REPORT OF THE COMMITTEE CONSTITUTED BY THE GHANA HEALTH SERVICE/MINISTRY OF HEALTH TO INVESTIGATE INTO THE ALLEGED CASE OF ABANDONMENT OF A PATIENT AT OJOBI BY THE TRAUMA AND SPECIALIST HOSPITAL, WINNEBA

July 2024

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2 BACKGROUND

Trauma and Specialist Hospital is a secondary referral facility under the management of the Ghana Health Service through the Regional Health Directorate, Central region. Following the upgrading of the former Central Regional Hospital into a Teaching Hospital, the facility was designated a regional hospital for the region and so receives referrals particularly in the areas of Trauma and Orthopaedics from other primary facilities within the region as well as adjoining regions.

On 13th June 2024, news broke that the facility had allegedly abandoned a patient in a bush at Ojobi in the Gomoa East District of the Central Region, and that the said patient had died. This Investigative Committee was subsequently constituted and commissioned by the Ghana Health Service/Ministry of Health to unravel the facts surrounding the matter and make appropriate recommendations to enable the Service to take an informed course of action.

3 THE COMMITTEE

The Committee consists of five distinguished members drawn from the various segments relevant to the case and a secretary. The table below provides details of members of the Committee.

Table 1: Details of Committee Members

S/N	Name	Designation	Role
1	Dr. Daniel Asare	Former CEO, Korle Bu Teaching Hosp and Board Chairman, Health Facilities Regulatory Authority	Chairman
2	Osagyefo Amanfo Edu VI	The Omanhene of Mankessim Traditional Area and representative of the Central Regional House of Chiefs	Member
3	Dr. Reuben Ngissah	Consultant, Trauma and Orthopaedics. Head, Department of Surgery, Greater Accra Regional Hospital	Member
4	Mr. Daniel Kudzo Fiawotror	Deputy Director, Department of Social Welfare and representative of the Ministry of Gender, Children and Social Protection	Member
5	Mrs. Gifty Aryee	Head of Nursing and midwifery, Greater Accra Regional Hospital	Member
6	Peter Obiri-Yeboah Esq	Director of Human Resources, GHS	Secretary

The Committee was inaugurated on the 20th of June, 2024 at the Director-General's Conference Room, Ghana Health Service Headquarters.

4 TERMS OF REFERENCE

The Committee had the following Terms of Reference (ToR):

1. Establish the identity and background of the patient at the centre of the matter,

2. Outline and report on all relevant events leading to the admission of the patient at the Trauma and Specialist Hospital,
3. Enquire into the diagnosis and management of the patient at the hospital,
4. Outline and report on all processes leading to the discharge and conveyance of the patient from the Trauma Hospital to Ojobi township,
5. Identify all persons involved in the discharge process and transportation of the patient from the Trauma and Specialist hospital to Ojobi as well as their respective roles,
6. Outline gaps (if any) in the admission, management and discharge of the patient,
7. Report on any other issue relevant to the subject matter, and
8. Submit a report with appropriate recommendations for consideration by **Friday 29th June, 2024.**

However, in view of the methodology employed, the Committee could not work within the above stated time frame and same was extended to Thursday 25th July, 2024.

5 PERIOD OF WORK

The Committee commenced work immediately after the inauguration on the 20th of June, 2024 and ended on Thursday 25th July, 2024. Within the period, the Committee held six (6) sittings.

6 METHODOLOGY

In gathering relevant information, the Committee employed mixed methods. This included face-to-face interviews with all relevant persons connected to the case, review and analyses of related medical records and reports, and conducted visits to the various scenes.

6.1 *FACE-TO-FACE INTERVIEWS*

The Committee travelled to Winneba on 25th June, 2024 and held interview sessions on 26th and 27th June, 2024 with individuals whose particulars have been presented in the table below. Another interview was held on 10th July, 2024 at the Ghana Health Service, Headquarters with the Acting Regional Director of Health Service for Central Region. The prime aim of these interviews was to have unadulterated rendition of all material facts which would enable the Committee reach unbiased conclusions.

Table 2: Details of officers interviewed by the Committee

S/N	Name	Position	Institution
1	Dr. Fredovich Anyemadu Asare	Senior Specialist (Orthopaedics) Acting Medical Director	Trauma and Spec. Hospital
2	Ms. Josephine Okine	Head of Nursing & Midwifery	Trauma and Spec. Hospital

3	Mr. Tijani Khidir Saed	Hospital Administrator	Trauma and Spec. Hospital
4	Mr. Eric Kwaku Arhinful	Physician Assistant with advanced training in psychiatry	Trauma and Spec. Hospital
5	Ms. Petrina Bingab	Nurse Manager in-charge, Female Ward	Trauma and Spec. Hospital
6	Dr. Frederick Yaw Dua	Clinical Coordinator	Trauma and Spec. Hospital
7	Mr. Evans Oddae Acheampong	Principal Hospital Orderly (stand-in ambulance driver)	Trauma and Spec. Hospital
8	Mr. Michael Peprah	Temporary staff assigned as transport Officer	Trauma and Spec. Hospital
9	Dr. George Prah	Medical Director	Trauma and Spec. Hospital
10	Mr. Kwame Asante Baidoo	Social Worker attached to the Trauma and Specialist Hospital	Department of Social Welfare
11	Ms. Vera Ahensowa Saah	Social Worker, Gomoa East District Assembly	Department of Social Welfare
12	Mr. Eric K. Agyapong	Municipal Director of Social Welfare, Winneba	Department of Social Welfare
13	Mr. Samuel Wilson	Nursing Officer	Ojobi Health Cent
14	Ms. Florence Baffoe	Health Promotion Officer	Ojobi Health Cent
15	Ms. Princella Tawiah	Senior Staff Nurse Psychiatry	Ojobi Health Cent
16	Ms. Akua Anowa Brew	Nutrition Officer	Ojobi Health Cent
17	Hon. Geoffrey Inkum	Assembly Member, Ojobi and presiding member	Gomoa East District Assembly
18	ASP S. Asante	District Commander of Police, Ojobi	Ghana Police Service
19	Chief Insp. Grace Asare	Kasoa MTTD	Ghana Police Service
20	Dr. Agness A. Anane	Ag. Regional Director of Health Service, Central Region	Ghana Health Service

6.2 REVIEW AND ANALYSIS OF MEDICAL RECORDS

The Trauma hospital currently operates an electronic medical record system via the Lightwave Health Information Management System (LHIMS) platform. The team therefore reviewed copies of reports on the patient generated from the system. The team again noticed that the patient who was first seen by staff of the Ojobi Health Centre had a folder. This was therefore examined, and relevant information extracted.

6.3 PLACES AND SCENES VISITED

The team visited places and scenes relevant to the mater which included:

i. Within the hospital
   a. The Accident and Emergency Ward
   b. The plaster room
   c. The female ward
   d. The morgue (where the remains of the patient has been kept for autopsy)

ii. Outside the hospital
   a. The spot where the late patient was reported to have been picked at the outskirts of Ojobi. The gutter in which the patient laid before pickup was critically examined.
   b. The Committee in the company of the Assembly member for Ojobi visited the point where the patient was reported to have been dumped by the hospital and interacted with some people who live close by to the spot.
   c. A visit was also paid to the Ojobi Health Centre to interact with the nurses who are on record to have reported the incident to the assembly member.
   d. The Committee was again at the Ojobi District Police Command to interact with the District Commander.
   e. Finally, the Committee visited the Motor Traffic and Transport Department at Kasoa Police Station.

7 FINDINGS AND OBSERVATIONS IN RELATION TO TERMS OF REFERENCE

After the various interviews and review of related documents, the team presents the following findings and observations in particular reference to its Terms of Reference.

7.1 THE IDENTITY OF THE PATIENT

The committee finds that the late patient neither hailed from Ojobi nor lived there during her lifetime. She was thus not known to the community. The committee established firmly that the first time the late patient was seen in the community was when she was picked from the gutter and transported to Winneba.

It was the observation of the committee that the nurse who first attended to the late patient attempted to solicit information which could help to establish her identity. However, in view of that fact that she was found to be mentally challenged, she could not provide coherent responses and since the news about her abandonment and death was widely reported in the media, no one had come forward as a relation as at the time of the Committee's visit.

In the light of the above, the Committee concludes that the late patient was mentally challenged, and did not hail from the Ojobi Community.

7.2 RELEVANT EVENTS LEADING TO PATIENT'S ADMISSION AT THE TRAUMA HOSPITAL

The Committee finds that:

i. The situation of the late patient was first reported to the psychiatric nurse at the Ojobi Health Centre whose particulars have been provided above (table 2 no. 11) by a passer-by.
ii. The said nurse, after verifying the case then invited the Assembly Member who visited the scene, reported the case to the social worker whose particulars have been provided above (table 2 no. 7) and left.
iii. It is also the finding of the Committee that the said social worker who was not at the scene remotely made all arrangements with her colleague at the Trauma Hospital whose particulars are indicated in table 2 no. 6, as well as with the National Ambulance Service for the transfer of the late patient from Ojobi to the Trauma hospital.
iv. The Committee finds that an amount of Three Hundred Ghana Cedis (GH₵300.00) being fees allegedly charged by the National Ambulance Service was paid by the social worker from her own resources before the patient could be transported. However, the receipt evidencing this payment was not made available to the Committee.
v. It was again the observation of the Committee that the patient before transportation was cleaned, had her dirty clothes changed by the nurses at the Ojobi Health Centre and was accompanied by the psychiatric nurse who handed the patient over to the accident and emergency department of the Trauma and Specialist Hospital with a referral note.

