

# SWORBHP LINKS

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## Trick? No, Treat!

I couldn't resist this title given the time of the year...

I have lost count the number of times paramedics ask us questions which start with "I am just asking this because I don't want to get in trouble with the Base Hospital..." While we love getting questions from paramedics, I really hope there will come a day when that introductory disclaimer is no longer used.

While your Advanced Life Support Patient Care Standards (your medical directives) are at times complicated, it is not the intention of the Base Hospital to trick you into making a mistake while treating your patients. In fact, we agree that some directives could be improved or changed, however, the current version of the medical directives represents the consensus of the seven Regional Base Hospitals (RBH). Unlike in years past, we are unable to change them locally or add new ones to suit our need.

The medical directives cannot account for every situation. If they did, your handbook would not fit in your pocket! For the benefit of the patients we care for, we need to hear from you when you encounter a situation where it seems the directives did not provide you with a clear direction, or, you were not sure how best to interpret the directives to treat your patient. We understand these situations are frustrating and anxiety provoking, but if you have felt this way, chances are other paramedics have felt the same. By letting us know, you provide us an opportunity to clarify our interpretation of the directives, speak to the medical science, and provide you (and others) a direction. No one is going to get in trouble, and no one is trying to trick you. Treating critically unwell patients is challenging and stressful, and we want to help.

Our education, professional standards, and medical director staff are always happy to hear from you if you have questions. If you prefer to remain anonymous, you always have the option to use the ASKMAC website. If you haven't heard of this, take a look here:

[http://www.lhsc.on.ca/About\\_Us/Base\\_Hospital\\_Program/askmac.htm](http://www.lhsc.on.ca/About_Us/Base_Hospital_Program/askmac.htm)

The medical directives allow you to treat your patients. We want you to feel comfortable using them. If you are ever unsure of the best way to implement them, ask us. We want to help. No tricks!

Michael Lewell, B.Sc., M.D., FRCP(C)  
Regional Medical Director

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## Emergency Department Process Improvement

Emergency Department (ED) overcrowding is “one of the most challenging issues currently facing the Canadian health care system” (Ospina et al., 2007, p. 340) and cannot be solved by focusing on the ED’s alone. It is a systemic issue which requires making improvements across the entire system (The Ontario Ministry of Health and Long-term Care, 2011). Bullard et al. (2009) cited the “top five causes of ED overcrowding as (1) lack of admitting beds, (2) lack of acute care beds, (3) ED length of stay for admitted patients, (4) increased complexity or acuity, and (5) occupancy rates of ED stretchers (primarily caused by output failure)” (p. 100).

In 2008, the Ontario Ministry of Health and Long-term Care (MOHLTC) began tackling this endemic problem. This initiative was called ED Pay for Results (ED P4R). The Ontario MOHLTC set targets for ED wait times for the 90<sup>th</sup> percentile (the maximum amount of time nine out of ten patients spend in the ED). For minor, uncomplicated conditions the target was four hours. For complex conditions requiring more time for diagnosis, treatment or admission the target was eight hours (The Ontario Ministry of Health and Long-term Care, 2010b). The focus of the ED P4R initiative was on EDs with the longest length of stay and poorest metrics. If participating hospitals were able to reduce their ED wait times to meet the targets set by the Ministry, they would receive a one-time funding bonus. Many hospitals within the Southwest LHIN have participated in this initiative.

Out of this work came another initiative called the Emergency Department Process Improvement Program (ED-PIP). This was a structured program intended to support improvements in ED length of stay metrics. The program built capacity within hospitals to ensure long term sustainable change through the utilization of LEAN methodologies and tools by reducing waste in the system from the patient’s perspective. The program was intended to support hospitals to move their ED metrics towards provincial Pay for Results targets. Since March 2009, over 100 sites have participated in the program across Ontario (Ontario Ministry of Health and Long-term Care, 2010a).

Improvement teams in hospitals examined patient flow from “end to end”: from arrival in the ED through to discharge from the inpatient units. In 2011 and 2012, three hospitals in the Southwest LHIN participated in this initiative: St. Thomas Elgin General Hospital; Grey Bruce Health Services, Owen Sound Site; and London Health Sciences Centre, University Hospital Site (Ontario Ministry of Health and Long-term Care, 2010a). Work is ongoing to sustain the gains made through this project work.

