Submission No 31

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

Organisation: New South Wales Nurses and Midwives' Association

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Submission by the NSW Nurses & Midwives Association into the Impact of Ambulance Ramping and Access Block on the Operation of Hospital Emergency Departments in NSW

NSW Nurses and Midwives' Association

Foreword

The NSW Nurses and Midwives' Association ('Association') is the registered union for all nurses and midwives in New South Wales. The membership of the Association comprises all those who perform nursing and midwifery work. This includes registered nurses, enrolled nurses and midwives at all levels including management and education, and assistants in nursing and midwifery.

The Association has approximately 75,000 members and is affiliated to Unions NSW and the Australian Council of Trade Unions (ACTU). Eligible members of the Association are also deemed to be members of the New South Wales Branch of the Australian Nursing and Midwifery Federation.

The Association exists to be a strong, influential union of members respected as a contemporary leader in society for its innovation and achievements. We welcome the opportunity to provide a response to this consultation.

This response is authorised by the Elected Officers of the New South Wales Nurses and Midwives' Association.

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Summary Statement

The Association acknowledges the factors affecting ambulance ramping and access block are multifactorial and that there is no one solution to the issue. The evidence in this submission, based largely on the lived experience of our members, demonstrates the current situation is impacting the whole healthcare system and therefore, solutions must be implemented. Without reform, the introduction of additional ambulances and paramedics into the system, while welcome, will simply mean more ambulance ramping.

Our evidence will demonstrate that improved staffing and skill mix levels in our Emergency Departments, in-patient wards and units, and community health settings must be implemented as a matter of urgency if the issue of ramping and access block are to be resolved. Without system wide reform, we will not find the answers.

It is clear the failure to reform staffing models for the nursing and midwifery workforce is a major barrier to resolving the crisis, and without addressing this we will continue to see poor patient outcomes and financial waste within the system. Shift-by-shift minimum enforceable safe staffing levels through the implementation of ratios is proven to be effective in improving patient care, improving patient outcomes, preventing adverse outcomes and deaths, recruiting and retaining staff and saving costs. It is the only measure that can break the cycle of nurses leaving the system as recruitment processes struggle to keep up with the loss of staff.

Recent experience in Queensland following the introduction of ratios into adult medical and surgical wards in 27 public hospitals in 2016, demonstrates that this investment in nursing care leads to better patient outcomes, shorter length of stay and lower re-admission rates.[1] *In addition to producing better outcomes, the costs avoided due to fewer readmissions and shorter length of stay (LOS) were more than twice the cost of the additional nurse staffing.*[2]

Our members' evidence shows they are suffering moral injury and physical and psychological injury under the current working conditions. They are expected to carry the weight of access block and implement inadequate, and at times, dangerous solutions.

Access block and overcrowding in emergency departments significantly impacts staff, resulting in work-related stress and decreased staff satisfaction. Many choose to decrease their clinical hours, therefore exacerbating ongoing workforce shortages. Health professionals who are relied upon to keep the public health system in NSW running, are being driven out by relentless physical and psychological pressures, many suffering fatigue and moral injury.

The people in need of emergency care and their loved ones are being let down when they are most vulnerable. The point that we can no longer rely on an ambulance to turn up in an emergency in a community as wealthy and advanced as NSW, is astounding. Patients are then waiting too long in emergency departments, leading to complications, longer length of stay and worsening access block.

Effective strategies, such as a combination of increasing workforce capacity and flow inside the hospital system, effective follow up by community teams to avoid 'bounce back' re-presentations, and proactively

[1] McHugh, MD, et al. Effects of nurse-to-patient ratio legislation on nurse staffing and patient mortality, readmissions, and length of stay: a prospective study in a panel of hospitals, The Lancet May 2021, https://doi.org/10.1016/S0140-6736(21)00768-6
[2] Ibid

reducing demand for hospital services with improved primary care measures, will assist and must be implemented.

As a result of lessons learned during the COVID-19 pandemic, there is a clear need to decrease hospital occupancy rates and increase the necessary clinical workforce to ensure it can be attracted and retained. It is no longer acceptable for public hospitals to routinely operate at maximum capacity with no reserve in times of surging demand.

NSW is currently paying the price for a failure to invest in primary and preventative care. According to the Australian Institute of Health and Welfare, preventable health risks, such as smoking, high blood pressure, obesity, physical inactivity and high blood cholesterol account for over a third of the total burden of disease and injury. The impact of reduced access to primary care and early intervention associated with the pandemic shutdowns has brought into sharp focus the value of these settings in avoiding demand for hospital services.

Non-communicable diseases referred to above represent over a third of the total burden of disease and injury, yet only a small percentage of health budgets are spent on public health and prevention. We know from international evidence that integrated health systems oriented towards primary care achieve better health outcomes for overall lower cost and greater equity, than a health system centred around hospitals[3].

The Association thanks the Committee for the opportunity to submit this paper and are willing to provide further comment should the Committee require. We note, however, the short time frame for this inquiry and, in addition to the following recommendations, strongly urge a comprehensive and collaborative review; such a review should include a wide range of healthcare professionals, academics and the voice of workers through their industrial representatives.

Definitions relied upon:

Ambulance ramping describes the situation where ambulances remain at hospital EDs, unable to offload patients due to capacity constraints of the location. This means those ambulance assets are unable to leave the hospital or move on to other urgent callouts, placing the community at further risk through longer ambulance response times.

When an ED is unable to move patients into inpatient hospital beds, that ED rapidly reaches capacity. **Access block** describes the situation when ED patients have been assessed and admitted but are delayed in the ED for more than 8 hours due to lack of inpatient bed capacity[4]. Otherwise referred to as bed block.

[3] **The quest for integrated health and social care: A case study in Canterbury, New Zealand, 2013, The Kings Fund, https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/quest-integrated-care-new-zealand-timmins-ham-sept13.pdf.**

[4] Access block in Australia: a policy priority for emergency care, May 2021 Briefing Document, Australasian College for Emergency Medicine, acem.org.au/access-block.

Recommendations

- The government must invest in the nursing and midwifery workforce by introducing mandated shift-by-shift ratios and safe staffing levels across NSW Health. The government should consult with workers and their representatives to implement enforceable minimum safe staffing levels as a matter of urgency.

- The government must ensure that nursing and midwifery pay rates are greater than those available to Queensland and Victorian nurses and midwives in order to slow the interstate migration out of NSW.

- The government must invest in well-resourced primary and community nursing and midwifery services, including aged care outreach services, hospital in the home, midwifery in the home, and nurse led chronic disease clinics. Investment in nurse and midwifery practitioners in these areas are a clear opportunity

- The government must invest in the enhancement of community mental health teams, including crisis teams.

- There needs to be an increase in inpatient mental health beds at all levels of acuity.

