

## Statement

Patient Name - [REDACTED]

I, Mrs Carlisle, wish to submit my statement and comments regarding the C Dif infection in the Northern Health Trust. Comments made relate to observations and experiences in Antrim Area Hospital and Braid Valley Hospital, Ballymena, unless otherwise stated and the statement will identify which of the two hospitals the points refer to.

The statement covers some main areas including,

- (1) Hygiene - breaches of hygiene and other hygiene issues
- (2) Communication regarding C Dif
- (3) Infection control issues
- (4) Our experiences and how C Dif dealt with
- (5) Antibiotic treatment
- (6) Laundry issues
- (7) Risk of colonisation with C Dif to family and visitors
- (8) Other general relevant and associated comments

There may be some overlap in the statement between these areas, at times, as comments may not always fall 'neatly' into one area being discussed.

Throughout two admissions to Antrim Area Hospital and a transfer to Braid Valley Hospital, we observed, over that lengthy period of approximately eleven and a half months, many breaches of good hygiene protocols and issues of concern. Examples include, not changing aprons and/or gloves between patients, moving from patient to patient to feed them without washing hands between patients even though physical contact was taking place, floors which appeared dirty, coagulated dried blood not cleaned from my mother's bed frame over weeks rather than days, a small amount of faecal matter on the floor beside my mother's bed, shaking my mother's bedding and blankets, when MRSA positive, in the presence of visitors, without regard for their health. These examples, which are taken from both Antrim and Braid Valley Hospitals or are applicable to both, would not be comprehensive. These will be detailed further as the statement progresses.

I would firstly deal my mother's second admission to Antrim Area Hospital in June/July 2007 (I don't have the exact date available).

When I arrived at the bay where my mother was being attended to, a male nurse was there, attempting to measure my mother's blood pressure and having physical contact, particularly as she was somewhat agitated. He was not using gloves or an apron. On observing this I highlighted to the nurse that my mother had MRSA and this should be on the form. He then looked at the form below which he had obviously not read, acknowledged that MRSA was noted on the form and then went to get gloves. I cannot now recall whether the blood pressure cuff being used was of a disposable type or not.

This incident raises some concerns regarding infection control as my mother was in an assessment type bay in A & E which was busy with other patients/potential admissions but no specific infection control procedures appeared to be followed in this situation. Whilst thorough hand washing after contact would probably be fine, even if gloves were not worn, I feel it exposed a vulnerability and weakness in the system and raises questions.

For whatever reason, time pressure etc, the nurse had not read the MRSA positive note; should the nurse have been following 'universal' infection control procedures ie with all patients regardless, did the ambulance crew pass the information on to the receiving hospital staff, did someone else fail to advise the nurse, did the nursing home tell the ambulance crew etc? The difficulty is that my mother was in close proximity to other patients in a busy bay in A & E. There was the possibility that other patients could have open wounds or be immune compromised. Would the blood pressure monitor cuff be used on another patient without sanitising (as said, I cannot recall now if it was a disposable cuff or not). Had I not arrived and made staff aware, how long would it have been until someone realised infection control protocols should apply.

How should information regarding infection status of a patient be relayed. It would appear that one cannot assume that someone would have time/opportunity to read the note. The chain of verbal communication is vulnerable. I feel Health Trusts need to look at this issue.. Someone may feel if

they have documented it, then it will be read, someone else may think it's on record or in the notes previously etc. Clearly one also cannot depend on patients themselves or their families passing this information on for a number of reasons.

While this focuses on MRSA I believe it is relevant, as how infection control is handled and enforced generally, has implications for all infections, including C Dif and the points raised by this incident, such as the way information is relayed, could apply equally to C Dif. Any failure to advise of a current C Dif infection or diarrhoea episode which could potentially be C Dif, leaves everyone vulnerable. It must be borne in mind that not all transfers/admissions are from other hospitals and nursing homes and, even if a C Dif infection were to be documented our experience would suggest that it may not get read.

Some time (I don't have the exact date to hand) following my mother's second admission to Antrim Hospital June/July 2007 she started having diarrhoea episodes. The staff on the ward did not advise us of this, let alone tell us what to do, but we found out 'by accident'. I then queried with one of the nursing staff why she was having diarrhoea and I specifically asked this nurse if they had any concerns it might be C Dif. I expressed my concern that it might be as I felt, in all probability, it was C Dif and it was not in keeping with how my mother would normally have been. The nurse said they had no concerns regarding C Dif and said it may be the *Kabiven* feed, even though it had never caused her any diarrhoea episodes ever before. The 'particular' or unusual odour would certainly have suggested to me that this was not a typical diarrhoea infection.

