16/6/00

Dear Barbara

I enclose copies of notes I have made regarding the statements from Code A and Code A Code A

I have shared these with Dr Barton and Dr Lord, and I am happy to discuss them further if you wish.

Yours Sincerely

Code A

Philip

General Notes

Throughout Mrs Richards admission, there was an air of dispute and disagreement, on a range of matter, between her two daughters.

Both daughters were given considerable, time, explanations, and support, including the opportunity to be involved in decisions regarding their mothers care often to the detriment of other patients and other duties we needed to perform.

Following the events from 11/8/98 to 13/8/98, and being aware that Code A was unhappy about aspects of her mothers care, as Clinical Manager I became closely involved in the care of Mrs Richards and her daughters, hence the frequency with which my name appears in nursing documentation and statements.

Throughout both periods of admission, we were aware of her daughters views and Code A intention to make a written complaint. Every effort was made to keep both daughters involved in decisions as they were made, and to keep them updated on their mothers condition. Nothing was kept from them, and Code A was afforded assistance with making her complaint.

Comments on Code A Statement

1. Page 6, Para 6

   Care was discussed with myself on 11/8/98. Aware that Code A felt agitation was wanting toilet and not pain, and that she did not want mother sedated. Information passed on. Mrs Richards was offered the toilet when agitated, still appeared in pain, and analgesia given as appropriate.

   Statement from SN C Joice shows analgesia omitted from am 12/8/98. Subsequent to this Mrs Richards did not sleep and had a poor night, and the following day had a fall. Balance between analgesia/sedation to keep pain free, and safe is a difficult one to achieve.

2. Page 6, para 7

   Mrs Richards was in pain, as would be expected having had a prosthetic hip. Analgesia was given to control pain.

3. Page 6, para 8

   A deterioration in a patients overall condition immediately following transfer is not unusual. Causes include the stress of transfer and adjusting to new surroundings and people. This would be more so were patients are confused.

   It can take anything from 3 to 10 days for a patient to settle in to the ward.

4. Page 7, para 1

   Mrs Richards was offered the toilet when calling out. Cause of shouting out was however determined to be pain, from her recently operated on hip.

5. Page 7, para 3

   Attempts were made to give Mrs Richards food and fluids. I would concur, this was not possible at times she was not rousable. Rehabilitation requires first that pain is controlled, and a mental state that can cope with instructions. Therefore our plan would have been to control Mrs Richards pain, and try to minimise her confusion, so that rehabilitation could be initiated.

6. Page 8, para 4

   This sounds like crossed wires, with a nurse (SN Brewer) trying to do more than one job at once. i.e. complete the drug round, and respond to a message she had been given that Mrs Richards daughter had reported she was in pain.

7. Page 8, para 9

   Mrs Richards was examined by an RGN (SN Brewer) soon after being found on the floor. At that point in time she reportedly was not in pain or distress, and there was no obvious injury. On reflection the injury should have been noticed, and acted upon earlier, but SN Brewer had a number of demands on her time, and would have needed to prioritise her work.

I would further not that on several occasions in the two days prior to the fall, Mrs Richards was observed to be in pain, and given analgesia, so this was not an obvious change in how she was presenting.

8. Page 9, para 5

   Mrs Richards was comfortable, but was not "deeply under"

9. Page 9, para 6

   Explanation given was in much greater depth. Told exactly what I planned to do in arranging the transfer, that member of staff would escort, enquired if daughters wish to travel in ambulance, that Haslar hoped to reduce dislocation with sedation, and transfer back to us, etc.

10. Page 9, para 9

    I would describe reduction under sedation as a procedure rather than an operation.

11. Page 10, para 5

    Prior to transfer back (I think late pm Fri 14th) Code A came to ward office and update myself and Dr Barton on her mothers condition, and that she would be transferred back soon. In view of previous events, I asked Code A quite openly, if she was happy for her mother to return to Daedalus Ward. Her response was a definite "Yes".

12. Page 10, para 9

Who said this? It was not identified in the hospitals complaint investigation, and I do not believe my staff would speak to a relative in the manner suggested.

This does not corelate with what Code A claims was said (point 6 in comments on Code A statement – page 5 para 7)

13. Page 11, para 4

    Admission to the ward occurred at a particularly busy time, with meals in progress, lunch time drug round, and staff writing up documentation, and preparing to hand over to the afternoon shift. Even so, the time frame for assessing and managing Mrs Richards pain was much shorter than is intimated.

