Submission No 34

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

Organisation: Health Services Union (HSU)

Date Received: 20 September 2022

Impact of Ambulance Ramping and Access Block on the Operation of Hospital Emergency Departments in New South Wales

The Health Services Union NSW/ACT/Qld represents some 47,000 workers in both public and private health as well as ambulance paramedics and disability and aged care workers. In the public hospital system, we cover all levels of support staff and health professionals, as well as junior medical officers.

The information we are supplying will reflect the experiences of our members who have provided information via interviews and online surveys, including a survey of more than 500 members conducted between August and September 2022 specifically to address the terms of this inquiry.

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

I unfortunately as a result of triage and bed block delays had an elderly patient die in the back corridor of a major tertiary facility. I feel this is a death without dignity. Despite my raising concerns in triage (after a significant delay) the patient was still directed to the rear corridor without any further assessment and died without dignity in a busy hallway in front of multiple other patients. Please note - the patient had a NFR [not for resuscitation] that was adhered to and was reported as a negative event, but the incident I feel is significant and avoidable - people deserve to die with dignity and privacy and other patients should not exposed to such events.

Paramedic, Hunter area

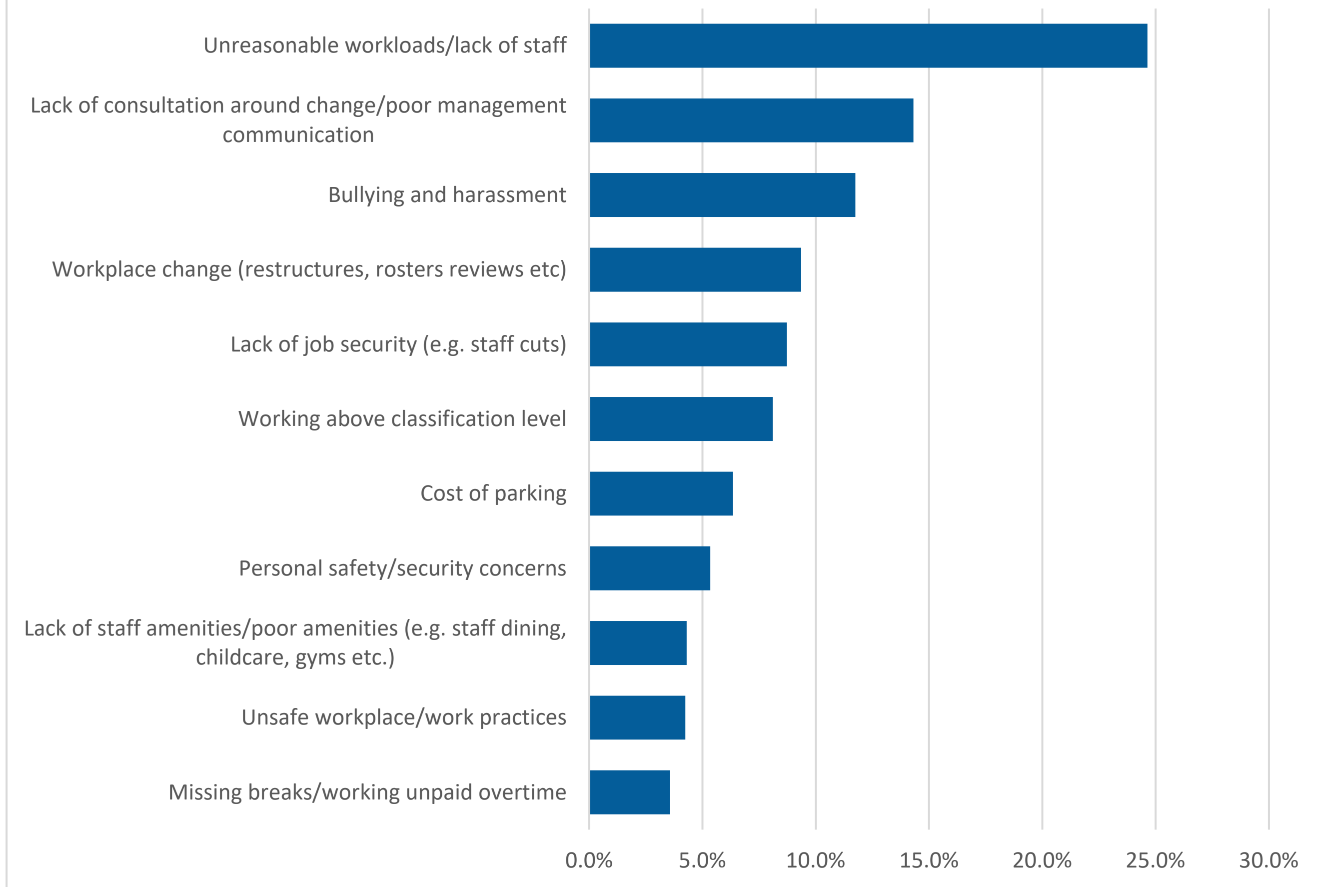
The term ''ambulance ramping' is a misleading one not in use among our paramedic members, who refer to these delays as 'bed blocks" or trolley blocks. They arise from delays in the process of getting patients through emergency departments and out to the wards, testing and treatment facilities they need for their care. The consequences of these delays can be distressing for patients and health workers alike.