The nurse advised me that they had sent off a sample to the lab but it would take several days for the results to come back (I believe she said 3-4 days); they would not treat it till they had the results back from the lab. At this point I have no recollection whatsoever of being given any advice regarding not using alcohol gel as it was not effective if it did turn out to be C Dif or of even enforcing that hand washing was critical whether or not you had direct

involvement with the patient's personal care. When C Dif was a strong possibility I believe we should have been advised at this earlier time to take precautions as if it were C Dif. If I were to describe the impression I was given, it was of a somewhat casual approach to the issue. Nursing staff did not seem to apply any more stringent hygiene measures at this point.

The diarrhoea episodes continued whilst waiting for the lab results which confirmed that my mother had a C Dif infection. Even when C Dif was confirmed, still no one advised us not to use the alcohol gel as it was ineffective against C Dif, offered us any explanation of what C Dif was, asked a doctor to have a word with us, advised us of possible contamination of surfaces, bed or bedding or made any attempt to be informative. One would have expected staff to have spoken to the family, emphasised the importance of thorough hand hygiene to prevent the spread of infection, taking care when having contact and not to use alcohol gel. One can imagine the potential for contamination of other surfaces and areas in the hospital, door handles, canteen etc, if appropriate measures are not advised or followed.

I would make a general point here, that whilst the media have done something to better inform the public, unfortunately, not everyone follows hand hygiene protocols, reads the infection control signs around hospitals and above beds. Many do not recognise the significance of the infection control signs above certain beds.

Personal experience would suggest that often people don't actually understand why it is necessary to follow these procedures unless it is highlighted directly to them. Sometimes there is the assumption that hospitals are 'clean' and many, understandably, do not appreciate that bacteria can be present but not visible - one may believe if it looks clean it is clean. Research indicates that 'adherence' is more likely when people understand why something is necessary or the rationale for it. There is, in my opinion, a definite lack of understanding of the whole area of 'cross-contamination' eg you may have just washed your hands or used alcohol gel but if you then go on to have physical contact with an infected patient or surface as you leave, hands may become re-contaminated

and bacteria may be spread to other surfaces or people one comes in contact with. Even wearing gloves, for patient contact, is only a useful practice if you remove them after contact and wash hands before touching other surfaces. I feel it is important to make this multi-faceted point as it applies specifically to C Dif as well to other infections.

I believe too many assumptions are being made that people, including medical and nursing staff will adhere to hygiene protocols. Neither can one assume that family will be in a position to advise all the patient's potential visitors to follow these protocols or will want to. They may feel embarrassed or awkward about doing so or may not even know or have contact with the patient's friends. Personally, I feel more needs to be done to ensure that everyone, hospital staff, porters, kitchen staff included, follows safe, hygienic practice every time, whether the patient is deemed to have an infection or not. One can never say with certainty that anyone is not carrying or incubating an infection, as yet undiagnosed. I have never observed any attempt at ward level in Antrim or Braid Valley Hospitals to encourage or remind visitors to wash their hands, not even when visiting isolation rooms. I appreciate staff have many tasks to deal with but the impression is that, while there may be exceptions, they generally don't bother, possibly not regarding it as their remit or because they don't have time.

I would also highlight the issue of children visiting a patient with their family, particularly when infections such as MRSA, ESBLs, C Dif and other infections are present. Parents may not think it necessary for the child to wash it's hands or use the gel, yet that child may be hugging a patient, sitting on the bed, holding onto the bed frame etc. Do the Health Trusts need to 'educate' parents to apply the same hygiene measures with their children when visiting? Young children's own immune systems are not fully developed and they, potentially, may touch lots of surfaces. Should restrictions apply in certain circumstances? I merely raise the point.

To return to my mother's C Dif infection - No-one on the ward (AAH) came to tell us that the lab results were back, confirming C Dif. Only when the

family asked directly if the lab results confirmed C Dif were we told that it was C Dif and, as already detailed, no further information was given. They may have mentioned that she would be given an antibiotic but that was all. No explanation was offered regarding the seriousness of C Dif generally, the degree and severity of the infection in my mother's case, or the particular strain of C Dif infection. We have yet to find out if it was the more virulent mutated one or the more 'common' strain. We would now like answers to these clinical questions ie severity from original diagnosis and beyond and the strain of C Dif.

My mother was commenced on antibiotic treatment *Flagyl* and whilst on *Flagyl* the diarrhoea continued but, as far as we understand, seemed to lessen either at the end of the antibiotic treatment or just after. I am unsure if she was ever truly clear of C Dif but she may have been free of diarrhoea episodes for two days. I do not know precisely. The C Dif recurred, if it had ever gone and I am unsure what happened exactly at this point. My mother possibly was not on any antibiotic. We would like to know to fill this gap in our knowledge.

