Submission No 707

INQUIRY INTO MONA VALE HOSPITAL

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Subject:

Summary

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Director
General Purpose Standing Committee Number Two
Parliament House
Macquarie Street
Sydney NSW 2000

To Whom it May Concern

I wish to respond to the first of the four "Terms of Reference" of the General Purpose Standing Committee Number Two inquiring into Mona Vale Hospital.

(a) The Closure of the Mona Vale Intensive Care Unit and the reasons behind its transfer to another hospital.

Background
I am an expert intensive care registered nurse with over 25 years experience in the intensive care specialty and I have worked at Tertiary, Metropolitan and Rural Intensive Care Units across NSW. I have been the Nursing Co-Chair of the NSW Intensive Care Clinical Implementation Group since April 2000 and have reviewed almost all the intensive care units across NSW and some in Victoria.

I am currently the Nurse Manager at Westmead Intensive Care Unit as well as the Director of Intensive Care Services for the *"old"* Western Sydney Area Health Services (WSAHS) now Sydney West Area Health Service.

Western Sydney Experience
Over the past four years it was becoming increasingly obvious across WSAHS that appropriate standards of patient care (See Joint Faculty of Intensive Care Medicine – Attachment 2) were unable to be reached let alone maintained to ensure the highest quality intensive care service across both Blacktown and Mt Druitt Intensive Care Units.

The Blacktown/Mt Druitt situation was not dissimilar to the Manly/Mona Vale intensive care circumstances and had functioned as one ICU over two campuses under the direction of one Director of Intensive Care since May 2002, with intensivists covering both units. In January 2004, the resignation of two intensivists from Blacktown/Mt Druitt intensive care units resulted in Mt Druitt being unable to be supported by intensivists. A decision was taken by the clinicians together with the AHS that Mt Druitt Hospital would provide a high dependency service managing post-operative patients and medical patients

requiring close observation but not ventilation. Patients requiring intensive care management would be transferred to Blacktown intensive care unit or on to Westmead ICU for more complex management.

Mt Druitt Hospital High Dependency Unit (HDU) has been in place for twelve months with patients admitted under the care of the primary team. The duty intensivist at Blacktown monitors the patients daily via the Mt Druitt NUMs daily report and is available 24 hours/day seven days/ week for consultations. Protocols are in place for the rapid retrieval of patients requiring intensive care management from the HDU and emergency department with intubated post-operative patients able to stay in the HDU for up to four hours under the care of the anaesthetist, and then either extubated or transferred out to Blacktown ICU for further management as required.

The Intensive Care Stream is currently about to pilot a telehealth initiative within the AHS and if successful will connect Blacktown ICU to Mt Druitt HDU. This strategy will not only support patient care but will also help with clinical education strategies, professional development, quality initiatives and networking.

It is my firm recommendation that a proposal similar to the Blacktown/MtDruitt Critical Care Service would function well across the Manly/Mona Vale Critical Care Service whilst the resolution of the political issues such as the location of the new hospital is sorted out and subsequently built. Mona Vale Hospital will not close its intensive care unit rather, it would provide a network of critical care across Manly/Mona Vale Hospitals to best meet the needs of the local population.

The "*increased risk of patients dying whilst waiting for retrieval from Mona Vale Hospital*" (as stated in the media) must be measured against the risk of death or adverse outcomes if the patient stays in a facility that provides a sub standard intensive care service. Increased morbidity and mortality has not been my experience at Blacktown/Mt Druitt, in fact, patient outcomes have improved. Emergency departments' specialists are experts at resuscitation and stabilization of patients and together with the Medical Retrieval Service, patients would be safely transferred to Manly ICU or Royal North Shore Hospital for more complex management. Emergency Departments and the Medical Retrieval Service commonly transfer trauma, burns, cardiac interventional and neuro interventional patients across NSW every day to where the patient can access the best care instead of receiving mediocre care at a hospital that is unable to provide the recognised standard of intensive care management.

