

## **CASE STUDY – The Story of My Aunt’s Hospital Care in South East Wales**

### **1. Introduction**

1.1. This is an account of my aunt’s hospital care in 2005 and 2006. I have tried to offer a factual account, but some of my perceptions do tend come through within the account and also in a brief discussion. Everyone should read this case study because I have little confidence at present that anything has actually changed for the better. There are pockets of good practice, so people tell me, but there are very few places where you can actually find out about where good fundamental nursing practice exists. There are obviously lists of innovation and clinical interventions on various internal NHS sites, but the nursing that the public understands about, that elusive fundamental care – where is the good evidence? I would be most happy to receive evidence that there is good nursing out there. Since my aunt’s discharge from hospital I did observe some wonderful nursing care in a nursing home and it did restore some confidence in nursing in Wales. I am a registered nurse and gerontologist who now works in education.

1.2. Miss Brown – a single and very frail lady of 91, and my only aunt, to whom I was very close, was admitted from a Christian Residential Home, where I kept a close professional and personal eye on her care, to an acute medical ward in a toxic state with cellulitis of her right leg during April 2006. Auntie was a retired missionary nurse and stoical Yorkshire woman.

1.3. The summary of her needs and medical history was: -

Osteoporosis, right hip replacement 2002 and history of previous falls. A small stroke in 2003 had left a weakness on her left side; she was in the early stages of a diagnosed vascular dementia, depression, poor mobility, poor appetite and a total anxiety about toilets and incontinence pads. A lack of ability to hold in her false teeth due to the stroke meant that she had difficulty in chewing and swallowing. She was also reluctant to drink, as she was concerned about her continence. She was allergic to eggs and had a history of asthma and bronchiectasis – which had developed in Africa. She was a very small lady – approximately 4 ‘ 10”.

1.4. As a person my aunt was quiet but not shy, very determined and could be very serious at times. My mother was the giggly girl but her sister was the more serious one. She was a strong person, very resolute and use to being pragmatic about lots of things including rules and routines. This was a character trait, which certainly

aided her when she went, alone, to the middle of war torn Africa in the 50's. She was also very generous with her time, doing kind deeds for other people in her village after retirement. At the age of eighty-eight she was the main listener to the children reading at the local playgroup every day and was walking at least 2 miles every day.

1.5. She was a wonderfully kind and highly qualified nurse and midwife who dearly loved all of her family, brothers and sisters and all their nieces. When she came home on furlough she always stayed with my parents and brought lots of interesting African gifts for us. She was a devoted Christian and lived her whole life in the service of the church and the people around her, even after she retired from missionary work.

## **2. *Background Comment – a previous admission to the same hospital***

2.1. She was admitted to hospital in March 2005 on Easter Monday with the same complaint, and at that time she fell out of bed in the Medical Assessment Unit and fractured her arm and received an injury to her head and neck. I had been away on leave abroad and had phoned the ward on the day she was admitted, giving a full medical, mental health, personal and falls history. Despite this and a repeated full history to the deputy sister on returning from leave the next day I found later, after her fall, that the Falls risk assessment form had been incomplete and did not contain any of the information I had given twice to two different nurses. Hence her assessment score for risk was low and no cot sides had been attached to the bed. She had rolled out of bed at 6a.m when no one was around.

2.2. The subsequent complaint investigation found that the Trust could not find the nurse who completed the form, or the agency staff on duty with whom I spoke from France for over half an hour, and the Deputy Ward sister also denied any memory of being informed of her full medical history.

2.3. My first view of my aunt on my return from holiday was to see her slumped sideways in a huge chair, her hair unkempt and a gown, which was obviously at least 4 sizes too big had fallen off her right shoulder exposing part of her chest. The patient next to her in this mixed sex ward was an older man, who could obviously see my aunt's exposed chest. I complained to the nurse in charge who just shrugged her shoulders and said that she had not control over this and that it wasn't a ward anyway so the Assembly policy did not apply as it was a Medical Assessment Unit, not a ward. Auntie then moved to three different wards, often without my knowledge, was visited by doctors, physiotherapists and social workers,

none of whom ever contacted me, despite the fact that on her record it said that I had Enduring Power of Attorney and was to be contacted about everything. I witnessed some behaviour by members of ward staff around dignity and respect issues which I complained about to the ward nurses at the time. Following Auntie's discharge from the rehabilitation unit, without the appropriate discharge plan, which contained information that she had contracted MRSA, she became much frailer.