- In consultation with nursing and midwifery representatives, including union representatives, as well as the university sector and nursing/midwifery educators, government should explore and implement measures that will support the development of the nursing and midwifery workforce. These would include adequately staffed environments to support quality clinical placements, appropriate graduate support, including increasing the number of nurse and midwife educators and enhanced transition to practice programs.

- The government must do more to protect nurses and midwives from injury in the workplace from:
  - Workplace bullying and harassment
  - Fatigue, burnout and moral injury
  - Violence and challenging behaviours.

Response to the Terms of Reference

The following submission by the NSW Nurses and Midwives' Association, along with the Australian Nursing and Midwifery Federation NSW Branch ('Association') draws upon the clinical experiences of nursing and midwifery staff employed in the NSW Public Health System.

More specifically, the Association notified members of the inquiry being undertaken by the Portfolio Committee No. 2 and encouraged feedback with regards to the Terms of Reference ('ToR'). We have included their voice within the relevant sections and added commentary where needed. This approach means that some comments may be linked to more than one ToR.

The Association has deliberately provided member experiences or commentary without identifying the individual. In this way, privacy has been preserved, encouraging the participation and feedback from members, some of whom continue to be targeted when they raise their concerns.

(a) the causes of ambulance ramping, access block and emergency department delays

The ambulance ramping and access block that is experienced within emergency departments (ED) across NSW is symptomatic of a health system in crisis.

Reports into activity and performance of public health services indicate a majority of metropolitan, regional and rural facilities are continuously struggling to meet demand impeding the capacity to deliver safe and effective clinical care for patients.

The demand for ambulance responses remains high, particularly for patients requiring an emergency (P1) response. According to Bureau of Health Information data, patients waited longer for an ambulance in the three months from April to June 2022, than in any quarter on record.

Data shows the NSW Ambulance service has been unable to promptly respond to the highest priority emergencies, due to being stuck in queues outside hospitals, unable to offload existing patients into the care of ED staff.

Incidents of ambulance ramping place increased stress on triage and patient flow managers in particular, but the pressure affects all staff within the unit. This pressure flows on to staff in the inpatient wards and units, which are typically inadequately staffed, as the ED staff try to create capacity

This pressure leaves nurses feeling unsafe, and concerned about the quality of care provided:

> *'I've been nursing 24 years, and 21 years in ED. I've never felt so unsafe in my entire career. I am speechless & overwhelmed on many of my shifts & that says something for an old hand like me. The acuity has increased, the aggression & violence has increased, the presentations have increased but the staffing ratios are worse, and the skills mix is worse with a much higher proportion of inexperienced staff.*

We fear for our patients knowing that we will struggle to provide care we know they need and deserve. Staff know they risk their registration every day that they come to work. It is not safe for patients and it is not fair to us.'

'Insufficient staffing in ED is unsafe. Staffing in our ED is reliant on us doing overtime which is causing burnout and sick leave. The constant pressure from management to have a plan to offload ambulances is so stressful. How can we have a plan if there is nowhere for them to go?'

'I work closely with hospitals to identify appropriate destinations for critical patients on behalf of the retrieval service. Every single day we call around to intensive care units in search of a bed to admit a patient, and the physical bed space is there, however due to staffing, the hospital is unable to accept the patient. We commonly have to default patients to their linked tertiary hospitals when there are no staff to care for the patients and these hospitals are forced to accommodate the patient. This could mean working above census, discharging a different patient to the ward to create space, or whatever other solution can be devised.'

Access block signals that a healthcare system is not operating as it should in terms of bed numbers and appropriate staffing levels. Whilst addressing ramping will require cross agency collaboration, and changes across the workforce, no solution will be sustainable unless nursing staffing levels are able to be set to meet demand. The Association is clear that funding must allow a ratio of one nurse to every three treatment spaces, one to one nursing for funded resuscitation beds, and the requisite number of triage nurses. The current staffing system is inadequate.

(b) the effects that ambulance ramping and access block has on the ability and capacity of emergency departments to perform their function

A crucial capacity constraint within emergency departments in NSW is inadequate staffing and skills mix across the system, compounded by bed block on the wards and units. It is clear that patients are being transferred out of EDs inappropriately. This places the patients at risk and creates unreasonable and unsafe workloads for staff on the receiving ward or unit. As can be seen by the evidence below, these inappropriate transfers lead to adverse patient outcomes. Whilst the human aspect of this is the most worrying, it is also clear that costs for patient care are extended through these adverse outcomes.

One patient flow manager from a major Sydney hospital described in detail how poor staffing and skills mix across the workplace significantly disrupts the transfer into inpatient care from an ED:

'I am a Patient Flow Nurse Unit Manager and ambulance ramping is probably one of the biggest stresses I experience. At times we have offload delays of 2+ hours and it puts an extreme amount of stress on a lot more people than most would think. Ramping may seem like the biggest stress is on ED staff and patient care in general, but the pressure in the rest of the hospital is immense. As a patient flow manager, I am pushed by Executives and General Managers to fix offload delays and ambulance ramping. That is seen as the priority, so even when wards aren't suitable for patients, or staffing and skills mix isn't appropriate, or there is a code of some sort happening on the ward, I am pushed to send patients up to clear ED and make capacity for ambulances when it isn't necessarily the safest option.

This means patients are forced on wards that aren't appropriately staffed. Ramping is seen as the biggest issue, and whilst it does affect community access to ambulance service, at least patients waiting in ED have the support of critical care nurses and paramedics. Time and time again patients are sent up to the ward that end up in the ICU as they aren't ward appropriate. Ambulance ramping is not just an immense stress on the emergency department and patient flow managers, but most importantly, understaffed and overworked ward nurses.

As mentioned above, patients that haven't been formally reviewed or admitted by teams are sent to the ward, and often end up as outliers as another team admit them. Outlier patients have higher risk of falls, delayed care, prolonged hospital admissions and re-admission rates. Decreased staffing or skills mix often sees us not being able to send patients to the ward. Often just getting in touch with the ward NUMs to allocate the patient is difficult because so often, due to staffing, they have a patient load and are often in full PPE inside a room and can't answer their phone. The impact, as mentioned above, is significant. Patients being sent to the ward when not clinically ready to allow offloading of ambulances often has significant impacts. Patients are being sent to the ICU, having falls, code blues, code blacks etc.'

Emergency nurses who shared their clinical insights repeatedly, described how being overwhelmed in the ED means patients do not receive the necessary safe standard of critical care. Constant exposure to a heightened level of workplace stress is also corrosive to the health and wellbeing of the staff, creating an atmosphere of tension and bullying. The evidence shows that paediatric patients, through to elderly patients are being put at risk.

'Patients are deteriorating in the waiting room waiting for a bed in acute. Elderly patients developing pressure areas for being placed in recliner chairs for greater than 24hrs waiting on beds.'

'Experiencing significant delays to offload due to bed block of between 20-30 admitted patients in ED, despite 8 ambulance offload beds in place. Sometimes all main department beds are full and there is nowhere for ED to do their business. This also creates waiting room risks with large numbers and long waits in the waiting room. The fast track area often has admitted patients, so one RN has to cover the admitted patients and the fast track patients. Acute patients occupy chairs in the triage area making it difficult for fast track patients to be seen. No one is safe in this environment.'

