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. Mrs Karen REED 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.

Mrs REED had visited my mother in the afternoon. Mrs REED 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. Code A 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 Code A *is* Code A *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'

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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.