Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF SIMON THOMSON

I, Simon Thomson, Regional Director for Ambulance Victoria, of 375 Manningham Road, Doncaster, say as follows:

1. I make this statement to the Royal Commission into Victoria's Mental Health System (**Commission**) in response to both a notice to appear dated 4 June 2019 issued to Ambulance Victoria (**AV**) by the Commissioner and Chair of the Commission, Penny Armytage, and the list of questions provided by the Commission that I have addressed in this statement.

2. I am the Regional Director for AV in the Barwon South West (**BSW**) region. I have held the Regional Director (or equivalent role) position since 16 November 2011.

3. I make this statement on behalf of AV. I am duly authorised to do so.

4. This statement is true and correct to the best of my knowledge and belief. I make this statement based on matters within my own knowledge, and documents and records of AV which I have reviewed. I have also used and relied upon data and information produced or provided to me by officers within AV.

5. This statement has been prepared with the assistance of officers of AV and lawyers.

Professional background

6. I commenced as Regional Director, AV in November 2011. Prior to this I held a range of management and paramedic roles including:

    6.1 Group Manager, AV (May 2008 - November 2011);

    6.2 Senior Paramedic Team Manager, AV (July 2005 - May 2008); and

    6.3 Ambulance Paramedic, AV (August 1999 - July 2005).

7. I am a registered paramedic in the national scheme regulated by the Australian Health Practitioners 1.1 Regulation Agency (**AHPRA**).

8. In terms of my education and qualifications I hold the following:

    8.1 Graduate Diploma in Strategic Leadership (College of Law & Education);

    8.2 Diploma in Management (Melbourne Business School);

    8.3 Diploma in Paramedic Studies (Monash University); and

    8.4 Diploma in Criminal Justice (Vocation Australia).

9. Attached to this statement and marked '**ST -1**' is a copy of my 'Curriculum Vitae' (**CV**).

Current role and responsibilities

10. As Regional Director of AV, I am responsible for the BSW Region, which is one of seven regions across Victoria. In that region, I am responsible for road emergency Ambulance Service delivery, including paramedic and volunteer responses. My direct responsibilities include ensuring emergency responses and operations comply with performance standards, government policy, and AV policy and procedures. I am also responsible for ensuring clinical services are of a high standard, and that there are continual operational improvements across the region.

11. Attached to this statement and marked '**ST -2**' is a copy of 'AV's organisational chart.'

12. I am also a member of the Senior Leadership Team (**SLT**) for Clinical Operations, a Division of AV. This SLT is attended by other Regional Directors and executive members of AV, with the primary focus on patient-service delivery. I also contribute to policy and organisational decisions and represent operations in various portfolios and organisational committees including:

    12.1 the Peak Best Care Committee;

    12.2 Safe Care Committee;

    12.3 Medication Safety Committee; and

    12.4 the Rural and Remote Area Health Committee.

(a) (1) What services does Ambulance Victoria provide in relation to people in crisis because of mental health-related issues?

13. In summary, AV provides the following services in relation to mental health related issues:

    13.1 responding to emergency '000' calls;

    13.2 conducting non-clinical triage for emergency '000' calls;

    13.3 treating mental health patients who have called emergency '000' without transporting them to a health facility;

    13.4 transporting mental health patients who have called emergency '000' to emergency care via ambulance; and

13.5 referring mental health patients for nurse, general practitioner, clinical or medication advice through our secondary triage service.

These services are described in more detail below.

14. AV receives and responds to '000' calls referred from the Emergency Services Telecommunication Authority (**ESTA**), a State Government agency, overseen by AV. Calls involve a range of medical situations, including mental health issues. Whilst calls are often patient-initiated, they may also be initiated by other individuals concerned for the wellbeing and presentation of the patient.

15. ESTA undertakes an initial non-clinical triage of the patient using an established questionnaire referred to as the *Medical Priority Dispatch System* (**MPDS**).[1] Calls are then categorised according to the chief complaint (eg. chest pain, mental health issues), and based on the responses are determined as either:

15.1 **Calls not of time-critical emergency**: Referred for secondary triage with the assistance of expert paramedics and registered nurses, and generally managed by providing patients with advice and referral to clinically appropriate services or self-care advice. Secondary triage may also result in emergency ambulance attendance, or non-emergency patient-transport. The secondary triage service uses the Adastra Electronic Patient Management System (patient management software used to support clinical decision-making); or

15.2 **Calls of time-critical emergency**: Ambulance resources are dispatched involving attendance by paramedic or AV First Responders. In some cases, joint attendance with paramedics and police is required if circumstances involve risk to the safety and well-being of paramedics or others. Ambulance response time varies, and the priority of the response is dependent on clinical need and available resources, with priority given to life-threatening incidents.

16. All calls to '000', including those concerning mental health issues, follow the process described above. The process additionally includes the following for patients with mental health issues:

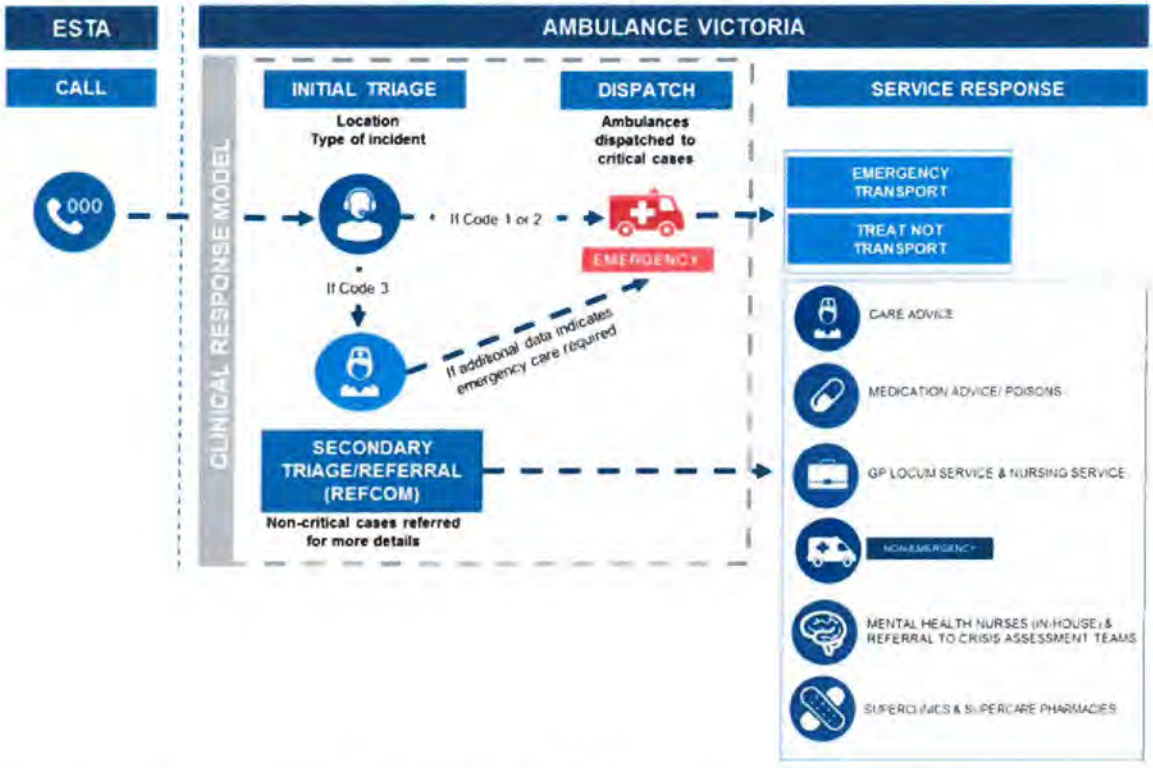
16.1 In February 2017, AV contracted Outcome Health for mental health nurses to provide advice in secondary triage to provide more comprehensive risk assessment and discussion with the caller or carer.

[1] Version 12.2.

16.2 Referrals to clinically appropriate services which may include referral to a locum doctor or nurse, or to a Crisis Assessment and Treatment Team (**CATT**).

16.3 The mental health management plans developed by AV to support secondary triage of mental health patients who are frequent '000' callers. These plans provide information in addition to that identified in the call to confirm health history, medication management, care in progress, linked support services and knowledge on patient specific de-escalation strategies to enable accurate assistance.

17. The following is a diagram of AV's services.



Source: Care Enhancement Call Centre System 2018 and Adastra Electronic Patient Management System 2019.

(a) (1)(A) Is the service limited to transporting people to hospital? What capacity is there for Ambulance Victoria members to provide information and support to people when attending a call out?

18. In responding to calls deemed a time-critical emergency, AV not only provides the patient transport, but also provides immediate care by way of assessment, urgent intervention (eg. cardiopulmonary resuscitation (**CPR**) if required), and administers medication if necessary. Given this, AV provides important support to health practitioners and/or Victoria Police.

19. Approximately 18% of mental health cases involving ambulance dispatch do not result in patients being transported to hospital. Patients may instead receive treatment from paramedics at the scene, or be referred to other mental health professionals and services, or simply decline paramedic assistance altogether.

(a)(2) Where does Ambulance Victoria fit within the mental health system?

20. AV plays a central role in the mental health system as first responder to mental health patients requiring immediate assistance and management, and by linking patients with services to ensure they receive ongoing support and treatment. AV also acts as a safety net for patients who have not been able to access other services.

21. AV was established under the *Ambulance Services Act 1986* (Vic) (**AS Act**) and primarily responds to medical emergencies, and provides medical intervention where necessary to prevent injuries. Section 15 of the AS Act sets out the objectives of services provided by AV which include the following:

    21.1 To respond rapidly to requests for help in a medical emergency;

    21.2 To provide specialised medical skills to maintain life and to reduce injuries in emergency situations and while moving people requiring those skills;

    21.3 To provide safe, patient centred and appropriate services;

    21.4 To provide specialised transport facilities to move people requiring emergency medical treatment;

    21.5 To provide services for which specialised medical or transport skills are necessary; and

    21.6 To foster continuous improvement in the quality and safety of the care and services it provides.

22. In addition to AV's role in responding to time-critical emergencies, as set out above, AV also has a role in providing transport for non-emergency cases. This role is regulated by the *Non-Emergency Patient Transport Act 2003*, the *Non-Emergency Patient Transport Regulations 2016* (**Non-Emergency Regulations**) and the Non-Emergency Patient Transport Clinical Practice Protocol (**Non-Emergency Protocol**). The Non-Emergency Protocol provides a practice framework in responding to and managing patients with a range of clinical conditions and acuities, including mental health issues. While the Non-Emergency Protocol is not exhaustive, it covers the majority of patient presentations. AV contracts Non-Emergency Patient Transport (**NEPT**) services to registered NEPT providers to provide some AV base resources.

23. Attached to this statement and marked '**ST -3**' is a copy of the 'Non-Emergency Protocol.' The Non-Emergency Protocol builds on the Non-Emergency Regulations

by describing further features of patient acuity that, under the regulations, determine the type of transport required for the patient, including patients with mental health issues. The protocol in Appendix 2 deals specifically with the requirements of the Act as it relates to patient transport.

24. The protocol for the Transport of People with Mental Illness 2014 (**Mental Illness Transport Protocol**), published by the Department of Health and Human Services, also provides specific guidance to AV, mental health professionals, consumers and carers on the transport of people with mental illness. The Mental Illness Transport Protocol is underpinned by key principles including:

24.1 services working collaboratively to facilitate the treatment and care of people with mental illness in the least restrictive way possible; and

24.2 support people with mental illness such that they are able to make and participate in decisions about their assessment, treatment and recovery.

25. Attached to this statement and marked '**ST -4**' is a copy of the 'Mental Illness Transport Protocol for the transport of people with mental illness.'

26. AV also has a specific role in transporting patients under the *Mental Health Act 2014* (Vic) (**Mental Health Act**). Under s 3(1) of the Mental Health Act, AV paramedics are 'Authorised persons' which provides statutory authority to transport and manage patients experiencing mental health issues and/or are subject to existing treatment orders. As 'Authorised Persons' of the Mental Health Act, AV paramedics:

26.1 may be directed by a registered medical practitioner to administer sedation to a person being taken to or from a designated mental health service or any other place under s 350;

26.2 may enter premises and apprehend a person for the purposes of taking them to a mental health service under s 353; and

26.3 may search a person required to be taken to a mental health service, if they suspect the person is carrying something that could help the person escape or presents a danger to health and safety, and seize and detain those things under ss 354 and 356.

27. Under s 351 of the Mental Health Act police officers and protective services officers have the power to apprehend a person with a mental illness who needs to be apprehended to prevent serious and imminent harm to themselves or others. Police may request an ambulance to transport the person to a designated mental health service, however, police are required to maintain custody of the person apprehended under s 351 and for this reason travel together with the paramedics. Upon arrival at the service, police maintain custody of the person until they are transferred to the care of the service for examination, or the person is made subject

to an Assessment Order. The ambulance paramedics can leave after providing a clinical handover although these patients often experience delays in receiving assessment at Emergency Departments.

28. In addition, AV provides Inter-hospital transfers (**IHT**) within catchment areas to and from services, and transportation for mental health patients subject to Inpatient Assessment Orders, Inpatient Temporary Assessment Orders and Inpatient Treatment Orders (all of these orders mandate treatment or assessment for mental health issues) where an ambulance is the most appropriate mode of transport in accordance with the Mental Illness Transport Protocol.

29. AV also provides transport for mental health patients from prisons to mental health services, including:

    29.1 patients in prison in acute mental health crisis;

    29.2 patients discharged from remand to a mental health service; and

    29.3 patients discharged from prison to a mental health service as a compulsory patient.

(b) What proportion of Ambulance Victoria time is spent assisting people affected by mental illness?

30. Mental health presentations represent approximately 11% of total emergency '000' calls received per annum. In 2018:

    30.1 there were a total of 60,468 incidents involving primary mental health issues that AV responded to by way of attendance. This figure includes 2,778 (4.6%) inter-hospital transfers; and

    30.2 190,000 patients received support through the secondary triage referral service, and of these approximately 25,000 (12%) involved mental health issues.

31. Once calls are referred, call times vary between 5 minutes and 60 minutes. There is currently no available data capturing call times specific to those involving mental health issues.

32. Of total emergency '000' calls involving patients with mental health issues who had an ambulance attend, 82% of these patients were transported to hospital As set out above, of the remaining 18% not transported to hospital, some received care from paramedics, others were referred to other mental health professionals and services, and a proportion declined paramedic assistance either by way of treatment and/or transport.

33. Median total case time for attendance where the primary issue was mental health was 91 minutes. That suggests that, in 2018, attendance for primary mental health issues required in excess of 90,000 hours of AV time.

(b)(1) How is this measured?

34. The proportion of emergency '000' calls and ambulance transports involving patients with mental health issues are measured by the number of electronic Patient Care Records (**ePCR**) for mental health issues compared against the number of total emergency '000' calls for AV.

35. A case is determined to be a mental health presentation based on a broad definition that considers calls triaged as mental health and also elements recorded on the patient care record where the primary reason for paramedic attendance concerns the patient's mental health and includes final assessment, nature of the case, and others in attendance at the scene (eg. CATT). This includes the majority of mental health related calls.

36. Data is drawn from AV's database which includes various sources of data including in-field, secondary triage, and computer aided dispatch records. In-field patient and treatment data is recorded by paramedics using a computer tablet at the conclusion of each case which produces an electronic patient care record and then synchronises with the database.

(b)(2) What are the trends in relation to: the number of mental health incidents that Ambulance Victoria responds to?; the complexities of mental health incidents that Ambulance Victoria responds to?; and the duration of mental health call outs?

The number of mental health incidents

37. Between 2015 and 2018:

    37.1 The estimated proportion of patients calling emergency '000' with primary mental health conditions remains relatively unchanged, however, the increase in the number of patient emergency '000' calls continues to rise.

    37.2 Since 2017 there has been a steady increase of approximately 13% in the management of mental health presentations through the secondary triage system. This increase is higher than the overall increase in patients being managed through the secondary triage service, which has increased by approximately 9%.

    37.3 However, mental health incidents attended by paramedics have remained at approximately 10% of AV's overall caseload.

38. The number of mental health incidents that AV responds to may also be understated in AVs statistics, because mental health issues may not be recorded as

the primary presenting medical issue. As outlined in the graph below, the number of mental health patients being managed through referral has increased overall with more patients being risk assessed as requiring an emergency response, reflecting the safety net provided by referral. The referral service also networks patients and family with Alternative Service Providers (**ASP**), there has been a significant increase in these referrals since the introduction of the Mental Health Nurses.

Source: Care Enhancement Call Centre System 2018 and Adastra Electronic Patient Management System 2019.

Complexities of mental health incidents

39. Mental health incidents are highly variable (ranging from issues able to be dealt with over the phone to very complex patients at risk of harm to themselves or others, requiring multiple AV crews, police, sedation and restraint). It is difficult to quantify changes in the complexity of mental health incidents to which AV responds. However, I consider the following:

    39.1 The number of emergency patients with a clinical presentation of suicide or suicidal ideation has increased by 52% between 2015 and 2018;

    39.2 The number of emergency patients presenting with psychosis has increased by 21.1% over the same period;

    39.3 The number of emergency patients presenting with substance abuse has increased by 26.2% over the same period; and

    39.4 Between 2015 and 2018, police attendance has remained stable with approximately 30% of mental health cases requiring police support.

The duration of mental health call outs

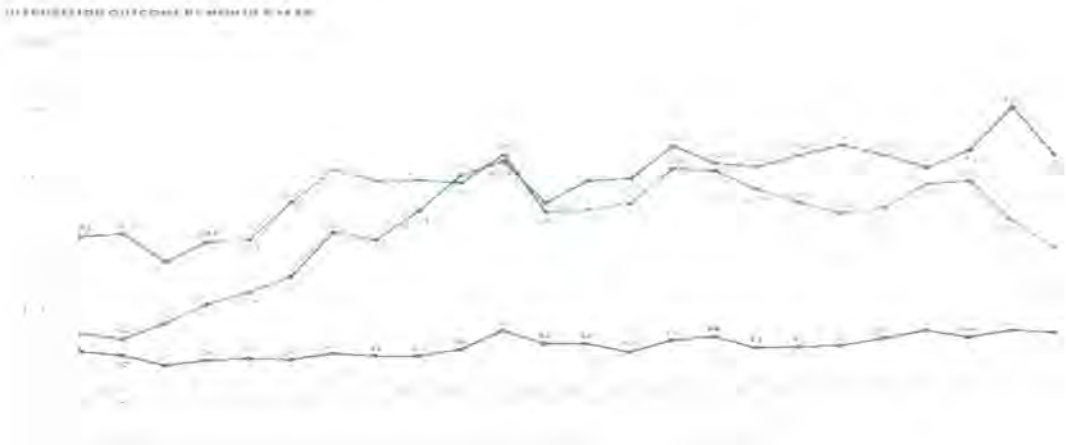
40. Between 2015 and 2018, the duration of mental health attendances has remained stable, at approximately 91 minutes on average.

(c) Why has Ambulance Victoria set up a mental health program as part of their secondary triage response?

41. As set out in paragraph 16.1 above, AV has introduced mental health nurses to the referral service to assist with the management of mental health patients. This has allowed AV to provide more appropriate and effective responses for patients with mental health issues. Whilst there is variation across cases, in general terms responses involve undertaking a risk-assessment, providing self-care advice, managing the patient with their existing care plan, connecting the patient to their general practitioner and/or case manager and mental health service, or managing the patient consistent with their existing care plan.

42. Since introducing mental health nurses to the referral service, there has been an increase of approximately 50% in the number of patients transferred to alternative service providers including community-based services. This has reduced the need to send paramedics and despatch ambulances to attend mental health patients unnecessarily.

43. Of 8,288 calls managed to through this service until 2018, 2,148 were initially coded for an ambulance response, but after review by a mental health nurse were able to be 'downgraded' to a more appropriate alternative to an ambulance response. This has improved connections for patients to appropriate community services, reducing the need to be transported unnecessarily to hospital. This also means more ambulances have been for more urgent or critical care (with a virtual saving of approximately $2.8 million in avoided ambulance resources). For a small percentage of patients, review by a mental health nurse provided a safety net to "upgrade" to a more urgent level of response. This is illustrated in the graph below with red indicating upgraded cases, green indicating downgraded patients, and blue indicating cases remaining the same.



Source: Care Enhancement Call Centre System 2018 and Adastra Electronic Patient Management System 2019.

(d) Please provide two (anonymised) examples of case studies of Ambulance Victoria's experience with people with mental health problems, which illustrate the complexities faced by Ambulance Victoria?

First case study

44. The patient in this case study was a 40 year-old male who presented with suicidal ideation on multiple occasions over a 3-day period, had a history of mental illness, an acquired brain injury and a history of illicit drug use.

45. On the morning of the first day, the patient presented initially displaying suicidal ideation having attempted to run into traffic. He was apprehended by police under s 351 of the Mental Health Act and transported to hospital by ambulance.

46. That afternoon, the patient presented for a second time displaying suicidal ideation, having attempted to run onto railway tracks at a south-eastern Melbourne railway station. The patient was again apprehended by police under s 351 of the Mental Health Act and transported by ambulance to a different hospital.

47. Later that evening, AV were called to the same railway station and encountered an identical situation to that previously responded to earlier in the day. The patient was again apprehended by police under s 351 of the Mental Health Act and transported by ambulance to hospital.

48. Close to midnight on the same day, AV were called to a different south-eastern railway station and encountered the patient expressing suicidal ideation and attempting to access the railway tracks. The patient requested paramedics transport him to hospital, which they did.

49. Two days later in the afternoon AV were called to a CBD railway station where the same patient was expressing suicidal ideation and attempting to access the railway tracks. He was apprehended by police under s 351 of the Mental Health Act and transported by ambulance to a hospital he had recently been discharged from.

50. Later that evening AV attended to the same patient in an inner suburb. He was upset and expressing suicidal ideation, ultimately requiring restraint and handcuffs to prevent serious and imminent harm to both himself and another person, and was then transported by ambulance to hospital using s 351 of the Mental Health Act.

51. In summary, this patient required ambulance attendance six times over a 3-day period involving a total of 9 hours AV utilisation, and was transported to four different hospitals. A number of complex issues arise from this case study including:

    51.1 Issues arose upon arrival at the first hospital due to the patient reporting to be of 'no fixed abode', which meant that he was regarded as not satisfying

the catchment requirements of the hospital. Catchment areas are based on 'patient' rather than 'location'.

51.2 Lack of coordination between services, including hospitals, given each service operated independently of the other.

51.3 Considerable resourcing demands on AV in responding to and assisting this individual over one discrete period.

51.4 As AV currently does not have access to patient mental health records. it was unclear if the patient had an existing mental health care plan. Not having access to the central record resulted in this patient attending multiple different hospitals. Currently AV is prohibited from gaining access to the electronic health information system under s 347 of the Mental Health Act, given it is not a 'mental health service provider' as defined in s 3 of the Mental Health Act.

Second case study

52. The second case is intended to demonstrate the operation, benefits and status of a new mental health service pilot being conducted by AV and Barwon Health in the Geelong region, involving a Prehospital Response of Mental Health and Paramedic Tram (**PROMPT**). The PROMPT pilot involves specialist mental health staff from Barwon Health joining paramedics in attending call outs where mental health may be a factor. Such calls may be attended by both paramedics and the specialist PROMPT team, or the PROMPT team may be the designated first response. The specialist team can arrive at call outs in normal vehicles to remove the risk that patients can become distressed by the sight of an ambulance.

53. The patient in this case study was a 32 year old male with a longstanding history of schizophrenia. He is well-known to mental health clinicians in the Geelong area and is case managed through a local community-based mental health service. He presented with suicidal ideation and required ambulance attendance.

54. After months of experiencing schizophrenic symptoms, the patient called emergency '000' presenting in an agitated state with suicidal ideation. He was assigned the code 'Psych, Suicidal' prompting immediate ambulance dispatch with a senior paramedic and senior mental health clinician. On arrival the mental health clinician determined that police attendance was not required. Under the traditional approach, prior to the introduction of the PROMPT pilot, a paramedic would have attended alone without the support of a mental health clinician.

55. The mental health clinician assessed the patient to be at low-risk of suicide, although determined he had run out of his usual antipsychotic medication so arranged for a short-term medication order with the on-call psychiatrist from the

Area Mental Health service. The mental health clinician also made contact with the patient's case worker and arranged for him to attend the next day.

56. This case study illustrates the positive benefits of involvement of mental health clinicians introduced under the PROMPT pilot program. Unlike paramedics who are highly skilled in managing severe trauma and critical illnesses, mental health clinicians have the skills and experience to assess and manage patients presenting with advanced mental health issues and threatening self-harm.

57. Under the traditional response model, an incident such as this would have required multiple paramedic attendance together with police in order to contain the patient to be transported to hospital. Often this would involve sedation of the patient as well as physical restraint. Such a response was not only resource heavy for a service already operating at capacity, but would also create a chaotic situation for a patient already experiencing significant stress.

58. The PROMPT pilot program is designed to provide a more effective response that is patient-centred, and involved greater coordination between services. PROMPT is a three month pilot and will be subject to review at the end of the period.

(e) What support does Ambulance Victoria need from mental health services

59. AV requires the following support from mental health services in order to deliver AV services with maximum efficiency and impact:

59.1 Full access to the electronic health information system containing patients' mental health records to inform AV responders and Clinicians triaging the patient to determine appropriate response;

59.2 Strengthening data and information services to achieve greater co-ordination between AV and mental health services. Currently, there is an absence of formal coordination between mental health services, including visibility on available beds ,which limits AV's ability to ensure patients are linked in with appropriate services including inpatient admissions (AV's role in coordinating access to critical care beds is an example of how this could work);

59.3 Priority telephone access for AV to mental health triage services (to discuss patients requiring emergency response and potentially avoid need for AV to transport patient to the emergency department) which could occur in a number of ways including establishing a dedicated 24 hour telephone line;

59.4 Electronic communication between AV and CATTs, to ensure more effective response to patients;

59.5 Remove 'on hold' telephone waiting time for the CATT triage engagement for both patient-initiated calls and AV triage calls. Delay caused by waiting time can prompt the need for police involvement;

59.6 Establish direct electronic and telephone links between secondary triage and Hospital Emergency Department clinicians to achieve optimal information sharing regarding pre-inpatient care; and

59.7 Consistency between mental health service providers about the process for patients to access mental health services.

(f) Would Ambulance Victoria send clinicians alone to respond to a mental health crisis, without involvement from Victoria Police? If not why not, and if so, why?

60. The majority of emergency responses to mental health patients are attended by paramedics alone because circumstances do not require police attendance due to the absence of threat of safety to paramedics. An assessment of risk is undertaken by the Ambulance Duty Manager on the control room and by the attending paramedics based on information provided at dispatch.

61. However, in approximately 30% of cases police attendance is deemed appropriate, either due to likely threat of harm and/or where s 351 of the Mental Health Act applies.

62. The Computer Aided Dispatch system 'flags' locations which might, based on AV's experience during previous call-outs, present a threat to safety of paramedics. In cases involving threat, police attendance is also required.

63. Police attendance may also be required in cases involving patients in the community who are subject to treatment orders under the Mental Health Act requiring admission to a mental health service.

(g) What education and training do Ambulance Victoria members receive in relation to mental health, and in particular in relation to mental health risk assessment and crisis intervention?

64. To qualify as a registered paramedic, AV members are required to obtain an undergraduate degree from an approved program.

65. All AV members are provided with formal mental health education as part of their undergraduate courses. However, mental health components of vary across courses given they are offered in a number of jurisdictions.

66. Upon commencing with AV, members complete a 3 week face-to-face induction program, tailored to the specific role of the member (ie. paramedic or triage responder), which includes the Occupational Violence Prevention Program

described below. After that time graduate and qualified Paramedics participate in a tailored training program to attain their Authority to Practise independently.

67. In 2017, the Occupational Violence Prevention Program was implemented to provide specific training on a range of workplace scenarios involving violent and aggressive patients, and dealing with a range of mental health presentations including negotiation and communication, and the use of ketamine and midazolam (drugs to sedate patients) in extreme circumstances where the patient is severely agitated. Paramedics are authorised to administer these medications. This was delivered as a full day face-to-face classroom and virtual reality training by an external provider in 2017, and continues to be provided to new AV members as part of their induction, as a Learning Management System Module.

68. Paramedics are required to complete continued professional development training, including electronic Learning Management System Modules, and face-to-face training, on mental health issues. For instance, AV has delivered training on:

68.1 paramedics responsibilities under the Mental Health Act;

68.2 mental health conditions and assessment and changes to clinical practice guidelines; and

68.3 mental health awareness training.

69. In terms of mental health support for AV members, given the challenging and stressful nature of work undertaken by those working in emergency services, in 2015 AV introduced its *Mental Health and Wellbeing Strategy 2015* (**Strategy**) to support its members and prevent psychological injury. The Strategy offers AV members confidential counselling and crisis support, a chaplaincy program, wellbeing program via e-Learning, workshops, and peer support programs which include the introduction of AV's first peer support dog named 'Bruce'.

70. Attached to this statement and marked '**ST -5**' is a copy of the 'Strategy.'

(g)(1) What de-escalation and communication skills training do members receive?

71. Paramedics receive specific training in management of agitated patients as part of the continued professional development program.

72. The Occupational Violence Prevention Program training described above also included some aspects related to de-escalation and communication skills.

(g)(2) Are there any gaps in the current training, if so what are they?

73. AV is aware that many paramedics do not feel adequately equipped to manage and care for patients with mental health issues. Improving existing training requires a

thorough assessment of current programs to determine deficiencies. However, current training could be improved by introducing the following:

73.1 ongoing mental health assessment training;

73.2 mental health first aid training;

73.3 de-escalation training based on risk assessment on individual circumstances;

73.4 improving capability of frontline staff, and

73.5 expanding use of telephone referral service and initial and secondary triage.

74. Improving existing training through the above measures, requires funding, and establishing a partnership between AV and mental health service providers.

(g)(3) How does Ambulance Victoria support its members to deal with people with mental health issues in the community?

75. AV supports its members respond appropriately to mental health patients in a number of ways which include:

75.1 Operating in accordance with Clinical Practice Guidelines (**CPG**) as identified in the following documents:

(a) **CPG A0106 Mental Health Status Assessment**: this document outlines categories for paramedics to observe, listen to and discuss with the patient in assessing their mental state.

(b) **CPG A0107 Mental Health Conditions**: this document outlines a decision support pathway to guide paramedics in adopting the correct care pathway based on their assessment.

(c) **CPG A0708 Agitation**: this document provides guidance for paramedics when attempting to manage patients who present at risk to themselves or others, and can also be applied to patients who may be suffering mental illness and includes verbal de-escalation strategies, physical restraint and pharmacological sedation.

75.2 CPD Training specifically around changes to the Mental Health Act and/or CPGs.

75.3 Providing mental health nurses to assist with secondary triage to provide consultation and advice.

75.4 Paramedic safety to reduce occupational violence risk regarding application of the Agitation CPG - chemical restraint. This lowers patient agitation and the need for physical intervention by paramedics.

75.5 Policy/procedure support such as *The Chief Psychiatrist's Guideline for Safe Transport of People with Mental Illness 2011* (**Safe Transport Guideline**).

75.6 Attached to this statement and marked '**ST -6**' is a copy of the 'Safe Transport Guideline.'

(h) Are there ways in which you think the demand for Ambulance Victoria's services to respond to people in crisis because of mental health issues, is changing or will change significantly in the future? If so, what do you think the most significant changes are likely to be?

76. As patient needs change, so too will the demand for, and skills required of, AV members in responding to people in crisis. For example, increases in patients presenting with alcohol and drug use, social isolation and depression and anxiety, may both increase demand for AV's services, and place pressure on AV to expand the roles and responsibilities of its members.

77. The demand on AV's services will be more acute where patients cannot access other health and social services, for example adequate drug and alcohol, and counselling services.

78. That is particularly so in rural and regional areas, where access to services may be more limited and AV is called on to fill the gap created by the absence of other services.

79. This demands that members receive relevant training, and paramedics are well equipped to respond appropriately by way of undertaking enhanced patient assessments for Mental Health patients.

80. AV's ability to properly support its members and ensure they receive appropriate and relevant training to meet demand, will largely depend on the level of funding received.

(i) What changes do you think would bring about lasting improvements to help people affected by mental illness, in relation to crisis response?

81. **Enhancing paramedic training and capability by the following:**

81.1 Improve confidence of paramedics in effectively communicating with people experiencing mental health issues.

81.2 Improve training in mental health assessment, mental health first aid training, de-escalation and effective communication practices.

81.3 Better integrate mental health clinical skills within in-service and university curriculum.

81.4 Further develop mentoring programs for AV members involving support from mental health professionals, to achieve optimum mental health practice.

81.5 Develop and support improved distribution of resources for mental health patients to ensure they have timely and appropriate access to services in their community.

81.6 Crisis Assessment Teams and/or multidisciplinary assessment and management in crisis to enable AV members to refer patients to CATT and other mental health services. This would improve direct access for patients.

82. **Addressing the following aspects of system design:**

82.1 An effective and sustainable mental health response must be embedded within a service system that promotes timely, accessible and non-stigmatising treatment options.

82.2 With most mental health related attendances occurring outside business hours, there is a clear need for mental health services or other appropriate facilities to offer treatment options at times that do not solely rely on emergency services.

82.3 Ambulance services must be involved in mental health planning and system design.

83. **Establishment of system coordination function**

83.1 Access to designated mental health beds, given their use is prescribed under the Act and their demand is high, requires system level coordination to reduce silos in individual services, improve coordination across the system; reduce unnecessary secondary transfers; improve utilisation of a scarce specialist resource; and improve the timely and appropriate access across Victoria for patients requiring this level of care, to be based on need. This would facilitate co-ordinated access to beds across the state, instead of it being individual service led.

83.2 In the context of similar demands placed on critical care beds in the general health care system and access to levels of service capability across the state as part of the state-wide trauma system, the mental health service system needs reform to establish a whole of system model of care that achieves timely access to designated mental health beds for acutely unwell mental health patients and improved continuity of care for all across the

illness spectrum. Systematic strategies in approaching trauma patients can potentially achieve better outcomes for patients, and co-ordinating access to beds would allow for timely access to specialised care.

83.3 This could be delivered through the establishment of a System Coordination function similar to the role Adult Retrieval Victoria in Ambulance Victoria play in the critical care system through:

(a) active facilitation of access to a mental health bed within Victoria when it is required and transfer of patients requiring urgent mental health care to another hospital if the hospital where they are being cared for does not have available designated beds; and

(b) the ability to authorise and nominate a hospital to receive the patient, regardless of catchment. This is called a defined transfer and reflects the focus on the patient's need for appropriate mental health care above the individual health service requirements.

84. **Strengthen mental health triage responses**

84.1 Consistent 24 hour availability of mental health triage is required, as are assessment services and alternative pathways for patients within the community service system where appropriate.

84.2 Expansion and availability of specialised mental health clinicians 24/7 in the secondary triage service, including more capacity in the after-hours period when demand outstrips access to available services and alternative responses are required.

84.3 Development and use of new technologies to provide telehealth/assessment responses when patients call 000 to enable visual as well as auditory assessment of mental health patients in an emergency.

84.4 Opportunities should be considered to streamline and better integrate system wide access to mental health triage to better connect callers to the right care for their needs and reduce unnecessary transports and care in emergency departments where appropriate.

85. **Shared emergency responses**

85.1 Use of shared responses, for example the PROMPT pilot in Greater Geelong where Paramedics respond with a Mental Health Nurse to low acuity mental health cases and seek to find alternative pathways and solutions to avoid where appropriate presentations to the Emergency Department. Pending outcome of the pilot this model could be rolled out in similar high demand areas.

86. **Better treatment and management approaches for mental health and drug affected patients - safety for patients and staff**

86.1 A more integrated pathway is needed for mental health patients in crisis that may present a risk to themselves or others, or emergency service personnel; for example more streamlined responses for police, paramedics and health services.

86.2 It would be desirable to consider changes to the catchment system approach for the admission/management of mental health patients. Inter-hospital transfers provide an increased burden on the ambulance service and is complicated by differing police catchment areas requiring multiple handover points of care.

87. **Forensic mental health and ambulance interface**

87.1 Exploration of barriers and challenges regarding the provision of community mental health care for individuals subject to custodial orders so as to avoid urgent transport to mental health facilities/hospital on completion of sentence.

87.2 Requests for transport for those in custody are often received late, and can require sedation for transport safety. This requires significant ambulance resources and required transport of sedated patients to hospitals rather than a mental health facility.

