



HASCAS

DIGNITY THROUGH ACTION
(Older People)

RESOURCE 3

DIGNITY WORKSHOP PACK

CASE STUDY B VARIATIONS

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ACTIVITY 3.1: CASE STUDY B1: MR MICHAEL SMITH (78 YRS) INDEPENDENT LIVING

(This a made up case study based on a number of real life experiences)

BACKGROUND

Michael Smith (78 years), a widower, lives alone. He had been a chef and hotel manager with a national company. He was injured, breaking his pelvis and legs, in a fall through an open cellar floor door when he was 55 years old. He took early retirement at the age of 60 with continued back and walking problems. He bought a flat with the compensation money. He now lives on a private pension and a state pension. His flat is on the second floor in a block of flats with lifts. The flat has a lounge, a bedroom, bathroom with walk in shower and a dining kitchen. The flat also came with a lock up garage. Locally there is a small supermarket (200m away) and the Library and local Day Centre are about 500m away. He has an older sister, Mary (80 years), who is resident in a local care home, and a daughter, Alice (55 years), who is a busy County Councillor and lives about 60 miles away. She keeps with in touch with her father with regular telephone calls and she tries to visit him about once a month. . Michael is fiercely independent but is daughter helps him with what he calls *'his private business'*, helping him with insurance, tax, bill paying and any major purchases because he often forgets to do things on time.

He has high personal standards and he tries to keep his flat clean and tidy. He has tried to remain mobile and used to walk to the local shops, library and day centre. He walks quite slowly and is frightened about falling. With the help of his daughter he had purchased a mobility scooter and he tends to use this to travel to the local shops and the library. Up to about 3 months ago he had been attending the local Day Centre and having lunch, but as a professional chef he had complained because he did not think the food was of adequate quality or value for money. He also did not like the organized activities organised. As a result he has been spending increasing amounts of time on his own in his flat and is seldom seen by his neighbours.

What brought Michael to the attention of Social Services was that a month ago he was involved in an argument with some youths at the local shops who he believed were trying to steal some bottles of wine. He was pushed about and he collided with a lamp post. Michael was taken to the local hospital with a head wound that required suturing and he also found to be suffering from concussion, dehydration and a degree of malnutrition. Because of his concussion he was admitted into the hospital for observations where his general physical condition improved rapidly. Prior to discharge he was visited by a social worker for assessment. He continued to insist that he wanted to live on his own, pay his own bills and look after himself. After a lengthy discussion with his daughter, he finally accepted the need for some help at home particularly with cleaning, laundry and cooking, as he recognised that he had not been eating or looking after himself as well as he might. An Independent Living Care Plan was developed which included care support at home. This support would be provided by an agency carer for 2 hours a day for 5 days per week to help with shopping, laundry, meal preparation and cleaning. The hospital's occupational therapist assessment indicated that he could walk, but that he needed aids to improve his confidence in getting some exercise and to reduce his concern about falling. It was recommended that he used a 'quad cane' for getting about his flat and a 4 wheel 'Rollator' walking frame for confidence during walking to the library or shops rather than use his mobility scooter. He was encouraged by the interest people were paying in him and enthusiastic about walking around again with some confidence. It was also suggested that he had some handrails fitted in his flat and that he used a shower chair.

I keep in regular contact with my dad by telephone and try to see him about once a month. I had not seen him for 5 weeks when I was telephoned by the Police who told me he had been injured. I visited him in hospital and I was shocked in the physical change that had come over him in such a short time. He used to be such a strong and confident man, but he now suddenly seemed quite frail. I know he had problems walking, but he always seemed to be able to get around especially after I helped him buy a mobility scooter. He kept the mobility scooter in his garage where he could charge it up, but he would struggle to take bags up to his flat and sometimes had to make several trips. I have often suggested to him to come to live with me and my husband, but he always said that he wanted to live on his own. I even suggested I could make the arrangements for him to move into a residential home nearer to us, but he said he did not want to live with other old people like his sister. I thought it was an excellent plan for him to have an agency carer to help him during the week. I checked with him about buying the recommended equipment and he insisted that you have to pay for everything. I went to town and bought the recommended walking aids and left them in the hallway of his flat as he was not allowed to leave things on the landing outside his door.

