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AmbulanceVictoria

24 December 2024

Coroner Catherine Fitzgerald
c/- Coroners Prevention Unit
Coroners Court of Victoria
65 Kavanagh St
SOUTHBANK VIC 3006

By email: cpuresponses@courts.vic.gov.au

Dear Coroner Fitzgerald

Coronial investigation into the death of Abraham Sleiman Transcendo | COR 2023 0988

We refer to Your Honour's finding into Mr Transcendo's death without inquest, dated 20 September 2024, in which Your Honour made the following recommendations directed to Ambulance Victoria (**AV**)/Adult Retrieval Victoria (**ARV**):

Recommendation 1(a)-(c)
That Adult Retrieval Victoria implement policy and procedure which will achieve the following outcomes:

(a) *Early dispatch of paramedics for time-critical cases whilst sourcing and/or confirming the appropriate destination or hospital to expedite transfer.*

(b) *Development of clear criteria for ARV coordinators to define time-critical neurosurgical emergencies to the closest centre without having to call for bed availability.*

(c) *Development of processes which will ensure a referrer contacts ARV initially for time-critical neurosurgical cases.*

Recommendation 2
That Adult Retrieval Victoria consider the submission of a business case for more available ARV resources and a 24-hour ARV ambulance and crew.

We write to provide AV/ARV's response to these recommendations.

Recommendations 1(a) and (b)

Recommendations 1(a) and (b) are under consideration.

AV's current operational work instruction 'WIN OPS 379 Interfacility Transfers' outlines the process of routine and high risk, time critical interfacility transfers (**IFT**). The resources required to complete the IFT will vary according to patient condition and other factors. The work instruction sets out the interfacility transfer processes for a Standard, Overnight, Complex and High Risk or Time Critical IFTs.

Time critical defined transfer guidelines already exist within Department of Health to supplement these processes. A copy of these guidelines is **enclosed**.

ARV has created a 'time critical workflow' which includes criteria for neurosurgical patients and prioritisation of early dispatch to supplement the existing work instruction. The workflow will be considered for approval in early 2025.

Recommendation 1(c)

An alternative to recommendation 1(c) will be implemented.

Early referrer contact is somewhat out of AV/ARV's control. However, AV/ARV has revised its ARV referral poster for distribution to health services statewide in early 2025 to highlight the importance of early referral and the services that ARV offers.

A copy of the ARV Early Retrieval Activation poster is **enclosed**.

Recommendation 2

Recommendation 2 and an alternative to recommendation 2 have been implemented.

ARV has considered the submission of a business case for more available ARV resources and a 24-hour ARV ambulance and crew. ARV/AV recognises that the objective of this recommendation is encapsulated in work completed to clarify AV's escalation processes and optimise AV's resources, especially in periods of peak demand.

In the face of increasing demand, and with the objective of optimising AV resources in periods of peak demand, AV developed its Escalating Patient Care and Demand Subplan and an Extreme Workload and Demand – Emergency Response Plan (**ERP**) Subplan. These subplans were approved in July 2024.

The Extreme Workload and Demand Sub-plan describes the management of the response to unusually high or extreme ambulance workload and demand events ('Orange' and 'Red' escalations of the ERP) with a major to severe impact on business operations.

As a Sub-plan of the ERP, the Extreme Workload and Demand Subplan works in connection with the Escalating Patient Care and Demand Subplan.

In addition, AV/ARV has been working with the Department of Health and health services across Victoria to streamline AV's escalation processes and optimise AV resources via the Timely Emergency Care 2 program ('AV TEC2').

Through AV TEC2, work is underway to identify, develop and scale workforce-driven solutions to improve patient care and create a safer, more satisfying workplace. The first phase of the project

involved engaging with frontline staff to build a shared picture about what is working, and which blockers need to be overcome to achieve and sustain improvement.

Engagement concluded in late October 2024. In total, 155 staff from a range of roles and locations engaged via survey or in-depth interview.

Respondents identified four key themes:

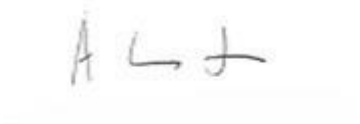
- Effective call taking and dispatch ensures emergency ambulances are available for patients with higher acuity needs.
- Optimising alternate pathways and supporting care being provided in place, virtually and outside emergency departments would reduce avoidable hospital transports.
- Timely handover at hospitals – and getting patients to the right place at the right time – gets paramedics back on the road swifty to attend the next time-critical emergency case.
- Resourcing and process improvements could help to maximise efficiency, enhance wellbeing and improve paramedic availability at key points of the day.

An Insights Report (**enclosed**) has been shared with AV's workforce, alongside the release of a call for expressions of interest (**EOI**) for frontline staff to join a Steering Committee to progress implementation.

Staff-led testing and implementation of improvement ideas will follow in 2025. This work will transition into AV's ongoing improvement program during 2025 to ensure an ongoing focus on implementation and continuous improvement.

If the Court requires further information from Ambulance Victoria, such as copies of all documents referred to in this letter, please contact AV's Coronial Lead, Amie Herdman, via email to: avlegal@ambulance.vic.gov.au.

Yours sincerely



Anthony Carlyon
Executive Director
Specialist Operations and Coordination

Andrew Keenan
Director
Complex Care

Enc

Enclosures:

1. Time critical defined transfer guidelines, Department of Health, January 2019.
2. ARV Early Retrieval Activation poster.
3. AV Timely Emergency Care 2 Improvement Program Insights Report, November 2024.

Time critical defined transfer guidelines

January 2019

Victoria's intensive care system

Victoria's State-wide intensive care system comprises public health service intensive care units and Adult Retrieval Victoria (ARV) supported by the Department of Health and Human Services (DHHS).

Adult Retrieval Victoria, a business unit of Ambulance Victoria, provides clinical advice, transport of critically ill or injured patients and bed-finding capability for adult patients admitted to a hospital.

Critical care transfers

A patient requiring urgent critical care and/or surgical intervention may need to be transferred to another hospital if the hospital where they are being cared for does not have the critical care, medical and/or surgical capability to meet their needs, or where the hospital has no intensive care unit bed available for a new patient.

Victorian health services are encouraged to make first contact with ARV directly for patients requiring inter-hospital critical care referrals. Referrals for these patients should not be delayed with communications to receiving facility inpatient teams and/or emergency departments.