In sum, the Committee finds that the Social Worker at the Gomoa East District made all relevant arrangements for transportation and staff of the Ojobi Health Centre provided the initial care and accompanied the patient to the Trauma Hospital. The Committee commends these officers for their initial respective roles.

7.3 DIAGNOSIS AND MANAGEMENT OF THE PATIENT AT THE HOSPITAL

The Committee finds after a careful review of all relevant documents and imaging studies that on the first day of admission i.e. 29th May, 2024:

i. The patient was well-received at the Emergency Department of the Trauma Hospital by the team of health professionals on duty.

ii. She had two main diagnoses being:

   a. Bilateral Tibiae and Fibulae Shaft Fractures
   b. Mental Disorder (Possible Non- Organic Psychosis).

iii. She was adequately resuscitated on the day of admission at the Accident and Emergency Department by the team of health professionals using crystalloid and parenteral analgesics.

iv. Bilateral splints using Plaster of Paris were applied to both lower limbs.

v. Initial laboratory and radiological investigations consisting of Full Blood Count and X-Rays of both limbs were requested.

vi. Deep vein thrombosis prophylaxis, using low molecular weight heparin (Enoxaparin) was commenced.

The Committee again finds that from day two of admission i.e. from 30th May, 2024, the patient:

i. Was commenced on antipsychotic drugs being Chlorpromazine and Fluphenazine Deconoate Injection as well as anxiolytic drugs consisting of Diazepam and Amitriptyline. These spanned from 30th May through to 2nd June 2024.

ii. Had her laboratory investigations reviewed on 2nd of June 2024 which showed a blood haemoglobin level of 7.6 g/dl but the clinical notes did not disclose any evidence to establish the cause of the low haemoglobin nor any attempt at correcting it.

iii. Was discharged by the attending Physician Assistant with further training in psychiatry via hand-written notes for community integration on 3rd June 2024 at 8:31am. The said discharge was never captured on the hospital's electronic platform, LHIMS.

The Committee, however, finds that contrary to the claim that the patient was reviewed daily by the attending physicians, there was no documentation in the LHIMS to support the claim.

In the opinion of the Committee, the patient was discharged prematurely considering the fact that she was rendered immobile from the multiple fractures she had sustained and as such could not move around on her own as well as the recorded low haemoglobin level which was not addressed.

7.4 PROCESSES LEADING TO THE DISCHARGE AND TRANSPORTATION OF THE PATIENT

The Committee established that:

i. Aside from the bilateral tibiae shaft fractures, the patient had mental health disorder which made her extremely aggressive resulting in the destruction of a hospital mattress on the ward. Although it was alleged that the patient attacked some patients in the ward, there was no evidence to confirm same.

ii. The aggressive behavior of the patient, the Committee finds, overwhelmed the nurses at the female ward. The Deputy Director of Nursing Service in-charge of the hospital was subsequently informed. She thus collaborated with the social worker and got the assistance of the Physician Assistant (Psychiatry) for the patient to be discharged from the hospital.

iii. The Committee finds that the above arrangement is contrary to established processes or formalities at the Trauma and Specialist Hospital where patients are properly discharged by attending doctors.

iv. The transport officer upon request from the Deputy Director of Nursing Service and the subsequent approval of the medical director released the hospital's ambulance for the purpose of transporting the patient out of the hospital.

v. Since there was no driver readily available, the transport officer arranged for the principal hospital orderly whose particulars have been provided in table 2 no. 7 to convey the patient to Ojobi.

vi. The dispatch team was made up of the social worker attached to the hospital, the principal orderly i.e. stand-in driver, a student nurse and a grounds worker. It was observed that this trip was not recorded in the transport records/logbook of the facility.

vii. The patient was conveyed out of the hospital without a clear knowledge of destination, no accompanying medications and without any plan for family reintegration as well as reviews.

viii. The patient was quietly abandoned in a wheelchair at a place outside of town and off-the main road, about 200 meters from the Ojobi Health Centre in an open space and was therefore exposed to the conditions of the weather.

The Committee finds the discharge process, transportation and community integration inappropriate and in sharp contrast to existing best practices.

7.5 PERSONS INVOLVED IN THE DISCHARGE AND THEIR RESPECTIVE ROLES

The committee identifies the following officers as key in the discharge process:

Table 3: particulars of officers involved in discharge and evacuation of patient

Activity	Persons Involved	Role
Discharge of patient	Deputy Director of Nursing in-charge of the hospital	Spearheaded arrangements to get the patient out of the ward without adherence to proper discharge protocol
	Physician Assistant	Certified manually that the patient was mentally stable and proceeded with discharge without recourse to protocol
Transportation of patient from the Trauma Hospital to Ojobi	Transport Officer	Arranged for hospital ambulance, a stand-in driver and fuel for the patient to be taken away
	Principal Hospital Orderly	Drove the ambulance conveying the patient from the Trauma Hospital to Ojobi upon the instructions of the transport officer

	Medical Director	Authorized the release of the ambulance even though the committee did not find any evidence to confirm that he had full knowledge of who was to be taken out of the hospital and where he/she was to be taken to
	Social Worker	Led the team to the point where the patient was abandoned

8 Gaps in the Admission, Management and Discharge of the Patient

After extensive review of relevant documents and face-to-face interviews, the Committee identifies the undermentioned as gaps in relation to the various sub-headings.

a. Admission

i. There was no formal referral letter from the social worker in Gomoa East district to her colleague social worker at the Winneba Trauma Hospital. This is contrary to the social welfare case management standard operating procedures as provided for in appendix 3.

ii. The Trauma Hospital upon receiving the patient who was described in the referral letter to have been knocked down by a vehicle should have formally notified the police. However, no such report was made but the patient was received, attended to and moved to the ward.

b. Management

i. Documentation on the patient's daily progress was scanty and not thorough. This applies to nursing, medical and social welfare.

ii. Although the hospital was aware of the patient's low haemoglobin level which was recorded to be 7.6g/dl upon admission, no investigation was conducted to ascertain the cause in order to correct the situation or any intervention instituted to shore up the low haemoglobin level.

iii. The psychiatric care extended to the patient was sub-optimal. Although, the hospital has a good number of psychiatric nurses who could have provided continuous psychiatric nursing care to the patient, there were no records to show their involvement in her management.

iv. Non-availability of dedicated financial support was a hinderance to care. Since the hospital relied solely on imprest approved and released by the medical director, care was restricted to what the imprest could afford.

c. Discharge

i. Protocol for discharge was not followed. Contrary to the well-established practices across the levels of the Service, the patient was discharged not because she was fit to go home but because she had become a nuisance to the facility especially the nurses who attended to her.

ii. Although the patient was taken out of the hospital, documentation as captured on the LHIMS indicated she had not been discharged as no corresponding entries were made.

iii. The patient was discharged without any evidence of home tracing, family preparation or community reintegration. Indeed, she was taken away from the hospital without any knowledge of where she was supposed to be sent to.

iv. There was no post-discharge care continuum for the patient. The patient was sent out without any medication for both anaemia and mental health disorder as well as when to report for reviews.

v. The patient, instead of being sent to the community, the Trauma hospital had the option of referring her to either Cape Coast Teaching Hospital or Ankaful Psychiatric Hospital for continuous management.

vi. For long term care, the late patient could have equally been referred to the Central Destitute Infirmary situated at Bekwai in the Ashanti region as evidence clearly showed that she had no home.

9 OTHER ISSUE RELEVANT TO THE SUBJECT MATTER

The Committee in addition to the above identified the following as relevant to the subject matter:

1. Issues relating to the alleged accident involving the patient

   The Committee after visiting all the relevant sites and interacting with the police at Ojobi and Kasoa concludes that the said patient must have been knocked down elsewhere and dumped at the outskirts of Ojobi since there was no case of accident recorded within the vicinity at the said period. Additionally, the possibility of sustaining bilateral tibiae fractures is unlikely by falling into the gutter which was found to be shallow.

2. Ineffective hospital management system in Operation

   The Committee observed the management system in place at the Trauma Hospital to be in sharp contrast to other similar secondary level health facilities. The committee's observation is in reference to the undermentioned four key hospital management members.

   a. The Medical Director
   It was observed that the medical director performed both administrative and support functions which are supposed to be the principal duties of other officers. For instance, the Committee noted that staff had to see him personally for imprest for petty supplies, approval for use of hospital vehicles including ambulance and issuance of fuel chits. The above, the

Committee notes, is contrary to best practice in hospital management within the Ghana Health Service.

b. The Clinical Coordinator

The role of the clinical coordinator in the provision of quality healthcare in GHS facilities cannot be over-emphasized. However, the situation at Trauma was observed to be different as the clinical coordinator had minimal knowledge about what went on in the facility as far as clinical care was concerned. The Committee was intrigued to note that the clinical coordinator knew nothing about the admission and discharge of the patient under consideration.

c. The Head of Nursing and Midwifery

The head of nursing and midwifery in-charge of the hospital was observed to exercise a lot of powers in all spheres of the hospital management with the overt approval of the medical director. In the instant case, she was observed to have veered into general administration, financial management, transport management and clinical coordination contrary the practice in the Ghana Health Service.

d. The Hospital Administrator

The Hospital Administrator was observed to have no knowledge about the instant case. The Committee finds this intriguing as a temporary employee who worked directly under his supervision was actively involved in the transportation of the patient from the hospital to Ojobi.

