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RESPONSE

The official voice of Paramedics Australasia

MSU

Scans, strokes and speed

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PARAMEDICS
AUSTRALASIA

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Scan, strokes and speed

For radiographer Francesca Langenberg, a normal workday now includes zipping through Melbourne traffic in an ambulance as part of a health team that includes paramedics from Ambulance Victoria.

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The multidisciplinary health team of Australia's first mobile stroke unit.

with Peter Jurkovsky

Relevance and support

Dear Members, a very warm welcome to the Winter Issue of *Response*.

We are pleased to bring you a magazine covering the issues that continue to create great interest in the paramedicine sector. In this issue we feature a range of relevant and engaging pieces including Response Q&A with our esteemed New Zealand colleague Sean Thompson (as our friends across the Tasman pursue their own quest for professional registration), and a not-to-miss 'day in the life' with Intensive Care Paramedic Paul Reeves. Paul was a keynote speaker at our inaugural Rural, Outback And Remote (ROAR) conference in April. He has enjoyed an amazingly diverse and challenging career in paramedicine and a day spent in his shoes in and around Alice Springs is a unique descriptor of pre-hospital care at its finest.

We also feature a story on Victoria's mobile stroke unit written through the eyes of a radiographer working as part of a health team that includes paramedics from Ambulance Victoria in this world-leading initiative. And we talk to paramedic Rebecca Colangelo, who is undertaking to cycle from Darwin to Port Lincoln to raise funds for *beyondblue*. On a similar important theme, a review on the Senate Inquiry on the role of Commonwealth, state and territory Governments in addressing the high rates of mental health conditions experienced by first responders, emergency service workers and volunteers is included in this issue. Our regular contributors Michael Eburn and Ruth Townsend provide their usual high quality commentary with their article on the ongoing topical issue of violence towards paramedics; and we profile two of our members – Jim Arneman and Leia Spencer – recipients of the Ambulance Service Medal in this year's Queens Birthday Honours.

Importantly, this is the last issue of *Response* to be published before the Paramedics Australasia International Conference (PAIC) which will be held in September – please join us on the Gold Coast for what will be the most engaging and inclusive conference ever held by PA.

Paramedic registration

Registration, and its inherent range of issues, continues to be the lead story in the sector. As described in various communications to members, the mandatory standards have now been approved by the Paramedicine Board of Australia (PBA). The five mandatory registration standards released by the PBA are:

- Continuing professional development (CPD)
- Criminal history
- English language skills
- Professional indemnity insurance arrangements
- Recency of practice.

The PBA also released a time-limited grandparenting registration standard that temporarily (a 3-year window) provides a path to registration for current paramedics who do not have an approved or accepted qualification but can demonstrate their competency via other training, qualification and/or experience.

The PBA has also approved an interim set of codes, guidelines and policies that outline the professional standards for the paramedic profession. The PBA describes this approval process as being required "to develop codes and guidelines for the profession to make professional standards clear, so they can deliver appropriate, safe and effective services within an ethical framework and that these interim professional standards are based on a multi-professional approach to health practitioner regulation revised in 2014, which will provide for the effective regulation of the profession under the National Law".

The four interim professional standards for paramedicine that took effect on 15 June are the:

- Code of conduct
- Guidelines for advertising regulated health services
- Guidelines for mandatory notifications
- Social media policy.

We will be discussing these in the months to come as registration approaches – in a broad sense through an analysis of the code of conduct and an in-depth review of the contentious mandatory notification guidelines. More immediately, an overview of the social media policy was published in the June issue of Rapid Response – it is an area where inadvertent commentary can lead to significant adverse professional consequences and an awareness of all aspects of the policy is imperative for all paramedics in the registration era.

> "PA is developing a member-specific platform that will provide everything a paramedic requires to meet this mandatory standard. We look forward to launching the new member CPD platform at PAIC in late September"

As a membership-based peak representative organisation, PA can assist paramedics and influence some of these standards through member benefits and resources. The two key standards where PA can play a supportive role are CPD and professional indemnity insurance arrangements. Beyond the commencement of registration, we will also play a strong role in providing general and legal advocacy if the unfortunate circumstance arises where a member paramedic is subject to a notification under the *Health Practitioner Regulation National Law Act 2009* (the 'National Law').

In relation to CPD, PA is developing a member-specific platform that will provide everything a paramedic requires to meet this mandatory standard. We look forward to launching the new member CPD platform at PAIC in late September.

Professional insurance

Professional indemnity insurance and paramedic practice has raised a number of questions in the sector. The unique employment demographic (compared to all other health professions) whereby a vast majority of practitioners are employed by a government supported ambulance service in all states and territories give rise to a clear conclusion that paramedics, in these circumstances, will be fully covered for professional indemnity insurance if acting within their scope of employment and they are not party to gross negligence or a criminal act. Due to the nature of the role and the skills associated with paramedic practice, paramedics, unlike many other health professions, are sometimes called upon to assist in medical emergencies when they not actively engaged by an employer – this is where individual, 'top up' professional indemnity insurance provides an extra layer of cover where third party arrangements can be problematic.

PA was delighted to announce and launch our new insurance partnership at PAIC 2017. Guild Insurance has for over 50 years provided health practitioners with leading professional indemnity and public liability insurance and partners with over 130 industry associations to protect more than 80,000 professionals.

PA members, on registration, will be able to access a suite of superior insurance products at significantly discounted premiums for professional indemnity, public and product liability and legal advocacy – PA will be providing Australian paramedics with peace-of-mind in relation to all insurance matters. The site is now live on the Guild Insurance website (www.guildinsurance.com.au/professional/paramedics) and members requiring insurance now can purchase a policy. Members will receive detailed information packages around the Guild Insurance products in the lead up to the registration participation date. We look forward to a long and mutually beneficial relationship with Guild in protecting the interests of paramedics.

> "PA will be providing Australian paramedics with peace-of-mind in relation to all insurance matters"

I wish you a safe winter in your personal and professional lives and I look forward to seeing a multitude of members and their families on the beautiful Gold Coast in September at PAIC 2018.

Peter Jurkovsky
President, Paramedics Australasia

Scans, strokes and speed

Radiographer Francesca Langenberg works alongside two Ambulance Victoria paramedics, a stroke neurologist and stroke nurse to make up a five-member crew on Australia's first 'stroke ambulance'.

Zipping through Melbourne traffic in an ambulance with sirens wailing and lights flashing has become part of a normal workday for radiographer Francesca Langenberg.

"You definitely don't want to suffer from motion sickness," she says. "It feels very fast!"

Francesca and the rest of the crew working on Australia's first dedicated stroke ambulance know that 'time means brain' in stroke cases. Every second counts.

To this end, the Victorian Government has invested $7.5 million to trial a Mobile Stroke Unit (MSU). The trial is part of research led by the Royal Melbourne Hospital (RMH) with the Florey Institute of Neuroscience and Mental Health, the University of Melbourne and Ambulance Victoria. It follows successful trials in Germany and America.

The MSU is a specially designed ambulance with an on board CT scanner, which the radiographer uses to image a patient's brain to detect the type of stroke they are experiencing. The team can then immediately start treatment on site instead of waiting until they reach a hospital. In addition, the unit plays an important role in helping to triage patients to the most appropriate hospital or clot retrieval centre.

Since the vehicle hit Melbourne's roads in November last year, early figures show it takes a median of 21 minutes from the time the crew arrives at the scene to completion of non-contrast and CTA scans and images reconstructed.

Francesca says the ability to scan on site can be life changing for patients. She recalls one of the first patients treated with tissue plasminogen activator (tPA) on the vehicle. "The patient was an elderly lady who had a left hemiparesis," she recalls. "We did a non-contrast scan that showed no haemorrhage followed by a CTA Circle of Willis.

"The CTA showed a clot and tPA was administered immediately. The patient was then transported to a clot retrieval centre. By the time we got to hospital her symptoms were already improving and she was able to lift her arm."

Operating within a 20 kilometre radius of the RMH, the MSU team is expected to treat up to 3000 patients each year. Figures from the unit's first few weeks of operation show that almost half the patients treated received a non-contrast scan, while around 30 percent had a CTA. Most (88%) had a final diagnosis of stroke and 24% who were diagnosed with a stroke were thrombolysed.

> "Everyone has a role but we all pull together to help wherever help is needed"

Francesca with an Ambulance Victoria paramedic

Francesca Langenberg (front right) with MSU team members

Francesca and the other specially trained radiographers work in shifts on the MSU alongside two Ambulance Victoria paramedics, a stroke neurologist and stroke nurse to make up a five-member crew. "Everyone has a role but we all pull together to help wherever help is needed," she says.

> "It's been great to work with the paramedics and other stroke professionals on board"

"It's been great to work with the paramedics and other stroke professionals on board," she says. In particular, she's gained an appreciation for paramedics who must work in traffic, rain and heat. "There have been days that I've wished for the nicely air-conditioned environment of the hospital radiology department!"

As the CT supervisor at the RMH for the past 25 years, Francesca says she was "privileged" to be part of the team of health professionals that helped get the MSU on the road. "I enjoyed the challenge of the entire development process, being part of something so new and to be delivering clinical service in the field."

Inside the mobile stroke unit

For the past two years, the group discussed how to best build an ambulance around a CT scanner, including how to ensure that the 438kg scanner would be secured during an accident. They also set out workflows and the crew's responsibilities.

As well as scanning, radiographers are responsible for the CT scanning protocols, transmission of images and the patient and the crew's radiation safety. They also perform daily calibration and quality assurance checks on the scanner.

During the trial period, the MSU is operating weekdays from 8am to 6pm and so far eight radiographers have been trained to work on it. They spend most of their shift in the unit, but if there are a low number of call

outs they help their CT colleagues at the hospital. “However, if we are called out we must be on the road in 90 seconds so we can’t stray too far from base and must be able to immediately leave what we are doing,” Francesca notes.

The ambulance can be dispatched in three ways: by an operator when someone calls 000; by paramedics who are already on the scene with a patient who they suspect is having a stroke; and by a clinician, such as a GP, who has a patient with stroke symptoms.

Despite Francesca’s extensive experience (she’s currently responsible for the hospital’s five CT scanners and a team of 40 radiographers) she says operating the scanner on the unit was a learning curve.

“The vehicle must be stationary and on level ground so that the scanner moves correctly,” she explains, noting that the team has jacks that they can use to level the vehicle. “The patient lies still and the scanner moves over them, compared to the radiology department where the scanner stays still and the patient is moved through it.”

Operating scanner

Further, a limited working space and maintaining patient privacy is also challenging, especially when scanning in shopping centre and fast food car parks, she adds.

These challenges aside, Francesca says the entire MSU experience has been a career highlight. “In all my years of radiography I have never felt so rewarded as when you see someone start to regain function once tPA has been administered,” she says.

“The patient then goes on to clot retrieval, if appropriate, regains full function and walk out of hospital a few days later. How good is that?”

Francesca at work

The stroke story

14,000 stroke patients treated in Victorian hospitals each year.

One in six people will suffer a stroke in their lifetime.

3000 Victorians died from stroke in 2014.

Every 10 minutes an Australian will have a stroke.

Source: The Victorian Government and The Stroke Foundation.

