

Introduction





Digital Clinical Practice Manual

Version 2020

While the Queensland Ambulance Service (QAS) has attempted to contact all copyright owners this has not always been possible. The QAS would welcome notification from any copyright holder who has been omitted or incorrectly acknowledged.

All feedback and suggestions are welcome. Please forward to: Clinical.Guidelines@ambulance.qld.gov.au

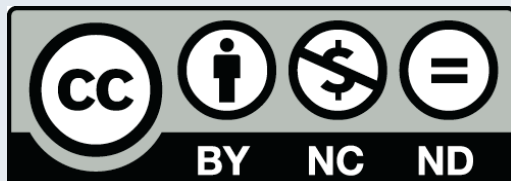
This document has been security classified using the Queensland Government Information Security Classification Framework as UNCLASSIFIED.

Disclaimer

The Digital Clinical Practice Manual (DCPM) is expressly intended for use by QAS clinicians when performing duties and delivering ambulance services for, and on behalf of the QAS.

The QAS disclaims, to the maximum extent permitted by law, all responsibility and all liability including without limitation, liability in negligence for all expenses, losses, damages and costs incurred for any reason associated with the use of this manual, including the materials within or referred to throughout this document being in any way inaccurate, out of context, incomplete or unavailable.

© State of Queensland (Queensland Ambulance Service) 2020.



This work is licensed under the Creative Commons Attribution-NonCommercial-NoDerivatives V4.0 International License.

You are free to copy and communicate the work in its current form for non-commercial purposes, as long as you attribute the State of Queensland, Queensland Ambulance Service and comply with the licence terms. If you alter the work, you may not share or distribute the modified work. To view a copy of this license, visit <http://creativecommons.org/licenses/by-nc-nd/4.0/deed.en>

For permissions beyond the scope of this license please contact:
Clinical.Guidelines@ambulance.qld.gov.au



Clinical Guideline Development Methodology

The QAS Digital Clinical Practice Manual (DCPM) is designed to provide QAS clinicians with relevant, value added, detailed clinical policies based on the best available evidence.

The methodology used by the QAS to develop and review clinical policy is informed by the AGREE II^[1] (Appraisal of Guideline for Research and Evaluation in Europe) instrument.

The QAS prioritises each new guideline development based on necessity, and organisational risk. In accordance with our organisational values, we proactively embrace new ideas for improving patient care and continually strive to ensure our practices remain contemporary, relevant and aligned with the needs of the community.

All clinical policies are reviewed every three years, and more frequently if the need is identified through one of the clinical feedback processes or through discovery from recently published clinical evidence.

Clinical policy development and review undergoes a multi-stage process involving input from a number of expert clinical content committees and interest groups to ensure policies reflect current needs.

We encourage all officers who have suggestions that may contribute positively to clinical policy development to submit their ideas by completing the online '*Clinical Policy Submission Form*', which can be accessed via the [QAS Portal](#). Submissions may be made for the introduction of a new policy or for a review of an existing policy and may include Clinical Practice Guidelines, Clinical Practice Procedures or Drug Therapy Protocols.

The QAS is committed to maintaining strict, non-biased editorial independence. Information relating to external funding and any competing or conflicts of interest that could potentially influence contribution can be requested by contacting Clinical.Guidelines@ambulance.qld.gov.au



2020 DCPM Guideline

Developers and Contributors

Editorial Lead

Mr Lachlan Parker, *Executive Manager – Clinical Policy Development, QAS*

Layout, Design & Illustrations

Mr Tony Middleton, *Instructional Designer, Medical Illustrator, QAS*

Editorial Team

Dr Stephen Rashford, *Medical Director, QAS*

Dr Daniel Bodnar, *Assistant Medical Director, QAS / Emergency Physician, Queensland Health*

Mr Tony Hucker, *Director – Clinical Quality & Patient Safety, QAS*

Ms Danielle Ironside, *Specialist Pharmacist, QAS*

Mr Steven Raven, *Clinical Policy Development Officer, QAS*

Contributors

Mr Luke Adams, *Critical Care Paramedic, QAS*

Dr Katherine Isoardi, *Clinical Toxicologist and Emergency Physician, Queensland Health*

Mr Wayne Loudon, *Critical Care Paramedic, QAS*

Mr Brendan Schultz, *A/Senior Paramedic Research Officer, QAS*

Mr Peter Murray, *Critical Care Paramedic, QAS*

The late Dr Colin Page, *Clinical Toxicologist and Emergency Physician, Queensland Health*

Dr Anthony Russell, *Endocrinologist, Queensland Health*

Photography

Mr Michael Marsden

Mr Shaun Webber, *Advanced Care Paramedic 2, QAS*

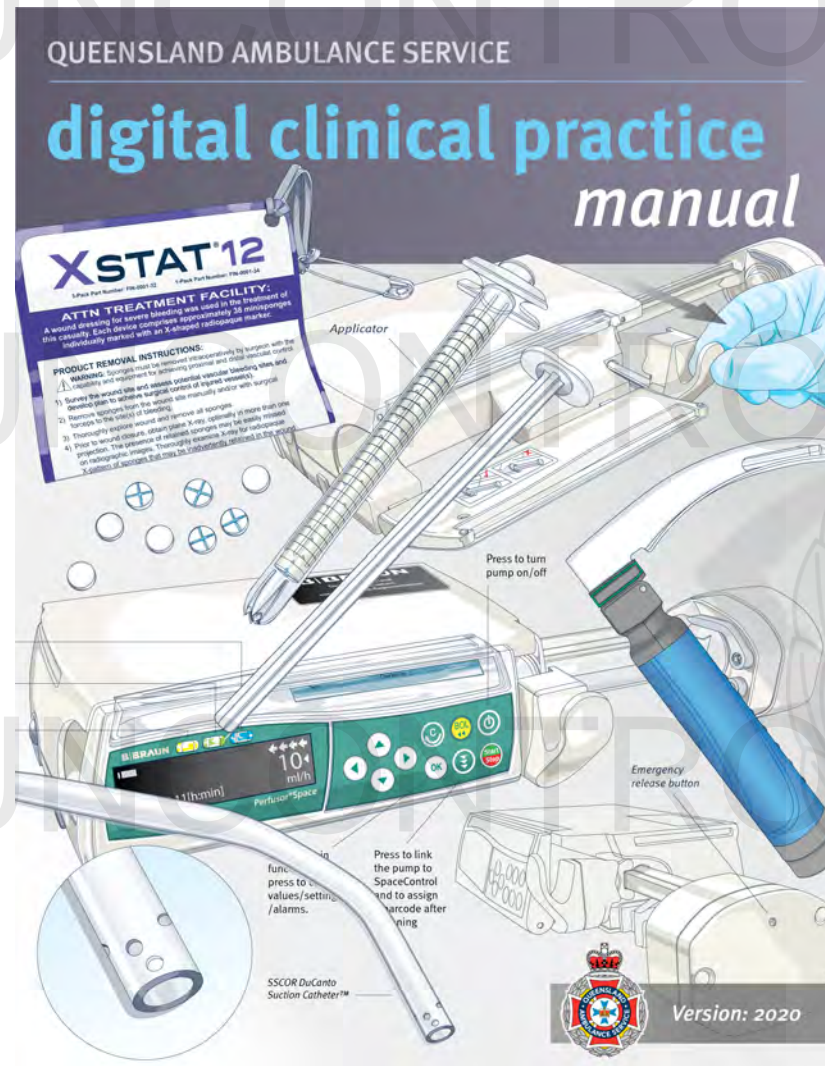
Indigenous and Torres Strait Islander artwork

Aboriginal and Torres Strait Islander artwork provided by Gilimbaa.



Digital Clinical Practice Manual

The QAS strives to provide high standards of emergency treatment, patient care and transport for the sick and injured. The DCPM reflects contemporary standards of clinical practice and includes systematically developed policies based on the best available evidence.



The DCPM is divided into eight (8) main sections:

- Introduction
- Clinical Practice Guidelines
- Clinical Practice Procedures
- Drug Therapy Protocols
- Current clinical research
- List of abbreviations
- References
- Resources

Clinical Practice Guidelines

Contains: 111 titles

Clinical Practice Procedures

Contains: 134 titles

Drug Therapy Protocols

Contains: 63 protocols

Gamma-hydroxybutyrate

Gamma-hydroxybutyrate (GHB) and its precursors gamma-butyrolactone (GBL) and 1,4-butanediol are recreational drugs ingested as liquids. Common street names of GHB include Fantasy, Grievous Bodily Harm (GBH) and Liquid E.^[1]

Clinical features

The duration of toxic effects is short, with complete recovery expected within 4–8 hours.^[1]

- Euphoria
- Drowsiness
- Myoclonus
- Agitation/Active behavioural disturbance
- Coma
- Bradycardia
- Hypothermia
- Respiratory depression

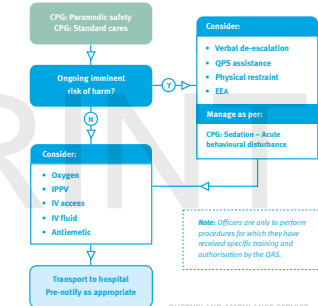
In toxic doses there is typically a rapid onset of coma. The patient is often rousable with stimulus only to return to unconsciousness once undisturbed.

Risk assessment

- In overdose, GHB can be lethal secondary to respiratory compromise.
- Ingestion of the GHB precursor GBL can cause life-threatening acidosis.^[2]

Additional information

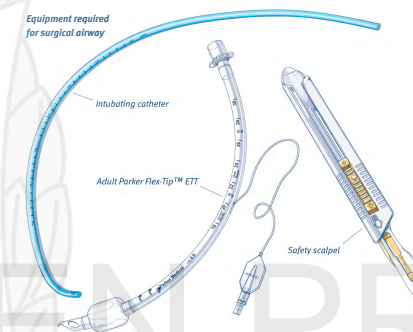
- Myoclonic jerking movements are common and may be confused with seizure.^[3]
- Coma longer than six hours duration suggests an alternate diagnosis or sedating co-ingestant.^[4]
- Full recovery is expected when good supportive care is provided.



Surgical cricothyrotomy

All clinicians conducting rapid sequence intubations (RSIs) must be skilled in failed airway techniques. Cricothyrotomy is a definitive rescue technique for the failed airway if time (i.e. preservation of oxygenation) does not allow for other approaches or if they fail.^[1] In addition, mental preparations to perform a surgical airway should be undertaken each time RSI is considered.

The QAS has adopted an open cricothyroid technique in adults as numerous studies have shown higher success rates in novice operators compared to 'over the wire' techniques.^[2]



Indications

- Can't intubate, Can't oxygenate (CICO) with decreasing SpO₂
- Primary airway attempt if ETT, LMA or BVM not feasible (e.g. massive facial trauma or burns)

Contraindications

- Child < 12 years of age
- Open tracheal injury
- Cardiac arrest

Complications

- High likelihood of blood obscuring the surgical field, this is a tactile rather than visual procedure

Calcium gluconate 10%

Onset (m)	Duration (m)	Half-life
1–3 minutes	30–60 minutes (in hyperkalaemia)	Not applicable

Schedule

- Unscheduled.

Routes of administration

Nebuliser (NEB)	CCP
Intravenous injection (IV)	CCP
Intraosseous injection (IO)	CCP

Special notes

- Ambulance officers must only administer medications for the listed indications and dosing range. Any consideration for treatment outside the listed scope of practice requires mandatory approval via the QAS Clinical Consult and Advice Line.
- All cannulae and IV lines must be flushed thoroughly with sodium chloride 0.9% following each medication administration.
- All parenteral medications must be prepared in an aseptic manner. The rubber stopper of all vials must be disinfected with a 2% Chlorhexidine /70% Isopropyl Alcohol swab and allowed to dry prior to piercing.

Adult dosages

- Suspected hyperkalaemic cardiac arrest
- Severe hyperkalaemia (with haemodynamic compromise AND/OR significant cardiac rhythm disturbance)
- Calcium channel blocker toxicity
- Hypotension associated with a magnesium infusion administration (that fails to respond to IV fluid therapy)

CCP	IV	10 mL (= 1 g) Slow push over 2–5 minutes. Repeated once at 10 minutes.
CCP	IO	10 mL (= 1 g) Slow push over 2–5 minutes. Repeated once at 10 minutes.

Hyperkalaemic acidosis

CCP	NEB	2 mL of 2.5% concentration (0.5 mL calcium gluconate 10% with 1.5 mL sodium chloride 0.9%) Repeated PRN. No maximum dose. Nebulised solution preparation: Mix 2.5 mL of calcium gluconate 10% with 75% mL of sodium chloride 0.9% in a 10 mL syringe to achieve a final concentration of calcium gluconate 2.5%. Ensure all syringes are appropriately labelled.
-----	-----	---



Clinical Practice Guidelines (CPGs)

The **CPGs** provide advice on best practice and are intended to guide clinician decision-making. They are not a substitute for clinical judgement. All variations to CPG treatment must be clearly documented and justified on the patient's eARF.

Gamma-hydroxybutyrate

January, 2020

Gamma-hydroxybutyrate (GHB) and its precursors gamma-butyrolactone (GBL) and 1,4-butanediol are recreational drugs ingested as liquids. Common street names of GHB include Fantasy, Grievous Bodily Harm (GBH) and Liquid E.^[1]

Clinical features



The duration of toxic effects is short, with complete recovery expected within 4–8 hours.^[1]

- Euphoria
- Drowsiness
- Myoclonus
- Agitation/Actual behavioural disturbance
- Coma
- Bradycardia
- Hypothermia
- Respiratory depression

In toxic doses there is typically a rapid onset of coma. The patient is often rousable with stimulus only to return to unconsciousness once undisturbed.

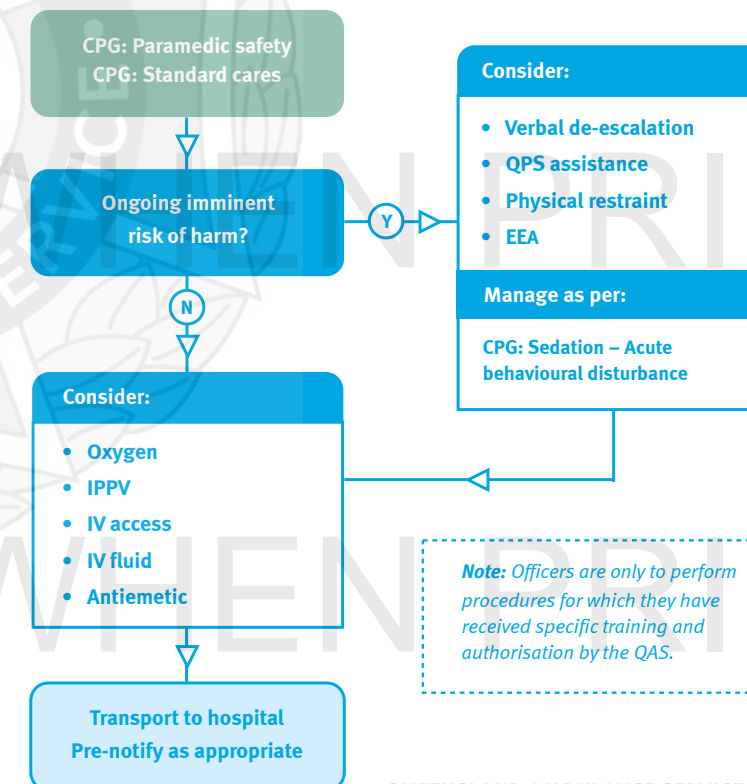
Risk assessment



- In overdose, GHB can be lethal secondary to respiratory compromise.
- Ingestion of the GHB precursor GBL can cause life-threatening acidosis.^[2]

+ Additional information

- Myoclonic jerking movements are common and may be confused with seizure.^[3]
- Coma longer than six hours duration suggests an alternate diagnosis or sedating co-ingestant.^[3]
- Full recovery is expected when good supportive care is provided.





Clinical Practice Procedures (CPPs)

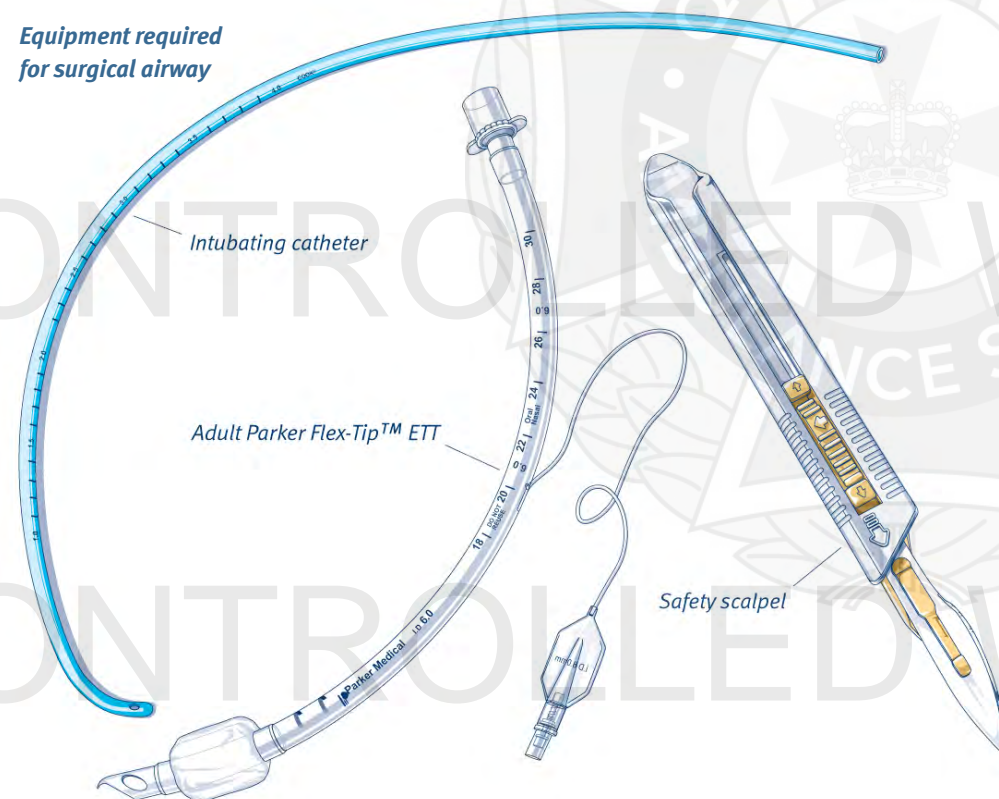
The **CPPs** are a set of prescribed clinical procedures developed to support consistency and quality in the performance of an activity.

Surgical cricothyrotomy

October, 2017

All clinicians conducting rapid sequence intubations (RSIs) must be skilled in failed airway techniques. Cricothyrotomy is a definitive rescue technique for the failed airway if time (i.e. preservation of oxygenation) does not allow for other approaches or if they fail.^[1] In addition, mental preparations to perform a surgical airway should be undertaken each time RSI is considered. The QAS has adopted an open cricothyroid technique in adults as numerous studies have shown higher success rates in novice operators compared to 'over the wire' techniques.^[2]

Equipment required for surgical airway



Indications

- **Can't Intubate, Can't oxygenate** (CICO) with decreasing SpO₂
- Primary airway attempt if ETT, LMA or BVM not feasible (e.g. massive facial trauma or burns)

Contraindications

- Child < 12 years of age
- Open tracheal injury
- Cardiac arrest

Complications

- High likelihood of blood obscuring the surgical field, this is a tactile rather than visual procedure



Drug Therapy Protocol (DTPs)

The **DTPs** contain specific protocols for the administration of pharmacological agents, expected to be followed in detail without scope for variation.

Calcium gluconate 10%

Onset (IV)	Duration (IV)	Half-life
1–3 minutes	30–60 minutes (in hyperkalaemia)	Not applicable

Schedule

- Unscheduled.

Routes of administration

Nebuliser (NEB)	CCP
Intravenous injection (IV)	CCP
Intraosseous injection (IO)	CCP

Special notes

- Ambulance officers must only administer medications for the listed indications and dosing range. Any consideration for treatment outside the listed scope of practice requires mandatory approval via the QAS Clinical Consult and Advice Line.
- All cannulae and IV lines must be flushed thoroughly with sodium chloride 0.9% following each medication administration.
- All parenteral medications must be prepared in an aseptic manner. The rubber stopper of all vials must be disinfected with a 2% Chlorhexidine /70% Isopropyl Alcohol swab and allowed to dry prior to piercing.

