We’ve been listening, have you been learning?
Foreword

At the Patients Association we hear many uplifting accounts of excellent NHS and Social Care. Our much missed late President, Claire Rayner, received some truly exemplary care. She was looked after with genuine compassion and consideration.

Unfortunately, however, all too often we hear distressing accounts through our Helpline. This is our third compendium of patient stories highlighting experiences of poor nursing and medical care – vulnerable elderly patients left without a drink, no one to assist them with their food, call bells put out of reach and patients left in agonising pain.

We at the Patients Association truly look forward to the day when no such publication is required and we can exclusively concentrate on celebrating good practice, such as are demonstrated in the Nursing Standard Nurse of the Year Awards. Until such a Health and Social Care utopia exists, we will continue to highlight problem areas and seek to offer solutions in our endeavor to achieve the idealism encapsulated in the Mantra ‘No decision about me – without me’

Katherine Murphy
Chief Executive
Patients Association
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>5</td>
</tr>
<tr>
<td>The Care Campaign</td>
<td>8</td>
</tr>
<tr>
<td>Testimonials</td>
<td>9</td>
</tr>
<tr>
<td>Positive Comments</td>
<td>11</td>
</tr>
<tr>
<td>1. George Frederick Taylor</td>
<td>12</td>
</tr>
<tr>
<td>2. Jane Dixey</td>
<td>15</td>
</tr>
<tr>
<td>3. Michael Groves</td>
<td>19</td>
</tr>
<tr>
<td>4. Joyce Jones</td>
<td>25</td>
</tr>
<tr>
<td>5. William Wood</td>
<td>29</td>
</tr>
<tr>
<td>6. Patricia Rattansi</td>
<td>33</td>
</tr>
<tr>
<td>7. Immacolata Lacovara</td>
<td>36</td>
</tr>
<tr>
<td>8. Sally Abbott-Sienkiewicz</td>
<td>39</td>
</tr>
<tr>
<td>9. Mavis Morris</td>
<td>46</td>
</tr>
<tr>
<td>10. Barry Woodward</td>
<td>57</td>
</tr>
<tr>
<td>11. Helena Grimwood</td>
<td>61</td>
</tr>
<tr>
<td>12. Patient A</td>
<td>66</td>
</tr>
<tr>
<td>13. Jessie Thayer</td>
<td>69</td>
</tr>
<tr>
<td>14. Brian Smith</td>
<td>74</td>
</tr>
<tr>
<td>15. Patient B</td>
<td>79</td>
</tr>
<tr>
<td>16. Maureen Nolan</td>
<td>87</td>
</tr>
<tr>
<td>Trust responses</td>
<td>91</td>
</tr>
</tbody>
</table>
Introduction

As with our previous two reports, ‘Patients Not Numbers, People Not Statistics’ (2009) and ‘Listen to Patients, Speak up For Change’ (2010) this report contains firsthand accounts of some of the very worst stories of poor care in Hospitals that have come to the attention of the Patients Association Helpline.

Each and every story remains distressing and leaves you with huge amounts of sympathy for the patients and relatives that were on the receiving end of care that, as one patient said to our Helpline about the care their mother received, “Would not be tolerated at a veterinary hospital.”

Since we launched the 2010 version of our report there have been several other reports published which support our concerns about poor elderly care. In February of this year the Parliamentary and Health Service Ombudsman published its report “Care and Compassion” which studied in detail the way the Ombudsman investigated ten complaints of poor elderly care.

The Ombudsman highlights several key issues in her report, dignity, hospital acquired infections, nutrition, discharge from hospital and personal care. All of these issues feature heavily in this report, with one or more in every story.

In the introduction to that report the Ombudsman says that of 9000 complaints received by her office in 2010, 18% were about poor elderly care.

These elements are present in virtually every story of poor care on hospital wards that we hear on the Patients Association Helpline. They are not isolated to any one hospital or trust. We hear stories of bad care from hospitals up and down the country, including those that have a good reputation in their local community and beyond. This is what makes tackling poor care such a difficult challenge, but one that urgently needs to be addressed.

In this year’s report we have also included previous accounts of unsatisfactory care at the same hospital experienced by the families involved. We did this because it needs to be understood that these stories are not isolated incidents, but represent a systemic problem within the National Health Service.

Following the launch of ‘Listen to Patients, Speak up for Change’ last year the Care Quality Commission (CQC) launched 100 inspections of acute NHS hospitals between March and June 2011. These unannounced inspections looked at the standards of dignity and nutrition on wards caring for elderly people.

One in five of the hospitals inspected were found to be delivering care that posed risks to the health and well being of patients, with two hospitals offering care that put people at an unacceptable risk of harm. In the report the Chair of the CQC, Dame Jo Williams rightly
praises those hospitals that were found to be delivering person centred care which ensured patients were treated with dignity and respect. However she also said;

“There is however a great deal in the reports to give cause for alarm. Around half of the Hospitals we visited gave our inspection team cause for concern. Twenty hospitals were not delivering care that met the standards the law says that people should expect”.

Whilst we welcome the CQC inspections, it should also be noted that the inspections picked only two wards per hospital, and visited on only one day of the year. That they still managed to find so many hospitals delivering unacceptable care is deeply concerning, and it would be logical to assume that a more detailed and comprehensive inspection regime would unearth many more problems at those hospitals and beyond.

We also strongly believe that, whilst the CQC should be applauded for identifying hospitals which are delivering poor care, only a long term action plan and repeated hospital wide inspections can ensure sustained and lasting improvements. It is simply not good enough to allow hospitals to make changes in the short term to pass follow up inspections, which mask a longer term culture amongst nursing staff who then allow standards to slip once the gaze of the CQC has shifted away to another problem hospital.

This was why last year we called for independent clinical ‘patient safeguarding champions’ that would be able to identify those wards where a long term cultural change is required, and continue to scrutinise those wards until they deliver the levels of care and dignity that the elderly people being treated there deserve. We continue to call for their introduction, and believe that they would be a crucial step forward in tackling poor care.

In each of our last two reports we have identified the complaints system as being an area where improvements need to be made, and prior to the reports publication the Ombudsman’s own report identified concerns with the complaints system.

Callers to the Patients Association Helpline continue to express no faith at all in the way complaints are handled within the NHS. Many callers complain that they have to jump through several administrative hurdles, such as lost complaint letters, incorrect permission forms or simply chasing an acknowledgement, before they even get to the stage of having their complaint considered by the hospital.

Once the complaint is considered, the quality and depth of the response varies widely between trusts. Some seek to conduct a detailed investigation, answering each question and ensuring that the Patient is not left feeling like their complaint has been dealt with in a cursory manner. Crucially, they offer an apology for any areas where standards have fallen below what can be considered acceptable.

Others fail to respond to questions, refuse to acknowledge fault and conduct brief and superficial investigations into the complaints of a patient or relative. Our Helpline team are
repeatedly told by patients that, in light of a previous bad experience with the complaints system by themselves or someone they know, they don’t feel it is worth complaining about an incident of bad care. If the complaints system is stopping patients from complaining, it is hindering the ability of the NHS to listen and learn.

Because of these wide variations in the standard of complaint handling we are repeating our previous call for a national survey of all complainants, to allow for a better understanding of which trusts are providing a good complaints system and which ones aren’t.

Our Helpline team hear reports of bad elderly care on an almost daily basis. For every story that is published in this document we have many others of equal severity in which the person who contacted us does not wish to talk about their difficult experiences in public.

The same elements that form the basis of poor care are heard with depressing frequency by our helpline. We know that if a patient or relative contacts us because nurses take forever to answer their call buzzers (or don’t answer at all) they are likely to also have had problems with one or more other key indicators - pain relief, eating and drinking, or toileting care.

In the 21st century, in one of the most developed countries and health systems in the world, patients should not be left starving or thirsty, they shouldn’t be left in pain and they shouldn’t be forced to urinate or defecate in their bed because the nurse designated to them says it’s easier for them to change the sheets later than to help them to the toilet now. Yet this is what is happening around the country every day.

The saddest thing is perhaps that in this report we have been able to highlight the cases of bad care where a relative is available to speak up for the patient. Yet there are many patients that have no one to speak up for them, and no relatives to challenge the care that nurses are giving them. It is for those patients that changes need to be made in the future, which is why, along with the Nursing Standard Magazine we have launched our Care Campaign.
The CARE Campaign

The Patients Association and Nursing Standard are launching the Care campaign to improve fundamental patient care.

The Patient’s Association has seen an increase in complaints about poor care. Most of the stories patients tell us are concerned with poor communication, assistance with toileting, pain relief and encouraging adequate nutrition and hydration. These are the four cornerstones of the Care campaign.

The campaign, which will be launched by Patients Association Vice President Angela Rippon OBE, will also shine a spotlight on the complex causes of poor care and provide a platform for debate among patients, nurses, doctors, managers and politicians.
Testimonials from patients that have previously been involved in Patient Stories.

Below are some comments about elderly care and the Patients Association from people whose accounts were featured in last year’s report:

“The care of elderly patients in hospital has been a subject that the Patients Association has been monitoring with great interest for sometime. It seems that official reports come and go and on the face it, little seems to improve. However, it is vital to keep this uppermost in people’s minds, especially those who can make a difference. Now hospitals have to register that this subject is a cause for concern, so this should be a first step to improving the care of elderly people.

I have had discussions with senior staff in our local trust and helped with a training DVD for all ward staff, on how not to neglect patients and their relatives. The hospital would not have listened to me without the backing of the Patients Association. I hope that should my aunt have to go into hospital again, she would not now be left regularly with no drink and no buzzer, and that my concerns would not be totally ignored – but I’m that confident that things have changed.

So it is important for organisations like the Patients’ Association to raise our concerns; individually it is all too easy to brush us away as an isolated case, it is only when these experiences are collated that we can prove we are not alone”. Susan Mistry, 2010 Patient Stories. Susan’s aunt Elsie was treated at St Helier Hospital, Surrey.

“It was sheer coincidence that my mother died on the day the Patients’ Association issued its first damning report into the appalling state of the care for the elderly in NHS hospitals on August 27 2009. Their report made headlines and was covered by the local media. I decided that because the elderly didn’t have time on their side; something needed to change and NOW - so I should join the PA’s campaign. I went on local radio and described the unnecessary suffering, humiliation and lack of human dignity my mother had experienced in Ipswich Hospital. I became even more heavily involved when the PA’s second report came out in December 2010. I’m forever grateful to them for prodding Secretary of State for Health, Andrew Lansley, into asking the Care Quality Commission to investigate Ipswich Hospital, along with 99 others.

Ipswich was found to be so bad it was actually breaking the law on elderly care. The result of these 20 months of campaigning has been that Ipswich Hospital’s Chief Executive, Andrew Reid, has apologised to me in person for mistakes made in my mother’s treatment. Extra money - £1million - has been funnelled into physically improving elderly wards. The hospital’s new, dynamic Head of Nursing has instigated changes, such as proper toileting rather than the automatic use of incontinence pads, and is determined to change nursing attitudes She’s taken me on a tour of the wards to see for myself how things are changing. ‘There’s still much to be done, it’s not perfect by any means, but we’ll get there’, she promised”. Angela Lawrence, 2010 Patient Stories. Angela’s Mother Muriel was treated at Ipswich Hospital.
“I was fortunate enough to come across The Patients Association whilst trawling the internet to find someone to give me advice after my mother, Anne Robson, died unexpectedly in early 2010.

When the PA asked whether I would consider our story being used in their 2010 Campaign “Listening to Patients Speaking up for Change”, I was shocked. I was shocked that Mum’s story was bad enough to be used - it is one of only 17 accounts taken from across the UK. I knew what Mum had been through was hideous, but to have a group such as the Patients Association agree with me really spurred me on to do everything I could to stop this neglect happening to other elderly patients - no matter which hospital they are in.

The PA has given me a voice - a voice that I would never have been able to achieve on my own. In December 2010 I was interviewed by the BBC and ITV for their news programmes, I spoke on the Today Programme on Radio 4, and did a 10 minute live interview on Radio Five Live as well as stories for several daily newspapers. Since then I have done countless interviews with television and newspaper journalists, and I am involved in the Patients Association campaign for 2011. I am attending Nursing Seminars and Focus Groups, all discussing how care for elderly patients can be improved across the NHS. Without the Patients Association, I would never have been given these opportunities.

As a group we are much stronger, we can shout louder and have our voices heard. Yet still the neglect continues. It deeply saddens me that there are elderly patients the length and breadth of this country being treated without dignity or human kindness. They are seen as numbers, not people. They are so unbelievably vulnerable, and they need our help to bring back the high levels of basic nursing care that we saw in hospitals in this country as long ago as the 1950’s.

My mother died a few hours after being discharged from a hospital that clearly did not give her the care that she needed. There is nothing whatsoever that I can do to change that. I will be eternally grateful to The Patients Association for listening to our story, and making it possible for me to feel that I can make a difference for others, if not for my Mum.” Liz Prior, Patient Stories 2010. Liz’s mother Anne was treated at West Suffolk Hospital
Positive Comments

“They realised immediately how poorly he was, helped him up and down the stairs to the toilet, and helped him walk to the ambulance at his request, even though he was tired and breathless.

They were kind, understanding and let him have his dignity. The care they gave cannot be faulted.” Carole Brown

“The care she received at Meadow Lodge in Lewes was exemplary. The nurses were very kind and caring, she was in a single room and treated as an individual and she began, at this point, to improve.” Liz Owen

“On Sunday the 20th of February a different sister was in charge, and the ward felt like a different place. Bells were answered promptly, staff voices seemed lower and the contact with patients felt so much better. Having sat on the ward for four days I observed that this particular nurses skills at running a ward were exceptional. The ward was a better place when she was around.” Jo Jacques

“We felt that our complaints were dealt with efficiently and effectively. The effort of writing a formal complaint was worthwhile and we would hope that others would do the same, and that other Hospitals would react in the same way” Angela Perry and Sally Forthergill.

“Before being admitted to hospital mum visited the Accident and Emergency Department twice. The nurses and doctors were just so lovely and very caring in what was a very busy A&E department before being transferred to Dickens Ward.

“When mum was admitted to the Dickens Ward she was treated really well and the staff were also very caring. On her second visit to Dickens Ward (26th March) my mother was very poorly and on Sunday 27th March, we were on “end of life care” the staff were just so kind. They ensured that she received all the dignity she was entitled to as a frail 94yr old lady. In particular they made sure that both my sister and I - my sister was at the time undergoing chemotherapy, so masks and gowns were found for her by the nurses on Dickens ward - could spend some time with our mother.” Maria O’Brien

“I have been a patient at Whipps Cross Hospital, as both an inpatient and an outpatient, for a number of years. During that time I have held a largely positive view of the Hospital, and have been grateful to them for the care and treatment they have given me”. Patricia Rattansi.

“The Hospital meals were delicious, hot, on-time and with an excellent menu variety. I now walk around there every day for my Midday meal in the Restaurant.” Barry Woodward
1) **George Frederick Taylor**  
By his daughter Gaynor Marshall

“As you can imagine, my mother was horrified when she then turned up in Hospital to discover dad sat beside his bed, quite literally sitting in his own faeces..... In general during dad’s time in hospital the nursing staff treated him as an object that they had to treat rather than a human being who should be included in his care and given the dignity that he deserves. . “

**George Taylor was admitted to Chase Farm Hospital in August of this year.** His daughter was shocked to see the standards of care provided to him, in particular the failure to attend to his toileting needs. She was especially concerned to see her father’s basic hygiene decline during his time at the hospital.

**Gaynor’s Account**

My father was admitted to Chase Farm Hospital on the 18th of August this year. At the time of being admitted he was diagnosed as suffering from a urinary tract infection and a chest infection. He was placed on Napier Ward.

We have significant concerns about the care that he received, and have subsequently, with the help of the Patients Association, made a formal complaint to the Hospital. We believe that the Hospital failed to give dad the dignity he deserved.

On one occasion during his time on the ward dad was sat in a chair by his bed and needed the toilet. He asked a nurse to assist him, but was told that she was too busy, and that it would be easier for her if dad relieved his bowels in the chair. She promised to clean it up later.

As you can imagine, my mother was horrified when she then turned up in hospital to discover dad sat beside his bed, quite literally sitting in his own faeces. Initially mum felt that dad must have been confused and must have misheard the instruction by the nurse. However the nurse confirmed to her that he had heard her correctly, and that she was too busy to assist him.

What makes matters worse is that the nurse didn’t come and clean dad up as promised. Instead my mother had to clean him up as best she could. It is an outrage that she had to do that.

For most of his time on the ward dad, who previously always looked after his appearance and hygiene, was not given a wash or a shave. Over time the smell around his bed became overpowering. At one point a member of our family had to leave my father’s bedside because they could not cope with the smell.
On another day I noticed a strong smell coming from my father’s cupboard. When I investigated the source of the smell, I found a pair of urine sodden Pyjamas stuffed at the bottom. It would appear that, after dad spilt a bottle of urine over himself, the nurse had thought the best thing to do would be to just put them in the cupboard and leave them there. She didn’t even put them in a bag.

Dad was an insulin dependent diabetic. However despite this we never felt his insulin levels were monitored properly, and as a result of this we believe that he didn’t receive the right amount of insulin throughout his time in hospital.

In general during dad’s time in hospital the nursing staff treated him as an object that they had to treat rather than a human being who should be included in his care and given the dignity that he deserves. Nurses were often very brusque with him, and would carry out medical procedures without either asking for his permission or telling him what they were doing. This just added to his general confusion and isolation.

As a family we never felt aware of what was happening with dad’s care and what the next steps would be. Throughout his time on the ward we repeatedly raised our concerns about the continued deterioration in dad’s health, and our belief that neither his Urinary Tract Infection, or his chest infection, were being treated properly. However we always felt ignored.

This became a particular problem when it came to the way dad was discharged. There was absolutely no consultation with dad or his family prior to his discharge from hospital. We all felt that he was nowhere near ready to be discharged and he continued to remain confused. It was also obvious to us all that his chest was not right.

We raised our objections with the medical team but they were ignored. In fact we felt that the nursing team was pushing quite hard for dad to be discharged, and we could not work out why they were so keen, given his continued bad health. They didn’t even listen when mum said that she would be unable to care for dad at home in his present state of health.

On returning home his health declined even further and on the 4th of September he was taken to University College Hospital as an emergency patient. On admission it was initially believed that he had suffered a stroke, however further diagnostic tests showed that his ill health was due to continued urinary tract and chest infections.

A doctor at UCH has suggested that dad should never have been discharged given the extremely poor state of his health. His condition improved within days of being admitted to University College Hospital.

We are continuing to complain about the care that my father received at the hospital. The Patients Association agreed to take it up as part of their casework pilot scheme, and as a
result of their intervention we have now met with senior members of the trust management scheme to discuss dad’s case.
2) Jane Dixey
By her daughter Jo Jacques

“The nursing staff need to realise that they have very frail elderly people in their care, and that they are people who deserve to be treated with dignity. Any hospital admission is traumatic. We all lose our independence and regress.”

Jane Dixey spent several weeks in the West Suffolk hospital earlier this year. Her daughter Jo complains that the nurses did not treat her mother, or other patients on the ward, with the dignity that they deserved. In particular she complains about a failure to effectively meet her mother’s toileting needs, and about the speed with which nurses answered the call bells.

My mother, Mrs Margaret Jane Dixey, was admitted to the West Suffolk Hospital on February the 7th 2011. She was an elderly woman who suffered from osteoporosis, and she eventually died on the 5th of April this year. During her time in hospital my sister and I, who live some distance away from the hospital, did our best to keep up to date with what was happening to her. Eventually I travelled up to Bury St Edmunds to be by her bedside.

Mum had been admitted to Hospital because she had suffered a broken leg, over an old break, after suffering a fall at home. She was admitted to ward F3 in anticipation of an operation. However on admission a decision was taken to treat her injury conservatively, using a full leg plaster. The plaster was very difficult for her to manage as she has minimal muscle in her legs. On the 11th of February she was transferred to F8 ward. Despite the obvious need for extra assistance from nurses given her condition, this never seemed to be forthcoming.

The philosophy of care for Ward F8 is “We believe that as nurses we will endeavour to provide timely holistic nurse led care in a supportive and nurturing environment which will facilitate a smooth transition to home or alternative care.”

I was told over the phone by mother almost immediately that during the day loud music, from the station Radio 1, was being played into the ward. My mother felt that this was for the benefit of the nurses working around her, and certainly not for the patients, who were elderly and required a peaceful environment in which to rest and recuperate. Mother was used to a considerably quieter environment, and she found the loud music to be very distressing.
When she asked them to turn the music down she was described as a ‘party pooper’. She didn’t understand what this phrase meant, and I had to explain it to her. I don’t think it was appropriate for a hospital ward to be considered to be a ‘party’ and I don’t believe that any in-patient would expect to be attending a party when they are admitted to hospital. Music in the near background does not help an elderly person, or anybody else for that matter, to hear or concentrate easily.

On admission my mother had been catheterised. On the 18th of February she was also very dehydrated, and her fluid balance chart showed that she had not had anything to drink since noon. She had a mug with a straw, which she was far too weak to use. In the hour that I was with her she drank at least a litre of water from a normal mug.

At one point during her stay my mother was in desperate need of pain relief. A doctor visited her and said that she could have more morphine straight away. She waited and waited, and it was only when she rang the buzzer and a nurse arrived that we discovered that no morphine was coming. We were told that this was because the doctor had given no instruction for it.

On Saturday the 19th of February I was with her for much of the day. She had a CT scan because the clinicians treating her suspected that she may have a Pulmonary Embolism [a blockage of the main artery of the lung]. At lunch time I was told that the scan had not detected any sign of this. However when I returned from my break my mother was very flustered, and believed that a member of the medical team had been to see her and discussed ‘her embolism’ and her need for bed rest. She had been sleeping and had just woken up to find someone standing at the bottom of her bed.

Because she was distressed I went off to find out further detail. I discovered that the doctor had actually said “About your embolism, you haven’t got one!” Not the clearest way to communicate with an elderly patient that had just woken up.