    Mrs Richards was in distress when she arrived with us. She was promptly assess by SN Couchman, and repositioned, following which Dr Barton was contacted, by phone and X ray agreed (there was a delay in actually getting Xray form signed) and given analgesia. Seen by Dr Barton later (?3.30pm) when she was comfortable, and we were able to X-ray.

    The majority of my time that afternoon, was given over to managing Mrs Richards care, and communicating with her daughters.

14. Page 12, para 1

This was not passed on to us. But the option to refer back to Haslar would have been considered when deciding how to care for Mrs Richards.

15. Page 12, para 4

Who acknowledged something had happened? We were not aware of anything specific having happened to Mrs Richards.

16. Page 12, para 5

Code A at this point was insisting hef mothers hip had become dislocated. X-ray was organised primarily at her insistence.

17. Page 12, para 7

Time delay before Xray was 3 ½ hours, which was not excessive.

18. Page 12, para 10

Pain control at this point reducing, but not controlling, pain.

19. Page 12, para 10

Presence in Xray responded to in original complaint

20. Page 13, para 1

Rather than transfer straight back, it was better to control pain and observe over night. See if pain settled, and if not decide how to proceed the following morning.

21. Page 13, para 6

Mrs Richards overall condition could already be seen to be deteriorating at this point. Difficult to nurse because of her response to pain, not eating and drinking. Intention of using syringe driver was to manage pain, keeping Mrs Richards comfortable, and allow nursing needs to be met. Strong analgesia is know to depress respiration and consciousness, but side effects in this situation would have been outweighed by need for effective control.

22. Page 13, para 6

Administration of fluids during palliative care, is based on patients needs. Not normally given, as evidence suggest they cause increased pain, for not measurable benefit.

23. Page 13, para 7

Explained that purpose of syringe driver was to manage Mrs Richards pain, as was Code A wish, and allow nursing care to be given.

24. Page 14, para 4

Medical and Nursing view was that Mrs Richards condition was deteriorating markedly at this point, and that death was impending. Recovery and rehab would have needed a positive response to analgesia, ie. Lessening of pain and gradually

withdrawal of analgesia. As had been our expectation Mrs Richards condition worsened, and more effective pain control was required.

25. Page 14, para 4

Throughout my many discussions with Code A from 17/8/98 onwards, no request was made to me for her mother to be transferred back to Haslar.

26. Page 16, para 2

Incident report says Dr Briggs notified, and notes that he was contacted by telephone. This corresponds with what is written in the nursing documentation.

27. Page 16, para 3

This is an error in the investigation which has since been noted. Dr Barton was not on e the ward when or after Mrs Richards fell. Dr Lord was on the ward, carrying out a ward round, but was not asked to see Mrs Richards.

Same issue in Comments on Code A Statement 17 & 40

28. Page 16, para 5&6

Code A own statement indicates she was informed whilst visiting that her mother had been found on the floor, and was notified, by telephone, that evening that a possible dislocation had now been noted, and was advised of the planned action.

29. Page 16, para 8

RIDOR not available to me at this time. Fall from chair would be same level Fall on different levels refers to ladders, steps, fall from significant height etc.

30. Page 17, para 1

Mrs Richards was assessed to be in pain, hence analgesia was given.

31. Page 17, para 2

Balance of pain control without preventing mobility and intake of diet can be difficult to establish. At this time, amount of analgesia was to much.

When analgesia was not given from 12/8/98 Mrs Richards did not sleep overnight, and fell the following day.

32. Page 17, para 5

Its not unusual for the condition of patients admitted to GWMH to deteriorate rapidly. Where appropriate a doctor would be called to see patients if there condition changed. By writing that nursing staff may confirm death, nursing staff may, where a death is straightforward, confirm death, with the doctor attending to certify at a later time. It does not mean that we necessarily expect death to occur.

33. Page 17, para 7

See point 27

34. Page 17, para 8

Suggest nothing was done. But 0830 Fri 14/8/98, first time Dr Barton had seen Mrs Richards since fall (note point 27), immediately examined, arranged Xray, and subsequently arranged transfer to Haslar.

Code A kept informed and involved throughout, allowed to accompany to Xray.. Escorts arranged for Xray, and transfer, and checked daughter could get to Haslar.

35. Page 18, para 1

One 5mg dose of Oramorph (half previous dose used), had been given prior to Dr Barton seeing Mrs Richards at about 3.15pm. Note later that this had settled her, but was not completely controlling her pain.

