

30 October 2006

Ministry of Health and Accident Compensation Corporation

Submission on Service Specifications Review: Primary Response in Medical Emergencies (PRIME)

1.0 Preamble

The intention of this submission is to provide advice from the perspective of current PRIME practitioners to the Ministry of Health (the Ministry) and the Accident Compensation Corporation (ACC) around the service specifications, definitions and changes needing to be taken into account to ensure the successful continuance of the PRIME scheme. Service specifications and definitions need to be cognisant of the establishment of Nurse Practitioners™ who practice in rural areas and will undertake to work as PRIME practitioners.

The New Zealand Rural General Practice Network (the Network) believes that the contracts and specifications need flexibility in their implementation to reflect the diversity, complexity and constraints of providing emergency care to New Zealanders living in rural areas. The Network further suggests that the revision of the service specifications and definitions provides a beginning point for input into the PRIME scheme. More work is required to look closer at PRIME training and an advocacy strategy to influence funding, delivery and management of PRIME. This is in order to support PRIME practitioners and the teams providing emergency care at “grass roots” in rural areas of New Zealand.

This submission includes material provided by Simon Bidwell (of the Ministry) and his “Starter for 10” outline of Service specifications and other examples of contracts and previous ACC and Ministry templates for PRIME contracts. The submission provides a brief outline of the history and issues around the PRIME scheme as practitioners know it.

The Network submits a number of recommendations based on:

- current research/surveys undertaken by the Network from PRIME and non PRIME practitioners;
- direct feedback from rural PRIME practitioners to this submission; and
- literature around PRIME both published and unpublished thesis material on PRIME.

1.1 History

The PRIME Service has been operational since 1998 in the South Island and 2000 in the North Island. The history of this service dates back to 1994 where media interest and public outcry centred on the failings in emergency services at two specific road traffic accidents in the South Island. Following these incidents, rural General Practitioner Dr Trevor Walker from Te Anau took time out from his practice to write a report for the Southern RHA, HFA and ACC and to design a system focusing on pre-hospital care – now known as the “PRIME System” (Walker, 1995; Toll, 2005). The policy document “Roadside to Bedside”, drafted by Wyatt

Creech in collaboration with the Ministry and ACC later became the policy base for the PRIME scheme. The PRIME scheme has been described as a national initiative demonstrating different agencies working together to provide acute accident and emergency care. It has been championed as an *example of different groups working well together, in support of rural health care services* (Creech, 1999; Rural Expert Advisory Group, 2002; Toll, 2005).

1.2

Current research and surveying of PRIME practitioners supports that the PRIME service is regarded as fundamentally sound and on the whole works well (Janes, 2006; Hyde, 2006; Toll, 2005).

1.3 Over view of issues surrounding PRIME

Concerns have increasingly been expressed, however, in the New Zealand literature and to the Network (New Zealand Rural General Practice Network; NZRGPN) about variations in implementing the PRIME service.

1.4 Funding and contracting

The contract and funding arrangements that were to enable and authorise rural Doctors and Nurses to provide a pre-hospital service to rural communities has been fraught from the beginning. The complexity of the contract retainer payments through a third party has raised concerns about the need to “ring fence” funding to sustain the PRIME service.

In 2000, the HFA chose to bulk fund the Order of St John, to provide retainer payments to General Practitioners, PRIME training courses and emergency medical kits to PRIME practitioners/localities. ACC PRIME contracted with Independent Practitioner Associations and those providers who were not members of IPAs were offered identical contracts. Individual localities were offered contracts through the Order of St John (Toll, 2006). Each group, acting as a caretaker for administering their part of the PRIME service to practitioners, charged the government management/administration fees on top of the funding allocated to support the service.

Currently the Ministry and ACC fund the PRIME system jointly. This includes:

- administration and coordination of the PRIME system;
- the maintenance of the PRIME committees;
- the supply of pagers to PRIME practitioners;
- audit of services;
- replacement of consumables from PRIME kits and new PRIME kits as needed; and
- distribution of retainer fees to PRIME localities.

The number of provider contracts appears to vary between Ministry of Health and ACC data. The Ministry has ring fenced funding for PRIME services in an agreement with the Order of St John. This funding encompasses the provision of the following components nationally:

- training;
- administration;
- fees; and
- equipment.

