HACSU
Health & Community Services Union

Ambulance Ramping in Tasmania

Submission of the Health and Community Services Union to the Select Committee on Transfer of Care Delays (Ambulance Ramping)

Background

The Health and Community Services Union (HACSU) is the largest union in Tasmania, representing over 10,000 members across a range of sectors.

Approximately 3500 of our members are employed in public health, primarily for the Tasmanian Health Service and Ambulance Tasmania.

The issues laid out in this submission are either known or have been reported to HACSU by members working in the relevant areas in health and community services, or are known to us through our ongoing involvement in representing health and community services workers and liaising with health and community services administrators for over 100 years.

We are a strong and rapidly growing union that remains committed to working with stakeholders to ensure the best health outcomes and community systems are properly supported to meet the needs of the Tasmanian community, now and into the future.

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[redacted]

"Every ramping instance feels like a game of roulette, it just feels lucky when nothing goes seriously wrong."

Ambulance ramping and bed block in Tasmania

a) **The causes of transfer of care delays, acknowledging Federal and State responsibilities;**

Transfer of care delays (or ambulance ramping) is a multifaceted challenge that affects the entire healthcare system, from the moment a patient requires urgent medical attention to their eventual admission and treatment within our healthcare facilities. To adequately address this issue, it is crucial to acknowledge the shared responsibilities of both the Federal and State Governments in the context of healthcare delivery.

Federal Government responsibilities

Funding allocation: The Federal government plays a pivotal role in healthcare funding allocation, which directly impacts the capacity and efficiency of our healthcare system. Adequate funding is essential to ensure that healthcare facilities, including emergency departments, have the necessary resources to provide timely care.

Health workforce: As the overseer of national health workforce policy, the Federal government shares the responsibility for ensuring an adequate supply of healthcare professionals, including doctors, nurses, and paramedics. Shortages in these critical roles can exacerbate transfer of care delays, as well-trained personnel are essential for prompt patient care.

Primary care: The Federal government has a responsibility to support and strengthen primary care services, including more allied health services, general practitioners and community clinics. Enhanced primary care can help alleviate the burden on emergency departments, reducing the likelihood of ambulance ramping due to non-emergent cases.

State Government responsibilities

Hospital capacity: State Governments are primarily responsible for hospital infrastructure and capacity planning. Insufficient bed availability, outdated facilities, and inefficient resource allocation contribute significantly to ambulance ramping and transfer of care delays. Investment in hospital infrastructure and capacity is vital.

Emergency medical services: The operation of ambulance services falls under the purview of State Government. Timely ambulance response and efficient patient handovers at emergency departments are essential to mitigate ramping. Adequate funding and resources for ambulance services are crucial.

Community health services: To reduce ambulance ramping and transfer of care delays, it is imperative that State Governments invest in community health services. These services can

provide an alternative to emergency department care for non-emergent cases, alleviating the pressure on emergency departments.

Allied health services based in the community are proven and effectual strategy to keep people healthier and/or keep underlying conditions managed which means less pressure on ambulance services and emergency departments.

Addressing transfer of care delays, especially ambulance ramping, requires a collaborative effort between the Federal and State Governments. Adequate funding, strategic workforce planning, enhanced primary care, improved hospital capacity, efficient emergency medical services, and robust community health services are all essential components of a comprehensive solution.

> *Ramping regularly kills my motivation to come to work and it's burning into my career.*
>
> *It leaves me fatigued and so beyond exhausted that I cannot recover.*
>
> *I often dread coming to work…I know that staff are calling in sick because they are so fatigued, they are a danger to themselves and others after spending 10 hours of a 14 hour night shift on the ramp.*
>
> *– Paramedic, Northern Tasmania*

b) The effect transfer of care delays has on:

(i) Patient care and outcomes;

Ambulance ramping profoundly impacts patient care and outcomes, warranting immediate attention and intervention from both Federal and State Governments. The Health and Community Services Union (HACSU) represents the dedicated workers who witness these effects firsthand and advocate for immediate improvements in patient care within the Tasmanian healthcare system.

Compromised patient safety: Prolonged delays in transferring patients from ambulance care to hospital facilities expose individuals to significant risks. Patients in need of immediate medical attention experience deterioration in their conditions while awaiting admission. It is a distressing reality for our healthcare workers that patients who should receive prompt care often endure unnecessary suffering due to these delays.

Increased mortality rates: Studies have shown a direct correlation between ambulance ramping and transfer of care delays and increased mortality rates. Patients with time-sensitive conditions, such as heart attacks, strokes, or severe traumas, are at a significantly higher risk of adverse outcomes when ambulance ramping prevents them from receiving timely treatment in the emergency department. This directly leads to avoidable loss of lives.

Prolonged pain and discomfort: Patients experiencing ambulance ramping and transfer of care delays endure prolonged periods of pain, discomfort, and anxiety. This suffering extends not only to the patients but also to their families who are left in a state of distress and uncertainty.

Overburdened healthcare workers: Our healthcare workers, especially paramedics and emergency department staff, bear the brunt of these delays. The strain on their physical and emotional well-being is substantial. They are forced to provide care in less-than-ideal conditions, often having to prioritise cases based on severity while knowing that others are waiting in distress.

