VOL 47
SPRING 2020

RESPONSE

ACPIC 2020
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COVER

Keynote Speaker at ACPIC 2020, Greg Page.

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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with Peter Jurkovsky

Observations, a wish and a prediction

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

I note with interest and endorsement the comments and observations of our CEO, John Bruning, in his message to members when describing the 'power of association' and the impact of COVID-19 on the community on the whole, paramedicine as a profession and the College in its representative role. The College will come through this crisis a stronger and more relevant organisation due, in part to some good fortune in a practical sense as a sector that must continue to operate during a pandemic, but predominantly this has been achieved by sound strategic planning and good decision-making with the foundational support from our members being the glue that holds everything together. Congratulations to John on the central role he has played in the evolution of the College – it is in excellent hands under his leadership.

On a personal note, I am retiring from the College Board and would like to thank all the fellow directors and executives I have worked with over six years, both at Paramedics Australasia and the College, for their wonderful friendship and support. It has been a highlight of my professional life to be afforded the opportunity to play a leadership role in a profession I love during such a momentous period, one that saw registration come to fruition and the creation of a single body to represent paramedics across Australia and New Zealand.

> "It has been a highlight of my professional life to be afforded the opportunity to play a leadership role in a profession I love during such a momentous period"

While certainly not wanting to diminish the support of any particular person I have had the pleasure to work with over the past six years, I must specifically acknowledge and thank Marty Nichols for his integrity, support and counsel after he commenced the merger journey with me and saw it through to its successful fruition. I would also thank Simone Haigh for her support and friendship as Vice-President of Paramedics Australasia and Vice-Chair of the College during these revolutionary times and it was an honour to witness her ascension as a leader in paramedicine through her initiation of the Senate Inquiry into the mental health of first responders.

I thought it opportune to leave you with some observations, a wish and a prediction in light of these unique times that have introduced us to many new terms and practices that have now become second nature to us all, and will probably be with us for generations to come.

First, the observations:

1. The community can be trusted and relied upon if they are provided with clear and comprehensible information and instructions in times of crisis, but it must be transparent and depoliticised.
2. We need to prioritise the most vulnerable in our community with much greater rigour.

Second, a wish:

Where a body (logically the World Health Organization) is supported and properly funded to ensure a world-wide, holistic and evidence-based response is available for all countries to access and apply in the case of a future pandemic. The model should have a rigorous prevention model because as the health economists will tell you, every dollar spent in health prevention is 10 saved in treatment

Finally, a prediction:

The most highly funded government department in this country's history will be formed in 2021 to be known as 'DOPPAR' (because any government department worth its salt needs a catchy acronym!) – DOPPAR is the new Department of Pandemic Prevention and Response.

As always, stay safe and I wish the new Chair well as they take up the role in early November and continue to communicate with you in pursuit of excellence in our profession.

Australasian College of Paramedicine

EVENTS 2021

19 March

Trauma on the Border

Friday 19th March 2021

Tweed Heads, NSW

One day paramedic conference covering all things trauma

26-28 May

Rural Outback and Remote Paramedic Conference

Wednesday 26th to Friday 28th May 2021

Broome, WA

Designed specifically for paramedics and allied professionals working in rural outback and remote areas

15-17 September

ACP International Conference

Wednesday 15th to Friday 17th September 2021

Canberra, ACT

An in-depth comprehensive paramedic conference that focuses on providing the education and research that paramedics need

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visit **www.paramedics.org/events** or email **education@paramedics.org**

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Australasian College of Paramedicine

with John Bruning

The power of association

I was reflecting recently on some of the early predictions on infection and death that COVID-19 could, or would likely have, in Australia and New Zealand if we did nothing to reduce infections. Those early predictions were concerning, but together our communities were able to work co-operatively and change those predicted outcomes – that is the power that a collective can have.

When thinking about the College, we have become 10,000+ members strong in the past few months and I see the opportunities that a strong and large association can have. We recently established our various advisory and member committees, and special interest groups (18 committees/groups in total with over 110 members involved) and this again highlights the power of association. These committees and groups will play a vital role in providing specialist knowledge and expertise guiding many areas of College activity.

While we are yet to truly flex our muscle as a paramedic association, I look forward to the impact we will have in the coming years through the power of our member association.

> “I look forward to the impact we will have in the coming years through the power of our member association”

Our online live education workshops continue, with excellent engagement from both members and non-members. Since the start of July to mid-October we have held 18 webinars with over 3700 attendances across those events – averaging over 200 attendees per webinar.

The College established a policy to ensure our events meet local COVID-safe requirements, and we delivered our first face-to-face session since March in Adelaide in October. We expect to run further face-to-face events before the end of the year.

I am hopeful that 2021 will see more face-to-face events, achieving important networking and interaction, but I imagine there will be some ongoing restrictions that will limit these activities. The shift to online has certainly served all our members well during this time, but especially those in regional, rural and remote settings, who can struggle to access quality education activities. The widespread engagement with our live webinars means that we will need to keep a comprehensive online program mixed with local face-to-face events next year.

Our fully online international conference (held over 21 to 23 October) had over 1100 attendees – numbers we could only dream about for an in-person conference. At the conference I presented the results of our member survey on the College’s strategic direction. The results have been positive and supportive of the direction we have taken but there are plenty of great ideas from members that will be incorporated into our Strategic Plan 2021–23. Thank you to all members who participated in the survey.

Our next issue of *Response* will be published in late January, so I wanted to flag with members the College office closure over the Christmas period. This year has been massive for the College and staff have worked successfully in what has been a challenging setting. With many members taking the opportunity to have a break from work over this period, we will close for up to four weeks for staff to recharge so they can come back refreshed to deliver all that our members expect in 2021. We will communicate exact dates of the office closure via *Rapid Response* at the end of November.

Enjoy the warming weather and stay well.

Shared goals

with Fabian Perez, Chair

Earlier this year the Student Committee was officially launched as a member committee of the College. The Committee is responsible for all areas relating to the engagement, development and transition of undergraduate student paramedics with an overarching objective of continuing students' relationship with the College beyond their graduation.

What we've accomplished so far

We've hit the ground running and still managed to achieve so much in such a short time, such as:

- launching the 'Student Talk' podcast series
- delivering online webinar CPD events specifically for students
- consulting with Ambulance Victoria on improving the student placement experience during the pandemic restrictions
- collaborating with paramedicine university societies to improve the student experience and deliver more events in 2021
- obtaining feedback from student paramedics via an online survey to help drive the Committee's direction and activities over the next 12 months.

We are working on some exciting events and initiatives for 2021, including an annual student paramedic conference, bringing back the Ferno challenges and delivering many more online and in-person CPD events and professional networking opportunities across Australia and New Zealand.

The exponential effect of collaboration

One of the most fundamental components in a progressive and successful committee is the capacity and capability of the people involved. I am lucky to be supported by an amazing team of motivated students from around Australasia who work tirelessly to turn ideas into reality.

We are already seeing the transformative effects that occur when this group of talented people come together and collaborate to achieve a shared goal.

Liam Bruton – Co-Chair

Liam studies at Western Sydney University and is currently in his second year of the Bachelor of Paramedicine degree. He holds the co-chair role and assists me to oversee the strategic objectives of the Committee and support fellow Committee members with projects they are working on. Liam's goal for the next 12 months is to improve representation for paramedicine students through a dedicated body that can work in the students' interest to develop the learning process and transition to practice and says,"By increasing Australasian students' involvement in the College, a new community of practice will be created with events and initiatives focussed at new practitioners."

Sherlyn Hii – Regional Coordinator

Sherlyn studies at the Australian Catholic University (Vic) and is currently in her second year of the Bachelor of Nursing and Paramedicine degree. She holds the regional coordinator role and is also an episodic producer on our Student Talk podcast series. She works closely with the regional representatives around Australia and New Zealand to ensure fair and equal representation of our entire student body. Her role ensures that students have a strong and proud voice within the professional discourse. Sherlyn's goal for the next 12 months is to see closer partnerships between the College and university societies by "working closely with these societies to provide a richer source of extracurricular activities for paramedic students".

Liam Sherlyn Dianne Jessica Anna Venessa Abby Jasmine Tahlia Simon

Dianne Jordan – Events & Education Coordinator

Dianne studies at the Australian Catholic University (Qld) and is currently in her second year of the Bachelor of Paramedicine degree. Dianne holds the events and education coordinator role and is the backbone to organising all our student events. Dianne's goal for the next year is to "support student experiences by organising events and educational resources that enhance their learning and motivate them to become the best paramedic they can be".

Jessica Nolan – Social Media & Marketing Coordinator

Jess studies at Auckland University of Technology and is currently in her final year of the Bachelor of Paramedicine degree. She holds the social media and marketing coordinator role and is also an episodic producer on our Student Talk podcast series. Jess is responsible for keeping students up-to-date with news, events and interesting content and literature. Jess' goal for the next 12 months is to "consistently post and interact with students and enhance the new student paramedic podcast".

Anna Musgrave – Research Promotion & Communications Coordinator

Anna studies at the Australian Catholic University (Vic) and is currently in her final year of the Bachelor of Paramedicine degree. She holds the research promotion and communications coordinator role and is responsible for promoting research opportunities available to students. In the next 12 months, Anna hopes to create connections with researchers in the paramedicine industry to create pathways for students to become involved in research. Anna says, "Students are the future of this industry and we want to make them a part of the research that will shape the future of paramedicine."

