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 7 OCTOBER 2022

Supplementary questions directed to Dr Kendall Bein, Emergency Department Staff Specialist:

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

1. In addition to your testimony, can you please explain why patient examination on an ambulance stretcher is difficult?

Access to patient

Examination of a patient is not theatrics and show. It is a targeted technique with a practiced skillset that benefits from the correct approach, careful patient positioning, patient co-operation and appropriate environment. A narrow ambulance trolley or corridor bed, in a busy, noisy ED thoroughfare, with access only to one side of the patient (usually ambulance trolleys queue against one of the walls of the corridor) limits what you can feel in a patient's abdomen or hear in a patient's chest with a stethoscope. There are many components of patient examination that are completely inappropriate to attempt on an ambulance stretcher or corridor bed due to privacy issues.

Privacy

Privacy is to a degree limited in most parts of the ED. It would be unrealistic to claim that one cannot hear what is going on in the adjacent resus bay or acute bed, despite a flimsy paper curtain being pulled across to separate it from the next bay.

It however is a completely different issue when one is on an ambulance trolley in what is often the busiest thoroughfare within the ED. There it is impossible to ask personal questions , expose parts of a patient for examination, perform intimate examination (Per rectal exam, Per vaginal exam, genital examination, examination of chest, breast or abdomen or butt) without exposing what should remain private to any patient, staff or member of the public who is walking by.

Local space, environment and equipment

Acute beds are set up for patient safety, privacy and for convenience of staff working with those patients. Measures like power points, wall suction and oxygen, vomit bags, swabs, cleaning gear, sharps disposal bins, that are readily available at the bedside are not available in the corridor. Many of these are valuable in patient assessment, or if assessment provokes an unexpected response from the patient.

Corridors are noisy, crowded with increased likelihood of interruption or being jostled, and frequently does not have the right lighting for patient examination (not enough or from wrong

direction) or too much (eg for care of patients with light sensitive headaches). None of this is good for assessing a patient.

Narrow beds are both an overbalance risk, and make some patient positioning impossible. Some aspects of some assessment or management require placing the patient in specific positions, standing / sitting / entering or exiting the bed etc all of which is markedly more difficult if not impossible in an ambulance trolley in a busy corridor.

Patient factors

It is much easier to establish rapport with a patient in a quiet, private, appropriately lit and set up environment that is what the patient expects from hospital treatment. It is much harder in an open noisy corridor on a hard uncomfortable bed that feels somewhat precarious, with all manner of strangers around you. Add to that discomfort and feelings of being in pain/unwell, anxiety over being ill and unsure, discontent with delays, etc and fear of the mental health patient (also access blocked often for days) trying to abscond down the same corridor you are stuck in being tackled by security. It is quite understandable that they are less ready or more distracted than is necessary and less able to assist with their assessment.

2. Does inconsistent admission and discharge protocols across hospitals in NSW impact on access block?

I am not sure I am best suited to answer this question. My personal experience is largely from a set of hospitals that have a robust and functional admission policy, and it has been many years since I worked on a ward. I base this answer on this personal experience and discussions with colleagues over their experience in other hospitals.

It must be noted that NSW health does have an admission policy.

https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2017_015.pdf though this document is predicated on assumptions that access block does not present a barrier to timely admission, that accessibility of, timely decision making capacity of, and lack of debate by admitting specialist will not prove a barrier to timely admission and onward flow. As such it is not well suited to the modern milieu.

Garling speaks to this Question 20:114 – 20:151 and recommendation 96:

“Within 6 months, every hospital should adopt a policy which permits, subject to the conditions described above, the practice that where a patient is to be admitted to a hospital from an Emergency Department or else a Primary Care Centre, the determination of the ward to which the patient is to be admitted rests with the medical officer in charge of the Emergency Department or the Primary Care Centre, as the case may be, and not with the medical officer (or ward staff) of the department to which the patient is to be admitted “

This is NOT reflected by NSW health policy (above)

The hospital in which I work has an admission policy that mirrors the recommendation of Garling. The decision to admit is made by a senior decision maker (ED physician or ED registrar)*. The AMO or his delegated representative is informed of the admission. Paperwork happens, and the process

of finding an appropriate bed begins. In the instance of the AMO disagreeing with the admission decision, it can be further discussed; however the essence is that this is a one way referral process. The admitting team may transfer care to another team after discussion and acceptance by that team, discharge the patient, or escalate the matter to the hospital CE for an executive level discussion and decision. These options happen rarely.