Where definitive management of a patient's condition is likely to be achieved by urgent transfer to another hospital, ARV will facilitate access to critical care and/or surgical intervention beds and coordinate transport of critically ill or injured patients.

Defined transfers

Demand for critical care services is frequently high and there may be periods when demand exceeds the immediate supply. This may lead to no ICU, high dependency unit (HDU) or post-operative bed being immediately available for a critically ill or injured patient. To safeguard patient care in these circumstances, ARV is authorised to nominate a hospital to receive the patient. This is called a 'defined transfer' and reflects the time critical need for appropriate care for a critically ill or injured patient.

Assessment criteria for defined transfers

The decision to authorise a defined transfer is at all times determined by the needs of the patient. In authorising a defined transfer, ARV may also take into account factors such as:

- the nature of the patient's clinical condition
- time critical defined transfer
- the nature of the surgical or other intervention/s required by the patient
- the capability and capacity of the referring health service
- the capability and capacity of the potential receiving health service
- any known or anticipated demands on the state's critical care system at the time of the defined transfer

VICTORIA State Government | Health and Human Services

- geographical proximity and default referral pathways that may exist for the patient's clinical condition
- the needs and considerations of the patient's family
- the distribution and frequency of previous defined transfers to the potential receiving health service.

Authorisation of defined transfer process

If a defined transfer process is required for a time-critical care patient the authorisation process will be as follows:

1. Decision to initiate the defined transfer process will be authorised by the ARV Medical Coordinator (or delegate) after consultation with the referring and receiving Consultant clinicians
2. The ARV Medical Coordinator (or delegate) will initiate a defined transfer where no suitable bed can be located to meet the needs of a critically ill or injured patient
3. The ARV Medical Coordinator (or delegate) will notify the receiving hospital bed coordinator of the patient's destination within the receiving hospital (ICU, Emergency Department, Operating Theatre)
4. The receiving hospital bed coordinator will communicate and operationalise the receiving hospital's response and actions.

Defined Transfer Procedure

Once the defined transfer has been initiated, ARV will:

1. Initiate a teleconference between ARV Medical Coordinator and the receiving clinical unit and the referrer, where appropriate
2. Coordinate the logistics of patient transfer
3. Document the decision to enact a defined transfer and the reasons why the decision was made.

Review of defined transfers

All defined transfer decisions will be collated by the ARV Case Review process, categorised and referred to the State Trauma Committee, Critical Care Clinical Network or Emergency Care Clinical Network. Formal reports detailing the incidence and analysis of defined transfers will be provided to the department by the State Trauma Committee, Critical Care Clinical Network or Emergency Care Clinical Network on a quarterly basis, or as required. ARV will also refer any issues arising with the referral and/or receipt of defined transfers by health services to the department.

ARV contact details

24 Hour Statewide contact number:	1300 368 661
Website:	www.ambulance.vic.gov.au
Email:	arv.admin@ambulance.vic.gov.au

Further information

For further information please contact:

Manager, Admitted Care Policy
Health and Wellbeing Division
Department of Health and Human Services

Telephone: 03 9096 1233

Website: Critical care transfers

Email: emergencyandtrauma@health.vic.gov.au

To receive this publication in an accessible format phone 1300 650 172 using the National Relay Service 13 36 77 if required, or email emergencyandtrauma@dhhs.vic.gov.au.

Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

ADULT RETRIEVAL VICTORIA

Adult Retrieval Victoria (ARV) is part of Ambulance Victoria and provides:

- Statewide critical care clinical advice, via phone or telehealth.
- Critical care transfers
- Major trauma advice and care coordination.
- Bed coordination via REACH.

Clinicians can request advice and/or retrieval by contacting a dedicated senior retrieval consultant at ARV on the statewide 24 hour phone line
1300 36 86 61

EARLY RETRIEVAL ACTIVATION

For all critical care transfers consider early activation

Why?

- Early retrieval activation ensures access to critical care advice and more effective retrieval response.
- Early activation and timely critical care transfer improves clinical outcomes.

Who?

- Patients likely to need transfer for critical care.
- Referral may precede availability of test results or investigations.
- For example:
  - Major trauma.
  - Intubated patients (requiring respiratory support).
  - Circulatory failure.
  - Severe sepsis.
  - Complex multisystem disorders with clinical instability.
  - Specialised critical care need.

How?

- PHONE - for immediate advice or referral escalate the local response team or system immediately and call 1300 36 86 61.
- INTERNET - streamline your referral and reduce your initial call time by utilising the ARV e-Referral form. Available via REACH - https://reach.vic.gov.au or via the QR code below.

1300 36 86 61
Statewide 24 hours

Ambulance Victoria

ARV
Adult Retrieval Victoria

Ambulance Victoria acknowledges the Traditional Owners of the lands in Victoria. We pay our respects to Aboriginal and Torres Strait Islander cultures and to Elders past and present and recognise that Aboriginal self-determination is a human right. We commit to working with our Aboriginal communities to improve our care and services in the spirit of partnership.

AmbulanceVictoria

Timely Emergency Care 2 Improvement Program

Insights Report

November 2024

AT AMBULANCE VICTORIA WE #CARE

Care Accountability Respect Excellence

FOREWORD

Thank you to everyone who contributed their time and participated in interviews, focus groups, and the survey to inform this insights report. The Timely Emergency Care 2 (TEC2) program aims to develop, scale and test workforce-driven solutions to improve timely access to patient care, and create a safer, more satisfying workplace.

We are tackling system challenges, and so much work is already being done to improve AV systems and processes towards our strategic vision of a world-leading ambulance service. Not all areas of opportunity identified during engagements are within AV's control, where we see broader opportunities we will seek to engage with system partners.

Our operational workforce at the point of care will often have the greatest direct impact on a patient's experience. However, as an organisation, operational and non-operational staff collectively shape the quality and safety of a patient's experience; it takes a village.

Over the coming months, there will be opportunities to be actively involved, using improvement methods and tools with subject matter knowledge to develop, test, implement, spread, and scale up changes that lead to improvement.

I look forward to your involvement as we strive to enhance timely access to emergency ambulance care in our community and work to alleviate workforce fatigue and burnout.