'For example, on my last night shift: there were, at one point, 5 ambulances ramped with patients all needing beds and likely admission (two of those for 7+hrs), 5 genuinely unwell patients in the waiting room awaiting admission/requiring monitoring (pancreatitis, compartment syndrome, facial swelling, cellulitis). Obviously, all of the cubicles were full of admitted patients (some who had been there for 70+hrs) and we resuscitated someone in the behavioural/psych assessment room as resus was also full.'

'Almost every shift starts with every bed full, at least 3 ambulances waiting to off-load their patients and a waiting room full of patients. I am often caring for patients who have been in the emergency department for over 24 hours. This involves numerous apologies and, understandably, dissatisfied patients, which is exhausting for all parties involved.

Recently, I received care of a patient from a paramedic who had been ramped over 2 hours as a category 2 patient who should be seen within 10 minutes. When I received care of this patient, he had deteriorated significantly and was transferred straight to resuscitation for life saving treatment. It is extremely taxing to work in a system that is reactive and clearly isn't meeting the needs of our community. I was also working a shift where the emergency department was at such extreme capacity, a code brown was activated. The hospital was completely full, and the only solution was to send patients to corridors on the wards upstairs. These patients were sent to areas which were not adequately resourced with equipment or staff. The safety and basic human right to access healthcare is degraded when patients are being sent to corridors.

I witness examples like this constantly and, like many, have become extremely disappointed by the healthcare system.'

'We only have 22 acute beds plus a 9 bed EMU dept, but commonly have 30 or so patients awaiting medical, paediatric and mental health beds. Surgical patients are prioritised.

We had one elderly lady awaiting a medical bed recently in our ED for over 100hrs, others average 24-30 hours. Confused, difficult patients requiring a "special" on the ward are left down in ED, as in the example above, usually without a special for extended periods of time. The busy ED environment is terrible for this cohort particularly but also for the mentally unwell and children. This effectively means we are caring for our normal numbers of patients on top of the 30 or so ward patients without any extra staffing enhancements whatsoever.'

'There is a lot of pressure from NSW ambulance control on the NUMS to "have a plan" to offload ramped ambulance patients. Calling relentlessly and becoming quite hostile while we are also trying to manage a very busy department. There is a lot of pressure on the triage nurse and the waiting room/COVID tent nurse managing unwell patients who should be on beds inside. The waiting room can have 20 or so patients. Some will be admissions, most will require pain relief, observations, ECGs etc. Staff ratios in this area are appalling and this area is becoming increasingly dangerous for patients and for nurses' psychological safety.'

'Yesterday when I came onto my 12hour shift that started at 7am, the handover nurses said there was a hospital bed block preventing patients from going up to the paediatric ward. I found myself salvaging the situation constantly for several hours, trying to call wards for equipment and medications that we didn't have or were short of. Constant back and forth paging of the paediatric registrar for reassessing and care plan updates or requests. Eventually there was a mass discharge of patients from the paediatric ward meaning there was an influx of beds that opened for ED paediatric patients. I hit two main problems: the first was that the paediatric ward nurses were refusing handovers for up to 30min periods, resulting in transfer delays, and secondly the ED medical officers were double clicking patients into bed spaces in order to "reserve" the spot for their next patient, then the medical officers would attempt to come and handover/request care interventions for the next patient. This resulted in me escalating the ward nursing delays to my manager, and also refusing to take responsibility for care of any patient that was not directly placed in a bed space yet, as it was not safe or possible to take on double-bunking.

There have been patients who have gone several hours without any observations documented or nursing notes written due to the inability to access a computer to document; this is due to the constant high-pace nature and high demand of physical duties required. ***Additionally, there are current recent patient deaths that are being investigated due to poor outcomes that could have been impacted by staffing shortages/skilled staff shortages on shift****.'*

'Whilst I do not work in the ED of my hospital, access block has a direct effect on the patients I look after. One recent example involves a young breast cancer patient who presented to ED with fevers following her first cycle of chemotherapy. Usually, these patients are fast tracked through to an isolation room in the ED whilst tests are carried out, as febrile neutropenia could potentially be life threatening. She called me 2 hours after arriving at the ED to say she hadn't been triaged and was in a waiting room full of sick people. When I went to review her, she had been moved to the ambulance waiting "bay" (it was essentially a drafty corridor with roughly 8 stretchers and ambos waiting behind her). She was sitting in a plastic chair whilst having rigors. Her oncologist came to review her and was unable to even examine her as we were in a public space.

Bloods were taken whilst she was in the waiting area, she was confirmed neutropenic and was eventually transferred to a single room in the private hospital. Luckily for her, nothing major happened except from it being a completely horrendous experience but it could have potentially been so different.

Unfortunately, this is not an isolated incident this year.'

There are substantial human and financial costs to the state's public hospitals when operating at full capacity. Incidences of ambulance ramping and access block appear to be getting worse year on year, and this is associated with increased mortality, morbidity and length of hospital stay.

The rising costs of healthcare could be curtailed effectively through investment in prevention, detection, and early treatment through a strong public health sector, primary care services, and effective primary health care.

(C) the impact that access to GPs and primary health care services has on emergency department presentations and delays

While typical General Practice patients, who do not require admission to hospital are not necessarily contributing to access block, the presence of these patients in ED waiting rooms creates added pressure and stress for staff working in these areas.

Lack of access to GPs, or other forms of primary care, means opportunities for early intervention are missed and minor conditions continue to escalate until an ED presentation is the only option.

The Association acknowledges the federal government's plan to create urgent care centres and the NSW government's recent commitment towards establishing a number of these bulk-billing urgent care centres in partnership with GPs, in an attempt to alleviate crowding in nearby EDs. The Association strongly recommends that suitably qualified Nurse Practitioners, as well as other nursing staff, are recruited for these services.

Emergency nurses who were consulted for feedback in this submission reported that co-located primary care initiatives do relieve some of the pressures in overwhelmed EDs:

> *'I work in a regional public hospital. We have lots of patients coming in for social admissions because family and carers are not coping and cannot seek appropriate assistance through GPs. This means that these beds are not available when needed for other patients in need of admission to hospital.'*

> *'The Blue Mountains has very poor GP coverage. Most wait times to see a GP are weeks to months. A lot of our presentations are cat 4 things that are more primary health care than critical care.'*

> *'These patients have more of an impact on the reception area overcrowding and can make the clinical in charge's (CIN) role very stressful, as the CIN have many more faces to observe and remain vigilant for deterioration (the Cat 2/3 patients blend into the crowd of Cat 4/5 patients when the area is full). In short, the GP patients will end up waiting several unnecessary hours in the reception area going unseen if there are higher category patients or an access block.'*

> *'There are limited GPs on the coast for our growing population and there is limited availability of bulk billing. People are presenting to hospital because they can't afford a GP visit. The vast majority of our presentations could have been seen by GPs but weren't. A lot of people also wait longer before presenting to the ED knowing the waits are excessively long & end up higher acuity due to this. Which impacts the department as it's not a simple easy fix presentation.'*

'Luckily, we have a fast track doctor who does see our GP patients who are sitting in the waiting room. Numbers have increased due to GPs in our area refusing to see patients with COVID-19 type symptoms and telling their patients to present to the emergency departments for care.'

