Australasian College of Paramedicine

RESPONSE

AUTUMN 2022

www.paramedics.org

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A CAREER HIGH

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COVER
Kasha Szewczyk

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

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

FROM THE CHAIR

CONTINUOUS IMPROVEMENT

with **Ryan Lovett,** College Chair

Welcome to the Autumn edition of *Response*.

This edition I wanted to take a more introspective approach to provide you with an update on how the College is positioning ourselves to better provide services to you, our members, and to better place us to represent and advocate more broadly for the profession.

The College's strategic plan sets out our vision, "A strong and influential College representing and supporting paramedicine", and purpose, "To advance and support excellence in paramedicine and patient-centred care". It is important to remember that the College, in its current form, is still relatively young, and there remains a lot of work to do to ensure that, following the merger, we have the right people with the right skills, and the right systems and processes to deliver on our vision and our purpose.

To ensure we are well placed to do so, late last year the Board approved an independent external organisational review. The review looked at College performance against our strategic objectives, department structures, employee roles and functions, what we were doing well and where could we do better. It was an invaluable exercise that highlighted a number of key opportunities for improvement.

The Board carefully considered the recommendations stemming from the review and has subsequently approved meaningful investment in building College capacity and capability. The main recommendations concentrated on ensuring the College was appropriately resourced to improve operational capacity to be successful today and into the future. This has seen an internal restructure, with Education being split out into a standalone unit (formerly Education and Research) and the creation of new units focusing on Member Services and Advocacy.

THE BOARD IS ALSO INVESTING IN ADDITIONAL RESOURCING IN EDUCATION THROUGH SUBJECT MATTER EXPERTS TO PROGRESS OUR EDUCATION CONTENT GOALS

The College strives to be the industry leader in professional development content for paramedics, and we know that we can never stand still. To build our education capability, the Board is also investing in additional resourcing in education through subject matter experts to progress our education content goals.

The past 12 months have seen the College prioritise the development of our advocacy capacity, which has led to numerous submissions, media activities, and attendances at hearings across a range of areas covering paramedicine and broader health care delivery. The establishment of a new and dedicated advocacy team staffed by individuals with demonstrated experience across government and health will see the College continue to improve our capability and be better positioned to lead the profession.

The Board's role is fundamentally one of governance, strategic direction setting, and oversight. Guiding the Board and the College in all that we do is our Constitution. Following the formation of the College in 2020, the Board committed to regularly review the structure and operation, including the Constitution, to ensure we remain contemporary and responsive. Shortly, a call will go out for members to express an interest in being part of a constitutional review group to provide feedback to the Board on the Constitution. We do not expect, nor are we seeking, significant change, but the Board does believe there is opportunity for refinement. Any proposed changes to the Constitution must be approved by you, our members, at a General Meeting and, as always, we will encourage feedback throughout the process.

It continues to be an exciting time to lead the College. The organisational review has identified opportunities for us to continue our growth and development, helping us to progress to a strong and influential College. We are advancing our plans to lead the profession through advocacy, education, and research, as well as ensuring the College is run sustainably and successfully.

Stay safe.

FROM THE CEO

PARAMEDIC EDUCATION AND DEVELOPMENT

with **John Bruning,** College CEO

In the 2021 Winter edition of Response, I spoke about our education plans and the clinical education resourcing we were investing in to generate new and interactive content, and to deliver on our purpose of excellence in paramedicine. As with many things, the initial investment takes time to show the value that it is creating, but I am excited to see the benefits that have now been realised from that investment with the first handful of our dedicated eLearning modules.

The Education team released the first modules in mid-March, and we now have a three-module obstetric series and three other modules on motor neurone disease, mentoring, and palliative care. Since the launch, there have been more than 800 enrolments in the modules, with the obstetric series being the most attractive to members. Our plan is to release new modules every month, building a strong library of interactive eLearning content for members.

An essential part of paramedic registration in both Aotearoa New Zealand and Australia is the requirement to undertake 30 hours of Continuing Professional Development (CPD). The Paramedicine Board of Australia and Te Kaunihera Manapou Paramedic Council expect the CPD to be relevant to your area and scope of practice, and that it directly contributes to improving your competence. It's important to note that these are the minimum standards required to practice in the profession.

The College's purpose is to advance excellence in paramedicine, and there is a significant opportunity for paramedicine to go beyond these minimum standards to enhance and elevate practice. I'm certain everyone has heard of SMART goals and, ideally, all paramedics should have a development plan that documents your learning goals using the SMART acronym, so that the CPD undertaken is targeted to your needs. In that way we can lift standards, practice, and improve patient care.

The College has our CPD tracker available for members to manage their professional development, which provides a section to create your personal development plan and set learning objectives. The CPD tracker allows members to connect learning back to these defined objectives, creating a seamless link between development, learning objectives and CPD undertaken. It is pleasing to see that more than 1100 members have development plans in the CPD tracker, but ultimately, every paramedic needs to have a development plan and defined learning objectives if we want to achieve excellence. If you don't already have a development plan in place, I strongly recommend using your CPD tracker on the College website and spending time to reflect on your practice and set learning objectives to improve the care you provide to your patients.

Conferences

It was great to be back to face-to-face conferencing with Trauma on the Border in March, where more than 180 attendees enjoying our one-day conference. It was also good to see more than 150 online attendances, and that we continue to create opportunities to engage with our education content no matter where you are.

We have hit conference season now, with ROAR on later this month in the Adelaide Hills, the Research Symposium (Sunshine Coast) and Student Conference (Sydney) in July, and our major international conference, ACPIC22, in Brisbane from 14-16 September. I know COVID hasn't gone away and the pressures on paramedics as we enter flu season will not dissipate, but we have greatly missed the ability to meet colleagues, rekindle friendships, and learn together through both light-hearted and robust debate over a cuppa and a treat at a conference. This is something we should prioritise for our enjoyment, wellbeing and development.

Stay safe and well.

EVERY PARAMEDIC NEEDS TO HAVE A DEVELOPMENT PLAN AND DEFINED LEARNING OBJECTIVES IF WE WANT TO ACHIEVE EXCELLENCE

COLLEGE CONSULTATIONS AND SUBMISSIONS

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

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

- The College attended the Federal Budget Lock-in following our pre-budget submission for funding to develop and trial community paramedicine in primary health. Unfortunately, we were not successful in securing funding for this initiative, but we continue to work on expanding the role of paramedics.
- The College has been engaging in the news cycle where opportunities arise to promote the greater inclusion of paramedics in workforce solutions and innovative models of care across Australian communities.
- Coming into the Federal election cycle, we have been meeting with numerous MPs and communicating with all federal politicians to advocate for role of Community Paramedics in health care solutions.
- The Advocacy team has drafted position papers on "Expansion of Health Services in Australia to deliver urgent care" and "The role of Paramedics in the Health Care system". These positions are still under development and part of consultation with key stakeholders.
- A key part of our advocacy work is to develop beneficial relationships with other colleges and professional groups (Australian College of Rural and Remote Medicine, Rural Doctors Association of Australia, Australian Primary Health Care Nurses Association) to engage with, and garner support for, the role of paramedics in innovative models of care. This work is ongoing.
- Following advocacy engagement work across all jurisdictions, the College was invited to and attended the ACT Allied Health Professional roundtable.
- The Advocacy team has also worked closely with the College's Education team and the Indigenous Allied Health Association to grow opportunities for cultural awareness education and training for all our members.

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

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

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

COLLEGE SPECIAL INTEREST GROUPS BECOME **WORKING GROUPS**

The College benefits from a number of groups comprised of members who work to advise the College and advance paramedicine in their respective spaces. Separate to our advisory and member committees, these groups have previously been referred to as Special Interest Groups.

From April 2022 onwards, Special Interest Groups have been renamed Working Groups to better reflect the work these members are undertaking to achieve goals and outcomes aligned with their targeted purpose. Rather than a discussion forum for those with a mutual interest, our Working Groups have evolved to be productive driver of progress and activity for the benefit of the College, and as such are to be recognised accurately according to their function.

First quarter highlights:

The **Women in Paramedicine Working Group** was established in July 2021 with a focus on supporting and advocating for the progression of women in Paramedicine. On International Women's Day on 8 March, the Women in Paramedicine Working Group launched its first IWD campaign under the theme #BreakTheBias. In this campaign, clinicians from across Australasia came together to celebrate the many roles that women undertake in the profession, with an emphasis on celebrating diversity and challenging stereotypes - "Break the bias: Be curious and ask why?". The working group is currently developing a membership survey on finding solutions for workplace issues for women in paramedicine.

The **Research Committee** completed Phase 1 of the Research Agenda for Australasian Paramedicine (RAAP) project - a survey of the paramedicine sector to determine research priorities and barriers and enablers to research being conducted - and is in the process of writing the results into a paper. The committee also announced the opening of the College's 2022 research grant applications. There are three grant categories that can be applied for: Early Career Research Grant, Higher Degree by Research Grant and the Research Dissemination and Translation Grant. For more information about the types of grants available and the guidelines for applications, visit https://paramedics.org/research/grant or contact research@paramedics.org. They also delivered their third workshop under the Research Mentoring Program.

The **Education Committee** worked on the education policy and framework, collaborating with the education team to develop a subject-matter experts' collaboration group, developed multi-modal education content, including multi-disciplinary problem-based learning.

The **TAS Member Committee** is continuing supporting future paramedics and provide opportunities for Tasmanian paramedics to develop their knowledge and skills. The committee continues to run a voluntary mentorship program for students at the University of Tasmania, in which Ambulance Tasmania paramedics meet monthly with the students to mentor them on both theory and practical skills. The initiative was implemented as a result of a lack of placement time during COVID-19 lockdowns and was aimed at providing collegial support to students.

The **QLD Member Committee** hosted an End of Life Law Workshop in partnership with Queensland University of Technology. This interactive workshop for paramedics across Australia used a case study format to explore some of the legal issues that can arise in practice for paramedics, and the role law plays in end-of-life care. This workshop was part of End of Life Law for Clinicians, a free training program for paramedics, doctors, nurses, and allied health professionals about the law relating to end-of-life decision-making.

The **Clinical Standards Committee** reviewed status of opioid analgesic stewardship and is in the process of developing the College's first clinical standard on "Paramedic Management of Pain".

NEW COLLEGE **APPOINTMENTS**

JULIE JOHNSON

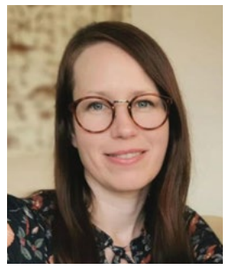
EDUCATION MANAGER

Julie Johnson has been working as the College's clinical education officer since June 2021 and has been instrumental in creating and developing our new eLearning platform. She has just been appointed Education Manager, bringing with her a wealth of experience in her more than 20 years in health education. Julie is a registered paramedic, a nurse, a clinical educator (nurse preceptor and paramedic clinical educator), asthma educator, and yoga teacher. She is a recognised leader in vocational education (a postgraduate qualification in tertiary and higher education) and is currently a research candidate investigating paramedic education post qualification. She was worked across a range of paramedicine sectors, including state ambulance service, primary health care, non-emergency, sports medicine and private paramedic practice in Victoria and New South Wales. While working as a nurse, she worked mainly in midwifery, surgical and rehabilitation and primary health care, and community care. Julie has also worked as both a paramedic and nurse in primary health care, in dermatology, GP practice, chronic disease management, women's health and midwifery. She has a special interest in, and passion, for equity in education, and is looking at how education is the key to professional growth and career happiness. She believes in developing education that is engaging, interesting and fun, and that is strongly aligned to sound philosophies and learning theories. Her recent projects include championing education for the South Pacific through the development and delivery of training in vocational paramedicine, facilitating the transition of knowledge for defence medics to civilian qualifications through a recognition framework and supported pathway to university.

JACINTHA VICTOR JOHN

ADVOCACY AND GOVERNMENT RELATIONS MANAGER

Jacintha has joined the College as Advocacy and Government Relations Manager. She has a Master of International Law LLM and a Bachelor of Law (Hons) LLB, has a NSW Practicing Certificate and was admitted as a Solicitor in the ACT's Supreme Court. She has more than eight years' experience in the legal and policy field, and has worked for federal and state government departments, political parties, the Law Council of Australia, and NGOs, and has undertaken private-sector consultancies, providing leadership guidance, technical support, training, coaching and mentoring to relevant stakeholders. Jacintha is known for her expertise in legal and policy work, stakeholder engagement, advisory services, contract management, international law, research and analysis, and corporate governance. She is recognised for her unwavering capability to manage clients and provide recommendations for resolving disputes. She has a strong background in legal document preparation and is proficient in conducting research and gathering clinical evidence and legislation to summarise and present information to the government and key stakeholders. She applies a meticulous approach to following organisations' legislative guidelines and interpreting and analysing operational blueprints to develop effective solutions.



JEMMA ALTMEIER

MARKETING AND COMMUNICATIONS MANAGER

Jemma has joined the College as our new Marketing and Communications Manager. She has worked in strategic marketing, communications and public relations roles at leading organisations and not-for-profits across Victoria, including the Royal Children's Hospital Foundation, the Spinal Research Institute, and the National Gallery of Victoria. Throughout her career she has delivered high-profile campaigns, managed major organisational projects and implemented communications to various stakeholder groups. Jemma is passionate about health and science communications and is thrilled to have the opportunity to work with the College.

NEW **HEALTHY BODY & MIND** HUB AVAILABLE FOR COLLEGE MEMBERS

The College has partnered with Health at Work to deliver our new Healthy Body & Mind Hub, a dedicated online space for College members that will provide you with a range of resources and learning to support your health and wellbeing. Fresh content will be available each month, and content from previous months will always be available within the hub, so you can be sure you won't miss a thing.

Members can access the Healthy Body & Mind Hub via the QR code below or via **paramedics.org/health-and-wellbeing/hub**

Embrace your health! This online education platform will give you easy access to a range of mind and body resources that will support your health and wellbeing ongoing.

Every month will feature:

Jump into Life newsletter: 5 contemporary articles presented in an online magazine style.

Mind & body feature: a deep dive into one specific topic in an online and printable poster series.

Self-development: Further your learning through challenges, podcasts & missions that relate to the monthly theme.

Recipe: a simple, delicious and easy to cook healthy meal idea.

Webinar: a 45-minute webinar presented by qualified professionals live & on demand.

Live Classes: 2 x Stretching and Mindfulness classes each week.

Better health is at your finger tips!

Australasian College of Paramedicine®

THE COLLEGE IS **DEVELOPING TRANSFORMATIVE WAYS** FOR OUR MEMBERS TO ENGAGE IN LEARNING

THE MORE THAT YOU READ, THE MORE THINGS YOU WILL KNOW, THE MORE THAT YOU LEARN, THE MORE PLACES YOU'LL GO – **DR. SEUSS**

How we learn and how we teach impacts our practice. Just like our clinical practice should be evidence-based, our learning and teaching must have strong connections to educational philosophy and learning theory.

Why?

