East Hampshire NHS
Primary Care Trust
Elderly Mental Health Services

From: Von Dixon
Administration Manager and
Data Protection and Information
Coordinator
St. James' Hospital

Tele: Code A

To: Maggie Vilkas
Janice Romer

cc: Juliette Diamond

Ref: VD/tp

Date: 12th January 2005

Re: Complaint (MC) Collingwood Ward

Please find attached the report complied re the above.

I apologise for the time delay, this was due to staff annual leave and sickness.

Please feel free to contact me if you require any further information.

Code A

Von

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ELDERLY MENTAL HEALTH

INVESTIGATION REPORT

BANK NURSE - MICHELLE COLEBOURN

COLLINGWOOD WARD
GOSPORT WAR MEMORIAL

Copies To:

Juliette Diamond
Maggie Vilkas
Janice Romer

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INVESTIGATION CONCERNING COMPLAINT FROM MRS RAMSDEN (RELATIVE) IN RESPECT OF: MICHELLE COLBOURN (BANK NURSE)

Date of Incident:	27th August 2004 (Incident 1) 2nd October 2004 (Incident 2)
Location of Incidents:	Both incidents occurred on Collingwood Ward.
Time of Incidents:	Incident 1 = about 8.30pm Incident 2 = around 10 - 10.30pm
Staff on Duty at Time of Incident: (Incident 1)	S Flowers M Suggett T Jones (BNA) M Colbourn (Bank Nurse) P Davies L Mullivale
Staff on Duty at Time of Incident: (Incident 2)	M Colbourn (Bank Nurse) N Ballard (NHSP)
Name of Investigating Officer:	Von Dixon
Terms of Reference for the Investigation:	Commissioned by Juliette Diamond, Senior Clinical Nurse Specialist. Complaint made by relative against a member of staff. Anyone involved of witnessing any incident to be interviewed

Introduction/Background Information:

Collingwood ward is a busy 21-bedded acute assessment unit in Gosport War Memorial Hospital. This ward cares for patients with dementia who at times have highly challenging behaviour.

This ward can have staffing problems, which are covered by bank, and agency staff

Incident Summary: (Incident 1):

Mrs R's mother (IH) was waiting for an ambulance to transfer her to QAH with a suspected fractured hip; the patient was being nursed on a mattress on the floor. It was alleged that there was a lack of competency of staff that used the hoist.
(Please see appendix 1).

What was happening before the incident: (Incident 1):

Mrs R received a call informing that her mother (IH) had had a fall and that she was being sent for an x-ray at QAH. Mrs R said that she would go to the hospital with her mother, the staff confirmed the ambulance had already been called and that they would be arriving within a certain time. Mrs R arrived half an hour before the ambulance. When Mrs R arrived, her mother was being nursed on the floor as agreed in the care plan.

Chronological Sequence of Events: (Incident 1):

Mrs R was waiting with (IH) for the ambulance to arrive to take her mother to QAH hospital for x-ray. SF had explained to Mrs R about her mother's possible fractured hip and that they were just being cautious.

Mrs R was with her mum who was in bed on the floor when the ambulance crew arrived. SF introduced Mrs R to the ambulance crew and then went off to do the paperwork.
(Please see appendix 5).

MC and two other nurses stayed in the room with the ambulance crew who stayed at the door. IH was being nursed on the floor as agreed at the family meeting. The ambulance crew asked why was the patient on the floor. MC said "hospital policy". Mr & Mrs R felt this reply was sarcastic. The ambulance crew asked what the matter was? Mrs R said that Michelle was uncertain but eventually said it could be a possible fracture arm and hip.

Mrs R felt that Michelle was very uninformative and very rude to the ambulance crew in what were reasonable questions, for example, the ambulance crew enquired how it happened and MC replied "a fall" when the crew further enquired what type of fall, the reply was "a fall is a fall"

There were 3 nurses in the room.

MS stated that one of the ambulance crew had a bad attitude and LM said she couldn't remember.
(Please see appendix 2 & 6).

Mrs R said that the staff went to get the hoist and the ambulance crew assisted them. MC and another nurse were leading the use of the hoist, the ambulance crew looked on from the doorway. The nurses seemed to be unable to position the slings correctly, which caused IH a lot of discomfort and pain. It was on the 3rd attempt before it was done correctly.
(Please see appendix 2, 4, 6 & 7).

What was the Outcome: (Incident 1):

The patient was taken to QAH for X-ray and no fracture was found. Patient was returned to Collingwood ward.

Findings: (Incident 1):

There are training issues in the use of the hoist.

On this occasion there seemed to be no one individual nurse taking charge of process. Who took responsibility?

Communication processes were not good between MC and the ambulance crew.

