

Chapter 1

Introduction





Digital Clinical Practice Manual

Version 2022

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

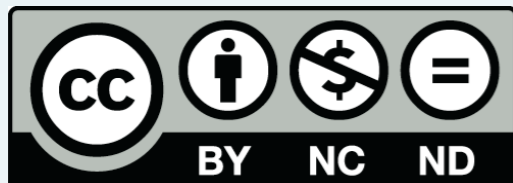
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Clinical Guideline Development Methodology

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 informed 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.

The QAS aims to review clinical policies 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

An Amendment Matrix outlining all clinical changes from the 2022 DCPM is available for viewing at the internal [QAS Portal](#).



2022 DCPM Guideline

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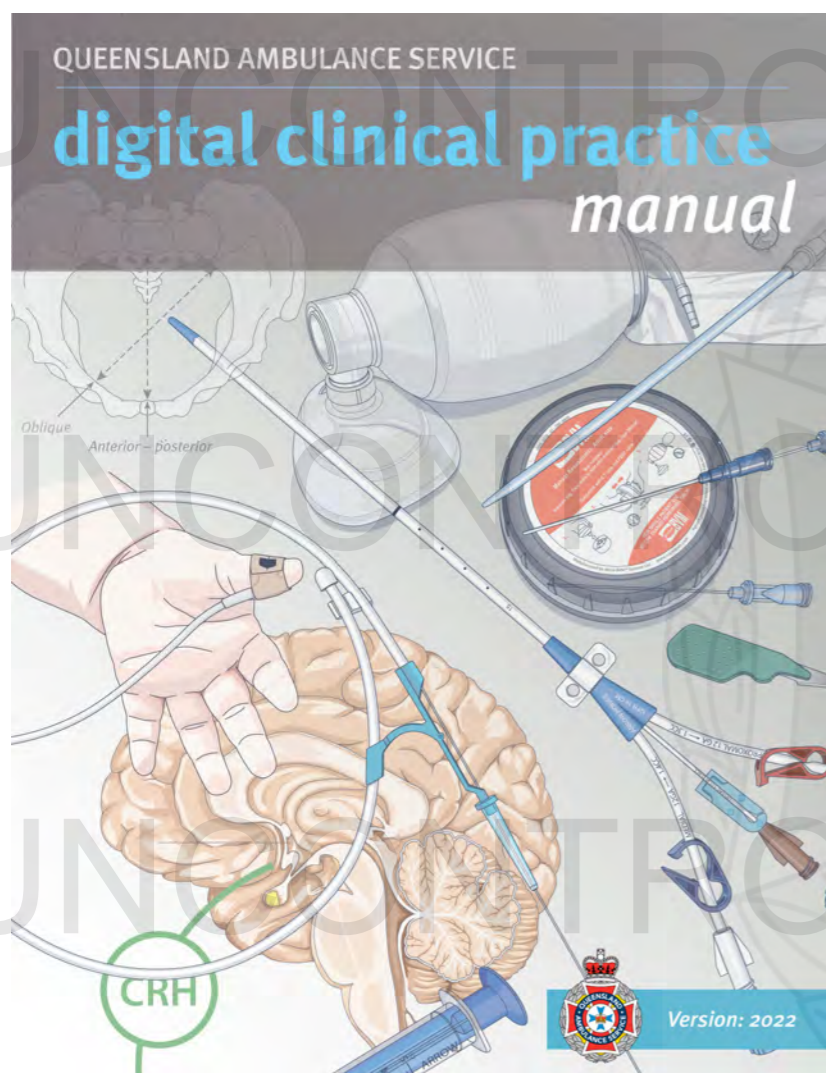
Aboriginal and Torres Strait Islander artwork provided by Gilimbaa.



Digital Clinical Practice Manual

The Digital Clinical Practice Manual (DCPM) includes a comprehensive collection of Clinical Practice Guidelines (CPGs), Clinical Practice Procedures (CPPs) and Drug Therapy Protocols (DTPs). These policies inform and guide clinical decision making by ambulance clinicians; provide instructions to perform authorised clinical procedures; and directions for the administration of authorised pharmacological agents in prescribed circumstances.

The CPGs, CPPs and DTPs have been systematically developed and are based on the best available informed clinical and pharmacological evidence at the time.



Clinical Practice Guidelines

Contains: 116 titles

Clinical Practice Procedures

Contains: 135 titles

Drug Therapy Protocols

Contains: 62 protocols

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

- Introduction
- Clinical Practice Guidelines
- Clinical Practice Procedures
- Drug Therapy Protocols
- Current Clinical Research
- Abbreviations & Acronyms, Glossary
- References
- Resources

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/Acte behavioural disturbance
- Coma
- Bradycardia
- Hypothermia
- Respiratory depression

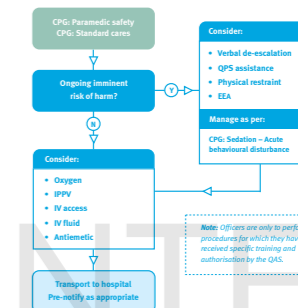
In toxic doses there is typically a rapid onset of coma. The patient is often rousable with stimulus only to return to unconsciousness once undisturbed.

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.^[1]
- Coma longer than six hours duration suggests an alternate diagnosis or sedating co-ingestant.^[1]
- Full recovery is expected when good supportive care is provided.



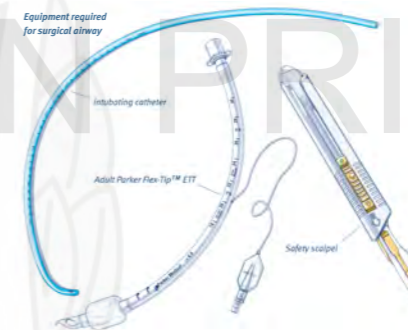
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Surgical cricothyrotomy

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



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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

Droperidol

27 August, 2020

Drug class

Antipsychotic

Pharmacology^[1]

Droperidol is an antipsychotic drug from the butyrophenone group that produces sedation.

Metabolism^[1]

Hepatic metabolism with biliary/renal excretion as inactive metabolites.

Indications

- Acute behavioural disturbances (with a SAT Score ≥ 3)

Contraindications

- **Absolute** contraindication:
 - Allergy and/or Adverse Drug Reaction
 - Parkinson's disease
 - Previous dystonic reaction to droperidol
 - Patients < 8 years
- **Relative** contraindication (requires consultation with the QAS Clinical Consultation & Advice Line):
 - Suspected sepsis

Precautions

- Hypoperfused state
- Concomitant use of CNS depressants

Side effects

- Vasodilation/hypotension
- Extrapyramidal effects e.g. dystonic reactions (rare)

Presentation

- Vial, 50 mg/2 mL droperidol (DORM®)

Onset (MINS)	Duration (HOURS)	Half life
5–15 minutes	4–6 hours	N/A

Schedule

- S₄ (Restricted drugs).

Routes of administration

Intramuscular injection (IM)	AC ²	CC ²
Intravenous injection (IV)	AC ²	CC ²

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Clinical Practice Guidelines (CPGs)

Clinical Practice Guidelines (CPGs) provide advice and recommendations that are intended to guide clinical decision-making and optimise patient care and safety. The CPGs are informed by a systematic review of relevant clinical evidence, combined with an assessment of the potential benefits and possible risks in most circumstances. It is expected that these CPGs will be applicable in most cases, and best efforts should be made to follow the relevant recommended treatment pathway. CPGs are not intended to replace sound clinical judgement and require sensible interpretation and application having regard for the specific clinical circumstances.

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Title of CPG

Gamma-hydroxybutyrate

January, 2020

Introduction to CPG

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

Includes details of the typical clinical presentation that the ambulance clinician can expect or anticipate

Clinical features

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

- Euphoria
- Drowsiness
- Myoclonus
- Agitation/Actue 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

Provides direction regarding the clinical and other assessments that should be undertaken by the ambulance clinician.

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.

Additional info

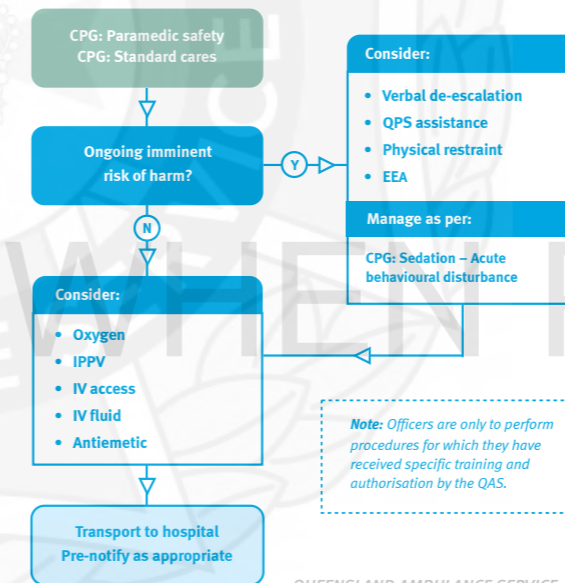
Additional Information that is relevant to the specific CPG and which is not addressed in another section of the CPG.

Flowcharts

Flowchart setting out, in sequential steps, the recommended clinical management.

