Ramping – A personal view of one night from an experienced Ambulance Dispatcher.

The State Communications Centre (SCC) for Ambulance Tasmania (AT) currently triages cases into orders of priority. Priority Zero is the most urgent, being a case where an immediate threat to life has been identified (e.g. cardiac arrest). Priority One is the next most urgent, being cases where the potential for a life-threatening situation is high, e.g. chest pain (which could indicate a heart attack). Both Priority Zero (P0) and Priority One (P1) cases are responded to by ambulance crews driving under emergency conditions, with lights and sirens active and exceeding the normal legal road speed limit where appropriate.

The remaining Priorities are P2 to P8, these being used for various tasks by the SCC. Priority Two is for cases that require immediate dispatch, but it is not believed to require a lights and sirens response. Priorities 3 and 4 are lower-acuity cases that often wait longer as they are not considered life-threatening at the time of the call, based on the answers to questions asked by the call-taker.

On one particular night in 2022, I was on shift as an Emergency Medical Dispatcher (EMD). My responsibility for that night was dispatching ambulances for Southern Tasmania. Other staff on duty included a Deployment Supervisor (DS), a Team Leader, other dispatchers and call-takers.

On that night the Royal Hobart Hospital (RHH) was exceptionally busy, as was the SCC. From the commencement of my shift, crews were ramped at RHH Department of Emergency (DEM). 000 calls continued to come into the SCC, most of them for the Southern region, many of the Priority One calls. The key part of the EMD role is to ensure that there is a response to the Priority Zero and Priority One calls. I work closely with the DS and the Operational Supervisors on duty in Hobart. Another important part of the role is to ensure that the crews receive a break. According to the Ambulance Award, crews are entitled to two breaks over the course of a long shift (one that exceeds 11 hours), and one break over the course of a shorter shift (eleven hours or less). On night shift, there are no crews working a shorter shift. Afternoon crews work an eleven and a half hour shift, and night shift crews work either a twelve or fourteen hour night. Shortly after the commencement of night shift, the crews on Afternoon shift are due their second break. So as a dispatcher on night shift I was immediately thinking about crews breaks as well as managing the emergency cases coming in (P0 or P1 cases). There were also some day shift crews that needed to finish duty. Crews can be clear from the hospital but if it is already past their finish time they cannot be responded to any cases (unless they choose to).

On this particular night the constant influx of calls combined with offload delays at the hospital meant that emergency cases waited. I logged around twelve such cases over the course of the first eight or nine hours of the shift. Some of these cases waited almost an hour. These were all Priority One cases, incidents that should have had an immediate response. As mentioned above, P1 cases are those that are considered to have a high potential for a life-threatening condition. One of these cases waited too long. The case waited for approximately forty-five minutes before a crew arrived. This was at a location that was only some 10minutes from the Hobart CBD. Shortly after the crew arrived on scene, the patient's condition had deteriorated to such an extent that they went into cardiac arrest. This case then became a Priority Zero. Backup was sent and the patient was able to be resuscitated but was of course transported urgently to RHH. However, if there had been no ramping at the hospital, that case would not have waited anywhere near that long. Although it may be that the patient may have still gone into cardiac arrest 45 minutes after the call, it is likely that they would already have been at the hospital when it happened. Alternatively, the crew may have been able to provide treatment sooner, possibly even preventing them from going into cardiac arrest at all. I do not know what the eventual

outcome was for that patient, except that they were still critical at the time of transport to the hospital.

The afternoon shifts in Hobart finish between 10pm and midnight. Occasionally the shifts are altered, and at the time of writing I cannot remember if any of those afternoon crews were rostered to finish later. Sometimes crews work until 1am or 1.45am, having started duty later. I do recall that on that night there were some stations that did not have a rostered ambulance crew. So we had the worst scenario of all – a hospital that was unable to manage the incoming patients (those brought in by ambulance, plus those that made their own way to the hospital), and we had less crews than we are supposed to. In such cases, requests for people to come in on overtime will undoubtedly have been sent out, but obviously not very many staff had accepted those requests.

