**Australian Nursing Federation**
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The Chairman
Education and Health Standing Committee
Legislative Assembly
Parliament House
PERTH WA 6000

The Australian Nursing Federation in Western Australia believes the Inquiry Into the transition and operation of services at Fiona Stanley Hospital is of great necessity because issues at this facility have been both serious and numerous, and directly affecting patient care.

The ANF's submission is only a small sample of the many reports that we received from a survey of our 2,000 members working at the hospital.

Most staff at FSH previously worked for years in high-pressure environments, including the state trauma centre at Royal Perth Hospital and Fremantle Hospital's emergency department, so the concerns these experienced clinicians have raised about patient care being compromised should not be dismissed as merely teething issues.

It should be noted that these serious issues have been occurring in a new health facility, which despite costing taxpayers more than $2 billion, does not even have sufficient numbers of employee parking bays, has had so few staff security ID cards that nurses have been forced to borrow them from colleagues, and has insufficient notice for those working rotating shift rosters. FSH has also not even been providing jumpers for registered nurses and midwives.

When raising the issues in the attached document, we have been mindful of being as specific as possible, without describing scenarios that risk identifying the ANF members who provided the information.

The ANF hopes that this submission we are making on behalf of our members is seen for what it is, a starting point for improvement, and we are willing to speak to the committee if so desired.

Our wish is that this facility succeeds, because it is the workplace of thousands of nurses and we want those frontline health professionals to work in an environment where they can feel confident they are providing the best possible care.

Yours sincerely

Mark Olson

Secretary – ANF IUWP

1. Patients and nurses have been suffering because patient-ratios have been as bad as one nurse allocated up to eight patients, and wards can be up to six FTE short. Many wards also have an inadequate skill mix to provide appropriate care. We have had numerous reports about understaffing from all over the hospital, including critical wards such as cardiology, oncology and the emergency department. Nurses have not been replaced when sick, and are expected to complete their work in shorter shifts. Wards often lack experienced and appropriately skilled staff, which impact patient care. These shortages have meant patients have been deprived of what nurses describe as “the basics”, such as going “without even a wash”, and not having soiled bed sheets and gowns changed in a timely fashion, leaving patients to suffer the indignity of lying longer than they should in dried faeces, blood and urine. Some of the many specific examples provided of the consequences of understaffing are listed below:

    a. Neonates have been put at risk because they have been admitted to the general paediatric ward alongside babies with RSV (respiratory syncytial virus), whooping cough and other illnesses, and we are told this has occurred because the hospital did not open all the cots available in the neonates unit. We believe this was to save money on having more nurses. However, this is a potentially lethal cost-saving measure – as nurses have said: “A two day old next door to a baby with RSV is a recipe for disaster”.

    b. “Very sick or trauma patients” have been put at risk in the emergency department, because it is often so understaffed, amid a high volume of presentations, that nurses and doctors have felt it is “dangerous for patients”.

    c. In the maternity department, staff have reported “often unworkable levels of patient allocation”, making it “difficult or impossible to give a high standard of care to the patients”. Staff have also reported being bullied by management under these harrowing conditions. Nurses say that “frequent inadequate staffing levels for the number of women and babies since day one” is “compromising safety and quality of care”.

    d. Stroke ward nurses have reported “always running short of staff”, and having no permanent Assistant in Nursing (AIN) on the ward, with understaffing resulting in injuries because the few there had to perform multiple turns of their patients, instead of this task being shared among more nurses, or having enough staff to have a turn team.

    e. In mental health units, nurses already accustomed to a challenging work environment, have feared that a lack of staff leaves wards “unsafe”. Concerns have also included that “duress pendants constantly don’t work”, and that there have been Mental Health Act breaches, with formed patients leaving the ward “with no authorised leave forms”. Nurses have resigned because they say they were not provided a “safe and non-abusive work environment”, and because they “fear there will be a major clinical incident”.

f. Neurology ward 6B has been understaffed at night, with only three nurses often allocated for 24 patients. On many nights, there have also been no clinical nurses. Staff feared they would be unable to cope if a “code blue” medical emergency occurred, if even only one nurse was away from the ward getting a patient scanned.

