Australasian College of Paramedicine

RESPONSE

WINTER 2022

www.paramedics.org

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COVER

Image: Lauren Del Bene.

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

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

FROM THE CHAIR

MOMENTUM BUILDS FOR BROADER PARAMEDIC ENGAGEMENT

with **Ryan Lovett,** College Chair

WE ARE SEEING OUR ADVOCACY AND VOICE FOR THE PROFESSION GAINING TRACTION IN NATIONAL MEDIA AND A CROSS-SECTION OF THE POLITICAL SPHERE

Welcome to the Winter edition of Response.

As I write this column, we find ourselves in the midst of what is anticipated to be a pivotal time for paramedicine and its position within the healthcare system at large. While pressures have mounted on health services, including ambulance services, hospital-based staff and GP clinics, we have been continuing to drive our advocacy work forward and looking to broaden exposure and discussions with relevant stakeholders about ways to better resource our health system through improved utilisation of our paramedic workforce.

I recently appeared for the second time on ABC's Radio National Breakfast program and was able to highlight the opportunities that exist to employ paramedics in the primary healthcare space, particularly in regional and remote Australia where we know there are critical workforce shortages. It was pleasing to have this concept supported in the interview by Royal Australian College of General Practitioners Vice President Dr Bruce Willett, and share the call for funding streams to facilitate such a solution.

As with the RN Breakfast interview, we are seeing our advocacy and voice for the profession gaining traction in national media and a cross-section of the political sphere. Our intent is to continue to build on this momentum as we look to raise the profile of the profession with national governments and in the health sector, having now been a nationally registered health profession in Australia since December 2018 and in Aotearoa New Zealand since April 2021.

With that national recognition and regulation now in place in both countries, the profession needs to ensure its ability to live up to the promise of a truly national health profession, charting a unified course and a cohesive path forward; building on the strength of our jurisdictional history but also ensuring our progress is not confined to a jurisdictional or employer level. We unequivocally respect and value the role of employers as key drivers of innovation and professional identity, and we see a great opportunity to foster collaboration to pursue our shared goals for paramedicine with the weight of numbers and a system-wide approach.

The College is addressing this priority of a collective approach by initiating discussions with a range of key stakeholders, including employers, medical colleges, government, regulators, healthcare workers and administrators, and ensuring a presence in forums and platforms where we can contribute to finding solutions. As John Bruning, College CEO, will mention in his column in the next edition of the Council of Ambulance Authorities' First magazine, the College's annual international conference is approaching in September. We will take the opportunity to hold some key strategic workshops and discussions at the conference to ensure broad input and consultation with our members and stakeholders and work to ensure that our voice is truly representative of our profession.

The current state of our healthcare systems is not sustainable, and while change can feel slow, it is critical at this stage to ensure we take a long-term view and a broader perspective, as actions taken now in one part of the sector have the potential to have consequences across the profession that may take years to move past.

For this reason, it is more important than ever to come together and work at national and regional levels so that we can leverage our collective experience and expertise for the benefit of our patients, our community and our profession.

Stay safe.

FROM THE CEO

WELLBEING IN THE TIME OF COVID

with **John Bruning,** College CEO

The health system continues to be under unprecedented pressure and stress with more virulent COVID strains and the resurgent winter flu. The term health system makes it easy for the community to forget that the health system is people; it relies on people delivering the service as paramedics, doctors, nurses, and other health professionals. So, a health system under pressure and stress is paramedics and other health professions under pressure and stress. Paramedics must be commended for the way you have, and continue, to care for the community and your patients.

The mental, emotional, and physical wellbeing of paramedics is paramount to the College. In normal times, the mental and emotional toll that working in emergency response has on paramedics is high, but the past two years has certainly added to that. The College made an important contribution to paramedic wellbeing through the Survive and Thrive symposiums from 2016-2018, which lead to improved efforts across the sector to better care for paramedics.

The College continues to work in this space through the Paramedic Wellbeing Working Group, who work with staff to support the mental, emotional, and physical health and wellbeing of paramedics. The Working Group is focused on initiatives, education, and research to improve paramedic wellbeing.

To support our members, the College has partnered with Health@Work to deliver a Healthy Body & Mind Hub; a dedicated online space for members to access a range of resources and learning to support your health and wellbeing. Content is updated each month, with some key resources this month covering Living Resiliently and including webinars on Overcoming Adversity and Bounce Back & Beyond, a 10-minute live class on Stress Management Techniques, a 30-day "Building Resilience and Overcoming Adversity" Challenge, a 10-minute fitness circuit live class, recipes, and a library to access all body and mind recorded classes. I highly recommend our members taking the time to look at the Hub and seeing if anything resonates with you to support your health and wellbeing.

Mostly, I want to remind you to take care of yourself; as the saying goes, you cannot pour from an empty cup. Find time to do things you love and that you enjoy and help you recharge and refresh. You are valuable, not just to the health system, but to your family and friends; remember that and ensure you prioritise yourself and things that are important to you.

ACP International Conference

Our flagship conference is now less than two months away and the program and workshops are coming together. There has been limited opportunity for the profession to get together in the past couple of years, so if you are like me, you will be looking forward to the chance to catch up with old and new friends in person. I hope you can join us!

Alongside of the usual conference program, the College will be running several strategic workshops with small groups to get input into key strategic areas. It's important the College helps lead the profession for the benefit of the profession, as the only national/international body in Australia and Aotearoa New Zealand that represents all paramedics and student paramedics. There are many vested interests in taking paramedicine in various directions, and it's important that paramedics have their voices heard in where the profession goes.

The strategic workshops will cover several key topics, such as the Future of Paramedicine, the Position of Paramedicine in the Health System, Paramedicine Level/Role Descriptors, Future Workforce Requirements, and Clinical Fellowship. These workshops will have limited space, so keep an eye out for detail on these and EOIs if you wish to participate.

Stay safe and well.

A DEDICATED ONLINE SPACE FOR MEMBERS TO ACCESS A RANGE OF RESOURCES AND LEARNING TO SUPPORT YOUR HEALTH AND WELLBEING

A NEW LOOK, **A NEW ADVOCACY TEAM** AND INNOVATIVE NEW APPROACHES

By **Jacintha Victor John**, College Advocacy and Government Relations Manager

Since joining the college in May 2022, I have been working closely with the College's Advocacy and Government Relations Leads Kirsty Mann and Michelle Murphy ASM to develop an advocacy strategy to deliver on our goal of advocating for expanded roles for the paramedicine profession within Australia and Aotearoa New Zealand's healthcare systems.

As I venture into the world of paramedicine and begin to better understand the profession, it is abundantly clear that the profession has steadily evolved and that primary care workforces have undergone significant changes. Our goal is to educate the government and stakeholders to recognise the unique contributions paramedics can make in improving health services nationally.

Health literacy is crucial to shifting policymakers' mindsets away from the traditional association of paramedics with the provision of emergency care within an emergency medical service and responding to life-threatening emergencies through the 000-call system. To strengthen current primary healthcare providers and address the existing workforce shortages and gaps in health services, policymakers need to expand paramedic roles that will benefit the health sector and, ultimately, all communities.

I'm excited to be part of this incredible journey to advocate for broader paramedicine placement within the health sector.

To achieve these goals, we have engaged a new media outlet to promote stories about the work paramedics doing and raise awareness across government, the health sector and the broader community about the work our members undertake each day.

We will continue to work in the background to change legislation and build unity and support for advancing the opportunities for paramedics to contribute to the healthcare needs of their communities.

Your voice

To give a voice to the paramedic profession, your voice is essential in developing our priorities and where we focus our advocacy. For us to successfully represent and advocate for you in a meaningful way, we require your engagement with us.

We ask you to share your experiences and ideas and have your voice heard on topics to help us along this journey.

Please take a minute to complete this short five-question survey. Have your say on what is critical to you and the future of paramedicine here or via the QR code:

College CEO John Bruning and Advocacy Manager Jacintha Victor John discussed the role of paramedicine with the Commissioner Adj. Professor Ruth Stewart and Deputy Commissioner Assoc. Professor Faye McMillan AM at the Ngayubah Garan Summit

College consultations and submissions

In the past three months, our advocacy efforts have involved:

- The College is part of the Smart AEDs NSW Working Group connecting with more than 30 industry leaders and stakeholders to understand and detail the current challenges in the industry and confirm ways in which the NSW Government can provide support in the capacity of governance and data architecture.
- The College attended the Australian Medical Association Virtual Town Hall Panel discussion on the AMA Ramping Report Card 2022.
- The College was invited to the rural health sector Ngayubah Garan (Coming Together) Summit, where we joined more than 50 other rural health stakeholders with the National Rural Health Commissioner to draft a Consensus Statement on Rural and Remote Health Teams (rural generalist multidisciplinary teams).
- The College continues stakeholder engagement work surrounding Urgent Care Clinics and Community Paramedicine as a critical part of our advocacy work.

Submissions

The College submitted the following submissions:

- Skills IQ Ambulance and Paramedic Industry Reference Committee (IRC) Industry Summary.
- Australian and New Zealand Standard Classification of Occupations (ANZSCO) Option Paper.
- Australian and New Zealand Standard Classification of Occupations (ANZSCO) Maintenance Strategy.

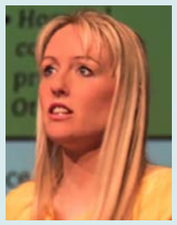
INTRODUCING **PARAMEDICINE** - THE COLLEGE'S NEW INTERNATIONAL PEER-REVIEWED SCIENTIFIC JOURNAL

In July 2022 at the ACP Research Symposium on the Sunshine Coast, Associate Professor Paul Simpson released new details about the College's exciting new journal, specifically its new name and editorial team. What was previously the "Australasian Journal of Paramedicine" will now officially become "Paramedicine", an international peer-reviewed journal that continues the long history of the College's commitment to scientific publishing in our profession.

Critical to the creation of its new identity as a truly international journal has been the recruitment of an Editorial Board with international representation and reach. The new editorial team consists of the Editor-in-Chief, Associate Professor Paul Simpson, and Deputy Editors Associate Professor Walter Tavares (Canada), Professor Julia Williams (UK), Dr Alan Batt (Canada) and Dr Kathryn Eastwood (Australia). The expertise of the Editorial Board is evidenced by their profiles described below.

Editor-in-Chief

Dr Paul Simpson is an Associate Professor at Western Sydney University (WSU) and an AHPRA-registered Intensive Care Paramedic with NSW Ambulance. Paul has been engaged in the paramedicine profession since 1996, working in a range of clinical and research roles in the private and statutory ambulance service settings. He was the inaugural Director of Paramedicine at WSU, and is the immediate past-Chair of the Australasian Council of Paramedicine Deans. Paul served as Chair of the Australasian College of Paramedicine' Journal Advisory Committee and was the Editor-in-Chief of the Australasian Journal of Paramedicine. He has a Master's in Clinical Epidemiology and a PhD in public health and community medicine, during which he investigated the clinical outcomes of older people who had fallen and received care from paramedics.



Deputy Editors

Dr Kathryn Eastwood ASM has been an Intensive Care Paramedic in Victoria since 2000, and is a Research Fellow in the Department of Epidemiology and Preventive Medicine at Monash University and the Victorian Institute of Forensic Medicine. Dr Eastwood was a Senior Lecturer at Monash University for 15 years, educating undergraduate and postgraduate paramedics, nurses and military personnel in pre-hospital medical care. She was an editor and author of the first Australasian Paramedicine textbook. In 2019, Dr Eastwood was honoured with an Australian Day award, the Ambulance Service Medal, for meritorious service in her research and educational activities. Her research ranges from Health Services Research, Epidemiology, Clinical and Educational Research and external-cause death-related research. She has sat on the editorial board of the Frontiers Public Health journal and actively peer reviews for a broad range of international journals. Dr Eastwood currently holds a National Heart Foundation Postgraduate Fellowship to conduct cardiovascular research at Monash University.

Dr Walter Tavares is a scientist and Assistant Professor in Health Professions and Practice in the Department of Health and Society, the Wilson Centre for Health Professions Education Research, the Institute of Health Policy Management and Evaluation and Department of Medicine at the University of Toronto in Ontario, Canada. He also holds an adjunct Associate Professor position with Monash University in Australia. He is an internationally trained paramedic with York Region Paramedic and Senior Services in Ontario Canada. He is co-chair of the McNally Project - a research capacity development strategy in Canada. Dr Tavares has a PhD in Health Research Methods with a specialization in education and teaches at both the undergraduate and graduate level. He has published extensively on and continues to study topics related to health professions education and assessment, and paramedicine as a community health and social services.

Dr Alan Batt is an adjunct Senior Lecturer in Paramedicine at Monash University, and Professor in the Paramedic Programs at Fanshawe College in Ontario, Canada. He originally qualified as a paramedic in Ireland, and since then has gained experience in nine countries across four continents. He is a scientist and co-chair of the McNally Project for Paramedicine Research - a research capacity development strategy in Canada, as well as a Fellow of the Higher Education Academy. Alan has a PhD with a focus on health professions education, and teaches paramedics and other health professions at both undergraduate and postgraduate levels. His program of research focuses on the changing nature of health professions education, the evolving role of the paramedic, social determinants of health, and the care of vulnerable and marginalized populations.

Dr Julia Williams is a Professor of Paramedic Science at the University of Hertfordshire in the UK, being employed in a clinical academic post in collaboration with South East Coast Ambulance Service NHS Foundation Trust, where she works clinically as well as being the Head of Research for the Service. In

CONTINUED ON PAGE 8

eLEARNING A HIT WITH COLLEGE MEMBERS

Our new Clinical Education Officer
Shonel Hall

More than 2000 people have enrolled in the College's new eLearning portal since its launch in March, and the feedback has been overwhelmingly positive.

"Finally, a good support tool for on-road paramedics. Bravo! So impressed and excited to use and share my new knowledge with confidence," was just one example of the comments we've received from our members, this one for our obstetrics module 4 on post-partum haemorrhage.

The eLearning portal is a valuable suite of evidence-based, professional education programs designed to enhance the transfer of skills and knowledge to real-life practice. Featuring case studies and activities that are based on real-world examples, it's 100% online and is specifically developed for paramedics and relevant to all paramedics irrespective of their level of practice. Our courses are peer-reviewed, adaptive and engaging, and are designed to be self-paced to enable members to work in accordance with their own schedules and study time requirements.

And to enable members to access eLearning on the go, we've now incorporated a mobile-friendly platform option. We're also receiving valuable feedback that we will use to further develop this important education tool.

Courses/modules now available include:

- Obstetrics module 1 – Management of physiological birth
- Obstetrics module 2 – Management of nuchal cord
- Obstetrics module 3 – Management of shoulder dystocia
- Obstetrics module 4 – Management of post-partum haemorrhage
- Wound care for paramedics
- Clinical training and mentoring
- Understanding and caring for patients with MND
- End of life law for clinicians (offered by the Palliative Care Education and Training Collaborative)

Courses currently in development include mental health (common mental illnesses in the community) and stroke, obstetrics module 5: Assessment and care of the pregnant patient, and the first module in Paramedic Responsibilities: Mandatory reporting.

We also welcome Shonel Hall to the Education Team as Clinical Education Officer. Shonel is a registered paramedic and registered midwife, and has worked in university education. Her background brings new skills and perspectives to our work and is helping to further advance our now extensive list of education materials and tools.

