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RESPONSE

Gerry Pyke
Frontline at Hunter Valley rescue

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COVER

Special Operations Paramedic Gerry Pyke. Photo by: Simone De Peak Published in Hunter Valley News

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Expanded Roles for Paramedics

with Ryan Lovett

Welcome to our Spring edition of Response. The surge in COVID-19 cases in New South Wales, Victoria and Aotearoa New Zealand in recent months has proved extremely challenging for Paramedics and has strained the health systems in those jurisdictions. The impacts are not confined to those jurisdictions; other states and territories have had to grapple with the repercussions of the pandemic and the burden it has placed on health services, with primary health under increasing pressure and health workforce shortages being experienced around the world.

As we move closer to national and international border reopenings, accompanied by an anticipated rise in COVID-19 cases and greater burdens placed on our health systems, the opportunity exists for Paramedics to be utilised beyond traditional ambulance-based roles to deliver connected, high-quality, community-based healthcare, and in turn bolster Australia's and Aotearoa New Zealand's pandemic response and future preparedness.

Paramedics are competent clinicians who have a long and demonstrable history of safe, effective and patient-centred independent practice. Every day, Paramedics in Australia, Aotearoa New Zealand, and around the world undertake high-risk procedures on the basis of their education, practice experience, and clinical judgment. Since the introduction of paramedic registration in Australia in 2018 and this year in Aotearoa New Zealand, they are increasingly working across a variety of healthcare settings, not just jurisdictional ambulance services. Both locally and around the world, various primary, community or extended paramedic models of care are being implemented that utilise a highly qualified paramedic workforce that is uniquely placed to support existing health infrastructure to deliver responsive, flexible, high-quality, and affordable primary and community healthcare services. Such models provide the foundations for the expansion in Australia and Aotearoa New Zealand of innovative contemporary care paradigms that respect and value the clinical contribution of Paramedics as partners in care.

> "Time and again, Paramedics have proven they have the willingness, capacity and capabilty to rise to any opportunity."

Paramedics provide a unique mix of robust clinical knowledge, skills in patient assessment, diagnosis, and the development and implementation of short-term care plans comprising procedural and pharmacological interventions, without supervision, for patient presentations ranging from cardiac arrest, myocardial infarction and respiratory distress, through acute and chronic mental health conditions, to childbirth, obstetric and newborn care, to primary and community care.

Paramedic education, knowledge, skills, and experience provide a comprehensive base to deliver patient-centred, high-quality, evidence-based care in a variety of formal and informal environments. Paramedics have been at the forefront of developing and supporting new community-based models of care, and throughout the pandemic have assisted with contact tracing, quarantine health, testing, vaccination, respiratory clinics and targeted mobile responses to isolated and remote communities and cohorts. Time and again, paramedics have proven they have the willingness, capacity and capability to rise to any opportunity.

However, Paramedics do not neatly fit into the medical, nursing or allied healthcare stream, instead providing a pragmatic, holistic, responsive health service spanning all facets of community and out-of-hospital care. As we move forward, we are advocating for expanded roles for the paramedicine profession within Australia's and Aotearoa New Zealand's healthcare systems that recognise the unique contributions Paramedics can make in improving health services nationally, that strengthen primary care provision, and that address the existing workforce shortages and gaps in health services; roles that will benefit the health sector and ultimately all communities.

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Advocating for you

with John Bruning

The past three to four months have been a busy time for the College with the strengthening of our advocacy work. Early this year we engaged Fifty Acres, a communications and engagement agency with a strong background in government and stakeholder relations, to help us progress our advocacy and leadership objectives. The College employed Michelle Murphy and Kirsty Mann as our Advocacy and Government Relations Lead for Australia and Aotearoa New Zealand, respectively, to complement and work with Fifty Acres.

We are regularly engaged with numerous consultations and submissions each month, in addition to working on a range of position statements to clarify our advocacy positions. Our first completed position statement is on Chief Paramedic Officers for Australia, with a position statement on a Chief Clinical Advisor, Paramedicine for Aotearoa New Zealand also being developed. Further position statements under development include community paramedicine and paramedics' role in primary health, paramedic COVID-19 vaccinations, access block and ramping, and the role of paramedics in the wider health system. Each position statement goes through many iterations, with input from relevant member committees, special interest groups and key stakeholders.

We have also been advocating for the role paramedics can play in the vaccination campaign through communication with the Australia Health Minister and Health Secretary, which led to discussions with the National COVID-19 Taskforce and Lt Gen John Frewen, and the Prime Minister's office. It was pleasing to see commonwealth support for the role paramedics can play as part of the health workforce during the pandemic. We have also engaged with all state and territory health ministers and the jurisdictional ambulances services on these matters, and are in the process of meeting with ministerial advisors.

From July 2020 to the present, the College has made more than a dozen submissions to various inquiries at national and state levels. Some of these submissions have a clinical and professional focus, such as the Kaunihera Manapou Paramedic Council consultation on Paramedic Competencies and Code of Conduct, while others address health system challenges, such NSW Legislative Council, Portfolio Committee No.2 - Health Inquiry into health outcomes and access to health and hospital services in rural, regional and remote NSW.

The College strongly advocated to the Primary Health Reform Steering Group for the inclusion of paramedicine in the Primary Health Care 10-year Plan, which has borne some success with paramedics now included in the steering group's recommendations. The next stage of consultation on the 10-year plan has begun, and the College will again work to ensure paramedicine is rightfully included.

A large amount of advocacy work takes place outside of formal submissions and position papers, with the College successfully engaging with the National Rural Health Alliance and the National Rural Health Commissioner and achieving greater recognition for paramedicine. Following a presentation from the College on solutions to rural workforce challenges, we were included in the Advisory Network of the National Rural Health Commissioner.

"The College strongly advocated to the Primary Health Reform Steering Group for the inclusion of paramedicine in the Primary Health Care 10-year Plan, which has borne some success."

The College also featured prominently in an ABC news piece on community paramedicine, with our Chair Ryan Lovett and Rural, Remote and Community Paramedicine Special Interest Group Chair Alecka Miles going on record to progress the role paramedics can play in primary and community health care.

I know we have considerably more to do and achieve in the coming years, but our initial advocacy efforts have been successful, and this bodes well for our future advocacy endeavours.

Stay safe and well.

Special Operations Paramedic, Gerry Pyke Photo: Simone De Peak Published in Hunter Valley News

Paramedic on the frontline of a tense search-and-rescue mission

Special Operations Paramedic Gerry Pyke was on the scene at AJ Elfalak's emotional rescue in NSW's Hunter Valley

For three days in early September, hundreds of searchers combed rough terrain in the Hunter Valley for missing three-year-old Anthony "AJ" Elfalak, whose disappearance from his family's property sparked a massive rescue effort and attracted nationwide media coverage.

Among those on the frontline of the rescue effort was News South Wales Ambulance Special Operations Paramedic Gerry Pyke, who provided on-site logistical support for Special Operations Teams and was the first medic on the scene to treat AJ when he was found.

Gerry said searches for children were always fraught with anxiety, with the parameters for survival lower than those for adults. Time can be critical; as time passes, the window of survival closes. And special considerations must be taken into account.

"Depending on their age, children may not have the capabilities or understanding of their surroundings, and that moving is not a good thing," he said. "They don't have years of experience to fall back on to help them in their decision-making. They lack the ability to make proper judgements, which could ultimately lead to their demise."

When he first arrived on scene, his initial role was to ensure the safety and wellbeing of the searchers, checking that they were properly hydrated, assessing how long they had been actively involved, and determining if any had medical conditions or injuries, or were suffering from fatigue.

Following a police briefing, he and his partner developed plans for different contingencies; planning that was underpinned by the rugged nature of the location.

"We were there because you could not drive an ambulance to their location. The terrain is hazardous, and most of the time we need to hike in with specialist equipment. Lifepaks and green kits are left at Base Camp, all equipment is carried in, and we do our best to treat and keep the patient alive until they can be airlifted out or carried out."

A police helicopter crew eventually spotted AJ, who has autism and is non-verbal, in a ravine drinking muddy water from a creek. Within minutes, Gerry and his partner had received the coordinates and began a 500m hike to the rescue site, where State Emergency Service personnel had wrapped AJ in a space blanket.

"At that moment I examined AJ and couldn't find anything that I was overly concerned with. His observations where ok. That he was found drinking water, dirty as it was, spoke a thousand words. Initially I thought he would be hypothermic, but his temperature was 35.9° and his BGL was 4.1."

When they began the hike out, Gerry went ahead to speak with AJ's mother to inform her of her son's condition and what would happen next. Once he was given to her, they were both placed in the back of an ambulance, where AJ fell asleep on his mother's chest.

It was highly emotional for all involved. As a paramedic attuned to people's emotions, it was a particularly poignant moment.

"You could feel the emotions and elation of everyone involved. Believe you me, the tears of happiness were just as intense as that of the family. Your whole mind and body go into these searches; you become aware of intimate details of the people you're searching for. You feel that their lives have been injected into your brain to absorb as much as possible about them to try help you understand who they are.

"It was a relief. I knew the search had come to an end; that those out searching could come back and go home to their own families and children. The searchers would be safe. They had succeeded in their role once again, and had proven that their skills and training had paid off. They will forever remember being involved in AJ's rescue."

However, Gerry said AJ's search and rescue was not just about a lost child; it was also about a shared concern that touched Australians throughout the country.

"People needed AJ's story for their own wellbeing during this pandemic. The distraction and joy it brought to so many going through some very terrible times gave people hope that their personal losses could somehow be vilified by finding AJ. The results of AJ's adventures could not have come at a better time, not only for AJ and his family, but for all Australians needing a win. And a beautiful win it was."

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5 minutes with...

Mitch Mullooly

Mitch Mullooly is embarking on new challenges following her three-year tenure as Chair of the College's Aotearoa New Zealand Member Committee. We chat with Mitch about her new role and opportunities for the growth of the paramedicine profession.

1. Tell us about your new role as People Leader with Whakarongorau Aotearoa, leading the COVID-19 clinical support line as part of the national telehealth service?

At Whakarongorau Aotearoa, we have three COVID services: COVID Healthline, Welfare and Vaccination. I have been appointed as one of the People Leaders for the COVID Healthline, where we have a fantastic and fast-growing team of Clinicians, made up of Registered Paramedics and Registered Nurses who use their clinical skills, knowledge base and experience to triage our Service Users who require a clinical assessment. This could be anything from mild vaccination side effects through to anaphylaxis, suicidal ideation through respiratory arrest, and everything in between. The role is extremely fast-paced, requiring the ability to act swiftly and decisively in an ever-changing environment, and to support our people by marrying the technical skills of clinical excellence and efficiency with the leadership skills of growing and nurturing others. I started with the organisation the day before Aotearoa New Zealand went into a national lockdown, talk about hitting the ground running!

2. As a member of Te Kaunihera Manapou Paramedic Council, what priorities have you identified for the continued development of the profession in Aotearoa New Zealand?

There are several large bodies of work that we are developing work plans for at this current time. These include the regulation of the EMT workforce and specialist scopes of practice. We are fully committed to the inclusion of the wider workforce and as we progress, and these proposals will be open for robust consultation from all our stakeholders.

3. What opportunities are there for the expansion of paramedics' roles within the national healthcare system?

Already we are seeing Paramedics step into several different roles within healthcare, which is tremendously exciting. Obvious areas such as telehealth, GP practice, multidisciplinary flight/retrieval teams, expedition teams, vaccination, and aged care. Other areas where I see huge potential would be in Population and Public Health. In Aotearoa New Zealand, we are currently undergoing a national health system reform, which includes a new body, Health NZ and a Māori Health Authority. It has been indicated that a strengthened national public health service within Health NZ will be developed to make sure Aotearoa New Zealand is always ready to respond to threats to public health, such as pandemics. This is where I see a great opportunity for paramedics and their dynamic skill set to flourish.

4. What challenges lie ahead for the profession, and how can those challenges be met?

Like any emerging discipline, one of the challenges we continue to face is the recognition and understanding of what we bring to the table. I recently presented at a Medicolegal Conference, where I outlined several of the skills that we perform as part of our everyday. I'm sure nearly every jaw dropped in that room when I did, as there were a lot of stunned faces staring back at me! Education throughout the health care system and the public is a key element in this. Having strong and robust advocacy voices, dynamic leadership with clear key messaging, and Paramedics themselves speaking up for the profession, having the courage and curiosity to explore other spaces. I believe anything is possible!

