Submission No 19

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

Organisation: Australian Paramedics Association (NSW)

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AUSTRALIAN PARAMEDICS ASSOCIATION NSW

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"We are not excelling, we are drowning": the ramping crisis and what it will take to fix it

Australian Paramedics Association (NSW) Submissions to the Inquiry into the impact of ambulance ramping and access block on the operation of hospital emergency departments in New South Wales

Introduction

In March 2022, Health Minister Brad Hazzard was before the Health Committee for Budget Estimates. A Committee Member asked the Health Minister about an incident where 12 ambulances were stuck in bed block at Westmead Hospital. In response to this question, Mr. Hazzard stated: *"The concept of what still causes major grief in other States – that is, ambulance block – is actually very rare now in New South Wales."* [1]

Mr. Hazzard is incorrect.

For Paramedics with decades of experience, ramping (more commonly referred to as bed block in NSW) is the worst it has ever been.

Bed block takes a massive physical and psychological toll on Paramedics. 2 in 3 Paramedics want to or are considering leaving the profession, and bed block has been identified by many as a contributing factor to burn out. Our members have provided evidence which indicates that bed block is causing patient distress and adverse outcomes, including patient deaths. Every day that the NSW Government fails to act on the bed block crisis is a day that people in NSW are put at continued risk. We warn that the content in these submissions is distressing.

The Australian Paramedics Association (NSW) ('APA(NSW)') is a registered trade union representing the majority of Paramedics working for NSW Ambulance ('NSWA'). After

[1] 'Portfolio Committee No. 2 – Health, Examination of proposed expenditure for the portfolio area', transcript, Page 38, last accessed 9/9/22, https://www.parliament.nsw.gov.au/lcdocs/transcripts/2877/Transcript%20-%20PC%202%20-%2010%20March%202022%20-%20Health%20(Hazzard)%20-%20CORRECTED.pdf

years of advocacy, we welcome the opportunity to provide Paramedics' perspective on the bed block crisis. We also note our frustration that it has taken years of advocacy to get to this point.

Our submissions are based on the experiences of our members and delegates and are informed by a member survey. 53% of respondents worked in metropolitan NSW and 47% worked in regional NSW[2]. Respondents reflected a relatively even spread of experience levels within NSW Ambulance[3].

[2]Regional and metropolitan are defined by NSWA as per this map of ambulance stations: https://www.ambulance.nsw.gov.au/__data/assets/pdf_file/0004/509278/DE222-Metro-and-Regional-Station-Maps-Jan-2021_V14.pdf

[3] 9% of respondents had worked for NSW Ambulance for less than a year, 28% for between 1-5 years, 18% for 6-10 years years, 17% for 11-15 years, 12% for 16-20 years, and 15% for over 21 years.

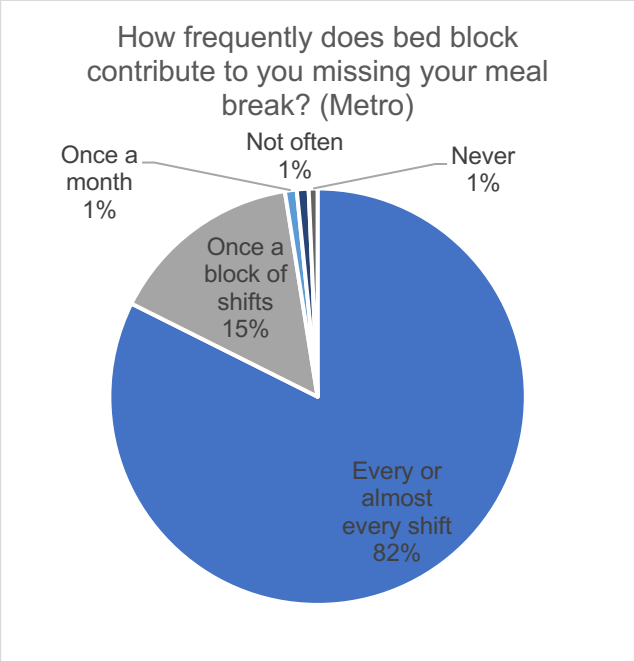
"It is the most demoralising issue that I have had to deal with in the past 20 years, and it just feels like no one cares": The impact of bed block on Paramedics