I also queried the need for catheterisation and was told by senior nursing staff that they could see no real clinical need for it. They asked whether my mother was usually incontinent, and when I said no they asked whether I would like them to remove it. A couple of hours later I was told that catheterisation was a routine protocol when someone had a long leg cast, as it might get wet and her skin was fragile. This kind of miscommunication was common. I have subsequently been told that unnecessary catheterisation can be considered an abuse.

However, having sat on the ward and witnessed how unresponsive the nurses were to the buzzers by patients’ beds, it was probably safer for my mother to have been catheterised. Ten minutes was the typical response time to a bell.

Mother had a regular hospital locker. The back of the locker, was unreachable for someone sat in the bed. The front of the locker was locked because it contained drugs. She would
have really benefitted from having somewhere to put her personal items that were in easy reach for her. When I asked the staff nurse where patients could put their personal belongings she simply shrugged at me.

My mother has poor eyesight and sensitive ears. In all of her time in hospital she had no access to anything to maintain her intellect. She was unable to see the clock in the bay, and in any event the hands on the clock had been bent, and could therefore only be read if you had some idea of the time already. The bedside radio was very difficult to manage, and my mother can’t cope with headphones as they hurt her ears. She really had no way of knowing whether it was morning or night. If we didn’t tell her she wouldn’t have known what day it was.

I spent my time with her giving her a précis of the day’s news, reading articles out of The Times, discussing the alternative vote, Mubarek leaving Egypt, the crises in Libya and discussing virtue ethics. She would have liked a clock with her, but she had nowhere to put it. At a time when I wasn’t on the ward Mum apparently dropped her rosary, and was told by nurse that if she was going to drop it then she shouldn’t have it. After that she was afraid that the nursing staff would take it away and as a result of this she asked my sister to take it away.

The ward gave me the impression of being a chaotic place, with bells left unanswered, and staff did not introduce themselves to patients, often the elderly patients were addressed in what I consider to be the most impertinent manner by the young members of staff. Often the staff would not tell the patients what they were about to do to them before moving them or taking blood.

My mother is used to having an assisted wash at home. However in hospital she was just given a bowl of cold water and told to get on with it. On one occasion she was given assistance and a good wash she was told it was because her daughter was coming.

On Sunday the 20th of February a different sister was in charge, and the ward felt like a different place. Bells were answered promptly, staff voices seemed lower and the contact with patients felt so much better. Having sat on the ward for four days I observed that this particular nurses skills at running a ward were exceptional. The ward was a better place when she was around.

On Monday the 21st my mother was lifted out of bed and put on a chair. After 20 minutes she had had enough. I kept her going, and after a further 10 minutes she rang her bell, intending to ask that a nurse assist her in getting back in bed. She was told that they could return her to her bed when they had finished with the meals and drug rounds. This would be at 1.15pm. They eventually returned at 1.35pm. She had originally rung the bell at 12.35pm. She had been left for an hour in extreme discomfort and pain.
On Tuesday the 22\textsuperscript{nd} my mother was being dealt with by a professional from another
discipline, and two staff were waiting to lift her into bed. The senior nurse approached her
bed, we watched her and waited for her to ask a question or make some kind of comment.
She didn’t look at or address her in anyway, and instead started to discuss the off duty rota,
and how to handle my mother with one of the other staff members.

The nurse with my mother spoke to me outside the ward afterwards to say how
unprofessional the senior nurse had been. Subsequently I could clearly hear the senior
nurse discussing her rota for the week ahead, and a conversation about a forthcoming
babyshower.

It was just dreadful the way that the nursing staff spoke to my mother and other patients. It
was almost like they were children. At one point they told her that ‘please is a word’ when
she was asking them for assistance. It would have been better they had started out by
calling the patients Mr and Mrs, and then waited to be invited to call them something more
informal.

The discharge nurse was great. She spoke to my mother and managed to find an out of
stock mattress to enable her to go home, as well as setting up the other necessary systems
that were required. I suspect that the staff rejoiced when I left.

Spending time on ward F8 was not a good experience. There are good staff on that ward,
and then there are not such good staff. The nursing staff need to realise that they have very
frail elderly people in their care, and that they are people who deserve to be treated with
dignity. Any hospital admission is traumatic. We all lose our independence and regress.
Wards are noisy places with bright lighting. Time in hospital with nothing familiar around
you will only lead to the total loss of the person. Even in the punishment block of the prison
the prisoner has something of himself around him.

My mother eventually died on the 5\textsuperscript{th} of April, and my sister and I vigorously pursued a
complaint against the hospital because we wanted to ensure that such poor care of the
elderly did not continue in the future.

The hospital response to our complaint was not particularly detailed, and it didn’t really
answer the concerns that we raised. It made statements of ‘fact’ but didn’t justify those
statements with any kind of evidence. For example in response to the accusation that loud
music was played into the ward disturbing residents, the response just said “Any music
played on the ward would be appropriate to the client group and on low volume.” It makes
you wonder how the hospital management investigated my complaint, and whether they
have any idea of what is really going on in the wards they are responsible for.

Whilst the response does apologise for the overall poor care received, I don’t feel the level
of investigation and detail reflect the degree of poor care that was delivered.
3) Michael Groves
By his daughter Carole Brown

“Even despite the often poor care he was receiving, my father had nothing but praise and gratitude for the people caring for him, and thanked them every time. However to us he said that nobody cares in here what happens to you.”

Michael Groves was admitted to hospital in February 2011, suffering from cancer of the Pancreas. In her account his daughter Carole tells us about the problems her father had in obtaining appropriate pain relief, assistance with his toileting and basic comforts like blankets and pillows.

She also tells us about incidents she witnessed in which other patients on the ward were not given any assistance with their eating or drinking, despite not being able to feed themselves.

Carole’s family also had a previous, similarly upsetting experience at this hospital, which she tells us about at the start of her account.

2008 Experience

In 2008 a 65 year old family member had been admitted to Stoke Mandeville hospital with an undiagnosed condition. Members of the family visited every day the medical team seemed to be different, and there was never anybody around to advise us of her condition or to tell us what they were going to do to make her better.

This continued for two weeks, and was blamed on the fact that we were approaching Christmas and many departments were closed.

The nursing staff were unhelpful and dismissive, and care was frankly perfunctory at best. When we asked to speak to a doctor we were told that we would have to wait. We did wait but very seldom did anybody appear and when they did they were often totally unaware of her case and had little information to offer.

A very close friend came to visit on the first day after she was admitted only to be left waiting at the nurses’ station while the only nurse available chatted to a friend on the phone for twenty minutes about her timesheet. The same friend, who was a former nurse herself, expressed concern that the patient was being left in damp sheets because she was perspiring. The nurse said that she did not have time to change the sheets. The friend offered to change the sheets herself and the nurse warily agreed to provide bedding and assist her.

She was frequently left waiting for forty five minutes or more once she had pressed her call button for assistance. The few nurses on the ward were far too busy. There was simply no
continuity of care and nobody seemed to know what was going on! The patient was in a
great deal of pain and this was managed badly for weeks. She was just given paracetemol
which she was unable to swallow and which were insufficient. For someone who had never
been in hospital in her life this was a terrible experience. There was no dignity given and a
hoist was used to move her when she got weaker—she told me that she felt like an animal at
the abattoir.

Christmas came and went and the patient was moved into a side room because by this time
she was suffering from an upset stomach. She called me in the early hours of one morning
to tell me that she had been unwell and that the two members of staff who helped her to
the bathroom had left her dangling from the hoist covered in faeces and refused to clean
her up until she was in bed. She said this made her feel filthy and demoralised.

She had been put on an air filled mattress because of bed sores and at some point around
the New Year the bed malfunctioned and deflated, she was left on the bare metal bed base
from around 10am until 7pm with the new mattress waiting in the hallway. A number of
friends visited that evening and as they sat with her heard two porters arguing about who
should change the mattress and pack the old one away. One protested that he wasn’t
having anything to do with it if there were body fluids on it. When we suggested that this
conversation wasn’t really appropriate we were told that she wouldn’t be getting better
care anywhere else in the hospital.

The time spent on Ward 6 at Stoke Mandeville was wasted and no progress was made in
those three weeks. A happy vivacious person with a wicked sense of humour became silent,
withdrawn and afraid. Neither she nor anyone else should ever have been treated this way
and we wish we had the strength to complain at the time, but it was just too upsetting.

2011 Experience

My father Michael Groves was seventy seven years old when he became unwell. Up until
his eventual diagnosis with cancer he had continued to work in a garden centre every
morning, which he had done since he retired.

He became unwell at Christmas 2010. In January he had blood tests which showed that his
liver was not working effectively. He was then sent for an abdominal scan in February 2011
at Wycombe Hospital, followed by an outpatient appointment at Amersham Hospital on the
14th of that month.

At that appointment he was told that he had cancer of the pancreas and was a very sick
man. He had been feeling unwell and had been unable to eat for some time.

An appointment for a Stent [an artificial tube inserted inside the body] to be fitted arrived in
the post, with the appointment scheduled for the 21st of February. By the 16th of February
he had become very poorly, was dehydrated and unable to tolerate anything by mouth.
I spent that morning on the phone trying to make our GP understand how poorly dad was. She kept saying that he would be fine to remain at home until the 21st. Finally she called someone at the hospital, who said that dad should attend Accident and Emergency. The ambulance crew that took him there were absolutely superb. They realised immediately how poorly he was, helped him up and down the stairs to the toilet, and helped him walk to the ambulance at his request, even though he was tired and breathless.

They were kind, understanding and let him have their dignity. The care they gave cannot be faulted.

On arrival at Wycombe Hospital he was extremely unwell, and was persistently vomiting. Whilst in Accident and Emergency he was put on oxygen and a cannular was inserted to enable pain relief to be administered. He was also given oral morphine for the pain, blood tests, a urine test and a chest X-Ray.

The doctor was lovely, explaining all that was happening. My father desperately wanted to go home, but she explained the need for Vitamin K to be in his blood ready for the fitting of his stent on the following Monday, and advised admission.

He was admitted to the Medical Assessment Unit, and the greeting we encountered there was not very welcoming. There were instructions that any visitor outside of visiting time would be turned away. Also only one family member was allowed to phone the ward and pass information on to other family members. I understand the importance of these instructions, but I am sure there were nicer ways to convey them.

He was put in a side ward, and over an hour passed without anyone coming to see him or doing observations on him. During this time I carried out an unsuccessful search for a blanket for his bed, as there was only a sheet on it, and a pillow as there was only one.

I then got him a urine bottle as he was not well enough to get to the toilet, even if anybody had told him where it was. I gave him his buzzer and told him he must press it if he needed anything. It was so hard to leave him that night, and I only managed to because of my hope that he would be cared for properly.

Two days later he was moved to a main ward and care improved considerably. The care was better and the attitude of nursing staff was much nicer. However even here he was twice nearly given a drug which his notes made clear he was allergic to. We wrote a note to keep in his pyjamas pocket, and each time the medication was administered he asked what it was. On one day whilst I was visiting him he was nearly given the drug for a third time I insisted that he was given a red allergy wrist band.

My father improved for a couple of days, even managing a little food and a cup of tea. We were so pleased that he was being looked after, it made such a difference. Unfortunately it
didn’t last, the stent didn’t have the required effect and everything went downhill from then on.

He had been given a date of the 28th of February to be transferred to Stoke Mandeville Hospital and the staff had told us to cross our fingers and hope that he was well enough. When the morning of the 28th arrived he was well enough and was transferred as planned. However on arrival we were told that they were unable to do a second stent as he was too poorly and he was being admitted to ward 10. When I spoke to the ward sister by phone shortly before leaving to see him, I was told that this was only a short term ward, and that he could be discharged, although the ward sister had not yet met him and knew nothing about him. This caused panic amongst the family as there was no care package arranged for dad at home.

On my arrival at the ward I found the sister that I had spoken to on the phone, who told me that she did not want to discuss my father’s case with me, and that instead I should find the nurse looking after him. However there were no nurses available to ask for anything. When I found my father he was freezing cold and needed another pillow and blanket, and again I had to go and look for them.

Eventually a nurse arrived by his bedside to carry out observations. My father was very poorly and upset that he couldn’t have his stent done, and said that he knew he would never get it. His mouth was dry and clogged up with mucus, and I had to ask a nurse for a jug of water and a glass. Why wasn’t he given these automatically? I also had to ask for someone to come and provide mouth care.

Tea came around and he was offered a choice of soup, a sandwich or a cup of tea. He said no thank you, as he couldn’t keep anything down. He was then offered some ice cream in a little carton, and said he would love a spoonful to freshen his mouth.

The nurse told him that this would be a problem as they didn’t have any spoons on the ward, and that he wouldn’t be told off if he used his fingers. I insisted that she find one, and by the time she came back it was so melted he could have sucked it up using a straw. However at least he did manage two mouthfuls.

My father complained that he needed to pass urine, but his catheter was hurting him. I tried to find someone to come and help with this but there were no nurses to ask. He was complaining that he was in pain and couldn’t urinate. The catheter bag was on his bed and was leaking.

I eventually found a nurse and explained that dad was in pain, he couldn’t urinate and his bed was a mess. However she then went to two patients before coming to him, leaving him in pain for even longer.
Because he was deteriorating so rapidly, we asked for palliative care to become involved, and for my father to be moved to a hospice as quickly as possible.

When we asked if we could speak to a doctor and we were told that we had to be at the ward at 9am the next day, and would then have to sit and wait. My mother and brother did this and were told that there would be a bed available in a hospice that afternoon/evening and that his condition was very bad.

That afternoon we received a phone call informing us to return and see the doctor. We went immediately and were told that he now was likely to have only hours to live, and may not make it through the night.

A bed in the hospice was unavailable as there was no transport until first thing the next morning. He needed his bowels opened, so I had to go and get a nurse to bring him a bed pan. She left him and he seemed to be taking a very long time, so I went and checked on him only to find she had not given him the buzzer, and had therefore just had to sit on the bedpan. Eventually we got a nurse to come and take him off.

He then felt his face and asked me to give him a shave and do his hair as he felt a mess. Surely this is part of personal care that should be done on someone’s behalf if they felt so ill.

Even despite the often poor care he was receiving, my father had nothing but praise and gratitude for the people caring for him, and thanked them every time. However to us he said that “nobody cares in here what happens to you”. Surely at this stage of his life he should have been entitled to some care and dignity. Everyone deserves the best in their last hours, not downright neglect.

We got into the ward very early on the morning of Wednesday the 2nd of March. I knew that time was short, because for the first time my father was not ‘with it’. There had been no response except pain frowns on his face and his legs writhing up in pain. I checked with the nurse who was supposedly looking after him, and asked her when he last had pain relief. She said that he had not had any, as he would have refused it.

I found this very difficult to believe and asked her to give him some immediately, which of course he didn’t refuse.

I started to question when the transfer to the hospice would be taking place, as time was running out. I was told that the ambulance staff were busy and we would have to wait until they returned from Amersham. I asked them to call the Ambulance Services again and a nurse told us that you sometimes had to wait from morning until night for transport.

A different nurse arrived with a doctor and told us that there was a significant risk dad could die during the transfer to the hospice by ambulance, and that moving him from the bed to the stretcher would be worse than pushing him. Despite this risk, we were so desperate to
get him away from the ward we decided to risk it. We felt it was our only chance of getting him the nursing care and medication he deserved.

Whilst my father was being pushed by a nurse to the back of the hospital for transfer, we learnt that this was common practice, and that it could have been done for him the afternoon before if the ward nurses had organised it.

Once in the hospice we were made to feel extremely welcome, and every care was taken of him. He was made comfortable, and although he was not responsive he was treated like a human being. He was treated with dignity and respect. Pain relief was administered. It was a huge difference. He was only there for an hour and half before he died, but he received more care than he had been given in three days on ward 10.

Whilst visiting my father on Ward 10, I noticed two other patients being given their lunch and left alone, before their uneaten lunch was just taken away from them. Nobody asked whether they wanted or needed any help. For one of those patients, on the second day the lid was taken off the food and a fork stuck in it. It appeared to me that the patient was physically unable to move, and his food was again taken away untouched, and no help was offered to encourage the patient to eat.

A relative of the patient in the bed opposite told me that her father in law had waited four and half hours for pain relief. She was so concerned about the care her father in law was receiving she decided to stay there during the night. She told me that my father was cold during the night and she pulled up his covers for him, and he thanked her very much for looking after him.

As an ex nurse I am absolutely appalled at the standard of care provided to these patients at a time when they need good care the most. My father was the most kind, hardworking man, only ever having what he could afford and always putting others first. He deserved so much more in his final days.
Joyce Jones was admitted to Hospital following a fall in December 2010. During her time in hospital she lost a stone in weight, and her daughter complains that the nursing staff were also inattentive to the needs of the patients under their care. Nurses didn’t record Joyce’s fluid levels and her daughter also complains that simple tasks, such as the need to wash her mother, were neglected.

Liz’s Story

My mother is Joyce Jones, aged 82; she is extremely lucid but suffers from long standing rheumatoid arthritis. She had gone Christmas shopping with my husband and fell over in Lewes High Street on Wednesday 15th December. She couldn’t get up, the ambulance was called and she was taken to the Accident and Emergency department at the Royal Sussex, arriving just after mid-day.

The Accident and Emergency Department was chaotic, there was nobody clearly in charge, although there were empty cubicles, a lot of staff, and often up to eight paramedics being kept waiting to hand over patients. My husband was with her and he was amazed at the obvious inefficiency of the system and waste of ambulance crew resources.

On admission, my mother was left on a trolley in a great deal of discomfort. She was X-rayed and I arrived within a couple of hours to see how she was doing. She was still in the corridor, and we could not understand this as in another part of Accident and Emergency there were lots of empty cubicles.

After she had been at the hospital (still in the corridor) for almost four hours, a doctor told us that nothing was broken, and that she could go home. However, she was unable to move off the trolley, so she was at that point pushed into the plaster room to wait for a further X-ray. During that period, three pairs of staff came in looking for another patient. It was decided to admit her to the short-stay ward; this was after 5pm.

On the short-stay ward, a nurse took basic details from her, as her notes had not arrived from Accident and Emergency, all of fifty feet away. I left the hospital at that point and returned at about 7.30pm. She had still not had the result of the second X-ray and was still in her outdoor clothes, unsure if she was to be kept in overnight or discharged. The ward was being run by a female staff nurse and a male health care assistant, who had a very
public row about the way in which the healthcare assistant was being managed. I asked both of them what was happening to my mother, but was told that we would have to wait to see a doctor.

At 9pm, we were still waiting. I went to the Accident and Emergency desk and spoke to a consultant, who told me in a very arrogant way that Accident and Emergency staff were organised in three teams, and that nobody in his care was waiting. At the time, I accepted this but on reflection I find it amazing that he took such a high handed and unhelpful approach, simply referring me back to the nurse on the short stay ward. She finally told me that my mother would be kept in overnight, and I helped my mother to undress and left for the evening.

When I arrived the following morning, my mother was still in a great deal of pain. She told me that she had not been able to eat any breakfast or to drink anything, as it had all been left on a trolley which was out of her reach.

I was there when the consultant came to see her. He confirmed that the second X-ray showed that nothing had been broken, and that she could go home. She then saw the discharge social worker and a physiotherapist, who decided that her pain levels and immobility were such that she could not be discharged that day as my mother could not support her weight and it was clearly totally impractical for her to manage at home. I would like to praise these three individuals for their kindness and consideration to my mother, a real contrast to her treatment from the night nurse on duty.

My mother stayed in the short-stay ward from that Wednesday until the evening of Saturday the 18th of December. The care was generally very poor. During that time, she had very little to eat or drink as everything was left on the trolley which was not within her reach; the bed had no call system operating and she relied on me to take her food and help her to eat it. This was fine as I was able to be there for a large part of each day, but not everyone has this level of family support and the hospital staff should be far more aware of peoples’ needs.

The staff nurse on duty on Friday and Saturday seemed unable to manage the ward, frequently saying that things would be “done in a minute” when in fact they were done much later or not at all. On several occasions, I witnessed staff ignoring patients, at one point I felt I had to intervene as two staff continued a private conversation while a patient was calling for help. After this had been going on for about ten minutes, I stood up and said loudly: “Am I the only one here who can hear that person calling for help?” At that point, a member of staff went to her bed. How long would the neglect have continued if I hadn’t been there to call attention to it? It should not be like this!
On Friday evening at about 11pm, I had a phone call from the ward, saying that my mother wanted to speak to me. She was talking about men with guns coming in and lining all the patients up against the wall. She was clearly hallucinating and I rang back and spoke to the nurse in charge who assured me that this was probably a result of painkillers or a urinary infection and she would refer back to the doctor for advice. I was extremely concerned as she did not have a urinary infection before she went into hospital, and I felt that this was because she was often unable to reach her drinks and also her fluid intake wasn’t recorded. The painkiller option was also a cause of worry – my mother weighed about seven and a half stone, and was being prescribed large doses of pain relief.

When I went to the hospital on Saturday, my mother was still extremely confused and not at all her usual self. After several fruitless attempts to speak to the staff nurse about this situation, I asked her to contact a doctor. We spoke to a very helpful doctor from the medical team, who examined my mother, and asked her standard questions to establish her level of alertness. She understood my concerns regarding inappropriate pain management (initially codeine and then oral morphine) and arranged transfer to a ward in the Barry Building.

My mother’s property did not go with her however, and I had to go back to the short stay ward on three separate occasions over the next few days to collect her things. This was despite a staff nurse telling me very emphatically that all of my mother’s belongings had left the ward when I first went back there. I find it amazing that it is possible for a vulnerable person’s possessions to be so badly looked after.

The transfer was to Jowers Ward, a specialist ward for older people where she stayed until Christmas Eve. She generally received reasonable treatment here, although some basic care routines (washing and feeding) were not consistently followed. Her drug regime had been changed and she also had antibiotics for a urinary infection. Special mention must be made of one nurse, who was extremely helpful, caring, kind and efficient. Why are these people so rare? They seem to be the exception rather than the rule and it would all be so much better if this could be reversed.

