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Copy: Ms. G. Wannell, Chief Executive.

9th July, 2003.

Dear Mr. Johnson,

Mary Edith Hunt, (Hospital No. C150590)

Thank you for your letter dated 24th June with references to documents available on the *Department of Health* web site.

I append a list of concerns –74 items grouped under 10 headings– relating to experiences whilst my mother was a patient in the West Middlesex earlier this year. I trust that you will be as eager to have them investigated as I am.

I should like to stress my belief that, while the eventual goal must be to improve conditions for patients, the initial emphasis must be upon an accurate and unflinching diagnosis of the problems which beset my mother's care and treatment, then on determining the underlying causes. It may be that some of the solutions will then be found to lie beyond the capabilities of the Trust. However, without a proper investigation, any proposed remedy can be at best partial and haphazard.

I look forward to receiving the results of your investigations and the recommendations proposed as a result. Please could you let me have an estimate of how long you think each phase is likely to take?

Yours sincerely,

In November I received a reply from Hazel Wallace, (with a covering letter from Gail Wannell): 28 occurrences of "*I am sorry*", 18 "*I am very sorry*", 21 apologies (one *sincere*, one *unreserved*), and 6 "*clearly not acceptable*": but with claims of (partial) improvements only in relation to points 3, 8, 9, 14, 23, 24, 25, 30, and 38. The only change apparently being monitored is no. 23 (cleaning arrangements).

C o n t e n t s

[EoC-p.184]: "***Patients/clients feel that they matter all of the time***"

Key to References

[CN*dd.mm*] Hospital Notes: Entry (mostly by doctors) in *Clinical Notes* on date *dd.mm*

[PR*dd.mm*] Hospital Notes: Entry by nursing staff in *(Patient) Progress Report* on date *dd.mm*

[EoC-] DoH *Essence of Care*, (www.doh.gov.uk/essenceofcare). References as in .PDF version.

1) Infection Control and Hygiene Practices

Cf. [EoC-p.58]: " ***State infection control arrangements that ensure health care worker and patient/client safety***"

1. ***Sterile Gloves***: On one occasion I saw a nurse pick rubbish off the floor in the corridor whilst wearing gloves, and then return, wearing the same gloves, to treat a patient. I have seen nurses drawing curtains whilst wearing gloves, prior to treatment: e.g. JB [14th April]. I do not know how sterile the curtains in the West Middlesex may be: but, in the hospital where my father died in February, I saw one that appeared to be soiled with dried fæces.

   1.1. Who are the gloves designed to protect: patients or staff?

   1.2. Why are staff not educated in elementary hygiene?

I am very sorry that when you were visiting your mother on the ward, one of the staff nurses picked up rubbish from the floor whilst wearing sterile gloves and then returned to treat another patient. That was clearly unacceptable. Sterile gloves are used by staff as means of protecting themselves but also as a measure to reduce the risk the cross contamination between patients. I would like to assure you that maintaining high standards of cleanliness and reducing the risk of infection is one of the hospital's highest priorities. To that end, all Trust staff receive training in the importance of hygiene and the hospital's infection control team hold regular training sessions with staff to raise awareness in this area. **I have asked Jacqui Whybrow to make sure that the issues that you have kindly raised about the use of sterile gloves are shared with the relevant staff.**

2. ***Isolation – Information***: On the 9th March my mother was moved into an isolation room. On the 13th March an A4 notice on red paper appeared beside the door, (although I did not see it until it was pointed out to me by another patient). [PR13.3] records "*MRSA+ of sputum*". I spoke to Staff Nurse JL, and was told that my mother had COPD and continuing infection. MRSA was not mentioned.

   On the 14th March I was told by the consultant of the MRSA diagnosis. When a friend suggested that I should ask for directions about physical contact with my mother and washing her laundry, I was told by a nurse that it would be sufficient to wash items at 60° Fahrenheit (sic!) [15th March]. In the absence of any instructions to the contrary, I continued to kiss her goodbye when leaving.

   2.1. What instructions should I have been given about physical contact?

   2.2. What instructions should I have been given about taking laundry home?

   2.3. If I was not given the correct information: why not?

I am sorry that the ward staff did not provide you with more information about physical contact with your mother after she developed MRSA. Ms Whybrow has advised me that it was still appropriate for you to continue to have contact with your mother and she has explained that due to your age, fitness and health it is unlikely that you would have been at risk of acquiring the MRSA infection. It was unfortunate, however, that the nursing staff provided you with confusing advice about the washing of your mother's laundry and I apologise for that error. **I have asked Ms Whybrow to make sure that the nursing staff are reminded of the importance of providing accurate and reassuring information to patients and their relatives.**

3. ***Isolation – Consensus***: On the 25th March I asked the registrar whether, in order to relieve the monotony of being stuck in a side room, I might take my mother in a wheelchair around the hospital grounds, (although the only park is car park). I was told that would not be possible, as the "infection control nurses" (whoever they might be) would object, because of the risk of infecting other patients. Yet the same week the physiotherapists took my mother for daily practice climbing the main staircase.

   3.1. Whose attitude concerning infection control was correct?

   3.2. Why is there no discussion / consensus / joined-up-thinking between staff?

Similarly, I am sorry that the nursing staff **[it was the *Registrar*]** were not more helpful and proactive when you suggested taking your mother in a wheelchair around the hospital. Ms Whybrow has advised me that the nursing staff could have and should have been more supportive when you made this suggestion and the risk of infection should not have been used as an excuse. I apologise for that failure. **Ms Whybrow has been liaising with ward staff to ensure that we learn from your experiences.**

4. ***Isolation – Effective Control***: A week after my mother was moved out of the side room, I noticed the patient who had been moved there leave the room, apparently going to join other patients at the entrance to the building for a cigarette. The red notice, (which was removed not later than the 4th April – though I have located no reference in the medical notes to its removal, nor any explicit reference to curing the MRSA infection), was back in position.

   4.1. If patients are genuinely considered to be a risk to other vulnerable patients, why are they allowed to roam and mix with them freely?

I see from your letter that you saw another patient who had been moved to a side room, leave the room, apparently going to join other patients at the entrance to the building for a cigarette. I am very sorry that the staff were not more proactive in encouraging the person not to leave her **[his]** room but I hope that you can understand that ward staff cannot prevent patients from leaving the hospital if they so wish. **[Either infectious patients represent a risk to other patients, (in which case their movements should be appropriately restricted), or they do not. In either event, patient + visitors + staff should all be accurately informed.]**

5. ***Food Hygiene***: I was surprised to see meals being served from a trolley on which all the plates were uncovered. Elsewhere I have noticed that covers are still on plates when the tray is given to the patient.

   5.1. Is it nowadays considered to be acceptable practice to wheel meals uncovered through the corridors, (where infectious patients and visitors may be roaming at large, coughing and sneezing)?

I am grateful to you for bringing this matter to our attention. It is clearly not acceptable to transport food on trolleys, with all the plates uncovered, It might be helpful if I explain that since the events you have complained about, the hospital has changed its' contractor for providing patient food. Nevertheless, to ensure that lessons are learned from your feedback, **I have asked Ms Whybrow to liaise with the catering supervisors to make sure that all food is transported in a safe way before it is served to patients on the ward. She has also fed your helpful observations back to the senior nurses on the wards who have responsibility for monitoring the arrangements at meal times.**

6. ***MRSA***: During the night 4th–5th March my mother had a severe bout of diarrhœa during the night, (saying that she'd had nothing like it since eating "*tons of plums with their skins on*" as a child); then on the evening of the 6th she had a number of violent coughing fits to try to bring up phlegm, and ended up breathless afterwards. I mentioned this to Charge Nurse SS, who ordered a nebuliser,

and said he would inform the night staff. On the nights 6th–7th and 7th–8th she was given oxygen, and on the 9th moved to the side room. [PR13.3] records "*MRSA+ of sputum*".

6.1. What do you consider to be the most likely route(s) by which my mother contracted MRSA?

I see from your letter that you ask what was the most likely route by which your mother contracted MRSA. It might be helpful if I explain that MRSA can be contracted both in the community and in a hospital setting. I have been advised that it is often only detected when pathology requests are made after a patient has been admitted to hospital. I am afraid that we are not in a position to provide a definitive answer to this aspect of your complaint but Ms Whybrow has explained that there are several ways in which the infection can spread. These include open wounds or through sputum. In your mother's case, having carefully reviewed her clinical records, Ms Whybrow considers that the infection was likely to have been acquired through the airborne route. **[Incubation period? Emphasis on sterile gloves / washing hands / …?]**

2) Facilities and Equipment

7. ***Feeding utensils***: When my mother became too weak to sit up to drink, I made enquiries about obtaining specialised crockery. I also left a message for the occupational therapist, who responded the following day by leaving a catalogue for *Keep Able* in Staines on my mother's bedside cabinet. In fact I had already visited the shop and determined that they sold nothing suitable for my mother's immediate needs. Following a recommendation from a friend, I placed an order with a shop in Whitton, *Additional Aids*, for a cup-with-spout for drinking soup, (described as a "Teapot Feeder"). Unfortunately this took a week to arrive, so that I was able to collect it only on the morning of the day that my mother died. (Having sourced the item, I contacted several other agencies: but found to my amazement that none was able to offer speedier delivery.)

7.1. Why are such items not provided by the hospital?

7.2. Why are such basic items not kept in stock, given that the alternative is to wait a week or more, fasting?

I am very sorry that the ward staff were not more helpful in providing your mother with a cup-with-spout (or "Teapot Feeder") to assist with the drinking of soup. I appreciate that your mother had become weak and could not sit up in bed to drink. We currently do not stock this type of equipment on the ward but **I have asked Ms Whybrow to explore this issue with her management colleagues in the Occupational Health and Dietetic teams.**

8. ***Oxygen points***: There appeared to be a severe shortage of these. When my mother was moved into a side room, I was told by two other patients in bay 11 (where she was previously) that this was because she needed oxygen, (corroborated by [PR9.3]), and that only one of the four beds in the bay had an oxygen point. I noticed that other patients were also moved around in search of oxygen.

On the evening of the 17th March two nurses attempted to fit a water bottle to the oxygen supply. Despite repeated attempts they couldn't get it to stop whistling. Although the bottle remained in the room for several days, it was never installed.

8.1. Why is there such a shortage of oxygen points?

8.2. Why are staff unable to exploit them as required?

I am sorry too, that the ward staff were not able to access oxygen for your mother as quickly as we would have liked. As you probably aware, the Trust is currently undergoing a major redevelopment programme and as part of that work a new hospital opened on the site in May of this year. The inpatient

area in the Medical Block where your mother was nursed earlier this year has been closed and is currently undergoing redevelopment. I acknowledge that at the time of your mother's admission there was limited access to oxygen points in some of the main ward areas. I apologise for the distress and inconvenience that the lack of facilities caused. I am pleased to report that as part of the new development, **all of the beds in the new hospital will have their own individual dedicated oxygen points.** If you feel that it would be helpful, **I would like to offer you the opportunity to visit the new ward areas so that you see at first hand the improved patient facilities.**

9. ***Power points***: On the 19th April I had to clamber round obstacles to drape an extension lead around my mother's bed and other furniture in order to plug in a nebuliser, owing to the shortage of power points in the bay.

    9.1. Why is there such a shortage of power points?

Similarly, it was regrettable that you had to climb over obstacles to drape an extension lead around your mother's bed and other furniture in order to plug in her nebuliser, owing to the shortage of power points in the bay. That was clearly unacceptable and unsafe. We recognise that **as part of the hospital redevelopment, we needed to improve the facilities that we are able to provide to our patients to enable greater access to services such as power points.** It might be helpful to mention that as part of the hospital redevelopment we are **now able to offer each patient their own individual entertainment unit which includes access to television, radio, direct line telephone and the Internet. [Cost? Off switch? www.guardian.co.uk/Society/health/news/0,8363,1188137,00.html Annoyance to other patients?]**

10. ***Bedding***: During the final week of my mother's life, I discovered that there was a shortage of blankets and pillows. I observed several patients over this period who had difficulty in obtaining what they required. On the 15th April I was advised by a nurse to pillage an unoccupied bed in Room 1, as the storage cupboard was empty.

    10.1. Why was there a shortage?

    10.2. Is this a regular problem?

    10.3. Why are support pillows (variously described as L- or V-shaped) not available?

I see from your letter that during the final week of my mother's life, you discovered that there was a shortage of blankets and pillows and you were advised by a nurse to pillage an unoccupied bed, as the storage cupboard was empty. That was clearly unacceptable practice and I apologise for any upset or inconvenience caused. **Ms Whybrow has spoken to the staff who were on duty at that time and they report that there was no record of bedding shortage during this period. [Since there patently *was* a shortage of *available* bedding, this indicates a problem with record keeping.] However, she has asked the senior nursing staff to keep this matter under review and to report any concerns to the hospital's facilities team who are responsible for managing these supplies.** Turning to your specific question as to why "L or V Shaped" pillows are not available, Ms Whybrow has explained that the **nursing staff are normally expected to use two ordinary pillows and shape them into a "V" shape for a patient,** if required. **[Unfortunately patients who are not yet dead may move, thereby destroying the arrangement.]**

11. ***Electric profiling bed frames***: Although my father had one of these during his final weeks in hospital, to make it easier and safer (both for staff and for him) to move him in bed, I was not aware of any in MD2/3/4 until the day before my mother died. The "sliding sheet" method of moving her up and down the bed an indeterminate number of times a day was ***visibly extremely painful*** for her, and must have exacerbated her pressure sores.

    11.1. Why did no one ever suggest putting my mother on one of these? It would have been considerably more comfortable for her. It would also have relieved the burden on staff.

Latterly it required two people every time she needed to sit up or lie down: often resulting in considerable delays while two were found!

11.2. A temporary Health Care Assistant brought in over Easter (to tend to a single patient) asked me for the "remote control", and was amazed that my mother did not have an electric bed. (The patient she was caring for *did* have such a bed.) Presumably other hospitals where she has worked have been better equipped or better organised.

Unfortunately, at the time of your mother's admission, I have to acknowledge that the hospital had limited access to electronic profiling bed frames. I appreciate that given her condition and prognosis, this type of equipment would have made her more comfortable **[or enabled her to be discharged!]** and I am sorry that we were not able to provide this. It might be helpful if I explain that the hospital is currently going out to tender with a view to improving our provision of this particular form of equipment. **Our ultimate aim is to achieve a standard of providing an electric profiling bed frame within four hours of it being deemed clinically appropriate. [When will this standard be achieved?]**

12. ***"Special air mattress"***: On the evening of the 2nd April an air mattress was taken into my mother's room: but it was agreed to install it the following morning. As I arrived on the afternoon of the 3rd, a nurse was removing the mattress. When I enquired why, I was told it could not be inflated, but that a replacement had already been installed. As I was not familiar with air mattresses, it was only on the 11th April that I learnt that, contrary to what I was told, no substitute had been provided.

12.1. How did it happen that a faulty mattress was brought?

12.2. What was the source of the confusion that a substitute had been provided?

12.3. Why is there no routine review to confirm that plans have been properly executed?

Similarly, **the Trust has recently entered into a new contract with a supplier who will be providing all of our special air mattresses. Ms Whybrow has acknowledged that at the time of the events complained about, the management of special air mattresses in the ward areas was poor. She has explained that the mattresses were often stored incorrectly and the control and monitoring arrangements were generally inadequate.** In your mother's case, these poor management arrangements, resulted in a faulty mattress being supplied and contributed to the confusion around the provision of a replacement. I apologise for that failure.

13. ***"Inflated ripple mattress"***: On the 10th April JT told me that a ripple mattress was ready to be installed the following morning. Only late on the afternoon of the 11th after speaking to the Senior Nurse did I discover that the air mattress ordered the previous week had never been installed. The ripple mattress was installed the same afternoon: but I later noticed that the attached pump began emitting a warning bleep every half hour. I told a nurse, who seemed rather disinterested and retorted that the beep could be stopped by switching the pump off and on again. He was not concerned that this would wake patients constantly throughout the night. After the night shift came on duty, I warned the sister about the pump: she said that would mean replacing the whole mattress, which would have to wait until the morning.

13.1. Why was a second faulty mattress brought?

13.2. Is there no check whether equipment returned to stores requires repair or replacement?

13.3. What checks are there that equipment is returned to stores? – I noticed a bedstead with mattress left *for several days* by the lift shaft.

As I have explained above, at that time, the arrangements for monitoring faulty mattresses on the ward were poor. We are confident, however, that **our new bed contract will significantly improve the management of faulty equipment and the provision of this important equipment.**

14. ***Physiotherapy***: On various occasions my mother was walked during visiting hours up and down the corridor using a Zimmer frame. On the 25th, 26th, and 27th March she was taken to the public staircase by two physiotherapists to exercise and improve her mobility, in the expectation that she would shortly be discharged.

    14.1. Is it standard or recommended practice for frail patients of limited mobility to practise in major thoroughfares such as public corridors and staircases? Surely there should be rooms, suitably equipped, where patients can exercise in safety in a controlled environment?

I am very sorry that your mother had to practise her mobility exercises in major thoroughfares such as public corridors and staircases. **That was clearly unacceptable and I apologise for the embarrassment and awkwardness [Danger!]** that this caused. I am pleased to let you know that as part of the redevelopment programme **each floor of the new hospital has its own dedicated therapy room** where patients can safely undertake their exercises in private and with dignity **[and safety?]**.