For a couple of weeks things seemed go quite well. There were 3 female carers allocated to my dad on a rotating basis. He liked the company and having somebody, especially women, to talk to. He liked having pots of tea made for him, but he found that each carer seemed to have like doing different things. One carer liked cleaning; one carer seemed to like spend the time doing his laundry or shopping, and the third carer seemed to spend a lot of time talking, particularly about the problems of her teenage son. She also talked about the women she cared for in the next block of flats who kept money in plastic bags and never spent it. It turned out that my dad liked this carer the best because she was so friendly, paid him a lot of attention and was always getting him to talk about himself. They would swap funny stories about the other older people in the neighbourhood.

After a few weeks dad started to make little complaints to me that the carers from the agency did not always seem turn up on time or stay for as long they were supposed to stay. He seemed to be given a lot of microwave meals or pies with tinned peas or beans. He had explained to them that he liked to eat a good breakfast and was not always ready for a lunch at 12 o'clock, so often he just had a small cheese sandwich with an instant soup at lunchtime and was left something in the fridge to heat up for tea. He had told them that he would really have liked more fresh vegetables and perhaps steak and chips or a pork chop, but they never cooked him anything like that. Sometime he would go and get fish and chips from the local shop leaving the prepared meal in the fridge or throwing it away so as not to upset his helpers. However the one thing that was really bothering him was the way the carers went out shopping. He sometimes wanted to be taken shopping with them, but he was finding that the carers did not want to do this and just go shopping themselves because it was quicker. One carer even said that it was safer if she did the shopping because the pavements were so uneven and that he might fall down and break his hips. She apparently suggested that he would then be in a wheelchair for a long time. The carer with the family problems always seemed to want to do the shopping. She seemed to take a long time and there never seemed to be much change out of the money he gave her and, although the products purchased were basically the same each week, they now seemed to be the cheapest supermarket brands. When my dad challenged her and asked her for the bill, she said that she had not been given one. He felt that he should contact the Agency, but he really did not want to complain because she did not seem to earn very much and she seemed to have a lot of personal problems with her son. He really did not want to create a fuss because the amount of money was small and most of the time it seemed OK.

What really upset him was that suddenly 'out of the blue' a new carer (*a young man who was a part-time student*) arrived one afternoon, not the morning as planned. My dad said that he would not let him into the flat, even though he said he had an ID card, because he dressed like one of the young men who had '*mugged him*' at the shops. I agreed with my dad that I would contact the Agency to check on hours and the rota. I also said I would arrange for him to be taken shopping. I contacted the Agency, explained who I was and tried to ask some questions. They were reluctant to talk to me and referred me to Social Services. I wrote a letter to the Social Services Department telling them who I was, making a number of points and asking them to contact me by telephone. After a week I telephoned Social Services myself and after speaking to a number of people I eventually spoke to a helpful lady who said that they would send someone out to talk to my dad, but it would be at least a week before this could happen.

Later the same week my dad telephoned me to tell me that a women – '*a Helen something or other*' and a student had just left the flat with his Rollator' walking frame. They had arrived and had said something about the '*local Council*' and '*mobility*'. He thought they were from Social Services, so he had let them in and they seemed nice and friendly. The student, without asking, had lifted in a large box into the hallway and left it there. Over a cup of tea, the lady started asking all sorts of detailed questions about him, how often he went out, how much money he had and what sort of benefits he claimed. She said she needed to bring her records up to date as all she had been given was his name and address and that he needed a walking aid. She spoke very loudly and slowly, but my dad, who is not deaf, just let this go as he was more concerned about watching the student unpacking and assembling some type of walking frame without wheels which looked a bit flimsy and which my dad thought he might have to pay for. The lady then asked the student to find a place to store the new walking frame because she said that it could not leave it unless it was stored away properly for health and safety reasons, unlike the way he had stored the '*borrowed one*' in the hallway. She then said she would ensure that he did not need to worry about the borrowed walking frame, because she would ensure it would be returned to the hospital. My dad, who was keeping an eye on the student moving coats from the hall way broom cupboard to his bedroom to make room for the new walking frame, said he was getting a bit confused, but that he did try to explain that he actually owned the Rollator walking frame and he did not want anything else. Meanwhile, the women was rolling up the three loose rugs from the floor of the lounge and putting them at the front door. She said these were dangerous and could cause him to have a nasty fall. The student moved his Rollator walking frame down to the van parked outside. After they had gone he felt very guilty because all they had only wanted to do was help him, but he had become frustrated with trying to explain to them about his Rollator' walking frame which he wanted back. They had also left his rugs on the landing and he did not know what to do about them. He was not sure where these people came from. I telephoned Social Services who thought his visitors were from a local Charity called '*Mobility Action for the Elderly*'.

