

Paramedic Safety **Taskforce**

FINAL REPORT

April 2016





Final Report (April 2016) Paramedic Safety Taskforce

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Foreword

The Queensland Ambulance Service (QAS) has made a commitment to ensuring the health and safety of our officers. Violent attacks against paramedics are a major concern for the QAS, the United Voice Queensland (UVQ) union and the entire community. As a result of ongoing consultation, the QAS engaged with UVQ to collaboratively establish the Paramedic Safety Taskforce (the Taskforce) in December 2015.

Unfortunately violent attacks in our workplace are a problem we cannot immediately eliminate. However I strongly believe we can do more to reduce the risk of harm to our staff and maintain the momentum within the community for education and awareness on this issue.

During the past four months, the Taskforce has undertaken an extensive research and consultation process to inform its findings, with members participating from around Queensland to listen and share their views and experiences of occupational violence in our workforce.

The Taskforce's Final Report is founded on a strong evidence base and provides an analysis of the issue at hand and the situational factors that can impact occupational violence. Most importantly it details the findings and recommendations made by the Taskforce to set the vision and direction for an overarching strategy to stop violent attacks against paramedics.

The *"Zero Tolerance - No Excuse for Abuse"* campaign, promoted through various media and social media outlets, was developed as a result of the recent serious assaults against paramedics and as outcome of the work of the Taskforce. The community support for the campaign has been significant and ongoing. One social media story reached more than 13 million people, gaining over 19,000 comments, most of which were overwhelmingly supportive of paramedics. Increased concern and awareness within the community helps to demonstrate the significant and constructive role the media has played in helping us to spread our message.

I am proud of the work the Taskforce has done and it has been a privilege to work with my fellow Taskforce members. I thank them for their dedication, hard work, extensive contributions and astute advice. I would also like to acknowledge and thank the Minister for Health and Minister for Ambulance Services, the Department of Health, UVQ and staff for their contributions, significant support and continued efforts into the future to reduce the risk of occupational violence for QAS staff.

I commend this Final Report to the Minister for Health and Minister for Ambulance Services and the Director-General, Department of Health.

A handwritten signature in blue ink, which appears to read 'R Bowles'.

Russell Bowles ASM
Commissioner
Queensland Ambulance Service
Taskforce Chair



Acknowledgements

QAS and UVQ led Paramedic Safety Taskforce would like to acknowledge and thank all staff who have provided their time and expertise to the review of occupational violence against QAS officers, and to the development of this Final Report.

A number of these key stakeholder staff have travelled from around the State to provide their accounts of experiences and views concerning occupational violence. This information has been fundamental to the success of the Taskforce, providing a greater insight into the effect of this violence on our people and what they believe are effective and practical recommendations to the issues and problems being faced by our paramedics.

The Taskforce also received advice from the Queensland Police Service (QPS) in their formal feedback as experts in this field. This feedback and participation has been invaluable to the Taskforce in understanding the impact of occupational violence upon paramedics in their professional role.

The Taskforce would also like to acknowledge the support and efforts of the Secretariat in the preparation and management of the project to deliver this Final Report.

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Executive summary

Paramedics are committed to helping and caring for others and they deserve our respect and gratitude for the important work they do in our community. The increasing prevalence of assaults on paramedics and other health workers in the Queensland community is of significant concern.

Assaults, whether they be physical or verbal on paramedics is inexcusable, and represents reprehensible behaviour. There were 170 deliberate physical attacks and 56 verbal assaults on ambulance officers in the 2014-15 financial year. This represents an increase from the 160 physical assaults and 33 verbal assaults on ambulance officers in 2013-14 financial year.

In December 2015, QAS and UVQ collaboratively established the Paramedic Safety Taskforce to investigate this issue of occupational violence being experienced by paramedics and provide practical strategic recommendations to reduce occupational violence against QAS officers.

The Taskforce chaired by the Commissioner QAS, maintained a key tenet in the review that the creation of a safe work environment for QAS officers to be of critical importance to ensure that our patients and the community continue to receive care that is timely, and adheres to the highest standards of clinical quality and patient safety.

The Taskforce's activities were assessed against the achievement of the following key initiatives:

1. **Education and training** – development of enhanced contemporary training modules combined with face-to-face practical sessions.
2. **Media and communication** – development and implementation a media and communication strategy directed at occupational violence. The strategy should include the utilisation of various media platforms, giving consideration to the internal communication requirements within QAS and an external communication strategy with the broader community.
3. **Data analysis** – analysis of assault data to develop best practices for occupational violence prevention strategies and policy development. This includes using quantifiable data sets such as WorkCover injury, Safety Health and Environment (SHE); current industry evidence base of best practice; and a consultative approach of frontline paramedic focus groups aimed at identification and recognition of practical workplace strategies and interventions.
4. **Internal structure and models** – mapping of technology and communications, procedures, guidelines and standard operating procedures (SOPs) to ensure occupational violence intervention strategies are accurately represented and adhered to by QAS supervisors.
5. **Linkages with staff support** – ensuring that a system is in place that provides effective and practicable early intervention strategies available to paramedics.
6. **Post incident response and support** – review of the current strategy undertaken by QAS Staff Support Service (in the context of a staff member encountering an incident of occupational violence pre and post incident) that provides a significant and multi-layered post critical incident response.
7. **Clinical practice and patient safety** – functional and relevant clinical practice and patient safety guidelines and appropriate response and support being provided to staff involved in incidents to minimise the risk of occupational violence.
8. **Research and development** – undertaking occupational violence related literature reviews including the identification of the latest developments and information on managing challenging issues related to occupational violence in the context of positive interventions.
9. **Technology options** – identification of the latest developments and information regarding technology that can assist frontline paramedics in the context of positive interventions.

To facilitate ongoing collaboration, engagement and progression of the recommendations contained within the Taskforce Final Report, the Paramedic Safety Implementation Oversight Committee will ensure the strategic oversight and coordination for the range of initiatives with the aim of ensuring that future strategies, systems and processes aimed at minimising the risk of occupational violence to QAS personnel are implemented.

The 'Paramedic Safety Taskforce Final Report' provides the direction and ongoing commitment to reducing the risk of occupational violence against QAS front-line paramedics in the performance of their duties and to raise awareness for the creation of a safer working environment.

It is therefore recommended that the Minister for Health and Minister for Ambulance Services:

1. **Notes the outcomes achieved from the nine initiatives that have been completed by the Paramedic Safety Taskforce.**
2. **Consider the fifteen final recommendations contained within '*Paramedic Safety Taskforce Final Report*' for implementation in QAS.**
3. **Note the role of the 'Paramedic Safety Implementation Oversight Committee', which will be responsible for the implementation of the recommendations of Paramedic Safety Taskforce endorsed by the Minister for Health and Minister for Ambulance Services.**



Summary of recommendations

Taskforce recommendation: Education and training

- 1** That QAS implement the outcomes of the Taskforce review of the 'Situational Awareness for Everyday Encounters' (SAFE) training program through the rollout of the revised SAFE2 training course to all frontline paramedics across Queensland by December 2016.

Taskforce recommendations: Media and communications

- 2** That QAS develop a media and communication strategy aimed at minimising violence against paramedics, including internal messaging to all staff by April 2016.
- 3** Working with Department of Health and UVQ, QAS will implement a public awareness campaign through mainstream and social media aimed at minimising violence against paramedics by April 2016.

Taskforce recommendations: Data analysis

- 4** That QAS undertake a detailed demographic modelling review of all QAS datasets pertaining to occupational violence against paramedics to determine the situational factors by April 2016.
- 5** That QAS implement the outcomes of the review by June 2016 ensuring that:
 - the investigations of occupational violence incidents are fulsome and insightful in all circumstances
 - QAS internal structures and initiatives are responsive to ongoing data collection and analysis.

Taskforce recommendation: Internal structures and models

- 6** That QAS implement the outcomes of the Taskforce review of supervisory models and process through the revision of Standard Operating Procedures relevant to reducing the risks and impacts of occupational violence and improving paramedic safety by June 2016.

Taskforce recommendation: Linkage with staff support

- 7** That QAS implement the outcomes of the Taskforce review involving the intervention strategies available to paramedics who are exposed to occupational violence through the development of a Directive and Guideline specific to 'Local Incident Management Practices' by June 2016. The Directive and Guideline will be incorporated into QAS on-line education and the SAFE2 training program.



Taskforce recommendations: Post incident response and support

- 8** That QAS conduct a review by April 2016, of current post-incident response and support strategies available to paramedics who are exposed to occupational violence during operations.
- 9** That QAS implement the outcomes of the review by June 2016, and ensure post incident response and support services remain available to all paramedics.

Taskforce recommendations: QAS clinical practice and patient safety

- 10** That QAS will introduce chemical sedation medication (Droperidol) into clinical practice for all Advanced Care Paramedics by October 2016 ensuring contemporary therapy is available for the treatment of patients presenting with acute behavioural disturbance.
- 11** That QAS implement the outcomes of the Taskforce review of clinical practice and patient safety guidelines regarding the management of acute behavioural disturbances by October 2016. These guidelines will ensure a graded approach to the management of acute behavioural disturbances, including the application of minimal painful stimuli in the patient neurological assessment.

Taskforce recommendations: Research and development

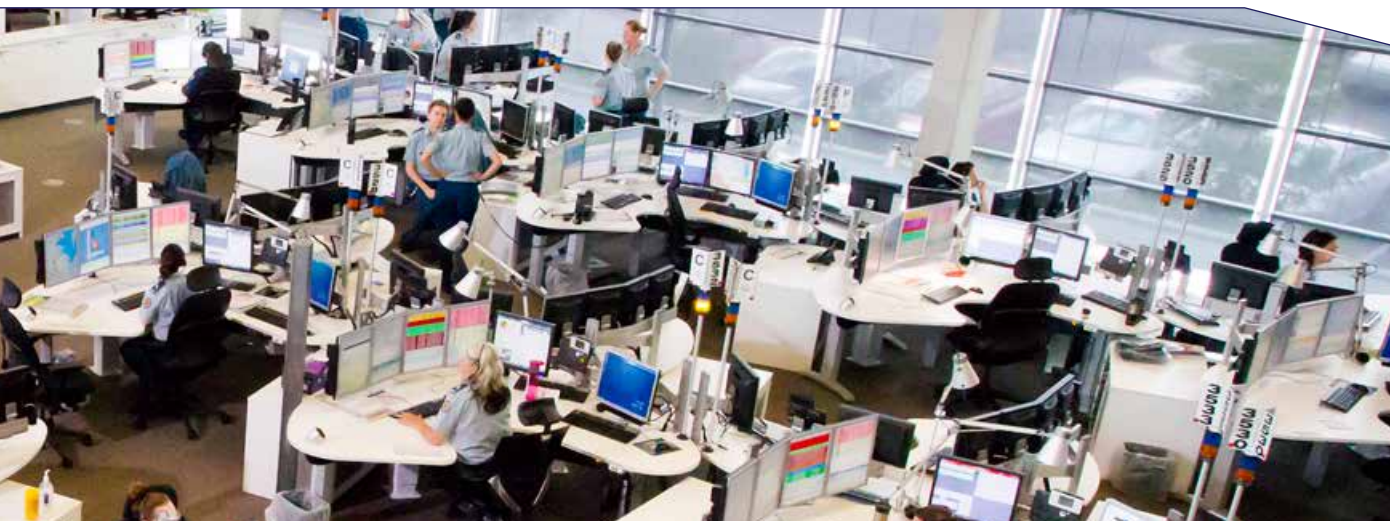
- 12** That QAS conduct a preliminary review of occupational violence related literature, with input from external stakeholders to identify the latest developments and positive interventions with respect to the management of occupational violence in ambulance services, by April 2016.
- 13** That QAS deliver a final research paper regarding the management of occupational violence in Ambulance Services, by December 2016.

Taskforce recommendation: Technology options

- 14** That QAS will further develop the findings of the Taskforce examination of potential technology options that will minimise the risk of occupational violence by November 2016.

Taskforce recommendation: Establishment of oversight implementation committee

- 15** That QAS establish a Paramedic Safety Implementation Oversight Committee by April 2016 to lead the implementation of the recommendations. The implementation of all recommendations will be completed by December 2016.



The Taskforce and terms of reference

The Paramedic Safety Taskforce was established in December 2015, with the aim of identifying effective and practical strategic recommendations to help significantly reduce occupational violence against QAS officers. This Taskforce was established to:

- » review current strategies, systems and processes to minimise the risk of occupational violence to QAS officers
- » review and identify opportunities for improvement and implementation.

Membership of the Taskforce is outlined in table 1

Table 1: Paramedic Safety Taskforce Membership

Paramedic Safety Taskforce committee		
Role	Name	Position
Taskforce Chair	Russell Bowles ASM	Commissioner, QAS
Taskforce Deputy Chair	Craig Emery	Deputy Commissioner, State LASN Operations, QAS
Secretariat (Project Manager)	Paul Coffey	Manager, Workplace Health and Safety, QAS
Secretariat Office	Kimberley Murphy	Senior Advisor, Safety and Claims Management, QAS
Paramedic Safety Taskforce strategic working group		
Key Stakeholder	Geoff Sharpe	Senior Organiser, United Voice Qld
Key Stakeholder	Debbie Gillott	Lead Organiser, United Voice Qld
Key Stakeholder	Elise Meakin	Senior Media Officer, United Voice Qld
Key Stakeholder	Dr Stephen Rashford ASM	Medical Director, QAS
Key Stakeholder	Dee Taylor-Dutton ASM	A/Deputy Commissioner, Service Planning and Performance, QAS
Key Stakeholder	Stephen Gough ASM	Assistant Commissioner, Capability and Development, QAS
Key Stakeholder	Dr Emma Bosley	Director, Information, Research & Evaluation, QAS
Key Stakeholder	Todd Wehr	Manager, Staff Support Services, QAS
Key Stakeholder	Michelle Baxter	Assistant Commissioner, Cairns LASN, QAS
Key Stakeholder	Tony King ASM	Director, Office of the Commissioner, QAS
Key Stakeholder	Michael Augustus	Director, Media and Communications, QAS
Key Stakeholder	Christine Axelby	Director, Human Resources, QAS
Key Stakeholder	Mark Whitby	Senior Clinical Educator, QAS
Key Stakeholder	Gavin Farry	Clinical Policy Development Officer, QAS
Key Stakeholder	Russell Nicholas	A/Executive Manager, State LASN Operations, QAS
Key Stakeholder	Liesel Cahalan	Paramedic, Metro South LASN, QAS
Key Stakeholder	Jade Wilkinson	Paramedic, Sunshine Coast LASN, QAS
Key Stakeholder	Paul Shaw	Manager, Maroochydore Operations Centre, QAS
Key Stakeholder	Colin Allen	Senior Operations Supervisor, State Operations Centre, QAS

This collaborative body brought together representatives from UVQ, paramedics, Operations Centre officers, and other key personnel. It was specifically tasked with:

- » providing advice to QAS and UVQ on issues of occupational violence impacting on QAS officers
- » reviewing and implementing strategies, training, approaches and procedures that actively monitor and manage all aspects of occupational violence related risk
- » reviewing existing service strategies and procedures and their efficacy and contemporise these if required
- » reviewing contemporary research, development and literature in occupational violence related risk in ambulance services
- » investigating and providing deliverable solutions to reduce the risk of occupational violence to QAS officers.

The principal functions of the Taskforce while undertaking these tasks were to:

- » consider approaches, findings and recommendations from other jurisdictions and ambulance services and determine whether they apply to QAS
- » provide operational advice to the Commissioner with regard to the effectiveness of current strategies, training and procedures on managing the risk of occupational violence
- » consult and share authoritative advice with peers.



The **Taskforce** methodology, interim report and recommendations

In addressing the requirements articulated through the Terms of Reference, the Taskforce developed the Paramedic Safety Taskforce Project Plan. This plan was developed to quality assure the work being undertaken by the Taskforce using agreed project methodology and associated governance structure.

The Paramedic Safety Taskforce Project Plan was endorsed by the group on 15 January 2016.

As per the endorsed Paramedic Safety Taskforce Project Plan, the actions and outcomes of the Paramedic Safety Taskforce were oversighted by the Commissioner QAS, Russell Bowles, and the Secretary of United Voice Queensland, Gary Bullock.

Through its methodology, the approved Paramedic Safety Taskforce Project Plan made the following assumptions:

1. The project had the approval of the Commissioner QAS to conduct the activities listed in the work breakdown schedule.
2. The Taskforce would participate in the timely delivery of the project plan.
3. UVQ is a key collaborative participant to this plan, and would be further supported by QAS representatives, including paramedics, Operations Centre officers and other key personnel.
4. The project plan would only change scope with approval of the Taskforce Chair and UVQ, if new information or oversight direction was reported.

Following analysis of the issues presented within the information relating to occupational violence as experienced by QAS officers, the Taskforce developed three key interim recommendations. Importantly, the Taskforce identified that education and awareness were two critical components required for change, but accepted that these initiatives alone are not a complete solution to the issues identified. In this respect, opportunities were identified to review internal and external practices and processes, which underpin and support the education and awareness initiatives surrounding occupational violence.



These recommendations were presented in the 'Paramedic Safety Taskforce Interim Report' on 29 January 2016, which was provided to the Director-General, Department of Health and Minister for Health and Minister for Ambulance Services.

Recommendation 1:

Education and training – QAS to redesign relevant training systems where paramedics can more easily identify, de-escalate and withdraw safely from certain confronting situations.

The Taskforce made a recommendation that QAS redesign and implement training programs for staff. The aim of this initiative is to mitigate the risks of occupational violence, assisting paramedics to identify, de-escalate and withdraw safely from potentially dangerous or confronting situations.

Recommendation 2:

Awareness, media and communications – In conjunction with the Department of Health, QAS is to develop and implement a suitable media and communication strategy.

The Taskforce made a recommendation that QAS should develop and implement a media and communication strategy directed at occupational violence. The strategy should include the utilisation of various media platforms, giving consideration to the internal communication requirements within QAS and an external communication strategy with the broader community.

Recommendation 3:

Internal QAS and external processes – QAS should investigate and give further consideration to a review of various processes that may support or assist with the management of occupational violence related risk and prevention.

The Taskforce made a recommendation that QAS investigate and give further consideration to a review of various processes, including:

- » **Data analysis** – detailed analysis should be conducted around available information regarding occupational violence data so as to help identify trends and provide opportunities to minimise the risk of occupational violence within QAS operational environment.
- » **QAS supervisory model** – QAS to scope and address the current supervision model, ensuring the strategy adequately addresses occupational violence related risks for paramedics.
- » **Linkages to staff support** – links with staff support should be identified (Priority One), supervisors, workplace health & safety staff specialists and other early intervention strategies.
- » **Post incident response and support** – QAS to undertake a review of incident responses and staff support, so as to ensure both an appropriate response and support is being provided to staff involved in incidents – including a review of local current strategies.
- » **QAS clinical practice and patient safety** – the clinical practice and patient safety guidelines and practices should be reviewed to ensure these adequately address a role in managing occupational violence related risk.
- » **Research and development** – complete a review of contemporary research and literature around occupational violence in the workplace.
- » **Technology options** – review technology options to identify the latest developments that may assist in managing issues related to occupational violence.



An analysis of the issue

The identification of effective and practical strategic recommendations to help significantly reduce occupational violence against QAS officers first required a complete understanding of the scale, prevalence and impact of the issue. Accordingly, the Taskforce sought to gain this understanding through an interrogation of QAS data relating to the issues being faced.

In this respect, QAS data relating to occupational violence is primarily sourced from QAS SHE system.

All QAS employees are directed to self-report any workplace incidents, including those relating to occupational violence/workplace assaults, utilising the SHE system. In addition, in certain circumstances where an affected employee cannot self-report the incident, the incident may be reported by the supervisor of the employee.

Notably, an employee reporting an incident of occupational violence is required by the SHE system to classify the incident as either:

- » a **'Deliberate Physical Attack'** (for example – where an officer may have been punched, struck or spat at by a person)
- » a **'Verbal Threat'** (for example – where an officer may have been verbally threatened by a person who says he intends to hurt the officer, or threatened over the telephone while performing the role of an Emergency Medical Dispatcher (EMD))
- » a **'Accidental Contact'** (for example – where a Paramedic may have been scratched by a convulsing or fitting patient).

The issue of occupational violence towards QAS officers is one that while multifaceted, is shown by the available SHE data to be now more pronounced than ever before. Occupational violence incidents comprise 9.4% of all QAS SHE incidents reported in the 2014/15 financial year (FY) and are currently 13.2% of all QAS SHE incidents reported in 2015/16 year to date (YTD) .

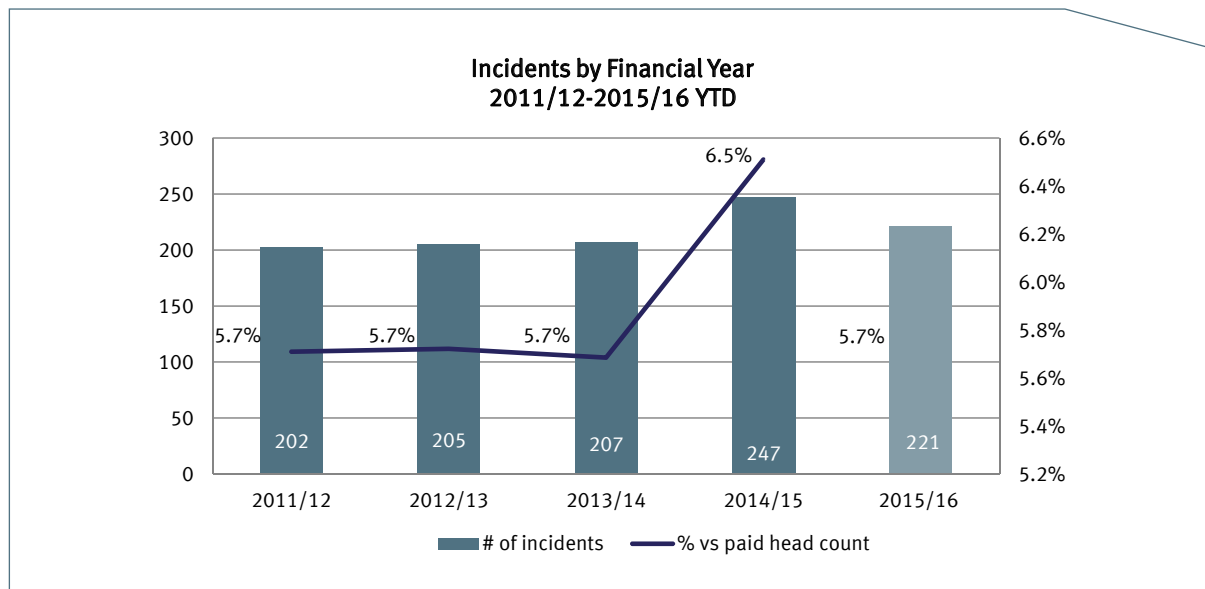
Notably, from 2011 until the present, the incidence of Deliberate Physical Attacks and Verbal Threats towards officers has continued to rise, with a total of 221 incidents being reported in the 2015/16 YTD period. Of these incidents, 210 have been categorised as being Deliberate Physical Attacks (142) and Verbal Threats (68). This figure represents 5.7% of QAS paid headcount for operational roles (which includes Paramedics, Patient Transport Officers, and EMDs), and is higher than any previous year from 2011 onwards.

Table 2: Self-reported incidents of Occupational Violence updated for 2015/16 YTD (as at 31 January 2016):

TABLE CATEGORY	2011-12 FY	2012-13 FY	2013-14 FY	2014-15 FY	2015-16 YTD
Deliberate physical attack	143	143	160	170	142
Verbal threat	44	38	33	56	68
Accidental contact	15	24	14	21	11
TOTAL	202	205	207	247	221

The current trend suggests that if assaults continue at the same rate for the 2015/16 FY, the total assaults experienced by QAS officers may exceed 370. This is a potential increase of nearly 50% on the 2014/15 FY. This scenario is unacceptable, and presents a highly compelling need for change (refer Graph 1).

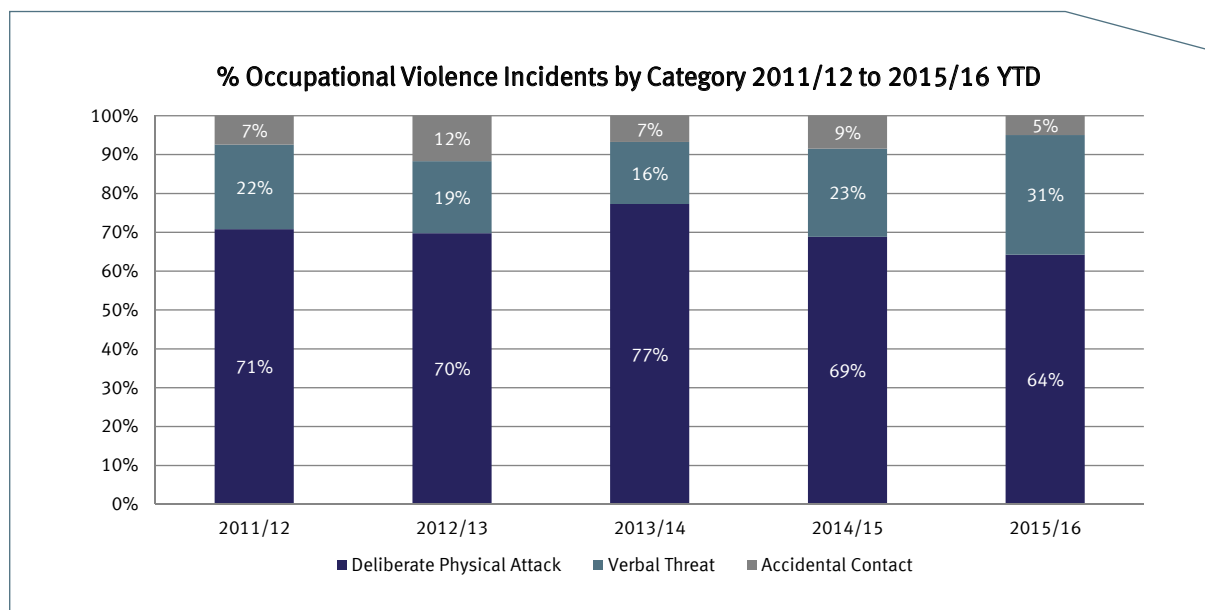
Graph 1: Incidents as reported in SHE as Occupational Violence Incidents by financial year, as a percentage of QAS operational paid head count - data as at 31 January 2016



Detailed analysis of the SHE data also provides important insights into the scale, prevalence and nature of the occupational violence being experienced by QAS workforce.

