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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: SHAW, FREDA VAUGHAN

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: REGISTERED GENERAL NURSE

This statement (consisting of 10 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: F Shaw Date: 15/03/2005

I am Freda Vaughan Shaw and I live at an address known to Hampshire Police.

I am a registered general nurse and my nursing midwifery council number is Code A

I qualified as a registered nurse for the mentally handicapped in 1975 at Lennox Castle Hospital, Lennox Town Glasgow.

I further qualified as a registered general nurse in 1977 at the Argyle and Bute Colle Nursing and Midwifery in Greenock. To obtain this qualification I undertook an 18 registration course.
I worked for a further year at Broadfield Hospital Port Glasgow completing in July 1978.

I left the nursing profession in that year and worked in a variety of other positions.

In March 1992 I began work as a D grade staff nurse at the Redcliffe Annexe which formed part of the Gosport War Memorial Hospital.

In 1995 I believe, this unit was closed down and all patients transferred to Dryad Ward at GWMH together with the staff.

I have worked at that Hospital since then and in 1995 I qualified as an E grade staff nurse.

My role responsibilities include taking charge of the ward in the absence of senior staff. I

Signature Witnessed by: Code A

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In 1995 I believe, this unit was closed down and all patients transferred to Dryad Ward at GWMH together with the staff.

I have worked at that Hospital since then and in 1995 I qualified as an E grade staff nurse.

My role responsibilities include taking charge of the ward in the absence of senior staff. I

supervise healthcare support workers and junior staff. I also have a responsibility for the training of student nurse who are on ward placement.

I have not heard of the term the Wessex Protocols.

Dryad Ward consists of 20 beds and primarily consists of elderly patients over the age of 65 yrs. The majority of these are fully dependant on nursing care and are usually in the ward for a 4-6 week period.

I have received on the job training in the use of syringe drivers. I believe I first used these in or around 1992. I have also attended study days in connection with the manufacturer's requirements relating to their use.

A syringe driver is a small battery operated motorised syringe pump which has been designed to deliver a constant dosage of medicine over a set period of time. It is primarily used for continuous pain relief to patients. It can also be used to prevent nausea in patients who are very sick.

The only person who can authorise the use of drugs administered through a syringe driver is a doctor. In the early years it was policy to allow up to three different drugs to be administered via the syringe driver in one dosage over a set period.

This early policy has since changed.

My understanding of the term the named nurse is that this is the person who is responsible for the nursing care of the patient. They nurses were usually allocated a four bedded bay and split into teams A and B. They were responsible for putting care plans in respect of those patients in place and keeping them up to date. The named nurse would be the person whom the family would speak to if that nurse was actually on duty at the time. If they were not then another member of staff would speak to them. On some occasions the care plans in the nursing notes would be completed by another nurse but show the named nurse on the heading.

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The time and date of all entries in those notes would usually be completed at the time if the patient was seriously ill but in other cases it would be completed when there was time to do so but in any case at the end of the duty tour.

My tour of duty has always been from 0730 to1330 (days) and 1415 to 2030 (lates).

I have been asked to detail my involvement in the care and treatment of Arthur Brian CUNNINGHAM , I can vaguely remember him, and from referral to entries in his medical notes exhibit (BJC 15) I can confirm that I was shown as the named nurse for him, but he was not admitted by me.

I can confirm that page 871 of the notes is an assessment sheet which details the following;
The patient's understanding of the condition

Communication
Elimination
Nutrition
Pain
Vital Signs

This is in my writing and on page 872 which is a continuation sheet I have both written my name as the assessor and signed same. I have dated this as 22/9/98 (22/09/1998).

Page 873 of the notes is the Barthel ADL Index for the patient Arthur CUNNINGHAM. The patients name is not written by me but the rest of the form is in my hand.
The form is dated 22/9/98 (22/09/1998) and the Barthel index indicates the patient's dependency on nursing staff. ADL means Activities of Daily Living.

It is a recognised method of assessing a patient's care. Arthur CUNNINGHAM's score of 0 means that he was totally dependant on nursing staff.

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Page 874 is an Abbreviated Mental Study; however this form has not been completed.

Page 875 is a Nursing Care Plan dated 21/9/98 (21/09/1998). I am shown as the named nurse but this form is not in my writing.

The problem is that the patient requires assistance to settle for the night.

The desired outcome is for the patient to have a peaceful night and wake feeling refreshed.

The evaluation would be nightly

The nursing action would be to offer a hot drink, attach a night bag to the catheter, arrange pillows in preferred position as he likes to lie on his side, and assist him to change his position overnight.