88. **Transparency and information sharing**

88.1 AV holds information on the care of mental health patients, including attendance and calls. It would improve care planning by AV paramedics to have access to patients mental health records so they are aware of patient attendances with their treating mental health professionals and/or health service.

88.2 AV is restricted from accessing the electronic health information system under s 347 of the Act, given it is not a 'mental health service provider' as defined in s 3 of the Act. Access to this information would assist 000 responders with management of patients, and continuity of care for those already linked in with mental health services.

88.3 AV does not have unique and individualised electronic patient care records. The electronic record is a case record only based on an episode of care. This reduces continuity of care for the patient and siloed practice that is not in the best interests of patients. Establishing an electronic personalised medical records system requires significant and funding.

89. **Opportunities for monitoring and surveillance of community mental health needs**

89.1 Coded ambulance data addresses an evidence gap by capturing harms that are not currently identified in other health morbidity data sets such as emergency department and hospital admissions.

89.2 Coded ambulance data is an important source of evidence to quantify the magnitude patterns and characteristics of acute mental health and self-harm, and serve as a reliable surveillance and early warning system.

89.3 Geographical and temporal mapping of coded ambulance data can inform policy, resourcing and service responses.

Signature: [signature]

Name: Simon Thomson

Date: 24 June 2019

Witness: [signature]

Name: AMIE HERDMAN

Date: 24 June 2019.

· 31 JOSEPH ST,
BLACKBURN NORTH, VIC.
· LEGAL PRACTITIONER.

Royal Commission into
Victoria's Mental Health System

ATTACHMENT ST- 1

This is the attachment marked 'Curriculum Vitae' referred to in the witness statement of "Simon Thomson" dated 24 June 2019.

Simon Thomson
C/- 375 Manningham Rd, Doncaster
simon.thomson@ambulance.vic.gov.au

Registrations

Registered Paramedic

Australian Health Practitioners Regulation Agency

Reg: PAR0002207488

Experience

Regional Director

Ambulance Victoria,

Nov 11 – Current

- Responsible for Ambulance Service Delivery for Barwon South West Region, previously statewide Air Ambulance and Metro West region.

Group Manager

Ambulance Victoria

May 2008 – November 2011

- Manage a lead a group of service delivery teams.
- Line management of 10 frontline managers and approx. 250 Paramedic staff

Senior Paramedic Team Manager

Ambulance Victoria

July 2005- May 2008

- Frontline Management role
- Leading service delivery team
- Responsible for clinical and operational performance of team

Ambulance Paramedic

Ambulance Victoria

Aug 1999 – July 2005

- Commenced as Student Paramedic, progressed to qualification in 2002
- Clinical Instructor providing supervision to student and graduate Paramedic

Education

Graduate Diploma – Strategic Leadership
College of Law, Education & Training
2018

Diploma Management
Melbourne Business School
2005

Diploma Paramedic Studies
Monash University
1999

Diploma Criminal Justice
Vocation Australia (AIPS)
1997

Training Programs

Lean Six Sigma Green Belt training, Melbourne Health
2014

Control Multiagency Emergencies, FESA WA (Level 3 Incident Controller accreditation)
2009

Undertake Emergency Planning, Attorney Generals Dept
2008

Strategic Command Course, Ambulance Vic & ASEM
2008

Co-ordinate resources in an multiagency response, EMA Aust Govt
2005

Simon Thomson
simon.thomson@ambulance.vic.gov.au

Internal AV Committees

Peak Best Care Committee

Safe Care Committee

Senior Leadership Committee – Clinical Operations

Medication Safety Committee

External Committees

Rural & Remote Area Health Committee (DHHS)

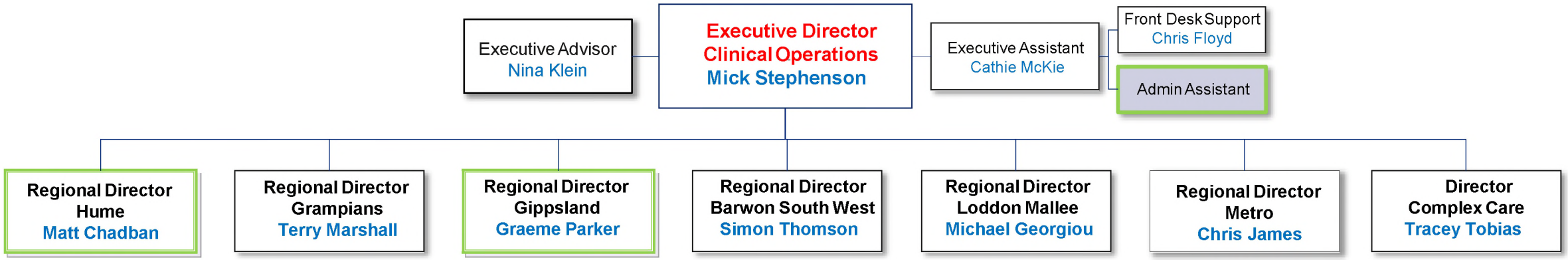
Simon Thomson
simon.thomson@ambulance.vic.gov.au

Royal Commission into
Victoria's Mental Health System

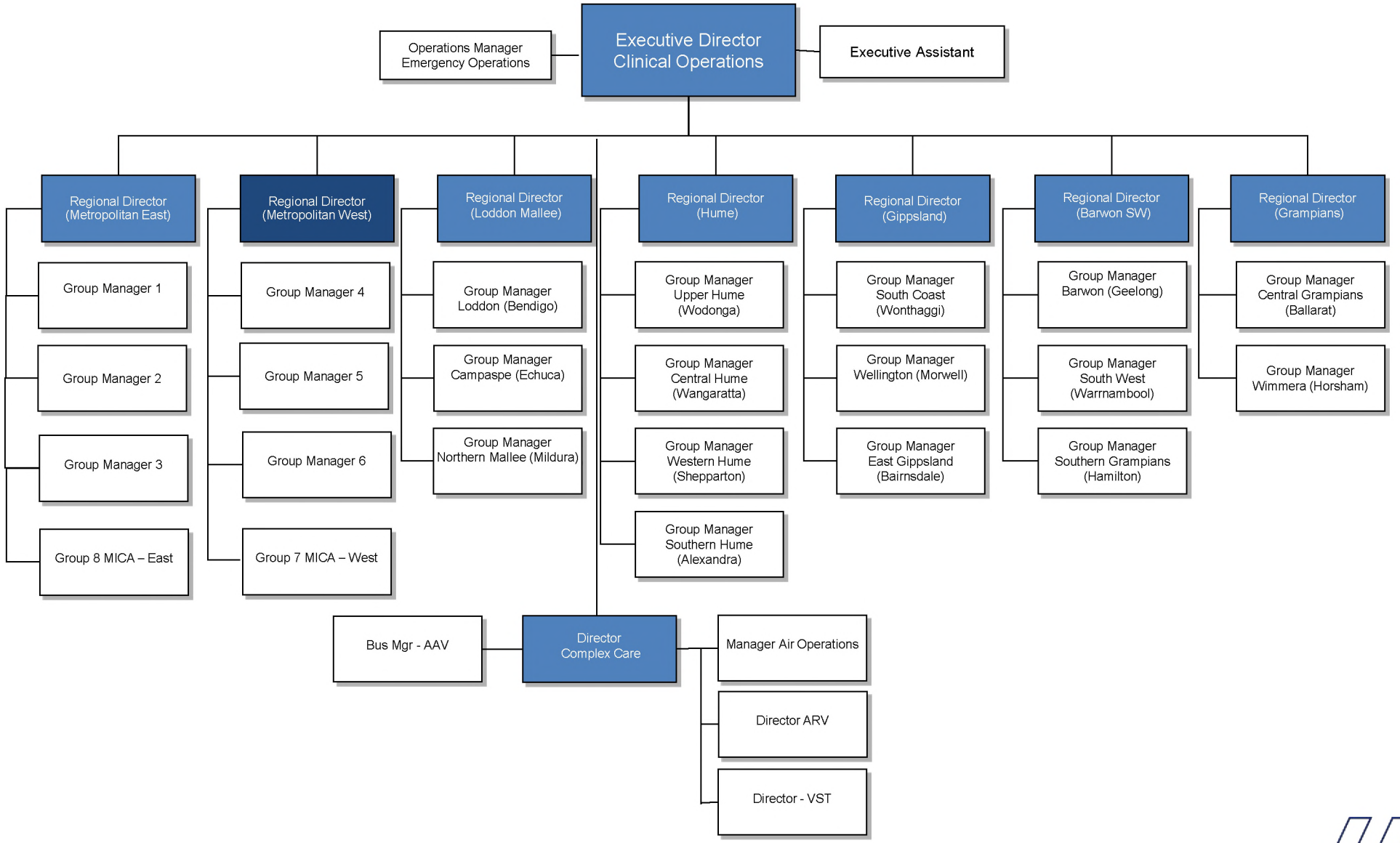
ATTACHMENT ST- 2

This is the attachment marked 'AV's organisational chart' referred to in the witness statement of "Simon Thomson" dated 24 June 2019.

Clinical Operations structure



Vacant


Operations Manager Emergency Operations
Executive Director Clinical Operations
Executive Assistant
Regional Director (Metropolitan East)
Group Manager 1
Group Manager 2
Group Manager 3
Group 8 MICA – East
Regional Director (Metropolitan West)
Group Manager 4
Group Manager 5
Group Manager 6
Group 7 MICA – West
Regional Director (Loddon Mallee)
Group Manager Loddon (Bendigo)
Group Manager Campaspe (Echuca)
Group Manager Northern Mallee (Mildura)
Regional Director (Hume)
Group Manager Upper Hume (Wodonga)
Group Manager Central Hume (Wangaratta)
Group Manager Western Hume (Shepparton)
Group Manager Southern Hume (Alexandra)
Regional Director (Gippsland)
Group Manager South Coast (Wonthaggi)
Group Manager Wellington (Morwell)
Group Manager East Gippsland (Bairnsdale)
Regional Director (Barwon SW)
Group Manager Barwon (Geelong)
Group Manager South West (Warrnambool)
Group Manager Southern Grampians (Hamilton)
Regional Director (Grampians)
Group Manager Central Grampians (Ballarat)
Group Manager Wimmera (Horsham)
Bus Mgr - AAV
Director Complex Care
Manager Air Operations
Director ARV
Director - VST

Royal Commission into
Victoria's Mental Health System

ATTACHMENT ST- 3

This is the attachment marked 'Non-Emergency Protocol' referred to in the witness statement of "Simon Thomson" dated 24 June 2019.

Non-Emergency Patient Transport

Clinical Practice Protocols

2018 Edition

Version 2

VICTORIA State Government | Health and Human Services

Non-emergency patient transport

Clinical Practice Protocols

2018 Edition

Version 2

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Contents

Abbreviations

Abbreviation	Description
ACP	Advance care plan
AED	Automatic external defibrillator
APGAR	Appearance, pulse, grimace, activity, respiratory effort
ARC	Australian Resuscitation Council
ARV	Adult Retrieval Victoria (formerly known as Victorian Adult Emergency Retrieval Coordination Service)
ATA	Ambulance transport attendant
AV	Ambulance Victoria
AV clinician	Ambulance Victoria paramedic working in the Ambulance Victoria communications centre
AV referral	A secondary triage service operated by Ambulance Victoria and staffed by registered nurses and paramedics
BGL	Blood glucose level
BVM	Bag valve mask
BP	Blood pressure
bpm	Beats per minute
CPR	Cardiopulmonary resuscitation
CVC	Central venous catheter
ECC	External cardiac compression
ECG	Electro-cardiograph
EN	Enrolled nurse (division 2)
GCS	Glasgow Coma Scale
GTN	Glyceryl trinitrate
Hg	Mercury
ICC	Inter-costal catheter
IHT	Inter-hospital transfer
IMI	Intra-muscular injection
IV	Intravenous
kg	Kilograms
km/hr	Kilometres per hour
L	Litre

L/min	Litres per minute
LVF	Left ventricular failure
m	Metre
mcg	Micrograms
mg	Milligrams
MICA	Mobile Intensive Care Ambulance
min	Minute
mL	Millilitre
mm	Millimetres
MRSA	Methicillin-resistant staphylococcus aureus
NEPT	Non-emergency patient transport
NFR	Not for resuscitation
NSTEMI	Non-ST segment elevation myocardial infarction
ODT	Orally dissolving tablet
PCA	Patient controlled analgesia
PEA	Pulseless electrical activity
pMDI	Pressurised metered dose inhaler
PICC	Peripherally inserted central catheter
PIPER	Paediatric Infant Perinatal Emergency Retrieval
prn	When necessary
PTCA	Percutaneous transluminal coronary angioplasty
PTO	Patient transport officer
RBG	Random blood glucose
RN1	Registered nurse division 1
RN1 CC	Registered nurse division 1 with critical care qualification
ROSC	Return of spontaneous circulation
ROTC	Refusal of treatment certificate
RR	Respiratory rate
SAED	Semi-automatic external defibrillator
secs	Seconds
SGA	Supra-Glottic Airway
SHERP	State health emergency response plan
TB	Tuberculosis
TE	Trained and Endorsed

VF	Ventricular fibrillation
VRE	Vancomycin-resistant enterococci
VT	Ventricular tachycardia

Purpose

The purpose of the *Non-emergency patient transport: clinical practice protocols* is to provide practice requirements to licensed non-emergency patient transport (NEPT) providers in the triage, care and transport of patients.

In accordance with the *Non-Emergency Patient Transport Act 2003* (the Act) and the Non-Emergency Patient Transport Regulations 2016 (the Regulations), the *Clinical practice protocols* set out additional practices that NEPT providers must follow. These additional requirements assist licensed NEPT providers, health services and other organisations to make decisions about the use of NEPT services for patients with a variety of clinical conditions and in a range of acuities.

The protocols also provide a framework for licensed NEPT providers in planning and organising their services as well as understanding the knowledge and training requirements for employees.

It is important to note that Ambulance Victoria is the point of contact for clinical emergencies.

2018 Edition – Review Overview

The 2017 edition of the NEPT CPP's have been developed with oversight from a multidisciplinary panel with representation from the NEPT sector, the Department of Health, Ambulance Victoria, and the Ambulance Employees Association - Victoria. The review process focused on the clinical aspects of NEPT care and has included consideration of current best practice standards and feedback from a broad consultation phase. The review also caters for the changes to the Ambulance Victoria revised clinical response model and the expected actions of the NEPT sector during State Health Emergency Response Plan events. There have been a number of clinical categories that have been used across the sector since the sector was legislated, these may have had different scopes of practice at various times, however the 2017 edition of the CPP's seeks to make it very clear that whilst there may be a range of clinical providers (e.g. PTO, EN, EEN, ATA, RN1, RN1 CC, etc) that the scopes of practice are aligned into functional groups.

2018 Edition – Paramedic Registration

A retiring term within the 2018 CPP's is the clinical level of 'Ambulance Officer'. NEPT staff contracted under this term are able to align their practice to the Ambulance Transport Attendant (ATA) scope of practice. For consistency of language the CPP's refer only to the ATA scope, this is to remove any confusion related to the commencement of paramedic registration in late 2018.

Associated with the commencement of paramedic registration in late 2018 a new clinical level and scope of practice will be developed for 'Paramedic' in the next edition of the NEPT CPP's. Any new practice level for paramedics will not come into effect until the commencement of paramedic registration and the CPP's will be updated accordingly. This will only relate to registered paramedics.

Guide to using the clinical practice protocols

The protocols set out the scope of practice for employees of licensed NEPT providers who are credentialed to a level of practice as described. While taking into account the variety of clinical conditions and range of acuities of patients that may be serviced by licensed NEPT providers, the types of conditions described in these protocols are not exhaustive. There may be exceptional times where they are confronted with a need to provide care beyond their scope of credentialed practice, and this in the emergency situation can be facilitated by a consultation with the AV communications centre staff or in the non-emergency situation, with the party requesting the service.

It is also acknowledged that the information provided in the protocols has been selected for the relevance to licensed NEPT providers and is not suitable for use in other clinical situations. In particular, the references to medications including use, contraindications, side effects and dose ranges are specific to the types of conditions seen by licensed NEPT providers.

Visual guide to the Clinical Practice Protocols

Scope of Practice

NB: To clarify more specific aspects of care, a guide including a detailed list of devices and interventions is also listed in Table 1: Authority to practice matrix; page 82.

No	Protocol/Skill	PTO	EN	ATA	RN1	RN1 CC
	Patient management					
	Clinical approach	✓	✓	✓	✓	✓
	Conscious state assessment	✓	✓	✓	✓	✓
	Perfusion status assessment	✓	✓	✓	✓	✓
	Respiratory status assessment	✓	✓	✓	✓	✓
	Time critical guidelines	✓	✓	✓	✓	✓
	Mental status assessment	✓	✓	✓	✓	✓
	Cardiac arrest					
	Manual defibrillation			✓	✓	✓
	Automatic/semi-automatic defibrillation	✓	✓	✓	✓	✓
	Oropharyngeal airway	✓	✓	✓	✓	✓
	Nasopharyngeal airway				✓	✓
	Supra-Glottic airway		TE	TE	✓	✓
	Bag Valve Mask Ventilation	✓	✓	✓	✓	✓
	IV cannulation				TE	✓
	Adrenaline (IV)				TE	✓
	Amiodarone (IV)				TE	✓
	Anaphylaxis					
	Adrenaline (via auto injector) (IM)	✓	✓	✓	✓	✓

No	Protocol/Skill	PTO	EN	ATA	RN1	RN1 CC
	Breathing Difficulties					
	Oxygen saturation monitoring	✓	✓	✓	✓	✓
	Oxygen (nasal prongs/face mask)	✓	✓	✓	✓	✓
	Titrated oxygen care based on oxygen saturation			✓	✓	✓
	Salbutamol (pMDI/neb)		✓	✓	✓	✓
	Ipratropium Bromide (Atrovent)		✓	✓	✓	✓
	Bag Valve Mask Ventilation	✓	✓	✓	✓	✓
	Breathing Difficulties (Choking)	✓	✓	✓	✓	✓
	Chest Pain					
	3 lead ECG monitoring		TE	✓	✓	✓
	12 Lead ECG		TE	TE	✓	✓
	Aspirin (oral)		✓	✓	✓	✓
	GTN (sublingual)		✓	✓	✓	✓
	Methoxyflurane (inhaled)		✓	✓	✓	✓
	Hypoglycaemia					
	Glucose paste (oral)	✓	✓	✓	✓	✓
	BGL	✓	✓	✓	✓	✓
	Glucagon (IM)		✓	✓	✓	✓
	Nausea and Vomiting					
	Ondansetron (oral)		✓	✓	✓	✓
	Oxygen Therapy					
	Pulse oximetry	✓	✓	✓	✓	✓
	Titrated oxygen therapy			✓	✓	✓

No	Protocol/Skill	PTO	EN	ATA	RN1	RN1 CC
	Pain Relief					
	Paracetamol (oral)	TE	✓	✓	✓	✓
	Methoxyflurane (inhaled)		✓	✓	✓	✓
	Stroke					
	Stroke assessment	✓	✓	✓	✓	✓
	Traumatic Injuries	✓	✓	✓	✓	✓
	Falls	✓	✓	✓	✓	✓
	Principles of Trauma Care	✓	✓	✓	✓	✓
	Cervical collars/spinal immobilisation	✓	✓	✓	✓	✓
	Arterial tourniquets	✓	✓	✓	✓	✓
	Pressure dressings	✓	✓	✓	✓	✓
	Traction splints	TE	TE	TE	✓	✓
	Pelvic splinting	✓	✓	✓	✓	✓
	Hospital Transfers					
	Maintenance of medication administration					
	Narcotic infusion (s/c)	✓	✓	✓	✓	✓
	IV Crystalloid		TE	✓	✓	✓
	GTN infusion		TE	✓	✓	✓
	Heparin infusion		TE	✓	✓	✓
	Blood products		TE	✓	✓	✓
	IV Crystalloid with potassium added		TE	✓	✓	✓
	Antibiotics		TE	✓	✓	✓
	Narcotic infusion (IV)				✓	✓

No	Protocol/Skill	PTO	EN	ATA	RN1	RN1 CC
	Other vasoactive medications (e.g. inotropes)					✓
	Anti-arrhythmic medication infusion (amiodarone or lignocaine)					✓
	Other treatments					
	Capped CVC for low acuity patients	✓	✓	✓	✓	✓
	PICC that is not in active use	✓	✓	✓	✓	✓
	TPN via PICC		TE	✓	✓	✓
	Chemotherapy infusion		TE	✓	✓	✓
	CVC infusion (including TPN)				✓	✓
	ICC				✓	✓
	Insulin infusion				✓	✓
	IV cannula insertion				TE	✓
	Arterial line					✓
	Intra-aortic balloon pump					✓
	Pacing wire					✓

TE = Where trained and endorsed

Section One – Patient Assessment

Clinical Approach

Notes

1. The Clinical Approach provides the standard of care expected for the systematic assessment, management, and re assessment by NEPT providers. In certain situations, transport of patients is key to patient care and should not be unduly delayed. If there is no clinical requirement to provide assessment and/or management (e.g. low acuity transport), this should be documented on the PCR.
2. The frequency of reassessment depends on the clinical situation. If management is provided using one of the CPPs, patients should be reassessed at a minimum of 15-minute intervals.
3. During inter-hospital transfers, some patients will have 'Clinical escalation criteria' recorded by the sending facility on their observation chart. These values will supersede the values otherwise considered as abnormal according to the assessment tools in these CPPs and the clinical escalation plan should be implemented in accordance with the instructions from the sending facility.
4. The pause and plan moment provides an opportunity for the caregivers on scene to discuss their clinical hypothesis of the patient problem, along with the plan for managing it. Ideally these discussions should be openly held in front of the patient to allow their input.
5. When the patient is first assessed, consideration should be given to not only how the patient presents at that time, but also where the patient is placed on their clinical trajectory. For example, a patient who has had a chest infection for three days is potentially much sicker than a patient presenting with a productive cough and high temperature on day one of their illness, although their VSS may be the same.
6. The dynamic risk assessment is highlighted as part of the clinical approach to reinforce to all staff that it is not expected that they put themselves at risk of injury during manual handling or any other procedure.

Conduct a dynamic risk assessment throughout each case, particularly prior to manual handling being undertaken

STOP – Scene Safety

2. Utilise standard precautions, PPE and personal safety awareness
3. Dangers

Assess – Primary Survey

If patient appears unwell, each point in the primary survey must be considered and identified issues addressed

- Response
- Airway (consider spinal precautions)
- Breathing
- Circulation (including haemorrhage check)
- Disability (AVPU)
- Exposure

Action – Basic Care

- Rapport, rest and reassurance
- Position appropriately

Assess – History and Secondary Survey

- Handover from health professionals / bystanders on scene
- History of presenting complaint e.g. DOLOR
- Patient medical history e.g. AMPLE
- Full assessment including:
  - Baseline vital signs survey
  - Conscious state assessment, PSA, RSA
  - Secondary survey / other relevant assessments

Activate emergency ambulance response if life-threatening condition identified (e.g. cardiac arrest, choking, unconscious, severe haemorrhage)

Action – Pause and Plan

1. Verbally identify clinical problems
2. Consider patient suitability for NEPT:
    a. If suitable for NEPT, verbally confirm treatment plan with team
    b. If not suitable for NEPT, notify AV communications. Consider remaining on scene vs. rendezvous / transport

If not suitable for NEPT, notify AV communications

Action – Management and Transport

- Manage patient using appropriate Protocol as required
- Reassess during transport as required

- Further management for accredited NEPT employees

Continue to provide regular situation reports to AV communications as required

Conscious State Assessment

Glasgow Coma Scale		
Assess	**Response adult**	**Score**
1. Eye opening	Spontaneous	4
	To sound	3
	To pressure	2
	None	1
2. Best verbal response	Orientated	5
	Confused	4
	Intelligible single words	3
	Incomprehensible sounds	2
	None	1
3. Best motor response	Obeys command	6
	Localises to pain	5
	Normal flexion (pain)	4
	Abnormal flexion (pain)	3
	Extension (pain)	2
	None	1
	A+B+C=	

AVPU

AVPU is a quick and simple to apply and is appropriate to determine conscious state whilst initial assessment is conducted and treatment is being established. A formal GCS should be undertaken in more complex patient presentations.

A patient cannot have a conscious state assessment done while asleep. They must be woken first. If the patient wakes and remains awake and alert, record this as an 'A' for AVPU. If the patient wakes but remains drowsy and appears inattentive, report this as a 'V'.

When assessed, does the patient:

Appear and respond Alertly? = **A**

Respond to Voice? = **V**

Respond to Pain? = **P**

Remain Unresponsive? = **U**

Not suitable for NEPT

- Reduction in GCS by > 2 points from the patient's normal conscious state within the past 24 hours (unless mechanically ventilated with a medical practitioner escort)
- Paediatric patient who is not alert and does not have a suitable clinical escort

Perfusion Status Assessment (Adult)

Assess	Adequate perfusion	Borderline perfusion	Inadequate perfusion	Extremely poor	No perfusion
Skin	Warm, pink, dry	Cool, pale, clammy	Cool, pale, clammy	Cool, pale, clammy	Cool, pale, clammy
Heart rate	60–100 bpm	50-100 bpm	<50 or >100 bpm	<50 or >110 bpm	No palpable pulse
Blood pressure	>100 mmHg systolic	80-100 mmHg systolic	60-80 mmHg systolic	<60 mmHg systolic or un-recordable	Un-recordable
Conscious state	Alert and orientated to time and place	Alert and orientated to time and place	Either alert and orientated to time and place or altered	Altered or unconscious	Unconscious

Not suitable for NEPT

- BP < 100 mmHg (unless normal for patient). A patient with acute hypotension which is expected (e.g. after dialysis) may be transported by NEPT
- HR < 50 bpm or > 100 bpm (unless normal for patient). A patient with a temporary pacing wire for bradycardia may be transported by NEPT

Respiratory Status Assessment (Adult)

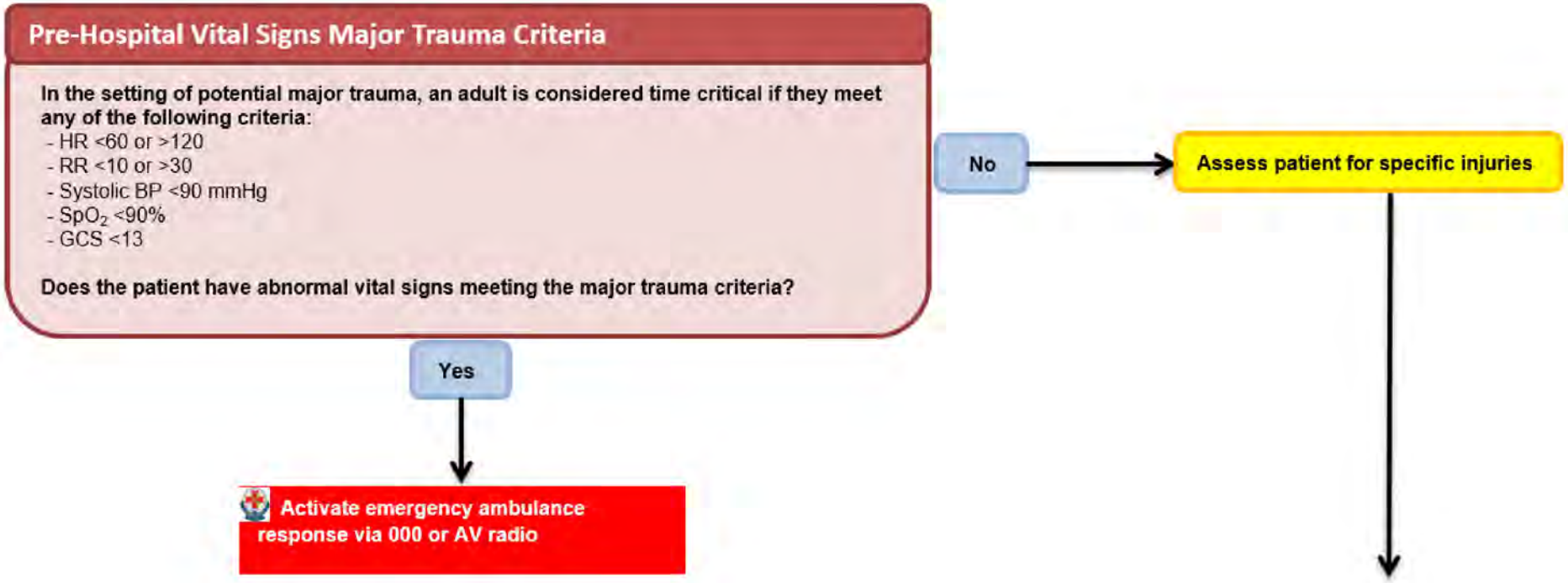
Assess	Normal	Mild distress	Moderate distress	Severe distress (life threatening)
General appearance	Calm, quiet	Calm or mildly anxious	Distressed or anxious	Distressed, anxious, fighting to breathe, exhausted, catatonic
Speech	Clear and steady sentences	Full sentences	Short phrases only	Words only or unable to speak
Breath sounds or auscultation	Usually quiet, no wheeze No crackles or scattered fine basal crackles, e.g. postural	Able to cough Asthma: mild expiratory wheeze Left Ventricular Failure (LVF): may be some fine crackles at bases	Able to cough Asthma: expiratory wheeze, +/– inspiratory wheeze LVF: crackles at bases - to mid-zone	Unable to cough Asthma: expiratory wheeze, +/– inspiratory wheeze, maybe no breath sounds (late) LVF: fine crackles – full field, with possible wheeze Upper Airway Obstruction: Inspiratory stridor
Respiratory rate	12–16 per minute	16–20 per minute	>20 per minute	> 20 per minute Bradypnoea (< 8 per minute)
Respiratory rhythm	Regular even cycles	Asthma: may have slightly prolonged expiratory phase	Asthma: prolonged expiratory phase	Asthma: prolonged expiratory phase
Breathing effort	Normal chest movement	Slight increase in normal chest movement	Marked chest movement +/– use of accessory muscles	Marked chest movement with accessory muscle use, intercostal retraction +/– tracheal tugging
Heart rate	60–100 beats per minute (bpm)	60–100 bpm	100–120 bpm	> 120 bpm Bradycardia (HR<50) a late sign
Skin	Normal	Normal	Pale and sweaty	Pale and sweaty, +/– cyanosis
Conscious state	Alert	Alert	May be altered	Altered or unconscious

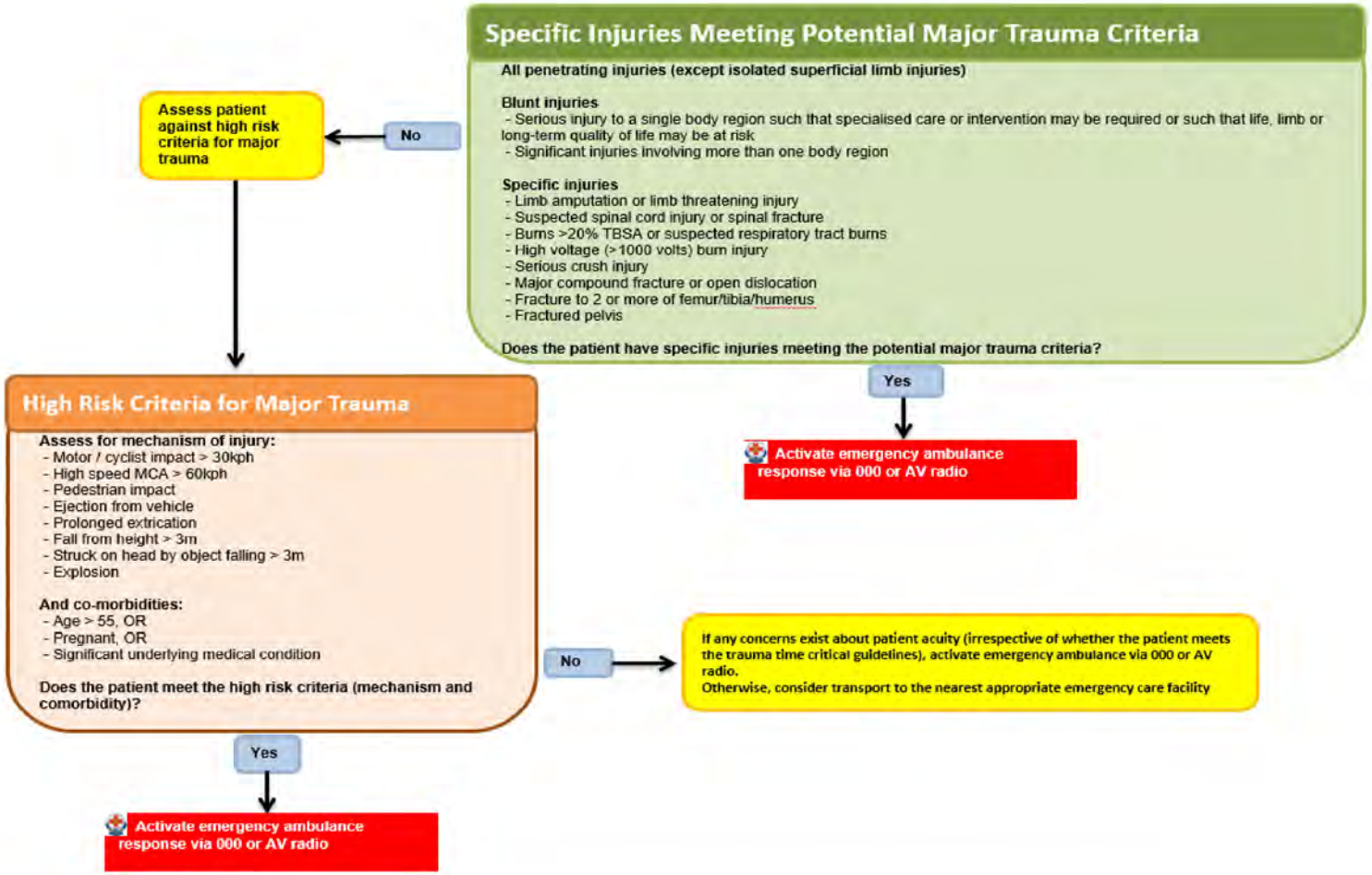
Not suitable for NEPT

- Moderate or severe respiratory distress (unless normal for patient)
- Respiratory distress which does not improve after rest or management with the Breathing Difficulties protocol

Trauma Time Critical Guidelines (Adult)

The trauma time critical guidelines are included for the purpose of identifying potential major trauma patient. As normal business, patients that meet the guidelines will be transported by an emergency ambulance. NEPT providers may be required to transport potential major trauma patients as part of major incidents or if the State Health Emergency Response Plan is activated. If unsure of transport destination or considering non-transport of a trauma patient, consult with the AV Clinician.





Not suitable for NEPT

- Patient meets any criteria for Major Trauma (Vital Signs, Specific Injuries or High Risk Criteria), unless assessed as suitable for NEPT transport by a medical practitioner and after consultation with Adult Retrieval Victoria (ARV)
- ARV patients (unless specifically approved by consulting retrieval physician)

Trauma Time Critical Guidelines (Paediatric)

For the purposes of the CPP clinical care, a child is defined as being aged under 12. The rationale for this relates to the physiological parameters and medication doses of older children being equal to adults. This principle does not relate to emotional care, mental health, or legal obligations of caring for a person under the age of 18.

