Submission No 9

INQUIRY INTO OPERATION AND MANAGEMENT OF THE NORTHERN BEACHES HOSPITAL

Name: Name suppressed

Date Received: 24 June 2019

The following is based on my recollection of events I experienced in NBH between 12 Nov and 16 Nov 2018. It is offered for what it is worth in a constructive way in the hope that similar issues do not happen again.

On Monday 12 Nov 2018 I visited my GP who recommended that I present myself to NBH Accident & Emergency as I had displayed symptoms that may have been caused by a Transient Ischaemic Attack. I arrived at the NBH at around 10.00am.

I was examined by a triage nurse some time later. I then waited and was admitted to an emergency admission ward late in the evening to await a bed in a normal ward. At no stage was I offered anything to eat or drink. At around 11.30pm I found some packaged sandwiches in a refrigerator near the nurses' station and, after checking the date on them, helped myself. I drank from a water bottle I filled from a bathroom tap. I was finally transferred to a ward at around 2.00am on Tuesday morning.

At around 7.00am on the Tuesday morning I asked for something to eat. The nurse pointed to a chart on the room wall and said that this wasn't possible as I was "nil by mouth". The only problem was that the chart was written up for a previous patient who had already vacated the room. Breakfast was produced after it was confirmed that the board hadn't been erased between patients.

Many tests were requested by the various medical staff who examined me and these occurred over the next few days as staff and facilities became available. To a layperson on the receiving end these seemed to be conducted in a professional and caring manner.

On the Wednesday, a nurse came into my room with my newly prescribed medications. The problem was that the medications she gave me were nothing like my understanding of what the various doctors had told me that I needed to start on. When I protested and said that I didn't think the medications were correct she asked if I was "Mr ”? As is my *christian* name and as the nurse involved was from a non-English speaking background, this to her seemed in order. However, upon further discussion, it transpired that there was another patient in the same ward whose *surname* was ". After a lot of searching and checking, the correct medication was finally found.

Later on the Wednesday, I advised a nurse that I didn't think that my Holter monitor was working correctly. She diagnosed that the unit had flat batteries but admitted that she had no idea how to change them. I asked her for fresh batteries and changed them myself. My wife (a former nurse) happened to be visiting me and was horrified. She asked the nurse where she trained and the response was "Western Sydney University".

By Thursday morning all my scheduled tests except one were done but the hospital had no idea when either the appropriate machine or staff would be available for the final test. It was finally done late on the Friday afternoon and I was allowed to go home.

I was given a Discharge Summary as I left the hospital but considerable follow-up was required by my GP's staff and myself to get the results of some of my tests as they were simply not available when I left.

At all times I found that the nursing staff tried very hard and were very personable but, in my opinion, the environment they were working in wasn't properly organized or managed. In addition most of the nurses were from agencies and there were clear language and cultural issues.