On Christmas Eve it was decided to transfer my mother to a rehabilitation unit in Lewes called Meadow Lodge. This transfer was, for my mother, one of the lowest points in her experience at the Royal Sussex. A member of staff came to tell her of the transfer mid morning, and before my mother knew, three people were trying to get her ready to leave – one washing her, one dressing her and another administering an injection. She said that she felt that it was too much all at once and nearly cried with the embarrassment and frustration of it all.
The care she received at Meadow Lodge in Lewes was exemplary. The nurses were very kind and caring, she was in a single room and treated as an individual and she began at this point to improve. It seems that she had broken her pelvis, despite the x-ray results, and the nursing team was great in helping her to mobilise and exercise. She was still very frail and had lost a stone in weight whilst she was in hospital.

After 15 days at Meadow Lodge, mum came back home and continued to make good progress, despite continuing pain for the next couple of months. She is now more or less back to her previous weight and fitness levels. So, I can report a happy ending to this tale of woe.

As a family, we are great supporters of the NHS but our experiences over this period have made us very concerned about the lack of efficiency and management at the Royal Sussex. I am particularly fearful for people who do not have anyone to advocate for them, and appalled at the lack of compassion shown by staff in “caring” professions. In addition, I am concerned at the way in which eating and drinking is now divorced from nursing – it is all part of patient care and should be an integral part of people’s rehabilitation. How can things improve? It is a big question – with no quick fix answer. But the medical profession must do all it can to help people when they are at their most vulnerable – if family members can be involved that is all to the good, but if people are on their own, they have the right to receive good care when they need it most.
5) William Wood
By his wife Sheila Wood

“He told me that at one point during the night of the 18th of December he pressed the emergency button because his breathing had become so laboured he felt he was gasping for his life. It was a full fifteen minutes before anyone responded to him.”

William Wood was admitted to York District Hospital in December 2010. His wife Sheila believes that both she and her husband were not kept up to date about the care of her husband, and that he was often neglected by the nursing staff.

When he was suddenly discharged just before Christmas the family were given very little information about the care and treatment he needed at home. Tragically he died on Christmas day 2010, whilst his daughter conducted mouth to mouth in an attempt to save his life.

Aged just fifty two, William’s story is a reminder that poor care is not confined to the elderly.

Sheila’s Account

My beloved husband, William David Wood, never suffered from anything more than a minor ailment in all of his life. We have been married for thirty one years, and we have had three wonderful children. In that time I have never known him to be off colour for more than a few days.

When he started to feel under the weather on the 11th and 12th of December it was quite unusual. After several days his condition had worsened, and I was becoming increasingly concerned. I felt that it was time to call the Doctor, as Bill was finding it increasingly hard to breath.

When the Doctor arrived he took one look at him and immediately phoned the ambulance. On the 17th of December, aged 52, my husband was admitted to York District Hospital. At that point we had no idea about the difficulties we would face in the days ahead.

Because of the rise in the number of incidences of a new strain of the Swine Flu virus, my husband was put in a room on his own until tests had been carried out to ascertain if this was what he was suffering from. Unbelievably the tests had to be carried out on three separate occasions because the results kept getting lost!
In a busy hospital you can expect that on the odd occasions an administrative error may lead to results being mislaid—although it is poor if this happens even once. But to lose results three times suggests that the reason is sheer incompetence.

I visited Bill each day, either alone or with one of my children. We stayed for the maximum amount of time that the visiting hours allowed, because he was alone in a side room. In my opinion during this time he received no nursing care at all. His breathing was getting worse, and Bill felt that he was not receiving the attention that he needed. His breathing difficulties were becoming more apparent with every visit. He was on oxygen, and pneumonia had been diagnosed.

He told me that at one point during the night of the 18th of December he pressed the emergency button because his breathing had become so laboured he felt he was gasping for his life. It was a full fifteen minutes before anyone responded to him. In my opinion, to take so long to answer when a patient is known to have breathing difficulties is atrocious. He could have died in that time.

During his time at the hospital I had tried to ask for advice several times, initially from nurses positioned at the nursing station, and then by requesting a meeting with a doctor. Despite my repeated requests nobody ever came to speak to me, so I didn’t have any discussions about my husband’s situation and how serious it had become. He himself never knew how serious his condition was, and was quite anxious that he was being left alone in a shuttered room, with just a machine outside the door monitoring his blood.

The only occasion on which we were told anything was when the consultant said that he was a very ill man, and that it could be a long road to recovery. He also said that Bill might never work again. Bill said that someone would just poke their head around the door each day and tell him to ‘keep up the good work’. Vague comments such as these did not provide any information, however, as to what was exactly wrong with Bill or what the next steps in tackling his condition were going to be.

My husband knew that he was not receiving the proper care or attention that he should have been, but due to his poor state of health and breathlessness he was unable to express himself forcibly. The drip the nurses placed in his arm was constantly falling out, which led to Bill becoming agitated. They used several plasters to try and hold this in, and in the end tried to bandage his arm to try and keep the needle in. It was highly unsatisfactory as his arm became painful and bruised.

Bill often had to point out to nursing staff that his ankles legs and feet were swollen, but this was literally shrugged off. A nurse did say at one point that they would raise his legs to tackle the swelling, but this never happened. Instead it was left to me on my visits to rub his legs and try to give him some relief from the pain, which he said was agonising.
After he had been suffering from breathlessness for so long we were pleased when he was finally hooked up to an oxygen supply. By this time his breathing had become exceptionally poor. However then, on the 22nd of December, we were told that he would be discharged!

I was at a loss to understand how someone that needed oxygen to manage his breathing difficulties could suddenly, and without warning, be judged to be healthy enough to be discharged from hospital. He wasn’t even able to walk to the car he was so ill. When I suggested to the medical team that this indicated that he was not well enough to go home, they just gave me a wheelchair.

We were given Amoxycillin, Erthromycin, Ibruprofen and supposedly (according to the drugs chart) Zopiclone to take home and give to Bill at the stipulated intervals. However the Zopicline was not included in the pre prepared package that was on his bed ready to take home with him. Aside from the drug instructions we did not receive any other information about caring for Bill.

During the days that followed his condition did not improve. He could barely speak without becoming frighteningly breathless. He seemed to react adversely to the Amoxycillin because he came out in red blotches (the leaflet warned that this was a possible side effect). When I phoned the NHS Direct Helpline for advice I was advised that we should carry on giving him the tablets as it was only a mild reaction.

On Christmas Day Bill was still very poorly in bed. I became increasingly worried about Bill’s breathing and general health as the day wore on, and by nightfall he had begun to speak in a manner that I would describe as goobledygook. He was completely incomprehensible.

I was so worried that I went downstairs to phone the emergency doctor. Whilst on the phone to the doctor I heard a thud upstairs. I dashed upstairs and found him on the floor having fallen out of bed. He seemed unconscious.

At this point the doctor, who was still on the phone to me, tried to explain to my daughter how she should start CPR. She did this according to his instructions until the paramedics arrived. They did all that they could but my husband died.

I still cannot understand how the seriousness of his condition went unnoticed. The Coroner’s report showed that my husband had chronic pneumonia, with one lung completely solid and another three parts solid. In a modern hospital, with all of the resources available to them, how does that get missed? Why was he sent home without any oxygen given that he had been on oxygen throughout his time at hospital. Finally, why were we not given any advice on how to look after him beyond just giving him drugs?

I still believe that the initial diagnosis of potential swine flu meant that staff was unwilling conduct further investigations and to treat him for anything else. I also believe that he was discharged so early because it was Christmas.
I would not wish anyone to have the lack of treatment that I witnessed. I have lost the man of my life, my children have lost the best father ever and it was all so unnecessary had the right care and attention been given.
6) Patricia Rattansi

“The bathroom on the bay where I was did not get cleaned for the whole of Sunday. I am certain about this as it was opposite my bed. It was filthy, with excrement covering the seat and in the pan most of the day. Dirty paper towels, covered in excrement were strewn on the floor where people had made attempts to clean it. ”

Patricia Rattansi went into Hospital to have a shoulder joint replaced. In her account Patricia talks about her concern that at the levels of hygiene on her ward, the poor wound care, and of her concern that she was moved around the hospital as if she was a ‘parcel’.

Patricia’s Story

I have been a patient at Whipps Cross Hospital, as both an in patient and an out patient, for a number of years. During that time I have held a largely positive view of the Hospital, and have been grateful to them for the care and treatment they have given me. However the care I received during my recent stay on Sage Ward has changed this view.

On the 17th of June 2011 I underwent surgery to receive a replacement shoulder joint. I needed the operation because I suffer from long term rheumatoid arthritis, which had severely impaired the mobility of the shoulder joint. I was obviously looking forward to having the surgery and trying to get back to normal.

The problems began at 6am on the 19th of June. I was asked by the nurse in charge to ‘do her a favour’ and let her move me from the side room that I was in to Rowan Ward, a Gynaecology Ward. She said that there was a new patient who needed my bed.

Wishing to be helpful, I agreed. In a matter of minutes I was moved by Porters to the ward which was a floor below. I now regret having agreed to be moved, as I believe that I should have been on an Orthopaedic ward so soon after surgery. In addition, I have been on biological therapy which suppresses my immune system, and that I was safer and better protected from illness and infection when I was in a side room. My belongings were piled on my bed and I was left in the new ward. A nurse came in and looked at me and went away again. I stayed in the room approximately 20 minutes alone until another nurse came in to tell me that I was moving back to my original ward. So the same porters arrived and
returned me to Sage Ward with my belongings. I deeply resented being moved around without concern for my needs as if I was a parcel and I complained to medical staff about this.

It is my understanding that this was a decision made by a clinical site manager. I asked to see her for an explanation but was told that she was not available. I subsequently got a message to say that she would see me on the 21st of June on the ward. I never did get to see her as I left hospital early for reasons which will become clear below.

The bathroom on the bay where I was did not get cleaned for the whole of Sunday. I am certain about this as it was opposite my bed. It was filthy, with excrement covering the seat and in the pan most of the day. Dirty paper towels, covered in excrement were strewn on the floor where people had made attempts to clean it.

When I complained I was told that the cleaner at the weekend did not like cleaning the bathroom and that staff had complained before but nothing had been done. Surely if medical staff request greater hygiene on their wards those requests should be met? Why was a cleaner employed who was known to not like cleaning toilets?

Several of the patients complained but nothing was done until the night staff came on duty after I showed one of the nurses the state of the place. It was clear that hygiene was not a major concern on the ward. This was further made obvious when one of the nurses, who was the nurse in charge that Sunday, failed to apply a dressing after removing someone’s wound drain. The dressing was only applied after the patient complained loudly about it. It concerns me that a nurse did not seem to grasp the importance of good wound care.

The guidance on visitors is not enforced. The notice outside the ward said that there should be no more than two visitors per bed. Confusingly the inpatient booklet says that you can have three visitors per bed. However several of the patients in my bay had more than eight visitors at a time. This noise went on from all afternoon and most of the evening from 2pm until 8pm. It left me unable to rest. During my stay on the ward I saw no attempts at all by staff to keep the number of visitors per patient down.

Throughout the night the noise from staff and the patients was incredible, and little was done to try and limit it. It was not an environment which made it easy for sick people to get better.

The night I spent on that ward was miserable thanks to staff and general ward noise. I was exhausted and decided I simply could not stay any longer. Despite living on my own, being disabled, and having temporarily lost the use of my right arm, I felt that at least I would be able to use the lavatory and wash in a clean bathroom. When I spoke to my registrar about my plans to self discharge she did not try to dissuade me. I asked her "am I being foolish? She replied "No". I left the Hospital on Monday the 20th of June.
There was more. When I was at home the Hospital Discharge Team who telephoned me on the following day claimed that I had declined district nurse attendance. This was untrue. Not only had we discussed the possibility of a district nurse before my discharge, I had even been given dressings for the district nurses use!

The Hospital Discharge Team asked me to contact my GP surgery to ask for District Nurses to attend me which I did. I was at this time only 3 days after major surgery. I was exhausted and found contacting the GP a new obstacle which was almost too much.

Thanks to my medical history I am aware that wound care is vital. Not having access to a district nurse to change my dressings could have resulted in very serious consequences, especially if I developed infection and this infection was not subsequently spotted. Fortuitously, I was told about the incorrect report about the district nurses before the situation became more problematic.

I think that it is reasonable to expect that ward staff in a hospital have some understanding of the need for basic hygiene and sanitary conditions. I also could not believe that the need for quiet in which patients can rest and recuperate was ignored in the way that it was. I also dislike the idea that patients can just be shuffled around a hospital as if they were just objects, rather than human beings.

When you see a senior nurse fail to provide a clean dressing to protect a chest drain, it causes you to question the general standard of nursing on the ward. It saddens and frustrates me that I had such a poor inpatient experience. Furthermore, it frightens me, as it is likely I will have to have more surgery at some time in the future, and could return to that ward.
7) Mrs Immacolata Lacovara
By her son, Matt Lacovara

“They treated her roughly and left her covered in bedsores and bruises. My sister had to have a separate meeting with the matron to discuss some rude and disgusting comments she had overheard the nurses making about mum. If they were making those kind of comments when we were there, I can only presume that they were making similar comments in earshot of my mother when we were not. It makes my blood boil.”

Mrs Lacovara was admitted to Central Middlesex Hospital on her 74th birthday. Her son Matt tells us that he feels the nurses treated his mother like a ‘slab of meat’, making rude and insensitive comments about her weight within her earshot.

My mother was admitted to Intensive Care at on the 12th of January 2011, at the Central Middlesex Hospital. It was the day of her seventy fourth birthday. She had been seen by a respiratory nurse the day before, who had diagnosed COPD [A lung condition which causes breathing difficulties]. The nurse requested that she went into hospital for a blood test, and after detecting a problem with her blood she was taken to Intensive Care and placed on a Bipap mask [A mask designed to assist with breathing].

She made a good recovery, but because of mobility problems she was unable to leave the Hospital and was transferred to Roundwood 3. I firmly believe that my mum’s death was due to the negligence of the nursing staff who were supposedly caring for her.

My mother was a big lady, as are so are many people in the modern world today. However we felt that from the outset, her size was an issue and impacted on the willingness of nurses to treat her.

Communication was also always a problem. English was not her first language and as a result, she would often struggle to make herself understood. This meant that sometimes she shouted, but it was only in frustration. We felt that the nurses instantly took against her because of this, when really they should have understood and appreciated the difficulties she was facing.

Whilst in Intensive Care the Bipap mask was left on mum throughout the night. On one occasion when we came in to see her in the morning, she was hoarse and could barely
When we asked her what was wrong, she said that she had been left to scream all night, in pain and alone. The Bipap mask had drowned out her pleas and so she had been left alone by the nurses.

On another occasion she was the last person that the physiotherapist saw when visiting the ward. We were shocked to see that the physiotherapist just hoisted my mother out of bed on to a chair. She didn’t want to give her any active treatment at all.

The physiotherapist treating mum at the hospital was extremely frustrated that she was not moved out of intensive care sooner. Instead, she had to wait six days for a bed on the ward. In the end I had to beg the matron to move her out of the Intensive Care Unit, as mum felt that she was being ignored there. My mother’s only wish was to come home.

I ended up having a meeting with the clinical head of the Intensive Care Unit to complain about the way my mother was left, mistreated and ignored. There were highly apologetic and said that they were grateful for my feedback.

My mother weighed 20 stone, which I do not feel is excessive in today’s society. However from the second that she arrived on Roundwood Ward we sensed that the nurses felt she was a burden to them. While we were there, we did everything we could for her and had we been allowed to stay beyond visiting hours, one of us would have stayed with her at all times, but the nurses would not allow us to stay beyond visiting hours, or allow us in before hand and we respected their rules. It was however clear that they did not give her an ounce of the care or attention that was at least expected by their job role.

They treated her roughly and left her covered in bedsores and bruises. My sister had to have a separate meeting with the matron to discuss some rude and disgusting comments she had overheard the nurses making about mum, while they were flitting through gossip magazines. If they were making those kind of comments when we were there, I can only presume that they were making similar comments in earshot of my mother when we were not. It makes my blood boil. My sister didn’t believe that the matron listened to her at all and even confirmed that no reprisals would come from the complaint made against the nursing staff, and the Matron assured her that they were highly professional and that no harm would come to our mother.

Despite all of this she never lost her politeness towards the people treating her, always saying please and thank you whenever they did anything for her.

When we arrived at the hospital on the terrible night my mother passed away, we discovered that a Do Not Resuscitate (DNR) notice had been placed in her file. None of the family knew anything about this, and we never knowingly signed anything like this on my mother’s behalf, nor would we have done.
Even if my mother had signed something, she would not have known what she was signing as English was not her first language. If she was told to sign she would have duly unknowingly have done so, trusting the medical staff it would be for her benefit. Even then she would have required help holding the pen and would not have known that she was signing her life away.

However, if there was a Do Not Resuscitate order on her file, as a family we believe it should have held no weight as her condition at Roundwood three was of improving compared to her initial assessment in the ICU. My mother seemed to be making a good and strong recovery, and we feel it was only her weight and lack of mobility which counted against her with the medical team.

I will always feel guilty I ignored my mother’s pleas to get her out of Central Middlesex Hospital. One of the few times I saw her smile during her time at the hospital was when I said I was going to discharge her myself. However I listened to the junior doctors and didn’t. I said it would be better for her to remain in hospital on their advice. They gave me various and sometimes contradictory reasons why she should remain as a patient. I will always wish that I had ignored them and brought her home instead.

We attended a family meeting on the afternoon, prior to my mother’s death that same night. At that meeting, medical professionals told us that she was making good progress. They even said that she would be able to come home at the weekend. As a family we were encouraged by this and started planning her home coming and making arrangements to bring a bed downstairs so that we could take care of her at home. We had no idea how serious her condition was.

We were there for every minute that visiting time allowed us, and on the night that she passed away my father asked to stay as he did not want to be away from his wife for another night, on this occasion, they agreed. He was present when she needed help to breathe and the nurses to help. However they wouldn’t, because of the Do Not Resuscitate order. Instead they stood back and watched my mother die in the arms of my helpless father.

Throughout the hospital I would notice posters claiming that the hospital treated the elderly with dignity and respect. However my beautiful mother was treated with no dignity or respect, instead she was treated like a slab a meat.

After my mother passed away I made a complaint against the hospital, but I didn’t feel that it was listened to at all. I felt that whilst we were listened to sympathetically, our concerns were really brushed under the carpet.

Our guilt of trusting the so called professionals and not listening to our gut instincts and the pleas of our mother to get her home will stay with all of us till our dying day.
“What happened that night was both unnecessary and horrific. As mums pain and discomfort increased, my stepfather tried unsuccessfully to console her. After numerous discussions with the staff, at approximately 1.30am, the nurse in charge paged a duty doctor to authorise more appropriate medication. One hour and forty minutes later the doctor arrived.”

Sally Abbott-Sienkiewicz was admitted to Glenfield Hospital in November 2010, as a cancer patient with a terminal diagnosis that contracted double pneumonia.

Her daughter Samantha complains that throughout Sally’s time at the Hospital her family repeatedly had to request more pain relief for her as it became apparent her life was coming to end. Samantha describes her mother’s pain as being, at times, ‘horrendous and horrific’.

Samantha’s Account

In August 2010 my mum, Sally Abbott-Sienkiewicz, was diagnosed with non small cell lung cancer, lymph node cancer and two brain tumours. Her condition was terminal, although she was advised that treatment may extend her life. She received Radiotherapy for her brain tumours and began Chemotherapy.

Unfortunately after her first Chemotherapy treatment she caught double pneumonia. She was treated as an in-patient at the Oncology Unit at the Leicester Royal Infirmary. Whilst she was there a scan discovered that her cancer had spread, and that further cancer treatment would not be of any benefit to her.

On Monday the 8th of November 2010 mum called her GP. She was concerned that she may have an infection as her breathing was worse than normal. The GP visited and confirmed that she had a chest infection and Pleurisy. Mum stressed to the doctor that she deeply feared going into hospital again, so he said he would start her on antibiotics at home. He said that hopefully the infection would start to clear within 48 hours, and if mum didn’t feel any worse by Tuesday that was a good sign. However, he also said that if she was not feeling better by Wednesday we should call and request a home visit.
On Tuesday morning mum was unchanged and we thought that this was a good sign. On Wednesday morning mum’s condition was worse, so my stepfather rang the GP surgery. He was told that the duty GP would visit mum as soon as possible. After the duty GP had examined mum he told her that he was going to get a hospital bed ready for her. This news was extremely upsetting to mum, and she became hysterical, fighting and arguing with my stepfather for around twenty minutes. She was scared to return to hospital, and my stepfather was distressed that he was unable to console her. My stepfather telephoned my aunt and I to come to the house and try to calm her down.

Unfortunately when we arrived she seemed to have suffered a stroke. Her speech was slurred and she couldn’t get up from the sofa. The left side of her face had also drooped. We rang the surgery again and asked for mum’s regular GP to come out and see her, which he did. He thoroughly examined mum and told her that the best thing for her to do would be to go into hospital, have scans and be put on intravenous antibiotics. I wanted mum to be treated by Oncology at the Hospital, as I felt that would be where she would receive the most suitable care. Unfortunately, although our GP agreed, she could not be treated there because she was not undergoing active treatment for her cancer.

Mum was taken into hospital by ambulance, and at 2.45pm we arrived at the admissions area of the Critical Dependency Unit at Glenfield Hospital. Mum was initially seen by a student nurse, who asked many routine questions. Her breathing was worsening, and so she was provided with oxygen. We were told that she would soon be seen by a doctor, but two hours passed and she had still not been seen. Obviously this also meant that she had not taken any medication.

At around 4.45pm mum was transferred to a side ward on the Critical Dependency Unit, and an X-ray was taken of her lungs. We were concerned that mum had not had a drink since the early hours of the morning, and felt that she may have needed a drip to prevent her becoming dehydrated. Our GP had also advised antibiotics so we were eager for mum to start these as well. In addition mum had not had any of the painkillers or other medication that she would normally have at home. We were therefore very anxious for her to see a doctor as soon as possible.

