Submission No 13

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

Name: Name suppressed

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Please consider this my submission into the Inquiry into the impact of ambulance ramping and access block on the operation of hospital emergency departments in New South Wales..

I work in a large rural NSW emergency department and consider that current conditions for nurses, doctors and patients are unsafe and psychologically unsustainable for staff. We have had at least 40 of around 150 ED nurses leave in the last 6 months and have had up to 30 full-time casual staff recruited to help. While this is a great interim measure, there has been no meaningful improvement in ED flow or workload, with no nursing staff enhancement to manage heavier loads either.

1a. Ambulances are ramped at our department because most days we have up to 30 admitted patients waiting 24-30 hours for a bed on the ward. These are largely medical patients, mostly elderly people. Surgical patients are prioritised and streamed to the wards.

We only have 22 acute beds! Patients are sleeping in recliner chairs in short stay areas too. We recently had an elderly lady with dementia awaiting a medical bed for over 120hrs. Occasionally children wait in our mixed adult/kids ED overnight, and this never used to happen. We have 2 toilets the kids share with all sorts of adults. Mental health patients can also have long stays of 64 hours or more in ED. We have had forensic psych patients in ED, locked in a small room, for a week. This is inhumane, EDs are noisy, confusing places. This leads to increased frustration and anger for mental health patients who become more volatile and harder to manage.

1b. Management of medical outlies is suboptimal, half managed by overrun ED Drs, with care not truly taken over by the admitting Medical teams. Studies have shown over and over that prolonged ED stays lead to poorer outcomes for patients.

New, potentially unwell patients are backed up in the waiting room and the COVID tent outside, when they should be on beds. The waiting room and COVID tent can have 20 or more people waiting, only cared for by the triage and Clinical Support Nurse who may be called on to assist in Resus or attend Rapid Responses as there are no senior nursing staff left to do these jobs now.

We regularly have patients with cardiac chest pain unmonitored, the CSN doing ECGs in the plaster room or other GP consult rooms.

ED Drs and Nurses are effectively managing a ward full of medical and other out-lies on top of our ongoing daily presentations without any staffing enhancement. It feels as if the NSW government has abandoned us, using us as a cheap ward without the additional expense. But it has made ED's quite dangerous places to be, so I imagine there will be, or should be some expensive lawsuits soon. Possibly also from burnt-out/injured staff.

I can name 2 occasions in the last 2 months where we had to start resuscitating 1 person in the corridor on an ambulance trolley (on the tannoy "resus team to ambulance bay"!)and the second was a baby we had to start resuscitating (ie bagging & tubing) in the corner of the Resus room on the resuscitaire. This because our 2 Resus beds were already full and there was nowhere to move them in the main

department. This is not acceptable. We need at least 1 acute/Resus bed always spare and this is routinely impossible now.

1c. In our area it is very difficult to access GPs. Patients will tell me at triage that they can't get into see a GP for a week. This is also my experience. There is now no after hours GP service in our area either.

Our ED also sees a lot of poorer people who also say they can't afford to see GPs as almost none bulk-bill locally. Also the cost and availability of specialists is a factor. There are long waits in our area to see expensive specialists. I believe the cost of private ultrasounds and MRIs is also a factor in increased presentations to our ED.

1d. Many acute ward beds are full of nursing home patients awaiting placement for months. I feel not enough has been done to stream these people off acute wards to empty beds, perhaps a new "nursing home ward" somewhere at a peripheral hospital. Our ED also usually has at least 2 Nursing home patients awaiting transfer back to their nursing home. Ambulances mostly won't transport these people overnight and we don't have 24hr or even late-night patient transport. Some of these patients are also sent to ED for things that a good call-out GP could manage-replace SPC/catheter etc.

1e. I have already described some of the impacts bed block has on patients and staff. Mental health patients become angry, violent and dangerous, but also traumatised. We have had an increase in injuries to our security/wardsmen recently. Bites, punches, shoulder injuries.

Elderly people are living for days on hard ED trolleys or even recliner chairs developing pressure sores. We had a confused elderly man with COVID locked in a room within an air-locked room, on his own for over 48 hours. No nurse special was available and he fell over 12 times!. One agency nurse left to look after him (plus 4 other patients) without extra support quit the next day. The patient was extremely lucky not to have died alone in that room, but he did need extra CT scans and imaging after the falls, with multiple minor injuries.

Emergency departments are not designed for long stayers-toilets and showers are limited and shared with a large cohort of unwell people with all sorts of communicable bugs, diarrhoea and other diseases. We have only 1 ensuite room. I wouldn't want to share an ED toilet, cleaning is haphazard.

1f. Current measures to address these ongoing issues in ED are obviously failing. We have been at peak block for over a year now. Temporising measures, stopping non-emergency surgery works but is not sustainable. Our sister hospital over the border in QLD has booked 20 private surgical beds daily. If our ED gets executive approval and the patient is agreeable we may be able to send 5 to the private sector. In practice this doesn't work for ED-it takes around 2 hrs to organise and then another 2 or 3 hours waiting on transport.

Our ED has been repeatedly constrained from calling a Code Yellow, (a new policy was only developed last year). There is absolutely no systematic approach and when the ED FACEMs in conjunction with the NUM ask hospital executive to go Code Yellow, they have been refused on multiple occasions. I

feel the power to call a Code Yellow should be with the ED team alone. If there are no beds available on the ward, and ED has only 4 acute beds left, then it should be called. Executive should attend day or night and find solutions. This does not happen for us. I have not been able to find a Code Brown policy.

1g. Our neighbouring QLD hospital has access to 20 private surgical beds daily. This is a good interim measure. But best not organised from within the ED as a cumbersome, slow process. Could be done from the wards or for planned admissions.

We need a co-located/subsidised GP after-hours Supercentre. I don't think the home visit Dr service is good value for money on the most part. Anecdotally utilised by very well young men etc. But I could be wrong-perhaps continue it with well people triaged to another service.

Streamline inpatients awaiting nursing home placement to another model-of-care. Less RNs required, more AINs. Much cheaper and easier to staff and better use of currently constrained resources.

Streamline less acute mentally unwell patients to another ward off-site. If necessary gazette our local regional sister hospital to facilitate this. The mentally unwell also need better community supports to keep them out of EDs. A local homeless shelter that accepts discharged patients 24hrs would be wonderful. We have a lot of unnecessary overnight visits from disruptive homeless people who would do much better with good community facilities.

Facilitate direct admissions to Mental Health Inpatient Units. Psych Registrars are doctors too and should be up to medically clearing a patient, or perhaps an ED Dr could be on-call to assess the patient on the ward. Psych wards need to be staffed by Registered Nurses who can clinically assess, treat and monitor patients. There is not much point in a solely Psych trained nurse. Most of these patients have co-morbidities/dual diagnosis so do need proper nursing care. A mental health clinic attached to the Mental Health Outpatients 9-5.

Better medical care in Nursing Homes-a Registered Nurse on shift 24hrs. Good visiting GPs/even Nurse Practitioners.

Perhaps a kid's clinic attached to the kid's ward 9-5. Assessed straight up by Paed's trained Drs and nurses.

No planned surgical reviews re-presenting to ED, They should be managed at a pre-admissions clinic elsewhere.