TH/4

BBH ICU
TUESDAY 03rd JUNE 03.

Dear Toni,

Today at 1130, approx, Dr Patel was in the BBH ICU discussing, with NPC Hoffman, CN Sturner and RN Boisen (myself), a patient who is in the unit. Then he said in our hearing that we should warn the staff who are working Thursday and Friday that he would be in the unit for the whole two days while my oesophagectomy is in here, until he leaves the ICU unit".

Having gotten no reply to this statement he then left the unit.

Kay Boisen RN.

TH2

From: Toni Hoffman
To: Glennis Goodman
Date: 18/06/2003 12:03pm
Subject: ICU patient

Dear Glennis,

This is a followup of yesterdays conversation with you concerning the patient in ICU. I wanted to keep you informed of the situation.At yesterdays meeting it was decided to wait another 24 hrs and reassess the pt. In the meanwhile the patient has again gone into AF, developed what looks like a chylothorax,and has some ? feeding coming out of the bottom of his wound. Dr Younis has been in and said that Dr Patel has accepted the patient needs to go to Brisbane and left the JHO to call around to try and find a bed. RBH no longer has a bed,PAH has no bed , neither does the Mater. TPCH said they would really like to help but they cannot as THEY do not have the facilties to care for such major surgery. Both PAH and RBH have expressed their concern at why such surgery was done here when we don't have an intensivist.Meanwhile the patient continues to deteriorate and we have no bed to transfer him to. I think before any more surgery of this type is done here we really have to examine whether we can offer the appropriate follow up care.I feel the patient has been compromised by yesterdays decision and he will be further compromised until an ICU bed is found for him in an ICU with intensivist cover,

regards Toni

TH3

From: Toni Hoffman
To: Darren Keating
Date: 19/06/2003 12:52pm
Subject: ICU patient

Dear Darren and Glennis,

I am writing to inform you of the situation that currently exists in ICU with The post -op patient Mr Graves. As you are aware Mr Graves underwent an oesophagectomy on the 6th June. He subsequently returned to theatre twice for wound dehiscence. He again returned to theatre last evening for repair of leaking jejunostomy. He remains ventilated on .55 % Fio2 and 5 peep. He is becoming more haemodynamically unstable and has been commenced on inotropic support, which is currently being increased. I am writing due to my continuing concern over the lack of sufficient ICU backup to care for a patient who has undergone such extensive surgery.Both the RBH and PAH have expressed concern about this surgery being done in our facility,without this backup.There remains unresolved issues with the behaviour of the surgeon which is confusing for the nursing staff. At present whilst there is consensus regarding transferring this patient to Brisbane there are no beds to be found anywhere in the state. I am very worried that this patients care has been compromised by not sending him to Brisbane on Tuesday, and whilst I realise it is easy to be wise in hindsight, and I do not wish to make an issue of this I would like this to be noted. I believe we are working outside of our scope of practice,for a level one Intensive Care Unit. The reality of the situation which currently exists in ICU is we know have an extremely ill patient who may or may not deteriorate further and the bulk of the responsibility for trying to liase with the two teams has been left to a very junior (but excellent) JHO. The ongoing issues regarding the transfer of patients and the designated level of this ICU may need to be discussed in more detail at a later date. The behaviour of the surgeon in the ICU needs also to be discussed,as certain very disturbing scenarios have occurred.

The current status is that we are awaiting a bed in a tertiary ICU,

Regards

Toni Hoffman

CC: Glennis Goodman

Opened & receipted by Darren Keating
19.6.03 @ 1452

TH4

From: Toni Hoffman
To: Glennis Goodman
Date: 24/06/2003 11:43am
Subject: issue

Dear Glennis,

I spoke with Cathy Fritz about the issue we discussed this am, and she will speak to Darren as I am quite concerned about keeping the other issues we have seperate,

I will update you tomorrow after I talk to Petrea again,

Thanks Toni

Relating to sexual harassment
- Petrea Pilotte

THS

From: Gail Aylmer
To: Allan, Liz; Baxter, Sharon; Hoffman, Toni; Jenkin, Di; Kuhnel, Faye; McDermid, Gwenda; Robinson, Ann; Smith, Karen; Tilsed, Joy; White, Jennifer; Williams, Janice
Date: 3/07/2003 12:13pm
Subject: wound dehisence

Hi all
I am (as I know a number of you are as well) becoming increasing concerned re the number of would dehisence that have occured over the last 6 - 8 weeks. While it does not appear that the dehisence is relating to infection, this needs to be investigated further to identify the cause/s.

Things to consider for example include - how frequently this is occuring? what type of surgery is involved? how many days post-op did the dehiscence occur? who the surgeon, assistants, scrub nurse etc were? what theatre did the surgery occur in? what ward they were nursed on? etc etc

I have investigated a couple, and in those cases the primary post-op dressing was left intact for >24hrs, thereby allowing for a reasonable wound union to occur before the ward staff came near the wound.

Can I ask you to gather any data you may have and come to the Seminar Room Monday 7 July at 0900hrs so we can investigate this situation further. At this stage I have not invited any medical officers.

thanks
Gail

Gail Aylmer
Infection Control Coordinator
Bundaberg Health Service District
Bundaberg Base Hospital
PO Box 34
BUNDABERG Q 4670
Ph: 4150 2273
Fax: 4150 2309

CC: Goodman, Glennis; Kennedy, Carolyn

TH6

From: Toni Hoffman
To: Glennis Goodman
Date: 9/09/2003 12:38pm
Subject: ICU patient

Dear Glennis and Darren,

I am writing to convey my concern regarding a patient in ICU and his ongoing care. P37 was admitted on the 29th August following an MVA , He suffered major chest injuries , multiple # ribs and splenic injuries. He was managed in the unit on CPAP for quite a few days , but has had complications including AF and syncopal attacks. He had a Ct of his chest yesterday, and I am informed he is to go to theatre tomorrow, for drainage of a haemothorax and ?+- ICC and ventilation. I am told that Dr Patel and Martin Carter have come to an agreement , by which Dr Patel will operate only if Martin Carter agrees to not transfer this patient.I wish to convey my concern for this patient and the aftercare that we cannot provide in our unit, I am informed he will also require further surgery for his spleen. I realise the best case scenario is he will just require ICC and short term ventilation , but my previous experience with a patient with these injuries, of this age, is they usually require longer term intensivist management and should have the back up of a cardiothoracic team , should there be complications, This Patients' rib # are very severe. I have discussed my concerns with Martin this morning,but wish to convey these to you both , as I feel we should have some guidelines about what type of surgery should be done here, in relation to our folowup care and the services we can provide.