Impact on mental health: The mental health of our members who are healthcare workers is a growing concern. Witnessing patients' suffering due to ambulance ramping and transfer of care delays, feeling powerless in the face of these issues, and fearing the potential consequences on patients' lives all contribute to significant stress, anxiety, and a greater prevalence of post-traumatic stress disorder (PTSD) among our dedicated members.

Reduced quality of care: The pressures and frustrations stemming from ambulance ramping and transfer of care delays can result in reduced quality of care. Healthcare workers find themselves unable to devote the necessary time and attention to each patient, leading to clinical errors or oversights.

Negative public perception: When patients and their families experience prolonged delays and suboptimal care, it erodes their trust in the healthcare system. Negative experiences can have lasting implications for public perception, making individuals hesitant to seek medical assistance in emergencies. There is a disconnect between the perception of dedicated health workers and the system in crisis in which they work. The public perceives health workers to be heroes, however the public perception of their health services continues to be eroded because of an inability of governments to deliver sustainable and innovative solutions to a known and long running issue, ambulance ramping.

Resource allocation challenges: Transfer of care delays also affect resource allocation within the healthcare system. The longer patients occupy ambulances and emergency department spaces, the fewer resources are available to address other critical healthcare needs, creating a cascading effect on overall healthcare delivery.

Ambulance ramping and transfer of care delays have far-reaching consequences on patient care and outcomes. Patients' lives are at stake, and healthcare workers are grappling with the emotional toll of witnessing these issues daily. Our members must deal with calls for ambulances, sometimes 000 calls, when there is no response available because all resources are allocated elsewhere.

This occurs in Tasmania on an increasing basis. The sole cause of this issue is ambulance ramping. When an ambulance is stuck at an emergency department with a patient, they are unable to respond to calls for assistance in the community, which is the core function of ambulance services.

> *I know I have left patients at home that should have gone to hospital... but ramping is such a trigger, it causes you to make bad decisions and I know this is true for other paramedics.*
>
> *– HACSU Paramedic*

(ii) Ambulance response times and availability;

Ambulance Tasmania's performance reports unequivocally reveal the grave consequences of ambulance ramping and transfer of care delays on ambulance services within our state. These reports provide concrete data that underscore the urgent need for systemic reforms to address the challenges faced by our healthcare system.

Delayed response times: Ambulance ramping and transfer of care delays directly lead to delayed response times for ambulances. As paramedics remain at hospitals with patients due to ramping, they are unavailable to respond to new emergency calls promptly. This results in longer waiting times for individuals in critical need of medical assistance, amplifying their suffering and increasing the risk of adverse health outcomes.

Increased call volumes: The prolonged presence of ambulance crews at hospitals exacerbates the strain on available resources. As more ambulances are occupied with patients awaiting transfer, fewer units are available to handle incoming emergency calls. The performance reports demonstrate that this increased demand often surpasses the capacity of the ambulance service, creating a backlog of emergency requests.

Resource allocation challenges: Ambulance ramping and transfer of care delays have a domino effect on resource allocation. Ambulance Tasmania is compelled to allocate a significant portion of its resources to cope with ramping-related issues. This diverts

resources away from other critical areas, leaving Tasmania's ambulance service stretched thin and less able to respond effectively to all emergency situations.

Impact on rural communities: Rural communities in Tasmania experience disproportionate consequences due to ambulance ramping and transfer of care delays. The limited availability of ambulances in these regions means that delays can be even longer, placing residents at an elevated risk during medical emergencies. This inequity in service access is a matter of great concern.

Healthcare worker burnout: Prolonged waiting times at hospitals not only affect patients but also take a toll on paramedics and ambulance staff. The strain of managing transfer of care delays leads to burnout among these dedicated professionals, which can ultimately impact their ability to provide high-quality care.

The impact of ambulance ramping and transfer of care delays on ambulance response times and availability is a crisis that demands immediate attention and intervention. Delayed responses and stretched resources put lives at risk and undermine the fundamental principles of our healthcare system. Our healthcare workers and the communities they serve deserve nothing less than immediate action to rectify these critical issues and ensure the safety and well-being of all Tasmanians.

> *The worst thing of all - worse than the patient dying on the ramp - was that they died in pain because we don't have access to scheduled medication in the Ramp Ward.*
>
> *I called the hospital staff several times on that shift, but they didn't come.*
>
> *– Paramedic, involved in the reported death of patient, Mrs Schram*

(iii) Wellbeing of healthcare staff;

Ambulance ramping directly impact the mental health and wellbeing of healthcare workers. The following psychological effects are prevalent among paramedics, other ambulance workers and other emergency department workers as they navigate the complex and emotionally charged environment created by these delays.

Burnout: The extended periods spent at hospitals while awaiting patient handovers place an immense burden on paramedics. The constant juggling of responsibilities, coupled with the frustration of stalled patient care, contributes to burnout. The relentlessness of this situation can lead to exhaustion, detachment from work, and reduced job satisfaction.

Stress and anxiety: The unpredictability and uncertainty associated with transfer of care delays create chronic stress and anxiety among paramedics and other healthcare staff. The perpetual waiting, coupled with concerns about patient outcomes, generates a heightened state of alertness that is emotionally draining.