In 1995, Dr Walker made recommendations to the funding authorities on a daily rate to be paid to practitioners as a retainer for attending emergencies (as agreed under the PRIME scheme). In 2000, the retainer payments to PRIME localities were \$20.00 plus GST per 24-

hour period on call. This was well under the \$50.00 plus GST recommended by Dr Walker in his original costing. In 2005, the retainer was increased to \$34.70 plus GST per 24-hour period. This remains woefully inadequate.

1.5

The Network recommends a review of funding around the provision of retainers to support pre-hospital services and to pay for attending PRIME medical emergencies in rural areas. Medical emergencies call outs make up the more significant number of PRIME call outs. The Network is concerned about inconsistencies around recognition and compensation for pre-hospital care for non trauma emergencies. Effective pre-hospital care for medical emergencies is proven to improve outcomes for patients and their families and has a more positive effect financially.

There appear to be inconsistencies in the roll out of the contract. For example, differences in how North Island PRIME providers and their South Island colleagues have been serviced. Inconsistencies are well documented in the databases (PRIME sites and the roll out and review of PRIME sites). There are reports of differences around triage and variations in the activation system and in some cases there are reports of a lack of, or drop off in, PRIME call outs to PRIME practitioners (Hyde, 2006). Other concerns have been expressed around:

- the provision/replacement of medical kits;
- the functioning of PRIME committees;
- a lack of funding provided for medical emergencies that make up the more significant number of PRIME call outs requiring advanced life support.

The Network's 2006 telephone survey of PRIME practitioners highlighted a range of positive comments about the accessibility and quality of PRIME education and delivery. However, there were a number of concerns expressed about accessibility to information about and availability of training courses. More recent feedback has informed the Network that although there was an increase in ease of accessing PRIME courses generally, there are now no courses available this year for new practitioners, and there is a lack of provision of PRIME education modules available in the practitioner's localities and at a time suitable for them to attend.

2.0 General Recommendations

2.1

The Network welcomes the review and alignment by the Ministry and ACC of the service specifications, specific terms and conditions (such as for training), pricing/purchasing/funding frameworks and processes, and a review of quality specifications.

2.2

The Network recommends that the key stakeholders (Network PRIME representatives, Rural practitioners working for DHBs, NZRCGP rural representatives, and Rural Nursing representatives) continue to work together as an umbrella group (such as the PRIME Advisory Group) to provide ongoing advice and support in the first instance to:

- the Ministry
- ACC
- PRIME committees

on PRIME issues.

3.0 Service specifications

3.1

Definition

The PRIME service is a system that contributes to the best possible outcomes of patients involved in trauma or non-trauma, medical, obstetric or psychiatric emergencies in rural areas. It is achieved by timely and appropriate interventions that continue during the rapid and safe delivery of patients to places of definitive care. It involves a co-ordinated response by primary health care practitioners, together with ambulance services, to emergencies in rural areas.

Comment

3.1.1 *The Network is aware of areas where ambulance services are staffed by volunteers. This result in situations where there may be a delay in ambulance response and the PRIME practitioner may be the sole responder to the emergency.*

3.1.2 *With centralisation of ambulance control centres there is a greater need for accurate triage and a nationally agreed activation system. The PRIME activation system in the original ACC and Ministry specifications needs to be accepted as the agreed as system for activating PRIME call outs.*

- At least 30 minutes standard driving time from a secondary hospital providing Level 3 or higher emergency department services as described in the Ministry of Health Tier Two service specification: and

3.1.3 *The 30-minutes standard driving time may be affected by geographical and climate constraints in various seasons. Flexibility needs to be built into the specifications to allow those localities where geographical or seasonal vagaries may mean that they would fulfil the requirements as a PRIME locality intermittently.*

- Within a 30-minute radius, there is not an ambulance service of Advanced Life Support (ALS) level available 24 hours a day, seven days a week

3.1.4 *Definition of (ALS): Advanced Paramedic with a Diploma in Ambulance: 2 years of clinical practice at paramedic level. Authorised skills and procedures: – Primary care, ambulance officer and paramedic skills plus: Endotracheal intubations/larageal mask insertion, intraosseous needle access, chest decompression, Thorococentesis or crichothyroidotomy, synchronized cardio version. Drug therapy as per protocol: Morphine, Metacloprominde, Naloxone, adrenaline (IM, IV, NEB), Atropine, Fruesimide, Amirodarone, Lignocaine, Midazolam, Diazepam, Promethazine, Salbutamol, GTN, aspirin, RSI for approved Advanced Paramedics. This list may change as the protocols are up dated (Bills, 2002).*

3.1.4 *The PRIME advisory group agreed (28 October 2005) that a Doctor or Nurse provided the service with a Rural Ranking Score >40 or a Notional Rural Ranking Score in the case of nurses. ACC was to undertake an analysis of whether they would move from 35-40 but to date this information has not been received by the advisory group (PRIME advisory; 28 October 2005). In light of the current review of the Rural Ranking Scale, the Network recommends that the rural ranking score*

in the definition for a PRIME area be 35 or a notional rural ranking score until there is agreement for a rural ranking score for Rural Nurses.

