**Submission No 53**

# THE IMPLEMENTATION OF PORTFOLIO COMMITTEE NO. 2 RECOMMENDATIONS RELATING TO WORKFORCE ISSUES, WORKPLACE CULTURE AND FUNDING CONSIDERATIONS FOR REMOTE, RURAL AND REGIONAL HEALTH

**Name:** Ms Vanessa Landenberger

**Date Received:** 16 November 2023

**Patient – David Brown**

To whom it may concern,

I want to share my dad's journey with you, and I hope there is something each of you can take away from this.

I'm not a nurse or a doctor and have never worked in the medical field or a hospital setting. What I'm sharing with you is a family's personal experience during the time our dad was a patient at Grafton Base Hospital (GBH).

I feel it's important to take you back to the beginning of my dad's journey to fully appreciate the impact of **staff not following procedures and systems that are designed to prevent inadvertent or accidental harm to patients.**

Our Dad's journey started with Grafton base hospital on [redacted] when we arrived by ambulance around 4 am.

Dad woke up on his bathroom floor unable to move. Experiencing excruciating back and head pain Dad managed to crawl his way back to his bed where he phoned for help. I arrived within minutes to find my dad in his bed, vomited on the floor, disoriented, cold, clammy, in and out of consciousness and unable to tell me what had happened. I phoned the ambulance and soon they arrived, and Dad was taken to Grafton Base Hospital.

Upon arriving at the hospital, we soon discovered that there was limited room in the emergency department (ED). Dad was taken to a single room located just down the hall from the ambulance entry. We stayed in this room for many hours waiting for x-rays and tests to determine if any serious damage was done from the fall.

This was a slow process but understand and accept there is a triage process and further testing can take time.

Mid-morning Dad was then moved from this room into the main ED area of the hospital where he was monitored until results were received. It was found that Dad fractured his L4 or L3 and will need to be admitted. The reason for the fall was unclear as this was an unwitnessed fall.

At this time my dad was receiving treatment for cancer (Immunotherapy) and we suspected the lesion on his brain may be a contributing factor to a possible seizure that led to the fall and unconsciousness. Doctors decided to treat Dad for a possible seizure and prescribe anti-seizure medication along with other medication to manage the pain from the fractured back.

Being admitted became very difficult and we soon learned that the hospital was in "Bed lockdown". At the time I had no idea what this meant but was soon informed by the nursing staff that Dad would remain in the ED until a bed became available on the ward.

**An ED is part of a hospital that provides emergency care to people who need urgent medical attention. An ED has highly trained doctors, nurses and other health professionals on-site to deal with emergencies. They assess, treat, stabilise and start the health management of people who have come to the ED with a serious illness or injury. The NSW Health website states that genuine life-threatening emergencies are as follows:**

- chest pain or chest tightness lasting more than 10 minutes
- Sudden onset of weakness, numbness or paralysis of the face, arm or leg
- breathing difficulties
- **unconsciousness**
- uncontrollable bleeding
- **A sudden collapse or unexplained fall**
- **Unexplained fitting in adults**
- Injury from a major car accident
- A fall from a great height
- Serious assault, including stabbing or shooting
- Severe burns, particularly in young children
- Infants who are fitting or have an ongoing fever
- Severe mental health concern

Dad presented with three genuine life-threatening conditions (highlighted above).

**The *NSW Patient Safety and Clinical Quality Program* outlines what a patient should reasonably expect while receiving care at a healthcare facility in NSW.**

- **Staff that are well-supported and part of effective teams and have access to the resources (including equipment and information) they need to do their work.**
- **Systems that are designed to prevent inadvertent or accidental harm to you while in the hospital.**

Unfortunately, the care Dad received fell short of this as I witnessed staff assisting Dad out of bed and taking him to the bathroom. This happened even though Dad was advised not to move and to keep his head still until test results were received and a full report available outlining the severity of Dad's condition and treatment plan.

At 5 pm we were finally advised that a bed became available, and Dad was transferred to [redacted]

On [redacted] Dad was discharged from GBH. It was decided that Dad would stay at my brother's home where he could recover from his fractured back and receive all the support and care he needed to recover.

