Independent Review of the Response to the North-West Tasmania COVID-19 Outbreak

September 2020

Introduction

The Australasian College for Emergency Medicine (ACEM, The College) welcomes the opportunity to provide its submission to this review of the actions taken in response to the COVID-19 outbreak in North-West Tasmania. As the peak body for emergency medicine, ACEM has a vital interest in ensuring the highest standards of emergency medical care for all patients. ACEM is responsible for the training and ongoing education of emergency physicians and the advancement of professional standards in emergency medicine (EM) in Australia and New Zealand.

ACEM acknowledges the public health challenges facing health departments in responding to the COVID-19 pandemic. From the outset, ACEM has communicated its expectations in responding to these in our correspondence with government and key decision makers, which referred to clinical guidelines developed in response to COVID-19[1]. The College also stressed our expectations in meeting key concerns raised by our members, including:

- *There is no patient emergency more important than the safety of our healthcare workforce.*
- *Appropriate, judicious use of personal protective equipment (PPE) is paramount.*
- *Planning for the increased numbers of patients requiring critical care services is important.*
- *Special consideration should be given to vulnerable people, both patients and staff, such as those who are older or have comorbidities, as well as Indigenous populations.*

During April 2020, the impact from COVID-19 on the hospital and healthcare system in the North-West region of Tasmania cannot be understated. The national eye was firmly focussed on this region given the outbreak among patients and staff, which placed enormous pressure on staff, and greatly increased the risks to patients. Further, the national lens resulted in hearsay and rumour flowing freely[2]. Whilst the impact on the healthcare workforce during the first wave in April was significant and seemed unprecedented in Northwest Tasmania it is noteworthy that this has been dwarfed by the impact of the second COVID-19 wave in Victoria on healthcare workers.

Our submission will outline that the experience at the North-West region of Tasmania is evident of ongoing systemic challenges across the Tasmanian Health Service (THS) in meeting the increasing demand of patient care. Engrained systemic inefficiencies, such as poor communication processes, unclear escalation protocols and a lack of responsibility, particularly of hospital executives, has increased the burden on ED staff to fill these voids.

[1] See Attachment A: Letter to Kathrine Morgan-Wicks 2 April 2020
[2] McIlroy, T 2020. *Police Investigate coronavirus dinner party*. Financial Review. [Online] As available via https://www.afr.com/politics/federal/tasmanian-cluster-sparked-by-illegal-dinner-party-20200414-p54jl1

We reiterate that ACEM is willing to work with the THS, hospital executives and policy makers to develop and implement reforms across the ED and broader healthcare system and we welcome the engagement that has occurred since June. Reforms are urgently needed as any additional pressure from COVID-19 runs a high risk of greater impacts than those already experienced in the North West region of Tasmania.

Pre-COVID-19 engagement and systemic limitations

ACEM has strongly engaged in recent reviews and consultations seeking to identify and address the challenges facing the Tasmanian healthcare system. As recently as November 2019, ACEM called for greater efforts to address fundamental problems at the Royal Hobart Hospital, and Launceston General Hospital, that resulted in the worst results in all of Australia for patient access block, quantified by the proportion of admitted patient waiting more than eight hours for admission into hospital from the ED, and 24 hour wait times.

Our data demonstrates that when compared to the rest of Australia, all EDs in Tasmania, including North West Regional Hospital, experience extreme waits for patients seeking urgent care. Indeed, aside from 2013-14, Tasmanian ED patients requiring admission into hospital have been waiting longer than any other jurisdiction from 2011-12 to 2018-19; in 2018-19 alone it took 22 hours and 44 minutes for most admitted patients (90%) to depart the ED, compared to the national average of 11 hours and 43 minutes[3]. These patients are often our most vulnerable with mental health patient access block far higher than all other patient presentation groups. This significantly adversely effects the way ED functions; in September 2019, ACEM's snapshot survey found that whilst the number of admitted patients waiting in the ED for hospital admission accounted for 42% of ED workload nationally, it accounted for 57% of ED workload across all Tasmanian hospitals (71% at Royal Hobart Hospital, 54% at Launceston General Hospital, and 56% at North Western Regional Hospital).We strongly advocate that addressing inpatient bed numbers, and staffing levels that align with predicted ED arrivals and patients sick/injured enough to require admission from ED would greatly contribute to systemic improvements[4].