This article was originally published in Spectrum (Vol 25, No 2, March 2018), the official magazine of the Australian Society of Medical Imaging and Radiation Therapy. It is reproduced here with permission.

Fast forward

Rebecca Colangelo is a woman on a mission, again. In 2008 Rebecca took up a long distance cycling challenge, riding from Perth to Melbourne. Ten years later she will hit the road again, this time riding north to south from Darwin to Port Lincoln.

In 2008, Rebecca Colangelo – a SA Ambulance Service paramedic based in Port Lincoln – cycled from Perth to Melbourne to raise funds for the charity Second Bite, which exists to provide access to fresh nutritious food for people in need.

"I also did it to challenge myself," says Rebecca of the 2008 ride.

"I was an outdoor education instructor and had completed several extended trips with groups of people in the past but wanted to experience the challenge of an extended solo trip."

Fast forward to 2018 and Rebecca is taking up the long distance cycling challenge again, this time from Darwin to Port Lincoln, a distance of over 3000 kilometres.

Rebecca is hoping her 'North to South' ride will help raise awareness of the work *beyondblue* do in the wider Australian community for mental health. It's also personal.

"As a paramedic, mental health issues are something we deal with personally and with our peers. There is still stigma around mental health issues and I am hoping that I can raise a bit more awareness and funds for the work *beyondblue* do," Rebecca says.

"My original idea was an emergency service-specific mental health organisation, but I was unable to find an Australian wide organisation."

As for the challenges of such a long distance ride, Rebecca says there are some things she is not looking forward to.

"Getting up each morning and getting back on the bike was challenging on my first ride, long kilometres and riding solo is difficult. Hill climbs, these are never fun."

> "There is still stigma in the community surrounding mental illness and this needs to be addressed. This ride is another way of hopefully breaking down boundaries. It offers a great talking point and a way of starting conversations"

And then there are the road trains and caravans that pass too close. Most of the time drivers are wonderful, and sensible, but occasionally someone doesn't pay attention. I am quite proactive about this and have lights and mirrors on my bike and I wear bright clothing."

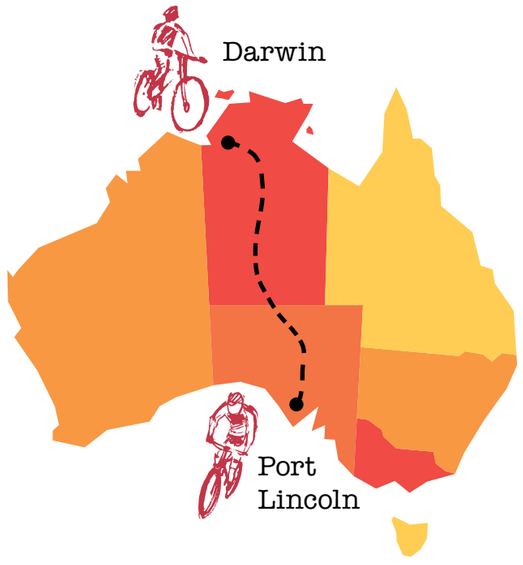
But there are also plusses, Rebecca says, and one of these is the people you meet along the way.

"Talking to lots of different people during the ride is something I'm really looking forward to. Seeing the road from different angles and the diverse environment up close is also something I'm looking forward to, and of course, dinner at the end of the day!"

So after more than one month on the road, what will she be most looking forward to?

"Having a nice hot shower, grabbing dinner at the pub with mates and going to sleep in my own bed!"

Well deserved.



Rebecca will be leaving Darwin on the 17 September and arriving in Port Lincoln by 20 October. We will be following Rebecca's progress via RESPONSE magazine and through our social media on Facebook and Twitter.

Find Rebecca on Facebook @ NorthToSouthBikeRideAustralia

You can support Rebecca's North to South challenge at https://individual-fundraiser-ongoing.everydayhero.com/au/north-to-south-bike-ride

RESPONSE | **Q&A**

Sean Thompson is an Intensive Care Paramedic with Wellington Free Ambulance, a clinical educator in the BHSc Paramedic degree program at Whitireia New Zealand, and immediate past chair of both PA's New Zealand Chapter and the New Zealand Paramedic Registration Working Group. In this Response Q&A, Sean talks to us about registration, the importance of counselling and the freedom found in running.

Q What attracted you to a career in paramedicine?

A I fell into paramedicine really. After high school I completed a degree in applied science and agricultural business and, not really finding my niche I travelled through my birth country Canada and the US for a year. This included six months working for the Coalition for the Homeless in New York with children from Harlem and the Bronx. I found myself very much at home working with people in all their rawness and vulnerability – something that is also at the heart of paramedicine.

Q You wear many hats: paramedic, lecturer, author and presenter. Which of these is the most personally satisfying?

A I find deep satisfaction in all of these. I am naturally fairly introverted but I love to be with people, sharing real life situations while also motivating and being motivated to grow. In paramedicine I enjoy the time consuming problem solving cases: the ones that aren't particularly glamorous but where you know you have helped to achieve something that is quietly profound.

Q Registration looks set to become a reality for New Zealand paramedics. As a key player in driving paramedic registration in New Zealand you must be very proud. Can you tell us what registration will mean for New Zealand paramedics?

A I'm extremely proud of where paramedicine has come and registration is a significant step. I'm involved in registration because I would rather be on the inside helping to make the system better than be on the outside throwing stones when I don't like what I see.

We all need to be mindful of why regulation is happening. Regulation protects the public from us. We have the ability to harm patients and effective safeguards need to be in place. Many paramedics see registration as the great hope for our profession. Yes, it will be significant for those who become registered; it will help demonstrate their competence measured against an independent national framework. However, paramedics are not the focus of regulation – patients are. Paramedics who put excellent patient care at the centre of their practice will do just fine but if we take our eyes off this we will struggle. This patient-centred approach applies to our ongoing professional development, organisational management, care of our own staff, our communication, documentation, drug checks, keeping up with current research, applying evidence to our practice, not cutting corners and viewing our errors as learning opportunities.

> "Paramedics are not the focus of regulation – patients are"

Registration won't be a perfect system. The financial cost may add strain to struggling families. We may see a double-dip in the paramedic workforce: the first as staff leave who are unable or unwilling to meet the demands of regulation, and the second dip a few years later when we realise that our skills are useful in environments other than frontline ambulance services. Ambulance services will be wise to plan for workforce change now and design flexible shift structures and positive work environments to retain good staff.

Registration will demonstrate that we have attained a high quality minimum national standard of competence


Sean Thompson

and with this will come recognition, respect and expanded work opportunities.

Q You are a frequent guest speaker at PA's Survive and Thrive symposiums, and you speak openly about your personal experiences of burnout. If you had to give one piece of advice to paramedics struggling with burnout, what would that be?

A There is no point in being a martyr. We are very good at helping others but typically poor at helping ourselves. Through my own ongoing journey with cancer as well as the challenges that come with just living life I have realised that every one of us is just one experience away from our own story of burnout or mental illness. I believe professional supervision should be mandatory but as it isn't, it's smart to find a good counsellor and meet up every six months just to keep on track and watch for early warning signs. If you are becoming depressed or feeling burned out – feeling flat, struggling with sleep, grumpy, not caring for yourself, making mistakes, cutting corners, feeling on edge – get some help. Have a chat with a colleague, friend, peer supporter, chaplain or counsellor. The first call will probably be the hardest but you won't regret asking for help. If you don't click with your first counsellor, hang in there until you find someone who is a better fit for you.

Q While on this subject, you are a strong believer in the practice of mindfulness and cognitive behavioural therapy. How have these two therapies helped you stay in focus as a frontline paramedic?

A To be honest I am less of a CBT and mindfulness fundamentalist these days. Any technique needs to be practical and applied simply in the course of my day. I've noticed that sometimes the pressure we put on ourselves to apply a certain technique or be mindful can actually add to our guilt and stress.

I do use breathing exercises, which I find really useful, and I have a few mantras that help guide me: "This too shall pass", "Is this my battle to fight?", "March to the beat of your own drum" and "I am enough". It's also good practice to aim to be the kind of person that your dog already thinks you are!

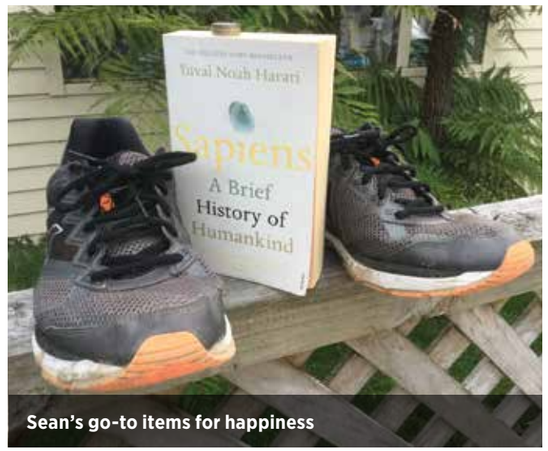
Q You are a clinical educator in paramedicine. If you had one key message to students, what would that be?

A Stay teachable: it's hard to learn if you already know.

Q And finally, you juggle many roles and clearly lead a busy life, including currently undertaking a Master in Professional Practice. What's your go-to when you need time out?

A The key is variety. We spend so much time in our work that we risk viewing all of life through the lens of whatever occupies the majority of our time. To counter this I watch a TED Talk every night on a topic I would never normally be exposed to. It builds my awareness and understanding through the context of history, human experience, culture, the environment, technology, creativity and where we might see ourselves in the future. I'm also reading *Sapiens* by Yuval Noah Harari which is the most readable and challenging history book I've come across.

To get me really grounded I run. Wellington is a city of hills, valleys, harbour and overgrown hidden parks. It is criss-crossed with tracks winding through river valleys, ridgelines with spectacular views, lush bush and famously unpredictable weather. There is nothing better than letting the trail take you at its whim and giving it the freedom to reinvigorate your soul.



Sean's go-to items for happiness

A day in the life...

Name: Paul Reeves
Role: Intensive Care Paramedic
Location: Alice Springs, Northern Territory

Winter has arrived in the Alice. It's a crisp minus 1°C and the two duty paramedic crews and I are checking our gear and prepping our vehicles for another red-centre shift. I'm a station officer at Alice Springs, but currently seconded to the Critical Response Unit (CRU). This trial Intensive Care Paramedic response vehicle normally operates from 11:00–23:00 and then on-call from home until 06:00, which makes for long duty periods. I am the only ICP for 500 km. Today I'm starting at 06:00, and it's dark and cold.

CODE-1: I hear P-crew dispatched to an unconscious two-year-old female. COMMS make contact, and with the benefit of already being mobile, I make scene first. Inside the house I'm presented with a small child lying motionless on the lounge room floor. My priority is life signs. I'm relieved to discover relatively normal vitals and begin tracking down the 'alive' patient pathway.

P-crew arrive and we continue the assessment and extract a history from the parents, which includes a preceding episode of seizure-like activity. The child is apyrexial and slightly hypoglycaemic on the back of a two-day history of diarrhoea and vomiting. She is now fully awake and alert but generally unwell.