3. Absence of key protocols in wards

A visit by the Committee to the wards revealed that important nursing and midwifery protocols for admission, and discharge were not available. There was also no demonstration of total nursing care which is a standard practice for Ghana Health Service facilities.

4. Display of dishonesty

The Committee observed that almost all persons who appeared before it rehearsed and presented fabricated stories to conceal respective shortcomings in the case under investigation. It took a lot of probing and document review which projected the various inconsistencies, disagreements and contradictions in the various accounts rendered by respective officers.

10 Recommendations

Based on the findings, gaps identified as well as other issues outlined as relevant to the instant case, the Committee makes the following recommendations:

That:

1. The employees of the Ghana Health Service who have been identified in table 3 as having contributed to the planning and evacuation of the patient from the hospital to Ojobi where she was abandoned and left at the mercies of the weather until her demise did not act appropriately. The Ghana Health Service should therefore take them through the established disciplinary processes for applicable sanctions according to their respective roles.

2. Since the social welfare officer attached to the hospital i.e. Mr. Kwame Asante Baidoo is not an employee of the Ghana Health Service, he should be released from the hospital and formally reported to his mother agency, the Department of Social Welfare for him to be taken through their internal disciplinary process.

3. There should be extensive capacity building for the various cadre of staff at the Winneba Trauma Centre on the use of approved protocols and clinical documentation.

4. The Ghana Health Service must revamp the management system at the Trauma Hospital for efficiency and improved quality of care.

5. The Ghana Health Service issues a directive for the setting up of dedicated fund for paupers at the various facility in the interim and engage the National Health Insurance Authority to chart out modalities for facilities to submit claims of such patients for reimbursement.

6. The Ghana Health Service/Ministry of Health should take steps to remove financial barrier to accessing mental health care and look at putting mental health services on NHIS minimum package scheme as recently done with dialysis.

7. The Ghana Health Service should expedite action for the conduct of autopsy to establish the actual cause of death as requested by the coroner.

8. The Ghana Police Service should assist in identifying the alleged hit-and-run driver as well as the identity of the said woman in the missing persons database.

11 Conclusion

The content of this report is an outcome of a thorough and independent examination and analyses of all material facts of the instant case. Throughout the process, the Committee was guided by the stated Terms of Reference and the need for interventions necessary for forestalling the reoccurrence of the unfortunate incident which occasioned the setting up of the Committee. The Ghana Health Service/Ministry of Health is thus entreated to ensure full implementation of recommendations contained in this report.

11 Conclusion

The content of this report is an outcome of a thorough and independent examination and analyses of all material facts of the instant case. Throughout the process, the Committee was guided by the stated Terms of Reference and the need for interventions necessary for forestalling the reoccurrence of the unfortunate incident which occasioned the setting up of the Committee. The Ghana Health Service/Ministry of Health is thus entreated to ensure full implementation of recommendations contained in this report.

12 Acknowledgement

The Committee expresses a heartfelt gratitude to all persons who contributed in various ways for the successful completion of this all-important assignment. The Committee is particularly grateful to the appointing authority i.e. the Ghana Health Service/Ministry of Health for the confidence and trust reposed in personalities selected and commissioned to undertake this all-important assignment. Specifically, the following are acknowledged:

- The Honourable Minister for Health
- The Honourable Minister for Gender, Children and Social Protection
- The Director-General of the Ghana Health Service
- The President of the Central Regional House of Chiefs
- The Chief Director, Ministry of Gender, Children and Social Protection

13 Endorsement

Members of the Committee hereby put their names and hands to this report and confirm same as the true outcome of investigations conducted on the case under reference.

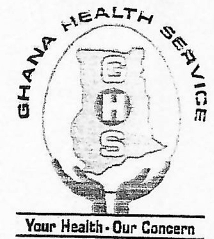
S/N	Name	Role	Signature
1	Dr. Daniel Asare	Chairman	[signature]
2	Osagyefo Amanfo Edu VI	Member	[signature]
3	Dr. Reuben Ngissah	Member	[signature]
4	Mrs. Gifty Aryee	Member	[signature]
5	Mr. Daniel Kudzo Fiawotror	Member	[signature]
6	Peter Obiri-Yeboah Esquire	Member/Secretary	[signature]

14 APPENDIXES

1. Terms of Reference
2. Referral Letter from Ojobi Health Centre
3. Social Welfare Case Management Forms
4. Mental Health Authority Letter
5. Patient Record printout from LHIMS/handwritten records
6. Pictures

In case of reply the number
and the date of this
letter should be quoted

Our Core Values
- Professionalism
- Discipline
- Integrity
- Teamwork
- Innovation & Excellence
- People Centred



GHANA HEALTH SERVICE
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My Ref. No. GHS/HRD/ODHR/2024/06

Your Ref...

June 20, 2024

DISTRIBUTION

ALL COMMITTEE MEMBERS

NOMINATION TO SERVE ON A COMMITTEE CONSTITUTED TO INVESTIGATE THE ALLEGED ABANDONMENT OF A PATIENT IN A BUSH AT GOMOA OJOBI BY THE TRAUMA AND SPECIALIST HOSPITAL, WINNEBA.

You have been nominated to serve on a committee constituted by the Ghana Health Service to investigate the alleged abandonment of a patient who was later found dead in a bush at Gomoa Ojobi by the Trauma and Specialist Hospital, Winneba. The composition of the Committee is as tabled.

S/N	Name	Designation	Role
1	Dr. Daniel Asare	Former CEO, Korle Bu Teaching Hosp	Chairperson
2	Osagyefo Amanfo Edu	Omanhene of Mankessim Rep. of Central Region House of Chiefs	Member
3	Dr. Reuben Ngissah	Consultant (Orthopaedics) Ridge Hosp	Member
4	Mr. Daniel K. Fiawotror	Deputy Director, Dept. of Social Welfare	Member
5	Mrs. Gifty Abankwah Aryee	Head of Nursing, Ridge Hospital	Member
6	Peter Obiri-Yeboah Esq	Director of Human Resources, GHS	Secretary

The Committee has the following Terms of Reference:

1. Establish the identity and background of the patient at the centre of the matter,
2. Outline and report on all relevant events leading to the admission of the patient at the Trauma and Specialist Hospital,
3. Enquire into the diagnosis and management of the patient at the hospital,
4. Outline and report on all processes leading to the discharge and conveyance of the patient from the Trauma Hospital to Ojobi township,
5. Identify all persons involved in the discharge process and transportation of the patient from the Trauma and Specialist hospital to Ojobi and their respective roles,
6. Outline gaps (if any) in the admission, management and discharge of the patient,

7. Report on any other issue relevant to the subject matter, and
8. Submit a report with appropriate recommendations for consideration by **Friday 29th June, 2024.**

It is our hope that you will bring your rich experiences to bear on the work of the committee so that the Ghana Health Service will be able to institute appropriate measures to pre-empt the reoccurrence of the unfortunate incident.

Thank you.

DR. PATRICK KUMA-ABOAGYE
DIRECTOR-GENERAL, GHS

Cc:

i. The Hon. Minister for Health
Ministry of Health, Accra

ii. The Chairman
Ghana Health Service Council

iii. The Chief Director
Ministry of Gender, Children and Social Protection
Ministries-Accra

29/05/2024 @ 2:30pm.

*We were informed by a passer by that a woman was lying in a gutter in obvious pains.
Went to see condition of client. Assemblyman was called who intend called Social ~~Sew~~ Welfare. Ambulance was called to convey client to trauma & Specialist Hospital.

O/E Patient looked untidy, both legs turned inwardly, in obvious pain. Abrasions on all limbs.

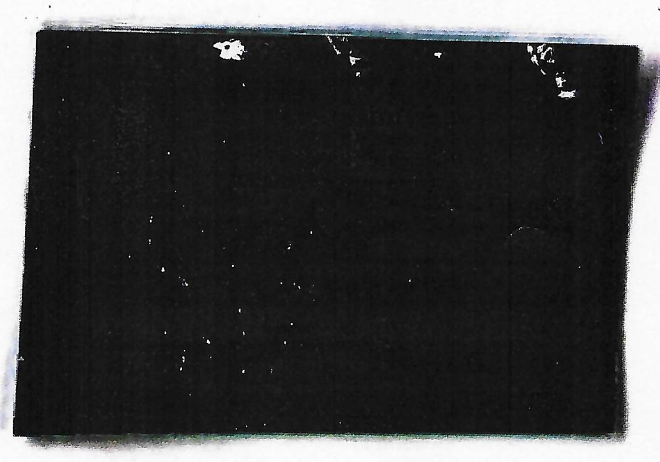
Δ ? compound fractures of both lower limbs 2° ? R.T.A.

Plan
1. Clean patient and transport to Trauma & specialist Hospital.

Tanda

Addendum @ 3:15pm.
Ambulance arrived and patient was carried into it and transported to trauma and specialist hospital. Client was accompanied by a nurse.

Tanda.