There is no doubt that bed block is a worsening problem in public health and arises from a general state of under-resourcing in a system that has long been in decline. The most obvious sign of this decline is understaffing and the excessive workloads that go with it, and this is endemic within the sector.

I have worked in health for 5 years and for that entire time the team I work within has never been fully staffed. We are currently at the lowest level of staffing I have ever experienced. We are tired of given extra time for an employer (State Government) who is unsupportive, is out of touch with what is actually going on and does not realise the financial waste that is occurring.

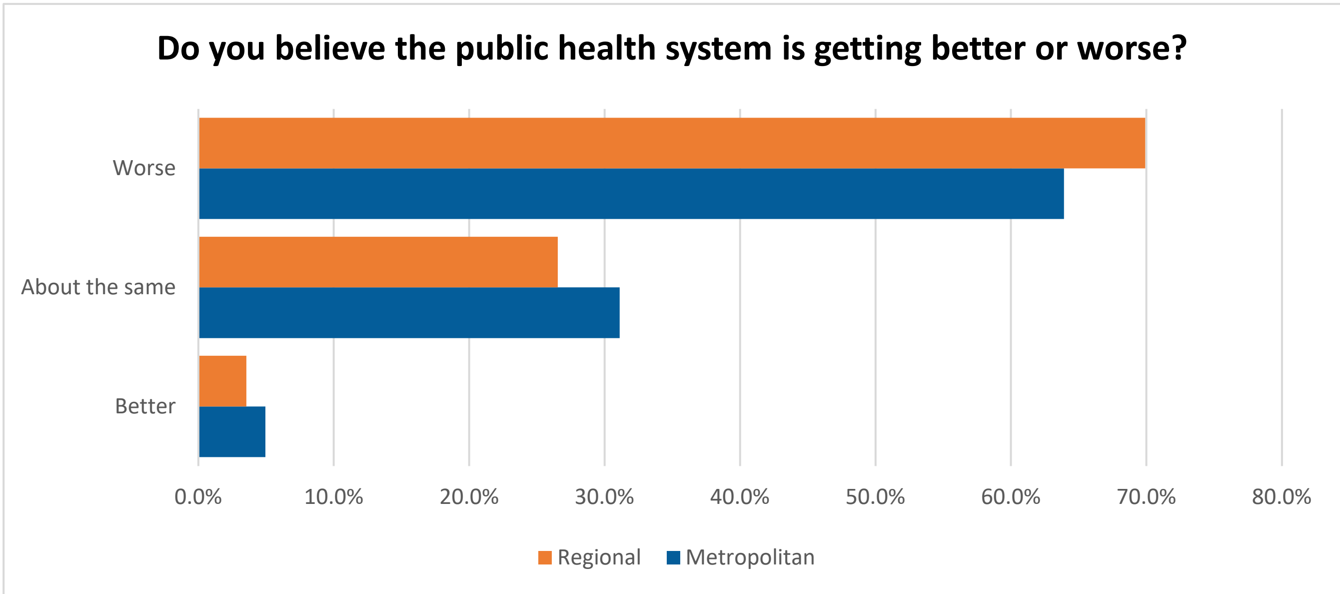
Health and Security Assistant, Southern Tablelands

Between November 2019 and February 2020, the HSU conducted a survey of more than 2000 members in public hospitals around the state and asked them to identify their most immediate concerns. Overwhelmingly the most common was staffing levels, with 24.7% of respondents identifying it as the number one issue and 51.7% putting it in the top three.



> *I work in pathology, and we do not have enough staff in pathology-Specimen Reception in particular-to comply with the required turnaround times for emergency patient results. This regularly affects patient diagnosis in the Emergency department and leads to longer wait times for admission/discharge decisions. NSW Health Pathology has introduced a deliberate regime of cost cutting: delaying staff recruitment, encouraging understaffing and relying on overtime expectations that are unsustainable.*
>
> *NSW Health and NSW Health Pathology appear to be focused on cost cutting and penny pinching to recover losses caused by Covid and possible privatisation motives. In reality, the NSW government is pushing for staff attrition by focusing on budget bottom lines. There is currently a huge "brain drain" caused by unattainable workload expectations (unpaid overtime), lack of executive support and the decision by some senior executive to dictate staff training and education requirements. Staff are leaving in droves because their qualifications are now deemed inadequate.*
>
> Technical Officer, Sydney District

One of the questions in that survey was: *Do you believe the public health system is getting better or worse?* While the participants overwhelmingly replied that the system was worsening, this feeling was stronger in the regions with 70% as opposed to 64%.

