

The case studies presented below (Cecil and Brenda) are illustrative of the diversity of need, impact of impairment and the ways in which the patient's sense of self is conveyed through conversation and observation. We also draw on organisational accounts presented in medical and nursing notes and the views of 'close others' conveyed in interviews. On admission, neither Cecil or Brenda had a formal diagnosis of dementia. Both were assessed as having a delirium, although there was uncertainty in the medical notes as to whether this was a consequence of the trauma that resulted in the acute admission or contributed to the event that began the journey into hospital.

Cecil

Cecil, 82 years old was admitted to Ambridge ward via A&E on 4 December following a fall. His wife heard the clatter, then moaning about 9.30 pm and found him lying at the bottom of the stairs. She called the ambulance, and her daughter, Janet. Janet came straight away with her son. When the ambulance arrived Janet went with her father and her son followed. Living at the furthest boundary of the catchment area, it was nearly midnight when they got to A&E. Causes of concern were fractures and internal bleeding as Cecil was on Warfarin. Following an assessment and various tests, he was admitted and transferred to the ward around 5am; Janet and her son stayed with Cecil until the transfer.

The Clinical Story (nursing notes)

Reason for admission: fall and head injury... was delirious and had a chest infection. No known dementia (normally oriented to time and place); some confusion; no hearing, speech or language deficit; GCS 14/15. Full trauma scan carried out in A&E and results NAD.

On ward admission

Will need full assistance at present due to confusion; awaiting medical RV, MRI, MRF, Waterlow, MRSA; no EOL (end of life) considerations, no mental capacity concerns and no problems with sleeping recorded on the relevant paper work. He has dentures and spectacles.

Washing and dressing x2 required; independently eating and drinking though needs assistance with red tray. He is dependent in terms of mobility (restricted) and at risk of falls; continent, pain (usually not); no anxiety/ breathing/ other problems. Health (underlying): TIA, DNT – Jan 2013, Bowel Cancer 2004, bilateral knee replacement.

Cecil observed

Cecil was first seen by the researcher on the 6th December (two days following admission) during general observation. Within a day of admission he had been moved from a bay to a side room in a high/low bed: his agitation and calling out had disturbed other patients, and he was seen as at risk of falling. At this point, he looked very withdrawn. Cecil had some personal effects in his room, including a picture of him and his dog. Over his bed was a Butterfly symbol to indicate dementia. In his notes was a chart with pictorial symbols in the first column and a description alongside providing personal information. For example: *Cecil is a picky eater; likes cereal and hates porridge; has always been a sociable person.*

Cecil was next observed on 12th December when shadowing the doctor. He is awake, bright and responds with 'hello'; answers the doctor's questions: 'not had a bad night'. Asked his date of birth and where he is, he is unable to answer and becomes upset. He's reassured; it's okay; the doctor will come back later. Later on, the doctor tries again: he does well counting backwards from 20, but is unable to answer questions about the Royal Family. He holds the doctor's hand who asks: 'are you in pain?' 'No'. 'Do you want to ask me anything'? He replies: 'Can I go home'? Later the doctor describes Cecil as 'very confused'; and that it is unclear how much is new or recent. The doctor notes that Cecil has had a hyperactive delirium since admission, a factor in his agitation.

A week later, during general observation late afternoon, the researcher sees Cecil walking with a Zimmer frame, being 'special-ed' by a staff member. He walks alongside the staff member from the day room down the corridor and back to the day room. One of the nurses' remarks: *'Cecil needs 1:1 care as he becomes very agitated'*.

On several occasions over the next week, Cecil was observed being coaxed to eat, usually expressing his disinclination by waving his arm and not opening his mouth. Interaction with staff during general observation mostly involved staff coaxing/instructing him to do things: taking medication, eating meals and him refusing/becoming angry.

Cecil's ability to communicate verbally was very impaired; he struggled to find the words, yet his eyes and face lit up when he was spoken to. He was regarded as 'difficult' and 'challenging' and interactions with staff over time became dominated by an 'instructional' mode of communication which in turn drew forth his resistance. This pattern of interaction was common in respect of patients with dementia deemed 'challenging on this ward. Several individual members of staff did, however, spend time with him, although mostly he was on his own.

