VOL 47
WINTER 2020

RESPONSE

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COVER

Steve Whitfield on a Mars Mission Simulation at the Mars Desert Research Station in the United States.

The Australasian College of Paramedicine acknowledge Aboriginal and Torres Strait Islander peoples as the traditional custodians of the land and sea in which we live and work, we recognise their continuing connection to land, sea and culture and pay our respects to Elders past, present and future.

The College acknowledge Māori as tangata whenua and Treaty of Waitangi partners in Aotearoa New Zealand.

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@ACParamedicine #ACPIC20

Australasian College of Paramedicine

with Peter Jurkovsky

Advancing professionalism

A warm welcome to the Winter Issue of *Response*.

As paramedics, we generally move between two communities – our professional one and our private one, the first obviously being paramedicine and the second our connection with the community at large, which is also predominantly centred around our families. These dynamics have been tested in many ways over the past six months with the ever-present COVID-19 threat, and we have all needed to make adjustments. The frontline nature of the paramedicine role has added to these stresses with the necessary use of bio-security precautions now being second nature – in often difficult and uncontrolled environments. The burden on families with a health professional member of the unit travelling to and from their workplace adds another layer of complication to the myriad of issues being faced by thousands of Australian households on a daily basis during these extraordinary times. Ambulance services throughout Australia and New Zealand have been required to adapt through expedited recruitment strategies to ensure workforce levels are maintained while a number of jurisdictions have seen paramedics extend their skillset beyond pre-hospital care to fill roles in areas such as testing and contact tracing.

> “Professionalism comes in many forms”

Professionalism comes in many forms ranging from rigorous and evidence-based educational foundations, effective communication and clinical competency, respectfulness, inclusiveness and the fundamental recognition that public safety is the paramount consideration in delivering care. This once in a lifetime crisis is a further opportunity for paramedicine to advance even further following the professional recognition afforded through registration nearly two years ago through the important, and often, extended role paramedics are playing during this pandemic.

While the notion of professionalism, as described here, is most often linked to the external depiction of the paramedic’s role in patient care, the internal aspect has never been more important than now – this being to look after each other.

College representative roles

Earlier this month, following an extensive expression of interest process, the College announced the successful applicants for the various College representative roles. These roles include a range of external bodies, specialist advisory committees, member committees for all jurisdictions and special interest groups.

Details of all these appointments are included in this issue of *Response* and I am delighted to welcome such a wonderfully skilled and experienced group of members who have offered themselves to take up these vitally important roles. The College, as the peak-body representative organisation in a recognised health field of endeavour, can be rightly proud to have such eminently qualified individuals nominate for these representative roles. An organisation such as ours is only relevant if its members play an active role and this is an excellent example of that principle at play.

I hope you enjoy reading this issue of *Response*. Please feel free to contact our Editor if you would like to contribute or refer something of interest to members.

As always, stay safe and I look forward to communicating with you regularly over the second half of 2020.

UNIVERSITY of TASMANIA

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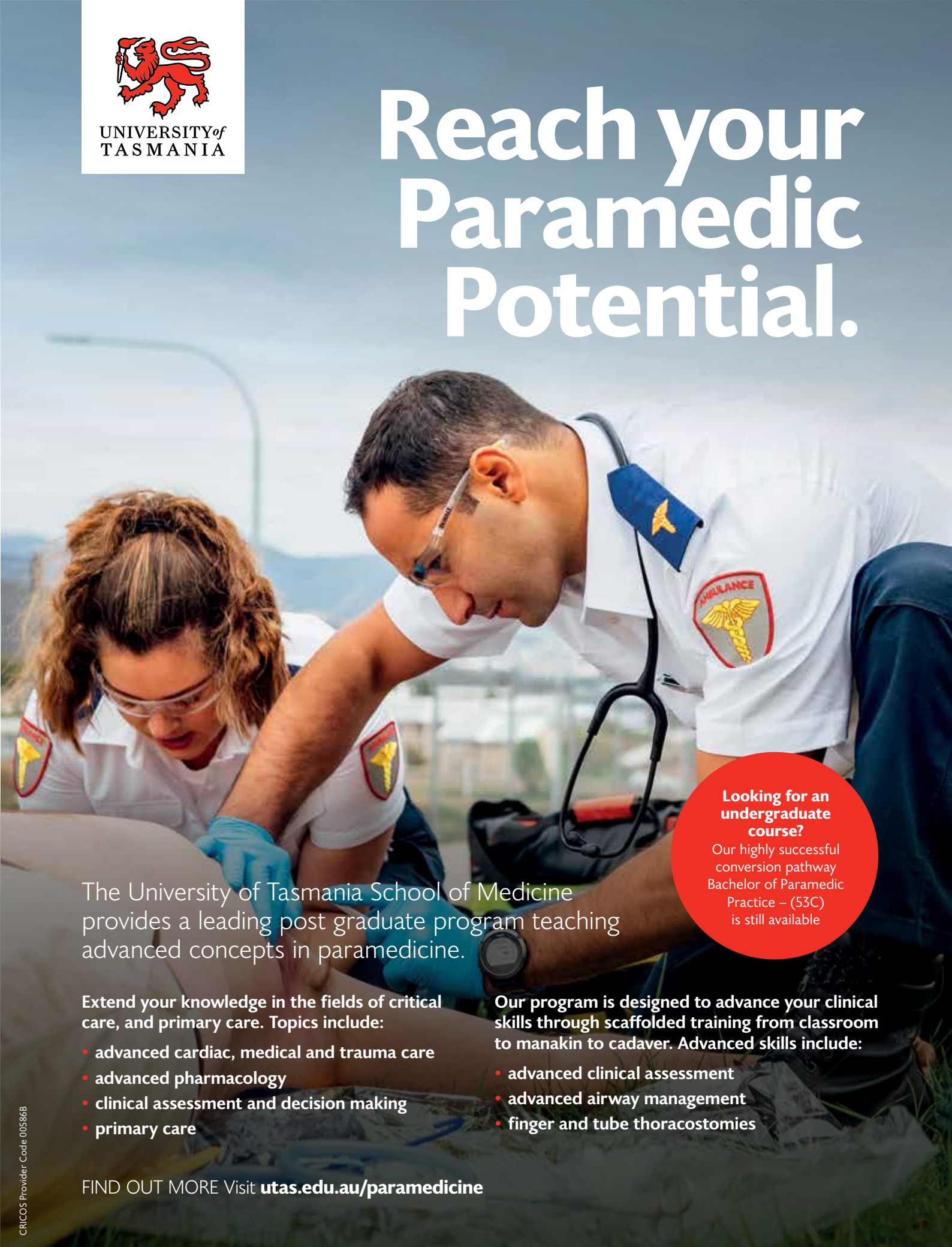

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with John Bruning

The new normal

When I hear people say "the new normal" I know they are speaking about the current nature of our lives and the future outlook with its constant uncertainty. But I also view this term in relation to the College and what we have been doing over the past four months and what we will continue to do into the future.

The College's live webinar education sessions have been incredibly successful with record attendance – more than 2500 attendances across 15 events since March – and we will continue to prioritise online events even when the option of face-to-face returns because of the ability for any member to attend any (or every) event. I'd like to acknowledge the time and energy given to the College by the volunteers who have helped organise our education events, and to all the presenters who have delivered a wonderful array of topics; without them we would not have been able to deliver this service to our members.

The College is developing a collaborative relationship with the UK College of Paramedics, which will see us working together on a number of opportunities to progress the profession in both countries. In the immediate term, the relationship has seen us share our online learning content with each other, adding 115 UK courses to our online learning library.

> "I am excited about our committees and groups starting, knowing how important they are"

Speaking of our online library, it has grown substantially over the past few months with the transition of Paramedics Australasia and Australian & New Zealand College of Paramedicine content to our website. We also have made available all the live webinars we have delivered, usually within a week of broadcast. We currently have over 360 online courses available and over the coming months this will reach more than 480 courses. I don't know anywhere else where paramedics can access such a large library of paramedic-specific content... and it's all free for members.

On the back of our education activities, and the support we have provided across the profession during these challenging times, we have experienced strong membership growth. We have seen over 1400 new students join the College, as well as consistent growth in registered paramedics finding a place with us. I am pleased to welcome all our new members to the College.

In the coming months the College's representative structure will be up and running, with the numerous advisory committees, member committees and special interest groups ready to play their role in ensuring we deliver for members and the profession. I am excited about our committees and groups starting, knowing how important they are, and I look forward to their input into the activities and direction of the College.

In the Autumn Issue of *Response* I flagged a member engagement process for members to provide input to the College's strategic direction and the next strategic plan; this work will begin in August. The College is also investigating professional indemnity insurance options for members and will undertake a survey of members to ascertain your understanding of PII and the need to hold this independently of your employer.

I look forward to engaging with members over the coming months.

The people behind 000

WHAT'S HAPPENED SINCE THE 2018 SENATE INQUIRY INTO MENTAL HEALTH OF FIRST RESPONDERS

By Erin Cotter-Smith and Simone Haigh

In March 2018 the Australian Senate referred an inquiry into the high rates of mental health conditions experienced by the 'people behind 000' – So, what's happened since?

