Journal of Emergency Primary Health Care

An International eJournal of Prehospital Care Research, Education, Clinical Practice, Policy and Service Delivery

ACAP Conference Abstracts 2003

Abstract No. 990056-1

“MANAGING PRE-HOSPITAL STAFF FOR PEAK PERFORMANCE”

Allison Ballard

Paramedic, Tasmanian Ambulance Service

The relative infancy of the emergent professionalism of pre-hospital practitioners brings with it an interesting dilemma – how to best manage professional staff in order to achieve optimal work performance, motivation, commitment to ongoing professional development, and staff recruitment and retention.

These are not new issues - they are longstanding universal issues confronting all organizations, regardless of organisational size, structure and function – and quite independent of whether the organisation is a private sector or government business.

Organizations may survive, but they are unlikely to achieve ongoing corporate success, or best practice, without optimal management of what is widely recognised to be an organization's most important “resource” - that is, its people.

Furthermore organizations that do not manage their staff appropriately may foster a culture in which staff “work-to-rule” and search out opportunities to undermine management rather than using their energy to make a positive corporate contribution. Forms of deliberate sabotage can become the norm, accepted, albeit often reluctantly, by employees who, as a general rule would much prefer to focus on the effective delivery of their core business

While there are many ways of managing people – some good, some bad - managing people to foster morale and motivation, to promote commitment to both work and the organisation, and indeed managing to retain staff should be a primary organisational goal. It is much more cost-effective to develop peak performance in, and retain existing staff, than it is to recruit and train new staff!

The managers of professionals face additional challenges...

Journal of Emergency Primary Health Care

An International eJournal of Prehospital Care Research, Education, Clinical Practice, Policy and Service Delivery

ACAP Conference Abstracts 2003

Abstract No. 990056-2

“TRENDS IN SURVIVAL, OUT OF HOSPITAL CARDIAC ARREST; MAN AND MACHINE”

Andreas M. Blahous

Research Officer, Australian Centre for Pre-hospital Research

The Australian Centre for Pre-hospital Research manages the Cardiac Outcomes Project on behalf of the Queensland Ambulance Service. The project aims to develop an evidence-base to assist in improving the pre-hospital treatment of patients experiencing an out of hospital cardiac arrest (OHCA) and, through improved resuscitation practices, to increase the likelihood of survival for these patients. It achieves this through the audit and analysis of case reports for each OHCA attended by the Queensland Ambulance Service for the state of Queensland. The research literature suggests that there are a number of factors that can positively impact on survival from an OHCA. These include having your arrest witnessed by a bystander or paramedic, receiving bystander CPR, receiving early defibrillation, and having a shockable rhythm during the arrest. Many of these factors though, are beyond the scope of influence of pre-hospital care providers. This study will investigate the influence of factors such as the level of paramedic skills and training (ICP versus non-ICP), make and type of defibrillator and response time on survival of patients experiencing an OHCA. Temporal trends in survival for the period 2000-2002 will be reported and discussed.

ACAP Conference Abstracts 2003

Abstract No. 990056-3

“PRE-HOSPITAL RESEARCH ACCESS – EASY ACCESS VIA THE INTERNET”

Mal Boyle

Senior Lecturer, Monash University Centre for Ambulance and Paramedic Studies

There is a sparsity of quality Australian pre-hospital research and a lack of a repository that lists current and completed research projects within Australia. There is also a lack of knowledge about how to easily access relevant pre-hospital articles.

Due to a lack of epidemiology education in current paramedic courses there is a lack of understanding by Australian pre-hospital care providers of the various epidemiological study types and medical literature searching processes. A need for links to abstracts of relevant pre-hospital topics may be an interim requirement until there is a better understanding by pre-hospital care providers of epidemiological study types and the methods of locating relevant pre-hospital articles.

The first part of the paper demonstrates the access to current research projects and a list of published and non-published Australian research articles in an internet data repository. The second part of the paper demonstrates the access to internationally published pre-hospital abstracts, and where available the complete article, for articles covering general and specific topics, eg rapid sequence induction for head injuries. This linkage is to the public domain Medline service PubMed.

This paper will demonstrate a web based repository for pre-hospital research articles and how it can be used as well as pre-established links to specific types of pre-hospital articles available in the public domain.

Journal of Emergency Primary Health Care

An International eJournal of Prehospital Care Research, Education, Clinical Practice, Policy and Service Delivery

ACAP Conference Abstracts 2003

Abstract No. 990056-4

“THE AUSTRALIAN DEFENCE FORCE RESPONSE TO THE BALI BOMBING, 12 OCT 2002”

Steven Cook

Squadron Leader, Royal Australian Air Force

Operation Bali Assist was an operation to evacuate Australian and other foreign nationals from Bali to Australia after the Bali terrorist bombing on the 12th October 2002. It was the largest aero medical evacuation by the Australian Defence Force (ADF) since the Vietnam War.

The mission was conducted in two phases. The first phase was the evacuation of 66 patients in five C130 aircraft from Sanglar Hospital, Bali to Darwin Hospital. The first aircraft arrived 17 hours after the explosion and this phase involved the establishment of a casualty clearing station at Denpasar Airport to stabilise patients prior to transport.

In the second phase, 51 patients were secondarily evacuated from Darwin Hospital to burns/trauma centres around the country for definitive care. (35 patients were transported by military aircraft and the rest by civilian agencies). This was coordinated by Emergency Management Australia (EMA).

The mission was successful due to adherence to disaster management principals and training and also the united and dedicated response of all people involved both military and civilian.

This presentation will include footage from the casualty clearing station and will discuss lessons learned from this tragedy.

ACAP Conference Abstracts 2003

Abstract No. 990056-6

“WHERE DOES PARAMEDIC EDUCATION GO FROM HERE? TIME TO GET SERIOUS ABOUT OUR EDUCATION”

ALAN EADE

Ambulance Paramedic

Metropolitan Ambulance Service, Victoria

To consider the requirements for the education of paramedics in the future it is appropriate to consider the scope of practice for paramedics in the future and the changing public perceptions of paramedics. I perceive the major impacts on paramedic services in the future to be;

- Evidence based medicine (EBM)
- Research
- Defensive medicine
- Primary care
- Paramedic practitioners

The chosen education model needs to provide sufficient education that the paramedic is able to be a part of all of the processes listed above. Specifically in relation to the current model the following improvements are required for undergraduate education;

- Greater knowledge of anatomy
- Greater knowledge of physiology
- Greater knowledge of pathophysiology of a greater number of diseases
- Greater knowledge of pharmacology
- Greater knowledge and understanding of the methods and benefits of research
- Improved physical patient assessment skills
- Greater attention to the concepts of primary care, social services, and referral to providers outside of the hospital system

By embracing the concepts of lifelong learning sponsored by the Australian National Training Authority (ANTA) and making all aspects of ambulance education modular to fit within the Australian Qualifications Framework (AQF) ambulance authorities provide maximum scope and opportunity. The system chosen should allow all of the ANTA recommendations towards Recognition of Current Competency (RCC) and also Recognition of Prior Learning (RPL).

A basic framework to accommodate the likely skills and responsibilities of paramedics in the future is discussed.

