RESTRICTED

DOCUMENT RECORD PRINT

Statement number: S226

STATEMENT PRINT

Surname: BARKER

Forenames: DEBARA

Age: 39 Date of Birth: Code A

Address: Code A

Postcode: Code A

Occupation: STAFF NURSE

Telephone No.: Code A

Statement Date: 29/06/2004

Appearance Code: 1 Height: 1.68 Build:

Hair Details: Position Style Colour

Eyes: / Complexion: /

Glasses: Use:

Accent Details: General Specific Qualifier

Number of Pages: 10

I am presently employed by Portsmouth Hospital Trust working as a degrade staff nurse in the new out-patients department at St Mary's Hospital , Portsmouth and have been so employed since February 2003.

I am a qualified General Nurse and a registered midwife, the midwife qualification has now lapsed. I was qualified as a general nurse in November 1985 and as a midwife in March 1991. I commenced my training in July 1982 at Hull District School of Nursing, I also attended the Hull School of Midwifery, September 1989 to March 1991.

From November 1985 I worked as a Staff Nurse at the Princess Royal Hospital, Hull and apart from a year off in 1993 to 1994 I worked as a Staff Nurse, trained in midwifery or been a staff midwife at various hospitals and nursing homes in Hull and Hampshire.

RESTRICTED

From September 1998 to January 2003 I was employed by Portsmouth Health Care Trust working as a staff nurse on Dryad Ward at Gosport War Memorial Hospital . Whilst there I originally worked sixteen hours a week, two eight hour shifts that could have been any two days of the week. It was either 7.30 (0730) am to 4.15 (1615) pm or 12.15 (1215) pm to 8.30 (2030) pm. In October 1999 I was working only on a Monday and a Friday from 7.45 (0745) am to 4.30 (1630) pm, I had this arrangement because of child care issues.

As a staff nurse my main responsibilities were assessing the care, giving the care and evaluating the care of the patients on the ward. The number of staff working on the ward at any one time varied greatly from 4 people in an evening to seven or eight in the morning, these figures are very approximate. I also supervised health care support workers, ie, untrained members of staff, whilst I would assess the care and evaluate the care of the patient the health care support worker would give the care on their own or with assistance depending on their ability, staffing levels. To administer drugs I was 'D' grade staff nurse and would have been supervised by an 'E' or 'F' grade staff nurse or the sister who is a 'G' grade. There were rare occasions when I would have been the most senior nurse on the ward. This would normally have been during the evening shifts.

There were three different teams working on Dryad Ward during October 1999, each team usually consisted of an E grade staff nurse, a D grade staff nurse and the health care support workers. It was set up like this so that each team was supposed to be responsible for six to eight patients and there was always supposed to be a member of that team on duty at any time. It worked well in the morning but in the evening because there was so few staff on duty it was not always practical. The named nurse was the person who was in charge of that team.

The care of the patients was the main priority of the nursing staff and all the patients were treated with dignity and respect at all times.

Syringe drivers were used on the ward at this time, they administer drugs continuously sub-cutaneously, ie under the skin. I would have changed and maintain the drivers, although I would have always done this in the presence of another trained member of staff.

I received on the ward training for the syringe drivers by other trained members of staff. I had not worked with syringe drivers before although I had worked with other similar pieces of medical equipment. The training I received could best be described as 'on the job' and was sufficient to allow me to do my job properly. I had no concerns over the use or the training with regard to the syringe drivers.

I have been asked to detail my involvement in the care and treatment of Elsie DEVINE . I have a vague memory of her, I can remember that she used to wander around the day room, she was an elderly lady. One morning when I came on duty either a Monday or Friday, I don't know the date, I had just entered the ward so it would have been about 7.45 (0745) am. Elsie was stood in the corridor swaying and really unsteady on her feet and agitated when I went to talk to her, as I tried to get her to go and sit in a chair or on her bed. I was concerned that she was going to fall over. She refused, so somebody went and got a chair, I don't know who, and brought it into the corridor and she still wouldn't sit down. I was holding her arm to support her. She then grabbed my arm and wouldn't let go. I can remember Code A , Gill HAMBLIN and Lyn BARRETT were present at some point but it was mainly Liz that was with me. Elsie then walked off up the corridor pulling me along with her as she still wouldn't let go of my arm. She was now becoming aggressive. We managed to get her into the lounge and at some point we managed to get her into a chair. At some point Gill HAMBLIN went to get Dr BARTON , I can't remember whether Dr BARTON came or not. Shortly after this Elsie was given an injection to calm her down. This was whilst Elsie was sitting in the lounge. Me and Liz sat with her for a short while, when she appeared to be dropping off to sleep I left to carry on with my work leaving Elsie with Code A

From referral to entries in Elsie's medical notes (identification reference BJC16/PG192/193, BJC16/PG184/185, BJC16/PG190/191, BJC16/PG188/189, BJC/16/PG222 & 223, BJC/16PG154 & 155, BJC/16/PG228 & 229, BJC/16PG200 & 201).

BJC/16PG200 & 201 relates to a Waterlow Pressure Sore Prevention Chart for Elsie DEVINE. This chart is a scoring system to see how at risk someone is of developing a pressure sore. As far as I can tell the only thing that I have written on there is the visit/case note number Code A These were normally completed over a weekend before the ward round for the following week. Although sometimes they were completed when the staff had the time.