Unfortunately, being home didn't last long. Dad became very unwell overnight with severe diarrhoea. Dad was unable to keep any fluids or medication down. This was very concerning and the risk of Dad experiencing a seizure was worrying. As a family, we decided to call the

ambulance and return Dad to GBH. We again waited many hours in the emergency department waiting for further tests and to be admitted.

Dad was finally admitted to [redacted] where we watched our dad deteriorate very quickly. Test results were not back, and we had no answers as to why Dad was so ill. At this point, Dad was losing more fluid due to the chronic diarrhoea than what the doctors and nurses could administer. The Doctor called a meeting with me and suggested I bring the family together and prepare for the worst. We were advised that the test results were still not back to confirm if the diarrhoea was caused by a C-diff infection or a reaction to the immunotherapy.

The test results were not coming back, and the treating Doctor was doing his best to treat Dad with different antibiotics but unfortunately, Dad was not responding. We couldn't understand why it was taking so long to get the results back and then we were advised that because Dad was admitted to GBH over a long weekend the test results would take longer to come back. The Doctor also informed us that living in a rural area also disadvantages us and there was nothing the hospital could do but wait for the results.

I couldn't believe what I was hearing but what could I do? So, we waited and watched our dad quickly start to lose this battle.

Dad's diarrhoea was not slowing down. The doctor decided it was best to use an intrarectal catheter so they could monitor the amount of fluid Dad was losing. Dad was losing fluid at an extraordinary pace. The bag was filling up quickly and it was not slowing down. Dad's body was starting to shut down and the family felt useless.

During this time, I was in contact with [redacted] Dad's Medical Oncology Specialist. [redacted] informed me that Dad's condition was likely caused by a reaction to the immunotherapy and the only way to stop the diarrhoea was to administer a high dose of steroids and a single dose of immunotherapy to counteract the reaction. This needed to be done under the care of the oncology team in Lismore and Dad would need to be transferred. Finally, some good news, but with this good news came bad news. Lismore was in "bed Lockdown" and Dad would not be transferred anywhere.

The Doctors at GBH advised they would begin treating Dad with the high dose of steroids as directed by Lismore and wait for a bed to become available in Lismore and arrange the transfer. Dad continued to deteriorate and was soon transferred to ICU where he received life-saving treatment and care from a team that worked well together. I'm lost for words with what I witnessed in the ICU room. The teamwork, passion and commitment to patient care went over and beyond anything I ever expected or imagined could be done. We are all so very grateful for all the staff in ICU.

ICU staff worked around the clock and soon Dad was transferred back to [redacted] where he was stable but still experiencing diarrhoea. Dad appeared to be in good spirits, and we started to have some hope that he might get through this.

On [redacted] we arrived at [redacted] to visit Dad, but the bed was empty. As you can appreciate, we immediately thought the worst. We thought we lost our dad. Very upset and confused we looked for a nurse to find out more. A nurse told us that Dad was transferred to Lismore earlier that morning. I was very confused, angry, worried, and upset that my dad was transferred without consultation with me. We were under the impression that Lismore was in lockdown and not accepting patients, so Dad was to be treated at GBH with treatment directed by the oncology team in Lismore. Nothing else was discussed so I assumed the original plan to transfer Dad to Lismore was no longer valid.

The hospital staff organised a Patient Transfer for Dad as a bed in Lismore became available. Patient Transport Service (PTS) as I understand it is for non-urgent transport only. Any patients requiring transport within 30 minutes or less are out of the scope of PTS. Since my dad's transfer was deemed non-urgent, I'm perplexed with why GBH staff did not phone the family to inform us about the transfer.

Dad was transferred without his phone charger and very little clothing as I collected many of his personal belongings the day before to wash. The family was very concerned for Dad and his mental well-being due to his lack of access to family support during this time.

Our concerns were amplified as Dad's ability to understand and remember things was impaired by his medications as informed by a doctor. Due to this fact, Dad and I made it very clear that any questions, concerns, incidents and or changes must be reported to me as his next of kin and power of attorney.