Venessa Carnaby – NSW & ACT Representative

Venessa studies at Western Sydney University and is currently in her second year of the Bachelor of Paramedicine degree. Venessa holds the state representative role for New South Wales and the Australian Capital Territory and is a liaison between the Committee and student paramedic societies within the region. She is also working on our Student Talk podcast series and says, "I am super excited to work on understanding what we can do to ensure students stay engaged with their new career for the duration of their studies."

Abby Goodwin – SA & WA Representative

Abby studies at Flinders University and is currently in her second year of the Bachelor of Paramedicine degree. Abby holds the regional representative role for South Australia and Western Australia and is also an episodic producer on our Student Talk podcast series. Abby's role is to advocate for student paramedics across South Australia and Western Australia and their professional development needs. Abby's goal over the next 12 months is to "help provide the paramedic student society with the events and resources they need to assist students develop as future paramedic professionals".

Jasmine Dietrich – Queensland Representative

Jasmine studies at CQUniversity and is currently in her second year of the Bachelor of Paramedicine degree. Jasmine is the regional representative for the Queensland and Northern Territory regions and an episodic producer on our Student Talk podcast series. Her role is to maintain contact with the universities within the region as a student liaison. Jasmine's goal over the next 12 months is to "optimise the student experience throughout their studies and create learning opportunities whilst having fun on the way".

Tahlia Harper – Victoria & Tasmania Representative

Tahlia is in her first year of the Paramedicine degree at Victoria University. Tahlia is the regional representative for Victoria and Tasmania, the Mental Health Special Interest Group student representative and an episodic producer on our Student Talk podcast series. Tahlia's role is to engage with Victorian and Tasmanian students and promote wellbeing and mental health across the board. Tahlia's goal for the year is to "improve support for students in their education through resources, events, communication and advocacy".

Simon Mclean – New Zealand Representative

Simon is in his final year of the Paramedicine degree at Auckland University of Technology, expecting to graduate in July 2021. His role is to maintain contact with the universities within New Zealand as a student liaison. Simon's goal over the next 12 months is to "build stronger connections with New Zealand paramedicine students and showcase the value of student membership".

ACPIC 2020 – a virtual success

Three days, 35 presentations, 50 speakers, 1100 attendees – the College's fully online international conference was hugely successful.

KEYNOTE SPEAKER
Commissioner Shane Fitzsimmons

KEYNOTE SPEAKER
Greg Page – Former Wiggle

Hosted virtually on a dedicated digital event platform, attendees were able to watch live sessions as they happened, engage with other attendees, and watch recorded sessions at a later time. From hypothetical situations and international panel discussions to clinical case studies and research presentations, it truly was a conference with global appeal.

DAY 1

The conference started with a Welcome to Country by Queensland paramedic Krystal Smith. Krystal noted that despite "an unprecedented past year... as a profession, we continue to rise". College Chair Peter Jurkovsky then officially opened the conference and welcomed all to the virtual platform.

Judith Barker, CEO St John Ambulance NT, was our first keynote speaker and addressed the importance of resilience. "Resilience is hard work. It requires us to be courageous and face difficult truths about ourselves and the situation that we are in." Judith provided some thoughtful and valuable tips and guidance on how to work towards resilience ("make sure you nourish your soul") and shared her personal tools and methods for staying resilient in her own life.

Continuing the theme of resilience, Shane Fitzsimmons, Commissioner of Resilience NSW, provided the background for the establishment of Resilience NSW in his keynote speech. Describing the lead-up through winter and spring to what was ultimately a devastating summer fire season for much of New South Wales (and Victoria), Shane spoke of the "communities razed to the ground" and the loss of 26 lives, including seven firefighters. It was "a scale and a toll the likes of which we've never seen before," he said. In the repair and reconstruction following disaster, central to the programs of Resilience NSW is "recognition of the extraordinary psychological and emotional toll"

GLOBAL PANEL

that these disasters take on communities and emergency services workers.

We were then joined by Dr Tony Smith, Clinical Director at St John New Zealand, who delivered an extraordinary and moving presentation on the Whakaari/White Island eruption. Describing how health services were "absolutely overwhelmed", Tony walked us through the incredible tasks that faced responders, the initial confusion that occurs with MCIs and the unique nature of the injuries sustained by the victims. Tony also shared his own mental health experience following the incident saying: "For the very first time in my career, I had to admit... I'm not okay."

Audience reaction was palpable through the comments, with much praise and gratitude to Tony for sharing the personal aspect of the tragedy and for highlighting the importance of taking care of yourself and others, with one attendee noting: "This would be a standing ovation if we were physically together".

> "Great to hear that the informal support from your peers was so valuable as well as the formal support. Thank you for your honest, brave and frank presentation" – Olga, attendee

Following the keynote sessions were a range of research presentations. Ben Meadley kicked off with a standardised protocol for monitoring cardiovascular and physical health in paramedics, which generated a lot of questions and discussions on the live chat.

> "Important research Ben. Well done for leading the way on this"
> – Helen, attendee

ACPIC 2020

YOUR PATIENTS. YOUR PROFESSION. YOUR FUTURE.

Kathryn Eastwood then presented *Ambulance dispatch of older patients following primary and secondary telephone triage in metropolitan Melbourne*. This was followed by Peter O'Meara with *Community paramedicine through multiple stakeholder lens using a modified soft systems methodology*.

Three clinical case studies were presented after lunch, with Michaela Malcolm's 'Major chest trauma' leading the way. Among the many comments and questions, attendee Jake noted: "That is an amazing case review, and something I can't imagine having to manage".

Scott Jones followed with 'Status epilepticus in the resource poor environment', and Steve Whitfield rounded up the session with 'From mud to Mars: paramedics in space'. All three sessions offered valuable insights into unique situations and left attendees with much to mull over.

Day 1 was capped off with three more research presentations, each highlighting the valuable research being conducted in the paramedicine field.

DAY 2

Day 2 began with a 'cases around the world' theme, with each presentation contributed to by three speakers, bringing their own unique perspective. Cases included 'Multi-system trauma – motorcycle crash'; 'IV adrenaline instead of morphine'; and 'Stroke'. These sessions generated much discussion from attendees relating their own experiences via the live chat and dialogue around current practices and possible future improvements.

The after-lunch session focussed on research, with two panel discussions covering the pre-hospital research agenda, led by Paul Simpson, Vivienne Tippett and Julia Williamson; and translation of pre-hospital research to practice, with Karen Smith, John Glasheen and Sonja Maria. Three 'Best of the Best' research presentations followed with Zainab Alqudah, Shayna King and Richard Pilbery. (For full details on the presentations and conference awards, visit the College website.) Two more research presentations focussing on training and education for mental healthcare and the impact of COVID-19 on paramedicine students completed the day session.

GLOBAL PANDEMIC PANEL

The evening of Day 2 saw a panel drawn together from seven different countries to address the issue facing us all in 2020 – the COVID-19 pandemic. The pandemic has seen many changes in our workload, our approach to infection control and PPE, communications centre and hospital systems and our capacity to undertake our usual health and wellbeing activities. The panel discussed some of the pos-

itive changes and professional growth for paramedics and paramedicine as a profession, as well as lessons learned from frontline responders. College Chair Peter Jurkovsky highlighted the panel discussion, saying: "If you're ever considering reviewing a session you may have missed for CPD purposes, this one should be on the list. It offered some extremely interesting insights into the impact and responses to COVID-19 in other jurisdictions, particularly as they relate to the early interventions and successful interventions in Taiwan, and when health systems are potentially overwhelmed as occurred in Italy."

DAY 3

The final day of ACPIC 2020 saw an extremely well-received clinical case study on 'Paramedic provision of palliative care' from Sascha Baldry, along with a group of excellent research presentations from Australia, the UK and Singapore.

> "The most exceptional presentation of the conference. So incredibly important and relevant. Outstanding patient centred professional practice" – Alan, attendee

Day 3's keynote session was the much anticipated The Yellow Wiggle Patient Experience with Greg Page. Greg shared his perspective on the sudden cardiac arrest he experienced on stage with the Wiggles. Greg's life was saved thanks to quick thinking bystanders who administered CPR and brought an AED to the stage. Greg now aims to educate others about the importance of knowing CPR and making AEDs more available in public places (and in homes) and has introduced the 'Heart of the Nation' initiative, which allows businesses to place a 'badge of honour' on their entry door to let the community know that there is an AED inside.

Before Greg's speech we had the privilege of hearing from the registered nurse who was first on the scene, Grace Jones, and the attending paramedics, James Urio and Jackson Scriven. As one attendee [also named Greg] observed: "There is no replacement for good procedures, training and teamwork. This is the perfect result from good systems within pre-hospital emergency care".

Following Greg's keynote speech were two highly relevant research presentations, continuing the discussion on cardiac arrest.

> "No airway equipment [was] available unfortunately so it definitely was difficult to maintain his airway. I had to continue with the jaw thrust and head tilt until ROSC was achieved" – Grace Jones

The afternoon session began with a panel discussion on advancing the profession with Alan Eade, Chief Paramedic Officer, Safer Care Victoria; Paul Gowens, Lead Consultant Paramedic, Scottish Ambulance Service; and David Waters, Chief Executive, Council of Ambulance Authorities.

The next panel looked at disasters, with a focus on New Zealand, and the strategies ambulance services have in place to ensure the wellbeing of frontline workers. The panel, comprising Amee Morgans (ESTA), Vivienne Tippett (QUT) and Brigadier Matthew Burr (ADF), then explored combined service pre-hospital incident command systems and changes in the communication centres thanks to the impact of COVID-19 on operational aspects of ambulance services.

