MM/YJM

Code A

03 August 1995

4378

Dear Code A

Further to your letter of 26th July, 1995 I have now had a report back from Gosport War Memorial Hospital on the two concerns that you raise about your mother's care there:

(A) Arrangements for X-Rays

1. A routine appointment for an x-ray was arranged by telephone for Tuesday, 1st November, 1994. The date of the telephone call was not recorded; the request form was dated Friday, 29th October, 1994. This department operates on a Monday to Friday basis only.

2. The x-ray was seen and reported on by a radiologist on 2nd November, 1994; the report was typed and put into the internal mail on 3rd November, 1994.

3. Whilst none of the radiographers working in the department can recall speaking with you on 3rd November, 1994, they confirm that it is not normal practice to give results verbally in that way - results are communicated via the general practitioner who had requested them.

4. The radiographers' normal practice is to telephone the general practitioner if an obvious fracture is detected. However, the type of fracture suffered by Code A was not obvious and in the opinion of the senior radiographer needed a skilled radiologist to report on it.

/continued - page 2

5. General practitioners are able, if they wish, to ask to view the x-ray plates, though do so only occasionally. On such occasions a note is made in the appointment book so that the plates can be left accessible for the general practitioner to see. There is no record of the general practitioner coming in to see your mother's x-ray plates.

(B) Admission to Sultan Ward

1. Code A was transferred from Haslar Hospital to Sultan Ward, Gosport War Memorial Hospital under the care of her general practitioner, Dr. Brand, on 18th November, 1994. She had been diagnosed as having a fracture of her right tibial plateau and a full length scotch case brace was in place. She had a past history of Alzheimer's disease, ischaemic heart disease and TIAs.

2. She was seen by a physiotherapist daily but was only able to mobilise with the aid of a zimmer frame and two nurses. She could only manage a few steps but on some occasions she would not stand at all making mobilisation impossible.

3. She was nursed between bed and chair. It was very difficult to get Code A comfortable in a chair as the top of her leg brace was inclined to dig into her thigh in this position. She was, therefore, only sat out for short periods.

4. Code A was on occasion incontinent. Sometimes the scotch guard cast was contaminated which staff were unable to remove to clean. It is, therefore, very likely that occasionally she smelt of urine, and I can appreciate this would have been distressing for you.

5. On occasions Code A refused to take her prescribed medication.

6. On 24th November, 1994 Dr. Brand referred Code A to Dr. Saafan of the Elderly Mental Health service as she had become increasingly confused, restless and difficult to manage, taking food and fluids reluctantly and in decreasing amounts, causing concern about dehydration.

7. She was seen by Dr. Saafan on 25th November and 1st December, 1994 and Dr. Saafan arranged for her transfer to Knowle Hospital on 7th December, 1994.

8. The ward staff report that Code A was a pleasant but very demented lady. The degree of dementia restricted the degree of constructive nursing care they were able to give.

9. Due to the period of time involved we were unable to establish the length of time it took for Code A name to be written on the name plate. Her name and that of her "named nurse" should have been completed within twenty-four hours of admission. If this was not the case I can only apologise and bring to the attention of all staff the impression this gives to carers.

I am sorry if you feel that inadequate care at Gosport War Memorial Hospital contributed to your mother's suffering. It does appear that failure to achieve the objectives for her physical care can mainly be attributed to her mental state. The staff of Sultan Ward are not expert at dealing with that which is why the advice of a specialist was sought.

The last few months of your mother's life must have been extremely distressing for you as well as for her, and I am sorry if what was already a difficult time for you was made worse by any shortcomings on our part.

I hope that this at least begins to clarify the position on the points you raised in your letter. I know that Mrs. Evans, the Hospital Manager, and/or Mr. Abbotts, the Service Manager for Gosport Health Services, would be very willing to meet you if you wish to follow up any of the points outlined above. They can be contacted at Gosport War Memorial Hospital - telephone 01705 524611, extension 2288 (Mrs. Evans) or extension 2264 (Mr. Abbotts).

Yours sincerely,

Code A

Max Millett
Chief Executive

Copy to: Mrs. I. Evans
Mr. T. Abbotts
Mr. W. Hooper

Portsmouth Healthcare NHS Trust

MEMORANDUM

From
Trevor Abbotts, Gosport Locality Manager, GWMH

To
Bill Hooper

Ref

cc

1 August 1995

Re Code A

Please find enclosed a report completed by Isobel following an investigation into the above complaint.

