Submission No 414

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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In my career at dozens of hospitals and other health care facilities, I still find it incredible that severe nursing shortages are allowed to exist, and more amazingly that the nurses and other staff tolerate this.
Among these facilities I worked 3 to 6 shifts a week in one site with a mix of ED and acute care beds where we will have several patients either from the ED itself or from the surrounding major and feeder hospitals in the LHD. They can be there for post-op rehabilitation or Respite care, or be on IV fluids and antibiotics.
We also had an aged care ward attached , with either one registered or an enrolled nurse on the night shift. Staffing numbers are always better during the day, though frequently never enough. Since COVID-19 the inadequate staffing situation has become worse, and this is the real danger.
There needs to be a mandated MINIMUM safe standard of staffing numbers in a facility, for the safe provision of care for all who present. As there are also babies, infants, toddlers the dangers become more paramount should there not be a safe staffing level, to deal with emergencies. Relying on "Ring the on-call person (could be another RN or the NUM, or the CEO) is dangerous and unsatisfactory, as the 10 minutes or more waiting for them to arrive spells disaster". This situation can occur during the day, but on nights there is only one staff member covering both the ED and the acute ward. While you attend an ED patient, no-one is available to look after the (possibly) 2 or more other patients in the Acute ward. Once again, with COVID, the only other nurse in the building who is in the aged care section is only allowed to assist if there is a MET call (resuscitation). Without a rostered second person in the ED/Acute section, any presentation can convert to a resuscitation within seconds, tying up the only nurse there, and blocking their attempts to call for help.
This system alone should be classified as dangerous, irresponsible, negligent.

A total of two staff in a facility like this, that includes an emergency department should not be allowed, and I would see it as a wonderful court case looking for a perfect venue.

Since Covid we have a third staff member (HSA/Wardsperson/Security) on duty most nights (but not always) but as it is not a nurse, there are still limitations to nursing care delivery.

Doctors are also 'on call' (sometimes on day shift, but always at night) and are allocated a house several streets away, or may live a few KM away. Doctors can be locums (from Tamworth, Cairns, Melbourne, Sydney, etc or from a main hospital over an hour away) and should an emergency require a Retrieval to the main hospital, the delay can be over two hours until their arrival. Telescreening does exist, but with only one nurse initially (and maybe two should th^{at} staff member in the aged care sector be free to help, or the on-call person arrive), it is the initial moments with only a single staff member trying to reassure or resuscitate (or treat the person) the danger is apparent.
Persons will say "but you have the ambulance officers or Paramedics that brought the person in" however the issue I raise is that it is AFTER the ambulance has dropped a person off and they have left that is the risk. To expect the ability to keep the ambulance staff until a doctor arrives is Fairytale!

The RN assesses, triage categorises, reassures, cannulates (if not already done by the ambulance) and starts a protocol of care (based on if the RN is FLECC trained – First-Line

Emergency Care- for work in a Remote Area facility. They call the on-call doctor as per situation and protocol.

The dangers escalate when a patient presents direct to the Emergency department door, with injuries including trauma. Many come with pain or severe pain, including chest (may be a heart attack). It would be wonderful to have the doctor there 24/7.
Should the case be critical, then we have limited and insufficient medications, and no facility for holding/caring for intubated patients. We do not have enough staff at night for a safe resuscitation, and trying to use a phone for assistance while doing CPR can be inappropriate or impossible. With Covid cases we don't have to worry as we can not intubate anyway due to the aerosol-generating dangers to staff and facility.

Any child under 16 MUST be transferred to the major regional hospital if they require hospitalisation, and any patient requiring cardiac monitoring must also go there, as do any who are actually ill (as we have inadequate facilities to admit them).

You have great staff (but they know they are understaffed, so stress levels can be high (an individual response) and we have a NUM and CEO who are on-call (but as they are salaried, they do not get paid for 'doing all that is required to support the staff and facility'.

There have been numerous documented health complications and deaths at regional hospitals in NSW (and probably nationwide), and the lessons from those events should have been obvious.

I came to this facility on request from the major hospital, and was told “we can't find nurses willing to work there”, and as I work at several hospitals in the LHD I have been told by many staff that I must be be suicidal to work at that site.

Remote Area Hospitals and health care facilities are an essential service to local communities, and should be staffed safely. There must be a MINIMUM safe staffing number, regardless of if there are any patients in the facility at night (else the ED should not be open).

There should also be a MINIMUM standard of equipment and resources for potential presentation of Covid-positive persons due to the current pandemic crisis.

Due to the risk of transmission to the existing patients in the facility (“especially the elderly”) any person with potential Covid-19 symptoms can not be allowed into this facility, so a separate inadequate room is allocated. The room has no air-conditioning and is a very small room usually used to house aggressive mental health cases. There is no toilet, no seating for family, no bathroom facility, no hand sink, and no intercom to use to call help. (Who could you call anyway at night. A bit like the initial ALIEN movie episode where “In Space No One Can Hear You Scream!”
Immediately the only nurse on the shift has no (immediate) second person to assist the RNIC (RN in charge) to don PPE and no-one to safe-check the masks. In addition there is no ready access to ANY rescue equipment (other than a portable oxygen cylinder and a portable

suctioning device)or drugs as you cannot allow this person into ED as it will contaminate everything, and then be transmitted into the facility via the air-conditioning.

My submission is that this is an excellent and essential facility, with staff and administrators who are trying to cope with and adapt to a crisis that could become overwhelming, but there needs to be a minimum mandatory safe standard of medical and nursing care, with on-site accommodation for on-call staff. There should be an immediate supply of extra staff to cope with the Covid-Crisis, to ensure that there is no cluster outbreak. Some staff with a sniffle or cough have been required to drive over an hour to a main hospital to be tested, (and then if they are positive or not they can drive back again) which is a strange way to avoid 'spreading' the pandemic.

The present NSW government is risking/ sacrificing the health of its front-line workers (and therefore the community at large). It is obvious that the real gravity of the situation is being ignored. If nurses or doctors complain enough, they could face de-registration, sacking, career loss.