Journal of Emergency Primary Health Care

An International eJournal of Prehospital Care Research, Education, Clinical Practice, Policy and Service Delivery

ACAP Conference Abstracts 2003

Abstract No. 990056-7

"IS IT TIME TO RE-ASSESS THE ROLE OF AMBULANCE OFFICERS?"

Christine Fahey

Research Fellow, University Department of Rural Health,
University of Tasmania

This paper explores issues surrounding the role of ambulance officers by posing the question "Should ambulance officers re-assess their role to better meet then needs of Australia's current and future health system?"

In considering this question I argue that the history of ambulance services and the non-reflexive official policies that define ambulance officer roles have driven the delivery of ambulance services for too long. The ongoing escalating demand for ambulance services may provide ambulance officers and policy makers with an ideal opportunity to review the role of ambulance services in Australia.

Several warning bells pointing to the need to re-assess the role of ambulance officers in current health care delivery are highlighted:

1. That the major performance measure used by ambulance services is response times. This reflects the fact that historically ambulance services are designed primarily to provide urgent life-saving treatment, despite the fact that the majority of patients do not have life-threatening illnesses.
2. That ambulance services worldwide are experiencing growing demand for services, with little understanding of the causes for this increase in demand.
3. That anecdotal evidence suggests ambulance services are increasingly spending time caring for patients whilst looking for a hospital to accept patients into their care, with ambulance officers required to spend long hours waiting with patients to be handed over to department of emergency staff.

I then suggest how this re-evaluation might proceed and who should be involved. Research and communication will be key factors. Ambulance services are currently poorly placed to review models of care, as there is a dearth of service delivery research. What is needed is a combination of expertise from economists through to behavioural scientists. Management, researchers and policy advisors will have important roles in evaluating services at the system level, while ambulance officers and researchers can ensure that those making decisions have relevant information from the field. Education providers must also be at the forefront of change, by ensuring the ambulance officers' curriculum reflects the changing environment.

There is increasingly an imperative for ambulance services to reflect on their role within the current health system and position themselves strategically to meet future health care needs. The increasing pressure on our health system sees governments attempting to contain health care costs. Unfortunately these pressures are set within an Australia where health consumers have rising expectations of care, and health service providers are increasingly afraid of litigation. There is no doubt that ambulance services have an important role in providing Australians with high quality care, but they need to ensure they are effective in the provision of this care by ongoing review and reflection. I conclude that 'yes', ambulance officers should re-assess their role.

ACAP Conference Abstracts 2003

Abstract No. 990056-8

“Ontario Pre-hospital Advanced Life Support Study (OPALS)”

Brian Field

Executive Vice-President, CAO Interdev Technologies Inc., Canada

In the mid 1990's, due to health services fiscal restraints, the Ontario Ministry of Health, policy makers required quality scientific evidence to support decisions to initiate or continue funding for expensive health programs. There was not convincing evidence for the effectiveness of ALS programs for critically ill and injured patients for the policy makers to move into the field of Pre-hospital Advanced Life support. This was in spite of considerable political pressure and pressure on the paramedic profession.

To resolve the impasse, an expert panel was formed to recommend a process for satisfying the government's need for scientific evidence and to address the political and professional pressures of the day. This expert panel included representatives from the research community, the government, paramedic unions, ambulance service operators and the medical community.

The result of this process was the development of the largest pre-hospital study of its kind world wide with an operational budget of 15 million dollars over 8 years.

This study has provided valuable evidence to Ontario communities and elsewhere, about the relative effectiveness of pre-hospital programs on the survival and morbidity of **cardiac arrest**, **major trauma** and **respiratory distress** patients. The study objectives included:

To assess the incremental benefits in cardiac arrest patient survival and morbidity that results from the sequential introduction of rapid defibrillation programs.

To assess the incremental benefit in survival, morbidity and processes of care that result from the introduction of pre-hospital ALS programs to multiple Ontario communities for patients with **cardiac arrest** (primary objective), **major trauma** and **respiratory distress**.

To conduct an economic evaluation of ALS programs for the same patient groups by estimating the incremental cost per life saved and per quality-adjusted life year.

This discussion will address two broad areas of the OPALS Project:

- 1) An overview of the origin of the OPALS project and the political and operational challenges that had to be overcome, and
- 2) The study results to date.

ACAP Conference Abstracts 2003

Abstract No. 990056-9

**“INFORMATION TECHNOLOGY IN EMS, THE ENTERPRISE WIDE SYSTEM
AND HOW IT ALL FITS”**

Brian Field

Executive Vice-President, CAO Interdev Technologies Inc., Canada

With the complexity and strange language of Information Technology, too often the “computer geeks” are handed the responsibility of developing information systems without sufficient control and vision from the administrative and user side of the business. This often leads to a system that is disjointed, poorly integrated and ultimately a disappointment to the user and business as a whole.

This discussion will be high on vision and low on “techno babble” with the aim to bringing some understanding of the role and benefits of Information Technology in the business and vision of EMS.

This discussion will provide an overview of several EMS technologies, beginning with the Electronic Patient Report. The discussion will demonstrate the need for the development of, and integration with several other IT systems. These systems, among others, will include human resource databases, online training/certification systems, medical device information and dispatch systems. The discussion will show how it all needs to fit together into an enterprise wide system to become useful to the paramedic and their management.

Several integration, network and data validation challenges will be identified which will demonstrate the need for high level understanding and commitment to the system as a whole as EMS begins to invest in Information Technology

The presentation will also include an overview of IT expenditure as a portion of total expenditure in Health as compared to other sectors such as Finance...and a comparison of IT expenditures of EMS within Health Care.

At the end of the discussion the participant should have a better sense of the tremendous potential IT offers to EMS and the importance of developing a road map to getting there.

ACAP Conference Abstracts 2003

Abstract No. 990056-10

“THE POTENTIAL BENEFITS OF USING SIMULATION TRAINING”

Major Kevin Gardner

Senior Instructor, Health Services Wing, Royal Australian Army

The potential benefits of using simulation training within the health care professions are now becoming recognised. This is not a futuristic concept. The use of simulation is here now and may be as varied as using simple cannulation arms to the most sophisticated computerised animatronics that simulate a vast array of life threatening conditions. The common aims of simulation training are to reduce the error rate in patient care and to use this as a means of learning and improving the performance of the responder. The aim of this presentation is to demonstrate how the Australian Army uses high fidelity mannequins in the education of a wide range of health care professionals including Medics, Nurses and Doctors. Secondly, the presentation will discuss how these mannequins can be used in both the pre-hospital and critical care areas and how this medium can be used throughout the training continuum of the health care professional.

Journal of Emergency Primary Health Care

An International eJournal of Prehospital Care Research, Education, Clinical Practice, Policy and Service Delivery

ACAP Conference Abstracts 2003

Abstract No. 990056-11

“INFECTION CONTROL IS NOT AN OPTIONAL EXTRA”

Kate Hipsley

Infection Control has been seen in the past as an optional extra, rather than something one can seamlessly make part of every day ambulance work. This presentation will address some of the challenges that the NSW Ambulance Service is currently addressing to ensure that Infection Control becomes inextricably linked to all activities.

