Submission
No 207

THE MANAGEMENT AND OPERATIONS OF THE NSW AMBULANCE SERVICE

Name: Suppressed

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Partially Confidential

General Purpose Standing Committee No2
Legislative Council
Parliament House
Macquarie St
SYDNEY NSW 2000

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Dear Committee Members

[following section omitted by secretariat to protect identity of author, as requested]

I feel that ASNSW's primary role is more like that of an emergency service, rather than a branch of Health NSW, and therefore could and should be modeled on NSW's other Emergency Service's.

I volunteered to upgrade my clinical level to P1, this involved an exam/practical assessments and a workshop. I did this for personal development and to benefit the community should the need arise. I have received nil remuneration for this skill increase.. As I did this in my own time I received time off in lieu of overtime at a later date. This upgrade includes the significant responsibility of the authority to "obtain, be in possession of, supply and administer Fentanyl......" a Schedule 8 Drug of addiction.

Having been in ASNSW for years I have never known the morale of the front line Ambulance officers to be as low as it is at present, I don't believe that the reason can be narrowed down to one particular cause.

I have identified numerous points which I have attempted to categorise into the five terms of reference. These points often entwine with and affect each other.

MANAGEMENT STRUCTURE AND STAFF RESPONSIBILITIES

- From a big picture perspective, I believe that the first and foremost issue which affects the ASNSW is the fact that ASNSW is a part of NSW Health. Health's issues are not necessarily ASNSW'S issues, our primary function is to provide initial treatment/intervention and transport the sick and injured to definitive care, a function that we do really well.
  Our focus now appears to be anything but, this is demonstrated by front line Officers fulfilling roles associated with NSW Health eg, Hospital liaison officers and Extended Care Paramedics. It would be a great day when the person in charge of the ASNSW is a uniformed officer similar to other services rather than a non-uniformed bureaucratic Chief Executive Officer. No wonder morale is low we are identified as a Service within a Department.

- There are Station Officers who are not even Qualified Ambulance Officers, let alone possessing any formal Management/Supervisory qualifications.

- I am lucky if I see my Station Officer once in 8 days, due to ASNSW stations having a single Station Officer. NSW Fire Brigades have a Station Officer on every shift.

- The ASNSW runs entirely on a Crisis management approach. A manager once told me that ASNSW is wholly a response service. How can this be when the NSW Government's approach to Emergency Management is the four step system of PREVENTION, PREPARATION, RESPONSE and RECOVERY? The answer is that ASNSW is not an EMERGENCY Service, refer to my first point.

- Us and them. Our management appears to focus on the needs of the Service and Health's bureaucracy eg. 'Off-stretcher times' rather than the needs of the staff, again refer to my first point.

STAFF RECRUITMENT, TRAINING AND RETENTION

- As I initially joined ASNSW as a PTO, I am aware of the application procedure and subsequent issues that I and others had when I decided to apply for Ambulance Officer. To my knowledge PTO's still have to apply with others 'off the street' as a general entry rather than an internal entry stream. Would it not benefit the Service to have Officers that already have some experience joining the ranks as Ambulance Officers?

- Not yet qualified (Level 2) Officers are rostered with Probationary (Level) 1 Officers and are expected to train and assess them as well as treat any unknowing patients, although they are not yet qualified to train or assess, or treat patients.
  In this situation both of these should be with a QAO to provide training, assessment and ultimate responsibility for the community's safety. ASNSW is a Registered Training Organisation, how can they make such a fundamental mistake? How many QAO's have been assessed by officers who are not qualified to assess them in the first place?

- Over the past two years I have been rostered with an officer of equal or greater skill level for a total of approx. 27 weeks. For the remainder of this time I have worked with Probationary or Level 2 officers. Whilst working with these Officers not only am I responsible for my actions and decisions but also for those of another person. For this responsibility I get nil remuneration or other benefit. What I do receive is a dilution of my advanced skills and knowledge.
  Similarly, on several occasions I have been required to work with a not yet qualified officer and also a recruit ride-along.

- At the completion of QAO I received a Diploma in Paramedical Science (Pre-hospital Care). As stated earlier I volunteered to undergo the training for the advanced skill level of P1. At the completion of P1, I received no VETAB or nationally recognised certification.

- At the completion of PTO training I received a Certificate 2 in Paramedical Science (Pre-hospital Care), but a transcript of study, which I believe to be an RTO requirement, was not available. My transcript still remains unavailable.

- It has occurred and remains likely that a trainee on his/her first on-road shift can be at a critical incident within minutes of the shift commencing.

This with little more than an introduction to their partner/ "clinical mentor". There is nil formal orientation to their new workplace. Compare this ASNSW practice to the Induction programs of NSW Health.

STAFF OCCUPATIONAL HEALTH AND SAFETY ISSUES

- With respect, I would invite the Committee to make a surprise visit to any ASNSW facility in Sydney Division. Where collectively, you will find stations that: are and/or have; infestations of vermin, exposed wires, in obvious neglect, in urgent need of repairs, lacking any ongoing maintenance, asbestos, trip hazards, inadequate heating/cooling, inadequate lighting, signage from bygone era's, inadequate security to name just a few infractions.
  Please then compare these facilities to other NSW Health installations. I believe that only with surprise visits will you see the true nature of the state of ASNSW infrastructure.

- Recently we have been issued with new kits, to replace kits which worked fine. These new kits are bulkier and more cumbersome. They are difficult to stow and remove in the vehicles.
  We have also had a change to a protocol which now states that we are to, "respond to the patient with the following minimal equipment", it then lists the exact same equipment which is now difficult to remove from the ambulance. I believed that in regards to OH&S systems that problems were to be engineered out of the equation not into it.