Nursing Issues

The shortage of nurses is a worldwide phenomenon and is well documented both locally and internationally. Intensive care nursing is an exciting, rewarding, albeit challenging specialty however it has not been immune from the chronic workforce shortage despite many and varied strategies implemented to combat the issue. As

society ages with technology and pharmacology able to keep us alive longer, as well as families wanting *"everything done for our 85 year old Mum, Doctor"* then the demand for intensive care beds will further increase and nurses to nurse the patients will increase also. Workforce shortages across all multidisciplinary teams will be one of the most potent drivers for combining small units to ensure critical mass of staff to provide critical mass of patients with the safest and highest quality intensive care available. Casualization of staff and the reliance on agency nurses also impacts on the ability of small units to access quality intensive care nurses on every shift particularly if there is sick leave and there is one permanent staff member and two agency nurses on night duty to manage the ICU.

Small intensive care units such as Mona Vale, Mt Druitt, Ryde, Auburn, Fairfield are unable to provide the volume of patients (critical mass) to expose nurses to the diversity of disease processes, patient management, pharmacology and technology that is required to maintain their skillsets. Even nurses who have post graduate qualifications in intensive care nursing are unable to remain current unless they are continually exposed to the complexities of a constant throughput of critically ill patients and ongoing professional development and education.

Nurses who are attracted to the intensive care environment have little incentive to work in a small ICU as their expertise is often under utilized as they have minimal exposure to the most critically ill. In stark contrast to this statement, the emerging junior and senior medical workforce shortage has now placed the nurse at the bedside in an even more vulnerable position than ever before. In an emergency situation, the nurse is often more knowledgeable and must direct the most junior of doctors in the absence of senior medical officers, despite the lack of maintenance of that particular nurses' skill set because they do not get day to day exposure to life threatening situations as nurses in larger ICUs.

Intensive care nursing over the past ten years has become more complex in many areas. Ventilators, infusion pumps, cardiac monitors and other monitoring devices such as capnography, dialysis machines, clinical information systems, radiology systems such as PACs, even electronic beds require constant and ongoing education and inservice to keep up to date with technology. It is rare that small units are able to provide regular inservice. When it is available, it is often difficult to make certain that all staff are able to attend as there is often only two staff on a shift and patients must also be cared for during the inservice time.

Small intensive care units are unable to participate adequately in Morbidity and Mortality meetings, Incident Monitoring Meetings, Journal Clubs, protocol and evidence based medicine guideline development, etc. This is often because of time restraints and secretarial support, lack of diversity of patients and a lack of continuity and participation senior medical staff and an extended multidisciplinary team. All of these activities are part of delivering a quality intensive care service.

Small hospitals have a dearth of clinical nurse educators so it should be mandatory that the nurses rotate through a bigger unit to ensure adequate exposure to a more complex intensive care unit, however this rarely occurs. Professional development opportunities (Scientific Conferences) are expensive and out of the reach of most intensive care nurses. Even if the hospital provided some funding it is often impossible for the nurse to be released from the roster, as there is no one to fill those shifts in small units.

Nurses across both Mona Vale and Manly have told me several times over the years that they are sick and tied of this debate. They are exhausted by the constant media barrage in their local press, the bad blood between some of the medical specialists and the inability of Government to make a decision whilst the Opposition is constantly playing one group off over another for their own political gain.

Nurses main priority is to provide excellence in the delivery of patient care and should not be distracted from their patients by this debate that has gone on for almost ten years!

Medical Issues

I have not covered medical workforce issues in this submission as I am sure my medical colleagues will discuss the impact of the shortage of intensivists, trainee intensivists and junior medical officers in their submissions.

Evidence Based Practice

There is growing body of evidence that states that intensive care units should manage between 10 –14 patients so that efficiency, outcomes and cost of care are balanced appropriately (See Attachment 3-7). Intensive care is an expensive resource and requires a robust whole of hospital infrastructure to underpin the service. Immediate 24-hour access to imaging including CT and MRI, pathology, infectious diseases consultation and other sub specialty consultations, availability to 24 hour operating rooms, etc is paramount to improve patient outcomes.

One larger ICU, in a brand new acute hospital located centrally on the Peninsula with this infrastructure would attract a quality workforce to an enviable "state of the art" intensive care unit. However, in the meantime, it is imperative that Manly/Mona Vale Critical Care combine resources to ensure a larger and more sustainable quality Service across the Peninsula instead of allowing the duplication of a pedestrian service because of ignorance, parochialism and self interest by some members of the local community and some isolated medical staff.

The politics must be removed from this debate so that decisions can be made and the residents of the Peninsula finally realise the quality Critical Care Service they are entitled to!

Your sincerely

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