Appendix B

Primary Health Needs Test Document (30th.May Meeting)

Omissions and Error Corrections

a) It states that Ms Hurricks was able to weight bear. This is fundamentally incorrect and there is multiple evidence in the documentation package to the fact that she **could not weight bear.**

b) It states that transfer was with the support of 2 carers and a handling belt. Normally 2 or 3 carers were present and a hoist was used

c) It states that there is no evidence to suggest Ms Hurricks was at a risk of choking. **This is not the case**. 18 instances were recorded of my Mother putting too much food into her mouth and trying to swallow between 27-10-98 and 15-9-01. In addition there are 4 records of my Mother vomiting in bed in 1999 and 4 records in 2000.

d) It states that Ms.Hurrick's skin remained intact during the period being assessed. **This is not correct.** There are instances of skin blistering.

e) It states that Ms.Hurricks needs were not particularly intense, lengthy or frequent. From the daily care record provided in the documentation package, the daily routine for my mother's care required **7.3 carer hours (min)** to 8.5 carer hours (max) over a daily 24 hour period.

f) It states that 'there was a need to monitor for signs of constipation and to administer laxatives on a required basis'. In 1999 my Mother had 15 District Nurse visits and 12 enemas administered. From December 2001 to October 2002, my Mother had 670 doses of Lactulose given, 340 doses of Sphagula and 300 doses of Senna.

Note! Although I have quoted from the 'daily care record', in reality there are not comments or records on every day. For example, in 2002, there are 69% of possible day records and about 40% in other years. The nightime records are much lower, around 15%.