**Submission No 21**

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

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**Parliamentary submission - Dr Pramod Chandru and Dr James Tadros**

**Background**

My name is Dr Pramod Chandru and this submission is written with the assistance of my colleague Dr James Tadros. We are both specialist Emergency Physicians and fellows of the Australian College of Emergency Physicians (ACEM). We have spent all of our medical education, junior medical officer years and speciality training time in Western Sydney, working in emergency departments significantly affected by access block and issues with ambulance ramping. We have both witnessed the effects this has on service provision that is central to our speciality and experiences of our patients attempting to access clinical care. Furthermore, as medical practitioners who now supervise and assist future doctors in our area of speciality, we have seen the effects that emergency department overcrowding has had on the medical and nursing workforce. We purport to convey our experiences in the hope that it might offer the honourable members tasked with this inquiry a fresh and concisely narrated description of the reality of working in Western Sydney emergency departments in 2022.

We wish to preface our submission by conveying that we opt out of ascribing the blame of a dysfunctional system on any individual or particular organisation but rather, a combination of factors has led to the current patient experience within our emergency departments. The current model had successfully provided world class healthcare but the currently is out of touch with expectations and standards of medical care and risk taking.

At the beginning of our careers, access block and ambulance ramping were exceptions to our clinical shifts, phenomena that were reserved for only the busiest days of the weeks. However, now as senior clinicians, neither of us can recall a shift in the last 3 years where access block and ambulance ramping has not affected clinical care. A significant driver for our writing of this submission is to advocate for those who fall under our responsibility and purview. Our patients often do not recognise that the care they are receiving is below what we might want to provide them. We are failing our junior doctors who's medical education, training, wellbeing and morale we are tasked with nurturing and caring for. We fall short of the standards we set for ourselves consistently due to hinderances in a system that is antiquated, all be it well meaning.

To keep our responses concise, we will aim to organise our thoughts around the key terms of reference for the inquiry.

***Causes of ambulance ramping, access block and emergency department delays:***

Looking beyond the definitions of these terms perhaps the easiest way to summarise the causes of these issues is to reduce them to three core problems

1) Impaired access to adequate disposition locations within the hospital system

   Our trained role as emergency physicians to understand our role in clinical care as being the acute assessment of a patient, formulation of a diagnosis, identification of severity, participation in early resuscitation where required and rapid arrangement of disposition of a patient (be it discharge, admission to ward, admission to a critical care unit, or transfer to another centre for further care). However it is not unusual, as senior clinicians, to commence a shift with a total hospital bed deficit of 35 - 45 admitted patients. This means that, prior to the commencement of our shift, we begin with a significant proportion of patients, often greater than the total number of emergency acute treatment spaces, awaiting beds within the hospital system. This term access block has been defined by various arbitrary numbers for research and policy purpose. Fundamentally the causes of access block are many, varied and complicated but, suffice it to say, access block seen within the emergency departments are a

reflection of an underlying friction within the system between one facet that functions 24 hours of the day 7 days of the week, and another facet which remains fully functional only within business hours, with few exceptions. And so, to think that these two systems might be able to interact in a way where one might be able to keep up with the other is a fallacy which sees delays to treatment and delays to assessment by inpatient subspecialty teams who ultimately provide definitive and often sub specialised care to patients. The consequences of these actions means that often on a clinical shift, where it is my responsibility to review new patients who arrive in the emergency department, my time and resources are consumed by these patients and their escalating needs.

2) Patient's awaiting investigations

Risk assessment and risk management are all strategies employed by emergency clinicians to rationalise investigations and provide patients with assurances and plans for their ongoing care. This is another key philosophical and existential ideal that is key to our profession. The idea that we negotiate the gulf between an individual's and the system's perception of the severity of their problem. The articulation of this risk falls on us as senior emergency clinicians. It is my job to explain to a mother, using my understanding of the evidence, current guidelines and consensus practice, why her one year old child who fell over and hit his head does not requiring a CT scan to ensure there is no bleeding on the brain. However, time, improvements in medical practice, political motivations and alterations in public perception of acceptable risk has seen a gulf between these two exceptions trend closer and closer together. This has many benefits for patient advocacy and certainly plays a role in enhanced healthcare provision. One side effect of this however is the performance of investigations that might have once been reserved for an outpatient setting (in a clinical scenario where a delay to definitive diagnosis might have been seen as acceptable) now occurs in the inpatient setting. This results in more scans, more investigations and more extensive testing in general for patients within emergency departments as clinicians are no longer willing to shoulder the burden of risk that the system is unwilling to share. This leads to patents waiting for hours before having investigations performed and adds a further layer of triage for resource limited testing on the emergency department clinician.