2.4. I made a formal complaint about her care and the fall, and sent a copy of this letter to one of the NHS Trust Board members who was also a senior officer in a local age organisation. I received, belatedly, a long letter outlining the investigation and upholding all of my complaints. I did not receive any reply or contact from the Board member.

2.5. I received a written apology eventually from the Trust but no action plan. The apology at the time meant little to me and even less to my aunt whose health had deteriorated significantly since her fall. Interestingly my aunt was initially described on her notes as being admitted to the hospital with a fractured arm, when this incident took place **in their hospital** and was the result of alleged negligence due to poor assessment and recording processes. Unfortunately I was unable to take this complaint to the next stage due to my own ill health in February 2006 following an accident. I however kept notes of her second admission, reminding myself that she was being looked after by the same people who supplied appalling care the first time. I was determined that if I did complain again that I would use other means where possible to complain and affect change.

### 3. The Care Account

3.1. It was Easter again in 2006 when she was admitted again but within one week Auntie had recovered from the infection with intravenous antibiotics but was very weak and needed full nursing care. She had no movement in her limbs other than to scratch her nose occasionally. She kept her hands under the bedclothes, did not call out and was unable to hold a beaker or feed herself.

3.2. I questioned the staff when I noticed that the fluid and food record at the bottom of the bed was frequently empty of details, and I did not know whether Aunt was actually eating any meals or receiving any fluids by mouth because she was so frail, and at times she refused to speak. I actually wrote in the record that it was empty and asked why, by putting a large question mark and signing it – having first asked the ward staff directly. The next day I noticed that staff had written in the record in retrospect. I reported this to the nurse in charge on that day. No

comment was made. I also asked for Auntie to be weighed, as I was concerned regarding her nutritional state and needed a baseline to compare in the future.

3.3. In the medical ward, her first ward after the medical assessment unit, I would arrive in the afternoon to see her sitting – or rather – slumped in a large firm vinyl chair and obviously in pain. Her back was very bony as she was already very thin and bowed with scoliosis and osteoporosis and I asked her how she felt. I requested that either a more comfortable chair was found for her and/or she was asked if she wanted to sit out in a chair. After that time Miss B was kept permanently in bed. I was astonished that none of the nurses perceived that with her medical history and the fact that she was uncommunicative most of the time that she might be in pain. There was no pain assessment tool in use. She was just left there, in a nightdress, often without a dressing gown on and she often felt cold. Her swollen leg with the cellulitis was often not resting on a stool as was suggested in her care plan.

3.4. Every time she was visited her drinking cup was never within reach. It was always at the bottom of the bed on the bed table. Her call button was nowhere to be seen and there seemed to be little active care notes at the bedside. To my view no real nursing care was happening, so I massaged her hands with cream which she enjoyed, and cut her nails, combed her hair and gently washed her face, because no one else seemed to do it. I also fed her when I visited.

3.5. Finally after several weeks it was suggested by the ward staff that my auntie required nursing care in the community and therefore the social worker was contacted to talk with me. I spoke with Auntie and explained that the nurses and doctors felt that she had deteriorated so much that she needed looking after all the time and that she would not be able to stay in this ward or go back to the residential home. This might mean going to a nursing home, which I would choose, carefully and consult with her. She nodded that this was acceptable and then said ‘whatever is best, don’t worry me with it all- I wish I could just die now, I am ready.’

3.6. A ward multi-disciplinary meeting was arranged with me, the residential home manager, and social worker and ward nurses present.