15. ***Allocation of resources***: On the 9th March my mother was moved to a side room; on the 14th March I was told by the consultant that she had contracted MRSA; on the 4th April I noticed that the sheet of red paper beside the door had been removed, which I interpreted as meaning that she was clear of MRSA – although this was not stated. (An entry in [CN8.4] –"*Aim to move out of side room into main bay for stimulation*"– was communicated neither to me nor to the Senior Nurse.) On the 11th April I had a discussion with the Senior Nurse, during which I enquired whether there was any continuing necessity for my mother to be kept in the side room, with only one wall to stare at, (since at that point she was too weak to turn over unaided). I was surprised to be told that it would not only be beneficial *for my mother* to be moved back into a standard bay, it would also be useful "*for us*", (i.e. the staff), because another patient was in need of a side room. Presumably my mother had at that point been kept in solitary confinement for a full week longer than necessary, which will have served only to deepen the depression which led to her death.

    15.1. Why was the written entry on the 8th April not communicated to anyone with relevant authority?

    15.2. Why is there no regular review and reassignment of resources by those responsible for allocating them?

I am very sorry that your mother could not have been moved **[could have been but wasn't]** from her side room into a standard bay sooner. I appreciate that this only compounded the depression that she was experiencing. Ms Whybrow has explained that side rooms are generally a scarce resource in the general wards and **she has assured me that the nursing staff would not have kept your mother in the side room longer than necessary**. **[My mother was kept there longer than necessary: partly because the written recommendation in [CN8.4] was not communicated to anyone; and partly because there was no regular discussion to review her needs.]**

3) General Nursing Care

16. ***Staff shortages***: Much of the time there appeared to be a severe shortage of nurses. This was not just my own observation, but was also the view of other patients.

16.1. I recall one patient explaining that pressing the emergency button was a complete waste of time: if a fellow patient had an emergency, it was necessary to send someone mobile in search of assistance. – Patients in an isolation ward have no fellow patients to look after them.

16.2. On the afternoon of the 19th March my mother slipped whilst attempting to sit down on the lavatory. I looked in all the bays in both (separately staffed) halves of MD4, and eventually found two nurses (in the "other" half) who were both on the telephone.

16.3. On numerous occasions after my mother became bed-bound, I experienced ***significant*** delays: firstly in finding a nurse to bring a commode, then in waiting while one was brought, and –later on– whilst a second was found to help with the "transfer".

16.4. On the 8th April my mother asked me to help her back into bed. I discovered that the bedding was wet and asked for it to be changed: but eventually gave up waiting and stripped the bed myself, so that my mother could lie down.

16.5. On the 12th April my mother told me that she had asked for a commode and then waited ¾ of an hour, by which time it was too late.

16.6. It was in this setting that my mother became "incontinent": incontinence caused simply by lack of a commode at the time that it was needed! I believe she then gave up attempting to ask, knowing that the emergency button seldom brought a timely response, and having discovered that I was unable to get commodes brought when needed, despite being mobile.

16.6.1. This is not just abysmally poor nursing: I consider it totally inhumane. When animals are kept in confined quarters which they are forced to soil, people call the RSPCA to institute legal proceedings.

16.6.2. Incontinence exacerbates bed sores: as nursing staff should be well aware.

16.7. On the evening of the 16th April my mother wanted to be turned. There was great delay in obtaining assistance, as the only nurse available at the time was pregnant and not allowed to lift patients.

FACTOR	BENCHMARK OF BEST PRACTICE (from[EoC-Chapter 7])
Information for patients/clients/carers	Patients/clients/carers have free access to evidence based information about bowel and bladder care that has been **adapted to meet individual patient**/client **needs** and/or those of their carer
Patient/Client access to Professional Advice re Continence, and Bladder and Bowel Care	Patients/ clients have **direct access** to professionals who can meet their continence needs and their services **are actively promoted**
Assessment of individual patient/client	Patients/clients positive responses to the trigger question **always leads** to an offer of an initial bladder and bowel continence assessment which if accepted by the patient/client is completed as described in Page 11, DOH 2000
Planning, implementation and evaluation of care based on the bladder and bowel assessment (To be completed only if an assessment has been performed)	The effectiveness of patients/clients care is **continuously evaluated** and leads either to the patients /clients needs being met or the modification of the care plan (e.g. referral on)

Education for assessors and care planners	Patients/clients are assessed and have care planned by professionals who have received specific continence care training and are **continuously updated**.
Promotion of Continence and a healthy bladder and bowel	All opportunities are taken to promote continence and a healthy bladder and bowel among patients/clients **and the wider community**.
Patient/Client access to Continence supplies	Patients/clients **have access** to appropriate 'needs specific' supplies to assist in the management of their incontinence
Education of the care deliverers	Patients/clients are cared for by carers who have undertaken continence care training which includes **ongoing updating**
A Physical and Social Environment Conducive to continence and a healthy bladder and bowel	All bladder and bowel care is given in an **environment conducive to the patients/clients individual needs**
Patient to Patient Support	Patients/clients/care[r]s have the opportunity to access other ps/clients/care[r]s who can offer support and this is **actively promoted**
User Involvement in service delivery	**Users are always involved in planning and evaluating services, and their input is acted upon**

I was particularly disturbed to read about the series of delays that you experienced in finding a nurse to attend your mother when she needed the commode or required changing when she was wet. I appreciate that this must have been an extremely distressing and upsetting time for both your mother and you. I agree that the nursing staff should have been more responsive to your mother's needs and I offer you my unreserved apologies for the repeated failures in care that you have highlighted. I see from your letter that you specifically express concern about the staffing levels on the ward at that time. **Ms Whybrow has checked the shift rosters from that time and has assured that the staffing levels and the nursing skill mix matched the dependency and the needs of the patients on the ward at that time. [Given that this was a repeated and regular occurrence, I suggest that the records were incorrect, *or* staff were absent *or* the needs of patients were incorrrectly assessed.] However, she will ensure that the issues you have raised about the poor standard of basic nursing care are raised at the hospital's nursing quality and risk group. [What changes have resulted? Is the result being monitored?]**

17. ***Emergency button***: More often than not, it appeared that there was no attempt to ensure that the emergency button was positioned within easy reach. This may not be an issue for healthy patients who are mobile: but should surely be a matter of routine concern for patients who are frail and immobile.

    17.1. Why are staff not trained to do this?

    17.2. Why are there insufficient staff to respond when a patient calls for assistance?

Ms Whybrow has advised me that your mother's emergency button should always have been kept in easy reach and I am sorry if this was not the case. It might be helpful if I explain that **in the new hospital wards we have successfully redeveloped and enhanced the call bell system into an intercom service. Under the new arrangements patients are able to communicate directly [is this accessible by patients with limited mobility?] with nurses who are based at the central station ["based" there does not guarantee that it is staffed at all times] and the nursing staff have an improved observation vantage point. We would be happy to demonstrate this system should you consider it appropriate.**

18. ***Missed Meals***: On the 24th March my mother wasn't given an evening meal. Having noticed that other patients *had* been given their meals, she enquired what had happened and was given a sorry-looking sandwich, which I found her eating when I arrived. I do not know how often this happens: but I find it shocking that it was allowed to happen at all. – Cf. [EoC-Ch.6].

    18.1. Why is there no procedure in place to ensure that patients –especially if frail and isolated in side rooms– receive all the meals that they should?

I was sorry to read that your mother was not offered her evening meal on 24th March and when she enquired she only received a very poor quality sandwich. **I would like to assure you that our nursing staff maintain close working relationships with the food hostesses and where necessary the hostesses will report any instances where patients do not receive/or refuse their meals. [When was this instituted?]** I am sorry that your mother was not given her evening meal on this occasion. **Ms Whybrow has discussed this aspect of your complaint with her senior nurse colleagues reminding them of the importance of effective patient nutrition management.**

19. ***Missed Drinks***: On several occasions I noticed while my mother was in the side room that, if the door was closed because she was being seen by doctors or assisted by nursing staff, no attempt was made to replenish her water jug. Although I was able to do this once the door was reopened, I wonder how long patients who don't have a timely visitor have to wait. – Cf. [EoC-Ch.6].

    19.1. Why do staff supplying drinking water not note patients they have been unable to tend, so that they can return later?

Similarly, I am sorry that the hostesses made no attempt to replenish your mother's water jug while she was in the side room. **Ms Whybrow has already raised this matter with Hostesses manager so that we can learn from this unfortunate experience.**

20. ***Feeding***: On the evening of the 1st April I overheard the nursing staff handing over to the night shift, and discovered that my mother had eaten virtually nothing all day. The attitude of the nurses was "*the doctors saw her this morning*", followed (when pressed) with a recommendation to ask for a doctor the following day!

    On the 2nd and 3rd she also ate very little. On the night of the 3rd I discussed the situation with a friend, who suggested trying to tempt her with chicken soup or mashed banana. The following day, (after three days of virtual fasting), my mother responded to this. The comment of a family friend later was: "*That's elementary nursing! We learnt all that in the Brownies!*".

    On the 4th I discovered that my mother, in her weakened condition, found it much easier to drink soup from a mug than from a bowl with a soup spoon. I suggested to the nursing staff that she might do better on soup or soft food for the time being. Although JT helpfully produced a printed menu, she was unable to find any confirmation that this was possible, although assured me that it would be. I passed on the recommendation about using a mug in preference to a bowl.

    20.1. Why was there no attempt by hospital staff to offer my mother alternatives? Was it lack of thought? Or lack of concern?

    20.2. What training is provided on recommending suitable alternatives for patients who reject the standard fare?

    20.3. Why is it felt that responsibility for feeding should be left to doctors?

    20.4. What policy is there for assisting patients who are unable to feed themselves?

FACTOR	BENCHMARK OF BEST PRACTICE (from[EoC-Chapter 6])
Screening / Assessment to identify patients/clients nutritional needs	Nutritional screening progresses to **further assessment for all** patients/clients identified as '**at risk**'

Planning, implementation and evaluation of care for those patients who required a nutritional assessment	Plans of care based on **ongoing** nutritional assessments are devised, implemented and evaluated
A conducive environment (Acceptable sights, smells and sounds)	The environment is **conducive** to enabling the **individual** patients/clients to eat
Assistance to eat and drink	Patients/clients **receive the care and assistance** they require with eating and drinking
Obtaining food	Patients/clients/carers, **whatever their communication needs**, have sufficient information to enable them to obtain their food
Food provided	Food that is provided **by the service** meets the needs of individual patients/clients
Food availability	Patients / clients have set meal times, are **offered a replacement meal if a meal is missed and can access snacks at any time**
Food presentation	Food is presented to patients /clients in a way that takes in to account what **appeals to them as individuals**
Monitoring	The amount of food patients actually eat is **monitored, recorded** and leads to **action** when cause for concern
Eating to promote health	**All opportunities** are used to encourage the patients/clients to eat to **promote** their own **health**

I am very sorry that YOU FELT that there was no attempt by the ward staff to offer your mother alternative food choices. We always strive to provide our patients with a varied and appetising choice of meals and, where possible, we endeavour to adapt our meals to suit individual needs or provide snack alternatives. Ms Whybrow has explained that where a patient consistently refuses their meals, she would expect the food hostesses to alert the nursing staff. The nursing staff would discuss this with the patient and where necessary involve the doctors and dieticians. I am conscious that at the time of your mother's admission **[I did not meet Jo Jones until the 11th April.]** you raised concerns about her feeding with the Ward Manager, Jo Jones. As you know, following discussion with Ms Jones, arrangements were put in place to monitor more closely your mother's nutrition intake. **[Ten days after I attempted to alert staff about this!]**

21. ***Constipation***: On a number of occasions my mother complained to me that she was suffering from constipation. As one example: on the 19th March Dr. S. arrived while I was visiting. I told him that she had complained earlier that afternoon that she had been constipated for some time. (The relevant *Health Care Assistant Form* has a *BO* entry for the 14th, *BNO* on the 15th & 16th, and no entries on the 17th or 18th – suggesting that she had probably been constipated for 5 days.) A nurse administered an enema, but then had to perform a painful "manual evacuation". This was only partially successful, but considered to be an improvement. The enema was recorded on the *Health Care Assistant Form*. Following this there were *BNO* entries on the 22nd, 23rd, 29th, 30th, and 31st March, (with no entries on the intervening days), and then "*BO (a.m.) small amount*" on the 1st April. From the hospital notes there is no indication that, following this partial manual evacuation, my mother passed anything at all for the next 12 days: nor that staff were at all concerned!

    On the 1st April during my visit my mother asked for a commode at 4:15. At 5:15 a nurse appeared, wanting to administer an enema, (5 minutes after supper had been served). I was told that the fæces were too hard, so another manual evacuation was performed. This episode finished at 6:05.

The entry on the *Health Care Assistant Form* for the 2nd April is unclear, having been run into the entry for the previous day. Over the following 17 days there are three *BO* entries, 6 *BNO* entries, (with an enema given on the 11th April), and no indication for the remaining 8 days. From these entries I assume that my mother was further constipated over the 8 days from the 3rd to the 11th April. On the 14th April I requested a commode, and was afterwards told by JB that he had performed a manual evacuation: although this is not recorded on the *Health Care Assistant Form*. – Cf. [EoC-Ch.7].

21.1. What policy is prescribed for effective monitoring of patients who are severely constipated?

21.2. What nursing care should have been given in this situation?

21.3. How do you account for what actually occurred?

I am very sorry that YOU FEEL that your mother's constipation was poorly managed by the ward staff. I do not underestimate how distressing and upsetting this must have been. Ms Whybrow has advised me that **there is no fixed criteria for managing patients with constipation**. **[But the EoC standards specify *assessment* and *continuous evaluation*: which did not happen.]** She has explained that individual care plans are normally developed and tailored to suit the needs of the individual patient. This is in line with the Essence of Care National Standards which you refer to in your letter. The nursing staff would be expected to apply their clinical judgement to any given situation and seek medical input where necessary. In your mother's case, **Ms Whybrow agrees that the level of monitoring and communication between the nurses and the HCA's could have been better** and **I have asked her to raise this issue at the Trust's quality and risks group meeting.**

22. ***Soiled bedding***: On the 9th April I poured hospital-supplied soup into a cardboard cup, but later found that my mother had spilt a lot of it down the wall and over the sheet. On the evening of the 10th I saw that she still had the same sheets on the bed. – Since at this point she was unable to use a commode unassisted, this should have been apparent to staff throughout the day.

22.1. How soiled does bed linen have to be before staff are required to change it?

22.2. With what frequency do you change bed linen that has not been soiled?

It was regrettable that your mother's bedding was not changed immediately when her soup was accidentally spilt onto her sheets on 9th April. You ask in your letter what frequency does the hospital change bed linen that has not been soiled. Ms Whybrow has advised me that **there are no fixed timescales for changing linen**. It is normally left to the discretion of the nursing staff who can assess how much time a patient spends in bed. Wherever possible, we will always look to involve the patient in that decision process.

23. ***General cleanliness***: On the 11th April I told 3 different nurses about the disgusting state of the height-adjustable table, half of which was completely covered in a congealing, sticky fluid. It needed not just a wipe but a good scrub: yet no one did anything. It was eventually cleaned on the morning of the 14th.

On several occasions I watched cleaners sweeping or washing (parts of) the floor. This was neither thorough nor –judging by the accumulated debris– as frequent as it should have been.

23.1. How filthy does the environment in the ward need to get before anyone will act?

23.2. What is the frequency of cleaning furniture when not yet foul?

23.3. What is the frequency of cleaning floors when not yet foul?

I am very sorry that the nursing staff were not more responsive when you alerted them to the disgusting state of the height-adjustable table. I apologise for that failure. Ms Whybrow has told me that she would have expected the nursing staff to respond to this immediately and **she has raised this matter with the relevant Senior Nurses**. It might be helpful if I explain that our cleaning regimes do vary from area to area in the hospital, but in a general ward setting, there is usually a continual cleaning cycle in process. I am pleased to report that following the opening of the new hospital **the Trust has changed cleaning contractors and developed improved monitoring arrangements. As a result, the hospital has seen a significant decrease in the number of complaints received about poor standards of cleanliness.**

4) Medical Nursing Care

24. ***Self Medication***: When my mother was admitted, I gave staff a list of the medication prescribed by her GP, and was later asked to take the medication in, as the hospital stocks only a limited range of drugs. Nurses then disagreed about how much my mother should retain to administer herself, each having their own opinion, until in desperation my mother complained to the consultant on the 5th March.

    24.1. Why can this not be resolved on the day of admission, or at least within 24 hours, (subject to revision and amendment if circumstances change)?

    24.2. Is it policy that this should be left to the discretion of whichever nurse happens to be on duty?

    24.3. To what extent does the policy specify classes of drugs, the method by which they are administered, and the physical and mental competence of the patient (which may alter)?

