Submission
No 296

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

Name: Name suppressed

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Partially Confidential

LEGISLATIVE COUNCIL
PORTFOLIO COMMITTEE NO. 2 – HEALTH
Inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales.

Please find listed below concerns and issues in relation to my father's stay at Dubbo Base Hospital (DBH) from 29-31 January 2018 and 12- 23 April 2018. These concerns and issues were previously raised with DBH, NSW Health Minister and the HCCC in 2018. The responses from the NSW Health Minister and the HCCC demonstrated their ineffectiveness and lack of willingness to address concerns and issues, as well as their impetus to implement change mechanisms in order to address the shortcomings of DBH and NSW Health.

Background:

On 29 January 2018, my 80-year old father was admitted to DBH, where my father was diagnosed with a minor stroke. My father was transferred to Liverpool Hospital on 31 January 2018, for treatment. My father elected to be transferred to Liverpool Hospital as opposed to Royal Prince Alfred (RPA) due to advice provided from DBH, which indicated that his minor stroke was a result of his carotid artery, and his stents were flowing/functioning.

*On 2 February 2018, Liverpool Hospital informed my father that he had a major stroke, his stents were not flowing/functioning, and he was to be transferred to RPA. Whilst my father was at RPA, he underwent numerous tests and was identified as a candidate for cerebral bypass surgery, specifically a **right sided radial artery graft ECA to vertebral anastomotic graft**, and on 22 February 2018, my father underwent this surgery. Unfortunately, my father contracted an infection in the wound, whereby he required two additional surgeries to assist in the repairing and management of the wound. During this time my father was in a confused and agitated state, which was termed **delirium**.*

My father was transferred to DBH from RPA on 12 April 2018, to await transfer to Lourdes Hospital for rehab, still suffering from delirium. On 23 April 2018, my father was transferred to Lourdes Hospital for rehab, prior to discharge to the family home on 17 May 2018.

(d) patient experience, wait-times and **quality of care** in rural, regional and remote NSW and how it compares to metropolitan NSW

- My father presented at DBH Emergency Department in January 2018. A CT scan was undertaken on presentation and it was determined that my father had a transient ischaemic attack (minor stroke); his stents were flowing/functioning; the stroke related to a blockage in the carotid artery; and no clot removal medication was administered. On advice from the attending doctor, my father elected to be transferred to Liverpool Hospital on 31 January 2018. On 2 February 2018, Liverpool Hospital informed the family that our father had a major stroke that was not related to a blockage to his carotid artery; his stents were blocked and not flowing/functioning; and my father was to be transferred to RPA. DBH's incorrect diagnose caused a wasted of resources, for both NSW Health and the family. The family were left questioning as to how DBH could make a misdiagnose of this magnitude? Why did DBH inform my father and the family that his stents were

flowing/functioning, when they were not? Why was DBH certain that the stroke was a result of the carotid artery? Why did DBH state that dad had a minor stroke when he had a major stroke? Why was my father not administered the clot removal medication? Do DBH staff possess the necessary skills and training in order to make the correct diagnose? Was this misdiagnose the failure of equipment? Or was this the failure of staff at DBH to utilise equipment correctly?

- On the morning of 17 April 2018, the Medical Registrar at DBH advised the family that our father did not have delirium but a degree of cognitive impairment and was not suitable for rehabilitation (rehab) at Lourdes Hospital. This was in direct contrast to advice provided by RPA. The Medical Registrar wished for my father to be discharged from DBH and send him home, this is despite my father not being able to attend to his own personal hygiene and requiring daily heparin injections. A patient advocate was engaged at the expense of the family, in order to safeguard my father's best interests and wellbeing. A teleconference was scheduled for the afternoon of 17 April, between the Medical Registrar, Patient Advocate and family members. During the teleconference, the same Medical Registrar informed the family that my father did have delirium and was suitable for admission to Lourdes hospital, and that the family should wait three months for my father's delirium to stabilise. This was the SAME advice that RPA had provided prior to my father's transfer to DBH. The Medical Registrar further stated that the family should look for alternative accommodation for my father, rather than him returning to the family home. Yet more contradictory advice from the SAME Medical Registrar, as this SAME Medical Registrar, had on the SAME morning sought to discharge my father from DBH. These actions further demonstrate a lack of *quality care* in rural, regional and remote NSW, as well as a lack of professional and competent conduct of a Medial Registrar. The family were left questioning the competency, skilling, decision-making and training of the Medical Registrar, as he displayed the inability to make a tangible decision or judgement on my father's condition and his treatment.

