RESTRICTED

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I am the above named person and I reside at an address known to the Hampshire Police. I am a retired Registered Staff Nurse having retired in November 1 999.

I trained as a Nurse at the Royal Portsmouth Hospital and finished my training in 1961. I was then a qualified State Registered Nurse. I left nursing straight after my training in 1961 in order to have a family. I had not specialised during my training and was only qualified in general nursing.

In 1971 I decided to return to nursing. I felt it was unlikely that I would b e able to specialise without pushing myself. I did not have this sort of ambition and was content to return to geriatric care. I went to work at St . Mary's Hospital in Portsmouth on a long stay Geriatric Ward. I was surpris ed that I did not have to do any form of refresher course after a 10 year break from my profession. Qualified Nurses were in great demand in those days an d I was under the guidance of a Charge Nurse who was always available if I needed any help.

After a year at St. Mary's Hospital on nights I found the travelling a bit much. I managed to find a vacancy at the Gosport War Memorial at the Northcotte Annexe as a Staff Nurse on a long stay Geriatric Ward which had 12 beds. Th ere were 4 male beds and 8 female beds on this ward. The patients were those that c ould not be nursed at home and their ailments ranged from strokes, severe heart attacks, arthritis etc. These patients were with us for general nursing ca re, mainly bodily care until they died. Some patients were with us for 5 – 6 years and I can remember one that was with us for 10 years. This was the time be fore Nursing Homes were able to take these sort of patients and also before the time of physiotherapy and care intended to assist the patients back into the community. I would only work on a Friday and Saturday night. There w ould only be me and an auxiliary Nurse on duty.

My direct supervisor would be a sister from the Gosport War Memorial Hospital. ; The Sister would generally visit twice during my tour of duty. She would always attend once in the evening and then her duties permitting once in the morning. My duty was from 1930 hours to 0730 hours.

The purpose of this ward was to provide the patients with good nursing care in their final years which would include administering pain killing drugs which ranged from analgesics to controlled drugs. The relevant drugs were always prescribed by a doctor. If memory serves me correctly there was a Consulta nt Geriatric Doctor in overall charge but the patients were still under their own GP's.

If a patient required analgesics as per their care chart I could administer this myself. If a patient required any controlled drugs then there had to be another registered Nurse present. The sister would fill this role and atte nd. The controlled drugs administered were all entered into the controlled drugs book which was known as the DDA book then and signed by both the Sister or other registered Nurse and myself. There were not many of our patients tha t were on the stronger drugs, i.e. controlled drugs. The more common of thes e was MST which was a Morphine based tablet and a Morphine Elixir or Morphine tablet. The only problem with giving pain killing drugs orally was the pat ient would always have to suffer pain as the effects of the drug wore off. The later introduction of syringe driver did away with this.

Around 1989 the lease ran out on the Northcotte Annexe and I moved to Redcliffe Annexe which is another Annexe of the Gosport War Memorial in The Avenue, Gosport. ; I continued to work Friday and Saturday nights from 1930 to 0730 hours. Redcliffe Annexe was another long stay Geriatric Ward with about 22 beds. The other Nurses that worked there were Anita TUBBRITT, Beverley TURNBULL, Sylvia GRIFFIN, Margaret WIGFALL and May KING. Again the Sisters in charge were b ased at the Gosport War Memorial Hospital and from memory were Sisters WALKER, GOLDSMITH and BROUGHTON. They would visit twice during the night once in t he evening and once in the morning. As this ward was larger than Northcotte Annexe we would have two Staff Nurses on duty when possible with two auxiliary Nurses. If there was only one Staff Nurse on duty we would have an extra auxiliary on duty. I predominantly worked with a Staff Nurse Anita TUBBRIT T although I worked with them all.

Redcliffe Annexe is a three-storey building but we only used the first two floors as wards and the third as a changing room. There would be two drugs trolleys, one on each floor. There was only the one drug cabinet which was on the first floor.

The patients were all long stay geriatric patients just as they had been at Northcotte annexe. I can remember that the Consultant was

Dr. LORD at this time but she was only on duty during the day. At night if a Doctor was required we would have to call a GP. I am not sure of the date but a Docto r BARTON joined the staff while I was working at the Redcliffe Annexe. I did not have personal contact with the Doctors as my shift would finish before their rounds.