FACTOR	BENCHMARK OF BEST PRACTICE (from[EoC-Chapter 4])
Choice about self-care	Patients/clients are **enabled** to make choices about their self-care and those choices are respected
Assessment of self-care ability	Patients/clients self-care abilities are **continuously assessed and inform** care management
Assessing possible risks for patient/client, carers when undertaking self-care	A comprehensive **ongoing** risk assessment is undertaken and all involved in management of self-care including patients/clients and carers are **aware of inherent risks and how these may most appropriately be addressed**
Knowledge and skills to manage self-care	Patients/clients/carers and advocates have the **knowledge and skills to manage all** aspects of self-care
Responsibilities for self-care	Patients/clients and practitioners are working in **partnership to establish their responsibilities** in meeting self-care needs
Access to services to support self-care	Patients/clients/carers and their advocates **understand and can access** the services that organisations can provide
Environmental factors to support self-care	The **environment promotes** patients/clients ability to self-care
Access to resources to enable self-care	Patients/clients can **access resources** that enable them to meet their individual self-care needs
User involvement in service delivery that promotes selfcare	Users **participate** in planning and evaluating services

I see from your letter that when your mother was admitted to the ward you provided staff with a list of the medication prescribed by her GP. I note that you were subsequently **[the same day]** asked to bring in further medication but found that the nurses were disagreeing about how much medication your mother was able to administer herself. I appreciate that this must have been very confusing and distressing and I am sorry that you had to witness this. **[I did not witness it: my mother had to deal with this in my absence.]** It might be helpful if I explain that under our current arrangements, all drugs brought into hospital by a patient are kept in an individual locker. The nursing staff have responsibility for assessing the patient's ability to self-medicate. Although this is essentially a clinical decision the nurses

are expected to follow supporting criteria and wherever possible will look to involve the patient in the decision making process. The criteria used, covers issues such as classes of drugs, the method by which they are administered, and the physical and mental competence of the patient. **Ms Whybrow has advised me that the nursing staff have received training from the hospital Pharmacist on this topic. [Was this just a one-off occurrence, or is it being included in the regular training programme?]**

25. ***Changing Dressings***: Prior to her admission, my mother was receiving weekly visits from the District Nurse, to change a dressing on an injury to her leg sustained in December. I took dressings, supplied by the District Nurse, to the ward every week. Getting the dressing changed by hospital staff was a rather hit-and-miss affair: sometimes the operation slipped for several days. On the 31st March Staff Nurse AF told me that the hospital did not stock dressings of that type, (3M "*Tegasorb*"

27. ***Pressure sores***: After my mother developed bed sores, I lost count of the number of people who responded immediately to the news with: "*That's a sign of bad nursing*". I understand that, once a patient has developed bed sores, they should be turned regularly: but believe that most days she wasn't turned at all. Indeed, it was often quite an ordeal finding staff just to help her sit up to eat, to lie down afterwards, or to use a commode.

In this respect, there also seemed to be a diversity of opinion amongst nursing staff about dressing the sore. On different occasions I was told that cream should be applied daily, or "*whenever she wants*". Equally, although I never saw the wound or the dressing, I learnt that different staff applied different dressings, and was told that one type should remain in place for 3 days, without being changed.

On the afternoon of the 16th April my mother complained that her bed sore was very painful, and asked me to fetch a nurse to look at it. After waiting about an hour, she attempted to smear some ointment on the wound herself: but obviously was unable to see what she was doing. No one came.

27.1. Why are patients at risk of developing bed sores not monitored and preventative action not taken?

27.2. Why do staff not agree how sores should be treated, instead of each following their own whim?

27.3. What action should patients or visitors take in order to obtain timely assistance with anointing, dressing, or turning?

27.4. What measures will you take to ensure that frail and vulnerable patients are anointed, dressed, and turned when required *without* having to ask staff?

FACTOR	BENCHMARK OF BEST PRACTICE (from[EoC-Chapter 8])
Screening / Assessment	**For all** patients/clients identified as '**at risk**' screening **progresses to further assessment**
Who undertakes the assessment	Patients/clients are assessed by **assessors** who have the required **specific knowledge and expertise**, and have **ongoing updating**
Informing patients/clients/carers (Prevention and Treatment)	Patients/clients and carers have ongoing **access to information** and have the **opportunity to discuss** this and its relevance to their individual needs, with a registered practitioner
Individualised plan for prevention and treatment of pressure ulcers	**Individualised** documented **plan** agreed with multidisciplinary team **in partnership** with patient/client/carers, with **evidence of ongoing reassessment**
Pressure ulcer prevention - Repositioning	The patients/clients need for repositioning has been assessed/documented/met/evaluated with evidence of **ongoing reassessment**
Pressure ulcer prevention - Redistributing Support Surfaces	Patients at risk of developing pressure ulcers **are cared for on** pressure redistributing support surface that meet their individual needs, including comfort
Pressure ulcer prevention - Availability of Resources - Equipment	Patients/clients have **all the equipment they require** to meet their individual needs
Implementation of individualised plan	The plan is **fully implemented in partnership** with the multidisciplinary team/patients/clients/carers
Evaluation of interventions by a registered practitioner	An evaluation which incorporates patients/clients/carers **participation in forward planning**, is documented

I do not underestimate what a distressing and upsetting period **[leading to depression]** this must have been and I am genuinely very sorry that your mother developed pressure sores during her admission.

You ask why patients who are at risk of developing bedsores are not monitored and preventative action taken. Ms Whybrow has explained that the nursing staff at this hospital use a nationally recognised system known as the "Waterlow" scoring system for assessing and reviewing a patient's risk of developing pressure sores. These assessments were completed for your mother. She has advised me that treatment plans for pressures sores can vary from patient to patient depending on their individual clinical need. However, she is sorry that the nurses were not more helpful and responsive to your mother. She has explained that treatments such as anointing, dressing and turning should form part of the patients care plan and **she would expect the nursing staff to discuss this with the relatives and look to develop a partnership. She will be discussing this issue with her senior nursing colleagues and she advised me that this aspect of healthcare will be included in the hospital's Essence of Care programme.**

28. ***Swollen legs***: On the 11th March my mother was given a footstool, as her lower legs were swollen and painful. On the 25th March I was told that, in order to treat the swelling, her diet was being supplemented with high-protein drinks. When I visited her on the 31st her legs were so swollen that I had to lift them onto the bed as she was unable to manage herself. Later that day she was seen by a doctor who told her that she was progressing well: but there is no mention in [CN31.3] of her legs.

    On the morning of the 1st April I left a message for the consultant, including mention of the swollen legs. On the 2nd April, Staff Nurse MA inserted a pillow under her legs, in order to drain the fluid: but this was immediately painful, transferring pressure to her bed sores, so not pursued. Later the same afternoon WH tried to use a thinner pillow to elevate the legs: but this was still too painful. He then suggested the recovery position, with an additional pillow at her back, which she found much more comfortable. That evening I was able to speak to the consultant, who said that, since my mother was too frail to send to Charing Cross for a scan; they would try twice-daily injections of heparin, in case there were a thrombosis in the leg.

    On the 16th April my mother was in great discomfort, so I asked the registrar to examine her legs: but no action was taken for 24 hours. By the 17th April the left leg had swollen to twice the size of the right one.

    28.1. Why do doctors not monitor all conditions from which a patient is known to be suffering?

    28.2. Why do doctors not attend patients when told that their condition has deteriorated and that they are in great discomfort?

    28.3. What practical measures can be taken to reduce the discomfort?

    28.4. What practical measures can be taken to reduce the swelling?

I am sorry that YOU CONSIDER that the doctors were not sufficiently responsive to your mother's problem with her swollen legs. You ask why doctors do not monitor all conditions from which a patient is suffering. It might be helpful if I explain that when a doctor is called to review a patient, they sometimes have to prioritise these requests and make a clinical judgement about which patients they should attend first. That notwithstanding, I agree that the medical team should have responded when you mother's condition deteriorated and she was reported to be in discomfort. I apologise for the upset and distress that your mother clearly endured. **Ms Whybrow has carefully reviewed your mother's clinical records and your detailed diary of events and considers that all of the appropriate practical measures (such as keeping her leg elevated and reviewing her diet) were undertaken to try and reduce your mother's discomfort. [No action was taken on the 1st April, nor on the 16th: a delay**

in each case of 24 hours or more.] She has added that the treatments to reduce swelling largely depend on the factors that caused the symptoms. For example, if a patient was suffering with water retention and this was causing swelling then a clinician may consider prescribing a drug to remedy this.

29. ***Holistic approach***: Care was very fragmented.

29.1. A week before admission my mother was prescribed *Nystatin* pastilles by her GP for oral thrush. These had to be sucked slowly and with an interval of one hour between any food or drink. Yet the hospital day was so broken up that my mother was unable to comply with the instructions.

29.2. On the 17th April, after my mother had developed bed sores and swollen legs, I pleaded with the registrar to consider *both* complaints and recommend a comfortable position. It should not be necessary to depend upon visitors to draw attention to such elementary concerns. Despite my request, my mother remained in great discomfort, and I felt that the request was not taken seriously.

I see from your letter that you express concern that your mother was unable to comply with instructions provided by her GP to take her Nystatin pastilles because she found the hospital daily routine was so disjointed. I appreciate that this must have been very frustrating and I am sorry that we were not able to achieve the same continuity of care that she enjoyed at home. Ms Whybrow has explained that wherever possible the nursing staff will try to accommodate the individual needs of the patient but she acknowledges that the nursing staff will often be required to administer drugs and treatments as prescribed by the doctors. I am very sorry that YOU FEEL that your complaints' about your mother's swollen legs and bedsores were not taken seriously by the Registrar. I would like to assure you that your concerns were taken seriously at all times and I am genuinely sorry if YOU FEEL that Trust staff were not prepared to listen to comments. **[No action was taken to find a comfortable position: the registrar did nothing on the 16th, then turned up at 4:00 on the afternoon of the 17th, and proposed doing nothing until the 22nd. My mother died on the 19th.]**

30. ***Appropriate medication***: On the 4th March my mother told me that she had had an angina attack. When she told a nurse that she had pains in her arms, she was offered a pain killer! Only later did she remember her GTN spray and ask the nurse to administer that, while a male nurse brought a cylinder of oxygen.

On the 7th March she told Dr. S. and a colleague in my presence that she had had an angina attack during the night and been given oxygen, but only later, when the pain persisted, had been given GTN spray.

30.1. Why had the nurse not been made aware of why my mother had been admitted, so that she could offer appropriate medication instead of a pain killer?

I am very sorry that the nurse who attended your mother on 4th March was not aware of why your mother had been admitted, so that she could offer appropriate medication instead of a painkiller. There was **clearly an unacceptable breakdown in communication** between the nursing and the medical staff regarding your mother's management and I apologise for this failure. **Ms Whybrow has spoken to the relevant Trust staff reminding of the need for effective and accurate communication between the disciplines.**

31. ***Administering medication***: On a number of occasions I had to go in search of utensils for taking the laxative powder *Fybogel*. It needs to be dissolved in water, requires vigorous stirring, and, because it congeals rapidly, needs to be topped up with water and stirred again. While nurses used to leave a sachet at appropriate times, they hardly ever provided a stirring implement, mostly omitted to provide a beaker or cup, and –so far as I am aware– *never* monitored whether the medication

was actually taken. My mother developed the habit of asking for evening tea or coffee simply so as to have a cup to use for the *Fybogel*.

Cartons of high-protein drink (which my mother and other patients reported as foul-tasting) were also supplied, rather less regularly: sometimes without a drinking straw. Consumption of these was also not monitored.

31.1. Why do staff not check that cups, stirrers, and straws are available when required?

31.2. Why is there no attempt at monitoring that such medication is taken?

I apologise for the lack of suitable cups, stirrers, and straws to administer your mother's medication. **I have asked Ms Whybrow to review the current arrangements in the new hospital to make sure that suitable supplies are available.** I am also sorry that your mother's Fybogel intake was not closely monitored. **Ms Whybrow will be raising this issue with the relevant staff.**

32. ***Drips***: On the 11th April my mother was given a saline drip for rehydration. I was not given any information about it, but noticed that it appeared to be operating very slowly. Late in the afternoon I queried this with a nurse, who said it should last for 10 hours, and adjusted the valve to speed it up. In the evening it still appeared to be operating slowly, so I queried the speed with the sister, who said it should last for 24 hours, because it was subcutaneous, and slowed it down. – It was obviously not comfortable, as I was told the following morning that my mother said she wanted scissors to cut the tube into her stomach.

32.1. Why is there no clear marking on these drips so that staff can check the speed that has been prescribed?

I turn next to your question about the markings on your mother's drip and the speed at which it worked on 1 April. Ms Whybrow has explained that once the saline drip had been prescribed by the doctors, the nurses would normally perform a calculation and set the drip up to run accordingly. Nevertheless, she was sorry to read that the drip made your mother feel so uncomfortable. **[Surely marking the drips would reduce confusion and permit checking?]**

33. ***Sputum***: On various occasions my mother was given pots to collect sputum for testing. Sometimes the pots were left for days on her bedside cabinet, without being sent off.

33.1. Why do staff not check that samples required are actually collected and sent for analysis?

I am sorry that your mother's sputum samples were not always collected and sent off for analysis. **I have asked Ms Whybrow to raise this issue through her senior nurses forums.**

5) Patients' Security

FACTOR	BENCHMARK OF BEST PRACTICE (from[EoC-Chapter 9])
Orientation to the health environment	All patients/clients are **fully orientated** to the environment, in order to help them feel safe
Assessment of risk of patients/clients with mental health needs harming self	Patients/clients **have a comprehensive, ongoing assessment** of risk to self with full involvement of patient to reduce potential for harm
Assessment of risk of patients/clients with mental health needs harming others	Patients/clients **have a comprehensive, ongoing assessment** of risk to others with full involvement of patient to reduce potential for harming others
Balancing observation and privacy in a safe environment	Patients/clients are cared for in an environment that **balances safe observation and privacy**

Meeting patients/clients safety needs	Patients/clients **are regularly and actively involved** in identifying care that meets their safety needs
A positive culture to learn from complaints and adverse incidents	There is a **no blame culture which allows a vigorous investigation of complaints and adverse incidents and near misses and ensures that lessons are learnt and acted upon**

34. ***Unpleasant Incidents***: On the 1st March, two days after her admission, my mother told me that the staff in MD3 were good, apart from an "*unpleasant incident*" which had occurred on the first night, but which she refused to describe until returning home, for fear that I would complain. Another occurred on the 12th March. As she died without leaving hospital, I do not know what these were. – Given the report in national media just before Easter about the desecration of a corpse in a hospital mortuary, (e.g. http://news.bbc.co.uk/1/hi/england/2957651.stm), anything is possible.

    34.1. Who was on duty in MD3 on the night 27th–28th February?

    34.2. Who was on duty in MD4 on the afternoon of the 12th March?

I was sorry to read that your mother reported that an unpleasant incident had occurred on her first night in the hospital and again on 12th March. **We take this matter very seriously** **[There is nothing to substantiate this claim.]** but I hope you can understand that it is not possible for the hospital to investigate this matter further or release staff information without knowing precisely what these incidents were.

35. ***Injury / Assault***: On the 8th April I sent a fax to the consultant, describing a distressing incident the previous afternoon where my mother was injured by a young male nurse, who had been sent (***most*** inappropriately and insensitively, in my view) to give her intimate personal care. When he left the room I noticed that an additional dressing had appeared on my mother's leg: applied so shoddily that just minutes later it was hanging by the tape on one side only. The incident left blood smeared over the floor and two large stains on the sheets. Another nurse changed the sheets and put my mother back to bed. Afterwards my mother pleaded with me several times to let her come home. A reply to other points in the fax was dictated on the morning of the 9th, together with an assurance that the ward manager had been sent a copy of my fax. I have heard nothing more about this incident. – Cf. [EoC-p.186]: "***State policies in place for chaperoning of patients. State evidence of audit***". [EoC-p.181]: "***Patients/clients care actively promotes their privacy and dignity, and protects their modesty***".

    35.1. What happened?

    35.2. Did any investigation take place that week?

    35.3. If there was no investigation: why not?

    35.4. How in these circumstances are patients or relatives supposed to complain?

    35.5. What safeguards are there for patients who don't have visitors or witnesses?

    35.6. Why are nursing staff who are not competent to apply a simple dressing left unsupervised?

    35.7. Why are nursing staff who injure patients left unsupervised?

    35.8. Why was I not given an explanation that week?

    35.9. Why, after three months, have I still received no response?

I appreciate that this is one of the most serious aspects of your complaint and in the circumstances, I think ***it would be helpful to meet with you face to face*** to discuss precisely what happened at the time.

36. ***Documented Rough Handling***: An entry in [CN14.4] records that "*she is refusing [illegible] because some of the nursing staff are 'rough' towards her*".

    36.1. Was this pursued?

    36.2. If so: what was the outcome?

    36.3. If not: why not?

I can confirm that no formal complaints were raised by staff about your mother's handling at that time. **[*Why* was nothing done?]**

37. ***Privacy/Dignity***: A few days before my mother died, several nurses (of both sexes) gathered around my mother's bed to adjust her position. Initially I was asked to remain within the curtains which had been drawn around the bed. During the process my mother's hospital gown was drawn up, exposing her genitalia to everyone. I do not know whether or to what extent she was aware of this. I am certain that, if she realised what I had seen, she would have been embarrassed beyond words. – Cf. [EoC-p.181]: "***Patients/clients care actively promotes their privacy and dignity, and protects their modesty***".

    37.1. What is *your* view of this occurrence? – Imagine that it were your own mother (or father).

I was sorry to read of the incident a few days before your mother died when her gown was drawn up. I would like to assure you that it was never the intention of Trust staff to cause any offence and I apologise for any embarrassment caused. **[I am left speechless by the insensitivity of this reply.]**

38. ***Wandering Patients (1)***: On several occasions my mother complained that male patients had come into her side room: examples include four times on the 10th March, and twice on the 2nd April. Sometimes one came in while I was present. I am not *aware* that anything untoward ever happened: but my mother (frail, vulnerable, and very recently widowed) still found this very distressing. If an intruder *had* become problematic, she would have had no defence: and, even if she had been able to reach and activate the emergency button, timely assistance would have been unlikely.

    38.1. What measures do you believe that you currently have in place to minimise the danger that patients are threatened (or feel threatened) by intruders?