Because educational philosophy and learning theories provide the conceptual frameworks that facilitate an individual's acquisition of knowledge, skills, and attitudes to achieve changes in behaviour, performance, and growth.

Our team of education professionals at the College are constantly working to develop transformative ways for our members to engage in learning. We appreciate that new knowledge needs to become integrated into existing knowledge while continually challenging perspectives, and enhancing opportunities for critical evaluation and self-reflection.

How?

- Comprehensive Professional Development Program
- Access to a range of activities to enhance clinical, leadership, professional and essential skills
- Maintain, improve and broaden knowledge
- Develop the personal and professional qualities needed throughout professional lives.
- Flexible framework of activities
- Enhanced exchange of expert and professional knowledge in a positive and supported learning environment
- Structured reflection to enhance competence
- Self-directed learning paradigm to support lifelong learning

Learning isn't just about teaching and retaining information.

"The way you mentor and provide clinical instruction for your students will stay with them," said College Education Manager Julie Johnson. "They will remember more of how you made them feel than exactly what you taught them. They will mimic the way they were taught when teaching others, and this is what fosters an inclusive culture, where respect and a sense of belonging are valued. You are mentoring the new mentors."

In March we launched our **new eLearning portal**, offering College members another valuable suite of professional education programs designed to enhance the transfer of skills and knowledge to real-life practice.

All eLearning is 100% online and specifically developed for paramedics and relevant to all paramedics irrespective of their level of practice. It features case studies and activities that are based on real world examples.

Our eLearning courses, which complement our already extensive range of CPD courses, are peer-reviewed, adaptive and engaging, and are designed to be self-paced to enable members to work in accordance with their own schedules and study time requirements.

Driven by industry need and equity in access to education, we have assembled a team of cross-practice expert collaborators and adopted an interdisciplinary approach to learning, recognising the implicit relationship between learning and professional growth.

New courses are constantly being added, and at present include:

- Understanding and caring for patients with motor neurone disease
- Obstetrics: Management of physiological birth, and management of a nuchal cord
- Palliative care: End of Life Law for Clinicians
- Clinical training and mentoring, touching on adult learning concepts in a way that can really improve how you work with students and new graduates.

We're also working towards making all our courses more mobile-friendly, as we recognise that many of our members may want to access content while they're at work or on the go. Our aim is to be the frontrunner in this learning space.

You can access our eLearning modules at: **https://paramedics.org/eLearning**

If you're a subject matter expert who would like to collaborate with the College, contact Julie Johnson at **Julie.Johnson@paramedics.org**

Australasian Journal of Paramedicine

A NEW ERA OF OPPORTUNITY – SECURING EXCELLENCE FOR OUR JOURNAL

PAUL SIMPSON

Interim Editor in Chief; Chair, Journal Advisory Committee at Australasian Journal of Paramedicine
Associate Professor; Director of Academic Program for Paramedicine at Western Sydney University

The Australasian College of Paramedicine (ACP) has a distinguished history of supporting, promoting and disseminating research in paramedicine. Central to that outcome has been its longstanding commitment to scientific journal publishing by way of what is currently our journal, the Australasian Journal of Paramedicine.

In 2003 the Australasian College of Ambulance Professionals (ACAP), the precursor organisation to ACP, published the inaugural edition of the Journal of Emergency and Primary Health Care (JEPHC).[1] JEPHC grew steadily over the following years under the stewardship of Professor Frank Archer, providing a platform to showcase Australian paramedicine research and increase translation of research into practice.

CHANGE IS THE LAW OF LIFE, AND THOSE WHO LOOK ONLY TO THE PAST OR PRESENT ARE CERTAIN TO MISS THE FUTURE – **JOHN F KENNEDY**

In 2012, JEPHC entered a transitionary period and went on a 12-month hiatus; the Journal needed reinvigoration, a new identity, and to be repositioned to ensure its survival into a second decade. The Journal re-emerged in 2013 with a new identity and a refreshed editorial team led by Associate Professor Malcolm Boyle.[2] Renamed and repositioned as the Australasian Journal of Paramedicine, the Journal again grew and evolved, proving itself to be a valuable disseminator of research in paramedicine and a strong proponent of Australasian paramedicine research and evidence-based practice.

Almost a decade later, in what might constitute a case of "back to the future", AJP has now entered a transitionary period as it seeks to build towards a third decade of growth and expansion. The past decade has seen substantial change in the discipline of paramedicine and rapid expansion of paramedicine research. Concurrently, scientific publishing in paramedicine has evolved, giving rise to new and innovative opportunities and modalities for disseminating evidence, stimulating critical debate and promoting an informed discourse in our profession. Against this background, it is essential that our Journal evolves to enable it to secure its position as an international leader in paramedicine research and scientific publishing.

In November 2021, AJP commenced a hiatus on new submissions that will continue until mid-2022. An interim Editor-in-Chief, Associate Professor Paul Simpson, was appointed to oversee the operations concurrent to a transition strategy being developed. A Journal Advisory Committee (JAC) with international membership was tasked to advise the College on the future direction of the College's Journal. The JAC has consulted widely with researchers in and outside of paramedicine, and with experienced leaders in the journal publishing space, to identify best practice models that will be sustainable and give the Journal the best opportunity to grow and prosper into the future.

The future of the Journal is bright. The review of the Journal's editorial and publishing infrastructure is complete, and the appointment of a new editorial board is imminent. Importantly, the renewed Journal will maintain its connections to the AJP and JEPHC era by bringing over the existing archives. Further, the Journal will continue its commitment to open access publishing at no cost to authors.

It is expected that the new Journal will launch in early 2023, heralding a new decade of excellence and progression with a stronger international focus and a resolute commitment to progressing the scientific discourse in paramedicine. The reopening of submissions for the first edition of the relaunched journal is expected in October 2022.

In the interim, the College is pleased to announce the release of the Volume 19 (2022) of AJP, consisting of articles submitted prior to the submission hiatus in 2021. Readers will note several enhancements in this volume, including a fresh and contemporary article format and primary author linkage to ORCID. Under the Journal's continuous publishing model, articles currently in the editorial system will continue to be published throughout 2022.

We find ourselves on the cusp of an exciting new era for the Journal; one that will be characterised by boldness, innovation and agility, and underpinned by a commitment to continuous quality improvement, and a focus on publishing high-quality international research and enhancing author and reader experience.

References:

1. Archer F. In this Issue. Journal of Emergency Primary Healthcare. 2003; 1(1)
2. Boyle M. Resurgence of an Australasian Prehospital Journal. Australasian Journal of Paramedicine 2013;10.1

COLLEGE INVOLVED IN UPDATING AUSTRALIAN GUIDELINES FOR THE MANAGEMENT OF ACUTE CORONARY SYNDROMES

The Heart Foundation, in partnership with the Cardiac Society of Australia and New Zealand, have recently begun the process to update the current (2016) Australian guidelines for the management of acute coronary syndromes (ACS). These guidelines focus on the diagnosis, management and secondary prevention of unstable angina, non-ST elevation acute coronary syndromes and ST elevation myocardial infarction, and will provide evidence-based recommendations for health professionals (including paramedics) caring for patients with suspected or confirmed ACS.

Excitingly, for the first time since the initial publication of the ACS guidelines in 2006, the integral role of out-of-hospital clinicians and systems in the management of patients with ACS has been recognised and prioritised, and the College was invited to be a member of the ACS guideline update Reference Group.

The Reference Group comprises nominated representatives from key stakeholder organisations that have national relevance in the provision of ACS care in Australia. The role of the Reference Group is to provide guideline oversight, by reviewing and contributing to the scope of the guidelines, the remit of the literature reviews, the guideline content, presentation, clinical recommendations and implementation approach. Members of the Reference Group will endorse the final guideline in consultation with the organisations they represent.

The College is represented by Suzanne Avis, a College member and academic with extensive national and international experience in research, evidence evaluation and guideline writing, focusing on resuscitation and emergency cardiovascular care.

The ACS guideline update has been initiated to address the current knowledge and practice “gaps” identified in the 2016 guideline, with the aim that the update will:

- Incorporate new, practice-changing evidence, including evidence supporting the critical role of early access to advanced care provided by out-of-hospital clinicians, and the state-wide, integrated systems of cardiac care implemented in most Australian states.
- To include specific recommendations for priority groups known to have worse outcomes from ACS, including women, people living in regional and remote areas, people experiencing socioeconomic disadvantage, people from culturally and linguistically diverse communities, and Aboriginal and/or Torres Strait Islander Peoples. The role that paramedics can play in providing both emergency care and secondary preventative care for ACS patients in regional and remote areas will be explored.
- To demonstrate person-centred care with consumer involvement in guideline development, and consideration of important patient-reported outcome measures and patient-reported experience measures to inform recommendations

The College welcomes input from members should they wish to comment on the integration of out-of-hospital care into the updated ACS guidelines.
Please email Suzanne Avis directly Suzanne.Avis@sydney.edu.au.

The Australian clinical guidelines for the management of acute coronary syndromes 2016 can be accessed here. **https://www.heartfoundation.org.au/conditions/fp-acs-guidelines**

LEARNING THE ROPES THANKS TO COLLEGE EDUCATION GRANT

Caringbah, Dharawal Country

THE INITIAL STEP OVER THE EDGE AND PUTTING WEIGHT INTO THE HARNESS WAS ALWAYS A NERVOUS MOVEMENT

Rappelling down the side of a cliff might not be everyone’s cup of tea, but for NSW Intensive Care Paramedic Harry Reeves it was not only an opportunity to explore a lifelong interest, but also a potential pathway to specialise in special operations and rescues.

Thanks to a College education grant, Harry, who works as on-road paramedic at Caringbah Station within their Metropolitan Operations division, was able to complete the “Abseil 3” course with the Australian School of Mountaineering.

The two-day course in the rugged terrain of the Blue Mountains involved learning to select and fit equipment, performing a number of abseils, and practising improvised rescue techniques, which proved particularly demanding in the sweltering December heat.

“On the first day I went through two litres of water pretty quickly,” he said. “Minimal shade cover on cliffs and sweating at the sight of some heights probably didn’t help!” he said. “The initial step over the edge and putting weight into the harness was always a nervous movement, but once I was on the line I was much more comfortable.”

A large portion of the course was spent practicing vertical access on a number of different rock faces and determining the best approach to each. He was also taught how to safely extricate a casualty using improvised evacuation methods such as lowering and raising systems.

“One of the main learnings from the course was the importance of conducting a thorough risk assessment and how to implement safety measures, especially when operating in small teams or independently. I learned how to mitigate risks such as weather and other environmental conditions. I also learned how to implement safety and belay systems for others that do not have experience abseiling or climbing.

“By the end of the second day I was able to comfortably make my way through the Serpentine Canyon in the Blue Mountains, which involved a number of abseils with a range of heights, obstacles and difficulties.”

Harry said in addition to his future career ambitions, the course was also beneficial in his current duties.

“I feel the learning form the course will lead to improved patient care as I feel that having a better knowledge of access and extrication techniques will assist in coordinating with special operations and rescue providers in creating plans. It will also prepare me to potentially apply for a role within special operations or austere paramedicine in the future, and how I can best position myself to gain a role in these fields.”

And while working at heights might be daunting for some, he highly recommended the course to others who also wanted to pursue such challenges.

“It’s definitely worth giving it a go. It’s an exhilarating and fun course to learn some new skills and broaden horizons for future roles.”

The College is committed to supporting members in their educational pursuits and offers a number of education grants each year that can be used for professional development activities. If you’re interested in applying, please visit: **https://paramedics.org/education/grant**

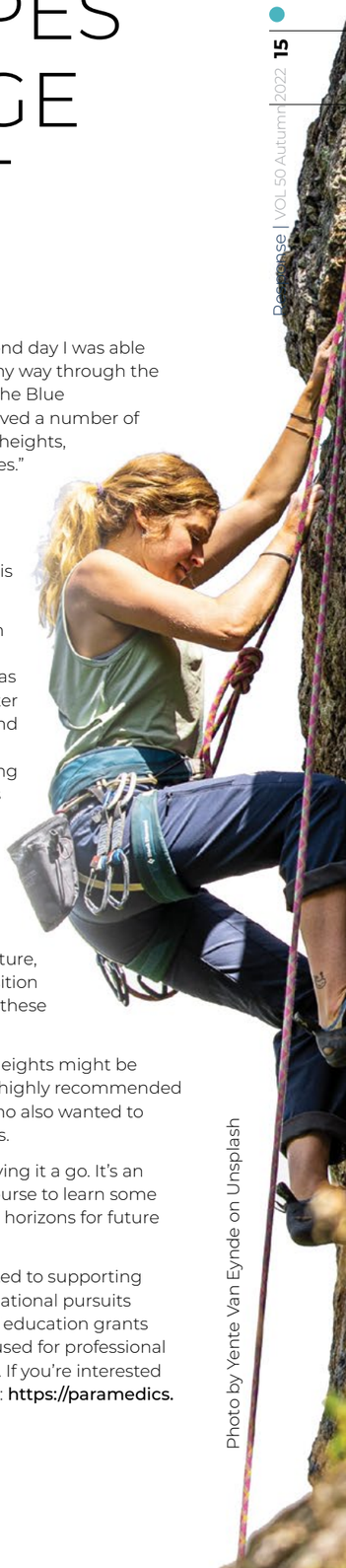


Photo by Yente Van Eynde on Unsplash

TRAUMA ON THE BORDER

2022 HIGHLIGHTS

THE BEST THING ABOUT CONFERENCES IS THAT PARAMEDICS HAVE A HUNGER FOR LEARNING, AND BECAUSE IT'S SUCH A BROAD SPECIALITY, YOU'RE ABLE TO GET A REALLY DIVERSE RANGE OF EXPERIENCES THROUGH OTHER PEOPLE PRESENTING AT THE CONFERENCE.
TASH ADAMS, CRITICAL CARE PARAMEDIC, QLD.

17 speakers

14 presentations

429 attendees

Keynote speaker McQuilty "Coco" Quirke

Held at Tweed Heads in northern NSW, the ninth Trauma on the Border conference brought together more than 400 paramedics from across Australasia for a hybrid one-day event.

The comprehensive program, delivered under the theme of "Driving professional change", offered attendees access to the latest developments in paramedic practice, current research and featured a host of speakers and presentations relevant to the priorities and needs of paramedics at all levels.

Keynote speaker McQuilty Quirke, a former medic in the Australian Army's Medical Corps, engaged attendees with his inspirational story of courage, determination and a positive mindset after battling post-traumatic stress from the physical injuries he sustained in-action while in Afghanistan. Through his extraordinary lived experiences, he shared invaluable insight and knowledge on a range of topics such as leadership, resilience, perspective, adversity, and how to develop better wellbeing and lifestyles.

Other presentations included the use of evidence-based systems to optimise trauma care, the areas of convergence between tactical combat casualty care in the military and civilian emergency services, and the knowledge and skills transfers that are shaping remote and austere emergency services response; the opportunities and challenges that are present at the intersection of paramedicine and aid and development; how streamlining medical and technical aspects of vehicle extrication through data-driven decision-making contributes to better long-term patient outcomes; and Queensland Ambulance Service's recently established clinical hub, which sees paramedics engaging in a new area of practice.

