<u>STATEMENT OF Joanne Margaret Turner</u> of address known to the Queensland Nurses' Union of Employees

Qualifications and experience

1. I am a Level 1 Registered Nurse employed at the Bundaberg Base Hospital in the Renal Unit. I have been employed in the Renal Unit for the past four years on permanent part time basis working five days per fortnight.

2. I can recall an incident which occurred in late 2003 when I was rostered to work an early shift in the Renal Unit. I can recall that enrolled nurse Carolyn Waters and registered nurse Lyn Yeoman were also rostered to work that shift. I was allocated to look after three patients. I can recall that two of these patients had recently had permacaths inserted for haemodialysis. It was my understanding that Dr Patel was the surgeon who had inserted the permacaths in each of the patients. I cannot now recall the names of those two patients.

3. A permacath is a Silastic tube which is inserted into the superior vena cava or right atrium of the heart. The procedure is performed in the operating theatre under strict aseptic technique. There are strict infection control protocols to follow when caring for a patient with a permacath because these catheters pose a high risk for serious infection such as septicaemia.

4. I was required to commence haemodialysis on these two patients and I was unable to withdraw blood from the permacaths. The permacaths were blocked. I was unable to obtain any inflow or outflow from the catheters.

5. I notified the renal registrar at the time. I cannot now recall the registrar's name. He advised me to call Dr Patel.

6. The usual process for unblocking a permacath is:

   a. Firstly, remove the heparin lock. A heparin lock is a bolus dose of heparin, an anti coagulant drug, which is injected into the catheter to stop the blood from clotting at the end of the catheter;

JT

b. Once the heparin is removed, it is then safe to flush the catheter with normal saline using low pressure such as a 20 ml syringe. The smaller the syringe the higher the pressure;

c. If the catheter is not able to be flushed under low pressure, there are other techniques used to assist in unblocking the catheter such as moving the patient into different positions to hopefully dislodge the catheter off the vessel wall and asking the patient to cough to create a positive pressure;

d. If these attempts fail to unblock the catheter, the doctor is notified.

7. I paged Dr Patel and he arrived shortly after. I told him about the difficulty I was experiencing with the two permacaths. He suggested that I flush them with saline and I recall him gesturing wildly and saying "*flush it Sister, just get in there and flush it!*". I was reluctant to flush the catheter because I had not been able to withdraw the heparin lock and told him that. He then said the catheters need to be flushed with Streptokinase. As it was an unusual request I obtained the hospital protocol regarding the use of Streptokinase and showed it to Dr Patel. He then disregarded this idea and said he would just use the saline flush.

8. I had already set up two separate sterile trays for each patient. The patients were situated side by side. He then picked up the sterile syringe without having washed his hands or applying sterile gloves and flushed the line on one patient. I then observed him moving toward the other patient with the same syringe and it was at that point I called to him and said words to the effect that "*this is this patient's set up*" to alert him to the fact that there were two separate sterile setups. I did not wish to appear rude to Dr Patel by stating the obvious which was not to cross contaminate the equipment. He put the syringe back on the first patient's setup. I asked him to put on sterile gloves and his response was "*Sister, I don't have germs*". It is my recollection that registered nurse Lyn Yeoman heard his response as well. At first I thought he was joking but the look on his face

YA

demonstrated to me that he was not joking and that he was annoyed by my insistence that he put on sterile gloves. He continued to attend to the patients but he did not put on sterile gloves when attending to either patient and did not wash his hands after attending one patient and then moving on to the other.

9. While he was attending to the patients I left him and reported the incident to my Clinical Nurse Consultant Robyn Pollock who was in her office. Robyn Pollock and I came out of her office, looked over towards Dr Patel and she could see him performing the procedure without gloves on. I went back to the patients and she returned to her office. She told me later that she had emailed Gail Aylmer, the Infection Control Coordinator, informing her of the incident.

10. When I returned to the patients, I observed that Dr Patel had managed to unblock the catheters.

11. He left the Renal Unit.

12. I attended to the haemodialysis of the patients.

13. I recall later discussing this incident with Robyn Pollock and Gail Aylmer.

........J. M. Turner...........
Signed: Joanne Margaret Turner

Date: 20 June 2005

I, Joanne Margaret Turner do solemnly and sincerely declare that the content of this my statement for the Bundaberg Hospital Commission of Inquiry (this declaration being at the foot of the last page of the statement comprising 3 pages) is true and correct to my knowledge and belief and I make this solemn declaration conscientiously believing the same to be true and by virtue of the provisions of the *Oaths Act 1867*.

....J. M. Turner.................
Joanne Margaret Turner

Declaration Taken By:

.......[signature]....................
Lawyer

Date: 20/6/05

A.