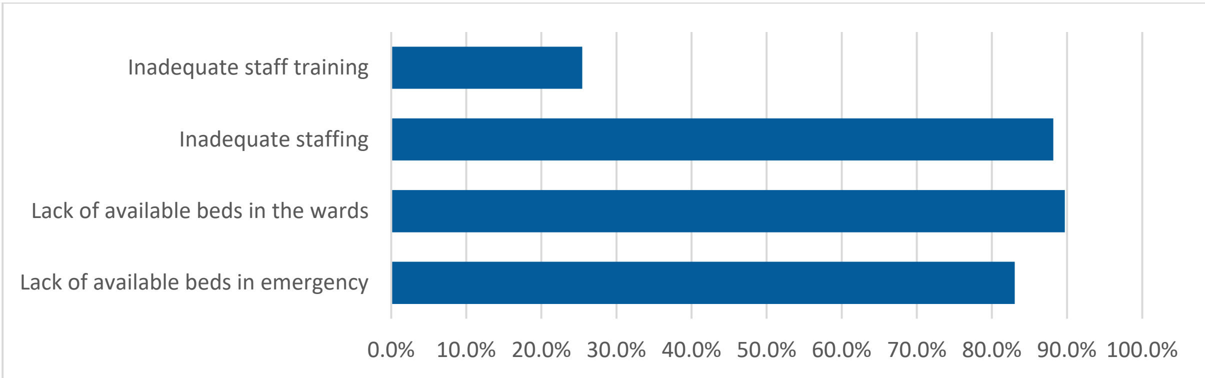


It is worth noting that these responses, which already reflected a crisis in public health, were recorded just before any impacts began to be felt from the COVID-19 pandemic. The latest quarterly report from the NSW Bureau of Health Information shows how performance standards by all measures have been steadily deteriorating in the years since. [See Appendix A]

According to the Report, between April and June 2022:

- almost one in 10 patients leave hospital without, or before completing treatment. Patients waited longer to be transferred from paramedics to ED staff, to be treated in ED and to be admitted to hospital (p3)
- the percentage of all patients who had their treatment start on time was 57.5% in urban hospitals and 72.8% in rural hospitals (p6)
- The percentage of patients transferred from paramedics to ED staff within 30 minutes was 69.5% in urban hospitals and 80.0% in rural hospitals (p9)
- one in 10 patients in urban hospitals waited longer than 1 hour 18 minutes to be transferred and one in 10 patients in rural hospitals waited longer than 53 minutes (p9).

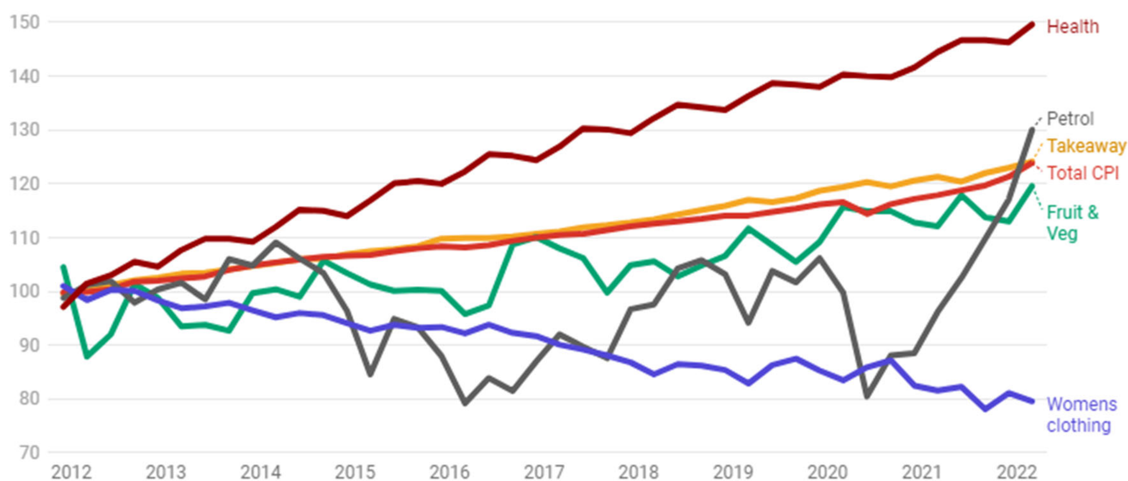
In our August/September survey ***we asked members which, out of a number of factors, they considered to be the main reasons for bed block and again the primary issues they identified centered around resources.***



The pressure on paramedics and emergency departments is made worse by the increasing difficulty people in the community are experiencing in finding alternative modes of treatment. Official statistics tend to show that bulk billing rates, for example, are holding steady or even increasing, but take no account of out-of-pocket expenses such as gap payments. In a recent academic paper, researcher Margaret Faux pointed out:

> *Out-of-pocket costs are the second-largest source of health funding in Australia after governments and make up around 18 per cent of health spending, a much larger share than in most other OECD countries. They limit consumers' access to care in all parts of the health system, including medical, dental, allied health and medicines. In 2016–17, the Australian Institute of Health and Welfare found that 663,000 people did not see or delayed seeing a GP at least once when needed and 974,000 people avoided or delayed filling a prescription because of cost.*

On top of this, consumer price data from the Australian Bureau of Statistics show health costs have for years been rising faster than any other spending category.



Our members see the effects of the lack of affordable services every day.