- Due to the nature of our duties we will be exposed and expected to perform our role in situations that are known to be Post Traumatic Stress Disorder causal factors. Why then is the ASNSW approach different to the approach of other services which face the same situations? There is no mandatory initial counseling, no peer debriefing, no limited exposure, no follow-up, no time off road, and no training; so that we can identify if a colleague is developing symptoms. Once again has a dedicated Critical Incident Stress Team which responds to all requests to provide initial counseling/debriefing and advice. You would believe that ASNSW as "best again" would have a system equal to or greater than its peers.

OPERATIONAL HEALTH AND SAFETY ISSUES

- Who is responsible when a not yet qualified (Level 2) Officer works for a rostered period with a not yet qualified (level 1/probationary) Officer, likewise when two not yet qualified (level 2) Officers work together? Another example of ASNSW not adopting a harm/risk management approach to their operations. This is likely to be occurring somewhere in Sydney as you read this.

- Ambulance crews are regularly dispatched to Police situations, ie sieges, self-harm, domestics and brawls with weapons, often prior to a police vehicle acknowledging the same job. Upon arrival the ambulance crew often find that the police are not yet on scene but are required, sometimes urgently. I can't help but wonder who looks after the medics when there in need. At times ambulance crews will 'stand-off' and await the Police, despite this being a required and accepted practice there is no procedure for 'standing off'. I personally have waited for police in excess of one hour, whilst 'standing off'. Often police on scene are not informed by their control of an ambulance response. Frequently ambulance crews arrive and are informed that they are not required, as the original caller requested the attendance of Police not Ambulance.

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The current ambulance dispatch warning system only identifies addresses and also requires a Police Event number. If the hospitals have a system that identifies individuals why can't ASNSW have a similar system for the safety of their Officers?

ANY OTHER RELATED MATTER

[following section omitted by secretariat to protect identity of author, as requested]

- The only system that I am aware of, that ASNSW employs to cover operational shortages, is the use of Officers called in on overtime. A long accepted technique in resource allocation in military, emergency and other services is to maintain reserves or a reserve component. It appears that ASNSW or NSW Health are the exceptions to this rule and that they can not learn from history.

  There appears to be no formula for the ratio of ambulance resources per head of population.

- I believe that the most recent single factor which has had a negative effect on frontline Officers is the introduction of "Pro Q&A" into our dispatch system. This "system" apparently categorises requests for an ambulance into predetermined response categories. As explained to me, simply, it dictates what crew goes and when and also how fast they go. Apart from an extremely brief introduction to this system at an equally extremely infrequent staff meeting, I have received nil instruction or explanation for various problems which commonly arise from this "system".
  This realisation came when I witnessed two of my peers (each possessing greater than 30 years experience and both Level 5 and Special Casualty Access Team (SCAT) qualified) , being dispatched to a job which, even I of considerable lesser experience and qualification, could determine from the information supplied that it would be a waste of their skills and experience.
  Commonly, I ask the original caller at an incident, why they provided incorrect information to the ASNSW call taker, ie "breathing problems", as I can clearly see that the patient is not having any "breathing problems". Just as common I receive complete denial or "I said "yes" just to get off the phone", or similar response. I would be interested to see the number of cases that are "not as stated" under this new "system". Most Officers will agree that we now receive a greater volume of information but deem that this information is useless, incorrect, not as stated, inappropriate, etc.
  Under this "system", why would I apply for Level 5 training and risk further stress by being dispatched inappropriately and also risk losing my

current work location? I have heard that the most recent Level 5 course didn't get close to 50% of the positions advertised.

- Ambulance officers are expected to drive vehicles under "urgent duty" conditions whilst performing their role. Anecdotally the risk of a vehicle accident has increased due to several factors including but not limited to, traffic volume, increased demand for services (including urgent transports between hospitals), and increasing community expectations. Why are my colleagues and I placing our livelihoods, mortgages, family and personal commitments at risk by performing our DUTY on our own personal drivers' licence? I believe that the community, my colleagues and I would appreciate the NSW Government in providing an Ambulance Officer drivers licence, where if I am involved in an accident whilst **performing my duty** I am personally not affected. I believe that the Australian Defence Force has this type of arrangement.

- It is known throughout the Service that the Service is blessed, ie better luck than management. I have concerns of the ASNSW's ability to cope with a mass casualty situation eg Waterfall and Glenbrook Train accidents, if it was to occur at a time other than shift change over, like these incidents did. Occurring at shift change over allows for the utilisation of both night and day crews, effectively doubling the available resources.

The main point which this situation highlights is that under the current operational system, how a relatively small mass casualty incident can drain available resources. How long can we operate like this before the inevitable occurs?
Likewise, how would ASNSW cope with a protracted epidemic/disaster when it barely copes with its everyday operations due to access block, inadequate staffing, not enough vehicles etc? Several years ago I was involved in a disaster/terrorism training activity that utilised off-duty crews. How can this be a true representation of our operational systems, capabilities and readiness?

An ambulance service with not enough ambulances, I ask, is the following situation effective resourcing. Frequently at commencement of shift in my area crews must await for the return of a vehicle from the previous shift, this can be up to a couple of hours. Whilst the crew is waiting the crew with the vehicle commonly keeps getting allocated to cases, thus incurring more overtime.

I have attempted to describe my thoughts to the best of my ability and knowledge. I would like to conclude that I write this out of hope for the future and believe that this is a unique opportunity for change.
The potential of ASNSW employees, particularly Ambulance Officers, should be harnessed rather than discouraged. I feel that although cultural change may be difficult it **MUST** occur for the greater good of our community.

Yours Sincerely