London Health Sciences Centre
Southwest Ontario Regional Base Hospital Program

SWORBHP LINKS

VOLUME 8 JANUARY 2012

Inside this issue:

Nice to Hear From You	2
Disclosure of Salaries $100,000 and More	3
Rural Paramedicine	4
Paramedic Patch: An ED Nurse Perspective	4
Congratulations!	5
The Science Behind FTTG	5
Recerts 2011—Feeling the Draft	6
Symptom Relief of Pain Delivered by PCPs—A Time for Action	7
Fixation Error	7
Ambulance Offload Nurse Initiative	8
Recerts From the Educator's Perspective	9
Upcoming CE	9
Trivia Fast Facts	9
Do eACRs Minimize Documentation Errors?	10
Distance Learning—A Personal Perspective	11
Ask MAC	11
Write to Learn	12

ISSN: 1927-8276

Paramedic Recognition Awards

In 2011 the Southwest Ontario Regional Base Hospital Program (SWORBHP) recognized 97 paramedics for their role in helping to save a life, or assist with bringing a new life into the world. A total of 83 Prehospital Save Awards and 14 Newborn Delivery Awards were presented throughout our region. In addition, five paramedics were honored with the Medical Directors Award of Excellence. SWORBHP is pleased to have the opportunity to recognize each of you for the vital role you play in serving your communities.

Congratulations to the recipients of the 2011 Medical Directors Award of Excellence.

Justin Hobson & Steven Brooks
Bruce County EMS

Justin and Steven were nominated for outstanding clinical judgment during a very difficult call, and demonstrated leadership in a complicated multi-agency response.

L to R: Dr. Don Eby, Local Medical Director, Justin Hobson, Steven Brooks, Dr. Michael Lewell, Regional Medical Director

Erik Natvik & Vanessa Zietsma
Middlesex London EMS

Erik and Vanessa were nominated for outstanding clinical judgment and actions during a difficult and complicated call.

L to R: Dr. Adam Dukelow, Local Medical Director, Erik Natvik, Vanessa Zietsma

Brenda Gingras
Essex-Windsor EMS

Brenda was nominated for outstanding clinical judgment and actions during a difficult call.

L to R: Dr. Michael Lewell, Regional Medical Director, Dr. Paul Bradford, Local Medical Director, Brenda Gingras, Matthew Gaudette, Paramedic Instructor

...cont'd from page 1

Paramedic Recognition Awards

SWORBHP would like to congratulate the following recent recipients of the Prehospital Save Award.

Perth County EMS
Heather Kiedyk, Dale Schwartzentruber, Scott Rutherford (April 15, 2011)

Huron County EMS
Tony Southwell, Greg Gordon (October 6, 2011)
Kevin Gorman, Cynthia Strickland (December 3, 2011)

Bruce County EMS
Dan Urbshott, Chris Wynn, Bill Gaunt (October 10, 2011)
Linda Isbester, Jennifer Miller (December 7, 2011)

Essex-Windsor EMS
Jeff Borghi, Slav Pulcer, Gerry Hedges (June 12, 2011)
Kristin Founk, Aaron Campeau, Ziad Fatallah (August 11, 2011)
Mike Gobet, Nisreen Karkanawi (September 1, 2011)
Brad Humber, Lisa Das Neves, J.P. Bacon, Mike Jacobs (October 10, 2011)
Mike Basinski, Keith Affleck, Marty Petro, Jamie Quick (October 10, 2011)
Marc Kobrosli, Tim Branch (October 22, 2011)

Cathy Prowd, CQIA
Operations & Logistics Specialist

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

Nice to Hear From You

SWORBHP recently completed the Ministry of Health (MOH) Base Hospital Review. We are delighted that we met or exceeded the standards set forth by the review team. The successful formation of the regional structure is a direct result of hard work and collaboration among former Base Hospital programs, EMS services, and front line paramedics. I would like to say thank you for your help in making SWORBHP what it is today.

As part of the Base Hospital Review, paramedics were asked to complete a survey, from which we received many comments. Without question, there are areas we can improve and this is only one of our challenges for the coming years. I would like to address a few of the comments received from paramedics.

"SWORBHP tends to be too ACP oriented and nothing changes for PCP"
We are well aware that PCPs form the vast majority of paramedics within the region. The decision to add auxiliary directives to the PCP scope remains up to a municipality. SWORBHP is supportive of adding any or all of the auxiliary directives. Since 2008, PCPs within SWORBHP have added CPAP, 12 Lead, Benadryl, Gravol, IV fluid, Dextrose, King LT.