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Incident Summary: (Incident 2):

Mrs R came to visit her mother (IH) on returning from holiday after Mrs R's daughter had contacted her to say IH had been put on sick notice. It was late when Mr & Mrs R arrived on the ward. It was alleged that MC spoke to Mrs R in a rude and off hand manner causing her distress and therefore not feeling able to see her mother.
(Please see appendix 1).

What was happening before the incident: (Incident 2):

Mr & Mrs R had returned from holiday early as they had received news from their daughter that (IH) had been put on sick notice, which means her condition was quite poorly.

MC and NB were on night duty, and were getting patients ready for bed (they were one nurse short of agreed establishment. Neither were permanent contracted Collingwood staff). MC was seeing to a patient who had just stripped off and urinated on the floor, whilst the other nurse went to get clean sheets and pyjamas.

Chronological Sequence of Events: (Incident 2):

Mr & Mrs R had returned from holiday late on the night of the 2nd October after a phone call from their daughter telling them that Mrs R's mother had been put on sick notice. Mr and Mrs R arrived on the ward at about 10.00 - 10.30pm after being let in by the night porter. Mrs R said that when they pressed the entrance button to the ward, the alarm went off.
(Please see appendix 2).

MC says that no alarm went off when Mr & Mrs R entered the ward, because if it had they would have run down the corridor to check to see if a patient had got out.
(Please see appendix 9).

Mr & Mrs R were making their way to the office when a young nurse was coming out of the side room. She explained who she was.
(Please see appendix 9).

MC was in a side room and asked NB who she was talking to. NB replied "visitors".
(Please see appendix 2).

One of the male patients had stripped off and urinated on the floor and MC was trying to protect his dignity while NB had gone to get clean sheets and pyjamas. MC was surprised when NB returned with two relatives who she did not recognise.
(Please see appendix 8 & 9).

Mrs R said that MC had said "Visitors, we don't have visitors at this time of night"

MC said, on being told there were visitors, "you are joking, it is a bit too late to visit now" or words to that effect. "I was trying to hide a patient who was naked behind me."
(Please see appendix 2 & 8).

Mrs R said that MC said "I know who you are, you can have 30 seconds" and MC muttered about only two of them being on duty.
(Please see appendix 2).

MC said that she had a patient trying to push past her who was naked and she said to Mrs R "okay you can have 30 seconds"
(Please see appendix 8).

Mrs R said that NB was there the whole time and she looked embarrassed. Mrs R was upset by what was said and put her hand up and said "it doesn't matter, I will come back tomorrow". MC said that she didn't go after them as patient care came first. MC sent NB with Mr & Mrs R to let them out.
(Please see appendix 2, 8 & 9).

Mrs R explained to NB how disappointed she was at not seeing her mum and that she had traveled six hundred miles to do so.
(Please see appendix 2 & 9).

What was the outcome of Incident: (Incident 2):

Mr & Mrs R left the ward in a distressed state without seeing IH, Mrs R's mother.

Findings: (Incident 2):

MC had less than a professional attitude when communicating with Mr & Mrs R.

The ward had no communication from the porter that relatives were on their way up.

No information conveyed at handover that IH relatives might possibly visit on return from holiday.

People had a different view as to whether the bell on entering the ward sounded, which could have alerted staff to either people entering or leaving the ward.

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APPENDICES

1

A02 1

6 October 2004

Dear Lesley

It is with much regret, that I find the necessity to complain in a formal manor, concerning the rudeness and lack of professionalism of one of your staff, especially as I have been so impressed by the care and compassion shown to me and more importantly my mother (Irene Hoare), by every other member of staff working on the Collingwood Ward.

The first occasion I witnessed Michelle's rudeness, was when it was thought that my mother had broken her hip after a fall at the end of August 2004. An ambulance was called for, during the evening to transport my mother to Queen Alexander Hospital for an x-ray. Sarah was on duty that night, and I believe it was her that rang me, to tell me what was happening. I of course, said I would come straight down to the hospital and would go with my mother to Q.A.

When the ambulance men arrived, one enquired why my mother had mattresses on the floor and not on a bed. To this Michelle replied "hospital policy" with no other explanation. When the ambulance crew asked how she might have broken her hip, they were told by Michelle it was a fall. They tried to find out what type of fall but were told by Michelle a fall is a fall, where I replied that I believed she had fallen to the ground from a standing position, I could not understand her reaction to what seamed reasonable questions.

Once the ambulance crew realised the extent of my mother's condition and what would be needed to lift her up onto the trolley, without causing her any more discomfort than necessary, they produced a winch. The putting on of the harness was taken over by the nursing staff, Michelle being one of them. First of all they had the harness twisted, someone mentioned this to Michelle, so then this was rectified, but they still could not get it right until it was finally noticed the harness was in fact UPSIDE DOWN. Michelle appeared to me to be in charge of the whole operation, but showed lack of training of how to use the winch competently, causing discomfort to my mother because the processes took far too long.

