SUBMISSION BY THE
NSW NURSES AND MIDWIVES' ASSOCIATION

The Northern Beaches Hospital Audit

NOVEMBER 2024

NSW NURSES & MIDWIVES' ASSOCIATION
AUSTRALIAN NURSING & MIDWIFERY FEDERATION NSW BRANCH

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50 O'Dea Avenue, Waterloo NSW 2017
T 8595 1234 (METRO) • 1300 367 962 (NON-METRO) **F** 9662 1414 **E** gensec@nswnma.asn.au

www.nswnma.asn.au

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This response is authorised by the Elected Officers of the New South Wales Nurses and Midwives' Association.

Contact details

NSW Nurses and Midwives' Association
50 O'Dea Avenue
Waterloo, NSW 2017
(02) 8595 1234 (METRO)
1300 367 962 (RURAL)
gensec@nswnma.asn.au

Introduction

1. The New South Wales Nurses and Midwives' Association (NSWNMA) is the industrial and professional body for nurses and midwives in New South Wales, representing over 80,000 members across the full spectrum of health care services in NSW, including public and private hospitals, midwifery, corrective services, aged care, disability, and community settings.

2. NSWNMA strives to be innovative in our advocacy to promote a world class, well-funded, integrated health system by being a professional advocate for the health system and our members. We are committed to improving the quality of all health and aged care services, whilst protecting and advancing the interests of nurses and midwives and their professions.

3. We work with our members to improve their ability to deliver safe and best practice care, fulfil their professional goals and achieve a healthy work/life balance.

4. Our strong and growing membership and integrated role as both a trade union and professional organisation provides us with a complete understanding of all aspects of the nursing and midwifery professions and see us uniquely placed to defend and advance our professions.

5. Through our work with members, we aim to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems, and the health of our national and global communities.

6. The NSWNMA thanks the Audit office of New South Wales for the opportunity to provide feedback on the Northern Beaches Hospital Audit.

Overview

7. Our submission focuses on the experience of our members employed at the Northern Beaches Hospital (NBH) as relayed through the Northern Beaches Branch of the NSWNMA. Our submission to this audit therefore relates specifically to impacts on patient care and work health and safety (WHS). Matters pertaining to administration, data, and funding arrangements are only informed by readily accessible public- facing information.

8. Whilst Public Private Partnerships (PPP's) are implemented to facilitate improved services, as well as "*achieve better value for money in the development, maintenance and operation of service-based infrastructure*[1]," the NSWNMA is of the position that the NBH PPP operates somewhat outside the legislative norms of public health service arrangements, compromising the safety and security of both patients and staff.

9. There are differences in governance structures between public and private hospitals more generally, this can lead to a lack of transparency in public-facing information which is inconsistent with expectations of publicly run hospitals. There is public accountability for expenditure on public hospitals and reporting requirements. Whereas private hospitals such as NBH do not have

[1] NSW Treasury. (2022). *Public Private Partnerships*. https://www.treasury.nsw.gov.au/projects-research/public-private-partnerships

equivalent governance, meaning there is less accountability for public spending. This lack of accountability creates ideal conditions for patient care to be influenced by profit.

10. As evidenced in the NSWNMA's 2023 Submission to the Special Commission of Inquiry into Healthcare Funding[2], PPP's historically fail in healthcare. Superficially, PPP's appear cheaper than traditional public investments, however, over time, they undermine fiscal sustainability[3]. Due to this, the NBH must be reverted to public hands.

Summary of Recommendations

11. All patients must have access to timely, safe, and quality care at the Northern Beaches Hospital, free from the influence of profit, and consistent with that experienced at equivalent public health facilities in NSW.

12. Urgent review of WHS practices, and prompt implementation of equivalent safe staffing ratios and appropriate skill mix to that in a Level 5 public health facility.

13. The implementation of and strict adherence to clear patient flow protocols, to address bottlenecking and care delays during triage in the Emergency Department.

14. Enhanced transparency in publicly facing data and ring-fenced funding to ensure safety and care is not compromised by profit-driven decisions, and to improve accountability.