"The Medical Director(s) do not believe in the ACP scope"
We believe in ALL paramedics, that it why the SWORBHP physicians are involved in EMS and extend our medical license for you to practice. Delegation is required by your profession, these are your rules, we did not create them.

"SWORBHP is too big, has too many decertifications, has to rely upon local medical directors, fails too many at recerts, de-activates only "disliked" paramedics, only punishes not educates."
SWORBHP has never decertified anyone. Last year we deactivated only 12 of approximately 1300 active paramedics for suspected clinical errors. In addition, eight paramedics were unsuccessful at annual recerts and were educationally deactivated. SWORBHP is not your employer, therefore the only "punishment" we could possibly inflict on anyone is further education. Most of the Local Medical Directors are the same physicians you worked with under the former BH structure, providing you with consistency and familiarity. We work together as a Medical Council so that we have a consistent approach across the Southwest.

...continued on page 3

...cont'd from page 2

Nice to Hear From You

"SWORBHP provides no positive feedback"
Over the past year, we have sent audit feedback congratulating you on well managed complicated calls, awarded nearly one hundred certificates and pins for successful field resuscitations and newborn deliveries, and created a Medical Director Award of Excellence. Nomination forms and further information can be found on our website. **Click Here** to visit our website.

On a final note, as emergency physicians, we provide care one patient at a time. As EMS physicians, and through your professional work as paramedics, we have the ability (through extending the use of our medical licenses to you) to enhance the care provided to thousands. We believe in and are fiercely proud of the work that you do every day as ACPs and PCPs: if we didn't, we wouldn't be here. Simple as that.

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

Disclosure of Salaries $100,000 and More

Since 1997, each March 31st the Ontario Ministry of Finance publishes what has come to be known as the "Sunshine List". This list is a result of the Public Sector Salary Disclosure Act (PSSDA) which requires public funded organizations to annually report details of employees who earn more than $100,000 in salaries and taxable benefits. Organizations impacted by this act include the Government of Ontario, Crown Agencies, Hospitals, School Boards, Municipalities, Universities, Colleges, Boards of Public Health, Hydro One, Ontario Power Generation, and public sector employers who receive significant dollars from the Provincial Government.

To comply with the act, LHSC is required to submit the salary and benefit details by the fifth business day of March for employees who meet the criteria of the PSSDA. The details reported include: government sector, name of employer, first and last name of employee, position, salary paid and taxable benefits. Employees that are seconded to other public funded organizations and are paid through LHSC are included in the report.

Information for calculating paid salaries and taxable benefits is based on reported income from the T-4 issued to the employee. The salary paid may include retroactive or grievance payments, and overtime. Calculating the salary rate based on what is indicated as salary paid would not be accurate due to the inclusion of payments such as overtime or retro. The inclusion of these payment types results in fluctuations on who is on the list from year to year.

Once the information is collated, reports for all employees with salaries and taxable benefits exceeding $100,000 are submitted to the funding Ministry. Additionally, should LHSC pay for an employee who is seconded to another public funded organization, a second report with these details is submitted to the organization the employee is seconded to. The organization must submit a report of attestation, signed by the highest ranking officer of the organization, indicating that all the provided information is accurately reflected in the submitted reports.

Details of the act, prior year disclosure, and requirements for reporting salary disclosure can be found at: **http://www.fin.gov.on.ca/en/publications/salarydisclosure/2011/**

Judy Aggerholm, CGA
Business Manager
Clinical Support & Business Development
London Health Sciences Centre

References

Ontario Ministry of Finance: Public Sector Salary Disclosure. Retrieved January 20, 2012. **http://www.fin.gov.on.ca/en/publications/salarydisclosure/2011/**

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

Rural Paramedicine

Imagine…you are dispatched code 4 for a patient who fell approximately ten feet, landing on his back and now complaining of breathing difficulties. Straight forward call right? In the rural setting it is anything but!