Dr Ben Meadley and QAS Critical Care Paramedic Tash Adams

Alex (Sandy) MacQuarrie and Professor Vivienne Tippett

Thank you
Thank you to the Conference Chair: Hayley Grant.

Thank you to the Conference Organising Committee: Wayne Loudon, Buck Reed, Julie Hughes, Tash Adams, and Alisha MacFarlane.

Finally, a huge thank you to Lead Event Manager Georgia Coetzee, supported by our College staff.

Thank you to our Event Partners: Zoll and Edith Cowen University.

Thank you to our Event Sponsors: Medical Developments International and Trauma and Sim.

Missed the conference?
Session recordings are available on the College website under Recordings, search the menu Trauma on the Board 2022. Recordings are free for College members: **https://paramedics.org/recordings**

EMSA 2022 CONFERENCE: THE FUTURE OF EMERGENCY AND PRE-HOSPITAL HEALTHCARE

The 2022 Emergency South Australia (EMSA) Conference will be held at the Adelaide Convention Centre from 12-13 August 2022.

Hosted by the Australasian College of Emergency Medicine, the College of Emergency Nurses Australasia and the Australasian College of Paramedicine, this bi-annual conference has been running since 2005 and is attended by more than 200 representatives from all sectors of emergency health services from the Fellowship of Australasian College for Emergency Medicine (FACEM) and paramedics, nurses and allied health professionals.

After a cancelled meeting in 2020 due to COVID-19, interest is high in the opportunity to come together for education and networking.

In 2022, the EMSA conference has three keynote speakers: Victoria Brazil (Professor of Emergency Medicine and Director of Simulation at the Gold Coast Health Service), College Fellow Alan Eade (Intensive Care Paramedic and Chief Paramedic Officer for Victoria) and Kate Curtis (Professor of Emergency and Trauma Nursing at the University of Sydney), who will bring a range of experience and knowledge to the program.

With the overarching theme "The Future of Emergency and Pre-hospital Healthcare", the program offers a mix of plenary sessions and hand-on workshops, focusing on changing demands, ways of working and technological innovations, and including such themes and topics as trauma, resuscitation, paediatrics, toxicology, end-of-life care, and caring for specific patient groups.

EMSA2022 Revived

Social highlights include a networking function on the Friday night and a highly anticipated masquerade dinner on the Saturday night.

For more information and to register, visit: **https://emergencysa.org.au**

2022 EMSA Conference Keynote Speakers Alan Eade, Kate Curtis (middle), Victoria Brazil

FEATURE

FROM THE HIGH SEAS TO THE DESERT, VARIETY IS KEY FOR CONTRACT PARAMEDIC

Aotearoa New Zealand

Intensive Care Paramedic Kasha Szewczyk's career has taken her from the desert lands of Australia's red centre to the Pacific Islands, from hinterlands to the outback, from the northern tropics to the Southern Ocean, and from exploration vessels to deep-sea and land rigs and floating production storage and offloading (FPSO) units.

Like many of her peers, she worked her way through the ranks of ambulance service, from Auckland Metro EMT to paramedic to ICP, but from the outset was drawn to working in remote areas.

"Contract work and helicopter work were always my main goals, ever since I decided to pursue a career in paramedicine. This requires a focus on remote medicine - expeditions, wilderness, tropical, extreme or hostile environments - as well as good grasp of primary care and common diseases.

"Early on I made sure to put my hand up for any remote work - rural stations at city peripheries, secondments, seasonal covers. A few years into my career I moved to Nelson, which meant a lot of rural work, long transport times, cell phone black spots. Then along came helicopters and work in the Australian outback, still in the ambulance service."

For contractors to be sure that paramedics can operate autonomously and are sufficiently skilled to handle any type of presentation with no back-up available, a range of skills sets are required for private sector and contract work, as well as defined lengths of service in paramedic practice and a number of different certifications in order to receive the requisite credentials. Kasha said it generally took two to five years of state-run/road ambulance experience to even be considered.

"I was sure to line up my ducks for when the time arrived. Then the first contract came, and it has snowballed ever since.

"Variety of experiences has always been the key for me. I have made a choice to not commit to one contract for an extended time. This has allowed me to accept a variety of contracts over the years, which has been both exciting and liberating."

She said that while there were times of "drought" and not knowing when the next job may arise, which could be "unsettling", there were also many regular ongoing contracts available for those who preferred more stability.

The nature of the work varies greatly, from clinical practice to health and safety, coaching and administrative tasks, and requires flexibility and ingenuity. At times, there is access to a fully equipped hospital; other times "it is you, your skills and a minimal pack with bare essentials in the middle of an austere environment, hundreds of miles away from any human settlement - these are the most exciting jobs for me".

For most of her career in contract paramedicine, she has worked as the sole paramedic, although this is dependent on the size of the crews. There can be one medic looking after a 120-strong crew or four medics on day and night shifts on large facilities like the Prelude FPSO, where there are more than 500 people on board, or anything in between.

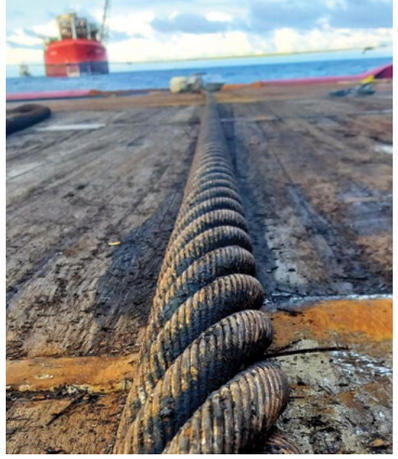
Regular rotations in the oil and gas industry range from two and four weeks on and an even amount of time off. However, Kasha has tended to gravitate towards longer contracts.

"My ship contracts have been around six to seven weeks; my outback contracts were three to four weeks. The longest one was 18 months in the Solomon Islands, with a few breaks, when I was a 'resident medic' for a development mission."

She said prevention was the focus in offshore/remote work, together with early detection and management of symptoms.

"Avoidance of escalation of any condition/illness is the key. Therefore, primary care, health promotion, sleep hygiene and fatigue management, hydration education, manual handling, and occupational health and safety are paramount.

"Mental health is also a big part of the job - long hours of work, isolation, separation from family or support networks, sometimes medication compliance issues for known disorders – all contribute to vulnerabilities. We are there to make sure we pick up on the early warning signs in time. And then of course there are incidents, and this can be just about anything, just like in regular ambulance service - trips, slips, falls, tool mishaps. Hand injuries are probably the main type of presentation."



> IT'S A GREAT LIFESTYLE, BUT NOT FOR EVERYBODY, AND THAT'S THE BEAUTIFUL THING ABOUT IT

Working in such environments builds camaraderie. "The crew often spends long workdays and weeks together. This creates a very special bond. The industry is huge, but somehow people's paths cross time and time again. When this happens, it feels like coming home. The friendships last forever."

For paramedics wanting to embark on a similar career pathway, Kasha said it was important to consolidate skills, training and experience, and to attain the necessary certifications. Ultimately though, word of mouth was the most powerful hiring tool - "If you're good, people will hear about you".

"There are many hoops to jump through to get to do offshore/remote/contract work, including certifications, training and experience. Line it up, have it ready for when the time comes. And be adaptable - the notice may be short, the contract may be longer than anticipated, you may not have your regular creature comforts and your routine - this is how this business works.

"It's a great lifestyle, but not for everybody, and that's the beautiful thing about it."

FIRST PARAMEDIC PRIVATE PRACTICE MODEL IN WA

WA's first paramedic private practice model benefits patients, staff and the health system.

Perth, Whadjuk Nyoongar Country

It was a tongue-in-cheek question that led paramedic Alecka Miles to begin working alongside doctors and nurses at Dianella Family Medical Centre in Western Australia - the only private health clinic in the state to employ a paramedic in such a capacity.

Alecka Miles
Paramedic

Following paramedic registration in Australia in 2018, the Dean of the School of Paramedicine at Edith Cowan University, where Alecka works as a community paramedicine postgraduate course coordinator, was jokingly asked if paramedics would now be able to work in GP clinics, such as they were in the UK.

The Dean, who is a GP and has worked with paramedics for more than a decade and understands their unique skill sets, replied, "That's a really good question. Let me speak to the practice manager at Dianella." A year later, Alecka was spending one day a week in clinical practice at the clinic.

"I was doing a benchmarking project with my postgraduate course at the time and looking at how paramedics were working in different areas," Alecka said. "I wanted to go into a GP practice and see how we could fit. So as part of that benchmarking, we organised a meeting with Dianella Practice Manager Julie Stojcevski, and she agreed to let me come in for a couple of weeks and work alongside the nurses and GPs and see what value we could add and what sort of things they do, and how paramedics might fit. At the end of that meeting, I was offered a job.

"It's the most amazing team, with so many forward-thinking practitioners, and it's a very multidisciplinary team. We've got GPs, practice nurses, a diabetes educator, a podiatrist and a physiotherapist, as well as a pharmacist next door. It's a phenomenal environment to work in."

Julie said it was a case of "thinking outside of the box". The clinic was looking at the ways in which quality improvements could be made, and how paramedics could be incorporated in the practice to provide support, particularly within the sphere of urgent care.

"We came up with this model, which we thought would be very beneficial because the paramedic would be able to work closely with the doctors, and at the same time we would also have quality improvement in urgent care to take the pressure off the hospitals. And it's a wonderful model, and we're able to demonstrate the different roles that paramedics are playing, and how this is benefiting the health system and healthcare delivery."

Alecka is skilled to tackle most emergencies including suturing shown here.

Dianella Family Medical Centre in Perth

It was a seamless integration, with the different practitioners aware of each other's strengths and the complementary nature of the different strands of professional practice. And for Alecka, staff are always available to guide her if she needs assistance or has questions relating to areas in which she is unfamiliar.

"We know each other's strengths and weaknesses. There's no judgement if there's something that you're not feeling confident about. Everybody is comfortable in their area of expertise; everybody is comfortable that there is an overlap in some of our skills and expertise. And egos are parked. We will often work as a team to ask questions and get a get a history," Alecka said.

> The skill set, the experience, and the knowledge that the practice as a whole has gained from having Alecka as a paramedic has been amazing

When she first joined Dianella, her work was predominantly focused on preventative health care home visits for the over-75 population, listening to their histories, assessing the safety of their home environments, and making recommendations for support services if needed, such as fall safety education and nutritional guidance, that are then fed back to the GPs. She later began to work in the clinic on patient health care planning and talking with patients about issues such as weight loss and the prevention of cardiovascular disease.

Recognising that her skills were also well suited for the treatment room, Julie expanded her role to cover hands-on patient treatment, including administering vaccinations, wound care and closures and suturing, and assisting with other skin procedures such as biopsies.

"That's been a new skill and it's frightening but also exciting. I feel like a student again, but I'm very lucky to have a great mentor who's a skin specialist and he's been wonderfully patient. I'm so grateful for what I'm learning from him."

Triage is also another important component of her work, with most walk-ins presenting after falls that result in wounds or fractures, as well as chest pains and myocardial infarctions. Julie said she was a multi-talented clinician who also did CPR training at the clinic and emergency trolley training with staff.

"She's an all-rounder in the treatment room. Emergencies are usually thrown her way because she's the most capable of doing that. She's established an excellent rapport with a lot of our patients, a lot of whom come in and say, 'I'm just here to see Alecka, she's going to do my wound', so she's very actively involved in our practice.

"The best part of having a paramedic here is her urgent care skills. Our patients call up, and if Alecka's in here she'll get on the phone and make an initial assessment, and if she feels there is a need, she'll say, 'Okay, I need you to come in straight away'. By the time the patient has come in, she's already liaised with the doctor, and we've got a plan in place. That whole emergency response for our patients - we never had that, so having that here now has definitely increased the flow of emergencies coming into our practice and eased the pressure on ambulances and the health system.

"It's the best thing that's happened to us. The skill set, the experience, and the knowledge that the practice as a whole has gained from having Alecka as a paramedic has been amazing. And moving forward, I would always ensure that we had a paramedic as part of our team."

THE SKY'S THE LIMIT FOR CRITICAL CARE FLIGHT PARAMEDIC

Aotearoa New Zealand

From her first shift on an ambulance, Felicity Lallier yearned to work as a flight medic. Her desire didn't wane throughout the years as she progressed through the ranks and progressively completed both undergraduate and postgraduate paramedicine degrees.

At the time, opportunities were limited, and her geographical location hindered her ability to apply for those that did appear. That changed three years ago when Search and Rescue Services Ltd, which operates air rescue and emergency helicopters in the central North Island, began independently employing their own paramedics instead of relying on road-based medics.

"I jumped at that, and I've been on board ever since as a Critical Care Flight Paramedic based first in Palmerston North and now in Tauranga," she said.

Her two-week induction training included hover-loading, day and night winch training, and using equipment under the helicopter in the wind. Initially it was a big learning curve. Going into the job, her assumption had been that the work would be the same as her ambulance duties, just in a different vehicle. She quickly learned that wasn't the case given the challenges of the flight settings, assessment procedures, and the often difficult terrain in which they operate.

"In terms of clinical differences, it's a very, very confined space. You can't hear anything, so I can't listen to lung sounds and it's often very difficult to talk to patients. So basically, all my assessment and most of my treatment has to be done prior to transport. That's different.

"We're quite often very rural, and sometimes there are no resources at all and often no cell phone reception, so we rely on satellite phone communication. There are also a lot of aviation factors that really increase the cognitive load - clouds, altitude, fuel, difficult terrain, rocks, cliffs, trees, rivers, steep banks. You find yourself in a lot of odd places, and sometimes it's just a matter of scooping up the patient and getting them out of there safely and doing treatment later."

Her time on the road in ambulance service provided a good grounding for her move into flight paramedic practice, teaching her to stay calm and slowly go through a process. Flying into an emergency situation, she's able to think about what is likely to be required and the clinical aspects of the airlift and treatment. She then closely works with her flight crew - a pilot and a crewman - on what needs to be done. On her shift, the crewman is also either a paramedic

IT'S A VERY CLOSE WORKING RELATIONSHIP WITH THE PILOT AND THE CREWMAN... WE REALLY DEPEND ON EACH OTHER TO EACH DO OUR JOBS THE BEST WE CAN

or EMT-qualified, but all have some degree of medical training.

"I always have the mentality that two heads are better than one, so I want to have the crewman involved as much as possible and helping.

"It's a very close working relationship with the pilot and the crew. We each have our separate roles, but to achieve a common goal, we really depend on each other to each do our jobs the best we can. The pilot is going to try and get me as close to the patient as possible, and they are thinking about the best and safest way to do that, so it's a very different environment than in an ambulance where the patient's presented to you in a different way."

The team also works closely with road-based ambulance colleagues, who are often at the same callout, and values their collaborative relationship.

"I try to get the most out of the resources that we have at each scene. It's about a team. Sometimes I can bring something to the party and sometimes I don't really add much value. It's really about working together."

