Legislative Council Acute Health Services in Tasmania Inquiry
2018 Update by ANMF Members

2018 UPDATE TO SUBMISSION BY GROUP OF ANMF SENIOR STAFF IN THE ROYAL HOBART HOSPITAL EMERGENCY DEPARTMENT

Our previous submission to the Legislative Council Inquiry into Acute Health Services expressed our concerns regarding adverse patient outcomes as a direct result of the RHH access block. We are alarmed to inform the committee, that despite some changes, there has been little to no improvement and the situation has continued to deteriorate. This is to the direct detriment of patient care and health outcomes, as well as staff well-being, retention and recruitment. In fact, as of today (24 August 2018), it was widely reported on radio that the RHH Emergency Department (ED) was again at Level 4 with over 60 patients waiting to be seen and 24 admitted patients in the ED awaiting a ward bed.

Access Block

As previously described, the RHH has had continuing and ongoing access block issues. Since our last submission the RHH has instituted a fourth level to the escalation strategy. Level 4 in the escalation strategy institutes a whole of hospital response to access block. From June 2018 to early August 2018 we noted that Level 4 escalation was initiated eight times. This is despite the fact that there has been no institution of flu season/increased presentations due to flu this year. Whilst the Level 4 escalations do eventually relieve pressure in the ED we have concerns that:

- The escalation strategy is still only initiated reactively rather than proactively. This results in the ED reaching crisis point far earlier with associated adverse patient events due to excessive waiting times and treatment pressures. There is also concern amongst clinicians that, whilst there are triggers to initiate a Level 4, the final decision for this rests upon the Southern THS Executive Director of Operations and there appears to still be resistance to this intervention.

- As the RHH are still the tertiary referral center in Tasmania, patients requiring certain time critical interventions and treatments (e.g. neurosurgical admission, cardiothoracic admission etc.) will still be transferred even if this means transfer to the ED whilst awaiting a bed. In one instance an intubated and ventilated patient requiring neurosurgical services and an ICU bed was transferred to the department at 0400 and was in ED until 1830. In an under-resourced and oversubscribed service, this places enormous pressure on all involved. The ED is not a suitable environment for a patient who needs ongoing 1:1 care and support.

- The ED is continuing to have excessive lengths of stay and, in particular, our mental health patients who often face a multi-day stay in the unsuitable ED environment
- Anecdotally, we are seeing an increase in SRLS/incident reports. We have grave concerns that we are seeing increases in patient harm/morbidity and mortality. The acuity level of our patients is on the rise but due to the pressures of access block we are unable to meet challenges in their care. Whilst our patient presentation numbers have increased less than projected, we are seeing an increase in the category 1, 2 and 3 patient presentations, whilst our lower acuity presentation (category 4 and 5) have decreased. This may also reflect that the community have been listening to our concerns and RHH pressures and utilising other health care options such as GP services.

The My Hospital government website clearly illustrates the access block issues the ED faces. 82% of patients discharged from the RHH ED occurred within the 4-hour NEAT (National Emergency Access Target). In comparison only 27% of patients admitted to the RHH from the ED could go to a ward within the 4-hour NEAT target. In fact, the length of time taken for 90% of the admitted patients to go the ward was just under 17 hours. The Australian Institute of Health and Welfare (AIHW) 2016-2017 Emergency Department Care report notes that Tasmania has the lowest rate in Australia for being able to admit patients in under 4 hours. This has a clear and detrimental effect on patient flow within and outside of the ED environment.

Since our last submission building works have been undertaken within the ED. There is now a larger clinic/walking patient care area with beds and chairs for waiting and treatment. The EMU (Emergency Medical Unit) has also moved and now encompasses two areas in A and J blocks respectively. This has increased the EMU capacity with beds and chairs but has created some logistical difficulties with the splitting of the unit into two. Despite these expansions, there are concerns that the ED is still only designed for a patient load of 30,000 people per year. We now see over 60,000 people per year and this figure is projected to continue rising. Whilst there are plans for a new ED in the RHH redevelopment, this has not had funding confirmed and therefore has no timeline or specific plans at present.