Governance

15. Our members are concerned about the perceived 'profit before patients' culture that prevails at NBH. For example, one member told us management had introduced additional day patient slots which has resulted in: no available place to accommodate a patient who may require follow up after a bad reaction or complication; patients having their treatment time cut so other patients can be fitted in after them, and staff forced to rush procedures leading to reduced quality care. One member told us *"sometimes staff move the unwell patient out of the bay to sit in a space between bays with no call bell, oxygen, electricity or curtains for privacy. This is so the next patient can start their treatment"*. Additionally, it is reported there is no investment in clinical education to support that clinical area, unlike similar public hospitals.

16. Whilst there is some evidence of clinical outcomes at NBH being equivalent, or better than those in similar public hospitals[4], reporting is limited and does not consider the compromised quality required to achieve reportable outcomes, such as that described above, and in comments below. Anecdotally, our members have reported bed allocation prioritises the need to maximise private income over patient needs, particularly those in ED waiting for a bed.

17. The NSWNMA has attempted to establish equivalence between NSW Health and Healthscope key performance indicators with limited success. We maintain that difficulty in accessing Healthscope

[2] The NSWNMA. (2023). *Submission to the Special Commission of Inquiry into Healthcare Funding.* https://www.nswnma.asn.au/wp-content/uploads/2023/11/NSWNMA-Submission-to-the-Special-Commission-of-Inquiry-into-Healthcare-Funding-Appendix-included.pdf
[3] International Monetary Fud. (2018). *How to Control the Fiscal Costs of Public-Private Partnerships.* https://www.imf.org/en/Publications/Fiscal-Affairs-Department-How-To-Notes/Issues/2018/10/17/How-to-Control-the-Fiscal-Costs-of-Public-Private-Partnerships-46294
[4] Bureau of Health Information Jan-March 2024 data. Available at: Bureau of Health Information - Data portal

key performance indicators would also be experienced by the public. Additionally, data that is available is high-level and would not capture the quality-of-care issues to the level of detail required, or identification of matters such as those described by our members within the body of this submission, and in the Appendix.

"The health care offered to the people of the Northern Beaches, in what is essentially and should be their local public hospital where they should have confidence that the treatment that they receive be at bare minimum equal to, similar or on par with any patient in any of their peer NSW Health facilities. It is my opinion that they do not, they cannot, and will not despite any arguments made, statistical data, provision of policy and procedure documents provided by Healthscope. Everything that happens within the Northern Beaches Hospital is driven by money, regardless of the poor patient outcomes that have occurred or occur on every shift of every day, and by virtue of this blatant erosion in adequate service provision the incredible challenges that this presents to staff on the ground, dealing with this both physically and mentally" NSWNMA NBH member

"Despite data that may be provided, our failed discharge numbers are high. They are not obviously formally recorded especially when patients return via ED as they are not recorded as a failed discharge on any of the data bases, even though their return to hospital is within the allotted timeframe and as a direct consequence of a complication of their primary admission diagnosis and management or complication of their surgical procedure. The latter I believe is higher in prevalence. That these patients are failed discharges is mainly noted in the triage notes recorded at the time of triage. A review of local rehab and respite facilities should be recording these failed admissions." NSWNMA NBH member

"Rates of patients who present to ED with what would be considered minor injury or illness particularly orthopaedic and plastics, are not reviewed and treated in ED. Instead, they are taken to the operating theatre then have a completely unnecessary general anaesthetic, with all the associated risks (including death) then must be recovered and discharged, often with no extra staff to facilitate safe discharges." NSWNMA NBH member

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WHS

18. Our members have reported the NBH operates outside usual safety parameters expected in comparable publicly run hospitals. Overall governance of areas such as management and response to 'code black' situations by reducing security guards, fire safety relative to provision of Fire Wardens and governance of risk more generally, is inconsistent and below standards in other settings. The NSWNMA wrote to the management of NBH about the reduction in security staffing in April 2024 on behalf of the NBH Branch. The Branch had raised WHS concerns, citing arrangements were inferior to those experienced by members working in comparable public hospitals.

"Staff no longer feel safe at work; when they press their emergency duress alarms, they often receive no response, only to discover that there is a Code Black on the ward and no security personnel available. There has been an increase in staff assaults and patients harming themselves within the department. Recently, a patient walked into the waiting room, went back outside, stabbed himself, and then returned for triage. Security staffing has decreased, limiting their ability to care for patients under duty of care, even when staff face physical threats from unpredictable or intoxicated patients." NSWNMA NBH Member

19. The NSWNMA is of the understanding that WHS compliance should be governed by an assigned officer, as per the *Private Health Facilities Act 2007,* at NBH. However, our members report limited knowledge as to who was fulfilling this role in the specified Audit timeframe. This is inconsistent with equivalent public health facilities in NSW, which implement systematic spot checks, and targeted periodic audits. NBH operates somewhat independently of such requirements, potentially generating negative and avoidable outcomes for our members.

