



# Ambulance TODAY

## MAD WORLD

Summer 2019 - ISSUE 2 | VOLUME 16

The global magazine for all  
people involved in  
ambulance provision

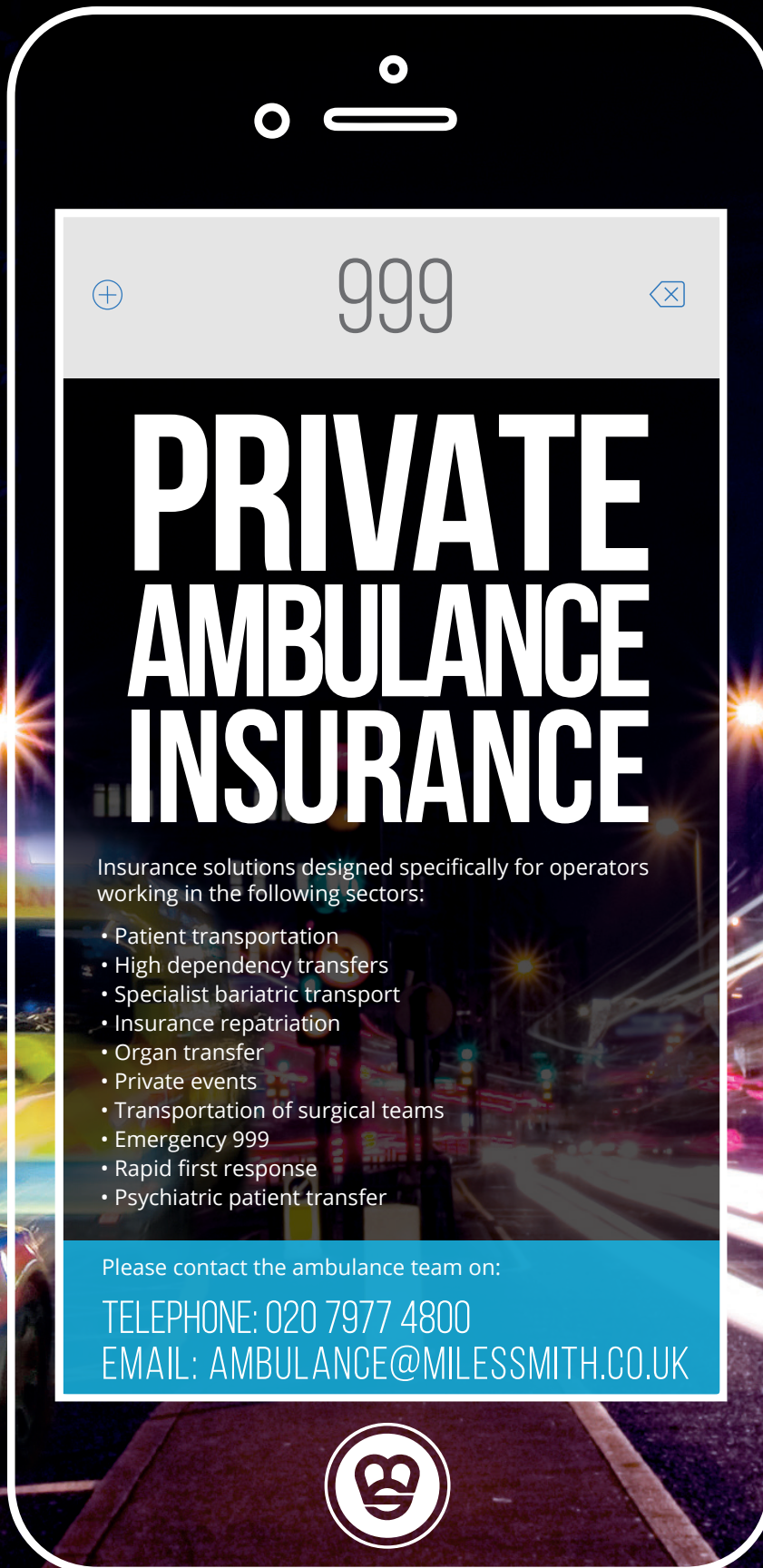
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# Look, Listen, Feel



**Joe Heneghan**  
Editor,  
Ambulance Today

For this edition, we decided to focus upon the theme of the mental health and wellbeing of ambulance personnel. Personnel is a very broad term, and deserves to be in this case, as an effective service places different burdens upon all of the different departments that form it, some glaring and unrelatable in their rarity to many, and some subtle and widely felt by all. It's fair to say that dispatch and field staff are placed in the most immediate risk of exposure to serious trauma, but each and every part of a service carries a burden equal to the responsibilities that its role carries. Management positions, for instance, are prone to high levels of stress and burnout due to the immense level of responsibility it can carry on all levels.

Why have we decided to focus on this? I'll be honest. I had taken a step away from EMS for a few years, dabbling in different parts of the industry here and there (I feel I should state here for clarity that I am not a medic, never have been), and when I recently came back to it, I was very relieved to see that talk around mental health and wellbeing seemed to be much more prevalent, as did, suitably, statements about the importance of reducing the stigma of talking about it either publicly or privately.

I must say that the Association of Ambulance Chief Executives (AACE) have, in conjunction with their fellow members of the Global Paramedic Leadership Alliance (GPLA), done a fantastic job at using the Ambulance Leadership Forum (ALF) and the accompanying GPLA summit, in order to bring people together in an open platform where they can talk about this, as well as a host of other vitally important and equally insightful matters.

There are many obvious reasons why it's important for ambulance services to address the issues around trauma, PTSD, stress, burnout, and overall mental health and wellbeing, the most practical being that stamina and resilience amongst staff are key to

an ambulance service being able to deliver a consistently high level of care. Other reasons largely revolve around the fact that ambulance services, universally, are seen as a type of family by their members, and no one wants to intentionally break a member of their own family by placing too much strain on them. Of course, the ugly truth is that this is not always strictly speaking the case, and nasty elements of politics and survival can sometimes prove the opposite of this sentiment. But, mostly, the former is true. People go into the ambulance service because it is a vocation, not just a job or a wage. And no one really wants to see their colleagues, people they can sometimes see as extended family in these cases, suffer in return for trying to be there for others in their hours of need.

Mental despair is something we can all probably relate to in some form or other. As individuals, we are all unique and so it manifests itself in different ways with all of us. Some of them comparable, some of them not. Some of them understandable, some of them not.

But one thing is consistently clear in all cases. Discussion is the key to fixing these problems or, in cases where that seems impossible, at least offering some relief until you can start to get better properly. Discussion offers understanding, and when you understand you can treat, and you can mend.

Also featured in this edition are Ambulance Victoria (AV), who respond to 840,000 emergency and non-emergency calls to the population of 6.4 million people in Victoria, Australia, every year. I mention them here because they are, in my opinion, a leading example of how to appropriately deal with problems concerning mental health and wellbeing in the workforce. You can read the article inside to get an understanding of just how awfully some cases of trauma and depression were manifesting themselves throughout the service.

Members and leaders of AV saw an emergency amongst their own and, with the compassion that comes naturally to them, and the expertise that they have spent years cultivating, they responded appropriately. And I mean appropriately. They have successfully created a culture where people can talk about anything they may feel is affecting them, in privacy and with confidentiality and without fear of recrimination, and it is seeing very positive results. They have not only responded practically, but they have also responded with empathy and emotional intelligence, and I believe that has gone a long way into their project's success.

So, this is why we decided to devote this edition of *Ambulance Today* to the now blossoming discussions of mental health and well-being. I am finally hearing these nomenclatures more than the very broad, yet still relevant, term 'resilience'. Mental health in EMS has always been a topic important to me and close to my heart because, like all of you, it has affected at least some of my loved ones in the past and, like many of you, it has also affected me. And, as mentioned before, no one wants to see their loved ones buckling under that kind of weight.

Talking about it is difficult. Speaking about the things that plague your mind forces you to recognise them in a new way and that is hard to face on levels so deep that it reaches the unconscious. But I have learned that speaking about it is nothing to be ashamed of. In fact, I have found a twisted sense of pride in it. If you knew half the things I had seen in my life, and saw me still standing there, talking to you about it, you would see that I'm not weak for showing my pain, but incredibly strong for being able to bear it. And I am certain that the same goes for many of you reading this.

**Joe Heneghan**  
Editor,  
June 2019

# I Am Totally Crazy

By Thijs Gras



**Sometimes I am stark, raving mad, lost in the wiggly ways of the labyrinth in my mind. What is going on there? Come again? I seem to have lost my senses; I am running around in circles. A funny walk seems to be going on in what we in The Netherlands call the upper chamber.**

I think you have to be a little crazy to do our job. We may not realise it every day, but we come across many special situations. In a way we are used to it, but sometimes it is too much. Young people, children, the dying or seriously injured – we have to deal with it. And the situations are a lot rougher, compared to a stretcher on which a victim is rolled into the A&E department – well immobilised, provided with an IV and adequate painkilling or intubated.

Recently it was my job to train a new colleague. He was an A&E nurse with a number of years clinical experience. We were called to a sailor who had probably drowned. It was a very cold day. Upon arrival we noticed a cardboard box, numerous life buoys and a pair of gloves floating in the water. Silent witnesses of a personal disaster. A ship laid opposite and was filled with anxious looking fellow sailors. We heard the guy dropped a box into the water and had wanted to retrieve it. His mates threw buoys towards him, hoping he could get a hold on one of them, but no, he went under, came back, but right before the eyes of his colleagues, he went under water again and never came back. The fire brigade had dispatched three diving teams and all went in, each in a different section. We prepared our stretcher and equipment and waited. After about 20 minutes one of the teams shouted: "we found him!" A motionless body was rushed ashore, we stripped him of



*The call-out as detailed by Thijs in the article*

his wet clothes, put him in a special stretcher for the drowned, started CPR and ventilation and shove him into the ambulance. There the doctor of the mobile medical team intubated him, my pupil and I secured an intra-ossal access. Under CPR we drove to the hospital. Unfortunately the sailor did not make it. For my colleague this was a very special and most impressive experience.

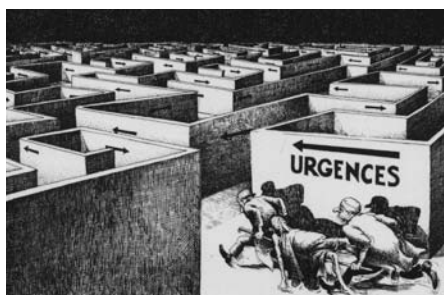
The way he felt himself involved in the whole situation made it special. It is this more personal involvement that bothers us when it is coming close to home or very emotional. One of our colleagues took some time out to recover from a few heavy incidents that happened in a short period, among them the killing of a whole family, including a five-year-old child, and a young man trapped in his vehicle who died practically under their hands. After a few months of recuperation and a few weeks as an extra team member, he was ready to work on his own again. On the very day he started, one of the first incidents was a young lady killed on the spot by a truck. The next day he was called to a lady of 75 with chest pain. When he and his colleague came into the house they were struck by the emotion. A lot of family members were gathered around, all crying. This was not a 'normal' chest pain and soon they found out that they had been called to the very family of the deceased girl from the day

before. An extremely weird twist of fate. These kinds of experiences cause deep scratches in anyone's soul.

There is no way to prevent or foresee them; they can happen any time, any place. You will have to experience and handle them. It is a good thing that we have a special team of colleagues that can be reached 24 hours after experiences like this. Everybody accepts that the talks with these colleagues help you in dealing with the rough situations. A stable home front is another important, but not always existing, factor. Being honest is another one: not the 'it does not affect me' modus.

On the other hand one should not overdo or overstress things. Everybody is different. In the words of Monty Python's messiah Brian: "you are all individuals". I certainly am. For me, being a bit crazy helps me in getting over nasty experiences. The goal is that by being crazy, you get a laugh, and laughing is very healing for your mental health. A laughter a day, keeps the shrink away. But if I would need one, I'd better welcome him or her, for there is no shame in seeking professional help when you cannot handle things yourself. I am an idiot, but I know this, and I can live with it.

Tell Thijs what you think about this article by emailing him at: [tgras@xs4all.nl](mailto:tgras@xs4all.nl)







### Pp.11 Ambulance Leadership Forum (ALF): Plotting the Future for UK Ambulance Services

An overview of this year's ALF event organised and run by the Association of Ambulance Chief Executives (AAACE) in the UK.



### Pp. 17-19 Ambulance Victoria (AV): Hiding in Plain Sight: Mental Health and the Four Pillars of a Resilient Workforce

Paramedic Paul Crole speaks about how recent partnerships between his service, Ambulance Victoria, and an Australian independent non-profit organisation, Beyond Blue, led to a strategic programme which has helped him and many others overcome the many varied issues which can surround mental health in EMS.



### Pp.20-21 EMS: Making A Difference for Sepsis Patients

EMS educator and Sepsis Alliance Advisory Board member, Rommie L. Duckworth explains the mechanisms of sepsis, its challenges of assessment and how to overcome them, alongside the Sepsis Alliance's partnership with NAEMT.

*This article originally appeared in the NAEMT News Winter issue.*



### Pp.22-23 EMS Best Practices: Sharing Proven Concepts from around the World

Senior European Marketing Manager for Zoll, Bas van de Wakker, outlines a recent workshop hosted by Zoll in Cologne, Germany, which oversaw an exploration of current knowledge around the resuscitation processes around current guidelines



### Pp. 24-25 Ambulance Control and Dispatch Stress: Who Are You Going to Call?

Control Training and Quality Assurance Manager of Northern Ireland Ambulance Service Health and Social Care Trust (NIAS), Jonny McMullan,

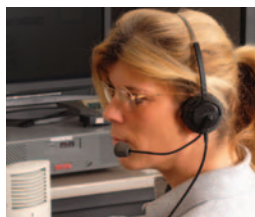
explains the emotional and mental stresses around dispatch work, to on a daily basis needs to continue to further grow and develop.



### Pp. 26-27 Coping as a Carer in 5 Steps

David Snelders of Rubik Minds and Associate Councillor for The Ambulance Services Charity (TASC) explains how, in many cases, depression unavoidably affects those

around you. David offers five insightful pointers that can help stabilise and heal those around you affected by your trauma and your relationships with them.



### Pp. 30-31 Emergency Dispatch Explores "X-Factor" for Suicidal Callers

Audrey Fraizer, of the International Academies of Emergency Dispatch (IAED) explains the X-Factor notion, as put forward by clinical

physiotherapist James Marshall – essentially the empathetic feel for communication which may make the difference between life and death for your caller. you affected by your trauma and your relationships with them.



### P.32 Paramedics Attend Tough Calls: How Best to Deal with Unwanted Memories?

Consultant Clinical Psychologist and Associate Professor of Experimental Psychology at Oxford University, Dr Jennifer Wild, explains the nature of

how the mind processes memories after witnessing traumatic events. Jennifer is also a Clinical Advisor for TASC.

