PORTFOLIO COMMITTEE NO. 2 – HEALTH

INQUIRY INTO THE IMPACT OF AMBULANCE RAMPING AND ACCESS BLOCK ON THE OPERATION OF HOSPITAL EMERGENCY DEPARTMENTS IN NEW SOUTH WALES

HEARING 5 OCTOBER 2022

Supplementary questions directed to Mr Gerard Hayes, Secretary, Health Services Union (New South Wales, Australian Capital Territory and Queensland):

Answers are to be returned to the Committee secretariat by COB Monday 7 November 2022

1. How often are paramedics working longer than their 12-hour shift?
   Our metro based delegates report that more often than not members are *required* to extend their shift.

2. How often are they missing their meal breaks?
   We have old data on this subject, however we are aware that members often go several shifts including night shift without receiving one break.

3. After such a long shift and missing out on eating, are they telling you they are too exhausted to get themselves home safely?
   HSU has claimed a $100 payment for all extension of shift situations to cover the cost of getting home safely. It's only the unfair government sector wages regulation that stands in way from this claim becoming a reality.

4. Are paramedics missing out on family time due to ramping?
   Absolutely

5. Are there cases where paramedics are taking patients for scans?
   This occurs from time to time but from our point of view it is not wide spread.

6. There is clearly problems that go beyond an ambulance being stuck in bed block. Could you please explain if there are issues facing your allied health members?

7. Is the overcrowding of Emergency Departments, including patients in corridors and waiting rooms, having an impact on hospital security staff?

Supplementary Question 6: There is clearly problems that go beyond an ambulance being stuck in bed block. Could you please explain if there are issues facing your allied health members?

The union's original submission to this Inquiry related the concerns of a range of health professionals. Their reports were remarkably consistent across the professions:

> *ED is not my primary work area, however there is absolutely constant pressure on all acute wards because of the bed block and pressures in ED. This has a terrible flow on effect where people's social circumstances and needs are totally overlooked and there is absolutely no breathing room to allow people the needed time to coordinate safe, appropriate and respectful discharges. This often leads to re presentation to ED, anyway, ironically building more pressure on the system.*
>
> Social Worker, Mid North Coast

> *Relentless pressure to discharge patients who are not necessarily well enough or functional enough, so beds are freed up. No time for any proactive work that will prevent patients deconditioning in hospital. Working to discharge priorities rather than what a patient clinically requires. Patients are discharged too early resulting in either representation to hospital or not recovering as best they could have, ultimately leading to a poorer functional outcome.*
>
> Occupational Therapist, Hunter area

> *When the pathology lab is under significant pressure due to inadequate resources (staffing, analysers etc) and this causes delays in the ability of ED to perform their role, the off-site management of NSWHP lacks any sense of urgency or any appreciation in the role played by their laboratories in contributing to local bed block and ambulance ramping.*
>
> Scientific Officer, Western NSW

Radiographers, who are frequently called to emergency departments for to deal with patients awaiting admission, are well placed to observe the difficulties caused by overcrowding and lack of staff, and how those issues create further problems in the wider hospital environment. We took statements from two such members, one rural and the other metropolitan, in response to this question.

> *Some of the issues that affect allied health include patients and ambulance trolleys in the hall ways, blocking safe access and transport of patients to X-ray and CT and back causing delays in others care. There is also a safety risk when transferring patients within the ED as the space needed to safely move bed is not there and it's easy to bump into patients around corners where they shouldn't be.*

This problem extends to being unable to locate patients that need scans as they do not fit in the spaces provided and are moved around or in the hallways but documented as being somewhere else. This causes delay in scans and treatment as we can't find patients.

We have started changing our policies so we can start dealing with some patients still in the care of the ambulance and on ambulances trolley to help minimise delays. However, some exams can't be done in this manner as it's a safety risk, it can be uncomfortable for the patients, or the outcomes can be subpar.

Another difficulty we often face is that patients are not correctly checked into the hospital if we are doing procedures on them while they're still in paramedics' care. This includes patients coming to the department on the trolley with no armbands, or the incorrect cannulas or no checklist of CT.
The other issue with scanning patients still on trolley is they often have not been fully assessed by the team and we end up having to perform more scans later and double or triple handing patients.

Radiographer, Nepean Blue Mountains LHD

In terms of ambulance Ramping, there is no point the government throwing money at the emergency departments alone to fix this problem without also considering all of the extra ward beds they need and the support services they utilise. Medical imaging being one of the most utilised of these. A significant proportion of patients that come through ED have some kind of imaging, yet our department/staffing levels are rarely if ever considered when reviewing this.

