Dear Lesley,

I hope these responses are adequate. I do have more detailed documentation if necessary. I shall be on annual leave from 14th September for two weeks. Mrs. Barbara Robinson is aware of this investigation and will be e sent a copy of it and my report sometime next week.

I will be in my office until 4.30 p.m. at St. Christopher's today.

Lesley - do you recall our telephone conversation earlier this week following a telephone call I received from Mrs. Richards other daughter, Code A asking for a copy of our response to her sister's complaint? There is obviously very serious problems between her and her sister which they are now trying to involve us (this was a problem for nursing staff when they were present). Code A did raise the question why her mother was not given fluids during her last few days of life. I have asked the Clinical Manager this question who confirmed that neither of the daughters raised this as an issue at the time. They were told that if their mother "woke up" they could give her fluids. She was given oral mouth care by nursing staff, although they could not complete this as the daughters would not allow them to remove Mrs. Richards' false teeth!

It is not usual to "actively" feed patients who are unconscious and dying, although if this process went on for too long intravenous fluids or sub-cutaneous fluids may be considered. These decisions are always made in consultation with the family if the situation arises or if the family raise the question themselves.

Are you happy to respond to Code A on this point and explain why she will not receive a copy of your response? Her address is below.

I apologise if this seem to be very "wordy".

Many thanks.

Sue Hutchings
Senior Nurse Co-ordinator

Code A

COMPLAINT MADE BY Code A RE STANDARDS OF CARE FOR HER LATE MOTHER MRS. GLADYS RICHARDS WHILST A PATIENT ON DAEDALUS WARD - G.W.M.H. FROM 11.08.98 TO 14.08.98 AND 17.08.98 TO 21.08.98

1. At what time did Mrs. Richards fall?
   Answer - 1330 hours on 13.08.98.

2. Who attended to her?
   Answer - S/N Jenny Brewer and H.C.S.W. Cook

3. Who moved her and how?
   Answer - S/N Jenny Brewer and H.C.S.W. Cook using a hoist.

4. No direct questions asked. Statement only. There is some question regarding accuracy of this statement:-

   Response (a) There was only one trained nurse on duty after 3.30 p.m.and prior to this the second Staff Nurse was completing consultant round. There fore would not have been available to speak to Code A (she states several trained nurses). Trained staff confirmed they would not have said it was Mrs. Richards dementia causing her to cry out; she had been given medication prescribed by Dr. Barton who was present on the Ward just after Mrs. Richards' fall. She was not given the stronger medication because Code A had previously requested that it was not to be administered as it made her Mother very drowsy.

   S/N Brewer did see Code A and gave her full details of the fall and the following actions that had been taken (statement by S/N Brewer attached).

5. Why the delay in x-raying Mrs. Richards?
   Answer - Code A was telephoned and informed once dislocation was suspected and informed of the Doctor's advise, to which she agreed. This included not transferring her Mother immediately to Haslar.

6. Why no medical examination? Why no x-ray? Why no transfer?
   Answer - Duty Doctor was given the full facts of the situation including Mrs. Richards' diagnosis and her age. He stated he felt it would be too traumatic to transfer to Haslar for x-ray at that time of the evening and the journey could cause considerable distress. He advised medication, i.e. Oramorphine (strong pain relief) and to arrange for x-ray the following morning. S/N Brewer agreed with this as did Code A when she was informed.

   Why no x-ray?
   X-ray at G.W.M.H only operational up to 5.00 p.m. Monday to Friday.

   Why no transfer?
   As above.

7. When returned from Haslar from the ambulance, was Mrs. Richards' position not checked?
   Answer - Her position was checked by an H.C.S.W. who immediately went to find a trained nurse and asked her to look at the position of Mrs. Richards' leg. Due to the considerable noise Mrs. Richards was making and, being untrained, she decided not to attempt to move Mrs. Richards herself.

