Submission

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INQUIRY INTO THE ROYAL NORTH SHORE HOSPITAL

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Submission to Joint Select Committee on the Royal North Shore Hospital

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I have worked as a Registrar in Emergency Medicine at Royal North Shore Hospital (RNSH) since 2005. I am registered as an advanced trainee with the Australasian College of Emergency Medicine. I have been extensively involved in health workforce research in recent years, including work on use of medical locums in NSW public hospitals with the Greater Metropolitan Clinical Taskforce, a project exploring alternative clinical roles within the hospital system with the Sydney Health Projects Group, and most recently I have participated in a study of all Emergency Physicians and Registrars in NSW with the University of Sydney Workplace Research Centre. I am a founding member of the Hospital Reform Group.

I would like to stress that the opinions expressed in this document are my own, not those of NSW Health or my colleagues at RNSH. They are based on my research, and my clinical experiences at RNSH, Nepean Hospital, the Canberra Hospital and associated network hospitals since I graduated in 2001. I would also like to state that I believe that the quality of care provided at RNSH is generally of very high quality, largely due to the commitment and dedication of medical, nursing, allied health and clinical support staff who work there.

The patient case-load at RNSH is more complex than at most other hospitals. Not only is RNSH the tertiary referral centre for Northern Sydney Central Coast Area Health Service, but it has state-wide referral responsibilities for major burns and spinal injuries. The complexity of the case-load does not appear to be reflected in funding, staffing or training levels at RNSH. Furthermore, in other health services in which I have worked, networked metropolitan hospitals have areas of specialty (eg aged care, orthopaedics) thus pick up some of the patient load from the tertiary hospital, yet this does not happen at RNSH.

RNSH has a commitment to quality and safety at high level, and led the way with implementation of clinical review and root cause analyses of adverse incidents via the QARNS committee. This is not reflected at ground level to the extent which I have seen in place in other hospitals. Although clinical protocols and guidelines exist, they are often not well-known to medical and nursing staff, reflecting a failure of orientation, training and communication. For example, at the Canberra Hospital, there were clear guidelines about ordering of diagnostic imaging and pathology. These were clearly displayed in clinical areas, and were well-known and often referred to by junior and senior doctors, nurses, radiographers, scientists and other involved parties. At RNSH, guidelines are often department specific and may be inconsistent, leading to confusion and uncertainty.

RNSH has a rigid approach to junior medical staffing compared to other hospitals in which I have worked. The Junior Medical Staffing Unit (JMSU) is responsible for recruitment, credentialing, rostering and payment of all intern, resident and registrar staff, yet JMSU staff can be difficult to contact, especially for the large proportion of junior medical staff who work rotating shifts. Timesheets and payments are often incorrect, leading to loss of goodwill of junior medical staff. It is especially difficult to arrange payment for unrostered overtime. It can be difficult to find contact details for on-call junior medical officers, and arranging cover for staff who call-in sick is problematic, and after-hours often becomes the responsibility of a senior clinician without support from medical administration.

RNSH relies heavily on overseas-trained doctors and locums to fill junior medical officer vacancies, especially in the Emergency Department (ED). The quality of overseas-trained doctors is variable, depending on their undergraduate medical education and amount of clinical experience. These doctors may have significant problems with language and different levels of procedural training to Australian-trained doctors. Supervision of doctors with poor language and procedural skills is a significant cause of stress for ED physicians and registrars. Locum doctors are increasingly used to fill gaps in the roster. Again, these doctors are of variable experience, are often not orientated to the clinical setting, and are paid in the order of three to four times the hourly rate paid to permanent staff, creating significant resentment and workforce stress. In recent months, many shift vacancies in the ED have been left unfilled.

Given the shortage of ED clinicians, rosters have become cumbersome. Emergency registrars work a high proportion of nights and weekends, and shifts do not fit a predictable pattern. This impacts on social and family life, ability to study effectively towards specialist qualifications, and thus on morale and job satisfaction. There is not currently adequate specialist Emergency Physician staffing to provide all-day supervision on weekends. It is also common to work with unfilled vacancies at junior levels. Currently, all non-clinical duties (participation in research and quality improvement, writing expert legal statements, study, preparation of teaching and training sessions) take place in Emergency registrars' own personal time over and above rostered clinical work.

Similar staffing problems exist within the nursing workforce, including working with unfilled vacancies or with poorly orientated agency staff. RNSH has been slow to adopt advanced nursing practice measures in place elsewhere. For example, at the Canberra Hospital, all ED nurses were expected to train in blood collection, IV cannulation, ECG interpretation and diagnostic test ordering, which enhanced the flow of patients through the department. Development of advanced practice career pathways may help to retain nursing staff in the ED at RNSH through improving job satisfaction.

