London Health Sciences Centre
Southwest Ontario Regional Base Hospital Program

# SWORBHP LINKS

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## Paramedic Recognition Awards

It is that time of the year again when we recognize individual paramedics with awards of distinction for their outstanding actions during particularly unique or challenging patient interactions. We believe it is essential that the base hospital team and the medical directors take time to formally acknowledge these paramedics with awards of commendation and excellence.

I would like to review the process the SWORBHP medical directors follow in selecting the recipients of these awards. Nominations come from various sources: peers, EMS management, professional standards staff from the base hospital, and the medical directors themselves. Through the review of literally thousands of calls, the final recipients are selected by the Medical Council.

The interesting side effect for us in participating in this process is the appreciation we gain for the dramatic and truly lifesaving work you do every day in providing care to the citizens of your communities. While the awards are important, it is **absolutely essential** for every paramedic within the SWORBHP region to understand that the base hospital staff and the medical directors are continually impressed and truly proud of the safety net you provide for the public through your work every shift. There are so many outstanding actions, so many dramatic and dynamic calls, so much professionalism and dedication demonstrated by all of you; we would hate to somehow have you feel your actions go unrecognized or somehow diminished by only selecting a few paramedics for the Medical Directors Award of Excellence. In fact, it is just the opposite.

On behalf of the entire SWORBHP staff, I would like to thank each of you for the outstanding service you provide. When a crisis happens, you are there to help, no matter the time of day or the conditions you face: that alone is worthy of an award of excellence.

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

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www.lhsc.on.ca/bhp

# Recognition Awards Recipients

## Medical Directors Award of Excellence

Congratulations to the recipients of the 2012 Medical Directors Award of Excellence.

**Zia Khogyani** - Huron County EMS
**LT Jimson** - Middlesex-London EMS
**Kevin Demarco** - Essex-Windsor EMS

L to R: Dr. Don Eby, Zia Khogyani

L to R: Dr. Adam Dukelow, Dr. Michael Lewell, LT Jimson, Dr. Michael Peddle

L to R: Chief Randy Mellow, Kevin Demarco, Dr. Michael Lewell, Dr. Paul Bradford

**Congratulations everyone!**

Cathy Prowd, CQIA
Operations & Logistics Specialist

## Medical Director's Commendation Award

Congratulations to the recipients of the new 2012 Medical Director's Commendation Award.

**Essex-Windsor EMS**
Cathie Hedges, Lori Poole, Victoria Diemer, Justin Hills (PCP Student)

**Middlesex-London EMS**
Lynda Jackson, Paul Moniz, Dustin Carter, Matthew Procek, Kurt Grubb

## Prehospital Save

**Perth County EMS**
Bradley Everett, Lorne Culbert - Dec. 1/11

**Middlesex-London EMS**
Chris Mortier, Scott MacDonald - Oct. 2/12
Shawn Peck, Ryan Hall - Oct.13/12
Sean Sutton, Celine Stokkermans - Oct. 24/12
LT Jimson, Dustin Carter, Matthew Procek, Kurt Grubb - Oct. 31/12
Sean Sutton, Celine Stokkermans - Dec. 19/12
Kevin MacKay, Jordan Whitmore, Dale Blanchard - Dec. 30/12

## Prehospital Newborn Delivery

**Middlesex-London EMS**
Shawn Peck, Lee Nordstrom, Carlo Castellani, Don Black - Nov. 16/12
Carlo Castellani, Robert Gordon, Andrew Hewson, Maggie Timmers - Nov. 25/12
Jason Schinbein, Orla Connolly - Nov. 26/12

**Essex-Windsor EMS**
Lori Poole, Hannah Chevalier, Tim Branch, Mark Kobrosli - Nov. 23/12

**Bruce County EMS**
Judy Brookshaw, Jordan Myles - Jan.12/13

# SWORBHP Says Good-bye to Severo Rodriguez

SWORBHP was very fortunate to have had Severo (Tre) Rodriguez as our Regional Program Manager for the past four years. Tre's passion for education was contagious, filtering down to many of the staff who completed certification as Quality Improvement Associates, Quality Process Analysts, Certified Patient Safety Officers, Nationally Certified EMS Educators, and Investigators with the Council on Licensure, Enforcement and Regulation; not to mention two staff obtaining their Masters Degree.

