Submission No 34

HEALTH SERVICES AMENDMENT (SPLITTING OF THE HUNTER NEW ENGLAND HEALTH DISTRICT) BILL 2025

Name: Ms Karen Orman

Date Received: 11 April 2025

Thank you for the opportunity to make a submission.

I am in support of this Bill to split the HNEAHS. Since the merger, the standard of care and services outside the Hunter Valley in particular have been significantly eroded. Not just in the larger hospitals such as Tamworth and Armidale, but more severely in the smaller community hospitals such as Manilla, Barraba and Wee Waa.

Working conditions for staff have declined to the point that many of the staff living in the local communities have left and have been replaced by locum, or temporary/labour hire staff. Many hospitals do not have a doctor on site and rely upon a Registered Nurse doing the examinations and providing information to the telehealth practitioner to provide any patient care. The standard of care has dropped significantly with food no longer being prepared on site, call buttons being unanswered for lengthy periods of time (sometimes not at all) and simple things such as dressings not being changed despite beginning to smell and more often than is acceptable, becoming septic and requiring further medicinal intervention (with the excuse being given to concerned family members that the patient did not request a change in dressings). Why should a patient, being a person ill enough to require hospital care, be expected to determine and request appropriate care standards in order for it to be given?

Until their individual passing in 2021, I was live in carer for my elderly father and guardian for my bachelor uncle. In both instances the final experience with the local hospital (being [redacted] and [redacted] respectively) was less than satisfactory. My father refused to return to hospital after his last stay because, despite there being a heat wave and the hospital being relatively new, the air conditioning was not operational for several days. Windows could not be opened and my father struggled to breathe because his heart condition meant that his body was under increased strain when placed in such environmental conditions.

The lack of care being given by nurses was such that I was not able to gain any respite from his care. In fact, it became more stressful because I had to be on hand at the hospital almost constantly to advocate for him and at times perform basic care myself due to lack of availability and concern from nursing staff. A sample of advocacy I had to make was:

1. I had to repeatedly advise the nurse on dispensing duties that he was in hospital due to having aspired a capsule into his lung and request that the capsule be opened and dispensed with a thickening agent to allow him to successfully swallow it. Each time I was advised they would update the records for the next shift and each time it was not done.

2. I had to be there to obtain and change dressings on his weeping odema myself several times a day as necessary, or to repeatedly insist staff do so. On the occasions my insistence had been acted upon, the nursing staff clearly were unhappy at having to perform such a duty.

3. I had to ensure that he was provided with food he was able to eat as an unknown member of nursing staff took it upon themselves to advise the kitchen he was to eat thickened food only, despite the dispensing staff having been repeatedly advised his only difficulty in swallowing was associated with medications in capsule form. This action was taken against

hospital policy and without any patient consultation. The standard of thickened food he was provided was largely inedible.

4. An offhand comment made to a staff member about the situation resulted in my father being subjected to a demeaning, bullying, defensive and angry phone call from the hospital administrator soon after having been discharged.

With regard to my uncle. He had a fall at his nursing home, resulting in a fractured hip and was taken to [redacted] Hospital by ambulance where surgery was performed approximately 48 hours later. His surgery had to be re-scheduled and delayed by 24 hours due to "emergencies" arising and the operating room/staff becoming unavailable.

After surgery I was advised he was recovering well and even though I was his Enduring Guardian and had asked to be kept informed, I was not advised, nor consulted when the decision was made to transfer him back to [redacted] Hospital for after surgery care. He advised the trip was excruciating for him and that he had not been consulted about the move either.

Up until that time, I had been conversing with him on the phone daily. I was unable to attend in person because my father was close to death and I was caring for him at home with limited assistance. My uncle was in good spirits and clearly lucid. Within 2 days of being transferred to [redacted] his condition had noticeably declined. He was agitated and while on the phone, I heard him lash out physically at staff and staff physically retaliate. Twenty four hours after that, he was no longer lucid on the telephone and did not know who I was.

Attempts to ask for tests relating to possible infection etc were met with resistance and advice that they would not be done for another 24 hours because that was when the catheter was scheduled to be removed. The sample had to then be sent away, resulting in another 24 hour delay. Once the results came in, they showed he did have an infection, but was advised nothing could be done until a doctor had reviewed the results and issued a prescription for antibiotics, which would be at least another 12 to 24 hours.

My father had passed away by this time and I was able to insist on seeing my uncle in person in the hospital, despite Covid restrictions in place at the time. He was clearly in severe pain. Not only that, the table with his fluids had been pushed away from his bed, out of his reach, his bed had been pushed away and out of reach of the wall, with his call button hanging on the wall. Conversations with the staff revealed an intense dislike of my uncle and as a consequence, a refusal to associate with him.