CONTINUED FROM PAGE 7

addition, she is an adjunct Professor at Queensland University of Technology in Brisbane, Australia, and a Fellow of the College of Paramedics in the UK. Dr Williams has extensive experience of undertaking research in a variety of healthcare settings involving a diverse range of topics, methodologies and methods. She has been immersed in the undergraduate and postgraduate education of paramedics over the years and is proud to have supported (and is still supporting) a growing number of paramedics through to successful completion of their doctoral studies. As Head of Research for the College of Paramedics (UK), she is committed to working to increase both the research capacity and capability of paramedics, while raising awareness within and outside the profession about the positive contribution paramedics can make to the development of collaborative healthcare research, policies and practice.

Where to next for Paramedicine?

The newly assembled editorial leadership team is progressing the development of the new journal infrastructure and processes, including editorial submission systems, journal policies, and a governance and oversight framework. An international advisory board is being assembled, and a recruitment for Associate Editors will commence in the near future. A partnership with a professional journal publishing company is nearing finalisation, adding expertise and reach that will ensure the journal's sustainability and prosperity into the future.

Paramedicine expects to open for new manuscript submissions in October 2022, with the first edition under the new brand planned for January 2023.

The emergence of Paramedicine as a truly international, high-quality peer-reviewed journal represents a major investment by the College and demonstrates its commitment to fostering research and evidence-based practice in the paramedicine profession.

For enquiries relating to Paramedicine, please contact Editor-in-Chief Associate Professor Paul Simpson at editor.paramedicine@paramedics.org.

COLLEGE RESOURCES **TO SUPPORT** PARAMEDIC HEALTH AND WELLBEING

The inherent stresses of the profession can take a toll on paramedics' physical and mental health. Recognising and understanding the need for paramedic self-care, particularly given the added challenges currently being faced across the health sector, we provide a suite of tools and materials to help our members maintain their wellbeing.

Our Healthy Mind & Body Hub, launched earlier this year in partnership with Health@Work, offers a range of information, classes, webinars, and activities to educate and empower that enable our members to make sustainable changes to safeguard their health and wellbeing. Fresh content is available each month, and content from previous months will always be available within the hub, so you can be sure you won't miss a thing. You can access the Healthy Body & Mind Hub via https://paramedics.org/health-and-wellbeing/hub

The College also partners with Fortem Australia to support the wellbeing and mental fitness of paramedics and their families/ inner circles. Fortem's comprehensive clinical support services, including psychology support and care coordination, can give paramedics a helping hand with any challenges they may be experiencing, for free and with privacy. Wherever you're located in Australia, you can book a support session. On-the-ground services are also in towns and cities along the east coast of Australia, covering communities around Melbourne, Gippsland, Southeast NSW, Canberra, Illawarra, Shoalhaven, Sydney, Newcastle, NSW Mid-North Coast, Northern NSW, Southeast Queensland and Brisbane. Their virtual activities, mental fitness toolkit, and resource library are available to anyone, anywhere, anytime.

And our Paramedic Wellbeing Working Group is developing and implementing initiatives, education, and research to improve paramedic wellbeing.

Round-the-clock crisis support is also available:

Australia

- Lifeline provides access to 24-hour crisis support, counselling, and suicide prevention services: 13 11 14
- Beyond Blue provides information and resources (including on PTSD), helpline – chat, email, or phone: 1300 22 4636
- SANE Australia is a national mental health charity working to support four million Australians affected by complex mental illness: 1800 18 72 63

Aotearoa New Zealand

- The Samaritans offer confidential, non-religious and non-judgemental support to anyone who may be feeling depressed, lonely, or may be contemplating suicide: 0800 726 666
- Need to Talk 1737 is staffed by government-funded counsellors 24/7. Phone or SMS 1737
- Lifeline Aotearoa provides access to 24-hour crisis support, counselling and suicide prevention services: 0800 543 354
- The Depression Helpline provides resources, self-tests: Helpline - email, SMS 4202, or phone: 0800 111 757

ACP INTERNATIONAL CONFERENCE **ATTENDANCE GRANTS**

The College recognises the costs of continuing professional development can be prohibitive for some paramedics. As the peak professional body, we are committed to supporting members in their educational pursuits and offers a number of education grants each year that can be used for professional development activities.

Our ACP International Conference Grants are available for members who would like to attend ACPIC, and are for a maximum amount of $500 each, although members can apply for a grant less than the maximum amount.

This year's conference, from 14-16 September at the Brisbane Convention and Exhibition Centre, is themed "Embracing Strengths, Shaping Futures", and will bring together people from around the world to discuss key sectoral issues and research, with expert speakers spanning the full scope of paramedic education and practice. Our program includes two full days of workshops, conference sessions and social events, and one day of pre-conference interactive clinical skills workshops and masterclasses.

Apply online for an ACPIC Attendance Grant at: https://paramedics.org/news/acpic22-edu-grant

Working Groups:
Paramedic Wellbeing
Community Paramedicine
Clinical Fellowship
Clinical Practice Guidelines
Violence, Abuse and Neglect
Women in Paramedicine
First Nations Peoples

Advisory Committees:
Research Committee
Professional Standards Committee
Clinical Standards Committee
Student Committee
Education Committee

Member Committees:
QLD Member Committee
SA Member Committee
NSW/ACT Member Committee
VIC Member Committee
WA Member Committee
TAS Member Committee
NT Member Committee
NZ Member Committee

COMMITTEE AND WORKING GROUP HIGHLIGHTS

The College benefits from a number of groups comprised of members who work to advise the College and advance paramedicine in their respective spaces. These Working Groups are separate to our advisory and member committees, and are a productive driver of progress and activity for the College.

Second quarter highlights:

The SA Member Committee held a Large Vessel Occlusion (LVO) and Endovascular Thrombectomy (EVT) event in Adelaide on July 7. It featured a multi-disciplinary panel comprising Professor Tim Kleinig, who discussed EVT, its background, and the importance of having a pre-hospital LVO screening tool; Dr Rebecca Scroop, who discussed the procedure of endo-vascular clot retrieval; and Lizzie Dodd, who discussed clinical handover, and everything involved in the pre-notification from SAAS to the EVT centre. More than 50 people attended the event, with another 50 tuning in for the livestream.

The TAS Member Committee conducted Referral pathways (TAS - North West) training on May 12. Through collaboration with several allied health services across the North West region of Tasmania, paramedics had the opportunity to improve their knowledge of the comprehensive services available. Developing an understanding of the referral process leads to better outcomes for patients, and implementing sound practices to identify and refer patients for the most appropriate services enhance paramedics capabilities. The committee also engaged in hands-on skills stations and education, linked with Ambulance Tasmania, with a large rollout of updated clinical guidelines taking place over the next year.

The Paramedic Wellbeing Working Group is raising awareness of all the great work that's being done in the paramedic wellbeing space to allow for the sharing of good practice. There's a lot of research projects and other initiatives focused on paramedic wellbeing, and the committee would like to encourage paramedics to share their stories about the work they're doing to increase awareness among the membership by sharing to the College's Twitter account using the hashtag #ParamedicHealthNow. The committee can then match this to the results of the Mental Health Priorities survey, in which members identified their priorities and what they would like the College to focus on, and use that information to identify guest speakers and start scheduling events in order of identified priorities. The committee is also continuing to liaise with external agencies to identify opportunities for College members.

Members of the College's Community Paramedicine Working Group: Alecka Miles, Matt Cook, Sascha Baldry, Dylan Schwartz, Peter O'Meara, David McLeod, Amy McCaffrey, Brendan Shannon, Angela Martin, Karen Stewart and Nicole Foster

The Community Paramedicine Working Group worked hard to develop a comprehensive program for the Rural, Outback and Remote Paramedic Conference held from 26-27 May in the Adelaide Hills. The annual event highlighted knowledge and skills to benefit paramedics, rural and remote nurses, retrieval and flight specialists, and other allied health staff working side-by-side in this unique environment.

The Research Committee has wrapped up Phase 1 of a survey of the paramedicine sector for research priorities and barriers and enablers to research, and analysis of data has been completed. A manuscript is in final phases of development. Phase 2, round two of Delphi consensus process, is underway. The final workshop for the research mentoring program was delivered in July, and the planning stages of the redesign of the program for 2023 has begun. The ACP Research Symposium 2022 was held at the University of Southern Queensland 14-15 July, where 20 abstracts were presented, along with panels, keynotes, and workshops.

The Student Committee delivered a successful ACP Student Conference (STUCON) on July 29 focused on clinical best practice, education and research, and bringing together students, researchers, educators and industry practitioners to explore current and emerging knowledge from around the globe.

PUTTING **KNOWLEDGE INTO PRACTICE** ON SITE THANKS TO COLLEGE EDUCATION GRANT

Lauren Del Bene
Ravensthorpe, Western Australia, Noongar Country

As the only Medical Coordinator at FQM Nickel's nickel mine and ore-processing site in a remote corner of Western Australia, paramedic Lauren Del Bene is tasked with supervising and mentoring a team of medics, nurses, a physiotherapist and an Emergency Response Team who provide emergency and occupational healthcare for a workforce of up to 400 permanent employees and contractors.

Wanting to further consolidate her skills and knowledge, in April this year she undertook an Advanced Life Support 2 course, made possible through a College education grant, that assessed her BLS and ALS skills and her ability to lead a resuscitation team.

In the lead-up to the course, she spoke with colleagues who emphasised that the knowledge she gained would be invaluable for her work as a clinical leader and would enable her to learn alongside other health practitioners, which in her course included clinical and remote area nurses, junior medical officers, psychiatrists and consultants.

I'VE BEEN ABLE TO USE WHAT I LEARNED TO TRAIN THE MEDICS

"I found the experience of being away from work and learning with these professionals a self-affirming and inspiring experience. They were able to teach me things, I was able to teach them things."

Since returning to work, Lauren has been able to put her learning into practice and has established a training and competency framework that integrates her ALS 2 knowledge, and has conducted a training session in resuscitation management and leadership involving a multi-casualty simulation, set up a work area in a safe setting, stationed both ambulances, and ensure all available equipment and resources are fully utilised.

Lauren Del Bene – passing on her ALS 2 training to her team

"I have walked away with a sense of pride and accomplishment in what I am able to achieve. I have renewed confidence regarding resuscitation management and my capabilities to lead my team, and I've been able to use what I learned to train the medics.

"I'm proud to be a member of the Australasian College of Paramedicine, which empowers and enables its members to be able seek out professional development opportunities through its grant scheme. I am incredibly grateful and honoured that I was afforded this grant."

INTERNATIONAL **PARAMEDICS DAY**
AUSTRALASIA **JULY 8** #servingourcommunities

FIRST **INTERNATIONAL PARAMEDICS DAY** A HUGE SUCCESS

The first International Paramedics Day on Friday 8 July was a great success, and the College thanks the many paramedics, services and organisations who contributed photos and videos that showcased the amazing and diverse work they are doing to serve their communities.

From across the Australasia region and from as far afield as Mexico and Iran In total, we received 31 videos that reached more than 8,500 people on social media, and close to 60 photos that reached more than 26,000 people. You can view all the photos and videos on the International Paramedics Day Australasia website.

The feedback from paramedics was tremendously positive and supportive:

St John New Zealand: A great way to celebrate our paramedics and first responders.

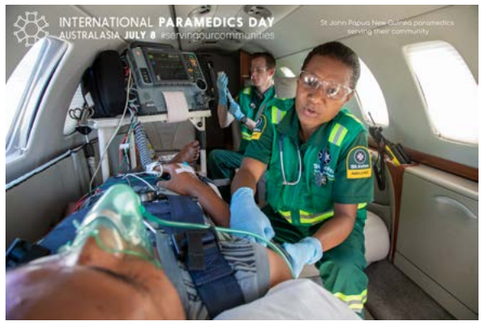
George Braitberg AM OStJ: A deserving acknowledgment of the hard work of our emergency and non-emergency staff.

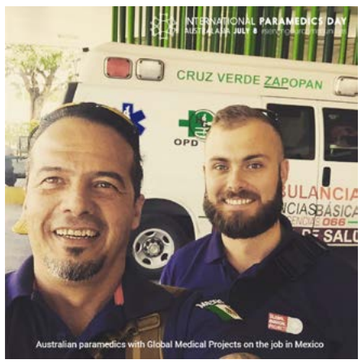
Harley Berridge: So good to see an International day of recognition and celebration for our hardworking paramedics. Still proud as ever to pull on the blue shirt!

We would like to thank all our partners and supporters who helped to make the day such a success: The Council of Ambulance Authorities, Te Kaunihera Manapou Paramedic Council, Australia's state ambulance services, St John NZ and Papua New Guinea, Wellington Free Ambulance, the Australasian Council of Paramedicine Deans, International SOS, Global Medical Projects, and Parabellum International.

We look forward to making International Paramedics Day 2023 even bigger and better, and to continuing to draw attention to the many dimensions of our profession and the range of work our paramedics are undertaking.

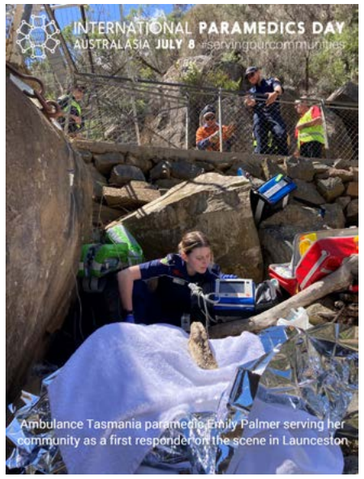

SA Ambulance Service Paramedic Bryony Simpson breastfeeding her baby girl before heading out on a 14-hour night shift to serve her community





Australian paramedics with Global Medical Projects on the job in Mexico

Newly minted paramedic Charlotte Bronson serving her community at her work on site north of Geraldton in Western Australia



Ambulance Tasmania paramedic Emily Palmer serving her community as a first responder on the scene in Launceston

ROAR TALENT ON SHOW AT 2022 RURAL, REMOTE AND OUTBACK CONFERENCE

More than 70 paramedics and allied health professionals joined us in the Adelaide Hills from 26-27 May for our annual Rural, Outback and Remote (ROAR) Conference, with another 63 taking part online via livestreaming.

Themed, "Breaking down Barriers", ROAR 2022 brought together specialists from across Australasia who, through a diverse range of areas from trauma, obstetrics and midwifery, cardiology, haematology, research, community care and much more, explored the theme within the context of paramedicine.

The two-day program featured a full line-up of presentations, workshops and panel discussions that were motivating and informative and well-received by all our participants.

We'd like to thank our event sponsors: Edith Cowan University, St John WA, Emergency Services Health, National Critical Care and Trauma Response Centre and Zoll. Our conference sponsors not only allow us to keep delivering conferences within reach of members, but also contribute to our practice through innovation and education.

We'd also like to thank Alecka Miles and Matt Cook, Sascha Baldry, Dylan Schwartz, Peter O'Meara, David McLeod, Amy McCaffrey, Brendan Shannon, Angela Martin, Karen Stewart and Nicole Foster for assisting in putting together a comprehensive rural and remote program, as well as the College team who helped make the event such a resounding success.

ROAR
RURAL, OUTBACK & REMOTE
PARAMEDIC CONFERENCE

ACP **RESEARCH SYMPOSIUM** 2022

Guest speaker
Professor Gerry (Gerald) Fitzgerald

On 14-15 July, the College held the first ACP Research Symposium in three years. Taking place on Queensland's Gold Coast, it was also livestreamed online on the final day for those people who were unable to attend in person.

The Research Committee, led by Chair Associate Professor Linda Ross, developed an exciting and engaging program that featured innovative research focused on excellence in paramedicine. Themed "New Beginnings", the symposium celebrated the new and diverse research happening in paramedicine that inspired delegates to consider future possibilities in the profession.