Infection Control Procedures

- The arrival of SARS highlighted the absence of appropriate procedures and necessitated a lot of work on the run.
- The logistics of implementing procedures across a diverse and geographically spread service.
- Once those procedures have been written and distributed, how do we ensure compliance?
- Working within the organizational culture.

Education

- From Infection Control education only at Induction - to all courses having an Infection Control component.
- “Logistics” again rears its ugly head!
- Who educates the educators?
- Maintaining own professional development.

Facilities, Equipment and Fleet

- Keeping the stations up to the job.
- “Nice piece of equipment, but how and where do we clean it?” – The necessity for mainly single use equipment.
- Sharps, waste and linen.

Staff Health

- Occupational Exposures and how to manage them.
- Staff Screening and Vaccination procedures – NSW Health policy puts the pressure on!

Liaison Activities

- NSW Health and Area Health Services.
- Infection Control Association.
- Other Ambulance Services.

In summary, there are large challenges ahead, but the battle is worth winning in the cause of patient and staff safety.

ACAP Conference Abstracts 2003

Abstract No. 990056-12

“PAIN MANAGEMENT: CAN EDUCATION MAKE A DIFFERENCE?”

Bill Lord

Senior Lecturer, Monash University Centre for Ambulance and Paramedic Studies

Freedom from pain is a fundamental human right. Clinicians have a moral obligation to relieve a patient's pain, yet there is evidence that the management of pain is at times manifestly inadequate. Although data relating to the management of pain in the pre-hospital setting is scant, experience gained from studies that have identified practice gaps in the emergency department setting could probably be applied to the pre-hospital context.

Interventions that influence mortality are frequently the focus of attention in the pre-hospital domain. While survival is an important outcome, non-mortality outcomes deserve increased attention due to the impact that paramedic care can make in the immediate and long-term health and well being of the patient.

Relief of discomfort – which encompasses pain – has been identified as a priority outcome measure for pre-hospital care agencies. Pain management is one area of care where paramedics are able to demonstrate significant benefits in patient outcome. However the efficacy of pre-hospital analgesia depends on several factors, including the knowledge, skills and experience of the paramedic. Education is an important component of this process, both initial and continuing. Yet the scope and depth of such education varies, with some paramedic education programs failing to recognise the importance of pain assessment and pain management. Whereas education relating to the management of chest pain receives significant attention due to the recognised correlation between pain and myocardial injury, the management other types of pain may suffer from the lack of an obvious pathological basis.

Pain management practice is also strongly influenced by the values, belief and attitudes of the individual paramedic. Education programs do not always address these attributes. Furthermore, education programs tend to use summative assessment to measure skill and knowledge acquisition at the completion of the course, rather than evaluating the influence that education has on clinical practice.

Education programs must encompass not only the physiology of pain, assessment of pain – particularly in paediatric and cognitively impaired patients - and analgesic pharmacology; paramedics must confront the ethical, social and cultural aspects of pain management in order to achieve appropriate standards of practice. Perhaps there is also a role for paramedics in patient education, as the patient's beliefs and values can themselves be barriers to effective analgesia. However those with the responsibility for ensuring that clinical standards are achieved and maintained need to realise that information disseminated during a course of instruction may have a minimal effect on behaviour, particularly in situations where group norms and organisational tradition are a dominating influence. These variables also need to be addressed in order to overcome barriers to effective pain management practice.

This presentation investigates the epidemiology of pain in the pre-hospital domain, and the evidence relating to the effectiveness of pain management in this setting. Current approaches to pain education will be discussed, and recommendations made regarding the future development of pain management education for paramedics.

ACAP Conference Abstracts 2003

Abstract No. 990056-13

**“TO RESUSCITATE OR NOT: DOES THE RESEARCH EVIDENCE PROVIDE ANY
ANSWERS IN CASES OF TRAUMATIC CARDIAC ARREST?”**

Bill Lord

Senior Lecturer, Monash University Centre for Ambulance and Paramedic Studies

Decisions about withholding or withdrawing resuscitation are fraught with ethical and moral dilemmas. This is particularly apparent when the death is sudden and unexpected, as is the case in cardiac arrest due to trauma.

Ambulance services, and the medical committees advising these organizations on clinical practice standards, have attempted to support the decision making process through the development of clinical practice guidelines or protocols. Such documents tend to provide explicit advice about withholding interventions in cases where death is clearly obvious, even to the lay public. However the paramedic will encounter cases of traumatic cardiac arrest where these guidelines do not provide definitive answers about the management of the case.

One could argue that in these cases it is better to resuscitate and allow medical officers to make decisions about the continuation of resuscitation. There are however some risks associated with this approach, which includes an increased risk of accidents when managing and transporting cases that are deemed to be time-critical.

Decisions relating to any clinical intervention should be defensible, based on sound reasoning, and informed by best evidence. As such, ambulance services need to ensure resuscitation algorithms take account of research that identifies clinical predictors of resuscitation success or failure. Paramedics should be able to use this evidence to confidently decide when resuscitation is futile.

This presentation examines current evidence relating to the resuscitation of traumatic cardiac arrest, and makes recommendations regarding the strengths and weaknesses of existing protocols that are designed to aid clinical decisions and actions in such cases.

Journal of Emergency Primary Health Care

An International eJournal of Prehospital Care Research, Education, Clinical Practice, Policy and Service Delivery

ACAP Conference Abstracts 2003

Abstract No. 990056-14

“THE POLITICS OF PROFESSIONALISM: SOME IMPLICATIONS FOR THE OCCUPATION OF AMBULANCE PARAMEDICS IN AUSTRALIA”

Kerry Mahony

Industrial Sociologist, School of Management, University of Western Sydney

The author explains how a range of health occupational communities have travelled down various pathways in a quest for professional status. Some have been more successful than others and the evidence indicates that the successful communities pursued political strategies and tactics. This paper draws on their experiences to suggest ways that Australian ambulance paramedics could proceed in their quest for increased professional status and autonomy.

Journal of Emergency Primary Health Care

An International eJournal of Prehospital Care Research, Education, Clinical Practice, Policy and Service Delivery

ACAP Conference Abstracts 2003

Abstract No. 990056-15

“VOLUNTEERISM – A FRESH PERSPECTIVE. A STRATEGIC RESPONSE TO RESEARCH FROM SA AMBULANCE SERVICE”

Ingrid Marshall

Director, Regional Services
South Australian Ambulance Service

Integration between volunteers and paramedics is fundamental to effective service delivery for SA Ambulance Service (SAAS). The following paper outlines the strategic response to research literature (*Stand Up and Be Counted*, *Value Your Volunteer or Lose Them*, and *Asking Volunteers*) that was undertaken by SAAS.

SAAS, like many other community organizations, faces the challenges of high volunteer attrition rates, diminishing regional resources, continual changes in community profiles and competition from other community agencies for volunteers. SAAS' goal is to become the **Volunteer's Choice** however to achieve this vision, a strategic management approach must be adopted. How does SAAS differentiate and leverage its brand within the local community and position itself as the most dynamic and rewarding volunteer organisation? What is the true impact of volunteerism on the 'paid' side of the service? How do we successfully integrate volunteerism and ensure that expectations of volunteers, career staff and community are achieved?