The second occasion was Saturday 2nd October 2004. My husband and I were holidaying abroad in Spain. On Friday my daughter informed me that Clinical Notice was given, and that I should make my way back. We were over 1,200 miles from home. We travelled by road all day Friday, stopping at night around 9.30 pm, after driving almost 600 miles. Saturday we set off early at 8 am for the final day of our journey.

We were getting close to home, and I was originally going to go home first, then ring the hospital to ask of my mother's condition and then hopefully see her for myself, as I was concerned for her and wanted to see her and let her know I was home.

When we reached Fareham, it was getting late and I did not want to waste time going home to Stubbington, so I asked my husband to drive us directly to Gosport.

We reached the hospital around 10.00 pm. late I know for normal visiting, but I felt this was not normal circumstances and knowing that my mother was in a room on her own thought the staff would understand and allow a short visit, just to put my mind at rest.

My husband and I gained access to the ward with the alarm ringing for a short time to alert staff that the door had been opened; we walked down the ward towards the ward office, when we noticed a member of staff walking towards us from one of the rooms to the left opposite the office. We asked if we could speak to the person in charge, to inform them of our wishes to see mum.

Michelle appeared from a room behind us, asking the other member of staff who was it? She was told it was visitors. "Visitors" she said "We do no have visiting at this time of night" to which I replied, I realised that that was normally the case, but I was Irene Hoares' daughter, "I know who you are" she interrupted, before I could explain further. "You have thirty seconds to see her"; she said pointing down the corridor towards my mother's room.

She spoke in such an off hand manor, I put up my hand to stop her continuing her remonstrating and fighting back the tears, I turned to walk out the ward, telling her I would came back on Sunday. Yes she replied angrily, go and come back tomorrow. With that we left.

I could not sleep that night, going over what had been said and how it was said, and over and over again thinking if anything should happen during that night to my mother I would never be able to forgive this awful woman.

The reason I make this complaint is because on two occasions now, I have heard the sharpness of this persons' tongue, both times to people who could defend themselves, but she is caring for people who are vulnerable, if she treats them badly, they may not be as able to complain, and so it will continue.

Yours sincerely

Code A

P S Ramsden.

Code A

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App 2

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ELDERLY MENTAL HEALTH SERVICES

Interview Notes Regarding Complaint of Nursing Practices
Statement Given By: Mrs Ramsden, 4th November 2004

Introduction and details of my role as Investigating Officer.

Q1. Can you tell me what happened on 27th August 2004?

Mum had a fall. I received a telephone call telling us about the fall saying she was going to QAH for an x-ray.

Q2. Who contacted you?

Sarah was there. I think it was Sarah who phoned.

Please continue?

The fall happened prior to the call but mother was showing increased pain, so I said I would go down and go in the ambulance with her. I was told that was fine if that was what I wanted to do. They had called the ambulance already and the ambulance would be within a certain time. I arrived half an hour before the ambulance.

Q3. How were you greeted?

Sarah greeted me explaining not really sure if mum had fractured her hip, being cautious. I was fine with that

Q4. Then what happened?

I was with mum who was in bed when they arrived. It was pointed out that mum had a suspected fracture.

Q5. Who arrived?

The ambulance crew.

Staff introduced me as her daughter, explaining that I was going with her.

Q6. Who introduced you to the ambulance crew?

I can't remember. I'm sure it was Sarah.

Sarah went to do the appropriate paperwork. Michelle was there with two other nurses (HCSW).

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Q7. What happened next?

The ambulance crew was standing in the corridor; mum was on the floor being nursed as agreed at family meeting. Then the ambulance crew stated why was the patient on the floor and the answer he was given was "hospital policy".

Q8. Who said that?

It was Michelle who said that.

Q9. Carry on?

My husband and I felt that this was said sarcastically. It didn't give any answer. The ambulance crew looked as if to say 'what does that mean?'

Mr R: *I had the impression the ambulance crew were not going to be given the option of helping to get my mother off the floor on to the stretcher.*

Mrs R: *The ambulance crew asked what the matter was and Michelle said it was a possible fractured arm, but I knew her arm was ok. They thought it was possible fracture of arm but the doctor had come back to me and confirmed the arm was not fractured, but Michelle didn't seem to know this. Then Michelle said possible fracture arm and hip.*

Once ambulance crew had been told it was a fractured hip, crew asked how did this happen and Michelle said, "It was a fall". He asked what type of fall and she said, "a fall is a fall is a fall".