One phone call can change everything

When the phone rang at 3:00am in 2016, it changed the course of paramedic Simone Haigh's life and set in motion a national Senate inquiry into the high rates of mental health conditions experienced by Australia's emergency service personnel.

The suicide of a close friend and colleague motivated Simone to address the patchwork nature of mental health support systems for first responders across Australia that was contributing to one first responder dying by suicide every six weeks.

There were calls for action – but changes on the ground were not happening fast enough.

The 2018 Senate Inquiry

On 27 March 2018, the Australian Senate referred an Inquiry into the role of commonwealth, state and territory governments in addressing the high rates of mental health conditions experienced by the people behind 000.

The inquiry came about as a result of Simone reaching out to Senator Anne Urquhart and relating her experiences. This stimulated nationwide conversation regarding the mental health of paramedics, police and fire professionals as well as volunteer and communications and dispatch staff working in the emergency services sector.

A call for a national action plan to address the high rates of stigma and mental health conditions among emergency services personnel was one of the key recommendations to come out of the inquiry.

The inquiry's final report drew heavily on Beyond Blue's landmark 2018 Answering the Call survey of over 21,000 emergency services personnel from across Australia and recognised the significance of workplace culture, stigma and the need for a collaborative approach to creating mentally healthy workplaces.

Things seemed to be moving in the right direction. The mental health and wellbeing of our emergency services personnel, as well as our volunteer and communications and dispatch staff working in the emergency services sector was finally starting to get the attention it deserved.

So... what's happened since?

The 2019–2020 bushfires left widespread trauma in our communities, especially for those on the frontline.

Much of the media attention focused on the firefighters, but everyone involved in the massive emergency response

felt the impact. As the profound mental health toll of the bushfire response was discussed regularly in the media, there was a renewed sense of hope that a national approach to supporting the wellbeing of emergency services personnel would be prioritised.

Perhaps the silver lining of this horrible disaster would be that the recommendations from the Senate Inquiry into the Mental Health of First Responders would finally be acted on.

And that action is needed.

Recently, several volunteer firefighters in southeast New South Wales have spoken out saying they feel let down by the Rural Fire Service (RFS) – which they say has offered them little to no mental health support following the bushfire season – even to those who lost their homes while fighting the fires.

Some say they haven't had a debrief or even received a phone call to check on their wellbeing since the fires and have been left to recover with no psychological help along the way.

Ben Shepherd from the RFS said support was being provided to volunteers and that more than 2000 members had either sought support or been proactively approached by critical incident support services. However, many RFS volunteers report that the support provided consisted of a bulk email providing the number to an Employer Assistance Program (EAP) telling responders to call if they needed help.

> "When will we start reaching in and stop expecting people in crisis to reach out?"

A NEW APPROACH TO WELLBEING IS NEEDED

Employee Assistance Programs are limited in their usefulness and do not fully meet the needs of emergency services personnel – especially when they are in crisis. These programs are also limited in their ability to effectively deal with the complex mental health and wellbeing needs of emergency service personnel and volunteers.

The existing evidence-base largely supports this, with one EAP industry trends report suggesting that only 6.9% of people actually use them. So does real-world feedback.

"The last thing I want to do when I can barely get dressed in the morning or when just going to the supermarket feels too hard is to call some stranger at the EAP and pour my guts out. Now if my actual service cared enough to take the time to call me and say 'just wanted to see how you were travelling' I would probably be more likely to admit that I wasn't doing real well." Volunteer firefighter – RFS

It's clear that a new approach to providing wellbeing support is needed. Perhaps this could be the silver lining that will come out of the devastating bushfires?

We need an approach to wellbeing that removes the onus on the individual 'reaching out' to one that promotes the organisation 'reaching in' to those who may be struggling.

We need an approach that is built on the needs of both currently serving and veteran members. We need an approach that welcomes first responder families.

We need an approach that is not based on sending a generic email to responders in crisis telling them to contact a stranger at an external EAP.

Volunteer organisations need a model that doesn't rely on other untrained or minimally trained volunteers to provide wellbeing support, potentially exposing them to risk of vicarious trauma and providing minimal benefit to the person in crisis.

The bushfires have unfortunately highlighted that nothing has really changed since the 2018 Senate inquiry. The issues that our emergency services personnel faced before in terms of adequate mental health support, stigma, organisational culture, fragmentation of services and the lack of specialised counselling services all still need to be addressed.

What will it take for us to see real change?

When will we start reaching in and stop expecting people in crisis to reach out?

Erin Cotter-Smith is an Associate Professor and Course Coordinator in the School of Medical and Health Sciences at Edith Cowan University. She is also a research consultant for The Code 9 Foundation and the Wellbeing Team Co-Lead for the Australian Red Cross, Emergency Services Victoria.

Simone Haigh ASM is an Intensive Care Paramedic with Ambulance Tasmania and Vice-Chair of the Australasian College of Paramedicine.

ACPIC 2020

YOUR PATIENTS. YOUR PROFESSION. YOUR FUTURE.

KEYNOTE SPEAKER
Commissioner Shane Fitzsimmons

Over 21 to 23 October, the College will host the most comprehensive, in-depth paramedic conference on the Australasian calendar in 2020 – ACPIC2020.

Due to COVID-19 restrictions, ACPIC2020 will be streamed live – allowing attendees anywhere around the globe to view the conference sessions.

ACPIC2020 will focus on providing the education that paramedics at all levels need: from student paramedics, on-road paramedics, intensive and extended care paramedics, flight and mobile paramedics, paramedic educators and academics, and senior managers.

CONFERENCE PLATFORM

The ACPIC2020 event platform will ensure attendees still enjoy a high level of interaction with speakers, sponsors and other event attendees. During the three-day event, attendees can view live presentations and interact with other attendees and speakers through our chat forums, as well as view recorded sessions if unable to watch all the sessions live.

Exclusive access to the ACPIC2020 event platform will remain active for two months post-conference, allowing attendees to re-watch session recordings and still participate in forum discussions with other attendees – useful for adding to the CPD hours necessary for registration.

CONFERENCE PROGRAM

The conference program supports the theme 'Your Patients. Your Profession. Your Future' and showcases a wide range of local and international speakers from Australian and New Zealand ambulance services; the Council of Ambulance Authorities; and health professionals and academics in the field of emergency medical services.

The conference days will be broken into three-hour sessions: 9.30am to 12.30pm and 1.30pm to 4.30pm daily, plus a special 'global pandemic' evening session.

> "Advancing paramedicine through professional development, education and industry leadership"

KEYNOTE SPEAKER

Commissioner Shane Fitzsimmons will be a keynote speaker at ACPIC2020. Commissioner Fitzsimmons led the NSW Rural Fire Service through the devastating summer bushfires and was recently appointed to lead Resilience NSW, a newly established agency set up by the New South Wales Government to "lead the whole-of-government prevention, preparedness and recovery effort". The agency will oversee and coordinate emergency management policy, service delivery and all aspects of disaster recovery at a state, national and international level.

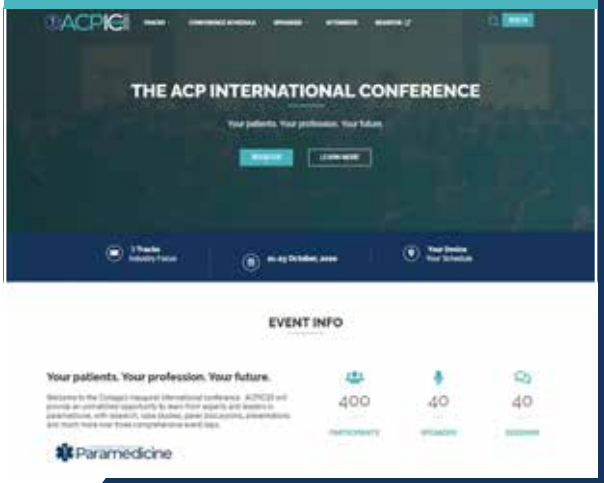
GLOBAL PANDEMIC EVENING SESSION

The COVID-19 pandemic has seen many changes in our workloads, our approach to infection control and PPE, communications centre and hospital systems, and our capacity to undertake many of our usual health and well-being activities. The global pandemic evening session will explore some of the positive changes and professional growth for paramedics and paramedicine as a profession, as well as discuss some of the lessons learned, provided by medical experts and frontline responders from around the globe.

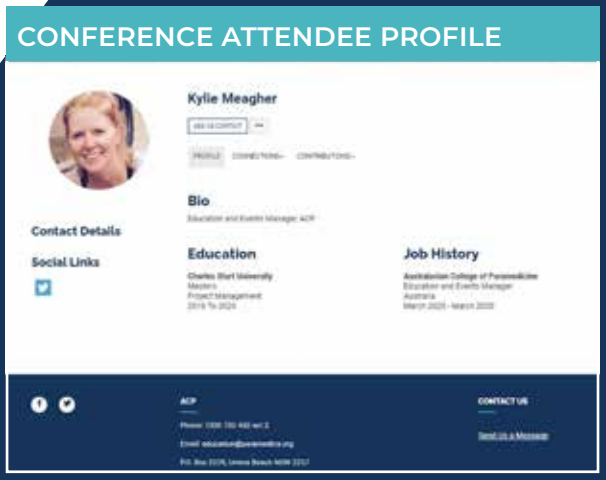
Tickets for ACPIC2020 will be on sale from August. Ticket sales will be promoted to all members via email and social media once available.