I contacted the charity and explained the situation and they located his Rollator walking frame and said it would be returned. As I write I am still waiting for my dad to have a visit from Social Services which I intend to be at so we can discuss the way the carers have been acting.

ACTIVITY 3.1: CASE STUDY B2: MRS JANICE ARTHUR (80 YRS) IN A CARE HOME

(This is a made up case study based on a range of real life experiences)

AN EXTRACT FROM THE RED ROBIN CARE HOME BROCHURE

Red Robin Care Home is located in Northborough, with easy access to the M28 motorway. The home is just 1/2 mile from the town centre and enjoys easy access to shops, public transport and local amenities. The home was built in 1987 and was renovated in 2000. It provides accommodation for 60 residents in one main building and two attached accommodation annexes. Our objective is to offer you first class care, respecting your individuality, dignity and privacy by offering you the maximum choice in a happy and safe environment. We offer:

- Individually planned care from trained staff under the direction of a professional manager.
- Three delicious meals a day and snacks.
- Daily housekeeping and linen services.
- Personal laundry services.
- A library/quiet Room, conservatories and an activity room.
- Assistance with medications and assistance with personal care.
- Additional services such as hairdressing and chiropody are provided at additional cost.
- A programme of social and leisure activities.

A qualified and experienced senior staff team provide 24 hour care supervision for the home, and they are ably supported by trained Care Assistants, catering and domestic staff. The team aim to provide comfort and companionship in a supportive environment. Each resident is encouraged to lead his/her own life in an independent manner. Recent innovations have been the provision of a multi-denominational faith and prayer room which is open to all residents and the creation of a large activity/hobbies room. There is a large dining room. Residents are encouraged to eat all their meals in the Dining Room, but arrangements can be made for residents to take light meals in their rooms. Each furnished individual bed-sitting room is bright and tastefully decorated with a large double glazed window. Many rooms have agreeable garden views. Each room has en-suite shower facilities. There is an emergency call system in each room.

MRS ARTHUR IN THE CARE HOME

This Case Study is about Mrs Janice Arthur (*a widow and a retired shop owner*) who normally lives with her daughter Elwira, a recently retired community nurse. Elwira's brother and his wife who live in Scotland had been injured in a car accident and so she had agreed to look after them for a few weeks. Mrs Arthur could be forgetful and uses a walking aid. Therefore her daughter arranged for her mother to have a short stay (*5 weeks*) at the Red Robin Care Home. Mrs Arthur was not particularly happy about leaving her home for this period, but she understood the reasons. She was anxious that this might be the start of moving into a residential home on a more permanent basis. Her daughter, who had power of attorney, planned to contact the Home most days to discuss how her mother was progressing.

I am Mary Jones and I was recently employed as an untrained Health Care Worker (HCA) at the Red Robin Care Home. In the first week at about at about 8am the residents were being 'got out of bed' and prepared for breakfast. We were providing help to the residents that needed assistance. I had been allocated to work with an experienced HCA, Lisa Phillips, who had worked for a number of years at the Red Robin Home.

One of the residents that needed assistance was Mrs Janice Arthur, aged 80 years, and who had been a resident at the Red Robin Care Home for 4 weeks. She had recently had a fall in the Residents' Lounge and has lost all confidence in walking. Lisa said that Mrs Arthur had been seen by the Home's GP after the fall and she had suffered no injuries. However, he thought that she was showing the early symptoms of dementia. Since the fall, Mrs Arthur's mobility had been reassessed and her Care Plan now stated that she had to be accompanied when walking with her walking aid from her room to other areas. We went to Mrs Arthur's room to get her up and dressed for breakfast, Lisa did not knock on the door and we went straight in. She opened the curtains with a flourish. Meanwhile, I smiled at Mrs Arthur and said 'good morning' and introduced myself because I had not looked after her before. Mrs Arthur who was still drowsy managed a quiet 'hello' back. Lisa then motioned to me to get to the other side of the bed and she started lifting Mrs Arthur into a sitting position. She then pulled the bedclothes back in preparation to turn Mrs Arthur's legs over the edge of the bed. She then proceeded to pull her forward out of the bed in an attempt to get her to stand up. It was then that we noticed that she had been incontinent of urine. Although she was wearing a pad her nightgown and bedclothes were wet. Lisa said loudly '*God you stink Janice and went to open the windows*'. She then said to me over Mrs Arthur '*we are a bit short of staff this morning, so we will get her up now, change her pad, dress her and we will deal with her later*'. She replaced Mrs Arthur's pad without washing her and pulled on her pants, dressing her in the slightly soiled and crumpled clothes from the chair which had also been worn yesterday. At this stage Mrs Arthur was becoming agitated and upset. Lisa said '*well she gets like this when she has to do things she does not want to do . . . but she has got to do it and you have got to show them who is in charge*'. Mrs Arthur was then helped to the chair and sat down. Lisa also said that Mrs Arthur often stayed in her room all day because she did not like mixing with the other residents in the Lounge which she found