SAAS has 800 paid staff and approx 1850 volunteers. All volunteers are located in country SA and support 74 volunteer ambulance stations. Until recently there has been limited documented evidence and understanding of the key drivers and motivations of volunteers within emergency services and other cluster industries across Australia. June 2002 saw the launch of *Asking Volunteers* and *Stand Up and Be Counted*. To complement these research and planning resources, findings from the *Value Your Volunteers (or lose them)* conference (held in Canberra in 2001) are also available. Collectively, this literature was to provide the cornerstone of SAAS' new volunteer strategy.

During 2002, SAAS identified the number one risk to the sustainability of the organisation was the effectiveness and stability of its volunteer workforce. SAAS volunteers commit on average 120 hours per month. This is a significant contribution from a relatively small group of individuals who provide an essential community service - but at what cost? Preliminary analysis highlighted the plethora of issues and problems that are associated with volunteerism and the integration of volunteer ambulance officers within an organisational structure.

In April 2002, SAAS confirmed its commitment to creating a more satisfying and rewarding experience for its volunteers and career staff by firstly, creating a new position - Director, Regional Services, who would not only be responsible for Country SA but also the development of a volunteer strategy aimed at retention, development and recognition of the volunteer services.

In response to the volunteer literature nine key strategies have been developed and implemented in SAAS.

SAAS is committed to ensuring that future volunteer strategies, processes and support structures are sustainable and relevant to the changing needs of volunteers and the organisation as a whole. SAAS also acknowledges that volunteer initiatives cannot be developed in isolation of the 'paid' side of the business and a fully integrated and cross functional approach across all facets of service delivery is the only 'winning formula'. SAAS is experiencing significant change – both cultural and organisational, the greatest challenge will be to engage and mobilise the staff and successfully lead the organisation through this momentous period.

Journal of Emergency Primary Health Care

An International eJournal of Prehospital Care Research, Education, Clinical Practice, Policy and Service Delivery

ACAP Conference Abstracts 2003

Abstract No. 990056-16

“Role of Paramedic Practitioner”

Andrew McDonnell

Senior Operations Officer (Clinical Support and Training)
Rural Ambulance Victoria (Australia)

The practice of caring for people outside the medical and hospital environments has changed considerably over the last 120 years. In the majority of western countries (and many Middle Eastern and eastern) formalization of ambulance services or emergency medical systems have evolved into an organized health system that care for members of the community who are in an acute health crisis.

Within the Australian context caring for people outside the medical and hospital environments has changed rapidly particularly over the last ten years. The move of “ambulance” (paramedic) education into Universities has seen the development of the professional paramedic with an appropriate qualification. In some cases the ambulance service has become only one place of employment, with paramedics being employed in areas such as educational institutions, research, patient transport, industry and private practices (e.g. “movie set paramedic”).

It has been well documented that Australia has a shortage of health professionals, particularly general medical practitioners (GPs) and registered nurses. This has become particularly evident in remote and rural regions. Traditionally registered nurses have worked in areas that have lacked a doctor. More recently the nursing profession has pushed for the creation of nurse-practitioners to further service these areas of Australia without a doctor. Paramedic practice has changed considerably with paramedics already performing and caring for patients that were traditionally the practice of the GP. In the United Kingdom (UK) it has been recognized that paramedics can perform advanced clinical practice which is not only advantageous to the patient, but to the entire health system and have developed the paramedic practitioner. So in Australia have paramedics been overlooked for providing primary health care in the community? Or do paramedics themselves fail to recognize their ability, education and potential scope of practice?

Despite the changes in clinical practice and the potential for the development of an independent practitioner, the profession remains in a state of flux and confusion. Unfortunately our profession cannot even agree upon the name of the practitioner, are we paramedics or ambulance officers? What do we practice, “ambulance”, “pre-hospital care”, “emergency care” or “paramedicine”? Should paramedics be registered or should they be under the control of ambulance services or health departments?

Without these questions being asked and answered, paramedics will never be able take control of their own unique discipline and/or move onto full independent practice.

Journal of Emergency Primary Health Care

An International eJournal of Prehospital Care Research, Education, Clinical Practice, Policy and Service Delivery

ACAP Conference Abstracts 2003

Abstract No. 990056-17

“Technological determinism: A social process with some implications for Ambulance Paramedics”

Dennis McIntyre

Lecturer, School of Behavioural and Community Health Science
University of Sydney

Medical technology has been presented as a driving force behind a range of social changes, both positive and negative. These changes include escalating health care costs and inequalities in health care outcomes, the deskilling and hyperskilling of health care practitioners, and increased human longevity and quality of life. Medical technology is sometimes clouded by mystique in that each new drug, device, or machine tends to appear as a thing with a life of its own, as if the technology not only arrived independent of social, cultural, political and economic forces but was also the driving force for social change. By not considering the emergence and adoption of a medical technology as a social process, the resulting social change appears as a natural consequence of technological innovation. This has been termed *technological determinism*. This paper examines technological determinism as a social process and provides some explanation as to why ineffective, expensive, and harmful medical technologies have proliferated since the late 1970's. Four implications arising from technological determinism are identified, and they all have consequences for Ambulance Paramedics and their everyday practice as health care professionals. Firstly, the intuition acquired as a skilled practitioner cannot be replaced by technology and an increase in invasive interventions has resulted in increased iatrogenesis. Secondly, there can be the blocking of a more effective and/or cheaper technology due to the resistance of powerful commercial and/or status groups. Thirdly, borrowing/sharing the technological symbols of an already dominant group may only serve to continue and/or construct a subordinate relationship. Fourthly, there can be a devaluing of Ambulance Paramedics when success is attributed to a technology rather than the skills of practitioners who use it.

ACAP Conference Abstracts 2003

Abstract No. 990056-18

**“EARLY IDENTIFICATION OF PATIENTS FOR THROMBOLYSIS BY INTENSIVE CARE
PARAMEDICS: A PILOT STUDY”**

John Murray

Clinical Support Officer, Queensland Ambulance Service

Larger thrombolytic studies have found that patients with ST elevation or new LBBB have a greater reduction in mortality compared to those with other ECG variants of infarction. Congruent with this, the American Heart Association and the American College of Cardiology have stated “*ample evidence exists that persons with suspected myocardial infarction and ST-segment elevation or bundle branch block should undergo immediate reperfusion.....*”. Where and how this reperfusion is best achieved is a situation specific issue but with new single bolus thrombolytic agents now available many ambulance services are already initiating thrombolysis before hospital.

Numerous studies have demonstrated that pre-hospital 12 lead ECGs do decrease ‘door to needle times’ but whether one considers, ‘door to needle time’ or ‘call to needle time’, these measures do not specify the seemingly more critical, but far more difficult to define, measure and control interval from ‘symptom onset to reperfusion time’.

With most Intensive Care Paramedic Ambulances in Queensland now equipped with 12 lead ECGs and approximately 19 000 cases of chest pain being managed by paramedics across Queensland each year, we undertook a pilot study to investigate;

1. whether ICPs can accurately identify patients for thrombolysis and
2. the potential for ICPs to administer a thrombolytic agent within clinically significant and internationally benchmarked time frames from onset of symptoms.