For more information on ACPIC2020, please contact education@paramedics.org or visit www.paramedics.org/events

CONFERENCE HOME



CONFERENCE ATTENDEE PROFILE



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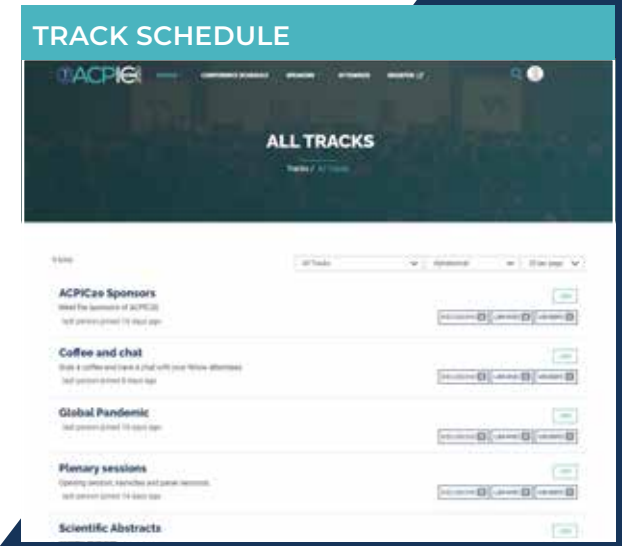

KEYNOTE SPEAKER

RESPONSE | Q&A

Matt Shepherd is an Intensive Care Paramedic, MICA Flight Paramedic with Ambulance Victoria and Chair of the College's Victoria Member Committee. In this Response Q&A, Matt tells us how he transitioned to paramedicine, and the many rewards he has found in his chosen profession.

Q What attracted you to a career in paramedicine?

A I was never a bright kid at school, I enjoyed playing sports but struggled to actually sit down and study. On finishing high school I accepted a position in nursing at Gippsland Institute of TAFE (which became Monash University the following year). However, I failed my first year due to the same difficulties applying myself.

The following year I was fortunate to do a placement in an emergency department and happened to observe the management of a patient in cardiac arrest. It then became clear to me what I wanted to do, and I was able to focus at university as I had a goal to work towards that I was finally passionate about.

I worked in the emergency department at Monash Medical Centre for four years and although I loved it, I kept seeing paramedics coming in with patients, telling me of the diverse scenes they worked in and how exciting it was. I submitted an application for the next paramedic intake – not expecting to get accepted due to the large number of applicants – and somehow managed to pass the application process and I have never looked back.

Q What's the best part of your job?

A Paramedicine is a fantastic job that allows you to help people and be there with them through some of the worst moments in their life. We have the opportunity to not only assist with the recovery of their physical injuries but also support them (and their families) emotionally through a potentially traumatic experience. Ensuring that we deliver the highest level of care is always very rewarding to me and I still gain great satisfaction from this.

I also enjoy being part of a team working alongside other agencies to facilitate expedient and advanced care to patients. When you see dozens of professionals working together to try and assist one person, it is really humbling and reminds me how grateful I am to be part of Australian emergency services.

Q And the toughest part?

A The unsociable hours. I have missed many birthdays, holidays and family gatherings (although this can sometimes be a good thing!) due to my job. The flip side however is having days off during the week and getting lots of annual leave.

The work we do is always going to be emotionally draining, which certainly takes its toll, so it's important to find something that gives you peace. Everyone is different, but I enjoy exercising and will actively seek the opportunity to get outdoors on days off (or before shift if I can) to rebalance.

Q You feature in the observational documentary series Paramedics, along with some of your Ambulance Victoria colleagues. Can you briefly describe this experience to our readers?

A *Paramedics* has been a valuable experience and I am grateful I had the opportunity to be involved. Some critics view it as an invasion of the patient's privacy during a very stressful moment and I can understand that, however I saw it as an opportunity to show the community the high level of skill and care that is delivered by paramedics in Ambulance Victoria, just as paramedics from New South Wales and Queensland do during *Ambulance Australia*. It

> “Ensuring that we deliver the highest level of care is always very rewarding to me and I still gain great satisfaction from this”

provides an insight for the community into our day-to-day work environment, but also allows us to deliver health-care messages to a wider audience. If we can help the community indirectly through them watching the show, then it has been worthwhile.

Q Who inspires you?

A There are many people that inspire me, but more than anything it’s someone with a ‘give it a go attitude’. I am impressed when someone is prepared to get out of their comfort zone to push their boundaries that bit further. It is very easy to sit back and watch others have a go and judge them if they don’t succeed. I appreciate how much courage and strength is required to take a risk and step up. No one is expected to be perfect, especially when starting out – and I am always willing to work alongside those that show they are prepared to be vulnerable, put in hard work, and make the effort to try to better themselves or others around them.

Q You have co-authored several peer-reviewed papers. Can you tell us what triggered your interest in research?

A The key word in this question is ‘co-authored’! I have never considered myself an academic, however through working at Monash University I have steadily gained more knowledge and experience in academia.

My first co-authored paper occurred through having beers with a colleague at a conference. The chat flowed to experiences I had gained during my time as a paramedic. I spoke of CPR induced consciousness, which he found fascinating and suggested ‘WE’ should write a paper on it. The papers have gradually increased since then, with a most recent prospective study looking at ETT cuff pressures during HEMS transport about to be sent to the publisher for approval. Next year I plan to be a lead author on my first paper, which will be a big achievement for me.

Q And finally, what’s your go-to when you need to recharge?

A As previously mentioned, I love to exercise. I take myself into the nearby hills and get lost on the trails amongst the trees. It’s best in winter when it’s cold, no one is around and the cloud covers the hills and drifts between the tree trunks, giving it a mysterious peaceful silence.

My kids and my wife also keep me grounded and remind me what’s important in my life.

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I was a medic on Mars... in Utah

BY STEVE 'SUNNY' WHITFIELD

It is below freezing. The crew sleeping quarters are stacked on top of each other, and I drew the short straw. It puts me at the top of a long ladder and right next to the thin metal boundary that separates us from the freezing Martian landscape.

> "If something goes wrong I have only the items I could bring – barely a backpack worth of medical supplies"

Sound weird? It should! I am part of a Mars Mission Simulation at the Mars Desert Research Station in the United States. Mars is about survival and scientific research. So is the simulation, and the freezing deserts of Utah are an ideal location for Mars research on Earth.

The question on most people's minds is how a paramedic from Australia ended up on a remote Mars simulation. There is no simple answer. My background is paramedicine, but I have been fortunate to work in a number of remote medical roles, which landed me here (excuse the pun!). Each crew member represents a different aspect of humanity and science. Crew commander Andrew is the resident geologist; Guy, the botanist and historian; Jen the architect and 'marsitecture' specialist; Larissa the acoustic engineer and artist; Shane the engineer who specialises in chemical engineering; and me, the crew medical officer and resident journalist. The range of expertise was deliberate and vital to keep the habitat and its life support systems running. As the resident medical officer, I have several roles – health and wellbeing of the crew being the most obvious – however, I also assist in the green house and science dome. Health checks are conducted daily on the crew members as well as analysing crew sleep cycles (NREM/REM) and fatigue.

Although I have worked on several remote medical projects, none are like this. Here, I have the clinical authority (it's my specialty among the multi-professional team) but if something goes wrong I have only the items I could bring – barely a backpack worth of medical supplies. This means a large part of my role is risk redundancy and prevention. However, this simulation is about research and I know something is bound to occur in the name of research!

SOL 5

The crew alarm buzzes gently downstairs and the reverberating grumble that echoes in the overhead pipes suggest that someone is already awake and downstairs. There is no privacy here; six crew members in eight metres squared. When the toilet is flushed it rumbles the whole habitat!

We are on Sol 5 (a day on Mars is 24 hours, 39 minutes and 35 seconds). I (literally) slide out of my sleeping quarters and down the ladder where I find Larissa, the acoustic engineer from New Zealand, monitoring the decibel levels of the echoing pipes. She also woke early to prepare breakfast for the crew (each crew member takes turns to prepare the meals).

After breakfast I am downstairs on the airlock level of the habitat helping prepare crew members for an extra habi-

tat activity (EHA). The atmospheric volume of Mars is less than one percent of Earth's. This means the crew must live within the airlock of the habitat. When scientific teams are heading out to conduct field research, they must don the EHA space suits before moving out through the first airlock to a five-minute depressurisation. Once outside, their time is limited by an oxygen supply that last approximately three hours. As part of risk redundancy, crews must be returning after two hours. This means once they have departed, I can attend to my other duties.

