Australasian College of Paramedicine
50 Years
RESPONSE
WINTER 2023
www.paramedics.org

MAKING A WORLD OF DIFFERENCE:

ICRC paramedic empowers ambulance services in world's hot spots **P20**

CULTURAL EVOLUTION:

AV CEO Jane Miller leads new era of organisational transformation **P18**

SEEING THE BIGGER PICTURE:

Paramedic develops first-aid visual learning tool **P22**

ON THE SPECTRUM:

The autistic patient **P32**

INSIDE

College News
04 Message from the Chair
05 Message from the CEO
07 Building relationships, driving change
08 The patient side of paramedics: Looking through a different lens
10 Lauren's update to come
11 Webinars, mentoring and ACPIC abstracts: What's new from the College's Research Committee
12 Collaboration and innovation at College's inaugural Critical Care Summit
16 Dr Paul Simpson leaves many legacies in his five years as College Research Committee Chair
17 Congratulations to our College-sponsored student award winners

Features
18 Cultural evolution: AV CEO Jane Miller leads new era of organisational transformation
20 Hato Hone St John delivers better health equity through innovative telehealth and telecare solutions
22 Making a world of difference: ICRC paramedic empowers ambulance services in world's hot spots
24 Seeing the bigger picture: Paramedic develops first-aid visual learning tool

Professional Practice
26 Unleashing the potential: Empowering paramedics with professional capabilities
29 How do we keep paramedics in paramedicine?

Clinical Practice
32 The autistic patient

Education
36 Fostering new career opportunities for paramedics
38 Developing clinical simulation that is purposeful, meaningful, and evidenced-based
40 A personal reflection on the transition into academia

Paramedic Wellbeing
42 Can social connection enhance resilience among paramedics?
44 How reasonable is "reasonable overtime" in an already fatigued workforce?

Research
46 Through the looking glass: Why is understanding the patients' perspective of paramedic-led healthcare important?
50 Enhancing rural and remote paramedic capability through mobile simulation: The GippSIM project

Legal/Ethics
54 SafeWork v NSW Ambulance

Moments in History
58 Thredbo landslide: Death strikes in darkness, mud, and ice

Sector News
60 Sustainability in ambulance
61 Get to know Ambulance Tasmania's new Chief Executive
62 Major milestone marks anniversary
63 Employment opportunities and different career pathways aplenty in SAAS
64 Crews provide critical support at iconic event in the heart of Australia
66 Ahpra news, NZ Paramedic Council news, National COVID-19 Clinical Evidence Taskforce

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COVER

Matt Earl, ICRC Prehospital Emergency Care Delegate, Somalia Delegation.

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

FROM THE CHAIR

COLLEGE'S CONSULTATIONS ARE HELPING TO SHAPE THE FUTURE OF PARAMEDICINE

with **Ryan Lovett,** College Chair

Welcome to the Winter edition of *Response*.

The importance of consultation cannot be overstated. As the peak professional body leading, representing, and supporting paramedicine in our region, consultation provides a platform for the College to gather valuable insights from our membership, the wider profession, and our stakeholder network. Likewise, feeding back the results and insights from our consultations is as critical as asking the questions themselves, and so in this month's column I will share some high-level results and updates on the consultations we released earlier in the year, and our next steps.

CONSULTATION ENSURES THE PROFESSION REMAINS IN THE DRIVER'S SEAT OF ITS FUTURE

The consultation surveys captured diverse and considered feedback from paramedics who live and work across Australasia, from those working in rural and remote areas where we know consumer access and workforce resourcing is a serious daily challenge, right through to academic and research roles where workplace flexibility and emerging roles dominate discussion. It can be said that the overarching sentiment, from paramedics across all settings, roles and locations, is the importance of professional recognition and person-centred care.

How paramedicine is widely recognised by governments and stakeholders has the power to effect change in policy and legislation, multidisciplinary models of care, funding reform, career pathways and opportunities, workforce wellbeing and, ultimately, person-centred care.

The first discussion paper "Paramedicine: Recognition as a standalone profession" outlined the clear differences between paramedicine and other health professions, the challenges that professional alignment presents, and the impact and opportunities that standalone status could offer for the profession. While the path towards recognition may not be clear and a stamp of status may not literally exist, the feedback from the consultation was indisputably in favour, with 95% of respondents choosing "yes, paramedicine should be recognised as a standalone profession". This is clearly an important sentiment for the profession, and through our work advocating for the profession, recognition underpins all our activities and messaging.

Not surprisingly, we received the highest engagement on the "Draft Clinical Practice Framework for Australasia" consultation, underscoring just how important a framework is for our profession. More than 80% of respondents were in favour of the proposed framework, with strong support also for proposed titles, timings, education and descriptors. Behind the scenes, we have actioned the next phase of consultation by appointing a special project group - comprising paramedics representing diverse roles across the profession - that will review the consultation feedback and make further recommendations in regard to levels and language, and we look forward to sharing progress in time. This work will flow into a complete career framework for paramedicine that covers clinical practice, education, research, leadership and management, and these will be addressed in separate consultations.

The third consultation we released proposed a model of professional practice programs, delivered by the College to ensure consistently high clinical standards across the paramedic profession to support better patient care. Overwhelmingly, 92.98% of respondents voted "yes" in support of a consistent, structured, clinical and experiential development program for graduate paramedics entering the workforce. In a time of emerging roles and an evolving healthcare landscape, these programs are becoming more important and will continue to be developed with further engagement from the profession.

Lastly, but certainly not least, was the final discussion paper that took a big-picture, forward-thinking view of the profession, identifying five priority areas in which to build a future-ready workforce. These areas covered creating positive workplaces, diversity and inclusion, professional capabilities, education and qualifications, and workforce flexibility.

Consultation is the exchange and collaboration of ideas; it guides informed decision-making and ensures the profession remains in the driver's seat of its future. Every comment provided is reviewed and considered, and I encourage everyone to continue to share your voice, ask questions and participate in the advancement of your College and our unique profession.

Stay safe.

FROM THE CEO

ENGAGING MEMBERS AND THE PROFESSION

with **John Bruning,** College CEO

In today's dynamic and rapidly evolving health landscape, associations such as the College play a pivotal role in connecting individuals, collaborating with stakeholders, and moving the profession forward. The success and relevance of the College relies on the engagement and active participation of its members, and the profession. Member engagement is a crucial aspect that can drive growth, foster collaboration, and enhance the overall impact of the College.

We have begun the process of recruiting four full-time Regional Engagement Officers, who will undertake "on the ground" engagement across Australia and Aotearoa New Zealand. The Member Engagement team will be working closely with local volunteers and members to improve our events and activities, engagement with and connection to the College, and ultimately growing our membership. Our objective is to achieve more face-to-face connection with members and the profession, ensuring we are bringing paramedicine together.

OUR OBJECTIVE IS TO ACHIEVE MORE FACE-TO-FACE CONNECTION WITH MEMBERS AND THE PROFESSION, ENSURING WE ARE BRINGING PARAMEDICINE TOGETHER

Member engagement has been challenged over the past few years, and there is clearly significant fatigue across the profession that has impacted participation and connection. The College relies on volunteers to support many of our activities, from conference organisation to research activities and everything in between. The College was founded on bringing the profession together and advancing paramedic practice. It is hard to do that without engagement that builds a strong and vibrant professional community.

With this in mind, the Board and Executive team have assessed how we are engaging members and the wider profession, and what we can do to better engage and connect with you. We are in the process of refocusing on our member services to better engage with members and all paramedics and students in the profession.

The Member Services team will now be called the Member Engagement team, with a clear objective of engaging and connecting with members and everyone in paramedicine. We have hired Alisha McFarlane as Member Engagement Manager and leader of this team. Alisha is an Intensive Care Paramedic, educator and academic, and a long-standing College member who has been an active volunteer supporting the work of the College. Having worked in both ambulance services and universities, as well as having a close relationship with the College, Alisha is ideally placed to lead our work in engaging and connecting with the profession.

Member and profession engagement acts as the cornerstone for building a strong and vibrant profession. When members actively participate, they contribute their expertise, share knowledge, and engage in meaningful discussions that enhances the College. This can be seen in the Chair's piece of this edition of Response and the highly beneficial engagement we achieved across our four consultations and the insight provided by members.

The College undertakes a vital role in representing the interests of paramedics and advocating for policy changes. Member and profession engagement becomes essential in this context, as a unified and engaged profession provides a stronger voice to influence policymakers and regulatory bodies. Active participation allows the College to gather diverse perspectives, understand member concerns, and articulate them effectively. By renewing our focus on member engagement, the College can amplify our advocacy efforts and have a greater impact on shaping policies that affect paramedicine.

With so much change ongoing, the College needs to adapt and remain relevant to the evolving needs of our members and the profession. Member engagement is vital for the success and longevity of the College. It fosters a strong community, drives innovation, enhances professional development, strengthens advocacy efforts, and ensures the College's relevance in a changing health landscape. By creating meaningful opportunities for collaboration, participation, and contribution, associations can build a thriving ecosystem that benefits both individual members and the profession as a whole.

Stay safe and well.

ADVOCACY IN ACTION a snapshot

We are the largest paramedicine peak body in Australasia advocating for all paramedics working across clinical and non-clinical settings.

We are future-focused and committed to improving person-centred care.

We advocate with decision-makers to build sustainable models of care that improve workforce flexibility, career opportunities, recognition of capabilities, and much more.

40+

Key government and stakeholder discussions

20

Consultation submissions

11

Key media items

142.4 MILLION*

Audience reach through media coverage

483

People responded to our first online College Poll

4

Discussion papers were released inviting the profession to engage in topics that will help shape the future of paramedicine

Launched *Advocacy in Conversation* podcast

Date range October 2022 – July 2023 (*estimated audience coverage rounded up based on publication-wide coverage)

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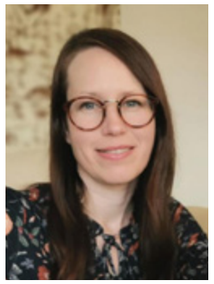
BUILDING RELATIONSHIPS, DRIVING CHANGE

By **Jemma Altmeier**,
College Advocacy and Government Relations Manager



The College has a strong advocacy voice. We represent all paramedics across emergency, urgent and primary care, as well as paramedics working in non-clinical roles. We actively lobby with governments to implement the changes needed to advance the profession and better utilise the workforce. We also build meaningful, supportive and collaborative relationships with stakeholders from across the sector as high-quality integrated care starts with collaboration and co-design.

Throughout the last quarter, we have continued to put pressure on federal and state governments across Australasia to recognise the profession's capabilities and expand opportunities for paramedics to work in multidisciplinary teams in urgent and primary care to improve healthcare access and outcomes.

Just last month, after almost a year in development, the Assistant Minister for Mental Health and Suicide Prevention and Assistant Minister for Rural and Regional Health, the Hon. Emma McBride MP, together with the Office of the Rural Health Commissioner, released the Ngayubah Gadan (Coming Together) Consensus Statement, something the College proudly collaborated on and endorses. This landmark Statement, defines Rural and Remote Multidisciplinary Health Teams within the contemporary Australian context, recognising the contribution of the health workforce in meeting the unique health needs in rural and remote communities, particularly for First Nations Australians.

To acknowledge the release of this important Statement, College CEO John Bruning spoke with Associate Professor Dr Faye McMillan AM, Deputy National Rural Health Commissioner - Allied Health and Indigenous Health, to discuss the development of the Statement and the impact it may have. This is a must-listen podcast for anyone working in or interested in co-designed healthcare with First Nations Australians, and we thank Faye, "a friend of paramedicine", for her time, knowledge and support.

On the opposite page is a snapshot of some of the activities the Advocacy Team has delivered across Australia and Aotearoa New Zealand.

Key submissions (May-July):

- AU: Department of Health and Aged Care - National consultation to improve alignment and coordination between the Medical Research Future Fund (MRFF) and Medical Research Endowment Account (MREA)
- QLD: Health Equity Implementation Feedback
- Aotearoa NZ: NZ Health Survey Feedback
- AU: Climate Change and Health Strategy
- AU: Department of Treasury: Measuring What Matters
- VIC: Diverse Communities Mental Health and Wellbeing Framework

The team will be recording another live session of Advocacy in Conversation at ACPIC 23, as well as pop-up activations. This is a great opportunity to learn more about the advocacy work the College does for its members and the wider profession.

Industry experts, influencers and change makers discuss current events, issues and resources impacting the paramedic profession.

www.paramedics.org/advocacy

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COLLEGE NEWS

THE PATIENT SIDE OF PARAMEDICS: **LOOKING THROUGH A DIFFERENT LENS**

By **Julie Johnson,** College Education Manager

We can all be accused of having tunnel vision at times. For whatever reason, tiredness, feeling overburdened, being too focused, or just not seeing the bigger picture can leave us unaware of the impact our lineal approach has on our patients. Seeing the world through another person's eyes might make us rethink. It would be great if it were as easy as putting on someone else's glasses, but it isn't. So how do we broaden our view of the world around us and what does professional learning have to do with it?

As paramedics, we move in circles that are privileged. We are invited into people's lives at times when they are most vulnerable. We are trusted to support people we have never met before and provide care and treatment for them at a time when they are feeling most scared. We are also privileged with knowledge and skills that others may not have. That can mean we make assumptions about how others see us, too. That tunnel vision can extend just as much to the expectation we have of our patients. We think they understand what a paramedic does, and where their skills and experience sit, but as many of us have been caught out, some of our patients and the community have little understanding of our complex role.

WE CANNOT KNOW EVERYTHING THERE IS TO KNOW ABOUT EVERYTHING, BUT WE CAN KEEP LEARNING

Continued professional learning can help to bridge some of the gaps. We can only influence our own behaviour, not everyone else's, but we can work towards educating our patients, our peers and our community. However, we need to look towards our own knowledge and examine if there are opportunities for us to improve, highlight areas for growth, and be inquisitive.

Let's look at it in perspective. Many times during a shift we attend people who tell us all sorts of things about their life, their history, and stories of the past, including sometimes past test results, medications and conditions. We listen and take what we need, leaving the rest, sometimes glossing over what we don't feel is important, or maybe what we don't understand. What we don't see is when we leave the patients in the care of the next healthcare provider; they often retell the stories and history over and over again. Little pieces of the puzzle get lost along the way.

Some of this information may be significant. How do you decipher what is important without the overburden of having to know everything? You can liken the pieces of learning we do along the way to ingredients in a complex recipe. If we throw them all in together, we might create a masterpiece or we might create an epic flop, too. Just as ingredients are carefully measured and included for the value they add, information is much the same. What we leave out is just as important as what we include. How we factor it into the mix is important; anyone who has added eggs to beaten butter too fast knows that it is very easy to curdle the cake mix and you have to start again.

What is the point of learning everything there is to know about Brugada syndrome if you haven't mastered sound ECG recognition or care of the patient with syncope? This doesn't mean that learning about Brugada syndrome isn't important, it means the learning has a place and an order. It is an ingredient in the process of learning. It means we are less likely to dismiss the male patient in their 30s or 40s who casually comments that they have fainted a few times for no reason, or that their father had a sudden cardiac arrest when he was 40. It is a piece of the puzzle that is key, and may be significant if overlooked. If you brush over that detail when the patient is relaying their story to the next healthcare provider, they may not bother to share that piece of information with them - it is therefore lost. In their mind, the paramedic didn't seem to think it was relevant so they omit it when retelling their story.

So back to education being the key. We cannot know everything there is to know about everything, but we can keep learning. We can plan our ingredients for the recipe of lifelong learning. Just like a creative masterpiece is multidimensional and far from boring, your professional learning portfolio should follow the same suit. Read a little, participate a lot, engage with others, investigate strengths and areas for growth, and be curious. Try not to limit your CPD engagement to just one style of learning. Try to participate in a live webinar, listen to a podcast, watch a recording, complete an eLearning course and read a journal article. You can build your knowledge in a subject by engaging in a variety of offerings. Consider looking at CPD as building your own creative masterpiece unique to your learning goals and career objectives.

Ways to learn with the College

eLearning courses: https://paramedics.org/eLearning

Live webinars: https://paramedics.org/events

Recorded presentations: https://paramedics.org/recordings

FREE microlearning: https://paramedics.org/eLearning/studyareas/free-microlearning

Conferences and events: https://paramedics.org/events

Podcasts: https://paramedics.org/podcasts

A WORD FROM THE COO: **ENHANCING YOUR MEMBERSHIP EXPERIENCE**

By **Lauren Daws**, College Chief Operating Officer

I hope this message finds you well and in high spirits as we move into one of the College's busiest times of the year. Within the College administration, we have been working hard behind the scenes on planning improvements all aimed at providing you with a better and more streamlined member experience. What follows is a short update on some of the things we are working on.

Improvements to our Continuing Professional Development (CPD) tracker: Enhanced usability

The College champions the importance of lifelong learning and the value of your continuous professional development. We have listened to some member feedback and are making some adjustments to our CPD tracker to ensure a more seamless and user-friendly experience. You may notice some small changes over the coming months that improve functionality and access to resources. The changes will not impact any of your data and you can continue to use the CPD tracker as normal. Beyond this, we also continue to work on the College website behind the scenes to ensure your member experience continues to improve.

Expanding our Regional Engagement Team: Growth and connection

As mentioned by our CEO, John Bruning, in his column, we are delighted to be recruiting a dynamic Regional Engagement Team. Their mission is to build stronger connections with our members across different regions, understanding your needs and catering to your unique requirements, and to grow our membership base to strengthen the College and enable us to provide more opportunities for members. We believe that fostering a more localised approach will allow us to better serve you and facilitate a stronger sense of community. Led by Member Engagement Manager Alisha McFarlane, we are excited to be moving into this phase in the second half of 2023.

A new focus for our student members: Investing in the future

We firmly believe in nurturing the next generation of paramedics, and that starts with our student members. To provide them with the best possible experience, we are strengthening relationships with university student societies and building our presence on campus and within the students' university experience. We aim to provide student members with valuable resources, opportunities, education and a strong support network to help them succeed as they embark on their professional journey.

ACP International Conference: Lead, Evolve, Impact

As I write this, we are now just six weeks out from our much-awaited International Conference, ACPIC23, scheduled for 13-15 September in Melbourne. This wonderful event will bring together the best research and clinical content for paramedics across our region and is a unique opportunity for knowledge exchange, professional development, and networking with experts in the field. Register at https://paramedics.org/ACPIC2023 today so you don't miss out on our interactive workshops, keynote speakers The ResusRoom, and Gala Dinner guest, Samuel Johnson OAM.

A note of gratitude

Before I go, I must extend my appreciation to the dedicated members of the ACP International Conference Organising Committee led by Lucy Oatley, and to our Conferences and Event Manager, Georgia Coetzee. Their meticulous planning and unwavering commitment have been instrumental in shaping this event. I must also thank Nigel Barr for leading the scientific element of our conference and the tremendous amount of work that has entailed to date. We are truly grateful for the committee's hard work and I hope to see you all in Melbourne in September for ACPIC23 for what will be a fantastic event.

As we forge ahead, our focus remains on serving you better and creating an enriching membership experience. We look forward to strengthening the College's foundations through strong growth and a robust member offering.

Thank you for being an essential part of our College. Your support is what enables the College to do the work to lead the profession forward and create new opportunities and experiences for paramedics in Australasia.

Warm regards,
Lauren Daws

WEBINARS, MENTORING AND ACPIC ABSTRACTS: WHAT'S NEW FROM THE COLLEGE'S RESEARCH COMMITTEE

Talking Research webinar

The College Research Committee is delighted to present the latest Talking Research webinar and special 50th-anniversary edition, shining a spotlight on 50 Years of Paramedicine Research. We were honoured to have esteemed paramedic scholars and leaders in this field guide us through the remarkable journey of paramedic research over the past five decades.

Hosted by the committee's own A/Prof Scott Devenish, in this session Prof Peter O'Meara explored the evolution of paramedicine research and the progress achieved by the paramedicine research community. Prof Bill Lord provided valuable insights into the current challenges faced by paramedicine researchers and advocated for initiatives to enhance the visibility of research as a career pathway. A/Professor Louise Reynolds concluded the session by highlighting the importance of strengthening the future research capacity within the profession while forging a robust evidence base to support and inform paramedic practice.

