VOL 46
AUTUMN 2019

RESPONSE

The official voice of Paramedics Australasia

PARAMEDICS
AUSTRALASIA

Study Postgraduate Paramedicine

ECU has a range of postgraduate Paramedicine courses that have been developed in close consultation with industry and are focused on clinical issues related to daily practice, as well as developing clinical decision-making and critical thinking skills.

Critical Care
- Graduate Certificate of Critical Care Paramedicine
- Graduate Diploma of Critical Care Paramedicine
- Master of Critical Care Paramedicine

Disaster and Emergency Response
- Graduate Certificate of Disaster and Emergency Response
- Graduate Diploma of Disaster and Emergency Response
- Master of Disaster and Emergency Response

Paramedic Practitioner
- Graduate Certificate of Extended Care Paramedicine
- Graduate Diploma of Extended Care Paramedicine
- Master of Paramedic Practitioner

Research
- Master of Paramedical Science by Research
- Doctor of Philosophy

These courses can be completed online or on-campus and are open to those with a relevant Bachelor degree, or equivalent prior learning.

Apply now for postgraduate Paramedical Science
ecugetready.com.au

QILT quality indicators for learning and teaching

ECU. Australia's top ranked public university for student experience.
Quality Indicators for Learning and Teaching – 2017 and 2018.

AUSTRALIA ECU EDITH COWAN UNIVERSITY

303ML 11121618 | CRICOS IPC 00279B

RESPONSE | Contents

04

ROAR – outstanding in the outback

It was 'Back to Alice' (Springs) for a powerhouse of rural and remote paramedicine and allied health experts presenting a vital and thought-provoking program at ROAR 2019.

PARAMEDICS AUSTRALASIA

BOARD OF DIRECTORS

President – **Peter Jurkovsky**
Vice-President – **Simone Haigh**
Treasurer – **Paul Thaw**
Brad Mitchell
Nathan Haynes
Colin Allen
Bronwyn Tunnage
Richard Galeano
Philip Bachelor
Community Representative
Stephen Cornelissen
Community Representative
Michael Eburn
Seconded Representative

CHAPTERS

QUEENSLAND
Chair, **Glen Morrison**
glen.morrison@paramedics.org
Vice-Chair, **Andrew Blumson**
andrew.blumson@paramedics.org
Secretary, **Jamie Rhodes**
jamie.rhodes@paramedics.org

AUSTRALIAN CAPITAL TERRITORY
Positions currently vacant

TASMANIA
Chair, **Ryan Posselt**
ryan.posselt@paramedics.org
Vice-Chair: **Rebecca Lunnon**
rebecca.lunnon@paramedics.org
Secretary, **Rose Cook**
rose.cook@paramedics.org

WESTERN AUSTRALIA
Chair, **Stewart Masson**
stewart.masson@paramedics.org
Secretary, **Mandy Edmonston-Fearn**
mandy.edmonston-fearn@paramedics.org

NEW SOUTH WALES
Chair, **Buck Reed**
buck.reed@paramedics.org
Secretary, **Joe Karleck**
joe.karleck@paramedics.org

NORTHERN TERRITORY
Chair, **Brock Hellyer**
brock.hellyer@paramedics.org

SOUTH AUSTRALIA
Chair, **Clare Collihole**
clare.collihole@paramedics.org
Secretary, **Lachlan Graham**
lachlan.graham@paramedics.org

VICTORIA
Chair, **Levi Karschimkus**
levi.karschimkus@paramedics.org
Secretary, **Jake Donovan**
jake.donovan@paramedics.org

NEW ZEALAND
Chair, **Mitch Mullooly**
mitch.mullooly@paramedics.org.nz
Secretary, **Bernard Varaine**
bernard.varaine@paramedics.org.nz

STAFF

Chief Executive Officer
Robyn Smith
robyn.smith@paramedics.org
Governance & Corporate Policy
Cassandra McAllister
cassandra.mcallister@paramedis.org
Communications Editor/Writer
Denese Warmington
denese.warmington@paramedics.org
Membership Services Coordinator
Meg A'Hearn
meg.ahearn@paramedics.org
Social Media Coordinator
Levi Karschmikus
levi.karschmikus@paramedics.org
eLearning Manager
Ally Batucan
ally.batucan@paramedics.org
Finance Officer
Cliff Jones
accounts@paramedics.org

NATIONAL OFFICE

Box 173, 585 Lt Collins Street,
Melbourne VIC 3000
Free call 1300 793 385
info@paramedics.org

ACN 095 065 580
ISSN 1836-2907

© Paramedics Australasia 2019.
All rights are reserved. All materials contained in this publication are protected by Australian copyright law and may not be reproduced, distributed, transmitted, displayed, published or broadcast without the prior permission of Paramedics Australasia or in the case of third party material, the owner of that content. All efforts have been made to ensure that material presented in Response was correct at the time of printing and is published in good faith. The views and opinions expressed in Response are not necessarily those of Paramedics Australasia and its executive or employees. The content of any advertising or promotional material contained within Response is not necessarily endorsed by Paramedics Australasia.
Published by Paramedics Australasia.

COVER

(L-R) Levi Karschimkus and Sarah Osborne at ROAR 2019. Levi is Chair of the Victoria Chapter; and Olivia was the recipient of a scholarship to attend ROAR 2019.

with Peter Jurkovsky

Ongoing engagement

A very warm welcome to the Autumn Issue of *Response* – your member magazine.

I would firstly reiterate that our thoughts go out to our colleagues and the wider communities who have suffered from the horrendous terrorist attacks in New Zealand and Sri Lanka in recent times. Our professional role as first responders at the forefront of these life-changing events is never easy and the need to support each other resonates with us as a representative organisation.

An enormous amount has been occurring in the paramedicine space since the last issue of *Response*. This Autumn Issue includes a review of the very successful second Rural, Outback and Remote (ROAR) paramedic conference held in Alice Springs; a day in the life of Queensland paramedic and 2018 Ambulance Service Medal recipient, Leia Spencer; an excellent health and wellness piece by our New Zealand Chapter Chair, Mitch Mullooly; a clinical article by Tim Bonser on cardiac rhythm management devices and a thought-provoking opinion piece by prolific contributors Drs Michael Eburn and Ruth Townsend on how paramedicine might look in 10 years now that paramedics have joined the ranks of health professionals registered under the Health Practitioner Regulation National Law.

Looking forward, we are delighted to be hosting the Paramedics Australasia International Conference (PAIC) 2019 'Broadening Horizons' in Hobart in late November with an outstanding list of speakers and events planned. Do whatever you can to ensure your attendance at this watershed event on the paramedicine calendar.

> "On the regulatory front, a number of important information items were published by the Paramedicine Board of Australia in the past week that registered paramedics should be aware of"

On the regulatory front, a number of important information items were published by the Paramedicine Board of Australia (PBA) in the past week that registered paramedics should be aware of. The PBA noted that more than 16,000 applications have been processed and registration has been granted, exceeding initial expectations. The 'grandparenting' period will continue until 30 November 2021, allowing the PBA to receive applications under these provisions until that time. After that date, only applicants with either approved, accepted or substantially equivalent qualifications will be qualified for registration in the paramedicine profession in Australia.

The PBA also reminded registered paramedics that the Code of Conduct for Paramedics had been in place since June 2018 and that the Code aims to help paramedics to provide effective regulated health services within an ethical framework stating, that "as registered health practitioners, you have a duty to make the care of patients or clients your first concern and to practise safely and effectively. Maintaining a high level of professional competence and conduct is essential for good care. The Code contains important standards of behaviour expected of paramedics". Codes and guidelines approved by the National Board may be used as evidence of what constitutes appropriate professional conduct or practice for paramedicine in proceedings against a health practitioner under the National Law or a law of a co-regulatory jurisdiction. Please be sure you familiarise yourself with these documents (available under codes, guidelines and policies on the PBA website).

This is also an appropriate segue to refer members to the regulators information video series which provides details to assist practitioners in the unlikely event that a 'notification' is made about an individual. The video series, called 'Let's talk about it', explains what happens when concerns are raised with the regulator, gives easy-to-follow information about the notifications process and addresses common questions, so consumers and health practitioners know what to expect when they interact with AHPRA and National Boards. The relevant video 'A notification has been made about me' features five health practitioners who work within the National Scheme and is directed at health practitioners who have had a notification made about them. As suggested, this is an unlikely event in person's professional career but it is helpful information that alleviates the tension around this process. Turn to page 22 in this issue of *Response* for a summary article.

The PBA also identified that the *Health Practitioner Regulation National Law and Other Legislation Amendment Act 2019* (Qld) has been passed by the Queensland Parliament as the host state for the National Law. The amendments include revisions to the mandatory reporting requirements for treating practitioners and an extension of sanctions for statutory offences.

The changes to the National Law intend to support registered practitioners to seek help for a health issue (including mental health issues). They will also increase the penalties (including the introduction of custodial sentences) for some offences under the National Law, including where people hold themselves out to be registered health practitioners when they are not. The mandatory reporting provisions in the National Scheme are not well understood in the sector so will be a focus of campaigns in the months to come to provide information about these important areas of the law.

The PBA also announced the membership of the new Paramedicine Accreditation Committee to be chaired by Emeritus Professor Eileen Willis. The Committee will exercise the accreditation functions for the paramedicine profession under the National Law, including:

- developing and reviewing accreditation standards
- assessing and accrediting programs of study
- monitoring approved programs of study and education providers to ensure they continue to meet accreditation standards
- advising the Board on issues in education and clinical training which may impact on paramedicine practice and approved paramedicine programs, and
- considering other matters as requested by the Board.

PA congratulates the new committee members on their appointments to this important role and look forward to providing input in the years to come.

As always, stay safe and the PA Board and Executive look forward to engaging with members as we continue to grow our membership in this exciting phase in the evolving professionalism of paramedicine.

Peter Jurkovsky
President, Paramedics Australasia

FEATURE

Back to Alice ROAR 2019

RURAL OUTBACK AND REMOTE PARAMEDIC CONFERENCE **10–12 APRIL**

by Robyn Smith, CEO of Paramedics Australasia

A powerhouse of rural and remote paramedicine and allied health experts presented a vital and thought-provoking program at PA's Rural, Outback and Remote (ROAR) Conference 2019.

It was 'back to Alice' (Springs) after the success of the inaugural ROAR in 2018 and the view of last year's delegates that the destination was perfect for rural and remote health discussions.

The program was intense and focussed on improving the delivery of remote emergency care and retrieval in rural and remote regions with presenters drawn from all regions of Australia, New Zealand and the USA. We looked at the skills, technology, health models and innovations that are leading improvement and sustainability in out-of-hospital care outside of urban areas. A range of workshops and interactive sessions that required active participation from delegates enhanced the program.

The level of participation, contribution and personal involvement at ROAR 2019 was truly inspirational. This was not a conference where delegates were watching the clock waiting for breaks or missing sessions, there was a great sense of shared purpose and willingness to listen and learn from each other. It was a privilege to join such dedicated and positive paramedics and allied health professionals. And in listening to many of the presenters talk about their careers, professional and personal development, the importance of having a mentor was raised a number of times as a core factor in an individual's success. PA will explore how we, as your professional organisation, may foster and facilitate mentoring across our membership and paramedicine more broadly.

I would like to personally thank Cassandra McAllister our ROAR 2019 convenor who brought together an international class event in collaboration with the dedicated health professionals who participated and supported the event, and in particular Judith Barker CEO of St John Ambulance Northern Territory and her team; Brock Hellyer, Chair of the Northern Territory Chapter of PA; and Paul Reeves, intensive care paramedic with the St John Ambulance Critical Response Unit in Alice Springs.

While we await further feedback from delegates on what they would like to experience at ROAR 2020, we can share with the broader membership that there was strong interest to hold next year's conference in Western Australia and potential destinations of Kalgoorlie and Broome were suggested. We'll keep you up-to-date and advise of dates well in advance.

Pre-conference workshops

Improvised medical skills for the austere medic

Steve Whitfield and Mick Stuth demonstrated the improvised medical skills needed to support patient care during extended extrications and focussed on the fundamental principles of basic life support in out-of-hospital care. Steve and Mick followed up their workshop with a conference session 'Where there is no ambulance', a fascinating big picture look at clinicians working independently and remotely in the out-of-hospital context with the added complexities of weather, geography and capability. In particular it was emphasised that capability is reduced by lack of resources in remote areas and so paramedics need to be resourceful and 'creative'.

