THE HOUSE OF ASSEMBLY SELECT COMMITTEE ON TRANSFER OF CARE DELAYS (AMBULANCE RAMPING) MET IN COMMITTEE ROOM 1, PARLIAMENT HOUSE, HOBART ON MONDAY 11 DECEMBER 2023

The Committee met at 9.00 a.m.

CHAIR (Ms Woodruff) - Hello, Ryan, thank you for coming in today. If you could read the statement in front of you, this is being broadcast live and it is also on the parliament's website broadcast.

Mr RYAN POSSELT, PARAMEDIC, AMBULANCE TASMANIA, MADE THE STATUTORY DECLARATION AND WAS EXAMINIED.

CHAIR - Online we have Anita Dow, who you know, Simon Wood member for Bass. Did you have a statement you wanted to start with or would you like us to ask questions?

Mr POSSELT - I have provided a written statement so I am happy for you to lead straight into questions and we might be able to find where the committee is looking for answers a little bit quicker that way.

CHAIR - Thank you. It was a really good detailed submission. This is the first time people have been listening to the story of a paramedic in the course of our inquiry. Could you describe what it was like for you when you started work as a paramedic, however long ago that was? What it is like for you when you go to a shift at the moment?

Mr POSSELT - I started as a paramedic in May 2010 for the New South Wales Ambulance service. I worked across about six different stations in both small rural areas, medium sized regional towns like Tamworth, through to the inner west of Sydney. I transferred to Ambulance Tasmania in 2015. The contrast was stark then, in 2015. Access block and ramping existed in Sydney hospitals, but even in 2015 the amount of ramping we were experiencing at the Royal Hobart Hospital far exceeded what I had seen at my time in New South Wales Ambulance.

Since 2015 it has got appreciably worse. We did have a period around 2018 where access block was very bad and we were having some of the nights that we are having in 2023, but it was not as protracted. It seemed to be a sharp spike over winter that correlated with probably not enough staffing within the ambulance service itself. Over the last two years ramping has gotten appreciably worse to the point I spend sometimes more than half my shift at the hospital with a single patient. On a bad ramping day in a 12-hour shift I might be able to respond to three emergency jobs in 12 hours with my partner because we are stuck at the hospital for such a protracted period.

On a good day, in the Hobart context without ramping, I can see about nine patients in 12 hours. It is impeding my response by about 60 per cent in my ability to respond as an anecdotal experience for me.

CHAIR - I am not sure if you saw the figures in the media last week, but in just eight years the number of hours that patients have been ramped has gone up from 2300 a year in total in 2015 to 37 000 in the last year. Does that surprise you? How does it make you feel?

Mr POSSELT - No, it doesn't surprise me at all. It means we don't have the ability to respond to jobs on road. That is the absolute end game for us is that there are patients in the community not getting ambulances in a timely manner. That is attributable largely to ramping, as well as delays to care, worse patient outcomes and poor patient experience as a result of ramping directly, but it also is impacting on workforce, both in the emergency department and in the ambulance service, because nobody wants to work in this environment. It is too hard. We are seeing too many poor patient outcomes that should never have been the case. There is too much pressure on single practitioners to make decisions that might impact patients' care, because they know the system if falling apart.

CHAIR - From the figures and the stories we're hearing, it has been a sudden and rapid decline over the last couple of years. As things have deteriorated, how's that made you feel when you've been going to work in the morning or leaving from a shift. How's it affecting other people you work with?

Mr POSSELT - I think there is multitude of person responses to this crisis. For me it changes my practice a bit and I am sure it does for other paramedics. I am more likely to apply high risk to leave patients at home than I would have perhaps in 2015. If we knew we could get a patient in and out of the hospital in four hours, get them checked over, safety net them within the emergency department, then transporting them from say Glenorchy or New Town into the hospital makes a reasonable amount of sense. More frequently, we are seeing that taking a patient from New Town to the hospital for what's essentially a checkup, bearing in mind that paramedics are not doctors, that we don't have the skills and training of doctors or nurses. We have a different skill set. We also don't have the testing that's available at the hospital, like scans and blood work so we work on very little information to make critical decisions to leave patients at home.

I think paramedics are erring more towards not transporting patients and taking that risk because they know if they take that patient in it will clog the system, the patient will have a poor patient experience and may, in some cases, actually get sicker. A great example, we go to a lot of patients who have chronic obstructive pulmonary disease, sometimes known as emphysema, and those patients are very high risk of getting respiratory infections. If we take them and sit them in a waiting room or even in a hospital unnecessarily, they can end up with a worse outcome than if we leave them at home.

We are taking on a lot of responsibility and that's resulting in quite a lot of pressured decision making for paramedics, especially when there's a protocol in place where a welfare check is issued at about a half hour mark if you are on scene with a patient. Often paramedics perceive that as a pressure to come on, let's keep moving. Should we go to the hospital or do we need to move on to the next job? Sometimes it feels, even though it won't be the service's position, it feels to paramedics like they are being pressured to make a quick decision and move onto the next job.

In addition to that, I think many paramedics feel a high degree of stress relating to emergency jobs that are not covered. I have reflected on this in my submission that when there is a lights and sirens job, the practice is that the communications centre reads out where that job is and where the response is coming from. For example, P1 Glenorchy responding from Glenorchy. Every shift, almost every second hour, a P1 is read out across the radio to all crews that has no response available and sometimes, they are a long way away. It can be P1 Dover no response and that results in its own psychological trauma because paramedics want to be

there. It is their nature. They want to be there to help. That's why they became a paramedic. There is a lot of psychological trauma that's happening as a result of not being able to respond.

Then when we do put on that P1 in Dover, the patient is a lot sicker because they have waited longer than they should have, which is then making our job more difficult and making the patient sicker, their outcome is worse and their hospital length of stay longer and fundamentally making the problem of access block a lot worse.

CHAIR - That's a terrible mix. You said you're now working fewer hours than you used to. I know that may be for other reasons, but has there been a change in staff turnover? Can you just tell me how you noticed the decline in the situation affecting staff, whether people are leaving, changing?

Mr POSSELT - Absolutely, there's been a big change in the workforce since I've been here since 2015. There is an enormous number of people working part-time that probably don't need to or shouldn't be in the sense that they're young, they don't have children, they don't have care and responsibilities. They're in the prime of their life where full time work is quite the norm, but so many paramedics feel burnt out that they can't come to work.

We work a four by four rotational roster, but it's not actually a four by four as we work a night shift, in which our first day off has 8 hours of work in the morning and that's considered a day off so it's closer to a five by three rotational roster because we then come home and sleep. We spend 16 hours of our first day off either at work or sleeping and recovering from that. Then we will go back to sleep at a relatively normal time to try to reset our body clocks to start work three days later at 7 a.m.

When I first started here in Hobart, it was quite common to get sort of two to three hours, it might've been split and you might've had three one-hour blocks on a nightshift where you were on station, you could maybe get 20 minutes of rest and prepare yourself for the next job. Today, that is not the case. You don't see the station. You quite often don't get your second meal break which means you'll work a 14-hour shift with one 30-minute meal break and you could cover 400 kilometres of driving overnight in the 14 hours.

Combine that with potentially standing in a hospital for six hours from midnight to 6 a.m. with no real job. The job is to monitor the patient but the ramp can be busy, but we can't do blood tests, we push patients around to CT and x-ray. We act as orderlies a lot, but there's a lot of taking blood pressure and then sitting, waiting for the next thing to happen, but we're not really busy.

The fatigue element is huge and I think that contributes to the enormous amount of staff we see that have gone part time. In addition to that, my understanding is there is a reasonable number of staff that have medical certificates that preclude them from working night shifts because of the psychological trauma and toll. The staffing level on night shift, combined with access block and ramping is resulting in us frequently having three to five ambulance crews for the entirety of south Tasmania.

CHAIR - Wow, that just sounds incredibly small.

Mr POSSELT - Yes.

CHAIR - What might it had been when you started?

Mr POSSELT - When I started the base number was six metro crews, plus branch stations at Huonville, Sorell and New Norfolk. Those branch stations have now changed to professional stations. We still have that base staffing level, but people aren't showing up because they can't cope, they can't do it anymore.

CHAIR - That's from nine stations down to, what did you say?

Mr POSSELT - We have had nights where there is three to five -

CHAIR - Three, a third of the station? Two thirds aren't being filled on night, not infrequently?

Mr POSSELT - That's right. We do end up with single officer responses because we end up so short we may have a single officer at Huonville, a single officer at Glenorchy. While they can provide a response, they can't transport a patient safely as a single officer and what winds up happening is we end up sending two resources to one job because they need to be backed up and that depletes our resources even more.

When you add in access block to it, as well as dramatic increases in workload, we're seeing night crews trying to play catch-up. Just my last night shift on Saturday is a great example. I finish work at quarter past midnight, I was the last afternoon shift to finish which is when we go to the skeleton crewing from midnight onwards. We had 10 jobs in the system and we had five crews. With an absolutely optimal system, a well performing system, there was at least two hours work for the ambulance service waiting, not to mention all of the jobs that would come in during that two hours. I don't know what the outcome was, but it is highly unlikely that they have caught up by the time the day crew start.

CHAIR - You have to then presumably often leaving your shift late, with overtime as you have said. Going home knowing your colleagues are working in that situation, working up against it and not being able to respond to the 000's, not being able to respond to priorities and you just have to go home. How do you wind down after a shift like that? How does it make you feel?

Mr POSSELT - I have always used active transport which does help. Riding my bike home from Glenorchy at 1 a.m. in the morning is a good way to wind down. But certainly, I have used alcohol in the past. It has become so normalised. Maybe if we go back four years pre-COVID19, I would sometimes stay back if my partner was willing and we would do an extra job after hours. I have finished contract jobs at places like the speedway and responded to on road jobs on the way home to try to help the system, to try to help the patient waiting for an ambulance.