CASE REF #________________

Department of Social Welfare
(Confidential)
Case Registration Form [Form #1]

Registration Details	
Date/Time	
Details of Complainant or Person who made the referral:	
Name:	
Designation:	
District:	
Region:	
Contact Number:	
Source	☐ Police ☐ Relative ☐ District Officer:________________ ☐ Child's parent/caregiver ☐ NGO:______________ ☐ Other:______________
Method	☐ Telephone ☐ Referral letter ☐ In-person ☐ Other (provide details)

Child and Family Details					
Child's Surname					
Child's Name (first and middle)					
Other Name/Child's Nickname (where applicable)					
Sex	Male ☐			Female ☐	
Date of Birth				Age:	
Religion					
Address/location (street/landmark, district, region,)					
Who does the child currently live with?					
Mother Name/Surname		DOB/Age		Status[21]:	
Address (include District & Region)					
Father Name/Surname		DOB/Age		Status:	
Address (include District & Region)					
Caregiver Name/Surname		DOB/Age		Status:	
Address (include District & Region)					

[21] Alive, deceased, unknown

CASE REF #________________

Child and Family Details	
Names, sex and birthdates (and ages) of other children in the family	

Protection concerns *(tick all boxes that apply)*

- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Child custody
- ☐ Child neglect
- ☐ Exploitation
- ☐ Abandonment
- ☐ Orphanhood - double or single
- ☐ Child maintenance
- ☐ Other, specify: ______________

Provide additional details on the reasons for referring the case:

Follow-up action to be taken

- ☐ Further investigation needed
- ☐ Referral of case to :____
- ☐ Other, specify:

Action to be taken:

Details of officer who register the case and received the referral

Name ____

______________________________ Designation

______________________________ Signature:

CASE REF #________________

Department of Social Welfare

(This report is confidential and is meant for the purpose of the Family Tribunal Proceeding)

Social Enquiry Report [Form #4]

Date:

Child and Family Details				
Child's SURNAME				
Child's NAME (first and middle)				
Other name/Child's Nickname (where applicable)				
Sex	Male		Female	
Date of Birth			Age:	
Religion				
Address (street, landmark district, region)				
Who does the child currently live with?				
MOTHER name/surname		DOB/Age		Status[22]:
Address (include District & Region)				
Mother's occupation				
FATHER name/surname		DOB/Age		Status:
Address (include District & Region)				
Father's occupation				
CAREGIVER name/surname		DOB/Age		Status:
Address (include District & Region)				
Names, sex and birthdates (and ages) of other children in the family				

3. Case referral and investigation *Who referred the case and why.* *Who was consulted, home visits, time spent conducting the investigation*

4. Background of child
Brief family history
What are the circumstances that led the child to be found in need of care and protection?

5. Home circumstances
What are the physical conditions of the home?
Family relations - parents, children, other adults in the home
Family strengths

5. Findings
Summary of key findings on whether child is in need of care and protection or not.
Capacity of parents or extended family to care for the child in the immediate and longer term

6. Social worker recommendations
What are the recommended actions for this case? If it is recommended to place the child in formal alternative care what steps have been taken to identify other options e.g. family strengthening services and/or placement with relatives in informal kinship care.

____
Name & Position of person who compiled the SER

____
Date

District Office:

Region:

____
Supervisor' name and signature:

____
Date

[22] Alive, deceased, unknown

CASE REF #________________

Department of Social Welfare
Referral Form [Form#10]

Date:____

Referral from:
Department (District/Region) ____

Referral to:
Name of organisation ____
Address of organisation ____

Dear ____

We are referring (name of client)____ to you to receive relevant services. The reason for the referral and the services required is as follows:
____
____
____
____

Thank you in advance for your help with this referral. We look forward to your prompt feedback to assist with the management of this case. Please complete and return the attached form [Referral Response Form#11].

Sincerely,

____

Case Manager/SWCDO
Telephone: ____
Email: ____
Address: ____
____
____

CASE REF #________________

Department of Social Welfare
Referral Response Form [Form#11]

Date:____

Dear ____ (case manager/SWCDO)

We have received your referral to assist your client whose name is ____
____

We understand that you would like us to provide the following services:

____

____

____

____

____

At this time we are (please tick one):

________ Able to provide the service/s

________ Unable to provide the service/s

________ Willing to put your client on a waiting list

We understand you will call to check on the progress of your client.

____

(Name of person filling out the form and title)

Telephone: ____

Email: ____

RESPONSES TO ENQUIRY

1. **Was the Ankaful Psychiatric Hospital contacted so that a case at the Trauma Specialist Hospital, Winniba (TSHW), could be referred there (i.e., Ankaful)?**

Response: The Social Welfare Officer (SWO) attached to the Ankaful Psychiatric Hospital (AnPH) said that he received a call from his colleague (Vera) from the Gomoa East Municipality enquiring about the process involved in admitting a vagrant patient. However, he failed to inform anybody in the clinical team or management about this interaction. Management found out these details from the SWO attached to AnPH when he was engaged following the release of a formal report by the SWO attached to TSHW, indicating that they had contacted AnPH.

2. **Is there a policy that any patient to be referred to the hospital should be able to move around?**

Response: There is no such policy that patients referred to the Ankaful Psychiatric Hospital (AnPH) should be able to move around. However, management found out from our interaction with the SWO attached to the facility that he explained to his colleague during the call that, based on past experiences, they would need to bring the patient to the outpatient department to be assessed clinically for the suitability of admission to AnPH. Based on the assessment, the clinical team will adopt the appropriate treatment plan, strategy, and approach to manage the case, as this is the standard procedure.

3. **As per (1) above, was the Trauma hospital told to come along with GH 9,000.00 cedis as a deposit before a case would be accepted or received?**

Response: No. In their phone conversation on the matter, the SWO attached to AnPH indicated to the SWO at Gomoa East that if the patient were to require admission following assessment at the AnPH OPD, the District Assembly would need to make arrangements to pay an advance to cover three (3) months of admission charges. This was based on the practice for some time now when vagrants have to be moved to the psychiatric hospital, AnPH engages the relevant district assemblies to pay at least three months of hospital bills to avoid a situation where vagrants are dumped or abandoned in the hospital to care for. In many instances, however, the patients have ended up being admitted to the hospital without the assemblies necessarily paying or playing their part in the patients' care.

4. Is MHA aware of these policies?

Response: The practice of engaging relevant district assemblies through their social welfare departments to pay for and be responsible for the care of persons with mental disorders found in public places of their respective districts is backed by law. Indeed, Section 73, subsections 4, 6, and 7 of the Mental Health Act, 2012 (Act 846) state as follows:

- (4) A District Assembly is responsible for the well-being of persons with mental disorders found in public places in the district
- (6) A District Assembly shall ensure in consultation with the appropriate agencies that a person with a mental disorder found in a public place after treatment is adequately rehabilitated and integrated back into society
- (7) A District Assembly shall make adequate budgetary allocation for the care of persons with mental disorders found in public places within the district.

HOSP... TRAUMA & SPECIALIST HOSPITAL

IPD ADMISSION SUMMARY

LHIMS

Report Generation Date Time: 13-06-2024 17:00:46

Patient Information

Surname: UNKWON
Patient No.: WI-A01-AAH6008
DOB: 01-01-1979
Admission Date: 29-05-2024
Admission No.: ADMT-54321

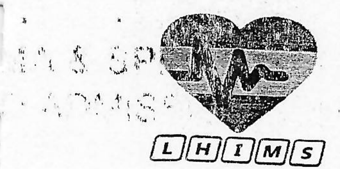
Other Names: UNKWON
Gender: Female
Age: 45 Year(s)
Admission Time: 16:14

Ward/Room History

#	Ward/Room	Bed No.	From Date	From Time	To Date	To Time	Transfer Reason	Status
1	Ward Trauma A/ E DETENTION BEDS	11	29-05-2024	16:14	31-05-2024	16:14	For feather Treatment	Bed Changed
2	Ward Trauma Orthopeadic and General Female Ward (TOGFW)	Bed 5	31-05-2024	16:14	03-06-2024	14:00	-	Discharge

Treatment Details

#	Date	Time	Doctor	Notes
1	03-06-2024	11:45	Ama Nyaneba Baiden	-
2	02-06-2024	21:39	Abigail Asor Duah	PATIENT IS MENTALLY DERANGED WAS ADMITED ON ACOUNTOF BILATERAL CLOSED TIB/FIBFRACTURE SEC RTA



TRAUMA & SPECIALIST HOSPITAL
IPD ADMISSION SUMMARY

Report Generation Date Time: 13-06-2024 17:00:46

#	Date	Time	Doctor	Notes
3	02-06-2024	14:16	DR. MICHAEL SEFA SARPONG	PATIENT IS MENTALLY DERANGED WHICH MAKES IT DIFFICULT TO BE REVIEWED BEING MANAGED AS A CASE OF BILATERAL CLOSED TIB/FIBFRACTURE SEC RTA CURRENTLY ON - CAP DICLOFENAC 75MG BD X 5/7 - TAB AMOKSICLAV 625MG BD X 5/7 - SC ENOXAPARIN 40MG DAILY X 48 HRS (COMPLETED) LABS DONE (29/5/24) HB - 7.6 G/DL PLT - 285 X 10^/L WBC - 16.4 X 10^/L COULD NOT BE ASSESSED DUE TO MENTAL INSTABILILITY O/E - AN ELDERLY FEMALE PATIENT WITH BACK SLAB ON BOTH LOWER LIMBS, NOT IN ANY OBV RESP DISTRESS, PALE, ANICTERIC, MODERTAELY DEHYDRATED. VITALS NOT DONE DUE TO CONDITION CNS - CONSCIOUS, GCS - 15/15 CVS- S1 + S2, M0. RESP - CHEST IS CLINICALLY CLEAR ABD - FLAT, SOFT, MWR, NON TENDER, NO MASSES, NO ORGANOMEGALY, BOWEL SOUNDS PRESENT. S/L - BOTH LOWER LIMBS IN BACK SLAB PLAN - TO DO XRAY OF BOTH LOWER LIMBS - DISCUSS WITH ORTHOPAEDIC TEAM
4	31-05-2024	09:20	EVANS WIL BERFORCE ANOKYE	-
5	30-05-2024	17:35	P.A Patricia Mensah	-
6	30-05-2024	17:34	P.A Patricia Mensah	-
7	30-05-2024	15:31	Regina Fordjour Marfo	-

