Portsmouth Hospitals NHS
NHS Trust

Complaints Department
Education Centre
St Mary's Hospital
Milton
Portsmouth PO3 6AD

[TIME \@ "dd MMMM yyyy"]

Code A

PRIVATE AND CONFIDENTIAL

Code A

(Please quote our ref. On all correspondence)

Dear Code A

You may not be aware but I have recently been appointed Chief Executive of this Trust and that is why I am responding to your letter regarding the care and treatment of your Code A

As you raise a number of issues in your letter I will give a brief summary of your Code A illness and then address your points individually. The information given below has kindly been supplied by Dr Iain Cranston, Consultant Physician who was responsible for Code A care while Code A was in Queen Alexandra Hospital.

I understand that Code A was admitted to Queen Alexandra Hospital from Gosport War Memorial Hospital (GWMH) suffering from a low salt level and secondary to this, confusion. From Code A medical history it would appear that the sudden deterioration had occurred concurrent with a slower more gradual deterioration of Code A mental function.

Initial investigation discovered that there were inappropriate secretions from the pituitary gland. The hormone from this gland regulates the sodium levels in the urine. This condition was corrected by restricting Code A Code A fluid intake and stopping Code A anti-depressants; which were deemed unnecessary by the psychiatrists. It is of interest to note that the onset of your Code A sodium level problems coincided with the start of this medication. The levels were maintained while on a supplemented normal diet and required no other specific action.

Other investigations revealed that Code A was not suffering from an infection nor was there any indication of hormonal abnormality. The return to a normal sodium level was associated with a marked improvement in Code A mental state. This to a point where your Code A no longer wished to remain in hospital.

Dr Cranston was informed at this time that Code A bed at GWMH was no longer available, therefore after consultation with Dr Quereshi, a member of the Elderly Medicine Team, your Code A was offered the following alternatives:

- A transfer to the Elderly Medicine Unit, South Block Queen Alexandra Hospital
- A transfer to the Elderly Medicine Unit, St Mary's Hospital
  (at either Code A would have received further observation of her weight on supervised a diet and monitoring of Code A sodium levels)
- Discharge home with a weekly day hospital review to check that Code A weight and sodium levels remained stable.

Code A was quite adamant that Code A wished to return home and have any further investigations and follow-up co-ordinated through the day hospital. Discharge was arranged to take place on a Saturday because the medical team had been informed that Code A who worked during the week would, on that day, be available to assist.

Meeting

Dr Cranston agrees that there was some confusion following Code A transfer from GWMH. Therefore following his Post Take Ward Round, his team decided that input from your Code A family would be helpful. Dr Cranston's Senior House Officer (SHO), Dr Logan therefore arranged a meeting with you for the Monday afternoon. Unfortunately, Dr Logan was unaware until late on the Friday that Dr Cranston had already booked annual leave for the Monday. It was therefore decided that the meeting would go ahead with Dr Logan. Again, unfortunately, Dr Logan was ill and Dr Deacon another SHO from Dr Cranston's team met with you. I would like to reassure you that Dr Deacon was not unfamiliar with your Code A care.

Following this, it was impossible to arrange a meeting with you as you were in Australia. However, staff attempted without success to contact both Code A

Dr Cranston was made aware that your meeting with Dr Logan did not go well and she therefore suggested a meeting between Dr Cranston and yourself. However, in the event neither of you were able to attend as Dr Cranston was away on 29 and 30 October and you had left for Australia over the weekend of 26 October 2001. By the time you had returned to the UK, Code A had been discharged.

Communication

As previously stated the transfer from GWMH was rather confusing. During the previous 5 weeks, investigation into your Code A condition had been planned and carried out by Psychiatry and the Elderly Care Physicians. It is unclear, but Dr Cranston assumes that Code A transfer to Queen Alexandra Hospital was planned by the Elderly Care Unit. However, when Code A was admitted it would appear that the Elderly Care Unit had no beds and as this team has a policy of not seeing patients when there are no beds your Code A was admitted to the Medical Assessment Unit. This again was cause for concern as although Code A required admission, Code A was not acutely ill and could have waited for transfer until an Elderly Care bed was available and this could have been undertaken at a more acceptable time.