Adult dosages

- **Suspected hyperkalaemic cardiac arrest**
- **Severe hyperkalaemia** (with haemodynamic compromise AND/OR significant cardiac rhythm disturbance)
- **Calcium channel blocker toxicity**
- **Hypotension associated with a magnesium infusion administration** (that fails to respond to IV fluid therapy)

CCP	IV	10 mL (≈ 1 g) Slow push over 2–5 minutes. Repeated once at 10 minutes .
CCP	IO	10 mL (≈ 1 g) Slow push over 2–5 minutes. Repeated once at 10 minutes .
CCP	NEB	2 mL of 2.5% concentration (0.5 mL calcium gluconate 10% with 1.5 mL sodium chloride 0.9%) Repeated PRN. No maximum dose. <i>Nebulised solution preparation: Mix 2.5 mL of calcium gluconate 10% with 7.5 mL of sodium chloride 0.9% in a 10 mL syringe to achieve a final concentration of calcium gluconate 2.5%. Ensure all syringes are appropriately labelled.</i>

QAS Field Reference Guide (FRG) application



A free application (App) titled 'QAS FRG' suitable for both Apple iPhone/iPad and Android phone/tablets, is available on the Apple App Store (iTunes) and the Android Market Place (Google Play/Playstore) respectively. The App provides clinicians with electronic access to selected Digital Clinical Practice Manual titles via personal devices.



CPG Amendments (clinical) – 2020 DCPM		
Document Title	Details of Change	Reason for Amendment
Cardiac / Acute coronary syndrome	CPG updated to prioritise early tenecteplase administration (tenecteplase → enoxaparin → clopidogrel)	Early tenecteplase administration improves patient outcomes.
Medical / Diabetic emergency: Hyperglycaemia	CPG updated to include: <ul style="list-style-type: none"> Measurement of ketones (MS LASN only) Information updated to include ‘<i>Mandatory transport criteria</i>’. 	The presence of high ketones may assist with the early identification of diabetic complications. The QAS is currently working with the MS Hospital & Health Service to identify if pre-hospital patient ketone measurement will assist with the provision on diabetes care. Hypoglycaemia associated with specific illnesses or symptoms is high risk.
Medical / Diabetic emergency: Hypoglycaemia	Information updated to include ‘ <i>Mandatory transport criteria</i> ’.	Hypoglycaemia associated with specific illnesses or symptoms is high risk.
Medical / Meningococcal meningitis and septicaemia	CPG updated to include: <ul style="list-style-type: none"> Consistent definitions with current literature. Mandatory early hospital notification requirement. 	The QAS Clinical Quality & Patient Safety Unit has been working closely with the Queensland Health (QH) Clinical Excellence Division to improve the early recognition and management of sepsis.
Medical / Sepsis	CPG updated to include: <ul style="list-style-type: none"> Consistent definitions with current literature. High and moderate risk factors. Mandatory early hospital notification requirement. Flowchart updated to mandate that QAS clinicians discuss ‘<i>high risk</i>’ patients with the QAS Clinical Consultation & Advice Line. 	The QAS Clinical Quality & Patient Safety Unit has been working closely with the Queensland Health (QH) Clinical Excellence Division to improve the early recognition and management of sepsis. The updated CPG aligns to current QH sepsis guidelines and has been approved by the QH State-wide Sepsis Steering Committee.
Neurological / Seizures	CPG updated to include the consideration of levetiracetam administration (CCP only).	Levetiracetam is an antiepileptic used to prevent seizures.
Neurological / Stroke & Transient Ischaemic Attack	CPG updated to include: <ul style="list-style-type: none"> Definitions and epidemiology information for haemorrhagic and ischaemic stroke. Information detailing advances in hospital reperfusion strategies (e.g. Endovascular Clot Retrieval (ECR)). The National Institute of Health Stroke Scale (NIHSS)-8 stroke assessment and the Modified Rankin Scale (MRS). 	The referral window for patients with suspected large vessel occlusion (LVO) has increased to 24 hrs from onset of stroke symptoms. The NIHSS-8 is a validated stroke assessment with 82% diagnostic accuracy for the identification of patients considered suitable for ECR referral.
Respiratory / Chronic obstructive pulmonary disease	CPG updated to include: <ul style="list-style-type: none"> Consistent definitions with current literature. Flowchart updated to emphasise the benefits of patient reassurance and minimising exertion 	Scheduled CPG review. Expanded explanation of the pathophysiology associated with COPD
Respiratory / Foreign body airway obstruction	CPG updated to include detailed instructions on ‘ <i>back blows</i> ’ and ‘ <i>chest thrusts</i> ’ (including diagrams).	To prevent clinician confusion.
Respiratory / Croup	CPG updated to include: <ul style="list-style-type: none"> Consistent definitions with current literature. Westley Croup Score (WCS) assessment. Flowchart updated to include the consideration of dexamethasone administration (ACP2 and CCP officers only). 	Administration of oral dexamethasone has been found to result in faster resolution of symptoms, reduced unplanned representations to medical care, reduced length of hospital stay and resulted in reduced sleep loss compared to no steroids (Bjornson et al., 2004; Geelhoed et al., 1996; Russell et al., 2011).
Resuscitation / Resuscitation – Adult	CPG updated to include consideration of Mechanical Chest Compression Device application after 3 cycles of ACLS.	To allow for consistent high-quality chest compressions for carefully selected patients being transported for Extracorporeal Cardiopulmonary Resuscitation (eCPR) and/or primary Percutaneous Coronary Intervention (p/PCI).
Resuscitation / Resuscitation – Newly born	CPG updated to include: <ul style="list-style-type: none"> Expected SpO₂ values of a newly born (full term) in the first 10 minutes following birth. Requirement for the administration of adrenaline (epinephrine) and consideration of fluid expansion if patient fails to respond and HR remains < 60/min. Information of the gestational age that resuscitation would be futile (replicated from <i>CPG: Obstetrics/Miscarriage</i>). 	Inappropriate oxygen delivery to a newly born contributes to eye and lung injury through free radical damage. QAS clinicians are to be aware that SpO ₂ readings may be lower than expected in the first 10 minutes following birth. To align the QAS CPG with <i>ANZOR Guideline 13.7 – Medication or Fluids for the Resuscitation of the Newborn infant</i> .
Toxicology & toxinology / Approach to the poisoned patient	CPG updated to mandate that when QAS clinicians attend patients with suspected poisoning/overdose all empty medication packets/poison containers etc are to be transported to hospital with the patient (if safe to do so).	Positive identification of the type and/or quantity of overdose agent can be extremely useful for determining clinical treatment requirements.
Toxicology & toxinology / Anticholinergic	CPG updated to include additional agents with anticholinergic properties.	To make QAS clinicians aware that there are a number of commonly found agents with anticholinergic properties.
Toxicology & toxinology / Beta blocker	CPG updated to include: <ul style="list-style-type: none"> Information on the additional risks associated with propranolol and sotalol overdose. Flowchart updated to include the consideration of sodium bicarbonate 8.4% administration for propranolol (only overdose) when QRS > 0.14 and terminal R wave in aVR. 	To ensure QAS clinicians are aware of the significant risks associated propranolol and sotalol toxicity (when compared to other beta blocking drugs). Sodium bicarbonate 8.4% administration is no longer considered a specific therapy for beta blocker toxicity not involving propranolol.
Toxicology & toxinology / Calcium channel blocker	Flowchart updated to remove the consideration of sodium bicarbonate 8.4% administration.	Sodium bicarbonate 8.4% administration is no longer considered a specific therapy for calcium channel blocker toxicity.
Toxicology & Toxinology / Corrosives	CPG updated to include paraquat toxicity.	Consolidation and simplification of QAS clinical practice guidelines.
Toxicology & Toxinology / Cyanide	CPG updated to separate ‘ <i>Life-threatening</i> ’ and ‘ <i>other symptoms of toxicity</i> ’ treatment pathways.	External toxicology advice provided to QAS.
Toxicology & Toxinology / Marine envenomation	CPG updated to include separate flowcharts for penetrating and non-penetration marine envenomation.	Consolidation and simplification of QAS linical practice guidelines.
Toxicology & Toxinology / Opioid	Updated flowchart to consider administration of glucose if patient hypoglycaemic.	Methadone overdose has been associated with hypoglycaemia.
Toxicology & Toxinology / Paraquat	Deleted.	Combined with <i>CPG: Toxicology & toxinology / Corrosives</i> .
Toxicology & Toxicology / Sympathomimetic	Deleted.	Combined with <i>CPG: Toxicology & toxinology / Psychostimulant</i> . Considered not required by CPG review team (including Clinical Toxicologist and Emergency Physician).
Toxicology & Toxicology / Tricyclic antidepressants	Flowchart updated to include the consideration of sodium bicarbonate 8.4% administration for signs of sodium channel blockade when QRS > 0.14 and terminal R wave in aVR.	Updated sodium bicarbonate 8.4% administration recommendations.
Trauma / Burns	CPG updated to include: <ul style="list-style-type: none"> Reduced parameters for the use of burnaid. Now only for adult patients with non-complex burns covering less than 10% TBSA, or paediatric patients with non-complex burns covering less than 5% TBSA, after adequate cooling with running water. Removal of the requirement to secure a patient airway prior to fluid administration. 	Improved patient safety – to avoid the inappropriate use of burn-aid in patients with significant burns who are better managed with the use of cling wrap, etc. To ensure the priority management for burns patients is cooling with running water in all cases. Consolidation and simplification of QAS clinical practice guidelines.
Other / Disc battery ingestion	CPG updated to include: <ul style="list-style-type: none"> New title <i>CPG: Other/Button battery ingestion/insertion</i>. To include information of insertion injuries. 	Improved patient safety.
Other / Recording of Life Extinct	CPG updated to include notifications to the Queensland Police Service only if death is ‘ <i>reportable</i> ’ as defined in the <i>Coroners Act 1973</i> .	The QAS Clinical Quality & Patient Safety Unit has been working closely with the Queensland Police Service and Coroner to reduce the requirements for police notification.
Other / Standard cares	CPG updated to include the benefits QAS clinicians using the QAS Communication Board to assist with patient communication.	The 2011 QAS Communication Board was a joint initiative between QAS and the Department of Communities. Previously only available in print, it has now been included as a resource in the QAS DCPM.
Other / Suspected abuse and assault	CPG updated to reflect current legislation.	Change in legislation.

CPP Amendments (clinical) – 2020 DCPM		
Document Title	Details of Change	Reason for Amendment
Access / Intraosseous – Long bones (EZ-IO®)	CPP updated to include: <ul style="list-style-type: none">Updated contraindications:<ul style="list-style-type: none">Fracture in target bonePrevious significant orthopaedic procedure at the site, prosthetic limb or jointIO catheter use in previous 48 hours (target bone only)Infection at the area of insertionExcessive tissue (severe obesity) and/or absence of adequate anatomical landmarksMandated use of the supplied NeedleVISE®.Requirement to attempt aspiration of bone marrow prior to flushing.EZ-IO® removal instructions.	Improved clinician safety.
Access / Intraosseous – Sternal (FASTResponder™)	CPP updated to include FASTResponder™ removal instructions.	Improved clinician safety.
Access / Intravenous – Peripheral intravenous cannulation	CPP updated to include: <ul style="list-style-type: none">Amended indication asking clinicians if there is a <i>‘clinical requirement for the procedure’</i>.Mandatory use of the <i>‘Emergency’</i> dressing (when available).Removal instructions.	Ensure unnecessary cannulation is avoided. Improved clinician safety.
Access / Intravenous – Peripheral intravenous cannulation (external jugular)	CPP updated to include: <ul style="list-style-type: none">Mandatory use of the <i>‘Emergency’</i> dressing (when available).Removal instructions	Improved clinician safety.
Airway / Rapid sequence induction	RSI checklist updated to include: <ul style="list-style-type: none">Pre-oxygenation with high flow nasal prong O₂ prior to RSI is now only a consideration (previously mandatory).Use of the SSCOR DuCanto Suction Catheter™ for significantly soiled airways is now a consideration.	Improved patient safety and to optimise intubation attempt.
Airway / Suctioning	CPP updated with the removal of the SSCOR DuCanto Suction Catheter™ pilot (now introduced across QAS).	The SSCOR DuCanto Suction Catheter™ facilitates oropharyngeal cleaning in cases of heavy airway soiling.
Assessment / Blood analysis – Glucose	CPP update to include new glucometer model.	New product introduced into QAS.
Assessment / Blood analysis – Ketones	New policy.	New CPP for the measurement of ketones (pilot in Metro South LASN only).
Assessment / Pre-hospital stroke assessment	Deleted policy.	Information on stroke assessment now included in <i>CPG: Neurological / Stroke and Transient Ischaemic Attack</i> .
Assessment / Waveform capnography	CPP updated to include: <ul style="list-style-type: none">Diagram and explanation of CO₂ capnography.Instructions for corpuls3 EtCO₂ monitoring.	Scheduled CPG review.
Behavioural disturbance / Sedation – Acute behavioural disturbance	CPP and checklist content has been amended from <i>‘Prepare the sedation pharmacology’</i> to <i>‘Prepare the appropriate sedation pharmacology after confirming the patients age and recommended dose’</i> . Requirement for ABD forms to be submitted removed.	Improved patient safety. ABD audit data collection complete.
Cardiac / Autonomous fibrinolysis administration	CPP updated to include: <ul style="list-style-type: none">Requirement for the CCP to contact the QAS Clinical Consultation and Advice Line if pre-hospital thrombolysis is contraindicated.Order of medication administration amended to promote early tenecteplase administration (tenecteplase → enoxaparin → clopidogrel).	QAS Clinical Consultation & Advice Line clinicians will provide early notification to the Retrieval Services Queensland medical coordinator to aid in early retrieval planning.
Cardiac / Autonomous pPCI referral	Checklist updated to include the contraindication <i>‘Suspected aortic dissection (including new neurological symptoms)’</i> .	Improved patient safety.
Cardiac / Decision supported fibrinolysis administration	CPP updated to include: <ul style="list-style-type: none">Requirement for the ACP2 to contact the QAS Clinical Consultation and Advice Line if pre-hospital thrombolysis is contraindicated.Order of medication administration amended to promote early tenecteplase administration (tenecteplase → enoxaparin → clopidogrel).	QAS Clinical Consultation & Advice Line clinicians will provide early notification to the Retrieval Services Queensland medical coordinator to aid in early retrieval planning.
Cardiac / Decision supported pPCI referral	Checklist updated to include the contraindication <i>‘Suspected aortic dissection (including new neurological symptoms)’</i> .	Improved patient safety.
Cardiac / Mechanical Chest Compression Device – corpuls cpr	New policy.	New equipment to assist in the delivery of effective and consistent compressions as a bridge to pPCI and/or Extracorporeal Membrane Oxygenation (ECMO).
Drug & Fluid administration / Blood warmer – EnFlow®	Deleted policy.	Removed from QAS due to international product recall.
Drug & fluid administration / Blood warmer – °MEQU	New policy.	Replacement for the withdrawn EnFlow® blood warmer.
Drug & fluid administration / Priming of a SmartSite® add-on burette set (with ball valve drip chamber)	Deleted policy.	Removed from QAS due to the state-wide (CCP only) introduction of the BBraun Perfusor® Space syringe driver.
Drug & Fluid administration / Perfusor® Space syringe driver	CPP updated to include: <ul style="list-style-type: none">QAS medication library instructions and content.Pressure adjustment instructions.	New equipment for the administration of infusions (CCP only).
Drug & Fluid administration / Oral	CPP updated to include soluble tablet administration instructions.	The QAS has introduced soluble medication.
Drug & Fluid administration / Staff Influenza vaccination	<i>‘Pregnant, breast feeding or planning pregnancy’</i> has been removed as a contraindication.	To be consistent with national recommendations.
Respiratory / Emergency chest decompression – cannula	CPP updated to include: <ul style="list-style-type: none">The Pneumodart® is the preferred chest decompression needle for use in patients greater than 50 kg (approx. 14 years).New patient weight requirements added for chest decompression with a 14 and 16 gauge.	Improved patient safety.
Respiratory / Emergency chest decompression – COOK Emergency Pneumothorax Set	Deleted policy.	Removed from QAS due to the introduction of the Pneumodart®.
Respiratory / Emergency chest decompression – Pneumodart®	CPP updated to include: <ul style="list-style-type: none">Contraindication added <i>‘Patients less than 50 kg (approx. 14 years)’</i> previously <i>‘Patients less than 12 years’</i> required discussions with the QAS Clinical Consult and Advice Line.The Pneumodart® is the preferred chest decompression needle for use in patients greater than 50 kg (approx. 14 years).	The Pneumodart® is the preferred chest decompression needle for use in patients greater than 50 kg (approx. 14 years). Patients less than 50 kg are to be decompressed using a 14 or 16 gauge cannula (depending on weight).
Resuscitation / Mechanical Chest Compression device referral	New policy.	New referral protocol for patients that may be considered appropriate for Extracorporeal Membrane Oxygenation (ECMO) and/or pPCI.
Trauma / Haemostatic – XSTAT®12	New policy.	New equipment for the treatment of haemorrhage from life-threatening junctional wounds that are not suitable for arterial tourniquet application (ECCP – HARU only).
Trauma / Orthopaedic splinting – Prometheus pelvic	CPP updated to mandate that during application excess neoprene is to be cut and removed allowing access to the inguinal region.	QAS has identified incorrect application being performed.
Trauma / Skin closure – Histoacryl® topical skin adhesive	Reference to QAS Wound Care Information brochure added.	A QAS Wound Care Information brochure is now available for printing (station level) and to be left with patients.
Trauma / Skin closure – simple interrupted suturing	Reference to QAS Wound Care Information brochure added.	A QAS Wound Care Information brochure is now available for printing (station level) and to be left with patients.
Trauma / Skin closure – Steri-Strip™	Reference to QAS Wound Care Information brochure added.	A QAS Wound Care Information brochure is now available for printing (station level) and to be left with patients.