> "Burns are common in remotes areas and banana leaves ease the pain"

> "Attending the ROAR Conference 2019 was an amazing experience. The acute rheumatic fever/rheumatic heart disease workshop delivered by Melissa van Leeuwen was most memorable and informative for me. Rheumatic heart disease is a heartbreaking reality that kills 1000 people every day. And it is 100% preventable"
>
> **Olivia Engeler**
> NT Chapter ROAR scholarship recipient

This workshop included a discussion around acute rheumatic fever and rheumatic heart disease – what it is, why it is something to be concerned about and how it is treated. It also looked at the anatomy of the heart, and provided a practical session on giving intramuscular injections and tricks and tips on giving Bicillin L-A.

> “Living and working remotely in Alice Springs makes it difficult to attend conferences due to travel times and expense. I am very thankful to PA, who provided me the opportunity to attend this conference with such a variety of knowledgeable speakers that I would not otherwise have the chance to experience. I particularly enjoyed the concurrent workshops, which kept us all engaged and interacting within the group. My favourite workshop was by Sukoluhle with her extensive knowledge of paediatric illness and captivating teaching style. The conference program also gave us an insight into the unique initiatives in Central Australia such as remote telehealth, remote community dialysis and maternity care. In addition to the core aspects of the conference, being exposed to other rural and remote paramedics from other states and also internationally was an invaluable experience to develop connections and learn from each others individual experiences”
>
> **Chloe Pryke**
> NT Chapter ROAR scholarship recipient

Essential skills in personal resilience

Amanda Akers facilitated a workshop around identifying the signs and symptoms of burnout followed by mindfulness exercises. Amanda, a clinical psychologist, works for CRANAPlus the peak professional body for the remote and isolated health workforce of Australia. Her work includes providing after hours, on-call telephone counselling for CRANAPlus Bush Support service for remote area health workers including paramedics. CRANAplus Bush Support Services recognise that the challenges that face remote health workers in their day-to-day lives (both at work and just in living remotely) are different than those living with the support found in larger regional and urban areas, and and offer unique and helpful resources that draw on its vast network and specialised knowledge. CRANAplus sees Bush Support Services as vital in retaining a healthy and resilient workforce in the remote sector and makes health worker support a priority.

Through Bush Support Services, CRANAplus is able to provide 24/7 personalised care for remote health workers and their families through a toll-free counselling service. PA members are able to access this free and confidential service, and remain anonymous if you wish.

Calls from mobile phones to the Bush Support Services 1800 805 391 toll free number can be returned at the caller’s request.

Welcome barbeque and reception

Aboriginal Elder and Arrernte woman Kumalie (Rosalie) Riley again provided a traditional Welcome to Country on spiritually significant land in the unique Akethe-le (Arrernte for ‘outdoor shelter’) within the Mercure Springs Resort with views across the MacDonnell Ranges and Todd River.

PA’s Vice-President Simone Haigh and CEO Robyn Smith officially opened ROAR, with Simone reflecting on the leading advocacy role PA played over a 30-year period leading to national registration of paramedics in 2018. She reported that PA continues to support its members to maintain their registration and in particular how the PA eLearning platform facilitates CPD accumulation and portfolio records. Delegates at ROAR had the opportunity to obtain 14 hours of CPD, including the required annual eight hours of face-to-face professional development.

Sukoluhle Mayo, paediatric nurse clinical educator

Program highlights

MRaCC Alice Springs

Dr Michelle Withers, an emergency physician at Alice Springs Hospital, overviewed the first year of operation of MRaCC, a retrieval experience we believe is like no other.

On 12 February 2018, a new and unique service went live in Alice Springs – the Medical Retrieval and Consultation Centre (MRaCC). Although the Central Australian Retrieval Service has been operating from the Alice Springs Hospital in conjunction with RFDS in various guises for many years, the opening of MRaCC caused a seismic shift in how retrievals are handled in Central Australia, bringing all co-ordination together via the one service. All clinics, stations, mines and anyone else requiring emergency advice or evacuation in the catchment area now call a single number to contact MRaCC, which is staffed at all times by specialist retrieval clinicians.

A focus of the service system is building a sustainable workforce with dedicated on the ground and local knowledge and keeping patients in the community where at all possible. Michelle commented that, “Since the red dust has settled, we are seeing obvious benefits to patients – better and faster communication, earlier specialist input, the use of telehealth and improved integration of care”. She admits that there are still vast gaps in services for rural and remote health services in the region and limited resources. Initiatives to address these issues include multidisciplinary training with remote area doctors, nurses and paramedics along with sharing of equipment, encouraging compatibility of equipment across services and exploring new ways of working and looking at innovation and technology.

Dual presentations from Paul Reeves

Intensive care paramedic and senior ambulance clinician with St John in Alice Springs, Paul Reeves was a pioneer of the inaugural ROAR conference in 2018 and has a unique depth of knowledge of delivering tactical and remote paramedicine.

In his session ‘Everything but the kitchen sink’ Paul facilitated an interactive session around the mixed experiences paramedics encounter in the equipment used to support patients.

Paul contends that medics love and hate kit!

> “We often love it to the point we hate it because we end up with just too much bulk and not enough of what we need”

Paul facilitated group discussions around different approaches to choosing, packing and carrying medical equipment for remote or resource limited environments along with strategies for achieving optimal performance, clinically, physically and mentally. He recommended that hand-carried equipment is appropriate if you are carrying up to 50 metres but for any further distance it’s important to use a double strap with the weight sitting on your hips.

Paul discussed personal sustainment gear for different environments in-

St John Ambulance NT employees

cluding performance hydration and nutrition, limitations and pitfalls. He emphasised the importance of hydration and nutrition for paramedics in rural and remote work settings and how the levels of both influence our ability to endure physically and mentally or may impair us.

> “The principle is we can probably do more with less provided you know how to use the equipment optimally”

Paul’s second session focussed on resuscitation in resource-limited environments. This thought-provoking session considered latest evidence of cardiac arrest management and how the findings could be translated into ‘real-world’ practice. Delegates were challenged to re-visit perceptions around the success of attempting RLE resuscitation and making judgements on if and when patients should be moved to hospital in an intra-arrest phase.

Eat Right. Train Smart. Be Strong

Mitch Mullooly, Chair of PA’s New Zeland Chapter is a paramedic and flight medic with St John New Zealand and an engaging health and wellness coach. Mitch developed a program called ‘Eat Right. Train Smart. Be Strong’, which concentrates on the three main pillars of wellbeing (nutrition, movement and mindset). Recently Mitch created an online community – Team ‘Fit for Duty, Fit for Life’ – where she runs regular nutrition movement and mindset challenges, all with the knowledge and encouragement of being a frontline paramedic and health and wellness coach.

Mitch enhanced the ROAR program by enabling delegates to spend time focussing on personal and physical health maintenance and tools for our wellness kits. She also delivered a range of well-attended sessions including early morning functional movement, a dynamic stretch session aimed at paramedic back pain, and her outstanding presentation on her Eat Right. Train Smart. Be Strong program. Thank you Mitch, for the uplifting experiences you provided to us all. Please consider joining her online community Team ‘Fit for Duty, Fit for Life’ that is full of knowledge and encouragement for the health and wellbeing of paramedics.

> “We greatly appreciated the invitation to present and participate in ROAR 2019 – it was a great conference and we learned a lot. We especially enjoyed the dinner on Friday (the food, the setting) and the opportunity to mingle and discuss collaborations with our new friends and colleagues”
>
> **Dr Chelsea White**
> Emergency physician, and Director of the University of New Mexico Center for Rural and Tribal EMS, USA

> “It was a pleasure to work with you at the ROAR Conference in Alice Springs. What an interesting and informative conference with such knowledgeable guest speakers and fun activities (fitness training and conference dinner). I thoroughly enjoyed being a part of the conference. I arrived home feeling inspired”
>
> **Amanda Akers**
> Clinical psychologist, CRANAPlus Bush Support Service

> “Both Steve and myself wanted to congratulate you on the amazing job you did organising the ROAR 2019 conference. We were so impressed! We also wanted to thank you for allowing us to be a part of it. We had an absolute ball!”
>
> **Steve Tebbett and Simon Leonard**
> Guardian Personal Safety Training

Personal safety tactics

Stephen Tebbett is a rescue retrieval paramedic at the SA Ambulance Service elite special operations team and Simon Leonard is an intensive care paramedic and rescue and retrieval paramedic at the SA Ambulance Service. They combine their extensive experience to Guardian Personal Safety Training and provided a highly interactive range of sessions on personal safety tactics for paramedics. We were given advice on understanding escalation and a range of de-escalation techniques, scene assessment and physical techniques to control violence.

> “Situational awareness is critical and the backbone of personal safety for prevention”

The facts reported from Guardian Personal Safety Training:

- Assaults on first responders tend not to be external - the dominance of assaults are in homes or buildings
- 80 percent of paramedics surveyed in nine countries have been assaulted physically in their career
- Safe Work SA states that being a paramedic is the most dangerous occupation
- Female paramedics are six times more likely to be assaulted than male paramedics in Australia
- Likelihood of first responder assault is greater in warmer months and on weekends
- Less than 50 percent of assaults are alcohol/drug related.

Lessons from New Mexico

Dr Chelsea White and Libby Melton joined us all the way from New Mexico to outline two tribal community EMS programs. In the Pueblo of Laguna Community, a collaborative effort between healthcare teams is addressing unmet and under-met medical needs. And on the Ramah Navajo Reservation, primary care paramedics provide minor emergency and urgent care in their station when the local clinic is closed. Their informative session presented many similarities, yet unique differentials between the challenges of first nation health in rural and remote settings in the United States and Australia. A common and significant priority is cultural understanding and empathy, which further emphasised one of the reoccurring themes of ROAR 2019 – individuals want to stay on land in their own community.

Dinner under the stars at Ooraminna Station Homestead

David Jaensch – community paramedic, Ceduda, SA

Broadening Horizons

An outstanding and moving tri-presentation was made under the title of 'Broadening Horizons'. It was an honour to hear personal, frank and raw narrative from three paramedics who have made very different successful and satisfying journeys in paramedicine. Current CEO of St John Northern Territory, Judith Barker, was born into paramedicine but having her father as the chief didn't mean she got an easy ride. Judith has never turned down a challenge and she encouraged ROAR delegates to step up to every opportunity offered along the way. She is also a very strong advocate around the value of a positive mentor in establishing and achieving your professional goals. Candidly, Judith did observe that her career has at times been all-consuming and has absorbed a great deal of her life and she would like to see greater support and flexible career pathways for women in the paramedicine workforce.

With his imposing frame, it is no wonder that Scott Jones is a former US marine hailing from Dolly Parton's neighbourhood in Tennessee! After leaving the Marines Corps, Scott trained as a paramedic in California and moved into various emergency services and educator roles before his family immigrated to Australia where he currently works as a Queensland Ambulance Service critical care flight paramedic in Mt Isa. Scott's warm and gentle nature hides some difficult life experiences in his youth that impacted on his life but didn't define who he has become or his sense of purpose. He has found his calling in paramedicine and having married an Australian woman he now shares a lovely handful of Aussie kids, some we met at ROAR!

The third presenter who provided an overview of his paramedic career was David Jaensch with 37 years experience with the SA Ambulance Service in various country communities including Murray Bridge, Port Lincoln, Whyalla and Ceduna. Having worked as a clinical team leader and operations manager David missed clinical contact and returned to his intensive care paramedic role before starting in the newly developed role of community paramedic in Ceduna. We were all inspired by David's commitment and sustained energy to improve health outcomes for his local Aboriginal community. Seemingly simple but fundamentally sound initiatives such as providing the local community with access to breakfast has had a profound positive impact on health outcomes and a significant number of locals are comfortable to have regular health checks to track their health improvement. A comment was made among the delegates that "we wish we could clone David Jaensch".

'Ngurra' – a home away from home

We were delighted to have Sarah Brown, CEO of Purple House join us and provide an overview of a highly successful program that has made overwhelmingly positive change to the high number of people in Central Australia that have kidney disease. Historically, for people from remote communities, getting the treatment they need meant packing up their lives and moving to a regional centre to be close to a dialysis machine. This meant leaving their work and home, and their country, and living in a place where few people speak their first language.

Purple House, and the Purple Truck, have brought comfort and cultural care through establishment of centres within remote communities along with a truck that can visit other locations. It is a truly inspirational story.

