Submission to the Tasmanian House of Assembly Select Committee on Transfer of Care Delays (Ambulance Ramping)

Introduction

I am a Registered Nurse (RN) who has worked at the Royal Hobart Hospital Emergency Department (RHH ED) since 2010. In my previous twenty-five years of nursing I'd had little adult ED experience, so I began right at the bottom of the RHH ED skill & knowledge ladder. I have since progressed through all skill levels and areas of the ED.

I have been an Associate Nurse Unit Manager (ANUM) for four years,. As an ANUM, nearly half of my shifts are as the ED Navigator (Nav) – the In-Charge RN of the ED. As Nav, amongst other things, I am responsible for patient flow into and out of the ED.

As the Navigator, I bring people into the ED from three main sources –

1 - the waiting room (WR). These people/patients arrive at the ED by whatever means (walking, own car, taxi, ambulance, police ...) and have been triaged as appropriate to wait in the WR; that is, their presenting problem and current circumstance does not require a bed for their immediate comfort, safety or medical management.

2 - from Ambulance Tasmania (AT). These patients are either brought directly to a vacant bed after being triaged, or, having been triaged as requiring a bed but with no suitable beds being available in the ED, they are 'ramped' in the TOC area – Take Over of Care – where the patient are under the direct care of AT staff, with access to care from ED medical staff, and limited ED nursing staff sometimes allocated to the TOC, availability depending.

3 - from Tasmania Police (TP), by arriving in, and sometimes waiting in, a TP vehicle due to operational reasons.

The ED is a sorting house. People present with their problem/s. The ED medical team assess the person/patient, intervene if/as required to stabilise the patient medically, and then decide whether or not to refer the patient to one of the RHH inpatient teams for admission by that team. If not for admission to the RHH, patients can be sent back to their place of residence, sometimes with a referral to outpatient services, GPs, allied health services etc, or transferred to another more appropriate hospital.

If being referred for admission, the ED doctors contact the inpatient unit of choice, and then the patient waits in the ED for the delegated doctor of that team to arrange a formal admission, mostly in person the ED. **1 - Out of hours and overnight, there is often a delay in the admission process, which does contribute to delays in the patient leaving the ED.** The admitting doctors have other duties to attend, which often take priority over admitting the patients waiting in the ED, who might have a bed bed on a ward -allocated.

Most wards require patients to be formally admitted before they will be accepted into that ward. Once admitted, the Nav uploads relevant admission details to make the Patient Flow Manager (PFM) aware of that patients admission, and thus their need for an inpatient bed on a ward – ideally on the home ward of the admitting team.

2 - **Sometimes the admitting doctor does not tell *anybody* that they have admitted a patient, so that patient's details are not uploaded until the admission is discovered by someone, which does contribute to delays in the patient leaving the ED.**

3 - Further, the Nav having quality time, free of disruption, is key to prompt uploading of patient admission details. A bed-blocked, understaffed out-of-hours ED is a disruption filled environment for the Nav. Clinical nursing tasks often take priority over access & flow tasks when the Nav has no assistance, generally out of hours and overnight. Sometimes the Nav is needed to assist in the resucitation area, or in triage, or with a patient emergency when resus is full, or to comfort distraught relatives.

Once the PFM has the admitted patients information, they allocate a ward according to various criteria;

- the admitting team – various medical, various surgical, paediatric, psychiatric, palliative, etc.

- expected length of stay – ward 3A for stays less than 72hrs Vs K10E for longer stays, K4W vs K9E/W etc.

- isolation status – does the patient have a transmissible infection (respiratory, diarrhoea & vomiting, shingles) or are colonised by a resistant organism (MRGN, MRSA, VRE, C diff) or are they at risk from others due to lowered immunity from treatments, disease or otherwise

- specialty care needs – e.g. cancer treatments, head injury care, burns treatments, end-of-life care

- is a patient safety observer available on the ward, or can they take a disruptive patient

As a general rule, the Nav then waits for a bed on a ward to be allocated, shown on the computer and/or communicated via MedTasker (the intra-hospital communication app) Once so, the Nav, or delegated RN, contacts the ward for a handover, the allocated bed/room number, and the time for transfer to that ward.