5 minutes with Mitch Mullooly
Continued from page 9

5. Reflecting on your career as a paramedic, what stand out as the most memorable moments?

I am extremely blessed as after 25 years there are quite a number! I've lost count of how many babies I have delivered, how many hands I have held and hugs I have given; however, as career highlights the two most stand-out moments would include being awarded the inaugural Council of Ambulance Authorities Women in Ambulance Honour for my ongoing leadership and passion for the physical and psychological wellbeing of ambulance personnel. And being appointed to Te Kaunihera Manapou Paramedic Council, especially after advocating for the regulation of the profession for many years, including being invited by the Minister of Health at the time to the Beehive in Wellington. Neither of these moments would have eventuated if I hadn't delivered all those babies, held all those hands and given all those hugs because these moments are the ones that have driven me to strive for better, both for our people and for our profession. These are truly remarkable times, and I couldn't be more excited about where our future lies!

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A life of service

Long-serving Queensland paramedic Evan Lloyd reflects on his 32-year career

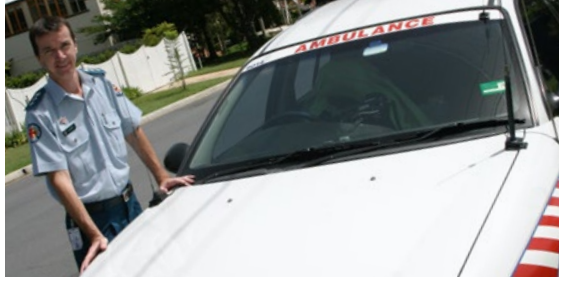
Recently retired Queensland Ambulance Service paramedic Evan Lloyd hadn't originally planned to become an ambulance officer. Serving in the Royal Australian Navy in the late '80s, his career path took a different turn while working alongside a sailor who was preparing to join the ambulance service. The nature of the work piqued his interest, and on leaving the navy he charted a new course.

"It was all a bit by accident, really," Evan said. "Before I knew it, I was a volunteer ambulance officer with the Mandurah Sub-Centre of St. John Ambulance Western Australia. After five years, I left as the Chairman of that branch and applied for a position on permanent staff. In front of me was an opportunity to get paid a full wage for a role I fell in love with."

The early '90s was an exciting, and often challenging, time to be an ambulance officer. The 16-week induction training covered standard clinical procedures and included driver training coupled with elements of rescue and a deeper integration with other emergency services. On the metropolitan roster, officers either drove ambulances or undertook all the attending for the entire shift.

"When I joined, the entire Perth metropolitan the roster was contained on one A4 sheet! When I commenced full-time, the total operational staff in WA was 330. Fast forward to my role as manager of workforce planning with the QAS in 2016, and I was overseeing the roster for 640 staff, and that was only part of the Brisbane metropolitan workforce."

> "I always imagined we looked like a skit out of Benny Hill, pulling over, getting out and running to the other side of the vehicle, jumping back in and taking off, lights and sirens blaring."



Back then, graduates of the in-house training in Perth were not allowed to undertake any Code 1 driving for their first month on-road. The focus during that month was on clinical familiarisation and consolidation, then came driving.

"For our first month on road, if you were on your driving shift for the day and a Code 1 came in, you pulled over the side of the road and swapped positions with the senior officer for the journey to the scene. I always imagined we looked like a skit out of Benny Hill, pulling over, getting out and running to the other side of the vehicle, jumping back in and taking off, lights and sirens blaring."

Students also didn't have clinical days or in-service education. At the commencement of their third year, they undertook an advanced clinical programme, after which they graduated as senior ambulance officers.

through the then-named Victoria University, at the time the only university to offer the course, and was, he believes, the third such graduate in Australia.

While the mechanics of the work, the tools used, and clinical reach have significantly changed in the past three decades, he said the nature of the profession hadn't fundamentally altered in his years on the job. The essence of the role remained largely the same.

"How we go about the role has contemporised, but not at the expense of deviating from our mission."

Career highlights are myriad, but the standouts include being named Ambulance Officer of the Year for the Southwest Region of the Queensland Ambulance Service in 2002, and in 1997 being awarded the Kevin Milton Smith scholarship through the WA Division of the Institute of Ambu-

> "How we go about the role has contemporised, but not at the expense of deviating from our mission."

The profession has progressively evolved throughout the years. When Evan began his career, the required academic qualification was an Advanced Diploma in Pre-Hospital care. To the amusement of his colleagues, in 1998 he enrolled in a Bachelor of Health Science - Paramedicine degree

lance Officers that afforded him the opportunity to spend weeks integrating with the Hong Kong Ambulance Service.

"In Hong Kong, I wore my WA ambulance service uniform. This included my service epaulettes which, at the time, were three stripes with the words 'Ambulance Officer' at the bottom of each epaulette. One thing I didn't count on was that in Hong Kong, the only role to have 'Ambulance Officer' on their epaulettes was the Commissioner!"

However, his fondest memory was working in the QAS Medical Directorate under Dr Stephen Rashford.

"I was very fortunate to lead the group that brought to the service an integrated clinical audit and review tool. This was followed by the development and implementation of a computer-supported drug-management tool for clinicians. This was the beginning of an era where the service was investing heavily in the transition to an electronic patient-care medium, and as a part of Dr. Rashford's team we forged a new way of clinical review and support. Prior to this such a review would take an average of 11 weeks to discover trends and variations."

And while he enjoyed his many senior manager roles responsibilities in the QAS, after 16 years he yearned for the excitement and challenges that came with being an operational paramedic, and in 2018 reverted his rank back to that of an Advanced Care Paramedic before ill-health hastened his retirement in 2020. Once a healthcare provider, he is now a patient himself with inoperable brain cancer.

"I am now at the hands of the very discipline I contributed to over 32 years. It's very humbling to see it all from the other side of the lens."

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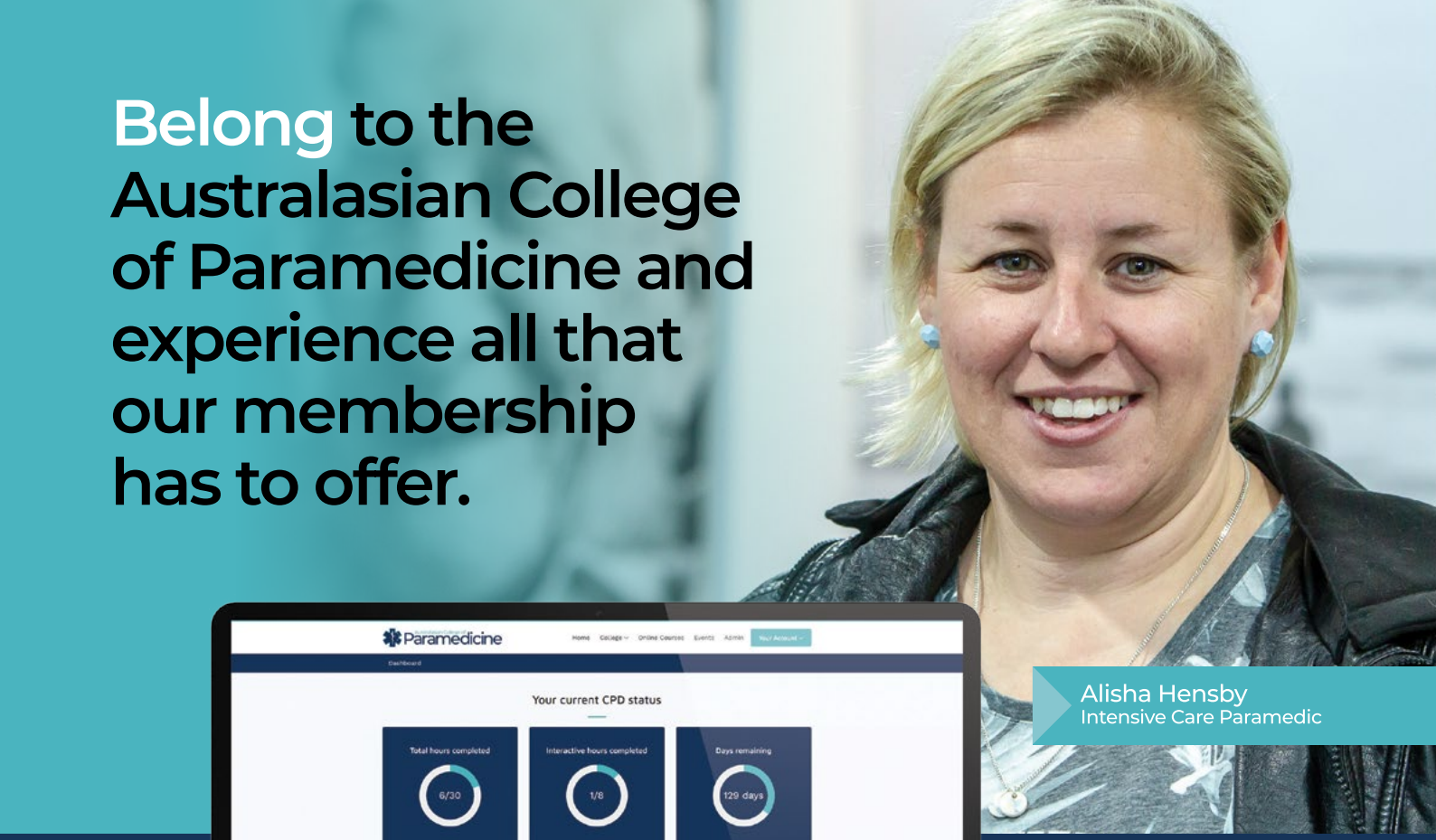

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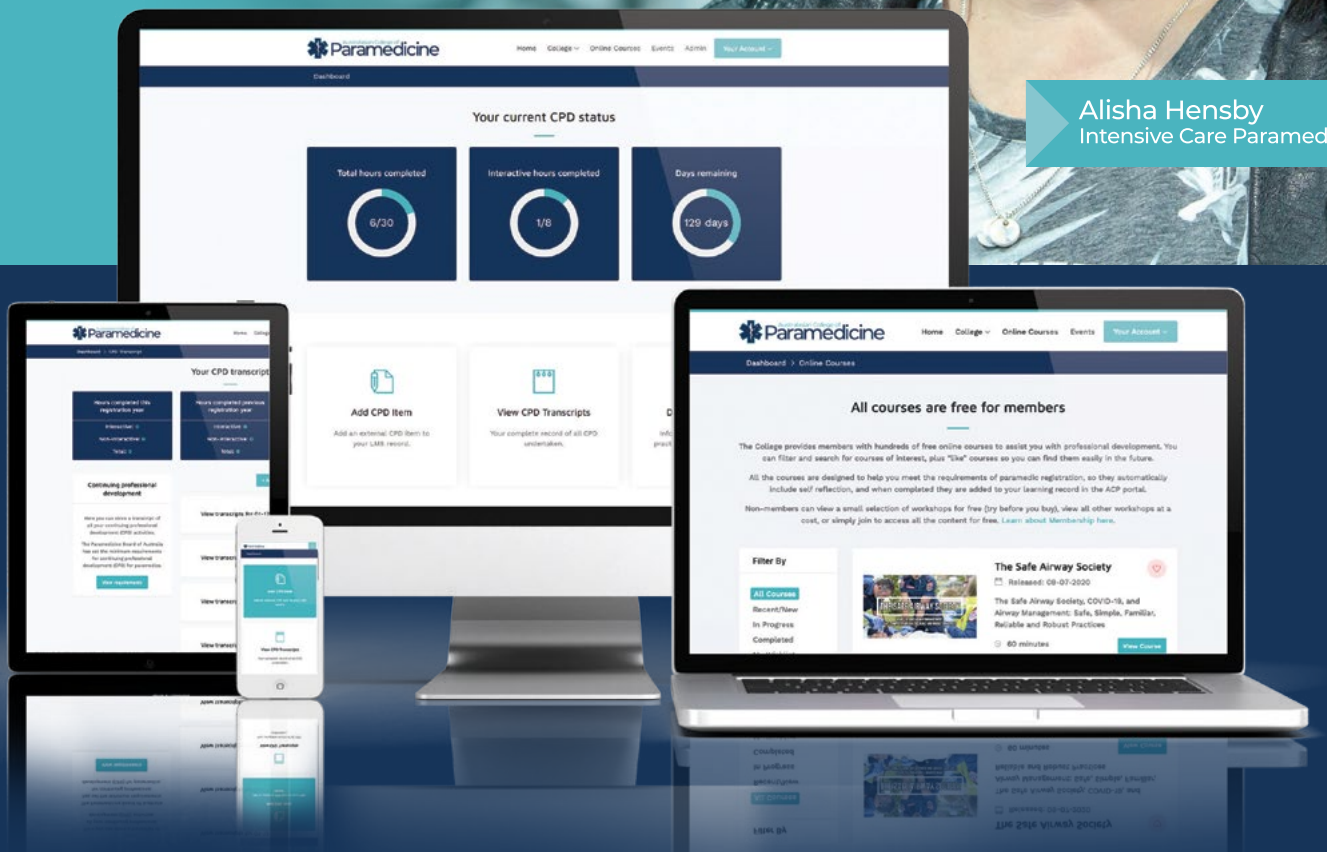

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Paramedics on the frontlines of a COVID-19 mental health crisis

Adequately addressing the issues facing Paramedics requires more resources and the reallocation of existing resources, where possible, to areas in most need, and a review of systems to further ease pressure.