The third panel of the afternoon addressed paramedic accreditation and explored questions including: What are the likely requirements of supervisors (preceptors/facilitators) under the accreditation standards provided by Ahpra? It also looked at placements as a key feature of pre-hospital learning – Are they still effective, how much, and what sort of placements are needed?

All three panel sessions elicited great discussion among the audience with plenty of questions thrown to the panellists. They are highly recommended viewing online for those who may have missed the live sessions.

ACPIC 2020 concluded with a review of a recent College member survey – helping to shape the future direction of the College – presented by CEO John Bruning. Peter Jurkovsky joined to close the conference, highlighting key points from the conference and lessons to take away. Through the sharing of a fascinating anecdote, Peter observed that "clarity and calmness under pressure are the most underrated characteristics", before thanking sponsors and all those personally involved in making the conference such a huge success.

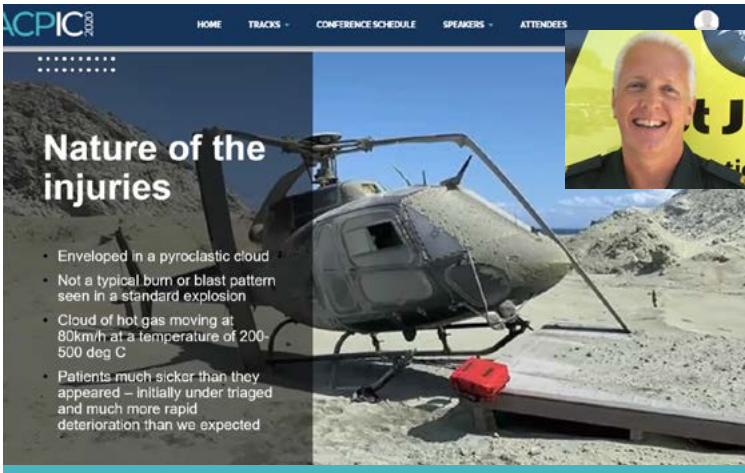
KEYNOTE SPEAKER
Judith Barker CEO, St John Ambulance NT

> “Thank you to all the facilitators and presenters. what an amazing conference for so many of us” – Sascha, attendee

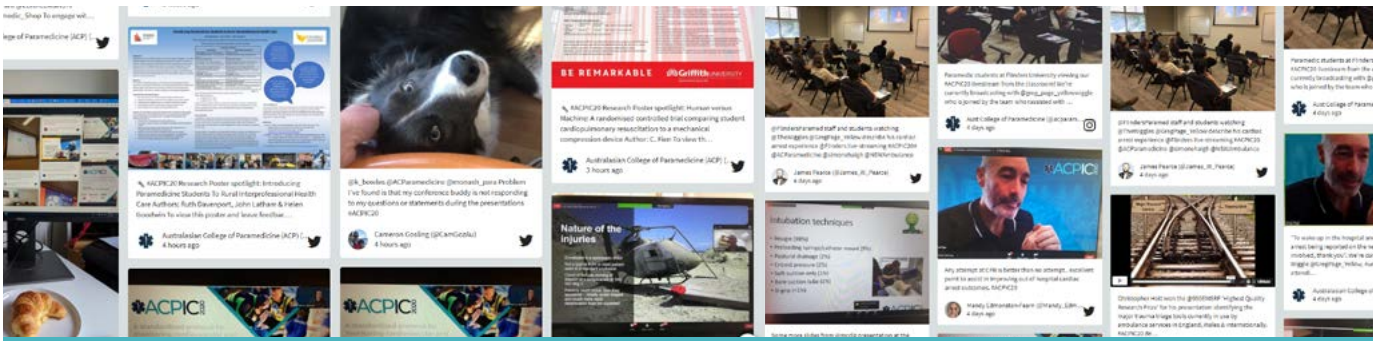
Acknowledgements

The College extends its sincere thanks to all those who made ACPIC 2020 such a success, including the incredible speakers, moderators and facilitators; the Conference Organising Committee led by Jamie Rhodes; our College Events and Education team led by Kylie Meagher; and the participation of all those who attended and joined in the discussions.

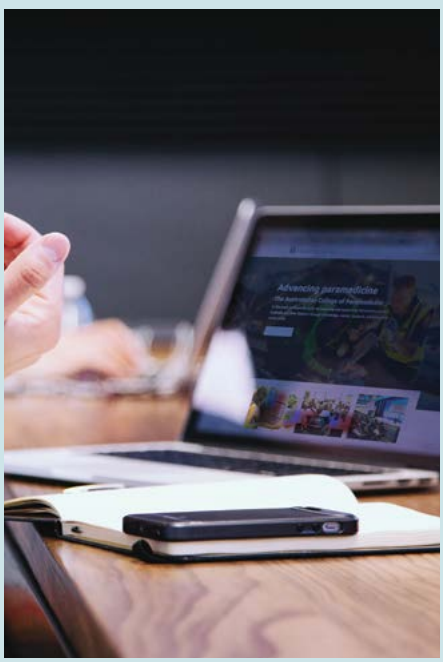
The conference platform will remain active for two months after the event, and ‘tickets’ can be purchased to access the platform and conference session recordings. Visit paramedics.org/events.



KEYNOTE SPEAKER
Tony Smith, Clinical Director, St John New Zealand



SOCIAL WALLS DURING THE EVENT



RESPONSE | Q&A

Julie Hughes is a Critical Care Paramedic currently working with the QAS High Acuity Response Unit in Brisbane. In this Response Q&A, Julie shares with us the motivation behind her career change from radiographer to paramedic, the importance of looking after yourself, and the healing powers of chocolate!

Q You started your career as a radiographer. Can you tell us what inspired you to make the move to paramedicine?

A When I started my radiography career my very first shift was in the emergency department. From that day on I knew that emergency was for me. However, as a new graduate I was rostered to work in every department, but I always looked forward to my emergency shifts. As time went on, I was also drawn to CT scanning as anatomy and pathology have always been a fascination.

All my dreams came true when a CT scanner was put in the emergency department and I was appointed senior radiographer in that department. But as time went on, I found myself craving something more challenging. For 10 years I had been in awe of the paramedics that arrived at our emergency department and wondered what went on outside the safety of my hospital walls. So I got up the courage to leave my comfort zone and applied to Queensland Ambulance Service and have not looked back.

Q Are there any particular skills you used as a radiographer that you now find beneficial to you as a paramedic?

A Radiography taught me so much as I imaged many different types of patient presentations in many different ways. Being a part of the hospital system provided me with a great understanding of patient journeys. As a radiographer we are involved in orthopaedics, gastroenterology, oncology, neonatal, neurosurgery, cardiology, outpatients, the list just goes on and on. The experience I gained in meeting patients (and their families) with their varied presentations and what treatments they underwent, and their outcomes was invaluable. One special skill that I gained is that I can visualise anatomy in my head which is absolutely priceless, especially when it comes to FAST scanning.

Q You currently work in a QAS High Acuity Response Unit, dealing with critically injured patients and major trauma. What helps you to cope with the mental challenges of such intense work?

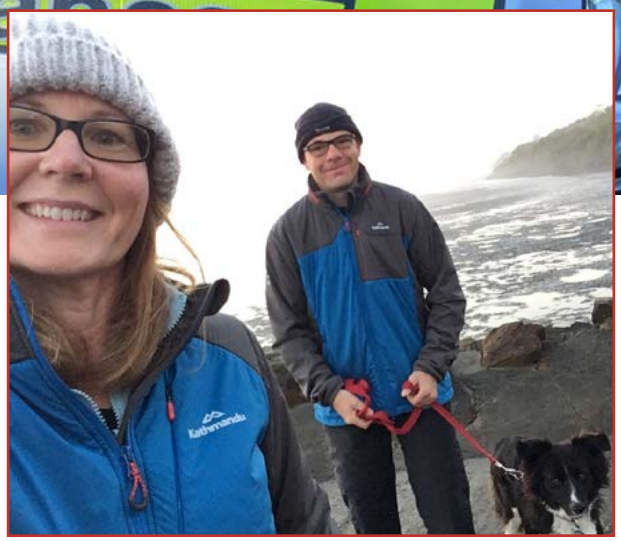
A This is a great question and a difficult one to answer, but in a word – chocolate!

Like so many paramedics I have that special ability to be able to switch into professional mode and then back to normal like nothing has happened; I somehow am able to process what I do. Don't get me wrong though, sometimes this can be tough. I joke that I am 'dead inside' but I know I'm not. I do cry and need the support of my incredible husband and friends, which I'm not afraid to ask for.

It sounds a bit cliché but looking after yourself cannot be stressed enough. Connections with family and friends, exercise, good nutrition with the odd/regular treat and plenty of rest is essential. Most of the time I have the work-life balance sorted.

Importantly, I am lucky to be surrounded by the right people. Every role has their own inherent stressors and having like-minded, supportive people to share experiences with and get advice from helps with processing the mental challenges.

From a personal perspective I think taking responsibility for your own currency in education, proficiency in skills and constant self-reflection allows you to grow and absorb the mental challenges easier, but just as important is setting realistic goals for yourself and patient outcomes.



> “One special skill that I gained is that I can visualise anatomy in my head which is absolutely priceless, especially when it comes to FAST scanning”

Q Who or what inspires you?

A The list of people who inspire me is endless: those that overcome extreme adversity, like Turia Pitt and Sophie Delezio; those that use their talents for good; and then there are just some people who are over-achieving machines who make me feel very inadequate. However, I am inspired most by seemingly ordinary people excelling at life without all the accolades and it’s these people who inspire me most to make a difference with the talents and privileges that I have been given.

Q You have a special interest in the critically ill patient and pre-hospital ultrasound. In your experience, how crucial to patient outcomes is this?

