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.

Investigation of Complaint made by Code A
Re: Standard of Care Received by her late Mother - Mrs Gladys Richards whilst Patient on Daedalus Ward Gosport War Memorial Hospital

Complaint made verbally to Lesley Humphrey - Director of Quality followed by written notes of events forwarded to myself on 21st August 1998.

Following discussion with Mr Bill Hooper - I was asked to commence investigation on 24th August 1998.

Commissioning Officer - Mr W Hooper
Investigating Officer - Mrs Sue Hutchings

Investigation commenced: 24th August 1998
Investigation completed: 11th September 1998

1. Background
2. Analysis of Events
3. Conclusion
4. Recommendations
5. Statements taken during the investigation
   - 5.1 S.N Margaret Couchman - September 3rd 1998
   - 5.2 S.N Jenny Brewer - September 3rd 1998
   - 5.3 Clinical Manager Philip Beed - September 8th 1998
   - 5.4 E.N Monica Pulford - September 8th 1998
   - 5.5 S.N Christine Joice - September 9th 1998
   - 5.6 Code A - September 10th 1998 (telephone statement) – withdrawn JMH

Other Documents

6. Accident Report Form
7. Riddor Form
8. Code A Notes

1. Background

Mrs Gladys Richards
D.O.B. 13.4.07
Died 21.8.98

Mrs Richards was admitted to Daedalus Ward Gosport War Memorial Hospital from Haslar Hospital on Tuesday 11th August 1998 following hemi-anthroplasty for fracture Rt neck of femur; this had been sustained as a result of a fall while Mrs Richards was a resident at Glen Heather's Nursing Home. Mrs Richards did suffer from degree of dementia but was walking with the aid of a zimmer frame and 2 nurses pain free; not requiring any analgesia when she was discharged from Haslar.

Wednesday 12th August 1998. Code A felt her Mother's dementia was mis-read by nursing staff - although Code A stated her Mother was able to communicate when she needed to go to the toilet, or when she was in pain. For some reason (not made clear to Code A) her Mother was given oramorphine - which caused Mrs Richards to become very drowsy and unable to take any fluids. At this point Code A suggested to nursing staff, she thought her Mother was in pain - but was told it was her dementia that was causing her Mother to cry and scream. On 13th August 1998 about 5 pm Code A was informed by Staff Nurse - her Mother had fallen earlier in the day.

It was a further 24 hours before diagnosis of dislocation of Rt hip was confirmed.

Code A has raised the following questions, which the investigation will focus on:-

1. At what time did Mrs Richards fall?

2. Who attended to her?

3. Who moved her and how?

4. Mrs Richards in pain, anxious, crying - calling out - told by trained and untrained staff "nothing wrong" - why?

5. Avoidable delay in being seen by Doctor and X-Ray ordered - why?

6. Why not transferred sooner?

7. Transfer back from Haslar to Gosport War Memorial Hospital? - leg not positioned correctly - not checked by trained nurse - source of pain not identified?

8a. Was there a nurse escort from Haslar - was anyone accompanying Mrs Richards in the back of the ambulance.

8b. When did Mrs Richards begin to show signs of being in pain and what caused it?

9. Why was Code A not allowed to see X-Rays and not involved in making decision "to do nothing" - allowed to die pain-free.

10a. Mrs Richards personal clothing - identified by cash's name tags all sent for "marking" day after 1st admission - despite Code A agreeing to do the washing daily - why?

10b. No clothes sent with Mrs Richards to Haslar.

10c. Following Code A insistence on her Mother wearing her own clothes and asking where they were, discovered they were at Laundry at St Mary's Hospital - returned to Daedalus - once taxi was ordered by nursing staff - still unmarked - why?

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

Daedalus Ward Action Plan
(in response to investigation re. Mrs. G. Richards)

1. Transfer of patients

Existing ward policy on transfer of patients allows a degree of discretion as to whether or not to transfer a patient if their condition changes. The purpose of this is to save patients and relatives the distress of transfer to a busy acute facility if contra-indicated by their overall condition and prognosis.

The following guidelines will now form part of the policy:

Where it is clearly evident, or highly probable, that an injury has been sustained, for which acute treatment is required and applicable, the patient will be transferred.

The patient and/or relatives are to be involved in deciding whether or not transfer is applicable, ensuring they are aware of the options and their consequences, with the aim of having their informed agreement for whatever decision is taken.

2. Marking of Clothing

Losses of personal clothing are inevitable when clothing is not marked, is upsetting for relatives, and takes up valuable nursing time (inevitably detracting from patient care).

An insistence that all personal clothing is marked has significantly reduced incidence of loss, but still poses some difficulty owing to the time lag required for initial marking.

An information leaflet (copy attached) advises patients and relatives of our personal clothing policy. Included in this is the option for relatives to mark clothing themselves if they wish to do so, which may be quicker than our own marking facilities.

Individual laundry bags are to be purchased for laundry being taken home (as soon as a suitable supplier can be found). These will be hung on patients wardrobes, making it easier for staff to identify when clothing is being washed at home, and allowing relatives to easily locate patients dirty laundry.