"ROAR was a fantastic experience, and I highly recommend it to all who work, or wish to work in rural, remote and austere environments. The conference is a great way to meet like-minded professionals, and those that understand the challenges of working rurally. It was fantastic to see the ways in which paramedicine has empowered patients to be interested and proactive in their own healthcare, to the implementation of programs like Purple House and Tribal EMS in the US to allow Indigenous people to stay on country and receive much needed healthcare. I look forward to making it each year as the conference grows"

Jake Lymn
WA Chapter ROAR scholarship recipient

ROAR 2019 Sponsors

Paramedics Australasia sincerely thank the following sponsors for their valued support of ROAR 2019:

Guild INSURANCE

St John

NATIONAL CRITICAL CARE AND TRAUMA RESPONSE CENTRE

Northern Territory CONVENTION BUREAU

edvoke

RESPONSE | Q&A

Glen Morrison is a registered paramedic; A/Chief Superintendent and A/Director of Operations, Queensland Ambulance Service; Chair of the Queensland Chapter of Paramedics Australasia; and a Board Director with St John Ambulance Queensland and the Queensland Ambulance Service Legacy Scheme. Glen has attained a Master of Business Administration through Southern Cross University.

Q What attracted you to a career in paramedicine?

A Being a paramedic is something that I have wanted to be since I was a kid. I joined St John Ambulance as a cadet (which cemented my career choice) and as a cadet I had the opportunity to gain some great experiences through learning first aid and putting these skills into practice helping out at local events. Getting to work alongside great professional paramedics gave me an insight into what it would be like as a career paramedic and inspired me to pursue this as a career choice.

I think the fact that I like people interaction also drew me to paramedicine as you get to listen and hear a vast range of stories and experiences and you're able to help and support people in a positive way in their time of need. The trust that patients had in me, even as a cadet with St John, and into my ambulance career is a great career motivator for me as a paramedic, the most trusted profession.

Q What skills carry over from on-road paramedic to operations?

A My current role relies heavily on my background and previous experience of being on-road. Some of the skills I have adapted from on-road to management are how I perform under pressure and learning how to communicate effectively with a wider range of people from a variety of different circumstances and backgrounds. I have acquired a high level of negotiation skills that greatly assist me in my day-to-day interactions.

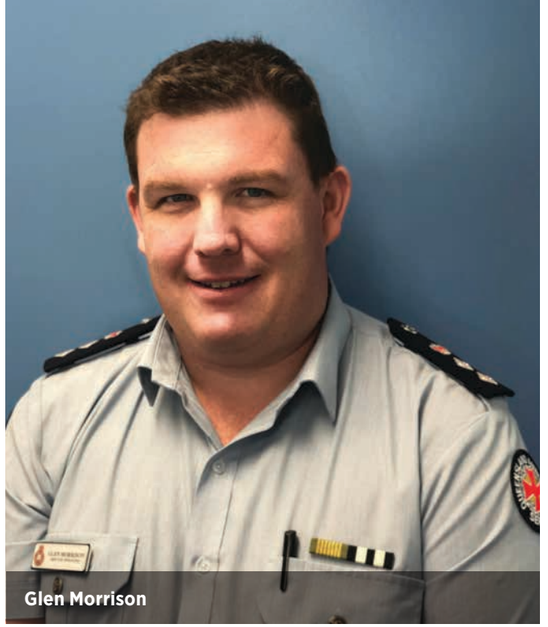
Sometimes it's easy to forget what it's like when you're not working on-road, so when I get the opportunity I like to get involved and do ride-alongs. I also find having a chat with staff at stations and hospitals helps keep a perspective on what's happening on the road and helps me to understand the challenges facing our staff.

Q Queensland is a diverse state, covering city, regional and remote areas. From an operations perspective, what are some of the challenges and difficulties you encounter?

A I have had the opportunity to work in some beautiful parts of the state and experience a wide range of challenges and experiences. One of the biggest challenges is the tyranny of distance in some of our regional and remote areas. Queensland has a robust system, and linkages with the broader health system requires coordination and interoperability of various services such as telehealth, aeromedical and retrieval services and marine resources, all while simultaneously complementing our on-road operations.

Working in North Queensland gave me firsthand experience in managing the challenges of daily operations. The area I oversaw encompassed everything from rural outback (Mt Isa) through to tropical islands (Palm Island), from regional farming districts (Burdekin, Ingham, Charters Towers) through to the busier city area (Townsville). Each area presented its own pressures and challenges, requiring individualised responses to ensure a streamlined and seamless patient journey from any area of the state bringing together multiple resources from the different areas.

The move back to Brisbane (Metro South), where I currently work as the A/Director of Operations, has thrown its own set of challenges due to the sheer volume of work and number of staff, being the LASN with the busiest workload and largest staff establishment in Queensland.


Glen Morrison

Q What do you see as being PA's biggest role in supporting its members?

A Now that we have transitioned to being a registered health profession I see the role of PA supporting its members through high quality CPD activities, as well as being a leading supporter of out-of-hospital research. The Queensland Chapter is working hard to think outside the box to make face-to-face CPD a welcoming and supported experience while being a great opportunity to create new networks and re-establish old ones. Given the demographic spread we have in Queensland this gives us an opportunity to think about other alternatives, such as online streaming and podcasts, to ensure all our members, regardless of their location, can access high quality professional development opportunities. The Queensland Chapter is increasingly more involved in academic research, with the Chapter's Secretary being Chair of the PAIC 2019 Scientific Committee.

> "I have had the opportunity to work in some beautiful parts of the state and experience a wide range of challenges and experiences"

To meet the needs of our diverse membership the Queensland Chapter has successfully undertaken the following activities (in addition to the traditional CPD events) since their election in August 2018:

- formal relationship with the Free Radicals Podcast Team
- increased engagement with our graduate paramedic workforce
- increased involvement in academic research (PAIC Scientific Committee and state-based research awards)
- travelling CPD Roadshow
- leadership CPD events about to roll-out across the state.

Q You are on the Board of QAS Legacy Scheme. Can you briefly tell us about the scheme and the support it provides to families?

A Queensland Ambulance Service (QAS) Legacy is a charitable organisation that provides a range of services to QAS families who have suffered the loss of a loved one through the diagnosis of a terminal illness or in the line of duty. QAS Legacy strives to ensure that no surviving spouse, partner or child will ever be forgotten.

More recently, QAS Legacy coordinated the Craig McCulloch appeal. Craig was tragically killed while responding to an accident on the 28 January 2019 in the Mackay area. QAS Legacy raised over $60,000 for his family, which will be used to support his children through schooling and other life essentials.

Specifically, the QAS Legacy scheme currently provides support to families through:

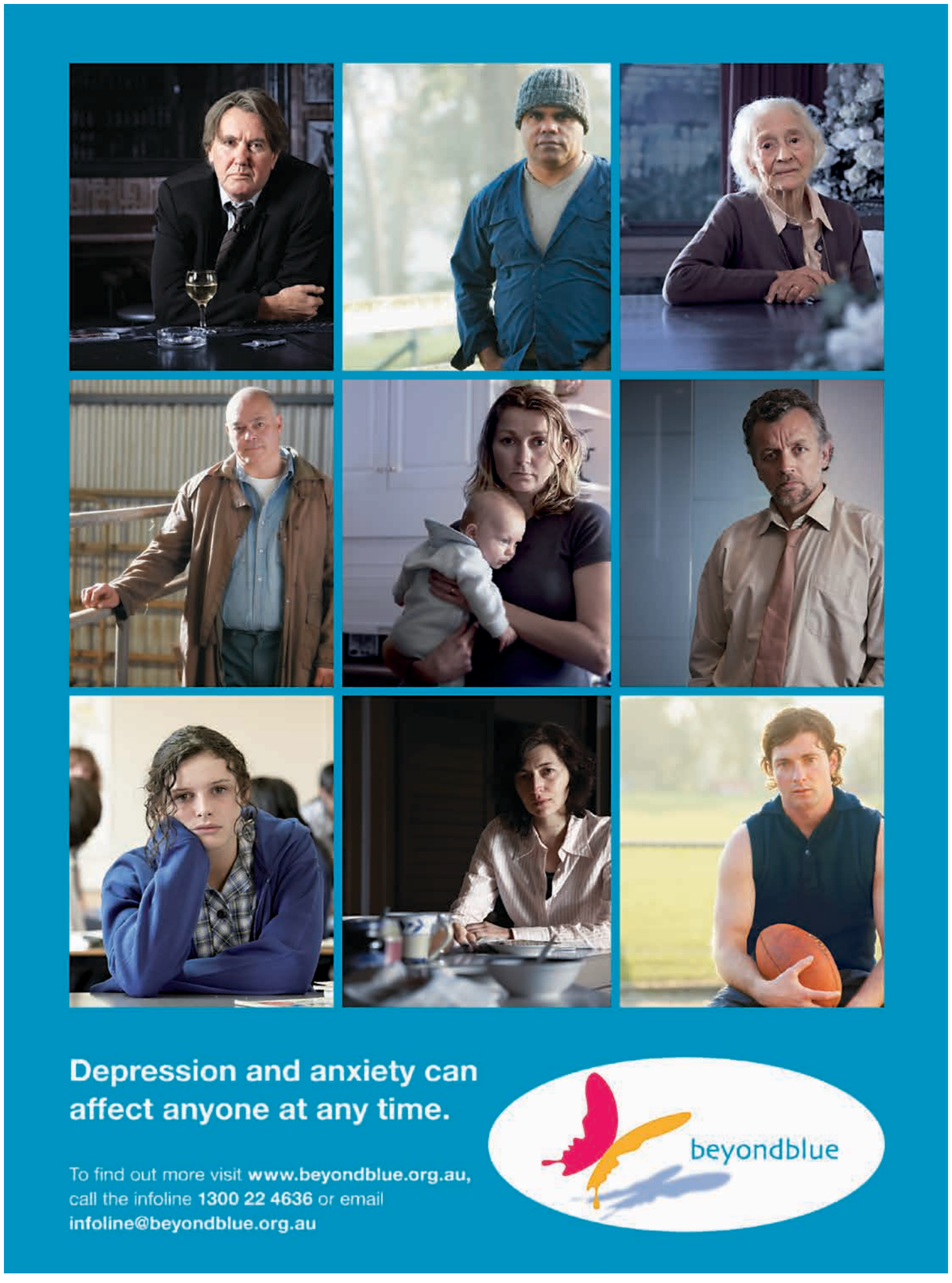
- bereavement – assists family with immediate pragmatic issues surrounding death
- education – provides monetary assistance towards fees, levies, books, etc
- technology – provides monetary assistance towards expenses associated with the purchase of computers and accessories
- extra-curricular activities – provides monetary assistance towards expenses associated with club sports, music, dance, swimming, etc
- funding to attend a defensive driving course.

A long-term goal of the QAS Legacy scheme is to further expand assistance for QAS legatees to provide monetary assistance towards tertiary education.

To find out more about the scheme, and to donate, readers can visit www.qaslegacy.org

Q And finally, we know that good health and mental wellbeing is vital for paramedics. What's your 'go-to' in this space?

A I love to spend time with my family, camping, heading up the beach in my 4WD and taking my two-year-old to the park. I find each of these is a great way for me to unwind from work.



A day in the life...

Name: Leia Spencer
Role: Officer in Charge, Gladstone Ambulance Station
Location: Gladstone, Queensland

As the Officer in Charge at Gladstone Ambulance Station in the southern part of Central Queensland Local Ambulance Service Network, I look after a staff of 33 paramedics. They're a great team to work with and I wouldn't change it.

My day usually starts at 5:30am, if I've had a good night's rest with no call-outs. The first two hours of the day I get to myself, and I spend those hours exercising and sitting with our bull terriers Kevin and Dixee soaking up the unconditional love!

My day

I arrive at work at 8am and walk through the doors to greet my team (this is where my day can deviate from the intended plan!). My staff all want a bit of my time before they go home or get sent out on a job. Issues range from faulty equipment to discussing jobs that went well, to leave needs and sorting out who left the dirty dishes in the kitchen sink!

After dealing with these issues, I walk to my office, switch on the computer and spend a fair bit of time on administration: adjusting leave and rosters, completing reports and investigations, organising vehicle/equipment services and repairs and, of course, dealing with the many other issues that I receive each morning.

After I reassess my day and 'to do' list, I grab the post office box key and head down to get our mail. This is not the worst chore I have to do, as the post office is next door to my favourite coffee shop!

> “ I love my job, and after nearly 24 years I still look forward to the adventures of the day ”

On the way to the post office I get my first case of the day. A single officer is attending a 36-year-old female with central chest pain and needs a second officer to assist and transport. As the Officer in Charge and the station’s critical care paramedic I regularly back-up crews, so I thought I could drop off the Clinical Supervisor Officer (who works in the office next to me) and then continue to my planned administrative tasks.

This was a well thought-out plan, but as we all know, things can change rapidly in this job! As we arrive on scene another case comes in – a 58-year-old male that has collapsed at a shop on the other side of town, also with chest pain. There are no available crews so I drop off my CSO and head to my second case of the day. (I still haven’t had my morning coffee yet!)

I arrive at the case; the patient is stable with an arrhythmia that caused the pain and collapse. He requires treatment and transport to Gladstone Hospital.