FRONT COVER and artwork on P.25 supplied by Daniel Sundahl, DanSun Photo Art  
Daniel has been a full time firefighter and paramedic in Canada since 2003. You can browse more of his work at [www.dansunphotos.com](http://www.dansunphotos.com) or visit his Facebook @DansunPhotos

**Also inside:** Regular features from The Ambulance Staff Charity (TASC), our international correspondents, The Paramedic Association of Canada (PAC), NAEMT education, and more.

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**If you work in the ambulance service UNISON is the union for you, whatever job you do.**

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# A Lot Done, More to Do: The Mental Health of Ambulance Staff

Colm Porter  
National Ambulance  
Officer,  
UNISON



**Over recent years it has become well known that if you work in the ambulance service you are much more likely to experience mental health problems than the general workforce. In fact, emergency services staff are twice as likely to identify problems at work as the main cause of their mental health problems.**

The recent conclusion of Mind's Blue Light Programme, which aimed to improve the mental health of staff working in the emergency services, has produced some interesting insight into how ambulance staff view their mental health compared to when the programme began in 2015.

The research from over 1,300 ambulance staff found that:

- 55% said they felt encouraged to talk about their own mental health
- 43% said their service supports people with mental health problems well
- 51% felt that attitudes towards mental health at their organisation were changing for the better

Although there have been welcome improvements over the past 4 years, such as 66% of staff now being aware of what support is available to them to help manage their mental health compared to just 44% in 2015, this should only be seen as the start of the journey, and the mental wellbeing of staff needs to remain a top priority for employers and trade unions.

Nationally UNISON has been working with the Association of Ambulance Chief Executives (AACE) and NHS Employers to implement mental health initiatives that will have a real and lasting impact for ambulance staff. This has seen the production of guidance to help trusts develop their own mental

health strategies. In January 2018, NHS Employers launched the Ambulance Workforce section of its website that has a core aim of making the ambulance service a place that promotes positive mental wellbeing. As part of this, resources such as "head first", which is a free mental wellness resource designed specifically for ambulance staff, and the leading healthy workplaces training programme for line managers that aims to create a culture of supportive leadership in the ambulance service were developed. Improving mental health in the areas of PTSD prevention and creating safe spaces for ambulance staff is also at the centre of "Project A" that many UNISON reps and members have contributed to since it began in 2018.



At a local-level ambulance services have been working with UNISON to improve staff mental health and wellbeing. Some of the different approaches include East Midlands Ambulance Service delivering "My Resilience Matters" training to staff, South Western Ambulance Service establishing their "Staying Well Service" and the Welsh Ambulance Service's powerful "Keep Talking" campaign, where staff share their personal mental health experiences and provide an insight into what has helped them to live with, or overcome, their individual struggles.

Despite all this work and a widespread commitment to the mental health agenda, challenges still remain. The

need to ensure that any new initiatives are delivering tangible changes for staff has to be ongoing. There has never been a more joined up approach to addressing mental health in the ambulance service but still the research from Mind suggests that more than half of ambulance staff do not feel their organisation supports employees with mental health problems well, while only 34% of ambulance respondents reported to have "good" or "very good" mental health.

Finally, you can't talk about the mental health of ambulance staff without talking about the unprecedented demand that is currently on the service. For too long the government's funding of the NHS hasn't kept up with demand and, as mental health and social care services struggle as a result of chronic underfunding, it's often left to the ambulance service to pick up the pieces. Of course, the nature of ambulance work means staff encounter traumatic events that the vast majority of people will never experience and these can be a trigger for poor mental health. This alone should be enough to highlight the need for targeted mental health support but excessive workloads are more likely to be cited as a factor to cause mental health problems.

In an ambulance service that is struggling to cope with demand there's only so much ambulance employers and trade unions can do to address staff mental health. The government needs to play its role too and properly fund the NHS.

Colm welcomes feedback from ambulance staff and can be contacted at:  
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# Setting a New PACE for Preshospital Emergency Care

## Paramedicine Across Canada Expo 2019 Canada's Premier Conference Event

Winnipeg, Manitoba, Canada will play host to Canada's largest EMS conference, Paramedicine Across Canada Expo, September 19 – 21, 2019. This year's theme is *Diversity in Paramedicine*, with programming that explores diversity in all aspects of paramedic practice.

Building on the success of previous biennial conferences held in Edmonton and Quebec City, PACE 2019 will explore the latest in research and evidence important to the practice of paramedicine, attracting delegates from across Canada and around the globe.

### Pre-Conference Courses

For those who are interested in extending their conference experience, PACE 2019 is offering three sensational pre-conference learning opportunities that will improve your practice:

#### LEAP Paramedic (September 18th)

Paramedics frequently see patients with chronic disease and life limiting illness, and may also be called upon to support families at the time of a loved one's death, accidental or anticipated.

LEAP Paramedic (Learning Essential Approaches to Palliative Care for Paramedics) is a blended learning program developed by Pallium Canada that provides learners with the essential skills and competencies of a palliative care approach. This course will help paramedics better support patients who have chosen palliative goals of care.

#### KinderMedic (September 18th)

KinderMedic is a one-day course designed to improve the confidence of paramedics when managing paediatric patients. The program is taught by paramedics working in paediatric critical care transport, and provides learners with a number of high-fidelity simulation opportunities to reinforce learning.

#### Geriatric Education for EMS (September 19th)

The Geriatric Education for EMS (GEMS) Core Provider Course is an 8-hour classroom course for Paramedics and Emergency Medical Responders. GEMS provides EMS practitioners at all levels with the skills and knowledge to address the unique medical, social, environmental and communications challenges of older adults.

### Research Symposium

NEW to the PACE conference experience, the Paramedic Association of Canada is hosting a 1-day Paramedic Research Symposium on September 19th. This event is open to all healthcare practitioners from any discipline!

Whether you're a first responder, primary or advanced care paramedic, nurse, physician or other health care professional, there will be something of interest to you at this event. The day will feature presenters from across Canada and around the world reporting on a wide range of topics relevant to paramedics, prehospital care practitioners and researchers as they present their research in both oral and poster formats.

### NEW - Simulation and Fitness Competitions

PACE 2019 is also excited to introduce two new competitions to this year's conference.

The *Paramedic Simulation Competition* will begin on September 19th as ten two-person teams compete in two challenging high fidelity scenarios designed to display their skill, teamwork and compassion. The targeted scope of practice for this competition is the Advanced Care Paramedic





as defined by the PAC National Occupational Competency Profile (EMT-P equivalent). The top three teams from day one of the competition will go on to compete on the Paramedic Market stage in the finals set for September 20th.

*The Paramedic Fitness Competition* is a unique 1 day event (September 19th) inviting paramedics from all corners of the world to test their fitness and skills against their peers. The event will be comprised of 3 preliminary workouts and 1 final workout. Each workout will emulate, to some degree, on-job tasks that will test both the strength and skill of each paramedic team. To recognize the varying degree of physical fitness among delegates, this will be a two-tier competition, with a “novice” and “expert” track.

### Paramedic Market

PACE 2019 is introducing an exciting and unique tradeshow concept that will provide a very relaxed and intimate atmosphere for both vendors and conference delegates.

The Paramedic Market will be an important gathering place for everyone throughout the conference, bustling with various activities and attractions. Once you have completed your on-site registration September 19th, you can join delegates and exhibitors from across the globe on the Market floor for our Night Market - Network Reception for an evening of entertainment, socializing and relaxation.

### First Nation Sweat

PACE 2019 is honoured to offer conference attendees a very unique opportunity to experience a traditional First Nations Sweat lodge ceremony.

Sweat lodges are used by indigenous peoples during certain purification rites and as a way to promote healthy living. The main purpose of a sweat lodge ceremony is to provide cleansing and healing to support you throughout your life journey. PACE2019 has arranged for a limited number of conference delegates to participate in this unique spiritual and cultural experience.

### Keynote Speakers

PACE 2019 is excited to have two of Canada's most dynamic health care speakers bringing their talents to our Winnipeg stage!

Mr. André Picard, health columnist with the *Globe and Mail* and author of numerous books including *Matters of Life and Death: Public Health Issues in Canada*, and *The Path to Health Care Reform: Policies and Politics*, will open the PACE 2019 conference. Picard is a seasoned communicator who employs a conversational style to reach his audience. He enlivens his research and commentary with personal stories to provide context for his audience, including anecdotes from patients and health professionals from the front lines.

Our keynote closing speaker will be Dr. Brian Goldman. Dr. Goldman's style on stage is earnest, heartfelt and sincere, making it clear that he has a passion for compassion. Dr. Goldman makes complex medical issues digestible for audiences and personalizes medicine and the human frailties of his profession. He is unafraid to address tough or controversial issues head on in a comprehensive way, with



edgy topics that include whistle blowing in health care, burnout among health professionals and racism in health care.

### Conference Educational Tracks

Running concurrently throughout the two-day conference program will be four educational streams:

- **Clinical** - Presentations related to frontline paramedic clinical care and skills, as well as research affecting paramedic practice;
- **Education** - Sessions tailored toward formal learning, training, educating and coaching within the profession of paramedicine;
- **Leadership** – Topics related to the knowledge, skills, values, thinking, practices, and communication strategies needed to develop leaders within our profession;
- **Specialty** - “Non-traditional” paramedic practice, including tactical, remote, collaborative care, community paramedic initiatives and others.

### While in Winnipeg...

Known as the “cultural cradle of Canada,” Winnipeg is Manitoba's cosmopolitan capital city, offering plenty of charm and featuring a host of world-class attractions that promise to entertain and delight everyone.

This four-season destination boasts a dazzling arts, vibrant theatre and nightclub activity, indie music scene, as well as a buzzworthy dining scene featuring award-winning chefs and global influences. While in Winnipeg you can enjoy the galleries, stunning architecture, diverse neighborhoods, parklands, shopping centres and boutiques, a multitude of contemporary attractions and much more.

Be sure to check out the many exciting vacation options that Winnipeg and Manitoba has to offer!

### Travel and Accommodations

PACE 2019 will be held at the RBC Convention Centre in Winnipeg, Manitoba.

Conference organizers have partnered with Delta Hotels by Marriott Winnipeg as the official event hotel for PACE 2019, and are pleased to announce that discounted airfare for delegates is available when flying with the **official PACE2019 air carrier, Westjet**.

**For more information on discounted travel and accommodation rates, visit the PACE 2019 web site at: [www.pacexpo.ca](http://www.pacexpo.ca).**



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# ALF 2019: Plotting the Future for UK Ambulance Services



By Joe Heneghan

Organised by the Association of Ambulance Chief Executives (AACE), the Ambulance Leadership Forum (ALF) brings together senior managers, international EMS leaders, suppliers and a host of others to address how best to improve ambulance services through new approaches to leadership, management and care.

Each year, all involved join forces to share ideas and best practice in a supportive and high-profile environment.

This year's ALF was yet again a roaring success. Hosted at Chesford Grange in Warwickshire, leaders and innovators from across the UK and beyond arrived to exchange ideas and review the previous year's progress.

In accordance with tradition, the two-day forum held a Gala Awards dinner on the first evening, handing out awards and giving some much-deserved recognition to those individuals and groups who have set new standards in regard to the diligence and commitment they apply towards their work. The awards recognised the high levels of professionalism, compassion and capability which they have exemplified during the past year.

In addition to this, the Association of Ambulance Chief Executives (AACE) also made the decision to accept academic abstracts for the first time this year which saw some particularly interesting submissions – a great opportunity seized by AACE to stimulate discussion on new ideas and findings.

And following from last year, the forum finished with two additional days being devoted to the Global Paramedic



ALF attendees

Leadership Alliance, which focused upon the impact of organisational culture on employee mental health.

## DAY ONE

Beginning with the presentations, which comprise the main body of ALF, the event saw just under forty individual speakers. A snapshot of some of the key presentations is as follows:

Chris Hopson, CEO of NHS Providers spoke about the constantly transforming landscape of EMS and how we can maximise its potential here in the UK through our reaction to those changes. Looking at how the ambulance service could possibly play a bigger role in the wider health care system in order to alleviate pressures on emergency services and to introduce rapid improvement for performance results in urgent and emergency care pathways.

By moving closer towards new models of care which would focus upon

macrolevel service provision (triaging at home and cutting down on hospital admissions) and by using sustainability and transformation partnerships (STPs) and Integrated Care Systems (ICSs) Chris believes we can speed up the transition to system working across integrated local health and social care systems.

Helen Bevan, Chief Transformation Officer of NHS Horizons spoke about Project A – an ideas platform developed by NHS Horizons on behalf of the ambulance service aimed at giving frontline staff a voice in prioritising points of change and how those changes should be undertaken. This comes from discussions between Helen and Simon Stevens, Chief Executive of the NHS, following his decision to fund a twelve-month long ambulance improvement programme.

However, it also largely comes from a very accurate observation, outlined by Helen in her presentation, that actually





*Attendees form up to spell 'NZ' standing alongside AACE Chair Anthony Marsh and representatives of St. John New Zealand to show solidarity with the victims of the Christchurch terrorist attack*

most change is pushed forwards by a few pillars of the service from frontline staff rather than those in management— often because these few people are at the centre of a web of communication and influence. They often know most, or all, of the staff, understand protocols, new legislation and managerial changes that affect the service and are usually incredibly helpful and supportive towards their colleagues. Therefore, these are often the most incisive people to offer feedback which affects service provision, and are also often the most effective at garnering support and raising morale amongst staff.

Pam Brown, Head of Diversity and Inclusion at WMAS, gave a blunt yet understanding and humorous talk about our actual levels of awareness regarding bigotry, discrimination and equality, and even simple misunderstandings that can lead to significant impacts on recruitment figures. If you have not yet seen it, then I would urge you to check out [www.rentaminority.com](http://www.rentaminority.com) - a spoof site highlighted by Pam in her talk.

Michael West from Lancaster University spoke about how compassionate leadership - placing large amounts of respect and focus upon listening to staff and understanding them - ultimately makes the job of improving high quality care much easier and more effective.

Yvonne Ormston MBE, outgoing CEO of NEAS, spoke about the overall culture

of EMS in the UK – its strengths, the challenges it faces, and how to overcome them. Largely focusing upon how to build bridges between management and staff, and how to improve relationships between staff where things like tribalism (often seen following mergers for example) take place, Yvonne shared many of the sentiments also raised by Michael West – namely listening to staff, maintaining raised visions and goals for high levels of quality of care, and focusing on cooperation and teamwork.

Finally, Sue Bergin and Abigail Pawlowski from NHS Improvement (NHSI) explained all about the NHSI Culture and Leadership Programme. With fifty trusts supporting the programme and another fifteen currently receiving support as they start it, the programme focuses upon using staff feedback in order to better understand the culture of an organisation and identify any changes that are needed, recognising such cultures as symbiotic with the workers that comprise them.

### RESEARCH ABSTRACTS

As mentioned earlier, this year also saw the presentation of various research abstracts.

Peter Easton-Williams of SECAMB delivered an incredibly well-presented qualitative study of the perceptions of current clinical performance feedback of UK paramedics and their attitudes towards patient outcome feedback.