A discussion with the administrator of the hospital resulted in me being advised of the following:

1. He had advised them upon arrival he did not need pain medication and so they took him at his word, despite him subsequently clearly being in severe pain, distress and lacking in cognitive abilities due to the infection.

2. They had not been advised by the nursing home (attached to the hospital) that he was on antibiotics for an aggressive skin infection prior to his fall and therefore had not been on antibiotics since the time of his fall, approximately 2 weeks earlier.

3. One of their Registered Nurses worked at the nursing home as well as the hospital and she had advised the administrator that he was always extremely difficult, angry and that he was a very unpleasant individual, so there was no medical reason for his current condition. (Words used inferred that they considered him to be "a difficult old bastard" and therefore not worthy of a more concerted effort in providing adequate medical care.)

Twenty four hours after managing to get him onto medication for the infections and pain relief, I receive a phone call from the local GP late in the evening advising me the remaining test results had come back had revealed his kidneys had stopped working. I was expected to give an on the spot answer as to whether to send him back to [redacted] to see if they could try to get his kidneys started again, or to start palliative care measures. It was left to me to seek information regarding the possible prognosis of a trip to [redacted] and what standard of living he would have if the additional medical intervention had been successful. When I said I needed a little time to think it through, I was given 20 minutes. The information was delivered in a manner that would suggest we were talking about a broken piece of equipment rather than a human being.

As per his wishes expressed in the Advanced Care Directive I gave permission for the palliative care to begin. I arrived at the hospital again the next morning to find that the dosages they had given him were insufficient but the locum/labour hire nursing staff ignored my concerns, advising that they would be reviewed when next a doctor was on the premises, which was expected to be not for at least 12 to 18 hours. Again, they showed little more than distain for my uncle while the casual staff member who lived within the community showed him a great deal of care and compassion. I had sat at my father's bedside only 2 weeks prior and therefore had experience with the dosages and they relief they could give someone passing. My uncle had a significantly greater body mass and yet his medication levels were less than that given to my father who had died peacefully in his sleep. My uncle died an unnecessarily painful death several hours before the staff were due to next consult a doctor on his behalf. He was clearly still in pain and was on insufficient dosage to minimise the fluid building in his throat and lungs. He would wake regularly, struggle to gasp air and then his eyes would roll back in his head before passing out again.

I did not lodge a complaint at the time,(nor do I wish to lodge a formal complaint now) as I was not in a mental or emotional position to do so. I had been carer for both my father and uncle for several years. They passed away within 2 weeks of each other and I was exhausted, while still having a lot on my plate to deal with associated with return of equipment to the hospital within specified time periods, funerals etc. I expect that very few formal complaints are lodged under similar circumstances due to the immense pressure, workload and grief families find themselves under immediately after a loved one's passing. Therefore, I doubt any data you have with regard to the standard of care being provided is entirely accurate.

These stories are not isolated. They are quite widespread within the region and the standard of care is dropping further. Services are being withdrawn and people are increasingly being

left to deal with inadequate or non-existent care. Hunter New England Area Health Service is adopting the viewpoint of centralising services to John Hunter Hospital in Newcastle at the expense of the outer regions of this service area, with the lack of available staff and the expense of providing services to these regions being cited as justification for withdrawal.

Complaints made to HNEAH regarding the standard of service provided are generally dismissed or ignored.

It is clear that the creation of Area Health Services that cover a large geographical areas to provide equity in population requiring service has been a failure. It is costing the tax payer and government a great deal more than is necessary due to centralisation of services. I am not across the figures, but would suggest that investigation in the the increased use of ambulance services to transfer patients to and from John Hunter Hospital (as well as between smaller hospitals) rather than providing adequate services at district/regional hospitals may support this. In addition, I suggest that figures associated with the additional length of hospital admission times due to lack of early intervention in medical conditions will show the centralisation of health services is also costing the Government unnecessarily.

However, I make this submission on humanitarian and compassionate grounds as well as economic. We live in communities - local, regional, state, national and beyond. These decisions affect human beings moreso than budget bottom lines. Not just those with medical conditions, but also their families, friends, loved ones and the front line workers who still live in and attempt to provide care to their community. The extra financial and emotional burdens that are placed upon all members of our communities begs the question "Do we really believe it is appropriate to place an economic unit per capita for hospital and medical care while ignoring the human cost?" I would suggest that it is possible, should the will exist, to find a balance between the two.

There are already examples (for example in Walgett) of how a high standard of health care can be provided to small communities at an economical and practical level and therefore the template exists to split the HNEAHS, allowing for a decentralisation and elevation of medical care being provided to those of us who live outside the Hunter Valley.

Thank you for your time and for allowing me to make this submission.