20. Publicly run hospitals have layers of accountability both at local and state level. Matters relating to compliance with WHS legislation are managed through escalation, local compliance checks, and have ongoing deliverables which the hospitals are expected to report on, a process which ultimately leads to the NSW Ministry of Health. NBH systems are localised, and our members have reported that decisions appear to be viewed through the lens of profit rather than prioritisation of safety.

"The nurses in the Northern Beaches Hospital do not and would not know how to answer a Warden Intercom Point phone in a fire, they have never been taught, please note there was some accreditation of fire wardens recently perhaps they know, I am not aware, I am not one of them. I was not afforded that opportunity or some of the other full time permanent after hours managers, a few of the casual after hours managers are designated fire wardens. Open disclosure: Only happens if there is no other way around it." NSWNMA NBH member

Staffing

21. Unlike public hospitals, private hospitals, including NBH, are not required to utilise staffing ratios, leaving decisions about numbers of nurses and midwives for management to determine. This has the potential to allow profit to be a consideration in decisions. One member working at NBH told us *"the ratio appears to be solely based on cost cutting and lack of understanding of the acuity of patients'*. And consequently, '*reduced nurse – patient ratios obviously have a detrimental effect on the quality of patient care, and it means that patients at NBH are at a disadvantage compared to other acute/in centre patients at public hospitals, certainly in Sydney"*.

22. Of significant concern to the NSWNMA is that whilst the State funds health service provision to public patients attending the NBH, as evidenced in the above quote, the level of nursing care being provided to patients at NBH can be lower than that provided at equivalent Level 5 public health facilities. This is a key risk of privatisation; lower costs being achieved through inadequate staffing.

23. The earlier example of an increase in places without employing additional staff means nurses working morning shifts in that department are unable to take lunch breaks. We refer to our submission to the Private Health Facilities Regulation[5] for more generalised commentary and examples from other privately operated hospitals.

Emergency Department Treatment Performance

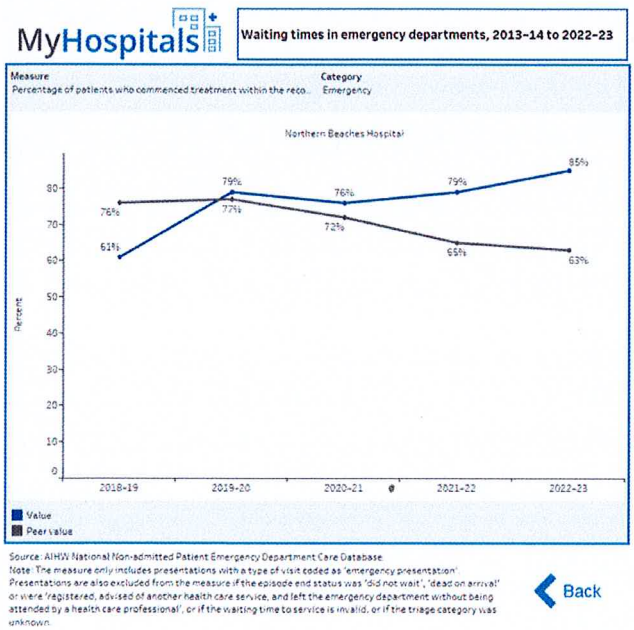
Triage

24. Clinical tools utilised within the public system to establish maximum wait times within the Emergency Department include the Australasian Triage Scale (ATS). The ATS ensures treatment relative to clinical urgency, via the implementation of five assessment categories, encompassing ATS 1- presentation with an immediately life-threatening condition, requiring immediate assessment and treatment, to ATS 5- presentation with a chronic or minor condition, for assessment and treatment within two hours.