Dr Tim Edwards of LAS spoke about how we can work to maximise the contribution of Advanced Paramedic Practitioners.

Head of Professional standards at the College of Paramedics Liz Harris identified factors affecting staff retention, a particular issue for EMS providers internationally.

John Miller from WMAS spoke about the risks of placing too many roles onto managerial positions and role conflict amongst service managers.

And finally, Steven Scholes presented a fascinating and in-depth abstract on the suitability of the Manchester Triage System in triaging patients and referring them into clinical pathways from the scene as a paramedic.



*Lynn Woolls of WAS receives the Exceptional Volunteer award from AACE Chair Anthony Marsh*

### DAY TWO

Day two saw the remainder of the presentations started by Kris Gagliardi and Daniel Ohs from St John New Zealand explain the challenges that come with taking on new managerial positions, especially in an organisation which sees clinical leadership roles at a relatively young age, and how these challenges can be approached.

Mark Gough, Senior Ambulance Lead at NHS Improvement, spoke about the Carter Report and specifically how we can apply these findings to improve operational performance and efficiency.

Ian Hough, Director of the Ambulance Radio Programme explained the latest



from the £390 million programme designed to replace outdated comms on a national scale.

Jennifer Izekor from Above Difference delivered an engaging presentation on cultural intelligence and diversity, pointed out the many benefits of prioritising cultural diversity and why it should be taken seriously.

Dave Etheridge OBE from Greston Associates Ltd and Graham Holland from ORH revisited the age-old discussion of response times.

Phil Collins, Head of IT at WMAS, explained the benefits of digital transformation within the ambulance service.

An incredibly important presentation, I thought, came from Jonny McMullen, Control Services Trainer at NIAS, who spoke about identifying stress amongst our dispatchers and how to tackle it.

A number of other presentations also took place to round off the conference, with Philip Astle and Volker Kellerman from SCAS talking about collaborative innovation; Rob Crossman (Working Time Solutions) and Chris Nelson (chair for UNISON South West and Allied Health branch) delivered examples of how to improve and optimise rosters; Jock Crawford from YAS and Anna Price from EEAS delivered a powerful presentation about what Freedom to Speak Up data could reveal about cultures within English ambulance trusts; Rob Lawrence, Chief Operating Officer of Paramedics Plus, came all the way from California to share the observations he has made on his travels between the UK and US; a group presentation from Brigadier Matt Blazeley, Commandant of the Royal School of Military Engineering, Sue Budden from London Fire Brigade, Nick Chapman CBE from holdfast Training Services, and Samir Maha from Babcock International all presented a talk on using partnerships with other frontline services in order to deliver effective solutions and lessons concerning best practice.

#### GPLA SUMMIT

Finally, the event rounded off with the Global Paramedic Leadership Alliance



ALF Gala Dinner and Awards Ceremony

(GPLA) which focused on the mental health and wellbeing of staff and how to promote resilience and support. The summit saw a gathering of leaders from AACE, the Council of Ambulance Authorities (CAA, which oversees Australia, New Zealand, and Papua New Guinea), the National EMS Management Association from the USA, and the Paramedic Chiefs of Canada.

This follows talks from the inaugural GPLA summit also held last year following ALF, where the attendees committed to improving leadership through identifying and promoting initiatives which promote psychological health. A ten-step framework was created, designed to significantly reduce the likelihood of psychological harm to staff stemming from workplace factors:

1. Promote a positive mental health culture in the workplace through leadership, communication, policy and procedure, environment and work/job design.
2. Reduce stigma around mental health conditions and psychological stress in the workplace.
3. Improve the mental health literacy of the workforce.
4. Develop the capability of staff to interact with and help someone experiencing a mental health crisis, from identification through to return to work.
5. Ensure that an integrated approach to mental health and wellbeing is woven through the workplace and that leadership at all levels model behaviours and practices that promote a mentally healthy workplace culture.

6. Share examples of best-practice and effective initiatives between services.

7. Collaborate to ensure staff, during each phase of their career, have adequate self-awareness, knowledge and support in relation to managing their personal mental health and psychological stressors.

8. Implement systems that provide the service with early notification of potential psychological harm related risk.

9. Collect, monitor and respond to data that evaluates the mental health and wellbeing of the workforce and the possibility of psychological harm occurring.

10. Seek internal/external specialist expertise when necessary to achieve improved mental health and wellbeing outcomes for the workforce.

As you can plainly see, this year's forum and the following GPLA summit were a huge success. A lot of progressive views were shared, an impressive footfall with interesting and innovative ambulance leaders from a wide mix of different continents and countries, a well-chosen selection of friendly and interesting exhibitors and, most of all, a genuine eagerness to change culture and introduce new ideas wherever possible which may increase the overall wellbeing of staff and maximise the potential for service delivery.

An excellent four days all round, and I already look forward to seeing what 2020 brings.

# Letter from America



Jerry Overton

*'Pressure'... a word that staff across the EMS system will be all too familiar with, a word that leading expert in global EMS innovation, Jerry Overton discusses in this column. With staff and patients' mental health becoming more of a focus, hear Jerry's opinions on how we must all change our attitudes towards caring for one another below.*

**Pressure pushing down on me  
Pressing down on you, no man ask for  
Under pressure that burns a building  
down  
Splits a family in two  
Puts people on streets**

**Um ba ba be  
Um ba ba be  
De day da  
Ee day da, that's okay**

**It's the terror of knowing what the  
world is about  
Watching some good friends screaming  
"Let me out!"  
Pray tomorrow gets me higher  
Pressure on people, people on streets  
"Under Pressure"**

It probably can be assumed that David Bowie knew little about EMS (except, perhaps as a patient), but reading those lyrics he sang certainly describes what is being experienced every minute of every day in our EMS systems this year, next year, and beyond. And it is a damn huge problem.

The pressures are everywhere . . . and impact every person. Just consider the following. In our control centers, there are pressures to . . .

- Process calls faster
- While assessing the patients more accurately
- Then, identify the right resource
- And dispatch that resource, quickly???
- While reallocating other resources
- AND, all during this time, provide a superior interaction to the calling party

- After which, for all this, the call taker can get audited

On the street, the pressures continue . . .

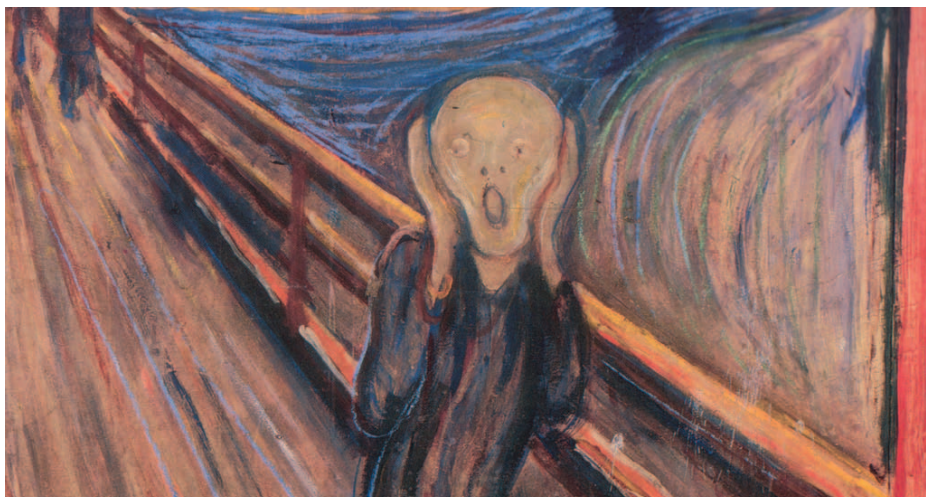
- It begins by attempting to meet an unrealistic response time standard, through increasing traffic and little obedience to blue lights
- As the demand increases
- For a changing patient demographic
- That is lower acuity BUT has more comorbidities
- To a facility where it takes forever to offload the patient
- AND, all during this time, provide a superior interaction to the patient
- After which, they get audited

The rewards, clearly, are few and far between. Most of the time, the patient outcome is not even known because the next call is waiting. It is no wonder there are recruitment and retention issues, but those are numbers and you are human.

Adding to this, now, are even more pressures of our changing world. Terrorist attacks, weather events, and active shooters have become the new norm. When a call is taken, a response begins, all may not be as it seems.

The mantra has always been "The patient comes first" and that is a difficult mantra to refute. But where do those that must care for that patient come? Tied for first? Second? Last? Honorable mention?

With demand for our services continuing to increase, literally in almost every country, something, anything must change to conserve the mental health of those that are making the difference, whether to the caller in the center or the patient on the street. Back in 2005, the futuristic document *Taking Healthcare to the Patient: Transforming NHS Ambulance Services* found demand increasing 6-7 percent annually in England and that has not changed. In that report, it recognized the overall decrease in the acuity level of the patient and called for the paramedic to be considered a professional member of the health







## Focus on Global EMS: United States of America

care team. However, what it did NOT address was the support that would be needed to handle the additional stressors.

That finally occurred in *Taking Healthcare to the Patient 2: A Review of 6 Years' Progress*, published by the NHS in 2011. The authors wrote "Ambulance clinical staff are out on their own and in pairs and do get to see a good deal of distress and pain. While dealing with life threatening emergencies can lead to posttraumatic stress, going to the less serious calls can be just as wearing." Not the most revolutionary statement, but at least it was there.

But did this lead to change? Not really. In fact, if there has been any change, it is for the worse. Back in my December 2016 "Letter to America" published here in *Ambulance Today*, I quoted Australia's *The Herald Sun* reporting Victoria's suicide rate for paramedics at 35.6 per 100,000 workers, three and one half time higher than police and fire. The latest from NAEMT is as follows, and it is not good.

- A 2015 survey of EMTs and paramedics published in the *Journal of Emergency Medical Services (JEMS)* found a high rate of suicidal thoughts among EMS practitioners. The survey found that 37% reported having contemplated suicide, nearly 10 times the rate of American adults, while 6.6% reported having attempted suicide. That's compared to just 0.5% of all adults.
- In 2016, NAEMT's National Survey on EMS Mental Health Services found that 37% of EMS agencies provided no mental health support for EMS practitioners, and 42% provided no health and wellness services. Even among those whose agencies provided counseling or resources such as employee assistance programs (EAPs), many EMS practitioners were reluctant to share their struggles for fear of being seen as weak.
- A 2017 survey by University of Phoenix of 2,000 U.S. adults employed as first responders, including firefighters, police officers, EMTs, paramedics and nurses, found 84% of first responders had experienced



a traumatic event on the job, and 34% had received a formal diagnosis of a mental health disorder, such as depression or post-traumatic stress disorder (PTSD). For those diagnosed with depression, nearly half cited incidents at work as a contributing cause.

- A study published online in *Prehospital Emergency Care* in November 2018 found high rates of suicide among EMTs. The study looked at all adult deaths in Arizona between 2009 and 2015 and found that those whose occupation was EMT had more than double the rate of suicides (5.2%) compared to non-EMTs (2.2%).

It is time to change . . . and care. There has been much emphasis lately on creating a "culture of safety" to protect your physical health in your surroundings. And that is how it should be. But little has been done to protect you and your mental health. Rechanneling that emphasis into a "culture of wellness" could be an answer. In fact, the two could be combined. It is no secret that physical well-being and emotional well-being are intertwined. And employers should understand that.

In these days when there is so much talk about "Return on Investment" and performance, it is overdue that leadership understand this that can ultimately be accomplished only by you, our most important resource. That "investment" means investing money

and time to assure that our workforce can perform. Lower stress means lower absenteeism and, actually due to the resulting decrease in overtime as workers are filling their shifts, it would logically follow that this means lower turnover too. That means a change of priorities for most agencies, and frankly the leadership of those agencies, but it does not take a rocket scientist to understand that if they are taking care of you, you will be better at taking care of your patients.

No, I am not Pollyanna and I do know that this is not going to happen overnight. But if we do not begin the dialogue, do not admit that this IS a problem, that this IS having an impact on you and your patients, it will never happen.



In the interim, take a little time for you. If you don't, there is a chance, and probably a damn good one, that nobody else will. So . . . in closing, perhaps we can all heed the words of Bob Dylan from his "Nothing Was Delivered."

*. . . as long as it takes to do this  
Then that's how long you'll remain  
Nothing is better, nothing is best  
Take care of your health and get plenty  
of rest*

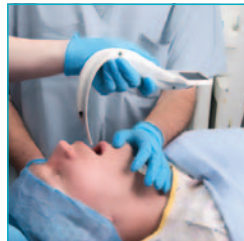
But, if that does not seem possible, there is always this from Seal's "Crazy."

*But we're never gonna survive, unless  
We get a little crazy  
No we're never gonna survive, unless  
We are a little crazy*



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# Hiding in Plain Sight: Mental Health and the Four Pillars of a Resilient Workforce

**At his lowest point, Paramedic Paul Crole would call in sick on night shift, then sleep in his car.**

**Standing just shy of six feet tall and solidly built, all it took was the sound of an ambulance siren to leave the 55-year-old father in tears.**



Paul Crole

"I went from being a very keen Clinical Instructor with students...to wanting to avoid work altogether," said Paul, an Advanced Life Support Paramedic with 17 years experience.

"At the time I couldn't even look at my uniform or anyone in a uniform.

"When I felt like this I would just come back to our branch for our meal break and I wouldn't even eat, I just couldn't eat, I was too churned up inside.

"I would just throw myself back in the couch and hope I could get a sleep for 30 minutes before we got another job. And that's just how I dealt with it. Totally withdrew really."

Paul was one of the hidden faces of an issue impacting the work and lives of

paramedics serving 6.1 million people in the Australian state of Victoria. The issue of workplace mental health and wellbeing.

"It wasn't something I thought would happen to me, whether that's ignorant, arrogant or naïve, but I never thought I would suffer this," Paul said.

"At that point I knew I needed to do something because there's a lot of stories within AV of paramedics with self-harm and suicide".

"Thankfully I never had those thoughts but I was aware that I was on a slippery slope and I wasn't going to get any better just doing what I was doing."

In 2015, Victorian paramedic suicide was three times higher than other emergency services personnel such as police and fire brigade, and four times higher than the Victorian average.

Ambulance Victoria CEO Tony Walker knew something had to change, and quickly.

"As the CEO, our people are my responsibility," Tony said.

"For too long, we accepted that workplace injury, including psychological injury, was just part of the job.

"Yet, as one of our paramedics put it so well, if we don't look after ourselves, we can't look after others."

When Ambulance Victoria (AV) committed in 2015 to building a mentally healthy workplace, their research confirmed it had work to do.

Only 40 per cent of staff were likely to seek support for a mental health

condition, less than half (48 per cent) knew how to identify warning signs in themselves or a colleague, and only half were familiar with self-care strategies.

"What was most confronting for me was the stigma that stood in the way of our people getting the help they need," Tony said.

"More than half of our staff reported they wouldn't tell anyone at work if they had a mental health condition and more than 40 per cent weren't even comfortable to talk confidentially with their manager."

One of the first steps for AV, which employs 5,600 people, was to form a strategic partnership with independent Australian non-profit Beyond Blue, an organisation working to combat issues associated with anxiety, depression and suicide.