Although technically not my problem, the life support systems and basic functioning of the habitat is a crew responsibility. If the engineers are involved in an EHA, the other crew members must work together to ensure the generators and water system are functioning, the solar batteries are charging, and the food stocktakes are complete. Likewise, if I am injured or incapacitated, the engineers must be able to care for me, so I spend time between tasks covering basic life support refreshers for the crew. Although it may sound monotonous, this place is a hive of scientific activity. In the science dome, crew members are processing micrometeorite samples collected from the previous EHA, food is being grown in the green habitat, and interior design to enhance astronaut psychological wellbeing has commenced in the crew quarters.

Just before lunch, the EHA team return with a collection of gypsum from the field sites as well as some more micrometeorite samples. After removal of the space suits and cleaning, we process the samples and gather for lunch. Lunch consists of dehydrated everything!

Following lunch, I assist Guy in the green habitat when an all systems alert is triggered. When this occurs, all crew are to return via the pressure tunnels back to the main habitat. Once there, we are advised that one of engineers was outside the airlock checking the solar batteries when a large bang was audible. Inside the habitat he was seen by the EHA commander to fall. From the habitat port window, his boots are visible next to a rover however, he is not responding to the radio communications. An emergency EHA is prepared to recover him.

> "...he will be hypoxic by the time he is through the airlocks and back inside"

As the crew medical officer, I must remain within the habitat while other crew members don EHA space suits to move through the airlock and retrieve him. This is not a fast process. While the crew conduct the retrieval, I unpack my kit and prepare the makeshift clinic on the bottom floor of the habitat. The retrieval team indicate that the patient is unresponsive, but being in the relative vacuum of Mars, they must get him inside before any real assessment can occur. Mulling things over in my head, a large bang would either indicate possible blast injury and burn, or an electrical injury. Either way he will be hypoxic by the time he is through the airlocks and back inside.

Once inside, his space suit is removed by crew members and it is obvious he has suffered a significant electrical injury from a battery malfunction. Although unconscious, he is maintaining a good blood pressure and ETCo2. The injury to his arm is significant. After a rapid assessment he is supported with wound dressing, pain relief, oxygen therapy and, as time progresses, fluid support. I relay the incident over CAPCOM to mission support and communicate the criticality of our engineer. The only issue is the signal travel time. Mars orbit is elliptical and at its nearest, approximately 60 million kilometres from Earth (occurs roughly every two years). This causes a substantial delay (anywhere from four to 24 minutes) in signal transmission time, known as one-way light time (the speed of light). Two-way light time is the time it takes to receive a reply

(eight to 48 minutes). However, this is when all systems are working and not affected by solar flares, geomagnetic storms and equipment failures. This means by the time the CAPCOM medical team receive my message, I will have been managing my patient for almost 30 minutes so my case details need to be pre-emptive and consider where I believe I will be in 30 minutes with this patient. Likewise, CAPCOM also pre-empt where my patient will have been for almost an hour by the time I will receive their advice.

Over the course of the next 48 hours, delayed updates are exchanged with the consultation team and I receive instructions based on the equipment I have in the habitat for an emergency escharotomy.

SOL 11

I am to take part in my third EHA to assist with the distribution of gypsum in an area known as 'white moon'. It's approximately 2.3 kilometres from the habitat and once through the airlock we will convoy two rovers to the site. The site is phenomenal – you can be forgiven for actually believing you are on Mars. The red rock and sand, deep canyons and small mountains dwarf our small team. While Andy and I are loading samples onto the rover, we hear Larissa call for help. She was extracting gypsum samples when she fell. Moving quickly in a space suit is not easy, nor is it advisable.

We find Larissa has impaled her left leg on a field tool. Although concerned about her injuries, our priority is to seal the suit breech and prevent hypoxia setting in. Andy produces a roll of duct tape from his tool kit and we secure the tool and tape the hole. Once sealed we carry her through improvised methods back to the rover for a rapid extrication to the airlock. Her suit continues to leak during the journey back. However, we successfully arrive at the habitat and once through the airlock her suit is removed and her wounds cleaned and dressed.

Freezing weather was forecast for the remaining days of the simulation, which kept us habitat bound. In reality, a very possible scenario. My role continued through this shut down with health and wellbeing support a priority.

PARAMEDICS IN SPACE

Paramedics in space may seem like a bit of stretch but remember 50 years ago it was only the elite who could attempt Everest. Access to the mountain has dramatically increased over the years and the number and experience of people shifted the medical needs of the area. Now there are fully equipped clinics staffed by doctors, paramedics and nurses in a remote area where once there were none. As paramedicine continues to evolve into primary care, the paramedic practitioner will become a staple in remote and extreme medicine.

Steve Whitfield is a paramedic and paramedic educator with over a decade of expeditionary and humanitarian experience. Currently a lecturer in paramedicine at Griffith University on the Gold Coast, Steve's research interest includes geography, remote medicine and human behaviour in extreme environments. Steve is a Fellow of the Royal Geographical Society and an Expedition Medicine Faculty member.

Acknowledgement

The author would like to thank the KJM Foundation and Dr Peter Stephenson for funding this research opportunity and progressing paramedicine.

Are they Triple OK?

We're always there to help. Let's make sure we help each other and ask R U OK?

'Are they Triple OK?' is an R U OK? campaign that aims to increase levels of peer and social support for police and emergency services workers nationwide. The campaign provides tips and resources to promote life changing conversations with police and emergency services workers at home and in the workplace to encourage early intervention and help-seeking.

The campaign resources include a conversation guide and personal stories from police and emergency service workers and volunteers that show the life changing impact an R U OK? conversation can have.

Three simple ways to get behind the campaign are to:

1. Visit the website and download the resources today
2. Share the resources within your service or agency
3. Share why you're supporting the campaign online and within your service and agency

ruok.org.au/triple-ok

R U OK? are grateful to the members of the R U OK? Police and Emergency Services Advisory Group whose input and advice guided the development of this campaign.

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R U OK?™

A conversation could change a life.

Ambulance detectives – an approach for best patient care

By Tammie Bullard

When we make a mistake in provisional diagnosis and treatment... how does it feel for our patients, or for ourselves?

For those who feel comfortable that we've been 'in the game' long enough to not be concerned, it's vital to know that it's not just new healthcare professionals making errors. One of the most common causes of medical mistakes and misdiagnosis is that of over confidence.

In the case of paramedics, we often remain oblivious to our incorrect clinical interpretations, as we generally don't see patients again and, unless adverse events occur, no notification will arise. Without recognition of such errors and their associated humbling emotions, we begin to risk becoming overconfident.

This does not necessarily mean complacency, although that certainly features in the mix. It can be related, instead, to the subconscious process of integrating a patient's medical history, symptoms and vital signs, with our medical knowledge and experience. Four types of bias often influence the combination, without us even realising it.

Availability bias can occur when conditions at the forefront of our minds are easier to retrieve. A practitioner is more likely to re-diagnose conditions that they have recently encountered, than consider other options less common, or less recent within their experience.

Representative bias, relating to the similarity of signs or symptoms we have seen before, makes some conditions appear blindingly obvious, therefore we may forget to consider the full range of potential options. A study of qualified and student healthcare providers, found that the addition of social factors such as alcohol use and recent redundancy, influenced decision making enough to render a list of clear CVA and MI symptoms less likely to be diagnosed accurately.

Confirmation bias tempts us to assess for factors that 'rule in' or confirm our suspicions, while failing to test and assess for factors that may 'rule out' our theory or suggest a differential diagnosis instead. Information may be sought solely to corroborate our thoughts, and upon gaining that confirmation, we may stop asking further questions, feeling that we have reached a satisfactory conclusion.

Anchoring bias, through which we set our thoughts so firmly on the things we know, or have seen before, can render us unwilling and, possibly, incapable of changing our minds to incorporate new knowledge. This has been highlighted in situations whereby diagnosing clinicians

have remained firm in their decisions, despite diagnostic evidence and autopsies to the contrary.

Closing the case, and therefore our minds, in terms of diagnosis, is a common cause of clinical error. With a natural human tendency to stop looking for other possibilities once we've found a good solution to a problem, we risk premature closure of our differential diagnostic thoughts.

So how can we avoid falling into these habits when we're fatigued and under pressure?

1. Discuss our findings and differential diagnoses aloud. This may be invaluable in maintaining an open mind, as well as encouraging the shared knowledge and experience of a colleague. If fear, ego or lack of confidence prevents us from doing so, we may be putting our patients, as well as our professional reputations and careers, at risk.

It may be that we are working with a crewmate who seeks to mock or discredit us, should they view this behaviour as 'weak' or 'unconfident'. This can make it undeniably challenging, in which case it may be necessary to either have a frank discussion about how their comments are affecting patient care, or simply work through our thought processes silently for the time being.

Even if the verbal commentary has to be internal, in our own minds, it is still possible to ensure that we purposefully step through the information and diagnosis options, thus maintaining safe habits to bring into future working relationships when the team dynamic permits.

2. Develop a habit of seeking to contradict any provisional diagnosis we have in mind. If we remain vigilant for additional information rather than dismiss it as irrelevant to the case we have formulated, we are actively seeking the best answer, rather than the easiest, quickest or most obvious.

