

SPECIAL COMMISSION OF INQUIRY  
INTO ACUTE CARE SERVICES IN NSW HOSPITALS

Before Mr Peter Garling SC, Commissioner

At Bankstown Hospital

On Tuesday, 13 May 2008 at 10.30am

Counsel Assisting: Ms Kelly Rees

Senior Legal Officer: Ms Clare Miller

1 THE COMMISSIONER: Good morning ladies and gentlemen,  
2 welcome to the sittings of the Special Commission of  
3 Inquiry into Acute Care Services in New South Wales public  
4 hospitals. I will commence the sittings by giving a formal  
5 direction. Having directed on 6 February 2008 that it is  
6 desirable, by reason of the content of the terms of  
7 reference and the nature of the inquiry, that all hearings  
8 take place in private. I direct that the hearing at  
9 Bankstown Hospital on Tuesday, 13 May 2008 is to take place  
10 in public.

11  
12 The purpose of today's hearing is that as part of a  
13 series of hearings, the Commission has travelled throughout  
14 the metropolitan area, regional and rural areas, to hold  
15 hearings at various locations to enable employees of the  
16 Health Service, patients, members of the public and other  
17 interested people to come and make submissions to the  
18 inquiry, to tell the inquiry about facts and matters  
19 relevant to the terms of reference that concern individual  
20 staff members, and draw to the inquiry's attention  
21 particular problems that exist within the system as a whole  
22 or at particular hospitals and where they can to offer  
23 solutions to those problems.

24  
25 So far it has been a very helpful exercise. I have  
26 obtained a lot of very good information and helpful  
27 information and suggestions, and I feel that by coming and  
28 holding hearings in various facilities I get a real sense  
29 of what the problems are confronting the staff at the front  
30 line.

31  
32 The way in which the inquiry works is that if you wish  
33 to draw anything to my attention you will be asked to come  
34 forward and take an oath or make an affirmation. There are  
35 two reasons for that. The first is that it obliges you to  
36 tell the truth, which at the end of the day is what I am  
37 interested in, and, secondly, it provides you with  
38 protection against detrimental action being taken against  
39 you to the extent that the law provides. So that, for  
40 example, issues of defamation don't arise when you become a  
41 witness in the inquiry.

42  
43 On the list of witnesses this morning we have a number  
44 who have indicated that they wish to give evidence in  
45 confidence and in private, and they will be accommodated.  
46 Generally I try to accommodate witnesses of that kind at  
47 the end of the hearing so that it provides minimal

1 disruption. We have two witnesses who have indicated they  
2 wish to give evidence in public. What I propose to do is  
3 to take that evidence, and then I will adjourn shortly to  
4 see if there are any more witnesses who wish to give  
5 evidence, and if not I will move to the confidential  
6 session. So we might commence with Mrs Fitzgerald and  
7 Ms Fernance.

8  
9 <LORRAINE FAITH FITZGERALD, sworn:

10  
11 <KAREN FRANCES FERNANCE, sworn:

12  
13 THE COMMISSIONER: I will need to ask you each to identify  
14 yourself. Would you mind giving the inquiry your full  
15 name?

16  
17 MRS FITZGERALD: Lorraine Faith Fitzgerald. I am a  
18 registered nurse.

19  
20 THE COMMISSIONER: I understand you are the President of  
21 the Bankstown Branch of the Nurses Association?

22  
23 MRS FITZGERALD: Yes.

24  
25 THE COMMISSIONER: How long have you been a registered  
26 nurse?

27  
28 MRS FITZGERALD: About 11 years.

29  
30 THE COMMISSIONER: And have you spent most of your time  
31 here at Bankstown?

32  
33 MRS FITZGERALD: All of the time.

34  
35 THE COMMISSIONER: And Ms Fernance, would you identify  
36 yourself to the inquiry and give me your full name?

37  
38 MS FERNANCE: Karen Frances Fernance.

39  
40 THE COMMISSIONER: I understand you are the nursing unit  
41 manager in the Cardiology Unit?

42  
43 MS FERNANCE: I am.

44  
45 THE COMMISSIONER: And you are the secretary of the  
46 Bankstown Branch of the Nurses Association?

47

1 MS FERNANCE: I am.

2

3 THE COMMISSIONER: I am very interested to hear what you  
4 have to say. The only rule is one person speaking at a  
5 time and just remember that the staff have to take down  
6 what you are telling us.

7

8 MS FITZGERALD: Okay. I will start by listing the topics  
9 that I am going to talk about. I am going to talk about  
10 staffing; directives from the Health Department and Area  
11 Health; failure of support services; manipulation of tools;  
12 and limitations on management.