Susan Kriening, R.N., B.Sc.N, MHS, ENC(C)  
Manager, Emergency Department  
University Hospital, LHSC

### References

Bullard, M.J., Villa\_Roel, C., Bond, K., Vester, M., Holroyd, B.R., & Rowe, B.H. (2009). “Tracking emergency department overcrowding in a tertiary care academic institution” *Healthcare Quarterly*, 12(3), 99-106.

Ospina, M.B., Bond, K., Schull, M., Innes, G., Blitz, S., & Rowe, B.H. (2007). “Key indicators of overcrowding in Canadian emergency departments: a Delphi study. *Canadian Journal of Emergency Medicine*, 9(5), 339-346.

The Ontario Ministry of Health and Long-term Care. (2010a). Emergency department process improvement ED PIP toolkit webpage. Retrieved from <http://www.patientflowtoolkit.ca/AboutPIP.htm>

The Ontario Ministry of Health and Long-term Care. (2010b). Emergency room wait times-emergency room targets webpage. Retrieved from <http://www.health.gov.on.ca/en/pro/programs/waittimes/edrs/targets.aspx>

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## Tricks of the Trade – The Power of Suggestion, Words and Actions

The use of words and actions can be powerful tools for treating patients. People who are injured or ill are often anxious about their injury or illness. They are scared that something is seriously wrong with them. They are afraid they will not recover or they are going to have pain and suffering.

Remaining calm yourself, using a reassuring tone of voice and not making sudden jerky movements are important tools you have to help them remain calm and reassure them things might not be as bad as they fear. This is particularly so with children.

Words and visual cues trigger anxiety and bad memories for some people. This is why it is very helpful to be careful how you use words. Don't tell someone, "I am going to give you a needle now", or say "this is going to hurt". Try saying "you might feel a little discomfort for a second or two".

Rather than stand in front of someone while you draw up medication in a syringe, allowing them to think about and anticipate the injection you are going to

give, try turning your back to them or holding the syringe low and out of sight. You can ask them to turn their head away so they will not see the needle coming and thereby not anticipate the discomfort of an injection or IV start. It is often helpful to get the patient talking about something else, such as giving you a detailed verbal description of a place they would rather be right then. This use of distraction and imagining a more pleasant experience is actually a form of light hypnosis.

These tricks of the trade are simple and surprisingly effective to reduce your patient's anxiety and increasing their comfort. Think about what else you can do to decrease their anxiety. Knowing how to increase your patient's comfort is one of the things that makes a great paramedic.

Don Eby, M.D., M.Sc., CCFP(EM) FCFP  
Local Medical Director  
Grey, Bruce, Huron, Perth

## Paramedic Recognition Awards

SWORBHP would like to acknowledge the following paramedics for their role in obtaining a prehospital return of spontaneous circulation (ROSC). Each patient survived to hospital discharge. Congratulations!

### County of Lambton EMS

Mike Rodger, Dawn McBean (June 10, 2012)  
Tara Douglas, Corinne Adamek (July 28, 2012)

### Grey County EMS

Sherry Foster, Paul Sollors (July 2, 2012)

### Essex-Windsor EMS

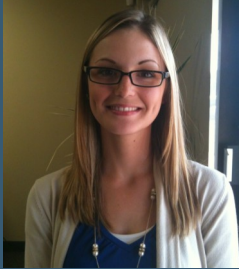
Julie Sylvester, Kenji Takeshima, Meikel Gobet, Corey Nelson, Ryan Lemay (January 5, 2012)  
Michella Mollicone, Justin Lammers (January 20, 2012)  
Holly Beck, Brad Humber, Allison Baars (January 22, 2012)  
Jason Renaud, Matthew Gosselin, Shawnee Morden, Amanda Rizzo (February 27, 2012)  
Adam Kidd, Mike Basinski (April 5, 2012)  
Ziad Fatallah, Jacey Brockman (April 10, 2012)  
Anthony Jaroszewicz, Ken Silver, Julie Sylvester (April 22, 2012)  
J.P. Bacon, Aaron M. Campeau (June 13, 2012)  
Deanna Owen, Tim Soulliere, Doug Litster (July 6, 2012)  
John Lassaline, Larry Johnson (July 18, 2012)

***Watch for introduction of the new "Medical Director's Commendation Award"...coming soon!***

Cathy Prowd, CQIA  
Operations & Logistics Specialist

## Up Close and Personal

In this edition of LINKS, we will take you up close and personal with Asha Rogers and Christine Hardie. We hope this allows you an opportunity to get to know each of them a little better.