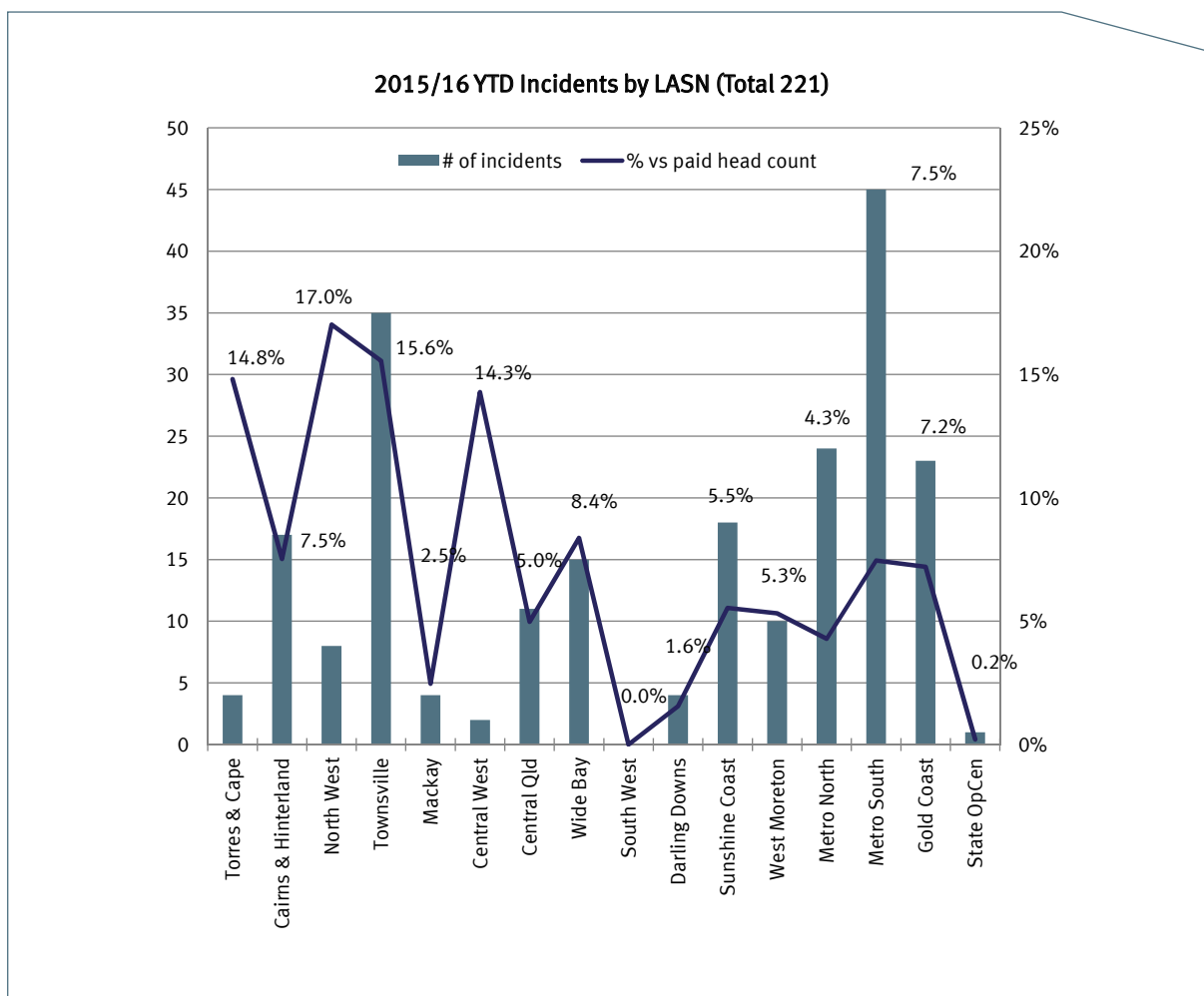
Since 2011 until the current time, Deliberate Physical Attacks have been the majority of reported occupational violence incidents (refer Graph 2).

Graph 2: Incidents as reported in SHE of Deliberate Physical Attack and Verbal Threat by Financial Year - data as at 31 January 2016



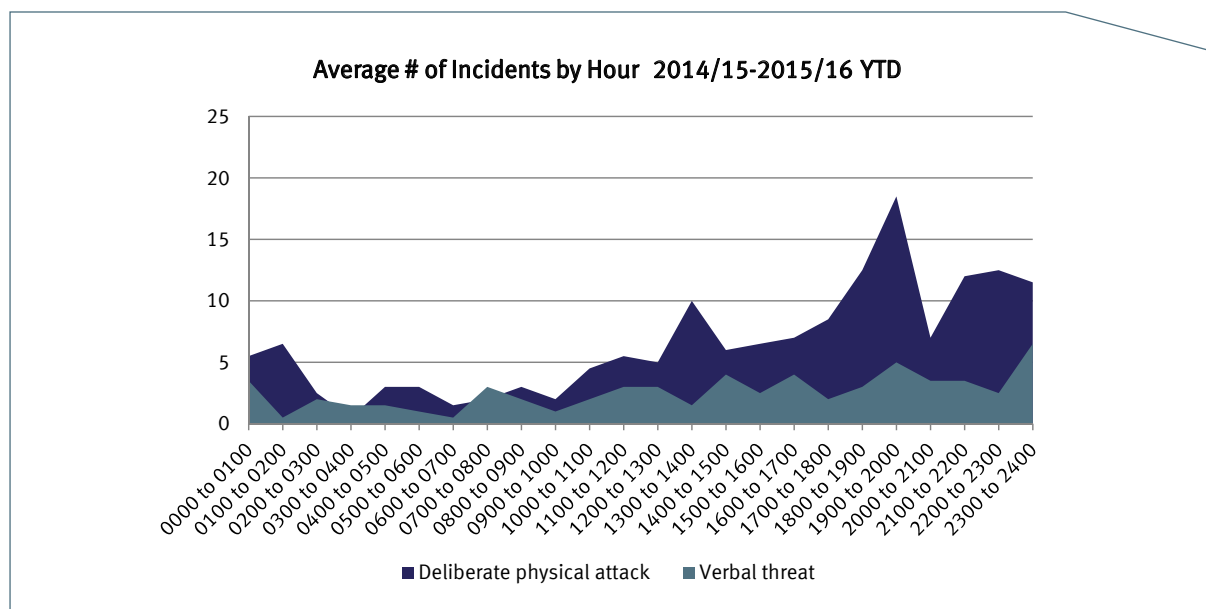
In the current reporting period (2015-16 YTD), Metro South LASN has recorded the highest number of reported occupational violence related incidents (45 incidents), followed by Townsville LASN with 35 reported incidents, Metro North LASN with 24 incidents, and the Gold Coast LASN with 23 incidents (Graph 3).

Graph 3: Incidents as reported in SHE of Occupational Violence by LASN, shown as a percentage of QAS operational paid head count - data as at 31 January 2016



Notably, an analysis of the average number of SHE-reported incidents by the hour-of-the-day from the 2014/15 FY– 2015/16 YTD period indicates that officers report being more exposed to a Deliberate Physical Attack between midday and 11:00pm, with the most significant spike being observed between 7:00pm and 8:00pm. Reported incidents concerning Verbal Threats trends slightly higher between 2:00pm and midnight, however incident numbers generally remain lower across the 24-hour time period than those relating to Deliberate Physical Attacks (Graph 4).

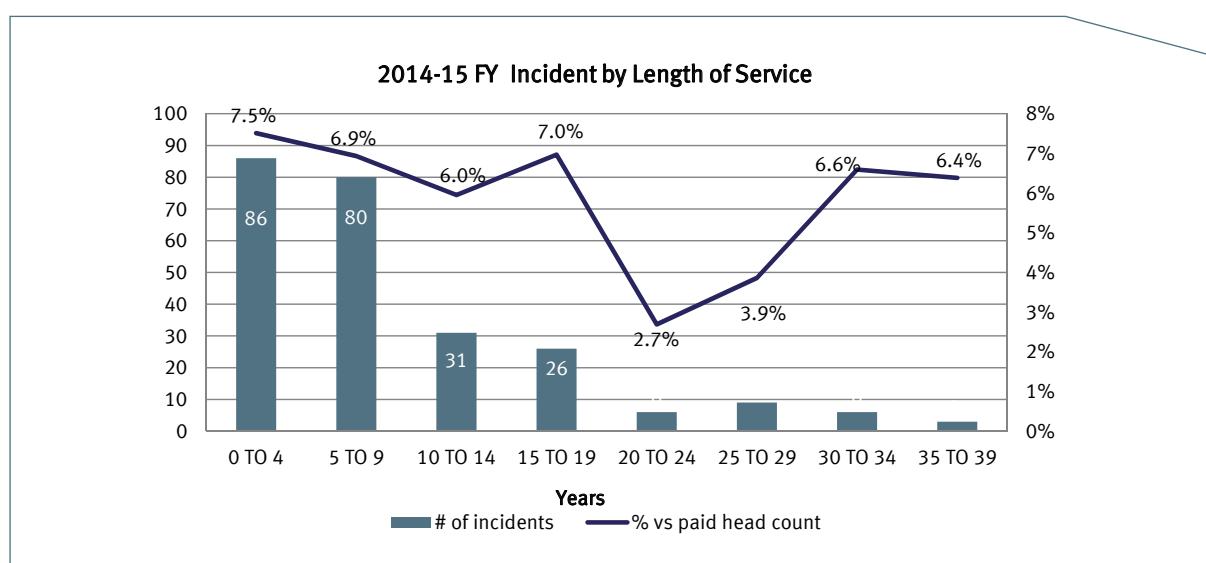
Graph 4: Incidents as reported in SHE of Deliberate Physical Attack and Verbal Threat for period 1 July 2014 to 31 January 2016



Further examination of the 2014/15 FY period demonstrates:

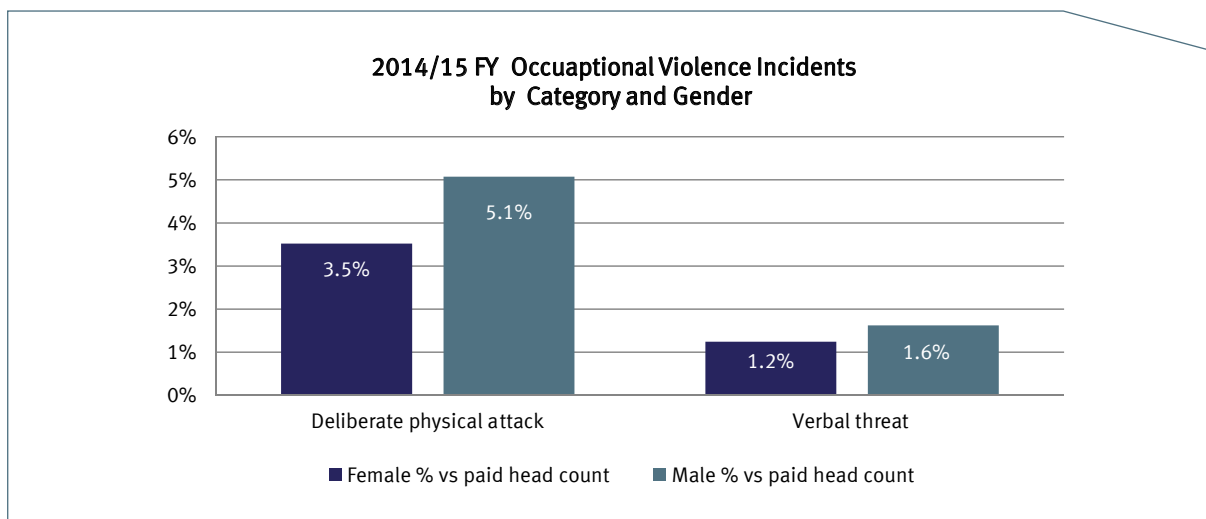
- » Approximately 67% of occupational violence incidents were reported by QAS officers with between 0 and 9 years' experience (this cohort represents 60.6% of the paid headcount of operational employees).
- » QAS officers with between 0 and 4 years' experience reported the highest number of occupational violence incidents (86 incidents) (refer Graph 5).

Graph 5: Incidents as reported in SHE by period of tenure (2014/15), as a percentage of QAS operational paid head count



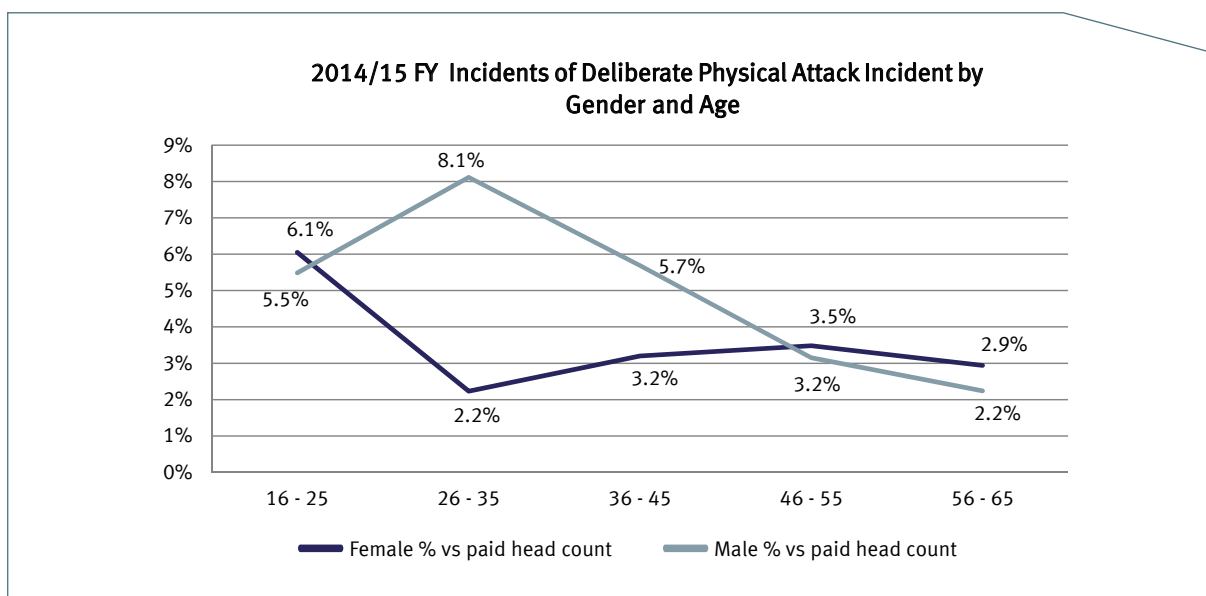
QAS SHE data also indicates that as a percentage of operational paid head count, male officers are more likely to report an incident relating to occupational violence (for both Deliberate Physical and Verbal Attacks), compared to female officers. This becomes more pronounced for instances of Deliberate Physical Attack, where of the total 170 Deliberate Physical Attacks reported in 2014/15 FY, 70% involved male officers (refer Graph 6).

Graph 6: Incidents as reported in SHE of Deliberate Physical Attack and Verbal Threat (2014/15) by gender, as a percentage of QAS operational paid head count



More specifically, based on this data, female officers aged under 25 years, and male officers aged 26 to 35 years are more likely to be exposed to a Deliberate Physical Attack than other age groups (refer Graph 7).

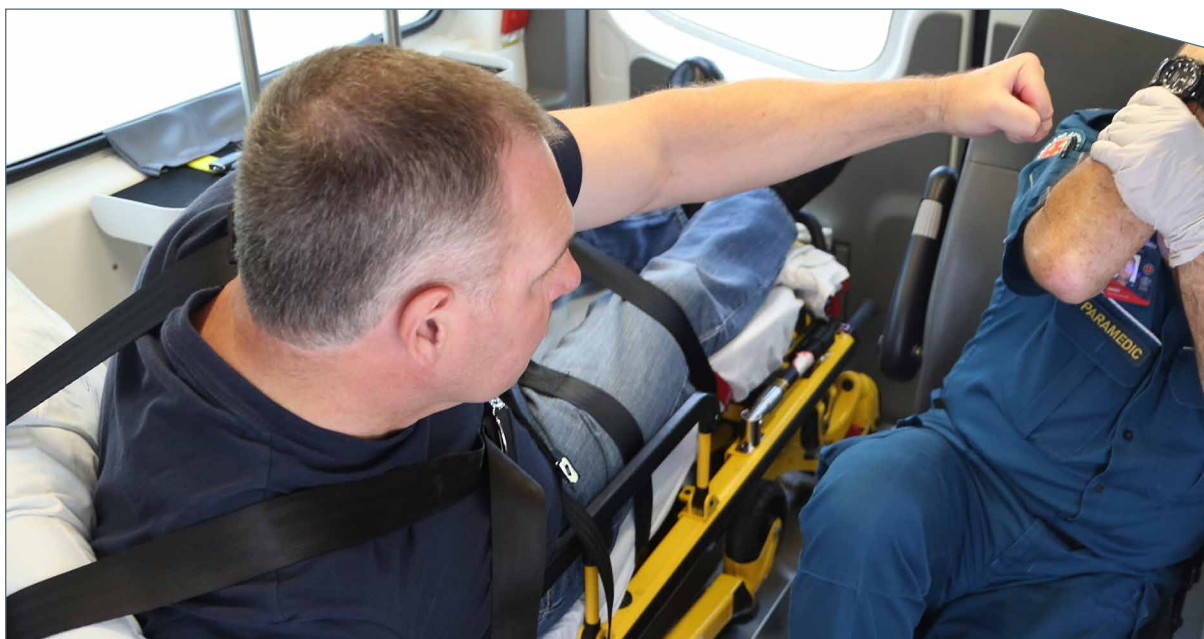
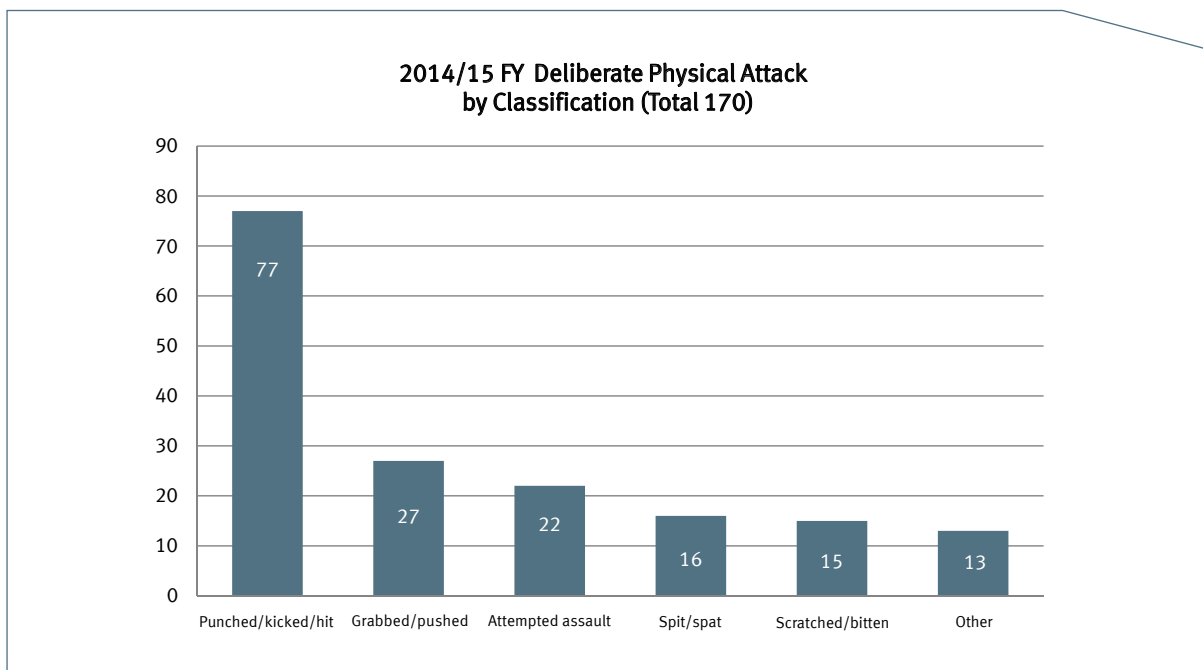
Graph 7: Incidents as reported in SHE of Deliberate Physical Attack (2014/15) by gender and age band as a percentage of QAS operational paid head count



Graph 8 highlights that of the (170) incidents categorised as Deliberate Physical Attack during the 2014/15 FY period:

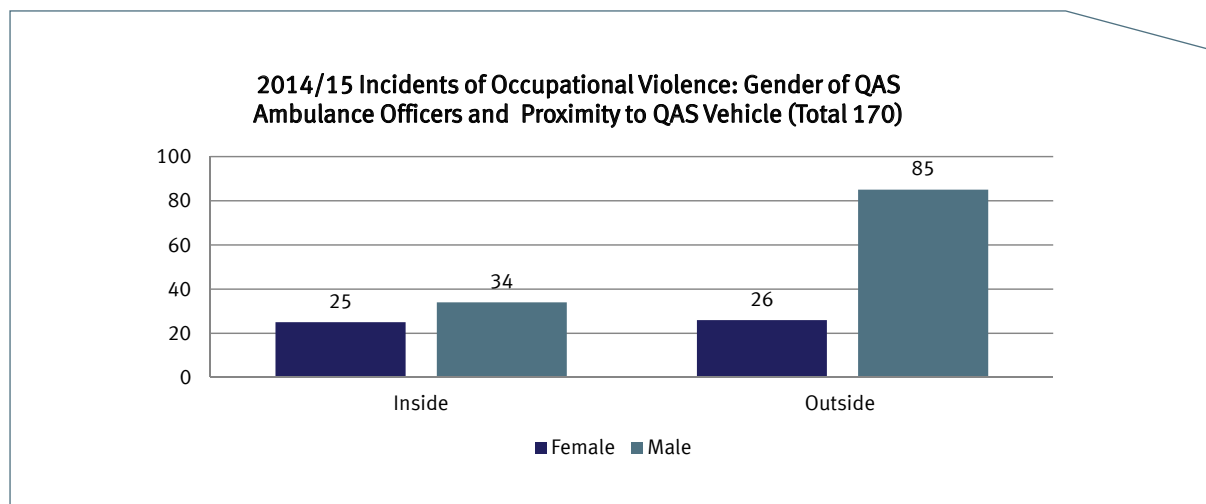
- » 45.3% (77) related to being punched, kicked or hit
- » 15.9% (27) related to being grabbed or pushed
- » 12.9% (22) related to an attempted assault
- » 9.4% (16) related to being spat at
- » 8.8% (15) related to being scratched/bitten
- » 7.6% (13) related to another incident.

Graph 8: Incidents as reported in SHE of Deliberate Physical Attack (2014/15) by classification



Through the 2014/15 FY period, 65.3% of the 170 Deliberate Physical Attacks were reported as having occurred whilst the paramedic was outside a QAS vehicle, with 34.7% reported as having occurred inside a QAS vehicle. Noticeably, the number of Deliberate Physical Attacks that were reported by males as having occurred outside the vehicle were greater (approximately 150% higher) than those that were reported as having occurred inside the vehicle. Whereas for female officers, reporting was more evenly spread between having occurred inside or outside of a QAS vehicle (refer Graph 9).

Graph 9: Incident as reported in SHE of Deliberate Physical Attack (2014/15) where the incident occurred inside or outside ambulance and gender



In summary, the occupational violence data reported by QAS officers indicates:

- » Occupational violence incidents comprise 9.4% of all QAS SHE incidents reported in FY 2014/15, and are currently 13.2% of all QAS SHE incidents reported in 2015/16 YTD.
- » From 2011 until the present, the incidence of Deliberate Physical Attacks and Verbal Threats towards officers has continued to rise, with a total of 221 incidents being reported in the 2015-2016 YTD period.
- » This figure is higher than any previous year, from 2011 onwards.
- » Since 2011 until the current time, Deliberate Physical Attacks have comprised the majority of reported incidents concerning occupational violence.
- » The current trend suggests that if assaults continue at the same rate for the 2015/16 FY, the total assaults experienced by QAS officers may exceed 370. This is a potential increase of nearly 50% on the 2014/15 FY.
- » Of the (170) incidents categorised as Deliberate Physical Attack during the 2014/15 FY period:
 - 45.3% (77) related to being punched, kicked or hit
 - 15.9% (27) related to being grabbed or pushed
 - 12.9% (22) related to an attempted assault.
- » QAS officers with between 0 to 9 years of service are more likely to be exposed to occupational violence than other employee cohorts, with those officers with between 0 to 4 years of service indicating the highest representation through the data examined.
- » Male officers are more likely to be exposed to an incident relating to occupational violence, compared to female officers.
- » The number of Deliberate Physical Attacks that were reported by male officers as having occurred outside the vehicle was far more pronounced (approximately 150% higher) than those that were reported as having occurred inside the vehicle, whereas those that were reported by female officers were more evenly spread between having occurred inside or outside of QAS vehicle.



