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Submission to the Legislative Council Government Administration

Committee 'A' of the Tasmanian Government:

August 2018

INQUIRY INTO ACUTE HEALTH SERVICES IN TASMANIA

The Tasmanian Branch of the College of Emergency Nursing Australasia (CENA) welcomes the Legislative Council Government Administration Committee 'A' Sub Committee inquiry into Tasmania's resourcing of the State's major hospitals to deliver acute health services, including mental health services. In line with the sub committees focus areas, members have provided content with all responses in this document referring to Emergency Department (ED) Services.

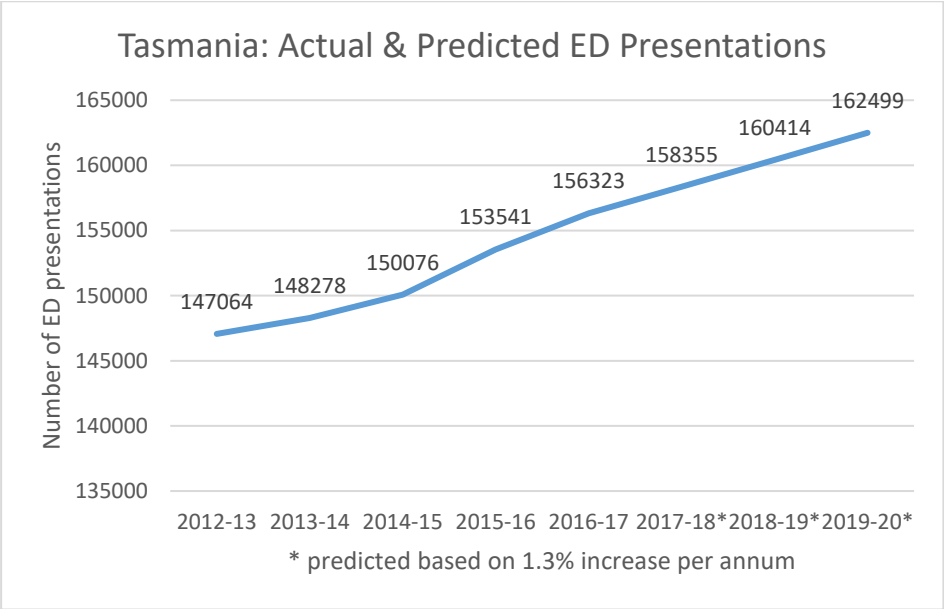
CENA is the peak professional organisation representing emergency nurses in Australia, and aim to provide a nursing perspective on emergency healthcare issues. We are very pleased to have the opportunity to contribute in this inquiry in order to promote optimal health care, safety and advocacy for our patient population.

(1) Current and projected state demand for acute health services;

a. Increasing demand for ED services is being observed across Tasmania with the greatest growth being seen at RHH. ED attendance growth is ahead of population growth (which sits at 0.3%pa state-wide). Each region has been identified as having a unique profile in ED presentations (refer to Appendix 1)

b. From 2012-13 to 2016-17 financial years there was a 6.3% increase in ED attendances across the 4 major public EDs, with 2016-17 reaching 156,323 ED presentations.

c. If this growth continues we can expect attendance numbers to reach over 162,000 in 2019-20.



Data available from www.aihw.gov.au

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(2) Factors impacting on the capacity of each hospital to meet the current and projected demand in the provision of acute health services;

Factors influencing ED services are numerous and complex with causes influencing access block often broken down into input, throughput and output.

a. Input

i. Increasing numbers of presentations.

ii. Increasingly complex healthcare needs.

iii. Aging population.

iv. Service availability, limited services available at time of need within the community while EDs are open 24 hours/day.

v. Low acuity patients, over 53% of the State's ED presentations are Category 4 or 5, the two least urgent triage categories (refer to Appendix 1).

vi. Community services for mental health lacking, the ED is not the best place for the majority of mental health presentations

vii. Representations to ED due to lack of community services or due to access block with patients awaiting urgent surgery returning due to acute episodes or to facilitate surgical procedures

b. Throughput

i. Increased number of admissions, with patients frequently held within ED for extended periods of time. Access block has been defined at boarding of patients in ED for greater than eight hours; patients in Tasmanian EDs are frequently well exceeding this.

ii. Limited assessment spaces for patients arriving during times of crowding.

iii. Crowded environments leading to challenges for staff to complete all assessments in a timely manner and to maintain confidentiality whilst conducting assessment and treatment.

iv. Long waiting times for mental health patients and delays to acute mental health beds

c. Output

i. Time taken to transfer patients back to Nursing Home or to District Hospital due to lack of access to appropriate transport services.

ii. Hospital access block increases length of stay within the ED and is well documented to increase overall hospital length of stay.

iii. Long waiting times to get into specialist clinics for review and therefore requiring ED to function as a site for urgent specialist review.