Participants enjoyed presentations and workshops delivered by a wonderful line-up of more than 20 guest speakers, including Professor Gerry (Gerald) Fitzgerald, Adjunct Professor at Queensland University of Technology's School of Public Health and Social Work, who delivered the keynote address.

There was a great sense of connectivity among attendees, with one delegate commenting: "I thoroughly enjoyed the ACP Research Symposium. The capped workshop numbers meant I was able to ask questions from experts and build a sense of rapport with fellow paramedics."

A highlight of the event was the announcement made by Paul Simpson, Editor-in-Chief of the College journal about its new title, Paramedicine, and the appointment of the Deputy Editorial Team: Professor Julia Williams (UK), Dr Kathryn Eastwood (Australia), Associate Professor Walter Tavares (Canada) and Dr Alan Batt (Canada). The College is looking forward to sharing more journal updates in the coming months.

Special thanks to the Research Committee members Nigel Barr, Robin Pap, Michelle Thomson, Cameron Gosling and Natalie Dodd for their efforts, innovative thinking and commitment, as well as College team members Amy Hutchison and Georgia Coetzee, who delivered an outstanding event.

Finally, a big thank you to the venue sponsor, the University of the Sunshine Coast, and our symposium sponsor, NobleOak.

ACP Research SYMPOSIUM

FEATURE

FOR MINING PARAMEDIC, IT WAS LOVE AT FIRST SITE

Lauren Del Bene
Ravensthorpe, Western Australia, Noongar Country

If you'd asked paramedic Lauren Del Bene five years ago where she'd see herself now, it wasn't in Western Australia's red sand desert country more than 500km southeast of Perth. But as the sole Medical Coordinator at FQM Nickel Australia's sprawling mine and ore-processing site, 30 minutes' drive from the nearest town, it's a career decision that has opened up a host of new opportunities for professional growth and development.

"I never thought I'd end up in mining," she said. "I thought I'd be on road doing emergency response."

After graduating in 2017, Lauren worked for a couple of years on road in Perth for a private ambulance company, and in patient transport and mental health. At the time, WA ambulance services' graduate intakes were limited, and she wasn't eager to relocate interstate. And while working for a private ambulance company wasn't her first choice, the experience enabled her to hone her skills in such areas as history-taking, patient communication and handling, driving, and relationship-building.

"But it wasn't what I really wanted to do, so I started applying for other jobs. I got three offers for jobs at the same time, and I picked this one because it was more about the lifestyle choice - it was residential, we got a house, and they also offered my partner at the time employment, so that's why I made this decision. The position has so many professional benefits and provides a depth of experience that might not happen, or at least happen within a different timeframe, through the ambulance services."

The site is large and the response area significant, with between 300 and 500 people on site at any one time. Lauren oversees and trains a team of medics, each of whom is a qualified medical technician, and is responsible for like clinical governance, compliance, fitness for work, injury management, and health promotion. The medical team also includes a physiotherapist and emergency service officers, who handle hazmat responses, rescues and natural hazards such as bushfires.

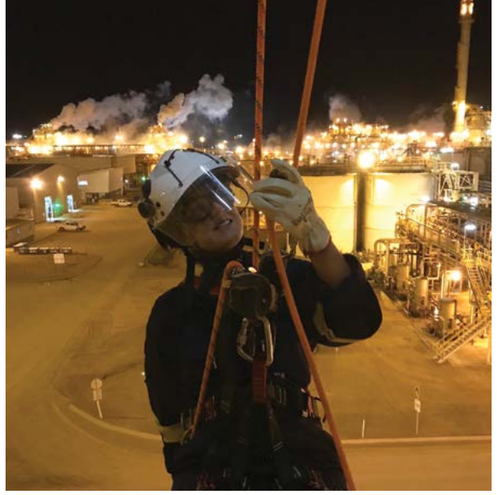
"I help support and back up the medics and have oversight over what they're doing. I can be an operational as a medic as well."

She typically works from 7am to 5pm, Monday to Friday, and is on call when needed. The presentations are predominantly occupational and primary health-related, along with personal illness and mental health issues, the latter exacerbated during peak COVID-19 periods when people were unable to leave due to lockdowns.

"We are quite remote, and that does have an effect on people. But people come to us for all sorts of things, and while we have rigorous workplace health and safety protocols in place, we do see work-related injuries, particularly muscular skeletal injuries, which are fairly common in mining. But we have a really good internal and external injury management system, so we do a lot of rehab, with the focus on ensuring people are able to return to work.

"That's something that I didn't realise this was going to be like, having people come in - it's almost like a GP clinic. You've got time to spend with people, take get their histories, go through your assessments, and then try and figure out how to best treat their signs and symptoms. But it gives me the opportunity to really expand my skill set and my knowledge and get

THE POSITION HAS SO MANY PROFESSIONAL BENEFITS



YOU GET TO PRACTICE A HUGE VARIETY OF DIFFERENT SKILLS WHEN YOU'RE WORKING REMOTELY ON A MINE SITE

extra qualifications that are applicable to the work that I'm doing.

The nearest hospital is in Ravensthorpe, 30 minutes away. And while not a tertiary facility, there are nurses, many of them specialist remote area nurses, and a telehealth doctor, as well and a doctor on call for priority medical presentations. Determining where to take serious medical cases and the logistics of patient transportation was based on assessing where they would receive the most appropriate level of care.

"After Ravensthorpe, we've got Albany, which is three-and-a-half hours' away, which is a Health Campus that's bigger, and then the other way we've got Esperance Hospital, which is two hours' away. If we've got someone who's critical, we usually get the Royal Flying Doctor Service out to take them to Perth, so we've got a number of choices.

"But critical emergencies can be scary when you're dealing with time-critical situations. We've got this person and we've got to keep them alive for 30 minutes until we get to the closest hospital or until the RFDS arrive."

The site also has telehealth facilities enabling them to contact doctors in Perth, primarily for guidance on injury management and treatment, and they have engaged a Perth-based health service provider to issue clinical directives as needed and to inform and approve site protocols and guidelines. Lauren has also written site-specific treatment protocols that have been approved by the service provider.

The operations she now oversees bear stark resemblance to those that greeted her on her arrival. Shuttered for years, the mine was brought back to life and was still in its initial maintenance phase when she took up her position. In the context of her department, it was "fairly unloved" and took a lot of time and effort to take it to its present level.

"I think the most rewarding part of my work has been able to help to be a part of our growth over the last couple of years. I've learned that I'm pretty resourceful in many respects, and there's been a lot of growth and a lot of learning. We have a great team, and it's been really rewarding to reflect on how far we've come.

"You get to practise a huge variety of different skills when you're working remotely on a mine site, and that's been the biggest development for me; it's being able to put everything into practice in that regard. Getting to know people and getting to be an important part of the workforce and the community has also been good, and that is what keeps me here and motivates me is to continue that two-way relationship.

"I love this job, and I love working with the team that I've got. I feel really honoured to be looking after this workforce and this community."

FEATURE

VICTORIAN COMMUNITY PARAMEDICINE MODEL IS BRIDGING GAPS IN HEALTH CARE

Riddells Creek, Victoria, Wurundjeri Country

As community paramedicine is starting to take a foothold in Australia, a team of paramedics and multidisciplinary health support partners in Victoria is further proving the effectiveness of the model, and in so doing is improving local community health outcomes, easing pressure on ambulance services, hospitals and GP clinics, and providing long-term preventive care and support for society's most vulnerable.

The aim of the non-profit HMS Community is to keep people out of ambulances and hospitals, and thus far it's been doing just that, with co-founder Paramedic Andrew McDonell already seeing a drop in ambulance and emergency department presentations.

The initiative was launched by McDonell and registered nurse Ranee Wilkinson following a general discussion about the number of people who went to emergency departments who probably didn't need to be there, and the number of people paramedics had no choice but to take to hospitals.

"That's how HMS Community Paramedic Service was born," he said. "We then went around talking to community health services about what paramedics could do, and one of those thought it was a no-brainer; that there was a gap that needed to be filled. They came back and said they'd be willing to refer to us.

"So, we took a risk and we ended up getting some good referrals from the community health service, and since then we've gone from strength to strength. We now have about 25 paramedics, as well as two registered nurses and 11 support partners."

HMS Community, which is also now backed by the National Disability Insurance Scheme and My Aged Care, takes a holistic approach to community healthcare, working in people's homes and in community centres and aged care facilities to provide through-practice treatment and longer-term patient support, particularly with vulnerable people who have fallen through the cracks in the health system.

HMS COMMUNITY PARAMEDICS ACT AS A CIRCUIT BREAKER

"We have many people who have become disassociated from their general practices, which were providing their initial health care, mental health support, medications, and wound care. Our job is to fill that gap between getting them back to health care and at the same time keeping them out of hospital and out of ambulances. A lot of our work is reconnecting those people back into general practice.

"Instead of sending someone to hospital, we fill that gap; instead of somebody getting unwell and being sent to residential aged care, we're filling that gap. Our multidisciplinary team of community paramedics, nurses and support partners act as a circuit breaker. And while we can't stop everyone from going to hospital, we can circuit-break people who are going to take up beds for a long time."

The HMS Community Paramedic Service model is all-encompassing and longitudinal, providing ongoing patient support and guidance and ensuring they maintain their health and are well connected to local health services.

Paramedic Meg McLean, who was one of the first to join, attends to a diverse range of health needs, from physical injuries and illness to disabilities and mental health issues, many of whom have largely been underserved by health services, particularly patients with conditions such as borderline personality disorder (BPD) who are often misunderstood and require specific expertise, which may not be readily available in some communities.

The bonds she's forged with the local community have also enabled others to alert her to potential health emergencies. In one instance, after being told by a concerned community member about someone who appeared to be in distress, she visited their home for a welfare check and found a woman who had suicidal thoughts, was self-harming, was vitamin D deficient, and had a peripheral oedema.

"She hasn't had ECGs. She only sees a doctor once a month to get Schedule 8 medication. So, I went out there for an hour and then referred her to a psychologist who diagnosed that she was suffering from BPD and social anxiety. Now she's got a well-managed care plan and can get all the support she needs. This was somebody who could only eat one once a day because she had no money; she couldn't afford hydrotherapy or physical therapy. She had some hemiplegia in her arm and leg; she just sat there. Now she's able to access all these services and receive all this help."

A LOT OF OUR WORK IS RECONNECTING THOSE PEOPLE BACK INTO GENERAL PRACTICE

HMS Community paramedics are also working closely with GPs, referring patients, suggesting medications, and offering a level of prolonged patient support in partnership with doctors and nurse practitioners, who are always in very high demand - a service welcomed by the doctors in their community. After referring one potential case to a GP, the doctor said: "Thank you; you've prevented him either going to hospital dying or him coming to me when he's at a point of crisis. You've made my job easier."

At present, they operate five days a week, although they do take calls on weekends if needed. Some patients pay for the services provided, but most are funded through NDIS and My Aged Care. With the community paramedicine model proving to be a success, there are plans to also set up in Wangaratta in the next couple of months. And they're lobbying with the state and federal government to boost funding for such initiatives.

"We're only a little organisation making a little difference, but if we had the resources to expand and grow, just imagine how many patients we could help, how many families, our fellow ambulance paramedics and hospitals and GPs," Meg said.

SOWING THE SEEDS OF CHANGE FOR PARAMEDICINE IN AOTEAROA NEW ZEALAND

Registered paramedic and nurse practitioner intern Shell Piercy is advocating for the broader deployment of paramedics within Aotearoa New Zealand's health system to address the systemic challenges that have befallen the sector, or as she calls it, "planting seeds".

Her vision is one of an effective, multidisciplinary system incorporating complementary allied health professionals that recognises and is inclusive of paramedics as highly skilled and versatile clinicians capable of filling current gaps and adding another dimension of comprehensive patient care. But the path forward is fraught with misunderstandings and misapprehension within the sector of the value and utility of paramedics in primary healthcare.

"I don't understand why people have challenges with it, but they do, so I run around planting seeds very gently. I talk to paramedics about working in primary healthcare and in a different healthcare context, I talk to nurses about how they can have paramedics working with them and what the benefits are, and I talk to GPs and urgent care physicians about incorporating paramedics into their teams - just very gently, all the time reinforcing it because what's best for the country's healthcare system and best for our patients is a healthcare practitioner who can help them with the problem in a holistic way - one that reduces emergency department presentations, that reduces the need to call an ambulance, that reduces the impact of illness, and ultimately gives them better health outcomes.

Registered Paramedic
Shell Piercy

WE NEED A SYSTEM-WIDE SHIFT. THE HEALTHCARE SYSTEM IS CRUMBLING

"We need a system-wide shift. The healthcare system is crumbling, so eventually people are going to have to do something. We don't want to be brought in at a time when everyone's desperate and we're the last resort. We'd love them to choose us because we're awesome, but the reality is people are going to become desperate enough and paramedics are going to be placed in these different locations before they know it."

She said the biggest hurdles were a lack of consensus on expanding roles for paramedics and a lack of understanding about what their capabilities were and in which settings they could best be utilised, despite paramedics already being employed, albeit at present in a relatively piecemeal manner, in variety of capacities within the national health system - in urgent care and GP clinics, in rural and remote areas, in palliative care, in District Health Boards, and at some of the larger hospitals.

With paramedic registration only launched last year, part of the problem was that many in health circles were not yet cognisant of the full scope of practice and the fact that paramedicine was a diverse profession peopled by highly skilled healthcare clinicians who Michelle said were perfectly suited to fill current workforce shortages and bolster the ailing health sector.

"People don't really understand what we do, and there's a lot of extremes. I've met doctors who think that paramedics are stretcher-bearers, and I've also met doctors who think that paramedics are autonomous prescribers. There is such a wide difference in beliefs and understanding about what paramedics can offer. Basically, they can't employ them because they're not really sure how to use them."

She said there was also a prevailing perception of clear delineations between the different health professions: Doctors were doctors, nurses were nurses, and paramedics were paramedics.

"We like those very clearly defined lines, but medicine's not like that. There are different specialities among doctors and nurses, and it's the same for paramedics - they cross the entire spectrum; they assess, they diagnose, and they treat patients in a holistic way. In terms of perceptions of where they sit within the health system, it's a tricky one. Some see nurses and paramedics as equals, some see paramedics getting more into a medical model. But rather than it being hierarchical, it's more about the model of care."

THERE IS SUCH A WIDE DIFFERENCE IN BELIEFS AND UNDERSTANDING ABOUT WHAT PARAMEDICS CAN OFFER

Compounding the challenges was the lack of representation at the national level. While Aotearoa New Zealand has a Chief Nurse, it is yet to employ at Chief Paramedic, which means there is no one in a position to directly advocate with the government at such a level.

"That's huge. There's no one in the Ministry of Health advocating for a such massive sector of health care."

She said the broader deployment of paramedics was not aimed at reducing the number of on-road paramedics; rather, it was about reducing the burden on them. But it did offer paramedics who may want to expand their professional horizons some alternative career pathways, supported by high-quality postgraduate education specialisation options, and ultimately was a win-win situation for national healthcare.

"The benefits are endless, really. A lot of paramedics recognise that now, and they're planting seeds as well."