I questioned the staff on [redacted] regarding Dad's transfer and why I was not informed. I was advised that a bed became available, and Dad was required to be transferred immediately. Confused by this statement as PTS is for non-urgent transport only, I asked my question again and this time I was advised that due to agency staff working on the ward, they would not be aware of the patient transfer process which I understand to be the NSW Health Hospital PTS process. After reviewing the PTS process, I can see that informing the next of kin and or family is not part of the process but understand it is a part of the discharge process where a checklist is used when discharging/transferring.

After successful treatment in Lismore for dad's condition he returned to Grafton on [redacted] where he was admitted back to [redacted] Finally, Dad was showing some improvement and we had some hope we would get him home soon and he could begin further treatment for cancer.

We again engaged with [redacted] a Medical Oncologist and Physician who was happy to start tablet treatment for Dad's cancer. We were advised that the cancer had spread and 1 lesion on the brain was now 6. Without treatment, Dad would have only months to live but with the treatment, he could have 12-18 months with very few negative side effects from the treatment. This was promising news, and one dad was pleased to receive which gave him hope. The first step to receiving this treatment was to be discharged from the hospital.

This was the moment that everything changed. The point in our dad's journey that would contribute to him losing his life much earlier than he should have.

Upon returning to GBH from Lismore on [redacted] Dad was progressing well with his recovery. His appetite was increasing, his memory was improving, the steroid dose was decreasing, and Dad commenced work with the hospital physio after being restricted to his bed for over 4 weeks. At this point, Dad had lost approximately 15kg, fractured his back, and was restricted to his bed. We knew the recovery was going to be long, but it was possible.

On Wednesday [redacted] Dad experienced his first incident. I did not receive a phone call from staff regarding the incident which was extremely disappointing and concerning. I was not informed about the incident by staff. I found out because my dad told me what happened, and I reached out to the staff to find out more. I have not seen any incident reports, I have not been informed of any review that has taken place to look at ways to prevent this from happening again.

Whilst on [redacted] the following happened:

- Wednesday [redacted] Dad was left in the shower unsupervised. He was found on the floor.
- Tuesday [redacted] Dad was left in the shower unsupervised. He was found non-responsive slumped over in the chair.
- Friday [redacted] was left in the shower unsupervised. He was found on the floor non-responsive, open wound to his forehead, and injured his shoulder.
- Outbreak of COVID-19 in the ward and Dad contracted COVID-19 and he was moved into isolation (No visitors for a period)
- Diarrhoea began again – Dad tested positive to C-Diff

The NSW Hospital Fall Preventions strategy has detailed information outlining how to identify patients at risk and implement a plan using an agreed flagging, handover, and rounding procedure that Identifies specific actions for any risk factors and records these in the patient notes and care plan.

This is yet another example of staff not following policies, procedures and systems that are designed to prevent inadvertent or accidental harm.

Staff on [redacted] care for some of our most vulnerable members of the community and require very specific care. Care that may take longer than your average patient, may require additional supervision and a little more patience and time. You may need to reassess your daily tasks depending on available staff or time constraints or even adjust due to the patient's ill health. Working together as a team on [redacted] is probably the most important factor which I sadly did not see.

After 9 weeks in the Hospital, the doctor agreed that Dad could be discharged to a nursing home. Dad arrived at Whiddon on [redacted] My mum, dad's wife is in Whiddon and has been for almost 5 years. Dad was Mum's full-time carer prior to her moving into the nursing home, but unfortunately Mum required more care than any of us could provide at home. Mum and Dad have been together since getting married in 1969. When Dad arrived in Whiddon he didn't want to see Mum as he was worried, he would upset her. Dad lost between 15-20 kg during his stay in hospital and had a big gash on his forehead from the last fall and he didn't want to upset Mum.