The flight crews work 12-hour shifts - two days, two nights, and four days off - and generally only deal with the most acute patients in a broad geographical range that covers coastal areas and islands, rural and remote communities, rivers, mountains and bush, the latter attracting campers and hikers who are prone to injuries from falls. A lot of their callouts are for road accidents and all-terrain vehicle rollovers in isolated areas that an ambulance may take hours to reach when time is critical in transporting patients to hospitals.

"I love being in the bush. I'm a very outdoorsy type, so I feel quite comfortable in that environment, and I don't seem to mind the heights. I don't mind those sort of austere environments, but it adds another layer of complexity."

About half of their time is spent transferring patients to different hospitals, such as moving a patient from a smaller hospital to an ICU in a larger facility. Learning about the types of drugs to use for emergency transfers and how to administer infusions has been another learning curve.

"Hospital transfers are currently about half our work. COVID changed things a bit, and we were down on our primary work. Now that the lockdowns are over, we're back to doing more primary work, but we're certainly still shuffling people from hospital to hospital."

"It's absolutely fascinating work. I feel very lucky that I get to do this, and I'm very grateful that I get to be of service to people. That's a great reward for me. It's really amazing."

CALL OF DUTY FOR TRAILBLAZING TELE-TRIAGE PARAMEDIC

Aotearoa New Zealand

In 2019, after 15 years as a paramedic with St John New Zealand, the last eight as an Intensive Care Paramedic, Jo Wilson was looking for a change of direction in her career. With few opportunities for paramedics beyond the ambulance service, she was excited to stumble across an advertisement online seeking tele-triage paramedics to work with Whakarongorau Aotearoa/New Zealand Telehealth Services.

A month later, she joined their first intake of paramedics, where she is now People Leader for Health Services. Whakarongorau Aotearoa runs Healthline, a 24/7 health advice phone line. It is a government-funded national telehealth service and is currently the only such service in the country to employ full-time paramedics around-the-clock in such a capacity. With paramedic registration imminent, Whakarongorau management recognised paramedics' unique subset of triage skills and the role they could play in tele-triage. Callers are now attended to by both registered nurses and registered paramedics.

"I started off as a tele-triage paramedic in 2019 and worked in that capacity until the end of last year," she said. "I moved into a management role and now look after a team of tele-triage nurses and paramedics, which is super exciting because it shows that there's progression and it enables me to help other paramedics progress within the organisation as well."

Jo said when people called Healthline, the paramedics are part of teams who undertake an initial assessment, provide medical advice and develop a plan of action, including how to manage their symptoms at home and determining if they needed to see a GP. They also help them to access out-of-hours GP coverage in rural Aotearoa New Zealand, doing primary triage over the phone to decide if an on-call doctor in that area needed to be called and helping to organise follow-up

care for the patient. For those living in isolated parts of the country who don't have access to a doctor, the team liaises with on-call nurse practitioners, doing patient handovers and having clinical discussions about cases.

Whakarongorau Aotearoa has also been at the forefront of the national COVID-19 response. When the pandemic surged in March 2020, a designated COVID Healthline was set up to provide specific COVID health advice and support, and to ensure the general Healthline service was still able to meet non-COVID demand. Jo said that during media updates from the Prime Minister, the Minister of Health and the Director General of Health, their advice had been to contact Healthline. "So essentially, we've been driving the response, which has been amazing to be part of."

Jo said the integration of paramedics into tele-triage had been smooth and was supported by nurses, who themselves had a wide variety of nursing backgrounds.

Whakarongorau Aotearoa// New Zealand Telehealth Services//

"When people come into the role, I think everyone just recognises that we all have quite different sort of backgrounds and skill sets, and together we bring this huge breadth of experience and information and knowledge to our work."

However, stepping into the pre-hospital medicines sphere, taking calls related to such issues as primary care and chronic illness, was not without challenges.

"I certainly had lots of questions when I first started, even as an Intensive Care Paramedic. There were definitely gaps in my knowledge, but I had fantastic support from the nurses around me and the senior nurses on the shift who were supervising at the time to sort of help me through it.

"Most days, particularly in the first six months, there would be something that I'd never heard of before, that I'd have to look up, or didn't have experience with while in the ambulance service, things that we wouldn't necessarily see, so I found them super helpful and supportive when there were things I wasn't sure about."

There were also challenges with navigating computer systems and software, and technology that isn't used in an ambulance, and in learning a new skill set that involved digitally managing patients and learning how to give advice and assist people over the phone.

"Paramedics are such tactile, practical people. You rely on what you can see and hear and feel and smell when you walk into a scene. When you're assessing someone over the phone, you've literally got your voice and your ears and that's it. And so being able to reach down the phone and physically figure out how you can assist someone accurately with just those two things has been a huge increase in skills for me.

"It's definitely increased my assessment skills considerably. I think if I was to go and work in an ambulance again now, I'd notice a huge improvement in my history-taking and assessment skills. The learning has been huge. It's been amazing."

The majority of Whakarongorau Aotearoa's Healthline staff work from homes across the country, "so we've got a workforce spread from the tip of the North Island right down to the bottom of the South Island".

"We've now got 43 registered paramedics working for us across the country in various roles, predominantly working on the phones doing tele-triage, as well as myself and two other paramedics who are now in management roles as well."

Registered paramedics with frontline experience who join Whakarongorau Aotearoa undertake a two-week induction to familiarise themselves with the systems, software and digital triage tools before spending a week in a contact centre in either Wellington, Auckland or Christchurch under supervision. They're then able to take live calls with, if needed, support from the People Leader and the Clinical Lead who oversee shifts for the whole country.

In addition to registered paramedics, Whakarongorau Aotearoa is also developing a new graduate program for paramedicine students and has already taken student placements. The initiative began in 2020 in response to the COVID-19 challenges St John Ambulance was facing in placing students in ambulances. Whakarongorau Aotearoa took on up to 30 students in its Auckland call centre and worked with them on developing their diagnostic assessment skills as tele-triage paramedics.

"I was part of setting up the paramedic student placement program. The students did well and found it to be a really important part of their learning. They have all found that their patient assessment skills have considerably improved because they've had some autonomy, with supervision, in assisting patients with the backup of our triage tools and good supervision from experienced paramedics and nurses.

OUR REGISTRATION IN 2021 HAS DEFINITELY OPENED DOORS FOR LOTS OF PEOPLE TO DO SOMETHING OUTSIDE AN AMBULANCE

"They received significantly more exposure than they'd get in an ambulance shift, which they thought was valuable. That was fed back to their lecturers, and it's essentially become part of the training now. As part of that, we've seen that, actually, there's a place for graduate paramedics with us, and so we're in the midst of designing a graduate paramedic program."

It marks another step forward for paramedics and the paramedicine profession as a whole in Aotearoa New Zealand, offering potential new career pathways and employment opportunities.

"Our registration in 2021 has definitely opened doors for lots of people to do something outside an ambulance."

FEATURE

THE GROWING IMPORTANCE OF NON-TRADITIONAL PARAMEDICINE

By Lance Gray – Registered Paramedic and Nurse
Lecturer Paramedicine, Australian Catholic University Manager Clinical Education, Ambulance Service Australia
Canberra, Ngunnawal Country

The rumble of the engines builds. Roaring crowds clamour at the edge of the racetrack in anticipation. Then the five red lights appear, one by one. Thunderous engines drown out the audience as the cars take off at lightning speed, and in quick pursuit me and my crewmate. We take the chase car around Turn One at 130km/h. Eyes engaged, looking ahead, then left, then right. All clear. We pass turns Two and Three without flinching. The radio clicks and a voice alerts us: "Victor One, a car is off on Turn Four and into the wall."

Okay. It's go time.

I'm already planning as my crewmate presses their foot down. We arrive to find a state-of-the-art race car against a concrete wall. I know I have 90 seconds to assess the driver, my patient, and make a decision about how best to manage them before the other cars approach on their second lap. This is the high-speed, high-adrenaline world of motorsport medicine.

This is just one of the many growing areas in "non-traditional paramedicine". This unique world sees paramedicine not conducted in the standard setting of a state or territory ambulance service, but in a multitude of different and challenging environments, from racetracks to mines, oil rigs, theme parks, hotels, casinos, rural medical centres, small and large-scale festivals, and the list goes on.

These vast and fascinating settings have traditionally been managed by first aid organisations. While this was a suitable solution in years gone by, the need for specialist paramedicine companies has increased with governments and companies seeing higher risk associated with sites and events like these, necessitating more advanced clinical assessment, knowledge and skills to ensure that the most appropriate care and management are provided to those seeking help.

Work conducted by Dr Jamie Ranse of the Mass Gathering Collaboration shows that large-scale events can impact on local health services, mainly through an increase in ED presentations and ambulance callouts. Dr Ranse's work also shows that having healthcare professionals present at these events can help reduce these impacts. This is paired with the year-on-year increases in demand that both state and territory ambulance services are facing, and the overcrowding of hospital emergency departments and commensurate issues of ambulance ramping and access block.

These system pressures have been building since well before the COVID-19 pandemic, which has pushed the health system to the brink. More thought is needed on how to better manage these pressures to ensure appropriate patient care and safety. With this in mind, now more than ever it's time for paramedics to be better integrated into the healthcare system with their skill in, and extensive knowledge of, assessing and treating patients in different environments.

For example, when working at a medium to large-scale event, Ambulance Service Australia's on-site medical centre will typically see between 60 to 100 patients across three days, with a referral rate of less than 10% to acute health services. We span the spectrum of professional practice, from Ambulance Paramedics to Advanced Care Paramedics, Intensive Care Paramedics and Extended Care Paramedics. We're able to provide acute wound management dressing, gluing, and suturing with appropriate follow-up, as well as:

- Simple medication management and referrals to pharmacies or local GP clinics if needed
- Acute dehydration management by providing time for the patient to stay with us and be monitored for hours and given medication/fluids as needed
- Simple fracture management and referral
- Mental health support
- Dealing with acute trauma patients requiring expert assessment and only referring those patients that have an acute need for hospital assessment.

Most of these presentations take time to assess, treat, wait and see - time that state and territory ambulance services often don't have at their disposal. With regular exposure to these types of environment and presentations, our paramedics are able to expertly handle these situations, saving ambulance services time and effort, and possibly hospital presentations. This is just one area in which paramedics can have a large impact and support the broader health care system and reduce the ongoing pressure they face.

Paramedics are in an ideal position to provide this kind of assessment and referral or discharge. Nowadays, paramedics are degree-educated health care practitioners undertaking up to four years of university training and clinical placements. Universities have recognised the need to diversify clinical placements for paramedic students and are now providing paramedicine students with placements outside of ambulance services, from maternity wards to mental health units, hospital emergency departments and other settings. This training provides paramedics with a wider knowledge of the health care system and the know-how to manage everything from acute care to minor injuries and illnesses in a non-traditional setting while also building their experience in working as a part of multidisciplinary teams.

Nevertheless, most of what makes paramedics so well suited to these different environments is situational awareness and adaptability to challenging, ever-changing environments. This level of training and knowledge is just the start for paramedics in non-traditional settings, and the examples I have given so far are still in the pre-hospital environment.

If we look at our colleagues in the United Kingdom, we see a picture of how paramedics can be better utilised in the healthcare system other than just seeing patients in the pre-hospital setting. They can be used in GP clinics to work up patients with primary care health issues and do home visits for health assessments. They can be used In EDs and ICUs as advanced clinical practitioners working up patients with acute and chronic conditions, ordering imaging, blood tests and procedures, and then interpreting them as part of a multidisciplinary team. They can work as part of in-hospital critical care outreach teams responding to medical emergencies. They can undertake medication-prescribing courses to become registered prescribers.

These roles will benefit the Australian healthcare system, particularly as nurse and doctor shortages become more frequent, notably in regional and remote parts of the country. We have a large, highly trained, capable workforce that can be integrated into the system to ensure that patients have timely access to high-quality healthcare.

Now is the time for the Australian healthcare system to move away from paramedics just picking up and transporting patients to hospitals and to recognise their importance in non-traditional ambulance settings and start to open up more roles for them in other health care settings. This is not about paramedics taking on other health care profession roles; it's about utilising them to build multidisciplinary healthcare teams focused on providing the right care at the right time and in the right location.

AMBULANCE DELAYS: "MORE PARAMEDICS" NOT THE SOLUTION

By Sophie Dyson
Sophie is a registered paramedic and qualified actuary who has been using data to make evidence-based change in the Australian health system for more than 20 years

While I was working as a paramedic in Sydney in March, a man pulled up next to our parked ambulance and asked, if he went home and called Triple Zero, could an ambulance take him to a particular hospital his doctor had instructed him to go to. I wondered why he couldn't simply continue driving to his destination. He explained he wanted to call an ambulance because parking at the hospital was difficult.

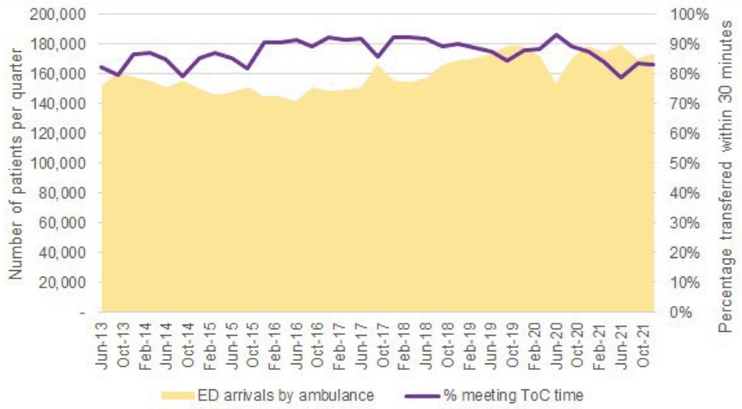
At a time when demand for ambulances is at an all-time high, this behaviour is frustrating. Ambulance ramping was a central issue to the recent Labor Party victory in South Australia, but ambulance workload and response performance is a perennial story that pre-dates the pandemic. Paramedics unable to respond to emergencies because they're waiting at hospital, or callers unable to get through to Triple Zero operators because of high demand, are visible and emotive indicators that something is wrong. Increasing ambulance capacity is only a short-term fix. Ambulance services are an integral part of the health system, and a system approach is needed to find a solution.

Ramping - a system problem

Ambulance "ramping" refers to paramedics being delayed in handing over care of their patients to the emergency department (ED). On arrival at ED, paramedics take patients into the ambulance bay to be triaged by the ED nurse. If there is no ED bed or treatment chair available and the patient cannot safely be transferred to the waiting room, paramedics must wait with their patient, making them unavailable to respond to other emergencies. The consequent reduction in ambulance response capacity lengthens response times.

Target times for transfer of care (ToC) from paramedics to EDs vary between states. In NSW, the target is 90% within 30 minutes , but during busy periods, ToC times can extend to several hours. As you would expect, as ED workloads rise, the proportion of patients transferred from paramedic to ED care within the target ToC time falls. The following graph shows the number of patients brought to EDs in NSW by ambulance between 2013 and 2021 compared with the proportion of patients meeting the ToC target.

