

**WITNESS STATEMENT TO THE PUBLIC INQUIRY INTO THE OUTBREAK OF
CLOSTRIDIUM DIFFICILE IN NORTHERN TRUST HOSPITALS**

WITNESS NAME: DOROTHY ORR

STATEMENT OF EVIDENCE

I, Dorothy Orr, say as follows:

1. My name is Dorothy Orr and I live at an address which is known to the Inquiry Team. I am the daughter of Mary Margaret Hughes who died on 11th January 2009 at Clonlee Nursing Home in Antrim. I have been a District Nurse for over 30 years.

My mother's pre-existing history

2. My mother was 90 years of age when she died. She suffered from osteoporosis which caused her problems and led to her having frequent falls and breaking various bones in her body. She also had an ileostomy bag. She was frail and had insipid dementia.

Admission to hospital

3. My mother lived in a house in Carryduff for about ten years with my father and my brother. My father had limited eyesight and my brother suffered from Down's Syndrome but they all managed as a team and helped each other.
4. My mother broke her hip on one occasion. Then two or three years later she fell and broke her leg quite badly in four places. She had also broken her wrist.

On each occasion she was treated at Belfast City Hospital and then returned home.

Antrim Area Hospital (first admission)

5. Then in May 2007 she was admitted to Antrim Area Hospital (from Rosemary Lodge Residential Home where she had been living since August 2006) for the first time following a fall when she broke a bone in her upper arm. She was examined at Accident and Emergency Dept and then admitted for approximately one month.
6. She was then discharged and transferred to Inver House at Moyle Hospital for further convalescence.

Inver House, Moyle Hospital

7. It was when she was in Inver that the family discovered that she had C. Difficile. She was in Inver for approximately four to five weeks during which time her symptoms cleared up and so she was discharged to Clonlee Private Nursing Home, Antrim.

C difficile

8. I was very annoyed to discover that my mother had C difficile during the first few days after her admission to Inver and I arranged an appointment with one of the doctors there. The doctor was very cross because my mother had been transferred to Inver for convalescence but Antrim Area Hospital had not informed Inver that she had C difficile and it was only when Inver were checking the computer for blood results that they noticed a laboratory report which stated that she had C difficile.
9. She stayed in Inver for about four to five weeks during which time her symptoms cleared up and so she was then discharged and went to Clonlee Nursing Home.

Antrim Area Hospital (second admission)

10. My mother had a further admission to Antrim Area Hospital in early 2008 (I cannot be any more precise regarding the date but presumably these details would be contained in my mother's hospital notes). She was admitted with a urinary tract infection, dehydration and renal failure.
11. On this occasion the family were told by Antrim Area Hospital that she had C difficile and so she was admitted to Ward A1 where she stayed for approximately four to six weeks. We were also told that Ward A1 was an isolation ward.
12. She was in a small six bedded ward with five other ladies who all had C difficile.

Ward A1

13. Antrim Area Hospital has three floors and A1 is on the lower level. It has a very long corridor with single rooms down one side and about three six bedded rooms down the other side.
14. There appeared to be a very high level of cleanliness and hygiene in A1 presumably because of the outbreak of C difficile.
15. My mother at this stage was very frail, reluctant to eat, would stop drinking and suffered from dementia. My father by this stage had already died on 9th June 2007.

Symptoms

16. The family were not aware of my mother's symptoms or of the fact that she had C difficile until we were told by the staff in the hospital. The reason for this is that my mother had an ileostomy bag and therefore her symptoms were not apparent to us.

17. She was given oral medication but I am not sure of the effectiveness of this. There was a problem in giving her IV medication as she found the drip in her arm to be painful and uncomfortable and sometimes they became dislodged. She was on antibiotics while she was in hospital.

Clonlee Nursing Home

18. Her condition improved in Antrim Area Hospital and she was discharged back to Clonlee Nursing Home where she died on 11th January 2009.
19. I think she would have been living in Clonlee Nursing Home for approximately six to nine months after her discharge from Antrim Area Hospital.
20. Her health was precarious because of her reluctance to eat and drink but she did not have any more C difficile as far as I am aware.

Visits

21. I visited on a daily basis. I would call with her on my way to work and again on my way home. Because I am a District Nurse I was able to visit at any time and I did not have to stick to the official visiting hours. My brother, Henry Hughes, visited every day at the official visiting times.

Care

22. Because of my mother's dementia she was not in a position to tell us anything regarding her care while in hospital. However from my own perspective and observation I felt that she was quite isolated.
23. Very little information was given to the family by the doctors and nurses. They were all very busy during the day and there were less staff on in the evenings.

24. On the second occasion when she was admitted to Antrim Area Hospital she was suffering from vomiting, dehydration and a urinary tract infection. She was initially admitted to one ward but then when the hospital found out that she had C difficile she was quickly transferred to A1.
25. If she was distressed then medication would be provided by way of tablets or a drip. She was receiving IV antibiotics and fluids
26. I would describe the care as "adequate" but it was not as attentive as it might have been. Sometimes the staff needed prompting. It was to be remembered that my mother was an elderly woman with dementia and could not communicate with the staff.

Transfers

27. The nursing home would have been very particular about consulting with families when someone was being transferred to hospital and made sure that they were aware of the arrangements. Unfortunately the Accident and Emergency Department of the Hospital would appear to have had a policy that families are not allowed access to patients when they are being admitted and I had to insist that I would accompany her during her admission as she was really incapable of giving any history or details by herself.