Access/bed block in the ED begins to happen when the number of admitted patients in the ED is greater than the number of available ward beds, and it increases until eventually there are no beds on wards left to allocate to admitted patients, so they have to stay in the ED to get the care and treatments their admitting team wants, while waiting for a bed on a ward – *any* ward.

ED beds become vacant when a patient leaves the ED, either due to admission and subsequent transfer to a ward bed, or by leaving the ED due to stabilisation or resolution of their presenting problem.

Ramping occurs when there is not a suitable bed available in the ED for an AT patient who has been triaged as needing a bed. In some circumstances, a patients' condition stabilises when they are on the ramp, to the extent that they can safely be moved from the ramp to the WR.

Ramping is a down-stream result of a lack of available beds on inpatient wards. It is not indicative of problems within the ED itself. I stress …

THE EMERGENCY DEPARTMENT IS NOT THE PROBLEM.

When there is no bed/access block, the ED functions really well. I suspect this is the same for the LGH and NWRH.

(a) the cause of transfer of care delays, ….

In my opinion, the main cause of TOC delays in the RHH ED is the continual lack of available beds in the RHH in-patient wards.

THIS IS NOT THE FAULT OF THE EMERGENCY DEPARTMENT

The secondary cause is the delay in getting patients formally admitted, and it occurs mostly out of hours.

<u>Lack of bed availability – the allocated bed is not ready</u>

As Navigator (or as the Emergency Medical Unit Nurse Team Leader, another ANUM-preferred role) **I hear this regularly.**

A core task of the Navigator is to update the PFM software (KYRA) so the Patient Flow Nurse Manager can allocate a bed to each patient, generally according to their admitting team, the intensity and skill of care required, their age, their expected length of stay, their infectious isolation status, and/or a mix of some or all of thee criteria.

When a bed is allocated, the Nav generally rings the ward Nursing Coordinator (NC) to handover the patient, get the allocated bed space, and find the preferred time of transfer. It is not unusual for the NC to say the allocated bed is not yet available. Common reasons are:

- the allocated bed is not actually empty. The patient is still in it;
    - waiting for transfer to another ward#

- waiting for transport home/to other accommodation#
- waiting for results and subsequent discussion with a doctor#
- waiting for allied health review#
- the patient died and is waiting for transfer to the mortuary
- the patient died and the staff are waiting for family/more family to arrive

In hours, these# patients might be transferred to the transit lounge (TL) to wait, **(4) but the transit lounge closes at 18:00 weekdays, 16:00 weekends & PHs. Also, the TL does have exclusion criteria, so it's not always a viable option to send some patients there.**

- the allocated bed is empty but they ward is waiting for the bed and room to be terminally cleaned. (**5) This is a common reason for delay. When I ask when the clean might be done by, I have often been told NOT FOR SOME HOURS.** A terminal clean is the comprehensive cleaning process required after an infectious patient leaves that room e.g. a COVID or other respiratory virus-laden patient; someone colonised with MRSA, VRE, C diff or some other medication-resistant microbe. Every surface other than the ceiling requires cleaning, as do all items in the room; furniture, fittings, handles etc. This is obviously a time consuming process, and, it requires attention to detail so transmission of the organism does not occur to the next room occupant. The constant need for teminal cleaning will be an ongoing issue into the future.

- the ward is currently short staffed and cannot accept the patient until the/a nurse comes back from break, a patient transfer, an imaging appt (CT, MRI, Xray etc) (**6) This is especially a problem after hours, when the Medical Imaging Department does not have nursing staff to care for patients in their department.**

- there is a MET call, CODE BLUE or BLACK happening which precludes accepting patients until the call/code has been stepped down because many staff are involved in that one event for one patient.

- it is too close to the end of that wards' shift, so the transfer is forced to wait until handover to the next shift has happened

<u>Lack of bed availability – there are no beds to be allocated</u>

This has been a more frequent occurrence in the last few months.