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d. Tasmanian Role Delineation Framework and Tasmanian Clinical Services Profile

i. There is a current mismatch in resources and expectations of level of service delivery.

ii. Increased demand at 'single service' hospitals with no added capacity in workforce or infrastructure to support this, for example maternity services in north-west Tasmania.

e. Redevelopment

i. Reduced flow coordination and bed capacity to meet current admission demand at RHH.

f. Infection Control

i. Lack of single rooms for isolation, particularly during winter and influenza season.

ii. Delays in bed turn-around times for rooms requiring infection control cleans.

ii. Long term issues in increased incidence and screening on multi-resistant organisms.

g. Mental health

i. Increased number of mental health presentations to the ED, with EDs acting as the 'front door' to mental health services.

ii. Lack of acute mental health beds – increasing demand and delays to ward, contributing to ED overcrowding, unsafe practices and environments.

iii. Issues with timely access and transition from acute mental health services into sub-acute, community mental health services and delays with discharges due to social/housing supports.

h. Increased inter-facility transfers

i. Due to the change in services at hospitals, as outlined in the Tasmanian Role Delineation Framework - for example the Mersey Community Hospital - there is an increased need for transfer of patients requiring in-patient specialties no longer offered e.g. surgical, obstetric, paediatric services.

i. Emergency department layout

i. RHH specific concerns:

1. Layout not user friendly

2. Corridor spaces too narrow

3. Limited storage space results in equipment in corridors and restricted access
4. Fire safety concerns
5. Increased overcrowding in particular 'high demand' areas.
6. Difficult to manage patients awaiting procedures to be performed in the ED with the number of acutely unwell patients
7. Limited expansion options adjacent to ED.
8. Does not meet the Australasian College for Emergency Medicine Design Guidelines for paediatric or mental health patients.

ii. LGH specific concerns:

1. Limited access to bathrooms and toilets for patients. For example, the LGH ED has two full bathrooms, this proves inadequate when boarding 20 or more patients (in-patient wards have a minimum of 1 bathroom: 4 patients).
2. Design and location of mental health rooms has also been raised as a concern by LGH staff.
3. Insufficient bed spaces to assess and treat new arrivals during times of crowding and access block.

j. Scope of practice and models of care

i. No pathways of supported learning for Nurse practitioners or advanced practice nursing

ii. Clear gaps with mental health which could be met with advanced practice nurses and Nurse Practitioner models of care

iii. Scope of practice with regard to Nurse Practitioners and Registered Nurses needs review to enhance nurse initiated procedures, nurse led discharge and nurse initiated medications.

iv. Nurse Practitioners routinely conduct assessments and manage care for patients with Motor Accident Insurance Board or Workers Compensation claims. At time of writing the paperwork for such claims cannot currently be completed by Nurse Practitioners under current law which needs revision and amendment.

v. Emergency nurses frequently are unable to work within their full scope of practice due to lack of governance, with limited avenues for innovation.

vi. No area for clinical innovation. Research is vital to innovation and further evidenced base change with ward based research nurses lacking.

(3) The adequacy and efficacy of current state and commonwealth funding arrangements;

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a. Number of locum consultants required to staff EDs in the North and North-West, this staffing model results in exorbitant costs to the health budget. Appropriate recruitment and retention must be a priority in managing ED funding.

(4) The level of engagement with the private sector in the delivery of acute health services;

a. Currently limited private Emergency Departments – South is only region to have access private ED services. Private EDs have the ability to utilise 'bypass' which results in increased presentations to the public ED.

b. Alternative models for care and partnership with the private sector would seem sensible in Tasmania given our size and limited resources.

c. CENA membership report increased private health patients being referred to public ED due to lack of consultant availability in the private sector.

d. Level of and limitations to general practice services – acute health services being used as a source for 'second opinions' and 'outpatient reviews', 29% of non-urgent patients in the north reported, by their general practitioner (GP), to present to ED (refer to Appendix 1).

e. Mental Health – link and engagement with Drug and Alcohol, detox services; Accommodation issues increasing in-hospital length of stay.

f. District Nurses – under-utilisation of community services and support to aid timely discharge; referral process from GP could go straight to District Nurses rather than to ED.

g. Universities – CENA membership are concerned about the quality of some post-graduate university-led courses due to lack of the requirement for clinical or practical assessments in such curricula (refer to Appendix 3).

h. No local university pathways for advanced practice roles such as Nurse Practitioners.

i. Referrals made by Nurse Practitioners cannot be made to private specialists as they cannot apply for a provider number whilst working in the public system inhibiting timely referrals.