*- it might be presumed that ED might misuse this power to just "admit under anyone and get the patient out of ED". In reality, we see the opposite – small delays in decision making are not infrequent due to ED senior decision makers taking extra time to be certain and not mis-admit a patient. Bad-faith admissions are practically unheard of.

Using this system, the admission process does not lead to access block. Access block is caused by patients for whom the admission decision has been made (often for hour or days) not being moved to an appropriate ward bed as there are no appropriate empty ward beds.

Colleagues who work in hospitals where an admission policy that has the admission decision made by the accepting team rather than by the ED, (a decision often made (declined) without review of the patient – just phone discussion) have described considerable (many hours even multiple shifts) delay to final admission and the commencement of finding a ward bed. This does lead to needless access block.

I recommend that NSW health policy be revised to reflect recommendation 96 of the Garling report. I believe the hospital where I work has an excellent example of such an implementation and that it could be used as basis for such a revision.

I do not believe I have a sufficiently in depth understanding of all discharge processes available to hospital wards to make a valuable assessment of the impact of variability of ward discharge process on access block. I do feel that ward engagement with throughput and discharge are a vital part of solving the problems of access block, that problems with engagement, throughput and discharge are greatly contributing to access block, and so would very much encourage seeking the opinion of experts on this matter when forming plans to fix access block.

Finally, consistent policy across all NSW hospitals would offer a small benefit in that the medical workforce is a mobile group, and learning new systems with each new hospital creates a small amount of needless friction in the process. This is benefit is dwarfed, or even becomes an exaggerated negative if the system implemented widely is bad (e.g. not one that follows Garling's recommendation 96). I would rather see an inconsistent mix of good and bad than see consistent badness across the board.

3. Has high levels of bed access block had any impact on your resuscitation capacity?

Yes

Resus Beds are constantly access blocked with patients awaiting mental health beds who require monitoring, containment and sedation for the safety of themselves and staff, and with Drug and alcohol patients requiring an HDU bed or large amounts of time to metabolise their intoxication to the point of safe discharge. An Access blocked resus bay is reduced resuscitation capacity.

The impact on patients can usually be partially mitigated by shuffling patients not requiring active rescucitation (though still more appropriately managed in a resus bed due to critical illness requiring care best available in a resus setting); or patients who are actually ready for moving to an acute setting but no acute beds are available due to access block filling acute beds with admitted patients, to what is functionally a resus corridor bed.

Other resus bay level impacts of access block includes delays in some time critical but not "resuscitation" procedures. Procedures such as re-location of dislocated joints, reduction of fractures, sedation for defibrillation of non-critical cardiac dysrythms, and paediatric sedation for suturing, all of which are best managed in a resus setting – the alternative being admission for management in the operating theatre or procedure suite with a long time delay to reach a ward bed, and even longer delay for suite availability. Some of these delays can markedly worsen outcome, and are undoubtedly painful and/or distressing for the patient while waiting. However these patients are necessarily delayed while more critical patients occupy our resus beds, and often these occupying patients are there for access block as described above. I have seen all of the above examples of patients requiring resus bay procedures delayed for hours due to access block.

Finally there are human and staffing factors. Staff tied up with access blocked patients are less available to engage in resuscitation teams. There is significant impact of increased cognitive load and interruptions of a crowded department.

But No

In a crisis we are trained to do the most good for the most people. We are adaptable. We can almost always magic up a resuscitation bed and team by moving a critically unwell, but not-requiring-active-management patient into a corridor within the resuscitation area, and try to keep them in the corner of our eye. This can lead to unwitnessed deterioration, escalation or absconding of mental health/drug and alcohol patients, patients who should be monitored will go without appropriate monitoring, and places undue burden on staff and patients. However, a resus bed can be created if these sacrifices are made.

But actually Yes

This is a key point to understanding; and a key lens to viewing ED and even hospital responses to access block.

The lens emergency physicians view a disaster through is that a disaster occurs when demand for medical resources outstrip what is available to deal with the problem. Be it a mass casualty situation such as a train derailment where the number of injured exceeds the ambulances, medical staff and hospital spaces to deal with them, the city to surf or giant open air concert where potential casualties, access to them, and resources at the scene can potentially be overwhelmed, or an overcrowded ED where patients requiring bed spaces outnumber those bed spaces.