    38.2. How will you reinforce them?

I was sorry to read that your mother complained on several occasions of male patients coming into her side-room. I appreciate that this must have been very distressing for her. You ask what measures does the hospital currently have in place to minimise the danger to patients from intruders. It might be helpful if I explain that since moving to the new hospital **we have introduced improved security measures which include swipe-card entry into the ward areas and installed extensive CCTV coverage which is continuously monitored by our security team.**

39. ***Wandering Patients (2)***: Other patients were similarly distressed. On the 8th April I assisted when a male patient was wandering the ward, alarming patients in other bays. On the 19th April a woman patient, obviously suffering from some form of dementia and extreme anguish, wandered into Room 10, (a bay of male patients who were middle-aged rather than elderly), and at least some of

whom were mobile. Although she was doing no more than wandering, they were all in various degrees of agitation, and anxious that she should leave their bay. – Cf. [EoC-p.148]: "***Patients/clients have a comprehensive, ongoing assessment of risk to others with full involvement of patient to reduce potential for harming others***".

39.1. Whatever the results of any assessment of the risk posed by one patient to others, ***all*** patients need to be safe, to feel safe, and to have effective access with timely response to help in the event of any emergency, whether real or perceived.

I apologise too, for the distressing experience on 8th April involving the male patient who was wandering the ward and the female patient who was suffering with dementia. **[Apologies are not enough. What is being *done*?]**

6) Communication

40. ***Between staff***: On two separate occasions, [CN17.3] & [CN2.4], the medical notes record a written recommendation to give my mother a special mattress, for prevention or relief of pressure sores. On neither occasion did this happen: nor, presumably, did anyone check whether this had been done.

[CN8.4] records: "*Appears depressed, feels useless … Aim to move out of side room into main bay for stimulation*". This did not happen either.

40.1. What procedures are in place to ensure that recommendations have been acted upon in a timely fashion?

40.2. Why did they break down on each occasion?

Special mattress — as I explained earlier in this letter, there was an unfortunate delay in providing your mother with a special air mattress because of the poor condition of the existing mattresses which were damaged by the poor storage arrangements on the ward at that time. It was not a question of a failure in communication. **[The first record of this is on 17th March, the same day that I raised the possibility of bed sores with the consultant: though she made no mention of a change of mattress. When I eventually saw the consultant on 2nd April, he suggested providing an alternative mattress. He and the nursing staff were unaware of any previous recommendation. If this does not represent a *total* failure of communication, I don't know what does!]**

I have noted your comments regarding moving your mother from a side room, I have referred to this matter earlier in the letter. This action was carried out as soon as an appropriate bed became available on the main ward. **[Jo Jones, the Senior Nurse for MD4, agreed to this suggestion when I met her for the first time on 11th April. She was not aware that it had previously been recommended.]**

41. ***Between staff and relatives***: Only very seldom was I able to get information from staff when I wanted. Information obtained from nursing staff was generally very simplistic, and sometimes patently incorrect, (such as sterilising laundry by washing at 60°F). Contacting doctors was far from easy. On the 8th April, having resorted to fax as a means of submitting my concerns, I had to wait over two days to obtain a partial response. On the 10th April, during the absence of the consultant, I was able to obtain a response only as a result of sending a fax to the Chief Executive: and the inaction by several members of staff that morning would almost certainly have led to my mother's death that weekend, before the consultant returned the following Monday. (In retrospect this would have saved my mother a further week of suffering: but I had no way of knowing.) In my view it is highly regrettable that office staff are insufficiently aware of the life-and-death

consequences of the inaction resulting from such a myopic view: it is totally unacceptable that senior doctors display this lack of concern!

41.1. What do you propose to do about training secretarial and administrative staff in awareness, concern, and appropriate action?

41.2. How do you propose to improve the attitude of doctors and nursing staff?

I am very sorry that YOU FEEL that Trust staff showed a lack of concern and were difficult to contact when you tried to obtain information. I see that you contacted the hospital by fax on 8th April. I understand that Dr Platt, your mother's Consultant, responded to your fax the following day (9th April) despite the fact that he was away from the office. He dictated his letter by telephone while he was in transit to a conference in Scotland. I am sorry that we were not able to meet your expectations in this regard. **[This does not address my questions about training and attitude.]**

42. ***Information for patients and relatives***: It was only during my mother's final days that I was offered any general information, (half of which was of dubious quality):

- on the 15th April, a recommendation to bypass the liaison service, (PALS), when struggling to identify appropriate contacts;
- on the 17th, on a suitable position for swallowing from the registrar, sitting at at least 45°, to avoid the danger of anything ingested getting into the lungs;
- – the following day the warning about sitting at at least 45° ***proved to be insufficient***, as my mother sipped a drink in the "correct" posture, yet some still went down the wrong way;
- on the 18th, advice on contacting doctors from the Clinical Ward Sister, with an assurance about the availability of staff over the 4-day bank holiday;
- – the following day the assurance about the availability of staff over the 4-day bank holiday ***proved to be worthless***, with fatal consequences.

42.1. Clear, correct, and comprehensive information in written form on issues affecting patients and visitors should be prominently on display in each ward. – Cf. [EoC-p.146]: "***Full orientation: made familiar with and understand the philosophy, people, services, environment, policies/processes/procedures and physical layout, know how to access key worker and relevant information***".

42.2. Why does PALS share office space with the hospital Complaints department? Is it not supposed to be totally independent?

I am sorry that it was only during your mother's final days that you were was offered any general information about her clinical management.

Turning to your concerns about the PALS team sharing an office space with the hospital Complaints department, I appreciate that this is not ideal but I hope that you can understand that while the redevelopment is going on the hospital has a shortage of available office space. I am pleased to let you know that since you made your complaint, **the Complaints Team have now moved into separate accommodation. [Has there been any improvement in the availability of information?]**

43. ***Consultation and Alternatives***: On the 13th April I spoke to Dr. T. who was on duty over the weekend, having worked at the West Middlesex for only one week. He enquired whether, given the extreme distress caused to my mother by the hospital environment and the reluctance of the "team" to allow her home, to die in a less stressful environment, anyone had discussed the possibility

of a hospice. No one had, despite my previous appeals in person and in writing. – Cf. [EoC-p.163]: "***Patient/clients are actively involved in continuously negotiating and influencing their care. Carers are involved at the request of the patient/client or if patient/client is unable to communicate/participate in planning and negotiating their own care***".

43.1. Can you encourage your existing staff to learn from newcomers?

43.2. Is there any process in place to encourage regular cross-fertilisation of ideas, promoting better practices?

Thank you for your kind comments about the information you were provided by the doctor who you spoke to on 13th April. As a teaching hospital we welcome new ideas from all sources and the promotion of improved practice. **[What –if anything– is actually being *done*?]**

44. ***Form of Address***: On the 10th April I included in a fax that my mother would prefer to be addressed as *Mrs. Hunt*: yet several nurses continued to whine *Maa-ryy*. – Cf. [EoC-p.186]: "***State how the name the patient/client wants to be called is agreed***".

44.1. Will you ensure that all staff adhere to patients' wishes?

I am very sorry that the ward staff failed to address your mother and I apologise for any offence caused. **I have asked Ms Whybrow to make sure that this is raised within the nursing teams to make sure that they adhere to patients' wishes.**

45. ***Poor spoken English***: During the seven weeks that my mother was a patient in the West Middlesex, I don't believe I encountered a single nurse in any ward whose mother tongue was English. Having myself worked for a number of years in a non-English-speaking country, I am sympathetic to the problems faced by staff from abroad. However, it is indisputable that all staff, of whatever provenance, should be able to communicate effectively with those in their sphere of contact (in appropriate media). While most nurses seemed reasonably able to cope with the language, a few did not.

45.1. I was surprised on the 28th February, when discussing with RV the medication prescribed by my mother's GP, to find that she didn't understand the word "pastille".

45.2. On the evening of the 18th March my mother said she had been given oxygen instead of a nebuliser, because a foreign nurse had not understood.

45.3. On another occasion a nurse was so indistinct that, even asking him to repeat what he'd said, I was still unable to make any sense of his utterance.

45.4. Less seriously, several nurses used inappropriate language, (e.g. talking about washing patients' "bums"). This could be remedied very simply by giving overseas staff a glossary of acceptable terms for use in a professional context.

I appreciate that a number of doctors and nurses do come from overseas but I would like to assure you that before joining the hospital we expect new staff to meet a working standard in written and verbal English. **[The working standard is either too low or else not being met.]** I am sorry if you found that language was a barrier to obtaining information about your mother's care. It might be helpful if I explain that we already provide staff with glossary of local terms. **[Is it in need of revision, or of further emphasis?]**

46. ***Telephones***: Contacting a ward by telephone is difficult. On the 28th February I abandoned my first attempt. Later in the morning I succeeded speaking to a nurse: but only after the automated

system had transferred back and forth a few times (presumably alternating between the two Nurses' Stations), and then after a manual transfer followed by a threat of a further manual transfer.

On the morning of the 10th March, the day after my mother was moved to a side room, I rang to enquire what sort of night she had had. I was assured that she had had a good night, had eaten a good breakfast, and would see the physiotherapist. My mother later denied all this.

On the morning of the 2nd April my call was apparently redirected three times. After 4–5 minutes an operator cut in and tried again.

One afternoon I saw a nurse answer a 'phone, enquire casually over his shoulder whether anyone had issued a "beep", assure the caller that no one had, and replace the hand set. Just afterwards a woman emerged from the immediately adjacent bay 10 and enquired whether anyone had yet responded to her beep request.

There is confusion about the correct numbers to dial from outside the hospital, with two different dialling prefixes, 8565 and 8321. Some staff are unable to quote the correct number. One even persisted adamantly that he *had* written down the correct number, although I had afterwards had to obtain it from staff on the switchboard.

On the 16th April a doctor left a message on my answering machine. He omitted to state his 'phone number: and, as he had started his post only the previous day, the operator on the switchboard had no record of him. However, she did eventually manage to track down his beep number.

46.1. Use of telephones might have been a black art 80 years ago, but nowadays should be as automatic as breathing.

46.2. Why do staff invent fiction? Possibly because it is quicker, for some, than checking the facts?

I apologise for the difficulties that you experienced trying to contact the hospital by telephone. I appreciate that this must have been very frustrating. As I explained earlier in this letter, we are striving to improve our communication systems and all patients have their own entertainment consoles which comes with a dedicated direct telephone line to the patient's bed. **[While the introduction of these consoles may bring certain benefits, they presumably do nothing to ease communication with doctors and other hospital staff.]**

7) Contacting appropriate staff

47. ***Job titles***: The plethora of job titles is quite baffling: not merely for patients and relatives, but also for hospital staff. As one example: I was informed at one point that the "old" title of *Sister* had been superseded by *Ward Manager*; later I was told it had become *Senior Nurse*; on the 17th April I found myself being addressed by a *Clinical Ward Sister*; and I have since heard that *Ward Manager* has become *Modern Matron*. On the 10th April I was told that the *Ward Manager* –unlike the old *Sister*– works only office hours. As for what responsibilities may be associated with each title, what the spaghetti-like hierarchy may be, to what source a patient or relative should turn for information, advice, action, or redress, (and how they may be contacted in a reasonable timescale), my mother's death bears witness that I failed to discover these secrets. Staff also do not know: the consultant's secretary told me on the 11th April that consultants do not have line managers. She stopped short of

telling me that they were all the result of virgin births. On the 14th she stated that even the secretarial staff do not understand the abstruse hospital titles and hierarchy.

47.1. It would be useful –not just for patients and visitors– to simplify the hierarchy and associated titles.

47.2. It would be useful to publish an explanation of the hierarchy, including responsibilities and line of command. – Elsewhere I have seen at the entrance to a ward a board with photographs of staff, names, and job titles, (although sadly no explanation of the hierarchy).

47.3. It would be useful to make accessible to patients and their visitors an explanation:

47.3.1. of the hierarchy of staff who are responsible for their care;

47.3.2. of how and when these individuals (where possible, named) can be contacted;

47.3.3. of how to appeal to a higher authority when necessary, during defined "normal" hours;

47.3.4. of how to appeal to a higher authority in an emergency out of hours, or when the standard procedure fails.

I fully appreciate that the plethora of job titles in the NHS can be confusing and I apologise for any upset caused by this. For the avoidance of any doubt, I can confirm that the person who effectively manages the day to day business of the ward and nursing activities is the 'Senior Nurse'. In your mother's case the Senior Nurse was Jo Jones who you met on the ward at the time. I am very grateful to you for your helpful suggestions about how we can better explain the Trust staff hierarchy, responsibilities and line of command. **I have asked Ms Whybrow to take this thoughtful proposal forward with her nursing teams.** **[What changes have resulted?]**

48. ***Availability of informed + competent + authorised medical staff***.

48.1. On the 8th April I faxed the consultant before 9 a.m. Twenty-four hours later I discovered that, owing to volume of work, he had not seen the fax until 8 p.m..

48.2. On the morning of the 10th April the consultant's secretary sent me a fax, (dated the 9th), in which the consultant stated that he had asked his team, during his absence, to speak to me. When I visited in the afternoon, I was told that the doctors had done their rounds in the morning. A nurse rang to enquire and said that I would like to speak to a doctor, but then told me that they were "probably" too busy to see me.

48.3. Late on the 10th April I sent a fax for the attention of the consultant's team during his absence. I was informed the following morning that, until he returned the following week, not even the registrar had any authority to act.

48.4. Nevertheless, the consultant's secretary assured me that the registrar would ring me that morning. However, that did not happen: and no explanation has been offered.

48.5. On the morning of the 14th April Staff Nurse JT beeped the Senior Nurse twice for me. On neither occasion was there any reply.

48.6. On the 16th April I received a call from the psychiatrist who had been assigned to my mother. However, as he was not the one who had seen her the previous week, and had not seen her notes, he was unable to answer any of my questions.

48.7. On the 17th April I was told by the Clinical Ward Sister that I should be able to ask to speak to a doctor any weekday between 9 a.m. and 5 p.m., (apart from one day a week when the whole team are in casualty). I had already discovered that nursing staff believed that in practice this was not possible after 4. Since visitors are not generally allowed into wards before 2:30, this effectively reduces the "window" to 1½ hours on just four days a week: with very little likelihood of actually seeing a doctor the same day.

48.8. On the 19th April –the evening that my mother died– JB "beeped" for a doctor at 7:30, [PR19.4]. He explained later that on a previous occasion he had beeped a second time when a doctor failed to respond, but had been reprimanded and told never to beep twice. Despite the inaccurate medical notes, my mother presumably died shortly before 10: although no one seems to know the exact time. I was informed verbally that the doctor arrived "about" the time that my mother died: in any event, too late to offer any form of assistance.

48.8.1. Why is it forbidden to beep more than once?

48.8.2. Is there any requirement for doctors to notify the beeper as to when or whether they expect to be able to see the patient in need?

48.9. Following my mother's death, I learnt that the doctor on duty that night had been the ***only*** doctor covering the entire hospital.

48.9.1. What is the customary level of "out-of-hours" cover by doctors?

48.9.2. Are any senior doctors available "out-of-hours"?

48.9.3. What are the average and maximum recorded number of times an hour that a doctor is beeped out-of-hours?

48.9.4. What are the average and maximum times needed in each ward to respond to an out-of-hours incident?

48.9.5. What are the average and maximum number of deaths per week when a patient dies before a doctor has responded to a beep?

48.9.6. What are the average and maximum number of deaths per week when a patient dies without a doctor having been beeped before the death?

I am very sorry that you were not able to access clinical advice from the medical team. I would like to assure that it is quite acceptable to bleep a member of staff more than once. **[Rather than attempt to assure me of this, it would be more productive to ensure that all staff are aware of the procedures.]** If a doctor receives a bleep but is unable to attend the ward immediately, I would expect that clinician to telephone the ward and provide a likely time of arrival. I am sorry that this did not happen in your case. I am afraid that you were wrongly advised that the on duty doctor was the only doctor in the hospital.

I can confirm that out of hours the medical team will usually comprise of one on-call Consultant, one Registrar and one Senior House Officer. **[So, ignoring staff in A&E, three doctors for the 300+ in-patients?]** In addition there would also be other doctors available in the A&E Department. I am afraid that the Trust does not keep the detailed information that you requested about bleep response times.

49. ***Beeping doctors***: Both on the night of my mother's admission [PR27.2] and on the night of her death [PR19.4] staff beeped for the doctor on duty. The extract which I have does not record

whether a doctor ever came on the first night. On the night that my mother died, the doctor arrived about 2½ hours after being beeped, by which time my mother was "unresponsive" and possibly already dead.

At 2:55 p.m. on the 13th March I asked to speak to a doctor, and a nurse beeped for one. By 4:30 I had heard nothing more, so asked Staff Nurse JL, who informed me that the doctors were still doing their rounds. I did not speak to any doctor that day. The following afternoon I repeated my request, and, after waiting 1½ hours, spoke to the consultant: 27 hours after my original request. He informed me that my mother had contracted MRSA. If he had not had that news to impart, I wonder how many more days I might have had to wait to speak to a member of the "team".

I see from your letter that you have asked a number of questions about the bleeping of doctors. I will try to answer them in order.

49.1. Are there different priorities of beep?

No, there is only one priority

49.2. What is the acceptable time to reply to a beep?

That would depend on the reason that the doctor was contacted and there is therefore no set acceptable time

49.3. What is the acceptable time to attend a patient following a beep?

Again, that would depend on the circumstances of the individual case.

49.4. What is the acceptable action when a doctor is unable to reply?

If a doctor does not respond to his bleep then I would expect the nursing staff to send another bleep or try to obtain a more senior doctor. The level of escalation and timing of the second bleep would be determined by the seriousness of the situation.