**Asha Rogers**  
Administrative Assistant

Asha joined SWORBHP in July 2012 as the Administrative Assistant. She holds a diploma in Office Administration Executive from Fanshawe College. In the past, she worked as the Administrative Assistant for Bradken where she directly supported the Machining/Engineering Manager. Asha has a passion for hard work and is always striving for excellence. She provides administrative support to Severo Rodriguez, Dr. Michael Lewell and Dr. Michael Peddle.



**Christine Hardie, ACP**  
Regional Paramedic Educator

Christine joined SWORBHP in September 2012 as a full-time Regional Paramedic Educator. She joins the program following seven years of teaching as a full-time Professor with the Paramedic Program at Lambton College. Christine is currently working towards a Bachelor of General Studies-science designation, CQIA/CQPA certification, and a Professional Certificate of Adult Education from the University of Western Ontario. Christine continues to be employed part-time as an ACP in the County of Lambton.

## Top Ten Reasons...

Listed below are the "Top 10 reasons that some days I wish I could trade my FRCP in Emergency Medicine for an EMCA". This list is intended to be light and humorous. I am hoping that some of our SWORBHP paramedics will try and come up with their own "Top 10 reasons I would like to trade my EMCA for becoming an ER MD", or perhaps add to the list I have created below. If you would like to create your own list and have it considered for publication in a future edition of the LINKS newsletter please submit it to [adam.dukelow@lhsc.on.ca](mailto:adam.dukelow@lhsc.on.ca).

"Top 10 reasons that some days I wish I could trade my FRCP in Emergency Medicine for an EMCA".

- 10) My toddler would have a lot more respect for me if I wore a uniform to work instead of green pajamas.
- 9) I could park anywhere.
- 8) I would get to save lives instead of handing out percocets.
- 7) I would get at least 8 hours of paid continuing education per year.
- 6) Driving fast with lights and sirens—nuff said!
- 5) Helmets and radios—just like CHiPs!
- 4) I would have health benefits and a pension.
- 3) Patients would never ask me when I would be done my internship and open a practice.
- 2) Who doesn't like to lounge in 20 year old lazy boy chairs and watch vhs tapes once in a while?
- 1) I could spend time coming up with impossible "what ifs" with my medic buddies and try to stump the SWORBHP Docs and ASKMAC!

Adam Dukelow, M.D., FRCP(C), MHSC, CHE  
Local Medical Director  
Middlesex London, Elgin-St. Thomas, Lambton, Oxford, Oneida

## Paramedics and Midwives — Demystifying the Relationship

In Essex County, we thought it would be a great idea to bring paramedics and midwives together for a workshop. The idea was to get a better understanding of each other's operational issues, scope of practice, training, equipment, and patient care challenges. The goal was to improve communication and work out some protocols to better support each other.

There are seven practicing midwives in Windsor, working in the hospital and in the prehospital environment, delivering almost 80 babies at home last year. In fact, I learned that midwives have a lot in common with paramedics. They work in pairs with mainly routine cases, and use surprisingly similar equipment, punctuated with rare crisis situations when they have only themselves to depend on.



After reviewing equipment and operational issues, it didn't take long to work out some mutually supportive understanding of patient practice (watch for the upcoming Webinar). With the help of the St. Clair College simulator lab (thanks Greg Skomash and Jamie Wilson) we learned how to deliver babies with complications for mother and baby...then the paramedic "what ifs" started.

Wanting to help facilitate the learning, I agreed to be the delivering patient. Much to my surprise, I was soon directed by a midwife to be face down on a stretcher, my rear end high in the air, and a hand pushing firmly into my vagina in order to keep pressure off my baby's prolapsing umbilical cord. The paramedics pulled out their Obstetrics kit, then reached for the Basic Life Support Patient Care Standards (BLSPCS). They quickly reviewed the *Midwives at the Scene Standard*, and while continuing to reference *Obstetrical Conditions*, one of them read... "Carefully insert gloved fingers into the vagina only to attempt elevation of the presenting part and only under the following circumstances..." (Emergency Health Services Branch, Ministry of Health and Long-Term Care, 2007). I'm not sure what was worse, the fact they read out loud, or that they may have forgotten I wasn't the actual patient! Needless to say, you could see the challenges in safely securing the patient and the need to work together in these situations.