Page 876 of the notes is Nursing Care Plan, for a night time assessment. I do not work nights and it would be unfair for me to comment on this care plan.

Page 877 of these notes is a Waterlow Pressure Sore Prevention/Treatment Policy dated 22/9/98 (22/09/1998). This is not in my writing at the top of the page, but the figures are in my hand. This form is used in relation to pressure sores and the following headings should be considered,

Patient's build/weight for height
Skin type and visual risk areas
Sex/Age
Continence
Mobility
Appetite
Neurological Deficit
Major Surgery

Trauma
Medication.

Arthur CUNNINGHAM's score was 20, which is known as a very high risk of pressure sores.

Page 878 of the notes is a Lifting/ Handling Risk Calculator. This form is not often used and indeed has not been completed in this case.

Page 879 is a further Nursing Care Plan. The top part of the form is not in my writing but the text of the form is in my hand.

On 21/9/98 (21/09/1998) under the problem sub heading I have written, "Large sacral sore present on admission.

SPSSS 3.4" I have signed this entry

On the desired outcome sub heading I have written "To aim to promote healing and prevent further breakdown

Under evaluation I have written, "Daily"

On the Nursing Action I have written, 1) Clean with normal saline
2) Apply Paranet with Allevyn
3) Secure with Hypafix

On 25/9/98 (25/09/1998) I have written, "Removed Granuflex dressing"
I have signed this entry.
SPSSS means Sterling Pressure Sore severity scale.

On page 880, which is a further Nursing Care Plan and I have written and signed two entries.

ON 24/9/98 (24/09/1998) I have written, "Dressing renewed using Paranet, covered with Allevyn secured with Hypafix" I have signed this entry.

On 25/9/98 (25/09/1998) I have written, "Dressing renewed using bordered Granuflex"
I have signed this entry.

Page 881 of the notes is another Nursing Care Plan regarding Arthur CUNNINGHAM. I have written this Care Plan which is dated 21/9/98 (21/09/1998). The problem is described as a blister to heel. Superficial grazing to both ankles.

The desired outcome is to aim to promote healing and prevent further breakdown.
The evaluation date was 4-5days.

The Nursing action is described as 1) Clean if necessary with N/Saline
2) Apply Duoderm dressing
3) Change dressing every 4-5 days

I have signed this entry.

Page 882 of the Nursing Notes is a Nursing Care Plan, which I have written the following entries;

22/9/98 (22/09/1998) "Duoderm applied to both areas" I have signed this entry.
24/9/98 (24/09/1998) "Dressings intact" I have signed this entry.
Duoderm, Paranet, Allevyn, Hypafix and Granuflex are all protective dressings.
Page 883 of the medical notes is a Nursing Care Plan written by me and dated 22/9/98 (22/09/1998).
The problem is described as requires assistance with personal hygiene due to Parkinson's disease. I have signed this entry.

The desired outcome is described as to aim to achieve an acceptable standard of hygiene. I have signed this entry

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The evaluation date is daily

The Nursing Action is described as 1) Daily bed bath/bath/shave

2) Ensure hair, nails, ears clean

3) Report any changes in skin condition

4) Apply Diprobase to any areas of dry skin

5) Ensure privacy at all times

I have signed this entry.

Diprobase is a type of moisturising cream

Page 884 of the notes is another Nursing Care Plan regarding bed baths. I have written and signed two entries

24/9/98 (24/09/1998) "Bed bath"

25/9/98 (25/09/1998) "Bed bath, liquid paraffin to dry areas."

Page 885 of the notes BJC/15 is another Nursing Care Plan which I have completed on 21/9/98 (21/09/1998).

For the problem, I have written, "Catheterised on admission"

I have signed this entry

For the desired outcome I have written "To aim to keep catheter patent and prevent infection"

The evaluation date "I have written, "Daily"

The Nursing action is described as 1) Change and date bag every 7 days

2) Observe urine for colour, odour and consistency

3) Empty drainage bag as required.

I have signed this entry.

Page 886 of the medical notes is another Nursing Care Plan. I have completed one entry;

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On 23/9/98 (23/09/2998) I have written, "Catheter bag emptied"
I have signed that entry.

On Page 837 of the medical notes BJC/15, this is a prescription sheet for the patient Arthur CUNNINGHAM. I can confirm that on 25/9/98 (25/09/1998) at 1015 hrs I administered 60 mgs of Diamorphine, 1200mcgs of Hyoscine and 80mgs of Midazolam through a syringe driver, over a 24 hour period.

Diamorphine is a painkiller

Hyoscine is used for drying up secretions in the chest

Midazolam is a sedative.

STATEMENT TAKEN - Code A