Throughout this time all the family were very concerned as the C Dif was having a very weakening effect on my mother. On the 24th July, 2007, my husband visited my mother and on returning home expressed deep concern saying she was very, very pale and she that she looked like a dying woman. During these latter days, while she had a cannula and drip for hydration, she didn't seem to be getting I.V. feed (*Kabiven*) to give her any nutrition. We would like further information about what was happening clinically as we are unsure of why this was. We feel communication at ward level was lacking and we were poorly informed. Some feed back from time to time would have helped and been appreciated. On the 25th July, 2007 my husband and I visited my mother and again the only way to describe her condition was 'like a dying woman'.

That evening we stayed a little longer as my mother seemed so poorly and when one of the night nursing staff came in to the room I expressed concern about my mother's condition. The nurse, who had been off for a number of days, agreed she was very pale and looked less well than she had been the last time the nurse was on duty. I believe her words were 'I think she's okay'. I was

surprised that the nurse did not notice or comment on my mother's breathing or seem to have medical concern about it. I felt my mother was definitely not 'okay'. I said to the nurse that I thought something was wrong with her breathing - which was, as I remember fast but panting and laboured or gasping at the same time. I do not remember whether I highlighted the concern about my mother's breathing before or after the nurse said 'I think she's okay'. As no-one at this point had alerted a doctor or spoken to us further, we returned home.

Somewhere in the region of 11.15 p.m. (I believe we arrived back at Antrim Hospital around 11.40 p.m.) we received a call from the ward asking us to return to the hospital urgently. On arrival, a female doctor spoke to us and explained briefly what was happening. The finer details I do not recall now but basically included mention of infection, concern about my mother's condition and we were advised that they would commence antibiotic treatment with *Vancomycin*. I felt the communication with this doctor was satisfactory and we were spoken to in a clinical but considerate manner. While not a good scenario, we at least knew what was happening.

*Vancomycin* was administered around this time as far as we know. Some family remained during the night then at around 7.45 a.m. a young doctor came in to administer *Vancomycin*. He was unable to do so but seemed to have tried his best, having made several attempts in my presence. He commented about having trouble finding a vein. As he was going off shift he said another doctor would be in later to administer the *Vancomycin*. He also said my mother's infection markers had been "up for a week or so". This was new information as no mention had been made to any of the family about this throughout the week. In fact we were not 'kept in the picture' with any information. Information we sought previously on two occasions and which was noted was never responded to. We still would like this matter clarified. As we kept a continuous vigil at the bedside on the 26th July, 2007, no doctor ever came back to administer further *Vancomycin* or to check on my mother. Her records seem to suggest that a doctor saw her at possibly around 11.00 a.m. but we did not see any doctor. Sometime after 11.00 a.m. a doctor did speak to me in the corridor, rather

clinically advising me that they did not feel my mother would make it through the day. Receiving bad news is not pleasant but some warmth or compassion would not go amiss. To say I'm sorry to have to tell you and a warm or sensitive tone makes a difference to the communication and the family's experience.

The family stayed with my mother continuously until she died at 4.20 p.m. Despite the fact that the family had stayed throughout the night and had been at hospital from early evening on the 25th July, other than one and a half hours and then throughout the day of 26th July, no-one on the day of 26th July offered us a drink of water or a cup of tea, when my mother was so ill and we were scared to leave the room.

From the doctor checked on my mother at 7.45 a.m. not one member of the nursing staff came to ask or check how my mother was, if she was comfortable or to check for further deterioration in her condition, or be generally supportive if needed. There was no sense of empathy or interest. Neither was there any enquiry if we would want to be alone or if the family would like someone to pop their head in from time to time to see how things were. Even an offer that if anything changed or we were concerned not to be afraid to ask, would have been a comfort. No-one explained how things may deteriorate or offered suggestions as to how we could make the situation as comfortable and dignified as possible. We were left from 7.45 a.m. with no-one seeming to take any interest and no communication towards us by staff. Around 3.15 p.m. - 3.30 p.m. we were concerned about my mother's breathing and had to go to the nurse's station to alert staff as no-one was monitoring the situation. At this point two nurses came down and we waited outside the door. We do not know what happened as we did not see. When they left there was a stark and immediate deterioration in my mother's condition for which we would like some clinical information. One nurse never spoke or looked at us and the other stated factually 'her breathing has changed', but that was all. She did not elaborate and they returned to their duties. My mother died at 4.20 p.m. with a gastric feed tube down her throat and the cot sides fully raised.