8 (a) How was Mrs. Richards brought from Haslar Hospital?
Answer - By ambulance and two crew. She was not escorted by a Nurse, this would have been the responsibility of Haslar Hospital to arrange.

(b) When did she start to show pain? What caused it?
Answer - Ambulance Crew commented to nursing staff she began screaming as soon as she was put into the ambulance and continued throughout the journey and on Daedalus Ward. The cause of the pain cannot be confirmed, but we do know Haslar Hospital were unable to provide an appropriate canvas to transport Mrs. Richards on. Two sheets were used instead. This did mean Mrs. Richards' limb was not supported as well as it would have been on a canvas when moved from bed to trolley to ambulance to trolley to bed on Daedalus Ward. This **may** have caused the pain.

8 (c) Request to see x-rays denied?
Answer - This was a decision made by individual radiologist. The Ward Staff are unable to influence their decisions. The x-rays Code A refers to did not come back to the Ward, they were seen in the Department by the Doctor and Consultant Radiologist.

8 (d) Decision made to do nothing but allow Mrs. Richards to die pain-free?
Answer - Dr. Barton did see Code A and involve her in the decision making process. Due to Mrs. Richards' age she would not be able to have surgical intervention for the Haematoma as this would involve general anaesthetic. Therefore, the priority was to keep her pain-free and allow a peaceful death with dignity.

TRIVIAL CONCERNS RE CLOTHING/LAUNDRY

1. Clothing sent for marking despite Cash's name on all items of clothing?
   Answer - All patients/relatives are informed on admission that to safeguard their belongings, clothing is marked with the name of the Ward. This includes clothing of patients whose relatives agree to do the laundry. This decision has been made on Daedalus Ward following several complaints from patients/relatives whose clothing was sent off to the Hospital Laundry by mistake and often never seen again.

Obviously, while Mrs. Richards' clothing had been sent for marking she was given hospital clothing to wear. This should have only been for a day or two. Unfortunately, unbeknown to Ward Staff, G.W.M.H.'s Laundry Marker had broken down so Mrs. Richards' clothing was sent to St. Mary's Hospital for marking. The Ward were not informed of this and, due to Code A stress at this time, a taxi was authorised to goand collect the clothing and return it to Daedalus Ward.

2. I have not been able to confirm if any Staff Nurse made any comment regarding getting Mrs. Richards up when she was so obviously near to death. I would find difficulty in believing any member of staff, either trained or untrained, would make such a comment.

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, Code A. She was admitted by Enrolled Nurse Pulford and Code A 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 Code A 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 Code A

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. Richrds to be put back into a safer chair using a hoist.

Code A 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 Code A and informed her of the fall, explaining she did not know how she fell but reassured Code A she had checked her mother before moving her. At this point S/N Brewer asked Code A if she thought her mother to be in pain. Code A 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.

Code A 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 Code A 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 Code A X-ray confirmed dislocation of (right) hip. Code A 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 (Code A 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 Code A arrived. S/N Couchman walked into the room and pulled back the covers and realised the leg was not positioned correctly. Code A 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. Code A 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.

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 Code A and her sister, Code A 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 Code A 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 Code A 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.

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

Statement by S.N J Brewer

Re: Mrs Gladys Richards - Patient Room 3 Daedalus Ward
Gosport War Memorial Hospital

On Monday 13th August 1998 I reported at 12.15 for duty on Daedalus Ward for a late shift. From 15.30 hrs I would be the Nurse-in-Charge when S.N Joice went off duty the only RGN on duty for that shift.

On passing the office door I noted that Mrs Richards who was in the room next door was agitated and calling out. I asked the Support Workers who were serving the dinner at the time to investigate the reason and to maybe try comoding her or change her position. Mrs Richards was sitting in a chair by her bed, she was commoded and then sat back in the chair.
During report I was briefed on the two new patients who had just arrived and about information for Dr Lord for the Stroke Round also generally any changes to other patients care.