3.1.5. The Network recommends that the service definitions should be aligned in both the Ministry and ACC specifications. However, the Network agrees that:

- ACC remuneration to PRIME practitioners centres on attendance by a PRIME practitioner or practitioners at an emergency in a rural location that has resulted in a “personal injury” requiring assessment and treatment services.
- Ministry of Health remuneration to PRIME practitioners centres on the attendance by a PRIME practitioner or practitioners at medical, obstetric or psychiatric emergency in a rural location that has resulted requiring assessment and treatment services.

3.1.5 The Network recommends that:

- the service specifications relating to the PRIME localities are not limited to a set number of localities and new localities are agreed to in conjunction with the stakeholders of PRIME;
- an up to date register of localities and practitioners is maintained and made accessible to all stakeholders.

3.2 Service objectives

3.2.1. General

The objectives of the PRIME service are to:

- Provide timely access to clinical skills that have the potential to improve outcomes for medical, surgical, trauma or obstetric or *mental health* emergencies in rural areas

3.2.2 Comments

The Network is aware that PRIME practitioners are frequently called using the PRIME activation system to de-escalate, assess and treat patients in an acute mental health emergency. This usually occurs where there:

- are no immediately available mental health emergency services;
- may be confusion as to the nature of the emergency; or
- may be a trauma, non- trauma emergency or substance use simultaneously and there is the need for immediate assessment to be carried out.

This excludes mental state examination for chronic conditions that would usually be carried out by mental health services.

3.2.3 Commencement and exit from services:

- The time the RCC request is received by the PRIME practitioner is the **commencement** of the call out to attend a trauma emergency or when agreement is reached with the Regional Control centre(RCC) that the call out is a PRIME call.
- The time of return to their normal residence or place of work (the place where the contact was made) is the **exit**.

3.2.4 The Network recommends that in cases where a PRIME call involves more than one casualty and more than one PRIME practitioner attends the PRIME emergency, the practitioners will be entitled to apply for remuneration from ACC.

3.2.5 The minimum call out period for PRIME services will be thirty minutes.

3.2.6 Location: Services will be provided at the location of the accident or at a location agreed to by the RCC.

The Network is aware of a number of incidents where patients have been in an accident at one locality and their condition changes en-route to a definitive care site. A PRIME practitioner is then contacted by RCC to provide emergency reassessment and intervention. Patients are therefore treated in an ambulance at a medical centre rather than the original accident site. This needs to be accepted as a PRIME call and compensated accordingly. There is a need for flexibility in these specifications for individual cases to be reviewed and compensated accordingly.

- Support the effective functioning of the wider emergency care system by providing timely advice on a patient's need for definitive treatment, and appropriate mode of transport to that treatment.
- 3.3.1 *The intent of these specifications is to improve pre-hospital patient intervention, timely interventions and improved patient outcomes and well-being by early and advanced life support.*
- 3.3.2 *The PRIME practitioner will communicate with the wider emergency team and advise on the patient's need for definitive treatment, and appropriate mode of transport to that treatment; regardless of being a Doctor or a Nurse. In the case of helicopter retrieval or request for more advanced medical back up/retrieval team the PRIME practitioner will consult with RCC and or the retrieval team.*
- 3.3.3 *Contribute to the aims of Roadside to Bedside: a 24-hour acute management system for New Zealand to ensure that patients get "the right care, at the right time, in the right place, delivered by the right person".*
- 3.4.1 *The Network agrees that PRIME practitioners provide services to support the wider emergency care system, within reason. All reasonable effort will be made to provide PRIME cover 24 hours a day, 7 days a week. There may be circumstances where a sole practitioner is not able to guarantee this 365 days a year but they should be still eligible to participate in the PRIME contract.*
- 3.4.2 *The service will include the concepts of Preparedness to respond; Activation, Response; On site medical management; Follow-up and debrief.*
- 3.4.3 *The service is supported by on line specialist medical advice either by radio/telephone communication and accessible by an 0800 number and/or radio.*
- 3.4.4 *The Network recommends that whoever delivers the PRIME service will have ongoing access to specialist medical advice and support. A registered nurse will be accountable to follow protocols and standing medical orders (Medicines Regulations 2002) that are not less than that of an advanced paramedic and are endorsed by a prescriber as per the Medicines Regulations (including subsequent guidelines and amendments).*
- 3.4.5 *The Network endorses that PRIME committees be empowered to maintain up to date registers of PRIME practitioners for their regions and that a national register of PRIME practitioners be maintained and made available to stakeholders.*

