Supplementary Submission No 38a

INQUIRY INTO HEALTH OUTCOMES AND ACCESS TO HEALTH AND HOSPITAL SERVICES IN RURAL, REGIONAL AND REMOTE NEW SOUTH WALES

Name: Name suppressed

Date Received: 6 December 2020

I am a registered nurse working within MLHD of NSW. I have been a registered nurse for 43yrs. My role for the past 8yrs has been in the emergency dept of our local hospital.

The shifts include 2 X 8hr shifts- a.m. (0700-1530) + p.m. (1300- 2130) and a 10hr shift for night duty (2100-0730). Each shift in ED has a sole RN working with a Dr. on call, and 2nd Dr. on call if needed. Mon-Fri a.m. shifts have extra nursing assistance when required from management ie: NUM or facility manager. But p.m. and ND shifts, the RN is also responsible for supervising and assisting in the rest of the hospital, which includes 18 bed acute ward, and 31 bed aged care unit, as well as triaging and treating those people coming to ED which provides x 4 beds. The workload for all nursing staff has become unmanageable, and are currently in dispute with the involvement of the NSWNMA, for unreasonable workloads, (safe minimum nursing levels) and breeching of WH+S (nursing staff working in isolation).

It has become commonplace to receive up to x 3 people at any one time complaining of chest pain, another suicidal ideated mental health patient, an person with acute abdominal pain, (all of which are triage 2 + 3) as well as queueing people in the waiting area for treatment of cuts and abrasions which cannot be triaged for 1-2hrs. The RN cannot get a scheduled meal break, constantly runs from dept to dept, finishes their shift dehydrated and exhausted. The heralded "holistic care" is idealistic and cannot be achieved despite our every efforts. Giving just a glass of water to a thirsty patient can seem to be a chore, when you are surrounded by insurmountable care needs of others. Waiting families become disgruntled and even angry for having to wait, despite our efforts to explain the complexity of care being received in ED.

Staff are working 12hr-18hr shifts to cover sick leave in all areas of the hospital- they are exhausted. So when, as a supervisor, we call staff to cover ongoing shift vacancies, there is no one willing to cover. Staff Recruitment has been ongoing by management for some time. In the long term, this is paramount, but receiving new staff, even post-graduate placement nurses, only compounds the workload for the RN managing the dept. Having to train them, as they graduate poorly skilled, check their competencies and documentation, and constantly picking up the extra missed workload for them. Agency nursing staff have been employed in our facility short term, and have expressed their shock at the workload we are submitted to. Few want to return.

Duty Dr's are employed by a medical centre alongside the hospital, with visiting rights to admit and treat patients within the facility. Not only do they work 8hrs in the medical centre, but also manage rostered on-call in ED as well for 24hrs from 0800- 0800, running between the medical centre and ED. Overnight, most medical direction is given by phone call. But when care needs to be escalated due to staff concerns or deterioration, it can be difficult to wake the Dr by ph, they can simply refuse to come to review the patient, in which case a STEP pathway is instigated (short term escalation plan). This pathway involves informing management on call, who are also asleep and not available, or not willing to come to your assistance.

Our local Dr's are also in the process of recruiting to lessen their workload, but are finding it difficult to recruit one willing to be on call and cover the hospital/ED out of hours. The Dr's, like the nursing staff, are human. Sleep deprivation and fatigue only breeds errors, and the recipient of those errors will be those who rely on us, and trust us, to provide optimal care with the best health outcomes- the public.