LHIMS

TRAUMA & SPECIALIST HOSPITAL
IPD ADMISSION SUMMARY

LIGHTWAVE EHEALTHCARE SOLUTIONS

Report Generation Date Time: 13-06-2024 17:00:46

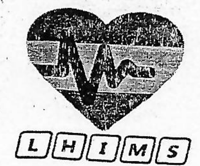
#	Date	Time	Doctor	Notes
8	30-05-2024	13:41	P.A MAUDRIN AIDOO	-
9	29-05-2024	17:49	Fuseini mohammed Zakaria	-
10	29-05-2024	17:03	EVANS WIL BERFORCE ANOKYE	-

Recommendations

#	Procedure Name	Recommended Date	Notes
1	Full Blood Count FBC (Automation)	29-05-2024	
2	Typhoid Rapid Test	29-05-2024	
3	BF for Malaria Parasites	29-05-2024	
4	Tibia/Fibula	30-05-2024	BOTH

Prescriptions

#	Drug Name	Frequency	Dose	Days	Quantity
1	**Sodium Chloride Injection, 0.9%(500ml)** [Sodium Chloride Injection 0.9%(500ml) | 0.9%(500ml) | Infusion - From **29-05-2024** To **29-05-2024**]	TDS	500 ML	1	0
2	**Dextrose in Sodium Chloride Intravenous Infusion, 5% in 0.9%(500ml)** [Dextrose in Sodium Chloride Intravenous Infusion, 5% in 0.9%(500ml) | 5% in 0.9% (500ml) | Infusion - From **29-05-2024** To **29-05-2024**]	BDS	500 cc	1	0
3	**ANTI-TETANUS SERUM** [ANTI-TETANUS SERUM | 1500 I.U. | Injection - From **29-05-2024** To **29-05-2024**]	Stat	1500 IU	1	0
4	**Diclofenac Injection, 75 mg/3ml** [Diclofenac Injection, 75 mg/3ml | 75 mg/3ml | Injection - From **29-05-2024** To **29-05-2024**]	Stat	75 MG	1	0
5	**Diclofenac Capsule, 75 mg** [Diclofenac Capsule, 75 mg | 75 mg | Capsule - From **29-05-2024** To **02-06-2024**]	BDS	75 MG	5	10
6	**Amoxicillin + Clavulanic Acid Injection, 1.2g** [Amoxicillin+Clavulanic Acid Injection, 1.2g | 1.2g | Injection - From **29-05-2024** To **29-05-2024**]	Stat	1.2 MG	1	0
7	**Amoxicillin + Clavulanic Acid** [Amoxicillin + Clavulanic Acid 625 mg | 500mg+125mg | Tablet - From **29-05-2024** To **02-06-2024**]	BDS	625 MG	5	12
8	**Giving Set IV Disposable Adult** [NA | NA | Injection - From **29-05-2024** To **29-05-2024**]	Stat	1 inch	1	0
9	**Fluphenazine Deconoate Injection 25mg/ml** [Fluphenazine Deconoate Injection 25mg/ml | 25mg/ml | Injection - From **30-05-2024** To **30-05-2024**]	Stat	25 MG	1	0
10	**Chlorpromazine Injection** [Chlorpromazine Injection | 25 mg/mL in 2 mLInjection | Injection - From **30-05-2024** To **30-05-2024**]	Stat	50 MG	1	1



TRAUMA & SPECIALIST HOSPITAL
IPD ADMISSION SUMMARY

Report Generation Date Time: 13-06-2024 17:00:46

#	Drug Name	Frequency	Dose	Days	Quantity
11	**Chlorpromazine Injection** [Chlorpromazine Injection | 25 mg/mL in 2 mLInjection | Injection - From **30-05-2024** To **30-05-2024**]	Stat	50 MG	1	0
12	**Diazepam Injection, 5 mg/ml in 2 ml** [Diazepam Injection, 5 mg/ml in 2 ml | 5 mg/ml in 2 ml | Injection - From **30-05-2024** To **30-05-2024**]	Stat	10 MG	1	0
13	**Chlorpromazine Injection** [Chlorpromazine Injection | 25 mg/mL in 2 mLInjection | Injection - From **31-05-2024** To **02-06-2024**]	BDS	100 MG	3	0
14	**Diazepam Injection, 5 mg/ml in 2 ml** [Diazepam Injection, 5 mg/ml in 2 ml | 5 mg/ml in 2 ml | Injection - From **31-05-2024** To **02-06-2024**]	BDS	10 MG	3	0
15	**Dextrose in Sodium Chloride Intravenous Infusion, 5% in 0.9%(500ml)** [Dextrose in Sodium Chloride Intravenous Infusion, 5% in 0.9%(500ml) | 5% in 0.9% (500ml) | Infusion - From **31-05-2024** To **01-06-2024**]	BDS	1 L	2	0
16	**Giving Set IV Disposable Adult** [NA | NA | Injection - From **31-05-2024** To **31-05-2024**]	Stat	1 cc	1	0
17	**Amitriptyline** [Amitriptylline | 25 mg | Tablet - From **02-06-2024** To **04-06-2024**]	Nocte	50 MG	3	6

Doctor & Nurse Notes

#	Notes	Type	Added By	User Type	Added On
1	PATIENT HAS BEEN SHOUTING AND CLAPPING THROUHOUT THE NIGHT,AWAKE THIS MORNING WITH PATIENT STILL CLAPPING AND SHOUTING.VITAL SIGNS CHECKED AND RECORDED, DUE MEDICATIONS SERVED. ALL NEEDED NURSING CARE RENDERED. PATIENT REASSURED AND MADE COMFORTABLE IN BED. CONDITION IS STABLE, AWAITING MO'S REVIEW.	Nurse Notes	Tetileonia Bosomtwe	IPD Nurse	03-06-2024 05:25
2	AT 10PM,VITAL SIGNS CHECKED AND RECORDED, PATIENT IS MADE COMFORTABLE IN BED AND REASSURED.	Nurse Notes	Tetileonia Bosomtwe	IPD Nurse	02-06-2024 22:33
3	PATIENT WAS OBSERVED ON THE FLOOR FROM THE BED, DESTROYED EVERYTHING IN THE ROOM AT 1:05AM, SHE DESTROYED THE OTHER PATIENTS BELONGINGS INCLUDING ALL THE OTHER STUFF IN THE CUBICLE (THE BED, PILLOWS AND HER URETERAL CATHERTER). THE OTHER PATIENTS HAD TO BE EVACUATEDFROM THE ROOM TO ANOTHER ROOM BECAUSE OF THE THREAT SHE POSED, THIS BEHAVIOR CONTINUED TILL THIS MORNING, MATRESSES IN THE ROOM HAD TO BE REMOVED BECAUSE SHE WAS DESTROYING THE FOAM, THE WHOLEROOM WAS LEFT IN A DEVASTATING MESS, SHE WAS RESTRAINED TO BED BUT SHE UNTIED BOTH HANDS. BREAKFAST HAS BEEN SERVED, MEDICATION HAS BEEN GIVEN, PATIENT DOES NOT CONSENT TO ANYTHING SAID.	Nurse Notes	Abigail Asor Duah	IPD Nurse	02-06-2024 07:54