Most of the issues we face as radiographers as a direct result of ambulance ramping are actually caused by ED staff "cutting corners" to accommodate for their unsafe and unrealistic workload. Emergency departments are often full to the brim of admitted patients who are stuck in ED because of a lack of funded inpatient beds. This means ED is often overflowing, placing strain on the nurses and medical staff who then (and they admit this) "cut corners" to save time. This in turn increases the workload of support services.

Some of these issues are:

- *NIX nurses are operating beyond their scope of practice, requesting multi-region imaging when they are not allowed to because "they are busy" and trying to expedite patient flow through department. A lot of unnecessary over imaging happens as a result (this increases radiographer workload and exposes patients to unnecessary radiation). When they finally see a patient, either the patient has often been over imaged (hand and wrist when only ever needed the hand) or incomplete imaging (requested an elbow but not the shoulder, patient has to come back). Either way, nurses who take liberties are increasing workload of medical imaging staff and putting patients at risk of unnecessary radiation exposure.*

- *Patients being sent to imaging without any sort of proper medical review or MTR. To try and expedite things ED doctors often just sit on a computer and read the triage notes of patients, then put in imaging requests without having seen the patient. This is done to try and "save time" but often has the opposite effect because they request the wrong area, not all the areas or the wrong kind of modality (because they never saw the patient). This increases our workload (and that of the wardsman) dramatically. It's honestly a waste of time. They need to evaluate their patients*

properly before sending them for imaging once. This would reduce transfers, patient slides, room set up and clean up. It would also reduce unnecessary imaging.

- *Patients never prepared by emergency nurses as per policy. Patients coming around for imaging completely clothed, without armbands or pain relief. This includes trauma, and significant fractures. Radiographers are at risk of patient blood exposure while changing patients into appropriate clothing/patient gown prior to imaging. All of this is supposed to be done in emergency but never is because the nurses "don't have time". This increases the radiographer's workload and causes issues around patient safety and comfort (never properly assessed or given pain relief etc)*

- *HUGE amounts of non-urgent imaging (especially CT) performed after hours. ED gets a free for all because "they are busy". So large CT lists are being performed after hours for patients who should be imaged during hours when medical imaging staffing supports this. For example staging scans or orthopaedics CTs for surgical planning. None of this has a "clinically urgency" in terms of patient wellbeing, but is deemed urgent by ED, from a patient flow perspective. This wouldn't be an issue if they funded appropriate CT staffing. Same goes for theatre. Most of our theatre work seems to happen after hours where we don't have enough staff (especially orthopaedics) because they are trying to clear theatre lists and inpatient beds*

They want to fix ED ambulance ramping… they need to look further than just ED. Patients do not get admitted or discharged home these days without a swathe of medical imaging.

Radiographer, Hunter New England LHD

Supplementary Question 7: Is the overcrowding of Emergency Departments, including patients in corridors and waiting rooms, having an impact on hospital security staff?

Our members working in security report that overcrowding in emergency departments is making it a lot harder to maintain a safe workplace, especially when there are potentially violent mental health patients. More waiting time for patients means an increase in their discomfort and stress levels, leading to an increase in anxious and aggressive behaviour. This is exacerbated by the cramped conditions. Members in both regional and metropolitan facilities reported comparable experiences:

> *It increases my work load it also draws other HASA's away from their wards to assist impact the wards within the facility*.
>
> *Means more work and responsibility for us.*
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> *The department becomes hard to work through and manage problems that arise there is little to no room.*
>
> *As security it does not affect us initially but as the waiting period extends for hours the patients tempers start to flare up.*
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> *Aggravated mental health patients experiencing prolonged wait times results in increased agitation, verbal and physical aggression, leading to a need for security intervention. The heavy build-up of patients in the ED waiting room and on ambulance trolleys together with a lack of communication and involvement by clinical staff with family members in waiting room results in increasing agitation and frustration. This is made worse by delays in transferring mental health patients/other medical patients to the MHU/ Wards.*

As well issues relating to their own working conditions, members also reported their concerns regarding the effect of crowding and delays on patient outcomes:

> *They stay in ED for long periods of time and sometimes they leave altogether without being seen.*
>
> *Slow transfer from ambulance trolley to an ED bed means the patient is not seen by a doctor but remains monitored by the paramedics. This means the investigation in why the patient has presented is delayed.*
>
> *The emergency department will push them out to wards as quickly as possible to make space for new patients, however if the wards are full, does that mean the wards are discharging patients before getting the quality of care needed? And the vicious cycle repeats as it isn't uncommon for patients to present again to ED within days of being discharged.*