Michael Georgiou

Regional Director
TEC2 Sponsor

These fieldworks insights will be used to inform the next stage of the AV Timely Emergency Care 2 project.

There will be a range of opportunities for people to remain engaged and contribute to this work.

For further information, see the TEC2 One AV page or contact: TECC@ambulance.vic.gov.au

Engagement identified four emerging insights

	1. Ensuring the clinical condition of the patient is matched with the appropriate type of resources at the time of dispatch	2. Best Care is connecting patients with the care that best suits their needs	3. When crews are at hospital waiting to handover patients, they are not in the community responding to calls	4. There are broader system barriers that are impacting on crew availability
Key Challenges	**Ensuring appropriate resource allocation. Too many non-urgent cases receiving an emergency response**	**Paramedics may opt to transport due to not feeling confident or supported in their decision-making – as well as barriers accessing suitable alternatives**	**A lack of capacity within hospitals, and inconsistent models for responding to ambulance arrivals, are having flow on impacts for ambulance availability**	**Resourcing and rostering challenges and outdated technology are impacting availability at key points of the day**
Emerging Opportunities	• Development of outcome-based performance standards to **improve understanding of patient urgency** • Increase **clinician oversight** to support **decision-making and resource allocation** • **Telehealth** should be used at point of call to better assess presentations • **Secondary triage** could be **better utilised** for low acuity cases • **Reforming** 'doctor requests' would help to **avoid unnecessary Code 1 dispatches**	• Additional clinical guidance and targeted training could help paramedics to **'treat not transport'** • An organisational acceptance of risk may **empower staff to leave patients at home** without fear of consequences if a patient deteriorates • Better knowledge of **alternate pathways** and refined models would provide an even better **safety net** to leave patients at home • Simplification of documentation for patients not requiring transport could **streamline processes**	• **AV offload models** are necessary to free up crews to respond to emergencies in the community – however they do not address the barriers to patient flow • **Senior AV staff** in **hospital-liaison roles** help to manage issues at peak periods • Improvements to the **arrivals board** would **inform decisions** about transport • The Department of Health needs to set **clear expectations** on ambulance handovers to **improve accountability** • Some **hospitals** are leading the way on timely offload. These **models should be replicated**	• Electronic **information sharing** and a mobile way to complete **patient records** would reduce administrative burden • Improved **workforce morale** and a focus on accountability would assist with **timely clearing** • **Rostering changes** would help to better manage meal breaks and **end of shift issues**

Engagement Approach

Engagement was conducted across the system to listen and understand current challenges and opportunities to improve

50 interviews were held in person in regional and metropolitan areas, and 105 online surveys were received from a range of frontline staff

Interviews with Paramedics	Interviews at communications centres	Surveys
35 interviews **10** sites	**15** staff **3** locations	**105** completed
On-ramp interviews at seven sites: • Ballarat Base Hospital • Footscray Hospital • Geelong Hospital • Maroondah Hospital • Monash Hospital • Northern Hospital Epping • Sunshine Hospital **Interviews at three major branches:** • Belmont Branch • Northwest Super Response Centre • South Super Response Centre	**Interviews with staff at:** • Ambulance Victoria Secondary Triage service • Ballarat State Emergency Communications Centre • Resourcing Hub (Tally Ho)	**Survey respondents included:** • On-road paramedics • MICA paramedics • Operational managers • Regional directors • Team leaders • Communications and resource centre staff • Other clinical and non-clinical staff
Respondents included ALS, MICA paramedics, and MATS crews ✓	**Respondents included resourcing staff and secondary triage clinicians** ✓	**Respondents ranged from frontline to non-clinical staff** ✓

Interviews were co-led by DH and AV and focussed on challenge, opportunities & what is working well

AV TEC2 interview questions

1. What is your role?
2. What does high-quality, timely emergency care look like to you?
3. What challenges most impact AV's ability to provide timely emergency care?
4. Is there anything that is currently working well to address these challenges?
5. What ideas do you have that could make the biggest difference to improve AV's provision of high-quality, timely emergency care?
6. Are you interested in being involved in future improvement activities related to this project?

The online survey was conducted in October 2024 to reach a breadth of voices across the organisation

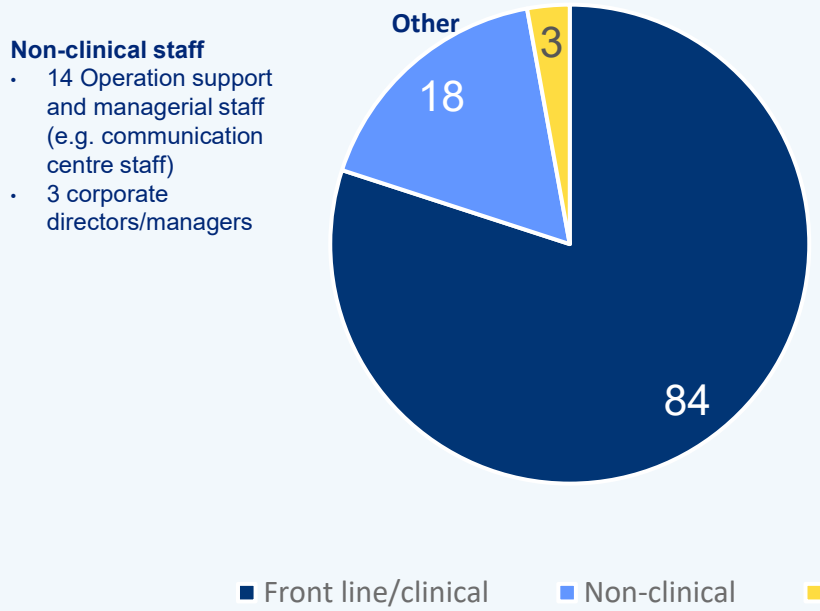
- **105** Survey responses received

- **90** Surveys completed online
- **15** Surveys completed face-to-face

- Wide range of clinical and non-clinical respondents
- **80%** of respondents were frontline clinical staff

- Extensive and thoughtful feedback received, with people taking on average **30 minutes** to complete the Survey.

