Submission
No 137

THE MANAGEMENT AND OPERATIONS OF THE NSW AMBULANCE SERVICE

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Submission to the Legislative Council General Purpose Standing Committee No. 2

into the Management and Operations of the NSW Ambulance Service.

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Committee Chair
Legislative Council
General Purpose Standing Committee No. 2
Parliament House
Macquarie Street
SYDNEY NSW 2000

I am an Ambulance Officer stationed at

In regards to the terms of reference and the Ambulance Service of NSW I make the following comments:

Management Structure and Staff Responsibilities:

• Station Management: Station Officers, managers of individual stations, are on-road officers. Their workload in station management is conducted when they are not out on the road performing ambulance duties. Station Officers should be given more off-road time to manage their staff. This should involve meeting the needs of staff regarding practical day to day issues of employment, emotional support, training issues, administration, managing station tasks, developing trust between officers (especially junior staff) and management so that officers with difficulty can approach management. There should be access for all staff to a station manager, or assistant. Currently most staff are not rostered on duty at the same time as the Station Officer. Large stations need more then one person in this role.

• Management Style: Many of the newer station officers have the reputation of being hard on their staff.

This type of approach and management style has plummeted morale and means that officers are always on alert for criticism from their immediate bosses. This is wrong. The immediate boss should be the first line of support.

On the issue of kits in cars, we are verbally advised on joining the job that we should arrive at work 20 minutes prior to start time to check the car and restock. Most of us do this, but we are not paid for this time. We absolutely should be. The Standard Operating Policies & Procedure's (SOPP's) don't specify a twenty minute prior to start attendance, if they did maybe we would be paid for this time "donated" every shift to the ASNSW. The cars and kits are generally very well stocked, officers take their role seriously. They should be treated seriously and acknowledged by paying them for their time..

In my opinion this transfer coincided with a drop in morale. By way of comparison inspectors would call into station and talk to people, have a cup of tea, talk over jobs. Their approach was friendly and often quite funny. They have years of experience on the road and would share their stories. They all have nick names that are used, in many respects, affectionately by staff on the road. At the same time though, they were serious as a manager of behaviour or work if required.

inspectors, however, do not take this approach. I feel that they do not know me or my circumstances, nor has any attempt ever been made to do so. When they come to station, it's usually a short visit, they spend no time with staff. Often they sit at the computer working. Their purpose appears to always be that of fault finding and being critical. I have never met some of the , who are responsible for me on road if we are on the same shift.

• Clinical expectations. In regards to cannulas, a qualified officer is expected to be able to insert cannulas. Qualified officers are in their fourth or subsequent year of service. The reality is that by your fourth year, you would be lucky to have had 4 rosters with a senior officer who can assist you with developing such skills.

The inspectors expect a level of performance from us but the structure of rosters limits access to working with experienced officers where skills are passed on and supported training given.

I think people in their first 5 years of service are continually challenged in their skill level by what is expected on the road but given limited opportunity to get training and support from senior officers who do the job without thinking about it. The past experience of these senior officers supports them every day on the road. More junior officers, apart from their time at the Rozelle Education Centre, do it alone. Junior officers are most often rostered with each other or with probationers.

It is therefore wrong for an inspector to imply blame for a lack of experience in the way they say things to officers on the road. Because even though one is "qualified" there isn't always the capacity to maintain skills via exposure to work of that nature or from rostering with senior officers.

Sick Leave: The inspector's demonstrate their view of sick leave via their actions.

I find this so wrong. It's disheartening. Work is hard enough, constant, unrelenting. Officers don't need this lack of support with its implied judgement and criticism from management. The reliance on filling such absences with overtime staff is also wrong. No one volunteers for overtime on night shift at busy stations on the weekend. Those of us at busy stations with absent staff on week-ends, are often understaffed for the shift.