It has become so frequent nonresponse P1's predominantly, non-response emergency jobs are so frequent that nobody is willing to do that anymore, because every second hour there is a P1 without a response. If I stay back and do that extra P1 and I take two hours out of my sleep to do that, there is just going to be another one that will be read out in that time frame anyway. I do not think many paramedics are ready to bear the burden of the system anymore.

CHAIR - I can see Anita has a question but I will finish up with one question. With the trajectory things are on, it sounds like we are heading into a situation where paramedics are being forced by the unhealthy, incredibly stressful situation they are working under, to walk away. It sounds as though, from what you are saying, the trajectory is more and more people not taking up these night shifts, especially Friday and Saturday nights where they are so stressful and they know they will be ramped in the hospital, maybe all night. Can you foresee a future where there is not going to be people turning up to staff shifts? That is already happening, isn't it?

Mr POSSELT - Yes, that is right. We have already got a huge dearth of staffing on night shift. There is not enough staff that come to night shift and it is really not their fault. The award we work under is a compensate wage, which means there is no financial benefit to coming into a night shift, you get paid the same on day shift as you do on night shift because it is all rolled into one hourly rate.

Other services use a penalty system which is an encouragement for people to come to work. Other services like London, that has struggled with the same problem, have bonuses. If you come in and work an overtime shift on a night shift, then you get a £500 bonus and that attracts that younger cohort. The cohort who are saving to buy a house, who want to go to Europe on a holiday. That attracts them to come. It is worth their while even if it is a horrible night shift - the financial remuneration makes it worthwhile.

We do see across the country; my understanding is the average career length for a paramedic is three to five years nationwide. Certainly, the crews we run in Hobart are very junior now, much more junior than when I started in 2015. These conditions, combining with ultra-stressed workloads, standing on the ramp for hours and hours which is not what we signed up for theoretically, but also skipping meal breaks, having no education, not having time to complete emails or safety events on the system because we are so busy, is leading people to quit early and find other jobs.

The majority of paramedics who have been around for some time have some sort of side hustle. They work 0.5 with ambulance and then they work 0.5 in a gym because they just can't do full time work anymore with ambulance.

CHAIR - Right, that is a devastating picture you are painting.

Ms DOW - Thank you, Ryan for your submission. It was really comprehensive along with your contribution this morning. In your submission you outlined a number of things that you think could be done on recruitment and retention. We are aware of the fact there are paramedics. They are not good short-term contracts over and over again and they're not being offered permanency within the Ambulance Service. I wondered if they are things that you put down there in your submission.

You have mentioned again the issues about not paying bonuses for night duties and there being no penalty rates for night duties. Is that something additional to this list that you had regarding pay parity, retention bonuses, educational opportunities, better career pathways, flexible working hours, housing is an issue and other incentives like gym memberships and the like and the extension of contracts beyond 12 months? Is there anything in that list that you thought afterwards that you'd missed or you would like to add to that, ways that we can better

support and encourage people to become a paramedic and to stay working in our health once they are a paramedic in Tasmania?

Mr POSSELT - Thank you, Anita. The list applies broadly to healthcare workers, not just paramedics. My view is that all employees want to feel valued. They want to feel that they uniquely contribute to the organisation or to their patients or to the service that they deliver. Within health care I do think that the whole spectrum of people who work within health from aides and cleaners to clerks to doctors to paramedics, are there for the right reason. They're there because they see themselves as contributing to community, to contributing to make people that little bit better, whether or not that is a lovely interaction that a cleaner has while they are wiping a table down and I can certainly reflect on that as a patient. Often the cleaners coming through when we had our babies or when my child's in hospital, are some of the friendliest interactions you have and it lifts your spirits.

People don't feel valued in the system. Some of the ways in which those play out in an example I have written in that list, Anita, is childcare provision. Parents are viewed as a bum on a seat, an FTE, and they are increasingly viewed as a problematic FTE because they have caring responsibilities because childcare calls them and says you need to come because your child's sick. They don't feel supported to continue to provide that service, to continue to contribute because their employer doesn't value them as an individual. They just value them as a number. For me, in the childcare space, the lowest hanging fruit is healthcare worker-specific childcare that is a government contract. It would be filled like that. One of my colleagues could not get childcare for her son and was driving before her 7 a.m. shift to Swansea to drop her son off at her mother's house and driving back and then doing a 12 hour shift and then driving back to Swansea to pick him up. This is not uncommon.

The other element is that day care doesn't understand particularly well that if you call me and say you need to come and get your son I may well be in Ouse or Dover with a patient and will not be able to get there for two hours. That's an element that is low hanging fruit for government to get a contract going. It would support nurses and paramedics and all of the healthcare staff, doctors as well, to be able to increase their FTE. Quite a lot of parents want to increase their FTE but don't have the ability to do so within a broken childcare system.

The other component of feeling valued, with Ambulance Tasmania I have not had any quarantine education since 2019. I have had mandatory Tasmanian Health Education Online (THEO) packages, which is the online learning modules, that I allegedly must do and I must find time to do somewhere in my shift where I frequently have two hours of overtime. There is an expectation from management that I find the time to do it.

CHAIR - You mentioned in your submission that you have to do these mandatory online training packages but because there is no time made available by Ambulance Tasmania for you to do them, other than when you're on shift with patients, then you are required by necessity to do them when you're ramped, with a ramped patient often. Then there is the conflict between providing focused patient care and not missing any little detail as well as doing what you are required to do, muscled up, I suppose, to do online training.

Mr POSSELT - That's right and it is the job of our immediate managers to make sure that we do have that training complete. They've got a directive, it's mandatory. A great example is the child protection mandatory training that needed to be completed by 30 June, I think it was. They don't have any ability to control the emergency workload so if we're out

responding to emergencies, our manager can't say you need to do the education. You're out on the road or on a job and it would be ridiculous to expect us to try to use a laptop while in the passenger seat of an emergency vehicle.

The only time that the managers have to enforce this is when we're ramped and our immediate managers are understanding but they have this dilemma where they need to have us do this training and the only time to do it is when we're ramped. The end result is our education suffers because we're going to and from our education package. We start it, if we start it on station, our pager goes off and we get a job. Then we come back to it and we don't know where we're up to. If we're on the ramp, we start it, our patient hits their buzzer, the patient has a seizure or an emergency on the ramp and you're back and forward, back and forward. Also, if the patient does call, you've got your head in a computer screen and you're not checking on your patient. That leads to patients being forgotten and poorer patient outcomes. No nursing arrangement would have floor nurses doing mandatory education while they're nursing on the floor. It just wouldn't happen, they would be given time -

Ms DOW - Has that always been the case since you started in 2015, or is that just in the last four?

CHAIR - That's what I was going to ask too.

Mr POSSELT - No, up until about 2018, we had four days of CPD that we were provided by the organisation. Something that has occurred since then, which is I think the service taking a view on an extraneous factor is that paramedics have become AHPRA registered which has a mandatory requirement of 30 hours of CPD a year. It's the opinion of staff that when that occurred, Ambulance Tasmania took the view that they did not need to provide education anymore because it was a personal responsibility under the AHPRA rules. Since, they've implemented $500 CPD allowance, which would barely cover a conference, but no CPD leave that is actually approved. There is some in the award but I know that people have been conveners of conferences and not been awarded CPD leave for convening a national or a state-based conference because the operational demand doesn't suit on the day.

Our education has fallen apart since 2015. There is an attempt for us to do, and it's written into the award now, that we get two days of CPD a year but so far, the experience is that it's cancelled more times than it's run because of operational demand.

CHAIR - In your submission, you said that ramping places patients at risk of worse health outcomes, and you provided a number of examples. For people who are listening today, who haven't read your submission, can you provide an overview of the ramping process and why it puts patients at risk? A lot of Tasmanians would think you're a very skilled paramedic, you're sitting there with them, why are they at increased risk on the ramp?

Mr POSSELT - Any delay to care in certain groups of patients will result in worse outcomes. There's lots of literature and evidence to support that. Examples include major heart attacks, strokes, infection. If you have a patient who has a very bad urinary tract infection and their body is responding in a manner that we refer to as sepsis, which is a type of inflammatory response that places you at risk of death, every hour without antibiotics increases your risk of dying. Paramedics can give antibiotics to some patients but these types of patients sit in the grey area where paramedics are not allowed to administer antibiotics but they do need antibiotics at the hospital and they may need a specific type of antibiotic.

We know that antibiotic resistance is a problem globally and antibiotic stewardship is important. Paramedics only carry one antibiotic which is a very high powered, broad spectrum antibiotic and it may not be the best antibiotic for something like urinary tract infection. These patients aren't quite sick enough to earn themselves a resus bed and they end up coming around to the ramp area, often not being seen within the desired time frame.

I read that our time to be seen within the clinically recommended time frame is somewhere around 30 per cent now. That means these patients who should be seen within 20 minutes might not be seen with 40 or an hour. We just sit and give them fluids in the case of an infection and wait. We can advocate for them, but if the department is chaotic and it's not the department's fault, it is absolutely nothing to do with the emergency department. They're working their butts off in there, but if we wait an hour to be seen by a doctor, it then takes 25 to 30 minutes to find a nurse to administer the antibiotics. Technically, per the directive we have from the ambulance service, we are not allowed to have those antibiotics administered while the patient is in our care, because it is not within our scope of practice.

CHAIR - And you are also not allowed to provide pain relief outside of your scope of practice.