Tony Walker

## Focus on mental health and resilience

During this period Paul Crole was off work getting the support he needed and the first fortnightly update from newly-appointed CEO Tony Walker really connected with him.

"I read it and I thought 'oh wow, this is a real person'," Paul said. "And so I emailed Tony just to say thank you. He got back to me within a few hours and said 'oh, look if ever you'd like to have a coffee', which blew me away, you know, the CEO wanting to talk to me.

"We caught up three times in the end over probably 12 to 15 months. Each time we just got a coffee and I would bombard him with a whole lot of notes and my thoughts about what I'd been through, what I was going through and how we could fix it."

It wasn't one traumatic case that triggered issues for Paul. Rather, it was a 'slow burn' of many aspects of the job.

"I guess if I look back on it, it was fairly insidious how it came across me very slowly," Paul said.

"It's everything, the shifts, the hours, the jobs you go to. I can see that in hindsight.

"Our Work Cover area, and the insurer and everything just pretty much was

about pat you on the back, 'that's no good, but we want you back at work.'"

The views of staff like Paul, volunteers, family members and other stakeholders were gathered through focus groups and consultations, and helped shape the AV Mental Health and Wellbeing Strategy 2016-2019.

The strategy was based around four pillars: improving understanding of mental health; reducing stigma; improving support, treatment and training; and developing partnerships that contribute to the other three pillars.

Under the strategy, AV has conducted full psychosocial surveys of its workforce in conjunction with trauma experts Phoenix Australia and mental health research organisation the Blackdog Institute and put all operational and corporate staff through a comprehensive mental health training program purpose-built for AV in partnership with *beyondblue*.

The results speak for themselves:

- 70 per cent of staff said they were likely to seek support for a mental health condition (up from 40 per cent).
- Almost 90 per cent of staff believed they could identify the warning



signs of a mental health condition in themselves or a colleague (up from 48 per cent).

- 90 per cent of staff were familiar with self-care strategies to keep them safe and well (up from 50 per cent).

That's flowed through to an increase in staff seeking help, with evidence showing that early intervention leads to better mental health outcomes.

In the 12 months after the first training rollout, AV experienced an 84 per cent increase in the use of their 24/7 psychological telephone support line, a 30 per cent increase in face-to-face counselling sessions and a 36 per cent increase in use of the AV Peer Support network.

It's also led to a 32 per cent reduction in mental health claims from 2014-15 to 2016-17.

At the launch of the strategy in 2016, *beyondblue* CEO Georgie Harman described the strategy as one of the best she had seen.

The strategy and AV's focused implementation of it over the past three years, has since been recognised with awards for the public sector, ambulance industry and business communication at the state, regional and international level.







Bruce's Graduation

*"Everyone can talk about mental health now, we see it a lot, even at the top of the organisation. This is a big change, this is positive. Even my manager told me he has seen someone for his mental health, and to me that was big."*

**Paramedic, AV.**

For Tony Walker, the awards are great recognition for the hard work put in by the team, but nothing beats hearing from staff about what it has meant for them.

"Today, our people come to work knowing how to keep themselves and their colleagues mentally healthy and well," Tony said. "If they experience an issue, they know where to go for support."

Change hasn't come without its challenges and Tony says the first step was admitting AV hadn't got it right in the past.

"That's not easy for an organisation, but it's essential," he said.

"Stigma has been another major challenge. It's a big issue right across our community and we had to make it safe for our people to have conversations about mental health."

A friendly Labrador dog called Bruce has been one of the answers. Bruce

helped AV pilot a Peer Support Dog program in the second half of 2018, visiting AV staff to help them deal with traumatic moments, reduce stress and open up conversations.

An Australian ambulance first, the program was so successful another three dogs graduated into service in April this year and up to 12 dogs will be employed across the state.

Less than a third of AV staff now report reluctance to talk to anyone at work

and only a quarter say they wouldn't talk to their manager.

"You can't change the culture overnight, but we're heading in the right direction," Tony said. "We're also clear on what we need to do and that means not just having the right training and supports in place, but also maintaining visible leadership on these issues and fostering open conversation."

When AV launched the strategy, it showed a video with family members of paramedics – a husband, a mother and a wife – speaking about mental health because it was too difficult to find a paramedic to speak up.

With every paramedic like Paul Crole who bravely steps forward to tell their story, it paves the way for others to get help.

These days Paul is back at work and back to getting great satisfaction from his job.

"I think we've always known (mental health) is there, but not spoken about it," Paul said. "Whereas now at least we're talking about it."

"I think the big thing is to admit that you're not all right. If someone asks you or they sense something about it, don't be afraid to say 'yeah you know, I am struggling' and just talk. Speaking about it is the biggest thing."



# EMS: Making A Difference for Sepsis Patients



By Rommie L. Duckworth, BS, LP

Sepsis is the body's overwhelming and life-threatening response to infection, which can lead to tissue damage, organ failure, and death. Sepsis patients transported by EMS tend to be older and sicker than patients who walk into the ED. With as many as 87% of sepsis cases starting in the community prior to hospitalization, EMS personnel are frequently the first medical contact for sepsis patients. This positions prehospital providers to have a tremendously positive impact on survivability and quality of life for these patients and their families.

## The Sepsis Myth

A common myth, even among healthcare providers, is that sepsis is a form of infection. While sepsis always begins with invasion of a pathogen (bacteria, virus, fungus, or parasite), sepsis is an improper reaction of the inflammatory and immune response similar in many ways to anaphylaxis as a potentially deadly response to a simple allergen. With sepsis, while the infection is not doing the patient any good, it is often the body's improper reaction that leads to shock, failure of organ systems, and death.

When a pathogen is detected by the immune system, messenger proteins known as cytokines trigger a local inflammatory and additional immune responses. The results include localized vasodilation and increased capillary permeability to help improve the immune system's ability to neutralize the pathogens. However, sometimes pathogens trigger a dysfunction of the immune response, resulting in a combination of physiological, immune, inflammatory/anti-inflammatory, and circulatory changes.

These changes can propagate throughout the body resulting in vasodilation (causing distributive



shock), capillary leakage (causing hypovolemic shock), and increased clotting, ultimately resulting in many smaller blood vessels being blocked by clots (causing obstructive shock), all at the same time. When one or more of these issues produce organ dysfunction it is termed septic shock.

## The Assessment Challenge

A challenge in the identification, assessment, and treatment of sepsis and septic shock in the field is the variety of presentations that can occur. The progress of sepsis is often subtle, moving the patient toward shock and doing so while also wearing away at the patient's ability to compensate so that by the time the shock is obvious it is much more difficult for the patient or provider to manage.

There is no test available in or out of the hospital that is specific to sepsis. Identification of sepsis and septic shock as well as treatment is based on a solid assessment. Begin by evaluating the patient's chief complaint and past history. If an infection has been identified or there is significant potential for infection, then the

first component of sepsis has been met and should be included in your differential diagnosis. Populations at high risk for sepsis and septic shock include the very young; the very old; those with a history of recent trauma, surgery, or cancer; or patients taking chemotherapy, steroids, anti-rejection, or anti-inflammatory medications.

Assess the patient for further signs and symptoms of infection as well as organ dysfunction or shock. There are currently many different sepsis assessment tools and criteria to help healthcare providers better identify, assess and treat sepsis and septic shock. Among the most widely used is the criteria for systemic inflammatory response syndrome (SIRS). Any patient who has an identified or strongly suspected infection and meets two or more of the following criteria is considered to be suffering from sepsis:

- Temperature > 38 C (100.4 F) or < 36 C (96.8 F)
- Heart rate > 90 beats per minute
- Respiratory rate > 20 breaths per minute or PaCO<sub>2</sub> <32 mmHg--
- WBC > 12,000 cell/mm<sup>3</sup>, <4,000 cell/mm<sup>3</sup>, or >10% immature forms (not typically assessed in the prehospital setting)





This is one of many sets of criteria used to help identify and categorize sepsis. Criteria are often modified to fit the resources, capabilities, and current level of sepsis education of EMS services with the goal of improving sensitivity and specificity. In one small study, EMS providers with sepsis-specific training were able to alert the receiving ED, lowering mortality from 26.7% to a rate of 13.6%. Care provided by EMS personnel can lead to faster treatment times in the ED. Transport by EMS decreased the time to antibiotic administration by 24% and decreased the time to receiving IV fluids by 50%. This underscores the importance of both sepsis-specific education for EMS as well as close collaboration with emergency department staff.

Guided by careful assessment and re-assessment, field care for victims of sepsis include airway, breathing and oxygenation support as needed as well as infusion of fluid resuscitation of 30 ml/kg IV/IO up to stopping points including improvement of signs and symptoms, rales, and enlargement of the liver. If signs and symptoms of shock do not improve with fluid administration, consider administration of norepinephrine 0.1-2 mcg/kg/min IV/IO to MAP >65 mm/Hg or epinephrine 0.1-1 mcg/kg/min IV/IO to MAP >65 mm/Hg. Additional prehospital care can include correction of hypoglycemia, hypocalcemia, and administration of antibiotics.

#### A Partnership to Improve Care

In an effort to advance leading-edge sepsis care through EMS-specific resources and education, the Sepsis Alliance, the leading sepsis organization in the U.S., has partnered with NAEMT to provide educational tools to EMS practitioners on recognizing and treating sepsis.

"Through our partnership with NAEMT, we will reach a broader scope of EMS and prehospital practitioners to provide them with the knowledge to recognize sepsis, begin appropriate treatment, and save lives," said Thomas Heymann, Sepsis Alliance executive director. "The Sepsis Alliance has developed a great curriculum of sepsis educational resources specifically designed for EMS



The Sepsis Alliance has public awareness and EMS education materials such as posters, badge buddies and ambulance decals, available on their website. Visit [sepsis.org/sepsis-first-response](https://sepsis.org/sepsis-first-response) to download or purchase.

and prehospital practitioners that we are so excited to share with NAEMT."

A one-hour online training module – *Sepsis: First Response* – teaches EMS practitioners how to identify sepsis, initiate treatment and effectively coordinate care with the emergency department and in-hospital colleagues. *Sepsis: First Response* is available on Recert.com, an online continuing education platform.

Consistently using recognized assessment criteria and treatment recommendations can help EMS providers work with emergency department and critical care staff to identify sepsis when others might miss it, begin treatment before others may start, and make a critical difference in the lives of some of the most challenging and rewarding patients EMS practitioners encounter.

The NAEMT–Sepsis Alliance collaboration will also include a survey to gauge sepsis awareness among prehospital practitioners and direct future stand-alone sepsis-specific education programs including pediatric sepsis and sepsis in older patients. Enhanced sepsis information will also be integrated into existing NAEMT education courses, including Advanced Medical Life Support (AMLS) and Emergency Pediatric Care (EPC).

"EMS practitioners are uniquely positioned to improve the early and vital care of sepsis patients at home, in transport and during transfers while

protecting themselves and the wider community. Resources from the Sepsis Alliance will reinforce the importance of sepsis awareness and latest knowledge for the best patient care," said Dennis Rowe, NAEMT immediate past president.

Rom Duckworth is an EMS educator and Sepsis Alliance Advisory Board member.

This article originally appeared in the NAEMT News Winter issue. Reprinted with permission.

#### Sepsis: First Response is available on Recert.com



NAEMT members receive 15% off Recert courses. The one-hour training video covers:

- ✓ Sepsis versus septic shock.
- ✓ The role of prehospital practitioners in sepsis identification, assessment and treatment.
- ✓ The role of vital signs such as blood pressure, mean arterial pressure, lactate, end-tidal CO2 and temperature.
- ✓ Justification for the escalation or termination of fluid resuscitation / pressor administration.

Expert commentary is provided by Chris Seymour, MD, associate professor in the Department of Critical Care Medicine at University of Pittsburgh School of Medicine and Lauren Epstein, MD, medical officer at the Centers for Disease Control and Prevention (CDC). "From the CDC perspective, sepsis isn't just a medical emergency, it's a public health issue," Epstein said. "First responders can have an enormous impact on the care that patients receive."



#### AMLS To Offer Enhanced Sepsis Education

NAEMT recently conducted a survey of Advanced Medical Life Support (AMLS) students that revealed students want more education on sepsis. NAEMT's AMLS Committee, in collaboration with the Sepsis Alliance, is at work on a new AMLS textbook chapter on sepsis that will be released in fall 2019 as part of the AMLS 3rd edition update.

[www.naemt.org/education/amls](https://www.naemt.org/education/amls)

# EMS Best Practices: Sharing Proven Concepts from Around the World



*By Bas van de Wakker,  
Senior Marketing Manager EMS Europe, Zoll Medical*

ZOLL Medical are off to an electrifying start this year, recently hosting workshops in Cologne, Germany, Birmingham in the UK, and Kotha, Finland, which of course focused upon resuscitation. The goal of the day was to build upon current knowledge around the resuscitation processes, specifically considering current guidelines. Using the workshop in Cologne as an example, the whole day was inspired by colleagues who measure their CPR data during treatment, collect the CPR data in a database and then review them as part for quality improvement.

Highly well-organised, the day started with a short resuscitation exercise involving all participants. This was about a one minute CPR cycle. The background was the self-assessment on a resuscitation simulator with regard to the pressure depth and rate without the support of a feedback device. The main topic here, which fortunately went through the day as a “red line”, was the Guideline-compliant “High Quality CPR”.

Invited to the event were John Tobin from the Arizona Mesa Fire Department, Joe Powell from the Rialto Fire Department in California, and Dr Marc Deussen, Medical Director of Rescue Service Mönchengladbach (Germany).



Over a period of six years, the Mesa Fire and Medical Department, Arizona, optimized its resuscitation process by using a self-developed “pit crew method” similar to the tightly timed workflow of a pit crew at a Formula 1 pitstop.

Four team members are on-site with each mission and during manoeuvre the manpower increases to six colleagues. Their motto? “It’s all about time”. Breaks during thorax compression are to be observed in the single digit range. A previously determined team

leader permanently observes the monitor of the ECG device and provides instructions on the pressure depth, pressure frequency and efficiency of the high-quality CPR. The team member responsible for compression changes as precisely as possible every 2 minutes. The initial assessment of the patient takes a maximum of ten seconds for a definitely unconscious patient. During this time, classic breathing and pulse are controlled. If the patient does not breathe adequately and does not show sufficient heart rate, CPR is started immediately.

John Tobin described the use of a feedback sensor during CPR as fundamental, stating that “If you are not using a feedback system, it would be like driving a car without lights in the dark”.

What seemed strange to many attendees, but proved efficient by the high percentage ROSC rate, is the actual process of resuscitation. In the first eight minutes, only CPR (including oxygenation of the patient) takes place using an oxygen inhalation mask with fifteen litres of O<sub>2</sub>. Also, the drug therapy, which is placed by an EZ-IO, came in last place for the colleagues from Mesa.