36. Page 18, para 4

Mrs Richards was very chesty from 19/8/98. Introduction of hyoscine to the syringe driver would have relieved discomfort, and made chest infection less obvious.

37. Page 18, para 5

Although no written information in contact record. I had discussed care of Mrs Richards with her daughter, Code A including her concerns about strong analgesia. These were passed on in hand over.

A significant proportion of my time on that day was taken up organising cover, and patient care for the following day, which I knew was going to be busy.

38. Page 18, para 9

Daughter was informed by telephone, as indicated in nursing notes.

39. Page 18, para 10

The following action was taken: Examined, repositioned, Dr Barton notified and Xray agreed, analgesia given. This is all recorded in both Code A statement and medical and nursing notes.

I did little else but supervise the care of Mrs Richards throughout my shift.

40. Page 19, para 2.

Question needs to be referred to Haslar. Our responsibility for a patient commences after they have been transferred to a bed on the ward.

If requested we could have obtained a canvas and poles. This would have caused a delay in transfer, and we would have needed to assess whether more discomfort

would have been caused in placing Mrs Richards on a canvas, as we would have needed to roll her from side to side to do this

41. Page 19, para 3

Mrs Richards pain and distress was known and being responded to immediately she arrived on the ward, by SN Couchman, and myself. To not have it under control within 30 minutes would not have been unusual

42. Page 19, para 11

Full hygiene needs were met throughout Both periods of admission, although this has not been fully documented.

43. Page 19, para 12

Again agree nursing documentation is lacking. This was noted in PHT investigation of complaint, and acted upon. Mrs Richards was encouraged to eat and drink wherever possible. Pain, confusion, and level of consciousness were factors which made eating and drinking difficult or impossible on several occasions.

44. Page 20, para 4 & 5

We have acknowledged that nursing documentation relating to Mrs Richards care is deficient. In mitigation I would have to say, that Mrs Richards daughters demanded a large proportion of our time, in providing psychological support and general conversation. The time given to Mrs lack and Mrs Richards had a subsequent effect on the time we had available for other patients, and record keeping.

I personally worked an 8 day stretch, from 17/8/98, and finishing late on most shifts.

Comments on Code A Statement

1. Page 1, Para 3

   Note contradiction between statements as to whether Code A was, or was not, happy with her mothers Care at Glen Heathers.

2. Page 2, para 4

   Sure he was delighted!

3. Page 2, para 4

   Appropriate level of sedation may have prevented wandering and reduced risk of falls.

4. Page 3, para 5

   Do we know the outcome of this investigation?

5. Page 5, para 5

   Yes I would agree Mrs Richards was in pain at this time.

6. **Page 5, para 7**

   This does not corelate with what Code A claims was said (point 12 in comments on Code A statement – page 10 para 9)

7. Page 6, para 4

   Bed would have been moved from wall, and patient lifted across (in this case on a sheet) from stretcher to bed. I was not present during the transfer, but would not have expected patient to have been rolled onto the bed.

8. Page 7, para 1

   Mrs Richards was not given analgesia by injection at any time on Monday 17/8/98. Action taken was to check limb position. Contact Dr Barton and organise Xray, and give analgesia orally.

   Dose of oral analgesia given was Oramorph 5mg at 1300, further 5mg at ??, 5mg at 1645 and 10mg at 2030. Dosage and administration discussed and agreed with daughters.

9. Page 8, para 1

   I have no recollection of using the words Code A attributes to me, and this would not be a phrase I would normally use. I know I discussed pain control options with both daughters, and recall Code A being particularly opposed to the use of Diamorphine.

There was some difference of opinion between the two sisters. Code A was nominated as her mothers next of kin, and was my main point of contact. She was extremely insistent that her mum be kept pain free.

Oral analgesia was used throughout the afternoon, and prior to the end of my shift (2030) Mrs Richards pain was controlled to a level acceptable to her daughter Code A

10. Page 8, para 6

At this point Mrs Richards was still in considerable pain, despite intermittent oral analgesia being given, and her overall condition was poor, caring for hygiene needs was difficult. Reviewed by Dr Barton who prescribed analgesia to be given sub cutaneously.

Before commencing sub cutaneous administration analgesia, I spent time with Mrs Richards daughters, ensuring they were aware how poorly their mother was, and that we didn't think she would survive, and discussed the plan to administer analgesia subcutaneously.

