The Surgical waiting list.

-as an example, a man has straight forward osteo-arthritis of the left hip. He is seen in a regional hospital outpatient clinic by an orthopaedic surgeon from Perth. It is determined that he needs a hip replacement but needs to also be seen at the RPH Orthopaedic Clinic before he can be considered to go on to the surgical waiting list. The wait is 14 months for the first appointment with the RPH Orthopaedic outpatients clinic and then it will be another two year wait on the surgical waiting list. The man is now on Oxycontin for the pain, there will be restricted movement leading to ongoing health effects, obesity from lack of exercise and corresponding follow on effects, increased cardiovascular disease risk, poorer lung function. So if the operation had been done at first diagnosis you would have a low risk, well , healthy patient with quick recovery time and no need for strong painkillers, instead you have a high risk patient with longer recovery time, a much higher use of all hospital resources and the possibility of prescription drug addiction.

GPs in regional areas can't access the hospital waiting list to see if a patient is on it unless you put a request in writing and wait at least four weeks for a response if you are lucky.

Patients are sent back and forward from regional areas to Perth for Specialists visits with no real liaison between GPs and Specialists. Surely the most number of patients should need pre-operatively in most cases is two. One to assess the patient who should be sent with all standard test results for that condition, two to review any further test results that were needed including standard pre-op requirements such as ECG, basic bloods, chest xray.

Mental Health

In one regional area where I worked, no patients assessed by GPs as needing a Psychiatrist due to an acute episode would be able to get an appointment without going through the area mental health unit. If there were no mental health staff in that unit at the time there was no opportunity to get the patient seen by a Psychiatrist. Referral to the local hospital only resulted in the patient being discharged within a few hours from ED or discharged the next day back to the local practice to manage although clearly the GP thought that the patient needed a greater level of care than could be provided.

Hospital Bed Numbers

I thought I saw some statistics from 6-7 years ago that had hospital bed numbers in WA should be 4 beds per 1000 head of population and 6 beds per 1000 head of population in areas of high indigenous populations. The number in 2003/2004 from the Dept of Health and Aging All about Beds was 2.47 per 1000 head of population. Pt Hedland Hospital was around 99 beds, now down to ? 60 beds or less, Geraldton hospital down to 66 beds from 120 beds. And you wonder why there is such a problem in Emergency Departments? I suppose the argument is there have been more resources being put in to Domicillary Care, Hospital in the Home,Palliative Care nurses etc. No beds in the floors above for patients to go to, leave an ED packed with ill people, leaving less room and staff to deal with critically ill patients.

There is also the difficulty in the community of getting patients referred to and seen by the vast raft of nurses and allied health staff apparently available such as Respiratory Nurses, Palliative Care Nurses, Dressing Nurses, HITH, ACAT. The GP and Practice Nurse usually end up trying to manage this patient in the community with the very limited if any time that they have available to do this.

The Role of the Community Nurse Generalist

Would it be possible to have more Community Nurses to be

-the liaison from hospital to home care services

-a resource for specialists to use from major hospitals to ensure all patients to be seen in outpatients clinics had tests needed and results sent with them to appointments, who could also liaise with GPs to help co-ordinate further tests that were required and do general health assessments to anticipate surgery needs to pass on to the Public Hospitals.

-ensure home services were provided such as OT visits for specialist equipment in the home, referral to social workers for family support and resources like respite services.

-resource for GPs to use to ensure HACC and aged care services were provided to their patients when needed.

Hospital Structures

When was the last comprehensive study done to determine the standard of care of patients received from University Graduate nurses Yr 1 to Yr3 as compared to the standard of care received from Hospital Trained nurses Years 1-3 post grad. in a General ward setting (ie. Not Specialist Units). Just asking the question, with all the evidence based nursing that is going on, send me the link if you can find one.

Bring back Charge Nurses on the Ward, the same one day in day out so there is some sort of continuity of care in all areas, patient care, staff training and rosters, staff development, staff support, liaison with Specialists. Different Ward Co-ordinators means no continuity of care, made even worse with the high use of agency staff. Also you have co-ordinators without the necessary skills or experience allocating and moving patients, leading to very poor care of patients and high staff dissatisfaction.