After the Christmas break, Cecil was still on the ward and in the side room. He appeared very withdrawn, although he called out periodically. The researcher approached Cecil's wife and daughter about participating in the research and both agreed; they also agreed that Cecil would have been pleased to take part. Signed caregivers' consent and advice from the personal consultee, enabled more focused observation and case note review. When the researcher went in to see Cecil with a member of staff to introduce herself, he smiled and responded; he struggled to say something but the researcher could not tell what: he seemed to enjoy having people with him.

The Clinical Story continued: Excerpts from nursing case notes

Lives with wife, unable to cope; no previous help from home care; request for referral/ contact assessment. Needs 24 hour care/ new care package for personal needs.

High risk of pressure sores; handling assessment x 2 required & side room; verbal encouragement; falls risk high during stay so far because of confusion at all times; needs assistance to toilet; hearing and communication deficits; urinary tract infection; high risk of pressure sores.

05/12: Patient nursed on high low bed; appears confused trying to climb out looking for his wife at beginning of shift; calling out, reassurance provided, eventually settled after taking meds; infection prevention plan; no falls to report, safety maintained, remains unsteady on feet.

06/12, 03.40: Slept on and off, asking staff to help him get out of bed. Eventually settled and slept; nursed on high low bed; taken meds and obs. stable at bed-time.

06/12, 18.00: Wanting to go to his wife this evening, delirious, remains confused throughout the day; remains high risk of falls, nursed on high/ low bed, no falls up to time of report. Bruising to left shoulder; appears to have discomfort and pain; x-ray performed this afternoon; bladder scan performed – nil residual; please observe. Standing transfers poor today, but has managed to stand unaided this evening – needed 1:1 at present, now back in bed.

08/12, 04.20: Incontinent of urine, assisted with hygiene needs, full bed change given several times.

08/12, 11.30: Rolled out from low bed and found on floor, no injuries sustained; hoisted back to bed, bleeped doctor for falls review, patient confused. Continue with antibiotics; await MSU results.

13/12, 06.00: Confused, urinating on the floor, redirected back to bedroom!

15/12: Urine infection treated, muddled.

16/12: Very muddled when trying to express his needs. Daughter raised concerns that patient will need support on discharge. Ward request for social work assessment.

18/12: In night very unsettled & agitated & aggressive (first time latter noted), needing up to 3 staff.

Pattern of agitation persists over the next weeks particularly at night. Ongoing urinary infection and delirium; becomes incontinent of urine from beginning of January; given Lorazepam when agitated.

Multi-Disciplinary Team Perspective

The MDT meeting on 16th December agreed that Cecil should be given more time prior to organising discharge to see if the delirium resolved; then the work with the physio would start. It was noted that Cecil's family wanted him home but that they were scared to leave him as they feared he would fall. The doctor and senior nurse expressed the view that Cecil needed 24-hour care; it was agreed that this would be discussed with his family.

Following discussion with the family, the MDT meeting on 23rd December agreed that as there was no resolution to the delirium, a long term care placement would be pursued. Whether this was to be a nursing home or specialist dementia unit (EMI home) would be confirmed when all assessments were completed and a funding decision made.

After the MDT, a Section 2 (assessment for social care) and request for a continuing health care (CHC) assessment, was sent to Adult Social Care. The care manager responded on 27th December with a request for a behaviour chart, details of the plan in place to resolve/ treat his behaviour, and for a psychiatric assessment; that without these, an assessment for care could not be completed.

On the 30th December, the social worker completed the CHC Checklist and met with Cecil's family.

On the 6th January, Cecil was assessed by the social worker. In the afternoon after his wife and daughter had left, Cecil was observed up and about at his own initiative, supported by staff. He went in to see the lady in the next door room to his.

On the 7th January, a nursing needs assessment was completed. The MDT meeting on the 10th January, confirmed that an EMI placement was required, based on the assessments.

Observation over the next weeks revealed that Cecil had become more and more withdrawn and always looked tired; he was often sitting in his room, head slumped on his chest; when anyone passed the door he looked up. He was often mentioned by staff as being 'very confused', very agitated at times. Cecil was viewed as a patient who was 'difficult to care for' on account of his agitation and 'refusal to co-operate'.

On 10th January, late afternoon, the researcher went in to see Cecil. He was on his mattress on the floor in the darkened room. He asks: 'what time it is please'. The researcher replies: 20 to 5. He repeats 25 about ten times; points to the end of his bed. She asks if he'd like his dressing gown (which is there), he indicates yes. However he did not want it when she gave it to him. He repeats 20 5, then: 'Night love' he says and she leaves, saying she will be sat outside if he needs anything. He turns over and reaches for a pillow on the mattress next to him, then he turns onto his back

again, eyes closed. After a few minutes he repeats the action. He tries to reach for his pillow then stops, his eyes closed, facing the door.