Nurses and midwives are regularly underutilised in the primary care sector and the failure to effectively invest in multidisciplinary community care means more reliance on scarce GPs and avoidable hospital presentations. The Association recommends increased workforce investment in community nursing, nurse practitioners, child and family health nursing, community mental health nurses and community aged care nurses in models of care that include home visiting, assertive outreach, telehealth, hospital in the home and the many other models of healthcare delivery that enable consumers to access essential care in community settings.

The Association recommends the establishment of more nurse and midwife-led clinics to enable patients to access timely interventions in the community with a focus on chronic disease management, preventive care and avoidance of costly complications and hospitalisations. Nurse and midwife-led models of care deliver proven positive care outcomes that are safe, effective, appropriate, cost-effective, or preferred.[5,6] Not only does effective primary care keep patients out of hospital, it also enables shorter length of stay for admissions, because discharges from hospital can occur safely and in the knowledge that good quality community support is available.

Public health, preventive health, and primary healthcare are key priorities heavily reliant upon a suitably sized, educated, and supported nursing and midwifery workforce. The importance of public health, preventive health and primary health care is now even greater, due to the widespread impacts of the COVID-19 pandemic on our community. Nurses and midwives working in public health and preventive health provide lifesaving immunisations, educate people about the need for regular health checks, identify risks for illness and chronic disease, and offer support and care for mothers and babies.

Nurses and midwives must be at the centre of public and preventative health strategies as part of their daily work routine, and also as clinical experts in collaborating with other multidisciplinary healthcare professionals to achieve intended outcomes in policy and practice. Public and preventative health, as well as the role of nurses and midwives in these fields, is often overlooked by policy or decision makers who are more focused on acute hospital services.

Not only is prevention better than cure, it makes the most economic sense. With an increasing chronic disease, cancer, and mental health burden, an ageing population, and many people in poorer health often from avoidable conditions (who are generally less productive), it makes sense to invest where possible. Investing in preventive health now will also enable a more effective and timely response to the impact of COVID-19, which will likely be felt for many years.

As our health care system begins to shift from the traditional emphasis on management of emergencies and acute illnesses or acute exacerbations of illness, to health prevention and management of chronic health conditions through a primary health model, the role of Nurse Practitioners in the health care team is increasingly important. Nurse Practitioners provide comprehensive care, not only in underserved

[5] Laurant M, van der Biezen M, Wijers N, Watananirun K, Kontopantelis E, van Vught AJAH. Nurses as substitutes for doctors in primary care. Cochrane Database of Systematic Reviews 2018, Issue 7. Art. No.: CD001271. DOI: 10.1002/14651858.CD001271.pub3. Accessed 16 September 2022.
[6] Sandall J, Soltani H, Gates S, Shennan A, Devane D. Midwife-led continuity models versus other models of care for childbearing women. Cochrane Database of Systematic Reviews 2016, Issue 4. Art. No.: CD004667. DOI: 10.1002/14651858.CD004667.pub5. Accessed 16 September 2022.

communities (including remote areas, aged care, Aboriginal and Torres Strait Islander peoples, and homeless populations) but across metropolitan and rural areas of clinical practice. They provide safe, affordable, expert clinical care within a variety of settings.

The introduction of the Nurse Practitioner role in Australia has improved primary health care access for marginalised, disenfranchised, and geographically isolated populations, while providing nursing expertise in such diverse areas as palliative care, cardiac health, mental health, pain management, alcohol and other drugs, and renal replacement therapy. Extending the services Nurse Practitioners can provide will reduce fragmentation of care by facilitating comprehensive assessment, evaluation, and treatment. It also offers increased opportunities to initiate health promotion discussions and disease prevention activities, thereby reducing the burden on hospitals of preventable health conditions.

'Community Nursing services have seen an increase in acuity and complexity of post-operative patients referred for wound management. The expectation is generalist community nursing priorities post-acute care over community referrals, including chronic wound and catheter management. Community nursing has become an extension of acute care services and no longer primary health care.

Our community nursing service has not seen any enhancements over the last 20 years that I have worked there. We provide our community with generalist community nursing, child & family nursing, stoma /continence service, diabetes including Leading Better Value Care, chronic disease care including respiratory, heart failure, breast care, men's health (prostate cancer), women's health, transitional care nursing and hospital in the home. We are also called on to review and provide care to inpatients, especially stoma and respiratory.

We are seeing increasing demand for community nursing specialist services (chronic disease/breast care/stoma continence) to provide services to inpatients. We are also experiencing increased pressure on hospital in the home (HiTH) nurses when unable to accept new patients due to our service being at capacity.

Due to our proximity to the border, recruitment has become almost impossible. Why wouldn't nurses be attracted to better pay and conditions on offer in Qld? Many non-government nursing services in Qld have better pay and conditions than the LHD.

All community nursing roles are specialty roles, including generalist community nurses, working autonomously who require knowledge and skills in wound care and palliative care. Recruiting experienced applicants is very difficult and new graduate RNs have limited knowledge in wound care, which increases pressure on experienced staff. Many of the community nurses are exhausted.

Community nursing services are often required to review their client list and discharge back to GP early only for the patients to be referred back due to deterioration in chronic wounds. HiTH are often under pressure to accept patients despite being at capacity. The lack of midwifery in the home (MiTH) services in our area means that mothers and babies are discharged early from Women's Care unit (4hrs-72hrs post-delivery), with the expectation that the child and family nurses will support these families with follow up care prior to 7 days post birth. Issues experienced: babies not establishing feeding, breast feeding issues, jaundice, newborn screening required, mother's exhaustion and stress. All this takes the child and family nurses away from their core role, especially supporting families with high risk factors.'

(d) the impact that availability and access to aged care and disability services has on emergency department presentations and delays

It is well understood that poor staffing and skills mix in the aged care sector means nursing care that could and should be delivered in the "home" residential aged care facility (RACF) environment is not currently available.

Often, residents are forced to rely on an ambulance to present to an ED and those who are admitted often need to stay longer than should be necessary, because the required skills are not available back in the RACF.

In terms of delayed discharges and avoidable ED presentations, a survey of salaried medical officers in NSW[7] indicated potentially avoidable presentations from aged care facilities occur on a daily basis. Input from members of the Association confirm this is a widespread issue. Most common reasons for potentially avoidable hospital presentations were falls, palliative care, behaviour management and catheterisation or re-catheterisation. Other reasons included simple wound care and pain relief. Causal factors were identified as lack of GP availability, lack of registered nurses, lack of knowledge and skills of staff employed in aged care facilities and lack of advanced care directives.