The transport crew arrives and we load the patient. I jump in the back of the ambulance and one of the officers drives behind us in my emergency response vehicle. It’s not long before we are at the hospital and I hand my patient over to the medical staff and complete the paperwork. As I leave the accident and emergency department I detour to the coffee van that sits in the hospital quadrangle. It’s now almost 11am, but I take the opportunity as the day feels like it’s not over messing with my plan of getting stuck into all those administrative tasks!

With coffee in hand I jump back in my vehicle, and my phone rings. There are many reasons for a call to my phone, but when I look at the screen and see ‘no caller id’ I suspect my day is going to take another turn.

The Operations Centre informs me that there is a man up the back of a rural town (up to an hour travel time) who has had a fall of more than 10 metres. I tuck my coffee into the drink holder and start responding to the scene.

When I’m about 10 minutes from the scene I hear over the radio that the primary crew has arrived. They are talking about driving to the back of the property and then getting out where they are on foot with the patient still a distance away. I look down at the vehicle dashboard and see the outside temperature is 38 degrees. I now regret drinking that coffee.

I arrive on scene and drive to the back of the property and see the ambulance. I look everywhere trying to spot the crew and as I grab for the radio I suddenly see two heads bobbing up and down as they make their way through the thick, long grass.

Luck is on my side as I have a four-wheel drive and can get closer to the patient. I pop it in to low gear and start to manoeuvre the grassy trail. I lose sight of my team as the terrain has now turned into large waves of grassy steep hills and old creek beds. I stop the vehicle, put it in to park. Out of the vehicle the heat of the day stings my face. I grab my kits and follow the primary crew to the scene. By the time I arrive at the scene I am covered in perspiration and craving water. We at least have some shade from a massive tree above, the one that the patient has actually fallen from.

The patient is unwell, and as we give a clinical report to the paramedic in the rescue helicopter we mention that he is an unstable spinal case and request to have him winched from the scene.

I am still fielding calls from the administration support staff, rosters and mechanics but the phone just rings in my pocket. I hope they are used to me not picking up and write it off to ‘on a case’ and not just ignoring them.

The helicopter sets down in a clear field a distance away and we send the farmer’s quad out to pick them up.

It takes a while to treat and package the patient for the helicopter and then finally he’s ready to get winched up and flown to Brisbane to receive further treatment. The helicopter sets back down at the field to assess and readjust before departure. We gather our kits and make our way back to our vehicles.

We pile our gear back in our vehicles, grab two bottles of water each and set the air-conditioning to high, and start the journey back to Gladstone.

By the time I get back to the station it is almost time for me to go home on-call and start a new day. The list of jobs for the day is still sitting next to my computer and as I walk through the station to my office there are staff wanting to discuss different issues. I grab some lunch and another water and sit at my desk trawling through emails while eating.

Another day

The next morning I am at work early so I can jump on a ferry and head to one of our industrial sites for a training exercise. It’s going to be a long day. There are reports and administration that I must get done today as my day was blown out yesterday and now again today.

I text my husband and tell him I will be home late. At 6:30pm I head home on-call again and ready for what the next 24 hours has in store.

I love my job, and after nearly 24 years I still look forward to the adventures of the day. Working with the best team probably has a great deal to do with that.

Leia was awarded the Ambulance Service Medal in the Queen’s Birthday Honours in 2018: "Her team at the Gladstone Ambulance Station continually meets operational performance targets set both at the LASN and State levels in terms of patient care, drug compliance, client services and QAS Service Delivery Statement targets. Her Critical Care Paramedic qualifications assist her to provide exceptional frontline clinical patient care education and leadership to her team. During the flood event in March and April 2017 following Tropical Cyclone Debbie, Ms Spencer was an integral part of the LASN Ambulance Coordination Centre Disaster Management team, ensuring QAS service delivery to patients throughout the flood event".

PARAMEDICINE IN 10 YEARS

What will it look like?

by Michael Eburn and Ruth Townsend

On 1 December 2018, paramedics joined the ranks of health professionals registered under the Health Practitioner Regulation National Law. Although it is unlikely that paramedics have noticed any significant changes to their professional life as a result, registration and regulation as a health profession will, in our prediction, open the door for a growth in the private paramedic field.

Today, every Australian state and territory (except Western Australia and the Northern Territory) operates an ambulance service. These ambulance services have some form of monopoly on the provision of emergency ambulance services. The jurisdictional ambulance services, and St John Ambulance in WA and the NT, are the only resources available to respond to triple zero emergency calls for ambulance services.

As there are only a limited number of ambulance services, there are limited employment opportunities for students currently studying paramedicine. The Australian government's job outlook predicts there 'are likely to be around 13,000 job openings [for paramedics and ambulance officers] over five years'.[1] These numbers include jobs for people with diplomas and non-emergency patient transport officers, not just registered paramedics.

The 2018 Report on Government Services states that there were over 7000 paramedic students in 2016 (1965 in their final year).[2] As the number of students in universities studying paramedicine grows, it is likely there will not be enough jobs to employ new graduates.

Australian governments have (through the Council of Australian Governments) entered into a Competition Principles Agreement, which is a statement of agreed principles of competitive neutrality, intended to ensure that government authorities do not unfairly compete with the private sector.[3] It may be possible to justify a monopoly in an area such as emergency ambulances given the risk to patients and the difficulty (if not impossibility) for consumers to make choices about who to call when they require help in an emergency.

Private emergency ambulance services

Registration may change that 'playing field' dramatically. With registration, entrepreneurial paramedics may see ways that they can enter the private market. If they employ registered paramedics, they will be able to turn to potential consumers (and government) and say that their employed paramedics have gone through the same assessment and training as paramedics employed by the jurisdictional ambulance services. These entrepreneurial paramedics will have an argument to take to government that the monopoly on emergency ambulance services can no longer be justified given the registered status of paramedics. The establishment of the independent Paramedicine Board of Australia, supported by the Australian Health Practitioner Regulation Agency (as authorised by the legislation) can ensure the professional standards of all registered paramedics whether in the private or jurisdictional sector are the same.

If that argument succeeds there will be a growth opportunity for private ambulance services. Take for example, any university campus. University campuses are complex in their planning and are effectively organised like small cities. An entrepreneurial paramedic (or vice-chancellor) might create a business model to provide emergency ambulances on campus to improve response times to those who live, study and work on campus. When not responding to emergencies on campus, paramedics could, for example, provide first-aid training, follow-up care and standby at sporting events. Equally, large corporations may prefer to contract with a private provider to provide an emergency response rather than waiting for the jurisdictional ambulance services.

State and territory governments may also see an attraction in contracting out ambulance services (as is currently the case in WA and the NT). Jurisdictional ambulance services allow governments to ensure that appropriate high-quality care is provided by paramedics. Registration should allow states to have confidence that private providers will employ staff that are suitably qualified and thus provide ambulance services of an equivalent quality to that provided by jurisdictional services. This would in turn allow private providers to respond to triple zero calls, an area that has typically been covered by state-based providers.

Event health services

A major change will be in the area of event health services, such as school fetes, sporting events and music festivals. There has already been a significant growth in private providers in this field. Before registration, event organisers may have said 'we need to have the paramedics' but there was no definition of what they meant. A private service provider could and did provide people with qualifications ranging from a basic first aid certificate to emergency medical practitioners, nurses and 'paramedics' (whatever that meant).

Television shows such as 'Ambulance' demonstrate to the public what paramedics can do and this in turn is likely to have the effect of informing the public's expectations of the type of service paramedics can provide. Where once the public may have accepted treatment by anyone calling themselves a 'medic', it is likely that the public may now expect to be treated by registered paramedics. This increased public awareness of who paramedics are and what paramedics do may work alongside their registered status to open market opportunities that may not have previously existed. For example, the recent controversy over pill testing at music festivals following a number of deaths has required a response from NSW Health. In December 2018, the government issued Interim Guidelines for Music Festival Event Organisers: Music

Festival Harm Reduction.[4] Although the guidelines envisage that first aiders will still be involved in the provision of some care, the reference to 'paramedics' now means registered paramedics.

Entrepreneurial paramedics may well see a growing opportunity to move into that market and offer, if not an all-paramedic, at least a paramedic *led* service. This may present a major challenge for event health service providers that are not staffing their teams with paramedics and will certainly be a challenge for community-based, volunteer first aid services.

Drugs authority

A critical issue to allow paramedics to take advantage of new opportunities will be how drug use is regulated. Currently a paramedic's right to carry and administer scheduled drugs is granted by their employer. If state and territory poisons or drug regulations are amended to allow a paramedic to carry and administer drugs, then registered paramedics will find even more opportunities to fill market gaps as they will have the authority to store and use drugs without a doctor's prescription or standing order. Whether governments will do this remains to be seen. Even so, part of the value of professional status that paramedics have now gained is that the profession can take the lead to determine the scope of the profession. It will be up to paramedics to make the case that it is appropriate to give drug authority to paramedics, not paramedic employers. If they are successful in that endeavour the opportunity for paramedics to expand their profession beyond jurisdictional ambulance services will know no bounds.

Expanding areas of practice

Other medical service providers may see the value in employing paramedics. For example, a general practice may see value in having a paramedic on staff to provide care in the clinic, to provide home care or transport patients. The Good Medical Practice: a Code of Conduct for Doctors in Australia talks about working with other health professionals and provides for delegation – that is, 'asking another health care professional to provide care on your behalf while you retain overall responsibility for the patient's care'. Before 1 December 2018 a paramedic was not 'another health care professional'. Now they are. A medical practitioner can be far more confident that engaging a paramedic and delegating patient care to him or her may be considered 'good medical practice' and this will open opportunities for paramedics. This model has been tried, with success, in the UK.

The prediction?

Registration is unlikely to change the nature of paramedicine in the very near future, but over 10 years the delivery of paramedicine, and ambulance services, could change in ways that we can barely imagine. How the profession changes will be up to paramedics – it is your profession and it is up to you to determine how it looks. We can see opportunities for paramedics to develop private emergency ambulance services and dominate the event health services market. Paramedics will also find it easier to move into other areas of health practice. A key issue will be whether paramedics gain drugs authority.

About the authors

Michael Eburn BCom, LLB, BA(Hons), LLM, MPET, PhD is an Associate Professor at the Australian National University College of Law and Paramedics Australasia Board member. He is the author of Emergency Law, and maintains a blog on Australian emergency law at https://emergencylaw.wordpress.com

Ruth Townsend PhD, BN, LLB, LLM, DipParaSc is a lecturer in law and sociology at Charles Sturt University. She is an editor and author of Applied Paramedic Law and Ethics and maintains a blog on health, law, ethics and human rights at https://healthlawethics.wordpress.com

References

1. https://joboutlook.gov.au/occupation.aspx?code=4111&search=alpha&Tab=prospects
2. www.pc.gov.au/research/ongoing/report-on-government-services/2018/health/ambulance-services/rogs-2018-partec-chapter11.pdf
3. www.coag.gov.au/sites/default/files/agreements/competition-principles-agreement-amended-2007.pdf
4. www.health.nsw.gov.au/aod/Documents/music-festival-harm-interim.pdf

CREATE A PUBLIC ACCESS DEFIBRILLATION PROGRAMME WITH AN ALL WEATHER MONITORED AED SOLUTION

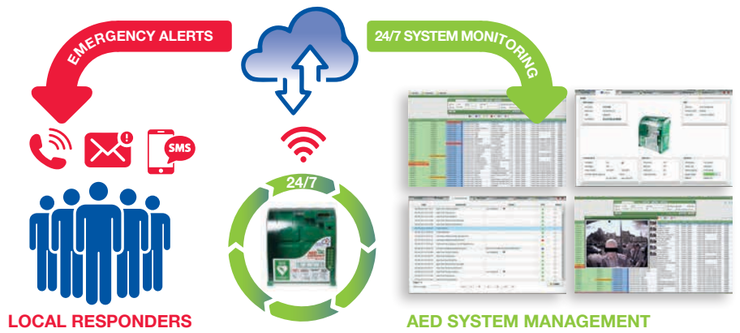
MORE THAN JUST A BOX, BENEFITS INCLUDE:

- Bystander access to a working AED
- Secure, weatherproof and reliable
- Automatic EMERGENCY SMS to local responders
- 24/7 system monitoring & remote programming
- Does not draw energy from the AED
- A community initiative to improve survival
- Tailor made for your community
- Upgradeable to the latest AED models
- Comprehensive maintenance available

ACCESSIBLE - AVAILABLE - OBVIOUS

FEATURES LED Screen / Infrared camera / Open or keypad access / Hands-free emergency phone / Climate controlled

CUSTOMISED RESPONSE MODEL



AUSTRALIAN DEFIBRILLATORS

Take the next step and contact us to discuss your community's needs and solution - AEDS - MONITORED "SMART" EMERGENCY CABINETS / PUBLIC ACCESS / CONSUMABLES

PHONE: 1300 DEFIBS (333 427) EMAIL: INFO@AEDS.COM.AU WEB: WWW.AEDS.COM.AU

Paramedics and notifications

Paramedics are now registered health practitioners under the Health Practitioner Regulation National Law Act (2009). So, what is the 'National Law', and what happens if a member of the public raises a concern or complaint about a paramedic's conduct, professional performance or health?