Note

Generic statement that clinicians can only perform clinical procedures for which they have authorisation.



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Red flags

May appear in the CPG to warn the ambulance clinician of a potentially high-risk situation.

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Clinical Practice Procedures (CPPs)

Clinical Practice Procedures (CPPs) provide a set of instructions that prescribe a method for performing a clinical procedure or task in specified circumstances. CPPs are informed by a systematic review of relevant clinical evidence and will support consistency and quality in the performance of specified activities. It is expected that the ambulance clinician will adhere to CPPs and any deviation from that which is prescribed, must only take place in consultation with, and under the instructions of, a credentialed clinician accessed via the *QAS Clinical Consultation and Advice Line*.

Title of CPP — *Temperature – BRAUN ThermoScan® Pro 4000*

Introduction — Relevant background information relating to the procedure

Graphic illustrations — Illustrations of equipment or apparatus and the technique required for their use.

Indications — Clinical indications for performing the procedure or task.

Contraindications — Clinical or other circumstances that would prohibit or caution against performing the procedure or task.

Complications — List of complications or adverse consequences that have been associated with the procedure or task.

February, 2021

The assessment of a patient's temperature is a valuable measure of systemic illness. Clinical studies have demonstrated that measurement by the tympanic route is superior to traditional sites (axillar, rectal and oral).^[1,2]

Body temperature is regulated by the hypothalamus which shares the same blood supply as the tympanic membrane. Changes in core body temperature are usually seen earlier at the tympanic membrane than at other sites.

The BRAUN ThermoScan® PRO 4000 ear thermometer reads the infrared energy emitted by the tympanic membrane and surrounding tissues to determine the patient's temperature.^[3] To ensure accurate temperature measurements, the sensor is warmed to a temperature close to that of the human body. When the BRAUN ThermoScan is placed in the ear, it continuously monitors the infrared energy until temperature equilibrium has been reached and an accurate measurement can be taken.

Indications

- The monitoring of temperature when clinically indicated.

Contraindications

- Blood or drainage in the ear canal
- Acute or chronic inflammatory conditions of the external ear canal
- Perforated tympanic membrane/s

Complications

- Nil

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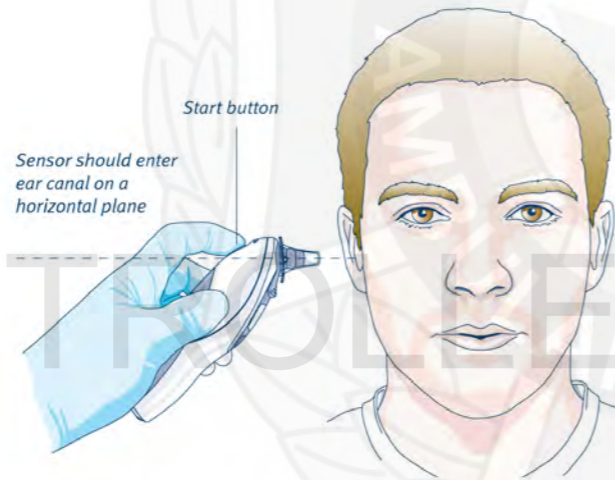
Clinical Practice Procedures (CPPs) *continued*

Procedure

A prescribed series of actions conducted in a pre-determined order that instruct the clinician on how to complete a defined task.

Procedure – Tympanic thermometer

- Place a new cover on the thermometer's probe.
- The thermometer will turn on automatically, a single beep will sound indicating the thermometer is ready for use.
- Gently place the covered sensor snugly into the ear canal, then push and release the start button.
 - If the sensor has been correctly inserted, a long beep will sound signalling completion of the assessment and the screen will display the patient's temperature.
 - If the sensor has been incorrectly inserted, a sequence of short beeps will sound and the screen will display 'POS' indicating a position error.
- Eject and dispose of the used probe cover.



+ Additional information

- To switch the temperature setting between Celsius and Fahrenheit:



- Tympanic temperatures should always be taken from the same ear as measurements do differ slightly between sides.
- The ear must be free of obstruction or excess cerumen and build-up in order to take accurate measurements.
- For persons wearing hearing aids the hearing aids should be removed and tympanic temperature assessment ideally delayed for 20 minutes.
- The range of normal temperatures varies from person to person and can be influenced by many factors such as time of day, level of activity, medications and gender.

Additional information

Additional Information that is relevant to the specific CPP and which is not addressed in another section of the CPP.



Drug Therapy Protocols (DTPs)

Drug Therapy Protocols (DTPs) include prescribed procedures and authorisation for the administration of pharmacological agents by QAS ambulance clinicians. Subject to a medical direction issued at the time ambulance clinicians must adhere to DTPs without deviation or variation. All DTPs must be read in conjunction with the QAS Drug Management Code of Practice.

Generic name of the medication
Glucose gel

Pharmacology
A broad description of the medication including the drug class and the mechanism of action.

Drug class
Hyperglycaemic

Pharmacology
Glucose gel is a form of pure glucose that is absorbed quickly in the intestinal tract after ingestion. It is the principal energy source for body cells especially the brain.^[1,2]

Metabolism
Glucose is broken down in most tissues and distributed throughout total body water.^[1]

Indications

- Symptomatic hypoglycaemia (with the ability to self-administer oral glucose)

Contraindications

- Unconsciousness
- Patients with difficulty swallowing
- Patients < 2 years

Precautions

- Nil

Side effects

- Nausea and/or vomiting
- Diarrhoea

Presentation

- Tube, 15 g glucose (Glucose 15™)

Onset	Duration	Half-life
≈ 10 minutes	Variable	Not applicable

Schedule

- Unscheduled.

Routes of administration
Per oral (PO)

FR EPTO AT P ACP1 ACP2 CCP

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Drug class
The 'drug class' to which the medication belongs. Classes are determined by similar structure and mechanism of action.

Metabolism
A description of how the medication is metabolised in the body and subsequently excreted.

Indications
Clinical indications for the administration of the medication by QAS ambulance clinicians.

Contraindication
Clinical or other circumstances that would prohibit or caution against the administration of the medication.

Precautions
Clinical circumstances in which the benefits of the medication may still outweigh the risks and must be evaluated on a case-by-case basis to ascertain if this is the case.

Side effects
List of potential complications and adverse reactions that have been associated with the administration of the medication. Note, this is not a complete list of all adverse drug reactions associated with the medication. Only those side effects most pertinent to the prehospital care setting are included.

Presentation
The physical appearance and dosage of the medication available for use by QAS ambulance clinicians.

Onset/Duration/Half-life
The time following administration at which the effects of the medication will commence; the duration of that effect; and the half-life of the medication or time required for the concentration of the medication in the body to be reduced by one half.

Schedule
The schedule in the *Standards for Uniform Scheduling of Medicines and Poisons* under which the medication is categorised.

Route of administration
The route and dose of administration of the medication according to the clinical indication and scope of practice of the ambulance clinician.



Drug Therapy Protocol (DTPs) *continued*

Adult dosages

The dosage of medication to be administered to patients who are 13 years of age or older, unless otherwise specified.

Paediatric dosages

The dosage of medication to be administered to patients who are 12 years of age or younger, unless otherwise specified.

Special notes

Additional information relevant to the specific DTP, that the clinician must be aware of and take into account when administering the medication.

Glucose gel

Adult dosages

Symptomatic hypoglycaemia (with the ability to self-administer oral glucose)



PO

15 g
Repeated once at **15 minutes**
if BGL \leq 4.0 mmol/L.
Total maximum dose 30 g.

Paediatric dosages

Symptomatic hypoglycaemia (with the ability to self-administer oral glucose)



PO

\geq 2 years – **15 g**
Repeated once at **15 minutes**
if BGL \leq 4.0 mmol/L.
Total maximum dose 30 g.

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 Consultation and Advice Line*.
- Patients are to swallow the entire contents of the tube where possible, to maximise the rise in blood glucose levels.

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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.



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 (ambulance clinician), 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, qualifications and authorisation of the ambulance clinician.

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 ambulance 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 clinician 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 patients' 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 must be made by contacting the appropriate Operations Centre (OpCen).

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

Basic Principles of Management



- identify and manage life-threatening conditions
- locate all patients first, if the number of patients is greater than resources at hand, 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 *(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 (2nd Edition)



The QAS supports the second edition of the *Australian Charter of Healthcare Rights* which describes the rights of patients using the Australian healthcare system. The Charter describes the rights that consumers, or someone they care for, can expect when receiving healthcare.

These rights have been adapted here for the consideration of QAS ambulance clinicians.

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

**AUSTRALIAN COMMISSION ON
SAFETY AND QUALITY IN HEALTHCARE**

All patients have the right to:

Access:

- Receive healthcare services and treatment that meets their needs.

Safety:

- Receive safe and high quality care that meets national standards.
- Be cared for in an environment that is safe and makes them feel safe.

Respect:

- Be treated as an individual, and with dignity and respect.
- Have their culture, identity, beliefs and choices recognised and respected.

Partnership:

- Ask questions and be involved in open and honest communication.
- Make decisions with their healthcare provider, to the extent that they choose and are able to do so.
- Include the people that they want in planning and decision making.