THREE AMIGOS: PARAMEDICS RESHAPING THE ECP MODEL

Aotearoa New Zealand

Dale Walters, Stacey Fisher, Warren Elliot

THE WHOLE INDUSTRY IS LITERALLY WATCHING TO SEE WHAT HAPPENS

Dale Walters

Stacey Fisher

Warren Elliot

At the Te Mata Peak Practice in Havelock North in Aotearoa New Zealand, paramedics Warren Elliott, Stacey Fisher and Dale Walters are at the forefront of a pioneering effort to introduce a new model of Extended Care Paramedicine that is reconceptualising the role of ECPs and expanding the scope of paramedic practice.

The three, all former St John New Zealand paramedics, are working as part of a multi-modal team of health practitioners that is the brainchild of the practice's Medical Director Dr Kunjay (KJ) Patel and St John Deputy Clinical Director Dr Craig Ellis, who together with another ECP subject matter expert developed a more contemporary ECP model that recognises and utilises paramedics' specialist knowledge and skills in the provision of primary healthcare.

Warren said it was a new way of thinking, based on the practice's need to keep up with growing patient demand and the belief that other clinicians could be brought in to take on additional complementary roles to both alleviate the burden and provide a new level of patient care.

"They're a very forward-thinking practice," he said. "They embrace nurses and nurse practitioners, and they're always helping out those who have a different clinical level. They see them as equals within the organisation, and they see benefits in that."

It's a vision shared by their allied health colleagues, making their integration into the practice seamless and fostering a collaborative approach among the different disciplines and a supportive professional environment.

Dale said the new ECP model was one that, like the paramedicine profession itself, was continuing to evolve.

"Throughout primary health, there is no standardisation of what an ECP is, so it's going to take several years for that to develop because our role is currently developing as we go along," Dale said. "But the base model was the St John Extended Care Paramedic system, and that's what we've been building on as we go along. And the whole industry is literally watching to see what happens."

All three started working at Te Mata Peak Practice in April and May, precipitated by a desire to expand their professional experience beyond ambulance service.

AFTER OUR ARRIVAL, THEY KNOCKED A THREE-WEEK WAIT DOWN TO ONE WEEK BY JUST HAVING US THERE

"I got to the point within my ambulance role where I couldn't do any of my skills, and taking them to hospital wasn't always the best option, but you really had no other option," Stacey said. "You're saving lives and it's really cool work, but in primary health you're doing that in a different way."

For Warren, it was an opportunity to step beyond his comfort zone and take his skills into primary care.

"I started to claw back things I'd forgotten, and I'm starting to utilise things that make me think a bit more and am slowly getting out of that comfort zone and stretching myself. And that's where I needed to be, so it was making that break, making that change from a comfortable place to something that allowed me to stretch out again."

At Te Mata Peak Practice, the bulk of their work is focused on preventive care, seeing people in their homes, conducting health checks, tele-triage, and working in tandem with a multidisciplinary team to build a more holistic healthcare framework for long-term patient wellbeing and care. For Warren, it meant "closing the loop" - being in a position to track someone's health over time and detect any health issues that may need to be addressed, as well as setting up targeted health maintenance programs.

"There's a myriad of duties," Warren said. "We've been told" to own the acute space, which we're starting to do and will develop as we go along. Our day will start with picking up the phone calls and looking at telephone triage - in the sense of, people ringing up and we help decide where they go. Will they go to a GP? Will they go to a nurse practitioner? Can they just come in and be seen by a nurse? Do they go to the emergency department? Or can we actually just deal with it over the phone, or do they come and see us in the practice as well?

"We've got those options, and as KJ told us about a couple of weeks ago, after our arrival they knocked a three-week wait down to one week by just having us there, so for the practice, there's been a huge benefit."

Beyond that, they are able to anything within their scope of practice, including recommendations for medications such as antibiotics and antivirals through a standing order with a local pharmacy or via doctor for approval, and chest inspections, respiratory inspections, and general consultations.

"I don't think we've actually really defined what we do, but we're certainly building upon it as we go along."

Dale said while what they were doing wasn't standard paramedic practice, it was in essence an extension of more traditional duties and was increasingly being recognised within Aotearoa New Zealand's medical circles.

"It's an amazing adaption of our skill set," Dale said. "We're used to interacting with other paramedics and emergency department staff, and we're actually bridging that now and doing something a bit different; we're using our natural abilities to be able to work and collaborate with other staff."

Stacey said what made it all work was the support and backing of their fellow health practitioners.

"All the GPs are on board; there's no hierarchy. There's no 'we're the doctors, you're the underlings'. The trust they've given us is incredible. They're in the background for support but they're not overbearing and they're not micromanaging. We have an amazing professional relationship with everybody here."

TAKING THE ROADS LESS TRAVELLED

Critical care remote-area Paramedic Nicole Foster's career has taken her from the Australian outback to the mountains of Nepal, the foothills of Kilimanjaro in Tanzania, and the halls of academia in Malta on a journey fuelled by her lifelong love of travelling off the beaten track and working in remote and austere locations.

She also wanted to follow in the footsteps of her mother, a paramedic in Melbourne and later a medical attendant with Ansett Airlines flying high-risk patients around Australia and the world.

"I'd always wanted to be a paramedic," she said. "But I'd never wanted to work in ambulance service; that was never my intention for my career. I like finding myself in remote and austere places; I like hiking and climbing and going off the beaten track, so that's why I wanted to work as a paramedic internationally."

The first step in her journey came in her final year of university paramedic studies at Edith Cowan University (ECU) when she was approached by St John NT to work in Australia's red centre - a life-changing three-year experience that saw her based in Alice Springs, Darwin and, for the majority of her stay, Tennant Creek. There she was able to work closely with the community, building a strong rapport with locals and developing a solid body of knowledge, skills and experience that would pave the way for her next step into international paramedic practice.

"I really loved my time up in the Northern Territory. I learned so much and I got the required minimum of three years' experience working in the ambulance service that a lot of private enterprises look for, particularly on mine sites. So, I was ticking that box."

A broken wrist and the need for a wrist reconstruction saw her return to Perth and ECU, where she mentored paramedic students - something she realised she not only enjoyed but was also good at. It provided a potential new career avenue beyond clinical practice; one that enabled her to use her knowledge and skills in a different manner, and one she was able to more fully explore during the injury recovery process.

In 2017, on the prompting of friends, she headed to Europe to train, work and consult with NATO members in tactical pre-hospital care and security. She then found herself in Malta, where she spent the next five years with the College of Remote and Offshore Medicine running their undergraduate program, visiting the country at least twice a year.

I LIKE FINDING MYSELF IN REMOTE AND AUSTERE PLACES

THE SCOPE OF PRACTICE ENCOMPASSES A LOT OF CRITICAL CARE SKILLS

"I managed to get a hold of some folks in Malta, ex-Special Operations Forces from the US and UK. Their backgrounds aren't in academia; they've gone through the military system, which is a completely different world. Their scope of practice is immense, we're talking surgery-level scope of practice. They said, 'Hey, we need more people from academia with university-level paramedic qualifications and experience - why don't you come work for us? (They also didn't have any females on staff at the time, which they wanted to correct)'.

"That's the best offer I've ever received, so I started heading out to Malta for anywhere from eight to 10 weeks, two to three times a year."

In between, she has honed her clinical care skills working in remote settings for three months at a time with NGOs in Nepal, Tanzania and Indonesia. At the end of 2017, she received a call from International SOS, the world's largest private medical company with locations around the globe, asking if she was interested in taking up defence contract work providing medical support for the Australian Defence Force on military training exercises.

"I did a few stints with them, anywhere from four to six weeks at a time going out with the teams there."

She's been working with International SOS ever since, including being contracted to smaller companies working in remote mine exploration and offshore work on vessels.

"They're always looking for paramedics in different countries, different areas. They're a fantastic company to work for. In terms of the type of work I do, it's very good for someone who's experienced and understands the scope of practice and what they should and shouldn't do in particular remote situations, but it's not ideal for those who are new to this and are reliant on protocols and guidelines. You need to be comfortable working in austere environments by yourself. And in defence force placements, for example, you're expected to have a have a very solid understanding of everything from intubation and chest drains to incision and drainage and nursing care."

Professionally, her overseas work has given her a lot of confidence in her own skills and decision-making, which is important in environments where there is often no back-up and no one to call for help.

"I am a paramedic who specialises in remote area and austere work, and the scope of practice encompasses a lot of critical care skills, what I call low-frequency high-risk. You're expected to have a very solid understanding of emergencies, to find and treat, assess, and manage life. That's what you're hired to do. And in these roles, you're also expected to have a very strong understanding of and experience in primary healthcare."

Along the way, Nicole has managed to rack up a number of other qualifications: A master's degree in Public Health and Tropical Medicine, US-level certification as a Critical Care Paramedic, and a Fellow of the Academy of Wilderness Medicine. She's also studying to become a Registered Nurse ("a few hours left!") and is completing a doctorate in health science.

She is also in the process of co-founding the International Health Research Institute, which will focus on pre-hospital research and health systems in countries lacking an effective pre-hospital system with the help of international training partners, some of whom have already been lined up from Guatemala, India, the US and West Africa, with more to come.

"We are trying to provide an international pathway for training companies to put their courses in a recognised and reputable qualifications framework, while also giving them the ability to step into academia, contribute to postgraduate education and see how it works, to get them to understand the politics and pathways that are involved at that level, and to also provide mentorship and a pathway to teach at a postgraduate level."

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UNIVERSITY STUDENT PARAMEDIC CLINICAL PLACEMENT HOURS – **IS IT TIME FOR A RETHINK?**

By **Lance Gray**

Currently, in Australia there are 16 approved study programs for paramedicine. Within each of these programs, clinical placement hours and locations vary widely. A paper published in 2014 by Health Workforce Australia looking at five universities providing paramedicine degrees demonstrated clinical placement hours varying from 200 to 1000 hours across three to four years of the programs. These placements occur in many healthcare settings, from ambulance services to hospitals and community clinics. The report also looked at key factors to a favourable placement for paramedicine students and found that excellent mentorship and inclusivity led to more positive placement experiences.

Since this report has come out, national registration of paramedics has come into place, but sadly no official further work on the optimum clinical placement hours for paramedicine. Under AHPRA, there is no requirement set on the minimum number of hours and it is up to the university to demonstrate the learning outcomes for students to register.

With healthcare being a highly practical, hands-on job with many complex factors that are hard to demonstrate in a clinical simulation environment, clinical placement is key to building well-functional universal healthcare professional. Clinical placement allows the student to develop muscle memory of skills and how they feel in real life. Placement also allows the student to practise and learn if the role is what they expect and want to do with their career.

The current amount of clinical hours leaves student paramedics with significant gaps when little or no placement is undertaken or there are large gaps between ambulance placements while students go to other settings. These other clinical placement settings are essential and help build a more rounded health professional, but still, this gap can lead to skill and knowledge fading for ambulance work. So these placements need to be balanced to ensure a correct mixture.

Multiple papers from Australia and overseas demonstrate that students generally have a positive placement experience and state that their time on the road provided more training than time in class. With that in mind, is it time to start looking at increasing the amount of clinical placement time we give student paramedics? Should APHRA set this to ensure that all students have access to the same experience?

Let's look at the United Kingdom model as an example to help shape ours. Some universities provide more than 2000 hours of clinical ambulance placement to student paramedics. Having worked in this model, I can see the benefits for students and the ambulance services. As a paramedic mentor, you are allocated a student or two for one full year and undertake 80+ shifts together. This allows the paramedic to provide more detailed feedback and guidance, and all of which are linked to better placement outcomes in research papers. The students see a more rounded caseload, not just a snapshot of four or eight days. They see the trends across a year, from flu season to asthma season and summer party season.

> THE CURRENT AMOUNT OF CLINICAL HOURS LEAVES STUDENT PARAMEDICS WITH SIGNIFICANT GAPS WHEN LITTLE OR NO PLACEMENT IS UNDERTAKEN OR THERE ARE LARGE GAPS BETWEEN AMBULANCE PLACEMENTS

As a paramedic, you can and want to help address any clinical/knowledge deficiencies, and you see the hard work put in by them and yourself. You see them progress through the many shifts you do as a team. The students feel more included in service life, and services have a high recruitment rate from these students as they know what to expect. This also has the benefit of being able to quickly mobilise a workforce, such as in the COVID pandemic. Ambulance services in the UK were able to induct them into the service rapidly to fill many vital roles. They already had a strong understanding of how everything worked from all the placement hours they had spent with the service. Australian ambulance services did this, but with much larger lead time and smaller numbers.

Now, is this what Australian universities should be aiming for? I think so, but there are many factors that first need to be addressed for this model to fit. Let's explore a couple of these factors. The first and biggest one is cost - primarily the cost to the student. If they have to be on placement for more hours, this is less time to work, and with the cost-of-living increase, this is not a feasible idea if the students are not supported during their placement time. The National Health Service/UK government provides students with a bursary to support them while on clinical placement. With shortages across all healthcare sectors, there needs to be a government rethink about how we fund the training of these programs to ensure we fix the current shortages and future-proof the whole healthcare system.

Another factor to consider is the mentorship of the student paramedics. Under the current APHRA paramedic standards, it is a requirement that paramedics mentor and teach students and graduate paramedics. However, as mentioned before, we know through research that students' outcomes on clinical placements are affected by the mentors or preceptors, and we can see that sometimes students are not getting the best treatment and support. If we are to add more clinical placement hours, we need to support the paramedics who will be taking these on.

> AN INCREASE IN HOURS WILL NOT ONLY LEAD TO BETTER OUTCOMES FOR STUDENTS, BUT BETTER RETENTION IN SERVICES AND ALSO THE CREATION OF A MORE ADAPTABLE WORKFORCE FOR THE FUTURE

How are you meant to assess them? How are you meant to teach them? And how are you meant to provide feedback to them? This is not taught during your study time; this is just expected. I see this in the feedback from paramedics in clinical placement logbooks. It's generic "good placement", "talked with families", "was a bit quiet but supported the paramedics well" comments. There is a lack of understanding about what we should be doing with these students while on placement, how we provide feedback to them and, most importantly, how to raise concerns that students are not meeting the placement goals and standards.

For this, I think there is an answer; we provide mentorship and facilitator training to paramedics. This short course provides foundational knowledge on assessing, mentoring, guiding, and providing feedback to the students. This supports both the mentoring paramedic and the students and allows for greater, more in-depth feedback and mentoring. Currently, in the UK, this is a requirement before having student paramedics. This course is called Practice Placement educator (PPed), a short one-unit course provided by universities. This can also help with the retention of paramedics. It provides further support and training to staff, increasing job satisfaction and happiness, which is a key for retention.

In summary, clinical placement is essential for all healthcare degrees; it provides fundamental learning and development for student paramedics. Placement hours need to be analysed further to help demonstrate how many are needed to build reliable, well-practised and trained healthcare professionals. An increase in hours, in my opinion, will not only lead to better outcomes for students, but better retention in services and also the creation of a more adaptable workforce for the future with whatever could be next around the corner for the healthcare system. However, this increase will require a complete system change, from government to universities and healthcare services. I'm sure that many more factors will arise to challenge this, but this is one small step to help start to improve the Australian healthcare system.

CARDIAC VENTRICULAR PACING: MECHANISMS AND SUBSEQUENT ECG PRESENTATION

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There are multiple sites of activation in the setting of ventricular depolarisation due to pacemaker stimulus. The contractile response to activation at each site can be further influenced by the amount of energy delivered down the pacing lead. Since 2015, there have been large shifts in how pacing is induced to make the cardiac contraction more physiologic and mitigate the risk of pacing-induced cardiomyopathy (PIC). This has been achieved through altering the site of activation from the traditional apical or mid-septal right ventricular lead placement options to one that targets the actual cardiac conduction system. This article will examine each of these sites and explain how they may be identified through an electrocardiogram (ECG).