Depression: The cumulative effect of witnessing patients in distress, coupled with the inability to provide timely care due to delays, can lead to depressive symptoms among paramedics and other healthcare workers. The sense of powerlessness and frustration in these situations often gives rise to feelings of hopelessness.

Post-Traumatic Stress Disorder (PTSD): Paramedics and other healthcare staff frequently encounter traumatic situations during their careers. Ambulance ramping and transfer of care delays, especially when compounded by adverse patient outcomes, can serve as traumatic events that contribute to the development of PTSD. The recurring nature of these incidents can exacerbate symptoms and impact long-term mental health.

> *After being ramped for two hours with chest pain, and when the hospital had finally completed the blood tests to determine if the patient was having a heart attack, she was informed by the doctor she had. I'll never forget the cry the patient let out.*
>
> *– HACSU Paramedic*

Moral distress: Paramedics and other ambulance workers are dedicated to providing timely and compassionate care to patients. Ambulance ramping and transfer of care delays force them into ethically challenging situations, where they are unable to fulfill their professional duties due to system-related constraints. This moral distress can result in guilt, shame, and moral injury.

Addressing the impact of ambulance ramping on healthcare staff wellbeing is a critical imperative. Failure to do so not only jeopardises the mental health of these essential workers but also undermines the overall quality of healthcare services provided to the community.

(iv) Emergency department and other hospital functions;

HACSU recognises the multifaceted and far-reaching impact of ambulance ramping and transfer of care delays on the functions of emergency departments (EDs) and other

hospital services. There are significant consequences of these delays they include efficiency, capacity, and overall effectiveness of hospital operations.

Strain on Emergency Department resources: Ambulance ramping and transfer of care delays place an enormous strain on ED resources, contributing to a cascading effect of challenges that ripple throughout the hospital.

ED overcrowding: Delayed patient handovers exacerbate ED overcrowding, as incoming patients cannot be admitted promptly. This overcrowding leads to prolonged waiting times, compromised patient care, and increased dissatisfaction among patients, paramedics and other healthcare staff.

Resource allocation: Hospitals must allocate a substantial portion of their staff and resources to manage the influx of patients stranded in EDs due to ambulance ramping and transfer of care delays. This allocation diverts attention and resources away from other critical areas of the hospital.

Patient flow: Effective patient flow is essential for timely care and resource utilization. Ambulance ramping and transfer of care delays disrupt the flow by occupying beds that could be used for new admissions. This disruption leads to inefficiencies and bottlenecks throughout the hospital.

Impact on hospital functions beyond the ED

Transfer of care delays do not only affect ED operations; they have a domino effect on various hospital functions:

Elective procedures: Hospitals often face the need to cancel or reschedule elective surgeries and procedures due to the unavailability of beds caused by ED overcrowding. These delays can have serious consequences for patients awaiting necessary treatments.

Inpatient care: Delayed patient handovers impede the ability to admit patients from the ED to inpatient units. As a result, inpatient units may experience delays in receiving new admissions and struggle to allocate beds effectively.

Nursing workforce: The nursing workforce faces the challenge of managing patients in the ED for extended periods. This situation places additional pressure on nursing staff and impacts their ability to provide timely and quality care.

Resource allocation: Hospitals must allocate additional staff and resources to address the backlog of patients in EDs. These resources could otherwise be directed towards enhancing patient care, research, and other vital hospital functions.

Patient experience: Prolonged stays in EDs due to transfer of care delays have a detrimental impact on the patient experience. Patients face extended wait times, which can lead to increased stress, discomfort, and dissatisfaction.

The urgent need for solutions: HACSU underscores the urgency of addressing the profound impact of ambulance ramping on ED and hospital functions. Immediate action is essential to safeguard the quality of care provided to patients and ensure the efficient operation of healthcare facilities.

> *There's constant blurring of care responsibilities by paramedics, nurses and doctors each bound by a different scope of practice and separate patient care documents leaves patients totally vulnerable to clinical errors, and healthcare workers to litigation.*
>
> *– Paramedic, Southern Tasmania*

We propose a number of solutions later in this submission

Systemic reforms: Governments and healthcare institutions must invest in systemic reforms aimed at improving patient flow, reducing ED overcrowding, and streamlining hospital processes. These reforms should prioritise the timely handover of patients from ambulance services to Eds.

Enhanced communication: Effective communication channels between ambulance services and hospitals are crucial. Implementing standardised procedures for patient handovers and information sharing can expedite the process.

Capacity expansion: Hospitals should explore opportunities to expand their capacity, including increasing bed availability, optimising resource allocation, and investing in surge capacity strategies during peak demand periods.

Performance metrics: Monitoring and reporting on transfer of care delays should be transparent and standardised. Hospitals and ambulance services should be held accountable for meeting specific benchmarks related to patient handovers.

Patient-centred care: Hospitals should prioritise patient-centred care by minimising delays, improving patient experiences, and ensuring that patients receive timely and appropriate treatments.