A lost laundry book will be used as a central reference of missing clothing. This will save time and effort in handling lost clothing complaints and be a more efficient means of trying to trace the items.

3. Nursing Records & Documentation

A programme of education on nursing documentation will take place on the ward involving all qualified and non qualified staff, relevant to their specific needs.

Internal audit of nursing documentation will take place at regular intervals, and involve all qualified staff, to identify areas of weakness, and consider developments and improvements.

4. Availability & Use of Bank Staff

Activity levels, combined with vacancies, long term sick leave and annual leave, made the period in question busy and stressful for qualified staff. Using qualified bank staff was not an option, as the reality is that contacting those on the bank list invariably draws a negative response.

This is a great pity as it is an option that the ward would and could have used, particularly as the budget existed to do so.

The recommendation is that the hospital seeks to recruit qualified nurses to the bank, who are available to work, and inducts them appropriately.

Daedalus Ward

Patient Information

Clothing

Patients on Daedalus Ward are encouraged to wear their own clothing if they wish to do so. Nursing staff will be happy to advise you on what type of clothing is most appropriate, this is particularly relevant if you intend buying any new items of clothing.

As an alternative to your own clothing the ward has a good stock of clean presentable clothing which patients may use.

If you are wearing your own clothing you may wish to send it home for laundering, in which case it will be left in the bottom of your wardrobe, or you may wish to use the hospitals laundry facilities.

Whether your laundry is being done at home or in the hospital, it is **absolutely essential** that it is properly marked. This can be done by the hospital laundry, and usually takes 3-4 working days (sometimes a little longer), or you can arrange for a relative to mark it.

Marking needs to be on a secure label, with a proper laundry marker, and must contain the following information:

Surname
Daedalus 05
GWMH

You should be aware that due to the high volume of laundry handled by the ward and hospital, clothing does periodically go missing. Provided it is properly marked it will usually reappear.

If you think some clothing has gone missing please inform a member of staff, who will record the details in our laundry book, and ask the laundry room staff to look out for the item.

Witness Statement: Mrs Margaret Couchman - Staff Nurse Daedalus Ward.

The following statement was taken by Mrs S Hutchings - Investigating Officer on 3rd September 1998.

Q1. Can you confirm you were the named nurse for Mrs Gladys Richards?

A. Yes

Q2. Did you complete the admission documentation on 11th August 1998.

A. No - not on duty - EN Pulford was responsible for completing the admission documentation.

Q3:1 Can you explain why Mental Test Sheet was not completed as Mrs Richards was diagnosed with dementia?

Q3:2 Can you explain why Lifting/Handling Risk Calculator Form was not completed?

A3:1) No
A3:2) No - I did not complete the admission documentation - but agree this should have been completed.

Q4. Were you on duty at the time Mrs Richards was found on the floor?

A. No.

Q5. Were you on duty when Mrs Richards was transferred back from Haslar Hospital?

A. Yes.

Q6. On arrival on the Ward, did Mrs Richards appear to be in any discomfort?

A. I was at coffee break at time of her arrival, but on my return I went into Mrs Richards room and introduced myself - I noticed Mrs Richards was in some distress and not positioned correctly - Code A offered to help me move her Mother - informing me she was a retired nurse, we straightened her, placed a pillow in between her legs - she immediately appeared more comfortable. I cannot be certain if she had a splint - I think she probably did.

Q7. When moving Mrs Richards with her daughter - did you notice any swelling around the hip?

A. No - Mrs Richards held her hand on her hip and said "it hurt".

Q8. Was she accompanied by a nurse from Haslar.

A. I cannot answer, I was not on the Ward at the time of Mrs Richards arrival.

Q9. How was Mrs Richards pain controlled?

A. Oramorph 10 mgs 4 hourly - given orally.

Q10. Was her daughter involved in making this decision?

A. After Mrs Richards was settled, the daughter tried to feed her Mother (HCSW took meal away to "mince") as Mrs Richards could not cope with "lumps". Code A felt her Mother was still in pain and she told me that the Surgeon at Haslar had said if the hip dislocated again - it was to be replaced. Pain controlled discussed with Code A - who was reluctant for her Mother to be given medication, but did eventually agree. Dr Barton contacted and advice sought - X-Ray form written and signed by me i.e. pp. By Dr Barton, but this was not acceptable to X-Ray Dept. - who insisted form must be signed by Doctor new form was faxed to Surgery and signed by Duty Doctor. Mrs Richards was X-Rayed at 15.45 hours.

Q11. Why would her clothing be sent for marking at the Hospital when her family had agreed to do her washing?

A. Not necessary, but I am aware Gosport War Memorial Hospital had run out of labels i.e. "Daedalus Ward", therefore it was sent to St. Mary's to be labelled.

Q12. Were you aware of the family's concerns regarding the standard of care their Mother was receiving?

A. Yes - the family told me in no uncertain terms.

Q13. It there anything else you would like to say?