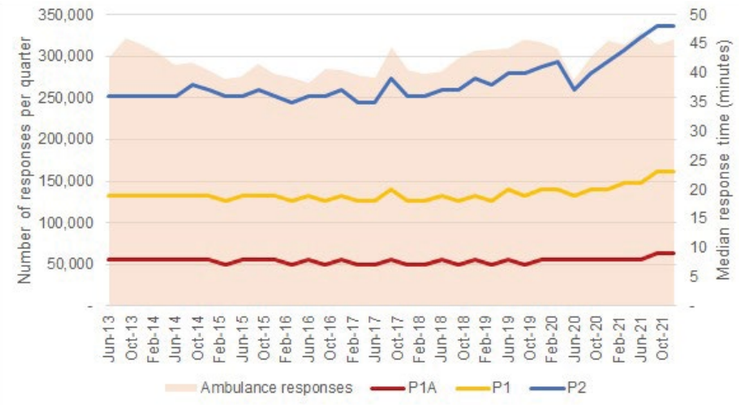
Figure 1: Ambulance arrivals per quarter vs proportion of patients meeting ToC target (NSW)



The relationship between ambulance workload and response performance is also clear. Each state determines its own response priorities; in NSW, the most urgent category is Priority 1A (P1A), all Priority 1 (P1) incidents get a lights and sirens response, and Priority 2 (P2) represents lower urgency incidents. The deterioration in response performance as ambulance workload increases is seen most dramatically in P2 median response times, as the ability to reassign vehicles to higher priority incidents has a protective effect on P1 and P1A response performance.

AMBULANCE SERVICES ARE AN INTEGRAL PART OF THE HEALTH SYSTEM, AND A SYSTEM APPROACH IS NEEDED TO FIND A SOLUTION

Figure 2: Ambulance responses per quarter vs response times by priority (NSW)



Why is this a system problem? There are almost nine million presentations a year to Australian EDs . Paramedics are delayed transferring patients from ambulance to ED because EDs are full, from the 25% of patients brought in by ambulance and the 75% who arrive by other means . EDs can't free up beds until patients are treated and discharged from ED, or transferred to a hospital ward (Australia-wide, just over 30% of ED presentations are admitted to hospital). The barrier to transferring patients from ED to wards is that the wards are full, and the barriers to discharging patients from wards include waiting for aged care or disability services, or patient transport. Downstream capacity and patient flow are the system issues here.

Financial incentives and convenience – looking behind the issue

System interrelationships exist on the demand side, too, with evidence of overlapping needs in demand for ambulances, ED treatment and the 38,000 GPs providing primary care in the community. Government data shows that across all Australian jurisdictions, ambulance services responded to three million Triple Zero incidents in 2020-21, of which 50% did not require an emergency (lights and sirens) response and 25% of patients were able to be treated and left at home, referred to their GP or another healthcare provider. In EDs, one-third of patients were deemed "potentially avoidable GP-type presentations" .

Care substitution between GPs, ED and ambulance is driven by financial incentives and convenience. For example, although ambulance services are not funded by Medicare, for most patients - those with pension cards, private health insurance or an ambulance membership - ambulance care is free at the point of care and there are no financial consequences for calling Triple Zero. The cost, almost $1,100 per incident, falls largely on state governments. For low-acuity incidents, that's a lot to pay for reassurance and a couple of paracetamol. If patients make their own way to ED for a health issue that does not result in admission, the average cost of an ED presentation nationwide, funded by Australian and state government is $616 .

Ambulance services recognise the issue of ambulance/ED/primary care substitution and the market failure that this represents. Several services have developed initiatives to address the high cost of dispatching an ambulance to low-acuity calls, while at the same time providing more clinically appropriate care - these initiatives include virtual care programs that provide telephone advice and referrals to other providers. The cost of providing virtual care, even with an ultimate referral to a private medical provider, is less than half that of sending an ambulance. Heightened demand during COVID-19 has resulted in an expansion of these services. From an ambulance perspective, they demonstrate an entirely rational response. However, from a whole-of-system perspective, the cost to government is still several multiples of what would be paid via Medicare for a telehealth consultation with a GP.

Where can we look for a solution?

The pandemic has been a time of innovation in healthcare delivery. Telehealth, originally introduced to support service provision in rural areas, has become the default method for talking to our family doctor. Smartphone apps record COVID-19 patients' vital signs and detect early indicators of deterioration. Algorithms predict the COVID-19 patients most at risk of hospitalisation and target patient monitoring resources more effectively.

With light at the end of the COVID-19 tunnel, we need to sustain the spirit of innovation and action to develop longer-term solutions to extended ambulance ToC and response times (and other health-system problems while we're at it). To do this, both demand and supply issues need to be tackled, as well as improving patient flow and care coordination. Australia's health system delivers an enviable level of care, but overlapping state and Commonwealth responsibilities have always created opportunities for blame - and cost-shifting. The rapid introduction of certain COVID-19 initiatives has exacerbated this situation, with similar services accessible through different pathways and a blurring of health-service responsibilities.

Navigating the path towards a comprehensive approach

When developing future solutions, we need to remove duplication and substitution, consider solutions through a whole-of-system lens rather than from the perspective of a single provider, and recognise the financial and other incentives that drive healthcare demand and supply.

Back to the driver who wanted to call Triple Zero to overcome the inconvenience of parking. Consider the financial impact of lost revenue if hospital parking for ED attendances was subsidised, compared with the savings from reducing the unnecessary dispatch of ambulances. How could these savings be applied to expand service delivery and provide more appropriate clinical care?

Next time ambulance ramping is in the news, don't think "we need more paramedics" (though that's always a welcome thought), think "we need to capitalise on COVID-19 ingenuity, develop sustainable solutions addressing both demand and supply, and take a whole-of-system view that recognises financial and other incentives". Even though it doesn't make a catchy soundbite.

This article was originally published in Actuaries Digital. It was written for a non-paramedic audience, hence the use of the term "ramping" and an explanation of what happens when paramedics take patients to EDs.

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PROFESSIONAL PRACTICE

Photo by Ahmed Zayan on Unsplash

IMPROVING THE CULTURE OF LEADERSHIP IN PARAMEDICINE

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Good leadership can be hard to define. There are as many theories as there are opinions about what it is. It's hard because it's more art than science, more about feelings than facts. But that does not diminish its importance in the environments in which we work.

Ambulance services are the ultimate people organisations. They are made up of people who are there simply to look after other people. Perhaps you don't work for an ambulance service. The advice in this article certainly also applies to you. Whether it's academia, mining, or any other role you undertake as a paramedic, chances are you're there to look after people or help others who intend to do so.

You will know if you work with a bad leader, and it's just as likely that it will be a topic of discussion in the workplace. It could even be a reason why some good people leave the service they work for. It could certainly contribute to some fairly poor morale for those who choose to stay. But good leaders make our roles great. They inspire us to give our best to our patients and to challenge ourselves clinically and professionally. They make showing up for long shifts worthwhile, and they can make a challenging environment enjoyable to work in.

The cultural shift in ambulance services, with changing demographics and a younger cohort arriving with undergraduate paramedic education, requires those in senior roles to look around the room at who will become our future leaders. Our future leaders will be those who choose the responsibility of leadership. They will be people who understand the changing needs of a younger workforce who may view their careers as being more fluid, or even temporary, than the generation before.

Employee retention is not the same as it was five years ago. Geographical boundaries seem less imposing and extended periods out of the workplace to try new directions is commonplace. We will need people who can intuitively speak a language that new generations understand, and connect with clinicians who grew up entirely in the internet age, where information has been comparatively easy to come by.

GOOD LEADERS INSPIRE US TO GIVE OUR BEST TO OUR PATIENTS AND TO CHALLENGE OURSELVES CLINICALLY AND PROFESSIONALLY

Leadership is a choice

If you're considering choosing to become a leader, I encourage you to do so. There will always be a need for new people to step up and take on leadership positions. You might think you're not ready, but the chances are you will never feel ready. It won't be until you test yourself that you'll know what you're capable of.

All you need to do is gradually increase your sphere of influence. Start where you are, in your own ambulance perhaps. Be a leader every day. Look after those around you - advocate for them. Then perhaps manage a small station, then a bigger one. Over time you'll learn your weaknesses, and then work on them. Become a follower of good leaders. Always challenge yourself. Leadership can be learnt, so learn it. Practice it. Become good at it.

It's also okay to choose not to be a leader. That's fine. It's not in everyone's wheelhouse to take on a leadership role. If you want to be the best paramedic you can be and provide top-level care to people in your community, do exactly that. You'll be admired for the care you provide and the person you are.

Our future leaders may be in the wings right now, but when they're ready they will need to choose the responsibility of taking care of those around them. While it is easy to view rank and leadership as being synonymous, there is a strong argument against this view. We have leaders today who choose to work as part of ambulance crews; leaders who have chosen clinical leadership through postgraduate education and being in senior paramedic roles where they spend their days helping other paramedics provide a higher level of care to their patients.

Some leaders have chosen a management stream and through the rank structure of their organisation can impact on the daily lives and working conditions of those around them. But having the rank does not mean you've chosen to be a leader. It's possible for a person to hold a rank and have authority yet fail to choose leadership as a personal responsibility. And it's specifically a personal responsibility because we deal with people. And the leader is a person. It's not something you switch on at the start of a shift. It has to be who you are and how you think.

Develop an environment of trust

Paul Zak, in his article "The Neuroscience of Trust", provides some startling figures for organisations where trust is high:

- 74% less stress
- 106% more energy at work
- 50% higher productivity
- 13% fewer sick days
- 76% more engagement[1]
- 29% more satisfaction with life
- 40% less burnout.

As a leader, your job is to build this trust. Paul Zak describes the key behaviours that leaders engage in to achieve trust, and each of them can be learnt and implemented in the paramedicine environment.

A good exercise is to analyse your own behaviours in the workplace and consciously ask yourself whether others would trust you to lead them. Do you model the behaviours you admire in those you look towards as exemplars of good leadership? If your team know that you prioritise their health, growth and happiness as their leader, you are well on your way to achieving your goals.

Simon Sinek puts it very simply as: "Leadership is accepting the responsibility to take care of the people around us". If the people you lead believe you have their interests at heart, you're on the right track. With the goodwill you generate by being authentically interested in others, you will then be able to encourage them to strive towards your organisational mission. It's never the other way around. People first, performance second.

More resources:

Zak, P, 2017, 'The Neuroscience of Trust", Harvard Business Review, January-February, **https://hbr.org/2017/01/the-neuroscience-of-trust**

Sinek, S, 2014, 'Why good leaders make you feel safe', TED, **https://www.youtube.com/watch?v=lmyZMtPVodo**

Anderton, P, 2016, 'Great leadership comes down to only two rules', TEDx-Derby, **https://www.youtube.com/watch?v=oDsMlmfLjd4**

[1] Engagement being defined by Paul Zak as having a strong connection to work and colleagues, feeling like a contributor, and having ample learning opportunities

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INSIGHT INTO **INAPPROPRIATE INTERNAL DEFIBRILLATION** IN THE PRE-HOSPITAL SETTING

Introduction

Paramedics frequently encounter patients with cardiac implantable electrical devices (CIEDs). Approximately 20,000 are implanted every year in Australia, with roughly one-quarter including the capacity to internally defibrillate the recipient.[1] An automated implantable cardioverter-defibrillator (AICD) is a complex device that incorporates a range of algorithms and electrical analysis features to discriminate between shockable and non-shockable rhythms. These include transvenous (leads inserted via vascular access) and subcutaneous (leads and device sit outside the thoracic cavity) devices. As with any electrical device, there can be associated issues.[2] This piece examines the occurrence of inappropriate internal defibrillation of a patient with an AICD in the setting of atrial fibrillation with rapid ventricular conduction while in the care of paramedics.

Situation

The patient was a 72-year-old male with an AICD implanted three years previously for protection against SCA after a LCx AMI. Given the PHx of chronic atrial fibrillation, his device incorporated a single transvenous lead with a capacity to pace and sense, along with a single defibrillation coil. An ambulance had been called due to him experiencing repeated shocks from his implanted device in the past 10 minutes. He was seated on arrival, alert and distressed with a concerned wife in attendance. He stated that he had felt three shocks in the past 20 minutes through his AICD despite being asymptomatic. His assessment is tabulated below.

Perfusion Status: HR 178/min and irregular, BP 142/68, skin slightly warm, pink and dry, GCS 15.

Respiratory Status: RR 18/min, air entry to bases on auscultation with basal bilateral fine crackles, no accessory muscle usage and Sats 96% on room air.

ECG showed atrial fibrillation with rapid ventricular response averaging 180/min with left bundle branch block (LBBB) pattern on 12 lead (see image 1). There was no complaint of chest pain/tightness.

Medication was low dose Metoprolol, Apixaban, Furosemide 40mg and Candesartan.

During loading, the patient noted a sudden and severe jolt while sitting still. He stated that his device had just “gone off”. The ECG was examined and a clipped high amplitude signal was noted that correlated with the jolt and resumption of rapid atrial fibrillation (see image 2). His heart rate at the time of the shock was noted to be approximately 190/min.

What is occurring?

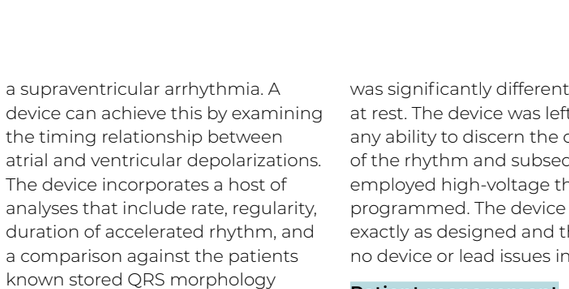
The patient is experiencing what is referred to as inappropriate shocks. The device has begun assessing a tachycardic rhythm in the first instance due to its rate exceeding the cut off, which for this patient is a single short duration VF zone of 180/min. The device will begin charging and deliver high-voltage therapy if the rhythm is confirmed and then exceeds a programmed variable amount. For this patient, it was 2.5 seconds’ duration. The implanted system only had a single lead; hence, rhythm interpretation can only be performed from the ventricle. In a device that also incorporates an atrial lead, analysis of the relationship between atrial and ventricular depolarizations can occur, which may allow the device to withhold therapy by identifying a supraventricular arrhythmia. A device can achieve this by examining the timing relationship between atrial and ventricular depolarizations. The device incorporates a host of analyses that include rate, regularity, duration of accelerated rhythm, and a comparison against the patients known stored QRS morphology at rest.

In this circumstance, the rate was satisfied, the rhythm was deemed regular given its high rate and that the morphology did not match the stored template due to rate related abberancy. The stored template of normal QRS morphology is used as a comparison against presenting rhythm prior to delivery of high-voltage therapy. The algorithm varies among manufacturers, but the principle is the same. There are multiple points on the stored electrogram template that are compared against the tachyarrhythmic QRS. Normal ventricular depolarisation via the His-Purkinje conduction system is markedly different to the cell-to-cell pattern seen in VT/VF. In this circumstance, the morphologic pattern of the supraventricular arrhythmia showed rate-related aberrancy that was significantly different to QRS at rest. The device was left without any ability to discern the origin of the rhythm and subsequently employed high-voltage therapy as programmed. The device functioned exactly as designed and there were no device or lead issues involved.