The COVID-19 pandemic and the recent sharp uptick in cases in New South Wales and Victoria have placed paramedics under increased stress, with greater day-to-day work complexities, longer call cycles, extended shifts, and insufficient breaks having a cumulative negative impact on their physical and mental health.

The repeated necessity to put on and take off personal protective equipment (PPE), constant vehicle cleaning, and ramping have also resulted in lengthy delays, particularly in reaching patients and administering treatment, and have added to the pressures of already strained health systems.

Clare Sutton, Senior Lecturer in Paramedicine at Charles Sturt University and Chair of the College's Paramedic Wellbeing Special Interest Group, said there were a number of compounding issues facing paramedics, including:

- The need to adapt to rapid changes in clinical guidelines and protocols and fear of clinical errors
- Having to stay up to date with an overwhelming amount of communication
- The requirement for enhanced levels of PPE that is not designed for the harsh pre-hospital environment
- Managing COVID-19 patients with complex and challenging clinical presentations
- Managing "routine cases" with the potential for additional complications who are presenting later in the course of their disease progression because they were attempting to self-manage to avoid hospitalisation and potential exposure to COVID-19.

"All of these factors result in increased cognitive load on a sustained basis leading to increased stress levels," she said. "There are delays getting to the patient's side and commencing treatment resulting from having to don PPE first. This can result in frustration and conflict due to the perceptions of the patient, family and bystanders that a delay will be detrimental. It's also stressful for staff who want to start treatment in a timely manner, especially in time-critical situations such as cardiac arrest."

The lack of time to take part in other activities after work due to late finishes on already long 12-hour shifts, in addition to a lack of energy, motivation and opportunities due to lockdowns, also have a detrimental impact on mental health, depriving people of an outlet to destress that also provides a protective buffer against the more challenging and stressful aspects of their job.

Ramping at hospitals, widely reported in national media in recent months, reduces the number of crews available to respond to emergency calls, requiring staff from outside their normal areas to respond to calls, with additional stress placed on paramedics resulting from a lack of local knowledge, and hospitals with different procedures to local hospitals.

Ms Sutton said adequately addressing these issues required more resources and the reallocation of existing resources, where possible, to areas in most need, and a review of systems to

further ease pressure. This included using non-emergency patient transport or other support services where available to cover hospital transfers, discharges to home addresses and the transporting of low-acuity cases to ease the burden on frontline crews.

"We need to use frontline crews for frontline work and reduce the burden of other tasks, such as vehicle cleaning. Having staff employed to clean vehicles at superstations or on site at hospitals to provide crews extra downtime to refresh and reset is one possible solution."

She also called on organisations to provide a range of support services for staff, and suggested regular check-ins and peer support to help paramedics stay connected.

NSW paramedic Jacquie Saunders said a program that was trauma-informed and recognised the extreme impact working during a pandemic has had on the paramedic profession, organisations and individuals was vital.

"I think acknowledging the huge impact of the pandemic, extensive lockdowns and the uncertainty of COVID in the workplace on all individuals, and planning a systematic progressive program utilising multiple services is needed nationwide, particularly as we learn to live with the new changes to our practice."

From listening to her colleagues and through her own experiences, Paramedic Jacquie Saunders said stress fell into four main categories: Personal, physical, mental, and professional.

On the personal side, she said paramedics were facing two realities: Being locked down outside of work, not seeing family and friends/community supports, and having to put children in daycare despite the risk to them so they can work on the frontline.

"There's nervousness about children catching COVID while in care, the stress and fear of bringing it home to loved ones. Even with restrictions easing, there is a question mark hanging in the air about the possible risk of transmission to others. In addition, the extended shifts and minimal breaks, in combination with the PPE requirements, days between shifts or the start of days off are spent recovering from the pure exhaustion of the shifts themselves. I know of many paramedics who have commented on never having been more fatigued after shifts than with the full PPE and COVID precautions."

Physically, not drinking or eating enough during shifts, fatigue from excess overtime, and lacking energy on days off are all issues with which paramedics are grappling. She said self-care could be hard to maintain during and directly after shifts.

Mentally, the constant stress of the pandemic and day-to-day work stressors mean that paramedics are exhausted.

"Some are questioning their future in the profession. They're overwhelmed and with limited choices to undertake self-care and social interactions outside of work due to being in lockdown. Mental health concerns expressed by colleagues are definitely on the rise. Increased anxiousness, depressive symptoms, decreased sleep and proper rest due to the pandemic and workplace stressors I believe have led to an understandable decline in paramedics' mental health overall."

She said professionally, unrelenting uncertainty and exhaustion were proving extremely taxing.

"Paramedic practice is also changing in response to the practice. All the uncertainty and constant fluid changes to recommended practice as the healthcare advice has evolved was and is overwhelming. The focus on detail of PPE and the high level of willpower put in to maintaining this adds to the exhaustion. Despite this, the efforts of all paramedics, continually doing this on a daily basis, time and time again, is phenomenal."

"I know of many paramedics who have commented on never having been more fatigued after shifts than with the full PPE and COVID precautions."

JACQUIE'S TIPS FOR COPING:

- Maintain connectedness: Talking with colleagues and using their support to assist with work challenges. Colleagues are a huge support network.
- Connecting through technology: Activities such as video conferencing with family and friends for trivia nights, food-tasting nights, board game nights, and virtual baking and gym classes. Fortem is an example of an amazing organisation offering so many activities throughout lockdown and now post-lockdown as well.
- Getting outdoors and being active: Activities such as exploring the local area, being out in nature, and swimming.
- Yoga and meditation sessions, which are free for frontline workers through Frontline Yoga: Learning to take time to breathe and be present in the moment helps to reduce the mental health impacts of factors over which people feel they have no control. I was a total sceptic until I tried multiple sessions.
- Regular check-ins with a psychologist/counsellor: Even when feeling mentally in a good space, this can help keep people grounded and address any negative habits that may have developed.

Dealing with uncertainty The reality of unpredictability: Some tools for management

A guide for first responders and families

First responders are exposed to traumatic events and exercise immense resilience in the face of stress. Contending with organisational stressors can affect the wellbeing of first responders, sometimes more than the work itself. Limited debriefing and recovery time, hierarchical management structures, and lack of recognition have also been shown to further impact wellbeing.

The families of first responders also make this journey, experiencing worries and helping to "carry the load" when members are on duty. Not only the events themselves, but also the anticipation and perception of those events in the months preceding and following, can lead to stress, anxiety, depression, and social challenges.

WARNING SIGNS AND RISK FACTORS

It's natural that you experience one or many of the following at some point after stressful or traumatic events, or in response to caring for someone who is a first responder. It's important to recognise when these warning signs start to become persistent and shape daily thinking and behaviour.

DEALING WITH UNCERTAINTY

CONNECT: Shift focus from the assignment during breaks or time off (e.g., calling loved ones back home or leaving the disaster site for a brief time).

SHARE: Anything is better than nothing. Share the parts that you can. This keeps the lines of communication open and maintains connection to each other.

PARTICIPATE: Being included is part of the process of remaining connected. For support networks, invite your first responder to events even if you're unsure that they can attend. Find ways to record events and share those memories (pictures, videos).

BE KIND TO YOURSELF: Adjust your expectations to acknowledge (potential) burnout and find moments to put your needs first, whether through rest, connection, movement, or whatever is nourishing and restoring of your energy.

PRACTISE PRESENCE: Practice mindfulness/meditation when you're not experiencing heightened levels of fear or worry so that it's easier to use these skills when most needed. Recognise what you are feeling or thinking, allow those experiences some space, understand what they are about, and show yourself some kindness in response.

GROUND: Allow your senses to bring you to the present moment. Begin by naming five things you can see and five things you can feel. This can be as simple as the window in your room or the clothing on your skin. It can also help to incorporate the other senses, naming things you can hear, smell, and taste.

BREATHE: We can manage physiological anxiety with controlled breathing. Match your in breath (four seconds or more) to your out breath. Count slowly as you breathe in and then slowly as you breath out. Do not pause between breaths.

ACCEPT: Acknowledge thoughts and worries, even if unpleasant. Accept the situation and the role of yourself/your loved one in service. Implement strategies to make life easier for you so that when situations come up which elicit a stress response, you know how to manage these.

PHYSICAL	EMOTIONAL & COGNITIVE	SOCIAL
· Fatigue, stress, being overwhelmed, high rates of sickness and days absent · Checking out, being mentally absent · Drinking to wind down, difficulty remaining still, insomnia · Shortness of breath (anxiety making it difficult for the nervous system to relax) · Sweating/racing heart (from worry, stress and fear, which accelerate the breath) · Muscle tension in neck, shoulders, jaw · Upset stomach/loss of appetite	· Angry outbursts and changes in patience/tolerance · Increased sense of isolation · Avoiding/withdrawing from others, decreased social life · Reduced confidence/trust, questioning self and others, feeling unsafe · Strong feeling that "something isn't right" · Unwanted and unpredictable thoughts or flashbacks · Difficulty switching off or compartmentalising · Feeling disinterested in and disengaged from self, others and things that usually give you meaning	· Not scheduling events due to uncertainty around first responder's attendance · Not wanting to go alone · Not knowing how to navigate conversations with others about partner's absence · Withdrawal from others · Nervousness leading up to the social event/cancelling at the last minute

https://fortemaustralia.org.au/wp-content/uploads/2021/09/Resource-Dealing-with-Uncertainty-Guide-Fortem-Australia.pdf

FORTEM AUSTRALIA

We support...

the mental health and wellbeing of first responders and their families – the people who protect and care for our community.

Every day, more than 300,000 first responders keep our communities safe. They are backed up by their families: partners, children and parents. All of them hold vital, and challenging, roles. We help them to be well, and stay well, through mental fitness and wellbeing activities and support services.

Free to first responders and their families

Family resillience

- Wellbeing activities
- Community engagement
- Care coordination

Mental fitness

- Peak Fortem
- Resources library

Clinical support

- One-on-one support
- Group programs
- Family sessions

Transition and Employment Program

- Transition support
- Employment support
- Alternative pathway support

Check our website for eligibility requirements.

Scan to learn more

Speak directly to our team

connect@fortemaustralia.org.au
1300 33 95 94
fortemaustralia.org.au

St John paramedics pivotal in Aotearoa New Zealand's COVID-19 vaccination rollout

St John paramedics are playing an integral role in Aotearoa New Zealand's COVID-19 vaccination campaign, bolstering the Ministry of Health's rollout and pandemic response efforts.

St John New Zealand Readiness and Response Manager COVID-19 Rebekah Judd said 130 paramedics who were trained vaccinators, and a larger number of event health personnel providing medical cover, were supporting the country's health system by working part-time at vaccination centres and events.

"It's the largest logistical project that the health service has ever undertaken," she said. "We have personnel at most of the large-scale vaccination events nationally, providing medical cover, monitoring patients post-vaccination, and managing adverse events. Some of our St John premises have also been utilised by local health initiatives as short-term locations for vaccinations."