13

14 I will start with staffing. We are talking on behalf  
15 of the branch, as you already know. There is a lot of  
16 frustration in constantly falling short of the adequate  
17 skills mix and numbers; needing better strategies to deal  
18 with unplanned absenteeism, other than taking the CNCs off  
19 the ward or offering a lower skill mix; the NHPPPD being  
20 worked out over 24 hours, not per shift, causing some  
21 shifts to fall short, so that the --

22

23 THE COMMISSIONER: You will have to explain that to me.

24

25 MS FERNANCE: There is a formula that was agreed upon in  
26 the award of nursing hours per patient per day. It works  
27 out roughly for a general medical and surgical ward at  
28 about 4.8 nursing hours per patient per day. So over the  
29 24-hour period you get an average of about 4.8 nursing  
30 hours per patient per day.

31

32 THE COMMISSIONER: Per shift?

33

34 MS FERNANCE: No, 4.8 hours of nursing hours in the 24-hour  
35 period. So some shifts are staffed differently. There's  
36 more staff on a morning shift and less on an afternoon  
37 shift. With casuals and agencies, a strategy might be to  
38 reduce the shift that they are offered, so instead of an  
39 eight-hour shift it is a seven-hour shift. It does save a  
40 little bit of money, budgetary restraints, but that leaves  
41 that shift short for some hours either at the beginning of  
42 the shift or at the end of the shift. You don't need so  
43 many staff members on the night shift. But the same thing,  
44 they could start or finish early. There are at times  
45 multiple start and finish times. I'm not sure that we have  
46 got on top of effective clinical handover, with starts and  
47 finishes - you might start at 7 to 2.30. You might start

1 at 1.30. You might start at 2.30. You might start at  
2 3.30. You might finish at 9.30, 10 or 11 o'clock at night.  
3 So sometimes there's multiples of start and finish times.

4  
5 MS FITZGERALD: Financial constraints from the South West  
6 Area Health Service making staffing difficult. Karen  
7 covered that in maybe a short shift, or something like  
8 that.

9  
10 Delays in approval for recruitment. Often there's  
11 delays. I know Margaret can approve nursing positions, but  
12 support staff such as clerical or wards people have to go  
13 to the whole area, so it slows down the whole process. So  
14 if we have a need now, it might take months for that to be  
15 processed and approved.

16  
17 THE COMMISSIONER: Is that for a position which is an  
18 established position? Say you have got a ward clerk, for  
19 example, and your ward clerk leaves and you have to replace  
20 the ward clerk, does that then still take you some weeks  
21 and months to end up with a person in the position.

22  
23 MRS FITZGERALD: Yes.

24  
25 MS FERNANCE: We currently have a position which will be  
26 vacant because of maternity leave in my department. We  
27 have known this obviously for some months. The process  
28 started in February to request recruitment for a 12 month  
29 contract into that position. Her leave starts in three  
30 weeks and I don't even think it has been advertised. I  
31 know it has been entered on what they call Easy Suite but  
32 it's lost somewhere in cyber space, who is approving it,  
33 and this person is likely to be on maternity leave before  
34 the position is filled.

35  
36 MRS FITZGERALD: Deployment of ward staff for escort  
37 duties, as escort nurses may not be available or there  
38 might be more than one patient requiring escort across the  
39 hospital.

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41 THE COMMISSIONER: Expand on that for me.

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43 MS FITZGERALD: We will order the transport depending on  
44 the level of care for the patient. Say if it's a high  
45 level of care, we might need CEA, or it might be  
46 appropriate to use hospital transport and, depending  
47 whether that person is on an infusion or is unstable, they

1 may require a nurse escort usually for the infusion, to  
2 look after the pump. If the escort is not available, the  
3 dedicated escort, then a person from the ward needs to be  
4 taken off the ward from direct patient care and taken just  
5 to manage a pump in that time that it takes to transfer a  
6 patient.

7  
8 THE COMMISSIONER: Where are these transfers going  
9 usually; is it interhospital?

10  
11 MRS FITZGERALD: Interhospital transfers, yes.

12  
13 THE COMMISSIONER: And if you take the infusion pump as an  
14 example, is that a particularly difficult management  
15 problem; does it require a registered nurse or an enrolled  
16 nurse?

17  
18 MS FERNANCE: It requires somebody with the competency to  
19 manage the infusion pump - a nurse. Previously, the  
20 ambulance officers themselves would just manage the pump  
21 because they have overall control of the patients through  
22 their own policy systems, but they request a nurse because  
23 the patient has got an infusion pump.

24  
25 THE COMMISSIONER: In terms of skill and capacity from  
26 your perspective, could a paramedic manage an infusion  
27 pump?

28  
29 MS FERNANCE: Most definitely. I think you would probably  
30 get to the type of infusion pump. There are multiples  
31 throughout the system. Bankstown Hospital here  
32 standardised all their pumps, so you go from one ward to  
33 another ward and it's the same system. That's not the case  
34 in the area. The ambulance, I suppose, would be then  
35 required to know how to press "Stop" on multiple - it's not  
36 insurmountable, though.

