

QAS CLINICAL PRACTICE MANUAL

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Cardiac

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Synchronised cardioversion
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Valsalva manoeuvre

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enFlow® blood warmer
Intramuscular injection
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Oral drug administration
Springfusor®
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Sublingual drug administration

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Respiratory

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Thorostomy

Resuscitation

Cardio pulmonary resuscitation (CPR)
Defibrillation

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Application of bandages and slings
Application of stifneck® collar
Care of an amputated body part
Combat application torniquet® (C.A.T®)
Donway traction splinting
Extraction board
Fracture reduction
Helmet injury
Manual inline stabilisation
NEANN

SAM Pelvic Sling™
Scoop stretcher
Vacuum splints

Other

Clinical consultation
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Sedation and procedural sedation

DRUG THERAPY PROTOCOLS

Adrenaline
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Aspirin
Atropine
Benztropine
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Calcium gluconate 10%
Ceftriaxone
Clopidogrel
Enoxaparin
Fentanyl
Frusemide
Glucagon
Glucose 5%
Glucose 10%
Glucose gel
Glyceryl trinitrate
Haloperidol
Heparin
Hydrocortisone
Hydroxocobalamin
Hypertonic saline 7.5%
Insulin (Actrapid®)

Ipratropium bromide
Isoprenaline
Ketamine
Lignocaine 2%
Magnesium sulphate
Methoxyflurane
Metoclopramide
Metoprolol
Midazolam
Morphine
Naloxone
Noradrenaline
Ondansetron
Oseltamivir
Oxygen
Packed red blood cells
Paracetamol
Phenytoin
Promethazine
Salbutamol
Sodium bicarbonate 8.4%
Sodium chloride 0.9%
Tenecteplase
Tirofiban
Water for injection

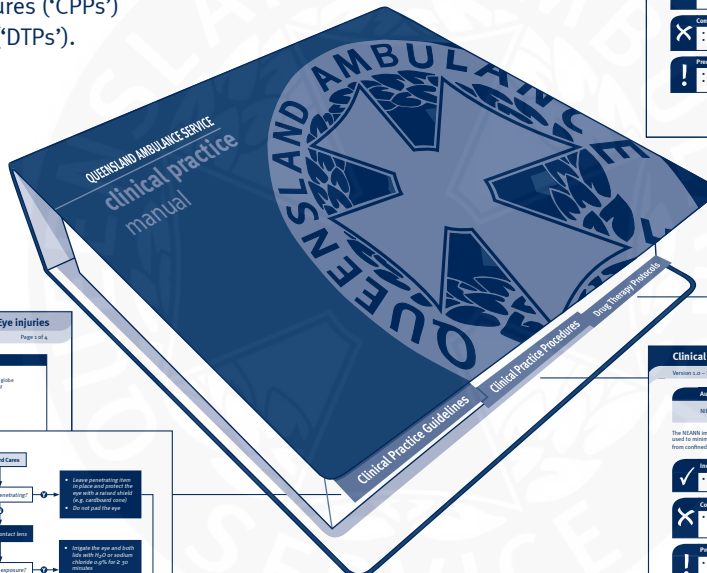
APPENDIX

Medical abbreviations

The QAS aims to provide high standards of emergency treatment, patient care and transportation for sick and injured people. The new CPM reflects contemporary standards of clinical practice in the pre-hospital environment. It includes assessment and treatment information based on expert evidence.

The CPM is divided into **three** parts:

- clinical practice guidelines ('CPGs')
- clinical practice procedures ('CPPs')
- drug therapy protocols ('DTPs').



CPGs

Clinical practice guidelines
Version 1.0 – September 2011

Eye injuries
Page 4 of 4

Eye injuries are common and may be serious despite a benign appearance. All patients with suspected eye trauma and patients who have an A&OC should have their eyes assessed and basic eye protection provided as required.