In May 2021, the Medicines Act 1981 was amended to enable non-registered health professionals to become vaccinators. In administering vaccinations, paramedics are not required to work under supervision as they are registered professionals; however, other non-regulated healthcare workers are required to work under supervision.

"The primary purpose of changing the legislation was to increase the response and support for Māori and Pasifika and meet the needs of those communities. This meant that the vaccinator workforce could be easily scaled up, particularly in areas where there is high need, with the aim of improving access for Māori and Pasifika peoples."

St John also has volunteers transporting vulnerable people to receive their vaccinations in rural areas where transportation is problematic for some communities, and has a fully cold-chain accredited campervan that provides additional support for rural and remote areas. It also operates a dedicated ambulance to transport ill COVID-19 positive patients from government-managed isolation and quarantine facilities to hospital - a concept that can be built on in the event of future outbreaks.

> "When the wider vaccination rollout started in July, we started to support the mass vaccination events, and provide medical cover, and have been ever since."

The Ministry of Health in Aotearoa New Zealand is leading the national COVID-19 vaccine rollout, and like Australia has adopted a tiered approach. The initial group to receive vaccinations were government border worker agencies and their families. St John frontline staff were part of the next phase.

"Initially we thought we might become providers of the vaccine, but we pivoted when we found that it would be easier to link in with District Health Boards to get our people vaccinated, which is what we did.

"We recruited and organised the training of a cohort of paramedic vaccinators, and they have been able to assist the DHBs. We also liaised with the DHBs every time a new vaccination site was set up to ensure that there was easy access for any emergency events. This helped us to form strong relationships with the site leads. When the wider vaccination rollout started in July, we started to support the mass vaccination events, and provide medical cover, and have been ever since."

The efforts of St John personnel have been well-received throughout the country, and potentially pave the way for the future expansion of the roles paramedics play more broadly in Aotearoa New Zealand.

"We're all in this together."

COLLEGE CONSULTATIONS AND SUBMISSIONS

The College regularly engages in government and industry consultations to represent and advance the interests of the paramedicine profession. This behind-the-scenes work is often a result of the dedication and hard work of our College's advisory committees and special interest groups.

The following is a list of consultations and submissions submitted to date by the College, along with submission dates.

The College will provide updates on future consultations and submissions as they occur.

Submission/Consultation	Organisation/Body	Date submitted
Introduction of CPAP during COVID	NSW Ambulance	18 September 2020
Consultation on scopes of practice, prescribed qualifications and fees	Kaunihera Manapou Paramedic Councilw	21 September 2020
Assaults on emergency services workers	NSW Sentencing Council	30 September 2020
Review of the Regulatory Principles	Ahpra	22 October 2020
Framework for identifying and dealing with vexatious notifications	Ahpra	22 October 2020
Consultation on Paramedic Competencies and Code of Conduct	Kaunihera Manapou Paramedic Council	3 December 2020
Acute Anaphylaxis Clinical Care Standard consultation	Australian Commission on Safety and Quality in Healthcare	14 December 2020
Low Back Pain Clinical Care Standard	Australian Commission on Safety and Quality in Healthcare	19 April 2021
Targeted consultation on draft amendments to Health Practitioner Regulation National Law	Health Chiefs Executive Forum	20 April 2021
Regulatory Guide chapter re Procedural Fairness	Ahpra	21 April 2021
Public consultation on revised regulatory principles for the National Scheme	Ahpra	19 May 2021
English Language Skills Registration Standards	Ahpra	26 May 2021
Revised code of conduct	Ahpra	5 July 2021
Primary Health Care Reform	Primary Health Reform Steering Group	27 July 2021
Developing the next National Plan to Reduce Violence against Women and their Children	Department of Social Services	30 July 2021
Ambulance Victoria Strategic Plan	Ambulance Victoria	26 August 2021
Inquiry into the provision of GP and related primary health services to outer metropolitan, rural, and regional Australians	Senate Community Affairs References Committee	30 September 2021
Opioid Analgesic Stewardship in Acute Pain Clinical Care Standard	Australian Commission on Safety and Quality in Healthcare	5 October 2021
Inquiry into the delivery of ambulance services in Western Australia	Legislative Council Committee Office of Western Australia	28 October 2021

For more information, contact the College's Policy and Project Officer Rachel Shanahan at **rachel.shanahan@paramedics.org**

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The College signs MoUs with Safe Airway Society and Fortem Australia

The College is pleased to announce it has signed memorandum of understandings with the Safe Airway Society (SAS), the interprofessional airway society for Australia and Aotearoa New Zealand, and Fortem Australia.

SAFE AIRWAY SOCIETY

The College and SAS are looking to build a positive and collaborative relationship, with regular discussions planned to identify opportunities to support each other to achieve our mutual objectives.

"It's particularly pleasing to see paramedics as a key part of SAS, bringing the knowledge and expertise of out-of-hospital airway management that is held within paramedicine to the awareness of other professions," said College CEO John Bruning.

The College encourages paramedics interested in airway management to consider joining SAS. Their membership fee is very reasonable, and is a great opportunity for them to have a say in airway management.

For more information on the Safe Airway Society, visit: https://www.safeairwaysociety.org/

FORTEM AUSTRALIA

Fortem Australia is a not-for-profit organisation that supports the mental health and wellbeing of first responders and their families - the people who protect and care for our community.

Fortem provides psychology support, both in-person and via telehealth, to eligible first responders and their families. Fortem also provides a range of resources and facilitates events and activities designed to connect families together to strengthen family bonds and build communities.

The signing of this MOU means that College members in Australia will have access to Fortem's services and support as Fortem continues to grow and expand. Our relationship with Fortem is underpinned by the College's commitment to the wellbeing of our members and all working in the profession.

The College is currently working on bringing a similar arrangement to members in Aotearoa New Zealand.

MORE INFORMATION FROM FORTEM AUSTRALIA:

Fortem, meaning "brave" in Latin, runs wellbeing activities designed to connect families together to strengthen family bonds and build communities.

Fortem provides psychology support, both in-person and via telehealth, to eligible first responders and their families.

Fortem's Transition & Employment Program supports national security and law enforcement personnel looking for new life and career opportunities following service with state and commonwealth emergency and security agencies. Fortem is working to soon extend the program to everyone in the first responder community, incorporating state-based emergency agencies.

Fortem is an official partner of The Royal Melbourne Hospital's 5 Ways To Wellbeing - connect, be active, keep learning, be mindful, help others. These strategies are integrated into all Fortem's activities, events, and programs to highlight the benefits of incorporating simple lifestyle changes into your day-to-day life.

Fortem is the charity behind Thank a First Responder Day, a day which illustrates the "power of thanks" for both the giver and receiver. In 2022, Thank a First Responder Day will be held on June 8.

Fortem has extensive not-for-profit experience, including developing and delivering similar projects through the veteran's charity Soldier On.

The Fortem team is currently at work in Sydney, Melbourne, Canberra, Yass, Goulburn, Wollongong, Newcastle, Northern NSW, Southeast NSW, Southeast Queensland and the Gippsland region.

Check the Fortem Australia website for tools, stories, and local activities that support your mental fitness and wellbeing.

fortemaustralia.org.au/

Women in Paramedicine SIG

July 2021 saw the establishment of the College's Women in Paramedicine Special Interest Group (SIG), which is focused on supporting and advocating for the progression of women in paramedicine. The SIG was established in response to the evolving requirements of the profession and to ensure the College continues to meet members' needs and addresses the challenges that women in paramedicine experience.

LINDSAY MACKAY, CHAIR

Lindsay has more than 15 years' experience working in ambulance services across the UK and Australia. Born in Scotland, she trained in England, where she began her paramedicine career before deciding to call Australia home. She is an Intensive Care Paramedic and trained as one of the first Community Paramedics. Lindsay is passionate about providing patients with the best care option for their needs, and is focused on improving health outcomes by reducing unnecessary hospital admissions. Because of this, she has been instrumental in establishing change within ambulance services and developing innovative alternative models of care, with a vision to support the delivery of a new era of modern ambulance service delivery. Lindsay currently leads Ambulance Victoria's Operational Triage Services directorate and is a valued member of its extended leadership team. Known for her strategic vision, drive, and ability to deliver, she is a dedicated leader to her colleagues, team and those within the community.

DR LOUISE REYNOLDS

Louise is a Senior Lecturer and registered paramedic. She began her prehospital career as a student paramedic with the South Australia Ambulance Service in 1992, where for the next 10 years she held various operational and non-operational roles before moving into higher education in 2003 at Flinders University. Louise was Australia's first female paramedic to attain doctoral qualifications, with her thesis describing the emerging professionalism of prehospital care practice. She has taught paramedicine at vocational, undergraduate and postgraduate levels across Australia and the UK. Her research expertise draws on a variety of interests using qualitative methodologies in paramedicine education, systems and leadership.

KIRSTY MANN

Kirsty is a registered paramedic with more than 15 years' experience in Aotearoa New Zealand's ambulance sector, including ambulance operations, HEMS, clinical development, and governance roles. She has a particular interest in pursuing equity in pre-hospital care for rural and remote communities and optimising patient outcomes through access to excellent clinical care. In her dual roles as Clinical Education Officer and Advocacy and Government Relations Lead with the College, she is committed to supporting paramedics' access to quality CPD that meets their educational needs to maintain registration, as well as advocating for the paramedic profession within Aotearoa New Zealand's wider health sector. She is passionate about enabling opportunities for women in paramedicine and proud to be a member of this SIG.

JULIE HUGHES

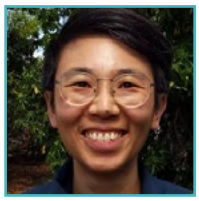
Julie is a Critical Care Paramedic currently working in Brisbane's High Acuity Response Unit (HARU). She joined the Queensland Ambulance Service in 2002 after a 10-year career as a staff/senior radiographer at the Royal Brisbane Hospital. Stationed in the Brisbane metropolitan area, she completed her Diploma in Prehospital Care and was awarded Outstanding Student of the Year 2004. She transferred to a rural, single-officer station in 2006 before returning to Brisbane to complete the Intensive Care Paramedic program, in which she was awarded 2008's Intensive Care Paramedic Practice Award for the highest grade point average. With permanent appointments in Brisbane HARU and as a Flight CCP at Brisbane's Rescue 500, she regularly relieves as a Clinical Support Officer, and in 2020 completed a Master of Traumatology. Julie has a special interest in trauma and prehospital ultrasound, as well as mentoring and learning from the next generation of paramedics. She is a casual academic at the University of the Sunshine Coast, is a regular presenter at conferences, and has been a chair and member of conference committees.

LAUREN CLOTHIER

Lauren is a full-time paramedic student studying a Bachelor of Paramedic Science at the University of the Sunshine Coast. Before starting her paramedic studies, she was employed as a Patient Transport Officer with HealthShare NSW, operating as part of the frontline response to the COVID-19 pandemic. Working in this patient-oriented role influenced her to pursue her first clinical position as an Advanced First Responder at high-impact sporting events across the Greater Sydney Area. This clinical experience affirmed her passion for prehospital care, driving her dedication and eagerness to pursue a career in paramedicine. Lauren is passionate about ensuring a diverse and progressive workforce that is driven to provide equal opportunities and is highly motivated in seeing fellow female clinicians experience great success.

MICHELLE MURPHY ASM

Michelle is the Advocacy and Government Relations Lead for the College and an Intensive Care Paramedic, with 27 years' experience across metropolitan and rural regions in frontline and senior management roles. She is currently the Operations Manager for Adult Retrieval with Ambulance Victoria. Michelle is passionate about paramedicine and the building of inclusive and innovative models of care that meet the changing needs of our communities. She has contributed to research, presentations and publications, focusing on improving health outcomes in vulnerable communities and out-of-hospital cardiac arrest. Michelle acknowledges the Boon Wurrung people, the traditional owners and custodians of the land where she lives.



RUIYI YIN

Ruiyi is a critical care flight paramedic with the Queensland Ambulance Service. In her 13-year career, she has worked in various metropolitan and regional areas, and is currently based in tropical north Queensland. She has held various roles during this time, including in operational management, education, and clinical support. Ruiyi has a strong interest in diversity and equity, particularly for women in leadership, and is passionate about increasing opportunities for all members of the profession through mentorship and advocacy.