The Navigator calls the ward and sometimes gets told there are no available beds for that patient, or any more patients, or gets a MedTasker saying the same thing. **The two most common reasons for no available beds are that the ward if full, or, that they are understaffed and cannot open all their beds (according to the agreed nurse-to-patient staffing ratios).**

Reasons for under-staffing that the Navigator hears are:
- sickness or other leave;
- high acuity patients (near ICU level care) already on the ward that require more than the anticipated number of nurses to care for them;

- patients who require near constant (not ICU level) care/observation due to multiple co-morbidities;
- patients with confusion, due to many different causes, who require more than anticipated observation and interventions, when Patient Safety Observers are not available.
- the need to keep a bed or two spare for 'expected unexpected' events, such as STEMI (heart attack) beds on the Cardiology ward, or emergency post-operative beds on surgical wards.

Another reason given for refusing to take a patient with complex or specialist care is that there are no accredited/skilled staff on shift to care for the patient in question.

Or, there are simply no empty staffed beds available in the hospital.

This happens disturbingly often.

… acknowledging Federal and State responsibilities;

A few weeks ago there was a mass discharge of long-term RHH patients who had been lingering as inpatients because, as I understand things, previously they were not discharged because they could not go to their accommodation of choice. **For the next week of two, ramping at the RHH ED was tens of minutes, not hours. I understand most of these patients required RACF placement or NDIS services – the lack of which are federal government responsibilities.**

We see many ED presentations that I believe could be prevented by:
- better staffed and resourced community health services,
- better staffed and resourced RACFs and supported accommodations.
- better staffed and resourced in-home care and monitoring services, especially for those older and more frail Tasmanians living home alone.

I believe the main factor in increased ED presentations in my time in the ED has been due to the incredible advances in medical technology, and therapies, over the past decades. In the 1990s I worked at the LGH when 'Casemix' was implemented. This was a tick-box flow programme for a variety of common surgical presentations, such that there were proscribed steps in a patients care journey to be marked off post surgical. On day 1 the patient should be dong this, on day 2 this, day 3 this etc. It was apparent to me that this system was based on healthy people with no co-morbidities and good health literacy. It thus came as no surprise to me when patients with e.g. chronic lung, heart or obesity issues etc. failed to progress as Casemix would have them. This lead to much longer hospital stays than planned/desired by hospital administration.

Now consider what the effect widespread administration of e.g. anticoagulants and anti-cholesterol drugs has had on preventing heart attacks and strokes – people who previously would have died are now either not having those issues, or they are surviving life threatening events. As such, they now live longer, only to be afflicted with more co-morbidities that make their health journey more complicated, requiring greater input by a

greater number of health specialists, sometimes in acute care settings. People live longer, get more frail, accumulate more health issues due to ageing, and thus survive, often with an increasing medication burden, which must be tinkered with regularly to keep the patient in optimum health. One only has to look at the age of ED patients, and their issues:
- fell over at home alone
- at risk to self and/or others due to cognitive decline, +/- carer fatigue
- at risk to self due to functional decline, +/- carer fatigue
- delirium due to e.g. urinary or respiratory tract infections, often due to inactivity, or inability to adequately care for self.

Many of these patients need a short hospital stay for 'fine tuning' or to get over their confusion causing infection that cannot be managed at their usual place of residence.

It is this increased need for hospitalization that I believe is a major problem health bureaucrats have either refused to address, or refused to acknowledge.

In my opinion, the failure to build a new RHH campus on a more central metropolitan site is the single biggest failure of state health administration.

A new and bigger RHH ED is being built. In effect, a bigger funnel for the same size bottle.