We throw our bags into the Zodiac and make our way to the island. This boat can get there in about five minutes because it spends as much time out of the water as it does in it. It's a windy day so ORNGE won't fly, despite our plea for assistance. We are now officially out of range, so we can no longer communicate with dispatch. Upon arrival, we find the patient sitting upright in a boat and a park warden is holding C-spine. The patient fell approximately ten feet and landed hard on his back. His vitals are stable, HR 98, BP 134/88, SPO2 98%. He has decreased air in the right lower lobe, and what used to be called 'rhonchi' over all lung fields. I ask if he is a smoker, he says, "Yeah; a pack every day for twenty years". He notices my bewildered face and adds, "I'm a welder". We collar and KED him but decide to leave him sitting upright, because he's comfortable in this position.

We slowly make our way back to land as the boat rocks up and down. I try to stabilize him as much as possible as we are tossed about in the Zodiac. His pain has him closing his eyes and screaming for pain medication. If only we had Fentanyl, or even Toradol. As I try to ward off sea-sickness, I notice my partner is a particularly alarming shade of green and sweating profusely. If only we could use Gravol!

We arrive at the Coast Guard dock and the patient asks, "Is it over"? I respond, "Almost…we just have to get you to the closest hospital". The patient quickly asks, "How long is that?" I respond, "About another 40 minutes". He swears. The call takes almost four hours in total, and that's about average...in a rural setting.

A low call volume in winter is offset in the tourist season. A busy day in an area where the closest hospital is 40 minutes away is maybe three calls….yup, that's it. One call can easily last anywhere from three to four hours.

So why would anyone want to live and work in a place where everybody comes to play? Well, it's certainly not for everyone.

Jason Angus, PCP
Bruce County EMS
Paramedic Rep - Base Hospital Utilization Committee

The Paramedic Patch: An ED Nurse Perspective

The transfer of information is a skill developed by paramedics—one that Emergency Department (ED) staff rely on to provide the important link for effective continuum of care. The importance of concise and accurate information during a patch cannot be underestimated. For example, a crew patches to triage with a 30 year old female patient, CTAS 2, MVC rollover, belted driver, airbags deployed, boarded and collared, decreased LOC, open tib/fib fracture, etc. The details given to the triage nurse will determine what needs to be done prior to the patient's arrival in the ED, such as the immediacy of finding a bed and what area that bed will be in. Will we use our last trauma bed? Do we need to notify an ED physician prior to the patient's arrival? Does RT or X-ray need to be notified? A cascade of actions occur prior to the patient's arrival based on the information provided during that patch.

ED staff rely on paramedics to "paint a picture" of the scene. This will help staff anticipate potential occult injuries and complications. Was there a passenger in the car and did they survive? Do we know any other personal information? This will allow us to broaden our scope of care for the patient (i.e., call in social work or a family member).

Remember, early notification is equally vital when transporting stroke and STEMI patients; enabling the ED to assemble the appropriate staff prior to your arrival. No job in the ED functions independently. We all rely on accurate and succinct handover of information to piece together a full picture of a patient's story in order to provide the highest quality of care.

Kelly Davis, B.Sc.N., R.N.
CBRN Response Team Specialist
London Health Sciences Centre

Congratulations !

I would like to recognize the following individuals for their extraordinary dedication and commitment to patient care, their profession, and LHSC. They have accomplished what many talk about, but very few actually do. Thank you for your dedication and drive for excellence.

Tracy Gaunt, Professional Standards Specialist, graduated from Walden University in December 2011 with a Masters of Science in Instructional Design.

Sue Kriening, Manager, Emergency Program University Hospital, graduated from Athabasca University in December 2011 with a Masters of Health Studies in Leadership.

Severo Rodriguez, B.A., MSc., NR-LP, AEMCA
Regional Program Manager

The Science Behind Field Trauma Triage Guidelines

There was a time when paramedics would attend to a trauma patient, complete a quick assessment and then drive quickly to the closest hospital. If this destination was not a trauma center, staff at the hospital would stop what they were doing, stabilize the trauma patient, and assess the injuries with lab work and limited imaging. This would often entail bringing in on call radiology and lab staff. The paramedics might then be called back to this hospital three or four hours later to do a stat transfer (for the same patient) to the trauma center, sometimes 30 to 45 minutes away, for further imaging and definitive care. Many paramedics questioned this course of action, wondering if bypassing closer hospitals and taking patients directly to the trauma center would make sense, perhaps achieving definitive care sooner.