During the report Mrs Richards continued to be agitated even though she had taken her diet and been made comfortable and checked for pain. Dr Barton had arrived to clerk in the new patients and was informed of the situation, she prescribed a p.r.n dose of haloperidol 0.5 mls as a backup to the b.d doses already prescribed. Mrs Richards was also written up for oramorph 5 mg - 10 mg p.r.n but her daughter had previously requested that this was not administered as it made her Mother very drowsy.

After report I proceeded to do the Drug Round and at 13.00 hrs administered the dose of haloperidol to Mrs Richards. On completion of the Drug Round at 13.30 hrs I was returning the trolley to the treatment room when I was informed that Mrs Richards was on the floor by HCSW Cook. This had happened in the space of 5 minutes as HCSW Cook had just attended to Mrs Richards.

I immediately checked Mrs Richard's on the floor. I straightened her legs and especially checked her Rt hip. The hip appeared to be correctly positioned I also checked for pain and Mrs Richards did not seem to have any at that time and did not seem to be too badly shaken by the incident.

My instinct would have been to put her to bed, but Mrs Richards daughter Code A had recently complained that the amount of time her Mother spent in bed did not complement her rehabilitation or quality of life.

I asked the Support Worker to find an alternative chair with a fixed tray in an attempt to make Mrs Richards safer. We then used the overhead hoist to position Mrs Richards in the chair.

At 14.00 hrs I commenced the Stroke Round because I was very busy I asked one of the Support Workers to document the incident on an Accident Form which I would later check and sign.

I commenced the Stroke Round with Dr Lord, S.N Joice was on duty for the Ward and I believe she was extremely busy.

I did not telephone Mrs Richards daughter about the accident as I knew she was due to visit and would rather tell her face to face.

I finished the Ward Round at approximately 16.50 hrs. I then had to interview relatives of new patients, one of whom was very ill. I also had to do the Drug Round, finish admitting the new patients and document the results of the round in the nursing notes. A very demanding schedule for which I had to prioritise the most essential work

At approximately 18.30 hrs I spoke to Mrs Richards daughter, whom I believe had arrived on the Ward late afternoon, I informed her that I had found her Mother on the floor at 13.30 hrs and apologised for the delay in informing her stating that I preferred to tell her in person. Code A Code A asked me in great depth about the type of fall and I explained that I could not tell how she fell, she may have slipped, I did not know, I related the circumstances and also how I had checked Mrs Richards. I asked Code A if her Mother was in pain, she said she did not seem to be, she was eating her tea. Later whilst I was finishing the Drug Round, Code A stated her Mother was in pain. I asked her if she wanted me to put her Mother to bed and check her, Code A said there was no rush, she would finish her visit and then we could put her to bed. Mrs Richards did not seem to be in pain.

We started to put other patients to bed and then I was called to a new patient who was choking on his own secretions it took until 19.30 hrs to settle this patient during that time Mrs Richards daughter left the Ward.

At 19.45 hrs I commenced to put Mrs Richards into bed. When she was lying on it I could see that her Rt hip was internally rotated and when moved caused her pain. At 20.00 hrs I telephoned the Duty Doctor, it was Dr Brigg.

I relayed the problem to him giving the age and diagnosis of Mrs Richards, I also stated that I suspected her hip was dislocated as it was internally rotated.

Dr Brigg judged that it would be too traumatic to transfer Mrs Richards so late at night, that it would be kinder to relieve the pain overnight and X-Ray her at the Gosport War Memorial Hospital when the department opened in the morning. I stated that she was prescribed oramorph and I would give her some. Dr Brigg also said that if there was a further problem we should contact him.

I felt this to be a satisfactory decision, remembering how disorientated Mrs Richards had been when first admitted possibly due to the transfer and her severe dementia.

S.N Florio had just arrived on the Ward for Night Duty and I was able to check a dose of oramorph 10 mg which we gave at 20.15 hrs. I asked her to observe Mrs Richards closely and to call the Doctor if she showed any sign of discomfort.