Combined with the relatively high volume of ambulance requests, the result was predictable. Cases waited. Most of them waited too long. Lower acuity cases waited even longer. Many of the lower acuity cases never got an ambulance during the night. Some were phoned and advised to make their own way to hospital, after a careful assessment over the phone by the DS to ensure that there were no obvious signs of any potential life-threatening symptoms.

When the Afternoon shifts had finished duty, there was then even less crews available. But there were still cases waiting. At one point around midnight (I can't remember when exactly), there were six P1 cases waiting. One waiting is considered bad! If there are no obvious solutions to finding a crew, the region will move to the highest 'Escalation' level – four. The Southern Region was at Level 4 for most of the night. This means that only P0, P1 and P2 cases are responded to, unless determined by the DS or TL that a lower acuity case (P3 or P4) warrants a response. However, usually if it is considered that such a case cannot be further delayed, for whatever reason, then they will upgrade that case to a P2 or P1.

I have been an emergency dispatcher for many years. Aside from a handful of individual calls that I have taken that were difficult and traumatic, that this was the worst shift I had ever experienced. Never before had I seen so many cases wait, and so many high priority cases at that. P1 cases should not be waiting thirty minutes before a crew is even allocated. The accepted timeframe is a few minutes or less!

At the end of the shift I was physically and mentally exhausted. I was anxious, irritable, morose and despondent. I drove home somehow. I probably should not have driven. I did not want to return to work. Despite the exhaustion, I had trouble getting to sleep. I cannot now remember if I had to return to work the next night. During the following months, I did not have any leave. I did not work any overtime. I had holidays coming up a few months later, but it was not soon enough. I went to my GP and took five shifts off prior to my holidays commencing.

One of the constraints of ambulance dispatch is that crews breaks entitlements are restrictive. After a period of time without a break, a crew enters what is called the 'Zero Zone'. This means that they cannot be dispatched to any cases except for Priority Zeroes. This means that a crew might be clear from the hospital, but if they are in the Zero zone, they cannot be dispatched to P1 cases. This is of course frustrating, but it is also essential for safety. A fatigued Paramedic cannot function effectively. They are only human beings, and working constantly without a break is a very hazardous proposition. I have previously had crews on shift have both of their nominated breaks within the correct time, but worked non stop for the whole rest of the shift – and were still too fatigued to continue for the last hour of their shift.

A fatigued paramedic might make a wrong calculation for a patient's drug dosage. A fatigued paramedic might make a mistake driving whilst on a P1 case and crash. The Zero zone protects them from being worked for the whole night without a break. Without the zero zone, some cases may indeed have had a faster response – but we are risking paramedics lives if we did that. Its worth mentioning that sometimes paramedics opt to respond to P1 cases when they are in the zero zone. This is partly due to their desire to help, although they are aware that they will receive more break penalty payments as well.

In my view, the causes of this situation are threefold.

Firstly, the hospital does not have sufficient beds. Either in the Emergency Department nor in the wards. Oftentimes I expect that they are also short of staff, resulting in a similar situation to AT where their capacity from the normal roster is actually reduced from what it normally would be.

Secondly, we do not have enough paramedics. This is at once obvious, but the acutely fatiguing nature of the paramedic's job and the change in their role (spending considerable time at the hospital unable to offload their patient due to ramping) is having a drastic negative impact on morale. Staff no longer wish to work overtime, as they are recovering from their rostered shifts. They are more likely to call in sick, sometimes just due to the anxiety they feel about how their coming shift may go, knowing that it is likely to be intense, non-stop with minimal breaks and a likely late finish.

Third, the health care role inevitably involves exposure to infectious disease of both a benign nature (e.g. picking up a cough from a patient – sometimes impossible to stop despite the use of PPE), and also other risks from patients (e.g. being attacked or threatened). I know a paramedic who missed a block due to a cold, then on their next shift was attacked by a patient and understandably did not finish their shift, then on the next week suffered from a different medical condition.