While I don't have any reference material, I am of the understanding that Australian hospitals used to be run at 80% capacity. When I reflect on my student nursing days on public medical wards in the 1980s, they weren't as busy as my ward colleagues report theses days, and I often leaned of hospital based student nurses being sent home for a few hours and complete their shift later that evening, a practice known as 'split shifts' … their work wasn't needed *all* day, only some of it. The hospitals were not, or ever, full. **Now, for reasons I can only speculate on, hospitals are now run at 100% capacity, so there is no surge capacity.** Staff are always busy, patients do not get the quality nursing care they used to get, management is constantly putting staff under pressure, all which goes to making the work less satisfying and attractive as a long-term prospect.

THE ED(s) ARE NOT THE PROBLEM

(b) the effect transfer of care delays has on:-

(i) patient care and outcomes;

Ambulance Tasmania crews are highly trained and skilled, and perform most admirably. The Tasmanian public, and our visitors, are lucky to have such a comprehensive, caring and free paramedic service. The major problem for TOC patients is that these same paramedics have

a defined scope of professional practice (SOP), which differs significantly from the ED nursing scope of practice. As such, TOC patients can have delays in having common medications administered (e.g. intravenous medications and some IV fluids) or common interventions (e.g. nerve blocks to relieve the pain of bone fractures, esp. neck of femur fractures) simply because they are in TOC. This is not a criticism of AT, it is a reality of bed-block. In contrast, a patient in the waiting room might get the IV medications because they would be classed as under the care of the ED.

When staffing allows, one or two CINs (Clinical Initiatives Nurse) are available to the TOC area to begin treatments as prescribes by ED doctors, provided the TOC crews allow these to happen. This generally depends on how strictly the TOC staff comply with their SOP. **In my experience, some AT staff are prepared to go out of their SOP for what they see as benefiting their patient/s, while others quite rightly refuse to do so, knowing their patients are not getting the care they otherwise might. This must be quite a moral challenge for AT crews of both attitudes.**

Another albeit minor TOC SOP issue is the movement of TOC patients from the TOC area for investigations (to Xray & CT) and transferring from the TOC area to the ED. **Some TOC crews will move patients themselves, others rightly refuse to and ask for an orderly to move the patient. In busy times, this is an extra demand on orderlies, which means there are more reasons for patient-flow delays.**

Another major negative for patients is being 'stuck' in the ED for hours, if not days. The ED was build and fitted out for short patient stays, and thus it is not appropriately set up for longer term patient stays. Problems encountered are;

- the development and/or exacerbation of delirium, a state of confusion which is known to be made worse by patients, especially the elderly, not being exposed to natural light. It is not the light as such that helps them, it is being able to see whether it is day or night. At present, and for the foreseeable future, patients in the RHH ED and the EMU have no access to windows, and thus natural light. **We already have big problems with confused patients, who require constant observation to ensure they stay safe, without making their problems worse for them, simply by still being in the ED.**

- on morning shifts, when the hospital is full, specialist inpatient teams flood the ED to see their admitted patients. This makes for an entirely new level of crowd and noise. Not good for confused patients. Additionally, the admitted patients need to have their breakfast, take their morning medications, and, if they're really lucky, have their morning hygiene attended to. So the inpatient teams want to have the attention of nurses to tell them about their management plans, the nurses need to get on with attending to their patients needs, all the while trying to staff an active ED whose doors are still open.

- patients tend to arrive at the ED following an emergency event, so they often come totally unprepared, and often this means they do not have their regular medications with them, or even a list of their medications. In this case, doctors and pharmacists must clarify what medications these patients need, and it is not unusual that these medications are not

available in the ED, so someone, and it's usually a nurse, has to find out where the drug in question can be sourced from, and then arrange for it to come to the ED. In a busy ED, when sick people continue to come in the department doors, this drug search is sometimes pushed down the priority list (unfortunately this *is* sometimes appropriate) and thus patient care can be compromised due to late or missed regular medications, and patients thus get anxiety on top of their presenting complaint.

(ii) ambulance response times and availability;

These are obviously hugely affected by having their crews stuck at the RHH. AT will no doubt address these issues.

