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Form MG11(T)

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of: ASTRIDGE, YVONNE ANN

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: CLINICAL MANAGER

Astridge ✓ R37

This statement (consisting of page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: Y ASTRIDGE Date: 25/10/2004

I am Yvonne Ann ASTRIDGE and I live at an address known to the Police. I am a Clinical Manager (RGN) at Gosport War Memorial Hospital and I have 25 years experience in the Nursing profession.

I began my training in 1979 at the Nightingale School of Nursing at St Thomas's Hospital London and qualified as an RGN in 1981, my pin number is 78C0813E.
From 1981 I was employed as a Staff Nurse at St Thomas's Hospital, London where I worked on a night pool for three months and for the next three months on an elderly care ward.

From 1985 to 1986 I worked at the Royal Free Hospital in London as a Staff Nurse on a medical ward

From 1982 to 1984 I worked at Abingdon Hospital as a Staff nurse on a GP ward with a maternity annex

From 1986 to 1987 I worked as an RGN Nursing Officer at a Nursing Home, where when on duty I was in charge of the Nursing Home, its staff and the care given to elderly clients. I was also responsible for recruitment of staff

From 1997 to 1998 I was employed as a Staff and Senior Staff Nurse at the Gosport War Memorial Hospital where I assisted the Clinical Manager (Ward Sister) in the administration of the Department and took an active roll in the development of nursing practice, where I was involved in the rehabilitation of stroke patients and I ran an NVQ group to help other Nurses

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study for NVQ qualifications.

From 1998 until 2004 I worked at St Christopher's Hospital in Fareham, on Rosewood Ward and latterly Shannon Ward this is a hospital for the elderly.

I recently returned to Gosport War Memorial Hospital where I am currently employed as the Clinical Manager (Ward Sister) on Dryad Ward.

I am an extremely experienced Nurse having kept up to date with all of my courses including stroke handling and positioning, critical companionship, stroke rehabilitation safe movement and handling of loads, care of the elderly and social services guidelines for the placement of patients.

I am also the holder of a City and Guilds Certificate in further and adult education and a further City and Guilds qualification for assessing a candidate's performance, and assessing candidate using diverse evidence. I also hold an English National Board qualification in the care of the elderly.

In 1996 I was the Senior Staff Nurse on Daedalus Ward at Gosport War Memorial Hospital where I would run the ward in the absence of the ward manager. But my primary role was that of patient care. At that time my line manager was Sheelagh JOINES .

I have had training in the use of IV drugs, but last used them in London in the 1980's. I have not given IV drugs in Hampshire.

The term Wessex Protocols, refers to the Palliative Care Book, used for guidance in what drugs are to be used in that care. I believe that these guidelines were used at the Gosport War Memorial Hospital.

Before 1996 I think it was, I had training in the use in the setting up of syringe drivers . This training would have been purely sessions on the ward. I believe that the brand of syringe drivers

used at that time was "Gravesby" and in fact I'm sure these are still used today.

There was formal training in the use of syringe drivers but I am unsure if this was before 1996. There have also been Syringe Driver refresher courses at the Queen Alexandra Hospital .

The Named Nurse is the nurse responsible for overseeing the care of patients, in broad terms. The named nurse does not actually need to do it.

My working hours in 1996 were 37½ hours per week and my tour of duty would have been;

0730 - 1615 for 2 days
0730 - 1330 for 1 day
1215 - 2030 for 2days

I have been asked to detail my involvement in the care and treatment of Elsie Hester LAVENDER . I can say that I have no recollection of this patient, but after reference to her medical notes (exhibit BJC/30) pages 95, 97, 99, 103, 105, 107, 109, 111, 113, 115, 117, 119, 121, 137, 151, 153, 167, 169, 171and 173, I can confirm that on the 27th February 1996 (27/02/1996) page 95, I was shown as the named nurse in the nursing care plan of Elsie LAVENDER which states that ,The problem, "the patient has painful shoulders and upper arms." The desired outcome is "To relieve pain and make Elsie more comfortable" The desired action is "Position patient for comfort. Elsie can lift her arms if given time and dependent on pain. Administer analgesia as prescribed and monitor effectiveness". I have no recollection of this document. On looking at this care plan however I would say that the nursing action in relation to drugs is satisfactory.

I can confirm that on page 97 of the nursing care plan dated 2nd March 1996 (02/03/1996) it is written "slight pain in shoulders when moved" This is signed Y ASTRIDGE and Code A . This is neither my writing nor my signature. It was policy at that time that a Healthcare support worker should have any entry countersigned, or a trained member of staff could sign an entry. I rather feel that Code A the health care support worker signed this entry. The account given

should and would be in order.