noisy. Lisa then made sure that the call bell was not activated, just the light. I asked why she did this and she said that Mrs Arthur kept pressing it for attention; asking for snacks between meals. We then left the room to deal with the next resident, leaving the door wide open. A little while later I was passing Mrs Arthur's room to find her sitting with her breakfast in front of her, it appeared that she had not touched any of the food or drink. I went back to Lisa and asked what to do. She said that Mrs Arthur had been assessed and that she was quite capable of feeding herself, so she must not be very hungry this morning. I went back to Mrs Arthur and asked her why she did not want her breakfast. She said that she could not eat because she did not have her teeth in. So I searched her room going through the cupboards and drawers. The teeth were nowhere to be found either in the room or on-suite bathroom. Mrs Arthur was becoming agitated again saying that she had not had her teeth for dinner last night, but she could not remember when she last had them. So I made sure she drank a cup of tea, before I went to report the missing teeth to Lisa. At about 11:30am Lisa asked me to 'wheel' Mrs Arthur to the Residents' Lounge ready to go into lunch because it would take too long to accompany her with her walking aid. I told Mrs Arthur that it was time for lunch and I was going to wheel her to the dining room. She said again that she did not have her teeth and could I find them. Lisa then said to her that she would be able to eat lunch because she could have the soft food option and that she would tell the dining room staff to organise it for her. We could look for the teeth later. I then went to find a wheelchair, but the only one not in use in the store room was broken, so I used the mobile 'toilet chair' to wheel her down to the Lounge where I left her to await lunch. I heard later that a member of staff wheeled her to the Dining Room and placed at the table where residents required assistance. She was offered shepherd's pie and pureed vegetables that was the 'soft food' option of the day. Mrs Arthur refused to eat it saying that she hated shepherd's pie and that she wanted the other option which was braised beef – as she had ordered. A portion of braised beef and whole vegetables was provided, but Mrs Arthur still did not eat it. When the catering assistant was clearing away Mrs Arthur's uneaten plate of food she told her that she ought to eat her food and not waste it like this. Mrs Arthur replied feebly that she was still waiting for her teeth.

I asked Lisa how to record the care given to Mrs Arthurs that day. Lisa said 'don't worry I have already done it'. Lisa showed me her completed notes that indicated that Mrs Arthur had that day been washed, taken for a walk with her frame and had eaten her breakfast and lunch. There was no mention of the missing teeth. I was not very happy about this, but I did not know what to do next. We made no further searches for the missing teeth.

The next day when I arrived on duty for a late shift I found that Mrs Arthur's daughter, Elwira was visiting her mother for the first time since arriving back from Scotland. She said that her mother appeared to have lost a great deal of weight during the last four weeks, her mouth was dry and cracked, she could not find her teeth or handbag and there was an unpleasant fishy odour in her room. She was concerned that mother had a confused and vacant expression. I offered to get the duty manager (Phillip Dano) to come and see her. I overheard part of conversation between them in the hallway.

Elwira was asking Phillip about her mother's condition and Phillip admitted that he had had been on study leave and had never met Mrs Arthur, but he had seen in her notes about her fall and her dementia. Otherwise he was quite sure she had been treated well during her stay, even though older women often became a bit confused due to the change of environment and took a few weeks to settle down. Elwira said quietly that she knew nothing about the fall and had no idea her mother was showing signs of dementia. This had never been mentioned by her mother's GP prior to her stay at the Care Home and this issue had never been raised when she had telephoned from Scotland on a regular basis. She went on to say that she was unhappy about the amount of weight her mother had lost, the fact that her teeth were missing and that she was showing signs of dehydration and the smell in her room probably indicated that she had a urinary tract infection. I did not hear the rest of the conversation, but I discovered later that Elwira found Mrs Arthur's handbag behind the on-suite bathroom door hanging from the coat hook where she had left it when she went to the toilet the previous evening before going to bed. Her teeth were inside the handbag!

