- I attended a case where I was a single officer, I was told my backup was coming from close by. On arrival the patient was unwell with a significant gastric bleed, after waiting for my back up to arrive for some time, I called to enquire of their location, only to be advised that communications had cancelled them and sent them to another case – this is against the policy of single officers and back up. I was told I could have a backup crew if they could get one off the ramp. I was located in Orielton at the time, I was then advised that all other crews were ramped and I would have to wait for an afternoon shift to start. I decided to travel with this patient on my own, advising Communications that they had subsequently put the patient and myself at risk by cancelling my backup without consultation and I now has the choice of staying at the location and the patient deteriorating or leaving and providing inadequate care but being closer to assistance. When arriving at DEM there was a prolonged time to tirage >10 min, and then the patient needed to toilet (with only me to assist), triage wanted blood tests and pending those, the patient was ramped – the on road duty managers called me 3 times to see what I was doing despite being able to see me on camera at the RHH.

- On the same day as the above case, I attended a case at Howrah (from my station at Sorell because I was the closest crew to that emergency), as a single officer. Again there was no backup dispatched to me, as per the policy, due to ramping of crews and no one available. This patient was also unwell and had difficulty extricating – again there was no backup available to assist and I decided to transport the patient by myself. This patient had a pulmonary embolus, and the care enroute was inadequate. Again, the on road duty managers called me – 4 times.

- Attended a case of female with recent diagnosis of ?liver cancer, pre-COVID. I was working with a UTAS student, as a single officer (this was also against the policy at the time). This patient was unwell and required assistance to extricate from her house, back-up was sent from the ramp. On arrival at DEM, this patient was ramped along the back corridor near the staff toilets. Whilst being ramped it became apparent that the patient had entered the actively dying phase. I liaised with hospital staff and triage multiple times over the hours of being ramped. Each time with fear, as I was forced to leave the patient in the care of a UTAS student, whilst seeking a more appropriate care option. The patients daughter and husband were in the waiting room but not allowed to sit with her due to ramping restrictions. Eventually this patient was moved to a room for the last minutes/hour of her life. Psychologically this impacted me negatively as this patient was not afforded the opportunity and comfort of having her family present with her during those hours, not to mention robbing the family of the time and above all else the inability to care for her sufficiently and in a safe and private environment – no basic level of dignity.

- Attended a mental health patient that had actively attempted suicide. This patient had also attempted to abscond from the ramping area. During the ramping time the Mental Health Order, which legally can only be in place for the hours outlined in the order, ran out - meaning that there was no legal standing for holding the patient at the hospital against their

wishes – a second mental health order can be put in place, however, the agreement and understanding of the order is that the patient is to be seen by a Mental Health Nurse within the time specified (3 hours from arrival at DEM). When this patient was attended to, the order had run out but luckily the patients was not aware of this, the MHN asked basic questions, in the corridor with other ramped patients at either side of the patient. Not only is this devoid of privacy, it also exposes others to a negative environment and experience. The patient simply stated that they no longer felt suicidal, and they were subsequently legally able to discharge themselves.

- Handed over a well know mental health patient on the ramp – again this is against procedure. This patient was violent and abusive, exposing all ramped patients to this behaviour and again providing no privacy or dignity to the patient. This patient was unable to walk and pulled himself off of the chair, and "bum shuffled" himself out the door and up the ramp, as he wanted to leave. Whilst myself and other staff attempted to return the patient to the hospital, he was swinging his fists trying to hit anyone he could – this continued for over an hour.

- I attended a patient with a significant pulmonary embolus, this patient was unwell and had vital signs to support this. We were asked to ramp in the corridor, despite the new "ramping area" being set up at that time – this patient was "too unwell" to go around but also was not given a resuscitation bay or a bed. On moving the patient onto a hospital bed the patient lost consciousness, became apnoeic, with a faint carotid pulse – ultimately pre-cardiac arrest. I pushed the Emergency Bell in the hallway and pushed this patient around to the resuscitation bays. After this occasion I left the hospital and left work for the rest of the day. This particular job had a detrimental effect on my mental health.

- I completed a transfer from the north of the state for a patient with an active cerebral bleed, that had been confirmed on CT. The patient was flown down for surgery and the case for retrieval was dispatched as a P1 to collect that patient and transfer to RHH under emergency conditions. I was assured by phone call to Communications that this patient was going up to MedSurg. On arrival at RHH DEM, this patient was ramped in the hallway. This active bleed, confirmed on CT, flown down, driven in emergency conditions – was ramped. No doubt the outcomes and quality of life for this patient were impacted. As the attending I subsequently had to stand by and watch this unfold.