Delayed discharges back to RACFs are also widespread. These delays can range from a matter of hours to several weeks. Transport was the most frequently cited reason for delayed discharge however, refusal by a relative to have the person returned to a facility and insufficient staffing levels at the facility were also causal factors. Frequently cited was the absence of a registered nurse at the facility and lack of trained staff at the facility.

Analysis of data trends have led researchers to predict a greater concentration of RACFs on a very high dependency population, with multiple comorbidities and care needs across multiple domains, including complex healthcare needs[8]. Given what the data indicates, it is essential every resident in RACFs is afforded a safe level of staffing and skills mix, including guarantees that registered nurses and enrolled nurses will always be present to deliver clinical care. Without mandated staffing and skills mix in RACFs, the NSW public hospital system will continue to deal with a growing volume of avoidable presentations.

[7] NSW Aged Care Roundtable 2019 Joint report on avoidable hospitalisations from residential aged care facilities in NSW and delayed discharge.
[8] Gibson, G. 2020 Who uses residential aged care now, how has it changed and what does it mean for the future? Australian Health Review 44(6) pp. 820-828.

Rising acuity, increased need for palliative care and lack of clinical expertise in RACFs have necessitated outreach programs, such as Hospital in the Home (HITH) across NSW. Although a better option for many, given the poor health outcomes associated with hospitalising older people, this shifts the cost of care onto public health services, since outreach services are funded and provided by Local Health Districts (LHDs).

Despite the obvious cost shifting onto LHDs, there are a growing number of programs in place, such as the GRACE program in Northern Sydney LHD[9] and South Eastern Sydney LHD Geriatric Flying Squad[10] and REAP[11] programs. These are services provided by LHDs that are a cost-effective means of reducing avoidable presentations to hospitals.

An evaluation of the REAP program to reduce re-admissions to a Sydney hospital evidenced cost effective reductions in the utilisation of hospital-related services. However, the program required monthly contact from a Geriatrician and Nurse Practitioner for six months[12], which was still less expensive that a re-admission.

Similarly, although an evaluation of the Geriatric Flying Squad revealed $1.4m potential cost savings, its implementation costs the LHD $400,000 annually to run[13].

'We have lots of patients in acute hospital beds awaiting nursing home placements.'

'Out of the current 117 ED accessible beds today in my facility, I have 26 delayed for this reason. That is 22% of acute beds used because of the issues in the aged and disabilities sectors.'

'Currently we have two under 65s awaiting NDIS plans, just taking up a bed, but not fit to be home alone. They have required little to no acute nursing care for weeks. We have multiple post-acute patients waiting for rehab beds, and there is even a wait list for our inpatient rehab service. We have three waiting more than a week for rehab.

We have aged care patients whose families no longer are willing to manage them at home. They are past the acute phase, be it medical or surgical, but then

[9] https://www.nslhd.health.nsw.gov.au/Services/Directory/Pages/GRACE-HKH.asp
[10] https://www.seslhd.health.nsw.gov.au/sites/default/files/groups/Sutherland_Hospital/southcare/Geriatric_Flying_Squad_2017Sep.pdf
[11] Cordato, N.J. et Al (2018) Management of nursing home residents following acute hospitalization: Efficacy of the 'Regular Early Assessment Post-Discharge (REAP)' Intervention JAMDA 19(3) online publication available at: https://www.jamda.com/article/S1525-8610(17)30693-X/pdf
[12] Ibid
[13] ACI (2012) ACI Clinical Innovation Program: Evaluation of a Geriatric Flying Squad Program of South Eastern Sydney Local Health District. Available at: https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0020/262802/Evaluation-of-Geriatric-Flying-Squad.pdf

need placement in an aged care facility. This can take many weeks. Sometimes an upgrade to their aged care package is requested and they need a respite bed before going home. The wait for respite can take two weeks, by which time some are ready to go home.

As I see it, the delay in discharges, mostly for aged care, is holding up the ability to admit surgical elective patients. The surgical wait lists get longer, the cancers have metastasised while people are waiting at home to be fit in to a list.'

'In our facility there are patients in the acute care wards who have been there for in excess of 100 days…why are they not either at our less acute facilities in Northern Rivers Health Service or in another care facility?'

'We often have nursing home patients in ED overnight because ambulances can't or won't transport them back overnight and we don't have 24hr patient transport.'

'Some of our RACFs aren't open or accepting patients 24hrs a day so the patients stay longer, then get delayed waiting for transport to return them. When NDIS funding is inadequate to fund carers, these people are brought to ED because they are unable to provide necessary care at home. These patients stay in the hospital for months on end - aggression increased & staff assaulted so patient gets moved to next ward (this has increased in the past 18 months).'

'Refusal of nursing homes to take patients back after hours causes significant delays in discharge. Patients that can't be placed are transferred to a ward when there is a bed available and stay in the ward until they find placement. This has lengthy delays and adds to bed block.

Very often, patients wait weeks and weeks for aged care placements. Additional to these delays, there is often COVID outbreaks in nursing homes, so they can't take new patients. They often send patients that are COVID positive to ED that are clinically well or not requiring hospital level care, simply because they are positive, and then don't accept them back until they are cleared from the COVID pathway. This puts massive stress on our COVID wards when the staff have to manage critically unwell patients, as well as

nursing home patients that sundown or experience significant confusion being out of their normal environment.'

'We always have patients that can't be discharged due to lack of available placements. Some for weeks to months on end. I have cared for many traumatic brain injury patients, who have averaged 6 month waits, from when medically stable to being discharged with appropriate services.'

(e) how ambulance ramping and access block impacts on patients, paramedics, emergency department and other hospital staff

At a time when NSW needs every available experienced nurse and midwife, the pressure of inadequate staffing and skills mix, and the failure by government to value nurses and midwives is driving them away.

Clinical staff are leaving the industry or leaving NSW and walking into roles in both Queensland and Victoria with better remuneration, knowing mandated minimum staffing systems provide a much safer and secure practice environment.

Nurses and midwives understand that the quality of the practice environment, including staffing and skills mix, will determine the standard of care they are able to provide. While mistakes and mishaps may appear as statistics for the decision makers outside the clinical environment, for Association members, every near miss, every mistake, every incident of missed care, every adverse event is felt deeply. Over time, this environment has a corrosive impact on their individual wellbeing.

There is widespread evidence of the existing workforce being over worked, refused leave, and not being free from work even when they are off shift as they receive countless text messages from the employer. The evidence below speaks to the moral injury this is causing; nurses and midwives know the level of care is inadequate and carry that burden. It speaks to the burnout as patients exact their frustration on who is in front of them.