Regards

Toni Hoffman

CC: Darren Keating

TH7

From: Toni Hoffman
To: Carolyn Kennedy
Date: 10/09/2003 9:25am
Subject: get me out of here

Dear CK,

I think I will be going the same way as GG as I can't stand this unit any more, They are going ahead with that op, we already have another vent and 4 other patients.I can't do any of the stuff i'm supposed to do when i can't get my admin days Martin doesn't communicate with me, bhe just makes deals with patel. Do you know anywhere I could go , even MT perry is looking better than this place any longer,

MAJOR GRUMBLE GUTS IN NEED OF SOMETHING.

t

TH8

From: Toni Hoffman
To: Darren Keating
Date: 6/11/2003 8:45am
Subject: Behaviour

Dear Darren

I just want to let you know of another issue with Dr Quresshi. There have been 3 occasions when he has behaved somewhat inapproriately with nursing staff (he squashed them up against the wall). The nurse involved thought the first 2 times it was a strange co-incidence. He "ran" into this nurse again yesterday. There is nothing one could say to actually state that a deliberate action occurred. Another nurse also reported the same type of behaviour, once again nothing you can really report, I wasn't going to report it as it seemed too airy -fairy but I thought I should just alert you to the fact. The nurse would probaly tell you about it, bu t I doubt put in a formal complaint.

If you need any more info or anything I am on 2254,

Toni

10

TH9

From: Toni Hoffman
To: Paddy Martin
Date: 25/02/2004 1:16pm
Subject: ICU on Saturday

Dear Patrick,

On Saturday an elective apronectomy was done on a patient, P50 , for whom they knew an ICU bed would be required + - ventilation, The ICU already had one ventilator and 4 other patients. P50 would have been their 6th patient. They had 3 staff rostered. Larka Fenton was called in. They had 2 other admissions from DEM. They were 18hrs under for that shift, 9 hrs 46 under for the evening and 6 for the night, On Sun am they were 7 hrs under. Jan Marks came in on her day off on Sat night, and Ann- Marie Soderstrom deployed here on the Sun am. They had 3 ventilated patients on Sunday AM. Two were transferred out. I imagine the AHNM tried as hard as they could to obtain more staff but were unable to do so. ICU may have been unable to take P50 from OT until more staff were obtained. Apart from being told it was a very busy weekend, and the decision to go ahead with an elective apronectomy on a pat with multiple medical problems, I have not been informed of any other issues that occurred and the staff have not complained to me of the workload. In ICU we accept that we will have busy periods where staff will work under and there will be corresponding times when the opposite will occur. If the situation was dangerous or unsafe, I believe the staff would have informed me before now, even with such terrible hours,

R/ Toni

Toni Hoffman NUM
ICU/CCU
PO Box 34
Bundaberg Q 4670
Ph:
Fax:

enqu rew - Feb 04

Document handed unofficially to Peter Leck. asked him not to "act upon issue yet"

TH10

ICU ISSUES WITH VENTILATED PATIENTS;

Designated level one unit, capable of ventilation for short periods of time 24-48hrs. Consistently exceed this. Can do this for short periods of time, but not longer than a few days. Level of Unit made clear to surgeons and this has appeared to distress some of the surgeons when their patients are going to require long term ventilation and be moved to Brisbane. Usually the process works well except when Dr Patel's patients are involved. When Dr Patel first came to BBH it was explained to him that we do not have the resources to ventilate long term patients. He then stated he would not practice medicine like this and would resign. He stated that he would not transfer his patients to other hospitals. He has consistently denigrated the ICU and made such comments such as:

"This would not have been missed on the wards" (Gentamycin being written up by physicians.)

He stated to one of the R.N's that he had "contacts" in Brisbane and would use them to block a patient being transferred. Dr Patel consistently vents his frustration at the current system by being insulting to the nurses and the ICU. He consistently talks loudly to his PHO and JHO about "How difficult it is to work in this ICU" How backward it is and how it is like working in the third world for him. He does not usually do ward rounds with the ICU physician and this causes problems with the ICU nursing staff when they are receiving conflicting orders about treatment. Dr Patel will not converse with the NUM.

The Director of the Unit, Dr Carter, is usually supportive and proactive about transferring patients, except when Dr Patel's patients are concerned. Dr Patel creates such an atmosphere of fear and intimidation in the unit that his behaviour is rarely challenged. Dr Patel has repeatedly threatened to

A) Resign
B) Not put any elective surgery in ICU.
C) Complain to the Medical Director
D) Refuse to complain to the Medical Director any more and go "straight to Peter Leck" as "I have earned him ½ million dollars this year."

Dr Carter has approached the NUM several times about increasing the Nursing FTEs so that we can "care for Dr Patel's patients properly". It was explained to him that it is a complicated process that requires much more than an increase in FTE's. We do not need more nurses when we are acting in our designated capacity. It is when we consistently act outside of this role for extended periods of time that these issues arise.

. There is such a feeling of disunity in the ICU at present, it is upsetting to the nurses and they literally refuse to care for Dr Patel's patients because of the disunity that exists. With Dr Patel's ventilated Patients it needs to be again reiterated that they will need to be retrieved to Brisbane after 24-48 hrs , or sooner if there are two ventilators in ICU. The admission and discharge policy of ICU must be adhered to.

On several occasions when Dr Patel's Patients have been in the ICU, he has refused to transfer his patient to Brisbane, even when the patients have deteriorated and have been in ICU for much longer than 24-48 hrs.

I have voiced my concern regarding the level of care required for some of Dr Patel's patients several times. I have accompanied Dr Jon Joiner to meet with Dr Darren Keating when the issue of doing oesophagectomies has arisen in the unit.