Helicopters in large urban areas were doing just that, building from experiences in Korea and Vietnam. Many studies began to look at this issue with various trauma systems, often focusing on different types of injuries (Hart, et al, 2006). A large multicenter trial published in the New England Journal pulled together data from multiple trauma treatment sites (MacKenzie, et al, 2006). It determined that moderate and severe multi system trauma patients had a 25% decreased mortality. Although this did not account for moving people around or extra distance; the data was compelling enough to prompt the Centres for Disease Control (CDC) to make a recommendation, in partnership with the American College of Surgeons, that patients be taken directly to a trauma centre (http://www.cdc.gov/fieldtriage/).

Essex County has had this arrangement in place for seven years and the paramedics have shown excellent judgment in safe implementation of this destination protocol. The Canadian Field Trauma Triage Guidelines will soon be rolling out in Ontario after incorporating local issues. Most areas have already implemented trauma patient bypass policies. This new Provincial Field Trauma Triage Directive will help bring this thinking to many other services.

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

References

Hart, R., Gerber, L., et al. (2006, June). Direct Transport Within An Organized State Trauma System Reduces Mortality in Patients With Severe Traumatic Brain Injury. *The Journal of Trauma*; 1250-1256

MacKenzie, E.J., Rivara ,F.P., Jurkovich, G.J., et al. (2006). A National Evaluation of the Effect of Trauma-Center Care on Mortality. *New England Journal of Medicine*; 354:366–378

Centres for Disease Control. (2011). Guidelines for Field Triage of Injured Patients: Recommendations from the National Expert Panel on Field Triage, in CDC's *Morbidity and Mortality Weekly Report: Recommendations and Reports*. Retrieved from: http://www.cdc.gov/fieldtriage/

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

Recerts 2011 - Feeling the Draft

Normally, a draft is just an annoying cool breeze on the back of your neck, easily stopped by a warm sweater. Unfortunately, the draft we felt this year was the new 2011 ALS Patient Care Standards, one that was not so easily overcome!

The SWORBHP training team met in December 2011 (as we do each year) to analyze the recertification courses conducted to date. We reviewed the approximately 300 online surveys that had been completed, paying particular attention to the written comments provided. The Regional Educators had ample time to provide their personal reflections. The process enabled us to determine what worked and did not work so well from both the learner and educator standpoint. Without a doubt, the most difficult challenge for both groups this year was dealing with draft directives.

In February 2011, the SWORBHP Education Program Committee began work on two different recertification courses for the fall; one with the new directives (Plan A), and one without the new directives (Plan B). This concurrent work continued until late April when it appeared from all sources that the new directives would be approved by July 2011. Everything quickly shifted to focus on Plan A, the release of the new ALS Patient Care Standards. Many hours of work went into planning and developing the pre-course webinars and quizzes which were designed as an introduction to the new directives. The videos were recorded in early July using the most current document – the April 2011 draft directives. By the time we posted the videos to our website in August, there was a newer version of the directives, but it too was only a draft. Copies of the August version were provided to each service for paramedics to review as they watched the webinars.

September brought a change in the breeze with yet another new draft. Paramedics attending recerts in the coming months received a personal copy of the September version. Each draft brought new insights; some minor, some more significant. By late October, and still working from draft documents, some of us started to wonder if we should have stuck with Plan B! On November 9th, word finally came from the EHS Branch that the 2011 ALS Patient Care Standards, Version 3.0 were now official. There were some changes to the document; mostly formatting, with no significant changes to the medicine itself.

In retrospect, the release of the directives this year was crucial. They contain the newest recommendations from the 2010 AHA Guidelines. Delaying the new directives to fall 2012 would have resulted in a two year gap between the new guidelines and revised directives. Additionally, the memo from the EHS Branch requires the new directives to be implemented no later than May 1, 2012. Our community college partners who introduced the draft directives in September 2011 will find their students better prepared for the inclusion of the new directives in both the provincial AEMCA and ACP credentialing exams beginning in the summer of 2012.

It will still take a bit of time to overcome the effects of that cool draft we all felt this past summer and fall. Our phased-in implementation plan presented in the recert course should serve as a warm sweater of sorts. With the directives in the final version, work is well underway in the development of a new pocket book for each paramedic, as well as a Frequently Asked Questions document to help clarify the directives.

All of us at SWORBHP have felt your frustration with the draft directives, and that cool breeze was a discomfort for us as well, even painful at times. Thank you for your patience and cooperation as we worked through this together. Here's to a draft-free recert course in the fall of 2012!

