Submission
No 176

THE MANAGEMENT AND OPERATIONS OF THE NSW AMBULANCE SERVICE

Name: Suppressed

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Submission to the Parliamentary Inquiry on the Ambulance Service.

My knowledge of the operations of the Ambulance Service in NSW are limited to the impressions and information I have from the experience of , who has served with the Ambulance service in . What, through discussions with and observation of , has become evident to me over time and concerns me about the functioning of the ambulance service, I have addressed below. As a psychologist working in schools I am aware of the insidious nature and deleterious effects of bullying on the individuals, groups and organizations when it is left unchallenged by leadership, which promotes, condones or is ineffective in its response against it. I apologise for the lateness of the submission and hope it can still be of some use.

1. Management structure and staff responsibilities
   - 1.1. There appears to be lack of skills amongst management at various levels in the organization to deal with problems experienced by ambulance officers especially in the area of conflict management; dealing with complaints of officers against other officers and dealing with reports of bullying and intimidation within stations.
     - 1.1.1. In the cases that I am aware of the complaints led to an escalation of bullying experienced by those officers who had made complaints about their treatment at the hands of their fellow officers.
     - 1.1.2. Instead of the problems being addressed effectively, the reporting officers appeared to be identified as the problem and the perpetrators were able to continue unchallenged to ridicule, harass and undermine the officers at work and in the community at large.
     - 1.1.3. Officers have been left feeling unheard, unsupported and even demonised by such responses from management at the station level and higher.
   - 1.2. Particularly at the station, qualified staff felt obstructed from performing their duties because of intimidation and harassment by staff that was not as up-to-date with current best practice models being taught. The problem was that these staff were senior either in terms of management status or their incumbency at the station and rather than being open to a newer way to do things appeared hostile and resistant to the treatment proposed by the newer, more currently trained personnel.
     - 1.2.1. There were occasions which were cited to me where less qualified staff ridiculed more qualified staff for 'over-treating' patients when training they had just completed had indicated that best practice was just such 'over-treatment'.
     - 1.2.2. When an officer raised discrepancies in treatment protocols and frustrations with not being able to treat patients appropriately with management, the report was dismissed as that officer having a problem fitting in with his colleagues.
     - 1.2.3. With such responses officers have felt unsupported by management who themselves appear to be intimidated by a deeply entrenched culture at the station that predated even their arrival.
   - 1.3. There also appeared to be a culture of disrespect, at worst, or cavalier attitude, at best, regarding the treatment of patients by some officers.
     - 1.3.1. In some cases this was dictated by a seemingly subjective assessment by an officer of whether or not the patients were considered deserving or merely histrionic, and involved little understanding of or compassion for the patient's experience of their condition.

1.3.2. One report I heard of involved the case of a elderly patient with possible dehydration, on a very hot day, being 'over-treated' by giving fluids; another involved appropriate support for the transport of a patient with back pain.

1.3.3. In both cases the more qualified officer felt he had to battle with his colleague to administer appropriate level of care dictated by his current training.

1.3.4. In both cases the relationship of that officer and his colleagues deteriorated as a result of these challenges.

2. Staff recruitment, training and retention

2.1. The lack of support, effective conflict resolution and conflict between training and application on the ground of skills has lead to officers becoming disillusioned, questioning whether their desire and commitment to being ambulance officers is misplaced.

2.2. Some have met with complacency and bullying at their stations that have lead to them

2.2.1. Leaving the service by resigning, by suicide or

2.2.2. Being victimised and their positions being made untenable through

2.2.2.1. Allocation of extra shifts away from those officers such that their incomes are sometimes halved, or

2.2.2.2. Sabotage of the officers reputation in the community, by other officers spreading unsubstantiated rumours about their mental health

2.2.2.2.1. This has the effect of making it difficult to work with other health professionals who have heard the rumours.

3. Staff occupational health and safety issues

3.1.1. There appears to have been a 'shoot the messenger' mentality, discouraging challenges and undermining the mental a physical well being of those who identify problems in the system. This happens by:

3.1.1.1. First suggesting to the complainant they are the problem and that their expectations need to be modified and they need to make more of an effort to get on with their colleagues

3.1.1.2. This then escalates into colleagues suggesting to the complainant that they have e.g. an anger management problem, again implying they need to change

3.1.1.3. There is little if any support for the complainant being afforded by management

3.1.1.4. Finally suggestions of the complainant having a mental health problem have been made in an attempt to erode their credibility.

3.2. The case I am most familiar with is that of

The personal consequences for individual complainants and resistors of the bullying culture have included:

3.2.1. Physical illness, both acute and chronic.

3.2.2. Financial stress due to loss of shifts, inequity in the allocation of overtime, costly investment in trying to obtain justice and the hidden costs of returning to the work force

3.2.3. Emotional stress resulting in depression, suicide, PTSD, isolation and a culture of alienation

3.2.4. Partial or complete disintegration of family relationships due to financial and emotional pressures.

4. Operational health and safety issues

4.1. The discrepancy, mentioned in (1.2) and (1.3) regarding what is being taught as current best practice in the training of new recruits and what is being practiced by some more

long serving officers and stations within the service as they interface with patients appears to be based on 2 different factors

4.1.1. That there is an opposing pressure perceived by some management for frugal fiscal management which may lead to a lack of willingness to utilise some resources identified as necessary for best practice patient care and a perception that such use is over-treating.

4.1.2. Disparity of training levels and currency of that training of some long standing officers in some stations has lead to conflict when new, more up-to-date officers try to execute their knowledge of current best practice.

4.1.2.1. In some cases that lead to officers feeling frustrated, confused and unable to do their job using what they were taught as best practice.

4.1.2.2. This discrepancy between education, expectation and the lack of follow-through in practice is undermining the ability of the ambulance service to provide a service of consistent quality through out NSW according to the experience of some officers.

4.2. In addition, the skills and training of management for dealing with difficulties at their administrative level is either lacking or not being implemented effectively and there is no sense of mentoring or support structures.