Another essential point to consider is the duration of CPR on the spot. High-quality CPR is performed on-site for at least 20 to 30 minutes, as it has been observed that the CPR is more efficient through the ambulance service than their local hospital staff. To maintain and improve this high standard, it would be essential for John and his team to perform CPR training at least every three to four months.

The Rialto Fire Department, California, represented by Joe Powell, managed a





similar standard to that of its Phoenix counterparts. Here a ROSC percentage of almost 71% following Utstein criteria was achieved!

It must be noted that the AutoPulse automated resuscitation system, manufactured by ZOLL Medical, played an important role in their approach. Joe presented seven tools in total from their 'Resuscitation Toolbox' that significantly impacted Rialto's outcomes! These were:



#### 1. AutoPulse – Continuous and uninterrupted CPR

Uninterrupted compressions have been shown to be one of the key components to saving lives, with other elements supporting compressions.

#### 2. APNEIC OXYGENATION

Initiates and maintains continuous oxygenation of patients from the time uninterrupted CPR is provided, until an advanced airway is secured.

#### 3. ResQPOD ITD

The ITD increases venous return, lowering thoracic pressure, pulling more blood back to the heart, whilst increasing preload and decreasing intracranial pressure (ICP).

#### 4. 30° Raising of Patient

By raising the patient 30°, ICP will decrease, and increasing preload allows for better perfusion to both the heart and brain – increasing the chance of survival to discharge and chances of the patient being neurologically intact.

#### 5. DELAYED DEFIBRILLATION

Patients with certain clinical findings are acidotic and have hearts that are less receptive to electrical therapy.



#### 6. EXPANDED USE OF CAPNOGRAPHY

Waveform capnography helps assess viability in continued placement of an advanced airway, and delayed defibrillation. It can also be an indicator of a patient who may ultimately survive but, requires additional time for resuscitation.

#### 7. DE-EMPHASIZING EPINEPHRINE

Prioritising the administration of epinephrine has led to more impactful interventions being delayed. With emphasis on high quality, uninterrupted CPR followed by appropriate interventions, such as delayed epinephrine, will be given when patient conditions are optimal and more receptive to pharmacological impact.

Marc Deussen closed the clinical part of the session. As Clinical Lead and MD at Rescue Service Mönchengladbach, Marc successfully implemented CPR feedback throughout his service there during 2014. At that time within the German CPR Registry, a National benchmark tool for EMS and Hospitals within Mönchengladbach was positioned at 36th place when looking at ROSC and survival to discharge. Implementing CPR feedback wasn't an easy start.

It is supposed that paramedics were concerned of 'big brother' watching them and possibly feared having to show data which revealed poor CPR performance. Many seemed reluctant to look at their data first.

"Today", he says, "medics walk in my office the moment they have uploaded their case over WiFi, eager to know what their CPR performance was at scene". A cultural change that has led to great improvement in CPR performance. Currently, Mönchengladbach holds the 4th position in the German CPR Registry. A great performance, but still not the first position they admire so much. Marc of course acknowledged that there is still room for improvement, but that even less solid data is better than no data to present at all.

So, the day started with one minute of CPR without CPR feedback and was closed by exactly the same session, only this time *with* feedback. It's probably no surprise that with the exception of a few attendees, all improved their performance on the spot!

For more information, please contact  
Bas on [bvdwakker@zoll.com](mailto:bvdwakker@zoll.com)



# Ambulance Control and Dispatch Stress: Who Are You Going to Call?



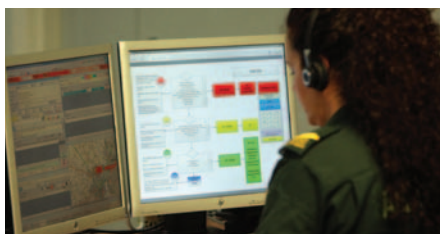
By Jonny McMullan,

Control Training and Quality Assurance Manager, Northern Ireland Ambulance Service Health and Social Care Trust

**There is no monopoly on stress. It affects us all in a myriad of ways, as the result of many different experiences, and with no regard for rank or position. Yet within an ambulance service there has perhaps been a hesitancy at highlighting any feelings of pressure or anxiety if we are not in a traditional patient-facing setting. The job that our operational colleagues perform day-in-day-out captures the public imagination and frequently provides stories of heroism, joy, and sorrow which exemplify the life and death decisions impacting patient care. It is against this backdrop that a growing literature on Dispatch Stress has emerged focussing specifically on the experience of Emergency Ambulance Control staff. If we can identify those stressors, specific to call-taking and dispatch, we can better understand how they impact the individuals who work within the emergency control room and potentially put strategies in place to provide the appropriate support mechanisms for each job role.**

If the pressures of life in the operational setting are understood to be so clearly recognisable what is it about the Control environment that is so different? Ironically, the literature would suggest that the roles of Emergency Medical Dispatcher (EMD

999 call-taker) and Dispatcher produce equivalent stressors but often as part of an inverted process. Consider the job facing the EMD when answering a 999 emergency. While we are not directly patient-facing we are the first point of contact with the caller or patient. The anticipation of what is to come next is often described by EMDs as worse than the task of managing a call itself. A loud bleep in your ear to identify receipt of a call and a deep breath before discovering whatever scenario is unfolding for the patient. Those first few seconds



NIAS dispatch

of heightened emotion when a caller is potentially experiencing the worst moment of their life are critical for the EMD in controlling the situation and ensuring the correct care is provided for the patient. The levels of caller management and customer service skills required to balance empathy and reassurance with assertiveness and protocol, all from the end of a telephone line, are difficult to imagine when an emergency is unfolding in real time. This means it is the EMD who holds the ultimate responsibility not only for calming the caller down to ensure the correct type of assistance can be provided but also to our operational colleagues in creating a scene that is safe and calm upon arrival.

Of course, the fact this all takes place in the non-visual environment of

the Emergency Ambulance Control adds an additional stress that should not be under-estimated: the impact of the 'unseen' on the imagination. EMDs regularly recount stories of the difficulty in "not being able to see" exactly what is happening. Not seeing the patient, not being able to intervene to physically help, doesn't remove a pressure from the job, it simply substitutes it for another. Descriptions of severe trauma, noises and sounds of patients in pain or distress and callers providing limited information can all send an EMD's imagination into overdrive. We are almost more scarred by the thought of what *could* be happening than by the reality of the situation and we seldom get the reassurance of knowing the outcome for the patient or receiving feedback on what *actually* occurred. I have been approached by so many EMDs seeking any small snippet of additional information from a responding crew or receiving hospital just to provide a degree of closure or understanding to a call. "It sounded horrific", "the way she was screaming", "I couldn't get them to tell me what was happening and it was clear there was so much more going on", "I got a really bad feeling about that one, I can't stop thinking about that poor boy" are all examples of the thoughts EMDs have when they finish up a 999 call. It is the not knowing and the unseen nature of the Control Room that means the lack of direct patient contact does not remove us from the vicarious trauma of dealing with emergencies but positions it in the darkest parts of our imaginations without us ever knowing if the reality is as bad as we presumed.

## The changing face of the 999 caller

If we accept at face value that these experiences are genuine and

### Biography: Jonny McMullan



Jonny joined NIAS over 10 years ago and initially worked as an Urgent Call Taker for 18 months, then progressing to EMD. Working as an EMD for four and half years, he then joined the Quality Assurance post as an auditor for a further two years, leading to his current role as Control Training and Quality Assurance Officer. He is also an EMD Mentor Instructor for the International Academies of Emergency Dispatch and sits on the EMD Mentor Board of Curriculum for the same organisation.



acknowledge the fact that the Control Room contains and creates its own set of stressors it may be fair to ask why, all of a sudden, we have witnessed a greater focus on Dispatch Stress and the impact it has on our staff? The answer would seem to point at two factors: increasing call volume and a changing level of public expectation.

All Ambulance Services across the UK and Ireland have witnessed an exponential increase in demand over the last decade and the effect this has had on call-taking and dispatch is twofold. Primarily, it increases the frequency with which we answer the phone; but it isn't volume that causes the main problem. Answering more calls leads to less downtime for EMDs, which in turn leads to reduced opportunity to recover from a distressing call or to take a break to compose ourselves before the next one. We can still be recovering from the trauma of an infant CPR call when the bleep goes off again and we are receiving the report of a hanging patient. Less time in between 999s limits our capacity to reflect on the call we have just taken and absorb any learning from the experience. We have no time to ask a supervisor for a case review or contact a crew for feedback as the next call is already queuing. Secondly, and most importantly from a dispatch perspective, increased call demands mean some patients wait longer and longer for a response. Resources have not grown at the same rate as demand. Dispatchers are regularly faced with the prospect of holding time critical calls, sitting without an available vehicle, and simply waiting for the next resource. Imagine the prospect of having one ambulance available but two critically ill patients in need of treatment. How do you choose? One dispatcher recently described it to me as "playing God but without the adoration". The pressure of making that decision, allocating the correct resource at the right time to the most deserving patient, in the face of constantly growing demand is a reality for dispatchers in all our Control Rooms.

As aware as we all are of the problems facing us on a daily basis the general public have also become acutely attuned to Control Room practice. Television shows, newspaper articles and Freedom of Information requests



Artwork by Daniel Sundahl, DanSun Photo Art [www.dansunphotos.com](http://www.dansunphotos.com)

have proliferated an overview of how Emergency Ambulance Control functions and the public have raised their expectations in line with this perceived insight into 'how things work'. Consider the longer waiting times for ambulances we previously discussed. Not only do they lead to increased caller anxiety and patient distress, but they encourage multiple call-backs for the same incident. This feeds directly back into the problem of increased call demand but also requires a very different set of caller management skills on behalf of the EMD. "I know you should've been here in 8 minutes", "of course you can see where the ambulance is, it's on your screen" or "I know you're being recorded and you have to send me an ambulance" are common statements from callers increasingly impatient at longer waiting times. The EMD not only has to check on the condition of the patient but we must also manage an irate caller who is concerned for their loved one and angry that the standards they believe to be in place are not being correctly applied in their case. The task of providing empathy, reassurance and care to a caller or patient who is berating you while you attempt to help them is an emotionally demanding job and one that EMDs are having to do with increasing frequency.

### Who are we going to call?

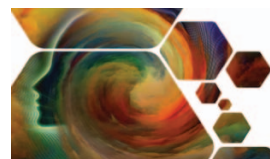
At a first glance then the picture would appear very bleak. Increasing call volume is not going to suddenly drop and the unseen nature of 999 call processing is not going to change to such an extent that we will not still have those thoughts of 'what if' or 'just how bad was it really'. If this is

the case, where can we go from here and are there any positive prospects on the horizon? I believe there are grounds for optimism; at the very least the discussion has been started. The fact there is an emerging literature on Dispatch Stress is a forward step in terms of recognising the specific nature of work within the Control Room and the workloads of the staff who inhabit them. It opens a space for staff to acknowledge their own experiences and share their stories, not only within their own Trusts, but within the larger ambulance community across the UK and Ireland.

Health and Wellbeing streams within Ambulance Trusts are being promoted as paramount to staff welfare and there are multiple success stories of peer support programmes, staff engagement exercises and compassionate leadership initiatives aimed at addressing some of the issues we have previously discussed. Resilience, CISM and TRiM are becoming more and more common as part of initial training and additional assistance is being offered to managers to enable them to provide appropriate support to staff when the pressures of the job become too much. Even this article, within this publication, is evidence of a change in approach towards the role of Control Room staff. What we must do then is keep the conversation alive and allow everyone the opportunity to seek whatever form of assistance or support they require; we need to care for the carers before we expect them to care for anyone else.

For more information, please feel free to contact Jonny via:  
[Jonny.McMullan@nias.hscni.net](mailto:Jonny.McMullan@nias.hscni.net)

# Coping as a Carer in 5 Steps



By David Snelders, Adv. Dip MCBT

**Coping with stress, burnout, and PTSD is full of pitfalls, each potential stumbling point unique to that person and their situation. When each case of mental trauma is so individual and unique to itself, there is a lot to look out for. But one area is, understandably but all-too-often, overlooked. What happens when those people propping up their loved one also collapse under the weight of their mental trauma? Most importantly, how can this be prevented? David Snelders of 'Rubik Minds' and TASC (The Ambulance Staff Charity) explains how to minimise the potential toxicity of mental strain when supporting your loved ones in five understanding steps...**

"I love him but nothing I do fixes anything for long enough. I sometimes daydream about running away. Then I feel guilty – how could I think that if I love him?"

Diana lives with and cares for her brother who has a mental illness. She has a job, friends nearby and a busy lifestyle but, underneath it all, she's struggling ... and nobody around her knows how much.

"He needs me – there's nobody else. At times, I just need somebody, too."

Powerlessness. Fear. Frustration. Just three emotions that you're likely to feel if you're in the same position.

## Biography: David Snelders Adv. Dip MCBT



David Adv. Dip MCBT, is based in the U.K. He is a qualified counsellor and an Associate Counsellor for TASC (The Ambulance Staff Charity). He helps people with Depression, PTSD, Anxiety, Stress and Bereavement.

He is a member of the Royal Society for Public Health and an Executive member of the International Institute for Complimentary Therapists.

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Watching a loved one suffer is an extreme test. Whether the person is injured, addicted to substances or harming themselves, your natural response is to want to take away the pain.

If it's a mental illness that's the cause of the suffering, your feelings can be in even more turmoil. Strange, unpredictable behaviours can be terrifying and confusing. While you're the one who's there, supporting them, listening to them and helping whenever you can, you're the one who may be attacked verbally or even physically.

It's not surprising that you feel afraid, sad, grief-stricken, angry – and then, of course, guilty. It's impossible not to worry about the future; as you struggle with each episode, you feel anxious and even overwhelmed.

Are you covering it up? Do you worry what other people will think if you try to explain what's happening? If so, you're not alone. Because of the stigma that's still attached to mental illness, many people in your position feel that they can't open up about it. This can increase your isolation, though, and leave you no way to get the information and support that you need.

Yes – the support that YOU need.

You can't help anybody if you don't look after yourself. Here are five steps you can take to make sure that you stay strong, calm and well:

### Share it

You'll find enormous relief from sharing your thoughts and feelings in a supportive environment among those who understand. TASC is there to help you with this; you don't have to suffer in silence.

### Read up

Read up about mental illness. What is your loved one's condition? How does it affect them and what are their treatment options? What tools, strategies and tips have others used to deal with it in their lives?

### Accept Reality

While you can offer valuable support and love, you cannot cure your loved one's mental disorder. Their symptoms may get better or they may get worse. Always speak to your GP as medication can help to restore stability and functionality – although it may not heal the condition. Be prepared to lower your expectations of what your loved one can do. For instance, he or she may only be able to work part-time or, in some cases, not at all.



### Set Boundaries

This is especially true if you feel resentful of your loved one's erratic behaviour. This is a clear sign that you're giving too much. Find a way to get a break from the situation. If the behaviour is physically or verbally abusive, you need to take a zero-tolerance approach. As hard as it is, consider if you need to leave the situation or make other arrangements for support and care.