A I believe that ultrasound has found its way into the pre-hospital environment for good and we will only see more and more indications for its use. In HARU’s catchment of southeast Queensland, pre-hospital FAST is now an expected intervention, assisting us to make life-saving decisions with regards to initiating treatment, ‘lighting up’ the trauma system and transporting patients to definitive care in the first instance.

Q You are a sessional tutor at the University of Sunshine Coast, and have completed a Master of Traumatology. If you had one key message to students, what would that be?

A Forget the apple, bring the tutor chocolate!

Be active in your career and profession and never lose your curiosity. At the end of each shift ask yourself “what did I learn today?” I believe in taking something from every day, which is summed up beautifully by the Brene Brown quote: “We are all so busy chasing the extraordinary that we forget to stop and be grateful for the ordinary”.

Q And finally, we all need to make time for ourselves. What’s your go-to when you need time out?

A I really enjoy a long hike or getting lost in a good book. I spend a lot – and I mean a lot – of time with my dog, and, chocolate!

Treating mentally ill patients without consent

by Michael Eburn and Ruth Townsend

Health professionals know that 'except in cases of emergency or necessity, all medical treatment is preceded by the patient's choice to undergo it'.[1]

Patients who are competent – that is, those who are able to understand the nature of the suggested treatment, weigh up the consequences of and communicate his or her decision – can refuse treatment.[2] This legal rule applies even if the patient is mentally ill and it applies even if the decision to refuse treatment appears to be insensible or lacking in reason. An illogical rationale for refusal of treatment is NOT evidence of a lack of capacity.

The issue

Where the patient is not competent then paramedics can provide care, based on the principles of necessity, in the same way that they can treat anyone who cannot consent. Challenges can arise for paramedics when they are called to treat people who appear to be mentally ill or mentally disordered, are assessed by the paramedic as needing treatment to prevent a serious harm to the patient but who have capacity to refuse consent for that treatment.

Legislation in every Australian state and territory provides for the involuntary detention and treatment of people with a mental illness provided certain conditions are met. But the issue for New South Wales paramedics is whether they have the legal authority to detain a person, that is hold them against their will, in order to provide treatment and transport to a mental health facility for further care?

The law

In nearly all Australian states and territories there is legislation authorising ambulance officers (i.e. employees of the jurisdictional ambulance services) or in the Northern Territory, paramedics, to detain and treat the mentally ill. Key terms are set out below (emphasis added):

- *Mental Health Act 2015* (ACT) s 80: 'A police officer or authorised ambulance paramedic may apprehend a person …'
- *Mental Health and Related Services Act 1998* (NT) s 31: 'A paramedic may detain a person …'
- *Mental Health Act 2007* (NSW) s 21: 'A police officer to whose notice …a request for assistance by an ambulance officer … is brought must, if practicable– (a) apprehend …' and s 22: 'A police officer … may apprehend …'
- *Public Health Act 2005* (Qld) s 157B: '… ambulance officer or police officer may detain the person …'
- *Mental Health Act 2009* (SA) s 56: 'An authorised officer [which includes an ambulance officer] … may take the person into his or her care and control …'
- *Mental Health Act 2013* (Tas) s 17: 'An MHO [Mental Health Officer which includes appointed ambulance officers] or police officer may take a person into protective custody …'
- *Mental Health Act 2014* (Vic) s 351: 'A police officer, or a protective services officer on duty at a designated place, may apprehend a person …'
- *Mental Health Act 2014* (WA) s 156: 'A police officer may apprehend a person if the officer reasonably suspects that the person …'

The Western Australia legislation does not refer to paramedics, presumably because the state of Western Australia does not operate a government owned ambulance service. The Northern Territory also contracts its ambulance service but has extended these powers to paramedics.

New South Wales is unique and problematic. Section 20 of the *Mental Health Act 2007* (NSW) says:

20 DETENTION ON INFORMATION OF AMBULANCE OFFICER

> (1) An ambulance officer who provides ambulance services in relation to a person may take the person to a declared mental health facility if the officer believes on reasonable grounds that the person appears to be mentally ill or mentally disturbed and that it would be beneficial to the person's welfare to be dealt with in accordance with this Act.
>
> (2) An ambulance officer may request police assistance if of the opinion that there are serious concerns relating to the safety of the person or other persons if the person is taken to a mental health facility without the assistance of a police officer.

Section 20 does not say an ambulance officer may 'detain' or 'apprehend' a person or refer to 'involuntary admission and detention'. The heading does not say 'detention by an ambulance officer'. It is detention by others 'on the information of an ambulance officer'. The power to detain is given to the mental health facility (s 18(1)(b)). The ambulance officer can take them to the facility and the facility can detain them on the basis of the ambulance officer's view and before they are assessed by a medical practitioner.

Rules of legal interpretation

As a rule of statutory interpretation every word must have meaning. Eburn has taken a literal view to statutory interpretation, that is, looking just at the words of the Act and noting the omission of the word 'detain' or 'apprehend' means that New South Wales ambulance officers do not have the power to detain, they only have the power to transport.

On that view, NSW Ambulance protocol *A3 Informed Consent, Capacity and Competency* which says that consent is not required 'when a decision is made to transport the patient under s 20 of the Mental Health Act 2007' (see also protocol *MH3 Enacting s 20 and s 81 of the Mental Health Act 2007)* is not consistent with the language of the Act.

Under the Act, both police and ambulance officers have a power to 'take' a person to a mental health facility (ss 20 and 22) but only police have a power to apprehend (ss 21 and 22). If the word 'take' (in s 20) were sufficient to mean 'take contrary to the patient's refusal' then the term 'apprehend' in ss 21 and 22 has no role to play.

In *State of New South Wales v Talovic* [2014] NSWCA 333 the NSW Court of Appeal had to consider the application of s 22 of the *Mental Health Act 2007* (NSW) and in the course of that decision, they also discussed s 20. Relevant to this discussion was the statement by Tobias AJA (dissenting) where His Honour said (at [187]):

> "Although I accept that the purpose of the Act is intended to be beneficial to the individual ..., nevertheless I see no reason to give the plain words of the statute a more liberal construction simply for that reason... There is no ambiguity in the words of the text and in my view they should not be departed from."

"Where the patient is not competent then paramedics can provide care, based on the principles of necessity, in the same way that they can treat anyone who cannot consent"

If this reasoning is accepted, then extending the interpretation of s 20 to include detention by ambulance officers is to give plain words more meaning than that intended to provide a benefit (i.e. authorise ambulance officers to transport patients directly to a mental health facility).

However, because of the controversy about this section of the Act, we approached two lawyers who practise in the area of mental health law for their advice. Their opinions were given independent of each other. Both took the view that s 20 would be interpreted to mean that New South Wales ambulance officers could take a person, against their will, to a mental health facility.

One of the lawyers (who asked not to be identified) took the view that s 20 is ambiguous when read with s 81 which says:

> 'A person authorised by this Act to take a person to or from a mental health facility or other health facility may:
>
> (a) use reasonable force in exercising functions under this section or any other provision of this Act applying this section, and
>
> (b) restrain the person in any way that is reasonably necessary in the circumstances.'

In interpreting an ambiguous provision they pointed to a purposive approach to statutory interpretation. The *Interpretation Act 1987* (NSW) s 33 says:

> 'In the interpretation of a provision of an Act or statutory rule, a construction that would promote the purpose or object underlying the Act ... shall be preferred to a construction that would not promote that purpose or object.'

Section 68(f) of the *Mental Health Act* says that one of the principles of the Act is to ensure:

> 'any restriction on the liberty of patients and other people with a mental illness or mental disorder and any interference with their rights, dignity and self-respect is to be kept to the minimum necessary in the circumstances.'

Allowing health professionals to treat those in need is more in line with that principle than providing that police must be involved in the detention of those in need of medical care. Reading s 20, with s 81, allows ambulance officers to detain those that need care is more in line with the purpose of the Act.

Vince Monardo of Monardo Legal took a similar view. On the issue of why s 22 uses the term 'apprehend' whereas s 20 does not, he said:

> "We are of the opinion that this distinction is present because s 22 has a focus on an action outlined by s 22(a):
>
> > a) the person is committing or has recently committed an offence or that the person has recently attempted to kill himself or herself or that it is probable that the person will attempt to kill himself or herself or any other person or attempt to cause serious physical harm to himself or herself or any other person, and
>
> Thus, the apprehension is relevant in s 22 as it is referring to the prevention of these acts. On the contrary s 20 isn't in place as a response to specific actions..."

The correct view?

Which view, that put by Eburn or these lawyers, is correct? There is no answer to that. Until a superior court, the New South Wales Court of Appeal or the High Court of Australia is asked to rule on the matter. Until then, these are 'arguments' and the lawyer's prediction of how they think a court might resolve the matter if asked. There is no evidence that the courts are being asked so presumably people are not challenging decisions by ambulance officers to detain persons. (That could be for many reasons including that people, after treatment, may be grateful for the decisions that were made or that paramedics are making excellent clinical decisions. Exploring the experiences of people who have been detained by paramedics is beyond the scope of this short review but may be an area of fruitful research.) In the absence of case law on the matter, however, Eburn is willing to accept the opinions of those specialist in mental health law who bring their experience of how the Act is interpreted and applied in practice.

Conclusion

In every Australian state and territory other than Western Australia, paramedics have statutory authority to deprive a person who meets the criteria under the relevant mental health or in Queensland, public health legislation and take them to a relevant mental health facility for definitive assessment and care.

