

Witness Statement Ref No.

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

WITNESS NAME: ELIZABETH MCNAB

STATEMENT OF EVIDENCE

I Elizabeth McNab say as follows:

Statement of Elizabeth McNab

1. My name is Elizabeth McNab and I live at an address that is known to the Inquiry team. I am the widow of Andrew McNab (known as Andy) who was admitted as an in-patient at Whiteabbey Hospital in or around mid July 2008. He remained there for eight weeks. I believe that he was diagnosed with the CDifficile infection in August 2008. My husband Andy is now deceased having died on 12 September 2010.

General Health of Andrew McNab.

2. My husband had suffered from ill health for several years. In particular he had suffered from Chronic Obstructive Pulmonary Disease (COPD). He had also suffered from oedema causing swelling to his legs and feet. He had been admitted on several occasions to Whiteabbey Hospital. He was well known at the hospital prior to his admission in

July 2008. Indeed, on one previous occasion he had contracted MRSA.

3. In the past he had always been treated very well in Whiteabbey and had said that on those previous admissions he had found care and attention of nursing and medical staff to be first class.
4. Prior to his July 2008 admission he had been on Warfarin. He had been attending a Consultant Medical Practitioner in Antrim Area Hospital who had warned my husband that he was always to be careful of the colour of his stools, particularly when on antibiotics with Warfarin. The colour of the stool should never be black.
5. He was admitted to hospital on this occasion in July 2008 for problems associated with oedema and his breathing. He had also developed a chest infection and was put on antibiotics. He was admitted to a single room at Ward 2 in the hospital. During the first week there was no difficulty. I saw him along with my son Drew on the Saturday at the end of the first week and Andy was in good form. We had arranged not to call up to see him on the Sunday but that we would be back on the Monday.
6. On the Monday of the second week of Andy's stay in hospital, I visited him along with our son Drew. We found that Andy had been moved to a double room to accommodate another patient. He was sharing this room with a patient who had Alzheimers Disease. The room was somewhat unkempt and I remember Drew having to tidy the room up when we were there. This was most uncharacteristic of the hospital and we put it down to the hospital having a bad day. It was the holiday period and the head nurse was certainly away on holiday at that time.

There seemed to be two people in charge at that time, a male nurse and a female nurse.

7. I got a terrible shock when I saw Andy. He was sitting in a chair drooling. He appeared drowsy and listless and “out of it”. Drew and I asked him what was wrong. Andy said to us that he didn’t know what was wrong with him. He didn’t appear to know when it was that he last ate, slept or had gone to the toilet. I recall that he was on a drip of antibiotics. He pleaded with Drew to ask someone what was wrong with him. Drew went and spoke to someone (I am not sure if it was a doctor or a nurse). I believe that Drew asked that Andy was not given any more Tramadol and that this was agreed with whoever Drew spoke with. .
8. By Tuesday of that week Andy was getting worse. The room was unsatisfactory. He was in a room with an Alzheimers patient, which was not right. Also, he found that he had to shout and shout to get any attention. Andrew had a bladder problem and needed to use urine bottles frequently. Also, when I visited him on the Tuesday night I could hear him shouting out for a nurse as I was on the corridor. I found him sitting on a commode, where he told me he had been left for 25 minutes. He also said that he needed his legs rebandaged as the dressing had been hanging off since 9 am . The male nurse eventually arrived, cleaned Andy and changed the bandages.
9. I found out from speaking to the wife of the patient with Alzheimers disease that when she arrived the same evening she had found her husband wandering on the corridor.
10. I think that after that incident that patient was taken out of the room. A lady was put into the room instead. Andy didn’t like that. He did not like

sharing a room with a lady. She remained there for a few days also before Andy was put back into a single room.

11. With each passing day the situation seemed to get no better. I began to notice Andy's clothes were becoming soiled. On the Tuesday of the third week I visited along with my son Ian and his wife Karen. The door to the room was closed. Ian opened the door to go in. There were two doctors with Andy. I believe that they were a male and a female doctor. They told Ian that they would talk to him once they had finished speaking to Andy. We were asked to wait in the visiting room.