KAITLYN KRAHE

Kaitlyn is an advanced life support paramedic based in Mparntwe/Alice Springs. Kait has been fortunate to work and learn on Larrakia land, Jawoyn land, in Nhulunbuy on Yolngu land and internationally as a Paramedic. Kait is a content creator for the education platform Outback Responders and a post-graduate student with a strong interest in intersectional feminism, the social determinants of health, cultural safety, and critical allyship. Kait hopes to continue to be a strong advocate for women and an ally to gender diverse, neurodiverse, and culturally and linguistically diverse folk in ambulance. Kait acknowledges the Arrernte people, traditional custodians of the lands on which she lives. Sovereignty was never ceded.

DANIELLE LITTLE

Danielle is an Intensive Care and Extended Care Paramedic with dual registration in both in Aotearoa New Zealand and Australia. She is currently working in remote and austere environments for the Australian Defence Force and in heavy industry, primarily on deep-sea dive vessels and on oil and gas facilities. Danielle began her career in Auckland in 2005 with St John Ambulance and was one of its first degreed officers to be employed. She has a long history of contributing to the education of ambulance officers, having actively contributed to writing the first draft of the internship programme for degree-based paramedics in Aotearoa New Zealand. During Danielle's time at St John Ambulance, she was a member of the clinical education team, as well as being a mentor to interns who were working towards their Intensive Care Qualification.

ALISHA MCFARLANE

Alisha is a Lecturer in Paramedicine at Charles Sturt University. She has been an intensive care paramedic for 18 years and is now focused on researching the experiences of women in paramedicine, specifically experiences of sexism, harassment and gender inequality. Alisha is Chair of the College's Clinical Standards Committee and a member of the Women in Paramedicine Committee. She is focused on promoting and driving change in the professional culture of paramedicine, and supports the equal representation of women in leadership positions. She has published in the area of paramedicine in prehospital care and applied paramedic law and ethics, and has contributed high-profile media commentary about women in paramedicine through "The Women's Agenda", a hub sharing the latest news and views affecting how women live and work.

STUCON 2021

WRAP UP

#STUCON2021

We were optimistic that we would be able meet our student paramedics face to face at Western Sydney University for a long-overdue in-person conference; unfortunately, COVID-19 took centre stage once again. Instead, our inaugural student conference, STUCON 2021, took place as a virtual one-day event on Friday 31 July.

Thank you to all our students and presenters who tuned in remotely and helped to create a stellar virtual atmosphere for the conference. Close to 140 student paramedics attended the conference online. There were also seven on-campus society events held at various universities nationwide (where possible with COVID-19 restrictions).

> “I really enjoyed hearing about the various roles others are doing and have done besides working for an ambulance service.” **Attendee**

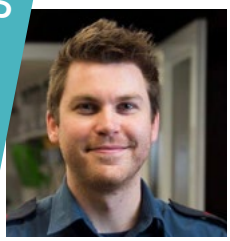
Students found the diversity of presenters and the wide-ranging topics covered in the presentations to be most valuable.

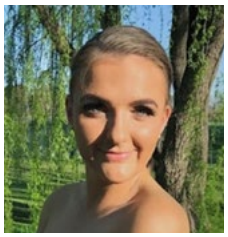
Some of the most interesting sessions were:

- How we changed international paramedic guidelines over Twitter - the hidden truth about social media and patient privacy, by Aidan Baron
- How the patient experience can improve the quality of paramedic care, by Dr Belinda Flannigan
- Mental health - positive forms of building emotional support, by Nicole Sadler

STUCON 2021

WRAP UP





Other sessions rated most relevant and valuable included:

- How to smash your grad year, and which pitfalls to avoid, by Ryan Parry
- Toxicology during COVID, by Alan Eade
- Panel Discussion: Learning to make our practice culturally safe
- Paramedicine in Higher Education – where can my degree take me?, by Bill Lord
- Laying the roadmap for your clinical career, by Dr Alex Cardenas

Our conference MC:

Buck Reed

Our conference speakers:

Aaron Farok, Aidan Baron, Alannah Stoneley, Alan Eade, Alex Cardenas, Ali Rengers, Alisha McFarlane, Belinda Flannigan, Ben Cant, Bethany Birkett, Bill Lord, Carlton Irving, David McLeod, J.D. Heffern, Kaitlyn Krahe, Kiara Bennett, Liam Langford, Lily Phillips, Luke Mackey, Mandy Edmonston-Fearn, Nicole Sadler, Ryan Parry, Sarah Sawyer, Sophia Flanagan-Sjoberg, and Whitney Hughes.

Our poster-presenting authors:

Alannah Stoneley, Amelia Maxwell, Chloe Deetlefs, Jasmin Sidhu, Joel Marriott, Rhys Hillsley, Ricky Lam, and Sophia Flanagan-Sjoberg

Our student committee:

Anna Musgrave, Jasmine Dietrich, Liam Bruton (Chair), Sherlyn Hii, Tahlia Harper, Thomas Marcus, and Venessa Carnaby

STUCON 2021





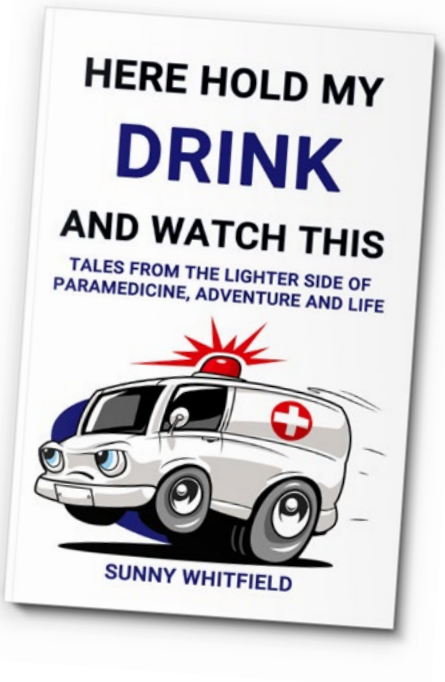

> “Had to watch in between work commitments, so being able to go back and watch the panel discussions was great. It was also good to hear the student research papers as it gives you an idea on how you are going with your own work.” **Attendee**

MISSED THE CONFERENCE?

All session recordings are available on the College website under “Online Courses”. Recordings are free for College members.

https://paramedics.org/courses?category=STUCON+2021

Here Hold My Drink and Watch This



Read an excerpt from Paramedic Sunny Whitfield's new book, "Here Hold My Drink and Watch This", which brings to life the work paramedics are daily faced with, finding humour and consolation among the confusion and chaos.

I was sitting in the front passenger seat of the ambulance driving through some of the heaviest rain and worst weather I had ever seen. For the last week or so, a large storm had been lashing the coast and our community was directly in its path.

We were driving the ambulance through a high-speed zone but we were struggling to see the markings on the road, so we had reduced our speed to a crawl. There were occasional breaks in the downpour allowing a brief orientation to roadside markers, but the wind continued gusting and unpredictable. Somehow through the low visibility and torrential rain we located our patient. He was a young lad who had been out storm chasing on his bike and had inevitably crashed, suffering a dislocated shoulder. Adam manoeuvred the ambulance so the side sliding door was alongside where the young lad lay, and I jumped out and was drenched in seconds. He stood with assistance and once inside, I slammed the sliding door shut and positioned the young lad on to the stretcher. Whilst I was retrieving some pain relief for the lad, Adam slammed the brakes on so hard that I was taken off my feet.

The sudden deceleration had caused the medication to splash in my eyes and I had been flung from the back of the ambulance to the front, where I landed on the gear stick. I turned to abuse Adam for his driving ability when I was suddenly lost in time.

Right there in front of the ambulance - silent and mesmerising - was a long, twisting white cloud reaching as far into the sky as I could see. It danced and twisted delicately in the sky and I had never seen anything so captivating yet terrifying. It descended lower and lower and soon it was low enough to disturb the ground with swirls of dust and debris.

When the dancing cloud finally touched down, it roared like an angry beast! Only fifty metres or so in front of our ambulance, we were both staring at the first tornado either of us had ever seen. We watched in awestruck panic as sheds were demolished, cars smashed by trees and roofs ripped clean off buildings. Despite the chaos outside, there was a moment of eerie silence within the ambulance.

The twister moved in a mesmerising, unpredictable path and all we could do was watch in amazement and fear.

I yelled to Adam to back up, but something was wrong. All he could do was rev the engine. Had either of us taken our eyes off the twister for even a second, we may have realised that I had knocked the ambulance into neutral when I was flung forward. With every useless rev of the engine, the twister seemed to get closer and closer. The ambulance began shaking, the roar became deafening ... and then nothing.

"The twister moved in a mesmerising, unpredictable path and all we could do was watch in amazement and fear."

This excerpt was taken with permission from "Here Hold My Drink and Watch This", a new book written by an Australian Paramedic Sunny Whitfield. The book is now available from Amazon, Booktopia, Barnes and Nobel, and Apple iBook's. Each paperback sold provides a year of clean drinking water to a person in a remote community in Nepal.

CAA2021 Awards for Excellence Virtual Event

Wednesday 17 November, 2021
12pm AEDT

Award Categories:

- Excellence in Technology
  (innovation or capability)
- Excellence in Clinical Practice
  (innovation or capability)
- Excellence in Staff Development
  (education improvement or innovation)
- Excellence in Patient Care
  (patient experience improvement or innovation)
- Excellence in Leadership
  (management practice and operational improvement and innovation)

New Category:

- Excellence in Mental Health and Wellbeing
  (innovation or operational improvement)

Live Streamed on CAA Facebook

The College welcomes new Clinical Education Officers

The College welcomes Aotearoa New Zealand paramedics Kirsty Mann and Stuart Cook in their new roles as Clinical Education Officers, working as part of our Education team to develop and deliver a broad range of clinical education content across multiple platforms for paramedics throughout the country, including face-to-face events and workshops, and interactive online learning activities and webinars.

Kirsty Mann

Stuart Cook

Kirsty is a registered paramedic with more than 15 years' experience in Aotearoa New Zealand's ambulance sector, including ambulance operations, HEMS, clinical development, and governance roles. She has a particular interest in pursuing equity in pre-hospital care for rural and remote communities and optimising patient outcomes through access to excellent clinical care. In her new role with the College, she is committed to supporting paramedics' access to quality CPD that meets their educational needs to maintain registration, and advocating for the paramedic profession within Aotearoa New Zealand's wider health sector. In her role as Advocacy and Government Relations Lead, she provides expertise for our Executive Leadership team, and supports the development of position statements and policy objectives to ensure strong paramedicine advocacy messaging and actions that meet the needs of the College and the profession.

Last month's Christchurch CPD event focused on performance under pressure and mass casualty incidents

Stuart is a registered Paramedic who has worked in the ambulance sector for more than 23 years in a multitude of roles spanning clinical operations, HEMS, programme development, and vocational and tertiary education, both at home in Aotearoa New Zealand and overseas. His varied background, along with his Master of Health Practice in Paramedicine, positions him well in helping the College develop Australasian paramedic education and mentoring models. His interests include remote and austere medicine, and the use of technology to facilitate remote education. He currently works as a Rescue Crewman/Intensive Care Paramedic on the GCH Aviation-run Westpac Rescue Helicopter based in Christchurch.

Paramedicine Board Ahpra

Ahpra News

ONLINE RENEWAL FOR PARAMEDICS IS NOW OPEN

Paramedics have until 30 November 2021 to renew their general or non-practising registration. You're encouraged to renew early to avoid delays - it might save you a call to Ahpra during the busy renewal period!

REVISED REGULATORY PRINCIPLES – SUPPORTING TRUST AND CONFIDENCE IN REGULATED HEALTH PROFESSIONS

The revised regulatory principles encourage a culturally safe, responsive and risk-based approach to regulation. The regulatory principles guide the National Boards and Ahpra when making regulatory decisions. Originally published in 2014, they have been updated to reflect both community expectations and a direction from the Health Council to strengthen the focus on public protection within the National Registration and Accreditation Scheme.

GRADUATING SOON? BE READY TO START WORK – APPLY NOW

Are you in your final year of an approved program of study and excited about starting work as a paramedic? Before you can start practising and using the protected title, "paramedic", you must be registered with the Paramedicine Board of Australia. Online registration for graduate applications is now open, and you can submit your application up to three months before you expect to complete your course.