In New South Wales that power is not clear because of ambiguity in the wording of the Act but accepting the view of lawyers expert in mental health law the authors accept that s 20 of the NSW Act is also likely to be interpreted to allow paramedics to treat a person who meets the criteria set out in s 20 even if that person is competent to and refuses consent to that care.

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Frontline empathy is a two-way street

by Tammie Bullard

Empathy may be a confusing and contrary word, but it is one with great value, particularly in providing a buffer against professional burnout and in building positive relationships with patients. As one of those 'soft skills' integral to the paramedic's toolkit, it is encouraging to see how widely its importance is increasingly promoted in training, service delivery, leadership and culture.

Confusion arises, for the most part, around the definition itself. Among similar concepts of sympathy, compassion, mimpathy, compathy, unipathy and transpathy, each holds different meaning to the individual. For simplicity's sake, a broad overview of empathy may be that of understanding how another may feel in any given situation. While compassion and sympathy are often used interchangeably, they are considered less developed, more reactive counterparts to the higher level of skill involved in being empathetic.

In the current climate, paramedics are feeling both the warmth of widespread empathy, for the role we are playing in pandemia, and the contrasting cold of its absence. Unintentional though this may be, the chill occurs when we are feared as potential contaminants, or dismissed, as we have no central hub to safely contain ourselves within, or forge solidarity against the danger of the outside world.

Never before has it been more obvious that maintaining empathy must not be forgotten or taken for granted. It's a two-way street whether we're in the midst of a pandemic or stepping through the routine of everyday life.

Photo by Annie Spratt on Unsplash

With the mutual co-operation of experienced, empathetic road users, both directions can flow in synchronicity. Keeping to our expected paths, indicating intentions, acknowledging courteous behaviour with thanks and resisting the urge to yell aggressively demonstrate our understanding. Respecting and following directions or signs, exercising patience when deviations arise and slowing down to give way when necessary make our empathetic approach to the situation obvious.

So how does this apply to pre-hospital roles?

Patients

We became paramedics with the aim of caring for patients during emergencies. Attempting to briefly understand their situation and how they may feel, can help us to deliver the best type of care. It might be 'just another call for chest pain' but labelling it such may render us blind to their needs and decrease patient satisfaction. In return, anger and complaints become more likely with a possible compromise to our physical, professional and psychological safety.

Bystanders

Passers-by don't sign up for emergencies they unexpectedly find themselves involved in. They stop to assist out of kindness or for a myriad of other reasons. An empathetic approach to enlisting their help, or moving them along, may gain reciprocal attention and co-operation more easily whilst reducing unnecessary frustration. Theirs as well as our own!

Colleagues

We wear the same uniform, but we're not necessarily the same people. While it's easy to assume that someone may be better or worse off, based on what little we know, unless we are intimately connected, the reality is that we have no idea. Maintaining empathy for colleagues, without preconceived opinion, may help to create unity and decrease work-based stress, whilst one-upmanship and pity contests only widen any divide.

Support staff

No matter our understanding of the other's roles, frontline and support staff work in vastly different environments. The nature of emergency services is that interaction between the two is limited, or non-existent, therefore throwaway comments regarding perceived demands, habits and attitudes to work quickly become inflammatory. Particularly as they are most often delivered by third parties interacting between both areas. Bi-directional empathy may be integral in avoiding resentment and increasing mutual respect, when the ability to build in-person relationships, cannot exist.

The organisations we work for

While more difficult to adopt, embracing this approach may benefit morale, motivation and mindset. Every ambulance service is made up of a group of humans surrounded by infrastructure. That's it. If we aim to understand and therefore empathise with how any service, as a whole, aims to fulfil its purpose, we gain clearer individual direction and reduced exposure to the stress caused by confusion or overwhelm. We may find ways of working with others to make this happen. We may realise that, individually, we do not fit the organisation's overarching aims and begin seeking alternative career pathways. We may strive for a leadership role in which we can attempt to promote positive change. We may simply free ourselves from the shackles of frustration by taking the 'personal' out of the 'entity' with an empathetic overview of that entity's goal, potentially increasing our professional longevity.

Interprofessional service providers

Interactions with police, firefighters, other emergency services, nurses, doctors, patient care assistants, nursing home staff, roadside recovery technicians and multiple other personnel are largely based on presumption. If we can empathise with the challenges they face, we may gain a better understanding of their situation. In exercising such an approach, it may encourage similar empathy towards the challenges we face ourselves, thereby improving rapport.

> "Never before has it been more obvious that maintaining empathy must not be forgotten or taken for granted"

The paramedic profession

Overall, paramedicine garners a positive response, but it is not something to be taken for granted. We continually step over the line from our territory, into that of others, quite literally. Most professions work at their place of business, where patients and customers step in, then step out. While visiting, they form an opinion of that profession, before leaving and returning to their own domain. Paramedics, however, enter the domain of others for every single call. Appearance, body language, demeanour, words and actions are the only tools we have to create an impression. No infrastructure, ambient music, soothing smells or reception staff to engender positivity. If we can use empathy and seek to understand how patients, families and bystanders may perceive our arrival and on-scene interaction, for each call, we are instantly equipped with greater potential to proceed safely and effectively.

Our loved ones

Those that keep the home fires burning need us to be ourselves when we are not in uniform. If families greet us with problems similar to three patients we've encountered today, this does not make them the fourth. The clock has to re-set so that we can listen, understand, validate and support them. When they mention stressors, which seem trivial after the enormity of what we've experienced during recent shifts, we absolutely must empathise, or risk losing meaningful connection with others, should we dismiss their concerns. Maintaining empathy for those we care most deeply about, may be vital in preventing their reluctance to interact with us over time.

Ourselves

We must, at all costs, maintain individual wellbeing otherwise, as with primary surveys, we are of no use to others when we put ourselves in danger. Self-empathy is pivotal in maintaining the boundaries that each of us must uphold, in order to feel physically and psychologically safe.

Ultimately, during each shift, we have a choice in whether we stick to our side of the empathy street or not.

We can choose to travel on the opposite side, where we continually run into obstacles along the way until we are left wondering why all of the other road users are frustrated with us. Would it be fair to still expect to bask in praise and attention for the paramedic profession, despite our lack of empathy and understanding for others?

Alternatively, we can harness and enhance this skill for the benefit of ourselves, our families, patients, colleagues, external associates, organisations and the paramedic profession. It does require some extra effort, without doubt, but we may then feel more deserving of the reciprocal empathy and compassion from those on the other side of our two-way street.

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Comprehensive pre-hospital clinical assessment of acute stroke patients leads to better outcomes

Thorough clinical assessment and history taking is critical to the delivery of acute stroke care reports Critical Care Paramedic Wayne Loudon.

Historically the assessment of acute stroke by pre-hospital providers has relied on the use of simple assessment tools that identify the most common physical signs of stroke such as limb weakness, speech difficulties and facial palsies. The emphasis was on maintaining a highly sensitive tool to avoid missing any potential stroke sufferers and although this remains very important the evolution of paramedic practice, education and training provides a platform for more nuanced and complex decision making to ensure that every patient, even with atypical symptoms is identified and provided with early definitive care.

What is the benefit of a stroke severity score such as NIHSS-8?

Stroke is not a static disease process and it is not unusual to see waxing and waning of stroke symptoms as the complex physiology of the brain attempts to improve perfusion of ischaemic areas by opening of collateral circulation. It is when these physiological responses to insult are overwhelmed that we see symptoms present. The severity of these symptoms can guide the decisions on reperfusion therapies in hospital but what is equally important is the entire clinical picture. There is no aspect of medical practice that relies on a single symptom or sign to make a diagnosis or guide treatment (we don't assume a patient has a STEMI just because they have chest pain).

The NIHSS-8 was developed as a stroke severity tool and as such has the capacity to identify all stroke from milder syndromes which may not be eligible for reperfusion therapies but would benefit from risk factor management (antiplatelet therapy, blood pressure management, etc) to large vessel occlusive strokes that may benefit from endovascular clot retrieval.

Should the NIHSS-8 be used in isolation?

The NIHSS-8 is a decision support tool that has been shown to be reliable in identifying those patients harbouring a large vessel occlusion to the middle cerebral artery, however it is not designed to be used in isolation.[1] The assessment of any patient presenting with neurologic symptoms should have a full neurologic assessment whenever possible since neurologic symptoms can be easily missed if the clinician does not perform a thorough assessment.

Along with a more thorough neurologic assessment there should be a consideration of risk factors that increase the likelihood of stroke such as the presence of atrial fibrillation, mechanical heart valve, sickle-cell disease, smoking, past stroke.

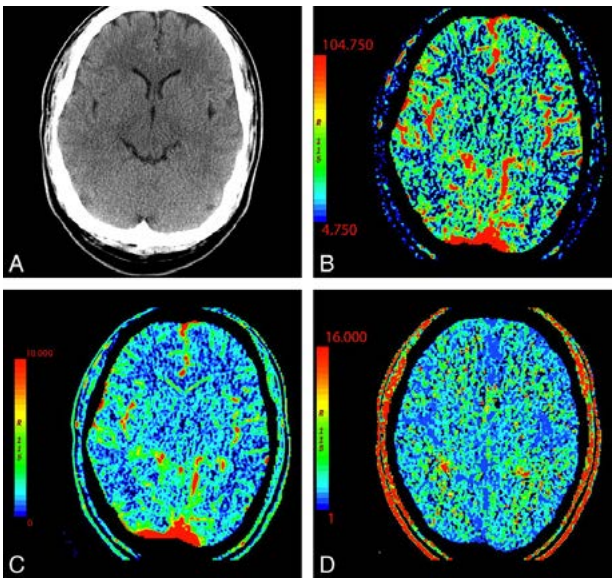
Also, most pre-hospital stroke tools focus on identifying the more common presentations (stroke involving the middle cerebral arteries, lacunar stroke) that would benefit from thrombolysis or endovascular clot retrieval and neglect those to the posterior circulation given their infrequency, vague symptomology and minimal acute treatment options.