I again felt that this was very uninformative. None of this had anything to do with me; I was just observing what went on between the ambulance crew and Michelle. I felt that she was very rude to the ambulance crew. It was surprising the way she spoke to them as I felt the questions were not unreasonable that they asked.

Q10. What would you say her attitude was?

Very off hand.

Q11. Tell me about the hoist?

The hoist was brought in and the ambulance crew assisted. The ambulance crew asked how we were going to get her up.

The room mum was in is small and there were quite a few people in there. 2 nurses and Michelle, myself, the bed and mum. Ambulance crew looking on.

Michelle and the other nurse were in charge.

Q12. Do you know the name of the other nurse?

No, I don't.

Q13. Please continue?

They started to slide the harness underneath mum to get it around mum, but the nurse and Michelle got it twisted. They were pulling and shoving to try and get the harness underneath mum.

Q14. Did this cause pain to your mother?

Oh yes because they were pulling and pushing as they had it twisted. It was causing more pushing and pulling then was necessary if they got it right in the first place. It was the other nurse who noticed this was twisted and told Michelle.

They pulled the harness out and slid it back under mum to fit it correctly. They still couldn't get it right, then the penny dropped. It was upside down! So they had to take it out again, third time lucky, they got it right. The ambulance crew looked at me and raised his eyebrows.

Q15. How long did it take to get the hoist correct?

About 10 minutes, even longer, about 3 times longer than it should have done.

Q16. Did the ambulance crew help?

No, they weren't going to get involved.

Q17. Please continue?

Once on the trolley they wheeled her down and ~~Mr R~~ I explained why she was going to hospital. Code A 21/10/04

When Michelle said, "a fall is a fall", I interjected and told the ambulance crew I thought she had fallen from the standing position and that her legs had given way and fallen to the ground. I felt Michelle's' reply was not very helpful.

Mr R said that Sarah had the details waiting at the office as mother was being wheeled out and then the ambulance crew asked Sarah about taking the drugs. Sarah said that she had given her drugs for tonight. The ambulance crew said they needed all of them. Sarah went and got them.

When we were in the ambulance, the ambulance man said he was not impressed with Michelle's attitude towards them.

Q18. Can you tell me about the attitude of staff on 2nd October 2004?

After mum had the fall, no hip broken, mum took to her bed. She didn't want to get up. Mum hasn't got up since the incident in August. Don't know whether the trauma caused a next step. She had a rapid decline.

We had booked to go on holiday for two months from September to October. I had spoken to Lesley about my concerns and should I go on holiday. Lesley said I needed a break and to go for a fortnight. She explained about clinical notice and what it meant. I was reassured that I should go. I had decided to come home beginning of October.

On 1st October we had started to come back, when my daughter text me a message "Please ring me". Mr R knew it was something about mum. I rang my daughter to find out what it was and she told me that mum had been put on clinical notice. It was early afternoon. We started to make our journey directly home instead of taking a more leisurely route. We travelled all day until 9pm. Telephoned my daughter at about 9pm to find out how mum was and to let her know where we stopped, so my daughter gave me the impression we could go in at any time and so was I given the impression.

We started out next morning and got straight on the ferry in the afternoon. Rang my daughter in England and decided to go home, ring the hospital to see how mum was. We got into Fareham later than expected; it was getting on for 10pm. I had been sitting thinking what I was going to do, I just wanted to see my mum and tell her that I was home, as I had not seen her for a month. I made the decision that I just wanted to go and see mum and not go home first. I didn't think it would be a problem. It was raised at the family meeting.

Q19. What time did you arrive on the ward?

I don't really know. It was 10ish.

Mr R saw the doorman who queried whether we had rung the ward first, but ~~they~~ We explained that we had just come back from holiday and that my mum was very poorly and explained that I was sure it would be all right. He did say we should have let them know. PSR read. 21/11/04

Q20. Did the doorman ring the ward?

No, he couldn't have. On hindsight I would have asked him to let them know.

So the doorman let us in. My daughter let me know we were not to go through Ark Royal. We pressed the button and the alarm went off.

Q21. What happened then?

We went into the ward. Nobody had seen us come in and I knew mum was in a room on her own. I wouldn't have gone in if she had been on the ward.

PSR. opposite

We were making our way to the office to find the nurses. We couldn't see any staff around. As we were walking to the office a younger nurse was coming out of one of the rooms ~~by~~ the office. She said, "hello, can I help you?". I explained I was Mrs IH's daughter and could I speak to someone in charge. It was quiet.

Michelle was in a sideroom. Michelle came out behind us and said to the younger nurse "Who were you talking to?" and the younger nurse replied "visitors".

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Q22. Do you know the nurse's name?

No. I haven't seen her before.

Q23. Please continue?