I'm paged for availability to attend a rollover MVC within the town limits with persons reported trapped. I really don't like leaving cases of this nature but that said, P-crew are solid and with the child stable in her present state and the address a short journey to hospital, I leave her in good hands. We briefly discuss a care-plan before I exit to the higher priority task.

A flicker of a thought in the back of my mind hopes that this is not how the whole day is going to be.

CODE-1: On-route update states that all occupants are out of the vehicle. We get a lot of MVCs in Central Australia and a large number of them roll (strangely in the middle of nowhere along an unbelievably straight section of road). This vehicle is lying on its side, half on the sidewalk and half on the front lawn of a private address. Police and fire services are present. Triage principles apply and although all five are standing (P3) a rapid assessment is required to grossly identify any pathological indicators.

The resounding finding is that all are physically well, and heavily intoxicated.

All ambulances were tasked to other jobs so a group huddle takes place and police assist in conveying under my escort to the ED. It's 2°C on a Sunday morning, we're five-minutes from hospital and each one of these occupants needs to be fully assessed in slow time. I hate this, I really do. This is not how the trauma courses go.

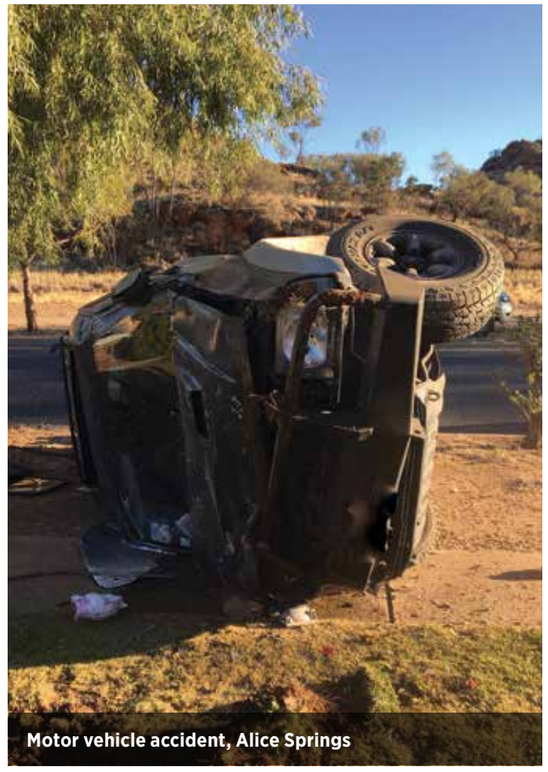
In a quiet moment after handing over to ED staff, along with providing scene photos so context can be applied to the thoroughness of their evaluations, I walk back to my car feeling a little flat. We all get asked by those outside of our profession, "what's the worst things you see". To their surprise it isn't always the goriest. In 25 years of emergency medicine and having worked across two war-zones, there probably isn't any anatomical separations, damage or destruction I haven't seen. However, on any other day, people wouldn't have survived this car crash. According to police, the car was intending to drive to the other side of town. People I know live in that street, and walk their children and their dogs on that sidewalk. I cycle past it on occasional Sunday morning rides. It's the preventable, avoidable and selfish events without any regard for others that breaks my heart. A drunk, drugged or careless driver leaves an aftermath that is devastating to behold and lasts lifetimes for those left behind. These are some of the worst things we see.

"A drunk, drugged or careless driver leaves an aftermath that is devastating to behold and lasts lifetimes for those left behind. These are some of the worst things we see"

On the way back to station I manage to grab a much needed coffee and croissant.

CODE-1: Another MVC, this time a motorcycle along a stretch of road near town. Details are sketchy but it turns out to be a motocross rider in an off-road area. My back up is T-Crew, Patient Transport Service (PTS), and we soon pinpoint the location and discover the rider after some entertaining off-road driving. He's upright, sat on the back of a ute, looking pale but alert and without any obvious distress. The story is he's lost control riding over 'whoops' at 50–60 km/hr and lost the front-end causing him to hit the ground hard. This is beyond common here – we have just come through another Finke Desert race weekend, which one retrieval doctor friend describes as "Central Australia's annually scheduled mass-casualty event".

The rider is stoic and doesn't know what the fuss is about,



Motor vehicle accident, Alice Springs

especially with fire and police activated, but the history of events suggests a significant concussion at least. His friend who witnessed the incident states he was unconscious and suffered a self-limiting seizure for approximately two-minutes. The trauma assessment reveals a fractured clavicle. Intravenous morphine reduces the pain from 7/10 to 3/10 and no further concerns are discovered on detailed assessment. Neurological examination elicits an improving recent memory and cranial nerve assessments are intact, however, my principle concerns are for a traumatic brain injury after what seems to be a concussive seizure.

CODE-2: The next job takes me to a football tournament at the town stadium to back-up PTS after a paramedic crew already in attendance are presented with a second unrelated patient. A young male with low neck/spine pain post-tackle has been collared and immobilised in the treatment room. There are no other complicating factors and the patient is alert and orientated with specific midline neck pain. I transport again with PTS but before we leave I re-adjust the semi-rigid collar to fit correctly.

The red centre

Inaccurate sizing and application is a particular bugbear of mine, although I don't necessarily support the evolving climate of hate towards semi-rigid collars in the pre-hospital setting in certain circumstances. Perhaps another article for another time!

CODE-1: Out to an Aboriginal community located 20 km outside town. A female in respiratory distress has me attending on a solo call with back up coming from the next available paramedic unit. The older woman is struggling significantly and has that angst that some respiratory patients get when they know they've left calling for help a little too long. Infective exacerbation of COPD on a history of ischaemic heart disease and heart failure. Thankfully she isn't one of our many renal dialysis patients, which often complicates management further. A thorough cardio-respiratory assessment keeps me on a respiratory primary and treatment with oxygen and bronchodilators gives some respite to her struggle. As I get to know this woman she reveals another sad story to do with the effects of alcohol on her family and how it denies this chronically debilitated woman people to help care for her.

The P-Crew back up and I hand over my findings and thoughts for onward care. They take my patient to the ED.

CODE-1: On clearing I get tasked again within the same community. Another woman in respiratory distress. Back up will be even longer this time as I know all crews are committed. A woman in her 40s, she has family around her including a 7-year-old son, 'L'. My patient has been unwell for a couple of days with cold-like symptoms but now has chest pain. She's tachypneic with below normal SpO2 although is working hard to compensate. She's warm with a temperature of 39.9°C and her pain is pleuritic in nature, focussed and very uncomfortable amidst her increased respiratory effort. Again, fortunately, she is not complicated with being a renal dialysis patient, however hypertension and diabetes are prominent in her medical history.

My patient is seated on her mattress, on the floor, among a myriad of people, pets and blankets. I recruit her son to help me with the IV as I need a steady hand to hold my torch. He's a wide-eyed and willing Aboriginal boy and we get to know each other better as we help look after his mum. IV fentanyl and a low-flow O2 take some of the pressure off the work of breathing. Fluids follow at a rehydration rate as MAP is adequate but I'm mindful of what her 'normal' BP may be and how well she self-medicates. ECG12 is sinus tachycardia without ischaemic signs and EtCo2 is low. PTS are my back up again (we work together a lot!).

On-route my patient symptomatically drops her BPs and I challenge with a fluid bolus. I'm concerned she's further along an infective process than first hoped. In RESUS Bay-2 I hand over my patient with pneumonia and a likely respiratory sepsis and make sure that 'L' is not forgotten or excluded.

For a fleeting moment I acknowledge the worst of outcomes common with sepsis and internalise a wish for the best for the two of them.

They are in good hands; Alice Springs Hospital is an incredible facility and a valuable resource within the Territory. The RFDS, in addition to aeromedical retrieval of remote area patients, provide the physical link to specialist services interstate. We cover response and retrieval by road and the new Medical Retrieval and Consultation Care Centre situated above the emergency department combine all these resources to help save hundreds of lives each year while caring for thousands more. This is indeed one of the most challenging environments in which to deliver modern-day-medicine.

"We cover response and retrieval by road and the new Medical Retrieval and Consultation Care Centre situated above the emergency department combine all these resources to help save hundreds of lives each year while caring for thousands more"

I have an observing retrieval doctor join me for the remainder of the shift into the evening. This is something that has grown as an ever-closer working relationship between the Alice Springs Hospital retrieval team and ambulance and has been helped along with my involvement in teaching on the Central Australian Retrieval Training (CART) courses held twice a year in Alice Springs. The CART course is primarily for the orientation and preparation of each new retrieval physician intake but also includes flight nurses, remote area nurses, intensivists, GPs and paramedics. It's an example of the recognition, value and importance the Alice Springs retrieval consultants place in developing multidisciplinary approaches to retrieval medicine.

CODE-1: Night falls and temperatures drop into low-single figures. The pager alarms and we drive to a high-priority Code-1: pedestrian versus car in town. A paramedic crew is already mobile and we see the station officer travelling in from another direction up ahead. This is going to be a few-minute response however, COMMS already update that CPR is in progress. We pull-up alongside the victim; the crew are beginning ALS with bystanders performing BLS and with the station officer and doctor, we have a strong team.

The resuscitation is uncomplicated in that access to the patient is unhindered. It's dark and about 4°C. There's no streetlights. I intubate with a video scope into a clear airway, bilateral lung sounds seem equal at the axillae. I have an EtCo2 trace, although I'd like it to be better. There's no resistance with the manual ventilator (bag) in the presence of a midline trachea. The doctor secures humeral intraosseous access as two paramedics prime fluids and gain additional access. The scene is calm, we're communicating with focus and purpose, speaking at normal volumes. We are collectively gathering information and sharing our findings as I take the lead. Our focus is to establish appropriate ALS and aggressively address what reversible causes we can. I'm also mindful of identifying futility in the process.

We still don't have clear details of what occurred in this incident. Trauma assessment is revealing multiple-lower limb fractures and a right-axillary deformity. A scalp laceration is also identified, although without any obvious cranial breach. Reassessment of the chest is feeding back diminishing breath sounds on the right so a 12 gauge needle is placed in the chest with improvement in air-movement. Simultaneous discussion is occurring with the doctor, and a second needle is placed on the left. Blood/air mix is soon evacuating from the left needle and the offer to create bilateral finger thotocostomies is accepted. Blood is drained from the left while the right has quite marked deformity (and I share caution with our colleague over becoming exposed to bone-stick injuries during the procedure).

We're just over 10-minutes in, airway is patent, chest has life-threatening injuries without an exclusion of tamponade (no ultrasound available), there's a head-injury, multiple lower-limb fractures and aggressive volume resuscitation (albeit without blood) has been delivered. After an initial rise in EtCo2 with compression operator change and again after accessing the chest it is now consistently below 10 mmHg. We've had no response and ECG is flat. Time of death is called shortly after.

Day's end

This sad note brings an end to a busy 'day in the life' in Alice Springs. Among the highlighted cases mentioned there were numerous other jobs that kept all crews active all day.

Of our earlier patients, the little girl was diagnosed with non-febrile, febrile convulsions. Not a typo and not common, but indeed a condition known to occur in association with rotavirus gastroenteritis.

No injuries or admissions occurred from the rollover and all occupants were cleared with the driver being discharged into police custody.