If you missed this milestone Talking Research event, it is available on the College website at https://paramedics.org/events/50-years-paramedicine-research and counts towards 1.5 hours of interactive CPD.

Our next topic is The Patient Experience, where A/Prof Belinda Flanagan, Robbie King and A/Prof Mats Holmberg will explore current research focused on the patient perspective of care. Don't forget to register for this event, being held on Wednesday 16 August, 7.30-9pm AEST, and read Robbie King and Alannah Morrison's corresponding article in this edition of Response "Through the looking glass: Why is understanding the patients' perspective of paramedic-led healthcare important?".

Paramedic Research Mentoring Program

The Paramedic Research Mentoring Program was envisioned by the Research Committee as a pathway for registered paramedics to learn about research directly from experienced paramedic academics. As we reach the halfway point of the 2023 program, we recently held our second workshop focused on Paramedicine Research Pathways. This engaging event featured guest speakers who generously shared their insightful and personal experiences in navigating diverse research careers.

Laura Stephensen eloquently reflected on her journey into paramedicine research, providing a valuable understanding of the benefits and complexities associated with conducting clinical research full-time. We were also joined by MICA flight paramedic Dr Ben Meadley, who shared his incredible story of achieving the dual role of clinician-academic and why this position is necessary for the continued development of the profession. Our workshop facilitator, A/Prof Paul Simpson, finished the session with a thoughtful exploration of what constitutes an academic's role, the realities of research as an academic in a university program, and the importance and significance of mentorship in building a successful and sustainable academic research career. Mentors and mentees will continue to meet for informal discussions monthly and we are looking forward to our final workshop in November. For those interested in learning more about the College's Mentoring Program please visit https://paramedics.org/research/mentoring. EOIs are now open for the 2024 program.

ACPIC 2023 scientific abstracts

ACPIC 2023 is the peak paramedicine event on the Australian calendar, offering a wonderful opportunity for paramedicine researchers to present their research to the broader paramedic community. This year, we received an unprecedented number of abstracts, which were meticulously reviewed and assessed by a selected group of peer reviewers and the ACPIC 2023 Scientific Committee. We would like to express our gratitude to all researchers who submitted an abstract and extend our congratulations to the successful ACPIC 2023 applicants! Don't forget to secure an early bird ticket to the conference, which are now available to purchase at https://paramedics.org/ACPIC2023.

Meet the researcher: Derek Collings-Hughes

Derek is a paramedic from Western Australia who originates from Aoteroa New Zealand. He currently balances several roles as an ambulance paramedic, a lecturer, and a PhD candidate. His research interests include professionalism, ethical decision-making, and using evidence to inform system improvements within paramedicine. His present research focuses on the epidemiology and emergency response to water-based emergencies in WA, aiming to improve emergency services' preparedness and response to these complex emergencies. In his moments of respite from work and study, Derek immerses himself in nature, enjoying mountain biking or hiking with his dog.

COLLABORATION AND INNOVATION AT COLLEGE'S INAUGURAL **CRITICAL CARE SUMMIT**

By **Georgia Coetzee,** College Conference and Events Manager

"I think that the concept of this type of conference is really exceptional. I think we tend to work in our own little silos, whether its clinical medicine, paramedicine, nursing or allied health, and so having everyone come together in the same room and collaborate and share experiences and learn from each other is a real breath of fresh air."

Dr Sanj Fernando, Critical Care Summit keynote presenter

SPEAKERS: **15** >> PRESENTATIONS: **9** >> ATTENDEES: **219**

On May 25-26, we held our inaugural Critical Care Summit in Tweed Heads, NSW. As the summit unfolded, it became abundantly clear that attendees were in for an exceptional experience. With a captivating blend of an insightful keynote presentation, interactive panel discussions, and thought-provoking workshops, the Critical Care Summit fostered an environment where collaboration and innovation thrived.

The Critical Care Summit was designed to bring all clinicians involved in the care of critically unwell patients together in a collaborative and collegial way, to share knowledge among peers and professions and to ensure that the patient is always at the centre of clinical decision-making. This new College event delivered a broad range of topics relevant to critical care and showcased the impact of interdisciplinary clinical care from the pre-hospital to the hospital setting.

Our comprehensive program brought together 15 skilled presenters from around Australasia, giving delegates the opportunity to experience a comprehensive paediatric masterclass, the ethics of critical care, how to adapt to the challenges in critical care, the art of low-fidelity

simulation, and some healthy debate on critical care controversies, to name a few. The diverse range of presenters enriched the discussions, providing multidimensional perspectives on contemporary care challenges.

As the sun set on the first day of the highly anticipated summit, attendees gathered for a comical and informal debate featuring some of the conference's esteemed presenters who argued "Critical care should only be for the cities". The lively exchange of humour set the stage for the networking drinks that followed. As conversations flowed, the networking drinks provided a relaxed atmosphere for professionals from diverse backgrounds to interact, exchange business cards, and lay the groundwork for future collaborations.

Day two began with a recording session of our podcast Advocacy in Conversation, with College CEO John Bruning joined by special guests Michelle Murphy ASM, Dr David Anderson, and Adjunct Associate Professor Gayle Christie. The panel discussed the impact of policy and legislation on paramedic scope of practice, while also sharing insights and perspectives on the existing and potential roles of paramedics in contemporary critical care. This podcast, as well as other College podcasts, can be found at https://paramedics.org/podcasts.

By the time day two drew to a close, attendees departed with new-found knowledge, practical tools, and a renewed sense of purpose to transform healthcare through collaboration. The Critical Care Summit not only fulfilled its purpose, but also laid the groundwork for continued conversations, innovation, and collaboration within the healthcare community.

The Critical Care Summit will return every second year, and I look forward to seeing you in 2025.

Thank you

Thank you to the Conference Organising Committee Co-Chairs, Dr Ben Meadley and Tim Andrews - from inception to completion, this wonderful event would not have been possible without them. Thank you to our Event Sponsors: Charles Sturt University, Monash University - Department of Paramedicine, Edith Cowan University and Trade Exhibitors: Diagnostica Stago and ZOLL Medical.

Missed the summit?

Session recordings are available on the College website under Recordings, search the menu "Critical Care Summit 2023". Recordings are free for College members: https://paramedics.org/recordings.

Advertorial

ACPIC23: THE ONLY DEDICATED PARAMEDICINE CONFERENCE IN AUSTRALASIA

Tickets are now available for the Australasian College of Paramedicine's International Conference (ACPIC23), the only dedicated paramedicine conference held in Australasia.

ACPIC23 has been structured to equip you with information and skills to assist you to lead the profession with your knowledge, evolve in your career, and impact others in a positive way.

Focusing on providing education and research that paramedics need, ACPIC23 is an in-depth comprehensive paramedic conference that attracts attendees from across Australia, New Zealand and beyond.

The ACPIC23 program includes workshops, conference sessions and social events, and is the ideal opportunity to boost your CPD in the presence of like-minded practitioners.

ACPIC23 will be held at the Crown Conference Centre, Melbourne, Victoria, from 13 – 15 September 2023.

For more information on the program, presenters and speakers, and to book your tickets, visit our ACPIC23 website – paramedics.org/ACPIC23

ACPIC MELBOURNE 2023

KEYNOTE PRESENTATION: **THERESUSROOM**

Popular podcasters James Yates and Rob Fenwick from TheResusRoom are coming to ACPIC23. In their signature laid back style, James and Rob will try to answer questions such as What is advanced practice? Should paramedics work in these roles? What's it like to work in advanced practice? What benefits are there for wider healthcare systems?, plus many more.

Combining research, best practice and insights from their (many) years of experience with banter and light-hearted commentary, this keynote address aims to be educational, aspirational and not too boring.

THE RESUS ROOM

GALA DINNER SPEAKER: **SAMUEL JOHNSON OAM**

Join us for our Gala Dinner, with special guest speaker Samuel Johnson OAM. Samuel is a much-loved Australian actor and is well known for his charity Love Your Sister which he lovingly co-founded with his late sister Connie.

Gather and connect with your colleagues and enjoy the premier paramedic event of the year. Limited tickets available.

DR PAUL SIMPSON LEAVES MANY LEGACIES IN HIS FIVE YEARS AS COLLEGE RESEARCH COMMITTEE CHAIR

After five years at the helm of the College's Research Committee, we bid farewell to outgoing Chair Dr Paul Simpson, who has been instrumental in developing and expanding paramedicine research capacity, establishing a range of innovative programs and events, and enabling and supporting paramedics to enter the research field.

Among his many legacies as the committee's Chair are the implementation of the Paramedic Research Mentoring Program, which provides registered paramedics who do not have any formal research training with an opportunity to learn about research from experienced paramedic researchers; the popular Talking Research webinar; the reinvigorated College Research Grants; and the inaugural College Research Symposium in 2022.

"One of my real passions is building the capacity of and providing opportunities for the next generation of people, who I think are going to be the ones who come along and change the world with research," Dr Simpson said.

"Throughout my tenure on the Research Committee, it was about building capacity in other people or helping them see their latent capacity that they may not realise they have, and trying to connect them with other people who might be able to help them on their way to making a real impact.

"It's what the College is really about - building people up and providing opportunities. And that's, I think, what my underlying philosophy has been. Honestly, the College has probably been one of the biggest sources of professional development for me over the years."

Dr Simpson - an Associate Professor at Western Sydney University, an Intensive Care Paramedic with NSW Ambulance, and Editor-in-Chief of Paramedicine, the College's peer-reviewed international journal - has long championed the need for paramedicine-led, evidence-based research and has been at the forefront of the profession's transition into academia and the development of alternative career pathways for paramedics in academia.

"We're now in the position of developing our own research. That's been a huge transition, and a slow one. We're making it, but we still have a long way to go. The infrastructure to support this is emerging; for example, how the college invests more in research than any other professional college in paramedicine around the globe, I believe.

"The Research Committee is a pretty valuable opportunity for those who are interested in research. One of the great things about the committee is that it's not just senior experienced people; we intentionally sought to make places available on the committee for novice and early career researchers, who can provide deep insights into what College members might really need."

Despite the progress that has been made, Dr Simpson said the lack of net growth in the number of researchers meant more work was needed to create long-term sustainable career opportunities. At present in In Australasia, the academic workforce is comprised approximately 161 full-time or fractional and 727 casual paramedicine academics.

"A key problem is that there aren't many research jobs in the jurisdictional ambulance service industry. We tend to get people going through a research Master's degree and a PhD, but then they come out the other end and many don't continue on to be active ongoing researchers. When we advertise for a paramedicine academic position in the university sector, the pool of applicants is smaller than one would expect, so we have a real transition problem."

Spearheading the College's first Research Symposium was a step forward in bridging the divide and one of many highlights in his years as committee Chair. Collegiate in spirit, it was designed for paramedics at all levels who were interested in research.

> IT'S WHAT THE COLLEGE IS REALLY ABOUT - BUILDING PEOPLE UP AND PROVIDING OPPORTUNITIES. AND THAT'S, I THINK, WHAT MY UNDERLYING PHILOSOPHY HAS BEEN

"It was an opportunity for people with a real research interest to come together; not just all the high-level people, but on-road people, young research students, PhD students and established researchers, mingling in the one place having coffee together where it didn't matter what level you were, it didn't matter what your experience was. It was giving them the chance to dip their toe in the research waters, make connections, and find mentors."

Dr Simpson's fondest memories are of the teamwork, collaboration and collective efforts of his fellow committee members.

"The college has a great group of people who were so much fun and very professional to work with. Whatever I might have led or whatever things I've been involved in, it was made possible by the good people on the committee who co-conceived and co-implemented all that we did. It was a collective success."

CONGRATULATIONS TO OUR COLLEGE-SPONSORED STUDENT AWARD WINNERS

The College congratulates the recipients of our 2023 Monash University sponsored awards, who were recognised for their achievements on May 24:

- **Morgan Walker** - ACP Academic Achievement Award
- **Lucinda Peacock** - ACP Honours Research Excellence Award
- **Ming Xuan Han** - Murray Black Professional Excellence Award

The Murray Black Professional Excellence Award is named after the late Ambulance Victoria paramedic Murray Black. Murray was known for his dedication and passion to his profession, his tenacity and honesty. It is awarded to the student from any year level who makes a significant contribution to the profession in line with the College's values, which include integrity, respect, accountability, competence and research.

We also congratulate the May 18 winners of two Victoria University College-sponsored academic awards at Victoria University:

- **Tahlia Harper (Bachelor of Paramedicine)** - Outstanding Graduate Student in Allied Health
- **Laura Jean Ireland (Bachelor of Paramedicine)** - College Award for Excellence in Academia in Paramedicine

Lucinda Peacock

Tahlia Harper (Bachelor of Paramedicine) and Laura Jean Ireland (Bachelor of Paramedicine)

Ming Xuan Han

CULTURAL EVOLUTION: **AV CE JANE MILLER** LEADS NEW ERA OF ORGANISATIONAL TRANSFORMATION

Melbourne/Naarm, Wurundjeri Country

When Jane Miller began her tenure as Ambulance Victoria CE in January this year, she brought with her a clear vision of the organisational changes needed to address the issues of workplace culture, gender equality, inclusion and diversity, and the potential to reshape the service.

As a clinician and leader in the hospital sector for more than 30 years - including Deputy State Controller of Health Service Operations with the Department of Health, and Chief Operating Officer, Executive Director of Strategy and Organisational Improvement and Director of Strategy and Improvement at the Royal Children's Hospital - Ms Miller has long been an innovator and forward-thinker, and it is these qualities that are enabling her to chart new directions forward at a pivotal time of change for Ambulance Victoria.

"My experience has shaped me in terms of understanding how high-quality care can be delivered, how we continuously learn and improve, and how we create the leadership skills and capabilities that are necessary to support team members to do their best work each and every day.

"I'm new to ambulance services, but we're still in the business of delivering high-quality patient care. My experience in hospitals has certainly given me very good insight into the relationships, the teamwork, and the communication needed to create the outcomes that we are all looking for and, for us as an ambulance service, that is being there for the community and delivering the best care when they most need it."

IT'S SOMETHING THAT WE'VE GOT TO REALLY BUILD INTO THE FABRIC OF THE ORGANISATION

Her ultimate aim is transforming AV, which will be laid out in a new organisational strategy. "The plan will underpin our transformation to be one of the highest performing ambulance services in the world in terms of our people's experience, healthcare outcomes for patients, impact and connection."

In the wake of the pandemic and its attendant stress on paramedics and the broader health sector, and in line with the reforms recommended in the Victorian Equal Opportunity and Human Rights Commission's confronting 2021 Workplace Equality at Ambulance Victoria report, there is a clear opportunity and need to reconceptualise the way in which the service operates, its organisational culture, and how its people are supported.

"Over the last five or so months that I've been on board, we have been working hard with our senior leadership team as well as our sector partners to set our new strategy. It's about transforming for better; recognising that there is absolutely fantastic work done each and every day across Ambulance Victoria, but that there are some very significant challenges as we emerge from a pandemic.

"There's ongoing health system pressure and there is a need for us to continue to focus on improving the services we provide and delivering better outcomes for our patients. We are working to prioritise new models of care for patient service delivery, supporting our people to really thrive in the workforce, and creating a safe, fair and inclusive workplace."

Ms Miller said transforming organisational culture was a priority, with the starting point being collective clarity about AV's purpose and values, and team members' shared expectations of workplace conduct and behaviours.

"It's something that we've got to really build into the fabric of the organisation. I think, for me, the most important part around that cultural transformation is to be very clear that every person at Ambulance Victoria has an important role in shaping that culture, and in enabling themselves and their colleagues to be their best selves in the workplace.

"As the Victorian Equal Opportunity and Human Rights Commission identified, there have been some very confronting experiences for our people and we weren't always providing a safe workplace. We absolutely have to be clear about what it's going to take to make sure that we are safe, fair, and inclusive. To do that, I think we need to engage in conversations about how we bring those values to life. What behaviours help us bring that to life? How do we really support our people to thrive and be part of this journey together?"

IT'S NOT GOING TO BE A SINGLE INITIATIVE, IT'S GOING TO BE A COLLECTION OF STRUCTURES AND PROCESSES TO DELIVER MEANINGFUL CHANGE

Ms Miller said equally important was a focus on "reflective practice" and the need to ensure a psychologically safe environment for people to speak up and share their experiences - a process that in turn would help identify opportunities for improvement.

That goal moved a step closer last month following an announcement by Victoria's Department of Justice and Community Safety that, in collaboration with AV management, employees, volunteers, unions, professional associations and the Department of Health, a restorative engagement scheme for the service will be launched in 2024.

The scheme and will offer a range of possible outcomes for current and former employees and volunteers, including individual apologies, statements of regret, and financial compensation, as well as restorative sessions with senior leaders.

"The process at the moment is around focusing on how we co-design the scheme to meet the needs of our people and the organisation. But we're also doing a range of things, of which the restorative engagement scheme is one part. We've established a new Professional Standards and Behaviours Department that provides different channels for people to report and raise workplace concerns, which again will help us understand experiences and enable us to act.

"There will also be training and capability around speaking up and for people to feel safe to voice their opinions in the workplace, and giving them the direction and the tools to be able to do that. It's all part of the cultural transformation; it's not going to be a single initiative, it's going to be a collection of structures and processes to deliver meaningful change."

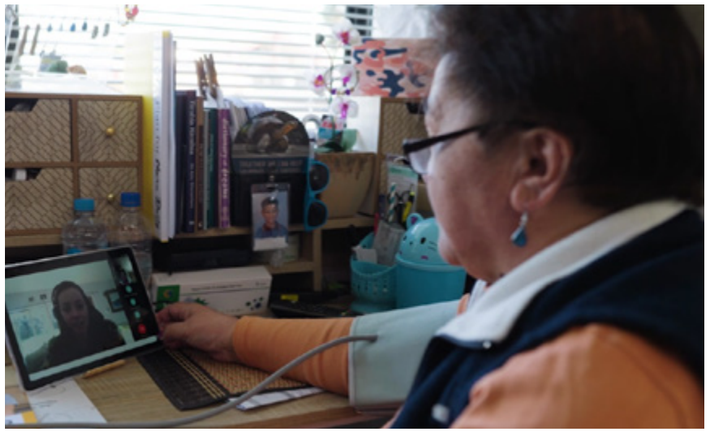
It's very much a holistic approach and one that not only looks to the future, but also reflects on the past as part of a necessary reckoning if the service is to effectively transform.

"It's about the future of AV and how it grows and evolves, building on what has come before with a steadfast focus on being a safe, fair, and inclusive workplace.

"There's enormous opportunity, but it takes fresh thinking and embracing opportunities to innovate across the breadth of organisational activities. This is the journey we're going on now."

HATO HONE ST JOHN DELIVERS BETTER HEALTH EQUITY THROUGH INNOVATIVE TELEHEALTH AND TELECARE SOLUTIONS

Tāmaki Makaurau/Auckland, Aotearoa New Zealand



Last year, Hato Hone St John began its Manaaki Ora journey and path towards achieving better health outcomes and equity for everyone - particularly Māori and Pasifika peoples.

Manaaki Ora is a five-year organisational strategy which sets out a guide based around five strategic aims that act as signposts, providing direction over the coming years.

In it signals a commitment to improving hauora Māori, health equity for all and community partnering, while also empowering our people to deliver innovative local solutions and building sustainability for future generations.

Research tells us that the average life expectancy for Māori is seven years less than non-Māori, with Māori also being twice more likely to die from cardiovascular disease and one-and-a-half times more likely to die from stroke. While life expectancy for Pasifika is five years less and one-in-three of all Pasifika deaths are from cardiovascular disease.

There is also a lack of trust in the national health system within Māori and Pasifika communities - sometimes resulting in their lack of engagement with services and critical appointments with their healthcare provider being missed.

To address this problem, Hato Hone St John has partnered in a pilot project with Pokapū o te Taiwhenua (a network within Te Whatu Ora - Lakes) on an innovative telecare initaitive called Whare Manaaki Pokapū 3.

Hato Hone St John National Equity Manager Dan Spearing said Whare Manaaki Pokapū 3 was a kaupapa (programme) designed to overcome the barriers people - particularly those who live in rural and isolated communities - may have in accessing healthcare through using video appointments and digital coaching.