Importantly, our data and consistent advocacy confirms that the capacity of Tasmania's healthcare system was ill-prepared to meet any significant additional burden. This is not solely a Tasmania problem, with decades of underestimation of ED presentations and resultant underfunding of the healthcare system in Australia resulting in gaps and shortages. However, the prevalence of access blocked patients in Tasmanian EDs is clear evidence that existing patient demand, and the required resources to meet this demand, was not aligned before the pandemic hit. Importantly, previously identified cultural issues regarding hospital and departmental executives across the state, unclear communication lines, and a lack of responsibility by hospital executives results in a fractured environment.

To be clear, the number of patients predicted to arrive at any given Emergency Department on any given day and the proportion sick/injured enough to require admission is entirely predictable to within around 10% (of volumes) so we continue to be frustrated when these numbers are treated as being a surprise. It warrants further clarity that access block is not an ED problem, but a systemic health system problem manifest with adverse effects in ED and requires whole-of-system resource and process improvement.

In the North-West, our members outline a pre-COVID-19 preparedness across the hospital as poor. Before the pandemic took hold there were ongoing staff shortages in the ED and across inpatient teams. This required relying on a locum workforce to fill these shortages and ongoing efforts to engage across the hospital, with attempts to communicate dominated through a heavily hierarchal process.

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[3] Australian Institute of Health and Welfare. Emergency department multilevel data. Canberra ACT: AIHW; 2020 [2020 June 4, Version: 2020060403; extracted 2020 February 21]. Available from: https://www.aihw.gov.au/reports-data/myhospitals/sectors/emergency-department-care.

[4] Australasian College for Emergency Medicine, 2020. *State-wide strategy needed to address Tasmanian access block crisis*. Available at https://acem.org.au/News/November-2019/State-wide-strategy-needed-to-address-Tasmanian-ac

In the days leading up to the closure of the North West Hospital, we understand that repeated attempts were made by senior ED staff to seek confirmation from the executive of an urgent need for increased resources and support. There was a real risk to the safety of staff, and patients, due to the material impacts from an increasing number of staff furloughed due to potential exposure of COVID+ transmission.

Responding to the outbreak

COVID-19 has exposed any cracks or failure in existing systems, process and practices. This is very evident in the North West region given:

- An unwillingness from staff in executive positions to openly engage with ED staff in managing the various stages of the pandemic, including leading up to the closure of the North West ED, and resultant use of the Australian Defence Force to staff the ED;
- A closed culture where staff were directed not to engage with colleagues across the system, for example how to manage increased patient loads with ambulance services;
- Resistance from senior executives to initiate necessary triggers to seek state-wide support; and
- Repeated warnings to staff from senior executives to limit any engagement with professional organisations, including Medical Colleges and the Australian Medical Association.

However, our members also outlined some positive engagement, in that the broader hospital staff and systems responded urgently at the height of COVID-19 impacts. Access block reduced to NIL and patients were greatly supported to get the care they needed, when they needed it, although this did occur at times of unprecedented and unpredictable decrease in demand and shut-down of other hospital functions such as cancellation of elective surgery and clinics . Although this demonstrates the potential for change, it was short lived.

Patient transfers and managing increased patient loads

The closing of the North West Hospital ED had significant impacts on the Mersey Hospital and Launceston General Hospital (LGH). Due to the number of ED and general medicine staff furloughed, all North West inpatients were decanted to either the Mersey medical ward, or the Launceston General Hospital. Staffing of the MCH medical ward was made up of the junior medical workforce who were tasked to run the ward without consultant support. This occurred for a period up to two weeks and placed both staff and patients at a very high risk of adverse outcomes.

Until the NWRH ED re-opened with ADF staff several weeks later after deep cleaning, all ED patients East of Mersey River in Devonport were redirected to LGH throughout the day, and after 10pm all ED patients from the entire North and North West of Tasmania were brought to the LGH ED. During this event, LGH presentations rapidly returned to pre-COVID numbers but now with an increased patient admission rate of up to 50%. At one stage there were over 120 inpatients from the North West community in LGH wards, all subject to public health quarantine restrictions.

The result for LGH was significant increase risk to staff from large movement of potential COVID infected patients being seen and managed at the LGH. This risk was further exacerbated by the increased patient numbers and access block, thus preventing any ability to adhere to social distancing requirements in the ED.