I do not discuss anything with the inspectors, I will not divulge any of my thoughts or feelings about the job to them because I don't feel there is a level of trust in the relationship. Given the nature of our work, looking after the community, it is not unreasonable to expect that the Service would look after us. Management

should acknowledge that people take sick leave. On paper and in formal situations like staff meetings they do in fact acknowledge this, but on the road when examples like that of the above are given, the implicit understanding taken on by the officers is that sick leave is wrong and that the inspector has every right to judge you for taking it. This is demonstrated by the fact that officers are given 14 (140 hours) days sick leave per year which is not excessive when you consider the length of our shifts. However, once you take 8 days you are called in to justify your leave, substantiate yourself to management because they consider your leave to have been excessive.

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

Management should deploy resources as equitably as possible for all concerned. Workload equity was not considered on that night despite the fact that for each station, the workload was no different to usual.

• Level 2 Officers. On completion of your first probationary year, as a new and clinically independent Level 2 officer, one can be posted to any station in NSW. When posted to the one is not posted permanently to an ambulance station, as was the case in the

prior to the realignment. As a Level 2 officer you can be sent to a different station every roster. This change in posting methodology has several impacts.

At a management level, obviously the workforce is more flexible, however if we had enough staff at each station this stop-gap method would not be necessary.

For the stations, the lack of new permanent staff replacing those leaving or transferring means that the day to day work of keeping the station operating is falling on fewer people. Not all people contribute to station life, so the burden is falling on the few motivated people amongst those who are permanently posted to stations. Work isn't allocated to people who are at the station for a roster period. They are less familiar with how the idiosyncrasies of each station operate and for whatever reason, it doesn't happen.

For the individual Level 2 officer posted to a different station each roster, the impact is greatest. First they have survived probation and so some of the pressure is relieved, BUT they don't get the chance to put their roots down, to feel a part of a station group, or to develop some longer term relationships with co-workers which are the best form of operational support (and in my opinion, currently the only form of operational support). They have limited or no opportunity to develop relationships with their immediate management, they have to learn the details of life at each station they go to.

Worse is to be a Level 2 officer, new to a station, never been there before, and to be rostered with a brand new probationer who also has never been there before. New probationers need lots of support, they are not driving yet, they have no idea geographically and are very new to clinical work.

Initially Level 2 is challenging anyway; in that officers are consolidating their skills, gaining independence and confidence and hopefully becoming solid clinicians. Level 2 officers in the don't need the added stress that comes from never knowing where they are going to be sent. They should not bear the burden of management incapacity to maintain staffing levels.

- Transparency. There is a large issue between on road officers and management regarding additional on-road resources. It is well known amongst officers that at station the officers feel that the workload has increased significantly over the last 2-3 years. Immigration and housing development has lead to significant increases in population in the local government area.

The issue of increased workload has been raised with management at the irregular staff meetings held on station.

These stats have been denied to them. How busy does a station have to be to "qualify" for another car? We don't know because we don't know how these decisions are made or how new resources are allocated. We don't know from year to year how many jobs are done in our station area. We don't know how many jobs we do for other areas, nor how many get done for us, because we are never told. In reality cars are sent all over the city. Individual ambulances follow the work on a closest car basis which is completely logical. We never stay in our own area because we are continually sent all over the place trying to meet the demand placed on the organisation. In the years I have been in the job, I have not seen an additional car capable of transporting patients come into service. There was an extra car at for a short period, but the sector can't maintain its staffing levels to keep that car operational. Rapid Responders go to jobs and much of the time call a car for transport. This ties up two vehicles and three officers. I think rapid responders should be replaced with a fully transport capable vehicle. I also think there should be an increase in Patient Transport Officers to handle the routine transports.

We are not shown statistics. We are not given information. In the annual and "Best Again" reports the Service loves to tout the line that calls to ambulance have gone up by xyz percent per year for that past number of years. This pride in our capacity to get the work done is not matched with any advocacy that we see to reduce the workload pressure felt in Nor is it

matched by any systematic and explicit process from NSW and Metropolitan management to increase resources based on population and demand increases.

I think the process should be transparent. When calls to an area increase by a specific benchmark amount, the area gets a new car on the road and the officers to staff it. We have tried to gather statistics from the Australian Bureau of Statistics to support the case for another car, It has been discussed it in staff meetings and with inspectors.