Situational factor examination

Quantitative and qualitative analysis

An extract containing all reported occupational violence incidents for the 2014/15 FY and 2015/16 YTD (as at 31/01/16), was acquired from the SHE incident report system.

To enable greater examination of patient specific and situational factors involved in these reported incidents these cases were matched with Computer Aided Dispatch (CAD) system and Electronic Ambulance Report Form (eARF) data.

It should be noted that for the 2014/15 FY data includes only reported Deliberate Physical Attacks. For 2015/16 YTD, all occupational violence incident reports were extracted, and results are labelled accordingly as to the inclusion of All Occupation Violence (All OV), or Deliberate Physical Attacks only.

The following provides an overview of the cases that were included for detailed manual record review (Table 3).

Table 3: Overview of reported occupational violence incidents

	15/16* YTD	%	14/15** FY	%
Occupational violence reports	219 *	100	170	100
Matched to QAS incidents	203	92.7	165	97.1
QAS incidents linked to SHE report	183 **	83.7	153	90.0
Liabe Person	Count of Incidents			
Patient	160	87.4	133	86.9
Bystander	16	8.7	9	5.9
Patient and bystander	2	1.1	1	0.7
Unknown	5	2.7	5	2.7

* deliberate physical, verbal, accidental

** deliberate physical only

• note 1 - that 2 cases (one verbal and one accidental) reported in 2015/16 have been excluded due to the incidents occurring in 2014/15 FY

•• note 2 - that there can be multiple SHE reports/incidents attributed to one QAS incident, due to multiple officers assaulted in the one QAS incident.

When occupational violence incidents are examined as a rate, there has been an average of 0.38 reported cases of occupational violence per 1,000 QAS incidents attended across the state (Table 4). It should be noted that the reported rates for LASNs with lower QAS incident counts are affected by statistical variability due to low numbers.

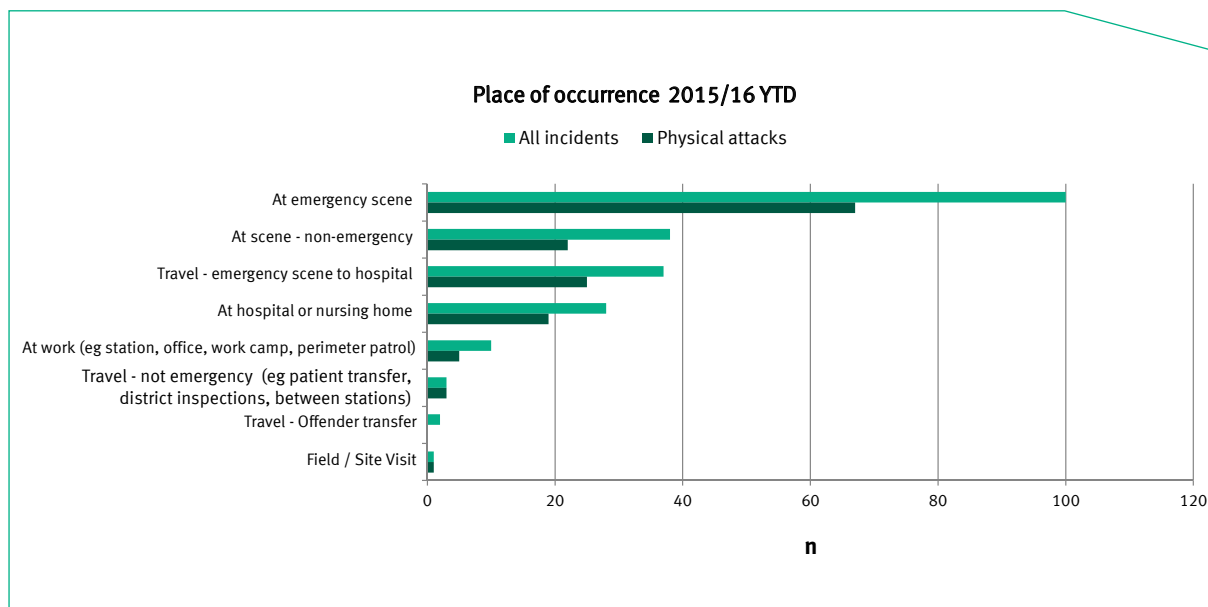
Table 4: Breakdown of total QAS incidents by LASN, SHE reports and incident rates

LASN	2015/16 YTD			2014/15 FY		
	Total QAS incidents	All OV		Total QAS incidents	Physical Only	
		SHE Reports	# SHE reports per 1,000 incidents		SHE Reports	# SHE reports per 1,000 incidents
CAIRNS AND HINTERLAND	38786	17	0.44	59310	8	0.13
CAPE YORK	1737	4	2.30	2920	1	0.34
CENTRAL QUEENSLAND	27359	11	0.40	45600	6	0.13
CENTRAL WEST	1101	2	1.82	2022	1	0.49
DARLING DOWNS	33987	4	0.12	57041	3	0.05
GOLD COAST	57740	22	0.38	93647	25	0.27
MACKAY	17228	4	0.23	27822	7	0.25
METRO NORTH	115345	24	0.21	194544	32	0.16
METRO SOUTH	121211	44	0.36	204006	40	0.20
NORTH WEST	5977	8	1.34	10103	3	0.30
SOUTH WEST	2493	-	0.00	4754	2	0.42
SUNSHINE COAST	50966	18	0.35	83440	10	0.12
TOWNSVILLE	38553	35	0.91	63999	15	0.23
WEST MORETON	30395	10	0.33	50070	9	0.18
WIDE BAY	29507	15	0.51	47092	8	0.17
TOTAL	572385	218 *	0.38	946370	170	0.18

* One SHE report attributed to QAS, Comms for 2015/16 YTD

The electronic ambulance report form records were reviewed manually to identify the physical setting of the assailant and Paramedics at the time of the assault. The majority of incidents occur at the scene (refer Graph 10).

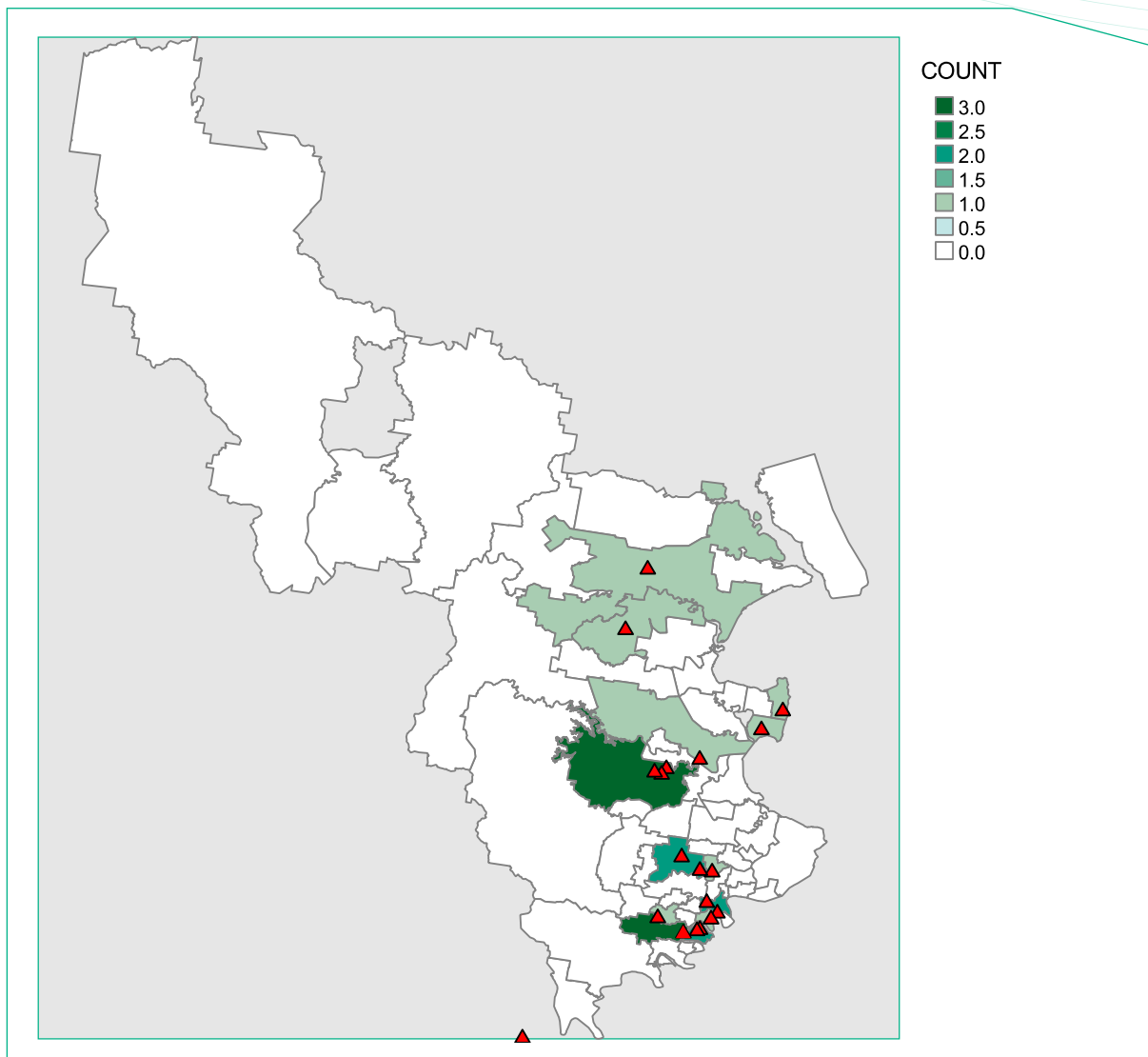
Graph 10: Place of occurrence from SHE data for 2015/16 YTD (*n = 219)



The incidents were mapped using GPS coordinates from CAD data (see maps following) for those LASNs with the greatest number of reported occupational violence incidents. Additionally these LASNs were also examined at station level.



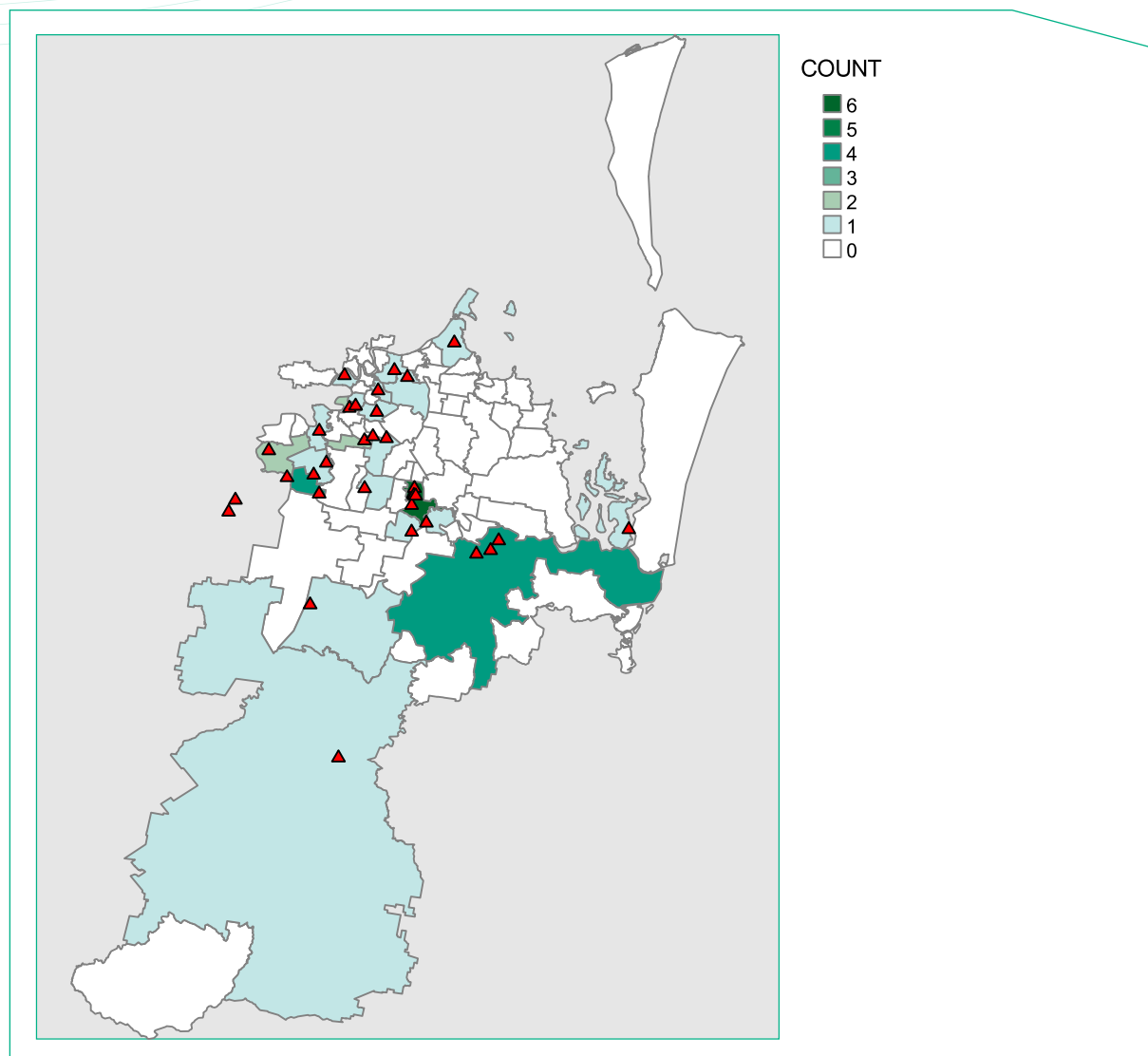
Metro North: Occupational violence incidents 2015/16 YTD



Metro North	All Incidents	
	2015/16 YTD	
Station	Total	Per month
Northgate	-	-
Roma St	4	0.6
Spring Hill	8	1.1
North Lakes	2	0.3
Caboolture	2	0.3
Chermside	3	0.4
Redcliffe	2	0.3
Other	3	0.4
Total	24	3.4

Deliberate Physical Attack				
2015/16 YTD		2014/15 FY		± change
Total	Per month	Total	Per month	
-	-	6	0.5	-0.5
3	0.4	5	0.4	0.0
6	0.9	4	0.3	0.5
-	0.0	3	0.3	-0.3
2	0.3	2	0.2	0.1
3	0.4	1	0.1	0.3
-	0.0	1	0.1	-0.1
3	0.4	10	0.8	-0.4
17	2.4	32	2.7	-0.2

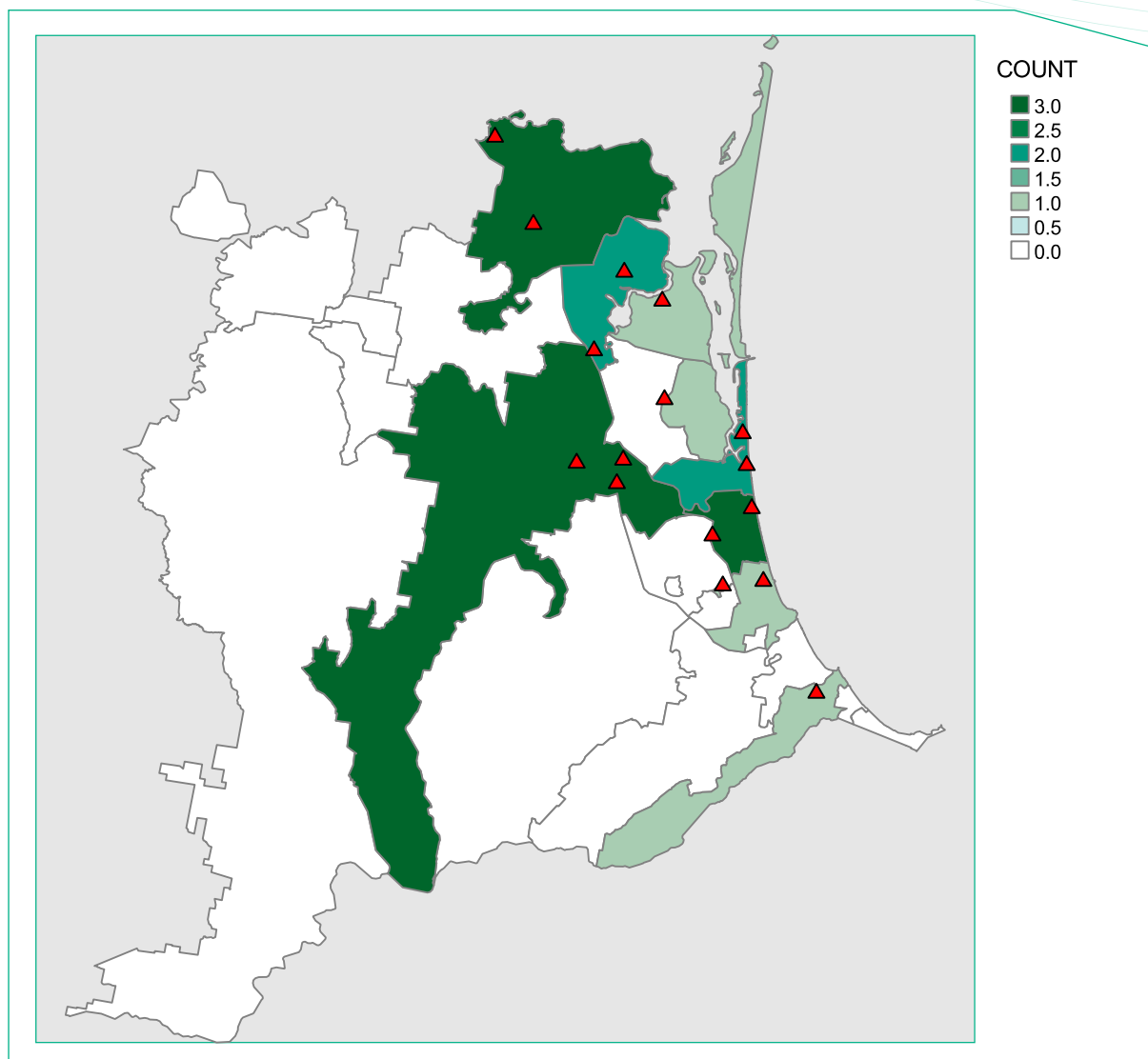
Metro South: Occupational violence incidents 2015/16 YTD



Metro South	All Incidents	
	2015/16 YTD	
Station	Total	Per month
Woodridge	8	1.1
Sunnybank Hills	7	1.0
Durack	7	1.0
Carina	4	0.6
Springwood	3	0.4
South Brisbane	3	0.4
Beenleigh	2	0.3
Logan West	2	0.3
Centenary	2	0.3
Jimboomba	2	0.3
Other	4	0.6
Total	44	6.3

Deliberate Physical Attack				
2015/16 YTD		2014/15 FY		± change
Total	Per month	Total	Per month	
5	0.7	1	0.1	0.6
5	0.7	4	0.3	0.4
3	0.4	3	0.3	0.2
3	0.4	1	0.1	0.3
3	0.4	7	0.6	-0.2
3	0.4	4	0.3	0.1
1	0.1	3	0.3	-0.1
2	0.3	3	0.3	0.0
1	0.1	2	0.2	0.0
2	0.3	2	0.2	0.1
4	0.6	11	0.9	-0.3
32	4.6	41	3.4	1.2

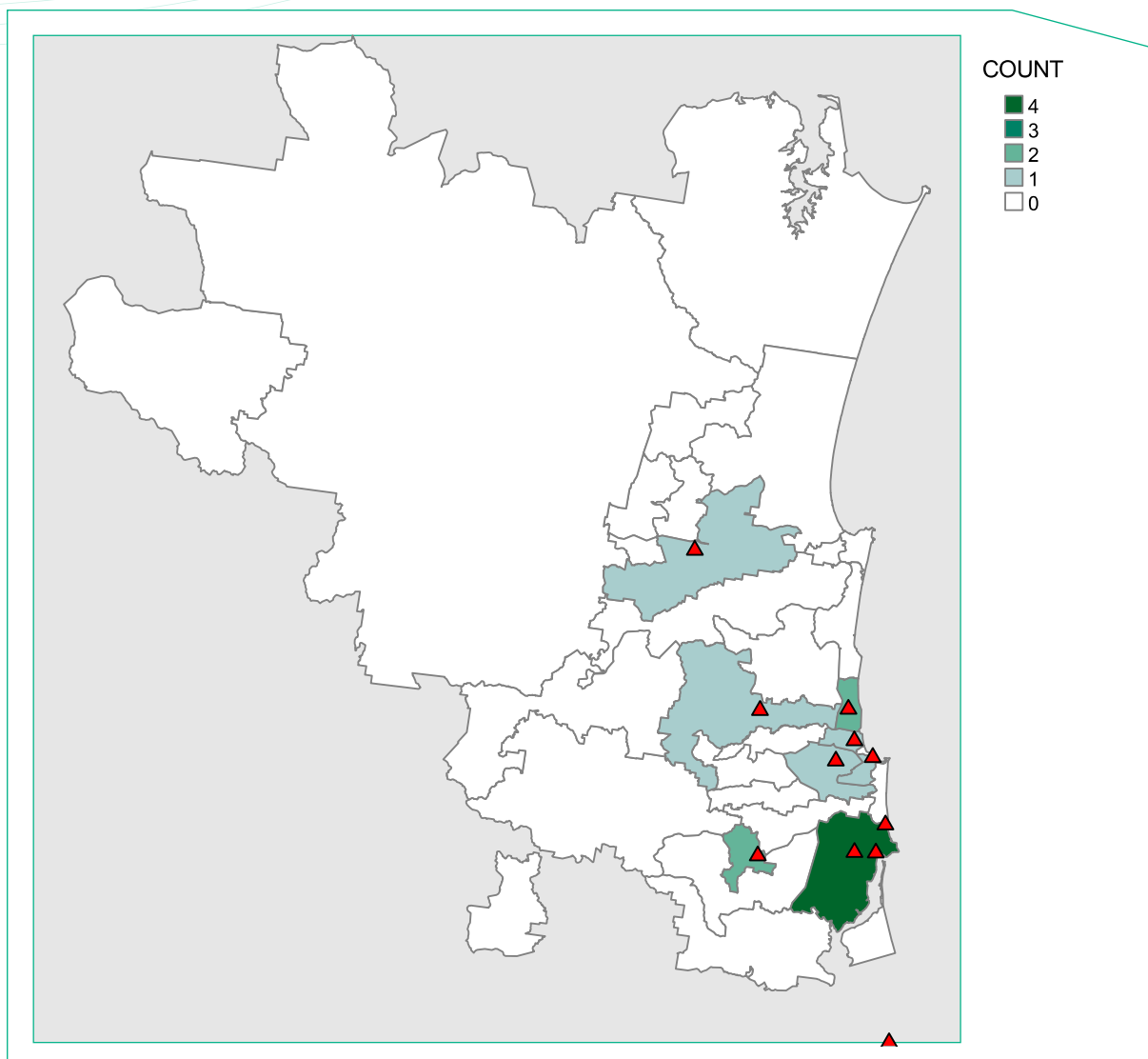
Gold Coast: Occupational violence incidents YTD 2015/16



Gold Coast	All Incidents	
	2015/16 YTD	
Station	Total	Per month
Southport	5	0.7
Nerang	4	0.6
Coral Gardens	3	0.4
Helensvale	3	0.4
Mudgeeraba	3	0.4
Coomera	1	0.1
Runaway Bay	1	0.1
Burleigh	1	0.1
Other	1	0.1
Total	22	3.1

Deliberate Physical Attack				
2015/16 YTD		2014/15 FY		± change
Total	Per month	Total	Per month	
-	0.0	3	0.3	-0.3
3	0.4	3	0.3	0.2
3	0.4	3	0.3	0.2
3	0.4	2	0.2	0.3
2	0.3	4	0.3	0.0
1	0.1	4	0.3	-0.2
-	0.0	4	0.3	-0.3
-	0.0	2	0.2	-0.2
1	0.1	1	0.1	0.1
13	1.9	26	2.2	-0.3