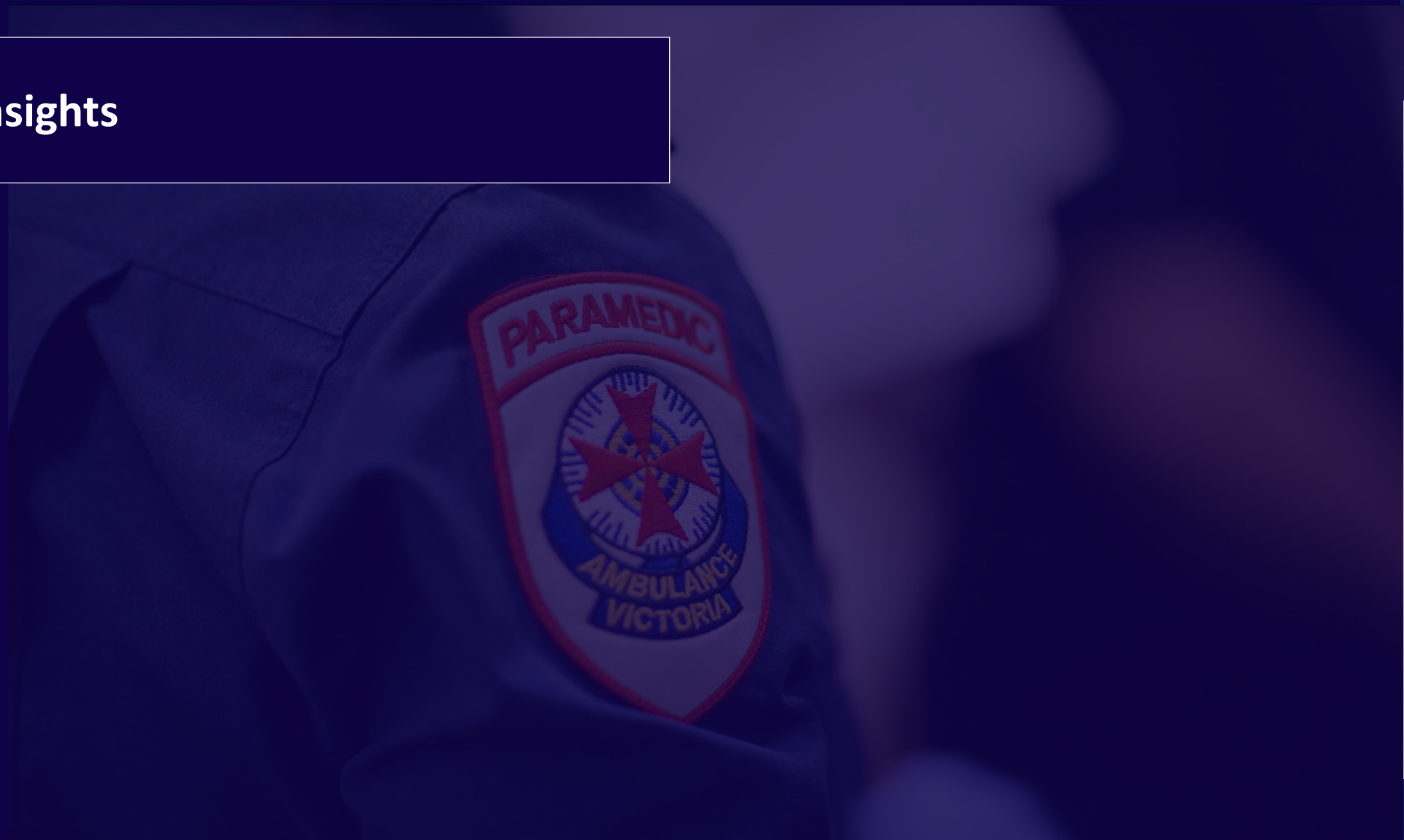
Graph 1. Proportion of survey respondents by role



Non-clinical staff
- 14 Operation support and managerial staff (e.g. communication centre staff)
- 3 corporate directors/managers

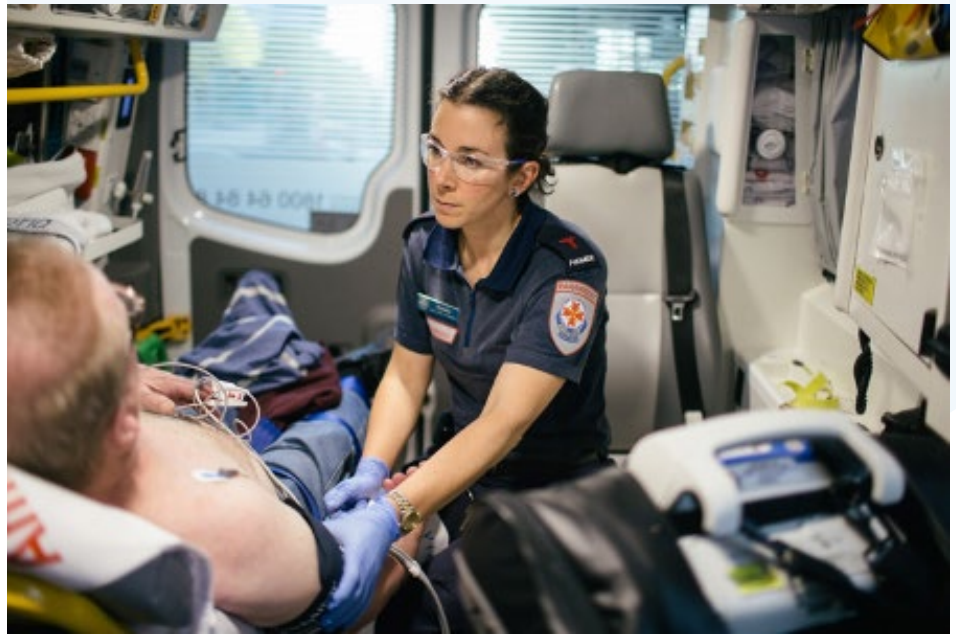
Front-line/Clinical staff
- 55 on-road or air ambulance clinical staff
- 20 MICA paramedics or trainees
- 3 first responders
- 1 ambulance community officer
- 2 community support officers
- 3 other health professionals/clinical staff

Key Insights



What does high quality Emergency care look like?