PARAMEDICINE BOARD OF AUSTRALIA SETS FEE FOR 2021-22

The Paramedicine Board of Australia (the Board) has reduced the registration fee for paramedics to $270. The fee for practitioners whose principal place of practice is New South Wales is $270. A full fee schedule is published on the Board's website: https://www.paramedicineboard.gov.au/News.aspx

Kaunihera Manapou Paramedic Council

Te Kaunihera Manapou Paramedic Council News

MANDATORY VACCINATION ORDER FOR PARAMEDICS

This Order legally came into effect at 11:59pm on 25 October, and requires every paramedic to receive their first vaccine dose by 15 November 2021, and be fully vaccinated by 1 January 2022.

COVID VACCINE GUIDANCE STATEMENT

The Paramedic Council has an expectation that all paramedic practitioners will take up the opportunity to be vaccinated unless medically contraindicated. Paramedics have an ethical and professional obligation to protect and promote the health of patients and the public, and to participate in broader based community health efforts.

GUIDANCE ON THE END OF LIFE CHOICE ACT AND ASSISTED DYING

From 7 November 2021 people who experience unbearable suffering from a terminal illness will be able to legally ask for medical assistance to end their lives under the End of Life Choice Act.

Visit Kaunihera Manapou Paramedic Council's website for more information: https://www.paramediccouncil.org.nz/

The National COVID-19 Clinical Taskforce

The National COVID-19 Clinical Evidence Taskforce brings together the peak health professional bodies across Australia whose members are providing clinical care to people with COVID-19. The Taskforce is undertaking continuous evidence surveillance to identify and rapidly synthesise emerging research in order to provide national, evidence-based guidelines for the clinical care of people with COVID-19. The guidelines address questions that are specific to managing COVID-19 and cover the full disease course across mild, moderate, severe and critical illness. These are "living" guidelines, updated with new research in near real-time in order to give reliable, up-to-the minute advice to clinicians providing frontline care in this unprecedented global health crisis.

Budesonide for children and adolescents

Conditional recommendation: Consider using inhaled budesonide for the treatment of symptomatic COVID-19 in children and adolescents who do not require oxygen and who have one or more risk factors for disease progression.

Casirivimab plus imdevimab (Ronapreve/REGEN-COV) in children and adolescents

Consensus recommendation: Consider using, in exceptional circumstances, casirivimab plus imdevimab in seronegative children and adolescents aged 12 years and over and weighing at least 40 kg with moderate to critical COVID-19 who are at high risk of disease progression.

Not recommended: Do not use casirivimab plus imdevimab in seropositive children or adolescents hospitalised with moderate to critical COVID-19.

Only in research: Do not use casirivimab plus imdevimab in children under 12 years of age without risk factors for deterioration who have mild or asymptomatic COVID-19 outside of randomised trials with appropriate ethical approval.

Sotrovimab for children and adolescents

Only in research: Do not routinely use sotrovimab outside of randomised trials with appropriate ethical approval for the treatment of COVID-19 in children or adolescents under 12 years of age and without high-risk factors for deterioration.

Consensus recommendation: Sotrovimab should be considered in exceptional circumstances for children and adolescents aged 12 years and over and weighing at least 40 kg with mild COVID-19 and at high risk of deterioration.

Consider using sotrovimab only in unvaccinated or partially vaccinated children and adolescents or those who are immunosuppressed regardless of vaccination status. Do not routinely use sotrovimab in fully vaccinated patients unless immunosuppressed. Decisions about the appropriateness of treatment with sotrovimab should be based on the patient's individual risk of severe disease, on the basis of age or multiple risk factors, and COVID-19 vaccination status.

Doxycycline

Only in research: Do not use doxycycline for the treatment of COVID-19 outside of randomised trials with appropriate ethical approval.

Continuous positive airway pressure /high-flow nasal oxygen therapy

Conditional recommendation: Consider using continuous positive airway pressure (CPAP) therapy for patients with persistent hypoxaemia (defined as requiring an $FiO_2 \geq 0.4$ to maintain SpO_2 in their target range) associated with COVID-19. Adjust positive end-expiratory pressure as required, most patients require pressures of 10 to 12 cm. Excessive pressures may increase the risk of pneumothorax. Adjust oxygen to maintain SpO_2 in the target range, FiO_2 0.4 to 0.6. Patients requiring CPAP for COVID-19 pneumonia are at high risk of further deterioration, requiring intubation and mechanical ventilation. Liaise with ICU and monitor closely for deterioration. If CPAP is not available or not tolerated, consider HFNO as an alternative using the same safety parameters as CPAP.

Updated recommendation for use of systemic corticosteroids in pregnant women

The Taskforce has updated the corticosteroids for pregnant or breastfeeding women recommendation to support the use of a slightly higher dose of dexamethasone if steroids are indicated for fetal lung maturity in women at risk of preterm birth.

Seven new treatment recommendations for pregnant and breastfeeding women

Sotrovimab for pregnant women

Following recent recommendations for the use of sotrovimab in adults, the Taskforce has reviewed the evidence in the context of pregnant and breastfeeding women. Three new recommendations have been developed for the use of sotrovimab in pregnant women, reflecting the adult recommendations.

Conditional recommendation supporting its use in pregnant patients within the second or third trimester

who are at risk of disease progression.

Consensus recommendation for pregnant patients that are unvaccinated/partially vaccinated/immunosuppressed.

Research recommendation regarding the need for rigorous data collection.

Casirivimab plus imdevimab (REGEN-COV) for pregnant and breastfeeding women

Conditional recommendation supporting its use in pregnant or breastfeeding patients that are seronegative.

Do not use recommendation for pregnant or breastfeeding patients who are seropositive

Only in research recommendation for mild or asymptomatic pregnant or breastfeeding patients.

Magnesium sulfate

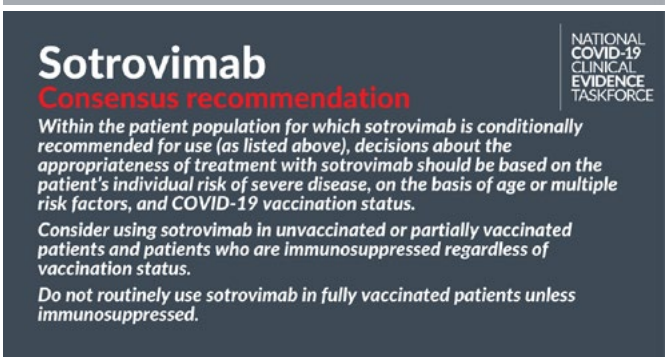
The Pregnancy and Perinatal Care Panel determined that there are substantial benefits for using magnesium sulfate for fetal neuroprotection in preterm birth, and for management of pre-eclampsia and eclampsia. There is currently no direct evidence to suggest additional harms of using magnesium sulfate for fetal neuroprotection in the setting of COVID-19.

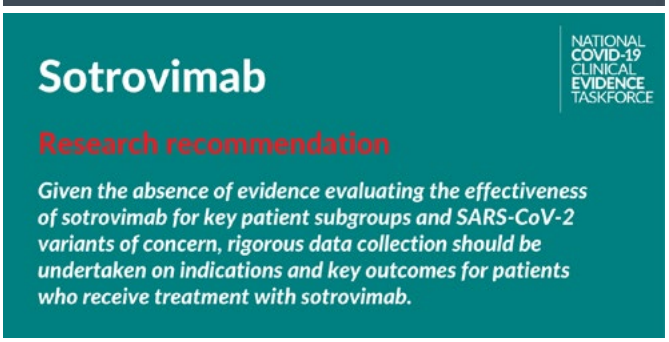
New conditional recommendation for casirivimab plus imdevimab (REGEN-COV) for post-exposure prophylaxis

Consider using subcutaneous casirivimab plus imdevimab as prophylaxis in seronegative or PCR-negative close household contacts of individuals with confirmed COVID-19. Currently casirivimab plus imdevimab is not available for use within Australia.

National COVID-19 Clinical Evidence Taskforce makes conditional recommendation for sotrovimab

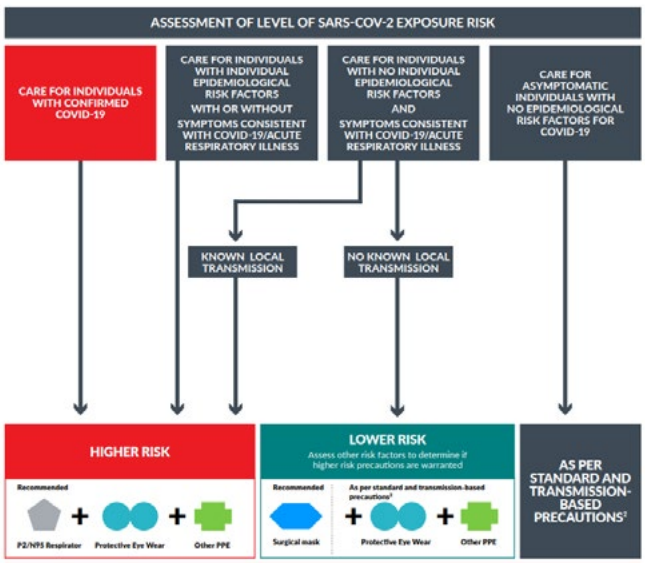
The National COVID-19 Clinical Evidence Taskforce, of which the College is a member, has published three recommendations on the use of sotrovimab for the treatment of COVID-19 in adults who do not require oxygen and who have risk factors for disease progression. These are the first recommendations from the Taskforce to use a drug to treat patients with mild illness.





New Respiratory and Eye Protection Decision Aid

As healthcare workers across Australia continue to face increased risk of exposure to SARS-CoV-2, the Taskforce Infection Prevention and Control Panel have developed a visual Decision Aid to help clinicians apply the PPE guidance in practice.



New immunodulatory treatments comparison table

The Taskforce has developed a comparison table of the recommended immunodulatory treatments (tocilizumab, baricitinib and sarilumab), including clinical and non-clinical information to help guide clinicians in selecting the most appropriate treatment for their patients.

Ivermectin FAQs

To support clinicians in providing evidence-based advice regarding the use of ivermectin as a treatment for COVID-19, the Taskforce has created a one-page pdf that covers our most frequently asked questions. This is available for download from the website here. The Taskforce recommends that ivermectin should only be used for the treatment for COVID-19 in the context of randomised trials with appropriate ethical approval.

Individual freedom, bodily integrity and public health orders: A decision of the Supreme Court of NSW

Dr Michael Eburn and
Dr Ruth Townsend

Kassam v Hazzard; Henry v Hazzard [2021] NSWSC 1320 (15 October 2021)

This case involved a number of people (the plaintiffs) who stated that they had made an informed choice to refuse to be vaccinated. This group asked the Supreme Court of New South Wales to set aside orders made by NSW Health Minister Brad Hazzard, Chief Medical Officer Dr Kerry Chant, the State of NSW and the Commonwealth of Australia. The proceedings challenged those orders which prevented "authorised workers" from leaving an affected "area of concern" and those which prevented some people from working in the construction, aged care and education sectors, unless they had been vaccinated with one of the approved COVID-19 vaccines.

The plaintiffs relied on various grounds to establish the invalidity. It was argued that the Public Health Act did not authorise the making of the orders, that the way in which the Minister exercised his power was unreasonable, that the orders were unreasonable because of their effect on fundamental rights and freedoms, that the orders were made for an improper purpose, that the Minister failed to take into account relevant considerations when making the orders, and that he was obliged to but failed to afford the plaintiffs natural justice. It was also argued that the orders conferred powers on the police that were outside their authority.