It involves having a qualified ambulance officer (paramedic or Emergency Medical Technician) or nurse visit the patient in their whare to do an assessment.

Raylene Halkett (EMT), Dan Spearing, Sue Westbrook (POKAPU O TE TAIWHENUA Coordinator), Lizzie Johnston (Hato Hone St John), Winston (patient), family friend, Mike France (Paramedic), Winston's dad

DIGITAL TELEHEALTH APPOINTMENTS RETAIN MANY OF THE BENEFITS OF A PHYSICAL CONSULT, INCLUDING FACE-TO-FACE TIME WITH A CLINICIAN AND QUALITY OF CARE

"On the day of the patient's appointment, our friendly kaimahi (staff) will bring clinical care directly to the patient's whare. They'll set up everything in their home for the appointment, so they can just relax with their whānau or support person there," Dan said.

Internet coverage is not necessary as the telehealth equipment has everything it needs to send the clinician the information they need in real time.

"They have all technology to check the patient's vital signs, they will also have a kōrero with them about their hauora (health) and connect them to any follow-up appointments with a clinician or specialist at a hospital."

Digital telehealth appointments retain many of the benefits of a physical consult, including face-to-face time with a clinician and quality of care. In addition, they bring significant convienience because the appointment can be had from the comfort of home.

"For many whānau, this one feature overcomes serious barriers to accessing health services including financial stress, insufficient time, as well as work and whānau obligations," Dan said.

Hato Hone St John and Pokapū o te Taiwhenua are currently pursuing sustainable funding options following a successful trial with whaiora living in Rotorua, Mangakino, Murupapra and Turangi.

Another innovative telehealth initiative is Manaaki Mamao, which has been developed in partnership with technology company Spritely and builds on a successful pilot that attracted Ministry of Health funding in 2021. This telemonitoring service is designed to improve access to healthcare for Māori and Pasifika with high blood pressure.

Participants are given a tablet computer that automatically pairs to a blood pressure monitor that they use at home and allows people to track their health vitals.

Malcolm Kendall, Hato Hone St John National Māori Advisor - Customers and Supporters, said Hato Hone St John knew all too well the consequences of hypertension (abnormally high blood pressure), which is a key risk factor for heart attacks and strokes.

The Manaaki Mamao service is closely linked to primary care providers who refer their patients to the service and are notified about any conditions that need follow-up.

WE SEE HUGE BENEFIT IN THIS TYPE OF INITIATIVE

"The Hato Hone St John telemonitoring clinical team works closely with GPs to help set up care plans and monitor health vitals and the St John Telecare team help with the home installation plus ongoing wellbeing and technical support," he said.

"It's easy and simple to use for everyone and means the patient and their health providers can address issues early before they become a problem because we can't change what we can't measure. Being able to see their readings gives whaiora (patients) something to aim for and to change.

Hato Hone St John also has ambitions of turning it into an ongoing programme that addresses other conditions such as diabetes, COPD, and mental health and wellbeing.

"We see huge benefit in this type of initiative that essentially puts the ambulance at the top of the cliff, which ultimately helps reduce pressure on both the ambulance service and the wider health system in the long term."

To offer "manaaki" to a person is to uplift their mana. It is done through respect, care, and support. Most of all, manaaki requires us to cherish and comprehend the many layers and parts that make up a person and a community. Each of us are shaped by our sense of belonging, identity, place and whānau. By understanding these better, we build deeper and more profound connections.

"Ora" encapsulates health and wellbeing. This is more than the absence of pain, sickness, and injury. Ora is the path that we are all on, working to ensure mind, body and wairua are the best they can be. Working together to enhance the health and wellbeing for all.

FEATURE

MAKING A WORLD OF DIFFERENCE: ICRC PARAMEDIC EMPOWERS AMBULANCE SERVICES IN WORLD'S HOT SPOTS

Across Europe, Africa and Asia, Nairobi-based Australian paramedic Matthew Earl has been on the frontlines of some of the world's most heated conflict zones working on prehospital development projects, building ambulance services in countries of need, and helping to strengthen the capacity and clinical capability of under-resourced emergency healthcare providers.

In his six years with the International Committee of the Red Cross (ICRC), where he now works as a Prehospital Emergency Care Delegate, Somalia Delegation, he has been posted to Bangladesh, Myanmar, Nigeria, Kenya, and war-torn Mogadishu and Ukraine. Each has posed its own set of challenges and required a high level of adaptability, resilience and vision.

"My mission in Ukraine was very challenging and rewarding for all of the conflict dynamics and the fact that we ran our own little service and we were always facing some interesting ballistics challenges, so to speak. We were basically running our own prehospital unit. We had eight trucks we were running with paramedics on board, responding day to day.

"But it's not something you can ever prepare yourself for. The first time I saw a big incident was the cruise missiles that started hitting Kyiv that were on our pathway to work. You're seeing playgrounds and roads being hit by missiles, you're seeing cars scattered all over the place, blood on the ground. It's a catastrophe. It's through exposure that you learn how to cope, and the more you're exposed to it, the easier it gets."

In many of the conflict-affected countries within which the ICRC works, both the concepts of prehospital healthcare and paramedicine as a profession are largely unknown. For Matthew, this can mean starting at the bottom and working up, assessing needs, available resources, systemic and staff capability and capacity, and then developing contextually appropriate and sustainable systems. Foreign paramedics can then be brought in to teach clinical protocols and skills and oversee operational development.

"Bangladesh was probably a good example of that for me. We went in there with the vague target of looking at how we can develop national-level services, but to start that we had to do research that that told us what the baseline was. For a project like Ukraine, where the EMS was relatively functioning, it was a case of just getting in there and filling some emergency gaps. So it really depends quite a lot on the context.

THE FIRST TIME I SAW A BIG INCIDENT WAS THE CRUISE MISSILES THAT STARTED HITTING KYIV

"In a lot of our East African contexts, you straddle emergency response and prehospital development, so you want to develop a service that's able to respond immediately to needs, but you also have one eye on the longer-term development of the project as well."

Matthew said the five main categories of development he focused on were governance and financial sustainability around a health service, including who controls it and how it's funded; operations, including fleet composition, communication with other units, how resources are dispatched and managed, and waste management; health system integration, including whether they are standalone branches or services, how services are related to the wider health system and their connection with hospitals, and their medical oversight; accessibility, including how the public accesses the services, the cost, health literacy around the available prehospital or emergency care services, and safety and security implications; and, lastly, training and education. This involves assessing if it is a context in which a paramedic can be deployed to conduct basic 30-hour first responder training to get people up and running, or if is there a need to engage with universities in developing longer-term training courses and programs.

"There's a lot of questions to be asked around that. Is it accredited, is it recognised? Do the staff have continuous professional development or are they trained once and go out there forever? So those five areas are the key areas that we do our assessments, and we then come up with baseline scoring, recommendations for the ministries, for the different organisations involved, and for the other international organisations and NGOs that might be working there. We then work on piecing together a program that's contextually appropriate."

In Somalia, a country mired in conflict for the past three decades, the emphasis is on building prehospital capacity for an underfunded emergency health service that has struggled to cope with the prevalence of large-scale, mass-casualty events. Because of the ICRC's organisational mandate to operate in areas of conflict, the opportunity existed to work in-country to develop a more formalised response capacity.

In 2019, it launched a program together with the Somali Red Crescent Society (SRCS) aimed at moving from existing first response operations to broader and more effective prehospital treatment and care. Initially focused on Mogadishu, the program now covers a number of other cities throughout the country.

"We started by looking at the formalisation of dispatching resources in Mogadishu, so we put together a computer-aided dispatch program, we did some training of dispatchers, we standardised the ambulance units and the training. This is all still a work in progress of course, but statistically in 2018 we were reporting around 400 patients a year; this year we're going to report 10,000. The change is astronomical.

AN ADVENTUROUS SPIRIT IS DEFINITELY REQUIRED

"The usage has changed a lot as well; it used to be purely trauma response, now the ambulances are used every day for a variety of different roles, so medical emergency response, traumatic emergency response, and non-emergency patient transport as well. It's really developing the full suite of prehospital usages."

"Seeing the change from just a rudimentary first aid team almost to the development of three different, essentially more formal, ambulance services with short code access numbers, with dispatch platforms, and with a patient footprint north of 10,000 has been a huge achievement and really satisfying to work on."

It's a professional pathway he encourages paramedics from Australia and Aotearoa New Zealand who are interested in embarking on a non-traditional career outside of jurisdictional ambulance services to consider.

"They're really well recognised and highly thought of. It's a group of services that a lot of the developing world is looking at to be a model. It makes sense to have more in the pool.

"It's something that I think is probably built into a lot of emergency care workers, but an adventurous spirit is definitely required. You need to be ultra adaptable and ultra patient, and also not afraid to occasionally put yourself at some degree of risk because the nature of the work is that we operate in conflict areas, so sometimes you do come across situations where it's a little risky, and you have to be comfortable with that.

"I count myself as very lucky. It's work that throws up a new challenge every day."

SEEING THE BIGGER PICTURE: PARAMEDIC DEVELOPS FIRST-AID VISUAL LEARNING TOOLS

Perth, Whadjuk Nyoongar Country

Former British Royal Army Medical Corps combat medical technician and St John WA paramedic Jerry Barrett has long struggled with dyslexia and reading difficulties throughout his childhood and working life.

To cope with the demands of studying, he turned to drawing pictures of what was being discussed instead of taking notes. It proved to be a successful strategy, at one point earning him a Johnson and Johnson award for his design of a CPR poster, and sparked an interest in applying visual images to health literacy material in communities where lower levels of literacy was often a challenge.

Eager to explore the world after leaving the army and training as an operating theatre technician, he headed abroad and found himself in India, where he worked across the country in often isolated and under-staffed medical clinics. There he came across a locally published book called "Where There Is No Doctor", which was designed for the heads of villages to enable them to provide basic first aid for their people.

I'VE ALWAYS ASSOCIATED TECHNICAL CONTENT WITH PICTURES BECAUSE I'VE FOUND IT'S THE EASIEST WAY FOR ME TO LEARN

"The medical system in India was quite diverse in those days; medicine and immediate care weren't available to many people in villages and literacy was a big issue," he said. "This book had some basic medical and clinical techniques written in pidgin English with hand-drawn pictures.

"I've always associated technical content with pictures because I've found it's the easiest way for me to learn. This book actually did the same as I had been doing - visually delivering clinical governance advice on how to cleanse wounds or how to do a first aid treatment, backed up by pictures so those who weren't fluent or entirely literate could work out what to do. So that always stuck with me."

Jerry, who now works as National Health, Safety Environment and Quality Coordinator with APD Engineering, said the biggest barrier for people with literacy and language comprehension challenges in learning first aid was the way it was delivered. He said the text-heavy health literacy materials that are the norm could be replaced by more effective and impactful picture-based content covering basic first aid techniques.

The concept took further shape when he moved to Australia in 2003 with his wife and spent five years working as an on-road paramedic with St John WA. On a visit to an art gallery run by one of his former army friends, he discussed his idea with some of local artists. All agreed it was a worthy endeavour.

"One of the artists said, 'That's a really good idea. I could help you do that because my basic art is very remedial, so I might have an idea of how to deliver first aid in the picture format'."

Fortuitously, a visiting professor from Curtin University visited the gallery, saw the artwork in development and, curious about the content and its purpose, asked what it was about. After being told about the project, he asked if he could contact Jerry.

"So he contacted me and we discussed it and he said, 'Have you ever thought about pursuing this academically?' Basically he offered me the chance to do either a master's program or a PhD to develop my idea into a tool, so I decided on a Master of Philosophy degree in international health.

"We decided to do my module on hygiene as I thought this would have the biggest impact on people. This is something that goes back to India; in some of the villages I'd gone into, they didn't understand the concept of infection control. So I developed a picture-based learning tool without any words based around the chain of infection, because I felt if someone understood that chain then they could quite easily break it by using soap and water and killing germs. It would save lives."

While the target of his research was East Africa, the challenge lay in finding an amenable isolated village with low levels of literacy. That connection was made through his professional association with Global Health Alliance WA. The organisation had been contracted to deliver two ambulances to an outreach program at an outpost in Tanzania.

"They asked me to go over and deliver them and at the same time I was able to find my resource group, my cohort. I then went back the second year and collected my data and delivered my training using the tool that I developed, and that culminated in my thesis completion."

The module is now being used by charities and missionaries in a number of countries in Africa, and he has self-funded and developed another on malaria prevention that was inspired by his time in Tanzania, where posters on clinic walls aimed at teaching people how to avoid catching malaria were long on words and short on pictures.

"I'd go into these clinics and there were all these posters on the walls of the clinic that were in Swahili, but these guys couldn't read Swahili; they could speak it, but they were illiterate. The villagers were saying, 'Can you please do something on malaria because we need to know about it?' I felt that would be a simple one to do. So under my own steam and budget, me and the artist produced that module."

The challenge Jerry now faces is in encouraging the larger development organisations to adopt the modules.

"It's such a new approach, I can't explain to people the concept of replacing words with pictures. I've sent the malaria module to charities and missionaries and they've taken it out to PNG, Ghana and some South African countries. It's a very simple, life-saving process. It's still a dream of mine to be able to get this out and to make a difference."

Jerry is happy to assist any non-profit organisations in communicating health care messages. You can reach him at: jerrybarrett2@icloud.com

UNLEASHING THE POTENTIAL: EMPOWERING PARAMEDICS WITH PROFESSIONAL CAPABILITIES

By **David McLeod**
NSW Central Coast, Darkinjung Country

The landscape of healthcare is continually evolving and as it progresses, healthcare professionals, including paramedics, are being recognised and appreciated for their invaluable contributions to patient care.

The Federal Government's recent announcement regarding healthcare professionals working at the top of their scope has accelerated the push to expand the capabilities of healthcare practitioners. In this article, we explore the concept of professional capabilities within the paramedic profession and its significance as a paradigm shift that empowers paramedics to meet the diverse needs of their communities and patients.

Traditionally, the paramedic profession has been guided by the concept of a “scope of practice”, defining specific tasks and responsibilities that practitioners are permitted to undertake within established legal and ethical boundaries. However, since registration in 2018, the paramedicine profession has embraced a more progressive approach, moving away from strict definitions of a scope of practice. Instead, it emphasises the importance of “professional capabilities” - a dynamic framework that encompasses the knowledge, skills and professional attributes required for competent and safe practice in Australia.

PROFESSIONAL CAPABILITIES OFFER A MORE COMPREHENSIVE AND VERSATILE SET OF COMPETENCIES

The introduction of the Professional Capabilities for Registered Paramedics by the Australian Paramedicine Board in 2021 was a momentous milestone that brought about a significant shift in the evolution of the paramedicine profession. These capabilities have proven to be of paramount importance, as they not only serve as a roadmap for paramedics' professional development but also play a crucial role in advancing the overall quality of patient care.

Unlike a traditional scope of practice that outlines specific tasks and responsibilities, professional capabilities offer a more comprehensive and versatile set of competencies. This versatility is a fundamental aspect of their significance as it allows paramedics to adapt and excel in a variety of situations, making paramedic highly valuable assets in the wider healthcare system. By empowering paramedics with these capabilities, they are better equipped to provide top-notch patient care across a wide range of clinical situations, whether it's responding to emergencies, managing critical conditions, or offering specialised primary healthcare outside of a jurisdictional ambulance service.

The introduction of the professional capabilities demonstrates a commitment to professionalism and excellence within the paramedicine community. It sets a standard for what it means to be a competent and proficient paramedic, instilling a sense of pride and responsibility in practitioners to drive their own professional pathway.

As the paramedicine profession embraces the concept of professional capabilities, it becomes crucial to stop relying solely on the term “scope of practice” when defining the abilities, skills and knowledge of the profession. Continuing to limit ourselves to a fixed scope of practice restricts paramedics from fully leveraging their wide range of capabilities and hinders their potential to advance in emerging primary health and community specialist positions.

With the flexibility provided by the professional capabilities, paramedics have the ability to tailor their professional practice to meet the specific demands of their chosen area of work. This adaptability enables paramedics to excel in specialist roles, such as critical care or community paramedics, as well as in emerging positions like paramedic practitioners.

By recognising and valuing the diverse capabilities of paramedics, we open doors to innovative models of care that benefit patients and the healthcare system as a whole. Empowered by professional capabilities, paramedics can expand their skill sets and knowledge, leading to more comprehensive and patient-centric care. This holistic approach fosters better patient outcomes, increased patient satisfaction, and improved overall healthcare efficiency.

The transition from a rigid scope of practice to a dynamic professional capabilities-based approach represents a transformative shift for the paramedicine profession. It is important now that as a profession we embrace and recognise the wide verity of professional capabilities within our profession. Now paramedics are empowered to become versatile and multifaceted healthcare professionals, capable of meeting the ever-changing needs of their communities and patients. This empowerment will help drive the future of senior paramedics and give ownership to individual clinicians to enhance their professional development in a wide range of specialties.

Senior paramedic practitioners, driven by their expanded capabilities, are pioneering innovative models of care that bridge gaps in healthcare services and address the unique needs of underserved populations. Emphasising professional capabilities over a restrictive scope of practice ensures that paramedics can advance in emerging primary health and community specialist positions, contributing significantly to the healthcare system's progress.

As the paramedicine profession evolves and adapts to the changing landscape of healthcare, embracing the concept of professional capabilities opens new opportunities and challenges the traditional notion of a rigid “scope of practice”. By moving beyond the confines of a predefined scope, paramedics can fully explore their diverse skill sets and expand their roles in the healthcare system. This shift allows paramedics to take on more comprehensive and varied responsibilities, not only in emergency situations but also in preventative care, health promotion, and community outreach programs.

By breaking free from the constraints of a fixed scope of practice, paramedics can better respond to the dynamic needs of patients and communities, ensuring they receive well-rounded, patient-centred care. This approach encourages continuous professional development and specialisation, empowering paramedics to pursue advanced training and qualifications in specific areas of interest. Embracing professional capabilities fosters a sense of ownership and pride within the paramedicine community, motivating practitioners to excel and actively contribute to the advancement of healthcare practices, benefiting the overall wellbeing of the population.

In the vibrant world of paramedicine, it's time to liberate ourselves from the restrictive shackles of the “scope of practice” jargon. Instead, let's unleash the full potential and capabilities that this incredible profession brings to the table. Just like keys that open doors to new possibilities, paramedics are the ultimate game-changers, ready to tackle any challenge with unwavering dedication and expertise.

So, let's rewrite the narrative and celebrate the ingenious artistry of paramedicine. Breaking free from the constraints of “scope of practice”, we unleash our profession’s potential. Together, we'll pave the way for a future where our professional capabilities allow paramedicine to make a positive contribution to contemporary healthcare. It's time to embrace the art of modern paramedicine -where possibilities know no bounds, and capabilities are ours to master.

IT'S TIME TO LIBERATE OURSELVES FROM THE RESTRICTIVE SHACKLES OF THE “SCOPE OF PRACTICE” JARGON

PROFESSIONAL PRACTICE

HOW DO WE KEEP PARAMEDICS IN PARAMEDICINE?
THE STATE OF THE CURRENT PARAMEDIC WORKFORCE

By **Stephanie Nixon**
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Paramedicine has undergone significant professional growth in the past decade. As a part of this growth and the recognition of professionalism, paramedics are being acknowledged as emergency out-of-hospital clinicians who can play a role within numerous private and public medical settings.

The greater health system is currently under strain, and the field of paramedicine is not immune (AIHW, 2022). Staff retention (or lack thereof) has been a well-documented problem throughout the world. The staff turnover within Emergency Medical Services (state-based and private) is estimated to be between 20-30% (Lawrence, 2021). A service at the high end of this spectrum could expect to see a completely new workforce every four years.

