

APP. A . 14.3.7

026

**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 Code A

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 Code A 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 Code A Code A 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 haematoma. 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.

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 ~~Philip's~~^{code A} 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".