A life in the day of Mrs W

David Kerr

David Kerr MD, Bournemouth Diabetes and Endocrine Centre, Royal Bournemouth Hospital NHS Foundation Trust

Clin Med 2008;8:515–6

Mrs W had an unpronounceable surname, which she had acquired from her husband who had escaped from the Nazi terror in Poland. She had no family, few friends but a robust constitution. Her East European accent and age-related middle ear disease made communication difficult but all her marbles were still intact. Despite her wishes to remain in her own house, she ended up in a nursing home. As far as Mrs W could see, there were few prospects for advancement here. Her day seemed to revolve around making sure that the staff were not disadvantaged – early to bed, early to rise, fixed meal times independent of need, television at full volume in the day room but otherwise sensory deprivation on a grand scale.

One day, her chocolate biscuit 'went down the wrong way' causing her to cough, wretch and regurgitate the offending biscuit along with her coffee. The nursing home reacted with alarm to the 'coffee-ground vomit', and phoned for an ambulance. Trying to track down an out-of-hours general practitioner was just too much hassle.

Mrs W thought that the green uniforms of the paramedics were rather fetching, although they found her difficult to understand with her curious accent and deafness. Confused with a urinary tract infection was the working diagnosis and these labels were to prove almost impossible to change. The hospital decided that perhaps the safest thing would be to admit her. Thus Mrs W entered the Kafka-like world of the acute admissions unit (AMU) of a top 10 performing NHS foundation trust. By this time, Mrs W needed the bathroom.

The AMU was a zoo and a noisy one at that. The 'bloody medical admissions' as the clinical director of surgery often referred to them were clogging up the system. All these ill people were preventing admissions of the income-generating elective surgical patients. Everyone was getting grumpy. The usual email had been sent earlier in the day asking the physicians on their rounds to discharge anyone they could. All this chaos compounded Mrs W's difficulty in understanding and making herself understood. Patience was not a virtue in the AMU. Mrs W was placed on a trolley (from the hospital's statistical viewpoint this could now be called a bed) in between a man smelling strongly of stale body odour and vodka and an older women in her 90s calling out repeatedly to speak to her father. After some time, Mrs W was attended by a nurse whose badge said 'Britney' in size 12 font although Mrs W couldn't read this as her glasses were still in the nursing home along with her teeth.

Mrs W still needed the bathroom but Britney had a job to do and recognised the importance of making sure every piece of information was collected in the orange temporary notes folder. Britney began with the two-sided minors assessment followed by the accident and emergency care plan (major) and the triage assessment. The papers were rather flimsy and had a tendency to change sequence every time another was added. The holes for filing were torn within seconds so it was unlikely that they would all survive, let alone in the appropriate order. No one seemed to mind. Britney's pen ran out and it was a struggle to find a replacement among all the flotsam and jetsam of the nurses' station. Eventually a turquoise pen was found bearing the logo of the drug company who provided yesterday's free lunch.

The triage assessment was particularly useful as Britney could copy the blood pressure (BP) and heart rate values directly into the inpatient assessment record without having to worry about finding the only fully working automated BP machine. She also transferred the finger stick blood glucose measurement of 13 made in the ambulance some three hours ago. Britney was getting hungry and her break was imminent so the plan was to finish quickly. She added the ambulance record sheet (three copies), the blank interim discharge form (two copies), two pages of sticky labels, two pages of smaller sticky labels to be used on the blood tubes (amounting to 50 tests anticipated during this admission) a consent form (wretching and regurgitation might mean an endoscopy for Mrs W), a thicker four-sided drug prescription chart (including separate, but stapled, section for diabetes prescriptions and warfarin) and the transfer to ward checklist.

Britney and Mrs W did struggle a little with the 24-page inpatient assessment record. The front page was straightforward, though neither had any idea about the predicted date of discharge and whether it would be different from the amended discharge date or the confirmed discharge date. Mrs W looked old to Britney so all the boxes were ticked that would invoke help from Social Services, home care, occupational therapy, physiotherapy and a myriad of other therapists during this admission. Mrs W was unim-

© Royal College of Physicians, 2008. All rights reserved.

pressed as she was not totally sure what half the names meant. Meanwhile there were lots of other boxes that probably could be ticked later – transport arranged, outpatient appointment organised, property returned, food parcel ordered, educational leaflet given and cannula removed. The sequence was haphazard but no one seemed to mind.

Page 13 of the inpatient assessment record continued with the initial risk assessment which contained the stern command that the manual handling risk assessment form must be completed as well. Next Britney completed the Waterlow pressure sore prevention/treatment policy (although she did not have the time to actually check Mrs W for bedsores) and over the page the multidisciplinary assessment record and care plan. She was sure that Mrs W would be comforted by the 11 goals of the 'initial care plan on acute admissions unit up to 72 hours' and the 11 problems highlighted in the ward-based care plan.

It took a long time to complete these pro formas and meanwhile Mrs W still needed the bathroom. This information was probably very similar to the information collected about Mrs W when she was in hospital one month previously after tripping over a rug in the home but the thought never crossed Britney's mind. It was usually very difficult to retrieve old notes after 17:00. In any case no one seemed to mind.

Dinner was arriving to add to the general chaos of the AMU. It consisted of a sandwich, a difficult to open pre-packed carton of chemically enhanced orange juice and a carton of yoghurt which seemed to fly in all directions after tugging at the protective plastic cap. The cap joined the general detritus around the bed as the bins were few and far between and generally out of reach. Mrs W had not received her usual pills – a statin, angiotensin-converting enzyme inhibitor, beta blocker, aspirin (which had been started during the previous admission after her fall), an antidepressant to help her sleep, and painkillers which had also been started during the previous admission although she was not in any pain. She also took a ghastly white mixture which she swallowed twice a day in an attempt to relieve the constipation caused by the other tablets. At this moment Mrs W felt as well as she had done for years. She still, however, needed to go to the bathroom but apparently that was not allowed until she had been formally clerked in by the anonymous doctor with a stethoscope around his neck. The doctor was very nice but Mrs W could not fathom why he was asking her for the day of the week and the name of the prime minister – surely he knew. The doctor was obviously very busy since he forgot to press on the arm after taking a blood sample so that Mrs W's pristine white sheets rapidly developed red and pink splodges. No one seemed to mind.

Later that evening Mrs W was wheeled to the specialist medicine for the elderly ward. Noise abounded with the usual evening chorus of calls and shouts to deceased loved ones, ghosts of things past and imaginary evils. Britney's colleagues dutifully added the Malnutrition Universal Screening Tool, stool and fluid balance charts and a falls risk assessment to the notes folder. As the new notes were 'temporary' the requests for tomorrow's blood tests, urine collection, electrocardiogram and X-rays were still on AMU somewhere so the hospital at night team foundation year 2 trainee was bleeped to re-write and add them to the notes. The forms asking for specialist opinions from cardiology (yellow) and respiratory medicine (purple) were also left blank in the back of the notes.

Mrs W finally made it to the bathroom and afterwards asked if she could go home now. Unfortunately the computer had crashed and no one could find her results. The IT department closed at 16:30 so Mrs W had to stay overnight. No one seemed to mind.

© Royal College of Physicians, 2008. All rights reserved.