Submission No 117

INQUIRY INTO OPERATION AND MANAGEMENT OF THE NORTHERN BEACHES HOSPITAL

Name: Name suppressed

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On the 7th November 2018, my mother (Mum) passed away at the Northern Beaches Hospital. I have since become concerned that the level of care that Mum received at the NBH directly contributed to the timing of her death.

Mum had been living in respite care at in the weeks leading up to her death. Her condition was stable with mobility being the prime reason for her admission to She was working on improving her mobility and hoped to return to living at home in the near future.

On the night of 31st October, Mum complained to the staff at about shortness of breath. The staff discussed her condition with her GP and determined that she should be admitted to NBH. I visited Mum at around on 7pm on 1st November and found her to be in good spirits in Ward She appeared to be breathing normally and asked for her walking frame to be brought into the hospital, as she was determined to regain her independent mobility as soon as possible (as had been discussed previously at . She did say that she'd had shortness of breath but had recovered and feeling ready to return to when the hospital was ready to release her, which was expected to be in a couple of days.

With Mum still in hospital two days later, I visited on Sunday 4th November to look for her walking frame and then proceeded to visit Mum at the NBH. I arrived around 1:45pm and at first had trouble entering the ward as the doors were locked and staff were not responding to the door buzzers. I eventually gained access to the ward only when someone else exited. Other families were waiting outside the ward with similar problems gaining entry.

What I found when I entered the ward was disturbing. Mum's condition had deteriorated significantly in the two days since I had seen her. That had not been reported to the family. Mum was in her hospital bed and complained to me that she was in great discomfort. It was just before 2pm and Mum informed me that she had been continually begging the staff to assist her out of bed and into the chair in her room so that she could sit upright and relieve the pain on her back. Mum had been using the buzzer in an attempt to alert staff, with no effect. She had been in bed all day, asking for assistance to get into the chair and in pain the whole time. She was visibly distressed and perspiring from the stress.

I immediately tried to get the attention of staff, however found this to be very difficult. The first staff member that I approached, just after 2pm, was abrupt and told me that there were no staff available to assist and we would have to wait until after the shift change was completed. They said words to the effect that "Yes, your mother has been on the buzzer all day". I returned to Mum's room and told her that help would be on the way but she would have to wait a short while longer.

Mum kept pushing the nurse call button, in pain and desperate for help. The same nurse came to Mum's room shortly after and told her she would have to wait. In a feeble attempt to relieve Mum's discomfort she adjusted the bed to a partial upright seating position, and roughly pushed pillows behind Mum to raise her further forward, however I could immediately see that this was not an improvement and indeed the angle of my mother's position in the bed combined with the angle of the bed had actually put more pressure on her back, not less. The nurse was adamant that this was all that could be done and left the room in a bit of a huff. Very shortly after, with Mum in even more pain, I assisted her to adjust the pillows and ultimately lowered the bed to the original position.

I tried to distract Mum with a newspaper and conversation, however it was clear that she was in too much pain and discomfort to maintain a conversation. She begged me to go and speak to the staff again.

At around 2:30 I returned to the nurses' station to seek an update on the timing of assistance to get Mum out of bed and into the chair. The same nurse again said to words to the effect that "we are still in the middle of a shift change and there is just no one available".

I continued to try to adjust mum's position and pillows to alleviate her pain, to no lasting effect.

During the next half hour I again tried to get staff to assist moving Mum into a chair and was again told that there were no staff available to assist.

Sometime close to 3pm a second nurse came to the room and said words to the effect "I apologise for the level of care being provided to your mother". By that stage I was extremely distressed by Mum's situation and bluntly told the nurse that it was obvious that the care being provided was grossly inadequate and that I would have no choice but to write to the hospital administration as well as my local state and local federal members of parliament to alert them to the terrible state of care at the NBH. The second nurse became visibly distressed, to the point of having tears in her eyes, and apologised profusely for the situation, saying that they were understaffed but the staff cared a great deal and were under terrible pressure. It was evidently a terrible working environment for the staff.

The second nurse assured me that she was gathering resources to bath my mother and get her into the chair. She left the room at that point and I stayed with Mum, reassuring her that it would not be much longer. My 20 year old daughter, my mother's grand-daughter, was in the room the entire time all this was going on, and was visible shaken watching the suffering of her grandmother during the period since we had arrived.

Around 3:30pm, the second nurse returned to the room alone but told me that other staff were on the way and that Mum would now be washed and assisted into the chair. She again apologised for the delay and the level of care being provided.