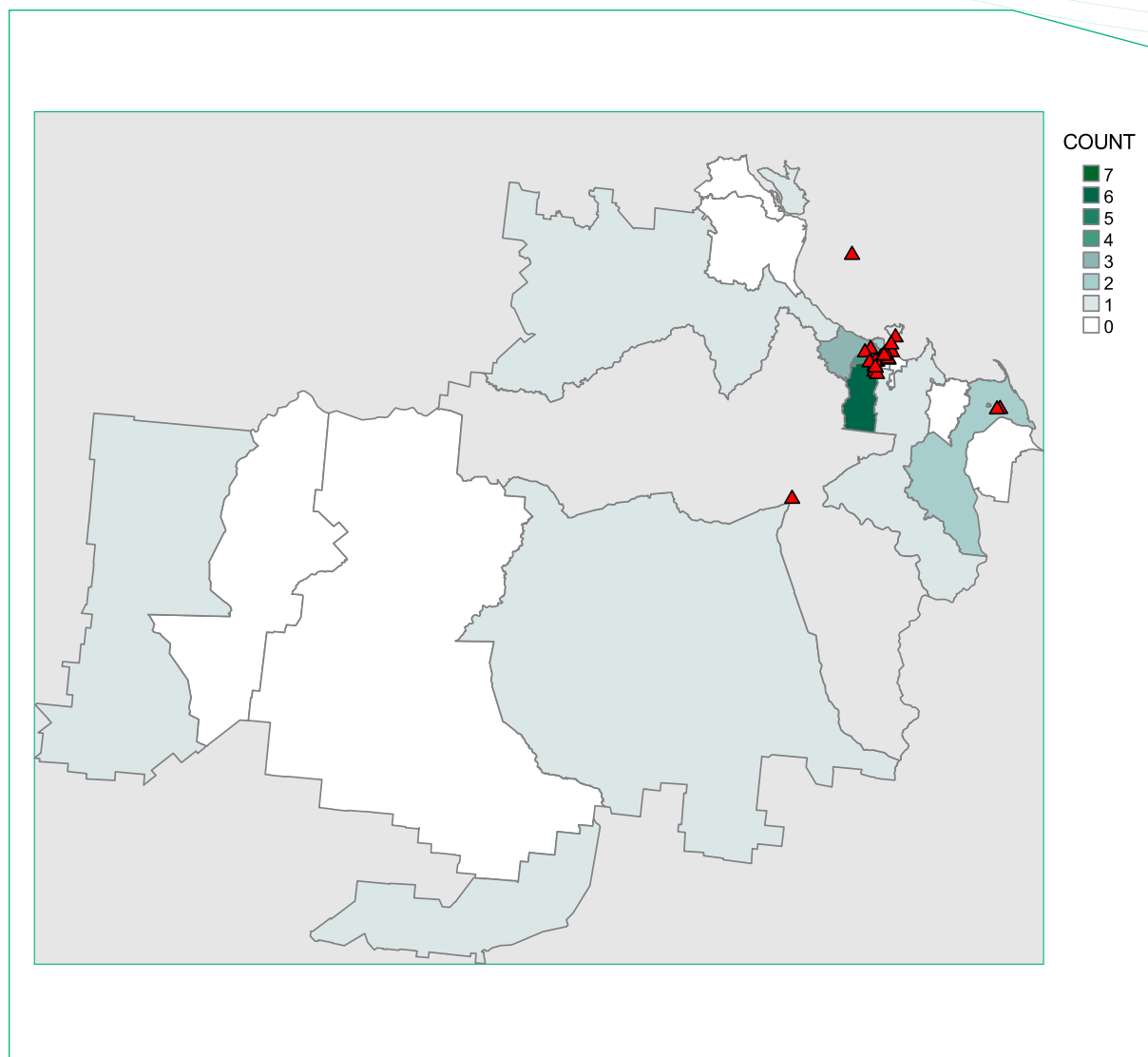
Sunshine Coast: Occupational violence incidents YTD 2015/16



Sunshine Coast	All Incidents	
	2015/16 YTD	
Station	Total	Per month
Buderim	3	0.4
Caloundra	3	0.4
Beerwah	2	0.3
Gympie	2	0.3
Tewantin	2	0.3
Kawana	1	0.1
Other	5	0.7
Total	18	2.6

Deliberate Physical Attack				
2015/16 YTD		2014/15 FY		± change
Total	Per month	Total	Per month	
2	0.3	1	0.1	0.2
1	0.1	2	0.2	0.0
2	0.3	1	0.1	0.2
1	0.1	-	0.0	0.1
2	0.3	-	0.0	0.3
1	0.1	4	0.3	-0.2
3	0.4	2	0.2	0.3
12	1.7	10	0.8	0.9

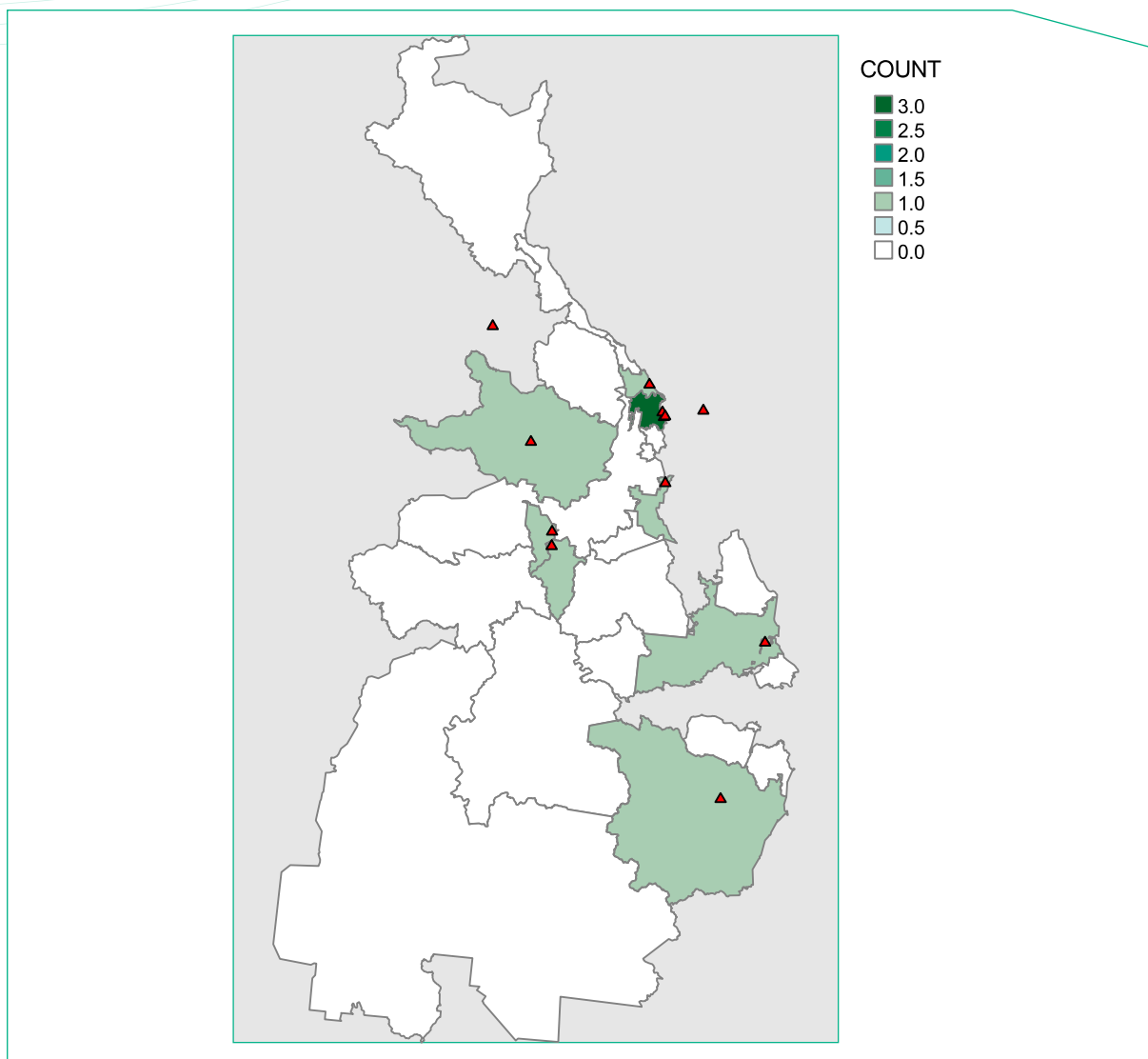
Townsville: Occupational violence incidents 2015/16 YTD



Townsville	All Incidents	
	2015/16 YTD	
Station	Total	Per month
Townsville	13	1.9
Kirwan	10	1.4
Northern Beaches	6	0.9
Ayr	2	0.3
Other	4	0.6
Total	35	5.0

Deliberate Physical Attack				
2015/16 YTD		2014/15 FY		± change
Total	Per month	Total	Per month	
9	1.3	7	0.6	0.7
5	0.7	-	0.0	0.7
2	0.3	3	0.3	0.0
1	0.1	1	0.1	0.1
2	0.3	4	0.3	0.0
19	2.7	15	1.3	1.5

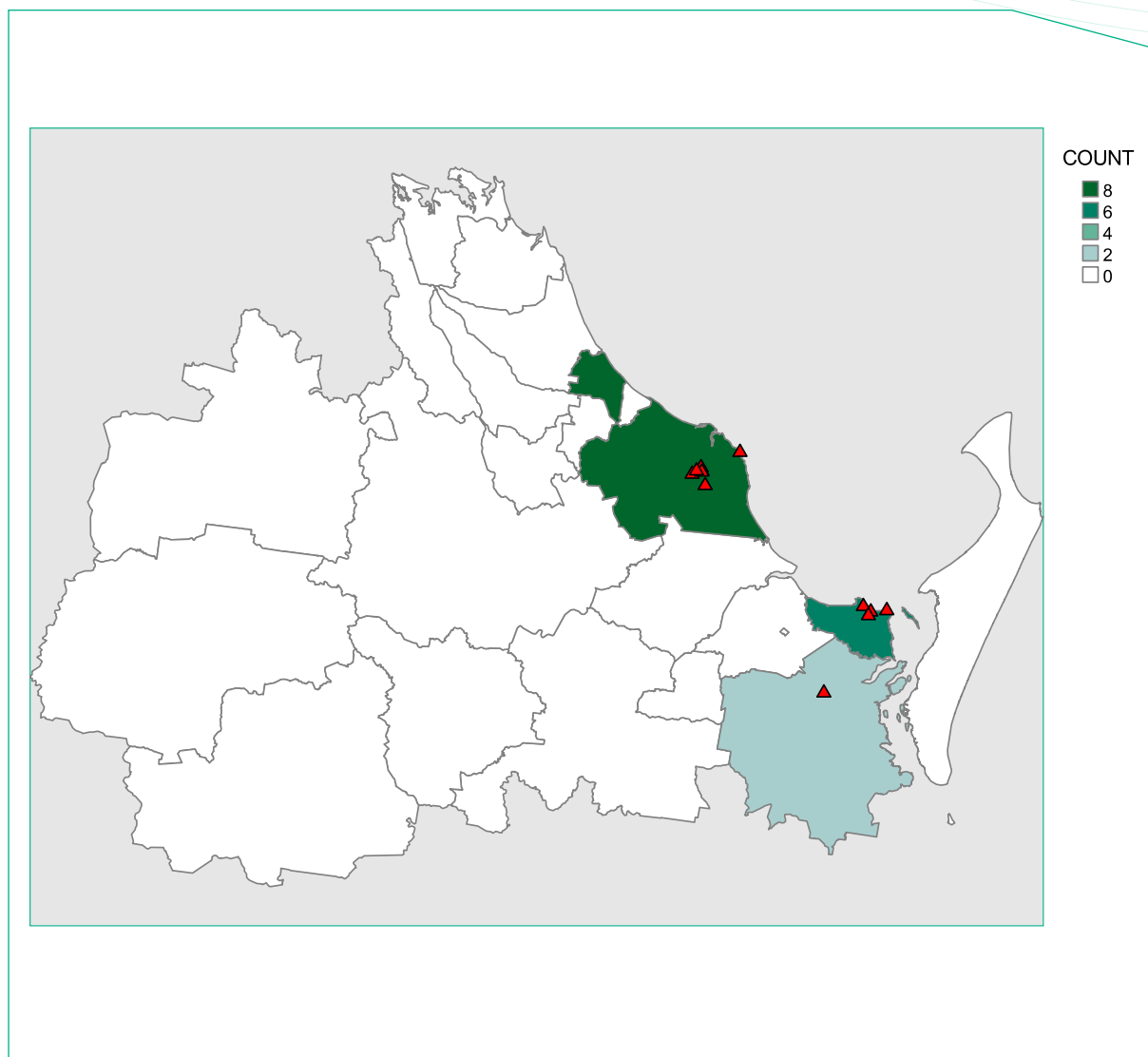
Cairns & Hinterland: Occupational violence incidents 2015/16 YTD



Cairns & Hinterland	All Incidents	
	2015/16 YTD	
Station	Total	Per month
Cairns	5	0.7
Atherton	2	0.3
Innisfail	2	0.3
Mareeba	2	0.3
Edmonton	-	0.0
Other	6	0.9
Total	17	2.4

Deliberate Physical Attack				
2015/16 YTD		2014/15 FY		± change
Total	Per month	Total	Per month	
4	0.6	1	0.1	0.5
1	0.1	-	0.0	0.1
1	0.1	1	0.1	-
1	0.1	1	0.1	-
-	0.0	2	0.2	-0.2
4	0.6	3	0.3	0.3
11	1.6	8	0.7	0.9

Wide Bay: Occupational violence incidents 2015/16 YTD

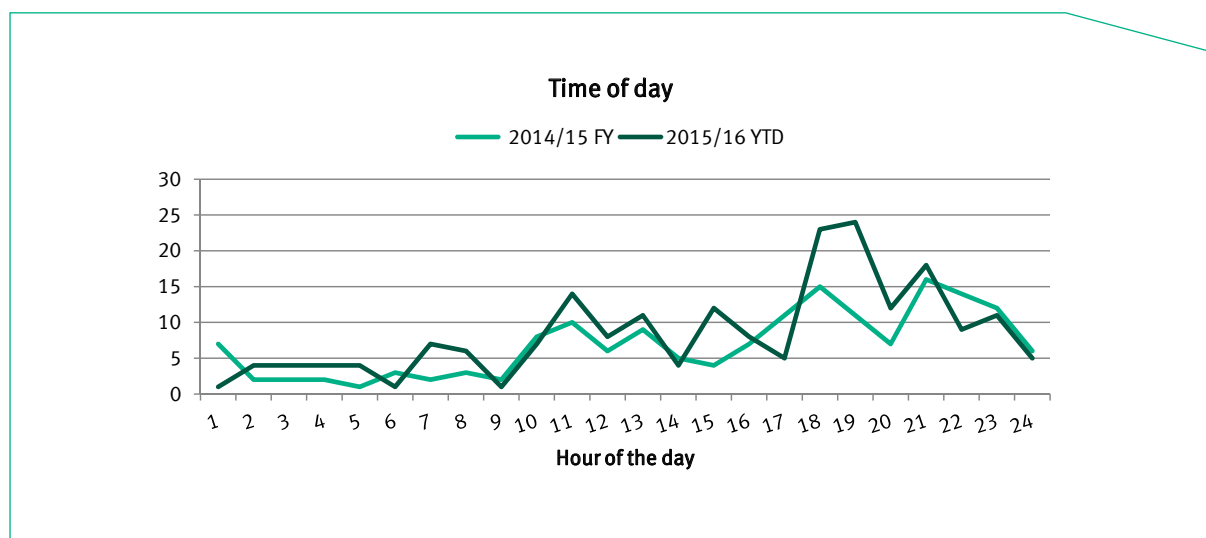


Wide Bay	All Incidents	
	2015/16 YTD	
Station	Total	Per month
Hervey Bay	5	0.7
Burnett Coast	4	0.6
Bundaberg	3	0.4
Maryborough	2	0.3
Other	1	0.1
Total	15	2.1

Deliberate Physical Attack				
2015/16 YTD		2014/15 FY		± change
Total	Per month	Total	Per month	
4	0.6	1	0.1	0.5
-	0.0	-	0.0	0.0
3	0.4	1	0.1	0.3
2	0.3	2	0.2	0.1
1	0.1	4	0.3	-0.2
10	1.4	8	0.7	0.8

Time of day of the reported assault was retrieved from the CAD record of 'Dispatch Time' of the case times, this was examined to validate the self-reported times within the SHE data collection. Graph 11 below displays that the peak incidence occurs around 6:00pm to 7:00pm in the evening, a decline is seen between 8:00pm to 9:00pm but it still remains elevated compared to the remainder of the time period.

Graph 11: Hour of day of incidents for 2014/15 FY (physical attacks only) and 2015/16 YTD (all occupational violence incidents)



The majority (61.3%) of occupational violence incidents are from priority code 1C and 2C, however this is confounded with overall demand, as nearly 50% of QAS incidents dispatched with these priority codes.

Table 5: Priority code and mechanism of injury for 2015/16 YTD

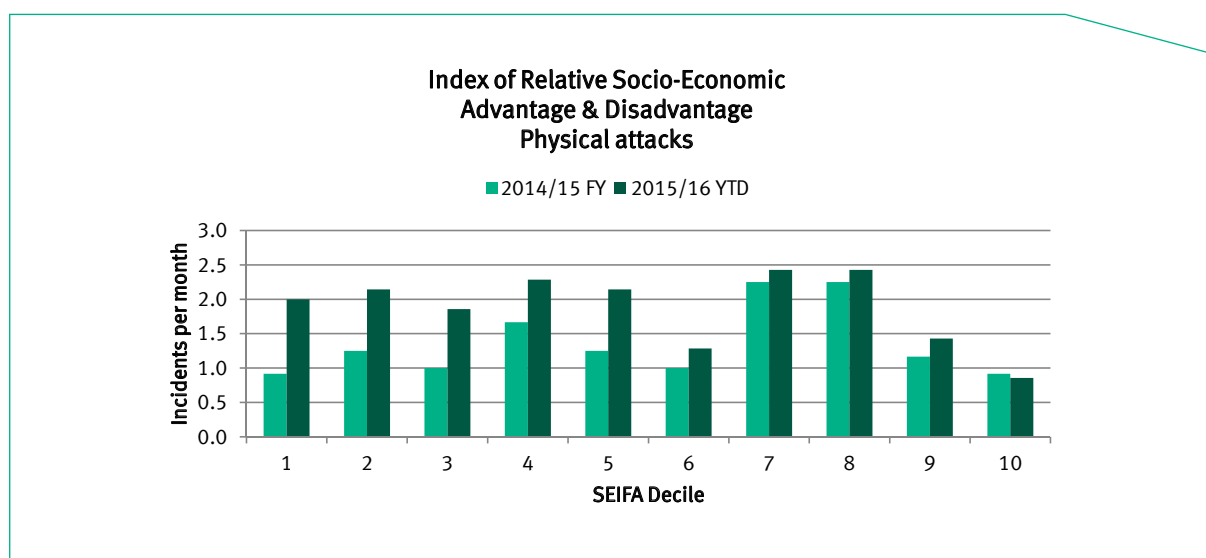
Priority	Accidental Contact	Deliberate Physical Attack	Verbal Threat	Total
1C	6	45	19	70
2A	2	22	17	41
1B	1	29	6	36
2CSL	0	6	5	11
1A	1	4	2	7
2BS	0	4	2	6
2B	0	2	0	2
3B	0	2	0	2
2BSL	0	0	1	1
2C	0	1	0	1
2CS	0	0	1	1
3A	0	1	0	1
4A	0	1	0	1
4B	0	1	0	1
Total	10	118	53	181*

* Note that there can be multiple SHE reports/incidents attributed to one QAS incident, due to multiple officers assaulted in the one QAS incident. Two cases have been excluded due to incomplete priority data.

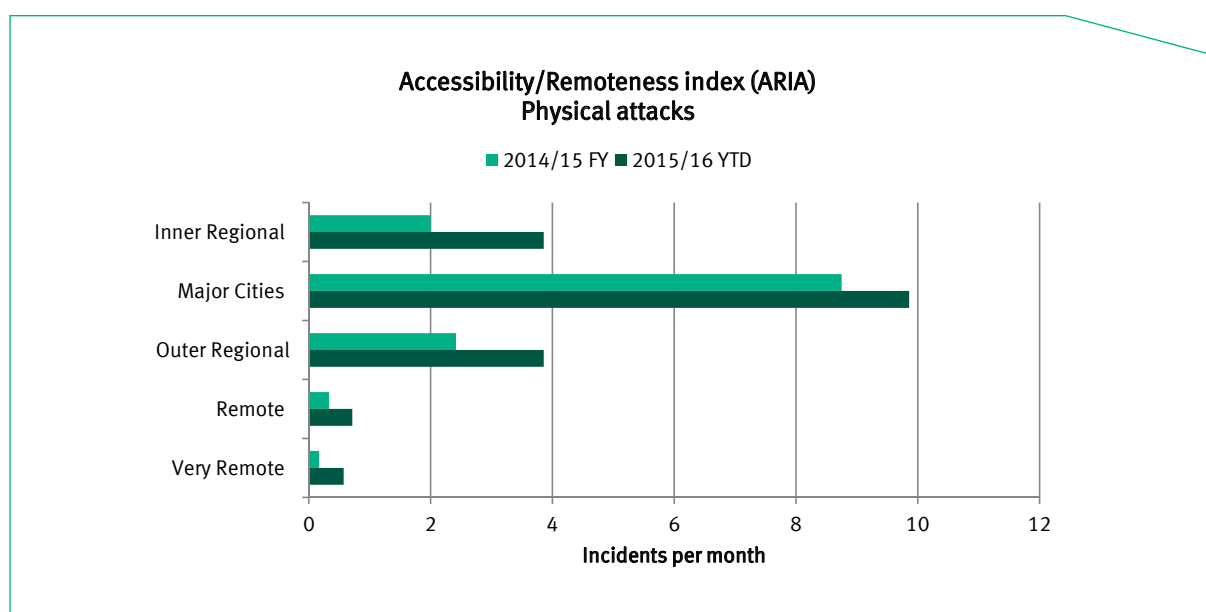
Information within the eARF relating to scene location was examined to explore further demographic characteristics of the cases at which the attending paramedics were physically assaulted. Based upon Scene Location Postcode, cases were examined by the Index of Relative Socio-Economic Advantage and Disadvantage (SEIFA). The SEIFA indexes are rankings. Each index ranks different geographic areas of Australia according to a 'score' that is created for the area based on characteristics of people, families and dwellings within that area. The index divides statistical areas into deciles (ten equal categories, based on population distribution as a proportion of the total population), with the 1st decile being the most disadvantaged and the 10th decile being the most advantaged.

The deliberate physical attack incidents per month are greatest in the upper middle SEIFA deciles 7 and 8 (refer Graph 12). It is worth noting that compared to the 2014/15 FY, in the 2015/16 YTD the average number of incident per month in the lower deciles has increased. The majority of reported cases occurred in the Inner Regional and Major Cities, where the main population base resides (refer Graph 13).

Graph 12: Deliberate physical attacks per month by SEIFA decile



Graph 13: Deliberate physical attacks per month by remoteness index



Information within the narrative case description contained in the eARF was examined to identify the role of the liable assailant. In the vast majority of cases (n=160), the assault was perpetrated by the Patient (Table 6).

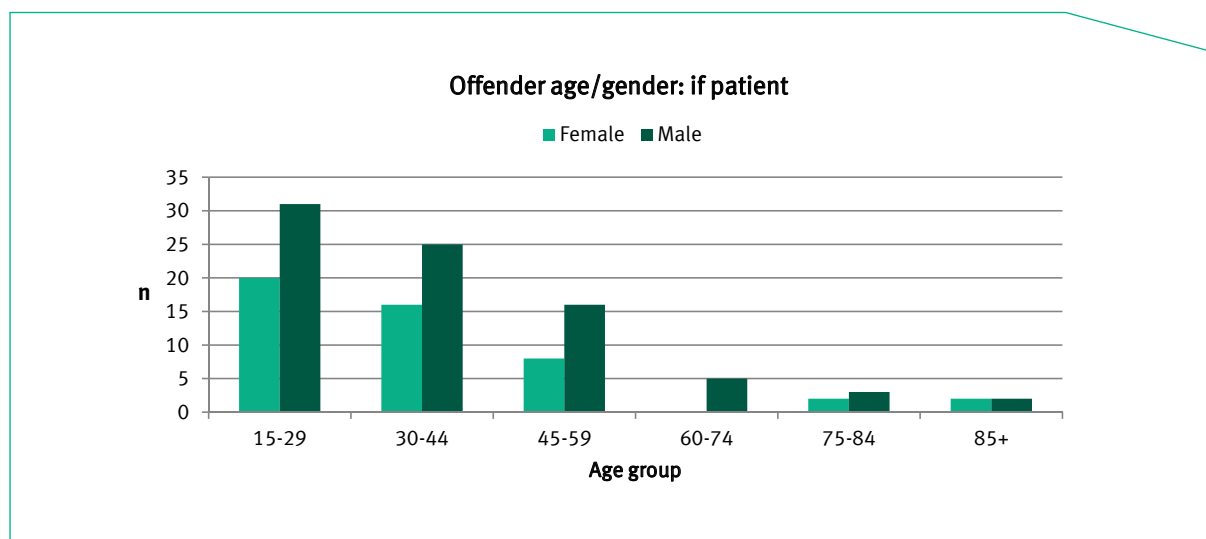
Table 6: Liable person and gender of offender 2015/16 YTD (All OV)

	Female	Male	Female & Male	Unknown	Total
Bystander	3	12	0	1	16
Patient	62	95	0	3	160
Patient and bystander	0	1	1	0	2
Unknown	0	1	0	4	5
Total	65	109	1	8	183

*If not mentioned otherwise in case description manual review, taken as patient on eARF to be offender

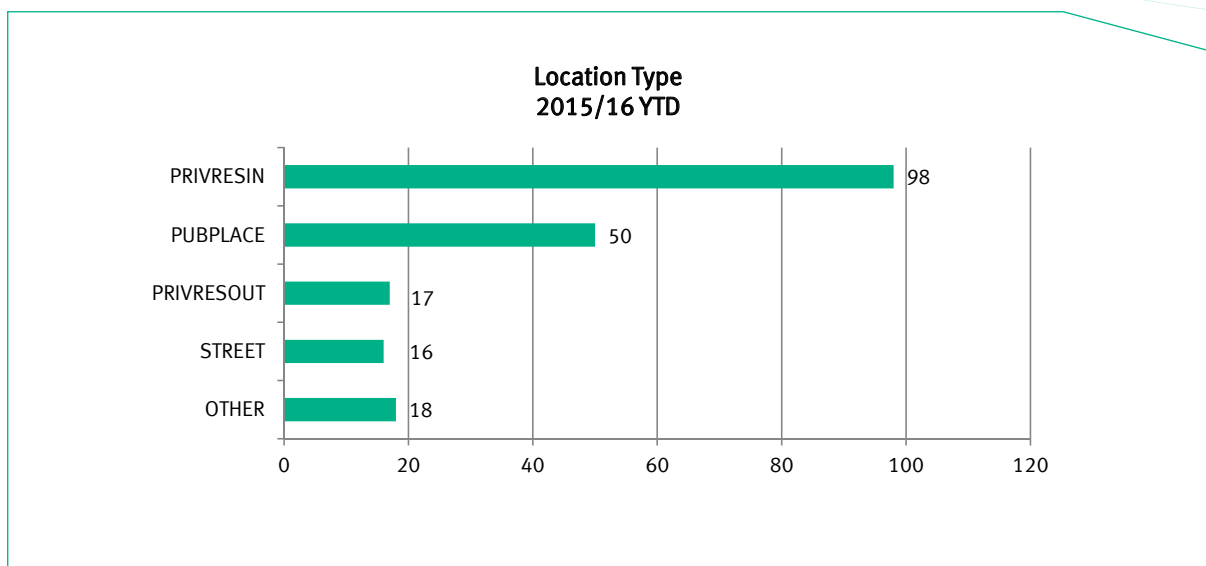
For cases where the patient was the offender, age and gender information showed that the majority were male and skewed towards the youngest age groupings, with incidence declining by advancing age (refer Graph 14).