A telephone conversation between myself and the ward nursing staff indicated that they had assessed her and she needed to go to a nursing home; however, when I pursued this further and the nurses were asked what nursing assessment tool they used, they replied that it was the social work assessment form. I also asked what nursing model/nursing assessment they used to come to this conclusion – they were unable to provide any information on this and her key nurse actually said that

she didn't know much about nursing models. No evidence was presented that any nursing assessment was undertaken or if it had been, without my knowledge, in a valid and evidenced based way. *Note - This is contrary to a nurse's code of conduct as they have a statutory responsibility around safety of the environment and nursing assessment of need.*

3.7. At the ward meeting, which the social worker chaired, it was very evident that the decision to move my aunt to a rehabilitation/long term care ward in another hospital rather than to a nursing home had already been taken. The nurse who attended the meeting was not her key nurse or the ward manager, and was an internationally recruited nurse with very little English or knowledge of the hospital's use of nursing models or assessment procedures and nursing care plans. She said nothing during the meeting and was not invited to comment by the social worker. The consultation with me occurred within this meeting, when it seems that the decision had already been made. However, my insistence on a formal nursing assessment meant that they seemed reluctant to try and send her to a nursing home where she would have to pay for her own care – despite the fact that her general condition and deterioration had occurred due to and following her hospital fall. I think that because I kept on reminding them of this they decided not to push too hard with their own agenda. I asked for a copy of the social work assessment and was promised this by the social worker. Despite trying to chase this up I never received it.

3.8. Auntie was moved to the long term/palliative care ward (not the rehabilitation ward as I had been informed) in the neighbouring hospital, the following week. Some of the nurses in this ward were familiar with her case, as they had known her from her previous admission in 2005. This caused me some anxiety but I vowed that I would be more proactive this time. Over the next few weeks I had several conversations with various staff nurses about Auntie's care and I noticed that the only record kept at the bottom of the bed was the medication record. There were no nutrition or fluid charts or even a care plan. If there were any these they were all kept in the nursing office or so they told me. So there was little opportunity to review Auntie's care myself – in terms of food and fluid record or any care plan without making an appointment to see these with the ward manager. With hindsight I wish that I had pursued this more, but at the time talking with the staff seemed enough. I presumed, wrongly so, that they were aware of my previous complaint and would therefore, I again presumed, be more careful in their nursing actions. I did gain an

impression of this in the way they spoke with me and that made me, sadly, trust them to some extent. **Note-** *when relatives/carers have busy lives and travel a lot they do have to lay their trust on the public servants who are supposed to provide good care. I visited every week and sometimes more than once a week, but was never sure or reassured that her care was secure when I wasn't questioning actions or lack of action. This caused considerable stress to myself and in particular to her sister, my mother, who was a retired nurse and blind.*

3.9. Auntie was given a special electronic bed, as she was not moving in bed at all. Full nursing care, including feeding, offering fluid and care of the mouth was required. The Fundamentals of Care (WAG 2003) booklet was there in abundance at the entrance to the ward and in the waiting area. However, I did not see any evidence that the nurses and their delegated support workers and other staff ever applied these Assembly guidelines. I did not see any psychological support offered to patients and I never observed any social interaction between the nurses and bed bound patients. For these patients the only activity was staring at the wall and other patients or talking with visitors if they were fortunate to receive them. Several patients in this 6-bed unit were blind and no suitable equipment or access to their call bells was noted. Life on each day must have been abysmal and monotonous for them. At every visit the nurses and healthcare support workers were observed to be sitting around the nursing station or they were efficiently changing the position of some bed bound patients. This was done with a great flurry of importance but I never once saw a nurse or healthcare support worker actually consulting with a patient, it was more – “Hello Joan we have come to turn you.”

3.10. I really wish that I could have helped them more often. Mum, Dad and myself would stay longer at visiting time and talk with the other patients. One old lady was 99 and just sat in a chair all day. She was totally blind and so couldn't leave her chair. She often asked for a cup of tea “Ooh – I could murder a cup of tea”– but there was no means on the ward to make one for her. Water was what was on offer, so I used to chat and joke with her to take her mind off the cup of tea. She was a really interesting person and we talked a lot about the old town and she also reminisced with my Dad who was from the same area of town. Whilst I was not obviously aware of the full circumstances I often asked myself why on earth did she need to be in hospital in a long-term ward – costing the NHS a fortune and she didn't want to be there. In my experience as a previous housing association manager covering residential homes and sheltered accommodation, these

environments can be really positive experiences and go some way to provide comfort and company – one of the sure ways of promoting well-being and preventing depression. Surely convalescence in one of these environments would be better, and much cheaper, than staying in a long-term ward when you don't need acute medical care. The nurses seemed to do nothing for her except put her into bed at night. This was a view of another patient with whom I talked.