49.5. What is the acceptable action when a doctor is unable to attend a patient?

I would expect the nurse to contact a more senior doctor

49.6. Why is it necessary to wait a day or more to speak to a doctor?

This was unacceptable and I offer you my sincere apologies.

49.7. Is there any means for getting to speak to a doctor urgently?

In office hours, it can sometimes prove quicker to make contact with a consultant via their own medical secretary. **[My experience with the consultant's secretary does not support this.]** Out of hours, we would normally encourage relatives to speak to the senior nursing staff who can bleep the on call doctor. **[Apart from the night of 19th April, when the doctor on call arrived after 2½ hours as my mother died, I was regularly told to enquire the following weekday.]**

50. ***Air call***: At 5 p.m. on the 2nd April, after I had attempted to speak to the consultant since early the ***previous*** morning, his secretary informed me that he was still in his clinic, and recommended asking the nurse-in-charge to "air call" him. Neither I nor the nurse-in-charge had heard this expression before.

50.1. Surely ***all*** nurses, not just those in charge, should receive ***full*** training about the methods available to contact staff, and how to use these?

I am grateful to you for bringing this matter to our attention. **I have asked Ms Whybrow to make sure that all nursing staff are told how to use the air call system.**

51. ***Religion***: On the 23rd June I was handed a copy of the hospital's *Annual Report 2001–2002*, (in lieu of a statement of policy about standards of care which I requested). On page 13 this states: "*The Trust's Equal Access Group is responsible for ensuring patients' needs are met in relation to diet, disability, religious matters, and language*". Yet on the 11th April I was told by the Senior Nurse that the hospital has chaplains available, but does not offer secular counsellors. – Since I believe that churchgoers represent approximately 1% of the population, this suggests that, in respect of counselling, the needs of most of the population are ***not*** being met.

51.1. How does the *Trust's Equal Access Group* propose to address this?

I am sorry that you were advised that the hospital is not able to offer a secular counsellors service. That is not entirely accurate as we are able to offer a separate bereavement counselling service. **[I was told that the secular counselling service was provided by chaplains! Do they also counsel believers of nonchristian faiths? This reply could be considered economical with the truth.]**

8) Professionalism

52. ***Nurses***: Some of the nurses were good. Others, however, including some of the senior ones, exhibited little or no concern. While in some cases it is possible that the apparent lack of concern stemmed at least in part from overwork, it was certainly not the sole factor. A telling comment from a nurse there one night, who obviously ***does*** care about the patients, was that some of her colleagues should realise that one day they might ***themselves*** be old, frail, and receiving care such as they now mete out.

Thank you for your observations about the variable standards of nursing care that you witnessed. I have noted your comments. **[And what is being *done*?]**

53. ***Doctors***: The attitude amongst doctors was also variable. Most appeared to be reasonably professional, several took pains to explain things, one considerately gave me his beep number in case I had any concerns, and several apologised on different occasions when unable to provide information requested. I was impressed by the behaviour of the consultant when I saw him: but found that he was extremely difficult to contact. However, I felt on a number of occasions that the registrar resented any discussion of my mother's wellbeing: and her own entries in the notes appear to confirm this.

Similarly, I am grateful to you for your comments about the attitude of doctors and the accessibility of the Consultant Physician, Dr Platt. **[What action has been taken to remedy the failings?]**

54. ***Administrative Staff – plea for action downgraded to complaint***: On the morning of the 11th April, when my mother's condition was critical, the consultant was absent, and I had been informed by his secretary that no one would take any action until the following week, I faxed an urgent plea for action to the Chief Executive at midday, after speaking to her secretary. Two hours later I was informed by another member of staff while the secretary was still at lunch that the Chief Executive was away all day, and that the fax had been passed not to a competent and authorised deputy for action, but to the Complaints Department for routine processing. Fortunately I was able to speak to MJ to whom the fax had been passed, and explain verbally (since the written word had obviously *still* failed to make any impression on anyone) that what was required was not

the slow wheels of bureaucracy but urgent action the same afternoon before staff left for the weekend.

54.1. Why does it appear that staff –even those frighteningly close to the top of the managerial hierarchy– have no sense of urgency, and lack any imagination as to the consequences of delay and inaction when patients are critically ill?

54.2. Why is there no policy for referring critical matters to a competent substitute, (whether superior, deputy, or colleague), when staff are absent or unavailable?

I am sorry that YOU FEEL that your concerns were downgraded to a complaint. I would like to assure you that your concerns were taken very seriously and there was no question of treating it as a routine matter. **[My concerns began to be addressed *only* after I had spent 5–6 hours desperately attempting to achieve some urgent action before staff disappeared for the weekend, when, following repeated 'phone calls, I succeeded mid-afternoon in speaking to Joe Johnson, who arranged for me to meet Jo Jones. – What policy (if any) is in place to ensure critical action? Who knows of its existence?]**

55. ***Duty of care – Not today***: [CN11.4] records "*No obs today. Obs stable yesterday*". This was the morning after I had faxed the consultant in desperation about my mother's refusal to take medication.

55.1. What is denoted by "obs"? Observations? If so: of what?

55.2. Was it responsible to assume –especially in the circumstances– continued stability?

I can confirm that the reference "No obs today. Obs stable yesterday' refers to observations which would include temperature, heart rate and blood pressure **[And 55.2?]**

56. ***Inadequate monitoring and communication***: On the day of my mother's admission, and for several days afterwards, we were informed that she was expected to return home in under a week. Indeed, as late as the 28th March, the prognosis remained "discharge next week". During the last week of March she was visited daily by the physiotherapists and appeared to be getting stronger. However, by this stage she had developed pressure sores: a problem which I had raised with the registrar on the 17th March, although incredibly a week later monitoring stopped for a period of 5 days. It is my firm belief that it was effectively the pressure sores that killed her, as the pain led to depression, followed by refusal of food, drink, and medication.

Other items in this document cite evidence of lack of monitoring and communication in regard to bed sores, constipation, swollen legs, provision of an air mattress, lifting of solitary confinement, etc..

56.1. What procedures, if any, are currently supposed to be in place to ensure:

56.1.1. effective monitoring of patients,

56.1.2. recommendation for action,

56.1.3. communication of these recommendations, and

56.1.4. checks that recommendations have been carried out?

56.2. Which individuals failed to act in accordance with these standards or in a professional manner exercising due duty of care?

56.3. What reasons were there in each case?

56.4. What measures will you institute to minimise the danger of any recurrence?

I am sorry that YOU FELT that your mother's monitoring and communication was inadequate. I would like to assure you that she was regularly reviewed by the medical team and the nursing observations were undertaken That said, I acknowledge that it was unacceptable that she developed pressure sores and I apologise for that failure. I have noted your further concerns about your mother's constipation, swollen legs and air-mattress provision. **I have asked Ms Whybrow to review the way that pressure sores are managed on the ward. [What were the findings of the review? What changes have resulted? What policy is in place for general monitoring and review? Is it being monitored for effectiveness?]**

57. ***Depression observed – but fatal inaction***: My mother was admitted to hospital just six days after her husband died in another hospital. She was deemed too unwell to attend his funeral. Shortly afterwards she contracted MRSA, was isolated in a side room, and developed pressure sores, all within the space of a week or so. Whilst in solitary confinement she developed depression, began to refuse food and drink, and later medication.

[CN7.4]: "*Agreed that PI appears depressed. Unfortunately 1/3 drug charts currently in pharmacy + we may need to commence antidepressant + [illegible] [illegible] if persistent symptoms*". – This was also the day that my mother was injured by a nurse.

[CN8.4]: "*Appears depressed, feels useless … Aim to move out of side room into main bay for stimulation*". (I faxed the consultant in the morning and spoke to his secretary in the afternoon, but did not see any doctor that day. I was not told of this recommendation. Neither was the Senior Nurse.)

[CN9.4]: "*Still feeling very low. ° pain ° specific problems* **…** *still e+d very little*"

[CN10.4]: "*Refusing all food & medication except nebuliser. [illegible] very low. Answers* 'I don't know' *to everything'* **…** *?ψ p/w [??]*": – What is "p/w"?

[CN11.4], (Duty Psych.): "**…** *Unable to finish assessment. Mary has been started on sertraline on 8/4/3*"

Sadly the drug did not achieve its intended result. I wonder whether side effects actually resulted in deepening her depression, and whether other damage may have resulted.

[CN11.4]: "**…** *PI medically stable* **…** *PI agrees she is depressed [illegible] regarding husband's recent death.* **…** *PI states that she wants to go home w[ith] her son*"

12th & 13th April: weekend; note by duty doctor [CN13.4] of conversation with me and advice to speak to "team" after the weekend.

[CN14.4]: There is a highly-illegible 3-page entry. The first page states that the reason for refusing food is rough handling by nursing staff: but there is no mention of any action. It also states that the antidepressants "*will take time*" to work: though the next page states "*will take weeks*". (My mother died just 5 days later.) The second and third pages record a conversation I had with the consultant. "*PI S/B Ψ on 11/4/03 who have (sic) agreed w[ith] our mx [??] plan.*" – What is "mx"?

"*Son states he has been sending faxes in [consultant's] absence + phoning secretaries but was told that [registrar] would be unable to authorise anything in [consultant's] absence.*" – Despite sending a fax late on ***Thursday***, 10th, telephoning on the Friday morning, and then in desperation sending a

fax to the Chief Executive, I was able to see no one from the "team" until late on ***Monday*** morning. ***But for the temporary improvement in my mother's condition over the weekend, I strongly suspect that she would have died during these 3½ days (half a week) when the "team" were*** **incommunicado*.*** **(*)**

The last of the 3 pages mentions that NGT (feeding by nasal tube) and ECT (electric shock therapy) were not considered appropriate. I was perturbed at the number of occasions when NGT was proposed by different staff: and alarmed that ECT should be mentioned even once.

Final note in [CN14.4] (in another hand): "*PR – patient refused; D/W nurse* re *catheter; will D/W [registrar]*". – What did the patient refuse? Did the discussion with the registrar take place: if so, about what, and with what outcome?

[CN15.4]: "*Still appears depressed. Feels cold. Refusing oral intake.*" That afternoon I was told by the Senior Nurse that my mother had been started on antidepressants on the 8th, had seen a Duty Psychiatrist on the 11th, and had been scheduled to see another psychiatrist (who turned out to be a locum) on the 22nd. I was surprised at the lack of any continuity.

[CN16.4]: "*Patient remains in poor spirits. Responding to questions.* ***…*** *Pain in bottom still bad. Bladder (sic) inserted yesterday.*"
Later entry by dietician records conversation with me. "***…*** *Main problem seems to be depression and unwillingness to eat/drink* ***…***"

[CN17.4]: "*Appears in better mood* ***…*** *Pain from catheter.* ***…*** *Still has pain from pressure sores.*"

Note by registrar: "*Whilst walking across hospital car park we were approached by Mr. Hunt who started asking questions about PI (swollen leg, feeding). I replied that these issues should be addressed in a more appropriate setting on ward.*" – My own notes (written shortly after the encounter) record that it took place the ***previous afternoon***: "*I asked them to look at Mum's now* ***very swollen*** *left leg, suggesting that previous vanishing of swelling was due to dehydration*". Despite this request, the hospital notes indicate that ***no action was taken for 24 hours***. I did ***not*** record or detect the dismissive "*should be addressed in a more appropriate setting*", believing (optimistically) that my mother's leg would be examined.

"*Son concerned* re *swollen (L) leg, pains in buttocks, concerned about sacral dressing* ***…*** *Discussed dressings w[ith] S/N on ward* ***…*** *Son stated he was concerned about patient's position in bed [illegible]I have [illegible] son to discuss this w[ith] nursing staff.* ***…*** *Son admits he has been feeding PI whilst PI is lying down*" – My own notes of this discussion record: "*[Clinical Ward Sister] fetched [registrar] back to talk to me: the heparin injections have been stopped, because of Mum's thin skin which was bruising easily; she will reinstate blood-thinning injections from tonight, and arrange for an ultrasound scan on Tuesday, to check whether there's a blood clot causing the swelling –* ***left leg now twice the size of right one!*** *Says she can't check the bed sores, as dressing was applied yesterday, and should be changed only on alternate days; the nursing staff should know more about how to position Mum to be comfortable; for eating or drinking, she needs to be at at least 45°, as a more horizontal position could allow anything swallowed to get into the lung, which could be fatal.*" –

No one previously gave any instructions about a safe position for swallowing. The use of the word "admits" in the registrar's notes seems rather loaded.

18th April: Good Friday – Bank Holiday – no entry.

19th April: Saturday – entry [CN19.4] (untimed) at my mother's death, believed shortly before 10 p.m., although I was later told (incorrectly) 10:20.

57.1. The disappearance or nonavailability of drug charts seems to have been a recurrent problem, suffered by other members of staff: and doubtless with consequences for the patients.

57.2. Is it recommended practice to prescribe antidepressants (with known side effects) before a patient has been assessed by a psychiatrist?

57.3. Why was there such a delay in seeing a psychiatrist after the antidepressants had been prescribed?

57.4. Why was the assessment on the 11th not completed? Did this happen later?

57.5. Was my mother alerted to the possible side effects of sertraline? I was told neither about side effects, nor even the name of the drug: but have since discovered that *common* side effects include drowsiness, weakness, anxiety, dry mouth, and changes in appetite; that *more serious side effects* include constipation, frequent urination, and blurred vision (all of which were preexisting symptoms); and that *dangerous side effects* include shuffling walk, persistent fine tremor, difficulty breathing, irregular heartbeat, and difficult speech. With the exception of difficult speech, I think ***all*** of these had become preexisting symptoms by the time sertraline was prescribed: some, for all I know, quite possibly the side effects of *other* prescribed medication. Any perceived deterioration in any of these symptoms would only have aggravated her depression. She did develop difficulty with speech during her final days, often substituting hand gestures: but not having been warned to look for side effects, I did not know how to interpret this. – What measures do you propose to institute to check for known side effects: in particular, where patients already display the same symptoms?

57.6. In a hospital, is it considered acceptable for medical staff to ignore requests to speak to relatives about a patient whose condition has deteriorated and is at death's door? If so, is it considered acceptable ***to ignore such a request for half a week***? **[See (*) above. Explicit response required!]**

57.7. Why was no action taken the day that I asked for my mother's extremely swollen and extremely painful leg to be examined?

57.8. Why are all patients and their visitors not made aware of recommendations such as a safe position for swallowing? – The (inadequate) advice was given only seven weeks after my mother's admission: and only when I complained of her physical distress because no one had indicated how, given the swollen leg and bed sores which she developed whilst in hospital "care", she could be put in a comfortable position.

57.9. Why, despite my request for action, was the issue of a comfortable position never seriously addressed?

57.10. There has been mention in recent years of an "internal market" in the NHS. Amongst the charges levied and monies credited, is there any payment or bounty that accrues to the hospital or to any department or member of staff when a patient dies? In addition to any such payment, is there any accounting procedure (or simply a perception within the trade) of financial or other benefit when a patient dies, a consultant episode is ended, and a bed is freed?

57.11. What is the frequency of use of NGT and ECT treatments: both generally, and specifically for elderly patients who entered hospital of sound mind but recently bereaved?

I see from your letter that you have prepared a very detailed sequence of events and have asked a number of questions about the meanings of some of the entries in your mother's clinical records. I think that the best way to take this aspect of your complaint forward would be for you to **meet with *the relevant clinician* with your mother's clinical records and talk through them. We would be happy to arrange such a meeting for you.**

I am sorry that your mother's drug charts were often not available. It might be helpful if I explain that these records are not always kept on the ward. I would like to reassure you that **it *was* clinically appropriate and reasonable for one of the physicians to prescribe your mother antibiotics *before* she saw a psychiatrist**. I am afraid that **it can sometimes take some time for a doctor from the mental health unit to visit the acute hospital** and I apologise for that delay. I can confirm that the doctor would have spoken to your mother about her drug regime but **it is unlikely that he would have listed all of the possible side effects of the drug. It is not practicable or reasonable for a doctor to explain all of the known side effects for the drugs prescribed**. The doctor considered that it was clinically appropriate for your mother to receive this drug. I am very sorry that the doctors were not able to respond to you sooner in the period immediately before your mother died. I appreciate that this must have been very upsetting. **[It was not merely "upsetting" for me, but the culmination of the sequence of inactivity and noncommunication which killed my mother.]** As mentioned earlier, I am also very sorry that the doctor was not able to attend your mother sooner when you asked for her swollen and extremely painful leg to be examined.

I am sorry that you received inadequate advice regarding the safe procedures for swallowing. **I have asked Ms Whybrow to make sure that this issue is raised with the senior nurses and to make sure that the lessons from your experience are shared and learned**. I am sorry too that YOU FEEL that despite your request for action, the issue of a comfortable position for your mother was never seriously addressed.

I can assure that there is no question of the Trust or any member of staff receiving a payment or bounty when a patient dies. It might also be helpful for me to explain that there is no set frequency of use of NGT and ECT treatments: both depend on the individual circumstances of the patient. **[I was not expecting there to be a "set frequency", but was enquiring about actual usage.]**

9) Record-keeping

Cf. [EoC-p.167]:"***Patients/clients records demonstrate that their care follows evidence based guidance or supporting documents describing best practice, or that there is an explanation of any variance***".