Patient management

In this setting, the capture of the inappropriate defibrillation episodes on the ECG by the attending paramedic crew is critical in the short term for the receiving hospital. It will allow them to accurately identify AF as the cause. Without recorded evidence of the event, there can be a significant delay in confidently identifying the event, exposing patient to further risk of inappropriate therapy. Device interrogation may be required, which may take hours in some settings to arrange. In the early stage, they will more than likely employ the use of a magnet positioned directly over the implanted device.

For nearly all AICDs, this will suspend its ability to defibrillate but not affect any pacing requirements.[3] These magnets are located on every crash cart in a hospital, commonly stuck to the side (see image 3). The purpose of therapy suspension via magnet in an AICD is typically for surgical procedures where electrical noise can be generated by EMI near the device (most commonly by monopolar electrocautery) then be detected and inappropriately treated. The other most common use is suspension of therapy during inappropriate or unwanted device behaviour. The patient will be continuously cardiac monitored, treatment continued, and the device will need to be manually assessed and potentially reprogrammed to limit the risk of reoccurrence while still ensuring protection against a potentially fatal arrhythmia.



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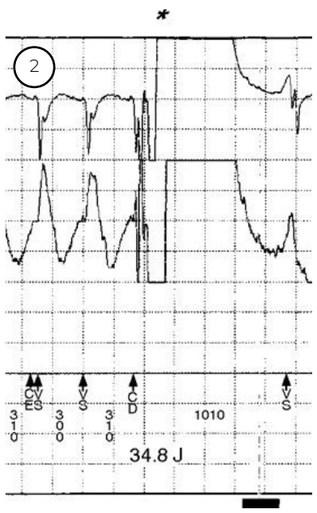

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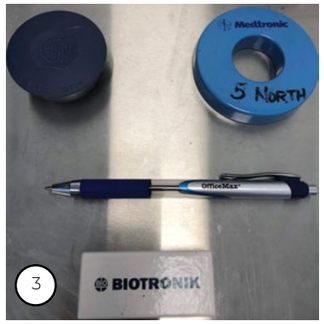

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Discussion

Inappropriate therapy from an AICD as described does occur in the pre-hospital setting. In an extreme setting, a detached lead can occur when the helical fixation falls away from the ventricular wall (this usually occurs in the first few days post-implant). Both examples expose the patient to repeated high-voltage shocks until rectified. This carries an obvious risk of psychological harm, possible induction of a fatal arrhythmia, and appreciable battery depletion. Regardless of the cause, ECG capture of the event if witnessed by paramedics is critical in reducing time to undertake the appropriate intervention. The application of a magnet to suspend therapy is a known option in the hospital environment and a guideline-driven option for use in the pre-hospital setting may be worth considering.

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STATINS, PARAMEDICS AND PATIENT EDUCATION

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Cardiovascular disease is the leading cause of death globally, with an estimated 17.9 million people dying in 2019 (WHO, 2021). This article looks at statins and their role in reducing the risk of cardiovascular disease, as well as the education role paramedics can play in callouts to patients in their homes.

Statins are the most prescribed drug throughout the world (Byrne, et al, 2019). Atorvastatin (Lipitor), Fluvastatin (Lescol), Pravastatin (Pravachol), Rosuvastatin (Crestor) and Simvastatin (Zocor) are the statin drugs currently available in the Australian market (Health direct, 2021).

Statins are prescription medications used to lower cholesterol. They block the enzyme 3-hydroxy-3-methylglutaryl coenzyme A (HMG-CoA) and are used to treat hypercholesteremia to reduce plasma cholesterol levels (Stancu, Sima 2001). These medications were historically prescribed to individuals with a moderate or high-risk of cardiovascular disease, or with established cardiovascular disease to reduce the risk of further complications (Bellosto, et al, 2004). Recently, these medications have been used in low-risk groups as a preventative measure, which has generated controversy over their use in this population (Byrne, et al, 2019).

Cholesterol is a fat-like substance produced by the body and also found in food. It is carried around the bloodstream by a lipoprotein. The two most common forms are high-density (HDL) and low-density (LDL). These are also referred to as good cholesterol and bad cholesterol, respectively. LDL can transfer cholesterol to artery walls, which in time builds up to a plaque that causes the arteries to harden and narrow (atherosclerosis). Over time, high levels of LDL can increase the risk of cardiovascular disease. Statins work to effectively reduce LDL and mildly increase HDL (Maron et al, 2000).

The build-up of plaque can lead to reduced blood flow through the arteries, and can also lead to plaque breaking off, resulting in blood clots that can stop blood flow (Heart Foundation, 2021). Without blood flow, or with reduced blood flow, the body is unable to maintain sufficient oxygen and nutrients to vital areas. This can lead to chest pain, heart attack and death.

Asymptomatic raised liver enzymes and an increased risk of diabetes were side effects noted in a 2014 paper that compared people on statins with those on a placebo (Finegold et al, 2014). The same paper found that side effects relating to nausea, myopathy, renal disorders, insomnia, diarrhoea, muscle aches, fatigue, gastrointestinal disturbances, dyspepsia, cancer, and constipation where indistinguishable from the placebo.

How does this relate to paramedicine?

Community paramedic models have been adopted in a number of countries, as part of which paramedics are assessing vulnerable patients and taking blood pressure, doing point-of-care testing such as blood sugars and clotting factors, and referring patients to the appropriate health care providers. A 2016 Canadian study demonstrates that the community paramedicine model can improve patients' health and reduce the burden on the health care system (Agarwal, 2016). Low-acuity patients are frequently calling ambulance services, and several services are looking at ways to decrease the growing workload (Eastwood, 2015).

Community paramedicine places paramedics in a unique position to gain a background history on patients and use this information to educate and refer them to health providers who can help with their current and ongoing needs.

For patients on statins, we need to ensure we are asking the right questions: Do they take their medication as advised? Do they have a well-balanced diet (and encouraging them to keep a food diary if they are a regular patient)? Do they have support systems in place (family, Blue Care, Meals on Wheels)? Are they active? Do they have regular appointments with the same doctor? Are their cholesterol, blood sugars, and liver function regularly checked?

Paramedics are also in a unique position to provide education on statins, cardiovascular disease, and diet, offering guidance on what patients can be asking their doctor and why blood tests and regular check-ups are essential. They can provide information on foods to avoid, such as highly processed food, and the intake of healthier foods for better health and wellbeing, such as fresh fruit and vegetables, and high-fibre diets that have been shown to reduce bad cholesterol (Better Health Channel, 2022), and encourage patients to ask their physician about being referred to a dietician.

In the future, we will see the expansion of paramedic roles. This could include things such as referrals to nutritionists and for blood tests, and enhanced patient education. This will immensely benefit patients and reduce the increasing burden of low-acuity ambulance calls and emergency department presentations.

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SHIFT WORK, HEALTH AND PARAMEDICINE: **TOWARDS A SUSTAINABLE CAREER**

By Dr Ben Meadley, PhD

Shift work is a necessary part of our roles as paramedics. However, negative effects on health and wellbeing can manifest if work is performed in opposition to circadian rhythms over extended periods of time. The consequences of shift work and circadian misalignment can result in a range of medical conditions, including metabolic syndrome, Type II diabetes, cardiovascular disease,[1] impaired health-related quality of life (HRQoL), weight gain, and poor mental health.[2-4]

The incidence of metabolic, cardiovascular, and inflammatory diseases reported in those performing shift work for extended periods is concerning. For example, a study of North American paramedics revealed >80% of paramedics were overweight or obese, >80% had elevated blood pressure, and <50% completed the minimum recommended amount of physical activity.[5] In a study of 747 Australian paramedics, mean body mass index (BMI) was above the threshold for overweight and HRQoL was lower than the general population.[6] Identifying and optimising health and wellbeing in paramedics requires attention to be paid to the central components of health, but achieving this can be challenging in this population.[6,7] It is essential that strategies to address poor paramedic health are prioritised.

While some areas of paramedic health and wellbeing, such as post-traumatic stress disorder and mental illness, have been well-studied,[8-11] research into these other key areas of health, such as diet, the incidence of cardiometabolic disease, and levels of physical activity, is limited. To explore this further, the team at the Paramedic Health and Wellbeing Research Unit at Monash University recently investigated whole-body health in two distinct groups of paramedics.

In the first study, we tracked shift-work naive graduate paramedics over the first 12 months of their careers at Ambulance Victoria (AV). We looked to see if any signs of poor health arose very early after commencing a career in paramedicine. In the 56 paramedics we studied, body weight and BMI decreased in males and increased in females. There was a small drop in self-reported mental health at six months, but overall quality of life and dietary intake did not change. Biomarkers of cardiometabolic health (i.e., insulin, glucose, lipid profile and c-reactive protein) were within normal range and did not change, except for a small increase in insulin. Baseline aerobic capacity (measured by treadmill VO2max test) was good, with no change noted at 12 months. Paramedics also wore activity monitors for the study period, and we noticed they completed less than the recommended steps per day (average ~7500), but levels of moderate to vigorous physical activity were slightly higher than recommended. Unsurprisingly, we saw that less physical activity occurred on day shifts and the first day off after a night shift.[12] So, for this group, there was no significant signal to poor health in the first year, and we need to follow them up down the track to identify when shift work related illness may appear.

In the second study, we looked at Intensive Care Flight Paramedics (ICFPs) working at the Helicopter Emergency Medical Service at AV. The data revealed that the cohort of senior and experienced ICFPs who had long-term exposure to shift work (20+ years) demonstrated high HRQoL, cardiometabolic health indicators within healthy ranges and physical activity outcomes exceeding those recommended in guidelines. In some cases, ICFPs complete more than triple the amount of moderate to vigorous physical activity when compared to the graduate paramedics.[13] A large amount of this activity was completed outside of work hours.

Given their long careers in paramedicine, a median age of 45 years, and compared to the information from the graduate paramedic study, the results from the ICFPs were somewhat unexpected. Although the ICFP job tasks may be very demanding and thus play a role in the excellent health profile of this group, their extended career should lead to at least some signs of poor health given the data from the wider literature. However, it seems that the high levels of physical activity, low BMI and relatively good diet given age and time in the profession were the most significant factors leading to a good health profile.

What is the message then for the majority of paramedics? Do these results mean that we should all aim to meet the same health standards as this sample of ICFPs in order to maintain good health? Well, probably not. There are likely other factors at play, including personality type, genetics, personal drive, and the physically demanding nature of the work that a paramedic performs. We don't have all the answers, and further research is needed in other key groups. This includes comparative studies between shift workers and non-shift workers over the first few years of practice, studies of mid-career paramedics, and larger and more sensitive studies to detect when poor health may manifest for paramedics, and how we may intervene. For the moment, we have reasonable data to indicate that a good diet, high levels of physical activity and keeping your body weight within a healthy range are sensible strategies to build a sustainable career in paramedicine.

Dr Ben Meadley, PhD, FACPara

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GRADE – A SYSTEMATIC APPROACH TO DEVELOPING CLINICAL PRACTICE GUIDELINES

Most paramedics are familiar with clinical practice guidelines (CPGs) and have used them in one form or another. The Institute of Medicine (IOM) defines CPGs as "statements that include recommendations, intended to optimise patient care, that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options".[1(p.4)] CPGs form a fundamental part of modern clinical practice. Rigorously developed guidelines based on the best available evidence enhances patient safety and can assist clinicians and patients in shared decision-making. Additionally, well-designed CPGs improve patient outcomes and reduce unwarranted variations in care and control cost.[2] But how should they be developed? In this article we talk about Grading Recommendations, Assessment, Development and Evaluations (GRADE) - a systematic approach to developing CPGs.

What is GRADE?

The development of CPGs is often inconsistent, particularly in the way the body of literature is rated in terms of the quality of the studies undertaken and the certainty of the results, which in turn informs the strength of recommendations. GRADE offers a methodological process that can be used to systematically summarise evidence and rate the certainty in that evidence and then develop recommendations to inform CPGs. GRADE is used by more than 100 organisations worldwide, including the International Liaison Committee On Resuscitation, UpToDate®, and the World Health Organization, and has become the most widely adopted approach for assessing and grading the quality of evidence and for making clinical practice recommendations.[3] Knowing about GRADE and how it works is important not only for guideline developers and researchers, but also for clinicians who use and rely on CPGs for their clinical decision-making.

How does GRADE work?

Developing CPGs is a team effort, and as such the process starts with assembling a guideline panel. The panel should include experts and key stakeholders, including clinicians, academics, methodologists, and patient and community representatives. The GRADE approach begins with the formulation of a PICO question.[4] In other words, the panel considers who is the population of interest, what are the alternative management strategies (intervention and comparator), and what are the desirable outcomes.[5]

Each outcome is then rated according to its importance as either critical, important but not critical, or of limited importance.[6] A systematic literature search is then conducted, aimed at identifying all applicable studies. If appropriate, a meta-analysis is performed; in other words, a statistical analysis is done that combines the results of multiple studies. As a final step in synthesising the evidence, the quality of evidence for each outcome across all included studies is rated.[7] Next, the process of formulating recommendations starts.

What is "quality of evidence"'?

In the GRADE framework, there are four levels of evidence, better described as quality of evidence. Although a starting point, study design is not the only determinant of the quality of evidence. GRADE recognises the traditional hierarchy of study designs and their potential to produce varying levels of evidence. Generally, randomized control trials (RCTs) provide more robust evidence than observational studies, and rigorous observational studies deliver better evidence than uncontrolled case series.[5] But the quality of evidence is also determined by the certainty that the panel has in it. Certainty is influenced by several factors. Some of these decrease certainty in the evidence[1-5], whereas others may increase confidence.[6-8]

Reasons for rating DOWN the certainty in evidence:

1. Risk of bias: The result of a study may be misleading if there are flaws in how the study was designed or conducted. These limitations jeopardise internal validity and pose the risk of bias.[8]
2. Inconsistency: Results from different studies may be inconsistent. To evaluate consistency, the similarity of point estimates, the extent of overlap of confidence intervals, and the statistical test of heterogeneity are used.[9]
3. Indirectness: Indirectness refer to differences in the population, interventions, and outcome measures between the included studies and those of interest to the developers of the guidelines.[10]
4. Imprecision: In GRADE, the primary criterion to make judgements about imprecision is the 95% confidence interval (CI).5 Imprecision may occur when studies include comparatively few patients and few events, and therefore the CI around the estimate of the effect is broad.[11]
5. Publication bias: Publication bias may occur when the likelihood of a study being published is affected by the findings of the study. There are several means to suspect publication bias, which would potentially result in the certainty being rated down.[12]

Reasons for rating UP the certainty in evidence:

6. Large effect: Rating the certainty of evidence up does not occur as often as rating it down due to the reasons outline in 1-5 above. However, the most common reason for rating up is a large effect.[13] This may be done when rigorously conducted observational studies show at least a twofold reduction or increase in risk.[13]
7. Dose response: As the name implies, a dose-response gradient is a graphical representation relating the magnitude of a dose to the response. If present in the results of observational studies, it can increase confidence in the evidence.[13]
8. Effect of plausible residual confounding: Sometimes all residual confounders (biases) from observational studies are likely to decrease the magnitude of effect.[13] In that case, the certainty of evidence may also be rated up.

