Submission

No 47

INQUIRY INTO THE ROYAL NORTH SHORE HOSPITAL

Name: Ms Lindy Batterham

The Director
Joint Select Committee on Royal North Shore Hospital
Parliament House
Macquarie St Sydney NSW

To the Committee,

Listening to all the stories erupting from RNSH, including those from the medical staff have been very distressing for me, because we too had a very painful and traumatic experience at the hospital one year ago this week with my 90 yr old mother, which ended in her untimely death because of dangerous lifting practices at the hospital.

Our nightmare started with an ambulance trip to Emergency because she was experiencing breathing difficulties as a result of her heart condition. She needed some oxygen and an alteration of dosage of her heart medication. The same symptoms had also occurred some seven weeks before, and at that time, on our request, the Ambulance had taken her to Sydney Hospital, where she was treated promptly with great care & after a few days was able to return home.

We had previously endured a number of negative experiences at RNS Hospital, on this day I pleaded with the Ambulance Driver to take us to Sydney Hospital where my mother's medical records & permanent staff who knew her were. A few years previously she had had an emergency lower limb amputation at Sydney Hospital -there she had been treated very well, but the driver said there was a spare bed in Emergency at RNSH & that's where the program was telling them to go & they had to follow orders. But as custom would have it, the program failed & from 6pm she was forced to sit/lie/dangle her leg in great discomfort on the ambulance stretcher for many hours in the corridor awaiting entry to the Emergency Ward. It really feels like being admitted into the inner sanctum when one finally gets inside. However, it's just the next phase of waiting, only in a bigger room with lots more action. The staff work really hard, but it was 3am by the time the Physicians in Emergency delivered their diagnosis & suggested Joyce be admitted to the aged care ward, so the Specialist could see her the next day & adjust her medications. They gave me the option of taking her home &

bringing her back as an outpatient but by this time Joyce was exhausted and because of all the wheelchair transfers she would need to execute to get to her bed, which take considerable effort, I judged it would be in her best interest to go up & get some sleep in the aged care ward.

How wrong I was because that's where her accident happened. It was definitely avoidable and what concerns me now is the staff's reluctance to learn from this mistake and their insistence on defending an unsafe practice that ended in my mother's premature death.

For the safety of all amputees I urge the committee to look into the OH & S issues relating to amputees in hospital. Joyce could still be with us now, but because one nurse tried to move my mum who was a large woman with only one leg from her wheelchair to a hospital bed without a rail or anything for my mother to hold on to and transfer her weight to, she was dropped to the ground, resulting in a broken hip. When I arrived about an hour after Joyce had been dropped, I found they had put her back in the wheelchair and given her painkillers to address the extreme pain she complained of, and then they left her sitting in her wheelchair, with no access to a buzzer, and without calling a doctor.

When I first saw my mother in this state of distress I, as a non medical person but with a Senior First Aid Certificate and as her Carer for many years, thought she clearly needed to lie down on the bed instead of being left sitting with her leg dangling unsupported on what appeared to me to be a possible fractured hip.

It was only after I insisted she be seen by a doctor & x-rayed for a possible fracture that these things finally happened. Then some hours later, having the orthopaedic surgeon tell us she would require surgery the next day was like a death sentence, because we knew, and he told us that it was high risk surgery, with her heart and vascular problems. However, there was no option, she had to have the surgery for the fracture.

After enduring extreme pain with the fracture, unable to find a comfortable position in which to lie, and having nil by mouth for over 30 hrs on a hot November weekend (& broken air-con) whilst awaiting surgery, we were then to experience another breakdown in process. The lack of communication

between surgery and the ward was inhumane. This is an area that needs to be looked at by the committee. What structures are in place to communicate between surgery and the ward? No-one should have to endure the indignity that we did. It was not until midnight that the ward nurse gave in to my requests and again rang surgery only to find they had packed up & gone, yet had failed to ring the ward to say Joyce's operation scheduled for midday(12 hrs prior) was off. She had stayed awake in anticipation, having nil by mouth for 30 hrs by then, and had been desperate for a drink of water for many , many hours.

The next morning she was taken to the operating theatre early. I had left the hospital about 1 am, but no-one rang me in the morning to say it was happening. I had wanted to be there for her pre op. Regrettably, she suffered a stroke during surgery & on regaining consciousness couldn't speak nor have much use of her hands, thus communication with her was greatly reduced.