Pre-Hospital Vital Signs Major Trauma Criteria

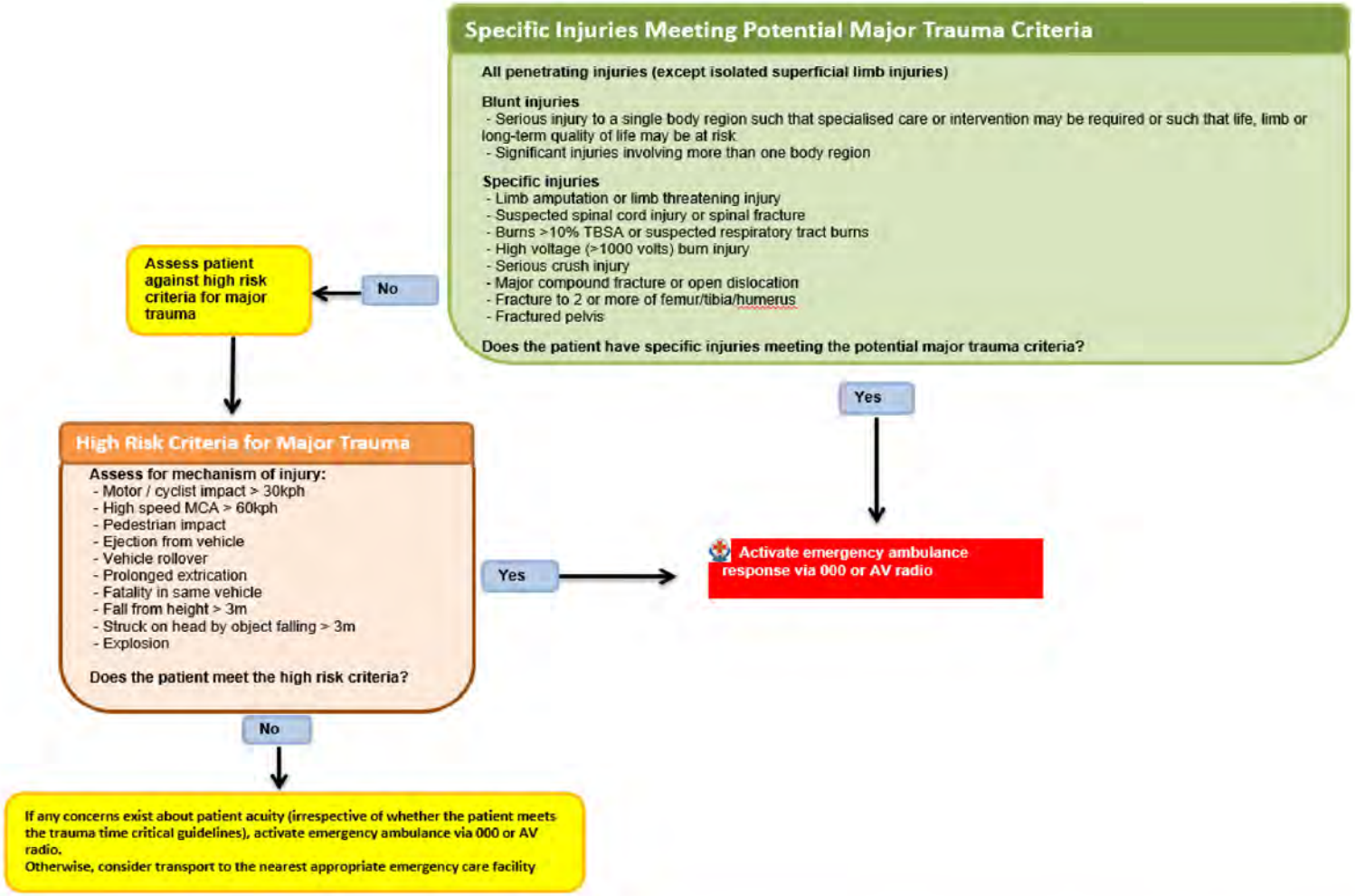
In the setting of potential major trauma, a child is considered time critical if they meet any of the following criteria (patients ≥ 12 years of age should be assessed as per adult time critical protocol) :

Age	0 – 3 mth	4 – 12 mth	1 – 4 yrs	5 – 11 yrs
HR	<110 or >180	<100 or >180	<90 or >160	<80 or >140
RR	>60	>50	>40	>30
Syst BP	<50 mmHg	< 60 mmHg	<70 mmHg	< 80 mmHg
SpO_2	< 90%			
GCS	<15 (or less than Alert on AVPU)			

Does the patient have abnormal vital signs meeting the major trauma criteria?

No → **Assess patient for specific injuries**

Yes → **Activate emergency ambulance response via 000 or AV radio**



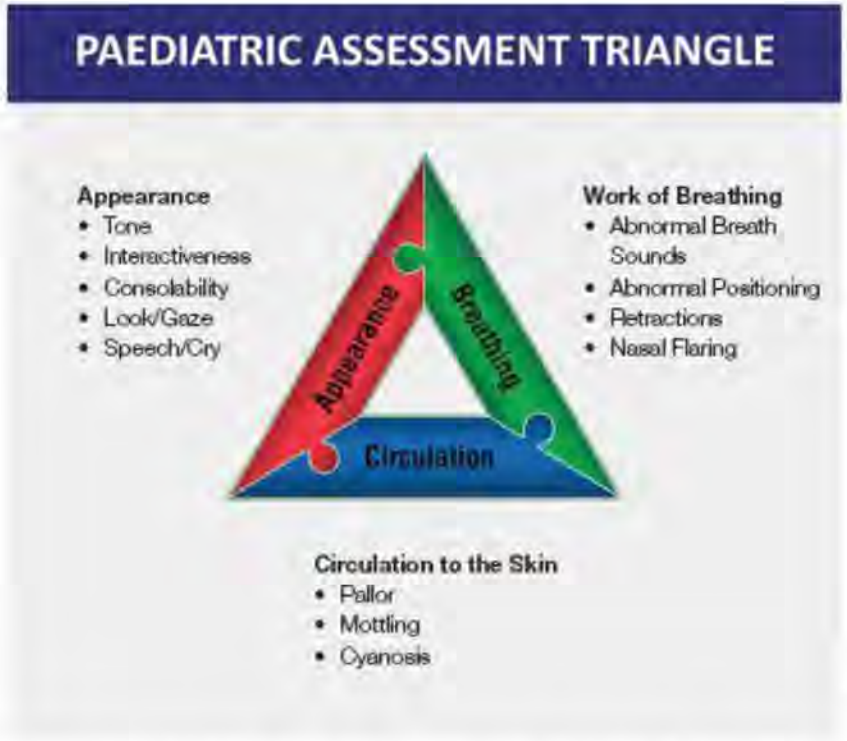
Not suitable for NEPT

- Patient meets any criteria for Major Trauma (Vital Signs, Specific Injuries or High-Risk Criteria), unless assessed as suitable for NEPT transport by a medical practitioner and after consultation with the Paediatric Infant Perinatal Emergency Retrieval (PIPER) service
- PIPER patients (unless specifically approved by consulting retrieval physician)

Paediatric Assessment

Initial Paediatric Assessment

It is important to form a rapid first impression of the patient's appearance, breathing, and circulation as illustrated in the Paediatric Assessment Triangle below. Visually evaluate mental status, muscle tone and body position, chest movement, work of breathing, and skin colour whilst also looking for obvious injuries. This assessment should not take more than a few seconds.



REFERENCE: Dieckmann RA, Brownstein D, Gausche-Hill M, eds. Pediatric Education for Prehospital Professionals: PEPP Textbook. Sudbury, MA: Jones & Bartlett Publishers; 2000.

If the child appears well with no signs of serious trauma, approach with a calm demeanour whilst explaining your actions to the parents and the child. If a well-appearing patient has experienced a high-risk mechanism of injury, consider the patient potentially unstable due to the risk of serious internal injuries.

For children with a poor appearance and evidence of significant injury, proceed immediately to the primary survey including any lifesaving interventions as appropriate.

Paediatric Normal Values

Descriptor	Approximate age range	Heart rate	Blood pressure	Skin	Conscious state	Respiratory rate
Newborn	Birth to 24 hours	110–170 bpm	>60 mmHg systolic	warm, pink, dry	alert, active	25–60 breaths per minute
Small infant	<3 months	110–170 bpm	>60 mmHg systolic	warm, pink, dry	alert, active	25–60 breaths per minute
Large infant	3–12 months	105–165 bpm	>65 mmHg systolic	warm, pink, dry	alert, active	25–55 breaths per minute
Small child	1–4 years	85–150 bpm	>70 mmHg systolic	warm, pink, dry	alert, active	20–40 breaths per minute
Medium child	5–11 years	70–135 bpm	>80 mmHg systolic	warm, pink, dry	alert, active	16–36 breaths per minute

Paediatric values are based on the Victorian State Government, Royal Children's Hospital and Monash Children's Hospital ViCTOR values.
Go to: www.victor.org.au for more information.

Paediatric Normal Weights

Age	Weight
<24 hours	3.5 kg
3 months	6 kg
6 months	8 kg
1 year	10 kg
1–9 years	Age x 2 + 8 kg
10–11 years	Age x 3.3 kg

Pain Assessment

Faces Pain Scale

Reference: Hicks CL, et al. The Faces Pain Scale - Revised: Toward a common metric in pediatric pain measurement. Pain 2001; 93:173-183.

In the following instructions, say "Hurt" or "Pain," whichever seems right for a particular child:

'These faces show how much something can hurt. This face *[point to left-most face]* **shows no pain. The faces show more and more pain** *[point to each from left to right]* **up to *this* one.** *[point to right-most face]* **It shows very much pain. Point to the face that shows how much you hurt** *[right now]*.**'**

Score the chosen face 0, 2, 4, 6, 8, or 10, counting left to right, so '0' equals 'No pain' and '10' equals 'Very much pain.' Do not use words like 'happy' and 'sad.' This scale is intended to measure how children feel inside, not how their face looks.

Verbal numerical rating scale

This scale asks the patient to rate their pain from 'no pain' (0) to 'worst pain possible' (10) and is suitable for use in children over six years of age who have an understanding of the concepts of rank and order. Avoid using numbers on this scale to prevent the patient receiving cues. Some patients are unable to use this scale with only verbal instructions but may be able to look at a number scale and point to the number that describes the intensity of their pain.

Mental Status Assessment

		LOOK FOR, LISTEN TO & ASK ABOUT ALL CATEGORIES BELOW *THE PATIENT MAY BE SUFFERING FROM SOME OF THE FOLLOWING EXAMPLES* **Remember verbal de-escalation strategies, active listening and calm/open body language**
OBSERVE	**Safety**	First responder, patient and bystander safety first is priority. Assess the scene for dangers i.e. location, weapon. Obtain police support early if required. Maintain vigilant reassessment of scene safety.
	Appearance	Look for signs indicative of mental health issues or poor self-caring; uncleanliness, dishevelled, malnourished, signs of addiction (injection marks/nicotine stains), posture, pupil size, odour.
	Behaviour	Patient may display; odd mannerisms, impaired gait, avoidance or overuse of eye contact, threatening or violent behaviour, unusual motor activity or activity level (i.e. wired or buzzing), bizarre/inappropriate responses to stimuli, pacing.
	Affect	Observed to be; flat, depressed, agitated, excited, hostile, argumentative, violent, irritable, morose, reactive, unbalanced, bizarre, withdrawn etc.
LISTEN	**Speech**	Take note of: rate, volume, quantity, tone, content, overly talkative, difficult to engage, tangential, flat, inflections etc.
	Thought Process	May be altered, can be perceived by patient jumping irrationally between thoughts, sounding vague, unsteady through flow when communicating verbally.
	Cognition	May be exhibiting signs of impairment such as; poor ability to organise thoughts, short attention span, poor memory, disorientation, impaired judgement, lack of insight.
DISCUSS	**Thought Content**	May be dominated by; delusions, obsessions, preoccupations, phobias, suicidal/depressed or homicidal thoughts, compulsions, superstitions.
	Self-Harm	Ask patient directly if they have attempted self-harm, suicide or are thinking/planning for these. Ask about previous attempts.
	Perceptions	Patient may be suffering from; hallucinations (ask specifically about auditory, visual and command hallucinations), disassociation i.e. 'I feel detached from my body', 'my surroundings aren't real', 'I am not in control of my actions'.
	Environment	Risk factors include; lack of familial and social support, addiction or substance abuse, low socio-economic status, life experiences, recent stressors, sleeping problems or comorbidities (either physical or mental health conditions).

Section Two – Adult Clinical Protocols

Please note: With the exception of anaphylaxis, where patients should be treated irrespective of age, medication doses only apply to patients 12 years and older. For treatment of patients 11 years and younger, consult for dose advice with the communications centre. For non-urgent enquiries this does not need to be the AV communications centre.

Cardiac Arrest (Adult)

Notes

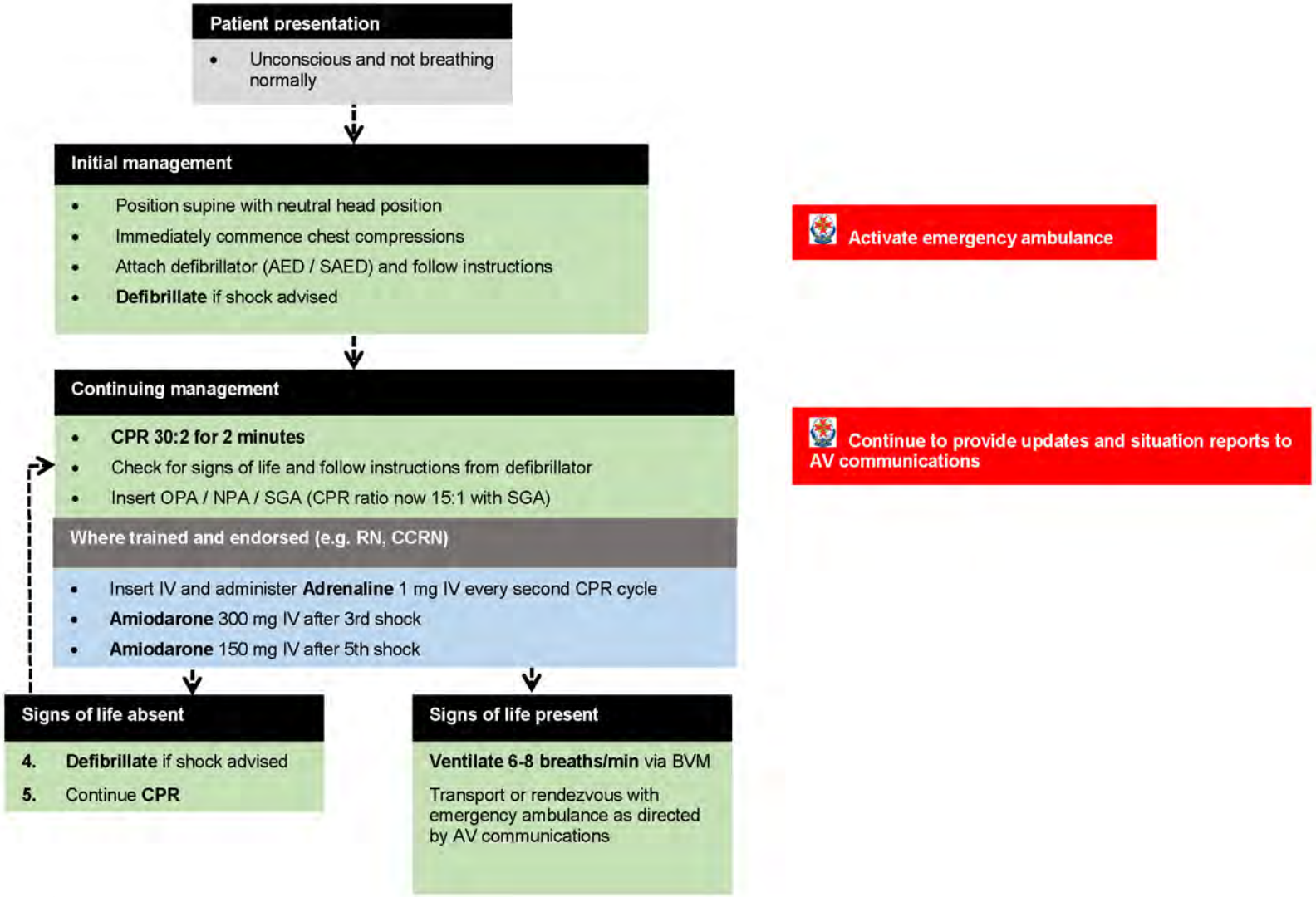
1. Signs of life: any patient who is unconscious and not breathing normally should be presumed to be in cardiac arrest and CPR commenced immediately. Palpation of a pulse is unreliable and should not be performed to confirm the need for resuscitation. The benefits of early and high quality CPR outweigh the low risk of injury to patients not in cardiac arrest.
2. The principles of high-quality CPR include:
    - Ratio of 30 compressions to 2 ventilations, at a compression rate of 100-120 per minute (one or two operators)
    - Where a supra-glottic airway has been established, modify CPR ratio to 15 compressions to 1 ventilation. Do not pause compressions for ventilated breaths.
    - Compressions should be performed to approximately one third of the depth of the chest (approx. 5 cm in adults), with complete recoil allowed after each compression.
    - Minimal interruption to compressions is essential. If it is uncertain whether or not a pulse is present, CPR should recommence immediately
    - Change operator every two minutes to improve CPR performance and reduce fatigue.
3. IV cannulation and medications are lower priority interventions than high quality CPR and early defibrillation.
4. For the purposes of the protocols, an automatic external defibrillator (AED) is regarded as being the same as a semi-automatic external defibrillator (SAED). AED/SAED operation has been shown to decrease the time to first shock compared to manual defibrillation.
5. Ventilations should be delivered with sufficient volume to cause rise and fall of the chest.
6. The decision to cease resuscitation efforts should only be made by an AV paramedic, a registered nurse or doctor. If this support is not available, consult with the AV clinician. Ceasation may also be considered where the crew is exhausted or in circumstances where the scene is unsafe.

7. Cardiopulmonary resuscitation or defibrillation may only be withheld if there is a not for resuscitation order, advance care plan/directive or refusal of treatment certificate that states that cardiopulmonary resuscitation be withheld.

   For home-to-hospital transfer, this documentation may be sighted, or it may be accepted in good faith by those present at the scene that this document exists, i.e. the document does not have to be provided to the attending crew. This may also include instructions communicated to NEPT staff by the patient's designated medical treatment decision maker[1]. NEPT health professionals must record full details of the information given to them and by whom regarding the patient's wishes. If there is any doubt about the patient's wishes for resuscitation, the default position of continuing resuscitation should be adopted. For inter-hospital transfer, or hospital-to-home transfer, copies of relevant documentation must be provided by the sending health service and included in the NEPT patient care record. Where a copy is not obtained, the NEPT crew must advise the sending health service that they will provide routine usual care to the patient should it be necessary.

[1] https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/advance-care-planning/medical-treatment-planning-and-decisions-act

Cardiac Arrest (Adult)



Anaphylaxis (Adult)

Notes

1. Anaphylaxis is a life-threatening medical condition. If anaphylaxis is suspected there must be no delay in administration of **Adrenaline** and activation of emergency ambulance.
2. Common triggers include foods, insect bites/stings, medications. A patient may have no prior history of anaphylactic reactions or may be unaware that they have been exposed to an antigen.
3. All suspected or reported anaphylaxis patients **MUST** be transported to hospital for observation, even if they have been treated prior to NEPT arrival and are now showing no signs or symptoms.
4. Standing or walking a patient with suspected anaphylaxis can result in a profound reduction in blood pressure and collapse. Position the patient supine as soon as possible and adjust the head height based on the patients' blood pressure.
5. This CPP refers to **Adrenaline** auto-injectors. Whilst national anaphylaxis guidelines refer to an adult dose of 500 mcg IM, most adult auto-injectors will deliver a 300mcg dose. This is an acceptable dose and the key point is that if a patient meets the criteria for anaphylaxis, they are treated with **Adrenaline** in a timely manner.
6. Where NEPT staff are authorised to draw up and administer medication from an ampoule, **Adrenaline** may be used from a 1:1000 (1 mL) ampoule. The recommended dose is 10 mcg/kg IM up to the age of 11 years, or 500 mcg IM for age 12 years and older.
7. If a patient has an existing anaphylaxis plan, this should be followed in conjunction with the CPP. If a patient meets the clinical criteria for **Adrenaline** administration, this should remain the priority treatment.
8. All patients who have received adrenaline for possible anaphylaxis must be transported for follow up medical assessment, even if symptoms have seemingly resolved.

Anaphylaxis (Adult)

Patient presentation

6. Sudden onset of signs and symptoms of anaphylaxis (see below)
7. Patient **may or may not** have a history of allergy or anaphylaxis

Assess

Anaphylaxis is likely if **either** of the below conditions are met:

- Signs / symptoms from **two or more** of the groups below (with or without exposure to antigen)
  - **R** Respiratory distress (SOB, wheeze, cough, stridor)
  - **A** Abdominal symptoms (nausea, vomiting, diarrhoea, abdo pain / cramps)
  - **S** Skin / mucosal symptoms (hives, welts, itch, flushing, angioedema)
  - **H** Hypotension (or altered conscious state)

OR

- Hypotension only (SBP < 90 mmHg) following confirmed exposure to known antigen

Management

- Adult
  - **Adrenaline 300 mcg auto-injector**
- **Oxygen 10-15 L/min** via non-rebreather mask (or face mask)
- Where possible, do not allow patient to stand or walk
- If inadequate perfusion, position patient supine with legs elevated
- If wheeze present, treat as per **Breathing Difficulties protocol**
- Repeat **Adrenaline auto-injector (same as original dose) IM after 5 minutes** if no improvement or deterioration
- If patient loses consciousness and is not breathing normally, manage as per **Cardiac Arrest protocol**
- **All patients who have received adrenaline for possible anaphylaxis must be transported for follow up medical assessment, even if symptoms have seemingly resolved.**

Activate emergency ambulance response

Provide situation report and commence transport / rendezvous as appropriate

Breathing Difficulties

Not suitable for NEPT

- Moderate or severe respiratory distress (unless normal for patient)
- Respiratory distress which does not improve after rest or management with the Breathing Difficulties protocol

Notes

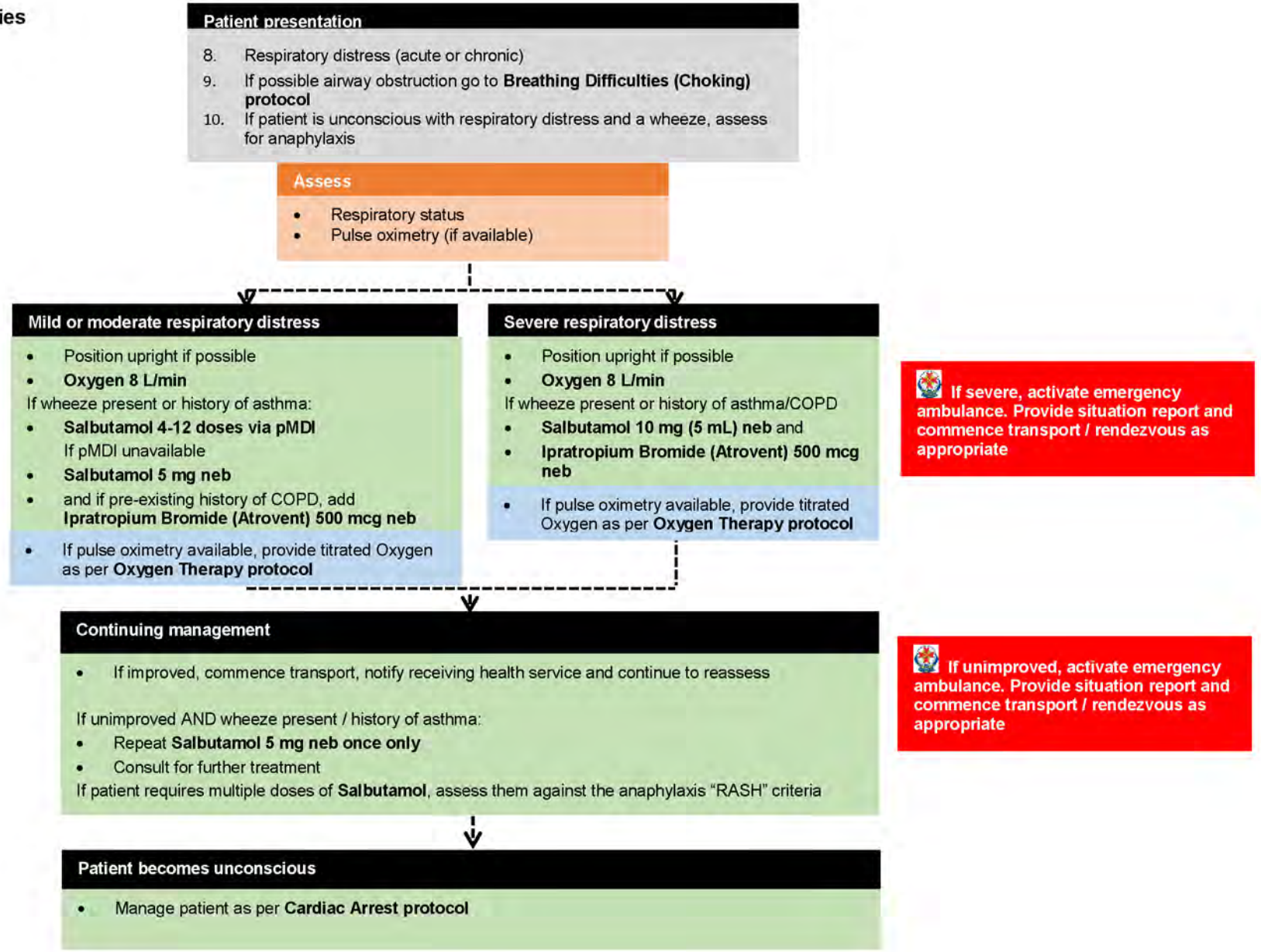
1. If pulse oximetry unavailable and employee not accredited in titrated oxygen administration, oxygen may be administered at the following rates:

Situation	Oxygen Administration
Oxygen therapy prescribed by medical practitioner for transfer	Prescribed rate (note in PCR)
Patient normally on home oxygen	Usual/prescribed rate (note in PCR)
Severe respiratory distress, awaiting emergency ambulance	8 L/min via face mask or nebuliser mask
Mild-moderate respiratory distress, transport via NEPT	8 L/min via face mask or nebuliser mask
Known COPD patient who becomes breathless during loading/transfer	2 L/min via nasal prongs initially. If breathlessness does not improve after 10 minutes, manage as per Breathing Difficulty protocol

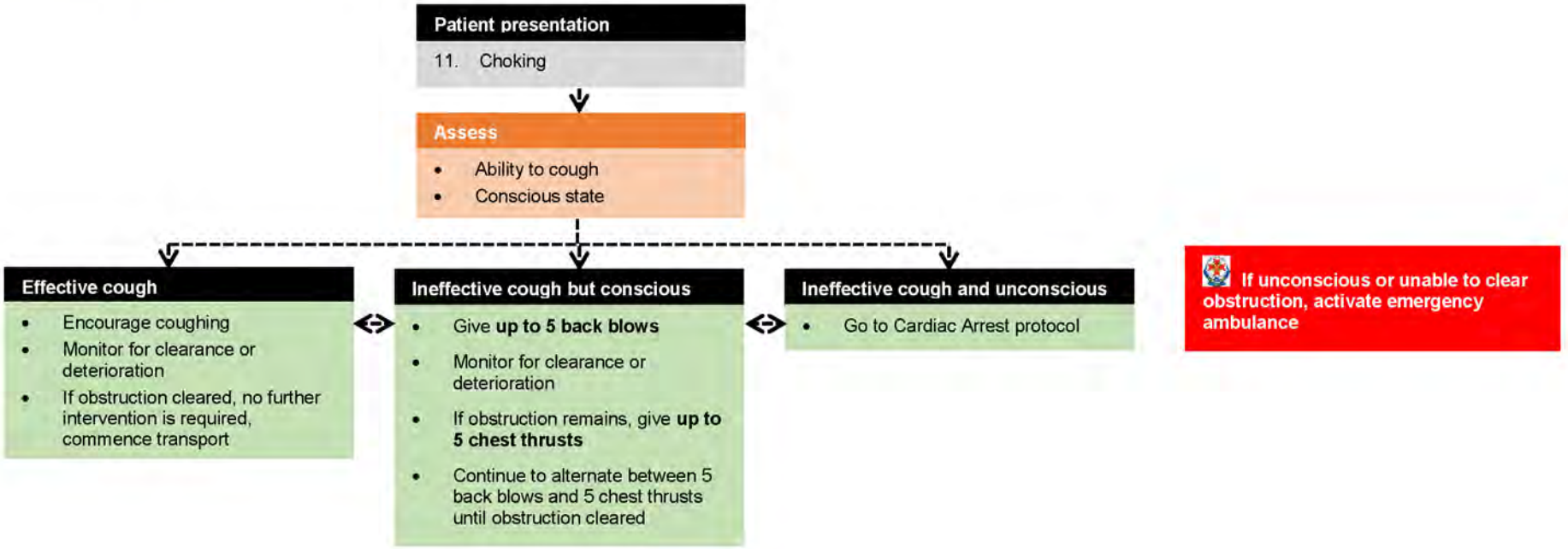
2. Patients with breathing difficulties and wheeze may benefit from **Salbutamol** and **Ipratropium Bromide** (**Atrovent**) therapy. **Salbutamol** may be administered by inhaler/spacer for asthma patients with mild to moderate distress. In combination they may be delivered by an oxygen-driven nebuliser (8 L/min) for the COPD patient, or the asthma patient with severe distress. Indications for therapy are:

Situation	Medication Administration
As prescribed by medical practitioner for respiratory distress	Prescribed dose (note in PCR)
Any exacerbation of COPD	Nebulised **Salbutamol** and **Ipratropium Bromide** (**Atrovent**) as per protocol
Asthma patient with mild-moderate respiratory distress, awaiting emergency ambulance	**Salbutamol** pMDI or nebulised as per Breathing Difficulties protocol
Asthma patient with severe respiratory distress, awaiting emergency ambulance	Nebulised **Salbutamol** and **Ipratropium Bromide** (**Atrovent**) as per protocol

Breathing Difficulties



Breathing Difficulties (Choking)



Chest Pain (of a possible Cardiac Nature)

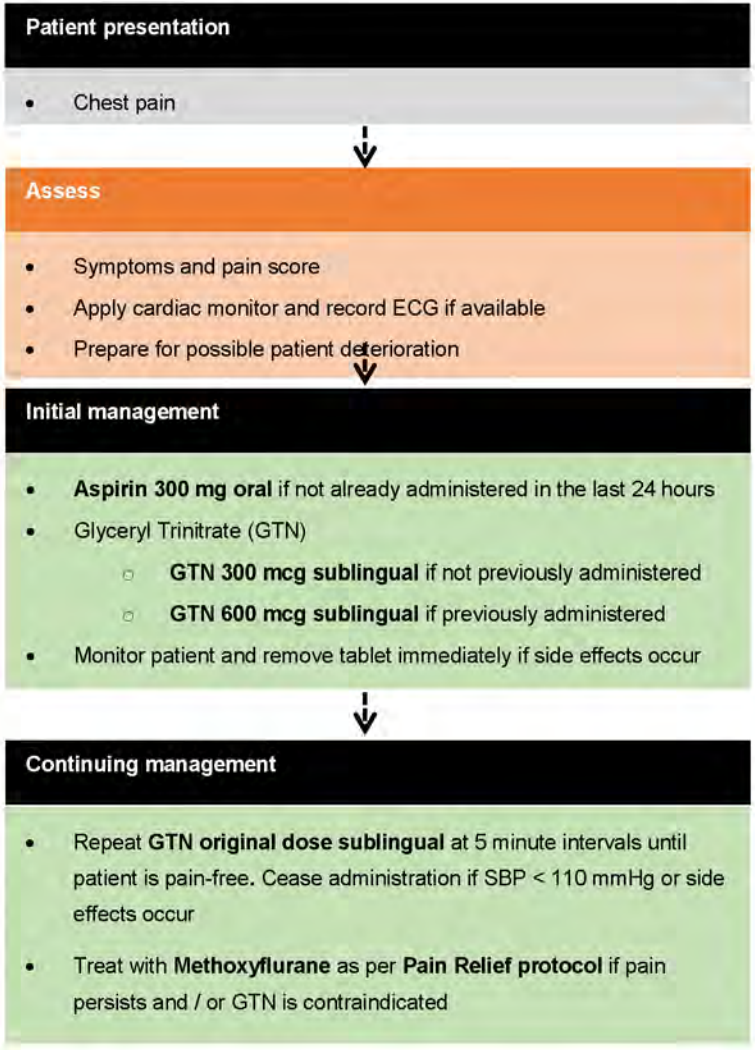
Not suitable for NEPT

- Adult patient (over 20 years) with potential cardiac chest pain that remains unresolved after administration their usual medication
- Patients requiring immediate time critical transfer for coronary angiography and/or cardiac surgery

Notes

1. During inter-hospital transfer of the patient with an acute coronary syndrome, mild chest pain which occurs despite **GTN** and heparin infusions may be treated with sublingual **GTN** and transport continued. An emergency ambulance need only be called if the chest pain does not promptly resolve with the administration of sublingual **GTN**, or the patient develops instability of vital signs or cardiac rhythm.
2. Similarly, chest pain that occurs during transport of a patient who has known ischaemic heart disease, where the chest pain is not an unusual occurrence for the patient may be treated with sublingual **GTN** and transport continued. An emergency ambulance need only be called if the chest pain does not resolve with the administration of sublingual **GTN**, or the patient develops instability of vital signs or cardiac rhythm. If the pain is not resolved or significantly relieved after 3 doses of GTN, or if the pain is significantly worse than the patient's normal pain, an emergency ambulance should be called (with consideration for time to hospital versus time to assistance).
3. For the patient who has had an episode of chest pain, continuous ECG monitoring should be provided even where the pain has resolved. If available, a 12-lead ECG should be acquired.
4. Patients with cardiac chest pain have potential to deteriorate rapidly. Emergency resuscitation equipment should be available and ready for use in anticipation.

Chest Pain (of a possible cardiac nature)



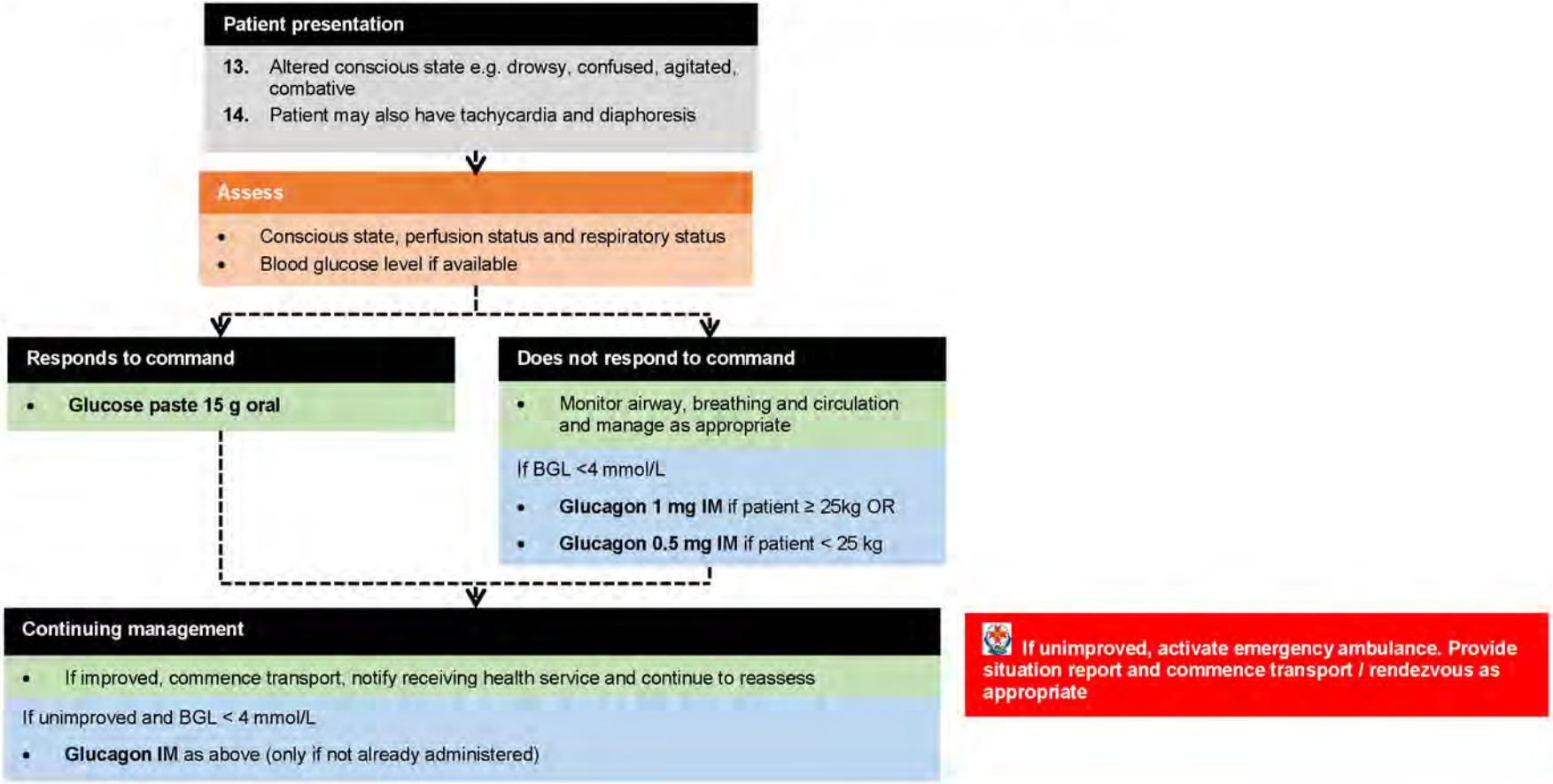
Notify AV communications

Activate emergency ambulance. Provide situation report and commence transport / rendezvous as appropriate.