(5) The impact, extent of and factors contributing to adverse patient outcomes in the delivery of acute health services; and

The impact of ED crowding and overcrowding is well documented to have significant consequences on patient outcomes and public safety. Please refer to CENA's position statement on ED Overcrowding and Access Block (refer to Appendix 2). CENA supports the ACEM position statement on ED overcrowding (available at https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Emergency-Medicine-Standards.aspx)

a. Increased time to treatment, such as:

i. Poorer outcomes for patients with chest pain (Pines et al., 2009)

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ii. Time to analgesia for pain resulting in decreased patient comfort (Derlet and Richards 2000; Bond et al. 2007(Mills et al., 2009)).

iii. Antibiotic for infection such as pneumonia leading to increased recovery time and potential sepsis (Sikka et al. 2010).

b. ED crowding increases risks to morbidity and mortality, this is well supported across Australia and internationally (Sprivulis et al. 2006; Richardson 2006; McCusker et al. 2014; Derlet and Richards 2000; Zhou et al. 2012).

c. Crowded assessment and treatment areas result in compromise in patient privacy and confidentiality (Gilligan et al. 2007)

d. Overcrowding – bed block, surge capacity, unsafe patient to staff ratios, unsafe number of patients in ED for work area is compromising care and effecting outcomes.

e. Feedback mechanism for adverse events is limited.

(6) Any other matters incidental thereto.

a. The causes of ED crowding are complex. Crowding is a symptom of issues outside the immediate influence of the ED for example, patients unable to access timely care within the community for low acuity health concerns often present to ED because they have exhausted alternatives (Sancton et al., 2018, Unwin et al., 2016), or inability of public patients to receive elective surgery in a timely manner, such as cholecystectomy, which results in multiple ED presentations for pain management.

b. Areas of concern identified by ED staff in the North at a bi-monthly ED / UTAS Research Forum include:

- Increasing mental health presentations and the associated increase of violence.
- Preventable re-presentations to ED (e.g. congestive cardiac failure, chronic obstructive pulmonary disease).
- End of life care in ED, particularly considering closure of palliative care services.
- Staff retention and turnover, pressure on staff, increased violence, and long term retention.
- Allied Health role in ED could be extended.
- Staffing levels & projected needs, recruitment & retention, particularly an issue in the North and North-West. In 2016 Launceston experienced a mass walk-out of ED consultants. Were exit interviews conducted? It was largely reported by the media this was related to pay disputes, however, there were multiple complex factors at play. How have these been addressed to

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facilitate future recruitment and retention of experienced emergency physicians?

- Importance of safe environment for patients & staff, currently lacking.
- Patient confidentiality is limited due to the impact of overcrowding.

c. Staff attraction and retention – membership feel current workplace demand is overwhelming staff, causing reduction in current staff FTE, affecting staff retention with senior staff leaving to work in other workplaces, and making recruitment difficult to attract senior staff into the ED environment. This is a concern in all major Tasmanian hospitals.

d. The level of education and training support for development of emergency nurses in Tasmanian public EDs is a concern for CENA members. CENA supports a ratio of one Clinical Nurse Educator to 50 staff head count, which is in line with the Australian College of Critical Care Nurses (ACCCN 2003, p.2) staffing position statement. The ratio of Clinical Nurse Educators within the public EDs is below the national standard, making it challenging to meet the learning and development goals for nursing staff progression in this specialist nursing area.

e. Recent loss of post-graduate emergency medicine (registrar) training at LGH ED. This could potentially lead to higher turnover of locum medical staff, a potential shortage of high-quality applicants to the LGH across all specialties, increased strain on nursing staff as they work with unfamiliar doctors and an increase in reliance on senior nurses, and increased risk of poorer patient outcomes related to medical staffing shortages.

f. There are no formal mechanisms in place for emergency nurses to provide strategic specialist advice to the senior nursing roles with the Department of Health or Tasmanian Health Service. The CENA membership welcome any opportunity for an emergency nursing advisor role to be developed to assist with provision of emergency nursing/care advice on strategic policy, workforce, education and training to inform Government priorities.