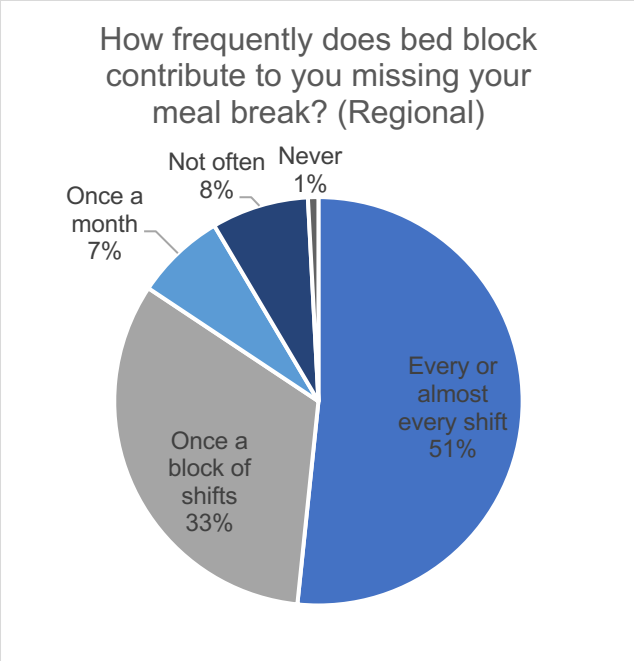
Bed block is not rare in NSW. It impacts Paramedics state-wide and on a near constant basis. 2 in every 3 Paramedics have this year experienced waiting over 4 hours in bed block. The Bureau of Health Information's *Quarterly Report – January to March 2022* confirms Paramedics' experiences of worsening bed block, finding that "1 in 10 patients waited longer than 54 minutes to be transferred, up from 32 minutes in 2019".[4] The report also found that we are seeing the worst transfer of care times since 2013, and more than 1 in 5 patients are not transferred to emergency department (ED) staff within 30 minutes[5].

This section of our submissions explains the physical and psychologic risks and harms experienced by Paramedics because of worsening bed block.

Access to meal breaks

Due to the amount of time ambulances are spending in bed block, any ambulance that is not in bed block is typically immediately assigned to a job. Consequently, there is very rarely time for a meal break. Paramedics typically work twelve-hour shifts. They are meant to access two thirty-minute crib breaks in that time, at their home station. We asked members how frequently bed block contributes to them missing their meal breaks[6].





[4] Healthcare Quarterly – January to March 2022, Page 4. At the time of writing these submissions, this was the latest report.

[5] Ibid.

[6] We note that a "block of shifts" in metropolitan refers to a block of four shifts, in regional a block of shifts can range from four shifts to eight shifts, depending on the roster.

For 97% of metropolitan staff and 84% of regional staff, bed block causes them to miss meal breaks regularly. Working shifts of a minimum of 12 hours without having the opportunity to eat, is extremely dangerous. The risks associated with this are exponentially increased considering the life and death decisions Paramedics must routinely make, both in treating patients and driving at high speeds.

Forced overtime

Bed block leads to forced extension of shift overtime. This happens in one of two ways:

- Paramedics are assigned a patient towards the end of their shift. They treat and transport the patient to hospital and begin waiting in bed block. Bed block results in them being extended past their usual finish time. A NSWA Work Instruction clearly outlines that cars should be sent to relieve crews once they are past their finish time and stuck in bed block, but this rarely happens.
- Paramedics are in extension of shift overtime by the time they handover patient care at hospital. If the crew are at a station utilising on-call rostering, or are less than one hour into overtime, if an emergency case is waiting they can and generally will be assigned that case.

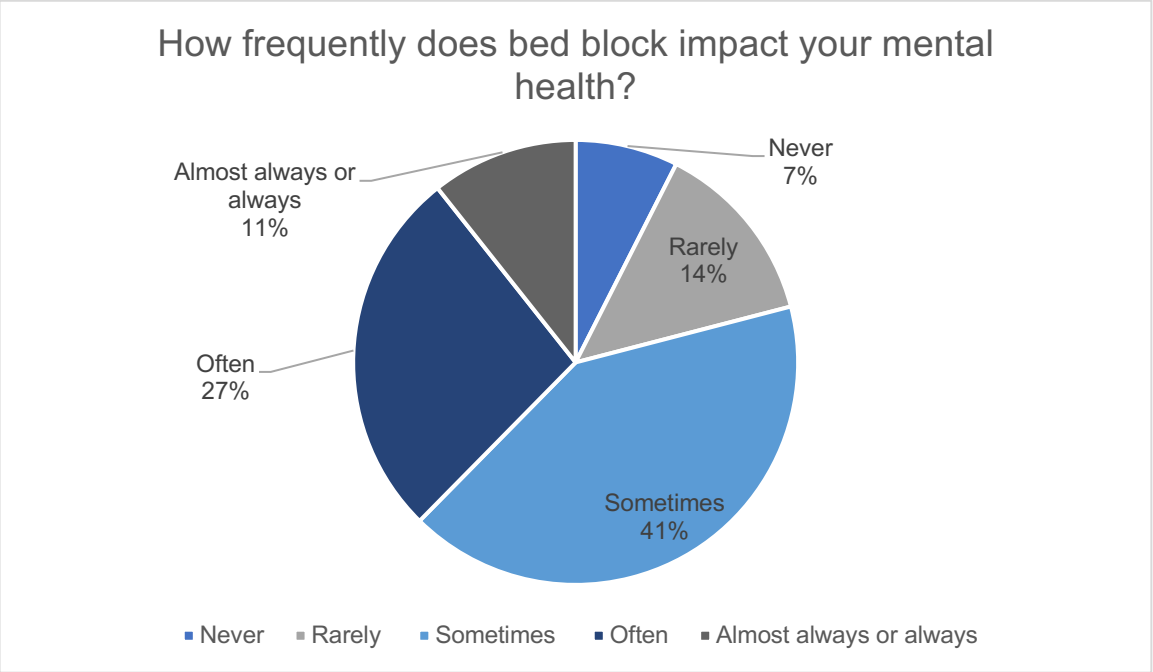
We asked our members how frequently bed block contributes to forced extension of shift overtime. In metropolitan, almost 2 in 3 of Paramedics report that every or almost every shift bed block contributes to them having forced extension of shift overtime, and a further third report that this happens once every block of shifts. In regional NSW more than 1 in 3 say they have had forced extension of shift overtime almost every shift or every shift, and a further 48% say this happens at least once a block of shifts. Because Paramedics are frequently sent away from their home station and community, some will have to additionally travel up to 60 minutes to get home after their shift ends late. They are frequently left with less than 8 hours at home to shower, eat, rest, spend time with family, and return to work for another shift.