It is important that all paramedics are aware of the legislation's objectives and guiding principles with a particular emphasis being placed on the overriding tenet of public protection. The objectives of the law are:

(a) to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered; and

(b) to facilitate workforce mobility across Australia by reducing the administrative burden for health practitioners wishing to move between participating jurisdictions or to practise in more than one participating jurisdiction; and

(c) to facilitate the provision of high quality education and training of health practitioners; and

(d) to facilitate the rigorous and responsive assessment of overseas-trained health practitioners; and

(e) to facilitate access to services provided by health practitioners in accordance with the public interest; and

(f) to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and to enable innovation in the education of, and service delivery by, health practitioners.

What is a notification?

Since 1 December 2018 when paramedicine became regulated under the National Registration and Accreditation Scheme (National Scheme), any one can make a 'notification' (complaint or concern) about a registered paramedic's conduct, professional performance or health to the Australian Health Practitioner Regulation Agency (AHPRA).

As well as being mandatory in some cases, notifications can be made voluntarily by any individual with a concern or complaint about:

- **Conduct** – a practitioner's professional behaviour is, or may be of a lesser standard than might reasonably be expected by the public or the practitioner's professional peers
- **Performance** – a practitioner practising their profession in an unsafe way or their skill or judgements may be below the standard reasonably expected of a health practitioner, or
- **Health (impairment)** – a practitioner has, or may have a physical or mental impairment, disability, condition or disorder (including substance abuse or dependence) that detrimentally affects or is likely to detrimentally affect their ability to practice the profession.

What happens when a notification is made?

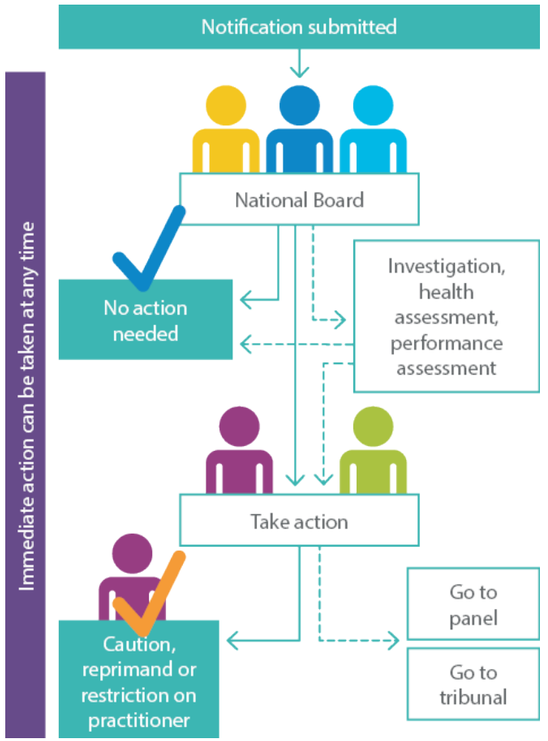
Anyone can lodge a complaint or concern about a registered health practitioner, however, not all concerns lodged meet the legal requirements of a notification.

Once a complaint or concern is lodged, AHPRA will make a preliminary assessment to determine if it is considered a notification under the National Law. If the concerns lodged do not meet the requirements for a notification, AHPRA will recommend that the Paramedicine Board of Australia (National Board) close the matter.

If the concerns lodged do meet the requirements for a notification, AHPRA may request further information from the practitioner and/or the notifier unless enough information has been provided initially in the concern or complaint.

> "Any actions taken by the National Board aim first to protect the public, not to punish the practitioner"

Once further information is provided, or if there is sufficient information provided with the notification, AHPRA will refer the matter on to the National Board for further assessment and a decision.



In complex cases, a notification can be involved in more than one stage at the same time and can take a number of possible pathways. One of the features of the National Law is its flexibility, so the notifications process can be tailored to the issues that have been identified in the notification.

Help is at hand

- If you are the subject of a concern about your health, conduct or performance, AHPRA has a range of services that can help.
  Visit **www.ahpra.gov.au/Notifications.aspx**
- AHPRA recently released a series of videos, including 'A notification has been made about me', specifically for practitioners who have had a notification made about them. The videos provide easy to follow information about the notifications process and address common questions.
  Visit **www.ahpra.gov.au/News/2019-03-04-lets-talk-about-it.aspx**
- Visit the Paramedicine Board of Australia for further information and assistance: **https://www.paramedicineboard.gov.au/Complaints.aspx**

Source: www.paramedicineboard.gov.au/Professional-standards/FAQ/Fact-sheet-notifications.aspx

Did you know?

Less than **1%** of notifications about practitioners result in their registration being cancelled or suspended.

More than **70%** of notifications result in no further action by the relevant Board.

11% of notifications result in a practitioner being cautioned.

12% of notifications result in a practitioner having restrictions placed on their practice.

63% of notifications don't proceed beyond initial assessment.

40% of all notifications are closed within 90 days.

Source: www.ahpra.gov.au/Notifications.aspx

Fitness training after a long break

In this second article in our new series by Mitch Mullooly focussing on paramedic health and wellbeing, Mitch provides her top tips for working out after a long break.

> “When it comes to working out again after a long break, slow and steady really does win the race! And remember, always seek the advice of your doctor before commencing an exercise program”

If you have ever had to take a break from fitness training for any significant amount of time, whether due to an injury, stressful times at home or at work, here’s what you should pay attention to when you start to work out again.

1. You can’t just start where you left off

You need to ease into it slowly. Start with lighter weights and easier movements to prepare your body and joints for more intense training later on when your fitness levels return.

2. Know your weaknesses and dedicate more time to working on them

We’ve all heard that full body, compound movements are the best way to go if you want to build a strong body and get more work done at once. But after a long break from working out things may look a little different for you, so pay special attention to strengthening those muscle groups that may need some extra coaxing along.

And this is important to keep in mind: if you are recovering from injury, please do the exercises your physiotherapist or physical therapist has prescribed for you. They may seem silly and ineffective if you’re used to doing bigger movements, but I see many people who didn’t do their rehabilitation exercises after an injury and, as a result, often have serious muscle imbalances (which are much harder to fix later).

3. You need more time to warm up

I used to be that person who would jump out of bed in the morning, walk into the gym or nearby park, do 10 squats and 10 push-ups as my warm up, and then jump right into my workout. I just didn’t seem to need a longer warm-up.

Well, that has changed (and I have aged!). I now take a lot of time to warm up, because I find that when I don’t, the potential for injury is higher. I do some core-specific exercises, a lot of dynamic stretches, and then work out. My warm up is as long, or sometimes even longer, than my actual workout.

4. Keep your workouts simple and short

Don’t overcomplicate your workouts. The actual workout part doesn’t have to be an hour long, and there’s no need to do 20 different exercises during one session. Take plenty of breaks between the exercises until you really feel that you have recovered.

Pick three or four exercises and do two or three rounds of each of them. For example, squats (you can do them with just your own bodyweight or using weights if you’re feeling okay), push-ups, lunges and plank-holds. Keep the weights moderate at first, and if you do plyometrics (jump training), make sure to ease into this as well.

5. Keep it to around three times a week

In addition to keeping your workouts simple, you also need to make sure you keep your schedule reasonable and give your body extra time to recover.

It doesn’t matter if your break from fitness training was caused by physiological or physical issues, or you were just too unmotivated, there’s no need to do more than three workouts a week, at least at first. If you push it, you may stress your body and mind again, and you’ll set yourself back even further. Take it easy and be kind to yourself!

6. Kick your ego to the curb

You may feel devastated when you find yourself not being able to do the things you used to do before. It doesn’t make any sense to compare yourself to that person who you were in different conditions. You needed that break for a reason. Just do your best to strengthen your body again and take one day at a time.

7. Pay attention to your body

Never push yourself through physical pain, especially when you’re coming back after an injury. Getting hurt is not worth starting the whole recovery process again. Know your body and your limits. Know what your signs are, such things as extreme exhaustion, lack of motivation, nagging pain or constant soreness, and take a break before your body forces you to.

8. Be patient

As much as taking a long break from exercise sucks, it can also teach you something – patience. Most people have to be extremely patient in slowly easing back to working out, which isn’t necessarily easy. What I’ve come to understand is that no success happens overnight.

Check out more fitness and wellness tips and challenges at the Team ‘Fit for Duty, Fit for Life’ Fitness and Wellbeing Challenge page at www.facebook.com/groups/1375168269191426/

About the author

Mitch Mullooly MPA is a paramedic and flight paramedic with St John New Zealand, Chair of the New Zealand Chapter of Paramedics Australasia, and a paramedic health and wellness coach.

eLearning CPD activities

As a registered paramedic you must meet the required 30 hours of CPD per year. Membership with PA offers access to hundreds of hours of eLearning content in a range of formats, and all our activities meet the AHPRA CPD Registration Standard and adhere to all approved guidelines. The following CPD activities are based on articles published in the Australasian Journal of Paramedicine. To earn valuable CPD hours, simply read the associated article at **https://ajp.paramedics.org** and then log in to PA's eLearning at **https://elearning.paramedics.org/moodle/** to complete the answers.

Article by Wong, Wilson and Grantham. Administration of oxygen therapy to patients with suspected acute coronary syndrome

Clinical scenario

An ambulance crew are called to a residential address of an 85-year-old male patient who is complaining of chest pain.

Situation

The patient complains of central dull chest pain that radiates to the left side of his chest and to his epigastric area. It has been present for the last 30 minutes. The pain is constant in nature with no palliative or provocative features. He reports eating a meal 45 minutes ago and complains of water brash in his mouth. He says that he has had this pain in the past but it is usually short lived.

Background

The patient has a background of chronic kidney disease requiring dialysis (Mondays, Wednesdays, Fridays), gastro-oesophageal reflux disease, smoked 20 cigarettes a day for 20 years, previous coronary artery bypass graft surgery, hypertension and type 2 diabetes. His medications are basal bolus insulin, metformin, aspirin, clopidogrel, bisoprolol, perindopril, EPO, vitamin D and calcium, risedronate and pantoprazole.

Assessment

On arrival he has a RR of 18 bpm, saturation of 92% with a good quality pleth, BP of 110/76 and is afebrile. On first glance the patient is hunched over clutching his chest with a closed fist sitting on a chair at his dining room table. His lungs are clear with no added sounds, heart sounds dual with a 3/6 ejection systolic murmur, abdomen is soft and non-tender and his legs do not demonstrate peripheral oedema.

Question 1

Which factor is least associated with coronary artery disease:
- dialysis
- previous coronary artery bypass graft (CABG)
- smoking history
- gastro-oesophageal reflux disease (GORD).

Question 2

Patients should have saturations titrated between 94–98%. What clinical situation would be an exception to this:
- the patient has chronic obstructive pulmonary disease (COPD) only
- the patient has COPD or carbon monoxide poisoning
- the patient usually uses home oxygen therapy
- the patient has an intracranial haemorrhage.

Question 3

What mode of oxygen therapy is most appropriate for this patient:
- 2 L nasal cannula
- 8 L Hudson mask
- 15 L non-rebreather mask
- no oxygen therapy.

Question 4

What saturations would be appropriate for this patient:
- 92–94%
- 94–98%
- 88–92%
- 100%.

Question 5

What is the indication for oxygen therapy in this patient:
- tachypnoea only
- tachypnoea and low SpO2 only
- hypotension, tachypnoea and SpO2
- low SpO2 only.

Question 6

If the patient had saturations of 100% on 2 L of nasal cannula oxygen therapy, what would be the most appropriate next step:
- give the patient 4 L of nasal cannula oxygen therapy
- wean the patient off oxygen therapy
- remove the oxygen therapy and stop recording SpO2 observations
- get the patient to take deeper breaths.

Article by Galka, Berrell, Fezai, et al. Accuracy of student paramedics when measuring adult respiratory rat: a pilot study

Clinical scenario

Patient: male, 68 years of age, complaining of sudden onset chest pain and shortness of breath.

