Dear Select Committee on Transfer of Care Delays (Ambulance Ramping). Thank you for the invitation to provide a submission on the Terms of Reference for the Select Committee on Transfer of Care Delays. Please note one section of my submission that I have requested to keep confidential at this stage.

I worked as a Registered Nurse in the LGH Emergency Department (ED) from 2013 until 2021. I am currently employed in the School Health Nurse program (DECYP) but still also remain an employee of the THS through the LGH casual pool where I continue to work occasional shifts in the LGH ED.

I primarily left the LGH ED because of the deterioration in working conditions caused in my opinion by access block, consequently, making it impossible for me to provide a basic level of care to patients. The transfer of care issues experienced in hospitals are also directly caused by access block. Access block (bed block) has been a progressively worsening situation that has led to significant deterioration in the quality of care provided to patients in our community who attend ED's (either via ambulance or patients self-presenting to the ED) and a significant deterioration in the workplace conditions for staff. Previous submissions have eloquently detailed many issues pertaining to the problems within the hospital system relating to Transfer of Care, so I will attempt to focus on issues that have not been as thoroughly addressed.

Problems with Management Culture

As a front-line worker, there has seemed seems to be a persistent disconnect between the realities faced by staff at the coalface and middle and upper levels of management within the hospital. I personally decided to become an ANMF workplace delegate to hopefully be able to work constructively and collaboratively with upper levels of hospital management to find solutions to these worsening issues.

Unfortunately, my experiences as an ANMF representative with hospital management were often adversarial and on multiple occasions required visits to the Tasmanian Industrial Commission to rule on issues that should have not required such a level of arbitration. My colleagues and I became so frustrated with the seeming inaction and lack of communication with hospital management that with the support of the ANMF, we conducted a daily "vigil" outside of the hospital. The purpose of this "vigil" was to try to raise awareness with the public about the deteriorating conditions for patients and staff within the ED. For fifteen minutes prior to the start of every afternoon shift, staff would meet at the front of the hospital to protest worsening conditions and request direct communication with levels of the Tasmanian Health Service Executive. This vigil continued for over 6 months and helped gain public support, improving staffing conditions as negotiated for by the ANMF. However, after six months, our requests for upper levels of management to speak directly with front line staff were ignored.

The recent Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings forensically highlighted the significant failings of the LGH management. In particular, Doctor Peter Renshaw, who played a significant role for over three decades in the management and culture of the LGH, was highlighted by the commission:

> *As we have flagged elsewhere, we found Dr Renshaw to be an unhelpful witness. He was defensive and pedantic. Each of the concessions he made, once confronted by the evidence, had to be extracted from him during hearings. We consider that Dr Renshaw failed to accept*

responsibility for his failures. He did not demonstrate even a modicum of self-reflection during our hearings. Dr Renshaw's approach to our Inquiry frustrated many affected parties, particularly victim-survivors and their families, who were understandably seeking some acknowledgment, reflection and, indeed, apologies. Dr Renshaw's omissions and fabrications amount to misleading our Commission of Inquiry. We do not make this finding lightly. Misleading a commission of inquiry undermines public trust and confidence in the process. Such an act by a senior state servant is unethical and unprofessional and brings the State Service into disrepute. Volume 6 (Book 1): Chapter 14 — Case studies: Children in health services 250

Staff at the LGH consistently commented to me in my role at the LGH as ANMF workplace representative that poor management culture played a significant role in the worsening of access block. This played out in a wide range of failures, from day-to-day instances of failure of the escalation policy to more significant episodes (please see confidential note on last page of submission). (**Note to committee:** please find the words on the last page of this document highlighted in red and underlined confidential. I am willing to discuss this matter in further detail pending legal advice.)

Suggestion:

A review of structures of management within the hospital system including but not limited to governance, communication, roles and duties, accountability for meeting or failing to meet Key Performance Indicators.

Problems with Escalation policy

The persistent failing of the escalation policy when access block was occurring has been a clear concern for staff over a long period. During the last few years of my employment at the LGH, the escalation level was seldom noted to be less than the highest level (level 3 or red). The policy clearly stated that if the highest level of escalation (level 3 or red) were reached, hospital wide triggers should return the level to level 1 (or green) within a prescribed timeframe. The solutions triggered by the highest escalation point seemingly never worked, meaning the ED was almost constantly at the highest level of escalation. This had a similar effect to a car alarm in the distance. Staff became used to working at a constant level of excessive acuity and accepted as normal what should be abnormal. The response from middle and upper levels of management to on the ground staff seemed to be essentially shoulder shrugs and pats on the back, admitting that they had exhausted the levers that they had to make a difference.

During my tenure as ANMF workplace representative the ANMF proposed a review of the escalation policy and a potential increase in escalation level (level 4) to replicate the escalation policy of the RHH. This proposal was not accepted.

Suggestion:

An independent review of the current escalation policies of Tasmanian Hospitals to question if they are fit for purpose in the context of chronic access block.

Problems with reporting unsafe incidents

Under the National Safety and Quality Health Service Standards, there is a requirement for health service organisations to have an effective incident management and investigation system in place. The LGH uses The Safety Reporting and Learning System (SRLS). Staff are required to report unsafe incidents via a computer-based system that generates a Severity Assessment Code (SAC). SAC ratings are used to gauge the severity of an incident or event. SAC 4 is considered low risk, SAC 3 is considered medium risk, and SAC 2 is considered high risk.

Staff have many concerns with the SRLS system. The process is onerous, takes up a significant portion of time and is not user friendly. These issues result in a vast under-reporting of unsafe incidents. Staff should theoretically be reporting all unsafe incidents that they witness, but on any given shift that may require dozens of reports (for example, if a triage nurse was to document every incident of a patient in the waiting room not receiving observations within the scheduled time as per their triage category). It is not only minor incidents which are not reported; often major incidents that should be reported are overlooked due to intense acuity and staff's requirement to prioritise patient care above paperwork.

Suggestion:

An independent review of the SRLS reporting system to question whether it is fit for purpose in the context of chronic issues within the hospital system.

[redacted]

[redacted]

[redacted]

[redacted]

Thank you for the opportunity to provide a submission to the inquiry. I am more than happy to have further contact with the committee if required.

Kind regards,

Thomas Millen (Tom)