David Vusich, ACP, NCEE
Coordinator, Training

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

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

Symptom Relief of Pain Delivered by PCPs — Time for Action

As health care providers, one of the greatest things we can do for patients is to relieve suffering. One of the greatest causes of suffering is pain. It is known that even in Emergency Departments, control of pain is not something that is well done, and ordering analgesics is often delayed.

Although the number of symptom relief drugs has increased a lot in the last 10 years, the one thing that is missing from the PCP ‘tool box’ is something to ease pain. There are several proposals being considered to fix this. Narcotics such as Morphine and Fentanyl are options. Unfortunately, there are a lot of logistical problems with the use of narcotics. They are required by law to be stored under lock and key, counted daily, and are targets for theft.

Grey County EMS has brought forth the suggestion to develop a directive to be able to give injectable Ketorolac (Toradol) for symptom relief of pain. Grey County EMS sees the highest number of downhill ski injuries in the region and on most winter days, Grey County paramedics feel like they just shuttle between the ski hills and the local Emergency Departments. In addition to ski injuries, injectable Ketorolac would be useful for other limb trauma, renal colic, severe back pain, etc.

Draft medical directives are being developed by other regional base hospitals to allow the use of Acetaminophen (Tylenol) and Ibuprofen (Advil, Motrin). ORNGE has a Ketorolac directive and this directive is being looked at by SWORBHP to modify it for PCP use. It is hoped that a proposal for a directive for pain relief will be sent to the Provincial MAC this year. The time for action on the problem of pain relief for PCPs has come.

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

Fixation Error

With respect to medical error, it is crucial to understand the various human factors that can precipitate adverse events and we must learn from each other’s mistakes. By the nature of our jobs, emergency staff are particularly vulnerable to cognitive errors as we are required to make diagnostic and treatment decisions quickly based on an often limited set of information. One common type of error, termed ‘fixation error’, occurs when health care providers concentrate exclusively on one aspect of a case to the detriment of other more important or contradictory features.

While working in the ED recently, I was called to the resuscitation room as the medics brought in a 75 year old gentlemen who was extremely SOB. He had a long history of severe COPD and had been admitted repeatedly over the course of the year for acute exacerbations. His most recent complaints were that of increased cough, SOB, and sudden onset chest pain earlier that day. Assuming another exacerbation, the medics had initiated prehospital CPAP, however on arrival to the ED he was still very tachypnic, hypoxic, and complained of unremitting chest pain. His initial ED EKG showed sinus tachycardia and his CXR had no obvious infiltrates. My staff and I carried on with treating a ‘COPD exacerbation’ with steroids, antibiotics, bronchodilators, and BiPAP...we even discussed intubation! After *forty* minutes of failed ED therapy, we repeated a CXR which showed complete collapse of his left lung from a pneumothorax. In hindsight, a smaller pneumothorax could be seen on his initial film but neither of us was looking for one. In the end, I inserted a chest tube to drain his pneumothorax and he felt instant relief and had normalization of his vital signs.

In this case, the medics and I ignored the elements of his initial history and physical exam (sudden onset CP, no fever/productive cough, decreased breath sounds) that should have pointed us in another direction. Avoid making the same type of error in your practice: leave room to revise your diagnosis, get another opinion if therapy is failing, and always rule out the worst-case scenario!

Sameer Mal, B.Sc., M.D.
PGY-4 Emergency Medicine
SWORBHP EMS Resident

Ambulance Offload Nurse Initiative

Over the last several years, Emergency Department (ED) overcrowding has become "one of the most challenging issues currently facing the Canadian health care system" (Ospina et al., 2007, p. 340). Overcrowding can be defined as demand for emergency care services exceeding the ability to provide care in a reasonable length of time (Ospina et al., 2007). It results in "increased patient suffering, prolonged wait time, deteriorating levels of service, and on occasion, a worsened medical condition or even loss of life" (CAEP, 2005, p. 2). Canadian research cited the main cause as the domino effect created when admitted patients occupy ED stretchers preventing new ED patients from accessing timely assessment and treatment (Drummond, 2002).