This presentation outlines the underpinning rationales, structure and results of this pilot study, and makes comment about the potential efficacy, safety and usefulness of pre-hospital thrombolysis in Queensland.

Journal of Emergency Primary Health Care

An International eJournal of Prehospital Care Research, Education, Clinical Practice, Policy and Service Delivery

ACAP Conference Abstracts 2003

Abstract No. 990056-19

“WOULD A PRE-HOSPITAL PRACTITIONER MODEL IMPROVE PATIENT CARE IN RURAL AUSTRALIA?”*

Dr. Peter O'Meara

Associate Professor – School of Public Health
Charles Sturt University, NSW

Introduction

Existing rural pre-hospital models have been criticised for being isolated from the health care system, and for following inflexible clinical protocols. Greater reliance on clinical judgement and informed decision-making in the pre-hospital setting offer the potential to improve patient care.

Methods

Soft Systems Methodology was used to develop and critically appraise the Pre-Hospital Practitioner Model as an alternative to existing models. This approach started from the philosophical viewpoint that pre-hospital services should be patient-centred. Soft Systems Methodology was used to structure the elements of pre-hospital systems and the relationships between them into metaphors and pictures that could be analysed.

Results

My analysis shows that the most powerful reason for advocating the pre-hospital practitioner model is that it places pre-hospital systems within a symbiotic relationship with the health care system. Unlike the existing emergency service models or the 'chain of survival' model, it is an integrated system that provides a range of services at multiple points during the patient-care cycle. Thus, the pre-hospital practitioner would have roles in the prevention of injury and illness, responding to emergencies, facilitating recovery, and planning future strategies for a healthy community.

Conclusions

Implementing this new model would see the pre-hospital system using its available capacity more effectively to fulfil broader public health and primary care outreach roles than is currently the case. Patients would be referred or transported to the most appropriate and cost-effective facility as part of a seamless system that provides patients with well-organised and high quality care.

*The full text of this paper has been published by *Emerg. Med. Jnl.*, March 2003; 20: 199-203.

Journal of Emergency Primary Health Care

An International eJournal of Prehospital Care Research, Education, Clinical Practice, Policy and Service Delivery

ACAP Conference Abstracts 2003

Abstract No. 990056-20

“CONSTRAINTS AND OPPORTUNITIES – EXPANSION OF THE ROLE OF THE PARAMEDIC”

Jennifer Short

Senior Lecturer, Charles Sturt University

The role of the paramedic

During the 1950s and 1960s ambulance services aimed to provide a quick response and speedy transportation. Over the past ten years the role of the paramedic has become more diffuse. A tripartite emphasis on access, stabilisation and transport can be discerned.

Source of the push for an expanded role of the paramedic

It is possible to discern two sources pushing for an expanded role for the paramedic:

- The first source of the push for an expanded role can be identified as coming from paramedics themselves.
- The second source of the push for an expanded role for the paramedic can be seen to be coming from health care payers.

Constraints

A number of constraints diminish the likelihood of the expansion of the current role of the paramedic.

- Doctors may balk at delegating any additional tasks to mid-level practitioners (paramedics).
- Nurses may identify that proposals for an expanded role for the paramedic are redundant because they mimic existing public health and community nurse roles.
- In a period of health care reform focused on cost containment it is particularly difficult to justify any expansion of a currently existing role. The exception may be an expanded role associated with implementing some form of economic discrimination within the emergency medical system.

Opportunities

Despite the existence of constraints, significant opportunities exist which strengthen the likelihood of the expansion of the current role of the paramedic.

- Given the current emphasis on cost containment, paramedics could expand their current role by performing the role of “Gatekeeper” with respect to access to health care facilities.
- In rural areas, paramedics could take on the role of “Out Of Hospital Emergency Care Provider”.
- Paramedics can perform the role of “Quality Assurance Assessor”.
- The role of “Researcher” can be undertaken by paramedics.
- Paramedics have the potential to fulfil the role of “Community Educator”.

Conclusion

Within a health care system characterised by an overriding emphasis on the necessity to contain costs and to use resources efficiently, the desire to expand the role of the paramedic appears fraught with difficulty. It can be argued however, that by expanding the role of the paramedic in order to fill current health care system deficiencies, patient care will benefit, whilst at the same time, greater levels of efficiency and effectiveness will be achieved.

* Within this paper, the term “paramedic” is used in the generic sense. That is, it is inclusive of more specialised terms such as Qualified Ambulance Officer, Advanced Life Support Officer, Mobile Intensive Care Ambulance Officer, etc.

Journal of Emergency Primary Health Care

An International eJournal of Prehospital Care Research, Education, Clinical Practice, Policy and Service Delivery

ACAP Conference Abstracts 2003

Abstract No. 990056-21

“A FIRST RESPONDER PROGRAM – A PROGRAM USING FIRE FIGHTERS AND AMBULANCE PARAMEDICS”

David Shugg

Senior Lecturer and Head of Professional Development Unit
Monash University Centre for Ambulance and Paramedic Studies

Using fire fighters to respond to medical emergencies in Melbourne was first advanced by a former Chief Fire Officer of the Metropolitan Fire Brigades Board (MFB) more than 20 years ago. At that time, he identified the need for fire fighters to be involved in other aspects of emergency response and to broaden their knowledge and skills. A Public Bodies Review also later identified this. However the real push occurred in 1990 when the Victorian Kennett Government was determined to reduce the expenditure on the public purse and started a vigorous program of downsizing and outsourcing to both reduce public expenditure and increase productivity. The fire fighter first responder program was seen by the Government as a way to effectively utilise fire fighters that were already in the system as a way of reducing the publicly criticized public ambulance response times to emergencies.

The MFESB formally introduced the First Responder Program in 1994 after a long period of consultation, negotiation and planning with stakeholders. Initially the program operated within an agreed designated small area where the MFESB units would be dispatched at the same time as the Metropolitan Ambulance Service to telephone 000 reported life-threatening emergencies. The pilot program was later expanded and now covers the entire Melbourne Fire District using 1380 first responder trained fire fighters.

Overall, the program has demonstrated a reduction in response times to life threatening emergencies. However, there have been some aspects that require further investigation. There have been significant challenges with the introduction and continuation of the service due to inter service issues, turf protection, cultural acceptance and communication problems.

The paper will present an overview of the planning, training and operations of the fire fighter first responder program in Melbourne. It will also discuss the benefits and difficulties encountered.

Journal of Emergency Primary Health Care

An International eJournal of Prehospital Care Research, Education, Clinical Practice, Policy and Service Delivery

ACAP Conference Abstracts 2003

Abstract No. 990056-22

“DEVELOPMENT OF A QUALITY CHECKLIST FOR AMBULANCE TRAUMA PATIENT CARE RECORDS”

Erin Smith

Research Officer, Monash University Centre for Ambulance and Paramedic Studies

The field of pre-hospital research continues to expand, with current Victorian based projects using ambulance patient care records (PCRs) to develop trauma related registries. Most pre-hospital research projects will at some time use information recorded on the ambulance PCR. The need for high quality data capture is therefore paramount.