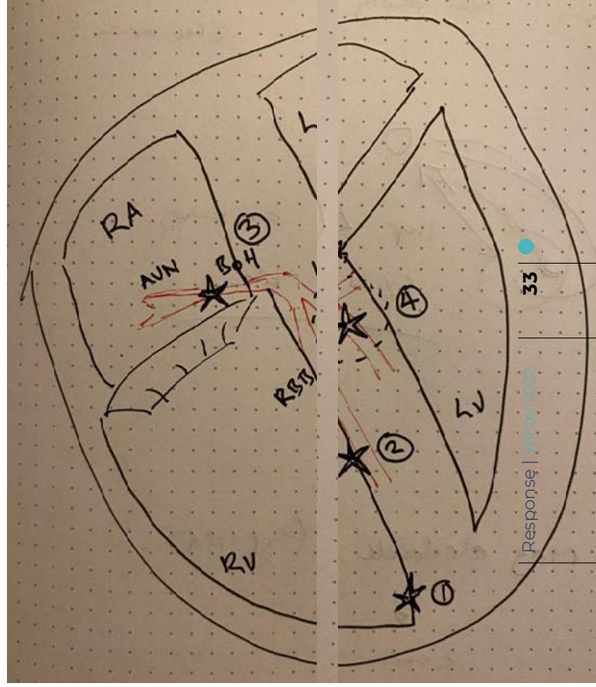
How does a pacemaker induce cardiac muscular contraction?

A pacemaker delivers an electrical impulse of prescribed amplitude and pulse width between two electrical poles. These poles are usually at the end of the pacing lead (bipolar configuration) or unipolar configuration (uses implanted device as one of the poles). The timing between pulses and subsequent cardiac contractions is regulated by a multitude of algorithms and timing cycles. The most common place for ventricular pacing today is through a bipolar pacing lead fixed to one of several points in the right ventricle (RV), the most common of these being the mid-septal region. Bipolar stimulation into the ventricular myocytes leads to depolarisation occurring in a cell-to-cell fashion as opposed to following the normal conduction fibres, which is much faster. Cell-to-cell conduction is demonstrated on an ECG by a broad, complex bundle-branch pattern. In a small subset of patients, cell-to-cell conduction in the RV-placed leads contributes significantly to the development of pacing-induced cardiomyopathy. This leads to heart failure requiring further intervention.

A type of pacing lead location that has gained increasing attention in the past several years is Conduction System Pacing (CSP). This involves targeting the actual conduction-system fibres, allowing a more rapid and physiologic cardiac contraction pattern. The process of delivering a pacing lead directly into the His Bundle generated huge interest at the Heart Rhythm Society 2015 conference. The aim of this system was to directly target the His bundle within the right atrium. If the anatomy was appropriate, the delivery of lead accurate and discrete energy levels was employed, and the resultant paced ECG showed near identical QRS morphology to intrinsic (see images 2 A-B). The cardiac activation followed the intrinsic pathway and an opportunity presented to correct BBB in a subset of patients by overcoming blockade with pacing distal from site. The BBB correction is possible given that roughly 90% of all His Bundle fibres are destined for the left bundle.[1]

There are however multiple challenges associated with attempting HBP, both intra/post-procedural and longer term.[2] The programming of the implanted device also requires additional consideration. This has led to the pursuit of Left Bundle Branch Area Pacing (LBBAP) where the bipolar pacing lead is burrowed into the interventricular septum from the RV side until it is seated within the LBB region, as demonstrated through 12-lead ECG changes during procedure and pacing behaviour when activated.

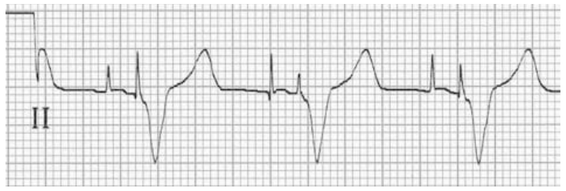
Site 1: RV apical pacing
Site 2: RV mid-septal pacing
Site 3: His Bundle activation
Site 4: Left Bundle Branch Area Pacing (LBBAP) site
The red area indicates conduction system pathway.



1. Traditional RV apical cell-to-cell pacing (broad slow QRS)

2. Traditional RV mid-septal cell-to-cell pacing (broad slow QRS)

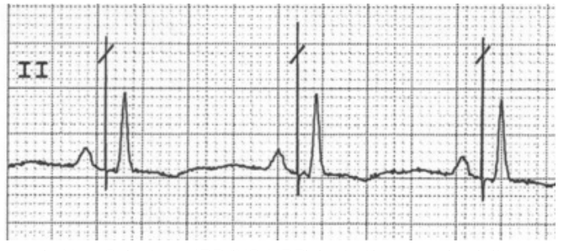
Lead deployed in the right ventricle resulting in depolarisation using traditional cell-to-cell slow pathway conduction (hence broad QRS). The most common sites for lead placement are apical and mid-septal regions.



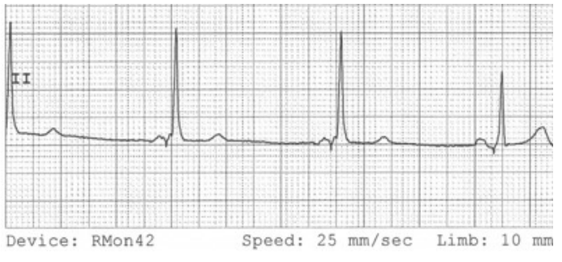
3. HBP

The lead is selectively placed into the HB, with a variety of ECG outcomes depending on tissue structure, energy used and specific lead placement. This image a shows selective capture of the His Bundle, whereas image b demonstrates both the capture of the His Bundle and some septal myocytes that are able to be stimulated around the site of activation, hence the ventricular pre-excitation as demonstrated by the pseudo-delta wave post-pacing spike.

a. Selective HBP (S-HBP) (note the isoelectric line after pacing spike)

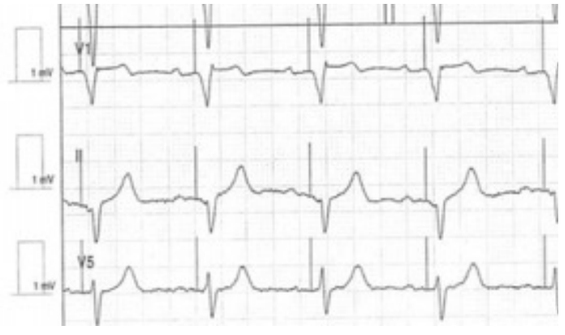


b. Non-Selective HBP (NS-HBP) (note the pseudo-delta wave after pacing spike)



4. Left Bundle Branch Area Pacing (LBBAP)

The latest style of conduction system pacing requires the pacing lead to be burrowed across the septum into the left bundle region from the RV. Specific placement is achieved using fluoroscopic landmarks (commonly requiring initial HB site identification) and electrical mapping of the region to ensure specific capture of the left-sided conduction system.



Relevance to pre-hospital practice

There are approximately 20,000 Cardiac Implantable Electrical Devices inserted every year in Australia.[3] First responders encounter them on a regular basis. Understanding some of the more subtle changes in ECG presentation may help pre-hospital staff understand how the heart is activated and avoid incorrect assessments of pacing behaviour. S-HBP-induced depolarisation, particularly with small pacing spikes on ECG, may be perceived as intrinsic cardiac activity or even reported as failure of the pacemaker to capture the cardiac tissue. The pseudo-delta wave may also be misinterpreted as an indicator of Wolff-Parkinson-White syndrome. LBBAP is gaining traction across the globe, and understanding how and why this mechanism is gaining favour may be of interest and professional value to those in the pre-hospital field.

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THE INTERNATIONAL PARAMEDIC ANXIETY, WELLBEING AND STRESS STUDY **(IPAWS)**: EXAMINING KEY INDICATORS OF PSYCHOLOGICAL WELLBEING AMONG GRADUATE PARAMEDICS

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Introduction

The idea that traumatic encounters can lead to poor mental health is not new and, "You must see some terrible things," (Kennedy, 1999, p. 1) is a truism that most paramedics have heard during their careers. This truism carries with it the widespread belief that the work of paramedics is traumatic, and indeed researchers investigating paramedic health have widely and explicitly assumed that such work is inherently stressful (Bennett, et al., 2004; Sterud, at al., 2006). Furthermore, exposure to such work-related traumatic events is thought to have negative mental health consequences (Wagner, et al., 2020).

There is a body of evidence supporting the assertion that paramedics experience poorer mental health than the general population, reporting higher levels of anxiety, stress, depression, burnout, psychological distress, sleep problems, suicidality and post-traumatic stress disorder (PTSD) (Jones, 2017; Lawn, et al., 2020; Newland, et al., 2015; Petrie, et al., 2018; Quaile, 2016; Sterud, et al., 2006; Wagner, et al., 2020). New exploratory research indicates that some of these illnesses may begin as early as paramedic student placement (Miller, et al., 2020). In spite of this, there are unanswered questions that make it almost impossible to confidently conclude that paramedic work leads to mental ill-health.

The main problem is that the vast majority of these studies have been surveys conducted at a particular point in time (or over a short time frame). This is like taking a photograph where you can see very clearly how things were at that moment in time; the great unknown is what happened before (and after) the snap

was taken. The huge implication of this simple fact is that it cannot be concluded (from most studies) that paramedic work leads to higher levels of mental ill-health. There are other possible reasons that could explain why paramedics might exhibit higher levels of mental ill-health, including pre-existing mental health ailments (Burton, et al., 2019). So, while there is evidence to support the idea that exposure to paramedic work is associated with poorer mental health, it is not conclusive. To obtain stronger evidence, a longitudinal study is needed (Wagner, et al., 2020). This is the vital role of the IPAWS Study.

The International Paramedic Anxiety, Wellbeing And Stress study (IPAWS)

The IPAWS study is a multicentre, longitudinal study of paramedic mental health and wellbeing, undertaken in collaboration with paramedic education institutions across the world. This study is designed to map psychological wellbeing among an international cohort of paramedic graduates over a five-year period in order to explore the cumulative impact of trauma on paramedic mental health and wellbeing (Asbury, et al., 2018).

The literature suggests that working as a paramedic may increase the risk of acquiring a stress-related health condition such as PTSD, burnout, anxiety or depression. Furthermore, high attrition rates and high intention to quit have been noted in first responder organisations which may be attributed to lowered levels of mental wellbeing or low job satisfaction (Blau & Chapman, 2011; Roberts, et al., 2021; Sutton, et al., 2021). However, the evidence suggests that resilience and social support act as protective factors and may mitigate the negative impacts of exposure to traumatic events or to organisational stressors (Austin, et al., 2018; Bilsker, et al., 2019; Gayton & Lovell, 2012; Mildenhall, 2012; Oginska-Bulik & Kobylarczyk, 2015; van der Ploeg & Kleber, 2003).

IPAWS is the first longitudinal study of paramedic wellbeing. The IPAWS study aims to identify any changes in mental health and job satisfaction in relation to resilience and social support among newly graduated paramedics over a five-year period. In order to achieve the study aims, the following variables are being measured:

1. PTSD
2. Burnout
3. Anxiety
4. Depression
5. Social Support
6. Resilience
7. Job Satisfaction

Variables were measured using six previously validated questionnaires: Hospital Anxiety and Depression Scale (HADS) survey, MOS Social Support survey, Job Satisfaction Scale, Connor-Davidson (CD-RISC), Davidson Trauma Scale (Frequency & Severity) and Maslach Burnout Inventory (MBI).

IPAWS update

The first round of IPAWS recruitment took place over an 18-month period (December 2017-May 2019) and recruitment is ongoing with participants completing annual surveys. Approximately 450 participants provided demographic information in the first round of data collection, with almost 400 participants completing the questionnaire component. Data provided is based on those who continued beyond the demographic section of the survey.

Participants were recruited from 28 centres worldwide including Australia (32.2%), UK (32.9%), New Zealand (12.1%), Finland (9%), Canada (7.2%), Republic of Ireland (4.4%), South Africa (1.3%) and other (0.9%). 57% were female and 43% male, with a median age of 29 years (range 22-60 years). Forty-one percent of respondents self-reported as not working or not yet working as a paramedic at the time of the Year 1 (baseline) survey. In the Year 2 survey, all participants were employed, although 6% were not employed as a paramedic.

The 59% of respondents working as a paramedic provided further detail on their work environment, with the two largest categories described as environments comprising a mix of urban and rural locations (34.4%) and urban-only environments (15.9%). Other work environments were categorised as industrial/military/other specialisations and different degrees of rurality and remote locations.

A more comprehensive report, including results of the measures of wellbeing obtained in the Year 1 survey will be covered in a separate publication.

The Year 2 follow-up survey was completed by almost 300 participants, and the number of participants for the Year 3 follow-up survey is currently in excess of 260 participants. Data collection for the Year 4 follow-up started in November 2021 and will continue until July 2023. The Year 5 follow-up (the final round of data collection) will commence in November 2023 and continue until July 2024.

As with all longitudinal studies, attrition rates can potentially impact on the generalisability of findings. The COVID-19 pandemic has placed significant additional pressures on frontline responders globally, including IPAWS participants. The IPAWS team acknowledges these additional challenges and would like to express our appreciation for participants' continued engagement throughout these difficult times.

Conclusion

Paramedics may see "terrible things" as part of their work (Kennedy, 1999), and while exposure to traumatic events cannot be prevented, more can be done to mitigate the impact of cumulative exposure on paramedic mental health and wellbeing. The data gained from the IPAWS study will contribute to our understanding of how the key indicators of psychological wellbeing, social support and job satisfaction among graduate paramedics change in line with occupational experience (Asbury, et al., 2018), and will help identify trends and inform strategies to support paramedic wellbeing and promote career longevity.

It is imperative that everyone associated with ambulance work do what they can to contribute to the understanding of paramedic mental health. Participants of the IPAWS study are encouraged to continue completing the annual questionnaires to help build the much-needed evidence base. The final reminders for the Year 3 follow-up survey have been sent and the survey link will remain open for responses until September 30th.

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THE TRANSITION FROM UNIVERSITY TO EMPLOYMENT IN PARAMEDICINE

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The shift from ambulance service-based training to university bachelor's degree-level training is still a relatively new concept in Australia. It has only been in the past decade that universities have been the main thoroughfare into paramedicine.

Prior to this the ambulances services recruited individuals and they were trained on the job. The shift to pre-employment training through universities is to recognise paramedicine as a profession and set a standard for a registered paramedic. Registration gives the public confidence and a guarantee that a paramedic will perform to a high standard and be appropriately qualified and trained (Williams et al, 2015).

This transition has several advantages and limitations. The advantages of pre-employment training include graduates becoming critical thinkers, having a higher level of skills and knowledge, and having an interest in research to further improve paramedicine as a profession (O'Brien et al, 2014). The disadvantages include not being "job ready", with no definition of job readiness to ensure universities are preparing students for the realities of graduation, students not having enough clinical exposure when they finish university, and graduates struggling to follow some service's strict protocols or guidelines given the universities' focus on graduates being critical thinkers and clinical decision-makers (O'Brien et al, 2014).

Currently, in Australia there are more students enrolled in paramedicine bachelor's degrees than jobs available for graduates. In 2021, 17,200 ambulance officers and paramedics were employed throughout Australia, and this set to grow by an additional 5,000 by the year 2025 (Australian Industry and skills committee, 2021). In 2020, there was just over 4,500 students enrolled in ambulance and paramedic-related qualifications, making the pathway into paramedicine for Australians very competitive (Australian Industry and skills Committee, 2021).