We would never have had my mother die with the indignity of a gastric

tube down her throat had someone explained that they would not administer pain relief or any other medication via the tube. We would have asked for the tube to be removed unless it was a medical requirement that it remain. In addition, they could have offered to lower or take down the cot sides on one side provided the family remained present for safety reasons. We did not know this at the time. This would have allowed family better access to offer comfort and reassurance instead of having to sustain an awkward position leaned over the cot side reaching down, especially for those with disability who could not manage. When my mother died we reported her death to the nurses station as no-one had said they would check back if we wanted, or advised us what we should do. Had we not done so they would not have known the time of death for their records. No-one offered their sympathy or condolences. We felt alone and unsupported. I would not wish to describe here how my mother looked during those final hours, suffice to say, she did not look like any dying person I'd seen. We believe my mother would not have died when she did had she not acquired C Dif infection. Ultimately, the immediate cause of death was septicaemia from the C Dif infection.

Again no protocols were explained as to who would take care of gathering my mother's personal effects in the room, or when and how. After a short period we left the room so staff could do whatever was necessary. We came back some time later and still no-one had offered to gather my mother's personal effects or enquired whether or not the family wanted to do it. Unsure of protocols and the apparent lack of interest we then took care of my mother's personal effects knowing that they would be under pressure to clean the isolation room and have it ready for another patient. My mother's body had still not been removed from the room despite it being some time from her death and none of the staff came to tell us when this might be or offer any assistance, despite being aware we had returned to the ward. We also needed to go and advise other family and friends of my mother's death and make funeral arrangements.

We had to remove items from the locker etc with the body still there which

felt uncomfortable and disrespectful in the circumstances. All the family found the attitude of the staff to be completely cold and compassionless. It felt like my mother did not matter and was depersonalised. All we expected was a few basic human courtesies. I would however, wish to commend one nurse on duty overnight on 25th - 26th July for her warmth and helpful positive approach.

I would now address the area of antibiotic treatment. While we can appreciate that *Flagyl* would be the initial antibiotic to treat C Dif and *Vancomycin* is normally reserved for sensitive infection which hasn't responded to other treatment, we do not know if for a second episode the alternative antibiotic *Vancomycin* could have been used at the start. As we do not know what strain of C Dif my mother had, we do not know if clinical experience shows *Flagyl* as being equally effective with both strains. The main point is, if my mother's infection markers were significantly up for a week at least why was *Vancomycin* not considered at an earlier date. Clearly the infection markers were indicating the antibiotic *Flagyl* was not effectively eradicating the infection. Did the C Dif infection be allowed to multiply for too long absorbing into the blood stream to cause 'septicaemia'? We feel further information and explanation is needed to, as yet, unanswered questions. Another point I would wish to raise is the delay in commencing antibiotic treatment while waiting on lab results, which do take time, especially when bacteria need to be cultured. I fully understand that it is always preferred, where possible, for good clinical reasons, to have the precise results of clinical tests and the sensitive antibiotic, to treat infection effectively. However, when there was evidence that C Dif was a strong possibility and the impact on the patient if it were, would it have been appropriate to commence *Flagyl* anyhow, whilst waiting on the results of the tests. Had this happened the outcome of the C Dif infection could have been different. We feel the 'waiting period' in commencing the antibiotic treatment allowed the bacteria to have a much stronger hold and proliferate making it harder to eradicate. We would like further clinical information on this point to clarify. Also, if there was knowledge of any other C Dif case on the ward that should have raised concern of a wider infection problem. We did ask staff if there was any other case of C

Dif on the ward and we were told that there wasn't. We would like to know if this information was accurate. Additionally, at this time did the ward know or be advised of a wider infection problem in the hospital generally or was that unknown at the time? Our family would be interested to know when Antrim Hospital first became aware that there was a problem with C Dif infection. Perhaps how wider infection problems in wards or hospitals are monitored, as opposed to individual 'localised' infection, could be examined to check that the system allows problems to be detected at the earliest opportunity and addressed immediately.

### **Laundry**

Still referring to my mother's second admission to Antrim Hospital, June/July 2007. During the C Dif infection with regard to laundry of clothing we were never voluntarily offered any guidance or advice by the ward about handling of laundry or appropriate wash temperatures or informed that disinfectants were useless against C Dif. Gowns are not offered until the infection is clear, even if requested. Latterly we bought inexpensive nightwear and disposed of it every day. We found that if faecal matter or pieces of used pads were still stuck to the nightdresses the soiled nightwear would not be separated. It would be put in a bag with another spreading the contamination. When C Dif contamination/faecal matter is on nightwear, the maximum wash temperature for most available materials is 60 degrees c. Machines only reach that temperature for a short period in the wash cycle and C Dif is not killed off at 60 degrees c so even with washed items it has to be assumed they are not sterile or necessarily free from C Dif. This is a problem for people being expected to handle infected laundry but given no guidance. In my opinion, people are not being properly informed about C Dif infection or hospital infections generally, or the risk that they could carry. I believe many share this opinion.