- 3.4.6 *The Network recommends that the lists of PRIME practitioners are subject to audit. The audit should review data relating to currency in attendance/competency in PRIME/advanced life support.*
- 3.4.7 *That the specifications recognise and delineate between nurses who are party to a rural contract with ACC but practice in a medical/health centre and those nurses who also undertake to attend call outs as PRIME Practitioners. Nurses practicing under the rural ACC contract and who do not attend roadside emergencies or do not respond to 111 call outs shall be excluded from these specifications.*
- 3.4.8 *The Network recommends that practitioners are supplied with and work from current evidence based national protocols that are known and recognised by all members of the emergency team. Training is available, accessible and updated at regular intervals not less than every two years. Training needs are assessed and training updates are modified according to the request of the practitioners and the local needs in conjunction with regional PRIME and ECCT Committees.*
- 3.4.9 *The Network recommends that there be regular reviews of the curriculum for initial PRIME training, training delivery modes, methods and facilitators. The Network further recommends that the PRIME course be accredited by the NZ Qualifications Authority and that recognition is sought for the PRIME training by both the Medical and Nursing Councils of NZ and their respective colleges.*
- Contribute to the New Zealand Health Strategy aim of ensuring a “high-performing system in which people have confidence”
- 3.5.1 *The Network recommends the further development and empowerment of the regional PRIME committees to work with practitioners to:*
- *review PRIME call outs;*
 - *ensure that there is supportive peer review for PRIME Practitioners;*
 - *provide or facilitate access to debrief to PRIME practitioners;*
 - *undertake audits of the PRIME system;*
 - *support clinical audit of individual PRIME calls; and*
 - *make recommendations and support education around clinical practice.*
- 3.5.2 *The Network recommends further review of the “Terms of Reference“ for regional PRIME committees and their relationships to the ECCT committees, and PHOs under the Primary Health Care Strategy roll out.*
- 3.5.3 *The Network recommends that quality monitoring systems are transparent and able to be reviewed by stakeholders and the PRIME Advisory Group on not less than an annual basis.*

Maori Health

Statistics show Maori are disproportionately represented in medical emergencies. Presentation to health services by Maori may be delayed as a result of cultural and socio-economic factors. The PRIME service must provide culturally appropriate services that recognise the needs of the patient and whanau/family in life and in the event of a patient's death.

4.0 Service users

The PRIME service is for anyone in a rural area with illness, injury, *mental health emergency* or obstetric complications who requires or is perceived to require immediate (within 30 minutes) pre-hospital assessment, stabilisation and/or treatment that is unable to be provided by a Basic or *Intermediate* Life Support-capable ambulance.

5.0 Access

Entry and exit criteria

Entry criteria: Service users will generally access the PRIME service by calling for an emergency ambulance through the '111' ambulance control system.

Where the PRIME system is activated through other means (such as when a patient or their family member contacts a PRIME GP in an emergency), the PRIME practitioner will inform the ambulance communications centre as soon as is practicable, and co-ordinate their response with the communications centre.

5.1 Distance

The PRIME service aims to provide access to appropriate skills within a rural community in a more timely fashion than could be delivered by an *ALS ambulance* from outside the community.

PRIME practitioners should make best endeavours to reach the scene of an emergency within *the quickest possible time* of being contacted by the ambulance control centre.

5.2 Time

The PRIME service will ideally be available 24 hours a day, seven days a week.

PRIME practitioners should respond to activation of their pager within two (2) minutes by contacting RCC.

Primary health care practitioners who agree to deliver the PRIME service will keep local ambulance services and the regional ambulance control centre informed of their availability.

Emergency ambulance services will include the availability of PRIME practitioners in their duty rosters and will have documented plans for backup from a higher-level ambulance service if PRIME practitioners are unavailable.

