From: [redacted]
To: transferofcare
Subject: Ramping Inquiry
Date: Monday, 9 October 2023 4:39:28 AM

Hello,

My name is [redacted] and I'm currently employed by Ambulance Tasmania as a paramedic. I thought I would take the time to share with you my experiences of ramping and some of the fundamental issues relating to it which the vast majority of people do not understand or realise. For obvious reasons I would appreciate it if you kept my personal details confidential however you are most welcome to use the details of this email as you see fit.

Firstly, I'll just give some context regarding ramping to ensure adequate understanding of the issue on your part. When we bring our patients to the RHH emergency department, if there aren't any available bed spaces/cubicles, and the patient is deemed too sick or inappropriate to be placed into the waiting room (which could be due to something as simple as poor mobility or someone who is unconscious due to being intoxicated with alcohol), the patient will be "ramped" and kept in the care of the paramedics. We will then proceed to take our patient up to the old Emergency Medical Unit where there are approximately 11 bed spaces. I would like to clarify here that this is an entire section of the emergency department which is not utilised by the hospital and instead serves to accommodate paramedics and their patients. Once we have taken our patients up to the ramp, we and our patient (s) are stuck there until the patient is eventually allocated a space within the ED. This could be 15 minutes or it could be as long as 8 hours (give or take). During this time, the doctors in the emergency department will still initiate treatment of the patient even though they are technically still under our care (e.g organising x-rays, CT scans, administering certain medications, doing assessments etc). In fact, sometimes patients will be treated and subsequently discharged from the ramp without ever technically being in the emergency department.

There are so many issues and risks associated with this process that it's genuinely hard to know where to begin, so I'll detail some in dot-point format:

- When patients are ramped with us, there is an expectation from the hospital staff that we will look after their every need which includes jobs that are completely out of our job description and training (e.g transferring patients around the emergency department in hospital beds, cleaning up after our patients if they make a mess, toileting the patients etc.). In fact, it's not just that there is an expectation to perform these duties, but there is often a necessity to do so. For example, if I am stuck with a patient on the ramp for several hours, and they are unable to walk or have poor mobility, and they suddenly need to use the toilet, that is now my problem to deal with. I would be well within my rights to call for a nurse to come and toilet the patient for us, but when the emergency department is busy (which is most of the time), the nurses seldom have the time to come and assist us as they are already overwhelmed by the demands of their job. It is also something that I, and I'm sure many of my colleagues, do not feel comfortable doing as it feels like passing the buck and has the potential to cause tension between us and the nurses. Furthermore, if there are multiple patients on the ramp, some of them will inevitably have to be neglected if we are required to toilet another. This poses risks to both patient safety and our own registrations as we are ultimately the ones responsible for their care while they are on the ramp. We are paramedics. We are trained to drive around in

ambulances and provide pre-hospital emergency care to patients. We are not orderlies. We are not ward aides. We are not nurses. Sadly, however, we are required to act as all 3 at times when we are on the ramp.

- Doctors will often try to commence treatment on ramped patients with medications that we are not permitted to give. Of course, in a lot of cases, this can be beneficial for the patient, however there are inherent risks associated with it to both the patient and ourselves. For example, a doctor might wish to commence antibiotic treatment on a ramped patient to treat sepsis as a delay in treatment could ultimately result in serious morbidity or even mortality. However, the administration of these antibiotics is not something which falls under our scope of practice as paramedics, and they can precipitate severe allergic reactions which could also result in serious morbidity/mortality. This presents a serious and unfair ethical dilemma to us whereby we are forced to make a decision which could potentially jeopardise the health outcome of our patient or our own registration and ultimately our career. One of my colleagues had this exact experience not long ago, and they refused to let the doctor commence treatment with antibiotics due to the associated risks. The nurse who was tasked with administering the antibiotics then told my colleague that if the patient deteriorated it would be their fault. It is completely unacceptable and wrong that we should ever be personally blamed for the failures of our healthcare system. In contrast, another one of my colleagues allowed a doctor to commence antibiotic treatment on their patient who was profoundly septic as they were concerned about their risk of deteriorating. This patient ended up having an anaphylactic reaction to the antibiotics and, in spite of this, they still remained on the ramp. Patients with life-threatening illnesses who present to the emergency department should never be ramped in the first place, and the fact that our hospital often lacks the resources to provide the necessary care to such patients is a truly damning indictment of our healthcare system as a whole.

- Ramping causes unnecessary conflict and tension between ambulance and emergency department staff. Although I believe it is unreasonable for emergency department staff to direct their frustrations of the healthcare system towards us directly, I can understand how it occurs. When we are ramped, we are occupying space in their work environment, and at times utilising their resources. During busy periods there could be upwards of 10 paramedic crews and patients occupying the hallways and ramping area of the emergency department. The ED staff are almost always busy and struggling to keep up with the workload, without having to worry about being held up in the hallway because there are paramedics in the way transferring their patient from an ambulance stretcher to a hospital bed for example. On one occasion I went to retrieve a wheelchair for my patient who couldn't ambulate very well as the treating doctor was happy to transfer them from the ramp to the waiting room. This was a particularly busy day in the hospital, and I couldn't find a wheelchair around the emergency department. I eventually located one in the room where the orderlies reside, and as I went to retrieve it an orderly got up out of their chair and confronted me about taking the wheelchair. They questioned me as to why my patient needed the wheelchair and said, in quite a hostile manner, that they wanted to keep the wheelchair where it was in case they needed it in future. I explained to the orderly that my patient couldn't walk very well, and that I needed the chair to assist them into the waiting room. I could have reminded the orderly in that moment that I was actually doing their job for them and, if anything, they

should be thanking me, but I decided against it as I felt it would be a pointless exercise. Once I returned to the ramp to assist my patient I turned around and realised the orderly had actually followed me back to the ramp, presumably to confirm that my patient's condition did in fact warrant a wheelchair and that I was being genuine. This is just one example of many instances where I have been made to feel by other staff in the emergency department like we are simply a hindrance to them.