Paramedic students prior to and after graduation are applying to multiple services throughout Australia and overseas to secure employment (Devenish et al, 2020). This will mean some graduates will have lengthy waits before being accepted into an ambulance service or paramedic employment, which lowers their confidence with skills and equipment and makes it harder initially when they are employed to feel confident and prepared. Graduates are also opting to go into the private sector, which can have limited case load, skill sets and resources. There are currently limited roles for paramedics outside traditional ambulance services, with just over 20% of registered paramedics employed outside of these services (National Rural Health Alliance, 2019).

THERE HAS BEEN A LACK OF PLACEMENT OPPORTUNITIES FOR UNIVERSITY STUDENTS, RESULTING IN FEWER ON-THE-JOB LEARNING OPPORTUNITIES AND LESS CHANCE TO INTEGRATE INTO THE AMBULANCE SERVICE

For years there has been a lack of placement opportunities for university students, resulting in fewer on-the-job learning opportunities and less chance to integrate into the ambulance service (Williams et al, 2012). COVID has meant that some students had placements cancelled or cut short and practical tutorials moved to online platforms when government restrictions came into place (Perkins et al, 2020). The pandemic also saw some states fast-tracking graduate programs and employing graduates as casuals to ensure they had sufficient staff numbers for a potentially overwhelming influx of triple zero calls. The impact of this fast-tracking is currently unknown, but more graduates are feeling less prepared despite studies showing that by the end of the graduate phase they are just as skilled as on-the-job-trained paramedics (O'Brien et al, 2014). This could be a reflection of the inconsistency of the graduate program, with each service providing differing timeframes, support, and staffing. Surveyed university students wanted to see further clinical placements in varied healthcare settings to help them feel more adequately prepared for post-graduation employment (Williams et al, 2012).

IDEALLY IN THE FUTURE, WE WILL SEE MORE PLACEMENT OPPORTUNITIES

Let's discuss a study by Devenish, et al., who investigated the professional socialisation of university-educated paramedics using a three-stage model. This model looks at the way students integrate into the world of paramedicine in different stages (2016). The first stage, anticipatory socialisation, is the individual's perception of paramedicine which is developed through television, family, friends, and media. This stage takes place before any integration into university, paramedicine, or the ambulance services.

The second stage, formal socialisation, occurs while undertaking tertiary study and the student forms a more in-depth understanding of the profession. This is when students begin to gain further knowledge about being a paramedic through lecturers, tutors, peers, and placements. Devenish, et al., study found that during the formal socialisation students were marginalised during placements, identified theory-practice gaps, and had a larger focus on emergency presentations over the social science aspects of paramedicine (2016).

The final stage, post-formal socialisation, is the transition from student to professional and navigating workplace culture, politics, and roles. Graduates initially have a large culture shock when they begin their professional employment with unfamiliar environments, hierarchies, and politics. Graduates found they needed to prove their abilities and fit into the workplace to become accepted as competent clinicians by their peers. Once they had completed their graduate portion of employment, paramedics felt underprepared to mentor new employees as they were still coming to grips with their own clinical practice. Australian Health Practitioner Regulation Authority (AHPRA) registration has mentoring as a key component and an expectation of registered paramedics; however, little guidance is offered in how to mentor (Bell & Whitfield, 2021).

Overall, graduates find the transition from university student to professional paramedic challenging due to a lack of clinical exposure, culture shock, and often a change in location or country to gain employment. They are acutely aware of their need for continuous professional development and the need to solidify their skills and knowledge. Ideally in the future, we will see more placement opportunities, such as mental health wards, emergency departments and paediatric wards, while also seeing an expansion to the paramedic role with employment opportunities in GP clinics, community nursing, immunisation programs, and prevention programs.

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By **Howra Al Timimy**
Paramedic student, University of Tasmania, Sydney, Wangal Country

WHY CULTURAL REPRESENTATION MATTERS IN PRE-HOSPITAL CARE

SUBSTANTIAL HEALTHCARE DISPARITIES ARE A DAILY REALITY FOR PEOPLE FROM CALD AND FIRST NATIONS BACKGROUNDS THROUGHOUT THE COUNTRY

Australia is home to a diverse population of culturally and linguistically diverse (CALD) people, and while the nation prides itself on its traditional values of equality, fairness and equality of opportunity, the national health system is failing to ensure equal access to health service and quality of care and treatment.

As the COVID-19 pandemic has demonstrated, substantial healthcare disparities are a daily reality for people from CALD and First Nations backgrounds throughout the country. And while this has been a long-standing systemic issue that predated the pandemic, the challenges inherent in accessing healthcare are continuing to grow.

This has long been recognised by social epidemiologists. Infectious disease distribution is patterned with systemic disadvantage that may often linger from historical roots. Accessibility to health literacy, secure housing, food and health facilities are privileges that disproportionately influence the level of protection and care people can have in a healthcare setting. Unconscious medical bias, language barriers and structural resource discrimination we may see in areas such as housing are a few of many reasons why we have witnessed higher rates of COVID-19 in CALD and First Nations people.

Underrepresentation among healthcare workers plays a significant role in understanding the lived experiences of communities disproportionately affected by COVID-19, particularly paramedics who typically have more direct community contact and through-practice experience.

Oximeters are a vital tool for paramedics in assessing oxygen levels for patients suspected to have respiratory infections. It determines treatment and how quickly a person can access that treatment. Mounting evidence driven by the pandemic has shown that these devices are substantially less accurate for people of colour, which has evidently led to delayed treatment. Oximeters record the amount of light that is absorbed in one's finger to determine oxygen levels in the blood. Naturally, light is absorbed differently for different skin tones, and its accuracy is limited to the standard it was tested on, which advantages lighter skin.

CULTURAL DIVERSITY SHOULD BE A CONCEPT ON WHICH WE CONTINUOUSLY REFLECT

Because of this, it is imperative to strike a balance between reliance on patient accounts and concerns and diagnostic tools that may potentially be biased. Understanding such nuances and reassessing these paradigms can often be difficult to navigate; however, taking the initial steps of listening to CALD and Indigenous perspectives and lived experiences can begin to make a difference. It will also guide decision-making, policy development, and program investment, ensuring everyone in the community is properly looked after.

Recent University of Tasmania graduate and now NSW Ambulance graduate paramedic Jessica Chow became aware of the importance of her cultural background while on a placement: "Having that diversity in the paramedic profession can help with the speed and ease of establishing a relationship with your patient and their loved ones." She wants to learn more languages to diversify her skill set and bolster cross-cultural communication in order to make CALD and First Nations patients more comfortable.

In any profession, seeing people who share lived experiences can often be inspiring. For CALD students studying paramedicine, being able to identify role models who share those experiences enhances their perceptions of the paramedic profession and boosts their confidence while training. When Jessica was a student, she saw other CALD paramedics as role models, "which reinforces the importance of diverse representation in any profession".

Student clinicians may encounter uncertainty in negotiating cultural barriers. Learning how to work effectively in cross-cultural situations is often one of the first things taught to paramedics in tertiary education. However, self-knowledge and self-awareness are often forgotten aspects of the curriculum as the focus is predominantly on behavioural and verbal awareness. This is not to say that one aspect is more valuable than the other, but before responding to jobs in which our cross-cultural skills must be applied, we need to also reflect on our own cultural identities.

Dr Aarti Bansal from the University of Sheffield's Academic Unit of Primary Medical Care said: "It is through learning about our own culture and by developing an attitude of respectful curiosity toward others that we can truly learn to work effectively in cross-cultural situations." She said our thoughts were subconsciously influenced, much like a knee-jerk reaction, by our biases and assumptions. "We have seen countless sources of research that often, with no malicious intention, some clinicians perpetuate healthcare disparities with their subconscious biases. This is to the detriment of everyone."

As paramedic students and working paramedics, cultural diversity should be a concept on which we continuously reflect. Whether from a CALD background or not, we need to elevate this in our conscious thinking to minimise the effect our assumptions have on our patients.

Patient care is a vital component of our work; the opportunity to challenge our assumptions enhances patients' experiences and improves service provision.

DEVELOPING A **RESEARCH AGENDA FOR AUSTRALASIAN PARAMEDICINE (RAAP)**: PAVING THE FUTURE OF THE PROFESSION

Amy Hutchison, Linda Ross, Paul Simpson

Australasian paramedicine continues to experience substantial growth in research activity that contributes to the profession's distinctive body of evidence-based knowledge. Australasian paramedicine research is characterised by diversity in focus and methodology, spanning quantitative, qualitative and mixed methods used to answer questions relating to all aspects of the profession.

While this diversity and breadth is positive, it can be argued that it has resulted in a compartmentalised research space that lacks a concentration of expertise and effort necessary to progress larger suites of research with a high likelihood of translational outcomes. Having a sense of shared research priorities could work as a catalyst to greater collaboration and more efficient deployment of the profession's research capacity. The identification and development of paramedicine research priorities will make a major contribution toward mapping the way forward for paramedicine research and improved healthcare system functioning in Australia and Aotearoa New Zealand.[1]

It is against that background that the College's Research Advisory Committee designed a large research project seeking to create a consensus-derived research agenda for Australasian paramedicine. The project is called the "Research Agenda for Australasian Paramedicine", or more affectionately "RAAP". Supported and funded by the College, RAAP commenced in 2021 and aims to create a prioritised agenda that can be shared by the profession.

Research agendas within paramedicine are not a novel concept. In fact, Australia led the way back in 2003 with an early attempt to develop an agenda using experts in a face-to-face forum.[2] Over the ensuing 15 years, research agendas have emerged from a range of countries, including the United States[3], Canada[4], Ireland[5], the United Kingdom[6], Norway[7], and the Netherlands[8].

Led by Associate Professor Paul Simpson and Associate Professor Linda Ross, the Research Advisory Committee is part way through the RAAP project, with a final agenda to be disseminated in September 2022.

The RAAP project consists of two phases:

Phase One

Phase One of the project involved a national survey of the paramedicine profession to identify: 1) the barriers and enablers to research being conducted, and; 2) to have each participant provide research priorities or topics they felt were important to be researched in the profession. The survey was run from November 2021 to January 2022 and was promoted through the College and at the ACP International Conference (ACPIC) last year. In total, there were 341 individual responses.

The survey also collected some basic demographic information about participants. A goal was to ensure that the data collected represented the profession as a whole and included participants at all stages of their career in paramedicine across all sectors and locations. As seen in Figure 1, there were participants from each state and territory of

Australia, and from both the North and South Islands of Aotearoa New Zealand. Participants in Queensland, New South Wales, and Victoria comprised the majority of respondents.

A breakdown of participants by industry sector is shown in Figure 2. While there was representation across non-emergency providers, defence/armed forces, education and the private paramedicine sector, the vast majority of participants were employed in jurisdictional ambulance services.

Most importantly, the survey aimed to determine what the participants perceived to be research priorities for the paramedicine profession. In total, more than 500 research priorities were suggested by the participants of the Phase One survey. These priorities were then coded and thematically analysed to condense this list and enable identification of common themes that would form the provisional list of priorities that would be put to the Expert Panel for consideration in Phase Two.

Phase Two

An Expert Panel of 63 participants was selected to take part in Phase Two of the project. In the Phase One survey, respondents were given the opportunity to nominate themselves for selection to the Expert Panel. Submissions were reviewed by the research team, with expert panellists selected on the basis of their expertise in the paramedicine industry in Australasia. The research team endeavoured to create a panel that had great diversity in gender, background, industry sector and location of engagement or work to ensure that there was appropriate representation from all identified stakeholder groups. Of particular note was a commitment to achieve balance across clinical, educational, research and management roles held by the panellists.

Phase Two utilises a consensus-based research methodology called the "Delphi process".9 In a Delphi consensus process, the Expert Panel review the original list of priorities derived from the Phase One survey and seek to gain consensus on a number of items over several rounds of voting. Before starting the first round of consensus voting, the Expert Panel was provided with "primer" material in the form of the Phase One results, together with published research agendas from several other countries.

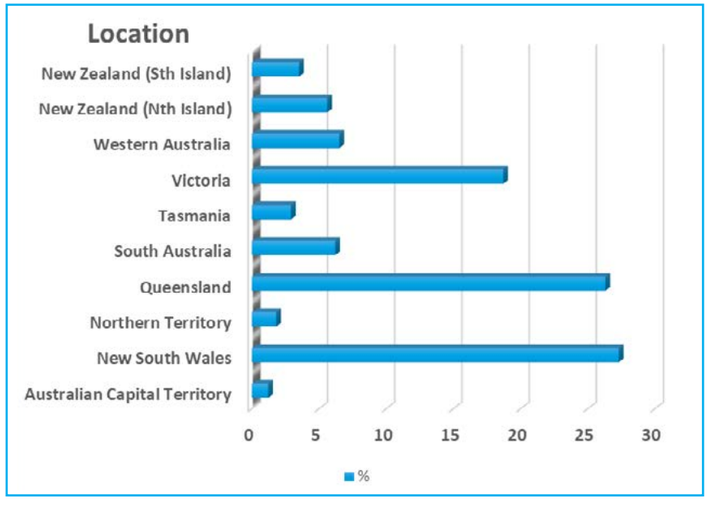
In each round of the Delphi, panellists are asked to provide a response to each of the 109 research priorities using a five-point Likert scale to indicate how strongly they feel each priority should or should not be in the final agenda. This is repeated over approximately three rounds, with the number of priorities reducing in each round until consensus is reached for the remaining items. A priority is added to the final research agenda if 80% or more of the expert panel agree or strongly agree with that the priority being in the agenda. Likewise, if 80% or more of the expert panel vote that they disagree or strongly disagree with a particular priority being in the agenda, it may be removed from further rounds of voting and therefore will not be added to the final research agenda.

In total, 109 research priorities were presented to the panellists in the first round. The second and third rounds of the Delphi consensus process are still underway, so a final agenda is still a little while away. The Research Advisory Committee is looking forward to sharing the results of the agenda with you at ACPIC in September, and in the publications that will result from this research.

The final product of the RAAP project will be a list of consensus-derived research priorities for the Australasian paramedicine profession. This final agenda can be used to unite the paramedicine profession to work toward a common goal: Filling in the knowledge and research gaps of the industry and using this new knowledge to drive the profession forward. This agenda can be used by the government, funding bodies, ambulance services, the private and industrial sector, and the profession as a whole to encourage and support research in paramedicine, to advance the profession for the benefit of patients and the healthcare system.

The Research Advisory Committee thanks everyone who completed the survey and those who make up the Expert Panel. Without your support, the agenda would not be possible.

Figure 1: Self-reported primary location of practice/engagement for RAAP phase 1 participants (n= 341)



Want to know more?