The Ambulance Offload Nurse position was implemented by the Ontario Ministry of Health and Long-Term Care in 2006 in an effort to assist EMS personnel in offloading their patients to allow them to "return to the street" sooner in an effort to improve their response to the 911 calls in the community (MOHLTC, 2009).The initiative was implemented at London Health Sciences Centre (LHSC) in January of 2009. It began with coverage by an experienced LHSC ED nurse with triage training eight hours per day. Over the years, the position has evolved to twelve hours per day and in January/February 2012 hours will expand to sixteen hours per day. The nurse triages ambulance patients and determines if they meet the criteria for offload which include: CTAS level 3, 4 & 5's who cannot be placed in a wheelchair, do not require cardiac monitoring, or are immobilized on a backboard. The nurse can care for 4-6 patients, depending on acuity. When there are no offload patients, the nurse can assist in the department as a second pair of hands.

LHSC Emergency Departments received 29,176 ambulances last year (April 2010 to March 2011). The University Hospital ED receives on average 38 ambulances per day or 29% of total ED volume. The Victoria Hospital ED receives 36 ambulances per day or 21% of total volume and the Children's Hospital ED receives 6 ambulances per day or 6% of total volume (Whalen, 2011).

Because the offload nurse position is filled by experienced ED RN staff, there has been variability in the ability to fill the position due to staffing shortages and vacancies. There is a strong commitment from the LHSC ED leadership to endeavor to provide maximal coverage to the offload position to ensure that EMS personnel are able to provide optimal coverage to the community of London and Middlesex moving forward.

Susan Kriening, RN, BScN, MHST, ENC(C)
Manager, Emergency Program
University Hospital
London Health Sciences Centre

References

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 Canadian Association of Emergency Physicians. (2005). *Taking Action on the Issue of Overcrowding in Canada's Emergency Department.* Retrieved from http://www.waittimealliance.ca/waittimes/CAEP.pdf

Drummond, A. (2002). No room at the inn: overcrowding in Ontario's emergency departments. *Canadian Journal of Emergency Medicine, 4(2),* 91-97.

The Ontario Ministry of Health and Long-term Care. (2009). Improving Access to Emergency Services: A System Commitment: Summer 2005. Retrieved from http://www.health.gov.on.ca/english/public/pub/ministry_reports/emerg_dept_05/emerg_dept_05.html

Whalen, L. (2011). [LHSC Emergency Department Monthly Stats]. Unpublished raw data.

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

Recerts From the Educator's Perspective

Having recently returned from maternity leave, I had the opportunity to enter the 2011-2012 recert program just like many of you. I was not involved in the development process, and so I began to partake in the pre-course webinars and quizzes as a Paramedic, rather than from the perspective of an educator. Keeping in mind that no online learning management system is perfect, and rationalizing that SWORBHP was still working with the draft directives, I felt as though the pre-course work successfully accomplished what it was meant to do; prepare me for the recert day. I attended a recert day having very little knowledge of what was to be expected, and came away from the day feeling both capable and confident with the new directives.

As an educator, I realize that along with online learning, no recert is perfect. However, I must say that initial feedback from the classes I have taught has been very positive. I always preface my courses by saying that my goal is to alleviate the paramedic oh-so dreaded grey area, commonly found in EMS. During class, I find paramedics not only comfortable with this grey area, but exercising educated clinical judgment. This will never eliminate the educator oh-so dreaded 'what if' questions, and so I continue to try to answer these both logically and academically.

Overall, it appears recerts are going well; they flow smoothly, are laid back, encourage group work and detailed discussion, and leave the paramedic comfortable and confident with the new directives. I have found that at the end of the recert day, we all realize the changes themselves are not onerous, but rather they are streamlined and simplified.

I truly hope that my interpretations are accurate, and if I am mistaken, please contact me and enlighten me. As always, please feel free to contact your Regional Paramedic Educator if you have any questions about the new directives, their application, or even their reasoning.

Stéphanie Romano, HBSc., AEMCA, NCEE
Regional Paramedic Educator

Upcoming Continuing Education Opportunities

January - Delegation of Controlled Acts

February - CBRNE

March - Geriatric Emergency Medicine

April - Seizures

May - Shaken Baby Syndrome

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!

