Submission

No 79

INQUIRY INTO THE ROYAL NORTH SHORE HOSPITAL

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SUBMISSION TO SELECT COMMITTEE ON THE ROYAL NORTH SHORE HOSPITAL

Category: Member of the Public/Patient

From:

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This submission is based on experience as a patient at North Shore Hospital. Whilst I have never been an-inpatient there, I do have considerable experience as an out-patient and a visitor to in-patients and will comment from these perspectives.

TERMS OF REFERENCE

1.0

(a) Clinical management systems at the hospital.

The hospital seems to be seriously short of practitioners e.g. nurses, physiotherapists, and top heavy with administrators.

(b)The clinical staffing and organisation structures at the hospital

- Priority given to employing administrative staff and all the support personnel they, in turn, employ, is resulting in under utilisation of resources, e.g. the hydrotherapy pool is used only 4 mornings per week, yet there is usually a waiting list for appointments. Those fortunate enough to get into the hospital's excellent hydrotherapy program can attend only twice per week for six weeks. They are then forced to either miss out on this valuable treatment or pay to attend an aqua class conducted by non-medical personnel. Having attended some of these classes after a period of excellent hydrotherapy treatment in the pool with a qualified and highly skilled physiotherapist, I am aware of the poor standard of much of the instruction in these classes, which seem to be conducted without any supervision by qualified medical personnel.

- Closure of beds has resulted in combining mail and female patients in the same wards. I have visited several in-patients in this situation and know from their experiences in the wards that they find this offensive and embarrassing. This practice is diminishing the little dignity patients have when in hospital. When visiting, I have witnessed situations where both male and female patients have been put into embarrassing situations, usually by overworked nurses.

(c) Efficiency, effectiveness and appropriateness of resource allocation and utilisation within the hospital, and in particular the operation of the Emergency department.

It is obvious, even to an outsider, that the hospital is short of funds to meet the needs of its clientele. The question has to be asked: How can a large public hospital meet the needs of its community if it is not funded adequately?

Social factors which obviously impact on Emergency Departments include:

- Increase in the aged population
- Increase in serious cases of flu in the winter months
- Decrease in the number of General Practitioners who bulk bill
- Marked decline in the number of General Practitioners who make home visits
- No Emergency Departments in local private hospitals
- Few local after hours Medical Centres.
- Few, if any, local 24/7 medical facilities.

It is understandable, then, that the public will use the local Emergency Department. What else can they do?

I have been a patient at the Emergency department on two occasions:

1. I was sent there from a private X-Ray service with a large clot in my calf. The prompt attention I was given could not be faulted. Excellent follow-up treatment at a specialist unit in the hospital, plus daily home visits by a qualified nurse, ensured complete recovery. It is important to recognise that the time spent in the Emergency Department was minimal, while the follow-up program provided by other services within the hospital was maintained for a period of approximately six weeks.
2. I attended the Emergency Department after hours with a breathing problem (I have a lung condition). The superficial examination was of concern, given my breathing difficulties and the pre-existing condition. This prompted my request for another doctor to assess my condition. This was eventually forth-coming, tests were taken, I was put on a nebuliser and medication was provided. I was given a letter for my GP to follow up my care. Both the GP and I were amazed when he opened the letter to find it was addressed to another doctor about another patient who had attended the Emergency Department for attention for an incomplete abortion. When I phoned the Emergency doctor responsible, it was agreed that the correct letters would be forwarded to the correct doctors. It was pointed that there was a simple way to prevent this occurring in the future – put the doctor's name on the envelope. He assured me that, forever more, he would do so. This was an error which could have serious outcomes for the patient and which ignored the requirements of the Privacy act.

On several occasions I witnessed, in the Emergency department, events which reflected poorly on the staff:

- About six to eight patients are sometimes given chairs to sit on in the Emergency Department, instead of a bed. These chairs are adjoining, so there is no privacy for patients. I was seated there directly opposite a young couple, the female being advised by the attending doctor to seek psychological attention for her health problem. The young woman was obviously embarrassed to have this discussion taking place in the public arena and was being comforted by her male friend/partner/relative. At no time did the doctor lower her voice or seek a more private area for the patient's ease. This reflects another failure to respect the dignity of each patient.

- Whilst in the waiting room, I witnessed a mother forcing her young child (aged 2-3 years) to eat. The child was distressed and started screaming, which prompted the mother to force even more food into his mouth. When approached by several patients urging the mother to

refrain, she acknowledged that her child was very ill and she hoped that if she made him scream he would receive immediate medical attention. *NOTE: This strategy didn't work.*

- On another occasion I drove my neighbour and her partner to the Emergency Department as she was ill. Despite the fact that she was close to vomiting we had to persist in our requests that she be given a bowl and taken away from the public waiting room to a more private area, where she could be observed by a nurse. Again- failure to respect a patient's dignity and right to privacy, plus failure to assist a patient who was, obviously, very ill.