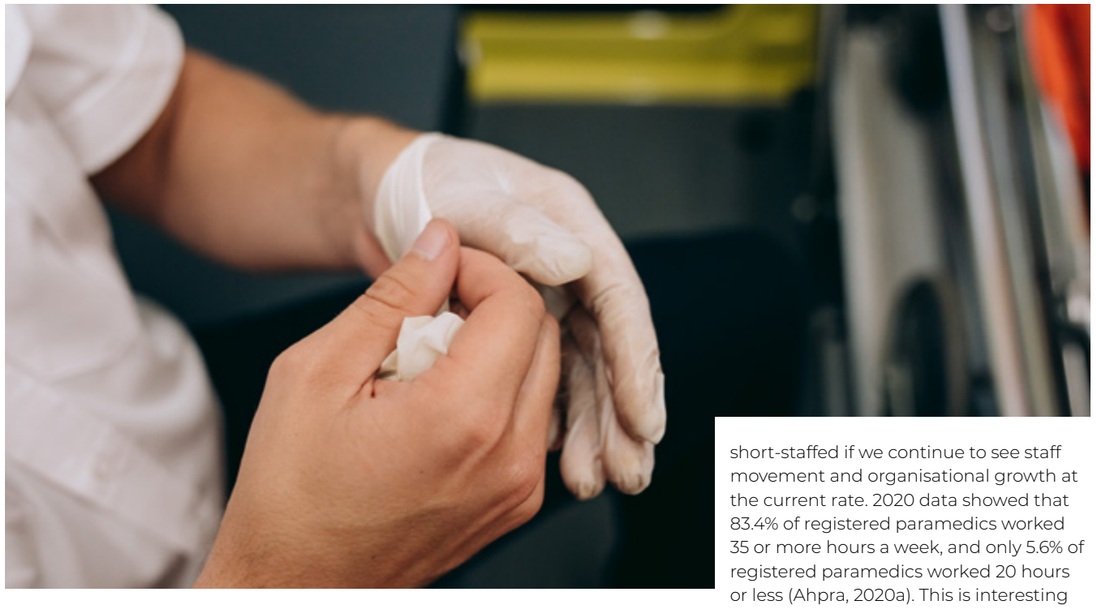
Constant turnover is not sustainable, and the cost to re-employ a frontline paramedic is significant. This is all without considering the adjacent costs, such as the psychological costs on the remaining paramedics who pick up the shortfall during times when services are short-staffed, and the cost to patients who may spend longer waiting for an ambulance response. The million-dollar question is that assuming the paramedics who are leaving these services are still working, where are they going?

The job market for paramedics is a vastly different landscape from that of a decade or two ago when the major employers were the state-based jurisdictional ambulance services (JAS). Throughout Australia and Aotearoa New Zealand there are 10 JAPs that together employ just over 80% of the registered paramedic workforce (Ahpra, 2020a).

THE JOB MARKET FOR PARAMEDICS IS A VASTLY DIFFERENT LANDSCAPE FROM THAT OF A DECADE OR TWO AGO

Employees in most organisations are only required to give a minimum two weeks' notice prior to resignation, but their replacement may take two or three months to be recruited, employed, and trained before being able to step into the vacant role (Lawrence, 2021). It becomes clear that staff retention isn't just an abstract concept, but rather a real-life, real-cost problem for many services.

A quick online search for "paramedic" on SEEK brings up more than 50 related roles for potential candidates. There are advertisements for rescue paramedics, private paramedics, paramedics in the oil and gas sectors, patient transport paramedics, and even paramedic practitioners. There are significantly more



opportunities available today for paramedics wishing to work in places other than the state-based ambulance services.

With the increased number of employers accepting paramedics in the private sector, it will likely continue to grow and expand with roles such as paramedic practitioner set to become commonplace both inside and outside state-based JAS. This has the potential to place significant competition on the industry as the state-based services fight to offer similar pay and benefits as the private sector.

THE NUMBER OF REGISTERED PARAMEDICS IN AUSTRALIA HAS ONLY RISEN BY 1.2% IN THE PAST THREE YEARS, WHILE THE NUMBER OF NON-PRACTICING PARAMEDICS HAS ALMOST TRIPLED

The number of registered paramedics in Australia has only risen by 1.2% in the past three years, while the number of non-practicing paramedics has almost tripled. The most significant increase in non-practicing paramedics is in the 25-34 age range, which begs the questions, how do we keep paramedics in paramedicine (Ahpra, 2020b; Ahpra, 2023)?

To begin, we first need to understand the demographic of the paramedic workforce. In March 2023, Ahpra statistics show that 51% of registered paramedics were male and 49% female, which is a swing of 5% towards females in the past two years (Ahpra, 2023; Ahpra, 2020b). Most registered paramedics work within major cities (66%) and only 2% work in rural and remote locations (Ahpra, 2020a). In 2020, there were just over 9,000 registered paramedic students throughout Australia (Ahpra, 2020a). According to current Ahpra and university statistics, there is still set to be a continual increase in the workforce in the next few years as students graduate. However, the statistics regarding current registered paramedics suggest that there is real potential for organisations to be left short-staffed if we continue to see staff movement and organisational growth at the current rate. 2020 data showed that 83.4% of registered paramedics worked 35 or more hours a week, and only 5.6% of registered paramedics worked 20 hours or less (Ahpra, 2020a). This is interesting when we consider some of the reasons paramedics are leaving the profession.

Why does retention matter?

A high turnover of paramedics in a service affects a range of things, but most notably it affects key performance indicators (KPIs) (Eubanks, 2022). KPIs are used to track measurable performance over time. Organisations use KPIs to look for strategies to improve performance and continually improve their service. These may be things like response times, pain reduction in trauma or medication management.

There are many factors that can affect KPIs. Prolonged ambulance response times, improper or rushed recruitment training, and a lack of available resources and personnel all have an impact on patient care, but also on a services' KPI, as fewer staff struggle to meet the same targets expected under previous staffing numbers (Eubanks, 2022). This can be exacerbated when new paramedics are employed. Through no fault of their own, new paramedics tend to be less experienced, which increases their risk of potential medication and treatment errors, and even vehicle damage (Eubanks, 2022). If organisations are not able to retain and grow the paramedics they have, they risk long-term KPI decline, which impacts the most vulnerable, the people calling for help.

What does literature tell us about staff retention and the reasons why paramedics leave paramedicine?

There have been many studies that have looked at the reasons why emergency medical technicians (EMTs) and paramedics leave the workforce. Most of the studies are based outside of the Australasian region, although their outcomes and conclusions can be extrapolated and localised. Common reasons for resignation include work conditions, a lack of opportunities for promotion, a lack of professional respect, wanting better pay/benefits/compensation, wanting to pursue further education, dissatisfaction with organisational management, desire for career change, physical/mental demands, and the association with pre-hospital work as a transient career or used as a stepping stone towards further degrees (Dopelt et al., 2019; Cash et al., 2018; Rivard et al., 2020; Belotto, 2017). Knowing the reasons is one thing, doing something about it is another.

PARAMEDICS ARE LEAVING EMPLOYERS, BOTH STATE-BASED AND PRIVATE, FOR A RANGE OF REASONS, AND MOST OF THESE ARE CHANGEABLE

What can employers do to retain their staff?

There is currently no literature that has evaluated strategies that could be adopted by paramedic employers for the purpose of staff retention. The literature that is available is derived from theories on the basis of why people are leaving the profession, how other medical professions are retaining staff, or what the literature says about job satisfaction. An evaluation of retention strategies is well warranted given the high turnover rate facing paramedic employers worldwide.

Montminy et al. (2021), discuss how organisational behaviour theory could be used to improve staff retention and some strategies that could contribute to positive workplace culture within ambulance that in turn improve staff retention. These strategies include having policies and procedures that put staff first and reduce burnout within an organisation. This would make paramedics feel like the organisation cares and will improve the longevity of the employee. A UK study recommends strategies that include reviewing pay level banding, improving the working conditions of employees, improving career progression opportunities, changing how ambulances are dispatched to calls, and improving retention premiums as incentive to stay (Edwards, 2021). These strategies would build on improving the organisation and pay conditions and would induce employees to stay.

Herzberg's two-factor theory shows that motivators for staying in a job include recognition, achievement, advancement, growth, responsibility, and job challenge (Eubanks, 2022). These factors point to employees needing to have fulfillment in their roles while being in a workplace that provides psychological safety (Eubanks, 2022). If these motivators can be adopted by employers, they will have a greater chance of retaining staff.

While the list of strategies organisations could implement to attract and retain staff is mostly restricted by time and funding, it is important that they recognise and understand what is driving paramedics out of paramedicine. Paramedics are leaving employers, both state-based and private, for a range of reasons, and most of these are changeable. Paramedics want fair pay, psychologically safe workplaces, opportunities for growth, and to be recognised as clinical professionals. Anne M. Mulcahy said it best: "Employees are a company's greatest asset - they are your competitive advantage. You want to attract and retain the best, provide them with encouragement, stimulus and make them feel that they are an integral part of the company mission".

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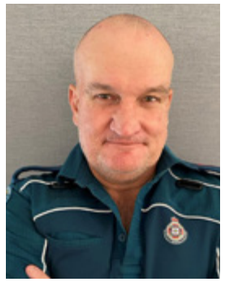
THE AUTISTIC PATIENT



By **David Birch**, QAS Paramedic
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While performing our duties as paramedics, there will be times when we will encounter an autistic patient. As we attend to the autistic person(s) that requires paramedic care, we may not be aware that the person has a hidden disability. In these cases, the paramedic will have to adapt their approach to ensure the patient is provided with the most suitable and efficient care possible.

Autistic people may respond in a way that is unexpected as autism is a spectrum condition. It is essential for paramedics to be able to recognise the signs that may indicate the patient is on the spectrum and alter their method of treatment accordingly.

A defining characteristic of the paramedic profession is the ability to attend any case and approach it with an open mind, a broad assessment, and an approach tailored to the needs of the specific patient. One type of patient demanding all these characteristics is the autistic patient.

Being a spectrum condition, autism spectrum disorder (ASD) is impossible to narrow into a specific set of signs and symptoms, and is often described as a hidden disability. Accordingly, paramedics must be aware of the common hallmarks of autism and use all the tools at their disposal to ensure the autistic patient is provided with efficient and effective patient-centred care.

IT IS ESSENTIAL TO BE ABLE TO RECOGNISE THE SIGNS THAT MAY INDICATE THE PATIENT IS ON THE SPECTRUM

A gendered epidemiology

It is believed that the relative rarity of autism diagnoses in females is due to the tendency of females to mask their symptoms. Girls tend to be more skilled at fitting in with their peers, and those with autism may repress their behaviour so they don't stand out as being on the spectrum.

Autism is often associated with a range of other disorders and tends not to be found in isolation. Commonly, the autistic person will also suffer from attention-deficit/hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), obsessive-compulsive disorder (OCD), and sensory processing disorder, to name a few.

Most commonly, autistic people suffer from anxiety and depression. This often results in autism being viewed by healthcare professionals and the public as a mental health condition rather than a neurological condition.

Clinical features

Like many others, autism is a hidden condition - just by looking at a person, it can be hard or impossible to determine if they have autism. However, there are numerous traits common to the autistic patient that may offer an indication to guide the paramedic's assessment.

Poor eye contact: People tend to lock eyes with others when interacting, but a person with autism may avoid eye contact. They may completely avoid looking directly at those they are engaging with, or do so inconsistently or fleetingly, or by looking out of the corner of their eye. It is believed that the eyes and face are so expressive as to overwhelm, stress and increase the anxiety levels in an autistic person.

Stimming - unusual movements and behaviours: This are behaviours that look unusual because they are considered out of the norm, but they are used by the autistic person to help them regulate and calm themselves. Examples of this are hand-flapping, twitching, jerks and head-nodding, but stimming can be many more different things.

Echolalia: People with autism repeat noises and phrases they hear. They may not be able to communicate effectively because they struggle to express their own thoughts.

Heightened sensitivity or sensory aversion: Autistic people may also be very sensitive to bright or flashing lights and loud noises, certain smells, and tactile stimulation.

Stereotyped behaviours: A person with autism may get "stuck" on certain habits, interests, or behaviours.

Meltdowns, "more than just a tantrum": A tantrum usually occurs when a person is denied what they want to have or what they want to do. Normally, when a person gets what they want or what they what to do the tantrum resolves. A tantrum is for an audience; it's done to persuade the person to whom tantrum is directed to give in to the tantrum-maker's demands. This is not the case with a meltdown as it's not an emotional response. Meltdowns are reactions to feeling overwhelmed and are often seen as a result of sensory overstimulation. Tantrums can lead to meltdowns so it can be hard to tell the difference between the two outbursts.

Medications: Several medications are prescribed to treat other conditions and symptoms often found in children and adults with autism, such as ADHD, anxiety, depression, sleep and seizure disorders. Ritalin is a central nervous system (CNS) stimulant, Dextroamphetamine is a CNS stimulant, Adderall is used for ADHD, Lovan is an antidepressant, Zoloft is an antidepressant, Vyvanse is a CNS stimulant, Intuitive is a non-stimulant ADHD medication, melatonin helps control sleep and waking patterns.

Risk Assessment

Paramedics may unexpectedly encounter a person with autism. Recognising the behaviour symptoms and knowing contact approaches can minimise situations of risk or victimisation of the person with autism, their caregiver, and the risk to the paramedic. You may learn the person has autism from dispatch, family member or someone at the scene, or the person himself or herself. Or you get no indication at all that the person is autistic until you're on the scene. In the same way we modify the way we deal with children or the elderly, the same holds true for children and the elderly on the spectrum. When dealing with someone with autism, their behaviour may mimic someone that is intoxicated.

AUTISM SPECTRUM DISORDER IS IMPOSSIBLE TO NARROW INTO A SPECIFIC SET OF SIGNS AND SYMPTOMS

Time: These are very complex cases that can require dealing with many different aspects. If the person is heightened or in meltdown, allow sufficient time to enable the patient to de-escalate themselves from their episode to a level of social engagement. It's better to let the person de-escalate themselves than to force them into a resolution they're not ready for.

Patience: A neurotypical person can take approximately four seconds to respond after being asked a question. An autistic person is going to need more time so allow for delayed responses (10-15 seconds) to your questions.

Speak in direct, short phrases, one question at a time: This will give the autistic person a better chance to understand and respond to your questions. If you have too much detail or are asking too much of the person, it will make it difficult to get a response or for them to answer the question you have asked. Do not start to ask another question until you have received an answer to the question you have asked.

Be literal with your communication: Avoid slang or expressions such as: "What's up your sleeve?" or "Are you pulling my leg?". Autistic people at very literal and do not understand the subtle nuanced meanings of slang, sarcasm and other similar jargon.

Personal space: Make sure there is safe distance between the patient and yourself because the autistic person may suddenly invade your personal space. Also, the autistic person may think you're invading their personal space. Some autistic people don't fully understand the concept of personal space. Particularly on your initial approach to the patient, this can cause a negative response.

Rapport: Try to build a rapport with the patient. Talk calmly and softly, model the behaviour you would like the patient to display. Find out what they are interested in and try to engage in that interest.

It's a team game: When treating someone on the spectrum, it's a team game.

Don't take it personally if the person prefers to engage with your partner. It could be that the person responds better to a male/female, young/old, whatever it could be. You might need someone outside of the crew to be part of the team - it could be a parent, relative or caregiver.

Technology: Autism is a spectrum disorder, and at one end of the spectrum the patient could be non-verbal, which is going to make communication difficult. This is where your iPad, mobile phone and technology is an asset and can also be part of the team. Consider using pictures, written phrases/commands, or computer images. The Picture Exchange Communication System (PECS) allows people with little or no communication abilities to communicate using pictures. Emojis can also be used.

Other stuff: If the individual is holding and appears to be fascinated with an inanimate object, allow them to continue to hold the item for the calming effect. It could be a small soft toy, a finger spinner or other such items. If you stop the patient from having this item, it will likely result in a negative response and could lead to the patient having a meltdown. Note to self: Be aware that the person may be experiencing a seizure or some other condition; don't let one condition blindside you to what is happening.

Evaluate for injury: The person with autism may not ask for help or show any indications of pain. There is a myth that people on the spectrum don't feel pain; rather, for some their pain response is very different from what we would normally expect.

One last thing

When handing an autistic patient over at a hospital, you must ensure that as well as the medical and clinical information about the patient, you also hand over information such as the patient's sensitivities, aversions, triggers, etc., to ensure that they can be placed in a suitable area in the hospital - for example, a cubicle in a quiet, less-busy area of the hospital with the lights dimmed. Also consider that the most appropriate destination might not be hospital; it might be the patient's doctor, psychologist, therapist or even the patient's own residence. Transporting the patient to someone who knows the patient well and knows what is needed in their treatment/management will result in better outcomes for the patient.

JUST BY LOOKING AT A PERSON, IT CAN BE HARD OR IMPOSSIBLE TO DETERMINE IF THEY HAVE AUTISM

Case study

An autistic patient who was the driver was involved in a motor vehicle accident in which a tree was hit head-on with moderate damage to the vehicle and a passenger suffering a bruise to the forehead. There were no obvious injuries to the driver due to the airbags being deployed. When the paramedic was talking to the driver, there was concern about a possible head injury as the driver had jerky hand movements, kept waving his hands in front of his face, engaged in what appeared to be repetitive babble and a series of tics when speaking. The second paramedic recognised that the patient was engaged in stimming and echolalia and asked if the driver was autistic, which the driver confirmed. The passenger said the driver's behaviour was normal when he was stressed or agitated. The driver was still assessed and treated in accordance with how a patient would be treated in a road traffic collision, but knowing the patient was autistic explained some of the behaviours.

For more in-depth information, watch David's presentation on "Autism awareness and understanding and paramedicine" at a QAS Sunshine Coast branch clinical night at: https://youtu.be/CkzXbjG7uiY

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FOSTERING NEW CAREER OPPORTUNITIES FOR PARAMEDICS

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Recently, the Victorian Government confirmed funding for a Paramedic Practitioner program1 that would see collaboration between the Department of Health, Safer Care Victoria and Ambulance Victoria.

While making his announcement at Monash University (the education provider for the program), the Premier stressed that this new clinical role was not only about providing quality patient care, it was also about providing diverse career opportunities for paramedics.

As a University, this comment resonated with us, as we look to graduate the next generation of paramedics into an ever-changing workplace. We often stress to our students that the "professionalisation" of paramedicine is continuing, and that they should focus on the skills that they learn throughout their degrees and consider how they could use them in different career settings.

One area that is continually developing for paramedics is a career in academia. In 2018, Munro et al2 discussed the conundrum paramedics face when entering academia. The team highlighted the loss of identity as a "paramedic" when clinical hours were ceased or greatly reduced, and difficulty identifying as an "academic" if the paramedic did not have the doctoral qualifications and associated scholarly achievements.

Meadley et al3 continued the discussion in 2022 with an editorial that highlighted the ongoing challenges for paramedics seeking academic roles. The paper discussed great advances for the profession with more paramedics enrolling in and completing higher degree research programs, while also presenting barriers, including limited flexibility for part-time employment within ambulance services. Overall, both pieces of work stressed that although academia was a career option for paramedics, Clinician Academic roles in paramedicine are still lagging behind medicine, nursing and other health professions.

MORE OFTEN THAN NOT, PARAMEDICS ARE STILL FORCED TO CHOOSE THE "ACADEMIC" OR "CLINICAL" ROUTE

Although progress can be slow, both universities and ambulance services are now challenged to see how they can improve academic career pathways for paramedics. At Monash University, we were able to learn from our nursing colleagues in the development of a Paramedic Academic Clinician role. We engaged with current paramedics to better understand the motivations and challenges for joining academia, while broadening discussions with doctors and nurses to see how the balancing of multiple roles can work. We needed a role that appreciated the unique skill set, knowledge and clinical experience that this person would bring to our education and research programs, while working within the limitations of academic appointments.

This year, we appointed our first Paramedic Academic Clinician. We added a para-clinical loading to the Senior Lecturer renumeration, and although this does not reach pay parity, this somewhat lessened the financial sacrifice made in the move to academia. This modification was not only financial, but also acknowledged that paramedic experience was essential in paramedicine education and research to the same level that medical experience is essential to medicine programs.

CAREER OPTIONS NEED TO EVOLVE WITH PARAMEDIC PROFESSIONALISATION IF WE ARE TO KEEP PARAMEDICS WITHIN THE CAREER

The role includes the traditional teaching load seen in universities, with current "on-road" experience adding to the validity of the courses. There is an expectation and dedicated time for research as paramedics continue to lead the ongoing development of paramedic education and clinical practice. Most importantly, there is emphasis on continued professional development as a clinician, with flexibility to modify work schedules when unique clinical opportunities present themselves.