Monash University Centre for Ambulance and Paramedic Studies (MUCAPS) is currently conducting studies in the area of trauma triage and mechanism of injury. These studies are conducted using a retrospective audit of all trauma patient PCRs. The project includes all trauma cases transported by ambulance in Victoria during the time period January 1 – December 31 2002. Victoria is serviced by two ambulance services, Metropolitan Ambulance Service (MAS) and Rural Ambulance Victoria (RAV). PCRs from both agencies for the time period were sampled for the study.

MUCAPS designed a quality checklist system, based on the Maryland Practitioner Clinical Medical Record Audit, by Amerigroup. The checklist was designed specifically for trauma PCRs, and random samples of the trauma profile, mechanism of injury subset and the sudden deterioration subset were assessed. This paper will present the process of developing the quality checklist, and the results from the quality audit of the first six months of data in the trauma registries.

Journal of Emergency Primary Health Care

An International eJournal of Prehospital Care Research, Education, Clinical Practice, Policy and Service Delivery

ACAP Conference Abstracts 2003

Abstract No. 990056-23

“YES I KNOW IT HURTS”

Stacey Solomou
Intensive Care Paramedic
South Australian Ambulance Service

If pain is subjective could it be argued that the management of pain in the pre-hospital environment is also subjective? The “Pain Score” approach certainly identifies the level of pain a patient is experiencing; however, does this alter the choice of analgesia provided by a Paramedic or Intensive Care Paramedic.

Ambulance Services across Australia provide pain relief via an array of pharmacological agents dependent upon clinical status and presenting conditions.

The South Australian Ambulance Service (SAAS) is no exception to this, offering pain relief via inhaled agents along with narcotic analgesics. Recognition should also be given to the use of oxygen therapy and splinting for the relief of pain, or should it? Do we employ these measures and do we actually consider them as effective adjuncts in the form of pain relief?

This presentation will discuss SAAS’s recent involvement in a previous and continual Methoxyflurane (Penthrane) study and the impact of inhaled analgesics with regards to dose related toxicity. Statistical data will be discussed which encompasses pain scores, presenting complaints and the choice and effectiveness of analgesic agents such as methoxyflurane in the pre-hospital setting.

Are we achieving an adequate level of comfort for patients experiencing pain, or are we just making them sicker? Do we even identify the need for pain relief, and if we do what is our first choice of treatment? How do we overcome the patient that simply doesn’t understand the lengthy description of the “pain score”? Do we give up explaining it after we have become hypoxic trying, or do we just simply say – YES I KNOW IT HURTS!!!

ACAP Conference Abstracts 2003

Abstract No. 990056-24

**“EXPANDING THE NATIONAL HORIZON – AN EXPLORATION OF NATIONAL
REGISTRATION FOR AMBULANCE PROFESSIONALS”**

Leah Trotta

Education Manager, Education Unit, South Australian Ambulance Service

National registration of the ambulance profession has long been discussed by both employer and employee bodies within the ambulance industry. Documentary evidence of these discussions represents a positive view of this concept. Despite this apparently agreeable environment, the ambulance profession in Australia has not made significant practical progress toward the establishment of a professional register or registering body.

The introduction of a national training package by the Australian National Training Authority which incorporates ambulance industry qualifications and the widespread adoption of this package sets a background to industry qualification. This newly attained position creates an environment which allows qualifications to be benchmarked or at least mapped to the national competencies. This, for the first time, offers an opportunity to compare qualification as an indicator of practice standards across Australia. This applies primarily to the Vocational Education and Training sector, but also to the tertiary sector as a basis for comparing qualification outcomes.

In turn, there is now an opportunity to identify a national standard for qualification and practice for ambulance professional. A national standard can, of course, lead to a national register. And, there are a number of experiences that the ambulance profession can draw on to chart its path toward national registration. These include the Australian examples of nursing registration, teacher registration and the certified practicing accountant models. Internationally, there are also models to draw on specific to ambulance industry registration.

If the ambulance profession is to progress practically toward national registration, then its potential advantages and potential disadvantages must be explored and we all need to consider the question “Why do it?”.

Additionally, it is important to explore the roles of the various key players in this issue, including the Australian College of Ambulance Practitioners, the Australian Convention of Ambulance Authorities, employee representative organizations and government. Each has a contribution to the debate and a role to play in the establishment and eventual management of a national register. What will the role of each be?

This presentation will also touch on the legislative differences between states and the management of this issue for the purpose of national professional registration.

In this presentation, I intend to draw the current debate together to inform the way ahead.

ACAP Conference Abstracts 2003

Abstract No. 990056-25

“Pre-Hospital airway management in severe traumatic brain injury – the importance of education, evaluation and research”

Helen Webb

Lecturer, School of Public Health, Charles Sturt University

Review of Literature

Traumatic Brain Injury (TBI) is a major cause of disability, death and economic cost to society. Brain injury evolves over hours to days after the primary insult. These evolving secondary insults have been demonstrated to have a deleterious effect on patient functional outcome (Brain Trauma Foundation 2000).

The deleterious effects of hypoxaemia on patient outcome following severe TBI have been well established. Pre-hospital hypoxaemia in TBI patients (arterial haemoglobin saturation < 90%) is a parameter associated with poor patient outcome (Brain Trauma Foundation 2000). The causality of hypoxaemia can include patient hypoventilation, lack of assisted ventilation or oxygenation, poor airway management, or the non-use of appropriate airway adjuncts.

According to the Brain Trauma Foundation (2000), the efficacy of pre-hospital treatment of brain trauma patients has not been adequately evaluated. Studies have shown the efficacy of pre-hospital care in the reduction of mortality rates following cardiac arrest, however, the ability of pre-hospital emergency care systems to reduce mortality rates in cases of severe trauma is unknown (Demetriades et al. 1996).

Methodology

A retrospective cohort study was undertaken to investigate the relationship between pre-hospital management and functional outcome of persons with severe traumatic brain injury Glasgow Coma Score (GCS) < 9 in the Sydney metropolitan area from June 1999 to July 2001. Descriptive analysis on airway management has been completed for the first 100 cases.

Results

On arrival at the Emergency Department (ED), 30% (n=30) of patients presented with an airway obstruction unrelieved in the pre-hospital setting. The major cause of airway obstruction was blood in the airway (23%). A total of 36.5% (n=19) of patients with a GCS of 3-4 (n=50), presented at ED with an airway obstruction.

On arrival at ED 10.0% of patients had an oxygen saturation level of less than 85% (n=10), 2.0% (n=2) with saturation between 85-89, 9.0% (n=9) with saturation between 90-94 and 67.0% (n=67) with saturation between 95-100%. In twelve cases, the oxygen saturation levels were not documented at ED.

Of those patients with a GCS of 3-4 (n=50), 18% received no airway adjunct, 60% received an oropharyngeal airway, 8% a nasopharyngeal airway and 14% were intubated.

Outcome was measured using the Glasgow Outcome Scale (GOS) at discharge from hospital. A total of 37.4% of patients died, whilst 6.1% of patients were in a persistent vegetative state. Severe disability was experienced by 17.2% of patients; moderate

disability by 5.1%, whilst 34.3% of patients made a good recovery (may have minor neurological or psychological deficits).

