Ramping enquiry submission – Ryan Posselt (Paramedic)

According to the Australasian College of Emergency Medicine Ambulance ramping/off-stretcher delays are caused by capacity problems within in-patient wards in the hospital. It is an indicator of systemic health care dysfunction. It reduces patient safety and increases the risk of adverse patient outcomes, including the death of patients in the ambulance and of patients in the community waiting for an ambulance.

This is an accurate statement that paramedics live with each and every day of their practice. Many paramedics will testify that the state of access block at the hospital not only places patient at risk of worse health outcomes but changes their practice, and is also is a very real stressor for paramedics conducting day to day duties.

When access block occurs, significant numbers of patients become "stuck" with paramedics. In recent years at The Royal Hobart Hospital, this arrangement has been formalised where Ambulance Tasmania has been allocated a physical ward with 12 beds. This is a fully functioning ward with a couple of exceptions; Paramedics are not authorised to administer the same level of care as the patient would receive in the hospital, and paramedics have been banned from using hospital equipment to fulfill their duties. At times paramedics have been on the receiving end of complaints just for using hospital stock to treat their patients. This means there is a risk that patients will not receive the same level of care they would otherwise receive in a timely manner. In my experience, this has resulted in unsatisfactory delays to:

- CT in the case of potential strokes

- Antibiotics in Sepsis

- Troponin levels in chest pain patients

- Pain relief in all patients

- Nerve blocks in neck of femur fracture patients

As an example, I recall a shift a few years ago where I arrived at work and was immediately dispatched to the Ramp to take over from night shift crews. On arrival, I was handed-over a patient with a confirmed neck of femur (hip) fracture. The patient was elderly, in their 80s and had fallen the day prior. They had received great care from the initial crew who attended the place of their fall, but on arrival at The Royal Hobart Hospital had been allocated to the ramp. In those days, paramedics were ramped in the main corridor of the emergency department. On bad days of access block, this created a chaotic environment, where patients were routinely forgotten about and received substandard of care.

It was not unusual to have patients deteriorate on the Ramp area, with seizures frequently occurring while patients were ramped as well as the occasional cardiac arrest. This still occurs today and rather problematically at the time, paramedics were not trained to operate hospital beds so had no idea how to use the CPR setting, resulting in delayed or ineffective CPR in the event of cardiac arrest. Furthermore, the treatment area was of inadequate space to perform a resuscitation.

In the case of the elderly patient with a hip fracture I arrived to find the patient lying in urine, and in severe pain. Using my personal connections to senior staff, I immediately escalated the situation. These patients have a very straightforward treatment pathway, and I understand since this time a formal pathway has been developed. They need referral to orthopaedics, a femoral nerve block and a catheter placed before they are admitted pending surgery.

In this instance however, the patient had been ramped for 17 hours. His care had been transferred between more than 10 paramedic crews in this time and this had directly led to undignified and substandard patient care with significant periods without pain relief. This case illustrates how ramping can effect even relatively routine patients in a negative manner. Technically, I shouldn't have allowed a nerve block to be placed while the patient was in my care because Ambulance Tasmania has taken the position that Paramedics should not accept care beyond their scope of practice. This is potentially the reason why the patient had not received adequate care since their arrival. We also know that continuity of care is important and effect patient outcomes. In this case, paramedics may have spent as little as 20 minutes responsible for the patient before handing over to yet another paramedic crew. Crews may well be responsible for 4 patients, so by the time they address more pressing patients, they have to hand over to another crew so they can respond on road, leading to outcomes such as this.

This example shows why The Australasian College for Emergency Medicine (ACEM) recommends that at least 80% of discharged patients should depart the ED within four hours. And why the National Emergency Access Target was introduced in 2012 with the aim of having 90% of patients seen and discharged by emergency Departments within 4 hours of presentation. Because when patients get stuck in the emergency department beyond 4 hours, it starts to effect up stream patient flow. It is not unusual to have multiple patients at any one time in the Emergency department at RHH beyond 24 hours.