This week we had a critically ill patient transferred back to ICU in extremis. He was a 46 year old male with a crush injury to his chest, multiple # ribs and a flail segment. He was shocked, in pain, tachycardic and hypotensive. The Anaesthetist in charge attempted to place an arterial line and a central line as well as transfuse the patient. At one point the patient went into ventricular standstill. Dr Patel was seen to make a comment to another surgeon and laugh. Dr Patel repeatedly stated in a loud voice the comments that this patient did not need to be transferred to Brisbane. He stated the patient did not need a thoracic surgeon. He asked the PHO "how much trauma had he done". He went on to say "no more trauma should be done at this hospital, if we cannot handle it" All of these comments were said in front of staff and other patients. A bed was arranged at PAH, and booked at around 1430 hrs. The clinical coordinator only needed to be notified to organise the retrieval. It was decided, before the

clinical coordinator would be called a CT needed to be done. There was a delay in obtaining an anaesthetist due to one being required for a perforated bowel. Dr Patel insisted the surgery for the perforated bowel be performed prior to the CT, despite the patient requiring ongoing resuscitation. I called Dr Carter and he agreed to transport the pt to CT. On return from CT it was agreed the patient would be transferred to Brisbane. I had previously voiced my concerns to Dr Gaffield that although I had heard Dr Patel say the patient did not need transfer as he did not need a thoracic surgeon, there were other issues such as a lack of pathology and blood bank support and the fact we did not have an intensivist or other equipment. The patient was sent to CT and then it was decided to definitively transfer him to Brisbane. There was some delay in contacting the clinical coordinator as they were doing a ward round. After about fifteen minutes the clinical coordinator phoned back and spoke with Dr James Boyd. This was about 1930 hrs, 4-5 hrs post the initial confirmation of the bed being available at the P.A. During this time Dr Younis had been trying to resuscitate the patient, insert central and arterial lines, administer blood and intubate and ventilate the patient. Three ICU nurses were involved with this patient throughout his stay. The Retrieval team arrived about 2215 and whilst attempting to prepare the patient for transfer he deteriorated and died.

My concerns are:

The staff in the ICU is expected to function outside of the role of the level one unit.

The behaviour of Dr Patel in intimidating, bullying, harassing and insulting the staff in ICU.

The interference of Dr Patel with this particular patient which delayed his transfer. (Dr Patel was asked to review the patient).

My concern that the personal beliefs of DR Patel concerning the types of patients he can care for here, actually endangers the lives of the patients as these patients that would be transferred to Brisbane are not being transferred early enough.

A Secondary concern of mine is the level of surgery which is performed that should only be performed in a tertiary hospital.

ASPIC minutes [illegible] Keating present.

BUNDABERG HEALTH SERVICE DISTRICT
RECORD OF MEETING

② Issues surrounding ICW & transferring of patients raised here officially again

Meeting of: ASPIC CLINICAL FORUM

Meeting No: 04/04

Date: 14 th April 2004 **Start Time:** 1220

Present: Martin Carter, Toni Hoffman, Darren Keating, Gail Aylmer, Gwenda Mc Dermid, Jenny White, Margie Mears, Di Jenkins,Karen Smith,Joan Dooley (guest speaker)

Apologies: Leonie Raven, Jenny Kirby,Jayant Patel.

Confirmation of Minutes: Martin Carter. **Seconded:** Karen Smith

Minute Taker: Toni Hoffman

Correspondence: nil

BUSINESS ARISING

Item No.	Topic	Discussion	Agreed Action, Person Responsible, and Time Frame
02/03-.1	Regional Analgesia Post op Pain	Forms are with Information Management being formatted.	Martin Carter.

TH11

BUSINESS ARISING (Continued)

Item No.	Topic	Discussion	Agreed Action, Person Responsible, and Time Frame
10/03-3	Infection Control Policies	This item has been placed on here by mistake for removal.	Remove
11/03-5	Colonoscopy Consents/ Bone Marrow Biopsys..	Overall working out well. Discussion ensued about where the consents are being done. Ongoing conversation and issue hold over to next meeting for further discussion	Peter Leck/ Darren Keating/ Margie Mears.
02/04-6	Risk management	Risk Register, ongoing .	All members.

Standing Agenda

Item No.	Topic	Discussion	Agreed Action, Person Responsible, and Time Frame
04/04-1	Performance Monitoring monthly performance and Cost Centre Reports.	All areas had increased activity, Budgets: DSU slightly over, increased activity and high cost drugs. OT: increased activity and high cost of drugs as well, over budget. PAC: 52 more pts seen Margie questioned why complaints don't come to them for review, Darren replied they would if they were serious enough or needed investigation. Process will improve with new adverse events policies. Anaesthetics: Martin has found his report fascinating and is examining it in minute detail (needs to get a life). Surgical; High acuity but within Budget. ICU: several long term vents for long periods OT budget way over, But overall remains in Budget, Director Of Anaesthesia / Surgery and NUM of ICU +-DMS or DNS need to have a proactive meeting about transferring ventilated patients. Theatre bookings: Muddy doesn't have any money, Darren won't give her any.	All members.
04/04-2	Infection Control	Gail Aylmer gave the Infection stats which looked very good, Some discussion ensued about how infections are reported. Gail is going to some workshops/ inservices and will feed back about this on her return.	Gail Aylmer and all Staff (responsibility to report)

4/04-3	Quality Management	Press-Ganey Report. Martin spoke on what he has done in relation to this and the Response regarding Pain control. Presented a case for an acute pain service run by nursing staff, which he will table with the appropriate people. Communication problems need to be addressed, as this is the main cause for concern ICU will look at how it can improve communication across the streams. All areas to look at how communication can be improved.	Martin Carter. ICU (will report back to next ASPIC meeting) All staff
4/04-4	Theatre Booking Report	ongoing	Karen Smith.

IEW BUSINESS

tem No.	Topic	Discussion	Agreed Action, Person Responsible, and Time Frame
	Listen to the Voices	Joan Dooley, Project officer, gave an overview about the Consumer and Community Participation Project. Surgical Ward and DEM are the pilot sites for this in the hospital.	Joan Dooley Project Officer.
	Wound Dehiscence.	Concern was raised by members of the group about where the numbers of wound dehiscence are being captured. If it is not identified in discharge summaries or picked up by coders, it could be missed, as some patients are experiencing wound dehiscence in the ward, some at home etc. Staff feel there has been an increase in wound dehiscence, but we have no stats at the moment. It was agreed that all areas would let Di know as a central person if a wound dehiscence has occurred, and we will look at how we are going to capture this data, First action is to fill in an adverse event form and sent to	All Members.