The care of the patients at the Redcliffe annexe was similar to that at Northcotte Annexe. I would check the patients care chart to see what medication had b een prescribed. The need for strong painkilling medication such as controlled drugs was determined on a sliding scale. If a patient was in pain then analgesics which are a milder form of pain control would be tried first. I f these did not relieve the pain then a stronger drug would be tried and so on until the patient could be made comfortable. The drugs could be administer ed in one of many ways, orally as an elixir or tablet, as a suppository or by injection. The one thing that all thee methods had in common was a lack of constant pain relief. As the effects of the drug started to wear off the patient would then suffer discomfort until they were able to receive another dosage. Their discomfort and pain could often be made worse by the need to turn them etc in bed. Staff would always report back if a patient appeared in more discomfort than normal and a record would be made of this.

At some time while I was working at Redcliffe Annexe I came on duty to find that a patient was receiving pain relief via a syringe driver. The syringe driver had obviously been set up during the day by staff. I had never seen this type of equipment before and had no training in its use. I made it clear that trai ning would be required if we were expected to care for patients who were receiving pain relief by this method. Very shortly after I and another staff had expressed our need for training it was received. A trainer came to Redclif fe Annexe and explained the theory and use of a syringe driver. By the time I had to use a syringe driver myself I had received my training.

The benefits of using a syringe driver are a better management of pain control, the patient does not suffer the peaks and troughs of pain encountered with other methods. A patient may have difficulty in swallowing and could therefore n ot take medication orally. The syringe driver would administer a constant dos e of medication over a 24 hour period. A syringe driver was only ever used for those patients who were in a lot of pain, to my memory they were in so much pain that they were nearly losing consciousness.

Before a syringe driver was used all other methods of pain control had been tried but been unsuccessful. The doctor would then sign the patient's card up statin g the drug, dosage and method of administration. It would then be the decisi on of the Staff Nurse when to actually start the patient on a syringe driver if this was a method recommended by the Doctor. I was personally reluctant to start the patient on a syringe driver until absolutely necessary as I wanted to make sure that all other forms of pain control had been tried before. Duri ng the time I worked at the Redcliffe Annexe very few patients received medication through a syringe driver. A syringe driver would only be used for administering Diamorphine originally but Hyoscine could also be mixed with this if the patient had fluid in the lungs.

About 1994 most of the patients from Redcliffe Ward were moved to Dyrad Ward which was part of the new building at the Gosport War Memorial. The staff from Redcliffe Annexe also moved across. There were about 20 – 22 beds on Dry ad Ward. Initially it was a long term geriatric care ward but as some of the patients passed away naturally or could be moved out to Nursing Homes their beds were filled with terminally ill elderly patients. Care for these pati ents was known as palliative care. A system started of assessing patients. ; Patients that showed signs of improving or maintaining their health without too much medication were sent to Nursing Homes. Those whose health was deteriorating and were expected to die sooner rather than later were admitted to Dyrad. I found this rather depressing as although patients would die on the long stay geriatric wards it would not be as regular as it was on a palliative care ward.

The patients on Dryad Ward were all suffering with serious conditions and the majority were in a lot of pain. Dr. BARTON was the doctor for this Ward am ong others. Dr. BARTON would attend the ward every morning during the week.&nb sp; She used to come in quite early so we would see more of her. My shifts had cha nged when we moved to Dryad as the staff were no longer allowed to work permanent nights and had to work flexi-shifts.

As a palliative care ward I found that the use of syringe drivers was becoming more common. As pain relief was more common on this ward I attended a pain relief control course in 1993 at the Gosport War Memorial. New methods of pain control were coming into use all the time now and one of the new methods was Fentanyl patches for pain relief. The syringe driver remained the last res ort though.

During the time I spent working at the Gosport War Memorial and its annexes I found the staff training more than adequate. Courses were always available and y ou decided which courses you wished to attend in order to improve your knowledge.&n bsp; Staff and ward meetings were established where you would discuss patient care.&n bsp; Dryad was a very happy ward. Daedelus Ward was not as cheerful and I was a ware that there were some grumblings over issues of staffing and the like. I th ink some of the reasons why Dryad was such a happy ward was due to the fact that Sister HAMLIN ran it so well.