TRAUMA & SPECIALIST HOSPITAL
IPD ADMISSION SUMMARY

Report Generation Date Time: 13-06-2024 17:00:46

#	Notes	Type	Added By	User Type	Added On
4	PATIENT SLEPT INTERMITTENTLY DUE TO HER CONDITION, AWAKE THIS MANE WITH NO NEW COMPLAINS LODGED. ASSISTED WITH PERSONAL HYGIENE, BED LINEN STRAIGTHENED. VITAL SIGNS CHECKED AND RECORDED PER LHIMS, DUE MEDICATIONS ADMINISTERED PER CHART. ALL NEEDED NURSING CARE RENDERED, PATIENT REASSURED AND MADE COMFORTABLE IN BED,AWAITING MOs REVIEW THIS MORNING	Nurse Notes	Tetileonia Bosomtwe	IPD Nurse	02-06-2024 07:26
5	AT 10PM, VITAL SIGNS CHECKED AND RECORDED, PATIENT IS MADE COMFORTABLE IN BED AND REASSURED.	Nurse Notes	Tetileonia Bosomtwe	IPD Nurse	01-06-2024 22:28
6	AT 10PM, VITAL SIGNS CHECKED AND RECORDED, PATIENT IS MADE COMFORTABLE IN BED AND REASSURED.	Nurse Notes	Tetileonia Bosomtwe	IPD Nurse	01-06-2024 22:28
7	PATIENT SLEPT WELL NOCTE AWAKE THIS MANE WITH NO NEW COMPLAINS LODGED.ASSISTED WITH PERSONAL HYGIENE, BED LINEN STRAIGTHENED. VITAL SIGNS CHECKED AND RECORDED PER LHIMS, DUE MEDICATIONS ADMINISTERED PER CHART. ALL NEEDED NURSING CARE RENDERED, PATIENT REASSURED AND MADE COMFORTABLE IN BED AND ENCOURAGED TO VERBALIZE CONCERNS. AWAITING MOs REVIEW THIS MORNING.	Nurse Notes	Tetileonia Bosomtwe	IPD Nurse	01-06-2024 06:56
8	AT 8:10PM PATIENTS CONDITION WAS SEEN TO BE DROWSY, RBS CHCEKED RECORDED 9.8., REFUSED BP MONITORING.	Nurse Notes	Abigail Asor Duah	IPD Nurse	31-05-2024 22:15
9	PATIENT WAS TRANS INTO THE WARD THROUGH EMERGENCY UNIT ON A STRECTCHER ACCOMPANIED BY A NURSE. A BED WAS OFFERED AND VITAL SIGNS CHECKED AND RECORDED AS TEMP-37.1,PULSE-124BPM,RESP-18CPM,BP-125/72MMHG AND SPO2-97%. ON OBSERVATION,PATIENT IS MENTALLY CHALLENGED,POOR HYDRATION AND DISORIENTED. SHE IS BEING MANAGED ON THE FOLLOWING MEDICATIONS :CAP DICLOFENAC 75MG BD X 5,TAB AMOXICLAV 625MG BD X 5,SC CLEXANE 40MG DLY X 2 AND IVF N/S $ DNS 1 LITRE. ALL DRUGS COLLECTED AND WERE INTACT. PATIENT IS UNDER CLOSE MONITORING	Nurse Notes	Ernestina Darfour Obenewah	Nurse Prescriber	31-05-2024 16:14

Admission Chief Complaint

#	Chief Complaint
	No admission chief complaint available

Additional Services

#	Additional Procedure	Rate Type	From Date	From Time	To Date	To Time	Notes
	No additional service available						

Diagnosis

TRAUMA & SPECIALIST HOSPITAL
IPD ADMISSION SUMMARY

Report Generation Date Time: 13-06-2024 17:00:46

#	Type	Code	Description	Code Status	Date
1	ICD10 Code	F29.00	Unspecified nonorganic psychosis	New	31-05-2024
2	ICD10 Code	G89.11	Acute pain due to trauma	Recurring	29-05-2024
3	DRG Code	ZOOM02A	Detention for Observation and Treatment - Adult	New	31-05-2024

Operations

#	Surgery	Date	OT	Timing	Chief Surgeon	Anesthetist
No operation available						

Diet

#	Menu Type	Menu Name	From Date	To Date
No diet available				

Clinical Notes

Sr.No.	Note
No Notes Available	

MINISTRY OF HEALTH

Bill No.: PBL-24/395806
Patient: UNKWON UNKWON
Patient No.: WI-A01-AAH6008
Age: 45 Year(s)
Sex: Female
Weight.
Diagnosis: --NA--
Bill Date: 30-05-2024
Directorate: --NA--
Unit Name: ANE Pharmacy
Type of Patient: Non-Insured
Date & Time: 30-05-2024 17:37
Prescribers name: P.A Patricia Mensah

Bill Details:

Item Name	Rate	Quantity	Total Rate
Chlorpromazine Injection [Chlorpromazine Injection, 25 mg/mL in 2 mLInjection, Injection, 50 MG, Stat For 1 Day(s)]	10.00	1	10
Diazepam Injection, 5 mg/ml in 2 ml [Diazepam Injection, 5 mg/ml in 2 ml, 5 mg/ml in 2 ml, Injection, 10 MG, Stat For 1 Day(s)]	6.00	1	6
		Gross Total (GHS)	16.00
		Pauper Discount (GHS)	0.00
		Total Payable Amount (GHS)	16.00
		Amount Paid (GHS)	0.00
E & O.E	CHECKED BY: DR. LAWRENCIA OSEI	Balance (GHS)	16.00

Payment Details:

Payment Date	Payment Mode	Paid Amount (GHS)	Receipt No
No Payment Data Found			

MINISTRY OF HEALTH

Bill No.: PBL-24/395584
Patient: UNKWON UNKWON
Patient No.: WI-A01-AAH6008
Age: 45 Year(s)
Sex: Female
Weight.
Diagnosis: G89.11 - Acute pain due to trauma
Bill Date: 29-05-2024
Directorate: --NA--
Unit Name: ANE Pharmacy
Type of Patient: Non-Insured
Date & Time: 29-05-2024 17:10
Prescribers name: EVANS WILBERFORCE ANOKYE

Bill Details:

Item Name	Rate	Quantity	Total Rate
Sodium Chloride Injection, 0.9%(500ml) [Sodium Chloride Injection 0.9%(500ml), 0.9%(500ml), Infusion, 500 ML, TDS For 1 Day(s)]	14.00	3	42
Dextrose in Sodium Chloride Intravenous Infusion, 5% in 0.9%(500ml) [Dextrose in Sodium Chlorida Intravenous Infusion, 5% in 0.9%(500ml), 5% in 0.9% (500ml), Infusion, 500 cc, BDS For 1 Day(s)]	12.00	2	24
ANTI-TETANUS SERUM [ANTI-TETANUS SERUM, 1500 I.U., Injection, 1500 IU, Stat For 1 Day(s)]	29.00	1	29
Diclofenac Injection, 75 mg/3ml [Diclofenac Injection, 75 mg/3ml, 75 mg/3ml, Injection, 75 MG, Stat For 1 Day(s)]	3.00	1	3
Diclofenac Capsule, 75 mg [Diclofenac Capsule, 75 mg, 75 mg, Capsule, 75 MG, BDS For 5 Day(s)]	1.00	[illegible]	10
Amoxicillin + Clavulanic Acid Injection, 1.2g [Amoxicillin+Clavulanic Acid Injection, 1.2g, 1.2g, Injection 1.2 MG, Stat For 1 Day(s)]	25.00	[illegible]	[illegible]
Amoxicillin + Clavulanic Acid [Amoxicillin + Clavulanic Acid 625 mg, 500mg+125mg Tablet, 625 MG BDS For [illegible] Day(s)]	4.00	[illegible]	[illegible]
[illegible] [illegible] Injection, [illegible] Stat For [illegible] Day(s)]	[illegible]	[illegible]	[illegible]
		Gross Total (GHS)	[illegible]

T&S

DAILY WARD STATE

WARD: TOFul 3/6/2024

Admission Name	Age	Male	Female	Officer
Georgina Asamoah	50yrs	—	✓	✓
Enestina Andoh	56	—	✓	
Elizabeth Aidoo	37	—	✓	

Transfers from ward	Age	Male	Female	Officer

Remained Previous Day	Total Admissions	Total Discharges	Total Deaths	Remained at Midnight
	3	1	—	~~13~~ 16

Dangerously ill Patients

Floor Patients

Med. Hospital Form

T.S HOSPITAL

DAILY WARD STATE

WARD: TOFul 31/5/2024

Office No.	Admission Name	Age	Male	Female	Officer
AAH6008	Unknown Unknown	45	—	✓	—

Office No.	Transfers from ward	Age	Male	Female	Officer

Remained Previous Day	Total Admissions	Total Discharges	Total Deaths	Remained at Midnight
11	1	1	—	11

Transfers in —

Transfers out —

Dangerously ill Patients —

Floor Patients —

P.T.O.

Med. Hospital Form

SURGICAL ADMISSION FORM S1

BED – 27

Name: Unknown Unknown
Folder No: AAH6008 Ward: Female ward
Age: 45yrs Gender: M ☐ F ☑
Occupation:
Residence:
Tel. No.:
Date / Time of admission: 31-05-24 @ 4:14pm
Marital Stats: Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐
Languages Spoken:
Next of Kin:
Relationship:
Tel. No:
Address:
Referred: Yes ☐ No ☐
Mode of Arrival: Ambulance ☐ Stretcher ☑ Ambulatory with Aid ☐ Wheel chair ☐
Admitting Med Doc:
Time Notified:
Provisional Diagnosis: Fracture of both legs, Mentally Retarded
Name of Admitting Nurse: Ernestina Darfuor NO
Rank/Signature:
Type of Patient: NHIS ☐ Paying ☑
Others:
Source of Information: Patient ☐ Other ☐
Unable to obtain History ☑

ACTIVITY

Activity	Yes	No
1. Orientation to ward	☑	☐
2. Orientation to staff	☑	☐
3. Ward protocol explained	☑	☐
4. Ward rounds	☑	☐
5. Drug rounds	☑	☐
6. Feeding time	☑	☐
7. Visiting hours	☑	☐
8. Kitchen/Bathroom & Toilet	☑	☐
9. Payment procedure explained	☑	☐
10. Hospital policies	☑	☐
11. Rules and regulations of ward	☑	☐

T: 37.1 P: 124bpm R: 18cpm
B/P: 125/72 RBS: FBS:
SpO2: 97%
Height: Weight:

Hypertension ☐ Diabetes CVA ☐
Liver Disease ☐ Respiration Disease ☐
Cancer ☐ Others:
Surgery ☐ Type:
Current Treatment:

PSYCHOLOGICAL HISTORY

Recent Stress:
Coping Mechanisms:
Support System:
Calm: Yes ☐ No ☐
Anxious: Yes ☐ No ☐

SOCIAL HISTORY

Religion:
Tobacco use: Yes ☐ No ☐
Drug Use: Yes ☐ No ☐ Specify……
Alcohol Use Yes ☐ No ☐