It makes me feel that the Service does not care about me or my increasing workload, it only cares that I turn up and get in the car. There is no tangible process by which additional resources are allocated and I suggest that the Service has no explicit planning in place to cater for predicted demand management.

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

Given that at any one time a good proportion of these cars are at hospitals off loading patients, I suggest that the whole area is critically under-resourced.

It would be an interesting question to find out what the population growth has been since the last car enhancements were made and under what statistical criteria are such enhancements made. On the ground we adopt the rubber band approach...we just keep getting stretched thinner and thinner. Workload is one of the biggest issues and it is not those behind desks who bear the burden of this issue.

Staff recruitment, Training and Retention.

Why is the service recruiting continuous classes of 50 people? For how long has this been happening? I suggest that the service cannot retain its staff because we just can't keep up the pace required, receive no job satisfaction, no support and in the end become burnt out and leave. In fact, it is often suggested that the ASNSW only wants us for 5 years, the longer we stay the more expensive we get. There appears to be no attempt to retain staff. We are highly valued by the community and they make our job fantastic. We have no evidence that the Service values us.

The new qualified Ambulance Officer position, called P1, involved taking on several extra drugs and responsibilities, advanced airways, treating more potentially life threatening conditions. Was there a performance based increase in remuneration? No. Currently we are told by the Industrial Relations Commission, while trying to seek acknowledgement of this unpaid increase in

skills and responsibilities, that we can't "double dip". There is no question of double dipping, once would be enough. The Service and the community gain the benefit of additional skills and enhanced treatment capacities of officers. Officers gain extra responsibility, more stress, more things to keep abreast of from a knowledge point of view, but not more money.

Recruitment: My comments in this regard are made under a separate submission. I believe they allow me to be identified and I am not willing for this to happen.

Training: All officers, once qualified, must participate in Certificate to Practice activities in order to build up points which accrue to maintain their continued accreditation as an officer. These activities include training probationers, writing papers on cases, participating in courses and so on. Many of the activities required by the service are done in our own time; we are not paid nor are we given time-in-lieu. The sheer volume of information we are expected to keep up with is excessive. Accreditation should be done in paid work hours.

We have clinical training officers on the road who are there to help us in any way. I had never had a clinical training officer see me on the road. These officers are available to conduct training, go through scenarios and so on. The reality in is that we are too busy. Whenever we set up a mannequin to do a cardiac arrest scenario for example, the phone rings and we are out on a job. I have never successfully completed an activity with the clinical training officer because we are interrupted. Time should be allocated to ongoing training.

The training and education we receive at the Ambulance Education Centre at Rozelle is fantastic. I think the education centre do a great job in getting raw recruits with no medical background ready. Truly it's exceptional. After eight weeks of training, and only hours of on-road work, I I felt so confident and in control at that scene. This is a testament to the work of the education centre at Rozelle.

• Retention: There are numerous issues that are leading to staff resignation. I don't know how many people are leaving the service nor do I know their reason for doing so. I suspect that there are numerous resignations from those that I have seen at my own station and those around me. One person rang before he was due to start work and said that he resigned. He just couldn't do it. How is it that officer's can be pushed so far that they can't face coming to work and resignation is the outcome?

Issues that I note regarding retention include:

- The entire way the Service deals with Level 2 officers, rural posting, their rosters and their permanent placement as detailed above.
- The continuous workload at busy stations. A fatigue policy that addresses rural officer fatigue due to night-time call outs and a requirement to be on duty the next day but has no discussion in that policy of metropolitan fatigue or the impact of continuous work over 10 hour days and 14 hour nights for staff at busy locations. This policy does discuss hospital transfers, suggesting they should be held over for day shift cars, but on the road isn't always the case.

In that time I had to sleep, eat, sort children, get ready for work and so on. The Service would say we can request a late start for the second night shift.

They would also say that I can tell the Duty Inspector I am fatigued and need to go off-road. I have never seen this done. In rural locations one can only do this at the end of a job, not the beginning.