> *GP's have dropped the ball so to speak and won't see patients face to face and are therefore presenting to the ED for low acuity problems. This includes elderly patients that could have a number of issues solved via a GP not through an emergency department. To quote one patient "this is my one stop shop, I can get everything done here at once. i.e.: bloods, X-ray, referrals.*

ICP, South Western Sydney

> *Too many low acuity patients are using the ED as they are unable to get into GP. This is the area that needs funding. More Ambulances are not going to fix the problem. I the current climate we will have all the extra cars stuck in block.*

Paramedic, Hunter area

A situation made worse by the conditions imposed by the COVID-19 pandemic:

> *Lack of GP appointments and GPs refusing to see anyone with respiratory symptoms, and high cost of GPs means these patients just come to the ED with non-ED presentations as they have no other options, and it's also free. The same things happens with patients calling an ambulance for the same reasons stated above. "I didn't know what else to do or who else to call" is a common complaint from patients to paramedics.*

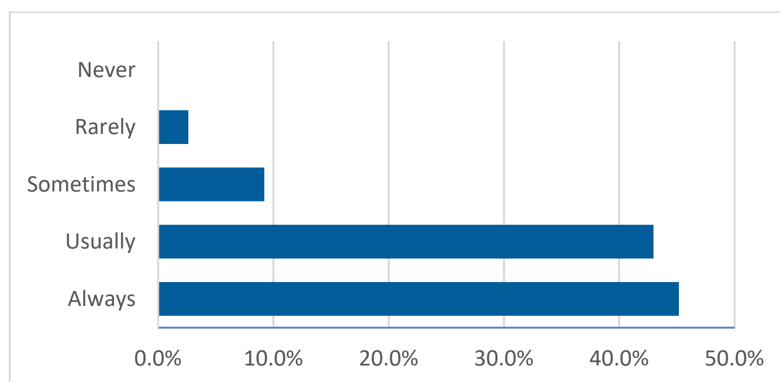
Paramedic, Central Coast

While we acknowledge that the furloughing of health staff has had an impact, the pandemic has shown a lack of redundancy in the system through a lack of investment in workforce over many decades.

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

The wording of TOR (b) reflects a misunderstanding of the causes and effects of access block. It implies that delays in ambulance practices cause delays for emergency departments when the reverse is true. The issue is that long waits in emergency departments impede the ability and capacity both of paramedics and of hospital staff, whether clinical, allied health, administrative, technical or security. The consequences are wide-ranging and are detrimental to patients and workers alike.

The August/September survey asked members working in public hospitals: ***How frequently does your facility's emergency department regularly experience delays in the assessment, treatment and admission of patients? How do these delays affect your ability to do your job?***



The delays to timely patient assessment and treatment have a ripple effect that spreads throughout the hospital system, wasting time, resources and treatment opportunities.

> *Backlog of patients in Emergency often leads to double and triple handling of patients for imaging as they are often not properly examined until they transfer from ambo trolley to acute bed and therefore not fully assessed in terms of what imaging they need and end up with multiple requests at different times.*
>
> *Many patients have stays of over 24hours in the emergency department waiting for a ward bed to become available. These patients are admitted as inpatients but cannot be moved out of emergency creating a backlog and delays for further patients entering emergency.*
>
> Radiographer, Western Sydney
>
> *Admissions not being done during the day causes extreme clerical demands into the evening and next day when less staff are working to complete the administrative aspects of admissions.*
>
> Administration Officer, Hunter
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> *When the pathology lab is under significant pressure due to inadequate resources (staffing, analysers etc) and this causes delays in the ability of ED to perform their role, the off-site management of NSWHP lacks any sense of urgency or any appreciation in the role played by their laboratories in contributing to local bed block and ambulance ramping.*
>
> Scientific Officer, Western NSW
>
> *I am responsible for booking patients in for theatre and organising the theatre list for the following days.*
>
> *The main issue will be that we will be unable to manage the workload for category 3 patients that have*

been delayed multiple times due to the bed crisis. We have been moving lists out to the private hospitals under collaborative care to try and reduce the number of patients on our wait list, but this is not a permanent solution.

Theatre Data Officer, Hunter

We over scan and thus over-irradiate patients. By not having enough staff to properly assess patients, doctors over order or panic order for everything instead of what the patient actually needs. They stay longer in emergency and those already in hospital are delayed as we are so busy with emergency which take priority.

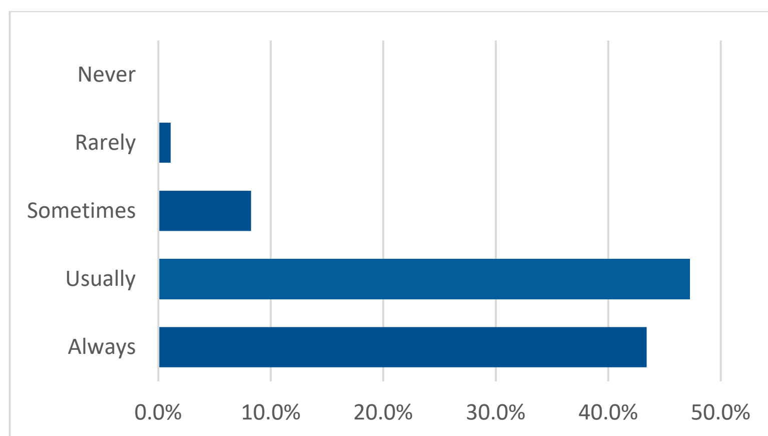
This is a reflection of a system that's struggling to work. It's been cobbled together and patched worked to the point where everything is the issue in some way. Staff are obviously tired but without adequate staff training in appropriate medical imaging orders we are inundated with scans that we can't keep up with. This delays patient discharges, thus delays a potential free bed. This then causes bed block which is very difficult to get out of.

