Statements to Board of Presbyterian Support Sept/Oct 2008

Members of the Board I thank you for being prepared to listen to the concerns that have been brought to me.

My questions to the board are the same questions I brought to Ron Hall last month:-

- Are you aware of what has happened and is happening at Cranford?
- Do you want to know?

As you may be aware, I have had a long involvement with Cranford (two decades).

I was, justifiably proud of what we had achieved, and hoped and trusted that when I left, I left the Hospice in safe hands.

I last worked there, as a clinician at the end of 2006. I have, subsequently, in 07 and 08, worked as a tutor/workshop facilitator.

I have remained in touch, and recently become alarmed by the staff distress I have observed.

They have described absolute failure to get their mounting concerns addressed internally.

I am aware that I bring to you hearsay evidence.

I had wished and offered to your chairman to bring with me a number of professional people who have been and are involved with the Hospice to give their concerns to you in person.

Your chairman declined this offer and requested that I present these concerns to you personally.

I further requested that these concerns be presented to the Board alone as a number of the concerns relate to Hospice management and the personnel concerned are now present.

Your chairman declined this request.

This year has become increasingly miserable for me, because of the ever increasing number of phone calls, encounters in the supermarket, at social events etc. Even when I got off the plane in Hong Kong recently!

Concerned people, upset, worried, and latterly extremely angry about what is happening to 'Our Hospice'.

Their voiced concerns soon began to be accompanied by requests to 'do something'. I started to avoid the supermarket.

Ron kindly agreed to meet with me, he listened and suggested that I produce a paper for the board. I offered to meet with the Board and suggested that it would be much better for the Board to hear the concerns first hand, rather than via a conduit.

This was declined in favour of collating bullet points for the Service Committee. I hope you have a copy of these.

I need to stress, that these points are a compilation of serious concerns from a wide range of people, including, but not limited to:-

Families of patients
Friends of patients
Admin staff
GPs
Hospital staff
Hospice staff at all levels,
current staff, and those who have 'chosen to leave' in unprecedented numbers.

I feel that this situation is too complex to be addressed in this way, and urge the board to do their own research, so that they may best manage the situation, urgently, before it becomes irretrievable, or becomes a circus in the public arena.

Dr E A Smales

Cranford Issues, 18 sep 08

As I well know, when you, or someone you love is dying, you are frightened, vulnerable, have multiple complex issues, and desperately need a safe place. Cranford used to be that place, it was very widely recognized and valued as such.

Sadly this is no longer the case.

The real list of serious issues, affecting patient care, and staff at Cranford, is far too long/complex to include here.

This list should not be regarded as complete.
It has been compiled after listening to a number of very concerned people.

Including, but not limited to,

- Staff, present and past,
- GPs
- Hospital staff
- Families of patients
- Members of the public
- Lawyers
- Winemakers

1. **The bottom line,** is that now, in spite of everyone's best efforts, **patient care has deteriorated**, to the point where their care not only falls below Current Best Practice, it is described as unsafe/unethical, patients are dying in pain and distress. This is traumatic for them, their families and friends and very distressing for experienced staff, who know, how different it can be, and who are struggling to get what the patients need/ deserve from inexperienced medical staff, who are unsure, hesitant, and acting in isolation because of the destruction of the team.

2 **Skill loss**, over the years Cranford had built up a very skilled experienced Inter Disciplinary Team. Palliative Care is the care of dying patients, they are complex often with multi system disease, things can change rapidly, requiring constant review, and considerable skill if they are to be well managed. Over the last year there has been a loss of 2/3 experienced medics, 2/3 experienced pharmacists, several nurses, a counselor, a massage therapist, a senior manager, and an increasing number of volunteers. There is concern over how/why these losses have been engineered.

3. **Destruction of the Team**, for years Cranford has not only worked at the forefront, of Current Best Practice in Palliative Care, it has been actively establishing what this is. ie acting as a resource and role model for others. The inter disciplinary team approach, not only maximizes patient and staff safety, it allows for continual learning and improvement, it enabled us to manage a large patient load in a co-operative way working with GPs and keeping as many people at home, as long/as much, as possible. It is now being introduced more widely, not just in hospices, but in hospitals The Cranford re-structuring has demolished this and is attempting to introduce the out- dated/hierarchical/hospital model, which does not work well for this complex group of patients, its inadequacy, resulting in poor care, was one of the drivers for establishing Cranford in the first place.