Australasian Triage Scale Category	Treatment Acuity (Maximum waiting time for medical assessment and treatment)	Performance Indicator Threshold
ATS 1	Immediate	100%
ATS 2	10 minutes	80%
ATS 3	30 minutes	75%
ATS 4	60 minutes	70%
ATS 5	120 minutes	70%

Australasian College for Emergency Medicine. (2024). *Triage.*. https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Better-Outcomes-for-Patients/Triage

25. Whilst the NSWNMA acknowledge that 85% of the NBH's emergency cases were reported as being assessed and had treatment commenced within the recommended timeframe in 2022-2023[6], our members tell us about an emphasis on achieving and exceeding performance indicators has been to the cost of patient and staff safety.



[5] The NSWNMA, (2024). *NSW Ministry of Health Draft Private Health Facilities Regulation 2024*. https://www.nswnma.asn.au/wp-content/uploads/2024/06/20240612-Draft-Private-Health-Facilities-Regulation-NSWNMA-Submission-EF150064.pdf
[6] Australian Institute of Health and Welfare. (2023). *Public Hospital: Northern Beaches Hospital*. https://www.aihw.gov.au/reports-data/myhospitals/hospital/h0753

"Overnight, there is only one triage nurse from midnight, compared to two triage nurses at Royal North Shore. On night shifts, I have been asked to access ports, insert indwelling catheters, or nasogastric tubes, as the Adult Acute Assessment (AAA) area is staffed with first or second-year nurses, who lack these skills. I have also been pulled from my area to serve as the airway nurse for paediatric and neonatal patients and have been asked to assist with patients in cardiac arrest. This leaves triage unattended, with over twenty patients waiting... I have personally witnessed multiple emergencies in the waiting room, including falls, collapses, cardiac arrests, anaphylaxis, STEMIs, and self-harming patients. If the triage nurse is in resus with the other two resus nurses, who will manage these emergencies?"
NSWNMA NBH Member

26. Whilst the NBH is seemingly efficient from a data perspective, the NSWNMA asserts that this is only achieved to the detriment of staff wellbeing. Our members are overworked, forced to constantly change roles, increase their workload, and fill service gaps in order to meet the demands of efficiency. It is simply unsustainable.

Fast Track

27. Publicly run Emergency Departments often implement Fast Track zones to expedite the care of patients with less urgent complaints to be discharged in less than two hours. To optimise care, Fast Track zones should be staffed by senior medical and nursing staff, with the knowledge and skills to make timely treatment and clinical decisions with minimal consultation required.

28. According to our members at NBH, prioritisation for efficiency and performance indicators over adequate care has resulted in allocated Fast Track zone beds being poorly utilised. Specifically, Fast Track beds are often filled by Adult Acute Assessment patients, who fall outside the pre-determined, non-complex criterion of the zone, meaning they often stay longer than the model of care's specified two hours. Not only does such practice increase nursing workloads and poor patient outcomes, but it ultimately renders the Fast Track model ineffective.

"At NBH, Fast Track serves as an overflow for Adult Acute Assessment due to bed block and pressure on the Nurse Unit Manager to meet ambulance offload KPI. Patients needing Adult Acute Assessment beds are placed in Fast Track when there are no available beds... We have seen an increase in poor patient outcomes from patients being placed in Fast Track beds, which lack monitors. Within the last six months, a 40-year-old woman was placed in Fast Track. The triage nurse escalated concerns to the Nurse Unit Manager and Emergency Department Consultant that this patient appeared very unwell. This patient remained in Fast Track for six hours until she was diagnosed with a subarachnoid haemorrhage and subsequently moved to Resus and transferred urgently to RNS." NSWNMA NBH Member

Transfer of Care

29. Staffing shortages and high acuity within the NBH Emergency Department have additionally impeded the efficient transfer of patients from ambulance paramedics to hospital staff within NSW public health facility targets. Such a target is met when patients are no longer on the ambulance stretcher, paramedic care is no longer required, and clinical patient handover has occurred. The Association understands that all NSW public facilities are expected to maintain a target of offloading 90% of patients within 30 minutes[7], however, this only occurred in 87.2% of patient transfers at the NBH between April and June 2024[8].

