London Health Sciences Centre
Southwest Ontario Regional Base Hospital Program

Leadership of optimal prehospital care systems

SWORBHP LINKS

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Inside this Issue:

New Year, New Beginnings

It is a strange thing to be the Regional Medical Director (RMD) of an Ontario Base Hospital. Most people, even in the field of prehospital medicine, are unfamiliar with the core functions of a Base Hospital. To then try and explain the day to day activities of the RMD, well suffice it to say, you get a lot of glazed looks in the eyes pretty quickly. Personally, I have always liked the fact that this job is behind the scenes, away from the dramatic life and death action that characterizes the practice of Ontario Paramedics. Being the RMD is not about action and notoriety, it is about policies, consensus, and evidence based guidelines. It is developing systems of care in the background which enable Paramedics to render truly patient outcome altering care for years to come for Ontario citizens in crisis.

I have often said when I work as an emergency physician in the emergency department; I am able to impact the care for the patients I see during my shift: a tremendous responsibility. What has always driven me in my work with the Regional Base Hospital, is if together we can develop a system of care that carries an improved outcome for patients (like STEMI or Stroke or Trauma), we have the ability to improve patient outcomes for thousands of patients. Given the sometimes glacial pace of change to operationalize true system wide transformation, it takes resiliency, quiet perseverance and a steadfast belief that what you are doing truly matters for patients.

Being the RMD for the Southwest Ontario Regional Base Hospital Program has been one of the greatest challenges of my professional career. I am fiercely proud of the public safety net that Paramedics provide Ontario citizens and I derive great satisfaction that, well behind the scenes, I played some small role in that system. Serving as the RMD has also been one of my greatest privileges, and to me, that is an essential distinction: the position is a privilege.

The rapidly evolving changes in paramedic practice demand dynamic medical directors with new insights, new ideas, and new energy. Those who know me know I have literally poured my heart and soul into this position and this program. I have given you my very best. Now it is time for someone else to do the same. I truly hope they eclipse my efforts.

In April 2017 I will no longer be the RMD for the Southwest Ontario Regional Base Hospital. I would like to thank you all for the essential work you do each and every day, it has been an honour to serve as your Medical Director.

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

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2016 Paramedic Recognition Awards

Award of Excellence

Perth County Paramedic Service

Matt Doughty
Randy Bonsma

Award of Excellence

Essex-Windsor EMS

Scott Miller
Steven Jacobs *(not pictured)*

Award of Excellence

Medavie EMS Elgin Ontario

Jill Foster
Jim Sinclair

2016 Medical Commendation Award Recipients:		
Tony Metayer	Kerry Nantais	Chris Foerster
Victor Dimitriu	Mike Manery	Keith Affleck
Gerry Hedges	Mike Gonzales	Jim McCann
Debra Dufour	Gary Long	Dawn McBean
Theresa Coulter	Dan McBean	Mike Rodger

We believe that being recognized for the excellent work you do as a Paramedic is very important.

In 2016 there were 251 recipients of the Prehospital Save Award and 59 recipients of the Newborn Delivery Award!

Congratulations to all recipients of the 2016 Paramedic Recognition Awards!

To view a complete list of award recipients, visit our website:
http://www.lhsc.on.ca/About_Us/Base_Hospital_Program/OpsLogistics/ParamedicRecogAwards.htm

To submit a nomination for a Paramedic Recognition Award complete on of our e-forms:
http://www.lhsc.on.ca/About_Us/Base_Hospital_Program/Forms/index.htm

Searching for Questions & Answers

SWORBHP ASK MAC
Medical Council's Prehospital Q&A Forum

Our Ask MAC website (askmac.sworbhp.ca) is a great resource Paramedics can use to ask questions related to pre-hospital care. We implemented Ask MAC back in January 2012 and to date there has over 350 questions submitted and answered through this website.

As our inventory of questions keeps growing, we strongly encourage Paramedics to search to see if your question has already been answered before submitting a new question. Over the past few months, we have improved the ability to search for questions and answers.

Here are a few tips on how to search for questions:

SEARCH BY CATEGORY:

You can search for questions by categories:

- ALS Patient Care Standards
- BLS Patient Care Standards
- Miscellaneous
- Etc.