- On the morning of 20 April, I was informed by the Social Worker that my father was competent and free to make his own decisions. However, it was several hours later before my father undertook the Mini Mental State Examination (MMSE) to determine his competency, where he scored 30/30. The family were absolutely astounded at this result, given observations of our father, who believed he was in Vietnam fighting the VC; having breakfast in New Zealand; and the delirium disturbances he exhibited. The family believed that DBH demonstrated an overarching desire to free up a hospital bed and their behaviour and decisions appeared to be disjointed, puzzling and bewildering. If the medical experts were unable to make a decision, how is the patient or the family able to make an informed decision based on their perplexing behaviour? The family believed that had there been no family member present, my father would have been thrown into the streets of Dubbo, when he was at his most vulnerable.

- During my father's stay in DBH in January 2018, my father was incorrectly administered *lithium*, instead of Vitamin D. This was due to the pharmacist incorrectly filling the script and the evening RN administering the medication and who failed to query the prescribing of the lithium. Family members were informed of the error. Why did DBH incorrectly

administer lithium to my father, and not query this error? Again, the lack of *quality of care* displayed by DBH, emphasises the level of competency of staff at DBH.

- My father was prescribed and administered quetiapine 25 mg at limited intervals at RPA, to assist with sleeping habits, wandering and his delirium. On his transfer from RPA to DBH, his quetiapine was increased to 50 mg at frequent regular intervals. On 20 April 2018, a quetiapine 50 mg tablet was found on my father's bedside table by my sister and myself. I immediately took the tablet to the RN's station, who informed me that she had watched my father take the tablet the night before, and was unable to explain why the tablet was left on my father's bedside table. Given that quetiapine is a chemical restraint, why was the family not approached and a discussion undertaken, regarding the increase of this medication, instead of informing the family that my father was to be prescribed this increased amount that was to be taken at frequent timeframes? Why was there a quetiapine 50 mg tablet lying on my father's bedside table, especially when he was in a confused state of mind? Given my father was suffering from delirium, how could DBH staff be so careless and leave medication in his reach?

<u>(e) an analysis of the planning systems and projections that are used by NSW Health in determining the provision of health services that are to be made available to meet the needs of residents living in rural, regional and remote NSW</u>

- Whilst my father was in DBH, the Aged Care nurse stated to my brother that RPA could have sent my father to Lourdes Hospital rather than him transitioning through DBH. She further stated that DBH was always rectifying Sydney's errors. The Age Care nurse's comments highlight an atmosphere of mistrust and lack of collaboration and communication between DBH, RPA and NSW Health. Notwithstanding, the lack of concern of feelings and the emotions for my father and the family. The family believe that this demonstrates DBH's lack of planning systems in forecasting and determining health amenities and services for the region.

- Whilst my father was transitioning through DBH (G Ward), his bed sheets were not changed for three days. My sister and I exchanged the dirty sheets for clean sheets, and made the bed ourselves. The ward, in which my father was accommodated had four beds with four buzzers attached to each bed. Of the four buzzers, my father's buzzer was the only buzzer that worked in the ward. However, my father was unable to use his buzzer due to the loss of his right vision from his stroke, as well as his confused state of mind. Staff made no attempt to position the buzzer for my father to see and use. Additionally, patients in the other three beds relied on my father to buzz staff for their assistance.

- RPA is a feeder hospital for regional NSW where individuals are regularly transferred for medical treatment from regional NSW. However, there is limited and affordable accommodation available in the hospital area. During my father's stay at RPA, over a three day period I stayed at three different accommodations, due to the lack of available accommodation. The Isolated Patients Travel and Accommodation Assistance Scheme (IPTASS) is available to assist with accommodation costs. However, costs are reimbursed at less than 50 per cent, with the claims process drawn out and time consuming. Additionally, IPTASS does not cover meal/incidental expenses. Given NSW Health is

unable to provide the relevant medical amenities and services in regional NSW, an alternative service provision/package needs to be designed, developed and implemented that is cost effective for patients and their carers.

- Studies have identified that people living outside major cities are likely to have long-term health conditions, such as heart, stroke and vascular diseases, compared to people living in major cities. What mechanisms are being put in place by NSW Health to address the lack of health amenities and services for residents in rural, regional and remote NSW who require hospital care other than to fly them to Sydney?

- There is no Geriatrician at DBH. Does this not articulate the lack of concern that the NSW Health Minister has for the health of rural, regional and remote NSW residents. It is concerning that individuals residing in rural, regional and remote NSW do not have access to adequate medical amenities and services that are afforded to individuals who reside in major NSW cities.