		Dqdsu. A definition of wound dehiscence was also requested.	
	MI Chart Audit	Presented as an example of the interesting information that can be gleaned form chart audits, and what can be learned from putting the qualitative data with the quantitative.	Resolved.

eeting Closed: 1240

ext Meeting: 12th May 2004

TH12

From: Linda Mulligan
To: Level Three Nursing Officers
Date: 23/04/2004 10:16am
Subject: Individual Meetings with me

Hi everyone-I thought I better let you know some of the things I would like us to discuss on our meetings that are coming up, since time will at a premium. As stated since I am new I would like to chat to you re the following in that meeting, so please come prepared:

*about your professional background, including any of your qualifications.

*If you have responsibilities for a unit with staff other than yourself I would like to know in writing how many Level 2, 1 ,ENs or AINs you have both in numbers and FTEs, and the part-time vs full time equivalents status.

*Staffs's qualifications relevant to your area, and any plans re staff development re the same

*Major accomplishments and issues for the area you are responsible for including budgetary status

*What you would change in nursing services or the organisation if you had an opportunity to ie what things do you really think are done poorly?? Plus your solutions for the same.

*Time frames for your PAD-ie when is it next due?

*Anything else you might like to raise for further discussion as we will be limited to an hour each.

I hope you all have a great weekend-I will be doing more packing (boy one never realizes how much they have till they move), see you all next week. Cheers Linda

Mrs Linda Mulligan
District Director of Nursing Services
Bundaberg Health Service
PO Box 34
Bundaberg Queensland 4670

Phone 07
Fax 07

Mrs Linda Mulligan
District Director of Nursing Services
Bundaberg Health Service
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Mrs Linda Mulligan
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PO Box 34
Bundaberg Queensland 4670

Phone 07
Fax 07

Mrs Linda Mulligan
District Director of Nursing Services

W

LINDAS COMPLAINT TH13

TEMPLATE TOLD AT NURSING 3/5/?? CAN'T TALK TO EACH OTHER

BUNDABERG HEALTH SERVICE DISTRICT

Enquiries to: Name, position

Telephone:
Facsimile:
Our Ref:

Dear (Staff member Name)

I am in receipt of a complaint concerning your alleged behaviour from a client (Client Name), on his recent visit to the "relevant details". The details of this complaint are attached in a copy of correspondence documented after receipt of the verbal or written complaint from "Client Name",.

I am required to ascertain whether there is any evidence to substantiate the allegations and therefore ask that you provide a written response in regards to these allegations to by the Close of Bussiness on (date).

To ensure the integrity of the investigation into the complaint against you, and to maintain utmost confidentiality of the process, it is expected that you do not discuss these allegations with any staff member or with (Client name) who has made this complaint against you. Should you fail to follow this lawful direction, disciplinary action may be instigated.

Should you need support through this complaint process, the Employee Assistance Service offers a confidential counselling service to all employees of Bundaberg Health Service District and they may be contacted on (07) 4152 2105. Additionally, you may wish to seek support of your relevant industrial group.

If you have any queries in relation to this process please do not hesitate to contact me re the same.

Yours sincerely,

(Name)
Nurse Unit Manager/Nurse Manager/Clinical Nurse Consultant
01/01/01

Office
Queensland Health
Bundaberg Health Service District
Bourbong Street
BUNDABERG 4670

Postal
PO Box 34
BUNDABERG 4670

Phone
4150 2025

Fax
4150 2029

W

TH14

TONI'S MEETINGS WITH DDON

17 MARCH 2005	1.30	RE ICU SUBMISSION
13 JANUARY 2005 (TONI, DI JENKIN & GAIL DOHERTY)	2.30	RE A CONFIDENTIAL MATTER
7 JANUARY 2005	11.00	RE ADON ACTIVITIES
23 SEPTEMBER 2004 (TONI & DILYS CARTER	9.00	RE HEARTSTART CONSENT
5 AUGUST 2004	12.30	RE PAD WAYNE JOHN
8 JULY 2004	11.00	RE PAD
25 JUNE 2004	11.00	RE ISSUE
17 JUNE 2004	3.00	RE CONCERN
11 MAY 2004	4.00	

W

THIS

28/3/04

REPORT ON INCIDENT ON 4-5TH MARCH BY KAY BOISEN (BBHICU)

PATIENT: P40
SURGEON: Dr. Patel
ANAESTHETIST: Dr. Berens
NURSE: Kay Boisen RN

Dear Toni,

On March 4th, Dr. Berens discussed with Dr. Patel, his concerns about P40, in my presence. This discussion focused on the patient's slow improvement, his ongoing problems and current deteriorating ventilatory status. As we had two ventilated patients in the unit, Dr. Berens suggested that P40 be transferred to a Brisbane ICU. Dr. Patel stated forcefully that he was going to approach the executive about staffing increases in the Bundaberg Base Hospital ICU, to accommodate post-op ventilated patients. Dr. Patel considered that if the BBHICU could not accommodate post-op ventilated patients, the hospital "would lose a lot of money". Dr. Patel then commented further, that he may have to consider not operating on any patient requiring post-operative care in this unit. Following this debate, Dr. Anderson reviewed P40 and advised that he warranted further surgery. P40 was returned to theatre, the same evening.

On the 5th March 2004, at around 4 pm, Dr. Patel reviewed P40. Dr. Berens was also in the unit at the same time. During this ICU visit, Dr. Patel told me that he had attended a meeting with members of the Executive, including Mr. Leck, and Ms. Hoffman. Dr. Patel stated that despite him telling both Mr. Leck and Ms. Hoffman that the unit was understaffed, they informed him that the unit was fully staffed. Dr. Patel commented that "it's not very good when you boss doesn't support you". I responded that the unit was fully staffed for a Level 1 ICU, which is only meant to cater for one ventilated patient for a duration of 24 to 48 hours. I felt as though Dr. Patel was indicating that Ms. Hoffman wasn't supportive of the BBHICU or the unit staff. Dr. Patel then immediately repeated his same statement about the unit being understaffed to Dr. Berens. Since this statement was in my presence, I reiterated the limitations of the unit's level 1 status, again, before Dr. Patel left the ICU.