3) Patient's awaiting transport to another facility

The paradox of having ambulance transport to a facility but no transport to return home dawns on many patients and their carers as their hospital care is completed. The arrangement of inter hospital transfers for those patient's deemed low risk, generally does not occur outside of operating business hours. This population of patients includes those with complex needs or restricted mobility, those from care homes and aged care facilities, or those without the means to organise transport for themselves. The presumption of a patient's ability to arrange paid private transport is often false. This means that that many patients take up acute care resources long after their need for acute care has ceased. These patients consume crucial hospital bed hours leading to a further lack of treatment spaces, further exacerbating ambulance ramping.

## ***Effects of ramping and access block on the ability and capacity of emergency departments to do their function***

### ***Ambulance ramping impact on patients, paramedics and ED and hospital staff***

Understanding the function of emergency departments and the role that clinicians play in it can be summarised into three core areas of concern.

1) Early identification, diagnosis and treatment of life threatening emergencies

Perhaps easily seen as the primary role of an emergency department and the core business of an emergency clinician, I would like to reframe the conversation around identification, diagnosis and treatment as one of adequate and accurate risk assessment, rather than one of medical expertise. It seems pedantic at first, but such a delineation is key to understanding the methodological flaws that often lead to clinical errors within emergency departments. An inadequate assessment of risk (i.e an inadequate and inaccurate assessment of the likelihood of a patient having or not having a life-threatening illness) is the fundamental reason behind the vast majority of clinical errors and may or may not be due to a deficiency in medical expertise. Indeed, my own ability to perform risk assessments and judgments on patients has been significantly impaired by a combination of a lack of treatment spaces, combined with an overwhelming volume of decisions which are required to be made in a short period with a high degree of accuracy. Trending towards more conservative risk assessments in these scenarios (for example assuming all patients who hit their head might have a brain injury and therefore will all require a CT scan) can lead to over investigation and increased lengths of stays which can worsen access block and ambulance ramping. Trending towards more aggressive risk assessments can lead to errors resulting in well publicised failures of detection of critical illness. The accuracy of an assessment performed in an appropriate clinical space with appropriate staffing and resources is vastly different from one performed in a clinical space that is not designed for that purpose, for example a plastic chair in a public thoroughfare.

One of the greatest tools in the risk assessment armament of an emergency clinican is the Australasian Triage Scale (ATS). This scale rapidly identifies patients who are to be seen urgently from those who can be seen less urgently. Due to the disparity between the volume of patients and availability of treatment spaces, leading to delays in treatment initiation, often patients who are of a less urgent category have now waited for so long that their clinical acuity has transcended their initial triage category. This is not a failure of the clinician who provided the initial triage but rather, a reflection of most untreated critical pathology. When deciding which patient to see a clinician must now contextualise that patient on the background of all other patient's waiting to be seen. This is time consuming and is never actively acknowledged or actively taught within any structured teaching or education program, primarily because it is below any acceptable standard of care. I fear that the medical fraternity has failed to be proactive in developing strategies to work with access block, or at least acknowledge that its presence might alter the understanding of risk around which we base so many of our clinical decisions. We must either repair the current system or begin accepting it and train our staff in navigating the dysfunctional system in a risk averse manner.

2) Public health and patient advocacy

Patient advocacy and public health is a challenge that perhaps came to the fore during the COVID 19 pandemic and is a story easy to follow in the headlines of the last 24 months, however, there are more subtle challenges that manifest themselves in emergency departments which reflect a larger public health crises in the community. Homelessness, lack of crisis accommodation, sexual assault and domestic violence, are all issues that clinicians working in the emergency department quickly identify as urgent. Urgency of a different kind, something humanitarian and widely deemed as unacceptable has historically seen these patients seek the only door that is constantly open for refuge. However, lack of resources and lack of any true coordination between different relevant organisations see delays in these patients finding safe environments. Their situation is personally no less urgent, but to the system that is forced to prioritise, their care is too often neglected. Challenges in the assessment and risk analysis of a well patient in a non-treatment space is only compounded by the presence of language barriers, intellectual or physical disability, mental health issues or domestic violence. Advocating for the care of these patients makes this far more complicated.

3) Staff wellbeing and education

The pressure and demands of clinical care and the management of unwell patients can be taxing on the time and mental capacity of senior emergency staff. Part of our role as supervising clinicians is to educate our future clinicians in the practice of emergency medicine and emergency care. For a clinician to learn an environment must be provided that is safe, controlled and supervised. The consequences of ramping and access block means that we are increasingly challenging our trainees with scenarios that we never encountered. We are demanding of them greater and greater risk-taking behaviour and teaching them norms that might not translate to safe clinical practice. Much is said about the nature of clinical gestalt and its ability to supersede even the most well-articulated risk calculators in decision making. However, the foundations of gestalt arise form a core of strong supervision and teaching neither of which are feasible in the current training environment. Furthermore, the burden of risk is a heavy weight to carry for the uninitiated. Sleepless nights contemplating decisions made in the heat of the moment is a plague on the profession, and as these decisions are made by less confident and less competent staff, the burden they lay on the decision maker is greater and greater. This war of attrition with one's own nerve is one of the foundational causes for burn out in the profession particularly amongst junior staff. As a senior clinician, I endeavour to protect my staff from the exposure to risk they suffer on a day to day basis but flaws in the system mean that an inadequate or inaccurate assessment can lead a clinician to believe that he or she is responsible for the error. In actual fact the error was made due to the system not providing an adequate environment in which to provide emergency care.