Situation

History: 1-hour history of sharp, sudden right-sided chest pain when mobilising to the toilet. Patient became short of breath at the same time and his wife states he is agitated. Patient returned home from a long-haul flight 3 days ago and was unable to wear compression socks on the plane due to a sprained ankle. Patient has been keeping his legs elevated, which has seen a reduction in the swelling of the ankle, however his right calf has become larger, red and warm.

Background

Medical history: hypertension, hypercholesterolaemia.

Medications: lisinopril, atorvastatin, daily low dose aspirin.

Social history: smoker (half pack/day).

Allergies: peanuts.

Assessment

- Airway – patent
- Breathing – present with mild distress; able to communicate verbally in sentences, no cyanosis, equal chest rise and slight friction rub over right chest
- Circulation – perfused, slightly diaphoretic, strong radial pulse

Your partner records the following vital signs:
- Heart rate: 95 bpm
- BP: 128/76 mmHg
- Respiration rate (RR): 16 breaths per minute
- Oxygen saturation: 91% RA
- Temp: 37.6 degrees
- BGL: 8.1 mmol.

Question 1

You were also assessing the patient's RR while talking to him and determined an RR of 28. Select all the possible reasons that might account for the difference between your recording and your partner's.
a) Your partner may have 'estimated' RR, presuming that the pulse oximetry would give the same information
b) The patient's RR could have changed this much depending on which group of breaths you measured
c) You partner may not have prioritised this vital sign, thinking there are more important areas to focus on, measuring the rate over 15 seconds or less
d) Your partner may not feel confident measuring an increase in RR.

Question 2

According to the research, which vital sign is the most likely sign a paramedic might forget:
a) heart rate
b) blood pressure
c) temperature
d) respiration rate.

Question 3

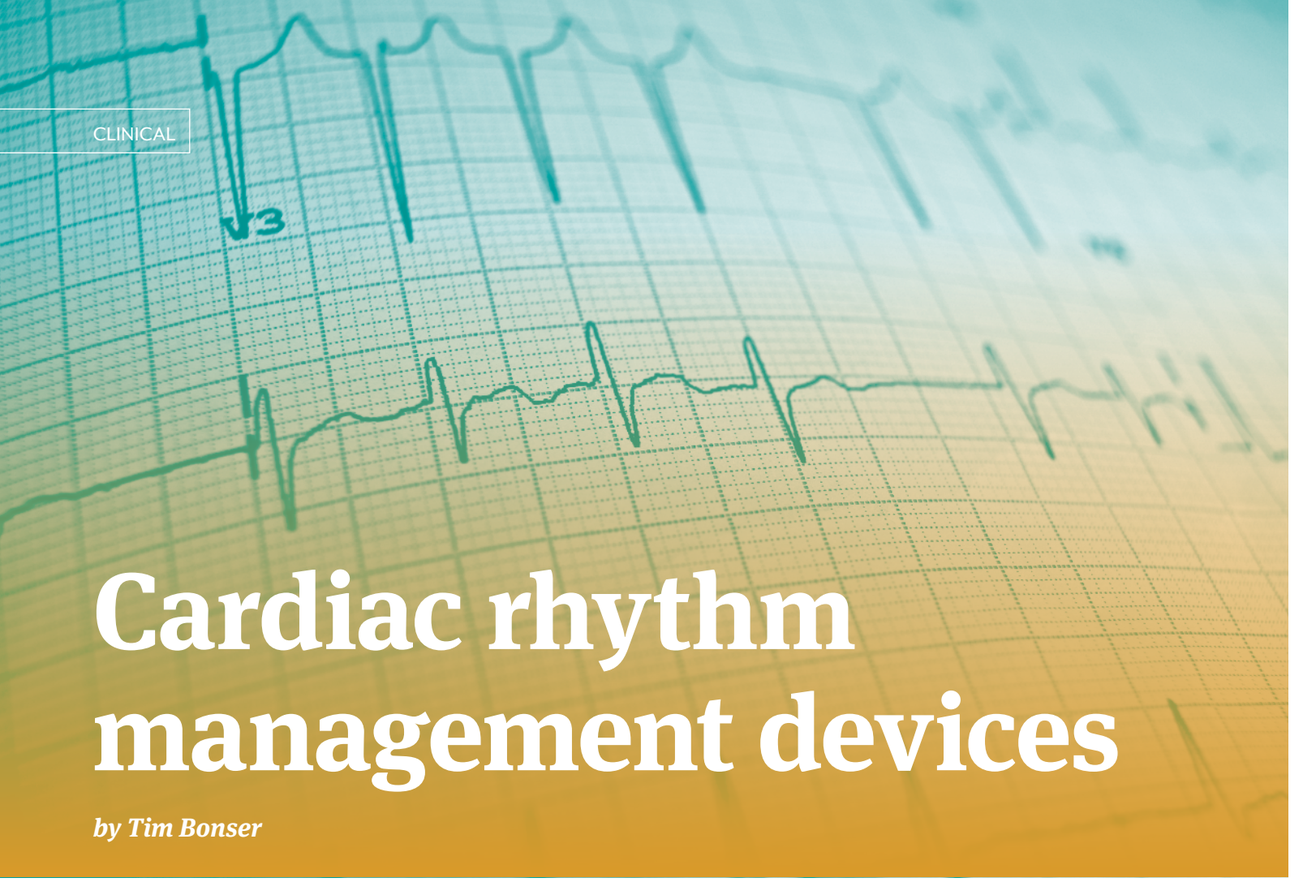
As a practitioner of patient-centred care, why is RR important?
a) RR is one of the earliest indicators of physiological decline
b) Because the nurse at emergency gets frustrated if you don't provide all vital signs
c) It's quick and easy to take
d) Complete paperwork is considered important for ambulance services.

Question 4

Consider the observations, with the RR of 28 that you recorded. Would this (as part of the overall clinical picture) alter your management of this patient, compared to the RR of 16 that was recorded by your partner?
a) No, my partner is treating and it is their decision as to how sick the patient is
b) Yes, I would raise the difference in RR with partner in a professional manner
c) No, irrespective of those two values, I would treat the patient in the same manner.

Question 5

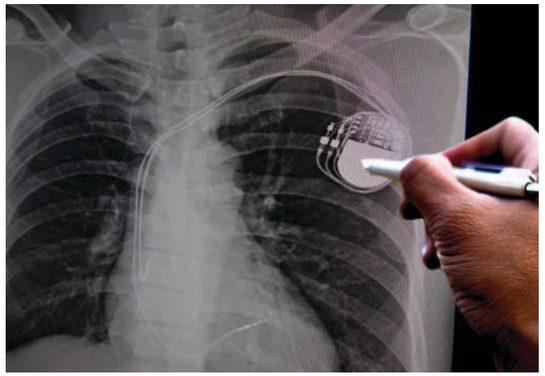
This study uses a double-blinded design where neither the students taking the measurements, nor the patients being assessed, know what the researchers are studying. Often people think that this is deceptive, however the study design was approved by an ethics committee. Which of the following is a possible justification:
a) Research participants shouldn't be told the purpose of the research unless they are at risk of harm
b) Students taking the measurements may have been subject to the Hawthorne effect and patients may have altered their RR
c) This is a student research project and not subject to the same ethical constraints as other research projects
d) All of the above are correct.



Cardiac rhythm management devices

by Tim Bonser

There are approximately 20,000 cardiac rhythm management devices implanted every year in Australia.[1] Roughly 75 percent of these are pacemakers. Given the high proportion of cardiac cases encountered daily in the out-of-hospital field, an overview of function and troubleshooting is essential. Awareness should also be given to the complexity of these devices.



Types of cardiac implantable electronic devices (CIEDs)

Implantable loop recorder (ILR) – subcutaneously injected cardiac monitoring device. Situated in the parasternal area left-sided. Indicates a patient with a history of unexplained and often infrequent syncope. A recent addition is the patient with cryptogenic stroke, where the ILR is looking to capture silent atrial fibrillation (AF). For the paramedic attending a patient with an ILR – particularly in the setting of collapse – be mindful of the high possibility of arrhythmogenic cause. About 20 percent of patients with ILR insertion will subsequently receive a pacemaker or implanted defibrillator.[2]

Permanent pacemaker (PPM) – bradycardia prevention device. Employs one or two leads (one pacing atrium and one pacing the ventricle, either through epicardial lead, septal/apical/right ventricular outflow tract placement, or through His bundle activation in the right atrium. The most common indication is sinus node dysfunction (seen in approximately two-thirds of patients) followed by third-degree atrioventricular nodal block, symptomatic second-degree type 1 AF with slow ventricular response, and post-atrioventricular nodal ablation.[3] Issues are rare with established pacing systems with lead fracture being a common cause.

Leadless PPM – pacing device implanted directly into the right ventricular apex, which obviates the need for transvenous leads. Single chamber only at this stage, hence no atrioventricular synchrony can be achieved. Most commonly implanted in elderly patients with AF (as the device cannot be extracted once the battery is exhausted) and issues around vascular access (haemodialysis is a typical example). Connects with tines that act as electrodes and complete the pacing circuit within the ventricle.

Cardiac resynchronisation therapy (CRT) – pacing device that employs the ability to pace the left side of the heart, usually employing left ventricular pacing lead placed through the coronary sinus, but also through epicardial lead placement. Has a New York Heart Association III/IV heart failure classification, usually with left bundle branch block and broad QRS and left ventricular ejection fraction (LVEF) of less than 35 percent. The aim of a CRT system is to restore synchrony between left and right ventricles and improve LVEF.[4]

Automatic implantable cardiac defibrillator (AICD) – most commonly uses a lead capable of pacing while incorporating one or more coils that permit delivery of anti-tachycardia pacing or high voltage energy through a range of vectors during ventricular fibrillation (VF) or ventricular tachycardia (VT) events of certain duration and rates. Common indications for implant include post-cardiac arrest, documented sustained VT, genetic disorders including arrhythmogenic right ventricular dysplasia and structural heart disorders.[5] The device can also be used for internal cardioversion of VT and atrial arrhythmias. AICDs now include an option that use a defibrillation electrode placed subcutaneously in the anterior chest paired with a device seated in the axillary line of the left chest. This avoids the need for transvenous lead implantation and eliminates the associated risks of systemic infection, endocarditis and mortality during lead extraction. The current iteration of subcutaneous AICDs do not offer anti-tachycardia therapy and have a higher rate of inappropriate therapy.[6]

How do I assess a CIED?

First need is to assess the need for information – context. The following questions are of value to the receiving hospital and can expedite interrogation of the device on arrival. Document all relevant data on the patient record, including the device location. Ask:

1. What device(s) do you have and where is it implanted?
2. Date(s) of implant?
3. Device function (e.g. PPM, AICD)?
   (Ask the patient for their device ID card,
   and have this available at handover if relevant)
4. Were there any issues with your device at
   the last clinic check?

How do I interpret a paced ECG?

A single chamber device (most commonly seen in patients with permanent AF) will present with either paced or sensed beats (Figure 1). Bear in mind that if the rhythm is AF with rapid ventricular response, a pacemaker will not have any control over the rate.

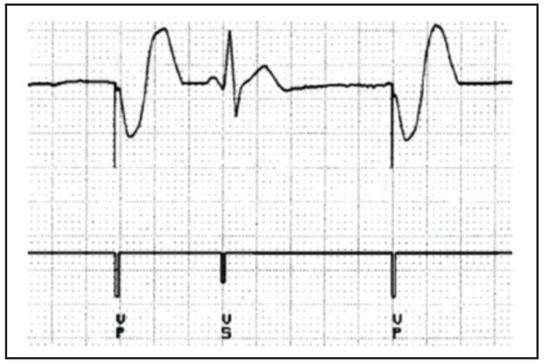


Figure 1. Single chamber pacing (Source: Medtronic Academy)

A dual chamber device (required where there is a need to preserve AV synchrony) will present with pacing or sensing in both the atrium and ventricle at a rate relative to programming (lower rate/sleep function), intrinsic atrial rate and rate response algorithm (rate acceleration algorithm that alters heart rate relative to activity, either by motion or changes in impedance through pacing lead) (Figure 2).

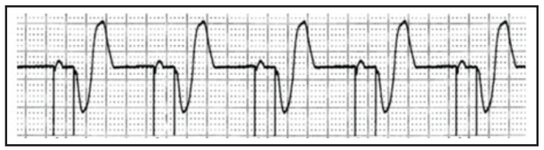
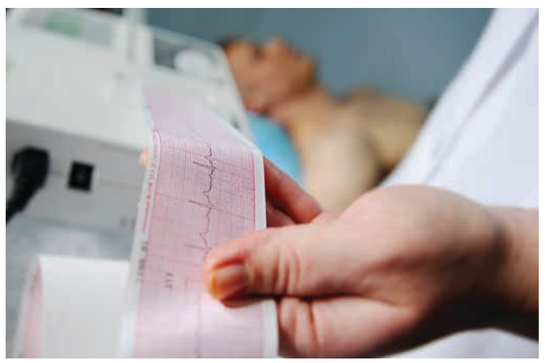


Figure 2. Dual chamber pacing (Source: Medtronic Academy)



Common issues

The following commonly encountered CIED issues, both perceived and genuine, warrant understanding by the paramedic.