4. **Loss of Resources, GPs express mounting confusion and frustration**. They /Cranford had established over time, a very cohesive, mutually supportive way of working, they could, 24/7 discuss problems with the in house team, the PCC, the pharmacist or the on call Dr. When patients were referred, they were seen for an Out Patient Review, as soon as feasible, baseline notes/drug chart were established. This enabled whoever was on call to be able to be constructive. This has gone, there are <u>no experienced pharmacy staff now</u>, only half the beds are being used, and very few OPs are being seen, so the on call Dr. usually has no idea about the patients in the community. Standards of care have fallen and continue to deteriorate.

5. **Refusal** of the CEO, the new director and new medical staff to acknowledge the history of Cranford, the value of the Team, its place in and its multiple connections to the community, not just locally but nationally and internationally.

6. **Lack of nursing leadership.** No-one would argue that there were some issues that needed addressing before this disastrous re-structure. Instead of listening to the then Med Director, who correctly identified lack of nursing leadership as one of the urgent issues, PSS commissioned an expensive review, which also identified this problem. Over a year later there is still no nursing leadership, even though the various ''fill-ins', have done a great job. One of them conducted a survey to try and get the current directors to address the deteriorating patient care, this confirmed what staff were saying. Nothing has improved have the Board even read the report?

Dr E A Smales

26 September 2008

Dear Libby

I understand that there is an opportunity to give feedback on recent changes to the service provided by Cranford Hospice. As a practising GP, this has been my experience in recent months.

- Recently when I phoned to ask a Cranford pharmacist to obtain an urgent Special Authority for a mutual patient, I was stunned to hear that there would be no pharmacist available until the next day. Yes, I can get a Special Authority myself, but it can take up to two weeks to get a reply to a manual application. Cranford pharmacists had an excellent system for immediate responses. Palliative care patients don't always have two weeks to wait.
- I also missed the opportunity to review that patient's drugs over the phone with the pharmacist. If you don't see many terminally ill patients in a year, you welcome the chance to have a Cranford pharmacist cast an experienced eye over prescribing, as they are very aware of drug interactions and safe doses for those who are very ill. They are also good at reminding me about part-charges for drugs.
- My colleague phoned Cranford for medical advice and after telling the entire story to Mike Harris, was then informed that he was the inpatient doctor and that she needed to speak to the community doctor. It was a simple question that he could probably have answered. Instead she had to wait while he found the right doctor, then she had to repeat the whole thing again. As you know, in general practice we run on 15minute appointments (on a good day!). We don't have time to do everything twice, and we don't know whom to ask for when we first ring.
- When I refer a patient for specialist review, I don't expect to be asked whether they can have an outpatient appointment at Cranford. Of course they can, that's what I referred them for. And I am disappointed to have the same patient referred back to me when things get tricky at home, because there are not enough doctors at Cranford now. When I refer a patient to any other specialty, the expectations are clear. At Cranford, this is no longer the case.

The relationship between Cranford doctors and general practice had improved substantially though it took some time. Now it feels less like a partnership; in fact I don't know what to tell patients about the hospice service any more, as I don't want to raise their expectations.

Let me make it clear that I still think the Cranford team are pretty special, and I appreciate the remaining relationship with my local PCC. But what is happening to the place?

Napier GP who prefers to remain anonymous at this stage.

Changes at Cranford Hospice.

Loss of several key staff members ie Kerryn Lum, Anne Denton and Sue Watson.
Anne and Sue left as a result of restructuring which dramatically changed the way they would be working and cut their hours back to such an extent it was not possible for them to continue working at Cranford.
This loss is putting huge strain on the team, they were an essential resource to Palliative Care in Hawkes Bay and Nationally.One of our Doctors told me several days ago she felt as if her right arm had been cut off and the Nurses working in the community feel cut loose without the 24hr Pharmacy advise which was always available and given generously no matter what time of day or night.

New medical personnel are inexperienced and hesitant resulting in poor sympton control on a regular basis.
This is often resulting in painful and distressing deaths which is not only bad for the patient and their family but also demoralising for staff who have worked so hard over the years to provide the best of care and now have to struggle at every turn to get the new Drs to prescribe appropriate medication to relieve pain and distress.

Changes in the support of the patients in the community has resulted in frustration among the GPs and the Community Nurses eg GPs refer for specialist care and they arc then told they have to "run" the care. Many angry Gps are saying what is the point of referring to Cranford if you can't get on with it, you are the specialists, you know what to do, don't keep phoning us to consult.