Over the next week, observations reveal a recurring pattern: Cecil is mostly in his room; he appears to have lost a lot of weight and is resistant to eating and taking medication. The following is illustrative: A HCA goes in to Cecil: 'Have you had something to eat?' 'No!' 'Here's your tea'. She kneels on the mattress next to him and starts to unwind the cord and adjust his bed.

'Sit up, sit up' the HCA encourages Cecil. 'Cecil, sit up. Right, I'm going to try you with this... don't go to sleep, Cecil; it's tea-time, are you going to have something to eat Cecil; open up, a bit more Cecil'.

Often when the researcher goes in to see Cecil; he is asleep, lying on his side on the mattress, facing into the wall, his arms out and eyes closed.

The family story (pieced together from the interview with Janet and her mother, Ivy with Cecil present).

Presentation of confusion

Janet: *We'd thought he had a little bit [of confusion] because he would forget certain things ...or else he'd come into my mum and say, oh have they all gone and she's, well nobody's been here and things, so we've put it down, but nobody had ever classed him... [Interrupts her flow to look at her Dad]*

I don't know, I think is he trying to pick something up, I don't know? 'Right, you sit back now'. So yeah, so it was fine ...you could cope. Oh what's he doing now? You could cope quite all right, but then it's just his fall and they've diagnosed his vascular dementia and they said they've waited long enough to see if he is going to get better, he says 50% do, 50% don't and unfortunately he's in the category...

Ivy: *Take that out of your mouth [to Cecil].*

Janet: *What's he doing?*

Ivy: *Picking something up off the floor.*

Janet: *But there's nothing there, he's just pretending. But yeah, so unfortunately he's in the category that does, that won't get better...Yes, he was all right before, because when we ...first came in and we were downstairs in the A&E and they're saying, well 'can you count from 1 to 20', and then they asked me if he could count backwards, where me and my son brought him in. And I looked and I said, 'there's no chance'. But he did. And I thought, well that even surprised me ...And then when we came to see him he was confused wasn't he, when he had a water infection you see. So we put it down to the water infection that was...making him. Because when he'd been in previously in January, he'd got a water infection then and that had sent him...funny as well. And so, but he'd never been right since he'd been in, in January, has he, he's always been a bit more confused than what he was before and he never came back the same. But then he's just... gone now and they've just said the fall has brought on a rapid, this rapid dementia and things, so yeah.*

Ivy: *Yes, but you see he's hardly eating. I look at his chart, but he's hardly eating and the portions that they give him, I know he wouldn't eat a lot anyway, but they're only tiny. So when it says he's eaten whole lot, it's only a little tiny...*

Janet: *A little bit... he has lost a lot of weight.*

Ivy: *Yeah, he didn't do a lot anyway; he didn't walk as much as...*

Janet: *...he had been doing, no, but they still managed fine at home and things together, didn't you? You helped each other, didn't you?*

Ivy: *You stay there in your chair[to Cecil]*

Janet: *Sit back in your chair.*

Ivy: *You'll fall.*

Janet: *Well have a rest then. Yeah, these tablets totally zonk him out, look he's thinking he's got it.... Yeah, well he's got the Zimmer there, but he also needs people with him as well, yeah, which before you see, he didn't have a Zimmer at home and things, he used to have a stick, didn't he, what?*

Ivy: *Yeah, but not in the house. No, he could, he could walk about no problem in the house.*

Janet: *But if he went out he needed a stick*

Ivy: *Eh, I don't know, he just wanted to stand up. I don't know why he wanted to stand up. That's it, you sit back down again, yeah, so.*

Janet: *What he's like all day, bless him....*

Later in the interview, the picture conveyed above of Cecil's dementia being of recent origin shifts: episodes suggestive of a more insidious onset over a longer period of time are recounted. Additionally a previous acute admission a year earlier documented in Cecil's medical notes records that Cecil's wife and daughter had expressed concern about his ongoing confusion.