HACSU calls upon Federal and State Governments, as well as healthcare institutions, to recognise and address the detrimental impact of ambulance ramping on ED and hospital functions. Timely interventions and systemic reforms are essential to alleviate the strain on resources, enhance patient care, and ensure the overall effectiveness of hospital operations

c) The adequacy of the State Government's data collection and reporting for transfer of care delays;

HACSU acknowledges the critical role that data collection and reporting play in healthcare management, policy development, and ensuring transparency and accountability.

Ambulance ramping poses significant challenges to the accurate and comprehensive collection of data related to ambulance services and patient handovers. Several factors contribute to these challenges:

Variability in definitions: There is a lack of standardised definitions and criteria for what constitutes ramping or a transfer of care delay. This variability makes it difficult to consistently identify and report on such delays across different regions and healthcare facilities.

Incomplete records: The chaotic and time-sensitive nature of patient handovers during ambulance ramping can lead to incomplete or inaccurate record-keeping. Paramedics and healthcare staff likely do prioritise patient care over documenting the delay.

Lack of real-time data: Many healthcare systems still rely on manual data entry and reporting, which may not capture real-time information on transfer of care delays. Delayed reporting hinders timely interventions.

Data silos: Data related to ambulance services, EDs, and hospitals may be stored in separate systems or databases, making it challenging to correlate and analyse data across the care continuum.

<u>Impact on reporting adequacy</u>

The challenges associated with transfer of care delays have direct implications for the adequacy of the State Government's data collection and reporting:

Underreporting: Ambulance ramping and transfer of care delays may be underreported due to inconsistencies in definitions and incomplete records. As a result, the extent of the problem may be underestimated, hindering effective policymaking.

Data lag: Delays in data entry and reporting can create a lag in the availability of information on transfer of care delays. Timely data is essential for identifying trends, addressing issues promptly, and improving patient care.

Inaccurate analysis: The lack of real-time data and the presence of data silos can lead to inaccurate analyses of the causes and consequences of transfer of care delays. This limits the State Government's ability to implement targeted interventions.
Resource allocation: Inadequate data on ambulance ramping and transfer of care delays can hinder informed resource allocation. Without a clear understanding of the extent of the problem, it is challenging to allocate resources effectively to address the issue.

Standardised definitions: Establish clear and standardised definitions and criteria for transfer of care delays to ensure consistent reporting across all healthcare facilities and regions.

Real-time data entry: Implement real-time data entry and reporting systems that capture transfer of care delays as they occur. This enables timely interventions and data-driven decision-making.

Integrated data systems: Promote the integration of data systems across ambulance services, EDs, and hospitals to facilitate seamless data sharing and analysis.

Quality assurance: Develop quality assurance mechanisms to ensure the accuracy and completeness of data related to transfer of care delays. Regular audits and validation processes can help identify and rectify discrepancies.

Transparency: Foster transparency in data reporting by making relevant information accessible to the public, healthcare providers, and policymakers. Transparent reporting encourages accountability and improvement efforts.

HACSU emphasises the need for improved data collection and reporting mechanisms for transfer of care delays. Addressing the challenges associated with data collection is essential for accurately assessing the extent of the issue, implementing effective solutions, and ultimately improving patient care and outcomes.

d) the State Government's response to transfer of care delays and its effects to date, and the efficacy of these measures;

HACSU recognises the critical role of government response in addressing transfer of care delays and their impact on the healthcare system.

> *Ramping has many negative outcomes on the patients which I'm sure the data would demonstrate. As well as a significant impact on community care and operations.*
>
> *What isn't being demonstrated or quantified is the significance of ramping on our culture, our morale, and on the people working in these areas daily.*
>
> *– Paramedic, Northern Tasmania*

Impact on Government response

Ambulance ramping delays have placed significant strain on the healthcare system, affecting both patients and health workers. The challenges posed by these delays have necessitated a government response, but their impact is not having any measurable effect on ambulance ramping.

Resource reallocation: Transfer of care delays have led to the reallocation of resources, including additional funding, staff, and infrastructure, to address the immediate issues arising from these delays. While these efforts are commendable, they have placed a considerable burden on the capacity of the public health system to continue to deal with increasing demand.

Policy development: The prevalence of ambulance ramping delays has prompted the State Government to develop policies and guidelines aimed at reducing these delays. These policies have necessitated substantial time and effort in their formulation and implementation.

The measures in reality are safety processes to attempt to control ramped patients more effectively. This does not seem to have had any positive effect on reducing ambulance ramping, albeit it does provide for a slightly safer environment for our Paramedic members.

Stakeholder engagement: The government has engaged with various stakeholders, including healthcare providers, unions, and patient advocacy groups, to address transfer of care delays. These consultations require ongoing resources and coordination.

Public awareness: Ambulance ramping delays have gained public attention, leading to increased scrutiny and accountability for government actions. Public awareness has contributed to pressure on the government to respond effectively. However, the issue has been known and worsening for over a decade. The public are rightly concerned that their resources are being used effectively and for the purpose they are designed.

Efficacy of Government measures

While the State Government has taken several measures to address transfer of care delays, their efficacy and impact on healthcare workers and patients need to be assessed.

Reduction in delays: The effectiveness of government policies and resource reallocation in reducing transfer of care delays should be evaluated. Have delays decreased, and to what extent, as a result of these measures?