37  
38 THE COMMISSIONER: Thank you.

39  
40 MRS FITZGERALD: Also under staffing, we have rare  
41 approval of overtime to cover if we're falling short.  
42 Rather than offering overtime they will try every other  
43 conceivable way of covering it. They don't want to give  
44 overtime. There are staff who might say "Yes, if I am  
45 going to get paid overtime, I might actually work it."

46  
47 Annual leave - previously HR would see what roster you

1 worked previously and give you your shift entitlements.  
2 Now we have to fill out paperwork to get these. It is just  
3 an added bit of paperwork that frustrates nurses.  
4

5 Directives from the Health Department and Area  
6 Health - we find that these increase the workload with no  
7 additional staffing given to us to manage these. An  
8 example is a falls risk assessment and pressure area scale,  
9 which increases the time the nurse must spend with filling  
10 out the paperwork and not actually in the patient care.  
11 Another example is a six-page admission form.  
12

13 THE COMMISSIONER: Take a falls assessment. I appreciate  
14 that is not in one sense direct patient care, but it is an  
15 important element of patient care, isn't it, because you  
16 are thinking to yourself as you do it, "What do I have to  
17 look out for to help this patient move from here to there",  
18 or whatever it may be.  
19

20 MRS FITZGERALD: Certainly. We are not discounting the  
21 importance of that, and yes it can hopefully prevent falls.  
22 But we normally find there is just this exacerbation of  
23 paperwork where we actually don't get to spend that time  
24 with the patient, so we might identify them as having a  
25 risk to fall, but there is less time we can be there with  
26 the patient to prevent them from falls.  
27

28 THE COMMISSIONER: You were about to tell me about  
29 admission forms?  
30

31 MRS FITZGERALD: Yes. There is a six-page admission form  
32 which has been rolled out across the hospital and it is  
33 across the area.  
34

35 THE COMMISSIONER: May I see that?  
36

37 MS FERNANCE: You can have that.  
38

39 THE COMMISSIONER: Is this the one that was based on a  
40 form that was first trialled on the North Coast?  
41

42 MRS FITZGERALD: Yes.  
43

44 THE COMMISSIONER: I appreciate this has additional work,  
45 and I appreciate the problem you raise about that, and I  
46 don't wish to discount that, but is this a useful form? Is  
47 it just full of too much not very helpful information?

1 What is your sense of this form?

2

3 MS FERNANCE: I'd like to see on it a section at least  
4 that says "not applicable". There isn't that. I could  
5 tick "no", "no", "no", "no", but that's not when I have  
6 assessed you for developing a pressure area. So I would  
7 like to see at least clinical judgment taken into  
8 consideration.

9

10 THE COMMISSIONER: Okay.

11

12 MS FERNANCE: A lot of the form then directs you to refer  
13 to allied health. I don't know why it is not  
14 multidisciplinary and allied health can't fill out that  
15 part of the form. We have to leave the patient to go to  
16 the computer to fill out a referral to an allied health  
17 member.

18

19 MRS FITZGERALD: It is also non-specific to specific  
20 areas. It is aimed at aged population, so what might be  
21 applicable to aged patients do not necessarily cover every  
22 patient, so why should every patient have that form filled  
23 out on them and waste our time?

24

25 There is an increase in electronic ordering. The  
26 admission/transfers are done on the computer. We have some  
27 support staff during the day, but after hours that is all  
28 done by nursing staff, and the general increase of time  
29 spent on the computer is away from our patients.

30

31 I will move on to the failure of support services.  
32 Clerks - it has taken over two years to obtain after-hours  
33 ward clerks set out by the Industrial Commissioner. We  
34 received those earlier this year in February. We are very  
35 grateful for them.

36

37 THE COMMISSIONER: What is the typical shift that a ward  
38 clerk works?

39

40 MS FERNANCE: During the day, probably 8 to 4.30.

41

42 MRS FITZGERALD: After-hour ward clerks are shared by  
43 multiple wards. It is first in best dressed. If several  
44 wards are having a busy shift then it is whoever the ward  
45 clerk can get to first.

46

47 THE COMMISSIONER: When you are sharing the clerk, does it

1 matter where they are located? In other words, if the  
2 clerk happens to be squatting in ward X as opposed to ward  
3 Y, is the reality of life that ward X gets all of the  
4 clerk's time?

