From: Peter Mulholland
To: transferofcare
Subject: Ambulance ramping inquiry submission
Date: Tuesday, 3 October 2023 1:43:51 PM

Dear Rosalie,

I wish to provide my thoughts on Ambulance Ramping in Tasmania. These are written from my perspective as a recently retired intensive care paramedic, having worked across a large range of areas in ambulance, the last seven years at a Northern Region rural branch station. I also hold a PhD with my topic being Interprofessional Learning for Rural Paramedics.

The following are some observations and thoughts from my experiences:

- Having worked in a rural area, on most occasions when taking patients to Launceston General Hospital (LGH) we would be ramped. This left the rural area without ambulance response for several hours at a time. Some examples included patients experiencing falls at home and waiting up to 4 hours for an ambulance. In at least one instance a patient has suffered a stroke, in another, a fractured hip. Where possible ambulance dispatch would attempt to have a local ambulance volunteer attend, however a shortage of volunteers meant this was rare. This has been helped in the last year with the opening of another rural station in a close area, however, this ambulance has to be available and volunteers are again scarce. Backup for this ambulance is still only possible from the Launceston area (if not ramped).

- When ramped with a rural patient at the LGH and a category one case occurred in the rural area, rather than the rural ambulance being allowed to 'unramp' a free crew was often sent from Launceston or Mowbray (if available). Again this led to delayed response, crews were unfamiliar with local areas, and towns crews would sometimes incur unreasonable shift extensions due to the time involved in responding then returning.

- A double standard at times existed. Our area included a major mountain bike facility. These patients were often trauma based. When attending LGH, mountain bike trauma would often be seen as a priority over other patients rather than being ramped. The argument being the potential for other injury. This is a valid point, but not when patients from other types of trauma or serious medical conditions are not treated the same.

- Ramping often occurred with critical patients, even when pre notified of arrival and injury/medical condition.

- Paramedic crews would sometimes spend most of their shift ramped, or rotating through the ramp.

- Missed or late meals are frequent when ramping. Those particular respondent is a type 1 diabetic and found it increasingly difficult to continue long term due to the unpredictable nature of meal times and hydration. The nature pod paramedic work inherently incorporates this, however the growth of ramping has made the situation more difficult.

- A culture of ramping seems to have been developed from early stages and is now difficult to control. I can remember when LGH had no ramping and when ramping began to take a foothold, a standard response from triage nurses, even before handover was given, was 'you are ramped'! This continues, and even when notifying of critical responses en route to LGH this response is sometimes given.

- It should be mentioned that some triage nurses are much more efficient than others. Some will give a standard ramped response whereas others will do all they can to assist.

- For ambulances turnaround time has increased dramatically. Often in a rural area we will have more than one patient to transfer from the rural hospital to LGH. The most critical is taken first. Previously a case would take up to 3 hours, with ramping this has extended out to a minimum of 4 hours. Often much longer.

- Throwing extra paramedic crews at the problem does not help. This only increases the number of crews ramped.

- Each ramped patient os required to have a paramedic crew to supervise their treatment. Sometimes a crew will care for multiple ramped patients to help crews respond tp other cases. Often staff will be bought in on overtime

to work on the ramp and not on road. When a crew is relieved to attend another case, they will only return with another patient to be ramped again.

- Why are paramedics doing what is essentially nursing care in the hospital environment? Should hospitals be allowing for staffing of a dedicated ramping area by nursing staff? Sometimes this can be difficult as patients cannot be offloaded from ambulance stretchers due to a physical shortage pf hospital beds. Surely an extra supply of extra beds/ambulance stretchers would help alleviate this. Training of nurses in the use of ambulance stretchers would also help.

- There is a complete lack of privacy/confidentiality for patients on the ramp. It is only common decency to be allowed to attend to toileting needs for example, in privacy rather than an open corridor.

- Should a patient be taken to x-ray or other treatment area they should be regarded as off the ramp, not returned to paramedic care as is often the case.

- The nature of working on the ramp does not necessarily mean each patient requires full time care of two paramedics. Often paramedics are simply waiting around without any need for complex patient care. An ideal situation would be the replacement of paramedics on the ramp with nursing staff. This in itself presents difficulties in that nursing staffing is already spread thin on the ground. Often it is difficult for paramedics to even find a nurse to assist with care or to give a handover. Again, the problem is not a shortage of paramedics, it his a shortage of nursing staff.

I hope these personal observations and thoughts are of some use. The topic of my PhD involved inter professional learning, and indeed paramedics and nursing staff will work and learn from each other to the benefit of patient care. However, this does not mean that paramedics should be seen as a means to an end to staff A&E departments when nursing shortages are an inherent part of the current system.

Regards
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