Most people do not understand much about how various bacteria behave or the implications if it is not isolated or eradicated including with the laundry

issue. Families can innocently take laundry into their own home and treat it similarly to other laundry they would do, perhaps risking cross-contamination by touching other surfaces in the process. One must ask how many people, when they have completed loading the contaminated laundry, would then wash their hands before closing the washing machine door and setting the wash programme. If they did not do this then C Dif contamination could be on the door handle of the machine and control panel to be touched again when doing subsequent washes to say nothing of other surfaces which could become contaminated. Most would also not understand the problem of C Dif bacteria potentially producing spores when not eliminated at the outset and how difficult C Dif spores are to destroy.

Disintegrating sealed bags for laundry which may be available, were not on offer but are not an answer. Firstly, they do not work in every machine, secondly they only fully disintegrate at a certain sustained temperature, could damage the machine and one has to ask how safe the chemical components they disintegrate to, actually are. If the clothing were to be tumble dried including in a washer dryer would the heat have any impact on residual chemicals. At a more basic level staff don't seem to pay much attention what goes into laundry bags. Between both Antrim and Braid Valley Hospitals we have found amongst the laundry a hook, a small piece of wood, a pen, pieces of tape, significant pieces of pad and a used swab. Had laundry not been checked beforehand any of this could have damaged the machine. I feel patient/families should be offered at least the choice of a hospital gown when there is a C Dif infection. Should they decline then appropriate advice should be given.

I would like to point out, that in our experience, no-one ever alerted us to potential health risks of C Dif to family or other visitors, particularly if they were receiving antibiotic treatment which could make them more vulnerable or if anyone had other health issues such as bowel conditions. It cannot be assumed that individuals will automatically make a connection between C Dif and a risk factor for them. There is no reason why they would necessarily know this.

We would like to know what the possibility/probability of colonisation with

C Dif bacteria would be to family and other visitors during the C Dif outbreak given the ongoing problems which developed. Does bacterial samples/evidence, if available, indicate that spores were produced from the C Dif bacteria during this C Dif outbreak? What are the health implications for individuals in the future given the potential risk of colonisation?

If beds, bedding, chairs and other surfaces could be contaminated with C Dif/C Dif spores what risk/probability might there be of colonisation occurring from physical contact with clothing even if hand washing did take place. To use an example, a typical scenario might be - one sits on a chair (not the patient's) touches the chair while sitting, touches clothing, clothing has contact with the chair, visitor washes hands before leaving, sits in the car on the journey home, sits and moves around the home wearing that clothing, returns it to wardrobe with other clothing; what is the level of risk (quantify) of colonisation given that the clothing, deemed clean and possibly of an un-washable material, may be used again in another setting. One will most certainly have physical contact with the seating/surfaces in their car or home regularly. Especially when there are questions about the level and frequency of cleaning in the ward this is not an unreasonable point to raise.

Continuing to discuss events during my mother's second admission June/July 2007 to Antrim Hospital I would also wish to highlight the following concerns regarding hygiene, cleanliness and infection control. My mother's bars of soap kept 'disappearing' and when replaced with a new bar it too would disappear. After replacing several bars of soap within days we decided to pull out the locker to see if any soap had fallen behind it or was put in a basin at the back of the locker. As we did so I saw a used syringe lying in the casing at the back of the locker. The strip running behind the locker and across the wall to the side of the bed had a considerable, visible layer of dust, clearly accumulated for some time. Running ones finger across part of the strip resulted in a significant amount of dust on my fingertip. Not knowing what the syringe had been used for or who it had been used for we did not touch it and assumed that it would be taken care of the following day when the room would be cleaned. No-one was

available to advise of this matter.

To my shock, on 26th July 2007, when gathering my mother's personal effects we checked behind the locker to ensure that nothing had fallen, and discovered the syringe still lying in the same place, clearly visible in the locker casing. From the first time it was noticed till the 26th July 2007 was an estimated three weeks. Given that there was an active C Dif infection plus MRSA We felt this was not acceptable. On another occasion our attention was drawn to an area of the floor which appeared to have something dried on it. I personally cannot say now for sure that it was blood but my recollections that it reminded me of dried blood. The other family member present also, independently, thinks it was blood. We used gloves and a clean tissue to wipe the area and the tissue was grey/black in colour. I was surprised at how dirty the tissue looked. Further inspection revealed the floor did not seem very clean. As this was an area where people could be walking, another area of the floor which should have been relatively clean was wiped with clean tissue but it too made the tissue dirty and black at a level one would not expect. We also observed several syringe covers lying on the floor, about seven in total. As this was not consistent with the number of injections my mother received in a day which could have been one or none, and certainly not seven, it would suggest these had accumulated and raises questions about the frequency and level of cleaning in the room.