Cleanliness

28. I did not witness any general cleaning being done during my visits. This may be because I visited early in the morning and late in the afternoon or early evening. Nor did I witness the cleaning of any spillages.
29. I do know however that the bed linen was changed on a regular basis. My mother's clothes were soiled on a daily basis and had to be changed regularly as did the bed linen. I actually purchased twelve new nightdresses for her and needed all of them.

30. Her soiled nightdresses were left for me in a bag by the bed. I was appalled at how badly soiled they were as she had an ileostomy bag which meant that it must have needed emptying or it had leaked. I made a special point of speaking to two or three nurses and explaining how often the bag should be checked otherwise it would leak. I was also concerned that when she returned to the nursing home that she had a wide area of excoriation at her side from the leaking of the ileostomy bag. The mark was about three or four inches wide and perhaps five or six inches long. Whenever my mother was admitted to Antrim Area Hospital on the second occasion her skin was perfect because the bag had been checked, emptied and changed on a regular basis but unfortunately she did not get the same attention or care at Antrim Area Hospital.
31. I was also not told that I could put the bag containing the dirty linen and nightdresses straight into the washing machine but rather I was taking them home, steeping them in bleach and then putting them into the washing machine. I wish that I had been told about the use of the laundry bags at an earlier date as this would have made the washing easier for me.
32. I also noted that one of the patients opposite my mother had four or five soiled laundry bags sitting at the bottom of her bed for about a week before they were removed. I mentioned this to the staff and they said "that it was because she had few visitors".
33. I had occasion to wash my hands in the en suite toilet and found everything to be clean and satisfactory.
34. I did not notice any smell or odour in the ward or hospital.
35. Each ward had a wash hand basin and gel dispenser and to the best of my knowledge all staff and visitors used these facilities.
36. The staff also wore the gloves and aprons that were provided but I do not think the visitors had access to these.

37. I was satisfied with the cleanliness of the ward, beds, lockers, corridors and other general areas.

Communication

38. I did not receive any written notices or leaflets at any stage from the hospital. I am however a District Nurse and would have been aware of the necessity to wash my hands and to take precautions regarding personal hygiene.
39. I was never given any specific information about the outbreak. I was aware that there was C difficile in the hospital and my father had C difficile when he was there and so I was aware of the symptoms. I was however surprised to hear that my mother had C difficile because I had not noticed any symptoms from her.
40. We also gained a lot of information from the press and media. Dot Kirby was seen outside the hospital and she was also seen outside Ward A1. I am not suggesting that this was done insensitively but I would have liked to have been given further information about the matter. I found in Antrim Area Hospital that if you wanted information you always had to seek it out.
41. Information was given out reactively rather than proactively. I never had any one to one meetings with any doctor or nurse regarding my mother's condition.
42. I think that where elderly people are concerned that a busy acute hospital is not the place for them because the elderly have special needs that really cannot be addressed in a busy acute hospital. They have different needs which need to be cared for in a different way. Time needs to be taken regarding nutrition, hydration and care for the elderly who cannot vocalise their needs.
43. I would have liked better communication and information from the staff. I feel that I should have been taken aside and told the full extent and gravity of the situation.

Food

44. The food in hospital is very poor. It is of poor quality, poor standard, poor selection and is not fresh. Patients also on occasions cannot reach the tray of food that is left for them as it is put too far away. More care should be taken with patients' food.
45. Fluids are also a major issue and fresh water in a glass should be within easy reach of every patient. This is not always the case.

General conclusions

46. The staff are all very busy and need to be given more time to interact with the patients. More information should also be given to families who feel sidelined. It is very difficult to get someone in authority to speak to you. Doctors should also make themselves more accessible to families.

My father

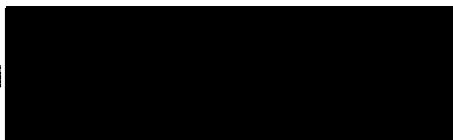
47. My father was also admitted to Antrim Area Hospital. He was born in 1913 and his date of death was 9th June 2007. He was mentally alert but had macular degeneration which meant that he had extremely limited eyesight. He was virtually blind, deaf in both ears and had a cardiac disease.
48. He was admitted to Antrim Area Hospital at the end of May 2007 with a septic toe. He required IV antibiotics. His condition deteriorated and he was kept in Antrim Area Hospital for approximately two weeks before he died on 9th June 2007.
49. He became very confused and distressed and also required assistance with his personal hygiene.
50. His care at Antrim Area Hospital was not at a level that I would have wished for. He was also put into a single room at the end of a corridor and I felt that he was

not getting the attention that he required. I also felt that the communication was poor and that I was not made aware of the seriousness of his condition.

51. Although the Ward Sister spoke sympathetically to me on one occasion, I had no interaction with any other member of staff and any communication with a doctor was done by phone.
52. My father's Death Certificate stated that the primary reason was septicaemia but the secondary reason for his death was C difficile.
53. The night before my father died a Minister, Rev. McCullough went into my father's room and he noticed he was apparently in some distress. The Minister spoke to me briefly after his death and told me that when he had entered my father's room, the bedclothes were off him and he was lying exposed on the bed. The Minister went to his assistance, covered him over, spoke some words of comfort, read and prayed with him. My father was apparently aware of his assistance and acknowledged his presence.
54. I just feel that the whole incident was just tragic and regrettable because I feel that he could have died with more dignity and in comfort and this did not happen.

I declare that this statement is true to the best of my knowledge and belief.

Signed



Dated: 29/9/10