A. After the syringe driver was commenced and Mrs Richards appeared more peaceful - the family's attitude appeared to change towards the staff.

Witness Statement: Mrs Jenny Brewer - Staff Nurse Daedalus Ward

The following statement was taken by Mrs S Hutchings Investigating Officer on 3rd September 1998.

Q1. How long have you worked on Daedalus Ward as 'D' grade Staff Nurse?

A. Since December 1996.

Q2. Did you have any involvement in the care of the late Mrs Gladys Richards?

A. Yes on Wednesday 13th August 1998 I was on late shift and after 15.30 hrs - the only trained nurse on duty. I was not the named nurse for Mrs Richards.

Q3. Where you on duty when Mrs Richards had a fall?

A. Yes.

Q4.1 Can you describe what happened and the action you took.

A. See attached statement.

Q4.2 Can you explain why you did not fully complete the Accident Form?

A. As I was busy with Dr Lord - a colleague completed some of the details for me and I signed it - I admit I did not complete all the details and Philip filled in parts that had not been completed.

Q5. Did you ask the Duty Doctor to visit Mrs Richards?

A. Dr Barton was on the Ward and was aware; as Mrs Richards did not appear to have suffered any injuries - I did not ask her to examine Mrs Richards. The Duty Doctor was contacted by telephone after 19.45 hrs when I noticed the internal rotation of Mrs Richards Rt hip.

Q6. How would you describe Mrs Richards mental state while she was on Daedalus Ward?

A. I am aware she suffered from dementia - but she was not my patient.

Q7. Did you speak to Code A (Mrs Richards daughter) on the day of the fall?

A. Yes - when she visited tea-time approximately I was completing the medicine round. I did not telephone her immediately after the fall as I felt it better to see her face to face.

Q8. What did you say to her?

A. I informed her that her Mother had fallen from the chair earlier, but she did not have any apparent injuries.

Q9. Were you on duty for the evening drug round?

A. Yes.

Q10. Did you ask Code A if she thought her Mother was in pain?

A. Yes. Code A reply was "not at the moment I am feeding her" - it was at this point I informed her of her Mothers fall. After this Code A did say her Mother was in pain (see Question 19).

Q.11 Who put Mrs Richards to bed that evening?

A. Myself and HCSW put Mrs Richards to bed at 19.45 hrs using hoist. At this time - I noticed the Rt hip to be internally rotated and painful. At 2000 hrs contacted Duty Doctor Dr Brigg and informed him I thought the hip to be dislocated - see statement.

Q12. Did you have any further involvement with Mrs Richards after the day of the fall?

A. Yes - only very little - she was not my patient.

Q13. Were you on duty when Mrs Richards was transferred back from Haslar?

A. No - I was a day off. I next saw Mrs Richards on Tuesday 18th August 1998 - I was on a late duty i.e. 12.15 pm - 9 pm (see attached).

Code A spoke to me whilst I was in the sluice, she was angry - telling me that her Mother "was walking yesterday at Haslar - she is here today and dying". My response was sympathetic - said I was sorry and maybe the journey from Haslar had upset her.

Q14. Were you aware of the disappearance of Mrs Richards clothing?

A. No.

Q15. Were you aware that the family agreed to do her washing?

A. Not aware - as Mrs Richards was not my patient.

Q16. Were you on duty on 19th August 1998?

A. Yes.

Q17. Did you ask the family to take Mrs Richards clothes away?

A. No.

Q18. Were you aware of the family's concerns regarding the standard of care their Mother received?

A. Yes.

Q19. Do you have anything else to say?

A. Yes - concerning Code A account of events, page 1 Code A refers to speaking to trained and untrained staff - there was only 2 trained staff on duty - S.N Joice and myself - I was completing the Consultants Round and I would not have blamed the dementia as a cause for Mrs Richards distress.

I did ask Code A if she thought her Mother to be in pain, she responded by saying "no - I am feeding her". At this point I did inform Code A that her Mother had had a fall - I had not previously phoned her as I wanted to see her face to face. After I informed her of her Mother's fall - she sought me out (I was still doing the medicine round) and informed me her Mother was in great pain. I told Code A I would come back and make an assessment with Mrs Richards on the bed - Code A asked me not to put her on the bed.

At this point - an emergency occurred with another patient and as the only trained nurse on - I had to attend. I did not want HCSW putting Mrs Richards to bed, so it was not until 19.45 hrs that I was able to put Mrs Richards to bed and that was when I noticed the internal rotation of the Rt leg.

PORTSMOUTH
HealthCare
NHS
TRUST

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

Witness Statement: Mr Philip Beed - Clinical Manager Daedalus Ward

The following statement was taken by Mrs S Hutchings, Investigating Officer on 8th September 1998.

Q1. How long have you been Clinical Manager on Daedalus Ward?

A. 18 months.

Q2. Were you on duty when Mrs Richards was admitted from Haslar Hospital on 11th August 1998?