The information regarding her X-Ray appointment was obtained from the X-Ray Department. Should further details be requested regarding these problems I feel they will need to address them through the Acute.

Also please note that prior to admission to Haslar Code A home address was Addenbrooks - Social Services Residential Home.

Many thanks.

Encs Code A

SENT TO TRUST HQ
2/8/95.

BILL

FILE COPY

Portsmouth Healthcare NHS Trust
MEMORANDUM

From
Isobel Evans Hospital Manager GWMH
Ref
IE/LP

To
Trevor Abbotts
cc

31 July 1995

Re: Code A

Report on my investigation on Code A letter of complaint concerning the care his Mother received at this Hospital.

I have spoken to the Staff of the relevant departments and examined documentation of Code A Code A care and have been able to establish the following in answer to Code A Code A comments.

Re: Code A visit to the X-Ray Department

1. A routine appointment for an X-Ray was arranged by telephone for Tuesday 1st November 1994. The date of the telephone call was not recorded, the request form was dated Friday 29th October 1994. This department operates on a Monday - Friday basis only.

2. The X-Ray was seen and reported on by a Radiologist on the 2nd November 1994, the report was typed and put into the internal mail on the 3rd November 1994.

3. Non of the Radiographers working in the department can recall speaking to Code A Code A on the 3rd November but confirm it is not their practice to give results in this manner.

4. The Senior Radiographer informed me that it was their normal practice to telephone G.P's if an obvious fracture was detected. The type of fracture suffered by Code A Code A was not obvious and in the opinion of the Senior Radiographer needed a skilled Radiologist to report on it.

5. No record was made of the G.P. coming in to see the X-Ray plates. Occasionally G.P's ask to view the plates and a note is made in the Appointment Book so the plates can be left accessible for the G.P's to see.

Re: Code A admission to Sultan Ward

1. Code A was transferred from Haslar Hospital to Sultan Ward under the care of her G.P. Dr. Brand on the 18th November 1994. She had been diagnosed as having a fracture of her right tibial plateau and a full length scotch case brace was in place. She had a past medical history of Alzheimer's disease, ischaemic heart disease and T.I.A's.

2. Code A was seen by a Physiotherapist daily, she was only able to mobilise with the aid of a zimmer frame and two nurses. She could only manage a few steps but on some occasions she would not stand at all making mobilisation impossible.

3. She was nursed between bed and chair. It was very difficult to get Code A comfortable in a chair as the top of her leg brace was inclined to dig into her thigh in this position. She was therefore only sat out for short periods.

4. Code A was on occasions incontinent of both urine and faeces and it was recorded that her urine was offensive at times. On occasions the scotch guard cast was contaminated which Staff were unable to remove to clean, it is therefore very likely that on occasions Code A smelt of urine.

5. On occasions Code A refused to take her prescribed medication.

6. On the 25th November 1994 Dr. Brand referred Code A to Dr. Saafan as she had become increasingly confused, restless and difficult to manage, taking food and fluids reluctantly and in decreasing amounts, causing concern on dehydration.

7. She was seen by Dr. Saafan on the 24th November and on the 1st December, who arranged for her transfer to Knowle Hospital on the 7th December 1994.

8. The Ward Staff report that Code A was a pleasant but very demented lady. The degree of dementia restricted the degree of constructive nursing care they were able to give.

9. They recall Code A as a pleasant and caring Son who frequently spoke to the Staff when visiting, they cannot recall him ever intimating that he was dissatisfied with the care his Mother was receiving or the level of information he received.

10. Due to the period of time involved, I was unable to establish the length of time it took for Code A name to be written on the name plate. Her name and that of her 'named nurse' should have been completed within 24 hours of admission, if this was not the case, I can only apologise and bring to the attention of all Staff the impression this gives to carers.

I understand from Code A records that she died on the 25th May 1995, I can understand Code A distress if he contributes any suffering his Mother endured to inadequate care on our part. It would appear that failure to meet the objectives of Code A Code A physical recovery can mainly be contributed to her mental state, which I confess we are not expert at dealing with and is possibly endorsed by Code A praise of the care she received on Barton ward which specialise in that field.

Code A

I. Evans

WATING Reply
T Mook

PORTSMOUTH
HealthCare
NHS
TRUST

27th July, 1995

Copy of complaint faxed through today.