Yours sincerely,

K Boisen RN

W

29th July 2004

TH16

ICU ISSUES WITH VENTILATED PATIENTS;

BBH ICU is a
Designated level one unit, capable of ventilation for short periods of time 24-48hrs. Consistently exceed this. Can do this for short periods of time, but not longer than a few days. Level of Unit made clear to surgeons and this has appeared to distress one of the surgeons when their patients are going to require long term ventilation and be moved to Brisbane. Usually the process works well except when Dr Patel's patients are involved. When Dr Patel first came to BBH it was explained to him that we do not have the resources to ventilate long term patients. He then stated he would "not practice medicine like this and would resign". He stated that he "would not transfer his patients to other hospitals". He has consistently denigrated the ICU and made such comments such as:

"This would not have been missed on the wards" (Gentamicin being written up by physicians.)

He stated to one of the R.N's that he had "contacts" in Brisbane and would use them to block a patient being transferred. Dr Patel consistently vents his frustration at the current system by being insulting to the nurses and the ICU. He consistently talks loudly to his PHO and JHO about "How difficult it is to work in this ICU" How backward it is and how it is like working in the third world for him. He does not usually do ward rounds with the ICU physician and this causes problems with the ICU nursing staff when they are receiving conflicting orders about treatment. Dr Patel will not converse with the NUM. Dr Patel has attempted to cause conflict with the staff in ICU, By stating the NUM is unsupportive of her staff.

The Director of the Unit, Dr Carter, is usually supportive and proactive about transferring patients, except when Dr Patel's patients are concerned. Dr Patel creates such an atmosphere of fear and intimidation in the unit that his behaviour is rarely challenged. Dr Patel has repeatedly threatened to

A) Resign
B) Not put any elective surgery in ICU.
C) Complain to the Medical Director
D) Refuse to complain to the Medical Director any more and go "straight to Peter Leck" as "I have earned him ½ million dollars this year."

Dr Carter has approached the NUM several times about increasing the Nursing FTEs so that we can "care for Dr Patel's patients properly". It was explained to him that it is a complicated process that requires much more than an increase in FTE's. We do not need more nurses when we are acting in our designated capacity. It is when we consistently act outside of this role for extended periods of time that these issues arise.

. There is such a feeling of disunity in the ICU at present, it is upsetting to the nurses, every time we have a patient of Dr Patels's the staff anticipate an argument. When Dr Patel's ventilated Patients require ongoing care or have been ventilated for longer than 24-48 hrs ,it needs to be reiterated that they will need to be retrieved to Brisbane after 24-48 hrs , or sooner if there are two ventilators in ICU. The admission and discharge policy of ICU must be adhered to.

On several occasions when Dr Patel's Patients have been in the ICU, he has refused to transfer his patient to Brisbane, even when the patients have deteriorated and have been in ICU for much longer than 24-48 hrs. He has done this when a bed has already been obtained. This has, on several occasions placed the patient in jeopardy as they have further deteriorated

I have voiced my concern regarding the level of care required for some of Dr Patel's patients several times. I have accompanied Dr Jon Joiner to meet with Dr Darren Keating when the issue of doing oesophagectomies has arisen in the unit.

This week we had a critically ill patient transferred back to ICU in extremis. He was a 46 year old male with a crush injury to his chest, multiple # ribs and a flail segment. He was shocked, in pain, tachycardic and hypotensive. The Anaesthetist in charge attempted to place an arterial line and a central line as well as transfuse the patient. At one point the patient went

into ventricular standstill. Dr Patel was seen to make a comment to another surgeon and laugh. Dr Patel repeatedly stated in a loud voice the comments that this patient did not need to be transferred to Brisbane. He stated the patient did not need a thoracic surgeon. He asked the PHO "how much trauma had he done". He went on to say "no more trauma should be done at this hospital, if we cannot handle it" All of these comments were said in front of staff and other patients. A bed was arranged at PAH, and booked at around 1430 hrs. The clinical coordinator only needed to be notified to organise the retrieval. It was decided, before the clinical coordinator would be called a CT needed to be done. There was a delay in obtaining an anaesthetist due to one being required for a perforated bowel. Dr Patel insisted the surgery for the perforated bowel be performed prior to the CT, despite the patient requiring ongoing resuscitation. I called Dr Carter and he agreed to transport the pt to CT. On return from CT it was agreed the patient would be transferred to Brisbane. I had previously voiced my concerns to Dr Gaffield that although I had heard Dr Patel say the patient did not need transfer as he did not need a thoracic surgeon, there were other issues such as a lack of pathology and blood bank support and the fact we did not have an intensivist or other equipment. The patient was sent to CT and then it was decided to definitively transfer him to Brisbane. There was some delay in contacting the clinical coordinator as they were doing a ward round. After about fifteen minutes the clinical coordinator phoned back and spoke with Dr James Boyd. This was about 1930 hrs, 4-5 hrs post the initial confirmation of the bed being available at the P.A. During this time Dr Younis had been trying to resuscitate the patient, insert central and arterial lines, administer blood and intubate and ventilate the patient. Three ICU nurses were involved with this patient throughout his stay. The Retrieval team arrived about 2215 and whilst attempting to prepare the patient for transfer he deteriorated and died.

My concerns are:

The staff in the ICU is expected to function outside of the role of the level one unit, repeatedly when the limitations of the unit are well known.

The behaviour of Dr Patel in intimidating, bullying, harassing and insulting the staff in ICU continues.

The interference of Dr Patel with this particular patient which delayed his transfer. (Dr Patel was asked to review the patient). This delay may have contributed to the outcome of this patient.

My concern that the personal beliefs of Dr Patel concerning the types of patients he can care for here, actually endangers the lives of the patients as these patients that would be transferred to Brisbane are not being transferred early enough.

A Secondary concern of mine is the level of surgery which is performed that should only be performed in a tertiary hospital.

TH17

From: Paddy Martin
To: Toni Hoffman
Date: 30/07/2004 1:28pm
Subject: Re: for your opinion,

Wow Love, that's all pretty heavy. It's very good though. My experience with Darren is to stick to facts and figures and not to be emotive. He absolutely turns off emotive approaches. Quotes percentages and figures to him and he responds much more favourably.