DTP Amendments (clinical) – 2020 DCPM		
Document Title	Details of Change	Reason for Amendment
Adrenaline	DTP updated to: <ul style="list-style-type: none">• Include infusion protocols for the BBraun Perfusor® Space syringe driver.• Remove infusion protocols for the Smartsite® add-on burette set.• Change of indication from ‘<i>Croup (with stridor at rest)</i>’ to ‘<i>Croup (moderate to severe)</i>’.• Amended dose (50 mcg) for newly borns in cardiac arrest.	Improved patient safety.
Amiodarone	DTP updated to: <ul style="list-style-type: none">• Include infusion protocols for the BBraun Perfusor® Space syringe driver.• Remove infusion protocols for the SPRINGFUSOR®.	Improved patient safety.
Calcium gluconate 8%	DTP updated with a new title <i>DTP: Calcium gluconate</i> .	QAS carries different concentrations of calcium gluconate.
Ceftriaxone	DTP updated to: <ul style="list-style-type: none">• Include new doses for adult and paediatric patients.• Include new contraindication ‘<i>Patients less than 1 month – consultation required</i>’.• New intravenous administration technique via (SPRINGFUSOR® 30 mL).	Improved patient safety.
Dexamethasone	New policy.	New DTP for the management of croup (ACP2/CCP only).
Fentanyl	DTP updated to include information on ‘ <i>Morphine Milligram Equivalent</i> ’ dosing for combined narcotic therapy.	Improved patient safety.
Fentanyl and midazolam (combined)	New policy.	New DTP for sedation to assist with the maintenance of an established ETT/LMA (CCP only).
Heparin	DTP dose for adults amended from ‘ <i>5,000 units</i> ’ to ‘ <i>5,000 units (or dose requested by the accepting interventional cardiologist)</i> ’	AN alternate heparin dose may be requested by the accepting interventional cardiologist.
Hydroxocobalamin	DTP updated to: <ul style="list-style-type: none">• Amended indication.• Improved preparation instructions.	External toxicology advice provided to QAS.Hydroxocobalamin (CYANOKIT®) preparation requires a specific procedure that may be confusing.
Hydrocortisone	DTP updated to include new dosages for the following indications: <ul style="list-style-type: none">• Asthma (excluding mild)• Acute exacerbation of COPD.	Improved patient safety.
Ibuprofen	DTP updated to include ACP2 and CCP authority.	Expanded authority for the management of moderate pain (due to acute inflammation and tissue injury)
Influenza vaccine 2020	‘ <i>Pregnant, breast feeding or planning pregnancy</i> ’ has been removed as a contraindication.	To be consistent with national recommendations.
Levetiracetam	New policy.	New protocol for the management of status epilepticus (CCP only).
Lidocaine 1% (lignocaine 1%)	DTP updated to include: <ul style="list-style-type: none">• New precaution ‘Severe kidney or liver disease’.• New indication ‘<i>To reconstitute ceftriaxone for the purpose of IM injection</i>’ (LARA and CCP only).• Amended doses for adults and paediatrics.	Improved patient safety.
Loperamide	New policy.	New DTP for the management of acute diarrhoea (EACP2/ECCP – USAR only).
Lorazepam	New policy.	New DTP for the management of post-ictal acute psychosis (as specifically authorised in AMP 139/12 – Toowoomba CCP only).
Magnesium sulphate	The indication ‘ <i>Severe life-threatening asthma (only in patients who have required IV salbutamol AND/OR IM/IV adrenaline (epinephrine))</i> ’ has been amended to ‘ <i>Severe life-threatening asthma (only in patients who have IM/IV adrenaline (epinephrine))</i> ’.	Improved patient safety.
Metoprolol	DTP indication amended from ‘ <i>ACS (unresponsive to sublingual nitrates and narcotic analgesia)</i> ’ to ‘ <i>ACS (unresponsive to nitrates)</i> ’.	Improved patient safety.
Midazolam	DTP updated to include: <ul style="list-style-type: none">• ACP2 authority for intravenous midazolam administration authority for adult patients presenting with seizures.• Requirement for the first dose of midazolam for seizures to be administered intranasally or intramuscularly (unless a patent intravenous cannula is already in situ.	Ease of administration. Not having patent intravenous access should not delay midazolam administration.
Morphine	DTP updated to include information on ‘ <i>Morphine Milligram Equivalent</i> ’ dosing for combined narcotic therapy.	Improved patient safety.
Morphine and midazolam (combined)	New policy.	New DTP for sedation to assist with the maintenance of an established ETT/LMA (CCP only).
Ondansetron	DTP updated to include the new indication ‘ <i>Significant Nausea AND/OR vomiting</i> ’ to replace previously stated indication ‘ <i>Nausea AND/OR vomiting</i> ’.	Improved patient safety. Ensure unnecessary administration is avoided.
Oxygen	Simplified oxygen administration guidelines.	Improvement on previously complex QAS oxygen therapy protocol.
Paracetamol	DTP updated to include: <ul style="list-style-type: none">• The indication ‘<i>Minor pain</i>’ has been amended to ‘<i>Mild to moderate pain</i>’.• Authority for soluble tablets.	To aid in the administration of paracetamol to patients unable to swallow tablets.
Phenytoin	Deleted policy.	Removed from QAS due to the introduction of the levetiracetam.
Propofol	DTP updated to include Infusion protocols for the BBraun Perfusor® Space syringe driver.	New protocol for sedation to assist with the maintenance of an established ETT/LMA (ECCP-HARU only).
Rocuronium	The presentation has been updated to a 50 mg / 5 mL vial.	100 mg / 10 mL vials are no longer available.
Salbutamol	DTP updated to remove CCP Intravenous administration authority.	Consolidation and simplification of QAS clinical practice guidelines.
Sodium bicarbonate 8.4%	DTP updated to include new ECG requirements for: <ul style="list-style-type: none">• TCA poisoning• Sodium channel blockade due to non-TCA poisoning	Improved patient safety.
Sodium chloride 0.9%	DTP updated to include new PHIFTEEN B (15-B) burns formula to identify the hourly parenteral fluid rate goal to be administered from time of injury.	Improved patient safety and simplified burns fluid replacement policy
Ticagrelor	DTP updated to include the 90 mg ticagrelor ODT presentation.	Ticagrelor tablet administration may be difficult in some patients. Ticagrelor ODTs have been introduced to aid in timely medication administration.



Powers of an Authorised Officer

The QAS Commissioner may authorise an officer or officers of a particular class or category, to exercise the powers that are outlined in the *Ambulance Service Act 1991* (Qld) (the Act).^[1]

The Act provides that an authorised officer, when providing ambulance services for the QAS, may take any reasonable measure to:

- protect persons from any danger or potential danger associated with an emergency situation
- protect persons entrapped in a vehicle, receptacle or vessel, or otherwise endangered
- protect themselves or other officers or persons from danger, potential danger or assault from other persons

Measures that may be taken for the purpose of protecting persons from danger or potential danger, or those who are trapped may include, but are not limited to, the following:

- enter any premises, vehicle or vessel
- open any receptacle, using such force as is reasonably necessary
- bring any apparatus or equipment onto premises
- remove from, or otherwise deal with, any article or material in the area
- destroy (wholly or partially) or damage any premises, vehicle, vessel or receptacle
- cause the gas or electricity supply or motor or any other source of energy to any premises, vehicle, vessel or receptacle to be shut off or disconnected
- request any person to take all reasonable measures to assist the authorised officer
- administer such basic life support and advanced life support procedures as are consistent with the training and qualifications of the authorised officer

Measures that may be taken for the purpose of protecting themselves, other officers and other persons from danger, potential danger or assault may include, but are not limited to directing that a person not enter into, or remain within, a specified area around the patient or the site.

What constitutes '**reasonable**' in any situation is that which a careful clinician of a similar class or category would do in similar circumstances.



The content of the DCPM, coupled with the education and training provided to QAS clinicians, will serve as a helpful guide as to what actions would be appropriate and reasonable in each circumstance.

Clinicians are also encouraged to discuss cases with a senior paramedic by contacting the *QAS Clinical Consultation and Advice Line*.



Role of the QAS Clinician



QAS clinicians have three primary tasks within the Queensland Emergency Medical System (QEMS).

1. the assessment and prioritisation of patient's immediate and definitive needs
2. delivery of the appropriate immediate care, while concurrently
3. organising the provision of definitive care in the most time efficient manner.

Clinicians must consider all resources available within the QEMS continuum when treating patients, including:

- Queensland Ambulance Service
- community
- other emergency services
- hospital based retrieval teams
- aeromedical (rotary and fixed wing) operations; and
- ancillary medical facilities and receiving hospitals.

All requests for additional resources are to be made by contacting the appropriate Operations Centre (OpCen).

Basic principles of management are goals of care that apply to all cases:

- identify and manage life-threatening conditions
- locate all patients first, if the number of patients is greater than resources, seek additional resources
- assess each patient's condition appropriately
- prioritise and manage the most life-threatening conditions first
- provide a situation report (sitrep) to the appropriate OpCen as soon as practical after arrival on scene

Basic Principles of Management



Basic principles of management *(cont.)*

- provide adequate oxygenation and ventilation
- optimise tissue perfusion
- identify and manage other conditions
- provide appropriate pain relief
- posture the patient according to the presenting condition
- ensure the maintenance of normal body temperature (unless otherwise indicated by QAS guidelines)
- provide psychological support at all times
- transport as necessary

When the number of patients overwhelms the existing resources refer to the QAS State Major Incident and Disaster Plan (SMID).^[1]



Australian Charter of Healthcare Rights



The QAS supports the *Australian Charter of Healthcare Rights* which describes the rights of patients using Australia's healthcare system. The Charter must inform the work of QAS clinicians to ensure safe and high quality service and best possible outcomes for patients.

Patients have seven rights under the *Australian Charter of Healthcare Rights*. These rights have been adapted here for the consideration of QAS clinicians.

Access:

Patients have the right to receive health care that addresses their healthcare needs.

Safety:

Patients have the right to receive safe and high quality care which is provided by clinicians with professional care, skill and competence.

Respect:

Patients have the right to be shown respect, dignity and consideration. Clinicians must show respect for the patient's culture, religion, beliefs, values and personal characteristics.

Communication:

Patients have the right to receive open, timely and appropriate information from clinicians in a clear and precise way.

Participation:

Patients have the right to be included in decisions about their healthcare.

Privacy:

Patients have a right to privacy and confidentiality of personal information. This should be guaranteed by clinicians through the appropriate handling of a patient's personal records.

Comment:

Patients have a right to comment on their care and have their concerns addressed by clinicians in a professional and prompt manner.

For further information please visit:
www.safetyandquality.gov.au

AUSTRALIAN COMMISSION ON
SAFETY AND QUALITY IN HEALTHCARE



Guide to Patient Decision Making in Ambulance Services



General information – patient decision-making ^[1]

- What is an ambulance service?
- Why is it necessary to obtain consent for ambulance services?
- What is the process for obtaining consent?

Decision-making and consent for adults with impaired decision-making capacity

- Urgent healthcare
- Use of force (including physical restraint and sedation) when providing healthcare to patients with impaired decision-making capacity
- Order of priority for decision-making involving a patient with impaired capacity
- Who can consent for an adult patient with impaired decision-making capacity?
- What are Advance Health directives?
- Advance Health Directives and directions relating to life-sustaining measures
- Decision regarding life-sustaining measures in an acute emergency for a person with impaired decision-making capacity

Informed decision-making and consent for children and young persons

- Who can consent for a child or young person?
- At what age can a young person provide consent for themselves?
- How to assess if a young person has capacity to provide consent (Gillick competent).
- Can a child or young person refuse ambulance services?

General information – patient decision-making

What is an ambulance service?

Ambulance services involve the rendering of emergency treatment and patient care to, and the transport of sick and injured persons.^[2]

The following examples are considered ‘ambulance services’.

- conducting a physical assessment of a patient;
- administration of drugs;
- administration of intravenous fluids;
- performing urgent invasive procedures;
- application of splints to immobilise limbs or joints;
- providing transport for a person to a hospital or health care facility.

Why is it necessary to obtain consent for ambulance services?

A person has a right to make decisions about health care, which includes decisions to accept or reject that which is recommended by the person’s health provider, or to choose one of a number of options that may be available.^[3] This right to make decisions would logically extend to include decisions about ambulance services. It is therefore essential that paramedics obtain consent from a patient before ambulance services are provided, or if the patient is not capable of providing consent, from a person that is authorised to make decisions for the patient if such a person is readily available.

Obtaining consent before ambulance services are provided is essential for two reasons. Firstly, it respects the patient’s right to make their own decision regarding the services that are recommended and secondly, it protects the clinician from any potential claims arising from the provision of treatment without authorisation.

What is the process for obtaining consent?

Consent can be provided in a number of ways. It can be implied, that is, the patient or decision-maker may indicate by his or her conduct, that they have no objection to the ambulance service that is proposed; it can be given verbally; or the consent may be provided in writing. Written consent for the provision of ambulance services in the pre-hospital setting is sought in very limited circumstances.

Irrespective of the method by which consent is provided, the consent must be valid. A valid consent requires:

- that the decision has been made voluntarily;
- the patient or decision-maker has been informed about the services/s that are proposed;
- the decision to consent related to the specific service/s that are provided; and
- the patient has the capacity to make the decision.

Voluntary decision

When making decisions regarding ambulance services, the patient or decision-maker must make a decision that is free from manipulation or undue influence that may be exerted by others, such as a family member, close friend, clinician or other health provider. This does not mean that a patient or decision-maker should not consult with family members or health providers when giving consideration to the various options that may be available. In fact, consultation and support from family and friends, religious and/or cultural leaders form a significant role for many patients and should be encouraged. The final decision, however, must ultimately be the patient’s and one that is made voluntarily.

Informed

The patient or decision-maker must, as far as practical, be advised of the following:

- the condition or suspected condition from which the patient may be suffering (diagnosis);
- the treatment options and ambulance service/s that are recommended;
- the reason and potential benefits of receiving the recommended service/s;
- the potential risks associated with each ambulance service that is recommended; and
- any alternative ambulance service/s or treatment options that may exist.

The information must be provided to the patient or decision-maker in simple terms and using language that the person is capable of understanding. The patient or decision-maker should be afforded reasonable time in which to consider and clarify the information.

Decision relates to treatment/service provided

The consent provided by the patient or decision-maker must relate to the actual treatment or ambulance service/s that is provided. If there is more than one treatment or service, consent must be sought for each.

Capacity ^[4]

According to the law, every adult is presumed to have the capacity to make decisions about health care, unless it can be demonstrated that they don't. A number of medical conditions or other circumstances can potentially impact on a person's decision-making capacity and can do so on either a temporary or a permanent basis.

Examples of such conditions or circumstances include:

- head injury;
- dementia;
- intellectual disability;
- mental illness;
- hypoxia;
- drug and/or alcohol intoxication; and
- severe pain.

However, it cannot be assumed that a person lacks the capacity to make a decision merely because of the presence of one or more of the factors that could potentially impact on a person's ability to understand. It must be demonstrated, by assessment, that the person does not have the capacity to make the decision at hand.

In Queensland, capacity means that a person is capable of:^[5]

- understanding the nature and effect of decisions about the matter; and
- freely and voluntarily making decisions about the matter; and
- communicating the decisions in some way.

The gravity of the risk involved and the more serious the decision to be made, are factors that must also be considered when assessing a patient or decision-maker's capacity to make the decision. The more serious the situation and the greater risk involved, the greater the level of understanding that is required.

Any questions as to whether a patient lacks the capacity to make a decision should be resolved by a medical practitioner however, this may not be practical in the pre-hospital setting, and in the time critical circumstances in which paramedics practice.

Circumstances will arise where the question must necessarily be resolved, in the first instance, by the attending paramedic. If the paramedic has any concerns regarding the assessment of a person's decision-making capacity, the paramedic should consult with the QAS medical practitioner.

The *Queensland Health Guide to Informed Decision Making*^[1] provides the following criteria for assessment of decision-making capacity:

1. *Does the patient understand the basic medical situation?*
2. *Does the patient understand the nature of the decision being asked of him or her? Understanding includes the following:*
 - *implications – benefits, risks, what the treatment entails*
 - *alternatives and their implications, including the implication of no decision*
 - *retaining the information (short-term memory function) sufficient to make a decision.*
3. *Can the patient use or weigh that information as part of the process of making the decision (for example, asking questions)?*
4. *Can the patient communicate a decision (for example, by talking, using sign language or any other means)?*
5. *Is the patient communicating the decision voluntarily (for example, is there an absence of coercion, undue influence or intimidation by the patient's family/decision-maker/s)?*

Decision-making and consent for adults with impaired decision-making capacity

In circumstances where a patient lacks the capacity to make decisions about ambulance services, the paramedic is to take all reasonable steps to obtain consent from a substitute decision-maker. What is reasonable will depend upon the degree of urgency in which the service is required, and practical considerations such as the physical location of the incident.

Consent for ambulance services may not be required for a patient with impaired decision-making capacity, if the ambulance service involves:

- minor, uncontroversial services that are necessary to promote the patient's health and wellbeing;^[6] or
- urgent services that are necessary to meet an imminent risk to the patient's life or health;^[7] or
- urgent services that are necessary to prevent significant pain or distress and it is not reasonably practical to get consent from a person who is authorised to provide consent for the patient.^[8]

Urgent healthcare

Healthcare and ambulance services may be provided without consent in circumstances where the person has impaired capacity for the health matter and the health provider reasonably considers that:

- the healthcare should be carried out urgently to meet imminent risk to the person's life or health; or
- the healthcare should be carried out urgently to prevent significant pain or distress to the person and it is not reasonably practical to get consent from a person who may be authorised to provide it.^[9]

Use of Force

It is acknowledged that the use of force may be a component of pre-hospital care, with the QAS suggesting restraint could be considered only in the following circumstances:^[1]

- when all other alternatives to avoid harm to the patient or others have been considered and are inappropriate or ineffective
- when the benefits outweigh the risk and distress (even temporary) that may be caused to the patient
- when a patient has the capacity to provide consent and they have done so
- where a patient lacks the capacity to consent, such consent has been provided by an appropriate substitute decision-maker, or the healthcare is in accordance with the legal requirements
- in accordance with
 - Paramedic Safety Guidelines, when appropriate safety measures have been implemented.
 - QAS Clinical Practice Guidelines, Clinical Practice Procedures and Drug Therapy Protocols.
 - Good clinical practice.
 - In accordance with Legal requirements and any relevant law ^[1,5,7, 10-13]

For patients who lack capacity to consent, or decline consent, the use of force may be appropriate where:

- The restraint constitutes 'healthcare' that is, where the practice, as a treatment, has a therapeutic effect upon a patient's physical or mental condition; and should be carried out urgently to:
 - meet imminent risk to the adults life or health; or
 - should be carried out urgently to prevent significant pain or distress to the adult and it is not reasonably practical to get consent from a person who may give it under the *Guardianship and Administration Act 2000 (Qld)* or the *Powers of Attorney Act 1998 (Qld)*

The use of force including initiating physical (Note: always undertaken by QPS) or chemical restraint (sedation) on a patient receiving health services is a very serious matter.^[1]

Clinicians must be aware that the use of force on a patient may lead to civil, criminal, disciplinary or professional conduct investigations against them, and their reasons may not be accepted as being justified unless their actions clearly accord with relevant professional, policy and legal requirements. If in doubt, it is recommended that clinicians seek guidance from a supervisor or a senior clinician via the QAS Clinical Consultation and Advice Line prior to initiating treatment.

The clinician is required to document fully in the patient's eARF, details regarding: the assessment of the patient's decision-making capacity; the clinical circumstances and why the clinician considered that the ambulance service was required urgently or required to prevent significant pain or distress; and information as to why it was not reasonably practical to obtain consent from a substitute decision-maker.

Order of priority for decision-making for a patient with impaired decision-making capacity

If a patient has impaired decision-making capacity, decisions regarding healthcare are to be made in the following order of priority:

- (i) If the person had made an Advance Health Directive giving directions that relate to the current circumstances, the matter can be dealt with under that direction (note that a direction to withhold or withdraw a life-sustaining measures will only operate if the additional conditions set out in the *Powers of Attorney Act* ^[14] have been satisfied – see below for further details);
- (ii) If one or more guardians have been appointed by the Queensland Civil and Administrative Tribunal, the matter can be dealt with by the guardian/s.
- (iii) If the person has appointed one or more attorneys, the matter can be dealt with by the attorney/s.
- (iv) The matter can be dealt with by a statutory health attorney.

Who can consent for an adult patient with impaired decision-making capacity?

If an adult patient lacks the capacity to make a decision regarding ambulance services, the clinician should ascertain if there is a substitute decision-maker who is readily available to make decisions for the patient. The clinician should also inquire as to whether the patient has made an Advance Health Directive.

A substitute decision-maker may include:^[15]

- one or more guardians appointed by the Queensland Civil and Administrative Tribunal; or
- one or more health attorneys appointed under an Enduring Power of Attorney or an Advance Health Directive; or
- a statutory attorney authorised by legislation.^[16]

Statutory Health Attorney

In the event that a person has not appointed a health attorney, a 'statutory health attorney' is authorised under the *Powers of Attorney Act 1998* to make decisions for the person. A statutory health attorney is the first of the following people who are readily available and culturally appropriate:

- (i) The person's spouse if the relationship is close and continuing;
- (ii) A person who is over 18 years of age and who is caring for the person (not a paid carer); or
- (iii) A close friend or relation over 18 years of age (not a paid carer).

An attorney or guardian has the power to make decisions regarding healthcare for and on behalf of the patient however, the authority to make decisions will only take effect when the patient is no longer capable of making decisions. When making decisions, the attorney or guardian must comply with the Health Care Principles set out in the *Powers of Attorney Act 1998*^[17] and the *Guardianship and Administration Act 2000*.^[18]

The Health Care Principles require the attorney or guardian to:

- consider the views and wishes of the patient;
- consider the advice of the healthcare provider;
- choose the least intrusive method of treatment available where possible; and
- ensure the decision is in the patient's best interest.^[19]

A decision made by an attorney or guardian will have the same legal effect as a decision that is made by the patient.

What are Advance Health Directives?

An Advance Health Directive is a formal document in which a person can provide directions regarding future health matters, which can include directions to request treatment, directions to refuse specified treatment, and directions to withhold or withdraw life sustaining measures. An Advance Health Directive is legally recognised however, the document must be:

- in writing;
- signed by the patient;
- signed and dated by an 'eligible witness'^[20] who attests to the capacity of the patient at the time; and
- signed and dated by a medical practitioner (not the witness) who must also certify that the patient had capacity to make the 'advance health directive' at the time.^[1]

A patient's Advance Health Directive will only operate if and when the patient loses the capacity to make decisions.

To be applicable, directions in a patient's Advance Health Directive must apply to the situation in question or the current clinical circumstances.

The paramedic is entitled to sight the original or certified copy of the Advance Health Directive.

An Advance Health Directive should not be relied upon in circumstances where:^[21]

- the document is defective (pages missing or the document is not signed, dated, and witnessed);
- the directions are unclear or ambiguous;
- the directions are inconsistent with good medical practice;
- if the clinical circumstances differ from those that are set out in the Advance Health Directive;
- if the patient's medical circumstances have changed to the extent that the direction in the Advance Health Directive may no longer appropriate;
- if the patient has done something that would suggest that they have changed their mind.