In discussing the use of sub cutaneous Diamorphine I was very aware of Code A Code A previous objections, and was at great length to ensure they understood our aim was to control Mrs Richards pain, and allow nursing care to be given, and also made sure they were aware of the side effects of opiate analgesia (although I was aware both daughters were well informed about medications).

I was informed by one daughter (Code A I think) that they had spend a lot of time discussing their mothers care. Following this discussion, in which both daughters had the opportunity to ask questions, and put forward their views, I was happy that they agreed with giving sub cutaneous diamorphine, midazolam, and haliperidol.

I did not give an indication as to when Mrs Richards might die, as I would not have known this.

11. Page 10, para 2

On 19/8/00 Mrs Richards became chesty. Hyoscine was added to the syringe driver, to make her breathing more comfortable. This would have masked the signs o chest infection.

12. Page 10, para 6

See Dr Lords comments regarding fluids during palliative care.

Code A never raised this concern with me at any time. I find this strange as I spent a large portion of my time on duty during the period 17/8/98 to 21/8/98 with both daughters as they asked numerous questions, and talked about a great many issues, related and unrelated to their mothers care. Inparticular Code A had informed me of their intention to make a formal complaint, the contents of which she showed to me, and which I acted upon where I could, and assisted them

in forwarding for investigation where I could not. This complaint made no mention of fluids.

Had the issue of fluids been raised, it could have been discussed at the time, so that we could have agreed how to handle their concerns and act accordingly.

13. Page 15, para 3

See letter from Mrs S Hutchings. Complaint was specifically from Code A

It is my understanding that Code A and Code A were in dispute at this point in time.

14. Page 16, para 3

Every effort is made to reduce risk of accidents, but it is not possible to constantly observe all patients, as nurses may be called to other locations on the ward to provide care.

15. Page 16, para 4

Documentation say fall from chair took place in room 3. But placing patients in sitting room does not alter risk of falls. Patients in sitting room are observed regularly, and other patients will call nurses when confused patients try to get up.

16. Page 16, para 6

With no resident doctor, nursing staff would examine initially and if safe return patient to bed or chair. Doctor would be called unless nursing staff are completely confident that no injury has been sustained.

17. Page 17, para 1

This is an error in the investigation which has since been noted. Dr Barton was not on e the ward when or after Mrs Richards fell. Dr Lord was on the ward, carrying out a ward round, but was not asked to see Mrs Richards. (same point as in comments on Code A statement, point 27)

18. Page 17, para 3

I agree with this. It was highlighted in the investigation of Code A complaint, and has been acted upon.

19. Page 18, para 5

I would expect bruising following a dislocation and reduction, but beyond this had no explanation to offer.

My impression of both daughters at this time, was that they believed something had happened to their mother that they were not being told about. This was not the case. She was in pain, and we were exploring causes and attempting to resolve, but there was nothing we were keeping from the family.

20. Page 18, para 6

At this point in time I was not aware Mrs Richards was transferred using a sheet. I would agreed that this is not normal practice, a canvas and/or patslide being the normal method used. However I do not believe a transfer using a sheet would in itself have resulted in the pain & distress Mrs Richards was experiencing.

21. Page 18, para 6

Mrs Richards would have been lifted, and not rolled.

SN Couchman attended Mrs Richards immediately she was made aware she was in pain. See Code A statement Page 6, para 4 & 5

22. Page 19, para 1

We already knew Mrs Richards, and where aware that she could become agitated, and that she had recently had a procedure which could result in some pain. It is also relatively common for patients to be unsettled and/or in pain when transferred to us.

In these circumstances it was no unexpected Mrs Richards was in pain on arrival on the ward, and would normal to allow time for her to settle, and to look at what is causing the pain.

23. Page 19, para 3

Daughters had been seen by Dr Barton Mon 17/8 and discussed surgical intervention. See Code A statement page 8, para 3 & 4

24. Page 19, para 4

Daughters were informed that bruising was the cause of the pain following Xray on Monday afternoon.

25. Page 21, para 1

Analgesia was given to manage pain.

26. Page 21, para 1

Because she was in pain

27. Page 21, para 4

Confusion and deafness are easily differentiated by experienced medical and nursing staff. Mrs Richards was most definitely confused, although her poor hearing and eyesight may have added to her confusion.