Mr POSSELT - That's correct. So many patients who present to the emergency department don't need intravenous morphine or Fentanyl. They need something a bit stronger than Panadol and something not quite so strong as morphine and that's sits outside of our scope. Medications like Panadeine Forte, Endone, Targin, these drugs are not within our scope of practice, because they are not ambulance appropriate drugs. They are long-term pain relief drugs so, we have never had a protocol that allows us to administer them. Technically we are not allowed to have them administered while the patient is in our care and that also goes for antibiotics.

We have a dilemma. Do we risk our employment by allowing a patient to receive care that's not within our scope of practice or do we let the patient suffer? What do we put first? Our own profession, our own career and the rules under which we work or the patient's needs. In the cases of patients who have genuine life-threatening illnesses, paramedics are tending towards allowing the care to happen on the ramp that they technically shouldn't. We are all there for the same reason which is to make people better and to improve health outcomes, but the risk is that we lose our job.

CHAIR - That is a serious ethical and moral issue to struggle with on a daily basis. We are trying to understand the extent of harm that happens to be people who are on the ramp. Can you give us some idea of how frequently patients are exposed to unnecessary risks, delays or the things that you have described? Is it regular, daily, occasional?

Mr POSSELT - Patients are at risk multiple times a day, genuinely at risk of worse health outcomes from ramping. That may contribute further to the access block cycle because the patient that has a delay to care also has a longer length of stay. The patient that didn't get their antibiotics who, if they had their antibiotics at the right time, maybe wouldn't have needed ICU. They now need to spend three days in ICU because they are so sick. Then the next day, a trauma patient comes in and he's in the resuscitation bay and they can't get upstairs to the ICU because ICU is full because the patient with the UTI, who didn't get their antibiotics, is in there. This happens.

I have seen an occasion - and this is an infrequent occasion - where a deal has been done between the resuscitation area and the emergency department and the intensive care unit where they had a patient who had come in via the helicopter and couldn't get them to ICU because ICU was bed-blocked. The only solution they could come up with was to remove a patient from ICU back to the emergency department who was not as sick as the patient as the patient they needed to get to the intensive care unit. A patient movement going back into ED to facilitate care of somebody who needed to be in ICU, which is possibly unprecedented and goes to show the extent that the emergency department staff are working to provide the care that's required for these patients. They are doing everything they can, but if there are no beds in ICU, then there are no beds in ICU.

Ms DOW - I wanted to ask you about the merits of having a practice review of paramedics. In your submission you have identified one of the main solutions being obviously having more beds available across the health system and you make reference to the south of state. You don't talk a lot about the community-based care and what things could be improved in relation to community-based care. Thinking more about, as you are speaking, your paramedic scope of practice would be useful to look at your roles and responsibilities. Perhaps, provide the ability to look at where the paramedics would be providing some of that care they are able to do due to their scope of practice.

How many are there in the paramedic practitioner role in Tasmania? Typically, how many of those would be out on the run or ramped in our hospitals and whether their extended scope of practice is useful in that instance?

Mr POSSELT - I will work backwards. There are no paramedic practitioners in Tasmania. There are different scopes of practice within the on-road cohorts which are governed by Ambulance Tasmania's clinical governance unit. These would include things like Aeromedical and Retrieval Paramedics, Wilderness Paramedics, Intensive Care Paramedics, Extended Care Paramedics, Community Care Paramedics and PACER, which is a psychiatric specialist. There is a range of different skill sets.

The key thing to point out is that community care paramedics or extending the scope of paramedics will not have any effect on access block or ramping.

It is the same as the Emergency Care Centres. Emergency Care Centres will not have a drastic impact on ramping. They will decrease the workload across the emergency department because there are less low equity patients who need to be seen. However, the emergency department at the Royal Hobart Hospital is set up in a way that has two completely separate units: one to see GP and low acuity type patients and one to see patients who may require admission.

Access block occurs solely in the group that is likely to require admission. Many people in the community think it is because people are calling ambulances that should not be. That contributes to our pressures on-road to provide a response but it does not contribute to ramping, very clear. There are elements of our scope of practice that could be improved, if we were trained to administer certain antibiotics and things that patients need on the ramp, that patients would get better care, but it formalises ramping.

I have provided some photos to the committee. These photos are taken in the ramping area. This was, that last check, the respiratory ward for COVID-19 but since I have been here it has about four or five different titles and been used for four or five different things.

CHAIR - This is the ramp?

Mr POSSELT - This is the ramp. That photo you are looking at, at the moment, Dr Woodruff, is literally the ramp area. There are patients behind those curtains. Paramedics look after patients in a ward. While it is lovely for us not to be in a corridor or in the back of an ambulance because we can provide better patient care, all it has done is formalised the ramping and allowed paramedics to languish longer, out of sight. Frankly, our ratios compared to nursing ratios are extremely expensive. We will quite often run two paramedics to one patient, where a nurse would be able to look after three patients on their own. From a cost perspective, it is a crazy way to run the system.

In addition to that, this shows there is physical space available that the department needs to step up and employ people who are not within the pre-hospital scope to work in this space. This would allow, Anita, those antibiotics to be administered because they are nurses, they are not paramedics.

CHAIR - You said there is a number of experiences of an adverse medical event while people are ramped. Is this recorded and, if so, how?

Mr POSSELT - Extreme circumstances are recorded. Day-to-day circumstances, I would suggest, are not. Delays to antibiotics, delays to CT for stroke, that type of event, I do not think it is the practice to record it, because everybody recognises this is the system we work in and this happens all the time. Not only that, everybody who is privy to that delay is so busy that they have no time to complete what's called an SRLS, the safety reporting event. Again, paramedics are not given quarantine time to complete an SRLS, if they ask for one -

CHAIR - If you can just explain what that is to people who are listening.

Mr POSSELT - The safety system that we use within the Department of Health is called the Safety Reporting and Learning System. It is a clunky, form-based system that takes too long to log an event. A simple event will take 20 minutes to log, even if it's like a power cord in the wrong spot-type safety event. The system is not fit for purpose within safety reporting and learning -

CHAIR - Tasmania's system overall or just in Ambulance Tasmania?

Mr POSSELT - Overall. It's not modern and we are not given the time, particularly paramedics, are not given the time to do it. The ambulance service will say that we have it available to us on our laptops, which we do, but I am not completing one, sitting in the passenger seat of an emergency vehicle going to a job, and every other part of my shift I have a patient - other than my meal break. There are some expectations that are not official expectations but there are some expectations that you will complete paperwork and do learning and report events on your half-hour meal break on your 12-hour shift.

CHAIR - The inquiry sent a number of questions to the Department of Health to try to get some understanding about the statistics related to ambulance ramping. One of the things

we asked was, how many patients had died while ramped in the past five years? The department's response was they had a look at their record data and the tracked data and their review, quote:

> … has not identified any instances where the time of a patient's death is recorded prior to transfer of care occurring.

And they went on to say:

> This is consistent with how emergency departments operate. In situations where a patient significantly deteriorates, such as going into cardiac arrest in the offload delay area, they are generally transferred to a resuscitation area, or other part of the emergency department. If that patient is subsequently pronounced deceased by medical staff, that will occur and be recorded in that location.

In other words, they say there's been zero deaths for ramped patients in the past five years across all of Tasmania. We find that hard to reconcile with the publicly reported media reports of the number of patients who have died on the ramp. Do you have any comments to make about what the department has said here?

Mr POSSELT - Yes, it's a lie. Where you record the moment of death is irrelevant. Where the patient deteriorated that led to their death is the point that matters. If you're arguing that a cardiac arrest on the ramp occurs and that the patient didn't die on the ramp, it's not true. It's absolute weasel words to try to say, 'Well no, they were actually in the resuscitation bay when they died'. Yes, we stopped resuscitating them in the resuscitation bay. And that is not necessarily the case that those patients do get moved to the resuscitation bays because routinely at the Royal Hobart Hospital, all four resuscitation bays are occupied, routinely. I'll come back to this point but it brings me to utilisation rates of critical resources: no resuscitation bay should be full in a hospital, ever.

It's the same for ambulance resourcing. The evidence suggests that ambulances should be available about 40 per cent of the time. We should have a utilisation per cent of 60 per cent, no more, because we need to be available to respond. We need to be on station when the job comes in, otherwise you won't have someone to respond. But our utilisation rate approaches 100 per cent. The resuscitation utilisation rate in the hospital at the Royal, I don't have a figure on but it would be absolutely no surprise to me if it's 75 per cent.

If a patient arrests on the ramp with an ambulance crew, sometimes there is nowhere to put them. Now, the department's submission to you also fails to cast the net wider for cases that are well publicised, so for cases that are well publicised in the public domain where ambulances didn't make the patient in time. There may not be evidence of a patient who died specifically while on the ramp in the ramping area but there is definitely evidence of patients who have called 000 themselves and who live in a metro area, complaining of chest pain and didn't get a response for 29 minutes and then were dead when the ambulance crew arrived. If you cast your net as narrow as the department has tried to here they may not find that anyone has died but it's not telling the true story.

CHAIR - In your view, dying on the ramp should incorporate a death from when the phone call, the 000, was made to the point at which they are received by the emergency department?

Mr POSSELT - Yes, but not only that, it's very hard to longitudinally track this but there is no question there are patients who are dying because of their delay to care. They didn't die on the ramp but they died as a result of the ramp.

CHAIR - This is because paramedics are sitting on the ramp and, like you've said, not able to go and answer 000 calls?

Mr POSSELT - It is, but it is also those examples of infections where a patient has a bad infection, they don't get their antibiotics. They go to ICU and they die because they had a two-hour delay to antibiotics because they were ramped.

CHAIR - And there is no way that Ambulance Tasmania records that?

Mr POSSELT - No.