FACTOR	BENCHMARK OF BEST PRACTICE (from[EoC-Chapter 10])
Access to current health care records	Patients/clients are **able** to access all their current records if and when they choose to, in a format that meets their individual needs
Integration - Patient/professional partnership	Patient /clients are **actively involved in continuously negotiating and influencing** their care
Integration of records - across professional and organisational boundaries	Patients/clients have a **single, structured, multi-professional/agency** record which supports **integrated** care

Holding life long records	**Patients/clients hold** a single, lifelong, multi-professional/agency record
High quality practice - evidence-based guidance	Evidence based guidance detailing best practice is available and has an **active and timely review process**
High quality practice	Patients/ clients records demonstrate that their care **follows evidence based guidance or supporting documents** describing best practice, or that there is an **explanation of any variance**
Security / confidentiality	**Patients/clients records are safeguarded** through **explicit** measures with an active and timely review process

58. ***Legibility, Intelligibility***: Some of the handwriting is so ***incredibly*** illegible that one can only conclude that the writer is ***deliberately*** trying ***not*** to communicate. In other places abbreviations of varying obscurity are used, without any consistency: č, c, w, and wi all apparently for "with", and "PO intake" for "food"? Looks like pompous PA output! (Interestingly, the "Duty Psych." does not hide behind the "Ψ" used in some entries.) The entry after my mother's death contains an abbreviation which administrative staff sought in vain in a volume of medical abbreviations. – Cf. [EoC-p.160]: "***It is accepted that all records must be legible, accurate, signed with designation stated, dated, timed, contemporaneous, be able to provide a chronology of events and use only agreed abbreviations***".

I am very sorry that some of the handwriting in your mother's notes is illegible. That is clearly not acceptable. **[So what corrective action has been taken? And what about the abstruse abbreviations, in contravention of the Best Practice Benchmark above?]**

59. ***Dates and Times***: While every entry has a date, (occasionally incorrect), under half have times. On the evening of my mother's death [CN19.4] records one 'phone call at 11:00 p.m., when in fact I rang twice, at 11:25 and 11:35; and [PR19.4] has an entry where the time of 19:00 appears on my photocopy to have been entered retrospectively. A computerised *Sputum Culture* report (Lab. Ref. No. 03W008299) appears to have taken 5 weeks to process. –

Req Rec'd	11/**03**/03
Samp Dated	11/**03**/03
Printed	16/**04**/03

Cf. [EoC-p.160]: "***It is accepted that all records must be legible, accurate, signed with designation stated, dated, timed, contemporaneous, be able to provide a chronology of events and use only agreed abbreviations***".

It was pleasing to note that every entry had a date **[sometimes incorrect!]** but I have noted your concerns about the accuracy of the times recorded. **[And what corrective action has been taken?]**

60. ***Incomplete Entries***: Many entries are incomplete, e.g. omitting answers to elementary who-what-why-where-when questions. [CN11.4] "*pressure relieving mattress*" [instruction communicated to whom? to be in place by when?] and (by the Duty Psych. on the following page) "*Unable to finish assessment*" [why? what plans to finish another time?].

I appreciate that some of the entries are incomplete and I apologise for that. **[What corrective action has been taken?]**

61. ***Ambiguity***: Despite assurances that hospital staff use precise terminology, (albeit often inaccessible to lay folk), this is by no means invariably the case. Various references in the notes to

pain in the bottom seem to be associated sometimes with constipation, at other times with the sacral sore.

I have noted your comments about the ambiguity of some of the entries in your mother's records. **[What corrective action has been taken?]**

62. ***Delayed Entries***: At least one entry [CN17.4] was written up the following day. That may or may not be the explanation for the errors it contains. – Cf. [EoC-p.160]: "***It is accepted that all records must be legible, accurate, signed with designation stated, dated, timed, contemporaneous, be able to provide a chronology of events and use only agreed abbreviations***".

It might be helpful if I explain that it is appropriate for a healthcare professional to make a delayed entry as long it is made clear precisely when the entry is made. **[There was no indication that delayed entries were so marked. How much delay is considered "appropriate" to meet the constraint of contemporaneity?]**

63. ***Missing Entries***: Entire entries have been omitted. The MD2 and MD4 *Health Care Assistant Forms* (below) give examples: but they are not the only ones. In particular, the *Progress Reports* typically contain brief entries by the daytime and nighttime nursing shifts, filling up at roughly a week to a page. However, following the daytime entry on the 17th April, there are over two full pages of notes (17th, 18th, and 19th) recording conversations with me: but ***no*** routine entries concerning my mother! The final entry in this section records my mother's death during the night shift. – Did someone decide on the 17th that my mother no longer warranted even a one-line entry twice a day?

It might be helpful to explain that the entries in a patients notes can vary from day to day depending on the clinical activity and the level of contact that the Trust receives from the patient's family. **[This response completely ignores the point! (Is this wilful?) Why was my mother's condition not even monitored –never mind addressed– over the 48 hours preceding her death?]**

64. ***Falsified Entries***: On the 19th April I arrived shortly before lunchtime. A Health Care Assistant changed the catheter bag and recorded details: but when I pointed out that an unknown person had recorded that my mother had eaten a ¼ of her lunch, went off and didn't return.

I do not want to appear unhelpful but I am not entirely sure that I understand your question. As suggested earlier, **it might be helpful to meet and discuss this point**. **[The entry that she had eaten ¼ of her lunch had been made *before lunch was served*!]**

65. ***Blame Culture***: Some entries have patently been made with the sole intention of exculpating the writer, e.g. [CN17.4], [PR19.4]. There are inaccuracies, distortions, and outright falsehoods.

    65.1. [CN17.4]: "*I replied that these issues should be addressed in a more appropriate setting on ward*" – I do not believe that either doctor suggested anything of the kind.

    65.2. [CN17.4] : "*Son admits he has been feeding PI whilst PI is lying down*" – I stated that she had sometimes been at an angle shallower than 45°.

    65.3. [PR19.4]: "*I managed to scrutinized (sic) her (sic) mother. I asked but there was no reply*" – When I asked the Staff Nurse for attention when my mother became restive, *before* the angina attack, I was given the excuse (which I accepted in good faith) that JB was occupied with another patient. He did not "scrutinise" or ask her anything on that occasion.

65.4. [PR19.4]: "*Suddenly, her son told me that his mother was having shoulder pain*" – When JB emerged from dealing with the other patient, two minutes after I had administered two puffs of GTN, I explained that she had had pains in her upper arms (not her shoulders) …

65.5. [PR19.4]: "*he gave GTN puff without informing prior giving (sic)*" – two puffs, not one. If JB had not decided, rightly or wrongly, that the other patient was in greater need, he would have been present and would not have felt uninformed.

To what extent does this reflect the personal insecurities of the authors, the working environment in the ward or department, or the corporate ethos of the Trust? – Cf. [EoC-p.151]: "***There is a no blame culture which allows a vigorous investigation of complaints and adverse incidents and near misses and ensures that lessons are learnt and acted upon***".

I am sorry that you were left with the impression that some of the entries in your mother's notes were made with the sole intention of exculpating the contributor. **I have noted your comments about your understanding of the various entries**. I would like to assure you that as a Trust we do try to adopt a no-blame culture but **I have noted your comments about the personal insecurities of the writers**. **[What corrective action has been taken?]**

66. ***Records remain unread***: Whatever staff may perceive the purposes of the records to be, it is evident that in practice they are seldom read. ([CN11.4] records that the Duty Psych. *had* studied them.) Recommendations about air mattresses [CN17.3], [CN2.4] and about moving out of the side room [CN8.4] were not put into effect until other events precipitated action. I wonder what other instructions were never executed.

I have noted your comments whether records are ever read. [What corrective action has been taken?]

67. ***Pressure sores***: A sheet entitled *MD2 Health Care Assistant Form* records that the skin was intact from the 3rd to 23rd March, although there are gaps for the 6th–9th, 17th, 18th, 20th, and 21st March, then ***a 5-day gap*** for the week 24th – 28th March inclusive. The entry for the 29th March reports "*reddish (R) cream applied, sore (L) teguderm applied*". (It was on the 17th March that my mother complained to me that she was sore, and I mentioned this to the registrar. [CN17.3] records "*Assured PI + son that nursing staff are [illegible] PI's pressure areas on regular basis. Suggested pressure relieving mattress*". We were ***not*** told that a special mattress was being recommended. Neither, it appears, were the nursing staff.) – Cf. [EoC-Ch.8].

A sheet entitled *MD4 Health Care Assistant Form* includes the following entries.

Date	Pressure areas, redness, requires dressing / intact
30.3	Sacral area slightly red
31.3	Sacral area red
1.4	Sacral area red
2.4	Sacral red **cream applied**
3.4	Red bottom
	(no entries for 4th or 5th)

6.4	Red bottom – **cream applied**
	(no entry for 7th)
8.4	Red bottom – **cream applied**
9.4	Red bottom – **cream applied**
10.4	[no entry in this column]
11.4	Red bottom
[crossed out]	[illegible] **Granuflex dressing applied** sacral sore
12.4	Red bottom
	Dressing done (covered c iodine ?)
	(no entries for 13th, 14th, or 15th)
16.4	Not seen
17.4	**Cream applied** to bottom
18.4	Red bottom **cream applied**
19.4	**Cream applied** dressing intact

Yet a sheet entitled *Waterlow Pressure Sore Prevention/Treatment Policy* contains four entries, at approximately fortnightly intervals, with no mention of a change of mattress. The first entry includes an injunction to monitor pressure sores daily. –

Date	Score	Evaluation Date	Mattress	RN Signature
27.2.03	13	[no entry]	Standard – **monitor pressure sores daily**	[illegible]
11.3.03	14	[no entry]	Normal mattress	[illegible]
29.3.03	13	[no entry]	[ditto marks] **(Despite recommendation in [CN17.3])**	[illegible]
10.4.03	13	[no entry]	[no entry]	[illegible]

[CN2.4] records "*Erythema around site of skin wound. Pressure sore (Grade II) L buttock. Not on special mattress. **…** The issue of good pain control (from pressure sore) and pressure sore prevention (special mattress & feeding [??]) needs addressing. **…** iv) special mattress*". On the 10th April JT told me that she had obtained a ripple mattress, (which I saw lying on the floor), to be given to my mother the following morning, [PR10.4]. That actually happened late the following afternoon: only after I raised the topic with the Senior Nurse. The mattress soon proved to be faulty, and was changed on the 12th.

A separate sheet entitled *Wound and Pressure Sore Chart* is rather more detailed than the *Health Care Assistant Forms.* The only entry is dated the 18th April: the day before my mother died. This is a

separate system of recording: the entry was not recorded on the *MD4 Health Care Assistant Form*, use of which was continued uninterrupted the following day.

67.1. Why are there gaps in the entries in the *Health Care Assistant Forms*: one lasting ***5 days***? (Sometimes they occur at weekends, sometimes during the week.)

67.2. Do the gaps mean that the member of staff omitted to fill in the form: or that the patient did not receive the necessary attention?

67.3. Why were there no checks after the recommendations in [CN17.3] and [CN2.4] that the special mattress had actually been installed?

67.4. Was any action taken in respect of the recommendation in [CN2.4] to address feeding?

67.5. Why was the *Wound and Pressure Sore Chart* not commenced a month earlier?

67.6. Why, once the *Wound and Pressure Sore Chart* had been started, was the *MD4 Health Care Assistant Form* not discontinued?

I have noted your concerns about your mother's pressure sore management. I am sorry that you were not advised that your mother would require a special air mattress **[The recommendation recorded in [CN17.3] was apparently communicated to no one. The recommendation recorded in [CN2.4] was not executed: and, although I was aware of it, believed naïvely that it had been performed, and did not know how to check.]**

There are number of reasons why there might be gaps in the entries in your mother's Health Care Assistant Forms. For example, Weekend periods when the HCAs are not normally working is one contributory factor and the fact that the HCA might not have anything to report on a particular day (s).I am afarid that I cannot give you an explicit explanation for the gaps. **[Does this mean that patients' needs for care and monitoring cease for weekends and bank holidays? I find this totally unacceptable!]** However, I reiterate my apologies for the difficulties in providing your mother with a special air mattress.
[I believe that this delay of 25 days morally constitutes criminal negligence.]

10) Miscellaneous

68. ***Hysterical Nurse***: Around 7 p.m. on the evening that my mother died she became restive, wanting to get out of bed and out of hospital. I told JB as he went past; he replied that he would come after attending to the patient in the next bed, which was curtained off. After a few minutes, my mother quietened down, then held her arms and said they hurt. I enquired whether she wanted her GTN spray; she said yes, initially had difficulty opening her mouth, but I was able to give her 2 squirts and then (as standard practice after administering GTN) looked at my watch and noted that the time was 7:10.

At 7:12 JB emerged from the curtain. I told him what had happened, and was surprised that his response was to berate me hysterically: "*How can I record the GTN, it hasn't been authorised, you should have called me, then I could have fetched the ECG machine and given her a trace*". The words are not *verbatim*: but I recorded his sentiments just five minutes after they were uttered.

During the preceding seven weeks I had given my mother GTN from time to time, and never received any complaint or admonition when afterwards telling a doctor. On the afternoon of her admission I administered GTN at 1:05, 2:05, 3:30, 4:15, telling the doctors in A&E every time. That night [PR27.2] records that GTN was administered by nursing staff in MD3 at 21:15 and 00:20, and a

new GTN spray ordered pending the arrival of the duty doctor. My mother told me on the 4th and 7th March that she had asked nursing staff to give her GTN to relieve an angina attack – the first time having been offered a pain-killer, and both times oxygen; on the 6th and 21st March she told me that she had "self-medicated" and later informed Dr. S.

At 7:15 I got JB to stop ranting over my mother's bed, took him out into the corridor, and suggested that, instead of arguing with me, he should go and fetch the ECG machine: which he did, returning at 7:19. At 7:29 he emerged from the curtain around my mother's bed, discarding some of the trace sheets in a Clinical Waste bag, and walked past the near Nurses' Station to the far one. I followed and was greeted there by JT with a smile and "*Hello, John*"; she informed me that a doctor had just been beeped for my mother. JB returned to my mother with a blood pressure machine and a nursing assistant, then left at 7:35. My mother said that the pain in her arms was "better".

At 8:10 HM dropped by, having been working on MD3 that day. She asked JB whether a doctor was coming: he replied that he had beeped, but daren't beep again, having been reprimanded for doing this on a previous occasion. "*All I can do is record what I've done, to cover myself*". (These words were also recorded within minutes of the utterance.)

I have noted your comments [where? for whose benefit? has anyone else read them?] which appear under this heading. It is not entirely clear whether they are any specific points that you are expecting the Trust to respond to here. **[Jesus wept! Do you consider *any* part of the above sequence defensible? – Inappropriate berating of relatives for proactively administering medication (previously sanctioned by doctors), pending attention from nursing staff? Doing this over a patient who is in need of attention? Neglecting to attend promptly to a patient? Motive for discarding evidence. Appropriateness of means of disposal. Inaction in escalating request for a doctor. Priorities: cover own actions, and bugger the dying patient!]**

69. ***Post Mortem Experiences***: At 10 p.m. my brother rang and said he had heard from the hospital that my mother had taken a turn for the worse. I went straight over to MD4, (5 minutes' walk), and found that my mother was already dead. A white sheet had been draped over the bed, her eyes were closed, her mouth was gaping; each bed in the bay had been curtained off. Since the privacy was only visual, and I did not want to distress the other patients, I tried to restrain the volume as I sobbed.

When my father died in (another) hospital in February, my mother and I were able to spend more time with him. Being in the middle of MD4, albeit with beds curtained off, was not conducive to grieving. When I emerged from the curtain, someone suggested I should go to the far Nurses' Station to speak to the Duty Doctor. (Whether she was the same one who had been beeped at 7:30, or whether there had since been a change of shift, I was not told.) I was told that I would have to return after the bank holiday, on the Tuesday afternoon, to visit the Patient Affairs Office. I was allowed to ring my brother.

I was asked whether I wanted to take my mother's possessions there and then. Although I said I would prefer to take them on Tuesday, I felt put under repeated pressure to take things immediately. As I returned to the bay, several orderlies had already moved the bedside cabinet into the corridor, and were stuffing the contents into green plastic carrier bags. One of the orderlies was filling in a *Patient Property List*. I was aware that it was incorrect, but felt in no condition to argue, so signed my name to her inaccuracies. I was not given a copy either then, or three days later at the Patient

Affairs Office.

Another orderly asked whether I wanted my mother's handbag. I could only assume that this was because she hoped I would offer it to her. While I had developed a good relationship with several of the nurses, and might have been happy to donate it to one of them, I had never seen that orderly before, and considered her question to be not only an impudence, but an irreverent one at that. (On the 10th April I had seen another woman orderly pilfering cartons –presumably milk– from a refrigerator.) After returning home her question still rankled, and I realised a further inaccuracy on the form: that there was no mention of my mother's wedding ring or wrist watch.

I rang the ward twice that night. The second occasion was concerning my mother's jewellery. The first one was to notify them of my mother's wishes to donate her cornea, organs, and body for transplants or medical research. I was surprised not to have been asked about this while still on the ward.

I have noted your comments about your experiences after your mother died. I was sorry to learn of your further difficulties. I see from your letter that you state that you signed your mother's property sheet despite it containing inaccuracies. For the avoidance of any doubt, It would be helpful if you could clarify if you consider that any of your mother's belongings were not returned to you by the hospital. **[If there were any discrepancies, the items themselves are (in this case) of no consequence. *But you have not responded* on the issues of lack of privacy to grieve, distress to other patients, pressure to conform to staff convenience, inaccurate records, failure to give a copy of the form, insensitive/irreverent/impudent behaviour, staff pilfering, or donation of organs. – I feel that the reply to this point typifies the quality of the reply to my entire letter, and internal expectations of the standard of service meted out to patients and their families.]**

70. ***Ambulance route***: When the ambulance took my mother to A&E, I expressed surprise that, instead of turning round to use the main hospital entrance 50 yards away, the 5TJ□fTf-56 yaryD0□mpma9-29.17

72. ***Bureaucracy – Discharge***: On the 19th March Dr. S. informed me that, since patients are usually discharged on a Thursday, he expected my mother to be allowed to return home on the 27th.