General management principles include:

- Irrigation with water or saline to remove biological material
- Real exposure, foreign body or chemical burn
- Protect eye with shield (cardboard cone or equivalent)
- Analgesia
- Avoid evisceration
- Pre-hospital transport if indicated

Clinical features (continued)

- Periorbital eye injury
- Accurately checked on subsequent shifts
- Obvious laceration or presence of contusion/bleed
- Squinting
- Blood over sclera
- Retinal injury
- Chemical exposure
- Traumatic myopia

Clinical features

- Irrigation with water or saline to remove biological material
- Real exposure, foreign body or chemical burn
- Protect eye with shield (cardboard cone or equivalent)
- Analgesia
- Avoid evisceration
- Pre-hospital transport if indicated

Additional information

- With acute eye trauma, the priority is initial stabilisation of the patient, stabilisation of the airway and transport to an appropriate facility (hospital or eye clinic)
- If possible, patients with eye injuries should have a visual acuity test as soon as possible
- Test one eye at a time
- Usually test the patient's left eye by right fingers
- Suspected patient on clarity of vision
- Do not force patient to squint to complete this
- Use for hand testing, or light projection
- Assessment of eye contents, including protruding or bulging eye injury or highly recommended, following significant increases in intraocular pressure and should be recorded
- It is recommended that medication is used in these circumstances regardless of wound size and eye injury
- It is highly recommended that medications such as antibiotics are avoided, due to the risk of allergic reactions occurring and preventing the injury
- Routine patching of eyes is no longer recommended, if patching is used, it is not to be placed over the globe. Be well and an eye with a penetrating injury
- Patching the eye for exposure following chemical exposure is not recommended
- Patching is recommended by all may have special requirements, consult with treating facility or QIC in light of restrictions. When flushing the globe, avoid repeated exposure eye down and back to avoid chemical
- Eye injuries associated with suspicious injury should be irrigated with saline solution
- Patched/patching for patients with eye injuries is subject to local procedures

Standard Care

Shield eye

Remove contact lens

Chemical exposure

Transport to hospital

Flowchart:

```
graph TD
    A[Shield eye] --> B[Remove contact lens]
    B --> C[Chemical exposure]
    C --> D[Transport to hospital]
    E[Shield eye with H2O or saline (flushing eye) for 15 minutes] --> D
    F[If necessary, remove contact lens] --> D
```

NOTE: Only use eye patches for patients who do not have normal vision and who are not transported to the QIC.

Eye injuries – Page 4 of 4

DTPs

Drug therapy protocols
Version 1.0 – September 2011

Salbutamol
Page 2 of 2

Drug class: Beta-2 adrenergic agonist

Pharmacology: Salbutamol is a short-acting sympathomimetic agent which causes bronchodilation. It is a selective beta-2 agonist with a beta-2:beta-1 ratio of 20:1. It has a low affinity for beta-1 receptors but also has intrinsic and chronotropic actions. Additionally it causes peripheral vasoconstriction through its direct stimulation of the alpha-1 receptors (alpha-1A and alpha-1B).

Indications:

- Bronchospasm
- Suspected type 2 diabetes

Contraindications:

- CAD
- Proliferative eye disease

Precautions:

- Avoid patients with narrow angle glaucoma
- Insulin resistance

Special notes:

- Different preparations of salbutamol are used for salbutamol and rescue therapy. The appropriate administration of salbutamol (salbutamol inhaler) will cause various adverse effects.
- For patients with COPD, inhaled salbutamol is to be delivered via a nebuliser mask at a rate of 4 L/min. For all other patients it is inhaled as appropriate.
- The manufacturer recommends that inhalers must be stored within the 15°C to 30°C range and are to be discarded if the contents are expired. The date that the inhaler is opened should then be clearly marked on the patient.

Adult dosages

NEB 5 mg

IV 4 mg

Paediatric dosages

NEB 0.5 mg

IV 0.1 mg

Adult dosages (continued)

Suggested hyperbaric oxygenation (HBO) during wound and debridement

NEB 5 mg

IV 4 mg

Paediatric dosages

NEB 0.5 mg

IV 0.1 mg

Notes:

- QICs offshore are not authorised to administer salbutamol
- Paediatric patients commencing with bronchodilator treatment for the first time
- QICs offshore are not authorised to administer salbutamol to paediatric patients presenting with suspected hyperbaric oxygenation related COPD exacerbation

Salbutamol – Page 2 of 2

CPPs

Clinical practice procedures
Version 1.0 – September 2011

NEANN immobilisation & extrication jacket
Page 1 of 4

Authorisation to practice

NEI

Procedure

- Explain the procedure to the patient and gain consent.
- Prepare the NEI – remove from the carry case and unfold.
- Check the buckle required, head supports and girth pads.