CHAIR - That information is silent?

Mr POSSELT - I don't think there is any place within the hospital system that would record that. Quite often, those types of patients don't wind up in the coroner's investigation because they had a clear reason for their death. I am not a medical practitioner, but my understanding is that a medical practitioner would be quite happy to write a certificate of their death because there is a clear reason for it. Quite often, those patients have no tracking whatsoever that ramping has contributed to their death.

CHAIR - When you're on the ramp and there is a PO which, for people who are listening, that's a critical life-threatening emergency, or a P1 which is a critical - is that how you describe it?

Mr POSSELT - Yes, a P0 and a P1 are lights and sirens jobs. A P0 is considered a cardiac arrest.

CHAIR - When they get called through, can you describe what happens if you're on the ramp? What's the process? Is it an orderly process?

Mr POSSELT - There is no process. If there is a P1 in the community with no-one to respond, it will sit until there is. A manager may come and try to move some patients around and frequently we have managers at the hospital trying to find spaces for patients. There is now a rapid off-load protocol which empties the emergency department into the wards.

However, the process itself, if you activate an immediate off-load protocol, you need to get wards prepared, orderlies to move patients. It is a half an hour to an hour process. The department gets a lot better after that but it still doesn't address the need to have someone to respond now to that emergency. If there is a P1 that has no response steps will be taken to try to address the overall workflow but it is not unusual. Two or three weeks ago, I went to a P1 that had waited 55 minutes with no response.

CHAIR - If you are on the ramp and you are being asked leave and go to a P1 or a P0, then you have to leave your patient who's on the ramp and someone else has to take up your patient and care for your patient.

Mr POSSELT - That's right. We need to have a clinical handover process. Our registration doesn't rely on us being able to respond to everybody within the system. It doesn't consider the system. Our registration as a paramedic considers our relationship with the patient we have in front of us. If I was to walk away from that patient without adequate handover of clinical care, my registration would be at risk because I have not taken due diligent care of the patient in front of me, regardless of what's happening in the community.

CHAIR - So you need to do a handover and then someone else has to come. How many patients might you end up caring for when things get really busy on the ramp? I guess you are on the receiving end, having to maybe take other people's patients if they go?

Mr POSSELT - The Ambulance Service's policy is that a crew is to take no more than three patients. There are paramedics who will take more and they risk their registration in doing so. Some paramedics will take up to eight as a single paramedic which, in my view, is highly dangerous. Given that emergency nurses work on a 3-1 ratio, 8-1 in that setting is asking for a disaster to occur, but there is 3-1 is the governed ratio maximum but because our patients have not been worked up by doctors, there is a reluctance to take that many as they can potentially deteriorate. Seizures on the ramp happen every other day. We have patients having seizures, emergency bells are usually pushed as a result of those seizures which is fine, that is the process. That is the risk you run if you take on three or four patients and your partner has taken one of them around to CT, it is just you and you have three patients and then one has a seizure.

There is no one else around, you are not in a department, it is just you, there is no doctor. You can push a button and people will come, but you need to give clinical handover. You need to be responsible with the people that are in front of you. That churn of paramedics to respond is problematic to continuity of care, which I reflected on in my submission about the person with a hip fracture. They had stayed on the ramp for 17 hours and probably been through 10 crews in that time. They just handover, yes, that is that man and he has got a broken hip, next patient, next job. That continuity leads to things like pain relief and catheters being missed in patients that should have had them.

CHAIR - It is a really dire situation you are describing. You have put a whole range of things. We have to wrap up now unfortunately. We have put a whole range of things in your submission that need to be done. They obviously all need to be done, but do have any comments you want to make to us about possibilities of things that could be done in the short term or would triage any of those really important tasks that need to be done to reform the situation as it is now?

Mr POSSELT - I have an idea and it is only a novel idea. I don't know if there is evidence for it or if it has been done elsewhere, but it makes a lot of logical and pragmatic sense to me. It is frequent that the emergency department has more than 20 patients who have had their emergency department care completed and waiting for their beds upstairs. Admitted patients under another team. They are admitted under general medicine, orthopaedics or under vascular surgery and the emergency department no longer has any jurisdictional care over them, other than nursing. If that patient needs something it is the responsibility of the admitting team

to deliver that care. That means that the vascular team should be caring medically for that patient.

To me it makes sense to implement a transfer of care lounge that is between a ward or whatever you want to call it, that is between the emergency department and the inpatient beds. There is plenty of space, as my photos demonstrate, there is 30 beds in that space, that patients could go to while they wait for their bed upstairs. They are not critical; the emergency department has determined they are not critical and they still have a physician team or a medical team looking after them remotely. All you need is nursing staff to care for them.

If you staff this solely on overtime with nurses - nurses tend to like overtime - they tend to pick it up, particularly if it is something that is a bit different to what they are normally doing. If you allow ward nurses on overtime to care for those patients, I believe it would be staffed. I believe it would give the right mix of care because you would have all manner of nurses that are in that area caring for those patients. You might have someone from the surgical disciplines or medical or geriatric disciplines, because they on overtime.

The other element to that, not only would that provide a place for admitted patients to go and therefore open up beds for ambulance patients to go within the department, but it may result in some of the culture changes that I referred to in my submission on the wards, where ward nurses are now exposed to some of the pressures within the emergency department.

CHAIR - There is more pressure on them to discharge patients.

Mr POSSELT - Yes, and they have a relationship with the home wards. They know the managers, they know the nurses up there and can make some representations from that transfer ward to say, hey Lucy, you are my mate, I work with you every day. Can you get this patient up please because *x, y* and *z*? There are better relationships, there are experiences that the nurses would get that may change their care on the wards and it would open up beds in the emergency department. It is something that could be implemented tomorrow, because all you need is overtime nurses. The beds are there, the bed spaces are there and it is a safe environment. You could literally put out an overtime ad tomorrow for 30 nurses to work in that department and see how you'd go.

CHAIR - Thanks. It sounds like an interesting suggestion. One response the Government could go to as a result of this inquiry could be to formalise more the situation on the ramp, to provide protocols and more support. That would essentially formalise it as part of the hospital's system. We are hearing from evidence the danger of that would mean creating a dark space where there is a sub-optimal patient care that becomes an entrenched part of the hospital system. The other way is to go into removing the bed block blockages happening within the hospital. Do you have a view about whether there should be some interim things to improve the situation on the ramp or just more pressure to removing the bed block issues at the hospital end?

Mr POSSELT - The question is grounded in risk. The highest risk patient is the patient that has nobody with them. The next highest risk patient is a patient on the ramp. The next highest risk patient is a patient in the emergency department. The next patient is the patient that is admitted, so it depends on where you want to focus your risk. If you want to allow people to languish in the community with nobody with them, which is a very high-risk strategy, then formalising the ramp with ambulance resources is where that risk will be focused. If you

want to focus that risk on admitted patients, then a solution like the one I've spoken about is where you want to focus your efforts. If you enhance ramp care, but leave it within the ambulance jurisdiction to manage, the only result will be longer delays to emergency response in the community. That's it. You will also probably wind up with more people going part-time in the ambulance service, higher turnover because fundamentally, if we wanted to stand in a hospital ward all day we would have done nursing. We are not nurses.

CHAIR - Thank you. That's a good encapsulation.

Ms DOW - Ryan, if you could prioritise two things that would make a significant difference right now to the workforce, of all of those things you listed, what would they be?

Mr POSSELT - I think that a combination of crew enhancement and ramping limitations are what paramedics would look for. If we provide more crews and are funded to provide more crews, it is not the cherry on top stuff, that is not what it is. It is doing safety reporting, it's doing education and stuff that makes us safe as people who practice in the field of medicine. It's not cherry on top stuff, but if you have more crews and less ramping there is then time to do the things we need to do make sure we maintain our ability to deliver professional and safe care.

Our nightshift crewing is fundamentally unsafe, even when there's no ramping. Because of the way the award works, no one wants to work more night shifts. Even on a day shift when we have maximum crewing, at 1 p.m. in the afternoon when we have the most ambulance crews available, we still have P1s with no response. It is across the board we need to have increased staffing levels and if you coalesce that with decreases in ramping, then all of the other stuff will come.

CHAIR - Thank you Ryan. We appreciate you coming in and giving us this information. There is nothing more real than your personal experience as someone who does that work every day. We thank you for doing the work you do and also sharing this with us.

I would like to remind you what you've said today is a proceeding of parliament. This committee is a proceeding of parliament and it receives the protection of parliamentary privilege. That's a legal protection that you can give evidence to this committee and speak with complete freedom without any fear of being sued or questioned in a court or a place outside of parliament. It means the protection you have is just here while you are giving the testimony to the committee. Any statements you make when you walk out that door that might be defamatory aren't covered by parliamentary privilege. Do you understand that?

Mr POSSELT - I do understand, thank you.

CHAIR - Thank you for coming in today.

THE WITNESS WITHDREW.

Mr CAMERON JOHNSON PARAMEDIC, AMBULANCE TASMANIA, MADE THE STATUTORY DECLARATION AND WAS EXAMINED

CHAIR - Before I start, online we have Anita Dow, and Lara Alexander, who will be online shortly, and Simon Wood. Before you give your evidence today I will ask if you have read the guide that was sent to you.

Mr JOHNSON - Yes, I did.

CHAIR - You will understand this committee is a proceeding of parliament and it has parliamentary privilege which gives you legal protection for anything that you say here. You have no risk of being sued or any other legal proceedings about what you say in this context. It is so that we can get the best possible information we can as a parliament when we conducting this inquiry.