Ambulance Ramping

Since our previous submission it has been noted that the ramping situation has worsened dramatically. The ED patient tracking and management system has had to be modified to ensure that the greater number of ramped ambulance crews/patients are able to be tracked and managed within the ED system. Whilst we are unable to access/provide the data that would demonstrate the increases in prevalence and increased waiting times patients are subjected to, we hold grave concerns that patients are suffering increased adverse events because of these delays.

We, and our colleagues, are concerned that there has been an increase in interventions carried out on ramped patients, due to the inability to accommodate these patients in an appropriate treatment area for their needs. There has been an increase in procedures performed in inappropriate areas due to the severe limitations on available treatment areas. We are concerned that this is placing both medical and nursing clinicians in evermore risky and error-prone situations whilst trying to care for significantly unwell people. The risk to patients is increased because these spaces are often not suitable (from an available equipment perspective) and are very difficult to work in if resuscitation is required.

There has also been a noted increase in tensions between Ambulance Tasmania (AT) and the ED. Some clinicians have commented that the working relationship between our two organisations is the worst seen in over a decade. Whilst this is unfortunate, it can hardly come as a surprise that morale between colleagues is decreasing when neither party is able to perform the duties required in a timely fashion. Each side is frustrated because there is no evidence of any apparent solutions in the near future.

Staff Effects

Our previous submission briefly mentioned some impacts on staff created by this pressurized and difficult work environment. Many of the nurses who perform the triage role are finding the pressures of bed block and the associated lengthy patient waiting times and ramping difficult to manage. The stressors of being unable to treat patients appropriately to due to space and resourcing constraints, is placing undue strain on our caring and resilient staff. There is distress amongst staff when very unwell and often complex care patients (who are often Category 3 patients – and therefore should be seen and treated within minutes) are faced with excessive and lengthy waits in the waiting room.

Patients and their relatives are understandably perturbed and upset when faced with lengthy waits before appropriate treatment spaces and, often treatment, can be provided. This can lead to upsetting and distressing interactions with staff, and occasionally results in negative media stories or editorials/letters to editor etc. These are demoralizing and contribute to an already difficult job, where we feel unable to speak out about the issues of concern due to our employee and State Service Act obligations.

Many colleagues are struggling with the pressures of the ED at present. Anecdotally, some are leaving, reducing work hours and/or working in other areas or roles. These are appropriate ways to individually manage the pressures of the ED environment, and there has been organisational discussion about encouraging resilience supports and, of course, utilizing the EAP (Employee Assistance Program). Whilst these are important measures to combat staff distress they neglect the fact that the staff in ED are already incredibly resilient and capable people. If the current ED situation is overwhelming the resilience capacity of already highly resilient people, then that does not bode well for staff retention and departmental functioning. A particularly pertinent issue considering the concurrent parliamentary inquiry into first responders mental health issues in Australia.

One of our nursing colleagues summarized the situation perfectly;

> ‘Most of us became nurses to care for and communicate with people, and to be with them at what is at times the worst time of their life. This is a privilege and they deserve our best care. But in the current climate I feel this is second place to just trying to get through a shift and deal with the sheer volumes of patients requiring our care when our ED is not really running as an ED should with access block.’

There is concern from our medical colleagues too that the current situation is affecting staff recruitment. Once coveted RHH ED registrar positions, are now struggling to attract applicants. This, in turn, has implications for accreditation. The situation where multiple department accreditations (LGH ED, RHH psychiatry etc.) have been revoked provides a stark background to the seriousness of this warning. The once protected registrar teaching time has, this year, been cancelled on occasions due to the Level 4

escalations. With the renovations in ED, there has been a reduction in seminar/office areas available for nursing and medical education.