Radiographer, Central Coast

I'm a scientist in the pathology lab and have raised my concerns with lab management that we directly contribute to bed block as we become overwhelmed with discharge and admission samples, particularly out of hours when working solo, as evidenced by numerous phone calls chasing delayed results. Our inability to provide timely specimen testing delays discharge processes on the wards and admission decisions in ED to the extent that specimen triage is determined by whoever is most persistent in seeking results. In addition, there has been a noticeable increase in the incoming specimens (unlabelled, wrong tube, wrong test etc) which is symptomatic of a department (ED) inadequately trained and under stress. This compounds already delayed testing as corrections need to be notified and followed up.

Scientific Officer, Western NSW

These results parallel those of paramedic members to a similar question: ***How frequently do your local emergency departments experience delays in the assessment, treatment, and admission of patients? How do these delays affect your ability to do your job?***



Where paramedic staffing levels are, and have been known for years to be, too low, having crews tied up for long periods waiting to hand over patients can only have a drastic effect on patient treatment and care.

Jobs build up as we do not have ambulance reserves to attend, we have to move crew from other towns into those areas with bed block leaving a gap in ambulance cover for certain areas.

Control Centre Operator, Western NSW

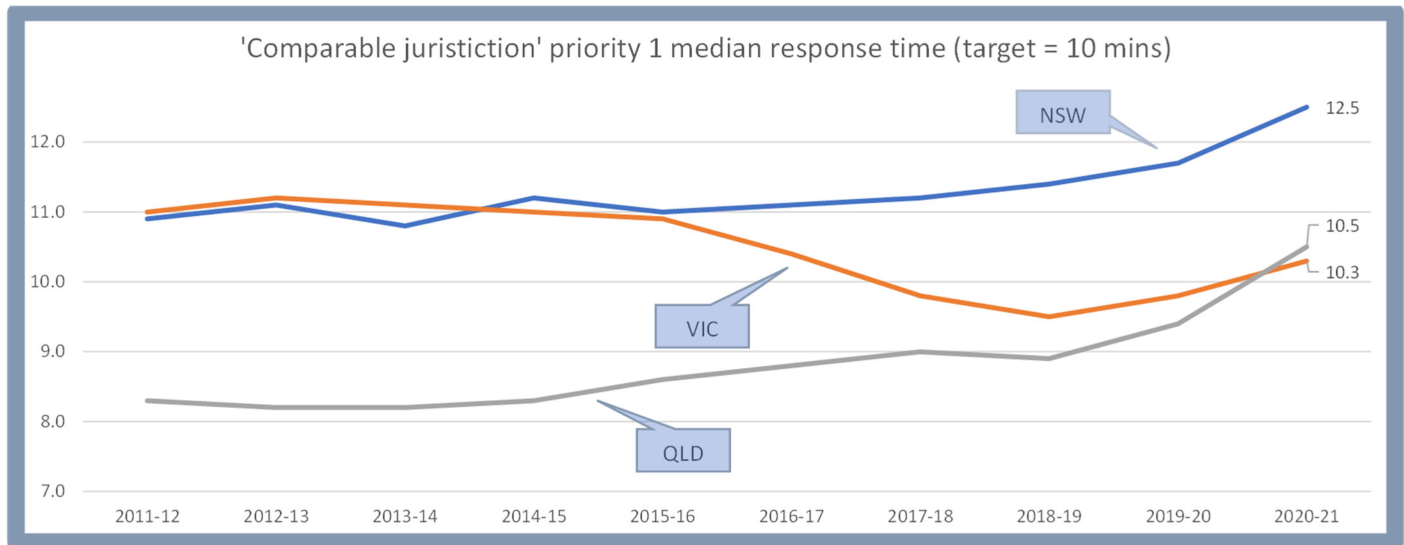
As a DOM the requirement to go to the ED to "Manage" TOC delays prevents us from doing so many of our frontline staff support roles.

Ambulance Duty Operations Manager, New England

Being delayed being triaged and "offloaded" reduces the available response time for other patients, reduces the available time for crib breaks and frequently results in completely missing breaks and/or unplanned overtime.

As an Intensive Care Paramedic I'm more often than not standing at hospital with a patient who doesn't need Intensive Care Paramedic interventions, whilst a paediatric cardiac arrest is going down. Or my fellow paramedics are requesting Intensive Care Paramedic back up.