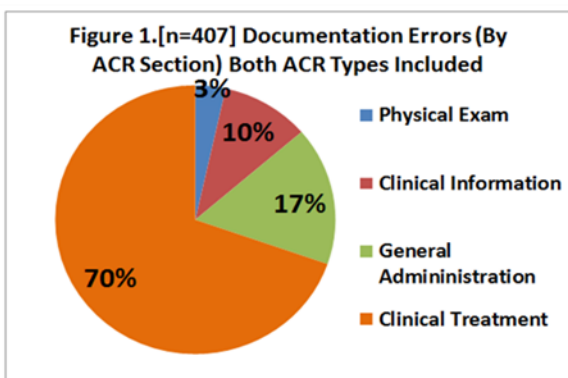
- Every square inch of the human body has an average of 32 million bacteria on it
- It takes a lobster approximately seven years to grow to be one pound
- Antarctica is the only country without reptiles or snakes
- Bats are the only mammal that can fly
- A honey bee must tap two million flowers to make one pound of honey

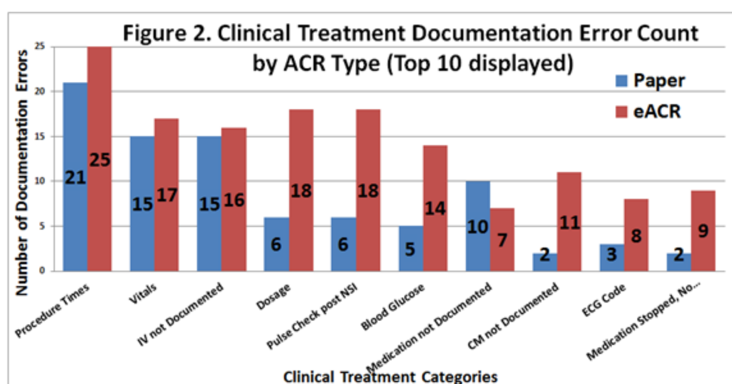
Retrieved from: www.corsinet.com/trivia

Do Electronic Ambulance Call Reports (eACRs) Minimize Documentation Errors?

By the end of spring 2012, 80% of paramedics within the SWORBHP region will be utilizing electronic Ambulance Call Reports (eACRs). One perceived benefit of the eACR is that it reduces documentation errors. Ahmed et al (2012) conducted a study to review documentation errors and compared their frequency between eACRs and paper ACRs (pACRs). In the study, Ahmed et al (2012) defined documentation errors as the absence or inaccuracy of information following an investigative process by the professional standards specialists and further characterize documentation errors in an effort to gauge clinical relevance.

Figure 1 represents documentation errors by ACR section. A total of 407 documentation errors were found spread across four sections of ACRs. 70% of the documentation errors in eACRs, and 69% in pACRs were found in the clinical information sections of the ACRs. Errors discovered in the clinical information sections of the ACRs were assigned to the following categories: procedure times, vital signs, medication administration, use of the cardiac monitor/defibrillator, performance of glucometry, airway procedures and basic resuscitation (CPR and oxygen use). See Figure 2





Ahmed et al (2012) concluded that the rate of documentation errors found in eACRs was 5.5 times higher than the documentation error rate in pACRs. The data presented above can be utilized to design countermeasures targeting the reduction of documentation errors. Some potential countermeasures can be a modification of eACR software and or enhanced training of paramedics on eACR platforms. Further analysis of data is required to determine the most robust countermeasure that will lead to effective reduction of documentation errors in the clinically relevant sections of the ACRs.

Adeel Ahmed, M.Eng, CQM/OE
Coordinator, Professional Standards & Performance Improvement

Reference

Ahmed, A., Rice, A., Mal, S., McLeod, S., Bradford, P., Eby, D. (2012). Frequency and description of documentation error types by electronic vs paper ambulance call reports (Abstracts for the 2012 National Association of Emergency Medical Services Physicians Scientific Assembly), *Prehospital Emergency Care;* 16(1):152–187(Abstract 83). doi: 10.3109/10903127.2011.624676

Distance Learning - A Personal Perspective

I recently graduated from Walden University with a Masters of Science Degree in Instructional Design and Technology, via distributive learning format. Let me dispel some myths about online learning and why it is the 'best' way to learn for many students. "About 80% of online students are undergraduates, and they are generally older and more likely to be working and have families" (Pope, 2006). While it may not be physically possible to attend classes, online learning gives learners the 'flexibility' to participate in a wide variety of courses at their own pace. Traditional classroom settings dictate your direction and allow little room for deviation, where online learning provides a guide for learning. Most of us recently completed a recert class where group discussion was the focus, compared to past recerts where we struggled to get through a day of lectures.