The NIHSS-8 is a decision support tool and is not there to take away from good clinical assessment, experience and judgement.

So how do we identify posterior circulation stroke?

Stroke to the posterior circulation is notoriously difficult to diagnose clinically and accounts for 20% of ischaemic stroke.[2] Therefore, a high index of suspicion is required along with a consideration of risk factors and presenting history. In any assessment the clinician should ask: "what can't I afford to miss?"

Clinical features	Anterior circulation	Posterior circulation
Visual field defect	+	++
Pupillary changes	+	++ (may be bilateral)
Dysarthria	++	++
Bilateral sensory/ motor symptoms	-	+++
Double vision	-	+++
Vertigo	May or may not be present	+++
Dysphasia	++	++
Altered level of consciousness	Unusual unless there is raised intracranial pressure or mass effect	Common in thalamic and brain stem stroke
Ataxia	-	++



Brian perfusion scan – From Lui YW, Tang ER, Allmendinger AM, Spektor V. Am J Neuroradiol 2010;31:1552-1563.

What is the role of the NIHSS-8 in areas without endovascular centres?

The NIHSS-8 is a reliable tool to indicate the likelihood of a severe stroke syndrome and therefore the presence of a large vessel occlusion or haemorrhage. The tool can then help communicate, using a common language, to receiving facilities or retrieval services that this patient may require early secondary transport to an endovascular centre.

What other critical information do receiving hospitals need?

- **Time of symptom onset or last seen well time** – this is critical to guiding thrombolysis treatment which is limited to 4.5 hours after onset (though some patient may still be eligible up to 9 hours) and endovascular clot retrieval which has most benefit within 6 hours (though some patients may be eligible up to 24 hours).
- **Anticoagulation status** – patients that are anticoagulated increase the possibility their syndrome is due to a haemorrhage and they will require reversal of the agent (where available) or this will impact their eligibility for thrombolysis.
- **Presence of family member or substitute decision makers** – if possible, they should accompany the patient as they will be required to consent for any reperfusion therapies the patient may be eligible for.
- **Pre-notification** – early notification of acute stroke reduces delays to imaging and treatment.

What groups are at risk of being under triaged?

Given the heterogeneity of symptoms in stroke and its effect of patient perception of disability clinicians can become mislead.

Vulnerable groups – mental health conditions, different cultural and language backgrounds and intoxicated/ alcohol abuse are at increased risk of miss diagnosis and missed diagnosis.

Stroke to the non-dominant hemisphere (usually right) – may lack the perception of their disability and downplay their symptoms.

Young patients – 30% of stroke presentations are in those under 65 years.[3]

The assumption of intoxication, mental health presentation or 'exaggerating' symptoms should be a diagnosis of exclusion in the prehospital setting and should not bias clinical assessment.

What if I'm still not sure of my diagnosis?

It is always safer to err on the side of over triage than under triage. The impacts of missing a treatable stroke are always far more significant than the embarrassment of over diagnosis.

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Why we lose motivation, and how to get it back!

by Mitch Mullooly

It's not surprising with the year that we've had, that we may be losing (or have already lost) our motivation to exercise. As the weather warms up we want to get out and about to enjoy it, but for some reason summoning up the motivation, or even the enthusiasm, has dissipated into the ether.

Sometimes it's easier to hide under our mental (or actual) blanket as it makes us feel safe, because sometimes it simply feels better to do nothing. And when we reflect back on what exercise was like, often all we remember is the discomfort and pain associated with it, which is hardly a cheerful prospect! It's incredibly difficult to go back to feeling tired and sore in the name of the greater good – that is, our health and fitness – because all we have are the memories of feeling tired and sore.

Memories and associations are the key component here. That's how our brain works – based on past experience we form associations, and we feel either positive or negative about a particular event or activity. If we went out with friends and had a bad experience, then we will be reluctant to go out with them or go to the same place again. And if the experience continues to be negative, well, we just might stop going out altogether and stick to good ol' Netflix!

Our brains are reward driven. We eat a slice of cake and we feel good. There's an instant gratification right there, consequences be damned. When it comes to exercise though, there is just pain and soreness and then the memory of the pain and soreness. There is but a promise of reward at a later date as it takes work to get fit and then even more work to stay that way. There are no actual guarantees though, just the possibility of getting fit and healthy if we work at it, somewhere down the road... perhaps. That's why cake wins over workout every time!

We can push, shame and force ourselves on a regular basis but no one can withstand continued misery forever. Everyone breaks eventually and then the cycle begins again. We force, we break, we start again – if we can bear it psychologically. One of the reasons we need a new diet or a new training system every single time is because we haven't formed those negative associations with the new shiny one yet so we feel we can give it a shot, hoping that this time it will be different. And every time it fails us because we continue to suffer, and that suffering creates negative neural pathways in our brains, making us more and more reluctant to repeat the experience.

So what can we do?

We must form positive associations with exercise instead by using any and all tools at our disposal. If we feel good before, during and after exercise the reluctance to do it again becomes less and less over time. Eventually, we are able to sustain our fitness and that is the ultimate goal.

Let's dive in!

STRATEGY #1 – REDUCE THE AMOUNT OF PAIN

When we feel our motivation is slipping and we are losing any desire to exercise, we should reduce the amount of pain inflicted, even remove it completely. The moment we accumulate enough negative associations with exercise our self-preservation kicks in and our brain tries to keep us away from any further discomfort. It's only natural to shy away from pain especially when it can be easily avoided. The way our brain sees it – no more exercise means no more pain. Remove the pain from the equation and the reluctance will lessen.

Action: Continue to exercise every day but significantly reduce the amount and/or the intensity of exercise until you no longer feel apprehensive about training.

> "Consistency is the only way to get lasting, permanent results in how we look and feel"

STRATEGY #2 – COMBINE EXERCISE WITH THINGS YOU ENJOY

This is why so many of us listen to music when we exercise. We feel good when we listen to music we like, and it helps us get through harder patches during our training sessions. It can sometimes help take our mind off the discomfort completely. Training with others, people whose company we enjoy, has a similar effect. We can partner up with friends or family or a group of people with similar interests and exercise together. That way we focus on the social aspect of training and not on the struggle. We don't always need a distraction, but it helps every now and then to create better memories and associations.

Action: Aim to make every training session a good experience.

STRATEGY #3 – USE AN INSTANT REWARD SYSTEM

It takes time to see results in the mirror. The health benefits of exercise go fairly unnoticed throughout life, we only tend to notice when things go wrong with our body but we rarely pay attention to it when we feel well. With this there is no instant reward for exercise unless we add something. I've found that having a training journal with a clear plan and ticking off the days and workouts completed can be incredibly satisfying as I measure my progress. We have to create a reward system that works for us, that's instant, something we get on completion of our workouts to compensate for the discomfort.

Food can be a powerful motivator too, but we don't have to reward ourselves with cake, as that would be counterproductive. We can however schedule our training so our breakfast, lunch or dinner comes directly post-workout serving as a reward for our struggle. Eventually our brain connects the two and we form positive associations with the physical activity.

Photo by Prateek Katyal on Unsplash

Action: Follow up exercise with an instant reward every time to create positive associations.

It really doesn't matter how hard we train if we seldomly do it. Consistency is the only way to get lasting, permanent results in how we look and feel. Unfortunately, finding the emotional strength to come back to exercise every single day is often a lot harder than the exercise itself. It's literally all in our head, it's how we see training, and our associations and connections in our brain. If all we expect is pain and stiffness, we are unlikely to do it again and we are certainly unlikely to stick to it long term, which is ultimately the goal with fitness.

In order to continue to stay motivated, and be able to schedule and show up for our workouts, we must first learn to tip the balance in favour of exercise. And we do this by turning it into a desirable activity, something we look forward to rather than recoil from. In order to change our relationship with exercise we must create good memories of the experience using every tool at our disposal whether it's instant rewards, gamification of the process, good music, good company or simply reduced physical stress and a better environment.

Staying motivated comes down to how we see exercise and what we remember about our last training session. Was it fun? Was the discomfort tolerable? Was there an instant gratification after? Did we enjoy at least some part of it? If the answer to all these questions is 'Yes' more often than 'No', having the motivation to exercise regularly will never again be a problem.

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Shift work and sleep

For paramedics and other shift workers, getting adequate quality and quantity of sleep can be a challenge.

Sleep plays an essential role in good health, safety and wellbeing. Getting enough quality sleep hours helps us to cope and recover from everyday demands, which is important for maintaining good mental and physical health. However, for paramedics and other shift workers – who, on average, get two to three hours less sleep than other workers – getting adequate quality and quantity of sleep can be challenging due to night and early morning work hours.

Shift workers are also at increased risk of health problems, such as digestive upsets, obesity and heart disease, and accidents due to excessive daytime sleepiness.

TIPS FOR PROMOTING GOOD SLEEP

The Sleep Foundation recommends that shift workers:

- make time for enough sleep
- try to go to bed at the same time every day and get up at the same time
- try to sleep in peace! This may mean removing the telephone from the bedroom and having heavy carpet or curtains in the bedroom to help absorb any noise (some shift workers find that wearing ear plugs to bed helps)
- keep the bedroom cool and dark
- avoid caffeine, sleeping pills, alcohol or cigarettes before going to bed
- if you can, sleep just before going to work. This is better than earlier in the day. If this is not possible, taking a nap before going to work may help.