Worker wellbeing: An assessment of the impact of government actions on the wellbeing of healthcare workers is crucial. Have measures improved the psychological and physical health of paramedics and other staff affected by transfer of care delays?

Patient outcomes: The ultimate goal of government response is to enhance patient care and outcomes. Are patients experiencing improvements in the timeliness and quality of care as a result of government interventions?

Resource allocation: An evaluation of the allocation of resources is necessary to ensure that resources are distributed optimally. Are resources being allocated efficiently, and is there a balance between short-term and long-term solutions?
Data collection and reporting: The effectiveness of government efforts in enhancing data collection and reporting related to transfer of care delays should be assessed. Is the government now equipped with accurate and timely data to inform decision-making?

<u>Recommendations for improvement</u>

Performance metrics: Establish clear performance metrics and benchmarks to measure the impact of government actions on reducing ambulance ramping delays and improving patient care.

Regular monitoring: Implement regular monitoring and reporting mechanisms to track progress and identify areas where adjustments or additional interventions are needed.

Worker support: Prioritise the wellbeing of healthcare workers by providing mental health support, training, and resources to mitigate the psychological effects of transfer of care delays.

Public engagement: Foster ongoing engagement with the public, healthcare professionals, and unions to maintain transparency, gather feedback, and adjust policies as necessary.

Long-term planning: Develop long-term strategies for addressing transfer of care delays, considering factors such as population growth, aging demographics, and changing healthcare needs.

e) **Measures taken by other Australian and international jurisdictions to mitigate transfer of care delays and its effects;**

f) **Further actions that can be taken by the State Government in the short, medium, and long term to address the causes and effects of transfer of care delays; and**

g) **Any other related matters incidental thereto.**

HACSU Ambulance members' experiences of ramping

Paramedic – Northern region

Ramping - on the regular kills my motivation to come to work and it is burning into my career. It leaves me fatigued and beyond exhausted that I cannot recover. I often dread coming to work pre an overtime message coming out about TOCD officer or limited staff on. I know that staff are calling in sick because they are so fatigued, they are a danger to themselves and others during operation after spending 10 hours of a 14 hour night shift on the ramp.

I despise being a single officer because although there are limited cases you can attend, you become the ramping officer, therefore 9.5 hours of the day is spent inside the LGH with no sunlight, limited movement, and lack of energy. The mood within the hospital when the ramping is present drops dramatically and effect our personal lives.

Although we know there are boundaries within the ramping policies and procedures, we tend to assist the nursing staff to help offload patients sooner but completing Ambulance skills utilising hospital resources. We often assist nursing staff with basic care of other patients that are offloaded because they are overworked and help where we can. We know that this issue is not one frontline staff members fault.

Branch Station Officer – North West region

Although I'm no longer regularly ramped in my current role, I do experience the consequences of offload delay and already poor resourcing on a near-daily basis. As a BSO working in rural Tasmania, with a response area covering 12% of the Tasmanian landmass, I usually make an effort to request a rendezvous with another AT resources so that I can return to my area of responsibility.

Increasingly, these rendezvous are becoming less and less common, directly attributed to high workload in urban areas, poor resourcing allocation, and offload delay at the North West Regional Hospital. The same occurs when I request back-up resources when I am responding as a single officer to a high-acuity case. This has caused increased stress to my work-life balance, and directly results in my community, and my family, being left without a nearby ambulance for often at least 3 hours.

I have been approached on my days off while in Woolworths and criticised by members of the public due to already poor perceptions of ambulance availability within this community. Several of my VAO's have also bore the brunt of angry and disgruntled locals relating to these issues. The impacts of offload delay directly exacerbate these issues.

Paramedic – Southern region

Ramping is clearly perpetuating systemic failures and shifting the issues of hospital bed block onto the community and paramedics. There are plenty of beds in the hospital, just no nurses to look after the patients that could be in them. Bed space is rarely the issue, lack of nursing staff is the real issue...and because there are not enough nurses, paramedics get left to fulfil their role- one which we haven't been trained well enough for, and one which we never wanted to do in the first place.

AmbTas has a transfer of care delay guideline that very clearly states that paramedics should not provide any care to patients outside of our scope of practice whilst ramped...but patients of often ramped for hours, sometimes days! Often paramedics are put in such an uncomfortable position that they are willing to risk their own professional registration to ensure a patient can receive the care they require whilst still ramped. This is not fair on paramedics. And it's not fair on patients. Paramedics are not experts on care inside a hospital, our domain is outside the hospital. I personally have had patients lie about patient treatment, literally sneak it behind my back, place official complaints about me for trying to follow AmbTas guidelines and policy. Ramping has created a sub-standard environment for patient care and has created an agar dish for interpersonal conflict. We know ramping can be prevented, and we even have some solutions, why are we not pushing to end ramping and all the negative outcomes to which it leads?

Ask any paramedic, they'll have a story about something terrible they've witnessed whilst ramped. Let us do our job that we love, the job that we signed up for and worked so hard to attain. End it now. We know you can.

Paramedic – Northern region

I have had many patients deteriorate on the ramp and be finally transferred to resus, even after trying to advocate for them to not be ramped through the initial triage and throughout the entire delay process, through Doctors and the Nurse Navigator. Just today my patient had a seizure on the ramp with me.