Graph 14: Age group and gender of offender (if patient) (All OV)



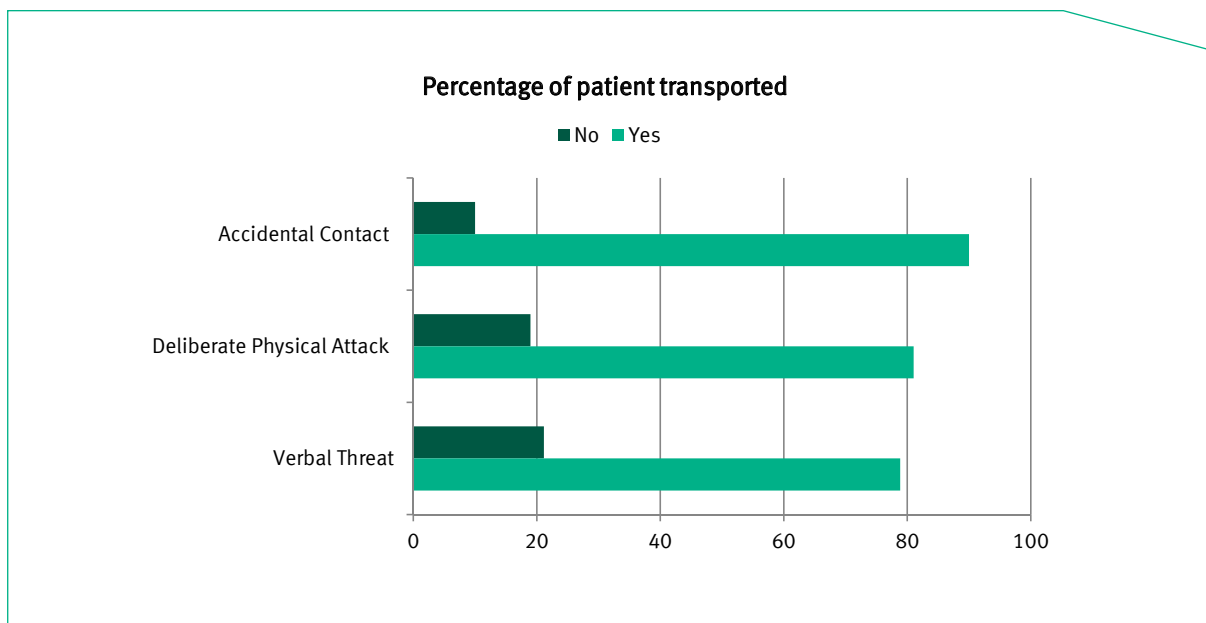
Notably, over half (n=115) of reported incidents occurred either inside or outside a private residence (Graph 15).

Graph 15: Location type of occupational violence QAS incidents 2015/16 YTD (All OV)



In over 80.0% of all occupational violence incidents, the attended patient was ultimately transported by QAS (refer Graph 16).

Graph 16: Patient transport by mechanism of injury 2015/16 YTD (All OV)



** Note this shows whether there was a transport related to the QAS incident. This could have been any unit assigned to that incident and is not necessarily the unit of which a crew member made a SHE claim

Medical Priority Dispatch System (MPDS) codes are applied by EMDs at the point of call taking to prioritise the ambulance response. MPDS codes provide descriptors of the case type based upon information provided by the caller. For over half of all cases (n=100), five (5) particular MPDS cards were assigned: Unconscious/Fainting (near); Psychiatric/Abnormal Behaviour/Suicide Attempt; Overdose/Poisoning (ingestion); Sick persons (specific diagnosis); and, Convulsions/Fitting (Table 7).

Table 7: MPDS protocol and breakdown of mechanism of injury 2015/16 YTD

#	Description	Accidental contact	Deliberate Physical Attack	Verbal Threat	Total
31	Unconscious/Fainting (near)	5	16	6	27
25	Psychiatric/Abnormal Behaviour/Suicide Attempt	2	14	6	22
23	Overdose/Poisoning (ingestion)	0	13	5	18
26	Sick Persons (specific diagnosis)	1	10	7	18
12	Convulsion/Fitting	0	13	2	15
17	Falls	0	7	7	14
10	Chest pain (non-traumatic)	1	5	4	10
21	Haemorrhage/Lacerations	0	7	1	8
4	Assault/Sexual assault	0	5	2	7
6	Breathing problems	0	3	4	7
1	Abdominal pain	0	3	3	6
9	Cardiac or respiratory arrest	0	3	1	4
29	Traffic/Transportation Accidents	1	3	0	4
13	Diabetic problems	0	3	0	3
30	Traumatic Injuries (specific)	0	2	1	3
2	Allergies	0	1	0	1
3	Animal Bites/Attacks	0	0	1	1
5	Back pain	0	1	0	1
18	Headache	0	0	1	1
20	Heat/cold exposure	0	1	0	1
27	Stab/Gunshot/Penetrating Trauma	0	1	0	1
32	Unknown problem (Collapse – 3rd party)	0	1	0	1
	Other	0	6	2	8
	Total	10	119	54	183*

* Note that there can be multiple SHE reports/incidents attributed to one QAS incident, due to multiple officers assaulted in the one QAS incident.

Table 8: Final assessment of occupational violence incidents 2015/16 YTD

Final Assessment (eARF)	Accidental contact	Deliberate Physical Attack	Verbal Threat	Total
Alcohol Intoxication	3	16	9	28
Drug Intoxication	-	16	3	19
Pain	-	8	6	14
Psychiatric Episode	1	10	2	13
Emotional Distress	-	5	5	10
Final Assessment Unknown	-	7	3	10
Seizure/s / Convulsion/s	2	6	2	10
Laceration	-	7	2	9
Overdose	-	7	2	9
Other - Specify	1	5	2	8
Unknown Problem	1	2	3	6
Altered Conscious State	-	3	2	5
Fracture/s	-	3	2	5
Other	2	21	10	33
Total	10	116	53	179*

* Note that there can be multiple SHE reports/incidents attributed to one QAS incident, due to multiple officers assaulted in the one QAS incident. Four cases have been excluded due to incomplete data.

Because of the relatively short timeframe for patient contact, and the uncontrolled nature of the on-scene environment, the presenting injury/illness and the associated treatment variables are the key data elements captured within the coded sections of the eARF. The QAS does not routinely collect coded data on the underlying cause or contributing circumstances of each case. However, useful information regarding the contributing role of various factors, such as alcohol and/or drugs, is often recorded in the free text section of the eARF. Detailed manual review of the case narrative was undertaken to identify emerging themes within the eARF records (Table 8).

The predominant theme was the indication of the involvement of alcohol and/or drugs in the patient's presentation. In 2015/16 YTD, over one-third of cases had alcohol consumption noted within the eARF and approximately one-quarter had evidence of drug involvement. Notably, only a very limited number of cases occurred at a licensed establishment, which is consistent with the earlier findings based upon Scene Location that over half of reported assaults occurred at a private residence.

Table 9: Manual review of eARF documentation of alcohol and/or drug involvement

	Deliberate Physical Attack		Accidental	Verbal Threat
	2015/16 YTD (n=118)	2014/15 FY (n=153)	2015/16 YTD (n=10)	2015/16 YTD (n=55)
Alcohol	42	68	2	16
Drugs	32	47		20
Licensed establishment	2	4		3

Another theme that was identified was that of a patient presenting with or providing recent history of seizure activity, as in 11% of reported cases for 2015/16 YTD.

Treatment information was also scrutinised to identify at which point in the assessment and treatment process the assault occurred (Table 10). In 2015/16 YTD, for those cases where it was able to be determined (n=85), approximately 60% of deliberate physical assaults occurred whilst active treatment was being administered.

Physical restraint was frequently applied to manage patient assailants, and it is notable that there is an increase in the use of physical restraint from 2014/15 FY (12 month period) to 2015/16 YTD (7 month period). If the current rate of physical restraint application continues for the remainder of the 2015/16 FY, then it would be expected that there will be approximately 150 physical restraint applications.

Table 10: Manual review of eARF case management

	Deliberate Physical Attack		Accidental	Verbal Threat
	2015/16 YTD	2014/15 FY	2015/16 YTD	2015/16 YTD
Timing of assault to treatment provided				
Prior	18	27	2	10
During	50	57	3	17
Post	17	34	2	11
Restraint used				
Physical	89	36	4	4
Mechanical	22	29	0	3
Pharmacological	18	25	3	4
Patient in seizure	13	15	3	2

Note that this information has been extracted from the free text section of the eARF.

In summary, the examination of situational factors revealed the following:

- » The majority of occupational violence incidents occur at the scene address location.
- » In the majority of cases the assault was perpetrated by the patient, as opposed to another party at the scene, and 59.5% of assailants were male.
- » The peak time for reported occupational violence was at 6:00-7:00pm in the evening.
- » For over half of all cases, five (5) particular MPDS cards were assigned: Unconscious/Fainting (near); Psychiatric/Abnormal Behaviour/Suicide Attempt; Overdose/Poisoning (ingestion); Sick persons (specific diagnosis); and, Convulsions/Fitting.
- » Of the reported occupational violence incidents in 2015/16 YTD, the most commonly recorded Final Assessments describing the primary problem for which the patient was assessed or received treatment were 'Alcohol Intoxication' and 'Drug Intoxication'.
- » From detailed manual review of the case narrative the predominate theme was the indication of the involvement of alcohol and/or drugs in the patient's presentation.
- » In 11% of reported cases the patient presented with or had recent history of seizure activity.
- » In 80% of occupational violence incidents the attended patient was ultimately transported to a hospital or other receiving facility.
- » In 2015/16 YTD, for those cases where it was able to be determined (n=85), approximately 60% of deliberate physical assaults occurred whilst active treatment was being administered.

- » Physical restraint was frequently applied to manage patient assailants and there is a notable large increase in use from 2014/15 FY (12month period) to 2015/16 YTD (7 month period).
- » It is essential for paramedics to remain situationally aware and alert to dangers in their environment. This is highlighted by the rate of incidents that occur at private residences, where paramedics are entering settings that are unfamiliar to them but potentially well known to the persons at scene.
- » The results of the detailed record reviews highlight that a particular risk factors are attending younger or middle age patients, particularly males, where there is a heightened index of suspicion of alcohol or drug involvement. This is of particular relevance where there is indication of altered conscious levels or seizure-type activity.
- » Particular caution should be used during the active treatment phase of cases, due to physical proximity of the paramedic to the patient, and the nature of management procedures that may rouse a surfacing patient suddenly.

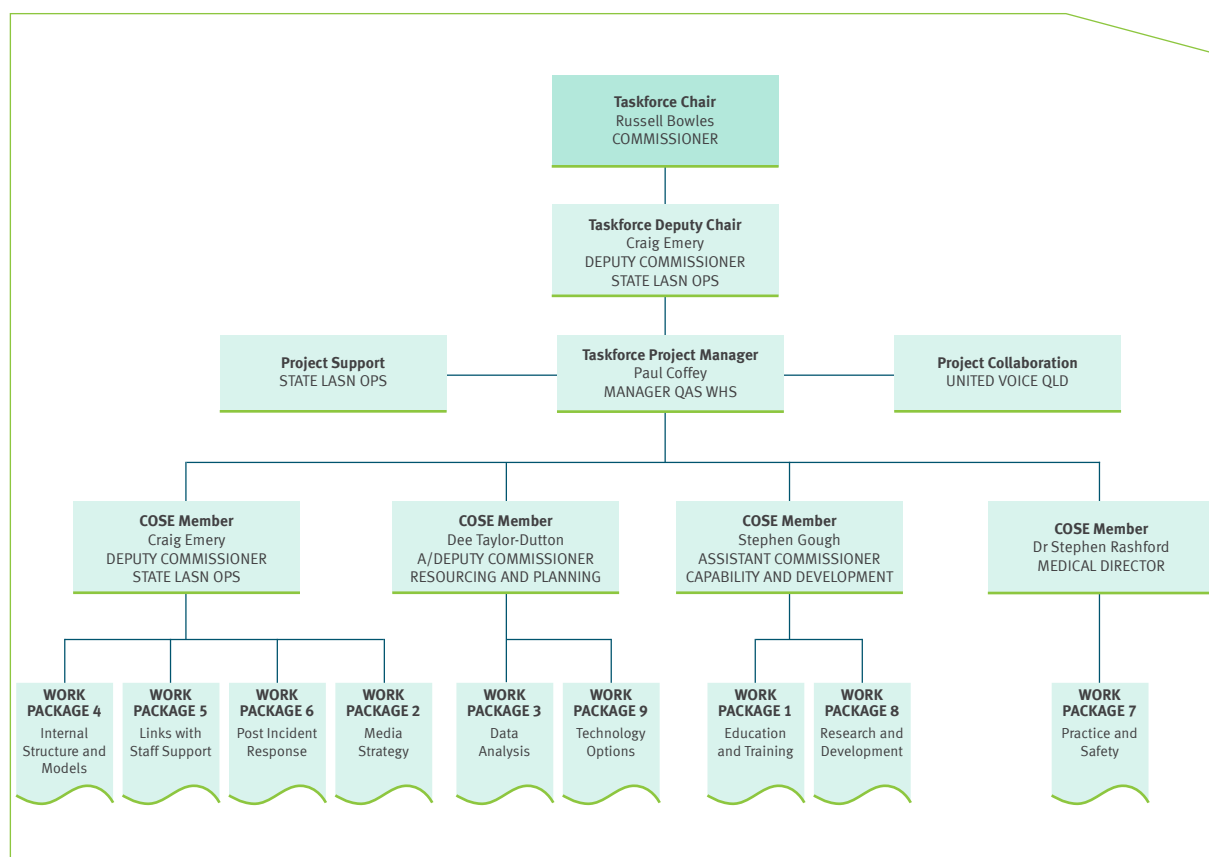


Initiatives arising from the Taskforce recommendations

The interim recommendations were delivered through actions contained within nine discreet initiatives, which were developed in support of the overarching approved Taskforce Project Plan. Utilisation of these initiatives allowed simultaneous work activities to be undertaken in order to deliver the recommendations of the Taskforce. Oversight and accountability for each of the nine initiatives, as they relate to the Taskforce, were articulated through the approved Paramedic Safety Taskforce Project Plan. The initiatives were defined as follows:

1. education and training
2. media and communication
3. data analysis
4. internal structures and models (QAS Supervisory Model)
5. linkages to staff support
6. post incident response and support (Priority One)
7. QAS clinical practice and patient safety
8. research and development
9. technology options.

Each initiative was assigned to an Executive Sponsor from QAS Central Office Senior Executive (COSE) cohort, and allocated to a Taskforce Working Group Lead for delivery, as indicated in the below diagram.





Initiative progress oversight, and completion

Through the approved Paramedic Safety Taskforce Project Plan, key success factors and specific task based requirements were established for each initiative along with indicative timeframes for delivery.

The Taskforce agreed that the timely delivery of the actions and outcomes associated with each initiative was essential for the delivery of each recommendation and in turn, the overarching success of the project. In this respect, the Taskforce established effective reporting processes to enable accurate and robust project oversight with respect to the status of each deliverable task associated with each initiative.

To enable complete project oversight:

- » each Initiative's Working Group Lead provided a weekly status report to the Initiative's Sponsor
- » once approved by the Initiative's Sponsor, this report was then provided to the project assurance function, where the information was verified, and collated into a Weekly Highlight Report
- » weekly Highlight Reports were then provided to the Taskforce Deputy Chair for delivery to the Taskforce as a standing agenda item at Taskforce meetings.

Importantly, the establishment focus groups comprising frontline paramedics, communications officers, and Officers-in-Charge (OICs) enabled functional consultative processes to be utilised by the Taskforce in the delivery the actions associated with each initiative. In this respect, prior to finalisation, the actions comprising each initiative were tested within these groups. This aspect of consultation was of critical importance in ensuring the practicality of the strategies and interventions identified by the Taskforce.

These processes ensured effective collaboration of actions across each initiative and enabled full consultative input by taskforce members and stakeholders.

Final Initiative reports were provided to the Taskforce in March 2016, including initiative outcomes and proposed future actions. These were collated in this Report, and denote the final status of each Initiative, as it relates to the Taskforce Recommendations.

On delivery of this Final Report, all actions as defined through the Taskforce Project Plan have been completed, noting that some strategies arising from each initiative will require ongoing implementation into the future. In this regard, to facilitate ongoing collaboration, engagement and progression of the recommendations contained within this Report, a specified implementation group will be established within QAS to provide the ongoing strategic oversight to the continued implementation of the Taskforce recommendations.

1: Education and training – actions and outcomes

Completion of this initiative involved the development of on-line modules that are combined with focused face-to-face practical sessions, to mitigate the risks of occupational violence, and assist paramedics to identify, de-escalate and withdraw safely from potentially dangerous or confronting situations.

To achieve this end, the Working Group initially undertook a review of the existing QAS training programs for effectiveness and currency. This review saw the redesign of the 'Situational Awareness for Everyday Encounters' (SAFE) training system. This system has been tailored for paramedics so they can more easily identify, de-escalate and withdraw safely from certain confronting situations. As an outcome of this Initiative, the initial SAFE training was contemporised and updated based on the advice and quality assurance from experts such as the QPS, and was informed through reliable research. Notably the involvement of the QPS in this process was invaluable, and feedback received about the program and the quality of the trainers has been extremely positive.

This process of redesign has cumulated in the development of the 'SAFE2' program, delivered through on-line modules that are combined with focused face-to-face practical sessions. Notably the delivery of this training may be achieved through an external provider, core QAS project team, and / or a 'Train-the-trainer' model.

In this regard, Courses 1-5 of the train-the-trainer program have been completed (approximately 40 officers), and the SAFE2 Skills video has been produced, edited and made available to officers via QAS Collaborative Learning Online (QASCLO) system. Further, the LASN rollout schedule for the delivery of the SAFE2 training has been developed, with rollout to all frontline staff having been commenced, and proposed to be completed by December 2016. QAS will continue to monitor this process of rollout across all LASNs, following delivery of this Final Report.

The actions arising through this initiative were tested, and agreed to at the established paramedic focus groups.

In addition, changes to QAS procedures and other information arising from the delivery of this initiative may be utilised to inform the development of specific training into the future.



Initiative 1 – Education and training**COSE Sponsor:**
Assistant Commissioner - Stephen Gough**Working Group Lead:**
Critical Care Paramedic - Mark Whitby

Key Success Factor

Development of on-line modules that are combined with focused face-to-face practical sessions. Training delivery may be through an external provider, core QAS project team, and / or a Train-the-trainer model.

Tasks	Timeframe for delivery
1.1 Conduct a review of QAS training programs for effectiveness and currency	Jan 2016
1.2 Redesign a SAFE training system that is tailored for paramedics so they can more easily identify, de-escalate and withdraw safely from certain confronting situations as required – the program should be contemporised and updated based on content experts and reliable research. This includes Quality Assurance from experts such as the QPS	Dec 2015 – March 2016
1.3 New Training Materials developed - Development of on-line modules that are combined with focused face-to-face practical sessions. Training delivery may be through an external provider, core QAS project team, and / or a Train-the-trainer model	March 2016
1.4 Preliminary report of proposed recommendations to Taskforce: 1.4.1 Include roll out schedule for implementation and delivery of the program to all frontline staff in early 2016	March 2016

Milestone activity	Project status
Development of new SAFE2 program	100% Complete
Train the trainer groups completed - Courses 1 – 5	100% Complete
SAFE2 Manual development	100% Complete
LASN rollout schedule for SAFE2 training	100% Complete
SAFE2 Skills supplemental video production (produced, edited and made available on QASCLO)	100% completion by April 2016
LASN SAFE2 Training Rollout	Ongoing after Final Report

Taskforce recommendation: Education and training

1. That QAS implement the outcomes of the Taskforce review of the 'Situational Awareness for Everyday Encounters' (SAFE) training program through the rollout of the revised SAFE2 training course to all frontline paramedics across Queensland by December 2016.

2: Media and communication – actions and outcomes

As an outcome of this initiative, QAS has conducted a campaign to raise awareness about the increasing frequency of assaults on paramedics and health workers in Australia. The campaign includes the utilisation of various media platforms, with consideration given to the internal communication requirements within QAS and external communication avenues towards the broader community. This outcome is consistent with the recommendation that QAS should develop and implement a media and communication strategy directed at occupational violence.

The intent of the campaign is to gather community support and consensus that assaults on paramedics are unacceptable and will not be tolerated, and that offenders will face legal consequences. In this regard, the Palaszczuk Government announced the implementation of a \$1.35 million, combined Department of Health and QAS public awareness campaign aimed at minimising violence against paramedics.

The resulting media coverage from the *“Zero Tolerance - No Excuse for Abuse”* QAS campaign was significant and has continued, with QAS Media receiving numerous enquiries from media outlets around Australia and in the USA in relation to the issue. A number of interviews with QAS paramedics who had been assaulted were also facilitated with regional media outlets. In this regard, QAS Media Unit has also facilitated numerous media interviews, some of which have been picked up by a national media audience, creating awareness of the occupational violence QAS staff were subjected to and what is being done to rectify it. For example, QAS, UVQ, and the Minister’s media team collaborated to produce a three-part feature with the Sunday Mail raising awareness *“Ambo safety”*.

Social media has proven to be a very successful platform to engage the public, our own staff and stakeholders on this topic noting that a number of subsequent online posts in relation to the issue have attracted strong reaction from the community. The reach of this campaign via social media has been unprecedented for QAS. The total reach of the initial Facebook post about the assault of a QAS officer is currently at more than 13 million, with 137,000 shares, 77,000 likes and more than 19,000 comments – most of which are overwhelmingly supportive. As an outcome of this initiative, QAS media will continue to use social media platforms to highlight the ongoing campaign and publicise key messaging and incidents as they occur. Headline banners have been developed for QAS Facebook and Twitter accounts and will be utilised as required.

Following the introduction of QAS Media Strategy *“Zero Tolerance - No Excuse for Abuse”* campaign, posters featuring the key messages *“Zero tolerance”* and *“No excuse for abuse”* have been placed inside ambulances and stickers have been placed on the rear of ambulances to further spread the reach of the campaign, with the Honourable Cameron Dick, Minister for Health and Minister for Ambulance Services, placing the first *“Zero tolerance”* and *“No excuse for abuse”* posters and stickers on our fleet. More than 1,000 ambulances across the state will carry this important public awareness campaign message. Posters were affixed to the inside rear left hand door window and stickers on the bottom right of the rear door. Smaller versions of the stickers were also produced and rolled out to all QAS nontransport vehicles state-wide.

Key Taskforce outcomes have been and will continue to be distributed to QAS staff by email, in the bimonthly electronic publication *“QAS Insight”* and QAS blog platform (once established). The use of the blog platform will enhance internal staff messaging on taskforce outcomes (for example, ongoing reminders of Safe Training initiatives and best practice de-escalation techniques).

Following market testing and research, a design concept has been approved for the combined Queensland Health and QAS public awareness campaign by the Minister for Health and Minister for Ambulance Services and the Government. Production commenced mid-March 2016 with the external media campaign commencing early April 2016. This campaign will include state-wide television, advertising targeted towards pubs/clubs/nightlife precincts, street posters, taxi backs, bus panels, and digital media. QAS will promote this multi-media campaign throughout our social media platforms. Ongoing media and social media exposure of assault-related issues that occur will be judged on a case by case basis. QAS Media will also continue ongoing liaison with the UVQ media team to develop best practice external awareness to reach targeted groups within the public sector and manage assault related issues that arise.

Please note, the actions arising through this initiative were tested, and agreed to at the established paramedic focus groups.

