Mary Parkinson

Gosport War Memorial Hospital Investigation

1) Quality

C 1) It was noticeable that all the Nursing staff and HCSW's were apprehensive about our investigation, and some said that they had not slept for several nights. They felt that at present, morale was low. Nevertheless, several HCSW's had been at the hospital for several years, and clearly enjoyed their work. Nearly all felt that they could easily approach their line managers, and would do so, including whistle blowing if needed.

C 2) Information about actual outcomes was scarce, but the assistant Physiotherapist that we saw, followed the patients into their homes, after discharge. Her husband drove a minibus, and former patients were taken to tea dances etc. However, many of the patients were in for short periods only, (Sultan), or were for continuing care or slow stream stroke rehabilitation.

C 3) There appeared to be little or no occupational therapy. There was a person appointed to that role, but she appeared to be very rarely there. Physiotherapy seemed to be good, with relatives encouraged to watch their relatives in the gym.

C 4) There was little specific information about access to X-ray, diagnostic services, or Hanover arrangements in the actual interviews, although it was stressed that no patients are admitted directly to any wards, apart form Sultan, the GP ward, who are admitted through their GP's. There was, however, concern that demented patients were being admitted, with the staff having no specific training in their care. Although all patients had been seen by a consultant or registrar before being admitted from acute wards, it was acknowledged that there was sometimes a time lag between the assessment by a consultant of their fitness for admission to GWM, and their actual admission. At times, patients had to be rapidly readmitted.

Concern about the availability of out of hour cover, particularly when supplied by Healthful was virtually universal. Out of hours care on Sultan Ward depended on whether or not a particular GP did his own on-call. The resulting delay of often several hours, resulted in access to essential services being unavailable during this time. One patient died while waiting for medical help.

C 5 There was considerable discrepancy between the comments by patients in the Stakeholder interviews, and the letters of thanks from patients and relatives pinned on to ward notice boards. Bells were easily within reach of most, but not all, of the beds, but there was no sign of any bells in the lounges themselves. On direct questioning about this, one nurse said that there were no bells in the lounges apart from one bell on the wall. This lounge was near the nursing station, and patients could therefore attract attention if they wanted, say to go to the toilet. However, when the Chaplain was asked what he thought about the availability of help to go to the toilet, he said that the patients were either mobile or catheterised. Certainly, there were possible concerns about the frequency of catheterisation of patients.

During the week there was a full staff presence in the wards. Patients did not appear to be supervised in the dining area, and one lady was seen spilling her cup of tea, which she had managed to lift off the table with difficulty, and a man did not appear to be safe sitting on a chair. Staff were seen to be feeding patients who were in bed, if they needed this.

TV's were available but not always turned on. Dryad Ward had a variety of games, jigsaws reading material including magazines, but Daedalus had very little apart from a few small print books, and one or two jigsaws. No patients were seen in Sultan Lounge.

C 6) All the wards were clean and attractive and appeared to be well maintained.

C 7) Positive patient experiences were evident from the displayed letters.

C 8) The negative experiences are recorded in the Stakeholder interviews. It is noticeable that the complaints of lack of food and fluid, or inappropriate fluid, applied to patients who were very ill and in bed. Lack of supervision in the dining room and ? excessive catheterisation were confirmed in ward observations and interviews with nursing staff.

H 1) There were possible concerns about difficulties some nurses experienced in addressing the probability that a patient who had perhaps been with them for some time was dying. This also applied to staff from the donor ward, who would send patients for rehabilitation who were obviously terminally ill. The chaplain calls regularly, and on Dryad ward, the former chaplain attends as a volunteer, and runs a much appreciated bereavement group. Some patients suffered when in pain, because of the fear of giving appropriate doses

of pain relieving drugs, and the non-availablity of anticipatory prescribing. This was exacerbated by the difficulty on accessing out of hours medical cover.

H 2) Relatives and carers appeared to be treated with sensitivity, although the seriousness of their relatives illness was not always appreciated, which caused distress. The chaplain is always available on request, although he does no bereavement after care, and will not take a funeral, even on request of the relatives.

H 3) Some nurses have done courses in bereavement, but there is no apparent training, and in particular, no training in recognising grief in the causation of some complaints. There is little recognition that anger is a normal part of bereavement and can exacerbate the degree of seriousness of the complaints. Staff were hurt and mystified at complaints being brought by relatives who had appeared to be so grateful for the help received while their relative was alive. The former chaplain does probably support staff on Dryad ward, but there appears to be little or no support for the staff when a patient dies or is dying.

H 4) The Chaplain said that there was not a cultural problem and other faiths did not impinge on the patients in GWM. However, he knew where the Rabbi was, should a patient or relative require his services. There is a weekly (Anglican) Communion Service in the chapel. All denominations are welcome to attend. Provision for other faiths does not seem to be needed at present.

H 5) Expectation of death does cause some difficulty for some staff, and there was no direct evidence of patients themselves being prepared for death, if that is the wish of themselves or their relatives.

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