"The Nurse Unit Manager is under pressure to meet the directive of offloading ambulances within 30 minutes of arrival. This key performance indicator (KPI) leads to inappropriate patients being offloaded to Resus, or patients requiring Resus being placed in Adult Acute Assessment beds. As a result, Resus becomes a revolving door, with patients frequently being moved in and out, which diminishes stock levels and significantly impacts patient care. Healthscope appears to prioritise KPIs over patient and staff safety." NSWNMA NBH Member

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[7] The Agency for Clinical Innovation. (n.d.). *Data Collection and Reporting*. https://aci.health.nsw.gov.au/networks/eci/service-management/performance/data-collection-and-reporting

[8] Bureau of Health Information. (2024). *Hospital Performance: Northern Beaches Hospital*. https://www.bhi.nsw.gov.au/search_local_hospital_performance.https://www.bhi.nsw.gov.au/search_local_hospital_performance.https://www.bhi.nsw.gov.au/search_local_hospital_performance.

Appendix

Dear Auditors,

I am writing to share my observations and concerns.

In my experience, the systems at NBH are inadequate for ensuring safe and high-quality healthcare. Staffing levels in the emergency department (ED) consistently fall short of those in public health hospitals like Royal North Shore. For instance, we operate with two nurses for four patients in Resus overnight, compared to one nurse per patient in public hospitals' resuscitation bays. While caring for these four patients, one nurse is also responsible for attending code blues for paediatrics and the ground floor, which can lead to situations where one nurse is responsible for four resus patients.

Critically unwell patients and those experiencing cardiac arrest require a team of skilled nurses. On night shifts, the only accredited advanced life support (ALS) nurses often are the triage nurse and two resus nurses. Recently, we received two bat phone calls simultaneously for two patients with overdoses requiring airway support. Both arrived at the same time and needed intubation. Ventilated patients require one nurse per patient and a skilled team for intubation, including an airway nurse, a nurse team leader, two drug nurses, and a procedure nurse. If there are only two ALS-accredited nurses on night shifts, where do you expect us to find additional support? On that night shift, the after-hours clinical nurse specialist (CNS) assisted one resus nurse with intubation, while the other patient was managed by the other resus nurse and the triage nurse, leaving triage unattended and the Nurse Unit Manager (NUM) to call the on-call consultant and ICU for transfer assistance. Meanwhile, the other two unwell patients were left to fend for themselves.

Overnight, there is only one triage nurse from midnight, compared to two triage nurses at RNS. As the only triage nurse on night shifts, I have been asked to access ports, insert indwelling catheters, or nasogastric tubes, as the Adult Acute Assessment (AAA) area is staffed with first- or second-year nurses who lack these skills. I have also been pulled from triage to serve as the airway nurse for paediatric and neonatal patients and have been asked to assist with patients in cardiac arrest. This leaves triage unattended, with over twenty patients waiting. Clerical staff who are not medically trained are left to oversee the waiting room and contact the triage nurse if someone walks in needing triage.

I have personally witnessed multiple emergencies in the waiting room, including falls, collapses, cardiac arrests, anaphylaxis, STEMIs, and self-harming patients. If the triage nurse is in resus with the other two resus nurses, who will manage these emergencies? More often than not, the resus and triage nurses overnight do not get their entitled breaks, resulting in increased burnout. While missed breaks are reportedly documented in the NUM shift report, staff are not compensated for them, and this issue is often overlooked. Despite management being aware, we are advised to escalate concerns to the NUM. However, when we do, there is often nothing they can do because there is no one to relieve us. Although the NUM may try to cover triage, managing a department while also triaging for an hour is simply not feasible.

Additionally, the NUM is under pressure to meet the directive of offloading 80% of ambulances within 30 minutes of arrival. This key performance indicator (KPI) leads to inappropriate patients being offloaded to Resus, or patients requiring Resus being placed in AAA beds. As a result, Resus becomes a revolving door, with patients frequently being moved in and out, which diminishes stock levels and significantly impacts patient care. Healthscope appears to prioritise KPIs over patient and staff safety.

There are pathways for nurses to work independently in Resus, triage, paediatrics, and as Clinical Initiative Nurses (CIN) at NBH. Nurses must complete training and be signed off as "green" to work night shifts and weekends in these areas. However, due to staffing shortages, new staff or those not yet "green" are often placed in Resus, triage, or paediatrics on weekends and weeknights without support from educational staff. This increases the pressure and workload on other staff members in these areas, who must support and oversee their less experienced colleagues, often leading to missed deterioration and poor patient outcomes. For example, two junior nurses working in paediatrics over a

weekend placed a two-year-old with abdominal pain in chairs, which breaches patient flow protocols that dictate all patients with abdominal pain should be in a paediatric bed. This patient had one set of observations recorded, indicating a heart rate of 200 (in the red zone), a red flag that was not escalated to medical staff or the NUM. The child was left to deteriorate in paediatrics with no further observations. Unfortunately, this child was found by the senior paediatric nurse at 10 o'clock to have worsened and shortly after suffered an intra-hospital cardiac arrest. This child has since passed away.