The need to see a doctor became even more pressing as mums breathing and pain was worsening by the minute. I explained this to the staff nurses and asked them how long we would have to wait. They said that mum was third on the list to be seen and it would probably be another hour. Although we understood that the ward was really busy, the sight of doctors and nurses standing at the reception desk laughing and joking was an uncomfortable one. By now mum was asking for her Lorazepam which was a painkiller prescribed by her GP to use whenever she needed.
A junior doctor eventually came to examine mum at approximately 6.20pm. She was unable to tell us how long it would be before mum got antibiotics or even pain relief, as her chest x-rays had not yet returned.

Mum was greatly distressed and in obvious pain and discomfort. My stepfather, in desperation, told the nurse that if they didn’t provide her with any treatment we would go home and get her medication. It was the only way we felt we could ease her pain and distress. Eventually my stepfather and brother had to drive home to get her medication in a desperate attempt to ease her suffering.

A detailed description of mum’s medication and requirements had been written by her GP for the benefit of the hospital staff. Why was this not read and her medication needs prioritised?

During this time I pleaded with mum’s doctor as she was clearly now so much worse than when she came into hospital. I explained that mum still needed all her usual medications that she took at home, and that I was sure these would help with her increasing anxiety and pain. Despite the level of pain and distress she had been left with only oxygen for around five and half hours.

When he eventually arrived the doctor was sympathetic and apologised for the situation, and within ten minutes had asked for a cannula to be put in. I explained to him mums normal drug requirements and he ensured that she got what she needed. The relief and reassurance that this provided to mum was clearly visible on her face.

At approximately 8.40pm we were advised that mum would be moved to ward 15. At around 8.50pm she was taken to the ward and placed in side room 4. As we left mum was still very poorly, and she was unable to speak or move around. However her anxiety was much reduced. She was more settled and happier that she was on a ward, where she believed she would now receive the care that she required.

My stepfather stayed the night with mum. It soon became apparent to him that the nurses in charge of the ward had been given instructions only to administer medication as prescribed by her GP. No one had taken into account mum’s worsening condition. Therefore, the medication provided was inadequate to meet her needs. As the medications that my stepfather had brought from home had been confiscated by the nursing staff he faced a challenging night dealing with the bureaucracy of the night duty staff that were unable to use any initiative to deal properly with the situation.

What happened that night was both unnecessary and horrific. As mums pain and discomfort increased, my stepfather tried unsuccessfully to console her. After numerous discussions with the staff, at approximately 1.30am, the nurse in charge paged a duty doctor to authorise more appropriate medication. One hour and forty minutes later the doctor arrived. He eventually agreed to prescribe a stronger sedative, which took a further twenty
minutes to organise and administer. By 4am mum was acceptably calm, but its effects wore off and proper care was not forthcoming until the day staff arrived for duty.

After needing to stay awake all night, my stepfather left the hospital at around 9.30am, to get some rest at home. My aunt and I returned to the hospital. We were told by the Macmillan Nurse that the next forty eight hours would be crucial to mum’s recovery, and that we would learn during this time whether the antibiotics were working.

Two hours later, at around 11.30am we were told by the same nurse that mum had been taken off the antibiotics and wouldn’t be getting any better. She told us that when mum had first arrived they thought they could control the infection, but that mum had deteriorated badly during the morning. She also said that a drug which had just been administered would dry up mum’s chest and stop what she called the ‘death rattle’. I found it outrageous that she could talk in such a matter of fact manner about my mum like that.

She said that they did not expect mum to survive longer than twenty four hours, and would ensure she received adequate pain relief and sedation. We were comforted by the thought that she would be adequately cared for in her final hours.

At around 12.15pm the nurses stopped mum’s Paracetamol drip. Throughout the day mum’s condition was under control, and she was sedated and in no pain. Mum started to come round from her sedation at around 4.30 pm. We were aware that this might happen, but had already been assured by staff that mum would receive medication within 20 minutes to ensure that she was not distressed and remained pain free. As agreed the nurse came in and administered a sedative, and mum settled down again.

As a family we suggested that mum be taken to a local hospice, as we now understood that mum was going to die. The nurses told us that it would be more harmful and distressing to move mum to move at this time. We felt we had no choice but to accept and trust the medical advice provided.

At around 6pm the ward staff changed over. The Macmillan Nurse confirmed before she finished her shift that all mum’s medication requirements were written up, and that everything was set up correctly for her and the night ahead. Within the next hour mum began to come round from her sedatives. Mum was very distressed and was trying to get out of bed. Obviously there was no way that she could, but she kept trying, writhing around the bed in pain, distress and fear.

She couldn’t talk to us properly because of her slurred speech, however she was aware of those around her and where she was. Concerned for mum’s physical and mental well being, we quickly requested that the night staff come and help her. The nurse came to the room and advised that mum couldn’t have a sedative, and that a painkiller would suffice. When we asked mum, who was aware of what was going on, what she wanted, she even managed
to say “sleep”. This request was disregarded by the nurse and at no time was any explanation provided for the refusal to give mum the sedative she so clearly needed.

After an hour mum was still awake, by this time it was 7 pm. Mum was clearly distressed and in great pain. Again we asked the staff for a sedative, something that would allow her to sleep and reduce her anxiety, but they refused to provide one. The family were very distressed seeing mum go through this prolonged discomfort when the day staff had managed to keep her comfortable. The nurses finally agreed to give her one injection. We continued to watch over mum, hoping that she would now begin to relax. However the sedative did not allow her to drift back to sleep, as it had done during the day.

Mum was still very aware, extremely anxious, and it was clear that her health was deteriorating by the minute. We requested that the nurse return to mum’s room and give her something to help. They said they couldn’t provide her with anything more as they hadn’t assessed her yet. The whole family were so upset that they were begging the nurses to help mum, but they just kept shaking their heads and said they couldn’t give her any further medication. To see a loved one in so much pain and distress, with no one prepared to help, left the family with the most unimaginable feelings of helplessness, confusion and fear.

The nurse in charge of the ward told my stepfather that there wasn’t enough sedative in the ward to keep my mum comfortable throughout the night. They said that if a sedative was provided now they wouldn’t be able to provide any further sedation later. My aunt was told the same thing. This was devastating news and created a feeling of panic within the family. It is unacceptable that there was not enough medication available.

The family now felt that help and medication had only been provided after constant begging to the night staff. In desperation, I phoned the Hospice and asked them whether it was acceptable for a dying patient to be in so much pain and distress. They replied that it wasn’t right and that they would phone back in 30 minutes and speak to the nurses in charge on my behalf. They said they would discuss different kinds of medication and ways to administer them. Thanks to the intervention of the Hospice mum was sedated again at 8.50pm.

An hour later mum remained in distress and pain. We asked if mum could have another sedative, but this request was refused. One of the staff said that mum was not a priority, and that they had many people on the ward to care for. They went on to say that it was the family’s job to soothe mum and keep her calm. As we had now been talking and trying to reassure mum for many hours and as her anxiety was mainly due to her pain, suffering and the nursing staffs refusal to provide adequate sedation, we found this advice to be incredibly insensitive.
Mum continued to be in pain for around another hour. At this point the whole family approached the nurses at their desk. In desperation we begged and pleaded that mum be given more sedation to keep her calm. Eventually the nurses gave her more sedative. They said that if mum was still distressed in a further 20 minutes they would give her a more powerful sedative.

Around 20 minutes later I approached a junior doctor who was now on the ward. I begged him to help mum and keep her calm. After my stepfather had been told that there was not Midazolam (a specific sedative that seemed to work really well for mum) we asked him to assure us there was enough suitable sedative on the wards to ensure that mum had a comfortable night.

He told me that there was enough and explained that its use had to be authorised. He promised that he would administer the drug as and when mum needed it. He also explained that the drugs in mum’s syringe pump would be doubled to help ease her pain and that this would be done very soon.

At approximately 11.45pm my stepfather advised the night staff that mum needed assessing and to be given the appropriate medication. We had little faith in the care that was being provided. My stepsister sat with my mum for a good 10 minutes and could see how mum was getting more and more agitated with every minute. She held her hand and tried to talk to her to calm her down. Mum was still trying to get out of bed and communicate as best she could. My stepsister asked her if she wanted pain relief and mum squeezed her hand very tightly and opened her eyes so wide. The look on her face will stay with us for the rest of our lives as it was a look of terror.

We feel that the nurse in charge should have assessed the situation and ensured that mum had been administered the level of sedation and pain relief required to ensure that she was as comfortable as possible.

We told mum that pain relief was coming and looked out of the door to see if any pain relief was on its way. We then went to the nurse’s desk and spoke to the night staff. One nurse said she would do her best to hurry the other staff, but there did not seem to be any urgency. After waiting for fifteen minutes that felt like a lifetime, nurses came into mum’s room and said that they would not be giving her any further medication. Given her distressed state this made us as a family very distraught.

However three minutes later they had changed their mind, and said they would provide more sedation. At around 1.15am mum was still awake, distressed, in pain and trying to get out of bed. The hospital night manager came to talk to us. She assured us that they would increase mums syringe driver for pain relief and keep her sedated. She explained that the family’s mistake was to keep asking for a sedative rather than a relaxant. However Sedation
was the term used throughout the day by medical staff. All we had said all night was that we wanted mum to be calm. Surely it shouldn’t be up to us to get the terminology right.

At 2.40am mum was still awake, distressed and in some pain. The nurses convinced us that an Enema might help with mums discomfort as apparently constipation is one of the worse feelings of pain that anyone can go through. We left the room so that they could proceed with the Enema. From outside of the room we could hear mum crying out in agony. The nurses came out and said that it hadn’t worked but that they would try again shortly.

My aunt and I went in to see my mum immediately. Her breathing was now even more horrific, she was in greater pain, but still very aware. I said to my aunt that I thought mum was dying and she agreed, so I ran to get the rest of the family. On my way to the family room I told the staff that I felt mum was dying and she needed to be sedated. Without checking on mum’s condition, they insisted it was just constipation causing the discomfort and so started to organise another Enema. I pleaded with them again to request sedation.

We knew mum was in her final moments with us and we wanted them to be as peaceful as possible for her. They came to the room and finally understood mums condition. They gave two sedative injections into her stomach and left the room. Mum fought well until the end, awake, distressed, terrified and in terrible agony. She finally died at 3.15am on Friday the 12th of November.

The above words cannot even come close to what mum and family members went through that night, lasting images of horror and fear of a loved one. On both nights the duty nursing staff seemed incapable, inadequate and lacking in compassion and empathy.

Given the condition mum was in, the staff should have been concerned enough to maintain a reasonable level of dignity for mum as a dying patient, instead mum was left suffering and distressed unnecessarily.
9) Mavis Morris
By her daughter Julie Norfolk

“Up until this date I had found it easy to contact the various wards each day and obtain from a member of the nursing staff very good information on my mother’s condition, and her progress or otherwise. However on her transfer to Tolgus ward this situation changed completely. Despite trying at many different times getting through on the telephone was frustratingly impossible. When someone did answer the information was inadequate, often inaccurate and inconsistent from one day to the next.

On many days I did not manage to speak to anyone. This was of course very stressful and worrying, given that I lived so far away from the hospital. The nursing staff also seemed to be ill informed, and I often had to explain mum’s medical history to them.

It wasn’t until the 8th of June that I was told by an Oncology nurse that I could actually contact her using the phone by her bed. The nurse was very dismayed that we had not been told this, especially because we lived so far away.”

Mavis Morris was admitted to Hospital for an operation in May 2011. In this account her daughter tells us of the poor communication she experienced, and her concerns about the clinical care she received. She also speaks about the intense frustration of watching her mother lose weight and deteriorate as she remains in hospital for much longer than planned.

Mum was considered by the health professionals to be a reasonably fit person for her age apart from a slight heart murmur which she was being treated for. There was no suggestion of a serious problem. Her communication was hampered by a severe lack of hearing, not uncommon in patients of her age. Her close family all lived some way away from Cornwall in Derbyshire and Telford.

In December 2010 we first learnt from mum’s gynaecologist that she may have cancer, and in January further tests were done. I went to an appointment with mum and she was diagnosed as suffering from primary peritoneal cancer. The consultant told us that the Chemotherapy treatment available was highly successful and would be administered in a course of 6 doses. They advised us that this should kill off the cancer but also warned that it could come back in 5-6 years time in which case more treatment could be given. Unfortunately operating was not an option as the nodules were spread too far across the area. Both professionals were
very supportive and in particular the Oncology Nurse gave mum her e-mail address in case we had any queries and her phone number to me for the same.

Mum began her Chemotherapy in February 2011 and she remained positive and independent. By March she had undergone three rounds of treatments and a scan showed good news, the cancerous nodules had shrunk sufficiently to allow for an operation to take place. The operation was a big one, and involved a full hysterectomy as well as potential removal of part of the bowel, and a scrapping of the peritoneum. When the consultant explained this to her mum told him to just ‘get her sorted’. The operation was booked for May.

In Early May mum started to experience severe pains in the bowel area of her abdomen, and went to her GP. I understand that the GP informed her consultant of the problems that she was having. The operation took place on May 10th 2011, and the consultant said that it had gone very well, and was confident about the outcome. The operation had however been extended to remove disease from the diaphragm and the liver, and also a large part from the colon. Mum was sent to the Tolgus ward after the operation.

On my way down to visit her I was phoned by a nurse and told that mums blood pressure was dropping, and that she was being moved to the High Dependency Unit (HDU). When I arrived she was clearly very ill but remained positive and was determined that she was at the start of her recovery. She remained on the HDU for a week, which was longer than she needed to but there was no beds available on either of the surgical recovery wards. I found the staff on the HDU to be very informative and helpful.

Mum was then transferred to the Poldark Ward, which is a surgical recovery ward. Soon after arrival however she developed a kidney condition and was transferred to the Kidney Unit. Despite several procedures and tests the Doctors were unable to identify what was wrong with her. Fortunately after one such set of tests her kidneys started working again.

During her time on the Kidney Ward mum was receiving regular physiotherapy, and the physiotherapist said that she was doing very well. She was able to walk to the kitchen or toilet and back again. She was not given any specific exercises for recovering from her condition however.

There was one problem that mum was struggling to get health staff to listen to, which was a severe and very painful ulcer that had developed on her tongue. This seemed to be getting increasingly worse, and was hampering both her appetite and her ability to chew food. As a result she was eating less. I had to make a number of requests to doctors and nurses before this was sorted out. A prescription was made for Difflame and Bonjela, although it took quite some time for this to arrive from the Hospital Pharmacy.
I told staff that I was concerned whether this was adequate for the problem—the medication didn’t really seem to be making a difference. Her continued lack of appetite was causing a continual weakening in her condition which went untreated by the nursing staff.

By the 30th of May mum had overcome the kidney complaint and had been transferred to Tolgus Ward (another surgical recovery ward). She appeared to be recovering well, was finding it easier to get out of bed and had started to eat reasonably well.

Up until this date I had found it easy to contact the various wards each day and obtain from a member of the nursing staff very good information on my mother’s condition, and her progress or otherwise. However on her transfer to Tolgus ward this situation changed completely. Despite trying at many different times getting through on the telephone was frustratingly impossible. When someone did answer the information was inadequate, often inaccurate and inconsistent from one day to the next.

On many days I did not manage to speak to anyone. This was of course very stressful and worrying, given that I lived so far away from the hospital. The nursing staff also seemed to be ill informed, and I often had to explain mum’s medical history to them.

It wasn’t until the 8th of June that I was told by an Oncology nurse that I could actually contact her using the phone by her bed. The nurse was very dismayed that we had not been told this, especially because we lived so far away.

However this was not a success as mum’s deafness meant that she couldn’t hear the phone to answer it. On several occasions I asked the nurses to go by her bed and answer the phone so that I could speak to her, but this proved to be impossible.

This left me in the distressing situation of having to rely on reports by the nurses, which seemed to be getting more inconsistent and inaccurate, causing me to become increasingly more upset.

On the 8th of June I spoke to a family member who said that the Hospital was ready to send Mrs Morris home. This was very distressing news as it was very sudden and completely at odds with the information given by the nurses on the ward.

The next day I had a lengthy discussion with Mum’s consultant, who said he was perfectly happy for Mum to go home the next day if the Occupational Therapist recommended this. I planned to come down to stay with Mum for several days on discharge (despite having a school age family in Derbyshire to care for). I also spoke to the oncology nurse who agreed with me that Mum was not ready to go home. From subsequent events I understand that on
this day Mum had a scan on her chest and was diagnosed with pneumonia. There was no
mention of any concerns regarding this in the telephone discussions that day or by the nurses
that evening.

On June the 10th I spoke to a nurse early evening and was informed she was not ready to go
home, she had not managed to eat much and was very tired. Again there was no mention of
the pneumonia.

The next day I was unable to speak to the nurse in charge of my mother’s care – but was
passed a very brief message that she had had a very good day, had walked some distance and
eaten really well. Again nobody mentioned to me anything about pneumonia.

Later that evening a family member who had visited the hospital that day spoke to me and
informed me of the pneumonia. This was of course a terrible shock and I phoned the ward
again as soon as the nurse changeover had completed. The nurse caring for Mum also had no
knowledge of the pneumonia and had to go back and check the notes – the nurses’ handover
seemed to be inaccurate and incomplete. The nurse confirmed to me that Mum had
contracted hospital induced pneumonia.

In view of the inaccurate and inconsistent information given to me about my mother, and her
apparent deterioration in condition, I decided to travel down to Cornwall again to see Mum
and also find out exactly what was going on and to ensure she was getting the care and
attention she deserved.

On June 13th I travelled to Cornwall early in the morning and spent the next 10 full days with
Mum in hospital staying there for nearly 10 hours each day.

On arrival early in the morning, Mum was being seen by the Stoma nurse and as I came to the
hospital bed side Mum burst into tears and said to the nurse “This is my daughter Julie, she
has come to take me home”. She was obviously in a terrible state. The nurse told me that
she was managing the stoma really well, but Mum was increasingly more worried about the rest
of her care.

I was then able to talk to mum. She had been on the ward so long she had become so fed up
that her health did not seem to be progressing in the right direction. In fact after sitting with
her all of that day, it was completely apparent that whilst mums kidney problem had cleared
up and the operation scar had healed up very well, the rest of her health had actually
deteriorated from when I had seen her in the kidney unit. I was not convinced of the level of
care that Mum had been afforded had been anywhere near adequate in the last few weeks. I
passed these thoughts onto the oncology nurse who promised to come to the ward as soon
as she could to review her progress.
Mum was still catheterised, still had a very bloated abdomen that nothing was being done about which made sitting out of bed extremely uncomfortable, she was unable to eat very much as she constantly felt sick and was retching, she still needed help to get out of bed and needed the support of a frame to walk, she could not walk very far without becoming completely breathless and exhausted.

She still had the ulcer which had appeared soon after the operation. The staff still did not seem to be treating this as a problem. The bonjela did not work and Mum had some other cream that did appear to be having an effect which had been brought in by a relative (checked with the doctor to use). The Difflame was still being used but not frequently enough according to the recommended dosage and when it ran out it took two days to replace causing much discomfort in the meantime. This also was seriously hampering Mums ability to eat and the only choice suitable on the hospital menu was gravy and mashed potato which Mum ate about a tablespoon full at each meal.

She was also extremely sore on her posterior which indicated poor hygiene and lack of daily washing. This condition was exacerbated by the infrequent showers and bed baths as these completely exhausted mum and the nurses seemed to be too busy to take the time with her to do them slowly, if at all.

In view of all this she was most comfortable lying in bed drifting in and out of sleep. She was seriously distressed about the level of nursing care and attention she was getting and told JN that the nurses were very abrupt with her, very bossy and they were not taking the time to listen. She was just being given brief instructions to eat, sit out of bed in the chair and walk around. All these she was finding extremely difficult and uncomfortable.

There is then the issue of the numerous different drugs and tablets mum was being prescribed. The drug chart stretched to over 2 pages long and seemed to have no logic or cohesion. The prescribing nurses just lined them all up on Mums’ bed table and then ticked them off on the chart to say she had had them. They took no account of the difficulty she was having taking anything due to the retching and sickness, and if she did take them and then vomited them back up no alternative action was taken.

I found the above situation just so completely unacceptable. This patient was supposed to have been discharged from hospital about a week after the operation. Mum had now been in this hospital for 5 weeks and considering her kidney problem had been sorted out more than 2 weeks ago, there was no improvement in her health – in fact under the supervision of the staff on Tolgus ward her physical and mental health had been allowed to seriously deteriorate.

Mum was in such a state of desperation I began making enquiries as to whether I could bring Mum back to Derbyshire to care for her at my home. (I was unable to take Mum back to her home in Newquay and stay with her there at such short notice due to many family
commitments back in Derbyshire.) This action was encouraged by the health staff at the hospital at all levels. I spoke to the GP surgery and local District Nurse in Buxton who were both appalled at the treatment and lack of recovery she was experiencing and were happy to try to help as far as they could, giving very good advice on how to approach the matter.

On the 14th of June there was no improvement in Mum’s condition and she had had a very disturbed night being sick and retching. This was also very upsetting for the other patients on the ward. After assessment of the situation overnight, I decided that whilst it was possible to care for Mum at my home, the journey up to Derbyshire would be such a trauma and almost impossible as the trip could not be in an NHS ambulance but in my car (A Fiat 500). So I persuaded Mum to consider a move to Newquay Hospital if a bed became available. After some discussion – by now she was so fed up of hospitals, she agreed and I asked for her name to be put on the relevant waiting list.

A ward doctor visited that morning to examine Mum’s chest. He decided that the level of fluid collection in her chest had actually got worse and ordered another X-Ray.

During the afternoon, I spoke to the occupational therapist who tried to give me a number of items of equipment to take to Mum’s home in Newquay. When questioned again about mums state of health and ability to function normally at home, the therapist said she was only really sending her home as she was so determined to go. This action seemed to have no thought of my mother’s deteriorating overall medical health; there had been no home visit, and no assessment of the family help close by in an emergency. The idea was just ludicrous.