Michelle said "visitors? we don't have visitors at this time of night".

I said that I did appreciate that, but that I was IH's daughter and I was just about to explain whey we were there. Michelle said, "I know who you are, I know all about you". She stood in the doorway and pointed down the end of the corridor. She said, "you have 30 seconds, that's all I am going to give you. I don't have visitors this time of night". Mr R said she muttered about only two of them on.

Q24. How did you feel about the way she spoke to you?

I was upset. Mr R said he was shocked that someone would speak to us that way. If she had nicely explained I could have understood.

I just put my hand up and said, "It doesn't matter, I will come back tomorrow" and she said, "Yes, good, come back tomorrow".

Q25. Who said that?

Michelle.

Q26. Where there any other witnesses?

The other nurse was there the whole time. She was young. She looked embarrassed.

We went to the door, we couldn't get out. The young nurse came up to let us out and I said to her how disappointed I was not to see my mum and that I have travelled over six hundred miles. I just wanted to see my mum. The young nurse didn't say anything and she said "goodnight".

Mum Code A 21/11/04

21/11/04 all night

I wanted to talk to Michelle to discuss how much was and of course I couldn't do that. I had another night of wondering. It was only the day before she was put on clinical notice. I just wanted to find out how my mum was. I didn't get to see my mum, I was lying there thinking, if my mum dies, I will never forgive that woman.

I left it til 8.30am to ring, as I didn't know what time the night shift left and I didn't want to speak to that woman. I didn't think it was unreasonable to go in under the circumstances and I was happy to explain why I had gone in.

I spoke to *Lesley Merry* ~~had said that either they or I had made a complaint~~ the next morning, she asked if it was me who called in the previous night (so would I mind) making a statement as I had said that it wasn't the first time Michelle had been rude. and told Lesley about the previous incident with the ambulance crew, she said there was a complaint made about that incident * Code A 21/11/04.

Signed: .. Code A **..... (Mrs Ramsden) Dated: .....** 21/11/04 **.....**

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ELDERLY MENTAL HEALTH SERVICES

Interview Notes Regarding Complaint of Nursing Practices
Statement Given By: Trevor Jones, 25th November 2004

Introduction and details of my role as Investigating Officer.

Q1. Regarding the fall and the use of the hoist on 27th August 2004. Were you there when the ambulance crew arrived?

I was on the ward.

Q2. Did you witness any exchange of information between MC and the ambulance crew?

No.

Q3. Were you involved in moving the patient onto the hoist?

No.

Q4. Can you tell me what happened?

The ambulance men came in the bedroom opposite the old nursing station. The ambulance crew came in and 3 nurses went in with them. I was dealign with other patients. I couldn't see anything as their were several people in the door way.

Q5. Could you hear what went on?

No, I wasn't really listening as I was talking to other patients.

Q6. Do you know who the three nurses were?

No, sorry I couldn't tell you.

Q7. Do you know why the patient was being nursed on the floor.

Only that the patient had a suspected fracture. There was no way we would move her as she was in pain.

Q8. If you couldn't use the hosit to lift the patient, how would you get her up?

We would have to lift her.

You would have to lift manually providing you couldn't get the strap under by turning IH.

Signed: Code A **(Trevor Jones) Dated:** 14/12/04

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App 4

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ELDERLY MENTAL HEALTH SERVICES

Interview Notes Regarding Complaint of Nursing Practices
Statement Given By: Pat Davies, 10th November 2004

Introduction and details of my role as Investigating Officer.

Q1. **Regarding the fall and the use of the hoist on 27th August 2004. Were you there when the ambulance crew arrived?**

I wasn't in the room, I was on the ward.

Q2. **Did you hear any exchange between Michelle and the ambulance crew?**

No, I didn't. I cannot remember.

Q3. **When were you called in?**

To help hoist Irene off the mattress to enable to get her on the trolley. Paramedics outside of room.

Q4. **Can you tell me what happened?**

It was very difficult; it is an odd shape room. We had to pull the mattress away from the room to get staff either side. Then brought the hoist in. IH had a suspected fracture we had to be very careful. I was the one by the wall. I had to cushion IH onto me while we tried to get the hoist under her.

Q5. **Who else was helping with the hoist?**

I can't remember, there was either 2 or 3 of us. I think Michelle was outside with paramedics. I really can't remember.

Q6. **What happened whilst using the hoist?**

I said in general, the hoist was the wrong way round and you had to reposition the sling. I knew we had a problem. I don't remember the sling getting twisted only that it was the wrong way up. I'm not sure if it was upside down or back to front, but I said a couple of times "This is the wrong way round."

Q7. **Did IH's daughter say anything about this?**

No, sorry, I really cannot remember.