The impact on patients is clearly demonstrated. An ongoing need to free up inpatient beds and allow ED patients to be admitted to a hospital ward for further specialist care, has the potential to result in elective surgeries being cancelled, causing further access delays elsewhere in a hospital and increasing waiting times. Cancelled and delayed operations, and inappropriate post-operative care settings are common. Mental health patients being managed in less-than-ideal circumstances is also common, placing the mental health patient, staff, and other patients at risk. There are clear system processes that must be improved, and again, minimum shift by shift safe staffing levels are a crucial part of any answer.

'New graduate nurses working casual shifts in ED means skill mix is dangerous and puts strain on experienced staff who have to care for their own patient load while also providing supervision and assistance.'

'For several months now we are routinely in bed block. 14 RNs have quit in 2 months, with the loss of many senior members of the team. Applications for

holidays are banned until these positions have been filled. Daily text messages are sent out trying to cover staffing short falls. Our ED often runs short of RNs. Sometimes we have to close beds. When patients occupy beds with no RN covering them, the next shift must catch up on the hours of care that have not been attended to for that patient.

The stress that this places of the NUM, triage RN and other nursing staff is incredible. This is not the level of care we want to provide to our community, and it is not the level of care that our community expects and therefore ED nurses are putting up with verbal and sometimes physical abuse almost every shift now.'

'I was employed as a full-time registered nurse in an emergency department for 2 years before leaving in March 2022. Ultimately, the additional pressure on my workload and feeling under-valued led to me seeking alternative employment, even considering working outside the nursing field. The situation of access block in hospitals is untenable and is not only impacting on the safety of patients but staff as well. Morale amongst staff is at an all-time low as leaving the nursing profession feels like the only relief from this completely overwhelmed system.'

'I ran an unscientific survey on a social media page about career change. Many of my ED colleagues were dismayed about what they had become. Many, a mere shell of the RNs they once were. Many dreaded the drive to work, fearful of what lay ahead and drove home fending off headaches and migraines with paracetamol and ibuprofen before briefly touching base with loved ones before collapsing into bed. Only after leaving the ED did they realise that the work was slowly consuming them, eating away from the inside, their families watching the downturn.'

'Obviously, we are incredibly understaffed and unable to deliver the care that we want to, that our community deserves and expects. It's a chaotic nightmare. Skill mix is a constant issue. We have senior staff being asked to do overtime at the end of their shifts or be on call, while RNs with only 1- or 2-years' experience are allocated to resus. We are burnt out and depressed by the quality of care we can give.

With current staffing it has only been luck that we have not yet killed someone. It is going to happen soon. Everyone is dropping hours because of this unsafe

situation. Many senior staff are leaving, and the proportion of inexperienced junior staff is growing.'

'ED and ward nursing staff are fed up with doing doubles which causes fatigue and burnout. Parts of ED are then closed because of sick leave. Many senior nurses have resigned at my hospital because it is unsafe. I am a year 7 RN and I am taking leave from 31/10/2022 - first week in January because I can no longer work the way we all have for 2 years now. I will retire on the 16/1/2023. Agency nurses are very common in my workplace and they are a great help. I am so sad the government can employ them at an exorbitant hourly rate and our permanent and casual staff are not worth a pay rise.'

'It is utter bedlam at our facility.'

'Despite moving multiple public operating sessions every week to private hospitals, we are still cancelling elective surgery for patients requiring overnight admission at least twice a week. These cancellations are directly correlated to access block in ED.'

'I work in the Operating Suite of a major Sydney hospital. Ambulance ramping has resulted in a reduced number of surgical beds due to the increased demand from ED. Patients are being nursed in the holding bay of the operating suite for more than 24 hours and some patients are being discharged directly from recovery, however, this cannot be charted electronically and recovery nurses are not qualified/experienced in providing discharge advice to patients.

Facilities for long-term care in the Operating Suite are totally inadequate, so is catering and nursing skills in the operating suite are highly specialised and do not cover the skills required for ward nursing. Recovery nurses can chart medications, but other nurses have neither the access or the training to chart medications and on-going care in the patients' e-records. Staff are stressed and concerned about taking on responsibilities beyond their normal scope of practice. Bed block has been occurring in recovery so surgery is being delayed over concerns that surgical patients cannot be safely recovered whilst staff are required to attend other patients who cannot be relocated to more appropriate

facilities in a timely manner. This has led to increased pressure to discharge patients directly from recovery.

Surgeons are complaining that their elective patients cannot be booked on their sessions due to lack of postoperative beds. Unfilled surgical time has been used by relocating the nursing staff from the session to the ED instead of clearing some of the emergency surgery patients from the ED. This has not been an efficient or effective use of nursing resources as OR nurses have an entirely different skill set than ED nurses and find it difficult to function safely in an environment where they have received little or no orientation. It is not uncommon for OR nurses to be redeployed to ED without orientation or supervision whilst surgical waiting lists blow out.'

'I have noticed that our scheduled mental health patients will wait for several hours and sometimes even up to 3-4 days before a bed becomes available. It is completely unacceptable, and I have seen MH patients go into psychosis and develop severe panic attacks.

Triage ambulance bay is often full when in bed block (most days). It was built for 5 stretchers but often has more & up to 9 or 10 stretchers crammed into a small space. The area is enclosed & it sits between resus bay (enclosed fire doors) & Acute (enclosed fire doors) - and triage leading to the waiting room which is also enclosed. Mental Health patients under a section 22 often bypass mental health unit & get brought into the triage area & sit amongst the stretchers. Most recently 2 section 22 were amongst 7 ambulance stretchers & one required a physical & chemical restraint, whilst both screaming out at each other. All patients waiting on stretchers were in amongst the scuffle - it was extremely unsafe. Mental Health patients are spending their entire admission in ED as no acute beds available.'

'I'd like to give a perspective from a community mental health nurse who brings patients to hospital. Due to a massive shortage of MH beds, we as a service contribute to the blockage problem. As we have no beds at any given time, we are forced to bring patients to ED as the entryway to psychiatric facilities. This is done in consultation with MH demand management and bed flow. A large portion of the time, we are bringing patients that require a special or 1:1 nursing care, often, multiple times a day. These patients are behaviourally disturbed, psychotic, and do not respond well to the environment of ED. Bringing this type of patient goes against my clinical judgement, as I am essentially placing other nursing staff at risk of violence and aggression. A recent example is a patient from my service who was brought to ED under the MH Act who required a psychiatric bed; he physically

assaulted a security guard and medical officer. I know for a fact that most weekends, there are 10+ MH patients in ED waiting for a bed to be available. This places excessive strain on the ED.'

'I work in community mental health. We often need to access assessment for possible admission when people become acutely unwell and are at risk of harm to themselves or others. Recently I had a 69-year-old client who had escalated into an elevated mood state. Her behaviour was chaotic, loud, disorganised and intrusive, and she was at risk both of harm to herself and of causing harm in the community. After calling both the mental health team in ED and the bed manager, I escorted her to the ED. For 4 hours, a new graduate nurse and I tried to manage her intrusive and irritable behaviour in the public waiting area. Our colleagues the ED triage nurses were even unable to see her due to the congestion and queuing of sick and distressed people in a public ED. There were 4 people under the MHA NSW being held in ED waiting admission to the inpatient unit.