Clinicians are required to consult with the QAS medical practitioner if these circumstances arise.

Advance Health Directives and directions relating to life-sustaining measures

The Powers of Attorney Act 1998 and the *Guardianship and Administration Act 2000* both define ‘life-sustaining measures’ as:

... healthcare that is intended to sustain or prolong life and supplants or maintains the operation of vital bodily functions that are temporarily or permanently incapable of independent function.^[22]

A person may provide a direction in their Advance Health Directive regarding life-sustaining measures requiring that a life-sustaining measure be withheld or withdrawn in specified circumstances.

A direction in a person’s Advance Health Directive to withhold or withdraw a life-sustaining measure cannot operate unless:^[23]

- (i) the patient has impaired decision-making capacity;
- (ii) there is no reasonable prospect of regaining capacity for health matters;^[24] and
- (iii) the patient is suffering from one of the following medical conditions:^[25]
 - a terminal illness or conditions that is incurable or irreversible and as a result of which, in the opinion of the treating doctor and another doctor, the patient may reasonably be expected to die within one year;
 - a persistent vegetative state;
 - be permanently unconscious;
 - have an illness or injury of such severity that there is no reasonable prospect that the patient will recover to the extent that their life can be sustained without the continued application of life-sustaining measures.

The clinician is required to sight the original or certified copy of the patient’s Advance Health Directive and documentary evidence from a medical practitioner that the conditions set out in the *Powers of Attorney Act* and referred to above, have been satisfied.

If the decision to withdraw or withhold life-sustaining measures is made in response to a direction in the patient’s Advance Health Directive, the paramedic must record in the patient’s eARF:

- the direction as it is provided in the Advance Health Directive and sighted by the paramedic;
- evidence that the additional conditions (set out in the *Powers of Attorney Act* and reproduced in the CPG) have been satisfied; and
- details of the clinical assessment which would demonstrate that the direction applied in the current circumstances.^[26]

Decision regarding life-sustaining measures in an acute emergency for a person with impaired decision-making capacity

In an acute emergency where cardiopulmonary resuscitation (CPR) is required, the clinician is not required to obtain consent before commencing CPR and other life-sustaining measures or continuing to provide CPR until such time as the clinician has had an opportunity to assess the clinical situation and to make reasonable inquiry regarding the patient's wishes and the identity and location of a person/s who may be authorised to make decisions for the patient.

In an acute emergency, CPR or other life-sustaining measures may be withheld or withdrawn without consent in circumstances where a **medical practitioner** considers, and issues a direction to the effect that:^[27]

- the commencement or continuation of CPR or another life-sustaining measure would be inconsistent with good medical practice; and
- consistent with good medical practice, the decision to withhold or withdraw the life-sustaining measure should be taken immediately.

A person's **guardian or health attorney** can provide consent to withhold or withdraw CPR and another life-sustaining measures however, the consent cannot operate unless the health provider reasonably considers that the commencement or continuation of the life-sustaining measure for the patient would, having regard for all the circumstances, be inconsistent with good medical practice.^[28]

Good Medical Practice

Decisions to withhold or withdraw cardiopulmonary resuscitation and other life-sustaining treatments from patients that lack decision making capacity, must be consistent with standards of good medical practice for the patient, having regard for the clinical circumstances and the location of the patient at the time.

The *Powers of Attorney Act 1998* and the *Guardianship and Administration Act 2000* define good medical practice as that which applies to the medical profession in Australia, having regard to the recognised medical standards, practices and procedures of the profession and the recognised ethical standards of the medical profession.^[29]

If the decision to withhold or withdraw life-sustaining measures is made by a **medical practitioner** in an acute emergency, the clinician is required record in the patient's eARF:

- the identity and contact details of the medical practitioner; and
- the clinical circumstances enabling the decision to withhold or withdraw the measure on the basis good medical practice and to do so immediately.^[30]

If the decision is made in response to consent provided by the patient's **health attorney or guardian**, the record must include:

- the identity of the health attorney or guardian;
- specific details of life sustaining measures for which the attorney or guardian is providing consent to withhold or withdraw;
- details of the clinical assessment and clinical circumstances; and
- the opinion of the health provider that the decision to withdraw or withhold life-sustaining measures in these circumstances is consistent with good medical practice.^[31]

Informed decision-making and consent for children and young persons

In Queensland, a person who is under the age of 18 years is considered to be a minor.^[32] The terms ‘children’ and ‘young person’ are often used by health providers when referring to patients that are minors. For the purposes of this guide, the term ‘children’ refers to a younger minor who is not likely to have the capacity to understand and make decisions about health care or ambulance services. The term ‘young person’ refers to an older and more mature minor that may have the capacity to understand the nature and consequences of a decision and be capable of making that decision themselves.

As with an adult patient, a clinician is required to obtain consent before any healthcare or ambulance services can be provided to a child or young person. An exception to this requirement would involve an emergency situation in circumstances where it was not possible or practical to obtain consent from either child or young person, or a person authorised to provide consent for the child.^[33]

Who can consent for a child or young person?

The child or young person

If the child or young person is sufficiently mature and understands the nature and consequences of the decision he or she is making, the young person can provide consent for themselves.

There is no set age at which a young person may be capable of making a decision about healthcare, the determination is related to maturity and ability to understand. A young person that has the capacity to make a decision about healthcare is said to be ‘Gillick competent’ (see opposite).

Biological parent

The biological parent is responsible for making decisions in relation to healthcare and ambulance services for their children. The authority to make these decisions exists irrespective of whether the parents are married, separated or divorced unless the authority has been altered by a court order.^[34] Adoptive or surrogacy parents have the same parental rights and responsibilities as those of the biological parent.^[35]

Consent from one parent is sufficient. In circumstances where both parents have an opposing view regarding the proposed ambulance service, the clinician should ensure that both parents are fully informed regarding the nature of the child’s condition, the risks associated with the recommended healthcare or ambulance service and the potential consequences if the healthcare or service is not provided. If the disagreement as between the parents remains unresolved, the clinician is encouraged to seek advice.

If the parents of the child are themselves under 18 years of age, and have sufficient capacity to make the decision, the parents can provide consent.^[34]

Clinicians are encouraged to consult with the QAS medical practitioner if there are any concerns regarding a parent’s capacity to make decisions for their child.

Grandparents and others

Grandparents, step-parents, de facto partners of a biological parent, siblings or others who may be caring for a child do not have legal authority unless they have been appointed as the child’s legal guardian.

Children placed in care

Under the *Child Protection Act 1999*, a child or young person can be placed in out-of-home care with either a foster parent or a kinship carer under a child protection order. In these circumstances, the foster parent or kinship carer will be granted either ‘guardianship’ or ‘custody’.^[35]

The nature of the care arrangements will determine the level of authority which the carer has in relation to decisions about healthcare for the child or young person. A person granted ‘guardianship’ has full parental responsibilities including the authority to make decisions regarding healthcare for the child or young person. A person granted ‘custody’ has the responsibility for managing the child’s daily care, which would include seeking ambulance services in response to an acute incident however it may not extend to include decisions about long term healthcare.

How to assess if a child or young person has capacity to provide consent – Gillick competent

When assessing a child or young person’s capacity to make a decision regarding healthcare and ambulance services, the following factors should be considered:^[30]

- the age of the child or young person (the older the child the more likely he or she will be able to understand and consent);
- the child or young person’s level of maturity and emotional development;
- the child or young person’s level of education and intellect;
- the child or young person’s social and family circumstances;
- the clinical circumstances and the nature of the child or young person’s physical and emotional condition;

- the complexity of the healthcare or ambulance service that is recommended;
- the risks associated with the healthcare or ambulance service and the consequences if the healthcare or service is not provided; and
- if the child or young person understands the nature of his or her condition, the healthcare or ambulance service that is recommended, the risks associated with the recommended healthcare or service, and the potential consequences if the recommended healthcare or service is not provided.

As with adults, the more serious the consequences or potential consequences associated with the recommended healthcare or ambulance service, or a decision to decline the healthcare or service that is recommended, the greater the level of understanding that is required. In circumstances where this may arise, it is strongly recommended that the paramedic consult with the QAS medical practitioner.

Can a child or young person refuse healthcare or ambulance services?

If a young person is Gillick competent and can consent to healthcare or ambulance services, the young person can also refuse the healthcare or ambulance services that are recommended.

In circumstances where the decision to refuse ambulance services is contrary to the best interests and wellbeing of the young person, and may result in a significant risk to the life or health of the young person, the clinician is required to consult with the QAS medical practitioner in relation to both the young person’s capacity to refuse ambulance services, and the young person’s decision to do so.

Introduction to Culturally Responsive Healthcare



Queensland is a culturally diverse state with 20.5% of Queenslanders born overseas and 9.8% speaking a language other than English at home.^[1] With such diversity, clinicians must be cognisant of their responsibilities when responding to patients from a diverse range of religions, cultures and spiritualities.

The QAS acknowledges that cultural and religious groups are not homogenous but rather dynamic and forever changing. As such, the following recommendations provide general information only and clinicians are encouraged to seek further information from each patient.

Spiritualities covered in the guidelines include:

- Aboriginal and Torres Strait Islander patients
- Hindu patients
- Muslim patients
- Sikh patients

These guidelines do not necessarily reflect the views of all Aboriginal and Torres Strait Islander, Muslim, Hindu and Sikh patients. They are not intended nor should they be relied upon as a substitute for further assessment of the patient.



Aboriginal and Torres Strait Islander Patients

The QAS acknowledges Aboriginal and Torres Strait Islander peoples as the Owners and Custodians of this country and pay respect to Elders past, present and future.

Aboriginal and Torres Strait Islander people should be warned that the following guidelines refer to the sensitive issue of death and dying.

As part of the QAS Aboriginal and Torres Strait Islander Cultural Capability Action Plan 2019–2022, the following guidelines have been written to enable clinicians to develop knowledge and behaviours needed to provide culturally responsive healthcare to Aboriginal and Torres Strait Islander people. This forms part of the Australia-wide focus aimed at decreasing the gap between Indigenous and non-Indigenous Australians.^[2]

The Meaning of Illness and Pain

For Aboriginal and Torres Strait Islander people, health is a holistic concept that is made up of “*not just the physical well-being of the individual, but the social, emotional, and cultural wellbeing of the whole community. This is a whole-of-life view and it also includes the cyclical concept of life-death-life*”.^[3]

For Aboriginal and Torres Strait Islander people, the meaning of illness and pain incorporates broader issues of social justice, equity and rights of the whole community. Health and wellbeing is interconnected with:

- Culture and spirituality
- Family and community kinships
- Historical, social and economic events
- Intergenerational loss and;
- Connection to land.^[4]



Paramedics must be respectful of these considerations as part of the QAS commitment to provide responsive and culturally appropriate health care to Aboriginal and Torres Strait Islander people.



An Aboriginal and Torres Strait Islander perspective of mainstream health

For many Aboriginal and Torres Strait Islander people, mainstream health services are feared and avoided. This is a result of decades of discrimination, poor treatment and a lack of culturally appropriate services.^[5] It may also be out of fear of:

- Being separated from kin and social networks
- Being taken to an unfamiliar environment
- Fear of the unexplained/not understanding
- Distrust for mainstream institutions and people in uniform.^[6]

Common problems experienced by Aboriginal and Torres Strait Islander people when using mainstream health services include:

- Being judged based on their looks
- Being spoken to in a patronising or condescending way
- Being blamed for their poor health
- Feeling intimidated around people in uniform and/or medical professionals
- Not understanding the terminology used by health care providers
- Not understanding hospital procedures or the treatment they are receiving
- Health providers failing to acknowledge cultural and spiritual concepts of health and wellbeing
- Perceiving hospital as a place people go to die.^[7,8]

Tips for paramedics:

- Be aware of and sensitive to the cultural beliefs of Aboriginal and Torres Strait Islander people.
- Explain that all information they provide will assist their treatment.
- Building genuine relationships is an important step in gaining acceptance by members of Aboriginal and Torres Strait Islander communities and a subsequent willingness to seek help from QAS.

Coping with pain

For Aboriginal and Torres Strait Islander patients, pain is often under-assessed and poorly managed due to cultural differences and misunderstanding of pain behaviours. Some Aboriginal and Torres Strait Islander patients are reluctant to express their pain. This may be due to:

- The association they make between pain and past colonial and segregation policies.
- Breaking Aboriginal lore (law) which brings shame to the patient and their community.
- 'Nonsense questions'. For example, if a patient has a broken leg, asking them '*are you in pain*' is considered a 'nonsense question' because they are highly likely to be in pain. An alternative to this question could be to say '*I can see you are in pain*', before continuing on with a more detailed pain assessment.
- The use of westernised numerical scales or visual tools to undertake an accurate pain assessment may not be understood by some Aboriginal and Torres Strait Islander people, particularly if English is not their first language.^[7]

To assist in the assessment of a patient's pain, paramedics should look for non-verbal indicators such as:

- Minimal speaking
- Lying on their side not wanting to face the paramedic or give any eye contact
- Turning their head away when asked questions by a clinician
- Hiding under their blanket
- 'Centering'. This can be interpreted as simulated sleeping and is a process that involves drawing into one's self spiritually and psychologically to block out the pain
- Lying completely still, wincing or grimacing, crying, head shaking or clucking of the tongue.^[9,10]

Barriers to Communication

Due to the historical and cultural differences between Indigenous and non-Indigenous Australians, clinicians need to be aware of possible communication barriers specific to Aboriginal and Torres Strait Islander patients.

Men's and Women's Business

Men's and women's business is distinctively separate. Where possible, patients should be treated by clinicians of the same sex. If this is not possible, permission should be sought from the patient and community before the patient is treated.^[11]

Shame

The concept of shame plays a significant role in Aboriginal and Torres Strait Islander culture and may be a barrier to seeking help.

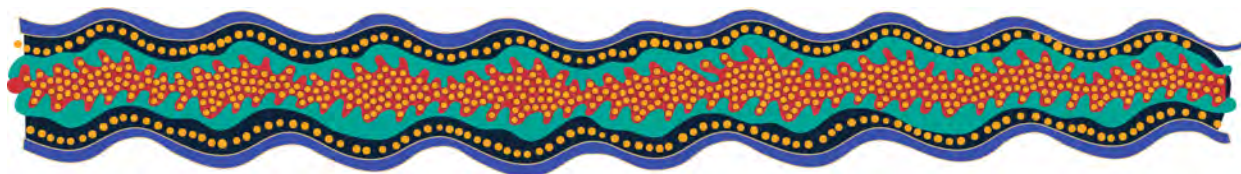
Shame may result from:

- Embarrassment
- Feeling disrespected
- Rudeness from others
- A breach of Aboriginal and Torres Strait Islander cultural norms or lore
- Talking about sensitive topics, particularly to a clinician of the opposite sex
- Not understanding the medical matters being discussed.^[7,12,13]

The Care Taker

The structure of Aboriginal and Torres Strait Islander society is based on a system of kinship. This defines where a person fits into their community as well as their rights, obligations and responsibilities.^[14] As such, the healing process of a patient often involves not just the individual, but the entire community. This is based on the belief that the community's health and wellbeing is determined by the health of each individual in the community, combined. Clinicians should consider the benefits of using communication strategies that involve the family or community, not just the individual. Some Aboriginal and Torres Strait Islander people also believe that illness 'takes over' a person. This will often excuse the patient from talking or relaying information to others. To compensate, a community member may relay information to clinicians on behalf of the patient.^[11]





Language

It should not be assumed that all Aboriginal and Torres Strait Islander people speak or understand English or that English is the dominant language spoken.^[11] Regardless, Aboriginal and Torres Strait Islander people generally view communication as a two-way process with the questioner and questioned both contributing information. As such, Aboriginal and Torres Strait Islander people tend to use stories or ‘talk around’ the topic to get a point across. With this in mind, clinicians should avoid ‘interrogational’ questions that require yes/no answers.^[15]

Tips for Paramedics:

- Explain why you need the information you are requesting.
- Avoid asking multiple questions in one sentence.
- Consider using empathetic, reflective and paraphrasing communication techniques.
- Allow the patient to deliberate rather than make immediate and quick decisions.
- Allow for moments of silent contemplation – this is a normal part of Aboriginal and Torres Strait Islander culture.
- Do not ask the person to continually repeat themselves as this can cause offense.
- Be honest and do not make commitments you cannot keep.^[10,15]

Social Etiquette and Greetings

Handshaking

Handshakes are not given in all communities. When they are, they are sometimes only given between people of the same sex. Clinicians should follow the lead of the community and only accept a handshake if offered by another person.

Touching

Physical contact is not always allowed and should be particularly avoided during times of death. As physical touch is required to treat patients, paramedics should explain the need to touch the patient, including why, where and how. Ask the patient if they would like a support person present and where possible, organise for a clinician of the same sex to undertake the treatment.

Eye contact

Direct or prolonged eye contact is considered by some Aboriginal and Torres Strait Islander people as staring and therefore intrusive, rude or aggressive. To show respect, Aboriginal and Torres Strait Islander people will lower their eyes. Clinicians should avoid eye contact until the person being treated or spoken to acknowledges and provides eye contact.

Nodding or Saying ‘Yes’

When Aboriginal and Torres Strait Islander people nod or say ‘yes’, it is often to show that they are listening and to demonstrate respect. In some instances, it may also be a way of patients pretending to understand because they are uncomfortable and want the conversation to be over.

Personal Space

Be conscious about the distance to which you are standing or sitting next to a patient. Standing too close to a patient may make them feel uncomfortable or threatened, particularly between people of the opposite sex.^[16]

Medication and Treatment

Whilst the introduction of Western medicine has changed the way many people understand and treat health, the role of traditional medicine is still of great significance for some Aboriginal and Torres Strait Islander people. Clinicians should be mindful of the importance of natural remedies (bush medicine) and consider the role this might play in how they care for and treat patients from an Aboriginal or Torres Strait Islander background.^[17] If a clinician suspects a patient might be using bush medicine, asking questions regarding this is an important step in building rapport, gaining trust and showing that you acknowledge the important role traditional medicine plays in the healing process for many Aboriginal and Torres Strait Islander people.

Tips for Paramedics:

- Ask the patient if, what and for how long they have been using traditional medicine and consider its clinical significance in your assessment and treatment of the patient.
- Ensure that the use of traditional medicine by the patient is recorded in the eARF.

Mental Health

For many Aboriginal and Torres Strait Islander people, mental health is determined by a combination of social and cultural determinants, spanning past, present and future. For example:

Social Determinants	Cultural Determinants
Historical/past events	Connection to land
Death of family and community members	Kinship
Substance and/or alcohol abuse	Ancestry
Education, employment, income, housing	Connection to community
Illness and disability	Connection to spirit

To ensure the provision of culturally responsive healthcare, clinicians should consider how Aboriginal and Torres Strait Islander traditions, customs and belief systems regarding mental health might inform the type of treatment, care and support that should be provided by paramedics.

The role of a traditional healer and the acting out of cultural rituals and customs is an important part of this process. Clinicians should be aware of these traditional and generally preferred methods of treatment for a mentally ill patient. For example:

- Advocacy, practical advice and guidance through yarning (talking) with immediate family
- Assistance from community and Elders
- Referring patients to a traditional healer for spiritual assistance
- The patient returning to their country to make a spiritual reconnection with the land.^[18,19,20]





Death, Bereavement and Mourning (Sorry Business)

For many Aboriginal and Torres Strait Islander people, death is not feared, but rather a time when a person's spirit is released to the Dreaming and returned to its sacred place in traditional country. The time before and after death involves a variety of customs, rituals and beliefs and is all part of the grieving process known as Sorry Business. In some instances, the entire community will shut down and a time for mourning will take precedent over all other community matters.

