Submission

No 18

INQUIRY INTO THE ROYAL NORTH SHORE HOSPITAL

Name: Mr Peter Egan

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Dear RNSH Inquiry Members,

Below is my experience of a long agonising wait at Royal North Shore Emergency on a quiet night and being admitted for treatment and, after four days in hospital and much contact with the health system since, the lessons learnt.

On 29 May 2007 at about 1am I arrived at the emergency department at North Shore Hospital with severe chest pain - My GP had advised at 5pm I go there straight away if the pain got worse overnight - he had not advised what he suspected but had ordered a CAT scan for the next morning.

After an agonising wait of 20 minutes or so I was asked to fill out a form (it might have been much longer while the triage nurse talked to a very senior citizen in a wheel chair and his relatives about difficulties with his medications). With some difficulty I managed to answer the questions semi-legibly.

The triage nurse did not attempt to handle two matters at once, nor did the other staff behind the screen assist her.

Some minutes later the triage nurse took me into a room and did an ECG, blood pressure and laser blood oxygen test. The ECG and blood pressure were OK except my resting heartbeat was over 90 (indicative of the pain). My blood oxygen reading was also about 90 (indicative of poorly functioning lungs).

Without telling me the likely diagnosis (pulmonary embolism - blood clot in the lung) or my triage rating (level 3 - urgent) she sent me back out to the waiting room.

During the wait, the other two or three other staff visible behind the glass took no interest in the people in the waiting area.

It was a very quiet night in the waiting room. No other patients arrived during the 2 hours I waited except for a couple of men (perhaps brothers) who came in shortly after my triage assessment with a 3 year old girl saying there was something wrong with her. After a number of repeated questions (the men spoke very poor English) and filling in of a form, the triage nurse took the 3 year old into the emergency ward and came back a few minutes later with the girl and liquid children's Panadol. After more questions to the men about medicines they had given the 3 year old, the nurse gave her the children's Panadol. After that the men changed their story somewhat - it appears they had already given her medication. The 3 year old looked perfectly fine and not tired despite it being near 2am so the nurse said to take her home.

After 3am, and more than 2 hours of agonising wait with chest wall pain, a junior doctor appeared and repeated the tests the triage nurse did and got the same result. It then took her 10 to 15 minutes to find the bits that make up a canula (in order to administer pain relief).

(Better stock control would have cut the tests and canula installation to less than 5 minutes)

I was then put on a trolley (sitting up - it was too agonising to lie down) and taken to another room for a chest X-ray. After 20 minutes or so the portable X-ray machine appeared.

(It was used first on a very senior citizen just bought in by ambulance from a nursing home after a fall.)

My X-ray showed an infection in a lung common with pulmonary embolism. After 4am I was taken on the trolley into the emergency ward and given pain relief. A CAT scan was required to confirm the diagnosis of pulmonary embolism, but it could not be requested in accordance with procedures until a lung specialist came to work about 9am.

About 9.30am I was taken to the nursing transit lounge to await a bed becoming available in the chest ward. About midday I was taken for the CAT scan which confirmed the pulmonary embolism (PE).

About 1pm I was taken from the nursing transit lounge to the chest ward. Some time after that treatment was started for the PE (twice daily injections of anti-coagulant plus pain medication).

A V/Q scan was ordered for more information on the PE and a Doppler ultrasound of my legs was also ordered to find the source of the blood clots - generally in the legs. About 4pm I finally fell asleep (still sitting up).

2 days later the V/Q scan was done. The Doppler ultrasound was only done after I was discharged on the 1st of June (three and half days after being admitted), but still in the ward waiting for the hospital pharmacy to deliver a bag of medications - I had been recruited for a comparison trial of a new anticoagulant drug versus the current standard treatment.

As the only RNSH Doppler ultrasound technician had too many patients to see, the doctors had arranged for the Doppler ultrasound at North Shore Private (available at short notice) and I was to go there once the medications had arrived.

As part of the anticoagulant trial I'm still a regular visitor to the hospital.

The extra visits to doctors and pathology labs outside the hospital due to records not being easily shared is annoying and expensive.

LESSONS LEARNED

1. Emergency department staff need to come out from behind the bullet-proof glass and take ownership of their waiting rooms, toilets and building approaches. (Willoughby Council is apparently responsibility for the 5 minutes parking spaces outside the Emergency Department front door.) Workcover does not accept this hands off approach for other businesses.