Medical colleagues have also expressed concern that there are fewer senior staff and this means decreased levels of support and safety mechanisms for junior staff whilst also increasing risk of adverse events for patients. There have been occasions where senior medical staff/Heads of Department are so distressed at the inability to provide appropriate patient care, that they have been reduced to tears. It should be noted that 'appropriate' care is not 'excellent' or 'exceptional' it is now reduced to 'adequate' care i.e. sufficient only to ensure the safety of the patient.

Summary

Since our previous submission there have been changes within the ED, wider RHH and THO. Some of these changes have been positive and there have been some indications that clinicians are being listened to and involved in some of the decision-making processes. However, this does not negate the grave concerns we hold regarding the safety of patients and the fact that the RHH is still unable to manage the capacity demands of day-to-day business. We remain alarmed that adverse patient events are occurring due to the unreasonable workloads being placed on the ED and the ED staff.

We are concerned that without identification and acknowledgement of the underlying issues that have led to this situation, these errors will be repeated in the future. We believe that there need to be clear plans formulated for the future to identify RHH capacity requirements in the long term. We also believe that the further stages of the RHH redevelopment, especially the ED, require the certainty of funding and timeframes to enable commencement.

In the short term, we believe that there needs to be a more predictive and proactive approach to managing capacity and patient flow to prevent the extremes of access block and excessive waiting/ramping times experienced in the ED. We believe a renewed focus on discharge planning and discharge support programs with appropriate resourcing to be a high priority. The completion of K block requires the institution of streamlined and improved admission and discharge processes in order to ensure that the issues faced presently are minimized and avoided.

We remain committed State Service employees and do not believe that we are in breach of the State Service in providing this general response to the Legislative Council. We hope it assists your deliberations and we look forward to the final report and recommendations for improving acute health services for the benefit of all Tasmanians.

2018 UPDATE ON THE LAUNCESTON GENERAL HOSPITAL EMERGENCY DEPARTMENT AND HOSPITAL WIDE BED BLOCK CONCERNS

Members at the Launceston General Hospital Emergency Department welcome the opportunity to provide an update regarding the current situation at the Launceston General Hospital and the challenges experienced specifically by those working within the Emergency Department (ED). Members are extremely concerned by the service, care and treatment that is afforded to those community members presenting the LGH Emergency Department and the risk to patient safety. The Launceston General Hospital has spent the majority of this year at Level 3 escalation which is its highest level of escalation. The primary cause of escalation is due to bed block. Lengthy wait times for in-patient beds are not uncommon in the Emergency Department with up to 16% of all admitted patients waiting 24 hours. Since 1 January 2018, 2 patients have waited 96-120 hours, 37 patients waited 72-96 hours and 47 patients waited 60 to 72 hours.

Access Block

As described, the Launceston General Hospital is routinely at its highest escalation level due to sustained bed block throughout the hospital, severely limiting capacity within the Emergency Department and increasing wait times. LGH ED members are concerned that:

- Ongoing bed block is resulting in poor quality of care and at times compromising patient safety. Patients on ambulance trolleys who have been brought with chest pain are at times waiting up to an hour before they are off loaded and fully assessed. There have been instances where these types of patients have shown to have had a cardiac event and have had to be rushed to the angiography suite for urgent treatment. Clearly an hour delay on an ambulance trolley has the potential to increase morbidity and mortality in these circumstances. The area is not close to meeting best practice guidelines.

- Mental health patients continue to experience significant wait times in the LGH ED with one adolescent patient recently spending nearly 3 days within the ED with no plan of care and no medical or psychiatry team willing to take over care of the patient. This particular patient was assessed by an inter-state psychiatrist who commented in the report that the adolescent was of the highest acuity that he had ever assessed. However, due to a lack of beds, this patient was eventually discharged home directly from the ED under child protection without a medical or mental health care plan.

- Despite ongoing delays in mental health patients, in-patient admission and development of treatment plans resulting in extended unnecessary length of stay and negative care experiences, repeated calls by ED staff to implement Psychiatric Emergency Nurses (PENs) on all shifts at the LGH ED have not been supported. THS have agreed to implement a PEN on late shifts only for a 12-month trial period. Whilst staff have been actively campaigning for additional PENs three nursing staff were assaulted in two separate incidents involving mental health patients.