Further increasing the risk of inattention from paramedics and consequential poor patient outcomes is an organisational expectation that paramedics will complete mandatory online training while they are ramped, partially because the organisation believes that paramedics are not doing much when they are ramped, and so its an opportune time to do training. This is completely false, it risks patient care and paramedic education as they are constantly interrupted and distracted while trying to complete online modules and often providing care below the standard they would like to deliver. There is no quarantined opportunity for paramedics to complete online mandatory education, and in an environment where crew utilisation is approaching 100% it is becoming less feasible to complete mandatory training while on station. Hence the move to expect it is done while ramped.

When patients are ramped at the hospital, and ambulance crews unable to transfer care the highest risk situation emerges where people in the community call 000 for an emergency and there are no ambulances to dispatch. In Tasmania, the practice is for dispatchers to read out where a priority 1 or priority 0 emergency is and where the responding ambulance is coming from. Multiple times a day, dispatchers are forced to read a priority response pending with no available response. On occasion, multiple priority jobs are read out over the radio all with no response. This places significant pressure on employees, be they paramedics or communication staff. It results in actual stress, as paramedis think "how can I help get to that sick person?" and dispatchers fret about how they will find a resource to meet the needs of the community.

I have responded to jobs as a single officer after I've already finished work because I can't imagine what it is like to be really sick, on your own and have no one coming. On numerous occasions I have also taken the step of calling the communications centre and asking permission to act as a triage officer, driving to uncovered patients, staying with them as required or down triaging them to allow for an ambulance to attend in a few hours. Ramping is also a significant contributor to unscheduled overtime. Paramedics will anecdotally report that 1-2 hours overtime at the end of a 12 hour shift is completely normal and an expected part of the day. This means paramedics are working 14 hours and beyond, and sometimes retuning the next day to do another 12-14 hour shift with a 9 or 10 hour break in between. In my view, this break is inadequate for the type of work paramedics do.

Emergency driving is an intense experience requiring significant cognitive load and concentration, when paramedics perform the most emergency driving of any emergency service, and they can cover 100s of kilometers under emergency conditions in a shift, a nine hour break is simply not enough to recharge in preparation for the next shift. I believe unscheduled overtime is a significant OH&S risk to the Ambulance Service and a major contributor to staff burnout. (Nationwide the average career as a paramedic is around 5 years.)

Access block and the resultant escalation in service pressures on-road also places pressure on paramedics to work faster and take more risk. It may be that paramedics conduct a less than thorough assessment to determine a patient doesn't need to go to hospital so they can get to an uncovered job. Although non-transport represents 15-20% of all ambulance presentations nation wide, adding time pressure on life changing decision making is likely to lead to errors and again places patients at risk. Again, some paramedics who feel stressed by the operational work load may take more risks when driving under emergency conditions because of a perceived heightened time pressure, increasing the risk of road accidents. I cannot speak on behalf of dispatchers and communications centre staff, but I can only assume they feel immense pressure when jobs keep coming in and they have no resources at their disposal.

Its not only true emergencies that suffer at as a result of access block and resulting service limitations. I recall a job I attended a few years ago. An elderly gentleman in a regional area north of Hobart had experienced decreasing ability to support himself at home alone, it was unclear if this was general decline or a medically precipitated decline in function. As I recall, concerned relatives called ambulance mid-morning, its was correctly categorised as a low priority call but because of service demands and access block, we did not get to the patient until around 3am the next day.

This scenario is patently unfair on the patient and their family.. One of the issues that arises here is the ambulance policy that does not allow call takers or communications centre staff to convey an expected time of arrival for the ambulance. Instead they simply say that the ambulance has been arranged and is on its way. This is clearly not the case in many situations and the lack of transparency of timeframes removes the patient and their relatives from making a pragmatic decision to seek alternative care or alternative transport to hospital. It is not unusual to attend patients within a 20 minute travel time of RHH who have waited beyond two hours for an ambulance. Many of whom could and would have made their own way to hospital had they been told the wait was beyond 1 hour.