28. Page 21, para 5

The annotation "Happy for nursing staff to confirm death", is used routinely were a deterioration of a patients condition is felt a possibility. It does not mean a patient is expected to die, but that it is something which might occur, given the patients overall condition.

It allows some discretion as to when a doctor might need to be called, should a

patients condition worsen, but does not prevent a doctor being called, where it is felt appropriate.

29. Page 22, para 1

No assumption, but a recognition that it was a possible event, should Mrs Richards condition change.

30. Page 22, para 2

Where did Code A get the notion of discharge to another hospital? Had we been able to rehab Mrs Richards discharge would have been to a Nursing Home.

31. Page 22, para 2

I find this a very odd thing to say given the number of extremely difficult patients we have/are managing, and have successfully rehabilitated and discharged.

32. Page 22, para 3

This would be an appropriate question to ask. It would be negligent to arrange transfer, without first considering whether the patient was fit enough for the journey, and procedure.

33. Page 22, para 4

I was present when the daughters were seen by Dr Barton. I would agree that she saw them only briefly (I believe she needed to return to carry out a surgery), but the daughters did have the opportunity to comment or ask questions if they wished.

If it had been requested I could also have arranged for Dr Barton to return later and see the family later that day, or any subsequent time.

34. Page 22, para 5

I was witness to Dr Barton writing in the medical notes, on the dates and times they are recorded as having been made.

35. Page 23, para 1

Responses due to deafness and dementia are very different. Mrs Richards was confusion not deafness

36. Page 23, para 2

Clearly one of these times is incorrect. I believe the ward round was in progress when the fall occurred, which would place the event on or after 1330, and mean that the 1300 time is incorrect.

This is a straightforward administrative error, as can occur when nurses are busy, as was the case on this day.

37. Page 23, para 2

Mrs Richards was examined by SN Brewer before being hoisted back into a chair. Question already asked and answered. In points 16 & 17 and comments on Code A statement point 27

38. Page 23, para 3

Need to ask SN Brewer why this was done. Errors should be scored through, and rewritten, so that the original error is clear to see. Or corrected by writing and amendment.

39. Page 23, para 4

Investigation by Mrs Hutchings says there was a policy not to transfer patients out of working hours. This is incorrect.

The decision as whether or not to transfer patients out of hours, is made on an individual basis, taking into account the problem and the patients overall condition and needs

The decision not transfer at night in this instance was taken by Dr Brigg, based on information supplied by SN Brewer, and Code A was informed of the decision at the time.

40. Page 23, para 5

See point 17 & Code A point 27

41. Page 23, para 5

I agree it would have been better all round if the dislocation had been recognised earlier in the day.

Once recognised Mrs Richards was not in any pain or distress, and the nursing records indicate she slept well overnight.

42. Page 23, para 5

See point 40

Dr Barton first aware of the fall and likely dislocation 0830 Fri 14/8/98. At which time she was immediately examined, and Xray followed by transfer to Haslar organised, Dr Lord notified, and Code A seen.

43. Page 24, para 1

Told by who? All subsequent nursing actions, as noted in nursing and medical notes and both daughters statements, indicate nursing staff were aware of Mrs Richards pain and taking steps to manage it.

44. Page 24, para 2

Comment regarding transfer on sheet has been added, with it being clear that this is the case. This is not unusual if further information needs to be added after

something has already been written. Nurses were trying to juggle completing documentation and providing care.

45. Page 24, para 3

115 is the time at which I made my entry into the records, having earlier spoken to the daughters, and before actually setting up the syringe driver.

46. Page 24, para 4

Subcutaneous analgesia was the most effective method of managing Mrs Richards pain, and allowing nursing care to be given. The term kindest is not something I would have said.

47. Page 24, para 5

See point 12

48. Page 25, para 3

Fall occurred in room 3

49. Page 25, para 5

Was aware from transfer letters that Mrs Richards condition deteriorated following transfer to us.

The process of transfer often has detrimental effect on patients. In most (but not all) instances, once the patient has settled in, which may take 1 to 10 days, they are okay.

Regardless of how a patient might have been prior to transfer, their care and treatment has to be based on how they present when the are with us.

50. Page 26, para 5

Mrs Richards was reviewed daily, via a report. Not specifically seen unless there are concerns.

51. Page 26, para 7

Usual for nursing staff to confirm death, where it is expected. Seen by Doctor next working day, to certify and issue certificate.

52. Page 26, para 7

Daughter and niece allowed to lay out Mrs Richards at their request.

53.