Our motocross rider was kept in for observation overnight. Follow-up CT was clear and he was later discharged with a fractured clavicle.

Both respiratory patients were admitted. The woman with respiratory sepsis was managed in ICU and is now recovering from her bacterial pneumonia with family close by.

Senate inquiry

It is hoped that a Senate inquiry into the management of mental health conditions within first responder organisations will save paramedic lives and those of other first responders.

The Senate inquiry was originally initiated by PA's Vice-President Simone Haigh, who has personally felt the devastating loss of several fellow paramedic friends who did not find the support needed to overcome their personal mental health challenges.

In December 2017, Simone approached Senator Anne Urquhart to discuss the high rates of mental health conditions among the first responders community (Ambulance Tasmania, Tasmania Fire Service, Tasmania SES, Tasmania Police and volunteers) and to request a senate inquiry. After many weeks of hard work and determination the terms of reference for the inquiry were created and the inquiry tabled in the Senate.

(L-R) Senator Anne Urquhart, Simone Haigh and Senator Doug Cameron

On 27 March 2018, the Senate referred an 'Inquiry into the role of Commonwealth, state, and territory Governments in addressing the high rates of mental health conditions experienced by first responders, emergency service workers and volunteers' to the Education and Employment References Committee for inquiry and report.

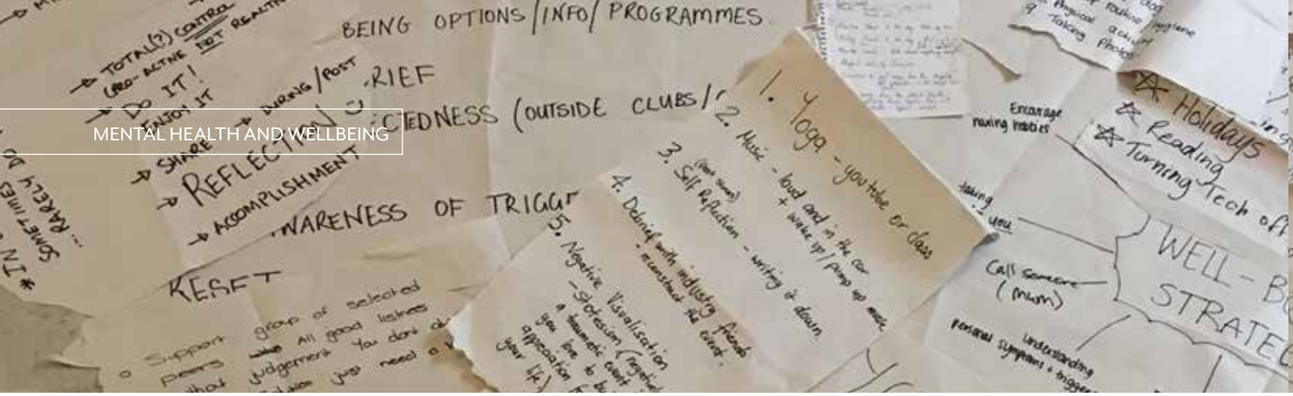
Simone was thanked by Senator Urquhart and presented with the Australian flag, which was flown at the Senate and presented with a special certificate of appreciation by the Senate.

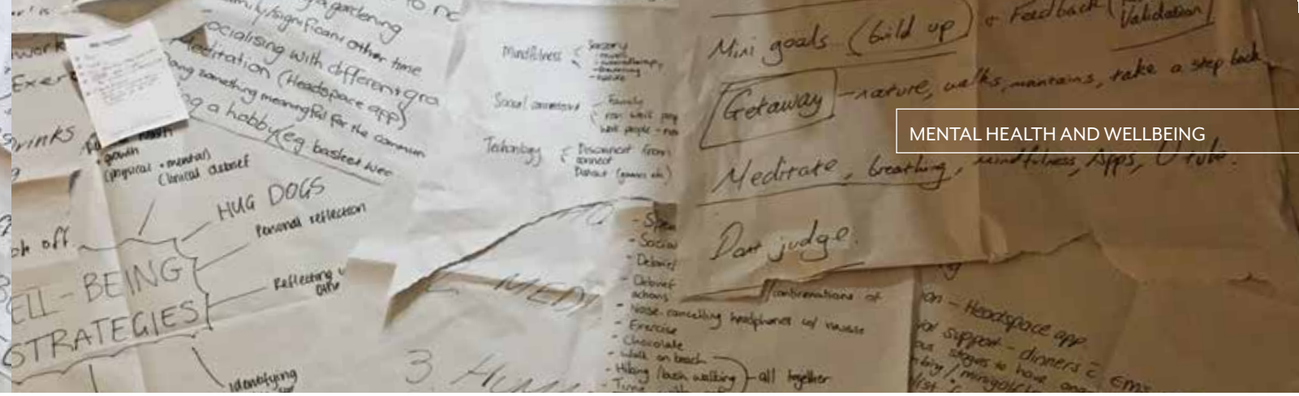
On the day the motion was passed, PA President Peter Jurkovsky said: "The issues need to be brought out into the open and Australians need to join together to help our first responders who save the lives of our family and friends every day and every night."

The Senate Committee then invited individuals and organisations to submit their opinions and proposals, and on 20 June 2018, PA's submission to the Senate inquiry was put forward. The submission was based on the available research and written by members of PA's Mental Health and Wellbeing Special Interest Group, Lisa Holmes (Chair) and David Dawson.

Full details on the inquiry are available at www.aph.gov.au/Parliamentary_Business/Committees/Senate/Education_and_Employment/Mentalhealth

PA's submission to the inquiry is available on our website.





Para Smart Workshop

At the recent Survive and Thrive 3 Paramedics Resilience Symposium Lisa Holmes, Chair of PA's Mental Health and Wellbeing Special Interest Group, held a 'Para Smart' workshop. Below are some of the wellbeing strategies shared by participants at that workshop. Our thanks to all the participants for their contributions and continued willingness to share.

Health

Exercise 3–5 times a week

- Running
- Team sports
- Gym
- Yoga
- Tai Chi
- Rock climbing
- Golf
- Surfing
- Motorbike riding
- Martial arts
- Walking ... set a routine and go
- Take healthy food and snacks when on shift
- Maintain hydration when on shift
- Prioritise rest and winding down before sleep
- Maintain a sleep routine and adapt when on night shift
- Avoid alcohol and drugs
- Scheduled time away from technology
- Connecting with nature – beach walking, water float, bush walking, camping
- Regular massage
- Laughter
- Meditation
- Relaxing music
- Hot yoga
- Breathing techniques
- Sensory mindfulness.

Support

- Seek specialist support
- Therapy/counselling
- Reflecting on your own triggers
- Honest debrief about the day with partner/family then move forward
- Are u OK? Day or similar campaigns
- Connect with family and friends daily
- Regular family/significant other time
- Journal writing – brain dump
- Reflecting on and acknowledging positive experiences
- Connecting/chatting with others outside of the job – being able to verbalise challenges and be prompted for more information which then aides your own understanding
- Worry box – visualisation of a problem, put it in a box and mentally lock it away
- Reward yourself
- Intimacy
- Naming the emotion – talking to self positively
- Choose to be positive
- Embrace the simpler things in life
- Focus on the positive and look forward
- Key support person outside of work
- Fur family – pets
- Negative visualisation – stoicism
- Music playlists for different times and emotions
- Positive start to the day and positive finish – take pride in something
- Travel – workplace separation – planning, resting, reflecting, refreshing.

Profession

- Contribute to a positive workplace culture: make cups of tea, bake, BBQs, social clubs, games and trivia nights
- Recognise your contribution to a harmonious workplace
- Be generous with compliments to colleagues
- Key support person at work – be that person for someone else
- Regular social debrief over coffee
- Mini goals – keep developing your practice
- Set and maintain professional boundaries
- Socialise regularly without 'shop talk'
- Having a sense of humour
- EMS workers and allied health workers coming together – understanding each other's roles
- Reset practices after traumatic calls
- Acceptance and acknowledging bad things happen – you don't have to own the responsibility
- Support group of selected peers – all good listeners without judgement, you don't always want a solution just need a good listener
- Be strict with downtime – work free
- Access and planning leave – something to look forward to
- Volunteer roles in an unrelated area
- Having a life outside of the job
- Pet therapy at work
- Don't judge others – patients and colleagues
- Physically removing uniform asap on getting in from work and showering
- Identifying and utilising professional support networks
- Maintaining personal and professional growth.

Websites

Fitness Passport

Scott Weingart's EMCrit blog and podcast

Beyondblue

Apps

Headspace

Smiling Minds

Sleep Well

Mindfullness

Books

Man's Search for Meaning by Viktor Frankl

Power V Force by David Hawkins

The Power of Now by Eckhart Tolle

Conference highlights

PAIC 2018 – a new era in paramedicine heralds the changes, opportunities and challenges of national registration and what it means for paramedics and ancillary workers in all facets of paramedicine.

PAIC 2018 will provide up-to-the-minute information on national registration with the Paramedicine Board of Australia participating and international experiences of national registration from the UK and Canada shared. Our workshops will show you the tools that Paramedics Australasia is developing to ensure our members are able to meet all the requirements of national registration.

> “Whether you’re new to conferences or a seasoned veteran who revels in the opportunity to learn and network, PAIC 2018 will have something for everyone”

Speaker snapshot

- Stephen Gough – Paramedicine the 15th health profession in Australia
- Julia Williams – Learnings from the UK paramedic registration system
- Joe Acker – A new era in paramedicine, the Canadian experience
- Lisa Holmes – Paramedic self-care
- Paul Reeves – Rural and Remote challenges
- Michael Eburn – Professional indemnity insurance and legal support for the new era
- Jake Carlson – Dealing with the unknown
- David Waters – Resuscitation, Australasia is leading the world
- Nick Prass – Challenges and opportunities for private sector employment.

Workshops

- Road crash rescue
- Registration toolbox
- Writing for publication
- Qualitative research methods
- Engagement verus burnout
- Ultrasound masterclass
- Financial planning for newbies
- Financial planning for retirement.

Stroke master class

A stroke masterclass will cover everything from stroke identification through to pre-hospital intervention. Graham McClelland, an award winning paramedic researcher, will share his learnings on the development and validation of a pragmatic pre-hospital tool to identify stroke mimics. Bronwyn Tunnage will share her extensive knowledge on the global trends in stroke care, and Skye Coote will provide an update on Australia’s first stroke ambulance. The session will wrap up with a panel discussion by leading experts, including the CEO of Stroke Australia, Sharon McGowan.

Case studies

PAIC 2018 will showcase a collection of case studies that will allow clinicians to share interesting and unique patient care experiences for the purpose of education.

FernoSim challenge

FernoSim is a high fidelity, fast-paced scenario-based competition designed to hone paramedics’ communication and clinical skills. Run on the afternoon/evening of Friday 21 September, FernoSim is a lot of fun and a great opportunity to network. Depending on the number of entries received, we may need to run a series of clinically based preliminary rounds on Thursday 20 September. Paramedic teams entering FernoSim should take this into account when planning their trip. Book now at www.ferno.com.au/events/paramedic-fernosim

Associate Professor Stephen Gough

Stephen is Chairman of the Paramedicine Board of Australia and Assistant Commissioner, Capability and Development within the Queensland Ambulance Service. He also holds adjunct associate professor appointments at several Australian universities.