Information:

- Receive clear information about their condition, the possible benefits and risks of different tests and treatments, so they can give informed consent.
- Receive information about services, waiting times and costs.
- Be given assistance, when they need it, to help understand and use health information.
- Access their health information.
- Be informed if something has gone wrong during their healthcare, how it happened, how it may affect them and what is being done to make care safe.

Privacy:

- Have their personal privacy respected.
- Have information about their health kept secure and confidential.

Give feedback:

- Provide feedback or make a complaint without it affecting the way they are treated.
- Have concerns addressed in a transparent and timely way.
- Share their experiences and participate to improve the quality of healthcare and health services. 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.



General information – patient decision-making

- 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

- When can treatment and ambulance services be provided without consent?
- Use of force and restrictive practices
- 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?
- How to assess if a young person has capacity to provide consent (Gillick competent).
- Can a child or young person refuse ambulance services?
- Can a parent refuse to provide consent for ambulance services for their child?
- Urgent and life-sustaining treatment of a child or young person
- Decisions to withhold and withdraw life-sustaining treatment for a child or young person
- Assessment and treatment of a child under the *Child Protection Act 1999*

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.^[1] The following is a non-exhaustive list of examples of clinical treatments and services provided by ambulance clinicians that amount to ‘ambulance services’:

- taking a history and conducting a physical assessment of a patient
- administration of pharmacological agents
- administration of intravenous fluids
- performing urgent invasive clinical 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/ambulance clinician, or to choose one of a number of options that may be available.^[2] This right to make decisions would logically extend to include decisions about all ambulance services. It is therefore essential that ambulance clinicians 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 legally authorised to make decisions for the patient if such a person is readily available. *(details regarding persons legally authorised to make decisions are provided below)*

Obtaining consent before ambulance services are provided is essential for two reasons. First, it respects the patient’s right to make their own decision regarding the services that are recommended and second, it protects the clinician from any potential claims arising from the provision of treatment or services 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/s that are 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:^[3]

- 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 relates 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, misrepresentation (false information), threats or undue influence that may be exerted by others, such as a family member, close friend, ambulance clinician or other health provider.^[4] This does not mean that a patient or decision-maker should not consult with family members or health providers/ambulance clinicians when considering the various options that may be available. Support from family, friends, religious leaders and cultural leaders can be very helpful for many patients and should be encouraged. The final decision, however, must ultimately be the patient’s decision and one that is made voluntarily.

Informed

The patient or decision-maker must, as far as practical, be advised of the following:^[5]

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

The information must be provided to the patient or decision-maker 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 that has been provided.

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 are provided. If there is more than one treatment or service, consent must be obtained for each.^[6]

For example, inserting an intravenous line plus administration of a medication plus applying a splint to a fractured leg.

Capacity

Capacity is about understanding. It is the patient's ability to understand the nature and consequences of their decision to consent or refuse recommended treatment.^[7] According to the law, every adult is presumed to have the capacity to make decisions about healthcare, unless it can be demonstrated, by assessment, that they don't. This is referred to as the 'presumption of capacity' principle.^[8]

There are a number of medical conditions and clinical circumstances that can potentially impact on a person's decision-making capacity on either a temporary or a permanent basis.^[9]

Examples of conditions and circumstances that can potentially impair decision-making capacity include:

- head injury;
- dementia;
- intellectual disability;
- mental health crisis;
- hypoxia;
- drug and/or alcohol intoxication
- severe pain, fear or profound fatigue.

It cannot be assumed that a person lacks the capacity to make a decision merely because of the presence of one or more of these factors. 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:^[10]

- 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.

Capacity is **not** a fixed state, meaning that a person either has capacity to make a decision or they don't. Capacity is determined according to the decision that is to be made. This means that the level of capacity, or understanding, that is required in any given situation, must be measured against the level of risk, or the potential consequences of that decision. Essentially this means that a patient may have the capacity to make some decisions, but not all.

This is referred to as the ‘*gravity of the risk*’ principle. In practice, the ‘gravity of risk’ principle essentially means that the more serious the patient’s decision in terms of clinical risk, the greater the level of capacity, or understanding, that is required.^[11]

The factors mentioned above can have varying effects on individuals and their ability to understand. In each case, it is important to determine if the patient has a level of understanding that is commensurate with the decision to be made. The following assessment guidelines may assist the ambulance clinician when assessing a patient’s decision-making capacity:

1. *Is the patient capable of retaining treatment information?*
2. *Does the patient understand the basic medical situation?*
3. *Does the patient understand the nature of the decision required of him or her? Understanding includes the following:*
 - *The treatment that is recommended and what it involves.*
 - *The recommendation and reasons for attending at a hospital or health facility.*
 - *The implications including both benefits and risks of the decision to accept, or to reject treatment and/or transport.*
 - *Alternatives and their implications, including the implications of no decision*
 - *Retaining the information (short-term memory function) sufficient to make a decision.*
4. *Can the patient use or weight the information that has been provided as part of the process of making the decision (for example, asking questions)?*
5. *Is the patient able to arrive at a clear choice and do so voluntarily (for example, is there an absence of coercion, undue influence or intimidation by the patient’s family, friends or health provider)?*
6. *Is the patient able to communicate a decision (for example, by talking, using sign language or any other means)?*

If the ambulance clinician has any concerns regarding the assessment of a person’s decision-making capacity, or is unable to determine with certainty, if a patient has the requisite decision-making capacity to make the decision, the clinician should consult with the *QAS Clinical Consultation and Advice Line*.

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

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

When consent is not required

Consent for treatment and ambulance services is not required for a patient with impaired decision-making capacity, if the treatment/ambulance service involves:

- minor, uncontroversial services that are necessary to promote the patient’s health and wellbeing;^[12] or
- urgent services that are necessary to meet an imminent risk to the patient’s life or health;^[13] 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.^[14]

Minor and Uncontroversial Health Care

In each case, it is the responsibility of the ambulance clinician to determine if the treatment/ambulance service is minor and uncontroversial. Minor and uncontroversial must be of a type that is necessary to promote the patient's health and wellbeing, and the ambulance clinician does not know, or could not be reasonably expected to know, that the patient objects to the treatment/ambulance service.^[15]

Examples of minor and uncontroversial treatment/ambulance services may include:

- conducting a non-invasive clinical assessment
- providing ambulance transport of a patient to a hospital or healthcare facility due to specific clinical needs.

Urgent healthcare

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

- the treatment/ambulance service should be carried out urgently to meet imminent risk to the person's life or health; or
- the treatment 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.^[16]

However, the treatment/ambulance services may not be carried out if the ambulance clinician knows the patient objects to the treatment and has done so in an Advance Health Directive.^[17]

The ambulance 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 ambulance clinician considered that the treatment/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.

Use of force and restrictive practices for patients with impaired decision-making capacity

The use of force or restrictive practices (physical and chemical restraint) represents a serious measure and should ONLY be considered in the following circumstances:

- when all other alternatives to avoid or minimize harm to the patient or others has been considered and are deemed inappropriate or ineffective; and
- when the benefit of using force or restrictive measures clearly outweighs any distress that the measures may cause to the patient

Any force or restrictive practices that are implemented MUST be carried out in accordance with good clinical practice and MUST be consistent with relevant CPGs and CPPs.^[18]

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

If a patient has impaired decision-making capacity, decisions regarding treatment and ambulance services must be made in the following order of priority:^[19]

1. If the patient has 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* ^[20] have been satisfied – see below for further details);
2. 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.
3. If the patient has appointed one or more attorneys, the matter can be dealt with by the attorney/s.
4. The matter can be dealt with by the patient's statutory health attorney.

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

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

A substitute decision-maker may include:

- 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.^[21]

Who can be a Statutory Health Attorney?

In the event that the patient has not appointed an attorney, a 'statutory health attorney' is authorised under the *Powers of Attorney Act* ^[22] to make decisions for the patient. A Statutory Health Attorney is the first of the following people who are readily available and culturally appropriate:^[23]

- The patient's spouse if the relationship is close and continuing;
- A person who is over 18 years of age and who is caring for the person (not a paid carer);
- A close friend or relative of the patient who is over 18 years of age (not a paid carer); or
- The Public Guardian

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 for themselves. When making decisions, the attorney or guardian must comply with the Health Care Principles set out in the *Powers of Attorney Act 1997* ^[24] and the *Guardian and Administration Act 2000*.^[25]

The Health Care Principles require the attorney or guardian to:

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

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.^[26] It is a legally recognized expression of a person's wishes with respect to future health care decisions. The Advance Health Directive can include directions to request healthcare, directions to refuse specified healthcare, and directions to withhold or withdraw life sustaining measures. An Advance Health Directive must be:

- in writing;
- signed by the patient;
- signed and dated by an 'eligible witness' (justice, commissioner of declarations, notary public or lawyer) who attests to the capacity of the patient at the time;^[27] 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.

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 ambulance clinician should sight the original or certified copy of the Advance Health Directive.

An Advance Health Directive should not be relied upon in circumstances where:^[28]

- the document is defective (pages are missing or the document is not signed, dated, and witnessed);
- the directions are unclear or ambiguous;

- the directions are inconsistent with good medical practice (*see definition below*);
- 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.