- Due to the overcrowding in the Emergency Department acutely unwell patients are spending significant periods of time being treated in the ED waiting room due to no available beds in the department. This means no privacy for the patient who is sitting shoulder to shoulder with another person while disclosing their medical information. It also means providing treatment in an uncontrolled environment which has the potential to increase risk to patients with regard to infection control and also in terms of lack of oversight and ongoing assessment due to lack of staff to tend to those in the waiting room. As previously discussed the main reason for this is due to the lack of available treatment spaces due to ED overcrowding.

- The acuity of patients is consistently increasing as are the numbers of presentations and the LGH ED consistently has its resuscitation bays completely full which means patients who are of the highest acuity are not able to be cared for in an appropriate environment. This also results in constant shuffling of patients around different bed spaces to make available the most appropriate treatment space for the next presenting patient. This situation is not only inefficient but a logistical nightmare at times. It also increases the risk to staff, who are moving beds, and the risk to patients who might occupy several bed spaces over a period of time leading to potential risks due to misidentification and confusion.

- Despite the ongoing challenges with regard to access to in-patient beds, available in-patient beds are not funded and permanently staffed. Ward 4D at the LGH has 29 available beds but is currently only funded permanently to 19. This has meant that the remaining beds have only been opened and accessible when casual and agency staffing permits. ED staff have repeatedly advocated for full funding and staffing of the full 29 beds on ward 4D, yet only 19 beds remain permanently funded and an additional 5 have been funded for a 6-month period taking currently available beds to 24. ANMF have lodged this matter with the Tasmanian Industrial Commission as it was agreed through re-benchmarking between local LGH management and ANMF that it was necessary to full fund and staff 29 beds (although the funding was not forthcoming). This matter is ongoing before the Commission.

- Additional identified capacity such as 4 beds on Ward 4K and 4 beds in ICU have not been funded and opened which could, if funding was available, relieve ongoing bed block issues.

The wait times of in-patient beds at the Launceston General Hospital are among the worst in the country. According to the My Hospitals government website between 2016-2017, not even half of the patients needing in-patient admission met the 4-hour NEAT target with 50% of patients waiting 7 hours and 35 minutes. However, the wait times for 90% of all patients awaiting in-patient beds is 22 hours and 38 minutes. While these wait times are an improvement, many patients are simply moved into the Emergency Medical Unit which is geographically located within the Emergency Department and is not an actual 'ward' area.

Ambulance Ramping

Ambulance ramping is a regular occurrence at the LGH ED and is increasing in frequency and volume. This means that there is whole category of patients who are not receiving care in a timely way, nor in an appropriate environment. As previously discussed this has resulted in less than satisfactory care outcomes for some of these patients and clearly places strain on ambulance officers who are also under pressure to off-load their patients.

The LGH ED is not equipped to have ambulance trolleys ramped in the ED itself. It has a very small designated area for one trolley next to the ED waiting room assessment bay. However, this area is consistently full of ambulance trolleys due to ongoing ramping which results in an overcrowded waiting bay area which not only compromises patient care, it also compromises the work health and safety of all ED Staff and ambulance officers working in the space.

Staff Effects

Working within the LGH ED has always been a challenging but rewarding nursing environment. However, the consistent and unresolved workloads due to bed block have placed significant strain on even the most senior, experienced, and resilient ED nursing staff members.

With no intention of being disrespectful, nursing colleges have described working in the LGH ED as like working in a “war zone’’. Yet all the calls for proactive management of the bed block situation appear to have gone unanswered by senior Tasmanian Health Service management. This situation has contributed to staff feeling undervalued and forgotten about.

Recently, after staff were seriously assaulted in the ED, it took over 24 hours before any management acknowledgement was made directly to the staff, which further highlighted the feelings of isolation. Staff feel that, despite the untenable working environment, there is no help or relief coming as it appears that the Department of Health and The Minister for Health just expect us to carry on as we always have done.