A. Yes - I spoke to Code A at some length and explained Plan of Care. For 30-60 mins. Mrs Richards was very calm/relaxed - 15 mins. after being seen by Dr she began to cry out. I was unable to differentiate between pain/dementia - I gave her dose of Oramorph - which settled her. I informed daughter of my actions, who appeared pleased with what I did. I did find difficulty in Code A approach to pain control, at times she appeared in agreement - other times she didn't

Q3. Were you on duty day of Mrs Richards fall 13th August 1998?

A. No - but the day before - I realised the Ward was going to be busy due to overall activity, admissions, discharges (a) I booked an additional HCSW for a.m. shift (b) Identified 3 patients that could remain in bed (c) Made everyone (all staff) aware it was going to be a busy day.

Q4. On the following day what did you do?

A. I assessed Mrs Richards for myself - she appeared to be pain free (having Oramorph the night before). Dr Barton was present - decision made to X-Ray, we also informed Dr Lord and sought her advice - she agreed with our action plan. I organised the X-Ray after Dr Barton had signed the form. I booked the X-Ray as soon as department opened. Mrs Richards was X-Rayed mid-morning.

Q5. Can you explain why there was a delay in Mrs Richards being seen by a Doctor following her fall - particularly as she had previously had # neck of femur?

A. I believe Code A is referring to the delay the night before. It is agreed between medical and nursing team, that if accident occurs outside of X-Ray Dept. hours - we would ensure patient is free of pain and referred ASAP the following day - obviously each patient is assessed individually and agreement reached with patients and relatives.

Q7. Would you agree/disagree, that a trained nurse should have observed the angle of her leg to have been abnormal especially as she was in so much pain/distress.

A. Yes.

Q8. Can you please describe what happened when Code A was called into the office to be seen by yourself and Dr Barton following X-Ray of Mrs Richards.

A. Dr Barton had spoken to Consultant at Haslar who agreed to take Mrs Richards back for manipulation rather than surgery. This was explained to Code A Code A booked Paramedic Ambulance, notified A & E and said we would take Mrs Richards back when ready. I asked Code A if she would like to accompany her Mother to Haslar. Mrs Richards given dose of Oramorph. There was approximately 1 hr delay for Ambulance. I did not feel this delay would cause any adverse effect to Mrs Richard's condition. A HCSW accompanied Mrs Richards.

Q9.1 Why was Mrs Richards not examined following her fall?

9.2 Why a 24 hr delay from fall to admission to Haslar?

9.3 Why was an X-Ray not arranged sooner?

A.9.1 Injury not apparent at time - I found it difficult to distinguish Mrs Richards cries from wanting the toilet or in pain.

9.2 See answer to Q6.

9.3 See answer to Q6.

Q10. Were you on duty on the 18th August 1998 when Mrs Richards returned from Haslar?

A. I was on a late duty that day.

Q11. When were you made aware of the apparent pain and discomfort Mrs Richards was in?

A. At the same time that Code A became aware. Sequence of events not as Code A Code A written. S.N Couchman received Mrs Richards and put her into bed. HCSW Jean Moss attempted to feed Mrs Richards lunch - which she didn't appear to want - S.N Couchman advised her to mince the meat. Code A arrived while Mrs Richards being fed - but Mrs Richards was not screaming at this time. Mrs Richards began to become distressed at the time of Code A arrival. Mrs Richards had not been in any distress/pain - if she had - we would have given her some analgesia. The whole situation became very "tense" - Mrs Richards screaming very loudly, both daughters very agitated and worried about another dislocation, this made the situation difficult to handle.

Q12. Can you confirm the family asked for further X-Rays of Mrs Richards hip?

A. Yes - they felt Mrs Richards hip had dislocated again.

Q13. Can you explain the problems with X-Ray Department?

A. Dr Barton contacted and she requested X-Ray Form to be completed. Form was pp - but would not be accepted. Dr Beasley was Duty Doctor who agreed to fax form - booked X-Ray - daughters informed at all times.

Q14. Are family relatives usually allowed to see X-Rays?

A. This would be dependent upon Radiographer in X-Ray dept. - the X-Rays were not forwarded to the Ward - seen by Radiologist in dept.

Q15. Can you recall how long from admission to examination by Dr Barton.

A. 3 hrs. approx.

Q16. Were the family involved in the decision making for pain control and use of syringe driver?

A. The decision to use syringe driver was made after a course of time, discussed with both daughters, this was one option offered - oral analgesia could be continued on 18th August. Medical opinion - by Dr Barton, was that a syringe driver would be the best way of controlling the pain - I explained fully the purpose of using a syringe driver and they both agreed.

Q17. Were you aware that following Mrs Richards first admission to Daedalus, her clothes - already with Cash's name tags, had been sent for marking?

A. Policy for all patients clothing to go for marking at Gosport War Memorial Hospital - unfortunately on this occasion the machine was not working, so they were sent to St Mary's but laundry lady - did not inform us of this.

Q18. Were you aware of the family's agreement to do their Mothers laundry?