A total of 56% (n=56) of patients were transported to the closest hospital which was an Area Trauma Hospital (ATH), 30% (n=30) bypassed the local hospital for an ATH and 14% (n=14) of patients were transported to a District hospital. All 14 patients initially transported to the District hospital were later transferred to an ATH for neurosurgical assessment and intervention.

Conclusion

Significant airway management problems exist within the pre-hospital setting with respect to patients experiencing severe TBI. A significant number of patients with severe TBI are experiencing hypoxaemia in the pre-hospital setting. Hypoxaemia has been demonstrated to adversely affect function outcome following severe TBI.

Implications for pre-hospital care education are widespread. Extensive curriculum content on airway anatomy, physiology, pathophysiology and effective airway management procedures are essential to improve neurological outcome. Moreover, evaluation of clinical practice needs to be undertaken to ensure an optimal relationship between pre-hospital management and patient outcome.

References

Brain Trauma Foundation 2000, *Management and prognosis of severe traumatic brain injury*, Brain Trauma Foundation, New York, USA.

Brain Trauma Foundation 2000, *Guidelines for the pre-hospital management of traumatic brain injury*, Brain Trauma Foundation, New York, USA.

Demetriades, D, Chan, L, Cornwell, E, Belzberg, H, Berne, T, Asensio, J, Chan, D, Eckstein, M & Alo, K. 1996. Paramedic vs private transportation of trauma patients, *Archives of Surgery*, **131**, pp.133-138.

Acknowledgments

The author wishes to thank Christine Meek and Garrick Burgess, graduate students, for their assistance with data entry.

ACAP Conference Abstracts 2003

Abstract No. 990056-26

“PROFESSIONALISM”

Andrea Wyatt

Senior Lecturer, Monash University Centre for Ambulance and Paramedic Studies

The issue of professional registration of paramedics is both topical and controversial. It is therefore timely that the many issues concerning registration are raised and discussed in open forums. This paper will examine the issues from the academic perspective.

A discussion of what is meant by ‘registration’ will lead to an overview of what is happening in other professions within Australia, and also what is happening within the paramedic profession internationally. These trends will be explored in light of the changing context of paramedic practice within Australia.

What does registration mean to the profession and what are the advantages and disadvantages involved in the introduction of registration? What impact, if any, will registration have on the paramedic and their practice? Is there a value-added benefit to be gained from registration over the existing situation?

The academic interest in these discussions arises from a number of perspectives. State or national guidelines that outline the standard of professional practice will need to be established, and academic institutions accredited to conduct courses that meet this standard. Similarly, there will need to be formal recognition and accreditation of continuing education programs. Who will bear the responsibility for such accreditations? Who will endorse the standards? What is the best academic model and infrastructure to support registration? Who will bear the ultimate responsibility for the practicing paramedic?

The paper will conclude by perhaps introducing more questions than it has managed to answer, however the purpose is to address the issues. The ultimate focus of professional registration must be to protect the community – will registration lead to this?

Journal of Emergency Primary Health Care

An International eJournal of Prehospital Care Research, Education, Clinical Practice, Policy and Service Delivery

ACAP Conference Abstracts 2003

Abstract No. 990056-27

“HOW CAN WE SHORTEN TIME TO TREATMENT IN ACUTE STROKE? – THE TIME WINDOW IN NEUROPROTECTION (TWIN) STUDY”

Dennis Young

Manager – Clinical Trials Division

National Stroke Research Institute, Austin Health, Melbourne

Stroke is one of the most feared medical emergencies, affecting around 40,000 Australians every year and being the most common reason for people becoming disabled. There are now effective treatments, for instance clot busting drugs, which reduce death and disability, but these have to be given within hours of stroke onset and can only safely be given in hospitals.

Some common drugs - for instance vitamin B3, melatonin, minocycline, caffeine - work in experimental stroke and are known to be safe. The sooner these drugs are given, the more effective they are likely to be. Because they are safe, they could be given at first contact with health services, by the attending ambulance crew.

The TWIN study plans to test a combination of such drugs in patients presenting to MAS (Metropolitan Ambulance Service) with symptoms of acute stroke. The primary end point will be death or disability at 6 months.

This is a new approach to stroke research, involving for the first time professionals responsible for pre-hospital patient care. We hope to develop treatments that could be given to patients in rural areas as well as in cities that would reduce the burden of stroke.

Journal of Emergency Primary Health Care

An International eJournal of Prehospital Care Research, Education, Clinical Practice, Policy and Service Delivery

ACAP Conference Abstracts 2003

Abstract No. 990056-7

"IS IT TIME TO RE-ASSESS THE ROLE OF AMBULANCE OFFICERS?"

Christine Fahey

Research Fellow, University Department of Rural Health,
University of Tasmania

This paper explores issues surrounding the role of ambulance officers by posing the question "Should ambulance officers re-assess their role to better meet then needs of Australia's current and future health system?"

In considering this question I argue that the history of ambulance services and the non-reflexive official policies that define ambulance officer roles have driven the delivery of ambulance services for too long. The ongoing escalating demand for ambulance services may provide ambulance officers and policy makers with an ideal opportunity to review the role of ambulance services in Australia.

Several warning bells pointing to the need to re-assess the role of ambulance officers in current health care delivery are highlighted:

1. That the major performance measure used by ambulance services is response times. This reflects the fact that historically ambulance services are designed primarily to provide urgent life-saving treatment, despite the fact that the majority of patients do not have life-threatening illnesses.
2. That ambulance services worldwide are experiencing growing demand for services, with little understanding of the causes for this increase in demand.
3. That anecdotal evidence suggests ambulance services are increasingly spending time caring for patients whilst looking for a hospital to accept patients into their care, with ambulance officers required to spend long hours waiting with patients to be handed over to department of emergency staff.

I then suggest how this re-evaluation might proceed and who should be involved. Research and communication will be key factors. Ambulance services are currently poorly placed to review models of care, as there is a dearth of service delivery research. What is needed is a combination of expertise from economists through to behavioural scientists. Management, researchers and policy advisors will have important roles in evaluating services at the system level, while ambulance officers and researchers can ensure that those making decisions have relevant information from the field. Education providers must also be at the forefront of change, by ensuring the ambulance officers' curriculum reflects the changing environment.

There is increasingly an imperative for ambulance services to reflect on their role within the current health system and position themselves strategically to meet future health care needs. The increasing pressure on our health system sees governments attempting to contain health care costs. Unfortunately these pressures are set within an Australia where health consumers have rising expectations of care, and health service providers are increasingly afraid of litigation. There is no doubt that ambulance services have an important role in providing Australians with high quality care, but they need to ensure they are effective in the provision of this care by ongoing review and reflection. I conclude that 'yes', ambulance officers should re-assess their role.

ACAP Conference Abstracts 2003

Abstract No. 990056-1

“MANAGING PRE-HOSPITAL STAFF FOR PEAK PERFORMANCE”

Allison Ballard

Paramedic, Tasmanian Ambulance Service

The relative infancy of the emergent professionalism of pre-hospital practitioners brings with it an interesting dilemma – how to best manage professional staff in order to achieve optimal work performance, motivation, commitment to ongoing professional development, and staff recruitment and retention.