It is my opinion that the above incidents indicate that the requirements of the Privacy Act have no place in the Emergency Department.

(d) Complaints handling and incident management
I am unable to comment.

(e) Interaction between area and hospital management, as it relates to hospital efficiency, effectiveness and quality of care.
Whilst I do not have the expertise to comment on the first part of this term of reference, my experience as an out- patient provides the background to comment on the quality of care. I have been involved in long term treatment in four separate departments at the hospital ,each being excellent examples of best practice and each proving to be very different from my experiences and observations in the Emergency Department:

1. On two occasions (2001 and 2002) I attended the Radiology/Oncology Unit, now known as *Northern Sydney Cancer Centre,* for daily radiology treatment over periods of several weeks. On all occasions the Unit represented best practice in every way- staff were highly skilled in their delicate work and respected the dignity and privacy of every patient. The unit was spotless; staff were friendly and accommodating at all times and treated each patient as the most important person they would see that day. This high standard did much to ease the tension experienced by oncology patients.

2. In 2004-2005 I was treated at The Clot Clinic for a large clot in my calf. Again, the treatment was dignified, my privacy was respected and the doctors'care was of the highest quality. Whilst the Clinic was in the old part of the hospital, this did not deter the doctors and staff from maintaining a very high standard of care.

3. Since 2004 I have been an intermittent out-patient at the Physiotherapy Department, which is situated in an old building. Office and medical staff are friendly and welcoming and exhibit, at all times, a high standard of skill and professionalism. The treatment is individualised and includes excellent advice for handling the condition at home and for maintaining the well-being gained at the hospital. The physiotherapists are skilled in putting their patients at ease and in equipping them to cope with their medical conditions. They even provide pages to illustrate the exercises to be practised at home. In this department patients are treated with dignity and their privacy is respected.

4. I have also attended classes, both in the cardiac gym and in Willoughby pool, conducted by staff from the Cardiac Health Unit.
   Nurses and exercise instructors are aware of their responsibility in relation to cardiac patients and conduct classes which are patient oriented and illustrate that recovery and long term health can be both enjoyable and successful for the patients.

The above examples of best practice illustrate that, despite the drabness of the work environment in the old buildings, there are units within the hospital which can rise above their surroundings and establish Centres of Excellence within a troubled institution.

This raises several questions which cannot be answered in this submission, but which may provide a direction for the Joint Select Committee:

- Why cannot the standard achieved in the four departments listed above, be achieved in the Emergency Department and in the wards?
- What sets the staff in the above four departments apart from the staff in the Emergency Department and in the wards?
- What are the factors that make a difference – Leadership? Pre-service training? In-service?
- What are the factors that inspire staff to achieve and then maintain, best practice, thus establishing Centres of Excellence ? Commitment? Work satisfaction? Leadership? A sense of, and respect for, the dignity of each patient? Staff Morale in the different departments? Persistence in up-dating skills? Awareness of new developments in patient care? Confidence that they can make a difference?

2. Strategies in place or proposed for improving quality of care for patients at the hospital which may also benefit NSW public hospitals

(a) The standard of cleanliness in some wards give reason for concern.

- Whilst visiting an aged patient I assisted another patient in the room, by offering to pick up something she had dropped from her bed. This necessitated crawling under her bed to retrieve the object. I found there balls of fluff the size of a child's hand, pieces of bread, an apple core and some sweets. How long was it since the last cleaning had occurred in that ward?
- The windows in the neurology ward hadn't been cleaned on the outside, for at least seven years, according to a staff member. How depressing was this for the patients as they looked out on filthy windows?

Proposal: Lift the standard by ensuring daily/weekly supervision and inspection.

(b) Culture of the workplace

- Media reports, including television footage, of cleaning teams in operation prior to the visit by the Joint Select Committee, indicate a culture of failing to confront the problems at the hospital and of hiding the evidence of those problems.

Proposal: Make unannounced inspections to ascertain the TRUE situation.

(b) The staffing arrangements at Emergency departments need to be reviewed:

- Having a nurse on Triage duty isn't effective. The nurse cannot order tests e.g. X-rays, scans, blood tests, etc. Her only purpose seems to be to categorise patients.

Proposal: Assign the Triage duties to a doctor as he/she has the authority to order tests immediately. This would greatly reduce time in diagnosing the patient's condition. When the tests had been performed and read, then the patient could be assigned a priority number. This could also improve patient morale, as there would be a sense of immediate attention, instead of the sense of futility when told to sit in the waiting room.

To conclude:

As public hospitals provide a public service, it seems unrealistic to expect them to be cost effective. How can they be when the spirit is to provide a free service to the community? *NOTE: This is not a suggestion that a charge be introduced. Rather, it is recognition of reality.*

Maureen A. Stephenson 10/11/07.

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