This is a good option if you are looking for a question related to a specific topic or medical directive

SEARCH BY DATE:

You can search for questions by the date they were posted.

This is a good option if you have recently submitted a question and want to see if it has been answered yet.

SEARCH BY KEYWORD:

You can search for questions by typing in a keyword(s) in the search box.

Each question posted is assigned with a number of keywords. We review the questions prior to posting and identify words that may be relevant when searching for a specific question.

Tips for searching by keyword:

Keywords are not case sensitive
Search for partial words (e.g. resus)
Search for acronyms (e.g. ASA, TOR)
Use more than one keyword to refine your search
Search for an exact phrase using quotations (e.g. "Base Hospital Patch")

If you have any questions or require any assistance with our Ask MAC website, please contact us at paramedicportalontario@lhsc.on.ca or 519-685-8500, ext. 75621.

Michelle Priebe, CQIA
Web and eLearning Design Developer

SWORBHP Research

The SWORBHP Region will once again be very well represented at the National Association of EMS Physicians annual conference. The SWORBHP Evidence of Practice (EOP) group had eight abstracts covering a variety of topics accepted. The conference will occur in New Orleans in January 2017. Your EOP team will likely have close to if not the most abstracts of any EMS Research group attending this important conference that sells out every year with over 1000 delegates.

"Say Again…I Don't Understand You" - Problems in Paramedic-Physician Telecommunication
- Columbus, M., Robson, J., Eby, D.

Structure of Termination of Resuscitation Patches
- Columbus, M., Robson, J., Eby, D.

Is the Presence of Hypoglycemia in Pre-hospital Seizure Patients a Myth?
- Columbus, M., Robson, J., Eby, D.

A Descriptive Analysis of Prehospital midazolam as a Chemical Restraint in Combative Patients
-Leggatt, L., Davis, M., Bradford, P., Morassutti, P., Van Aarsen, K., Leschysna

A Descriptive Analysis of Prehospital Refractory Ventricular Fibrillation
-Schappert, A., Chau, B., Leung A., VanAarsen K., Davis, M.

Fatigue, Shiftwork, and Safety Outcomes in Canadian Paramedics
-Donnelly.M., E.A, Bradford, P., Hedges, C., Davis, M., Socha, D., Morassutti, P.

What Influences Safety in EMS? Investigating Stress, Fatigue, and Safety Outcomes
-Donnelly. M., E.A, Bradford, P., Hedges, C., Davis, M., Socha, D., & Morassutti, P.

Impact of EMS Direct Referral to Community Care on Services Received
-Lewell, M., Dukelow, A., Loosley, J., Pancino, S., Van Aarsen

View SWORBHP Research & Publications at: lhsc.on.ca/About_Us/Base_Hospital_Program/Research.

If you are interested in prehospital research opportunities and or joining the EOP group please contact Adam Dukelow (adam.dukelow@lhsc.on.ca).

Adam Dukelow, M.D., FRCP(C), MHSC, CHE
Medical Director of Innovation & Research

SWORBHP Education & Quality Council

Our Education and Quality councils are composed of Paramedics, Service Quality/Education specialists, SWORBHP representatives, and local College Educators. The Councils originated in June 2016, have met three times to date and will continue to meet quarterly in 2017. The Councils have been well received, well attended and have initiated great dialogue!

With the spring implementation of the *Intelligent Quality Evaluation & Management Suite* (IQEMS) system, the Quality Council has been actively discussing reporting requirements, reviewing processes, policies, procedures and student audits, just to name a few.

The Education Council is working collaboratively to develop and implement strategies to improve support for Paramedics at both the service and regional levels. Current initiatives include implementing training for emergency childbirth, the new BLS-PCS and ALS-PCS, and just culture.

Deb Janssen, Co-Chair
Quality Council

Cindy Harrison, Co-Chair
Education Council

EMS Fellows International Elective: San Diego

This past October I had the opportunity to do an international elective in San Diego, California. As a part of the EMS Fellowship I completed last year, we are encouraged to spend 2-4 weeks with another EMS service. The purpose is to see how they operate and bring back what we've learned. They say once you've seen one EMS service, you've seen one EMS service and that's definitely true!