Furthermore, transfer of care delays significantly degrades morale and promote fatigue due to lost hours in sleep on night shift, managing multiple patients with limited resources, and inability to be released from shift due to being 'stuck' on the ramp at the end of shift.

Paramedic – Southern region

There’s constant blurring of care responsibilities by paramedics, nurses and doctors each bound by a different scope of practice and separate patient care documents leaves patients totally vulnerable to clinical errors, and healthcare workers to litigation.

As a result, patients often just get left, with frustrated paramedics chasing ED staff for interim stop-gap measures such as pain relief or bedside ultrasounds. Paramedics do their best to provide improvised nursing care to high needs patients. A delay in proper assessment/care planning for patients clearly shows its impact. Patients are frustrated, in pain, largely unfed as they are not included on the hospital meal list, not medicated (regular meds need to be documented and administered by ED staff) and are increasingly being seen to deteriorate clinically.

Every ramping instance feels like a game of roulette, it just feels lucky when nothing goes seriously wrong.

Paramedic – Northern region

Ramping has many negative outcomes on the patients which I'm sure the data would demonstrate. As well as a significant impact on community care and operations. Again, which the data can demonstrate. What isn't being demonstrated or quantified is the significance of ramping on our culture, our morale, and on the people working in these areas daily.

The ramping situation has stripped paramedics of their identity and their purpose. Paramedics are effectively given the scope of a student nurse and told to watch their patient being left untreated, as they hang out in this political limbo. I can confidently say that the people and the service would improve dramatically with a time cap on ramping. 1hr is a good start point and an attainable goal. This should be the immediate action put in place.

Paramedic – Northern region

I was ramped and another crew got a Priority Zero and had to offload their patient to the hospital. The patient was very unwell and having runs of VT, with an altered GCS, on the background of having had an unwitnessed fall. The crew had to go and take their monitor. The hospital staff were seemingly disinterested in this very unwell patient and left her lying in the hallway without any monitoring. I then got paged to a Priority One and had no chance to follow up or take further action. I can only assume something was sorted out because I haven't heard about it in the news or through a coroner's report. But this sort of thing happens regularly and is the most stressful part of the job. I've been ramped with palliative patients lying in the hallway and dying amongst the chaos instead of somewhere more dignified for them and their families.

The mental toll is enormous. We are constantly coiled springs, waiting for something bad to happen until action is taken by those with the power to act. People die needlessly and have adverse outcomes because of ramping. How many more deaths until this is taken seriously - good staff are leaving because of ramping. We don't need more 'therapy dogs' or wellbeing officers; we need the actual problem fixed.

Intensive Care Paramedic – Southern Region

You have mentioned the issues of mental health and wellbeing, however the safety of the physical environment is also in need of expansion.

As you know, we ramp in two places, the corridor at RHH DEM and also TOC. When in the corridor it is not unusual to have 4-5 patients on stretchers there, making physical space an issue and movement through the space. This is worsened where a patient is on a mental health order, or there is a takedown happening in the department. There are other aspects of patient safety and privacy that need to be considered, I have seen sensitive examinations and also toileting on stretchers happen in crowded corridors. The privacy of the patient and their dignity is often compromised, and that creates a risk for our colleagues as well.

Paramedic – Northern region

Ramping is your main reason for burn out. We sit there for the majority of our shifts getting stuck in the negativity that creeps onto us, spreading like a virus that informs the culture. We are made to sit there, whilst the nurses and doctors tend to our patients as if we are grounded by our parents, whilst community members practice the same patience waiting for us to respond in their most dire life moments. For three months I started every shift with a page to the ramp as the echoes of the more experienced paramedics of a better time where we were able to practice our profession and genuinely help our community members ran through my head.

I once had to call an ICP to the ramp because it took so long to even triage prior to being ramped, the patient was deteriorating towards death despite all I did at scene to stabilise them and bring them to the hospital for treatment. When friends tell me they went to the hospital my immediate response is 'I'm so sorry'.

The effects of ramping on our patients start before we go to hospital, convincing a patient to stay at home is universally considered a victory despite the risks, only due to the fact there is ramping. The entire culture of treatment changes during those rare times where news of the availability of beds spread like wildfire. The worst is when you are ramped past midnight, sitting underneath the bright lights of ED whilst your patients snore, often in hospital beds, being tended to by hospital staff, treated by hospital tools and medications, and you know you'll be there until 8am. It's as if the 5 year burn out rate has been engineered.

Paramedic – Southern region

When patients are ramped with us, there is an expectation from the hospital staff that we will look after their every need which includes jobs that are completely out of our job description and training (e.g transferring patients around the emergency department in hospital beds, cleaning up after our patients if they make a mess, toileting the patients etc).

In fact, it's not just that there is an expectation to perform these duties, but there is often a necessity to do so. For example, if I am stuck with a patient on the ramp for several hours, and they are unable to walk or have poor mobility, and they suddenly need to use the toilet, that is now my problem to deal with. I would be well within my rights to call for a nurse to come and toilet the patient for us, but when the emergency department is busy (which is most of the time), the nurses seldom have the time to come and assist us as they are already overwhelmed by the demands of their job.