Respondents provided a **vision** of what high-quality emergency care **looks like…**



Appropriate: *the right resources, right cases, right patients, right advice, right responses, right skillset, accurate triage, accurate dispatch*

Timely: *expedient, efficient, responsive, prompt, right/quick/clinically appropriate timeframe*

Outcomes-driven: *patient centred, best possible care, right clinical decisions for patients*

Value-based: *respectful, supportive, communication, calm, responsive, patient-centred, patient-focused and targeted care*

Insight one: Ensuring the clinical condition of the patient is matched with the appropriate type of resources at the time of dispatch

Effective call taking and dispatch ensures emergency ambulances are available for patients with higher acuity needs

What are the key challenges?

Call taking doesn't **always identify the true clinical condition** of the patient	**30-second call targets** do not provide sufficient time to understand patient need. An **inflexible call script,** use of **leading questions** and a lack of **clinical input** are leading to inappropriate dispatch *"Dispatching should be facilitated by health care professionals [with] more targeted questions than the arbitrary….are you short of breath?" - On-road paramedic* *"[There is] a lack of clinical oversight to the dispatched cases, as clinicians are … only able to review those deemed sickest." – On-road paramedic* Symptoms like **chest pain and shortness of breath** can trigger a Code 1 response when not required *"…There are plenty of examples such as someone calling for stubbing their toe but reporting difficulty breathing [due to pain] being dispatched as a code 1." – On road paramedic*
Often N**on-urgent cases are receiving an emergency response**	MICA is not always being used to respond to the **most critically unwell patients** *"[There are] significant instances of MICA unavailability for critically unwell patients, or MICA resources being dispatched to code one cases not requiring emergency interventions." – On road paramedic* There are concerns about **multiple resources for low acuity cases** and the timeliness of **Code 2 responses** *"Over triaging cases..[is] tying up multiple resources responding to one case…" – On road paramedic* *"Inappropriate coding.. affect[s] patients with lower coding that still require urgent intervention." – MICA* Care plans are helping alleviate pressure, but more can be done to minimise the **impact of frequent callers** *"Frequent flyers…divert resources away from more critical cases." – On road paramedic*

What good practice or emerging opportunities were identified?

Ensuring patients receive an appropriate response at the **point of call** is key to achieving optimal patient outcomes	**Increase clinician oversight to support decision-making and resource allocation**. Several models were recommended. *"Having a paramedic review jobs as they come in and giving them the power to upgrade/downgrade would allow us to attend patients that actually need us." – On-road paramedic* **Telehealth should be used at point of call** to better assess presentations *"Lack of video triage means things that could easily be verified …have to be taken at the word of the caller.. This could aid more appropriate dispatch." – On-road paramedic* More **targeted use of MICA resources** would better meet community needs *"MICA need to be saved for 0's and crew request only, not dispatched to code 1 and 2." – First responder*
Employing technology to **divert low acuity cases** at point of call	Equipping staff to decline sending an ambulance, using video technology to aid in decision-making and **enhanced VVED** referrals would avoid unnecessary dispatch *"VVED works well but [this] could be done by triage services at the time of call.." – On road paramedic*

> *[The biggest challenge is] MICA being tied up with low [acuity] cases due to being the "closest" car and not being available to attend cases in which our skills are required.* ***– MICA paramedic or trainee***

> *The dispatch grid is risk averse to the point it paradoxically generates risk.*
> ***– MICA paramedic or trainee***

67%
of survey respondents identified appropriate resource allocation as a major challenge

Note: Major reforms to call taking and dispatch would need to be progressed in partnership with Triple Zero Victoria

Insight two: *Best Care* is connecting patients with the care that best suits their needs

Optimising alternate pathways and supporting care being provided in place, virtually and outside an emergency departments would reduce avoidable hospital transports

What are the key challenges?

Lack of support and clear pathways result in missed opportunities for leaving patients safe in place

A **lack of clarity** on when to 'treat not transport' and **confusion about the right pathways** impacts infield referral

> *"Paramedics are not empowered or provided with the right skills to confidently refer patients away from ED…the easy approach is to transport these patients for a "checkup" at hospital." – On-road paramedic*

A **fear of repercussions** if a patient deteriorates can result in unnecessary transport

> *"Often patients not requiring transport have the more thorough and comprehensive assessment for clearly benign issues, but paramedics a petrified of adverse outcomes." – On road paramedic*

It can be **difficult to push back** on patients who do not want to access an alternative service

> *"On occasion after advice from AV and VVED [patients] still request transport and there is no legal framework to support non-transport. So, transport is undertaken." – On road paramedic*

There are barriers impacting the **effectiveness and utilisation of alternate care pathways**

Wait times mean some paramedics will only use VVED if they are certain the patient will not require transport

> *"VVED is empowering ambulance crews to leave greater number of patients at home... However, the process can be long, [and] the risk adversity of the doctor can affect outcomes. With more...testing VVED could be even more effective." – MICA trainee or CSP*

Priority Primary Care Centres (PPCCs) are a good alternative, but **inconsistent entry criteria and the absence of services** such as onsite radiology and pathology are limiting their uptake

> *"It is great to have other options …including VVED and PPCCs, [but] this does not always work well. In the area I work the PPCC often refuses or refers [patients] with chronic illnesses to ED." – On road paramedic*

What good practice or emerging opportunities were identified?

The VVED is providing a safety net to leave patients at home. It could be enhanced to divert more low acuity patients in-field

A **standardised approach to referring suitable patients to the VVED** could enhance its utilisation in-field

> *"Utilisation of more in-depth guidelines which better checklist patient presentations and highlight extra assessments and history taking could improve VVED utilisation." – On road paramedic*

Information on 'success stories' could **help to build confidence** in the VVED

> *"I strongly recommend 'case reviews'…that demonstrate just how effective VVED can be. Cases where many paramedics may otherwise think that VVED would not have been appropriate." – On road paramedic*

Targeted training and support would help build confidence to 'treat not transport' and address protracted scene times

Enhanced **clinical guidelines could support accurate assessments,** while upskilling paramedics in having '**difficult' conversations and a culture that supports clinical decision-making** could avoid unnecessary transport

> *"Non-transport …could be improved with robust checklists inbuilt to the CPG app." – On road paramedic*

> *"[We need to be] … empowered to direct the patient away from ED without being forced to transport just because this is what the patient elects to do" – MICA paramedic*

> *"[We need] CPD days around safety netting and identifying patients who don't require transport... Paramedics need to hear this information from high up clinical managers…" – On road paramedic*

> *In regional areas there is often nowhere else to physically take patients who require something that VVED can't provide via video link. E.g. X-rays, bloods, stitches, casts.*
> ***– On road paramedic***

> *[We need to] … increase paramedic skillsets [in] patient assessment to enable more patients to be referred/ followed up with alternative service providers.*
> ***– MICA paramedic***

23%

of survey respondents noted positive changes arising from the increasing availability of alternate pathways including the VVED.