First off, I had an absolutely outstanding and rewarding experience and I can't thank my UCSD/SDFD hosts enough for allowing me to complete this elective. California is obviously a lovely place to be. But, San Diego itself affords a very rich EMS history and are at the forefront of furthering the practice of EMS and community partnerships.

During my visit I had the chance to do ride-alongs with Land EMS, Helicopter EMS and even Border patrol EMS (BORSTAR). I also got to sit in and participate in continuing education (CME) sessions, service and county-level medical council meetings, journal club, research updates, and even get a glimpse into their community paramedicine program. I also participated in the medical tents/mass gatherings of a San Diego Chargers game and Southern California Tough Mudder event. It was a pretty action-packed and rewarding month. I have so much to say about my time! Please feel free to contact me, or stop me in the ED if you'd like to hear more!

During their semi-annual CME event I was floored by the similarities in the issues they are currently dealing with in their system: off-load delay, mental health system crisis, PTSD and other workload stressors, fiscal constraints and new equipment hiccups (they are adjusting to the electronic-stretcher system). New and emerging advances in prehospital medicine were also discussed including destination-policies for STEMI, stroke, trauma and peds as well as double-sequential defib and the increased (successful!) use of community AEDs. Sidenote: They have an absolutely outstanding community outreach and education program regarding awareness, education and immediate access to bystander CPR and AED. (www.sandiego.govsdprojectheartbeat). On the ground, their directives and scope of practice seem essentially in-line with ours. They have a similar off-line and on-line patch system PRN with the local ER.

Of course, one of the biggest differences is the private vs public system. On the ground with direct patient care, there seems to be minimal difference. Under EMTALA all patients have a right to be treated and we picked up patients at the mission as well as multi-million dollar homes. However, after speaking to some of the locals, unlike in Canada, after their ambulance ride, they get a $3000 bill. That's just for the EMS service. One person I spoke to was involved in an MVC on the highway, taken to the hospital, had what sounds like a pan-scan, luckily, no injuries were found and she was discharged home. However, was then faced with a $3000 ambulance bill and $27,000 hospital bill. The hospitals all advertise and some had water fountains and valet parking.

The other big difference from a systems perspective is that the city of San Diego has a fire-EMS service. So, all major medical calls will get attended to by both a fire-truck which as a trained paramedic with a monitor, defib, and minimal drugs ; as well as an ambulance with at least an EMT (BLS -level) team.
Their education system is very different from ours. Technically, one can be on the road in as little as 3 months with an EMT course (and certification). Most, however have more training than the bare minimum. Some of their protocols were different than our system (RSI and Chest tube insertion for their helicopter service, they employ RNs and regularly have Emergency Medicine residents regularly fly instead of Critical Care Paramedics).

Their community paramedicine was very much directed to the issues that they have in their community. For us, it seems to be chronic health issues and care-at-home. For them, it's the homeless population. Recently, there's been an explosion in the number of homeless in the city. It's likely from a number of factors including temperate weather, mental health issues and the increasing cost of living in California.

San Diego is a large army town, with naval base and nearby Miramar (Top Gun!). Among the 18 major hospitals in the area, is Balboa hospital. Which is the naval hospital. It was a very different experience picking up current or vetran forces members (and their family) and taking them to a dedicated army hospital. It was the neatest and most orderly ED I've every been in! They are also acutely aware of potential conflict and disaster management and have an extensive system in place for such attacks.
Although our EMS systems are very different: the environment, structure of care and culture; they are also very similar. It was very much affirming that we currently practice the most evidence-based and up-to-date medicine in our neck-of-the-woods. Although we don't have valet parking or fountains, we provide outstanding care to our community (and it's covered!). You have a lot to be proud of.

Lauren Leggatt, BHSc., M.D.
EMS Fellow

Behind the Scenes

SWORBHP has partnered with Health Sciences North Centre for Prehospital Care and Sunnybrook Centre for Prehospital Medicine to implement a centralized data quality management solution using the Intelligent Quality Evaluation & Management Suite (IQEMS).