We would like to take this opportunity to thank Tre for:

- his endless energy and encouragement as we worked through projects such as creation of the Paramedic Registry, our amazing SWORBHP website, and our phone Apps;
- his dedication to ensure we received Accreditation from the Continuing Education Coordinating Board for Emergency Medical Services (CECBEMS);
- his 24/7 support when we needed to deal with time-sensitive issues;
- his vision and dream to see us achieve what others only imagine.

Congratulations on your exciting new role as CEO and Executive Director of the National Registry of Emergency Medical Technicians (NREMT). We know your vision and passion for EMS will continue to inspire many for years to come.

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

Dr. Michael Lewell and Dr. Paul Bradford are shown presenting Tre with a certificate of appreciation on behalf of Dr. Anthony Campeau, Senior Manager of Operations EHSB, for his service to the Province of Ontario, and the Ontario Base Hospital Group Executive.

L to R: Tre Rodriguez, Dr. Michael Lewell, Dr. Paul Bradford

# Treat the Patient AND the Monitor

Paramedics and other health care professionals are taught from the very beginning to always "treat the patient not the monitor". There is no question the patient's history and physical exam are of paramount importance to providing quality care. However, we must incorporate the information provided by the monitor. I would argue that "treat the patient not the monitor" is intended to be applied when the patient looks sick but the monitor says they are fine (i.e. have normal vital signs, etc.). This does not hold true when dealing with the opposite. Many of the audits I have been involved in recently were calls that had gone poorly and the paramedic decided that the monitor was wrong or not functioning properly. In retrospect, it was clear that although the patient looked well, the monitor correctly pointed out that they were in fact hypotensive and required immediate attention. Physicians, nurses and other health care professionals make this same cognitive error in Emergency Departments and on hospital wards every day. Lets work together and change the mantra to "treat the patient AND the monitor".

Adam Dukelow, M.D., FRCP(C), MHSC, CHE
Interim Regional Program Manager
SWORBHP Strategic Planner

# SWORBHP Smartphone Apps

The SWORBHP smartphone Apps are now available on iPhone. The App containing the PCP medical directives is available in the App Store under the name SWORBHP PCP. The App containing the ACP medical directives is currently being reviewed by Apple and will be available as soon as possible. The Apps are available for iPhones that are running iOS version 5.1 or later.

Thank you to all who participated in the beta testing of the iPhone Apps. We received plenty of feedback, the majority of which has been implemented into the application. Any feedback that was not implemented in this release is being prepared for future updates. All versions of the SWORBHP smartphone Apps are available at: www.sworbhp.com/mobile_app

Alan Rice
Programmer, SWORBHP

# Top Ten Reasons...

In the last newsletter I wrote a light-hearted "Top 10 reasons that some days I wish I could trade my FRCP in Emergency Medicine for an EMCA". I asked paramedics in the SWORBHP region to respond with their "Top 10 reasons I would like to trade my EMCA for becoming an ER MD". The only response I received is published below:

10) I would love to wear PJs to work instead of my County issued uniform.
9) FRCPs get to work in a climate controlled environment, instead of dealing with mother nature.
8) Your patients come to your workplace (Emerg), we have to find ours, often while dealing with inaccurate directions.
7) All of your patients arrive from EMS pre-packaged, usually in a supine or semi-sitting position.
6) When you need a lift assist or require C-Spine packaging, you always have extra hands nearby.
5) When your patients get rowdy, security is a phone call away, or already in your department. The ETA of the police is never fast enough.
4) You get to page the RT prior to the VSA/airway compromised patient arriving in your department. We have to try and maintain an airway, and generally not in ideal settings.
3) The general public give you RESPECT, you are God and we are still "Ambulance Drivers".
2) FRCPs can cash in on the nurse's pot luck meals, we usually get called out during our meal break.

And the number one reason I would trade you my EMCA for your FRCP is…
1) YOU MAKE MORE $$ an hour than I do!!!

Marion Taylor, EMCA
Huron County EMS

Thank you to Marion for taking the time to respond with her own Top 10.

Adam Dukelow, M.D., FRCP(C), MHSC, CHE
Interim Regional Program Manager
SWORBHP Strategic Planner

# See...We're Listening

In early 2012, the SWORBHP Education Department sent an electronic survey to the paramedics and service operators asking what you would like to see at the 2012-2013 recert course. At the time, we weren't sure what to expect, but we were pleasantly surprised by your feedback! According to that survey, the top three topics you wanted to see covered were Acute Cardiogenic Pulmonary Edema, Medical and Trauma TOR, and Neonatal Resuscitation. For those of you who have completed your recert this year, we hope you found our coverage of these topics helpful. For those of you who have yet to complete your recert, that was a sneak peak!