(iii) the well-being of healthcare staff;

I have seen many skilled experienced ED nurses staff leave the ED in my time, many because they did not want to work under such pressure any more, or, they believe the department is unsafe and they do not want to be held legally liable for a problem not of their making. There are plenty of much better paid jobs interstate which do not come with as much pressure and concern, or, they are getting out of heath care totally because of their disillusionment.

Nurses and doctors chose Emergency Department work for a variety of reasons. For nurses, a major reason is that they do not like ward nursing, just as there are many ward nurses who do not like ED nursing. With the advent of bed-block and poor patient flow, there is a lot more ward-nursing happening in the RHH ED (and I'm sure in the LGH & NWRH too) which is a real turn-off for some staff. It's not the work they want to do.

During times of ramping, the Navigator is constantly reminded of the TOC patients requiring better care - by doctors, CINs, AT officers and nurse managers. There are phone calls from pathology and imaging departments, telling of TOC or WR patients with results that require urgent actions, all the time assessing the needs of people not presenting by AT. There are stressed nurses telling you they have not got the time or hands to deal with the workload being imposed on them by the TOC escalation process – Tier 1 & 2. Many nurses and doctors have not had their meal breaks, and AT crews are dropping off patients with much less handover than 'normal', making staff feel unsafe and compromising patient safety. Doctors are asking for resus bays to perform comfort seeking procedures of patients who have been waiting hours to have e.g. their fractured leg put back into alignment, **but the Navigator has to keep playing the board game of 'Get patients out of TOC by prematurely moving other patients out of the ED' as an imposed priority.**
This is stressful and takes a toll. More often than not these events occur outside business hours when ancillary staffing is lower, the Navigator has no clinical support to keep running the department, the transit lounge is not open and there is push-back from the wards to accept rapid transfers, regardless of the Tier processes.

The CIN role was implemented to deal with the increasing number of triaged patients being asked to wait in the WR instead of getting a bed inside the ED. While waiting, basic investigations are be performed by the CIN in patient assessment spaces; basic physical assessment, vital sign recording, blood tests, ECGs, bladder scans. As TOC time delays and patient number grew, CINs were also tasked to cover TOC patients. The skills and knowledge sets of many AT officers would allow them to do some of these tasks, but their SOP prevents this. Doctors attend TOC patients as per triage priority, and if any investigations or tests are requested, the CIN attends to those tasks too. In times of high TOC and WR patient numbers, the CINs are put under even more pressure. Accompanying nurses to Xray and CT is also outside AT crews SOP, so CINs get called for these tasks too. Now, consider fifteen of more Triage CAT 2 or 3 patients in the WR and five or more CAT 2 and 3 TOC patients. **Under these circumstances nursing staff fear that an adverse event will happen that they will be held accountable for – when they are the sole nurse for more than tem WR patients.**

Many nurses ask not to be CIN. It stresses them out too much. They find working in a waiting room full of patients who should be in a bed distressing, not to mention the occasional snide comments made to or about them while going about their invaluable work. Please consider that a CAT 2 triage means the patient should be seen by a doctor within 10 minutes, which in the 'old days' always meant a bed in the ED if not a resuscitation area bed. Nowadays CAT 2 patients are regularly are ramped.

As Navigator, I have often addressed a full waiting room at the beginning on night shifts, explaining why they are waiting, telling them that there will be no beds, asking them not to take out their frustrations of the ED staff, and requesting their patience if they choose to stay. **I started doing this because ED clerical staff came to me (as Navigator) complaining of abusive behaviours from frustrated patients and relatives asking when they/their loved one would be going inside the ED, after having waited medically inappropriate times given their presenting complaint.**

HACSU has implemented a number of industrial actions since ramping and TOC has become commonplace. It is extremely frustrating to ED nurses and doctors that many of these actions only impact patient care and put more work onto ED staff. There is no public or government or health department knowledge of these actions, and therefore I struggle to understand why the bans are even thought up, let alone implemented. They don't make a difference to ramping, they create tension between some AT crews and ED staff, and I believe they are an unnecessary cause of stress.