The IQEMS software was developed and implemented by Sunnybrook Centre for Prehospital Medicine approximately eight years ago. The system is fully web-based, allowing the Centre to audit 100% of all data in a timely, cost effective and efficient way. The software supports the management of many base hospitals continuing quality improvement endeavors including data mining, peer reviewed and compliance auditing, secure communication with stakeholders, investigation and self-reporting, efficient workflow and document management, statistical reports and data visualization.

Each clinical audit consists of data that is sorted and put through a series of filters which are computerized algorithms based on medical directives or other standards. The filters compare paramedic procedures with the directives and/or standards in order to identify variance in practice.

An implementation project team was assembled in May 2016. Their objectives included facilitating the migration of the IQEMS system to a centralized datacenter; modifying the current software to support multiple base hospitals and to conduct a Privacy Impact (PIA) and Threat Risk Assessments (TRA) on the software and infrastructure. Additionally, the team has been working diligently with our vendors to stream raw data to our central repository.

We are very excited to be implementing an electronic QA process. A go-live date has yet to be determined, however, we are anticipating early spring 2017.

Please don't hesitate to contact me if you have any questions or would like additional information.

Debbie Janssen, BMOS
Coordinator, Quality Assurance & Business Functions

Meet the Team

Curtis joined the Southwest Regional Base Hospital Program in November 2016 as a Prehospital Programmer Analyst. Prior to joining SWORBHP, Curtis worked as a Software Developer within Information Technology Services for both St.Joseph's Health Care and London Health Sciences Centre.

Curtis has been a welcomed addition to the SWORBHP team as we move forward with automating both our Educational and Quality Assurance processes. At the provincial level, Curtis will play an active role in implementing the Intelligent Quality Evaluation & Management Suite (IQEMS) system, with future plans on enhancing our Paramedic Portal. At the regional/local level, Curtis will be working on developing a very robust SWORBHP website, which will house secure content, applications, forms, etc. to help us better communicate with our partners.

Naloxone - We Welcome the Change

We welcomed the Opioid Toxicity Medical Directive to the PCP Scope with open arms in 2015, and we're going to do the same with even more change coming July 2017. The changes noted during your recert were just the beginning; here's an update!

- Both the PCP and ACP Medical Directives are identical
- The maximum number of doses has been increased to 3 with a dosing interval of 10 minutes for the SC/IM and IN routes, and an immediate dosing interval for the IV route
- The Mandatory Patch Point has been removed from the Medical Directive

Why the changes you ask? I suspect you already know the answer, but here are a few:

Reason #1:
For several years now, community-based programs have been offering Naloxone to the public in an attempt to reverse the potentially fatal respiratory depression caused by opioids.

Reason #2:
The rate of opioid overdoses has increased over the years. In SWORBHP region alone, we've seen an increase from 194 administrations of naloxone in 2013 to approximately 300 in 2016.

Reason #3:
The future is unknown. We've recently seen in the news that the large animal tranquilizer carfentanil has now made its way into the streets. Carfentanil is an analogue of the synthetic opioid analgesic fentanyl, and is 100 times more potent than fentanyl. In the event of an overdose involving carfentanil, multiple doses of naloxone may be required.

Reason #4:
Research and evidence. A review of calls from one base hospital in Ontario found that 98% of BHP patches for Naloxone led to authorization for its administration; and that in 100% of these cases, the patient was transported to the ED. The results show that Naloxone administration led to clinical improvement with a low incidence of adverse events and that paramedic compliance with the medical directive is high.

In addition to these new changes and their rational, there is educational emphasis on IV administration of Naloxone and specifically the need to titrate to effect. For example, when administering Naloxone via IV, only do so until the desired affect has been reached. Once that desired effect has been reached (for example, adequate respiratory effort), the dose of Naloxone is complete. If the patient deteriorates, another dose can be administered to effect (maximum 3 doses).