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Q8. Why do you feel there was trouble with using the hoist?

I think with IH being poorly, we were trying to get the sling around her as quickly as possible to save any distress, but on this occasion perhaps there was too many staff trying to help.

Q9. Why was the patient being nursed on the floor?

Patient had series of falls and she was complaining of different aches and pains in parts of her body. It was discussed in the meeting for safety issues as the patient had quite a few nasty falls.

Q10. If you couldn't use the hoist, how would you have got the patient off the floor?

I really do not know. We couldn't have used a PAT slide.

Q11. Any protocols/procedures in place for this?

To be honest, I do not know.

Q12. Is there anything else relevant you would like to add?

I have always found Michelle helpful and good to me. She gets on with everyone. She is great wit the patients.

Signed: Code A ..... (Pat Davies) Dated: 27/11/09

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East Hampshire NHS
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ELDERLY MENTAL HEALTH SERVICES

Interview Notes Regarding Complaint of Nursing Practices
Statement Given By: Sarah Flowers Friday 10th December 2004

Introduction and details of my role as Investigating Officer.

Q1. Regarding the fall and the use of the hoist on 27th August, were you there when the ambulance crew arrive?

I was on the ward.

Q2. Did you help with the hoist?

No, I don't think I did. I went to get the paperwork together.

Q3. Can you tell me what happened?

It was at crossover time, I remember the ambulance crew coming in. I remember there being some concern because it wasn't sure if the hoist would hurt I.H. as she seemed to be in a lot of pain.

Q4. Can you remember who was involved with the use of the hoist?

No, I cannot remember who was on that day

Q5. Did you witness any conversation between M.C. and the ambulance crew?

Not that I can remember.

Q6. If the hoist couldn't be used to lift I.H. onto the trolley, how would she be moved?

I don't really know, you decide at that time.

Q7. Is there any Policy/Procedure for lifting patients from the floor?

I am not entirely sure, I know there are ways not to do it.

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Q8. Is there anything relevant you want to add?

No. As far as I remember I was doing the paperwork, it was a long time ago.

Signed: ..... (Sarah Flowers) Dated: .....

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ELDERLY MENTAL HEALTH SERVICES

Interview Notes Regarding Complaint of Nursing Practices
Statement Given By: Maggie Suggett, Wednesday 8th December 2004

Introduction and details of my role as Investigating Officer.

Q1. **Can you tell me what happened on the 27th August 2004?**

M.C. was on duty. It was late. I.H. was being nursed on the floor as she was a big risk for falling. The ambulance crew had arrived. It was how we were going to get I.H. onto the hoist as she was in so much pain. We couldn't use a PAT slide because of the mattress she was on. It was a bit of a fiasco, but we did get her on to the stretcher.

Q2. **Can you tell me who was helping with the hoist?**

M.C., P.D., Y.B.

Q3. **Did you witness any conversation betweem M.C. and the ambulance crew?**

No. I felt that one ambulance crewmember was rude and had a bad attitude.

Q4. **Can you remember what went wrong using the hoist?**

I can't really remember. I don't know if we were using the correct sling. I.H. was in a lot of pain and I think we were just a bit panicky.

Q5. **Do you know how you would get I.H. up without a hoist?**

No, I don't.

Q6. **Is there a procedure to follow if a hoist cannot be used?**

No - I don't know.

Q7. **Is there anything else that might be relevant?**

It was a very stressful situation and the ambulance crew didn't help at all. You would think they could have given a little bit of help.

Q8. **Can you remember getting the hoist twisted?**

No.

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Q9. Put on back to front?

No, it just seemed we had the wrong sling. It was just that I.H. was in so much pain and we wanted to get her onto the stretcher as quickly as possible.

Signed: Code A ..... (Maggie Suggett) Dated: 30.12.04....

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ELDERLY MENTAL HEALTH SERVICES

Interview Notes Regarding Complaint of Nursing Practices
Statement Given By: Leanne Mulvihill, Wednesday 8th December 2004

Introduction and details of my role as Investigating Officer.

Q1. Can you tell me what happened on the 27th August 2004?

I.H. was being nursed on the floor as she had several falls and she was very poorly.

Q2. Were you there when the ambulance crew arrived?

Yes I was. As I am pregnant I didn't get involved as much as some staff.

Q3. Did you witness any conversation between M.C. and the ambulance crew?

I can't remember. I know what M.C. is like. She says what she thinks. She is quite forthcoming with her words but I don't remember any specifics.

Q4. Did you help at all with the hoist?

No, as she was being nursed on the floor, I didn't help. I was with the ambulance crew at the door.

Q5. Can you tell me what happened when the hoist sling was being used?

