Submission

No 39

INQUIRY INTO THE ROYAL NORTH SHORE HOSPITAL

Organisation:

Name: Dr Wendy Michaels

Telephone:

Date Received: 9/11/2007

Theme:

Summary

Submission

by

Dr Wendy Michaels

to the

Parliament of New South Wales Joint Select Committee

on the

Royal North Shore Hospital

The following submission is based on my observations of, and interactions with, staff and systems of the Royal North Shore Hospital in conjunction with a number of admissions of my father, Ronald Guy Michaels (born 1915) as a patient in emergency and other wards over a number of years, but in particular during admissions in April 1998, February 1999, October 2004, and October 2007.

I note that while the itemised terms of reference for the inquiry focus on particular aspects such as "systems", "structures", "resource allocation", "operational management" and "complaints handling", there is general provision in "Term of Reference 1" for comment on "quality of care for patients". I intend to address three aspects relating to "quality of care" and one aspect concerning "effectiveness of complaints handling" (subsection (d)). To support these brief comments I enclose copies of correspondence relating to complaints made by me to the RNSH in 1998 and 2004.

Problematic aspects of "quality of care for patients":

(a) **Mis-diagnosis in Emergency.** On two occasions of my father being brought into emergency by ambulance his condition was not correctly diagnosed. On the first he was actually discharged after some hours with the diagnosis of TIA despite having brain abscesses (he was readmitted three days later and the diagnosis eventually established after an MRI); and on the second occasion he was admitted after a severe fall in which he was knocked unconscious, provided with a pace maker and discharged despite some congestive cardiac failure and subdural haematomas not being detected. My observations and interactions with staff suggest insufficient staff available to deal with the demand, and inexperienced, overworked and weary staff with inadequate supervision to properly assess patients. This is obviously a situation detrimental to good quality patient care.

(b) **Mis-communication with patients and families both via telephone and in the wards.** While I experienced numerous instances of miscommunication, one particular example of the difficulty of obtaining patient information over the phone involved twenty minutes of being shuffled from one ward to another with each one telling me that my father had been moved to another ward and the final one telling me that he had been discharged from the hospital the previous evening. (None of which was correct. He was in Ward 10 A despite two different "voices" telling me he was not in their ward according to the computer.) Misinformation also circulated at all levels in the wards – as the attached documentation evidences. This misinformation includes mis-notations in ward notes (I had the opportunity to witness the manipulation of records as a cover up for my complaint). My recent observations (October 2007) suggest that staff relationships, both in terms of working in medical teams and interacting with patients and

families has further deteriorated. I witnessed sharp exchanges between staff and rudeness from staff to patients – indicative of low morale levels – a factor that inevitably detrimentally affects patient care.

(c) **Poor physical conditions in wards.** Even if you discount the shabby wards and corridors as being less than conducive to promoting patient well-being, the physical condition of the hospital is deteriorating in such a way as to prove deleterious to patient health and recovery. I have witnessed numerous incidents of malfunctioning medical equipment and lack of equipment as basic as a chair for a patient (or his visitor) to sit in. Indeed when I recently requested that a chair be found for my father to get out of bed and sit in, I was told there were none to spare! Of more concern is the lack of cleanliness. On one occasion I witnessed a patient's visitor demand a bucket and mop to clean a particularly dirty ward floor. Moreover, as a visitor I have picked up discarded papers, cups, medications and even used syringes left lying on ward floors, and have wiped down trays and table tops. There can be no argument that such conditions are hazardous to health in normal situations let alone in what should be an antiseptic hospital environment.

Ineffectual "complaints handling"

Included in this submission is correspondence relating to complaints I made to Royal North Shore Hospital following my father's discharge in 1998 and again in 2004. Despite letters from the then Executive Director (1998) and the Patient Representative (2004) I do not believe that any real consideration was given to my detailed account of the problems with staff, communication and patient care. I hold the view that the intention of the hospital bureaucracy was to wear me down with its responses to such a point that I would drop the matter.

The complaints outlined in my 2004 correspondence do not take the matter to its final conclusion. I document that conclusion now for the Select Committee in order to underline the seriousness of the issue that was brushed so deftly aside by the hospital administration at the time.

> Within two weeks of my father's discharge in October 2004 from RNSH Ward 10A on the advice of the Occupational Therapist named in my correspondence, my father was admitted to North Shore Private Hospital – initially with a diagnosis of congestive cardiac failure, then the diagnosis of subdural haematomas (bleeding between the brain and the cranium) was established. These haematomas were the result of the fall for which he was initially admitted to RNSH Emergency in early October. He was never able to go home again, to live independently and to experience that "100% certainty of never having a fall" as promised by the OT. Indeed he has had a number of falls, one of which returned him to emergency at RNSH in October 2007. The outcome for this patient has not been quality care.

The point for the committee to consider here, is that not only was there yet another initial missed diagnosis in an over-extended emergency department, and a grave error made by a very junior, inexperienced, occupational therapist, but importantly, the systems at RNSH did not detect and prevent these errors. In other words, there were not structures in place to ensure proper quality care for this patient.

I put it to the Committee that this is both an individual and a systemic failure, and I would further suggest from my most recent observations (October 2007) that such issues and problems that I attempted to bring to the attention of the administration in both 1998 and 2004 have not been addressed in any shape or form at RNSH.

Dr Wendy Michaels

Attachments

Correspondence
relating to patient care for Ronald Guy Michaels
at Royal North Shore Hospital 2004 and 1998

A. 23 October 2004 Dr Wendy Michaels to Neil Young
B. 26 October 2004 North Sydney Health to Dr Wendy Michaels
C. 6 November 2004 Dr Wendy Michaels to Neil Young
D. 9 November 2004 North Sydney Health to Dr Wendy Michaels
E. 16 November 2004 North Sydney Health to Dr Wendy Michaels
F. 24 November 2004 Dr Wendy Michaels Colin Murray
G. 29 November 2004 Gladys Berejiklian to Dr Wendy Michaels
H. 29 November 2004 North Sydney Health to Dr Wendy Michaels
I. 1 December 2004 Dr Wendy Michaels to Cathy Marshall

J. 29 June 1998 Wendy Michaels to Dr Norbert Berend
K. 30 June 1998 Norbert Berend to Ms Wendy Michaels
L. 10 July 1998 Dr Wendy Michaels to Dr Norbert Berend
M. 22 July 1998 Norbert Berend to Ms Wendy Michaels
N. 12 August 1998 Wendy Michaels to Professor Norbert Berend
O. 27 August 1998 Professor Norbert Berend to Ms Wendy Michaels