Submission No 53

INQUIRY INTO OPERATION AND MANAGEMENT OF THE NORTHERN BEACHES HOSPITAL

Name: Mrs Darien Northcote

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“Mis-treatment” at the Northern Beaches Hospital.

- Saturday 20 April, male presented to ED feeling very unwell and in significant pain from a sore leg. After several hours, a diagnosis of pneumonia was made and a prescription for antibiotics provided. For the leg pain, the medication was changed from Targin (prescribed 10 days earlier by the hospital’s medical centre since the ED wait on that day was expected by staff to be in excess of 4 hours) to Panadeine Forte and patient advised that constipation may result. At no time was it considered that perhaps, as a 73 year-old, he should be admitted to hospital. Was this because it was Easter and cost savings were being considered?
- After 6 days of alternate constipation, diarrhoea and vomiting, as well as appearing and acting as if heavily drugged to the point of collapse, he returned to hospital on Friday 26 April, now unable to hold down any food, drink or medication, to be admitted with pneumonia, kidney failure and delirium.

Over the course of the next week, while individual nurses and doctors were pleasant and appeared to be competent, the actual care given was abysmal.

- On day 1 the patient had a catheter inserted and for several days he excreted some cloudy thick substance suspended in the urine. I could not find anyone who could explain what this was which I found a little unsettling and unsatisfactory.
- On day 2 or 3 of his stay, when the patient was having great trouble breathing, he was given a nebuliser followed by another. When he still couldn’t get any relief, I asked the nurse to put him on oxygen. She refused, saying the nebuliser was all he required. Thankfully I found another nurse whom I was able to convince that oxygen was necessary.

  If being on oxygen was actually considered unnecessary, why was the patient still receiving it more than 24 hours later?
- Having entered the hospital (Friday) with a heart rate of 72, I observed that the patient’s heart rate was, for three days (Monday – Wednesday), at a level of 40 to 45 beats per minute, with the recording machine beeping a warning for such a low rate. The patient has seven stents and is on several medications for heart problems; despite providing his cardiologist’s name to the staff at least daily, it is unclear whether the cardiologist was contacted at all, even though has rooms at the hospital. Since the medical staff of the hospital made changes to the patient’s medication, I would have expected that would definitely have had some input to such a decision, having looked after him for some 16 years.
- Until I complained on the Thursday, to the Nurse Unit Manager, the diarrhoea was not treated, even though the nurses had had to change the bed a number of times and provide the patient with up to 6 pairs of disposable padded underwear in a day in the intervening period, as well as helping him to the bathroom. In fact, when I complained on the Thursday I was told by a doctor that my ill husband should have told the staff that he needed some “Gastro Stop” tablets; surely a mistake as he was the patient, not the doctor, and had no knowledge of medication available or appropriate for his condition.
- Until I complained on the Thursday, he was not treated for ongoing vomiting or nausea and no one seemed to care that he had hardly eaten any food in the time he had been there, other than a little soup and ice cream; again I was told by a doctor that the patient should have told the staff that he needed “Stemetil” for this problem. How would a normally healthy person, in acute ill-health, and being the patient, know what medication was required? I was also advised by the Nurse Unit Manager that I should be providing food for him to eat if he was not eating the hospital food. If this is the case, why does the hospital provide any meals and why does it have a dietician? I did, however, bring in water, as the hospital drinking water was also making the patient ill.
- While chest X-rays were taken regularly for the first few days, no chest X-ray was taken after Monday 29 April but he was discharged on Friday 3 May as being well, with an X-ray not being

considered necessary (the patient did ask about this), and supposedly only requiring three more doses of antibiotics (36 hours' supply).

- At the time of departure (Friday 3 May, afternoon), the patient was hastily ejected from the hospital and made to walk out of the ward and to the car even though he could barely walk a few paces at a time without assistance. No wheelchair or assistance of any kind was provided or offered.
- Other than for the antibiotics, no advice was provided about the change of, and addition of, medication to be taken, with regard to whether these were to be ongoing or temporary.
- The follow-up recommended was with the GP or the heart specialist, with no suggestion that any further attention was required for his pneumonia. On follow-up with the GP five days later, a chest X-ray confirmed that the pneumonia was still very much in evidence and a further two courses of antibiotics were required as well as intensive physiotherapy before it was considered that he was now well enough to continue rehabilitation on his own.
- While it appeared that individual staff took appropriate readings of his vital signs, it is obvious that no one actually assessed the implications or coordinated the findings or effectively communicated the results. I noted that there was a patient information board in the room; at no time during his stay was anything written on this so one could not say, on several counts, that the National Safety and Quality Healthcare Service Standards were being adhered to as touted by the hospital's website.
- I also question the point of having the "My Health Record", given that a low heart rate was recorded for the patient on an earlier visit to this hospital (Tuesday 12 March) for a cortisone injection into the spine (for which, incidentally, two doctors have since intimated that the injection was incorrectly placed, which explains why it did not work in relieving the pain for which he was subsequently drugged, on the advice of the hospital's medical centre and emergency department, to the point of the pneumonia and kidney failure that resulted in his hospital admission).

  It appears that this health record was not accessed when the patient was presenting with low heart rate again and the matter was being treated in isolation, hardly a glowing endorsement for patient care.
- A written complaint has been made to the hospital but not using the hospital's feedback form as, while the Nurse Unit Manager did say, when I expressed a desire to complete a feedback form, that there were feedback forms available, at no time was one provided nor was I directed to where I could obtain one, so I do question the sincerity of management being desirous of receiving feedback.
- A response has been received from the hospital that simply glosses over the facts in an attempt to exonerate the hospital (of course the patient received treatment for diarrhoea and nausea but was any treatment provided before my complaint on the Thursday? That is certainly not the impression given by the doctor sent to speak to me after my complaint.)

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