ANMF
Tasmanian Branch

AUSTRALIAN NURSING & MIDWIFERY FEDERATION (TASMANIAN BRANCH)

SUBMISSION

Legislative Council Sessional Committee Review of Acute Health Services in Tasmania

2017

Australian Nursing & Midwifery Federation
(Tasmanian Branch)

Organisation Overview

The Australian Nursing and Midwifery Federation (ANMF) is the largest union representing nurses and midwives in Tasmania. We operate as the State Branch of the federally registered Australian Nursing and Midwifery Federation. The Tasmanian Branch represents around 8000 members and in total the ANMF across Australia represents over 250,000 nurses, midwives and care staff. ANMF members are employed in a wide range of workplaces (private and public, urban and remote) such as health and community services, aged care facilities, universities, the armed forces, statutory authorities, local government, offshore territories and more.

The core business of the ANMF is the industrial and professional representation of nurses, midwives and the broader nursing team, through the activities of a national office and branches in every state and territory. The role of the ANMF is to provide a high standard of leadership, industrial, educational and professional representation and service to members. This includes concentrating on topics such as education, policy and practice, industrial issues such as wages and professional matters and broader issues which affect health such as policy, funding and care delivery. ANMF also actively advocates for the community where decisions and policy is perceived to be detrimental to good, safe patient care.

ANMF is not affiliated with any political party. In fact, we guard our independence vehemently. ANMF is keen to influence policy responses of all political parties on issues relevant to the nursing and midwifery professions and in the interests of healthy public policy.

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ANMF Australian Nursing & Midwifery Federation Tasmania

1. Introduction

The ANMF welcome the opportunity to provide a submission to the Legislative Council Sessional Committee Review of Acute Health Services in Tasmania. ANMF take this opportunity to thank members of the Legislative Council for recognising a need for review.

The ANMF provide this submission on behalf of our 4000 members working in the Tasmanian public sector. We acknowledge that the Tasmanian acute health and hospital services work in tandem with a broad range of publicly and privately funded community services. All sectors are reliant upon each other to provide the full spectrum of quality health services needed for Tasmanian residents and visitors. ANMF acknowledge that a failing of services in one sector will significantly impact the functioning of the other. ANMF believe the complete Tasmanian public health system, including preventive health, is under unprecedented pressure resulting from number of factors, including a lack of capacity in the acute health services.

The Tasmanian Health Service (THS) provides acute healthcare through the public hospital system. The service also incorporates primary and community health services, such as mental and oral health services. Acute care services are provided by many sites across the state, including smaller district hospitals which deliver some acute and subacute services. ANMF recognises a number of these facilities experience resource problems associated with funding shortfalls, further compounding issues in Tasmanian major acute care facilities.

This submission will generally focus on the 4 major acute care hospitals within Tasmania; the Royal Hobart Hospital (RHH), Launceston General Hospital (LGH), North West Regional Hospital (NWRH) Burnie and the Mersey Community Hospital (Mersey).

As an aside, the ANMF has experienced the need for increasing industrial workplace representations at all these sites: particularly at the Hobart and Launceston Hospitals. It is our belief that this increase in representation and industrial unrest is entirely due to factors such as poor staffing and under-resourcing.

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ANMF have a strong collaborative relationship with many senior acute care staff. We strive to resolve industrial disputes as efficiently as possible for our members and welcome the opportunity to represent nurses and midwives on a range of reference groups.

2. Current and projected state demand for acute health services

In 2013 the Tasmanian State of Public Health report, released by the then Population Health Services, provided insight into the state of Tasmania's health needs.[1] The report indicated that, in 2013, Tasmania's health system was not in crisis but clearly warned that demand for treatment and care for chronic conditions would continue to increase fuelled by relatively poor risk factor profiles in Tasmania as well as an ageing population. In 2016 Public Health Services conducted a follow up population health survey that clearly supported the 2013 predictions. Key factors from that survey showed a substantive increase in chronic conditions, particularly diabetes, eye diseases, depression/anxiety and an aging population.

The 2016 survey found that, overall, Tasmanians felt more stressed and less healthy in 2016 compared to previous years, with significantly more Tasmanians reporting financial hardship and food insecurity. Socio-economic disadvantage was found to significantly contribute to poor self-assessed health, poor dental health, and low health literacy. The proportion of adults with fair or poor health continued to increase and there were more Tasmanians reporting elevated levels of psychological distress in 2016 than in 2009.[2]

Despite a clear, ongoing increasing demand for health services the Tasmanian acute care system has been shrinking relative to demand. The most recent Australian Hospital data statistics indicate that the average available beds in Tasmania's public hospitals increased by as few as 0.8% between 2013–14 and 2014–15 periods.[3] During 2015-2016 Tasmania had on average fewer available hospital beds than other hospitals in Australia. In 2017 bed numbers have begun to fall. Tasmania is now experiencing a crisis in its health system as the previously predicted public health statistics catch up with a heavily underperforming acute health system.

[1] http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0017/132263/State_of_Public_Health_2013_LR.pdf
[2] http://www.dhhs.tas.gov.au/publichealth/epidemiology/tasmanian_population_health_survey_2016
[3] http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129559918

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The Australian Institute of Health and Welfare (AIHW) data from 2014/15 shows that Tasmania was and continues to function at least 82 beds short of the national average, with another 200 beds, or 16.7%, needed to reach the weighted average. The implications of this shortage are revealed by many measures. Relative to its population Tasmanian public hospitals care for far fewer patients than any other jurisdiction. The number of overnight separations per 1,000 population was 15% below the national average; same-day separations were 18.5% below. There were 659.8 patient days per 1,000 population in 2014-15, far fewer proportionately than other states.

An extra 20.8% of bed days would have been needed to reach the national weighted average.

Emergency department lengths of stay are above the national average, but the critical bed shortage means Tasmanian patients are at much higher risk than other Australians of being faced with bed block when seeking admission through emergency departments. This issue has been explored by some of our members in the Emergency Department at the RHH and is found at appendix A.

3. Factors impacting on the capacity of each hospital to meet the current and projected acute health care demand

Tasmanian public hospitals have been the subject of significant and inconsistent change with every term of government. There has been failure of all levels of Government to invest in primary and preventive health care in Tasmania and there is no single plan for the health system. Bipartisan support could help solve some of these issues. There is an urgent need to prioritise health care within Government, to provide consistent health frameworks particularly within our major hospitals.

3.1 Workforce:

The Tasmanian health care system is dependent on the knowledge, skills and capacities of its workforce. Chronic underinvestment in the health workforce and absence of structured workforce planning is placing at risk the current and future provision of high-quality services. Staff numbers in all our major public hospitals have been critically inadequate for some years and the situation has

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not been addressed. The rate of increase in the numbers of doctors, nurses, allied health professionals and other staff is inconsistent with the increased growth in patient demand.

In August 2017 there are currently 124 permanent and 122 fixed term nursing and midwifery vacancies and international recruitment has commenced. Yet, by the same token, new graduates of nursing are unable to find positions and we run the risk of losing 'our' graduates to other States.

National statistics show Tasmania's public hospital system has limited capacity; treating a lower proportion of people than any other in the nation, even though many Tasmanians need more care than others. This means the chance of a patient, other than the most seriously ill, being admitted to a public hospital in Tasmania are the worst in Australia. Currently, the rate of increase in admissions has fallen to its lowest level in many years. Over the last two years, the increase in weighted separations – the measure of admitted patient services, weighted for cost and complexity – was 1.3% at the RHH compared with 11.2% in the previous two-year period. At the LGH, the figure fell from 12.9% to 3.2%.

3.2 Implications of prolonged staff shortages:

Staff who are forced by shortages and funding restrictions to take care of many more patients than is clinically appropriate cannot perform at the level of safety, quality and efficiency that the community requires and deserves. A doctor, nurse or paramedic working unduly long and stressful hours, often with repeated double shifts, has compromised cognitive, response and judgment functions. Problems are much more likely to occur and do occur, every day, in our hospitals. For patients, this means a significantly higher risk of complications and, for some, death.

A research study on the effects of overtime, equates working double shifts of 17 hours straight to that of a blood alcohol level of 0.05 with peoples response times 50% slower.[4] Nurses regularly work double shifts at an unacceptable rate, with recent figures from January to June 2017 revealing an average of

[4] Williamson, A.M. and Feyer, A-M. Moderate sleep deprivation produces impairments in cognitive and motor performance equivalent to legally prescribed levels of alcohol intoxication. *Occupational and Environmental Medicine.* 2000. 57: p.649-655.

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360 per month or 12 doubles a day. (In the same period last year; 275 double shifts were worked per month). This is unacceptable and has implications for safe patient care as well as for the health of the nurse. Staffing a hospital by way of double shifts also clearly has cost implications.

A rigid application of the number of FTE staff employed has led to considerable expenditure on overtime and temporary replacements. The use of Agency nurses and midwives has sharply risen in order to cover shortages. In some areas the lack of benefits, for example accommodation, which is available in other remote areas, does not make Tasmania an attractive option for employment. The willingness of nurses to move to the State is also impacted by lower wages here relative to other states.

Having short term staff provides an additional impost on the permanent staff who have to familiarise these new workers with policies and procedures and the 'way ' of working on the ward.

Logically it would seem sensible to employ extra permanent staff which would not only benefit patient care but lead to consistent quality care delivery. This would include putting increased resources into the employment, and retention, of local nursing graduates in Tasmania.

3.3 Nursing overtime

For many years the acute sector has relied on nurses working overtime and double shifts to plug gaps in rostering caused by problems with recruitment, retention or restricted hiring of nursing staff. Like all of Australia, Tasmania's demand for nurses significantly exceeds supply. Forecast projections indicate shortfalls across Australia of approximately 85,000 nurses by 2025.[5] Tasmanian needs to start to focus on providing opportunities for our graduates before they find work, and permanently settle, in other states and territories.

