## INQUIRY INTO OPERATION AND MANAGEMENT OF THE NORTHERN BEACHES HOSPITAL

Name: Name suppressed

**Date Received:** 25 July 2019

## Partially Confidential

## **Northern Beaches Hospital Submission**

I'm lodging this submission on behalf of my mother hospital recently

who was a patient at your

She was admitted on 30 April 2019 and was there for approximately 6 weeks. We experienced many issues and had concerns about her treatment. I will summarise the key areas of concern in bullet point format:

- We felt the need to have a family member present around the clock otherwise essential medications were missed
- We were regularly told that certain medications had been stopped, and when we
  insisted the doctor had told us the medication was being continued, the nurses then
  'found' the medication re-written up in another chart
- Despite advising mum needed anti-nausea medication before opioid pain killers, this never seemed to be documented as it happened over and over again if we were not present
- The surgeon in charge of her care continued non-surgical treatment until mum became an emergency case. Even then he was resisting surgery. We sought opinions from two external surgeons who both said they would have operated earlier. We eventually arranged for one of those surgeons to operate on her as we had lost confidence in our NBH surgeon's care or ability
- When mum was seriously ill, we asked to sleep over and were told we had to sleep on the floor of the hospital. We did so without a mattress or bedding – only a duvet that we brought in ourselves
- Mum overheard the intensive care nurse saying about her "I can't wait to get rid of her...I'm just too busy with this many patients" – it was very upsetting for her. We believe she was released from intensive care before she was ready and experienced a number of complications as a result
- We frequently changed the bedding and bathed mum as it didn't happen on too many occasions
- She had an infected wound that was ignored until it literally burst open one day it seems that could have been taken care of more proactively
- Mum had a breathing/heart related episode when on Ward 5C. The first doctor who
  appeared asked the next person coming in if he was a doctor (he wasn't) and said to
  him "I don't know what to do." Mum was administered various medications and
  afterwards no one could remember what she was given and in what dosage (there
  were about 8 people in the room at the time)
- The head ward nurse post surgery never once introduced herself to us and was very defensive when I approached her to say hello. She was definitely avoiding us, as she probably heard we had agitated for better care for my mum
- We were told by one of the doctors that mum should see a speech pathologist to work out why she was having trouble swallowing and was vomiting a lot. The speech pathologist refused to come to the floor and see mum.
- Our treatment improved markedly when we shifted from public to private patient care − I feel sorry for the public patients ⑤

- When she was moved between wards (happened three times) the nurses never knew what was going on and where she was going. The other wards always seemed to push back at the idea of another patient. One nurse even said to another 'is there a protocol for changing patients between wards' and the response was 'I don't know'.
- The wards always seemed to run out of tissues/wetwipes/blue-sheets/gloves. They had to bribe other wards to give them some
- It took 36 hours to get some medication dispensed from the pharmacy downstairs...the request wasn't sent down for over 12 hours, then we were told none was in stock, then it was delivered to the wrong ward, then when it arrived it had the wrong dispenser on it??? Everything seemed hard.

These are only the things I can remember but there were more. Happy to chat in person. We felt lucky mum got out of there alive and will never go back..