BJC16/PG/192 & 193 relates to a handling profile on Elsie DEVINE that I completed on the 22nd October 1999 (22/10/1999). It is a means of identifying risk factors with regard to moving and handling the patient and it would give an assessment of the patients ability. On that date I assessed Elsie's communication as 'no problems'.

Compliance as 'maybe difficult due to confusion'

Pain as 'No' (none).

Skin integrity as 'dry but intact' which means that she had no pressure sores.

Client/carer preference as not stated.

The movement evaluation is a guide for the nursing staff as to what the patient can do at there best and at there worst, ie, tummy/rolling - at best verbal prompting at worst use of a glide sheet.

BJC16/PG184 & 185 relates to a personal hygiene care plan for Elsie DEVINE. It is written by me and is what it says. On 22nd October 1999 (22/10/1999) I wrote Mrs DEVINE may require assistance with personal hygiene due to confused state, the desired outcome I required was to achieve a standard of hygiene acceptable to Elsie, with a daily evaluation, the nursing action I required was.

1. Give assistance with washing and dress as and when required.
2. Offer daily shower/bath.
3. Ensure Elsie is washing herself properly
4. Ensure nails are kept trimmed and clean
5. Give assistant with oral hygiene requirements
6. Main dignity and privacy at all times.

The hygiene care plan relates to washing and dressing. The rear of this form outlines the care offered/given. I have recorded the following entries.

25.10.99 (25/10/1999) self caring this morning.

29.10.99 (29/10/1999) --------------------------- this line indicates 'care given as per plan.

1/11/99 (01/11/1999) -----------------------------

8/11/99 (08/11/1999) -----------------------------

12/11/99 (12/11/1999) ---------------------------

14/11/99 (14/11/1999) Assistance given washing and dressing

15/11/99 (15/11/1999) General bath given.

I signed all my entries.

BJC/16/PG190/191 is a Bowel Nursing Care Plan completed by myself on the 22.10.99 (22/10/1999). It reads, 22.10.99 (22/10/1999) may have a tendency towards constipation. Desired outcome: To aim to achieve regular bowel movements.

Evaluation ??? or interval - daily

Nursing Action, 1. check if bowels have been opened daily.

2. Give apperments when required (upperments are suppositories or medicines used to open your bowels).
3. Note and report any changes to stools: colour, frequency, consistency, odour.
4. Encourage oral fluids and a well balanced diet.
5. Maintain privacy and dignity at all times.

Again on the rear of the form I have recorded and signed daily occurrences.

25.10.99 (25/10/1999) 2 x glycene suppositories given, Elsie says that she has had her bowels opened.

12.11.99 (12/11/1999) Elsie says that she had her bowels opened yesterday.

BJC/16PG188 and 189 relates to an night time 'sleep' nursing care plan. I didn't write this form and it would have been completed by a member of the night team. The only thing I have written on this form is the unit number Code A

Having reviewed the personal nursing care plans that I completed, they are completely normal and as a trained member of staff would give me no cause for concern.

BJC16/PG222/223 is a form that is used to record a summary of significant events. It is completed on admission and through out the patients stay in hospital recording all significant occurrences, ie, consultant visits, family messages, any deterioration in the patients condition.

I have made three entries on this form that I have dated and signed.

25.10.99 (25/10/1999) S/B Dr REID to continue for bloods to be taken - this means seen by Dr REID, Dr REID was a consultant based at the Queen Alexander Hospital, Cosham, to continue as we had been doing, ie, not to change anything, for bloods to be taken, Dr REID required Mrs DEVINE to have a blood test.

1/11/99 (01/11/1999) S/B Dr REID, commence amiloride 5 mgs OD to be weighed twice weekly for the visit. To see son. This means that Mrs DEVINE was seen by Dr REID, he prescribed amiloride 5mg, this is a diouretic - and would help to dispose of Mrs DEVINE's excess fluid, to be weighed twice weekly this would be to see if the diouretics were working and/or to prevent dehydration. Dr REID asked for Mrs DEVINE to have a home visit. This was part of the patients discharge planning. To see son means for the staff to update her son as to what had been going on.

21.11.99 (21/11/1999) 8pm (2000) condition continues to deteriorate slowly, family have visited, all care continued driver satisfactory. This note means what it say, all care's continued means that she would have been turned frequently, washed, changed, generally made comfortable and all her needs catered for. Driver satisfactory, means that the syringe driver was working alright and didn't need changing.

I believe that BJC/16PG154 & 155, the entry dated 25.10.99 (25/10/1999) related to the ward round of Dr REID on that date that I have mentioned in Mrs DEVINE's summary of significant events on the same date.

BJC16/PG228/229 relates to Mrs DEVINE's contact record and any contact that the nursing staff have with social workers, occupational therapists, family members are recorded here.

RESTRICTED

Statement number: S226

DOCUMENT RECORD PRINT

On 12.11.99 (12/11/1999) I recorded S/B to BUTTRESS social worker who also saw Mrs DEVINE. To have 2 x hrs care chart completed, S/W would like to speak to Mrs DEVINE's daughter Ann . Mrs DEVINE will pass on the message to her. The 2 x hrs care chart is a form that the social workers give to the nursing staff so that it can be completed to assist with the discharge plan.

Taken by: Code A

Signed: Code A

Signature witnessed by:

RESTRICTED