Hypoglycaemia

Notes

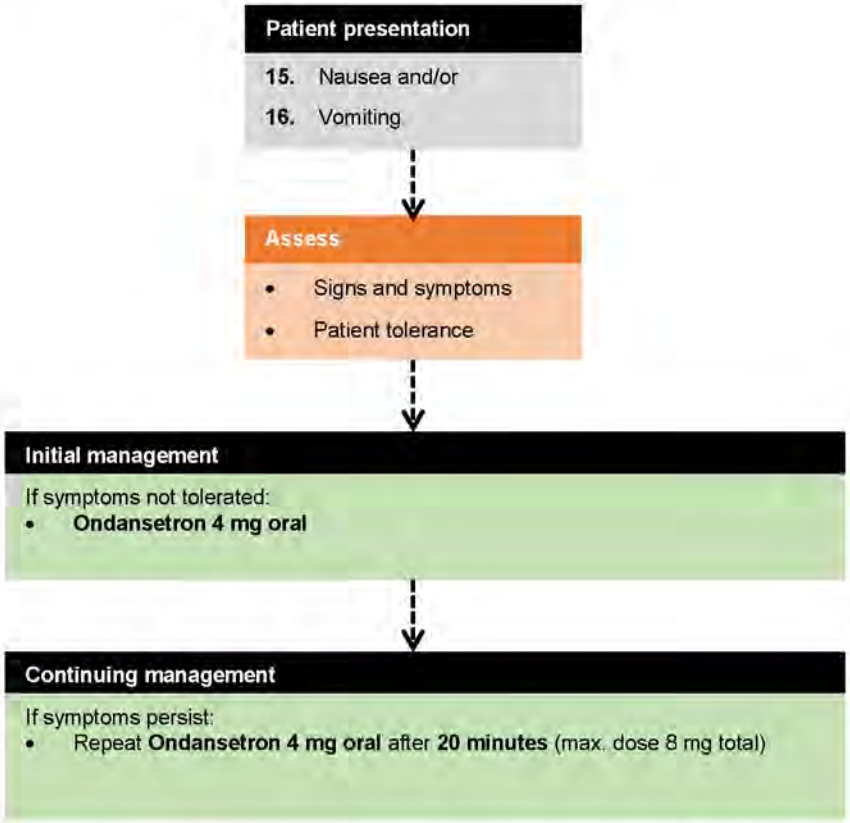
1. The treatment of hypoglycaemia is authorised for NEPT employees if:
    - It occurs in a patient with a history of diabetes mellitus, and hypoglycaemia is found on arrival or occurs during transport
    - A patient with diabetes mellitus presents to the NEPT employee with signs or symptoms of hypoglycaemia at a public event.
2. Since **Glucagon** may take some time to take effect and is not always effective, the patient may need subsequent evaluation by a registered medical practitioner. Activate emergency response ambulance and rendezvous with or await emergency ambulance.



Nausea and Vomiting

Notes

1. There are several physiological mechanisms of nausea and vomiting. **Ondansetron** may not be effective for all types. If symptoms are being tolerated, basic care and transport is acceptable.
2. Dehydration can exacerbate symptoms of nausea. If not contraindicated (e.g. fluid restriction) and practical to do so, the patient may be hydrated with oral fluids before and during transport.

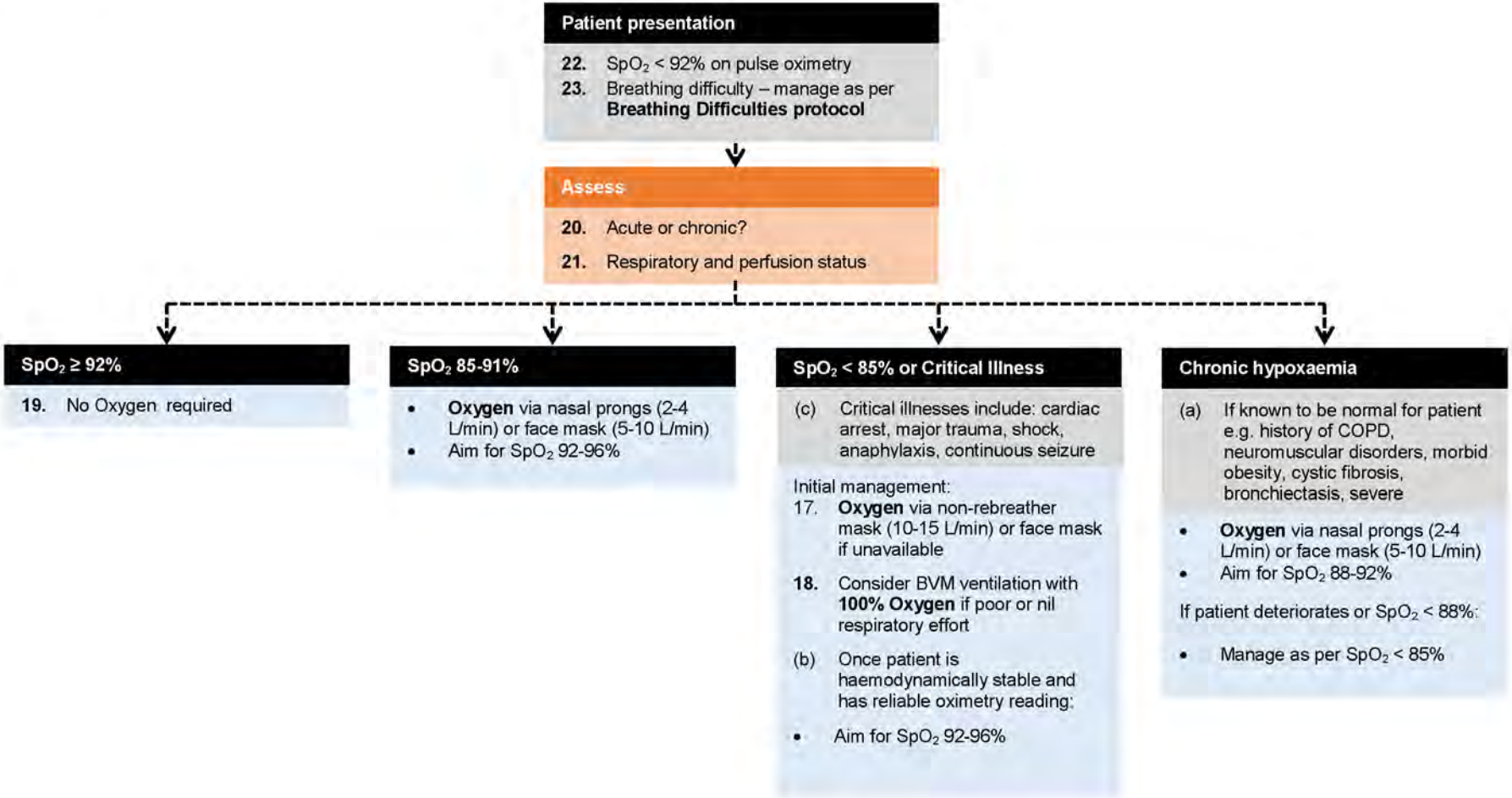


Oxygen Therapy

Notes

1. **Oxygen** is a treatment for hypoxaemia, not breathlessness. Where pulse oximetry is available and the NEPT employee is accredited to do so, the Oxygen Therapy Protocol should be used to titrate **Oxygen** administration to the patient's requirements.
2. Excessive **Oxygen** administration may be detrimental in some acute conditions (e.g. acute myocardial infarction, COPD or stroke). High flow **Oxygen** is still indicated in patients with critical illnesses, including cardiac arrest, major trauma, shock, anaphylaxis and continuous seizures.
3. Pulse oximetry may be unreliable in patients with peripheral vascular disease, severe asthma, severe anaemia, cold extremities, or severe hypotension. False low readings may also occur with nail polish or dirty/infected fingernails, or L.E.D. lighting.
4. Patients with carbon monoxide poisoning will not have a reliable pulse oximetry reading. Administer maximum **Oxygen** therapy for these patients irrespective of saturation reading.

Oxygen Therapy



Pain Relief

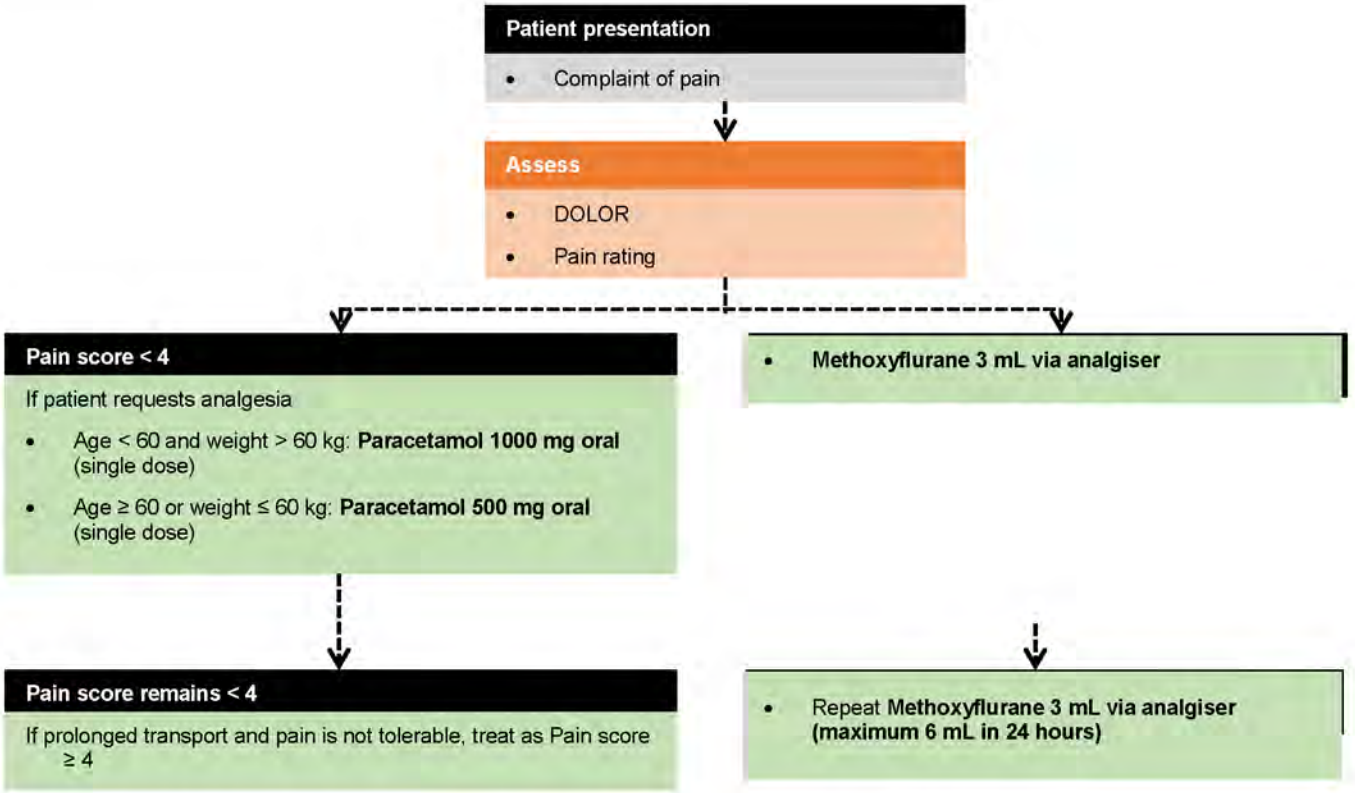
Not suitable for NEPT

- Patient > 60 years with sudden onset (<24 hours) and severe abdominal pain where a dissecting aortic aneurysm has not been excluded by a medical practitioner
- Patient with an undiagnosed headache where the treating medical practitioner suspects acute intracranial pathology

Notes

1. Consider non-pharmacological analgesic options, e.g. ice-packs, splinting, patient position, heat-packs, or distraction therapy
2. **Paracetamol** is an effective analgesic for mild-moderate pain and may be considered where a patient reports a pain score of < 4 and requests analgesia. Note that **Paracetamol** has a longer onset and duration of action than **Methoxyflurane**.
3. **Methoxyflurane** is authorised for use by NEPT if:
    - Pain is moderate to severe.
    - Patient is conscious and able to self-administer the **Methoxyflurane**.
    - The maximum dose of **Methoxyflurane** for any one patient is 6 mL per 24-hour period. Under no circumstances is this to be exceeded.
    - Ensure there is adequate ventilation in the treatment space.
    - May be administered in combination with **Paracetamol.**

Pain Relief



If pain is still unimproved and not tolerated despite management, notify the communications centre. For non-urgent enquiries this does not need to be the AV communications centre. Provide situation report and commence transport / rendezvous as appropriate

Palliative care/Advance care directives

Notes:

1. The Department of Health and Human Services supports a person's right to articulate wishes for medical treatment and care in advance through any of the following;
   - appointment of a medical decision maker
   - documentation of wishes in an advance care plan or directive
   - refusal of treatment certificate.
2. NEPT providers and staff may provide or withhold treatment based on an advance care directive if the documentation is sighted or accepted in good faith by those present at the scene that the documentation exists. NEPT staff must include details of advance care directive discussions and decisions in their documentation.
3. The NEPT sector in Victoria plays an important role in the continuum of care of Victorians and should consider the key principle of advance care directive strategies including;
   - advance care directive as part of 'usual care'
   - advance care directive as 'everyone's business'.
4. For home to hospital transfers, documentation of an ACP, ROTC or an NFR (or equivalent), that states that cardiopulmonary resuscitation be withheld, may be sighted, or it may be accepted in good faith by those present at the scene that this document exists. If copies of such documentation are available, they should be included in the NEPT patient care record. If documentation is not available the NEPT health professionals must record full details of the information given to them and by whom regarding the patient's wishes. If a substitute decision maker is nominated (usually a person with enduring power of attorney (medical treatment)), this person's details should also be noted in the NEPT patient care record. If there is any doubt about the patient's wishes for CPR, the default position is to treat, as necessary.
5. For inter-hospital transfer or hospital to home transfer, copies of relevant documentation must be provided by the sending health service and included in the NEPT patient care record. Where a copy is not obtained, the NEPT crew must advise the sending health service that they will treat the patient should it be necessary.
6. Regardless of time critical criteria (including abnormal vital signs), palliative care patients with a pre-existing terminal illness and not for advanced life support, may still be transported by NEPT, provided a not for resuscitation order (or equivalent), advance care directive or refusal of treatment certificate is sighted by the NEPT staff. If such documentation is not sighted, then NEPT staff must advise the sending health service they will treat the patient with usual care should it be necessary.

   NB. For inter-hospital transfer or hospital-to-home transfer, copies of the relevant documentation must be provided by the sending health service and included in the NEPT patient care record. Where a copy is not obtained, the NEPT crew must advise the sending health service that they will treat the patient should it be necessary. For home-to-hospital transfers, documentation of a not for resuscitation (or equivalent), advance care directive or refusal of treatment certificate that states that cardiopulmonary resuscitation be withheld, may be sighted, or it may be accepted in good faith by those present at the scene that this document exists. If copies of such documentation are available, they must be included in the NEPT patient care record.

7. If the patient unexpectedly dies in transit (and where a decision has been made and documented not to treat/resuscitate), contact the AV Clinician who will assist with advice on patient care and transport destination.
8. NEPT staff, other than Registered Nurse Division 1, are unable to verify life is extinct.

Stroke

Not suitable for NEPT

- Acute onset of stroke symptoms within 4.5 hours (unless a medical practitioner has evaluated the patient and determined that they are suitable for NEPT).

Notes:

1. Acute stroke is a time critical medical emergency and patient outcomes are directly related to the speed of treatment. Where acute onset of stroke symptoms is within 4.5 hours, notify AV Clinician urgently to discuss case.
2. Symptom onset time is taken from when the patient was last seen symptom-free. If the patient wakes up with symptoms, then the time is taken from when they were last witnessed well (e.g. bedtime).

If a NEPT provider is uncertain whether a patient with stroke symptoms is more suitable to be transported by emergency ambulance, this should be discussed with the AV Clinician and/or the registered medical practitioner who has evaluated the patient. If there will be a significant delay for emergency ambulance response to a patient with acute stroke symptoms, the NEPT provider should discuss the most appropriate transport option and destination.

Stroke

Patient presentation

- Symptoms of stroke

Assess

1. Symptom onset time

Assess – Melbourne Ambulance Stroke Screen

Assessment		Normal	Abnormal
Facial droop	Pt shows teeth or smiles	Both sides of face move equally	One side of face does not move as well as other
Speech	Pt repeats "You can't teach an old dog new tricks"	Pt says the correct words with no slurring	Pt slurs words, says the wrong words or is unable to speak or understand
Hand grip	Test as for GCS	Equal grip	Unilateral weakness
Blood glucose level	Test for BGL (if available)	≥ 4 mmol/L	< 4 mmol/L

Management

- Monitor airway, breathing and circulation
- Support affected limbs
- If BGL < 4 mmol/L, treat as per **Hypoglycaemia** protocol
- Transport

If patient condition deteriorates during transport, notify ambulance communications

Principles of Trauma Care

Not suitable for NEPT

- Patient meets any criteria for Major Trauma (Vital Signs, Specific Injuries or High Risk Criteria), unless assessed as suitable for NEPT transport by a medical practitioner and after consultation with ARV
- ARV patients (unless specifically approved by consulting retrieval physician)
- Undiagnosed spinal cord compression symptoms where the treating medical practitioner suspects spinal cord injury (unless transport by NEPT specifically approved)

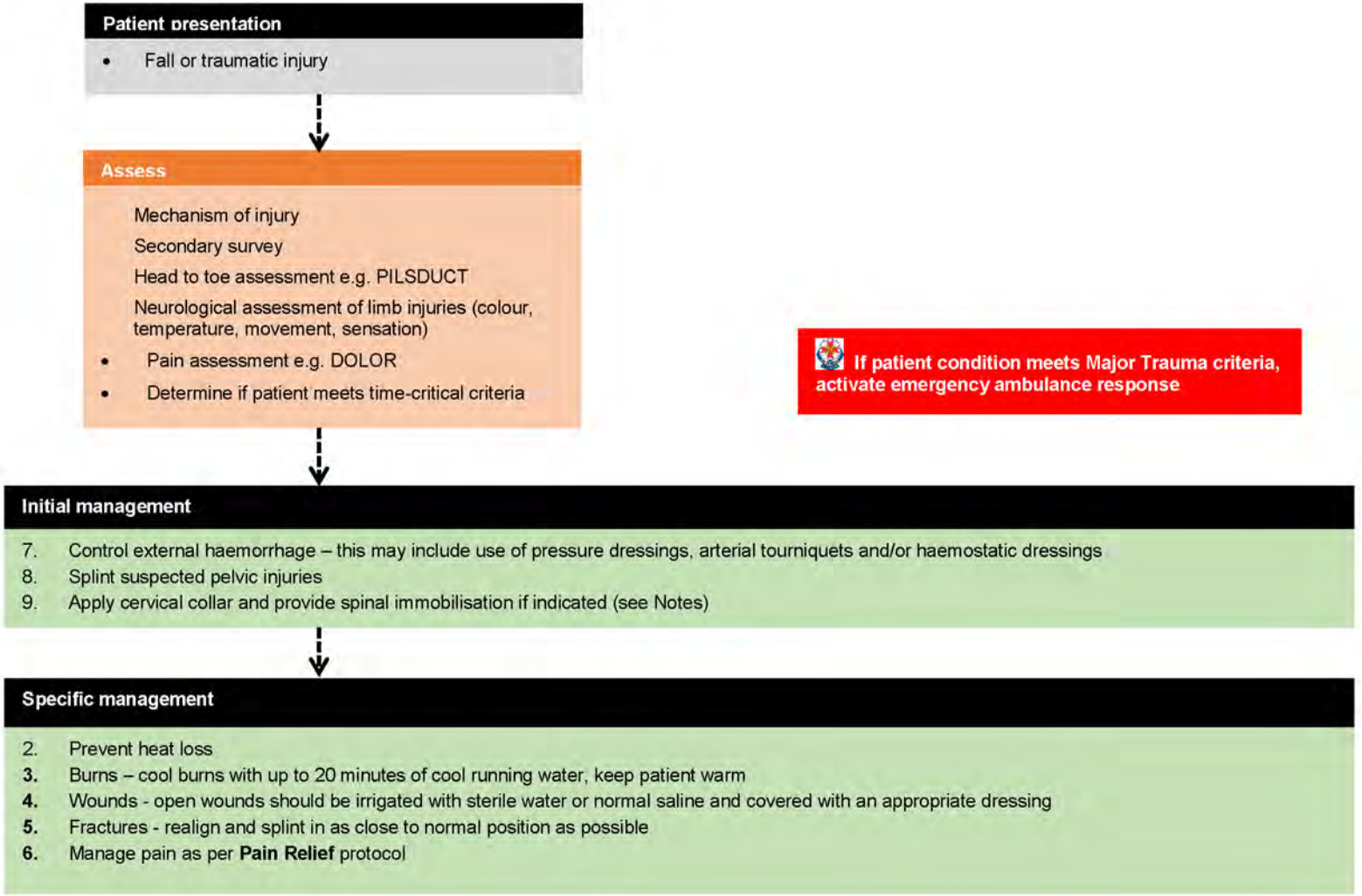
Notes

1. In cases of clear traumatic cardiac arrest, haemorrhage control and managing correctable causes become the priority prior to commencing chest compressions. This will include pelvic splinting in the setting of significant blunt pelvic injury.
2. For any potential major trauma patient, hypothermia is a significant concern. Preventing heat loss is an important priority.
3. Mechanism of injury is a significant risk factor indicator. Understanding how the incident occurred is key to understanding care urgency and priorities.
4. If a patient has suffered a blunt head injury with or without loss of consciousness and now presents with GCS 13-15 and any of the following:
   - Any loss of consciousness >5 minutes
   - skull fracture - depressed, open or base of skull
   - vomiting more than once
   - neurological deficit (loss of function or sensation)
   - any reported seizure activity

   this should be considered a significant blunt head injury meeting the potential major trauma criteria and AV attendance should be requested.
5. Spinal immobilisation is indicated if the patient:
   - Meets Major Trauma Criteria
     OR
   - Has a mechanism of injury suspected to cause spinal injury (such as fall with head strike) AND any of the following:
     i. Age > 55 years
     ii. History of bone disease (e.g. osteoporosis, osteoarthritis, rheumatoid arthritis) or muscular weakness disease (muscular dystrophy)
     iii. Unconscious, altered conscious state or period of loss of consciousness
     iv. Drug or alcohol affected
     v. Significant distracting injury (e.g. extremity fracture or dislocation)
     vi. Spinal column pain/bony tenderness
     vii. Neurological deficit or changes

6. Timely and effective pain management is important for long term patient outcomes. Severe trauma pain will require large analgesic doses. Consult the AV Clinician in these cases.
7. Effective splinting can reduce pain and blood loss and should be performed where possible.
8. Patients who have fallen but have no apparent injury still require thorough assessment and close monitoring.
   Higher risk falls include patients:
   - on anti-coagulants; e.g. warfarin, heparin, enoxaparin (clexane), dabigatran, rivaroxaban
   - with incomplete recall of how the fall occurred
   - who have spent an extended period of time on the ground (there is no specific timeframe defined as safe/unsafe)
   - who have collapsed due to an underlying medical cause.
9. Burns cases hold unique assessment and management challenges. Cooling the burn is a care priority, however keep the patient warm. Monitor for developing airway compromise.
10. In the case of a multiple casualty situation, or in circumstances that result in activation of the State Health Emergency Response Plan, NEPT resources may be responded to assist, and directed by a Health Commander to treat and transport patients that fall outside their normal acuity levels.

Principles of Trauma Care



Section Three: Paediatric Clinical Protocols

Cardiac Arrest (Paediatric)

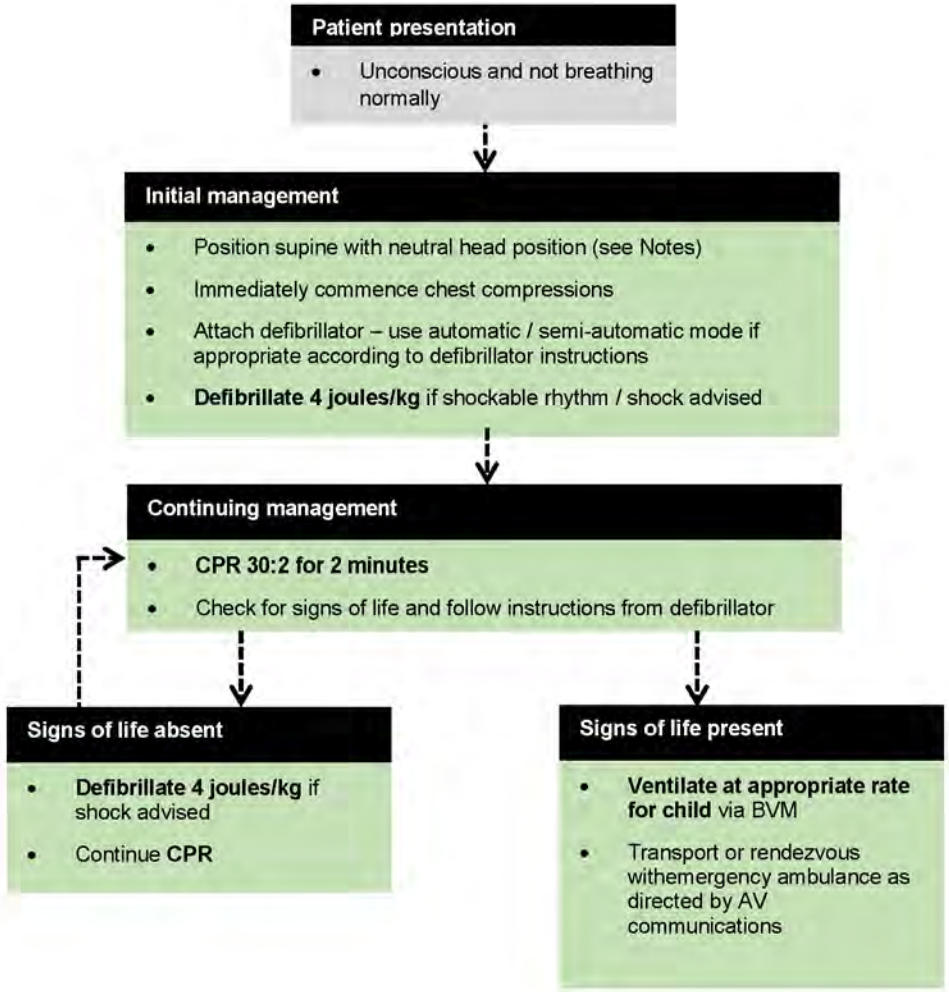
Notes:

1. This protocol should be used for cardiac arrest in patients < 12 years of age. Children 12 years and above can be managed according to the Adult protocol
2. The basic principles of paediatric life support are similar to those of adults. Effective airway control and adequate ventilation with oxygen supplementation is the keystone of paediatric resuscitation.
3. Some procedures need to be adapted for differences in paediatric anatomy. Small children, infants and newborns may need a small amount of padding beneath the shoulders to keep the occiput from causing too much flexion of the head and compressing the neck. Noisy breathing, stridor or wheeze and/or neck and chest soft tissue retraction on inspiration are signs of significant partial airway obstruction.
4. If spontaneous ventilation is not present, an appropriate size oropharyngeal airway should be inserted and assisted ventilation should be commenced immediately using supplemental oxygen. Ventilations should be delivered with sufficient volume to cause rise and fall of the chest.
5. CPR rates and ratios are shown below:

Age	CPR ratio	Compression Rate	Technique
Newborn (birth up to 24 hours)	3 compressions : 1 ventilation	90 compressions per minute with 0.5 second pause for ventilation	Two finger or two thumbs One third of the depth of chest
Infants (1 day up to 1 year)	30 compressions : 2 ventilations (one rescuer) 15 compressions : 2 ventilations (two rescuers)	100-120 compressions per minute	Two finger or two thumbs One third of the depth of chest
Small and Medium Child (1 to 11 years)	30 compressions : 2 ventilations (one rescuer) 15 compressions : 2 ventilations (two rescuers)	100-120 compressions per minute	One hand or two hands One third of the depth of chest

6. Automatic or semi-automatic defibrillators can be used in children if the appropriate settings and attachments are available. If not accredited in manual defibrillation and an automatic or semi-automatic defibrillator without paediatric settings/attachments is the only option, it should be applied and utilized until further assistance arrives. If defibrillation is required, delivering a higher joulage than the standard is less harmful than failing to defibrillate.
7. If accredited in manual defibrillation, 4 joules per kg should be delivered rounded up to the nearest setting.

Cardiac Arrest (Paediatric)



Activate emergency ambulance

Continue to provide updates and situation reports to AV communications

Anaphylaxis (Paediatric)

Notes

1. Anaphylaxis is a life-threatening medical condition. If anaphylaxis is suspected there must be no delay in administration of **Adrenaline** and activation of emergency ambulance.
2. Common triggers include foods, insect bites/stings, medications. A patient may have no prior history of anaphylactic reactions, or may be unaware that they have been exposed to an antigen.
3. All suspected or reported anaphylaxis patients **MUST** be transported to hospital for observation, even if they have been treated prior to NEPT arrival and are now showing no signs or symptoms.
4. Standing or walking a patient with suspected anaphylaxis can result in a profound reduction in blood pressure and collapse. Position the patient supine as soon as possible and adjust the head height based on the patients' blood pressure.
5. This CPP refers to **Adrenaline** auto-injectors. Whilst national anaphylaxis guidelines refer to an adult dose of 500 mcg IM, most adult auto-injectors will deliver a 300 mcg dose. This is an acceptable dose and the key point is that if a patient meets the criteria for anaphylaxis, they are treated with **Adrenaline** in a timely manner.
6. Where NEPT staff are authorised to draw up and administer medication from an ampoule, **Adrenaline** may be used from a 1:1000 (1 mL) ampoule. The recommended paediatric dose is 10 mcg/kg IM up to the age of 11 years.
7. If a patient has an existing anaphylaxis plan, this should be followed in conjunction with the CPP. If a patient meets the clinical criteria for **Adrenaline** administration, this should remain the priority treatment.
8. All patients who have received adrenaline for possible anaphylaxis must be transported for follow up medical assessment, even if symptoms have seemingly resolved.

Anaphylaxis (Paediatric)

Patient presentation

11. Sudden onset of signs and symptoms of anaphylaxis (see below)
12. Patient **may or may not** have a history of allergy or anaphylaxis

Anaphylaxis is likely if **either** of the below conditions are met:

- Signs / symptoms from **two or more** of the groups below (with or without exposure to antigen)
  - **R** Respiratory distress (SOB, wheeze, cough, stridor)
  - **A** Abdominal symptoms (nausea, vomiting, diarrhoea, abdo pain / cramps)
  - **S** Skin / mucosal symptoms (hives, welts, itch, flushing, angioedema)
  - **H** Hypotension (or altered conscious state)

OR

- Hypotension only (relative to age) following confirmed exposure to known antigen

Management

- Child > 5 years / 20kg
  - **Adrenaline 300 mcg auto-injector**
- Child ≤ 5 years / 20 kg
  - **Adrenaline 150 mcg auto-injector**
- **Oxygen 10-15 L/min** via non-rebreather mask (or face mask)
- Where possible, do not allow patient to stand or walk
- If inadequate perfusion, position patient supine with legs elevated
- If wheeze present, treat as per **Breathing Difficulties protocol**
- Repeat **Adrenaline auto-injector (same as original dose) IM after 5 minutes** if no improvement or deterioration
- If patient loses consciousness and is not breathing normally, manage as per **Cardiac Arrest protocol**
- **All patients who have received adrenaline for possible anaphylaxis must be transported for follow up medical assessment, even if symptoms have seemingly resolved.**

Activate emergency ambulance response

Provide situation report and commence transport / rendezvous as appropriate

Section Four: Pharmacology

The following section describes the pharmacology of the medications contained in the CPPs. The doses in the individual medication sheets are the doses that are required to be delivered to patients as specified in the CPPs.

Adrenaline

Doses	150mcg intramuscular (Autoinjector) 300mcg intramuscular (Autoinjector) 10mcg/kg (< 12 years of age) – drawn out of ampoule 500mcg IM (all patient 12 years and over) – drawn out of ampoule 1 mg IV (Adult cardiac arrest)
Indications for use	Anaphylaxis Cardiac arrest
Contraindications	Nil of significance for the above indication
Precautions	Nil of significance for the above indication
Side Effects	• Tachycardia • Hypertension • Dilated pupils • Feeling of anxiety/palpitations
Special notes	The ideal location for IM injection is the mid-outer thigh. Other suitable sites include the mid line upper arm (deltoid) All patients receiving Adrenaline for possible anaphylaxis are to be transported to an emergency department. IM Adrenaline has a short duration and patients must be closely monitored for reoccurrence of symptoms.

Amiodarone

Doses	150mg intravenous 300mg intravenous
Indications for use	VF/pulseless VT, refractory to defibrillation
Contraindications	Nil of significance for the above indication
Precautions	Nil of significance for the above indication
Side Effects	• Hypotension • Bradycardia
Special notes	Amiodarone is only to be administered by trained and endorsed staff.

Aspirin

Doses	300mg oral
Indications for use	Cardiac chest pain/discomfort
Contraindications	• Hypersensitivity to aspirin/salicylates • Actively bleeding peptic ulcers • Bleeding disorders • Suspected aortic aneurysm • Chest pain associated with psychostimulant overdose and SBP > 160mmHg
Precautions	• History of peptic ulcer • Asthma • Patients on anticoagulants (e.g. warfarin)
Side Effects	• Heartburn/nausea/gastrointestinal bleeding • Increased bleeding time • Hypersensitivity reactions
Special notes	Aspirin is not be administered by NEPT for any condition other than chest pain/discomfort of a cardiac nature.

Glucagon

Doses	1mg intramuscular 0.5mg intramuscular
Indications for use	Diabetic hypoglycaemia (low blood sugar) with altered RBG < 4 mmol/L and altered conscious state
Contraindications	Nil of significance for the above indication
Precautions	Nil of significance for the above indication
Side Effects	Nausea and vomiting
Special notes	Not all patients will respond to glucagon and it is important to ensure early transport/activation of paramedic back-up in all cases of hypoglycaemia. Intramuscular times: - Onset: 3-5 minutes - Duration: 12-25 minutes

Glucose Paste

Doses	15g oral
Indications for use	Diabetic hypoglycaemia (low blood sugar) with altered RBG < 4 mmol/L and altered conscious state but able to cooperate.
Contraindications	Inability to swallow due to altered conscious state
Precautions	Nil of significance for the above indication
Side Effects	Nausea and vomiting
Special notes	Not all patients will respond to glucose paste and it is important to ensure early transport/activation of paramedic back-up in all cases of hypoglycaemia.

Glyceryl Trinitrate

Doses	300mcg sublingual/buccal 600mcg sublingual/buccal
Indications for use	Cardiac chest pain/discomfort
Contraindications	• Known hypersensitivity • Systolic blood pressure < 110 mmHg • Heart rate > 150 per min or < 60 per min • Sildenafil (Viagra), vardenafil (Levitra) use in the previous 24 hours or tadalafil (Cialis) use in the previous 2 days • Ventricular tachycardia
Precautions	• No previous administration of GTN • Elderly or frail patients
Side Effects	• Hypotension • Tachycardia • Headache
Special notes	• GTN is susceptible to heat and moisture. Tablets must be stored tightly sealed in their original container • Do not administer a patient's own medication as it may not have been stored in optimal conditions • Sublingual/buccal effects - Onset: 30 sec–2 minutes - Peak: 3–5 minutes - Duration: 15–30 minutes.

Ipratropium Bromide (Atrovent)

Doses	500mcg nebulised
Indications for use	Mild/moderate/severe respiratory distress with a pre-existing history of COPD Severe respiratory distress with a wheeze or pre-existing history of asthma
Contraindications	• Known hypersensitivity to atropine or its derivatives
Precautions	• Glaucoma • Avoid contact with the eyes
Side Effects	• Headache • Nausea • Dry mouth • Skin rash • Tachycardia (rare) • Palpitations (rare) • Acute angle closure glaucoma secondary to direct eye contact (rare)
Special notes	Ipratropium Bromide (Atrovent) must be nebulised with salbutamol and is administered as a single dose only.