The lack of a state or local workforce plan has resulted in shortages particularly in specialty units. These include intensive care, emergency,

[5] https://www.health.gov.au/internet/main/publishing.nsf/Content/34AA7E6FDB8C16AACA257D9500112F25/$File/AFHW%20-%20Nurses%20detailed%20report.pdf

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neonatal intensive care, mental health, midwifery, paediatrics and operating theatre units. UTAS has also withdrawn some post graduate courses e.g. Midwifery. Because these are areas that require highly qualified nurses with specific skill sets, the speciality care areas are experiencing the largest gaps in recruitment and retention of nurses. Consequently these areas also record the highest overtime rates in Tasmania.

Nurses across all four major Tasmanian hospitals are now working steady and regular overtime hours. Many Nurse Unit Managers (NUM), who are ANMF members, report that inefficiencies in employment systems further compound recruitment problems. They report waiting three months, or sometimes longer, to employ nurses into vacant positions: including for positions which would be regarded as 'entry level'. These delays mean that, in the meantime, some potential applicants find work elsewhere.

The NUM's are frustrated they cannot employ more nurses because of bureaucratic processes. Recruitment to a vacant funded position requires nine levels of endorsement, including sign off of the selection report by the North /Northwest CEO. These processes take considerable time: often months. While trying to recruit, NUM's have roster shortages that must be filled – usually by overtime and double shifts. This reflects poor system management and puts patients and nurses' safety at risk. It also increases the cost of health care.

Despite years of monthly data having been provided per ward per month in 2016, the Minister's Office suddenly refused to provide ANMF with the double shift data information. ANMF are only able to speculate as to the reasoning for this refusal. The change in process does not provide confidence in the transparency of the operations of the THS.

The refusal to provide the information is merely timewasting as ANMF can still obtain the overtime/double shift data through an official request for information. This is done for a few reasons, one being out of concern for the safety of our members. Working overtime for extended periods increases staff fatigue, anxiety, risk of injury, burn out and lowered morale. Both staff and patient safety are at risk when regular, excessive overtime is worked.

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3.4Clinical governance

During 2015 the Minister for Health implemented a major restructure of the Tasmanian Health Service (THS). This process was known the *One State, One Health System, Better Outcomes White Paper*. ANMF believes the delay in restructure has impacted greatly on the stability of acute care services/

The most significant impact has been the development of a highly centralised and politicised system which appears to lack leadership responsibility on the ground. The restructure has seen permanent executive services removed from all major THS settings and acting positions. This resulted in the development of a large gap between 'on ground' staff and executive able to make decisions. Removal of CEO's from each hospital to a single CEO responsible for the entire system has left senior hospital staff with little leadership support. Decision making appears to have been made without clear understanding of the on-ground issues for each site. The governing council have not addressed the significant risks and the safety concerns being raised by senior nursing and medical staff within the THS.

This issue could not be more clearly displayed than in the unfolding of the RHH redevelopment process. Lack of direct management by senior hospital executive has seen minimal meaningful engagement with senior medical and nursing staff to review projected impacts of the redevelopment process. No clear modelling was made available to senior staff. The lack of strategic planning is the direct result of a loss in bed numbers and the crisis management situation. ANMF was a member of the Professional Reference Group who wrote to the Premier at the conclusion advising of a number of unmitigated risks. Unfortunately many of these have eventuated e.g. risk of the loss of bed flex capacity resulting in extra bed block. Many senior nursing staff across the four hospitals report feeling unclear on the exact decision-making structure, delegation and accountability at executive level. Constant reshuffling and backfilling of senior positions has added to the confusion.

An example where a clear agreed strategy was announced by the Minister in April 2016, but poorly implemented with no clear accountability, was the *Patient First Strategy.*

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The *Patient First Strategy*, outlined 19 priority actions to manage demand in the LGH and RHH Emergency Departments and improve whole of patient flow, yet few have been delivered. Many actions remain unaddressed and performance on others is in decline.

1. A list of unacceptable 'red flag' events in our Emergency Departments. Not complete.

2. Evidence based escalation policies. - In the last week a *Level 4 escalation plan* was introduced after some 12 months in draft form at the RHH: 2 months into winter. This Plan should have been in place before the start of winter to help with peak patient flow. In the first week, the RHH moved to a level 4 status due to bed block as a result of influenza admissions. This resulted in delays for all non critical surgery, the conversion of 10 beds in the Ambulatory care day unit for overnight use and early discharge of many patients.

3. ANMF acknowledge the policy provides clear guidance to senior hospital staff and a structural approach to managing bed block. However, that the hospital was immediately escalated to level 4 merely highlights the crisis of the system. The whole hospital had been at the level 3 for months yet nothing was done to prevent the inevitable escalation. The policy is not a solution for long term bed block and will greatly impact on the health of the community, as access to elective surgery is reduced. ANMF also recognise the impact on the ambulatory day procedure unit staffed with overtime and flow on impacts for day patients. The inevitable effect will be that some patients in need of specialised day procedures will face delays.

4. Transparent, published principles for ED care. Not implemented.

5. Clinical Initiative Nurses. Not implemented at LGH, were already in place at RHH.

6. Psychiatric Emergency Nurses at the Royal. - In place on most shifts at RHH and identified as required at LGH, but there is no funding to implement.

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7. More efficient discharge - ANMF members are not aware of any new formal policy regarding discharge planning. Members indicated that in many circumstances patients are being discharged earlier than clinically indicated in an attempt to free up bed space because of the ongoing bed block. The RHH medical staff association reports 10% of patients aged 65 and over from general medical wards are re-presenting post discharge within one month. These patients often return 'sicker' than when they left so early discharge is not an effective mechanism and ultimately leads to increased pressure on the hospital system.

8. Better discharge planning. – Criteria Led Discharge has not been implemented at any hospital.

9. Winter illness strategies. - ANMF members are not aware of any new policies in this area.

10. Working better with the private and not-for-profit hospitals. - In Southern Tasmania 8 beds have been purchased within the Hobart Private Hospital to be filled by RHH patients, in assisting with patient flow, however there are problems admitting after hours.

11. Timely discharge summaries.- ANMF members are not aware of any new policies in this area.

12. Connecting patients to bulk-billing GPs. - ANMF members are not aware of any new policies in this area.

13. Better utilisation of rural hospital beds. – Work has been undertaken with New Norfolk Hospital. However staff in these areas need further assistance and education to manage more acutely unwell patients. There also needs to be clear protocols for contacting medical staff for ongoing management of these patients.

14. Enhanced role of Paramedics. Unsure.

15. Support for very long-stay patients. - ANMF members are not aware of any new policies in this area.

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16. Recognising the role of clinical leadership. - ANMF members are not aware of any "annual performance review" as outlined.

17. Statewide consistent admissions policies. - ANMF members are not aware of any new policies in this area.

18. Statewide Clinical Handover framework. - ANMF members are not aware of any new policies in this area.

19. Any other measures to improve patient flow.

20. Statewide roll-out. - ANMF members are not aware of any new policies in this area and all three regions have different escalation policies.

Similarly, in the North West of the State, the North West Integrated Maternity Service implementation occurred in December 2016. At that time birthing services were relocated from the Mersey Community Hospital to the North West Private Hospital via a service level agreement between the Tasmanian Health Service and the North West Private Hospital. At the time the Minister indicated that this decision was made to improve the continuity and quality of care for pregnant women in the North West of the State.

However, it has become apparent that the reverse of this is true. Women are receiving disjointed maternity care, lack of continuity of care pre and post birth and increasing induction and caesarean rates. Midwives, who are no longer able to participate in deliveries, are losing their skills (which potentially impacts upon their right to remain a registered midwife) meaning that these skills are likely to be lost to the service.

Strategically, despite the reconfigured service being implemented over 6 months ago, no evaluation or ongoing review of the service efficacy has been undertaken and several grievances have now been raised.

3.5 Bed block

Bed Block occurs when patients needing care have to remain in emergency departments for eight hours or longer because ward beds are unavailable. A literature review undertaken for the Australasian College of Emergency

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Medicine found that waiting times over 8 hours increased a patient's relative risk of death by between 20% and 30%. The research showed that bed block in Australia accounted for at least 1,500 avoidable deaths in 2003.[6] Bed block in Tasmania it is occurring at almost twice the national average. This implies, conservatively, that 70 to 80 people may die avoidably each year in Tasmania as a direct result of the bed shortage. Bed block is accentuated in Tasmania because there are limited options, as might occur in Melbourne or Sydney, to transfer patients between hospitals.

Bed Block occurs in all four Tasmanian acute care hospitals however the Royal Hobart and Launceston General Hospitals are the worst affected. For the first two months of 2017 the number of patients who spent more than 24 hours in the RHH emergency department was 132 compared to 35 for the same period in 2016. There has been several days when all treatment spaces in the emergency department are occupied by patients needing admission, but for whom no beds are available. The percentage of ambulances unable to offload a patient in 30 minutes in 2017 thus far is 13% compared to 4% in 2016. Having ambulances waiting to unload patients reduces emergency response times. ANMF members from Emergency Department at the RHH have outlined their daily lived experience in appendix A provided as part of this submission.

Much of the bed block at the RHH is related to a physical decrease in the number of available beds which, in a small part, can be contributed to the RHH redevelopment. However historical bed data collected by ANMF since 2010 shows the number of beds has failed to increase to reflect long term increases in demand for acute services. The reality is that, since 2010, the number of beds available at the RHH have dropped significantly despite an increase in demand. Much of this reduction has occurred in surgical and mental health beds. The reduction in any number of beds, regardless of the department reduces capacity for flexibility during peak flow. Previously surgical beds were historically changed to medical beds during periods of demand, such as flu season. At this time elective surgery could still continue with only minor disturbances. However there is virtually no flexibility available in the current system.