Ivy: *And he used to get up in the morning when I told him to and get himself dressed.*

Janet: *Sometimes he used to get a bit confused with that, didn't he?*

Ivy: *Aye.*

Janet: *Because they couldn't understand why he's like that ... they've done all their, he's had loads of scans and things to try and see, and I honestly think that they still don't know why he is like that. I don't think they've got an answer, all they've said is, he's got vascular dementia and it's just been a rapid onset of it...*

Ivy: *At home he just, basically he just used to sit in his chair, didn't he and he used to have telly on, not that he took a lot of notice of it, but it was just something there. But he couldn't really do a lot, could he anyway. And since he stopped driving at the start of this year and I think he really missed that didn't he as well. But he just wasn't safe to do the driving, and especially with the roads being as busy as what they are. He just used to potter about...*

Janet: *Yes, yeah, but then you were frightened that he'd park the car and forget where it was, so.*

Ivy: *It was his last bit of independence really where he could go and do things for himself, so I think that really upset him when he had to give up the car. Because sometimes in here he still thinks he's got it, doesn't he, he's thinking back and he still thinks he's got it... They are kind to him here aren't they and things?*

Janet: *Well I don't know, he gets aggressive with them sometimes, doesn't he?*

Ivy: *Well sometimes he does, if he's in one of them moods, doesn't he, if they're trying to tell him something and he doesn't want to do it, isn't he? But we say, he's not really like this, he's not...he's not been an aggressive person.*

Janet: *No, it's not in his nature.*

Ivy: *No, but he's just, he doesn't know; he just doesn't know what he's doing... which in one sense is good that he doesn't know he's like this...*

Janet: *No, I don't think he knows, my dad, I don't think he realises what is happening.*

Ivy: *He doesn't even realise he's in hospital.*

Janet: *Because sometimes he'll say, I think I'll go upstairs and you say, no, you're in hospital*

Ivy: *He says, I'll go and have a bath and go out for a pint.*

Janet: *He thought he was driving, didn't he? What did he say, dear?*

Ivy: *Can't find bloody accelerator or something he was saying.*

Janet: *And he was trying to get down and trying to do some of the other things wasn't he?*

Ivy: *But then one of the nurses said that she'd sat in with him one day and she says 'I didn't know he used to work in a printer's office'. She says we had a right good chat and that was when he was...*

Janet: *No, but how old was he when he worked in the printers?*

Ivy: *Well, from leaving school...that was good, yeah.*

Janet: *Exactly, yeah, well I brought a picture of my dog up with him, so, and he'd been telling everybody, this is Casper, well actually it's Tilly. We did have a dog called Casper who died, but, so he could remember Casper, he can't remember Tilly obviously, so he was just reminiscing or telling everybody.*

A nurse comes in to administer medication – it takes some time: the nurse repeatedly asking Cecil to open his mouth and take the tablet; he, resisting. *'Hello, do you want to open your eyes please, so I'm just going to give you a tablet... Hello, open your mouth love, open your mouth, yeah...Do you want some more drink, that's it, have another, is that nice?'*

[The nurse leaves]

Cecil: *Aye.... broke*

Ivy: *What do you want?*

Cecil: *I ... forget*

Janet: *Don't get up out of your seat.*

Ivy: *You stay there, OK? He just thinks I'm getting on at him all the time.*

Janet: *Then he'll tell you to shut up won't he?*

Ivy: *He will tell me to shut up, yes.*

Janet: *It's like, God she doesn't...half get on at me.*

Ivy: *You can't blame him*

Cecil: *I ... when do we go out?*

Janet: *What, when are we going out, you're in hospital aren't you at the moment?*

Ivy: *Yeah, you see, he keeps saying no, but I keep giving it him and things, but whether they do here, if he says no then they might just leave it, but he doesn't know he's saying no, he doesn't understand that he's saying no. So he, because it's like when they try to do blood pressure things, isn't it... a lot of [notes] says refused, but I don't think he understands.*

In a conversation with the researcher 13th January, Janet and Ivy describe their difficulties in identifying a suitable home. They had been advised by the social worker to look for a dual registered home. Janet had searched on the internet but found identifying dual registered homes not straightforward and they were unclear as to whether he would need to be in a specialist dementia unit: *"I found a nice one if he isn't EMI, it's nice, but if he is then I just don't know... we just don't want to bung him anywhere do we?"* They explained that as they wanted a home near to where they lived which was in a different local authority area, hospital staff did not have the local knowledge to help: *"so you just feel like you're on your own really"*.

Cecil was discharged to an EMI home on 28th January. He had spent 55 days in hospital. He died shortly after his admission.