On the day following Code A admission, GWMH was contacted about your Code A medical history, they were unable to add much to what was already known, although it was stated they did not believe Code A to be suffering from depression.

Once Code A condition had stabilised GWMH were again contacted but staff were told that Code A bed had been allocated to another patient. Until this time Dr Cranston had been under the impression that Code A was to return there. Plans were therefore made via the Elderly Medical Team for Code A post discharge needs.

Communication with Elderly Care Team – Follow-up Requirements

Dr Querishi discussed your Code A follow-up needs with Dr Cranston. He was quite happy to list Code A for further in-patient management at St Mary's Hospital or, to arrange weekly follow-ups at the day hospital. In light of the dramatic improvement in Code A mental state and Code A increasingly voiced desire to be allowed home, Code A was approached about Code A discharge. There were attempts to contact other members of the family but these proved unsuccessful.

A letter confirming what was discussed, was sent to the Elderly Care Team shortly afterwards

Communication – GP

Discussion following Code A admission to Queen Alexandra Hospital did not seem relevant simply because Code A had already been resident at GWMH for the previous five weeks. Dr Cranston received a telephone call from your Code A GP on 13 November asking him to clarify Code A follow-up arrangements, this he did, responding the same day.

On-going Communication

The on-going issues of Code A slow mental decline over months were not those requiring Code A admission to an acute facility such as Portsmouth Hospitals NHS Trust. Such investigation should continue either as an out-patient or in a residential unit, if deemed appropriate. These issues would of course have been better discussed face to face. However, Dr Cranston would like to emphasis that many attempts were made to contact several members of your family. Dr Cranston also personally attempted, several times on 31October and 1 November 2001, each attempt meeting with failure.

Communication – Discharge

Dr Cranston runs a clinic and The Royal Hospital Haslar on Friday mornings and therefore was not involved in the discussion about Code A discharge. Clearly any discharge over the weekend will mean that General Practitioners, Social Services etc., will not be contacted until the following working day. It is standard practice however, within the Trust, that this be fully explained to relatives so they are aware of potential problems and the need for increased family support. Although I understand that the situation deteriorated following Code A Code A discharge, Dr Cranston has stated that your Code A was very insistent about going home, Code A arguments to do so were well reasoned and Code A was self caring. Lastly, as Code A mental state was much improved there is little that could have been done but accede to Code A wishes. Further, as stated in the summary the Saturday was decided upon to fit it with the wishes of you Code A and, following exhaustive attempts to contact other family members.

Lack of Care

You will note from the information given above that Dr Cranston spent considerable time talking to other professionals about Code A and attempting to contact members of your family. In retrospect he believes there were several areas which could have been better dealt with. He believes Code A admission should have been as result of a direct referral to the Elderly Medical Team as Code A was not acutely ill. This would have avoided a late night admission and more importantly the number of ward moves Code A suffered. Policy on transfers has now been altered and patients will no longer be moved after 9pm. Sadly, with the Trust running almost constantly at a 100% bed occupancy, ward moves are inevitable. Direct admission to the Elderly Care Unit would have avoided this.

Dr Cranston states that although there is no evidence to support his theory, he feels that the ward moves may have been a contributory factor in the developing of a pressure sore because of the number of different nursing teams involved in Code A care.

I am very sorry that this was such a distressing time for your family and I fully appreciate how very difficult it must have been for your Code A

I do hope that this letter has addressed the issues you raise and would especially like to apologise for the length of time it has taken to respond. Unfortunately, the Complaints Department has suffered severe staff shortages in recent months, these have now been addressed, although I understand this will be of little comfort to you.

If you would like to discuss this matter further I would suggest you contact my Complaints Manager, Code A Code A The address and telephone number is shown at the top of this letter.

Finally, thank you for taking the time to write and bring this matter to my attention. I have for your convenience enclosed additional copies for you to pass on to your GP and the Members of Parliament who received copies of your original complaint.

Yours sincerely

Alan Bedford
Chief Executive