Although this is a good first step we have not yet addressed all of the concerns raised in the current literature and further work is required to see these roles adopted on a larger scale. It would be beneficial to investigate opportunities for joint positions across universities and employers of paramedics, or at least acknowledgement of academic employment as an eligibility criterion for flexible work arrangements so that paramedics are not working night shifts and then heading straight to uni to educate our next generation.

Universities, ambulance services and other employers of paramedics would benefit by working together to support paramedics who are keen to seek academic roles. University paramedicine programs often suffer reasonably high staff turnover, which can affect the quality of the teaching and the moral of remaining staff.

Ambulance services are also facing challenges maintaining experienced paramedics, with recent data showing that more than 50% of registered paramedics are under the age of 35 years4. More often than not, paramedics are still forced to choose the "academic" or "clinical" route, and this is a loss for the profession and all who serve it. Sustaining both careers in silos often comes at the detriment of the paramedics' health and wellbeing, and therefore neither employer gets the best employee on the day.

So as the profession embarks on different career options for paramedics, we need to do so in consultation with those seeking other challenges. We need to push our current boundaries to explore different employment models, and all parties need to work together to improve flexibility. Career options need to evolve with paramedic professionalisation if we are to keep paramedics within the career that so many are passionate about.

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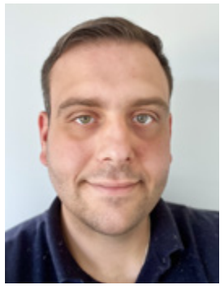

DEVELOPING CLINICAL SIMULATION THAT IS PURPOSEFUL, MEANINGFUL, AND EVIDENCED-BASED

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Clinical simulation is a teaching strategy that uses artificial or simulated patients, manikins or other high-fidelity devices to create realistic learning experiences for health-care students. Simulation can be used to teach a variety of clinical skills, including communication, teamwork, and decision-making.

A substantial body of evidence supports the use of clinical simulation in healthcare education. A systematic review of 100 studies found that simulation-based learning effectively improved clinical skills, decision-making, and teamwork. The review also found that simulation-based learning could reduce medical errors.

So we know it can be beneficial, but how do we use it best to ensure that learners get the most out of it? Most educators, especially new/developing ones, will teach in the way they were taught. Over the last decade, there has been a wealth of new evidence on teaching and learning strategies for clinical simulations. Let's explore how we can make clinical simulation more meaningful, purposeful and guided by the best evidence.

It all starts with one question: What learning outcome/s do you want the student/learner to demonstrate or understand? And: What are they taking away from this simulation?

MOST EDUCATORS, ESPECIALLY NEW/DEVELOPING ONES, WILL TEACH IN THE WAY THEY WERE TAUGHT

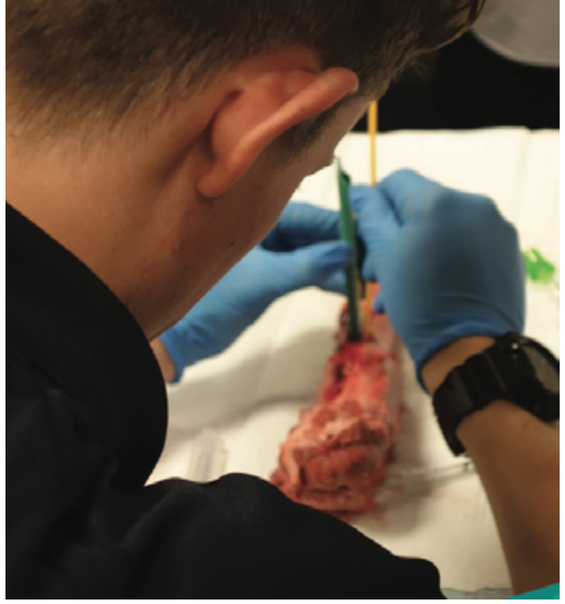
Most of us have participated in a clinical simulation that had no clear learning outcomes; how did it make us feel? Most came out with a feeling of failure because we didn't know what needed to be archived in the simulation. If you are thinking of running a clinical simulation for students or colleagues, make sure that the first thing is that there is a clear learning outcome. From here, we need to ensure that these outcomes are appropriate for the learners undertaking them. Not too hard, leading to a fear of simulation or the “got ya” scenarios. Not too easy, causing boredom or lack of interest in simulation and discouraging reflective practice. They should be in the Goldilocks zone. A zone aimed at stretching the learner's cognitive load, building confidence and encouraging reflective practice. This should focus on a learning theory of scaffolding, moving the learner from novice to expert.

The second step is making clinical simulation a safe and motivational space. You want your learners to feel motivated to try and undertake clinical simulation. No fear of judgment or anxiety about what will happen to me. A supportive and inclusive environment that actively encourages reflective practice. One of the best ways to do this is by having a robust and straightforward structure for how clinical simulations are run and undertaken; having an explicit and standardised structure for how clinical simulation is undertaken provides clarity for all involved. Learners know what to expect and how the simulation will work. This helps them to have a clear understanding and helps build confidence in simulation as they know that no surprises will be thrown at them. Educators have a simple structure to help develop these clinical simulations. This is also helpful for new educators, so they don't end up just making something up on the spot.

Most research supports a simple structure like Prebrief - Scenario - Debrief.

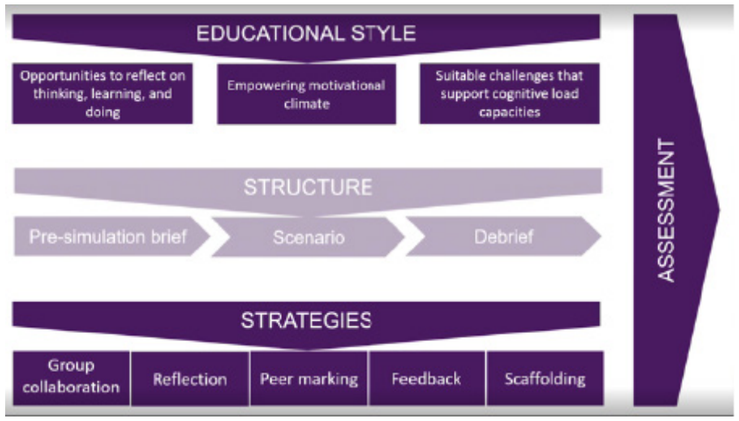
Prebrief: This is a fundamental step for the students to understand what they are trying to archive in this clinical simulation. It explains the learning outcomes and what the following simulation will entail. It helps builds confidence and safety for learners. No “got ya” scenarios.

Scenario: This can incorporate all levels of simulations, Low, medium and high-fidelity. The use of technology is a great way to help build these scenarios and make them more interactive. However, research shows that low-fidelity simulation can sometimes archive better results than the most extensive and fancy simulation. It all comes down to the learning outcomes you have set for the simulation.



MASTERING SIMULATIONS AND HOW TO RUN THEM TAKES TIME AND PRACTICE

Debrief is argumentatively the most crucial step in the simulation. This is where most critical learning is undertaken. Reflection is the key here. What was done well, what was done ok, what could be improved and what are we going to take away and reflect on? There are many different tools for providing feedback, and more space is needed to cover them all, but let's look to research to improve on a couple of points.



Here is a diagram created by the Australian Catholic University, Faculty of Health Science, staff on principles of clinical simulation, many of which are discussed above. It shows the education style used in clinical practice, the best structure and education strategies used for clinical simulation.

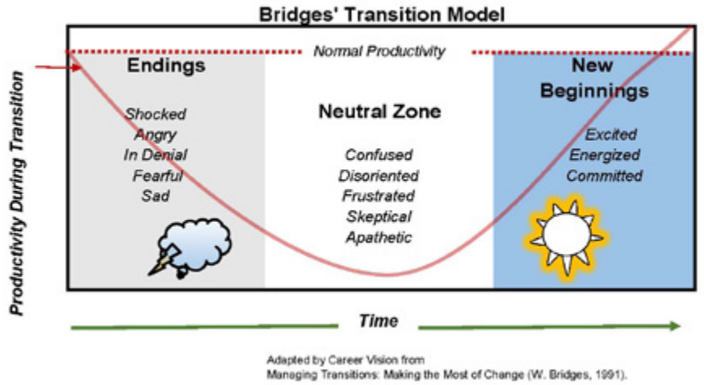
Faculty of Health Sciences, Australian Catholic University, 2023

First, ensure you have peer feedback built into your feedback section. There is growing evidence that peer feedback is a robust way for learners to build new knowledge and improve practice, both for the learner undertaking the simulation and for the one providing feedback as they watch the simulation with a more detailed eye. This is two-way learning as the person giving feedback also gets to reflect on their practice or knowledge. Educators need to support and guide this. Giving feedback does require knowledge and understanding.

The second point is that educators need to learn to give detailed feedback. Most people know the good-bad-good approach to feedback, but what do we truly learn from that? As educators, we need to provide detailed feedback that links back to the learning outcomes and describes how the learner met those. Then the educator should help build the points for reflection by the learner on how they can improve their knowledge or skills. This feedback should motivate the learners to reflect further on the simulation and undertake further study or training to improve. This is another point in the cycle that should make simulation purposeful, meaningful and motivating for the learners. They should be coming back wanting more.

We know that the more simulation is done, the better the effect of simulation on performance. We also know that any skill mastery takes 10,000 hours of practice. This is the same for educators. Mastering simulations and how to run them takes time and practice. So, everyone needs to remember: Practice, practice, practice.

A PERSONAL REFLECTION ON THE TRANSITION INTO ACADEMIA



By **Chris Mullen**
Lecturer in Paramedicine, University of Tasmania
ICFP with the Aeromedical Division of Ambulance Tasmania
Hobart, Muwinina and Palawa Country

I DID NOT EXPECT TO BE FEELING AS EMOTIONALLY AND PROFESSIONALLY CHALLENGED AS I DO

Paramedicine is a career choice that can be both challenging and fulfilling, exhilarating but fatiguing, and still be an amazingly rewarding career with longevity when there is variation and options to explore the many facets of the profession.

However, as with many paramedics' experiences, there comes a time to decide whether the years of accumulated knowledge and mastery of the profession should be shared to develop the new era of paramedics, and to help educate and nourish the rapidly changing workforce and industry. This may also be driven by an opinion that we as health care professionals should govern our profession through education, as we seek to develop it. Our ambition is to inform contemporary, evidence-based medicine that will provide the most appropriate healthcare no matter the prevailing circumstances (O'Meara, 2006).

The question of how we do that is, in some way, a reason for a paramedic to step into the academic arena: To share their knowledge and experiences and support education with the confidence that their practice is contemporary and clinically sound.

This was certainly my experience as I made the decision to venture into academia after a long career in clinical paramedicine, mostly in ambulance services. Now that I am here, I did not expect to be feeling as emotionally and professionally challenged as I do, especially in an area where I thought I had at least some expertise.

In many ways, the dichotomy of emotions driving my perception of academia are so far explained by career rupture, a concept that was explained as the sensation of "leaving one thing without fully leaving and entering another without fully parting" (Ebaugh, 1988). Throughout my working life, I have known myself and have been known by others as a paramedic but haven't yet experienced myself as anything else. I have a real reluctance to fully part with the clinical aspects of paramedicine because I still really enjoy the challenge and am reluctant to lose my identity as a practicing paramedic (Munro et al., 2018). This is potentially fuelled by a void of experience in academia and not really knowing what the expectations are of being an academic in a university setting.

However, it is comforting to know that the literature suggests that I am not alone in my emotions when transitioning into academia. While not fully fitting the phenomenon of "no man's land of professional identity' (Munro et al., 2018), as I still identify myself as a practicing paramedic, I certainly feel my identity as an academic is not yet informed as I haven't yet established a research portfolio or have a PhD.

There is a shared desire among most paramedics transitioning into academia to be a role model for the new student, to transfer knowledge and mould the future generation of our profession. There is also a shared trepidation in navigating the academic world as we come to realise what the role of an academic actually entails versus university expectations.

There is also a strong feeling of unpreparedness when contemplating embarking on a PhD or contributing to journal publications. This in itself is enough to exaggerate the feelings of being a novice, of being underqualified and inexperienced for academia (Santoro & Snead, 2013). In that respect, it raises the question of how someone can identify as an academic without having contributed to the world of academia? How does someone identify as an academic when the literature suggests that it takes a novice academic around seven years to transition to independent performance? This is especially pertinent, particularly when the university has set some stringent expectations to be met within the two-year probation period (Munro et al., 2016).

IT IS UP TO US AS PARAMEDICS, EDUCATORS, ACADEMICS AND OUR COMMUNITY OF PRACTICE TO SHAPE THE FUTURE OF PARAMEDICINE

However, over the short time I have been immersed in the academic world, I have reflected on some of these factors or barriers to transitioning into academia to influence a change in my perspective as an academic. The support and guidance from colleagues around university and course policy and procedures have helped to unlock and understand the intricacies of how a university works. Regular team meetings and mentoring sessions have helped decipher the never-ending list of acronyms and complexities hidden in the codes in academic language - there are more acronyms in academia than in the aviation world!

Being involved in academic education sessions in the wider academic community has also enabled me to witness the experience of academics with many years in the industry. There is also comfort in recognising that there are many more like "ME" out there, experiencing the challenges of being the novice academic who are perhaps stuck, or at least fluctuating between the zones of the Bridges Transition model (Bridges, 1980).

Through engaging in teaching and contributing to the development of learning material, I have experienced some validation of my ability as a lecturer and academic, which has certainly provided a boost in confidence in the academic world. The feelings of being a novice again have been a difficult concept to accept after a long and successful career in the ambulance setting in high-performing positions.

I am noticing a shift in my perspective and personal identity as I embark on this journey. Over time, I am now feeling more established in my role, but don't think I will fully identify as an academic until I have my first publication or embark on a PhD - perhaps this is still a novice perspective.

One realisation I have as I navigate the transition into academia, is that the driver for my career ambition was forged early on in my paramedic career. I strongly believe in the necessity for paramedicine to be governed and moulded by paramedic professionals and academics. This realisation reinforces the notion that it is up to us as paramedics, educators, academics and our community of practice to shape the future of paramedicine as we shape our evolving profession.

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CAN SOCIAL CONNECTION ENHANCE RESILIENCE AMONG PARAMEDICS?

By **Dominic Hilbrink**, Fortem Australia

Social connection is the key to a happy life. How do we know this? Well, for a start, the longest running study on life satisfaction tells us so. In 1938, researchers at Harvard University began a study that has continued to this day. What the researchers found was clear. Whether you grew up in poverty or came from a privileged background, the key to a happy, healthy and fulfilling life was connection to others.

SOCIAL CONNECTION IS LIKE AMMUNITION TO FIGHT STRESS

We are wired for social connection

The findings above make perfect sense when you think about how we evolved as humans. Our brains, bodies and emotions were shaped over many thousands of years living in small tribal groups in hostile environments. For our ancestors, social isolation from the tribe meant almost certain death. Our survival depended on forming long-lasting social bonds.

Research shows how people with low social support are less tolerant to stress. When people feel that no one has their back, they are much more vigilant.

So if having good social connections is tied to greater emotional and physical wellbeing, it's not surprising that social relationships are also important when it comes to resilience, because they help to reduce stress and suffering in a number of ways.

How does this relate to paramedics?

Beyond Blue's national survey of the mental health and wellbeing of first responders in Australia found that social support had the strongest relationship to resilience. In other studies, researchers found that a sense of belonging was associated with lower distress and protective against developing Post Traumatic Stress Disorder after trauma. Paramedics with higher levels of social support reported better sleep quality and reduced impact of occupational stress on sleep, even on days with especially high stress.

How does social connection increase resilience?

Researchers generally agree that resilience involves our capacity to cope and bounce back from challenges. It is our ability to bend, not break under stress. But most definitions of resilience focus on the individual and fail to acknowledge how individuals are embedded in social networks.

Physiological responses to stress

The effects of social connection are reflected in how our bodies respond to stress. Whenever we perceive a threat, our nervous system springs into action, setting off a cascade of bodily reactions. These fight or flight reactions, although designed to help us respond to danger, are often uncomfortable and part of what we experience as stress.

Social connection helps to tamp down the stress response. When we feel that we have social support, we are physiologically much more at ease. The presence of supportive others during stressful events activates a physically felt sense of reassurance and is a direct antidote to stress in the body.

So, our social connections help us to recover from stress more quickly and effectively while also providing some protection against the wear and tear on our minds and bodies that comes from regular exposure to stressful events.

Social networks as a "container"

With good social support, we perceive challenging events as less threatening. Having strong social support can actually improve our ability to cope with problems on our own by increasing our self-esteem and sense of control and mastery. Furthermore, a reliable social network isn't just useful in emergency situations; strong relationships with friends and family can bolster our mood, improve flexibility and motivate us to adopt healthy rather than risky coping behaviours.

Social connection is linked to purpose

If something feels futile or pointless, it's much more likely to wear us down. But if we have a clear mission based on shared values, the sense of purpose this creates changes how we think about challenges.

Purpose makes things that suck a little more bearable. The mundane job of completing paperwork; the gruelling job of keeping a patient stable during a rescue operation; the relentlessly exhausting marathon of mass casualty incidents - our experience of these things can be improved when we have a sense that they matter.

Social connection increases our sense of purpose. Many paramedics are driven by a sense of duty and service to the community, and a number of studies have shown how helping others has benefits for the giver as well as the receiver.

Why focus on promoting social connection?

Social connection is at the core of what we do at Fortem. Resilience programs tend to focus on individual skills and capacities. To protect and enhance the resilience of paramedics, we want to go beyond focusing on personal strengths to creating opportunities to strengthen the container of social networks.

Fortem's programs harness the natural building blocks of resilience that evolved in our tribal groups. They are not just inclusive of families, but are family-focused. We don't differentiate between "work" and "home" stress; we want to improve the wellbeing and resilience of every member in the family unit as well as the unit as a whole.

Fortem's wellbeing activities target the modifiable determinants of wellbeing. These are controllable things that we can build into our lifestyle which are proven to increase wellbeing - with social connection having the greatest impact. The key is getting the right dose of this good stuff to counterbalance the stress inherent in paramedicine.

Social connection activities can also facilitate early intervention when a more targeted level of support is needed. Seventeen percent of those who accessed our psychology support first connected with us through a wellbeing activity. These activities are a novel and low-threat way of building trust and familiarity with a comprehensive mental health support service, so participants know where to turn when help is needed.

Fortem's model of care differs from traditional mental health services as it emphasises supporting participants to make early and accessible investments in their wellbeing. It focuses on building resilience and facilitating early intervention rather than solely responding to ill-health, both of which can contribute to sustainability in the first responder workforce.

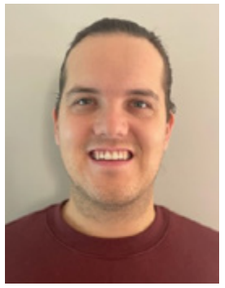
Conclusion

Social connection means having people around you that you feel are part of your life and you feel part of theirs. It involves a sense of belonging, of being part of something bigger than you - a sense of "we-ness" rather than "me-ness". It involves having people that you can share your joy with, and who you can turn to for support when you're in trouble - whether that's someone to talk to, someone to hold you or someone to give you a helping hand when you need it.

We are not made to survive alone. We are wired for connection, and this is crucial for our individual and collective wellbeing. As the first responder community continues to face unprecedented disaster events, along with the inherent challenges of serving the community, now more than ever it is not about survival of the fittest, but survival of the connected.

FORTEM AUSTRALIA
Supporting THE BRAVE

HOW REASONABLE IS **“REASONABLE OVERTIME”** IN AN ALREADY FATIGUED WORKFORCE?



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Paramedics are a fatigued workforce. Shift work, long hours, commute times, pandemics and compassion fatigue are some significant contributors to an individual’s fatigue level. As a front-line worker, paramedics are the first response to requests for service related to health, wellbeing, mental ill health and traumatic injuries within their community. They have commonly been voted the most trusted profession - they are there for the community, but who is there for them?

For more than 10 years, paramedics have consistently reported high levels of fatigue, even falling asleep at the wheel at times (Sofianopoulos et al., 2011). Shift extensions, or mandatory overtime, is a key issue for many paramedics and one that causes much distress in their work life balance and fatigue management. This is a critical aspect of the Fatigue Risk Management Framework (FRMS) process that needs to be challenged to improve overall safety.