Ambulance clinicians are required to obtain advice from either the patient's general practitioner or medical specialist or the *QAS Clinical Consultation and Advice Line* if any of the above listed circumstances arise.

Advance Health Directives and directions relating to life-sustaining measures

The *Powers of Attorney Act 1998* and the *Guardian and Administration Act 2000* both define 'life-sustaining measures' as:

... health care that is intended to sustain or prolong life and supplants or maintains the operation of vital body functions that are temporarily or permanently incapable of independent function.^[29]

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.

The *Powers of Attorney Act 1998* provides that direction in a person's Advance Health Directive to withhold or withdraw a life-sustaining measure cannot operate unless:^[30]

1. the patient has impaired decision-making capacity;
2. there is no reasonable prospect of regaining capacity for health matters; and
 - a. the patient is suffering from one of the following medical conditions:
 - b. a terminal illness or conditions that is incurable or irreversible and, in the opinion of the treating doctor and another doctor, the patient may reasonably be expected to die within one year;
 - c. a persistent vegetative state;
 - d. be permanently unconscious;
 - e. 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 ambulance clinician should sight the original or certified copy of the patient's Advanced Health Directive and documentary evidence of, or be informed by the patient's treating medical practitioner, that the conditions (as 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 ambulance clinician must record in the patient's eARF:

- the direction as it is provided in the Advance Health Directive and sighted by the clinician;
- 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 that would demonstrate that the direction applied in the current circumstances.^[31]

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) and/or other life-sustaining measures are required, the ambulance clinician is **not required** to obtain consent before commencing CPR and other life-sustaining measures. The ambulance clinician can continue to provide CPR until such time as the clinician has had an opportunity to assess the clinical situation, and to make reasonable enquiry regarding the patient's wishes and the identity and location of a person/s who may be authorised to make health decisions for the patient.

In an acute emergency, CPR or other life-sustaining measures may be withheld or withdrawn without consent, in circumstances where the patient's **health provider** (medical practitioner, QAS medical director or medical officer or CCP credentialed to work on the *QAS Clinical Consultation and Advice Line*) issues a direction to the effect that:

- 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.^[32]

A person's **guardian or attorney** can provide consent to withhold or withdraw CPR and other 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.^[33]

Good Medical Practice

Good medical practice is defined 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.^[34]

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.^[35] 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 may not have the capacity to understand and make decisions about healthcare/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, the ambulance clinician is required to obtain consent before any treatment/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 the child or young person, or a person authorised to provide consent for the child.^[36]

Who can consent for a child or young person?

The child or young person

If a 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.^[37]

There is no set age at which a young person may be capable of making a decision about treatment and ambulance services. The determination of capacity to consent 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 below*).^[38]

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.^[39] Adoptive parents have the same parental rights and responsibilities as those of the biological parent.^[40]

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

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

Ambulance Clinicians are encouraged to contact the *QAS Clinical Consultation and Advice Line* 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’.^[41]

The nature of the care arrangements will determine the level of authority which the carer has in relation to decisions about healthcare/ambulance services 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 day to day 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/ambulance services, the following factors should be considered:^[42]

- 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, attitude 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 treatment/ambulance service, or a decision to decline the services that are recommended, the greater the level of understanding that is required. In circumstances where this may arise, it is strongly recommended that the ambulance clinician consult with the *QAS Clinical Consultation and Advice Line*.

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

If a young person is Gillick competent and is deemed capable of providing consent for specified treatment/ambulance services, it would be logical that the young person could also refuse the ambulance services that are recommended, however this has not been resolved.

Courts can override a Gillick competent young person’s decision to refuse treatment on the basis that the decision is contrary to the young person’s best interests, however, this is rarely done.^[43]

In circumstances involving a Gillick competent young person’s decision to refuse treatment/ambulance services against advice, the ambulance clinician should:

- explore the reasons why the young person has refused to provide consent;
- encourage the young person to discuss their decision with a parent or adult before refusing to give consent; and

- explore if alternative healthcare options may be appropriate in the circumstances, and acceptable to the young person.

In circumstances where the decision to refuse treatment/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 ambulance clinician is required to contact the *QAS Clinical Consultation and Advice Line* for direction.

Can a parent refuse health care or ambulance services for their child?

The parent of a child has the authority to make decisions regarding healthcare/ambulance services for their child. The parent must exercise this authority and make those decisions ‘in the best interests of the child’.^[44]

In circumstances where a parent is refusing to provide consent for recommended ambulance services, the ambulance clinician must consider if that parent’s decision is contrary to the child’s ‘best interest’ and one that could potentially result in the child suffering serious harm.

If the ambulance clinician believes that the parent’s decision to refuse treatment/ambulance services for their child is not in the best interests of that child, the clinician **MUST** contact the *QAS Clinical Consultation and Advice Line* for direction.

Urgent and life-saving treatment for children

In circumstances where a child or young person requires urgent and potentially life-saving treatment/ambulance services, and it is not possible or practical to obtain consent from the young person or the parent, treatment/ambulance services must be provided without delay.

Ambulance clinicians are expected to make reasonable attempts to obtain consent from either the child/young person (if they have decision-making capacity) or the child’s parent, before treatment/ambulance services are implemented. However, in some situations it may not be possible or practical for this to occur.

If it is not possible to obtain consent, treatment/ambulance services are to be provided without delay, if the ambulance clinician believes the services are required immediately in order to avert a serious risk to the child or young person’s life or health.

If treatment/ambulance services are provided without consent, the ambulance clinician is to document the following in the patient’s eARF:

- Details of the assessment of the child or young person’s capacity to make decisions
- What steps were taken to obtain consent from someone with authority to provide consent
- The treatment/ambulance services that were immediately necessary and provided
- Decisions to withhold and withdraw life-sustaining treatment for a child or young person

All ambulance clinicians must contact the *QAS Clinical Consultation and Advice Line* no greater than 15 minutes after the commencement of life-sustaining measures in cases involving a patient who is less than 18 years of age.

Decisions to withhold and withdraw life-sustaining treatment for a child or young person

The principles that apply when making decisions regarding the withholding or withdrawing of life-sustaining measures for a child or young person include:^[45]

- The parent/s of a child is legally authorised to make decisions for the child if the child is unable to make decisions themselves.
- Decisions regarding the withholding or the withdrawal of life sustaining measures for a child **MUST** be made in the best interests of the child.
- The wishes of a child who has obtained sufficient understanding of their condition and who had been involved in decisions regarding treatment options, should be given substantial consideration.

- Legal intervention may be required when disputes between ambulance clinicians and other health providers (healthcare team), the child's wishes, and the parents, cannot be resolved.

Assessment and Treatment of a child or young person under the Child Protection Act 1999

An ambulance clinician may clinically examine and/or provide treatment to a child or young person if a police officer or authorised child safety officer requests that the examination and/or treatment be provided.^[46]

The examination and/or treatment that is provided must be reasonable. Parental consent for the examination and/or treatment is not required in these circumstances.



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 Traditional 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]



Ambulance clinician 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 ambulance clinicians:

- 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, clinicians should look for non-verbal indicators such as:

- Minimal speaking
- Lying on their side not wanting to face the clinician 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 ambulance clinicians:

- 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, clinicians 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

While 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 ambulance clinicians:

- 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 ambulance clinicians.

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.

Ambulance clinicians 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]



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 ambulance clinicians consult the patient about their personal level of religious observance and practice.^[21]

Coping with Pain

Ambulance clinicians 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

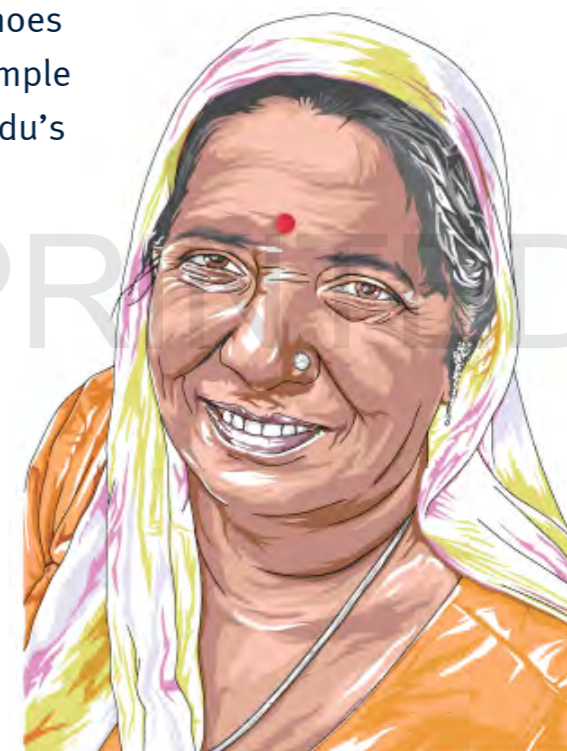
Handshaking normally only takes place between two people of the same sex. Handshakes are generally gentle rather than firm. As an alternative to handshaking, some Hindu people may clasp their hands together or hold their hands in a prayer position and bow.