**After 9 weeks of hospital stay and only 9 days in Whiddon, Dad passed away surrounded by love on 27 July 2023. Dad did not get to start his cancer treatment. We his family had only weeks with him, not months like we had hoped.**

**Most significantly and sadly, Dad did not get to see his wife again.**

17 October 2023

Ms Vanessa Landenberger

Dear Vanessa,

I write to confirm our discussion on Thursday 12 October 2023 regarding your concerns about the care and treatment your father, David Brown, received at Grafton Base Hospital during his stays

I extend my condolences on the loss of your father, and I apologise that the care and treatment your father experienced was not at the standard expected.

As a result of my investigation into your father's care, and our conversation, I advised the Nursing Unit Managers (NUMs) of the relevant wards are now taking the following steps to ensure patients receive the expected level of care. These actions include:

- Use of your father's story, as told by you, as an education tool to reinforce with staff the importance of risk assessments and management plans as a means of reminding staff these activities are connected to a person for a reason. This education will take place on all wards and at hospital wide education sessions with staff. I will also share your father's story at our relevant committee meetings. As part of this conversation and education the importance of teamwork in daily nursing activities will be addressed with staff.

- NUMs will continue to reinforce the importance of clinical handover and that relevant risks and plans for patients are discussed during this time.

- Staff who have not completed the appropriate risk assessments or management plans for patients are undertaking a written reflection activity of the care they have provided. These completed tools are being themed to assist managers to identify specific education opportunities for staff.

- NUMs will also remind all staff that it is an expectation that the family/carer is contacted prior to transfer to another facility.

During our meeting we discussed the following aspects of your father's care:

- Delayed transfer from the Emergency Department (ED) to the ward.

  As you had been advised the hospital was at full capacity on and your father waited in the ED until a ward bed became available. This time of the year is one of increased activity for many hospitals and it was appropriate that your father wait in ED and receive care until his ward bed became available.

**Grafton Base Hospital / Maclean District Hospital**
**Management Office**
**P.O. Box 269, GRAFTON NSW 2460**
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Health
Northern NSW
Local Health District

While your father was in ED you reported staff had assisted him to the toilet when he had been told he was not to walk due to a suspected fracture in his spine. It is our expectation that staff provide appropriate handover to one another related to patient's conditions to ensure safety.

- Lack of notification of transfer to Lismore Base Hospital.

  It is our expectation that nursing staff advise families/carers of the impending transfer of a patient from our care to provide an opportunity for a visit prior to the transfer.

- Risk assessment and management plans.

  Upon return to Grafton Base Hospital (GBH) from Lismore a falls risk assessment and management plan was enacted. This plan identified that your father required supervision when walking. This assessment is required to be reviewed each week or when a change in condition occurs.

  Your father was left unsupervised in the shower on [redacted] and should not have been. After his fall on this date a repeat falls risk assessment and updated management plan was needed however this did not occur. He was reviewed by a doctor who documented that he tried to telephone you at the time.

  Your father was left unsupervised in the shower on [redacted] and should not have been. After he was found unresponsive he was reviewed by a doctor. At that time a repeat of all risk assessments and updated management plans was needed however this did not occur.

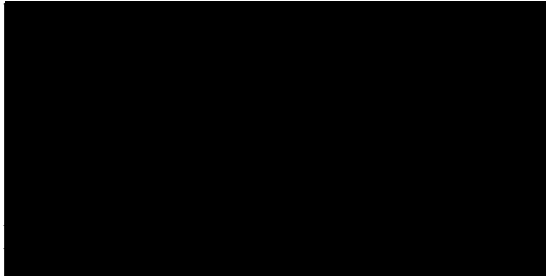
  Your father was again left unsupervised in the shower on [redacted] and should not have been. After his fall on this date, he was reviewed, and a repeat falls risk assessment and updated management plan was put in place.

- COVID 19 outbreak.

  Following the falls your father did contract COVID 19 whilst in GBH. During our discussion we confirmed we had a number of patients who did contract COVID 19 at that time and we are unable to identify the source.

Thank you for bringing your concerns to our attention and meeting with me to discuss them in detail. Your feedback will help us to improve services and provide better care through the actions we have agreed to take.

If you have any further queries or would like to discuss anything further, please feel free to contact me on [redacted]



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