Adjunct Professor Joe Acker

Joe is the Director of Clinical and Professional Practice for the British Columbia Ambulance Service in Canada, Adjunct Professor at the University of British Columbia and Adjunct Senior Lecturer at Charles Sturt University.

Graham McClelland

Graham is a paramedic with the North East Ambulance Service in the UK and a Stroke Association Research Fellow. Graham won the 2018 research prize at the 999 EMS Research Forum held in Scotland.

Dr Bronwyn Tunnage

Bronwyn is the Head of Research and Postgraduate Studies in the Department of Paramedicine at the Auckland University of Technology. She has a broad clinical background that includes working as an intensive care paramedic in New Zealand and as a registered nurse in the UK.

Dr Michael Eburn

Michael is a barrister and Associate Professor in the School of Legal Practice at the Australian National University College of Law. He is regarded as a leading expert in the law relating to emergency management and the fire and emergency services. Michael may be best known for his popular blog Australian Emergency Law that provides regular and up-to-date commentary on legal issues that apply to the Australian emergency services.

Professor Julia Williams

Julia is Professor of Paramedic Science at the University of Hertfordshire in the UK. She chairs the College of Paramedics’ Research and Development Advisory Committee and is a member of the 999 Research Forum, the National Ambulance Research Steering Group and the Council for Allied Health Professions Research network.

For all things PAIC 2018, visit www.paic.com.au

Mandatory prison sentences

by Michael Eburn and Ruth Townsend

Offering paramedics a placebo rather than protection

In response to increasing incidents of injury to paramedics caused by bystanders or patients, there has been a call for mandatory prison sentences for those convicted of assaulting paramedics and emergency service workers generally. Governments, particularly the state government in Victoria, have responded promising that people will be sent to gaol.[1] The call was particularly vocal after the Victorian County Court ordered two women to serve community correction orders rather than gaol time after pleading guilty to a particularly vicious assault in 2016 that has left the paramedic victim still unable to work.[2]

The claim is that sending offenders to gaol will protect emergency workers from future violence. It is argued here, however, that the promise of mandatory sentence is simply delivering a placebo, that is "A ... procedure prescribed for the psychological benefit to the patient rather than for any physiological effect" or "A measure designed merely to humour or placate someone"[3] rather than effective or meaningful protection. Mandatory sentencing won't protect paramedics from future violence because 1) most people who commit an offence against a paramedic will not be doing a cost-benefit analysis so the risk of imprisonment is not likely to be at the forefront of their mind and 2) sending people to gaol after the event necessarily shows that the desire for protection hasn't worked.

The patient

Paramedics provide an emergency health service so it follows that the patient is someone who at least might be in need of emergency health care. They may be suffering from any number of illnesses or injuries that impact their capacity to form rational decisions and/or control their actions.

While there are reports of 'assaults' on paramedics it is unclear how many of them are actual 'assaults', that is, an intentional application of force by a person who is conscious and competent at the time. While paramedics may be subject to violence that is not the same as being 'assaulted'.

There may be some patients who do deliberately apply force. People are allowed to refuse treatment. To treat someone without consent is itself an assault and a person may use reasonable force to resist that assault.

Apart from using force in self-defence, we may have some sympathy for a potential defendant.

Paramedics are exposed to traumas that most of us can barely imagine and that compounds over time. It is no surprise that they may self-medicate, particularly if they do not feel they are supported by their service. Many will leave the service that was essential to their self-identity. Whether it's suicide, drug overdose or some other condition, some may require assistance from their former (or current) colleagues. What is the correct outcome for a former paramedic, suffering post-traumatic stress disorder, who becomes distressed to realise he or she is being loaded into an ambulance and strikes out hitting colleagues they have worked with?

If the paramedic's actions were intentional and not reasonable force in self-defence then that is an assault; but is prison the appropriate response? Paramedics may be more willing to sympathise with the offender who they see as 'one of their own'.

People other than patients

Bystanders may also assault paramedics. An offender who sees that a paramedic is rendering care to someone the offender has just beaten up may see that the paramedic is on the 'wrong' side and so attack him or her. For that offender gaol may be an appropriate sentence.

> "People have a right to refuse treatment and that raises complex decision making for paramedics when trying to decide whether the refusal is competent and binding"

But there may be others. Imagine an intellectually disabled adult who sees paramedics treating his mother. He may not know what is going on. He may fear that paramedics will take his mother and he does not know what will happen to him so he tries to fend them off. That is not 'self defence' nor defence of others because he's not at risk and he's acting to protect his interest, not hers. But would prison be appropriate? If he believed that the paramedics were harming or intending to harm his mother, an attack on them may be justified as 'self-defence' even if the belief is mistaken.

Mandatory sentencing does not remove discretion

Even with mandatory sentencing discretion remains. The first discretion lies with the paramedic who decides whether or not to complain to police or assist with their inquiries. The paramedic assaulted by their PTSD-affected colleague may choose not to report the matter. The paramedic struck by the intellectually disabled young man terrified at what's happening to his mum may 'understand' and not report it.

Second, there is discretion vested in police. They don't have to charge everyone. They have to consider the evidence and whether there are reasonable grounds to suspect that an offence has occurred and whether there are reasonable prospects for success. Considering the person's state of health they may determine that they could not succeed. The resources of the state should not be directed against a person unless there are reasonable prospects of success. Police also have the option of what to charge a person with. They may choose to charge a person with a lesser offence if that does not carry the mandatory penalty if they and/or the victim think that is appropriate in the circumstances.

In making the decision to prosecute, the DPP will consider many factors that a judge may consider in sentence if a prosecution is successful. The discretion remains but rather than being decided in open court it would be made in the offices of the DPP.

The effect on paramedics

Mandatory gaol sentences will have adverse impacts on paramedics. More cases where the inevitable outcome is gaol will be defended. A person can expect a discount on sentence for an early plea of guilty but if the outcome will be gaol either way, there may be little to be gained. Further, a person is more likely to receive legal aid if 'a conviction is likely to result in a term of immediate imprisonment' which is the intended outcome of these reforms.[4]

If cases are defended they will take longer and paramedics will be required to attend court and give evidence. Where the defence is that the offender's actions were not willed (in legal speak that the offender was an 'automaton') there will no doubt be competing experts to discuss the impact of the patient's illness or injuries on their capacity to form the intention to strike the paramedic. Where the defence is that the person was mentally ill such that they did not know the nature and consequence of their action, then that too will tie up expert evidence.

Where the claim is self-defence the conduct of the paramedics will be subject to close scrutiny. People have a right to refuse treatment and that raises complex decision making for paramedics when trying to decide whether the refusal is competent and binding, or not. While various statutory and other legal principles may mean a paramedic is not liable for taking action, they won't stop a patient, facing gaol, arguing that they had refused treatment and were therefore entitled to resist the paramedics. No doubt minute details of what was said and done will be gone through to see if there is reason to find that the patient had indeed refused treatment or that the paramedics' actions support the patient's claim that he or she had some fear. Even if that fear is unreasonable when seen objectively, given what was happening to them they may be able to show they had a fear and their response to that fear was reasonable in the circumstances as they understood them.

For the paramedic, the job is just 'another day at the office'. For the patient, it's the worst day of their life or at least not a good day and whether it's due to drugs, the injuries or simply fear of what's happening to them they may be acting out of very basic 'fight or flight' responses. When 'flight' isn't an option, fight may be. When they recover they may be able to see the irrationality of their response but they have to be judged at the time. The point of law is to punish the offender's criminality so if the offender's response was a reasonable response to the world as he or she perceived it at the time that will be a defence.

Paramedics may be concerned when it comes to treating people that refuse consent or the like, that their conduct will be subject to scrutiny. That can be expected with any prosecution but if more cases are going to be defended, that is likely to increase.

The most trusted profession

Paramedics are constantly rated as one of, if not, the most trusted professions. That trust may be eroded if people fear that if they call the paramedics for their unconscious friend or family member, then that person may end up in gaol if they become agitated or violent.

What's the problem with gaol sentences?

The answer is nothing per se. For some people and some crimes they're necessary. The problem with mandatory sentences is that they often lead to injustice. They lead to injustice as they assume that all offending actions are of the same seriousness and more importantly, criminality. A person who rings triple zero to bring an ambulance to his or her location so that they can assault the paramedics and steal their drug box is very different from the patient suffering PTSD who is traumatised by the prospect of being loaded into an ambulance. But with mandatory gaol sentences the starting point of the response to their offending is the same. Judges need the discretion to impose gaol terms but there are alternatives and they are there because experience has shown that they can be more effective at preventing future offending.

Finally, gaol is not an effective crime prevention measure. In their report into mandatory sentencing, the Victorian Sentencing Advisory Council said: "it is unclear how accurate a mandatory sentencing regime is in targeting potential recidivists. At the same time, there is much evidence that suggests that imprisonment itself increases the likelihood of recidivism".[5]

Governments don't believe in mandatory sentencing

It is clear governments don't believe in mandatory sentencing despite the rhetoric. Before the decision in *DPP v Warren and Underwood*[2] paramedics had been told that there was a mandatory six-month gaol term; so how could a judge avoid that sentence? The answer is that the sentence wasn't mandatory. The legislation had allowed a judge to impose a lesser sentence if 'special circumstances' warranted that sentence. Both the first magistrate and then the judge on appeal had found that special circumstances did apply. And those special circumstances were not, as suggested in some commentary, that the offenders were affected by drugs or alcohol at the time. They related to their level of intellectual development and maturity that impacted their own experiences as children including extensive histories of being sexually abused.

> "... mandatory gaol terms will not decrease the risk of or actual event of occupational violence directed toward paramedics and they may have adverse effects for paramedics"

New Zealand has also moved to introduce mandatory sentencing but it too, isn't mandatory. Under the proposed law set out in the *Protection for First Responders and Prison Officers Bill* (NZ) a court would be required to impose a minimum sentence of six months imprisonment on any person convicted of the new offence of 'injuring first responder or prison officer with intent'. The judge need not, however, impose that sentence if in the judge's opinion, 'a sentence of imprisonment would be manifestly unjust'.

Governments can promise mandatory sentences but leave the details, including exceptions, to the judge because they know, as the examples in Victoria and New Zealand show, the details are not reported; just the headline 'mandatory sentence'. But governments also know that all cases are different and have to be judged on their own facts, and only judges not legislators can do that.

So what's to be done?

Stephen Odgers, barrister said: 'The criminal law is a blunt and brutal method of social education. Yes, we want to educate our community to engage and to behave in a civilised way, but you shouldn't rely on the criminal law as the key mechanism for doing that."[6]

Let us attempt an analogy. A person is obese and smokes. They are at risk of coronary disease. They have a coronary occlusion and an ambulance is called. Paramedics attend, apply their high level of skills to keep the patient alive and reduce the potential damage. The patient is transported to hospital and surgeons perform a bypass and the patient is discharged home with no adverse consequences. The acute response has been effective. But the patient is still at risk of coronary disease. The removal of that blockage has no effect on this arteries and the fat in their circulatory system. If they have another occlusion they can't blame the paramedics or the surgeons for not having dealt with the blockage that had not yet occurred and could not be identified. What is required to avoid the second occlusion is to do the hard work on the body. Changing lifestyle and habits and that requires support. Simply telling a person to get fit and quit smoking won't work.

