Submission No 356

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

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Introduction

I have spent the last 45 years as a Registered Nurse. My employment, in the main, has been with NSW Health across specialties, positions, geographical areas, departments in hospitals and community health centres. My clinical practice and knowledge have never been called into question and my Performance Development Review (PDR) and Monthly Accountability Meetings (MAM) would pay testament to this.

The last 17 years have been in the Taree Aged Care Assessment Team (ACAT) and the last 14 years as the Clinical Nurse Consultant (CNC) Psychogeriatrics. This position worked very closely with our fly in Specialist Psychogeriatrician, Together we have worked with clients presenting with some very challenging behaviours due to their diagnosed Dementia and sometimes Mental Health issues compounding all of the above and in a variety of settings including the Manning Base Hospital directly and indirectly in consultation with the Geriatricians and Psychiatrists, in Residential Aged Care facilities, all community health settings and client's homes when necessary. In all, a very demanding and onerous group to manage, and virtually impossible to oversee the cares without the assistance, input and guidance of Dr xxxx

We introduced the technology of telehealth to supplement the service we provided. It was a very important service and achieved great outcomes for our aged and very challenging individuals who otherwise ran the risk of less desirable outcomes, viz over sedation, falls, pneumonia and, sadly, premature death in some cases.

Background

I commenced employment with The Taree ACAT in 2002, initially as a Registered Nurse and then to the position of Clinical Nurse Consultant. The CNC position has always worked closely with the visiting Psychogeriatrician.

The Psychogeriatrician position was available on a Fly In Fly Out (FIFO) basis of one day per month. My role as CNC was to triage referrals to ensure that the position was used in the

most cost - effective manner for appropriately referred clients. All referrals were required to have a GP referral. As the CNC I also gathered the relevant medical information and provided an initial accurate assessment of the referred client's Mental Health and cognitive state and these assessments included the following , the Mini State Examination (MMSE) and the more complex Addenbrookes Cognitive Examination (ACE III). The role also provided follow up between appointments to clients, families and relevant others e.g Residential Aged Care Facilities (RACF). It needs to be remembered that the role of a Psychogeriatrician is that of Psychiatry of Old Age and not to be confused with a Geriatrician as a Physician of Old Age as sometimes happens and reality is that the Psychogeriatrician role also supports the Geriatricians.

Situation

The treatment that has been afforded me and about the service I have been providing for the past 14 years I find utterly repugnant. I am grossly disappointed with the lack of attention to the HNELHD CORE principles, by the very people who promote, nay demand that we all abide by. The service I have supported and provided has been ridiculed, negated, criticised, and declared non-viable and of low priority.

These negative sentiments have been made by the most recently appointed acting manager who readily and openly volunteered that she knows nothing about Psychogeriatrics.

In December 2019 our Specialist Dr xxxx left our service having provided her resignation in September 2019 in order to give the service ample notice. This resignation was sent to xxxx, Area Director of Mental Health Services HNELHD as the Taree ACAT did not have a recognised manager at that time. The resignation was forwarded on to Aged Care promptly. In December 2019 Dr xxxx and myself held our final clinic by way of telehealth. At that clinic, in Forster, time was allowed for the incoming ACAT acting manager to discuss the service with Dr xxxx so as to enlighten the manager on the complexity of the clients we assess , develop plans for ongoing care and management for.

In January after the Christmas break I met with said manager and was instructed to send out a letter to all the local GP's to let them know that Dr xxxx ,as visiting specialist was leaving

HNE LHD and the service was unavailable for the time being and provided contact details for alternate services that could be considered in the meantime.

A meeting was held in February 27th 2020 with Mental Health Service Manager We were informed by the Mental Health Manager that all the funding that Aged Care had for a Psychogeriatrician would go to Mental Health and they would duly employ a half such a position. This was later found to be at variance with reality. It came to light at a meeting attended by another Mental Health staff member that this was not to be.

Around this time, we also had an ACAT meeting where at the end of the meeting I was told that the Psychogeriatrician position would not be filled. Given my long term and close association of working with the Psychogeriatrician I found this a disrespectful way to be informed. This was a service that had been running successfully for 17 years and was I deserving of some professionalism and courtesy. Several staff approached me after were horrified when they realised that this was the first time, I had received this information for certain and they also considered this a disrespectful way of finding out.

It was somewhat gob smacking, given the well-known increasing retiree rate in this area and general increase in the aged population, to be informed by the manager that service was no longer a priority for Medical management to consider. I was told this on numerous occasions. Any time the topic of a Psychgeriatrician and the Psychogeriatric service came up it was automatic that the response would be that the service was not a priority. A meeting was planned with the Director of Medical Services Manning Base Hospital to decide the future of the Psychogeriatric services, however I was not included in that forum and I have never been informed as to the outcome other than the service is not seen as a priority. I feel that it was a gross oversight that the Psychogeriatric service was not represented at that forum.