- We are isolated on the ramp. Because the Emergency Medical Unit is a separate area to the ED, if we have an emergency we are often on our own. On one occasion I was looking after 3 patients on the ramp, one of whom was a young, ill-tempered and hostile man in their 20s with a criminal history who was ostensibly drug-seeking. The paramedics that brought him in had in fact given him some morphine as he was complaining of chest pain, despite the fact that he had been investigated through cardiology already with all findings demonstrating there were no cardiac issues whatsoever. The triage nurse had indicated that once a blood test/ECG had been conducted on the ramp and signed off by the treating doctor, he could potentially be offloaded from the ramp and into the waiting room. I had hoped that because he had been recently given pain-relief, he would be content until the ECG/blood-test had been performed. Unfortunately, as is often the case, the emergency department was very busy and nobody came to complete the tests, and I was unable to as I was monitoring my other 2 patients. Half an hour or so passed and this patient became disgruntled and started to demand more pain relief from me. I told him I wasn't able to give him any but assured him I would call for a nurse to come up, which I did. Another 10 minutes or so passed, and still no one came. The patient then started to become verbally abusive, shouting and swearing that he was in pain and needed more pain-relief. He then started to call the Emergency Department phone number and verbally abused the ward clerks when they answered. I didn't actually realise this until one of the ward clerks called me on the internal phone on the ramp to inform me what had happened, and insinuated this was a problem they were expecting me to fix. I called a nurse again to explain what was happening and asked if someone could please come and do the blood test/ECG so that a doctor could sign off on them and we could get this patient off the ramp and into the waiting room. Still no one came. He was becoming more and more agitated and I was beginning to feel unsafe so I decided to leave the ramp to find the Clinical Coordinator and explain what was happening and that I needed help. This of course meant I had to neglect my other 2 patients and leave them unattended during that time which posed a risk to their safety and also my registration as, if anything adverse happened to them, I would have been held responsible. Unfortunately, in that moment, I felt I had no other choice. The Clinical Coordinator then assigned a nurse to return to the ramp with me to perform the blood test/ECG, and also administer a NSAID for additional pain relief. Once that was completed the nurse took the ECG/blood test results straight to the treating doctor and afterwards I was informed the patient could be offloaded into the waiting room. I approached the patient and explained to them what was happening, and that I would escort them to the waiting room. So once again, I had to temporarily neglect my other 2 patients while I escorted them out of the ramp and, while walking him out to the waiting room, he verbally abused me again as he felt he was being unfairly treated. Upon reflection of that experience, I can't help but think - what if he escalated even further and became physically aggressive towards me? No one would have been there to help.

- Ramping prevents ambulances from responding to people in the community when there already isn't enough ambulances to meet the demands of the public. Here are some pretty damning statistics to help contextualise the seriousness of this point:
    - The population of Hobart and its surrounding suburbs is approximately 250,000
    - On a night shift, assuming we are fully crewed, there will be 9 full paramedic crews available to respond in the greater Hobart area.
    - Therefore, on a night shift (assuming we are fully staffed), this equates to 1 paramedic crew per 27,000 people.

      However, we are very rarely fully staffed. This is largely due to staff fatigue/burnout, but once one or two people call in sick it causes a snowball effect whereby more people will call in sick as nobody wants to come to work when we are short-staffed. Therefore, it is not uncommon for us to be missing 2-3 crews on a night shift, and the ratio could be as high as 1 paramedic crew to 35,000-40,000 people. On one of my most recent night shifts we were down 2 crews and the region was extremely busy, as was the emergency department. Throughout the whole night every crew was either on a job, or they were ramped, and there was constantly around 10 ambulance jobs waiting at any given time. Now, imagine on a night like this, if you or somebody you loved had a medical emergency. Imagine calling 000 to request an ambulance and being informed that there was none available, and they weren't sure how long it would be until they could dispatch one to you. This is the reality that we are all living with, however, I don't believe many people realise it....

- Ramping is a gross misuse of Government money. Not only do paramedics cost more to employ than nurses, but in the last couple of years Ambulance Tasmania have also introduced a new model whereby staff can work on the ramp on overtime in an attempt to ameliorate the stress on the service. This means paramedics can work on the ramp and get paid 1.5x their substantive wage (approximately $80 an hour for a year 1 paramedic or around $120 an hour for managers). Therefore, an 8 hour shift on the ramp would see a manager earn nearly $1000 in overtime wages. This has, admittedly, been a relatively effective temporary solution to ramping, but is a fundamentally flawed concept and incurs a considerable financial burden on what is an already underfunded and under-resourced service. As an alternative to the current ramping model, the hospital could simply employ a few additional nurses in the ED specifically to look after ramped patients. This would not only be a more cost-effective solution but, for reasons I've already mentioned, would significantly improve Ambulance Tasmania's capacity to respond to patients in the community, and also improve the level of care provided to ramped patients as nurses are specifically trained to look after patients in a hospital setting, unlike us.

These are just some of my experiences and opinions regarding the issues related to ramping as it simply isn't possible to detail all of them in one email. I sincerely hope what I have shared might be of some assistance to you in the inquiry into ramping.

Regards,

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