**Submission**

**No 64**

# INQUIRY INTO THE ROYAL NORTH SHORE HOSPITAL

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Submission to the NILE Inquiry,

Into " Royal North Shore Hospital",

From Dr Greg Purcell

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" I never despair, but wait and see,
Heaven will come to the aid of me.
I never despair, but see and wait,
Hoping Heaven won't come too late!"

J Robin 1975.

1. Background
2. Current Problems
3. Operational Management and Area and Hospital Interactions
4. Clinical Management Systems
5. Resource Allocation
6. Short Term Requirements and Long Term Strategy for Improvement

1. Background:

The Anaesthesia and Pain Management Department, (Anaesthetists and Pain Physicians, incorporating more than 50 specialists amounting to 30+ FTE's) aims to provide a comprehensive range of anaesthetics and pain management therapies at a "state of the art" world class clinical level to the patient's attending RNSH and to ensure an educational and academic ambience to enable an optimal teaching environment for training up to 24 anaesthetic registrars and pain physicians in all clinical areas and to encourage life long learning, clinical research and resource skills. Specialists also engage in teaching and training medical and nursing students and allied medical support staff.

The Department encompasses the Pain Management Department, Pre Anaesthetic & Pre Admission Clinics, Perfusion Services for Cardiac Surgery and Transfusion Support and Sydney Simulation Centre. It aims to achieve a dynamic learning and teaching environment that attracts registrar applicants and specialist personnel and has a halo effect and flow on benefit to local and statewide public and private hospitals.

Most anaesthetists wish to practice regularly with specific surgical disciplines and surgeons to enable progressive development of their skills, expertise and experience. Historicaly they have completed their training by 30-35 years of age and perform specialist clinical duties for the next thirty years. Remuneration in public hospitals usually precludes early retirement. Anaesthesia is highly dependant upon a skilled focussed individual not distracted by personal or psychosocial issues with a life long commitment to a safe and secure clinical outcome, a heavy clinical workload and to an inordinately onerous and poorly remunerated on-call and emergency roster.

Anaesthetists need to work closely and professionally with their surgical colleagues to enable optimal patient outcome and satisfactory resource usage. The systemic shortcomings in achieving what needs to be done are now so pervasive that camaraderie disintegrates and relationships are strained and often dysfunctional.

## 2.Current Problems

### Case Load/mix change

RNSH has a background “elective” surgical case load (including brain tumors, heart surgery, cancer, caesarians etc) that need operation, however the urgent or emergent case load has progressively increased (trauma centre, fractures, haemorrhage, ectopics, miscarriage) so that 70 % of the total case load is now of the urgent classification. This has lead to more operating theatres being dedicated to ‘emergency’s’ and progressive reductions/cancellations in ‘elective’ activities.

### Recurrent Cancellations

The inadequate clinical resources and nursing shortage incessantly impose cancellations. On a daily basis, there is either:

- No hospital beds
- No ICU/HDU beds
- Nursing and staff shortages
- Inadequate equipment/resources
- Intercurrent patient problems

that particularly major surgery, eg brain tumors, heart surgery, thoracic and oesophageal surgery and aortic and vascular operations have distressingly frequent cancellations. These are major disruptions to patients, doctors and staff yet now seem sadly inbuilt into the system.

### Nursing Shortages

For a variety of reasons, including poor remuneration and heavy on-call duties, a severe nursing shortage exists and allied to the systemic harassment to get things done, the morale of clinical staff is so eroded that sick leave, apathy and dissociation are prevalent and empathy and caring evaporating.

Senior Staff Departures

The loss of the experience, leadership, teaching and mentoring skills of senior surgeons, anaesthetists, physicians and nursing staff leaving prematurely, due to anger, disillusionment and frustration with the administration and resources at RNSH over the past fifteen years is palpable and painful. It has left such a void that innumerable part time staff are unable to fill. Poor patient experiences will invariably follow.

Increasing After Hours Workload

Due the increasing urgent and emergent workload, and the difficulty integrating such cases into a surgeon's weekly clinical commitments , such cases often need to be done after hours or on weekends. Over 50 % of the total case load is finished or performed after 3pm and almost 50% of cases are done after 5pm or on weekends. This now necessitates running extra theatres into the evening and on weekends. These are more difficult to staff and are poorly remunerated for the disruption. If more operating theatres were available during the day, a greater proportion of these cases could be done more safely between 8am and 3pm with appropriate and secure backup.

A review of O.R. utilisation in 2005 ( A. Bott), identified utilization of over 94%,, which was regarded as unsustainable, and that to approach a more effective, functional, SAFER and less hectic O.R. utilization of about 80%, recommended that 3 more operating rooms were urgently needed.

3. Operational Management

There is a significant functional gap between the management of the hospital and those who perform the clinical service delivery.

There is no dissemination of any strategic management plan. For example, if confronted with staff sick leave that necessitates a reduction or cancellation in services, it is uncertain whether the goal is to complete "elective" surgery or to clear the unscheduled ("emergency") cases. This has a significant impact on decision making and resource allocation.

There are no systems to control "elective" surgical bookings. Lists are submitted several days before, and reviewed the day before by the surgical team. Average operating times are usually not available for any procedures often due to the nature of the cases, to guide the length of theatre lists. Day before surgery cancellations are encouraged by administration to ensure there are no day-of surgery cancellations. Day of surgery cancellations are analyzed by administration, day before cancellations are not.

There are other examples of inadequate measurement of performance which results in suboptimal use of theatre. For example the start time of 8am is dutifully noted and managed. What occurs after 8am is often not looked at. There are instances every day of under usage of theatres by delays caused by inadequate or failed equipment, staff shortages, patients not yet admitted, failing lifts, excessive call times etc.