- When patients are ramped they were/are also exposed to patients being moved into, or going directly into a resuscitation bay. On multiple occasions I have taken patients post cardiac arrest, or traumatic event into a resuscitation room in the view of ramped patients, exposing them to the traumatic event and providing little privacy or dignity to the patient.

- Whilst ramping in the corridors it was commonplace to undertake 12 lead ECGs on patients, both male and female. Risking exposing them to others on the ramp, as the ECG placement goes directly onto the chest of the patient, around the left breast. Whilst every attempt can

be made to ensure privacy, this is no doubt an awful experience for the patient and is certainly not dignified.

- Whilst ramping in the corridor it was no unusual to see or have to assist a patient to toilet in the corridor. Whilst every attempt is made to ensure privacy it is quite obvious to those around that the patient is toileting. This would occur as the “ramping room” would have patients in it and a bed will not fit into the “relatives room” and all other rooms were full. There was literally no place for a patient on a bed to toilet privately. If the patient was well enough, they could be put onto a commode or wheelchair and taken to the toilet, but for those too unwell on a bed, there were no other options.

- Whilst ramping in the corridors it was common practice to insert IV cannulas, this would block the hallway for the time it took to insert a cannula. People would not usually wait and would push past or walk past in one way or another. Increasing the risk of needle stick injury to the clinician, patient or the person walking past. This invasive procedure would occur in the view of other patients exposing them unnecessarily and increasing their risk of being in contact with another patients bodily fluids.

- The new “ramping area” is a festering pool where patients go and are then forgotten about by the hospital. Whilst waiting in this area you can be expected to undertake many nursing duties – which is against policy but if you do not do them it is detrimental to the patient and their outcomes. You are in a position of being responsible for going against policy and procedure or being the cause of poor outcomes and quality of life for the patient.

- Whilst in the ramping area it is an expectation that you can go and get your lunch there and have a break, at times Communications staff will see that as your allotted break, or perceive that you have had a sufficient rest.

- Whilst ramping in the hallway, staff were expected to care for as many patients as possible. 2 low acuity patients per qualified paramedic was the policy. However duty managers pressured and demanded that you could take more. When a paramedic worked with an intern the number of ramped patients was reduced to 1 per paramedic and intern due to the intern not being able to practice independently. Duty managers and Comms staff would demand that in these circumstances, you take 2 or more patients and often related if you didn’t take them to your lack of ability as a paramedic. “Can’t you handle two” etc. Or would tell other crews that you “wouldn’t take their patient” resulting in them not being able to leave, and causing friction amongst workers and increasing the pressure to take another patient.

- Ramping nightshift crews and holding them over occurred regularly, as regularly as almost every shift. The policy was that ramped nightshift crews were to be relieved by the first available crew – pending a priority 1 case or a priority 0 (cardiac arrest). It was the norm that the nightshift crew would be held over until a day shift crew arrived at the hospital, after attending a case, with their own patient, and then once they were triaged and ramped, they would relieve a nightshift crew. Zero attempt was made by Communications Duty Manager to relieve the ramped nightshift crews, when calling to ask what their plan was it was

inevitable that they would refuse a crew for relief and were not proactive about relieving the crews as per the policy – this would cause the nightshift crews into forced overtime and push out a 14 or 12 hour shift into a 17, 16 or 14 hour shift, and then the crew would need to return to their station and unpack and then drive home fatigued. This in turn increased the amount of staff calling in sick for the second night shift due to being fatigued and generally unsupported.

- Whilst being ramped at RHH, both in the corridors and in the "ramping area" communications officers, communications duty managers and on road duty managers would call to ask; "how long will you be" "are you done yet" "can you hand over" "when can you leave" or to tell you "we have P1's waiting" "we have jobs waiting" "we need you to respond" "we don't have free crews", constantly and persistently applying pressure to the on road staff, multiple times a day, and impacting on their mental health and wellbeing.

- The constant pressure on the ramp that is applied by TAS Communications Officers, TAS Communications Duty Managers, TAS On Road Supervisors, DEM nursing staff and DEM Doctors is completely unacceptable and has significant negative impacts on the mental health of the on road staff. Not to mention that the ramp is already a breeding ground/cesspit for and of inter-ambulance conflict, negativity and poor workplace culture.

- I have made safety reports about multiple situations, some of the above mentioned, that occur on the ramp. For almost all situations it was deemed that "no harm" was caused as the patient did not die or did not show any signs of harm at the time. There is no doubt that almost all of these patients received substandard care, endured prolonged recovery and had less than optimal outcomes. We either care about patients or we don't. There is no point conducting case reviews and auditing at TAS, if we offer substandard care and that is "ok" because "no one died". We either have integrity, or we don't.