Thank you for the opportunity to provide feedback to this inquiry. Should you require clarification or further information, please do not hesitate to contact the CENA Tasmanian Branch President Jodi Donoghue via email at jodi.donoghue@cena.org.au

On behalf of the Tasmanian branch of CENA, sincerely

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APPENDIX 1

Demand for acute services

Ongoing PhD work of Claire Morley and Maria Unwin (University of Tasmania)

Supervised by Professor Leigh Kinsman, Dr Elaine Crisp, Dr Jim Stankovich, Mr Scott Rigby and Professor Greg Peterson,

Emergency department

***Trends in ED presentations Tasmania 2010-11 to 2013-14*[1]**

Results demonstrated that there are wide-ranging regional variations in ED usage that may relate to access to quality primary care and the ageing population.

State-wide presentations increased by 3.4% (139,352 to 144,130 over 3 years). Regional variations included an increase in presentations of 16% in the South, 5.1% in the North and a decrease of 3.9% in the North-West. Per capita presentations were consistently lowest in the South and highest in the North-West. The South recorded a significant increase in per capita presentations of those aged 75 years and over (p = 0.001), increasing at a rate of 12.5 per 1,000 residents per annum (95% CI 5.8 – 19.2).

Why do non-urgent patients attend ED (Launceston)?

A total 477 surveys of were completed by "non-urgent" patients over a six-week period in 2015 [2]. Data identified:

- 31.4% would prefer to be managed by their general practitioner.
- 28.9% were referred to the emergency department by a health care provider.
- 42.1% of category 4 and 5 presentations in the population group were under 25 years of age.
- 6.9% indicated that cost was a contributing factor.

These results indicate that 8,000 non-urgent patients per year present to the Launceston ED that would prefer to be seen by their GP but are sent to the ED by their GP or other healthcare provider.

Cost was not a significant factor in the decision-making process to attend the Emergency Department and those aged 15 to 24 years were over-represented. The most common presenting complaint for all age groups was musculoskeletal problems.

Expansion of existing primary health services with strategic future planning of more targeted primary care provision could reduce the burden placed on the ED. Future improvements should focus on providing the right service at the right time to the right patient.

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APPENDIX 2 – from https://cena.org.au/standards_policies

Position Statement

Approved: March 2015

Emergency Department Overcrowding and Access Block

Purpose

This position statement outlines the position of CENA in relation to overcrowding and access block in Australian Emergency Departments.

Definitions

Overcrowding

Overcrowding refers to when the functioning of an Emergency Department (ED) is impeded by the number of patients waiting to be seen, undergoing diagnosis and treatment, or awaiting transfer from the ED. A consequence of overcrowding is that safe levels of staffing or the physical space of the department are exceeded.[1]

Access block

Access block is defined by the Australasian College for Emergency Medicine (ACEM) as patients in the emergency department that require inpatient care but are unable to gain access to appropriate hospital beds within a reasonable time frame, that being 8 hours (Table 1).[2]

Table 1: Definitions of Access Block

Australasian College of Emergency Medicine (ACEM)[1]	Proportion of patients whose spend greater than 8 hours in the ED from arrival to admission destination.
Australian Council on Healthcare Standards (ACHS)[3]	Time in ED from presentation to admission that exceeds 8 hours.
NSW Health Definition[4]	Delay of greater than 8 hours from the time of medical assessment to departure to in-hospital bed. Ready for departure time to actual departure time that exceeds 4 hours.

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Surge

Surge is a sudden significant increase in the demands placed on an ED given the normal capacity within which the ED can reasonably maintain standards of care and can contribute to overcrowding.

Ramping

Ramping occurs when ambulance services are unable to complete the transfer of patient care due to ED overcrowding within a time frame that is clinically appropriate because of a lack of clinical space in the ED.[2] Ramping delays the departure of ambulance personnel from the receiving institution, which in turn increases ambulance turn around and decreases services for the community. Ramping may also be referred to as offstretcher time or ambulance turn around time.

Background

Access block significantly contributes to overcrowding in the ED and reflects a systemic lack of capacity within the health system rather than inappropriate patient presentations to the ED.[5] When the ED becomes overcrowded, physical capacity and safe staffing resources are exceeded, impeding the functionality of the ED and delaying care.[6,7] This is distressing for patients and has a substantial impact on staff workload. Exposure to access block has been associated with significantly longer length of stay[8] and increased morbidity[9] and mortality.[10,11] Access block also adversely impacts on staff by increasing work-related stress and reducing job satisfaction.[12] This can influence workforce sustainability.