g. Nurses say patient acuity was not considered in the new scheme of staffing wards, which has contributed to understaffing. They describe how “many of our patients require two nurses to do much of the personal care, and wound dressings are numerous”, but “there simply is not enough time to do the job properly”. A lack of ward-based support staff has also been repeatedly identified as directly affecting patient care.

h. Staff also report that across the hospital many wards have been propped up by large numbers of agency staff, and that permanent staff have resigned because of last minute rostering, not being able to get holidays, and being “generally unhappy” with the operation of FSH. Many who remain describe leaving work every day “with the feeling I might’ve forgotten something important and left chaos behind for the next shift”, and then coming to work the next day “feeling that this is unsafe for the patients and for us”. These are comments we have not heard since before the ANF Workloads Full Bench Case in 2001.

2. Patient care has also been severely impacted by services and supplies provided by Serco. This includes having jobs that are logged in the system requiring the attendance of Serco staff, completed well after they are required. This means nurses and doctors have been forced to pick up extra work, to the detriment of patient care.

   a. One example occurred in February in one of the wards opened in Phase 3, involving a patient who required an air mattress following surgery, because he had a high risk of developing pressure sores, and had poor circulation. He did not get the mattress for more than two days, because of supply delays, and also because the product that was delivered was broken. By the time the mattress arrived, the patient's tissue had become necrotic, and amputation was discussed as an option.

   b. Resources which have been daily in short supply have included basics such as dressings; gowns and urine bottles – with bed-ridden patients sometimes forced to urinate in washbowls. Linen that is supposed to have been cleaned has also been returned dirty. Nurses justifiably describe these circumstances as “disgraceful” for an Australian tertiary hospital.

   c. In another case of poor service, a diabetic patient with an insulin pump, who was admitted to ward 2A in April, and who was receiving ongoing haemodialysis three times a week, was missing out on her dinner, because she was not in her bed at mealtime due to her treatment. It was stated it was “too complicated” to get the meal delivered to the dialysis unit, as this is in a

separate building. The patient had to resort to having her husband bring dinner from home, which he re-heated in the dialysis unit microwave. Staff rightfully say this situation is “unacceptable in a world-class facility”.

d. Not having porters on wards has also caused many delays, as nurses have to log a job and simply wait until it is attended to by Serco staff. Nurses describe that Serco staff often arrive to collect patients for a procedure when the patient has already gone to the relevant area, or “has gone home weeks or days” earlier.

3. Patients have been put at risk in operating theatres, because despite a great deal of publicity surrounding issues with how instrumentation returned after sterilisation, incorrect equipment continued to be found in instrument trays opened bedside in operating theatres. Parts of instruments also continued to be missing from such trays. This meant nurses and doctors had to struggle to find the correct instruments, with patients lying anaesthetised on the operating table – which nurses have labelled an outrageous and dangerous situation. This occurred despite alleged “quality checks” that were instituted to combat previous disturbing incidents, where instruments had returned from sterilisation either missing parts or still contaminated with bone and tissue. The Health Department had to take back the service from Serco because of those issues, yet incidents persisted for some time after.

4. The outsourcing of pharmacy services has delayed and complicated the supply of what can be life-saving medication in the Inflammatory Bowel Disease section, where one patient recently died after being given the wrong medication, and another nearly lost their bowel after waiting more than six weeks to get their medication.

5. There have been reports of unnecessary delays for operations for Category 1 elective surgery patients, which are those defined as having the potential to deteriorate quickly to the point where they “may become an emergency”, and also cancer patients have not been getting treatment in a timely fashion because the appointments system has not been working correctly.

6. Insufficient numbers of security swipe ID cards have meant nurses have been forced to waste valuable time scrambling to try to borrow them from others, in order to access the likes of operating theatres where expectant mums were having emergency surgery, or to obtain vital medication. Other sections including rehabilitation have also been affected by the lack of swipe IDs, as have casual agency nurses. Nurses have said a lack of security cards meant not only could they not access certain areas without borrowing a swipe, but they also could not access patient notes, so pivotal clinical information was not being recorded. Staff have rightfully asked what is the point of having a security system using cards, if you are having to borrow them from others?