Please remember that these changes took affect on December 23, 2017 and that our SWORBHP MEDLists are a great resource for a refresher on many medication groups. See April 2014 for our Opioids MEDList, and never hesitate to contact us if you have any questions. http://www.lhsc.on.ca/About_Us/Base_Hospital_Program/Education/medlist.htm

Stephanie Romano MSc.Ed., HBSc., AEMCA
Education Coordinator

Reference:
(2016). DEA Sounds Alarm on Elephant Tranquilizer Carfentanil. Medscape Medical News. Retrieved November 3, 2016 from http://www.medscape.com/viewarticle/869182

Knowledge Translation

As a user of social media, I have come across many positive postings which assist with knowledge translation, provide an excellent overview of a particular topic and provide accurate facts when it comes to prehospital care. However, the social media world is not safe from fallacies, inaccuracies and potential political agendas. Some recent postings have implicated that the OBHG MAC is not responding to the opioid endemic that has hit our province and is withholding paramedics from providing optimal prehospital care. This could not be further from the truth.

In fact, the exact opposite has occurred. With the release of the ALS PCS version 4.0 and 4.1, the OBHG MAC developed and endorsed multiple recommendations to ensure that prehospital management of opioid toxicity was evolving based on best evidence available. After reviewing this evidence, multiple changes were made to the opioid toxicity medical directive.

Furthermore, in September of 2016, the OBHG MAC unanimously endorsed the following recommendation to the Ministry of Health and Long Term Care:

“The MAC endorses a “patient first” approach which authorizes paramedics to implement new evidence based practices once properly trained and authorized by the RBH and paramedic services rather than delaying implementation for an “in-force” date”.

Social media can be a great source of information to help drive prehospital care forward. However, on the flip side, one must ensure that every post, blog, and link is critically appraised and ensure that the information presented is not always taken at face value without an in-depth dive in to the topic at hand. So as a fact check, the OBHG MAC has indeed responded to the opioid toxicity crisis and has done everything within their mandate to ensure that evidenced based care is being implemented in a timely fashion.

Matthew Davis, M.D., M.Sc., FRCP(C)
Medical Director of Education
(A) Local Medical Director
Elgin, Middlesex, Oneida, Oxford

The Administration of IV Fluid Bolus

There are differences in how PCPs and ACPs administer IV fluid boluses within the SWORBHP region. A study of IV bolus administration looked at 220 randomly sampled electronic ACRs (iMedic platform) where code 351 – fluid bolus – was used. 8 Paramedic services were included, 3 with both ACPs and PCPs.

The study found that once a decision was made to administer an IV bolus, ACPs gave more fluid (on average almost twice as much), gave it faster, and were more likely to use a larger (18) guage IV cannula, when compared to PCPs. There were some differences between the services. PCP average total amount range (161 – 325 ml). ACP average total amount range (276 – 525 ml). Documentation of fluid bolus administration was inconsistent. While the documentation in some services was excellent, in some services documentation had multiple deficiencies. The most important documentation deficiencies included failure to record how much fluid was given and the times when a bolus was started or stopped. Chest auscultation for fluid overload status was documented only 28% of the time when more than 250 mls of fluid was administered. It is particularly important to document the total amount of fluid given for ongoing care of the patient in the Emergency Department.

...continued on page 4

The Administration of IV Fluid Bolus - cont'd from page 6

When the data was analyzed, a number of interesting observations emerged. Blood pressure readings tended to fluctuate wildly and sometimes without any obvious reason. A systolic blood pressure of less than 90 was present 50% of the time on the first recorded blood pressure. A single low reading induced a paramedic to initiate an IV and start a fluid bolus. When the BP was checked again a few minutes later the BP was frequently found well above 90 so the bolus was stopped. In these cases, the bolus ran only a short amount of time and a small amount of fluid was administered. This could be avoided if the BP was confirmed to be low with a second reading before an IV was started. In the study cases, the blood pressure was rechecked before starting an IV bolus less than 30% of the time.

The medical directive on IV bolus administration is unclear. The SWORBHP Medical Council is reviewing the findings of the study and will be making recommendations for the provincial Education Sub-committee to clarify the procedure for administering IV boluses. In the mean time we can improve our documentation.

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

Independent Double Check for Prehospital ECG

We have all seen the critical roll paramedic ECGs have in the detection of acute ST Elevation Myocardial Infarction (STEMI) (Nam et al, 2014). Paramedics are doing ECGs and making life and death decisions about bypassing local hospitals, activating the Cath Lab, and bringing in staff for emergency angioplasty in PCI centres. In more rural locations, identifying STEMI on an ECG may decrease time to thrombolytic by ensuring the acute coronary syndrome patient gets the correct bed in the ER for faster door to needle time. Local research has shown the ECG done in the field can affect ER patient dispositions, as there is valuable information on the ECG done closer to symptom onset than those done in ER after paramedics have treated the patient (Davis et al, 2011).