I telephoned Mrs Richards daughter at 20.30 hrs and told her that I felt her Mothers hip was dislocated and that I had contacted the Doctor, I conveyed his advice and informed her that I had given her Mother a dose of oramorph for the pain. I asked Mrs Richards daughter if she

was satisfied with this and she answered "Yes" and thanked me. I told her that I would keep her informed.

I gave report to the Night Staff and after documented in the nursing notes the report to the Doctor and the action advised. I documented on the Accident Form that I had informed Code A Code A of the accident but did not update the form further.

I left the Ward at 21.30 hrs as I had further paperwork to complete and Mrs Richards was sleeping comfortably.

On 14.8.98 I was a Day Off but came to the Ward at 06.30 hrs to deal with something unrelated to my ward work

My Ward Manager was due on at 07.30 hrs and I went to the Ward Office to convey the facts to him about Mrs Richards. Whilst I was there Mrs Richards daughter telephoned and I informed her that her Mother had spent a comfortable night which she had. I also told her that she would be X-Rayed as soon as the Department was open.

Dr Barton had arrived by then and was writing the Request Form.

I then went home. My Ward Manager later telephoned me and informed me that Mrs Richards had a dislocated hip and that she had gone to Haslar Hospital.

15.8.98 - I worked over the weekend - Mrs Richards was still at Haslar Hospital.
It was my day off on 17.8.98 and I believe that Mrs Richards returned to the Ward to Room 4.

I reported for duty at 12.15 am on 18.8.98 and took report. Mrs Richards was in bed and she had a syringe driver set up as she could not take oral analgesia. I was not in charge of the Ward on this shift.

As I commenced my work Mrs. Richards daughter stopped me in the corridor by the sluice. "What do you think of this" she said. "My Mother was walking at Haslar yesterday and now she's back here she's dying". I was distressed that she felt like this and politely tried to explain that I felt that all the coming and going from Haslar to Gosport had not done her frail mother's condition much good. Mrs Richards daughter just shrugged her shoulders and walked off.

I had no more contact with her after this day.

....Code A RGN.

S.N J Brewer RGN

9-9-98 ....Date

3

COMPLAINT MADE BY Code A RE STANDARDS OF CARE FOR HER LATE MOTHER MRS. GLADYS RICHARDS WHILST A PATIENT ON DAEDALUS WARD - G.W.M.H. FROM 11.08.98 TO 14.08.98 AND 17.08.98 TO 21.08.98

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4. No direct questions asked. Statement only. There is some question regarding accuracy of this statement:-

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   S/N Brewer did see Code A and gave her full details of the fall and the following actions that had been taken (statement by S/N Brewer attached).

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   Answer - Code A was telephoned and informed once dislocation was suspected and informed of the Doctor's advise, to which she agreed. This included not transferring her Mother immediately to Haslar.

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   Why no x-ray?
   X-ray at G.W.M.H only operational up to 5.00 p.m. Monday to Friday.

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   Answer - Her position was checked by an H.C.S.W. who immediately went to find a trained nurse and asked her to look at the position of Mrs. Richards' leg. Due to the considerable noise Mrs. Richards was making and, being untrained, she decided not to attempt to move Mrs. Richards herself.

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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. Richrds to be put back into a safer chair using a hoist.

Code A 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 Code A and informed her of the fall, explaining she did not know how she fell but reassured Code A she had checked her mother before moving her. At this point S/N Brewer asked Code A if she thought her mother to be in pain. Code A 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.

Code A 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 Code A 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 Code A X-ray confirmed dislocation of (right) hip. Code A 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 (Code A 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 Code A arrived. S/N Couchman walked into the room and pulled back the covers and realised the leg was not positioned correctly. Code A 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. Code A 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.

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 Code A and her sister, Code A 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 Code A 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 Code A 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.

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

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