Forced overtime results in Paramedics making clinical decisions while fatigued, and Paramedics driving home when fatigued. It is worth highlighting that a survey conducted by APA (NSW) in May 2022 found that 3 in 4 of Paramedics had recently been too tired to drive home safely.

Forced overtime also leads to Paramedics missing out on family time or time with loved ones. For a day shift, end of shift overtime will often mean you get home at around 2000 or 2100. For a night shift, end of shift overtime will often result in you getting home at around 0800 or 0900. This means that Paramedics frequently miss dinner with their family, putting their children to bed, or getting them ready for school, due to end of shift overtime. As one Paramedic has said to us: *“I spend more time staring at a patch on the wall in that…corridor than I do with my own family.”*

Psychological stress

Beyond the simple safety issues of not getting to eat, and working hours that are too long, the psychological stressors of bed block are one of the most significant workplace risks Paramedics currently face. 8 in 10 Paramedics say that bed block has an ongoing impact on their mental health. Of those, 1 in 4 say their mental health is often impacted by bed block, and a further 4 in 10 say it is sometimes impacted by bed block.



Bed block has fundamentally changed the job of a paramedic in NSW. Paramedics are, largely, no longer responding to emergency work. For the most part, they now act as an extension of the Emergency Department. They have no power, no resources, and nothing to provide their patients with comfort.

Disempowerment at work is a significant stress for Paramedics, with 1 in 3 Paramedics say they constantly feel unsupported by NSWA and 1 in 3 Paramedics say they constantly feel disempowered when stuck in bed block. This is reflective of research which has shown that "negative ramping experiences were…associated with symptoms of depression, anxiety, stress and PTSD"[7]. Interestingly, the research notes that those who had a better confidence in their skills tend to be worse impacted by bed block[8]. Paramedics in the research reported feelings of powerlessness. The sense of

[7] Phillips, W. J., Cocks, B. F., & Manthey, C. (2022). Ambulance ramping predicts poor mental health of paramedics. *Psychological Trauma: Theory, Research, Practice, and Policy.* Advance online publication. https://doi.org/10.1037/tra0001241

[8] Ibid

disempowerment and being left without support are common themes when you ask Paramedics about their experiences with NSWA and NSW Health.

The issue of rest areas at hospital is indicative of how this sense of abandonment has become a major stressor. It took months of advocacy from APA (NSW) for NSWA to introduce mobile work trailers so Paramedics would have somewhere to sit and complete notes. Before these trailers were introduced, Paramedics were sitting on concrete floors or trestle tables, and often had to use hospital bedding to keep warm. Following the advocacy of APA (NSW), many hospitals have introduced work trailers. However, some sites which experience major bed block frequently, including Blacktown and Westmead, have still refused to put in place work trailers. Instead, Paramedics are left sitting on trestle tables next to overflowing PPE bins.

Paramedics are routinely, significantly stressed by not being able to get to patients who need help. 4 in 10 Paramedics say they almost always or constantly feel stress relating to not being able to get to jobs due to being stuck in bed block.

Paramedics comments on the crisis are indicative of the extent to which their mental health has been impacted by bed block. Below are some of the responses we received from Paramedics when asking about the mental health impacts of bed block:

- *“Bed block is no longer "Monday madness’ or the odd chaotic Friday night, it's every day... It's exhausting coming to work knowing that's how my day will be spent. It's soul destroying trying to be the patients advocate time and time again only to be sent to the waiting room or ramped for hours on end causing avoidable deterioration if not death because there's only so much we can do. A job that I studied passionately for 3 years for has now become a means to pay the bills while I watch my mental health suffer. Stress levels are at an all-time high and morale an all-time low.”*
- *“It’s hard to communicate just how significant of an impact bed block has on me.”*
- *“It is the most demoralising issue that I have had to deal within the past 20 years, and it just feels like no one cares”*
- *“It’s feeling helpless because we can only do so much.”*
- *“Depressing knowing that at the start of shift I will almost certainly be stuck in bed block and having 1-2.5 hours OT as a given. Missing family time every shift.”*
- *“The service doesn’t really care about paramedics…the service only cares about KPIs and stats”*
- *“It has got so bad I am actively looking for employment elsewhere”*

It is difficult to comprehensively explain the impact that bed block has on Paramedics. The next section of our submissions looks at the impact of bed block on patients. While reading the next section, we would encourage the committee to reflect on the distress they feel reading these submissions, and how it must pale in comparison to the stress felt by those living these submissions daily.