WHAT ABOUT NAPS?

Short naps of up to 15 minutes can help promote alertness levels. Where possible, a short nap in the afternoon before starting a night shift may help reduce sleepiness throughout the shift.

SWITCHING OFF YOUR THOUGHTS

Some people lie awake in bed at night (or day) and cannot switch off their thoughts. If this is you, there are many ways you can regain focus to prepare your body and mind for sleep. You can:

- listen to quiet music
- practise mediation
- try focussed breathing exercises
- take a warm bath
- read a book
- make a 'worry list' by writing down your worries on a piece of paper, then let them go, knowing you have done your worrying for the day.

STILL CAN'T SLEEP?

- Try not to engage in mentally stimulating activities close to bedtime. Use the last hour or so before sleep to relax your mind.
- If you can't fall asleep within a reasonable amount of time, get out of bed and do something else for half an hour or so, such as reading a book.
- If you have tried and failed to improve your sleep, you may like to consider professional help. Talk to your GP – they can refer you to a sleep specialist to identify if there is an underlying sleep disorder.

QUICK RELAXATION EXERCISES FOR QUALITY SLEEP

- Consciously relax every part of your body, starting with your toes and working up to your scalp.
- Think of a restful scene, then concentrate on the rhythmic rise and fall of your breathing.
- Focus on a mantra – repeat a word or phrase slowly and constantly.

Sources

Better Health Channel
The Sleep Foundation


ARE THEY TRIPLE OK?
We're always there to help.
Let's make sure we help each other and ask R U OK?
ruok.org.au/triple-ok
R U OK?™
A conversation could change a life.

Self-care for the frontline

Many frontline healthcare workers are overwhelmed, worried and exhausted right now due to the ongoing effects, both immediate and long term, of COVID-19 infections in the community. This is especially the case for those living in Victoria.

Given how demanding this time is, and the uncertainty of what the 'new normal' will look like for us all, it's important to pause and consider how you're coping and how best to keep on top of your mental health. Being mentally strong will ensure that you can effectively take care of yourself and take care of others.

Depression among healthcare workers

In the context of the worldwide pandemic, there are concerns that clinical depression is going to significantly increase, particularly in healthcare workers.

Healthcare workers are in a unique situation, paradoxically, experiencing high levels of satisfaction from their roles caring for others, while simultaneously experiencing elevated stress associated with their roles, and higher levels of depression than the general population.

RESOURCES FOR STRONG MENTAL HEALTH

The following resources have been specifically designed by the Black Dog Institute to help healthcare workers support their own mental health and wellbeing.

- Personal check-in and self-care planning templates to keep on top of your mental health: Weekly mental health check-in and self-care planning
- Information for healthcare workers on how to identify depressed feelings and how to get help: Depression in healthcare workers during COVID-19
- Relaxation techniques to help with stress that can be practised in the workplace or at home: Quick relaxation techniques for healthcare workers
- Tips to manage worries about health – many healthcare workers are worried about catching COVID-19, for themselves, and out of fear of passing it on to vulnerable clients and/or loved ones: Managing health anxiety
- Practical ways to help keep anxiety at bay if you are feeling overwhelmed right now: Tips to manage anxiety during times of uncertainty

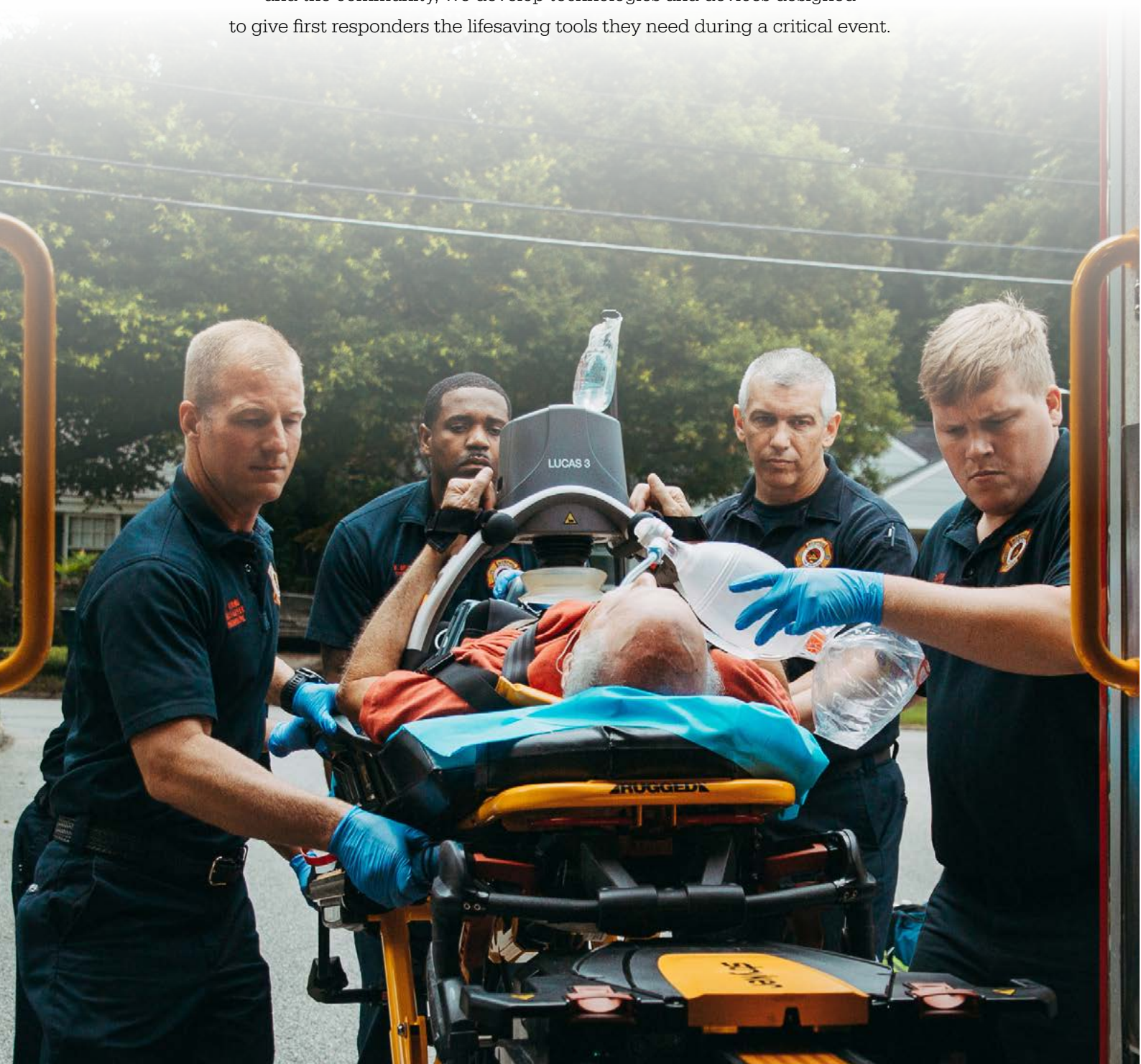
Further resources and factsheets can be found on the Black Dog Institute website.

stryker

Emergency Care

Lifesaving tools for lifesaving teams.

Working in partnership with our customers across EMS, hospitals, and the community, we develop technologies and devices designed to give first responders the lifesaving tools they need during a critical event.



Supporting research

Research is a critical enabler in supporting the delivery of timely, high quality and evidence-based health care to improve outcomes for patients. In this first article in a new series on research in paramedicine, we take a quick look at the College's Research Mentoring Scheme.

The College provides a number of opportunities for members to be involved in research. From research grants and a mentoring scheme to opportunities for researchers to present and disseminate their research to peers via our international conference; and promoting third party research studies that need support.

Research Mentoring Scheme

One of the aims of the College's Research Committee is to support early-career and established researchers through our Research Mentoring Scheme.

Mentors are individuals with research experience and knowledge who are committed to providing support to early-career researchers wishing to undertake a research project, or those considering research as a career pathway.

Mentoring is an important part of an early-career academic's development. Mentees engage with a mentor that can provide advice and support regarding research planning and conduct, identifying opportunities for research collaboration and promotion, helping to build and extend professional networks, and complementing the advice and guidance provided by any official research supervisory teams.

> "The College provides a number of opportunities for members to be involved in research"

Mentors can also be a source of support for mid-career researchers embarking on projects in a new research topic or methodology.

Reasons for seeking a mentor

The mentor-mentee relationship is important and every person's reasons for seeking a mentor may be different. Some reasons may include:

- help getting started on a research project
- general advice on balancing work, life and research
- advice on grants and funding applications
- identifying and refining topics of interest for research within industry
- turning ideas into answerable research questions
- getting help searching the literature
- support on understanding the existing evidence-base for a research question
- assistance in applying for fellowship applications
- professional networking
- advice on collaboration across disciplines
- advice on specific research methodologies
- publication advice.

Reasons for becoming a mentor

Being a mentor is different from the role of a research supervisor and is an informal support and guidance role. Individuals will have differing reasons for wanting to become a mentor such as:

- developing the next generation of paramedic researchers
- supporting the development of a body of research in paramedicine
- sharing knowledge and expertise in a less formal role than traditional higher degree by research supervision.

In the next article in this series, we profile a successful mentor-mentee relationship.

To find out more about the College's Research Mentoring Scheme, and to complete an application form, visit our website.