Portsmouth HealthCare NHS Trust
28 JUL 1995
General Manager, Fareham/Gosport

WITH COMPLIMENTS

PORTSMOUTH HEALTHCARE NHS TRUST CENTRAL OFFICE

St James' Hospital
Locksway Road, Portsmouth, Hants PO4 8LD
Tel: 01705 822444 Fax: 01705 293437

Code A

MM/YJM

27th July, 1995

4378

Dear Code A

Your letter of 26th July, 1995 has been received today. The issues which you raise will be fully investigated with the people concerned and I will write to you again as soon as I have the information I need. Normally I would hope to get back to you within three weeks.

Yours sincerely,

Max Millett
Chief Executive

Copy to: Mr. W. Hooper

Code A

26 July 1995

Mr Max Millett
Chief Executive
Portsmouth Health Care Trust
St James Hospital
Locksway Road
PORTSMOUTH
Hants

COMPLAINTS SEN
TO TRACEY &
ISOBEL
27/7/95

Dear Sir

Re: Code A

I am writing to ask if you would be kind enough to clarify the protocol and procedures related to the process of G.P.s in the Gosport area referring and receiving the results of X Rays at the Gosport War Memorial Hospital.

Also, the protocol of the reception of patients onto the ward of the above hospital.

I enclose a section of a letter of complaint in relation to the treatment that my mother received by various agencies and would like comment as to the process that she experienced following referral by the G.P. in the X Ray Department and also the quality of care at her subsequent admission from Haslar Hospital.

Thank you for your attention to these letters.

Yours faithfully

Code A

in dealing with the elderly and mentally impaired. I also acknowledge that my mother could be verbally offensive and experience, at times, mood swings. However, the behaviour was not so extreme as to cause disruption or upset to staff. At least, that is my understanding.

However, it would seem that a combination of the general stresses and strains and the prescriptive methods of working and dealing with other agencies that exacerbated the following experience that my mother suffered.

In the early afternoon of 26 October 1994 I received a telephone call from a member of staff at to say that my mother had bruised her leg in the bath. Also that the GP, Dr from the had been called as she was not weight bearing. It seemed that he had not felt the injury to be anything more than a bruise.

I visited my mother later than evening. It was evident that she was in considerable pain, distressed and not happy to put weight on her leg. I queried her condition as to injury and was told that it seemed that she had a low pain threshold and that the GP had instructed staff to administer analgesic and to weight bear her. In speaking to the Manager, about my concerns, in particular the lack of an X Ray, I was told that the GP had examined my mother; there had been a query related to arthritis in her knees, something which she has never experienced.

The upshot of this conversation was the subsequent attempts by both myself and to encourage my mother to walk. It was clearly a distressing experience for her and for me to be engaged in this exercise. I was told that despite my concerns that the leg was perhaps damaged in some way, that my mother had had the ability to lift her leg from the grounds and therefore unlikely that it was broken. therefore, it was clearly important to get her mobilised so that the unit could function, given the staffing arrangements.

I visited my mother on 27 October 1994; there was still no change in her inability to walk and it seemed that she was also refusing her medication. She appeared disturbed and distressed and expressed a wish to die. Again I expressed concern to staff and they also believed that the GP should be called out again. I did also indicate that I felt an X Ray should be arranged.

When I visited on 28.10.94 I was informed that the GP, had visited and had told staff not to weight bear her and that he would arrange for an X Ray. The X Ray was arranged for Tuesday, 1 November at the War Memorial Hospital. Meanwhile, I continued to visit my mother daily and continued to express concern about her general condition.

On 1 November my mother was conveyed to the War Memorial Hospital where she had her X Ray. Later, when I visited to see my mother on enquiring about the X Ray results, staff had been told that the diagnosis of the result would take between 5 and 12 days.

On 2 November I again visited my mother and was told that (her own GP) had been called out to my mother as staff had been

unable to rouse her earlier. The GP visited and diagnosed a TIA. He was asked by a staff member about my mother's X Ray and condition of her leg and indicated that he did not know about this particular problem.

On 3 November I telephoned the to speak with Dr and/or Dr but neither were available. Following this I visited the X Ray Department at the War Memorial Hospital. There I spoke to a radiologist about my mother's Tuesday visit and whilst she recalled the appointment, she was not able to tell me the results because of confidentiality and because of not being certain as to whether or not the Consultant had read the plate. I was told that the process took between 3 to 12 days and a letter would be sent or the GP picked up the information.