DECISION

The Court rejected all grounds of challenge of the orders and dismissed the proceedings. The Court noted the following in its decision:

- It is not the Court's function to determine the merits of the exercise of the power of the Minister. It is a matter for Parliament to determine what powers are granted to the Minister. The Court could determine if the Minister was working within the power the Parliament had delegated to him, but could not determine if he should have that power.
- The Court also observed that the respective merits of policy and fact in regards to COVID-19 responses were also a matter for others; that is, public health experts and government, not the court. That is, the fact that the Minister, or any decision-maker, has options is a matter for them. The Court cannot decide that they should have preferred one option over another. The Court's only function is to determine the legal validity of the orders, which includes "considering whether it has been shown that no Minister acting reasonably could have considered them necessary to deal with the identified risk to public health and its possible consequences".
- With respect to the effect of the orders on the rights and freedoms of those who choose not to be vaccinated, particularly with regard to their right to bodily integrity, the court noted the argument based on the principle of legality, that is "in the absence of a clear indication to the contrary, it is presumed that statutes are not intended to modify or abrogate fundamental rights". The problem for the plaintiffs was that the very purpose of the Public Health Act 2010 (NSW) is to allow the Minister to restrict individual rights in the interests of public health. In other words, the Public Health Act gives the necessary "clear indication" that it is intended to limit rights and freedoms, so the principle could offer no assistance.
- The Court found that the orders do not limit individual bodily integrity. Vaccinations are not compulsory; a person is free to choose to get the vaccine or not. The judge said, "When all is said and done the proper analysis is that the impugned orders curtail freedom of movement, which in turn affects a person's ability to work (and socialise). So far as the right to bodily integrity is

concerned, it is not violated as the impugned orders do not authorise the involuntary vaccination of anyone".

- In terms of limits on individual freedom, the degree of limitation on movement differs according to vaccination status. The Court found that curtailing the free movement of people, including their movement to and at work, are the very type of restrictions that the Public Health Act clearly authorises and does so for a clear purpose - public safety. The court found the exercise of this power reasonable. It said that if the orders interfered with individual freedom on an arbitrary basis unrelated to a risk to public health, for example on the basis of race, gender or the holding of a political opinion, then that would risk being invalid because it was unreasonable. However, "the differential treatment of people according to their vaccination status is not arbitrary. Instead, it applies a discrimen, namely vaccination status, that on the evidence and the approach taken by the Minister is very much consistent with the objects of the Public Health Act".

Davis v Minister for Health [2021] NSWCATAD 310 (25 October 2021)

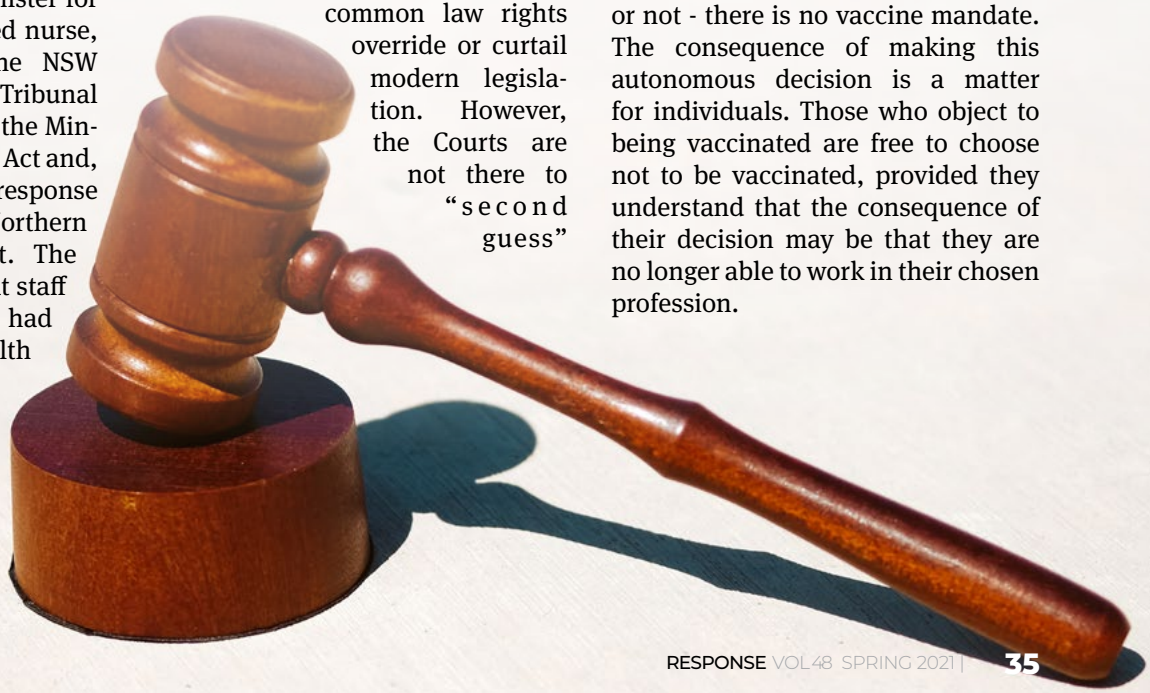
As this paper was being prepared for publication, a further decision was handed down in Davis v Minister for Health. Ms Davis, an enrolled nurse, brought proceedings in the NSW Civil and Administrative Tribunal challenging orders made by the Minister under the Public Health Act and, further, challenging the response to those orders by the Northern NSW Local Health District. The Minister's order required that staff employed by NSW Health had to be vaccinated. The Health District's response was to advise Ms Davis that as she had not provided evidence of her vaccination status, she was placed on unpaid leave and invited to make submissions on whether her employment should be terminated.

The Tribunal determined that it did not have the jurisdiction to review the Minister's decision: "The function of determining the legal validity of the PHO [Public Health Order] is, as confirmed in Kassam; Henry at [68], for the Supreme Court to discharge, and not this Tribunal." The actions taken by the Health District were also outside the Tribunal's jurisdiction. The power to suspend or terminate Ms Davis' employment was to be found in the Health Services Act 1997 (NSW) and that Act did not give any "relevant source of jurisdiction for the Tribunal to conduct review of such a decision".

This case did not determine the merits of a claim, only that the Tribunal did not have the jurisdiction to review the decisions, but it is a further defeat for those seeking to resist the response to the COVID pandemic.

DISCUSSION

Many people, including some paramedics, have objected to the scope and nature of the response to the COVID pandemic. Many cases are being brought in the Australian courts. It is appropriate that the Courts are available to air grievances and to allow people to challenge these far-reaching decisions. Many want to argue that the decisions are invalid on irrelevant or misguided grounds, including a belief that historical common law rights override or curtail modern legislation. However, the Courts are not there to "second guess" authorised decision-makers. Their only role is to determine if the decision-makers have acted according to law as determined by Parliament.



So far, the Courts have generally determined that the decision-makers are acting within their power (see also for example Loielo v Giles [2020] VSC 722 and Palmer v Western Australia [2021] HCA 5). Kassam and Henry v Hazzard confirms that in NSW the Public Health Act does permit limitations to be placed on individual liberties in the interests of the collective. In this way it is no different from many other laws, including, for example, road traffic laws. These laws are necessary to maintain public safety. These laws are an example of a freedom paradox. In giving up some freedom, for example the freedom to speed without penalty, we create freedom. That is, we give up some freedom to get a greater freedom. Knowing that everyone is more or less abiding by the road rules allows us to be free of the fear that there is a high chance of being killed or injured while travelling. We know the risk of harm exists, but we factor in that the risk is very low, therefore we feel safer and therefore freer to make travel choices.

In terms of the impact of this decision on paramedics and other health care practitioners, what the court has said is that individuals are able to voluntarily decide to get vaccinated or not - there is no vaccine mandate. The consequence of making this autonomous decision is a matter for individuals. Those who object to being vaccinated are free to choose not to be vaccinated, provided they understand that the consequence of their decision may be that they are no longer able to work in their chosen profession.

Randomised Controlled Trials

Michelle Thomson | Harry Reeves | Amy Hutchison

INTRODUCTION

We live in a time of increasing demand and patient expectation. More than ever before, it is required that paramedics prove that the medicine they practice is based on the best scientific evidence. Evidenced based medicine (EBM) is a systematic approach to clinical problem-solving using the best available research, clinical expertise, and patient values[1]. When appraising and understanding evidence pertaining to a topic, it is important to look for research with the highest available level of evidence from the "hierarchy of evidence" (Figure 1).[9]

Randomised control trials (RCTs) are considered "Level II" evidence.[9] RCTs seek to compare the impact of an "intervention" to a "control" on a defined outcome, trumped only by a systematic review of well-conducted RCTs, which is considered "Level I" evidence.[9] In this article, we'll delve into RCTs and their applicability to paramedicine, provide advice on how to assess quality, and discuss the role of the paramedic as "on road" contributors to an RCT.

Figure 1: Levels of Evidence (Source: National Health and Medical Research Council)

Level of evidence	Study design
I	Evidence obtained from a systematic review of all relevant randomised controlled trials
II	Evidence obtained from at least one properly designed randomised controlled trial
III-1	Evidence obtained from well-designed pseudo-randomised controlled trials (alternate allocation or some other method)
III-2	Evidence obtained from comparative studies (including systematic reviews of such studies) with concurent controls and allocation not randomisation, cohort studies, case-control studies or interrupted time series with a control group.
III-3	Evidence obtained from comparative studies with historical control, two or more single arm studies, or interrupted time series wihtout parallel control group
IV	Evidence obtained from case series, either post-test or pre-test/post-test
V	Non-analytic studies (case report), expert opinion, and formal consensus documents (position statements)

METHODOLOGY OF AN RCT

RCTs are highly regarded in the scientific community and are often used to inform changes in clinical practice[6]. In order to conduct an RCT, is it important to ask whether the research is needed due to unavailable literature or uncertainty in the medical field. This is termed "clinical equipoise". The basis of an RCT is simple; randomly assign patients to two or more groups and compare the outcomes. The first group of patients will receive the treatment that is being experimented, and the second group receives a conventional treatment or a placebo[6]. The design of a RCT is illustrated in Figure 2.

Randomisation can be done in a number of ways, for example:

Simple randomisation: Essentially, the simple "coin toss" principle. Patients get allocated one by one, which is highly effective, until there is a long run of tails causing an uneven spread.

Block randomisation: This method creates clusters of participants, using a random pattern to assign them to

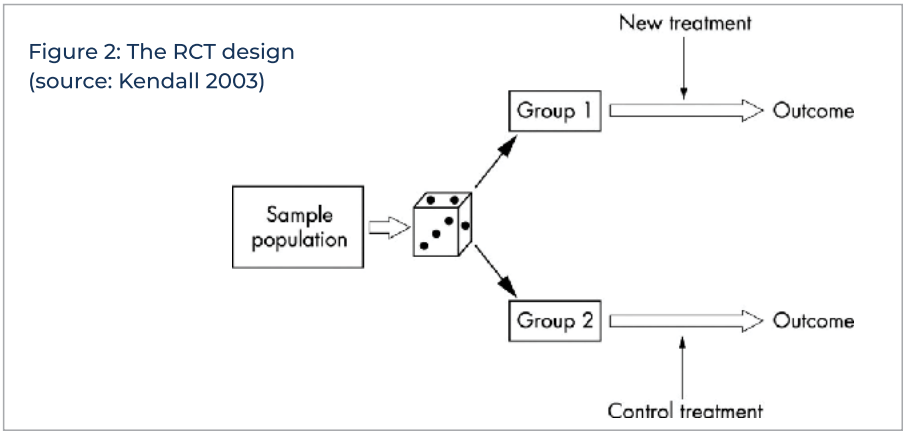


Figure 2: The RCT design (source: Kendall 2003)

different treatment arms, while allocating equal numbers in each cluster (e.g., AABB or ABAB).

Paramedics will, in most instances, be responsible for the enrolment of an eligible patient and their subsequent randomisation to an intervention or control group while managing concurrent clinical care priorities, so diligent adherence to the RCTs study protocol is critical to the successful conduct of the trial.

RCTS PERFORMED IN PARAMEDICINE

While RCTs are simple in theory, there are countless factors that make them logistically challenging to carry out. Managing an RCT in any environment is difficult, but the out-of-hospital setting presents its own unique challenges.

The PARAMEDIC-2 trial is a prime example of this[11]. This study was a double-blinded, randomised controlled trial to determine if patients who had an out-of-hospital cardiac arrest (OHCA) had improved survival outcomes with the administration of adrenaline versus a placebo. Adrenaline has been routinely used in OHCA as there appeared to be evidence that it increased chances of a return of spontaneous circulation (ROSC); however, expert concern existed surrounding the risk of poor neurological outcomes. This concern created equipoise, and was the basis for considering a trial to better understand its use in this setting. [11]

In the PARAMEDIC-2 trial, trial-trained paramedics were provided with uniquely numbered, identical pre-prepared packs that had either adrenaline or saline in them. More than 8,000 patients were part of this trial, and all were treated according to the ALS algorithm. This trial concluded that adrenaline administration demonstrated improved long-term survival, but there was no evidence that it improved neurological outcomes. While this study has contributed to greater knowledge in OHCA, further research is still needed. As the PARAMEDIC-2 trial demonstrates, RCTs are integral to the development of a body of research that informs clinical practice.