To learn more about the RAAP project, you can hear from Chief Investigator Paul Simpson, Peter O'Meara, Robin Pap, and Louise Reynolds in the Talking Research: Developing our national research agenda webinar, which can be accessed on the College website at: https://paramedics.org/recordings/TRmay22

Figure 2: Self-reported primary employment setting for RAAP phase 1 participants (n=341)

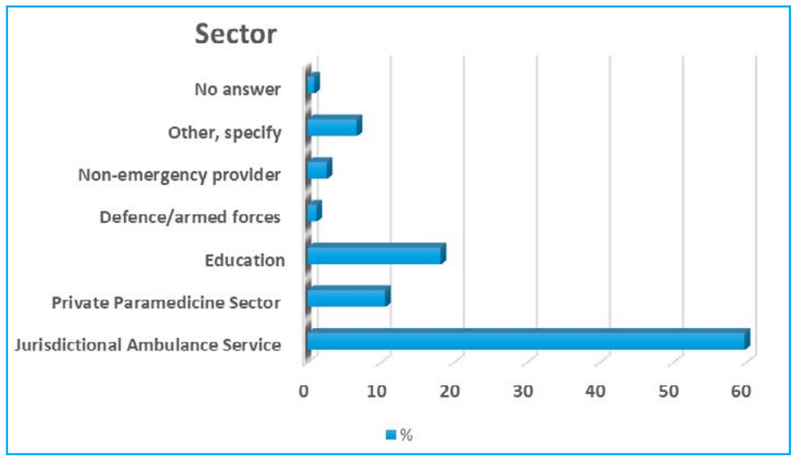


Figure 3: Demographic and professional characteristics of RAAP phase 1 participants (n=341)

- 84% of respondents were registered paramedics and 13% had dual nursing and paramedicine registration
- 53% of respondents had less than 15 years' experience in paramedicine
- 44% of respondents had some postgraduate education, including 10% with PhD's
- 68% of respondents had no research experience or considered themselves to be novices
- 67% of respondents ranged from moderately to extremely interested in conducting research

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WAYS TO LOSE YOUR JOB...

PART 1

By **Michael Eburn**

In this first of two articles, I'm going to discuss ways paramedics have found to lose their job or their registration. Part 1 will deal with challenges to public health, and in particular COVID measures. Part 2 (to be published in the next issue of Response) will analyse unfair dismissal applications made by paramedics in order to identify relevant lessons for paramedics about what conduct is likely to lead to termination.

Challenging COVID measures – the AHPRA position

The Australian Health Practitioner Regulation Agency (AHPRA) has developed a policy statement for all 15 registered health professions, including paramedicine (https://www.paramedicineboard.gov.au/Professional-standards/Codes-guidelines-and-policies/Position-statements.aspx). The COVID-19 vaccination position statement (9 March 2021) says:

> While some health practitioners may have a conscientious objection to COVID-19 vaccination, all practitioners, including students on placement, must comply with local employer, health service or health department policies, procedures and guidelines relating to COVID-19 vaccination...
>
> Any promotion of anti-vaccination statements or health advice which contradicts the best available scientific evidence or seeks to actively undermine the national immunisation campaign (including via social media) is not supported by National Boards and may be in breach of the codes of conduct and subject to investigation and possible regulatory action.

Two notable (and unsatisfactory) cases

There have been notable cases involving paramedics who have taken a stand either against the vaccine program generally or against the specific requirement that all paramedics or health workers must be vaccinated. Some of those have lost their job, others have lost their registration.

Mr John Larter was a NSW paramedic who has become a popular speaker at many protests against mandatory vaccines for health workers. His registration as a paramedic was suspended by the Paramedicine Council of NSW. In response to a question in Parliament, the Minister for Mental Health, Regional Youth and Women representing the Minister for Health and Medical Research said (at https://www.parliament.nsw.gov.au/lc/papers/pages/qanda-tracking-details.aspx?pk=88617):

> Under confidentiality provisions in the Health Practitioner Regulation National Law (NSW), the reasons why Mr Larter was before the Council cannot be disclosed. However, the Paramedicine Council of NSW has the power to take interim immediate action against a registered paramedic if it is satisfied it is appropriate to do so for the protection of the health or safety of any person, or persons, or if it is satisfied that the action is otherwise in the public interest. The Council may take interim immediate action by either imposing conditions on, or suspending, the paramedic's registration.

Serious complaints about a paramedic (or any registered health professional) must be referred to the relevant tribunal - in NSW, the Civil and Administrative Tribunal (NCAT) (National Law (NSW) s 145D). The decisions of the tribunals are published on websites such as NSW Case Law (caselaw.nsw.gov.au) and AustLII (austlii.edu.au). Summaries of Tribunal and Professional Standards Panel decisions are also published on the AHPRA website. Members of the public and the professions can read these to see what was alleged, why it was held to be a breach of professional standards, and why the penalty imposed was considered appropriate. Less serious matters may be referred to a Professional Standards Committee (s 145B). The decisions of the committees are not public. A Committee can caution a practitioner or impose conditions on their practice (s 146B). A committee cannot suspend or cancel a practitioner's registration. NSW has a council for each profession. The Paramedicine Council (s 150):

> (1) ...must, if at any time it is satisfied it is appropriate to do so for the protection of the health or safety of any person or persons (whether or not a particular person or persons) or if satisfied the action is otherwise in the public interest -
>
> (a) by order suspend a registered health practitioner's or student's registration ...
>
> (2) A suspension of a registered health practitioner's or student's registration under subsection (1) has effect until the first of the following happens -
>
> (a) the complaint about the practitioner or student is disposed of;
>
> (b) the suspension is ended by the Council.

The inference is that Mr Larter was suspended by the Council acting under s 150, but why they felt the need to take that action, and what happened after that, is not clear.

Mr Larter took his concerns about the vaccine program to court - Larter v Hazzard (No 2) [2021] NSWSC 1451. He was unsuccessful in his application for declarations that various public health orders were invalid. The effect of those orders was unless he received a COVID-19 vaccination he was "prohibited from working as a paramedic in New South Wales". In September 2021, he was quoted as saying "he has no intention of getting the COVID vaccine" (Canberra Times, September 20, 2021). Mr Larter also ran as a candidate for the Senate at the 2022 Federal Election. On John Larter's webpage, he describes himself as "a former Paramedic". Presumably, his position on getting a vaccine has not changed and he is still unable to work as a paramedic. One might also infer, but I cannot confirm, that he is no longer employed by NSW Ambulance ("Veteran paramedic John Larter set to be sacked after Supreme Court DISMISSES bid to overturn vaccine mandate", 7News, 18 June 2022).

Notwithstanding his description as a "former paramedic", a search of the AHPRA database of registered practitioners shows that, as of 18 June 2022, John Edward Larter is a registered paramedic with his principal place of practice in Tumut. His registration is subject to conditions requiring him to practice under supervision and not to supervise or train other practitioners.

Another paramedic who made news for her anti-vaccination views was Sally-Ann John. A report from the Daily Mail (UK) (3 August 2021) says "Sally-Ann John, 52, has been stood down from NSW Ambulance after posting a TikTok video of herself marching down George St on July 24". The video, available online (https://www.dailymail.co.uk/video/news/video-2467587/Video-NSW-Paramedics-tirade-marching-Sydney-lockdown.html), is actually an audio recording and a picture of Ms John in her ambulance uniform. A search of the AHPRA register shows that Ms John is a registered paramedic, but her registration is currently suspended. Again, there are no published reasons for her suspension on either AustLII or NSW Case Law, nor is there any reference to action against her on the AHPRA website. In the absence of any published reasons, paramedics might infer, but it is impossible to know, what Ms John did that was considered contrary to professional standards or a threat to the community that warranted her suspension.

In terms of "learning lessons", this situation is problematic. Without published reasons by either NCAT, a Committee, the Paramedicine Council, AHPRA or the Paramedicine Board, paramedics cannot identify what it is that either Mr Larter or Ms John are alleged to have done, how that breached the professional expectation of paramedics, and why their conduct warranted immediate suspension. Without that, other paramedics cannot learn what is expected from them and what constitutes unprofessional conduct or a breach of the AHPRA Policy Statement. That is not a satisfactory position.

Unfair dismissal

Other practitioners have challenged decisions to sack them for failing to obtain COVID or influenza vaccines (see australianemergencylaw.com/2022/04/01/requiring-covid-vaccines-for-emergency-workers). One recent case is Giggs v St John Ambulance Western Australia Ltd [2022] FWC 1362. Public health orders required that anyone entering a residential aged care facility in Western Australia had to have a current influenza vaccination. Giggs refused and was dismissed on the basis that she could no longer perform her job as a paramedic. The Fair Work Commission found that the decision to terminate her employment was not "unfair". St John Ambulance employees had to comply with the public health orders. Her view that the science did not support the making of the orders was irrelevant.

In another case, Munn v Health Secretary [2022] NSWIRComm 1044, a number of NSW Health employees, including a NSW Ambulance paramedic, challenged the decision to implement mandatory vaccinations on the basis that there had not been the consultation required by the Work Health and Safety Act 2011 (NSW). The respondent argued that the implementation of the vaccine mandate was not made under that Act but in response to a requirement imposed by the Public Health Act. Commissioner O'Sullivan agreed. He said:

> The Health Minister made the Health Orders which applied as of law upon the respondent. There were consequences for failure to comply with the Health Orders. The respondent, in complying with the Health Orders, had a positive obligation placed on it to take all reasonable steps to ensure that health care workers comply with the Vaccination Requirements … the duty under sub-section 47(1) of the WHS Act to consult was not engaged …

If a practitioner wants to oppose orders made by authorised officers, they need to go to court to challenge the orders themselves. This is what Mr Larter did, as did the plaintiffs in Kassam and Henry v Hazzard [2021] NSWSC 1320. So far none of those cases have been successful. In the absence of a binding declaration by a competent court, employers have to comply with the public health orders and employees have the choice to comply or lose their job.

But merely asking questions might be ok

Thiab v Western Sydney University [2022] NSWSC 760 may be a case that goes against the trend of the cases discussed above. It is a case that must be approached with caution. First, it is not an unfair dismissal case; Ms Thiab was a student nurse studying at the University of Western Sydney (UWS). Because it is not a unfair dismissal matter, its application to paramedics will be limited. It will, however, be of particular interest to paramedic students, particularly as UWS does offer a degree in paramedicine. Second, the action against Ms Thiab was governed by legislation governing the University, not the Health Practitioner Regulation National law, save that students were expected to comply with the Code of Conduct applicable to nurses.

Ms Thiab's problems began on 30 August 2020 when she attended a clinical placement and (at [25]) in the course of a conversation with her mentor, Ms Reardon, she "expressed views about COVID-19 vaccination which Ms Reardon found unsatisfactory". In particular, Ms Reardon interpreted these statements as "spreading misinformation" about COVID-19 vaccines and saying that "Dr Kerry Chant [NSW Chief Health Officer] was wrong". At the time, there was no general mandate requiring nurses to be vaccinated but there was a hospital policy to that effect. Ms Thiab refused both a vaccination and daily rapid testing, so she was sent home. The University then cancelled all of her future placements.

On 10 September, Ms Thiab advised the university that she had been vaccinated and she was again issued placements in order to complete her degree. She attended her next placement on 25 October but was again sent home after a conversation with her nursing mentor. In those conversations, she asked about the safety of COVID vaccines and how she should answer patient questions. The nurse took Ms Thiab to be expressing anti-vaccination views. The unchallenged evidence from Ms Thiab (at [52]) was that she was "merely raising questions about the safety of COVID-19 vaccination in a moderate and unexceptionable way. She went so far as to present herself as having been, at least by 25 October, a supporter of vaccination".

Justice Parker, in the NSW Supreme Court, found that the UWS procedures had miscarried. He said (at [127]):

> … it was not Ms Thiab's actual conduct which concerned [the decision-makers]. Rather, they thought that she held anti-vaxxer beliefs and that those beliefs were undesirable in nursing practice. Once they had reached these conclusions, they apparently considered it unnecessary to investigate precisely what she had said and done.

In short, they did not identify if or how she spread misinformation or identify how that fell short of expectations. Rather, they acted on her political beliefs rather than specific actions, and that was prohibited by the UWS governing law. Further, her conversations with senior mentors, asking questions, was not "spreading misinformation". His Honour said (at [109]):

> The Code [of Conduct] repeatedly and understandably requires nurses to act on the "best scientific evidence". But to question the scientific evidence for the safety of a vaccine, so long as it is done rationally, could hardly, if ever, be regarded as contravening this requirement. Nor would pointing to the possibility of long-term effects or the possibility of adverse effects in some clinical situations.

Conclusion

It is hard to draw too many conclusions from the material presented, not least because there are no published reasons that explain how Mr Larter and Ms John breached the Paramedicine Code of Conduct (or other relevant law) and why suspension was the appropriate response.

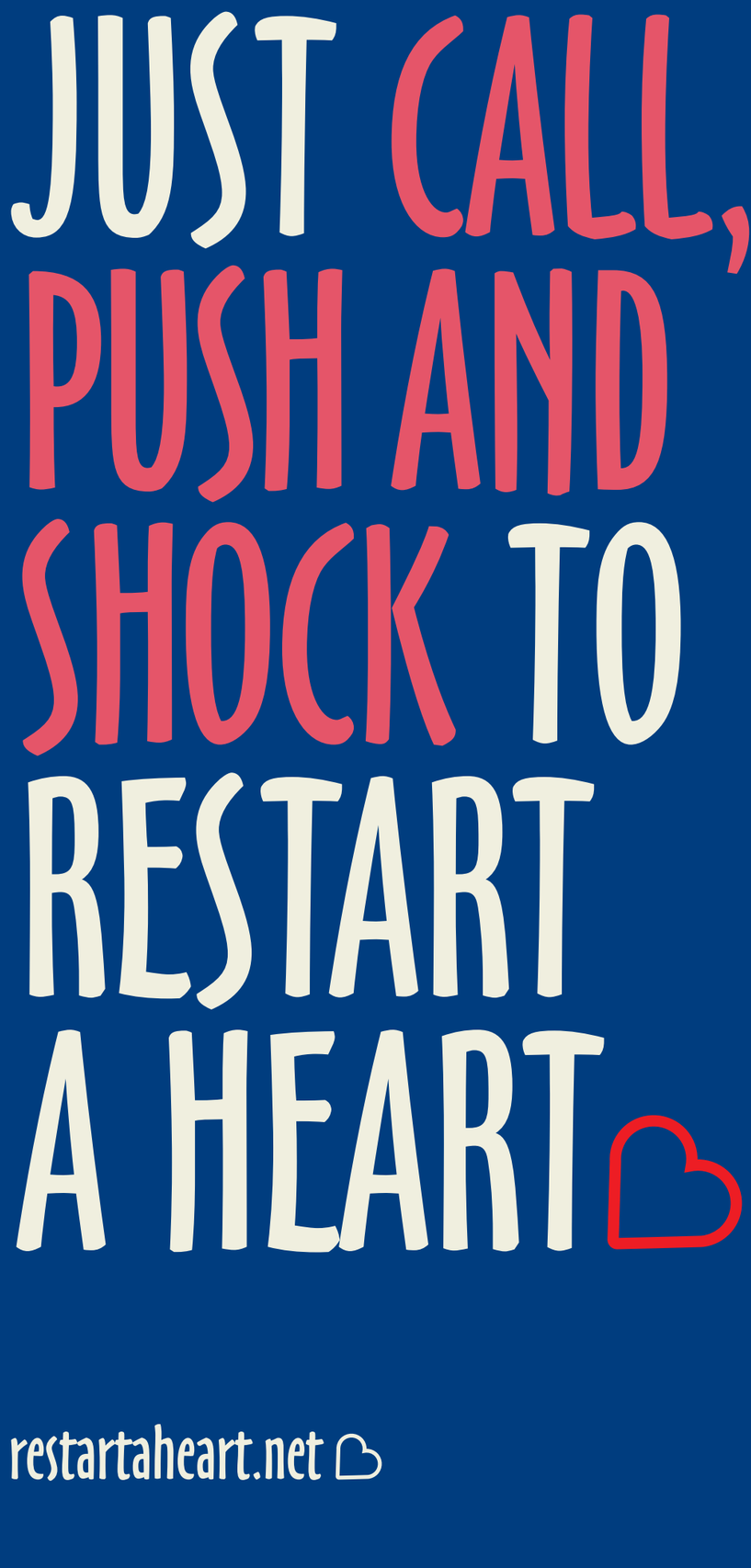
What we can conclude, in this first article on how to lose your job, is that paramedics who fail to comply with legal requirements where that means they cannot perform their job can expect to lose their job. An argument that the requirements are excessive or not lawfully made is not an issue the employer or an industrial tribunal can deal with.