Initiative 2 – Media and communication

COSE Sponsor:
Deputy Commissioner - Craig Emery

Working Group Lead:
Director QAS Media - Michael Augustus

Key Success Factor

The Taskforce has made a recommendation that QAS should develop and implement a media and communication strategy directed at occupational violence. The strategy should include the utilisation of various media platforms, giving consideration to the internal communication requirements within QAS and an external communication strategy with the broader community.

Tasks	Timeframe for delivery
2.1 Scope development and implementation of a suitable media and communication strategy that considers both an internal communication strategy (within QAS) and external (external media, social media and similar)	Jan-Feb 2016
2.2 Promote new occupational violence initiatives to all staff to prevent or reduce the likelihood of occupational violence	Feb-March 2016
2.3 Report on findings to Taskforce	March 2016

Milestone activity	Project status
Proactive Media Campaigns in Metro and Regional media markets	100% Complete
Stickers and Posters on all single stretcher vans, twin stretcher modules, and 4WDs	100% Complete
Messaging in bimonthly electronic publication "Insight" and QAS blog	100% Complete
Implementation of the \$1.35 million combined Department of Health and QAS public awareness campaign. Campaign will include TV, Digital, Radio, Out of home billboards	Ongoing after Final Report

Taskforce recommendations: Media and communications

2. That QAS develop a media and communication strategy aimed at minimising violence against paramedics, including internal messaging to all staff by April 2016.
3. Working with Department of Health and United Voice, QAS will implement a public awareness campaign through mainstream and social media aimed at minimising violence against paramedics by April 2016.

3: Data analysis – actions and outcomes

This initiative focussed on the effective use of data analysis to develop best practices for occupational violence prevention strategies and policy development. The Occupational Violence Data Analysis Working Group, comprising both QAS staff and UVQ representation, were tasked to undertake this body of work.

Occupational violence data analysis and demographic modelling

As an outcome of this initiative, detailed demographic modelling of QAS' datasets involving occupational violence against QAS officers was undertaken, involving both a quantitative and qualitative analysis, to determine the situational factors associated with the incidents, so that this could inform best practice for occupational violence prevention strategies and policy development.

However, due to the limitations of relevant searchable fields in SHE, this process was undertaken manually. Hence, it is recommended that QAS continues to evaluate options available to provide a contemporary replacement for the SHE system. The following categories were used to determine the situational factors associated with an incident:

- » drugs
- » alcohol
- » whether the patient had had a seizure
- » location of incident e.g. licenced premises, metropolitan vs rural, private residence
- » demographic / characteristics of offender – age, sex and whether the offender was a patient or bystander
- » timing of assault (prior, during, post) to treatment provided
- » whether QAS officers used a restraint when treating the patient (physical, mechanical, pharmacological).

Analysis was also to include whether the occupational violence incident occurred in or around a Drink Safe Precinct, however this could not be determined with the current location coordinates, and will require separate body of work undertaken with detailed mapping provided by Public Safety Business Agency (PSBA).

In conducting this quantitative and qualitative analysis, the following datasets were utilised:

- » WorkCover claims
- » SHE incident reports
- » eARF related to the SHE incident report
- » Government Wireless Network (GWN) duress activation report
- » LASN Assault Registers (where available).

The QAS Workplace Health and Safety (WHS) Unit will continue to provide enhanced daily reports to QAS Senior Executives, and monthly reports on occupational violence incidents to QAS Board of Management.

Data matching was undertaken to correlate all GWN duress activation data provided by Telstra with the SHE database to determine whether there is any near-miss data that is not being captured by the SHE system and to identify under-reporting by QAS staff in QAS SHE system. Although GWN duress activation data has only been available since November 2015, a total of 10 duress activations have been made in this period, which have been analysed. All incidents had been reported in the SHE system, with the exception of three incidents which are undergoing further analysis as there were insufficient identifying details to make the comparison in SHE. An outcome of this process is for the GWN Director to provide the WHS Unit with monthly reporting of GWN duress activations so that these can be correlated with the SHE database for further trend analysis in respect of near-miss occupational violence incidents.

In addition, Assault Registers were obtained from the LASNs and matched against SHE to determine any near-misses and the degree of under reporting. It was noted that whilst the majority of occupational violence incidents matched the SHE database, there was no standardised reporting format across the LASNs and some LASNs did not maintain an Assault Register. Hence, this review recommended the QAS WHS Unit develop a standardised LASN Assault Register template, to provide consistency and uniformity in data reporting when matched against both SHE and GWN data.

Industry standards

A preliminary investigation of data reporting and data definitions from other national and international jurisdictions highlighted the requirement to develop a consistent approach to assault and WorkCover definitions in order to provide comparable reporting and to identify current industry evidence best practice. A questionnaire was submitted to the Council of Ambulance Authorities (CAA) for dissemination to ambulance services from other Australia and New Zealand jurisdictions regarding the data definitions and to obtain information regarding work they are doing regarding occupational violence against their staff. This will form another body of work in the development of a CAA data dictionary to enable QAS to determine the comparability of assault data against other jurisdictions, as well as to identify current industry best practice for occupational violence against ambulance staff.

QAS Occupational Violence Data Dashboard

Through this process of analysis, a 'data dashboard' was developed which will enable QAS' WHS Unit to provide enhanced daily, monthly, annual reporting of SHE data as it relates to occupational violence. In conjunction with the development of this dashboard, it was determined that QAS Information Support and Research and Evaluation Unit would continue the demographic modelling of data to enable further identification of trends and to inform future initiatives to reduce the impact of occupational violence on QAS officers. The draft QAS Occupational Violence Data Dashboard was completed and presented to the Paramedic Safety Taskforce on 4 March 2016, and is based on a similar format to the Queensland Health Occupational Violence Data Dashboard.

Review of LASN incident investigation process

In reviewing LASN SHE incident investigation processes and outcomes, a high-level review of 201 occupational violence incidents was completed. This review involved reviewing each SHE-report and determining from this report, whether both the causes of, and appropriate actions with respect to the incident had been identified and recorded. Based on this methodology, of the 201 SHE-reports reviewed it was found that:

- » 95% (191) investigations met a minimum standard (a cause identified and an action taken).
- » 5% (10) of investigations did not meet a minimum standard (either cause and/or action not identified).

In respect of QAS SHE incident investigations, the Working Group found that QAS has the following resources in place and available on QAS Portal to assist officers completing SHE incident investigations at an appropriate standard, ensuring a root cause is identified and managed:

- » Workplace Health and Safety Standard (Core) – Incident Reporting and Investigation
- » QAS Workplace Incident Reporting and Investigation and Corrective Action Procedure
- » QAS Workplace Health and Safety Incident Investigation Guide
- » LASN Directive 08-15: QAS Operational Incident Reporting.

In addition to these resources, a standardised SHE Incident Investigation Report and Guide for Managers and Supervisors were drafted to ensure best practice for occupational violence incident investigation is consistent across all QAS.

As an outcome of this Working Group, the following actions have been recommended for QAS WHS Unit:

- » To provide feedback to individual LASN Managers on the outcome of the audit of LASN incident investigations involving occupational violence where the investigation was found not to meet a minimum standard, to ensure the root cause is identified and managed.

- » To work with each LASN Manager across the state, to improve the standard of SHE incident investigations involving occupational violence. This includes relevant officers undertaking the Incident Cause Analysis Method (ICAM) Basic Investigator and Lead Investigators' courses, as well as the one day internal QAS course to ensure the root cause of SHE incidents have been identified and managed. ICAM is a holistic systemic safety investigation analysis method. This course presents a step by step outline of the investigation process and provides practical tools and guidance for examining the contributing factors of an incident, with a focus on identifying latent systemic health, safety and environmental deficiencies. It aims to identify both local factors and failures within the broader organisation and productive system that contributed to the incident, such as communication, training, operating procedures, incompatible goals, change management, organisational culture and equipment. Implementation of this recommendation will continue across QAS following the finalisation of this report.

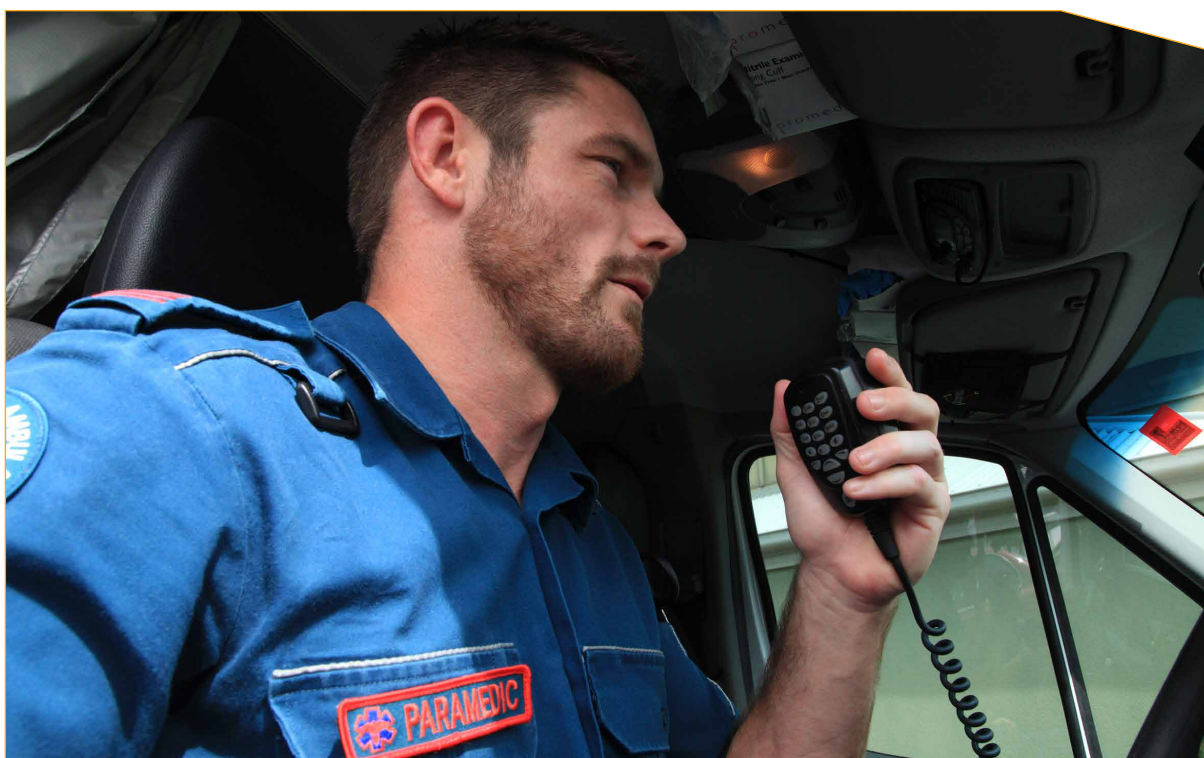
The actions arising through this initiative were tested, and agreed to at the established paramedic focus groups.

Achievements and outcomes

Through this initiative, the following achievements were delivered:

- » Detailed demographic modelling of the available QAS data has been undertaken involving both a quantitative and qualitative analysis.
- » A draft QAS Occupational Violence Data Dashboard was completed, which provides meaningful trend information to responsible managers and supervisors.
- » A standardised Incident Investigation Report and Checklist for Managers and Supervisors for Occupational Violence Incidents was drafted.
- » QAS GWN Director to provide QAS WHS Unit with monthly reporting of GWN duress activations, so that cross matching against QAS SHE records can occur.
- » QAS WHS Unit developed a standardised LASN Assault Register template.

Following release of this Paramedic Safety Taskforce Final Report, QAS will continue to monitor any of the outcomes and future initiatives recommended for implementation.



Initiative 3 – Data analysis

COSE Sponsor:
A/Deputy Commissioner - Dee Taylor-Dutton

Working Group Lead:
Manager QAS WH&S - Paul Coffey
Director, Information, Research and Evaluation, QAS - Dr Emma Bosley

Key Success Factor

Assault data analysed and used to develop best practices for occupational violence prevention strategies and policy development. This includes using quantifiable data sets such as WorkCover injury, SHE; current industry evidence base of best practice; and a consultative approach of frontline paramedic focus groups aimed at identification and recognition of practical workplace strategies and interventions.

Tasks	Timeframe for delivery
3.1 Data Collection and Analysis: Conduct a detailed analysis to help identify trends and provide opportunity to minimise the risk of occupational violence within QAS. Investigate quantifiable data sets such as QAS SHE system, and WorkCover injuries	Dec 2015
3.2 Industry Standards: Undertake a review of current industry evidence base of best practice	Jan 2016
3.3 Focus Groups: Facilitate a consultative approach with frontline paramedic focus groups aimed at identification and recognition of practical workplace strategies and interventions	March 2016
3.4 Review of LASN incident investigation processes and outcomes following incidents – ensure a root cause analysis has been undertaken and risk mitigation strategies identified with findings reported	Feb 2016
3.5 Preliminary report of proposed recommendations to Taskforce. Include identification of any barriers to the implementation of evidence based practices and to implementation	March 2016

Milestone activity	Project status
QAS WHS Unit to work with each LASN Manager to improve the standard of SHE incident investigations involving occupational violence	100% Complete
Draft QAS occupational violence data dashboard	100% Complete
Conduct demographic modelling of data	100% Complete
QAS WHS Unit to continue to provide enhanced daily incident reports to QAS COSE group and monthly reports on occupational violence incidents to QAS Board of Management	100% Complete
QAS to continue to evaluate options available to provide a contemporary replacement for the SHE system	100% complete with ongoing actions after Final Report
GWN Director to provide monthly reporting of GWN duress activations to the WHS Unit for ongoing cross reference against reported SHE incidents of occupational violence	100% complete with ongoing actions after Final Report
QAS WHS Unit to develop a standardised LASN Assault Register template	100% complete
QAS to work with CAA to develop a standardised data dictionary for assault and WorkCover definitions	100% complete with ongoing actions after Final Report

Taskforce recommendations: Data analysis

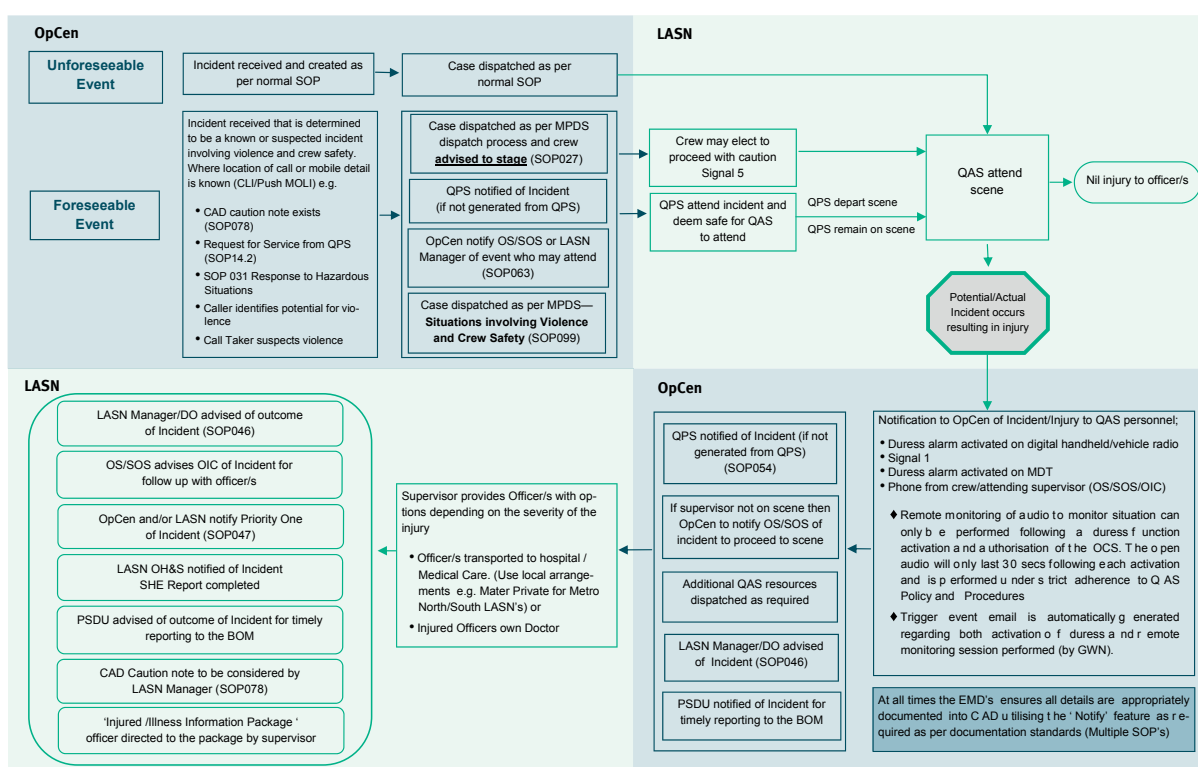
4. That QAS undertake a detailed demographic modelling review of all QAS datasets pertaining to occupational violence against paramedics to determine the situational factors by April 2016.
5. That QAS implement the findings of the review by June 2016 ensuring that:
 - The investigations of occupational violence incidents are fulsome and insightful in all circumstance
 - QAS internal structures and initiatives are responsive to ongoing data collection and analysis.

4: Internal structure and models – actions and outcomes

In undertaking this initiative, the Working Group sought to conduct a review of the current supervision model and process to ensure the functions being utilised across the organisation adequately addresses the occupational violence related risk for paramedics.

Through this review, the group translated the current supervision model into a staged process map. This process of mapping incorporated the consideration of QAS technology and communications, procedures, guidelines and SOPs to ensure occupational violence intervention strategies were accurately represented and adhered to by QAS supervisors. As an outcome of this process, the Occupational Violence Management Process (OVMP) flowchart was presented and accepted at the Taskforce meeting, which was held on 22 December 2015. The taskforce noted that the model represented was very sound. Additionally, each proposed action arising through this initiative was tested, and agreed to at the established paramedic focus groups.

Through delivery of this initiative, the OVMP has been mapped against all 7 QAS Operations Centers and 14 of the 15 LASNs. To ensure completeness of OVMP flowchart, this action included rigorously testing the process against 28 actual occupational violence cases from receipt of call



This process of testing has indicated that the supervision model represented through the OVMP appropriately and adequately addresses the occupational violence related risk for paramedics. In addition, the review also identified opportunities for the use of technology to reduce the risk of occupational violence, including the Inter-CAD Emergency Messaging Service and the establishment of a dedicated police number for use by QAS Operations Centers.

Additionally, through this process, it has been recommended that the update to a number of SOPs to ensure currency with the Taskforce findings and recommendations. These updates are primarily focused on the notification processes deployed in the event of an occupational violence incident. In this regard, and consistent with the recommendation of this Working Group, work has commenced within QAS to update the notification provisions of the following SOPs, and to develop appropriate training requirements for each amendment as required:

- » SOP046 – Notification of Senior Officers
- » SOP047 – Notification/Activation of Priority One and Peer Support
- » SOP054 – Police required – Signal One duress
- » SOP099 – Situations involving violence and crew safety.

Finalisation of the amendments to these SOPs is scheduled to occur following delivery of this Final Report.

The actions arising through this initiative were tested, and agreed to at the established paramedic focus groups.

Initiative 4 – Internal structures and models		
COSE Sponsor: Deputy Commissioner - Craig Emery		Working Group Lead: A/Executive Manager, State LASN Operations - Russell Nicholas
Key Success Factor	Mapping of technology and communications, procedures, guidelines and SOPs to ensure occupational violence intervention strategies are implemented in the supervision model.	
Tasks	Timeframe for delivery	
4.1 Conduct a review of the current supervision model to ensure the strategy is adequately being addressed for occupational violence related risk for paramedics	Jan–Feb 2016	
4.2 Investigate and conduct mapping of technology and communications, procedures, guidelines and SOPs to ensure occupational violence intervention strategies are implemented in the supervision model	Jan–Feb 2016	
4.3 Test assumptions and efficacy of current guidelines and responses	Jan–Feb 2016	
4.4 Report on findings and activity to Taskforce	March 2016	
Milestone activity	Project status	
Development and endorsement of Supervisory Model Process Map to ensure strategies address occupational violence risks for paramedics	100% Complete	
Real occupational violence cases tested against process map	100% Complete	
Update the following SOPs, with associated training requirements developed for each amendment as required: <ul style="list-style-type: none"> • SOP046 – Notification of Senior Officers • SOP047 – Notification/Activation of Priority One and Peer Support • SOP054 – Police required – Signal One duress • SOP099 – Situations involving violence and crew safety. 	100% complete with ongoing actions after Final Report	

Taskforce recommendation: Internal structures and models

6. That QAS implement the outcomes of the Taskforce review of supervisory models and process through the revision of Standard Operating Procedures relevant to reducing the risks and impacts of occupational violence and improving paramedic safety by June 2016.

5: Linkages with staff support – actions and outcomes

Delivery of this initiative incorporated a review to incident response and staff support. This review was directed towards ensuring that when required due to an occupational violence related incident, managers, supervisors, the Employee Assistance Service (Priority One), WHS staff specialists and other early intervention strategies are activated, and reported.

The review itself involved the Working Group collating current LASN practices for managing staff support for occupational violence related incidents. This process would confirm that a system is in place, which provides effective and practicable early intervention strategies for officers. Notably in this regard, Initiative 4 (Internal Structures and Models) and this initiative are closely aligned.

In the delivery of this initiative, and through review of incident response and staff support, the Working Group recommended the development of 'Local Incident Management Practices' that could be used generically across all LASNs. These practices would also incorporate appropriate linkages to the broader occupational violence strategy, and the existing support arrangements for QAS officers who sustain a workplace injury or illness.

In this regard and as a result of this recommendation, the Injury and Assault Pathway Flowchart was developed. This action in turn resulted in the drafting of a QAS Injury and Illness Package, along with appropriate governance controls through an associated QAS Directive and Guideline, to ensure consistency and reliability of management action.

These packages were tested and agreed to at the paramedic focus groups, and are being incorporated into the SAFE2 training (see Initiative 1). Once approved these will also be loaded onto QASCLO and deployed across QAS



Initiative 5 – Linkages with staff support

COSE Sponsor: Deputy Commissioner - Craig Emery		Working Group Lead: A/Executive Manager, State LASN Operations - Russell Nicholas
Key Success Factor	Ensure a system is in place that provides effective and practicable early intervention strategies available to paramedics.	
Tasks		Timeframe for delivery
5.1	Undertake a review to incident response and staff support to ensure Priority One, supervisors, workplace health and safety staff specialists and other early intervention strategies are activated and reported on	Dec 2015
5.2	Collate current LASN practices for managing staff support for occupational violence to ensure an effective system is in place that provides real-time operational and practicable early intervention strategies available to paramedics	Jan-Feb 2016
5.3	Review existing 'worker kits' and consider the development of a state-wide consistent kit for all QAS. Link strategy with existing support arrangements for QAS officers who sustain a workplace injury or illness	Jan-Feb 2016
5.4	Develop, publish and promote staff support links	March 2016
5.5	Report on findings to Taskforce	March 2016

Milestone activity	Project status
Development of 'Local Incident Management Practices' that could be used generically across all LASNs	100% Complete
Development of Directive and Guideline	100% Complete
Updating relevant SOPs (where required)	100% Complete
Upload materials to QASCLO education and SAFE2 training	100% Complete
Approval /Issue of Directive & Guideline, Upload to QASCLO	100% complete with ongoing actions after Final Report

Taskforce recommendation: Linkage with staff support

- That QAS implement the outcomes of the Taskforce review involving the intervention strategies available to paramedics who are exposed to occupational violence through the development of a Directive and Guideline specific to 'Local Incident Management Practices' by June 2016. The Directive and Guideline will be incorporated into QAS on-line education and the SAFE2 training program.

6: Post incident response and support – actions and outcomes

A comprehensive review was undertaken by the Working Group, which examined the current strategy undertaken by QAS Staff Support Services, in the context of an officer encountering an incident of occupational violence. The aim of this review was to ensure that a system is in place to provide effective and practicable early intervention strategies available to officers, and to ensure that a multi-layered post potential critical incident response exists for staff.

This review examined and outlined the current strategy undertaken by QAS Staff Support Services in the context of an officer encountering an incident of occupational violence before and after an incident, and found that from a psychological perspective, occupational violence of QAS officers would be considered a potentially critical incident, in much the same way that a potentially traumatic incident might be experienced.

The review noted that as with all critical incidents, the potential impact of occupational violence upon a staff member can be varied. Some instances may cause no personal emotional distress, while others result in significant personal distress, including an inability to continue working, with varying levels in between. The level of potential distress on an individual is not necessarily determined by the level of violence that has occurred, but often relates to a multitude of other factors (i.e. previous experiences of trauma, psychological meaning attributed to the event, sense of personal control, personal values, concomitant stressors etc).

The review also found that QAS Staff Support Services currently provide a significant and multi-layered post potential critical incident response. This is supported by a Critical Incident Stress Debriefing Policy, a Peer Support Officer Policy and a Standard Operating Procedure for activation of Priority One and Peer Support (SOP47).

In addition to the response provided by QAS after the incident, there are considerable levels of pre-incident psychological education and other resilience building strategies provided through the Priority One Program. Resilience building and information pertaining to effectively coping and supporting others prior to and post critical incidents is provided to all new QAS operational staff, Managers and Supervisors, and Peer Support Officers.

The level of psychological support provided following a potentially critical event relating to occupational violence will vary, dependent upon the needs of the individual/s affected by the incident. Research demonstrates that a “one approach fits all” model is not necessarily helpful and in some instances can be potentially more harmful. It is for this reason that different avenues and options are available to QAS officers.