Procedure (continued)

- Slide the NEI round the back of the patient, so that it is no higher than the top of the patient's head. It fits in the neck opening, position jacket fully.
- Ensure the three flaps of the device are snug under the patient's arms. Check carefully the device is not pinching patients.
- Release the girth straps from back of the NEI and pull them tight. Check carefully the device is not pinching the patient's arms, neck or chest. Pull the girth straps tight. If either arm between the patient and chest flaps. Slide both straps under the legs and buttocks until they are in the girth field, and girth.
- Release the patient's arms to shoulder height, then position the chest flaps against the chest. Apply straps from top to bottom. Girths, unless they hold, difficult to fit on older patients, the straps are not tensioned. Pull the girth straps tight. If either arm between the patient and chest flaps. Slide both straps under the legs and buttocks until they are in the girth field, and girth.
- If patients do not take the straps snug, the NEI, slide the blue girth pads onto each neck, leg strap.
- Connect the leg straps to the buckles on the same side and tighten by pulling.
- Recheck straps to confirm comfortable fit for fit.
- Use the appropriate amount of head pads to

NEANN immobilisation and extrication jacket – Page 1 of 4

The **CPGs** cover a range of clinical conditions and situations commonly encountered by paramedics in the pre-hospital environment. In the case of a clinical condition, each CPG provides:

- information regarding a typical clinical presentation
- the diagnostic pattern associated with the relevant condition
- guidelines for clinical management.

The **CPPs** cover specific clinical procedures that may be performed as part of the clinical management of a patient. The use of specific items of equipment carried by QAS ambulances is also addressed through relevant CPPs.

Clinical practice guidelines

Version 1.0 – September 2011

Eye injuries

Page 1 of 4

Eye injuries are common and may be serious despite a benign appearance.

All patients with suspected eye trauma and patients who have an AOC should have their eyes assessed and basic eye protection precautions implemented.

General management principles include:

- Irrigation with water or saline for chemical or biological fluid exposure, foreign body or thermal burns.
- Protect eye with shield (cardboard cone or styrofoam cup)
- Anti-emetic
- Position patient head up

Clinical features

- Significant eye injury may be present, despite normal vision and minimal symptoms.
- If eyelid oedema makes opening of the lids difficult – attempt gentle, associated and documented flushing.
- General symptoms:
 - pain or sensation of 'foreignness' in the eye
 - red
 - cop
 - spot
 - imp
 - hae
 - fluid
 - chem
 - sens
 - pain
 - blur
 - red

Additional information

- With most eye injuries the priority is initial stabilisation of the patient, protection of the eye and transport to an appropriate facility (preferably one with an ophthalmologist).
- If possible, patients with eye injuries should have a visual acuity test completed.
 - Test one eye at a time.
 - Initially test the patient's ability to count fingers (question patient on clarity of vision).
 - Should the patient be unable to complete this, test for hand motion, or light perception.
 - Do not delay initial treatment to perform visual acuity test.
- Administration of an antemetic following penetrating or blunt eye injury is highly recommended. Nontoxic significantly increases intraocular pressure and should be avoided.
 - It is recommended that ondansetron is used in these circumstances especially if opioid pain relief is given.
 - It is highly recommended that medications such as maxillo are avoided, due to the risk of dystonic reactions occurring and perpetuating the injury
 - Routine padding of eyes is no longer recommended. If padding is used, it must not place pressure on the globe. **Do not pad an eye with a penetrating injury.**
- Reducing time for irrigation following chemical exposure is beneficial.
- Patients transported to GPs may have special requirements. Consult with receiving facility or QCC as to light restrictions.
- When flushing eyes, place injured/damaged eye down and flush from medial aspect.
- Eye injuries associated with capsicum spray should be irrigated until pain subsides.
- Preferred positioning for patients with eye injuries is supine with head elevated.