ACTIVITY 3.1: CASE STUDY B3: MISS BROWN (91) IN HOSPITAL

(This real life case study (See Note 1) is an abridged version reproduced by permission of the author.)

Miss Brown (91) was a very small lady – approximately 1.5m. She retired age 70. She had been a highly qualified, well-known and respected missionary nurse and midwife in Africa amongst all religions and a woman who devoted her whole life to the service of other people. She was quiet, but not shy, very determined and could be very serious at times. She was a strong person, very resolute and use to being pragmatic about lots of things including rules and routines. This was a character trait, which certainly aided her when she went, alone, to the middle of war torn Africa in the 50's. She was also very generous with her time, doing kind deeds for other people in her village after retirement. She was a wonderfully kind person and dearly loved all of her family, brothers and sisters and all their nieces. She was a devout Christian and lived her whole life in the service of the church and the people around her, even after she retired from missionary work. She was a talented painter, wrote poetry and gave talks on her life as a missionary nurse. She was admitted to a hospital's acute medical ward from a Residential Home, in a toxic state with Cellulitis of her right leg during April 2006. Her needs and medical history were: osteoporosis, right hip replacement 2002 and history of previous falls. A small stroke in 2003 had left a weakness on her left side; she was in the early stages of a diagnosed vascular dementia, depression, poor mobility, poor appetite and a total anxiety about toilets and incontinence pads. Inability to hold in her false teeth due to the stroke resulted in difficulty in chewing and swallowing. She was also reluctant to drink, as she was concerned about her continence.

I am a qualified nurse and this case study is a factual real life account of my aunt's hospital care.

First Hospital Admission

My aunt was admitted to hospital when I was on holiday. My first view of her on my return from holiday was to see her slumped sideways in a huge chair, her hair unkempt and a gown, which was obviously at least 4 sizes too big had fallen off her right shoulder exposing part of her chest. The patient next to her in this mixed sex ward was an older man, who could obviously see my aunt's exposed chest. I complained to the nurse in charge who just shrugged her shoulders and said that she had no control over this and that it was Medical Assessment Unit, not a ward. During the following night my aunt fell out of bed fracturing her arm and receiving an injury to her head and neck. Auntie then moved to three different wards, often without my knowledge and was visited by doctors, physiotherapists and social workers. None of these staff members ever contacted me, despite the fact that on her record it said that I had Enduring Power of Attorney and was to be contacted about everything.

Auntie was discharged from the rehabilitation unit, without an appropriate discharge plan which would have contained information that she had contracted MRSA. During her hospital stay she had become much frailer. I made a formal complaint about her care and the fall, and I received a written apology eventually from the Trust, but no action plan. The apology at the time meant little to me and even less to my aunt whose health had deteriorated significantly since her fall.

Second Hospital Admission

I kept more detailed notes about her second admission with again, Toxic Cellulitis, as I was determined that if I did complain again I would use everything in my means to complain effectively and to affect change. Eventually, with intravenous antibiotics, my aunt recovered from this infection, but was very weak and needed full nursing care. She had no movement in her limbs other than to scratch her nose occasionally.

Auntie's Nutritional State

She kept her hands under the bedclothes, did not call out and was unable to hold a beaker or feed herself. She was frail and at times refused to speak. The fluid and food record at the bottom of the bed lacked details, and I did not know if she was actually eating any meals or receiving any fluids by mouth. I actually wrote in the record that it was empty and asked why, by putting a large question mark and signing it – having first asked the ward staff directly. The next day I noticed that staff had been writing up records in retrospect. I reported this to the nurse in charge on that day. I also asked for Auntie to be weighed, as I was concerned regarding her nutritional state and needed some measures for the future. I also noticed that her drinking cup was never within reach as it was always at the bottom of the bed on the bed table. Her call button was nowhere to be seen and there seemed to be few active care notes at the bedside. After two weeks on the ward a sub-dermal (*under the skin*) infusion was set up, because it was recognised that Auntie was 'not drinking'. It took several forceful enquiries to find out what fluids Auntie was actually taking and the method they were using to maintain her hydration. Up to this time it was evident that Auntie had been refusing to drink and eat, but there was no evidence of any approaches to try different feeding methods. Over the next few weeks I had further conversations with various staff nurses about Auntie's care and I noticed that the only record kept at the bottom of the bed was the medication record. There were no nutrition or fluid charts or even a care plan. If there were any they were all kept in the nursing office or so