Dr. Bradford...the all too willing patient!

The level of consultation and pre-screening midwives conduct for safe home births was very impressive. It was remarkable to learn how much time they spend with their clients, building a supportive patient relationship. Midwives have a very demanding schedule, and like paramedics, love the challenge of their work. What an amazing group of people!

Paul Bradford, B.Sc., M.D., CCFP(EM), FCFP, CD  
Local Medical Director  
Essex-Windsor, Chatham-Kent

### References

Emergency Health Services Branch, Ministry of Health and Long-Term Care (2007). *Basic Life Support Patient Care Standards Version 2.0*. (p. 5:4viii).

Look for us on the Web  
[www.lhsc.on.ca/bhp](http://www.lhsc.on.ca/bhp)

## Recert Support—Keeping SWORBHP Connected to You

Welcome to Recert Season! We hope you've found our online learning management system user-friendly, and its contents helpful in preparing you for your recerts. We've added a few features this year to ensure you feel supported and have your questions answered in a timely and consistent manner. Here are two of our new additions:

### **Online Forums!**

Check out the **Online Forums** on the 2012-2013 Recert Website (found at [www.lhsc.on.ca/bhp](http://www.lhsc.on.ca/bhp)). Here you can post questions to your Regional Paramedic Educator and have them answered in an online classroom environment where your fellow colleagues can benefit from both the question and the answer! To find the Forums, log into your online recert account and click on 'Forums' either in the horizontal toolbar or on your home page. Then click on the discussion topic that is led by your Regional Paramedic Educator. Once in the forum, you can post a question and read answers to previously posted questions. Please use this resource – it's there for you!

### **Live Chats!**

Now available are **Live Chats!** Scheduled for September 14, October 18, and November 14. Here you'll have the opportunity to actually chat online with both a Regional Paramedic Educator and a Local Medical Director! Pose those pressing questions and discuss the answers you receive. These 1-2 hour sessions are available to generate discussion, and provide reason and rationale to the questions you've asked.

Once again, we've created these tools for your benefit; please feel free to use them at any time during recert season for clarification related to any of your medical directives.

Stéphanie Romano, MSc.Ed., HBSc., AEMCA, NCEE, CQPA  
Education Coordinator

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## Trivia...fast facts!

- Neil Armstrong stepped on the moon with his left foot first.
- A fathom is 6 feet (1.8 metres).
- The names of all the continents end with the letter they start with.
- On every continent there is a city called Rome.
- An atomic clock is accurate to within 1 second in 1.7 million years.
- The pleasant feeling of eating chocolate is caused by a chemical called anadamide, a neurotransmitter which also is produced naturally in the brain.

Retrieved from: <http://didyouknow.org/fastfacts/trivia/>

# Stroke Patients—Last Seen Normal Time

The recommended total time from symptom onset to reperfusion for eligible patients is 4.5hrs. This is broken into 2 phases: pre-hospital and ED. The pre-hospital phase, which starts with symptom onset, and includes on-scene management and anticipated transport time, should be less than 3.5 hours. Therefore, last seen normal (LSN) time is a crucial key to help determine if a patient is eligible to receive the clot buster tPA. Without a clear time of onset, most recanalization strategies may be prohibited. If the exact time of stroke onset is not known, we rely on the “last time” the patient was known to be normal. Through careful questioning, EMS can assist with the determination of the time the patient was last seen by a reliable witness to be asymptomatic or normal. The table below outlines two case scenarios involving Mr. Smith and illustrates the dialogue between the paramedic and the witness in order to determine (LSN) time.