Clinical features (continued)

- Penetrating eye injury:
 - abnormally shaped or collapsed globe
 - obvious laceration or presence of protruded tissue
 - hyphema
- Blunt eye injury:
 - orbital injury
 - traumatic cataracts
 - hyphema
 - occasionally vitreal detachment
- Retinal detachments:
 - can occur spontaneously or months after an injury
 - history of light flashes
 - presence of floating black specks
 - curtain-like narrowing of peripheral vision
- Flash burns:

Standard Cues

Blunt or penetrating? →

- Leave penetrating item in place and protect the eye with a raised shield (e.g. cardboard cone)
- Do not pad the eye

Remove contact lens →

Chemical exposure? →

- Irrigate the eye and both flaps with H_2O or sodium chloride 0.9% for 2-30 minutes
- If capsicum spray, continue irrigation until pain subsides

Irrigate eye with H_2O or sodium chloride 0.9% for 15 minutes →

- If foreign body present, attempt removal with a moist cotton bud

Transport to hospital

Pre-notify as appropriate

Note: Officers are only to perform procedures for which they have received specific training and authorisation by the QAS.

Eye injuries – Page 2 of 4

Clinical practice procedures

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Intramuscular injection

Page 1 of 2

Authorisation to practice

Intramuscular injection

Additional information

- The speed of absorption is faster than the subcutaneous route, owing to the muscle tissue having a greater blood supply.
- An advantage of the IM route as opposed to the subcutaneous route is that the muscle can accommodate a larger volume of fluid being injected, i.e. 3-5 mL in an adult in the vastus lateralis and approximately 2 mL in a child, also in the vastus lateralis
- For any calculated IM volumes that exceed 2 mL, the dose must be split and administered at different IM sites.
- The use of Unisafe® syringes is highly recommended.

Indications

- The administration of medications via the IM route

Contraindications

- Evidence of infection or trauma at the injection site

Complications

- Pain
- Bleeding

Approved injection sites

The deltoid muscle for an IM injection

Authorisation to practice

Version 1.0 – September 2011

NEJ

Indications

- To facilitate safe extri

Contraindications

- When the patient is actual time critical and the application of the NEJ will delay transport to a trauma centre, or

Precautions

- Chest straps that are not with respiratory effort
- Goin straps need to be jacket and neck move
- Incoore head padding hyperextension or hyp
- Immobilising the head the torso section may

Procedure (continued)

- Slide the NEJ round the back of the patient, so that it is no higher than the top of the patient's head. If this is not possible, position jacket firmly in the patient's armpits.
- Ensure the chest flaps of the device are snug under the patient's arms. (Adjust carefully for children and pregnant patients).
- Release the groin straps from back of the NEJ and hold both straps together, ensuring they are not twisted. Pull the groin straps down either side between the patient and chest flap. Slide both straps under the legs and buttocks until they are in the garter fold. Pull groin straps and leave.
- Raise the patient's arms to shoulder height, then position the chest flaps against the chest. Apply straps from top to bottom (green, yellow, then red).
- The green straps should cross the chest, unless the patient has chest injuries or breathing difficulty, for the latter cases, the straps can run vertically.
- For patients that need to be lifted using the NEJ, slide the blue groin pads onto each black leg strap.
- Connect the leg straps to the buckles on the same side and tighten by pulling.
- Recheck straps to confirm comfortable but firm fit.
- Use the appropriate amount of head pads fit

NEANN immobilisation and extrication jacket – Page 2 of 4

The **DTPs** provide directions for the use of pharmacological agents that have been authorised for use by QAS paramedics when performing duties for the QAS. A DTP exists for each pharmacological agent and provides parameters for its use in the pre-hospital environment.

To further assist QAS paramedics, a **Field Reference Guide (FRG)** has been created and issued to each paramedic. The FRG includes an algorithm for all CPGs as well as other reference material that may be helpful in the field. Paramedics are individually responsible for ensuring their personal FRG is updated to reflect periodic changes to the CPM.

Drug therapy protocols

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Drug class
Beta adrenergic agonist

Pharmacology
Salbutamol is a direct acting sympathomimetic agent which mainly effects Beta 2 (B₂) = adrenoceptors. It primarily acts as a bronchodilator but also has inotropic and chronotropic actions. Additionally it lowers serum potassium levels through its direct stimulation of the sodium/potassium ATPase pump, drawing potassium into cells.

Metabolism
Hepatic with excretion by the kidneys.