### Take heart

We're getting better at understanding and treating severe and chronic mental illness all the time. People get better and learn how to cope effectively. Relapses may happen, but they become rarer and shorter. There is hope!

Being there as a support and a carer for someone who's suffering with a mental



illness will be your greatest challenge. While they may not ever completely heal, you can learn how to manage the stress of the situation by looking after yourself.

The best place to start is with Step 1!



# TASC

THE AMBULANCE STAFF CHARITY

Supporting present and past ambulance staff  
and their families in time of need

**TASC (The Ambulance Staff Charity)** is a national charity dedicated to improving the lives of past and present ambulance staff and their families. We're here to help you in times of need and can provide services to support your mental, physical or financial wellbeing. Learn more on our website: [www.theasc.org.uk](http://www.theasc.org.uk)

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or email [support@theasc.org.uk](mailto:support@theasc.org.uk)

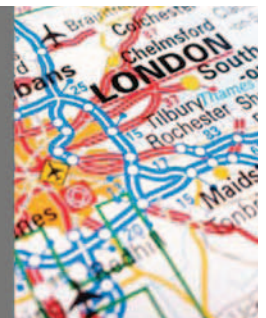
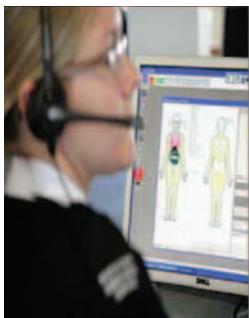
For any further information, advice, guidance or help with mental health, email [david@rubikminds.co.uk](mailto:david@rubikminds.co.uk)



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# Ducks, Dogs, and Danger: Life on the Frontline as an Emergency Veterinary Medic



By Mr Matthew Chinnery, Veterinary Surgeon

It's not always easy to talk, think, or read about the things bothering you, even when they can offer potential solutions. So here is your emotional relief for this edition. Take a deep breath, forget that ache in your head for a moment, and look at the poor cute little beaver over there. Look at him, go on. Or her. It's even on a little stretcher.

Dierenambulancen, or Animal Ambulances, can be found throughout The Netherlands, with different non-merged/ regional animal ambulance services taking care of specific areas. The dierenambulancen are veterinary emergency services which provide first aid to injured and sick animals and, of course, transport them to the nearest vet or clinic. The images here are taken from Dierenambulance Rotterdam and Dierenambulance Amsterdam.

So, who are they? And is it a real Ambulance? Well, the answer is they are your animal-loving heroic counterparts and, yes, the ambulances are real ambulances. They look the real deal and go nee-naw and everything.

The ambulance is specially equipped for first aid animal care and is, as you would imagine, staffed by volunteers, 24 hours a day, 7 days a week. In some cases, this can be arranged in a 'picket' fashion – that is, they simply



park up at home, or put their feet up, maybe get a few jobs done, perhaps see the family, and rush out as soon as a call comes through for an injured, stranded or trapped, or lost animal. If only, ey? Imagine all those warm dinners just waiting for you at the ready in your own kitchen in between calls. It is common though that an office or base is also available and I should, joking aside, make it clear that these are very professional and serious setups that take their clinical effectiveness and rescue operations towards animals just as seriously as we do towards humans. And their protocol is just as stringent and as subject to change as your own. Theirs, however, relies upon things like the Flora and Fauna Act or national and international crisis situations.

## The Kit

So how serious is the interior? They stock up on all the clinical and operational necessities you would think necessary:



*Baby swans, freshly rescued by Dierenambulance Amsterdam – cygnet theft has been a growing problem across the Netherlands with eggs and chicks being taken for sale in Eastern Europe*



A New Volkswagon Dierenambulance, Image Supplied by Dierenambulance Rotterdam



*This little hare had been separated from its mother. It's in loving hands now thanks to Dierenambulance Amsterdam, and they managed to find its warren not too far away – always leave baby hares if you find them, even if you think they may look lost*



*This newborn kitten had been rescued by Dierenambulance Amsterdam. You can even still see the umbilical chord.*



## Focus on happier things



Animal Ambulance Interior:  
Image Supplied by Dierenambulance Rotterdam

- Bandages and other general first aid material
- Disinfectants (separate types for volunteers and animals)
- Gloves (obviously)
- Waste bags (ditto)
- A stethoscope (Gotta hear how 'ruff' those chesty coughs are)
- Chip reader (Vital for lost, trapped, and injured animals to be returned to their loved ones)



Patients such as this heron are more easily subdued than drunken patients when they turn aggressive, Image Supplied by Dierenambulance Rotterdam

- Oxygen and Oxygen case
- Stretchers are also common (you try shifting a St. Bernard that's dead weight)
- A catch stick and leather gloves are available for catching and handling animals (birds of prey and cats can be particularly dangerous for volunteers... no surprise with the latter there)

Lockable plastic trays for deceased animals (I don't even know what to say to that...practical and necessary really)

So that's it. No lessons to be learned, no discussions to take away. Just a pleasant little Animal Ambulance tending to all of the poor, sick, injured, and scared little floofs, puppies and good bois of the world.



This little baby Jay was found stranded but Dierenambulance amsterdam nurtured him back too full health until he was mature enough to be set free again



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# Emergency Dispatch Explores “X-Factor” for Suicidal Callers

Audrey Fraizer

**Clinical Psychologist James Marshall calls it the “X-Factor” in the successful management of 911/999 calls involving mental crisis and risk of suicide.**



The “X-Factor” is a chief reason why a person in a suicide crisis may not call 911/999 even though the person needs help, or why the call is made yet the caller does not cooperate.

The X-Factor is *ambivalence about living and dying*—the caller struggling with suicide is often torn between two radically different sets of thoughts and feelings.

Whether the caller ultimately decides to lean further toward death, or lean toward life and collaborate with the dispatcher in pursuit of solutions for pain and suffering, may depend upon how emergency dispatchers (and field responders) understand and deal with this ambivalence.

Marshall said emergency dispatchers (and field responders) typically feel under-prepared to manage callers at risk of suicide. Because they lack qualified training on this call type, they often feel considerable frustration and carry false assumptions into these calls.

“When callers at risk of suicide will not cooperate in giving us an address, answering the next question about weapons, or separating from the means, it can seem as if they are just choosing to be difficult or ‘messing with us,” he said. “We may conclude this person really doesn’t want help and is just ‘yanking our chain’. The thinking might be, ‘if the person is really serious, it’s going to happen, and there’s nothing we can do about it.”

Marshall said research shows such assumptions are inaccurate; the assumptions miss an honest explanation for an at-risk person’s struggle to cooperate and establish judgments of callers that can make the outcome worse. It’s far more likely that callers struggling with suicide are tangled in life-and-death ambivalence. The individual had to rally courage to call 911/999 and start the conversation, while fearing an address will result a circular struggle — back to the hospital that didn’t help before.

No report of suicide ideation should ever be taken lightly, no matter how low-risk it may seem.

He dismisses the prevailing belief that when callers report suicide ideas yet deny immediate intent to complete suicide that they are *just trying to get attention* or just sending out a “cry for help.” Many callers whose struggles seem insincere or minimal many still make attempts. While those attempts may not be life-threatening, research shows a first attempt increases the risk of more attempts that can be more lethal through time.

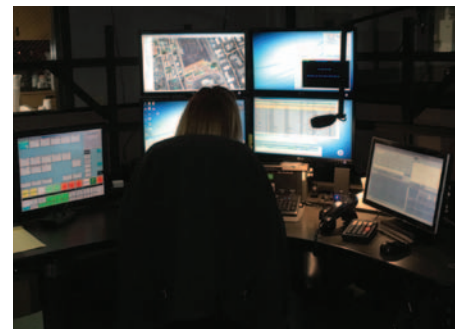
Whenever the caller shows signs of suicide risk without specifically stating it, the emergency dispatcher should ask directly about such risk, e.g., “Are you thinking of killing yourself?” These signs include:

- Talk of feeling pain
- Hopelessness
- Helplessness
- Feeling trapped/ talking of being trapped
- “Burden to others”
- Feeling Alone<sup>1</sup>

The key to success is recognizing and helping with the X-Factor.

The emergency dispatcher must wade in and “*meet the caller in the dialogue of the suicide struggle...help the caller express reasons for dying. Understanding the reasons for dying evokes the caller’s impulses to find reasons for living.*”<sup>2</sup>

Encouraging a caller to talk about reasons for dying helps discharge the toxic energy that drives suicide behavior. That ability to push toward a connection, rather than over-distancing for the sake of self-protection, can provide a buffer to keep the person from falling off the proverbial cliff.



“Yes, the dispatcher’s primary job is to ensure the safety of the caller and all those on scene; yet when they are struggling to cooperate, the most powerful way to achieve that safety is to build a life bridge of empathy by joining them where they are at mentally,” Marshall said. “And when they know they are truly being heard and cared about, they are less apt to escalate when your field responders arrive.”

Marshall highly recommends a direct approach to the call.

“Now is not the time to indirectly ask about risk,” he said. “While you may be afraid that asking, ‘Are you thinking of killing yourself?’ will increase the risk, the research doesn’t support this. You can ask the question. A caller is apt to feel more understood.”



In his book, “The Resilient 9-1-1 Professional,” Marshall urges centers to provide specific training to emergency dispatch in management of calls involving suicide risk and mental illness for two reasons: such training empowers responders with confidence that they are fully prepared, and this mindset protects their own mental health and retention in their profession.<sup>3</sup>

“Some callers, despite all we do, will still take their own lives, and we cannot take personal responsibility for that outcome,” he said. “But, dispatchers are far more apt to truly ‘let the call go’ when they know they’ve been prepared to deliver their best effort.”

Statistically, chances are high that an emergency dispatcher will answer a call placed by a suicidal individual. The World Health Organization (WHO) estimates that approximately 800,000 people die from suicide each year, which represents a global mortality rate of 16 people per 100,000 or one death every 40 seconds; it is the second leading cause of death among 15–29-year-olds globally.<sup>4</sup>

The black armband Ryan Dedmon wears around his upper right arm is a reminder of the profession and people he holds dearly but chose to leave — except in his heart — for his own well-being.

Dedmon is a former dispatcher for the Anaheim Police Department (APD), Calif. In mid-November 2013, he emptied the contents of his locker and walked away after 11 years in a law enforcement career he adored.

He took the shootings, stabbings, rapes, robberies, assaults, and other violence in stride. But nothing prepared him for the call he answered on a Saturday afternoon in spring 2013.

“911 Emergency.”

“I need the Anaheim Police Department,” the caller said.

“This is the Anaheim Police Department. Where are you?”

“I’m at a business at 1234 N. Kraemer Pl. in Anaheim.”

“What is your emergency?”

“I am really sorry I had to call you and involve you in this. I have a handgun, and I am going to shoot myself. I will be dead by the time police get here. You will find me outside in the rear parking lot. There is a note I have written in my back pocket. The note has contact information for my family. I am so sorry. Goodbye.”



The caller was dead from a self-inflicted gunshot wound by the time police were able to reach the scene. Although Dedmon had handled other suicidal callers during the three years since Johnson, this call was different.

“Public service is in my heart and mind,” he said. “And I was a damn good dispatcher. But what I will handle better this next time is taking care of myself.”

As Dedmon shows, the trauma of a caller threatening to end his or her own life takes an emotional toll on the emergency dispatcher. Their high level of responsibility and unknown outcomes add up to extremely high levels of personal stress.

While research into causes and level of stress among emergency dispatchers is relatively recent, a study conducted in 1997 showed that 33% of the 607 New York Police Department’s 911 communication center employees evaluated showed major depression signs; 13% in the survey said suicidal callers were a significant cause of high emotional distress second to the injury or death of a child.<sup>5</sup> A 2008 study by Roberta Troxell found that 39 percent of dispatchers had experienced intense fear, helplessness and horror relating to callers at risk of suicide.<sup>6</sup>

Helping emergency dispatchers manage the X-Factor is at the core of Marshall’s guidance. He envisions these instructions being used on par with similar pre-arrival instructions for cardiac arrest, choking, and other life emergencies found in the Medical Priority Dispatch System™ (MPDS®).

Ultimately, Marshall said meeting the caller empathetically where they are at can also create biochemical changes in the dispatcher that boosts empathy, boosts resilience, and protects their health at the same time, as he has found in his own research. In other words, the emergency dispatcher can assist the caller while, at the same time, managing his or her own well-being.

“That increased ability can go a long way in boosting their confidence and producing the best possible outcomes,” he said.

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**For more information about MPDS and the IAED, visit the website at:**  
**[www.emergencydispatch.org](http://www.emergencydispatch.org)**

# Paramedics Attend Tough Calls: How Best to Deal with Unwanted Memories?



**By Dr Jennifer Wild,**  
*BSc (Hons), MSc, DCLinPsy*

**The aftermath of a traumatic experience can be a confusing thing for many of us. How can you identify signifiers of PTSD when it's normal to have some of them early on? Are you even sure that what you have been through has affected you all that much? Is there something small, or something larger lurking underneath the surface? Dr Jennifer Wild, Associate Professor of Experimental Psychology at the University of Oxford, lays out a few basic approaches to dealing with what may be a traumatic experience in a healthy and balanced way, and how to recognise signifiers that need further help to get you back on track...**

On 7 May 2019, dispatch relayed a category 2 call, which John and his crewmate picked up. They were told a man had fallen down next to Ladbroke's, wounding his head. The caller had hung up on the control desk and no more information was available. It didn't sound urgent, but John knew that the information relayed in such calls didn't always match what they found. When he and his crewmate arrived on scene, the man was in cardiac arrest.

## **Biography:** Dr Jennifer Wild, BSc (Hons), MSc, DCLinPsy.



Dr Jennifer Wild, BSc (Hons), MSc, DCLinPsy, is a Consultant Clinical Psychologist and Associate Professor of Experimental Psychology at Oxford University and also works as clinical advisor to The Ambulance Services Charity (TASC), where she offers guidance on accessing evidence-based interventions for common mental health problems. Jennifer is passionate about reducing suffering in people who dedicate their lives to improving public health and safety – our emergency workers. She is dedicated to developing effective programmes for emergency workers that will reduce the likelihood of developing PTSD and depression.

Jennifer conducted the first large-scale prospective study of predictors of post-traumatic stress disorder (PTSD) and depression in newly recruited paramedics. She is now funded by MQ to develop and evaluate an intervention to modify predictors of PTSD and depression in student paramedics, a trial that is underway.

Jennifer has worked in an advisory role to the Cabinet Office on best practice for developing interventions to improve resilience and wellbeing in emergency workers. Jennifer has collaborated and worked with Mind, the mental health charity, to evaluate existing resilience interventions for emergency workers and then to develop and evaluate an evidence-based intervention. The intervention she developed with her team led to significant improvements in resilience compared to an alternative intervention and standard practice in a randomized controlled trial, and is being made more widely available to emergency services across England. Jennifer has co-developed a number of interventions that are now recommended as first-line treatments for PTSD and social anxiety by the National Institute for Health and Care Excellence.