5  
6 MS FERNANCE: Often that's the case. You can page them to  
7 come. There are some wards within Bankstown Hospital that  
8 will have multiple admissions and discharges - 10 in a  
9 shift. If that form takes an hour and a half, multiplied  
10 by that, and then there is the electronic part, the  
11 admissions and the discharging process which is all  
12 electronic which is all well and good, but we then have to  
13 get to the computer to fill in the electronic part of it.  
14

15 It would be good to have support services in the form  
16 of clerical support to relieve us from doing that clerical  
17 part of putting the notes together. We can page them, but  
18 we are all aware that other wards are probably worse off  
19 than we are, so we all just try to do it ourselves.  
20

21 THE COMMISSIONER: The electronic recording of medical  
22 records as a broad proposition is a very important tool and  
23 a very useful tool. For example, this morning when I was  
24 at Cumberland Hospital, they are able to predict when their  
25 next admission is, if it is coming through the hospital  
26 system, where it is coming from, what level of care will be  
27 required, and when the person is likely to arrive. It is  
28 actually an extremely useful tool.  
29

30 I appreciate your point about the initial workload  
31 involved. I have been wondering whether the input into the  
32 electronic medical records is something that needs to be  
33 done by a nurse, or a doctor - a clinician - or whether it  
34 can be done by a clerk or an administrative person. Do you  
35 have a view about that? Is it clearly one way or the  
36 other, or is it perhaps a mixed issue?  
37

38 MS FERNANCE: I could imagine a little bit of everything -  
39 a little bit of all of the above, but at the end of the day  
40 Cumberland Hospital is probably fed differently to an acute  
41 service. They have probably got a patient who has been  
42 referred to them. They have some control over their entry  
43 and what is going to be required of them to come into the  
44 hospital. We don't necessarily have that control.  
45

46 I am sure there are parts of the electronic medical  
47 record that could be entered by other than a clinician. I

1 don't know what they would be, and they would have to be up  
2 to negotiation and consultation about what we as nurses  
3 think we can do and what we can't do. Part of the problem  
4 is a lack of consultation, I suppose. Right now, if I  
5 wanted to electronically refer to a physiotherapist or a  
6 social worker, only a clinician can do it.

7  
8 THE COMMISSIONER: But does it take you longer to do it  
9 via the keyboard than it would to write it out?

10  
11 MS FERNANCE: No, but I would have written it out at the  
12 bedside with the patient there. I wouldn't have had to  
13 leave the patient to go to the computer. When the concept  
14 was first introduced we were asked how many computers we  
15 wanted and we wanted twice as many as what we got. So  
16 getting access to a computer, logging into that computer -  
17 I have left my patients to go and do it. I think perhaps  
18 if the hardware followed the electronic - maybe there is a  
19 chance for things like that to be introduced, but not  
20 without the consumables, without the software.

21  
22 While I was doing your admission, I would have asked  
23 you specific questions that led to whether you needed to be  
24 referred to one or all of the allied health services and I  
25 could do that while I was still talking to you, but now I  
26 have to leave you to go to the computer to do it.

27  
28 THE COMMISSIONER: So you complete your patient  
29 interaction at the bedside?

30  
31 MS FERNANCE: Yes.

32  
33 THE COMMISSIONER: And then you have to move to the  
34 computer and do your three or four referrals or whatever it  
35 is going to be?

36  
37 MS FERNANCE: That is right and all the other electronic  
38 data.

39  
40 MS FITZGERALD: Still talking about the clerks, leave not  
41 being replaced, inadequate management of leave.

42  
43 THE COMMISSIONER: "Leave not being replaced", is that all  
44 leave?

45  
46 MS FITZGERALD: Not all leave. Maybe two or three clerks  
47 from different wards may have asked for annual leave, and

1 they may all have been approved, but they will only have  
2 one to be replaced and so wards might have to go without or  
3 share for part of that day, and that impacts on the nursing  
4 they have to pick up.

5  
6 THE COMMISSIONER: So no replacement for sick leave?  
7

8 MS FITZGERALD: There may be some.  
9

10 THE COMMISSIONER: I suppose depending how long the person  
11 is away for?  
12

13 MS FERNANCE: Leave at short notice is something that we  
14 have all learnt to adapt to, but even annual leave, leave  
15 with notice, may be replaced by four hours of the day. My  
16 concern would be that they may be taken off the part time,  
17 the after-hours ward clerk roster to fill the day shift.  
18

19 MS FITZGERALD: Also, if it might be for sick leave, or  
20 whatever, then the NUM would be able to replace them. You  
21 already had the workload, and so then it would probably  
22 fall back on a number of nurses to do these things. The  
23 fact that they are not available 24 hours, seven days a  
24 week, we do have some in emergency and medical records but  
25 they are sitting down doing their job down there, and they  
26 are not helping the wards if they have followed the  
27 admissions and discharges.  
28

29 Ward persons - the staff find they are often not  
30 available. Previously this has been due to lack of  
31 staffing. We have actually had an increase in staffing  
32 recently, but we find we have a roster system where we can  
33 look at it and see that we have them for an hour here and  
34 an hour there. We find that when they are due on our ward  
35 they can be called away to do other jobs. They can be  
36 paged, and they will leave our ward. We might have left a  
37 shower for them to do, so then we have to put that back on  
38 our workload and try to get that done.  
39

40 Delays in patient movement - if we need to page a  
41 wardman to transfer a patient to another ward or discharge  
42 a patient, it is all time consuming. They have the wards  
43 there going around trying to give support, and we are  
44 trying to call them away to come and do work for us so we  
45 can continue the patient flow.  
46

47 THE COMMISSIONER: Take your unit where you are, your

1 ward, how many beds are there?