A. Yes - but I would still want clothing to be marked - I did explain this to Code A Code A

Q19. Can you give any explanation why their request for their Mother to wear her own clothes - was not carried out?

A. They had been sent for marking.

Q20. Were you aware of the family's concerns regarding standard of care for their Mother?

A. Yes.

Q21. Did you or Dr Barton have any discussion with the family regarding "feeding" Mrs Richards during her last four days of life (to include I/V fluids)?

A. I do not remember specially talking about feeding/fluids apart from giving a drink if Mrs Richards woke up. The family did not raise this as a concern at the time.

Q22. Do you have anything else to add?

A. We did find nursing Mrs Richards difficult at times - due to the difference of opinion between both daughters regarding management and pain relief of their Mother.

Witness Statement taken from Monica Pulford Enrolled Nurse Daedalus Ward

The following statement was taken by Mrs S Hutchings - Investigation Officer on 8th September 1998.

Q1. Please state your role/grade and how long you have worked on Daedalus Ward.

A. Enrolled Nurse - 'D' grade - many years.

Q2. Were you involved in looking after Mrs Gladys Richards?

A. Yes. On day of admission spoke to Code A - checked her surname generally chatted - Mrs Richards was quiet. During supper she (Mrs Richards) asked to pass urine, so we helped her use commode - she was "weight bearing".

The following day I was on early shift - I fed Mrs Richards her breakfast (in dining room) she became "fidgety" - a sign she needed to pass urine - along with another member of staff, we took Mrs Richards to the toilet - I do not recall any further problems during my shift.

Q3. You admitted Mrs Richards on 11th August 1998 and completed the documentation?

A. Yes - most of it.

Q4. Can you explain why the section for "Pain" was not completed?

A. No - negligent of me not to have done so.

Q5. Can you explain why the section for Mental Study was not completed?

A. I was advised by Clinical Manager to leave, it would be addressed later.

Q6. Can you explain why the section for Lifting/Handling Risk Calculator was not completed?

A. I was advised by Clinical Manager to leave, it would be addressed later.

Q7. Were you on duty when Mrs Richards had her fall?

A. No - I was a day off.

Q8. Were you on duty on 17th August 1998 when Mrs Richards returned from Haslar?

A. No - I came on duty later at 3.30 pm Code A was not there - Code A Code A was with her Mother who had been given oramorph. Philip and I made Mrs Richards comfortable about 2.15 pm she became quiet and settled. Code A came back into room and kissed her Mother and woke her up again - she became very noisy and distressed. Mrs Richards had been crying/screaming for most of the afternoon.

Q9. Did you have any further involvement with Mrs Richards?

A. No.

Q10. Were you aware the family had agreed to do Mrs Richards laundry?

A. I am not sure.

Q11. Do you have anything else you wish to say?

A. No - as I only work part-time - I did not have much involvement with the family.

Witness Statement of S.N Christine Joice - Staff Nurse Daedalus Ward

The following statement was taken by Mrs S Hutchings Investigating Officer on 9th September 1998.

Q1. Please state your grade/role and length of service on Daedalus Ward.

A. RGN 'E' - 5 years on Daedalus.

Q2. Did you have any involvement with Mrs Gladys Richards?

A. Yes - giving her medication - not involved in any personal care - I work primarily on the Stroke Team - I do not have much involvement in continuing care patients - see statement attached.

Q3. On Mrs Richards return from Haslar on 17th August 1998 did you admit her?

A. No - I saw her arrive on stretcher with ambulance crew - I was at Nurses Station.

Q4. Can you recall which Ambulance Service brought Mrs Richards in and was there a nurse escort?

A. It was Mainline Ambulance - and there was not a nurse escort.

Q5. How was Mrs Richards transferred from stretcher to bed?

A. I do not know - I was not involved - two HCSW assisted.

Q6. Did you attend Mrs Richards during this time at all?

A. No - S.N Couchman returned from coffee break and went into Mrs Richards.

Q7. Did you have any further involvement with Mrs Richards that day?

A. No.

Q8. Please describe Mrs Richards condition on the 18th August 1998?

A. I was on late shift - I saw Code A leave Mrs Richards room crying and walking towards Activities Room - I followed her - she was very angry and upset and implied I was not telling her everything - I tried to reassured her this was not true.

Q9. Did you give Mrs Richards any fluids whilst you were on duty during 18th August or 21st August 1998?

A. No.

Q10. Did the family ask any questions regarding feeding or giving fluids.

A. No.

Q11. Were you aware the family wished to do the laundry for Mrs. Richards?

A. No.

Q12. Do you remember making any comment to daughters regarding the need for clothes "as we get patients up here" when Mrs Richards was obviously so poorly?

A. No - I couldn't imagine any of the staff making any comment about getting patient up when they were so obviously very poorly.

Q13. Do you have anything further to say?

A. No.

Statement: S.N. C Joice - S.N Daedalus Ward

On the 12th August 1998 - late duty - not met Mrs Richards before - but concerned about her because she looked drowsy: she was pale in colour. I checked her drug chart - she had been given Oramorph at 6 am and Haloperidol.