As you would've heard me say to Ryan Posselt, the protection doesn't follow you as you walk out that door, it's just while you're in here. This is a public hearing today and it's being livestreamed so that means that members of the public or journalists might be present and your evidence might be reported. It means that if you want to make any other comments about your evidence outside of this room that you won't be covered by parliamentary privilege but any words that you say here today are. Do you understand that?

Mr JOHNSON - Yes, Dr Woodruff, I understand.

CHAIR - Thank you so much for coming in, Cameron. We've read your submission. It's really detailed and it provides a lot of information. We're going to ask you some questions about that but first of all, maybe you'll tell us how long you've been a paramedic and a bit about your experience when you started here in Tasmania and how things have changed for you?

Mr JOHNSON - I started my paramedic training in the United States in 2002. I completed that the following year and worked over there until 2004. I returned to Tasmania and had to go and get a degree to be able to work in Australia so I went to Charles Sturt University and did the second year of their program which qualified me with a diploma which got me into a job in Hobart. I worked here until 2011 and then moved to Adelaide and worked in Adelaide as a paramedic until 2017. I then moved back here to Tasmania for family and work reasons and have been here since.

The first six months I worked in the north-west and I have been in Hobart since the end of 2017.

CHAIR - How have you found things from when you moved here, coming from interstate but also previously from overseas? Have things changed since you've been here working since 2017?

Mr JOHNSON - In my submission I made a bit of a point that from 2002, or back then, there was no ramping in the US. When I came to Tasmania and worked in Hobart we were still delivering patients to the old emergency department that was accessed off Argyle Street and there was a section of the corridor that we used to hand over and transfer care immediately. I do not remember being ramped down there other than just for brief delays with triage.

In 2008, the new department was opened and that's when ramping started in the corridor. Initially, there was some outrage: ambulance crews standing around not being able to respond and how bad that was. We transfer fairly quickly but from memory, this is 15 years ago, it was within months that we would be there for hours, waiting. Then the associated issues with ramping and stresses and everything else came along.

From being back in Tasmania since being in Adelaide, there was ramping in Adelaide, a different form. We used to ramp in the ambulances, which, as frustrating as it is, it doesn't involve the extra hazards that we have here when we are ramping inside the hospital and now that we ramp inside our own ward. I believe that's still the situation in Adelaide because I was talking to some colleagues in a conference in September. Treating ambulance patients under hospital guidelines and procedures is certainly not done in that state. But that was ramping in Adelaide and then coming back to Hobart, Tasmania, it was certainly the worst ramping.

Straight off the bat you could be ramped with patients for a number of hours. Initially it was in the corridor until the day the borders opened that the (inaudible) ramping ward was established and has since moved to (inaudible) because of some redevelopment works at the hospital.

CHAIR - How do you feel when you drive to a shift in the morning or the evening?

Mr JOHNSON - I also mentioned in my submission this has had a very much personal impact and it has provided me with a lot of stress over the years. That is around the issue of ramping, but also some events that have happened on the ramp and the associated hazards and issues and lack of resolution since on the part of Ambulance Tasmania management. I will say the job has lost its shine. I have been seeking professional assistance through the critical incident psychologist for a number of years and I do touch base from time to time.

It impacts on your decision making at work when you decide whether you are going to transport a patient or not. Although you try to do the best thing all the time, I will not deny that at times, if you can avoid the Royal Hobart Hospital, you avoid the Royal Hobart Hospital and try to use the private hospitals as much as you can. Try to refer people to GPs or anything else, because you know they are either going to be stuck in the corridor or the ramp ward or they are going to be in the waiting room for a number of hours for their condition which is, obviously, a lower acuity.

More and more recently and since COVID-19, the ramping of the category 2 patient has become more and more prevalent. This is even more concerning because those patients are quite unwell at times or, as I have mentioned in my submission, you are ramped as a category 2 while the hospital does their investigations with blood work, CT, x -ray to find out exactly what is wrong with them. From there, they will either go into a resuscitation bay if they are sick or if they are not, the waiting room.

These tests take time, I am guessing between one to two hours to get all those things done and you are just standing there. You are hypervigilant because you are not sure what doctor is going to come around the corner and suggest what therapy or start some treatment and you are going to have to discuss the existing measures. It is a very nerve-racking process that plays on your mind. Having to advocate for patients when you know they need the treatment, but it is outside of a policy or a protocol is stressful to say the least.

CHAIR - Is that something that never happened when you were a paramedic earlier in your career? There was never any pressure to work outside your scope of practice?

Mr JOHNSON - This is a hospital ramping phenomenon. As paramedics, we are obliged to follow protocols or guidelines that we operate under, that is a long-standing situation. It was the same with the United States where we have protocols and the same in Ambulance Tasmania where we have had protocols. Now we have moved to guidelines, but because we are not medical doctors we have to operate within those guidelines. I guess it is for a patient safety mechanism, it is a way to ensure a degree of quality assurance with clinical practice. It is also a way to ensure best practice.

When we go into the hospital and the hospital starts to do their treatments and we know, as Ryan said earlier, that some treatments like antibiotics are needed quickly to reduce the stay in the hospital or reduce the effects of the illness longer term. When we start those treatments, it raises a whole lot of grey area on our own scope of practice and our own limitations on our knowledge and the way we work with those medications or infusion apparatus and how we make it safe. We also know the patient will benefit from it. We also know it is outside policy which if we breach policy, we are subject to the Registered State Service Act. It is a very nerve-racking situation and we see different paramedics apply different standards and that in itself leads to angst among co-workers and in between the agencies.

CHAIR - You are talking about a whole new condition of expertise you are required to have as a paramedic by being virtue of being on the ramp, the rules, the paperwork, the balancing of risk in a completely different way to the sorts of risks that you have been trained to balance. You have been a paramedic for many years now and you need to get professional assistance in order to be able to continue to do this work. There are so many young, very low level of experience paramedics who are working now and the average time I think is 3 to 5 years. That is an Australian figure. I don't know if it is Tasmania. How do the new paramedics cope in this ramped situation?

Mr JOHNSON - As a delegate, I am a bit of a focal point for people to come and air their grievances about situations and share examples. One of the examples was in my submission. I see people who are frustrated. They are frustrated because they want to do a job that they've trained for but they get stuck in this kind of sedentary, sitting around observing patients. But it is also nerve-racking because not all but some see that inherent danger and hazards involved in it.

They will come to be with examples of, 'Cam, the other day I had this patient, the doctor came out with a infusion - started the infusion'. There is the professional disrespect because they didn't even ask them. There's also that awareness of 'Are they allowed to do that? I didn't think they were and if something went wrong am I going to wear it?'.

I have to give them the black and white answer which is we have the transfer-of-care policy or protocol. That is a breach and if something was to go wrong then you're going to wear a fair degree of responsibility for that. So, I see them do that, but I also see a lot, not turn a blind eye, but adjust more in the, 'I don't want to create problems, I don't want to speak up because I think this is not right but it is a doctor and they know what they are doing and we'll let it kind of go'.

I could go to the ramp ward now and walk around and probably identify two or three breaches of protocol. People mean the best intentions, both AT staff and the THS staff, but it is not what we have agreed on. That policy or protocol was borne out of a number of serious events a number of years ago. It is the only control measure that we have to make it as safe as we can.

CHAIR - Ambulance Tasmania, would it be fair to say, is overseeing a workplace situation for staff which has changed dramatically in the last especially two to five years where ramping hardly existed and now is common place and increasing, by the latest figures. How would you describe the approach of management to training and supporting paramedics through this new and very stressful experience and high-risk situation of being on the ramp, not being able to answer to 000 calls, having to hear them go unanswered with people in P1s and sitting maybe for hours, maybe for the whole shift, just sitting on a ramp? How've they responded?

Mr JOHNSON - Simply, not well. We have gone from ramping in ambulances and in corridors. That was before COVID. COVID presented that issue with droplet contact, airborne transmission, so having people jammed in a corridor and we have seen the photos on the ABC News of crews lined up in the corridors, which effected the opening of the new paramedic wards which was exclusively no COVID patients, but ENH has a COVID section, which is often staffed by the same paramedics that look after the other patients. We have gone from corridors to wards. We had a control measure that is quite comprehensive and at the Royal clearly says that if hospital treatment is required, hand over the …. So, the hospital must take custody of the patient and the responsibility. We see that daily that it doesn't happen. We have an off-load delay protocol introduced at the LGH that is similar to the Royal Hobart Hospital except the clause in it says, 'the hospital may start therapy'. So, they have much the same document with some variance, and we see the worst ramping in the country at the LGH.

CHAIR - Is it entrenched as an extension of the hospital? It's not actually in the hospital but it's still an extension but paramedics are still stuck there?

Mr JOHNSON - Yes.

CHAIR - The worst of all worlds, in a way.

Mr JOHNSON - It makes no priority for that crew then to get a bed because they already have a bed. It's an ambulance stretcher, and they're getting hospital treatment. So we go from corridor to ward. It's a policy that's actively breached daily.

We have no training. I wrote a brief package, as agreed, during the consultation phase with our agreement on the hazards and the control measures of ramping to be included in our single training day this year. That was taken out because of time. I've since been asked to look at drawing up a new one, but I'll see where that eventuates. That was suggested to at least capture new staff and staff ongoing with their annual training that was being reintroduced this year, we haven't had training for a number of years now, to -

CHAIR - What do you mean you haven't had training for a number of years now? On what?

Mr JOHNSON - As an operational road paramedic, when I came back to Tasmania in 2017, I think it was two days a year of training. When we became registered with AHPRA, the service essentially said that training is now your responsibility and -

CHAIR - That was mentioned previously as possibly being four days a year somebody else has said.