Intensive Care Paramedic, Hunter area



Australian Government Productivity Commission. (2022, February 1). *11 Ambulance services - Report on Government Services 2022*. www.pc.gov.au. https://www.pc.gov.au/ongoing/report-on-government-services/2022/health/ambulance-services

As shown in the *Australian Government Productivity Commission. (2022, February 1). 11 Ambulance services - Report on Government Services*, NSW jurisdiction's response times continue to be significantly behind other states. We know that every ambulance tied up in bed block is one fewer ambulance that can treat 9-year-old patients experiencing cardiac arrest or an elderly patient with a fractured hip lying in agony at the bottom of her stairs. This means when patients are finally treated, they present to EDs with more complex problems.

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

One of the clearest examples of the impact of the failing aged care system on NSW hospitals is in the Illawarra. Earlier this year the HSU made a GIPA request for the number and percentage of beds occupied by aged care residents.

On 1 March 2022, 8.6% of available beds were occupied by aged care residents, 64 beds in total. This represents a 3% increase from 1 March 2020 (pre COVID). In this same month local aged care providers had confirmed that across the Illawarra and South Coast, 210 residential aged care beds had been shut over the previous 2 years.

The lack of available beds in residential aged care has shifted the responsibility and cost of care onto NSW Health. Beds that would have otherwise been available to transfer patients to are occupied by aged care residents who should be receiving care in a residential aged care facility.

The full extent of this impact is not understood. However, if the Illawarra is a reasonable example, on any given day 817 of the state's 9,500 beds are filled by aged care residents, many of whom may only be there because of the lack of availability in the aged care system.

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

Our members have frequently expressed many points of concern arising from the lack of timely patient care: issues which begin in emergency and may flow through the entire treatment period and extend even to post-discharge conditions.

Within the emergency department, patients awaiting triage may be crowded into waiting rooms or lined up along corridors. Along with fears for their immediate health and comfort, members point out the lack of privacy and of basic human dignity that such situations afford.

> *If there is bed block in the hospital elective patients end up getting cancelled. There have been multiple instances of patients being in hospital and requiring surgery, only to end up with COVID-19 from being exposed on the wards. This means their surgery is delayed.*
>
> *Patients are cancelled multiple times, which means they are breaching their wait days, which then gets escalated to the Ministry. They are also left in pain due to cancelled theatre, which could potentially lead to more complications.*
>
> Theatre Data Officer, Hunter

> *Several patients have been thrombolysed in the corridor. The standards of patient care have substantially reduced in other ways also. I witnessed a patient on an ambulance stretcher have a team of doctors arrive to assess him and they pulled back the patient's sheet and clothing - fully exposing him without underwear on. They did not introduce themselves, ask consent or make any attempt to protect the patient privacy and dignity. This indicates a clear dehumanisation of patients that is reinforced by not "being under hospital care" at the time.*
>
> Intensive Care Paramedic, Hunter area

> *Patients have delayed treatment due to not being admitted immediately. Our patients are all crowded together (out the door on occasion) and this impacts patient privacy. Our mental health patients have their dignity taken away when brought in by police and paramedics into crowded ambulance waiting bays. The minister's need to make surprise visits to these hospitals especially Gosford and Wyong hospitals and see how bad it is every day. It is like we are in a third world country*
>
> Paramedic, Central Coast

> *Very negative impact, no privacy, not enough staff to provide quality services, pressure to discharge other patients before they are really ready to go home, patients leaving before they get properly treated.*
>
> Social Worker, Central West

This 'pressure to discharge' is one of the more hidden effects of bed block and its implications for patient care: the imperative to keep patients moving through the system in order to make more beds available.

Our members in the allied health professions are particularly well-placed to assess the risks and observe the consequences of pushing patients through the system without adequate regard for their conditions and circumstances.

> *Very poor outcomes for patients not able to access social work and highly crucial support for social issues in a timely manner. Frustration for patients which means their engagement with practitioners is poor. Total disregard for the importance of the social determinants of health.*

ED is not my primary work area, however there is absolutely constant pressure on all acute wards because of the bed block and pressures in ED. This has a terrible flow on effect where people's social circumstances and needs are totally overlooked and there is absolutely no breathing room to allow people the needed time to coordinate safe, appropriate and respectful discharges. This often leads to re presentation to ED, anyway, ironically building more pressure on the system.

Social Worker, Mid North Coast

Relentless pressure to discharge patients who are not necessarily well enough or functional enough, so beds are freed up. No time for any proactive work that will prevent patients deconditioning in hospital. Working to discharge priorities rather than what a patient clinically requires. Patients are discharged too early resulting in either representation to hospital or not recovering as best they could have, ultimately leading to a poorer functional outcome.

Occupational Therapist, Hunter area

I am usually called just prior to discharge and there is a lot of time pressure to get the person discharged. The person is usually very stressed and just wants to be discharged, so engaging and working with them can be difficult.

Social Worker, Central Tablelands

It is only to be expected that in the stress of the moment patients and their loved ones may react with varying levels of distress and hostility, which will be directed to paramedics, hospital workers and even, given the crowded conditions, to other patients.

