

Mrs. L. Lack,

Code A

MM/BM/YJM

22nd September, 1998

4378

Dear Mrs. Lack,

I am writing further to my letter of 25th August, 1998 now that I have received the report from **Code A** who has been investigating all the matters you raised concerning the care provided for your mother, Mrs. G. Richards, prior to her death on Friday, 21st August, 1998.

I should like to reiterate how very sorry I am that your grief has been compounded by so many concerns, but that you for having taken the trouble to write, as this has resulted in a very thorough investigation, and given us the chance to explain and/or apologise for the problems you identified. It has also meant that staff have reviewed procedures and improvements are being implemented as a result.

I should like to respond to each of the points you made, using the numbering system from your notes.

1. At what time did Mrs. Richards fall?
She fell at 1330 on Thursday, 13th August, 1998 although there was no witness to the fall.
2. Who attended her?
She was attended by Staff Nurse Jenny Brewer and Health Care Support Worker Cook.
3. Who moved her and how?
Both members of staff did, using a hoist.

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4. After the fall

Your mother had been given medication prescribed by Dr. Barton, who was present on the ward just after her fall. I understand that it was not your wish for your mother to be given stronger medication because it made her drowsy.

5. Why was there such a delay in dealing with the consequences of the fall?

With the benefit of hindsight it is possible to assume that your mother's dislocation could have been identified much earlier and we can now only apologise for that delay if that was the case. It is notoriously difficult to establish degrees of pain or discomfort in dementia sufferers, but staff now recognise that more attention should have been paid to your mother's signs of discomfort, and your own expressed concerns about that.

6. Why no x-ray? Why no transfer?

These delays were a direct result of the failure to identify a problem earlier in the day - because the x-ray department at Gosport War Memorial Hospital only operates from 9 a.m. to 5 p.m. I understand that you did appreciate this when it was discussed with you on the Thursday evening, and agreed with the advice that it would be best to defer a transfer to Haslar until an x-ray based diagnosis had been made. The transfer to Haslar was organised as soon as possible after the situation had been confirmed by x-ray, on the morning of Friday, 14th August, 1998. It is a matter of great regret that this delay occurred, and we accept and apologise for the fact that the standard of care fell below that which we aim to provide.

7. Why when she was returned to bed from the ambulance was her position not checked?

When your mother arrived on the ward two health care support workers saw her into bed and then went to inform Staff Nurse Couchman that your mother had arrived. They had realised there was a problem and that professional advice was needed. Staff Nurse Couchman came and checked her position, and I believe you assisted her in straightening your mother's leg and placing a pillow between her legs.

8. (a) How was she brought from Haslar?

She was brought by an ambulance with two crew.

(b) Was there an escort/anyone in the back with her?

There was no nurse escort - this would have been arranged by Haslar had it been thought necessary.

(c) When did she start to show pain and what caused it?

The ambulance crew commented that she showed signs of being in pain as she was put into the ambulance. The cause of the pain has not been specifically identified.

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(d) Why was my request to see the x-rays denied?

The x-rays were seen in the x-ray department by the doctor and the consultant radiologist. The decision to keep x-rays in the department and not to send them to the ward rests with the consultant radiologist, not the ward staff, and your request may not have been relayed to the department.

(e) Decision to do nothing but provide pain relief?

Dr. Barton felt that the family had been involved at this stage as she discussed the situation fully with you. She made sure you were aware that the surgical intervention necessary for the haematoma would have required a general anaesthetic and clearly your mother was not well enough for such a procedure to be undertaken. Therefore, the priority, and only realistic option, was to keep her pain-free and allow her to die peacefully, with dignity.

9. Clothing sent for marking despite being named already

As a result of previous problems the ward have adopted the practice of marking all patients clothing with the ward name - a procedure designed to help, which on this occasion, did the absolute opposite. The laundry marker at Gosport War Memorial Hospital had broken down, so your mother's clothes were sent to St. Mary's Hospital and meanwhile she was given hospital clothing. In attempting to meet your completely reasonable request for her own clothes to be returned, a taxi was authorised which in the event brought the clothes back - still only bearing your mother's name. Whilst, as you say, this was a trivial problem on the scale of the real issues, it was a quite ridiculous consequence of a well-intentioned policy which served to cause unlooked for stress. The process is being reviewed as a result of your complaint.