Brenda

Brenda is 90 years old and had prior to her acute admission been living in extra-care housing with carers coming in three times daily. Her family described her as very sociable, and although she had become more forgetful over the previous year, she was 'managing' at home and very involved with family activities.

On the 6th December, Brenda came to A&E with a urinary tract infection and was transferred overnight to the medical assessment unit for further investigations. The next day she fell on the unit and sustained a hip fracture. Following surgery, Brenda was moved to Oak ward on the 8th December; she had also developed post-operative delirium.

In the course of the next two weeks, Brenda was very ill and acutely confused. Her case notes indicate that she was very poorly, 'un-cooperative' (pulling out her IV cannula; trying to climb out of bed) and incontinent. During a ward round in mid-December, the geriatrician notes that Brenda has dementia; that there is uncertainty about the degree of impairment until the delirium resolves; and that staff need to observe closely for changes in behaviour and attention.

Toward the end of December, Brenda picked up. She was moved from a single room to a bay and referred to Adult Social Care before Christmas for an assessment to plan discharge.

The Clinical Story (nursing notes and MDT)

09/12: Comfortable post-op night

10-28/12: Noted that patient is very confused; incontinent at night; very ill, and placed in one of the side rooms.

27/12: Possible infection; stool sample sent for analysis; very sleepy.

6/01: MDT: The consultant comments that Brenda has/had delirium on top of dementia so they need to work out what is reversible. They query sepsis, UTI: 'she's got hyperactive delirium'.

10/01: Brenda appears to have had a settled night...'chatting away...'

12/01: Spitting tablets out despite multiple encouragements and explaining importance of taking medication.

13/01: Nurse spoke to Mental Health worker –will assess Brenda's mental health.

13/01: Settled in the afternoon, but 'found wandering at times without Zimmer frame'. Assisted with toileting by HCAs

14/01: Wandering around bed area at times overnight. Incontinence cares given, used toilet with supervision.

15/01: Has been mobilising well with her Zimmer.

Similar to Cecil, Brenda was regarded by staff as 'challenging' particularly during these early weeks on the ward. At the same time, she enjoyed conversation, conveyed interest in the people around her and expressed gratitude to staff for the help provided, and staff responded positively to her.

The researcher's first direct contact with Brenda was on the 6th January. In her field notes, she describes the Butterfly symbol over Brenda's bed, indicating that she has dementia. The Butterfly folder at the foot of her bed, provides information about her preferences:

Makes me anxious: being in pain

Makes me happy: friends, family and socialising

Food and drink dislikes: currants, raisons, coconut, green beans.

Food and drink likes tea with no milk or sugar, cranberry juice

You know I'm in pain; I tell you.

I can walk normally to the toilet.

Brenda is described by staff as looking much better. In conversation with the researcher, she says she is waiting to go to the hairdresser today; that she's looking forward to it because she'll feel better afterwards, but is anxious that she doesn't know when she's going or where.

Brenda presents herself as someone who doesn't want to offend anyone. She tells the researcher: 'I always say thank you; I'm very grateful; I've got a lovely family; I'm very lucky'. She says she always gets on with people; doesn't make enemies; and that since she left school has not fallen out with anyone.

Brenda enjoys chatting to people; she always has a few words with staff and with the caterers bringing drinks and meals and they joke with her. She keeps a solicitous eye out for other patients in the bay. In a conversation with the researcher she remarks on the swollen legs of the patient in the bed opposite, and says the lady might need her legs covering up (the researcher notes that the patient's legs and catheter tube are visible as her nightie has bunched above her knees). Brenda often expresses anxiety about reaching her buzzer at night; she mentions it to the researcher every time she sees her. Staff comment that Brenda gets up at night and 'wanders'; her daughter says that she was used to getting up at home during the night to use the toilet. Is she looking for the toilet during the night?

Who is planning for Brenda's discharge?

10/01: The ward manager in conversation says that Brenda hasn't been assessed yet by the social worker. Initial discussion with the social worker had indicated that social services were looking to getting her back home with a support package. The ward manager comments that Brenda isn't safe to go home: she gets up at night, wanders, and is at risk of falls. She considers that Brenda needs an assessment bed (step-down bed without rehabilitation) with a view to a long term care placement. The social worker had asked for a mental health assessment prior to carrying out a social care assessment.

13/01: At MDT, ward staff report that the social worker has requested a mental health assessment before proceeding: no further information about progress. Some cynicism expressed by staff: is this a delaying tactic on the part of Adult Social Care?