A number of ambulance services’ Enterprise Bargaining Agreements (EBAs) stipulate that paramedics are not allowed to refuse “reasonable overtime”, while others indicate there must be a “valid reason to refuse”. It is not clear when reasonable becomes unreasonable within these agreements, nor within the literature.

When the average turnaround interval for cases is from 90-120 minutes (pending acuity of presentation, availability of other resources/departments, referral pathways, transport, etc.), it can result in a paramedic’s shift extending to more than 14 hours plus commute time to their residence, particularly when they are response ready until the last minute of their shift. This can be further compounded by those who complete periods of on-call. Unlike the nursing profession, where clinicians can hand over the care of a patient to the oncoming shift, paramedics are required to complete the care of patients, clean and refuel ambulances, restock provisions and complete other end-of-shift duties prior to going home. The question to be asked is: Is this “reasonable overtime” reasonable?

Despite there being minimal literature on paramedics, 80% of nurses report being satisfied with rostering practises within their hospitals (that includes 12-hour shifts) due to perceived enhanced work-life balances (Stimpfel et al., 2012). Conversely, however, within this same study there was a clear relationship between shift duration and high levels of burnout, intention to leave the profession and patient dissatisfaction levels. This was poignant in shifts >13 hours in duration (Stimpfel et al., 2012).

A systematic review found shifts >8 hours carried an increased risk for workplace accidents, which cumulated to double that risk in a shift of 12 hours duration (Wagstaff & Sigstad, 2011; Matre et al., 2021). Bae (2020) further found shifts >12-hours in duration resulted in poor quality of nursing care, poor patient safety, increased errors/near errors, poor patient satisfaction and increase in patient mortality from pneumonia. Donnelly et al. (2019) found paramedics were 1.9 times more likely to be injured at work, 2.2 times more likely to make a medical error/experience an adverse event (i.e., knock out an endotracheal tube) and 3.6 times more likely to engage in safety compromising behaviour (i.e., exceeding the speeding limit when driving non-emergently) when fatigued.

As a profession, in collaboration with organisations, we have to find a balance between the acceptable risk appetite of fatigue management and continuous service delivery. In other words, what level of risk is the organisation willing to impart of their paramedics in order to respond to a request for service? Naturally, the answer to this question is multifactorial, highly subjective and perhaps controversial. Further, it is highly dependent on roster formation, type of shift, length of shift, acuity of presentation, being on-call, and dependent on an organisations’ fatigue mitigation/ambulance dispatch procedures.

Acknowledging all the differences among services, we hope to gain consensus on the term “reasonable overtime”. If you are interested in participating or hearing about the results of this project, please contact matthew.ferris@monash.edu or visit https://monash.az1.qualtrics.com/jfe/form/SV_baoCIRSIVSu4SBU

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THROUGH THE LOOKING GLASS: WHY IS UNDERSTANDING THE PATIENTS' PERSPECTIVE OF PARAMEDIC-LED HEALTHCARE IMPORTANT?

By **Robbie King**
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Alannah Morrison
QAS Executive Manager of Initial Services, UTAS Adj Researcher

How well do we know our patients? As paramedics, we hold pride in our ability to interpret ECGs, translate clues from history-taking into working diagnoses, manage a range of presentations and apply technical skills, but how well do we understand the patients' experience?

This editorial provides an explanation of "patient experience" (PtX) with relevance to paramedicine; what PtX is, the importance of PtX in informing paramedic practice and, importantly, why more research on PtX in paramedic practice is required to improve the delivery of genuinely patient-centred care.

Why is patient experience important in healthcare?

Health professional understanding of PtX is demonstrated to contribute to improvements in quality patient care and outcomes.[1,2] Both the World Health Organization (WHO) and the Australian Commission on Safety and Quality in Health Care (ACSQHS) recommend that measures of PtX are used in the design and assessment of initiatives in healthcare.[3,4] Perspectives of healthcare often differ between patients and health professionals.[5,6]

The WHO identifies the patient as the "expert" in experiencing healthcare; therefore, understanding their perspective is required to guide the design of patient-centered health systems.[3] Knowledge of the patient's perspectives can allow paramedics to better understand their patient's holistic needs, what is important to the patient, and to offer healthcare that is truly patient-centred. Understanding the PtX further supports paramedics in their ability to demonstrate evidence-based care and the professional capabilities expected of them.[7,8] For example, an understanding of PtX acquired using rigorous research supports the paramedic to effectively communicate clearly, sensitively and effectively with the patient and other relevant people as required by the PBA professional capabilities for registered paramedics.[7]

Furthermore, adding the patient's voice in an evidence-based manner, provides contextual meaning to quantitative, epidemiological data often used to guide policy.[5,6,9] For example, in Australia the report on government services reports are used to guide jurisdictional ambulance service healthcare policy, which subsequently impacts how paramedics deliver healthcare.[10] However, current scholarly knowledge regarding the PtX of paramedic-led healthcare is scarce.[11,12] It is not clear to what degree the voice of the patient is used to inform jurisdictional ambulance service policy or paramedic-led healthcare.[6,13]

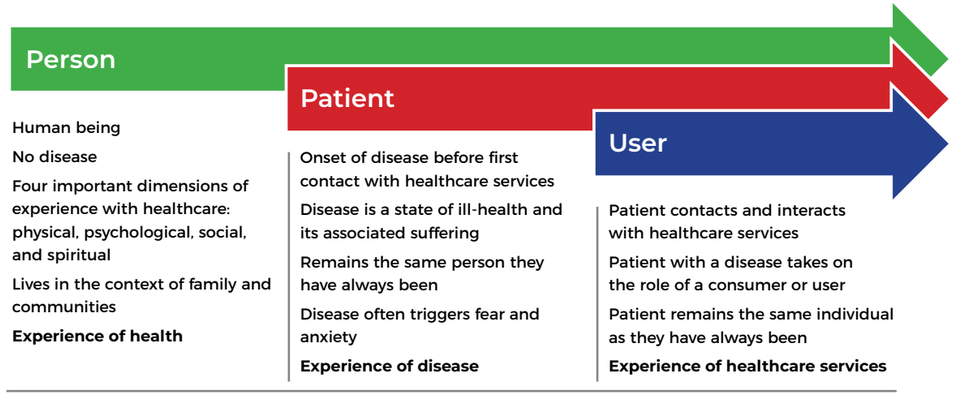

Figure 1: A conceptual framework for understanding patient experience. Understanding the Patient Experience: A Conceptual Framework.[15]

What is patient experience?

Patient experience is the sum of the encounters and interactions patients experience throughout their healthcare journey.[14,15] This may be shaped by prior beliefs, expectations, needs, and personal and contextual circumstances that influence the individual's subjective interpretation of healthcare.[16] PtX extends beyond clinical outcomes to include aspects of care that are important to the individual. In hospital settings, this has been demonstrated to include: Interpersonal interactions, such as being heard, informed, cared for and treated as a human being; clinical quality interactions, such as receiving the right care at the right time; care delivery interactions, such as personal care needs being seen to; and administrative interactions, the feedback being welcomed and acted upon.[17]

Definitions of patient experience are continually being refined, although broader concepts of what constitutes PtX have been commonly recognised. Oben[15] presents a framework of PtX that recognises a person's transition as an individual experiencing health through experience of disease and experience of healthcare services as depicted in Figure 1. Ultimately, PtX acknowledges that the patient is human; a unique individual with personal circumstances that are impacted when they suffer ill-health.

It is worth acknowledging that PtX differs from measures of patient satisfaction. PtX aims to explore and provide insight into factors that impact on a patient's interpretation of healthcare. Patient satisfaction is about expectations of care and to what degree these were met.[18,19] Some examples of ways to better understand patient experience include the use of qualitiatve research methods, patient feedback, or focus groups.

Patient experience in paramedicine

The limited research that has explored the PtX of paramedic-led care provides valuable insight into how patients themselves interpret the meaning of that care. Evidently, value is placed on demonstration of the paramedic's professional competency, concurently with compassion and empathy, which in turn reinforces the individual's confidence.[16,20-22] Patient care should consider a biopsychosocial approach. Considering the person as a whole, their individuality and unique circumstances, which requires emotionally supportive care alongside the medical assessment and interventions provided.[16]

Further rigorous qualitative research is required to explore how PtX may contribute to evidenced-based paramedic practice; a setting in which outcomes of healthcare are difficult to quantify.[23] Some specific patient presentations have clearly defined performance measures, such as survival to discharge rates following Out-Of-Hospital Cardiac Arrest (OOHCA). However, these limited patient presentations do not accurately reflect the full breadth of patient presentations

that paramedics regularly attend, resulting in paramedic healthcare going largely unmeasured. Paramedicine differs from other health disciplines in the absolute diversity of patients they care for, including their multiplicity of medical and social concerns, ranges of lifespan, and the unlimited environmental settings in which care is delivered. The complexity creates a challenge of how best to educate paramedics, and how their performance of healthcare delivery is both measured and acknowledged.

If PtX is used to guide policy and clinical practice, the design and method of measurement tools need to be relevant, of high quality, and methodologically rigorous.[5,13,17] Such patient-reported-experience-measures (PREMS), generated using systematic evidence-based processes, are already used in many health settings and disciplines. This includes emergency departments (EDs), in-patient hospital services, general practitioners, and nursing.[17,24] However, in Australia, no validated, psychometrically tested mechanisms have been designed, or are used, to explore PtX in the setting of paramedic-led healthcare. The ACSQHS does offer a question set to assess patient experience; however, it was developed to provide a consistent PtX measure of admitted patients to hospital or day surgery clinics, and does not include paramedic-led care.[17] It is yet to be examined whether this question set captures all dimensions of care important to patients using emergency ambulance services.

Current evaluation measures of ambulance service output measures have been questioned.[9,25] There are nationally reported indicators of ambulance services' performance as part of the Australian Government Productivity Commission Report on Government Services (ROGS) for health.[10] While OOHCA and pain relief are measured, these are purely statistical from paramedic and hospital patient documentation without patient inclusion.[26] Importantly, the ROGS largely reports on time intervals and system functions rather than clinically meaningful patient outcomes or, importantly, PtX.

When paramedic performance is measured by the speed of their treatment and transport, rather than quality patient care, paramedics are required to prioritise time efficiency rather than safe, professional, patient-centred care.[27-29] While ambulance services may argue that rapid response times are important for patient safety, reportedly on 5.8% of patients triaged in a Code One response were suffering a life-threatening condition.[30] While decreased time with the patient is not always attributable to improved patient experience, increased time does permit the paramedic to demonstrate compassion and empathy for the patient and, further, consider engaging the patient with the most appropriate healthcare, which may not always be the most time-efficient healthcare. Valuing time spent with the patient also allows the patient to feel heard and understood by the paramedic.

These measures of ambulance service outputs also include an annual "Patient Experience survey" of patients transported by ambulance services. This survey was developed and is administered by the Council of Ambulance Authorities.[31] This measure of care is used to report on satisfaction as an indicator of "effectiveness" as an output of jurisdictional ambulance services. However, the methodology provided does not demonstrate whether the survey has been designed using reliable, psychometrically validated tools.[31-33] Quotations from patients are provided; however, there is no explanation of how the qualitative data was analysed, nor does this survey capture the breadth of paramedic-led healthcare; for example, it excludes 13% of ambulance services' highest risk consumers, those who receive healthcare however are not subsequently conveyed to a hospital ED.[31]

In a maturing profession such as paramedicine, understanding the patient perspective will contribute to a body of knowledge and the development of a theory of practice which may, in turn, underpin paramedic education.[34] Knowledge of experiences of patients who use paramedic-led healthcare will assist paramedics to differentiate their profession from other health professionals, further contributing to professionalisation of paramedicine. This also may inform defining paramedic role identity that may challenge some preconceptions about the paramedic role and allow the profession to diversify. Importantly, understanding patients' perspectives through evidence-based research provides valuable insight from the patient to paramedics, which may provide paramedics confidence in offering patient-centred care beyond the organisational key performance indicators based on time intervals.[27,35,36] Historically, paramedicine has focused on valuing the biomedical and technical aspects of healthcare. This may be a result of paternalistic influences from medicine, the effects of jurisdictional ambulance services' vocationally based educational systems, and key performance indicators unrelated to patient outcomes such as time-based targets and system efficiency measures. Now paramedicine is establishing its professional identity and functioning more broadly than traditional ambulance service models, an in-depth understanding of PtX is required.

Summary

Understanding patient experience is recognised as improving patient outcomes and useful in guiding improvements in healthcare system design.[3] However, current knowledge is scarce and mechanisms to measure the patient experience of paramedic-led healthcare require validation.

Generating quality research is useful to challenge current models of paramedic-led care, and influence quality improvement.[37] Further research using a qualitative social inquiry approach will be useful in providing in-depth knowledge of what contributes to positive patient experience and the needs of paramedic patients. Understanding what is important to patients served by paramedics may support the profession as it matures to define its professional identity.

Leaders of health service organisations have a responsibility to develop partnerships with consumers to inform the design, delivery and evaluation of care.[2] Policymakers should include validated measures of PtX as key performance indicators of Australian jurisdictional ambulance services. The patients' perspective is necessary to provide contextual meaning to epidemiological data.[5]

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ENHANCING RURAL AND REMOTE PARAMEDIC CAPABILITY THROUGH MOBILE SIMULATION: **THE GIPPSIM PROJECT**

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Introduction

Simulation in healthcare is recognised as an adjunct to real-life clinical case exposure. Simulation opportunities are important in low-workload environments to ensure that high-acuity, low-occurrence (HALO) skills are maintained to deliver best care[1]. Several studies have demonstrated the benefits of simulation and skills practice in paramedicine[2-4]. Additionally, studies involving obstetric physicians have reported significant improvement in clinician confidence and competence as well as improving self-ranking of performance during actual cases following simulation exposure[5,6].

Ambulance Victoria (AV) is a state-based ambulance service, with a workforce of 5,010 operational staff[7], comprised of Advanced Life Support (ALS) paramedics and Mobile Intensive Care Ambulance (MICA) paramedics. Regional areas also utilise community-based volunteer First Responders (including Ambulance Community Officers, or ACOs). Several static simulation facilities and programs exist across AV; however, these are located at tertiary institutions in metropolitan Melbourne or large regional centres[8]. In the Gippsland region of Victoria, paramedics serve a population of 271,266 people across 41,556km^2. The distribution of the population across the region means that there are small communities in geographical isolation. We sought to develop a mobile simulation vehicle that could be used to bring simulation opportunities to paramedics and first responders in these locations.

The GippSIM mobile simulation pilot project was funded via community-raised funds (Helimed 1 Ambulance Auxiliary). An ambulance was reconfigured with a high-fidelity manikin and simulation monitor (iSimulate RealiTi, ACT, Australia) to enable mobile simulation. We aimed to determine if mobile simulation was feasible to increase exposure to HALO skills, and test delivery methods to inform the credentialing needs of AV staff.

Measurements

A pre-deployment survey (Survey Monkey Inc, San Mateo, California, USA) was sent via email to all paramedics and first responders across Gippsland, formulated to assess exposure to predetermined HALO skills in both operational and simulation environments (Table 1). The survey also asked staff to rate their attitude towards simulation.

The GippSIM unit was introduced via in-service advertising and an introduction video and was accessible to staff via senior clinical education staff (Clinical Support Officers or CSOs), Team Managers (TMs) or Paramedic Educators (PEs) for three months. For the subsequent three months, alternative duties paramedics (e.g., pregnancy or return to work) operated the unit. After the initial six months, a "hybrid" delivery model was used where the vehicle was placed in larger regional centres and CSO/TM/PE staff were encouraged to use the resource. Incidence of simulation of pre-defined HALO skills were entered into a master spreadsheet by facilitators.

Table 1: Predetermined HALO skills

Skills list	Relevant skillset
Tension pneumothorax chest decompression	ALS, MICA
Adult CPR	FR, ALS, MICA
Adult defibrillation	FR, ALS, MICA
Paediatric CPR	FR, ALS, MICA
Paediatric defibrillation	FR, ALS, MICA
Paediatric drug administration	FR, ALS, MICA
Thrombolysis for STEMI	ALS, MICA
Drug-facilitated Intubation (IFS/RSI)	MICA
Intubation without drugs	MICA
Inter-hospital transfer for endovascular clot retrieval in stroke	ALS, MICA
Mechanical ventilation	MICA

Following the pilot period, a post-deployment survey was sent to operational staff, assessing if: i) Staff had been exposed to the resource; ii) If they had undertaken any HALO skills either operationally or in simulation; and iii) To rate their likelihood of undertaking further simulation. A separate survey was sent to the simulation facilitators to rate which delivery method was most effective.

Results

The pre-deployment survey was sent to 542 staff with a completion rate of 12.6% (n=68). The post-deployment survey was sent to 584 staff with a completion rate of 9.4% (n=55) (Figure 1).

More senior staff responded to the post-deployment survey, indicating that the population of experienced staff were possibly more engaged after having been exposed to the GippSIM unit (Figures 1 & 2).

Respondents to the pre-deployment survey were male 51% (n=35) and female 49% (n=33); however, fewer females responded to the final evaluation (male 62.5% (n=34), female 37.5% (n=21)). The qualification (skillset) of respondents was primarily ALS paramedics during the pre-deployment survey (57%, n=39), but the number of MICA paramedic responses rose from 19% (n=13) to 38% (n=21).

72% of respondents had been exposed to the GippSIM unit at least once during the trial period. The frequency of operational case exposure to HALO skills for respondents remained largely unchanged during the trial period, with adult resuscitation and defibrillation the most frequent (Table 3).

An increase in exposure to pre-hospital thrombolysis for STEMI was noted, as well as mechanical ventilation and drug-facilitated intubation for MICA paramedics. There was an increase in exposure to all the identified HALO skills in a simulated environment.

Pre-deployment, 22% of respondents (n=32) felt anxious about simulation; however, 98% (n=67) saw value. In the post-deployment survey, respondents ranked their level of comfort with simulation 6.2/10, yet 86% (n=46) of respondents indicated that they would seek further simulation in the future. Facilitators felt that once engaged in simulation, participants benefited from the exposure in some capacity. Facilitators also found conducting simulation for others to be beneficial to their own practice.

Discussion

Due to the geographical distribution of staff across Gippsland, providing high-fidelity equipment for static simulation use would have been cost-prohibitive. This resource allowed equipment and educators to be brought to the learner. Sung et al., reported that the management of innovation and change in an organisation requires a broad and inclusive approach to ensure widespread access to new opportunities[9].

The project recognised the importance of accessibility in rural areas and achieved strong engagement. The physical presence of the resource at locations motivated staff to participate in simulations instead of leaving expensive equipment unused in a training room. While this project focused on HALO skills, it also provided opportunities to assess other skills. Lower-risk skills with low frequency, such as patient transport decisions and alternative pathway referral, could be included in future evolutions.