The only thing we have to prove, as paramedics, is that we can carry out our roles to the very best of our abilities. In doing so, patients receive the highest level of care possible, the organisations we work for maintain good standing within the local community, the prehospital profession gains momentum and respect within the medical world, individual reputations remain intact and are enhanced over time, and we go home and sleep soundly at night, free from work related concerns. We may be labelled as 'indecisive' or 'over thinkers' or 'over treaters' or 'stress heads' or other unkind terms, but the benefits of that extra effort will always outweigh any annoyance those labels leave behind.

3. Use the limited time we have initially upon arrival, to make our best decision, but keep going back to the tried and tested primary and secondary surveys we're all familiar with for the remainder of the call.

It often appears impressive to new paramedics, that some clinicians will attend a patient and immediately pick a diagnosis, before sticking with it unwaveringly. While this may look slick and professional to the untrained eye, vital, potentially life threatening, information may be missed. Working with a provisional diagnosis and confidently reassessing for improvements, deterioration and reactions to treatment is safe, thorough, proactive and professional.

Similarly, if we imagine ourselves watching a thriller, in which the lead detective has a murder suspect in their sights, we feel frustrated when they don't talk to colleagues about every aspect of the case. We start willing them to share information that may change their mind.

During our second cup of tea, we find it infuriating that they are still fixated on the original suspect, despite new clues coming to light. Why won't they just look around and re-assess before it's too late?

By the time we've spent the final nail-biting hour on the edge of our seats, watching them arrest and charge the wrong person, we are incensed that the killer has escaped and another innocent victim had to suffer unnecessarily.

Perhaps we can apply the same to paramedicine and adopt the ambulance detective approach to best patient care and professionalism?

Tammie Bullard is the author of The Good, The Bad & The Ugly Paramedic. She is a columnist, paramedic and sessional lecturer based in Western Australia.
www.gbuparamedic.com

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What are the characteristics of strong mental health?

By Simon Rosenbaum and Jill Newby

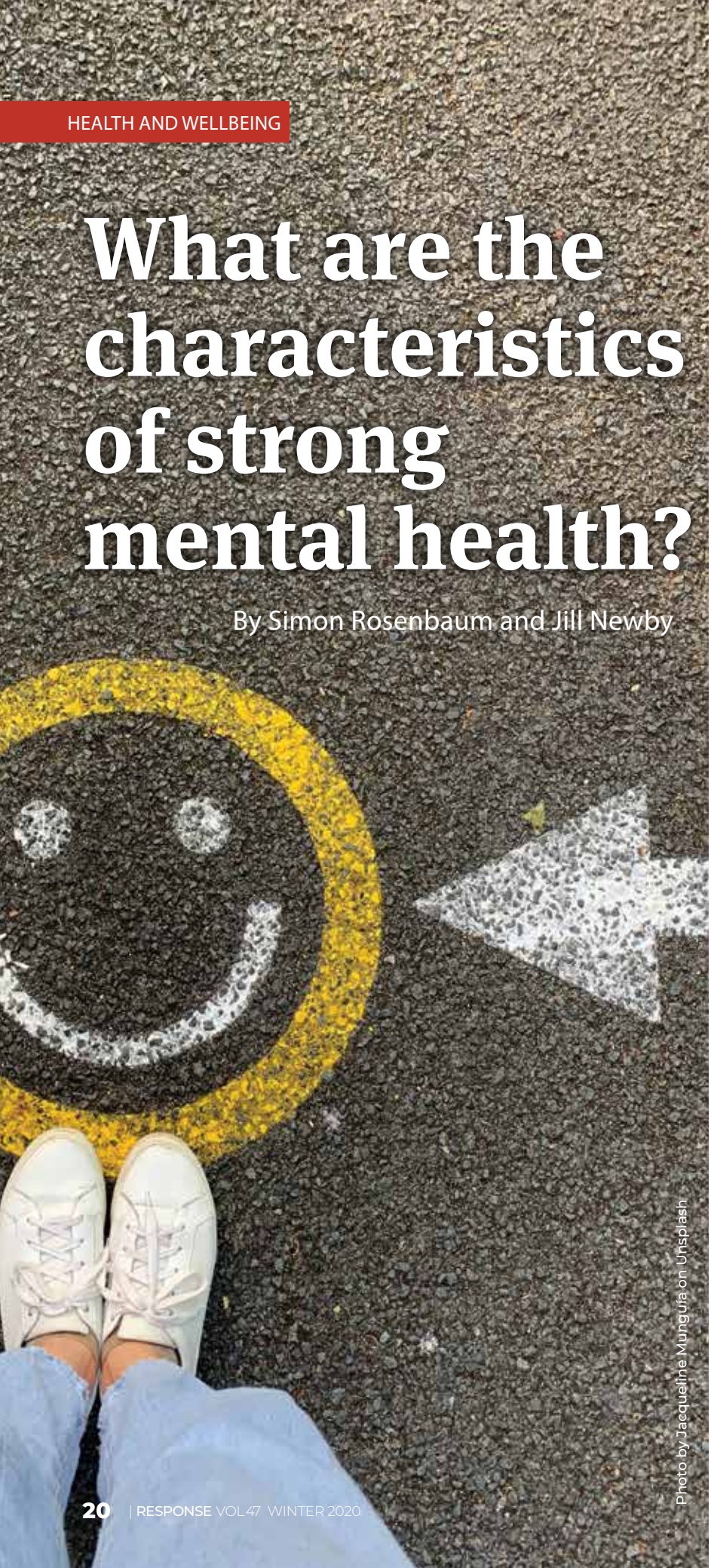

Photo by Jacqueline Munguia on Unsplash

Amid the coronavirus pandemic we are being warned of a 'second wave' of mental health problems that threatens to overrun an already weakened mental health service.

As we emerge from this crisis, while some people may need specialist help with treating mental illness, everybody can benefit from strategies to improve mental health. This is because mental health is more than just the absence of mental illness. Positive mental health is a combination of feeling good and functioning well.

Mental illness vs. mental health: what's the difference?

Mental health and mental illness are not simply two sides of the same coin. Mental health, just like physical health, exists on a spectrum from poor to optimal.

With physical health, some days we naturally feel stronger and more energetic than others. Similarly, some days our mental health is worse than others, and that too is a natural part of being human. We may feel tired, grumpy, sad, angry, anxious, depressed, stressed, or even happy at any point in time. These are all normal human emotions and aren't on their own a sign of mental illness.

Someone living with a mental illness can be experiencing optimal mental health at any point in time, while someone else can feel sad or low even in the absence of a mental illness.

Differentiating between poor mental health and symptoms of a mental illness is not always clear-cut. When poor mental health has a sustained negative impact on

> “Positive mental health is a combination of feeling good and functioning well”

someone’s ability to work, have meaningful relationships, and fulfil day-to-day tasks, it could be a sign of mental illness requiring treatment.

What does positive mental health look like?

Mental health is more than just the absence of mental illness.

Positive mental health and wellbeing is a combination of feeling good and functioning well. Important components include:

- experiencing positive emotions: happiness, joy, pride, satisfaction, and love
- having positive relationships: people you care for, and who care for you
- feeling engaged with life
- meaning and purpose: feeling your life is valuable and worthwhile
- a sense of accomplishment: doing things that give you a sense of achievement or competence
- emotional stability: feeling calm and able to manage emotions
- resilience: the ability to cope with the stresses of daily life
- optimism: feeling positive about your life and future
- self-esteem: feeling positive about yourself
- vitality: feeling energetic.

How can I cultivate my mental health?

Your mental health is shaped by social, economic, genetic and environmental conditions. To improve mental health within society at large, we need to address the social determinants of poor mental health, including poverty, economic insecurity, unemployment, low education, social disadvantage, homelessness and social isolation.

On an individual level, there are steps you can take to optimise your mental health. The first step is identifying your existing support networks and the coping strategies that you’ve used in the past.

There are also small things you can do to improve your mental health and help you to cope in tough times, such as:

- helping others
- finding a type of exercise or physical activity you enjoy (like yoga)
- getting good sleep
- eating healthy food
- connecting with others, building and maintaining positive relationships
- learning strategies to manage stress
- having realistic expectations (no one is happy and positive all the time)
- learning ways to relax (such as meditation)
- counteracting negative or overcritical thinking
- doing things you enjoy and that give you a sense of accomplishment.

How do I know if I need extra support?

Regardless of whether you are experiencing a mental illness, everyone has the right to optimal mental health. The suggestions here can help everyone improve their mental health and wellbeing, and help is available if you’re not sure how to get started.

However, when distress or poor mental health is interfering with our daily life, work, study or relationships, these suggestions may not be enough by themselves and additional, individualised treatment may be needed.

If the answer to RUOK? is no, or you or your loved ones need help, reaching out to your local GP is an important step. If you are eligible, your GP can refer you for free or low-cost sessions with a psychologist, exercise physiologist, dietitian, or other allied health or medical support services.

Simon Rosenbaum is Associate Professor and Scientia Fellow in the School of Psychiatry at UNSW Sydney.

Jill Newby is Associate Professor, Clinical Psychologist and MRFF Career Development Fellow at UNSW Sydney and the Black Dog Institute.