Mr JOHNSON - That's what we want, but it was two days back then. Those two days would turn into two days of surge work, so you'd come in for training but end up at the ramp or manning an ambulance, and then at least since COVID-19 we haven't had any face-to-face training other than the online service updates and the latest (inaudible) and all this other stuff that's done in your own time, as Ryan said, usually on your lunch break.

No formal clinical or operational training, but that's been (inaudible) as we put it in our current agreement, so we're getting two days a year, working on one day this year and one day next year as a start point. We want to include some information on ramping and the hazards and the control measures so that staff were all reset and calibrated to be able to have discussions with THS staff over contentious issues like starting treatment outside of scope, or advocating for patients who were category 2 and required a resuscitation bed straight off the bat rather than being stuck in the corridor and getting blood work and CT over the next two hours being a whole lot of unknowns with our clinical state.

CHAIR - So that hasn't happened yet though? No. How do you feel about staff wellbeing and staff concerns, the impact on staff and the risks that staff are experiencing on the ramp? How do you think they're being addressed and responded to then? What would you say about that?

Mr JOHNSON - We do keep track of the - the day before you work, they release a running sheet of the staff for the next day. It's called a muster. You'll often look at that to see who you're working with because we're often working with different people at different times. They have listed on the muster the transition-of-care staff for that next day. Often, it's blank, but often it's the same names that you'll recognise who tend to work in that area.

All I can surmise from that is that some people don't mind working in there or are happy to work in there but a lot of people aren't. We had to sit down with southern management last year and discuss staff being directed to go to the ramp to work when there were vacancies. Some people were literally in tears about being sent to work on the ramp because they really don't want to do it for a variety of reasons, whether that's an issue with registration, safety or just sitting around doing nothing or just not being respected or whatever. We had a meeting and agreed that unless you volunteer to work on the ramp you don't have to go there and work if you're sent as a case when you are shift.

If you get ramped with your patient that's bad luck. That's your patient. That's your responsibility. You manage that as you see fit. But I have had an example where I was directed to go to the ramp and I said no and I copped a bit of flak from my manager about it. I clearly said this is what we have agreed with the union. I would rather go and do that priority one that is waiting, which is what I did.

CHAIR - One of the situations you outlined in your submission relates to the risks that are posed to patients by the provision of medication to ramped patients. For those listening

who haven't read your submission, can you describe the case of the person who came off their motorbike?

Mr JOHNSON - That was a gentleman who came off his motorbike in the Kingston area and I attended. It was at the end of my shift or towards the end. He was stable but in a bit of pain and we administered him the medication, I believe Fentanyl but I would have to doublecheck my patient record.

CHAIR - That's what you said in your submission.

Mr JOHNSON - I think I checked that from the SOS report. We took him to the Royal and he was ramped. I believe he had leg and hip pain.

CHAIR - A young man?

Mr JOHNSON - Yes, he hit a small dividing road , a fairly solid object. It was a wet road. I don't think he said he was going very fast but still it was a fair impact. He was ramped and it was towards the end of my shift so I ended up handing him over to another paramedic who, from memory, was probably working solo. They were sent to the ramp, which is often the case. If your partner calls off they will try to send you to the ramp to cover patients.

I handed over and left. The next day I was advised by that paramedic that the patient was then administered further opiate medication by the hospital and there was some kind of adverse event. The only way they could reconcile the amount of medication that the individual had received, because it hadn't been written in the chart, was through the drug of dependency book. I asked if they had SLRS-ed it and I am guessing they said no.

CHAIR - Which is the Safety Learning Report Scheme System.

Mr JOHNSON - There's not a whole lot of compliance with that because a lot of people see it as quite time consuming and there's never really a resolution, so kind of pointless. I did mine and submitted that. I believe I received feedback at some point. I can't recall but there was no real follow up. That stuck with me because it highlighted how dangerous it can be very quickly for someone who is relatively stable and just needed pain relief, but the complicated care that becomes of the ramp in the corridor in a chaotic environment.

CHAIR - It meant that a young person, essentially had some sort of an overdose experience.

Mr JOHNSON - I would have to check SRLS what the exact adverse reaction that was reported, but often if they were trying to find out how much they had, they were probably under the effects of that opiate which can be drowsiness through to unconsciousness. I don't believe, unless it wasn't in the feedback, it wasn't a serious interaction or adverse event.

CHAIR - What is the common experience that's happening underlying this example? There was a series of things that went wrong in this situation. How common are the issues that you have used as this case study?

Mr JOHNSON - This happens regularly. My last shift I had a patient who was ramped. They were diabetic. They were category 2 because they were quite an unwell diabetic. We

have a room off the side of the ramp corridor and they were taken in there to get some blood work done and all the investigations. Half an hour later, because I closed the door, I tapped on the door and they had an infusion running and they had some vials of insulin in the little dish by the bed. With no consultation, still my patient because they were still under may care, but the staff had already started hospital treatment. I forced handover at that point.

This is a regular occurrence and when you involve two agencies, say AT have their obligations with their guidelines and then the hospital wants to start treatment and I fully understand that.

CHAIR - That is where you really want to do the handover, so you can go out and be free to do the work you need to do.

Mr JOHNSON - As per the transfer-of-care protocol, handover occurs at that point, so the THS needs to take that patient and put them wherever. It is not up to the ambulance service to dictate that, it becomes their patient. That is where we will reduce those examples of the double dosing or mixing medications together because we have two agencies caring. Mostly what we do in ambulance world is all fairly safe but at the same time, things like, Schedule 8 medications have serious adverse effects if used without care.

CHAIR - It sounds like there is the inevitable confusion that happens where there are multiple handovers on the ramp of patients, to different people providing care and different protocols for interventions and treatments, depending on who is there. You also have emergency doctors and other people coming in providing medication pain relief to your patient while they are on the ramp. They are coming in and having an intervention, but they are still under your care.

Mr JOHNSON - Correct.

CHAIR - If anything happens as a result of intervention they are under your care, so there are mixed messages. How does that have an impact on you, your colleagues working in that and on the patients?

Mr JOHNSON - For me, having been around for a little while, having seen the different systems, different ways of ramping, different issues and being involved as a delegate and a health and safety representative I hear and see the hazards quite clearly. You could even sit down there and say, okay, this is what is going to happen with this patient and you can guarantee, five minutes later, they will bring out some infusion pump or something. We know that is what they need, but it adds to the mix, that danger.

I have to speak up when I see it. I will have the conversation with staff about handover and compliance with the protocol and that what they are doing does not make me feel safe, or the patient. That can often lead to a handover, because the staff will then go back to their boss and say this is what been said and we need to handover. It has led to some quite ordinary interactions in the past, which has provided me with some stress.

CHAIR - It is setting up people who were working in professional collegial relationships, emergency department staff and paramedics, it is now creating this boundary dispute over who is responsible. Who has essentially the legal protection of their agency, either the THS or Ambulance Tasmania for whoever is responsible. It is this grey area and the patient is caught

in the middle. With both sets of staff - what I am hearing - is there is more opportunity for combative rather than cooperative connections, because of the pressure.

Mr JOHNSON - We get taught the concept of graded assertiveness, so when we see something that is not quite right to mention in the first instance, okay this is not sitting well. We get to a point where there is an exchange, certainly nothing inappropriate, but we need to deal with that situation. I see where a lot staff then also want to avoid that, they will let something go because they do not want to have that hard conversation.

CHAIR - Your submission says staff have been disciplined by managers for speaking up about breaches in the protocol or for not allowing treatments to occur until patient handover is completed. Can you go into a bit more detail about that?

Mr JOHNSON - I also had a colleague that was, again, quite assertive in wanting to comply with that protocol. Was taken into an office by three doctors and counselled on how inappropriate it was to stop a treatment that provided that individual with a lot of stress. That was reported to me -

CHAIR - Even though it was clearly stated on the protocol -

Mr JOHNSON - Correct. I've put in numerous Safety Reporting and Learning System reports, probably dozens over the years on treatments that have been started or delays in treatment on the ramp, mentioning outside of the agreed control measure and either got no feedback or inappropriate feedback. Summaries suggest it's the best thing for the patient at the time, from ambulance managers.

I questioned a manager on one occasion about an SRLS feedback I received about care on the ramp I thought was inappropriate. I can't remember the exact situation, but it would've been a similar either delay or commencement of treatment as per the hospital. That manager was actually quite rude to the point where they threatened me. While I didn't report it to the ambulance service at the time because I thought it was just an anomaly with them having a bad day, I did report it to the union at the time. That manager has since retired.

CHAIR - In your experience, not infrequently, when you're making a complaint or a report about where you've been forced to work outside of the rules you've been given for working within the protocol or the other guidelines, you're not getting support from management, in fact you're getting the opposite.

Mr JOHNSON - Yes, often if there's an issue I'll discuss it with obviously the THS attending staff initially. Part of the graded assertiveness, try to work it out at that level. At some point though, it normally ends up with a phone call through our communications centre to the on-duty supervisor. At times, I'll just request them to attend the hospital because it's literally two blocks away, just to come down and see for themselves what's going on. Again, going back to the control measure, which is the protocol, I'll insist on handover, or I insist on handing over to anyone else that is happy for that treatment to start and for me to leave the hospital. That has often been done in conjunction with a supervisor.