Bring back team nursing. How can you competently care for patients when you might spend two hours of the day away taking patients back and forward for procedures, as well as meal breaks etc? And how can another nurse cover your patients as well as their own if they are doing the same thing. Throw out taped handovers and go back to ward walk around handovers. I can't help thinking that if either of these measures were in place that the maternity patient I read about in an eastern States hospital would not have bled to death over several hours. Patients need to be seen at handover, if nothing else it means that either you as the nurse going off duty have found them all in a stable state at handover and vice versa for the nurse coming on duty.

After returning to the workforce from a long absence from nursing to a major teaching hospital, I found that many RNs could not do an ECG or read it, did not know the procedures for collecting straightforward pathology tests without looking it up, could not put in an IDC or put down a naso-gastric tube, did not adequately complete the preparation for many test that a patient was having performed, did not review fluid balance charts and consider fluid or electrolyte imbalance, or consider the importance of regular observations in reviewing a patient's progress. There should be less emphasis on using a myriad of evidence based forms to determine a patient's likelyhood of developing a DVT, pressure sore, risk of fall etc. and more emphasis on developing well rounded nurses who would provide all this care from a good general knowledge base.

I search for any information on hospitals that may consider re-introducing a team approach but can find very few if any. I think Hollywood Hospital may have something like it and SJOG Murdoch to a certain extent with Graduates. I am hopeful that this would lead to a significant increase in staff morale and thus retention.

Portability

Nurses need to be able to have the opportunity to move from ward to ward when they can, even for a relieving basis to get extra experience. I can't imagine what the cost is from micro-managing each ward.

-staff having to apply for each job-contracts being drawn up for each individual position and each individual level instead of just being employed by the hospital at a certain level and being able to work anywhere.

-Nurse Managers doing HR duties, spending large amounts of time entering hours, leave etc instead of nurses just submitting then own timesheets once a pay period.

-clinical nursing staff doing stores orders, IV fluids and drug orders.

-staff should have more flexibility to work at other hospitals and areas within a health service as well.

-have there been any reviews of this way of managing cost structures in hospitals, the mini accounting unit called the ward I mean, compared to the all of hospital approach to accounting. This review would have to allocate a monetary value to the units of time that clinical staff spend doing these financial, accounting and HR duties.

Chemotherapy and Radiation therapy patients

Patients have told me that although they are public patients and attending public hospitals for their chemotherapy, they are treated as outpatients for their visits and being billed accordingly by the Oncologist. I'm not sure if they are private patients if they would also be billed for the cost of their chemotherapy. Also if they are private patients and they are not admitted to hospital as a day patient for their chemotherapy, this would lead to a huge cost over time for these patients as they are not covered by their private health.

Statistics

There has to be a better way of assessing bed use and patient cost. ICD-10-am is crude in its ability to give more in depth and diverse patient information, that should be possible with modern technology. Patient cost should be weighted by patient age, existing co-morbidities, presenting condition, allied health costs, diagnostic testing costs etc. This algorithm should also hopefully be able to used to anticipate length of stay for the patient and lead to better use of beds within a hospital setting.

The health system is a mess, there has been too much emphasis on the academic and not enough emphasis on the practical care of patients. The health system should work with Doctors, Specialists, Allied Health staff and Nurses to determine what is the best way to tackle certain areas. An example of this is somewhere there were some ENT specialists and anaesthetists who got together to operate on some indigenous children. They did it over a week as a team I think, and I'm not sure how many they did but at least, that would have cleared a bit of the back log for ear operations. There is an orthopaedic surgeon here who is very pro-active in trying to clear the waiting list for hip and knee replacements but people's access to this are limited to the catchment area into which they fall from regional areas. There should be specific areas targeted so that at least something is achieved (small bricks eventually build a house).

Finally

Please don't give us another layer of nurses for this that and the other thing, give us strong community nursing and population health units that can work with GPs, Specialists and hospitals in a more seamless way to provide better preventative care, more inter-active care with patients at home and better access to health services and hospitals.

Kind Regards,

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Registered Nurse.