"Patients are dying in bed block and its completely avoidable": The impact of bed block on patients

Paramedics' responses to our survey evidence that patients suffer indignities and embarrassment, experience worse clinical outcomes, and can die due to bed block.

The stories provided in these submissions barely scratch the surface of the on-road experiences of worsening patient care due to workload and bed block.

Hospital treatment beginning in bed block

97.6% of Paramedics have seen patients begin hospital treatment in bed block. The impacts of treatment beginning on stretcher/in ambulance bays concern patient comfort, privacy and safety, and the way this changes the scope of Paramedic practice. Treatment in bed block has become necessary to ensure all patients are cared for and can be triaged appropriately, but is about as far from best practice as a health system could really get. The fact that it has become a necessity is indicative of the depth of the health system crisis. Some examples of treatments occurring in bed block include mobile x-rays in parking lots, MRIs, pathology, medical history being taken, portable ultrasounds in bed block, nerve blocks being placed, paramedics transporting patients to x-ray and CT machines in hospital, catheters being inserted, IV fluids beginning, joints relocated in hallway, and fractures reduced in bed block. Paramedics have reported being in bed block for so long, with patients in such a declining state, that they have had to prepare for their patients going into arrest: "*I've seen a STEMI patient [patient having a heart attack] kept in the ambulance bay due to no beds so they put a Lucas [CPR] device on top of a trolley and kept it next to the patient in case they arrested in the ambulance bay.*" Patient treatment beginning in bed block is a sign of a system in crisis. It results in patients having little to no dignity or privacy, and delays Paramedics in being able to respond to emergencies in the community.

Patient embarrassment and indignities

8 in 10 Paramedics report that they have seen bed block cause patients embarrassment and other indignities. Paramedics make every effort to ensure patients have as much privacy as possible, but when a patient is stuck in an ambulance bay or in the corridor of a hospital, privacy simply cannot be achieved.

A key issue for patient wellbeing, care and dignity is not being able to access the bathroom. Many patients require assistance to get to the bathroom and use the toilet. This can be particularly sensitive for women who only have two Paramedics who are men who are available to assist them. Many patients are not able to be mobilised due to illness or injury. If they are too embarrassed to ask for a bed pan or bottle, or cannot use a bed pan or bottle, or if there are no bed pans available, this results in them soiling themselves on stretcher. Those who have access to and can use a bed pan or bottle have no privacy when using them.

An example provided by a paramedic is distressing*: "I spent 3 hours in a corridor with a…[patient] with frequent diarrhoea requiring multiple bed pan changes and*

cleaning….[this was] extremely distressing to the [patient] who had no privacy or dignity". Another Paramedic succinctly summarises the situation in most hospital corridors: *"…Unwell patients…being stacked side by side on top of one another for hours on end and having to endure the vomiting, coughing, crying, [defecating]"*. Patient dignity is lost in the bed block crisis.

Medical privacy is not able to be achieved in bed block. Patient history, exams, and diagnostic questions all occur in bed block, again either in hospital corridors or in ambulance bays. Paramedics broadly report that x-rays, ECGs, femoral blocks, and injury exams, have all been completed without privacy. An ECG involves exposure of the chest and breasts, a femoral block requires removal of pants and or the gown for access. One patient has unfortunately had to have a conversation with a surgical team in the hallway of a hospital about whether they could save his necrotic foot. At one hospital, patient details are read out over the loudspeaker intercom, resulting in all patient and staff being able to hear personal information.

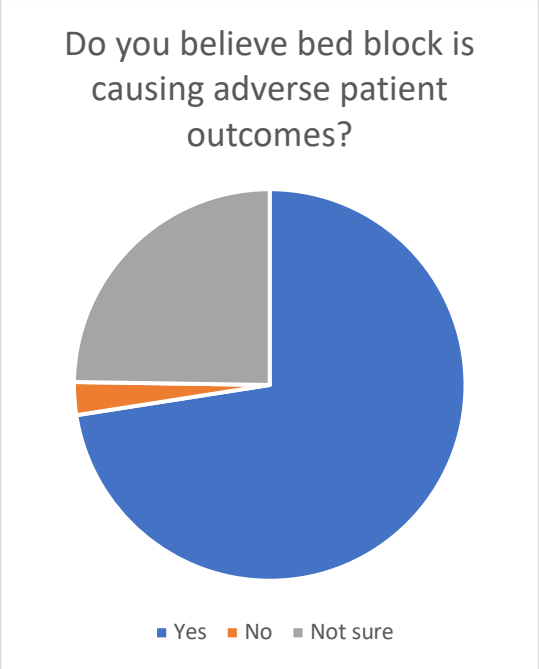
Many patients are also forced to go through very difficult situations surrounded by dozens of strangers, in a noisy area, with no privacy. For example, a Paramedic has reported caring for a patient miscarrying while stuck in bed block. Stretchers are also often are so uncomfortable that patients require additional pain relief just to make it through the extended wait time.

It is worth drawing particular attention to the impacts of bed block on mental health patients. Sometimes, due to the stress and long wait times of bed block, mental health patient behaviours escalate to the point where they are dangerous to themselves or others, so they have to wait outside in the ambulance bay rather than in the hospital corridors. Paramedics have reported distress at having no option but to sedate or restrain patients for their safety and the safety of others. Dementia patients also experiencing increased distress in bed block due to the environment.