- 3.11. It was discovered in the first week that the nurses and health care support workers were changing Auntie's nightdresses frequently but were putting them loosely in the drawer of her bedside unit. Auntie had developed, during a previous hospital admission, an MRSA infection. Directly above this bedside unit was a notice board with a formal notice from the infection control nurse on how relatives were to deal with dirty linen. It specifically stated that all dirty linen should be put in plastic bags.
- 3.12. It took 5 weeks of talking with various staff nurses, leaving plastic bags in the bedside locker drawer, and also leaving notes attached to these bags, as well as firm words with the healthcare assistants and the deputy ward manager, before the dirty linen was put in plastic bags in her drawer every week. Following my initial complaint three healthcare assistants came to Auntie's bed and leaning over the bed table looking down on my mother, who is 92 and my father age 89 who were sitting down, started to give numerous excuses as to why there were no bags in the drawer. We all felt bullied and were shocked that the staff nurses had allowed this conversation to happen.
- 3.13. I again requested that the staff weigh Auntie, as I was concerned about her food intake and weight. She wouldn't tell me herself whether she was eating anything, so I would bring in various titbits that I knew she liked. On 20<sup>th</sup> June a weight of 43Kg was noted on the record and I took this as the baseline. Note - *After Auntie's discharge, I was informed by one of the senior nurses of the whole unit that this weight had been approximated (i.e. the nurses had just looked at Auntie and guessed her weight). However, this nurse then left a message on my phone to say that a weight had been recorded at this time on the notes, of 43Kg, so it has never been actually established whether this was accurate or not.*
- 3.14. Over the 5 months until discharge to a nursing home I also asked weekly for the ward to arrange for her hair to be washed and cut. Auntie never had her hair set; she always had a simple short style, as her hair was very fine. Every time the

nurses agreed to arrange it was never done, despite me offering to arrange it myself or wash her hair in the ward for her. The nurses said that this was not possible. I remember the special funnels we used to use to wash patients hair in bed. We used to pull the head of the bed away and wash the hair using towels and bowls underneath to catch the water. It was simple enough and without fail it made every patient feel so much better – and cared for.

3.15. Her hair was never washed with water and in that time she never had a bath or shower; and I know how therapeutic warm water can be to a frail body. Again, this was always promised and I felt in limbo most of time, wanting to believe them and then being let down. This was very difficult to manage all these requests when I was also working and had a very demanding job involving travel.

3.16. After two weeks on the ward a sub-dermal (under the skin) infusion was set up, as Auntie was 'not drinking'. The staff had told me this after several forceful enquiries as to what fluids she was actually taking and the method they were using to maintain her hydration. Up to this time it was evident that Auntie was refusing to drink and eat but there was no evidence that different approaches were made to try different methods. I tried very hard to feed her when I visited – but there was never evidence that the food or drink was ever within her reach or in a special beaker or other equipment; or had even been offered. Auntie loved chocolate and I told the staff that I had left some chocolate for her in her bedside drawer and gave it to her when she visited. This chocolate was never offered to Auntie by the ward staff. The amount of chocolate and sweets she liked never changed from one week to the next. As far as I am aware no named nurse asked her what she really liked to eat. She was given those high calorie drinks and yoghurts which she hated as she would screw her face up to them when I tried to feed them to her. However, she was happy to eat a soft peach and a ripe fig when I brought them in.

3.17. Despite asking different nurses about her nutritional status no offer was ever made to discuss her records and her family's concerns. I was not even informed whether she had a key nurse. My mother, her sister, and also a retired nurse, felt increasingly frustrated and worried, as Mum was blind and couldn't see Auntie's face or judge her condition.

3.18. The ward was for patients with continuing care needs and also palliative and terminal care. During this time I observed a patient obviously in pain being ignored by a nurse who just walked past to attend to another patient's enquiry. It wouldn't

have taken much to just put a hand on the patient's arm and reassure her that she would attend to her after this other patient's needs.

