SIOBHAN MARIE

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: STAFF NURSE

This statement (consisting of 8 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: Siobhan COLLINS Date: 04/02/2006

I am Siobhan Marie COLLINS and reside at an address known to the Hampshire Police.

In 1987 I qualified as a Registered General Nurse (RGN) in Limerick.

My nursing midwifery council pin no is 93L0013C.

From 1987 to 1994 I worked as a RGN at the Limerick Regional Hospital.

Between July 1994 and October 1995 I did agency work with the Crown Nursing Agency. I worked as a D grade Nurse at the Queen Alexandra Hospital, Portsmouth. I normally worked on B3 ward, which was a general medical ward.

From October 1995 I was employed by the Fareham and Gosport Primary Care Trust as a D grade Registered General Nurse working at St Christopher's Hospital, Fareham Whilst at St Christopher's in 1996 I applied for and was accepted as an E grade RGN.

In November 1997 I commenced working as an E grade RGN on Dryad Ward, Gosport War Memorial Hospital; Dryad Ward was at that time a continuing care ward comprising of 20 beds for elderly patients.

Four of the beds were for Respite Care.

In July 2003 I left Dryad Ward and commenced working on Sultan Ward as a grade F RGN.

As far as I can recollect I commenced using Syringe Drivers in January/February 1996. There was a set procedure in the use application of syringe drivers. Two trained members of staff were required to check the "five rights" which are:

1. Confirm that is the right patient's name, d.o.b match the details as per the prescription.
2. Confirm the right dose to be administered.
3. Confirm that it is the right drug.
4. Confirm that it is the right date.
5. Confirm that it is the right hour to administer.

Syringe drivers were used for the administration of controlled drugs to patients who were no longer able take them orally. The syringe driver delivered a controlled amount of the drug over a 24 hour period.

Initially the syringe driver was set up by inserting a butterfly needle subcutaneously into the patient.

It was a requirement for the controlled drug to be administered by two trained nurses.

The drugs are stored in a locked cupboard within a locked cupboard. A register was kept recording all controlled drugs administered to patients. The entry in the drug register was normally signed by the nurse administering the drug, this was witnessed, by another trained nurse.

Whilst on Dryad Ward I was contracted to work for 25 hours a week. I worked mainly night shift, which commenced at 2015 hours and finished at 0745 hours. I would normally work 3 nights one week followed by 2 nights the following week.

My responsibilities on the Ward at that time included supervising the health care support workers.

Administering controlled drugs to the patients. To oversee the smooth running of the ward this included maintaining a safe environment for patients and staff.

I also dealt with the relatives of the patients on the ward.

I have bee asked to comment on the use of the following;

ANC - I have not heard of this term. I have been told that it means, "All Nursing Care" This would not usually be written by Nursing Staff. If I had seen this term I would assume that the person was quite poorly and not able to do much for themselves regarding nursing interaction. It is a broad term for the fact that everything would need to be done for them, in relation to hygiene, feeding and dressing etc.

TLC - Tender Loving Care. This I feel would mean that the patient was gravely ill and it would probably mean that the patient would not be resuscitated. The task would be to keep the patient comfortable but nothing more would be done to improve the patient's condition.

"I am happy for staff to verify death" This is a term I have heard at GWMH and elsewhere, usually in Nursing Homes. This would indicate to me that the patient is expected to die soon. If death was expected the Doctor was never called out to verify death.

This would be the case if the patient was not responding to treatment; there was a decline in general mobility, the patient was unconscious; they could not or would not eat and drink; their blood pressure dropped; their pulse was irregular/fast; their breathing would be laboured; urine output would be reduced due to renal failure; her colour would be pale and perhaps blue on some occasions.

There were no ward rounds on night duty but on the occasions I have worked a day duty on Dryad Ward. Dr BARTON did a ward round each day during the week where she would walk to each bed and speak to each patient. A nurse would accompany her with a report on each

patient from night duty.

I worked a 20 hour week in 1998 which consisted of 2 nights per week.

I have been asked to detail my involvement in the care and treatment of a patient named Geoffrey PACKMAN from referral to entries in his medical notes (Exhibit Reference BJC/34) I can state that on page 77 of the notes I have completed a form detailing The Barthel ADL Index in relation to Geoffrey PACKMAN (Mike).

I have recorded the scores for three days, 23/8/99, 30/8/99 1/9/99. The index is made up of various activities of daily living;

	23/8/99	30/8/99	1/9/99
Bowels			
0-Incontinent			
1-Occasional Accident	2	2	0
2-Continent			
Bladder			
0-Incontinent			
1-Occasional Accident	0	0	0
2-Continent			
Grooming			
0-Needs help		0	0
1-Independent			
Toilet			
0-Dependent			
1-Needs some help	0	0	0
2-Independent			
Feeding			
0-Unable			

1-Needs help	2	2	0
2-Independent			
Transfer			
0-Unable			
1-Major help	1	0	1
2-Minor help			
3-Independent			
Mobility			
0-Unable			
1-Wheelchair Independent	0	0	0
2-Walks with help			
3-Independent			
Dressing			
0-Dependent			
1-Needs help	1	0	0
2-Independent			
Stairs			
0-Unable			
1-Needs help	0	0	0
2-Independent			
Bathing			
0-Dependent			
1-Independent	0	0	0
Total	6	4	1

The Barthel score indicates that the patient was getting worse in that he was unable to do less and less.