Right ventricular (RV) pacing avoidance algorithms – the ECG shown in Figure 3 illustrates a paced rhythm demonstrating P waves without subsequent QRS. Each device company has an algorithm that is designed to reduce ventricular pacing and permit dropped beats (dependent on programming). If this is seen, note it and capture an ECG strip for handover. Also note if the patient is symptomatic to the dropped beats. This is usually normal device function and frequently causes concern in the out-of-hospital setting. The aim of this function is to limit the deleterious effects of RV pacing (pacing induced cardiomyopathy).[7]

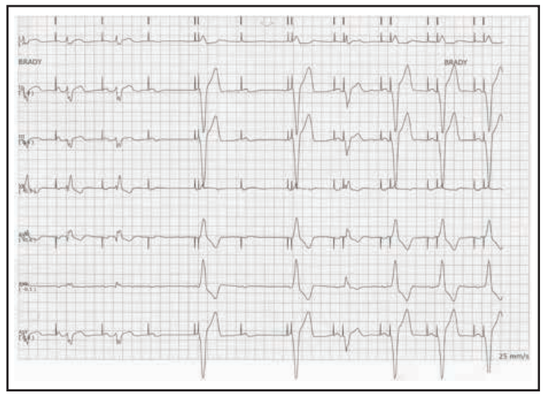


Figure 3. Normal RV pacing avoidance. Note the short PR interval in paced beats post loss of conduction. This is a give-away of normal device programming

Lower rates – an implanted device will do whatever it is programmed to do based on what it sees. A patient may have a programmed lower rate as low as 30/min. If a patient is encountered at rest between 11pm and 6am, they may have a sleep function activated that permits a rate drop during these hours. This is usually at 40–50/min and may confuse the attending crew. Take an ECG strip, document rate (based on ECG assessment, not the rate identified by the monitor) and include in notes and at handover.

Ventricular pacing at stable and high rates (usually about 130/min) – if a stable accelerated paced rhythm is encountered (usually at a rate that is near the upper tracking rate of the device) there is a risk that the device can confuse the T wave and perceive it as an intrinsic P wave. The result is called 'pacemaker mediated tachycardia' (PMT) or 'endless loop tachycardia' (Figure 4). The device will then pace the ventricle, misconstrue the T wave (due to programming issue) and then immediately pace the ventricle again. This cycle continues until a magnet is employed or the device is assessed and reprogrammed. Again, capture an ECG strip and include this at handover.

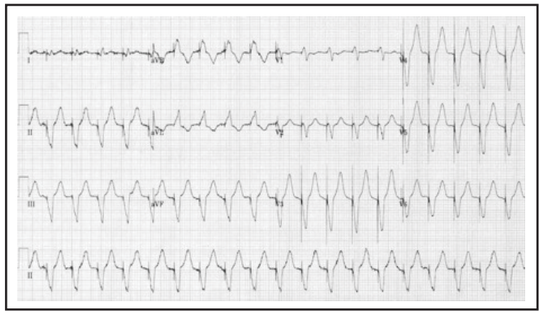


Figure 4. ECG showing a PMT rate of 136/min

Anti-tachycardia pacing (ATP) – this is a programmable function that allows an AICD to overdrive pace a ventricular tachyarrhythmia relative to a host of functions that discriminate between ventricular and supraventricular arrhythmias. If criteria are satisfied, the device has a range of programmable responses it can employ to avoid the escalation to high voltage therapy and its subsequent psychological and battery issues. Figure 5 illustrates a typical example of ATP burst response to VT, where eight pulses are employed at a rate slightly faster than the cycle length of the VT. On cessation of the ATP, the arrhythmia has ceased, and sinus rhythm has been restored.

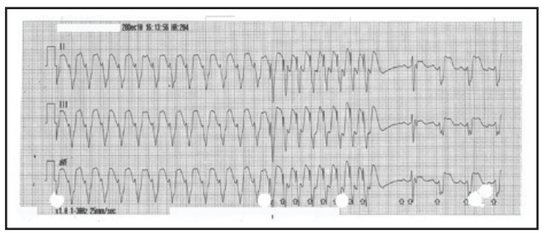


Figure 5. Application of ATP with subsequent reversion of VT

Defibrillation pad placement with CIED

The recommendation across all device manufacturers is to avoid placing the external defibrillation electrodes directly over the CIED. The delivery of high voltage energy during defibrillation can damage the AICD or PPM. The response to either right pectoral placement or left axillary in the setting of AICD placement is antero-posterior placement of pads or inferolateral in the left axillary region and/or directly superior over right anterior pectoral placement. The main aim is to ensure an appropriate vector for defibrillation energy to be delivered. If no option exists, follow standard pad application protocol. It should also be noted that an AICD has a programmed response to each presenting arrhythmia. It will employ a set number of programmed responses then cease to act until rhythm changes. Therefore, you may see a patient being actively internally defibrillated then have this line of therapy cease despite persistence of a shockable rhythm.

Summary

CIEDs are complicated devices that warrant due consideration from paramedics attending patients in the out-of-hospital field. Technology is constantly expanding and device behaviours, pacing styles, algorithm behaviours and response to arrhythmias all require (at the very least) a basic understanding to avoid confusion and ensure an accurate handover.

About the author

Tim Bonser DipAmbParamedicStudies, GradDipEmergencyHealth (MICA), CERT IV TAE is an IBHRE-certified cardiac device specialist and senior clinical specialist at Medtronic Cardiac Rhythm Heart Failure Division of Cardiovascular Group ANZ.

References

1. Mond HG, Crozier I. The Australian and New Zealand cardiac pacemaker and implantable cardioverter-defibrillator survey: calendar year 2013. Heart Lung Circ 2015;24(3):291-97.
2. Samii SM. Indications for pacemakers, implantable cardioverter-defibrillator and cardiac resynchronization devices. Med Clin North Am 2015;99(4):795-804.
3. Stevenson I, Voskoboinik A. Cardiac rhythm management devices. AJGP 2018;47(5):264-271.
4. Akhtar M. Human His-Purkinje system normal electrophysiologic behaviour. Card Electrophysiol Clin 2016;8:641-82.
5. Cheng L, Zhang J, Wang Z, Gao H, Wu Y. Recent approaches to His-Purkinje system pacing. Chinese Medical Journal 2019;132(2).
6. Akerström F, Arias MA, Pachón M, et al. The importance of avoiding unnecessary right ventricular pacing in clinical practice. CalvoWorld J Cardiol 2013;5(11):410-19.
7. Carrión-Camacho MR, Marín-León I, Molina-Doñoro JM, González-López JR. Safety of permanent pacemaker implantation: a prospective study. J Clin Med 2019;8(1).

Australian Resuscitation Council update

by Dr Kylie Dyson, PA's representative on the Australian Resuscitation Council

The International Liaison Committee on Resuscitation (ILCOR) have moved to a continuous evidence evaluation process (replacing the release of guidelines every five years) to enable significant new research to influence guidelines sooner and for new research questions to be addressed sooner. At the end of 2018 ILCOR published an annual summary publication that summarises the ILCOR task force analyses of published resuscitation evidence. The summary includes an analysis of the use of anti-arrhythmic drugs during and immediately after resuscitation (www.ahajournals.org/doi/pdf/10.1161/CIR.0000000000000611).

In addition, ILCOR has published two new draft Consensus on Science with Treatment Recommendations (CoSTR) documents: Advanced Airway Management During Adult Cardiac Arrest, and Vasopressors in Adult Cardiac Arrest. Keep an eye on the ILCOR CoSTR website (https://costr.ilcor.org) for the opportunity to comment on draft CoSTRs and to stay up-to-date with the latest evidence.

16 October is Restart a Heart Day, which aims to increase awareness and promote CPR. In 2018, more than 20,000 people participated in CPR training events in Australia and New Zealand. Mark it in your calendar for 2019 and consider how you can help out this year with your chapter or ambulance service.

I encourage you to attend the Australian Resuscitation Council Spark of Life Conference, which is taking place at the International Convention Centre in Sydney over 9 to 11 May. The theme of the conference is 'Resuscitation – it's about time' and attendees will learn about the latest resuscitation science and, importantly, its translation to resuscitation practice. Visit **https://resus.org.au/spark-of-life-conference-2019** for further information. I hope to see you there!

Keep up-to-date by following ARC on Facebook and Twitter @ARC_Resus

20% OFF

Guild Insurance

Our partnership with Guild Insurance provides members with insurance products that are specifically developed to meet your needs as a paramedic. The product combines professional indemnity and public liability insurance under the one policy wording. Members can enjoy over 20% discount off standard rates with Guild Insurance.

Guild INSURANCE

TRAVEL CLUB BENEFITS EXCLUSIVE ACCESS

Corporate Traveller

Through our exclusive travel arrangement with Corporate Traveller, members can enjoy reduced rates for Qantas Club and Virgin Lounge memberships and exclusive access to Travel Club. Travel Club benefits include hand-picked exclusive deals, 10 percent off travel insurance, free bonus nights, flash sales and Club giveaways.

CORPORATE TRAVELLER bring an expert on board

25% OFF

RM Williams

The RM Williams Benefits Program provides members with a 25% discount off the RRP of RM Williams products from their core range.

R. M. WILLIAMS EST. 1932. AUSTRALIA

20% OFF

Elsevier Health

Members receive a 20% discount off the checkout price at www.elsevierhealth.com.au

ELSEVIER

Exclusive DISCOUNTS MEMBERS ONLY

As a member of Paramedics Australasia you are entitled to a range of discounts and savings through our exclusive partnership arrangements. Visit our Member Portal for further information at www.paramedics.org/members-portal/

PARAMEDICS AUSTRALASIA

PA highlights

No time to catch up with our Facebook or Twitter feeds? Check out a few highlights from what's been happening around our Chapters and National Office. All the latest paramedic news can be found at https://www.paramedics.org

Victoria

Almost 100 Victorian paramedics and student paramedics recently met in Melbourne to hear a powerful presentation on post-traumatic growth by Canadian paramedic-artist Daniel Sundahl ('DanSun'). You can see more of DanSun's work (above) and connect with him via https://twitter.com/DanSunPhotoArt

DanSun (right) is pictured below alongside Don Gilles from the Code 9 Foundation.

Newly appointed Victorian Chapter representative Laura Wirth and Chapter Chair Levi Karschimkus (pictured below) met with Ambulance Victoria Peer Support Dog 'Bruce', in South Melbourne. (Yes, he's adorable!)

Queensland

Every year the Queensland Chapter supports academic excellence in paramedicine with the Malcolm McDonald Award for Clinical Excellence. Congratulations to the recipients of this year's award.

(L-R) Jonica Fernandes (first year), Jessica Wyatt (second year), and Hanneke Klooster (third year) pictured with Malcolm McDonald and Queensland Chapter members.

The Hands on for Auslan presentation drew a packed crowd. The presentation was live-streamed and is now available at PA eLearning.

New South Wales

The NSW Chapter recently met for their ACM and to elect a new committee. The new committee is a great cross-selection of student, graduate, university, military, private and state service paramedics, and represents all of the core membership groups. The committee is working on NSW-based CPD events, and on growing the NSW membership by learning and understanding what the members in their jurisdiction want and need.

(L-R) Kristina Maximous, Nateisha Allison, Cassandra McAllister (PA National Office), Buck Reed, Joe Karlek, Craig Campbell, Helen Hoare, Peter Mangles, Zamri Burns. (Absent are Carpet Hughes and Craig Nolan.)

South Australia

The South Australia Chapter was well represented at ROAR 2019 in Alice Springs.

BOARD MATTERS

Fellowship of Paramedics Australasia

The Board of Paramedics Australasia encourages members to consider applying for Fellowship status, our prestigious member status awarded to paramedics in recognition of significant professional achievement.

Fellowship recognises the experience and contribution of paramedical leaders to both Paramedics Australasia and the profession of paramedicine.

Members who are admitted to Fellowship of Paramedics Australasia are entitled:

- to be known as a Fellow of Paramedics Australasia
- to use the post-nominal 'FPA'
- to receive and display the Paramedics Australasia certificate of Fellowship.

Applications for Fellowship to Paramedics Australasia are assessed on the basis of the professional leadership, commitment and achievements of the applicant.