It is also something that I, and I'm sure many of my colleagues, do not feel comfortable doing as it feels like passing the buck and has the potential to cause tension between us and the nurses. Furthermore, if there are multiple patients on the ramp, some of them will inevitably have to be neglected if we are required to toilet another. This poses risks to both patient's safety and our own registrations as we are ultimately the ones responsible for their care while they are on the ramp. We are paramedics. We are trained to drive around in ambulances and provide pre-hospital emergency care to patients. We are not orderlies. We are not ward aides. We are not nurses. Sadly, however, we are required to act as all 3 at times when we are on the ramp.

Doctors will often try to commence treatment on ramped patients with medications that we are not permitted to give. Of course, in a lot of cases, this can be beneficial for the patient, however there are inherent risks associated with it to both the patient and ourselves.

For example, a doctor might wish to commence antibiotic treatment on a ramped patient to treat sepsis as a delay in treatment could ultimately result in serious morbidity or even mortality. However, the administration of these antibiotics is not something which falls under our scope of practice as paramedics, and they can precipitate severe allergic reactions which could also result in serious morbidity/mortality. This presents a serious and unfair ethical dilemma to us whereby we are forced to decide which could potentially jeopardise the health outcome of our patient or our own registration and ultimately our career. One of my colleagues had this exact experience not long ago, and they refused to let the doctor commence treatment with antibiotics due to the associated risks.

The nurse who was tasked with administering the antibiotics then told my colleague that if the patient deteriorated it would be their fault. It is completely unacceptable and wrong that we should ever be personally blamed for the failures of our healthcare system. In contrast, another one of my colleagues allowed a doctor to commence antibiotic treatment on their patient who was profoundly septic as they were concerned about their risk of deteriorating.

This patient ended up having an anaphylactic reaction to the antibiotics and, despite this, they still remained on the ramp. Patients with life-threatening illnesses who present to the emergency department should never be ramped in the first place, and the fact that our hospital often lacks the resources to provide the necessary care to such patients is a truly damning indictment of our healthcare system as a whole.

Ramping causes unnecessary conflict and tension between ambulance and emergency department staff. Although I believe it is unreasonable for emergency department staff to direct their frustrations of the healthcare system towards us directly, I can understand how it occurs.

When we are ramped, we are occupying space in their work environment, and at times utilising their resources. During busy periods there could be upwards of 10 paramedic crews and patients occupying the hallways and ramping area of the emergency department. The ED staff are almost always busy and struggling to keep up with the workload, without having to worry about being held up in the hallway because there are paramedics in the way transferring their patient from an ambulance stretcher to a hospital bed for example. There are many instances where I have been made to feel by other staff in the emergency department like we are simply a hindrance to them.

We are isolated on the ramp. Because the Emergency Medical Unit is a separate area to the ED, if we have an emergency we are often on our own. On one occasion I was looking after 3 patients on the ramp, one of whom was a young, ill-tempered and hostile man in their 20s with a criminal history who was ostensibly drug-seeking. The paramedics that brought him in had in fact given him some morphine as he was complaining of chest pain, despite the fact that he had been investigated through cardiology already with all findings demonstrating there were no cardiac issues whatsoever. The triage nurse had indicated that once a blood test/ECG had been conducted on the ramp and signed off by the treating doctor, he could potentially be offloaded from the ramp and into the waiting room.

I had hoped that because he had been recently given pain-relief, he would be content until the ECG/blood-test had been performed. Unfortunately, as is often the case, the emergency department was very busy and nobody came to complete the tests, and I was unable to as I was monitoring my other 2 patients. Half an hour or so passed and this patient became disgruntled and started to demand more pain relief from me. I told him I wasn't able to give him any but assured him I would call for a nurse to come up, which I did. Another 10 minutes or so passed, and still no one came. The patient then started to become verbally abusive, shouting and swearing that he was in pain and needed more pain-relief. He then started to call the Emergency Department phone number and verbally abused the ward clerks when they answered. I didn't actually realise this until one of the ward clerks called me on the internal phone on the ramp to inform me what had happened, and insinuated this was a problem they were expecting me to fix. I called a nurse again to explain what was happening and asked if someone could please come and do the blood test/ECG so that a doctor could sign off on them and we could get this patient off the ramp and into the waiting room. Still, no one came. He was becoming more and more agitated, and I was beginning to feel unsafe, so I decided to leave the ramp to find the Clinical Coordinator and explain what was happening and that I needed help. This of course meant I had to neglect my other 2 patients and leave them unattended during that time, which posed a risk to their safety and also my registration as, if anything adverse happened to them, I would have been held responsible.

Unfortunately, in that moment, I felt I had no other choice. The Clinical Coordinator then assigned a nurse to return to the ramp with me to perform the blood test/ECG, and also administer a NSAID for additional pain relief. Once that was completed the nurse took the ECG/blood test results straight to the treating doctor and afterwards I was informed the patient could be offloaded into the waiting room. I approached the patient and explained to them what was happening, and that I would escort them to the waiting room. So once again, I had to temporarily neglect my other 2 patients while I escorted them out of the ramp and, while walking him out to the waiting room, he verbally abused me again as he felt he was being unfairly treated. Upon reflection of that experience, I can't help but think – what if he escalated even further and became physically aggressive towards me? No one would have been there to help.