Further, bed block has significant impacts on patients who self-present to mental health emergency departments. In many of these emergency departments, mental health patients are simply placed on waiting chairs in corridors. They are then surrounded by other mental health patients who have been brought in by Paramedics, some who may be displaying distressing behaviours. The wait times for these patients are awful, as one Paramedic reflected: *"It is demoralising to see a [patient] sit there for over 12 hours even into the next morning when you come in for your second shift and they are sleeping on the floor."* This can be particularly upsetting for patients who have not been in a mental health emergency department before, or who have trauma related to hospitals.

Adverse outcomes for patients

More than 7 in 10 paramedics believe that bed block is causing adverse patient outcomes. One Paramedic simply says: *"Patients are dying in bed block and is completely avoidable".* Another states: *"We get [to a job] and find someone so ill/dead and we have to live with the knowledge that if we had gotten there just two hours earlier, it would have been a completely different outcome".* In short, Paramedics believe that bed block, by delaying hospital care and ambulance response times, is harming patients.



84% of metro Paramedics report that every or almost every shift bed block has stopped them responding to a job in their community, and a further 13.5% say that this happens at least once a block of shifts. 52% of regional paramedics say bed block has resulted in them not being able to respond to a job in their community every shift or almost every shift, and 32% say this happens once a block of shifts. As one Paramedic said, *"It's horrible hearing jobs go down that are in dire need of Paramedic response and we have to sit on our hands and listen and not do anything".*

Bureau of Health Information data reflects the experience of Paramedics, with the latest quarterly report showing that ambulances are currently only getting to 37.7% of emergency patients within 15 minutes, and 79.5% within 30 minutes[9]. 6 in 10 emergency patients aren't getting an ambulance on time. The highest priority incidents, 1As, which include heart attacks and patients who cannot breathe, are only getting attended to on time 60% of the time.[10] Bed block is a substantial contributor to those delayed response times.

Below are some examples relayed to us by Paramedics of times when they feel bed block has impacted their patients' health. The details included below are distressing. We have omitted details that could identify patients and summarised most examples to make them accessible to people without a clinical background. We have requested that some examples be suppressed from the publicly accessible version of this submission due to the nature of the incidents.

Ectopic pregnancy

A patient was stuck in bed block with a suspected ectopic pregnancy. On arrival to ED her vital signs were okay but she was in extreme pain with an increasingly firm abdomen. Paramedics pushed for the patient to be treated with more urgency and were moved to

[9] [9] Healthcare Quarterly – January to March 2022, Page 11. At the time of writing these submissions, this was the latest report.

[10] Ibid.

a non-monitored room and told to offload. When they again escalated concerns, a doctor came to do an ultrasound which confirmed massive amounts of free fluid in the abdomen. By the time the patient was moved to a resus bay, she had been waiting for 1.5 hours.

Gastrointestinal blead

A patient with gastrointestinal bleeding had been waiting for an ambulance. Paramedics were delayed in responding by more than 2 hours. The patient arrested and died shortly after arriving at the emergency department.

Delayed treatment of sepsis

We have received multiple examples of patients experiencing sepsis being stuck in bed block, or having a delayed ambulance response, and their condition worsening.

At one hospital, a patient in sepsis waited 45 minutes to be triaged. When the Paramedic followed up the next day, the patient was in resus with “hours to live”.

On the Central Coast, a car that had been stuck in bed block for hours attended a patient who had been waiting for six hours for an ambulance. They were in critical sepsis by the time the Paramedics arrived and later died at hospital.

Another paramedic relays a story of bringing a septic patient to hospital, and was bed blocked for 45 minutes. They had repeatedly flagged their patient was deteriorating with several staff members, and had gone through every treatment protocol possible. By the time the patient was transferred to the care of hospital, their blood pressure was so low the Paramedics were readying to perform CPR.

Other examples of adverse outcomes

The above provides a small sample of stories we received when asking Paramedics about the impact they had seen of bed block on patients. Some other, brief examples are included below:

- Multiple patients who were having heart attacks waiting for hours in bed block[11]
- Multiple examples of patients who have been assessed as having a likely stroke waiting for hours in bed block. For instance, one suspected stroke patient waited three hours at a Central Coast hospital, another teenage patient with a suspected stroke and a stroke history waited over an hour in bed block to be assessed by a physician.
- A crew diverted from attending a teenager who was post overdose to attend another job out of their area due to cars being stuck in bed block. The teenager was time critical due to the nature of the overdose and risk for further self-harm.
- A patient with intracranial bleeding after a fall with worsening symptoms waited for several hours in bed block
- A Paramedic who was stuck in bed block at Maitland Hospital when they heard two cardiac arrests occur in Cessnock. The nearest car at the time was 40 minutes away.
- Paramedics arrived at hospital with a patient in cardiac arrest and were told to wait in the corridor because all the resus beds were full. As a result, a hallway full of patients and bystanders had to watch these Paramedics perform CPR.
- A patient with shortness of breath waited 40 minutes for an ambulance response. By the time the ambulance arrived, they were in cardiac arrest and pronounced dead shortly after.
- An elderly patient with a compound tibia-fibula fracture was stuck lying on the floor for three hours waiting for a response and could not receive adequate pain relief, as Intensive Care Paramedics were stuck in bed block.
- A new mother with decreased consciousness, and a low heart rhythm waited over 2 and a half hours on stretcher. It was eventually identified after advocacy from the Paramedic that she had a brain bleed.
- A patient who was hit by a car was left waiting for 45 minutes in the middle of a busy road as Paramedics were delayed due to bed block

