Inquiry Witness Statement of

Jean BEATTIE

BACKGROUND

1. My full name is Jane Beattie. I use Jean rather than Jane. My contact details are known to the Inquiry. I was admitted to the Vale of Leven Hospital ("VOLH") in early 2008, around the end of January 2008. I was 54 years of age when I was admitted to VOLH. I was advised I had Clostridium Difficile ("C. *diff*") on 9 February 2008 by telephone call to my home, from a doctor at the VOLH.

Dates of stay in Vale of Leven Hospital

2. I was admitted twice to the VOLH. I was admitted round about the end of January 2008. I was discharged on the 8th February 2008. I was then re-admitted on the 9th February 2008 and was discharged on 18th February 2008.

Reasons for Admission

3. In late 2007, I had a chest infection which developed into pneumonia. My GP had prescribed me penicillin. I had an allergic reaction to the penicillin, and thought I was having a heart attack. I called NHS 24 who called an ambulance for me. I was taken by ambulance to the VOLH. This was in late January 2008.

General Health at Admission

4. My general health before admission to the VOLH was not too bad. Generally my health has not been as good as it once was since turning 50.

5. I am employed as a support worker. I work in a day unit and assist those with mental and physical disabilities. I assist them with toileting needs etc and use lifting equipment and aids.

C DIFFICILE

6. I was discharged from my pneumonia-related stay on 8th February 2008. I remember it being a Friday and the hospital staff were keen to get the ward emptied for the weekend. I wasn't feeling great on discharge, but wanted to get home. I felt ok to go home.

7. I called a taxi, got home, made a cup of tea and went to bed. As the day went on I felt worse. I had an awful night. I had bad sickness and diarrhoea I was hot, cold and shivering. I thought at the time that it would pass. The next morning my mum and sister Isobel came to visit. While they were visiting me, the phone rang. It was a doctor from the VOLH. He told me I had C. *diff* and told me to come back to VOLH immediately.

8. On arrival at the VOLH on 9th February 2008, I waited for 5 hours in the Medical Assessment Unit. Nobody mentioned C. *diff* to me while I was there. I was placed in the General Assessment Unit. I was not isolated. The doctors and nurses who saw me did not wear aprons, or gloves. I was eventually taken to an isolation room.

Location

9. During my first admission I was in ward 6, room 17. I am shown Ward 6-ORIGINAL **(PRODUCTION NUMBER 10)** and have pointed this out for you. I remained in ward 6 room 17 for the full duration of my stay until discharge on the 8th February 2008. I did not move to a different ward at any time. It was a 3 bed room. There were two older ladies also in the room with me. One lady was not of sound mind, and regularly tried to attack me. The other patient was dying. The room was small. The beds were very close together. There were 3 lockers. There was hardly any room to move. The lady who was dying was removed 3 days following my admission and replaced with another lady. Therefore there were always 3 patients occupying 3 beds.

10 On my second admission on 9 February 2008, I was taken to ward 6, room 12 following my 5 hour spell in the Medical Assessment Unit. This was a single bed room that was used for isolation purposes. There was an isolation sign in the window. The door was left open most of the time so that I could see down the corridor. This was despite the fact I was in isolation. I found this odd. I was made aware by one of the nursing staff that I was not to leave the room.

Effect of C. Difficile

11. I suffered awful sickness, diarrhoea and hot and cold sweats while I had C. *diff* during my second admission. I lost 17lbs in weight and was very weak.

12. I received antibiotics via a drip and tablets that were foul. I cannot remember the name of the tablet. I also was given fluids.

13. I was in hospital from 9th February 2008 until 18th February 2008 with C. *diff* symptoms and was in isolation for that entire period.

14. I had no further C. *diff* symptoms on discharge but it did take me some time to get back to work and get my strength back.

15. I was off work for about 5 or 6 weeks in total from the date of my original admission with pneumonia in late January 2008.

Information given about C. Difficile

16. I was given no information by staff about the cause or nature of the C.*diff* infection, or about the risk to myself or others.

17. My friend downloaded some information from the internet and brought it in to the hospital. It was only at that point that I realised C. *diff* could be a very serious infection. I asked a nurse about it. The nurse explained it in medical terms and it went right over my head. The nurse did not give me the impression that it was serious. The nurse explained that antibiotics could cause it. The nurse did not mention risk and in fact it sounded like it was something she dealt with every day. The nurse was nurse was very matter of fact.

18. I was not aware that I had been or was being tested for C. *diff* at any time during either admission to the VOLH.

19. I was not given any documentation by staff relating to C. *diff.* I am shown C Diff Advice Leaflet- by NHSGGC **(PRODUCTION NUMBER 1)** and C Diff Advice Leaflet – by HPS **(PRODUCTION NUMBER 2)**I have not seen these documents before. I presumed that because I was in isolation I was infectious. No staff member told me that it C. *diff* was infectious.

20. I did not know that people had died from C. *diff* until I saw it in the papers. I think it was the Lennox Herald. I now know that people had died of C. *diff* before my admission.