Each day as I walk across the ED car park and see the queues out the door, I thank the goodness my retirement is approaching soon.'

(f) the effectiveness of current measures being undertaken by NSW Health to address ambulance ramping, access block and emergency department delays

According to Association members, the key strategies adopted in public hospitals and health services to manage ambulance ramping include pressuring nursing staff to undertake unsafe workloads in unsafe environments and ignoring triage categories if it means an ambulance can be offloaded.

For the emergency department, this means people with a less urgent triage category, who have self-presented, are waiting even longer. Rationing of clinical care means patients are also being discharged from care too early, meaning re-presentations in a more acute state are inevitable.

Bureau of Health Information data for the April to June 2022 quarter shows almost one in five patients who left an ED without, or before completing treatment, tended to re-present within three days.

'Patients are regularly discharged to make room even when it is not in line with their clinical needs. Patients are told to leave because they need the bed and to see their GP to sort out the rest. Patients moved out of beds that shouldn't be and placed in a chair because a sicker person or bed bound person needs the bed.'

'We are always full plus ramped ambulances which puts pressure on us to 'offload' acute or unwell patients into the waiting room. Ambulance patients are often given a bed quicker than self-presenting patients (even if they have stroke like symptoms, chest pain, trauma etc). Our NUM will override our triage and place some patients into the waiting room (even though they came by ambulance and are too unwell to sit for 12 hours in a cold waiting room). One NUM offloaded a child that had IM adrenaline for her anaphylaxis (father was ICU RN – and he was not happy). We worry that the self-presenters (more of them now because they cannot access an ambulance) are being treated as second class citizens and have less access to acute beds in ED

Non ambulance patients are disadvantaged because hospital administrators are calling the NUM to move the ambulance patients off the ambulance stretcher and into the waiting room. This also delays the process by up to 12 hours. Other patients who drive in are pushed to the back of the queue to allow offloading of ambulance patients.'

'We are experiencing significant delays to offload due to bed block of between 20-30 admitted patients in ED despite 8 ambulance offload beds in place. Sometimes all main department beds are full and there is nowhere for ED to do their business. This also creates waiting room risks with large numbers and long waits in the waiting room.

We are under significant pressure from NSW Ambulance to offload with all levels of the organisation called to make it happen. Sometimes the Clinical NUM, the NUM, FACEM (Staff Specialist in Emergency Medicine), Operations Manager and Executive on call may all be called for the same ambulance.....no one can get their jobs done as they are too busy answering to NSW Ambulance Service. We all understand why there needs to be a community response for ambulances and why it needs to be a priority but the pressure to offload ambulance (even if it is only 1 delayed) is the same even if there is no compromised community response.

There is pressure to offload ambulance patients rather than bring in sick acute patients in the waiting room. If you arrive by ambulance with the same triage priority as someone who self presents you jump the queue. Leaving complaints and disgruntled patients having to managed by nurses in the waiting room. Aggression and abusive behaviour are experienced just about every shift.'

'The NUM is dealing with constant phone calls from Executive asking why the ambulances are not being offloaded but Executive are not able to provide the

resources required for this to happen (nursing staff to operate short stay and transfer of care, nursing staff to open more beds on the ward, nursing staff with the appropriate skill set (e.g. advanced life support) to escort the patients).

The other major issue with such a high focus on ambulance offloading is that unwell patients who do not arrive by ambulance are left in the waiting room for extended periods of time due to the pressure on the NUM to offload ambulances first even if the patient with the ambulance officers are not as unwell as the patient in the waiting room. For example, we had a 92-year-old gentleman with a Hb of 65 in our waiting room for over 7 hours recently due to Executive pressuring the NUM constantly to offload ambulances and not being willing to listen when she tried to explain the clinical needs of the patients in the waiting room who are also waiting for a bed within the ED.'

'Every day we are beyond bed capacity opening unfunded beds using staff on overtime and now agency staff to try and provide care in these areas. Ventilated critical care patient staying in ED. Opening a condemned area to create 'beds' that was not environmentally safe particularly re infection control.'

'We only have 22 acute beds plus a 9 bed emergency short stay unit, but commonly have 30 or so patients awaiting medical, paediatrics and mental health beds. Surgical patients are prioritised.

We had one elderly lady awaiting a medical bed recently in our ED for over 100hrs, others average 24-30 hours. Confused, difficult patients requiring a "special" on the ward are left down in ED, as in the example above, usually without a special for extended periods of time. The busy ED environment is terrible for this cohort particularly but also for the mentally unwell and children.

This effectively means we are caring for our normal numbers of patients on top of the 30 or so ward patients without any extra staffing enhancements whatsoever.

There is a lot of pressure from NSW ambulance control on the NUMs to "have a plan" to offload ramped ambulance patients. Calling relentlessly and becoming quite hostile while we are also trying to manage a very busy department. There is a lot of pressure on the triage nurse and the waiting room/COVID tent nurse managing unwell patients who should be on beds

inside. The waiting room can have 20 or so patients, some will be admissions, most will require pain relief, observations, ECGs etc. Staff ratios in this area are appalling and this area is becoming increasingly dangerous for patients and for nurses' psychological safety.'

'Patients are discharged frequently due to bed space limits. Re-presentations have increased, patients returning within 24hrs after discharge from wards some not even lasting 4hrs at home before returning. Patients are returning for pain relief whilst waiting for outpatient ultrasounds as they are unable to get into GP for scripts for pain management.

ED presentations are all about early discharge to move them out. Mostly younger patients with no co-morbidities - bloods/ fluids / pain relief then send them home with GP follow up & ultrasounds as an outpatient. Pain is not always relieved prior to discharge either. This is risky and I worry about them.

Delays to transfer to our tertiary facility due to them also being in bed block means patients are waiting in our small facility and it is often not in the interest of the patient. Having unwell patients sitting in a facility with no ICU for several hours because there is nowhere to transfer to puts their lives at risk.'

For other inpatient wards and units, there is immense pressure placed upon the Nursing/Midwifery Unit Managers and patient flow managers to identify patients who may be suitable for early discharge. This then increases the workload for the nurse/midwife on the floor to fast track these patients and their care.

Whilst this is an issue across the system, it becomes more apparent within mental health inpatient settings. Regardless of acuity level, mental health patients are being pushed back out into the community without the assurance of therapeutic follow-up.

When a patient experiencing an acute mental health crisis presents to an overcrowded emergency department, they are often left in the waiting room to wait for treatment. The chaotic nature of an emergency department can lead to an exacerbation of the mental illness, which can then lead to a further deterioration of the acuity of the patient and an increase in aggression.