[6] Forero R, Hillman K., *Access Block and Overcrowding: A Literature Review* prepared for the Australian College for Emergency Medicine (ACEM) available at: https://acem.org.au/getattachment/a9b0069c-d455-4f49-9eec-fe7775e59d0b/Access-Block-2008-literature-review.aspx

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RHH Beds

	Surg	Trolleys/cl	Med	DCCM	WACS	Aged	Psych		Total	
6/30/2010	106		103	14	77	60	42		402	
6/30/2011	115		103	14	77	60	42		411	
6/30/2012	78		105	14	77	68	42		384	
6/30/2013	80		113	14	77	64	38		386	
6/30/2014	81		110	14	71	64	38		378	
6/30/2015	81		105	14	77	64	38		379	
6/30/2016	81		112	14	77	69	33		386	
5/23/2017	73	12	109	14	77	69	32		374	386

3.6 Emergency care

Emergency Departments (ED) are a critical component of Australia's health care system, providing care for patients who require urgent medical attention. Emergency services are provided in the RHH, LGH, NWRH and Mersey. ED's generally experience higher presentations of patients on Saturday, Sunday and Monday, with 69% of presentations occurring between the hours of 8 am and 8pm.[7] However peaks of presentations can occur at any time.

Patients who present to the ED are 'triaged' on presentation, according to the urgency of their need for care. A patient is said to be 'seen on time' if the time between presentation at the ED and the commencement of their clinical care is within a specified time appropriate for their triage category. In 2014–15, about 74% of patients were seen on time, including almost 100% of Resuscitation patients (who must be seen immediately, or within seconds) and 79% of Emergency patients (who must be seen within 10 minutes).

In all four major Tasmanian hospitals ANMF members continue to report that demand for emergency care exceeds the physical and other capacities of the hospital. In many cases, patients are being treated in corridors, waiting rooms and other inappropriate points of care. This results in an

[7] Australia's Health 2016, AIHW, p 318
http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129555788

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increased risk to patient health and safety, along with professional and other risks to staff. It can often mean that patients are providing personal information effectively in a public space. These matters cannot be adequately addressed by emergency department staff alone. In most cases, the issues relate to patients being held in the ED due to a lack of other services, primarily inpatient beds. As has been noted, failure to provide sufficient beds to meet demand increases a patient's risk of serious complication or death, while costing the hospital significantly more.

It is therefore critical in responding to ED demand to address the matters raised in relation to managing our public hospital activity and patient flow.

Long waiting times are associated with delays in time sensitive treatments for serious conditions typically requiring admission to hospital.

Waiting times in the LGH and RHH are now excessive with bed block occurring on an almost daily basis. This has been occurring since 2016 and has increased in severity in 2017. It is now common for patients to wait in excess of 12 hours for medical review and as long as 24 to 48 hours for ward admission.

A workplace health and safety review of the RHH ED was conducted in 2016. Findings included:

- Inadequate space for patients waiting in the waiting room, resulting in obstruction to the emergency exit doors.
- Lack of available space and chairs for medical staff to take bedside notes,
- Corridors blocked by wheelchairs, beds or other pieces of equipment lined up along the walls, restricting two way access.
- Inadequate storage space resulting in a shower room being used as a storage area, limiting the area to one shower.

The review concluded that current facilities in ED are unsafe for current and future operations. The environment is increasing the risk of musculoskeletal injuries, fatigue and potential workplace stress injuries. Consideration should be given to enlarging the ED.

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ANMF have approached management regarding this matter however the same unsafe working conditions continue. No new measures have been implemented to address and rectify the safety concerns. Alarmingly, ANMF members report problems with space in the RHH ED are worsening as the bed block crisis deepens during the winter flu months.

The LGH ED also experiences regular bed block and ambulance ramping. Much of this is related to a lack of available medical beds within the hospital. Recent reports from ANMF's LGH ED members provided the following concerns:

- Patients regularly placed in areas not designed to hold patients – this also means a lack of appropriate call mechanisms to allow patients to notify staff if they require help. Also means difficulties in responding to rapid deterioration in patient condition as space restrictions impact on the ability to treat urgently.
- Inadequate staff, including support services, to provide patient care.
- Patients are being treated in chairs or beds in open areas with limited privacy. This restricts the ability to perform ECGs, physical assessments, or deliver appropriate parental analgesia, etc.
- Ward bed closures have occurred as a result of inadequate availability of nursing staff and this impacts on emergency staff.
- Minimal support for senior hospital staff working above ED nursing management.
- Failure to call a code yellow or implement escalation reviews.
- Lack of planning in preparation for the upcoming flu season.
- Reduced, or no, access to casual or agency staff for sick leave cover in ED.
- Inadequate employment of ED registrars. Sometimes reduced to only 1 where a minimum of 2 is required.
- Recent avoidable deaths, resulting from delays in medical review and ambulance ramping.
- Insufficient ED consultants previously there were 7/8 consultants, currently only 3 employed with locums assisting as available.
- No Psychiatric Emergency Nurses (PEN) employed at the LGH DEM resulting in long delays for mental health patients to see medical staff.

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- No Navigator ED nurses as employed in the RHH affecting patient flow through the ED.

3.7Acute Mental Health Services

Mental health care in Tasmania is an area of major concern for ANMF members. Acute mental health care is a highly specialised and challenging area of nursing. Nationally nurses working within mental health care have one of the oldest age profiles of any area, with significant numbers of highly qualified staff likely to leave the workforce in the next few years.[8] There are presently real problems in attracting and retaining qualified mental health nurses in specialist mental health services.

The situation for patients with mental health problems needing to access acute services in Tasmania is troubling. Every day, mental health patients at the RHH, LGH and NWRH experience prolonged delays in receiving specialised treatment or awaiting inpatient beds. Premature discharge is common and can have fatal consequences. ANMF members report that patients who have attempted suicide regularly chose not to wait for specialist treatment after facing considerable (sometimes 24 to 48 hours) delays in the ED.

10 of 42 acute mental health inpatient beds in Tasmania have been cut over the last few years. The RHH now has only 32 acute inpatient beds, which is seven beds fewer than the national average, as a result psychiatric bed occupancy at the RHH is routinely now over 100%.

Unfortunately, under these circumstances there are also higher rates of violence and injury, increased staff sickness, significant difficulties with morale, and serious problems in recruiting and retaining staff at all levels.

The Government's accommodation plans for the acutely mentally ill patient as part of the RHH redevelopment remains unsatisfactory. This is true of both the temporary and the future facility. Both have insufficient beds, are too small and lack appropriate facilities for patients and staff.

[8] Mental Health Nurse Workforce data available: https://mhsa.aihw.gov.au/resources/workforce/mental-health-nursing-workforce/

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Research supports contemporary mental health facilities being situated on the ground floor of any setting, with access to therapeutic (and secure) green spaces. However, both the current temporary and future permanent, mental health facilities are on the second and third floors of the RHH, with little access to the outdoors. Patients wish to go outside may need to be escorted: the risk of absconding is high. These escorts also need staff.

National Institute of Health and Welfare (NIHW) data recommends 24.3 mental health beds per 100 000 people in a catchment area of persons aged between 18 and 65. That figure provides a minimum of 39 mental health beds in Hobart. There are currently 32 mental health beds in the RHH. On top of these recommendations it is necessary to adjust for other issues such as age demographic, poverty and other factors. The real needed bed capacity is likely to be much higher when adjusted for these demographics.[9]

Nursing and medical staff in conjunction with the ANMF have been appealing for increased resources, including more available beds for Tasmanian mental health services for at least 2 years. As Public Health data revealed in 2016 the number of individuals experiencing mental health concerns has increased in Tasmania. Bed availability and service delivery forecasting should always match epidemiological data. Health supply should be ready to meet health demand. Instead, in Tasmania, the reverse has occurred, with a steady decline in services despite evidence that need was increasing.

This failure in service delivery was highlighted two weeks ago when the Royal Hobart Hospital accreditation by The Royal Australian and New Zealand College of Psychiatrists was frozen. The impact of this will be felt heavily by patients. The loss of accreditation means medical staff training in psychiatric care will no longer be available to the RHH.

Because of this patients will wait longer to be seen in the Emergency Department as they are usually assessed by the psychiatric registrars. Patients, already admitted to the wards will wait longer for treatment

[9] https://mhsa.aihw.gov.au/resources/facilities/beds/

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services. The pressure on nursing staff will increase, particularly in assisting with mental health events and hospital wide code black procedures. In an area with low nursing recruitment and retention the impact on existing mental health nursing staff will be great.

Increasing reports of mental health patients presenting to the Mersey Community Hospital and the North West Regional Hospital in conjunction with drug and alcohol co-morbidities is creating unsafe and working conditions for nurses and other patients. The Mersey Community and the North West Regional Hospitals need Psychiatric Emergency Nurses to assist with implementing appropriate management plans for these types of patients.

Clinical Liaison nurses are desperately needed to assist inpatient areas with ongoing management when psychiatric patients leave the emergency department. Recent reports from nursing staff that managing patients with mental health illnesses and drug addiction is particularly difficult and there have even been instances where nurses have had to monitor and prevent illicit drug use and drug dealing from patients rooms. Clearly this is inappropriate and completely outside the scope of nursing practice.