Indications

- Bronchospasm
- Suspected hyperkalaemia (with QRS widening AND/OR AV dissociation)

Contraindications

- KSAR
- Patients < 2 years

Precautions

- Acute pulmonary oedema
- Ischaemic heart disease

Salbutamol

Side effects

- Anxiety
- Tachyarrhythmias
- Tremors
- Hypokalaemia and metabolic acidosis

Presentation

- Nebule, 5 mg/2.5 ml salbutamol
- Ampoule, 500 mcg/1 ml salbutamol

Onset	Duration	Half-life (elimination)
2 – 5 minutes (NEB)	16 – 60 minutes (NEB)	6.6 hours
1 – 3 minutes (IV)	10 – 20 minutes (IV)	

Schedule

- S4 (Restricted drugs)

Routes of administration

Nebuliser (NEB)

Intravenous injection (IV)

Special notes

- Different preparations of salbutamol are used for nebulised and IV routes. The inappropriate administration of nebulised salbutamol solution IV will cause serious adverse effects.
- For patients with COPD, nebulised salbutamol to be delivered via nebuliser must be at a rate of 6 l/minute. For all other patients 8 l/minute is appropriate.
- The manufacturer recommends that nebulisers must be stored within the foil packet and are to be discarded three months after opening. The date that the foil packet is opened should then be clearly marked on the packet.

Adult dosages (continued)

Suspected hyperkalaemia (with QRS widening and/or AV dissociation)

NEB 500 mcg
Single dose only.

Paediatric dosages

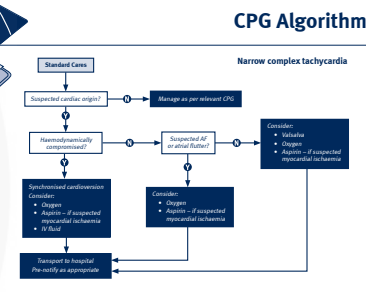
Preparation	NEB	IV
Bronchospasm	2 – 2 years – 5 mg Repeated PRN, No maximum dose.	2 – 2 years – 5 mcg/kg Single dose not to exceed 250 mcg. Repeated once at 30 minutes.

Notes:
QAS officers are not authorised to administer salbutamol to paediatric patients presenting with bronchospasm under the age of 5 years.
QAS officers are not authorised to administer salbutamol to paediatric patients presenting with suspected hyperkalaemia with QRS widening and/or AV dissociation.

Adult dosages

Preparation	NEB	IV	IM
Bronchospasm	5 mg No maximum dose.	500 mcg Repeat at 15 minutes interval.	5 mg Repeat at 15 minutes interval.

Notes:
QAS officers are not authorised to administer salbutamol to paediatric patients presenting with suspected hyperkalaemia with QRS widening and/or AV dissociation.



Atropine - Adult dosages

Asystole/presence of pulse

1 mg IV
2-3 years – 5 mg
Total maximum dose 3 mg
5-9 years – 10 mg
Total maximum dose 30 mg

Note: QAS officers are not authorised to administer atropine to paediatric patients.

Heparin

Precautions:

- Antipsychotics, Selective Seric. Inhibitors

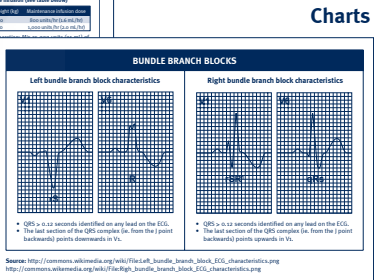
INDICATIONS:

- For patients with STEMI (as defined in the QAS primary care algorithm) treated with 180-360 mcg who have been accepted for PPCI
- Critical care patients requiring anticoagulation during interfacility transport

CONTRAINDICATIONS:

- KSAR
- Recent administration (or for prophylactic thrombolysis, unless specifically authorised under the protocol) (all have increased GIP and GII's capacity safety separation (see table)

Note: QAS officers are not authorised to administer heparin to paediatric patients.



Drug Therapy Protocols

POWERS OF AUTHORISED OFFICERS

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

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

- protect persons from any danger or potential danger associated with an emergency situation
- protect persons trapped 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 a purpose of protecting persons from danger or potential danger, or those that are trapped may include, but are not limited to, the following:

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

- administer such basic life support and advanced life support procedures as are consistent with the training and qualifications of the authorised officer.