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

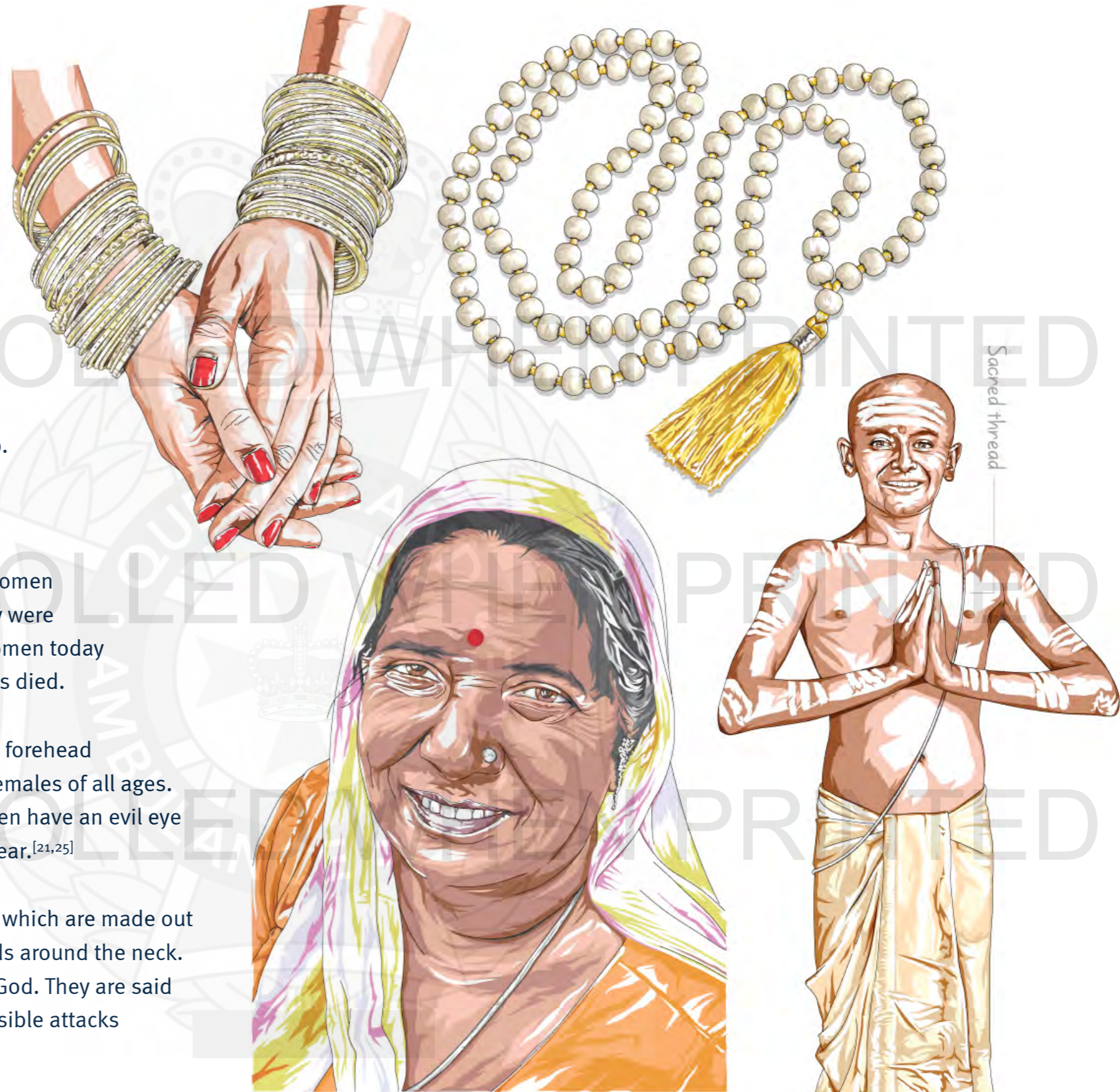
If the situation allows and a patient is wearing any of the below items of religious significance, clinicians should talk to the patient about any religious protocols or sensitivities that they should be mindful of while treating the patient.

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 must not 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 an ambulance clinician suspects a patient might be using traditional medicine, asking questions regarding this is an important step in gaining a better understanding of the patient's needs in light of their religion and/or culture.

Additionally, some Hindus 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 patient's 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]

**While 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]



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 ambulance clinician 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

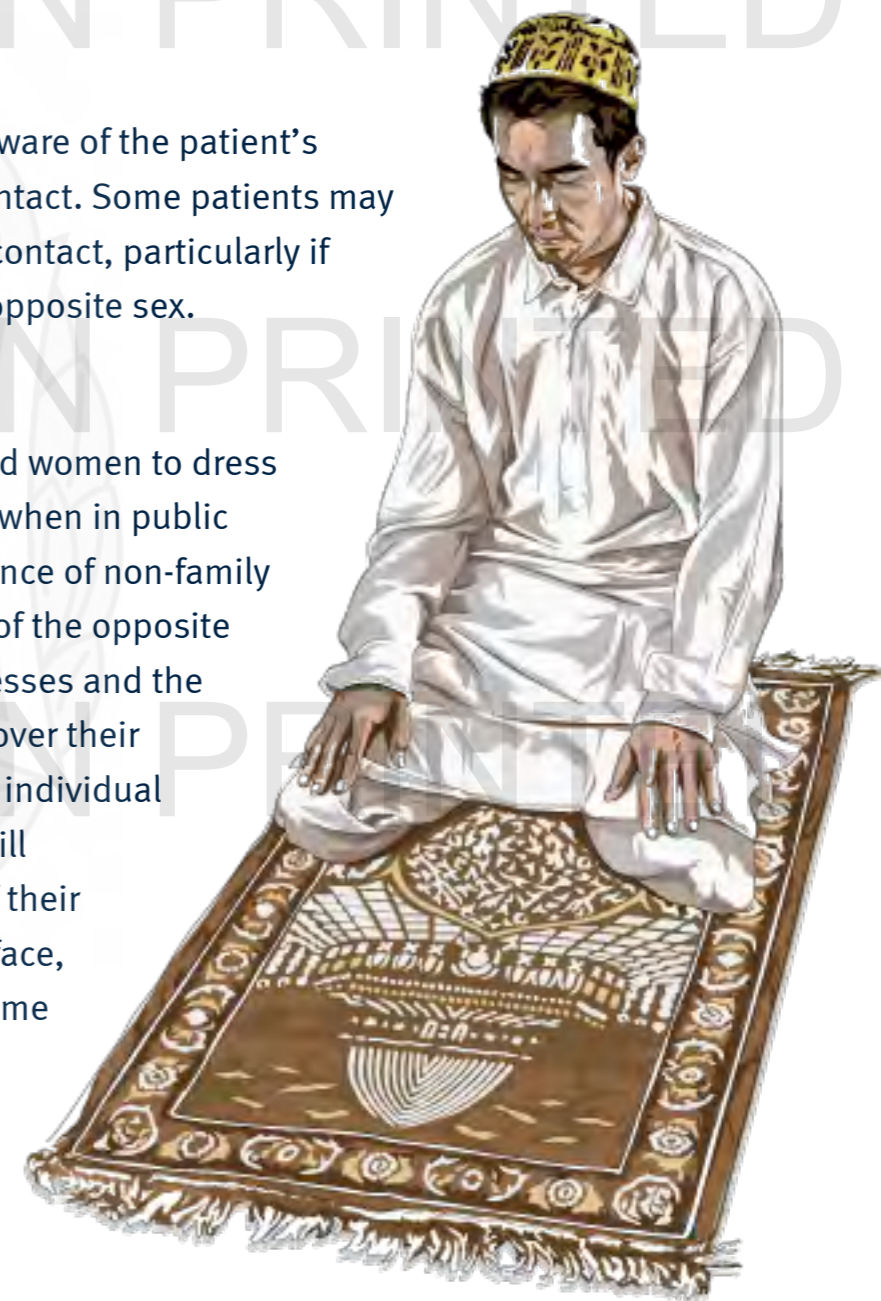
Some Muslims regard the left and right hands to serve different functions. The left hand is used for cleaning and the removal of dirt and the right hand for touching other people, waving, eating and handling items.

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.