ECG analysis is a fundamental piece of information for making decisions critical to best patient care in real time situations, and can change the treatment for the patient. Learning to perform and read ECGs takes some training and paramedics have varying comfort and experience with this valued skill. It is not enough to rely on the machine read, as we have all seen cases not picked up, and sometimes artefact interfering with the computer algorithm interpretation. Paramedics are familiar with independent double checks with medications, and reading ECGs can benefit from that same patient safety culture. We have seen cases where one set of eyes missed an ECG injury pattern that was recognized by the partner. It is not always possible for both medics to look at the ECG due to driving issues, yet there are many more opportunities where paramedics can each do their own evaluation and then discuss. This could be a first response truck reviewing with a transporting crew, or just seeing the value in having your partner routinely double check. There can be many causes of distraction and consequent missed findings, including sleep deprivation, shift work, stress, competing scene priorities, radio, allied agencies, not really knowing how to read ECGs, or not knowing what the letters STEMI stand for and too embarrassed to tell anyone. Make it a plan to get an independent double check on ECGs.

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

References:
Nam, J., Caners, et al (2014). Systematic review and meta-analysis of the benefits of out-of-hospital 12-lead ECG and advance notification of ST-segment elevation myocardial infarction patients. Annals of Emergency Medicine. 64(2): 176-186

Baby It's Cold Outside

Although the days are slowly getting longer, we still find ourselves in the midst of an exceptionally cold winter season. While there are some purported benefits of hypothermia that underlie the rational for therapeutic hypothermia post-ROSC, accidental or environmental hypothermia can also lead to a variety of metabolic and physiologic derangements that can manifest in the prehospital realm.

It seems straightforward to suggest that preparing for the elements and dressing appropriately is enough to prevent hypothermia and cold illness. However, there are still some patient factors that contribute to cold illness and hypothermia, specifically those at extremes of age, and those with pre-existing metabolic and endocrine derangements (eg. hypothyroidism and diabetes).

The two main categories of cold related illness are frostbite and hypothermia. Frostbite is the direct freezing injury to peripheral tissues that are exposed to the cold and have less blood flow, including the nose, ears, fingers, and toes. Hypothermia, on the other hand, is defined by a core body temperature less than 35^0 C, and occurs when heat loss exceeds physiologic heat production. Depending on core temperature, hypothermia is defined as mild (32-35^o C), moderate (28-32^o C), or severe (<28^o C). Symptoms vary from patient to patient, and can range from increased shivering and slight behavioural changes in the mild category, to cardiac arrhythmias, decreased level of consciousness, to eventually coma, ventricular fibrillation, and cardiac arrest.[1] Given the degree of variation in patient presentation, it's important to be cognizant of the role of temperature as a factor in any patient presentation, particularly during these winter months.

The good news is that once you've identified someone as hypothermic, the treatment hasn't really changed all that much despite years of ongoing research efforts. In general terms, the goals of prehospital care for hypothermic patients are to rescue that patient from the cold environment, examine them for any complication of hypothermia, insulate them from further heat loss, and finally transport. There have even been two recent studies published in *Wilderness and Environmental Medicine* that look at the best methods for prehospital rewarming. The quick-and-dirty summary from these studies is that the use of vapor barriers along with heat pads as well as the potential removal of wet clothing offers the best means of increasing a patient's skin temperature and comfort.[2,3] You might even be intrigued to know that these research efforts have supported the notion that hot beverages don't help hypothermic patients.[3] You read that right, there is a study that partly examines the utility of hot beverages in hypothermic patients.

In summary, check a temp. Be wary of hypothermia in patients with vague complaints, especially those at risk. Prevent heat loss, increase heat production, and we'll all get through this winter.