Emerging from this narrative is the impression that our system and its communication tools are designed for a smooth and functional system. Another example of this, is the script that a patient should not eat until paramedics arrive. Now if we consider that statement in the context of the previous patient, an elderly gentleman, potentially malnourished, dehydrated and/or suffering an infection such as a urinary tract infection, we can see that withholding oral fluids actively makes the patient more unwell. This piece of script is designed for patients suffering a surgical emergency who require immediate surgery on arrival at hospital. Yet, the system is so dysfunctional, that many patients struggle to be triaged within 20 minutes of ambulance arrival, let alone offloaded, worked up, conveyed to theatres and anaesthetised. The only group of patients who truly benefit from this advice is E0 and E1 surgical patients, which I estimate represents less than 1% of all comers, and that group will likely receive their anaesthetic and operation regardless of their fasting state. This advice would not cause harm if the system was functioning as it should and ambulances dispatched in a timely manner. But we need to recognise the system is not functioning as it should and adjust the advice accordingly.

Not only do these narratives talk to a system designed when everything is working well, it also talks to a system where risk is not shared equally or appropriately.

A patient may be held as an impatient for an extra 24-48 hours because medical staff are a little concerned that they may not be quite ready for discharge. A triage nurse may take the decision to ramp a patient that is borderline for the waiting room but would almost certainly be ok. A paramedic might choose to transport a patient who could probably stay at home but they don't have the organisational support to leave them. A communications team leader may upgrade a case from non-emergency to emergency because its waited a little bit too long. A ward may choose not to accept new patients from ED because shift change over is half an hour away and it will be easier for everyone if the new admission comes after the next shift starts. A nursing home insists a patient who has fallen needs to go to hospital because they've had a minor headstrike and need a CT. A nursing home isn't coping with a new difficult dementia patient so they need to go to hospital instead of cause a ruckus in the home. A GP advises a patient that they need to go to hospital for assessment and choose to use an ambulance even though the patient's husband has driven them to the GP in the first instance.

These are the types of risk based decisions that healthcare workers make everyday, and every single one of them contributes to Ambulance availability. None consider the risk of a patient that is on their own with no health worker with them. The way risk is assessed and managed doesn't have the capacity to identify the unknown risks, only the known risks. But interestingly, most of these decisions do not contribute to access block or ramping.

At the opening I defined access block as being fundamentally an inpatient capacity problem. I fully support this definition as developed by ACEM. There are some modifiers that could be introduced that may ease access block and the consequential ED overcrowding, ambulance ramping and the nations worst emergency response times. However, the vast majority will result in a tinkering around the edges of the problem. And yes, that tinkering may lead to a temporary reduction in the problems we see today but it will not last.

The only solution here is to bolster in-patient services in the major hospitals of Tasmania. If the hospital is operating beyond 80% of its physical capacity most of the time now, then it is clear to me that Government needs to start planning for an additional facility. If staffing is the primary problem, then Government needs to address the underlying problems with recruitment and retention of experienced staff. Specifically including:

- Pay Parity with the mainland
- Retention bonuses
- Generous educational opportunities
- Real and accessible career pathways within Tasmania
- Flexible work hours and provision of in house, long hours childcare
- Assistance with housing
- Additional opportunities like discounted gym membership & great onsite staff facilities, such as bike parking and showers
- Guaranteed ratios and minimum staffing levels
- Abolishment of the use of temporary contracts beyond 12 months

Ramping and access block is a complex issue and I hope the committee finds this contribution helpful to their decision making. I am happy to make myself available for any future hearing into the

matter to ensure Tasmanian's get better access to acute healthcare services and my colleagues in health get a fair go.

Yours Sincerely

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