Jennifer has over 80 publications in the area. She is dedicated to raising awareness of common mental health problems and their effective treatments. Her work is regularly featured in *The Times* and on the BBC. She frequently appears in the media giving expert advice on trauma-related problems.

The man reminded John of his father. He was about the same age with a similar shot of white hair. John performed CPR with members of the public shouting at him to work faster. The man died.

Sometimes you can walk away from a call, reset, and move onto the next relatively unscathed. Then there are those incidents that really get to you, and always seem to get to you. They remind you of someone or some situation in your personal life. Or you find the crippling circumstances in which some people live tough to bear. These calls may flash to mind as if out of nowhere, pulling you to the past and making you feel like the whole thing you wish had never happened is happening all over again.



Such memories are unwanted and uncontrollable, yet normal in the aftermath of the most difficult call outs. They usually fade with time and are not something to be too concerned about although they can, of course, interrupt your focus and knock your confidence.

Having helped many paramedics recover from post-traumatic stress disorder (PTSD), the severe stress reaction that can develop after trauma, such as witnessing other people die or suffer, I am often asked: 'what should I do after the really tough incidents?'

The short answer is.... Nothing. Try to let the memories come and go without trying hard to push them away. Research our team has carried out found that trying to push the memories away causes them to come back more often.

Of course, it's important to follow your service's operational guidelines after critical incidents. Then remember something important: it is normal for our minds to replay tough and



## Focus on peace of mind



traumatic events until they settle. It is normal to question our actions in challenging circumstances. All of this is normal for the first several weeks after a traumatic call-out.

The majority of people after trauma adjust and stay well. People are, for the most part, resilient. It is a minority who will go on to develop longer-lasting PTSD symptoms.

Of course, this doesn't mean that paramedics are safe from risk, and research we've conducted shows that paramedics are at greater risk of developing PTSD and other forms of psychological distress compared to the general population.

But the good news is that there is natural recovery with PTSD symptoms, especially in the month after trauma. This is why the National Institute for Health Care and Excellence (NICE) recommends 'watchful waiting' after trauma: monitoring symptoms and waiting to see how things settle in the first month. It is also why the NICE guidelines for PTSD recommend no psychologically-focused debriefing to prevent or treat PTSD – it interferes with natural recovery.

What is less clear is the trajectory of PTSD amongst paramedics. Do paramedics benefit from natural recovery from PTSD at a similar rate to that of the general population or are they more susceptible to persistent and enduring PTSD due to the nature of their work?

To answer these questions, longitudinal studies are needed in which we track paramedic health over time and importantly learn much more about paramedics who stay well their entire career and paramedics who do not.

We need to identify the psychological, behavioural and organisational factors that support paramedics to sustain good health, including recovery from episodes of PTSD. Similarly, we need to know much more about the factors linked to persistent PTSD and psychological distress amongst paramedics.

Only then can we be clearer about how best to protect paramedics from developing PTSD and other forms of psychological distress, and what intervention or training is best placed to help at different stages of a paramedic's career.

**For more information, please contact Jennifer on:**  
[jennifer.wild@psy.ox.ac.uk](mailto:jennifer.wild@psy.ox.ac.uk)

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# From the Africa Desk of Ambulance Today: Compassion Fatigue vs Compassion Satisfaction



By Michael Emmerich

*"When you're compassionate, you're not running away from suffering, you're not feeling overwhelmed by suffering, and you're not pretending the suffering doesn't exist. When you are practicing compassion, you can stay present with suffering."*

Sara Shairer - <https://eftraining.co.uk/what-is-compassion-fatigue/>

In the emergency first responder profession, where we witness trauma first-hand, it is at times difficult to be fully aware of the impact that "direct trauma" has on us as practitioners and how to differentiate between direct trauma and vicarious trauma. Research suggests that EMS personnel experience many reactions after exposure to a traumatic event. Admitting to being emotionally affected is regarded as difficult as it may lead to being perceived by their peers as not tough enough for the job. The attitude of 'no one dies on my watch' is common amongst EMS personnel. This leads to EMS personnel often suppressing their emotions and feelings associated with the reality of their work in order to live up to this image of being strong and resilient.

"Injury mortality rates in South Africa are approximately six times higher than the global average. One of a handful of studies conducted amongst EMS personnel in the Western Cape found higher prevalence of exposure to critical incidents compared to their counterparts in other low-income countries."

*African Journal of Emergency Medicine  
Volume 5, Issue 1, March 2015*

This Quarter we attempt to unpack and understand the lived experiences of compassion fatigue, vicarious/secondary trauma (ST), and burnout.

These three terms are complementary and yet different from one another.

*-Compassion Fatigue (CF): Also called "vicarious traumatization" or secondary traumatization (Figley, 1995). The emotional residue or strain of exposure to working with those suffering from the consequences of traumatic events. It differs from burn-out but can co-exist. Compassion Fatigue can occur due to exposure on one case or can be due to a "cumulative" level of trauma.*

*The American Institute of Stress -  
<https://www.stress.org>*

*-Vicarious Trauma (VT): is a process of change resulting from empathetic engagement with trauma survivors. Anyone who engages empathetically with survivors of traumatic incidents, torture, and material relating to their trauma, is potentially affected.  
<https://www.bma.org.uk>*

*-Burnout: a "syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed. It is characterized by three dimensions: 1) feelings of energy depletion or exhaustion; 2) increased mental distance from one's job, or feelings of negativism or cynicism related to one's job; and 3) reduced professional efficacy.*

*The American Institute of Stress -  
<https://www.stress.org>*

Despite the differing theories and terminology of the three concepts, each is directly associated with the concept of empathy. There are two key components: *cognitive empathy, the ability to take someone's perspective, and affective empathy, whereby an individual share a similar emotional response to others' experiences* (Smith, 2006).

With empathy holding sway as a common factor in CF, VT and burnout, it would make sense then to conclude that cognitive and affective empathy would impact differently on the life of the practitioner. For example, a professional empathising emotionally may experience more emotional consequences than an individual empathising cognitively. In addition to increased experiences of trauma, increased case load and less clinical experience, it is therefore suggested that the nature of empathetic engagement in work-related scenarios would therefore be an important dimension to consider in understanding the development and intensity of CF as experienced by EMS practitioners.

Conversely, burnout does not necessarily mean that our world views have been damaged or that we have lost the ability to feel compassion for others. Most importantly, burnout can be easily resolved; *(but can it be in the current financially driven, dehumanised environment practitioners work in?)*

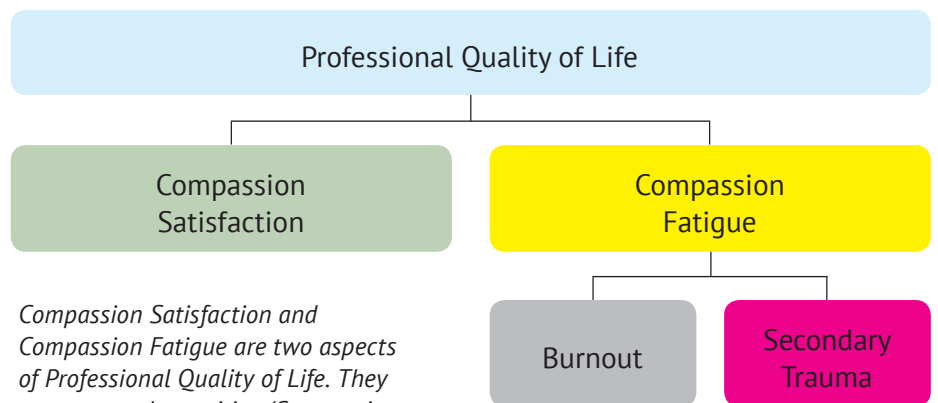


Conversely this is not the case for CF and VT.

As one is vicariously exposed to trauma, both directly and indirectly, one begins to exceed one's resilience (or ability to cope) to these events, and one is then prone to develop CF (or sometimes also referred to as Secondary Distress Syndrome). Once our chronic exposure to trauma exceeds our coping mechanisms, CF then becomes evident. CF has been described as the convergence of secondary traumatic stress (STS) and cumulative burnout (BO); a state of physical and mental exhaustion caused by a depleted ability to cope with one's everyday environment. This can impact standards of patient care, relationships with colleagues, or lead to more serious mental health conditions such as post-traumatic stress disorder (PTSD), anxiety or depression.

How do we then best protect vulnerable workers, to prevent not only CF, but also the health and economic consequences related to the ensuing, and more disabling, physical and mental health outcomes. To fully understand CF, we possibly need to move away from theoretical explanations and models and focus on a more relational understanding of professionals lived experience of their own and others' (patients, peers and family) distress. This would involve a narrower focus on problem solving, via person centred compassionate care. Remember authentic and sustainable self-care begins with you. Understand that the pain and stress you feel are normal displays, resulting from the care giving work you perform on a regular basis.

Examine the positive and negative aspects of one's work influences, and how it affects one's professional quality of life. This leads us to a better understanding, whilst helping those who experience trauma and suffering. This can in turn improve our ability to aid them and keep our balance in this process.



*Compassion Satisfaction and Compassion Fatigue are two aspects of Professional Quality of Life. They encompass the positive (Compassion Satisfaction) and the negative (Compassion Fatigue) parts of helping others who have experienced suffering. Compassion fatigue breaks into two parts. If working with others' suffering changes you so deeply in negative ways that your understanding of yourself changes, this is vicarious traumatization. Learning from and understanding vicarious traumatization can lead one to vicarious transformation.*

Dr. Beth Hudnall Stamm – ProQOL

*Professional Quality of Life Model (Stamm, 2012)*

An excellent article to read is *Transforming Compassion Fatigue into Compassion Satisfaction: Top 12 Self-Care Tips for Helpers*, by Françoise Mathieu, M.Ed., CCC – see the link below

#### In closing;

*"integrated intervention programmes are needed to assist EMS personnel working in this sustained high-stress environment. The findings can assist health care educators in the design of co-curricular activities intended to help in the development of resilience and the psychological wellbeing of EMS personnel."*

*Exposure to daily trauma: The experiences and coping mechanism of Emergency - Llizane Minnie a,\* Q3, Suki Goodman b, Lee Wallis*

Healing begins from within, and being committed to a self-care plan, with clear boundaries in both your personal and professional life and understanding one's negative behaviours and their root cause is key to this. Internal self-healing in our profession is a life-long

management plan, but as you continue to do the necessary internal work, life will and can, begin to change for the better.

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**Tell Michael what you think about this article by emailing him at: [mikesnexus@gmail.com](mailto:mikesnexus@gmail.com)**

**If you have any ideas for special feature articles on ambulance care in any part of Africa, we would like to speak with you about them.**

**Equally, if you have any news items you would like us to run either in our magazine or on our daily-updated global ambulance news website please email us at: [editor@ambulancetoday.co.uk](mailto:editor@ambulancetoday.co.uk)**

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# Ambulance TODAY



# It's Time to Talk About Post Traumatic Stress Disorder (PTSD)

**Most people will experience a traumatic event in their lifetime, but ambulance workers must deal with difficult and distressing situations every single day.**

While PTSD is usually associated with soldiers, it's much more common in ambulance workers. Dr Jennifer Wild, Associate Professor at Oxford University and TASC's Clinical Advisor, studies PTSD in emergency service workers. Dr Wild said:

*"Studies estimating the rates of PTSD by self-report put the prevalence of PTSD at 20% among paramedics. Whereas research that's come out of King's College London has identified between 5-7% of soldiers who are likely to develop PTSD."*

However, a 2018 survey by the GMB<sup>1</sup> reported an even higher figure with almost 40% of ambulance staff saying they have experienced PTSD at some point in their career.

At TASC (The Ambulance Staff Charity), we are seeing the consequences of these traumatic situations on our ambulance staff's mental health and are supporting a growing number of ambulance staff who are suffering from PTSD symptoms as a result of their work, sometimes months or even years later.

*Between March 2018 and February 2019, over 84% of people who received mental health support from TASC had PTSD/PTSD symptoms.*

## What are the symptoms of PTSD?

- Re-experiencing the trauma through flashbacks, nightmares or intrusive memories
- Avoiding things that remind you of the trauma, feeling emotionally numb or detached
- Feeling constantly alert, having problems sleeping or unable to concentrate
- Negative beliefs or feelings, such as blaming yourself for the trauma or feeling like nowhere is safe

*Ambulance staff seeking support from TASC for their mental health issues has risen from 8% of cases in 2015 to over 80% in 2018.*



## How can TASC help?

We're here to support you during your time of need so you can continue to do the job you love. Everyone is different which is why we work with a range of qualified experts to offer confidential mental health support services tailored to you.

We can provide funding for you to see a local counsellor for confidential one-to-one talking therapies. We believe that people get much more out of their counselling when they are empowered to take control of their treatment and our team will support you to choose your own professionally-registered counsellor and arrange your sessions at a time that's convenient for you.

We can also provide specialist talking therapies for people affected by traumatic events as well as residential support at a Police Treatment Centre for people needing more intensive support.

If you need support with your mental health or have experienced any of the symptoms of PTSD, please get in touch with TASC's Support Services Team on:

**T: 0800 1032 999**

**E: [support@theasc.org.uk](mailto:support@theasc.org.uk)**

**W: [www.theasc.org.uk](http://www.theasc.org.uk)**

## Get involved!

At TASC we are truly grateful to everyone who has volunteered, donated or fundraised for us. We are dedicated to being there to support our ambulance community in their time of need, but we can only do this with your support. There are many ways you can help:

- Make a donation - Text AMBULANCE to 70085 to donate £3 (plus your standard rate message charge)
- Make a regular monthly donation at: [www.theasc.org.uk/amber](http://www.theasc.org.uk/amber)
- Host your fundraising event with our support or take on one of our fundraising challenges
- Volunteer and help promote TASC's services in your spare time

**If you would like more information on how you can support TASC, email: [fundraising@theasc.org.uk](mailto:fundraising@theasc.org.uk) or if you would like to become a volunteer please email: [volunteering@theasc.org.uk](mailto:volunteering@theasc.org.uk).**

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Communications code AR01

Twin paramedics retire after almost three decades caring for Londoners



'Miracle worker' twin paramedics are retiring this week after a combined 56 years of saving lives. London Ambulance Service's Mark and Chris McCarthy, 57, have worked their last shift from Friern Barnet station, after treating thousands of patients during their 28-year careers.