All the staff concerned with the care of your mother were deeply saddened at her experience, and sincere apologise are proffered to you and your sister for the problems which occurred, and the failure of the service to meet your very reasonable expectations. The only constructive aspect I can identify is that lessons have been learned and the experience will benefit future patients, although I fully appreciate that such benefits have little relevance to yourselves.

You may be aware that your sister, Mrs. McKenzie, has telephoned Mrs. Hutchings as she wishes to see this correspondence. I am writing to her to confirm that it is personal to you, although, of course, I hope that you will feel able to share it with her. If you unable to do this then she will need to raise a complaint of her own.

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Should you wish to pursue the matter further my secretary would be very happy to arrange a meeting with Mrs. Barbara Robinson, Hospital Manager, at your convenience and I would be grateful if you could contact her on Code A within one month should you wish this.

Thank you once again for writing so comprehensively of your concerns.

Yours sincerely,

Max Millett
Chief Executive

Code A

Taken from original complaint investigation

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.

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.

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

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.

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.

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.

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, patients age and dementia. The Duty Doctor felt it would be too traumatic to transfer Mrs. Richards 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. 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.

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.

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. Baldacchino 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 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.

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.

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 reoccurrence. 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".

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.

When did dislocation occur, i.e. when she fell? or when hoist was used?- unable to define.

Once x-rays confirmed dislocation, transfer to Accident and Emergency at Haslar was arranged - as appropriate.

In view of Mrs. Richards' previous fracture I feel she should have been transferred to Haslar the night before and that S/N Brewer should have insisted on this when contacting the Duty Doctor. S/N Brewer did agree with the Doctor that transferring Mrs. Richards at that time, i.e. 8.30 p.m. - 9.00 p.m. would have been too traumatic for Mrs. Richards. You could argue, due to Mrs. Richards's dementia, would she have been aware of the time?

Haslar Hospital were responsible for organising transport to transfer Mrs. Richards back to Daedalus Ward. It appears they booked Main Line Ambulance Services who were not happy about transferring Mrs. Richards without a canvas to lie her on. Haslar apologised and gave them two sheets instead. The Ambulance Crew confirmed to the nursing staff that Mrs. Richards began crying/screaming immediately they put her into the ambulance. They were given instructions to keep her flat. This may have been the cause of Mrs. Richards' distress or pain due to the transfer from bed to trolley to bed at Daedalus.

A nurse escort did not accompany Mrs. Richards. Unable to confirm the position Mrs. Richards was in in the ambulance, but once in bed it was noted her leg was not straight but at an angle. This would have caused some considerable discomfort. Once her (right) leg was straightened, within a few minutes of arrival she stopped crying out.

Once further x-rays confirmed no further dislocation, medical, nursing and family were involved in making the decision of how to treat Mrs. Richards - in view of Mrs. Richards age of 91 years. Agreement was made that she must be kept free of pain, therefore syringe driver was put in situ to ensure continual pain relief, the outcome of which was explained fully to both daughters.

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's 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.

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.

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.

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.

Sadly, Mrs. Richards's 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.

Sadly, Mrs. Richards last few days and her death were not how her daughters had hoped her end would be, i.e. she did not regain consciousness and they felt they could not say "goodbye". The nursing staff were very aware of this and tried to involve the family as much as possible. Regarding the "trivia" part of the complaint, i.e. clothing being sent away for marking. It is policy on Daedalus Ward for all patient's clothing to be marked with the Ward name. This decision has been made in the light of complaints from relatives whose clothing has disappeared. This includes clothing of patients whose relatives agree to their laundry. It is a safeguard in case an article of clothing is put into the Hospital Laundry Bag by mistake. Unfortunately, at the time Mrs. Richards was admitted the marking machine at G.W.M.H. was broken so the laundry lady sent it to St. Mary's for marking but failed to inform the Ward of this. Steps have now been taken to ensure Wards are kept informed.

The nursing staff are sorry that this added to the stress the family were already suffering. As a result of this investigation an action plan will be recommended by myself to ensure we reduce the risk of further complaints of this nature.

RECOMMENDED ACTION PLAN (to be agreed with Service Manager)

1. Review agreed "policy" of medical consultant team not to transfer patients to Accident and Emergency, Haslar outside of working hours (i.e. G.W.M.H. X-Ray Dept.).
2. Review nursing records and documentation.
3. Further training on records and documentation for all staff.
4. Review marking of clothing "policy".

Code A

11/9/98