When it was decided by the consultant for my mother to have a gastric tube inserted, the first attempt was unsuccessful as the tube was not fully in place. The tube was removed and thrown on the table. Later another nurse returned, lifted the gastric tube off the table and reinserted it. Nothing was done to sterilise or wipe it. I expected they would use a new gastric tube and did not think this was a very hygienic or safe practice. When the process was complete they left the room, paying no attention to the fact that any bacteria plus mucous from the oesophagus and stomach would be on the table. I thought this was disgusting and cleaned the table top myself with paper tissue and *Hibiscrub*. I assume this was not acceptable nursing practice as there is the risk of

introducing infection into the stomach and digestive tract from any bacteria which may be present on the table.

On this ward we also noticed a plastic wash basin out in the corridor near the sinks outside the isolation rooms. The basin may have been set on something. We could never tell if it was clean or dirty or why it was there. It remained there quite some time. I also noticed, when going to wash my hands at one of the sinks in the corridor, a tube lying in the sink. I decided against using that sink as the water would have splashed off the tube over my hands and arms and spread germs. I recall returning to the sink another time, which I presume was on a different day, and thinking - surely that tube isn't still lying in there. If the tube was not to be re-used then why was it not disposed of in clinical waste instead of it being left in a sink spreading germs, where doctors and staff have to wash their hands. If it were to be re-used, which is unlikely, then people washing their hands over it would just increase the contamination of the tube.

I would also add the following comment regarding collection of crockery and cutlery from isolation rooms. When kitchen staff collect dishes/cutlery etc after meals and enter each isolation room they do not seem to wash/clean their hands each time yet there is no guarantee that each person is isolated with the same infection. Potentially, as kitchen staff go between rooms they could carry bacteria from plates and cutlery etc the infected person has handled or bacteria from contaminated surfaces in the previous room into the next one. C Dif could potentially be carried between isolation rooms, as could other infections. I'm making the assumption that in the rest of the ward these items are all collected first. When C Dif was diagnosed nursing staff did wear gloves and aprons for personal care on the occasions we recall.

During my mother's first admission to Antrim Hospital in August 2006, following A & E assessment and a short time in one ward, she was admitted to another unit.

While the medical care my mother received on the ward was critical in those early weeks we also noted matters of concern with regard to hygiene and

infection control. A significant amount of my mother's blood had got on the bed frame but was never cleaned. Family arrived to visit and observing this blood along with some which had dripped on to the floor, cleaned both as much as possible. By this time some of the blood on the bed frame had become dried and was difficult for us to remove without proper cleaning products. Some clearly visible blood remained but it was never cleaned off the bed frame the whole time the bed was in use. We expected that someone would be responsible for cleaning this. On another occasion the *Kabiven* IV feed was running out over the floor for some reason. It was running from beside my mother's bed across the floor to the next bed. Despite the fact that staff came in and out the bay no-one seemed to do anything to deal with it. This milky liquid remained on the floor the whole time we were present - several hours, and was still there when we left. We put some paper towels on the floor to 'plug' it from running further as it already covered quite an area. The heat in the ward would have had a detrimental effect on the milky *Kabiven*. We suspect that there is no support cleaning staff available for spillages and once they leave the ward for the day they do not come back.

While a lot of hand washing did go on I did observe staff going between patients, having skin contact, without washing their hands. I saw a nurse go between all the patients in the bay without changing her gloves, washing her hands or using alcohol gel. I observed inconsistency between nurses doing identical tasks. One male nurse always used gloves when re-positioning patients and having contact while various nurses did not bother and did not sanitise or wash their hands afterwards despite having the same level of physical contact. They may have gone to another patient immediately after. One evening I observed two nurses as they progressed around the bay dealing with more intimate care of patients. Curtains were drawn. One nurse came from behind the curtain, did not change her gloves, and went to the next patient with the same gloves. Aprons, when worn, were not always changed between patients either. On one occasion my recollection is of a nurse going round every patient in the bay without sanitising her hands between patients. One evening a

nurse and an auxiliary were dealing with patient personal care together. The nurse changed her apron and gloves and washed her hands at the sink. She seemed to look at the auxiliary as if wondering why they were not doing the same but said nothing. This other individual did not bother.

One day we had noticed something in my mother's mouth which turned out to be a large hardened disc of food, about the size of a two pence piece at least. I tried to retrieve it but could not manage. A nurse at the next bed who had been feeding a patient and, as far as I can recall, had hand contact with the patient's mouth, came to assist. She did not sanitise her hands but put her fingers straight into my mother's mouth. While there is no excuse for carelessness, I do feel that there isn't probably enough recognition given to the demands of nursing often elderly patients with complex needs. Feeding stroke patients for example can be time consuming and is difficult to rush because of risk of choking, infection into the lungs etc and yet staff do have to 'rush' as there is pressure to get the meals over whilst keeping them as warm as possible. Under pressure of competing demands staff are more likely to 'cut corners', forget or just not take the time to follow hygienic practices.