(iv) Emergency Department and other hospital functions

TOC patients increase work for all ED staff, without getting a corresponding staffing ratio increase. If AT cannot provide a TOC crew, and TOC patients are accruing, AT crews in the TOC area will take over care of departing crews, so more ED staff resources get redirected to the TOC area for whatever length of time. This often means walking to & fro from the TOC to the ED, and again, and again. It's time consuming and is time away from ED other patients.

Tier 1 & 2 responses, when TOC transfers are prioritised to allow faster return of crews back on the road, are significant interruptions to basic ED functioning.

While the ED is supposed to keep functioning, that is, patients randomly attending the ED by whatever means, and ED staff attending the patients already inside and needing care, a major patient transfer event is supposed to happen simultaneously, with orderlies and Clinical resource nurses from the main hospital supposedly being re-directed to assist in the ED. In reality, this support is rarely found, generally due to inpatient MET calls, out-of-hours CT and MRI assists, Code Blues and Code Blacks, and staff absences, so ED patient care suffers and ED staff suffer.

(d) the State Government's response to transfer of care delays and it's effects to date …

The opening of the Hobart Urgent Care Centre in Bathurst Street has made a significant difference to the RHH ED Mountain (Mt) care area attendances, and has no doubt been great for the patients treated there faster than otherwise, **but it has made no difference to TOC transfer delays in the ED.** One could argue that less patients in the Mt area means one or more Mt beds could be used as River area overflow, but the entire Mt area is not well set up for inpatient stays, and the Mt area is not staffed for inpatient stays.

**The National Emergency Access Target (NEAT) stipulates that a pre-determined proportion of patients should be admitted, discharged or transferred from Australian emergency departments (EDs) within 4 hours of presentation. Targets that varied from state to state were set for all Australian EDs by the National Partnership Agreement in 2012[1] in response to evidence that ED overcrowding and prolonged length of stay were associated with increased in-hospital mortality.[2,3] The original aim was to incrementally increase the target to 90% in all jurisdictions by 2015, in line with the "4-hour rule" target set in the United Kingdom in 2010.*

www.mja.com.au/journal/2016/204/9/national-emergency-access-target-neat-and-4-hour-rule-time-review-target

(f) further actions that can be taken by the State Government in the short, medium, and long term to address the causes …

Short term:

Fund and recruit more Clinical Resource (a.k.a. Float RN) nursing staff to be available for:
- off-ward/department transfers all hours
- S4 & S8 drug transfers from pharmacy, and ward drug counts
- Code Blues, MET calls and similar crisis events

Have more termial cleaning teams available 24/7.

Have more Patient Safety Observers available 24/7.

Find more Psychiatric inpatient beds.

The ED regularly has admitted Psychiatric patients staying for two or three days.

Start thinking and planning about health as a wholistic issue, not just limited to one Department or Ministry.

Get your Federal counterparts thinking similarly.

Start thinking about running hospitals at 80% capacity again.

Accept that Tasmania does not currently have the tertiary hospital bed capacity the Tasmanian population needs, and start addressing this basic problem as a priority.

Please do not implement the 60 minute TOC transfer agreement HACSU has made with the Premier, due to commence in April 2024, unless the LGH, NWRH & RHH ANMF ED delegates agree to its implementation.

Medium term:

Interstate pay parity. I have witnessed a constant stream of nurses leaving the RHH ED, and Tasmania, because they can get better pay for less stressful work elsewhere.

Work with Federal Government and Departments to improve Residential Aged Care Facilities staffing, service capacity and medical services available, to mean fewer inappropriate and/or unnecessary ED attendances from RCAFs.

Have an alternate location for ED patients to remain who have been medically cleared and are waiting for psychiatric review and probable admission.

Support the full implementation of the Aged Care Royal Commission

Keep thinking and planning about health as a wholistic issue, not just limited to one Department or Ministry, and begin doing it.

Keep your Federal counterparts thinking similarly.

Begin running hospitals at 80% capacity again.

Practice a whole-of-government bipartisan approach to health care delivery.

Thank you for the opportunity to make this submission.