You asked for curriculum delivery to be more hands on. You asked for scenarios and skills that were practical in nature; situations that really pushed you to use and practice your skills. As you've probably guessed, this is why our educators have lugged around all those supplies and mannequins!

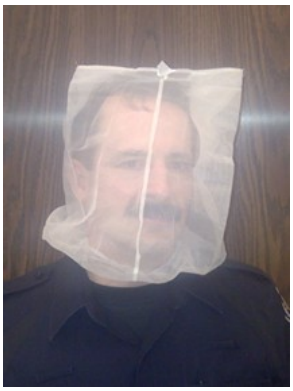
As for the no-stress atmosphere – that was all us! Joking aside, we are very aware that testing causes stress, and stress can lead to paramedic inaccuracy or paramedic error. Our goal this year was to find the balance within a stress-free learning environment, while still asking you to complete a written assessment. Please correct me if I'm wrong, but to date, most of you seem to be walking away quite satisfied. Does this mean we've succeeded? Please remember to complete your post-course evaluation and let us know.

Stéphanie Romano, MScEd., HBSc., AMECA, NCEE, CQPA
Education Coordinator

**Look for us on the Web**
**www.lhsc.on.ca/bhp**

# Keeping Patient Spitting Under the Hood

A new device is being used in emergency rooms within the SWORBHP region. The Spit Sock Hood has been adapted from successful use in the United States. Essex-Windsor EMS is in the process of rolling out this new device and we may soon see it used by other EMS services in Southern Ontario. The Spit Sock Hood can decrease paramedic and health care team exposure from contaminated saliva. (Spit Sock Hood, 2013). In the past, alternate techniques were used to deal with angry, intoxicated, substance abuse, or mental health patients with a penchant for striking out against others, launching powerful streams of potentially contaminated saliva. Observed but not endorsed techniques included, holding a towel up over the patient, using a pillow case, surgical mask, or using the hockey fight jersey pull-over technique to protect caregivers. These techniques posed a risk to the patient by covering their airway, or making ongoing assessment more difficult by limiting exposure. The Spit Sock allows for full assessment and safer response. The device is see-through, fully breathable, and easily removed if there is a change in patient status. It is small and provides splash protection to health care providers, while allowing for improved access to and monitoring of the patient.



Mike Gobet models the Spit Sock Hood

These calls often involve multi-agency response, with patients who are high risk for violence, possible excited delirium, and altered LOC from meds or illicit substances. It is not uncommon in the ER to treat the patient then have to treat the paramedic(s), which often includes taking blood samples, combined with stressful serial serological follow up. The Spit Sock appears to offer the opportunity to mitigate potential paramedic injury. It can be thought of as PPE, with better patient access than the usual mask.

The Spit Sock Hood measures 17" x 9.5"

Mike Gobet, ACP, AEMCA, B.ScN, RN
Essex-Windsor EMS

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

**Reference**

Spit Sock Hood (2013). Retrieved from http://www.spitsock.com

**Self-Report Hotline**
**1-888-997-6718**

**Self-Report Email**
**selfreport@lhsc.on.ca**

# Self-Reporting—What Happens Next?

We have been asked what happens after a paramedic self-reports a variation or issue on a call. The self-report hotline and email system are checked daily by our team. Once we receive the self-report, our team assistant will send an email confirmation within 24-48 hours acknowledging receipt. The self-report is sent to one of the Professional Standards Specialists along with the applicable ACR for review and processing.

If you have not received an email confirmation within 24-48 hours, or have not heard from us within a few days of receiving your email confirmation, we ask you to email or phone one of us directly (in case of a failed self-report message).

This process has been implemented to reduce any potential anxiety for the paramedic and to work together in a timely fashion to complete the appropriate follow up and closure.

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

# Upcoming CE Opportunities

**ECG Review Part 1 - January 30th**
**Stress in EMS - January/February (exact date TBA)**
**ECG Review Part 2 - February (exact date TBA)**
**Midwifery in EMS - February 25th**
**ECG Review Part 3 - March (exact date TBA)**
**Trauma Pain Control in EMS - March (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.**

# Trivia…fast facts! What is it called?

- Mid-men, the male versions of mid-wives, are called accouchers.
- The plastic things on the end of shoelaces are called aglets.
- The white part of your fingernail is called the lunula.
- The device at the intersection of two railroad tracks to permit the wheels and flanges on one track to cross or branch to the other is called a frog.
- The working section of a piano is called the action.