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Exercise and a growth mindset

by Mitch Mullooly

Think about the last time you tried a new exercise, workout or fitness-related skill. Did you suck at it? Did you find that it gave you an awesome boost of motivation? Or, did facing that 'suck' instantly make you feel hopeless and want to throw in the towel?

If you responded with an affirmative to the first, you most likely have a growth mindset around health and fitness. However, if you were met with the latter, you almost certainly fall in with the majority of people who have more of a fixed mindset when it comes to exercise. It is also possible to be somewhere in the middle; at times having more of a growth mindset and at other times falling more into a fixed mindset.

The great news is that you can actually change this limiting mindset and when you do, you will open up a whole new world of possibilities and make significantly more progress with your health and fitness journey than you ever thought possible before.

So, what does it actually mean to have a fixed mindset or a growth mindset around health and fitness?

Fixed mindset vs. growth mindset

I first learned about 'growth mindset' in a book by the American psychologist and Stanford University Professor Carol Dweck, in which she breaks down the two basic principles of how most people tend to approach life: with a fixed mindset, or with a growth mindset.

A fixed mindset typically means that you believe your skills and abilities are fixed or predetermined, so you are either good at something or you are not. People with this mindset are inclined to believe that there is not much you can do to change – who you are is who you are.

A growth mindset means you naturally believe that no matter where you are starting from, you can and will improve.

If you have a growth mindset around your health and fitness journey you believe you can get healthier, fitter and stronger no matter where you may be starting from. Consistent, inspired action (i.e. putting in the work) with proper goal setting and perseverance will get you there.

On the other hand, if you have more of a fixed mindset around health and fitness, you probably have a broad underlying belief that no matter what you do, you won't improve.

Why mindset isn't always absolutely black and white

Unsurprisingly, having a fixed mindset versus growth mindset is not always so black and white. More likely than not, you believe you are good at certain things, and often these are the activities you have been good at since you were a kid.

For example, if you are a runner, you may have always found running enjoyable, and even showed a natural tal-


Photo by Dallas Morgan on Unsplash

ent for running when you were younger. You may have been told by others that you were always good at running. And you are probably confident that if you want to, you could get even better at running provided you have clear goals, a good training plan and the right support.

Yet when it comes to an upper-body strength exercise like pull-ups or push-ups, you might believe you just suck at them. You may have always been told you had a weak upper body (many women fall into this category), or maybe you just believe (or have been told) that runners can't also have strong upper bodies.

> "Focus on the process, rather than the outcome by itself"

Whatever your reason, you may believe that any time or work you put into upper body workouts is generally useless, you are not going to get much better, even if you try.

But see what happens here?

You believe you are good at running, so you actively work to improve at it. You don't believe you're good at upper body strength work so you avoid working on it and, as a result, don't make any upper body strength gains.

Essentially, what this means is that if you believe you can't improve, you're unlikely to see any improvement. If you genuinely believe that you will never get better at something, you are unlikely to put any of the necessary time or effort required to actually make any progress. And no effort equals no improvement.

How to develop a growth mindset around fitness

I strongly believe that no matter where you are starting from, you can improve. Yes, it will take work. Yes, it will take time. But it will always be worth it when you look back at how far you have come. Here are the key approaches you will need to adopt to develop a growth mindset around fitness and exercise.

Growth mindset #1: You believe that talent is grown, not something you were born with

Author Steven Kotler says that: "believing that talent is something we are born with and cannot change will ultimately limit your ability to improve." The reason is this:

If you see a high performer such as an elite athlete and you immediately think: "I wish I had their talent," you are then unlikely to take the action steps needed to improve.

On the other hand, if you notice that same high performer and decide to figure out how they got so good at what they do and then put in the necessary time and work involved you are going to see improvement.

Having a growth mindset is an important first step toward goal setting and achievement, because this is the mindset you'll need to allow yourself to try.

Growth mindset #2: You proactively set short- and long-term goals

Having a growth mindset is the first step in the process, but it will not get you very far if you don't do the actual work! To really see progress, you must get really good at setting both short- and long-term goals, then chunking

them down into manageable and doable steps. For example, if you have a goal of competing in a triathlon, your goal setting process might look something like this:

Long-term goal: Compete in triathlon. It is important that you give yourself a realistic amount of time to work toward this bigger goal. This will depend on several factors, including your current fitness level, current known weaknesses, amount of time available to train each week (factoring in shiftwork and recovery time), available triathlon dates that work, and so on.

Short-term goals: You will want to find or create a training plan that addresses all of the above and ideally breaks down your training into days, weeks and months. The key is to chunk your goals into smaller, manageable steps that then allow you to track your progress and adjust as needed while working toward your bigger, long-term goal.

Growth mindset #3: You place effort before talent

"Effort is what ignites that ability and turns it into accomplishment." – Carol Dweck

If you want to really make progress toward a long-term goal, you not only have to believe you can get better, you also need to place effort before talent.

A great example is this (and parents, I know you will relate!): it's very easy to look at a cluster of little kids on a soccer field and see that a few of them naturally seem to know what to do with the ball, they are more coordinated, and often seem to possess more athleticism than the other kids.

What you can't see from this image alone though, is what will happen with the non-athletic looking kids if they put in the necessary time and practise. If they work hard and their more talented-seeming mates don't, many of them will actually surpass the other kids at some point.

Believing that effort counts more than talent is a vital piece of developing a growth mindset.

Growth mindset #4: You need to cultivate true grit

Another key mindset shift is learning to develop grit – the need to combine persistence, ambition and self-discipline in the pursuit of your big goals. And that might take months, years or even decades to realise.

Grit is what allows you to actually stick with your goals even when you hit obstacles or plateaus, which you most certainly will at some stage.

As Dweck tells us: "The passion for stretching yourself and sticking to it, even (or especially) when it's not going well, is the hallmark of the growth mindset. This is the mindset that allows people to thrive during some of the most challenging times in their lives."

Growth mindset #5: You embrace failures and imperfections

Having a growth mindset can be incredibly vulnerable because when you allow yourself to try something you care about, you are also setting yourself up for possible failure. After all, if you try really hard at something and ultimately fail, it's expected that you will feel disappointed. But being open to failure is a key piece of developing a growth mindset. If you don't allow yourself to fail, you won't allow yourself to really try.

Dweck further advises: "The growth mindset allows people to value what they're doing regardless of the outcome. They're tackling problems, charting new courses, working on important issues. Maybe they haven't found the cure for cancer, but the search was deeply meaningful."

The key here is to change your mindset around your goal to focus on the process, rather than the outcome by itself.

Growth mindset #6: You embrace the word 'yet'

And no, that's not "Are we there yet?"!

When you discover that you struggle to do something, flip the script. Instead of "I'll never be able to do this" try, "I can't do this... yet." This can apply to nearly anything in fitness:

I can't do full pull-ups... yet.

I can't run 5 kilometres without stopping... yet.

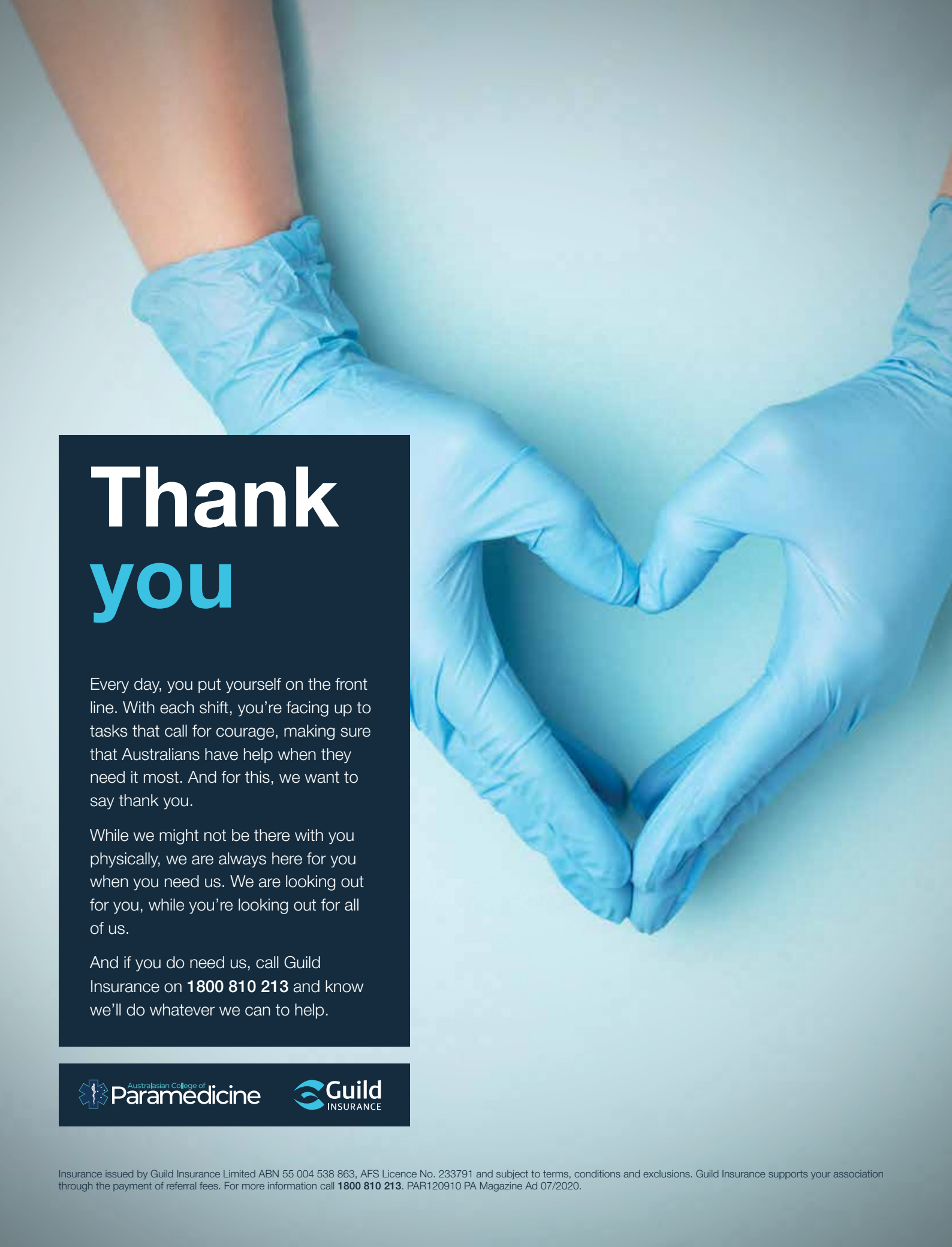
I can't do 100 burpees in a row without feeling like I want to puke... yet.