- 3.19. I also observed two porters enter this 6 bed unit, go straight to the bed of a sleeping patient who was holding a vomit bowl; unplug and detach the bed and start to wheel it out of the ward without even saying anything to the patient. This patient woke up in surprise, asked the porter where she was going. He replied gruffly "X ray" and carried on pushing the bed without acknowledging that the patient was also asking for some tissues, as she was feeling sick. I found her tissue box for her whilst the trolley carried on moving. I spoke to the porter that this was no way to treat an ill patient and that he was being most inconsiderate and disrespectful. He just shrugged his shoulders. I was surprised that no nurse or healthcare support worker had accompanied the porters to the bed first. I reported this lack of respect and dignity towards this patient to the porters' manager the same day.
- 3.20. Six weeks before discharge Auntie developed scabies – a patient had been admitted to the ward in the previous weeks with this condition. I reported to the nurses that Auntie had rather an itchy rash on her neck and was scratching it raw. Several of the scabs looked several days old and yet the nurses weren't aware that she might be infected – I had to tell them! I was then told that there was scabies on the ward. We had not been informed of this prior to Auntie catching it. When I spoke with the staff nurse on the phone I was told that it was passed between patients, in the air – which is incorrect.
- 3.21. I had a blood condition, which prevented me from visiting an infectious area, and so could then not visit for several weeks. The ward was actually closed to visitors for about a week. When the ward was eventually open I visited and although the staff and visitors were still using gloves and gowns, I observed a ward domestic collect up cups and water jugs without wearing protective equipment. I had also observed during the first week that the scabies was diagnosed, nurses and health care support workers attending to each patient's pressures areas in the 6-bed section without changing their gloves at all. I informed the nurse manager of this risky practice. I also said that in the time that Auntie had been on this ward I had not seen one nurse or health care support worker wash their hands between patients. This was because they all wore vinyl gloves and went between patients with the same gloves on in the 6-bed unit.
- 3.22. My husband and I were visibly shocked when we saw Auntie after a 3-week break – she looked unkempt, straggly hair, blood blisters on her face and neck and

chest. She was picking at the bedclothes and trying to throw them off whilst talking all the time. She was very confused.

I reported this to the nurse in charge who didn't seem to be aware of her confusion. I did suggest that it might be due to the drugs given for the scabies and also the fact that she seemed very dehydrated (her sub dermal infusion had been taken out). The nurses had not noticed this, or so they told me, but it was very obvious to me that this behaviour had not suddenly happened. Auntie looked very ill. I spoke with the visiting doctor who had been called to see her at my request and asked whether her nutritional state was affecting her organ function. I was informed that her blood chemistry was abnormal and kidney function tests were below normal limits, so her kidneys were beginning to fail. No treatment was suggested and no reason given for a cause.

3.23. I couldn't wait to get her out of this hospital. I felt that their lack of care was causing her great suffering and that she was dying. I spoke with the continuing care nurse and demanded that the assessment be speeded up. I was angry and told her that I held this Trust entirely responsible for the state of my aunt's health now and its deterioration since her fall out of the bed in the medical assessment unit the previous year.

3.24. The following week I received a letter from the Trust stating that she was 'borderline continuing care' and for me to look for a nursing home where they had NHS beds.

3.25. A week later, we had found a local nursing home Auntie was discharged there. Within one day she had been given a bath, the drip removed, and an hourly regime of fluids using a small syringe, which easily went into her mouth, was set up successfully. Her hair was cut and for once, I saw that she was being turned on different sides so that she could see different parts of her room. I met the nursing team responsible for Auntie's care and observed carers offering and giving her small drinks every hour. These were recorded on a chart in her room and signed. On admission to the Home she was also weighed – 36Kg. Miss B had lost 7 Kgs – approximately 15lbs. This is a very significant amount for a low starting weight and maybe one of the reasons for her physical state regarding her blood levels, juddery movements and deteriorating kidney function.

3.26. Two months on she was still being offered very regular drinks of what she fancied which was usually Horlicks, brought downstairs into the lounge and put in a

special supportive chair, on her more communicative days. She began to communicate better and would ask to stay longer in the chair on some days. Her needs were very complex but fully met by good fundamental expert nursing care. Her care had improved considerably due to excellent nursing management and hence her quality of life had improved. She was beginning to regain the weight she lost in hospital. She had a wonderful Christmas in the home with family visiting and her 90-year-old brother came over to see her from USA as well as her younger brother from Cornwall. Her older brother aged 97, a retired GP from Manchester, had visited her not long after she arrived at the home. She had worshipped this brother and it put a smile on her face to see him.