Reports this week, from ANMF members in the LGH, indicated that the Mental Health Crisis Assessment Team (CATT) servicing Northern Tasmanian recently had no consultant psychiatrist support for two weeks. In the past CATT staff have had a training psychiatrist available part time.. Patients with mental illness accessing support at the LGH, or through the northern CAT Team, are now receiving second rate mental health care. This is increasing the risk of suicide and other complications for people in the community and within the acute care setting

The absence of mental health liaison nurses also impacts on the escalation of violence on general wards with patients with dementia and those affected by ice, commonly assaulting nurses. As one nurse commented “it has become normalised” to experience violence. ANMF has called for a Zero Tolerance to Violence against nurses. De-escalation training has not been standardised across the State and is often not offered to many high risk areas. There needs to be more trained security staff after hours. Busy, stressed staff, also have insufficient time to try to

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calm down patients who are agitated – particularly when they are in general (rather than psychiatric) beds.

3.8 Elective Surgery Waiting Times

Four public hospitals provide elective and emergency surgical procedures, with the majority of procedures being provided by the RHH and LGH.

Prioritising and scheduling patients for elective surgery is an important consideration for all hospitals. To cope with the demand Tasmanian's overstretched public hospitals must concentrate on prioritising the most surgically urgent cases, particularly those patients for whom long delay might be life-threatening. This is known as emergency surgery.

Elective surgery is defined as anything that can be delayed for 24 hours or more. Elective surgery is planned surgery that can be booked in advance, because of a specialist clinical assessment, resulting in placement on an elective surgery waiting lists. Waiting time for elective surgery is calculated from the time a patient is placed on a waiting list, until admitted for surgery. Elective surgery waiting times are affected by many factors including, demand, staff resourcing, available operating theatres and post operative beds. Surgeons are responsible for assignment upon assessment of their patient to one of three elective surgery urgency categories – Category 1 (surgery is recommended within 30 days), Category 2 (surgery is recommended within 90 days), or Category 3 (surgery is recommended within 365 days).

For many years, Tasmania has consistently held the longest median waiting time for elective surgical procedures in Australia. The Australian Institute of Health and Welfare's (2015/2016) Hospital Statistics show Tasmania continued to record the longest median waiting times for elective surgery in Australia, on every measure, with a median 72 day waiting period across categories. This is an increased waiting time from 55 days in the same period of 2014/15. The shortest recorded waiting time in Australia during 2014-2016 was in Queensland at a median of 29 days.[10]

[10] http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129557693

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Tasmania is at least 60 % behind Australia in delivery of elective surgery on a per capita basis.

ANMF recognise and appreciate that a small percentage of Tasmania's increased waiting time, since 2014, is due partly to an attempt by the DHHS through Federal funding, to admit patients who had been waiting the longest, with large increases in the numbers of patients admitted for specialist surgery such as ear, nose and throat surgery, ophthalmology, urology and orthopaedic surgery, with the proportion of admissions for patients who waited more than 365 days increased from 9.4% to 15.5%.[11]

However, that Tasmania continues to perform at the lowest rate in Australia for median elective surgery waiting times, while it continues to record some of the lowest rates of health in Australia is a major concern to ANMF. As Tasmania's public hospital systems continue to experience a crisis in bed capacity ANMF predicts a further decrease in elective surgery during 2017/18 and therefore increasing median waiting times.

Other data show the overall situation for people in need of surgery to be even worse. It should be appreciated that these national figures only count people who have been placed on a waiting list by a surgeon. AIHW data show as many as 11,000 Tasmanians are believed, by their GPs to need surgical care, yet have not been able to have their first surgical consultation. These patients remain off the official elective waiting list appearing only on clinic waiting lists.

It is not possible from the statistics to reach a firm conclusion about how many people in Tasmania are unlikely to be able to secure surgery for which they have a demonstrated clinical need, except to observe that it is likely to be very high numbers. The situation is by far the worst in the state's two major hospitals, the RHH and LGH where more specialised surgical procedures are concentrated. On average Tasmania performed 35,603 category 1, 2 and 3 elective surgeries in 2015/16.[12]

[11] Ibid

[12] Adapted from http://www.myhospitals.gov.au/hospital/613000003/north-west-regional-hospital/waiting-times-elective-surgery

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The Royal Hobart Hospital which is the major tertiary hospital for elective surgery performed only 69% of its allocated Category 1(within 30 days), 35% of category 2 (within 90 days) and 65% of category 3 (within 365 days) surgeries in 2015/16. This leaves on average 52 percent of people requiring surgery across categories waiting longer than required at the Royal Hobart Hospital in 2015/16.[13]

Launceston General Hospital performed a total of almost 14,000 surgeries in the 2015/16 with approximately 49% left waiting outside their recommended waiting period. [14]

North West Regional Hospital, performs the lowest amount of surgery in Tasmanian and has less specialised surgical procedures available. It conducted around 2905 surgeries in 2015/16, with an average of 28% of people left waiting for surgery outside the recommended time.[15]

Mersey Hospital provide mostly orthopaedic and gynaecological surgeries and sees a higher number of category 3 patients. It performed a total of 2995 surgeries in 2015/16 with 23 percent of patients left waiting outside the recommended waiting period.[16]

3.9 Royal Hobart Hospital Redevelopment

ANMF support the need for an improved acute care facility in Hobart. But, since commencement of the RHH Redevelopment ANMF have consistently raised concerns regarding the impact on safety, staff morale and loss of services. Redevelopment of a hospital on site is predictably a challenging task. ANMF commend the tireless effort of the RHH workforce to maintain safe and quality care to the best the circumstances allow. However, many ANMF members report feeling frustrated, daily, by an obvious lack of clear forward planning to account for increased demand and change of services associated with the RHH redevelopment.

[13] Ibid
[14] Ibid
[15] Ibid
[16] Ibid

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Since commencement in 2012, the redevelopment has placed considerable strain on all levels of service across the RHH. The flow on affect being felt in the community sector as bed shortages often mean earlier patient discharge.

Throughout all stages of development, many wards and departments have experienced mergers and service changes to gear up for physical changes to the building. Throughout the redevelopment department merges and physical moves have become a normal yet stressful part of the process.

As many as 20 ward or departments have experienced physical moves, or merges since 2012. Nursing staff in many departments are expected to increase their skill set, as wards merge with differing specialty areas. For example, the orthopaedic ward recently merged with the special surgical ward 5A, that included, ear nose and throat (ENT), burns, plastics and urology and now also includes acute medical beds. Both areas require nurses with elevated level of expertise to manage patient needs. The ward continues to experience a shortage of skilled burns, plastics, ENT and urology nursing staff. Many orthopaedic nursing staff feel unsafe when caring for the new patient skill set and are concerned for patient safety. One result of staff feeling unsafe has the fact that skilled nurses have left to take up non-nursing positions or move interstate. This experience is not uncommon for several amalgamated wards.

A seemingly insignificant effect of the redevelopment has had a significant flow on effect across the entire hospital. This is the increase in lift use by redevelopment staff who have added to the numbers of people accessing the lifts. An unexpected consequence of this has been a slowing of patient transfer times across the hospital.

The slowing of patient transfer between departments sees nursing staff, who complete transfers, off their ward or department for extended periods of time. This leaves one less nurse on the floor to assist with patient care. Patient transfers can occur several times a shift, more in areas of specialised care, as patients move for X-ray, CT scans or to the operating theatre. Due to the unpredictability of transfers from day to day, it is difficult to quantify the nursing hours lost. No extra nursing hours have been provided to cover these now expected delays. Other delays include food services transfers,

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orderly services delay when assisting with lifting patients in wards, television services, pharmacy and pathology transfers. All delays in service delivery increase patient stay and cause delayed discharge, further compounding bed flow across the hospital.

Another crucial example of poor forward planning can be seen in the predicted numbers of beds placed in the temporary J Block decant facility. Medical and mental health wards were moved into this facility in 2016. At the time 42 beds were available on the Department of Psychiatric Medicine (DPM) yet plans and building reduced the size to 32. This drop in bed numbers was a surprise and serious concern for many ANMF members working in DPM.

A similar display of unsatisfactory forward planning occurred with the decant of the medical ward 2B into 2J. Although the drop-in bed numbers in this instance were obvious sometime prior to decant into the J Block facility, no strategic plan appeared to have been developed to manage any increase in beds during high demand periods. Many senior nursing members had highlighted a concern with this but their concerns went unheeded.

In the 2 weeks before the scheduled decant of the B block complex at the RHH. ANMF, at the request of members, were visiting 1BN medical daily. The ward was operating with sometimes 20 extra beds open above its capacity of 26 during. This was outside flu season and was considered to be a low demand period. Opening these beds was done to increase patient flow out of the emergency department, allowing elective surgery to continue at a normal rate. During this time the medical ward was staffed by almost double the number of regular FTE nursing staff and extra medical interns. Extra nursing staff were drawn from the casual staff pool which resulted in loss of casual nursing availability for other wards leading to an increase in overtime and double shifts worked across the RHH.

ANMF at the time made regular request for access to strategic plans for peak periods including during the upcoming 2017 flu season. This information was constantly denied. ANMF members employed in senior management positions, who attempted to raise concerns, reported being told their numbers were incorrect and there was no net loss of beds. ANMF note these

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members calculations have proven consistent with what is now currently available.

The bed capacity at the RHH is insufficient and now at dangerous levels. The result of this is consistent daily bed block and ambulance ramping. Ambulance ramping is caused by severe overcrowding in emergency departments. Nursing staff cannot admit and attend to new patients brought in by ambulance. Ambulances are forced to wait and care for patients until beds become available. Ramping is now occurring daily. The result means several ambulances are taken out of the system for hours at a time. On occasion, this accounts for every ambulance in Hobart, leaving the city to be serviced by country crews who are often volunteers and wish to serve their own communities

Recently, ANMF members in RHH maternity were informed a number of beds would be changed from maternity services to medical beds to accommodate low flow. ANMF understand this comes at least one month before maternity services reaches an anticipated peak in birthing service demand. Members of maternity are, as yet, unsure how the beds will be staffed. But, members are very concerned at the loss this poses for critical maternity services.