Our results demonstrate that staff are willing to utilise a mobile simulation platform when given the opportunity,

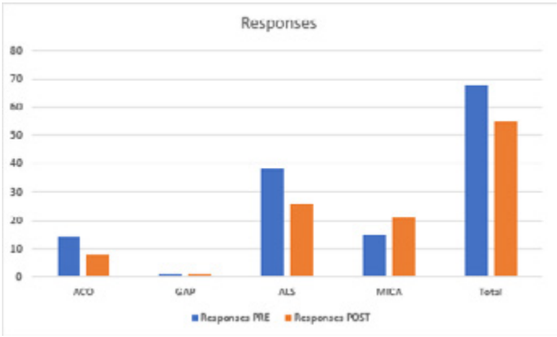

Figure 1: Number of respondents by skillset

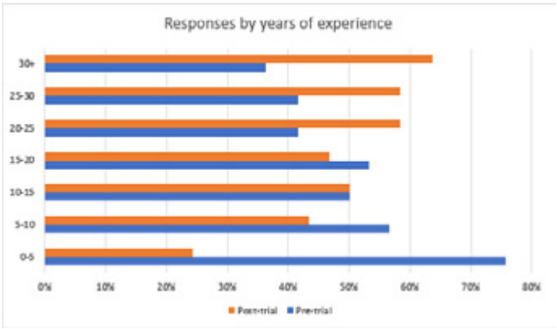

Figure 2: Demographic of responses to pre and post-trial surveys by years of experience

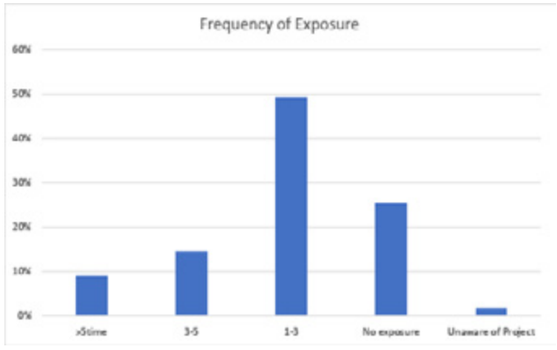

Figure 3: Frequency of exposure of survey respondents to the GippSIM during the trial period

No of skills performed within last 12-months	Pre-trial Actual case (n=68)	Pre-trial Simulation (n=68)	Post-Trial Actual case (n=55)	Post-Trial Simulation (n=55)
Adult CPR	52 (76.47)	57 (83.82)	49 (89.09)	50 (90.91)
Adult defib	41 (60.29)	55 (80.88)	44 (80.00)	47 (85.45)
Paed CPR	4 (5.88)	45 (66.18)	6 (10.91)	35 (63.64)
Paed defib	0	0	0	0
Thrombolysis: STEMI	15 (22.06)	15 (22.06)	31 (56.36)	24 (43.64)
Paed drug administration	20 (29.41)	17 (25.0)	30 (54.55)	17 (30.91)
Drug-facilitated intubation	12 (17.65)	15 (22.06)	20 (36.36)	25 (45.45)
Intubation without drugs	12 (17.65)	15 (22.06)	17 (30.91)	17 (30.91)
Inter-hospital transfer: Stroke	10 (14.71)	0	8 (14.55)	3 (5.45)
Mechanical vent	22 (32.35)	22 (32.35)	30 (54.55)	29 (52.73)

Table 3: Operational simulation-based exposure to HALO skills during the trial period

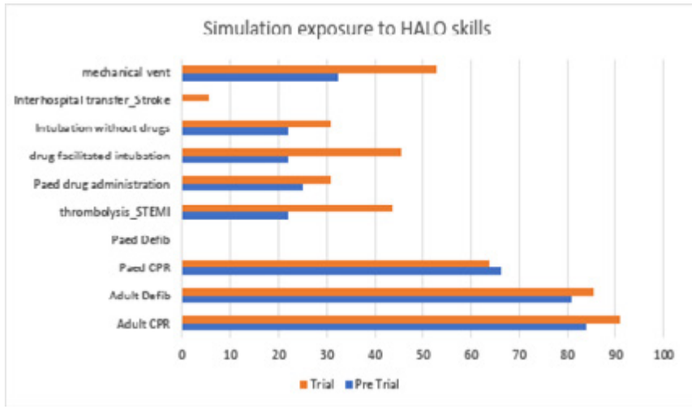

Figure 4: Proportion of respondents who had undertaken simulation-based HALO skills during the trial period

leading to a positive shift in attitude and culture towards simulation and skills maintenance.

Effective facilitation was essential to success. Placing the vehicle in a region and expecting managers to use it without dedicated facilitation did not yield effective utilisation. The highest engagement occurred with a dedicated facilitation model, which requires regular and ongoing resources for suitable facilitators. Despite the potential costs, it is important to consider the anticipated reduction in patient harm. The value of simulation, as discussed by Maloney et al., extends beyond a single financial perspective and should consider the expenses and returns for the patient, the clinician, the organisation, and the broader health sector[9-11]. Interestingly, facilitators reported an increase in their own clinical confidence from supervising simulations, especially as time progressed.

Clinical performance reporting allows staff and managers to identify gaps in specific HALO cases or skills. For instance, remote paramedics can be alerted if they haven't performed a medication-assisted intubation for a while, enabling targeted deployment of the mobile simulation resource. Moreover, paramedics in remote locations often assist other healthcare providers in emergency care, making mobile simulation suitable for multidisciplinary team training, as seen elsewhere[6,12].

An additional benefit of this trial was the integration of manual-handling practices. Ambulance services are exposed to a high manual-handling injury burden[13-15]. Efforts to improve manual-handling practices and to reduce work-related injury are valued by ambulance services, and the opportunity to embed these principles into a simulation were noted to be beneficial[7]. Future projects should aim to embed manual-handling equipment and training into their model.

Conclusion

The GippSIM mobile simulation project has demonstrated that a well-equipped, fit-for-purpose vehicle with appropriate facilitation and accessibility can be embraced by staff. The attitudes of staff towards mobile simulation are favourable and optimistic, with an increase in exposure to HALO skills. Further research should be undertaken to determine whether such investment in mobile simulation corresponds to improved patient outcomes and/or a reduction in clinical error.

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SAFEWORK V NSW AMBULANCE

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In April 2023, NSW Ambulance entered a plea of guilty to a criminal charge under the Work Health and Safety Act 2011 (NSW). Many paramedics welcomed this plea in the belief that the ambulance service was being held to account for the poor management of its internal investigations and, in particular, how one paramedic was treated. In fact, these issues were not relevant to the plea or the final penalty.

This article will discuss the case of SafeWork NSW v Crown in the Right of New South Wales in respect of the Ambulance Service of NSW [2023] NSWDC 134 (2 May 2023) (hereafter 'SafeWork v NSW Ambulance').
I will put the prosecution into the context of the criminal law, what the allegations were and how the matter was resolved, and explain why the issues of how Paramedic Jenkins' treatment were irrelevant. Finally, some implications for what the judgement might mean for NSW Ambulance and its employees will be considered.

Work Health and Safety (WHS) and the Criminal law

A breach of the Work Health and Safety Act 2011 (NSW) is punished by the criminal law. In a criminal prosecution, the prosecutor is required to identify the facts that are said to constitute the breach of the law. When considering a prosecution under the Occupational Health and Safety Act 1983 (NSW) (now repealed), the High Court said: "The common law requires that a defendant is entitled to be told not only of the legal nature of the offence with which he or she is charged, but also of the particular act, matter or thing alleged as the foundation of the charge'.[1]

An accused has the option to enter a plea of guilty or not guilty. On a not guilty plea, the prosecutor must bring evidence before the court to prove the alleged facts are true and make legal argument to the effect that the facts, if true, mean the accused has breached the law. The judge rules on issues of evidence and, where there is no jury, determines questions of guilt or innocence. The court (whether a judge alone or a judge sitting with a jury) does not conduct a wide-ranging inquiry into the conduct of the accused to try and determine if any offences have been committed. The role of the court is to determine whether the prosecution has met the burden of proving its case. A judge may think the evidence reveals that the accused has committed an offence other than the one charged but, as a general rule, they cannot substitute that offence for the one alleged by the prosecution.[2] The Court's job is to determine whether the accused is guilty or not guilty of the offence alleged by the prosecution.

Where an accused enters a plea of guilty, the breach of the law is admitted. Usually, and in this case, the prosecutor and the

accused, now called the defendant, agree on a statement of facts which are submitted and the judge sentences the defendant on the basis of those facts.

In the matter of SafeWork v NSW Ambulance the prosecution alleged that the Ambulance Service had committed an offence contrary to s 33 of the Act. Section 33 says:

Failure to comply with health and safety duty – Category 3

A person commits a Category 3 offence if -

(a) the person has a health and safety duty, and

(b) the person fails to comply with that duty.

Maximum penalty -

(a) in the case of an offence committed by an individual (other than as a person conducting a business or undertaking or as an officer of a person conducting a business or undertaking) - 575 penalty units, or

(b) in the case of an offence committed by an individual as a person conducting a business or undertaking or as an officer of a person conducting a business or undertaking - 1,155 penalty units, or

(c) in the case of an offence committed by a body corporate - 5,770 penalty units.

A penalty unit is $110, so today the maximum possible penalty is a fine of 5,770 x $110 or $634,700.[3] At the time of the offence by NSW Ambulance, the maximum possible penalty was a fine of $500,000.[4]

A category 3 offence is the lowest offence level. A category 2 offence occurs where the defendant's action "exposes an individual to a risk of death or serious injury or illness" (s 32). A category 1 offence exposes an individual to a risk of death or serious injury where the conduct of the defendant amounts to gross negligence or recklessness (s 31). Because this allegation was brought under s 33, there was no suggestion that the conduct of the defendant exposed anyone to a risk of death or serious injury or illness. The importance of this is discussed further, below.

The relevant health and safety duty was identified as the duty set out in s 19(1), that is the duty "to ensure, so far as is reasonably practicable, the health and safety of workers". The allegations against NSW Ambulance were that it:

- routinely failed to comply with its own policies and procedures in relation to the storage and handling of restricted medication;
- occasionally failed to ensure that the removal of restricted medication from the safe was witnessed by a second clinician;
- occasionally allowed clinicians to sign the register as a witness without actually having witnessed the removal or return of restricted medication from the safe, even when rostered as part of a dual crew;
- occasionally failed altogether to ensure that clinicians witnessed and recorded the removal or return of restricted medication from the safe on the register, even when rostered as part of a dual crew;
- did not always ensure the removal of the unused portion of the restricted medication from its original packaging before disposal;
- failed to ensure that clinicians, including Paramedic Jenkins, always disposed of restricted medication in the presence of a witness;
- failed to ensure consistent methods of disposal of restricted medication across different stations; and
- failed to provide space on EMRs to document the witnessing of the disposal of restricted medication.[5]

That it:

... failed to implement formal procedures and policies for:

- unannounced independent station audits to assess compliance with restricted medication policies;
- escalation processes for corrective action after any unannounced audit;
- regular audits of restricted medication use as recorded by EMRs so as to identify atypical use;
- responding to any identified patterns of atypical use of restricted medication;

- regular trend reporting on reported incidents involving restricted medication; and
- reviewing trend reports to identify potential misappropriation of restricted medication.[6]

And that "managerial staff at ASNSW had not completed their three yearly certifications in respect of the MMOP [ASNSW Medications Management Operating Procedure PRO2016 dated 12 January 2017] and the MMPD [ASNSW Medication Management Policy Directive PD2016-018 dated 12 January 2017] which meant that not all staff had received training on those procedures".[7]

The risks to workers were identified as:

[28] Risks to the health and safety of workers, including Paramedic Jenkins, could arise where paramedics handling Restricted Medications, including Fentanyl, misappropriated the Restricted Medications whilst working for their own illicit consumption.

[29] In particular, there was a risk that such conduct may cause impairment to the workers' judgment, including Paramedic Jenkins', either by way of an acute intoxication or because of impairments associated with long-term drug misuse that could affect their capacity to undertake their required functions, including driving and providing medical assistance, with a consequential risk of harm to themselves or other workers (the Risk).'[8]

In a case such as this, it is incumbent upon the prosecution to show that there was something the defendant could have reasonably done to mitigate the risks to health and safety.[9] It was alleged that what the ambulance service should have done was:

(a) Ensuring that whenever a paramedic was working as part of a dual crew, the removal from the safe, return to the safe, and the disposal of Restricted Medications was witnessed by another paramedic and the witnessing recorded on the Restricted Medications Register;

(b) Conducting unannounced independent station audits to assess compliance with Restricted Medications policies (including policies relating to storage, maintenance of registers [including witness signatures], stock checks and integrity checks) to be conducted by an independent clinician and implementing an escalation process for corrective action;

(c) Conducting regular audits of patterns of use of Restricted Medications as recorded in the eMR by paramedics to create trend reports so as to identify any atypical use which may suggest possible misappropriation and implementing a policy to respond to and identify atypical use, including by requiring notification to and consultation with the immediate supervisors of any paramedic identified as involved in such atypical use;

(d) Creating regular trend reports on reported incidents involving Restricted Medications in the NSW Health Incident Information Management System to identify potential risks associated with the use of such Medication and reviewing these trend reports to identify potential misappropriation;

(e) Providing every managerial staff member with line management duty for paramedics, specific training as to the contents of the MMOP and MMPD.

As noted, the Ambulance Service entered a plea of guilty, admitting that the relevant conduct amounted to a breach of the duty under s 19, and that they were indeed guilty of the offence under s 33. Considering the circumstances of the offending and that this was the Service's first offence, District Court Judge Strathdee imposed a fine of $187,000. 50% of the fine went to SafeWork, the remaining 50% was returned to government consolidated revenue, i.e. the very pool of money that funds the Ambulance Service.

The relevance of Paramedic Jenkins' death

The issue of missing drugs, and the misuse of drugs, came to the ambulance service's attention after a paramedic reported that vials of fentanyl had been tampered with. Suspicion fell on a Tony Jenkins, a local paramedic who was subject to investigation. The Sydney Morning Herald reported that:

> ... Tony Jenkins was pulled into a meeting with NSW Ambulance and accused of misusing the highly potent synthetic opioid fentanyl. He was allowed to leave the meeting alone, hours before his shift was supposed to end, and died by suicide a short time later ...

Many paramedics have reported that they believed that this prosecution arose from the service's treatment of Paramedic Jenkins, and that despite having put serious allegations to him, he was allowed to leave on his own and was not offered appropriate support.[10] Again the Herald reported that:

> Jenkins' nephew Shayne Connell, who is also the chief executive of suicide prevention organisation LivingWorks, told the Herald on Tuesday it was "pretty significant" that a NSW government agency had pleaded guilty in a court case relating to the suicide of an employee.
>
> "Tony asked for help the day that he died. He was clearly in need of support ... and that help wasn't forthcoming," he said.
>
> Gerard Hayes, the secretary of the Health Services Union and a former paramedic, said Jenkins was not the last serving paramedic to die by suicide and the pressure on frontline service workers had only grown.
>
> "This is significant, for [NSW Ambulance] to basically say they've failed to live up to the standards they signed up to," he said. "This is an opportunity now to look at that total engagement ... to ensure that best practice is there. You can't plead guilty twice."[11]

The discussion above shows why the hopes expressed by Mr Hayes and Mr Connell were misplaced. The allegations against the ambulance service, and which were admitted, related to the audit and inspection of restricted drugs. The Crown did not suggest that the service's internal investigation or its support for Mr Jenkins was a breach of the Act and so these were not matters addressed by the court.

Further, and notwithstanding Mr Jenkins' death, the judge reminded herself (and anyone who cares to read the judgment) that the prosecution was for breach of s 33, that is it was not suggested that the service's conduct exposed anyone to a risk of death or serious injury.[12] Had the judge made any finding of a link between the service's conduct and Mr Jenkin's death, that would have been contrary to established sentencing principles. The court was to sentence the service only for the offences that it had been admitted. Mr Jenkin's death would only have been relevant if it was alleged either that he had died while at work while affected by a prohibited drug or if it was alleged that the breach was failure to support Mr Jenkins, which it was not.

Implications

The implications of this judgment are not that the ambulance service has to do more to support or counsel its paramedics or that it has to amend the way it conducts internal investigations. If anything, the opposite is true. Paramedics have to be trusted with drugs to do their work. As Her Honour said:

Because it involves intentional criminal conduct, the risk is also one that has to be managed in circumstances where the worker can be expected to be taking care to conceal such offending from their employer, often using sophisticated means to do so.[13]

The list of things that the prosecutor said the service could and should have done indicate what the implications are - requiring paramedics to sign off on each other's removal, return and destruction of drugs; unannounced independent station audits; regular audits of the use of drugs by individual paramedics; and notification to and consultation with the immediate supervisors of any paramedic identified as being involved in atypical drug use.

The court noted that many paramedics had observed behaviours by Mr Jenkins that may have suggested drug use but "None of Paramedic Jenkins' behaviours were reported to ASNSW ..."[14] Presumably the Ambulance Service will also be taking more steps to ensure paramedics report on their colleagues.

Closer supervision and immediate reporting may mean more paramedics, rather than less, are likely to be "pulled into a meeting with NSW Ambulance and accused of misusing" restricted drugs. And using restricted drugs is likely to see practitioners referred to, in New South Wales, the Paramedicine Council to determine if they are impaired and/or dismissed from their employment.[15]

Conclusion

Paramedics and Mr Jenkins' family hoped that the Ambulance Service of NSW was being held to account for what they believed was inappropriate, heavy-handed treatment of Mr Jenkins. Treatment that led to his death; a death that, it is argued, could have been avoided if the service had offered appropriate support.

The reality is that the prosecution did not allege any failing by the Ambulance Service in its dealings with Mr Jenkins. This case was not "a court case relating to the suicide of an employee"; it was a case about the application of service rules regarding access to and auditing of drugs. The suicide of the employee did not bring the matter to the Ambulance Service's attention, nor was it relevant in the final prosecution. Those who hoped Mr Jenkins may have been vindicated, or the Ambulance Service would be blamed or were publicly accepting responsibility for his death, will be disappointed with the outcome.

Footnotes

i. Kirk v Industrial Relations Commission; Kirk Group Holdings Pty Ltd v WorkCover Authority of New South Wales (Inspector Childs) [2010] HCA 1, [26] (French CJ, Gummow, Hayne, Crennan, Kiefel and Bell JJ).

ii. There are exceptions to that rule, e.g. a person charged with murder can be convicted of manslaughter; a person charged with an offence of driving with a certain level of alcohol in their blood stream can be acquitted of that offence and convicted of an offence involving a lower alcohol level but these statutory exceptions to the rule need not concern us here.

iii. Crimes (Sentencing Procedure) Act 1999 (NSW) s 17.

iv. SafeWork v NSW Ambulance, [3] (Strathdee DCJ).

v. Ibid [86].

vi. Ibid [87].

vii Ibid [91]

viii. Ibid [97].

ix. Kirk v Industrial Relations Commission [2010] HCA 1.

x. I draw those conclusions from discussions on various social media sights. I do not reference particular posts as the authors did not intend their comments to be subject to discussion so the statements here are my summary of my understanding of the concerns being raised.

xi. Angus Thomson, 'NSW Ambulance pleads guilty over death of 'happy-go-lucky' paramedic', Sydney Morning Herald (online) 9 April 2023, https://www.smh.com.au/national/nsw/nsw-ambulance-pleads-guilty-over-death-of-happy-go-lucky-paramedic-20230404-p5cy2w.html.

xii. SafeWork v NSW Ambulance, [104].

xiii. Ibid, [107].

xiv. SafeWork v NSW Ambulance, [40].

xv. Health Practitioner Regulation National Law (NSW), Part 8, Division 4; Michael Eburn, 'Ways to Lose Your Job Part 2' Response, November 2022.

By **Peter Dent**, Former Paramedic
Ambulance Victoria

Editor of The Beacon, Ambulance
Historical Society of Victoria

Melbourne/Naarm, Wurundjeri Country

DEATH STRIKES IN DARKNESS, MUD, AND ICE

Bravery, selflessness, and the putting aside of personal safety and risk are hallmarks of this incredible rescue against seemingly insurmountable odds in our mountains' roughest and most unforgiving terrain.

At 11.30pm on 30 July 1997, most guests in Thredbo's Carinya and Bimbadeen ski lodges had retired to bed in the tranquillity of the snow-covered terrain at the base of Crackenback Mountain. Within 10 minutes, and without any prior warning, there came a deafening rumble as 3,500 tonnes of liquefied earth and debris cut a deadly pathway down the slope from the roadway above, sweeping away the two lodges and claiming the lives of 18 of the 19 guests.

Only one person, Stuart Diver, 25, would survive after enduring a horrifying 65 hours pinned under the rubble before being rescued. His wife, Sally, lay dead beside him, both entombed under a slab of concrete with an average airspace of 400mm.

In this nightmare situation, the frustration and despair were overwhelming as rescue work couldn't begin until the first light of the late winter dawn. When dawn finally broke, a massive rescue effort involving 1000 people began.

Given the scale of the devastation, the New South Wales government asked Victoria's Metropolitan Ambulance Service (MAS) if it could send an observer team to the site as this was to be first formal Urban Search and Rescue (USAR) deployment to a major structural collapse in Australia. By the time of the landslide, each state had a reasonable if somewhat immature USAR capability in place, with equipment caches meeting the United Nations' standard.

Then MAS Manager Operations Support Tony Pearce (now Inspector General for Emergency Management, Victoria) and three Metropolitan Fire Brigade USAR operators headed to Thredbo.