About 5 pm Code A visited Mrs Richards - she expressed her concerns regarding her Mothers condition/drowsiness. I informed her of the medication she had been given - reassured Code A I would inform Doctor if she deteriorated. I asked HCSW to put Mrs Richards into bed - a hoist was used - she woke up and began to cry out. Code A Code A assisted her Mother with her supper (soup). Mrs Richards continued to be very noisy - but I was very reluctant to give any further medication due to Code A concerns; eventually she settled and went to sleep - no further problems for the remainder of shift.

On 13th August 1998 - I was on early shift - Night Staff reported Mrs Richards had been noisy all night - I commenced the Drug Round - I attempted to give her the Haloperidol - she screamed and pushed it away - so it was not given. I asked the HCSW to let me know when they had got her up. I would give her medication then - this time she took the medicine. I was the only trained nurse until 12.15 pm - when S.N Jenny Brewer came on duty - I gave her a report on all patients. I then completed admission process on new patient and Jenny commenced medicine round.

I cannot remember who told me that Mrs Richards had slipped out of her chair - or what time. I did not follow up the report of the fall - as I understood S.N Brewer had dealt with her. I now realise I should have checked her.

I do not recall going into Mrs Richards room during the afternoon up to 3.30 pm when I went off duty; I cannot remember if she was making any noise.

HSE Health & Safety Executive

Health and Safety at Work etc Act 1974
The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995

Report of an injury or dangerous occurrence

Filling in this form
This form must be filled in by an employer or other responsible person.

Part A

About you

1 What is your full name?

Philip Beed, Clinical Manager

2 What is your job title?

Daedalus Ward
Gosport War Memorial Hospital
Bury Road, Gosport
Hants PO12 3PW
Tel. (01705) 603218 FAX 580360

3 What is your telephone number?

About your organisation

4 What is the name of your organisation?

PORTSMOUTH HEALTHCARE NHS TRUST.

5 What is its address and postcode?

TRUST HEADQUARTERS
LOCKSWAY ROAD
MILTON
PORTSMOUTH. HANTS. PO4 8LD

6 What type of work does the organisation do?

HEALTH CARE

Part B

About the incident

1 On what date did the incident happen?

13 / 8 / 98

2 At what time did the incident happen?
(Please use the 24-hour clock eg 0600)

1330

3 Did the incident happen at the above address?

Yes ☑ Go to question 4

No ☐ Where did the incident happen?

- ☐ elsewhere in your organisation – give the name, address and postcode
- ☐ at someone else's premises – give the name, address and postcode
- ☐ in a public place – give details of where it happened

If you do not know the postcode, what is the name of the local authority?

4 In which department, or where on the premises, did the incident happen?

DAEDALUS WARD Rm 3 GWMH.

Part C

About the injured person

If you are reporting a dangerous occurrence, go to Part F.
If more than one person was injured in the same incident, please attach the details asked for in Part C and Part D for each injured person.

1 What is their full name?

GLADYS RICHARDS

2 What is their home address and postcode?

C/O GLENHEATHER NURSING HOME

3 What is their home phone number?

4 How old are they?

91

5 Are they

- ☐ male?
- ☑ female?

6 What is their job title?

RETIRED

7 Was the injured person (tick only one box)

- ☐ one of your employees?
- ☐ on a training scheme? Give details:
- ☐ on work experience?
- ☐ employed by someone else? Give details of the employer:
- ☐ self-emoloyed and at work?
- ☑ a member of the public?

Part D

About the injury

1 What was the injury? (eg fracture, laceration)

DISLOCATION OF HIP PROSTHESIS

2 What part of the body was injured?

(R) HIP

Continued overleaf

3 Was the injury (tick the one box that applies)

- [ ] a fatality?
- [x] a major injury or condition? (see accompanying notes)
- [ ] an injury to an employee or self-employed person which prevented them doing their normal work for more than 3 days?
- [x] an injury to a member of the public which meant they had to be taken from the scene of the accident to a hospital for treatment?

4 Did the injured person (tick all the boxes that apply)

- [ ] become unconscious?
- [ ] need resuscitation?
- [x] remain in hospital for more than 24 hours?
- [ ] none of the above.

Part E

About the kind of accident

Please tick the one box that best describes what happened, then go to Part G.

- [ ] Contact with moving machinery or material being machined
- [ ] Hit by a moving, flying or falling object
- [ ] Hit by a moving vehicle
- [ ] Hit something fixed or stationary

- [ ] Injured while handling, lifting or carrying
- [x] Slipped, tripped or fell on the same level
- [ ] Fell from a height

  How high was the fall?