During the meeting the local hospital administrator turned up and confirmed she had put Mum on the waiting list for Newquay and hoped a bed would become available by the end of the week. This really did lift Mum’s spirits.

That evening the oncology nurse visited mum whilst I was with her. She was appalled at the deterioration that had taken place in my mother’s health since she had last seen her on Thursday 9 June when she was last on duty. I recounted to her observations as detailed in my diary of 13 June 2011. Judith had a thorough look at the file, drug charts and the results of the X-Ray that day. When she saw the X-ray her immediate reaction was “This needs to be looked at by a doctor, preferably a medical doctor urgently”. She asked the nurse in charge what follow up had been done and was told she thought “someone had been asked to look at it”. She also considered the number of drugs prescribed to be ridiculous and said she would ask for a full review of Mum’s care first thing in the morning. She agreed a move to Newquay hospital would be good for Mum but that the chest problem needed to be sorted out first. I felt quite confident now that something was going to be done.

On June the 15th I visited in the morning to find mum quite distressed after another very disturbed night. Mum was now only able to eat small amounts at each meal time if anything at all and was becoming really very weak. The drug chart had been reviewed and many of the
medicines withdrawn and the important ones replaced where necessary with liquid forms making them easier to digest. However the new ones did take quite some time to arrive from the pharmacy. The nursing staff still seemed to be more concerned that she was not eating anything rather than getting to the bottom of why and there was no sign of the X-ray charts being reviewed by an appropriate doctor.

The Physiotherapist turned up to walk mum to the door and back which proved to be too exhausting for her and she had to be put on Oxygen immediately afterwards.

I became very upset at this lack of progress following the very positive action plan set out by Judith the previous evening. A very good friend to my mother and I, who is a retired very experienced chartered physiotherapist, agreed to come down from Hampshire to see her to try to lift her spirits. She arrived that evening at the hospital and spoke at length to mum.

I left her to talk to Mum who was delighted to see her. She was disturbed to see my normally optimistic mother so cast down. Mum told her how she felt the move to Newquay Hospital would be good for her and how very sick and excessively fatigued she felt but she was prepared to try and eat so it was arranged we would bring some eggs in the following day.

On June 16th we arrived at the hospital early to catch the consultant on his ward round. He remained upbeat about mums recovery and said the deal was that if she started to eat and her chest was ok she could go to Newquay Hospital. He repeated that he wanted a medical doctor to look at her x-rays and I asked him why this had not been done earlier. Another doctor present said it had been requested.

Despite the consultants second request and my constant reminding the nursing staff - not at any time that day were these all important x-rays reviewed.

I also made the consultant aware of the lack of physiotherapy especially chest physio - Mum had not seen the chest physio for 2 days. I told him about the inconsistent nursing care, in particular, at handover times along with the lack of physical care - Mum was not being helped or encouraged to recover.

He agreed again that a move to Newquay Hospital could help Mum’s recovery but he went to great lengths to explain that he could not be responsible for 50 or so nurses all the time and ensure they had been passed the right information.

We thought this was exactly why comprehensive medical records are written.

The Consultant suggested that I remain in close contact with the oncology nurse as she was always aware of his decisions and this may lead to less inconsistent information.

I began to wonder who was in charge of mum’s day-to-day care, and who was ensuring all the various bodies carried out their duties correctly.
When a relative went in to see Mum, the physiotherapist was with her and had just tried to walk her again, this time with an oxygen mask as her SATs were low. She asked the physio if Mum had been shown any post-op bed exercises or breathing exercises - both of which would have occupied mum both physically and mentally, but the physio did not know. As the physio prepared to leave the relative asked her again if she was going give Mum some chest physio as advised by the consultant. The physio explained she could not do that as today she was wearing a blue top and you had to be wearing a white top to carry out chest physio!

This young physio was not even aware mum had pneumonia –we were left wondering whether anyone on this ward look at records before treating a patient. (I also observed a lady in the bed opposite mum being prescribed the wrong medication as they had not checked her records)

Subsequently, we asked for a meeting with the Staff Nurse in charge of mum. This nurse’s general opinion and that of her colleagues was that Mum was not trying hard enough to carry out tasks such as walking, sitting and eating.

We both pointed out that all these tasks rendered her exhausted and in pain. The nurse then said that if Mum continued to refuse to eat and would not accept a feeding tube then “they would have to consider withdrawing treatment”.

I was speechless and too upset at this comment.

The relative that was with me suggested if Mum could be offered more palatable food it would be easier to swallow but the nurse interrupted her saying they had already done that and Mum refused anything.

How odd as that morning we had cooked a fresh scrambled egg for Mum and she ate it! After this meeting we were saddened at the lack of interest and nursing care shown to her. We no longer knew which way to turn after this meeting and felt isolated.

For the rest of the day and through Friday, Saturday and Sunday, I tried desperately to keep Mum’s spirits up and encourage her to do all the tasks required by the nurses as above. I helped Mum to walk around and to the shower, to eat and drink as much as she was able, to sit out in the chair and try to do some bed exercises as suggested by our physiotherapist friend. But mum was becoming increasingly reliant on the oxygen as her SATS seemed to be dropping at the slight physical exertion, this was causing the great discomfort of a constantly dry mouth, much weaker in strength and spirit and eating less and less due to the feeling of sickness and lack of appetite. The nursing staff had no reaction to this deterioration, continuing to blame Mums state on her, and doctors were not in attendance at all.

I continually tried to ask if the X-Rays had been looked at and what the result was. Most of the time the nurse in charge of my mother was unavailable, busy doing something else, or gave an unsatisfactory response, and no one else seemed to know either.
The oncology nurse was unavailable to advise in this period as she was not at work on these days. Mum’s consultant was also understood to be off over the weekend.

By Sunday morning, I was so worried about Mum’s worsening health that I insisted on talking to the nurses responsible for Mum in the corridor of the ward (even though this afforded no confidentiality). I felt that she was so much weaker in strength and in spirit and wanted to know what was being done about it? The nursing staff admitted quite freely that they did not know what to do with mum and suggested I talk to the ward manager (back off holiday on 20 June) and the doctor in charge. They also did not seem to know anything about the X-rays or what had been done about them – this was now 5 days after the X-Rays had been done.

Later that day I found a young doctor sat at ward desk and asked her if she could look at Mum’s notes to see if the results of the X-ray review had been noted on her file. The doctor was in the process of turning the computer off ready to go home. Her response to my question was “they must have been looked at by now and they were probably OK, otherwise you would have heard.” The doctor refused to turn the computer back on to check if any follow up by her or anyone else was needed.

I was so enraged at the blasé attitude of all the staff over the weekend and made a list of matters to be addressed on Monday morning. These were:

1. There was a serious problem with mums breathlessness and there was an immediate drop in her SATS levels as soon as she did any movement. What was causing this, what was the underlying problem?
2. The continuing sickness and retching – the nurses were saying this was a mental blockage – were they sure it was not a physical problem, as mum was losing the will to try to eat.
3. No exercises had been given post-operation – the extremely distended abdomen was making it impossible for mum to do anything other than lie down.
4. I was worried my mother was losing the strength to get better as everything was becoming so difficult.
5. In view of all the above I wanted to insist on next available bed at Newquay Hospital to improve mums state of mind and nursing care.

A meeting was arranged to discuss these concerns. The clinicians present all agreed that my concerns were highly appropriate. The Deputy Consultant present was dismayed to announce that the X-Rays had still not been reviewed and immediately made some rather heated phone calls. The oncology nurse arranged for the Palliative Team to become involved to give mum and I another line of support. The Ward Manager said she would review mum’s file to catch up on last week and would chase up the bed at Newquay. The oncology nurse also suggested that I to talk to PALS for some added support.

Within 20 minutes of the meeting, a medical doctor had arrived to examine mum. He estimated that she had approximately 1 – 1.5 litres of fluid in her chest cavity and said he was
ordering a drain of that fluid immediately. This was not done for 36 hours and when it was attempted, the fluid was too thick to drain off.

On the 21st of June Mum was moved to the heart wing of the medical ward.

On June the 22nd the attending doctor confirmed she did not have a heart problem at all, as her murmur was being managed by previously prescribed medication.

At 4pm the medical consultant arrived to do the completion of the chest drain. This was absolute agony for mum despite having a local anaesthetic and took some time to complete. Mum was exceptionally brave to manage this and relieved when it was over. She even managed to eat twice the amount she had been eating at a meal previously. The fluid that came out of Mum’s chest can only be described as about 1.5 litres of butterscotch sauce, obviously highly infected. A sample was sent off for analysis.

That evening the consultant and the oncologist visited mum to check her progress. She was in very good spirits and was laughing and joking with them. Separately, the consultant advised me that he envisaged mum’s recovery would now be very rapid, she could go to Newquay Hospital and possibly come back to Treslike from there for the last two sessions of chemotherapy. There was a high expectation now of positively going forward to a full recovery. I planned to visit in the morning and then go home to Derbyshire at lunchtime, returning the following Monday to establish the progress on a bed at Newquay. In the meantime I arranged for PALS to visit mum over the weekend and for them to bring her messages and photos by e-mail from all the family.

The next day, the 23rd of June, I received a call in the very early hours, from the nurses attending to mum. They said that her blood pressure had dropped considerably and that they were calling the doctor. They advised not to come in to the hospital yet and that they would keep me informed.

At 3am, mum’s condition had not improved and the nurses wanted me to attend in hospital, which I did. On arrival the doctor advised that they were struggling to get her blood pressure up and her condition was rapidly deteriorating. My mother died at around 4am.

Mum was suffering from cancer but was undergoing a course of treatment which at the outset was deemed curative. This treatment was proceeding as scheduled when she contracted pneumonia whilst in hospital as result of sub-standard medical and nursing care.

My mother wished to recover and tried to maintain a positive outlook even when she was very poorly.

Mum was subjected to carrying out impossible tasks without any consideration for the underlying pneumonia. She was patently too ill to perform these tasks and when we said so we were ignored by the nursing staff.
The care that mum received leaves me feeling that poor clinical practice, incompetent management of information and appropriate prompt action based on that information, and a lack of holistic and joined up care has led to my mother’s completely unnecessary death.
10) Mr Barry Woodward

“On admittance to Hospital I had been given a saline drip because I was dehydrated. When I was admitted to the ward the bag was replaced. I made the mistake, which was entirely my fault, of keeping my dressing gown on. The result of this was embarrassing. I had diarrhoea but could not use toilet paper because my right arm was restricted by the dressing gown and my left arm was restricted by injury.

I asked for the drip to be removed, until I took the dressing gown off. I asked three nurses and 5 healthcare assistants before my arm was released some six hours later.”

Mr Woodward was admitted to Derby Royal Hospital in October 2011, suffering from a gastric illness. He complains that nurses were not attentive to his needs, in particular when it came to the administration of pain relief. This culminated with his allegation that he had to prevent a nurse from administering an unexpected injection.

I was admitted to Derby Royal Hospital on the 6th October 2011. I made notes of my care during my illness, and when I read them again after I was discharged I felt it was important to contact the Patients Association and reveal all that happened. I hope that by doing so I can help to ensure that there will be significant improvements in the future.

I am a 68 year old insulin dependent diabetic, who lives alone with two cats for company, and began to feel ill on Wednesday the 5th of October. I was shaking, cold, and felt too weak to get out of bed until the afternoon. I turned on the central heating and returned to bed until 6pm. By then I felt even worse and used my mobile phone to call for an ambulance.

I had three telephone assessments, via the ambulance service, NHS direct and another organisation. At around 7pm a decision was taken to send an out of hours doctor instead of an ambulance. I don’t know why it takes three separate assessments over the phone to reach this decision.

I was told that the out of hours doctor would take up to 4 hours to arrive. Eventually she arrived just after 10pm, and the first thing she said to me was “why did you not phone for an ambulance”! I said that I had, but that she had been provided instead. She said that an ambulance should have been provided when requested, and she made the necessary telephone calls to arrange for an ambulance to take me to Hospital.
The ambulance arrived three hours later. I can see the hospital from my bedroom window and had I known of the delay I could have walked to Accident and Emergency within 15 minutes. Altogether it took seven hours for an ambulance to arrive after my initial request, and three hours after the doctor made a request.

I was admitted to the Accident and Emergency Assessment area. Whilst there I heard staff out in the corridor arguing about the disappearance of a patient’s medical notes. They eventually agreed to start new notes for that patient.

I was then moved to another assessment unit. Later that day I heard more staff arguing about the loss of another patient’s medical notes. Again the solution appeared to be to agree to start new notes. A discussion then ensued about what should be entered for earlier events. Several guesses appeared to be being made, and presumably entered. I could only hear, and could not see, the staff involved.

Before entering the hospital I was being treated by my GP for an injury to my left arm. He had arranged an X-ray and I was awaiting the results. Because I was admitted to hospital with a gastric problem, I was not receiving any treatment for my arm. I was taking paracetamol for the pain until a nurse saw and removed the tablets. She said a doctor would have to approve their use. I then asked three nurses (blue uniforms) and five Healthcare Assistants (grey uniforms) for pain relief. It was eight hours before I was given paracetamol.

My packet of paracetamol was not returned to me. Instead I was offered one tablet and told to ask if I needed more. Since it had taken eight hours of begging to get one tablet I wondered how long it would be before I could get anymore.

Later that evening a nurse appeared wearing a vest with the slogan “Drugs Issue- Do not Disturb”. I began to explain my need for pain relief when suddenly we were interrupted and the drugs nurse rushed away. She left my drugs out of the safe so I helped myself to the box of paracetamol. Nobody noticed.

The nurse returned thirty minutes later, without the vest. I asked her where it had gone and she said that there was no point in using it as I could see for myself that other staff would just ignore it.

On admittance to hospital I had been given a saline drip because I was dehydrated. When I was admitted to the ward the bag was replaced. I made the mistake, which was entirely my fault, of keeping my dressing gown on. The result of this was embarrassing. I had diarrhoea but could not use toilet paper because my right arm was restricted by the dressing gown and my left arm was restricted by injury.

I asked for the drip to be removed, until I took the dressing gown off. I asked three nurses and 5 healthcare assistants before my arm was released some six hours later.
I was then moved to a side room. My patient notes had disappeared, and a healthcare assistant happily offered to start new notes if I could remember the details that were in my previous notes! I loudly and firmly demanded that my existing notes were found, and that they were likely to be near to the bed I was in previously. This is where they were discovered.

By now I was well into my second drip bag when a Healthcare Assistant questioned where all of the fluid was going. I had only been asked to supply urine samples for measurement and recording. The Healthcare Assistant said that if the water is not coming out of my mouth, is not retained and was not coming out of the front, where was it going? From this point onwards the staff kept proper records of my urine and bowel output.

During the night I received blood sugar tests as well as the usual Blood Pressure, temperature and pulse. Then I was allowed to inject my own insulin. Early the following morning I overheard a male Healthcare Assistant telling the nurse that the blood sugar test meter must be faulty as he had done his own reading and it had been 2.1. At least two nurses tried to get him to go and see a doctor at once but he laughed it off and said if he felt ill next week he might find time to go to the doctor.

I have subsequently learnt that a fit young person can have a blood sugar level of 2.1 and be perfectly healthy. However I did not know it at that time. I did know the importance of keeping my own blood sugar levels above 4, and found it very disconcerting that the machine may have been faulty, or the healthcare assistant so ill that his judgement may be seriously questionable.

The consultant came around on Saturday morning and I had to forcefully ask for the results of the X-Ray on my left shoulder. He then told me the results, for which I was grateful.

I was moved to Ward 11 on the third floor, on the Saturday. I watched as another Drugs Nurse was touring the ward. She too had discarded her ‘do not disturb’ vest and was constantly harassed by one of the young men in the ward, until I spoke up and sharply told him to let her concentrate. He laughed and said that all the nurses were trained to multi-task. I pointed out that any errors would most likely not kill him. He went into a sulk.

I had been informed that, barring any complications, I would be released the next day. I was now feeling much better. That was until 10pm, when another drugs nurse (wearing her vest!) woke me up. I was surprised since I had not been told of any new drug issue. When I asked her to explain she said that I must have another Prophylactic Injection like the one I had that morning.

My internal alarm bells instantly started ringing and I said that I had been given no such injection. She said that the doctor had written it on my patient notes. This triggered more internal alarm bells!!! No Doctor had mentioned this to me. As I have already said I had heard medical professionals discussing the lost notes of other patients.
I asked the nurse what the injection was supposed to be for and she said that it was to stop internal bleeding! Internal alarm bells were now joined by Air Raid Sirens because I did not have internal bleeding, and had not had any for the duration of my stay in hospital. I flatly refused to allow her to administer the injection. This episode left me greatly concerned.
Helena Grimwood was admitted to Southend University Hospital on the 27th of September. In this account her daughter Hilary complains that her mother’s toileting needs were neglected by nurses, and that the cleanliness of the toilet facilities themselves leave much to be desired. She also talks about how her mother would become ‘desperately thirsty’ because she was not offered enough to drink, and how the situation could have been so much better if the nurses had taken the time to talk to her mother and find out her needs.

My 96 year-old mother, Helena Grimwood, was admitted to Castle Point ward, Southend University Hospital, via the Accident and Emergency Unit, on Tuesday September 27th 2011, having suffered a fall at her care home.

Two years previously she had been an inpatient at that same hospital. We feel that at that time she was truly neglected by the nursing staff—she was given nothing to drink, and barely anything to eat. On one occasion she was left with nothing to eat aside from a packet of crisps that had been left for her by the nurses. It was explained that she needed the salt as she kept pulling out her drip, which was needed to re-hydrate her. My mother was in an isolation, observation single room, next to the nurse’s station. Often when I visited her I helped her to struggle to the toilet as she had not been helped regularly enough by the staff. She is a dignified, self-aware, old lady, proudly independent in her personal habits, and so rather than soil the bed she made herself get out of bed to visit the toilet across the room, despite being in a much weakened state. To do this, she needed to pull out her drip.
The staff explained to me that the crisps were there (unopened) because she was confused and pulled out her drip. Her stay in the hospital at that time resulted in her suffering a heart attack, and we believe the poor care she received was a strong contributory factor to this.

After arriving at Accident and Emergency in September 2011, an X-Ray revealed a pelvic fracture and I was informed that this is managed with medication to control the pain. I was also informed by a member of the Accident and Emergency Team that such fractures heal in a few months. The doctor in A&E informed me that he wanted to discharge my mother back to her care home as this would be best for her. I insisted on her being admitted because I wanted another X-Ray of her hip as this did not appear on the X-Ray, and I wished to have an ulcer on my mother’s leg swabbed and cultured in order to get the best treatment. The ulcer had been sustained in the care home and had been unresponsive to their care procedures for months. The A&E doctor tried to dissuade me from getting my mother admitted as ‘more X-Rays could be harmful to your mum’ and because very elderly people respond better in an environment that they are used to, not in hospital.

I visited my mother every day, often twice a day while she was in hospital, until she returned to her care home in the late afternoon on Wednesday, October 5th.

On Thursday, 29th September, my mother asked to be taken out for a change of scene. I was told by a staff nurse this would be appropriate. I found a wheelchair and while taking my mother downstairs to the coffee shop I noticed a haematoma the size of a 50p piece on top of her head. It was palpable and raised. I asked her if she had hit her head when falling in the care home. She said emphatically that she had not, and the care home verified this.

I reported the haematoma to one of the nurses on the ward. However, when she looked in my mother’s notes nothing had been documented about this damage to my poor mother’s head. I commented that while the hurt to my mother wasn’t annotated, the damage was nevertheless there on her head, and was very real and evident. The nurse noted the damage to my mother’s head. I was told that there would be further investigation into the incident and its reporting/lack of reporting.

However, I heard nothing, in spite of requesting information while mum was on the ward. No-one could explain to me how my mother had been hurt.

My mother was discharged back to her care home on Wednesday, October 5th. By this time the damage to her head – ie, the haematoma – had faded somewhat, but the immediate bruising from that area has now dispersed across her scalp to cover a considerable area.

My mother has now informed me that while in hospital she was shifted up the bed by two ‘girls’, either side of her and with an arm each under each of her arms, and in being moved
up the bed her head came into contact with the rails at the head of the bed. My mother also now has a painful arm, which may be owing to this inappropriate method of moving a very elderly and very fragile person.

Also, on discharge, my mother’s sacrum was very red and sore; the skin had not broken. Whilst in Castle Point Ward (a stay of 8 days) she sat without cushioning protection on a hospital chair for most of each day. The fragility of an elderly person’s skin and the risk to it breaking down, should have merited preventative measures; for example, providing her with an anti pressure-sore cushion. There was an air mattress on her bed, which she occupied for around 10 hours overnight; she occupied her chair for around 12 hours each day with no protection for her bottom or lower back.

My mother is 96, and is still a strong, independent, woman, in her right mind, albeit a little forgetful. She comes from a generation that does not complain and stoically ‘puts up’ with the treatment meted out to them by people viewed as being in authority and whom she views as ‘knowing more than she does’, including care assistants.

I don’t actively seek evidence of neglect, but past experience has encouraged me to be vigilant about my mother’s care in hospital. This is not the first time my mother has experienced poor treatment, benign neglect and a lack of ‘duty of care’ in Southend University Hospital. Increasingly, I view my mother’s hospital referrals as occasions when her comfort and self-esteem places on me the responsibility for monitoring the basic care she receives. I have not complained about previous neglectful and, it must be said, unwittingly cruel treatment, but on this occasion I made a complaint as I felt the care she received really should not be brushed aside.

The following conclusions regarding elderly care are based on my observations accumulated over the many years of caring for, and monitoring the care of, my mother. Subjectively acquired they may be, but it’s possible that my conclusions and perceptions may yet contain nuggets of information that could lead to some inspired care planning for all much older people in hospital.