Prior to attending the group session, SWORBHP gave us a 'taste' of online learning by asking us to complete a quiz which focused on the Medical Directives for 2011. The quiz was just a glimpse of what is possible to achieve through an online learning module. Imagine being able to log on to a wiki space (at 2:00 a.m. in your PJs) where you can work together and share ideas and resources with fellow students (St. Germain, 2011).

Annual training is a must for us, but it does not need to be something we dread. Future sessions can include online games-based training. Chynoweth (2011) noted "playing games engages people in solving problems and motivates them to do it. Alongside that is the story-telling aspect, which improves people's recall of what they learn". Online learning gives you this flexibility and the possibilities are endless. Just ask me.

Tracy Gaunt, MSc., NCEE
Professional Standards Specialist

References

Pope, J. (2006, November 9). Number of students taking online courses rises.
http://www.usatoday.com/tech/news/2006-11-09-online-learning_x.htm

St. Germain, E. (2011, July 6). Five Common Pitfalls of Online course Design
http://www.facultyfocus.com/articles/online-education/five-common-pitfalls-of-online-course-design/

Chynoweth, C. (2011, December 4). Game over for Dull Training.
http://www.thesundaytimes.co.uk/sto/public/Appointments/article834482.ece

We are excited to announce our new "Ask MAC" web page!

The Medical Directors of SWORBHP are offering a new opportunity for paramedics to ask the Medical Advisory Council questions related to the medical directives, discuss a challenging or unique call, or present any other relevant topic for discussion.

Our "Ask MAC" web page is located on our Base Hospital website at:
Link: www.lhsc.on.ca/About_Us/Base_Hospital_Program/askmac.htm

Paramedics can anonymously submit a question or comment (or add your name and contact information if you like). Each week, Medical Council will review the submissions and we will post the questions and answers on the website for everyone to read.

While the "Ask MAC" web page is a new and unique opportunity to specifically ask Medical Council questions, SWORBHP continues to encourage all paramedics to ask us questions at any time.

Our contact information can be found at:
Link: www.lhsc.on.ca/About_Us/Base_Hospital_Program/OpsLogistics/Contact_Information.htm

If you have any questions, feel free to contact the Base Hospital.

Write to Learn

A principle known to adult educators is that adults learn in many different ways. For example, adults can be auditory, visual, or kinesthetic learners. Some prefer to jump in and try things out while others like to sit back, watching and reflecting on the experiences of others. There are independent learners, and there are social learners who enjoy group discussion as a way of learning.

One effective method for enhancing learning used in many disciplines is a writing assignment (Meyer, Fisher, & Pearl, 2007). There are many forms of writing assignments such as student journals, portfolios, research papers, case studies, professional journal summaries, and even personal blogs. As a tool for learning, writing is supported by faculty and students alike for increasing critical thinking and higher order thinking skills. Through writing, we can go beyond the memorization of factual knowledge by reflecting on how the material affects us in a personal and relevant way (Brent & Felder, 1992).

> ***"Through writing, we can go beyond the memorization of factual knowledge…"***

Paramedics in the SWORBHP region have opportunities to gain Continuing Education (CE) credits by using writing as a learning tool. For those unable to attend webinars live, recorded versions are posted to our Base Hospital website www.lhsc.on.ca/bhp. After watching the webinar, paramedics submit a short written summary explaining one or two key highlights of the presentation, and discuss how this information impacts their practice as a paramedic. The same process can be used for reviewing journal articles or lectures that are applicable to pre-hospital care. CE credits can be granted for completed research projects, or written articles that are published in a recognized, professionally related paramedicine or prehospital care journal.

Even in the absence of CE credits, writing can serve as a powerful medium for personal reflection and expression of our thoughts and emotions, helping us to make sense of what we are experiencing. Certainly there are those who don't enjoy writing, and for many it is an acquired skill that takes time to develop. But it is a method that many people use to add meaning to their learning. After all, it is your write to learn!

David Vusich, ACP, NCEE
Coordinator, Training

References

Meyer, J. A., Fisher, B. J., & Pearl, P.S. (2007). Students' perceptions of the value of a self-study writing assignment. *Journal of Instructional Psychology, 34(4)*, 234-241

Brent, R., & Felder, R. M. (1992). Writing assignments: Pathways to connections, clarity, creativity. *College Teaching, 40,* 43-48

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

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

Editor-in-Chief
Severo Rodriguez

Editor
Cathy Prowd

Associate Editor
Tracy Gaunt

ISSN: 1927-8276