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

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

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

Paramedics are also encouraged to consult with senior officers, clinicians and medical specialists if the circumstances warrant.

Forced entry

On occasion, officers may be left with no choice but to forcibly enter premises to locate a patient.

1. Officers on scene must advise that they are unable to rouse a response from any person at the premises or gain entry without force.
2. The communication centre will then follow standard procedures to ascertain the correct address has been given and will attempt to call-back the caller.
3. Once the communication centre has carried out standard procedures and verified the address by radio, the attending officers are to verify the address at the scene and notify the communication centre that they intend to make entry to the premise in accordance with the above directions. Every effort is to be made to cause the least damage as possible.

4. In these situations officers are to ensure the communication centre is notified of the measures taken to gain entry and if the building cannot be secured.
5. If the patient's condition requires urgent transport, the communication centre is to notify the QPS and/or a senior QAS officer of the situation.
6. Every effort must be made to notify the owners/residents of the premises of the damage.
7. The use of forcible entry to gain access to premises is to be recorded on the ARF, including actual damage caused to the premises to gain entry.

ROLE OF THE PARAMEDIC

The role of the paramedic lies within the Queensland Emergency Medical System (QEMS). Paramedics have three primary tasks:

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

The Paramedic must consider all resources available within the QEMS continuum when treating a patient, including QAS resources, community resources, other emergency services including aeromedical resources, ancillary medical facilities and receiving hospitals.

Obtaining the most appropriate care in the most efficient time-frame may encompass the following options:

- paramedic to administer care on-scene if trained and authorised
- rendezvous with an Intensive Care Paramedic (ICP) or appropriately trained officer on-scene
- rendezvous with an appropriate Doctor or ICP enroute
- utilise aeromedical services
- clinical consult with a doctor
- transport patient to the most appropriate definitive care specific to their needs.

The paramedic must make these decisions in conjunction with QAS Policy & Procedures, clinical training, experience and available advice.

BASIC PRINCIPLES OF MANAGEMENT

Basic Principles of Management are goals of care that apply to all cases:

- Review all communication centre dispatch information.
- Consider all environmental factors and approach a scene only when it is safe to do so.
- Identify potential and actual hazards and take the necessary precautions.
- Ensure the safety of yourself, other officers and emergency services personnel, your patients and the public.
- Ensure the scene is as safe as is practicable.
- Request assistance as required.

The basic principles of management also apply to all patients. Paramedics must:

- identify and manage life threatening conditions
- locate all patients first. If the number of patients is greater than resources, seek additional resources.
- assess the patient's condition appropriately
- prioritise and manage the most life threatening conditions first
- provide sit-rep to communications as soon as possible after arrival on scene
- 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
- provide psychological support at all times
- transport as necessary

Where the number of patients overwhelms the existing resources refer to the QAS Multi-casualty Management Plan.^[2]

INFECTION CONTROL

This guideline describes QAS infection control procedures for prevention of infectious disease transmission in the ambulance environment. The full guideline is on the DES portal.^[3] Effective infection control is based on good hygiene centred around practices that arise from identifying hazards and implementing risk management procedures. Strategies for infection control are based on current understanding of the aetiology of infections involved and the most effective ways to control them.

STAFF SUPPORT

Paramedic work sometimes exposes staff to circumstances they find very difficult to cope with.

Sudden Infant Death Syndrome (SIDS), is one such circumstance and the following is provided to assist in the management of SIDS outside the clinical scope:

- Attempt resuscitation if appropriate.
- Treat the baby as a baby, rather than a body. Use the baby's name if you can.
- Do not hurry the baby away from the house.
- Separation from the baby should occur when the parents are ready.
- Carry the baby to a place of comfort in the home and allow parents to remain with their baby if they wish.
- Other children need not be removed or separated.
- Explain that it could be SIDS but this will be confirmed after 'an autopsy' is completed. Explain that our laws require an autopsy to be carried out to ascertain the cause, if possible, of any sudden, unexpected death, whatever the age of the person.