12. Before the doctors came out I spoke with a nurse. She told me that there was concern as Andy's stools were very black. The doctors never came and spoke to us in spite of saying to Ian that they would.

As I have said previously, Andy had been warned about the risk of his stools going black when warfarin was mixed with antibiotic. Andy believed that the overuse of antibiotics on him at Whiteabbey by the doctor treating him during that stay caused him to contract CDifficile .

This was the first night that Andy's laundry was left "bagged-up" for me in a sealed bag to collect. No one ever said to me that they suspected that Andrew had CDifficile, or that I should be careful when handling or washing his clothes, or that I had to wash my hands prior to and after visiting him. No one ever told us that we had to wear aprons or gloves when visiting him or to rinse our hands with gel. Indeed, no one told me to be careful when washing Andrew's clothes right up to the time that he left hospital.

13. I know that Andy was becoming anxious about his own health. He phoned me that night about midnight. He got very sentimental and emotional. I have no doubt that he was frightened. The next day he

apologised for phoning me so late in the night. I actually phoned a young Scottish nurse whom I had got to know simply to ask if I could speak to a doctor about Andrew's condition because I was so concerned about his health. She told me that the doctor would not speak to me over the phone but that I could make an appointment to see him that afternoon if I was visiting. I was unable to come up until that evening and so I could not get to see a doctor.

On the Friday of that third week Andy had a blood transfusion.

14. By the time Andy was transferred back to a single room, his condition had worsened, if anything. On the Saturday (at what I believe was the end of the third week) I visited along with our son Drew and Andy's nephew John. Ian and Karen and another of our ^{GRAND AUNT} sons, Scott, were there too.

Andy couldn't eat, he had stomach cramps and he was passing what was effectively black water. We went home on the Saturday after close of visiting time. I was just in through the door when the phone rang. Andy was on the phone. He told me that he had just been told that he had CDifficile.

15. I was so upset I was unable to go back up to the hospital. Drew went up with John and when they came back they had a leaflet. The leaflet had an arrow drawn on it and against it was the handwritten comment "this is what you have". They told me that the hospital had informed Drew that they proposed to treat the condition with more antibiotics.

16. I was angry. I felt that the hospital had known earlier than that day and that they had waited to tell Andy until visiting time had finished.

17. I went up with Drew to see Andy on the Sunday. Prior to coming up to the hospital we had checked on the internet about CDifficile. If anything, this had made me more upset.

18. We visited him in his room. He was in agony with his stomach. He was only able to sip milk that he had been given for the pain in his stomach. No one came at all while we were there to explain anything to us. Andy asked me to go and see if I could get some more milk for him.

Communication.

19. I went out to the nurses' station and spoke with a nurse and asked her for some milk. There was another nurse there who appeared to be writing up something. I was very upset. I asked her what sort of strain of CDiff my husband had contracted. She went and spoke to the other nurse. They appeared to be whispering to each other. I became very upset and told them to forget it. I went back to Andy's room.

20. One of the nurses followed me down. She told me that they did not know what strain of CDiff Andrew had contracted but that they would make enquiries at Antrim Area Hospital. I told them I did want to know as I knew that they had other cases of CDiff in the hospital. Drew had found this out from speaking to another visitor in the hospital a few days before. The nurse acknowledged that they had other cases. I asked was it possible that one of the nurses had infected him by carrying it from another patient. She said that it might be possible. She then went and got me a leaflet about the condition. I was not given any more information. At no time did anyone take us as a family and explain to us what the condition was, how it affected Andy, what precautions required to be taken and so on. I can say that we, as a family, were ultra cautious about cleaning our hands but no one from

the hospital ever came to speak to us about it. The only occasion to my knowledge that washing hands was mentioned was on the Monday after the diagnosis when our granddaughter Lorna was asked by a nurse on leaving if she had washed her hands.