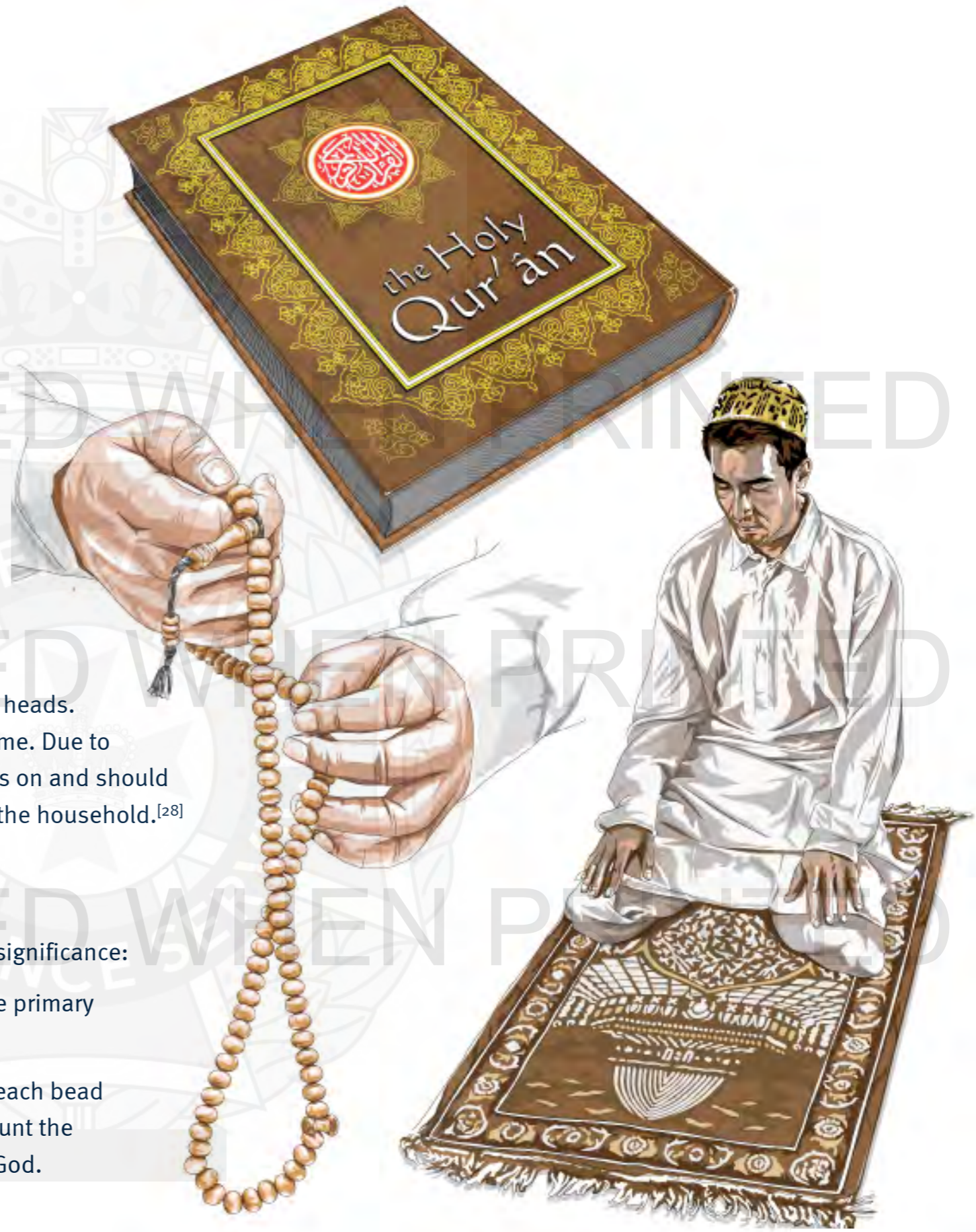
Modesty

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 ambulance clinicians

- Organise for the patient to be treated by ambulance clinicians of the same sex.
- If a male clinician 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]

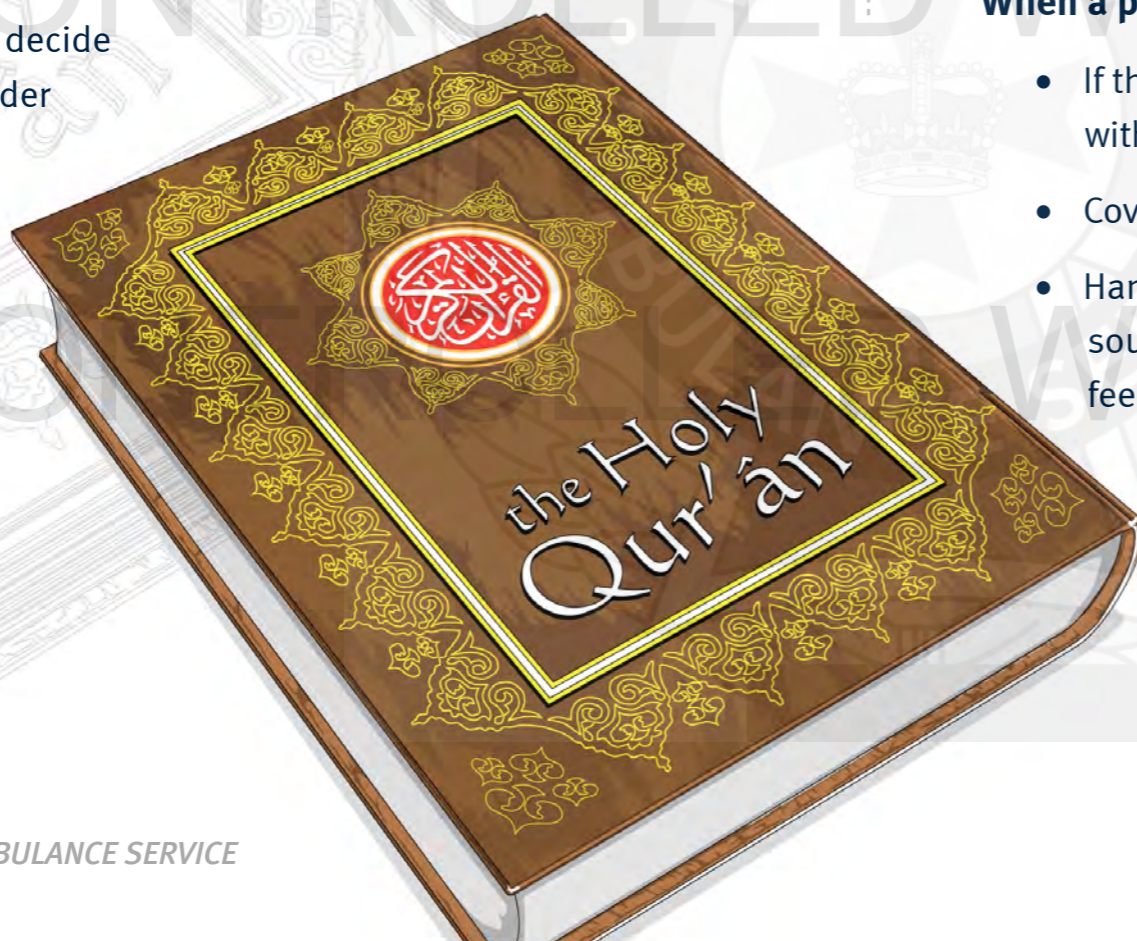
Mental Health

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]

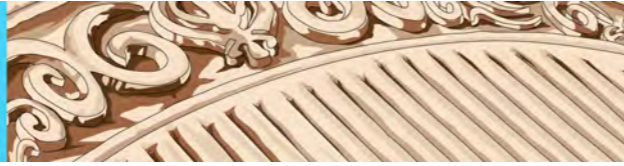
When a patient is nearing death:

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 ambulance clinicians 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 clinician 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 ambulance clinicians 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.

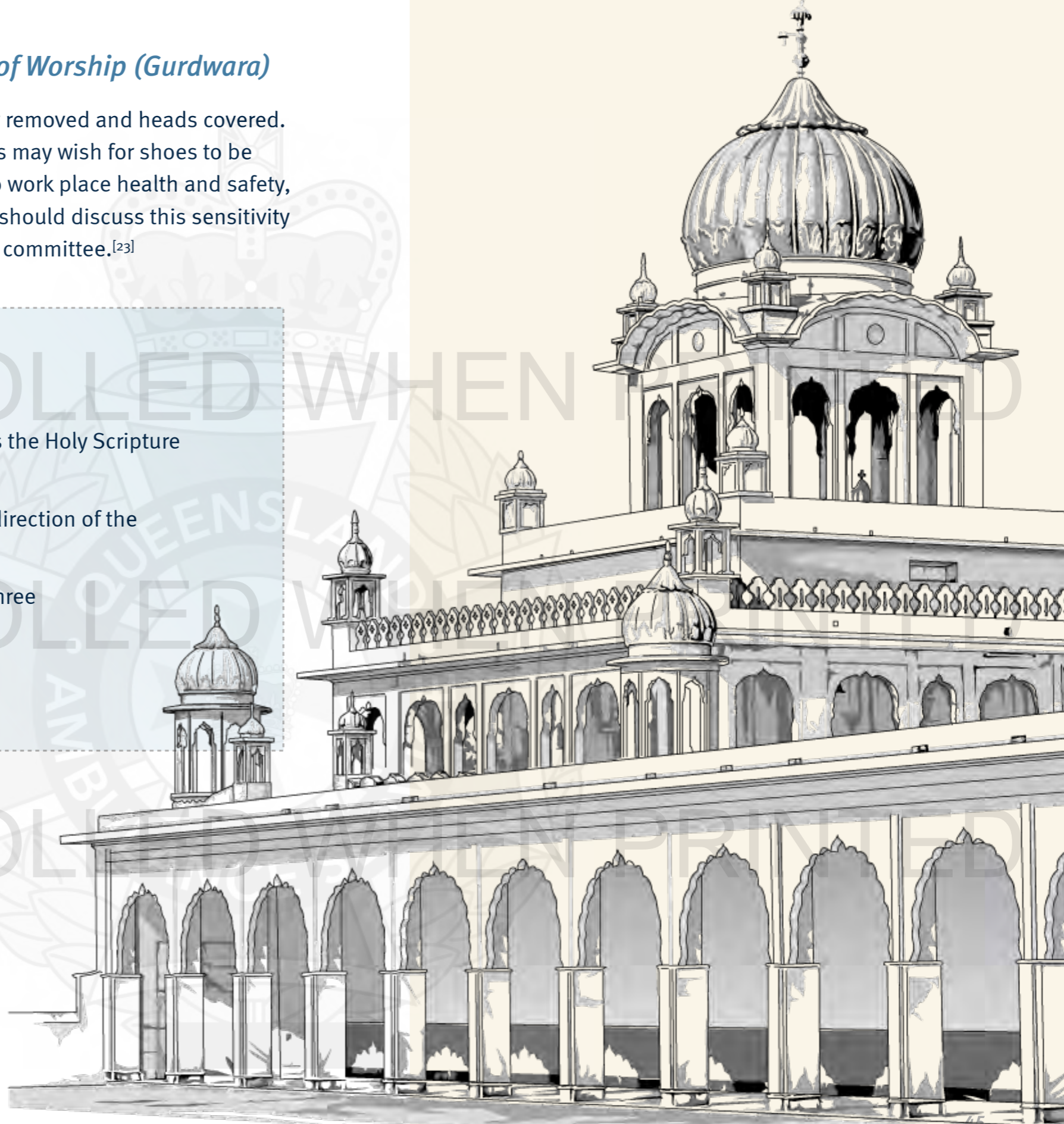
In addition, the turban is sacred and where possible, should not be touched. If the head needs to be touched for treatment purposes, explain this to the patient and ask for permission before removing their turban. Place the turban on the patient's lap or if lying down, stomach. Under no circumstance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