If I am stuck in the hospital with my patient on my stretcher, confidentiality is breached with all patients and any waiting family members hearing everybody else's presentation at triage. It distresses the patient and their families if they are waiting in the corridor, joining a queue and watching others in the queue.

Paramedic, Illawarra

Patients may experience delays in access to imaging due to delay in assessment by medical staff who can order the appropriate imaging. This can cause patients to be aggravated when they eventually reach Radiology & this can then result in having to spend more time with patients to calm the situation.

Radiographer, Sydney District

The physical design and structure of Triage areas and emergency departments were never built or designed to have multiple stretcher patients crowded into them. Patients waiting on stretcher are usually unable to be isolated appropriately and are frequently exposed to such things as violent and agitated/aggressive mental health patients, infectious Patients, and potentially secondary infectious diseases. Patients become distressed. frustrated, angry and anxious due to these situations.

Ambulance Duty Operations Manager, New England

As an administration staff member, we are the first in line to receive complaints. We are always being abused by patients, family, friends, and carers. It makes it difficult for us to perform our job.

Emergency Department Administration Officer, Illawarra

All these factors contribute to an environment where workers deal with constant stress from excess workloads, unreasonable hours, inadequate resources and difficult interactions.

By admissions not being done during the day causes extreme clerical demands into the evening and next day when less staff are working to complete the administrative aspects of admissions.

Administrative Officer, Hunter area

Often ambulance bays do not have any seating for paramedics, which can lead to physical strain after multiple hours of standing resulting in decreased ability to perform tasks and deal with subsequent patients. The process of waiting is also mentally draining, particularly if you are managing a complex patient who still requires active interventions whilst waiting for hours. It's an unspoken truth that if you've been ramped the majority of the day with forced overtime that the likelihood of you being able to perform at peak the next day is going to be severely limited. Often times people will just call in sick to try and recover from the day previous.

Increased disillusionment with the service and the health care system, lowering overall morale can perpetuate poor attitudes and burnout.

Paramedic, Western Sydney

Significant stress on myself and my team to meet demands beyond our abilities in unrealistic time frames given multiple competing complex priorities acrid the whole health system.

Social Worker, Mid North Coast

We're unable to safety access rooms to remove rubbish and linen due to overcrowding of areas /zones. Patients are waiting for treatment and blocking corridors and hallways. Significant lack of staff across all disciplines. No room to safely move beds around the emergency dept or between imaging, theatre, equipment etc. It stresses everybody out staff, patients and visitors.

Health and Security Assistance, Hunter area

Two recent reports from paramedics illustrate how the cumulative effects of bed blocks can escalate an emergency into a crisis, and the impacts workers feel from these conditions.

There have been many occasions recently where significantly unwell patients have had lengthy delays to being appropriately managed in the ED. E.g. and 80yo female fallen head first down a full flight of stairs with a comminuted fracture and signs of closed head injury was unable to be offloaded onto any bed at all, let alone a resus/trauma bed. Other patients needing emergency response are left waiting for unsafe periods. Non-emergency patients e.g. elderly people on the floor are left completely unattended for hours such that what would have been a minor event becomes a significant one. Lengthy delays weigh on all members of staff in any capacity, and change the dynamic within the ED. This extends to patient care.

Over consecutive shifts the fatigue exponentially increases, not only because of longer work time but less available sleep time in between shifts. This then overflows into all other aspects of work including completion of training or administrative tasks on station, available energy and motivation for mentoring/training other staff etc.

Intensive Care Paramedic, Hunter area

Having only worked for NSW Ambulance for 5 months, I am already feeling the individual drain of the overall poor system management contributing to bed block. I am acutely aware that this is a multi-faceted issue, with no simple, one-size fits all solution. However, I'd like to share my recent experiences in order to put into context the drain this issue has on staff.

My most recent block of shifts consisted of four, 12-hour shifts. My first day shift, commencing at 5:45 am and over that day, we were sent further and further north up the central coast, in order to cover the increasing number of ambulances stuck at hospital waiting for a bed. Despite our treatment and referral decision making never being based on reducing the strain on the health system, we increasingly attempt to leave patients at home wherever safe and possible and inform them of the significant delays they will face on arrival. We arrived with our last patient of the day at approximately 14:00 on a Friday afternoon, with an end of shift time of 18:00, at Gosford Hospital. We were met with 8 crews already waiting and had to stage ourselves in the hallway around the corner from triage as there was no space left in the large ambulance triage bay. We continued to cardiac monitor and run fluids for our patient in the corridor until approximately 17:30 when we were informed that a nurse from upstairs would be coming down with a few beds to take over care of our patient. This nurse arrived at 18:30 and we were able to handover care within triage and go home. We had no crib break that day.

The second day shift commenced at 06:45 and ran similarly to our first, doing our best to leave those who didn't need urgent care at home with a referral to the GP. However, due to both the scarcity of GP's accepting patients, the removal of bulk billing from the majority of practices, the lack of practices that open over the weekend, and the lack of aged care teams to assess, treat or visit patients at home, weekends normally mean care cannot be referred to the community and patients must be transported for small issues such as antibiotics or imaging. We were again continually moved up and down the coast for cover of crews and stations in bed block. Despite the significance of many patients' clinical condition, we still wait 1-2 hours on average with each patient requiring transport.