Methoxyflurane

Doses	3ml inhaled
Indications for use	Pain relief
Contraindications	• Pre-existing kidney disease • Patients taking tetracycline antibiotics • Exceeding total dose of 6 ml in any 24 hour period • Personal or family history of malignant hyperthermia • Muscular dystrophy
Precautions	• Pre-eclampsia • The inhaler must be held by patient so that if unconsciousness occurs it will fall from patient's face • Patient must be supervised at all times during Methoxyflurane administration
Side Effects	• Drowsiness • Exceeding maximum total dose of 6 ml in 24 hour period may lead to kidney damage.
Special notes	Analgesia commences after 8-10 breaths and lasts for approximately 3-5 minutes once discontinued.

Ondansetron

Doses	4mg oral
Indications for use	Nausea and vomiting
Contraindications	• Known hypersensitivity to ondansetron • Concurrent apomorphine use • Known Long QT syndrome • Low potassium or low magnesium • Phenylketonuria
Precautions	• Nil of significance for the above indication
Side Effects	• Headache • Fever • Dizziness Rare: Allergic reaction, seizure, tachyarrythmias, extrapyramidal reaction, visual disturbances (including transient loss of vision)
Special notes	Ondansetron may not be effective for all types of nausea and vomiting

Paracetamol

Doses	500mg oral 1000mg oral
Indications for use	Pain relief
Contraindications	• Total paracetamol intake exceeding 4g in 24 hour period • Paracetamol administrated within past 4 hours
Precautions	• Impaired liver/renal function • Elderly or frail patients
Side Effects	• Hypersensitivity and severe skin rashes (rare)
Special notes	There are multiple brands and formulations of paracetamol available. Carefully check for previous intake before administration.

Salbutamol

Doses	5mg or 10mg nebulised 100mcg inhaled
Indications for use	• Breathing difficulty with wheeze and/or history of asthma • No relief from patients own Ventolin administration.
Contraindications	Nil of significance for the above indication
Precautions	Continue to administer Oxygen 8 L/min between doses
Side Effects	• Tachycardia • Muscle tremor
Special notes	• Unused nebules remaining in the pack at the completion of a case should be disposed of. • Nebules should be stored in an environment < 30 degrees Celsius. • The effectiveness of salbutamol differs between patients so it is important to ensure early transport/activation of paramedic back-up where required.

Section Five: Further Information

Handover

It is widely recognised that clinical handover efficiency and effectiveness can be improved with a standardised model of delivery. All caregivers involved in the care of the patient have a shared responsibility for ensuring effective, high quality communication of relevant clinical information at clinical handover.
When providing pre-arrival information, or handing over a patient to another health care professional, patient information may be provided in a structured way using the IMIST-AMBO model. This model is detailed below. Further information is available on the department's website:
http://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/acute-care/emergency-care/patient-transfer.

IMIST-AMBO model:

- **I**dentification (such as patient name, age, gender)
- **M**echanism of injury or medical complaint (such as presenting problem, how it happened)
- **I**njuries or information related to the complaint (such as symptoms or injuries)
- **S**igns (vital signs such as HR, RR, BP, GCS, BGL)
- **T**reatment and trends (such as treatment administered and patient response to treatment, trend in vital signs)
- **A**llergies
- **M**edications (such as patient's regular medications)
- **B**ackground history (such as patient's medical history)
- **O**ther information (such as social situation, relatives present, scene of health event.

Long duration cases

The nature of the NEPT sector is that some patient transfers can be over long distance, or take extensive periods of time (eg; distance, traffic delays, time waiting at health services). An area of risk is when patients transition between providers or transportation platforms, in these settings the cumulative total transfer times can be very large. It is important to the quality of the patient care and their experience that these extended time periods do not interfere with the wellbeing of the individual. It is therefore an expectation of all providers who have patients in their care to ensure that the basic activities of daily living are reasonably catered for; toileting, hydration, nutrition, and pressure area care/position change. For ambulant patients it may be appropriate to insert mobility breaks into extended transport road journeys.

Neonatal transport incubator

Some NEPT contractors work closely with the Victorian Paediatric Infant Perinatal Emergency Retrieval (PIPER) service. On occasions this service engage NEPT providers to transport neonates using a transport incubator cot. The incubator available in Victoria and strategically stored in 'host' hospitals around the state is the V808 Transport Incubator.

The incubators can be transported by NEPT without having PIPER on board where the case has been assessed by PIPER as being suitable. Under the PIPER guidelines, the child must meet a series of criteria (as assessed by PIPER) on a case by case basis to be considered for this type of transport. In broad terms, the child will not be unwell in these cases.

Where the patient is being transferred from a higher level service to lower level service (i.e. 'transfer down'), the acuity level of care offered by NEPT should be considered medium or above. The load format should be a single stretcher vehicle, however a double stretcher vehicle may be considered if the infant can be visualised AND consultation has occurred with PIPER prior to loading.

Transfers from a lower level service to a higher level service (i.e. transfers up) are considered to be emergency ambulance cases, however may be transported by NEPT as a high acuity case using high acuity transport service (HATS) where these providers are available to meet the timeframe requirements. This is assessed and triaged by PIPER in negotiation with the transport service provider. A single stretcher vehicle is required in these cases.

Support material for the incubators (including incubator host locations) can be accessed from the Royal Children's Hospital web-site:
https://www.rch.org.au/piper/guidelines/Statewide_incubator_documents/

Mnemonics table

Area	Mnemonics
Signs & symptoms of a fracture	**P**ain **I**rregularity **L**oss of movement or power **S**welling **D**eformity **U**nnatural movement **C**repitus **T**enderness
Treatment of fracture	**F**ix **R**eassure

	Afford limb support **C**over any wounds **T**ry for natural position **U**se appropriate splint **R**eact to haemorrhage **E**very occasion suspect fracture **S**hock – Treat & manage
Pain assessment	**D**escription **O**nset **L**ocation **O**ther symptoms **R**elief
Situation Report	**S**ex **A**ge **D**escription Injuries **E**stimated time of arrival (ETA)
History and Secondary Survey	**A**llergies **M**edications (current) **P**ast Medical History **L**ast Meal **E**vent that prompted the call for an ambulance
Pre-Arrival Notification	**M**echanism of Injury/main presenting problem **I**llness or Injury **S**igns & Symptoms, including vital signs survey **T**reatment provided and response to treatment

Report back on uncontrolled situations in major disasters or incidents	**E**xact location **T**ype of incident (e.g. traffic accident, chemical/**b**iological/radiological [CBR], HAZMAT, etc) **H**azards at scene (e.g. power lines, vapour, spillage etc.) **A**ccess and egress **N**umber of casualties (walking, stretcher, deceased etc.) **E**mergency services at scene required (e.g. additional ambulance resources and other agencies)

Scope of NEPT services

Licensed NEPT providers deliver a range of services including: transfers to and from health services or day procedure centres and home or residential care services, inter-hospital transfers (IHT) and public event duties. There may be a requirement under the State Health Emergency Response Plan (SHERP) for deployment at a major incident or disaster. These protocols are applicable to each of the types of services provided by licensed NEPT, except where described in exclusions below (p. 12).

Suitability for the use of NEPT services

The suitability of NEPT to transport a patient is dependent on five factors:

1. *Authority to practice*

   The *Non-Emergency Patient Transport Regulations 2016* set out the qualifications for health professionals employed by NEPT services as well as the categories of health professionals that are needed to transport (by road or air) depending on the acuity classifications: low, medium and high (see Section 5).

   In addition, these clinical practice protocols describe the different levels of authorised practice across a range of symptoms, assessments and intervention for the different types of NEPT health professionals. These are set out in Section 3.

2. *Time critical nature of the condition*

   The *Non-Emergency Patient Transport Regulations 2016* refer to patients whose 'condition is time critical' or whose 'condition is likely to become time critical during transport' as not suitable for NEPT.

   To provide further information to assist decisions regarding patients that are 'time critical', these protocols identify a range of symptoms that are time critical along with a range of symptoms that are not considered time critical regarding a patient's suitability for transport by licensed NEPT providers. These are set out in Section 4.

3. *Patient acuity*

   The Non-Emergency Patient Transport Regulations 2016 set out the classes of transport service based on the acuity (low, medium, high) of the patient and the type of transport (road or air). These include a description of the patient characteristics for low, medium and high acuity.

   All levels of acuity may be transported by NEPT subject to the provisions of the regulations. To provide further information to assist decisions regarding acuity, these protocols describe further features and examples of acuity. These are set out in Section 5.

4. *Public Event Duties*

Licensed NEPT providers, with transport capability, may provide first aid to any ill or injured person at a public event. In addition, the use of medications outlined in these protocols (such as pain relief) is allowed.

When a patient requires transport, a registered medical practitioner, who has physically assessed the patient, may determine the most suitable resource for transport. Where a registered medical practitioner is not in attendance, the licensed NEPT provider will contact Ambulance Victoria (AV) communications (by phoning 000) for advice regarding the most suitable transport.

5. *Major Incidents and the State Health Emergency Response Plan*

In cases where a licensed NEPT provider has been deployed to provide services as part of the State Health Emergency Response Plan (SHERP), the licensed NEPT provider may facilitate transport of any patient (including high risk and/or time critical patients) to hospital or receiving location as directed by the SHERP Health Commander. The deployment of NEPT services as part of SHERP may only be authorised by the SHERP Health Commander (Department of Health, 2013).

SHERP (Department of Health, 2013) outlines the arrangements for coordinating the health response to emergency incidents that go beyond day-to-day business arrangements. In these situations, there may be insufficient emergency ambulance resources immediately available to provide transport to hospital or other designated receiving location.

Exclusions to the use of NEPT services

The following specified conditions require transfer by emergency ambulance (regardless of the recommendation of a registered medical practitioner):

- expected requirement for a lights or sirens (Code 1) transport
- A provider must not transport a patient if the patient's condition is time critical or is likely to become time critical during the transport as described in the *Non-Emergency Patient Transport Regulations 2016.*

Change of patient condition before or during transfer

Despite appropriate triage at the point of call, unexpected patient deterioration may have occurred during the time between referral and arrival of NEPT. If any clinical criteria are present on arrival that indicate that the patient should be regarded as a high risk time critical patient, then an immediate referral to AV communications (by phoning 000) must be made for advice. In the absence of appropriate medical care and/or interventions, should the patient require an emergency ambulance, NEPT health professionals are to commence and maintain applicable emergency care, within their scope of NEPT practice, while waiting for ambulance arrival.

If any high risk time critical criteria develop during transport, NEPT must consult with AV communications (by phoning 000 or via AV radio) and may be directed to either proceed to the nearest appropriate health service, or rendezvous with an emergency ambulance at a designated point. Furthermore, if the acuity level changes during transfer that would necessitate a change of skills required, then the NEPT employee should contact the licensed NEPT provider to seek advice.

The Regulations require that all NEPT providers ensure staffing of vehicles is appropriate to the clinical needs of the patients. In the event that a NEPT professional believes the patient's needs are beyond the capabilities of the attending crew (for example, a change in acuity level), contact should be made with the NEPT provider to seek advice.

Unplanned attendance at patient incident

In the normal conduct of NEPT activity, it is possible a NEPT provider will come across or be called for assistance. If the situation may require an emergency ambulance response, NEPT must contact AV communications (by phoning 000 or via AV radio) and provide a situation report, including any location details that will facilitate emergency ambulance attendance. A NEPT patient care record is required for such unplanned attendances.

Non-transport by NEPT providers

NEPT crews are not endorsed to independently decide that a patient is suitable for non-transport. If a patient refuses, or a crew considers a patient suitable for a non-transport care plan, the following must occur:

- two sets of observations should be documented at least 10 minutes apart, to identify any potential for short-term deterioration,
- the authoring requester must be contacted to discuss the circumstances, confirm that non-transport is appropriate and outline what further care the patient is being offered,
- the patient left with clear instructions as to when and who to call back, if required,
- the discussion with the authorising requester and the instructions for the patient clearly documented on the patient care record.

NOTE: The authorising requester can be the requesting hospital, medical practitioner and in the case of an NEPT provider working for and on behalf of AV, the Communications Clinician.

Base level of emergency care and equipment required

The Non-Emergency Patient Transport Regulations 2016 only mandates the following equipment: a shock advisory external defibrillator, portable oxygen, suction and a bag valve mask device. The regulations also recommend that a provider must ensure that any vehicle used to transport a patient carries all the equipment and supplies necessary to meet the patient's clinical needs for the duration of the transport.

Occasionally in rare events such as extreme weather, multiple drug overdoses, acts of terror, or multicasualty accidents, NEPT services may need to be engaged under SHERP arrangements. Accordingly, the following vehicle equipment is mandated: two arterial trauma tourniquets, pelvic binding capability, and cervical collars.

There is a growing incidence of anaphylaxis in the Victorian population and an associated societal expectation of all health care givers to have access to adrenaline for episodes of anaphylaxis. For this reason, all NEPT providers are required to carry an auto-injector or Adrenaline ampoules and train all staff to recognise the signs and symptoms of anaphylaxis and administer the appropriate dose in these cases.

Authority to practice

Health professional categories

The Non-Emergency Patient Transport Regulations 2016 set out the requirements for health professionals of NEPT services. In addition, the *Clinical practice protocols* describe the different levels of authorised practice for the different types of NEPT health professionals.

The different types of NEPT health professionals include:

- ambulance transport attendant (ATA)
- patient transport officer (PTO)
- enrolled nurse (EN)
- registered nurse division 1 (RN1)
- registered nurse division 1 with critical care qualification (RN1 CC).

Health professionals categorised as a registered nurse division 1 with a critical care qualification require a critical care qualification *and* experience in the intensive care unit, coronary care unit, emergency department or equivalent unit of a hospital within the preceding 24 months. The authorised practice for each type of health professional, applicable to the management of patients with certain types of symptoms, is described in Scope of Practice matrix.

It is the responsibility of NEPT providers to ensure that their staff have the minimum qualifications as shown in the table below. Further, providers must ensure that staff maintain registrations with any applicable state or national professional registration authority.

Staffing qualifications

Classification	Minimum professional qualification
Patient transport officer	Certificate 3 in Non-Emergency Patient Transport*
Enrolled nurse division 2	Diploma of Nursing*
Ambulance transport attendant	Diploma of Paramedical Science*
Registered nurse division 1	Bachelor of Nursing*
Registered nurse division 1 critical care	Graduate Certificate in Critical Care Nursing*

Medication administration

Scope of practice

It is not permissible for NEPT employees to administer any fluids or medications outside their individual credentialed scope of practice, unless there has been consultation with a registered medical practitioner or the AV Clinician if the case is undertaken for and on behalf of AV or is an emergency situation. For all medications that are administered, the NEPT employee must sight the original medication order and provide a legible photocopy of the original medication order with the NEPT patient care record, or if given under consult, record the details of the consultation including name, contact number, level of credentialed practice and employer. This includes consultation with the AV Clinician.

If a patient requires or may require administration of a medication during transfer outside these protocols, then a registered nurse or registered medical practitioner escort from the sending health service is required. A registered nurse or registered medical practitioner employed by the sending health service who is escorting the patient may carry and administer any medications or perform any therapeutic procedures that are within their scope of practice in their sending health service. In addition, a registered medical practitioner employed by a Licensed NEPT provider, can obtain and use any medicine for use in the lawful practice of his/her profession (*Medications Poisons and Controlled Substances Act, 1981*).

Staffing requirements

The minimum staffing requirements for the variety of NEPT patient acuities and transport platforms are determined by the *Non-Emergency Patient Transport Regulations (2016)* and summarised in Appendix 2.

Table 1: Authority to practice matrix*

NB. Please consider this table in light of the Scope of Practice as outlined in pages 12 – 14.

Symptom	PTO, EN, ATA/AO, RN1, RN1 CC	EN, ATA/AO, RN1, RN1 CC	RN1, RN1 CC	RN1 CC
Breathing difficulty	• Oxygen	• Salbutamol • Ipratropium Bromide (Atrovent)		
Cardiac arrest	• Semi-automatic external defibrillator			
Cardiac chest pain and monitoring		• Aspirin, Methoxyflurane • Glyceryl trinitrate (GTN) - sub lingual • ECG Monitoring		• Pacing wire
Hypoglycaemia	• Glucose paste	• Glucagon1		
Pain relief		• Methoxyflurane	• Analgesia[2,3]	
Neurological examination	• Glasgow Coma Scale (GCS)[4]			
Maintenance of medication administration	• Narcotic infusion (subcutaneous)3	• Intravenous (IV) Crystalloid • GTN Infusion • Heparin Infusion • Blood Products[7] • IV Crystalloid with potassium added[8] • Antibiotics[5]	• Narcotic Infusion IV[2]	• Vasoactive medications[6] • Anti-arrhythmic medication infusion (amiodarone or lignocaine)
Other treatments	• Capped Central Venous Catheter (CVC) for low acuity patients[9] • Peripherally inserted central catheter (PICC) that is not in active use	• Total parenteral nutrition via PICC[12] • Chemotherapy infusion[14]	• CVC[10] • Intercostal catheter(ICC)[16] • Total parenteral nutrition via CVC[12] • Insulin infusion[13] • IV cannulation[15] • Bladder washout	• Arterial line • Intra-aortic balloon pump[11]

**Practice items are read cumulatively from left to right*

Interpretive notes for Table 1

1. Selective authorisation – pre-existing annual competency.
2. An IV infusion of an analgesic (by IV pump or patient controlled analgesia device) may be maintained during transport provided that:
   - the infusion consists of a narcotic, with or without ketamine
   - the patient has been clinically stable on the infusion for at least one hour prior to transport
   - for all medications that are administered, the NEPT employee must sight the original medication order, in addition to providing a legible photocopy of the original medication order in the NEPT patient care record
   - the medication order includes the amount of medication(s) added to a volume and type of fluid, and clinical parameters for the withholding or cessation of the infusion
   - for IV pump infusions, the infusion dose range must be prescribed and may be adjusted according to patient need. No bolus dose may be given during transport.
3. A subcutaneous infusion of an analgesic may be maintained during transport by all NEPT staff provided that:
   - the patient has been clinically stable on the infusion for at least one hour prior to transport
   - there is no expectation that the licensed NEPT provider will be required to adjust the dose of the medication or change the syringe or IV infusion flask.
4. PTOs are able to use the GCS to assess conscious state when they have been assessed as competent in the use of this tool by a Registered Training Organisation or through in-service training or competency assessment by the Licensed NEPT provider that employs them.
5. The administration of an antibiotic is only permissible if:
   - the transport is prolonged and it is not feasible or medically appropriate to administer the antibiotic prior to or following the transport
   - for all medications that are administered, the NEPT employee must sight the original medication order, in addition to providing a legible photocopy of the original medication order in the NEPT patient care record
   - the medication order includes the dose of the medication, the rate of administration, and the volume and type of diluent (if needed)
   - the antibiotic has been administered within the preceding 24 hours without adverse effect.

6. The administration of vasoactive medications (dobutamine, adrenaline, noradrenaline, isoprenaline) is only permissible if:
   - the patient has been clinically stable on the infusion for at least one hour prior to transport
   - for all medications that are administered, the NEPT employee must sight the original medication order, in addition to providing a legible photocopy of the original medication order in the NEPT patient care record
   - the medication order includes the amount of vasoactive medication added to a volume and type of fluid, the range of rate of administration, and the target blood pressure.
7. The administration of blood products (packed cells, fresh frozen plasma or platelets) is only permissible if:
   - the indication for packed red cells is chronic anaemia, with no evidence of acute blood loss, or hypotension (<100 mmHg) or tachycardia (>100/min); and
   - the patient has been stabilised on the blood product infusion for at least 30 minutes prior to transport
   - for all medications that are administered, the NEPT employee must sight the original medication order, in addition to providing a legible photocopy of the original medication order in the NEPT patient care record
   - the medication order includes the blood product, and rate of infusion; and
   - the cross match form is sighted by the licensed NEPT provider, and the identification number of the blood product is noted on the NEPT patient care record; and
   - no new bag of any blood product may be commenced during transport; and
   - at the conclusion of the infusion, the line may be flushed with normal saline (supplied by the sending hospital) at a rate specified by the sending registered medical practitioner; and
   - infusions of colloid (such as albumin or gelatin) must be replaced with crystalloid (without additives) prior to transport.
8. Any IV infusion with additives requires administration via a pump device (note: Hartmann's solution contains potassium, but in physiological concentration, and therefore does not need a pump device).
9. The transport of patients with a CVC, who otherwise meet the criteria of low acuity are able to be transported as low acuity. Catheters shall not be in active use during transport and be capped, locked and secured. A PICC or femoral vein catheter line has minimal risk of air embolism and may therefore be regarded as a peripheral venous catheter.
10. There is a risk of air embolism if disconnection of a CVC in active use occurs, therefore a RN1 must supervise a patient meeting this criteria.
11. An intra-aortic balloon pump must be supervised by either an appropriate medical perfusionist or RN1 CC nurse (who has current (annual) competency in the make and model of the balloon pump being used), and a registered medical practitioner.
12. Total parenteral nutrition is administered either via a CVC or PICC. In either case, the solution must be administered using a pump device. The rate of infusion must not be changed during transport.

13. The administration of insulin by infusion is only permissible if:
    - the patient has been clinically stable on the infusion for at least one hour prior to transport

- for all medications that are administered, the NEPT employee must sight the original medication order, in addition to providing a legible photocopy of the original medication order in the NEPT patient care record
- the medication order includes the amount of insulin added to a volume and type of fluid and the rate of administration
- a glucometer (or similar device) is available at all times during the transport to enable measurement of blood sugar, along with the availability of both glucose paste and glucagon.

14. An infusion of chemotherapy delivered via an ambulatory pump or equivalent, which is low risk of potential complications, may be transported by all staff levels provided there is no expectation of any management of the infusion by NEPT staff. The NEPT vehicle must have a cytotoxic waste spill kit. Staff should have annual competency training on the management of spills of either agent or body fluids that contain cytotoxic agents.
15. If deemed clinically necessary, an RN1 with current competency in IV cannulation may replace an existing IV cannula that has occluded during transport. In the event of failed attempts proper consideration must be given to the need for the cannula, patient comfort and the preservation of viable cannulation sites.
16. Prior to transport, a chest x-ray must be performed following insertion of ICC to confirm correct placement of tube.

Time critical patients

The *Non-Emergency Patient Transport Regulations 2016* refer to patients whose 'condition is time critical' or whose 'condition is likely to become time critical during transport' as not suitable for NEPT. To provide further information to assist decisions regarding patients that are 'time critical', Table 2 below identifies symptoms and characteristics of patients that are considered time critical as well as symptoms and characteristics that are not considered time critical. Health professionals who are responsible for assessing the suitability of patients for transfer by NEPT need to consider the time critical nature of the symptoms and characteristics along with other factors. Patients with time critical symptoms and characteristics are not suitable for NEPT unless specific exceptions are noted in the Table 2 below.

Furthermore, while taking into account the variety of clinical conditions and range of acuities of patients that may be serviced by licensed NEPT providers, the types of conditions described in this section are not exhaustive. It is therefore accepted that NEPT health professionals continue to use their clinical judgment (within the authority to practice of these protocols) in applying these guidelines. In addition, while the Non-Emergency Patient Transport Clinical Practice Protocols will be updated regularly, it is expected that NEPT health professionals remain up to date on changes to clinical practice and protocols, using their clinical judgment when the Non-Emergency Patient Transport Clinical Practice Protocols are no longer recognised as current best practice.

Significant pain does not necessarily make the patient time critical. Patients requiring pain relief may be transported if the pain relief required is within the authority to practice as described in Section 3 and the pain relief protocol in Section 8.4. Pain relief that may be required during transport needs to be documented prior to transfer including authorisation of the treating registered medical practitioner if applicable. For all medications that are administered, the NEPT employee must sight the original medication order, in addition to providing a legible photocopy of the original medication order in the NEPT patient care record.

Table 2: Time critical level of risk

Symptom	NOT TIME CRITICAL Suitable for NEPT	TIME CRITICAL Not suitable for NEPT
Perfusion status • Blood pressure (BP) • Heart rate • Skin • Conscious state	• A patient with known chronic (>24 hours) hypotension who has no other signs of poor perfusion. • A patient with acute (<24 hours) hypotension, which is usual for the patient (e.g. after renal dialysis). • A patient with known chronic (>24 hours) bradycardia or tachycardia who has stable blood pressure. • A patient with a temporary pacing wire to treat bradycardia can be transported.	Decreased perfusion: • BP <100 mmHg systolic • Heart rate <50 or >100 bpm excluding those patients previously defined as medium acuity.
Respiratory status • Rate • Appearance • Ability to speak • Noises • Skin colour • Conscious state • Heart rate	• Patient's respiratory status is normal or has been confirmed as normal for their condition by their treating medical practitioner. For example, history of chronic obstructive pulmonary disease. • Respiratory rate and/or heart rate are borderline readings compared to normal values and the patient may appear distressed as a result of the patient's transfer to the stretcher and/or vehicle. In this instance the borderline readings are not sustained or further deteriorating.	RR >20 or <8 breaths/min and HR > 120bpm (AV, 2014) and one or more of the symptoms of severe respiratory distress where onset is within last 24 hours.
Conscious state - Glasgow Coma Scale (GCS) • Eye opening • Verbal response • Motor response	• Alert and oriented. • A patient with documented chronic (>24 hours) altered conscious state (e.g. severe dementia) who has no signs of acute deterioration (GCS changed by >2 points).	Acute deterioration of GCS (>2 points) in preceding 24 hours. *Exception:* Mechanically ventilated high acuity patients with a GCS <13 who have a registered medical practitioner escort may be transported via NEPT where authorised by the treating medical practitioner.
Chest pain/acute coronary syndrome	• A patient with a suspected coronary syndrome who has post Percutaneous Coronary Intervention (PCI) inflation pain only (i.e. pain is not supported by an enzyme rise and/or ECG changes). • A patient who normally self-administers GTN for chest pain and whose pain has fully resolved within 2 hours of the onset of pain. • A patient with identified/diagnosed non-urgent chest pain.	• A patient over the age of 20 years with chest pain which could be of cardiac cause and who still has pain after their usual medication. • A patient who has failed to re-perfuse with thrombolytic therapy and requires immediate transfer for PCI. • A patient who has undergone coronary angiography and requires transfer for immediate cardiac surgery (e.g. because of coronary artery dissection or other immediate life threat). coronary syndrome who has ischaemic chest

	• A patient with diagnosed non-ST segment elevation myocardial infarction (NSTEMI) who has been haemodynamically stable for > 2 hours and does not require pain relief including GTN.	pain within the two hours prior to transfer and where the medium risk factors are not applicable.

Symptom	NOT TIME CRITICAL Suitable for NEPT	TIME CRITICAL Not suitable for NEPT
Suspected stroke	A patient whose stroke symptoms and conscious state are stable and a registered medical practitioner has evaluated the patient.	A patient with onset of acute stroke symptoms within 4.5 hours. *Exception:* Where a registered medical practitioner has evaluated the patient and determined that the patient is stable and suitable for NEPT.
Headache	• Normal presentation of headache symptoms for this patient. • A patient where sub-arachnoid haemorrhage has been ruled out by appropriate investigations or a registered medical practitioner has made an alternative diagnosis. • A patient with an undiagnosed headache, where a registered medical practitioner has approved the use of NEPT so that the patient can be transported for further testing. • A patient with a diagnosed subdural or sub-arachnoid haemorrhage where a registered medical practitioner has assessed the patient as haemodynamically stable.	A patient with an undiagnosed headache where the treating medical practitioner suspects acute intracranial pathology.
Spinal cord injury	• A patient where spinal cord injury has been ruled out by appropriate investigations or a registered medical practitioner has made an alternative diagnosis. • A patient with a diagnosed spinal cord injury where a registered medical practitioner has approved the use of NEPT so that the patient can be transported for further management. • A patient with an acute undiagnosed spinal cord injury where a registered medical practitioner has approved the use of NEPT so that the patient can be transported for further investigations and/or management.	• A patient with undiagnosed neurological symptoms where the treating registered medical practitioner suspects spinal cord injury.

Symptom	NOT TIME CRITICAL Suitable for NEPT	TIME CRITICAL Not suitable for NEPT
Abdominal and back pain of a non-traumatic nature	• Back or abdominal pain in patient <60 years. • A patient over 60 years with acute abdominal pain (<24 hours) where a registered medical practitioner has excluded the diagnosis of an aortic aneurysm. • A patient over 60 years with acute abdominal pain (<24 hours) where a registered medical practitioner has approved the use of NEPT so that the patient can be transported for further testing.	A patient over 60 years with sudden onset, severe acute abdominal pain (<24 hours) when the diagnosis of aortic aneurysm has not been excluded.
Suspected meningococcal septicaemia		A patient with evidence of septicaemia +/- a rash suggestive of this condition.
Obstetric		• A patient with vaginal bleeding in the third trimester • A patient in active labour.
Palliative care	Regardless of time critical criteria, palliative care patients with a pre-existing terminal illness and not for advanced life support, may still be transported by NEPT, provided an NFR order (or equivalent), ACP or ROTC is sighted by the NEPT staff. If such documentation is not sighted, then NEPT staff must advise the sending health service they will treat the patient should it be necessary.	
Trauma	• A patient who does not meet the criteria for potential major trauma (see Trauma Time Critical Guidelines in Section One). • A potential major trauma patient who has been assessed by a registered medical practitioner as being stable for transport. The medical practitioner must consult with ARV for all potential major trauma patients prior to authorization of NEPT.	• Patients with criteria for potential major trauma (see Trauma Time Critical Guidelines in Section One). • All Adult Retrieval Victoria (ARV) patients. *Exception:* Unless the consulting retrieval physician specifically approves the use of NEPT • Paediatric patients meeting criteria for potential major trauma. • All Paediatric Infant Perinatal Emergency Retrieval (PIPER) patients unless the consulting retrieval physician specifically approves the use of NEPT.

Patient Acuity

The Non-Emergency Patient Transport Regulations 2016 set out the classes of transport service based on the acuity (low, medium, high) of the patient and the type of transport (road or air). These include a description of the patient characteristics for low, medium and high acuity. In addition to these descriptions, these protocols describe further features of acuity. These are detailed in Table 3 below. The acuity is to be decided in conjunction with the interpretive notes attached to Table 3.

Furthermore, while taking into account the variety of clinical conditions and range of acuities of patients that may be serviced by licensed NEPT providers, the types of conditions described in this section are not exhaustive. It is therefore accepted that NEPT health professionals continue to use their clinical judgment (within their authority to practice) in applying these protocols.

Patient acuity needs to be assessed by an appropriate health professional:

- Low acuity patients require assessment by an appropriate health professional (as described below) that the patient is suitable for low acuity NEPT transport.
- Medium and high acuity patients require assessment by a registered medical practitioner that the patient is haemodynamically stable.
- The appropriate health professional is expected to determine that the transport is clinically necessary.

In the context of these protocols, an appropriate health professional is one of the following:

- a RN1 who has examined the patient; or
- a registered medical practitioner who has examined the patient; or
- an AV Clinician who has determined that the patient complaint is not urgent, based on a discussion with the patient or an RN1 or registered medical practitioner who has seen and examined the patient; or
- a paramedic or RN1 working for AV's telephone referral service who has triaged the patient to NEPT according to medically approved triage guidelines; and
- a mental health practitioner, if applicable.

A mental health practitioner is any of the following who is employed or engaged by a designated mental health service: a registered psychologist; registered nurse; social worker; or registered occupational therapist.

Definition of low acuity patient

A low acuity patient is a patient who has one or more of the following conditions—

(a) impaired cognitive functioning requiring supervision;

(b) if the patient is not transported by an aeromedical service, chronic diagnosed shortness of breath in relation to which there has been no recent change.

In general, **low acuity** patients may either walk to the vehicle/stretcher or require some assistance with manual handling as provided by one or two PTOs, and require monitoring and intervention limited to the PTO skills in Table 1, page 81. If transported by air, they should be accompanied by one ATA/AO as a minimum.

Definition of medium acuity patient

A medium acuity patient is a patient who requires—

(a) active management or intervention; or

(b) specialised equipment requiring monitoring; or

(c) observation and monitoring of an intravenous infusion that does not contain any vasoactive agent other than glyceryl trinitrate.

In general, **medium acuity** patients may require some assistance with manual handling as provided by one ATA/AO or an ATA/AO and a PTO, and require monitoring and intervention limited to the ATA/AO skills in Table 1, page 81. Some medium acuity patients will require an RN1 skillset. If transported by air, they should be accompanied by one ATA/AO or RN1 as a minimum, with consideration given to how the patient will be unloaded at the receiving end of the journey.

Definition of high acuity patient

(1) A high acuity patient is a patient who requires—

(a) active management or intervention; and

(b) one or more of the following—

(i) cardiorespiratory support;

(ii) a higher level of care than that required for the transport of a medium acuity patient;

(iii) observation and monitoring of an intravenous infusion that contains vasoactive agents;

(iv) transport by PIPER's neonatal emergency transport service, PIPER's paediatric emergency transport service or ARV, excluding patients who have received treatment and are being returned to their home or transported to another facility.

In general, **high acuity** patients will require manual handling as provided by a PTO and an ATA/AO as a minimum, and require monitoring and intervention to the level of RN1 or RN1 CC as per table 1, page 81. High acuity patients may be transported by a PTO and ATA/AO or a single PTO if an escort from the sending facility (nurse or medical officer), or if an escort from ARV or PIPER is accompanying them. If transported by air they require a minimum of an ATA and an escort from the sending facility (nurse or medical officer), or an escort from ARV or PIPER.

In all patient acuity types, the skill-set should be checked against table 1, page 81 to ensure that the appropriately qualified skill-set is requested to accompany the patient.

Table 3: Patient acuity

	LOW ACUITY	MEDIUM ACUITY	HIGH ACUITY
Example Patient Types	• Permanent tracheostomy patients (> 3 months) breathing spontaneously with no treatment required, with/without need for oxygen, and all other factors low acuity (breathing problems not the reason for transport) • A patient being transported who requires clinical assistance and/or supervision during the transport • Persons with mental illness that are not under sedation	• Patients requiring oropharyngeal suctioning for a chronic condition where there is no compromise of the patient's airway • Permanent tracheostomy patients breathing spontaneously who may require infrequent suctioning • Persons with mental illness that require monitoring or management at a health service • Patients with a fully assessed neurologic event who are stable being referred for further investigation/return or admission • Patients with an IV Patient Controlled Analgesia (PCA) pump • Patients with stable atrial fibrillation, including those at a residential care service • Patients with musculo-skeletal pain requiring methoxyflurane for transport or transfer to stretcher	• Patients requiring oropharyngeal suctioning for a complex condition where the patient's airway may be compromised • Non-permanent tracheostomy patients, who are breathing spontaneously[1] • Patients with mechanical circulatory support[2,3] • Persons with mental illness that require monitoring, management or intervention at a health service
Patient Condition	• A patient with documented chronic (>24 hours) altered conscious state (e.g. severe dementia) who has no signs of acute deterioration (GCS changed by >2 points) • Chronic diagnosed shortness of breath – may need oxygen during transport • Inability to travel in a normal seated position • Inability to walk more than a few steps unaided	• Home ventilation patients[4] • May require cardiac or other type of monitoring • Intercostal or CVC (as defined in Section 3, Table 1) • Recent fracture of the spinal column where there is not spinal cord involvement • IV infusion managed by the patient or visiting nurse • IV infusion of crystalloid fluid, containing glyceryl trinitrate or heparin using (an) infusion pump • IV infusion of crystalloid fluid, with or without an infusion pump (non-vasoactive)	• Patients with an illness or injury which requires active monitoring or treatment by a registered nurse or registered medical practitioner • Mechanical ventilation patients[5] (not home ventilation) • Intravenous infusion of a vasoactive medication • Central or arterial line in active use for monitoring or therapy • Patient of PIPER or ARV

	LOW ACUITY	MEDIUM ACUITY	HIGH ACUITY
Multiple patients	• Multiple patients in one transfer can occur. However, when one patient is unloaded and transferred into a health facility, the comfort and security of the other patients must be considered • Note that patients who are potentially infectious with diseases (see Infectious disease below) must not be transported with other patients • Patients may only be left unattended in a NEPT vehicle if: o The patients are cognitively stable, and agree to be left unattended. o The cabin temperature is comfortable with the vehicle engine not running	Two of the following medium acuity patients may be multi-loaded by road: • where observation and monitoring of an intravenous infusion of a crystalloid fluid, with or without an infusion pump is required • where care of an ICC or CVC is required Note that patients who are potentially infectious with diseases (see Infectious disease below) must not be transported with other patients. Medium acuity patients who are multi-loaded, **must not be left unattended** in the vehicle	High acuity patients cannot be multi-loaded
Infectious disease	• Patients who are potentially infectious with diseases (such as influenza, measles, mumps or TB), or colonisation with multi-resistant organisms (such as MRSA, VRE, MDR-TB or CRE) must not be transported with other patients (Department of Health, 2012) • Following the transport of such patients, the vehicle must be cleaned and disinfected in accordance with standard infection control practices[7]	As per low acuity[7]	As per low acuity[7]

Interpretive notes for Table 3

1. Tracheostomy patients may be transported by a RN1 CC provided that the tracheostomy was performed more than five (5) days prior to transfer. For patients within five (5) days, a registered medical practitioner who has the appropriate skills and equipment to undertake the task of tracheal tube replacement or intubation must accompany the patient.
2. For patients with an intra-aortic balloon pump, extra-corporeal membrane oxygenation or similar circulatory support device, careful consideration of the potential for patient instability needs to be given by the approving registered medical practitioner. In particular, there must be awareness of the possible delay in arrival at the receiving hospital given the inability of NEPT to travel as an emergency vehicle.
3. All patients with mechanical circulatory support must have either an appropriate medical perfusionist or RN1, and registered medical practitioner escort. The circulatory assist device must be loaded by the NEPT staff or with an appropriate lifting device, as medical and nursing staff at the sending or accepting hospital will be unable to assist with the manoeuver of equipment into the vehicle.
4. NEPT staff must be able to perform tracheal suctioning, connection of the ventilator to the tracheostomy (if the patient can't) or connection of a bag or valve device to the tracheostomy for the administration of ventilation should the ventilator fail.
5. All NEPT high acuity mechanically ventilated patients must be accompanied by a registered medical practitioner who has the appropriate skills and equipment to undertake this task.
6. Licensed NEPT providers need to consider the space requirements for safe working practice when multi-loading patients with equipment.
7. Standard precautions should be used at all times and this includes: hand hygiene; use of protective equipment such as gloves and eye protection when necessary; appropriate cleaning; and respiratory/cough etiquette. Good hand hygiene, including the use of alcohol based hand rubs, is critical. This should be performed at a minimum before and after touching patient and patient equipment.