"When we arrived, some 14 hours after the event, it became apparent to us that the NSW complement was already tiring. We were not permitted to function in an operational capacity even though our NSW counterparts were desperate for assistance," Tony recalled.

"Jurisdictional politics were at play, and while the MFB Chief Officer had made a number of offers of assistance, they were each knocked back. Eventually, the MFB Chief spoke to his ACT counterpart and got agreement for a Victorian USAR Taskforce to be staged in the ACT, not far from Thredbo, so as to be readily deployable if NSW agreement could be reached.

"Eventually our small 'on-site team' was invited on to the slip to be integrated into NSW multi-agency teams, and eventually the Victorian Taskforce was despatched from the ACT to support the response and were again integrated into NSW teams.

"It was pure luck that myself and MFB Officers Mark Treverton, Mick Goland, Gary Egan, and Mark O'Connor ended up being part of the Stuart Diver rescue team. Our multi-agency rescue team was on a late shift, and late into the evening our teammate, NSW firefighter Steve Hirst, thought he heard a voice from under the rubble.

"Eventually, after a significant amount of effort, it was confirmed that there was someone alive under the slabs. That person was Stuart Diver, who revealed that he was trapped along with his wife Sally.

"We worked for a number of hours to try and get to him, but due to the dangerous nature of the rubble pile, there were multiple times when the tunnelling approach needed to be revised. We were relieved at around 2am and handed over to another team. By the middle of the next morning, we were back on site and Stuart had still not been recovered and the NSW Police site leader decided that it was appropriate for us to once again take over the rescue.

"The story is now history and we got Stuart out in the early afternoon. After more than 60 hours trapped under multiple concrete slabs in cold but relatively mild conditions for the time of year. He had suffered reasonably minor injuries and was transported to hospital. Unfortunately, and sadly, Stuart's wife Sally was deceased, and it took some further hours to eventually retrieve her body."

SUSTAINABILITY IN AMBULANCE

In the lead-up to this year's World Environment Day in June, here at the CAA we asked ourselves the question: "What is sustainability in ambulance"?

As part of the CAA 5-Year Strategy, a deeper dive and formal approach is intended on the subject, but for now the first thing to work out is what do we mean by "sustainability"? A good starting point, with help from the Oxford Dictionary, is that sustainability is "the degree to which a process or enterprise can be maintained or continued while avoiding the long-term depletion of natural resources". That is, how long can we keep doing a thing until that thing has a negative or detrimental impact on the world around us?

As the world continues to grapple with the challenges posed by climate change, sustainability is a key issue that must be addressed in all sectors, including healthcare.

Ambulance services can play a critical role in promoting sustainability and reducing their environmental impact, making World Environment Day an important opportunity to highlight the importance of sustainability in our sector.

As we all know, ambulance services are essential to the health and wellbeing of communities around the world. They provide life-saving care to people in need, often in emergency situations. However, ambulance services also have a significant environmental impact. For example, they consume energy and resources, generate waste, and contribute to air pollution through their use of vehicles.

There are however several ways that ambulance services can plan for and promote sustainability.

One important strategy is to continue to investigate, and where possible, adopt more efficient and environmentally friendly vehicles. This can include the use of hybrid or electric vehicles, which produce lower emissions and are more fuel efficient than traditional gasoline-powered vehicles. Many Australasian ambulance services already use bicycles to assist in environments where speed is still paramount but getting through crowds would be impossible for a motor vehicle.

Another area worth considering, as long as it is operationally safe to do so, is ambulance services practising and adopting eco-driving practices, including driving at lower speeds and avoiding unnecessary idling.

Many industries are closely examining their supply chain and consumables' usage with the aim of reducing waste generation. This can be done in many different ways, and as we saw in FIRST #12, initiatives such as St John NT's uniform recycling initiative helps reduce landfill and textile waste.

A part of a review of an organisation's consumables also covers the use of facility resources, implementing energy-efficient lighting and HVAC (heating, air-conditioning and ventilation) if possible and, as an example for our sector, promoting telehealth and other remote healthcare services to reduce the need for ambulance transport.

The annual World Environment Day is a great opportunity to promote sustainability in ambulance services, as well as to showcase sustainability efforts and to promote best practices. If you are aware of positive initiatives underway in your organisation, we would welcome your thoughts. It might even make a good entry for the 2024 CAA Awards for Excellence.

GET TO KNOW AMBULANCE TASMANIA'S NEW CHIEF EXECUTIVE

In late 2021, Jordan Emery was approached about taking on the Executive Director of Operations role at Ambulance Tasmania.

The timing was ideal as he'd been considering the opportunity to continue his professional and personal growth in other settings, so after 14 years with New South Wales Ambulance, Jordan decided to take the plunge and move to Tasmania.

"I knew Ambulance Tasmania was embarking on some important work to improve culture and the experience of the everyday people who contribute to caring for others. It seemed like an amazing opportunity and, candidly, I haven't looked back," he said.

Earlier this year, the now-former Chief Executive of Ambulance Tasmania, Joe Acker, announced his retirement from the service and Jordan decided to throw his hat in the ring after acting in the role on multiple occasions.

On 2 June 2023, it was announced that Jordan would be appointed to the top job - a move that Jordan describes as an awesome responsibility and incredible privilege.

Photo credit: The Advocate

LEADERSHIP IS FAR LESS ABOUT YOU AS THE INDIVIDUAL AND FAR MORE ABOUT WHAT YOU DO FOR OTHERS

"My main goal as Chief Executive is to lead the team at Ambulance Tasmania to deliver world-class care to Tasmanians. In order to achieve this, it is really about ensuring our people feel safe, valued, and empowered to be the very best versions of themselves when they show up to work each day.

"When people are able to propose new ideas, challenge the status quo and admit to making mistakes without negative consequences, organisations are able to thrive, become more innovative, and team members are more invested. That is the culture I am passionate about creating and helping thrive at Ambulance Tasmania - and I am lucky because lots of our people want that as well."

Jordan's ambulance career began in New South Wales in 2008. He's had several defining moments in the past 14 years which have fuelled and sustained his passion for paramedicine, but one particular experience really sticks out.

"When I was undertaking my clinical placement, I had the privilege of attending a woman who had attempted suicide in Sydney. Somewhere along the journey to hospital, I held her hand and continued to do so until shortly after we were triaged and offloaded. As we left, she said, "Thank you for holding my hand. I haven't felt human touch in such a long time". Her story is one that speaks of the profound impact we can have on the individuals we care for, even when we are not performing advanced clinical skills or necessarily life-saving interventions."

After moments like this, gaining experience and learning on road, Jordan has some advice for anyone wishing to pursue leadership opportunities and roles.

"Leadership is far less about you as the individual and far more about what you do for others. In particular, it is about how you help other people achieve their fullest potential so that teams and organisations thrive well after you, as the leader, are gone. It's also about being able to hold space and create a path forward when you have two competing ideas.

"As a leader, rather than picking a side or getting caught up in binary thinking patterns, it's about acknowledging the significance of both positions and then charting a path forward. It's not about indecision or indifference to the other perspective, but rather about what Barack Obama called 'duality'. I think it's a critical skill for leaders in an increasingly polarised world.".

MAJOR MILESTONE MARKS ANNIVERSARY

An incredible 20,000 patients have received lifesaving stroke care over the past decade thanks to the Victorian Stroke Telemedicine (VST) service, which has recently expanded to two new locations.

Run by Ambulance Victoria (AV) and now operating across 20 regional hospitals throughout Victoria and Tasmania, VST allows clinicians to collaborate across organisational boundaries and provide time-critical care locally.

AV's Director of Stroke Services Professor Chris Bladin said the service played a fundamental role in stroke treatment.

"Many hospitals do not have a stroke specialist on site or lack around-the-clock access to this type of expertise, making VST a game-changer in the emergency care of patients," Prof Bladin said.

"Every minute matters when suffering a stroke, which is why VST is crucial. The world-class service connects patients with expert doctors who provide diagnosis and treatment, enabling them to receive the right care at the right time regardless of their location."

Prof Bladin said patients were receiving clot-busting drugs an average of 40 minutes earlier and often within an hour of arriving at hospital.

"VST provides more than just acute stroke care, with the service now delivering out-patient, in-patient and rehabilitation support across several regional hospitals.

"In an effort to streamline the process, a dedicated call-taker has also been added to better coordinate calls and complete clinical documentation."

Retired Melbourne resident Marina Dunn was enjoying a holiday in Tasmania when she experienced stroke symptoms on Good Friday earlier this year, which prompted her partner to take her to Launceston General Hospital.

Ms Dunn was immediately admitted to emergency where she underwent a VST consultation.

"I was amazed at the speed in which everything happened. They did it all there - they were fantastic," she said.

Ms Dunn said she highly recommended the service as it allowed her to be moved to a general ward by the afternoon.

"I don't know if all hospitals treat their patients with a stroke like that, but they acted quickly. I couldn't have had any better care."

Ambulance Victoria's Director of Stroke Services Prof Chris Bladin using the VST cart to speak to a patient. Photo: Ambulance Victoria

Currently VST operates in 18 regional Victorian hospitals and two sites in northern Tasmania.

Albury Wodonga Health Director of Nursing, Medicine and Cancer Services Brett Pressnell said the Wodonga campus went live with the service last month and had already conducted eight consultations.

"It's a vital tool offering speedy access to world-standard stroke care," Mr Pressnell said.

Portland District Health (PDH) Director of Medical Services Dr Andrew Walby said VST will soon be available to its community.

"Historically, if a patient presents with stroke-like symptoms at PDH, they will have a CT scan and then be transported to another hospital for treatment," Mr Walby said. "This service determines the type of stroke much faster, as well as the seriousness of symptoms, and allows for medication to be administered on-site at PDH."

VST is one of a range of health services AV provides to the community as part of its ongoing commitment to world-class research and best care for patients across the state.

KNOW THE SIGNS OF STROKE

- Face - Check their face. Has their mouth drooped?
- Arms - Can they lift both arms?
- Speech - Is their speech slurred? Do they understand you?
- Time is critical - If you see any of these signs call 000 straight away

EMPLOYMENT OPPORTUNITIES AND DIFFERENT CAREER PATHWAYS APLENTY IN SAAS

Chelsea Mawer found her way to Adelaide and the SA Ambulance Service (SAAS) initially through basketball. And it is basketball that is helping her to cement South Australia as her new home.

The experienced paramedic joined SAAS in its recruitment drive earlier this year from Tasmania. Chelsea had been working in Tasmania's north for three-and-a-half years on a short-term contract basis. She was looking for an opportunity to "become a better paramedic" with a permanent role.

She visited Adelaide in January for a basketball competition, and she loved the city; "It's like Tassie but better".

"I'm absolutely loving it, it's such a beautiful place to live. The traffic isn't as bad as what I thought it would be and I've already found a basketball team to play with. I just feel like I've been welcomed with open arms in all aspects to be honest."

It wasn't just the environment that enticed Chelsea; she did her research into career development and opportunities to diversify. SAAS has a Mental Health Co-Response model, where a mental health practitioner is paired with an ambulance paramedic.

"There's a lot of opportunity to upskill. In Tassie the only opportunities you have are to go ICP or ECP, and at the moment they're not running any courses. Whereas here, there is the mental health car which is absolutely awesome, and I have a massive heart for mental health."

Once in SA, Chelsea was interested in learning about the alternate pathways available, such as the Virtual Care Service and Priority Care Centres.

SAAS is grateful Chelsea chose to move to Adelaide to further her career.

"I want to become a better paramedic. I want to extend my career and I know that I needed a new environment and new opportunities to reach for otherwise I know I would become quite stagnant."

Chelsea is working in Adelaide's north and is being supported through a standard three-month probation period. Following this, she'll be granted an Authority to Practice in SA.

Executive Director Operations (Metropolitan) Paul Lemmer said he looked forward to welcoming more paramedics like Chelsea to the service.

"This is the first time SAAS has opened up lateral recruitment on such a wide scale to both paramedics and Intensive Care Paramedics who've not completed an internship with us," Paul said.

"It's an exciting time for us to bring in the experience from across the country, and hopefully from around the world, to help grow our service and its capabilities to meet increasing demand.

"If you're looking to live in a vibrant yet affordable city or escape to the SA countryside, please reach out and have a chat about your expertise as a paramedic or Intensive Care Paramedic."

SAAS is in the middle of delivering a +$300 million operational growth plan that includes an increase in staffing, new and rebuilt ambulance stations, and a boost to its fleet. Five new stations will be built in metropolitan Adelaide, and the Emergency Operations Centre is getting a new home alongside the State Health Control Centre. Three country stations will be rebuilt and seven will undergo significant upgrades. One metropolitan station will be rebuilt and three will be upgraded.

Recruiting wise, SAAS is looking for 350 new staff, including paramedics and Intensive Care Paramedics, emergency medical dispatch support officers, ambulance officers, dispatchers and clinical team leaders.

If you are an experienced paramedic or experienced Intensive Care Paramedic looking for a change, SAAS has multiple opportunities across the state. Go to: https://saambulance.sa.gov.au/work-with-us/who-we-employ/paramedic-experienced/

CREWS PROVIDE CRITICAL SUPPORT AT ICONIC EVENT IN THE HEART OF AUSTRALIA

As the dawn breaks on an icy morning in Alice Springs in the Northern Territory, the atmosphere is adrenaline-charged as crowds gather and line the track. Competitors and helicopters begin their start-up sequence. Dust fills the air, turning the sun a fiery red as the leader of the vehicles, none other than the legend Toby Price, plants his foot to the throttle, signalling the start of the 2023 Tatts Finke Desert Race.

It's 7am and the crew from St John NT are on standby at six medical checkpoints stationed along the 226km track. With a contingent of more than 50 paramedics, volunteers, paramedicine students and support staff, this is the 31st year that St John NT has provided the medical and retrieval support for both participants and spectators at the race.

The work for the team from St John NT began almost as soon as last year's winner had crossed the line. Months of planning, logistics and coordination go into the preparations of what Alice Springs Manager of Operations and Commander of the event Matt Cowie has labelled ''a logistically challenging beast of an event".

"Finke is a highly competitive and equally high-risk event, with some of these vehicles and bikes travelling in excess of 200km per hour along extremely challenging and unforgiving terrain," Matt said. "We know we will get patients, the number and severity are something we won't know until the dust settles, so we must plan for this event as a potential Mass Casualty Incident until proven otherwise."

With the closest hospital hundreds of kilometres away, it is a mammoth combined effort, with Matt and his team, including paramedic Tori Passarin who was responsible for ambulance event logistics, working with event organisers, NT Police, Fire and Emergency Services and the Alice Springs Hospital to provide critical support in the planning and implementation of health and safety.

Along with the people power, 4WD ambulances were stationed at the start and finish, as well as all medical check points. Three more were on the move following the racing pack, supported by three roving helicopters and two road ambulances on standby to receive the incoming.

This year the team treated more than 50 people, with 28 people transported to hospital.

"Fractured clavicles, arms and femurs are some of the major injuries we treat, along with abdominal trauma, the occasional flail chest and plenty of concussions," Matt said. "Basically, if it can get broken, you'll probably see it happen at Finke."

This year the team treated more than 50 people with 28 people transported to hospital – Photo Paul Neil

Some of the vehicles and bikes travel in excess of 200km per hour along extremely challenging and unforgiving terrain – Photo Paul Neil

Three roving helicopters were at the ready to receive the incoming – Photo Paul Neil

Despite the extreme and challenging conditions, the iconic event remains a firm favourite among staff and volunteers who travel from Darwin, Katherine and Tennant Creek to join the team in Alice Springs to provide critical support for the weekend of adrenaline-fueled racing.

Camped out at their stations along the track for three nights, the crew braved sub-zero temperatures to ensure the safety of patrons and participants.

A base is also set up at the medical clinic at the Finke overnight camp with 4x4 ambulance and response vehicles on site, where paramedics are supported by a doctor from the Alice Springs Hospital Emergency Department (ED) as well as an ED nurse and two primary care nurses.

BASICALLY, IF IT CAN GET BROKEN, YOU'LL PROBABLY SEE IT HAPPEN AT FINKE

Now in its 47th year, the event is the largest off-road race in the Southern Hemisphere, with thousands of competitors and spectators coming from across Australia and overseas to witness bikes and buggies fly over dusty dunes on the challenging track.

Crowd control is one of the biggest challenges for organisers, with spectators eager to get as close to the action as possible. This is a high-risk event, and there is real danger not only to race participants, but also to spectators. Areas identified as dangerous are sectioned off with warning signs displayed and Spectator Marshals on duty.

Finke Desert Race President Antony Yoffa said the safety of participants and spectators was paramount, and St John NT was critical to ensuring the event was as safe as possible.

"We could not run Australia's Ultimate Desert Race without the first-class standard of care from St John NT," Antony said.

"Over the past 30 years, they have become an integral part of the event from the planning process leading up to the event, to the gold standard care and support they provide at the event."

With the event growing bigger, and the drivers and riders pushing the limits each year, the team from St John NT are already formulating a "war game" for next year's event to ensure the safety of spectators and competitors. As one of the many unique experiences in which paramedics in the NT have the opportunity to participate, the Finke is clearly marked on the St John NT event calendar.

St John NT has provided the medical and retrieval support for participants and spectators at the race for more than 30 years – Photo Paul Neil

Camped out at their stations along the track for three nights, the crew braved sub-zero temperatures to ensure the safety of patrons and participants – Photo Paul Neil

The event is a mammoth combined effort for the team at St John NT, including Matt Cowie and Tori Passarin – Photo Paul Neil

Paramedicine Board – Ahpra

For all the latest news from the Ahpra Paramedicine Board, visit: Paramedicine Board https://www.paramedicineboard.gov.au/

Ahpra and National Boards release social research results

Ahpra and the Paramedicine Board of Australia have released results from surveys of practitioners' sentiment and perceptions about their role and work. A report specific to the paramedic profession survey results has been published by The Paramedicine Board.

Find out more at: Read the Reputational Insights 2021 - Paramedicine Board of Australia report at https://www.paramedicineboard.gov.au/News/20230626-Ahpra-and-National-Boards-release-social-research-results.aspx

You have professional obligations and not just at renewal

Registered paramedics have professional and legal obligations throughout the whole year of registration. These include renewing your registration by 30 November each year; complying with the requirements of the standard for continuing professional development; having adequate professional indemnity insurance (PII) arrangements in place (not relevant to paramedics with non-practising registration); only practising within the scope of your PII arrangements; meeting the requirements of the standard for recency of practice; ensuring you are safe and competent in any practice you carry out; meeting the Board's ethical and professional expectations as outlined in the Code of Conduct (https://www.ahpra.gov.au/Resources/Code-of-conduct/Shared-Code-of-conduct.aspx); and complying with the mandatory reporting obligations set out in the National Law.

Find out more at: https://www.paramedicineboard.gov.au/News/Newsletters/March-2023.aspx

New engagement and support team to help Aboriginal and Torres Strait Islander practitioners with their registration

Earlier this year, Ahpra established a new Aboriginal and Torres Strait Islander Engagement and Support team to help Aboriginal and Torres Strait Islander applicants, registrants and stakeholders through the registration process. The support team forms part of Ahpra's commitments to providing culturally safe services to its applicants, registrants and stakeholders. Find out more at: https://www.paramedicineboard.gov.au/News/Newsletters/March-2023.aspx#new-team

Kaunihera Manapou Paramedic Council

At its Āperira/April hui/meeting, Te Kaunihera Manapou|Paramedic Council agreed that it was appropriate to develop a statement to provide guidance to those paramedics supporting ākonga/ students who are on clinical placements.

Working with ākonga/students is a responsibility of the paramedic role that contributes to the further development of the profession. The statement is available on Te Kaunihera's website, and is intended for paramedics as individuals, rather than employers at the organisational level.

The statement can be accessed at: www.paramediccouncil.org.nz

The National Clinical Evidence Taskforce

Funding was discontinued for the National Clinical Evidence Taskforce and the COVID-19 guidelines as of 30 June 2023. These guidelines are no longer continually updated but will remain online until the guidance becomes inaccurate and/or no longer reflects the evidence or recommended practice. Find out more at: https://clinicalevidence.net.au

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