- An overall lack of management support and a critical management attitude.

- No evidence of sector level management advocacy to increase resources or support for on-road staff.
- A shift structure that requires 10 hour days and 14 hour nights set up when

  wasn't as busy as it is now. We do 48+ hours in four days. We never have a lunch break, we rarely finish on time. Now 30% of ambos are women and there are children at home. Kids don't see much of their ambo parents during their four days on shift.
- The move to 12 hour shifts promises nothing better. We will have shorter nights but longer days. With this arrangement, on day shift, my kids will be asleep when I go to work and asleep when I return. I won't see them at all.
- Given the nature of our work, what we actually do on the road, these hours are excessive and no longer match with family structures.
- Families bear the brunt of fatigued ambo parents. I am very grumpy at home. I do not like this aspect of myself, and I try my hardest to not be so, but the truth is my tolerance levels are minimal. I was so unhappy to return to work after my last annual leave because I did not want to return to being the person I was prior to that leave.
- The rate of pay. The only thing that makes being an ambulance officer a reasonably paid job is the amount of unscheduled overtime we do and the penalties. Removal of penalties and introducing 12 hours shifts with two twenty minute crib breaks, as desired by the Service, will increase the level of resignation in my opinion.

- I don't see any people being given access to part time hours as a way of relieving these stresses. Generally it is those returning from maternity leave that have access to part time hours.

Staff Occupational Health and Safety:

Fatigue and the shift arrangements are the biggest issues for me as an Ambulance Officer. I can not continue to work the hours required. I have been drawing on my internal resources for less then years, dealing with lots of frustrations from management and the way the service operates. I feel as though there isn't much more inside to draw on. I am often unhappy and frustrated at work following a negative interaction with on-road management. I sleep really badly. My children and family suffer. The cost is too great and the benefit too small.

We often play down the importance of what we actually do each day. When people call an ambulance, we go to them, assess, make decisions, treat and transport to "definitive care". This process shouldn't be underestimated. It's important and I do great job. I don't judge patients; their level of education, cultural, religious or sexual background. I don't judge their reason for calling an ambulance. I enjoy helping them. Clinically I think I'm doing well. (Not that anyone has ever formally told me so). Semi-regularly I go to someone who is very sick or injured. They require immediate ambulance assistance and of course, it is enormously satisfying to put all the good parts of the job together and to see

and do an important job well. To save a person's life, to talk to their family afterwards, it's an honour. I find I get dragged so far down by the way the rest of the organisation works, separate to that individual on-road interaction with patients, that the significance of ambulance work is forgotten in an effort to survive in the job.

Operational Health and Safety Issues: My submission has been prompted by the death of Trent Speering and the murder by him of his mother. What would have happened on that day if his mother wasn't there? Would he have gone to an ambulance station and killed ambulance officers instead? Would he have gone to my station? No one can answer these questions. I have never felt as exposed as I have in the last week with the knowledge that this event occurred and that he had made threats to other officers. I didn't know the officer and have no immediate cause for concern from him. But I may have been in the wrong place at the wrong time. Therein lies the inherent risk of our work. We never know where we will be and who we will meet and whether they mean us any harm. I am disturbed that the situation with Trent Speering went as far as it did. What did management do? How much were they aware of?

Will on-road officers ever be told the full story?

What is going on with the S8 drugs on stations? I know of three or four stations that have had their drug safes emptied due to theft of the Morphine, Midazolam and/or Fentanyl in recent weeks. Are officers with addiction issues stealing the drugs? Why? How is it that they can go so far down that path and no one help them? Why do they get there? What has happened to them as individuals? The Service approach to drug inconsistencies is to

No restitution of their reputation and no faith from that officer in management's capacity to handle this issue.

Other Related Issues:

My submission is also motivated by a belief in equity, fairness and justice; by the notions of citizenship and public participation in the parliamentary process. I also believe that unless Ambulance Officers on the road are treated with more respect by management; unless we are given more resources in the way of cars and people and unless fatigue at busy metropolitan stations is addressed we will continue to resign in great number.