The analogy (if it's not obvious) is that the occlusion is like the paramedic assault. You can remove the offender but it has no impact on the risk to the next paramedic. What needs to be done is the hard work on the body of the community. Fund education, mental health services and drug rehabilitation. Don't demean people who, for whatever reason, can't work in the current community. Make Newstart liveable. And before people argue that we are suggesting spending money on offenders, not victims, we are suggesting taking those steps so people don't become offenders. People who have committed offences (like Ms Warren and Ms Underwood) may receive support to change their lifestyle including close monitoring, but society would be safer if that support was offered before people committed crimes.

The problem is that this type of work is expensive, slow and unpopular in today's rhetoric. Politicians can win more votes with the 'tough on crime' rhetoric rather than saying 'not everyone can pull themselves up by their bootstraps – and everyone deserves support even if we don't actually like them very much and even if they resist, and will fail, and may need the threat (but not necessarily the actuality of gaol) to turn their lives around'.

What's more, governments recognise that long-term programs are more likely to reduce violence than acting after the violence has occurred.[7]

Conclusion

Our argument is NOT that gaol terms for people who assault paramedics are not called for. Neither are we arguing that it is okay to intentionally assault paramedics. It's not; and that's why it's illegal, as it should be.

Fundamentally our argument is that mandatory gaol terms will not decrease the risk of or actual event of occupational violence directed toward paramedics and they may have adverse effects for paramedics. If we're right, we predict no significant downturn in violence due to the type of changes proposed in Victoria, but we do predict more cases will be defended, more paramedics will have to give evidence in court and the conduct of the paramedics will be subject to closer scrutiny. Community trust in paramedicine may be diminished. These potential costs are achieved for the benefit of making paramedics think the government has done something for them; but it hasn't, it's only done something for itself. By offering mandatory sentencing the government is offering a placebo, a remedy 'to humour or placate' those calling for something to be done.

The full version of this article, including extensive case examples and references, can be found on our website at https://www.paramedics.org

About the authors

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Ambulance Service Medal awarded to PA members

The Ambulance Service Medal (ASM) was introduced into the Australian system of honours in 1999. It recognises the 'distinguished service by the men and women of Australia's ambulance organisations'. In the Queen's Birthday Honours 2018, two PA members – Jim Arneman and Leia Spencer – were awarded the ASM.

Jim Arneman is an Intensive Care Paramedic with the ACT Ambulance Service. Here, he led a major cultural and organisational reform program – 'Blueprint for Change' – to increase the capacity of all staff to better communicate with each other.

On learning of his nomination, Jim said: "Hearing I was being honoured with the ASM was a terrific surprise. It has been a wonderful recognition of the importance of the ACT Ambulance Blueprint for Change project, which focusses on leadership and staff wellbeing. I've been blessed to be mentored by and work with lots of great paramedics on this project and throughout my career in paramedicine."

Jim Arneman

Leia Spencer is a Critical Care Paramedic and Officer in Charge at Queensland Ambulance Service in Gladstone, where she provides frontline service delivery to the local community. During the flood event in March and April 2017 following Tropical Cyclone Debbie, Leia was an integral part of the disaster management team, ensuring QAS service delivery to patients throughout the flood event.

Leia says she is constantly inspired by a quote from Marie Forleo: 'Success doesn't come from what you do occasionally. It comes from what you do consistently'.

On learning of her nomination Leia said: "I was stunned when I received the nomination back in May. I see my colleagues go above and beyond for their community all the time so for me it was a big surprise that I was nominated. And of course I am very honoured to have received the ASM."

PA President Peter Jurkovsky congratulated Jim and Leia on their ASM, saying: "Your passion and dedication to our profession has been recognised and you are a role model in paramedicine and also in your community, and we are very proud to have you as a member of our organisation. The honour must also be a matter of pride for your family and colleagues."

Leia Spencer

We congratulate Jim and Leia on their well-deserved achievement. You can read their full bibliographical notes at www.gg.gov.au/queens-birthday-2018-honours-list

Improving the patient experience

by Robyn Smith, CEO, Paramedics Australasia

The NSW Ambulance Patient Experience Summit 2018 – held in Sydney on 21 June – brought an agenda filled with key influencers, clinical experts and real-life experiences to highlight how crucial the patient experience is and how New South Wales can continue to improve service to the public.

This is the second year I have attended this event. Last year's event focussed on mental health issues and I found this year to be just as thought provoking and inspiring. Dominic Morgan ASM – NSW Ambulance Chief Executive – and summit facilitator, journalist Sandra Sully, ensured that we were not only there to listen, with full participation and interaction throughout the day in work-shopping ideas and participating in polls. The activity and self-reflective exercises were balanced by some truly inspiring real-life experience presentations, with hardly a dry eye in the room.

Summit facilitator Sandra Sully

Dominic opened the summit by urging staff to build on their understanding of how to enhance the experience of all those the service comes into contact with – and to be mindful that while our patients rely on paramedics for exceptional care, they should also be able to rely on the delivery of exceptional compassion and communication. Compassion and communication were key words and values heard throughout the presentations – Every Patient, Every Journey, Every Experience. Compassion in treating patients, colleagues and ourselves.

Professor Michael West from the UK's Kings Fund addressed the summit via video link. Michael is a foremost expert on exploring the links between compassionate leadership and innovation and ways we can ensure collaboration across boundaries in health and care. He explained that compassionate care in health care systems is grown by compassionate leadership and one of the keys is to be present and to listen.

Robyn Smith and NSW Ambulance Chief Executive, Dominic Morgan

So, what is compassion to Michael? "Compassion for me is the health care assistant I saw who stayed for an hour after her shift had ended, holding the hand of an elderly lady who was in distress and talking to her lovingly and caringly, until she was calm again. It was the GP who told me she danced in her surgery that day with an elderly lonely man when she discovered they had a shared interest in dancing."

Dr Jamie Fox further challenged us to visualise what compassion looks like as a behaviour. Several definitions of compassion were put forward along the lines of,

Compassion is to:

- Recognise suffering
- Believe in common humanity
- Connect emotionally to every patient as 'mood' is a two-way contagion and patients feel your calm
- Find the joy and remind yourself the good you do every day
- Have an open mind
- Find our common humanity.

The components of compassion were also seen in light of how humans are impacted by messages, with 7 percent responding verbally, 38 percent responding vocally and 55 percent responding in a non-verbal sense. Therefore, in over 50 percent of patients we need to observe body language to ensure we can communicate and show compassion.

Steve van Aperen

Communications expert Steve van Aperen provided a high level of insight into reading and analysing human behaviour through sharing his past role as a former police officer and having trained with the FBI, LAPD and the US Secret Service. Steve gave us guidance on how the patient experience can be transformed through improving human rapport, building trust and communication. He also gave us some tips on how to read body language in order to detect deception, a skill he honed successfully solving a number of homicide cases.

Laila Hallam – Board member for the Clinical Excellence Commission – provided a completely different viewpoint of patient-centred care having become an accidental advocate for her father over 10 years ago. With his rapidly failing health and the loss of his ability to speak, Laila acted as her father's voice and endured a flawed patient care experience. In particular she felt that her family weren't afforded compassion and communication, and the significant information they wished to convey about her father's condition was not heard or valued.

> "Every Patient, Every Journey, Every Experience"

It is a testament to her commitment to the memory of her father and for improved patient-centred care for all families that Laila has interrupted her sales and marketing career. She is now focussing on working with health care organisations to understand, recognise and facilitate the immense value and knowledge that patients and their families contribute to their own personal health care to deliver better health outcomes.

The role of mental wellbeing in patient care was presented by NSW Ambulance Chief Psychologist Raelene Hartman. NSW Ambulance has been driving mental health support initiatives and has covered a lot of ground in the past year following the successful mental health focussed summit in 2017. The service is currently expanding the internal staff psychology service with a team of psychologists across New South Wales and new support pathways through a pro-active strategy.

It is estimated that in the paramedic career 11 percent will experience PTSD, 10 percent will experience depression and a further 15 percent will suffer from anxiety.

It is clear we can never become complacent about mental health and wellbeing and it must always be a priority. Dominic said there is a role for ambulance services as well, as the key professional bodies, to continue our research, programs and assessment of these initiatives.

The Hon Brad Hazzard MP

The Hon Brad Hazzard MP – NSW Minister for Health and Minister for Medical Research – addressed the summit and confirmed his support for New South Wales paramedics. Minister Hazzard has overseen record investment in health infrastructure and services across the state. In the recent budget, the NSW Government committed to a record paramedic workforce boost and will fund an extra 750 paramedics and ambulance control centre staff over the next four years. The first round of recruitment of 200 paramedics and control centre staff will be realised over the next 12 months.

Thank you to the management and staff of NSW Ambulance for the presentation of an excellent Summit on Patient Experience.

Board matters

Your Board and management team are strongly focussed on preparing for our paramedic members to enter national registration in Australia later this year. PA has established a national registration implementation fund to support the development of a range of services and tools to ensure our members are prepared for national registration compliance.

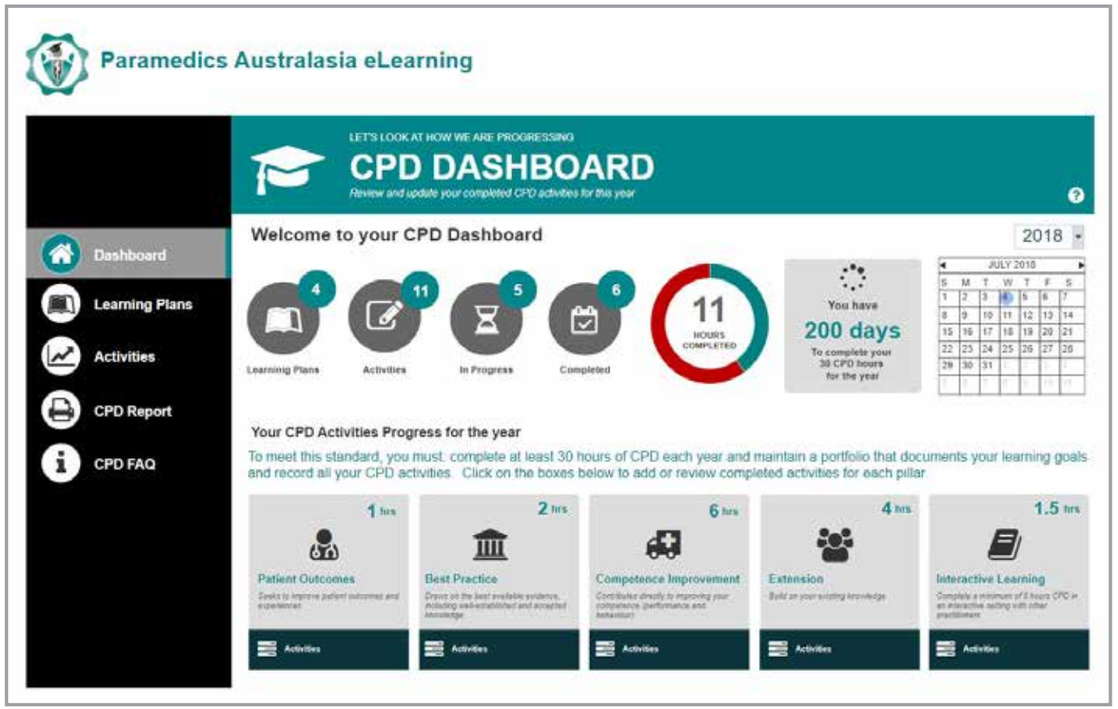
To help the profession get ready for national regulation later this year, the Paramedicine Board of Australia (PBA) has announced the date registration opens.