Two weeks ago, the 5A special surgical and orthopaedic ward was forced to convert 6 beds from surgical to medical. This means staff in an already stressed situation, working outside their skill set, are now being asked to manage medical instead of surgical patients further compounding their anxiety. But more concerning is the flow on affect this will have for the already reduced capacity of special surgical and orthopaedic elective surgery procedures. Any decrease in available post operation beds will result in slowing of elective surgery and increased waiting periods. The result being patients in the community get sicker and the rate of emergency procedures increases, as does the increase in patients accessing the emergency department. This form of revolving door medicine is both predictable and preventable.

ANMF welcome recent news from RHH senior executive regarding possible increase in bed numbers and understand the following options are in development stages: 5 September; 6 beds and 2 recliner chairs in old renal

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unit on the lower ground floor, October; 5 beds in old transit area, end of Nov; Meeting room ED 3 beds and 5 treatment chairs and May 2018; 22 beds Repat with 10 single rooms

ANMF acknowledge some progress is now being made to resolve the bed crisis. However, ANMF remains incredibly concerned for the safety of staff and patients at the RHH. We reiterate that the problem of bed block will not be solved any time soon while demand for hospital services continue to increase state wide. We hold grave concerns for the number of available beds in the completed RHH redevelopment and while inadequate recruitment planning and retention of nurses and other health service staff continue, patient safety will be at unnecessary risk.

The new K-Block is meant to provide an extra '250 beds', but this is only true if existing wards (to be vacated) are kept operational. If maintaining the current bed capacity, in addition to K-Block, it equals 250 beds. However, the actual net gain will be far less as these wards are planned to move to the new K block.

3.10 Hospital Avoidance to reduce bed pressures

3.10.1 hospice@HOME

The cessation of Commonwealth funding for the successful Hospice@HOME four year trial program which provided a 24 hour call centre and nurses and care staff to support those who are dying at home 24 hours a day, has had a major impact on palliative care , Emergency Departments, hospitals and families. The program has been closed to new clients from 31 March 2017.Current budgets fund the call centre only but they have no health professional to refer client to after hours, potentially forcing families to call an ambulance and transfer their loved one member into ED, for pain relief or urgent care.

3.10.2 Community Rapid Response Team

Another trial program in Launceston aims to keep people out of hospitals. It has managed to treat 400 people in their homes with only 10% of the cohort needing to present to the ED. Despite this success the Commonwealth funded program limps along with year to year funding, It currently has

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another 12 months funding only. This yearly funding means that nursing staff have to continually re apply for their positions. More recently five decided to not reapply. These programs once proven to be a success, should be permanently funded by the Tasmanian Government in order to enable best practice and treatment of Tasmanians.

3.10.3 Preventive health

The lack of health promotion, and preventative healthcare in Tasmania is impacting on the huge demands for our acute hospitals for treatment. Any program enabling hospital avoidance should be explored and implemented if proven to be valuable. These include initiatives such as nurse led walk in clinics embedded in communities with access to mental health, and child health nurses.

3.11 Lack of data analytics

There is currently a myriad of data but it is inaccessible for the clinicians and managers to access to support management and decision making. Data analytics is needed to develop dashboards for Nurse Unit Managers and other managers to support management of their wards/units. Systems and processes are not contemporary and do not support the clinical manger to manage, rather it becomes process rather than outcome driven.

4 The adequacy and efficacy of current State and Commonwealth funding arrangements

Gathering a clear and accurate picture of the funding provided by State Government to the acute care sector is not always easy as costs and data are often skewed by what is presumably a deliberately confusing budget reporting. ANMF work closely with many community stakeholders to gather data and evidence to assess the state of our health system. In February 2017, independent health policy analysist Martyn Goddard released the following breakdown of Tasmania's Acute services funding extrapolated from AIHW data:

> *Tasmania's health and hospital system is, by almost every parameter, the least capable in the nation. Despite receiving very large allocations*

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from the GST pool in recognition of this state having the nation's oldest, sickest and poorest population, none of that money is being spent on recurrent funding of public hospitals. Tasmania is funded, by GST money reallocated from other states, to spend well above the national average on running its hospitals. In fact, the Tasmanian government spends less than the average. In 2014-15,Tasmania spent $335 per head less than the crude national average on recurrent health funding and $728, or $375 million, less than the weighted average.

Tasmania relies more heavily on raising money from individuals – that is, from non-government sources – than any jurisdiction other than NSW: $82 million in the year under study.

Since then, the Commonwealth Grants Commission has revised its calculation of comparative health needs. In 2014-15, Tasmania was granted $170 million in recognition of its specific health needs; in the current financial year, that has risen to $251 million. In each of its budgets since being elected in 2014, the present government has made substantial real cuts to recurrent health funding. The current shortfall in spending, compared with what has been made available in GST funding, means the gap has risen sharply since 2014-15.

5 The level of engagement with the private sector in the delivery of acute health services;

Australia has one of the highest out-of-pocket health expenses in the developed world. 8% of Australians defer seeking specialist medical assistance because of the cost. One of the reasons for this are problems with supply and demand of specialist medical services. Access to some specialist services as an outpatient in Tasmania requires a long wait - months to a year in some clinics. Some public specialist outpatient services in the north of Tasmania don't even exist, meaning patients must travel to Hobart, or pay to see a private specialist. Patients living in Hobart are also facing long delays and many are also faced with paying to access private review. Waiting times for private specialists are also at suboptimal levels with some patients waiting as long as 6 months for some specialities. These long delays mean many patients get sick while waiting for review and end up in the ED's.

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Access to private health insurance in Australia has largely remained stable in terms of the total number of people with health insurance.[17] But recently the composition of health insurance has been changing. Most health insurance premiums include some sort of deductible element. That is, patients must first pay a fee from $500 to $5,000 before accessing the health care. And significantly, an increasing proportion of premiums have some sort of exclusion. For example, many exclude orthopaedic or cardiac implants.

The combination of these facts means patients are receiving, higher bills when they go to a private hospital so are now accessing private hospitals at reduced rates. Increasing rates of patients are using their private insurance to go to a public hospital.[18] Access to treatment in private hospitals is reduced nationally. There is no reason to expect Tasmania to be different.

Some private hospitals in Tasmania have emergency department facilities with limited access due to medical availability. However, most require a minimum upfront fee for access which is a significant barrier for many people. As a result patients often choose to present to the public ED when given the choice. Furthermore, many specialised services are not available in Tasmania's private hospitals, so patients have no choice but to attend a public hospital for care.

AIHW data indicates that 25% of inpatients in Tasmania's public system had private health cover in 2016, which includes patients covered by DVA, workers compensation and MAIB.[19]

As a result of the current bed crisis in the South of Tasmania, ANMF understand the THS is currently purchasing 8-10 beds in the private hospital exclusively for the use of public patients. The beds are staffed by Hobart Private Hospital Staff with some medical back up from the RHH. It is expected that these beds will be utilised for simple elective surgery cases and simple medical patients. But it has been reported by ANMF members that these beds are underutilised as not all elective surgery patients are

[17] http://www.aihw.gov.au/australias-health/2014/health-system/
[18] https://theconversation.com/aged-and-confused-why-the-private-health-insurance-industry-is-ripe-for-reform-50384
[19] http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129559918

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suitable, many acute medical admissions are unsuitable and upon occasion HPH does not have enough staff to open the purchased beds. In particular our members have told us of an example that Orthopaedic patients are not allowed to be admitted to HPH Annex beds simply due to Surgeon preference.

6. The impact, extent of and factors contributing to adverse patient outcomes in the delivery of acute health services

As previously mentioned the work load for ANMF industrial staff has been steadily increasing over the last 18 months, resulting from higher numbers of workplace grievances in the Public Sector. The delivery of acute health services and impact on patients can best be summed up by providing many stories from ANMF members working across Tasmania in the 4 major hospitals.

6.1 Note from the Field, Personal Stories of ANMF Members.

6.1.1 One Step Forward, Two Steps Back-

"I've worked in the Tasmanian Health system for all of my career, but I have never seen it under this much stress and close to breaking point. The word 'breaking point' is a phrase often used in society and sometimes, it is used very liberally to attract attention (often when it's not warranted). But, I can tell you today that the Tasmanian health system and in particular the RHH is close to breaking.

At the RHH I see patient safety being put at risk. For example, it was proposed recently (by a senior member of staff) that a acutely ill (suicidal) mental health patient be admitted to a general medical ward,. In this environment, this patient would have been nursed by unskilled staff, placed in an environment with multiple hanging points and risk them absconding. This is an example of how desperate we are getting at the RHH and how even ludicrous and unhelpful ideas are being proposed.

For a long time now Nurses at the RHH have been telling senior management and government that we are lacking enough inpatient, overnight beds. This is acutely evident from the constant bed block in our ED. But, senior

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management and government don't listen to the reality on the ground. Up to a year before the B block closure (to make way for the building of K block) nurses at the RHH kept saying we will not have enough beds after B-Block is closed. But, they were not listened to. Pleasing the Health minister and his minders and being beholden to the budget constraints has lead the RHH to be in an almost continuous bed crisis. All of this could have been avoided, bed block could have been minimised if senior management had listened to staff, ANMF, AMA and media commentators. Only now, whilst we are in crisis, they are listening. Long term planning could have avoided this. Personally, I have never been as afraid to work in the RHH as I do now. As a manager, I spend my time attempting to minimise the system impact on patients. I spend a lot of time trying to create safe patient care environments, when the system I work in is heading in the opposite direction (i.e. patient care is increasingly put at risk). The saying "One step forward and two steps back" is the environment I work in. The solutions being proposed for the RHH Bed crisis, do increase pt care space, but a certain level of risk is being tolerated…so hence solutions (one step forward) are being provided, but we have to stomach the risk (two steps back)."