However, to carry on as we always have done is impossible. Recruitment is difficult already, but it will end up being impossible to recruit nursing and allied health staff to the LGH ED if the bed block issue is not resolved. Nursing staff in the LGH ED work in the ED as they thrive on being able to provide high quality care to patients in a time critical environment when patients are at their most vulnerable. But sadly, providing high quality care is not sustainable, as staff are only able to achieve at best the bare minimum and still go home after each shift worried that it was not good enough and worrying how many patients were left at risk. This is not what nursing staff sign up to and many staff members are also concerned about their own professional registration when they know patient care is compromised on a daily basis and they are powerless to improve it.

The long-term medical staffing issue has had a detrimental and long-lasting impact on the ED workforce, governance and respect within the LGH as a whole. The long-term under-performance in being able to recruit to the mandated acceptable levels of medical staffing is unacceptable and needs to be addressed, as it is fundamental in helping the ED to be able to deliver care in the way it should.

This lack of clear leadership, consistency in practice and decision making from the senior medical staff, directly impacts on nursing staff and is a major factor in fueling dissatisfaction. Everyone is trying to do their best, but the best – day in and day out – is no longer able to cope with the demand.

Industrial Action

LGH ED staff were so concerned by the persistent risk to patient care and safety due to bed block at the LGH ED that they launched industrial action on 19 March 2018 after failing to have any proposed solutions addressed by local Tasmanian Health Service management.

This industrial action was aimed at highlighting the bed block issues to the Minister for Health with those in the LGH ED waiting room encouraged to send postcards directly to The Minister highlighting their joint concerns with the length of wait time at the LGH ED.

Despite, over 1000 postcards being sent and numerous requests for meetings by ANMF on behalf of members no response or meetings to discuss members proposed solutions were held by local senior management or any higher executive members until 10 July 2018. This is nearly four months after industrial action had commenced. Due to a lack of progression on the previously discussed issues, members in the LGH ED resolved to escalate industrial action on 31 July 2018, which has involved wearing of badges, T-shirts, giving information to patients and their families about the bed block issue and a community rally will be held on 31 August to support the call for resolution to the bed block issue.

Summary

The challenges of bed block at the LGH ED are wide and far reaching, impacting upon both patients, their families and staff alike. Staff at the LGH ED wonder what action, adverse patient outcome or crisis must occur before the situation is addressed. We do not want to see this ending in a coronial enquiry.

Evidenced by the industrial action by ANMF members at the LGD ED the concern for patients and the ongoing impact to safe and quality care is a very real and present threat and despite, some local dialogue between local management at the LGH around the ongoing concerns, it does appear there is any immediate relief to this crisis due to a lack of funded and permanently staffed beds.

We request that the committee considers as part of its deliberations a recommendation that the Tasmanian Health Service be appropriately funded in order to open and safely staff all available beds the Launceston General Hospital. Further, we invite the committee members to attend the Launceston General Hospital Emergency Department as part of the Inquiry which we believe will fully illustrate the complexities of the challenges which words cannot do justice to.

We thank you for your consideration of our submission and support to allow us to raise these concerns without risk to our employment.

2018 UPDATE ON THE NORTH WEST INTEGRATED MATERNITY SERVICES PREPARED BY ANMF NWIMS REPRESENTATIVES.

Members working within the North West Integrated Maternity Service (NWIMS) welcome the opportunity to provide an update on the 2017 submission to this Committee which highlighted significant challenges experienced by Registered Midwives working within the North West Integrated Maternity Service and the women accessing ante-natal and post-natal care at the Mersey Community Hospital Clinic and the North West Regional Hospital Clinic. Members are disappointed and concerned to advise that while some interim progress has been made, many concerns remain unresolved and midwives are feeling very undervalued and remain concerned for the care of women accessing the North West Integrated Maternity Service.