The need for deference. My mother prefers to be addressed as Mrs Grimwood by people she doesn’t know very well, and by people who are very much younger than herself. People of 96 are unused to over-familiarity but would never be impolite and say how they would rather be addressed. My mother was married for nearly 50 years until widowed, and is proud of her status of “Mrs Grimwood”. She was always addressed by her first name, however, even by people less than a quarter of her age.
My mother is in her right mind and has full capacity to make her own decisions. This will have been evident from the documents sent from her care home. Thus, it’s right that she is asked directly about her hydration, toileting, nutrition, pain level.

However she is very deaf – even with two hearing aids. My mother will NOT admit to NOT being able to hear a person asking her a question (which is likely the case with many elderly people). She may well agree with whatever is being said to her in order to appear helpful, and to gloss over the fact that she cannot hear the person speaking to her – she is very proud, even when in acute pain.

My mother will often tell me, her daughter, ‘I’m 96 and it takes my brain a while to catch up. Speak more slowly and more CLEARLY’. She recognizes that she can’t assimilate and process information quickly these days. Her understanding of this is an indication that she is not dotty! It’s a perfectly reasonable request for those speaking to her to take a bit more time with her.

Because her view is that ‘there are others worse off than me’ and ‘nurses are so busy’ she will take the route of NOT BEING A NUISANCE to nurses and health-care assistants and rather than ask them to repeat the question – which is time consuming (e.g. ‘they are so busy’) – she responds by guessing what’s being asked: ‘no I don’t need anything I’m alright thank you’ (e.g. she ‘doesn’t want to be a bother to busy people’). Two minutes extra spent with her, speaking slowly and clearly, would elicit a truthful answer and result in proper care of her.

Every time I visited my mother during her 8-day hospital stay, she was desperately thirsty. She would drink 3 beakers of water or juice as soon as I arrived, then a beaker of tea; I found her thirstily the same in the evening. She could not fill the beaker herself as the lids are difficult to remove/she hasn’t the strength to pour from a jug of water and anyway, she is too ‘shaky’ to pour the water without spilling it. So she tells herself she is not thirsty, and dehydration leads to confusion and bladder infections!

My mother would ask me to take her to the toilet when care assistants had been dilatory. Each time (4 times) this was an urgent request, and not because she had an infection, or had been drinking a lot – she had not been toileted for a long time. Despite the pain from her fractured pelvis she controlled her bowels in order to stoically and painfully walk to the bathroom to use the toilet with me.

Incidentally, the toilet seat was smeared with faeces yet her need was so urgent she sat on it anyway. She couldn’t wait for me to clean it. Her frailty meant she used her hands to steady herself on the seat as she sat down.
Very elderly people often have such dignity and consideration for the feelings of others that they will desperately try to control their bowels/bladders until a nurse/healthcare assistant has the time to take them to the toilet. That elderly person should certainly be afforded the comfort and consideration of being aided to go to the toilet far more frequently than is the practise now.

Under the heading: Improving Services the hospital’s website claims:

‘The team regularly provides wards and departments with information about the way in which patients, carers and visitors view their services through the comments and complaints received.

‘This helps wards and departments review the way that they deliver their services, so that there is a constant focus on improving care and service delivery to provide services that our patients tell us they want.

‘We also provide training and awareness sessions to staff at all levels and in all specialist areas based on REAL PATIENT EXPERIENCES [my emphasis] and we:-

• Actively promote service improvements.

In my letter to the Hospital I stressed to those who make up the many, many tiers of obfuscating administrative responsibility that:

My mother is a REAL person.
Often over the past few years she has been a REAL patient.
Her experiences in hospital of neglectful care, and lack of duty of care, have been REAL
I have observed her very REAL desperation with regard to thirst
I have observed her very REAL desperate anxiety when no nurse/healthcare assistant has responded to her urgent need to go to the bathroom
My mother suffered very REAL severe bruising to the top of her head
This bruising was very possibly the result of the very REAL inappropriate handling of my mother and possibly the very REAL paucity of training with regard to the correct approach to moving elderly, frail people
The redness and soreness on my mother’s lower back is the very REAL result of a lack of proper seating for her.

In their policy documents the hospital make it clear that it is their objective to ensure that patients are involved in their care. However where very elderly patients are concerned such ‘involvement’ is mere lip service. My mother can certainly participate in becoming ‘fully engaged’ in her own treatment but only when she has been awarded the empathy and timely consideration that her amazing age deserves, and only when her immediate needs for hydration, toileting, pain relief, nutrition have been humanely considered.
12) Patient A

“The horrible thing is that my mum was not alone in this situation. I witnessed the old lady in the bed opposite being left with a bowl of steaming hot soup which she pulled towards her before I could stop her, and poured it all over her upper legs. When the nurse was called she said she was busy and would be along in a minute! The lady suffered scalding to her legs and the Doctor had to be called. ”

Patient A was admitted to hospital after suffering from a stroke. She was transferred to a further hospital, and in this account her daughter catalogues the failings of care that occurred on the ward there. She complains that nurses were inattentive and uninterested, that they failed to give her mother proper assistance with her toileting needs and even failed to help patients in potentially dangerous situations. Her mother felt that whilst on the ward she was treated like a ‘lump of meat on a butchers block’. She has remained anonymous because she is concerned that speaking out may jeopardise the care she and her family receives in the future.

My mother was taken into hospital after suffering a massive stroke due to a blood clot.

The next day mum was transferred from her initial hospital to a different one. Our experiences there, and the care that was given, was nothing short of horrendous.

Some of the nurses did not appear to be attentive to the needs of patients at all. Any request for assistance had to be made at least two to three hours in advance of it being needed, because a long wait was not unusual. Often your request went completely unanswered.

Whenever you needed any help from a nurse you generally had to ask several times. You could see that the nurses were becoming irritated by your reminders, but this irritation didn’t seem to make them respond to the needs of patients or relatives any quicker.

They would often complain that the reason they couldn’t respond quicker was because the ward was understaffed. Patients on a stroke ward are, because of their condition, heavily dependent on nurses. There shouldn’t be staffing issues on a ward like that.

However, even if there should have been more nurses to cover that many patients, the effects of the understaffing shouldn’t have become a problem for patients. Its up to the hospital to sort it out, not the patients to bear the brunt of staffing issues.

The ward was dirty and untidy. On at least two occasions during my mother’s stay, I arrived to find urine soaked pads left on her bedside table, alongside her drinking water. The over bed table was never cleaned and we made sure we did it ourselves each day with antibacterial wipes. The shelf behind mum’s bed was thick with dust when she was first admitted, and I had to clean this myself.
Quite often you would find sticky patches on the floor of the ward, or things would be dropped and simply left where they fell.

In the early days mum appeared to be in control of her bladder as she knew she needed to go to the toilet, but as she was unable to get up she would ask for a bedpan. It would take so long for the nurses to bring her one that she would often end up being forced to wet herself, which she found extremely degrading.

When asked by mum for a bedpan one nurse said “Look, it’s just as easy for me to clean you as it is to put you on the bedpan. Just do it and I will sort it out.” You can imagine what this sort of response does to a fragile and frightened old lady who was always very particular about her appearance and personal hygiene.

This same nurse left my mother lying in her own diarrhoea. By this time mum had a catheter in place, so as well as the outrageous and unnecessary affront to her dignity, this represented a real infection risk.

After 9 weeks mum was transferred to a rehab hospital nearer to home. I had left at the hospital two changes of day clothes, a dressing gown, socks, slippers and a fleece. However, on what was a freezing cold day, she had been discharged in a short sleeved nightgown, with just a blanket over her.

She had food all down her chin from the last meal that she had eaten. She was also beside herself because she had asked for the bedpan just before leaving the hospital, but her request had been denied. You can imagine that this resulted in her soiling herself whilst in transit.

The horrible thing is that my mum was not alone in receiving poor care at this hospital. I witnessed the old lady in the bed opposite being left with a bowl of steaming hot soup which she pulled towards her before I could stop her, and poured it all over her upper legs. When the nurse was called she said she was busy and would be along in a minute! The lady suffered scalding to her legs and the Doctor had to be called.

Another patient had waited so long for the lavatory that she stood up and urinated on the floor. The nurse came and grabbed a towel from her bedside chair, mopped the floor with it and then left it on the chair! Luckily the lady in the next bed told the lady’s daughter-in-law and she was able to get rid of the towel.

Most of these patients could not sit up on their own. Despite this, meals were brought and left on the over bed table. It was often left to visitors to try and lift the patients up so that they could feed them. I asked why the nurses could not come round before meal times to make sure everyone was ready for their evening meal, but again was met with the answer that this was not possible because they were short staffed.
Very often the meals would be cold by the time the patients were sat up, meaning that they became even more inedible than they have started out. The pureed food offered to these patients was abysmal. I had to take in food every day for mum- I couldn’t expect her to eat what I would not.

Mum herself said that during her time in hospital she had been treated like a ‘lump of meat on a butchers block’. I feel extremely angry that my mother’s final days were so degrading and frightening. I have to say that not all staff were like this, some were very helpful and caring towards patients. I remember walking down the corridor praying that certain staff would be on duty as I dreaded the way that I virtually had to crawl on my hands and knees begging for help from some staff.

When I wrote to the hospital to tell them about the problems and lack of basic care I received a reply which more or less said I was exaggerating or was being untruthful. My only reason for writing to them was to try to alert those in charge to the woeful state of affairs on this ward but they obviously did not care and just closed ranks.

I feel strongly that this sort of attitude should not be allowed to carry on. These elderly people deserve compassion and the best of attention.
13) Jessie Thayer  
By her daughters Angela Perry and Sally Fothergill

“Mum has always been very particular about her appearance and personal hygiene. We found it hugely distressing to find her with dirty fingernails and dirty teeth. She also had food all over her clothes. We took an apron in with us for mum to wear when she ate, but it was barely used, unless a member of family was present.”

Jessie Thayer was admitted to Hospital in 2011, after suffering a stroke. She had been treated at the same Hospital the proceeding year, and received care that was so poor the family subsequently made a complaint.

This account, written by her daughters, shows that the level of care received had not improved since her time as a patient at the same hospital in 2010. Nurses did not attend to Mrs Thayer’s Hygiene needs, leaving her family distressed by her appearance. Angela and Sally also witnessed their mother, and several other patients, being left without food because they could not manage to eat on their own, for example carrying out a simple task such as opening a sandwich packet.

Finally, their account shows the value of a successfully handled complaint, leaving the sisters to say that their faith in the hospital is restored.

Angela and Sally’s Account

Mum was admitted to Frimley Park Hospital as an emergency admission on Monday the 7th of March 2011. It was thought that she had suffered a stroke, so she was admitted to the stroke ward later that day.

The Doctor that treated her on the stroke ward decided that she had in fact suffered an epileptic fit, and after almost two weeks she was moved to the G3 rehabilitation ward. Up until this time her care was good, the staff were caring and the information was readily available. We felt that mum’s consultant in particular was interested in her and her condition, listened to the information given by my sister and mum, and proposed a course of action which was in mum’s best interests.
2010 Experience

Mum had stayed been a patient in this hospital for around a week in 2010, and most of that stay was spent on wards F7 AND F8. On that occasion the medical care that she received was extremely good, and the nurses were very kind to her, but I still had to write a letter of complaint.

During her 2010 stay we had found it very difficult to get any information on her condition and treatment. Nurses would not say anything over the phone due to patient confidentiality, and with only evening visiting it was not possible to speak to anyone who was aware of what was going on. My mother, who was at that time 90 years old and very deaf, also suffered from memory loss.

This meant that she was not able to remember anything that she had been told by a doctor. It was only when I mistakenly arrived on the Thursday to bring her home that I was able to speak to a doctor and find out more about her condition.

I say that I arrived mistakenly because I had been told on the Wednesday that I would be able to bring her home. I rang the ward on Thursday afternoon and was informed that mum was sat in discharge waiting to be collected. I duly arrived on the ward to discover that this information was wrong, and that they were awaiting a social services assessment of her needs, which would not be completed until after the Bank Holiday weekend, on the Tuesday.

When I phoned on the Tuesday after the Bank Holiday I was told that there was actually no need for a social services assessment as she already had a care package in place. I had already explained this to them, and that transport had been arranged to take mum home that afternoon. This was very upsetting, as mum lived with our ninety year old father, and I or my sister should have been there to help settle in. By arriving home alone and in Hospital transport mum would have become even more confused.

Before mum had been admitted to Hospital she was found to have an ulcer on one of her toes, and I was due to take her back to the practice nurse. Of course this wasn’t possible once she was an inpatient. I asked the medical team whether someone could check it and was told that this would not be a problem. However as far as I and the nurse who discharged her are aware, it was never looked at.

The original dressing was still on so I imagine she didn’t have her feet washed or examined during her time at Hospital. When I visited her the night after her admission I noticed that she still had day old blood in her fingernails, and I had to arrange to get her hands cleaned properly.
Given these experiences the previous year, I was obviously apprehensive about the care that my mother would receive this time around. These concerns were realised when I visited the ward for the first time.

The atmosphere and general feel of the ward was really quite distressing and mum herself was very upset. The room she was in was completely bland, and there was no television to look at or window to see out of; because of this mum was not able to tell whether it was day or night. It would appear that for the majority of time mum was just sat in her chair, or was on her bed, with no stimulation at all. I took in various games and activities which the family used with her when they visited.

In the time mum was in hospital she incurred several injuries. She suffered a gash on her arm when she fell whilst being helped out of bed on the stroke unit; a pressure sore; an abrasion on the back of her left leg and a cut on the shin of her right leg where the walking frame was allowed to fall on her. These injuries were dressed but the dressings were changed infrequently, and often only when requested by my sister or myself.

There also seemed to be a lack of staff as it could be very difficult finding help when needed. My sister took one patient to the toilet and helped her undress, because she was unable to find a member of staff to help. We were aware of patients ringing their help bells which were ignored by staff, even though on at least one occasion a nurse was sitting at the nurse station. As a family we felt like every conversation with nurses had to be a confrontation.

During mum’s stay the ward was closed to visitors for 4 days due to an outbreak of vomiting and diarrhoea. However when we rang to find out the situation on the second day of the closure, the nurse from the ward didn’t even know that it had been isolated. I found this worrying to say the least.

We were not happy with the attitude of some of the members of staff who made us feel like we shouldn’t be there. One nurse was even overheard to say that the work would be ok if it wasn’t for the relatives. There were however two healthcare assistants and a sister who were very helpful.

The meals were good but some patients needed more help than was offered. I often found that I had to help the lady in the next bed to mum with her food. One evening mum had ordered sandwiches but when I arrived hadn’t eaten them, because she wasn’t able to get into the packet. Her fortified drinks accumulated in her basket as she didn’t know what to do with them, and she was unable to open the containers.

Mum has always been very particular about her appearance and personal hygiene. We found it hugely distressing to find her with dirty fingernails and dirty teeth. She also had
food all over her clothes. We took an apron in with us for mum to wear when she ate, but it was barely used, unless a member of family was present.

Her hair was unwashed. An appointment was requested with the hairdresser but unfortunately she was on sick leave. Eventually a Health Care Assistant washed her hair, for which we are extremely grateful.

My mother over many years suffered from sore eyes and frequent bouts of Conjunctivitis. We pointed out to the medical team how red rimmed her eyes had become, and requested some kind of treatment. The response was repeatedly that eye drops were being administered. However these were ‘Pilocarpine’ which my mother used for many years following cataract surgery, they were not a treatment for Conjunctivitus.

When my sister eventually got quite cross with the staff nurse and offered to bring in the prescription drugs for her eyes herself, a doctor visited. My sister felt the doctor was quite patronising and although she did not doubt our word in relation to mum’s medical history, she also said she would have to monitor the situation herself.

Still nothing was being done, however after another request a blood test was taken which we were told showed no infection. However a few days later we noticed that drops were being administered.

The cleanliness of mum’s clothes was a constant issue. In the handout provided by the ward it requests that dirty washing be taken home regularly. But the ward staff didn’t put mums dirty clothes into blue bags as they were supposed to. Instead they just threw them into the locker, mixing them up with her clean clothes.

On two occasions mum was left with no batteries in her hearing aids. As she is profoundly deaf you can imagine the difficulties that this caused. She had new batteries in her handbag, and it was also very easy to collect these from the reception desk at the main entrance. However none of the nurses did this for her.

In all mum was in hospital for seven weeks, and five of those weeks were spent on the rehabilitation ward, waiting for a social services assessment of her needs. When we spoke to the social worker about the lack of stimulation we were told that Frimley Park was an acute hospital and not a rehab hospital. If that was the case why was she not transferred?

It is a great pity that rehab facilities on the Geriatric Wards are not as good as they were in Fleet Hospital, where mum was treated for a stroke several years ago. There was no lounge where mobile patients could meet, and perhaps be given activities. I am sure that this, and some interaction with others, would stimulate them greatly.

Most of the patients that I spoke to that were visiting elderly relatives felt the same way. We all felt that we were banging our heads against brick walls in trying to get some help. One man kept saying that he wanted to get his mother released- as if she was in prison! We
felt the same. It really doesn’t say much about the treatment she received that we feel she would have been better off if she had been in a prison.

When mum was discharged from hospital we wrote formal letters to the Chief Executive and Head of Nursing at Frimley Park Hospital listing our concerns. We sent copies to the local MP, the Hospitals Patient Liaison Organisation, and the Patients Association. The Patients Association Helpline offered support on the next steps to take. Following receipt of those letters we were contacted by a PALS coordinator (Patient Advice and Liaison Service) and subsequently attended a meeting at the Hospital with senior medical and nursing staff to discuss issues raised in our letters.

We were pleased to find that our complaints had been taken seriously, with many of our concerns having been addressed and others in the process of being dealt with. The management team were ‘ready to listen’ to our account of our mothers treatment whilst under the care of Frimley Park Hospital, and anxious that improvements were made to procedures on that particular ward. They appeared to be grateful that we gave specific details enabling practices to be re-examined and were receptive to any suggestions made by us.

A recording of this meeting was sent to us and we were asked if we were happy with the way in which the hospital had dealt with our complaints.

We felt that our complaints were dealt with efficiently and effectively. The effort of writing a formal complaint was worthwhile and we would hope that others would do the same, and that other Hospitals would react in the same way.

Unfortunately Mum was readmitted to hospital a few weeks later but this time we had no complaints at all and she was very well cared for. Our faith in Frimley Park has been restored.
14) Brian Smith, by his wife Margaret Smith

“The nurse in charge arrived telling me that they wanted to move ‘the body’. That wasn’t a body, it was my husband.”

Summary

Brian Smith was admitted to the Pilgrim Hospital Boston in January 2011. Throughout his time on the ward his wife Margaret faced a constant battle to ensure that his medication was administered when required, that he had access to his buzzer, and that he received basic comforts such as an extra pillow. She was left alone and searching for nursing staff as her husband passed away.

Margaret’s Account

From A Hospital Bed

When destiny throws down the newest Mantle
   We lay in quiet acceptance on her shawl.
   In peace we sleep and thank the lord
      For times both good and bad.
   In war we cry and curse at good
      That life could be so short.
Tonight I shall lie wide awake reflecting
   Of how the hand of fate stepped boldly by.
And stole my life, once piece by piece
   In secret from my soul.
I waited for myself to wake
And say it wasn’t so.
The power to walk, that now seems to escape me,
   The will to live increases day by day.
   The power to live as children live.
A mothers waning care
   I tell myself it isn’t so.
My heart is beating there
I hear you whisper words I cannot answer.
I watch you smile the loving way you do.
I take my heart and give it now.
   In thanks for better times.
Brian’s health had been deteriorating for the last eighteen months and by December 2010, and he had become extremely lethargic and was in need of almost constant oxygen. I knew that, given the decline in his health, his long term outlook was not a positive one. We had discussed his prognosis and Brian decided he wanted to die at home adding “I want to live as long as possible”.

On Friday the 21st of January it was agreed that Brian would be admitted to the Scarborough Ward of Skegness and District General Hospital, because he would need further medication for his worsening chest infection, which were not available to him at home. If it had been possible to administer intravenous antibiotics and Furosemide without going to hospital Brian could have had his wish and I could have given him constant care. The GP offered him a bed in the local hospital. As he was feeling so unwell Brian gratefully accepted, saying “Somebody has to do something for me”. Nothing was done. I have since discovered that none of the nurses at Skegness Hospital is qualified to administer infusions or fit a cannula for intravenous injections, so leaving them unable to give Brian the antibiotics and Furosemide he needed.

On Saturday the 22nd I went to visit Brian, taking a new supply of antibiotic tablets supplied by the local pharmacist. When I arrived the medication was snatched from me by the sister on duty, and I had to repeatedly stress the importance of administering the drugs, as they hadn’t been administered and were overdue. The ward sister finally administered the drugs after my second request.

Brian was in a single room with a television, he was not attached to any medical monitoring equipment to check his oxygen levels, blood pressure or respiratory rate, despite his heart failure, arrhythmia and chest infection. He was struggling to breathe, and asked me to get him more pillows. The nurse that I spoke to said that they did not have any more pillows available to give to him, and instead proceeded to raise the head end of the bed. This was visibly causing Brian a great deal of discomfort, but she carried on until I insisted that she stop.

When I returned to the ward that afternoon I was amazed to discover that new pillows had been found, Brian had spilt his water over the original pillows. I don’t understand why a nurse couldn’t have got these sooner. By this stage, to the best of my knowledge, he had not been examined by a doctor, and no medication had been prescribed to treat his breathing problems.
At 5.27am on Sunday the 23rd of January I received a phone call from the hospital to say that Brian had been taken to the Pilgrim Hospital by ambulance because his condition was deteriorating. I had to wake up my neighbour and ask him to take me to the hospital as quickly as he could. When I arrived Brian was in the resuscitation room, being well cared for.

Brian told me that he had fallen out of bed twice, and knocked over his water again. He also said that he was unable to reach his buzzer, and that “I could hear a TV, it sounded like a film. Women’s voices laughing. Nobody heard my calls for help”. A staff nurse at Skegness Hospital later denied that this had all happened, and said that Brian was hallucinating. However I have photos of the bruising, which I believe he sustained when he fell out of bed.