Insight three: When crews are at hospital waiting to handover patients, they are not in the community responding to calls.

Timely handover at hospitals – and getting patients to the right place at the right time – gets paramedics back on the road swifty to attend the next time-critical emergency case

What are the key challenges?

Paramedics experience long delays in handing over patient care – causing frustration and impacting ambulance availability

While poor patient flow is a driving factor, inconsistent **triage processes** and criteria for **offloading to the waiting room,** delays at **shift change,** and a lack of urgency to **assume patient care** are all impacting timely handover

"Everyone has become comfortable leaving patients on the stretcher." – On road paramedic

"Fit to sit…is a streamlined way to reduce unnecessary AV ramping. A barrier to this… is each health service tend to apply it differently and often lack consistency within the same facility. – MICA paramedic

The **clumping of ambulance arrivals** is contributing to handover delays

The ambulance arrivals board is not always accurate, limiting its usefulness. This was attributed to technology challenges and poor crew compliance. Paramedics will travel further if they think it will enable more timely care.

"There is minimal operational intelligence to distribute patients appropriately across the health network." – On road paramedic

Crews are not always well placed to **manage this situation by liaising with hospital staff**

"[Crews] are not empowered or confident to have an informed conversation with the hospital [who have control over offload]. So, [they] say very little and are ramped…for many hours" – On road paramedic

What good practice or emerging opportunities were identified?

Clear expectations are needed to improve consistency at the ED/ambulance interface

Revised safe to wait (fit to sit) policies and greater accountability for implementation is a priority

"Paramedics need a greater say on determining patients who are fit to sit. This should be made clearer in AV policy and hospitals should be given notice to this effect." – MICA paramedic

Clearer statewide policies around timely handover would help **promote consistent practice**

"[This] should be a policy of the Department of Health which is applicable at all hospitals in Victoria. Too often we deal with AV policy vs Hospital policy, and they do not align…" – On road paramedic

Enhanced AV offload models and escalation processes would help to get crews back on the road

One crew to multiple patients on the ramp should be routine practice. Other offload models (e.g. single responders monitoring patients on ramp), would also get crews on the road quickly

"We need to take immediate steps…by training paramedics to manage patient in situ at the ED while simultaneously returning crews to the road to respond." - Other health professional and/or clinical staff

"Bring back HALOs and dedicated APOT crews/areas as done during the pandemic." – on road paramedic

Strong relationships help to manage issues at the AV/ED interface. Having **infield managers proactively work with hospital staff** and manage crews at peak periods supports timely care. HALOs worked well during COVID.

"AV could assign a senior manager to each of the hospitals...who is responsible for prolonged off stretcher times." – on road paramedic

This must be backed up by efforts to better distribute arrivals, so patients are **going to the right place, first time**

"Software [should] be introduced which takes into account ED and Hospital capacities and provides real-time information for destination selection…" – On road paramedic

> *I want to be in the community serving people who need me with the skills that I've been trained with…not stuck at hospital.* ***– On road paramedic***

> *If paramedics can leave the ED in a timely manner, we will be able to get the right resource to the patient and time on scene will be less of an issue.* ***– Operation support***

92%

of survey respondents cited time at hospitals waiting to handover patient care as a primary challenge.

Insight four: There are broader system barriers that are impacting on crew availability

Resourcing and process improvements could help to maximise efficiency, enhance wellbeing and improve paramedic availability at key points of the day

What are the key challenges?

Resourcing challenges are creating flow on impacts for crew availability	**Difficulties filling night shifts** can reduce fleet availability and lead to crews traveling long distances to respond to call outs – impacting timely care and increasing the risk of overtime. Issues are amplified in regional areas. For some, the prospect of **working as a single responder overnight** can lead to staff calling in sick. *"After 2am staff numbers are thin …"– Operation support* The **management of meal breaks** could be improved to enhance crew availability at key periods *Staff noted that rostering issues result in paramedics taking meal breaks at the same time, often during peak demand periods. Crews taking meal breaks at their home branch can also make them unavailable for potentially long periods if they have travelled far*
Paramedics have a **lack of understanding and accountability** around expectations for clearing in a timely fashion.	Patient records are not always being **completed in a timely way. Outdated technology** is a contributing factor *"Crews are waiting sometimes hours until [patient] is offloaded before starting [or] completing VACIS / paperwork, extending clear times" – role not specified* *"PCRs should only take 20 minutes or so, not the hour or more currently in practice." – On road paramedic* *"[Crews] spend an hour …using an archaic computer program (VACIS 3) to enter in the patient's information"– On road paramedic* Crews may **protract handover processes or avoid clearing from cases to avoid dispatch** near end of shift. Some crews use their meal break at end of shift to ensure they finish on time *"Post COVID there is an apparent lack of motivation ..to complete paperwork in a timely fashion and clear quickly...I would say the main [contributing] factor is end of shift management" – On road paramedic*

What good practice or emerging opportunities were identified?