NEPT Patient Care Record

Licensed NEPT providers are required to maintain a NEPT patient care record for the range of services they provide including transfers to and from health services or day procedure centres and home or residential care services, inter-hospital transfers, public event duties and deployment required under SHERP. In addition, attendance at unplanned patient incidents also requires a NEPT patient care record. This section sets out the requirements for NEPT patient care records and handover. The NEPT patient care record should also be maintained in accordance with the licensed NEPT providers' records management practices.

As described in Section 1, each licensed NEPT provider must have a system of audit in place to identify and review any variations to routine care. This system should form the basis of the clinical risk management and quality improvement program of each provider. Variations to routine care, as described in Section 1, should be submitted to the department.

Patient record requirements

Patient acuity

For low acuity patients, the NEPT patient care record must include a brief description of the clinical features that confirm that the patient is low acuity. Unless otherwise clinically indicated, the measurement and recording of vital signs is not required. The name and contact details of the appropriate health professional (if applicable) who assessed the patient as stable for the duration of the transport needs to be noted in the NEPT patient care record.

For medium acuity patients, the NEPT patient care record must include a brief description of the clinical features that confirm that the patient is medium acuity and the name and contact details of the registered medical practitioner and appropriate health professional (if applicable) who assessed the patient as stable for the duration of the transport.

For high acuity patients, the NEPT patient care record must include a brief description of the clinical features that confirm that the patient is high acuity and the name and contact details of the registered medical practitioner and appropriate health professional (if applicable) who assessed the patient as stable for the duration of the transport. The names and contact details of the registered nurse or registered medical practitioner escort or the staff member of PIPER or ARV must also be recorded, if applicable.

Measurement of vital signs must occur prior to transport and on arrival at the receiving facility. Vital signs are to be recorded at minimum half-hourly intervals (15 minutely if a CPP is used and more frequently if the patient is unstable) or as designated by the sending health service or registered medical practitioner that authorised NEPT. When transporting a patient who is receiving services for a mental illness and who has not received sedation, behavioural observations only should be recorded half-hourly for the duration of the journey.

Medication administration

For all medications that are administered, the NEPT employee must sight the original medication order, in addition to providing a legible photocopy of the original medication order in the NEPT patient care record, or if given under consult record the details of the consultation including name and registration or employee number of the authorising person.

NFR, ACP or ROTC

For home to hospital transfers, documentation of an NFR (or equivalent), ACP or ROTC that states that cardiopulmonary resuscitation be withheld, may be sighted, or it may be accepted in good faith by those present at the scene that this document exists. If copies of such documentation are available, they should be included in the NEPT patient care record. If documentation is not available, then the NEPT health professionals must record full details of the information given to them and by whom regarding the patient's wishes. If a substitute decision maker is nominated (usually a person with enduring power of attorney (medical treatment), this person's details should also be noted in the NEPT patient care record. If there is any doubt about the patient's wishes for CPR, the default position of continuing CPR should be adopted.

For inter-hospital transfer or hospital to home transfer, copies of relevant documentation must be provided by the sending health service and included in the NEPT patient care record. Where a copy is not obtained, the NEPT crew must advise the sending health service that they will treat the patient should it be necessary.

Audit and record requirements

Each licensed NEPT provider must have a system of audit in place to identify and review any variations to routine care. This system should form the basis of the clinical risk management and quality improvement program of each provider.

Variations to routine care should be submitted to the Department as indicated below.

Patient care records for the following circumstances must be forwarded to the Manager, Private Health Services Regulation Unit, and of Health and Human Services, for review:

Specifically instances as described at https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/clinical-risk-management/sentinel-event-program

- death of a patient (immediately)
- significant patient risk (immediately).
  - A significant risk is one where there is a high probability of a substantial and demonstrable adverse impact. In each case a significant risk will be sufficiently serious to warrant an immediate response to reduce the risks to patients. This may include interventions or changes to systems, clinical care or clinical practice (Australian Commission on Safety and Quality in Health Care, 2012).
- any case where a patient has suffered cardiac arrest during NEPT care whether or not the patient has a 'not for resuscitation' or 'refusal of treatment' certificate (quarterly)
- any transfer of a patient with mechanical circulatory assist device (quarterly)
- any case where an NEPT crew consult for and are authorised to provide treatment outside their individual authority to practice
- any adverse event (quarterly).
  - An adverse event for the purposes of this document is defined as any unplanned event resulting in, or having the potential to result in, injury to a patient or an unintended outcome. It isn't necessary that any harm actually occurred, or that there was a mistake or error (Department of Health, 2011).

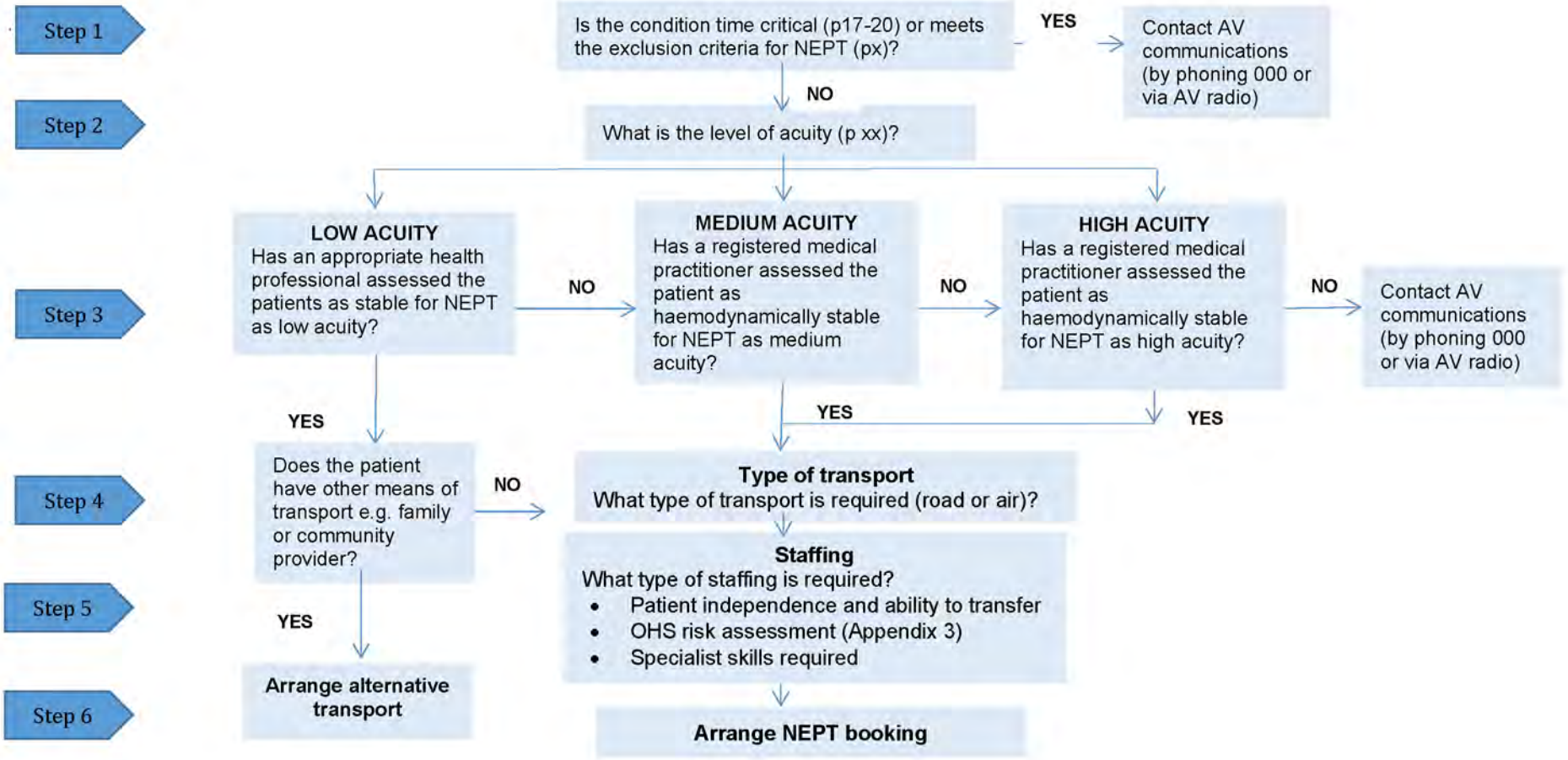
Please forward records to:

The Manager
Private Health Services Regulation Unit
Department of Health and Human Services
19/50 Lonsdale Street
Melbourne VIC 3000

Section Six: Appendices

Appendix 1: Assessment of a patient for a NEPT service

This protocol applies to transfers to and from health service or day procedure centre and home or residential care service, and IHT.



Appendix 2: Mental Health Patients

Key message

These protocols have been updated to reflect the recent amendment to the *Non-Emergency Patient Transport Regulations 2016* regarding the transport of patients with mental illness. This amendment aligns with changes to the *Mental Health Act 2014.*

The objective of the *Mental Health Act 2014* is to ensure that assessment and treatment of persons with mental illness are provided in the least restrictive way possible. Transport for persons with a mental illness should be arranged in the most timely and least restrictive way possible. This includes travelling in a private vehicle or mental health agency car rather than a stretcher vehicle if appropriate, and travelling in a NEPT vehicle rather than an emergency ambulance if appropriate.

Changes to these protocols now reflect this 'least restrictive' principle. They have been amended so that persons receiving services for a mental illness, who are assessed as stable and suitable for transport according to the criteria in the *Non-Emergency Patient Transport Regulations 2016* and these protocols may be transported by NEPT services regardless of:

1. the departure and arrival points of the transport
2. the level of acuity; (persons with a mental illness may now be transported by low acuity NEPT services if appropriate)
3. whether restraint and significant sedation, or repeat doses of sedation, may be required.
   (As NEPT providers cannot use restraint or sedation, this would only be permitted where the requirements of the *Mental Health Act 2014* are met. For example, if the person is accompanied by an authorised person (under the *Mental Health Act 2014*) who takes responsibility for the use of restraint, or by someone authorised to administer sedation).
4. whether they are compulsory (formerly called involuntary) patients.

Authorised persons under the *Mental Health Act 2014*

Under the *Mental Health Act 2014*, Authorised Persons include paramedics working for Ambulance Victoria, police officers and registered medical practitioners employed or engaged by a designated mental health service or a mental health practitioner. A mental health practitioner is any of the following who is employed or engaged by a designated mental health service: a registered psychologist; registered nurse; social worker; or registered occupational therapist.

Authorised persons have particular powers under the Act to:

- use bodily restraint and sedation to enable a person to be safely taken to or from a designated mental health service or any other place. Bodily restraint may only be used if all reasonable and less restrictive options have been tried or considered and have been found to be unsuitable and the restraint is necessary to prevent serious and imminent harm to the person or to another person. The use of restraint must be documented by the person who used the restraint in accordance with their organisation's records management practices;
- search a person who is subject to transport under the *Mental Health Act 2014* if they suspect that the person is carrying something that could help the person to escape or that presents a danger to health and safety;
- seize and detain items that could be used to help the person escape, or is a danger to health and safety.

Sedation for safe transport

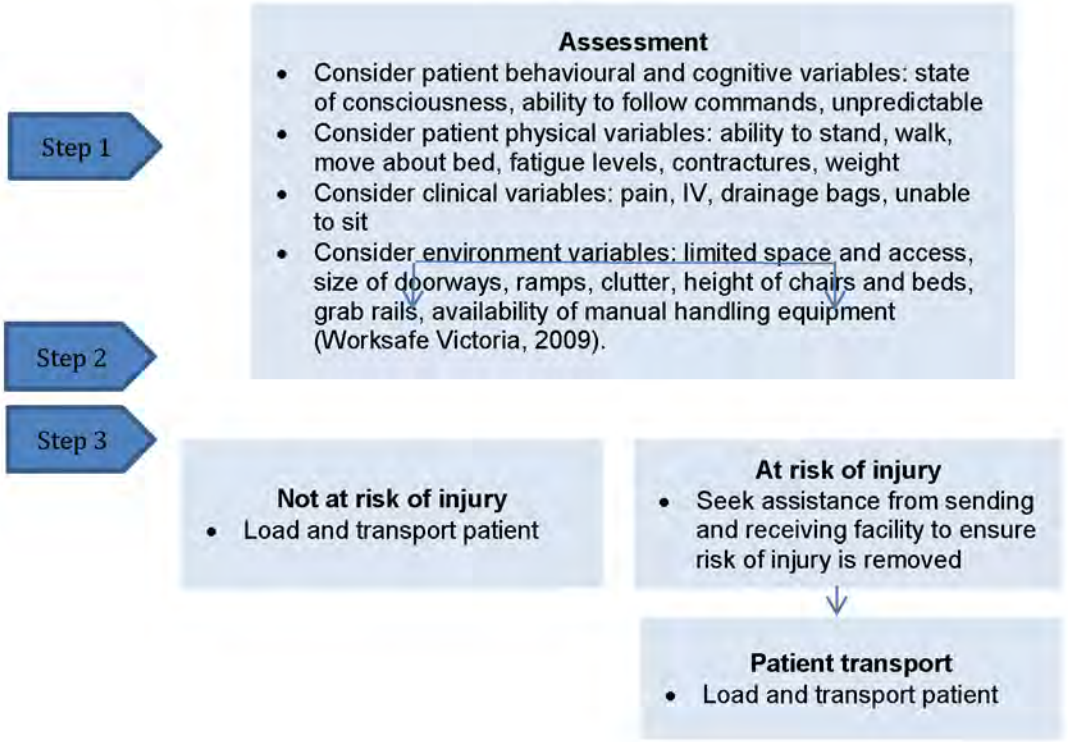
Under the *Mental Health Act 2014*, a registered medical practitioner can administer sedation to enable a person to be safely taken to or from a designated mental health service or any other place if all reasonable and less restrictive options have been tried or considered and found to be unsuitable and if the sedation is necessary to prevent serious and imminent harm to the person or to another person. The registered medical practitioner may direct a registered nurse or ambulance paramedic (as an authorised person under the *Mental Health Act 2014*) to administer the sedation.

The use of sedation must be documented by both the person prescribing and the person administering the sedation in accordance with their organisation's records management practices.

Further information on the changes to these protocols to reflect the Mental Health Act is available at: http://www.health.vic.gov.au/ambulance/nept.htm

And at: https://www2.health.vic.gov.au/mental-health/mental-health-services/transport-for-people-in-mental-health-services

Appendix 3: Risk assessment and management for loading a patient into a vehicle with a single operator



Royal Commission into
Victoria's Mental Health System

ATTACHMENT ST- 4

This is the attachment marked 'Mental Illness Transport Protocol for the transport of people with mental illness' referred to in the witness statement of "Simon Thomson" dated 24 June 2019.

Department of Health

health

Protocol for the transport of people with mental illness 2014

State Government Victoria

Protocol for the transport of people with mental illness 2014

If you would like to receive this publication in an accessible format please phone Mental Health Branch on 9096 8287 using the National Relay Service 13 36 77 if required, or email: mentalhealthreform@health.vic.gov.au

Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

This work is available at: www.health.vic.gov.au/mentalhealth

(1406008)

Foreword

This protocol provides guidance on the transport of people with mental illness, contributing to improvements in the delivery of services. It is designed to help health and mental health professionals, Ambulance Victoria, non-emergency transport providers, consumers and carers to arrange appropriate transport for people with mental illness.

This protocol replaces the *Ambulance transport of people with a mental illness protocol 2010*. It has been updated to reflect the *Mental Health Act 2014* (Act) and changes to transport practice.

The protocol is based on continuing the collaborative relationship between health and mental health professionals, Ambulance Victoria and non-emergency patient transport providers. These relationships are essential to providing high-quality services and transport to people with mental illness.

Additional copies of this protocol can be obtained online from www.health.vic.gov.au/mentalhealth

Greg Sassella
Chief Executive Officer
Ambulance Victoria

Pradeep Phillip
Secretary
Department of Health

Contents

Definition of terms used in this protocol

Act refers to the *Mental Health Act 2014*. Appendix 1 provides more information on the Act.

Ambulance paramedic/s refers to paramedics working for Ambulance Victoria (AV).

Ambulance Victoria (AV) refers to the Victorian state ambulance service, which provides all emergency ambulance services and some non-emergency patient transport.

Authorised person is defined under the Act as a:

- police officer
- ambulance paramedic
- registered medical practitioner employed or engaged by a designated mental health service
- mental health practitioner.

Bodily restraint means a form of physical or mechanical restraint that prevents a person having free movement of his or her limbs, but does not include the use of furniture (including beds with cot sides and chairs with tables fitted on their arms) that restricts the person's ability to get off the furniture.

Designated mental health service is a public hospital, public health service, denominational hospital, privately-operated hospital or a private hospital within the meaning of section 3(1) of the *Health Services Act 1998* that has been prescribed in the Mental Health Regulations 2014, or the Victorian Institute of Forensic Mental Health. Designated mental health services are listed at: http://health.vic.gov.au/mentalhealth/services/approved.htm

Mental health practitioner is any of the following employed or engaged by a designated mental health service:

- registered psychologist
- registered nurse
- social worker
- registered occupational therapist

Non-emergency patient transport (NEPT) refers to transport provided under the *Non-Emergency Patient Transport Act 2003* and Non-Emergency Patient Transport Regulations 2005. NEPT practice is guided by Clinical Practice Protocols published by the Department of Health.

Non-emergency patient transport (NEPT) staff refers to clinical staff employed by services operating under the NEPT regulations. NEPT staff includes doctors, registered nurses, ambulance transport attendants and patient transport officers.

Patient has a legal meaning under the Mental Health Act and refers to a compulsory, security or forensic patient. This should not be confused with the use of the word 'patient' by some transport providers to refer to all clients.

Registered medical practitioner means a person who is registered under the Health Practitioner Regulation National Law to practise in the medical profession other than as a student.

Executive summary

People with mental illness may need to be taken to or from a hospital or mental health service. Transport choices should be appropriate to the person and their circumstances and should use the least restrictive option possible.

The various transport options, including more detailed information about emergency ambulances and the role of police, are explored in this protocol to assist health and mental health professionals, transport providers, carers and people with mental illness to make appropriate transport decisions.

Mental health triage is generally the first point of contact for people with mental illness, their carers or others seeking assistance. Further information about mental health triage is located on page 10.

At times, emergency ambulances are the most appropriate transport option. Anyone can call for an emergency ambulance by dialling 000. The ambulance response time will be determined by the person's clinical needs and available resources. The 000 call takers may also refer callers to a secondary triage service to determine if an alternative response may be appropriate. See page 6 for more information.

The *Mental Health Act 2014* (Act) has resulted in significant changes in terminology and some changes in practice that will affect transport decisions. See page 12 for further information about the Act.

This document replaces the *Ambulance transport of people with a mental illness protocol 2010*. It is designed to reflect changes resulting from the Act as well as changes to Ambulance Victoria's (AV) practice.

Purpose

This document is designed to assist health and mental health services to provide transport for people with mental illness in the least restrictive way possible and to inform consumers and carers about transport options.

It outlines the range of transport options available, and provides more detailed information about the use of emergency ambulances, non-emergency patient transport (NEPT) and police assistance.

It complements the *Protocol for mental health – Department of Health and Victoria Police* (www.health.vic.gov.au/mentalhealth).

Where a proposed transport will cross a state border, additional guidelines may apply. Refer to www.health.vic.gov.au/mentalhealth/crossborder for guidance on cross-border mental health arrangements.

Key principles

Services should work collaboratively with the person, other services, practitioners, families and carers to facilitate the treatment and care of people with mental illness in the least restrictive way possible, supporting people to make and participate in decisions about their assessment, treatment and recovery.

The Act includes mental health principles that must be regarded by a person performing any duty or function or exercising any power under or in accordance with the Act, including the provision of transport. The mental health principles also represent good practice for working with any person with mental illness.

In summary, the mental health principles are:

- assessment and treatment should be provided in the least restrictive way possible
- service provision should aim to bring about the best possible therapeutic outcomes and promote recovery and participation in community life
- people receiving mental health services should be supported to make or participate in decisions about their assessment, treatment and recovery, including decisions that involve a degree of risk
- people receiving mental health services should have their rights, dignity and autonomy respected and promoted
- people's medical and other health needs should be respected and responded to
- people's individual needs should be recognised and responded to, including needs related to culture, language, communication, age, disability, religion, gender, sexuality or other matters
- the distinct culture and identity of Aboriginal and Torres Strait Islander persons should be recognised and responded to
- the best interests of children and young persons receiving mental health services should be recognised and promoted as a primary consideration
- dependents of people receiving mental health services should have their needs, wellbeing and safety recognised and responded to
- carers (including children) of people receiving mental health services should be involved in decisions about assessment, treatment and recovery wherever possible
- carers (including children) should have their role recognised, respected and supported.

Transport options

In all situations where a person requires transport to or from a designated mental health service or any other place, the decision about what form of transport is appropriate should be based on an assessment of the:

- person's mental and/or physical state
- person's immediate treatment needs to prevent serious deterioration in their physical or mental health, or serious harm to the person or to another person
- likely effect on the person of the proposed mode of transport
- availability of the various modes of transport, including private and NEPT vehicles
- distance to be travelled
- the person's need for support and supervision during the period of travel, including any potential safety issues
- expressed preferences of the person and/or their family or carer. Reasonable efforts should be made to help the person to make or participate in decisions about their transport and to transport them in the least restrictive manner possible.

Before arranging transport to a designated mental health service, a health or mental health professional should contact the receiving designated mental health service to make arrangements for the person to be received at the service. Contact details for mental health triage at each designated mental health service can be found at http://health.vic.gov.au/mentalhealth/services/index.htm.

The least restrictive transport option possible should be used. A range of transport options are described below.

Private vehicle

A private vehicle driven by a family member, carer or friend may offer the person a supportive and familiar form of transport. Consideration should be given to the willingness and ability of family members, carers or friends to provide safe transport, as well as the person's mental and physical state.

Taxi

Transport by taxi in the company of a family member, carer or friend may be appropriate for a person who needs to travel to or from a designated mental health service. Consideration must be given to the physical and mental state of the person and the availability and affordability of the taxi service.

Mental health service vehicle

Mental health practitioners have access to service vehicles and may transport people to or from a designated mental health service. Where the person does not require active monitoring or medical care and there are no perceived risks to the safety of the person or the mental health practitioners, agency vehicle transport may provide a less restrictive means of transport than ambulance or police vehicles.

In situations where a person is being transported to an inpatient service in a service vehicle, it is preferable that two mental health practitioners travel with the person, as driver and escort. A family member, carer or friend may also accompany the person in a service vehicle; however, consideration must be given to ensuring that the accompanying person has the means to return home.

Police may be able to provide an escort as a means of reducing the risk associated with transport in a service vehicle. If a police escort is arranged, clear expectations need to be established between

mental health practitioners and police regarding communication of the need for police intervention, the type of intervention required and the role of the mental health practitioners in the event of police intervention being required. The person remains the responsibility of the mental health practitioner and police will leave on arrival at the destination, provided it is safe to do so.

Non-emergency patient transport (NEPT)

NEPT may provide a more timely response than ambulance in non-urgent cases where NEPT is able to meet the clinical needs of the person.

NEPT includes high, medium and low acuity road and air transport. Low acuity services are staffed by Certificate III qualified patient transport officers. Medium acuity staffing includes at least one diploma qualified ambulance transport attendant or registered nurse with bridging qualification. High acuity staffing includes a registered nurse or registered medical practitioner.

Medium and high acuity NEPT transport must be authorised by a medical practitioner. Low acuity NEPT may be authorised by a medical practitioner, a nurse who has examined the patient, a mental health practitioner or paramedics or nurses working in ambulance triage and dispatch.

NEPT staff are not authorised persons under the Act and cannot use force or bodily restraint or administer sedation. However, NEPT may be used as a transport platform for a person requiring bodily restraint or sedation during transport, provided the person is accompanied by and in the care of someone authorised to undertake the restraint or sedation under the Act. The person administering the restraint or sedation is responsible for any associated documentation.

The NEPT Regulations and Clinical Practice Protocols can be accessed from:
http://health.vic.gov.au/ambulance/nept.htm

NEPT may be booked:

- by contacting a licensed provider (http://docs.health.vic.gov.au/docs/doc/List-of-NEPT-services-in-Victoria) or
- through Ambulance Victoria by calling **1300 366 313** (more information and booking form at: http://www.ambulance.vic.gov.au/About-Us/How-we-work/Non-Emergency-Transport.html).

Note on recent changes

The NEPT Regulations 2005 and Clinical Practice Protocols were changed in August 2014 to reflect the *Mental Health Act 2014*. The changes mean that persons receiving services for mental illness who are assessed as stable and suitable for transport according to the general criteria in the NEPT Regulations may be transported by NEPT services regardless of:

- the departure and arrival points of the transport
- the level of acuity
- whether restraint and sedation may be required during transport. As NEPT providers cannot use restraint or sedation, this is only permitted where the requirements of the Act are met, for example if the person is accompanied by an authorised person under the *Mental Health Act 2014* who takes responsibility for the use of restraint or a person authorised to administer sedation in accordance with the Act.
- whether the person is being transported under a provision of the Act or the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*.

Ambulance

An ambulance must always provide transport if the person's medical needs can only be met by an ambulance service.

Further information about calling for an ambulance is provided on page 6.

Police

Police transport should only be considered where a person cannot be safely transported by any other means. The experience of being apprehended and/or transported by police can be traumatic.

Less restrictive transport alternatives to police transport could include an ambulance with an accompanying mental health practitioner or police member in the ambulance.

Police procedures for transporting people with mental illness can be found in the *Protocol for mental health – Department of Health and Victoria Police*.

Calling for an ambulance in an emergency

What to expect

Anyone may call for an emergency ambulance by phoning 000 and requesting 'ambulance'.

The person requesting the ambulance should be prepared to answer questions such as:

- What is the exact address of the emergency?
- What is the phone number you are calling from?
- What is the problem, tell me exactly what happened?
- Are you with the patient now?
- How old is s/he?
- Is the person conscious?
- Is the person breathing?

Location

Calling from a fixed (as opposed to a mobile) telephone line automatically provides the call taker with the address of the telephone, so an ambulance can respond even if the caller cannot give accurate location details.

Health or mental health professionals calling from a different location to the person requiring the ambulance should ensure the call taker is told that the site of the emergency is different to the location of the caller.

Ambulance response time depends on clinical need and available resources. All calls are categorised according to urgency to ensure that ambulances reach incidents with an immediate threat to life first.

The 000 call takers ask a series of questions to determine urgency. When mental health practitioners call 000, they may be asked how long the person can wait based on their clinical situation. This is to determine whether there is an immediate threat to life, an urgent response to an acute mental illness is required or whether adequate care is currently being provided but the person needs to be transferred to another place. NEPT services may be used to respond to less urgent incidents.

All callers to 000 are requested to provide a contact number. At times, the clinician overseeing the ambulance call taking and dispatch process may need to contact the caller to ask further questions about the person's condition or advise the caller of any significant delays.

If a mental health practitioner is concerned about the impact of any delays on the person's clinical condition, they should request to speak to the AV clinician. If the practitioner still has concerns, they should contact the director of clinical services responsible for mental health services in that area (or their on-call delegate) who can discuss the situation with AV's group manager for the region.

In some circumstances, particularly in some rural areas, the person will need to be transported to the nearest appropriate designated mental health service for admission, rather than the catchment area service the person should normally be admitted to. This may occur where:

- the person's wellbeing might be adversely effected by a long distance transfer at that time, or
- a long distance transfer at that time might adversely affect the provision of acute ambulance care in the rural community from which the ambulance will need to be dispatched.

In such cases, it is expected that the ambulance service will have available, within 12 hours, suitable transport for the interhospital transfer to the appropriate catchment area service.

Any issues with ambulance response times may be referred to the region's Emergency Services Liaison Committee (ESLC) for review following the event (see page 11 for more information on ESLC).

Secondary triage

Where a request for ambulance attendance is not urgent, the call may be directed to AV's secondary triage service, RefComm. The RefComm service can assist with further assessment of the person and determination of the most appropriate response, including arranging access to a general practitioner (GP), mental health triage and other services. The RefComm service is not able to be contacted directly – it is designed to identify and divert 000 calls that do not require an emergency ambulance response.

If you are looking for advice on the most appropriate service for a person with mental illness, you should contact mental health triage by following the instructions at page 10.

Handover

It is good practice for the person requesting the ambulance to be present when the ambulance arrives so that:

- a handover can be provided, including any appropriate documentation
- the person to be transported is not left alone
- family or carers can be debriefed if necessary.

Exceptions to this can occur where the nature of the emergency (for example, a suspected drug overdose) necessitates an ambulance being called and arriving before the caller can reach the person for whom the ambulance is being called.

Where possible, the handover should include:

- relevant personal details of the person with mental illness
- briefing on the person's physical and mental state
- details regarding any sedation administered
- risk assessment and any need for bodily restraint
- transport and inpatient admission requirements
- ensuring all documentation has been completed correctly.

Escort

In some instances, AV may require a mental health practitioner to accompany the person. In this situation, roles and responsibilities during transport must be clearly specified and agreed between the parties in advance.

Consideration should also be given to whether a family member, carer or friend should accompany the person, if this is deemed appropriate by the attending ambulance paramedics or non-emergency patient transport staff.

Section 351 – Police powers

Under section 351 of the Act, police may apprehend a person who appears to have mental illness and as a result needs to be apprehended to prevent serious and imminent harm to the person or others. Police may request an ambulance to transport the person to a designated mental health service.

Police are required to maintain custody of a person apprehended under section 351, even where ambulance provides the transport. Upon arrival at the service, police maintain custody of the person until the person is made subject to an Assessment Order or the person is transferred into the care of the service for examination to determine whether to make an Assessment Order. The ambulance may leave after providing a clinical handover.

Who pays for ambulance and non-emergency patient transport (NEPT)?

In general, people are responsible for paying fees for the ambulance services they receive. Ambulance services, including NEPT, are not covered by Medicare.

People with a valid Pensioner or Health Care Concession Card and their dependents as listed on the Card and some other card holders do not have to pay for ambulance services arranged through AV on 000 or the NEPT booking line (1300 366 313).

People may also be insured for ambulance and AV NEPT fees through AV's Membership Subscription Scheme or private health insurers.

People with mental illness are not required to pay for emergency ambulance or NEPT transport if they are compulsory patients, being transported under s351 or being transferred between major hospitals and residential mental health facilities. In general, they are responsible for paying for transport to or from many rural hospitals or 'community' settings, including their home, general practitioner, residential aged care facility, community health centre or private specialist.

In some circumstances, ambulance fees will be covered by the Transport Accident Commission (TAC), WorkCover, the Department of Veterans' Affairs (DVA) or another organisation.

More information about responsibility for ambulance and AV NEPT fees can be found at: http://www.health.vic.gov.au/ambulance/guidelines/index.htm

Police assistance

Involving police in transporting a person with mental illness is appropriate:

- if the person is in police custody (including apprehended under section 351 of the Act), or
- to prevent serious harm to the person or to another person.

Police involvement can take several forms:

- accompanying the person in another vehicle (such as an ambulance or mental health service vehicle)
- escorting another vehicle (such as an ambulance or mental health service vehicle)
- conveying the person in a police vehicle, after all other transport options have been considered and found to be unsuitable.

If a carer or mental health practitioner wishes to request both police involvement and ambulance attendance in an emergency, they should contact both the police and ambulance services (with separate 000 calls) and arrange to meet at a common location.

On arrival at the scene, paramedics may request police attendance if they believe serious harm to the person or another person may occur.

The decision by a paramedic or mental health practitioner to request police involvement should reflect a clinical risk assessment of both the person's current and previous known risk behaviours, and the objective of providing safe transport in the least restrictive manner possible.

Police will determine the most appropriate level of police involvement for a person in their custody.

If NEPT staff attend an incident and deem that the person is unsuitable to transport via NEPT they should contact the agency that dispatched or arranged the transport. If they have safety concerns they should call 000 and remove themselves from the scene if necessary to ensure their own safety.

What should people with mental illness, families and carers do?

In an emergency (for example, following an overdose), someone should call for an ambulance on 000.

In general, people with mental illness who appear unwell need to be assessed by a health or mental health practitioner to determine the required intervention and transport. The first point of contact for a person seeking assistance for a person with mental illness is mental health triage.

Contacting mental health triage

All designated mental health services provide 24 hours per day, 7 days per week triage services.

To contact your designated mental health service:

- use the internet to go to http://health.vic.gov.au/mentalhealth/services/index.htm
- click on the first letter of your suburb name
- choose the appropriate age for the person.

The triage service phone number will be highlighted in yellow.

If you do not have access to the internet, call 000 if you need urgent assistance or call your local hospital and ask to be transferred to the mental health triage service.

The mental health triage service will assess the person's situation and may arrange or recommend:

- an in-person assessment in an emergency department
- outreach or other community treatment options
- an emergency ambulance.

Calling an ambulance (000)

In some instances people with mental illness, families or carers may need to contact ambulance services directly by calling 000.

The 000 call takers will categorise the request to determine urgency relative to other 000 calls. This may include secondary phone triage by RefComm for situations that are non-urgent and may be better managed with an alternate response, for example through liaison with a designated mental health service.

At times, upon arrival at the location, ambulance paramedics responding to the call may believe the person appears to have mental illness but does not require immediate transport to a hospital. In these circumstances, they may ask the AV clinician to contact the local designated mental health triage service to arrange the most appropriate management (such as referral for non-urgent assessment).

If the person appears to have mental illness and requires hospital treatment but refuses ambulance transport, the ambulance paramedic must contact the local designated mental health service triage service to arrange a more timely or urgent response.

Improving services

Emergency services liaison committees (ESLC)

Each designated mental health service has an emergency services liaison committee comprising representatives from mental health services, ambulance, police, consumers and carers. The committees meet on a regular basis to:

- develop and update local protocols for interagency service cooperation and coordination (including designated mental health triage services)
- address operational service issues, including any use of force, restraint or police transport
- agree on joint case plans for shared consumers, particularly those who present frequently or who have multiple and complex needs
- arrange interagency training and information sessions to share knowledge and skills, including induction sessions and partnering opportunities
- inform the central Interdepartmental Liaison Committee (IDLC) of ongoing and systemic issues requiring attention.

The IDLC has an oversight and monitoring role of ongoing or systemic issues requiring attention, local initiatives and achievements and recommendations.

The IDLC is responsible for establishing and maintaining a formal monitoring and reporting framework to support and communicate with the local emergency services liaison committees. The committees are responsible for implementing local initiatives and resolving local issues.

Appendices

Appendix 1: The legal framework – the *Mental Health Act 2014*

All references to 'the Act' refer to the *Mental Health Act 2014*.

The Act enables a person to be taken to or from a designated mental health service in the following circumstances.