2. Its not acceptable that people only get treated if there is a bed/trolley available in the emergency ward or they are a child with a trivial medical issue. The number of beds available is not that significant.

Many patients could be treated sitting in a chair. People already wait in chairs while receiving treatment in the nursing transit lounge.

If in the unlikely event they run out of chairs, the Emergency Department could even treat some people on the floor. I would not have minded sitting on the floor attached to a drip to avoid the agonising 2 hour wait for treatment and pain relief.

3. Junior staff can treat/assess many patients with minimal supervision of senior staff, thus initiating treatment early while awaiting more senior staff input. Medicine is very procedure driven in diagnosis and treatment and in most cases junior staff know the relevant procedure.

Conversations between staff regarding my diagnosis and treatment seemed to last no more than 30 seconds. The triage nurse could diagnose what was wrong with me. The nurse monitoring me while I waited for the chest X-ray could also diagnose my problem and tell me what other tests would be done.

4. There seems to be plenty of staff in the emergency ward, even if many are junior or in a training role.

5. Doctors don't seem to have much respect for the diagnostic opinions of experienced nursing staff.

6. All the staff I came in contact with did their jobs well, they cared for their patients, they followed procedures doggedly, they kept extensive appropriate medical records.

7. The problems of RNSH are in its leadership, management and procedures - the emergency waiting room situation being a prime example.

8. There is great need for a national medical records system. RNSH generates huge quanties of records requiring many staff to manage. Nurses and Doctors and technicians should be directly entering data into the system using I-phone style devices.

RNSH's primary medical records office employs 50 people. There are several other sets of records kept separately by departments (e.g. X-ray, nuclear medicine). I would guess 300 staff at the hospital are primarily managing records.

Getting copies of records for visits to various external specialists and my GP was a real pain and they mainly arrived to late resulting in more tests being ordered.

It takes one month for a patient to get a copy of his/her written records from RNSH but only 30 minutes to get copies of x-rays. Copies of nuclear medicine scans and reports appear not to be available to patients. CAT scans and nuclear medicine scans are 3D graphics - they can only be effectively stored electronically and are thus not available to external doctors.

In terms privacy, I expect electronic records are much more easily protected than paper records. As a patient in pain I could not have cared less to see my medical records published and still don't. However, the Inquiry members and the Parliament can no doubt devise appropriate safeguards.

9. Patients should have access to their records in hospital - to better understand their medical issues and to check that hospital staff have organised/are organising the relevant treatments.

10. In a well organised hospital utilizing a national medical records system, with specialists on call via a national video conference facility, in most cases patients could be seen immediately they present to the emergency department, then tests quickly ordered and carried out, diagnosis made and treatments commenced within an hour or two. (I could have been admitted for just one day then treated as an out-patient rather then the nearly 4 days I spent there.)

11. RNSH is very undercapitalised in terms of equipment/labour ratios. The buildings are poorly laid out causing inefficiencies necessitating many more staff than otherwise necessary.

The various clinics could share reception and administration people if co-located in bigger spaces.

The medical records system is very people intensive (see further comment above). Government needs to learn capital and labour management of its businesses from the likes of Woolworths and BHP.

12. Public hospitals should be able to utilize external services such as ultrasound if not available internally within hours.

13. Many people brought to Emergency departments late at night are elderly residents of nursing homes often with multiple medical issues already being managed with a cocktail of drugs. They may have had a fall or some condition has worsened.

Without access to their medical records, the job of the Emergency staff is much more difficult. Pregnancy emergencies now have special procedures, the very elderly also need special procedures and perhaps separate facilities to the rest of emergency admissions. At present, it is very difficult for nursing homes to get copies of the medical records of their residents when they return from hospital.

14. There is an apparent shortage of some medical specialists. A national medical records system will assist make them more efficient, as will more support staff in certain circumstances.

15. Some follow up medical consultations (where circumstances permit) should be done by telephone at reduced rates - It should not take a an in-person consultation to say diagnostic tests give an all clear.

16. A 24 hr GP clinic at the hospital would significantly cut the number of people treated by the very expensive emergency departments.

17. RNSH patient food is appalling - much worse than I ever experienced at boarding school. Poor food is not going to assist patient recovery. Poor food may be a cost issue. There are many businesses capable of providing better service.

Note: There is no attachment to this email.

Regards
Peter Egan