In this regard, QAS Priority One Staff Support Service critical incident management model (including occupational violence) can be broken down into different stages. These are:

- » Prevention and Preparedness (Pre and Post Incident)
- » Response and Recovery (Post Incident)
- » Quality Assurance (ongoing).

Exposure to Potential Critical Incident including Occupational	PRIORITY ONE				Quality Assurance
	RESPONSE	RECOVERY	PREVENTION	PREPAREDNESS	
Notification Pathways	Access Pathways Staff Support Services	Tailored Critical Incident Response / Services	State Wide Wellbeing and Mental Health Education and Training	Priority One Quality Assurance Strategies and Reviews	
» Staff Member » Ops Centre » Officer-in-Charge » Operations Supervisors » LASN Manager » Exec Manager » WH&S (SHE Report) » Family Member » Peer Support Officers » University Students	» Duty Peer Support Officer » Peer Support Officer » LASN specific External Counsellors » Priority One Internal Staff Counsellors » 24hr phone Counselling	» Contact and Engagement » Connection & Support » Screening /Triage » Defusing » Psych. First Aid » Referral: – Psychological Counselling/ Treatment – Trauma Based specific psychological interventions – GP Intervention – other. » Follow-up » Manager Mentoring /Support » Station Visits	» Manager/Supervisor Training » Manager Mentoring Program » 'Finding the Silver Lining,' Preparedness Program » PSO Training: – Induction – Refresher » PSO Supervision » Development and dissemination of electronic / paper based education: – Brochures – Newsletters – Posters » External Counsellor Org specific education and development » Training Operational Workgroups: – Operations Centre Manager – Operations Supervisors – Officer in Charge – University Students	» Feedback - annual stats to Exec Management re nature of activities » Development and review of SOPs re activation and response processes » Review and Refinement of Education and Training Programs » Ongoing Research » Priority One Program Reviews	

Notification pathways

This review also noted that following an incident of occupational violence there are a number of different ways that Priority One would be notified. It is this multilayered approach that provides options for QAS officers, including supervisors, following a critical incident. These would include:

- » **The affected staff member** – At times staff members proactively access support through Peer Support, or internal or external counsellors.
- » **Operations Centre, Operations Centre Supervisor** – QAS has in place SOP047 intended for use following a critical incident. This procedure outlines the procedure to activate Peer Support.
- » **Direct Operational Manager** – This can include Officer in Charge, Operations Supervisor, Senior Operations Supervisor etc. This manager may access Priority One for the officer, through the Operations Supervisor or directly to a Peer Support Officer or Internal or External Counsellor.
- » **LASN Manager or Board of Management** – The LASN Manager and Board of Management may access Priority One for the Officer directly through internal or external Counsellors or the Executive Manager, of Staff Support.

- » **Workplace Health and Safety (WHS)** – LASN WH&S professionals may access Staff Support for the officer through the internal or external Priority One Counsellors. QAS' WHS Unit accesses Staff Support for the officer through the SHE notification reports. SHE-reports that are flagged as occupational violence are forwarded to the Executive Manager, Staff Support who ensures that the officers are followed up by a professional Counsellor.
- » **Family Member** – Immediate family members of QAS officers also have access to Priority One contact numbers. There are times when an immediate family member or partner of a QAS officer may contact Priority One through internal or external counsellors.
- » **University Students** – University students undertaking their on-road placement also have the option to access Priority One following a critical incident in the context of their work placement. This might occur through Peer Support or internal or external counsellors.

Access pathways for staff support Services

Notably, the response and recovery stage of QAS Priority One critical incident response model can be broken down into two areas:

- » Staff Support Services
- » Critical Incident Response Management.

QAS has a significant evidence based multilayered Staff Support model. The multilayered aspect of this model provides an opportunity for QAS officers and their immediate family members to access Staff Support following an episode of occupational violence in a number of different ways. This includes:

- » **Confidential 24-hour free telephone counselling** – This service is accessible from anywhere in Queensland to both QAS officers and their immediate family members. This service may be utilised by the affected individual staff member or to provide advice to QAS Managers and supervisors following an incident of occupational violence.
- » **Self-Referral Counselling** – QAS provides a personal counselling service that enables employees or members of their immediate family to have face-to-face counselling with one of the 50 external specialist counsellors available throughout Queensland. In addition, there are four internal full time staff counsellors including the Executive Manager of Priority One. Following an incident of occupational violence a staff member may choose to access any one of these counsellors proactively or on the advice of a manager, Internal Priority One Counsellor or Priority One Peer Support Officer (PSO).
- » **Peer Support Program** – Research has shown that, in most instances, a Peer Support intervention following a critical incident is the most effective strategy for reducing emotional distress and providing an opportunity for further referral if required. PSOs may make contact with staff members following an incident of occupational violence in two ways:
 - Proactive follow up – The nature of Peer Support means that PSOs are more likely to be aware of an incident occurring early through hearing about the incident and making contact with the staff member.
 - Through activation of the Peer Support system through the Operations Centre (SOP 47) – An 'on duty' Peer Support Officer will be activated to follow up an officer following a potential critical incident to provide an opportunity for emotional downregulation and defusing of the incident, provide normalisation of reactions and potentially offer a referral pathway for additional care (i.e. Priority One Counsellor, GP etc). In the context of a critical incident it is most appropriate for this to occur in the first 24 – 48 hours.

Tailored critical incident response/services

The review also noted that following an episode of occupational violence there are a number of services that can be implemented or accessed, dependent on the requirements of the individual situation/person that may occur through any, or all, of the Staff Support Services. These include:

- » **Contact and engagement** – In many instances following a critical incident, supportive contact with the individual can provide an opportunity for decreasing emotional hyper-arousal. This may occur through a supervisor or upper level manager, PSO, external counsellors or internal counsellors. A review of the Priority One Program demonstrated that an interaction with a Priority One PSO or Counsellor can provide an individual with a greater sense of organisational connectedness which is positively correlated with higher levels of resilience and lower levels of post-traumatic stress and burnout.
- » **Screening/Triage** – Following an episode of workplace violence an early contact with a Priority One PSO or Priority One Counsellor can provide an opportunity for early screening of the staff member to assess if additional supports may be required.
- » **Support** – Following an incident of workplace violence Priority One Counsellors and PSOs can provide the individual with additional supports. This might include additional psychological supports, and/or help them to explore other available supports i.e. family, manager/supervisor, GP etc.
- » **Psychological First Aid** – QAS Priority One PSOs are able to provide their colleagues with Psychological First Aid following a critical incident. This is an evidence informed approach that enables emotional and practical support to promote natural recovery. It aims to reduce the initial distress, meet current needs, promote flexible adaptive coping and encourage adjustment to the current situation.
- » **Trauma based specific psychological interventions** – QAS Priority One Counsellors are specifically chosen for their expertise in utilising evidence based trauma interventions. These interventions may be necessary following an incident of workplace violence if the staff member has been significantly detrimentally affected by the incident.

Managers' Mentoring and Support – Priority One offers managers mentoring and support for them to be able to access advice on how best to provide support to a staff member following a critical incident or any other organisational or psychological concern. This can be accessed through the internal or external counselling network.

- » **Station Visits** – In some instances involving or vicariously impacting upon multiple staff members within the same station one or more station visits by an internal and/or external counsellor and a local Peer Support Officer can be helpful and offered through the Priority One program.

State-wide wellbeing and mental health education training – The review also noted that QAS currently provides significant training and education to all levels of the organisation pertaining to pre-critical incident psychological interventions, resilience building and coping strategies. In addition to this it also provides ready access to a range of free and confidential support options that may be accessed pre and/or post critical incident.

QAS Managers and supervisors – All QAS Managers and supervisors are required to undertake a one day face to face training session provided by Priority One designed to provide them with information and skills to provide support to staff members and how to access additional supports if required following a critical incident. In addition to this training they are provided with a resource folder providing ready access to the information provided within these sessions.

Manager Mentoring – All QAS Managers and supervisors' have access to internal and external counsellors to provide advice and mentoring when dealing with staffing issues that can be accessed in the event of an incident of occupational violence.

'Finding the Silver Lining' Preparedness Program – All new operational officers are required to undertake the 'Finding the Silver Lining' Program. This program is a comprehensive resilience building program that covers a number of ambulance specific psychological areas including critical incident stress. This program also requires all new operational officers to access an external Priority One counsellor, ensuring that they know how to access the services available to them should they require it at any stage in their career. The "Finding the Silver Lining" text book and work book are also made available to all operational officers across the state.

Peer Support Officer Training – PSOs are carefully chosen and comprehensively trained to be able to provide an initial critical incident response following a potential critical incident including an incident involving occupational violence. PSOs are also required to undertake ongoing training through refresher courses and supervision through the internal and external counsellor network. It should be noted that QAS Peer Support model has been internationally recognised as a ‘gold standard’ model, being replicated in other ambulance services such as London, Scotland, Northern Territory as well as other industry such as Australian Broadcasting Commission, Child Safety, Queensland Fire and Emergency Services.

Development and Dissemination of electronic and paper based educational materials – QAS Priority One Program develops and disseminates a range of education materials both in paper and electronic format. This includes: brochures, posters, newsletters etc. These materials are designed to provide QAS officers with information relating to critical incidents among other topics prior to and following an event that might occur as well as provide advice on what is helpful following an event. This allows an opportunity for normalisation of potential emotional hyper-arousal following an incident to reduce anxiety and assist in removing barriers to accessing additional support.

Organisational Specific Education and Development to QAS External Priority One Counsellors – QAS Priority One Program carefully selects external counsellors on their experience and ability in providing trauma based interventions. Ongoing training is provided to these counsellors ensuring that they are aware of the specific needs of the organisation and current evidence based psychological interventions.

Mental Health Training of Operational Workgroups – In addition to the above, QAS Priority One Program provides training to a range of different work groups within QAS. This includes but is not limited to training provided to:

- » Senior Operational Managers
- » Operational Managers
- » Operations Centre Managers
- » Ambulance Educators
- » University students prior to undertaking their first year on road placement
- » Operational frontline staff members.

Priority One quality assurance strategies and reviews

To ensure that QAS Priority One critical incident management strategy is up to date with current best practice and is meeting the needs of the organisation, the Priority One Program undertakes a number of quality assurance strategies. These include:

- » **Review of usage data** – This data is reviewed on an ongoing basis and available to QAS Executive Managers. This enables an opportunity to recognise risk areas, and areas that might require additional resources.
- » **Development and review of Standard Operating Procedures** – The ongoing review of the critical incident response process, through collaboration and feedback from organisational work groups has and continues to provide an informed approach to the refinement of these processes.
- » **Review and refinement of education and training programs** – Education provided to all areas of the organisation is specifically tailored and continuously reviewed based on the current needs of the individual work groups.
- » **Ongoing research** – QAS is actively supportive of research undertaken to assist in providing support to QAS officers. The Priority One program has been actively involved in a number of research initiatives that have enabled a greater understanding of specific needs and provided an evidence informed approach to refining staff support systems and interventions within an ambulance context.

- » **Priority One Program Reviews** – QAS Priority One Program has proactively undertaken two external reviews of the Staff Support Services available to QAS staff to ensure that the needs of QAS officers continue to be met by the services provided and that the program is providing 'best practice' in staff support. The most recent review, released in 2012 was externally conducted by an expert committee, chaired by Associate Professor Jane Shakespeare-Finch from Queensland University of Technology with advice from Emeritus Professor Beverley Raphael and chaired by a mixture of representatives from QAS and external psychologists. The review found that QAS officers who had accessed the Priority One Services showed higher levels of resilience, higher levels of organisational connectedness and lower levels of secondary traumatic stress and burnout.

Additionally, SHE-reports specifically pertaining to incidents of occupational violence are forwarded to the Priority One State Office and followed up by an internal Priority One Counsellor. This will often occur after contact by a PSO and sometimes after or prior to a contact with an external Priority One Counsellor.

It should be noted that all of these access pathways and strategies are not singular or linear but may operate concurrently and on a continuum following an incident of occupational violence. An officer who experiences an episode of occupational violence may access the Staff Support Service through a number of different pathways. They may access support from a PSO in addition to an internal and/or external counsellor.

In this respect, the review has found that a multilayered strategy is in fact utilised by QAS for critical incident management, which may include incidents of occupational violence. This strategy ensures a tight 'safety net' is created for those of our officers who may experience an incidence of occupational violence, by ensuring that they are able to access the most appropriate support pathways, when required, as dependent on their needs.

The actions arising through this initiative were tested, and agreed to at the established paramedic focus groups.

Initiative 6 – Post incident response and support

COSE Sponsor: Deputy Commissioner - Craig Emery		Working Group Lead: Manager, Priority One Services - Todd Wehr
Key Success Factor	Review of the current strategy undertaken by QAS Staff Support Service in the context of a staff member encountering an incident of occupational violence pre and post incident and that provides a significant and multi-layered post potential critical incident response.	
Tasks		Timeframe for delivery
6.1 Undertake a review of incident response and staff support to ensure the appropriate response and support is being provided to staff involved in incidents – including a review of local current strategies		Jan-Feb 2016
6.2 Report on findings to Taskforce		March 2016
Milestone activity		Project status
Review of the current strategy undertaken by QAS Staff Support Services to ensure a multi-layered post potential critical incident response exists for staff		100% Complete

Taskforce recommendations: Post incident response and support

8. That QAS conduct a review by April 2016, of current post-incident response and support strategies available to paramedics who are exposed to occupational violence during operations.
9. That QAS implement the findings of the review by June 2016, and ensure post incident response and support services remain available to all paramedics.

7: QAS clinical practice and patient safety – actions and outcomes

As an outcome of this initiative, all QAS Clinical Guidelines, Protocols and Procedures that relate to occupational violence have been reviewed. This review was undertaken with the assistance of QAS' Clinical Quality and Patient Safety Team, with input from key paramedics and paramedic UVQ representatives, under the direction of QAS Medical Director. The object of the review was to ensure that functional and relevant clinical practice and patient safety guidelines, along with appropriate response and support, are being provided to staff involved in incidents to minimising the risk of occupational violence.

Through collaboration with identified key stakeholders, the Working Group had benchmarked QAS clinical practice against other industry best practice strategic interventions. Facilitated by the discussion of clinical practice and patient safety guidelines and practices that relate to the management of occupational violence, benchmarking enabled the development of new guidelines, consistent with contemporary best practice arrangements.

In addition, through this review the Taskforce also undertook an examination of current QAS chemical restraint options and current alternative agents (including a review of the role and potential expansion of sedation for appropriate clinical scenarios). Following this review, the introduction of Droperidol into QAS paramedical practice is approved and anticipated for update and release in October 2016.

The outcomes of this review will see the provision of enhanced information made available to every QAS paramedics on their QAS iPad contained within QAS Digital Clinical Practice Manual (DCPM) and QAS Field Reference Guide (FRG) on the officer's own portable smart devices. The enhanced information focusses on practical material that supports paramedic decision making, clinical interventions that encourage a consistent and safe approach to patient care, and to reduce the risk of paramedic exposure to violence to as low as reasonably possible. This indicates a shift to a more pragmatic, yet safe approach to assessment of patients with a high risk of violence, which will minimise the likelihood of hostile response to treatment. These actions arising through this initiative were tested, and agreed to at the established paramedic focus groups.

Specifically, as a result of this review, the following QAS clinical governance instruments are scheduled to be approved following finalisation of this Final Report, in support of ongoing clinical practice and patient safety. The draft amendments and additions that are to be finalised are as follows:

- » **Clinical Practice Procedure (CPP) Sedation Assessment Tool** – Amendments will incorporate clinical indicator/identifier of a potentially violent patient, elucidating when there is a requirement for the use of the QPS and defining the clinical threshold for chemical sedation.
- » **CPP Sedation Acute** – Acute behavioural disturbance – Addition to Clinical Indications to include SAT score, Contraindications when unsafe to approach patient, all patients who require parental administration of pharmacology will require sufficient resources to physically restrain the patient, and therefore a QPS response is mandatory prior to restraint attempts. This will ensure consistency with the SAFE2 training.
- » **CPP Neurological Assessment** – The application of minimal stimuli to provoke response and to be noted within complications - that the application of a painful stimuli to the intoxicated patient has the propensity to elicit a violent response.
- » **CPP Glasgow Coma Scale** – Same additions as CPP Neurological Assessment
- » **CPP Primary and secondary survey** – Additional note in complications in relation to paramedic safety.
- » **Clinical Practice Guideline (CPG) Paramedic Safety** – The addition of the POP risk assessment within the guideline.
- » **CPG Acute Behavioural Disturbance** – Graded approach to the management of acute behavioural disturbances, with references to particular interventions and triggers to avoid escalation. Aim is to rapidly de-escalate situations.
- » **CPG The physical restrained patient** – Mandating that QPS is the first point of contact before sedation commences and paramedics are not to initiate physical restraint unless extreme circumstances dictate.

- » **Drug Therapy Protocol (DTP)** – Droperidol was presented to the QAS Medical Advisory Council in March 2016, where introduction into QAS clinical practice was supported. The QAS will make application to Medical Regulations Queensland in April 2016. If approved, will then notify QASEC in July 2016, for introduction into the DCPM in October 2016.
- » **QAS Field Reference Guide (FRG)** – Inclusion of the POP threat assessment, within the FRG Checks.

Initiative 7 – QAS clinical practice and patient safety		
COSE Sponsor: Medical Director, QAS - Dr Stephen Rashford		Working Group Lead: Director, Clinical Quality and Patient Safety, QAS - Tony Hucker
Key Success Factor	Functional and relevant clinical practice and patient safety guidelines and appropriate response and support is being provided to staff involved in incidents to minimising the risk of occupational violence.	
Tasks	Timeframe for delivery	
7.1 Undertake a review of clinical practice and patient safety guidelines and practices and modify CPP/ CPG (where applicable) to ensure these adequately address a role in managing occupational violence-related risk	Jan-Feb 2016	
7.2 Collaborate with identified key stakeholders to benchmark QAS clinical practice against other industry best practice strategic interventions and develop new guidelines where appropriate. Discuss clinical practice and patient safety guidelines and practices that relate to the management of occupational violence in consultation	March 2016	
7.3 Report on findings to Taskforce 7.3.1 Includes training and refresher education strategy to all staff for revised CPP/CPGs	March 2016	
Milestone activity	Project status	
Review QAS management of “Acute Behavioural Disturbances Guidelines”	100% Complete	
Amendments to CPG “The restrained patient”	100% Complete	
Amendments to CPG “Paramedic safety”	100% Complete	
Development of POP threat assessment tool for insertion within QAS Field Reference Guide App.	100% Complete	
Inclusion in the April 2016 DCPM update: <ul style="list-style-type: none"> Paramedic Safety The Physically Restrained Patient POP Threat Assessment 	100% Complete	
Review of the role of physical restraint for patients suffering acute behavioural disturbance due to mental illness	100% Complete	
Examination of current QAS chemical restraint options and current alternative agents, including review the role and potential expansion of sedation for appropriate clinical scenarios	100% Complete	
CPP/CPGs to be approved: <ul style="list-style-type: none"> CPP Sedation Assessment Tool CPP Sedation Acute – Acute behavioural disturbance CPP Neurological Assessment CPP Glasgow Coma Scale CPP Primary and secondary survey CPG Paramedic safety CPG: Acute Behavioural Disturbance CPG: The physical restrained patient DTP: Droperidol -> supported by the QAS Medical Advisory Council (March 2016) -> Application to Medical Regulations QLD (April 2016) -> Notify QASEC (July 2016) -> DCPM (October 2016) QAS FRG: Inclusion of the POP threat assessment 	100% complete with ongoing actions after Final Report	

Taskforce recommendations: QAS clinical practice and patient safety

10. That QAS will introduce chemical sedation medication (Droperidol) into clinical practice for all Advanced Care Paramedics by October 2016 ensuring contemporary therapy is available for the treatment of patients presenting with acute behavioural disturbance.
11. That QAS implement the Taskforce review of clinical practice and patient safety guidelines regarding the management of acute behavioural disturbances by October 2016. These guidelines will ensure a graded approach to the management of acute behavioural disturbances, including the application of minimal painful stimuli in the patient neurological assessment.



8: Research and development – actions and outcomes

Delivery of this initiative was aimed at undertaking a review of occupational violence related literature, and evidence based industry best practice. This review was aimed at identifying the latest developments positive interventions with respect to the management challenging issues related to occupational violence in QAS workplace. Notably, this initiative and Initiative 3 – Data Analysis are closely aligned.

This review, along with input from other external bodies (including the CAA, universities, health agencies, and physicians) along with collaborative focus group forums allowed the identification of best practice occupational violence prevention strategies balanced with frontline paramedic and healthcare worker perceptions and experiences.

The themes under investigation within the review included:

- » definitions of violence in WHS reporting
- » predicting risk of violence
- » organisational buy in
- » administrative and behavioural interventions for occupational violence prevention
- » management of acute behavioural disturbances
- » occupational violence risk communication/reporting tools
- » paramedic resilience and protective factors.

An initial investigation of the peer reviewed literature revealed that minimal evidence exists that addresses the issue of occupational violence within the pre-hospital setting. Consequently, the Working Group chose to concentrate on the relevant literature identified within an Australian and New Zealand context in the last 16 years, as the types of violence exposure and violent crime within the Northern American context appears quite different.

Notably, the Working Group also noted that there is a lack of locally based pre-hospital specific literature. However approximately 220 peer reviewed articles were initially identified describing occupational violence in the health sector context.

The Working Group observed that the vast majority of related literature found within Australia and New Zealand describing occupational violence within the health sector, predominately focuses on Emergency Department settings, along with Mental Health and Community settings. Of particular interest to this literature review were studies that describe behavioural and administrative interventions, and which have also been empirically evaluated. Initial screening revealed three Australian and New Zealand studies that address occupational violence and paramedical services directly. These studies are survey based retrospective observational studies, with no interventions, one of which was undertaken with QAS.

Importantly, through further screening and analysis of the information available, two factors stand out within the literature as being predictive of violence, these being:

1. a previous episode of violence
2. increased levels of intoxication.

Further evaluation of available literature and studies will remain ongoing following the delivery of this Final Report.

In delivering this initiative, the Working Group also convened a collaborative focus group, involving members of QAS Clinical Quality and Patient Safety Unit, along with frontline employees, consisting of mixture of senior on-road Advanced Care and Critical Care Paramedics. Input from regional QAS Stations was also facilitated via Skype and teleconference. Through this focus group the Working Group received valuable experiential evidence with respect to the issue of occupational violence in the paramedical setting. This evidence included:

- » protective factors that reduce assault risk on paramedics (before, during event)
- » risk factors that increase risk of assault on paramedics (before, during event).

Additionally and importantly, the process of review also indicated a number of mental health related themes and some gaps in the education of paramedics as it relates to the issue of occupational violence. Notably, given that the management of challenging behaviour is an integral component of a paramedic's role in the provision of care to sick and injured patients, the Working Group found that the prioritised inclusion of training to recognise, prevent and manage behavioural disturbances and occupational violence (e.g. within university courses for trainee paramedics) is of significant importance.

The Working Group also completed an analysis of the management of acute behavioural disturbances, as undertaken by other Australian ambulance services. This review included a focus on restraint and sedation agents, including drug therapies and clinical procedures from each service. This aspect has linkages to the outcomes of Initiative 7 – Clinical Practice and Patient Safety.

The actions arising through this initiative were tested, and agreed to at the established paramedic focus groups.

Following delivery of this Final Report, ongoing research will continue within QAS to identify the latest developments and information on managing challenging issues related to occupational violence in the context of positive interventions. This process will also form a component of the long standing Kenneth James McPherson (KJM) Foundation research program.

Initiative 8 – Research and development

COSE Sponsor:
Assistant Commissioner, QAS - Stephen Gough

Working Group Lead:
Clinical Policy Development Officer, QAS - Gavin Farry

Key Success Factor	<ul style="list-style-type: none"> » Undertaking occupational violence related literature reviews with University involvement. » Collaborate focus group forums for identification of best practice occupational violence prevention strategies balanced with frontline paramedic and healthcare workers perceptions and experiences. » Identify the latest developments and information on managing challenging issues related to occupational violence in the context of positive interventions.
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Tasks	Timeframe for delivery
8.1 Conduct literature review of evidence based industry best practice strategic interventions. Maintain alignment with Queensland Health (QH) research and development (where applicable)	Dec 2015
8.2 Collaborate with universities and LASNs for paramedic focus group research	Jan-Feb 2016
8.3 Collate current LASN practices to manage occupational violence, frontline paramedic and other healthcare workers' perceptions and experiences	Feb 2016
8.4 Identify the latest developments and information on managing challenging issues related to occupational violence in the context of positive interventions	Feb 2016
8.5 Literature review presented to Taskforce	March 2016

Milestone activity	Project status
Commence review of contemporary research and literature	100% Complete
Contact external stakeholders (CAA, universities, health agencies, physicians)	100% Complete
Review of Australian Services Management of Acute Behavioural Disturbances - Focus on Restraint and Sedation Agents	100% Complete
Complete discussions with QAS WHS for consideration for analysis of matched SHE-reports and eARFs - these cases will be used in a broader review of current clinical practice guidelines and interventions	100% Complete
Ongoing Research and Literature Review as part of the KJM Foundation research program	100% complete with ongoing actions after Final Report

Taskforce recommendations: Research and development

12. That QAS conduct a preliminary review of occupational violence related literature, with input from external stakeholders to identify the latest developments and positive interventions with respect to the management of occupational violence in ambulance services, by April 2016.
13. That QAS deliver a final research paper regarding the management of occupational violence in Ambulance Services, by December 2016.