Paramedics should be aware that:

- Some Aboriginal and Torres Strait Islander people will engage in traditional practices to identify those who have passed.
- In many communities, it is taboo to mention the name of a deceased person. It is believed that if you mention a deceased person's name, you are calling the spirit back to the world. A substitute mourning name may be given.
- In Torres Strait Islander culture, a relative will assume the role of 'Marigeth' (Spirit Hand). This person supports the grieving family by caring for their needs, informing family of the person's passing, coordinating funeral arrangements and being the family spokesperson.
- Aboriginal and Torres Strait Islander people do not like being touched by strangers, particularly during Sorry Business. If you wish to express your condolences, saying 'sorry' (normally without eye contact) is most appropriate.
- Loud mourning, sorry cuts (cutting of the skin) and seeing/talking to spirits and totems is a normal and culturally significant part of Sorry Business. It should generally not be seen as a form of self-harm or mental illness.
- The family of a deceased patient may request a lock of hair or nail clipping from the deceased person's body.
- Some Aboriginal and Torres Strait Islander people believe that death does not result from natural causes, but is caused by another person. This may lead to retaliation.^[11]

Hindu Patient



Overview

The Hindu faith is the world's third largest religion. It follows the understanding that:

- The universe is God's creation and everything in the universe is God
- Each person is intrinsically divine and the purpose of life is to seek and realise the divinity within
- Hindus follow an ethical code of conduct that values truth, love, peace and non-violence
- Hinduism does not rigidly impose beliefs and practices on an individual
- There are hundreds of diverse sects and no central doctrine authority.

As the Hindu faith places responsibility on the individual to practise his or her religion, levels of practice will vary. There are also personal and cultural variations that will need to be considered. Because of this, it is important that paramedics consult the patient about their personal level of religious observance and practice.^[21]

Coping with Pain

Paramedics should consider the possible role of religion and culture in shaping a Hindu patient's perception and acceptance of pain. For example, a central belief of the Hindu faith is the concept of karma. This is the belief that every thought, word and action influences one's life. Some Hindus consequently accept pain and illness as part of karma.^[22]

Social Etiquette and Greetings

Hands

Some Hindus regard the left and right hand to serve different functions. The left hand is used for cleaning and the removal of dirt and the right hand for touching other people, waving, eating and handling items.

Handshaking

Handshaking normally only takes place between two people of the same sex. Handshakes are generally gentle rather than firm. As an alternative to handshaking, some Hindu people may clasp their hands together or hold their hands in a prayer position and bow.

Touching

When attending to a patient, some women may prefer to be cared for by a clinician of the same sex. Some may also wish to have a family member present.^[21,23]

Entering a Patient's Home or Place of Worship

It may be preferred for hats and shoes to be removed prior to entering temple buildings, prayer rooms and a Hindu's home. This stems from the belief that wearing footwear inside is unhygienic and disrespectful. Due to work place health and safety requirements, clinicians are required to keep their shoes on. Clinicians should discuss this sensitivity with the patient and family.^[24]



Items of Religious Significance

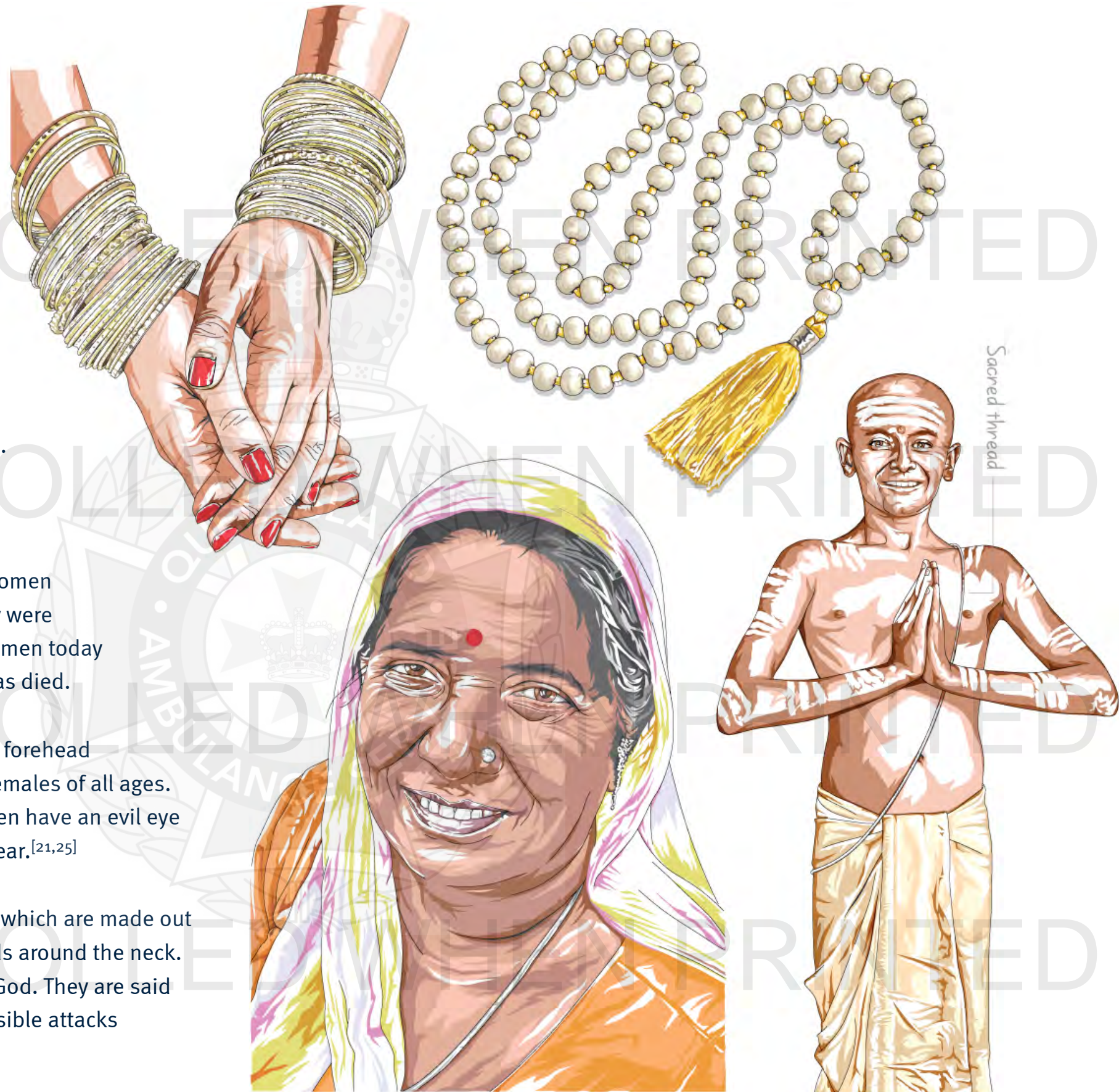
If the situation allows and a patient is wearing any of the below items of religious significance, clinicians should talk to the patient about any religious protocols or sensitivities that they should be mindful of whilst treating the patient.

Sacred thread: A sacred thread (normally white) is sometimes worn by Hindu boys and men. It passes across the heart, from the left shoulder to the right hip. A black thread, which is normally worn around the waist, is worn to ward off bad spirits.

Necklace/glass bangles: Traditionally, Hindu women wore a necklace or glass bangles to signify they were married. These are still worn by some Hindu women today and are not to be removed until her husband has died.

Bindi: A bindi is a round marking placed on the forehead between the brows and is worn by males and females of all ages. It is used to ward off bad spirits. Babies will often have an evil eye drawn onto their forehead, wrist or behind the ear.^[21,25]

Tulsi beads: Hindus may wear Tulsi neck beads which are made out of wood. They are normally worn in three strands around the neck. Tulsi beads symbolise a person's surrender to God. They are said to protect from bad dreams, accidents and possible attacks by weapons.



Medication and Treatment

Some Hindus practise traditional medicine as an alternative to, or in conjunction with Western medicine. If a paramedic suspects a patient might be using traditional medicine, asking questions regarding this is an important step in gaining a better understanding of the patients needs in light of their religion and/or culture.

Additionally, some Hindu's believe that relatives of an ill person have a duty to devote as much time as possible to care for them. This coincides with the belief that the elderly should be cared for by their sons, daughters and younger members of the extended family.^[25] Clinicians should consider the benefits of using communication strategies that involve the family, not just the individual.

Mental Health

Depending on the person, some Hindus regard mental health as a taboo subject that should not be discussed. For some Hindus, mental illness is considered to be:

- An imbalance of the mind, body and soul
- An absence of inner peace
- A result of past and current life actions (karma)

To ensure an accurate assessment of a patients mental health needs, clinicians need to be aware of the spiritual connection that some Hindu patients may bring to their understanding of mental health. For example, some Hindus believe in concepts such as witchcraft, spirit possession and the evil eye.^[26]

**Whilst clinicians should be aware of these beliefs, most Hindus are open to seeking clinical treatment when required. It may or may not be preferred for this to take place in conjunction with traditional healers/medicine.*



Death, Bereavement and Mourning

Hindus commonly believe that death and dying is an inevitable part of one's life based on the concept of rebirth and reincarnation. As per the Hindu scripture, the Bhagavada Gita 2.20, *"...the soul there is neither birth nor death at any time. He has not come into being, does not come into being, and will not come in being. He is unborn, eternal, ever-existing and primeval. He is not slain when the body is slain"*.^[27]

As with all religions and cultures, the way in which patients and/or family responds to death will vary. In traditional Hindu culture:

When a patient is nearing death:

- Pre-death rituals may be requested by family
- Some patients may prefer to be placed on the floor to be closer to earth.

When a patient has died:

- Upon dying, the patients family and/or religious leaders should be contacted immediately
- Public demonstration of grief is uncommon
- Modesty remains important after death. If needed, the deceased should be handled by someone of the same sex, with modesty and dignity.
- If the situation allows, none of the items of religious significance should be removed from the patient.^[21,24]



Muslim Patient

What is Islam?

Islam is based on the revelations from Allah (God) to the Prophet Muhammad 1400 years ago and is the world's second largest religion.

It follows the understanding that:

- There is only one God
- Islam translates to mean '*submission to the will of Allah*'
- There are five pillars of Islam. These include: *declaration of faith, five daily prayers, fasting, charity and pilgrimage to Mecca*
- The sacred text is the Quran
- The preservation of life overrides all guidelines presented below

As Islam places responsibility on the individual to practise his or her religion, levels of practice will vary. There are also personal and cultural variations that will need to be considered. Because of this, it is important that paramedics consult the patient about their personal level of religious observance and practise.^[28]

Coping with Pain

Muslims tend to believe that ill health and subsequent pain is predestined by Allah. Muslim's are encouraged to put their trust in God and express thankfulness for whatever illness God has decreed upon them. Seeking medical aid does not negate a Muslim person's commitment or trust in God but is rather encouraged as a means of preserving life.^[29]

Social Etiquette and Greetings

Handshaking

Some Muslims prefer not to shake the hand of a person from the opposite sex, unless that person is related.

Hands

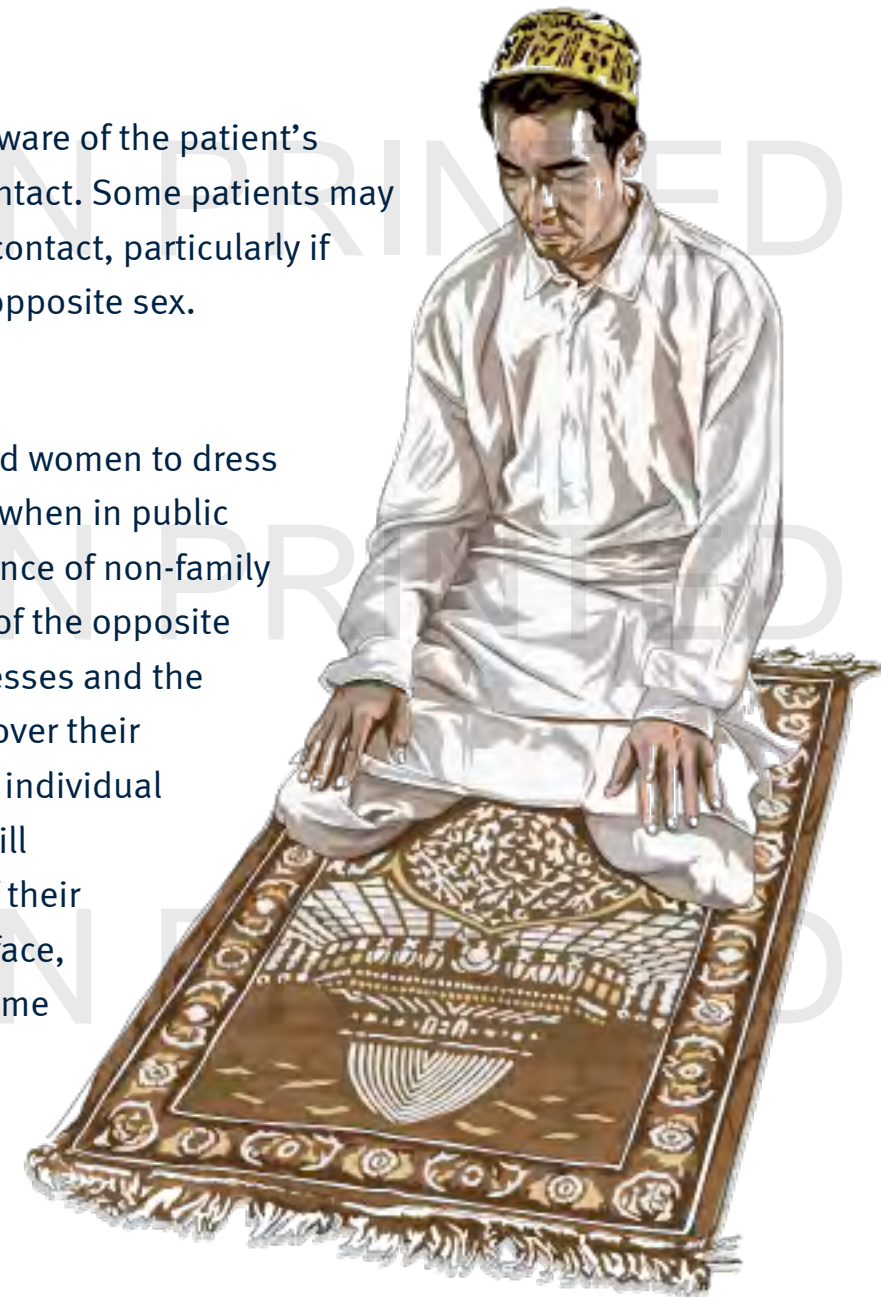
Some Muslims regard the left and right hands to serve different functions. The left hand is used for cleaning and the removal of dirt and the right hand for touching other people, waving, eating and handling items.

Eye contact

Clinicians should be aware of the patient's preferences for eye contact. Some patients may prefer not to give eye contact, particularly if the clinician is of the opposite sex.

Modesty

Islam requires men and women to dress modestly, particularly when in public and when in the presence of non-family members and people of the opposite sex. How a Muslim dresses and the extent to which they cover their body is decided on an individual basis. Some women will not expose any part of their body other than their face, hands and feet and some men will not show the skin between their navel and knees.^[23,28]



Tips for paramedics

- Organise for the patient to be treated by a paramedic of the same sex.
- If a male paramedic must treat a female patient, a member of the patient's family should be present.
- Consider if it is possible to do the examination without having to remove clothing.
- If possible, ensure that the patient is not exposed to members of their family or the public.

Entering a Patient's Home or Islamic Place or Worship (Mosque)

Prior to entering a mosque, shoes are removed and women cover their heads. Similar practises may be followed when entering a Muslim persons home. Due to workplace health and safety, clinicians are required to keep their shoes on and should discuss this sensitivity with the Imam (mosque leader) or members of the household.^[28]

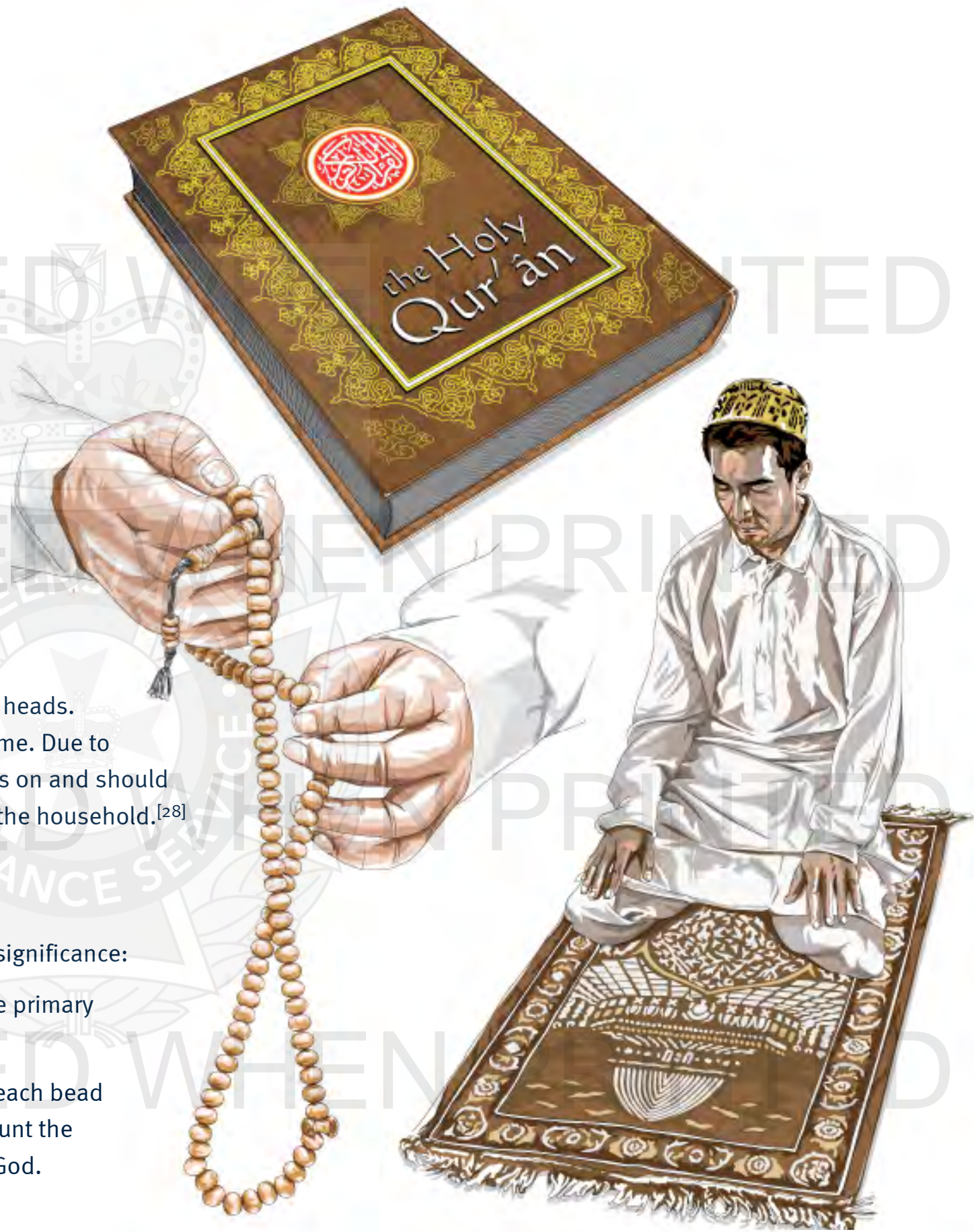
Items of Religious Significance

Listed below are items considered by many Muslims to be of religious significance:

The Quran: The Quran is the principal text of the Islamic faith and is the primary source of every Muslim's faith and practise.

Prayer beads: Prayer beads are normally comprised of 99 beads, with each bead representing the ninety-nine names of Allah. Beads help the user to count the number of times they have read certain verses in the remembrance of God.