Hygiene and cleanliness

21. During my original admission to ward 6, room 17. I was not told of any precautions about hygiene to be observed by visitors or indeed by myself. There was a gel dispenser at the front door of ward 6 and one inside room 17. There were signs encouraging use which were reasonably obvious. I do not remember being told to use the gel, and I do not remember any visitors being encouraged to use the gel. My visitors tended to use it as most of them are in the caring profession.

22. During my second admission to the isolation room, ward 6, room 12, on 9th February 2008 there were aprons and gloves and a wash hand basin outside the isolation room. I wasn't advised to tell my visitors about wearing the aprons or gloves, or indeed about washing their hands. I presumed it was barrier nursing. My visitors are also in the caring profession so I assume they knew to wear the aprons, gloves etc and to wash their hands with soap at the wash hand basin. There were no bathing or showering facilities. The room had a wash hand basin and a commode. I was never offered a bed bath, or a wash in the whole time I was in there. I had to make do with washing myself in the small wash hand basin. It was very difficult. Nurses who were treating me or attending to me wore aprons and gloves.

Laundry

23. I was surprised at the lack of laundry facilities and lack of information about laundry.

24. I wasn't given any information on what to do with dirty laundry during my first admission to ward 6 room 17, for pneumonia. My visitors took my dirty laundry away in any old plastic bag.

25. During my second admission in isolation, ward 6, room 12, my son took my washing home. He was not given anything to put the washing in. I simply put it in a carrier bag and he took it home. I was told by staff that there were no laundry washing facilities available. I asked staff if there was not a red bag facility. I know from my prior experience of working in elderly care that washing belonging to anyone who is infected would be placed in a red bag. I told my son to make sure that he washed my clothes in a hot wash. My son was given no information or instruction from the medical or nursing staff regarding removal of laundry from hospital, how it should be packaged for removal, or how to wash the items.

26. In my experience of working with the elderly in my profession, even the cutlery and crockery that an infected patient had used would be put in a bag. Nothing would leave the room unless it was in a bag. In VOLH during my time in isolation, nothing seemed to be bagged. My food was delivered and taken away in the same manner as it had been during my original admission. It was delivered by an auxiliary. My plates, cups etc were taken away as normal. Nothing was placed in a bag . There appeared to be no special instructions in relation to any of this for an infected patient.

VOL HOSPITAL

Impressions

27. During the time of both admissions my general impression was that the there were too many beds in rooms. I witnessed this not only in ward 6 room 17, but also noted in general that rooms appeared cramped. The building badly needed upgraded and redecorated. I felt as though it was being deliberately run down. When they eventually did spend money, they spent it on a fancy entrance to the building, not on the things that really mattered such as patient care.

28. Spacing of beds in bays and rooms was poor. Ward 6, room 17, had 3 beds. It was cramped. There was barely any room between beds. Visitors had to sit on beds as there was little room to sit elsewhere. My mum sat on my bed on a few occasions because of confined space. On one occasion I was having fluid drained from my lungs, and room 17 was full of visitors, who were visiting the lady who was dying. There were 4 or 5 students around my bed along with the doctor and the curtain was pulled around me. There was no space at all.

29. Ward staffing levels were low. The staff generally were run off their feet. Many of the patients were elderly and I felt that they should have been on an elderly ward as they needed extra care.

30. The cleaner in ward 6 room 17 was a wee marvel. She had little time and worked very hard. She even moved cabinets and beds, even though she mentioned to me that she wasn't supposed to do that for

health and safety reasons. She did it to try and make the room cleaner. She was certainly overworked. I was never removed from my room so that the room could be deep cleaned either in ward 6 room 17 or in isolation in ward 6 room 12.

31. I wasn't aware of seeing ward management during either of my stays. I was aware of the ward Sister. She was a little brash. She had a very curt manner with staff and patients alike. She was however very busy and seemed to be very efficient. Most of the staff were approachable. Most of the time there were staff available if you needed them, but naturally you would have to wait sometimes if the staff were with another patient. This is true both of the ward 6 room 17 and also the isolation room, ward 6, room 12. In the isolation room I buzzed if I needed anyone.

32. During both admissions, I was given fluid by a drip. I was also able to drink water from a bedside jug. I do not remember being told to drink.

33. Food was bland, but fine. I was able to eat during both admissions to the VOLH.

34. In ward 6, room 17 there was little privacy and dignity. The room was so cramped you could hear and see most things, even when the curtain was pulled around my bed. The lady who was dying certainly didn't have any privacy or dignity and her family had requested a single room but had not been given it. It was also not very nice for us to watch someone dying.

35. While In isolation, in ward 6 room 12, the door was left open. If I wanted privacy to wash, I would close the door. The staff new that if the door was closed I wanted privacy.

36. I have no objection to my witness statement being published as part of the evidence to the Inquiry. I believe the facts stated in this witness statement to be true.

Signed...

Dated......19/4/10......