Brian was given a Furosimide infusion and was catheterised to remove excess fluid. The latter procedure left him in great pain. It leaked and he seemed to be permanently urinating.

Later that day Brian was transferred to the Critical Dependency Unit, still at the Pilgrim Hospital, and his prescribed medication was not given to him, despite the fact that it was again overdue. The leaking catheter was causing Brian’s bed to become soaked, and it was still giving him a great deal of pain. It was only after I pointed this out to the nurses and asked them to make Brian more comfortable that they came to change the sheets.

One of the nurses shouted at Brian to “stay sitting up!” despite his protests that he was physically unable to. Before I left that night they had to change the bed sheets again, because the catheter was still leaking.

Shortly before leaving that Sunday the consultant arrived, accompanied by several other doctors. I was excluded from my husband’s bedside, but was able to overhear that he had double pneumonia. The consultant left without acknowledging me.

On the 25th of January I called the hospital and was told that he had been moved to ward 8B. The nurse I spoke to told me that Brian had had a good night. I asked the nurse if she could help him phone me as he found his mobile difficult to hold. When I spoke to Brian he contradicted the nurse’s assessment of his night.

He said that his breathing was much worse, and that he was in extreme distress. When I visited later I had to wait twenty minutes for the lift, because priority was being given to beds and equipment. I found this frustrating, as it meant twenty minutes less time with Brian.

Although he was still fully conscious and aware of his surroundings, it was clear that Brian was struggling for his life, and this was confirmed when he was examined by a pleasant doctor. I sat by his bed and bathed his clammy face and neck.

Brian was due to be administered an antibiotic at 2pm and he was anxious that this should be done as he felt this would improve his breathing. This couldn’t be done because the
cannula had been removed. I went to a nurse’s station to ask a doctor to do this and eventually a doctor arrived and fitted a new cannula.

I expected the doctor to administer the long awaited Antibiotic at this point. However he explained that this had to be done by the nurse in charge. I returned to the nurses’ station to ask for the nurse in charge to do this as a matter of priority, but he was too busy with other patients. Too busy to attend to a dying patient in their time of need. That nurse did not attend to my husband until after his death.

I continued to try and comfort Brian. We discussed plans for the future, and in particular how we would extend his new train set, which remained unopened in its box.

After a time Brian became restless, saying that he was trying to turn over. He grabbed the bed rails, his body contorted and his eyes looked upwards. I pressed the buzzer but didn’t get any response. I had to run into the corridor screaming that I needed help urgently. There was a female wearing a white coat who I assumed to be a doctor. She looked at me askance and carried on with her paperwork.

I ran back to Brian’s side, threw the pillows on the floor and gave him mouth to mouth and chest compressions, as he clearly wasn’t breathing. Eventually a ‘crash team,’ arrived. A nurse took over chest compressions and the doctor checked his vital signs. The nurse with the resuscitation cart commented that something was missing from the cart, which possibly made it unusable.

I kept calling Brian’s name to try and wake him up, but the doctor said that it was not possible to revive him, so I agreed to stop the resuscitation. I couldn’t believe that I had lost the love of my life.

Someone asked me whether I needed help packing his belongings. I said yes, but nobody came. The nurse in charge arrived telling me that they wanted to move ‘the body’. That wasn’t a body, it was my husband.

I asked the nurse whether it would be possible for me to use the toilet. He said that that I would have to use the toilet eight floors down, where I could wait for my transport. Nobody seemed to care about how I was getting home.

I sat by the bed and kissed him, stroking his hair. I took photographs to remind me that he was not alive anymore. Nobody from the bereavement service, or the Chaplain came to help me. No hospital staff offered assistance. I had to phone neighbours and ask them to take me home.

Two nurses eventually came to wash him, and they let me stay. I combed his hair and cut a lock to take home with me. I watched it grow darker until my neighbours came and took me home.
I am still trying to pursue a complaint with Pilgrim Hospital. It has been extremely difficult to do this on my own, and I do not yet feel that my questions have been answered. I will continue to pursue my complaint until I feel that people have been held to account for the appalling care that Brian received.

WITHOUT YOU
Without you there will be no more tomorrows,
Just leaving me a life of yesterdays.
The heartache and the memories tear my sorrows
As I slide down beneath the icy waves.
Without you in the evening of our love -time
Remains behind a life I can’t forget.
And when I look to see your face beyond me
I clearly see the features that I met.
I dream of days when castles filled the sunshine
And parting ways was never on our minds.
Will I ever see another Springtime
When leaves stretch out to meet the Summer skies?
I,
I’ll pour my share of memories in a bottle
That floats upon the ebb and flow of life.
There will never be one more tomorrow
But I will always be your be your darling wife.
This was the last poem I wrote for Brian.
An extract appears on a memorial in our front garden attached to a chainsaw carving of an eagle.
Margaret Smith
15) Patient B,
By her daughter

“She was not given a choice of food, calcichews for her bones, was not hoisted, not hydrated nor visited by a physiotherapist. Every day that I visited, the first thing she said was “Give me a drink!” It was only after I repeatedly insisted that my mother be offered these things that she gradually was given them over the weeks that followed.”

Summary

Patient B was admitted to hospital on January 11th 2011, after a fall which led to her sustaining a fractured arm and a previous hip injury.

In this account her daughter complains that the Hospital Staff misinterpreted her mother’s pain relief needs, did not give her mother enough to drink, often failed to keep her warm enough and did not listen when she raised her concerns.

My mother, , aged 94 years, was admitted to St Richard’s Hospital, Chichester on Tuesday January 11th 2011 following an incident at home in which her right humerus was fractured. She already had a suspected hip fracture which was being treated conservatively at home with analgesics (prescribed by her GP) and the advice of the community physiotherapist.

As her main carer, I believed, along with her immediate family and GP, that she was too frail to undergo surgery; and the GP wrote a letter to this effect which was shown to the medical staff in Accident and Emergency on admittance.

Prior to the incident, and despite the hip fracture, my mother was able to sit reasonably comfortably, feed herself adequately and enjoy her food. She was *compos mentis* and enjoyed watching TV and going out in her wheelchair. I was aware that she had a moderate degree of kidney failure and a degree of anaemia; she was hypothyroid (controlled well with Thyroxine), and had osteoarthritis of the spine which caused her immobility for more than eight and a half years.

In Accident and Emergency a full medical history was given and the GP’s letter shown, including the fact that she had not been weight-bearing for many years. This was subsequently repeated in the Acute Medical Unit (AMU). In the AMU she was administered Oramorph and large doses of Paracetamol, which the GP’s letter had stated she was...
sensitive to (these caused vomiting and confusion), insulin to stabilise her potassium-sodium balance, blood and antibiotics for a Urinary Tract Infection and a non-existent chest infection.

On the 14th of January my mother underwent a hip replacement without my consent. She was not in a fit state to give consent herself due to the medication she was given. I queried this with the ward staff (I had been on the ward for 10 hours each day in the preceding days) and arrived as my mother was being taken down for surgery; and later with the anaesthetist when my mother had already been taken down (because I had asked to speak to someone involved) and was told that consent was not necessary. When I mentioned that my mother had not been walking for many years, the anaesthetist told me that the operation was necessary to make my mother “easier to manage” by the nursing staff and that they did not know “how long she would linger”.

That same day I was told by the consultant’s locum that my mother was extremely ill and that she would be put on active treatment but if she had a relapse, she would not be resuscitated. No discussions took place with my mother or myself about the decision not to resuscitate in the event of an emergency.

The locum said that something had gone “terribly wrong” during the hip replacement procedure. She did not explain what had gone wrong. The active treatment (as far as I know) consisted of antibiotics, morphine patches and IV analgesics, anti-emetics (for vomiting) oxygen to help with her respiratory rate, saline and glucose drips in succession and several units of blood.

I was told three days after the operation, on the 17th of January, that it had been unsuccessful because of my mother’s advanced osteoporosis; and that the end of the prosthesis shaft had penetrated her femur. No apology was forthcoming and the surgeon believed that she had been mobile and told me people could walk again even with after this kind of injury was sustained during an operation.

He said that, had he known that my mother had not walked for so long he would not have operated, I asked him why he had not spoken to me (I was in the hospital all day during the days preceding the operation and arrived just as my mother was being taken down); I also asked why he had not looked at her notes or telephoned me (the family had left several numbers). He could not give a reason. I and my older brother refused the offer of a second operation.

On the 20th of January my mother’s treatment caused her terrible suffering: by this time she had not eaten for 10 days and was regularly vomiting; she was semi-comatose, all her limbs were swollen with oedematous [excessive fluid in the cells] and she was losing fluid from
her arms. I asked if a more gentle approach would be possible and on my return to the ward, less than two hours later, all monitors and drips had been withdrawn and I was told (again without any discussion) that my mother was on the Liverpool Care Pathway and had only days to live. The details of the Plan were not explained to me until I was able to ask the consultant’s locum the next day who said she would be under the care of “our wonderful nurses”.

On the Liverpool Care Pathway my mother was given irregular care and irregular doses of morphine, dependent on which nurse was responsible on that particular day. She was still semi-comatose but continued to want to eat and drink. She was able to communicate, when the effects of the morphine wore off slightly, that she would like to return home.

Nursing care was infrequent throughout the next few days. Mother not washed until 12.15pm (lunchtime) on the 23rd of Jan, and was in fact only washed that day after I insisted. It also became apparent in the course of those days following the adoption of the Liverpool Care Pathway that my mother was clearly not ready to die; she was eating a little and was asking for drinks, I requested that she come off the Liverpool Care Pathway.

On the 28th of January I had a meeting with the consultant and a doctor from the local hospice. I had requested that my mother be cared for by the Hospice at Home Scheme when I believed she was dying. Because she had been on irregular doses of intra-muscular morphine and morphine patches, they decided to ‘rationalise her morphine intake’ by putting her on a 12 mcg Fentanyl patch every 3 days for pain control (morphine) with supplementation by Paracetamol if needed. I showed the consultant a copy of the GP letter.

The next day mother returned to the main ward but was not given any active treatment. It was obvious from the start that she was being treated very differently from the other patients on the orthopaedic ward. She was not given a choice of food, calcichews for her bones (as she suffered from osteoporosis), was not hoisted, not hydrated nor visited by a physiotherapist. Every day that I visited, the first thing she said was “Give me a drink!” It was only after I repeatedly insisted that my mother be offered these things that she gradually was given them over the weeks that followed.

However, she was never offered hydration or rehydration (unlike the other patients) even though there was a hospital acquired infection (diarrohea and vomiting) on the ward which was cordoned off for two weeks during February.

On the ward, my mother experienced intermittent hypothermia over a period of 2-3 weeks. This was not always noted by the staff and I had to alert them. She was never showered, her dentures were never cleaned, put in or taken out, and her own teeth were never cleaned. She was unable to use her hands because of contractures.
On the next day staff expressed concern that mother had been shouting out “leave me alone!” when the Healthcare Assistants moved her; and interpreted this as her way of saying she needed more pain control. They did not ask her if she needed it. However, when I asked my mother if she was in pain, she said “no” and that she was “comfortable”. The staff did not believe me when I said the shouting out was more from fear than pain. Unfortunately my mother is very deaf and tended to nod if she could not hear. I constantly explained this to the ward staff.

On the 5th of February the ward seemed very short staffed. I think that this may have caused the nurses to forget to administer mother’s Thyroxine, and I had to do this myself.

On the 6th of February my partner looked at the drug chart and noticed that the prescribed dose of the Fentanyl patch had been more than doubled to 25mcg. This concerned me because it should be used with caution in elderly people with reduced kidney function. It is also associated with altered mental state leading to aggression. My mother was continuously bad-tempered on the lower dose. Anyway, she had good pain control and it was shouting from fear which the staff interpreted as pain.

When I arrived the following day, my mother drank for over 10 minutes (from a dessert spoon). I alerted staff to mother’s low body temperature. As a result the hot air blanket was put on.

I was told by the Ward sister that I should stick to normal visiting times and should not come on the ward in the mornings because she had complaints from other patients. (At that time all the patients were very old, were deaf and sleeping most of the time). However, she did say that she would allow me to come in at lunch and supper meal times so I could feed my mother.

On the 8th of February I found mother dehydrated and hallucinating. I spoke to a doctor on the ward who said he would not rehydrate her even though I informed him she was hallucinating (I was so taken aback that I forgot to ask why), but he agreed to try sitting her in a chair. I overheard him saying to the staff nurse “Try it just once.”

The following day I challenged nurses as they tried to give my mother more pain relief, because I felt they were only administering it because they had misinterpreted her needs, and were not aware of the instructions of the consultant. I explained that mother was comfortable and had told me that she was not in any pain. I am not sure they were aware that my mother had by now come off end of life care (the ward sister had shown surprise when I told her the evening before), or that the consultant had ‘rationalised’ the dose.
On the 11th of February mother was very thirsty. She was completely forgotten at breakfast, and her tea was just left at the end of her bed, where she couldn’t reach it. A few days later my partner looked at the drug chart and noticed that my mother had not been given Thyroxine for three days. I was naturally concerned as she had been on it for 30+ years. The staff nurse at first said she did not know why and then that the Endocrinology Team had stopped it.

That evening I asked again about the Thyroxine. I was told that the Endocrinology team had taken her off Thyroxine but that it had now been reinstated.

The next day, after days of persistently asking, it she was hoisted into the chair for the first time. This, only after I had asked the Patient Advice and Liaison Service to intervene on my behalf.

On the 19th of February mother was obviously dehydrated. The ward doctor said she would need to be given IV antibiotics before changing her catheter.

On the 20th mother was quite bright and chatty and wanted to be hoisted for lunch. The nursing sister then changed her catheter and on my return to the ward, my mother had been hoisted and was sitting in the chair, ashen faced, unresponsive, and clearly not well in contrast to how she had been. I asked the sister what had happened and she said she had merely changed the catheter without any problem.

As the afternoon wore on mother became increasingly more dehydrated, confused and was hallucinating.

Over the course of the next three days mother was unresponsive and semi-comatose. I could not rouse her. She did not have an appetite and drank very little. The staff did not give her breakfast or Thyroxine because “she is too sleepy”.

It was not until I insisted in knowing what else had been given to my mother at the time of the catheter change, that I was told she had simultaneously been given an intramuscular injection of Gentamycin (it is my understanding that this can have serious adverse effects when given to elderly people suffering from dehydration or renal failure).

On the 27th of February the ward was short staffed, so they didn’t hoist mother up for lunch.

On the 1st of March I was contacted by a senior officer from Social Services and was told that a safeguarding alert had been requested against me by members of the ward staff, and that this was just as much to protect me as my mother. When I went into the hospital later that day, I was told by the investigating officer that “you should respect the health
professionals judgement. “I told them that I could not do so when they were misinterpreting my mother’s wishes over the issue of pain relief.

It was sometime later, after my mother had been discharged from the hospital, that it was ruled by the investigating officer that it was my word against that of a member of the ward staff, that there were no historical issues and that there was no intent on my part to do harm.

When I went on the ward that day, mother had not been out of bed because the ward’s hoist had broken. The gentleman whose wife was in the next bed insisted they borrow a hoist from another ward. Only his wife was hoisted. I asked but my mother was not hoisted.

At a multidisciplinary team meeting that I attended each member of the team reported what would need to be done if my mother was discharged home.

The Ward Sister said that my mother was being repositioned 4 times a day with daily bowel movements and was being hoisted onto a chair and commode regularly. I disagree with this. I had asked for a bed pan for my mother two evenings previously and my mother did not produce anything; if I didn’t ask her to be hoisted, she was left in bed and was never hoisted on to a commode.

At that meeting I was not able to ask questions about the operation as the surgeon was not present. I was asked to write them down for the PALS team to deal with but have never received an answer.

On the 4th of March I had a message on my mobile answer phone from a young male doctor, who was a member of the orthopaedics team. He reported that he had examined my mother, that he did not think it was advisable to re-operate and that she should not be hoisted. He said that he had left a bleep number in my mother’s notes so that I could contact him if I had any further questions. My mother had already been hoisted that day when my niece visited.

The next day my mother was lethargic, falling on one side, hallucinating and uncomfortable. She said she felt weak and as if she was falling over. She was on a slow saline drip and did not want to eat. I was asked to give her a powdered calcium medication to counteract high potassium. It was unpleasant and she would not take it. I noticed that her right leg was in an awkward position (turned inwards and flat on bed). It appeared as if her hip was dislocated.

In the afternoon she became agitated and was making continuous involuntary twitching movements of her head and arms (the staff did not explain this and I assumed it was due to her high potassium levels). She tried to eat her hand.
The mattress on the bed was deflated and mother was extremely uncomfortable – it took an hour and a half to work out why. I realised that her unstable leg was now always going to be in that position. Mother said “If they want to kill me, they’ll kill me.”

In the morning of the 6th mother was unresponsive. I was unable to get mother to drink much and staff did not attempt to give thyroxine because mother was asleep. I left the hospital around 1pm and returned at 4pm, to discover that mother had not been given anything to drink in my absence. (The cups around her bed were in same position with same amount of liquid in them). Mother was thirsty again.

On the 8th of March I asked the staff nurse if she would contact the young orthopaedic doctor on his bleep number in the notes (the one who had examined my mother). She took the notes away and when she returned she said there was no record of his visit or bleep number. Mother’s right leg was still contorted. She was very uncomfortable. Her left foot was protruding from the side of the bed.

The discharge coordinator came to see me on the ward, and I felt she was putting pressure on me to get my mother discharged. She said that it did not matter if things were not in place at home at the time of discharge as they could be sorted out later.

On the 11th of March I was given low potassium diet sheets. I asked to talk to someone from the Orthogeriatrics team. A young female doctor told me that mother had been taken off Salbutomol, (despite just having been given a Salbutomol Nebulizer) and that her potassium level had come down. I mentioned my mother’s contorted leg because the Healthcare Assistant had said light-heartedly that it had been like that for several weeks. I only noticed it after examination by the doctor from the orthopaedic team. In the afternoon Mum vomited several times.

The next day I was told that Mother had had cereal for breakfast (without dentures?). She was very thirsty. I was asked by an agency nurse how much she had eaten for lunch. I should have been asked every day what mum had eaten so it could be monitored. However this was one of the few times I had been asked.

Pain relief that had been dissolved in water was given to mother without asking. I asked her if she wanted pain relief and she answered “no”.

On the 14th of March I arrived at the hospital at 11.30 am. Mother was not washed or changed until 11.30 am. All other patients up and washed. I was told by a Healthcare Assistant that “We did not want to tire her”. I put her teeth in and her glasses on. I also gave her extra breakfast as she was hungry. She was extremely thirsty.
In the afternoon I discovered mother had been left lying uncomfortably on one side with her face in her pillow. I could not give her a drink and asked the Healthcare Assistants to move her. They said they did not want to move her legs. I had to ask the staff nurse to pull her up in the bed so I could feed her but it was not until after supper and one and half hours later, that she was properly repositioned.

On the 17 March an email was sent to say mother was to be discharged tomorrow – there was no indication as to what time. I rang the ward to find out and was told they did not know. I was told I could not travel with her in the ambulance because there would not be enough room as other patients would be sharing it.

Despite sending an email to the Discharge Coordinator, she did not ring me and I had to ring the Nursing Home to find out that my mother’s discharge would be in the afternoon.

Mother was discharged to a nursing home. I had to arrange this myself as her social worker showed no signs of arranging a home care package and it was deemed that my mother did not qualify for continuing care. I was not permitted to travel with her in the ambulance. Two brown envelopes were given to the Ambulance crew: one for the GP; one for the home. In the evening the nurse from the home asked me when the Fentanyl (morphine) patch had last been changed and when she was last given her weekly phosphate injection “for her bones”. I said I did not know. I was told by the Home Manager that she had been told by the hospital that my mother should only be sitting up for an hour due to her unstable hip. At the hospital I had always been told that she should not stay up for more than an hour so as not to tire her.

When I cleaned my mother’s few remaining teeth that evening, her gums were bleeding profusely and I noticed the skin on her legs was flaking off.

Things did not improve greatly when my mother went into the local authority nursing home. She was injured (cuts and bruising) three times, left in her wheelchair for long periods of time, she was not washed until lunchtime, bed linen was not always changed, meals sometimes did not arrive. Dementia patients went into her room: one tried to get into bed with her; another put her walking frame on my mother while she was in bed.

She also suffered hypothermia on a number of occasions, when she was left with a thin cover and the window open, and developed pneumonia from which she did not fully recover. Her social worker made very little effort to arrange for her to be cared for at home until the occupational therapy assessor intervened on my behalf. My mother was very ill when she eventually returned home and died on 1 July only three days later.
16) Maureen Nolan
By her daughter Maria O’Brien

“My mother has been an integral part of all my lives, hands on mother and was definitely a hands on grandmother and delighted in her great-grandchildren. It was a massive help to all of the family that she received such good care during her last stay in Northwick Park Hospital.”

Maureen Nolan was admitted to Northwick Park hospital on two separate occasions, once in 2009 and then again in 2011. We included this recollection of the care she received, written by her daughter, because it shows the marked difference that bad and good nursing care can make to a patient and their family.

It also demonstrates that, while incidents of poor care and neglect such as those included in this publication happen far too often, good care happens on a daily basis, and should be applauded.

Over the last few years my mother has had cause to be admitted to Northwick Park Hospital, Harrow, on several occasions. Her story highlights both what can be good and what can be bad about hospital care, and proves that good nursing care makes a massive difference, not just to the patient but to the family as well.

December 2009 Experience

My mother was admitted to hospital on Tuesday 2nd December 2009. She was diagnosed as having a urinary tract infection.

My mother had long suffered from Trigeminal Neuralgia and my sister and I spoke to Doctors and Nurses on A&E and advised staff that my mum must have Pregabalin and Tegretol in order to prevent Trigeminal Neuralgia. They assured us this information would go with her notes to Dickens Ward where she would be going after A&E.