Anyway, I'm baaaaaackkk!

>>> Toni Hoffman 07/30/04 01:01pm >>>

for your opinion,
Hol Bol

Toni Hoffman NUM
ICU/CCU
PO Box 34
Bundaberg Q 4670
Ph:
Fax:

Patricks response to how Darren would respond to my statement

TH18

From: Toni Hoffman
To: Martin Carter
Date: 4/08/2004 11:18am
Subject: Re: ICUISS~3

tHANKS mARTIN,
the other 3 staff who cared for this pt are writing statements. I will get you copies. The QNU legal people have been involved and I hope we can prevent a repeat of this, as I believe we give good care here, part of that is recogniseing when we need to transfer people out, I want to continue our good care and our working as a team. and stop his disruption,
Toni

Toni Hoffman NUM
ICU/CCU
PO Box 34
Bundaberg Q 4670
Ph:
Fax:

>>> Martin Carter 4/08/2004 10:18:07 >>>
Hopefully, this is what you were after

MARIAN CARTER'S STATEMENT REGARDING MR BRAMICH.

Case Report – Desmond Bramich

TH19

Desmond Bramich
DOB 15/4/48
Deceased 28/7/04

This gentleman was admitted through the emergency department at 1946 following a trauma call. He had sustained a crush injury to the right side of his chest when he had been trapped under his caravan for ten minutes approximately three hours earlier. He was transferred to the hospital from the accident site by helicopter.

On arrival his observations were noted to be

Respirations	30
Saturations	96%
Pulse	107
Blood Pressure	147/93
Haemoglobin	153

His past medical history included gastritis, haemochromatosis, Hepatitis A and Left Bundle Branch Block (LBBB).

Bilateral large bore cannulae were inserted as was an intercostal drain (under ketamine and morphine.

The trauma screen radiography showed an enlarged heart, a right sided chest tube, subcutaneous emphysema, ?contusion ?inflammation to the right lung and probable fractures to the 6th and 7th ribs on the right.

The abdomino-thoracic CT showed bilateral fractured ribs, bilateral pneumothoraces with a right sided intercostal catheter. There was extensive surgical emphysema over the right hemithorax with mediastinal air extending into the neck. Pulmonary contusions were also noted. There was no intra-abdominal pathology demonstrated.

The possibility of cardiac contusion was considered and serum troponin measured. The level was 0.04 (just significant). Any other diagnostic criteria were complicated by the pre-existing LBBB.

He was admitted to the Intensive Care Unit for overnight observation.

On the following day, the 26th he was sufficiently awake and comfortable to be discharged to the surgical ward on a patient controlled analgesia regime. His chest radiograph showed collapse and consolidation on the right with multiple rib fractures.

He continued well until about 1300 on the 27th when he collapsed with a recorded blood pressure of 50 systolic. The floor anaesthetist was contacted and went to the surgical ward to assess the patient who was in acute respiratory distress and haemodynamically unstable. A haemoglobin taken during this phase showed a level of 77. The patient's conscious level was fluctuating and he was complaining of severe chest pain. The Right sided intercostal drain was noted to be non-functional at this time. The patient was, therefore, transferred to the Intensive Care unit

Upon arrival in the Intensive Care Unit a second intercostal drain was inserted at the request of the anaesthetist whilst the patient was intubated for respiratory support. The Director of Anaesthetics was called to review and advise on further management of the patient. His decision was to arrange for the patient to be transferred to a tertiary centre in Brisbane, where the capacity to provide thoracic surgery, long term ventilatory support and a blood bank with the capacity to provide products for massive transfusion were co-located. The flight coordinator was contacted at 1620 to arrange a retrieval flight.

In the interim a further abdomino-thoracic CT was performed to exclude an intra-abdominal catastrophe. This demonstrated marked change with the right hemithorax being full of blood with a mass displacement of the mediastinum to the left. There was no evidence of pericardial fluid.

Fluid resuscitation continued, the patient receiving in all:-

- 11 units of blood,
- 4 units of fresh frozen plasma,
- 3,000 ml crystalloid
- and 2,000 ml colloid.

Despite this the patient remained hypotensive and was commenced on vasopressor agents.

The Director of Surgery reviewed the patient and decided to do an ultrasound guided pericardiocentesis despite the evidence of the CT. This produced 2-3 ml blood. He then had a discussion with the family and informed them that there were no plans to

transfer the patient to Brisbane stating that the patient had a pulmonary contusion leading to massive haemothorax and was haemodynamically unstable at that time. The retrieval team had been despatched at 1930. The team arrived at 2300 and it was decided that the patient should be transferred after an aggressive bout of resuscitation. Unfortunately the patient arrested and despite all attempts at resuscitation was declared dead at 0010.

Post mortem confirmed that there was ~3,000ml of blood in the right hemithorax and the right lung was collapsed. There were fractures of the 6th and 7th ribs on the right as well as the sternum. The right ventricle had been abraded and the visceral pericardium perforated, blood within the pericardial cavity is attributable to this. Cause of death is internal haemorrhage.

<u>Areas of concern</u>

1. The delay in the arrival of the retrieval team. Request logged at 1620, despatched at 1930 and arrived at 2300.
2. Lack of coordination of care – two surgical teams involved. Mixed messages being conveyed to the family over the advisability of transferring the patient.
3. Pericardial paracentesis being performed without any indication (see CT and PM report).
4. Lack of radiology support – CTs not reported until 30/8/04

[illegible] WG because
Surgeon in [illegible]
for [illegible]
Continued [illegible]
He was NOT ill enough for [illegible]
Delayed [illegible]
[illegible]

TH20

From: Toni Hoffman
To: gcostello@rfdsqld.com.au
Date: 17/08/2004 3:44pm
Subject: see attach

Hi Gerry,

Here is the statement I wrote concerning the pt we spoke about,

toni

Toni Hoffman NUM
ICU/CCU
PO Box 34
Bundaberg Q 4670
Ph:
Fax:

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ICU/CCU
PO Box 34
Bundaberg Q 4670
Ph
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ICU/CCU
PO Box 34
Bundaberg Q 4670
Ph:
Fax:

w

My name is Toni Hoffman; I am the Nurse Unit Manager of the Intensive care/ Coronary Care Unit at Bundaberg Base Hospital. I have been employed here in this capacity since June 2000. I am a Registered Nurse, Midwife, and hold post graduate qualifications In ICU, a Graduate Certificate in Management and a Master of Bioethics.