For every incident we have raised here, there will be many more like it, unreported. The ambulance service cannot plan for every eventuality, and there will be times when someone calls for an ambulance and none are immediately available. But this shouldn't be an everyday occurrence. It shouldn't be expected to happen. And it shouldn't be happening because cars are waiting to transfer patient care for four or more hours at the nearest hospital.

[11] It is worth noting that there is a clinical distinction between a heart attack and a cardiac arrest. A heart attack is when there is a blockage in the heart which stops blood getting to the heart, resulting in heart tissue dying. The result of a heart attack can be cardiac arrest.

Causes of bed block

Bed block is an issue born of decades of inaction and failure to invest in a functional health system. In this section of our submissions, we look at the issues commonly identified by Paramedics as causing bed block.

Community care access and low acuity workload

The bulk of Paramedic work is increasingly work that can and should be undertaken in a community healthcare setting, but is not due to the lack of affordable and accessible community care. The lack of accessible community care leads to last resort 000 calls and avoidable emergencies, and more frequently results in Paramedics doing more low acuity work. State-wide, 97% of Paramedics believe that lack of community care contributing to bed block.

Patients are experiencing wait times for GPs of weeks or even months, and as a result Paramedics are acting as "*mobile GPs*" and are *"constantly called to people who can't get into a GP*". One Paramedic has said *"If I had $1 for every job I've attended where a patient says sorry I tried to get to my GP but they weren't available I'd be able to retire".* A Paramedic ran through the issue succinctly, stating:

> *"I attend on average 3+ cases a shift that could be managed through a GP, but a lack of access (including face to face) and patient understanding leads to increased inappropriate ambulance calls. Thus when we finally arrive at these cases late when GPs are closed, working with the [patient] for a non-transport pathway is an uphill battle, leading to…unnecessary transports and then bed-block".*

The accessibility of GPs is also, of course, linked to affordability of GPs. There simply are not enough bulk billing GPs in most communities, resulting on a reliance on ambulance services.

Anecdotally, GPs are also more frequently referring work to the ambulance service. Paramedics feel that increasingly GPs are advising patients who do not require emergency care to call an ambulance to go to hospital. GPs face a myriad of their own challenges, including being overworked and under-supported by federal and state governments. We are not raising this issue for the proposes of targeting the practice of certain GPs, but rather to draw attention to the pressure GPs are under, and the consequential workload pressure that Paramedics face.

Exacerbating the impact of the lack of affordable community care is the poor triaging system utilised by NSWA. Paramedics say that the triaging system routinely misclassified low-acuity work as emergency, and emergency work as low-acuity, and many members have identified improving the triaging system as a key action in reducing bed block. The current triaging system does not allow for clinical nuance, forcing call takers to follow strict guidelines, and as a result it will often misclassify work. This is dangerous for non-emergency and emergency patients alike.

The lack of GPs and community care options has a consequential effect of making it challenging to utilise non-transport care pathways, where Paramedics refer patients to

community health services instead of transporting them to hospital. If the triaging system was poor, and continued to result in low-acuity patients being sent ambulances, but there were adequate referral pathways, the impact on hospitals could be lessened. Many patients would prefer at home care, or a referral to an alternative clinical pathway, to a stressful visit to hospital and hours waiting on a stretcher. Too often, Paramedics have difficulty utilising non-transport pathways due to not being able to book an appointment with a community care service. It is worth noting here, as well, there are compounding issues with the utilisation of non-transport pathways, including Paramedics not being well educated or well supported in utilising these pathways. A 2017 NSW Auditor General's report on 'Managing demand for ambulance services' found *"Less than a quarter [of Paramedics] agreed that they had received enough training or could easily refer patients to services other than hospital emergency departments. Only 26 per cent agreed that their manager would support their decisions when using non-emergency department options for patients."* [12]. In short, Paramedics are not well supported by either NSW Health or NSWA to help patients get the most appropriate care they need.

Aged care facilities lacking appropriate resources and skills

Aged care facility resourcing is a significant contributing issue to bed block. Due to a lack of clinical staff at aged care facilities, Paramedics do a large amount of low-acuity work transporting patients between aged care facilities and hospitals. Because this work is low-acuity, these patients often wait for a long time in bed block. Many Paramedics believe that 24/7 RNs and better access to GPs is key to providing aged care facility residents comfort and care within their facility. Paramedics note that facilities with 24/7 RNs call far less often than those who don't. One Paramedic summarised the issue clearly:

> *"Lack of RNs at residential aged care facility leads to increases in after-hours calls, leading to hospital stays and ED stays as facilities will not accept residents returning home without an RN."*

We note the current action being taken at a federal level to mandate some level of 24/7 coverage. The state government must take any action possible to support these efforts, and advocate for them to be expedited. The state government must also do more to support nursing students and current nurses to reduce burnout[13].