72.1. This is patently associated with some archaic notion of administrative convenience rather than any medical consideration. Why do such practices persist?

I am sorry that you were told that patients are usually discharged on Thursdays. I would like to assure you that this is not accurate. The discharge process can occur on any day. **[If this is so, what measures have been taken to correct the impressions of doctors and other staff?]**

73. ***Ordering equipment***: Ordering equipment for my mother considered to be necessary for her discharge took longer than the Occupational Therapist expected. She believed that this was due to the recent change of supplier. In the particular case of my mother, the equipment was delivered by *Huntleigh National Care* on the 7th April, after they failed to keep an appointment made for the 4th. Since my mother died without returning home, she was not "blocking a bed" pending delivery of the equipment. However, since at the time the equipment was ordered she was expected to be discharged on the 27th March, this represented a potential block of 11 days.

I was sorry to read about the difficulties that you experienced ordering the necessary equipment to help your mother to be discharged. **I have asked Ms Whybrow to liaise with her Occupational Therapy (OT) colleagues who manage this process**. **[What progress has been reported?]**

74. ***Installing equipment***: Owing to a printing alignment error on the *Delivery / Collection Note* which obscured the instructions, it was only after the delivery man had left that I discovered that he should also have installed the items. In the absence of any installation guide, I fitted the items as best I could. Only when they were collected after my mother's death did I learn that the instability of the toilet frame was because I had fitted it back-to-front.

74.1. Will you take measures to ensure that, when specialist items are delivered, they are also installed correctly?

I have noted your comments and will make sure that they are forwarded to the relevant OT staff. **[What progress has been reported?]**

Once again, I would like to offer you my sincere condolences on your sad loss and I would like to take this opportunity to personally thank you for the considerable time and effort that you must have put into compiling such a detailed and comprehensive complaint. I have tried to respond in as much detail as possible but I feel that some of the questions you ask and information requested would be better provided in a face to face meeting. Nevertheless, I hope that the above information and explanations are helpful to you. To take matters forward, I would like to offer you the opportunity to meet with the relevant Trust staff to discuss your complaint in more detail, If you would like to arrange a meeting please contact Ms Amanda Jones on 020 8565 5273. She would be happy to help you.

Yours sincerely

Hazel Wallace
Chief Executive **[Is this a job-share with Gail Wannell?]**

cc: Ms J Whybrow

Extract from BGS Comp-§A2: *NHS Medical Services for Older People*

British Geriatrics Society, *Compendium of Guidelines, Policy Statements and Statements of Good Practice* (www.bgs.org.uk/compendium).

… All wards admitting older patients as medical emergencies should be staffed with doctors, nurses and therapists who have received training in the special needs of elderly people. **…**

Good multidisciplinary working embodies:

- Starting with the patient's agenda and wishes.
- Good co-ordination of care, and good-well recorded communication (e.g. multi-disciplinary notes).
- Avoidance of overlap or repetition by good communication and MDT meetings.
- Treatment goals which are realistic, achievable and take account of the patient's and carer's wishes.
- **Medical treatment which is functionally oriented and complementary to multidisciplinary goal setting.**

…

Unfortunately there is sometimes a cultural 'gulf' between general and geriatric care in both medical and nursing attitudes and skills

What are the skills essential for good geriatric care?

1. Appropriate skills in nursing staff with an interest in 're-enablement' nursing, recognising that it requires patience and takes longer for a disabled patient to be encouraged to 'do it himself', than the quicker option of doing it for him. The American term, Rehabilitation nursing is useful.
2. Adequate training in the skills of acute medical nursing.
3. Special clinical skills and knowledge of continence, confusional states, mobilising strategies, prevention, assessment and management of falls, sensory impairments, social aspects and support networks.
4. Skills and interest in discharge planning.
5. The MDT approach to care planning and management must be central to the patient's treatment.
6. The skills and confidence to ensure that doctors listen to them!
7. Medical skills in the assessment of occult presentation of acute disease, multiple pathology, investigation in perspective and MDT leadership.
8. Paramedical staff must be part of the ward culture and team, and not optional visitors.
9. Consultants should be ward based, know and work with their MDT. Patients scattered round a hospital are anathema to good care for vulnerable frail people.
10. The centre point of decision making is a (weekly) MDT meeting, with consultant leadership.

Extract from BGS Comp-§G6: *The Abuse of Older People*

British Geriatrics Society, *Compendium of Guidelines, Policy Statements and Statements of Good Practice* (www.bgs.org.uk/compendium).

Neglect signs

1. weight loss;
2. unkempt appearance, unshaven, inadequate or dirty clothing, or poor hygiene;
3. pressure sores or uncharacteristic problems with continence;
4. inadequate food and drink;
5. inadequate or inappropriate medical treatment or withholding treatment; and
6. a patient who is left in a wet or soiled bed.

Abusive practices

Within hospitals or care settings, institutional attitudes and practices may exist which can indicate abuse, for example:

1. inflexible routines which suit the needs of staff and not patients;
2. patronising or bullying attitude of staff towards patients;
3. lack of choice, privacy and respect for patients;
4. run-down facilities and lack of suitable equipment;
5. poor continence management;
6. inappropriate and frequent use of restraints; and
7. lack of care plans for patients.

Extract from BGS Stan-§6: *Acute assessment and general hospital care*

British Geriatrics Society, *Standards of Medical Care for Older People*
(www.bgs.org.uk/homepages/zips.htm)

… Any illness or change in health, i.e. new symptoms or a change in level of function in an older person should trigger assessment and investigations to ensure an accurate diagnosis aimed at a speedy return to the previous level of function; **…**

Acute hospital care

Implications for specialist services for older people:

Services for older people must have in place:

...

Clear policies

3) Clear policies regarding the following care processes:

- Manual handling;
- Nutrition assessment;
- Pain management;
- Restraint;
- Pressure sore risk assessment;
- Wound care;
- Infection control; and
- Decisions about 'Do Not Resuscitate' orders

Locally agreed protocols

4) Locally agreed protocols for the management of the common symptom complexes in older people (which should be shared widely throughout all wards and departments):

- 'Off Legs' (deteriorating self-care);
- Unexplained collapse;
- Dizzy spells;
- Falls;
- Incontinence;
- Acute confusion (delirium); and
- Febrile illness cause unknown.

Extract from DoH: Guidance on Clinical Governance

Health Service Circular HSC 1999/065, (www.doh.gov.uk/clinicalgovernance/hsc065.htm)

Key Policy Principles

7. The challenge posed by the new statutory duty of quality in the NHS is to transform the delivery of primary, hospital and community care so that consistently better outcomes are produced for patients. … The public also expects that clinical governance will be able to prevent the kinds of incidents, crises and serious failures in standards of care which, although not common, have been a very visible feature of the past.

The Vision For The Next Five Years

14. For clinical governance to be successful, all health organisations must demonstrate features such as:

- An open and participative culture in which education, research and the sharing of good practice are valued and expected
- A commitment to quality that is shared by staff and managers, and supported by clearly identified local resources, both human and financial
- A tradition of active working with patients, users, carers and the public
- An ethos of multi-disciplinary team working at all levels in the organisation
- Regular board level discussion of all major quality issues for the organisation and strong leadership from the top
- Good use of information to plan and to assess progress.

15. Above all clinical governance is about changing organisational culture in a systematic and demonstrable way, moving away from a culture of 'blame' to one of learning so that quality infuses all aspects of the organisation's work.

Clinical Governance: Its place in the wider picture

20(c) Clinical governance needs good information to assess the quality and performance of services

The availability of good information is essential to any programme of quality improvement. Such information is necessary, for example, to:

- Identify the scope for improvement within available resources (a baseline assessment)
- Ensure that a planned quality improvement or an investment in developing a service has in fact resulted in the desired change (monitoring progress).
- Make comparisons between a local service and its counterparts elsewhere to identify scope for improvement benchmarking)
- Provide information to the public about the quality of services provided by a health organisation (openness and public accountability)
- Monitor adverse outcomes of care (early warning of serious service failures).

20(e) Poor performance

Weaknesses in the quality of care provided by a local health service can result from poor performance by individual health professionals. Although such occurrences are small in proportion to the high standards maintained by the majority of practitioners, they have a disproportionate impact. They can have serious repercussions for individual patients and their families, but they can also lead to a more general loss of public confidence in a local service. Recent experience has shown that the present mixture of professional self-regulation and NHS procedures has not been successful in preventing, recognising and dealing effectively with the problem of poor clinical performance.

20(f) Learning from experience

… Historically, this is not an area where the NHS has always been strong. An expert advisory group, chaired by the Chief Medical Officer, has therefore been convened to look at ways in which the

NHS can most effectively learn from service failures and adverse events, drawing on existing good practice in the NHS and other sectors.

The 4 Key steps to be undertaken in Year 1 by April 2000

...

32. ... It should, as a minimum, include:

- A searching and honest analysis of organisations' strengths and weaknesses in relation to current performance on quality
- The identification of any particularly problematic services (drawing where possible on objective data or feedback from users of services or referring agencies)
- An assessment of the extent to which data are in place for quality surveillance
- Establishing whether there are deficits in key mechanisms (e.g. for risk management, multi-disciplinary clinical audit, supporting information management, patient participation)
- Making sure that there is integration of quality activities and systems
- Establishing explicit links to Health Improvement Programmes, National Service Frameworks - and for PCG/PCTs, locally identified priorities
- Designing the ways in which underpinning strategies (i.e. information management and technology, human resources, continuing professional development, and research and development) will support clinical governance within the organisation.

...

35. Reports to the board will be an important part of the accountability mechanisms that underpin clinical governance. The nature, range and importance of the clinical governance issues which are taken to the board will be crucial to the development of the whole programme within the organisation. The content of the board's agenda will send a powerful signal to the whole organisation, to the local media, the public, and to the health organisation's partners. The more substantial and searching the issues the board discusses, the more it will be concluded that the organisation has a clear sense of direction on clinical governance and is taking it very seriously.

Benefits Arising from Clinical Governance: The *Vision for the next five years* **ANNEX 1**

Areas of Change	Benefits of Change
A new culture in NHS organisations	Open and participative, and can demonstrate this both internally and to external bodies such as the Regional Office of the NHS Executive and the Commission for Health Improvement Able to demonstrate a commitment to quality, shared by staff and managers, and supported by clearly identified resources, both human and financial. These resources are part of an agreed development and implementation plan and their use is reviewed by the Board as part of their discussions on clinical governance Working routinely with patients, users, carers and the public An ethos of multi-disciplinary team working at all levels of the organisation Informed and underpinned by education and research activities which are focused on the needs of the organisation and improving the quality of services Regular Board level discussion of the big quality issues for the organisation and strong leadership from the top. Good use of information to plan and assess progress
Inequity and variability	Unjustifiable variations in the quality of care provided (including outcomes, access, and appropriateness) between services in different areas are reduced through quality improvement NHS organisations are working to ensure that they are making progress against recognised benchmarks.

Areas of Change	Benefits of Change
Involving users and carers	An organisation-wide strategy for involving patients, users, carers and the public, including strategic plans for communicating with them Designated senior individual to oversee patient, user, carer and public involvement strategy User representatives on clinical governance committee/groups Use of involvement methodologies e.g. patient panels, focus groups Training and education for all individuals on effective patient, user, carer and public involvement.
Sharing of good practice	Evidence that individuals and organisations are actively learning from others, for example by actively seeking out and making use of examples of good practice and of the ways in which particular issues have been tackled elsewhere Wasteful duplication of effort is minimised.
Detecting and dealing with poor performance and adverse events	Poor performance is the concern of all clinical and managerial staff Clear mechanisms for the identification and management of poorly performing clinicians; routes for other clinicians to voice their concerns about performance of their colleagues (taking account of new national policies and procedures) Poor performance procedures aim to identify practice as it begins to slip, and to proactively support and develop clinica staff, enabling sustained improvements in the vast majority of cases without risk to the quality of patient care.

Annex 2:

- A designated senior clinician responsible for ensuring that systems for clinical governance are in place and monitoring their continued effectiveness
- Ensuring the clinical standards of National Service Frameworks and NICE recommendations are implemented
- Workforce planning and development (i.e. recruitment and retention of appropriately trained workforce) is fully integrated within the NHS organisation's service planning
- Continuing Professional Development: programmes aimed at meeting the development needs of individual health professionals and the service needs of the organisation are in place and supported locally
- Effective monitoring of clinical care with high quality systems for clinical record keeping and the collection of relevant information
- Processes for assuring the quality of clinical care are in place and integrated with the quality programme for the organisation as a whole
- Clinical risk systematically assessed with programmes in place to reduce risk

4. Procedures for all professional groups to identify and remedy poor performance, for example:

- Critical incident reporting ensures that adverse events are identified, openly investigated, lessons are learned and promptly applied
- Complaints procedures, accessible to patients and their families and fair to staff. Lessons are learned and recurrence of similar problems avoided
- Professional performance procedures which take effect at an early stage before patients are harmed and which help the individual to improve their performance whenever possible, are in place and understood by all staff
- Staff supported in their duty to report any concerns about colleagues' professional conduct and performance, with clear statements from the Board on what is expected of all staff. Clear procedures for reporting concerns so that early action can be taken to remedy the situation.

Extract from the NHS Plan

A plan for investment, A plan for reform; July 2000; Cm 4818-I; (www.doh.gov.uk/nhsplan).

The NHS is a 1940s system operating in a 21st century world. It has:

- a lack of national standards
- old-fashioned demarcations between staff and barriers between services
- a lack of clear incentives and levers to improve performance
- over-centralisation and disempowered patients.

NHS staff wanted to see:

- *more staff* – the top priority was more staff and fair pay
- *training* – more training and improved management skills for all staff
- *joined-up working* – more joined-up working with social services at community and primary care levels
- *less bureaucracy* – reduced administration and bureaucracy and improved funding systems
- *prevention* – more action to help prevent ill health
- *working conditions* – better conditions and aids to recruitment and retention, and more flexible working patterns
- *waiting* – like patients, NHS staff want to see a faster NHS
- *care centred on patients* – staff share patient frustration that the system is too focused on its own needs and doesn't properly meet the need of individual patients
- *national variations* – better performance and accountability systems to reduce variations in service across the country
- *autonomy* – local services to have more control over the way they were organised, with less control from Whitehall.

Demarcations between staff

2.17 Old-fashioned demarcations between staff mean some patients see a procession of health professionals – often recounting the same details to the GP, practice nurse, hospital booking clerk, hospital nurse, care assistant, therapist, junior doctor and consultant. Information is not shared and investigations are often repeated. Delay seems designed into the system.

2.18 Unnecessary boundaries exist between the professions which hold back staff from fulfilling their true potential. Three quarters of house officers do two or more basic tasks not specifically requiring medical training. Up to 40% of patients seeing an orthopaedic consultant in outpatients would be better off being treated by a trained physiotherapist in the first instance. These practices frustrate staff and cause longer waits for patients.

2.23 Rigid institutional boundaries can mean the needs of individual patients come a poor second to the needs of the individual service. On one day in September last year, 5,500 patients aged 75 and over were ready to be discharged but were still in an acute hospital bed: 23% awaiting assessment; 17% waiting for social services funding to go to a care home; 25% trying to find the right care home; and 6% waiting for the right home care package to be organised. Almost three quarters were not getting the care they needed because of poor co-ordination between the NHS and other agencies. This experience is repeated daily

2.30 A small minority of organisations and individuals within the NHS persistently fail to deliver high standards of care. The instruments for dealing with persistent failure are old-fashioned and inadequate. The NHS needs a system which spots problems early, takes action swiftly and can act decisively. Persistent failure should be met with an escalating scale of sanctions.

Disempowered patients

2.33 The relationship between service and patient is too hierarchical and paternalistic. It reflects the values of 1940s public services. Patients do not have their own health records or see correspondence about their own healthcare. The complaints system in the NHS is discredited. Patients have few rights of redress when things go wrong.

Bedside televisions and telephones

4.19 In an age of cable and digital TV, with over half the population owning mobile phones, people increasingly expect to have access to these services wherever they are. It is no longer acceptable for patients to have to wait for a nurse to wheel a trolley to their bed or have to stand in a draughty corridor if

they want to make a call. With the new resources, the NHS can do much more to provide better facilities at the bedside.

What about the unacceptability of having to wait for a commode?

9.3 For every example of good practice there are too many examples where change has yet to take place. Best practice can no longer be an option. Managers and clinicians across the NHS must make change happen.

10.18 Patients need an identifiable person they can turn to if they have a problem or need information while they are using hospital and other NHS services. Usually situated in the main reception areas of hospitals the new patient advocate team will act as a welcoming point for patients and carers and a clearly identifiable information point. Patient advocates will act as an independent facilitator to handle patient and family concerns, with direct access to the chief executive and the power to negotiate immediate solutions. In mental health and learning disability services, the Patient Advocate and Liaison Service team will build on and support current specialist advocacy services.

As a result of this NHS Plan:

- all NHS trusts, primary care groups and primary care trusts will have to ask patients and carers for their views on the services they have received
- all patients leaving hospital will be given the opportunity to record their views about the standards of care they have received in writing or electronically through new bedside TV information services.
- every local NHS organisation, as well as care homes, will be required to publish, in a new Patient Prospectus, an annual account of the views received from patients – and the action taken as a result. The Patient Prospectus will set out the range of local services available, the ratings they have received from patients and the place they occupy under the Performance Assessment Framework.