2

3 MRS FITZGERALD: Twenty-four.

4

5 THE COMMISSIONER: Do you have a ward staff person four  
6 hours a day or two hours a day? What do you get with your  
7 24-bed ward?

8

9 MRS FITZGERALD: Maybe two hours maximum. No more than  
10 that.

11

12 THE COMMISSIONER: So when you are discharging patients  
13 and they have to be moved to the transit lounge or  
14 discharge lounge, or home, wherever they are going, who  
15 would usually move those patients?

16

17 MRS FITZGERALD: The wardsmen.

18

19 MS FERNANCE: There are a couple of options. First we  
20 would probably ring the transport department. There's a  
21 nurse who works in the transit lounge, she can often give  
22 us a hand.

23

24 THE COMMISSIONER: So she can come up and pick someone up?

25

26 MS FERNANCE: She can, or one of the nursing staff off the  
27 floor will take the patient down stairs. It depends. If  
28 you really need to get that patient out for whatever  
29 reason, like someone is waiting down stairs in the  
30 10-minute carpark, we may arrange for a family member to  
31 pull up at the hour park and get the patient down there.  
32 We will often do it ourselves.

33

34 THE COMMISSIONER: I was interested to ask because one of  
35 the things which has come to my attention as I travel  
36 around is that one of the reasons for delays at the  
37 emergency department end is the freeing up of beds in  
38 wards. One of the reasons why ward beds are not freed up  
39 is that the discharge procedures are not as efficient or as  
40 timely as they might be, and I was therefore interested to  
41 ask whether the simple consequence of not having a ward  
42 staff member, a ward officer, in fact can be one of the  
43 blockages in that system?

44

45 MS FERNANCE: Of course it can.

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47 THE COMMISSIONER: Please go on.

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MRS FITZGERALD: Also if the ward person is busy doing their jobs and trying to get patients transferred, we might have equipment that we need to transfer for repair and often that is left. Of course it is a lower priority. That might take a couple of days for us to arrange transport, and say "We have this equipment there" and it will take a while, so it is a delay in equipment being fixed or taken to another ward area, wherever it needs to go.

MS FERNANCE: Within the failure of support services there's little anomalies that are sometimes difficult to negotiate. One them might be where a patient comes back from a procedure or from whatever and needs sandwiches; they have missed lunch, they need something to eat. So you ring down stairs to food services, the kitchen, but they are busy plating up the next meal, so they can't bring the sandwiches up. You can ring the transport service and say that you need sandwiches brought up from the kitchen - "We don't do food." You can have little anomalies like that.

We have a system of chutes, Lamson chutes they call them. We send things from one department to another department. I know it took some negotiating a short time ago when we had a tube that was broken, it wasn't working, and we needed something picked up from the pharmacy department to be brought up to the ward, or vice versa - something simple like that. We ring transport and they say, "We don't do that." So there's anomalies within the same hospital, in the same division, that sometimes seem insurmountable. You think the best way to get this done is to go and do it ourselves. Sometimes we have to, sometimes we want to, and sometimes we should, but because we do, those little anomalies never get addressed or fixed and it just seems to be ongoing.

THE COMMISSIONER: Listening to you I understand the problem, but it doesn't immediately appear apparent to me that the transport section would be doing internal deliveries in a hospital. Is that one of its purposes? It sounds to me more like motor vehicles and people going from facility to facility.

MS FERNANCE: There are two branches within the transport service. I am sure people with a better understanding of

1 it than I have would be able to explain it. There is a  
2 wardman, a person who would assist us with clinical  
3 things, and you would have then a porter service just like  
4 you would have someone going around collecting the mail.  
5 You would be able to call them up and say, "Can you take  
6 this scanner from this ward to that ward for me?" Or "Can  
7 you pick up a patient from that ward and bring them to that  
8 diagnostic department to have their test?" So there are  
9 movements of patients and movement of equipment within the  
10 hospital. It's covered by the same service that provides a  
11 driver for the patient vehicle or the hospital ambulance.

12  
13 MRS FITZGERALD: I will move on to security issues.  
14 Security may not be available to the wards in the hospital  
15 when called due to incidents in emergency or in-house.  
16 Should there be an incident in a general ward often we find  
17 that they are tied up, and we are left trying to manage.  
18 That adds to the feeling of staff not feeling safe in the  
19 work environment.

20  
21 THE COMMISSIONER: Can you give me a sense of how often  
22 that would occur? Are you talking about a incident once a  
23 day in the hospital somewhere where the security staff are  
24 tied up, as you are talking about, or are you talking about  
25 that happening less frequently?