The Fast Track (FT) area is designed for a two-hour model of care for patients with minor presentations. However, at NBH, Fast Track serves as an overflow for AAA due to bed block and pressure on the NUM to meet ambulance offload KPIs. Patients needing AAA beds are placed in FT when there are no available beds. FT has no established patient-to-nurse ratio, typically operating with two nurses during the day and sometimes one overnight (known as the Front of House (FOH) nurse). I have worked both as the FT nurse during the day and as the FOH nurse at night. You can have anywhere from six to fifteen admitted patients, plus FT patients. We have seen an increase in poor patient outcomes from patients being placed in FT beds, which lack monitors, while one nurse manages up to twenty patients at a time. If Resus is busy, the FOH nurse is often pulled to that area, leaving the FT patients unattended, which is not an isolated incident but a regular occurrence.

Due to the lack of nurses, patients miss intravenous antibiotics, observations go unattended, and patients deteriorate behind closed doors, as one nurse cannot be in multiple places at once. Within the last six months, a 40-year-old woman was placed in FT room 3. The triage nurse escalated concerns to the NUM and ED Consultant that this patient appeared very unwell. This patient remained in FT for six hours until she was diagnosed with a subarachnoid haemorrhage and subsequently moved to Resus and transferred urgently to RNS. This patient received only one set of observations while in ED, even during a day shift when staffing levels were supposedly adequate.

I can recall at least two other instances of patients needing AAA being placed in FT overnight who missed their intravenous antibiotics, leading to increased septic conditions and resulting in ICU admissions with significant health repercussions. Not only does the nurse face the challenge of being spread thin, but they also carry the emotional burden of guilt for not being able to provide the care they wish to offer, with patient health suffering as a consequence. The dumping ground of FT can also include patients who are immobile or at high risk of falls. It often takes a patient falling in FT to secure them a AAA bed or for them to become critically unwell and require a resus bed, even though FT is not designed to care for such patients.

In the Paediatric ED, staffing consists of two registered nurses from 07:00 to 19:30, one nurse team leader from 10:00 to 22:30, and two nurses from 19:00 to 07:30 for seven beds and four paediatric chairs. This results in a nursing ratio of one nurse to four patients, compared to RNS, where the ratio is one nurse to three patients. The nurse team leader is responsible for managing bed flow and overseeing paediatric patients in the waiting room. Interestingly, when auditors come to assess the department, the paediatric chairs are often not used, and a curtain is pulled around them. If the paediatric chair model does not comply with regulations, why are we expected to use them?

The Emergency Short Stay Unit (SSU) is an 11-bed area staffed with three nurses from 07:00 to 15:30 and two nurses from 15:30 to 07:30. SSU bed 11 is one of three isolation beds in the department. Consequently, sick respiratory or febrile neutropenic patients often end up here. Reviewing febrile neutropenia audits shows that patients not given intravenous antibiotics within the first hour are frequently in SSU bed 11. The ED SSU is predominantly staffed with agency nurses and junior ED nurses and can have patient ratios of one nurse to five patients. There have been multiple shifts where the NUM has sent a nurse home, leaving just one nurse to manage a minimum of five patients, with no backup for checking medications or even using the restroom. NUMs are consistently told that ED is overstaffed, leading to casual and agency staff being sent home early, prioritising staffing hours over the needs of patients and staff.

Amid staffing shortages, staff burnout, and increasing demand, there has been a significant rise in Riskman reports for aggressive incidents. Staff no longer feel safe at work; when they press their emergency duress alarms, they often receive no response, only to discover that there is a code black on

the ward and no security personnel available. There has been an increase in staff assaults and patients harming themselves within the department. Recently, a patient walked into the waiting room, went back outside, stabbed himself, and then returned for triage.