- 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 clinicians 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 one's 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:

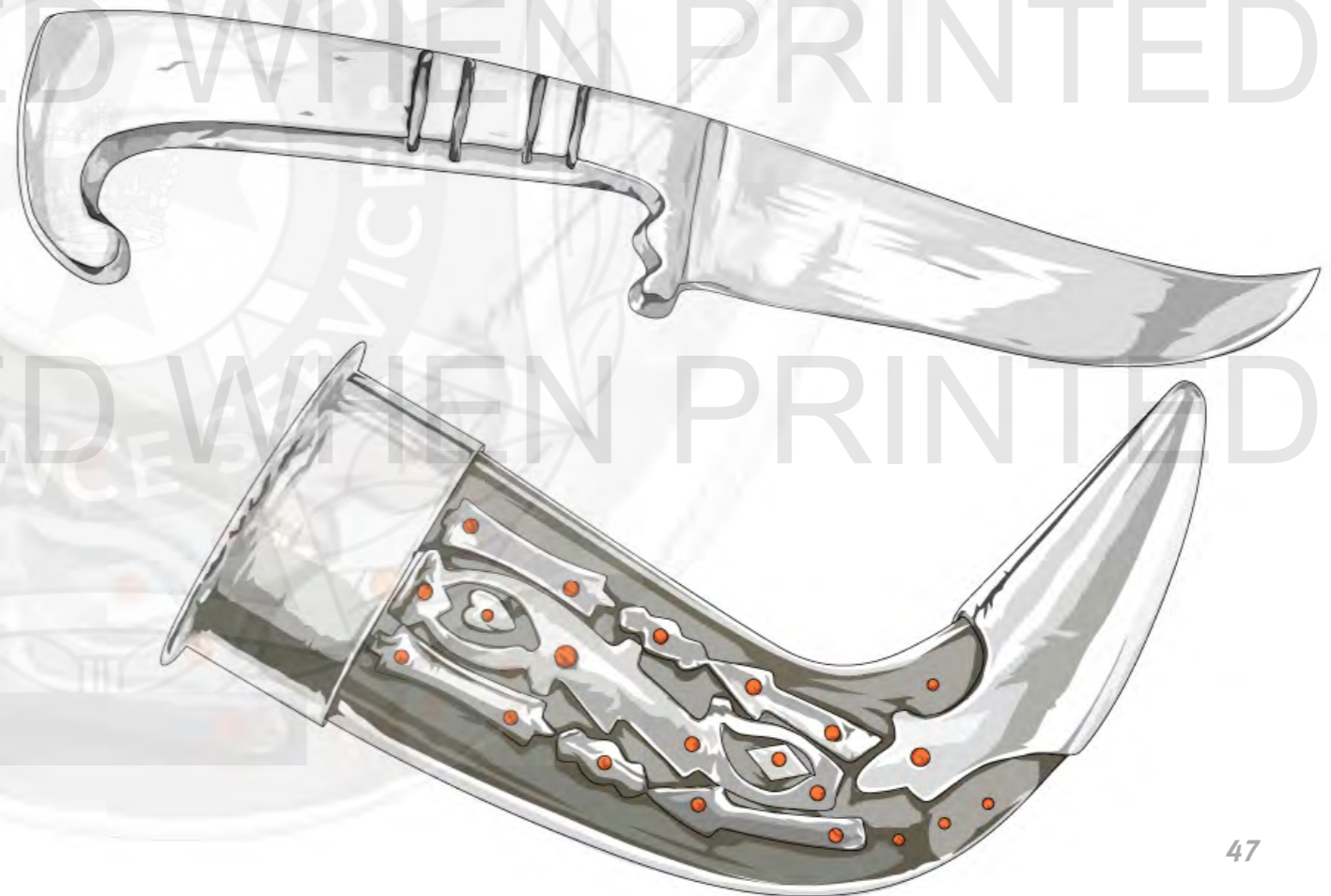
- Providing the patient with an opportunity to connect to social networks and engage with others
- Contributing to the moral uplifting of the person^[37]
- Contributing to a sense of purpose
- Helping a Sikh feel more engaged and closer to the Sikh faith.

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]

**While these non-pharmacological approaches to treating mental illness should be considered by clinicians 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:

- Ambulance clinicians 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 ambulance clinicians 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
- Ambulance clinicians 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]





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 control practice.

(available to QAS personnel via the [QAS Portal](#))

Drug Management



The QAS has a responsibility to ensure that drugs are supplied, stored, carried, administered, and disposed of in accordance with the *Medicines and Poisons (Medicines) Regulation 2021* and adequate records of these practices are retained.^[1]

The ***Drug Management Code of Practice***^[2] describes the framework for drug management within the QAS. *The Drug Management Code of Practice* must be read in conjunction with the QAS Drug Therapy Protocols.

(The Drug Management Code of Practice is available to QAS personnel via the [QAS Portal](#))





Clinical Documentation

The Queensland Ambulance Service Completion of Patient Health Records Policy Statement and The Queensland Ambulance Service Completion of Patient Health Records Procedure, describes the QAS requirements for completion of patient health records.

The electronic Ambulance Report Form (eARF) is the primary patient health record completed by QAS clinicians.

Completion of an eARF and other relevant supporting patient health records is an essential and integral component of patient care.



Clinical Documentation

As stipulated by relevant DCPM guidelines, additional supporting patient health records, when required, include but are not limited to:

- Cardiac Reperfusion Checklists
- Clinical Trial Records
- Death and Cardiac Arrest Form
- Emergency Examination Authority (EEA)
- Prisoner Observation Recommendation Forms
- Recognition of Life Extinct (ROLE) Form
- STEMI Capture Forms

Comprehensive documentation ensures appropriate continuity of patient care at a receiving facility in addition to a variety of other functions including legal, research, quality assurance and billing requirements.

The Queensland Ambulance Service Completion of Patient Health Records Policy Statement and The Queensland Ambulance Service Completion of Patient Health Records Procedure are available to QAS personnel via the [QAS Portal](#).

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.