NEUROLOGICAL ASSESSMENT

Oriented: Person ☐ Place ☐ Time ☐
Confused ☑ Sedated ☐ Alert ☐ Restless ☐
Lethargic ☐ Comatose ☐
Pupils: Equal ☑ Unequal ☐ Reactive ☐ Sluggish ☐
Extremity Strenght: Equal ☐ Unequal ☐
Speech: Clear ☐ Slurred ☐ Other ☑

MUSCULOSKELETAL

Normal ROM of Extremities: Yes ☐ No ☐

	RA	LA	RL	LL
Paralysis:	☐	☐	☐	☐
Contractures:	☐	☐	☐	☐
Joint Swelling:	☐	☐	☐	☐
Pain:	☐	☐	☐	☐
Paresis:	☐	☐	☑	☑
Others: (Specify)	☐	☐	☐	☐
………	☐	☐	☐	☐

RESPIRATORY

Pattern: Even ☐ Uneven ☐ Shallow ☐ Dyspnea ☐ Other……
Breath Sounds: Clear ☑ Unclear ☐ Other……
Secretions: None ☐ Others……
Cough: None ☑ Productive ☐ Dry ☐
Others:

CARDIOVASCULAR

Pulse Pacemaker ☐ Regular ☑ Irregular ☐
Strong ☐ Weak ☐ Thready ☐
Absent ☐
Edema: Abesent ☑ Present ☐
Site:
Nature: Pitting ☐ Non-Pitting ☐
Perfusion: Warm ☐ Dry ☐ Diaphoratic ☐
Cool ☐ Hot ☐
Pain ☐ Area:

GASTROINTESTINAL

Oral Mucosa: Dry ☐ Moist ☑ Dysphagia ☐
Otther……
Bowel Sounds: Present ☑ Absent ☐ Hypo Active ☐
Hyper Active ☐
Abdomen: Soft ☑ Distended ☐ Tenderness ☐
Diarrhoea ☐ Connsripation ☐
Fecal Incontinence ☐ Hemorrhoids ☐
Pain ☑ Area: legs

GENITOURINARY

Retention ☐ Anuria ☐ Hematuria ☐
Dysuria ☐ Incontinence ☐ Lesions ☐
Pain ☑ Area: legs
Catheter: Yes ☐ No ☑
Others:

SURGICAL ADMISSION FORMS 2

APPEARANCE

Pallor ☐ Jaundice ☐ Bleached Skin ☐
Wounds ☐ Rashes ☐ Cuts ☐
Others...
Well Nourished ☐ Emaciated ☐
Other's Specify...

NUTRITION

Appetite: Good ☑ Poor ☐ Fair ☐
Meal Pattern: Once ☐ Twice ☐ Thrice ☐
Four or more ☐
Diet: Normal ☑ Vegan ☐ Vegetarian ☐
Low Salt ☐ Low Fat ☐ Low Carbs ☐

PRESSURE SORE SCREENING CRITERIA

[Pressure sore screening criteria] Total= 0

Turgor (adequate elasticity, skin warm and moist) 0=
Poor turgor, skin cold and dry 1=
Areas molted, red and Denuded 2=
Existing skin ulcer/Lesion 3=

Bowel and Bladder Control: Total= 2

Always able to ask for bedpan 0=
Incontinence of urine 1=
Incontinence of Feces 2=
Total Incontinence 3=

Rehabilitative State: Total= 4

Fully Ambulatory 0=
Ambulatory with Assistance 1=
Chair to Bed Ambulatory Only 2=
Confined to Bed 3=
Immobile in Bed 4=

GLASGOW COMA SCALE FOR ADULTS

PARAMETR	SCORE	TICK
Eye Opening		
Spontaneous	4	✓
Response to speech	3	
Response to pain	2	
No response	1	
Verbal Response		
Oriented and Appropriate	5	
Disoriented and Confused	4	
Inappropriate words	3	✓
Incomprehensible sounds	2	
No response	1	
Best Motor Response		
Obeys commands	6	
Localizes pain	5	
Withdraws from pain	4	
Flexor response	3	
Extensor response	2	
No response	1	✓
TOTAL	8	

MANAGEMENT

....
....
....
....
....

INVESTIGATIONS / TREATMENT

INVESTIGATIONS
1. FBC
2. Grouping and cross match
3. ....
4. ....
5. ....

TREATMENT
1. Cap Diclofenac 75mg bd
2. Tab Amoxiclav 625mg
3. SC Clexane 40mg dly
4. ....
5. ....

NURSING MANAGEMENT

PROBLEMS IDENTIFIED

Pain (legs)

STRENGTHS IDENTIFIED

....

CARE PLAN GOAL

Patient will be relieved from pain within 80 minutes

NURSING ORDERS

1. Reassure Patient
2. Make her comfortable in bed.
3. ~~Check vital signs~~
3. Check and record vital signs.
4. Serve prescribed analgesics

NURSING INTERVENTIONS

- Patient reassured of competent nursing care
- Patient was made comfortable in bed.
- Cap Diclofenac 75mg administered
- Vital signs checked and recorded

EVALUATION

Patient's pain was relieved after 45 minutes

NURSE I/C NAME: Petrina Bingal

REFERRAL FORM - OJOBI HEALTH CENTRE

DATE:

DAY 29	MONTH 05	YEAR 2024

NAME OF REFERRING FACILITY Ojobi HC

ADDERSS OF REFERRING FACILITY

CLIENT/ PATIENT INFORMATION

SURNAME Unknown			OTHER NAME	
SEX F	AGE		INSURED/NON INSURED	NUMBER

ADDRESS OF CONTACT PERSON/ RELATIVES (INLUDE TEL. NO)

Trauma & Specialist Hospital

REFERRAL DETAILS

NAME OF HOSPITAL REFERRED TO

DIAGNOSIS ? fracture of both legs, ? Mentally retarded

PRESENTING COMPLAINT (S) 5902-96

Brought in by Passersby, seen waiting with in Pain

EXAMINATION FINDINGS	TEMPERATURE	BP	WEIGHT	HEIGHT	PULSE
obviously in Pain, both legs turned inwards with abrasion	37.1°C	131/86			110 bpm

RESULTS OF INVESTIGATIONS CARRIED OUT —

COMMENT For further Investigations & management

TREATMENTS GIVEN —

REFERRING OFFICER Abigail T. Tempew

NAME OF REFERRING OFFICER

SIGNATURE

POSITION P.A.

NAME OF RECEIVING OFFICER

SIGNATURE

POSITION

FEEDBACK

RBS - 5 9mmol/l

RSB:

SPO2: 97%

TRAUMA SPECIALIST HOSPITAL

WINNEBA

ACCIDENT AND EMERGENCY DIRECTORATE

TRIAGE SHEET

Patient's Name: Unknown Unknown

Chief Complaints: Fracture of both Legs, Mentally Retarded

Date: 29/05/24 Time of Arrival: 4:10pm Age:

Sex: M / F

Part 1: Triage Early Warning Score (TEWS)

Mobility	Stretcher	2
Respiratory Rate	~~72f~~ 18bpm	1
Heart Pressure (RR)	124bpm	2
Blood Pressure (BP)	125/72mmHg	0
Temperature	37.1	0
AVPU	Alert	0
Trauma	Yes	1

FINAL TEWS SCORES: 6

INTIAL TRIAGE COLOUR: RED (ORANGE) YELLOW GREEN BLUE

PART 2: The Discrimination List

1. Does the patient need to be triage to a higher colour on the discriminator list?

   YES (NO)

2. What was the discriminator?

PART 3: FINAL TRIAGE COLOUR: RED (ORANGE) YELLOW GREEEN BLUE

REFERRAL FORM - OJOBI HEALTH CENTRE

DATE:

DAY 29	MONTH 05	YEAR 2024

NAME OF REFERRING FACILITY Ojobi HC

ADDERSS OF REFERRING FACILITY

CLIENT/ PATIENT INFORMATION

SURNAME Unknown			OTHER NAME	
SEX F	AGE		INSURED/NON INSURED	NUMBER

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Trauma & Specialist Hospital

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obviously in Pain, both Legs turned inwards with abrasions	37.1°C	131/86			110 bpm

RESULTS OF INVESTIGATIONS CARRIED OUT —

COMMENT For further Investigations & management

TREATMENTS GIVEN —

REFERRING OFFICER Abigail T. Tempew

NAME OF REFERRING OFFICER	SIGNATURE	POSITION P.A.
NAME OF RECEIVING OFFICER	SIGNATURE	POSITION

FEEDBACK

NURSES TREATMENT SHEET

NAME: Unknown Unknown AGED: 48yrs

SEX: F WARD: OLE

DRUG	TIME	29/5	30	01	2	3	4	5
IVF NS 1.5L & DNS 1L	6							
	10							
	12							
	2							
	6	[signature]						
	10							
	12							
Inj ATS 1500 IU stat	6							
	10							
	12							
	2							
	6	[signature]						
	10							
	12							
IV Amoxiclav 1.2g stat	6							
	10							
	12							
	2							
	6	[signature]						
	10							
	12							
Inj Diclofenac 75mg stat	6							
	10							
	12							
	2							
	6	[signature]						
	10							
	12							
Cap Diclofenac 75mg bd x 5/7	6			AD	AD	AD		
	10							
	12							
	2							
	6		refused	EA	ED			
	10							
	12							
Tab Amoxiclav 625mg bd x 5/7	6			AD	AD	AD		
	10							
	12							
	2							
	6		refused	EA	ED			
	10							
	12							
SC Enoxaparin 40mg daily x 48hrs	6			NIL				
	10							
	12							
	2							
	6	[signature]	[signature]					
	10							
	12							

Review 8/6/24 @ 8:31 am

+ Psychiatry unit

Called to review urgently on the ward on the account of bizarre behaviour on the ward on earlier days (attacking other patients and destroying already applied POP cast).
Client was admitted through the A/E ofa an RTA with no known information or relatives.