The Ambulance rostering system does not allow for sick leave. Occasionally extras may be rostered by accident, due to errors or having sufficient staff available on that line. But extra staff are usually absorbed by other staff calling in sick. The answer is clearly that at all times there should be additional staff rostered to assist in covering sick leave (similar to what airlines do). These staff should be on standby and prepared to head to whichever station may otherwise be short.

We also need to have a mature discussion about the length of shifts that ambulance and other health care staff work. We need to think carefully about how we can both motivate people to work night shifts but also make sure that they are looked after and managed so that they can keep doing it. We need to rethink the notion of full-time work and how we compensate for that. Should emergency health care workers be working a 40 hour or 42 hour week?

Perhaps we should consider that working just 30 hours in emergency health care (especially if it includes working between midnight and six am) as actually being equivalent to full time work? Currently someone working full time will actually work for 48 hours or more in a five day period, before having three days off. Is that actually safe? It is a proven fact that working night shifts risks long-term health and well-being. A woman in remission from Breast Cancer was told by her Oncologist that if she went back to working night shift that she would have an 80% chance of the cancer returning. Understandably, she chose not to return to night shift work.

The Ambulance employees union, Health and Community Services Union (HACSU), has for some years been advocating for workers aged 55 and over to be given priority for removal from night shift work. This has so far been largely ignored by Ambulance and Health Department management, due to cost.

Unfortunately in my view, it is cost that is not being considered, at least, not adequately.

These costs include;

-The cost of emergency worker's health, both physical and mental.

-The cost of sick leave.

-The cost of workers compensation and associated claims.

-The cost to the Health Department (HD) when they (almost invariably) fight workers compensation claims.

-The cost in overtime when the HD is unable to cover staff on long term workers compensation due to Human Resources (HR) making up rules that essentially mean that they are unable to replace those positions, leaving gaps in the existing staffing levels, solely due to HR 'rules'.

-The cost in further sick leave generated when stressed staff take time off partly because they are working short.

-The cost in overtime due to failures by the Health Department and Ambulance to ensure there staffing levels are sufficient to enable the roster to be filled.

Many of these costs are not considered by HD or Ambulance, partly because of the way that budgets are calculated by Government departments. There is therefore no incentive to proactively manage these issues, because the cost of failing to do so is not part of the normal budget. It comes under overtime, or workers compensation, or other extraneous funds, outside of the department's control.

By the same token, it can be measured that the concept of 'ramping', also known as 'transfer of care delays' is also a budgetary function. Rather than attempting to manage their inability to cope with the number of patients they have internally, hospitals transfer the problem to ambulance. They are also health care professionals, they already have the patient in their care, therefore it is the safest option to let them maintain that care as best as possible until the hospital is ready.

But this creates a false sense of safety, because of the factors that surround it. The ambulance crew is then unable to respond to other health emergencies in the area. The hospital has transferred all of its problems to another agency. It will take the patient from Ambulance when it is ready. There will be no budget pressure, no staffing pressure. Any shortages experienced by the hospital is offloaded to Ambulance, becoming their problem. Ambulance then have significant pressure to find other ways to manage incoming calls (some now do exist, such as Secondary Triage and PACER), and as above, sometimes fail to even get to a call, as people cancel or are advised to get their own transport to hospital.

The hospital is operating at capacity, maximising efficiency and senior management might think that apart from sick leave issues, that everything is going just fine.

But it is far from fine. A hospital operating at maximum efficiency, in other words with every bed occupied for the maximum possible time, may sound like a good thing. This is indeed why the hospital has so many fewer beds than it used to. The whole idea was to maximise efficiency. An empty hospital bed still has a cost, of course.