Other observations and concerns include nurses washing their hands and when disposing of the paper towels, frequently do not use the pedal mechanism on the bin but instead lift the lid by hand to dispose of the towel. One cannot assume that the bin lids are free of bacteria or contamination and there is the risk of re-contaminating hands or spreading infection, particularly if it is the lid of a clinical waste bin. This practice happened in both Antrim and Braid Valley Hospitals. The alcohol gel dispenser at my mother's bed was always empty and was never filled. However, the sink was next to her bed on this ward. Patients who could feed themselves did not receive assistance with hand hygiene before eating. A nurse drained a catheter bag into a urine bottle and set the bottle on the patient's table for a time. A nurse lifted a spoon from the back of a sink on the ward and used it for a patient without it being properly sterilised. A nurse also lifted a spoon from the back of a sink, rinsed it under the tap dried it with a hand towel and used it to administer medication to my mother. I said to the

nurse is that okay and her reply was “what do you think would be wrong with it”. Given that it had been sitting where bacterial contamination was possible via splashes etc I felt it should have been properly sterilised before using it with a vulnerable patient. On another occasion I found used gloves sitting on my mother’s locker top. I disposed of them in clinical waste and cleaned the top of the locker.

#### Curtains around the bed

Staff would deal with patient care, toileting etc and when finished would pull back the curtain with their gloves still on. I would assume any bacteria on gloves could transfer to the curtain and create a potential source for transfer of infection, including C Dif, through subsequent hand contact touching the curtain. Would a safer practice be to remove one glove turning inside out then pull back the curtain and complete the hand washing?

#### Water Jugs

One day I observed a girl with a trolley of water jugs. I expected her to lift all the used jugs and replace the jugs at each locker with a new jug of fresh water. To my surprise she took the jugs off the lockers two at a time, tipped any remaining water down the sink on the ward then tipped the new water from the new jugs on the trolley into the used jugs and replaced them back on the lockers. I could not quite see the logic unless it was to save having to wash jugs. The problem I see with this is that these used jugs emptied two at a time, when refilled, may not be put back on the same locker as they were taken from. A different patient or family could be handling the used jug of another patient, and this girl will have handled many used jugs, more potential for transfer of infection. One has to ask what was done with the jugs which were returned to the kitchen, were these washed after handling?

Emptying water jugs down a sink used to wash hands after all types of patient contact and those jugs being returned to the locker again has potential for contamination. I do not know how regular a practice this was but it seems inadvisable. Is it not more simple that all the ‘old’ jugs are collected separately by one person and another person replaces them with the fresh jugs of water or

one person collects all the 'old' jugs then washes their hands and replaces with fresh water jugs.

On this ward, one day I observed a nurse cleaning a bed and locker. She was applying a great deal of effort and seemed to be doing her best. In fact it was exhausting watching her. It seemed difficult somehow to clean the underside. I do not recall any cleaning of the bed frame. This is unclear. The nurse then started to clean the surfaces and drawers of the locker but missed one surface. In a very short time, one to two hours, the bed was re-made and a new patient was in the bed space. I doubt they even had time to clean the floor in that area.

Consideration needs to be given to the speed of turnover of beds and how that may impact infection control. Residual bacteria would not get time to 'die off' before the bed is back in use. I feel while these situations recorded were not observed in the period under investigation they have relevance to the C Dif infection. Any breach of hygienic practice or vulnerability in the whole infection control system will impact C Dif infection. They are therefore pertinent to the investigation. Some of these observations were repeated, may be relatively common amongst staff generally and could easily still occur during the period under investigation.

I would like to record here my mother's own comments on cleaning in the A & E long stay ward where she spent a few days in June 2006. She commented that the isolated area next to her bed 'wasn't half cleaned' and little time was spent. She also said that when the cleaner had come in she offered to move out of the bed to enable them to clean under it. She alleged that the cleaner said it wasn't necessary as she did not need to clean under the bed.

#### Computer Database

As far as we are aware the existing computer database records former patients with MRSA but does not hold the same details of carriers of other resistant infections such as ESBLs. A patient may be admitted carrying an ESBL infection but this may not be discovered until the patient notes are requested and arrive from medical records which could be the next day at least.

In the meantime if staff are not advised, for whatever reason, there is potential for infection to be spread should 'universal' precautions be lax. There may be an application to C Dif. Would it be useful record on computer patients who have been affected by C Dif episodes?

Finally, comments relating to my mother's admission to Braid Valley Hospital September/October 2006 following transfer from Antrim Hospital. On the day of arrival at Braid Valley Hospital my mother was swabbed for MRSA and the results came back positive. As this was done on arrival this means my mother had acquired the MRSA in Antrim Hospital. She had never been in hospital for many decades, until 2006. She almost never used antibiotics and in the community she had no contact with MRSA.