These are not new issues - they are longstanding universal issues confronting all organizations, regardless of organisational size, structure and function – and quite independent of whether the organisation is a private sector or government business.

Organizations may survive, but they are unlikely to achieve ongoing corporate success, or best practice, without optimal management of what is widely recognised to be an organization's most important “resource” - that is, its people.

Furthermore organizations that do not manage their staff appropriately may foster a culture in which staff “work-to-rule” and search out opportunities to undermine management rather than using their energy to make a positive corporate contribution. Forms of deliberate sabotage can become the norm, accepted, albeit often reluctantly, by employees who, as a general rule would much prefer to focus on the effective delivery of their core business

While there are many ways of managing people – some good, some bad - managing people to foster morale and motivation, to promote commitment to both work and the organisation, and indeed managing to retain staff should be a primary organisational goal. It is much more cost-effective to develop peak performance in, and retain existing staff, than it is to recruit and train new staff!

The managers of professionals face additional challenges...

ACAP Conference Abstracts 2003

Abstract No. 990056-16

“Role of Paramedic Practitioner”

Andrew McDonnell

Senior Operations Officer (Clinical Support and Training)
Rural Ambulance Victoria (Australia)

The practice of caring for people outside the medical and hospital environments has changed considerably over the last 120 years. In the majority of western countries (and many Middle Eastern and eastern) formalization of ambulance services or emergency medical systems have evolved into an organized health system that care for members of the community who are in an acute health crisis.

Within the Australian context caring for people outside the medical and hospital environments has changed rapidly particularly over the last ten years. The move of “ambulance” (paramedic) education into Universities has seen the development of the professional paramedic with an appropriate qualification. In some cases the ambulance service has become only one place of employment, with paramedics being employed in areas such as educational institutions, research, patient transport, industry and private practices (e.g. “movie set paramedic”).

It has been well documented that Australia has a shortage of health professionals, particularly general medical practitioners (GPs) and registered nurses. This has become particularly evident in remote and rural regions. Traditionally registered nurses have worked in areas that have lacked a doctor. More recently the nursing profession has pushed for the creation of nurse-practitioners to further service these areas of Australia without a doctor. Paramedic practice has changed considerably with paramedics already performing and caring for patients that were traditionally the practice of the GP. In the United Kingdom (UK) it has been recognized that paramedics can perform advanced clinical practice which is not only advantageous to the patient, but to the entire health system and have developed the paramedic practitioner. So in Australia have paramedics been overlooked for providing primary health care in the community? Or do paramedics themselves fail to recognize their ability, education and potential scope of practice?

Despite the changes in clinical practice and the potential for the development of an independent practitioner, the profession remains in a state of flux and confusion. Unfortunately our profession cannot even agree upon the name of the practitioner, are we paramedics or ambulance officers? What do we practice, “ambulance”, “pre-hospital care”, “emergency care” or “paramedicine”? Should paramedics be registered or should they be under the control of ambulance services or health departments?

Without these questions being asked and answered, paramedics will never be able take control of their own unique discipline and/or move onto full independent practice.

Journal of Emergency Primary Health Care

An International eJournal of Prehospital Care Research, Education, Clinical Practice, Policy and Service Delivery

ACAP Conference Abstracts 2003

Abstract No. 990056-20

“CONSTRAINTS AND OPPORTUNITIES – EXPANSION OF THE ROLE OF THE PARAMEDIC”

Jennifer Short

Senior Lecturer, Charles Sturt University

The role of the paramedic

During the 1950s and 1960s ambulance services aimed to provide a quick response and speedy transportation. Over the past ten years the role of the paramedic has become more diffuse. A tripartite emphasis on access, stabilisation and transport can be discerned.

Source of the push for an expanded role of the paramedic

It is possible to discern two sources pushing for an expanded role for the paramedic:

- The first source of the push for an expanded role can be identified as coming from paramedics themselves.
- The second source of the push for an expanded role for the paramedic can be seen to be coming from health care payers.

Constraints

A number of constraints diminish the likelihood of the expansion of the current role of the paramedic.

- Doctors may balk at delegating any additional tasks to mid-level practitioners (paramedics).
- Nurses may identify that proposals for an expanded role for the paramedic are redundant because they mimic existing public health and community nurse roles.
- In a period of health care reform focused on cost containment it is particularly difficult to justify any expansion of a currently existing role. The exception may be an expanded role associated with implementing some form of economic discrimination within the emergency medical system.

Opportunities

Despite the existence of constraints, significant opportunities exist which strengthen the likelihood of the expansion of the current role of the paramedic.

- Given the current emphasis on cost containment, paramedics could expand their current role by performing the role of “Gatekeeper” with respect to access to health care facilities.
- In rural areas, paramedics could take on the role of “Out Of Hospital Emergency Care Provider”.
- Paramedics can perform the role of “Quality Assurance Assessor”.
- The role of “Researcher” can be undertaken by paramedics.
- Paramedics have the potential to fulfil the role of “Community Educator”.

Conclusion

Within a health care system characterised by an overriding emphasis on the necessity to contain costs and to use resources efficiently, the desire to expand the role of the paramedic appears fraught with difficulty. It can be argued however, that by expanding the role of the paramedic in order to fill current health care system deficiencies, patient care will benefit, whilst at the same time, greater levels of efficiency and effectiveness will be achieved.

* Within this paper, the term “paramedic” is used in the generic sense. That is, it is inclusive of more specialised terms such as Qualified Ambulance Officer, Advanced Life Support Officer, Mobile Intensive Care Ambulance Officer, etc.

Journal of Emergency Primary Health Care

An International eJournal of Prehospital Care Research, Education, Clinical Practice, Policy and Service Delivery

ACAP Conference Abstracts 2003

Abstract No. 990056-23

“YES I KNOW IT HURTS”

Stacey Solomou
Intensive Care Paramedic
South Australian Ambulance Service

If pain is subjective could it be argued that the management of pain in the pre-hospital environment is also subjective? The “Pain Score” approach certainly identifies the level of pain a patient is experiencing; however, does this alter the choice of analgesia provided by a Paramedic or Intensive Care Paramedic.

Ambulance Services across Australia provide pain relief via an array of pharmacological agents dependent upon clinical status and presenting conditions.

The South Australian Ambulance Service (SAAS) is no exception to this, offering pain relief via inhaled agents along with narcotic analgesics. Recognition should also be given to the use of oxygen therapy and splinting for the relief of pain, or should it? Do we employ these measures and do we actually consider them as effective adjuncts in the form of pain relief?

This presentation will discuss SAAS’s recent involvement in a previous and continual Methoxyflurane (Penthrane) study and the impact of inhaled analgesics with regards to dose related toxicity. Statistical data will be discussed which encompasses pain scores, presenting complaints and the choice and effectiveness of analgesic agents such as methoxyflurane in the pre-hospital setting.

Are we achieving an adequate level of comfort for patients experiencing pain, or are we just making them sicker? Do we even identify the need for pain relief, and if we do what is our first choice of treatment? How do we overcome the patient that simply doesn’t understand the lengthy description of the “pain score”? Do we give up explaining it after we have become hypoxic trying, or do we just simply say – YES I KNOW IT HURTS!!!