15/01: Brenda has been walking with a Zimmer frame; and has made her way to the day room. At visiting time, the researcher talks to Brenda and her family (son, daughter-in-law and grandson). The family say they haven't a clue about what is happening about discharge, and suggest that the nurse they spoke to didn't appear to know anything either. Brenda's daughter-in-law says that she didn't feel she could ask more of the nurse and leans to one side to demonstrate how the Nurse's body language conveyed that she was busy. She wanted to ask about how Brenda was eating, but felt the Nurse was too busy. The family know that there is mental health assessment planned but have heard nothing further. They say they always have to initiate discussion with staff about what is happening.

The family report that Brenda's medical care has been good and that her health has definitely improved.

Although Brenda can communicate her needs, often in conversations she will say to the researcher that she needs to go to the toilet and presses the buzzer. When the staff member comes, she will ask about her pain medication; or talk about the pain in her back. It is unclear whether she's forgotten about wanting assistance with toileting or that this is her way of expressing a general need. Brenda has arthritis and experiences pain and discomfort, unconnected with the fracture.

In conversation on 10th January, Brenda tells the researcher that she'll be going home in 2 or 3 days; she wants it to be today. In responding to the researcher as to how she feels about going home, Brenda replies that she is looking forward to it. 'They'll be able to come every day (her family) only half mile away...do my cleaning and everything'.

From conversations with ward staff, Brenda herself and family members, different perspectives emerge about when Brenda will be discharged and to where. It is unclear who holds the whole picture and who is leading on discharge planning.

The ward manager expresses concern as to whether Brenda is safe to go home; the social worker wants a mental health assessment done before any options are considered as Brenda was managing on her own before; and Brenda just wants to go home.

Brenda's family are unsure about the extent of her confusion. She did forget things before but she was very confused and not herself following admission and surgery until around Christmas. They wonder how much of the confusion might be due to the environment and under-stimulation on the ward. They all consider that they have to initiate conversations with staff; staff will never come to them to convey what is happening.

What should happen to Brenda? Different perspectives

The social worker

Brenda is incontinent with care needs at night – so how will she manage returning to where she was before? She acknowledges that Brenda may have fewer needs in her own environment. In conversation with a junior physio, the social worker advocates putting Brenda in a temporary rehab bed: she has two places available now.

The physiotherapist

The senior physio has documented that Brenda has 'no rehab potential'. She will do as instructed under supervision but has 'no carry over'. Her view is that Brenda needs 24-hour care.

Social worker and physios

The social worker asks for informal feedback from two physios on the ward. One explains that in the opinion of her senior colleague, there was nothing more that therapists could do for Brenda. The three debate the merits of referring her for rehab and whether she would do better in her own familiar environment. For the social worker the options are a step down bed with no rehab at a distance from where she was living to assess need for long term care; or a rehab bed to give her a chance to get back home. Getting back home is what Brenda and her family want. The social worker's preference is for the rehab bed: Brenda *'will be pushed to be independent and will be in a more normal and sociable environment, for example eating with others'*. The physios consider making the referral; get out a form but decide that they cannot do it, given their senior colleague's assessment. For the social worker, there remains the problem of how Brenda will manage night time needs.

The occupational therapist (OT)

The researcher is approached by the OT. She has made the referral for a rehab/assessment bed for Brenda having discussed it with the social worker. They both agreed that Brenda would be better out of the hospital environment. Although it was uncertain whether she would be able to go back to

her own flat: *'I'd like to give her the chance'*. Their decision, she explained had been a joint one: between herself, the social worker, Brenda and her family.

20th January: Brenda is discharged to the rehab bed today. Ward staff had tried her with the commode by the side of her bed the previous night and she had used it without asking for help. She had spent 43 days on Oak ward.

The family assessment of the ward

The researcher talks with the family as they get Brenda ready to leave. Their experience of the ward is mixed. *"it's just getting hold of staff to talk to..."* And Brenda often had to wait a long time after ringing the buzzer for someone to come. Her daughter-in-law, Anne comments that Brenda had got into *'hospital mode'* in that she was in the habit of pressing the buzzer for assistance. Anne says that she's been telling her to just go to toilet herself if she needs to go, to get better. Anne shakes her head to indicate that Brenda wasn't doing this. The researcher asks how Anne thinks Brenda will manage in the assessment unit. Anne replies that she doesn't know... Brenda has been getting up at night herself and asking for help during the day, so she is incontinent (from waiting for the buzzer to be answered).