#### 4. DISCUSSION

- 4.1. This above case study illustrates the lack of accountability by registered nurses for the nutrition and feeding of patients in hospital. It also illustrates the lack of accountability for the poor use of records and care plans and the appalling lack of adherence to infection control policies and procedures. It shows how fundamental care, which is after all real nursing care is there for heal the spirit as well as the body. Feeling warm, clean, fed and safe makes being very ill almost more bearable and is every patients' right as a human being. This happened in the nursing home and we could see the difference.
- 4.2. This case study demonstrates the lack of leadership from the senior management nursing team right through to the Nurse Executive. This is because my aunt had been in the same hospital before and I had made a similar type of formal complaint. Nothing had changed and yet during this time the Trust had received glowing accolades for personnel management. No one it appears bothers about finding out about the quality of nursing care. There seems to be no independent monitoring of the experience in inpatients. Excuses such as an old building, lack of equipment, not enough staff, high turnover of patients doesn't wash with me and neither should it with any member of the public. Nurses have a code of conduct to report unsafe environments and do something about it. Not to do and accept the status quo is breaking their code of conduct and they can be reported, disciplined by their regulatory body and struck off in some cases. The Community Health Councils are supposed to be in place in Wales for the patients' interest and are independent of the NHS. When they find poor care and other failures during their visits how to they ensure that these are remedied and enforced. Has no one heard of the Human Rights Act (1998)? Why is it not used in these case?

- 4.3. I have spoken to other people with relatives in this hospital who have witnessed poor nursing care and yet have never complained.
- 4.4. It could almost be considered that had not my aunt been discharged to a nursing home following a week when her health status began to deteriorate significantly, and then staying in hospital might have considerably speeded up the end of her life.
- 4.5. The case study illustrates the dangerous, undignified and abusive nature of my Aunt's so called "care" provision. Her fundamental need for care was not met and the service provided actually led to a deterioration of her health status – physical and mental.
- 4.6. My aunt died in April 2007. She died with dignity and peace, nursed in a wonderful caring environment in the nursing home, close to where my parents and I live. We were able to visit her very regularly and her individual needs were respected. She gained some weight and some movement, and she was involved in the social as well as the spiritual environment of the home. She was treated as an individual personality and the family unit respected and involved. My confidence and also my mother's confidence, as she is a nurse too, were temporarily restored by some wonderful fundamental nursing care in this home. I cannot thank the Nurse Manager and all her staff at the home enough. They should be very proud of their involvement at the end of Auntie's life.

## 5. **My Action Following My Aunt's Hospital Discharge**

- 5.1. In October 2007 following Auntie's move to the Nursing Home in the August I made an attempt to meet personally with the Director of Nursing for the NHS Trust. A meeting date was finally agreed at the end of December. All my concerns of Auntie's care were discussed, including the concerns I had around the safety of the nursing environment around fundamental nursing care; and the fact that this type of neglect had occurred to her the previous year and by the same group of nurses. I gave some names of nurses and wards to the Director. I told her that I had come to her on three counts, as a registered nurse citing my duty of care to report an unsafe environment for patients, as a person with a specialised interest and research in gerontology who was interested in networks to share good practice; but also as an educationalist who would be interested in supporting any teaching which would be required to affect change.