CHAIR - I want to finish with an email that was sent to all southern paramedics, it said:

> Hello all, recently we've had a few safety instances where patients have been administered medication by the RHH in the transfer of care delay area by the RHH without consulting with paramedics, who are providing care for the patients. In some of these circumstances, the medications have sat outside the scope of practice for the paramedic and in one instance the patient has experienced adverse effects from medication.
>
> This clearly has patient safety implications and the practice sits outside the agreed offload delay policy as the intention was that the patient would remain in the care of Ambulance Tasmania paramedics. We have discussed these issues with the Royal Hobart Hospital emergency department and have a process in place to manage these situations if they occur.
>
> To assist us maintaining patient safety, please ensure that we also adhere to the attached policy. Where you think there may be a risk to patient safety, or where a proposed action falls outside of policy, please have a conversation with the RHH in the first instance. Where the issue cannot be resolved at this level or you become aware of a situation that has already occurred that compromises patient safety, please contact the OS to escalate the issue appropriately.
>
> Please continue to raise issues through SRLS, but also ensure that the OS is notified in real-time. For other issues that do not require an SRLS, please liase with your OSBSO team leader in the first instance who can provide advice, resolve or escalate issues as appropriate.

Is that your experience, Cameron?

Mr JOHNSON - That's the first email I've had like that in ever. We've often asked as a union to send out regular reminders of that protocol. That was the intention of the training day to have a 15-minute session to say this is the protocol and highlight the key points which are if hospital treatment is required, handover occurs and to escalate it through the OS if need be if it couldn't be worked out with the THS staff. In the first instance, escalate it and then to report it. I wrote that brief training package for them which wasn't included in this year's training day.

That's all we've wanted because having a control measure like a protocol is the second lowest form of control measure being administrative. It is still subject to interpretation or compliance but at least it's a start. That was put in place a number of years ago because of the lack of any controls in that ramping environment.

CHAIR - Do you have confidence that management is listening to you and that when you make complaints about breaches and protocol that you'll be supported and listened to?

Mr JOHNSON - The last feedback I received was about a month ago and that was about a patient who had been ramped as a code stroke. They were suspected of having a stroke with strong indicators. They were ramped and they were CT'd whilst ramped. I reported that as it should have been handed over and then CT'd as part of optimal care. The feedback I received basically told me that's the optimal care to do CTs while ramped. I can provide that if need be but that email there, I've never seen anything like that.

CHAIR - If you could table that for the committee, what you just mentioned, that would be helpful. There is something that appears in writing but from your testimony it doesn't appear to be what's happening in practice. That's your experience anyway.

Mr JOHNSON - Dr Woodruff, I could go up there now and we could identify some breaches in that protocol and sub-optimal patient care in the ramp.

CHAIR - And then you could report them but not be supported in the reporting.

Mr JOHNSON - Often you don't even get feedback and when you do, it's very generic. There was a period where a particular manager was dealing with SRLS feedback portion and it was literally cut and paste.

CHAIR - Thank you. Anita Dow has been waiting very patiently. Anita.

Ms DOW - Thanks, Cameron, for coming in today and presenting to us, and for your submission. I want to ask you how you would describe the culture of Ambulance Tasmania?

Mr JOHNSON - I think the culture of Ambulance Tasmania was highlighted with the resilience scan that was performed a couple of years ago and the whopping negative 69 score that they received.

Ms DOW - Publicly, the service has said they have implemented a number of those recommendations. Have they all been implemented? Do you think that the service has benefited from that or would you still describe the culture as poor?

Mr JOHNSON - I believe the Cultural Action Plan is 78 pages. We are still waiting for training because that was one of the recommendations and as part of that training I suggested as a union, that we needed some awareness on the hazards and control measures for ramping. That still hasn't happened.

Ms DOW - Thank you.

Mrs ALEXANDER - I want to understand, are ambulance or other paramedics allowed to use what virtually would be called in other health settings 'chemical restraint', like the narcotics and others you have described, to sedate and calm down a mental health patient? I thought it would have been quite a specific provision, especially under human rights and chemically restraining patients.

Mr JOHNSON - We have a guideline and we are authorised to use droperidol for chemical restraint of a patient having an acute behavioural crisis. It is not done on the ramp and shouldn't be done. I don't have any examples where that has been done, but as part of the protocols and control measure, we have agreed that mental health patients shouldn't be in that ramped environment. They are and one of my submissions was about a mental health patient. There was no need for the use of restraints in that situation but we do have a guideline. We do have a guideline and we do have a medication that we use to get people who are having an acute crisis where they are a danger to themselves or others, under control. We also have soft mechanical restraints to facilitate safe transport as well, if needed.

CHAIR - Cameron, I have a few clarification questions from your submission and thank you for the detail. The patient examples you give are really harrowing and hard to read. I wanted to ask about triage and get your views as to whether things have changed at all from the situation that you described where you said there's only one triage nurse and often it can take 45 minutes to even be triaged. Your suggested measure was for an ambulance triage time of five minutes and a patient offload time of 30 minutes as the standard, which is 30 minutes in. That would be five minutes for triage and 25 minutes for the offload process. In your experience, is it still the case that there's just one triage nurse on any shift in the ED?

Mr JOHNSON - Yes, often. From recent memory, particularly at night, often there might be 2-2, but one triage nurse may be busy triaging public patients or in the waiting room seeing patients or in the little treatment area they have, taking bloods or doing something for someone who is positioned in the waiting room but they're being 'worked up'.

Often the nurse has to have a break, so there's no-one there so you wait. The 45 minute waiting, I'm pretty sure I SRSLd that one on that occasion and often it's bad because after the 45 minutes you'll get triaged and then you'll put your patient in the waiting room because they're always appropriate for the waiting room. However, out of respect and that professional courtesy, you'll go through the triage process when I could've just put my patient in the waiting room because they could have presented to the hospital themselves but we gave them a ride for whatever reason. They're the ones where, again, that would save me 40 minutes of ramping on that shift, on that one occasion. If it happens three or four times in the shift there's a couple of hours wasted.

CHAIR - In that particular instance, having an extra nurse, dedicated and prioritised to ensuring that the ramp is cleared as fast as possible, a triage nurse.

Mr JOHNSON - Yes, from my experience in the US, we had a dedicated triage nurse, they had the public entrance nurse and they had one for ambulance entrance so there were no delays. As soon as we handed over to that nurse we often had a doctor in attendance as well so we handed over to the doctor at the same time. There was no double handling of handovers as well because I'll give my handover to the triage nurse at the Royal, then I'll do another handover to the clinical intervention nurse, the one who works on the ramp, a roving nurse. Then I'll give another handover to the intern doctor who comes out to have the first look at the patient because they're a category two and they need to be seen within 20 minutes or whatever the rules are.

Then, if they're sick enough, the consultant will come out and I'll have another handover to them. You can see it starts adding up. Then, I'll handover to another paramedic because I need to have my meal break. That was the situation in the US.

In Adelaide, I know at Flinders Medical Centre they had the public entrance and they had nurses there, but we also had a nurse in the back with the ambulance ED so we could at least be triaged right away. Now, if you're still ramped, you're still ramped, but often if you're able to put your patient in the waiting room they'd go straight through so that would save a lot of double handling and time-

CHAIR - And presumably increase patient safety by making sure there's not any Chinese Whispers effects with information, or I suppose you're delivering it to each separate person. It's just that it's the waste of time having to do it multiple times.

Mr JOHNSON - The intern doctor goes back out to the main area to speak to the consultant to say this is what the paramedic has told me so there is a bit of Chinese Whispers going on. Often, if it sounds like they're going to be sick, the consultant will come out and then I'll do another handover and clarify anything that he might've been incorrectly advised on but straight away, 45 minutes of triage. If I could put my patient in the waiting room, then I have just wasted 40 minutes for no reason. If I am going to be ramped because they are a category two, then it is 40 minutes I have delayed at least the first set of bloods to be done. Then I have to wait another two hours until that is all done, before they are either told to go into the waiting room because they are okay or into a resuscitation bay because they are quite sick, having a heart attack or whatever.

CHAIR - You mentioned triage by diagnostics. Can you describe the practice for people listening. Then I would like to know whether there is a formal protocol that governs this? Is that formal approach that hospitals are taking and is it happening in all hospitals?

Mr JOHNSON - I don't believe it is a formal protocol. I would be surprised if it is because, it certainly is not best care. It also depends on -

CHAIR - This is where a person comes in and they are ramped, but it is clear they need a number of diagnostics; they will need an x-ray or blood tests taken. Whilst those things are happening, they will remain on the ramp.

Mr JOHNSON - Correct. They are ramped as a higher category, category two. They have abdominal pain, chest pain, suspected stroke symptoms or something and you are ramped. Often with those patients we will ramp in the corridor, because it is closer in proximity to a resuscitation bay just in case they do take a deterioration rather than going around to the ramp ward which is quite remote from the resuscitation area. While you are in that corridor they will still send you down for CT, x-ray, a clinical iniative nurse will come out and do bloods, confirming the triage by diagnostics.

At the end of that process - which can take between an hour and two hours depending how busy they are - some have been sent to the waiting room because they are okay, their bloods are fine or the x-ray is clear. They go to wait just like everyone else. If they are quite unwell, suspected heart attack or anything like that, then they go to a resuscitation bay and a handover occurs. As I said, it certainly is not a formalised practice that I believe happens and it will often depend on who is triaging. Some personalities will do it more than others.

CHAIR - Not a formal protocol or anything, but is something happening and it has crept in just in all hospitals in Tasmania, are you aware of?

Mr JOHNSON - It is only my experience recently at the Royal Hobart Hospital, because I only work southern region. I hadn't noticed it before we started routinely ramping category two patients. Up to the last year or two to traditionally ramp patients are the lower acuity. People who are either a false risk, so it is risky to put them in the waiting room in a chair or they are elderly, or they have dementia and need to have someone watching them, but there is no requirement for any ongoing critical treatment. This triage by diagnostics that has crept in with category two is because we are seeing more and more of these patients ramped.