I can confirm that on page 99 of the notes, dated 22nd February 1996 (22/02/1996) the following is written in the nursing care plan, the problem, "Restricted mobility" The desired outcome "To increase mobility and encourage independence" the Nursing Action, "To assist Elsie to transfer from bed to chair x 2 nurses. Refer to physiotherapists" I didn't start this care plan. My name is at the top means that I am the named nurse, not that I wrote the entry. This is not my writing nor do I recognise whose it is. I would add that if it is painful for the patient to get up then they remain in bed. The patient has the final say if they get up or not.

I can confirm that page 103 and 105 of the notes is a nursing care plan dated the 22nd February 1996 (22/02/1996). and reads, the problem," Unable to care for hygiene needs unaided" The desired outcome," To promote an adequate level of hygiene" the nursing action " Assist to wash and dress daily, offer a bath regularly. Ensure hair teeth and nails are cared for. Encourage independence where possible" This entry of page 103 is written by me but page 105 which is a continuation for page 103 is not. I would add that patients are asked if they can wash and clean their teeth. If not, this should be done with assistance from a nurse. A care plan means a plan of how to address a problem which the patient has. If there is no problem then there is no care plan. In general there is a specific care plan for every problem.

Page 107 dated the same day is another nursing care plan with the named nurse, SSN.Y ASTRIDGE; this is not in my writing and states, Problem, "leg ulcer on R leg and dry skin." Desired outcome" To aid healing." Nursing action," Dress alternate days with kattostat soaked in n/saline, cover with NA dressing and 9x9- bandage. Apply emulsifying ointment to both legs. Even though I am the named nurse I would not necessarily issue such instructions. N/saline means normal saline.

Page 109 dated the same date is a continuation of page 107 regarding leg ulcers. This is not my writing.

Staff would interact with the patient by asking such questions that were necessary and recording

such in the notes. In 1996 it was common practice to ditto entries if those were unchanged, it not however practice now.

I can confirm that on page 111 and 113 of a nursing care plan dated the 22nd February 1996 (22/02/1996) I am shown as the named nurse, but this is not in my writing. The following is written, Problem, Indwelling urinary catheter. This means pertaining to a tube left within an organ for draining. Potential problems of, a) trauma b) infection c) Retention of urine. Desired outcome, to minimise the risk of trauma, infection and retention of urine. Nursing action; catheter care to be carried out daily. Monitor urine output and report. Test urine if infection suspected. Secure tube at catheter to leg to minimise trauma.

This is what I would call a bog standard care plan to assist the patient with the toilet.
The catheter would be inserted if the patient had retention of urine, in the main.
Permission of the patient is required to pass (insert) a catheter, or if that patient is incapable then a medical decision would be necessary. For the catheter to work correctly it should be clean and in working order. If the patient is in retention, with a large amount of urine in the bladder, then in turn it can cause back pressure on the kidneys. Of course once the patient is better then the catheter would be removed.

I can confirm that on pages 115 and 117 dated 21st February 1996 (21/02/1996) of a nursing care plan of Elsie LAVENDER, where I am shown as the named nurse, again this is not in my writing, and the following is written. Problem, red and broken Sacrum.

Desired outcome, to heal. Evaluate daily. Spray minute broken area with Betadene. Nursing action, 24/2/96 (24/02/1996) broken area sprayed with Betadene and signed by a nurse. The other entries are signed by other medical staff, not by me.

Betadene is an iodine spray which kills bacteria. It was a standard pressure sore treatment, but is not used in the same way now. I have reviewed the rest of the entries and it would appear that apart from the spray, iodine dressings were also used.

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From viewing the notes I can see that on admission her sacrum was red, she was overweight, immobile and not able to get out of bed. On the 27th February 1996 (27/02/1996) the area was blackened, this is bad news for the sacrum.

The Sacrum is the triangular bone just below the lumbar vertebrae.

I can confirm that on page 119 of the notes dated 1st March 1996 (01/03/1996) to the 6th March 1996 (06/03/1996); I am again shown as the named nurse. These entries are not in my writing. The following is written, Problem, "Constipation due to medical problems". Desired outcome; "monitor bowel action daily. Give a high fibre diet and plenty of fluids. Give suppositories or enemas as required". Nursing Action; "Suppositories and enemas given with little result and patient continues to leak faecal fluid". These notes are written by other medical staff and not by me.

From viewing the notes I can see that the patient was not eating and drinking, therefore she was likely to be constipated. She was in pain and this would not encourage the bowels to open. The use of suppositories and enemas was a reasonable course of action.