In my view, this is exactly what got us into this mess. I believe that during the early 1990s, a bureaucrat in the United Kingdom working for the National Health Service, worked out all of the associated costs of a hospital bed. All possible factors were taken into account. The cost of staff, doctors, nurses, orderlies, cleaning staff, the cost of medications, electricity, bedding, cleaning, equipment, etc. This was calculated for each hospital. Then they investigated how often a bed was occupied. It was

considered therefore that if a bed was empty, then the money spent on that bed was being wasted. Unsurprisingly, it was discovered that the bed occupancy rate in many cases was quite low. The bureaucrats determined that this meant that these hospitals therefore had too many beds. This is why the bed numbers were cut. And this methodology was soon brought to Australian health bureaucrats and consequently bed numbers were cut in many hospitals in Australia, including in Hobart at the Royal Hobart Hospital and at the Launceston General Hospital.

So it may seem that the hospitals are running totally fine and according to hospital senior management there are no problems. This is because they are offloading their problem to Ambulance and by default to the wider community. Also because they think that if their bed occupancy rate is at 98 or 99 per cent then that's what it should be.

However there is a very big problem with having a bed occupancy rate of 98% or 99% - it means that there is no fat in the system. There is zero spare capacity to deal with a sudden unexpected surge in demand. There is no capacity to manage a natural disaster or any event that results in a sudden influx of patients.

At the time of the Port Arthur Massacre, both Ambulance Tasmania (then known as Tasmanian Ambulance Service -TAS) and the RHH were lucky. The case load that day was exceptionally small. It just so happened that extra helicopters were available. The hospital was not especially busy. Twenty patients suffering from gunshot wounds were transported by helicopters and road ambulances to the RHH. All twenty recovered from those wounds and survived. Tragically of course, 33 people were killed.

It is highly questionable that the hospital would be able to cope with the sudden influx of twenty trauma patients today. We can easily imagine all sorts of possible disasters that could cause such a number, a bus crash, bushfires, etc, the possibilities are almost endless. But it is not the potential causes that is the issue. It is our ability manage and help those people when it happens. We do not have that ability, thanks to the desire for 'efficiency' overriding common-sense. We do not after all have fire stations commensurate with the average or median demand. If we did, then there would be far fewer fire stations in Tasmania and far fewer professional and volunteer fire-fighters. Because for more than half the year these people are required to do comparatively little. If we managed their average useage to availability, in the same way that has been done for the hospitals, then it is very obvious that during a period of emergency bush fires that towns and suburbs in Tasmania would be overwhelmed by fire and many lives lost. Because of course we do not manage the Fire Service in the same way. We manage it according to the highest possible demand level, or at least as close to the worst possible scenario that we can. This makes sense – we are trying to manage that scenario. In 2013 when record-breaking high temperatures were set during the fires in the Tasman Peninsula and Dunalley area, those resources were needed. Significantly, no lives were lost due to those fires. Partly due to how well it was managed and the resources that were put in to place. We may not be so lucky again next time.

Yet if we compare the above method for managing a known threat (bushfires) and how we manage an equally well-known issue (health), we are doing this completely differently. Why?

I also attach for relevance the following document by Jeremy Sammut; Why Public Hospitals Are Overcrowded: Ten Points for Policymakers.

Whilst this document is some 14 years old, the difficulties that we face are unchanged and, if anything, worse. Therefore, I think it is vitally important that consider the situation of a decade+ ago to compare – what has changed, what has improved and what has gotten worse? What is working and what is preventing this from getting better? These questions need to be more specifically applied to what is happening in the hospitals – however I am unable to answer them, due to my role being external and impacted by ramping, rather than involved directly.

I can also relate one other personal story – when a friend attended RHH DEM via ambulance (with chest pain), they were fairly quickly assessed and offloaded into a cubicle. Not long after, they were told that they would be admitted. But they were not taken up to the ward for at least four hours. However, on arrival they were told by nursing staff on the ward that they had been ready for the patient for some hours. Whilst this is merely a single anecdotal event, it is clearly shows that at least on that occasion, a communication failure had occurred.

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