I.H. was in a lot of pain and she was crying out with pain and her family were quite concerned. I know it took a long time because of the mattress being on the floor.

Q6. How many staff were helping?

4 staff, including myself.

Q7. Please continue?

Under normal circumstances it wouldn't take 4 staff. Normal hoisting would normally be 2 people with 3rd person to assist.

Q8. If I.H. couldn't be got up using the hoist, how would she have got up onto a trolley?

I didn't think about it. That was one of the issues raised by the ambulance crew, as they are not trained to use hoists. PAT slide could not be used because of

different heights between trolley and mattress.

Q9. Who did the ambulance crew say this to?

It was a general statement stating that they were not there to do the manual handling. There were several people in the room, including her family.

Q10. Do you know of any policy/procedure for lifting patients who are being nursed on the floor?

Not that I am aware of. Usually the patients can help themselves to get themselves up. Patients are normally nursed on the floor if they are continual fall risks and cot sides cannot be used.

Q11. Is there anything else that might be relevant?

At the time I know there was an issue with ambulance crew. about nursing on the floor and the manual handling. I.H.'s family were quite concerned as she was crying out in pain.

Signed: ..... (Leanne Mulvihill) Dated: .....

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East Hampshire NHS
Primary Care Trust

ELDERLY MENTAL HEALTH SERVICES

Interview Notes Regarding Complaint of Nursing Practices
Statement Given By: Michelle Colbourn on Wednesday 15th December 2004

Introduction and details of my role as Investigating Officer.

Q1. What happened on 27th August 2004?

I.H. was being nursed continually on the floor because of risk of falls.

Q2. Can you remember anything that happened regarding the hoist?

I can remember vaguely the ambulance crew saying they wouldn't lift her from the floor because (a) you are not allowed to lift and (b) you couldn't lift off of the floor with the height of the trolley.

Q3. Do you know of any procedure if the hoist is not being used?

No, nothing at all. Only 2 hoists, one goes to the floor.

Q4. Can you remember anything that happened?

I can remember the ambulance crew being there, the daughter being there and the room was small. I can remember we had to physically lift the mattress up to get the hoist leg under it. There was a lot of pushing and shoving to get I.H. up.

Q5. Can you tell me what happened the night you were on duty, 2nd October?

There were only 2 of us on duty and a H.C.S.W. from the Agency who didn't know the ward. She usually worked on Haslar. We had 19 patients, 4 of them terminally ill, one being I.H. Ordinarily, I would do the drugs but I was having to help H.C.S.W. to get them ready and into bed. It got to about 10.25pm, one of the male patients had stripped off and urinated on the floor. I was in his room with the door blocked open. The H.C.S.W. had gone to get some clean pyjamas/sheets. When she came back, she had two people with her. It was I.H.'s daughter and husband, not that I recognised them at the time, as I was a little bit too stressed.

I was in the doorway with the naked client, trying to shield him with a towel and the H.C.S.W. said, "they have come to see their mum". I said, "you are joking, it is a bit too late to visit now" or words to that affect.

Q6. Were you informed at handover that Mr and Mrs Ramsden might visit?

No, nothing was said and the porter did not phone either. Just found people had turned up whilst I had a naked man standing behind me.

Q7. Please continue?

Then the daughter said, "I have travelled six hundred miles to get here". It was at that point I said, "Who is your mum then?"

Q8. What did Mr and Mrs Ramsden say?

He stood with his hands on his head and then he started to walk away.

She identified who her mum was. I can't remember if she said Irene or Mrs H.

All this time I had a patient trying to push past me whilst naked. He had no insight to his nakedness. I replied, "Oh, ok, you have got 30 seconds".

Q9. How did Mrs Ramsden react?

Emotionally she said, "forget it" and started to walk away. I wasn't going to go after her, the patient care came first. I sent the H.C.S.W. with them because they needed the code to get out.

Q10. How long were they on the ward for?

I only saw them while we had the altercation.

Q11. How long did the conversation last?

About a minute.

Q12. Please continue?

The H.C.S.W. let them out and came back. She said to me she is not happy at all. She pushed past me. I did try to explain there were only two of us on duty and she said, "If her mother dies, she will never forgive you".

Q13. Who said that?

Mrs H's daughter. ***I had to call her in the next night as I.H. was poorly. She deteriorated in her condition and Mr and Mrs Ramsden came in and they were fine, no mention of anything.***

On reflection I asked the H.C.S.W. what she would do. I.H. had her medication about 8..30pm and she was just starting to settle down. If I.H's. daughter had gone in it would have disturbed I.H's sleep pattern, which we were having trouble with.

Q14. If you hadn't been with a patient, would you have let Mrs Ramsden see her mum?