	Scenario A: Mr. Smith on Couch – Witnessed Event	Scenario B: Mr. Smith with stroke symptoms upon awakening in a.m. – Unwitnessed Event
EMS	Mrs. Smith, I need to collect some information that will help us with Mr. Smith’s care when he arrives at the hospital. It is important that we determine when your husband was symptom free. This will help the doctors determine if he is eligible for the clot buster medication.	
EMS	Do you recall what time Mr. Smith was watching TV?	Do you recall what time Mr. Smith went to bed?
Mrs. Smith	Yes, I was doing dishes, it was about 7:00 pm. We finished dinner and he was telling me about his golfing day. He took the dishes to the sink, thanked me for dinner and left the kitchen to go into the living room to watch TV.	Yes he came to bed around 11:00 pm.
EMS	When Mr. Smith was watching TV, did he speak with you during this time?	Did he say much to you at this time?
Mrs. Smith	Yes, he mentioned he wanted some tea.	He told me he had to get up for an early morning meeting.
EMS	How did his speech sound at this time? Do you recall what time this was?	Did he look fine to you at this time?
Mrs. Smith	His speech sounded fine. It was around 7:30 pm.	Yes
EMS	What happened when you brought him tea? Did you notice anything different then?	You mentioned that when you woke up in the morning to remind him to get up, his speech was slurred. Is that correct?
Mrs. Smith	Yes, I noticed that his right arm was swung over the side of the couch. He couldn’t hold the tea cup.	Yes
EMS	What time was this?	What time would you say it was?
Mrs. Smith	It was 7:30 pm. He couldn’t move his arm, and he said he felt funny. I called 911.	It was around 6:00 am.
EMS		Was there any other time during the night that Mr. Smith was awake?
Mrs. Smith		Yes, he usually gets up around 4:00 am to go to the washroom.
EMS		Did you see or speak to him at this time?
Mrs. Smith		No, I just saw the light in the washroom go on. I know he came back to bed. I fell back to sleep.
(LSN) Time	Mrs. Smith saw Mr. Smith leave the kitchen walking and talking normally. We can say with great confidence that his (LSN) time was 7:00pm.  We can also say that Mr. Smith’s symptoms started around 7:30 pm, or between 7:00 and 7:30 pm.	We can say with great confidence that Mr. Smith’s (LSN) time was 11:00 pm.

Finally, obtaining telephone numbers of relatives and witnesses and asking them to come to the ED as quickly as possible to provide additional history and consent will help physicians with the crucial next steps.

Gina Tomaszewski  
 SWO Regional Stroke Acute Care Coordinator  
 University Hospital, LHSC

## Blood Glucometry

**FAQ:** When should I perform a blood sugar on a patient?

**Answer:** This is a common question among paramedics when they receive an audit asking why one was not performed. The Advanced Life Support Patient Care Standards (2011) indicates a blood glucometry is to be performed when a patient has an altered LOA, agitation, seizure, or symptoms of stroke.

The BLS Patient Care Standards (2007) states a blood glucometry is to be performed for the following patients:

1. The information on scene indicated the patient is a known diabetic, and;
2. The chief complaint or presenting problem (non-trauma) consists of one or more of the following:
  - decreased level of consciousness
  - seizure, stroke, syncope
  - violent, bizarre or unusual behavior
  - hyperventilation
  - alcohol, drug ingestion
  - hypoglycemia (insulin) reaction—known or suspect
  - nausea/vomiting/sweating/malaise/feeling unwell/other non-specific complaints

The Hypoglycemia Medical Directive states a final blood glucometry must be attempted and documented if a patient refuses transport to hospital.

Tracy Gaunt, M.Sc., NCEE, CPSO  
Professional Standards Specialist

### References

Advanced Life Support Patient Care Standards (2012). Hypoglycemia Medical Directive for PCPs, pg. 40.

Emergency Health Services Branch, Ontario Ministry of Health and Long Term Care (2007). *Basic Life Support Patient Care Standards*, 2-27.

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Self-Report Hotline  
1-888-997-6718

Self-Report Email  
[selfreport@lhsc.on.ca](mailto:selfreport@lhsc.on.ca)



## Upcoming CE Opportunities

October 31, 2012 — Diabetes Review (Webinar)

November 2012 — DNR Review (Webinar) - exact date TBA

Remember to check our website regularly for information on upcoming Webinars and rounds.

[Click here](#) to visit our website and view the page dedicated to Continuing Education.



## Comments?

If you have comments or feedback on the newsletter, or have an article you would like to have considered for publication in a future edition of **LINKS**, please send to:

C. Prowd, Operations & Logistics Specialist  
Southwest Ontario Regional Base Hospital Program  
c/o Grey Bruce Health Services  
1800 8th Street East, Box 1800, Owen Sound, ON N4K 6M9  
Phone: 519-372-3920, ext. 2449  
Email: Catherine.Prowd@lhsc.on.ca

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**Editor**  
Cathy Prowd

**Editor-in-Chief**  
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**Associate Editor**  
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