By reframing this, it gives you room to grow and helps get rid of that feeling that a challenge is impossible. Because if you can't do something you want to be able to do, you likely just haven't put in enough time or effort to get there yet. The more challenging the goal, the harder you will have to work to achieve it.

It all starts with having a growth mindset. From there, it takes the right goal setting techniques, developing and cultivating grit, and embracing failure as part of the process.

You're just not there... yet. But wherever you are at, keep going!

Mitch Mullooly MACPara is a paramedic with St John New Zealand; Chair of the New Zealand Member Committee of the Australasian College of Paramedicine; Member of the New Zealand Paramedic Council; and a Health and Wellness Strategist specialising in paramedic wellbeing – helping you reverse the negative effects of physical and psychological fatigue to make you fit for duty and ultimately fit for life!



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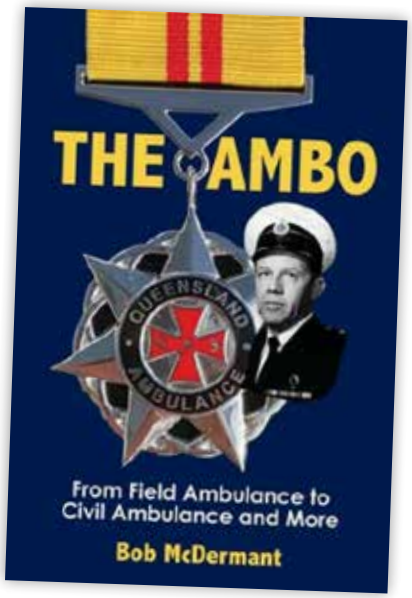
The Ambo

Since the launch of his book in late 2019, former Queensland Ambulance Transport Brigade State Council Chief Training Officer Bob McDermant has become somewhat of a media personality, attending book launches and media interviews. His most recent – at the age of 97 years – was a starring role in a segment about his life and career for the ABC's 7.30 Report.

Bob – a former Australian ambulance officer who served in the Field Ambulance in WWII and afterwards pursued a 39-year career in the Queensland Ambulance Service – played a major part in overhauling and modernising the ambulance service and the training of staff.



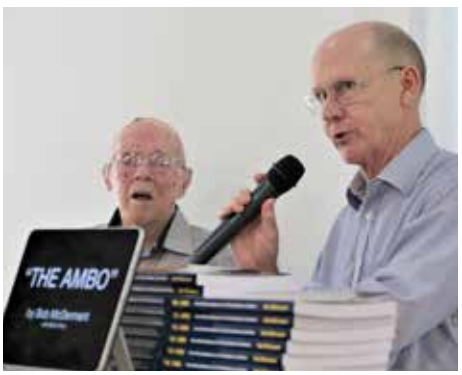
> "It was never too late to keep trying. So I live by that. It becomes a message for other people"
>
> – Bob McDermant

His book, *The Ambo: From Field Ambulance to Civil Ambulance and More*, details his extraordinary life and long history of service with the QAS. Bob's contribution was recognised in 2010 when he was awarded the Queensland Ambulance Service Distinguished Service Medal.

The 7.30 Report segment, Bob McDermant looks back on nearly 40 years as a paramedic is currently available for viewing.

(L-R) Greg McDermant (Bob's son), Bob McDermant and Mick Davis (QAS Heritage and History Manager) at Birtinya Ambulance Station for partial filming of the 7.30 Report segment.

QAS paramedic Michael Okulov shows Bob through a new ambulance.



Bob and Greg at the launch of *The Ambo*.

Images courtesy QAS Media.

FREE BOOK GIVEAWAY

Response is giving away free copies of *The Ambo*.
The first six readers to email info@paramedics.org with the subject heading 'FREE BOOK GIVEAWAY' will receive a copy. Good luck!

College members appointed to NZ Paramedic Council

(L-R) Bronwyn Tunnage, Sean Thompson and Mitch Mullooly

A special congratulations go to our College members Bronwyn Tunnage, Sean Thompson and Mitch Mullooly on their recent three-year term appointments in the category of health practitioner members to the Paramedic Council of New Zealand.

Bronwyn is a College Board Director, and Senior Lecturer in Paramedicine at Auckland University of Technology and the departmental research leader. She is also an honorary Research Fellow at St John New Zealand and past Paramedics Australasia Board Director.

Sean is the Systems Manager in Advanced Care Planning at Capital & Coast District Health Board and an Intensive Care Paramedic with Wellington Free Ambulance. He is also the immediate past chair of both the Paramedics Australasia New Zealand Chapter and the New Zealand Paramedic Registration Working Group.

Mitch is a paramedic with St John New Zealand and Chair of the College's New Zealand Member Committee. Mitch is also a health and wellness strategist specialising in paramedic wellbeing, and a regular columnist for *Response* magazine.

On announcing the appointments, the Hon David Clark said, "The well qualified and experienced individuals appointed now will ensure the high professional standard to which paramedics work will be maintained and enhanced into the future."

Other appointed members to the Paramedic Council are: Carlton Irving and Nigel Watson (health practitioner members, two-year terms); David Ivory (layperson member, three-year term); and Bernadette Pereira (layperson member, two-year term).

> "The newly appointed New Zealand Paramedic Council is a diverse group of appointees and it is exciting to be part of a team that represents paramedics, and the patients we are called to protect. Each member of the Council brings with them diverse ethnic, geographical, personal and professional identities. My personal aim is to ensure that paramedicine under the Health Practitioners Competence Assurance Act is future focussed, straightforward to navigate, well communicated, and has our Maori heritage and the principles of partnership, participation and protection woven throughout its structures" – Sean Thompson

Women in Ambulance

The Council of Ambulance Authorities recently released its Women in Leadership Strategy. The Strategy follows the launch earlier this year of the Women in Ambulance campaign, which was designed to "highlight successful and hardworking women in ambulance services across Australia, New Zealand and Papua New Guinea".

CAA General Manager, Mojca Bizjak-Mikic said, "While progress is being made in this space it is important that this topic stays front and centre and we actively work towards a more gender-balanced workplace, where women have the same career opportunities as their male counterparts, hold leadership roles and have a chance to contribute to building better services.

"We hope that with this Strategy we start putting building blocks in place that will lead to a more gender-balanced ambulance industry and introduce more women to senior and executive management roles and sector leaders."

The Women in Ambulance campaign recognises 58 women who have been awarded the CAA Women in Ambulance Honour for their work and career progression and are being championed as role models to the rest of the workforce. You can find out more about the recipients at https://www.caa.net.au/women-in-ambulance-subpage

College representative roles

The Board is pleased to announce the following member appointments for various external and College roles.

External representation

Brad Mitchell – Ambulance Education Committee (CAA)
Alan Eade – Professions Reference Group (Ahpra)
Kathryn Eastwood – Australian Resuscitation Council
Peter O'Meara – National Rural Health Alliance.

Advisory Committee Chairs

Paul Simpson – Research Committee
Alisha McFarlane – Clinical Standards Committee
Liz Thyer – Professional Standards Committee
Fabien Perez – Student Committee
Simone Haigh – Awards and Recognition Committee.

Member Committee Chairs

Mitch Mullooly – New Zealand
Buck Reed – NSW/ACT
Matt Shepherd – VIC
Glen Morrison – QLD
Clare Toms – SA
Brock Hellyer – NT
Paul Pulleine – TAS
Mandy Edmonston-Fearn – WA.

Special Interest Group Chairs

Clare Sutton – Mental Health and Wellbeing
Elliott Bates – Paramedic Specialists and Practitioners
Wayne Loudon – Clinical Fellowship
Alecka Miles – Rural, Remote and Community Medicine
Sonja Maria – Clinical Practice Guidelines.