Mr Desmond Bramich, a 55 yr old male, was admitted to the ICU on the 25-07-2004 after being involved in an accident where he had been pinned under a caravan when it slipped. He sustained a crush injury to his chest, multiple fractured ribs, a flail segment, Haemo - pneumothorax. He was stable during his initial stay in the ICU and was transferred to the surgical ward at 1400 on the 26-07-2004. Around 1200 on the 27-07-2004, ICU staff were notified a patient was deteriorating on the ward and required transfer to ICU. ICU was full and it was necessary to transfer out another patient before we could accept Mr Bramich back. He returned to ICU at 1300 on the 27-07-04. On his return he was diaphoretic, hypotensive and tachycardic.He was complaining of extreme chest/ back pain. Dr Younis, the anaesthetist was attempting to resuscitate Mr Bramich, by himself initially, as the other doctors were either busy with other patients. Three nurses were assisting Dr Younis. Blood was being delivered, and mention made of obtaining some platelets. Dr. Carter, Head of Anaesthetics came into the ICU at this time and stated "if the patient is going to need blood products, he will need to be flown out." We do not have access to platelets etc at BBH; at night, they need to be obtained from Brisbane... One of the doctors rang Prince Charles Hospital, but there were no beds there. The doctor from Prince Charles later called back and stated that a bed had been obtained for Mr Bramich at Princess Alexandra Hospital. This phone call was taken by me at approx 1430. The coordinator just stated the surgeons needed to speak to each other and then the retrieval team organised. I passed on this message to Drs Boyd, Gaffield, Warming ton and Carter. The surgeons in Bundaberg wished to do a CT prior to speaking to the surgeons in Brisbane... Meanwhile Dr Younis was still attempting to place a central line and an Arterial line in the patient. The patient went into Ventricular standstill whilst the central line was being inserted, an arrest was called and some atropine given.

Dr Gaffield had brought Dr Patel into the unit to review MR Bramichs' x-rays. Dr Patel heard the patient was to be transferred to Brisbane. He stated in a very loud voice, that the patient did not require transfer to Brisbane. He also stated the patient did not need a cardiothoracic surgeon, he asked the PHO, Dr Boyd, how much trauma he had done He also stated he would "stop doing trauma here if we could not handle it". I went and spoke to DR Gaffield and voiced my concerns about the delay in getting Mt Bramich to Brisbane. I was concerned Mr Bramich would die if we did not expedite the transfer. Dr Gaffield explained he wished to do a CT scan so he could give a definitive handover.

In the interim, Dr Patel came into the ICU, informed the staff he had perforated a patient's bowel, and required an anaesthetist, to repair the same. Another emergency was occurring and we did not have another anaesthetist to accompany Mr Bramich to CT. I rang and asked if Dr Carter could do it as the transfer was being further delayed. Dr Carter agreed, the CT was done and Dr Gaffield stated the patient would definitely be going to Brisbane. The phone calls to Brisbane were made with my assistance as Dr Boyd was unsure of the transfer procedure. We had some difficulty accessing the clinical coordinator at one point as they were having handover and we had to make several calls through switch.

Once the clinical coordinator had spoken with Dr Boyd and the retrieval team were on their way, I spoke with the after-hours nurse managers, the night staffs were here and I felt able to leave. (I was due off at 1630) The family had been told he was to be transferred; Dr Boyd had spoken to them and the procedure and accommodation in Brisbane, as well as

the patient's condition. The retrieval team arrived at 2015, he became increasingly unstable and he arrested and died at 0012.

Subsequent events in relation to the transfer of the patient were bought to my attention by the staff in the morning. At some point Dr Patel changed his mind about tne patient not requiring transfer, to being far too ill to be transferred. The staff involved in the incident believe that Dr Patel impeded this patients' transfer to Brisbane. They are also concerned about his treatment of the family. I have offered and attempted to access EAS for the staff. I believe this is a coroner's case, and as such, expect to be involved in the investigation.

TH21

From: Toni Hoffman
To: Linda Mulligan
Date: 26/08/2004 9:49am
Subject: ICU INCIDENT

Dear Linda,

I am attaching the report I have written concerning the care of MR Bramich and my concerns. MY first report was written in haste as I was asked to lodge it ASAP with DDSQU, as a sentinal event. Two of the other staff have written reports. One has accessessed EAS , But has had difficulty in doing so, so has been using a private psycologist. I have made several calls to EAS and none have been returned to me, I understand they are down some staff as well.I have discussed my concerns with DR Carter. A thorocotomy is booked for this Friday. DR Carter did ask me whether we are comfortable caring for a thorocotomy, DR Patel assurred him the pt would not be ventilated. I am concerned that large scale surgery is being sceduled on a Friday when over the weekend not all available staff are here.

Thanks

Toni

Toni Hoffman NUM
ICU/CCU
PO Box 34
Bundaberg Q 4670
Ph:
Fax:

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W

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TH22

From: Linda Mulligan
To: Toni Hoffman
Date: 26/08/2004 5:12pm
Subject: Re: ICU INCIDENT

** Confidential **

Dear Toni-Thank you for this additional information, it will be sent on a part of the review of the incident.

I have just arrived back to the office and urgently requested information re tomorrow's case you have outlined. I tried to call to speak to you personally, but have left, hence this email. Dr Keating has sought information re the same, and has confirmed the case is not a thoracotomy (which has been confirmed by Martin Carter who has seen consent form), but rather a wedge resection and the plan is for the patient to return to the Surg Ward, therefore advised suitable for this case to proceed.