The overall quality of evidence is determined by subjectively, yet reproducibly, rating the quality of evidence across all outcomes considered critical for answering the PICO question.[14] Ultimately, the reviewers will rate the quality of the evidence as high, moderate, low, or very low (Table 1).

Table 1. GRADE quality of evidence[5]

Quality of evidence	Meaning
High	The reviewers are very confident that the true effect lies close to that of the estimate of the effect.
Moderate	The reviewers are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different.
Low	The reviewers' confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect.
Very low	The reviewers have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect.

How are recommendations made?

In the GRADE approach, there is a clear separation between the quality of evidence and the strength of recommendations. The strength of a recommendation is an expression of the extent to which the panel is confident that the desirable effects of an intervention outweigh the undesirable effects (or vice versa) and is categorised as "strong for" or "weak for" (or "strong against" or "weak against").[5] In addition to quality of evidence, there are several other factors which need to be considered to decide if recommendations are strong or weak. These include the balance between desirable and undesirable outcomes, confidence in values and preferences and their variability, and whether the intervention represents a wise use of resources.[5]

Summary

GRADE is an outcome-focused tool that provides a systematic approach to evaluating evidence and providing recommendations that are feasible for the environment they are intended. The strength of GRADE is its ability to consider not only the quality of results in a study, but also the methodological rigor, which then creates the level of certainty or confidence in the body of evidence which will inform recommendations. The public and healthcare professionals expect recommendations to be made based on the best available evidence at the time. It is therefore important that guideline development is transparent in this process. Using the GRADE framework supports this transparency.

Want to know more?

BMJ published a series of articles on the GRADE approach. The first in the series of five articles is available here: **https://www.bmj.com/content/336/7650/924**.

The GRADE Handbook is freely accessible at this website: **https://gdt.gradepro.org/app/handbook/handbook.html**

Get involved by contacting one of the two GRADE Centres located in Australia: JBI Adelaide GRADE Centre: **https://jbi.global/grade** or Melbourne GRADE Centre: **https://melbournegradecentre.org**

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LEGAL ISSUES FOR PARAMEDICS OUTSIDE THE JURISDICTIONAL AMBULANCE SERVICES

By Michael Eburn and Ruth Townsend

Historically, paramedics were seen as synonymous with the state-run ambulance services (the "jurisdictional ambulance services"). With registration, paramedics are looking for, and finding, new ways to practice. Some of those are quite different to traditional paramedic/ambulance practice; others are providing traditional ambulance - emergency out-of-hospital care and patient transport - services but with a private ambulance provider. In many cases, legislation has failed to keep pace with the changing nature of paramedic practice. This can have implications for those working outside the jurisdictional ambulance services. This article identifies some of the legal issues that paramedics should be aware of when looking to practice outside the jurisdictional services.

The focus of this article is private ambulance services (i.e., those that look most like the jurisdictional services), but the discussion will be relevant to paramedics in any area of private practice. The discussion will be less relevant to paramedics who are practicing away from a jurisdictional ambulance service but still within a state-operated health service (e.g., a public hospital, community clinic, mental health service, etc).

Legislative limitations

Employees of the jurisdictional ambulance services may enjoy special statutory authority or protection. For example, employees of the Queensland, South Australian and Tasmanian ambulance services may interfere with private property when required to protect persons from "danger or potential danger associated with an emergency situation" (Ambulance Service Act 1991 (QLD) ss 13, 37 and 38); Health Care Act 2008 (SA) s 61; Ambulance Service Act 1982 (TAS) s 14A. Employees of the ACT Ambulance Service may be delegated to exercise the Chief Officer's emergency powers (Emergencies Act 2004 (ACT) ss 34 and 39). Paramedics employed by the Ambulance Service of NSW are exempt from personal liability "for any injury or damage caused by the member of staff or officer in the carrying out, in good faith, of any of the member's or officer's duties" (Health Services Act 1997 (NSW) s 67I). These statutory authorities and protections will not extend to paramedics employed by private ambulance services.

Powers under mental health legislation are also, generally, limited to state-employed paramedics. The Mental Health Act 2007 (NSW) s 20 empowers "ambulance officers", that is an employee of the NSW Ambulance Service, to transport a patient to a mental health facility. It is not an authority granted to any registered paramedic. That is also true in the ACT (Mental Health Act 2015 (ACT) s 80 and definition of "authorised ambulance paramedic"), Queensland (Mental Health Act 2016 (QLD) s 808 and definition of "ambulance officer"), and Tasmania (Mental Health Act 2013 (Tas) s 212 and definition of "ambulance officer"). In Victoria, authorised officers include "ambulance paramedic", but that term is not defined (Mental Health Act 2014 (VIC) ss 3 and 350). In South Australia, the power to detain and transport a person suspected of having a mental illness can be extended, by the chief executive of the South Australian Ambulance Service, to any employed "... ambulance officer, or ... volunteer ambulance officer, with an organisation that provides ambulance services" (Mental Health Act 2009 (SA) s 56 and definition of "ambulance officer"). The power does not come to a paramedic by virtue of their registration, but could be extended to paramedics employed by approved private ambulance providers.

Neither the Northern Territory nor Western Australia have government-operated ambulance services; rather, they contract with private providers (in particular St John Ambulance) to provide ambulance services. In Western Australia, it is police, and not ambulance officers or paramedics, who can apprehend a person suspected of being mentally ill and requiring detention and treatment (Mental Health Act 2014 (WA) s 156). Only in the Northern Territory does the power to detain people suspected of being mentally ill extend to paramedics by virtue of their registration (Mental Health and Related Services Act 1998 (NT) s 31 and definition of "paramedic"). Any paramedic, regardless of their employer, may exercise those rights and responsibilities in the Territory.

LEGAL/ETHICS

We have argued before that granting the authority to possess, supply and administer scheduled drugs to paramedics, rather than their employers, will go a long way to allowing "paramedics to take advantage of new opportunities" ('Paramedicine in 10 Years: What will it look like?' (2019) Vol 46 Response pp. 18-20, at p. 20). As it is, paramedics employed by both jurisdictional and private ambulance services (generally) depend on an authority from their employer to use scheduled drugs. The important thing to note, in the context of this article, is that this authority is not transferable. A paramedic employed by a jurisdictional ambulance service may be used to having a variety of therapeutic drugs at their disposal but find that the drugs available are much more limited if they move outside of that service.

Employment status

A critical issue for paramedics thinking of joining a private ambulance provider or any private health care provider is their employment status. A relevant example may be a private ambulance company that has secured a contract to provide event health services or onsite work-related emergency care, and then seeks to engage paramedics so that the company can meet its contractual obligations. The company could employ paramedics but, anecdotally at least, we are aware of private providers seeking to engage paramedics as independent contractors, rather than employees.

The whole point of a company that has entered into a principal contract with a client and then subcontracted with someone to meet those obligations (rather than employing them) is to try to shift liability. Where the liability falls will depend on the answers to questions such as:

- Who is responsible for paying tax?
- Who is responsible for providing the tools of trade?
- What uniform is worn? (If this member is required to wear a uniform that identifies the principal contractor, then it is more likely to be seen as employment.)
- Who sets the hours of work?
- Who sets the rate of pay?

Organisations like Uber, Deliveroo, courier companies, etc., are finding that courts are looking beyond what they claim are the arrangements to identify the real relationship between the parties (Hollis v Vabu [2001] HCA 44). The critical issue is what are the rights and liabilities of each party, rather than how they describe the relationship. If a person is in effect an employee, then they are an employee; saying that a person is an independent contractor does not make it so (Construction, Forestry, Maritime, Mining and Energy Union v Personnel Contracting Pty Ltd [2022] HCA 1).

Working as an independent contractor is, by definition, not employment. A person who wants to work that way should obtain an ABN, comprehensive professional indemnity insurance, and workers' compensation insurance. You should determine your charge-out rates and the sort of services you offer. You then offer to contract on your terms. By way of comparison, think of the building industry. If a client contracts with a builder, they (should) understand that the builder will engage subcontractors. Those subcontractors come on to the site in their own vans, their own uniforms, etc. We can identify who is employed by the builder and who is an independent contractor. The builder sends the client a bill and is responsible for the quality of the work. But if there's an issue, the builder can look to the subcontractor to make good any losses. That is, the client has a contract with the builder, the builder has a contract with the subcontractor, but it's all clear and understood.

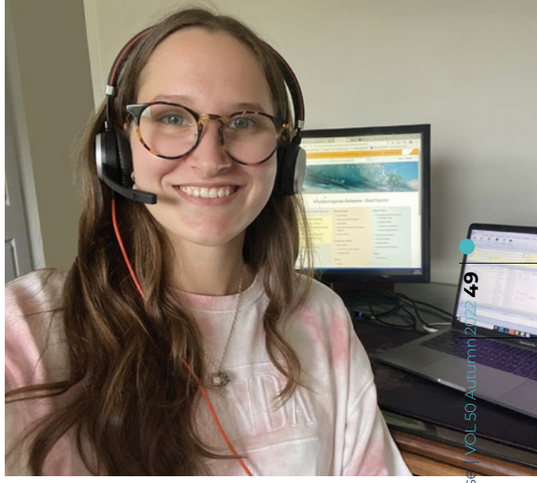
In the paramedic context, if the principal contractor has entered into a contract with an event provider and realises that in one area there are services they cannot provide, they may then contract with ABC Paramedics to come in and provide the paramedic services. If the ABC Paramedics wear their ABC uniform and provide those services for the fee they have set or at least negotiated, all well and good. If, on the other hand, the principal contractor says to a paramedic, "I'll pay you $50 an hour take it or leave it, you'll wear my uniform, and this is your scope of practice", then that's employment no matter how much they try to disguise it. But their effort to try and disguise it should be seen as a "red flag" and it is likely to lead to long and costly disputes (at least between insurers) should there be any adverse outcome.

Conclusion

Registration brings with it new opportunities for paramedics, but there isn't a "level playing field" with the state-operated jurisdictional ambulance services. Employees of those ambulance services enjoy statutory rights (and responsibilities) that do not extend to paramedics employed by private providers. Further, there is no question that the jurisdictional ambulance services operate by employing paramedics with the benefits and protections that this provides to the employees.

Registration does allow paramedics to establish their own business models and to invent new ways to practice. Paramedics who wish to contract, or subcontract, may find that this creates new opportunities to contribute to their community and earn a larger income. But there is also a risk particular in these early days where paramedics may be encouraged to think of themselves as contractors when they are really employees. This can carry its own risks - to both finances and reputation.

Paramedics who are thinking of moving out of the jurisdictional ambulance services should carefully consider, and if necessary get legal advice, on their rights and responsibilities in their proposed new practice.



Telehealth placement improves paramedic student's assessment skills

Aotearoa New Zealand

Recent graduate and newly registered paramedic Emma Archer credits her student placement in telehealth triage with Whakarongorau Aotearoa/ New Zealand Telehealth Services with vastly improving her patient clinical assessment skills; skills she believes will stand her in good stead when she begins working in the ambulance service.

Emma spent three weeks with Whakarongorau Aotearoa while in her final year of paramedicine studies at Auckland University of Technology as part of the second cohort of students to undertake placements working on Healthline, a 24/7 health advice phone line. It is a government-funded national telehealth service and is currently the only such service in the country to employ full-time paramedics around-the-clock in tele-triage.

IT'S SUCH A DIFFERENT SORT OF ENVIRONMENTAL SCENERY THAN PARAMEDICS ARE USUALLY EXPOSED TO, AND THERE ARE SO MANY BENEFITS

Whakarongorau Aotearoa// New Zealand Telehealth Services//

Emma applied for her placement in the midst of the COVID-19 lock-down in Auckland while looking for a different avenue of professional development. While her studies largely focused on emergency response, she felt less emphasis was placed on lower-acuity cases.

"In this telehealth role, a lot of it is dealing with patients who have the lower-acuity symptoms, and we're referring them on to their GPs or to urgent care clinics," she said. "It's such a different sort of environmental scenery than paramedics are usually exposed to, and there are so many benefits not only for students, but also for me as a new clinician.

"I constantly learnt more about assessment skills, and I feel that when I do eventually go back on the road and work in an ambulance, I will be a lot more confident and comfortable in my assessment skills because I know a lot of the good questions to be asking patients."

The students are provided with constant support from the Healthline paramedics, doctors and nurses, who were on hand to give advice on patients' dispositions and symptoms. In the first week of her placement, she was trained in taking calls and introduced to the software and digital clinical assessment tools that were used.

"We then had a mentor; he and the People Leader would would sit with us and listen to our first calls and let us know what we could improve on, and they'd show us what to do while we were assessing. They also taught us good questions to ask patients, such as asking them if they're short of breath, because, of course, over the phone it's hard to assist someone properly because you can't see all of the vital signs, you can't see them in front of you."

After being taught the basics of the job, they then moved into a clinician role, with paramedics and nurses listening as they took calls and assisting when needed.

She said the biggest challenge was learning to conduct assessments over the phone and how to interpret the information being provided by patients. Good listening skills were vital.

"You have to go by what people are saying. Initially, that was the biggest challenge for me because I worried that I was misinterpreting what someone said and there could be something really serious going on. But I think, over time, that changed. As I said, there's lots of support, and you know that as long as you're really thorough in your assessment, you're not going to miss anything serious."

She said her experience working in tele-triage helped to build her assessment skills and built her confidence in assessing patients.

"We learn lots of little sorts of tips and tricks of the trade throughout this role that you don't really learn in university, and I feel that every student would benefit from this type of clinical placement.

"My advice to other students would be to be open and try new things. Even if you're keen on working in the ambulances, it will still benefit anyone as a clinician to do this placement. I honestly think that it should be a part of the degrees. Throughout the degree, you learn little bits about medical conditions and presentations and assessment, but this clinical placement, or this role, will really help to bring that all together.

"You know the right questions to be asking someone and you know how to properly assist someone."

A welcome face-to-face return for CAA Congress

Over 2020 and 2021, we saw the entire world of face-to-face events come to a screeching halt as we navigated a global pandemic. Everything from sporting events and festivals to conferences and meetings came to an eerie standstill as in-person events seemingly became a thing of the past. The CAA Congress was one of the many events that was put on hold. While we can all agree that the past two years have been exceptionally difficult, there has been a silver lining. Despite the devastating impacts of COVID-19 on the events industry, it seemed we all found a greater appreciation for the inspiration and connection that face-to-face events bring. As appreciation rises, in-person events have once again become a beacon for leaders, thinkers, and innovators alike.