As Ryan said, the resuscitation bays are full or the rest of the department is full. They do not want to use the resuscitation bay because they have a paramedic to stand with them and raise the alarm if there was something to happen. It is unfair on us and the patient. They should take those patients, immediately work them up straight away and then transfer them like Ryan said to a holding area or into a general ED bed, because at that point you know exactly what is wrong with them and can forecast. Have nursing look after them and forecast a progression on their illness rather than having the unknowns in a corridor with a paramedic.

Often, if you are by yourself, you literally cannot leave the patient or if you are in a partnership, one of us will go and get something to eat.

CHAIR - What if you need to go to the toilet?

Mr JOHNSON - You can't, not if you are by yourself.

CHAIR - That could be for hours and hours.

Mr JOHNSON - It also goes to the point if you are working with a graduate paramedic. A graduate paramedic does not have the scope of practice, they are still doing their 12 to 18 months of on-the-job confirmation training, because they already have an undergraduate.

CHAIR - You cannot leave them because they do not have that scope of practice, even if there are two of you.

Mr JOHNSON - We cannot leave them because if we left and something was to happen they do not have the clinical insight with experience but also, they do not have the authority of practice to say, I will give this medication or do something. Literally, you're stuck with that patient, which is why I'm reluctant to take more than one patient on the ramp, because now suddenly now you've two patients and an intern to watch. That becomes very quickly overwhelming, if you have that insight and awareness of the hazards on ramping.

I know a lot of people are happy to look after eight patients. Ryan said eight, but I've actually had someone report 11 patients to one paramedic in the [inaudible] ward on one day. I know some people are happy with that, but that is just crazy dangerous. Then if you have an intern with you, effectively not there because they do not have authority, you are also putting them in that difficult position, because now they're trying to do the best thing and they're a new employee. They probably don't want to say too much.

CHAIR - We’ve been trying to get some information about the number of adverse outcomes that happen to patients on the ramp. We understand a lot of things aren't logged like the increased risk to patients from not having interventions provided early enough. Not having access to medications or treatment early enough. Things have progressed and worse, when they might not otherwise have.

We asked the Department of Health about the number of patients who died on the ramp in the last five years. Their answer was there have been no patients at all who have died on the ramp. I'll read their response:

> The movement of patients between locations is administered through the TrakED emergency department information system.

> A review of these two datasets over the period 2018-19 to 2022-23 has not identified any instances where the time of a patient's death is recorded as prior to transfer of care occurring.
>
> This is consistent with how emergency departments operate. In situations where a patient significantly deteriorates (such as going into cardiac arrest) in the offload delay area, they are generally transferred to a resuscitation area or other part of the ED. If that patient is subsequently pronounced deceased by medical staff, that will occur and be recorded, in that location.

What do you think about the department's response?

Mr JOHNSON - Very slippery. I was involved in the care of a stroke patient. This is a female in her late 40s who got up to go to work and had a stroke. Quite clearly having a stroke. There was quite clear neurological involvement. We were ramped at the Royal. They were busy, we get it, we were ramped. We were sent around for CT because it was urgent; they did the CT. At that point, the neurological team upstairs came down and got involved with the patient. Now you had an ambulance team, and it was me and another crewman. You had the neuro team, which I think from memory was a couple of doctors. Then, because they came down, the ED doctor got involved as well, so we had an ED team involved.

That patient was in the corridor given the clot busting drug, which from my understanding is a very heavy drug in that it has some very serious side effects. If it were to be administered, the patient would need to have ready access to an intensive care bed. This is in the back corridor of the ED. My colleague I was working with had to ask if we wanted to hook them back up to the cardiac monitor.

I reported this incident and the excuse given by all the people involved was that handover did occur at some point. They didn't make it clear, obviously, but that was the way they weaselled out of it. Because they said handover did occur because that treatment was outside of paramedic's scope.

CHAIR - Even though the paramedics were still caring. Someone just came in and did an intervention, which is what you're saying happens all the time. During the time they're doing that, they're still under the care of the paramedic.

Mr JOHNSON - There was no handover. They were still in our care.

CHAIR - It might be they were under dual care, but they're definitely still under the care of the paramedic.

Mr JOHNSON - But because I reported it as a safety event, and quite a serious one, because of the nature of that medication and it was clearly inappropriate. As soon as that medication was given, handover did occur into a resuscitation bay because the doctors were nervous about it.

As I had reported it, the feedback that was given to me was that one of the teams at some point said that handover had occurred and there was no breach of the protocol because handover had occurred. Clearly, these are weasel words and with that statement about patients who die

on the ramp, we know from at least two experiences in the media and there are probably another two that come to mind, they've died on the ramp but they are sent to the resuscitation bay and all measures are taken to try to save them.

CHAIR - I am not sure that was the case with the woman who died in extreme pain in the Royal Hobart Hospital in the waiting room, the ambulance ramping room. Lara, you have your hand up. We have to conclude unfortunately. Do you have one more question?

Mrs ALEXANDER - You have recommended that one of the measures would be to have a permanent triage nurse 24/7. It seems like a basic and simple solution. Did you get any feedback on your recommendation because you are also part of that workforce, that group that you're on about transfer of care? What feedback have you received on this very simple but effective solution?

Mr JOHNSON - None. That committee has since established a protocol. I believe it's out for consultation on the 60-minute handover. I've read it and whilst it's a good start, there are still a couple of things in there that may still create some issues with actual handover but I believe it is still under consultation.

As far as putting on extra nursing staff for triage to streamline that process to get ambulances back out on the road, no feedback. Over the years, we have suggested numerous control measures to make the area safer, such as having a dedicated paramedic for the infectious section of the current ramp ward. I could go up there now but we know that's never enforced or made to occur for a number of reasons. Staffing issues with the ramp ward, lack of supervision and paramedics don't have the best training when it comes to infection control. Generally, we look after one patient at a time so it's not a focus of our training, although increasing patient safety is one of the new health, safety and quality measures.

Over the years as HSRs, as delegates, as a union, as staff members and having other staff members approach me and discuss what they've talked to Ambulance Tasmania, as I said earlier, we have gone from ramping in the relative safety of the back of an ambulance in a corridor to now having our own ward which is unregulated. There is no nursing care, there is fleeting doctor care with the introduction of hospital therapies. It's quite a hazardous environment and the off-load procedure that hopefully we will get through as part of our agreement, this latest one that's out for consultation, it's the greatest control measure, which is elimination, getting rid of ramping and the associated issues, as soon as possible.

CHAIR - You mentioned the ACT. You said that they'd minimised ramping in a much more controlled environment through robust policy and a much better culture on the issue. You were sceptical that throwing more money at the emergency department would help in the long-term because it's about bed blockage, which you pointed out very clearly. That's the problem with ambulance ramping. It's not a problem with Ambulance Tasmania. It is a problem with bed block and patient access into the hospital. Can you mention anything about the ACT? The committee would be keen to look at their policy situation.

Mr JOHNSON - I have had a quick look through that document. It is quite -

CHAIR - Which document is that?

Mr JOHNSON - The ACT offload protocol. It is quite basic and it does spell it out that after this time the patient becomes the hospital's and if there's any issues around clinical care, it is discussed with the relevant personnel within the ambulance service and the hospital, or the hospitals.

CHAIR - Do they have strong KPIs or policies about the triage time of five minutes and patient offload time of 30 minutes?

Mr JOHNSON - They had the time limit. I'm not sure about the actual KPIs. I'm guessing they would be at some point -

CHAIR - You propose to legislate, to have those as actual formal legislative lengths of time.

Mr JOHNSON - I think policy procedure is one thing and we see at the moment with clinical management during offload delay protocol that we see very low compliance with it and we see a lot of different interpretation or use of it. Clearly, it's not working. The next step up from that is essentially law, having it that a hospital will not keep an ambulance for more than 30 minutes. That means five-minute triage time is the only way to nip this in the bud because we see the different interpretations or the turning a blind eye to the current control measures, which I think are quite adequate and clearly define AT responsibilities, THS responsibilities, medical staff, nursing.

It's just not adhered to and it puts people in those difficult, ethical situations and we see the adverse events. We see the mismatching of care. Clearly, we need to have something a little bit stronger, and if that means legislating, and that means for all health services, including private hospitals. We're seeing ramping more and more at the private hospitals, albeit it's a lot less time and it's a lot safer because they don't start treatments. That needs to be considered to stop this.

Once everyone is on the same page and requesting an education package that is rolled out to new employees or staff on an annual basis on current trends, issues, hazards, risks, and then the appropriate control measures or techniques to manage those tight situations, using greater assertiveness or discussing concerns and then involving managers, and everyone on the same page it would work a lot better. At the moment, it's very much each individual patient and we see that as patients are individuals and they need individualised care, it just gets messy very quickly. We see time and time again, on a daily basis, patients ramped when they shouldn't be, paramedics put in positions when they shouldn't be, the THS staff are clearly under the pump. What happens inside the hospital, they're the best experts to resolve that, not us, we have nothing to do with the hospital, but get us out of there and the hospital will sort it out, surely.

CHAIR - We've got to call this session to a close, unfortunately. It's been a rich conversation with you, thank you so much Cameron. On behalf of the committee, thank you for your detailed submission, for the testimony you've given us today, and for the experience that you've given to the committee, as well as your thoughts on how things should change. We value the work that you and other paramedics do every day for the Tasmanian community.

Mr JOHNSON - Thank you for starting this.

CHAIR - Just before we leave, I will remind you about what I said at the beginning about the fact that this committee's hearing is being governed by parliamentary privilege and that means you have the support against any legal proceedings for what you've said in the room. When you leave the room, even if you're reporting on the things you've said today, if you say them in a public forum then you will not have the protection of parliamentary privilege. Do you understand?

Mr JOHNSON - I understand.

THE WITNESS WITHDREW

The Committee suspended at 11.09 a.m.