It appears there is conflicting information, which at the best of times is difficult to sort out, but even more so this late the night before the surgery. This highlights to me the issues/strategies with communication that you and I have discussed previously are not resolving and further action needs to occur. In light of this matter not just involving nursing I will look at proceeding to involve others in discussing the issues at hand. Thanks Linda

Mrs Linda Mulligan
District Director of Nursing Services
Bundaberg Health Service
PO Box 34
Bundaberg Queensland 4670

Phone
Fax

>>> Toni Hoffman 08/26/04 09:49am >>>

Dear Linda,

I am attaching the report I have written concerning the care of MR Bramich and my concerns. MY first report was written in haste as I was asked to lodge it ASAP with DDSQU, as a sentinal event. Two of the other staff have written reports. One has accessessed EAS , But has had difficulty in doing so, so has been using a private psycologist. I have made several calls to EAS and none have been returned to me, I understand they are down some staff as well.I have discussed my concerns with DR Carter. A thorocotomy is booked for this Friday. DR Carter did ask me whether we are comfortable caring for a thorocotomy, DR Patel assurred him the pt would not be ventilated. I am concerned that large scale surgery is being sceduled on a Friday when over the weekend not all available staff are here.

Thanks

Toni

Toni Hoffman NUM
ICU/CCU
PO Box 34
Bundaberg Q 4670
Ph:
Fax:

thorocotomy etc attached + theatre booking request attached

L

TH23

13:19 26 AUG 04
(TMS2.P137)

Bundaberg Hospital
COMPRESSED THEATRE LIST by Session
For Friday, 27 AUG 04 SESSION HOURS
For No Theatre Group

Th..	Sess	Time	Patient name.. Number.......	Sex	Age	Ward	Bed	Procedure.........	Anae.	Surgeon........	Attendin
OR1	AM	08:30		M	5	CW*		R/O K WIRES LEFT ELBOW.		DR CHAUDHRY A	
		08:45		F	77	12		LEFT HEMI (BIPOLAR) ARTHROPLASTY.			
R4	AM	08:30		F	16	DSU*		DEBRIDEMENT OF TOE NAIL. **DIABETIC**.		DR PATEL J	
		09:00		F	46	DSU*		LAPAROSCOPIC CHOLECYSTECTOMY.			
		10:00	P249	M	68	12*		LEFT THORACOTOMY, WEDGE RESECTION. ** ALLERGY **			

otal number of sessions = 2

→ drains blocked on
→ specialled in wards
→ equipment accessed from ICU.
Phone call booked for Thorac
→ 1st Thoracotomy
→ verbally spoken about thoracotomy

BUNDABERG HOSPITAL

P249

SURGEON'S REPORT

BUNDABERG 4670
Ph(H)
Ph(B)
DNWV

D

PENSIONER

TH124

DATE: 27 - 8 - 04

DIAGNOSIS & OPERATION PERFORMED:

(L) UPPER LOBE WEDGE RESECTION.

SURGEON: Patel ASSISTANT: [illegible] ANAESTHETIST: Carter

DETAILS OF OPERATION: Notification Correct Count

GA
(R) LATERAL POSITION
~~[illegible]~~ THORACOTOMY INCISION OVER ~6th RIB
DISSECTION THROUGH FASCIA / EXT INTERCOSTALS.
PERIOSTEUM SEPARATED FROM 5th RIB. ABOVE
5th INTERSPACE ENTERED / PLEURA DIVIDED
LUNG CAVITY ENTERED
(L) LUNG DEFLATED / RIB SPREADER INSERTED

FINDINGS: APEX (L) LUNG TETHERED / SCARRING
SMALL NODULE @ APEX
~~[illegible]~~

PROCEDURE: APEX LUNG DISSECTED OFF PLEURA.
6th RIB # WHILST ATTEMPTING TO SEPARATE
5th & 6th RIBS. ~~[illegible]~~
GIA 80 STAPLER x 2
LUNG RESECTED AS A WEDGE
TIP OF WEDGE NOT RESECTED c GIA.
→ OVERSEWN c 3/0 DEXON IN 2 LAYERS
SMALL AIR LEAK → OVERSEWN 3/0 DEXON
NO FURTHER AIRLEAK NOTED ON LUNG REINFLATION
& IMMERSION IN SALINE
WASHOUT 2.5 L WARM SALINE
HAEMOSTASIS / INTERCOSTAL NERVE BLOCK
~~[illegible]~~

DRAINS x 2
32G TO BASE ~~& POST~~
28G ~~ANTERIOR~~
BROUGHT ~~THROUGH~~
LAT CHEST WALL

CLOSURE: DEXON 1/0 TO APPROXIMATE RIBS.
3/0 DEXON ~~[illegible]~~ CLOSURE CHEST
WALL IN LAYERS
STAPLES SKIN + DRESSINGS

MR73A

TH25

Bundaberg Health Service

THEATRE BOOKING REQUEST

UR NUMBER P249

SURNAME

FIRST NAME

DOB ☒ M ☐ F

Affix Patient Identification Label Here

SURGEON

PATEL

Insurance Status:	☐ Medicare Only
☐ Privately Insured	☐ Workers Compensation
☐ Veteran Affairs	☐ Motor Vehicle Accident

Is patient ready for care? ☑ Yes ☐ No --> Date when ready / / (= DEFERRED ADMISSION)

Available at short notice? ☑ Yes ☐ No

Previous Medical / anaesthetic problems? ☑ Yes ☐ No Ex-Smoker

Suitable for PAC 3 months prior to surgery? ☐ Yes ☐ No NA

Urgency Category:

☒ 1 Admission essential within 4 weeks *(Very early admission desirable for a condition that has the potential to deteriorate quickly to the point that it may become an emergency)*

☐ 2 ☐ Admission desirable within 6 weeks
☐ Admission desirable within 12 weeks *(Admission acceptable for a condition causing some pain, dysfunction or disability but which is not likely to deteriorate quickly or become an emergency)*

☐ 3 Admission not required within 12 weeks *(Admission at some time in the future acceptable for a condition causing minimal or no pain, dysfunction or disability which is unlikely to deteriorate quickly and which does not have the potential to become an emergency)*

Provisional Diagnosis: LT. Lung Nodule

PROCEDURE(S) LT. Thoracotomy
Wedge Resection

If autologous blood required, please tick number of units: 2 ☐ 3 ☐ 4 ☐

Estimated operation duration: 120 (mins) Expected length of stay: (days) 5

Admit: ☐ Day ward ☐ Same day as surgery ☐ Day before surgery (state reason below)

Medical Officer's signature: [signature] Date. 12 / 8 / 04

OPERATION: 27/8/04 930 Office Use only PAC APPT: 18/8/04 1400 Office Use only