Improved technology and accurate data reporting could help to reduce clear times	A **mobile way to complete patient records and handover to hospitals** would streamline processes and enable crews to finalise paperwork on the road. This needs to be supported by **improved accountability** for clearing *"Having crews clearing hospital is clearly a challenge for managers to enforce."– On road paramedic* *"Scene and clearing time KPIs must be reported on a individual level to re-introduce some amount of personal responsibility and discipline" – role not specified*
More flexible rostering could help to address resourcing challenges and staff fatigue	**Shorter night shifts** and staggered start and end times would enable better back up for crews when approaching end of shift, and help to minimise instances where staff take meal breaks at the same time **Gradual signals are being introduced to help** mitigate the risk that crews get dispatched near end of shift. Incentives to work nights and weekends could also help to address challenges

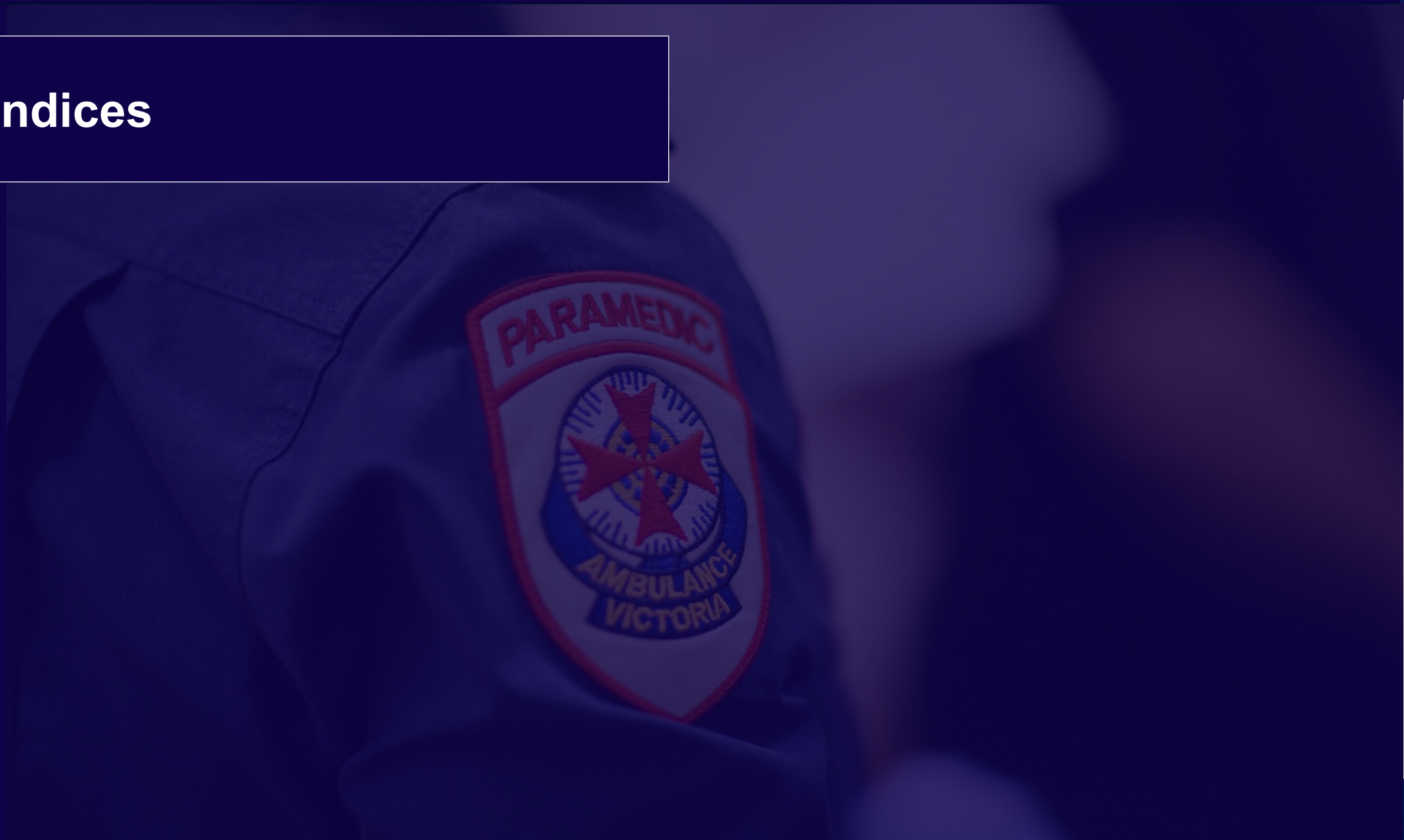
> *[The greatest opportunity is to] improve morale. Currently paramedics have little enthusiasm for clearing and becoming available. It's not uncommon to see paramedics lingering at hospital.* ***– On road paramedic***

> *AV rostering needs to change with staggered shifts. Having an entire service change shift at the same time leads to chaos at change over and crews working overtime.*
> ***– Operation support and managerial staff member***

36%

of survey respondents identified returning paramedics to the road quickly following patient offload as a challenge.

Appendices



Additional challenges raised in consultations

What are the key challenges?	
Providing the right resources to the patient before dispatch	
Demand for emergency ambulance services from **lower acuity patients** is high	There is a **lack of public awareness** about when to call Triple Zero and **unrealistic expectations** to be seen quicky in the emergency department when arriving by ambulance *"[We need] education to the public about what constitutes an emergency." – on road paramedic* *"People feel entitled to a free trip to the hospital. We are not an uber service" - On road paramedic* **Many patients are not acutely unwell**, but struggle to access care in community due to cost, gaps in service delivery or a lack of awareness about alternatives. *"[Ambulance] is always the easy option… People should be initiating access to primary care themselves" – On road paramedic* *"[Paramedics] are picking up the slack for primary care, and hospital care, and community mental health care who all fall back on us when their systems aren't working..." – On road paramedic* *"Lack of education amongst the public about alternative pathways causes significant delays on scene" – first responder*
Inappropriate referrals and a poor availability of alternate resources from other providers are contributing to demand	Health care providers, such as GPs, often request a **lights and sirens response** when this is not clinically necessary. This impacts on emergency ambulance availability *"[We need] Greater emphasis on training of …other healthcare providers (particularly GPs) on which situations require an ambulance and which patients are able to self-present to hospital." – first responder* *"There are certain facilities that will default to 000 call and transport recommendation for all patients and on enquiry they know VVED exists but do not have time to complete this process" - On road paramedic* Inappropriate requests, such as for **verification of death**, are also driving demand. This is particularly an issue overnight when suitable providers (e.g. palliative care) are not available *"We are now a 24/7 bridging services as every other health service is only available business hours." – On road paramedic* Ambulances are being used for **non-emergency patient transport (NEPT) overflow** *"..we commonly attend non emergency cases such as transporting of patients to their weekly dialysis appointments due to lack of non emergency resources." - MICA paramedic or trainee*