We have very few Out Patient Appointments available now compared to the 2-3 a day that we previously had.
This results in many patients never being seen by a Cranford Dr. Previously it was mandatory for every new referral to have an OPA as soon as possible after their referral. This provided a base line assessment and knowledge to inform ongoing advice and care.
This has led to an unacceptable situation especially when a patient in the community is in a critical situation or is dying and the Cranford Dr is reluctant to get involved as they "don't know the patient".
This puts an unacceptable load on the Community Nurses and again frustration for the GPs who have referred for the specialist service for their patient.

Due to the "shortage" of Drs it is now common practice to have only 4-5 beds open and when there is a vacancy no more than one admission a day is allowed. This again puts an unacceptable load on the community team.
It seems that the new Drs are busy protecting themselves from the business of a fully functioning Hospice that once was Cranford.

Senior Nurses

1. A review of restructuring processes 2007-2008, including redundancies of three senior managers and two senior pharmacists, is requested. Were these reviews conducted in accordance with good employment practice?

2. Redundancies and resignations since October 2007 include hospice manager, principal nurse, medical director, counsellor, massage therapist, and two pharmacists. Several staff members have taken stress leave. Many others are expressing levels of stress, distress and low morale. In accordance with good OSH practice, how is the current management dealing with this? Do staff members feel supported? How, practically and tangibly, is this support being offered? How has this affected patient care?

3. What has been the impact of further reduced medical cover on patient care, and on actual relationships with other providers including rural and hospital palliative care teams and general practice teams.

4. What has been the impact of the loss of senior pharmacists on remaining clinical team members, and on patient care?

5. What has been the impact on the nursing team resulting from the delayed arrival of the Nursing Director, appointed late 2000 and still yet to arrive in the country?

6. Public relations — how have recent changes affected the community's image of their hospice? Have the changes, and the reasons for these changes, been openly and honestly communicated to the Hawkes Bay community and to Cranford's many benefactors?

7. There have been a number of new appointments during 2008. Does Cranford have the right people in the right jobs now?

8. Asking the right questions of the right people will be crucial to the Board obtaining accurate information. How will the Board ensure that they are fully and accurately briefed?

Medical Staff

Concerns –

- Inadequate treatment of patients. New Drs not experienced & not willing to use expertise of others (eg Clinical pharmacists!)
- Safety of patients (few team checks/back-up- as above)
- safety for staff (few team checks/backup)
- Inadequate service for GPs to refer to. (PCCs just have to refer patients back to GPs if in strife – no O.P.s available, & little team backup)
- responsibility/ obligation to community for all money raised (2000) for a service of 10 beds plus Out Patient clinics.
- Staff morale at an all time low, staff afraid to speak out in case they lose their jobs next.
- The reputation of the Hospice & of Support as the community & GP's discover the inadequate service.
- The probable resulting loss of contract from the DHB & the end of the Hospice as we know it. Betrayal of the community & all they have put in to it..

Former Staff Member

Hi Libby,

hope these help, please let me know if you required any clarification.

- The nursing & medical staff will have to be up skilled to pick up a lot of the basic daily tasks previously done by the pharmacists. Both these teams are already very busy, where will they find time to do this? Let alone who will train them?

- Current Pharmacist not experienced enough or able to cope;
  Christina was taken on with the thought that she could be trained as a palliative care clinical pharmacist, by the other 3 very experienced pharmacists. After 9 months of part time work at Cranford, she only knows the basics & is unable to be the complete pharmacy team. She also has very little support & is only able to do about 12 hours a week.

- At least 4 days a week there is currently no pharmacy cover, therefore no checking of charts, prescriptions etc. As everyone is currently working in a busy & stressful environment, this lack of 'safety net' is quite frightening.

- Team moral is at an all time low, the pharmacy team was the most stable team throughout the history of Cranford, this has now been removed along with 36 years experience. Staff have lost friends as well as colleague's. Lots of staff on the edge of stress leave, wondering who is next?

- PCC's phoning in for 'specialist palliative care' advice are being referred to GP, where is the specialist palliative care?

Present Staff Member

2008
Kenyn's submission
via Libby

SUBMISSION TO BOARD OF GOVERNANCE
PRESBYTERIAN SUPPORT EAST COAST
Re: Cranford Hospice

"You don't say 'How do I adapt this approach to Maori?'
You start from the premise 'What is important to Maori?' and build around it."
Prof. Mason Durie

The words of this respected scholar and champion of Public Health are easily paraphrased when reviewing the current situation at Cranford Hospice.

What is important to Cranford?
Who would know the answers – and there are several answers - to this question?

