Submission

No 45

INQUIRY INTO THE ROYAL NORTH SHORE HOSPITAL

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Royal North Shore Hospital Emergency Department

Submission to Parliamentary Inquiry, November 2007

Dysfunctional Planning

My daughter is employed as a Registrar in Emergency Medicine at RNSH.

I have visited the Department many times in the last few years, personally for treatment of a leg wound with a major infection, as a visitor when my mother has been a patient on a number of occasions, and most recently when my wife was a patient with heartbeat and pacemaker problems. I have also been asked recently to assist with a review of signposting and workflow problems being experienced in the Department.

I have had over 25 years experience as an architect specialising in hospital planning and design until I retired from active practice in 2001, and since then have been employed part time with my previous practice in assessing health care facilities in Northern Sydney Health area against Department of Health Guidelines, which include RNSH. I have also been providing expert witness services on a number of building and architectural legal cases for a number of solicitors.

In the late 1970's, I had the pleasure of being a consultant to the New South Wales Hospital Planning Advisory Service (HOSPLAN), and participated in determining and documenting guidelines for Operating Theatres, Emergency Departments and 30 Bed Ward Planning Guideline which was published and ratified as the contemporary standard for patient accommodation in NSW hospitals at the time. I was also involved in development of Signposting guideline document, mobile patient bed and mobile bedside locker to facilitate patient movement within hospitals.

It is with this background that I feel compelled to comment on the planning of the Emergency Department, which based on my observations and experience is in itself a major contributor to the problems being experienced at the facility, and results in poor function, staff frustration patient and visitor confusion.

I have not commented on the detailed matters being addressed in the recent study completed in draft form in October 2007.

My observations are as follows:

1. Ambulant patient entry not obvious from approach road to Department, resulting in drivers following road to ambulance entrance, where there is no parking, access is by security code and therefore denied them.
2. Clerical staff offices are the located immediately on entry to the department, they are often unoccupied, or occupied by staff who cannot be engaged. The triage assessment staff are located at the point most remote from the entrance, which is confusing and causes great anxiety with patients and visitors. It is also difficult for staff to monitor and overcome this problem.
3. The waiting area is a thoroughfare from the entry, it should be a cul de sac, the entry should be direct to the triage assessment desk. The public toilets are remote from the waiting area in an unrelated major public corridor, incapable of being oversighted by staff or waiting patients or visitors in the waiting area. This is very dangerous for overall management of the waiting patients and visitors.
4. Access and egress for patients and visitors from public areas is very confused and conflicts with ambulance delivery to resuscitation cubicles, treatment areas and staff traffic inside the department.
5. Resuscitation cubicles are poorly and indirectly located for urgent and complicated ambulance deliveries,

6. Resuscitation cubicles are poorly located so that they are isolated from other treatment and support areas within the department resulting in unnecessary staff movement and lack of oversight and interaction required for good function.
7. Minor treatment area (EMU) is poorly located for nature of the movement of staff patients and visitors to the waiting area, which is typically characteristic of short stay treatment, rather than long stay for observation whilst waiting for admission to wards.
8. Planning and design of staff work areas lack privacy from patients when delicate and private and personal matters are being processed. Patients interrupt the staff because they believe that they are being ignored, and feel free to listen to clinical conversations, and overlook clinical records.
9. The Department entry is used inappropriately for the out of hours entrance to the Maternity Department, interrupting emergency staff by seeking directions to Maternity.

This is illustrative only, I have not undertaken an exhaustive study. Similar problems exist in other areas of the hospital.

I believe that the poor functional planning creates great inefficiency and inconvenience for staff which wastes a lot of their time, effort and energy, and contributes to poor morale and performance.

I would recommend that the planning of the department be reviewed to improve functional performance. I am available for further discussion if required, but recommend that a hospital architect with appropriate expertise and experience be engaged to replan the Emergency Department to achieve a properly functional unit.

Lindsay Skinner B Arch FRAIA

10 November 2007