26  
27 MRS FITZGERALD: I think from what we hear at the branch  
28 it wouldn't be a daily occurrence. It can come in fits and  
29 starts depending on the patients who are admitted to  
30 hospital and their relatives. You might have a problem  
31 patient, and that might be a daily occurrence for a week,  
32 or however long they are admitted, or it might be an  
33 occurrence once a week or every fortnight.

34  
35 We have security doors in place to secure clinical  
36 areas after hours, but there's also other areas that don't  
37 have those security doors or have them on the front and not  
38 on the back. That can enable patients and relatives who  
39 get to know the hospital to be able to go around the back  
40 and enter the ward after hours. That also adds to staff  
41 not feeling safe in their environment.

42  
43 Moving on to pharmacy, our pharmacy is not open on  
44 Sundays, and it is limited hours on Saturday and after  
45 hours on weekdays. It becomes the job of the nurse or the  
46 nurse manager to get those drugs that we require for the  
47 patients, that are not held as imprest drugs in the ward.

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Moving on to stores, there is no longer --

THE COMMISSIONER: Let me understand that point about pharmacy. Presumably there are going to be three broad categories of medication. You are going to have some medication, I think you called it imprest, which you hold in bulk on the ward and can then access for distribution to the patients. That is relatively straightforward; you just have to keep your supplies at an appropriate level.

Presumably as well, particular patients will have inpatient medication which will be dispensed from the pharmacy - again, subject to storage and the appropriate place and the right quantity, that can be managed relatively easily. What sort of medication then needs to be accessed after hours by the nurse unit manager? What gives rise to that need?

MRS FITZGERALD: The second category, so if a patient gets admitted say at 5 o'clock on a Friday afternoon, we need to find the medication, or we can get a lot of that from imprest, but then what is not on imprest we need to go on to the computer and find out what ward might happen to stock that on their imprest and get it from them, or then to contact the nurse manager to then get it from pharmacy if we can't access it.

THE COMMISSIONER: Or I suppose if a patient being treated after hours requires an additional form of medication that they don't have dispensed by the pharmacy, you need to get hold of it either from your imprest stock, someone else's imprest stock, or else as you say via the pharmacy.

MRS FITZGERALD: Yes.

THE COMMISSIONER: Who has authority to access the medication after hours when the pharmacist is not present?

MS FERNANCE: The after-hours manager traditionally would go into the pharmacy itself. That has been a difficult process up until recently, but there is an after-hours drug cupboard. The nurse managers tell us that they would be in and out of that after-hours drug cupboard on multiple occasions within their shift.

MRS FITZGERALD: Stores - the stores are no longer located

1 in the hospital. It goes to an area storage. That can  
2 often lead to lengthy delays in getting stock. Many of the  
3 problems we have at the moment relates to incorrect stock  
4 getting dispensed; the orders get mixed up; it's not  
5 picked correctly. It takes time to sort out, and the ward  
6 will often be short of crucial stock that we need, and then  
7 we have to try and borrow from other wards.

8

9 THE COMMISSIONER: What is the delay between when you  
10 order and when the stock is delivered, now that it is  
11 coming from off site?

12

13 MS FERNANCE: If we could actually go through the exact  
14 process, the processes involved from the moment the order's  
15 put through at the ward level, to find out where those  
16 delays were, we would be able to fix them. We don't know.  
17 Someone will blame someone who will blame someone  
18 somewhere, and it gets to "the company didn't supply it".  
19 I think the further away they take our stores department,  
20 the longer are the delays in getting those stores, the  
21 consumables, to the clinical areas. It just seems to be an  
22 ongoing problem.

23

24 MRS FITZGERALD: Food services - being short staffed,  
25 unable to provide a full service on occasion, and then that  
26 relates to nurses having to go and do what they would  
27 normally do. Also at the bedside to spend that extra time  
28 opening packages and setting the patients up for meals.  
29 There are longer waiting times in cafeteria if there is  
30 only one staff on. That pretty much covers food services.

31

32 Education and training - clinical nurse consultants  
33 and clinical nurse education positions have not been filled  
34 in a timely manner. New staff don't get the supernumerary  
35 days; usually they are given three supernumerary days, and  
36 often if numbers are short, it is like, "You had one  
37 supernumerary day yesterday, so you had better just go in  
38 and be one of the numbers to look after the patients  
39 today."

40

41 THE COMMISSIONER: Is that new graduates, as well as staff  
42 who are otherwise qualified coming in?

43

44 MRS FITZGERALD: Yes, overseas staff, staff in general.  
45 Workload impacts on the ability of staff to support  
46 newcomers. As we find we are being snowed under, we can  
47 give less support to the new incoming staff and to guide

1 them in the right direction and to ensure that they are  
2 learning appropriately.