6.1.2 Neurosurgical care at the RHH

The Tasmanian neurological service is a highly specialised state-wide service providing both acute medical and surgical services. Neurosurgical procedures include surgery on the brain, spinal cord and nerves. Common procedures include removing tumours and blood clots in the brain and spinal cord, treatment of head or spinal injuries, repairing malformed blood vessels in the brain and spinal cord, repairing damaged nerves, and surgical treatment of diseases such as epilepsy and Parkinson's disease. Around 385 neurosurgical operations were performed at the RHH in 2015/16.

ANMF members at the Royal Hobart Hospital report that the Neurosurgical unit surgical waiting list is growing at a rate of around 60 patients per week. This is because of slowed surgery due to bed block, coupled with increases in patients requiring neurosurgical treatment. The number of patients waiting requiring review by a surgeon who are not yet on a waiting list is also increasing.

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Neurosurgeons report being unable to get enough theatre time to meet demand, due a restriction on the total number of patients that they are allowed to operate on. Each of the 2 full time surgeons could have an additional two days of operating time if space and beds permitted.

Bed availability on the 24 bed neurosurgical unit is restricted as 4 beds have been re badged as medical beds to meet the Royal Hobart
Hospital shortage in acute medical neurological beds adding. This has resulted in a reduced capacity for neurosurgical patient admissions further compounding the delay in neurosurgical procedures.

ANMF members are concerned the unit is at risk of losing its neurological training accreditation and its senior training registrar. the restriction on surgical cases and the inability to provide endovascular services 24 hours a day, may lead to the college of neurosurgeons removing the accreditation. The solo endovascular interventionist doctor can not normally work 7 days a week, and is at times unavailable to treat acute bleeding aneurysms. This is exacerbated as the current interventionist is on 3-month sabbatical with his organized cover unavailable for an unknown amount of time.

6.1.3 RHH Cardiology Department

The cardiology unit manage patients with acute cardiac conditions that require hospitalisation for management. Cardiac disease is a leading cause of death in Australia. Demand for acute cardiac care is high and patients are often managed for several days in hospital. In 2017 senior RHH management decided to open additional beds on the cardiology unit with inadequate nursing staff resources available care for the patients. 7 additional nursing staff were needed to cover the opening of these beds. Although recruitment of new nurses was commenced it only occurred after the beds were open. As a result existing nursing staff were asked to pick up extra shifts or work overtime to cover the roster gaps.

The ward increased its rate of casual and agency staff to cover gaps in the baseline rosters. The overall result meant skilled nurses were required to work additional hours to assist less experienced staff. Some shifts were worked with no senior staff available. The flow on effect resulted in slower discharge of patients and increased bed flow problems.

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6.1.4 Acute Dialysis Unit (ADU)

The ADU (RHH) provides dialysis treatment for patients with acute and chronic renal failure. Nursing staff have highly specialised skills and are cannot be replaced by general nursing staff. Tasmania experiences a shortage of renal trained nurses and roster gaps are common: gaps are worsened if there is sick leave. In July 2017, the ADU was moved and a partial merger to another unit occurred. The aim was to free up space for more medical inpatient beds. There was limited consultation with nursing staff until the 'plan' was well and truly advanced. Several issues developed that had not been considered by redevelopment and executive staff. Nursing staff felt this was a result of poor forward planning and lack of consultation with them as ground staff who best understood the needs of the patient group. They were concerned for the risk to patient safety if the matters were not met.

Highlighted issues included:

a) Decreased number of bed/chairs on the ADU will result in the increased frequency of instances of satellite dialysis[20] on other units around the RHH.
b) The lack of clinical support when undertaking satellite dialysis.
c) The manual handling issues arising from the satellite dialysis units has already resulted in injury to staff members resulting in workers compensation.
d) The skill mix within the unit needs to be considered when satellite dialysis is being undertaken.
e) Additional staff resourcing was not clearly considered.

6.1.5 Ambulatory Care Centre (ACC)

ACC is a nursing-based medical day care facility operating from Monday to Friday. Patients undergoing medical procedures and are discharged home; same day specialises in vascular access and other high level nursing interventions. This space was designed and built as a day procedure unit

[20] Satellite Dialysis means that a qualified nurse from the unit has to perform dialysis on another ward. There are problems in that this nurse can only care for one patient at a time and has no back up support from experienced renal nurses.

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and opened in late 2016. In June 2017 ACC staff were informed that a decision had been made to open 10 overnight beds on the ACC day procedure unit.

The decision to open the beds was made with limited or no consultation between senior management and ACC nursing staff. There was very limited time provided for casual and agency nursing staff to ensure they are orientated to hospital and unit based policies and procedures. Staff accepted the RHH was in crisis and the beds needed to be opened and attempted to make the process work.

However, they were concerned regarding the limited availability of nursing staff to manage the facility. They were also concerned regarding infection control risks posed by patients staying in what was a day procedure unit. The lack of consultation prior to announcement of the decision left nursing staff confused and feeling that their opinions were not worthy of consideration. In addition they were concerned for patient safety. Early collaboration in the plan would have allowed staff to feel included and less threatened by the proposed changes. It would also have allowed for the early identification of possible problems.

6.1.6 Operating theatres

Many nursing staff working in the operating theatre (RHH) raised concerns that as a result of bed flow problems patients were nursed for extended periods overnight in the recovery room. Usually patients spend a brief time in recovery before returning to the ward bed. . Medical staff, finding it difficult to complete their daily surgical lists, kept surgery running much later into the evening. On many occasions in 2016 patients were left in recovery overnight as a result of bed block and no ward for them to go to. This meant theatre and recovery staff were required to work overtime to care for patients overnight.

Nurses in operating theatres require specific skills to scrub in and assist with operations. The skilled nursing shortage in the operating theatre is currently so large that as few as 10 nursing staff are able to cover the theatre on call roster for overnight emergency procedures. With a minimum 2 on call staff required, per night this meant that nurses were rostered on call 1 in 5 nights a week. There was also limited flexibility for sick leave cover. Nurses on call

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were also rostered to work regular day shifts, despite often having been called in over night. Many nurses in the operating theatre are regularly exhausted and desperate for additional skilled staff. Operating theatre nurses are in high demand across Australia with many hospitals resorting to recruiting internationally to fill gaps.

6.1.7 North West Integrated Maternity Services

The North West Integrated Maternity Service is a public inpatient and birthing service delivered by the North West Private Hospital in Burnie and antenatal and postnatal care delivered by the Tasmanian Health Service at the Mersey Community Hospital, the North West Regional Hospital in Burnie and at a number of other rural sites via outreach services. The service was an initiative of the Government's One Health System reforms aimed at putting the health and safety of North West mothers and babies at the forefront of decisions.

Unfortunately the service appears to be failing the women on the NW Coast. ANMF members are struggling with a service delivery model that is under staffed, under resourced and under governed. Specifically members are concerned about:

a. The increased rates of caesarean sections on the NW coast, a key indicator on the performance of a service.
b. The service is not aligning with National Safety and Quality Standards,
c. No evaluation of the service has occurred since the service re-structure and implementation
d. The service does not align with best practice standards by not meeting the needs of patients, having a decreased in rather than increase or maintenance of continuity of care
e. Policy and procedures are out of dated and do not reflect the service reconfiguration.
f. There is a total of 5.61 FTE vacant across the service.
g. Management positions are incorrectly classified, NUM's work across multiple sites up to 40km's apart.
h. There is no dedicated administration or HR support across the service.
i. Overtime and working short is increasing.

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j. Student trainees are not able to be witnessed birthing as the public Midwives have no access at the North West Private Hospital. Similarly there is a deskilling of current Public Sector Midwives as they are unable to participate in birthing.
k. Facilities at the North West Ante-natal clinic do not provide for confidential consultations, 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

6.2 RHH ANMF Senior Nursing Staff submission

See Appendix A.

7. Any other matters incidental thereto.

Access to efficient and effective health care is considered a fundamental right in Australia. All levels of government should make affordable health care a priority.

Increases in GP Medicare co-payments are undoubtedly having an impact on choices patients make in their health care across Australia. Access to GP's in many parts of Tasmania are difficult enough. Lack of choice, availability, increasing fees and reduced rates of bulkbilling plus the Co-payment will mean some patients avoid making necessary GP visits. This contributes to patients becoming sicker and ending up in hospital because of a lack of preventative care.

Anecdotal information from ANMF members in ED's across Tasmania suggests that, patients arriving at medical departments are often needing emergency care, have multiple comorbidities and cannot be seen by a GP. There has not been an increase in number of patients attending the ED instead of the GP. Rather, this suggests patients are not accessing medical care and are becoming sicker.

ANMF recognise that the significant and sustained cuts to Preventative Health Services in Tasmania are impacting on morbidity and mortality of the population.

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Vaccine refusal rates have increased across Australia and will continue to do so without sustained funding for preventative health. The impact of any disease outbreak on our over stretched health system could be catastrophic. Rates of STI's (such as chlamydia, syphilis, gonorrhoea and HIV) have increased amongst young Tasmanians. Hepatitis C rates continue to climb particularly amongst injecting drug users. Each of these disease can have serious complications and if not adequately treated by a GP will require hospitalisation. Education for the prevention and management of life style related diseases such as obesity, diabetes and heart disease are in urgent need of review.

Failure to address these issues will result in continued and sustained crisis in Tasmania's health system. With future demand for acute care services likely to rise considered and collaborative long term solutions must be implemented as soon as possible to increase access to acute services in Tasmania. Or, in the alternative, provide access to care services without a need to use the hospital sector.