After riding a wave of postponement, cancellations, and uncertainty, it is with great enthusiasm that we invite you to CAA Congress 2022 to do all the things that we haven't been able. Join us to be inspired, think outside the box, and work together to elevate the pre-hospital sector. Complete with heavily anticipated specialised Forums, a jam-packed Expo, a captivating Welcome Function, and the glamorous Awards for Excellence Gala Dinner, CAA Congress 2022 is expected to be Australasia's premiere event for the pre-hospital sector.

Congress - A place to be inspired

From August 11-13, 2022, we welcome you to Sydney's world-class International Convention Centre on picturesque Darling Harbour - a place to be inspired. The Congress will feature a range of engaging speakers presenting on a broad range of topics within the emergency services and health sector. Expect for the message to not just be heard, but understood, absorbed, and acted upon.

Facebook: CouncilofAmbulanceAuthorities

Twitter: CAAAustralasia

Linked In: Council of Ambulance Authorities (Australasia)

Keynote Speaker Spotlight:

Dr Norman Swan

Dr Norman Swan hosts The Health Report on ABC's Radio National - the world's longest running health program in the English-speaking world. Dr Swan has won many awards for his work, including Australia's top prize for journalism, the Gold Walkley. He was the third person to be awarded the prestigious medal of the Australian Academy of Science and was given an honorary MD by the University of Sydney on its 150th Anniversary. He has consulted to the World Health Organization and co-chaired a global meeting of health ministers in Bamako, West Africa, focused on evidence-based policy and priorities in health research. He has been the Australian correspondent for both the Journal of the American Medical Association and the British Medical Journal. Dr Swan will paint a picture of what health systems will look like in the next 5-10 years. He will review what the last two years of pandemic, demand management growth and health surge has done to the sector and how the systems need to adapt to be better for our patients, teams, and the public.

Julie Piantadosi

Julie Piantadosi is one of Australia's most sought-after coaches and trainers. Her business consulting is revolutionary and helps leaders make the shift from ordinary to extraordinary through simple and effective tools. Let her help you unlock your full potential. With more than 12,000 seminars delivered in 42 countries, Julie will leave you transformed and ready to take action. As an NLP Master and cognitive behavioural coach, she has trained companies such as Qantas, BMW, Porsche and Kenneth Cole, to name just a few. As a 9/11 survivor, Julie encourages us to dig deeper, carefully consider our daily choices, reconstruct our attitudes, and increase our self-awareness to unlock our full potential.

For a description of all speakers, keep an eye on the CAA Congress website at http://www.caacongress.net.au/. Tickets are available to purchase through the CAA Congress website. We will be thrilled to welcome you to ICC, Sydney, in August 2022. To stay updated with all things Congress, keep an eye out on our socials. We look forward to seeing you, your organisation, and your colleagues then.

Paramedicine Board Ahpra

Still more to do to make healthcare safe for our LGBTQIA+ communities

What's it like to access healthcare as a LGBTQIA+ patient? Accessing healthcare as a LGBTQIA+ patient is the focus in the latest Taking care podcast episode. Patients Jasper and Toby talk about their healthcare journeys and challenges. They offer their advice for others experiencing the same and what practitioners can be doing to better support these communities. Find out more at: https://www.paramedicineboard.gov.au/news/2022-04-12-LGBTQIA-pod-ep.aspx

Service charter launched – setting the standards of service

The new Ahpra Service charter (Service charter) was launched in April, setting the standard of service the public and health practitioners can expect when interacting with us. The new Service charter includes five high-level principles which guide our work to meet our vision for communities to have trust and confidence in regulated health practitioners. The charter then steps out those principles in clearly articulated commitments for when people interact with us. Find out more at: https://www.paramedicineboard.gov.au/News/2022-04-11-service-charter-launch.aspx

Advance copy: Revised Code of conduct for 12 professions

Twelve National Boards have published an advance copy of their revised shared Code of conduct (the code) and are encouraging practitioners to familiarise themselves with it before it comes into effect on 29 June 2022. The code sets out National Boards' expectations of professional behaviour and conduct for practitioners registered in these professions, which promotes safe and effective care and helps to keep the public safe. Practitioners have a professional responsibility to be familiar with and to apply the code. Find out more at: https://www.paramedicineboard.gov.au/News/2022-04-06-advance-copy-revised-code-of-conduct.aspx

Supervised practice framework in effect

The Supervised practice framework (the framework), developed by the Paramedicine Board of Australia (the Board) along with 12 other National Boards and Ahpra, is now in effect. The framework outlines the National Boards' expectations and supports supervisees, supervisors and employers to understand what is necessary to effectively carry out supervised practice. The framework also includes the principles that underpin supervised practice and the levels of supervised practice. Find out more at: https://www.paramedicineboard.gov.au/News/2022-02-01-Supervised-practice-framework-in-effect.aspx

Audit – be ready

All registered paramedics are required to comply with the Board's registration standards and declare whether they were compliant when renewing their registration. The Board and Ahpra conduct regular audits to assess practitioners' compliance with the standards. Find out more at: https://www.paramedicineboard.gov.au/News/Newsletters/March-2022.aspx#audit

Kaunihera Manapou Paramedic Council

2022 Kaunihera election

Kaunihera is pleased to advise that following its first hui of the year, members re-elected are: Carlton Irving as Manukura/Chair, and Bronwyn Tunnage as Manukura Tuarua/Deputy Chair. Read more in the first 2022 eNewsletter: https://paramediccouncil.org.nz/common/Uploaded%20files/Publications/Newsletters/20222403%20P%C4%81nui%20March%202022.pdf

Joint Statement Midwifery Council and Paramedic Council

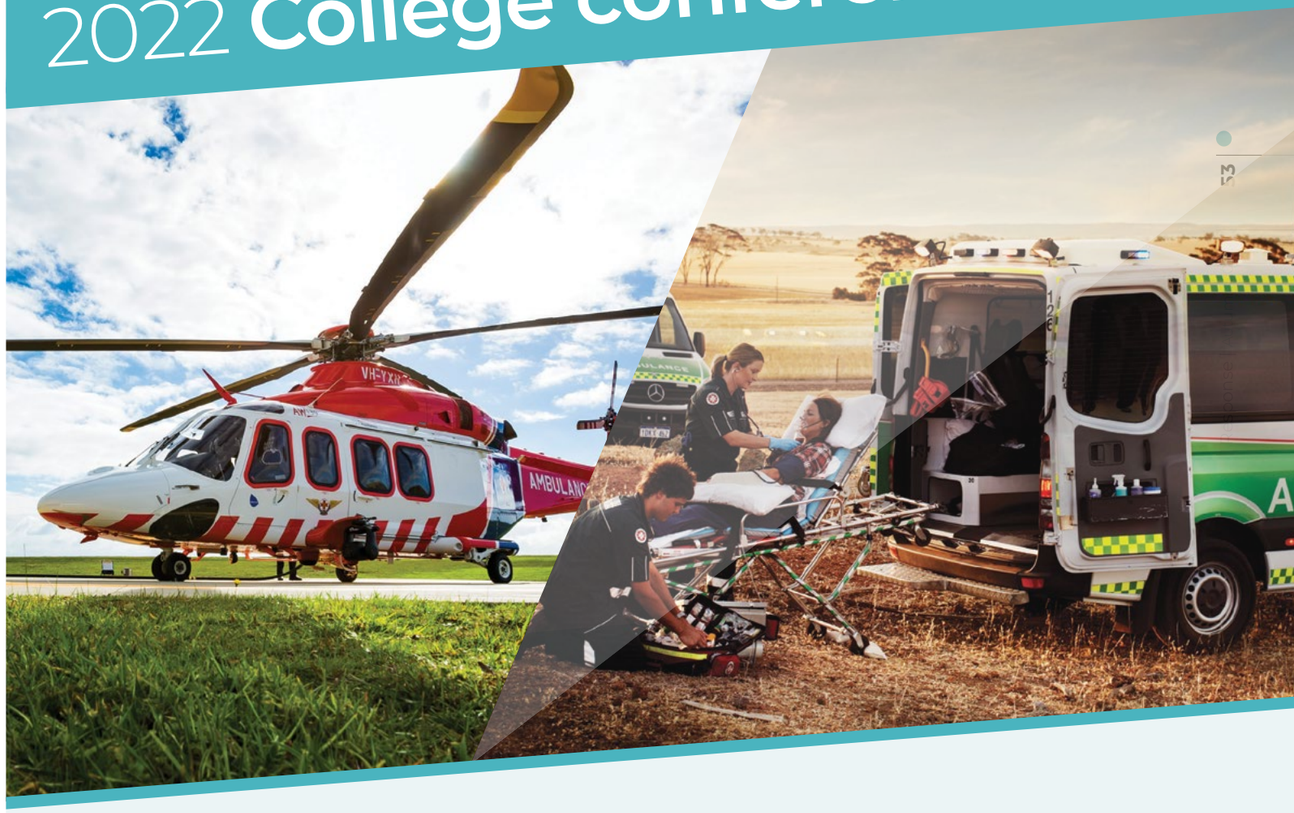
Collaboration and Professional Relationships.

Both Te Tatau o te Whare Kahu (Midwifery Council) and Te Kaunihera Manapou (Paramedic Council) are responsible authorities under the Health Practitioners Competence Assurance Act 2003. Our purpose is to protect the health and safety of the public by ensuring that midwives and paramedics are fit and competent to practise their professions. Both Councils require members of their profession to demonstrate effective and respectful inter-professional communication and collaborative practice at all times that promotes individual and whānau safety. Effective interprofessional practice is an expectation of the Codes of Conduct for both professions and is specifically identified as a standard of competence. Read more at: https://www.paramediccouncil.org.nz/PCNZ/About/Publications/News/Joint-Statement-Midwifery-Council-and-Paramedic-Council.aspx

Annual Report 2021

The annual report for the year ending 31 March 2021 is available here: https://www.paramediccouncil.org.nz/common/Uploaded%20files/Publications/Te%20Kaunihera%20Manapou%20Annual%20Report%20-%202021.pdf

2022 College conferences



ROAR Rural, Outback & Remote Paramedic Conference

Rural Outback and Remote Paramedic Conference
Adelaide Hills SA 26-27 May 2022

ACP Research Symposium

ACP Research Symposium
Sunshine Coast QLD 14–15 July 2022

STUCON

Student Conference
Sydney NSW 29 July 2022

ACPIC

ACP International Conference 2022
Brisbane QLD September 2022

Find out more
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THE NATIONAL **COVID-19** CLINICAL EVIDENCE TASKFORCE

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

Taskforce updates Sotrovimab remark (v54.0)

The Taskforce has updated the remarks on its sotrovimab "for use" recommendations to include:

The Taskforce is aware of in vitro data suggesting a potential reduction in efficacy of sotrovimab against the BA.2 subvariant; however, the clinical implications of this remain unclear.

There are no changes to the strength or direction of the recommendation. The sotrovimab recommendations are high priority recommendations and will be updated as soon as new evidence becomes available.

Taskforce notes TGA provisional approval for Evusheld

The Taskforce notes that on 24 February 2022, the Therapeutic Goods Administration granted provisional approval for tixagevimab and cilgavimab (Evusheld) for pre-exposure prophylaxis (prevention). Following access to the clinical study reports for TACKLE and STORMCHASER, the Taskforce has made six new recommendations on the use of monoclonal antibodies tixagevimab plus cilgavimab (Evusheld):

Adults

Conditional recommendation

Consider using tixagevimab plus cilgavimab (Evusheld) within five days of symptom onset in unvaccinated* adults with COVID-19 who do not require oxygen and who have one or more risk factors for disease progression.

Within the patient population for which tixagevimab plus cilgavimab is conditionally recommended for use (see remark), decisions about the appropriateness of treatment with tixagevimab plus cilgavimab should be based on the patient's individual risk of severe disease, on the basis of age and multiple risk factors, COVID-19 vaccination status and time since vaccination.

* Individuals who had received one or more doses of SARS-CoV-2 vaccine were excluded from the trial. The efficacy of tixagevimab plus cilgavimab is unclear in individuals who are up-to-date with vaccination or partially vaccinated. See consensus recommendation for guidance on use of tixagevimab plus cilgavimab in vaccinated patients or in immunocompromised patients regardless of vaccination status.

In adults with confirmed COVID-19 who do not require oxygen, tixagevimab plus cilgavimab probably decreases the risk of hospitalisation if taken within five days of onset of symptoms.

Consensus recommendation

In addition to at-risk unvaccinated adults, also consider using tixagevimab plus cilgavimab (Evusheld) within five days of symptom onset in adults with COVID-19 who do not require oxygen and:

- Are immunocompromised regardless of vaccination status; or
- Who are not up-to-date with vaccination and who are at high risk of severe disease on the basis of age and multiple risk factors.

Pregnant or breastfeeding women

Only in research settings

Do not use tixagevimab plus cilgavimab (Evusheld) for the treatment of COVID-19 in pregnant or breastfeeding women outside of randomised trials with appropriate ethical approval. Currently, there is no direct evidence for the use of tixagevimab plus cilgavimab in pregnant or breastfeeding women. Trials are needed in special populations, including pregnant or breastfeeding women. Until further evidence is available, do not routinely use tixagevimab plus cilgavimab for the treatment of COVID-19 in pregnant or breastfeeding women unless they are eligible to be enrolled in trials.

Children and adolescents

Consensus recommendation

Consider using, in exceptional circumstances, tixagevimab plus cilgavimab (Evusheld) for the treatment of COVID-19 within five days of symptom onset in children and adolescents aged 12 years and over and weighing at least 40 kg who do not require oxygen and who are at high risk of deterioration.

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

Decisions about the appropriateness of treatment with tixagevimab plus cilgavimab should be based on the patient's individual risk of severe disease, on the basis of age or multiple risk factors, and COVID-19 vaccination status.

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

Only in research settings

Do not use tixagevimab plus cilgavimab (Evusheld) for the treatment of COVID-19 in children under 12 years of age without risk factors for deterioration who do not require oxygen outside of randomised trials with appropriate ethical approval. These recommendations are consistent with the Taskforce recommendations on the use of sotrovimab in this population.

For post-exposure prophylaxis

Only in research settings

For people exposed to individuals with SARS-CoV-2 infection, do not use tixagevimab plus cilgavimab for post-exposure prophylaxis outside of randomised trials with appropriate ethical approval. Evidence suggests that administration of tixagevimab plus cilgavimab has little impact on preventing SARS-CoV-2 infection when administered as post-exposure prophylaxis in people who have been in close contact with an individual with confirmed COVID-19.

Evusheld is administered by intramuscular injection.

The above recommendations join the Taskforce Evusheld pre-exposure prophylaxis recommendation published on 28 February 2022. The Taskforce notes that as of 24 March 2022, the TGA has not approved Evusheld for treatment or post-exposure prophylaxis.

CONSUMER PANEL RECRUITMENT

Would you like to use your experience to improve the care of Australians with COVID-19? The National COVID-19 Clinical Evidence Taskforce is seeking two new members to join its Consumer Panel. The Taskforce produces the national guidelines for clinicians caring for people with COVID-19 that are used across Australia. Find out more at: https://covid19evidence.net.au/news/consumer-panel-recruitment/

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