Applying for Fellowship to Paramedics Australasia

The Board assesses and determines Fellowship with the guidance of a committee of existing Fellows. Members wishing to advance, or to nominate someone to the status of Fellow, are required to initially meet the criteria set by the Board to establish their eligibility to undertake the elevation process.

Paramedics Australasia Fellowship Selection Criteria

Any member applying for Fellowship of Paramedics Australasia must be a current and continuous financial full member of Paramedics Australasia for at least five (5) years and meet a range of criteria. This includes meeting at least three (3) of the following five (5) criteria:

a) a minimum 10 years experience as a professional paramedic

b) a minimum five years professional membership of Paramedics Australasia

c) postgraduate qualifications in a paramedic-related discipline

d) a minimum two years experience in a senior management or senior academic position

e) has made an outstanding and exemplary contribution to Paramedics Australasia and/or its aims and objectives.

In addition to meeting the above criteria, members applying for Fellowship need to provide evidence of contribution to leadership within paramedicine, relevant postgraduate education and published or unpublished work.

Currently, PA has 66 Fellows. Fellows meet annually at a formal dinner held during our international conference. Successful candidates for Fellowship in 2019 will be invited to the Fellows Dinner at PAIC 2019 (in Hobart in November) and formally awarded this prestigious status.

In addition, Fellows of PA assist in a range of activities that currently includes curating PA's heritage and history preservation and presentation along with plans to celebrate the 50-year anniversary of PA in 2023.

Further information and application forms are available on our website. Visit **https://www.paramedics.org/fellowship/**

(L-R) Paramedics Australasia Fellows Malcolm McDonald and Mick Davis at PAIC 2018. Malcolm was presented with handmade silver cufflinks, bearing his initials, as thanks for his outstanding contribution to the organisation.

Abbreviation of the protected title 'paramedic'

Since the commencement of registration in December 2018 of suitably qualified Australian paramedics, a number of our members have approached the Board enquiring as to whether paramedics can use the abbreviation 'RP' (registered paramedic) in their title.

It would appear this would be appropriate given that we are familiar with abbreviations in health professions including RN (registered nurse). The Board subsequently sought approval from AHPRA for utilisation of the RP abbreviation, however this is not straightforward.

The current (interim) advertising guidelines (cross professional) state:

"Advertisers should avoid developing abbreviations of protected titles as these may mislead the public (e.g. 'pod', 'psych', 'RN'). It may also be misleading to use symbols, words or descriptions associated with titles."

Additionally, we were advised that all National (health profession) Boards will be consulting publicly on revised advertising guidelines in the near future and that PA's feedback on this along with other issues will be welcomed as part of the process. We will make the consultation details available to our members in due course.

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

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

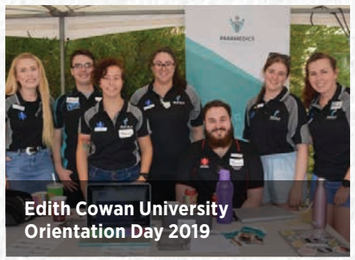
worksafe.vic.gov.au/itsneverok

VICTORIA State Government

WorkSafe VICTORIA

WASP... buzzing!

by Taryn Stewart, WASP President


Edith Cowan University Orientation Day 2019

On 22 February Western Australia Student Paramedics (WASP) attended the orientation day and student guild fair at Edith Cowan University. The campus was buzzing with the excitement of new students eager to begin their journey as a #unistudent. The WASP tent was a big success, with many new student paramedics approaching with questions and interested in hearing about the CPD and social events on offer this semester. Most students were just glad to hear that others felt as nervous as they did!

WASP events so far this semester have included:

- 'Pizza and Chill' – a great way to get students involved and chatting about their semesters, and any challenges new students may have experienced
- A classic sausage sizzle (onions under the sausage!) in support of students completing their intensive workshops in April.
- A 'vertical rescue and extraction' (run in collaboration with Safety Direct Solutions). The workshop included the removal of a spinal patient from a crumpled vehicle, abseiling down two stories, a confined space rescue and a brief mass casualty planning session. Students persevered through fear of heights and confined spaces to successfully complete all opportunities provided during the night. Feedback from the event has been excellent, with both SDS and WASP keen to run the workshop again in semester 2.

Vertical rescue and extraction participants

The 2019 WASP hoodies are now on sale, and we are excited! They are a bargain at $45 each, and are due to be delivered right in time for when the chilly weather kicks in. The link to purchase one of our hoodies is **www.wastudentparamedics.com/LookinGood**

ORIENTATION DAY
ACU BRISBANE

Transitioning to practice

by Jack Phillips, CSUSPA President

CSUSPA Bathurst held their first CPD night for the year on 8 April. We were lucky to have Glen Beasley – a paramedic based out of Katoomba with over 15 years of experience – speak about the transition to practice. Also speaking was Lawrence Agar, an extended care and intensive care paramedic, currently the station officer at Orange Station. We had 72 students and faculty attend, with an additional 15 watching online!

Make the dream of becoming a doctor a reality. Earn your MD at OUM.

"Completing medical school was a tough assignment, but with OUM's unique curriculum and continued support, I graduated as a culturally, worldly, more rounded doctor."

Dr Paris-James Pearce, Melbourne – OUM Class of 2016

Attractive fee structure. Over 200 students currently enrolled.
50 graduates in Australia, New Zealand, Samoa and USA.
Study under top international medical school scholars,
Pre-Clinical home study - world leading 24/7 online service.
Clinical Rotations can be performed locally, Interstate or Internationally.
Graduates are eligible to sit the AMC exam or NZREX.

Apply now for courses starting January & July
No age restrictions.

INTERNATIONALLY ACCREDITED
OCEANIA UNIVERSITY OF MEDICINE
www.oceaniamed.org Call 1300 665 343

OUM

Are you getting your Rapid Response?

***Rapid* Response** is a great way to keep up-to-date with what's happening in your profession.

Delivered every month directly to your email inbox, *Rapid* Response provides easy access to the important news that just can't wait.

If you haven't been receiving *Rapid* Response, update your membership details at https://www.paramedics.org – go to 'membership'.

Forgotten your log in details?
Contact our Membership Services Coordinator at membership@paramedics.org

Rapid Response
Your monthly paramedic news resource
PARAMEDICS AUSTRALASIA

AUSTRALASIAN JOURNAL OF
PARAMEDICINE
PARAMEDICS AUSTRALASIA

Selected abstracts

The following abstracts are from the Australasian Journal of Paramedicine, Volume 16, 2019. The AJP now employs 'continuous publishing', so check out the AJP website regularly for new articles related to out-of-hospital and paramedic education research: **https://ajp.paramedics.org**

An audit of paramedic administration of oxygen therapy to patients with suspected acute coronary syndrome

Christopher Chun Wen Wong, Anne Wilson, Hugh Grantham

Introduction

In the past, high flow oxygen was routinely administered to patients with suspected acute myocardial infarction. Recent evidence has suggested there is no benefit from hyperoxaemia, and in these patients it might result in adverse outcomes. The Australian and New Zealand Council of Resuscitation (ANZCOR) guidelines previously recommended routine oxygen therapy, but a recent change has occurred. The ANZCOR current guidelines recommend

selective use of oxygen therapy in patients with suspected acute myocardial infarction, to achieve oxygen saturations ≥94% and <98%. Because the change occurred recently, the South Australian paramedic adherence rate to the ANZCOR guidelines was unknown. Therefore, the aim of this study was to determine the South Australian paramedic adherence rate to the ANZCOR oxygen use in acute coronary syndrome recommendations.

Methods

A retrospective audit of patient case notes was conducted, for patients with chest pain presenting via ambulance to a tertiary hospital emergency department, during a 3 month period. Paramedic administration of oxygen therapy was then compared against the ANZCOR recommendations.

Results

Paramedics treated a total of 111/139 (79.9%, CI: 72.4-85.7%) in line with the ANZCOR guidelines and the treatment of 28/139 (20.1%, CI: 14.3-27.6%) fell outside of the recommendations.

Conclusion

Although the results demonstrated a degree of compliance, this could be improved through clinical education, a review of the local chest pain guidelines, an introduction of a drug protocol for oxygen therapy and future research investigating the reasons for non-compliance to the best practice guideline.

This article can add valuable points to your CPD portfolio. Log in to eLearning at https://elearning.paramedics.org/moodle/ and complete the multiple-choice questions associated with this peer-reviewed article.

Serious injuries in the mining industry: preparing the emergency response

Russell Jones, Marcus Cattani, Martyn Cross, Jessica Boylan, Alan Holmes, Colin Boothroyd, Joan Mattingley

Introduction

Paramedics are employed by Australian and international mining and petroleum organisations to provide emergency medical response, injury prevention, health promotion, chronic disease management, medical referral, primary healthcare and repatriation co-ordination for miners in exploration, construction and production. These are challenging roles given the often isolated, potentially hazardous and clinically unpredictable nature of the sites where these paramedics work. The purpose of this article is to review injuries that occurred in the mining industry with a view to sharing this information with paramedics who work within the mining sector.

Methods

Data was collected under legislative authority by the Western Australian Department of Mines, Industry Regulation and Safety (DMIRS). Data efficacy was optimised via strong legislative support whereby all organisations involved in mining activities are legally compelled to report to the DMIRS all accidents involving injury.

Results

A total of 837 injuries were reported during the 6-month period between 1 July and 31 December 2013. These comprised 658 serious injuries, including three fatalities, and 179 minor injuries. Sprains and strains were the most common injury comprising 69% of injuries followed by fractures 10%, lacerations 6%, crushing injuries 5%, bruises and contusions 4%, and dislocations and displacements 2%. Foreign bodies, punctures, bites, amputations, chemical effects, thermal burns, flash and arc burns and loss of consciousness each recorded less than 1% of the injuries.

Conclusion

Findings presented in this article can be used by paramedics working in the mining sector across Australia and worldwide. Paramedic awareness of the nature and cause of injury is useful for optimally preparing paramedics to perform appropriate diagnosis and treatment and to minimise patient mortality and morbidity.

Measuring trauma symptoms in paramedicine

Elizabeth A Whiting, Shane Costello, Brett Williams

Background

The trauma experienced as a paramedic can have a devastating psychological impact on both professionals and students in training, and increases the risk of developing post-traumatic stress disorder (PTSD). Paramedics are often placed in high-risk situations involving multiple or sustained trauma and also experience high levels of occupational stress, which can produce adverse psychological and physiological responses. Despite these risks, understanding trauma and its various manifestations in paramedicine has not been well documented.

Methods

This narrative review describes the history and changes in diagnostic criteria, and contrasts the methods of measuring PTSD symptomology with the current criteria.

Results

PTSD was first defined in the Diagnostic and Statistical Manual of Mental Disorders, third edition in 1980, however the diagnostic criteria and associated measurement tools failed to reflect the repeated and vicarious traumatic events experienced by paramedics. Currently, the majority of the measurement tools used to assess post-traumatic stress are still aligned with superseded diagnostic criteria and many only classify the symptoms of PTSD as present or absent with little consideration given to symptom severity. Consequently, these existing measurements of PTSD are out dated and inefficient in their ability to identify and measure PTSD using the revised criteria.

Conclusion

The development of a more specific measurement tool, which reflects the DSM-5 diagnostic criteria of trauma-related stressors within this population, will allow for a more comprehensive measurement of symptoms. Future research undertaken in this specific field will also help to inform education and training programs to assist with the negative impacts of trauma and aid in management and treatment of PTSD in paramedics.

Better through experience.

Guild INSURANCE

It's not all lights and sirens

You'll sleep soundly knowing you're covered by a comprehensive insurance policy developed specifically for you. For over 54 years Guild Insurance has been providing health professionals with leading professional indemnity and public liability insurance. We partner with over 130 industry associations to protect more than 80,000 professionals.

As the endorsed insurer for Paramedics Australasia (PA), we are working together to develop insurance products that keep pace with the changing needs of the paramedic profession.

To find out why PA believe that no other insurer represents better value for their members, call us on **1800 810 213** or visit **guildinsurance.com.au**

Guild INSURANCE PARAMEDICS AUSTRALASIA

Insurance issued by Guild Insurance Limited ABN 55 004 538 863, AFS Licence No. 233791 and subject to terms, conditions and exclusions. Guild Insurance supports Paramedics Australasia's ongoing projects, lobbying and research through the payment of referral fees. Please refer to the policy wording and policy schedule for details. For further information, contact us on **1800 810 213**. GLD4533 Paramedics Response Magazine Advert 04/2018.

PARAMEDICS
AUSTRALASIA

Paramedics Australasia International Conference

PAIC19

BROADENING HORIZONS

28–30 NOVEMBER 2019

Wrest Point • Hobart • Tasmania

WREST POINT

Photo credit: Roger Wong