Unclear and unavailable personal protective equipment (PPE)

To meet this increase in patient demand, a considerable increase of additional PPE was required. This assisted in managing the risk to staff, and other patients, due to the unknown level of community transmission among patients now presenting from the North West communities. All ED staff were required to wear at least surgical mask and eye protection for the entire duration of their shifts, and any external staff entering the ED also had to adhere to this, including inpatient medical staff, nurses, house services, food services, cleaning, retrieval, support, security and admin staff. As an example of this increased use of PPE, the LGH ED alone used over 700 masks per day during this period.

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The impact on PPE stocks and subsequent escalating fear of PPE running out significantly heightened the anxiety of LGH staff, and the wider community over the potential for resultant local spread of COVID-19 infections. This environment resulted in strained relationships between hospital and health service staff, for example, between the North West ambulance staff and ED staff due to significant delays in unloading patients into the ED. Additionally, admitted patient medical reviews in the ED were recurrently significantly delayed, or non-existent, due to the high-risk environment the LGH ED was then viewed to be. Sentinel events occurred to patients in the high-risk zone of the ED, where speciality staff were reluctant to attend, leading to significant morbidity and mortality. We are aware of 2 RCA reports highlighting deaths in ED attributed to the difficult working conditions due to this period of increased COVID-19 in the North West region.

We understand that during this COVID-19 Outbreak Response, no additional staff or equipment was made available to the LGH ED to assist with the significantly increased workload, risk and mental stress of the new environment. Thankfully hospital wide COVID preparation strategies allowed for two surgical wards to be allocated to manage the North West community quarantine patients. However, this did not alleviate the ED risk as all patients still required ED assessment and treatment prior to admission, in an ED environment of mixed quarantined, at-risk patients, and low-risk patients from the North West.

A lack of communication

Of final note is the issue of communication during the implementation of this Response. Our members highlight a lack of pre-notification to ED staff, including senior consultants, of the decision to close and the subsequent re-direction of patients and ambulances to LGH ED. Unfortunately, the recollection they have of being made aware of such a decision was from publicly available media releases and articles. Given the immediate impacts this decision was going to have, formal notification was essential to support staff to prepare and respond to the anticipated impacts

Reforms and next steps

Following the reopening of the North West ED, our members report a return of worse than ever access block and a reduction of staffing levels. As previously outlined, locums have been used to fill ongoing staffing vacancies, however no locums are now able to work at the North West ED due amongst other reasons to travel restrictions. The ongoing impacts of border closures, both national and international, needs to be urgently addressed to ensure EDs are staffed at safe levels. Our members report that short term measures to meet this gap, including undertaking additional shifts (some of which are unpaid), is not sustainable and removes all capacity to manage staff leave or staff illness. It is notable that this is occurring across numerous state borders in Australia in the second wave of COVID-19.

Our members have outlined a recent experience of access block at the North West ED, as below:

Sunday 23 August

- *Out of the 15 beds in the ED, 9 were occupied by patients who had spent 8 hours or more waiting for a bed in the hospital;*
- *Of these, 4 had spent longer than 24 hours in the ED.*
- *Of these 4, one had spent over 40 hours in the ED.*

We also outline recent figures from LGH demonstrating the prevalence of access block:

Monday 31 August

- *Out of the 25 acute beds in the ED, 21 were occupied with admitted patients who had all spent greater than 8 hours waiting for a bed in the hospital;*
- *Of the 22 admitted:*
    - *7 had spent greater than 24 hours in the ED – the longest wait being 62 hours;*
    - *9 had spent greater than 12 hours in the ED*
    - *4 had spent greater than 8 hours.*

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ACEM reiterates – we consider it is unethical to see a return of access block, which is associated with increased mortality among all other patients arriving to the ED[5]. Although community transmission is low, or NIL in Tasmania, there is a high risk of significant impacts if a COVID-19 outbreak was to occur again as has happened with devastating effects in Melbourne. Patients spending excessively long waits in EDs are at higher risk of adverse outcomes, including potential exposure to COVID-19. This is particularly relevant for high risk patient groups, including elderly patients, those who present with comorbidities, intoxicated patients and those presenting in mental health crisis.