A chronic underinvestment in the nursing workforce is placing the future provision of high-quality acute care services at risk. That is, investment in the actual workforce rather than just at an undergraduate level where there continues to be significant generation. There is no fully costed, funded long term plan for the current or future health workforce in Tasmania. That in itself creates risk. There has been no planning for required new staffing to facilitate the new RHH K Block or 22 beds at the Repatriation Hospital next year. With significant nursing and midwifery shortages, lower wages in Tasmania and lack of planning, staffing becomes the highest risk factor.

There has also been a gradual decline in the investment in the nursing workforce development. The number of Nurse/Midwife Educators continues to decline and be placed under pressure. The new graduate intake in the Transition to Professional Practice Programs (TPPP)is inadequate despite increases in the numbers graduating from Universities. The sector should be encouraging new nurses to take up opportunities because retirement of experienced nurses, in large numbers, is soon to begin.

Even more worrying is the decline in the number of graduates employed in the last year or two and the virtual incapacity of these nurses and midwives

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to gain permanent positions in Tasmania. Permanency is important for many young professionals if they are applying for home or other bank loans.

We know the number of nurses and midwives that will leave due to workforce ageing will increase over the next three to five years. This will place enormous strain on the health care system as experienced and highly qualified clinicians and managers are lost to retirement.

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APPENDIX A.

Legislative Council Acute Health Services in Tasmania Inquiry

Submission by group of ANMF senior staff in the
Royal Hobart Hospital Emergency Department.

This submission relates directly to reference point 5 of the inquiry, and will describe the impact, extent of and factors contributing to adverse patient outcomes in the delivery of acute health services at the Royal Hobart Hospital (RHH) from our work perspective.

Our Role

We are a group of senior ANMF nursing staff from the RHH Emergency Department (ED), and it is our role:

- to coordinate the clinical care of patients (Clinical Coordinator role)
- to assist/navigate the patient flow through the ED (Navigator role)
- we are the clinical senior nurse leadership group, and complement our Nurse Unit Manager (NUM), Clinical Nurse Consultant (CNC) and the Clinical Nurse Educators (CNE's).
- we support and resource the nursing staff on shift and other support staff in the ED. We are also the main communication interface after hours for issues related to the ED and communicate with the rest of the hospital and After Hours Nurse Managers.

Our role is varied and rewarding, as we manage a complex and changing environment to provide the best possible care to the patients of the Southern health region and also those patients from around the State requiring RHH resources who may spend time in our ED.

However, the RHH access block/bed block situation of the last few months has placed the RHH and RHH ED under extreme and unrelenting pressure, and, as a direct result of this, it is evident that patients are experiencing excessive waiting times for emergency department treatment and/or ward beds. There has also been a concerning and distressing rise in the number of adverse clinical incidents, with the result being that patients are potentially faced with poor outcomes. The risk is that a patient may die unnecessarily as a consequence of this situation. This

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submission will address four main areas of concern which are a direct result of unprecedented access block at the RHH.

Access Block

The Australasian College for Emergency Medicine (ACEM) defines access block as

> 'the situation where patients who have been admitted and need a hospital bed are delayed from leaving the ED because of lack of inpatient bed capacity' (App 1).

ACEM also recognise access block as

> 'the single most serious issue facing Emergency Departments in Australasia as it negatively affects the provision of safe, timely and quality medical care to patients' (App 1).

For many years the RHH ED has had issues regarding access block, particularly during the busy winter months where hospitals around the State experience increased patient presentations and the associated rise of patients requiring inpatient care.

As we write this submission, the RHH has been under level 3 escalation strategy consistently for the month of July 2017. This is the highest level of escalation of the RHH escalation plan and indicates that the RHH is under extreme bed pressure. This has associated flow on effects for elective surgery, planned patient admissions and ED processes. It is now a common event most mornings for staff on arrival to find a department full of 20 or more admitted patients awaiting inpatient beds. The RHH ED is only a 27 bed department and so our expected patient presentations of approximately 160 patients or more must now go through our ambulatory, low acuity area and the available beds in the acute and high level care area which includes our 4 bed resuscitation area. The Committee may be able to access the RHH ED monthly presentation rates for the years 2015-2017 to compare.

Multiple research papers show that access block, and prolonged ED stays, is directly associated with increased morbidity and mortality rates. The Tasmanian ED Clinical Advisory Group (CAG) notes that patients who spend greater than 8 hours in an ED have a 30% increased risk of death than those patients staying less

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than 8 hours (App 2, page 3). The Committee may be able to request the RHH ED length of stay statistics showing the number of patients per month having 24+ hour stays for the years 2015-2017. We believe the figures to have increased alarmingly in the areas of duration of stay and also number of patients affected. Our patients are suffering because of these increases in length of ED stay.

The following is an example of the impact of access block and overcrowding:

- Patient X was triaged as a Category 2[21] patient following arrival to the RHH ED via ambulance. As no beds were initially available the patient was forced to wait with the ambulance crew (ramped) for 30 mins until a bed became available. When admitted to a bed a heart tracing (ECG) was performed by a nurse and identified by the nursing and medical staff as being indicative of a heart attack (STEMI). Patient X was moved to the resuscitation area and appropriate treatment and management commenced.

- During this time Patient Y arrived, also suffering a STEMI with associated cardiogenic shock (critically unwell with poor cardiac output and function). Immediate treatment and management in the ED resuscitation area was commenced and it was determined that Patient Y should go to the Cardiac Cath Lab for definitive care in approx 20 mins

- Unfortunately Patient X deteriorated at this time and suffered a cardiac arrest (VF arrest) which was appropriately managed in the ED but meant that Patient X now became the priority patient for Cath Lab interventions. Patient X went to Cath Lab, was treated but due to the RHH access block situation was unable to access an appropriate inpatient bed in the High Dependency Unit/ Intensive Care Unit (HDU/ICU) or Cardiac Care Unit (CCU) and so was forced to wait in the Cath Lab for 5 hrs until such time as a bed was available.

- Patient Y stayed in the ED during this time, critically unwell and unable to access the definitive care which may have assisted their recovery. After 5 hrs the Cath Lab was finally able to accept Patient Y. Unfortunately, during transport to the Cath Lab Patient Y suffered a cardiac arrest and was unable

21 A category 2 patient is, according to the *Guidelines on the Implementation of the ATS in Emergency Departments* in need of urgent (within 10 minutes) assessment.

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to be resuscitated. The staff involved who had cared for this patient were devastated, even more so when the family were not given sufficient time to grieve with their loved one (as outlined below).

- Unfortunately, due to the access block situation the ED had no free resuscitation or acute care cubicles but was notified that there was a trauma patient expected imminently. Therefore, the body of Patient Y had to be moved quickly to the morgue which prevented the ED staff from being able to fully care for the family. This rapid transfer, and inability to provide family support, also prevented several ED staff from being able to appropriately process the events, leading to many of the staff involved being so distressed that were unable to work the next day whilst they processed the events of this stressful and distressing shift.

The impacts of access block are real and cannot be underestimated. The effects on hospitals, ED's, ambulance services and patients and their families can be catastrophic. Whilst access block is a problem facing hospitals around the world, we are concerned (certainly in our experience) that the scale of the issue at the RHH is unprecedented and a direct threat to the ongoing safety of the community. Despite recommendations from clinicians plans and strategies to combat and address the situation have been ignored or are only being put into place at a very late stage, thus allowing an untenable and unsafe situation to continue.

Ambulance Ramping and ED Surge

The access block situation at the RHH has flow on effects on other services – most notably Ambulance Tasmania (AT). According to the agreed Key Performance Indicators (KPI's) outlined in the State Service Agreement (SSA) of 2017-2018, 85% of ambulance patients should be offloaded within 15 mins (App 3, page 19). If there are delays to this transfer of patient care then the ambulance is considered to be ramped with the patient and unable to return to duty out in the community.

Due to the level of access block at the RHH, the ramping times and number of patients affected by ramping have increased significantly. The Committee may be able to access the data comparing ramping numbers and duration for the years 2015-2017. Whilst the RHH ED has had issues with excessive ramping in the past, the ED has undergone extensive internal processing changes over the last couple of years to ensure presenting patients can be effectively and efficiently moved

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through the ED. However, since the redevelopment and the associated reduction in inpatient flex beds, these initiatives have been overwhelmed by the level of access block experienced.

It also means that our ability to manage both predictable and unpredictable patient surges are severely limited. It is known that the ED experiences peaks and troughs of patient presentations throughout the day, and whilst the numbers may vary on a day-to-day basis, the general averages and times remain the same. There are also predictable surge times with AT, and a functioning ED is able to manage these surges with minimal ramping and patient offload delay.

As we are a clinical group of nursing staff our ability to access this data for the purposes of this submission is limited, however we provide this evidence as honestly as we can. Whilst we are not privy to the inner workings of the AT service, we are aware from media and collegial reports that AT are struggling to adequately resource the community demands during times of surge and the inability for them to safely offload their patients into our care at the RHH only increases this pressure and compounds this problem.

The pressure experienced by the ED staff impacts upon those patients in the waiting room of the RHH ED. The ED staff are acutely aware of the impacts upon the AT of ramping and the need to facilitate their release back to the community. They also need to also balance this need against those acutely unwell patients in the waiting room. This can mean that there are numerous unwell patients in the waiting room with little or no observation or interventions, despite the best efforts of the triage and CIN (Clinical Initiatives Nurse). The CIN nurse is often called away to deal with patients requiring resuscitation as we have only 2 allocated nursing staff for a four bed resuscitation area whose patients often require1:1 care. This means, particularly on a night shift, that the 1 triage nurse is expected to triage all the patients arriving to the ED, and monitor and provide interventions for 20-30+ patients waiting in the waiting room. This is an unreasonable expectation and is physically impossible for one person to achieve. Once again our patients are put at increased risk because of flow-on effects of access block.