- 5.2. Following this meeting the Director did not contact me to acknowledge the meeting and straight after Christmas I emailed her the case study. Although I knew that it had been received the Director of Nursing did not acknowledge this, or the fact that I had even visited her. Twice I had to email her to ask what was happening. In early March I contacted her again for further information on what, if any action the Director had taken following the meeting to address my concerns. This was not forthcoming and a deadline then given the Director was overrun – so I contacted the Community Health Council, took advice and made a formal complaint to the Chief Executive of the Trust via the Community Health Council advocate.
- 5.3. It is very disturbing to know that this Director of Nursing did not even acknowledge my visit to her and didn't seem to appreciate how difficult it must have been for me, as a nurse, to face another much more senior nurse about their responsibility for the conduct and care provided by their staff to a very vulnerable older person and my relative. Surely this is only common courtesy to a member of the public who is paying taxes to receive health service provision which would include good customer care protocols. Also the information I gave to her and the concerns for nursing care and the specific nursing environment that I had stated was unsafe and detrimental to the patients' well being had not seemed to be formally acknowledged to me. The fundamentals of care (direct nursing care) had not been met and my aunt had been in kidney failure due to malnutrition and neglect by the time she was discharged from hospital.
- 5.4. Over 6 weeks had elapsed before the Director issued a brief email in response to my email reminders of no acknowledgement or information on action taken.
- 5.5. Following this the formal complaint resulted in a full investigation, which upheld again, all my allegations and concerns. When I asked the investigator, a Senior Nurse brought in from the community directorate what had happened to any of the nurses whom I had named I was politely told that they could not tell me. I am presuming that these nurses are still working on this ward and the unit despite the fact that all my allegations of nursing neglect seemed to be upheld.
- 5.6. A Senior Nurse Manager was then transferred from another hospital to deal with the complaint in the form of an action plan. The Community Health Council now no longer wished to be involved. I requested to be involved with the monitoring of this action plan and to date have met three times with this nurse. Training programmes have been set up and there has been a promise to involve me in patient stories. Observations of care have been undertaken as part of this nurse's Clinical Leadership programme and the Manager and another senior colleague assure me

that these will be regular occurrences. However, all this information has been given to me in the safe environment of the Senior Manager's office – and although I have asked once to visit the wards, nothing as yet has been forthcoming. I also keep insisting that whilst training is good, observations of care very relevant, independent monitoring is the most important in order to check the real quality of care. I understand now that Trusts have to complete a self-assessment form from Health Inspection Wales. Does this mean that there is no real inspection of care? I will persevere with this as it helps me to cope with the grief of losing my aunt and the awful suffering that she endured which I seemed powerless to change, despite trying. At this point when she left hospital I felt really ashamed of my profession and had lost confidence in ever seeing dignified and high quality nursing care ever again.

## 6. POSTSCRIPT

- 6.1. My aunt, Miss Brown, until her retirement age 70 years, was a highly qualified, well-known and respected missionary nurse. She designed and supervised the building of two large hospitals and schools of nursing and midwifery in the Congo, Zaire and Rwanda Burundi. She was trained and undertook major surgical operations in the absence of surgeons as well as Caesareans as an experienced midwife. She was a well-known missionary in Africa amongst all religions and a woman who devoted her whole life to the service of other people. She was a wonderful nurse and had spent a considerable time as a Queen's nurse and community midwife in Yorkshire and middle England before receiving the call to become a missionary nurse. She was so committed that she then undertook a postgraduate nursing dissertation and study in French in Belgium on Kwashiorkor – the disease of malnutrition, before travelling by boat alone to the Belgian Congo. She arrived in the Congo during the riots and massacres of nuns and other local people. She had so many friends from around the world. These friendships and experiences are included in her memoirs, which are soon to be published.
- 6.2. Following her retirement she became a very active member of the community in her village in Devon. She was a talented painter, wrote poetry and gave talks on her life as a missionary nurse. She was distraught during the genocide in Rwanda in the 1990's and wanted to go back there to help. Several of her 'adopted family' out there were murdered. She had suffered significant tragedy herself and seen a great deal of suffering during her life but had fought a personal battle to give her all to her missionary work.

- 6.3. It is very sad that up until the last 8 months of her life her experience of being nursed by her own profession in these two hospitals in Wales was so neglectful and poor; and was the most significant element in her health deterioration and her mental well-being. This was despite efforts by her family to report and try to change this environment in a dignified manner. Her family felt that they had failed her, but the nursing 'family' in those hospitals significantly failed her too.
- 6.4. At the meeting with a senior nurse following a second investigation into the nursing care provided to my aunt in 2006 I asked her "Can you, with your hand on your heart, reassure me that there are no more Miss Brown's in your hospital." Her answer was "NO". I was not sure whether she answered this way because she had tried to find out and couldn't, or whether no effort had been made to see if there were any more patients with similar experiences.

Enough is enough - what do we all do next?

Lorraine Morgan October 2007

A Dignified Revolution