Note 1: The full Case Study by Morgan, L., (2009), Staff Tutor, Faculty of Health and Social Care, The Open University in Wales available at: <http://dignifiedrevolution.org.uk/>.

they told me. So there was little opportunity to review Auntie's care myself – in terms of food and fluid record or any care plan without making an appointment to see these with the ward manager. With hindsight I wish that I had pursued this more. I visited every week and sometimes more than once a week, but was never sure or reassured that her care was secure when I wasn't questioning actions or lack of action. I again requested that the staff weigh Auntie, as I was concerned about her food intake and weight. She wouldn't tell me herself whether she was eating anything, so I would bring in various tidbits that I knew she liked. Eventually a weight of 43Kg was noted on the record, but I later found out that this weight had been approximated (*i.e. the nurses had just looked at Auntie and guessed her weight*).

Comfort and Wellbeing

In the Medical Ward, her first ward after the Medical Assessment Unit, I would arrive in the afternoon to see her sitting – or rather – slumped in a large firm vinyl chair and obviously in pain. Her back was very bony as she was already very thin and bowed with scoliosis and osteoporosis. I requested that either a more comfortable chair was found for her and/or she was asked if she wanted to sit out in a chair. After that time my Aunt was kept permanently in bed. It appeared that none of the nurses perceived that with her medical history and the fact that she was uncommunicative most of the time she might be in pain. No pain assessment tool appeared to be in use. She was just left there, in a nightdress, often without a dressing gown on and she often felt cold. Her swollen leg with the Cellulitis was often not resting on a stool as was suggested in her care plan.

Auntie was eventually given a special electronic bed, as she was not moving in bed at all. I did not see any psychological support offered to patients and I never observed any social interaction between the nurses and bed bound patients. For these patients the only activity was staring at the wall or at other patients, or talking with visitors if they were fortunate to receive them. At every visit the nurses and healthcare support workers were observed to be either sitting around the nursing station or changing the position of some bed bound patients. This was done with a great flurry of importance, but I never once saw a nurse or healthcare support worker actually consulting with a patient.

Personal Appearance and Hygiene Matters

It was discovered during the first week that the nurses and health care support workers were changing Auntie's nightdresses frequently, but were putting them loosely in the drawer of her bedside unit despite her MRSA history and the formal notice above her bed from the infection control nurse on how to deal with dirty linen. It specifically stated that all dirty linen should be put in plastic bags. It took 5 weeks to ensure the dirty linen was put in plastic bags in her drawer. Over the 5 months until discharge to a nursing home I asked weekly for the ward to arrange for her hair to be washed and cut. Auntie never had her hair set; she always had a simple short style, as her hair was very fine. Every time the nurses agreed to arrange it was never done, despite me offering to arrange it myself or wash her hair in the ward for her. The nurses said that this was not possible. Occasionally I massaged her hands with cream which she enjoyed, and cut her nails, combed her hair and gently washed her face, because no one else seemed to do it. I also helped feed her when I visited.

Moving to Long Term Care

Finally after several weeks it was suggested by the ward staff that Auntie required nursing care in the community and therefore the social worker was contacted to talk with me. I spoke with Auntie and explained that the nurses and doctors felt that she had deteriorated so much that she needed looking after all the time and that she would not be able to stay in this ward or go back to the residential home. This might mean going to a nursing home, which I would choose carefully in consultation with her. She nodded that this was acceptable and then said *'whatever is best, don't worry me with it all - I wish I could just die now, I am ready'*. A ward multi-disciplinary meeting was arranged with me, the residential home manager, and social worker and ward nurses present. However, it appeared that she had already been assessed and it was planned she would be transferred to a rehabilitation/long term care ward in another hospital rather than to a nursing home. Auntie was actually moved to the long term/palliative care ward.

Follow Up

A week later, we had found a local nursing home, Auntie was discharged and within one day she had a bath, the drip removed, and given fluids. Her hair was also cut. Two months on she was still being offered very regular drinks of whatever she fancied, and on her more communicative days brought downstairs into the lounge and put in a special supportive chair. She began to communicate better and would ask to stay longer in the chair on some days. Her needs were very complex, but were met in this new nursing environment by good fundamental expert nursing care.