Submission
No 126

THE MANAGEMENT AND OPERATIONS OF THE NSW AMBULANCE SERVICE

Name: Suppressed

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Dear Members of the general purpose standing committee,

I would like to draw to your attention the need for increased skill levels in rural and remote communities.

In past years there has been a skill level that was specifically developed in response to the need of specific interventions required in rural and remote communities. This skill level is known as Advanced Life Support (ALS) and offered patients of smaller communities more specialised care when required and similar to the services offered in the metropolitan area's where Intensive Care (IC) paramedics are stationed, at present there are very few Paramedics trained in rural and remote communities to the level of IC paramedic.

In recent years training to ALS has ceased, whilst the skill level of a qualified paramedic has increased with the introduction of P1 training there is a need for specific interventions in a rural/remote community not just in metropolitan areas.

As a level 2 paramedic awaiting P1 training I value having colleges that have ALS qualifications combined with P1 qualifications and have relied on their qualifications on numerous occasions to give patients the most appropriate treatment when necessary. In the near future my community will be reduced to one paramedic with combined P1 and ALS qualifications with no provision in place to increase qualifications of paramedics from P1 qualifications.

As a brief outline of interventions that my community and others will be without, when ALS paramedics are not available include; The use of midazolam for Limb realignment and difficult extrication as well as patient management which is used to sedate patients suffering mental health conditions in which they could be a danger to themselves or others. The use of a sedative for the aforementioned condition provides a far better method of management in comparison to the patient being unwillingly escorted by police.

Morphine will be unavailable, Although there are other forms of pain relief available morphine has been known as one of the most effective ways of pain management.

During a cardiac arrest an ALS officer can administer two types of medication these are adrenaline and atropine which may lead a better outcome other than CPR and defibrillation alone.

A tension pneumothorax can be decompressed by a ALS paramedic. This is a condition in which air escapes from a hole in a lung and builds up pressure in the chest inhibiting the undamaged lung from functioning properly, although the need for decompression is rare the condition when present is an extremely serious and requiring decompression. The previous mentioned ALS skills and pharmacological interventions are not a complete list of interventions that an ALS paramedic can perform a full summery can be provided on request.

As ALS officers retire or move away from rural and remote towns the communities no longer have the standard of care they once had and the out going officers are often replaced with level 2 officers awaiting P1 training which can take approximately two years before being undertaken. I would also like to mention some communities have been with out ALS paramedics for a long period or have never had them so at present these communities are not receiving the same service as others.

Some of the interventions performed by ALS paramedics are essential in life threatening cases and in a rural/remote environment back up from IC paramedics is a long way off.

Geographical packages have been implemented for the use of some medications by level 2 officers who would not normally be able to use these medications until they have P1 qualifications these packages should also be developed for interventions by paramedics who are not currently allowed to perform certain tasks or give certain medications within communities that are lacking back up of more qualified officers. The implementation of course should only be in immediately life threatening cases or as determined by specific criteria.

The ASNSW has in place a variation of protocol notification for paramedics that work outside their scope of practice as a system that is provided to support paramedics who implement interventions outside there skill level when they deem it absolutely necessary and often within consultation with a local doctor. This process is not widely accepted across the service and paramedics will often be hesitant to perform outside their scope of practice as they may be scrutinised for it.

A solution to this would be that the service acknowledges that paramedics that feel in life threatening situations that a certain intervention is required that they enable them to perform this

skill outside there scope of practice with more confidence by giving education and advising the types of situations in which it is acceptable to operate outside there scope of practice in exceptional circumstances. For example a level 2 paramedic may be called to a property 70km from a hospital on there own and need to treat a child with extreme anaphylaxis and the use of adrenaline is not part of there current scope of practice, or an asthmatic in extremis requiring adrenaline. Another example could be a P1 paramedic attending an car accident many km from town in which the patient has a tension pneumothorax requiring immediate decompression. These situations may be rare although they are situations that may be encountered. Another example would be in the case of P1 officers attending a cardiac arrest many km from the hospital, the use of cardiac drugs would increase the chance of a better outcome from the patient.

I would suggest that the service implements training programs to assist paramedics to deal with these situations that are outside there normal scope of practice as support to variations of protocol with education programs, or enlisting more geographical packages so that these rural and remote communities have a similar level of care to people in the city. Once the programs are developed they could be implemented as on station training programs with ongoing competency tests that are assessed by station officers and/or regional educators.

I would also recommend that there is a level of paramedic that is specifically trained to meet the needs of a rural and remote community, so that protocol variations and/or geographical packages are not the "fill gap" relied upon. A higher level of training in rural and remote may also slow down the turn over of staff in these area's as many will appreciate the opportunity to advance their training instead of applying for a transfer not long after they are posted to the position.

I thankyou for allowing me to submit my concerns and ideas to the enquiry.