Statement of Paul Haines

Special Commission of Inquiry into Healthcare Funding

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1. I am a Registered Nurse ('RN') and a Paramedic. I was first registered as a nurse in the United Kingdom following the completion of a Higher Diploma in Nursing from Napier University, Edinburgh in 2003. In 2009 I was registered as a Paramedic in the UK following the completion of a Foundation Degree in Science (Paramedical Science) at St George's Medical School in London.

2. I migrated to Australia in 2012 and was subsequently registered as a nurse in Australia. I was first registered as a Paramedic in Australia in December 2018 when paramedicine was included as a health profession under the National Registration and Accreditation Scheme.

3. I make this statement in my capacity as a member of the New South Wales Nurses and Midwives' Association ('NSWNMA').

4. I am employed by Southern NSW Local Health District and work in the Emergency Department ('ED') of Yass District Hospital ('YDH'). I have worked in the ED since 2016. In 2018 I became a Clinical Nurse Specialist ('CNS') and remain in this role. I currently work on a part-time basis. I am also employed as a Paramedic by the ACT Ambulance Service part-time.

5. YDH is a small regional health service with a 4 bed ED and 10 bed inpatient unit. YDH provides outpatient care services including an outreach midwife, a child and family health nurse, community mental health team, a dietician, a physiotherapist, an occupational therapist, a speech pathologist and dental services.

6. Through the NSWNMA I have been asked by Mr Stuart Jacobs, Principal Solicitor for the Special Commission of Inquiry into Healthcare Funding, to provide a statement to the Inquiry regarding my personal experience of procurement issues.

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7. Below I have detailed four major procurement issues that I have either personally observed or have discussed with colleagues. I have also outlined the impact those issues have had on the delivery of care to patients and the wellbeing of staff.

Stock ordering issues

8. At YDH there previously was no minimum or maximum levels of required stock to be kept within the hospital. I am aware that a project is currently being undertaken to resolve this issue. This project has been initiated by a local nurse who is currently undertaking non-clinical work. To the best of knowledge, other facilities within the LHD do not have any minimum or maximum stock levels.

9. There is no identifiable staff member at YDH that has accountability for the ongoing maintenance of stock levels (e.g. a purchasing officer).

10. Stock is usually ordered when clinicians identify a lack of stock of a particular product, and then place the item on a list to be ordered by a Clinical Support Officer.

11. Multiple people have the authority to order stock however there have been communication issues resulting in gross over or under ordering of various stock items. For example, a large order of a product might be placed on the list and purchased and then before it has arrived, or has been unpacked, another clinician might recognise the lack of stock and initiate an order. There does not appear to be any system to identify or track what stock has been ordered and when.

12. There is also no system to be able to identify which stock items might be reaching their expiry and need to be ordered. For example, forensic blood analysis equipment is seldom used and often expires prior to use. It can appear that we have sufficient stock, but without any mechanism to track expiry dates of stock batches, we can be left with no useable stock.

13. There are many stock items that are seldom used at YDH, but are essential to have (e.g. paediatric emergency airway equipment).

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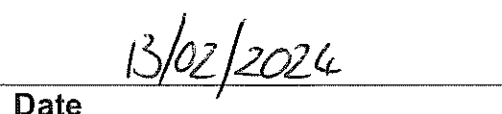

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14. Equipment such as this usually has to be ordered in bulk. Depending on the item, it could be 50-200 units that needs to be purchased as minimum. For a smaller facility like YDH, an appropriate stock level to maintain would be less than 5. If a bulk order is purchased then the majority of this stock will expire before it is able to be used, and has to be disposed of. Aside from the cost of the unused stock being wasted there are costs associated with disposal. Depending on the item, there might be significant costs for disposal e.g. needles and syringes.

15. Ideally, orders for stock for smaller hospitals such as YDH would be shared between hospitals. However, other hospitals within the LHD are often unwilling to share consumable stock items due to each hospital having their own individual cost code. This means anything purchased against the cost code for a hospital will come out of the budget allocated for that hospital.

16. Issues relating to stock can pose a significant risk to patients. In the above example, not having a system in place or a person accountable for management and maintenance of stock levels can result in discovering that stock has expired at the time of intended use.

17. In my view, these unnecessary costs and procurement issues are due to a lack of appropriate processes/procedures in the ordering and managing of stock.

Hospital redevelopment

18. In late 2017/early 2018 it was announced that YDH would be undergoing an $8 million dollar redevelopment.

19. Prior to the commencement of the building works in 2019, I had some informal conversations with building contractors when they were onsite. They indicated to me that the redevelopment wouldn't be as straightforward as they had hoped and

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foresaw lots of issues with the building, due to its age, that meant the project would go well over budget.

20. Health Infrastructure held a consultation with staff before construction began. Staff were provided with plans and asked to provide feedback. I was informed that some staff raised concerns regarding a proposed 'mental health room' that did not allow sufficient observation of a patient. The plans also meant that ED staff would have no view of the waiting room. As we are a small ED (1-2 nurses on each shift) a line of sight to the waiting room is critical to be able to observe patients while they are awaiting review.