We train for and plan ahead for how to manage a variety of disasters. One of the key factors however is that the intent of management shifts from doing the best for every patient (which is possible only when adequate resources are available) to doing the most good for the most patients (which is necessary when resources are limited) accepting that there will be increased risk for some, and missed opportunity for less harm to occur for others.

ED overcrowding, access block and ambulance ramping are all examples of this definition of disaster – demand has overwhelmed available resources, and necessary compromises are made to ensure that harm is minimised.

Garling points out 20:87 "Where overcrowding compromises the provision of safe care, I regard it as dangerous and unacceptable". We have normalised the intolerable. We have taken what should be a disaster plan and turned it into standard operating procedure. We should have plans to handle all manner of disasters. However we should put still more energy into systems to make sure that those plans never need to be used.

If a surveyer looked at bend in a railway and saw there was potential for a train derailment at that point, it makes sense to bank the track against the turn, install and enforce systems to make the trains slow down as they approach the turn, create signalling systems to notify if there were any derailment or even issues with the track, create access roads for disaster teams "just in case" a derailment occurred etc. I.e. to create disaster plans. If a manager looked at all this great work done to minimise potential harm from derailment, and decided this means that it's OK to speed up trains around the turn and run them in the wet and snow "because we have a plan to manage a disaster" you would think this insane. They should not consider it OK to increase the risk of a derailment just because you have a plan to deal with it. However, this is where we find ourselves in the case of ED access block. We have a constant state of disaster, we are managing on disaster plans, and because we are (just) coping it becomes normalised and standard practice. The system sacrifices the safety and best outcomes of patients for the convenience of not having to fix access block.

4. Have there been instances where a critically ill patient has needed to be moved out of the resuscitation bay prior to them being stable?

Yes. Frequently. As mentioned in 3. above, doing so has morphed from what should be a disaster plan into standard operating procedure.

It is worth making the distinction of resuscitation – requiring active efforts to manage a critically ill patient to prevent imminent threat to life, limb or compromise of recovery. As opposed to critically ill – real potential for deterioration resulting in compromise or threat to life and limb requiring active support or monitoring. Both are critically ill, however resuscitation also requires active management hence a resus bay. Assessment, support and care of critically ill can occur in other arenas (resus corridors, ambulance trolleys, acute care beds without the nursing vigilance, elbow room and bedside resources provided in resus bays) provided the system is willing to accept significant and unwarranted risks and potential harms.

There are multiple instances each day where critically unwell patients begin their resuscitation stay, and even spend multiple hours of their resus stay outside of resuscitation bays. In the hospital where I work, there are locations listed on Firstnet (the patient tracking software used in NSW) including "Resus Waiting room" "Resus TOC 1" and Resus TOC 2" none of which are resus bays – they are chairs or a place in a corridor, all of which are destinations for critically ill patients where those critically ill patients can spend hours. That they are coded into the software is clear indication that the disaster management system has been normalised to the point of standard operating procedure. I do not believe this is unique to the hospital where I work.

5. Will Urgent Care Centres help to address access block?

No.

Urgent care centers target a completely different patient group to those access blocked in EDs so cannot reduce their number.

I will not discuss whether Urgent care centres might have utility outside access block, or whether they are staffable, or if the costs might be spent better elsewhere. That is outside this question.

Urgent care centres see patients who will go home after treatment. If they need admission to hospital they will be referred to an ED.

Access blocked patients require admission to a hospital ward bed. Patients going home at the end of their ED stay are rarely if ever access blocked* and do not require a hospital ward bed. (*- I am discounting those who spend so long in ED that they complete the entirety of their hospital treatment during their days of delay in the ED – see tabled document for examples https://www.parliament.nsw.gov.au/lcdocs/other/17850/Tabled%20document%20-%20Dr%20Kendall%20Bein-%207%20October%202022.pdf however these patients can't be managed in urgent care either).

If Urgent care centers have any viable access to public hospital beds without going through an ED (which may be negotiable through arrangements with hospitals and public hospital AMOs), they do not have access to a different set of public hospital beds separate from those accessible by EDs – hence any patient admitted directly from urgent care to a hospital ward means an access blocked patient in ED would remain access blocked unable to reach that bed i.e. no net decrease in access block. In the instances where an urgent care centre can access a private hospital bed, that bed should be equally or more accessible to an ED.