As staff form the single largest budgetary item for RNSH, it is beholden on management to ensure that the complex infrastructure is working that enables the rostered doctors, nurses and allied staff to work effectively when they are scheduled to work.

Previous hospital management publicly declared the lack of support and direction from area management and noted a lack of confidence in and competence of senior area management personnel.

The change to a single Chief Executive controlled large Area in 2004 with the inordinate potential of the C.E. to appoint or dismiss almost every other appointment in the area, to redistribute funding and to only be responsible to the D.G. is inappropriate and flawed. The architects of this change have much to answer for.

4. Clinical Management.

The interventional clinical services e.g. interventional neuroradiology and cardiology, have allowed such advances in the management of acute brain and heart disorders, such as subarachnoid haemorrhage and evolving cardiac infarcts, and RNSH has led the way in Australia with the introduction and expertise necessary, yet there has never been adequate or reasonable funding for these new services offered statewide. The CEO did not effectively pursue discretionary funding for such endeavours, arguing that newer and more costly clinical therapies needed to come out of the current inadequate budget. And when the Health Department did occasionally provide support it was inadequate, often based on ancient and archaic funding models and late in coming and invariably slow to get where it was needed.

Patients currently needing to come to RNSH for tertiary cardiac and neurosurgical surgical services often wait inordinate times before often hasty transfers, due to the lack of hospital beds , operating theatres and intensive care beds . The 97.5% occupancy rates at RNSH therefore contributes to the 99% bed occupancy rate at Gosford Hospital. Specialty surgical registrars are unfortunately invited, if an urgent in-area transfer must be made to RNSH, to triage and initially manage such patients in the ambulances lined up in the carpark outside Emergency.

Anaesthetists left without effective HDU or ICU resources , rather than cancel cases are put in the precarious position of providing suboptimal postoperative care to enable surgery to be provided rather than allow the patient to be a situation where they could be delayed and recurrently cancelled.

The inadequate funding for the new Maternity building left the HDU ward on Labour floor( allegedly for 4 patients) unable to safely manage 2 patients, an anaesthetic bay that only just accepts a bed( no room to do any procedures) and a nursing station and handover room that is embarrassingly inadequate.

Clinical care is compromised incessantly.

5. Resource Allocation.

Any complex organization has its strengths and weaknesses and in such a dynamic service, good leadership needs to support the strengths and reinforce the weaker areas. The need to have reliable, safe, efficient and progressive equipment is critical in all areas and yet clinicians are compromised every day with ineffective and inefficient equipment that undermines safety and puts patients and staff at risk.

A survey ( D. Latta, 2005) revealed some $30 million equipment needed purchase or replacement at about that time. Little has happened in the meantime—any capital or equipment finds have been relocated to meet operating costs.

* Dangerous elderly dialysis machines were replaced by public donation.

* The Majority of the operating tables are over 35 years old; nurses and doctors need to crawl under the sterile drapes to change the table during operations.

*A specific anaesthetic ventilator failed recurrently in MRI. It was 27 years old.

*The echocardiography for heart surgery is ancient and is deemed unrepairable and obsolete by the maintenance company.

* Patients need to go to Wyong for a high grade 3T MRI.

* All the anaesthetic ventilators in the O.R.s need replacement.

The list just goes on.

None of the above would sit comfortably with any aspirations for Clinical Excellence, and none provide confidence in a safe and efficient practice.

6. Summary.

A List of several short term, medium and long term goals and strategies is attached.

The State Health Department presently has and apparently wishes to retain, the commission to run public hospitals. It is inappropriate to incessantly blame inadequate Federal funding as the source of shortcomings. This posture generates such despair in the system.

Hospital spokespersons, bureaucrats and politicians unashamedly and unethically distort information and lie to the community. M. Iemma declared recently on morning radio that RNSH had just received 43 extra beds( no extra beds have arrived this year); R Mathews of DoH, declared RNSH had 599 acute beds, whereas 24 of these are bassinetts for well newborn babies and 18 are recliner chairs for patients having outpatient dialysis.

Leadership and engagement are required, not poor management and political subterfuge, otherwise we are all wasting time and energy.

“ Better to light a candle than to curse the darkness.”

| Short Term | Medium term | Long term |
|---|---|---|
| o Increase Acute Beds ( at least 48-50 immediately,i.e. 2 wards)<br>o Increase ICU/HDU beds( 10-12) and dedicate overnight beds to enable access for next day's surgical patients.<br>o Clinical Nursing Staff Incentives – especially to resource acute areas e.g. ICU/OR/Recovery/Emergency, e.g. free parking, child care, gym<br>o Achieve bed occupancy of 84-85% rather than 97.5%<br>o Purchase/Replace equipment-more than $30 million and MRI.<br>o Utilize Agency nursing staff up to 15% of total allocation to enable surge beds and full bed utilization<br>o Increase ORs and appropriate nursing FTEs, to achieve 80-85 % O.R.occupancy rather than 94%. | o Further Increase Acute Care Beds( another 25beds/1 ward), so total acute medical/surgical > 400.<br>o Enable comprehensive range of surgical services, with mix of urgents: "electives" 50:50.<br>o Further Increase Operating room numbers to enable most cases between 8am and 3pm.<br>o New hospital planning to be comprehensively reviewed-current plans illconceived and grossly inadequate and inappropriate. | o Encourage and support Private Patients in RNSH<br>o New specialist Private Hospital eg Orthopaedics, run by " RNSH"<br>o Abandon PPPs comprehensively.<br>o Start private nursing agency to increase "pool" size.<br>o Enable billing of all/ insured patients in EMU,and other incentives for Em docs to see more pts.<br>o Prepare for large influx medical students<br>o On site nursing training/accommodation. |

Dr Greg Purcell, Nile inquiry submission, Nov 2007.