Compulsory assessment and treatment by a designated mental health service

Assessment Orders

An Inpatient Assessment Order enables a person who is subject to the order to be taken to a designated mental health service to be examined by an authorised psychiatrist to determine whether they have mental illness and require compulsory mental health treatment.

A registered medical practitioner or a mental health practitioner may make an Assessment Order for a person if they have examined the person and are satisfied that the Assessment Order criteria apply. The criteria require the practitioner to be satisfied that the person appears to have mental illness and appears to need immediate treatment to prevent serious deterioration in their mental or physical health or serious harm to the person or to another person.

The practitioner making the Assessment Order must be satisfied that there is no less restrictive means reasonably available to assess the person. Assessment should only occur in an inpatient setting if the practitioner is satisfied that the assessment cannot occur in the community. A registered medical practitioner or mental health practitioner may vary a Community Assessment Order to an Inpatient Assessment Order if assessment cannot occur in the community.

Temporary Treatment Orders

A person subject to an Assessment Order must be assessed by an authorised psychiatrist, who may make a community or inpatient Temporary Treatment Order. The Temporary Treatment Order has a duration of 28 days unless revoked earlier.

The authorised psychiatrist must be satisfied that the criteria for a Temporary Treatment Order apply to the person and there is no less restrictive means reasonably available to enable the person to be treated immediately. Treatment should only occur in an inpatient setting if the authorised psychiatrist is satisfied that it cannot be provided in the community.

A person made subject to an Inpatient Temporary Treatment Order who is not already at a designated mental health service must be taken to a designated mental health service as soon as practicable.

Treatment Orders

If a person remains on a Temporary Treatment Order at the end of the 28-day period of the order, the Mental Health Tribunal (Tribunal) must conduct a hearing.

The Tribunal may make a Treatment Order if it is satisfied that the treatment criteria apply to the person. The Tribunal will also decide the setting (inpatient or community) and duration of the order. The Tribunal may only make an Inpatient Treatment Order if the Tribunal is satisfied that the person cannot be treated in the community.

An authorised psychiatrist may vary the setting of a Community Treatment Order to an Inpatient Treatment Order at any time if they are satisfied that the person cannot be treated in the community.

A person subject to an Inpatient Treatment Order who is not already at a designated mental health service must be taken to a designated mental health service as soon as practicable after the order is made or varied.

Transfer of patient

An authorised psychiatrist may vary an Assessment Order, Court Assessment Order, Temporary Treatment Order or Treatment Order to enable a compulsory patient to be taken to another designated mental health service. An authorised psychiatrist may also make a direction that a forensic or security patient be taken to another designated mental health service.

Patients absent without leave

Section 352 of the Act provides for the apprehension and return of patients who are absent without leave.

A patient is absent without leave if the person is absent from a designated mental health service without a grant of leave of absence, or if the setting of a Temporary Treatment Order or Treatment Order has been varied from community to inpatient and the person has not yet been taken to the designated mental health service.

An authorised psychiatrist or a member of staff of the designated mental health service may arrange for a person who is absent without leave to be apprehended and taken to a designated mental health service. If ambulance transport is required, mental health service staff should contact 000.

The mental health service staff should be prepared to provide written notice confirming that the person is absent without leave. This may be:

- a prescribed form from http://www.health.vic.gov.au/mentalhealth/mhactreform/mh-act/forms.htm
- a statement on hospital letterhead.

Ambulance Victoria may request that the health service faxes the notice to the ambulance communications centre. Otherwise, it may be provided to the ambulance personnel attending the scene.

Ambulance paramedics can contact the ambulance communications centre if they need to confirm the legal status of the person.

The authorised psychiatrist or mental health service staff are responsible for making the necessary arrangements for the patient to be received at the designated mental health service. If there are no beds available at the local designated mental health service, the authorised psychiatrist or designated mental health service staff should still make arrangements to receive the person and arrange for an out of area transfer.

Taking a person to a designated mental health service

The Act gives authorised persons the power to enter premises and apprehend a person. This applies where a provision of the Act enables a person to be taken to or from a designated mental health service or any other place.

Before entering premises, an authorised person must:

- announce to any person at or in the premises that the authorised person is authorised to enter the premises
- state the basis of the authority to enter
- give the person an opportunity to permit the authorised person to enter the premises.

If the authorised person is not permitted entry to the premises, they may use reasonable force to gain entry. On gaining entry, the authorised person must, to the extent that is reasonable in the circumstances:

- identify himself or herself to the person to be apprehended
- explain to the person why they are to be apprehended
- give the person details about where they will be taken.

Searching a person

An authorised person may search a person who is being transported under the Act if the authorised person reasonably suspects that the person is carrying anything that presents a danger to the health and safety of the person or another person or that could be used to assist the person to escape. The authorised person must explain the purpose of the search to the person being searched to the extent reasonable in the circumstances.

The power to search under the Act includes:

- quickly running the hands over the person's outer clothing (a 'pat-down' search) or passing an electronic metal device over or close to the person's outer clothing
- requiring the person to remove only his or her overcoat, coat or jacket and any gloves, shoes or hat
- examining those items of clothing
- requiring the person to empty his or her pockets or allowing his or her pockets to be searched.

The authorised person must, as far as is reasonably practicable:

- seek the person's cooperation
- inform the person whether they will be required to remove clothing during the search and why this is necessary
- conduct the search as quickly as possible
- provide reasonable privacy for the person being searched
- if the person being searched is aged 16 years or under, conduct the search in the presence of a parent or another adult if it is not reasonably practicable for a parent to be present
- conduct the least invasive kind of search practicable in the circumstances
- for a 'pat-down' search, ensure the search is conducted by an authorised person of the same sex as the person searched or by a person of the same sex as the person searched under the direction of the authorised person.

The authorised person may seize and detain a thing found as a result of a search if they are reasonably satisfied that it presents a danger to the health and safety of the person or another person or that it could be used to assist the person to escape.

If a thing is seized or detained under the Act, the authorised person must make a written record specifying the thing seized and detained, the name of the person from whom it was seized or detained, and the date on which it was seized or detained.

The authorised person must give the following things to police as soon as practicable after they are seized:

- a prohibited weapon, controlled weapon or dangerous article within the meaning of the *Control of Weapons Act 1990*
- a drug of dependence or a substance, material, document or equipment used for the purpose of trafficking in a drug of dependence within the meaning of the *Drugs, Poisons and Controlled Substances Act 1981*
- a firearm within the meaning of the *Firearms Act 1996*
- a thing that the authorised person believes would present a danger to the health and safety of the person or another person if it were returned to the person.

Anything seized that is not given to police must be stored securely.

The authorised person must ensure that other items are stored for safekeeping so that the items can be returned to the person when it is safe to do so.

Use of restraint and sedation for safe transport

The Act provides for the use of bodily restraint and sedation to enable a person to be safely taken to or from a designated mental health service or any other place.

Bodily restraint – section 350(1) (a)

An authorised person may use bodily restraint on a person who is required under the Act to be taken to or from a designated mental health service or any other place if all reasonable and less restrictive options have been tried or considered and have been found to be unsuitable and the bodily restraint is necessary to prevent serious and imminent harm to the person or to another person.

Ambulances have approved restraints that can be used if all less restrictive options have been tried or considered and found to be unsuitable. If restraint is necessary, it is good practice to use these restraints before considering transport in a police vehicle.

The use of restraint must be documented by the person who used the restraint in accordance with their organisation's records management practices.

Sedation – section 350(1)(b)

A registered medical practitioner can administer sedation to enable a person to be safely taken to or from a designated mental health service or any other place if all reasonable and less restrictive options have been tried or considered and found to be unsuitable and if the sedation is necessary to prevent serious and imminent harm to the person or to another person. The practitioner may direct a registered nurse or ambulance paramedic to administer the sedation.

Ambulance paramedics and registered nurses may also administer sedation within the ordinary scope of their practice.

The use of sedation must be documented by both the person prescribing and the person administering the sedation in accordance with their organisation's records management practices.

Transport of minors

The requirements of the Act, including the requirements relating to transport, apply to people of all ages. The Act includes a principle that children and young person's receiving mental health services should have their best interests recognised and promoted as a primary consideration.

Appendix 2: Additional resources

Ambulance fees guidelines refer to:
http://health.vic.gov.au/ambulance/guidelines/index.htm

Cross-border mental health arrangements:
http://www.health.vic.gov.au/mentalhealth/crossborder/index.htm

Mental Health Act 2014 forms are available at:
http://www.health.vic.gov.au/mentalhealth/mh-act/forms.htm

Mental Health Regulations 2014:
http://www.health.vic.gov.au/mentalhealth/mh-act/regs.htm

Mental health triage guidelines and resources:
http://www.health.vic.gov.au/mentalhealth/triage/index.htm

Non-Emergency Patient Transport (NEPT):
http://health.vic.gov.au/ambulance/nept.htm

Victoria Police mental health protocol:
http://www.health.vic.gov.au/mentalhealth/police/index.htm

Royal Commission into
Victoria's Mental Health System

ATTACHMENT ST- 5

This is the attachment marked 'Strategy' referred to in the witness statement of "Simon Thomson" dated 24 June 2019.

Ambulance Victoria

Mental Health and Wellbeing Strategy

2016-19

ambulance.vic.gov.au

Foreword

Ambulance services workers face obvious and unique mental health challenges in addition to the rewards of their line of work.

Unsurprisingly, the incidence of mental health problems amongst emergency services workers is considerably higher than in other professions.

Suicide rates at Ambulance Victoria are significantly higher than the Victorian average. They are also significantly higher than those of other emergency services providers, including fire services and Victoria Police.

For too long we have accepted that injury, including psychological injury, is part of the job for AV people. This assumption is unacceptable and cannot continue. Reform is now underway at AV.

This AV Mental Health and Wellbeing Strategy is part of our comprehensive response to the recommendations of the Ambulance Performance and Policy Consultative Committee Action Plan.

This strategy has been developed through extensive consultation with stakeholders along with input and feedback from *beyondblue*.

It is fully supported by all levels of leadership and management within AV and will be implemented in partnership with our people and their families, management, executives, unions and of course, the AV Board.

Mental health and wellbeing is a vital component of our wider commitment to improving the health and safety of all people who work at AV. As such, the development and implementation of this strategy is aligned and integrated with the AV Health and Safety Strategy 2016-19.

Doing the right thing for our people's mental health also makes sense from an operational and business perspective. Reducing rates of psychological injury and helping our people to be fit for work will help reduce absenteeism, improve the capacity and safety of those working with a mental health issue and reduce workers' compensation claims.

Our world class delivery of pre-hospital care for the Victorian community has saved many lives. The actions arising from this strategy will demonstrate that we are now just as committed to saving our own.

It signals something important to all our people at AV: you are not alone.

Ken Lay APM
Chair
Ambulance Victoria

Contents

"If we don't care for ourselves, we can't care for others. We need to look after ourselves first."

– Paul, MICA paramedic

The health and safety of our people is critical. At Ambulance Victoria, we are committed to improving the mental health of our people.

Whilst ambulance work is rewarding, it also comes with a range of challenges, which we are addressing as an organisation.

In line with the AV Health and Safety Strategy 2016-19, which provides a roadmap for sustainably improving the health and safety of our people, this AV Mental Health and Wellbeing Strategy provides a three-year roadmap toward creating a mentally healthy workplace and improving the mental health of our people. This strategy will contribute to reducing our psychological injury rates and keeping our people well and at work.

This strategy has been developed through extensive research and in consultation with our people and their families, as well as beyondblue.

CEO message

Our Mental Health and Wellbeing Strategy provides a whole of organisation approach to addressing mental health issues, centred on each and every one of our people. It is designed to support you at every stage of your employment including recruitment, as your role changes within our organisation and as you transition out of Ambulance Victoria, at the end of what I hope is a rewarding career with us.

Our strategy builds on the work undertaken by our Psychological Health and Wellbeing Consultative Group which was established in 2015 to help improve the health and psychological wellbeing of our people and their families.

I have the honour of chairing this Group which is made up of union and paramedic representatives, operational and corporate AV managers and Executive and mental health professionals. The seniority and diversity of the group's representatives is unprecedented in our organisation, and indicates how serious we are about working together to address this most critical of issues.

The AV Mental Health and Wellbeing Strategy, along with the AV Health and Safety Strategy 2016-19 provide a clear roadmap for developing a mentally and physically healthy workplace.

This strategy is informed by available evidence and extensive stakeholder consultation, and will build on existing support services while also planning for future mental health initiatives. We are proud to be the first ambulance service in Australia to deliver a strategy in this form.

There is no question that we need to take action to reduce psychological injury and ensure our people are fit to work and supported to return to work. Our strategy is only the first step and we need to address the objectives presented in this document as a matter of urgency. The Psychological Health and Wellbeing Consultative Group, the Executive team and the AV Board are united in our commitment to delivering meaningful improvements in mental health and wellbeing for you and your families.

I give you my commitment that I will support this strategy by promoting and supporting mental health and wellbeing at every level of the organisation and by strengthening our partnerships between mental health care professionals, unions, our leaders, individuals and their families so that you're fit and well for work and life.

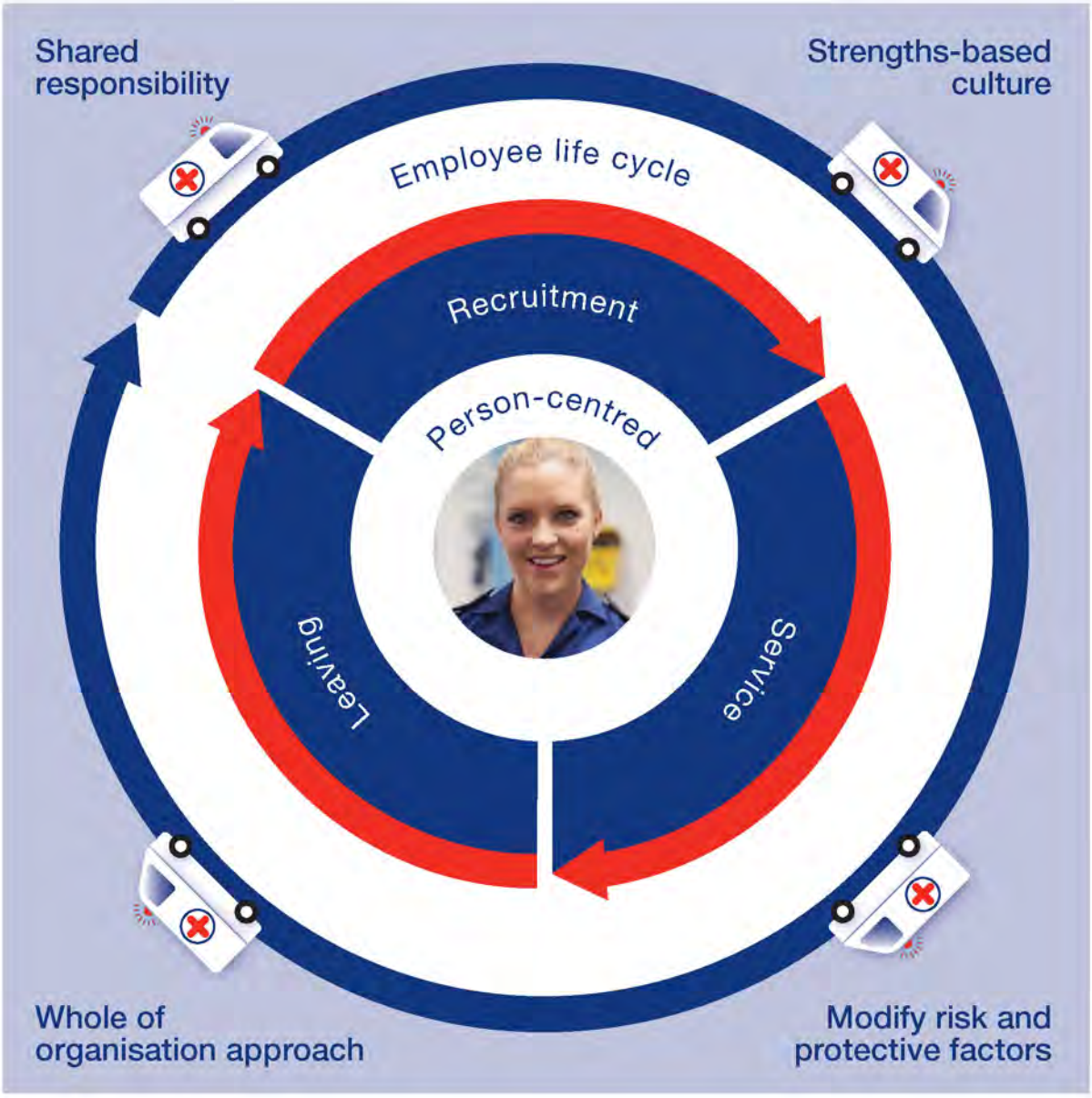
Mental health and wellbeing is everyone's responsibility. Lives depend upon it. I commend this strategy to you and urge you to consider your role in delivering it.

Together, we will make a real difference.

Assoc Prof Tony Walker ASM
Chief Executive Officer,
Ambulance Victoria

Our model for mental health and wellbeing

The Ambulance Victoria mental health and wellbeing model centres on supporting our people at all stages of their employment with us.



The Ambulance Victoria model provides a framework for promoting the mental health and wellbeing of our people.

Our model is based on six key principles:

1. The **person-centred** approach.
2. Mental health is a **shared responsibility**.
3. A **whole of organisation approach**.
4. Building a **strengths-based culture**.
5. Protecting mental health by **modifying risk and protective factors**.
6. The needs of an individual change throughout their **employee life cycle**.

The AV mental health and wellbeing model is based on the 'Good practice framework for mental health and wellbeing in first responder organisations' (*beyondblue*, 2015).

Our model has a strong focus on prevention and early intervention approaches to mental health and adopts the principles of the trauma-informed care framework. It is based on shared responsibility for mental health and wellbeing. We all have a role to play in promoting good mental health at AV – our people and their families, work colleagues, health care providers, unions, AV management and executives, the AV Board and the Victorian Government.

1. Person-centred

At the heart of our model is each of our people. As such, our model focuses on the individual employee's needs and our approach is one of consultation with, and participation by our people.

The model recognises that good mental health and recovery mean different things to different people, and illustrates how our mental health and wellbeing initiatives will support the changing needs of each individual, at every stage of their career at AV.

2. Shared responsibility

Our model emphasises our shared responsibility for the mental health and wellbeing of everyone in our organisation.

This includes each individual taking responsibility for their own mental health and wellbeing.

3. Whole of organisation approach

We take a whole of service approach to mental health, with every layer of the service including the AV Board, Executive, managers and individuals as well as key external partners playing a role in fostering a mentally healthy workplace.

4. Strengths-based culture

We promote mental health and wellbeing by developing the positive aspects of work as well as workers' strengths and capabilities as part of a strengths-based culture.

We intervene to address mental health issues among our people, regardless of whether the workplace was a contributing factor.

5. Modifying risks and protective factors

We work to protect mental health by reducing work-related risk factors for mental health conditions and increasing protective factors.

To support this, we seek to understand our people and their needs, and how workplace factors impact on people's mental health, and identify strategies to best support us all to stay mentally healthy.

6. Employee life cycle

We recognise that our people's mental health needs evolve through the course of a career.

Policies, procedures and practices related to internal and external recruitment, service and return to work, and retirement all play a key role.

- **Recruitment** – when an employee enters our workforce or commences a new role.
- **Service** – an employee/first responder's active engagement in duties within their working life. This period may involve exposure to critical incidents and the need for support to return to work.
- **Leaving** – when an employee transitions out of their current role to another role at AV, to another employer or to retirement.

Ambulance Victoria will provide mental health and wellbeing and suicide prevention training in an effort to reduce the rates of mental illness and suicide among our people.

About this strategy

Delivering a high quality ambulance service is dependent on the skills and dedication of our people and Ambulance Victoria is committed to supporting the mental and physical health of our people at all stages of their employee life cycle.

The AV Mental Health and Wellbeing Strategy is a key step in building a mentally healthy workplace. It sets the framework for our three-year plan to support the mental health and wellbeing of our people and their families, and reduce psychological injury.

This strategy aligns and integrates with the AV Health and Safety Strategy 2016-19, launched in May 2016, to improve the physical and mental health of our people. Both strategies deliver on objectives in the AV Corporate Plan January 2016 – June 2017, which sets out the actions we are taking in response to Victoria's Ambulance Action Plan.

According to Instinct and Reason's *"Employer of Choice"* study, as well as being the right thing to do for our people, investing in mental health makes good business and operational sense. Workplaces with a positive approach to mental health and wellbeing have increased productivity, improved worker engagement and are better able to recruit and retain talented people. Investing in mental health also saves lives.

The AV Mental Health and Wellbeing Strategy is based on comprehensive research, including the application of the 'Good practice framework for mental health and wellbeing in first responder organisations' (*beyondblue,* 2015).

Input and feedback from *beyondblue* has informed this strategy.

It is further informed by extensive consultation with stakeholders including our operational and corporate staff, unions, the Psychological Health and Wellbeing Consultative Group, OHS Committee, the People and Culture Committee and the AV Board of Directors.

In an effort to better understand the mental health needs of our people, focus groups and additional consultation sessions were conducted earlier this year with operational and corporate staff from metropolitan and regional areas, first responders, management as well as the families of our people.

The feedback and opinions gathered from these sessions have directly influenced this strategy and several of the suggestions made at these sessions have already been actioned.

Implementation of the AV Mental Health and Wellbeing Strategy will be driven by the AV Executive team and the AV Board and will include a program of regular reporting.

All our stakeholders have a role in the successful delivery of our strategy.

Protecting the mental health of our people

We need to better understand how workplace factors impact the mental health of our people so that we can strengthen protective factors and minimise risks to keep our people safe and well at work.

Working within an ambulance service brings numerous rewards including community appreciation, ongoing professional development, the opportunity for corporate staff to support service delivery to the community, camaraderie between staff and most importantly, the opportunity to make a meaningful difference to the lives of others.

However, there are also numerous job-specific and organisational challenges that have been reported to have a negative impact on the mental health and wellbeing of our people.

What we know

- Higher levels of depression, anxiety, post-traumatic stress disorder (PTSD), stress and fatigue have been reported by people who work in emergency services.
- A National Coronial Information System (NCIS) report published in June 2015 indicated that the suicide rate among paramedics is four times higher than the Victorian average and three times higher than other emergency services personnel such as police and fire services.
- Some research indicates that paramedics tend to experience higher rates of PTSD than fire-fighters.
- Paramedics tend to experience higher levels of organisational stress in comparison to those in other occupations according to some research. This may include risk factors such as:
  - Shift-work.
  - Long working hours.
  - Repeated exposure to death, violence and trauma.
  - Difficult interactions with members of the public.
  - High levels of responsibility.
  - Lack of rostering flexibility.
  - Frequent shift extensions.
- Our corporate people report higher levels of depression, anxiety and stress than our operational people. While corporate employees are typically not directly involved in critical incidents, their role may see them exposed to second-hand accounts of potentially traumatic events which can leave them vulnerable to secondary traumatisation.
- Mental health related WorkCover claims at AV make up 8% of all claim types yet account for 24% of total claim costs.
- A quarter of our people with a psychological claim are away from work for 80 days or more, which is higher than manual handling claims, where a quarter of people will be away for six days or more.
- One of the biggest challenges to our success will be reducing stigma and building help-seeking behaviours among our people.

* Includes extracts from the AV Health and Safety Strategy 2016-19

What we need to understand better

- The mental health status of our people and the drivers of poor mental health.
- How mental health risks change at different stages of employment at AV.
- The specific needs of paramedics, corporate staff and volunteers in metropolitan and rural areas.
- How to support the families of our people.
- How to support our psychological support staff.

Our Commitment

Ambulance Victoria will improve the mental health and wellbeing of our people by:

- Promoting good mental health and wellbeing through supportive leadership at all levels.
- Reducing stigma and isolation so that people feel safe to speak up and seek help.
- Preparing our people to meet the unique occupational mental health risks they may face at AV and supporting them to maintain their own mental health through the different stages of their career with AV.
- Developing a culture that supports our people to recognise mental health issues in themselves and others and seek help early.
- Making evidence-based treatment and recovery programs available and encouraging their use.
- Reducing suicide rates at AV.
- Strengthening partnerships between our people, families, leaders, unions and health providers to reduce stigma and increase understanding of mental health support pathways.
- Undertaking research that improves our understanding of mental health and wellbeing at AV.

Ambulance Victoria cannot accept that injury, including psychological injury, is part of the job. Delivery of our services to the community should not come at a cost to our people's health, wellbeing or lives.

We must act to reduce the suicide rate among paramedics, which has been reported to be four times higher than the Victorian average and three times higher than other emergency services personnel such as police and fire services.

Our people say:

"Whether we are in an operational or corporate role, all of us at AV need to support, understand and offer empathy to each other regarding our mental health. We all have a part to play in looking after ourselves and each other, across all areas of AV."

– Andrea, Non-Emergency Patient Transport

"In the past we were expected to be tough, suck it up and cope. It's good to have permission to openly talk about mental health and these issues."

– Paul, MICA paramedic

Strategic Objective 1:

Understand the mental health and wellbeing needs of our people

Why it's important

To provide effective support, we need to better understand the mental health needs of our people.

Mental health needs vary at different stages of employment and in different workplace environments.

Ambulance Victoria has about 4,525 staff including about 390 corporate staff and more than 3,775 frontline paramedics and ambulance community officers. There are also more than 400 Community Emergency Response Team (CERT) volunteers who provide an emergency response and support in rural areas.

Our efforts to support our people must be tailored to address their changing requirements through recruitment, operational service (including transition to new roles within AV), and as they exit the service.

Preliminary data (AV's SMART program 2007-12) indicates the psychological profile of operational staff presents a mostly positive picture. Corporate staff reported higher levels of psychological difficulty during the same period. Research indicates families of ambulance services personnel can also be impacted by their loved one's role.

We also need to better understand the effectiveness of mental health initiatives delivered to support our people, so we can learn from our experiences to continually improve outcomes for our people and the communities we serve.

What we are doing

We partnered with Phoenix Australia and Black Dog Institute in 2016 to undertake an external review to identify the best practice organisational wellbeing strategies that have proven success in an emergency services environment.

To understand the mental health and wellbeing needs of our people we will implement more targeted, frequent and useful research, with collection and analysis of data to determine:

- How mental health is impacted through the different stages of the employee's life cycle.
- The unique workplace factors that lead to higher suicide rates at AV compared with other emergency service providers.
- The mental health needs of all our staff.
- Why our corporate staff appear to experience higher levels of depression, anxiety and stress than our operational people.
- The impact of mental health issues in our people on their family and social supports.

What success looks like

By working together, our people will be better prepared, protected and supported to maintain good mental health and wellbeing throughout their career at AV. They will have greater personal mental health skills and knowledge and will thrive in our strengths-based culture.

In a workplace environment where maintaining good mental health and wellbeing is valued and practised at all levels of the organisation, the stigma of mental health issues will abate and more AV people will seek help as they need it.

Our knowledge base will improve through research and more reliable reporting and through more regular reviews of the mental health and wellbeing of our people.

We will gain a deeper understanding of mental health impacts and issues outside the workplace through better communication and collaboration with families, colleagues, managers and social support networks.

Our mental health and wellbeing initiatives will focus on the areas of most need, as identified through research and reporting. The value of our programs will be assessed, enabling us to continually refine and improve them.

Key facts

- Mental health risks change at different stages of employment at AV
- We need better knowledge of the mental health status of our people
- The drivers of mental health need to be fully understood
- We need to better assess and review the value of our mental health initiatives

Our goals

- We have an accurate picture of the mental health status of our people
- We understand what contributes to good mental health in our people
- We deliver high value, effective mental health initiatives for our people
- Discussion of mental health issues is encouraged and supported

Strategic Objective 2:

Promote mental health at all levels of Ambulance Victoria

Why it's important

A workplace culture that encourages open conversations about mental health is a significant contributor to reducing stigma.

One of the biggest challenges to our success will be reducing stigma and building help-seeking behaviours among our people.

People from traditionally masculine cultures are known to seek help for mental health issues at low levels. This may be linked to more negative long-term mental health outcomes, including suicide.

The case for improving mental health and wellbeing for our people is compelling. We have an opportunity to improve mental health outcomes for all our people and their families, and save lives.

The business benefits for improving workplace mental health and wellbeing are also clear. Benefits include improved productivity and health promotion, a reduction in staff turnover, less unplanned leave, improved capability, minimised workplace risks and fewer compensation claims.

What we are doing

- Demonstrating a whole of organisation commitment to the mental health and wellbeing of our workforce through investing in the development and delivery of the AV Mental Health and Wellbeing Strategy that will be the blueprint to guide mental health reforms.
- Educating our workforce on the importance of supporting and maintaining good mental health across all areas of the organisation and through every stage of the employee life cycle.
- Educating our workforce to address and break down the stigma attached to mental health conditions so they are able to have the conversations about mental health; acknowledging their role in not only their own mental health, but those of their colleagues and social supports.
- Developing new ways of engaging with the families of our people.

What success looks like

Our people will operate in a positive and mentally healthy work environment. They will be well informed about the mental health risks at various stages of their employment and will more readily discuss mental health issues with their colleagues, managers and families.

Supervisors and managers at all levels will be accountable for maintaining a mentally healthy workplace and will have an open and understanding attitude to what our people say about the pressures of their work or other problems.

We will work with unions, mental health care experts and social support networks to build a common understanding of the human and operational benefits of good mental health and wellbeing and will drive a united effort to attain it.

Our people's families will be more aware of the warning signs of mental health issues and will feel capable and encouraged to engage with their loved one, and with us to seek and offer support.

We have strengthened our organisation by providing our people with skills to help them have difficult conversations. We are working to address workplace stressors that may contribute to mental health issues such as job design, rostering, and part time work options.

We speak openly and positively about mental health so that people can ask for help without fear or discrimination.

Key facts

- Failure to seek help for mental health issues can lead to long-term negative mental health outcomes, including suicide
- The leadership team at AV is committed to driving change to promote mental health and wellbeing at all levels of the organisation
- A united coordinated response must be supported by everyone
- Fostering a mentally healthy work environment makes good business sense

Our goals

- Everyone is accountable for maintaining a mentally healthy workplace
- Families and support networks of our people are engaging with us throughout the employee lifecycle to address mental health-related issues
- Workplace risk factors are reduced and we develop our people's strengths and capabilities
- Reducing stigma helps create a culture where people feel safe to speak up early if they are struggling

Strategic Objective 3:

Deliver comprehensive mental health interventions and training throughout the employee life cycle

Why it's important

Mental health requirements may change for an individual according to the role they are undertaking and their previous experiences.

To increase capability and resilience, and reduce the potential impacts of mental health issues at AV, programs and resources must be tailored to consider mental health during recruitment, service and transition phases of AV careers.

Providing early intervention mental health initiatives to support our people at different stages of their career at AV will minimise the impacts of poor mental health on them personally and on their contribution to the organisation.

Providing clear pathways to help is fundamental to supporting our people and for creating a mentally healthy workplace that keeps people well.

What we are doing

- In 2016, we partnered with *beyondblue* to develop and deliver organisation-wide mental health training for our people, which includes suicide prevention. This $1.2 million initiative is supported by funding from the Victorian Government.
- We will utilise the recommendations from our external review (see Strategic Objective 1) to identify ways to improve our current suite of AV wellbeing services to drive improved mental health outcomes for all our people through every stage of their employee life cycle.

What success looks like

Our people have the capability to maintain their own mental health and wellbeing, with access to comprehensive mental health support at all stages of employment. This starts with all potential candidates being screened and assessed to ensure their suitability for the role.

New recruits will receive mental health awareness training including resilience and self-care, information about stress management, coping skills, recognising warning signs, suicide awareness, the benefits of seeking help early and details of the available mental health supports at AV.

While in service, our people will be aware of an ever-improving range of mental health programs and supports that are available to them and their families. They will feel encouraged to access these programs and supports to build their personal resilience. They will be supported through stressful work situations and mental health issues, including support through the transition to new roles within AV and as they leave the service or retire.

Increased understanding of mental health throughout the organisation will foster a cultural change that reduces the stigma associated with mental health issues and encourages early intervention.

Suicide prevention is our highest priority

We are taking action to prevent suicide by:

- Promoting good mental health and wellbeing for each of our people.
- Reducing workplace risks and strengthening protective factors.
- Addressing stigma and promoting early help-seeking.
- Improving the mental health skills and capability of our people so they can recognise the warning signs of suicide and take action.
- Restricting access to means by improving medication management practices.
- Creating a culture where it is safe to talk about suicide.
- Encouraging and supporting the sharing of personal stories.
- Learning from other like organisations such as the Australian Defence Force. The ADF has successfully implemented suicide prevention strategies.

Key facts

- Better understanding of mental health and access to appropriate information and programs can prepare and protect our people for the challenges they will encounter
- We must build mental health programs and resources based on prevention and early intervention for the recruitment, service and retirement stages of AV careers
- Increased understanding and discussion will directly contribute to addressing the stigma around mental health

Our goals

- All potential candidates for roles at AV are psychologically screened to assess suitability for the role
- All AV people receive mental health awareness training and are equipped with skills to look after themselves and each other
- Mental health resources, prevention and early intervention services are available to support our people and their families
- Evidence-based mental health initiatives are implemented to prepare, protect and support our people at all stages of employment

Strategic Objective 4:
Strengthen our mental health and wellbeing partnerships

Why it's important

The Ambulance Victoria Board and Executive leadership team understand that working collaboratively across the organisation and with our mental health and wellbeing partners will enable us to leverage the expertise and resources of others to implement this strategy efficiently and effectively. As this is the first mental health and wellbeing strategy of its kind for ambulance services in Australia, we will explore the potential to share our framework and programs with our counterparts in other states, so that we might collaborate to deliver common resources.

We can learn from the experiences and initiatives of other emergency services organisations, such as the Australian Defence Force, whose internal campaign to address stigma *"Some of the toughest battles are faced within"*, resulted in very positive outcomes for their members.

Resources developed by organisations such as *beyondblue* can provide practical information and advice for addressing mental health issues in first responder organisations.

What we are doing

- We have taken some important first steps in strengthening health and wellbeing partnerships over the past year to drive positive mental health and wellbeing reforms.
- Our Psychological Health and Wellbeing Consultative Group will oversee and recommend initiatives and promote improved communication and collaboration.
- We recognise the need to strengthen our partnerships with the families and social support networks of our people and better define the roles stakeholders should play in supporting and enabling the mental health and wellbeing of our people.
- We will explore opportunities for direct funding support for the implementation of this strategy, including strategic alliances with other emergency services organisations that face similar challenges.

What success looks like

We have strong partnerships with mental health organisations and experts to deliver best practice mental health support to our people.

We work collaboratively across the organisation and invest our resources and funding efficiently and to maximum effect.

Our stakeholders have successfully advocated for adequate funding and resources to implement the AV Mental Health and Wellbeing Strategy.

Our leadership, managers, unions, people and their families understand and fulfil their respective roles in supporting the mental health and wellbeing of everyone at AV.

Partnerships to assist the implementation of the AV Mental Health and Wellbeing Strategy have resulted in increased awareness and skills to manage mental health and reduced depression, anxiety, stress and suicide among our people.

We are engaging effectively with our people's families.

Key facts

- Fostering mental health partnerships will enable us to maximise the resources needed for implementation of the AV Mental Health and Wellbeing Strategy
- AV can leverage the expertise and resources of others, and also offer our knowledge and support to other emergency services organisations
- A collaborative approach in our organisation and with our external partners and people's families will help us better protect our people and prevent suicide

Our goals

- Investment in mental health and suicide prevention is appropriate to reduce the rates of mental health issues and suicide. This has not only improved the mental health and wellbeing of our people, but has also reduced business costs
- We have strengthened partnerships with mental health organisations and experts to deliver best practice mental health support to our people
- Mental health, capability and job satisfaction levels of our people have increased

Deliverables

Year 1 (2016-17)

- Develop the AV Mental Health and Wellbeing Strategy.
- Commence organisation-wide mental health awareness training, including suicide prevention training.
- Undertake review of mental health services with an independent expert mental health provider.
- Undertake a Psychosocial Wellbeing Survey to establish prevalence rates and gain understanding of the mental health of our people.
- Implement psychological screening of recruits.
- Enhance and implement medication management policy and procedure to address access to drugs.
- Review job design and continue actions to improve work-life balance (for example flexible working conditions, fatigue reduction).
- Implement 40 hours per annum training for our people including:
  - Safety leadership training for managers.
  - Training to address occupational violence.
- Address manual handling issues linked to high comorbid mental health problems.
- Develop and implement an alcohol and other drugs policy and procedure.
- Implement strategies to build a stronger culture of support for mental health and wellbeing.
- Implement workplace behaviour strategies to reduce bullying, incorporating the recommendations of the Victorian Auditor-General's Office.