Urgent care centres cannot reduce access block, as their patients will either:

a) Be going home at the end of the day, and hence if they attended ED instead of urgent care, then they would not be access blocked, hence no reduction in access block.
b) Require admission – so will either
    a. be referred to ED for admission, becoming access blocked in ED, delaying their admission by the time taken in urgent care centre plus referral, and duplicating work, or,
    b. if systems are negotiated and miraculously function as intended (a thing that AMOs rooms seem to fail at more often than not) such that direct hospital admission were possible, would be directly admitted to a hospital bed, that would mean one less bed that would be useable by an ED access blocked patient – ie zero net gain.
    Also note – this is not the planned function of urgent care centres – it would ask them to function as emergency departments

Urgent care centres will not decrease the number of patients in ED requiring admission to a ward bed because those patients will still need admitting to a ward bed. Anything that does not increase the numbers of empty ward beds will not reduce access block.

Urgent care centres have potential to increase access block, and can increase ED attendances and increase ED work. This has been experienced in some areas where Urgent care centres have been co-located or closely located to EDs. The argument described in Prof James Mallow's Submission 26 https://www.parliament.nsw.gov.au/lcdocs/submissions/79679/0026%20Professor%20James%20Mallows%20.pdf page 18 describes this as it applies to GP clinics. The same argument applies to urgent care centres.

6. What do you believe are the top three actions a NSW Government can undertake to reduce ambulance ramping and access block in Emergency Departments?

1. **Generation of more empty ward beds** through a combination of

- Measure number of beds needed and provision of more ward beds to meet those needs
- Assessment of roadblocks in flow (access to radiology, theatre, procedure suites, discharge resources) and feed back and funding to hospitals to solve roadblocks locally
- Decreased hospital length of stay through systems that create ward team engagement with flow
- Review and possibly revise the proportions of elective admissions and acute admissions
- Widespread understanding that 85% hospital occupancy is good for the hospital, for patients and flow, and that those 15% (ish) of empty beds are essentially reliable surge capacity for the daily ebb and flow of patients and are both to be used by inflow, and to be emptied by forward flow.

I describe one example method to achieve this in my submission page 13 onward. There are likely others. As discussed during the hearing (transcript pg 22 in response to the question of the Hon Aileen MacDonald) it would require buy-in at all levels – At the state level re provision of resources for change, impetus for change, and acceptance that change will bring teething problems that should be viewed as challenges to overcome not failure to be punished. At the Hospital level with implementation, transfer of responsibilities, assistance with distribution of resources, information and guidance. At the ward clinician level with engagement in flow (may require funding a few fractional FTEs). At the ED level with process change and wearing the brunt of the teething problems while change happens and systems adjust. At the community level where it may result in some worsening of elective surgical lists. It is likely to be self sustaining once established, but the establishment process is going to be rough.

2. **Create a valid hospital access block target**.

The ACEM's HAT (hospital access targets – described in submission 16 page 5: 4.3 . https://www.parliament.nsw.gov.au/lcdocs/submissions/79666/0016%20Australasian%20College%20for%20Emergency%20Medicine.pdf is one such measure. I suspect it is too large, cumbersome, game-able and, with its many components will be degraded with the argument "We are meeting bits of it, and that's enough". That said, it is a good time target that ACEM experts in hospital flow agree will help.

I would recommend a simpler, single target:

Average ED Length of stay for all patients

- Who have Total hospital Length of stay (ED plus Ward) > 24 hours or
- Transferred to another hospital or equivalent (rehab facility etc) regardless of time spent or
- Died in ED or in hospital, or discharged against medical advice regardless of time spent

To be less than [choice of time target].

I would suggest [choice to time target] to be between 4 and 6 hours – 4 being preferable.

In comparison with ACEM's HAT, this measure is much more robust to gaming, however as mentioned in my submission, it has its own limitations, including that it is not an immediate measure – with at least a 24 hour delay to the measure being available, longer if patients are remaining in the ED longer than 24 hours. This is somewhat mitigated by recommendation 3 below if it were implemented. However, to detect access block in the hospital at a given point in time is just a matter of seeing if there are any admitted patients in the ED not moving to a ward bed, so this limitation is trivial.

3. Actively target the prevention of and accountability for the intolerable aspects of poor hospital flow

Create a NSW health directive whereby

- Any patient in ED > 12 hours is a mandatory notification to the hospital executive
- Any patient in the ED > 24 hours is a mandatory notification to the NSW health minister
- Make a commitment to investigate every such ministerial notification and endeavour to correct the cause of the problem
- Create accountability by having a record for each hospital of numbers of such ministerial notifications and when they occurred available on a public register such as https://www.aihw.gov.au/reports-data/myhospitals