Later I again visited my mother and was concerned and frustrated at the processes involved. On 4 November I telephoned Dr at 6.00 pm to express my concern about my mother. On asking him about her condition he explained that she was a frail, elderly lady who had made a good recovery from her TIA better than expected. I then asked him about the X Ray results of my mother's leg and he stated that he was not aware of any problem with her leg and if X Ray had found anything then they would have telephoned him. He had been on leave and Dr Brigg had covered his patients.

Later at 9.30 pm I received a telephone call at home from Dr . He said that he had been to and that staff there had indicated my concern for my mother's injury to her leg. It was as a result of this that he was telephoning.

He confirmed that the X Ray had indicated a fractured leg and that he had arranged for my mother to be admitted to Haslar Hospital on Saturday, 5 November. He then went on to say that a letter would need to be taken and asked if I could collect this and also take my mother by car to the Accident and Emergency Unit. I agreed to pick up the letter but felt that he should arrange transport. He indicated that he would leave a message with surgery staff to make a 999 call for an ambulance. When I arrived at the surgery the clerk did not know anything about this arrangement. Dr stood feet away whilst I explained and spelt my mother's name but made no effort to acknowledge me.

The ambulance arrived at at 10.55 am. My mother was admitted to the hospital, seen by a doctor and X Rays taken by 12.30 pm. By 1.00 pm she was on E6 Ward, her history was taken and also a list of the medication that she was prescribed at . My wife and I waited until 3.30 pm so that she could be seen by a doctor with us present. We left to get a meal and returned at 4.30 pm during which time a doctor had seen my mother, the information being that a decision about what to do with her leg would be taken on Monday, 7 November.

On visiting on 6 November it was evident that my mother was less amiable. My wife asked if she had been given her medication; we were told she had.

I visited on 7 November and was told by the Staff Nurse that my mother had been too difficult to start treatment and it had been put off. On asking about her medication I was told that this

should have accompanied my mother from the home and that the hospital had no access to medicines over the weekend.

On 8 November I visited my mother to find her wrapped up like a doll in a deep sleep. She had been given her medication. On 9 November her leg was placed in a soft plaster. She remained at Haslar Hospital until 18 November. Whilst there staff did begin to try to mobilise her. On 18 November my mother was transferred to the War Memorial Hospital. This was on the grounds that being incapacitated she could not be cared for by , the notion being that she would convalesce and receive physiotherapy at this hospital.

The hospital conditions and the ward that my mother was in appeared comfortable. However, it seems that neither staff nor ward were able to care for her in a meaningful way. It took a week for my mother's name to be written on the name plate. It was as if she was a non-person. No-one approached me about the treatment my mother was receiving except one staff nurse who expressed concern about her lack of appetite. One senior nurse seemed ambivalent about her progress. There was no mention of physiotherapy; it just appeared that she was shifted from bed to chair as a matter of convenience. She was also at times smelling of urine. I was told that the psychiatric geriatrician had been to visit my mother and it seems because the staff seemed unable to cope with her he agreed that she be admitted to Barton Ward at Knowle Hospital. On admission here on 7.12.94 it seemed that staff did understand the problems and slowly my mother's appetite and chinks of general well-being began to emerge.

However, she had changed; her dementia increased, she lacked confidence and was still not able to mobilise herself. In fact it seemed with the plaster still on that she had, in fact, forgotten that her leg existed.

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Following meetings and ward rounds it was agreed that my mother now needed a different type of care from that provided by
As a result of this and the need to get her settled Ranvilles was chosen as being the most suited to her needs. She was still not walking, although the plaster was removed prior to her leaving Knowle Hospital on 2.1.95.

27-JUL-1995 12:20 FROM TRUST CENTRAL OFFICE TO F/G LOCALITY P.01

HealthCare NHS TRUST

FAX

Please telephone 01705 · 894378 if any page is missing or indistinct

To

Fareham/Gosport Locality Headquarters

For the attention of

Bill Hooper

From

Max Millett

Date

27th July, 1995

Fax No.

Pages (inc. this sheet)

6

The attached complaint was received at the Trust Central Office on 27th July, 1995. Could you please investigate all the matters raised urgently and let me have a full response no later than 14th August, 1995 so that I can reply to Code A I feel that a personal approach might be the best way to deal with this one. With thanks.

Code A

MM/YJM

27th July, 1995

4378

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