Ramping prevents ambulances from responding to people in the community when there already aren't enough ambulances to meet the demands of the public. Here are some damning statistics to help contextualise the seriousness of this point:

The population of Hobart and its surrounding suburbs is approximately 250,000.
On a night shift, assuming we are fully crewed, there will be 9 full paramedic crews available to respond in the greater Hobart area.

Therefore, on a night shift (assuming we are fully staffed), this equates to 1 paramedic crew per 27,000 people. However, we are very rarely fully staffed. This is largely due to staff fatigue/burnout, but once one or two people call in sick it causes a snowball effect whereby more people will call in sick as nobody wants to come to work when we are short-staffed.

Therefore, it is not uncommon for us to be missing 2-3 crews on a night shift, and the ratio could be as high as 1 paramedic crew to 35,000-40,000 people. On one of my most recent night shifts we were down 2 crews, and the region was extremely busy, as was the emergency department. Throughout the whole night every crew was either on a job, or they were ramped, and there were constantly around 10 ambulance jobs waiting at any given time. Now, imagine on a night like this, if you or somebody you loved had a medical emergency. Imagine calling 000 to request an ambulance and being informed that there was none available, and they weren't sure how long it would be until they could dispatch one to you. This is the reality that we are all living with; however, I don't believe many people realise it...

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

to look after ramped patients. This would not only be a more cost-effective solution but, for reasons I've already mentioned, would significantly improve Ambulance Tasmania's capacity to respond to patients in the community, and also improve the level of care provided to ramped patients as nurses are specifically trained to look after patients in a hospital setting, unlike us.

Paramedic – involved in the reported death of patient, Mrs Schram

The worst thing of all – worse than the patient dying on the ramp – was that they died in pain because we don't have access to scheduled medication in the Ramp Ward. And I called the hospital staff several times on that shift, but they didn't come.

Anonymous quotes from HACSU Ambulance members survey – October 2023

Seeing someone sustain a compound fracture from an attempt to toilet them while ramped, was worse than most call outs I have attended in the community. The Ramp Ward and Corridors are so dangerous, we need qualified nurses working inside the hospital.

After being ramped for two hours with chest pain, and when the hospital had finally completed the blood tests to determine if the patient was having a heart attack, she was informed by the doctor she had. I'll never forget the cry the patient let out.

One night, a mental health patient tried to escape the Ramp, and an ambulance manager had to tackle them and they both fell to the floor, at great risk of injury because we have no security support

Being threatened by nurses that they will call the Regulator (AHPRA) because you insist the patient should get a bed, rather than get a saline drip and endone in the hallway, creates an unpleasant work environment in an already stressful job

I know I have left patients at home that should have gone to hospital....but ramping is such a trigger, it causes you to make bad decisions and I know this is true for other paramedics.

I know of other paramedics that have been 'disciplined' for advocating strongly for their patients whilst ramped.

If I wanted to be a nurse and work in a hospital, I would have done a Bachelor of Nursing, not a Paramedic Degree.

The hospital staff get to go home when their shift ends - but paramedics that are ramped have to call their supervisor, handover their patient to another crew (increasing clinical risk) and return to station – often over an hour past their knock off time, or even later depending on the length of drive back.

My psychologist said when I start recognising that the Ramp is getting me stressed out, angry, or frustrated, to go outside and try the many techniques we discuss to manage these symptoms.

I have definitely called off sick for shift because the hospital was busy and it was likely I would get ramped for hours.

One night shift, there was no ambulance at the station. My phone rang and it was the boss - they said a taxi had been dispatched to take me to the hospital, so the ramped dayshift crew could go home, and I was ramped even before my shift officially started.

The Ramp has been subject to several Cease Work Directions and Provisional Improvement Notices, and even subject to WorkSafe Tasmania orders - yet it is as bad and unsafe as ever.

I had a patient on a Protective Custody Order (Mental Health Act) ramped one night, and after two hours they absconded from the ramp. The subsequent investigation by Ambulance Tasmania found that I should have restrained them to a stretcher as soon as I was ramped, despite them being cooperative on arrival to the hospital.

I was sent to the ramp one night so another crew could knock off - their patient was restrained to the ambulance stretcher, and at the four-hour mark (as per the Mental Health Act) I had to let them go because the hospital failed to see them in the legal timeframe.

I love being an emergency paramedic, but I have sat interviews for other jobs, even unrelated to emergency services and health, because I despise ramping and all its hazards and risks so much.

I have left shift 'sick' because I was ramped.

It's so bad now, that some community members request to get ramped because they get to stay on our stretchers and cared for, because they don't want to go into the Waiting Room due to high demand on the ambulance service and the hospital.

It's an awkward conversation sometimes to tell your patient they must go into the Waiting Room because there are no beds in the hospital, and we must leave to rescue other callers of 000.

I have asked my ambulance boss to redeploy me somewhere else in government if he can't stop ramping.

Survey results

- 67% of HACSU ambulance members said they'd considered leaving ambulance Tasmania because of ramping

- 80% of HACSU ambulance members said they've ignored policy or compromised normal operations due to ramping

- 93% of HACSU ambulance members said they've felt unsafe personally and professionally due to ramping