15.1 Older people make up the largest single group of patients using the NHS. People over 65 account for two-thirds of hospital patients and 40% of all emergency admissions. Too often they are treated in inappropriate acute hospital settings because there is nowhere else.

15.7 Health services in partnership with social services and other agencies will need to recognise the specific needs of older people in caring for them:

- demonstrating proper respect for the autonomy, dignity and privacy of older people
- treating the person, not just the most acute symptoms, by taking account of the full needs of older people, including the importance of good nutrition, maintaining tissue viability and enabling the older person to remain as active as possible while in hospital
- making high quality palliative and supportive care available to those older people who need it
- ensuring good clinical practice which recognises the complexities of caring for older people, for example, by promoting the good practice recommendations contained in the most recent report of the National Confidential Enquiry into Peri-Operative Deaths.

Extract from RCN Clinical Practice Guidelines: Pressure Ulcer Risk Assessment and Prevention

(www.rcn.org.uk/resources/guidelines.php)

1.1.2 The cost of pressure ulcers

Pressure ulcers represent a major burden of sickness and reduce quality of life for patients and their carers – requiring prolonged contact with the health care system, and causing pain, discomfort and inconvenience (Franks et al, 1999). The financial costs to the NHS are also substantial (Cullum et al, 1995). Preventing and treating pressure ulcers in a 600-bed general hospital costs between £600,000 and £3 million a year (Touche Ross, 1993), excluding litigation costs.

7.3 Individuals who are considered to be acutely at risk of developing pressure ulcers should sit out of bed for less than two hours.

7.4 Positioning of patients should ensure that:prolonged pressure on bony prominences is minimised; bony prominences are kept from direct contact with one another and friction and shear damage is minimised.

7.5 A written/recorded re-positioning schedule agreed with the individual, should be established for each person 'at risk'.

Person-centred care

The rights of patients and their carers to be fully informed and share in decision-making is a central tenet of a number of recent policy documents – for example *The New NHS.Modern. Dependable* (DoH,1997); *Our Healthier Nation* (DoH, 1999); and, specifically about the rights of the child, the United Nations convention (United Nations, 1991).

Involvement and partnership in care are central to the delivery of a service which responds to users' individual needs.

- users should be made aware of the guideline and its recommendations
- users should be involved in all aspects of pressure ulcer risk assessment and prevention, from involvement in assessment to shared decisionmaking about pressure redistributing devices

A collaborative inter-disciplinary approach to care

Pressure ulcer risk assessment and prevention should be seen as an inter-disciplinary issue. Adopting a team approach requires each member of the team to take responsibility for facilitating and improving communication, sharing care and responsibility for care. Such an approach requires health care professionals to understand and respect each other's roles in the delivery of that care.

- all members of the inter-disciplinary team should be aware of the guideline and its recommendations
- health care teams need to articulate the role of each member in the management of risk assessment and prevention of pressure ulcers.

Organisational issues

Organisational issues influence the quality of pressure ulcer risk assessment and prevention.Health care service providers need to ensure:

- care delivered in a context of continuous quality improvement where improvements to care following guideline implementation are the subject of regular feedback and audit
- commitment to and availability of education and training to ensure that all staff, regardless of profession, are given the opportunity to update their knowledge base and are able to implement the guideline recommendations
- patients are cared for by trained staff, and that staffing levels and skill mix reflect the needs of patients.

3.2 The following extrinsic risk factors are involved in tissue damage and should be removed or diminished to prevent injury:

Pressure which causes compression and possible capillary occlusion, which if prolonged can lead to ischaemia.How high the pressure must be and how long it must be exerted to cause damage depends on the individual's tissue tolerance. The key factors are intensity and duration of pressure.

Shearing occurs when the skeleton and deep fascia slide downwards with gravity, whilst the skin and upper fascia remain in the original position.Deep necrosis can occur when the shearing between two layers of tissue leads to stretching, kinking and tearing of vessels in the subcutaneous tissues. Shearing forces should not be considered separately from pressure: they are an integral part of the effect of pressure. Shearing most often occurs when individuals slide down or are dragged up a bed or chair.

Friction occurs when two surfaces move across each other. It often removes superficial layers of skin. Friction damage often occurs as a result of poor lifting techniques

Extract from DoH *Essence of Care*, (www.doh.gov.uk/essenceofcare)

p.52

FACTOR	BENCHMARK OF BEST PRACTICE (from[EoC-Chapter 5])
Individual Assessment of personal hygiene needs	All patients/clients are **assessed** to identify the advice and/or care required to maintain and promote their individual personal hygiene
Individual assessment of oral hygiene needs	All patients/clients are **assessed** to identify the advice and/or care required to maintain and promote their individual oral hygiene
Care for personal hygiene negotiated and planned based on assessment	Planned care is **negotiated** with patients/clients and/or their carers and is based on assessment of their individual needs
Care for oral hygiene negotiated and planned based on assessment	Planned care is **negotiated** with patients/clients and/or their carers and is based on assessment of their individual needs
Environment within which oral and personal hygiene needs are met	Patients/clients have access to an environment that **is safe and acceptable** to the individual
Provision of Toiletries for own personal use	Patients/clients are expected to supply their own toiletries **but** single use toiletries are provided until they can supply their own
Providing assistance with personal hygiene when required	Patients/clients have access to the level of assistance that they require to meet their **individual** personal hygiene needs
Providing assistance with oral hygiene when required	Patients/clients have access to the level of assistance that they require to meet their **individual** oral hygiene needs
Information and education to support patients in meeting personal hygiene needs: particularly if these are changing or are having to be met in unfamiliar surroundings.	Patients/clients and/or carers are provided with information/education **to meet their individual personal hygiene needs**
Information and education to support patients in meeting oral hygiene needs: particularly if these are changing or are having to be met in unfamiliar surroundings.	Patients/clients and/or carers are provided with information/education **to meet their individual oral hygiene needs**
Evaluation/Reassessment of personal hygiene and how effectively these are being met.	Patients/clients care is **continuously** evaluated, reassessed and the care plan **renegotiated**

Evaluation/Reassessment of oral hygiene needs and how effectively these are being met.	Patients/clients care is **continuously** evaluated, reassessed and the care plan **renegotiated**

p.56

- Patients/clients have no care planned
- Planned Care is not based on assessment of patients/clients individual needs.
- Planned Care is based on assessment of patients/clients individual needs.
- Planned care is negotiated with patients/clients and/or their carers based on assessment of their individual needs

p.64

- Patients/clients care is not evaluated or reassessed.
- Patients/clients care is evaluated but the patient/client is not reassessed
- Patients/clients care is evaluated and the patient/client reassessed.
- Patients/clients care is continuously evaluated, the patient/client reassessed but the care plan is not renegotiated.
- Patients/clients care is continuously evaluated, reassessed and the care plan renegotiated.

p.76, Table, Food & Nutrition, item 9:
The amount of food patients actually eat is monitored, recorded and leads to action when cause for concern

p.78: Statements to stimulate comparison group discussion around best practice

- State the components of screening and the definition of 'at risk'
- State the components of the assessment and the evidence base.
- State who completes the screening.
- State when the screening is undertaken
- State who completes the (XXX) assessment.
- State the timing of assessment, frequency, trigger to re-assess
- State protocols in use

p.79: Planning, implementation and evaluation of care for those patients/clients who required a nutritional assessment

- Patients/clients nutritional assessments have not led to a plan of care
- Plans of care based on the nutritional assessments are devised but not implemented.
- Plans of care based on the nutritional assessments are devised and implemented
- Plans of care based on the nutritional assessments are devised, implemented and evaluated
- Plans of care based on ongoing nutritional assessments are devised, implemented and evaluated

p.124 Pressure sores

- Patients/ clients pressure ulcers, or their risk of developing a pressure ulcer is not ascertained
- ***Patients/clients are not consistently screened for the presence of, or risk of developing, pressure ulcers***
- Patients/clients are screened but this does not lead to more detailed assessment of those patients/clients identified as 'at risk'
- For all patients/clients identified as 'at risk' screening progresses to further assessment

p.127: Individualised plan for prevention and treatment of pressure ulcers

- ***No plan or no documented plan***
- Documented plan not individualised based on patient/client assessment
- Documented plan is individualised but does not include agreement from multidisciplinary team in partnership with patient/client/carers.
- Individualised documented plan agreed with multidisciplinary team in partnership with patient/client/carers.
- Individualised documented plan agreed with multidisciplinary team in partnership with patient/client/carers, with evidence of ongoing reassessment.

p.128: Pressure ulcer prevention – Repositioning

- The patients/clients need for repositioning has not been assessed
- ***The patients/clients need for repositioning has been assessed and documented but not met***
- The patients/clients need for repositioning has been assessed/documented and met
- The patients/clients need for repositioning has been assessed/documented/met and evaluated
- The patients/clients need for repositioning has been assessed/documented/met/evaluated with evidence of ongoing reassessment

p.149: Balancing Observation and Privacy in a Safe Environment

- State if there is an up to date observation policy, who is involved (e.g. MDT) and if this is audited. This should include who observes the patient/ client (e.g. qualified/unqualified, the status awarded the task and how it is ensured that observations are supportive and therapeutic)
- State if the observation policy is a feature of training / updated.
- State if resources allow the increased observation of patients in the evening and at night and prior to discharge
- State how staff skill mix, staff roles and ***attention to gender of staff*** have been adapted to release staff to carry out clinical observations e.g. administrative support
- State what opportunities there are for privacy and maintaining dignity during observations
- Describe how you inform/educate the client regarding the observational processes and how their satisfaction with these processes are ascertained
- State how carers satisfaction with observation and privacy is ascertained
- ***State how the privacy of women and other vulnerable groups are secured***
- State what environmental safety checks are made re removal of any obstructions to observation and preventing access to means of suicide and e.g. window opening, safety glass, structures that could be used in suicide by hanging, safe storage of drugs and other harmful products, effective administration of drugs to prevent stockpiling.

p.166: High Quality Practice - evidence based guidance

- There are no documents available in support of high quality practice
- Evidence based guidance detailing best practice is available but there is no review process
- Evidence based guidance detailing best practice is available and has an active and timely review process

p.184: Attitudes and behaviours

- Patients/clients experience deliberate negative and offensive attitude and behaviour
- Patients/clients experience thoughtless behaviour and careless insensitive attitude
- Patients/clients experience a sensitive, empathetic attitude on an ad hoc basis (at certain incidents/event)
- Patients/clients feel that they matter all of the time.

Summary of reply from Hazel Wallace, dated 21.11.2003

The response to many points is an apology, ***or*** "*I have noted your comments*", ***or*** "*I have asked Jacqui Whybrow*": but with no indication of any further action. Where improvements ***are*** claimed, (mostly due to the new hospital building or a change of subcontractors), there is no indication of any monitoring of any sort: with the sole exception of point 23, with unspecified monitoring of cleaning by the new contractors.

1) Infection Control and Hygiene Practices (1–6)

Requests to Jacqui Whybrow for liaison with relevant staff

2) Facilities and Equipment (7–15)

New "hospital" has oxygen and power points, and therapy rooms
New contract for special air mattresses

3) General Nursing Care (16–23)

New cleaning contract
Patronising denials start to creep in: "*you feel*", "*you felt*"

4) Medical Nursing Care (24–33)

Training given by pharmacist on self-medication by patients: ***is this regular, or just a "one-off"?***
"Nurse Consultant" recently recruited for Tissue Viability
Pressure sores – will be included in the hospital's *Essence of Care* programme: ***when?***

5) Patients' Security (34–39)

New hospital building has CCTV
Agreed that injury / assault on 7th April requires investigation: ***unconscionable delay***
Other items ignored, (36–Documented Rough Handling, 37–Privacy/Dignity): ***gross insensitivity***

6) Communication (40–46)

New hospital building has patient consoles: ***but largely irrelevant for contacting staff!***

7) Contacting appropriate staff (47–51)

The reply on secular counsellors, (item 51), is misleading. How many other replies are?

8) Professionalism (52–57)

The replies to points 52 & 53 seize on praise, but ignore the criticism
Point 57.6, (ignoring requests about a patient at death's door for half a week): ***still ignored!***

9) Record-keeping (58–67)

Have points 63 (Missing Entries) and 64 (Falsified Entries) been wilfully misinterpreted?

Reply to point 67: "I am afarid (sic) that I cannot give you an explicit explanation for the gaps": not giving an explanation is ***woefully inadequate***, when gaps result, for example, in a ***delay of 25 days in supplying an air mattress!***

10) Miscellaneous (68–74)

Point 68 (Hysterical Nurse): I repeat here the hospital response (in red) and my annotation. –

I have noted your comments [where? for whose benefit? has anyone else read them?] which appear under this heading. It is not entirely clear whether they are any specific points that you are expecting the Trust to respond to here. **[Jesus wept! Do you consider *any* part of the above sequence defensible? –**

1. **Inappropriate berating of relatives for proactively administering medication (previously sanctioned by doctors), pending attention from nursing staff?**
2. **Doing this over a patient who is in need of attention?**
3. **Neglecting to attend promptly to a patient?**
4. **Motive for discarding evidence.**
5. **Appropriateness of means of disposal.**
6. **Inaction in escalating request for a doctor.**
7. **Priorities: cover own actions, and bugger the dying patient!]**

I deeply deplore the fact that the response deploys a barrage of avoidance techniques. Although there are words written against each point, in many cases points have been ignored or denied, (often with a dismissive "*you feel*"): and in almost every case replies have not been provided for subordinate items. Where failures or shortcomings have been admitted, they have often just been noted or delegated (mostly to Jacqui Whybrow): with no further comment. The insensitivity and lack of imagination displayed amazed me: until the realisation dawned that these symptoms are probably pandemic amongst hospital staff and NHS functionaries, and lie at the root of many of the problems which beset the institution.

Without prejudice to any actions which may emerge as desirable during or following the meeting on 14th April 2004, I should like the following. –

1. I should like to accept the offer of a tour around the new wards at a mutually convenient date, including the various demonstrations mentioned.
2. ***Full*** investigation into the injury / assault on 7.4.2003, whilst being seen by a young male nurse (sent by the registrar –most inappropriately and insensitively– to give my mother intimate personal care), ***and*** why this has not been investigated before, (despite my fax to the consultant on 8.4.2003).
3. ***Full*** investigation into delays:
   - 25 days for provision of air mattress, recommended in [CN17.3] & [CN2.4] (†);
   - 10 days in monitoring intake of food, after I alerted nursing staff;
   - 3 days to move out of side room, recommended in [CN8.4] (†);
   - 24 hours in seeing my mother after being told that my mother's left leg had swollen to twice the size of the right one;
   - 2½ hours before a doctor arrived – just in time to complete the death certificate;

   † But for a fax to Gail Wannell and resultant meeting with Jo Jones, these delays would have been even longer.
4. "Robust" answers to all points in my letter of July 2003, without evasion, half-truths, or denials, taking account of my responses to the reply of November 2003.

5. Where action has been taken:
    - the date that it (last) happened;
    - the frequency or regularity with which it will be repeated;
    - details of the monitoring of the effectiveness which has been instituted;
    - where practicable, a measure of the resultant improvement in patient care or perception.
6. Where action has ***not*** been taken, an explanation.
7. I should like a follow-up meeting, after improvements have been made and are believed (with some supporting evidence) to be working.

Categorisation of problem areas

Concrete

- Staffing levels / time constraints
- Physical resources

Procedures

- Nursing care: training / standards / expectations
- Records
- Communication
- Delay / inaction
- Monitoring / review

Staff

- Contacting
- Availability
- Attitude
- Competence

Observations from tour of new building, 21.4.2004

1) Few leaflets on display in atrium: limited selection – mostly on pensions!
2) Lift up to wards small and cramped.
3) Direction signs, (e.g. "*Way Out*"): too few, too small, and often printed by staff.
4) Colour coding of signs in outpatient clinics too subtle to aid navigation.
5) Doors to wards opened for mail trolley, and then left open. – Should they be open during visiting hours? If so, lock open; if not, close automatically.
6) Waste bins for paper towels too tall to fit under wash basins: so not always nearby.
7) "*HospiCom*" consoles by beds problematic: neither of us could select some of the menu items.
8) Telephone numbers are determined by location, not patient, causing confusion, disturbance, and delay when patients are relocated. Does the software not allow the number to follow the patient?
9) Observations by one experienced nurse who had worked in the old building:
    a) *still* too few power points;
    b) fittings and trims are coming adrift, after just one year;
    c) too little storage space;
    d) wash basins too small for staff to scrub forearms;
    e) just one sluice per ward, located near entrance, not near beds;
    f) cleaning services no better than with previous subcontractor;
    g) isolation wards still cramped for patients who need lots of equipment;
    h) points can be raised at monthly ward meetings – but there is no feedback.
10) Cleanliness: stained carpet in relatives' room; dried blood on chair in shower; dried beverage on table by empty bed, (with jug of water).
11) Patient names above beds in Syon ward, but Richmond ward has names of neither patients nor responsible staff. If there are concerns about patient confidentiality, surely at least the preferred form of address could be indicated?
12) Richmond ward seemed very noisy during the visit.
13) Plumbing: one toilet out of action; two showers had damaged walls near safety rail.
14) Some staff continue not to wear name badges, or to wear them so that the name is not visible.
15) CCTV: there are 44 cameras, but only 4 monitors. What is the staffing level? What is the industry standard to monitor 44 locations?