O/E

Stable and calm, afebrile, ajaundiced but mildly dehydrated.
1+11+0 m

Chest - c/c

MSS - Bilaterally # both legs,

MSE : Good Rapport, calm appearance, calm behaviour (receptive), affective congruence, mood (mildly depressed), nil delusions, nil hallucinations, fairly good memory ST/LT, abstract thinking - poor, good insight (ability to tell why he is here),

(-) Bilateral # both legs
- Resolving head Concussion.
- Condition stable

A/Plan

→ Treatment for # already done

⇒ C/T treatment + Discharge +
Social welfare to begin Community
re intergration and family involvement

Follow up later ~~when~~ when client
is re intergrated and treatment thereof
is done for #.

[signature]

Admission And

I. P. No.	Name	Address
505 (44)	Esi Kooba	c/o Esi Akoako [illegible] Ahumaka
2912 (44)	Salamatu Arthur Ref In: Our lady of Grace Asikuma	c/o Fatimatu Alhass (Sister) Mankessim-Ba 0240753892
2352 (45)	[illegible] Malik Ref Inf Wesley Clinic - Kasoa	c/o [illegible] Abdul 0535369406 [illegible] Kasoa [illegible]
[illegible] (46)	Suhena Bondzie Ref In St Luke's Cath Hosp. Apam	c/o Adjoa Dede 0539573[illegible] Apam Daughter
[illegible]8 (47)	Ruth Ansah	c/o Elizabeth Hagan 0[illegible] Gomoa [illegible]
005 (48)	Unknown Unknown	
[illegible]2	Afua Gantey	c/o
[illegible]	Rose Kyeremanu	

Discharge Register

Age	Sex	Prov. Diagnosis ~~Occupation~~	Final diagnosis ~~Ward~~	Date of Admission	Date of Discharge
78	F	Acute Tonsilitis. Sev. Normocytic normochromic Anemia ?Cause. Known HPT, UTI.		28/5/24 @ 7:10pm	5/06/2024 @ 4:51pm
40	F	Open Injury of Left Knee		29/5/24 @ 2:40pm	25/06/24 @ 8:30pm
59	F	Hyperglycaemia/ Gluteal Abscess ~~HHS, DKA~~		30/5/24 @ 12:40pm	12-06-24 @ 5pm
97	F	Rt femur fracture		30/5/24 @ 1:00pm	31/5/24
16	F	SCD/VOC		30/5/24 @ 3:30pm	01/06/24 @ 4:50pm
45	F	Bilateral Tib/Fib Same fracture		31/5/24 @ 3:30pm	3/6/24 @ 11:30am
86	F	Femur/neck fracture		01/05/24 @ 8:30am	
72yrs	F				

No.	Name	Time	Temp	Pulse	Resp	BP	SpO2	
	[illegible]		36.[illegible]	101	20	146/92	99	
	31—5-24	10	36.2	110	20	153/76	99	
		2	37.2	106	22	114/79	97	
		6	37.2	106	22	114/79	97	
			36.7	111	20	148/95	98	
23	Elizabeth Nyarko		36.3	91	20	79/59	98	7.7
			36.0	91	20	79/51	97	~~8.~~
			36.1	99	20	78/52	96	
			35.9	90	19	88/55	97	
			36.1	98	18	79/53	98	
25	Zaratu Malik		36.5	119	19	85/66	98	15.6
			36.1	116	21	96/74	98	~~24.0~~
			36.5	114	20	87/66	100	
			35.8	112	20	98/67	96	
			36.0	88	20	86/61	99	
15	Sabina Bondzie		36.1	83	19	8[illegible]/82	98	7.9
			36.1	90	19	98/51	99	
	DISCHARGED							
13	Ruth Ansah		36.2	107	19	121/79	99	
			36.1	101	20	117/81	98	
			36.1	104	20	114/69	100	
			36.9	103	19	100/64	97	
			36.4	96	21	106/72	98	
27	unknown	6am						
		10am						
		2pm						
		6pm	37.1	124	18	125/72	97	
		10pm	37.0	100	25	100/60	98	

01-06-24

Bed	Name	Time	T	P	R	BP	SPO2	FBS
19	Patience Armah	6am	36.1	95	20	136/90	99	RA
		10am	37.0	109	21	130/90	99	
		2pm	36.7	102	22	124/84	96	
		6pm	36.7	92	20	103/72	98	
		10pm						
23	Elizabeth Nyarko	6am	36.1	98	25	88/58	97	8.0
		10am	36.3	99	22	110/90	99	
		2pm	36.6	102	20	83/57	97	
		6pm		97	19	71/45	96	
		10pm	36.1	95	20	84/54	98	
25	Zaratu Malik	6am	36.4	108	25	81/61	99	23.4
		10am	35.5	109	24	86/60	96	
		2pm	35.8	108	21	84/56	98	
		6pm	368	109	22	107/44	99	
		10pm	36.4	100	25	100/60	99	
27	Unkown	6am	36.2	98	20	110/70	98	
		10am	37.0	80	20	100/60	97	
		2pm	36.8	97	19	115/75	98	
		6pm	36.0	100	25	130/80	99	
		10pm	36.2	95	18	125/70	98	
76	Mary A. Cha[illegible]	6am						
		10am	36.1	79	21	128/68	96	
		2pm	36.0	68	20	115/[illegible]	97	
		6pm	36.1	79	21	141/124	[illegible]	
		10pm	36.1	80	20	120/80	97	
12	Rose Kyemani	6am						
		10am						
		2pm						
		6pm	37.5	93	21	153/89	98	
		10pm	36.1	90	20	145/90	99	

15	Zaratu Malik	36.1	106	25	112/70	99	27.9	
	2 - 6 - 24	36.9	108	24	85/62	98		
		36.7	103	24	112/60	99		
		37.1	112	21	90/67	98		
		36.7	110	20	141/65	97		
16	Elizabeth Nyarko	36.1	96	20	86/59	97	6.9	
		35.5	97	21	86/54	97		
		36.0	102	20	78/51	98		
		36.4	104	20	92/64	100		
		36.2	99	20	89/49	99		
18	Veronica ~~Asante~~	36.4	96	20	99/71	99	5.2	
		37.5	102	21	99/63	99		5.
		36.2	105	20	93/46	95		
		36.3	104	20	88/47	99		
		37.6	97	20	100/62	97		
19	Patience ~~Armaah~~	36.4	100	25	139/96	99	18.8	
		36.8	97	25	119/76	98		23
		36.4	96	24	115/74	99		30
		37.2	94	21	118/78	99		20
		36.7	93	20	125/88	98		31.
22	unknown.	36.2	86	20	110/60	99		
		36.0	90	20	100/60	97		
		36.3	95	19	120/60	98		
		36.5	100	25	110/60	98		
		37.0	80	20	125/80	99		
VIP	Georgina Cann	36.1	105	24	126/84	91		9.2
		36.2	112	21	122/91	95		9.3
		36.7	105	20	124/82	98		16.4
12	Monica Gyasiwaa	36.0	103	20	109/74	78		
		36.2	93	20	105/78	100		
		36.0	100	22	112/82	100		

No.	Name	Time	Temp	Pulse	Resp	BP	SpO2	
		10pm	37.5	12?	18	136/110	67	
13	Rose Kyomani	6am	37.0	69	19	155/85	98	7.2
		10am	37.1	78	19	160/85	97	
	3 — 6 — 24	2pm	36.7	78	22	165/88	95	
		6pm	37.2	96	22	120/67	95	
		10pm	36.3	105	21	138/80	95	
15	Zainabu Malik	6am	36.0	98	24	80/66	99	6.0
		10am	37.1	101	23	92/67	97	
		2pm	35.9	109	15	85/63	96	
		6pm	36.7	108	18	144/70	97	
		10pm	37.0	110	20	119/68	99	
16	Elizabeth Njarka	6am	36.9	89	20	79/60	97	5.1
		10am	35.8	97	28	86/55	98	
		2pm	34.7	94	19	86/54	99	
		6pm	35.8	92	23	81/54	95	
		10pm	35.3	90	22	96/58	94	7.0 Rec Int [illegible]
18	Veronica Asante	6am	37.1	87	21	99/72	96	
		10am	37.3	97	36	123/66	93	
		2pm	37.8	97	15	87/52	92	
		6pm	36.3	97	26	105/54	97	
		10pm	37.7	96	20	105/72	96	
19	Patience Armaal	6am	37.1	85	21	134/95	97	19.2
		10am	36.5	93	32	110/70	97	
		2pm	36.8	109	22	149/99	99	
		6pm	36.3	93	34	120/84	95	
		10pm	37.7	89	-	125/79	98	
27	Unknown	6am	36.3	90	20	120/80	99	
		10am	36.0	100	25	100/60	98	
		2pm						
		6pm						
		10pm						

GHANA POLICE
GHANA POLICE
SERVICE WITH INTEGRITY
OJOBI
AND