Inappropriate ED presentations by patients who should have attended a General Practitioner or other primary health service do not cause ED overcrowding or access block. Rather, the combination of an aging population, increasing numbers of ED presentations and reduced inpatient capacity contributes to overcrowding and access block.[12, 13] In Western Australia, the introduction of the Four Hour Rule Program (FHRP) in 2009 was associated with a marked reduction in access block. The key intention of the program was to improve the quality of patient care by admitting, transferring or discharging a predefined proportion of patient presenting to a public hospital ED within four hours.

Targets set within the FHRP were achieved through strategies that implemented queuing theory and improved patient flow, and have coincided in decreased morbidity and mortality.[14] In 2011, these targets were replaced by a nationwide program called the National Emergency Access Target (NEAT).

Access block is not solely an ED issue but is reflective of a systemic lack of capacity across the service. Overcrowding and access block place patient safety at unacceptable risk and are associated with adverse patient outcomes. Sites must have processes and mechanisms in place to incorporate the efforts of the ED, site and wider health service to overcome this problem.

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Position

1. Emergency Departments must have escalation processes in place to address overcrowding, access block, and surges in presentation. This needs to be in conjunction with a whole of hospital response.
2. Agreements must be in place between the receiving institution and ambulance service to ensure safe patient care with shared responsibility in the event of ramping. This includes but is not limited to:

    - Safe monitoring and senior medical review of all patients on the 'ramp'
    - Commencement of assessment and basic investigations by emergency staff
    - Ongoing surveillance for deterioration of ramped patients and escalation of care as appropriate
    - A safe environment for the patient and staff to transit in.
3. Strategies must be in place to address specific patient groups that contribute to department overcrowding as a result of requiring complex assessment. For example, the elderly, patients with mental health illness and those requiring isolation.
4. Strategies that incorporate a whole of hospital response in the presence of access block and ambulance ramping, must be established to expedite the timely transfer of existing inpatients awaiting admission and restore operational safety.
5. Processes for the assessment, ongoing review and escalation of patients who have arrived to the ED via means other than an ambulance must also be in place.

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APPENDIX 3 – from https://cena.org.au/standards_policies

Position Statement

Approved: October 2015

Postgraduate Qualifications in Emergency Nursing

Purpose

An Emergency Nurse Specialist is defined as a registered nurse who has professional preparation and significant experience in the emergency practice setting and who is able to demonstrate the ongoing achievement of the College of Emergency Nursing Australasia (CENA) practice standards.[1] CENA recognises that the educational preparation of specialist emergency nurses is vital for the provision of safe, high quality, evidence based care to the community. This position statement defines the minimum expected requirements for postgraduate emergency nursing courses.

Background

Emergency nursing requires complex decision making, advanced interpersonal communication and teamwork skills, all of which are dependent on high levels of knowledge and professional behaviours.[2] Tertiary education provides greater depth of knowledge and enhanced skills, which improves safety and quality of patient care and empower nurses to provide better outcomes for patients.[3-8] CENA believes that a consistent standard is required in order to achieve the intended professional and clinical outcomes of a postgraduate qualification in emergency nursing.

Position

1. CENA strongly advocates the pursuit of postgraduate qualifications in emergency nursing.

2. A postgraduate qualification in emergency nursing should be recognised at Australian Qualification Framework[9] level 8 (Graduate Certificate / Graduate Diploma) as the minimum standard for emergency nurse specialists.

3. Hospital based education programs for which credit is granted at Graduate Certificate or Graduate Diploma level should also have evidence of meeting Australian Qualification Framework[9] level 8 standards in terms of content and complexity of assessment tasks.

4. The curricula of postgraduate emergency nursing qualifications must provide appropriate theoretical and clinical experience, including a clinical assessment component, to prepare nurses to meet the domains of the Practice Standards for Emergency Nursing Specialist.[1]

5. Education providers are encouraged to provide flexible modes of program delivery that enable nurses greater access to postgraduate education in emergency nursing.

6. Nurses pursuing postgraduate qualifications in emergency nursing should have access to clinical and academic support and guidance from appropriately qualified staff. These staff will have completed academic qualifications equal to, or higher than, the qualification being pursued.

7. CENA supports continued collaboration between education providers, health care organisations and consumers to improve the quality of postgraduate specialist education for emergency nurses.

8. CENA supports initiatives by healthcare organisations to provide financial or career incentives for emergency nurses to undertake postgraduate qualifications in emergency nursing.

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