9: Technology options – actions and outcomes

To identify the latest developments and information on technology that can assist frontline paramedics in the context of positive interventions, this review was undertaken with the assistance of representatives from the State Operations Centre LASN, QAS Information Communication and Technology (ICT) Program and QAS Fleet and Equipment Unit, with input from paramedic UVQ representatives. The actions arising through this initiative were tested, and agreed to at the established paramedic focus groups.

Following this review, a report was developed by the Working Group, which presents a consolidated view of the current, and potential future technology options for paramedic safety, which was tabled at the Paramedic Safety Taskforce meeting on 24 March 2016. The scope of this document includes safety systems technology used by paramedics while undertaking their duties, encompassing the Operations Centres, vehicles, equipment and associated processes.

This report contributes to the research of new technology and systems by providing the ‘current state’ picture of safety systems technology in use by paramedics across Queensland. The findings of the Working Group in this respect are noted below.

Current State assessment

The review found that the technologies currently utilised that contribute to the safety of paramedics in situations involving violence and crew safety are as follows:

1. In-vehicle radio across the State

- » Government Wireless Network (GWN) for South East Queensland:
 - includes duress button on radio
 - provides GPS coordinates and map view of location
 - has the ability for EMD to initiate ‘open microphone’ on specific radio.
- » Press To Talk (PTT) satellite radio for Torres and Cape LASN and Cairns and Hinterland LASN:
 - provides remote area communication capability
 - plans are in place to roll out this technology to specific vehicles in Townsville, Darling Downs and Wide Bay LASNs.
- » Very High Frequency (VHF) / Ultra High Frequency (UHF) for the rest of State.

2. Portable radio across the State

- » GWN for South East Queensland:
 - includes duress button on both radio and Remote Speaker Microphone (RSM)
 - provides GPS coordinates and map view of location
 - has the ability for an EMD to initiate ‘open mic’ on specific radio following a duress activation.
- » VHF / UHF for the rest of State:
 - UHF includes duress button on radio for Townsville, Ayr and Mount Isa areas (project underway to also roll out this functionality to Cairns)
 - VHF – no duress.

3. Mobile Data Terminal (MDT) across South East Queensland

- » Automatic Vehicle Location (AVL).
- » Duress button located on both front console and rear cabin.

4. Townsville, Mt Isa and Ayr areas with AVL

- » AVL vehicle tracking system which is independent of CAD and not managed by QAS Fleet and Equipment.

5. CAD interface for whole of State

- » Caution Notes recorded against an individual premises to warn EMD and responding paramedics that violence information is relevant to that address.

6. Mobile phones across State

- » Satellite phones in remote areas.
- » Mixture of both personal and vehicle issued phones.
- » If Triple Zero (000) is dialled, then Mobile Phone Location Information (MoLI) is automatically supplied, providing Operations Centre staff with additional estimated location information.

7. QAS Operational iPads across the State

- » Use of FaceTime and instant messaging.
- » Also provides GPS location of device, however this is not currently integrated with any program in QAS.

8. Closed Circuit Television (CCTV) cameras on hospital ramps

- » Primary role is to assist with management of hospital demand.
- » Coverage is only at major Queensland public hospitals, except for the following locations:
 - Lady Cilento Hospital
 - Gladstone Hospital
 - Rockhampton Hospital second camera.

9. Hema HN7 navigation tool fitted to a number of regional and remote vehicles

- » Provides the additional benefits of showing rural properties and routes not commonly found on the standard QAS Garmin satellite navigation system.
- » In single officer response locations, the installation of a separate camera mounted in the patient compartment allows the Hema screen to be used by the officer when driving the ambulance as a monitor, allowing the officer to remotely observe a patient if required.
- » Hema HN7 is currently fitted in the following LASNs:
 - North West LASN: all 28 vehicles (Toyota Modular units have patient camera)
 - Cairns and Hinterland LASN: 21 vehicles, 12 fitted with patient camera
 - Torres and Cape LASN: all vehicles fitted with HN7 and patient camera
 - Central West LASN: 6 vehicles fitted for trial, no patient cameras
 - South West LASN: all 4WD vehicles fitted with HN7, no patient cameras.

Training for use of these technologies is covered through combinations of initial training processes, and on-the-job training. Use of duress procedures on radios are covered where the location has that capability, and all EMDs are provided training in managing 'Signal One' procedures (where the paramedic calls 'Signal One' requesting urgent police assistance via radio/telephone. For GWN and MDT, training manuals are available on QASCLO and refer to duress activation.

Latest developments – current projects in progress

The review undertaken by the Working Group also sought to identify those future state technology options, and latest developments, which would provide a positive intervention in managing issues related to occupational violence. In this regard, the Working Group identified a number of technology projects (that form a part of the broader QAS ICT program), which will contribute positively towards paramedic safety into the future.

These options include the following:

1. Inter – CAD Emergency Messaging System (ICEMS) project:

- » This consists of an application allowing CAD systems to integrate.
- » Current scope of this project is for state-wide integration of QAS, QPS, and Queensland Fire and Emergency Services (QFES) CAD systems.
- » This has the potential to integrate with interstate and other agency CAD systems.
- » Allows Operations Centre officers to contact QPS and QFES without using triple zero or an Operations Centre telephone line.
- » The system allows for immediate visibility of QPS and QFES response and communications (e.g. EMD can talk directly with QPS Communications to verify when dispatched officers are at location).
- » Implementation of this system is expected to occur in late 2016, with a dependency on the Emergency Services Computer Aided Dispatch (ESCAD) upgrade occurring.

2. Expansion of GWN outside of South Eastern Queensland:

- » Work is currently underway to develop the roadmap for GWN expansion, pending funding approval.
- » This is currently in an early conceptual stage.

3. Paramount ProQA:

- » This is a feature that is available in VisiCAD 5.7, which could be implemented when the ESCAD upgrade occurs in late 2016.
- » This feature provides an extra 'offenders' tab for EMD Call Takers to record additional information about potential offenders at an incident, reported by the caller (e.g. clothing colour, male / female, colour of hair etc).
- » The feature also has the capability to provide an early warning to paramedics via the MDT, providing further detail in respect of the information collated in the 'offenders' tab.

4. Future State-wide Mobile Data Project

- » The primary purpose of the Future State-wide Mobile Data Project is the identification of a suitable contemporary and viable mobile data communication solution for QAS to extend its mobile data capability to the rest of the State.
- » Items to be considered as part of this investigation include:
 - in-vehicle mobile data applications, operating system and hardware platform
 - the environment the solution will operate within to avoid conflict with other technologies
 - the ongoing support and maintenance of the solution.
- » Prequalification and validation testing of the solution is underway with evaluation for Proof of Concept (POC) which commenced in March 2016 and will end in May 2016.

5. The Public Safety Communications Program:

- » The Public Safety Communications Program has been established to develop a future vision and strategic

plan for Queensland's public safety agencies (QAS, QFES, and QPS). The vision and strategic plan are underpinned by four principles and has stated objectives that include improving officer safety through outcomes such as greater access to real-time information, integrated systems, and coordinated responses.

- » The vision for Public Safety Communications is to be evaluated in the near future; however strategies supporting the vision are already being developed against agency priorities.

6. South West LASN investigation into suitable systems for telecommunication redundancy:

- » The LASN is reviewing innovative ways to extend satellite communications range from vehicles and buildings. These include:
 - satellite communications devices such as the Iridium GO that extends the use of smartphone and tablet devices by providing a 30 metre radius WiFi connection through a small powered device and an application installed onto the smartphone / tablet
 - portable Iridium satellite phone base mounts that connect via an extension cable to an antenna positioned outside.

7. Potential use of 'The Viewer' (QLD Health application) on QAS mobile devices:

- » 'The Viewer' is a read-only web-based application that displays consolidated clinical information sourced from a number of existing Queensland Health enterprise clinical and administrative systems. This resource is currently utilised on desktops for a limited number of staff in the QAS Clinical Quality and Patient Safety Unit. However further review is needed to determine whether a modified version of the patient viewer is able to be utilised from operational iPads. Current limitations exist in respect of the extended process required to access the database, given the highly secure information contained in the database. Further work is required to work through the ICT security processes associated with the database, including accessibility from an operational iPad, costs involved, and whether the system can be limited to pertinent patient mental health history information

Operations centre technology options

The Working Group also sought to assess QAS communications infrastructure, and identified potential actions and remedies that the Paramedic Safety Taskforce could undertake in contribution toward paramedic safety. In this regard, the following technology solutions were investigated as they relate to the issue of occupational violence in the paramedical setting:

- » "Paramount ProQA", using the 'Offender' tab (detailed above).
- » Integration of database information from available systems such as the statewide Queensland Health mental health database and the QPS CAD into QAS Operations Centres to provide additional information regarding patient's mental health history/violence history/etc.
 - Access to the Queensland Health mental health database is currently available within the QPS Communications Centre in Brisbane. This service operates over five nights per week (Tuesday to Wednesday between 5 and 10pm and Thursdays to Saturdays between 4 – 12pm). It involves a mental health clinician working in the communications centre, providing statewide support to police officers responding to mental health patients and is facilitated by Queensland Health's Forensic Mental Health Services.
 - ICEMS (detailed above) – will provide interCAD messaging between QAS and QPS, with further detail provided below.
 - Caution Notes within CAD of any addresses where violence has occurred against paramedics – in accordance with existing QAS policy (detailed above in CAD interfaces for whole of state).

Through this analysis the Working Group recommends that further analysis be undertaken with respect to the following technology options:

- » 'Offender tab' in Paramount ProQA application for all MPDS Determinant 25 – 'Psychiatric emergency/ suicide attempt' cases should be implemented with the ESCAD upgrade in late 2016.
- » Access to available mental health data pertaining to a specific patient from the statewide QH mental health database to assist QAS EMDs to determine the staging requirement for responding paramedics, and to assist responding paramedics to understand the patient's medical and violence history before responding to a mental health patient. This also offers other opportunities for improved patient safety and clinical referral pathways outside of improving officer safety for paramedics. A meeting was held with the Director, Queensland Health's Forensic Mental Health Services and QAS on 14 March 2016 about this program and further work needs to be done following delivery of this Final Report to develop this concept further.
- » Access to dangerous person data from QPS's databases regarding a location or a patient's likely violence history/any previous flags to QAS Operations Centres – to be explored following delivery of this Final Report when implementing ICEMS in late 2016, and on an interim base until then.

It is expected that this process of analysis will be ongoing following the delivery of this Final Report.

Paramedic wearable technology options

In seeking to identify the latest developments and information on technology that can assist frontline officers, the Working Group also undertook research and gathered relevant information about on-person wearable technologies that may contribute toward improved paramedic safety. Through this process the following technology was researched:

- » radio technology:
 - UHF / VHF Radio network devices
 - GWN devices.
- » 3G/4G/Satellite devices
- » personal body cameras
- » fixed location dependent devices
- » weapon options, such as Tasers.

Vehicle technology options

In seeking to identify the latest developments and information on technology that can assist frontline officers, the Working Group also undertook research and gathered relevant information about in-vehicle technologies that may contribute toward improved paramedic safety. Through this process the following technology was researched:

- » covert duress within patient compartment, linking through to vehicle cabin to alert the driver of an incident
- » CCTV (HEMA or multichannel CCTV were explored)
- » Press To Talk (PTT) satellite radio (an opportunity to review QAS' current Tait radios outside the GWN area to include the capability to have duress available has been explored); and PTT satellite radio with duress function rollout to remote LASN areas who currently do not have this capability
- » Byron Group's "Smart Ambulance" project – reviewing whether this future project by the Byron Group includes any vehicle technology that QAS could consider for improved paramedic safety. The Smart Ambulance will have a duress system activation accessible from anywhere in the vehicle or by the paramedic's personal device that activates 360 degree digital video recording, in-car voice warnings, and distress texts to multiple agencies with vehicle identification and location. The Smart Ambulance is also fitted with security entry glass to protect paramedics from attacks occurring outside the vehicle. Confirmed that this technology cannot be retrofitted across the QAS fleet, and would only apply for new vehicle builds.

Industry standard practice

In developing these technology options, the Working Group reviewed industry standard practice for use of technology by ambulance services with similar occupational violence issues to QAS and how they are implemented to benefit paramedic safety. This incorporated the consideration of:

- » the London Ambulance Service policy on treatment for known violent or mental health patients
- » the South Australia Ambulance Service processes regarding information on enhanced questioning by EMDs for violent and mental health incidents, including de-escalation techniques
- » access to Queensland Health's mental health database, which is currently used by QPS
- » Ambulance Victoria's policy regarding paramedic safety
- » liaison with QPS Communications to determine the ability to disseminate relevant information to QAS Operations Centres regarding patient history regarding violence/other relevant factors
- » utilisation of Paramount Pro-QA with the Offender tab
- » ways and processes to integrate mental health data into QAS operations from QPS/QH Mental Health.

Recommendations

In summarising, through a collective analysis of QAS Technology Current State of Play and QAS projects already in progress; Operations Centre, Paramedic, and Vehicle technology options; and Industry Standard Practice, the Working Group recommends the following options for further analysis:

1. Operations Centre technology options:

- » Adoption of the 'Offender' tab in the Paramount ProQA application, following CAD upgrade in late 2016.
- » Sharing of information between QPS and QAS CAD platforms to provide relevant information pertaining to a location's history for violence using ICEMS.
- » Sharing of information between QH mental health database and QAS to provide relevant information pertaining to a patient's mental health/violence history.

2. Paramedic Wearable technology options:

- » Current portable VHF / UHF radio technology across Queensland (outside the GWN area in South Eastern Queensland) also has the capability to duress, but this has not been configured on most radios (excluding Townsville LASN). Analysis to be conducted on:
 - the potential cost for duress configuration
 - requirements to make this possible
 - cost for such a configuration
 - if adopted, whether there is an additional need for integration with GPS capability to ensure the location of the paramedic can be identified (e.g. using a mobile data terminal/other device).
- » The further implementation of PTT satellite radio across the rest of Queensland. These radios have capability for duress and use of a wireless handset up to 300m, but are not currently configured to facilitate this capability (note these are a paramedic wearable and a vehicle technology option). Analysis to be conducted on:
 - other potential sites for these radios to be installed
 - the potential cost for handset and duress configuration
 - the strategic direction and interfaces of the Public Safety Business Agency (PSBA) with this technology
 - if adopted, whether there is an additional need for integration with GPS capability to ensure the location of the paramedic can be identified (e.g. using a mobile data terminal/other device).

3. Vehicle technology options:

- » CCTV/Hema HN7 Navigation – this technology provides enhanced navigation in remote areas and also capability to view the patient compartment using a remote camera (i.e. increased patient safety for single officer responses). In this respect, further understanding is required of any legal implications applied to installed cameras within vehicles. This includes:
 - capturing but not storing images (i.e. where the camera image is viewable from the driver's compartment but is not recorded)
 - capturing and storing images (i.e. images and / or audio are recorded and stored for future access)
 - legislative obligations of the organisation and policy requirements.
- » The provision of a covert duress button from the patient compartment to the driver's compartment.
- » The further implementation of PTT satellite radio across the rest of Queensland (as detailed in paramedic wearable technology options above).

Notably, scheduled analysis and potential implementation of these options will continue beyond the time of this Final Report as a part of the broader QAS technology program. This will serve to ensure that QAS latest technology solutions and information will continue to be sought, and deployed by QAS to develop a safer workplace for its officers.



Initiative 9 – Technology options

COSE Sponsor: A/Deputy Commissioner, QAS - Dee Taylor-Dutton	Working Group Lead: A/Director, Brisbane Operations Centre - Colin Allen – communications related technology Executive Manager, Fleet and Equipment QAS - Ian Tarr – Paramedic / vehicle related technology Director, ICS Programs, QAS - Jane Adams – current QAS technology
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Key Success Factor	Identify the latest developments and information on technology that can assist frontline paramedics in the context of positive interventions.
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Tasks	Timeframe for delivery
9.1 Undertake a review of technology options to identify the latest developments that may assist in managing issues related to occupational violence in the context of positive interventions	Jan-Feb 2016
9.2 Report on findings to Taskforce	March 2016

Milestone activity	Project status
Review and identify the latest developments and information on technology	100% Complete
Current Technologies – State of Play Report developed	100% Complete
Review of latest technology developments already in progress for implementation in QAS was completed	100% Complete
Conduct further analysis on Operations Centre technology options, including: <ul style="list-style-type: none"> Adoption of the 'Offender' tab in the Paramount ProQA application, following CAD upgrade in late 2016 Sharing of information between QPS and QAS CAD platforms to provide relevant information pertaining to a location's history for violence using ICEMS Sharing of information between QH mental health database and QAS to provide relevant information pertaining to a patient's mental health/violence history Continue Caution Notes within CAD where paramedics have encountered violence on previous presentations, as facilitated under existing QAS policy 	100% complete with ongoing actions after Final Report
Conduct further analysis on Paramedic Wearable Technology Options, including: <ul style="list-style-type: none"> Current portable VHF / UHF radio technology across Queensland (outside the GWN in South Eastern Queensland) to determine the capability and cost to activate duress, including the need for integration with GPS capability to ensure the location of the paramedic can be identified (e.g. using a mobile data terminal/other device) Further implementation of PTT satellite radio across the rest of Queensland, including capability, cost and the need for integration with GPS capability 	100% complete with ongoing actions after Final Report
Conduct further analysis on Vehicle Technology Options, including: <ul style="list-style-type: none"> CCTV/Hema HN7 Navigation – undertaking further analysis of legal implications that apply for installed cameras within vehicles Covert duress button within the patient compartment of ambulance vehicles Further implementation of PTT satellite radio across the rest of Queensland, as detailed above 	100% complete with ongoing actions after Final Report
Industry Standards – complete a review of current industry evidence based practice – also incorporated under Initiative 3 – Data Analysis	100% complete with ongoing actions after Final Report

Taskforce recommendation: Technology options

14. That QAS will further develop the findings of the Taskforce examination of potential technology options that will minimise the risk of occupational violence by November 2016.





Paramedic Safety implementation oversight committee

The Paramedic Safety implementation oversight committee will be established to lead the implementation of the Taskforce recommendations. To facilitate ongoing collaboration, engagement and progression of the recommendations contained within the Taskforce Final Report, the Paramedic Safety implementation oversight committee will ensure the strategic oversight and coordination for the range of initiatives with the ultimate aim of ensuring that future strategies, systems and processes aimed at minimising the risk of occupational violence to QAS personnel are implemented.

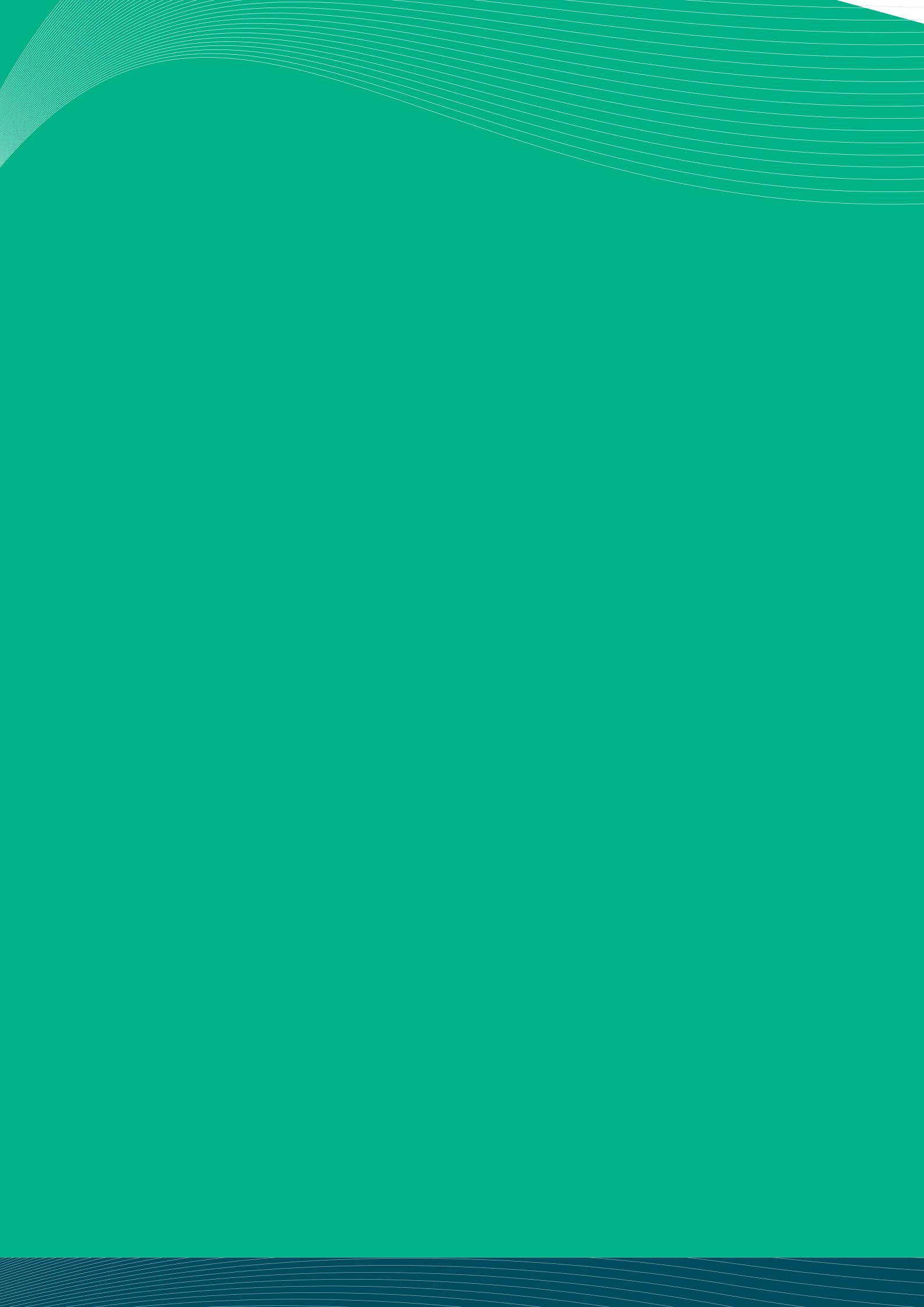
The Paramedic Safety implementation oversight committee will provide strategic oversight of the implementation of the recommendations contained within the Paramedic Safety Taskforce Final Report.

The committee will:

- » provide strategic leadership in relation to the implementation and effectiveness of the Taskforce recommendations on managing the risk of occupational violence to paramedics
- » develop an implementation plan detailing key deliverables and timeframes pertaining to the implementation for each of the Taskforce recommendations
- » provide high-level advice to the Director-General, Department of Health and the Minister for Health and Minister for Ambulance Services in relation to strategic and operational issues impacting on the implementation of the Taskforce recommendations
- » engage with relevant Department of Health and external government stakeholders.

Taskforce recommendation: Establishment of oversight implementation committee

15. That QAS establish a Paramedic Safety Implementation Oversight Committee by April 2016 to lead the implementation of the recommendations. The implementation of all recommendations will be completed by December 2016.



Conclusion and recommendations

The operation of the Paramedic Safety Taskforce has provided an effective vehicle to review and enhance the future safety for our paramedics in response to the risk of exposure to unexpected episodes of occupational violence.

The Taskforce is confident that through the delivery of each initiative as outlined in this Final Report, each key success factor relevant to the Taskforce recommendations has been achieved. Through the delivery of practical and working solutions, these achievements will serve to reduce violence against QAS officers, and will help to protect our officers in the event of violence or assault while at work. These achievements will contribute to QAS' goal of building a safer workplace for all officers.

The Taskforce also notes that increased awareness, delivered through a dedicated media and communications strategy, will assist with improving public knowledge of assaults against all health workers and the impact this can have on staff and their families. In this regard, the Palaszczuk Government's implementation of a \$1.35 million combined DoH and QAS public awareness campaign aimed at minimising violence against paramedics, due to roll out through 2016, will be pivotal in developing public knowledge of, and protecting our officers from the dangers posed by occupational violence in their workplace.

To facilitate ongoing collaboration, engagement and progression of the recommendations contained within this Final Report, an implementation group will be established within QAS to provide the ongoing strategic oversight to the continued monitoring of the implementation of the Taskforce recommendations.

The Paramedic Safety Taskforce acknowledges that its achievements and successes to date have been realised through the collaborative approach adopted by QAS and UVQ. This approach, when combined with the expert advice provided by external bodies at the forefront of best practice in the area of occupational violence, such as the QPS and the university sector, along with experiential advice provided by frontline paramedic and communication staff within QAS, have enabled the development of organisationally tailored outcomes to improve officer safety. These achievements have been reinforced through the support and endorsement provided to the Taskforce by the Director-General, Department of Health, UVQ and the Minister for Health and Minister for Ambulance Services.

The 'Paramedic Safety Taskforce Final Report' provides the direction and ongoing commitment to reducing the risk of occupational violence against QAS front-line paramedics in the performance of their duties and to raise awareness for the creation of a safer working environment.

It is therefore recommended that the Minister for Health and Minister for Ambulance Services:

- 1. Notes the outcomes achieved from the nine initiatives that have been completed by the Paramedic Safety Taskforce.**
- 2. Consider the fifteen final recommendations contained within 'Paramedic Safety Taskforce Final Report' for implementation in QAS.**
- 3. Note the role of the 'Paramedic Safety Implementation Oversight Committee', which will be responsible for the implementation of the recommendations of Paramedic Safety Taskforce endorsed by the Minister for Health and Minister for Ambulance Services.**