There is a lack of mental health beds in NSW. The current allocation of these beds and units has no ability to keep up with the demand on the services. Therefore, mental health patients can experience poorer health outcomes as they are pushed out of the acute and subacute areas and back into the community earlier than they should. These patients are more likely to represent to the emergency department for further treatment.

(g) drawing on other Australian and overseas jurisdictions, possible strategies, initiatives and actions that NSW Health should consider addressing the impact of ambulance ramping, access block and emergency department delays

The undeniable need for mandated shift-by-shift nurse-to-patient ratios and safe staffing levels in maternity across the NSW public health system has never been more apparent.

Every day throughout the COVID-19 crisis, nurses and midwives persevere through dangerous and demoralising working conditions to keep hospitals and health services open and to meet an ever-growing demand. However, the toll on the clinical health workforce is profound.

'The situation of access block in hospitals is untenable and is not only impacting on the safety of patient's but staff as well. Morale amongst staff is at an all-time low as leaving the nursing profession feels like the only relief from this completely overwhelmed system. It is extremely common and normalised for nurses to be talking about leaving the profession. The hats nurses must wear has expanded significantly throughout the pandemic with limited compensation for the hard and sometimes dangerous work we do. As ambulance ramping increases wait times blow up and so does the violence towards staff. The emergency department is becoming an extremely difficult place to work with the high number of patients and limited staff.'

Long before the pandemic, nurses and midwives were being forced to work short staffed with a decreasing mix of skills, take on excessive amounts of overtime, care for more patients and work longer hours. Rather than responding to our ever-changing health system, the Nursing Hours Per Patient Day (NHPPD) staffing model continues to show that it is no longer fit for purpose. It is not transparent, and it is able to be manipulated.

The pandemic has pushed an already exhausted health workforce to the brink.

'Today was one of the worst shifts in a long time. I work in a major Sydney hospital emergency department as a triage nurse. We can safely care for 60 patients. At our worst today, we had over 120 patients, with ambulances waiting more than 2hrs for a bed (this includes category 2 patients). Our 6 resus beds were full with 10 patients, 4 being highly agitated scheduled MH patients and 4 ambulances waiting to offload. As we only have 5 nurses allocated to resus (1 being a coordinator and not taking patients), we were obviously unable to special the MH pts close enough. This led to a situation where the MH patient attempted to smother a stroke patient with a pillow, twice.

Patients are receiving substandard care. Waiting times are blown out: a category 2 patient can wait 8hrs for a plan and cat 3 and beyond are simply forgotten. Nursing staff are always left to plead with patients to stay despite knowing they are receiving horrible care. This week a scheduled patient

waited 74hrs in emergency for a MH bed. I estimate that 60% of patients allocated to the short stay unit don't get there as there is no beds. Instead these patients are referred to their GPs even though we know they won't be able to get an appointment. Estimated 40% of these pts re-present. If a GP Clinic could be set up similar to Canterbury Hospital, it would significantly alleviate the pressure on this ED.'

Throughout these challenges, nurses and midwives were forced to adapt to rapidly changing work environments. Each peak demanding more of nurses and midwives, as conditions deteriorated, staffing vacancies deepened, scope of practice was diluted, and untrained staff were introduced into care models. All this resulting in inferior care being provided to patients.

This staffing crisis is not confined to metropolitan hospitals. Serious staffing and safety issues exist in regional and rural health facilities, as exposed during the recent parliamentary inquiry by this Committee into *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*. Current staffing in community hospitals and Multi-purpose Services is far from the sufficient minimum staffing levels needed to provide safe patient care.

The Association believes NSW needs a transparent, shift-by-shift nursing and midwifery ratios system, with an appropriate skills mix and staffing levels based on the number of patients in each ward, unit or service.

Nurse-to-patient ratios and improved maternity staffing are necessary to ensure current staff are retained and to prevent more nurses and midwives leaving the public health system due to burnout, early retirement or seeking better conditions and pay in other states or territories. Ratios will safeguard the future health workforce, ensuring less experienced nurses and midwives receive the clinical support and guidance needed early in their careers.

Early career nurses and midwives or novice practitioners should not be put in a position where they are the most senior nurse or midwife on shift in an ED, and a new shift-by-shift staffing model can prevent this from occurring.

In 2014, a landmark study was published in medical journal, The Lancet, demonstrating the link between nursing workloads and patient outcomes involving half a million patients in 300 hospitals across nine European countries.[14] This study was a culmination of decades of research that linked nurse staffing levels with patient safety, satisfaction, length of stay and readmissions.

In 2016, these findings were put to the test in Queensland with a rigorous prospective evaluation conducted on the implementation of minimum nurse-to-patient ratios in medical-surgical wards in 27 public hospitals that care for 83% of patients hospitalised across the state.[15]

The Queensland results, published in 2021, are stunning and should be looked at very carefully and seriously by decision makers in NSW seeking solutions to this current crisis. After implementation of nurse-to-patient ratios, mortality rates were significantly lower compared to comparison sites; re-admissions increased in comparison hospitals but not in intervention hospitals; and while length of stay

[14] Aiken LH, Sloane DM, Bruyneel L, et al. Nurse staffing and education and hospital mortality in nine European countries: a retrospective observational study. Lancet 2014; 383: 1824–30.
[15] McHugh, MD, et al. Effects of nurse-to-patient ratio legislation on nurse staffing and patient mortality, readmissions, and length of stay: a prospective study in a panel of hospitals, The Lancet 2021, https://doi.org/10.1016/S0140-6736(21)00768-6

(LOS) decreased in both groups post implementation of ratios, the reduction was most pronounced in intervention hospitals.

Most significantly in terms of the current situation in NSW, in addition to producing better outcomes, the costs saved due to fewer readmissions and shorter LOS were more than twice the cost of the additional nurse staffing. It is further confirmation that if NSW implemented minimum staffing ratios in the public hospital system, it would very effectively reduce LOS and readmissions, thereby increasing capacity and relieving at least some of the pressures experienced today.

(h) any other related matters

The Association has been campaigning for minimum nurse staffing ratios to be phased in for many years, underpinned by the growing body of evidence that demonstrates the links between patient outcomes and staffing.

The Association recognises that ratios are not the single solution and a wide range of measures are needed to address the current staffing crisis. However, it is clear that other solutions will not be successful without the introduction of ratios. The evidence from Queensland suggests investing in minimum staffing will relieve some of the capacity constraints in NSW public hospitals and health services, through shorter admissions and fewer readmissions.

Equally important will be the role of mandated minimum staffing in attracting and retaining nurses and midwives. The Association holds grave fears NSW is entering a dangerous downward spiral in terms of its ability to effectively attract and retain a robust nursing and midwifery workforce.

Fatigue and burnout, compounded by moral injury, is driving experienced nursing and midwifery staff out of the sector, which is impeding the quality of the practice environment. This undermines the development of new and less experienced clinical staff. Adoption of mandated minimum staffing ratio will give NSW an opportunity to stop this exodus.