Given the things we observed on the ward in Antrim Hospital I feel the most likely source of MRSA infection was through poor hygiene on the ward. My mother must have become MRSA positive whilst in a communal ward in Antrim Hospital without staff knowing, which illustrates how vulnerable patients can be to transfer of infection, particularly when infection is undiagnosed and high standards of hygiene are not maintained.

With regard to C Dif outbreak in Braid Valley Hospital, one Sunday around January 2007 we became aware of an infection issue on the ward. We later discovered that my mother was affected by diarrhoea episodes. The only information given at this point to the family member was to 'do your hands' but not specifically to wash them or not to use the alcohol gel in these circumstances. When we later questioned if the infection was C Dif the nursing staff spoken to refused to confirm it was C Dif and the way our questions were answered they were clearly being evasive. No advice was given. The following day the sister on the ward did confirm, when asked, that it was C Dif. I was aware they were commencing antibiotic treatment with *Flagyl*. From what I remember I had to ask for the information I got. As my mother was already in an isolation room and her only visitors were family and the first person to have C Dif in this outbreak, (January 2007) was some distance from my mother, the C Dif had to be spread through poor hygiene amongst staff and/or breakdown in

infection control.

During my mother's stay in Braid Valley we regularly noticed issues of concern regarding hygiene and infection control. Examples include staff going between patients without washing their hands. Staff going between patients, when feeding them, without washing their hands. No alcohol gel in my mother's isolation room for some time. A dispenser was eventually filled when requested. However, there was a sink in the room. Stains on curtains around the bed. I cannot say if the stains could not be cleaned, only that the stains made the curtain look dirty. A small amount of faecal matter was observed on the floor beside my mother's bed, when we were asked to come to the hospital one day, as she was unwell. A nurse did clean it a short time later and perhaps due to the urgency of the situation it had gone unnoticed for a time. One day a nurse, carelessly, in my opinion, threw a blanket from my mother's bed across the ward on to a chair for visitors, disseminating particles and skin flakes into the air. These particles were visible in the air. Another example was of staff vigorously shaking my mother's bedding, in the presence of visitors, sending particles around the room. Staff frequently did not wear aprons when dealing with infected patients despite bodily contact between themselves and the patient. As far as I could tell patients who could feed themselves were not given assistance with hand hygiene, before eating. On one occasion a nurse was dealing with my mother. The task necessitated hand hygiene afterwards yet the nurse clearly hesitated then decided she would wash her hands. In my opinion, particularly in an isolation room, there should be no question of hesitation.

On a further occasion, in one of the bays, I was trying to ascertain which blanket was my mother's. The nurse present at the time said it did not matter as they all had MRSA. While I understand this, it disregards the fact that other bugs, viruses etc can be passed between patients including via blankets. The fact that they may all have had MRSA is irrelevant. Patients may be a carrier of bacteria which do not harm them but may be detrimental to another patient. While examples cited may not necessarily have been observed during the C Dif outbreak at Braid Valley Hospital, as previously stated, they are relevant to C Dif

infection as any breakdown in infection control procedures create an environment where infection, including C Dif can be spread.

The main point to make regarding antibiotic treatment during the C Dif outbreak in Braid Valley Hospital is the 'delay' in commencement of antibiotic treatment while waiting on the lab results, which I have already discussed when dealing with C Dif infection at Antrim Hospital. The comments already made regarding collection of crockery, 'curtains around the bed' and health risks to visitors under Antrim Hospital also apply to Braid Valley Hospital and need not be repeated.

Other matters include lack of space and bed and patient's chairs too close together increasing the likelihood of transfer of infection. Staff were limited in what they could do about this. On one occasion I observed a doctor, with a number of patient files, place them on a trolley which sat at the end of the corridor, and start to work with these files. Perhaps the doctor thought he had no other place to go. However, this trolley was used for the delivery of food, crockery etc to the wards so should not be used as a work surface given the risk of spreading germs and infection onto the surface which could then transfer to food.

I would also comment on kitchen staff who are also employed to work as cleaners, as was the case in Braid Valley Hospital. While there is no reason the employee cannot do both, provided they carefully follow hygienic practices, are properly trained and have the necessary command of the language to understand the training, it is hardly ideal.

In closing, I would emphasise that during my mother's hospital stays she was confirmed as having MRSA, and C Dif twice, in two separate outbreaks, weakening her body, causing her undue suffering and leading to septicaemia. This is totally unacceptable and the family not only have had to come to terms with her death but also the factors surrounding it. We welcome this inquiry and await it's findings.

## **C Dif Inquiry**

The contents of this statement are accurate to the best of my knowledge and belief.

Signed Y Carlisle (Mrs)

Date 10th September, 2010