What are the key challenges?	
Supporting patients not requiring transport	
VVED cannot divert demand at **all times of day**	**A lack of 24-hour chemists** presents challenges with leaving people at home overnight.
Knowledge and capability gaps can impact responses on scene	**Some crews feel they do not have the skills to respond to mental health call outs.** When transport is required, this can be challenging for staff, particularly when it involves restraint. The level of information collected during call taking can mean **paramedics are not well prepared** if a patient's condition is significantly different to what was captured at point of call
The **right crews** need to support diversion	**MICA crews** should not be assisting people to access the VVED *"Having a MICA paramedic go through the relatively lengthy process of planning and implementing alternative care pathways with the input of VVED or other providers is not an appropriate use of scarce intensive care resources." - On road paramedic*
Timely handover of patient care at hospitals	
Handover performance is **hospital (and sometimes shift) dependent**	**Less experienced triage staff** are less likely to move someone to the waiting room *"Once at hospital… junior staff also do not want to make a risky decision so the easy thing to do is to keep all the patients ramped." - On road paramedic* **Responsiveness to high acuity cases** could be improved in some cases *"Crews [are] pre notifying hospitals, yet hospitals [are] not acting to then escalate care as appropriate. E.g., not sending patients straight to CT for a pre notified stroke" - On road paramedic* **Gaps in services overnight** can create blockages *"If there is no discharging, surgery, pharmacy, physiotherapy or radiology after hours, how are we supposed to move people through the ED's?" – MICA paramedic*
System barriers impacting on crew availability	
Inefficient interhospital patient transfers impact ambulance availability	Transfers can be **arranged prematurely** (e.g. before diagnostic testing completed, when there are no beds available). Requests can also be **poorly timed** – such as for non-urgent transfers overnight. This can be problematic as there is less coverage if crews get ramped at hospital. *"A low acuity transfer to Melbourne is a minimum 4hr turnaround, adding in…ramping and this can easily [be] a full shift.." – Corporate Director/Manager*

Additional opportunities raised in consultations

What good practice or emerging opportunities were identified?	
Providing the right resources to the patient before dispatch	
Awareness raising and process improvements could help alleviate pressure and re-set expectations	A public education campaign could **strengthen awareness of alternatives** and clarify that an ambulance will not be dispatched if it's not required *"The VVED has been a gamechanger… I can't believe how many people don't know about it. It's out there but people just don't know about it." – On road paramedic* *"There should be a tick box in the ePCR to indicate an individual needs education surrounding the appropriate use of emergency ambulances" – On road paramedic* **Increased communication on wait times** could also help to manage patient expectations **Reforming 'doctor requests'** would avoid unnecessary Code 1 dispatches
Process & system improvements could **enhance secondary triage operations**	Ceasing the **default upgrading of Code 2 patients** if they cannot be reached within an hour and **technology/process changes to increase call answer rates** (e.g. changing from an outbound system, enabling calls to come up as 'triple zero') were suggested for exploration **Proactive virtual follow-up with Code 2 patients** experiencing a long wait could mitigate risk The **aged care pathway to VVED** is helping to alleviate demand. More Code 2 and 3 cases could be diverted to this service by secondary triage clinicians Rather than sending an ambulance, triage clinicians could contact patients to check suitable alternatives **when NEPT is at capacity** (delay care, referral to VVED, personal transport used)
Supporting patients not requiring transport	
Several ideas were raised to **reduce time spent on scene** and unnecessary patient transport	**Reduced documentation for patients not requiring transport** could streamline processes **Access to a brief secondary consult with an AV clinical** could be explored as a rapid alternative to VVED in peak periods when there is a critical need to get crews back on the road 'One up' crews could be used strategically to divert low acuity cases from hospital, noting that it can be easier to leave patients at home when **responding in a single responder vehicle**. *"A fleet of SRU responders [could] attend…Code 2/3 jobs where either non-emergency transport or other transport means could be used" – Corporate director/manager* **Broader enhancements to the VVED** could be explored to reduce time on scene *"A system for us to put in... patient history and the [outcome of assessments] for rapid access by VVED clinicians could improve this process." – On road paramedic* Improved processes to manage **transport to and from Urgent Care Centres** – e.g. a mandatory review by VVED of all patient requests seeking transport to a hospital ED Access to **greater patient information** for crews to review in transit to assist with downgrading

What good practice or emerging opportunities were identified?	
There are other **supports that could help crews in-field**	**TelePROMPT is an effective service to divert patients with mental ill health** from hospital, and connect them in with more appropriate supports New care pathways for patients with **complex social needs** could be explored. This could be a referral option at point of call, but would also support crews in-field **Greater patient information** could inform clinical decision-making for repeat presentations *"Every time we attend a patient it's like a first presentation… Access[ing] case sheets.. for patients who AV have previously attended [would help]" – On-road paramedic*
Timely handover of patient care at hospitals	
Some hospitals are leading the way on timely offload. These models should be replicated	Activities such as utilising all **ED spaces, early clinical review, use of roaming nurses, and the ability to 'flex up'** and change approach in periods of high demand work well *"The Northern… flex with ease between front triage and AV and are geared to continually pull patients from the waiting room for investigations, assessment and meds whilst they wait. Triage assessments are consistent, rapid, safe and geared towards offloading AV patients quickly."– On-road paramedic* **Senior accountability for ambulance offload i**s key. Regular engagement between senior AV managers and hospital staff **(e.g. monthly liaison meetings)** helps to support problem solving
Other ideas were shared to **reduce time in transit and at hospitals**	Replacing batteries in ageing **Emergency Lifting Cushions** would avoid transport delays **Mandatory offload** to the waiting room (for suitable patients) after a certain time period, and/or **hospital-led models of rapid offload** could be explored *"Employ some of the surplus graduate paramedics… to work in EDs to care for overflow…. This has to be owned by the ED" – MICA paramedic*
System barriers impacting on crew availability	
Resourcing, practice and process changes could help to maximise fleet availability	Better oversight, clear guidelines and more consistent use of direct to ward transfers would help to avoid **inappropriate interhospital patient transfers** and avoid ramping **Medium Acuity Transport Services** crews could be better used as part of resource escalation The scope of practice for ARUs could be increased (e.g. to administer medications such as Heparin) to **provide a stop gap prior to the arrival of intensive care backup** **Greater upskilling for junior paramedics**, and support for experienced crews to aid retention More **specialised units** (e.g. falls ambulance, nursing home response units) could be explored