Paramedics, based anywhere in Australia, will be able to apply to register via an online application portal from 9am (AEST) on Monday 3 September 2018. While participation day is yet to be announced, the sooner you lodge your online application, the sooner your application to be registered under the protected national title as a paramedic can be assessed.

"The PBA's decision to start receiving and processing applications for registration in September is to give the profession as much time as possible to complete their applications well ahead of regulation taking effect," said Board Chair Associate Professor Stephen Gough ASM.

To be able to continue to practise the profession in Australia, all paramedics will need to be registered or have applied for registration with the PBA before regulation takes effect later this year.

The national fees for paramedic registration, which will include a one-time application fee of $190 and an annual registration fee of $275, have also been set. The same fees will apply to paramedics in all states and territories and will be reviewed annually by the PBA. A full schedule of fees for different types of registration will be announced in the coming months.



PA's CPD program

One of the key cornerstones of national registration is the CPD framework. The PBA's minimum requirements for continuing professional development for paramedics applies to all registered paramedics except those with student or non-practising registration.

To meet this standard, paramedics are required to:

1. Complete at least 30 hours of CPD each year that:
   (a) seeks to improve patient outcomes and experiences
   (b) draws on the best available evidence, including well-established and accepted knowledge that is supported by research where possible, to inform good practice and decision-making
   (c) contributes directly to improving your competence (performance and behaviour) and keeping you up-to-date in your chosen scope and setting of practice
   (d) builds on your existing knowledge, and
   (e) includes a minimum of eight hours CPD in an interactive setting with other practitioners.
2. Maintain a portfolio that documents your learning goals, records all your planned CPD activities, your reflection on how these CPD activities have or are expected to improve your practice and evidence of having completed these activities.

Please be rest assured that the CPD/eLearning platform PA has developed for members will provide more than adequate opportunities for members to meet these requirements and maintain a secure portfolio and history of your CPD activities in the event you are selected for a CPD audit.

We look forward to launching the CPD/eLearning program at PAIC 2018 – a new era in paramedicine at the Gold Coast in September and you can start accessing your portfolio at that time.

Up for the challenge

Emergency services personnel are fighting it out for the winner of 'give the most blood donations' during the Australian Red Cross Blood Service Emergency Services Blood Challenge 2018.

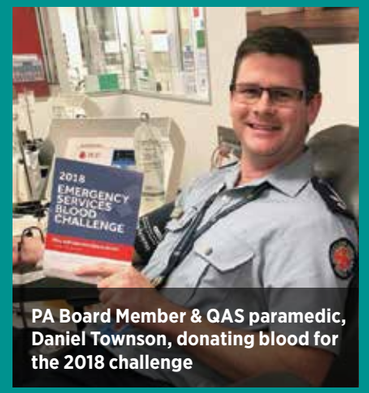
Last year's winner Victoria Police, made an amazing 9422 donations. As each donation saves up to three lives, that's up to 28 266 lives saved!

Who will take the title in 2018? Join the challenge and help your crew beat the other states and services.

How to get involved

- Simply join the Red Cross Blood Service's group donation program – Red25 – and donate blood during the challenge.
- Register for the self-service system, a secure convenient place where you can manage your details, group memberships and appointments.
- To join your Red25 group: select the 'Red25 group' tab, search for the group you wish to join, select the group and click to submit.
- To make an appointment: select the 'Appointment' tab and follow the prompts through to making a donation appointment from 1 June to 31 August.
- Give blood to have your donation automatically added to your group's tally.

For more information, visit **www.donateblood.com.au/emergency-services-challenge**



PA Board Member & QAS paramedic, Daniel Townson, donating blood for the 2018 challenge

PA highlights

No time to catch up with our Facebook or Twitter feeds? Haven't read Rapid Response lately? 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

▲ Congratulations to Victoria University paramedic graduates Rana Moussa (Professional Excellence Award) and Lauren Cornall (Academic Achievement Award) who received sponsored awards from the Victoria Chapter recognising their academic achievements in 2017. They are pictured here with Chapter Chair Levi Karschimkus.

▲ Almost 100 Victorian paramedics representing both public and private industries joined the Victoria Chapter in Melbourne for a paramedic registration information evening. This event featured influential Victorian figures including PBA members Paul Fisher (Executive Officer) and Associate Professor Ian Patrick (State Practitioner); Alan Eade (Chief Paramedic Officer Victoria) and Peter Jurkovsky (National Registration Working Group Chair and PA President). The event was recorded and is available through PA eLearning.

▲ The Victoria Chapter is proud to reward research excellence at each university which offers an undergraduate paramedic program in Victoria. In May, our chapter committee member Dr Kathryn Eastwood attended the Monash Medicine, Nursing and Health Sciences Student Award Ceremony to recognise the achievements of four students. Kathryn is pictured above with the following recipients:

- Ellie-May Maguire – Murray Black Professional Excellence Award
- Ashleigh Delorenzo – Paramedics Australasia Academic Achievement Award
- Michaela Ashlee Reiss – Paramedics Australasia Academic Achievement Award
- William Murray Bartley – Murray Black Professional Excellence Award.

WESTERN AUSTRALIA

▲ WA Chapter members at the 2018 Annual Chapter Meeting.

SOUTH AUSTRALIA

▲ Three teams competed for the opportunity to represent SA at the Fernoosim challenge at PAIC 2018 in September. The winning team was Pat, Bill and Aaron.

ACT

▲ ACT Chapter members at the 2018 Annual Chapter Meeting (L-R) Liam Langford (Chair), Matthew Mihaly (Secretary) and Anthony Groves (Treasurer).

NEW ZEALAND

▲ Wellington Free Ambulance celebrated mother's day with Hannah Latta, flight Intensive Care Paramedic, PANZ Committee Member and new mum – pictured here with her son Sam.

National Office

▲ Kathryn Eastwood, Ally Batucan (PA eLearning Manager) and Matt Johnson at the PA CPD portfolio planning session.

▲ Nathan Haynes (PA Board member) and his father John, both presenters at Survive & Thrive 3 symposium, held in Queensland in May.

▲ Speakers at Survive & Thrive 3 skyping with PA's Manager-Governance & Corporate Policy, Cassandra McAllister before the symposium.

TEAM AUSTRALIA EMS

▲ Students learning about bandaging for the management of severe bleeding.

▲ Students reflect on their shifts with American Medical Response and the San Diego Fire Department. They attended a huge range of medical and trauma calls and learnt so much from their American mentors.

▲ Students learning about the systems, fleet and operational structures with the San Diego Lifeguard Fire Rescue Teams.

Gold Coast Trauma

by Brittany Shaw, Queensland SPA Rep

When 70 eager students turned up to Gold Coast Trauma 2018 the atmosphere was buzzing with excitement.

Day one

Day one started with a lecture on tactical first aid by Snr Constable Dustin Osborne from the Queensland Police Service (QPS). The lecture covered violent trauma in hostile environments and showed us everything from blast and ballistic trauma to different assessment tools that can be utilised in volatile situations. Dr Don Campbell from the Gold Coast University Hospital followed with an interactive selection of trauma case studies showing what procedures and interventions can be offered to patients once they are on the trauma room bed. After morning tea

Sgt Pat O'Reilly from QPS joined us with a presentation about crime scene forensics before the workshops began.

Workshop one was presented by Stacey Williams and Charmaine Rainer from Zoll Medical. They demonstrated just how difficult it is to provide high quality CPR and introducing us to the world of pacing and defibrillation. Workshop 2 was where things got a little messy, with Snr Sgt Damien Hayden and Snr Constable Dustin Osborne running us through how QPS stop the 'red stuff' from pouring out before our arrival. We got hands-on with arterial bleed control by direct pressure and tourniquet application, as well as application of chest seals and emergency bandages.

Day one finished with presentations from Phil Davies (QAS CCP) and Terry Savage (NSWA ICP). Phil's presentation on 'the mechanism of injury and the element of luck' walked us through multiple case studies related to road traffic crashes, and allowed us a greater understanding into why it's just as important to look at the scene as a whole as it is to assess your patient. Terry then followed with 'paramedic wellbeing and longevity on road'. With over 30 years in the service, Terry's sense of humour on the topic and realistic perspective allowed us to take something away. The acceptance that we will have bad days, but the knowledge that we can get through alongside real world examples was an invaluable lesson to us all.

Day two

We were treated to a lecture and interactive workshop by Paul Omanski from the Queensland Fire and Emergency Services (QFES) where we gained a greater understanding of patient extrication from a vehicle.

Wing Commander Alexandra Douglas from the RAAF and GCUH presented next with 'lessons in combat casualty care'. This presentation discussed how different countries work their medical evacuation and treatment in active battle regions, comparing UK, US and Australia methods. This wasn't the only time we heard from Wing Commander Douglas, who ran us through a workshop on 'doing more with less in trauma'. This workshop focussed on a single case study, which made us think about long-term patient management with minimal resources.

ACU graduate Lesa Myers gave a thought-provoking presentation on reducing trauma in transgender patients. We were then split into smaller groups to take part in scenarios focussing on how to raise questions with patients and how to continue the conversation with a patient once you find out they are transgender.

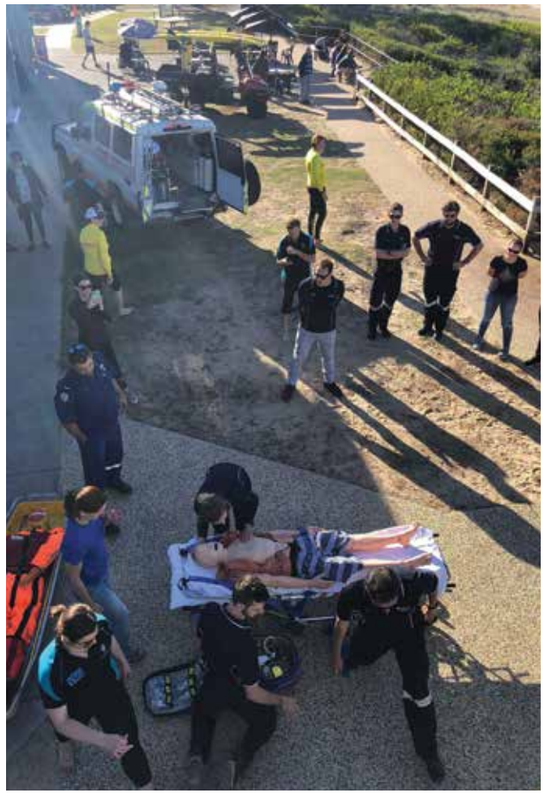
Scott Whimpey from First Aid Accident & Emergency woke everyone up from their food comas after lunch with an interactive seminar on 'back to basics'. This workshop covered the basic skills that often get forgotten after first-year, such as how to get an unconscious patient safely out of a chair.