There is no obvious reason why the principles of the Treaty of Waitangi – partnership, protection and participation – were not applied to the review and two subsequent restructures of Cranford's service. Therefore, thank you for the opportunity to provide this submission, albeit by proxy. It is unfortunate that we are instructed to be "brief" and confined to relating "directly to specifics under any of the six points" on the list compiled by Dr Smales from wider feedback. It is difficult to be succinct about 18 months of controversy; however, any true window of opportunity is better than none.

This submission illustrates my concern for patients and families, who have their own voice, and also for Cranford's staff team, who do not. Those Board members who are familiar with the principles of extracting themes from qualitative data will have no difficulty in identifying the issues. The fact that current staff are afraid to provide open and direct feedback to the Board for fear of retribution from management speaks volumes, regardless of whether or not this is an accepted line of communication.

- *"It's bad enough working here already; everything I do is judged and considered wrong. I can't risk making it worse." (Clinical staff)*
- *"There's so much I want to say to them, but I need to keep my job." (Non-clinical staff)*
- *"What's the point? They didn't take any notice of our feedback before. It's just a farce, so they can say they've "consulted" but they're not really listening." (Clinical staff)*
- *" I don't trust myself to be able to speak to them. I didn't expect this to affect me so much, which is why I'm asking for stress leave." (Clinical staff)*

Patient/Whanau Care
A number of factors have contributed to the decline in standards of patient care, and these overlap to some extent with issues in teamwork (below). Staff, other providers, and whanau have said that the high standards of care and support that they had come to expect are no longer being met, and this has been confirmed by work collated by one of the RNs at the request of management. Contributing factors, in no particular order, include:

- Wide variation in prescribing practices.
- Inexperienced medical staff dictating policies and protocols based on personal preferences, with lack of genuine discussion about imposed changes in practice. There **is** a place for "eminence-based" practice in palliative care.
- A lack of respect for individual staff competencies and strengths.
- Dismissive attitude by medical specialists, to careful nursing assessment.
- The loss of pharmacy knowledge to back up decision-making has removed an important safety net for prescribers and those administering drugs.

Loss of Resources
Quite apart from the loss of skilled people who have been instrumental in the development of palliative care not only locally, but nationally and internationally, the Board should not underestimate the impact of recent events on the community of Hawkes Bay.

A separate submission from a local GP illustrates the impact for our fellow health professionals.

The community feel fobbed off by a whitewashed version of events in recent newsletters, that does not match with what they can see happening to their hospice. They are waiting for honest communication from the Board and Executive management.

- *"How dare they describe redundancies as 'collateral damage'? Collateral damage is about buildings and equipment, not about people." (Longstanding Cranford benefactor)*
- *"We have asked the CEO to explain why staff are choosing to leave. He has said it is their choice. He has not explained why. He did not listen to our question – we're not silly." (Presbyterian Church Op Shop volunteers)*
- *"They had the cheek to ask us for another donation. We are not going to promise them anything." (Chair of local Trust Board)*

Though income from Connections Op Shops may be helping to pay for the redundancies, it is ironic that the person who fought for the Op Shops for Cranford has not only accepted redundancy, but has been banned from Cranford's premises by management.

One wonders what the role of Planning, Funding and Performance is in dictating the shape of a service that it only partially funds, and where the voice of the other major funder – the Hawkes Bay community – is?

Cranford's Place in Hawkes Bay, and in Palliative Care
Others will have spoken or written eloquently about this.
May I simply remind the Board of the seven values that underpin our dealings with *tangata whenua*, and ask why the same courtesies have not been extended to the Cranford team.

1.	*Aroha ki te tangata*	Respect for people
2.	*He kanohi kitea*	Meeting face to face
3.	*Titiro, whakarongo, korero*	Look, listen, speak
4.	*Manaaki ki te tangata*	Looking after people, reciprocity
5.	*Kia tupato*	Caution; cultural safety, reflective practice
6.	*Kaua e takahia te mana o te tangata*	Do not trample on the mana of the people
7.	*Kia ngakau mahaka*	Be humble; do not flaunt your knowledge

This is as succinct as I can be. I am grateful to the Board for being courageous enough to reflect on the process so far, and hope that further damage can be controlled. In November 2007, I asked in an email to John Gould that the Board begin to acknowledge and address the concerns of Cranford staff as the first, vital step towards rebuilding mutual trust and respect. I asked that the Board take the time to visit Cranford staff as a visible demonstration of conciliation. Almost a year later, might it finally begin to happen?

Dr Kerryn Lum
28 September 2008