3

4 Also there are occasions when the CNEs and CNSs are  
5 made to cover the floor if the floor is short. If we are  
6 short of staff, then they will have to come out of their  
7 offices and that limits their ability to be trained  
8 appropriately.

9

10 Moving on to managers, I would like to bring up the  
11 decreased level of trust between clinical staff and their  
12 managers as set out in the survey by the Workplace Research  
13 Centre at the Uni of Sydney. I think there was a dramatic  
14 drop in the level of trust that we have between the staff  
15 and the managers. We used to always trust our managers  
16 implicitly, and now we tend to not trust them.

17

18 THE COMMISSIONER: Do you know why that is so?

19

20 MRS FITZGERALD: I think the pressures that the managers  
21 have upon them, that they need to reach certain goals and  
22 targets, and the fact that they are not given all they need  
23 to provide for our needs on the ward. Would you like to  
24 add anything else?

25

26 MS FERNANCE: No. I'm one of those managers.

27

28 MRS FITZGERALD: It also impacts on managers. It is a  
29 larger health service area now. The manager is getting  
30 further away and that means that they are less accountable  
31 and responsible for the decisions made.

32

33 THE COMMISSIONER: What level of managers are you talking  
34 about there?

35

36 MS FERNANCE: Probably at the highest level. I got a new  
37 manager when they introduced the clinical streams.

38

39 THE COMMISSIONER: That is a cardiology stream?

40

41 MS FERNANCE: Yes. I have got two now, I suppose. One at  
42 facility level, who does a marvellous job I might add, and  
43 one at the stream level. I am not sure what their roles  
44 are. What you define, "that's the role of the stream  
45 manager" and "that is the role of the facility manager".  
46 So I think at that level, and it may go back to that lack  
47 of consultation again, and just decisions that are made at

1 that level, at the highest of levels, and the impact it  
2 actually has on who is going to implement that terrific  
3 idea, and what impact is that going to have on the patient;  
4 not just the nurse, and not just the support service, but  
5 what impact is implementing that new process going to have  
6 on the patient.

7  
8 I often think that the further away - we are now a  
9 bigger area and management, the highest level, seems to be  
10 further away and buried further with each kilometre. I am  
11 not sure what the answer is, but I would like to see  
12 management come back to the facility, and the facility be  
13 responsible for its triumphs and its mistakes and be  
14 accountable to its own staff population and community.

15  
16 THE COMMISSIONER: I recognise the strength of that  
17 argument and the difficulty of having managers in remote  
18 locations. Of course, some Area Health services that are  
19 much larger than this one have that problem, but  
20 multiplied. There has to be some sensible allocation of  
21 resources across areas, because otherwise segments of the  
22 population miss out. One gets duplication unnecessarily,  
23 and it weakens the provision of services if you have a  
24 cardiac catheter lab in every hospital, for example. As  
25 much as it would be a good idea, you don't have the staff  
26 to support it, so you will necessarily get debates about  
27 where it has to go and how many hours a day it has to work,  
28 and so on.

29  
30 I think there is a real tension there in that sort of  
31 issue as to how centrally you organise the system and how  
32 you organise the system by devolution out to individual  
33 hospitals. I'm not sure there is an easy and obvious  
34 answer. But is there an answer to the stream problem you  
35 are talking about, Ms Fernance, where you have got a  
36 facility manager and a clinical stream manager. That it's  
37 really a matter of communication more than anything else?  
38 A matter of articulation of what everybody does and where  
39 they fit in; where you fit in; what their role is; what  
40 your role is, what issues you can decide here in the  
41 facility and what issues have to be decided on an area  
42 basis? Is that perhaps one of the steps towards resolving  
43 that tension?

44  
45 MS FERNANCE: I suppose possibly, but members come to our  
46 meetings monthly and indicate to us their level of  
47 frustration over the simplest of things; that that system

1 doesn't work with that system, that department doesn't work  
2 with that department, and nobody is listening and nobody is  
3 hearing me, and nobody can do anything about it, and we are  
4 drowning in managers. I don't know about the leadership  
5 part of it. We can talk and talk and talk and try to tell  
6 anybody who will listen to us what our concerns are, what  
7 our situation is, and I know it is not just here at  
8 Bankstown. We all know it is all over the place, but  
9 nurses are still coming and telling us that, for whatever  
10 reason, and every day is different, they are struggling  
11 within the system.

12  
13 THE COMMISSIONER: All right. I understand that.

14  
15 MRS FITZGERALD: I will move on to manipulation of tools.  
16 One instance is interpretation of the nursing hours per  
17 patient per day. Interpretation of the reasonable workload  
18 tool. We have mentioned a little bit before in using  
19 shorter shifts to cover the ward, and multiple start and  
20 finish times are a complication of that.