Photo by CDC on Unsplash

Participating in research

Have you ever considered volunteering as a participant in a research study? The College promotes various research studies that need the support of paramedics and paramedic students to advance the paramedicine profession and its workforce. The following current studies are seeking participants.

STUDY: What are the current mental health priorities for Australian and New Zealand paramedics and paramedic students?

STUDY PURPOSE: The College's Mental Health and Wellbeing Special Interest Group is conducting research to determine what the current mental health concerns are for Australian and New Zealand paramedics and paramedic students. The College has established a number of special interest groups to meet the needs of our members and the wider paramedic and paramedic student community. To ensure that these groups are aligned with community needs, we aim to ascertain the current mental health concerns of our members so that we can develop a plan that is valid and up-to-date.

MORE INFORMATION: https://paramedics.org/news/research-mental-health-priorities

STUDY: COVID-19 and frontline paramedics

STUDY PURPOSE: To better understand the mental health and stress impacts of COVID-19 on frontline staff, this study seeks to understand the mental health and stress impacts of COVID-19 on frontline paramedics. It mirrors and is being run in conjunction with research with frontline workers from police, family services and community health.

MORE INFORMATION: https://paramedics.org/news/covid19-research

STUDY: Investigating the paramedic mindset: adaptive and dysfunctional emotional detachment in Australasian paramedics

STUDY PURPOSE: The purpose of this project is to determine the levels of adaptive (helpful) and dysfunctional (unhelpful/harmful) emotional detachment in paramedics working in Australia and New Zealand, and to see if there is a relationship with perceived sense of community within their work group or environment.

MORE INFORMATION: https://paramedics.org/news/research-paramedic-mindset

STUDY: Investigating the impact of volunteering on the development of resilience in student paramedics

STUDY PURPOSE: Resilience has been identified as a protective factor that impacts on how effectively people are able to employ coping strategies to mitigate the negative impacts of exposure to traumatic events or to organisational stressors. This research will involve surveys and interviews with student paramedics to determine their thoughts on what helped to develop resilience and to establish whether volunteering offers an effective medium to assist with the development of resilience.

MORE INFORMATION: https://paramedics.org/news/student-vol-research

Australasian Journal of Paramedicine

Australasian College of Paramedicine

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.

How effective are paramedics at interpreting ECGs in order to recognise STEMI? A systematic review

Jordan Lily Funder, Linda Ross, Steven Ryan

The use of an out-of-hospital 12-lead electrocardiograph (ECG) has long been the salient test used when assessing ischaemic chest pain and is the only clinical tool available to paramedics that allows for early diagnosis and triage of acute coronary syndromes. This ultimately indicates whether urgent percutaneous coronary intervention is indicated. Therefore, the ability to apply and interpret a 12-lead ECG are key skills for paramedics with potentially significant effect on patient outcomes. This study's objective was to review and summarise existing literature pertaining to the ability of paramedics to correctly identify STEMI via 12-lead ECGs.

Methods

Ovid Medline, Ovid Emcare and CINAHL Plus were all searched using synonyms of keywords such as paramedic, ECG, diagnosis and STEMI. Two investigators independently screened the titles, abstracts and full texts of the articles against the inclusion and exclusion criteria. Any conflicts that arose were discussed between the two investigators to meet consensus.

Results

Of the 2126 articles initially identified, nine studies were relevant and examined the ability of paramedics to identify STEMI on out-of-hospital ECGs. Results indicated that increased additional education provided to paramedics, and the implementation of protocols and/or tools demonstrated a higher degree of accuracy regarding STEMI recognition.

Conclusion

Seven of the nine articles had a strong general consensus that paramedics can independently interpret 12-lead ECGs in order to identify STEMI, however not all studies were of good quality. The importance of the pre-hospital ECG in the setting of STEMI is well established, however the ability of paramedics to independently interpret them requires further study.

CPR quality among paramedics and ambulance officers: a cross-sectional simulation study

Milena Talikowska, Stephen Ball, Dan Rose, et al

High quality cardiopulmonary resuscitation (CPR) improves survival from cardiac arrest, yet CPR quality is often suboptimal, even among trained rescuers. St John Western Australia sought to gather anonymous baseline data on CPR performance by paramedics and ambulance officers in a simulation setting.

Methods

In a cross-sectional study, participants performed 2 minutes of CPR on a manikin. CPR quality was recorded and compared to recommended standards. Comparisons were also made between women and men.

Results

The final cohort comprised 1320 participants; 56% paramedics, 20% transport officers and 18% volunteer emergency medical technicians and emergency medical assistants. More than half achieved an overall score of 90% or greater. The median compression score was 96% (IQR 83–99%) while the median ventilation score was 94% (76–99%). Par-

ticipants achieved the recommended chest compression fraction of ≥60% in 98% of cases. More than half of participants had 99% or more of their compressions reach a depth of ≥50 mm. Two-thirds (68%) recorded a mean compression rate in the range 100–120 compressions per minute. Although there were significant differences in the percentage of compressions deep enough ($p<0.01$) and the 2-minute mean compression depth ($p<0.01$) between men and women, the effect size was small. However, men were less likely than women to fully release pressure on the chest after compressions ($p<0.01$).

Conclusion

This study provides useful baseline data about CPR quality in a manikin model. Participants achieved relatively high scores for most CPR quality metrics and complied with CPR guidelines in the majority of cases.

Assessing competence of undergraduate paramedic student practice: a preliminary evaluation of the Australasian Paramedic Competency Assessment Tool

Anthony Clement Smith, Ann Framp, Patrea Andersen

With the recent introduction of registration for paramedics, and an absence of assessment tools that align undergraduate paramedic student practice to competency standards, this pilot study undertook to develop and evaluate a competency assessment tool designed to provide a standardised approach to student competency assessment. This paper reports the first part of a two-part enquiry evaluating the efficacy of the Australasian Paramedic Competency Assessment Tool (APCAT) to assess the practice competency of undergraduate paramedic students.

Methods

With a focus on gathering professional opinion to evaluate the usability of the tool and inform its development, a mixed methods methodology including a survey and open-ended questions were used to gather data from paramedic educators and on-road assessors in Australia and New Zealand. Data were analysed using descriptive statistics and content analysis.

Results

The outcome of the evaluation was positive, indicating that 81% agreed or strongly agreed that the tool was user-friendly; 71% believed that expectations of student performance and the grading system was clear; 70% found year level descriptors reflected practice expectations; and 66% believed that the resource manual provided adequate guidance.

Conclusion

The APCAT is simple and aligns student practice expectations with competency standards. Results indicate the support for a consistent approach for assessment of undergraduate paramedic student competence. Further research will be undertaken to determine the efficacy of using this tool to assess students in the clinical setting.

Barriers and opportunities for workplace violence interventions in Australian paramedicine: a qualitative study

Brodie John Thomas, Peter O'Meara, Kristina Edvardsson, Evelien Spelten

Workplace violence directed at paramedics by patients and bystanders is a persistent and pervasive issue. There is little available evidence supporting the effectiveness of current interventions in the paramedicine context. No studies have reported on potential barriers and there is little evidence supporting opportunities for more effective interventions. The objective of this study was to make an inventory of current workplace interventions and explore the barriers and opportunities for these interventions as perceived by paramedics.

Methods

Ten paramedics were interviewed about their experiences and insights into workplace violence. The interview data underwent thematic and narrative analysis.

Results

Seven interventions were highlighted, 10 barriers and 12 opportunities for current and future workplace violence interventions were discussed. The majority of the barriers related to culture in society, attitudes of staff, and lack of capacity for the ambulance service to take action following violent events. The opportunities raised included co-design of interventions, culture change for paramedics and communities, accountability for paramedics and perpetrators of violence, increased ambulance service options following violent events, and improving feedback to staff.

Conclusion

The findings of this study suggest that interventions are likely to be more effective and sustainable if they are evidence-based, co-designed, address all levels of healthcare, and evaluated. Important areas for future research include a focus on consequences and accountability for perpetrators and strategies for ambulance services and paramedics to participate in public health approaches to reducing violence in communities.

Report aggressive and violent behaviour. It's never OK.

Up to 95% of our healthcare workers have experienced verbal or physical assault, but these incidents are currently chronically under-reported. Aggression and violence is never OK. Report it to your employer, so together we can work towards reducing these incidents and stop it happening to you or your colleagues again.

AGGRESSION AND VIOLENCE AGAINST HEALTH WORKERS. IT'S NEVER OK

worksafe.vic.gov.au/itsneverok

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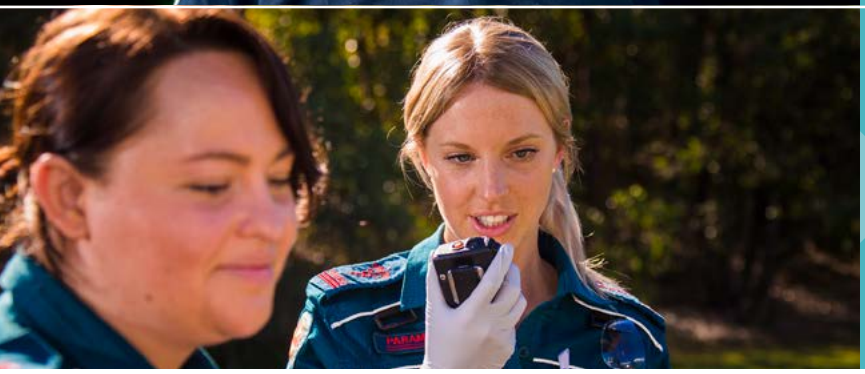

Promoting paramedic health and wellbeing

Advancing paramedicine.

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