After being accidentally dropped, to being operated on & suffering a stroke in surgery, Joyce battled on for another four days with me too frightened to leave her unattended, and when the social worker came to talk to me bedside, 3 days after surgery about the need to look to the future & face up to the fact that I could no longer care for my mother at home & I would need to find a high dependency room in a nursing home, Joyce gave up and took her last breaths.

The staff wheeled my mother into one of those 'treatment/store' rooms after she passed away in the ward, where I sat with her for a couple of hours saying my goodbyes & trying to come to terms with the frightening & traumatic series of events over the previous six days at the hospital that had led us to this point of no return, whilst staff flitted in and out, getting their supplies.

However, it gets more worrisome. A couple of weeks after my mother's death, I had a follow-up meeting with the Ward Manager and the Director of Nursing at the hospital, along with the patient representative staff member and a friend of mine for support. I needed to understand why one nurse would think it was appropriate to try to move an amputee without any

equipment or support, on her own. I thought this could not possibly be according to policy.

This is, regrettably where I saw the Nursing team work at its strongest, as we were told that all OH & S policies and procedures were adhered to, and it was considered safe to move her this way. I was flabbergastered to hear this, but not as much as when I read the incident report I had requested. Some detail and sequence of events were quite different from how I had remembered and documented them. It was clearly a cover-up but the staff were sticking together. I felt great despair that there appeared to be no lessons learnt and that among other things, other amputees could continue to be subjected to unsafe handling practices.

My experiences over the years tell me that the issues of RNSH are not confined to the enormous pressure on the Emergency dept. That's often just the beginning. Much seems to come down to lack of staffing, and the stream of casual nurses and doctors which is related to funding and family-unfriendly working conditions. It's clear that until we improve conditions and pay for nurses and acknowledge the incredible work they do for us all, we will continue to have resourcing difficulties. There are not enough fully trained staff on the wards. The aged-care ward should have a higher ratio of staff because the patients seem to have greater needs.

I can fully understand why families feel the need to hire a private nurse if they can't be there themselves. I wouldn't leave my mother's side until she was asleep at night because she needed that intensity of care, & there was no way she was going to get it without me or another family member attending to and advocating for her basic needs to be met. Often I would be feeding & attending to other patients in her room too, because the assistance was just not there. It reminded me of 1977, when I was attending to my ill boyfriend in Goa Hospital, South India. However, there they gave the carer food and a mattress to slip under the patient's bed so we could at least lie down & snooze a bit.

I will be traumatised by my mother's last six days for the rest of my life, having the flashbacks of witnessing her dying in a nightmare of pain, frustration, extreme discomfort, powerlessness and eventual resignation. I advocated for her as best I could all along, and without me at her side for

most of her waking hours in the hospital it would have undoubtedly been intolerable for her.

I probably have post traumatic stress disorder as a result of my mother's last six days at RNSH. After caring for her at home to the best of my ability for many years, to watching her die in such a brutal, undignified and unnecessary way still haunts me, and I won't be able to have closure until after we have finished with the Coroner who, incidently, is still awaiting an autopsy report before determining whether there will be an inquest.

Thank you for taking the time to read my submission. The second document attached is a detailed journal I wrote as it was happening, one year ago this week. I am happy to forward the one page written report I received from the hospital if you request it.

Yours sincerely

Lindy Batterham

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ACCOUNT OF JOYCE BATTERHAM's ADMITTANCE TO ROYAL NORTH SHORE HOSPITAL:

Friday 10th November 2006.

6pm Joyce arrived by ambulance at RNSH Emergency Department with breathing difficulties. She was on oxygen and lay on the ambulance stretcher for some time before being transferred to a hospital bed. The ward was very busy and it was a long time before she was seen to. She was uncomfortable in the bed, she had a pressure sore on her bottom, and her poor circulation meant her leg was giving her some discomfort in the lying position. She found it more comfortable to sit up and lower her leg down from the bed.

Around midnight After blood tests, chest x ray etc, two doctors assessed her in Emergency and told us all was fine, she just needed her heart meds adjusted –she could go home & come back as an outpatient or be admitted & attended to as an inpatient. Because of the time, her age & weariness by that stage as well as mobility difficulties, it was decided she would be better off being admitted to the ward. I found some sandwiches for her to eat, and a cup of tea from the vending machine, because she had not been able to eat or drink until then. I stayed with her till about 1.30am, when she was trying to go to sleep whilst awaiting being transferred to the ward.