21. Unfortunately, that feedback did not result in any of changes being made to the plans for those rooms. Shortly after the refurbishment, there was a serious adverse event involving a mental health patient in the 'mental health room' leading to the patient needing resuscitation.

22. The ability to incidentally observe acutely unwell patients, especially those who might be isolated due to their presentation, is critical to be able to detect deterioration and prevent adverse events.

23. During the project, I asked for a wall clock to be purchased for the refurbished part of the ED but this was not approved. Clocks are an essential tool used by nurses in clinical practice and watches cannot be worn for infection control reasons.

24. When the first big storm came after the refurbishment, water poured through the roof and flooded the ED. We had to divert ambulances and call the SES to cover the roof. Substantial rectification work was then undertaken on the roof.

25. The refurbishment project was not finished properly. The last task that the contractors were undertaking was the painting of the refurbished area. The contractors finished up the job without some of the rooms being painted. As these areas could not be used until they had been painted, nurses from YDH came in on their days off to finish the painting.

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Duress alarms

26. We have not had a functioning duress alarm at YDH in the 7 years I have worked there. Personal duress alarms are an essential tool that supports the safety of staff in the ED. We have had several different systems of duress alarm over the years. Many of these alarms have simply not worked; and where they have worked, we haven't been able to identify the location of the person who has set off their alarm. Where a system theoretically should have been able to identify the location where the alarm has been set off, the system has directed us to the wrong place.

27. As a nurse working in an ED, we encounter many challenging situations that require support to de-escalate. There is a considerable risk of violence on every single shift. This risk for us is compounded by our isolated location and lack of access to timely police assistance 24/7. On a night shift, only one nurse is located in the ED. It is essential that the person working has the ability to quickly and discreetly alert staff in the inpatient unit if they need help.

28. I chair the Health and Safety Committee at YDH and issues relating to duress alarms are a standing item on our meeting agenda and are something staff have raised concerns about on many occasions.

29. I am aware SafeWork NSW have published guidelines on preventing and responding to work-related violence which recommend the use of a duress alarm as the first step in response to a violent work-related incident. These guidelines also outline the need for policies on the 'testing and maintenance of communication and duress equipment'.

30. The local Director of Nursing has started doing regular duress alarm checks however, since the duress alarms are faulty, they are removed and not replaced. Nursing staff have also taken it upon themselves to test equipment and report when they are not functional. We currently do not have enough duress alarms for each staff member in the ED to wear one.

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31. We recently had an agency nurse on a night shift have threats of violence made toward them. They activated their alarm but there was no response due to the alarm not functioning. To the best of my knowledge, that nurse has not returned to work at the hospital due to this incident.

32. From my experience working in other facilities, I know that there are duress alarms available that are functional and fit for purpose. Effective safety mechanisms require appropriate investment. It is frustrating to see the amount of money and effort that has been spent on trying to rectify the current ineffective system without success.

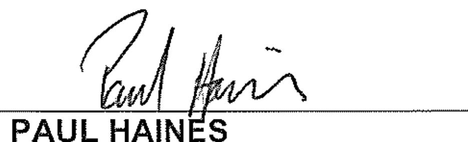
Transfer of patients

33. YDH have a radiography service that currently only operates from 9am – 3:30pm, Monday-Friday. Previously we had access to a radiographer on-call outside of these hours. A few years ago, a decision was made that the service would no longer provide an on-call radiographer.

34. In the ED there are a number of emergency clinical pathways that require an x-ray to be undertaken as soon as possible.

35. Without access to x-ray out of those hours, patients are having to be transferred from YDH to other hospitals (and often in an emergency ambulance) for what is a simple diagnostic test that could be performed at the hospital. The labour cost of providing this service is not only then shifted to a different hospital, but there are much greater costs incurred by the ambulance service.

36. As a paramedic, I am aware of the significant costs involved for using an emergency ambulance service. This includes the labour cost (possibly overtime or on-call) of 2 paramedics along with the costs associated with transport. The nearest hospitals are either 45 minutes or an hour from YDH.



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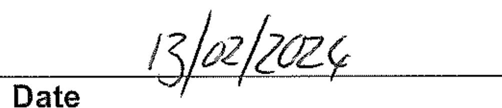

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37. There is also the ethical dilemma and risk of taking the only emergency ambulance out of town for non-emergencies. This cost shifting is designed to reduce local budgets but adds unnecessary expense to the overall health budget.

38. The other consequence of this is the delay and disruption to the delivery of care to patients. Removing this cost from a local budget and shifting to other services also fails to communicate the demand for this service locally.

39. Out of hours there is no access to a patient transfer service for the transfer of patients between hospitals. This also results in patients being transferred to other hospitals or home in an emergency ambulance.

40. The costs of a fully equipped emergency ambulance and paramedic staff costs are significantly higher than for a patient transfer vehicle. Again, these non-emergency transfers can hamper access to an ambulance in an emergency.

END OF STATEMENT

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