Chris said: "Retiring was a very difficult decision to make but we do everything together so it seemed natural to retire together. We've had incredible careers, met amazing patients and



worked with some great people. My wife said I was too squeamish to do this job and I'd only last three days, so I proved her wrong!" The brothers, who were both black cab drivers before joining the ambulance service, say it has changed considerably since they joined in 1991. Mark said: "The training and skills are unrecognisable – paramedics now all have degrees and it's a true profession. "Years ago, we would literally pick up patients and get them straight to hospital, whereas now we stabilise and treat them on the scene before taking them to a specialist centre – it's so much better for patients now. "There have been difficult times over the years, and in this job you do see some horrible things, however, we've always had each other for support. I'd definitely recommend it as a career – it's been a real privilege to treat so many patients over the years." Brian Wilson is one of the patients who owes his life to the twins. The 68-year-old father and grandfather collapsed at his home in North Finchley five years ago and Chris and Mark were there in minutes. Brian said: "I collapsed earlier that day and was taken to hospital but tests didn't find anything wrong so I went home. I remember thinking I must be sick as I was seeing double – not

realising they were twins at the time!" Brian's heart stopped beating and the twins performed cardiopulmonary resuscitation (CPR) before taking him to Barnet Hospital. Brian added: "They are miracle workers. I would not be here today if it wasn't for them and I can't thank them enough for what they did. They were incredibly calm, and professional and so experienced - it's such a shame they're retiring. I am really appreciative to all ambulance workers – they do an incredible job." The brothers plan to keep up their paramedic skills by working a few shifts a month, but will spend more time with their families as well as doing hobbies they enjoy – including boxing at Finchley Boxing Club.

Isle of Wight NHS Trust Ambulance Service can't wait to celebrate Restart a Heart Day (RSHD) 2019

Following the Isle of Wight NHS Trust Ambulance Training and Community Response Services (ATCoRS) success in training of over



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1000 people in CPR on Restart a Heart Day last October, the ATCoRS team has now adopted Island schools as part of their CPR guardian scheme and will kick start this year's Restart a Heart Day (RSHD).

Starting on 20th May 2019 the Isle of Wight NHS Trust Ambulance Service will be the first UK (United Kingdom) Ambulance Service to commence 2019 RSHD celebrations.

The IW NHS Trust ATCoRS team will be providing free CPR training sessions throughout the year to Island school children in a pledge to help make every Island child a lifesaver. Brighstone Primary School will be the first school to receive their free CPR training on Monday 20th May 2019.

The ATCoRS will also be offering free CPR training at various venues across the Isle of Wight in support of Restart a Heart Day, 16th October 2019. More information regarding the training sessions will be published throughout the year on their website [www.isleofwightambulance.co.uk](http://www.isleofwightambulance.co.uk)

Louise Walker, Head of the ATCoRS explains; "We know first-hand only too well how important it is for people to learn lifesaving skills and we are thrilled to be part of the Restart a Heart Day campaign again."

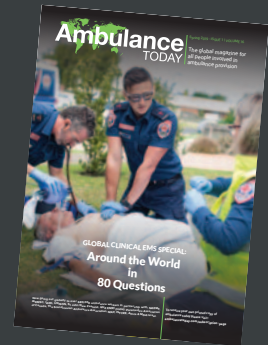
Victoria White, Head of Ambulance, IW NHS Trust said "We are proud to be supporting



Restart a Heart Day again this year. We feel it is so important that people know how to recognise cardiac arrest and do not feel afraid to provide CPR and use an Automated External Defibrillator (AED), as it is proven that bystander CPR and early defibrillation greatly increases survival rate for an out of hospital cardiac arrest.

Unfortunately cardiac arrest can occur at any time to any one which is why the Isle of Wight Ambulance Service is passionate about educating our community and we are grateful to all the schools that have committed to our free CPR training sessions.

## Ambulance TODAY



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North East Ambulance Service NHS Foundation Trust

### Cyclist alive - thanks to CPR and local defibrillator

A cyclist is alive and well thanks to people coming to his aid and a community defibrillator being close by.

Ray Honour was competing in an event at the South Shields Velodrome when he collapsed just as he started the last lap of a veterans' race.

Heather Huntley and Damon Devine were both watching the event at the time and came to Ray's aid, calling 999, beginning CPR and mouth-to-mouth resuscitation and calling for someone to collect the community defibrillator.

North East Ambulance Service call handler Gary Mayne immediately dispatched an ambulance on blue lights to the address and talked them through the situation.

Having handled calls for the ambulance service for 12 years, Gary has helped thousands of patients. He explains, "I can talk to between 45 and 120 patients every shift with different conditions and people can sometimes be nervous about giving CPR or using a defibrillator so it was a huge relief to know that

Heather and Damon were there and that they were willing to help Ray whilst the ambulance was travelling. We can see any community defibrillator within a 500 metre distance of a patient in need in our systems and we know what difference they make."

Damon, who has never given CPR before, said, "The race was on the last lap when I heard a shout for assistance. A man was on the floor; he was no longer breathing and we couldn't find a pulse. Heather was fantastic at giving instructions. She is first aid trained and told me exactly what to do. We gave Ray a number of shocks with the defibrillator. It was an amazing piece of kit – it just told us what to do all the way through it."

Rapid response paramedic Clare Edmonds was part of the North East Ambulance Service team that were sent to the incident. She helped to get Ray's heart started and helped transport him to hospital.

Hugely passionate about the value of community based defibrillators, Clare explained: "We can help to revive the heart once we get to a patient in Ray's condition, but without early CPR and defibrillation, he could have suffered cerebral damage that would have made a difference to his future quality of life.

"Heather and Damon's actions helped to ensure that Ray had the best chances for a full

recovery. If there hadn't been a defibrillator in the community and if the people at the event hadn't used CPR, Ray might not have had the same chances to be here with us all. Not many people get the chance that Ray has had and I hope that he is able to make the most of his life in the future after his experience.

"Cases like this are the best example for why we need to increase the number of defibrillators in the community."

Joined by his wife Joanne and mum Joan, 47-year-old cycling enthusiast Ray Honour, from Fleetham Close in Chester-le-Street reunited with the team who helped to save his life to say thank you recently. He explained, "It's unbelievable what people did for me on the day. I have made such a good recovery, I probably feel as fit if not fitter than before. I'm on the right medication and my heart is better.

"I can't really remember anything of the actual incident. All I remember was that I was doing quite well in the race – leading in my category. I came round and started the last lap. The next thing I remember was being in the back of the ambulance. I'm so grateful to everyone for what they did for me that day."

Ray was taken to South Tyneside Hospital and later transferred to the Freeman Hospital, with his daughter Rebecca by his side.

It's only after the incident that he found out



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that there were hereditary heart problems on both sides of his family. He's had three heart stents an internal defibrillator fitted, has had to give up his driving licence for six months and is taking a break from cycle racing – after which he'll talk to his family and doctors and then decide whether he'll race again. For now, he's already back in the saddle to cycle to work in Peterlee.

In a bid to increase the number of defibrillators in the community, NEAS recently launched a campaign to raise awareness of their value and to offer funding from its charitable trust in key areas.

Community development officer at NEAS, Alex Mason, adds, "When a heart stops beating, oxygen is not being transported to the brain and other vital organs, and within four to five minutes, brain damage will start to occur without intervention. A victim's chance of survival falls by around 7 to 10 percent with every minute that defibrillation is delayed.

"Evidence suggests that over a quarter of adults living in the North East currently wouldn't perform CPR or use defibrillator for fear that they might hurt the person or do it wrong. Only 8.7% of patients who had resuscitation attempted on them in the North East survived to be discharged from hospital last year."

## Are you really fine?

According to the Mental Health Foundation, the average adult will say "I'm fine" 14 times this week, Mental Health Awareness Week, yet less than 20% will actually mean it!

It's been known for some time that approximately 1 in 4 people in the UK will experience a mental health problem each year. In England, 1 in 6 people report experiencing a common mental health problem (such as anxiety and depression) in any given week.

Over recent years, we have been working hard to improve the support we provide to our staff. Given the types of cases that they deal with, we need to be sure that we get better at making sure their mental wellbeing really is 'fine'.

Director of Workforce, Kim Nurse, said: "We have 24-hour support through their management team, our Staff Advice and Liaison Service (SALS) and the Trust is employing two psychotherapists who will provide dedicated help for staff. We also procure specialist support from an external counselling service The Listening Centre who can support staff with a variety of help.

"With a workforce of over 5,000, we want to be certain that we have a range of support in place to assist our staff stay mentally well in addition to their physical health. We know that some of the cases that our staff deal with



are extremely difficult, so we want to do as much as we can to support their wellbeing.

"Another important development for the Trust is our training of hundreds of staff in Mental Health First Aid courses. These courses teach our staff to spot the symptoms of mental health issues, offer initial help and guide a person towards support. The training teaches people to listen, reassure and respond, even in a crisis - and potentially reach out to someone before a crisis happens. Feedback has been really positive, and all courses have been fully attended with a waiting list for staff wanting to be included in the future.

"As a Trust we have moved forward significantly, but recognise that we need to keep moving forward so that we can continue to support our staff so that they can support the public when they need us most."

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### Air Ambulance appoints anaesthesia expert to its Board

Reaching the sickest quickest – St John An international expert in intensive care and the battle to reduce deaths from Sepsis has joined the Board of Trustees at Air Ambulance Kent Surrey Sussex, the life-saving time critical emergency care charity.

Professor Andrew Rhodes is a member of the Executive Committee of the Surviving

Sepsis Campaign and Professor of Anaesthesia & Intensive Care Medicine at St George's University Hospitals NHS Foundation Trust in London.

The air ambulance operates 24/7 and serves the 4.7m residents of Kent, Surrey and Sussex, as well as the huge number of people that travel through the area on business or pleasure each year.

Commenting on his appointment to the Board of Trustees, Professor Andrew Rhodes said: "Air ambulances are an integral part of the emergency care community. I've seen first-hand

how their speed of response and the expertise of the on-board doctors and paramedics have made a very positive impact on outcomes for patients, most of whom are in seriously life-threatening conditions.

"I'm delighted to play a small part in helping the team at AAKSS improve patient procedures still further, and to advise the Board on potential developments such as on-board anaesthetics."

Dr Helen Bowcock, Chair of Air Ambulance Kent Surrey Sussex, added: "We conducted an open competitive process to recruit a Trustee with relevant medical expertise and are delighted that Andy applied and has accepted our invitation to join our Board. In our mission to deliver the best possible patient outcomes we very much value his clinical experience as a Professor of Anaesthetics as well as his international reputation in research and in clinical governance.

"As we continue to innovate, to deliver outstanding patient care and to increase our investment in research he will provide particularly valuable oversight and guidance as a Trustee."

In addition to his work for St George's, Professor Rhodes is also a Senator and past President of the European Society of Intensive Care Medicine.



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## Paramedics sleep rough for charity

Big-hearted Paramedics and Emergency Care Assistants from South Western Ambulance Service NHS Foundation Trust (SWASFT) Swindon Station are set to sleep out rough for 24 hours to highlight the issue of homelessness this week.

On Thursday 28 February 2019, Paramedic Chris Kirby will be joined by colleagues in support of local charity 'The Swindon Night Shelter' which provides emergency accommodation, food and clothing for homeless people.

The SWASFT team are doing the 24-hour sleep-out on the steps of Swindon Ambulance Station for the second year running. They are hoping to beat last year's total of £2,000 which they raised for Shelter.

Paramedic Chris Kirby said: "Sleeping out last year opened all of our eyes as to what it must be like for those homeless patients we treat, and how the thought of being homeless as a continuous cycle rather than a one off might affect an individual's mental health."

"It highlighted things that you would never even consider such as road noise when you are trying to sleep, foxes coming for a sniff, how cold a pavement gets after a few hours, and the absolute boredom of staying in one place for

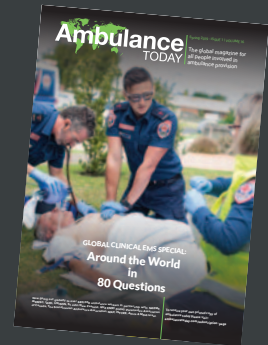


fear of losing your spot if you move.

"The passing public were very supportive and kindly gave us several rounds of free coffee and food. This year, inspired by our new neighbours, the Swindon Night shelter, we shall be raising money for this local charity with a target of £3,000. We have built good relationships with the shelter, and hope to create a referral pathway to them within the coming months. We would actively encourage people to run similar events - it definitely creates an understanding for those who have no option but to sleep rough."

The SWASFT team sleeping out this year will be: Chris Kirby, Ollie Dalton, Charlie Goldsmith, Adrian Sawyer, and two new faces: Lee Stagg and the Wiltshire Deputy County Commander Jane Whichello.

# Ambulance TODAY



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### Cartwright Conversions supplies state-of-the-art ambulance to Ascension Island in the middle of South Pacific Ocean



They've got a school, a hospital and an airport runway. Now people living on Ascension Island have finally got a state-of-the-art civilian ambulance.

The population of just fewer than 700 will benefit from a new vehicle supplied by Cartwright Conversions. Until it arrived at the island, the only medical transport available was a basic military-style Land Rover with no medical equipment on-board.

Cartwright Conversions supplied an ex-demonstration model with extra equipment and a powerful engine that could cope with the climb from the island's port of Georgetown to the inland settlement of Two Boats.

Nathan Millington, Director of Operations and Facilities, for the Ascension Island Government, said: "Cartwright went over and above to get this on the road and they kept us updated with what they were doing. They went the extra mile and I can't recommend them highly enough".

The vehicle was sent out on a cargo ship that anchors off Ascension on the way to the Falkland Islands, then had to complete the last sea mile on a flat barge before being lifted by crane onto shore.

Steve Shaw, Managing Director of Cartwright Conversions said: "This was definitely one of our more unusual requests and we were delighted to help out."

Cartwright Conversions is part of the Altrincham-based Cartwright Group, one of the largest trailer manufacturers in the UK. The converter produces a number of specialised vehicles including ambulances, patient transport, police and security, welfare and other bespoke conversions.

For more information about the full range of conversions' products from Cartwright visit the website: [www.cartwrightconversions.co.uk](http://www.cartwrightconversions.co.uk) or call 0800 0320 279.



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### Eberspächer acquires vehicle climate control specialist Kalori



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With lower power consumption and reduced weight, the new versions have almost doubled the service-life intervals of previous models. Quieter fuel pumps, brushless motors and new CAN bus interface, together with step less heat output providing the ultimate in temperature control.

Climate control systems combine an independent heater with an air conditioning unit to provide automatic temperature control in the vehicle to maintain a constant temperature for the patient and a comfortable working environment for the crew.

User controls vary from simple manual control such as the 802 modulator with built in heater diagnostic function, to the fully automatic digital climate controller which offers total temperature control for both heating and air conditioning.

Keeping drugs within their critical temperature range within an Ambulance is another problem that Eberspächer has a solution for. The Ambutronic is a 7 Litre, all stainless steel refrigerator, specifically developed for easy installation into emergency vehicles.

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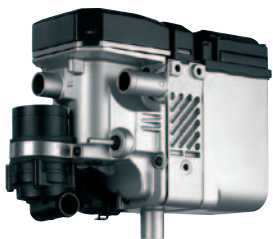
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Stone Hardy are agents for all the major tail lift manufacturers, and they have many blue-chip companies as their customers, with a turnover of approximately £10m a year, and a skilled and knowledgeable workforce with a wide range of experience in all aspects of the industry.

In 2016, the company upgraded their facilities in Bathgate by moving to a new site. More than £1 million was invested during 2015-17 in a new fleet of fully-equipped service vans, and six new rapid response vehicles, providing genuine national coverage ability for its 76 engineers.

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### Webasto Engine Off Technology



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For an informal chat, call  
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