Prayer mat: Prayer mats are used to kneel on when praying.^[28]



Medication and Treatment

For some Muslims, illness and pain is Allah's will and a way for them to atone their sins as part of spiritual enrichment. Despite this, the preservation of life overrides all Islamic religious guidelines, rules and restrictions. When required, medication and treatment is generally accepted.^[28]

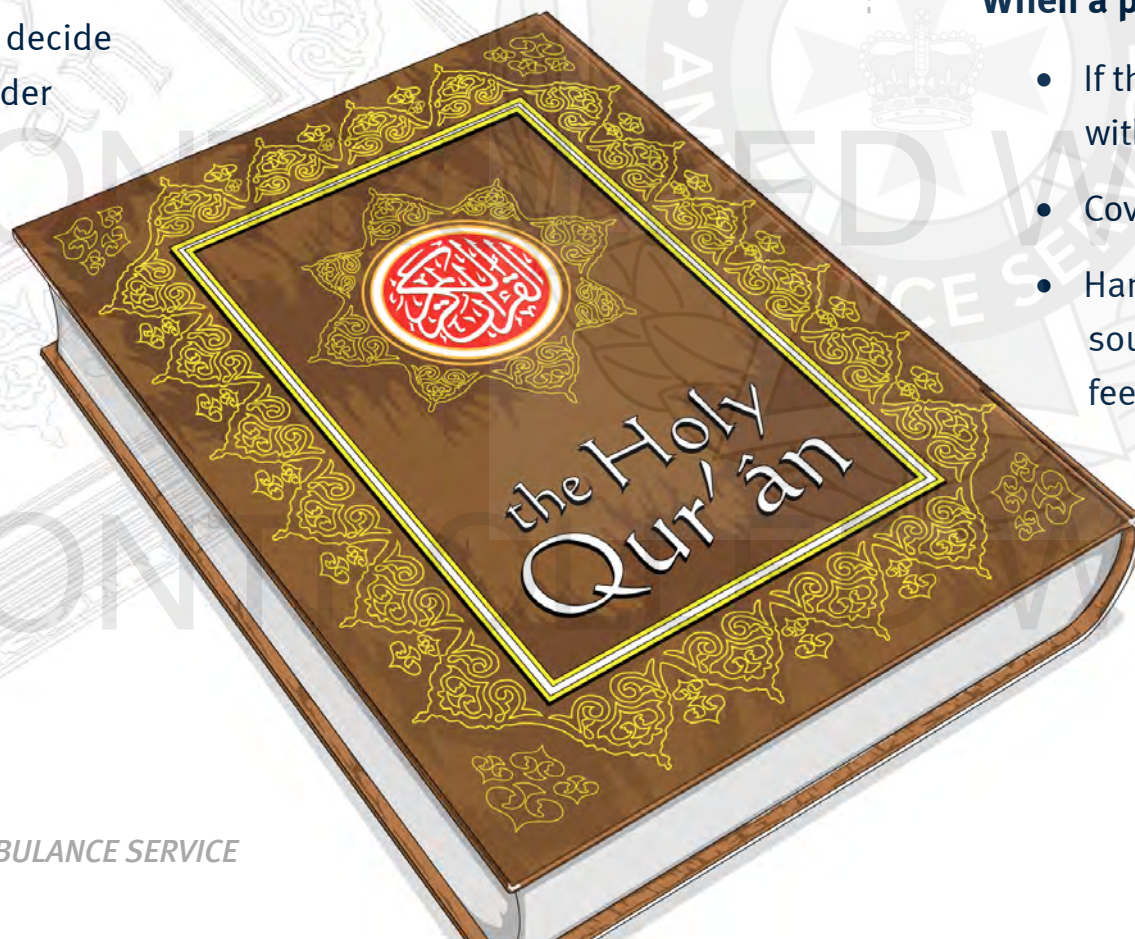
Mental Health

For many followers of Islam there is a strong cultural stigma attached to mental illness. It is often said to be caused through spirit possession, bewitchment or looking at people with an evil eye.

As such, patients may be reluctant to access health services and instead, seek assistance through religious avenues. Clinicians should be aware of the following religious-based coping strategies used by some Muslims:

Seeking advice

Some patients may decide to approach the leader of their mosque (Imam) for advice relating to the teaching and principles of the Quran and how it can assist them in dealing with their illness.



Traditional healer

A traditional healer is used when an individual believes mental illness is a result of being possessed by spirits. The traditional healer will exorcise the spirit through reading the Quran, praying, burning frankincense or through herbal remedies.^[30,31]

Death, Bereavement and Mourning

As with all religions and cultures, the way in which Muslim patients and/or family responds to death will vary. In traditional Islamic culture, death is a natural process of life that is predestined by God. According to the Quran, *"We belong to God and to Him we shall return."*^[32]

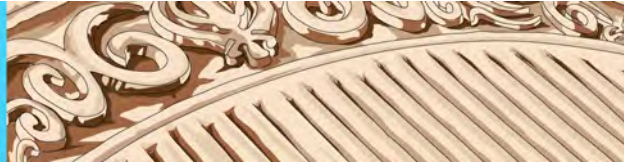
When a patient is nearing death:

If death is imminent, the family may wish to perform customary rituals. This might involve sitting next to the patient's bed and reading the Quran and praying to Allah to ask for the peaceful departure of the soul.

When a patient has died:

- If there is no family on scene, consider contacting a mosque within the local area and ask for a religious leader to attend.
- Cover the body and face with a clean sheet.
- Handle the body as little as possible. Muslims believe that the soul remains with the body until buried and can consequently feel any pressure applied to it.
- Rule of modesty still applies after death. If possible, the deceased should be handled by a paramedic of the same sex.
- Upon dying, public grief is allowed for three days. Following this, many Muslims will remain stoic and show little emotion. This stems from the belief that death is predestined by God and should not be opposed.^[50]

Sikh Patient



What is Sikh?

The Sikh faith was founded in the 15th Century in northern India by Guru Nanak Dev Ji and is the world's fifth largest religion. It follows the understanding that:

- There is only one God
- The soul goes through cycles of birth and death (reincarnation). The ultimate goal is to destroy this cycle and achieve salvation and unite with God
- Sikh's follow the 'Saint-Soldier' concept which comes from the core beliefs of constant meditation and remembrance of the Creator, the importance of earning a living through honest hard work, and the importance of justice and freedom for all
- Sikh's do not believe in ritualistic worship, such as fasting, performing pilgrimage, superstitions or worshipping of idols and/or the dead
- The Sikhs have 10 Gurus (Spiritual Teachers) and the Holy Scriptures (Sri Guru Granth Sahib Ji) as their Perpetual Guru.

As the Sikh faith places responsibility on the individual to practise his or her religion, levels of practice will vary. There are also personal and cultural variations that will need to be considered. Because of this, it is important that clinicians consult the patient about their personal level of religious observance and practise.



Coping with Pain

Accurate pain assessment and management is dependent upon paramedics being aware that different people experience pain in different ways. Clinicians should consider the possible role of religion in shaping a Sikh patient's perception and acceptance of pain.^[33]

Social Etiquette and Greetings

Handshaking

Handshaking normally takes place between males. Some females may prefer to greet a male in the traditional way, which is to fold hands in the prayer position and lightly bow the head.

Touching

When attending to a patient, some women may prefer to be cared for by a paramedic of the same sex. In a situation where a woman is grieving someone's death, some women may only prefer for a close family member to touch her.

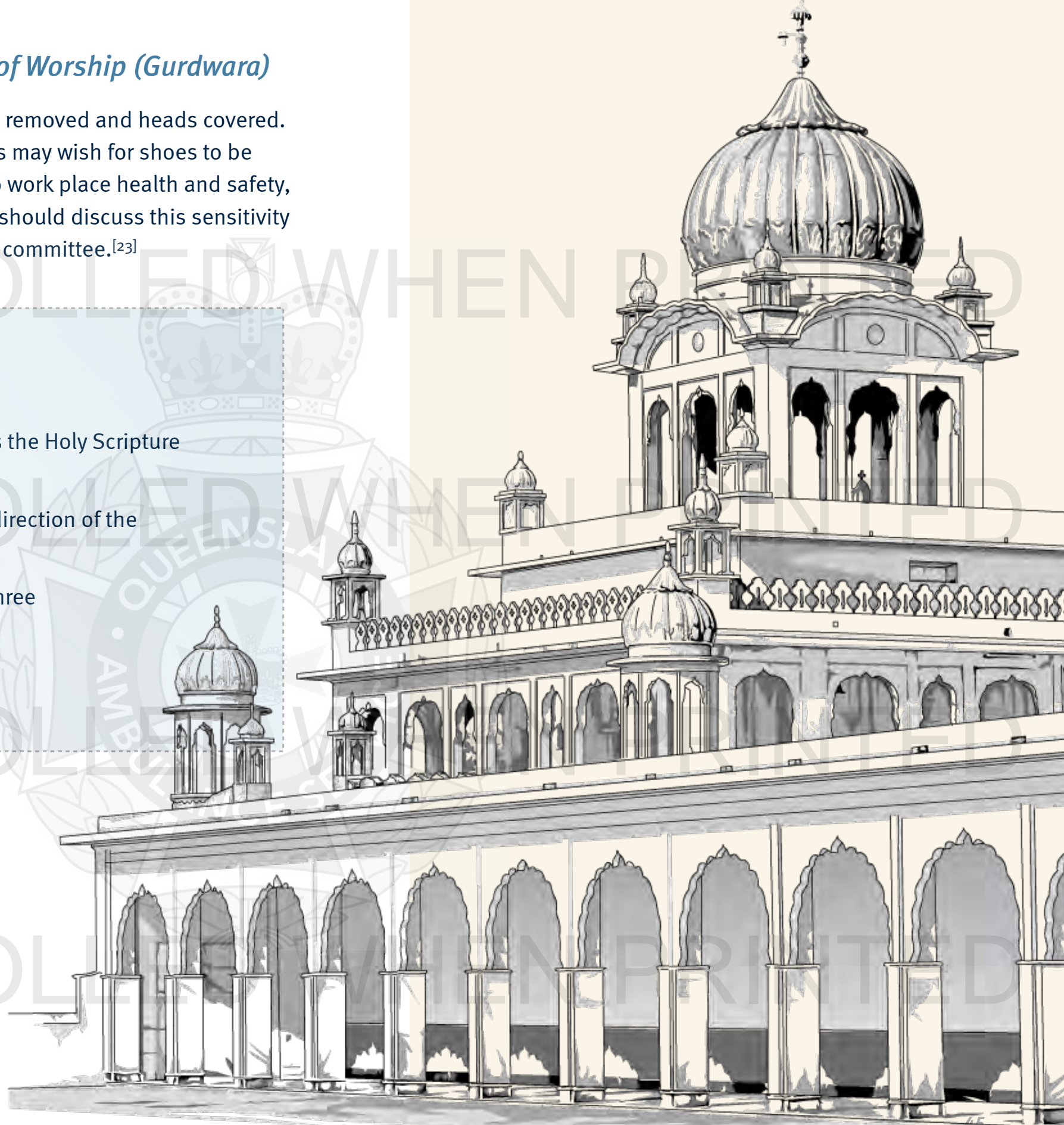
In addition, the turban is sacred and where possible, should not be touched. If the head needs to be touched for treatment purposes, explain this to the patient and ask for permission before removing their turban. Place the turban on the patient's lap or if lying down, stomach. Under no circumstance should the turban be placed on the floor.^[23]

Entering a Patient's Home or Sikh Place of Worship (Gurdwara)

Prior to entering the Gurdwara, shoes are normally removed and heads covered. Similarly, when entering a household the residents may wish for shoes to be removed if any scriptures are housed there. Due to work place health and safety, clinicians are required to keep their shoes on and should discuss this sensitivity with the Gurdwara priest (granthi) or management committee.^[23]

Tips for paramedics

- Upon entering the Gurdwara, bow towards the Holy Scripture to acknowledge their presence.
- Do not turn your back or point feet in the direction of the Holy Scriptures.
- Sensitivities should be considered in all three places of worship within the Gurdwara. These include the prayer hall, dining hall and kitchen.



Items of Religious Significance

If the situation allows and a patient is wearing any of the below articles of faith, talk to the patient about any religious protocols or sensitivities that paramedics should be mindful of before touching or removing them.

Sikhs who have been baptised are required to wear five articles of faith (also known as the 'five K's') at all times.

Kesh (uncut hair): Men and women believe that hair is a divine gift from God and should not be cut. Uncut hair (over all parts of the body), shows a willingness to accept God's gift as was intended. It is a symbol of courage, loyalty and commitment.

Kanga (wooden comb): Sikhs are required to use the Kanga to comb their hair twice a day to ensure cleanliness of the body and mind. This is based on the belief that hair should be cared for properly as it is a gift from God and the medium for enlightenment.

Kara (steel band): The Kara serves as a reminder to keep ones consciousness with God at all times and remain committed to carrying out actions that are righteous and in line with the teachings of the Guru.

Kirpan (sword): The Kirpan represents the importance of fighting injustice and oppression. This forms part of serving, protecting and respecting the freedom and good will of others.

Kachera (undergarment): The Kachera serves as a symbol of chastity and a person's commitment to controlling lust and maintaining modesty.^[33]



Medication and Treatment

Many Sikhs practise traditional medicine as an alternative to or in conjunction with the biomedical treatment options favoured by mainstream health services.

In addition to this, many Sikh's believe that relatives of an ill person have a duty to devote as much time as possible to caring for them. This coincides with the belief that the older person should be cared for by their sons, daughters and younger members of the extended family.^[29]

Mental Health

Depending on the person, some Sikhs regard mental health as a taboo subject that should not be openly discussed, particularly among family and members of the Sikh community. Clinicians should be mindful of the possible sensitivities regarding mental illness and consider the following religious-based coping strategies that take into account the teachings of the ten Gurus and the fundamental beliefs of the Sikh faith.

Sewa

Sewa is defined as 'selfless service'. It focuses on engaging in community volunteering without reward or personal benefit.^[36]

Some Sikh's believe that the act of Sewa can assist in a person's mental health and wellbeing by:

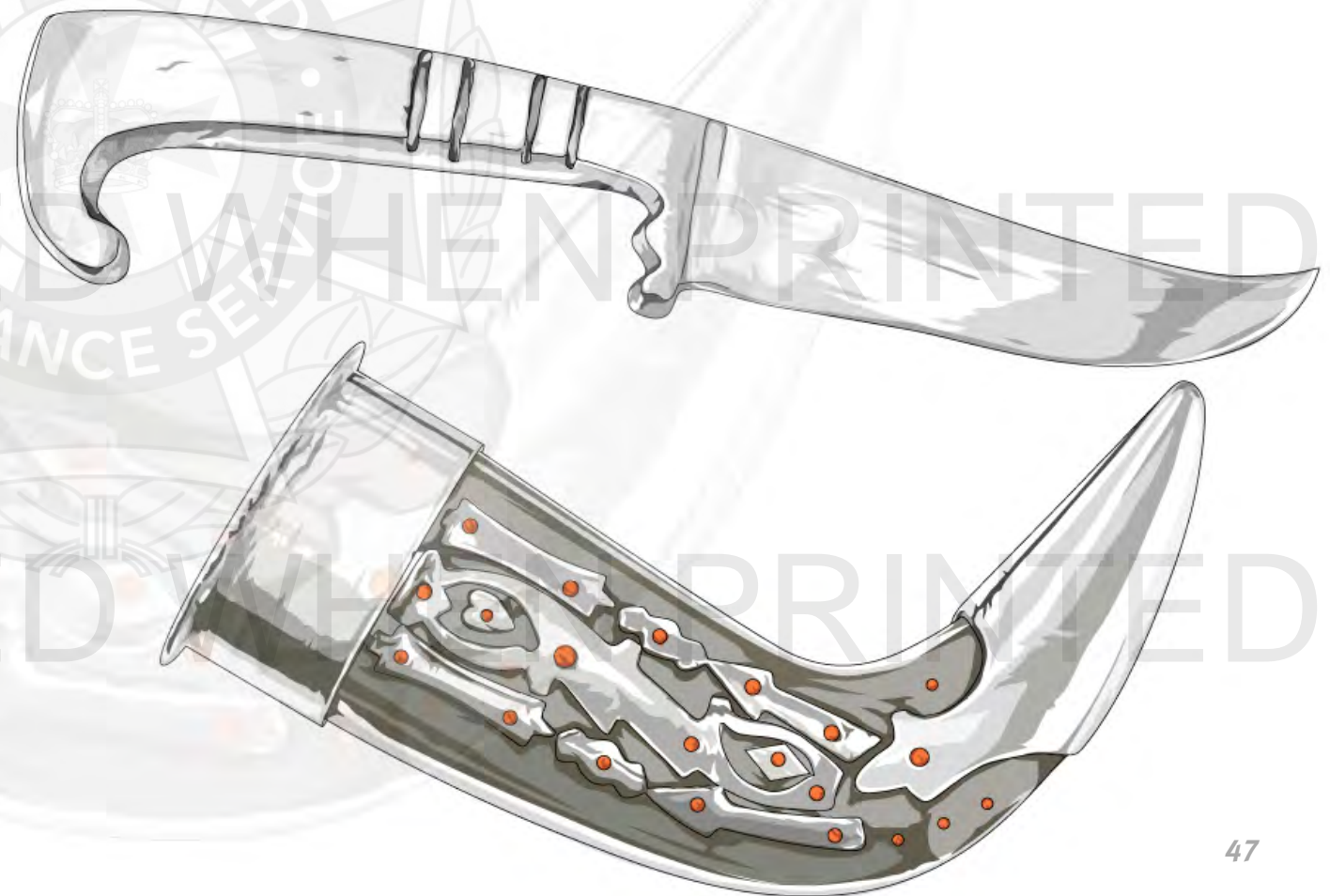
- Providing the patient with an opportunity to connect to social networks and engage with others
- Contributing to the moral uplifting of the person^[37]
- Contributing to a sense of purpose
- Helping a Sikh feel more engaged and closer to the Sikh faith.

Simran

Simran refers to meditation and/or prayer. A patient may benefit from prayer because it can assist in:

- Helping the person be in the present moment, letting go of the past and minimising feelings of anxiety
- Finding peace and value in life.^[34]

**Whilst these non-pharmacological approaches to treating mental illness should be considered by paramedics as a possible point for discussion with patients, most Sikh's are open to seeking clinical treatment when required.^[57]*



Death, Bereavement and Mourning

As with all religions and cultures, the way in which patients and/or family responds to death will vary. In traditional Sikh culture:

When a patient is nearing death:

- A family may wish to recite prayers or read religious scriptures to the patient
- The patient may be given Holy water to sip
- The family may want a Granthi (Sikh priest) to attend and recite a prayer.

When a patient has died:

- Paramedics should not remove any of the five articles of faith or the turban after death
- The family of the deceased should be contacted immediately and asked by paramedics if there are any religious considerations that need to be taken into account
- The family may wish for a close relative or Granthi (Sikh priest) to arrive and conduct a prayer or pay respect before the body is moved
- The family may wish to wash and clothe the body immediately after death
- The body should be covered with a clean sheet
- Paramedics should be mindful that only family members tend to touch a Sikh woman when she is grieving someone's death
- Men and women may sit separately during times of mourning.^[35]



Understanding Domestic and Family Violence (DFV)



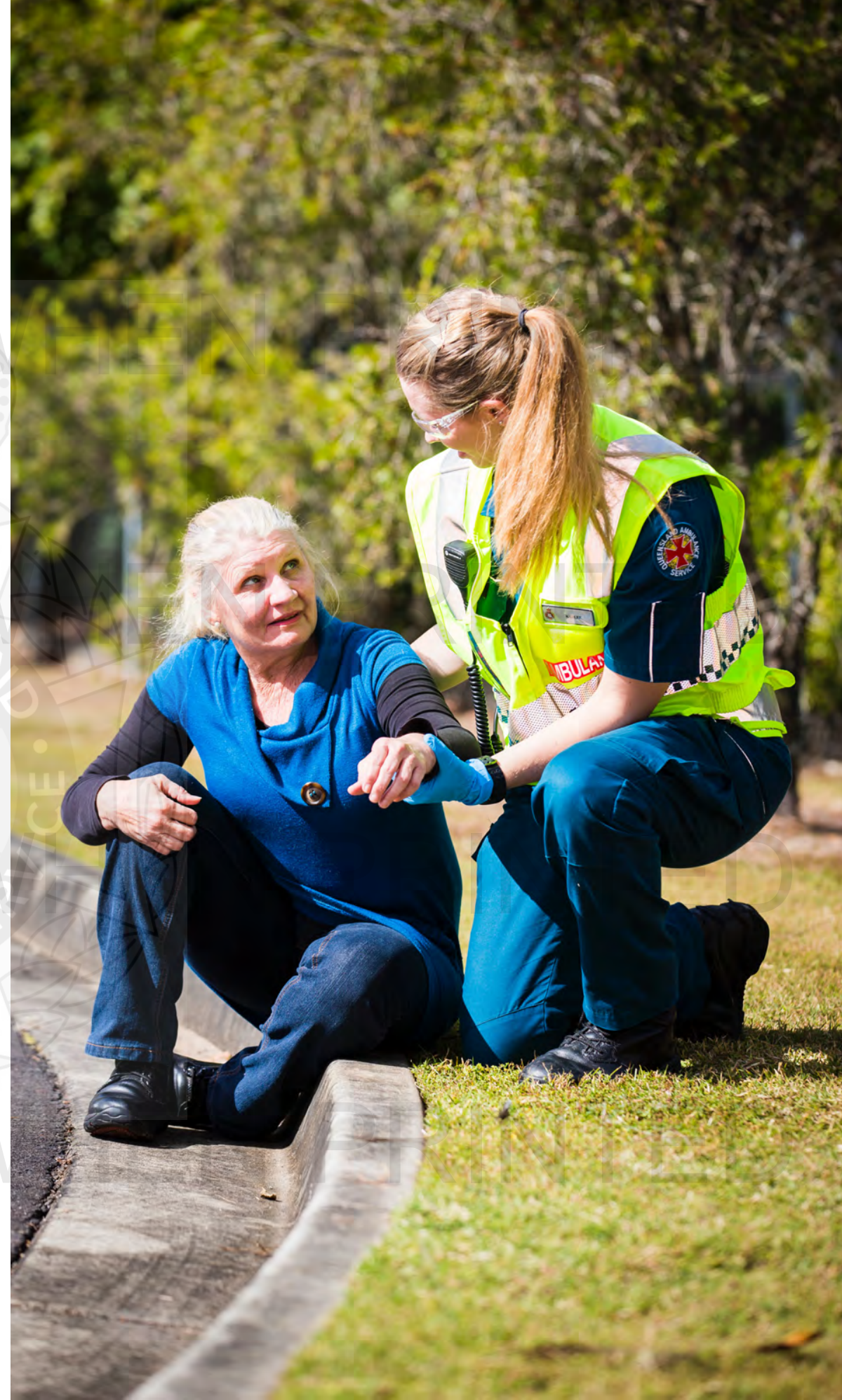
The 'Not Now, Not Ever: Putting an End to Domestic and Family Violence in Queensland' Report released on 28 February 2015 made recommendations for the QAS and the Queensland Police Service (QPS), that both services will be expected to provide further DFV information to victims with the objective of protecting the victim and ensuring that all presentations to either service are an effective portal to decisive and appropriate action.