While ED and systemic improvements are starting to be realised at the RHH, the impact felt across the state is less than promising. We recommend action to resolve the following issues in the North West region, and LGH, given the high impacts continued to be experienced by patients and staff. We recommend:

- Emergency care meets the ACEM Quality Standards6 with the additional components required for COVID-19 safe care;
- Emergency care is part of an integrated and co-ordinated system providing efficient care to the community which minimises the risk of infection transmission. This includes
  - community solutions for care, housing and 'home' isolation for people experiencing homelessness and those facing housing insecurity, poverty and overcrowded households
  - a strategy for care of vulnerable patients including older people, those with mental health challenges, and those with disabilities who rely on home carers to access healthcare, while enabling the goal of people safely remaining at home.
  - continual development of and investment in telehealth or virtual models of care, residential aged care facility "in-reach" programs, and, care close to home to increase hospital avoidance.
- EDs and healthcare systems monitor the impact of system changes in order to identify and respond to unintended consequences, such as delayed access to time-critical interventions or increased mortality, and to identify additional opportunities to streamline care.
- Certainty of PPE supply and availability to ensure workforce safety;
  - Unified and transparent approach to PPE distribution, education of its use and implementation across all THS sites;
- Actively addressing the severe levels of access block and prolonged ambulance ramping, to decrease the high risk of further outbreaks spreading in these environments where there is mixed, undifferentiated patients of all risk levels;
  - For example, streamlining front of house assessment to enable patient cohorting based on infectious risk, diverting presentations to non-ED clinics or telehealth consultations, admitting from the community or triage to inpatient units directly, and generally facilitating rapid transit through EDs. These measures have removed bottlenecks in patient flow and eliminated ED crowding, thereby maintaining safer ED environments for patients and staff
  - For example, include streamlined care pathways bypassing or limiting time in the ED, the use of technology to remotely assess and treat patients and a complete reassessment of who actually needs to attend an ED with the provision of easy alternative options;
- Increased transparency of data, including levels of healthcare worker infections and origins of these infections;
  - Related is the need to address issues of staff physical distancing requirements in clinical and non-clinical spaces as this is a significant source of healthcare worker infection.
- Transparent systems that outline executive staff responsibility in responding to the pandemic;
  - This includes clear lines of accountability and communication for those who are tasked to act in managing the pandemic, including THS site pandemic response coordinators, hospital executives and the senior clinical workforce;

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[5] Berg LM, Ehrenberg A, Florin J, Östergren J, Discacciati A and Göransson KE. Associations between crowding and ten-day mortality among patients allocated lower triage acuity levels without need of acute hospital care on departure from the emergency department. *Annals Emerg. Med.* 2019. 74(3):345-356. Available at: https://www.annemergmed.com/article/S0196-0644(19)30331-2/fulltext

[6] Australasian College for Emergency Medicine. Quality Standards for Emergency Departments and other Hospital-Based Emergency Care Services. 1st Edition 2015

- Streamline internal processes to ensure adequate capacity to recruit FTE staff and reduce a reliance on locums.
  - Our members report that there has been a strong reluctance to actively recruit towards recognised staffing requirements. Suggestions put forward to recruit and fill those shifts have been blocked. This ensured the region was understaffed as we entered the outbreak. This is ongoing as internal processes have precluded creation of adequate FTE to meet service delivery requirements.
- Greater resources to improve staffing levels for any ED that experiences a situation similar to that experienced by the North West and Mersey hospitals.
  - For example, supporting staff from other regions of Tasmania to work in the North West and Mersey EDs in a locum capacity;
  - For example, adopting the use of teleconference and video conference capabilities ED tele-health consultations, where appropriate and technically feasible.
- More supports for improving the wellbeing of ED staff;
  - Emergency physicians have a significant risk of "burnout syndrome" which is higher than physicians in general. This has adverse impacts on patients including decreased quality of care and patient satisfaction, as well as increased rate of medical error and malpractice risk.[7] An absence of joy and meaning experienced by a majority of the healthcare workforce is in part due to the threats of psychological and physical harm in the workplace compounded by poor design of work flow and increasing amounts of non-value adding activities.

We understand that there is little to no instances of community-based transmission in Tasmania[8]. This is a positive circumstance that has provided the opportunity to take stock and plan for the systemic supports required to manage the next wave of the pandemic. We welcome ongoing discussion and are willing to engage further with the Review in its work.

Thank you for the opportunity to provide feedback on the proposed reforms. If you have any questions or require further information, please do not hesitate to contact Nicola Ballenden, Executive Director of Policy and Strategic Partnerships on 03 9320 0444 or Nicola.Ballenden@acem.org.au.

Yours sincerely,

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[8] As per the date of submitting this submission.