Our afternoon shift, commencing at 10:00, almost always involves us taking over other day shift's patients in order to help them get off on time in the early evening. This regularly means after 3+ hours with our own patient, we then take over other crews with an earlier finish time and could spend upwards of 6 hours in the ED waiting with different patients for beds. Our night shift begins with crew after crew alerting dispatch that it was over an hour since their shift ended, with no estimated offload time for their patient

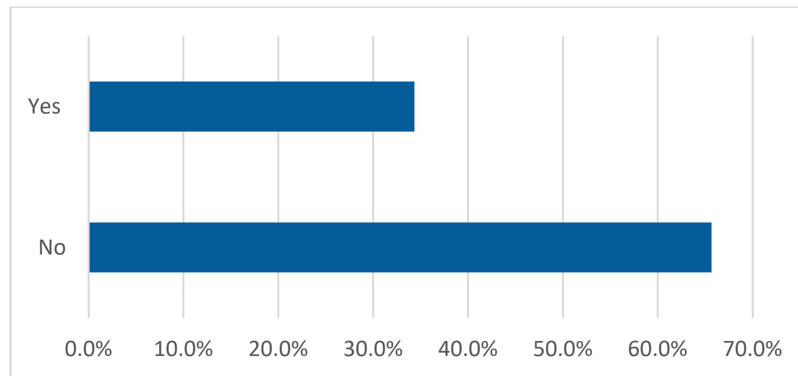
The danger to paramedics with these forced EOS hours is immense. I have, on a number of occasions, had to pull over on my way home and have a nap because I had started to micro sleep. It's not clinically, morally or ethically appropriate to expect someone to work 15+ hour shifts with very minimal down time. Compounding this, on the central coast, we have a dangerous lack of community resources to appropriately care for the explosive population growth, especially for the ageing population in the region. Our shift on Friday is proof that options exist to clear emergency ambulance crews from the triage bay, but they aren't enacted unless crews are so overwhelmed, there are no emergency ambulances on the entire coast.

Paramedic, Central Coast

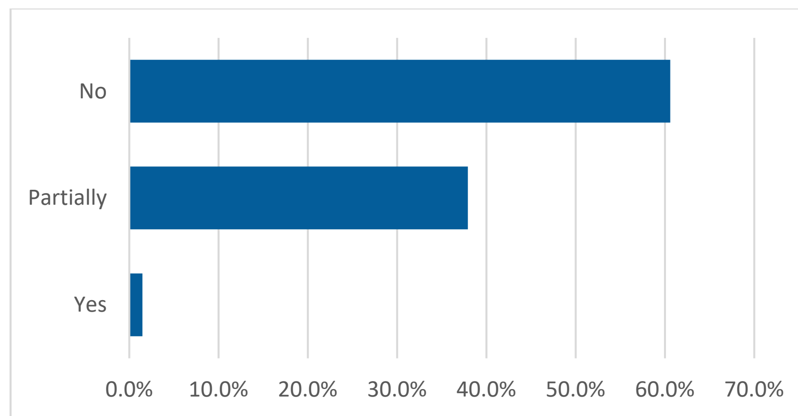
Conclusion

'Ambulance ramping' or bed block is a symptom, not a cause. It reflects a public health system failing as the result of years of neglect. In both public hospitals and the Ambulance Service the central underlying workplace problem our members report is always the crucial issue of insufficient material resources and inadequate staffing levels, which in turn make for employees who are increasingly subject to excessive workloads, inadequate training opportunities and workplace stress. The result is a poor level of service both in the range and quality of treatments available and in the physical environment in which those services are delivered.

There are few signs that these conditions are likely to change anytime soon. In our recent survey we asked: ***Are you aware of any action that hospital management has taken to address emergency department delays?*** **Responses were similar for both ambulance and public health.**



For the minority (34.5%) who answered 'yes', we followed this with: ***Was that action successful?***



Where members reported successful or partially successful action, details supplied show that it tended to be of extremely narrow scope, local band-aid solutions most often at the level of a positive response to advocacy on behalf of a single patient, or the allocation of one extra staff member.

Clearly this is an issue which can only be addressed at the state level. Health spending accounts for around one third of the total NSW budget and it is time attention was directed to how that funding is allocated.

Recommendation

We don’t need a band aid. We need system-wide reform. Currently health accounts for a third of the state budget and we cannot see that health will take up to fifty percent. We need to transparently ventilate our concerns, to explore if and where exploitation, profiteering from and wastage in the system is occurring. We need to accurately assess where the blockages and choke points across health that prevent the efficient flow through from the time an ambulance is called, a patient is delivered to the ED, and is ultimately moved through the system and is discharged.

We need all stakeholders, the NSW Government, the Federal Government, the aged care and disability sectors, the broad health workforce, to participate so that we can make permanent changes that result in the best patient outcomes.

We need a Royal Commission into NSW Health.