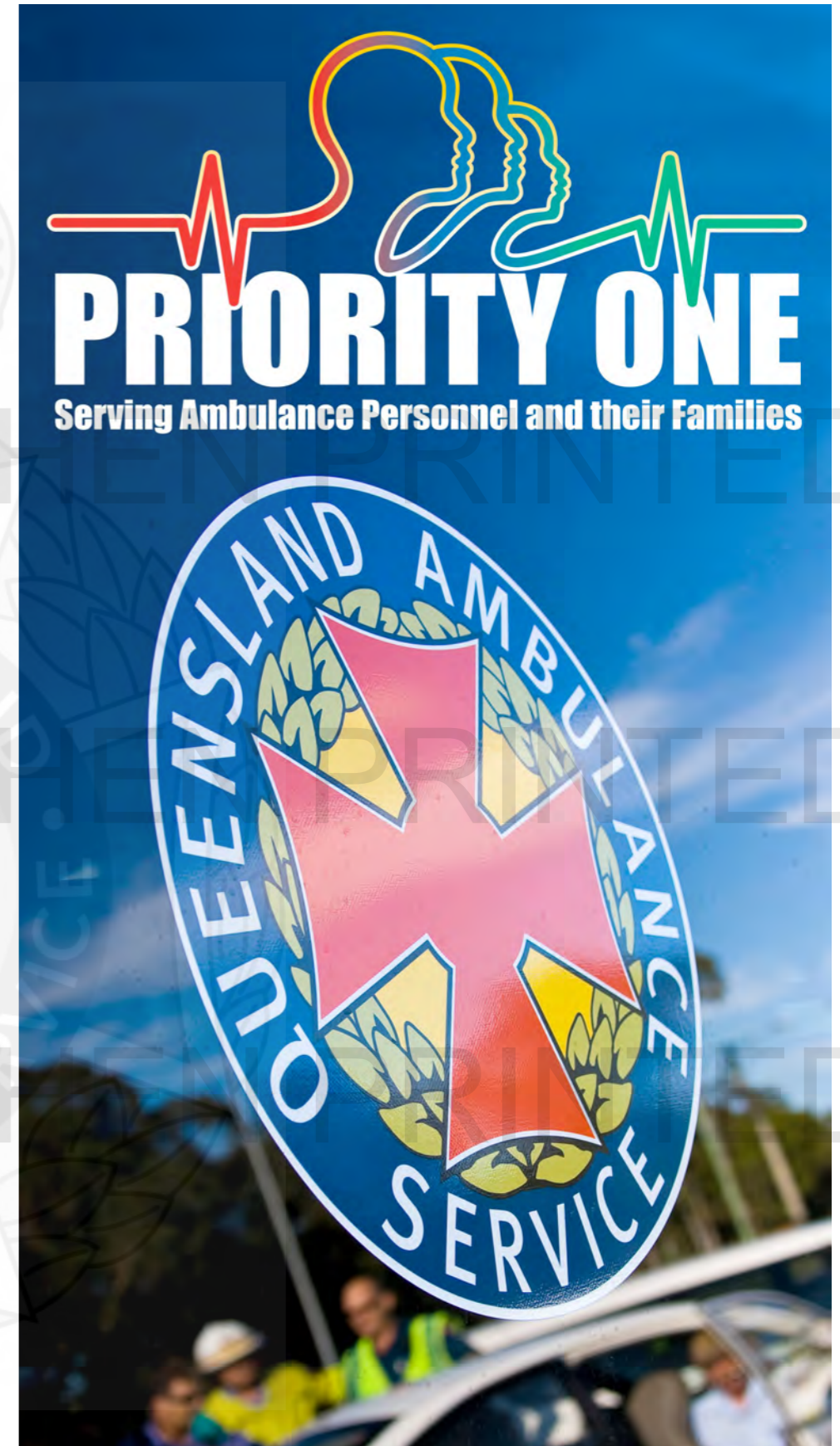
Clinicians are highly resilient people who generally cope well with the multiple stressors inherent in their profession. However, the very nature of ambulance work means that occasionally clinicians may find their normal coping strategies less effective. This may be associated with the type or nature 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 ambulance officer
- 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 region are available in all QAS stations and on the **QAS Portal**.



Telephone
counselling
service

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 ambulance clinician must stop and evaluate the risk before continuing, judiciously putting in place controls to eliminate or minimise any hazards. This can include requesting 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 pre-hospital 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, all clinicians must 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 QAS personnel 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**

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 QAS personnel 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 ambulance clinician safety concerns.

All clinicians can be further supported and gain expert advice through the QAS Workplace Health and Safety (WHS) Unit, Regional 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
 - 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
 - CPP: Resuscitation / Mechanical chest compression device referral
 - CPP: Other / Suspected large vessel occlusion stroke referral
 - Clinical redirection policy – Robina Hospital.
- The patient is unable to be definitively managed at the local hospital.
- When in the opinion of the operations 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

Region	Hospital	Major trauma service	Regional trauma service	pPCI	Stroke lysis	Endovascular clot retrieval	Obstetrics	Paediatrics
Far Northern	Cairns Hospital		●	●	●		●	●
Northern	Mt Isa		●		●		●	●
	Townsville University Hospital	●		●	●	●	●	●
Central	Mackay Base Hospital		●	●	●		●	●
	Rockhampton Hospital		●		●		●	●
Darling Downs & South West	Toowoomba Hospital		●		●		●	●
Sunshine Coast & Wide Bay	Bundaberg Hospital		●		●		●	●
	Hervey Bay Hospital		●		●		●	●
	Nambour Hospital	Refer to District Local Work Instruction						
	Sunshine Coast University Hospital		●	●	●		●	●
Metro North	Caboolture Hospital		●		●		●	●
	Redcliffe Hospital		●		●		●	●
	Royal Brisbane & Women's Hospital	●		●	●	●	●	
	The Prince Charles Hospital			●	●			●
Metro South	Ipswich Hospital		●		●		●	●
	Logan Hospital		●		●		●	●
	Princess Alexandra Hospital	●		●	●	●		
	Mater Hospital Brisbane		●	Pending	●		See Note #1	
	Mater Mothers' Hospital						●	
	Queensland Childrens' Hospital	●						●
	Queen Elizabeth Jubilee II Hospital				●			
	Redland Hospital				●		●	●
Gold Coast	Gold Coast University Hospital	●		●	●	●	●	●
	Robina Hospital	Refer to District Local Work Instruction						

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 a 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 or CCP; 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	PTO	AT	AM	P	ACP1	ACP2	CCP
Adrenaline (epinephrine)	E		I		I	I	I	I
Amiodarone							I	I
Aspirin	I		I		I	I	I	I
Atropine								I
Benztropine (benzotropine)								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		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		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		I		I	I	I	I
Phenytoin								E
Propofol								E
Rocuronium								E
Salbutamol	E		I		I	I	I	I
Sodium bicarbonate 8.4%								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

University student paramedics must practice under the **direction** and **direct supervision** of the attending ACP2, CCP or ambulance medical officer.

- ACPs may administer medications that are outside the ACP2 scope of practice, only in instances where:
- The administration is at the **direction** of the attending CCP or ambulance medical officer; and
 - The ACP2 is under the **direct supervision** of the attending CCP or the ambulance medical officer.

LEGEND:

I = Independent practice, **C** = Prior consultation and approval required, **E** = Authorised under an approved extended scope of practice – consultation may still be required, **P** = Pilot being undertaken by specifically trained and authorised paramedics

Category	Procedure	Registered Paramedics							
		FR	PTO	AT	AM	P	ACP1	ACP2	CCP
Access	External jugular intravenous cannulation								I
	Intraosseous – peripheral							P	I
	Intraosseous – sternal								E
	Peripheral intravenous cannulation							I	I
Airway Management	Direct laryngoscopy						I	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								E
	Blood analysis – iSTAT®								E
	Blood analysis – Glucose	E		I		I	I	I	I
	Blood analysis – Ketones							P	P
	Endotracheal tube cuff manometer								I
	Invasive blood pressure							E	E
	Myotatic stretch reflexes							E	E
	Pulse oximetry	I		I		I	I	I	I
	Temperature	I		I		I	I	I	I
	Ultrasound – Focused assessment with sonography for trauma								E
	Waveform EtCO ₂ 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	I
	12-Lead ECG STEMI interpretation (advanced)								I
	Autonomous fibrinolysis administration								I
	Autonomous pPCI referral								I
	Cardiac monitoring			I		I	I	I	I
	Decision supported fibrinolysis administration							I	
	Decision supported pPCI referral							I	
	Modified valsalva manoeuvre			I		I	I	I	I
	Synchronised cardioversion								I
	Transcutaneous cardiac pacing								I
Drug/fluid administration	Adrenaline (epinephrine) auto-injector	E		I		I			
	Blood warmer								E
	Central venous access device – IVP								P
	Continuation of an established intravenous fluid infusion			E		I	I	I	I
	Intramuscular	E		I		I	I	I	I
	Intranasal							I	I
	Intravenous							I	I
	Metered Dose Inhaler (MDI) with spacer	I		I		I	I	I	I
	Nebuliser (mask)	E		I		I	I	I	I
	Nebuliser (T-piece)								I
	Oral	I		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	I
	Sublingual			I		I	I	I	I
	Syringe infusion pump – Perfusor® Space								I
	Syringe infusion pump – SPRINGFUSOR® 30								I
Obstetrics	Bimanual compression			I		I	I	I	I
	Breech delivery			I		I	I	I	I
	Nuchal umbilical cord			I		I	I	I	I
	Physiological cephalic delivery			I		I	I	I	I
	Shoulder dystocia			I		I	I	I	I
Respiratory	Bag valve mask ventilation	I	I	I	I	I	I	I	I
	Chest seal			I		I	I	I	I
	Emergency chest decompression – needle (cannula)							I	I
	Emergency chest decompression – Pneumodart®							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	I
Resuscitation	Cardiopulmonary resuscitation	I	I	I	I	I	I	I	I
	Defibrillation – Automated External Defibrillator	I	I	I	I	I	I	I	I
	Defibrillation – manual							I	I
Trauma	Arterial tourniquet	E		I		I	I	I	I
	Cervical collar	I	I	I		I	I	I	I
	Facial packing								I
	Femoral traction splint			I		I	I	I	I
	Fish hook removal							E	E
	Fracture reduction								I
	Haemostatic QuikClot® combat gauze	E		I		I	I	I	I
	Helmet removal	I	I	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
Recognition of Life Extinct (ROLE)				E		I	I	I	I
Regional anaesthesia: digital block								E	E
Sedation – procedural									I
Suspected large vessel occlusion stroke referral				I			I	I	I

Student paramedics must practice at all times under **direct** supervision.

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