6.0 Service components

6.1 Processes

Planning

PRIME practitioners will have access to a PRIME committee, as described in the terms of reference, which develops plans for local and regional emergency response. Regional and local planning will include, but is not necessarily limited to:

- availability of ambulance resources;
- medical and nursing on-call rosters;
- triage protocols and procedures for activating a PRIME response;
- procedures for obtaining specialist medical advice;
- major incident plans; and

- planning for emergency response during infectious disease epidemics.

Response

Response to emergencies in rural areas is coordinated through the regional ambulance control centre, described in the joint Ministry/ACC Tier Two service specification.

An on-duty PRIME practitioner will be notified by the ambulance control centre by pager, or other means, of any emergency where their attendance may be required. The practitioner may then decide to attend the incident, or request additional information from the ambulance control centre before deciding whether to attend the incident.

PRIME practitioners should aim to be at the site of the emergency as rapidly as is practicable after being notified of an incident.

6.2 On-site Medical Management

The aim should be to complete the on-site phase of a PRIME response within *the quickest possible time*.

Comment

The ideal is to aim for the patient reaching definitive care within 1 hour (the Golden Hour) but where geography, weather and/or the situation constrains assessment and stabilisation, the on site phase of a PRIME response will vary. Such situations as:

- *multiple trauma victims;*
- *delays in support systems arriving;*
- *trapped patients in vehicles;*
- *dangerous situations;*
- *geography;*
- *inclement weather conditions.*

may alter this.

The functions of the on-site phase include:

- *assessment;*
- *resuscitation;*
- *stabilisation;*
- *recognition of the conditions that cannot be stabilised on site;*
- *preparation for transportation to places of definitive treatment.*

Critical Action Checks should be carried out. These are:

- Safety and System
- Airway and cervical spine control
- Breathing
- Circulation
- Danger to brain or spinal cord
- Environment
- Forward planning

The PRIME practitioner will not perform unnecessary procedures, x-rays or other diagnostic investigations that delay the transport of the patient to the site of definitive care.

Contact should be maintained with the ambulance control centre whenever possible.

Transport

The patient(s) will be transported rapidly and safely to definitive care by the most expeditious route. Patients should continue to receive optimum care during transport.

To ensure safe transport, patients may need to be taken to small hospitals or community facilities for resuscitation, stabilisation or assessment. Procedures performed at these locations are directed toward preparation for safe transport, and non-essential procedures that delay transport should not be performed.

Choice of transport types and modes depends on:

- geographical and meteorological considerations
- need for speed
- level of intervention required en route
- availability of vehicles and personnel.

Decisions on transport types and modes are made by the senior on-site ambulance officer in consultation with the ambulance communications centre, PRIME practitioners and/or on line medical advisors.

6.3 Review

PRIME committees will undertake *monitoring of all PRIME call outs and case review of selected emergency responses*, with priority given to those identified by PRIME practitioners, or other stakeholders, or sentinel or reportable events (see terms of reference at Appendix I). Case reviews will consider:

- Triage of incident by communications centre, quality and timeliness of information made available to ambulance and PRIME practitioner
- Appropriateness of resources dispatched to incident
- Care provided at the scene, including use of equipment, drugs, or other clinical interventions
- Delivery of patient to hospital-based care and care provided during treatment
- *Support needed by PRIME practitioners especially in areas of high trauma or specific cases, or where there may be new practitioners.*

7.0 Settings

The PRIME service is provided in a pre-hospital, community-based setting. The place where the service is provided to the service user.

7.1 Common settings may include motor vehicles, other accident sites, a person's home or work place, community facilities or recreational areas, or back country sites.

The PRIME practitioner may accompany a patient in the ambulance to the place of definitive care.

8.0 Definitions:

Service levels

Where a service is provided at different complexity levels by different providers and the purchase units for a service do not recognise differences between services, the levels of service should be defined. Where possible an existing classification should be used, eg NZ Role Delineation Model. Where no classification system exists, the service specification

should specify the expected differences in service levels. Service levels may be delineated in a variety of ways, eg service user types (risk factors), facility size, available technology, presence of related services.

Intermediate Life Support (ILS) PRIME service: provides assessment, stabilisation and treatment of patients in the pre-hospital setting at least equivalent to assessment, stabilisation and treatment able to be provided by an ILS ambulance service. (*This needs to be defined per the current definition of Ambulance personnel.*)

The PRIME service will be supplied at the scene of the emergency situation wherever that may be and that the PRIME practitioner may accompany the patient(s) from there to a place of further treatment or management.