This is exemplified by the story of Patient Q:

- She was identified as being at risk for an ectopic pregnancy and triaged appropriately. All beds and resuscitation areas were full in the ED and AT

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crews ramped in the corridor.

- Patient Q deteriorated and collapsed, a trolley was brought to the waiting room and she was taken into the department. However, there was no ability to move others in the department or resuscitation area
- Patient Q was treated and resuscitated in the corridor outside the resuscitation bays. There was no patient privacy, equipment had to be gathered in a rush and the patient treated as best as possible until she was able to get to theatre for definitive management. This is not a safe level of care nor a community expectation of acceptable and reasonable care

Another example:

- Patient W presented with resolved chest pain via ambulance, triaged appropriately but due to no available beds in the ED, were placed in the waiting room. Whilst not ideal, from the waiting room they should have been able to have an ECG, blood tests, chest x-ray etc through the CIN and ED Dr's.
- They did receive an ED Dr review in the waiting room and assessment room. The appropriate referral to Cardiology was made as the patient was suffering from unstable angina. This would usually mean the patient would be in a bed, having continuous cardiac monitoring and regular vital sign observations. Instead this patient was in the waiting room with many others also requiring care and interventions.
- The patient had the Cardiology review and admission paperwork completed, including the request for continuous cardiac monitoring/telemetry. This patient was fortunate not to suffer any adverse events in the ED waiting room but was also fortunate enough to be allocated a bed on the Cardiology ward where they were able to receive appropriate nursing care and medical management.

We have had multiple clinical incidents occurring because patients have had to face excessive wait times, instead of receiving appropriate and timely management and treatment. This has directly resulted in many patients becoming more unwell, requiring more intensive and invasive treatments and management, and requiring longer inpatient admissions. It is of immense concern to us that we are at crisis point most days whilst trying to manage our everyday workload. Should there be a disaster or mass casualty event within the community we fear that the RHH would be extremely pressed to mount an appropriate response.

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Excessive Lengths of Stay

As described, access block has effects on patients awaiting management and treatment within the ED, the AT resources and community response, but it also has implications for those patients facing excessive times waiting for a ward bed.
As previously mentioned, the available evidence clearly links increased lengths of ED stays with increases in patient morbidity and mortality.

Recently, there has been a large media focus on the number of patients requiring psychiatric care who have been within the ED environment for many hours, and in a high proportion of cases, for multiple days. We are fortunate to have the expertise of Psychiatric Emergency Nurses (PEN's) within our ED, and they have made an invaluable contribution to improving the care and outcomes of patients requiring their services. However, of recent times there has been an unreasonable demand placed upon them. With patients being caught in the ED for many days, this reduces the PEN's ability to be available to assess, treat and manage new patient presentations. There are increased and unacceptable wait times for patients to be able to seen and assessed. There are often extended wait times for labile and unpredictable patients who may be brought to the ED with police assistance. This then prevents the police from returning to their community responsibilities. However, we must ensure that the staff and patients under our care remain safe and therefore we can only release the police once it appears that we have a controlled situation.

For those who are unaware about the ED environment it is a place which does not recognise day or night. The lights in the ED remain on 24/7 so that we can operate safely. There is constant noise from machinery beeping, staff talking, patient assessments. There are patients who may be loud, verbally or physically aggressive from intoxication and/or physical or mental health issues. Children and babies may be upset and/or crying. We are able to access a small number of physical ward beds (provide a greater level of comfort and wound prevention) at times for some patients but this is not available for all. This means that patients are often sleeping on narrow ED Trolleys for extended periods of time, with associated wound/pressure area risks for those vulnerable patients.

Our ED layout means that there are 5 toilets accessible to patients and the public within the department, with 2 extra toilets in specific single/isolation rooms for

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single patient use. We can often have over 50 + patients in the ED and waiting room with their families and/or friends utilising these facilities. Only 1 shower is available for use in the main ED but due to the number of people in the department we discourage its use as it then makes a bathroom unavailable for use for a period of time. Our regular catering supply consists of sandwiches, juices, tea and coffee but we do not have access to the catering schedule that the wards do which means patients may not be receiving regular fluid/food opportunities as they would on the ward. Whilst we do our best to compensate and ensure appropriate and regular nutrition, the ED environment is not conducive in facilitating this as more pressing priorities often take precedence.

How can it be expected that those people suffering from acute medical and/or mental health issues are able to recover with days of interrupted rest, poor nutrition, abnormal sights and sounds and uncomfortable surroundings and little ability to even wash/refresh themselves? It can be of no surprise then that mental health patients are often leaving against medical advice after 2-3 days of waiting in the ED environment. Or they are requiring interventions to prevent them leaving if they have been assessed as being unsafe/unable to leave and are held under the mental health act. Often these interventions are distressing to both patient and staff, and may have been avoided if a more suitable environment had been able to be provided.

Another at risk population is the elderly. Elderly patients often present with multiple co-morbidities and illnesses which predispose them to complications in treatment. These factors compounded with the ED environment predispose a significant patient population to delirium. This medical condition has adverse effects on a patient and frequently complicates treatment, management, inpatient length of stay, cost of stay and health recovery.

Due to the limitation of isolation/single rooms within the RHH, the ED is also often heavily loaded with patients requiring isolation for various reasons. This places additional strain on ED resources but is also of concern as our space limitations mean that staff are managing both infectious and immunocompromised/at risk patients next to each other. High patient numbers, with limited staffing resources , put pressure on the effective (and protective) management of potential cross contamination. We strive to maintain high levels of infection control management but the inherent risks remain, particularly during the winter flu season or community illness outbreaks, eg gastroenteritis, etc.

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We are constantly battling to minimise the risks to these vulnerable patient groups but we are limited as to what we can achieve within the ED environment. With multiple competing priorities and physical limitations, staff try their best but are acutely aware that it is often not enough.

Staff Effects

The effect this intense level of daily stress, critical and near-miss incidents, and patient distress is having on staff is significant. As the senior members of staff on shift, we are often faced with trying to soothe and comfort distressed staff in situations which should not be faced on a regular basis. Staff are required to constantly apologise to patients and their families for the extended and unreasonable lengths of stay in ED. We are also requested to let patients know, if they are admitted to the Surgical Short Stay Unit, that they may not be allocated a bed but may be staying in a recliner chair for the duration of their admission.

Our front desk staff of experienced nurses and clerical staff are constantly forced to apologise for excessive waiting times, and faced with needing to attempt to de-escalate distressed and agitated patients and family members.

This constant demand to provide high level service, whilst acknowledging the distressing failings of the system and its effect on our patients is incredibly wearing. It is affecting the morale of staff and also the resilience of staff. This, compounded with the constant requests for staff to perform extra or double shifts, and the usual winter illnesses have lead to us noticing an increase in sick leave for staff.

THS and RHH Responses

Despite clear and evidence based clinician warnings and data projections of service requirements, the THS and RHH proceeded with the demolition of B-Block and the associated reduction in bed stock, which has led to the access block/care provision crisis as it now stands. It is our perception that there has been inadequate and ad hoc planning at this late stage instead of the expected considered and strong leadership necessary to safely guide the RHH and its patients through this change period.

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Despite the 'Patients First' Government Action List (Appendix 4) which notes that the 'winter illness strategy' will be in place at all THS sites prior to winter, the RHH is only looking at opening the 'winter ward' in late August/Early September. This should see it more accurately named as the 'Spring Ward'. There are also changes to the THS South Patient Flow Escalation Management Plan, however the draft of this is still under consultation and the ED sub plan and triggers are still being reviewed. We acknowledge that there have been management strategies and yet more are still being planned and initiated. It is our opinion that these strategies could have been considered and employed in a more timely fashion, prior to the RHH being placed in such a precarious operational footing.

Despite numerous reviews and projects designed to identify and proffer solutions to organisational issues the problems remain and the situation continues to worsen. We have received good support from our direct line managers (NUM, CNC, ED Medical Director, and the Critical Care Assistant Director of Nursing) who have provided leadership, strategic planning and clear departmental direction, however whilst this has been of benefit in leading the ED through extensive change management it cannot compensate for wider organisational failings.

The RHH ED has been involved in the THS Clinical Redesign program, with many of the key recommendations initiated. We have been the focus of the Tasmanian Governments 'Patients First' action paper. Where able, the RHH ED has adapted and initiated many key recommendations to improve patient care and patient outcomes. It was noted in the 'Review of Access to Emergency Care at the Launceston General Hospital and Royal Hobart Hospital' (Appendix 5) that we are 'engaged' and 'keen to improve care for our patients', and that 'excellent work' through clinical redesign has been occurring (pages 3, 6). We make mention of this because we do take our roles and responsibilities seriously and our patients are at the forefront of our work and our striving to perform with excellence.

We have not taken the decision to make this submission lightly, however as nurses it is our fundamental duty to advocate and care for our patients. As we are aware of our obligations as State Service employees we have only provided a general response to the Legislative Council in order to assist their deliberations. We do not believe we are in breach of the State Service in doing this. However, we feel that the crisis situation occurring at the RHH is placing the community at risk, and prevents access to safe and timely medical care for a growing number of our

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patients. We hope that the Legislative Council can investigate and make the appropriate recommendations to the THS and RHH Executive Board to ensure that this situation can be avoided in future through the provision of clear organisational leadership and governance measures.

Thank you for taking the time to consider our submission, we have also included a number of documents that may be of use. . If you have any further queries please do not hesitate to contact us via our Union, the Australian Nursing and Midwifery Federation (Tasmanian Branch).

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