Several emails were sent to my manager by me requesting information and some guidelines on the service to be provided in lieu of the service she had dismantled. To date I have not received any replies. Nothing was forthcoming from her until a Pilot support position was created for the ACAT team in April. It was proposed that position would provide support however, the other members of the new proposed team were absent including myself, due

to planned and emergency leave. The opportunities to create a service were minimal. The support position , in an email suggested she had found information to help with the service we may create. The service was the SOS Telehealth Service managed by St Vincents Hospital Sydney. This is a service with many staff of different disciplines including Psychogeriatricians, Neurologists and Allied Health and they provide a telehealth service to some regional areas. The service isn't client focused but rather a staff resource. This is a gold standard service with permanent full-time staff. Before the dismantling of the Psychogeriatric Service, I had suggested that we use telehealth, as I had been using the technology for the past 7 years. I had suggested to my manager that we could use telehealth back in January 2020, however this was ignored.

A further meeting with the manager on the 8th April 2020 I again met with her and my clinical practice was brought into question and threatened with performance management because there were only a couple of clients on my caselist and the service could not be justified with those numbers. As mentioned previously I was directed to send a letter to all the local G.P.s to let them know that Dr xxxx , as a visiting specialist was leaving HNE LHD and the service was unavailable for the time being. My manager failed to see the that as relevant to a service that relies on G.P. referrals.

To reiterate at this point there was still no guidance or direction on what the plan was for the service despite seeking this from my manager.

Again guidance was sought from my manager on what resources the service may receive but yet again no information was forthcoming. I offered to seek out telehealth services but, once again, no information or response was received.

I attended a meeting Union Staff Consultative Committee (LMNC USCC) 25th March where General Manager was present. I took advantage of her presence and asked about the plan for the Psychogeriatrician position I was told that Taree ACAT had never had a Psychogeriatrian or funding and it was all Mental Health. I disputed this information. She said she would seek clarification. She went on to say that no change was warranted in the current service by saying that as we have Geriatricians managing the patients with

behaviour problems, we don't need a Psychogeriatrician. This statement by the General Manager came as a shock. I found it disappointing that the General Manager would not be better aware of services available in the service she manages.

At a later meeting I was summoned to a catch up that was nothing short of an attack on why I hadn't completed the service setup. I still had not received any input, advice or guidance on what that service may look like. The other staff involved in this team , had been on leave planned and unplanned as had I.It was necessary for the other two staff to be involved as I was due to go on extended leave for 17 weeks and they would be the two working the service.

There were comments from my manager about one of my CHIME notes appearing in quadruplicate which happens if the internet is slow, and happens regularly at the end of the day when the vast majority of clinicians are logged in. Regular users and clinicians are only too aware of this. There was also a complaint about a clinical note I had written about a client with complex needs. My manager was of the opinion that the note didn't have enough details about the complexity of the client. The clinical note was a summary of a home visit and was accurate and concise. Any colleague following on from me, in my absence, would be aware of the complexities and not all issues are addressed at every visit, only those that are impacting at that time. They would know that they must read more than one clinical note to know the story. There was also a complaint that my CHIME diary wasn't full. We have always been told by CHIME educators that the CHIME diary isn't a record of our daily work. CHIME is a medical records system. At this same meeting my manager said she doesn't understand Psychogeriatrics and this is very apparent. Disappointingly she had made the same comment late last year which is why the meeting was arranged with herself and Dr xxxx.

The above events happened over the period January to July and I am employed 24 hours a week.

On a separate issue

The topic of excess annual came up at the February House meeting with the understanding that people who had excess leave had already been informed personally or by email and that this excess is based on staff accruing two years' worth of leave only. I had received neither contacts and my leave had already been arranged for July onwards for planned travel. I was surprised to receive an email demanding I take my excess leave, or I would be paid out. I was stunned for a number of reasons; I had received no prior contact, I was given one months' notice and threatened with being paid out when this is only available to leave other than the leave I had.

I assessed the amount of leave I had, and I would have 0.1 days in excess of the pro rata amount of leave for Permanent Part Time (PPT). I was given a link to a document by my manager that has already been superseded. The Leave matters manual refers to 30 days and no apportioning for PPT. I responded to the email and the reply from my manager said that the two-year period had now been reduced to 18 months so therefore I was even more over the limit. I was not able to find any information on the change to this time nor was the staff at N.S.W.N.M.A. It seemed pointless attempting to discuss this leave excess as the rules were evolving to confirm her stance.

I have now been on my planned leave since July and not due back to work until November 17th 2020.

I find the workplace atmosphere toxic and the management could easily fall into the definition of bullying and disrespectful. I am disgusted by the lack of attention to the CORE principles. I have no desire to return to my workplace. It is sad to leave a service that was highly regarded but now in tatters and a shadow of its former self. I have no idea on where future clients will go for assessment and first class treatment and this saddens me.

It would be a shame if my words are falling on deaf ears. An honest ,professional and responsible manager would take heed and act accordingly in a review of staff in an open, honest and confidential manner. For these criteria to be met it will need to be attended

external to the Manning site. Staff deserve better than what they are receiving and at the end of the equation is improved care and outcomes for our clients.

I will be forwarding my resignation accordingly.

I would like to take this opportunity to thank you all for making it so easy to leave.

Vicki Morrison
CNC Psychogeriatrics