Submission No 141

INQUIRY INTO OPERATION AND MANAGEMENT OF THE NORTHERN BEACHES HOSPITAL

Name: Mrs Debbie Watt

Date Received: 28 July 2019

Submission re Northern Beaches Hospital

I would like to report the experience I had with my brother, , being in Northern Beaches Hospital in February/ March this year (2019). My brother was admitted in February with aspiration pneumonia. Having cerebral palsy and being quite sick I was quite alarmed that he was placed a long way down the end of the corridor away from the nurse's station as he had limited speech and ability to communicate, which was even more compromised being unwell. With his CP he was also unable to operate the buzzer for the nurse. I was also concerned that there did not seem to be enough staff, when my brother became quite distressed and needed to be moved. We had to wait for 10 minutes before someone came and then I had to help them move him.

I left on the Wednesday night, feeling uneasy and quite concerned as I also realised the staff in Ward 4C seemed to mostly all be from non English speaking backgrounds, so I didn't feel confident in communicating my concerns to the few staff that were there. I was shocked to receive a phone call at 2.20am the following morning, from the registrar on duty, saying my brother "had taken a turn for the worse" and wanting to know what my instructions would be, should things progress further. He asked me some very confronting questions, whether I wanted my brother resuscitated and questioning me about his quality of life. Needless to say, I told him to do what they needed to in order to keep him alive.

My brother ended up in intensive care, later on that morning. In hindsight, I wasn't all that surprised as I felt uneasy leaving him the night before with what I felt to be inadequate care. I was shocked to learn from the intensive care nurse on duty the following morning that up to 90% of the patients in ICU came from the wards, due to a shortage of staff, however, this correlated with my experience.

My father, husband and I had a meeting with the registrar and the social worker that morning to further discuss my brother's situation. I was not very impressed with this meeting or the way it was run. We sat down on one side of a small conference room and the hospital staff sat on the other, including the social worker, who I thought was supposed to be supporting us. It felt like it was us and them, even moreso when the registrar started down the path of wanting to know my instructions and questioning me again about my brother's quality of life. I took offence and was quite angered by their lack of tact and empathy and felt like I was being coerced into agreeing with what they wanted, which was to not try to revive my brother, as I felt this was the easier option for them. I was also given incorrect information by the registrar, who said my brother had had a cardiac arrest. I found out later that he had a respiratory arrest - he had a mucous plug and after deep suctioning was able to breathe again.

Fortunately my brother received excellent care in IC. The nurse there said she was not letting my brother go back to the ward without a proper management plan, including being placed near the nurses station. ended up in the private ward in 4B, being placed directly opposite the nurses station, which is what should have happened in the first place. From then on in, he

received excellent care. It saddens me that there is such a huge distinction between public and private in this hospital, moreso than in any other hospital I have been in and seen.