*Definition of (ALS): Advanced Paramedic with a Diploma in Ambulance: 2 years of clinical practice at paramedic level. Authorised skills and procedures:
– Primary care, ambulance officer and paramedic skills plus: Endotracheal intubations/ laryngeal mask insertion, intraosseous needle access, chest decompression, Thoracocentesis or cricothyroidotomy, synchronized cardio version. Drug therapy as per protocol: Morphine, Metoclopramide, Naloxone, adrenaline (IM, IV, NEB), Atropine, Frusemide, Amiodarone, Lignocaine, Midazolam, Diazepam, Promethazine, Salbutamol, GTN, aspirin, RSI (?) for approved Advanced Paramedics. This list may change, as the protocols are up dated (Bills, 2002).*

General Practitioner: means any person registered as a medical practitioner under the “Medical Practitioners Act” 1995 (and subsequent amendments) and the Health Practitioners Competency Assurance Act 2003; who provides primary and continuing care to individuals, families and to a practice population and holds vocational registration with the NZMC in that field.

8.1 Nurse Practitioner: means any person registered as a Nurse Practitioner™ under the Nurses Act 1977 (and amendments) and who provides primary and emergency care to individuals, families and populations within their designated scope.

8.2 Registered Nurse: means a nurse currently registered as such under the Nurses Act 1977 (and subsequent amendments) and the Health Practitioners Competency Assurance Act 2003, working under the scope of practice of a Registered Nurse.

8.3 PRIME practitioner: means a

- General Practitioner (or his/her Locum tenens)
- Nurse Practitioner™
- Registered Nurse

who holds a PRIME contract and has been suitably and appropriately trained.

9.0 Equipment

Each physical clinic or location from where the PRIME service is provided, or a PRIME practitioner is based, will have access to a PRIME kit, comprising items necessary for the assessment, stabilisation and treatment of patients. This PRIME kit is to be maintained by St John.

Where there is a Doctor and a Nurse Practitioner or Nurse on PRIME call more than one PRIME kit may be required. The Network recommends that each PRIME practitioner should be provided with a pager and a medical kit.

- 9.1 The PRIME kit will contain at least those items listed at Appendix II *but not be restricted to those said items.*

Protective clothing such as "Full overalls; safety glasses, leather gloves, reflectorised jackets and jerkins with "PRIME PRACTITIONER" on them should be added to the initial PRIME kits.

- 9.2 *The Network recommends that Practitioners specify the types of packs required for their areas based on geography and most common call outs.*

- 9.3 *The Network recommends that the original Schedule 2 in the ACC specifications be amended to incorporate the above recommendations, that is – more than one kit may be appropriate to distribute to each locality; and the kit is modified to the locations requirements but is similar to those used by St John ambulance service in the South Island. The kit should include oxygen and laryngeal masks.*

PRIME committees will review the contents of the PRIME kit at regular intervals (no more than 6 monthly), and will recommend additions or other changes to the composition of the kit where these have the potential to improve outcomes in medical emergencies and/or improve the quality of the service provided.

10.0 Support services

A list of all the support services that are required to be provided as an integral part of the service and are included in the service price (eg intensive care, hotel services, diagnostic tests, allied health).

10.1

The Network recommends where there is a need for debriefing a PRIME practitioner after an emergency or critical incident that there is provision in the contract for services to be purchased to undertake debriefing and that this is organised in conjunction with the regional PRIME committee.

Facilities

N/A

Key inputs

An indicative list of key inputs such as professional staff, consumable supplies, pharmaceuticals.

The PRIME service is provided by a health practitioner with a professional medical or nursing qualification. In addition, the PRIME practitioner will have received appropriate education and training in emergency response, including but not necessarily limited to:

- At least the full PRIME course or equivalent in *Advanced Life Support*.
- Medical or nursing continuing education sufficient to maintain emergency response skills developed through the PRIME course. This should include, but not necessarily be limited to, PRIME refresher training at appropriate intervals.

- Orientation *and clinical supervision* in local emergency protocols and procedures *will be the responsibility of the locality in conjunction with the regional PRIME committee.*
- *Other suitable training that is endorsed by the general practice and nursing colleges and is acceptable to ACC.*

We are happy to provide further information in support of this submission.

Kirsty Murrell-McMillan
 Rural Nurse Representative on the PRIME Advisory Group
 on behalf of the New Zealand Rural General Practice Network

References

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