Service Delivery

The concern relating to the NWIMS not being the continuity of service model that was promised to women in the North West remains and staff are particularly concerned about these ongoing matters:

- The crossing over of women from the public (for ante-natal and post-natal care) and private system (for birthing services) is difficult to navigate for women and midwives. It appears that no one seems to be in charge and taking responsibility for the continuity between these services and ensuring accountability.
- Sharing of documentation is a major issue. There are many delays with accessing inpatient and outpatient documents from the North West Private Hospital (NWPH). The NWPH often do not document on the only shared database (obstetrix) and this impacts on the ability to provide informed and timely care the next time the patient presents to Tasmanian Health Services.
- There are currently issues relating to access for unplanned assessments. This started with removal of the Resident Medical Officer roster to antenatal clinic at Mersey at the beginning of August. The role had been in place since the NWIMS inception and loss of the position has impacted upon assessments for women of the area.
- Communication is extremely poor throughout the service – particularly between medical staff, North West Private Hospital to the Tasmanian Health Service.
- There is poor communication and inclusion in process development of services outside of NWIMS, i.e. LGH/QVMU who provide birthing services to women of this area also.
- There is poor understanding across obstetric and maternity services in the State of what care is, and can be, provided by THS NWIMS services due to poor communication and consultation when the service was first developed and implemented.
- There is still poor development of policy and guidelines to guide practice for midwives and medical staff across the NWIMS regarding service delivery models and associated requirements for safe and quality care.

- Facilities at the North West Ante-natal Clinic still do not provide for confidential consultations (conversations can be overheard), the work space is too small to carry out safe consultations, women are required to walk down the corridor and use the public Hudson Café toilets to collect intimate swabs and urine samples.
- Members held back on proposed industrial action in November 2017 when it was agreed that an evaluation of the entire NWIMS would be carried out. To date no report has been provided following that service review and members have not even been provided with interim feedback.

Patient Effects

- Patients get the 'run around' between services due to poor communication and poor understanding of service provision changes. For example, a patient can ring Mersey ante-natal clinic for advice, be directed to the NWPH for assessment, arrive at the NWPH (having travelled from Devonport), only to be told they are "too busy" referring the patient to the NWRH Clinic for assessment.
- Access to services is inequitable across the region in terms of care closest to home particularly with altered assessment clinic (Pregnancy Assessment Clinic) at Mersey.
- There will always be women who just present for assessment no matter what they are told, there is risk involved in this because midwives are being undermined and prevented from using clinical skills to determine course of action with the proposed removal of assessments at the Mersey.

Staffing Effects

- Reduced midwives in outreach areas puts greater pressure on those staff working in Rural Health Outreach Funding as well as on NWIMS THS staff and services.
- The NWIMS service is short staffed and consistently relies on agency midwives to keep staff at an appropriate level.
- Staff morale is very low. Staff are felling unheard, unconsidered and generally fed up. There are only two casual staff in the pool and both have limited availability to allow for leave relief both planned and unplanned.
- There is limited opportunity for staff to access training due to inadequate staffing levels.
- Birthrate plus© (the maternity staffing model that is under development) has had many limitations for data collection and we are now embarking on a process of further data collection which will better reflect the work performed, especially in Extended Care Midwifery with intention for review of this in 2019.

Summary

The North West Integrated Maternity Service remains a service which does not provide the level of service or continuity of service that it was intended to. Many of the challenges highlighted in the 2017 submission remain and new challenges have emerged.

Registered Midwives working within the NWIMS are extremely dedicated midwives who care a great deal for the women who access the service, their colleagues and the service itself. It is considered that this commitment and care is what has enabled to ensure that service has continued to the level it has to date.

However, this is not sustainable. The challenges described above must be addressed in order to ensure a safe, high quality and sustainable service which offers the continuity of care promised when implemented. We thank the Committee for its acceptance of this update on NWIMS and hope that recommendations to improve NWIMS will be considered.

We thank you for allowing us to raise these concerns without risk to our employment.