Retrieved from: http://didyouknow.org

# Why Did I Get a Minor?
# The Inside Scoop on Professional Standards

After the auditor has reviewed a call and found an instance where there was a deviation from either patient care standards or medical directive, the Local Medical Director will review the call and make comment. Some calls are evaluated by the Local Medical Director through a delegate (Professional Standards Specialist). After the call has been reviewed, the next step is often to have the paramedic crew provide some feedback so the Local Medical Director can better understand the variation in standard. In 50% of the calls, this feedback is sufficient, allowing us to determine there was no change in patient outcome. In some instances, we assess the potential for a change in patient outcome as defined in the Patient Care Deficiency Classifications below.

Confusion arises from the notion that you are being assessed on the 'quality' of your deviation from standard. This is not true. All deviations from standard are serious. We do scale the deviations to allow us to focus in on the ones that are assessed to have the greatest impact on the patient, but this scale is based on an assessment of patient impact. The critical, major, and minor are intended to denote the potential impact on the outcome of the patient. This involves subjective analysis of findings, so the scale is not 'scientific'.

The intent is to help us separate the important deviations from the less influential deviations so we can direct our educational and remediation resources to the most appropriate topics. Getting a closure letter that suggests the deviation was a major omission does not mean you are a worse medic than your partner who may have received a minor omission. Both of you deviated from standard and need to take steps to prevent recurrence. The difference is you may see the topic of the "major" patient impact during your next recertification.

***Patient Care Deficiency Classifications:***

**Critical Omission/Commission**
A critical omission/commission is defined as the performance of Controlled Act(s) for which a Paramedic is not currently authorized to perform; or an action or lack of action by the Paramedic that has a clear negative effect on or held the potential to negatively affect patient morbidity with a potentially life, limb or function threatening outcome.

**Major Omission/Commission**
A major omission/commission is defined as an action or lack of action by the Paramedic that has affected or held the potential to negatively affect patient morbidity; however, the outcome was not deemed to be life, limb or function threatening.

**Minor Omission/Commission**
A minor omission/commission is defined as an action or lack of action by the Paramedic that did not have any direct effect on patient morbidity; however, may have negatively affected patient care in a way that would delay care to the patient or lengthen the patient's recovery period.

Paul Robinson, ACP, AEMCA, CPSO
Professional Standards Specialist

# A Brief Overview of the Coroners Act

Coroners originated in England during the 12th century (Coroner, n.d., para 1). Coroners were originally appointed by the King to investigate deaths occurring within the realm. The current Coroner system continues to have the same purpose.

The Ontario Coroner system is based upon the Coroners Act ("Coroners Act", 1990). The first purpose of a coroner's investigation is to answer five questions. Who was the deceased? Where did they die? When did they die? What was the cause of death? What was the manner of death? Manner of death is classified as natural, accidental, suicide, homicide or undetermined. The other purposes of an investigation are to determine whether an inquest is necessary and to collect and analyze information about the death to prevent further deaths in similar circumstances. A coroner's investigation or inquest does not assign blame or liability. Its purpose is to discover what happened to an individual with the goal of preventing untimely deaths.

Section 10 of the Coroners Act says it is the duty of every person to report a death to a coroner when it is believed the deceased died as a result of violence, misadventure, negligence, misconduct, malpractice or unfair means. In other words, all manners of death that are not 'natural' require reporting. In addition, some deaths that result from a 'natural' cause do require reporting. These natural causes include dying during pregnancy or a complication of, a death that is sudden AND unexpected, or when a person dies from a disease or sickness that the person was not being treated for by a legally qualified medical practitioner. Deaths occurring in certain situations such as those under custody or inpatients of a psychiatric facility also require reporting. A percentage of people dying in long term care facilities also require their deaths to be investigated.

In the next addition of the newsletter, I will discuss the implications of the Coroners Act for paramedic practice.

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

**References**

Coroner (n.d.). In *Encyclopedia Britannica.* Retrieved from http://www.britannica.com/EBchecked/topic/138338/coroner

The Coroners Act R.S.O. (1990), Chapter C.37. Retrieved from http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90c37_e.htm#BK19

# 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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