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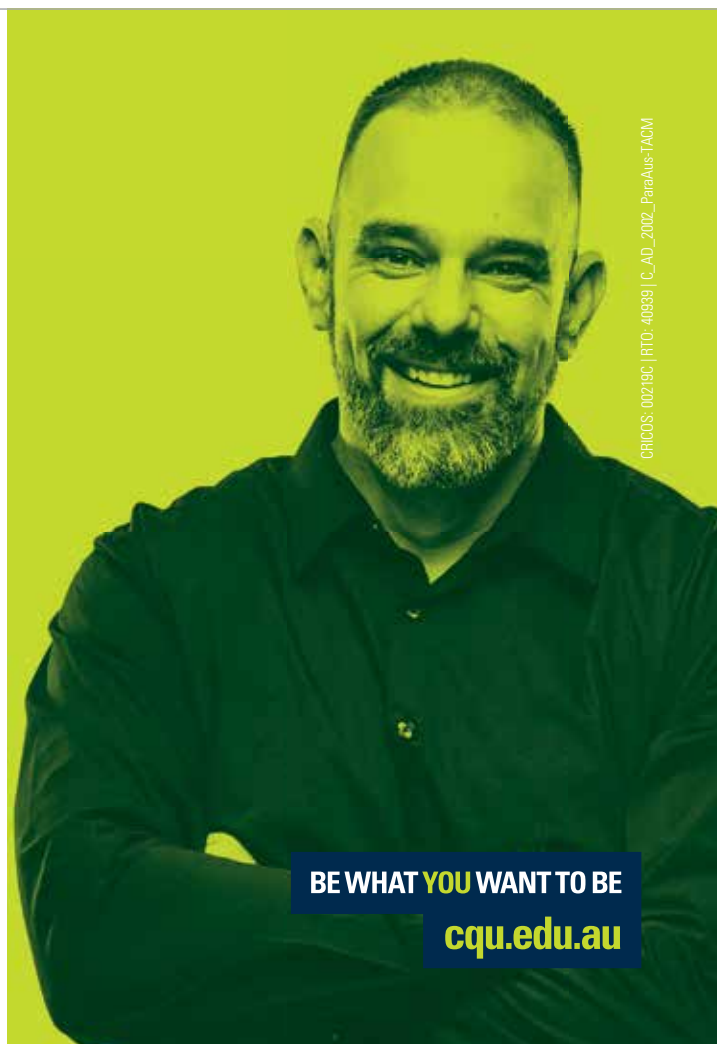
*These courses contain units that require compulsory attendance at residential schools.



Complimentary scenarios to prepare for the COVID-19

The Coronavirus (COVID-19) has created a healthcare crisis that has put a major training burden on hospitals, emergency medical services, and long-term care facilities, among others. To assist you in preparing your staff and teams, Laerdal Medical and partners have created a set of free scenarios to help you prepare.

In these scenarios, the participants will encounter a patient with suspected Covid-19 who experiences a cardiac arrest with a shockable rhythm.

Learning objectives:

- Use donning/doffing procedure
- Consider a limited use of Aerosol Generating Procedures (AGP's)
- Perform airway management for a casualty with suspected Covid-19
- Maintain a secure BVM seal
- Recognize and treat a cardiac arrest with a non-shockable rhythm
- Identify transport consideration of suspected Covid-19 patient

Use this scenario with: Resusci Anne Simulator, Resusci Anne Advanced SkillTrainer, ALS Simulator and SimMan ALS.

Resusci Anne Advanced SkillTrainer

Mobile ALS training for advanced healthcare professionals

Key features include:

- RAAST is designed for task and team training to ILS and ALS curriculums;
- Airway management with BVM or supraglottic airway devices.
- Live defibrillation with ShockLink and training pads or paddles (select the right manikin configuration)
- ECG monitoring 3 leads
- External Cardiac Pacing
- Pulse monitoring
- IV insertions
- Quality CPR (QCPR) feedback to measure and improve CPR performance (Guidelines 2015)
- Debriefing of CPR quality performance and recorded events
- Create and edit scenarios (SimPad Plus)

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What's new in the AJP?

The following selected abstracts have been taken from the Australasian Journal of Paramedicine, Volume 17, 2020. The full text articles can be found at https://ajp.paramedics.org
The AJP employs continuous publishing, so check the AJP website regularly for new peer-reviewed paramedicine research and review papers.

Responding to a cardiac arrest: Keeping paramedics safe during the COVID-19 pandemic

Steve Whitfield, Alexander MacQuarrie, Malcolm Boyle

The impact of the coronavirus disease, COVID-19, and the source virus, SARS-CoV-2 on ambulance services globally has been wide-ranging. There is an expectation this could result in an increased demand on the operational resourcing of ambulance services, hospitals and other healthcare facilities. As the infection and screening profile of the virus evolves, so too does the clinical care guidelines for frontline healthcare providers. The frequent updates to guidelines, processes and recommendations have left many healthcare providers, paramedics included, struggling to keep up with the changes.

Community paramedicine in British Columbia: A virtual response to COVID-19

Michelle Brittain, Christopher Michel, Leon Baranowski, Richard Armour, Amy Poll, Jennie Helmer

The British Columbia Emergency Health Service has worked collaboratively with health authorities throughout the province since 2015 to improve the delivery of healthcare in rural and remote communities through the community paramedicine program. In response to the COVID-19 pandemic to minimise the risk to providers and patients, as well as conserve personal protective equipment, home visits and community engagement opportunities were suspended. However, the COVID-19 pandemic saw a large increase in the number of patients referred to the service and so alternate approaches to patient care delivery were urgently required.

Risk of psychological distress, pervasiveness of stigma and utilisation of support services: Exploring paramedic perceptions

Kelly Mackinnon, Timothy Everett, Lisa Holmes, Erin Smith, Brennen Mills

Introduction

Paramedics are exposed to significant and cumulative stressors that contribute to poor mental health. The provision of effective and engaging mental health support is essential in improving overall wellbeing. Many ambulance services have adapted their available support services to reflect this need. However, there remains limited research into the perceived efficacy of these services and barriers that limit uptake from paramedics.

Methods

Paramedics and ambulance volunteers from Australia and New Zealand were invited to complete an online survey consisting of a series of Likert-scale and open-ended response questions. The well-validated Kessler Psychological Distress Scale was also incorporated into the online survey.

Results

A total of 184 participants completed the survey. A total of 50 (27%) participants reported high/very high levels of psychological distress. Participants exposed to at least one adverse event while working reported higher psychological distress scores than those that had not. Just over half (51%) of all participants disagreed/strongly disagreed there was no stigma associated with seeking mental health support from paramedic colleagues and 54% of participants disagreed/strongly disagreed there was no stigma from managerial staff.

Conclusion

These findings suggest paramedics are at a greater risk of psychological distress than the general population. This is particularly problematic given there is a clear perception of ongoing stigma among paramedics associated with the utilisation of mental health support services. Future research should explore methods for reducing stigma and encouraging help-seeking behaviours in this vulnerable population throughout all phases of an emergency service workers career.

Soiled airway tracheal intubation and the effectiveness of decontamination by United Kingdom paramedics (SATIATED2): A randomised controlled manikin study

Graham McClelland, Richard Pilbery, Sarah Hepburn

Introduction

Vomiting and regurgitation are commonly encountered in out-of-hospital cardiac arrest, but traditional paramedic suctioning techniques may be insufficient to manage severely soiled airways. The Suction Assisted Laryngoscopy and Airway Decontamination (SALAD) technique was developed to help clinicians manage soiled airways. SATIATED2 reports the impact of SALAD training in North East Ambulance Service (NEAS) in the United Kingdom following the original SATIATED study in the Yorkshire Ambulance Service.

The primary research question was: Among NEAS paramedics, does the addition of SALAD training, compared to standard training, improve the success rate of intubation for the soiled airway?

Methods

A randomised controlled trial of SALAD was conducted using a modified airway manikin capable of vomiting. The intervention comprised SALAD training and the introduction of the DuCanto catheter. Paramedic volunteers were block randomised into two groups: A01A02B01 who made two pre-training intubation attempts and one post-training attempt, and A11B11B12, who made one pre-training and two post-training attempts. The primary outcome was intubation success rate at the second attempt. The time taken to intubate was recorded as a secondary outcome. SATIATED2 was registered with ISRCTN (ISRCTN17329526) and funded internally with commercial support from SSCOR who supplied the DuCanto catheters.

Results

One-hundred and two paramedics (51 AAB, 51 ABB) were recruited between August and December 2019 with 99 participating (50 AAB, 49 ABB). The primary outcome was intubation success rate on the second attempt (A02 vs. B11) which were 86% without SALAD and 96% with SALAD; a non-significant improvement of 10% (95% CI: 1–21, p=0.09). The total intubation success rate pre-training (A01+A02+A11) was 75% (112/149) compared with 98% (145/148) post-training (B01+B11+B12).

Conclusion

NEAS paramedics demonstrated improved, but non-significant, intubation success rates in a simulated soiled airway following SALAD training.

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