Andrew Schappert, BSc., M.D
SWORBHP EMS Fellow

References:

1. *Fudge, J. Exercise in the cold: Preventing and managing hypothermia and frostbite injury. Sports Health. 2016;8 (2):133-139*
2. *Henriksson, O., Lundgren, P., Kuklane, K. et al. Protection against cold in prehospital care: Wet clothing removal or addition of a vapor barrier. Wilderness and Environmental Medicine. 2015;26:11-20*
3. *Oliver, S., Brierley, J., Raymond-Barker, P. et al. Portable prehospital methods to treat near-hypothermic shivering cold casualties. Wilderness and Environmental Medicine. 2016;27:125-130*

Just Culture Workshop

On April 4-6, 2017, SWORBHP has engaged Paul LeSage, a career paramedic and senior leader in public safety organizations to deliver his exceptional two day course called Collaborative Culture of Safety followed by a one day Collaborative Risk Analysis course. These sessions lay the foundation for the Just Culture model of organizational improvement that has been developed by Paul and his colleagues based on their experiences in public safety and aviation.

You may be wondering what exactly is a just culture? Just Culture refers to an organizational model where both the system and the individual are collaboratively responsible for managing risk to achieve better outcomes. The key to this philosophy is combining analysis of human behaviour and system design with the goal of increased risk mitigation, rather than fault finding. The Just Culture model has been developed for use by highly trained professionals working in complex environments, where errors can quickly have disastrous consequences. This aptly describes the world in which Paramedics function on a daily basis.

This course provides a foundational framework outlining how the key principles of Just Culture can be incorporated into public safety organizations in the pursuit of safer systems and better patient outcomes.

After taking the course in April 2016, I can say without a doubt, this is the best program I've been exposed to in my career as a paramedic. I'm enthusiastically looking forward to attending again and being a part of something that has excellent potential to further the conversation locally on how just culture can be incorporated into the world of prehospital care.

Michael Kennedy, CCP(f)
Prehospital Care Specialist

References:
LeSage, Paul J., K. Scott Griffith and Charles A. Gruber. Collaborative Culture of Safety: Improving Safety and Reliability with a Focus on Systems, Behaviours, Errors Analysis and Accountability. SG Collaborative Solutions LLC, 2015.

SWORBHP CME Opportunities

For a list of all Upcoming CME Events view our event calendar:
http://www.lhsc.on.ca/About_Us/Base_Hospital_Program/Upcoming%20Events/index.htm

Certification

The Provincial Certification Standard Version 2.0, Appendix 6 of the ALS PCS Version3.4 comes into force February 1, 2017. The Standard sets out the requirements and processes related to Certification. SWORBHP practices will be required to change to some extent to ensure compliance with the new Standard. The Ontario Base Hospital Group Standardization Working Group is working through the components of the Certification Standard and taking the "what" in the Standard to develop a provincial approach to the "how". In other words, we are developing Provincial definitions and processes to enable a standardized approach to Certification for all Ontario Paramedics.

The biggest change comes in the Maintenance of Certification section where the Paramedic shall not have an absence from providing patient care that exceeds ninety (90) consecutive days. The change from past practice is the addition of "providing patient care" to the ninety day timeframe. In addition, a Paramedic shall either provide patient care to a minimum of ten(10) patients per year whose care requires assessment and management at the Paramedic's level of Certification, or where a Paramedic is unable to assess and manage the minimum of ten patients per year, demonstrate alternate experience, as approved by the Medical Director, that may involve one or more of the following: other patient are activities; additional CME; simulated patient encounters; and clinical placements. SWORBHP is currently developing a fair and reasonable process for all paramedics who may not meet the MOHLTC determined minimum standard of clinical activity.

A benefit to the new Certification Standard is Provincial Cross Certification. In other words, if you move to another region, that Base Hospital will recognize your current Ontario certification. This is something that we at SWORBHP have been working on for about two years and are taking a lead provincially.
Once we have more clarity, we will communicate any changes in our current practice that affect you as front-line Paramedics. Rest assured that we will work with all of you on an individual basis to ensure compliance to the Standard. Our intention is to support you in your practice and ensure you maintain your Certification.

Susan Kriening, RN, BScN, MHS, ENC(C)
Regional Program Manager

Reference:
Certification Standard Version 2.0, Appendix 6 of the ALS PCS Version3.4

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:

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