On page 78 of the notes, on 23/899, I have written in a nursing care plan for sleep the following;

Problem - Mr PACKMAN requires full assistance to settle at night.
Desired Outcome - To ensure Mr PACKMAN has a comfortable nights rest.

Evaluation Date - Daily

Nursing Action - 1) Ensure George is positioned comfortably to aid a restful night
2) Administer Analgesia as Required
3) Ensure urinary catheter is draining satisfactorily
4) Ensure call bell is close at hand
5) Ensure privacy at all times

I have signed this entry S COLLINS.

On page 78 I have further written on 23/8/99,
"Did settle for long periods" I have signed that entry S COLLINS.
On page 78 I have further written on 24/8/99,"
Slept for long periods following Temazepam 10mgs" I have signed that entry S COLLINS.

On page 81 of the notes I have written on 2/9/99,
"Condition remains ill but comfortable. Syringe driver satisfactory overnight. Oral hygiene attended to" I have signed this entry S. COLLINS.

This would indicate that the syringe driver was running correctly, it having been set up before I came on duty.

I have cross referenced this entry with page 10 of the Dryad Ward Controlled Drugs Record

Book (Exhibit Reference CDRB/48) . This shows that I administered 10 mgs of Temazepam to the patient to help him to settle. This was witnessed by C.Evans .
I have also cross referenced this entry with page 168 Of the medical notes which also shows that I administered 10 mgs of Temazepam to Mr PACKMAN at 2210 on 24/8/99.

This medication was written up by Dr BARTON on 4/8/99 in a variable dose of 10-20 mgs to be taken orally

I gave this medication because it had been written up by Dr BARTON, and the patient needed assistance to settle for the night.

On page 82 of the notes on 23/9/99 I have written in a nursing care plan regarding constipation the following;

Problem - Due to immobility George is prone to constipation

Desired Outcome - To try to achieve a regular bowel movement pattern

Evaluation - Daily

Nursing Action - 1) To try & encourage adequate fibre in Georges diet.
2) To encourage adequate fluid intake.
3) Administer aperients as prescribed
4) Ensure privacy at all times

I have signed this entry S COLLINS
Aperients are a laxative

Also on page 82 of the notes dated 24/8/99, I have written,
"B.W.O." I have signed this entry S COLLINS. This means Bowels Well Open.

On page 84 of the notes dated 23/8/99 I have written in a Nursing Care Plan for Urinary Output,

the following;

Problem - Mr PACKMAN has a urinary catheter in situ.

Desired Outcome - To ensure free drainage of catheter & try to prevent infection.

Evaluation - Daily.

Nursing Action - 1) To ensure adequate oral fluid intake
2) Ensure drainage bag is emptied as required
3) Change bag every 7-8 days & date same
4) Report any problems regarding drainage, change in colour and consistency of urine
5) Ensure privacy at all times

I have signed this entry S. COLLINS.

On page 86 of the notes dated 23/8/99 I have written in a Nursing Care Plan for Personal Hygiene;

Problem - George is unable to maintain his own personal hygiene & requires full assistance

Desired Outcome - To achieve an acceptable level of Personal Hygiene

Evaluation - Daily

Nursing Action - 1) Offer daily bed bath
2) Ensure hair, nails & ears
3) All pressure sores to be redressed as per chart daily
4) Ensure dental care is attended to daily
5) Ensure privacy at all times

I have signed this entry S. COLLINS.

On page 90 of the notes dated 24/8/99 I have written in a Handling Profile;

PATIENT RISK FACTORS	EFFECTS OF RISK FACTORS ABILITIES/HANDLING NEEDS
Communication	Fully oriented in time & place
Compliance	Good
Pain	Needs to be controlled
Skin integrity	Large Sacral Sore
Client/Carer Preference	___
ENVIRONMENTAL RISK FACTORS	
Pressure Relieving mattresses	Nimbus 3
ADDITIONAL HANDLING CONSTRAINTS	
Urinary Catheter	Catheterised on admission

24/8/99
S COLLINS
S/N

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On page 92 and 95 of the notes I have written in a Nutritional Assessment Tool for Geoffrey PACKMAN dated 23/8/99

Appetite/Dietary Intake
0=Normal 0
3=Reduced
4=Fluids

Age
2=65-74 2
3=75-80
5=80+

Ability to Eat
0=Independent 0
1=needs help
2= Swallowing/Chewing
Difficulty
3=Unable to eat solid food
4=Unable to eat or drink

Skin Type
0=Healthy
3=Dry/papery 3
3=Oedematous 4
4=Red/broken/wound 4

Build/Weight for Height
0=Average
4=Obese 4
3=Underweight

4=Recent

5=Severely undernourished

Total Score 17

Oedematous means that when the legs and hands are swollen this could indicate that the patient is at risk from cardiac failure.

Temazapam is a medication in tablet form used to help patients to sleep. SC