- Reassure parents that an autopsy is a detailed operation carried out with gentleness and care by a pathologist. Tell the parents that the police will call and that this is normal. Tell the parents a formal inquest is not necessary if death is due to SIDS and that parents are not required to identify the baby at the Coronial Services Centre.
- Reassure the parents that, if it is SIDS, there is nothing known that they or anyone else could have done to prevent the death.
- Explain if the baby had blood, vomit, facial or body discolouration that these can occur after or during the dying process and are probably not the cause of the death of their child.
- Allow parents to express their shock and disbelief. Respect cultural mourning customs.
- Ask the parents if they would like you to telephone anyone for them or help them to do so in order that they can have support, e.g., relatives, doctor, workplace, SIDS.

If needed, call 1800 628 648 for SIDS 24-hour crisis service. SIDS counsellors are also available for ambulance staff.

Other traumatic events are managed by paramedics as per relevant guidelines and procedures. However outside the clinical requirements of these cases there may be difficulty in the management of personal emotions, thoughts and coping mechanisms.

All QAS staff should familiarise themselves with the Priority One counselling service through the DES Portal and the important service they provide.^[4]

QAS CLINICAL SCOPE OF PRACTICE LEVELS

PARAMEDIC – ADVANCED CARE 1	PARAMEDIC – ADVANCED CARE 2	PARAMEDIC – INTENSIVE CARE
<p>PARAMEDIC – ADVANCED CARE 1</p> <p style="text-align: center;">Paramedic Advanced Care 1, plus:</p> <p>Skills</p> <ul style="list-style-type: none"> • 12-Lead ECG acquisition (auto interpretation) • Adult CPR • Application of aseptic dressing • Assess vital signs • Breech delivery • BVM ventilation • Cardiac monitoring • Glucometry • Intramuscular injections • Intranasal drug administration • Laryngeal mask airway insertion • Nasopharyngeal airway • Nebulised medications • Normal cephalic delivery • Oropharyngeal airway • Primary and secondary assessments • Semi automatic defibrillation • Use of cervical collar • Use of pelvic binder • Use of spinal movement restriction techniques • Use of traction splints • Use of vacuum splints <p>Pharmacology</p> <div style="background-color: #e0e0e0; padding: 5px;"> <p>Acetylsalicylic acid Adrenaline Box Jellyfish antivenom Ceftriaxone Fentanyl Glucagon Glucose gel Glyceryl Trinitrate Methoxyflurane Midazolam Morphine Oxygen Ondansetron Paracetamol Salbutamol Water for injection</p> </div>	<p>PARAMEDIC – ADVANCED CARE 2</p> <p style="text-align: center;">Paramedic Advanced Care 1, plus:</p> <p>Skills</p> <ul style="list-style-type: none"> • 12-Lead ECG acquisition (acquisitions/STEMI recognition) • Capnography • Intravenous access • Intravenous drug administration • Laryngoscopy with Magill forceps • Manual coronary care • Thoracic decompression (consultation) <p>Pharmacology</p> <div style="background-color: #e0e0e0; padding: 5px;"> <p>Glucose 10% Hydrocortisone Hydroxocobalamin Ipratropium bromide Magnesium sulfate (envenomation only) Metoclopramide Naloxone Oseltamivir Sodium chloride 0.9%</p> <p>* Includes QAS graduate induction program</p> </div>	<p>PARAMEDIC – INTENSIVE CARE</p> <p style="text-align: center;">Paramedic Advanced Care 2, plus:</p> <p>Skills</p> <ul style="list-style-type: none"> • 12-Lead interpretations • Endotracheal intubation • External jugular venous cannulation • Gastric decompression • Intraosseous access • Intravenous infusions • Procedural sedation • Synchronised cardioversion • Thrombolysis/cardiac reperfusion • Transcutaneous cardiac pacing <p>Pharmacology</p> <div style="background-color: #e0e0e0; padding: 5px;"> <p>Amiodarone Atropine Benzotropine Calcium gluconate 10% Clopidogrel Enoxaparin Haloperidol Heparin Ketamine Lignocaine 2% Magnesium sulfate Promethazine Sodium bicarbonate 8.4% Tenecteplase</p> <p>* ESOR</p> <p>Controlled mechanical ventilation Insertion of an arterial line Frusemide Glucose 5% Hypertonic saline 7.5% Insulin (Actrapid®) Isoprenaline Metoprolol Noradrenaline Packed red blood cells Phenytoin Tirofiban</p> </div>