21  
22 Limitations on our management which we have been kind  
23 of covering. Our nursing unit managers are being tied up  
24 with additional duties limiting their ability to be  
25 clinical managers to ensure patient flow. They are busy  
26 doing staffing, pays, stores, HR.

27  
28 THE COMMISSIONER: Can you tell me - and I appreciate it  
29 will vary - typically how much of a nursing unit manager's  
30 day is spent doing clerical, administrative and similar  
31 tasks that don't require the input of a very senior  
32 clinician? Are you talking half of the day, 70 per cent?

33  
34 MS FERNANCE: I would say 70 per cent of the day would be  
35 work done in the office, taken away from managing the  
36 clinical situation.

37  
38 THE COMMISSIONER: Of that 70 per cent, does it all  
39 require the input of a senior clinician, or is it work that  
40 could be done by someone who does not have your level of  
41 skill and experience?

42  
43 MS FERNANCE: Most definitely work that can be done by  
44 other than a nurse. We are talking about filling out  
45 maternity leave paperwork. If I had a pay inquiry and I  
46 rang the pay office, they would say to go to your NUM  
47 first. Systems like that - stores systems, electronically

1 ordering of consumables - things like that.

2

3 MRS FITZGERALD: Hospital managers cannot make decisions  
4 to recruit into available positions without the approval  
5 from the area, and also financial constraints and  
6 directives from the area. That is it.

7

8 THE COMMISSIONER: Thank you both for telling me about  
9 that. Just before you go there is one thing I wanted to  
10 ask you about. I made a note earlier. Handovers - are  
11 handovers done all in the same way across the hospital, or  
12 do they vary from ward to ward?

13

14 MRS FITZGERALD: They are varied. I know on our ward we  
15 usually go to an area and sit down and give a little  
16 handover. In other wards I know there's trials of walking  
17 around and giving handover in front of each patient.

18

19 THE COMMISSIONER: Is anybody doing tape recording  
20 handovers, dictaphone handovers?

21

22 MS FERNANCE: Not that I'm aware of.

23

24 THE COMMISSIONER: Do you have a view about what is the  
25 most effective form of handover, whether it should be at  
26 the patient's bedside, in whole or in part, or in a room?

27

28 MS FERNANCE: I know they are trialling walk-around  
29 handover. It has its good points and its bad points. A  
30 good point would be that the handover is quicker. The  
31 staff most likely get off on time. The bad point is if you  
32 go into room 1 and get a handover for room 1, you don't  
33 know what has happened to the patients in room 6. So when  
34 the nurse looking after that end of the ward goes on a meal  
35 break and somebody rings up and asks what is happening, you  
36 don't know.

37

38 So I suppose that they all have their benefits and  
39 their limitations, and I suppose just continuing to trial  
40 different methods until we get something that works on  
41 every ward. Some wards are long stay wards, so it may not  
42 suit a ward which has a length of stay of three to five  
43 days; that suits one that has three weeks.

44

45 So I suppose again the consultation and being able to  
46 input what works on one ward, won't work on another. In a  
47 cardiology department I need to find out specific disease

1 related information that is going to direct me to referring  
2 a patient to different allied health areas. That is not  
3 taken into consideration in the new admission form, and  
4 things like that. I think Lorraine touched on that  
5 earlier.

6

7 THE COMMISSIONER: And in your ward, Mrs Fitzgerald, how  
8 do you do a handover?

9

10 MRS FITZGERALD: We go to an allocated area and do an oral  
11 handover.

12

13 THE COMMISSIONER: Of all patients in the ward to all  
14 nurses in the ward?

15

16 MRS FITZGERALD: Yes.

17

18 MS REES: In relation to the multiple starting times and  
19 the shortest shifts, might that be partly referable to  
20 trying to have more flexible working hours to give nurses,  
21 for example, who have young children at school, or need to  
22 care for someone at home?

23

24 MS FERNANCE: We always takes those things into  
25 consideration, and we would do that with the permanent  
26 staff members on each floor. We would have flexible  
27 rostering as far as we could on each individual ward and  
28 the NUM would manage that individually. What makes it  
29 difficult for us is an agency nurse will be booked for a  
30 seven-hour shift instead of an eight-hour shift, so they  
31 may not start until 3.30 with the same finishing time or  
32 they might finish earlier, but a permanent staff member  
33 would have started at 2.30. So we have lost the hour out  
34 of the nursing hour per patient per day, but we have also  
35 lost some handover. So that afternoon shift has handover  
36 and now an hour later they are handing over to someone who  
37 is starting at 3 o'clock and then someone else is handing  
38 over to someone who is starting at 3.30.

39

40 THE COMMISSIONER: Thank you both very much. We will take  
41 a short adjournment now and see if there are any further  
42 witnesses who wish to give evidence in public. If not, we  
43 will resume at about midday and go to the confidential  
44 witnesses.

45

46 ADJOURNMENT OF PUBLIC HEARING

47

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