The health system is often a first point of contact for individuals who have experienced DFV. It is important to understand that DFV affects individuals across all socioeconomic, social and cultural groups.

The presence of children adds to the sensitivity of these cases. Witnessing DFV may affect the way in which children behave in their relationships, continuing the cycle of violence. The highly sensitive nature of these cases presents a difficult challenge for responding to such incidents.

When responding to a case of DFV as the initial responding service, your primary responsibility is your own personal safety and the immediate medical assessment and treatment of the victim. If a risk assessment returns a high likelihood of immediate danger for any involved parties, including QAS staff, immediate QPS involvement is required.

It is possible that the information contained in this section may cause some employees to feel uneasy and trigger personal experiences, reactions and feelings. If this is the case, you are encouraged to seek assistance from Priority One, or other applicable specialist services. Further information on support services can be found within the DFV Support Services section of this guideline.



What is DFV?

As explained in the *Queensland Domestic and Family Violence Protection Act 2012*, domestic violence means behaviour by a person (the first person) towards another person (the second person) with whom the first person is in a relevant relationship that:

- Is physically or sexually abusive
- Is emotionally or psychologically abusive
- Is economically abusive
- Is threatening
- Is coercive
- In any other way controls or dominates the second person and causes the second person to fear for the second person's safety or wellbeing or that of someone else.

The contemporary understanding of DFV is a person being subjected to an ongoing pattern of abusive behaviour by an intimate partner or family member.

This behaviour is motivated by a desire to dominate, control or oppress the other person and cause fear. It includes behaviour that is physically, sexually, emotionally, psychologically or economically abusive; threatening or coercive; or any other way controls or dominates another person causing fear.

Violence may occur in all kinds of families and in family relationships extending beyond intimate partners, parents, siblings and blood relatives. It includes violence perpetrated by extended family members, same sex partner, or from a carer towards the person they are looking after.

Cultural groups may have a different interpretation of who is considered 'family'. Aboriginal and Torres Strait Islander and culturally and linguistically diverse (CALD) populations may have definitions of 'family' that extend to relationships within extended families, kinship networks and communities.

Common Myths and Attitudes

Attitudes of the community may reinforce and excuse DFV. Victim blaming is common and shifts the focus from accountability of the person who commits DFV or abuse. Often the focus is on what the victim/survivor does or doesn't do rather than questioning the behaviour of the person who commits the violence or abuse. For example, expecting that a woman leave an abusive relationship assumes that women choose to stay and this continues to remove accountability from the person who commits DFV. Leaving the relationship is the most dangerous time and there are a range of psychological and practical things that need to be put in place for victims to be able to leave safely.

Attitudes about gender roles and behaviours are often learnt and reinforced in the early years and may influence how individuals view and respond to incidents of DFV. For example: boys will be boys, men should take control and make decisions in relationships, boys don't cry and woman's work is around the home.

There is often a misconception that a person's social status; for example, levels of education, race or socio-economic status are determinant to DFV.



***DFV does not discriminate,
it can occur in all areas
of the community.***

Recognising the Signs of DFV

DFV can affect any person regardless of gender, age, socioeconomic status or cultural background. While both men and women can be victims and use behaviours associated with DFV, it is important to acknowledge that the reported rate of DFV committed against women is significantly higher than it is for men. The vast majority of those who commit violence are men. About 80% of all violent assaults (including sexual) are carried out by men against other men and women.

Women from particular groups in the Australian community are at higher risk from DFV and its effects, and can face barriers in accessing support and protection. They include:

- Aboriginal and Torres Strait Islander women
- Women with disabilities
- Older women
- Women from culturally and linguistically diverse (CALD) backgrounds
- Lesbian, Gay, Bisexual, Transgender, Intersex, Queer, Questioning (LGBTIQ+)

Risk Factors

The following risk factors may indicate a person is at higher risk of experiencing or committing DFV.

Risk factors for victims

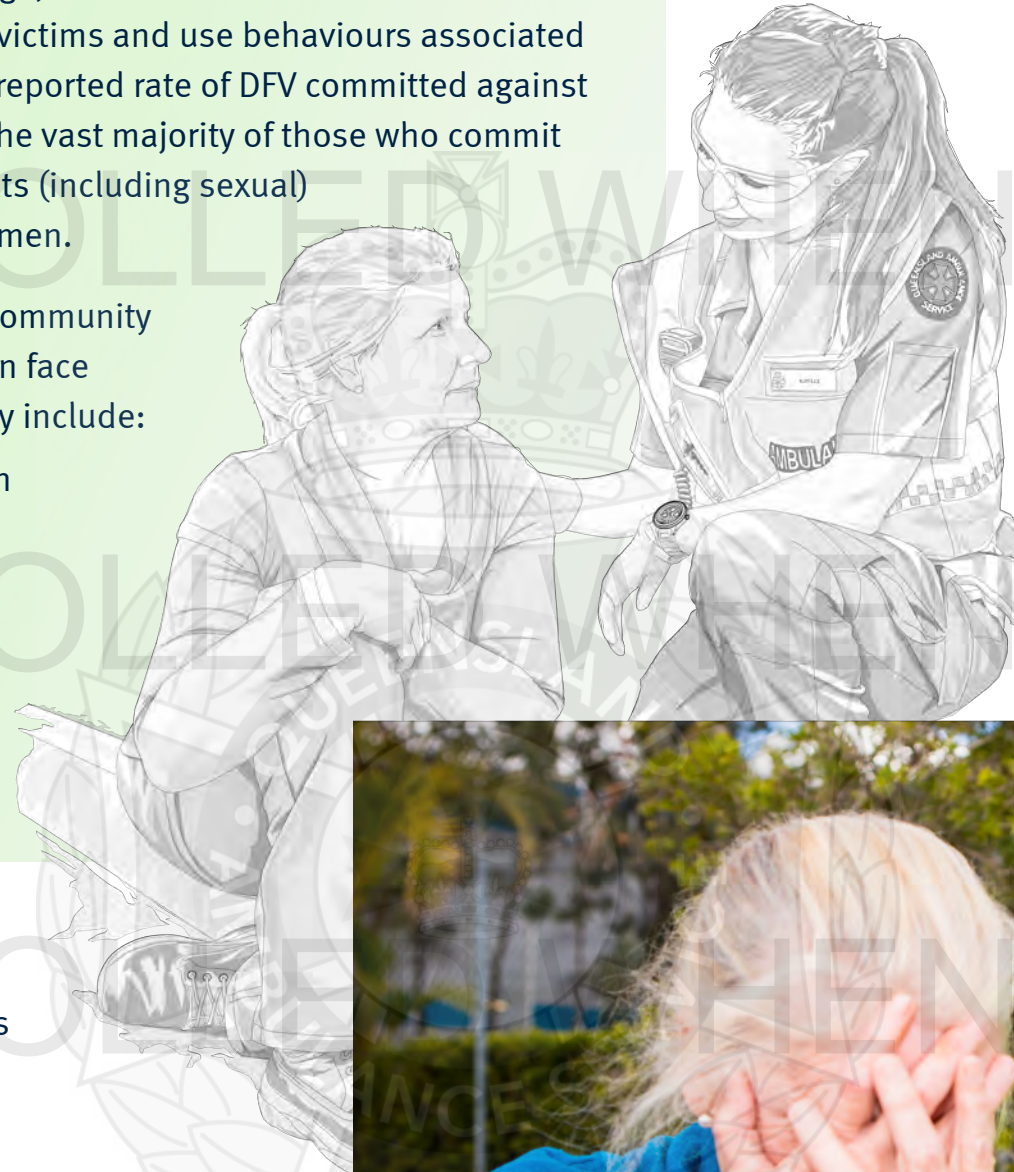
- Pregnancy and the postnatal period
- Mental health issues
- Substance abuse
- Isolation

Relationship risk factors

- Recent separation or plans to separate
- Financial hardship or stress
- Escalation in severity and frequency of violence

Those who commit DFV risk factors

- Threats to kill
- Strangulation
- Access to/use of weapons
- Substance abuse
- Stalking
- Sexual violence
- Threats or direct harm to children
- Suicidality
- Threats or harm to animals and pets
- Breach of intervention order
- Jealous, controlling behaviour
- History of violence





Types of Abuse and Violence

DFV is described as a pattern of abusive behaviour in any relationship that is used by one person to gain or maintain power and control over another intimate partner, this abuse and violence can take many forms. Violence can be severe and leave obvious injuries, but some victims may be subject to more subtle abuse that may not leave physical injuries. Abuse and violence may be any of the following.

Physical abuse

Injuries from physical abuse may range from minor trauma, which may or may not be visible, to broken bones and lacerations, head injuries and injuries to internal organs. For many victims, the abuse occurs regularly. Some are threatened with weapons, such as knives, or household items such as a hot iron, cigarettes or a length of rubber hose. Physical abuse can take many forms such as smashing property, or killing or hurting family pets.

Emotional abuse

Emotional abuse may include subtle or overt verbal abuse, humiliation, threats or any behaviour aimed at scaring or terrorising the person experiencing the abuse. The victim may lose their confidence, self-esteem or self-determination. Emotional abuse can take many forms including threats of suicide, extreme jealousy and stalking or harassment at work or through the use of technology.

Social abuse

Isolating the victim from family and friends, and other contacts in the community.

Elder abuse

Any act occurring within a relationship where there is an implication of trust, which results in harm to an older person. It can be physical, emotional, financial, and sexual or neglect. Older people may face barriers to seeking help for elder abuse including physical disability, diminished cognitive function and lack of awareness that their experiences amount to abuse.

Adult sexual assault

Adult sexual assault involves any type of sexual activity to which there is no consent. This may or may not involve penetration or physical contact with the victim (for example, exposure). It is important to note that people with disability or the elderly may not have consented, or they may have lost their ability to consent (for example, those with dementia).

Child sexual abuse

For children, sexual abuse may involve forcing or enticing them to take part in sexual activities, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative or non-penetrative acts. The abuse may include non-contact activities such as involving children in looking at, or in the production of, pornographic material or watching sexual activities, or encouraging children to behave in sexually inappropriate ways.

Neglect

Neglect is the persistent failure to meet the basic physical and/or psychological needs of a person for whom you are caring, such as failing to protect from physical harm or danger, or failure to ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, the other person's basic emotional needs.

Indicators of DFV

The following indicators are associated with victims of DFV and may be signs for identification during a call out.

Physical

- Unexplained bruising and other injuries (especially to the head and neck)
- Bruises at various stages of healing
- Injuries on parts of the body hidden from view
- Injuries sustained do not fit the history given
- Accidents' occurring during pregnancy
- Miscarriages and other pregnancy complications

Psychological / Behavioural

- Emotional distress (anxiety, indecisiveness, confusion)
- Partner does most of the talking and insists on remaining with the patient
- Appearing anxious in front of partner
- Psychosomatic and emotional complaints
- Reluctance to follow advice
- Self-harm or suicide attempts
- Submissive behaviour/low self esteem
- Drug and alcohol abuse

Indicators in Children

Physical

- Difficulty in eating/sleeping
- Physical complaints
- Underweight (in infants)
- Unexplained bruising and other injuries

Psychological / Behavioural

- Aggressive behaviour and language
- Dependent, sad or secretive behaviours
- Depression, anxiety and/or suicide attempts
- Bedwetting
- Appearing nervous and withdrawn
- 'Acting out', for example cruelty to animals
- Difficulty adjusting to change
- Noticeable decline in school performance
- Regressive behaviour in toddlers
- Fighting with peers
- Delays or problems with language development
- Overprotective or afraid to leave parent
- Psychosomatic illness
- Stealing and social isolation
- Restlessness and problems with concentration
- Abuse of siblings or parents
- Exhibiting sexually abusive behaviour
- Alcohol and other drug use
- Feelings of worthlessness
- Psychosomatic and emotional complaints

Please note these are not exhaustive lists, but may provide guidance on things to look out for to check on the welfare of a patient.

Responding to Disclosures from Someone Experiencing DFV

- Non-judgemental and careful listening is critical during the conversations – this can be empowering for the person who has been abused. Do not tell them what to do, but rather help them to explore options that are available.
- Communicate belief in what you are being told – *‘that must have been frightening for you...’*
- Validate the experience of abuse – *‘it must have been difficult for you to talk about this...’*
- Affirm that violence is unacceptable behaviour – *‘violence is unacceptable; you don’t deserve to be treated in this way...’*
- Show support toward the victim – by taking time to listen and provide information about who can further assist
- Respond to any concern about safety – offer referral to specialist support services such as DV Connect, 1800 Respect (only if safe to do so)

Tips for Paramedics:

Never ask:

- Why don’t you leave?
- What could you have done to avoid the situation?
- Why did he/she hit you?

Responding to those who use or commit DFV or abuse

Those who use or commit DFV will access pre-hospital and health services however your highest priority is to consider the safety of victims and their children. As a first responder you may engage with those who commit DFV, who come from all socioeconomic, cultural and social groups; who will often attempt to minimise their responsibility for violent behaviours and convince themselves and others that they are not responsible. If a person discloses violence, ensure you reinforce that violence is not acceptable and refer them onto an appropriate support service (listed in the next section).

Tips for Paramedics:

Never ask:

- Questions of the person who use or commits DFV in the presence of a victim or a victim in the presence of a someone who commits DFV.
- Questions about behaviours of the person who uses or commits DFV – this is the role of specialist clinical staff.



Referral

Prior to providing any suggestions to the victim, confirm they are seeking further DFV information and assistance. Ensure the victim is aware that clinicians are not authorised to provide legal advice or directly advocate on the patient's behalf. Patients in these cases may refuse service. The goal is to provide the best outcome for the victim while still respecting their right to choose.

You may make a referral to DVConnect with the victim's consent using the dedicated service line on 1300 308 884. Once referred, DVConnect will contact the victim to provide further assistance.

DV Connect can organise refuge, accommodation and transport for the victim along with ongoing assistance tailored to their specific situation, wants and needs. If the victim doesn't wish for a DVConnect referral, alternative solutions to DFV can also be suggested at your discretion.

Where you suspect DFV but are unable to provide referral details to the victim, you may discuss your suspicions with a hospital staff member at handover so they can provide further support when they take over care of the patient. This will be paramount where the person who committed the violence or abuse is present when you are treating the victim.



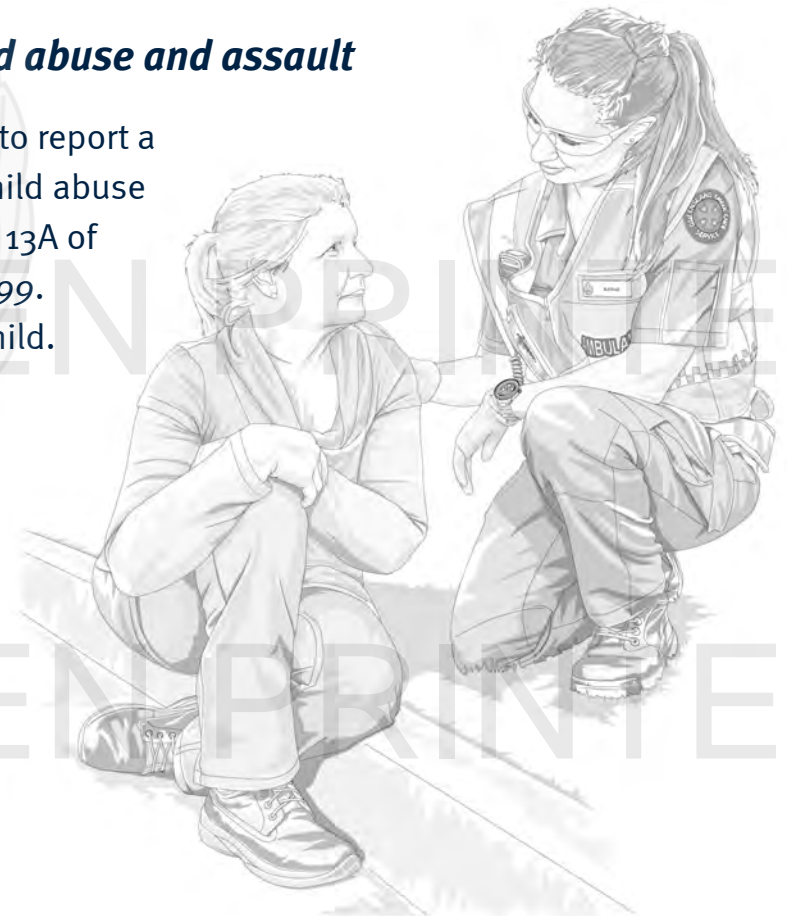
DFV Support Services

- DVConnect Womensline – **1800 811 811** (24 hours, 7 days a week)
- DVConnect Mensline – **1800 600 636** (9am to midnight, 7 days a week)
- Elder Abuse Helpline – **1300 651 192** (9am to 5pm, Monday to Friday)
- Sexual Assault Helpline – **1800 010 120** (9am to midnight, 7 days a week)
- 1800 RESPECT – **1800 737 732** (24 hours, 7 days a week)
- Lifeline – **13 11 14** (24 hours, 7 days a week)
- Mensline Australia – **1300 789 978** (24 hours, 7 days a week)
- Policelink – **131 444** (24 hours, 7 days a week)
- Legal Aid Queensland – **1300 651 188** (8:30am to 5pm Monday to Friday)

Reporting of suspected abuse and assault

Clinicians are encouraged to report a reasonable suspicion of child abuse and neglect under Section 13A of the *Child Protection Act 1999*. This Includes an unborn child.

All relevant information should be passed onto a hospital staff member to follow their own reporting requirements.



Infection Control



The ***Infection Control Framework***^[1] describes procedures to provide a safe working environment for all QAS personnel and patients through evidenced based infection prevention and control practice.

Drug Management



The ***Drug Management Code of Practice*** ^[1]

describes the framework for drug management within the QAS.

The QAS has a responsibility to ensure that drugs are supplied, stored, carried, administered and disposed of in accordance with the *Health (Drugs and Poisons) Regulation 1996* and adequate records of these practices are retained. ^[2]





Clinical Documentation

The **Operational Procedure – Completion of Clinical Documentation**^[1] describes the QAS requirements for the completion of an Electronic Ambulance Report Form (eARF). Completion of an eARF is an essential and integral component of patient care. Comprehensive documentation ensures appropriate continuity of patient care at a receiving facility in addition to a variety of other functions including legal, legislative, research, quality management and billing requirements.

Staff Support Services



The QAS Staff Support Services (Priority One) exist to promote the mental health and well being of QAS staff and their families.