Paramedics can also expect to lose their job - and perhaps their registration - if they actively discourage people from following public health advice. The AHPRA policy statement requires practitioners to follow "the best available scientific evidence" but science is contestable. If any comfort can be drawn from Thiab's case, it is that questioning the science, if done "rationally" and in an appropriate context should not be seen as a breach of any code of conduct. Publishing papers based on evidence, or asking, rational questions of superiors or mentors, should not be seen as spreading misinformation. Having the debate on social media or speaking at protests criticising the public health advice and the motivation of those giving that advice may be.

Attribution

Historically, this column has been co-authored by Dr Ruth Townsend and I. Dr Townsend is a member of the NSW Paramedicine Council and an employee of the University of Western Sydney. She did not join me in writing this paper. The views expressed here are mine alone; Michael Eburn.

It is acknowledged that the reasons given by the Paramedicine Council for Larter's suspension are discussed by Justice Adamson in his decision in Larter v Hazzard (No 2) [2021] NSWSC 1451, but that is not readily accessible to paramedics. Paramedics and community members should not have to go looking to see if there are related court decisions to find why a paramedic has been suspended. The natural place to look is the records of the Paramedicine Council or the Paramedicine Board, and neither provide the relevant details.



JUMP ON BOARD WITH THIS YEAR'S **RESTART A HEART** CAMPAIGN

By **Jordan Furnell**, Campaign Coordinator, Council of Ambulance Authorities

Out-of-hospital cardiac Arrest (OHCA) affects thousands of Australians and their families every year. In Australia and Aotearoa New Zealand, about 30,000 people will suffer OHCA. Unfortunately, nine in 10 of those will not survive.

This is a terrifying statistic. OHCA can strike otherwise healthy people at any stage of their lives, leaving young families without parents, children being taken away from their loved ones, and grandparents being robbed of their hard-earned retirement.

As a community, we can improve this horrifying situation. A good starting point is to spread the message of **CALL. PUSH. SHOCK.**

CALL. PUSH. SHOCK. is an easy way to remember the steps to restart heart. When a bystander recognises that someone has suffered OHCA, they can:

1. CALL. Call 000 and ask for an ambulance. The emergency call-taker will also provide assistance on the next two steps.

2. PUSH. Begin cardiopulmonary resuscitation (CPR) compressions. Even if the responder is not trained in CPR, any attempt at compressions is better than no attempt.

3. SHOCK. If an automated external defibrillator (AED) is available nearby, have someone run and get it. The call-taker will be able to alert you to any community-accessible AEDs in the vicinity.

When someone suffers OHCA, the best way to give that person a chance at survival is to call 000 and begin CPR as soon as possible. One part of the problem is that not enough people know how to perform CPR. While any CPR is better than no CPR, untrained bystanders are far less likely to be comfortable beginning compressions.

The Restart a Heart campaign aims to change this. By spreading awareness on how to recognise OHCA and how to respond, Restart a Heart is looking to drastically improve survival rates.

In order to do so, the campaign has some important goals:

- Increased awareness of the message **CALL. PUSH. SHOCK.**
- Increased knowledge in detecting a cardiac arrest
- More AEDs in the community
- An increase in people trained in CPR
- Mandatory CPR training in schools

For the past five years, the campaign has been growing bigger and bigger in Australia and Aotearoa New Zealand. In 2022, updated public-friendly branding has been launched, along with a new line of merchandise. After two years of virtual events, live activations are back in the plan for this year.

The events will be held in various locations throughout October, including flagship events in Adelaide, Sydney and Wellington. Airports in capital cities are getting involved to host CPR education activations, as are other community groups and schools.

A partnership with Build-a-Bear began in 2021 and has continued this year. Through this, there will be education sessions held at each of the Build-a-Bear Workshop locations throughout Australia on Thursday 13 October. It will be a fun way to spread CPR knowledge to children and parents nationwide.

Restart a Heart is welcoming new supporters throughout 2022. Organisations looking to get involved can earn their own AED, a CPR education session and more goodies than you can poke a stick at (including loveable Heartly, the Build-a-Bear).

Sports clubs, community groups, schools, and businesses large or small have specific ways to make the most of the support options offered. Head to restartaheart.net (or just Google Restart a Heart) to find the level of support that best suits you as an individual or organisation.

Be sure to follow all the developments of Restart a Heart on social channels. You will constantly see the best ways to spread awareness and information on out-of-hospital cardiac arrest.

And always remember: **CALL. PUSH. SHOCK.**

Paramedicine Board releases latest registrant data March 2022

Read report here: Paramedicine Board of Australia – Paramedicine Board releases latest registrant data March 2022

New Accreditation Committee members appointed

The Paramedicine Board of Australia (Board) announces the updated membership of the Paramedicine Accreditation Committee (Committee).

Following an initial 3 years of establishing and commencing the accreditation process for paramedicine programs of study under the National Registration Accreditation Scheme, all positions on the inaugural Committee were advertised for appointment for the next three-year term.

Read full story: https://www.paramedicineboard.gov.au/News/2022-06-07-new-accreditation-committee.aspx

Code of conduct for paramedics is in effect

The revised Code of conduct (the code) for paramedics is in effect with resources to help practitioners understand and apply the code also published.

The Paramedicine Board of Australia (the Board), along with 11 other National Boards, is pleased to see the revised shared Code of conduct come into effect today and is encouraging all practitioners to familiarise themselves with it.

Read full story: https://www.paramedicineboard.gov.au/News/2022-06-30-Code-of-conduct-in-effect.aspx

Paramedicine Board acknowledges paramedics on international day

The Paramedicine Board of Australia (the Board) is today acknowledging the hard work and dedication of paramedics on International Paramedics Day.

Today is the first ever Australasia International Paramedics Day, celebrating the important work of paramedics and responders around the world.

Read full story: https://www.paramedicineboard.gov.au/News/2022-07-08-Board-acknowledges-paramedics-on-international-day.aspx

Have your say on the English language skills registration standards – public consultation opens today

Public consultation on the English language skills registration standards opened 13 July, 2022. National Boards are inviting practitioners, community members, employers, education providers and other stakeholders to have their say.

Read full story: https://www.paramedicineboard.gov.au/News/2022-07-13-English-language-skills-registration-standards-public-consultation.aspx

Te Kaunihera Zui

Would you like the opportunity to meet members of Kaunihera via Zoom during their August hui? Kaunihera welcomes those who are available to an open forum1 Zui where you can meet Kaunihera members, kaimahi and our cultural advisor.

Kaunihera Zui

Date: Friday 12th August 2022

Time: 3.30pm – 4.00pm.

2022 Kaunihera hui dates

Kaunihera has agreed the following dates for 2022:

· Friday 12th August 2022

· Friday 7th October 2022

· Wednesday 7th December 2022

To read the latest newsletter, please visit: https://bit.ly/3oQIlNi

COVID-19 TASKFORCE

The Taskforce brings together the peak health professional bodies across Australia whose members are providing clinical care to people with COVID-19.

We are 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.

Australia is a world-leader in the development of living guidelines through the work of the Australian Living Evidence Consortium and in partnership with Cochrane, the world's most trusted provider of health evidence. This considerable expertise has now been deployed to ensure every Australian clinician has access to a single source of trustworthy advice about critical aspects of COVID-19 care.

Taskforce updates

To reflect changing language from ATAGI and to remove confusion among clinicians about what 'up-to-date' with vaccination means, the Taskforce has replaced this terminology across all relevant adult recommendations.

Vaccination status has been removed from the recommendation wording. Clinicians are now encouraged to make treatment decisions based on an overall assessment of the likelihood of progression to severe disease, based on age and other risk factors, including whether an individual has received a COVID vaccine dose, or had a SARS-CoV-2 infection, in the last 3–6 months.

Revised risk classification tool for adults mild COVID-19

Further to the revised vaccine language, the risk classification tool has also been updated with changes to age and comorbidity criteria.

To simplify clinical decision-making, the Taskforce guidance aims to help clinicians identify which patients are most likely to benefit from Paxlovid or Lagevrio, within the PBS eligibility criteria. In the absence of definitive evidence, this guidance is based on the consensus clinical expertise of the Taskforce.

The Decision tool for Drug treatments for at risk adults with COVID-19 who do not require oxygen has also been updated today.

TaskforceTV - COVID-19 care in the remote setting

In Episode 7, host A/Prof Tari Turner speaks with Dr Lorraine Anderson about the experience of COVID-19 in rural and remote settings, accessibility of treatment, comparisons with metropolitan response, and future improvements for care in rural communities.

A trained GP, Lorraine is the Medical Director of the Kimberley Aboriginal Medical Services, based in Broome, and has worked in Aboriginal health and rural areas for more than 12 years, predominantly in the Pilbara. She is a member of the Taskforce Paediatric and Adolescent Care Panel.

Updated paediatric recommendations for remdesivir

Following access to the clinical study report from the CARAVAN trial, the Paediatric and Adolescent Care Panel has incorporated the results into the evidence profile for the antiviral remdesivir.

These results, in addition to the clinical expertise of the panel, were sufficient to update the recommendations on the use of remdesivir in children or adolescents to the following recommendations:

Consensus recommendation

Consider using, in exceptional circumstances, remdesivir for the treatment of COVID-19 within 7 days of symptom onset in children and adolescents aged 28 days and over and weighing at least 3 kg who do not require oxygen and are at high risk of deterioration, where other treatments are not available / appropriate.

Consider using remdesivir only in children and adolescents who are not up-to-date with vaccination, or those who are immunosuppressed regardless of vaccination status. Do not routinely use remdesivir in children and adolescents who are up-to-date with vaccination unless immunosuppressed.

Decisions about the appropriateness of treatment with remdesivir should be based on the patient's individual risk of severe disease, including their age, presence of multiple risk factors, and COVID-19 vaccination status.

Consensus recommendation

Consider using, in exceptional circumstances, remdesivir for the treatment of COVID-19 in children and adolescents aged 28 days or older and weighing at least 3 kg who are hospitalised with severe COVID-19 (considered likely to progress to ventilation), who require systemic corticosteroids and oxygen but do not require non-invasive or invasive ventilation, where other treatments are not available / appropriate.

Note: Remdesivir is not TGA approved for mild disease in children < 40 kg.

Do Not Use

Do not start remdesivir in children and adolescents hospitalised with COVID-19 who require non-invasive or invasive ventilation.

Decisions to provide remdesivir to a child or adolescent should be based on the individual's combination of risk factors for deterioration and made in consultation with a paediatrician with expertise in the management of COVID-19 in children.

Please refer to the full recommendation and remark on our guidelines platform MAGICapp for further information.

New paediatric drug treatments decision tool

The Taskforce has now developed a paediatric decision tool to assist clinicians in deciding which drug is more appropriate for their individual patient.

The tool is based on the adult version with input from the Paediatric and Adolescent Care Panel, the Disease-Modifying Treatments Panel and the Guidelines Leadership Group.

Children and adolescents who are suspected to be at high risk of deterioration should be managed by and discussed with a multidisciplinary team.

New recommendation for oestrogen-containing therapies

Following publication of three cohort studies, the Primary and Chronic Care Panel has reviewed its guidance on the use of oestrogen-containing therapies.

The previous two recommendations were based on a theoretical increased risk of venous thromboembolism (VTE), with severe and critical COVID-19 leading to a higher theoretical risk of death. However, the new evidence from one large and two smaller cohort studies suggests that oestrogen supplementation in post-menopausal women may be beneficial as it was shown to reduce the risk of death.

As a result, the Taskforce makes the following consensus recommendation:

In women who have COVID-19 and who are taking oral menopausal hormone therapy (MHT), manage these medications as per usual care. In women who stop or suspend oral MHT, review the indication for this and consider transitioning to a transdermal preparation. Manage transdermal MHT as per usual care.

Decisions around stopping hormone therapy should be discussed with the patient or their substitute / medical treatment decision-maker. The goals of patient care need to balance the preferences and values of the patient, based on discussion and consideration of the patient's individual circumstances.

Consumer Panel welcomes new members

Earlier this year the Taskforce undertook a recruitment drive to bolster diversity on the Consumer Panel, with a focus on cultural and general experiences of living with or caring for someone with a chronic condition.

Last night the Taskforce was delighted to welcome four new members:

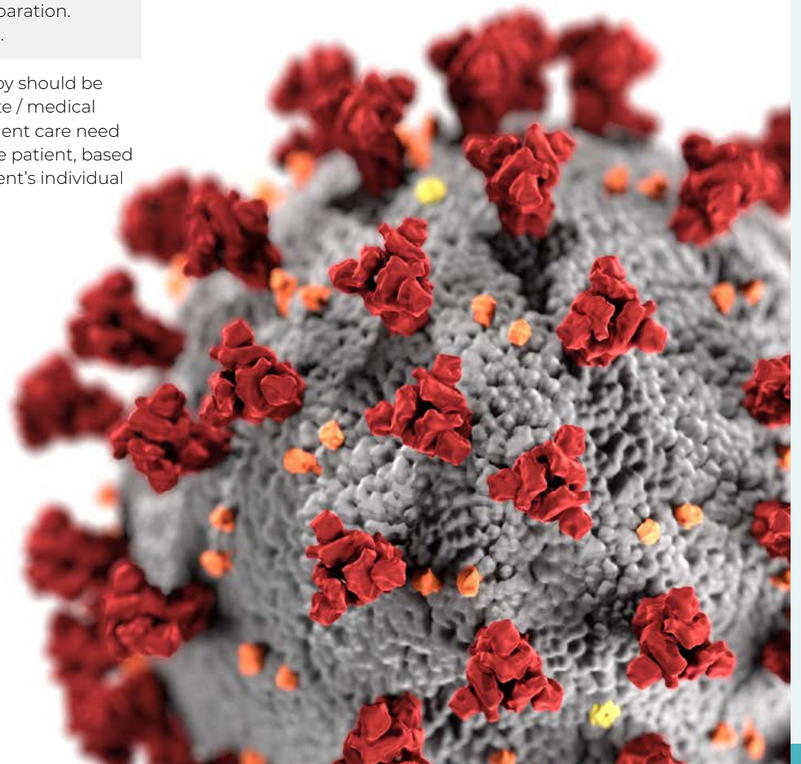
- Kealey Griffiths
- Michelle King
- Irene Mewburn
- Puspa Sherlock

We look forward to their input and their lived experiences shaping the guidelines over the coming months.

Sadly, the Panel also farewelled two members, Mya Cubitt and Elle Peters-Wisniak. The Taskforce is extremely grateful to Mya and Elle for sharing their unique insights and their thoughtful consideration for fellow consumers over the last 12 months.

At the meeting, the panel reviewed the paediatric recommendations on the use of nirmaltrevir plus ritonavir (Paxlovid) and their preferences and values statement will be incorporated into a future version of the guidelines.

Information collated from COVID-19 Taskforce communications. Check the website for more information: https://covid19evidence.net.au/



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