21. I do recall a young doctor speaking to my daughter Shauness one day in Andy's room and he said that if the antibiotic for CDiff did not work for Andy they could change it to another. I asked him what the 'strain' was and he told me they did not know yet as the tests for that took a couple of weeks and were done outside Northern Ireland

Events after the diagnosis.

22. On the following Tuesday, 3 days after the diagnosis, Andy was moved back into his original room (that is the first room that he was in when he was admitted to Ward 2).

23. Andy was feeling very "down". He told me that day a nurse had said to him "you're not the only patient" when he asked for a commode. He felt that he was being left unattended until he was about to soil himself and had in fact soiled himself a couple of times.

24. The following day when I was visiting Andy needed a commode. Some time passed before he was brought one. I asked him later where the contents of the used commode had been put and he told me that it was put in the waste bin- this was the same waste bin that we opened and closed to dispose of paper towels.

25. He was unable to sleep in a bed due to his discomfort and preferred to rest on a recliner. Indeed, apart from the time that he shared the

room with the Alzheimers patient and then the lady, he stayed mostly on a recliner.

26. I became even more concerned that his room would be clean. Even prior to him being diagnosed with CDifficile I used antibacterial wipes on the surfaces in his room. I was very conscious of the risk as Andy had contracted the MRSA bug on a previous occasion from the hospital. I used to wipe down his recliner with antibacterial wipes that I bought myself. I would have cleaned his walker. I also cleaned his table and his locker – indeed, anything that I thought was a surface where infection could lie.

Cleaning.

27. I am aware from what Andy told me that the room he was in last was cleaned daily. However, the tidiness generally on that ward seemed lax. I remember on several occasions picking up items that seemed to have fallen to the floor. I have to say that this was not typical of our experience in the Whiteabbey Hospital. We had always had the best of treatment previously and I would never have remarked on an absence of standards there before.

. Clothing and protection.

28. I noticed that the staff always wore gloves and aprons whenever they entered Andy's room once he had CDiff. However, if the staff were pulling up a seat to sit with or to examine Andy, they would not have taken the glove off, so the glove would have been in contact with the underside of the chair before an examination began. That sort of thing worried me though I never said anything about it.

29. On one occasion, Andy was getting his oxygen mask put on. The nurse who was putting it on dropped it on the floor. She then picked it up and went to put it on him. I had to intervene and ask her to provide Andy with another clean mask. I always associated an infected mask as being the reason why Andrew contracted MRSA on the earlier occasion. Exactly the same thing had happened and I never had the courage to challenge it, so I blame myself for Andy contracting MRSA.

30. I was not in the room when staff attended to Andy but he did say that they washed their hands. We cleaned our hands on entering the hospital before getting into the lift. The hospital provided a pink foam. Also, as we had touched a button in the lift, there was liquid soap provided so that we could redo our hands. This was in the room itself. We knew to do this after Andrew contracted MRSA. We were not told to do this by any of the staff nor did they monitor us in terms of washing our hands or applying cleanser.

31. I think that there were signs advising us to wash hands but they were small and not very prominent. My view is that they are too small and should be bigger to be more noticeable. Also, I do not believe that there was much signage about concerning the washing of hands.

32. We were not provided with gloves, aprons or gowns.

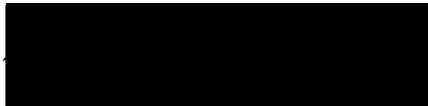
Effect of the Condition.

33. Our lives changed completely after Andy's illness. He was no longer able to drive so we did not go out. He would rarely come out of his bedroom once he was discharged home. I was tired continuously as I was looking after him. He was still suffering from emphysema (and

oedema on occasions) but his loss of mobility and independence I put down to him having contracted CDiff, as he changed completely after taking the condition.

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

Signed:



Dated: 5TH JAN 2011