Saturday 11th November

Around 2pm I arrived in ward 11D to find my mother sitting in her wheelchair, beside her bed and visibly in acute pain . I asked Joyce how she was feeling and she responded that she was feeling absolutely terrible. She said she had an accident & had fallen from the bed whilst transferring and her leg was giving her severe pain. She said the nurse had given her some painkillers but they hadn't helped. She was in extreme discomfort and could not lift her leg onto the rest plate of her chair due to it causing her sharp pain. The leg was dangling down unsupported & giving her acute pain. Her nurse's bell was up on the wall-way out of her reach. I rang it three times over approx 10 mins with no response so I went looking for staff.

I found Sister in the Nurse's station who told me Joyce had slipped out of bed when a student nurse was helping her transfer from wheelchair to bed. When I said JB was now in intense pain and asked if a doctor had been called, Sister said no, she was aware of her pain and administered

Endone but said Joyce's notes showed that she had been experiencing pain in her leg the night before in Emergency & they had given Panadol for it. The Sister didn't seem to realise the pain Joyce was experiencing now was a result of the fall and quite different from the pre-existing discomfort in her leg. Sister said nothing about having tried to page a doctor at this stage.

We went in to see JB –it was staff changeover time and another nurse arrived bedside. I think she asked why JB was in the wheelchair, was she going somewhere? It was decided JB would be more comfortable in bed. Joyce was asked to put her leg on the floor to transfer –she said she thought it was too painful to weight bear. They encouraged her to try and they would assist. Joyce attempted to oblige but the pain was too intense. I initiated the idea there could be a fracture, she seemed to need an xray, be seen by a doctor and she clearly needed something stronger for the pain. My concern was great because JB is very stoic, not a complainer but was verbalising & expressing the extremity of the pain.

"This is the worst pain I've ever had. Oh, agh ,agh"

The three staff present seemed to be floundering about how to get JB onto the bed, I suggested they call a wardsman to help lift her because she clearly was unable to weight bear, and they couldn't lift her. This was done- and after not too long a wardsman arrived & four staff members together lifted my mother onto the bed. I noticed blood on the floor & upon inspection found my mother was bleeding from a cut on the toe. I pointed this out to the nurse, who just put a band-aid on but did not clean the wound first.

I spoke with others in the room. One visitor, the daughter of the patient alongside, was present when the accident occurred and, although the curtain was drawn and she did not see the fall, she heard it, as did the patient opposite. The visitor said she got up to see the nurse trying to then lift my mother (a big woman) from the floor on her own. She said to the nurse she needed to get someone to help, that she should not continue to try to do it alone. I asked this woman if she would write down what she had witnessed, but she declined, saying she also works at the hospital in an admin position, and was fearful of repercussions i

About 2.30pm . I again say she needs an xray. It was looking like a fracture. Sister decided to call the Dr to attend.
Approx 3pm Dr arrives. Examines & orders morphine and xray.
3.20pm First dose morphine administered. No relief for JB. Still experiencing acute pain. Staff prepare for Xray with black sheet.under JB. Difficulty in moving JB because of her discomfort.
3.45pm 2nd dose morphine administered.

Some time later we went down for JBs Xray. We returned to the ward. My notes from this time on are less exact regarding times, however I am still clear about sequence & content of events.

About 7.00pm The orthopaedic surgeon visited JB. Informed us she did indeed have a broken hip as a result of the fall and would require surgery to address the pain. The Doctor explained the surgery was 'high risk' because of my mother's existing conditions, but to not have the surgery would leave my mother in a lot of pain for an extended period so there seemed no real option but to have the surgery. Dr said because of more urgent cases, she was scheduled to have surgery at midday Sunday.

Approx six weeks prior to this JB was in Sydney Hospital because of similar breathlessness symptoms related to her heart condition. Tests revealed her corroted arteries were blocked - Drs advised that surgery could rectify this condition but because of my mother's pre-existing medical condition, surgery was not advised, so I was well aware that any surgery was going to be high risk. The Anaesthetist confirmed it was too risky to give her a general anaesthetic.

10pm I stayed with my mother till she was sleeping. She was somewhat drowsy with the morphine but was still unable to get comfortable.