Being a pragmatist at my core I walk into my shifts fully aware that the medicine I will practice and the care I will provide will be below the standards that I set for myself. We are taught never to forget these standards, and so to face them every day as a failure can be an exhausting. Though I have a healthy respect of the professional repercussions of any potential errors I might make due to improper risk assessments, I fear facing myself. I fear that I would become an unpleasant bedfellow. If this is how I, an emergency practitioner 9 years into my career feels, I can only imagine how a fresh faced junior medical officer must feel when opening the doors to a department for their first shift.

***Effectiveness of current measures***

***Drawing on other overseas strategies that should be considered***

In answering this term of reference I again preface that we do not wish to ascribe the full volume of failures on any particular individual or system, and whilst we both, as senior doctors, have a wealth of stories that might be interpreted as perhaps being the case, we wish to explore some current strategies being employed within the system, the reasoning behind their inception and some suggestions that might address the fundamental issues that are resulting in the perilous nature of the emergency health system.

1) Prioritisation of ambulance offloads

In a well-meaning attempt to resolve the deficiency in ambulances able to provide care to the community, the prioritisation of ambulance offloading has been a major health initiative across many local health districts. The data is closely tracked and the offload times are advocated for with great enthusiasm by patient flow coordinators and ambulance staff alike. The dangers of empirical assumptions that ambulances should be offloaded means that those patients who walk in to emergency department will have their care de-prioritised in an effort to aid the system. This again leads to the friction between individual and system risk assessment when its understanding of patient experience. The regular offloading of patients into wheelchairs or patients who have issues and difficulties with providing self-care, in combination with a constant stream of ambulances, often sees patients sleeping on chairs in the emergency departments waiting rooms or unable to take themselves to the toilet. The prioritisation of ambulance offloads is an imperfect solution to the wrong problem and leads to delays in

care to those patients who arrive to emergency departments by other means. Furthermore, patients who were once deemed safe for offload into the waiting room may no longer be safe after prolonged waiting times and delays to clinical assessment.

2) Suggestion for improvement
With a problem that manifests itself in many ways and affects the patient experience in so many aspects, it can sometimes be tempting to forget where to core issues lie. Fundamentally there are two primary issues driving ramping and access block that any future solution will be required to address.

i) The interaction between a system that functions over 24 hours and a system that functions within the constraints of "usual business hours".

The future of the health system will require an increase in after-hours resources to bridge the deficits between after-hours care and in hours care. Weekend ward rounds and outpatient clinic access has aided this but in truth the service provision by a hospital is starkly different in the after-hours context. Efforts must be made to extend the functioning hours of the hospital service to match the ever-increasing demands and expectations that are being placed on emergency departments. Furthermore, patient expectations is such that waiting 12 to 18 hours for a specialist review of a condition is often seen as an unacceptable delay. Such systems exist in the form of hospitalist services and acute medical services that function in extended hour formats to allow for senior decision making in an afterhours context to better facilitate flow with the hospital. But the ability of these systems to flourish is both funding dependent and dependent on a shift in the long-standing inertia of the medical fraternity regarding this issue. Further compounding this is the challenges faced by a lack of coordination between different elements of a system. Obtaining specific forms of tests unique to one hospital but completely unavailable at another often results in patients being sent from one department to another and then back again purely for the sake of having a test performed, this brings with it delays in transport and delays in diagnosis that could be improvement and minimised with better coordination between individual hospital both within the same local health districts and even between health districts.

ii) Risk assessment at the core emergency practice

Future strategies to be considered regarding changes to the function of emergency departments should be made in an effort to improve the accuracy of risk assessment provided to patients. This might take place in many forms and might include the establishment of after-hours medical resources (such rapid access clinics have become vogue and demonstrate a good solution that, when well used, can divert a significant number of patients from the emergency department to an area where an adequate risk assessment can be performed to better refine a patient's clinical care). Improvements in help lines and emergency care hotlines might allow for the early streaming of patients to appropriate models of care. The allocation of after-hours imaging and pathology modalities (provision of ultrasound and MRI imaging from the emergency department for select indications is still not widely available in after-hours settings despite making up a core part of patient assessment for multiple disease processes). Ideally there should be an established requirement of minimum levels of access to imaging and pathology for all emergency departments of a certain size. The variation of care experienced by patients between emergency departments within the same district and especially between districts is exceptionally difficult to rationalise and some effort must be made to centralise resource allocation and standardise patient access to medical resources especially between tertiary centres across New South Wales.

We thank the principle investigators in this enquiry for taking the time to consider out submission and hope it has provided a clinical context within which their inquiry can be considered.

Yours Sincerely

Dr Pramod Chandru
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