Portsmouth HealthCare NHS Trust
MEMORANDUM

From
Code A

BFR/svn

To
Dr Lord

Bill Hooper ✓
Nicky Pendleton
Dr Jane Barton
Lesley Humphrey

31 December 1998

Re; The Late Gladys Richards

Althea, I have discussed your points with Bill Hooper and he has asked me to reply to your letter to Code A The following is our response to your two comments;-

1 **"Review agreed "policy" of medical consultant team not to transfer patients to A & E, Haslar outside of working hours."**

As you quite rightly say there is no written policy to this effect. The use of the word "policy" was an unfortunate way of putting it. As you will know there is an unwritten agreement between Dr Barton and the staff that each patient is assessed as to whether it is in their best interests to be transferred to Haslar particularly if their prognosis is very poor.

On this particular occasion no doubt it would have been in Mrs Richards' best interests to have been transferred immediately and we agree that S/N Brewer should have insisted upon it.

Thank you for the clear instructions you have sent to the wards.

2 **Complaints Procedure**

It is our policy to send the appropriate consultant a copy of any complaint as soon as it is received. The Trust procedure is then followed and if the response includes any statements from medical staff they are shown the letter before it is sent out from Max Millett.

Please accept our sincere apologies for omitting to send you a copy of the original complaint in August '98. There is no explanation for the procedure failing on that occasion and we are really sorry that this has caused you to be unaware of what has turned out to be a serious complaint.

Please do not hesitate to contact me if you wish to discuss any of the above more fully or if you would like to talk about the policies and procedures at Gosport War Memorial which should be similar to those in the Dept of Elderly Medicine.

22nd December 98.

Dear Lesley, BCU

In addition to the 2 pages of the requested report on the late Gladys Richards I have 2 further comments to make, and would value a written reply to these from yourself, Barbara Robinson and Bill Hooper.

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 Department)" This statement is taken from Code A signed CONCLUSION of 11/9/98. Copy attached - *Note 2.*

This statement is false. I am the sole member of the medical consultant team for NHS Continuing Care at GWMH at present. Neither I or any of my predecessors have recommended such a policy. There is no written policy regarding transfer of patients to A & E at Haslar. If there is one as mentioned I would be grateful for a copy as I have not been able to find one either at QAH or Gosport. It is expected that anyone suspected of a fracture or dislocation is sent to the nearest A & E department and if there is a reason for not doing so this is documented in the notes.

Further I was not consulted about this complaint in August or September. Inspite of a statement that is an insult to my professional integrity I find out by chance on the 18th December - more than 3 months after it was written. Why?

At no point was either myself or the duty Consultant Geriatrician involved in making the decision not to transfer Mrs. Richards to Haslar on the night of 13/8. I attach a Memo (*Note 3*) that has gone out to Daedalus and Dryad wards, Dr. Jane Barton, Dr. A. Knapman so that appropriate action can be taken if similar events occur over the Christmas and New Year weekends. This memo contains temporary guidelines of what should be done in the event of a suspected fracture or dislocation and hasn't been agreed by the medical or nursing staff on Deadalus and Dryad wards yet. I will discuss this further with Code A and Consultant Colleagues so that a suitable policy could be circulated to all NHS Continuing Care Wards of the department.

2) There seems to be discrepancy in the way in which complaints are handled at QAH and GWMH. If there is a compliant on the acute ward at QAH Code A sends me a copy as soon as it arrives requesting a response and then sends me a copy of the final statement before it is sent out to the complainant. This is not the case in Gosport and I'm writing to request that the system that is and always has been operational in QAH is carried out in Gosport and hope that this will happen with immediate effect.

Sincerely,

Code A

Althea Lord
Consultant Geriatrician

copies:
Barbara Robinson
Bill Hooper
Nicky Pendleton

Note 2

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. Code A stayed with her mother until early evening and was asked if she felt her mother to be in pain. Code A did not feel her mother was. Code A 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.

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