Possibly, but I do believe that at St. James Hospital or Queen Alexandra Hospital you wouldn't be able to just walk in. It is courtesy to ring and let the ward know someone is coming. Even the porter didn't ring.

Q15. Did you hear any alarm?

No, nothing at all. If we had heard that alarm, we would have round down the ward thinkingof the patients was trying to get out.

Q16. How many night staff are usually on duty?

It is usually 3. There are a lot of highly disturbed patients. We didn't even have a twilight nurse on duty.

There are patients wandering around naked and people wouldn't visit that late on the ward.

I do believe the whole situation arose because we were short staff and stressed out. We were trying to keep the dignity of a patient. I know we should have had the door closed, but we needed to listen out for the other patients.

Q17. Is there anything else relevant you would like to add?

It is relevant we were both agency and bank staff. There was no nurse who knew the ward, patients or relatives on duty.

Signed: .. Code A **(Michelle Colbourn) Dated: .....**

App 9

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East Hampshire NHS
Primary Care Trust

ELDERLY MENTAL HEALTH SERVICES

Interview Notes Regarding Complaint of Nursing Practices
Statement Given By: Natasha Ballard, Monday 6th December 2004

Introduction and details of my role as Investigating Officer.

Q1. Can you please describe what happened on the night of 2nd October 2004?

Michelle Colebourne and myself were dealing with one of the other residents. It was a male and I went off to get some sheets. As I came back, there were two relatives standing at the side room.

Q2. Who were the relatives?

I.H.'s daughter and husband.

Q3. Please continue?

The door was open, giving full view of everything that was going on in the room. I think it was about 10.30pm – 11pm. I said to Michelle there were relatives outside wanting to speak to her. She then closed the door.

Q4. Who?

Michelle.

Q5. Please continue?

Michelle came back out, it only seemed a few seconds then she had the discussion with them.

Q6. Who was the discussion with?

Michelle and I.H.'s daughter.

Q7. Were you present at the discussion?

I was, but I didn't get involved. Mrs Ramsden wanted to see her mum.

Q8. What was Michelle's reply?

It was very late to come visiting when other residents are in bed. Mrs Ramsden explained that she had been away and hadn't seen her mother and she was getting very upset. There was something said by I.H.'s daughter and Michelle replied "you can see her for a quick 10 minutes"

Q9. Did Mrs Ramsden go to see her mother?

No, she got very upset and walked out.

Q10. Why do you think she didn't see her mother?

Michelle was saying it was very late to visit. Mrs Ramsden said she would be back in the morning.

Q11. What was Michelle's reply?

I don't know. Mrs Ramsden stormed up the corridor. Michelle asked me to let her out.

Q12. What happened?

I let Mr and Mrs Ramsden out as Michelle gave me the code.

Q13. Did Mrs Ramsden say anything to you?

She said, "This is wrong, I should be allowed to see my mother". That was it, they both walked past me and went.

Q14. Do you feel that Mrs Ramsden was spoken to politely?

I wouldn't say polite. Michelle was annoyed that no one had let her know that relatives were on their way.

Q15. Please continue?

I was quite shocked on coming back from getting the sheets to find people standing there, especially as it is supposed to be a secure ward.

Q16. Is there anything else relevant you would like to tell me?

It is very hard to remember. I know the gentleman didn't say anything.

Q17. How long did this exchange take place?

Not long, it was a quick discussion and them Mr and Mrs Ramsden decided to leave.

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NB: *I can see where both were coming from, Mr and Mrs Ramsden wanting to visit I.H. but it is also supposed to be a safe environment for the patients. General hospitals have visiting times.*

Signed: Code A **(Natasha Ballard)** **Dated:** 10-12-04

App 15

PROFESSIONAL DOCUMENTATION

CLIENT/RESIDENT NAME... Irene Haone .....

DATE	W/R	SIGNATURE
26/8/04	Zopiclone PRN prescribed	
	Tamazepam and Mirtazipine stopped	
	Paracetamol Stopped, senna stopped	
	regular, changed to PRN	
	PRN Lorazepam stopped	sflowers
27/8/04	Complaining of pain in (L) hip.	
Pm Shift	Sought advise from senior	
20:30	nurse. Pnme care called	
	Advised by doctor to send	
	Irene to casualty. Daughter	
	informed. Casualty informed	
	Awaiting transport at time	
	of report. Daughter has come	
	in to accompany Irene to	
	QA.	sflowers
29.08.04	Due to pain on movement, asked	
	Irene if she mind having a catheter,	
	She gave her consent. 5/Day Size	
	10mls balloon	
	the catheter inserted. This is after	
	Short term awaiting for X-ray	
	on Thes Daughter to be informed.	[illegible]
29.08.04	Daughter Out with hubby, message	
	left with Sean.	[illegible]