Security staffing has decreased, limiting their ability to care for patients under duty of care, even when staff face physical threats from unpredictable or intoxicated patients. We have been advised to call the police for assistance. A scheduled patient recently self-harmed while in a safe assessment room because security was preoccupied with three scheduled patients. It appears that NBH is prioritising financial gain over staff and patient safety. How many more incidents must occur before meaningful action is taken?

Over the past few years, we have observed an increase in failed discharges and surgical readmissions. Patients returning with complications post-surgery or post-discharge are becoming more common, adding further strain to an already overburdened ED.

Patients often remain in the ED for nearly 24 hours, with beds only becoming available at around 22-23.5 hours, just prior to breaching the 24-hour limit and incurring a penalty. Patients admitted for telemetry frequently sit in the waiting room for over 12 hours without telemetry, only for staff to be instructed to place them on telemetry for transfer to the ward. Triage, CIN, and Fast Track nurses are frequently subjected to verbal abuse regarding long wait times and patients' discomfort. We do not have the time to file Riskman reports every time we are sworn at or threatened.

AAA consists of 22 beds within the ED, staffed with 6-7 nurses. Two nurses typically manage a 1:3 patient ratio, while four nurses handle a 1:4 ratio. There is a float nurse available from 15:00 to 00:30. AAA is predominantly staffed with new starters and agency nurses. In comparison, RNS has a nurse-to-patient ratio of 1:3 in AAA, with a nurse team leader per 12 patients. At NBH, the float nurse is often a phlebotomist or is relieving breaks, thereby impacting the patient load of the nurses. The lack of a team leader, unlike RNS, often leads to patient deterioration being missed, as new starters may lack essential skills like intravenous cannulation, catheter insertion, and nasogastric tube placement. Patients can deteriorate without appropriate monitoring, ultimately becoming critically unwell and needing to be moved to Resus. Nurses carry the burden of these oversights and the resulting patient deterioration.

Junior nursing staff frequently end up in tears, feeling overwhelmed and unsupported. Senior nurses bear the additional burden of guiding these less experienced staff while managing an already heavy workload. Our staff retention rates have diminished, and many are considering leaving for public hospitals that offer better staffing support and patient ratios.

ED Management is aware of the increasing acuity we face. Despite requests for more staff, executives believe they can simply pull and move staff as needed. However, this approach leaves patients unattended or with insufficient nursing support, leading to dangerous double patient ratios.

To ensure efficient and effective healthcare delivery at Northern Beaches Hospital, several improvements could have been implemented. Firstly, a thorough review of staffing levels and patient ratios in high-acuity areas, such as the ED and Resus, should have been prioritised. Increasing the number of ALS-accredited nurses on night shifts and ensuring that skilled personnel are available during peak hours would significantly enhance patient safety. Additionally, investing in ongoing training and support for new and junior staff would help to build their confidence and competence, reducing the risk of missed deterioration in patients. Furthermore, establishing clear protocols for managing patient flow and effectively utilising available resources, such as creating dedicated roles for triage during busy periods, could alleviate the pressure on staff and improve patient outcomes.

Regarding accountability, I believe private hospitals should be required to report on patient outcomes in the same manner as public hospitals. Transparency in patient outcomes is essential for maintaining standards of care, fostering trust among patients, and ensuring that all healthcare providers are held accountable for their practices. Public reporting of outcomes can highlight areas for improvement,

promote competition based on quality, and ultimately lead to better healthcare delivery across both public and private sectors.

There is growing evidence that profit-driven motives may have impacted patient outcomes during this period. The emphasis on meeting KPIs and financial targets appears to have overshadowed the commitment to patient safety and care quality. Instances of overcrowding in Fast Track and insufficient staffing levels in critical areas suggest a prioritisation of efficiency over adequate care. As seen in various reports, facilities focused on profitability often struggle with resource allocation, leading to compromised patient care and increased adverse events. By acknowledging and addressing these issues, we can better align the goals of healthcare delivery with the fundamental objective of ensuring patient safety and well-being.

In conclusion, I urge you to consider the necessity for Northern Beaches Hospital to revert to a public hospital model. The current structure prioritises profit over patient safety and care quality, which is detrimental to both patients and staff. A public system would restore the focus on delivering equitable, safe, and high-quality healthcare to our community.

Thank you for your attention to these critical matters.

NSWNMA member, NBH