Sunday 12th November
8.30am JB had nil by mouth from midnight due to expected surgery at midday. I sat by her side throughout the day awaiting surgery. It was a very hot day and the air conditioning did not seem to be working in her room as it was very hot. Throughout the day she was very parched and I was giving her sips of water through a straw that she rinsed then spat out just to whet her mouth. She was also on an oxygen mask which dried her out. I was also

sponging her with a cool face cloth I'd brought from home. This experience reminded me of caring for my then partner in a South Indian hospital in 1975, where family members were expected to do the caring. There was no way the staff at RNSH could have met my mother's needs on that day, given the demands on them with other patients. JB was most uncomfortable, which was exacerbated because she was an amputee. She had not been able to move, due to the pain in her broken hip,

8pm I requested that the Theatre ward be rung to see whether JB was still scheduled for surgery. (It was 8hrs later than the scheduled time). Reluctantly this was done, and we were told JB was still on the list, & if they cancelled they would notify the ward.

12 midnight I again requested Theatre be contacted to see what was going on. Message came back theatre was closed for the day. There had been NO communication to inform us of this and the staff on ward 11D were not able to tell me when surgery was to be rescheduled. I gave my mother a big drink of water, tried to make her comfortable and left her for the evening. That was the last time I was able to communicate with my mother.

13th November

8am I rang the ward to see if they knew what time surgery was to take place. I was told that she had already gone down to surgery. I was very upset at this because we knew this was high risk surgery and I wanted to be there to support my mother as she went in. I asked when they were going to let me know and was told they didn't have my contact details (next of kin) because the notes had gone with JB to surgery. If all went well they thought she might be out by about 11am and I was promised they would ring me on my mobile as soon as she could be seen.

I came into the hospital around this time & went to see the Patient representative. I had planned to make an appointment to talk over some of my concerns, but Nick Rich invited me in to talk about my concerns then. I had a friend, Gary Stark with me at this time. Nick took notes and agreed there were some concerns regarding my mother's case, was apologetic on behalf of the hospital and proceeded to find out what stage my mother was at, & if I could go in to be with her during recovery. The answer was no, and so we waited for a number of hours in the ward for her return.

When JB was brought back mid afternoon, she was still groggy & unable to communicate. It took a few more hours to determine that this was not the

after-effects of the anaesthetic, but that she had suffered a stroke during surgery and her ability to speak clearly was negated.

The following three days post surgery were very traumatic for my mother and myself witnessing her trauma. She tried to communicate & I tried to understand her, but apart from communicating that she had pain & discomfort or that she needed a drink, it was futile. She couldn't recover from the fall, let alone the stroke. She died in my presence on Thursday afternoon. If I had taken her home from the Emergency ward when given the option, she would probably still be alive today.

Post death meeting with Senior Nursing staff.
I kept in communication with Nick Rich, the Patient Representative at RNSH, who has his own report of the case. He facilitated a meeting with the Nursing Unit Manager of the ward, and the Nursing Manager some weeks later. I had presumed that the Nursing sister who dropped my mother whilst helping her transfer to her bed was not following protocol, because I cannot see how it could be considered safe along OH & S regulations for one junior nurse to transfer an amputee without a handrail on the bed on her own. When my mother became an amputee four years ago, I was not permitted to bring her home from the hospital until the Occupational Therapist inspected our home and saw that all the necessary rails had been installed. I expected that an amputee's safety needs would be attended to in hospital, and that she would be provided with a handrail to enable her to safely transfer. If there is no rail, there is nothing for one to hold onto whilst transferring and this is clearly why the transfer was not successful. If there had been two people helping her without a rail that may have helped, but a portable handrail should be standard equipment for amputees in hospital.

I had asked to be provided with a written report of the incident, which was tabled at the meeting. This report was not consistent with my memory of the events after the fall, with discrepancies in the matter of details concerning the time the doctor was called and the fabrication of how the bleeding toe was dealt with. (a minor issue in the scheme of things but showing disregard for truth). I had gone home on the night of the 11th and written down what had happened that day.

At this meeting I was told that the nurse was in fact following hospital procedure, and my mother had been assessed as being safe to transfer without a rail and with one staff member, despite her records also stating she was 'high risk falls.' This makes me despair for any amputee's safety in the hospital, because the only other thing they could hold onto would be a sheet, which would not be satisfactory. I am not looking to blame but am looking for change and acknowledgement of problems so that life-threatening accidents for amputees are prevented in the future.

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Yours sincerely

Lindy Batterham
Daughter
Senior next of kin