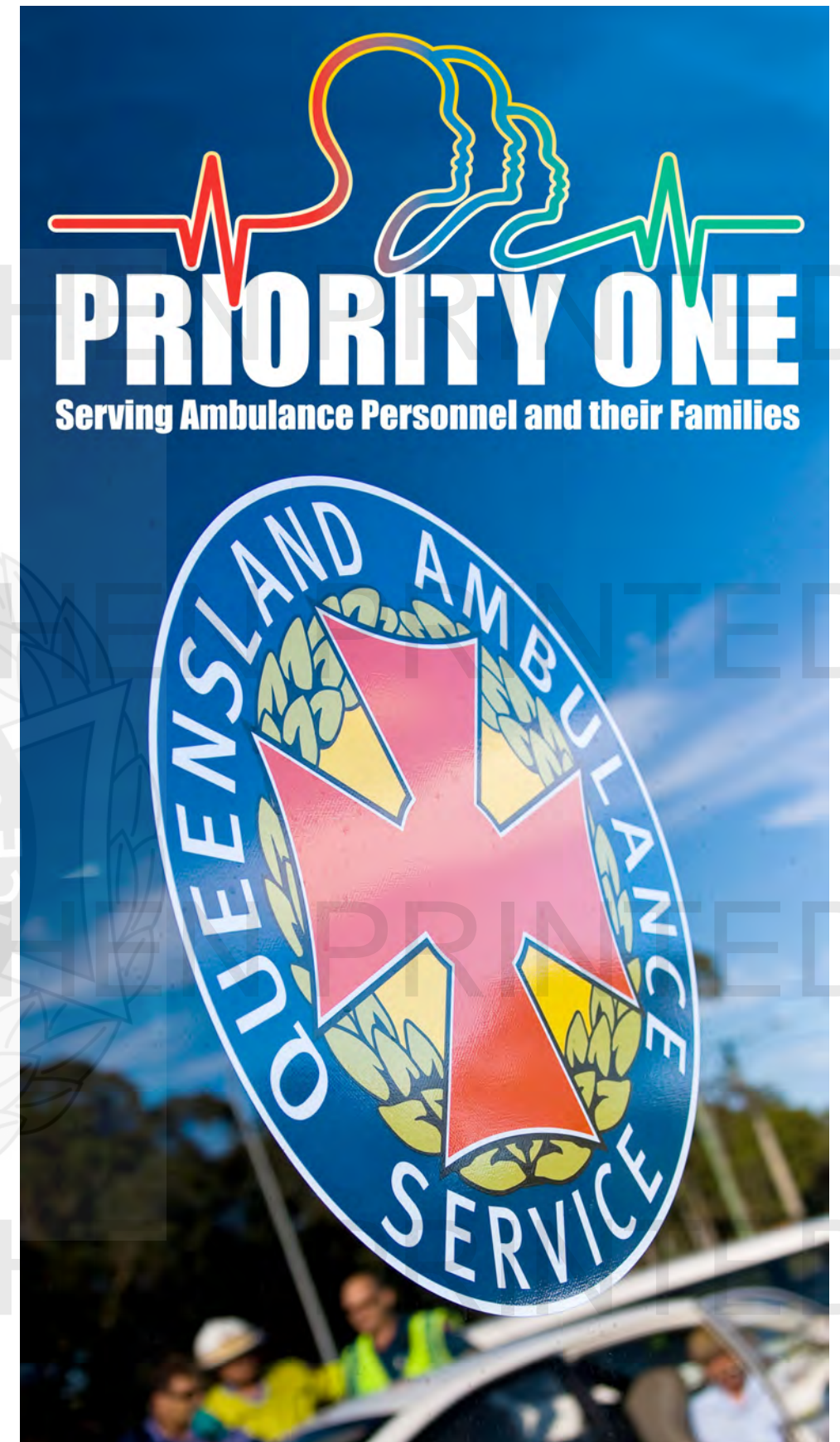
Clinicians are highly resilient people who generally cope well with the multiple stressors inherent in their profession. However, the very nature of ambulance work means that occasionally clinicians may find their normal coping strategies less effective. This may be associated with the type or nature of an event, but most commonly occurs when clinicians personally identify with the event, the patient or family members.

They may experience heightened emotional reactions, often intense sadness and/or anger and/or a general irritability. They may feel confused, bewildered or numbed. They may find themselves ruminating persistently about aspects of a case. These and other uncomfortable sensations are normal reactions to distressing experiences.

Cases that have a higher propensity to trigger such reactions include:

- death or serious injury to a work colleague
- death or serious injury of children
- events with excessive media interest
- victims known to the paramedic
- serious multiple casualty incident

Most commonly staff are affected by a case that carries a personal meaning for them.



To reduce the impact of such events it may be helpful to:

- take time out to reduce emotional, cognitive or physiological hyperarousal, which is common after psychological trauma. The earlier this is done the better.
- find out more information about the incident to *'fill in the gaps'* and minimise catastrophisation.
- realise that these emotional reactions are normal and appreciate that discussion with a trusted colleague or Peer Support Officer (PSO) can help to reduce their intensity.
- maintain healthy diet, exercise and sleep regimes.
- spend time/stay connected with loved ones.

Where symptoms persist for greater than a few days it is important to take the initiative to speak with one of the many professional counsellors available through the **QAS Priority One Program**.

Where symptoms persist for greater than a few days it is important to take the initiative to speak with one of the many professional counsellors available through the **QAS Priority One Program**.

Contact details for counsellors and PSOs specific to your Local Ambulance Service Network (LASN) are available in all QAS stations and on the **QAS portal**.



There is someone who cares



Clinician Safety



The clinician working environment is highly varied and dynamic with the potential to cause injury or illness to any staff member working in any role within the QAS.

The personal safety of all responders is the number one priority of the QAS.

Every circumstance encountered in the pre-hospital environment should be risk assessed and approached with **safety as the number one priority** ensuring the responders return home at the end of their shift safe and well. Entering the scene of a case and when approaching any task the clinician should ask themselves:

*“Do I see, hear or smell, or sense any danger to myself, my partner, bystanders or the patient?
Is there anything that will prevent me from safely managing this patient or completing this task?”*

Safety is the responsibility of everyone within the QAS. When a scene, circumstance or action is deemed unsafe the officer needs to stop and evaluate the risk before continuing, judiciously putting in place controls to eliminate or minimise any hazards. This can include asking someone to assist, withdrawing from a scene, use of Personal Protective Equipment (PPE) or requesting further QAS or other agency resources. Due to the dynamic nature of the paramedic environment, continual reassessment regarding safety needs to occur as the scene or task develops.



The culture of safety can often go against the culture of heroism and putting oneself on the line for the job and the patient. Making it home safely at the end of the shift is the priority, the individual needs to recognise and respond appropriately to any risks or hazards that are encountered.

To support the QAS commitment to creating a positive and safe working environment, all individuals are required to:

- communicate safety concerns immediately and effectively
- demonstrate safety leadership, looking out for those around you
- clarify the required and expected safety values
- realise their personal impact on safety outcomes
- demonstrate a positive safety attitude
- take responsibility and accountability for safety
- increase safety awareness and preventative behaviours
- improve understanding and implement problem solving and safe working processes
- monitor, review and reflect on personal effectiveness with **safety as the No.1 priority**

However, if an incident does occur or a hazard is identified, it is the responsibility of every individual to report the incident, hazard or near miss. Reporting incidents, hazards or near misses allows for development of corrective practices proactively preventing harm to clinicians, the public and patients.



The **Safety Health and Environment (SHE)** reporting system can assist all officers to be proactive regarding safety in the workplace. By evaluating incidents, risks and hazards the QAS strives to achieve a safe working environment for everyone.

QAS Station Officers in charge provide the first contact in relation to paramedic safety concerns.

All clinicians can be further supported and gain expert advice through the QAS Workplace Health and Safety (WHS) Unit, LASN Health and Safety Advisors (HSAs) and the Staff Support Service, Priority One.

For more information on:

- QAS Workplace Health and Safety visit the *Human Resources (HR) portal site* or contact [REDACTED]
- Reporting a hazard, incident or injury visit the *HR portal site* or contact [REDACTED]
- *Priority One, Staff Support Services* visit the *HR portal site* or contact [REDACTED]



Public Hospital Clinical Matrix

All public patients should be transported to the closest public hospital emergency department (ED), except when one or more of the following exist:

- The patient is covered by established QAS by-pass criteria:
 - CPG: Other / Pre-hospital trauma bypass
 - CPG: Neurological / Stroke and Transient ischaemic attack
 - CPP: Other / Acute stroke referral
 - CPP: Cardiac / Autonomous fibrinolysis administration
 - CPP: Cardiac / Autonomous pPCI referral
 - CPP: Cardiac / Decision supported fibrinolysis administration
 - CPP: Cardiac / Decision supported pPCI referral
 - Robina Hospital – Medical Admissions Unit Local Work Instruction (LWI).
- The patient is unable to be definitively managed at the local hospital.
- When in the opinion of the supervisor, treating clinician or **QAS Clinical Consultation and Advice Line**, the patient is required to be transported to a specialist hospital. This may include patients with illnesses known to a specific hospital (e.g. dialysis, chemotherapy, STEMI), recent inpatient admission (< 14 days) at a specific hospital or when specialised treatment is required at a tertiary hospital (e.g. neurosurgery etc).
- When in the opinion of the supervisor, the patient will experience a lengthened patient off stretcher time (POST).
- When in the opinion of the PACH clinician, the patient would benefit from being transported to a more appropriate destination.



Major Queensland Metropolitan Public Hospital Admission Capabilities

Local Ambulance Service Networks	Hospital	Major trauma service	Regional trauma service	pPCI	Stroke lysis	Obstetrics	Paediatrics
North West	Mt Isa Hospital		•		•	•	•
Cairns and Hinterland	Cairns Hospital		•	•	•	•	•
Townsville	The Townsville University Hospital	•		•	•	•	•
Mackay	Mackay Base Hospital		•	•	•	•	•
Central Queensland	Rockhampton Hospital		•		•	•	•
Darling Downs	Toowoomba Hospital		•		•	•	•
Wide Bay	Bundaberg Hospital		•		•	•	•
	Hervey Bay Hospital		•		•	•	•
Sunshine Coast	Nambour Hospital	Refer to LASN Local Work Instruction					
	Sunshine Coast University Hospital		•	•	•	•	•
Metro North	Caboolture Hospital		•		•	•	•
	Royal Brisbane & Women's Hospital	•		•	•	•	
	The Prince Charles Hospital			•	•		•
	Redcliffe Hospital		•		•	•	•
Metro South	Logan Hospital		•		•	•	•
	Princess Alexandra Hospital	•		•	•		
	Mater Hospital Brisbane		•	Pending	•	See Note #1	
	Mater Mothers' Hospital					•	
	Queensland Children's Hospital	•					•
	Queen Elizabeth Jubilee II Hospital				•		
	Redland Hospital				•	•	•
Gold Coast	Gold Coast University Hospital	•		•	•	•	•
	Robina Hospital	Refer to LASN Local Work Instruction					
West Moreton	Ipswich Hospital		•		•	•	•

Note #1 – Pregnancy Assessment Centre (entire pregnancy up to delivery and up to 6 weeks postpartum).



QAS Clinical Levels

Clinical Level	Abbreviation	Minimum Requirements
Volunteer – First Responder	FR	<ul style="list-style-type: none"> Advanced First Aid; QAS First Responder training program; Maintain skills and currency specific to the clinical level; AND Credentialed by QAS to practice as a FR.
Patient Transport Officer	PTO	<ul style="list-style-type: none"> Maintain skills and currency specific to the clinical level; AND Credentialed by QAS to practice as a PTO.
Ambulance Technician	AT	<ul style="list-style-type: none"> Maintain skills and currency specific to the clinical level; AND Credentialed by QAS to practice as an AT.
Ambulance Manager	AM	<ul style="list-style-type: none"> Registered Paramedic with the Paramedicine Board of Australia; Maintain skills and currency specific to the clinical level; AND Credentialed by QAS to practice as an AM.
Paramedic	P	<ul style="list-style-type: none"> Registered Paramedic with the Paramedicine Board of Australia; Maintain skills and currency specific to the clinical level; AND Credentialed by QAS to practice as an P.
Advanced Care Paramedic 1	ACP1	<ul style="list-style-type: none"> Registered Paramedic with the Paramedicine Board of Australia; Maintain skills and currency specific to the clinical level; AND Credentialed by QAS to practice as an ACP1.
Advanced Care Paramedic 2	ACP2	<ul style="list-style-type: none"> Registered Paramedic with the Paramedicine Board of Australia; Maintain skills and currency specific to the clinical level; AND Credentialed by QAS to practice as an ACP2.
Critical Care Paramedic	CCP	<ul style="list-style-type: none"> Registered Paramedic with the Paramedicine Board of Australia; Maintain skills and currency specific to the clinical level; AND Credentialed by QAS to practice as a CCP.
Extended Scope of Practice – Flight Paramedic	ESoP - FP	<ul style="list-style-type: none"> CCP; QAS Flight Paramedic Training Program; Maintain skills and currency specific to the clinical level; AND Credentialed by QAS to practice as a FP.
Extended Scope of Practice – High Acuity Response Unit	ESoP - HARU	<ul style="list-style-type: none"> CCP; QAS High Acuity Response Unit Training Program; Maintain skills and currency specific to the clinical level; AND Credentialed by QAS to practice as a HARU paramedic.
Extended Scope of Practice – Local-area Assessment & Referral Unit	ESoP - LARU	<ul style="list-style-type: none"> ACP2; QAS Local-area Assessment and Referral Unit Training Program; Maintain skills and currency specific to the clinical level; AND Credentialed by QAS to practice as a LARU paramedic.
Ambulance Medical Officer	AMO	<ul style="list-style-type: none"> Registered Medical Practitioner with the Medical Board of Australia; Credentialed by the Chief Health Officer as a Specialist in Retrieval Medicine and Pre-hospital Care or an accredited advanced trainee of a critical care discipline; Maintain skills and currency specific to the clinical level; AND Credentialed by QAS to practice as an AMO.

Drug Therapy Protocol	Registered Paramedics							
	FR	PT0	AT	AM	P	ACP1	ACP2	CCP
Adrenaline (epinephrine)	E	E	I		I	I	I	I
Amiodarone								I
Aspirin	I	E	I		I	I	I	I
Atropine								I
Benztropine (benzatropine)								I
Box jellyfish antivenom			I		I	I	I	I
Calcium gluconate								I
Ceftriaxone						I	I	I
Clopidogrel							I	I
Dexamethasone							I	I
Droperidol							I	I
Enoxaparin							I	I
Extended life plasma								E
Fentanyl						I	I	I
Furosemide (frusemide)								E
Glucagon			I		I	I	I	I
Glucose gel	I	E	I		I	I	I	I
Glucose 5%								I
Glucose 10%							I	I
Glyceryl trinitrate			I		I	I	I	I
Heparin							I	I
Human fibrinogen								E
Hydrocortisone							I	I
Hydroxocobalamin							I	I
Hypertonic saline 7.5%								E
Ibuprofen							I	I
Insulin (Actrapid®)								E
Ipratropium bromide						I	I	I
Isoprenaline								E
Ketamine								I
Levetiracetam								I
Lidocaine 1% (lignocaine 1%)							E	I
Loperamide							E	E
Loratadine							I	I
Lorazepam								E
Magnesium sulphate							I	I
Metaraminol								E
Methoxyflurane	I	E	I		I	I	I	I
Metoprolol								E
Midazolam						I	I	I
Morphine						I	I	I
Naloxone						I	I	I
Noradrenaline (norepinephrine)								E
Ondansetron						I	I	I
Oxygen	I	I	I	I	I	I	I	I
Oxytocin							I	I
Packed red blood cells								E
Paracetamol	I	E	I		I	I	I	I
Phenytoin								E
Propofol								E
Rocuronium								E
Salbutamol	E	E	I		I	I	I	I
Sodium bicarbonate 8.4%							I	I
Sodium chloride 0.9%						I	I	I
Sucrose 24%							I	I
Tenecteplase							I	I
Ticagrelor							I	I
Tirofiban								E
Tranexamic acid							I	I
Water for injection			I		I	I	I	I

				Registered Paramedics					
Category	Procedure	FR	PTO	AT	AM	P	ACP1	ACP2	CCP
Access	External jugular intravenous cannulation								I
	Intraosseous – peripheral							E	I
	Intraosseous – sternal								E
	Peripheral intravenous cannulation							I	I
Airway Management	Direct laryngoscopy							I	I
	Laryngeal mask airway insertion – Paed (≥ 8 yrs) & adults						I	I	I
	Laryngeal mask airway insertion – Paed (< 8 yrs)								I
	Magill forceps							I	I
	Nasopharyngeal airway insertion			I		I	I	I	I
	Oral endotracheal intubation								I
	Oropharyngeal airway insertion	I	I	I	I	I	I	I	I
	Rapid Sequence Induction								EC
	Small bore transtracheal ventilation								E
	Suctioning	I	I	I	I	I	I	I	I
	Surgical cricothyrotomy								E
	Assessment	Blood analysis – CoaguChek®XS							
Blood analysis – iSTAT®									E
Blood analysis – Glucose		E	E	I		I	I	I	I
Blood analysis – Ketones								E	E
COAST score								I	I
Endotracheal tube cuff manometer									I
Invasive blood pressure								E	E
Myotatic stretch reflexes								E	E
Pulse oximetry		I	E	I		I	I	I	I
Tympanic temperature		I	E	I		I	I	I	I
Ultrasound – Focused assessment with sonography for trauma									E
Waveform EtCO2 nasal							I	I	I
Behavioural disturbances	Emergency Examination Authority			E		I	I	I	I
	Sedation – acute behavioural disturbance							I	I
Cardiac	12-Lead ECG acquisition						I	I	I
	12-Lead ECG STEMI identification (basic – including STEMI identification)							I	
	12-Lead ECG STEMI interpretation (advanced)								I
	Autonomous fibrinolysis administration								I
	Autonomous pPCI referral								I
	Cardiac monitoring		E	E		I	I	I	I
	Decision supported fibrinolysis administration							I	
	Decision supported pPCI referral							I	
	Synchronised cardioversion								I
	Transcutaneous cardiac pacing								I
Drug/fluid administration	Adrenaline (epinephrine) auto-injector	E	E	I		I			
	Blood warmer								E
	Continuation of an established intravenous fluid infusion		E	E		I	I	I	I
	Intramuscular	E	E	I		I	I	I	I
	Intranasal						I	I	I
	Intravenous							I	I
	Metered Dose Inhaler (MDI) with spacer							E	E
	Modified valsalva manoeuvre			I		I	I	I	I
	Nebuliser (mask)	E	E	I		I	I	I	I
	Nebuliser (‘T’ piece)								I
	Oral	I	E	I		I	I	I	I
	Priming of a blood solution (gravity flow) pump set							E	E
	Priming of a gravity flow giving set							I	I
	Priming of a Space Infusomat® SafeSet Line							E	E
	Subcutaneous								I
	Sublingual			I		I	I	I	I
	Syringe infusion pump – Perfusor® Space							E	I
	Obstetrics	Bimanual compression			E		I	I	I
Breech delivery				E		I	I	I	I
Nuchal umbilical cord				E		I	I	I	I
Physiological cephalic delivery				E		I	I	I	I
Shoulder dystocia				E		I	I	I	I
Respiratory	Bag valve mask ventilation	I	I	I	I	I	I	I	I
	Chest seal		E	I		I	I	I	I
	Emergency chest decompression							I	I
	Emergency chest decompression – tube thoracostomy								E
	Emergency chest decompression – finger thoracostomy								E
	Non-invasive ventilation – CPAP							I	I
	Positive end expiration pressure								I
Resuscitation	Cardiopulmonary resuscitation	I	I	I	I	I	I	I	I
	Defibrillation – semi-automatic	I	E	I	I	I	I	I	I
	Defibrillation – manual							I	I
Trauma	Arterial tourniquet	E	E	I		I	I	I	I
	Cervical collar	I	I	I		I	I	I	I
	Femoral traction splint			I		I	I	I	I
	Fish hook removal							E	E
	Fracture reduction								I
	Haemostatic QuikClot® combat gauze			I		I	I	I	I
	Haemostatic XSTAT®12								E
	Helmet removal	I	I	I		I	I	I	I
	Immobilisation / extrication jacket			I		I	I	I	I
	Nasal pack								E
	Pelvic circumferential compression device			I		I	I	I	I
	Skin closure – simple interrupted suturing							EC	EC
	Skin closure – skin stapler							E	E
	Skin closure – Steri-strip™			I		I	I	I	I
	Skin closure – Histoacryl® topical skin adhesive							EC	EC
	Tooth replantation			I		I	I	I	I
	Other	Acute stroke referral			I		I	I	I
Direct infiltration of local anaesthetic								E	E
Emergency evacuation from home dialysis				I		I	I	I	I
Orogastric tube insertion									I
Phlebotomy									E
Recognition of Life Extinct (ROLE)				E		I	I	I	I
Regional anaesthesia: digital block								E	E
Sedation – procedural									I