RCTS IN AUSTRALIAN PARAMEDICINE

Australia has a rich history of RCTs exploring different areas in paramedicine. Here are just a few examples of RCT design being used to answer diverse research questions. In 2010, Bernard et al conducted an RCT in Victoria comparing rapid sequence intubation (RSI) to non-RSI for patients with severe head injury.[4] In 2011, Jacobs et al published a prehospital RCT from WA investigating adrenaline versus placebo in OHCA and providing a platform for the more recent UK PARAMEDIC-2 study.[5] In 2015, Stub et al published the high-profile AVOID trial from Victoria, in which they compared air to oxygen therapy in non-hypoxic patients experiencing ST-segment myocardial infarction.[12] In 2017, Mikolaizak et al reported an RCT investigating a falls referral intervention in NSW for older people who had fallen and were not being transported.[8]

ETHICAL ISSUES ASSOCIATED WITH RCTS

Human research must be conducted in line with the National Health and Medical Research Council's National Statement on Ethical Conduct in Human Research along with Good Clinical Practice Guidelines as mandated by the International Conference on Harmonisation[2]. Basically, these documents serve to protect the people being researched and the clinicians and researchers involved in the project.

The main concepts in these guidelines are:

- Gaining informed consent from the people being researched.[2] This means providing them with information about all aspects of the research project and ensuring they are willing to participate. This can be particularly challenging in paramedicine in time-sensitive contexts where the patient may not be able to provide informed, valid consent. We recommend the article by Armstrong et al (https://bmcmedresmethodol.biomedcentral.com/articles/10.1186/s12874-017-0423-4) as an excellent resource for learning more about prehospital consent models and associated issues in RCTs.
- Maintaining privacy and confidentiality.[2] The researchers will identify the patient by a number or a unique code and must remove anything with any personal identifiers.
- Rigorous trial management, data handling and record keeping.[2] This serves to ensure that critical data doesn't reach the wrong hands and is kept secure for up to 15 years after the study ends.
- Reporting of adverse reactions or ethical breaches.[2] Any time there is a severe reaction or event as a result of the research project, it must be reported to the study team and the ethics committee to determine whether the research project is suitable to continue.[2]

HOW CAN YOU TELL IF AN RCT IS RIGOROUS?

There are several factors that determine if an RCT has been conducted in a way to produce rigorous results. The biggest clues are hidden in the study design. Some to consider are:

- Sample size: Was the study successful in enrolling enough patients to meet the predetermined sample-size calculations? If not, the study may be considered to be "underpowered" and may be more prone to an erroneous result.[7]
- Randomisation technique: Was the study randomised in a proper way? Computer-generated randomisation would represent the "gold standard".
- Allocation concealment: Ideally, allocation to intervention or control should be concealed until after a patient is enrolled, reducing the chance of selection bias emerging. For example, the EVIDENCE trial currently underway in NSW utilises a smartphone app to allocate a patient to the intervention or control after they've been enrolled.[10]
- Blinding: This refers to making sure, whenever possible, that paramedics, participants and analysts are "blind" to who received the intervention or the control. Blinding reduces the potential for bias. A study can be "single blinded" (where the patients do not know to which group they've been allocated), "double-blinded" (neither paramedic or patient knows) or "triple-blinded" (neither paramedic, patient nor the researcher assessing the outcomes knows). However, it is not always feasible to "blind" the paramedics. For example, the AIRWAYS-2 trial from the UK could not blind paramedics as it was comparing endotracheal intubation to supraglottic airway in OHCA.[3]
- Loss to follow up: Was an outcome determined for all the patients enrolled in a study? Sometimes, patients are enrolled into an RCT and receive an intervention or control, but for a range of reasons are "lost to follow up. This introduces uncertainty when comparing overall outcomes for two groups. The more patients lost to follow up, the less robust the final result will be.

There are some great resources available for free that can help you asses the quality of a RCT. We recommend the JBI suite of quality assessment tools, available at https://jbi.global/critical-appraisal-tools.

SUMMARY

Well-conducted RCTs constitute a high level of evidence that have the potential to profoundly influence paramedic practice and improve the quality of out-of-hospital care. They are challenging to conduct and complex to design. Paramedics play a critical role in contributing to the success of an RCT; it is important that paramedics increase and develop research literacy in relation to RCTs as this may promote point-of-care engagement in clinical trials and increase capacity to interpret evidence and integrate it into practice.

WANT TO KNOW MORE?

If you want to learn more about the basics of how RCTs are conducted and hear from some researchers who have worked on RCTs in the paramedic setting, head on over to the College website and look at our latest Talking Research Webinar.

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The demographic and clinical practice profile of Australian remote and industrial paramedics: Findings from a workforce survey

https://doi.org/10.33151/ajp.18.959

Joseph James Acker, Ms
Tania Johnston

Introduction

A large workforce is employed in remote environments in the Australian mining and fuel sectors. Whereas paramedics are increasingly assuming roles as healthcare providers in these locations, little is known about industrial paramedic practice. The aim of this exploratory study was to better understand the demographics, education, clinical practice and work environment of the Australian paramedic workforce in remote and industrial settings to inform future research and education for the emerging specialty.

Results

Paramedic participants working in remote and industrial settings are predominately male (86.5%) with the majority aged 35 to 44 years (38.7%). Their job titles range widely and include paramedic, intensive care paramedic, industrial, mine and offshore paramedics. Participants report an average of 15.4 years of total healthcare experience and working in the remote or industrial health sector for a mean of 7.1 years, primarily in Western Australia (34.2%). These paramedics often engage in continuing education, with 45% studying at a vocational or tertiary institution at the time of the survey. Most respondents (63.9%) describe their employment as directly or indirectly related to the natural resource sector and 75.7% have experience in remote settings such as camps, mining sites, offshore platforms, vessels or small communities. Most practitioners (59.5%) work in a full-time capacity and can perform core paramedic skills including intravenous cannulation, 12-lead electrocardiogram interpretation, chest needle decompression and restricted drug administration. More than 40% of those actively working in the sector report having endotracheal intubation and intraosseous access in their scope of practice. They also administer immunisations, antibiotics and other prescription medications, manage chronic diseases, and perform low-acuity skills typically included in a community paramedic role.

Conclusion

This workforce survey is the first of its kind designed to gain a broader understanding of the paramedic practitioners who work in remote and industrial settings and the characteristics of their work environment. Key areas highlighted by this study serve to inform professional regulators, educators and employers with respect to the skills that remote and industrial paramedics perform and the education that is required to support the evolving specialised practice.

Describing a 12-hour ambulance shift during a second wave of COVID-19 in London

https://doi.org/10.33151/ajp.18.976

Alexandra Rengers, Emma Day, Steve Whitfield

Introduction

The coronavirus disease (COVID-19) and infectious virus, SARS-CoV-2, have strained international health care systems, placing pressure on

health care systems including ambulance availability. Ambulance officers and paramedics have been at the forefront of this pandemic and particularly exposed. Under normal operational circumstances, ambulance delivery is challenging with research demonstrating that ambulance work is one of the most dangerous professions due to a multitude of reasons. It remains one of the most dangerous jobs in countries including Australia, the United Kingdom and the United States of America.

There has been little published regarding the experiences of frontline paramedics during the COVID-19 pandemic. This critical reflection will describe a 12-hour emergency ambulance dayshift in central London during the second wave city-wide lockdown. It also discusses the impact COVID-19 has on day-to-day operations, and discusses several strategies currently employed to reduce paramedic exposure to COVID-19.

Conclusion

The COVID-19 pandemic has impacted the delivery of ambulance services around the world. More emphasis must be placed on risk mitigation strategies and PPE measures to safeguard paramedics so they can continue their vital work in the community. This critical reflection was a description of a 12-hour shift in London during the second COVID-19 outbreak in 2021. It is intended for this critical reflection to add to the experiential data of paramedics working during a pandemic.

The role of educational theory in the future development of paramedicine as a profession: An integrative review

https://doi.org/10.33151/ajp.18.941

Andy Bell, Sara Hammer, Amy Seymour-Walsh

Introduction

Paramedicine is at a critical juncture in its history as a healthcare profession. The evolution of paramedic practice in Australia over recent decades has culminated in its inclusion as a nationally registered, accredited, healthcare profession, while similar development is also occurring worldwide. Although paramedic education has developed over time, it is now the moment to determine whether existing educational approaches can adequately support its ongoing evolution as a profession. This article shares findings of a systematic, integrative review of characteristics of professions, allied health education and paramedic education literature.

Results

The literature review highlighted consistent themes relevant to paramedic education such as, the socio-political definition of a profession, methods for the identification of a profession, paramedicine as a distinct healthcare profession and the contemporary paramedic education framework.

Conclusion

Based on findings from this integrative review, we conclude that there is a potential misalignment between existing paramedic curricula and the educational scaffolding required to develop practicing paramedic professionals. We recommend further investigation of this potential misalignment as part of conceptualising an effective, quality, educational framework that is fit-for-purpose.

A comparison of Australasian jurisdictional ambulance services' paramedic clinical practice guidelines series: Adult anaphylaxis

https://doi.org/10.33151/ajp.18.915

Matt Wilkinson-Stokes, Desiree Rowland, Maddison Spencer, Sonja Maria, Marc Colbeck

Introduction

This article forms part of a series that seeks to identify interjurisdictional differences in the scope of paramedic practice and, consequently, differences in patient treatment based on which jurisdiction a patient is geographically located within at the time of their complaint.

Methods

The current Clinical Practice Guidelines of each Australasian domestic jurisdictional ambulance service (JAS) were accessed during June 2020 and updated in August 2021. Content was extracted and verified by 18 paramedics or managers representing all 10 JASs.

Results

All JASs use intramuscular adrenaline as a first-line agent for adult anaphylaxis. Beyond this, significant differences exist in all treatments: five services provide nebulised adrenaline; 10 services provide adrenaline infusions (one requires doctor approval; one provides repeat boluses); six services provide nebulised salbutamol; two services provide salbutamol infusions (one requires doctor approval; one provides repeat boluses); five services provide nebulised ipratropium bromide; eight services provide corticosteroids (two restricted to intensive care paramedics (ICPs)); five services provide antihistamines for non-anaphylactic or post-anaphylactic reactions; four services provide glucagon (one requires doctor approval); magnesium is infused by ICPs in two services; 10 services allow unassisted intubation in anaphylactic arrest; one service allows ICPs to provide sedation-facilitated intubation or ketamine-only breathing intubation; eight services allow rapid sequence induction (two restricted to specialist roles).

Conclusion

The JASs in Australasia have each created unique treatment clinical practice guidelines that are heterogeneous in their treatments and scopes of practice. A review of the evidence underlying each intervention is appropriate to determining best practice.

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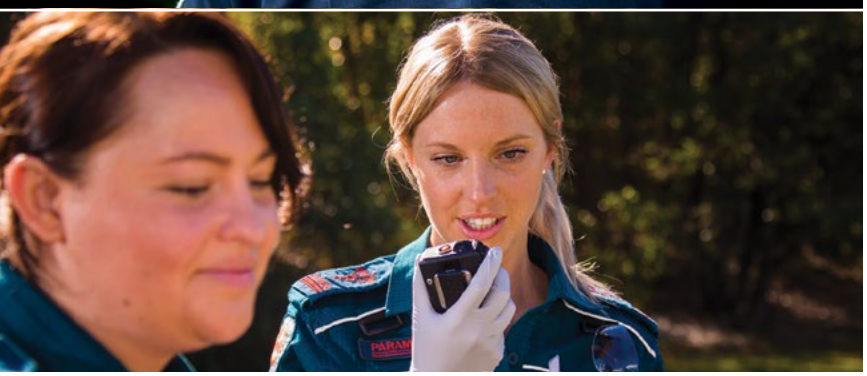

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