  ____ metres
- [ ] Trapped by something collapsing

- [ ] Drowned or asphyxiated
- [ ] Exposed to, or in contact with, a harmful substance
- [ ] Exposed to fire
- [ ] Exposed to an explosion

- [ ] Contact with electricity or an electrical discharge
- [ ] Injured by an animal
- [ ] Physically assaulted by a person

- [ ] Another kind of accident (describe it in Part G)

Part F

Dangerous occurrences

Enter the number of the dangerous occurrence you are reporting. (The numbers are given in the Regulations and in the notes which accompany this form)

1

Part G

Describing what happened

Give as much detail as you can. For instance

- the name of any substance involved
- the name and type of any machine involved
- the events that led to the incident
- the part played by any people.

If it was a personal injury, give details of what the person was doing. Describe any action that has since been taken to prevent a similar incident. Use a separate piece of paper if you need to.

Patient sat in chair. Subsequently found on floor by Nursing Staff

Part H

Your signature

Signature

Code A

Date

14 / 8 / 98

Where to send the form

Please send it to the Enforcing Authority for the place where it happened. If you do not know the Enforcing Authority, send it to the nearest HSE office.

For official use

Client number | Location number | Event number | ☐ INV REP ☐ Y ☐ N

PORTSMOUTH HEALTHCARE NHS TRUST

RISK EVENT RECORD FOR ACCIDENTS / INCIDENTS

Ref: 16895

PLEASE GIVE FACTUAL INFORMATION ONLY

A: DETAILS OF THE EVENT Completed by person in charge of shift/area

1. Type of event: Patient ✓ Staff Other person Client Property Product Equipment Incident

2. What was the result? (tick all boxes that apply)
Injury / ~~ill health~~ ✓ Damage Theft Loss (under £1,000)

3. Person(s) directly involved (one form for each person injured)

(a) If patient/client; Name: GLADYS RICHARDS
Male/female: F Date of birth: 13/04/07
Service/residence used: GWMH Hospital No.: G099198
Diagnosis/condition: FRACTURE (A) NECK OF FEMUR
Mental Health Act Status: Formal Informal Not applicable ✓
Has a similar event happened to this person before? Yes ✓ No
Specify: AT GLEN HEATHERS NH.

(b) If staff: Name: Pay Number
Job title Dept/division
Are they: An employee Agency Bank Locum Contractor
Was s/he on duty at time of event? Yes No
If yes, what hours were they working?
Did they work after the event? Yes No If yes, until when?
Has a similar event happened to this person before? Yes No
pecify

(c) If other person: Specify (e.g. visitor/volunteer)
Name: Home address:

4. Product: Food Medical Clinical waste Other
Specify

5. Property: Trust Personal Specify type of property

6. Equipment: Specify type Serial No.
Manufacturer:

7. What happened? Patient sat in chair in room 3 Found on floor by nursing staff

8. Which of the following best describes the event? Tick all boxes that apply
Fall Slip/trip Handling/lifting Hazardous substance
Sharps/needlestick Medication/drugs Infection
Abscondment Fire/flood System failure* R.T.A.
Security Self injurious behaviour Verbal threat
Physical threat Violence to person Violence to property
Other ✓ Specify FOUND ON FLOOR.

* If system failure: Gas Electricity Medical gases Other

9. When and where did the event occur? Date: 13/8/98
Time of day: 1330 ~~am~~/pm Location: DAEDALUS WD.

10. Which of the following best describes the consequences?
(a) Injury/Ill health: Strain/sprain Bruising Burns Infection
Laceration Fracture Dislocation Amputation
Death Other ✓ Specify Painful Hip.

(b) Damage: Repairable breakage Vandalism/defacement
Destruction beyond repair Other Specify

(c) Theft: Vehicle Equipment Personal property Money
Medicines/drugs Provisions Other Specify

(d) Loss: Trust property Personal property Money
Amount Other
Specify:

If loss greater than £1,000 use Rapid Reporting System For Critical Events

11. What immediate action was taken and by whom? Checked For injury. None apparent At time Hoisted from floor to chair + Safety table put in front.

12. If Injury/Ill Health:
(a) Was patients' doctor notified? Yes ✓ No Seen By? Dr Briggs
Treatment prescribed/given: Contacted for tel. Advised Co telephone analgesia PRN mane

(b) Has next of kin been informed? Yes ✓ Date 13/8/98.
Name of person informed: Code A Relationship DAUGHTER
How informed? (e.g. phone) Telephone.
No Why not?

(c) Did staff/visitor attend Occupational Health / A&E? Yes No
Treatment prescribed/given:

13. Were there any witnesses? Yes No ✓ Name:
Relationship/status e.g. visitor
Home Address:

14. Is this event: Major ✓ Minor No apparent injury/negligible

15. Has this event been noted in the patients's Medical & Nursing Notes? Yes ✓ No By Whom?

16. Person Completing This Section
Name (capitals): J.M. BREWER Title: STAFFNURSE
Signature: Code A Date: 13-8-98

PLEASE PASS THIS FORM TO YOUR IMMEDIATE LINE MANAGER

B: INTERIM REVIEW / FOLLOW-UP ACTION to be completed by line manager of area / service