On Wednesday 3rd December the hospital pharmacist telephoned my sister and asked for clarification on her medication. I understand they also telephoned mum’s GP.
My mum was taken to Dicken Ward, where once again my sister went through all the medication with the nurse who showed her how she had written down the meds on the drug chart. We were assured she was now receiving all her medication. However, she was starting to get “tingling pains” in her face, which is an indication of an onset trigeminal attack.

On Thursday 4th December mum was transferred to Fielding Ward. She was now getting more and more pain in her face and we asked that her medication be increased until such time as the attack was over.

On Friday 5th December we discovered that she had not been given any of her medication for the pain. Given that the pharmacist knew about mum’s needs, and someone had phoned the GP, we presumed that the prescribed pain relief was being administered. However although the prescribed drug, Tegratol, was on the ward, it was not being given to mum.

On Saturday 7th December mum was in pain for most of the day – she was being given some pain relief but not all of her medication. My sister spoke with the ward sister on that day. Tegratol had been started but on a low dose along with the Pregabalin. We asked that the Tegratol was increased. A typed note explaining how to give Tegratol (this instruction had been given to us by the GP) was given to the Sister who promised to ask the doctor to increase the dose. On Sunday 8th December Tegratol was now being given but only twice a day (2 x 100ml). We explained yet again that this was not going to be sufficient to get on top of her pain. We spoke to a different ward sister and she spoke to the doctor on call who finally agreed to increase the dose up to 400ml per day if required.

My mother was admitted to Northwick Park Hospital pain free suffering from a urinary tract infection - this had been dealt with but she was in almost constant pain since she was admitted.

If the doctors and nurses had read her notes they would have understood her condition. We have taken three years to get and keep her relatively pain free by maintaining her on a low dose of medicine and increasing as and when she gets an attack. Once the attack subsides the medication is reduced. We understand that she may get sleepy as a result of medication, as well as old age, but it is preferable to keep her pain free rather than see her writhing in pain and screaming for someone to help her.

At 93yrs old with limited mobility, along with other ailments, my mum did not need to be in pain. We did not want to hear her say that life is not worth living when she has a pain, which is, for the most of the time, controllable. My sister and I felt that the level of care my mother had received since going into Northwick Park Hospital was unacceptable.

**However, despite raising my concerns and complaints, nobody listened.**

My mother was also discharged with a cut on her leg, which the ward nurse said my mum had done herself!!! This is very debatable – she was far too frail and unable to reach down her leg. She also contracted MRSA, which we believe was contracted through this leg injury.
A very unhappy time for my beloved mum and family watching her and despite all my concerns, nobody listened!!

**December 2011 Experience**

The difference in care received in 2009, compared to the care received this year was amazing, even though it occurred in the same hospital, and in part, the same wards.

Mum was in hospital for just over a month between March and April this year. The care she received was wonderful.

Before being admitted to hospital mum visited the Accident and Emergency Department twice. The nurses and doctors were just so lovely and very caring in what was a very busy A&E department before being transferred to Dicken Ward.

When mum was admitted to Dicken Ward she was treated really well and the staff were also very caring. On her second visit to Dicken Ward (26th March) my mother was very poorly and on Sunday 27th March, we were on “end of life care” the staff were just so kind. They ensured that she received all the dignity she was entitled to as a frail 94yr old lady. In particular, they made sure that both my sister and I could spend some time with our mother - my sister was at the time undergoing chemotherapy, so masks and gowns were found for her by the nurses on Dicken Ward.

My mother’s five grand-daughters (+ boyfriends) and great-grandchildren – spent a “lovely” afternoon with my mum on what we thought were her last days and the staff made this possible. I don’t have all the names of the staff that were caring for the whole family on this Sunday 27th March 2011, but I asked the hospital to convey to them my heartfelt thanks for what they did for mum and for us.

Although on the 27th we thought mum was living through her last days, she had other ideas and on Monday 28th she “rallied” slightly and was transferred for her second visit to James Ward.

It’s hard to express my thanks to all of the doctors, sisters and nurses on James Ward, who performed their work so wonderfully and looked after mum so well. The registrars and consultants and in particular younger male doctors – They took the time to discuss mother’s health with both myself and with my sister, never rushed and always showed concern for mum’s wellbeing, showing such concern. We must also include the sister from the End of Life Team who was a credit to the nursing profession.

Our wonderful mother has been an integral part of all our lives, hands-on mother and was definitely a hands-on grandmother and delighted in her great-grandchildren. It was a massive help to all of the family that she received such good care during her last stay in Northwick Park Hospital.

There was only one fly in the ointment (there has to be one). On one Friday my sister was in James Ward, and was gowned up due to her chemo treatment. She felt fit and well. luckily,
my mother was in a side ward so my sister was able to sit with mum. However, the Ward Sister on duty that day was very hurtful and brusque when she saw my sister asking her “what is that get up you are wearing”? My sister informed her of her ongoing chemo treatment at Hammersmith Hospital. My sister was very embarrassed having to explain her condition again in front of my mother (we hadn’t told mum – it didn’t seem necessary, causing her further distress).

My sister went to the door and explained that she was a cancer patient currently going through chemotherapy and therefore had been advised by the nurses on Dicken Ward that she should cover up when visiting my mother. In fact it was the extremely helpful staff on Dicken Ward (Sunday 27th March) who got the gown and masks from the isolation ward. This brusque unsympathetic Ward Sister just said “Huh.”? My sister explained that she was not bringing any infection onto the ward. It was more a worry in case she contracted anything from the hospital that would disrupt her next treatment.” Ward Sister again said “Huh” and then walked away. Not a very caring attitude from a Ward Sister!

My sister had enough to contend with her own treatment at the Hammersmith Hospital, my mother’s end of life care etc, and certainly didn’t expect such a tirade from a member of the nursing profession of all people – it was so insensitive and not necessary especially as all the staff we had met in James Ward, doctors and nurses alike, have been aware of my sister’s ongoing chemotherapy. It was just such a pity that the wonderful treatment we have had at Northwick Park Hospital should have been marred by one very unhelpful, uncaring and insensitive Ward Sister.

However we refuse to let it spoil the good treatment, care and concern for my lovely mother that we experienced at Northwick Park Hospital this year and have told all family and friends how well my mum and all my family have been looked after at the hospital for the last couple of months in what was a very stressful and painful time for us all.

My wonderful and lovely mum died very peacefully, at home, with all her family on the morning of the Royal Wedding, Friday 29 April 2011 aged 94yrs
Responses from the NHS Trusts

1. George Frederick Taylor

Barnet and Chase Farm Hospitals NHS Trust said:

We were extremely concerned to receive this complaint about Mr Taylor’s care whilst being treated in one of our hospitals.

The Trust is undertaking an investigation and we will ensure that the appropriate action is taken.

We have arranged for senior members of the Trust to meet with the family and a representative of the Patients’ Association.

We have worked closely with patients and their families to ensure the care patients receive is of a high standard.

The Trust has focused on dignity and respect and to ensure we are achieving high standards so far this year, we have had feedback from over 5,000 patients. In September 97% of patients scored us as excellent for treating patients with dignity and respect.

We have introduced frequent ‘comfort rounds’ to ensure nursing staff are assessing patients comfort, pain, and toilet requirement regularly. All our patients have continence assessments undertaken and the appropriate plan to support them is put in place. Mr Taylor’s complaint shows that our standards were not met.

We constantly monitor the safe use of medicines and have noted that management of diabetes was highlighted in some complaints. We have put in place a range of measures to ensure that patients with diabetes are treated and maintained during their time in hospital.

The Trust is grateful to the Taylor family for bringing this lapse in care to our attention.

2. Jane Dixey

Stephen Graves, Chief Executive of West Suffolk NHS Trust, said:

Mrs Dixey was discharged from West Suffolk Hospital on 22 February and passed away on 5 April. We were very sorry to hear this sad news and would like to take this opportunity to once again extend our condolences to Mrs Jacques and the rest of her family.

We have carried out a full and thorough investigation into Mrs Jacques’ concerns and have sent her a detailed response. We have also passed on our sincere apologies for any anxiety or distress which Mrs Dixey felt whilst in our care. The observations made by Mrs Jacques have been raised with our staff and we can assure her that lessons have been learnt as a result.

As part of our investigation, we have reviewed Mrs Dixey’s extensive medical notes. They show she was regularly offered fluids and was not dehydrated during her admission. In addition, they document Mrs Dixey’s consent to the insertion of a catheter, which it was later agreed would be left in place for medical reasons. We are sorry if Mrs Jacques does not feel this was clearly explained to either herself or her mother.
We are committed to ensuring all of our patients are treated with dignity and have clear expectations of how our staff should behave. We regularly reinforce the importance of showing courtesy and respect to everyone using the hospital and actively encourage staff to challenge any colleague who does not maintain the high standards we would expect.

3. Michael Groves

Buckinghamshire Healthcare NHS Trust said:

We were incredibly sorry to hear Ms Brown’s concerns regarding her father’s experience in our hospital. Ms Brown has been in touch with the hospital and we have thoroughly investigated the matter and fed back our conclusions directly.

We understand that it must have been a very difficult time for Mr Grove’s family, and we are sorry if some of our attempts to help keep them informed were not perceived as such at the time. We acknowledge that there were some elements of Mr Grove’s basic care that fell below the standard we expect on our wards. We expect our staff to care for patients with courtesy and compassion and it is clear in some instances this did not happen – for which the Trust and the staff involved are truly sorry.

We have learnt from the concerns raised by Ms Brown and we have reminded our staff of their responsibility to ensure our patients have a good experience when in our care. Although we receive over double the amount of accolades to complaints for the services we provide, we are never complacent. We take those instances very seriously where we did not meet people’s expectations and ensure swift action plans are put in place, to learn from the experience of others.

We have developed service standards that we expect all staff to adhere to and our matrons work hard to ensure they are met in every part of the organisation. We believe we have made improvements and a recent CQC inspection into dignity, respect and nutrition for older people concluded that they were satisfied with the care that we provide.

4. Joyce Jones

Duncan Selbie, Chief Executive Brighton and Sussex University Hospitals said:

I completely agree with Mrs Owen that the lack of compassion shown by some of our staff towards her mother whilst she was in our care is distressing. The feelings of sadness, anger and disbelief at the lack of kindness and compassion sometimes shown by those working in the caring professions is felt as much, if not more, by the majority of NHS staff who do share and uphold these values.

Our Accident and Emergency Department and the adjoining short stay ward can be exceptionally busy. I am certain it must sometimes feel impersonal and chaotic for patients and their families and it is our job not only to alleviate pain and treat a patient’s illness or injury, but also to do all we can to minimise their fear and anxiety and make them feel safe and looked after. An organisation cannot mandate its staff to get this right. We each have a personal responsibility to make eye contact, say hello with a smile, speak with kindness, listen with sympathy, treat all our patients with the kindness and compassion we want for our own loved ones; and to not walk by when we witness someone else behaving unacceptably.
It is my personal responsibility and the responsibility of every person who manages others to lead by example and actively demonstrate this every day. We have to think in terms of what I can do, always do our best and demand the same from everyone we work with. When we received Mrs Owen’s complaint in January I personally apologised to her for our failings in the care her mother received and since then her story has been shared with all the staff involved. We strive every day to do better than this and I believe that on most days for most patients we do.

5. William Wood

**York Teaching Hospital NHS Foundation said:**

York Hospital was profoundly concerned and saddened by this course of events. We responded immediately on learning of Mr Wood’s sad death by launching an urgent serious untoward incident enquiry. The results of this have been shared with Mrs Wood and her family. Independent external case reviews were sought from both an Acute Physician and a Respiratory Physician. Both confirmed significant shortcomings in the discharge of Mr Wood who was profoundly sick with a severe pneumonia. This diagnosis was made on his admission and appropriate urgent treatment given for bacterial pneumonia. Both external physicians indicated that the in-patient care he had received up to the time of discharge did not significantly fall short of good clinical practice but drew attention to major failings in his clinical assessment at the time of discharge. We were unable to confirm that laboratory results had been lost but rather that several samples had been taken in order to exclude pandemic influenza. Sadly however our care fell significantly short in respect of his discharge. We recognise with great regret that this has contributed to so sad an outcome. Major learning has arisen within the hospital as a result of this and clinical practice has changed. We are profoundly sorry that the standards of care our patients rightly expect of us were not met.

6. Patricia Rattansi

**Dr Nancy Fontaine, Director of Nursing and Quality, Whipps Cross University Hospital NHS Trust said:**

We were shocked and saddened to hear Mrs Rattansi’s story and the issues she has raised. It is even sadder that she has previously received good care at Whipps Cross. We apologise unreservedly, and are responding to these deficiencies. It is not acceptable to provide care which falls below basic clinical and cleanliness requirements.

In 2009, we spoke to over 500 patients and relatives, and this process led to a clear set of promises to all our patients:

- that we are kind – so patients feel cared for
- that we are excellent – so patients feel confident
- that we are professional – so patients feel safe
- that we are always improving – so patients feel our care is getting better

We did not fulfil our promises to Mrs Rattansi and there is no excuse for this. We have identified seven areas for improvement:

- **Providing safe, clean care at all times** - Ensuring standards are maintained seven days a week, 24 hours a day
- **Cleanliness of toilet and bathroom facilities** - Ensuring standards are adequately monitored. We now temporarily close facilities which require immediate cleaning and have clarified lines of responsibility between clinical and domestic staff. Inspections are carried out three times daily
• **Bed management** – we aim only to move patients if clinically necessary and only after consultation with and agreement from the patient

• **Clinical practice** - All nurses are trained in wound care, and are regularly appraised on correct dressing procedures. These are audited by senior nurses every month to ensure compliance.

• **Attitude displayed by staff** – All ward staff and senior nurses have been reminded of the importance of clear communication with patients, and involving patients in all decisions about their care

• **Maintaining a ward environment which is conducive to rest and recovery** - All staff are aware that patients may have a maximum of two visitors at any one time. Sometimes, concessions are made due to cultural needs or when a patient’s condition means that relatives need to see them urgently. All ward staff have been reminded that if any patient has more than two visitors, they must not disturb other patients

• **Arrangements for discharging patients** – we have introduced a discharge leaflet and checklist which ward staff complete with every patient. This ensures that patients have information about any medication they need to take, any ongoing support they need and that they know who to contact at the hospital if they have any concerns once they have left

7. Immacolata Lacovara

The North West London Hospitals NHS Trust said:

Mr Lacovara complained to The North West London Hospitals NHS Trust earlier this year and our full investigation and response to him were subsequently scrutinised by the Parliamentary and Health Service Ombudsman. The Ombudsman’s office reported that it would not take this complaint any further, as it was satisfied with our investigation and response. We are sorry about the concern and distress Mr Lacovara and his family experienced and that they have found no comfort in our full investigation and response.

We would also add that the Care Quality Commission (CQC) carried out its annual spot check inspection of privacy and dignity standards at our hospitals earlier this year, and the Trust met the essential standards.

We are pleased that every elderly patient who spoke to the CQC said our staff had preserved their dignity and treated them with respect.

8. Sally Abbott-Sienkiewicz

Suzanne Hinchliffe, Chief Nurse at Leicester’s Hospitals said:

It is clear that we completely failed Mrs Abbott-Sienkiewicz and her family and for that we remain very sorry.

It’s our job to make people well, and if we can’t do that then we have a responsibility to make them at least comfortable and pain free in their final days. We didn’t do that for Mrs Abbott-Sienkiewicz and we recognise that this has had a lasting and awful impact on her family.

Looking back over the events of the 48 hours when Mrs Abbott-Sienkiewicz was in our care, it’s clear that we failed to respond to what ought to have been obvious...she was in pain and the pain killers were not working. We also failed to escalate her worsening condition to a doctor which compounded the problem. Since talking with Mrs Abbott-Sienkiewicz’s family we have taken action
on the concerns that they raised. These include better communication between staff and relatives so that they understand what treatment is being given and why, making sure we have appropriate amounts of pain medication on wards to meet those differing needs of palliative patients, creating a pain care plan for patients when they are admitted to a ward including clear instructions of how we will be monitoring pain, and additional training for our staff in caring for patients at the end of their life and more importantly on improving staff behaviours and attitudes so that they show compassion, empathy and consideration when dealing with patients and their relatives.

We have looked again at the notes of the meeting which took place between the family and our clinical team and the letters which we sent to the family in response to their complaint. It’s clear that we have not answered their questions properly or given them sufficient time and support to really get to the heart of this. We will be contacting them again to see if we can answer all of their questions and help them get closure on what we know was a hugely distressing time for them.

9. Mavis Morris

Royal Cornwall Hospitals Trust Chief Executive, Lezli Boswell, said:

I am sorry that Mrs Norfolk felt that her mother’s care did not reach the high standard that we aim to provide to all of our patients and for the upset this has clearly caused. Every one of our patients has the right to be treated with a professional standard of care. I have only recently been made aware of the issues raised by Mrs Norfolk and an investigation is now underway. We take every complaint about our services very seriously and each one is subject to a thorough investigation to establish the facts and ensure we learn from the experiences of patients, their family and carers. I would be happy to meet with Mrs Norfolk and her family once our internal investigation is complete.

10. Barry Woodward

Brigid Stacey, Director of Patient Experience and Chief Nurse, at Derby Hospitals NHS Foundation Trust said:

I would like to offer Mr Woodward an apology that his experience at Royal Derby Hospital was not as it should have been.

We are very keen to learn from the experiences of our patients and I would like to invite Mr Woodward to contact my Assistant Director of Nursing, Kerry Pape. Kerry will be able to work with Mr Woodward to ensure that we learn from his experience.

We know that the issues Mr Woodward raises are important to all our patients. This is why we routinely gather data on a number of issues including privacy, dignity and pain management. Our own data shows that we perform well in these areas, but we are not complacent and continue to improve our services using a range of information sources including patient feedback.

We also value the opinion of external assessors and we were recently inspected by the Care Quality Commission as part of their national programme of unannounced visits. They had no concerns about the privacy, dignity and nutritional needs of our patients.

11. Helena Grimwood

Sue Hardy, Director of Nursing at Southend University Hospital NHS Foundation Trust said:
We are extremely sorry that Mrs Grimwood and her daughter had such a poor experience at our hospital. If the care that Mrs Paviour describes in her complaint is accurate, she has every right to be angry.

We are conducting a full and thorough investigation and have suggested a date to meet the family to discuss our findings and the steps we have taken as a result.

13. Jessie Thayer

Mary Dunne, Director of Nursing, Quality and Patient Services at Frimley Park Hospital NHS Foundation Trust said:

We were very concerned about the shortcomings Mrs Thayer experienced in the care we provided and have apologised to her family.

We are grateful to Mrs Thayer’s family for helping us to thoroughly investigate the issues raised so that we could address them. This enabled us to share a number of improvements that were already in the process of being implemented and we have been pleased to learn that Mrs Thayer’s family recognise the high standard of care she received on her most recent stay with us.

The Trust is investing more than £1m refurbishing the elderly care wards, which will make a huge improvement to the environment including reducing wards from six bedded to four bedded bays with en-suite facilities which will increase the privacy and confidentiality for patients.

In addition we have introduced a number of initiatives aimed at embedding dignity, nutrition and quality of care into the ward culture.

For example, the appointment of dementia champions on each ward to lead on best practice and the ward introducing relatives’ communication clinics where they can discuss concerns and discharge plans as well as receive timely updates on the patients’ wellbeing.

In addition we have introduced a ‘This is Me’ booklet as part of patient records where individual preferences and requirements are highlighted by carers. The Butterfly Scheme improves safety and wellbeing for patients with dementia and memory impairment.

The ward has reviewed staff levels and increased staffing to ensure care is delivered. We have also introduced a second hairdresser.
Some of these initiatives were in the early stages during Mrs Thayer’s initial time with us and they are now fully integrated.

We were particularly concerned that Mrs Thayer’s daughters observed some staff on occasions behaving in an unhelpful way. This is not tolerated by the Trust and we will take action when staff can be identified.

We aim to deal with all complaints and feedback in an open, honest and timely way as we believe this helps us to achieve our ambition of providing the safest and best possible care for every one of our patients.

The Care Quality Commission recently acknowledged the overall high standard of care at our hospital following an unannounced inspection and the great majority of our patients have a positive
experience. However we recognise that we can always improve and welcome any opportunity to do so.

14. Brian Smith

United Lincolnshire Hospitals NHS Trust said:

We would like to express our sincere condolences to Mrs Smith and to confirm that the Trust is committed to working with her to resolve the concerns she has raised. We have carried out an investigation into the issues and the Director of Nursing and Patient Services is meeting with Mrs Smith to discuss the outcome.

A new management team has been in place at the Trust since April 2011 and is committed to ensuring we deliver good standards of care consistently across our hospitals. We are making many changes to the way we deliver care and are ensuring that we learn from the experiences of patients and their relatives or carers, such as Mrs Smith to make further improvements where necessary.

15. Patient B

Cathy Stone, Director of Nursing and Patient Safety, said:

Firstly I would like to express our condolences to the Patient B’s family for their loss. It is always sad to hear that people are unhappy with the care received by themselves or a loved one, and we go to great lengths to encourage people to tell us of their experiences, and to learn lessons whenever appropriate. We also work closely with the Patients Association to ensure we hear about and investigate any concerns raised with them.

I cannot comment directly on any individual patient, apart from to say that all of the complaints made in this case were extensively investigated at the time. The findings were shared with the family at the time and we have always been prepared to meet with them should they wish.

The Trust demands the very highest standards from our staff and, although we can never be complacent, in the overwhelming majority of cases that is precisely what they provide for patients. The results of recent national inpatient surveys, unannounced inspections from the Care Quality Commission, and visits by Patient Experience Action Teams suggest our patients are receiving the very highest standards of care.

16. Maureen Nolan

The North West London Hospitals Trust

We fully investigated the issues raised in relation to Mrs Nolan’s care in 2009 and gave full explanations at the time.

Subsequently, we were delighted when Mrs O’Brien sent a letter complimenting us on her mother’s care. However, we were saddened by the insensitive manner in which her sister was treated and will ensure that the member of staff concerned never behaves in that way again.