Information technology is under-utilised at RNSH. We still rely on paper hard-copies of old medical records, which must be searched by hand, and often cannot be physically located while the patient is in the ED. We use an

intranet-based radiology system which does not have adequate resolution for accurate diagnosis of some common conditions. The version of EDIS (Emergency Department Information System) we use is out-of-date. We are yet to implement measures such as electronic medication and test-ordering, which may not only reduce the time taken to order a scan, but will remove potential for human error by flagging mistakes or duplication. To put this in context, ED clinicians currently have to walk to the radiology department to order a CT scan, a process which takes the senior doctor away from the department for 10-15 minutes. Communication with GPs and outpatient services would also be enhanced by development of electronic medical records and emailed discharge summaries.

The ED currently interacts with inpatient teams in an inefficient manner. Inpatient team registrars have competing roles reviewing ward inpatients, reviewing clinic outpatients, attending meetings and teaching sessions, and reviewing patients presenting to ED. In some cases, careful rostering could reduce conflict between these roles. Inpatient teams are often reluctant to review patients in ED before diagnostic test results are available, regardless of whether results will impact on the decision to admit or discharge the patient. If inpatient teams could be involved earlier, time taken to admission or discharge of ED patients could be potentially reduced. Unlike other tertiary hospitals, RNSH has no senior ICU medical staff located in the hospital after-hours, which can delay review of critical patients and decisions to admit or discharge patients from ICU. Arrangements for physician review are variable, occurring via registrars during the day (0800-1630) and direct to specialists after-hours, which can increase the case-load for the in-charge ED doctor. Increasingly, as patients spend more time in ED waiting for a ward bed to become available, ED doctors are undertaking routine patient reviews and diagnostic tests for inpatient teams on top of the case-load of new presentations.

The physical environment of the ED at RNSH contributes to inefficiency and poor morale. The clinical areas are usually dirty, posing an infection risk. The assumption is that all staff will clean up after themselves, but the reality in a busy ED is that there is little time to do so. Other hospitals employ a cleaner in the ED. The lay-out of the ED is dysfunctional, with poor separation of clinical and clerical areas, poor signposting, a lack of private areas for assessment of patients with sensitive conditions, and location of the area for ambulant patients (ET/EMU) at the back of the department distant from the waiting room. The resuscitation bays are located between the main assessment area and triage, and resuscitation equipment is located behind the patients in each bay, making immediate access difficult. It is impossible for senior clinical staff to physically oversee the department, and staff constantly walk between the triage desk and assessment areas, looking for patients, clinical notes or medical records. The department is treating increasing numbers of agitated and aggressive mental health patients without adequate facilities for their assessment and care, posing a risk to clinical staff and to other patients in the ED.

The population presenting to ED at RNSH is ageing. We have an Aged Care Assessment Team (ACAT) in place in ED to assess the social supports needed by these patients, however there are poor systems for communicating their often complex medical histories or any existing plans regarding suitability for resuscitation or invasive treatment. Elderly patients are often referred from nursing homes without consultation with ED staff prior to ambulance transport. It may be useful to create an Aged Care Liaison Unit within RNSH to support nursing homes in caring for patients out of hospital and to develop guidelines for advance directives around end-of-life issues. Guidelines for communication of clinical information between aged care facilities and the ED should also be developed. On a similar note, Canberra Hospital had a GP liaison unit, consisting of administrative staff and a clinical nurse consultant who was available via mobile phone for GPs with questions about accessing hospital services. The CNC would seek telephone advice from relevant specialist consultant or registrar staff regarding clinical problems, reducing the burden of patients presenting to ED for review and aiding management of complex but non-acute patients in the outpatient setting.

Pressure on staff parking at RNSH also remains a source of discontent. Parking fees are deducted from payroll and costs have risen in recent months, however it can be very difficult to find a parking spot near your work location, cars are chaotically positioned, and parking fines are issued frequently. There are few security measures in place for staff walking back to their cars after finishing a late shift.

I would like to conclude by saying that despite my negative comments, I believe that we do a lot of excellent work at RNSH. However, clinical staff feel that we are being asked to do more and more with less and less. Our commitment is being tested. The answer is not necessarily more money, but a thorough review of the way that things are done, with implementation of creative, flexible, locally appropriate and technologically supported strategies for improving patient experiences of the hospital. A one-size fits all approach will not work, clinical departments and services must be encouraged and resourced to develop their own strategies, then to work together towards better patient care.

Thank you for your interest and best of luck with the inquiry.

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