The final message of the conference came from Natasha Adams, a CCP with QAS, who walked us through 'pause and prepare'. Using her own experiences as an example, Natasha showed us all just what stress can do to a situation – whether you are aware of it or not – and how this can be adapted and developed into something that benefits the situation.

SPA would like to thank our generous sponsors, presenters and workshop facilitators, without whom Gold Coast Trauma 2018 would not have been possible. Griffith University generously provided the facilities for our conference – a special thanks to Mal Boyle, Debby Findlay from the Paramedicine Faculty and Nemo from security. Our Gold Sponsor United Voice provided the catering sponsorship and numerous items for our conference bags – special thanks to Debbie Gilliot and Jason Bramwell. A sincere thank you to the PA Queensland Chapter, Zoll Medical and First Aid Accident & Emergency for their generous contributions.

CPD by the Sea

by Amelia Perris, SPA Co-Chair (State Rep)



CPD by the Sea made a return to CSU Post Macquarie campus in late June. Last year we hosted speakers from all occupations within our industry highlighting alternate career paths. This year our theme was 'Grow your Potential' featuring resume-building techniques, gaining potential through experiences from international placements to being a positive part of a local community as a paramedic, and a firsthand experience of the transition from university to full-time work.

Day one started with our livestream team from South Australia all set up ready to cast to the world, as well as a strong SPA team of four ready to greet the attendees. Our first three speakers were James Martin, Sam Burbidge and Siobhan Graham who challenged our thoughts on belonging in a small community, international opportunities, and the hard honest truth about the differences between university and work. We then moved into a rotation of workshops covering resume writing, interview tips, career progression and case studies, with mistakes discussed by all.

Day two kicked off with a registration forum with Buck Reed updating us on the upcoming registration roll out and what it will mean for students and recent graduates, both employed and yet to be. Moving onto a wellbeing topic, we had Josh Smyth present Mental Health and Me, with personal experiences and top tips for keeping our own mental health in check when on-road. We finished up the formal presentations and our livestream broadcast with Krista Cockrell sharing her experiences working in the US and what the transition to Australia was like for her.

The SPA team then cooked up a storm on the barbeque, which was sponsored by the local society CSUSPA-PM. Fuelled up, we all travelled down to North Haven SLSC for our seaside simulation, facilitated by Phillip Ebbs and assisted by NSW Ambulance, consisting of a water extrication performed by surf club members followed by a handover to the students and then a cardiac arrest drill.

We had wrap-up drinks back in Port Macquarie for a relaxed way to end the weekend.

This was my second time at CPD by the Sea (assisting Siobhan Graham last year) and it was a joy to see what this event has become. The support from the entire SPA team – but especially Erin, Lewis and Dasha who made the whole weekend run smoothly – and CSU has again provided extended learning for all student paramedics.

Building paramedics, maintaining skilled practitioners

Jean-Paul Veronese

The following editorial and abstracts have been taken from the latest issue of the Australasian Journal of Paramedicine Vol. 15, No. 2, 2018. **Available at https://ajp.paramedics.org**

Building and maintaining skilled paramedics is a key component within the health system. Most paramedics never forget their first day as a new graduate or newly qualified paramedic, often with mixed feelings about being 'unleashed on the world'. Many new paramedics will be given the keys to a freshly stocked ambulance and be expected to attend to a vast array of calls ranging from minor to challenging. My own experience was not different to most others, with the first day consisting of two paediatric drowning resuscitations an hour apart followed by a motor vehicle accident entrapment and a fall from height with spinal injury. For the most part, these calls went surprisingly well. However, for those parts that didn't go as well or could have been better, the clinician is often left with thoughts of 'what if' and 'if only I had…'. Herein lies the importance of quality education followed by an appropriate work environment that fosters good practice.

Medical education is typically delivered across health sciences faculties within higher education institutions. Departments that have traditionally fallen under the banner of health science education include medicine and allied health professions such as nursing and physiotherapy, with paramedicine one of the latest disciplines to join the professions. Despite paramedicine being relatively new by comparison – only having been around for several decades – as a profession it has grown rapidly. However, despite its rapid growth there remain some areas that reflect this infancy. One area is the variation in practice and educational standards, both locally and internationally.

With this in mind, building clinicians to work in these various environments remains a challenge. Medical education has recognised for years that several factors influence the successful performance of any competency. These include the learner's knowledge of what is required, the component skills required to accomplish this, the correct attitude that displays a confidence and willingness to do what is required, and maintaining a professional environment that supports appropriate behaviour. These core components have been summarised into a taxonomy of learning domains that is still widely recognised today. These components include the cognitive, affective and psychomotor domains.

The cognitive domain involves adult knowledge acquisition and development of intellectual skills. Bloom's taxonomy outlines how learners ascend through the levels of intellectual skill, from simple recall of information through to evaluating and creating new information.[1] Similar models include Bigg's SOLO taxonomy, which describes levels of increasing complexity in a learner's understanding of subjects.[2] These and other models are used as means of learning, teaching and assessment of the cognitive domain. Teaching strategies are generally comprised of a multi-modal approach, which has been outlined in a previous editorial within this journal.[3] While these have proven to be effective models to work with, the execution becomes more of a ne juggling act: balancing the right amount of information needed by the learners, while not overloading them.

The psychomotor domain involves adult skill acquisition. Simply put, this is comprised of physical movement, coordination and use of the motor-skill areas. Several models are widely used throughout medical education the including Simpson, Harrow and Dreyfus models of skill acquisition.[4-6] Traditionally, medical education relied on the Halstedian mantra 'see one, do one, teach one', but this has lost favour due to concerns with patient safety.[7] Simulation-based training has been offered as a replacement for practising on patients and has widely been accepted as the new method of teaching skills.[8] Paramedicine learners progress from performing simple tasks such as oropharyngeal airway insertion in the form of an isolated clinical skill, through to more complex simulation-based scenarios involving critically ill and injured patients in the simulated setting. Learners are expected to achieve competency level within these models, and only progress to proficiency and mastery level after several years of practice as qualified clinicians. Assessing competency can also prove to be a challenging process in education, as assessment rubrics traditionally possess outcomes that may or may not always be reflective of the learner's competency level. Traditional rubrics also generally possess very stringent quantitative means of assessment. Assessment rubrics that possess both aspects of qualitative and quantitative measures should be considered to gauge an overall perspective of skill competency, as well as possessing characteristics of reliability and validity.

Even with skill acquisition being more reliant on simulation-based teaching, a key component to completing the learner's competency is performing skills on patients under direct supervision. A learner who has practised their skills sufficiently and is competent in the simulated setting should be well prepared to perform learned skills on patients under direct supervision. This is a key transition point for the learner. Learners must also achieve a set number of skills to safely practise autonomously after they have graduated and qualified. Several challenges exist with attaining these numbers, including low frequency of opportunities or cases to perform these skills, or supervisors who are unwilling to allow learners to 'practise' on their licence for fear of reprisal.

Once competency is achieved, skill decay – or 'de-skilling' – can occur over time if the skill is not performed frequently. This occurs faster among novice clinicians than it does among the more experienced. With the varying nature of calls attended by paramedics, the opportunity to stagger the level of skill decay through practise becomes a predicament not only for the paramedic, but the patients they attend. Systems can ensure patient and practitioner safety by implementing robust continuous quality improvement systems, which have been shown to improve outcomes.[9-11] Simulation-based interventions to avoid skill decay could be a solution to this, and remains an active area of research. Ultimately, the journey from paramedic learner to graduate should be one of constant learning, with robust systems in place to support this process. These systems are vital in ensuring the health and safety of both the patient and the paramedic. The old adage 'rescuer-safety first' should always remain our priority.

About the author

Jean-Paul Veronese BT (Emergency Medical Care), MSc (Emergency Medicine), is a Lecturer in Paramedicine at the School of Medicine, Griffith University, Queensland.

A list of references is included in the online version of this article (https://ajp.paramedics.org)

Selected abstracts

Preparing for the real thing with practice interviews: a graduate paramedic perspective

Linda Ross, Nicholas Moffatt

Introduction

Behavioural interviews are a critical component of the job application process for ambulance services in Australia. They involve role specific open-ended questions that are designed to test an applicant's skills, eligibility and experience. It is a process that is standardised and can be practised to increase familiarity and performance. Existing literature supports the benefits of practice interviews ahead of real interviews to improve applicant performance and subsequent employment success. The objective of this study was therefore to examine paramedic graduates' perceptions on the value of participating in practice interviews before seeking employment with an ambulance service.

Methods

Students enrolled in the Bachelor of Emergency Health (Paramedic) at Monash University in Victoria took part in a cross-sectional pilot study. Three paper-based surveys were created to assess the value of practice interviews. Both quantitative and qualitative methods were used.

Results

Fourteen (n=14) students participated. All participants agreed or strongly agreed that practice interviews would help them gain employment. All participants perceived that practice interview helped improve their confidence and preparation for their actual interview.

Conclusion

Practice interviews were found to be a positive and worthwhile undertaking. They increased confidence and improved preparation through practise and feedback. Participants agreed that they were valuable and perceived that they led to improved performance in their real interviews and subsequent employment success.

Read the full article at https://ajp.paramedics.org

The knowledge, attitudes and preparedness of Australian paramedics to manage intimate partner violence patients – a pilot study

Simon Sawyer, Angela Williams, Auston Rotheram, Brett Williams

Introduction

Australian ambulance services are currently attempting to improve their capacity to respond to intimate partner violence (IPV) patients, which is a significant contributing factor to the morbidity and mortality of women. Leading health organisations have called for increased training for frontline health care workers, however there is a paucity of literature on the current preparedness of Australian paramedics. A description of the preparedness of Australian paramedics to manage IPV patients has the potential to inform curricula and practice development.

Methods

We surveyed a cohort of qualified Australian paramedics using the modified Physician Readiness to Manage Intimate Partner Violence Survey.

Results

We received 28 completed surveys (16.5% response rate), that revealed most respondents (89.3%) believed they had encountered IPV patients while working as a paramedic, yet only one participant reported comprehensive education or training on the management of such patients. Participants reported low knowledge and preparedness to manage IPV patients. Participant attitudes were poor for self-efficacy, confidence and preparation, and generally neutral for items regarding attitudes toward women and IPV patients.

Conclusion

This study adds to mounting evidence that paramedics frequently encounter IPV patients, have insufficient education and training, and are not prepared to manage such patients. While the results of this study should be interpreted with caution due to a low response rate and small sample, it appears that Australian paramedics would benefit from targeted educational packages that provide the necessary knowledge to recognise and refer patients, modify inappropriate or insufficient attitudes, and prepare paramedics to effectively manage IPV patients.

Read the full article at https://ajp.paramedics.org

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- Can provide better stabilisation of a globally unstable pelvic fracture than an external fixator. [4]

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