Aged care facilities are a primary cause of unnecessary or low acuity transfers to hospital. End-of-life care directives are too often not completed for aged care residents, resulting in patients being transported to hospital when they may not wish to. Some transfers occur in circumstances where it seems to make little sense. One Paramedic provided the example of patients being sent to hospital when they are symptomatic for

[12] December 2017, 'Managing demand for ambulance services' , New South Wales Auditor-General's Report, Available here: https://www.audit.nsw.gov.au/sites/default/files/pdf-downloads/Managing%20demand%20for%20ambulance%20services.pdf, last accessed 9/9/22

[13] Paramedics wholeheartedly support nurses and midwives call for fair wages and ratios.

confirmed COVID, only for the hospital to transfer the patient back to the aged care facility once they note their care directive declines life prolonging measures.

Bed block is worsened by a high number of low acuity jobs from aged care facilities. These patients wait hours in ED, unnecessarily and often to their detriment. These patients generally could be treated intra-facility, by an RN, a GP, or even an Extended Care Paramedic, trained in at home care.

Failure to support the ECP program

For every patient diverted from an emergency department, the Extended Care Paramedic (ECP) program saves the health system money, reduces pressure on the hospital system, and provides at home care to patients, helping them avoid costly and stressful visits to hospital. ECPs can provide antibiotics, fix catheters and gastronomy tubes, do sutures, address dislocations, and more. Despite the evident value they bring in avoiding transfers to hospital, the ECP program is routinely ignored by NSWA.

The previously mentioned 2017 report into managing ambulance demand notes that analyses across other jurisdictions have found that "Extended Care Paramedics…achieve higher non-transport rates compared to regular paramedics"[14]. Unfortunately, NSWA do not monitor or assess the ECP program in a systematic manner as noted in reports in both 2013 and 2017[15]. The same 2017 audit found that there was a "lack of clarity" around governance and oversight of the program. APA (NSW) has been advocating for over a decade for clear governance, assessment, safety and management structures of the program. NSWA has refused, and ECPs widely report feeling unsupported by NSWA.

ECPs are routinely used to 'stop the clock' on response time Key Performance Indicators. They are often tasked as a single responder to inappropriate high acuity jobs. When inappropriate tasking occurs, there is a risk that an ECP attends a patient who requires urgent transport to a hospital, and they cannot transport them due to not having a stretcher. This is immensely dangerous for patient and Paramedic.

Further, NSWA has recently notified APA (NSW) that they intend to place location limits on specialist positions, disallowing specialists from moving between stations unless to an "identified" specialist position. To the knowledge of APA (NSW), there are no formally funded/identified ECP positions outside Sydney, Wollongong and Newcastle. This could mean that if any ECP wishes to move to a regional location, they may be forced to give up their specialist credentials.

In short, the ECP program has potential to improve patient care, reduce bed block, and reduce costs for the health system. Despite this, NSW Health have not invested in the program, and instead use ECPs to hit response time KPIs and fill gaps in general Paramedic rosters. Even worse, NSWA is actively restricting regional communities from

[14] December 2017, 'Managing demand for ambulance services' , New South Wales Auditor-General's Report, Available here: https://www.audit.nsw.gov.au/sites/default/files/pdf-downloads/Managing%20demand%20for%20ambulance%20services.pdf, last accessed 9/9/22

[15] Ibid

having access to specialist Paramedics who could reduce the need for stressful hospital visits, and reduce the pressure on local rural hospitals and health centres.

Resources of regional hospitals

Regional hospitals are under-resourced, both in staff and equipment. 85% of regional Paramedics agreed or strongly agreed that better resourced rural hospitals would reduce bed block. Too often, patients are transferred to major regional centres due to a local hospital not having a GP, an x-ray machine, or a CT scan. These transfers are often non-urgent and result in a small community being left without an ambulance for six hours or more. Regional and rural towns are some of the most vulnerable to adverse outcomes occurring due to Paramedics being on a long-distance transfer, as often a town is covered by just one ambulance at a time. Bed block is worsened by transferred patients from smaller hospitals, but also consequently worsens the risks for communities in smaller regional towns of being left without an ambulance.

Lack of safe staffing in ED

Paramedics will always loudly, proudly support the fight for nurse-to-patient ratios. It is essential not only to the safety of nurses and midwives and their patients, but also essential for the safety of Paramedics and our patients. 9 in 10 Paramedics say that safe staffing ratios would reduce bed block. Unsafe staffing numbers lead to beds being closed in ED. It also leads to longer patient care times in the ED, which slows down the capacity of ED staff to free up beds for Paramedics by discharging patients or transferring them to a ward. Reduced staffing in wards also impacts the ability of staff to transfer patients from ED to a ward. The impact of unsafe staffing is not only felt in metropolitan Sydney, but state-wide. Paramedics strongly support nurses and midwives fight for safe staffing ratios, and see it as a key action in addressing the bed block crisis.