Years 2 and 3 (informed by the outcomes of Year 1)

- Review progress against the AV Mental Health and Wellbeing Strategy.
- Continue mental health and wellbeing training programs including:
  - Organisation-wide mental health awareness training, including suicide prevention training.
  - Mental health training for managers.
- Develop a family engagement plan.
- Implement the AV SMART program review outcomes.
- Introduce online annual psychological screening for all our people.
- Incorporate outcomes of the service review into the strategy.
- Undertake biannual Psychosocial Wellbeing Surveys of our people and compare outcomes.
- Develop and implement new recruitment process for promotion and transfer.
- Develop and implement family violence policies and initiatives.
- Incorporate mental health and wellbeing education into graduate program.

Measures of success

The success of this AV Mental Health and Wellbeing Strategy will be evaluated via a number of measures. The outcomes will contribute to delivering the key performance indicators of the wider AV Health and Safety Strategy 2016-19. We are working with expert mental health organisations to mature our approach to measurement and develop meaningful key performance indicators based on the data included below.

Objective	Data
Understand the mental health and wellbeing needs of our people	▸ AV Psychosocial Wellbeing Survey – baseline conducted Sept-Oct 2016 and every two years thereafter. ▸ Review by Phoenix Australia of: – the impact workplace factors have on our people's mental health – AV's existing mental health and wellbeing initiatives.
Promote mental health at all levels of Ambulance Victoria	▸ People Matters Survey. ▸ Psychology and Support Service (PSS) annual utilisation report – Increase in utilisation of all support services. ▸ PSS client feedback surveys.
Deliver comprehensive mental health interventions and training throughout the employee life cycle	▸ Mental Health Matters @ AV Evaluation Report by *beyondblue.* ▸ Monitor and review Health and Safety Key Performance Indicators including: – Safety leadership – Reduction in hours lost to injury – Reduction in psychological injury claims. ▸ Reduction in sick leave. ▸ Reduction in the incidence of bullying and harassment.
Strengthen our mental health and wellbeing partnerships	▸ Partner with expert external mental health providers including *beyondblue*, Phoenix Australia, and Black Dog Institute. ▸ Partner with the Council of Ambulance Authorities (CAA). ▸ Conduct bimonthly Psychological Health and Wellbeing Consultative group meetings.

Following implementation of the organisation-wide mental health awareness training from June 2016 to June 2017, it is anticipated AV will see an increase in WorkCover claims, prevalence rates and increased use of services due to greater levels of awareness among staff and improved help seeking. However, the long-term trajectory and outcomes are expected to show a reduction in claims and prevalence rates, and most importantly, a positive impact on suicide rates.

Existing programs

This AV Mental Health and Wellbeing Strategy provides a three year framework that builds upon the following existing services.

24 hour telephone counselling and crisis support service

Our people and their immediate family members have available to them a dedicated, confidential and free 24 hour telephone support line, which includes access to peer support, psychological and chaplaincy services.

The psychological support component of this service provides 24/7 telephone counselling and crisis support, as well as consultation and advice for managers on matters relating to managing mental health issues in the workplace or other psychological health matters.

Chaplaincy Program

AV Chaplains offer a range of pastoral and support discussions, in addition to providing such services as may be needed to support the spiritual needs of our people and their families.

Confidential and free counselling

The Victorian Ambulance Counselling Unit (VACU) provides our people and their immediate family members with free and confidential counselling services with approved, registered psychologists.

e-Learning packages

We provide a range of online training packages to our people, including:

- Online Health, Safety and Wellbeing induction package for all new employees.
- Occupational Violence Education.
- Fatigue, You and Your Family Online Learning Program.
- Leadership essentials, effective team communication, and emotional intelligence.

Face-to-face Workshops

We offer regular workshops for staff on a range of topics including:

- Courageous Conversations.
- Team Effectiveness.
- Communicating as a Leader.

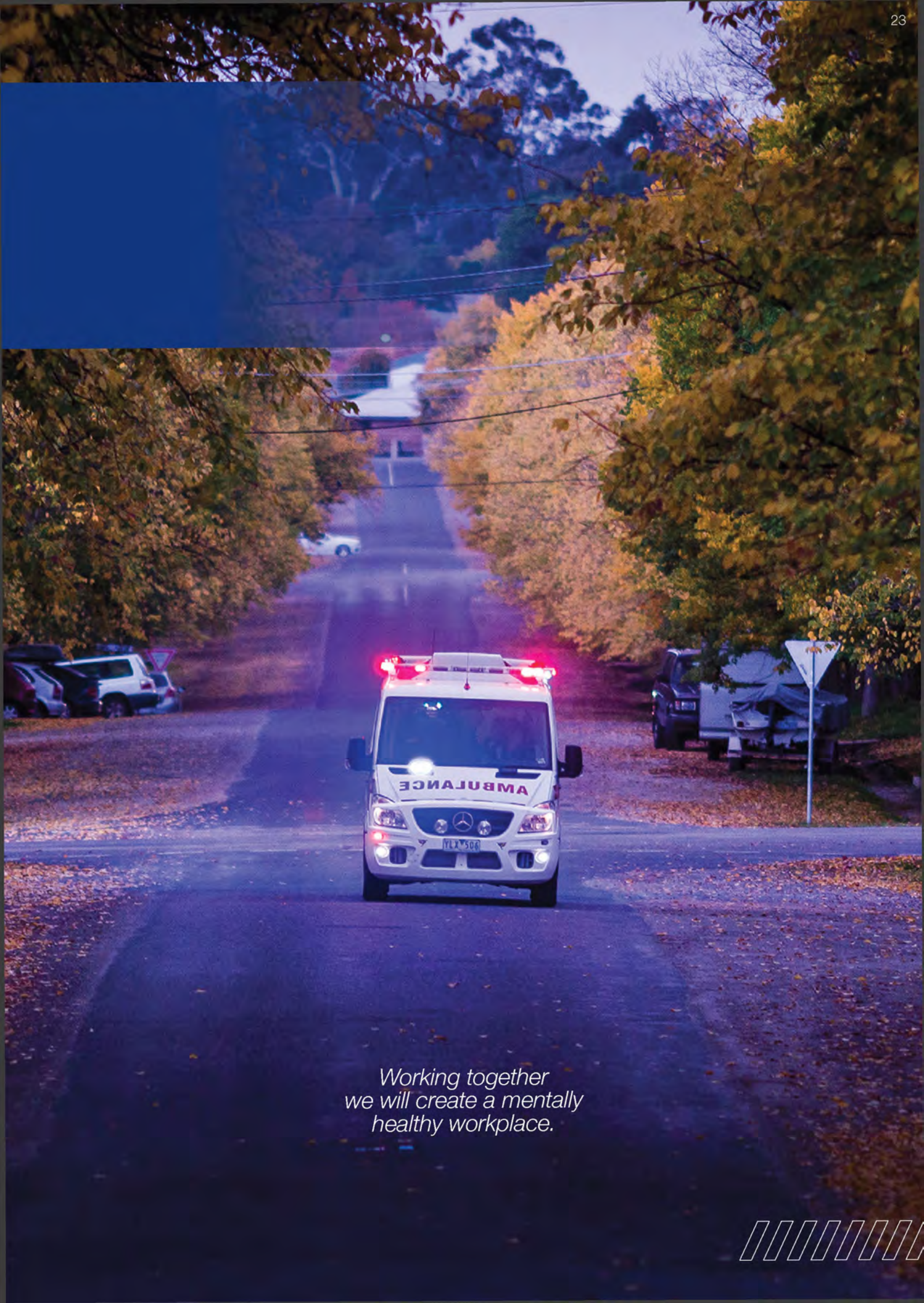
Peer Support Program

Peer Support officers are volunteers who have received training in assisting other staff in coping with work-related or personal issues.

The Peer Support network provides proactive and reactive peer support to our people at key times such as following their involvement in critical incidents or other potentially traumatic events.

SMART (Stress Management and Resilience Tools) Program

The SMART Program is a prevention and early intervention program aimed at assisting AV employees to manage their psychological wellbeing and resilience in a proactive way. This program is free-of-charge, voluntary and delivered by the Victorian Ambulance Counselling Unit (VACU). The SMART Program is available annually to all of our people, both operational and corporate.



Working together
we will create a mentally
healthy workplace.

If you're an employee or volunteer at AV and you are concerned about your own safety or the safety of someone else, please seek help immediately via the VACU 24-hour counselling service on 1800 626 377 or call 000 for immediate assistance.

ambulance.vic.gov.au

Royal Commission into
Victoria's Mental Health System

ATTACHMENT ST- 6

This is the attachment marked 'Safe Transport Guideline' referred to in the witness statement of "Simon Thomson" dated 24 June 2019.

Safe transport of people with a mental illness

health

Chief Psychiatrist's guideline

Key messages

- Mental health patients have the right to safe transport that minimises interference with their rights, dignity and self-respect, and that reduces the likelihood they will experience the transport as a traumatic event. This right, however, needs to be balanced with the safety of all concerned and the active management of risk. Any restriction of a person's rights needs to be reasonable and proportional.
- Transportation not only enables access to mental health care but is also a point of care provision itself.
- Transport carries potential risks and so deserves an appropriate level of consideration and collaboration to make the situation as safe as possible for all involved.

Contents

1. Purpose and scope

This guideline outlines sound practice principles and procedures for mental health professionals who are making decisions about people experiencing mental illness who require transport.[1]

These decisions need to be made when a person requires transport for assessment or treatment in the following circumstances:

- when voluntary or involuntary patients in the community need transport to an inpatient facility and/or an emergency department
- when community treatment order (CTO) patients have had their orders revoked and need to be returned to hospital
- when patients are being transported between hospitals.

2. Related guidelines

This guideline complements and draws together key themes in the memorandums of understanding between the Department of Health (Mental Health, Drugs and Regions Division), Victoria Police and Ambulance Victoria.

Other relevant guidelines and protocols include the following.

Department of Health and Victoria Police protocol for mental health, 2010
www.health.vic.gov.au/mentalhealth/publications/police-mh-protocol0910.pdf

Ambulance transport of people with a mental illness protocol, 2010
www.health.vic.gov.au/mentalhealth/publications/amb-transport0910.pdf

Department of Health, *Program management circular to Victorian AMHS: Cross-border mental health services: Victoria and NSW*
www.health.vic.gov.au/mentalhealth/crossborder/0_op_guide.pdf

Department of Health, *Cross-border arrangements with South Australia (SA)*
www.health.vic.gov.au/mentalhealth/crossborder/sa.htm

3. General principles

Transportation not only enables access to mental health care but is also a point of care provision itself.

Transport carries potential risks and so deserves an appropriate level of consideration and collaboration to make the situation as safe as possible for all involved.

Mental health patients have the right to safe transport that minimises interference with their rights, dignity and self-respect, and that reduces the likelihood they will experience the transport as a traumatic event.

1 People with a mental illness requiring transport are referred to as patients in this document.

This right, however, needs to be balanced with the safety of all concerned and the active management of risk. Any restriction of a person's rights needs to be reasonable and proportional.

Patients should be encouraged to make their own decisions and arrangements for transport wherever possible and when clinically and legally appropriate.

The impact of transport decisions on any family, friends or carers involved also needs to be considered.

The patient's legal status under the *Mental Health Act 1986* (the Act) will impact significantly on the choice of transport used, as will the scope of practice and role of the transport provider. For example, patients who are involuntary and require sedation or restraint may only be transported by emergency ambulance.[2]

4. Specific considerations

Mental health professionals involved in determining the most appropriate way to transport a patient should consider a range of issues including:

- the patient's legal status
- current and past mental health history and presentation
- the patient's physical health
- the patient's immediate treatment needs
- the risk of harm the patient poses to themselves and others
- the distance to be travelled
- the patient's need for clinical support, supervision and sedation during the period of travel
- the available modes of transport
- the likely effect on the patient of the proposed mode of transport
- information from other service providers, family or carers
- the availability of appropriately trained staff for assessment and escorting, particularly in rural and regional areas
- whether there has been any reference to transport preferences as part of a consumer's advance statement.

Even though there is often pressure to transport a patient rapidly, it may be that a period of time spent addressing particular clinical or psychosocial needs before transportation will allow for a safer or less distressing trip, for example:

- a patient waiting to see the doctor for a risk assessment before moving to another hospital
- a patient wanting to secure their property or animals before being taken to hospital
- delaying transport until family members are present to support the patient.

5. Transportation options

Safe transportation requires matching the clinical care needs of the patient with the appropriate transport options, and is underpinned by safety considerations, the principle of least restrictive care and risk management.

An emergency ambulance must be used where a person has an urgent need for medical treatment for a physical or mental illness, or where sedation or mechanical restraint is required.

In other circumstances, it is useful to think of transport options as a hierarchy – from least to most supported.

2 *Mental Health Act 1986*

5.1 Transport by private vehicle or taxi

In many instances, a private vehicle driven by a family member or friend, or a taxi with a patient travelling either alone or accompanied by a friend or family member may provide the most accessible and acceptable mode of transport.

When deciding whether to transport a patient in a private vehicle or taxi, the mental health professional should consider:

- the patient's current mental state, especially their risk of behaving in an erratic or unpredictable manner
- the patient's understanding of the purpose and destination of the transport and their acceptance of this
- the driver's understanding of the purpose of the trip and its destination, their knowledge of the patient[3] to be transported, and their willingness and availability (for example, it would be unreasonable to expect a taxi driver to monitor the patient's needs)
- the distance to be travelled
- patient's history of using this mode of transport and their willingness to engage with the transport option
- the patient's relationship to the proposed driver
- the safety or any risk issues that may impact the driver or other passengers in the vehicle.

The mental health service should not try to persuade a family member or friends to transport a patient if they are reluctant to do so.

5.2 Transport by mental health service vehicle with accompanying clinical staff

Where the patient is known to the treatment team, and there is no clinical or safety need for an ambulance, the use of an agency vehicle to transport a patient from the community to an emergency department or inpatient service may be the preferred means of transport.

When deciding whether to use an health service vehicle for transport, the mental health professional should consider:

- the patient's current mental state, especially their risk of behaving in an erratic or unpredictable manner
- the patient's previous transport history
- the patient's understanding of the purpose and destination of the transport and their acceptance of this
- the distance to be travelled and the time of day
- the clinician's knowledge of the patient and their history
- the placement of the patient in the vehicle (the back seat next to a clinician, not behind the driver)
- the patient's willingness to be transported by the proposed driver
- the safety needs of all those in the vehicle.

When transporting a patient in a health service vehicle it is generally safer to have an additional worker as well as the driver in case of any change of patient circumstances or need to contact others for assistance.

3 Information should be provided to carers with either the consent of the person or in circumstances where it is required for the person's ongoing care and the persons will be involved in the provision of that care, or to prevent serious and imminent threat (see Mental Health Acts. 120 a).

5.3 Transport by ambulance

Ambulance Victoria has primary responsibility for the transport of people with a mental illness who need treatment in hospital and are too ill to be transported by clinical staff alone.

Ambulance transport and attendance is guided by the protocol *Ambulance transport of people with a mental illness 2010.*

An emergency ambulance must be used where a person has an urgent need for medical treatment for a physical or mental illness, or where sedation or mechanical restraint is required. In these situations there is an increased need for observation and clinical supervision of the health and wellbeing of the patient.

5.3.1 Accessing Ambulance Victoria

A request for an ambulance can be made by dialling 000 and requesting 'ambulance'.

Calls will then be transferred to Ambulance Victoria (AV).

When requesting the ambulance you should be prepared to provide relevant information such as:

- the current location and planned destination of the patient needing transport
- the patient's age, diagnosis, current medical condition and mental state
- the patient's current medication regimen and whether there is any evidence of recent medication abuse
- whether the patient is intoxicated, in withdrawal or experiencing any other substance-related problems
- the legal status of the patient (voluntary or involuntary) and the readiness of any associated documentation
- any safety issues or alerts that would help AV prioritise the call appropriately
- the availability of clinical staff and whether the patient is known to those clinicians
- the name of the person or service who will be receiving the patient
- whether the patient requires restraint or has the potential for violence
- whether or not police assistance is required
- if it is safe for the paramedics to approach the scene, and who is at the scene with the patient
- whether the patient has been sedated
- the contact number for the most appropriate person to advise on the patient, should a call back be required.

This information enables the ambulance service to prioritise the request without delays and determine the appropriate response.

All calls for interfacility or critical transfers are assessed by the clinician located at the AV communication centre. Should issues arise with transport, the clinician can be contacted through the communications centre.

Calling from a fixed telephone (as opposed to a mobile) automatically provides the emergency communications centre with the address of the telephone so an ambulance can respond even if the caller cannot give accurate location details.

5.3.2 Attending

It is good practice for the mental health professional requesting the ambulance to be present when the ambulance arrives. This ensures that:

- the person being transported can be identified correctly and introduced personally to the transporting team
- a clinical handover is provided and appropriate documentation passed on
- the person to be transported is not left unaccompanied
- any necessary communication or debriefing with family or carers can take place.

Exceptions to this can occur, for example, where the nature of the emergency, such as a suspected drug overdose, necessitates an ambulance being called and arriving before mental health staff can attend the person.

5.3.3 Escorting

It is not generally expected that a mental health professional will accompany the person when they are being transported by ambulance, although this may be requested if deemed appropriate by the attending ambulance or MICA[4] paramedics.

At times, people will request, or require, an escort to travel with them to ensure adequate support. An escort may be a family member, a friend, a mental health professional or a police officer. This will be determined by the person's needs and risks.

In regional areas in particular, mental health professionals may need to accompany the person in the ambulance due to variations in ambulance crew arrangements in smaller communities.

If an escort is accompanying the person, it is particularly important that the roles and responsibilities during transport are clearly specified and agreed between the parties in advance.

5.3.4 Accompanying mental health professionals

If a mental health professional accompanies the person their role requires specific discussion prior to transport commencing and will depend on the needs of the person being transported and the type of transport involved.

The mental health professionals should:

- help prepare the patient for transport or hospitalisation including helping them gather necessary items for their stay
- support and reassure the patient while en route
- ensure the other members of the treating and receiving mental health teams are aware of the transport plans
- ensure the relevant mental health and statutory documentation to authorise transport has been completed (see section on legal framework)
- be responsible for providing patient and carers information about transport arrangements.

4 Note: In this document emergency ambulance officers are referred to as ambulance paramedics or MICAs (as per AV protocols). The Mental Health Act refers to 'ambulance officers', which essentially includes both the above classes.

5.3.5 Handing over

Best clinical practice in any patient transport event begins and ends with detailed clinical **handover** between all those involved.

Information that needs to be handed over includes:

- briefing on the patient's physical and mental state
- relevant personal details and next of kin contact numbers
- details of arrangements made for any dependent children or animals
- details regarding any sedation administered and need for restraint
- risk assessment
- transport and inpatient admission requirements
- the patient's legal status
- the nature of any documentation that will accompany the patient
- the name of any receiving clinician or service expecting the patient.

The best form of communication in these circumstances is usually face-to-face discussion between the various professionals at the scene.

Non-emergency patient transport

In some areas, non emergency transport is available. This transport option is governed by the *Non-Emergency Patient Transport Act (NEPT) 2003* and the Non-Emergency Patient Transport Regulations 2005. Ambulance Victoria manages the call-taking and dispatching related to non-emergency transport.

NEPT providers can transport people from one mental health service to another mental health service or from a mental health service to the patient's place of residence if some NEPT service requirements are met.

NEPT providers cannot transport a person to an approved mental health service under a provision of the Mental Health Act or the *Crimes (Mental Impairment and Unfitness to be tried) (CMIA) Act 1997*. This includes, for example, patients subject to requests and recommendations, sections 9, 10 or 12 involuntary patients under the MHA and forensic patients under the CMIA.

5.4 Transport by police vehicle other than where a person has been apprehended under section 10 of the Mental Health Act

Transport of a person with mental health problems by police should always be the option of last resort when all other transport options are considered unsuitable.

Police may be requested to attend when there is a significant risk of harm to the person or others in the course of transport. Transport in a police vehicle is more restrictive and may add to stigma for the person and family of those who are mentally ill.

In some situations, however, the ambulance paramedics may determine they cannot provide transport without assistance. Where it is agreed that police transport is appropriate, AV's senior communication officer will contact Victoria Police. Police involvement with transport occurs in accordance with the *Victoria Police and Department of Health protocol for mental health 2010*.

Police involvement can take several forms:

- escorting another vehicle (such as an ambulance or mental health agency vehicle)
- accompanying the patient in another vehicle (for example, an ambulance or mental health agency vehicle)
- transporting the patient in a police vehicle.

Mental health professionals can request police involvement at any time. This request should reflect a clinical risk assessment of both the patient's current and previous behaviour. However, police are responsible for determining the most appropriate form of police involvement.

If the mental health professional assesses there is a need for **both ambulance and police** services to ensure safe transport, then the police should be contacted concurrently with the ambulance service and arrangements made to meet at a common location.

The ambulance communications centre will coordinate meeting arrangements.

On arrival, ambulance, police and the mental health professionals will liaise regarding their roles in the transport of the patient.

It is good practice for the mental health professional who requested the police involvement to be present when the police arrive. This ensures that:

- the patient being transported can be identified correctly
- a clinical handover is provided and appropriate documentation passed on
- the patient to be transported is not left unaccompanied
- any necessary communication or debriefing with family or carers can take place.

Exceptions to this can occur, for example, where the nature of the emergency necessitates police being called and arriving before mental health staff can attend the patient.

This transport needs to be carried out with as much discretion as possible to ensure the patient's privacy and dignity are protected.

6. The law relating to transport of mental health patients

Practices related to safe transport are guided by a specific legal framework. Mental health professionals should be acquainted with the laws relevant to safe transport prior to commencement of transport. These include those listed below.

Mental Health Act 1986
www.legislation.vic.gov.au (Victorian Law Today)

Mental Health Regulations 2008
www.legislation.vic.gov.au (Victorian Law Today)

Crimes (Mental Impairment and Unfitness to be Tried) Act 1997
www.legislation.vic.gov.au (Victorian Law Today)

Crimes (Mental Impairment and Unfitness to be Tried) Regulations 2010
www.legislation.vic.gov.au (Victorian Law Today)

The non-emergency patient transport guidelines, 2008
www.health.vic.gov.au/mentalhealth/pmc/non-emergency-transport.pdf

The Victorian Charter of Human Rights and Responsibilities Act 2006
www.legislation.vic.gov.au (Victorian Law Today)

6.1 Legal requirements of involuntary patient transport

There are three main mechanisms or pathways for patients to be transported under the Act.

6.1.1 When a request and a recommendation have been made

Section 9 of the Act provides for the commencement of involuntary treatment. The usual procedure is for a request (Schedule 1) and recommendation (Schedule 2) to be completed prior to transportation.

This documentation is then sufficient authority for any of the following to take the person to an approved mental health service:

- the person making the request
- a member of the police force
- an ambulance or MICA paramedic, or
- any other person authorised by the person making the request.

A request (Schedule 1) can be completed by any person over the age of 18, including a relative of the person, a mental health service staff member or an AV clinician.

A recommendation (Schedule 2) is completed by a registered medical practitioner. The same medical practitioner cannot complete the request and cannot be a relative or guardian of the person being admitted.

Both documents are required for the person to be taken without consent to an approved mental health service. The request or recommendation alone is not sufficient to authorise transport for the person.

6.1.2 When a request and an 'Authority to transport without recommendation' have been made

Section 9A of the Mental Health Act provides an alternative power to transport a person requiring involuntary treatment. Under section 9A, a mental health practitioner may complete an *Authority to transport without recommendation* (Schedule 3). This can be done if the mental health practitioner believes a person meets the involuntary admission criteria and should be taken to an approved

mental health service for examination but a doctor is not available within a reasonable period to consider making a recommendation despite all reasonable steps having been taken to secure the attendance of a doctor.

Both the request and the *Authority to transport without recommendation* forms must be completed prior to transport commencing.

6.1.3 When an involuntary patient who is absent without leave is apprehended

Sections 43 and 53 of the Mental Health Act provide for the apprehension and return of involuntary patients and security patients who are absent without leave.

Under section 43 if a community treatment order (CTO) or restricted community treatment order (RCTO) is revoked, the person is deemed to be absent without leave. Sections 14D, 15D, 36C and 36D, in conjunction with section 43 of the Act, provide for the person's apprehension and return. Written notice of the revocation must also be given to the patient being MHA form 10 *Revocation of community treatment order* and 15A *Revocation of a restricted community treatment order*.

Section 53 of the Act contains similar provisions for security patients.

The Act does not prescribe any forms to authorise the transport of a person who is absent without leave but simply provides that such a person can be apprehended and transported at any time by any of the *authorised persons*.

To arrange transport, mental health clinical staff should ensure a written notice, confirming that the person is *absent without leave*, is faxed to the relevant ambulance communication centre.

This may be either:

- MHA10 *Revocation of community treatment order* or MHA15A *Revocation of restricted community treatment order*, or
- a letter on hospital letterhead.

Ambulance and MICA paramedics can contact the relevant ambulance communication centre to confirm the status of the person. In some circumstances the person will need to be transported to the nearest appropriate and approved mental health service for admission, which may not be the person's catchment area. This may occur where either:

- the person's wellbeing might be adversely affected by a long-distance transfer, or
- a long-distance transfer at that time might adversely affect the provision of acute ambulance care in the community.

In such cases, it is expected that suitable ambulance transport for the interhospital transfer to the appropriate catchment area service will be available within 12 hours.

6.2 Use of restraint and sedation for safe transport

Only a patient who has been either recommended, is involuntary or is being transported under the 'Authority to transport' (section 9(7A) of the Mental Health Act) may be mechanically restrained for the purpose of transport to an approved mental health service.

Ambulance and MICA paramedics, certain professionals employed in mental health services and members of the police force are authorised to enter premises and use such force and physical and/or mechanical restraint as is reasonably necessary to ensure safe transport. A **'prescribed person'** is a member of the police force, an ambulance paramedic or one of the following:

- registered medical practitioner
- registered nurse
- registered psychologist
- social worker, or
- an occupational therapist.

They must also be employed, appointed or engaged to provide care and treatment to people with a mental disorder in either:

- an approved mental health service
- a child and adolescent psychiatry service
- a premises licensed under section 75 of the Act
- a hospital admitting or caring for people with a mental disorder
- a mental health service of a community health centre
- a psychiatric outpatient clinic, or
- a community mental health service.

The mental health professional must ensure the appropriate forms are completed as soon as they are able to do so. These forms remain with the patient during transport and transfer.

6.2.1 Restraint – section 9B (2)

The Mental Health Act section 9B and the Mental Health Regulations 2008 Regulation 6(4) Schedule 4 forms 1 and 2 provide for the use of restraint and sedation for the purposes of safely transporting a person to an approved mental health service. Only prescribed persons[5] are authorised to use restraint for a patient under the Act.

Ambulances have been supplied with approved restraints that can be used if necessary and after all less restrictive options have been considered and assessed as unsuitable. If restraint is considered to be necessary, it is good practice to use the option of these restraints before considering transport in a police vehicle.

The use of restraint must be documented on the Schedule 4, Form 1 *Particulars of use of restraint* by the person who used the restraint.

6.2.2 Sedation – section 9B (3)

A prescribed registered medical practitioner (defined under section 7 of the Act) can administer sedation if they believe it is necessary for the safe transport of a person. The practitioner may direct another registered medical practitioner or a registered nurse to administer the sedation. Ambulance and MICA paramedics are not able to administer sedation in these circumstances. If continued sedation is likely to be required during transport the referring practitioner must make appropriate arrangements for this to occur. This may include providing a registered nurse escort or arranging for sedation to be provided by a health service en route to the final destination. The question of whether ambulance and/or MICA paramedics should be permitted to administer sedation is currently under review as part of the review of the Act.

If sedation is required, both the person prescribing and the person administering it must document this on a Schedule 4, Form 2 Mental Health Act Regulations 2008 *Particulars of use of sedation*.[6] To ensure their safety, involuntary patients who have been sedated must be transported by ambulance.

5 Refer to definitions for list of *Prescribed persons* under section 7 of the Mental Health Act.

6 Any reference to a function or obligation of the authorised psychiatrist of the treating AMHS concerning a person on an NCSO also applies to a private practitioner where the private practitioner has primary responsibility for providing treatment and care to a person on an NCSO.

7. Emergency power of apprehension for people on non-custodial supervision orders (NCSOs)

7.1 Legislation

Section 30 of the CMIA provides an emergency power for the apprehension of a person subject to an NCSO. The person must be failing to comply with the order and be a serious danger to themselves or the public. Depending on the terms of the order, a person may present a danger to themselves or others but still be unable to be apprehended using this power, as they may not have breached the conditions of their NCSO.

The people who are an 'appropriate person' and able to apprehend people under section 30(6) are:

- a person having supervision of the person under the order ('the supervisor')
- a member of the police force
- an ambulance officer
- a person who is a member of a class prescribed for the purposes of this section, being a: registered medical practitioner; registered division 1 or 3 nurse; registered psychologist; social worker; or occupational therapist – who are employed by a public sector mental health service that is an approved mental health service or a community mental health service to provide care and treatment to people with a mental disorder.[7]

A person on an NCSO who is apprehended under section 30 must be taken to an approved mental health service. For the purpose of apprehending the person and taking them to an approved mental health service, an 'appropriate person' may, with such assistance as is required and such force as may be reasonably necessary:

- enter any premises in which they have reasonable grounds for believing that the person to be apprehended may be found
- use such restraint as may be reasonably necessary to enable the person to be apprehended and taken safely.

7.2 Clinical decisions concerning apprehension

Where the authorised psychiatrist of an area mental health service (AMHS) is concerned that a person is breaching the terms of their NCSO and may pose a serious danger to themselves or others, the authorised psychiatrist of Forensicare and the Chief Psychiatrist must be notified immediately.

The authorised psychiatrist of Forensicare and the authorised psychiatrist of the AMHS will together determine whether a person has complied with their order and make an assessment of the danger posed by the person's presence in the community. If it is decided that apprehension and admission are necessary, the authorised psychiatrist of Forensicare and the authorised psychiatrist of the AMHS will decide how and when the person is to be apprehended under section 30 of the CMIA.

To be consistent with the *Victorian Charter of Human Rights and Responsibilities Act 2006*, the apprehension and transport of a person subject to an NCSO under section 30 should be undertaken by the least restrictive means possible in the circumstances and in a manner that ensures the safety of the person and others, and minimises interference with the person's privacy, dignity and self-respect.

Members of the treating team and other clinical staff who are included in the definition of 'appropriate person' may apprehend a person subject to an NCSO under section 30. Clinical staff not included in the definition of 'appropriate person' may also accompany and assist an appropriate person in apprehending the person. If the person is likely to cause a risk to staff or others, assistance must be sought from the police.

7 Refer to Reg. 3 Crimes (Mental Impairment and Unfitness to be Tried) Regulations 2009

In order for a member of the police force to comply with section 30, the member must form a reasonable belief that the person has not complied with the supervision order and is a serious danger to themselves or the public. Members of the treating team will need to provide the police with sufficient information about the person and their circumstances to enable the police to come to a view about whether the person should be apprehended. It will usually be appropriate for a member of the treating team to accompany the police when the apprehension is made. The same principles will apply where the ambulance service is to apprehend the person.

Where there is a dispute regarding appropriate action, the Chief Psychiatrist may be consulted and involved in resolving the dispute. The authorised psychiatrist of Forensicare or the authorised psychiatrist of the AMHS may refer the matter to the Chief Psychiatrist.

7.3 Admission

Under section 30(2) of the CMIA, the apprehended person is to be taken to and detained in an 'approved mental health service'. In making the decision to apprehend a person subject to an NCSO, consideration must be given to which approved mental health service will be most appropriate to meet the needs of the person. The authorised psychiatrist of Forensicare and the authorised psychiatrist of the AMHS will liaise to make this decision. Admission may be to the inpatient unit of the AMHS or to Forensicare's Thomas Embling Hospital. In some circumstances a person may be admitted to the local service pending a bed becoming available at Thomas Embling Hospital. Admission to Thomas Embling Hospital will only be considered where a person cannot be managed safely or appropriately through the AMHS inpatient unit.

7.3.1 Transfer between approved mental health services

A person who has been apprehended under section 30 may be transferred from one approved mental health service to another. This may be necessary where the person has been admitted to the local AMHS pending a bed becoming available at Thomas Embling Hospital. Alternatively, a person may be transferred from Thomas Embling Hospital to the inpatient unit of the AMHS when the person's mental state has settled or to facilitate discharge planning.

The Chief Psychiatrist has the power to direct the transfer of a forensic patient from one approved mental health service to another. The Chief Psychiatrist must be satisfied that the transfer will be of benefit to the patient or is necessary for the patient's treatment. Where a forensic patient is transferred to another approved mental health service, any documents relevant to the detention and future treatment of the patient must be forwarded at the same time. A forensic patient may appeal against a transfer to the Forensic Leave Panel.

Definitions from the Mental Health Act 1986 and Mental Health Regulations 2010 used in this guideline

An **authorised person** means;

(a) a registered medical practitioner
(b) a registered nurse

(people are authorised for the purposes of administration of sedation and restraint to enable safe transport)

A **mental health practitioner** is a registered nurse, a registered psychologist, a social worker or an occupational therapist employed by a public sector mental health service (within the meaning of section 120A of the Mental Health Act) that is an approved mental health service or a community mental health service, and are engaged in the provision of acute psychiatric assessment and treatment functions in the community.

(this is described for the purposes of use of the "authority to transport without recommendation")

A **prescribed person** means:

(a) a member of the police force
(b) an ambulance or MICA paramedic; or
(c) a member of the following categories of health professionals:
    (i) registered medical practitioners
    (ii) registered nurses
    (iii) registered psychologists
    (iv) social workers
    (v) occupational therapists—
    employed, appointed or engaged to provide care and treatment to persons with a mental disorder in an approved mental health service, a child and adolescent psychiatry service, premises licensed under section 75 of the Act to provide ECT, a hospital admitting or caring for persons with a mental disorder, a mental health service of a community health centre, a psychiatric outpatient clinic or a community mental health service.

(these descriptions are in place to allow prescribed people to bring patients for treatment)

A **prescribed registered medical practitioner** is a registered medical practitioner who is—

(a) in general practice
(b) the registered medical practitioner who recommended that the person receive involuntary treatment from an approved mental health service
(c) the head of the emergency department of a hospital
(d) employed as a registered medical practitioner by a psychiatric service within the meaning of section 106 of the Act
(e) a psychiatrist
(f) a forensic physician

(these descriptions allow for identification of those who can prescribe sedation for safe transport of patients)

A **registered nurse** means a person registered under the Health Practitioner Regulation National Law—

(a) to practise in the nursing and midwifery profession as a nurse (other than as a midwife or as a student); and
(b) in the registered nurses division of that Profession.

A registered medical practitioner means a person registered under the Health Practitioner Regulation National Law to practise in the medical profession (other than as a student).

A **registered psychologist** means a person registered under the Health Practitioner Regulation National Law to practise in the psychology profession (other than as a student).

Useful resources

National safe transport principles 2008, Australian Health Ministers' Advisory Council, Mental Health Standing Committee, Safety and Quality Partnership Subcommittee
http://www.health.gov.au/internet/mhsc/publishing.nsf/Content/3545C977B46C5809CA25770D00093C93/$File/National%20Safe%20Transport%20Principles%20FINAL%20-%20endorsed.pdf

Ambulance transport of people with mental illness protocol, 2010
www.health.vic.gov.au/mentalhealth/publications/amb-transport0910.pdf

Department of Health and police protocol for mental health, 2010
www.health.vic.gov.au/mentalhealth/publications/police-mh-protocol0910.pdf

Non-emergency transport of people with mental illness, 2008
www.health.vic.gov.au/ambulance/nept.htm

Victorian mental health services cross-border agreements with other states
www.health.vic.gov.au/mentalhealth/crossborder/0_op_guide.pdf

Victorian Charter of Human Rights and Responsibilities Act 2006
www.legislation.vic.gov.au (Victorian Law Today)

Guidelines for the transport of psychiatric patients, NSW Health Department, 1991, reviewed January 2010
www.health.nsw.gov.au/policies/PD/2005/PD2005_044.html

About Chief Psychiatrist's guidelines

The information provided in this guideline is intended as general information and not as legal advice. Service providers should obtain independent legal advice if they have queries about individual cases or their obligations under the *Mental Health Act 1986*.

Further information

For further information contact the Chief Psychiatrist on 9096 7571 or 1300 767 299 (toll free).

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