I can confirm that on page 121 of the notes, dated the 22nd February 1996 (22/02/1996), that a nursing care plan was started. These entries are not in my writing and I do not recognise whose it is. I can say that the following page 123 is linked to page 121. The following is written; problem," Requires assistance to settle for night". Desired outcome, to ensure patient has adequate sleep. Nursing action, "transfers to seat with assistance of 2 nurses" On page 123 the entries range from 22nd February to 3rd March 1996 (03/03/1996) and appear to be a nightly record of her sleep pattern. It also shows analgesic given and records that medication was refused on 1st March 1996 (01/03/1996). I also observe that there are blank spaces on 25/2/.96 (25/02/1996), 27/2/96 (27/02/1996), 28/2/96 (28/02/1996) and 29/2/96 (29/02/1996). It was the practice back then that if there was nothing to report then it would be left blank.

I can confirm that on page 137 of the notes dated 5th and 6th March 1996 (06/03/1996) that this is a doctor's drugs prescription written by Dr BARTON . On 6th March at 0945 hrs I gave the

patient 100 mgs of diamorphine for pain relief and 40 mgs of midazolam as a sedative.

I can confirm that on page 151 of the notes BJC/30 at 1700 on 22nd February 1996 (22/02/1996), this is an admission summary and written by me. I am unsure though if I actually admitted the patient. The entry states," 83 yr old lady, insulin dependant, registered blind, atrial fibrillation; (an irregular often rapid heartbeat) had a probable brain stem CVA 5th Feb 96 (05/02/1996). CVA means a Cerebrovsacular accident (Stroke). She now has problems with her grip in both hands and also experiences pain in arms and shoulders. She can transfer with 2 nurses. Seen by Dr BARTON, medication prescribed. Catheterised size silastic (a trademark for a substance similar to rubber) which drained 750 in the first hour? Retention. General bath given and leg ulcer on right leg redressed. Area on left leg appears healed". This entry is signed by me.

On 23rd February 1996 (23/02/1996) I have written, "Referred to physio, FBC ESR U's & E's taken". This entry is signed by me. FBC means Full blood count. ESR means check for sedimentation speed of erythrocytes when spun.

"S/B Dr BARTON. Antbiotics prescribed for probable UTI ". This entry is signed by me. UTI means urinary tract infection.

Transfer with 2 nurses' means that the patient can be got out of bed and into a chair, with a 90 degree turn with 2 nurses

S/B means seen by Dr and medication written up. U's and E's mean urea/creatine and electrolyte in bloods taken

I can confirm that on page 153 of the notes of Elsie Lavender dated 27th February 1996 (27/02/1996) that I have written "Bloods taken" This means that blood samples were obtained from the patient. I have no idea why these were taken. It could have been because of a spoiled previous sample, or some other results were required or that the patient's condition had deteriorated. This would probably have been authorised by a doctor, and a blood nurse would

RESTRICTED

have taken the sample.

I can confirm that on page 167 of the notes which is an abbreviated mental study dated 22/2, that I wrote the name Elsie Lavender on the top of the page. This is a mental test score of which the patient scored 10/10, which means that this lady had all her marbles.

On page 169 of the notes which is a Waterlow Pressure Sore Prevention/Treatment Policy dated 22/2/96 (22/02/1996), I can confirm that I wrote the patients name at the top of the page. This is what we call a Waterlow score and details the patient's susceptibility to bed sores. This patient has a score of 21 which is very high and places that patient as a very high risk. A score of below 10 is ok, a score of above 10 is a risk, a score of above 15 is a high risk and over 20 is, as I have said is a very high risk. If the patients appetite is poor this just adds to the problem.

On page 171 of the notes also dated 22/2/96 (22/02/1996) which is Lifting/Handling Risk Calculator. This patient scored 15, which means she was difficult to move. Any score of above 10 means that a specific care plan is needed.

On page 173 of the notes which is a Daybar Basic Nutritional Assessment Plan, the patient has scored a 3 which is ok. A score of above 5 means that the patient would usually need additional nutritional supplements. A score of below 5 means that the patient would require reassessing regularly. This plan is no longer used.

I have been asked to comment if I have any issues regarding patient care at the Gosport War Memorial Hospital. I would like to say that if I did have any concerns then I would not work at the Hospital. It is a good hospital and the standard of care is excellent. The use of diamorphine was in my estimation an ideal way of making patients more comfortable and I had no problem with its use in syringe drivers in 1996.

Taken by D WILLIAMSON