1. Is there anything else to report? (e.g. change in symptoms/condition) Seen by Dr Baxter 16/8/98 + Xray shows dislocation - transferred to Haslar for reduction
2. Describe the action taken to prevent a reoccurrence? Remain on bed over weekend
3. Person completing this section: Name (capitals): PHILIP BEED Title: C. Manager
Signature: Code A Date: 14/8/98

PLEASE PASS THIS FORM TO YOUR SERVICE/DEPT. MANAGER

C: MANAGERIAL ACTION & REPORTS

1. Is this a RIDDOR? Yes ✓ No Specify: Fatality Specified major injury ✓ Dangerous occurrence >3 Day absence (staff)
Flammable Gas Incident Dangerous Gas Fitting Date reported to the HSE By Phone or Form F2508? Form
2. What further action is needed? Patient transferred to Haslar Hosp.
3. Please attach all necessary reports / information (e.g. medical reports for staff, RIDDOR forms, loss reports, witness statements etc)
4. Person completing this section: Name (capitals): SUE HUTCHINGS Title: SNL Nurse Coordinator
Signature: Code A Date: 18/8/98

Now separate & forward copies as shown; file top copy centrally. DO NOT FILE PATIENT FORMS IN THEIR CASE NOTES

REPORTING ACCIDENTS AND INCIDENTS

1. The Risk Event record must be completed by the person in charge of the shift/area, ideally as soon as possible after they become aware that the event has occurred but definitely before the end of the shift.

2. The record is forwarded to their immediate line manager within 24 hours, for follow up and to ensure all relevant information has be provided.

3. They forward the record within 3 days to the nominated line manager for risk events who is responsible for: ensuring appropriate and effective action has been taken; completing all necessary reports e.g. RIDDORs, loss report forms etc.; and sending copies of all forms to the Risk Adviser, and copies of staff accident forms Occupational Health.

4. Detailed notes for completing the record are given in Appendix l of the Trust Policy on Reporting and Reviewing Risk Events. Copies of these guidance notes can also be found on your local Health and Safety Noticeboard.

REPORTING CRITICAL EVENTS

The Trust has a rapid reporting system for critical events, i.e. serious, untoward events which severely harm a person, service property/premises or the Trust as a whole. These include:

- Suicide or attempted suicide whilst under care or treatment by the Trust
- Serious (or unexpected) injurious behaviour to self or others; e.g. serious injury as a result of physical violence towards a member of staff from a client or member of the public
- Suspicious death, or totally unexpected death in a service environment where this is considered untoward e.g. learning disability services in community houses
- Drug or treatment error that harms the client/patient
- A fault with equipment or medical device that resulted in harm to a person (NB all faults with medical devices should be reported immediately to the Risk Adviser even if they have not caused any harm)
- Absence off appropriate cover or support when required clinical or non clinical, e.g. on call medical staff or out of hours managerial advice
- Threat of severe violence or aggression to staff, client, patient or other person.
- Suspected unsafe conduct, misconduct or malpractice e.g; breach of confidentiality, inappropriate treatment
- Racial harassment/racially discriminatory behaviour
- Missing person or abscondment lasting beyond 3 hours, and where they or others are at risk (e.g. due to mental health state or mental health act status, i.e. section)
- Bomb alert or other major security scare
- Potentially adverse or damaging - to client, staff, the Trust
- Inability to obtain equipment or drugs, e.g. out of hours in 'an emergency
- Severe damage to premises or Trust property, e.g. flood, fire, vandalism, severe damage by a client, leak or emission of hazardous substances
- Security breach e.g. theft, break-in, access to confidential material such as medical records
- Major theft and/or loss of £1 ,000 or more e.g. computer theft (hardware and software), sensitive data/information (which may or may not involve a break-in)
- Lack or failure of essential systems, e.g. medical gases, computer systems, heating

NB THIS LIST IS NOT EXHAUSTIVE

All critical events must be reported to Trust Central Office; a report centre has been set up and can be accessed on 01705 894369/4378/4260/4114, or Fax 01705 293437.

Procedure:

1. The report centre can be contacted by phone or fax, using a completed Critical Event Record, immediately that the event occurs or is discovered to have occurred. Ideally this should be done by the person in charge of the shift/area, but anyone can send in a record form if they feel it is necessary. Forms are available in all clinical/service areas, and from nominated line managers for risk events.

2. All Executive directors based at Trust Central Office will be alerted as soon as possible after the event has been reported . A file is set up and kept at the Report Centre for each event.

3. One of the Executive Directors is nominated as the lead Director (LD) for each event, responsible for initiating an immediate response and investigation where necessary, identifying who else needs to be informed and involved, and for ensuring the Divisional General Manager has been notified. Detailed procedures for the Lead Director e.g. for arranging a Critical Event Review, are available at Trust Central Office.

4. The Divisional Manager is responsible for communicating with the person(s) reporting the event to keep them informed of the findings of any investigations, and for implementing any actions recommended as a result.

5. The Lead Director is responsible for ensuring all necessary action has been taken and that this is reviewed at regular intervals.