I understood from what the nurse said and her body language that we should leave the room to allow the staff to get on with process of bathing Mum and getting her into the chair.

My daughter and I left the hospital distressed but with the thought that hopefully this was a momentary lapse in care at the hospital and now that I had demanded attention Mum would receive an improved level of care. Given the attitude of the second nurse and her apparent distress at my suggestion that I would write to her superiors, I decided not to write an email to the hospital or local members. That is a decision I regret to this day.

I was unable to attend the hospital on Monday 5th November or Tuesday 6th November, however I did retrieve Mum's walking frame from her home on the 6th and made plans with my brother to meet at the hospital and visit Mum on Wednesday 7th November.

I know now that on the morning of Wednesday 7th the medical staff deemed Mum's condition to be sufficiently improved that they notified the respite care facility that she would be returning to them on that very day.

Sometime around 11:20am on Wednesday 7th the hospital alerted the family that Mum had suffered a heart attack and had been transferred to intensive care. I made my way to the hospital, as did my brother and my mother's brother, . There was confusion and a lack of

communication when and I arrived at around 12:20pm. At first we waited in the ICU waiting room, where we again had trouble contacting staff. Eventually we spoke to , a hospital counsellor, and were told at around 12:50pm that the doctors were working to stabilize Mum. At around 12:55pm we were told that it would be at least 30 minutes, and perhaps much longer, before we could see our mother and speak to the doctors. It was suggested that we grab lunch while we wait. and I then went downstairs to the cafeteria, however just after 1pm I received a call from and was told that we should come up to ICU immediately. and I were then admitted to the intensive care ward where Mum was being treated at about 1:10pm. The attending Doctor told us that Mum had 'gone silent' during the process of being moved from the bed to the chair that morning and had not regained consciousness since. He said that Mum was being maintained by the ventilator but that she would likely pass away at any moment. I estimate that Mum passed away about 20 minutes later, at around 1:30pm.

What followed was more confusion and lack of communication.

As other immediate family arrived, we were asked to leave the room and that Mum's body would be relocated to an area in the hospital mortuary for us to say our final farewell. We left the room at around 2:05pm and then waited for 3 hours in the cafeteria for notice that we could see Mum. We had trouble contacting hospital staff but at one point I was able to speak to and was told that Mum would be relocated soon. We were not receiving any information from the hospital and were just left to wait in the cafeteria for no updates and no support. Sometime later I again contacted and at that time was advised that the hospital staff had been unable to transfer Mum to the mortuary because there were no staff available, so we would have to return to ICU to say our final farewell. This 3 hours of waiting, inattention from the hospital, lack of communication and confusion about what was happening to Mum caused additional stress for the entire family.

We returned to the ICU after 5pm with my two daughters (my mother's grand-children), my son, my wife, and myself. The hospital staff had done some work to remove the various medical devices that had been attached to Mum, however there was still blood on her arms and on her sheets from the removal of equipment. One of the staff apologised and said that he had done what he could to clean up, but this obviously made for a distressing sight for the family, particularly for the grand-children.

After saying our final farewell we left the hospital.

Looking back at the whole period of my mother's time in the NBH, the overwhelming impression that I have is one of a lack of organisation, under-staffing and an inadequate level of care. I feel that I tragically misjudged what I thought would be the return to an appropriate level of care following my complaints, and that I should have done more to demand better ongoing care after November 4th, and indeed between November 1st and November 4th. My family and I live with the guilt of having assumed everything would OK in the hands of the hospital, when I clearly should have done more. At the time we had no expectation that these would be Mum's last days.

Reflecting on Mum's condition on Sunday 4th November, I am concerned that her level of distress on that day, a direct result of the lack of care and resources at the hospital, may have continued through the 5th, 6th and into the 7th. I am concerned that Mum may have been left in the distressed state for those days that I was unable to visit. Being in such a distressed state would be a health risk to anyone, let alone someone with health complications. I am concerned that the stress of the 4th and possible continuation of that condition from 4th to 7th may have directly contributed to her

untimely death. Furthermore, I am concerned that Mum's treatment from the 1st to the 4th may have directly resulted in the deterioration of her health that I clearly observed on November 4th.

I would like the inquiry to conduct an independent review of records related to Mums hospital care and death, particularly to gain an understanding of the attention given to her over her whole period of care at NBH, and what happened in days and hours leading up to her death.