“Band-aid” and abandoned solutions by NSW Health

When we asked Paramedics to consider “What strategies have you seen NSW Health or NSW Ambulance try and introduce to reduce bed block”, and many, many responses simply stated “none.” Many other responses said words to the effect of “N/A” or “not a lot” or “nothing”. It is safe to say that Paramedics broadly do not believe that any substantive efforts have been taken by NSW Health to manage bed block. Programs such as the ECP program or Virtual Clinical Care Centre are great, but are under-supported and under-utilised by NSWA. They can also only do so much in an environment devoid of accessible and affordable community healthcare.

The primary strategy currently utilised by NSW Ambulance when bed block worsens is that a Health Relationship Manager (HRM) and/or Duty Operations Manager (DOM) may attend the hospital in question to liaise with senior hospital management to discuss solutions. This has mixed results, generally relying on the strength of the relationships between the HRM or DOM with hospital senior management. It also relies on there being something the hospital can do to prioritise offloading patients. Often the beds simply are not available, and they cannot be created out of thin air.

Previously, there have been two transfer of care programs introduced to reduce the time spent by Paramedics in bed block. One of these is known as the “Ambulance Relief Team” (ART) and one is known as “TOC” or Transfer of Care. In the former, Paramedics would take up an overtime shift and station themselves at hospital. Paramedics on road would then handover patient care to the ART crew and respond to the next job. The TOC program saw Paramedics transfer patients to hospital beds stationed in hospital corridors or handover bays, and formally transfer patient care to a nurse assigned by the hospital to care for those patients. The ART program no longer operates. The TOC program operates very rarely, and only at a small number of hospitals.

Generally, there has never been anything but “band-aid” solutions to the issue of bed block, and no solutions that prioritise both Paramedic and patient safety.

Recommendations: Reforms to ensure every patient gets the right care, at the right time

Speaking briefly to recent reforms, they demonstrate the power that health workers have when we take action. APA (NSW)'s continued advocacy has lead to commitments for 1850 new Paramedics, 25 new community care centres, and support for expanding regional Patient Transport operating hours. These are significant investments from the NSW Government, and will make a significant difference to our lives on road. However, they are not enough, and will not sufficiently address the long term causes of bed block. Substantive, courageous reforms are needed, and without these we will once again experience the horrors of bed block, but with more Paramedics, and more ambulances stuck, unable to help our communities.

Recommendation One: Permanent Paramedic work zones at hospital

The problem of bed block will not go away overnight and immediate relief is required for Paramedics. Every hospital which experiences bed block should immediately provide Paramedic's with a mobile work trailer for Paramedics to use to write clinical notes, drink, and eat out of the elements. Paramedics cannot continue to huddle in sheets, work on trestle tables next to PPE bins, or feel on the brink of fainting due to heat stress.

Recommendation Two: Consultation on models for temporary transfer of care options

Consultation with unions should be undertaken to consider models of temporary transfer of care options, and if these could be implemented in a manner that is safe for Paramedics, patients and hospital staff. If it can be done safely for patients, paramedics and hospital staff, this may be required in the interim while bed block remains chronically dangerous. Transfer of care options should never be a long-term solution.

Recommendation Three: Investment in hospital system infrastructure

In consultation with unions, model and increase hospital resourcing in line with community needs, including beds and staff where needed.

Recommendation Four: Safe nurse-to-patient staffing ratios

Nurse-to-patient ratios are desperately needed in Emergency Departments and all hospital wards.

Recommendation Five: Investment in the Extended Care Paramedic Program

The Extended Care Program has proven immensely valuable since its inception, and yet since its inception, NSWA has let the program languish and left the clinicians without support. We recommend the following actions to immediately support existing clinicians and expand the workforce:

a) NSW Ambulance should, in consultation with unions, determine a management structure and safety plan for Extended Care Paramedics

b) NSW Ambulance should, in consultation with unions, identify priority non-metropolitan stations which would benefit from Extended Care Paramedics
c) NSW Ambulance should immediately remove any location limits on specialist positions, allowing specialists to work anywhere in the state
d) NSW Ambulance should allow regional Paramedics to train as ECPs without relinquishing their regional position
e) NSW Ambulance should commit to expanding the ECP workforce and should consult with unions about the extent of investment required

Recommendation Six: Investment in affordable community and mental healthcare

A greater state-wide investment is needed to ensure no-one is left waiting for weeks on end for a GP appointment or mental health care. Along with more Extended Care Paramedics, we need more bulk billing community healthcare centres, state-wide. 25 community healthcare centres is a great start, but we need to make sure these resources are not only limited to Sydney. Importantly, community care also means community mental health care that is free and accessible. Communities across NSW deserve the same standard of care.

Recommendation Seven: 24/7 Patient Transfer Officers, state-wide

Sometimes, due to a lack of resourcing or patient need, transfers need to happen. 24/7 PTOs would ensure that wherever possible, Paramedics remain available for emergencies.

Recommendation Eight: Review of regional hospital resourcing

In consultation with unions, NSW Health should conduct a comprehensive review of the resourcing of all regional, rural and remote hospitals and multi-purpose health facilities with a view to providing staffing and equipment enhancements as the need is identified.

Recommendation Nine: Review of the triaging system

Urgent reform is required to the triaging system, to ensure that every patient gets the right care, at the right time.