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Paramedic Practice — The Application of Knowledge, Skill and Ability

'Practice' is the term used to describe what a professional does when they work. Paramedic practice is the work a paramedic does with patients. It has three components, knowledge, skills and ability. Knowledge is a combination of facts and information gained through education and experience. It is the 'why' of practice. Skill is the capability to do a procedure. It is difficult to explain how to do a skill to another person. A person has to experience the 'feel' of doing it, to develop a skill. Skill is the 'how' of practice. Ability is the application of knowledge and skill to the particular needs of a client or patient. It is the 'where' and 'when' component of practice. Practice is what professionals do. It is what paramedics do.

The three components of practice are all important. Without knowledge, a professional doesn't understand what to do or why they do what they do, they just react to situations. Without skill a person doesn't know how to do what needs to be done. Without ability they don't know where or when to apply the knowledge and skill they have.

Knowledge, skill and ability have different memory characteristics. Knowledge is the easiest to obtain and the easiest to forget. Skill is more difficult to acquire, but once it is achieved it can be maintained with occasional repetition. Ability, the when and where of application of knowledge and skill, is gained through experience, feedback and self reflection on whether knowledge and skill were applied correctly.

Practice is a complex interaction between knowledge, skill and ability. In the next article I will discuss how professionals go about developing and maintaining each component of their practice. Watch for the next article in the July newsletter.

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



Strategies to Reduce Documentation Errors

Today, approximately 80% of paramedics in our region utilize electronic Ambulance Call Reports (eACRs). Documentation errors found in eACRs were 5.5 times higher than the documentation errors in paper Ambulance Call Reports (pACRs) (Ahmed et al., 2012). Here are some recommendations to help paramedics effectively counter these errors:

- Consider obtaining a full list of problem and procedure codes applicable to your eACR platform from the Service Operator. This action should facilitate proper coding of problem and procedure codes as eACR applications have additional codes compared to pACRs.
- Enter vital signs values in the appropriate boxes provided by the software and avoid adding any numeric values in the notes section of the dialog box or other free-form text directly in the results section. This should enable the eACR software to display the data appropriately.
- Review general administration and clinical information sections of the ACR before closing the call. If the procedure sequence is clinically relevant, then the sequence has to be documented as occurring at different times, otherwise the default setting of the eACR platform will arrange and display the procedures in alphabetical order once the call is saved.

SWORBHP is currently developing a Webinar to provide paramedics with additional tips aimed at reduction of documentation errors. The date for this online event has not been finalized. A notice will be published once the date has been set. For other upcoming events, please visit our website: www.lhsc.on.ca/bhp.

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

Recerts 2012-2013 — What do YOU Want to See?

It's hard to believe we have just completed the last of the 2011-2012 recerts, and we're already planning the next one! That's right; we've begun the planning process for what will comprise both the content of your next recert, as well as how that content will be delivered.

Each year we deliberate for hours about whether to teach or test, how to teach or test, and what to teach or test. This year, we're trying something a little different; we're asking you for your input!

For so many years your recerts have been dictated to you, and you've never really had a voice in the process. Well this year is different. We strive not only to ensure patients are cared for safely and effectively, but to ensure paramedics are supported so they are safe to practice. For this reason, we hope you find that we do care what you think, and really want to know what you feel you need to be better at what you do.

A survey was recently distributed via email for your anonymous feedback. We're looking for your input on topics for recerts, as well as how you would like to see the 2012-2013 recert delivered. We asked for input related to the content. For example, which medical directives you would like to see covered and how you would like to see them delivered, e.g., online, lecture, or scenario, and even what methods of delivery you find effective. We encourage you to share your thoughts!

The survey is one avenue you have to contact us and provide feedback. You're always welcome to do so by contacting any one of the SWORBHP staff by phone or email, or even using the Ask MAC site.

Your input means a lot to us, please feel free to share it!

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

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

A Consistent Approach

The medical care provided to patients by paramedics in the setting of an emergency is complex. Every patient encounter is unique, and poses new management challenges. Guiding paramedic practice primarily through Medical Directives is called “off line medical control”. The advantage of this form of delegation is the avoidance of a paramedic needing to patch and speak directly with a physician for each of the over 30,000 controlled medical acts performed by paramedics last year in the Southwest Region. The disadvantage of Medical Directives is that they cannot account for each individual situation that a paramedic may encounter. If they did, imagine the size of your protocol book! This is why as Medical Directors, we cringe with the “what if” questions, because we know the Medical Directives will not provide the answer for every unique situation.

Real time verbal contact through patching with a Base Hospital Physician (BHP) is called “on line medical control”. The advantage of this form of delegation is that unique challenges, rare events, and high risk situations can be discussed with a physician and decisions can be made jointly “in the moment”. The blending of off line and on line medical control is how your Advanced Life Support Patient Care Standards (ALS-PCS) have been created.

One further disadvantage of Medical Directives is that they may be subject to interpretation. We see this not only amongst paramedics but even amongst Base Hospital Medical Directors, many of whom actually authored the ALS-PCS originally! Variability in Medical Directive interpretation is a real issue for paramedics. Base Hospital programs need to be consistent with our teachings and with quality assurance audits and remediations.

In an effort to decrease the variability in interpretation of the Medical Directives, SWORBHP has created a link on our website called ASKMAC.

http://www.lhsc.on.ca/About_Us/Base_Hospital_Program/askmac.htm

Every week, questions related to the Medical Directives from paramedics across the Southwest region (and even some from beyond) are addressed by SWORBHP Medical Directors and the answers are posted. Please take a moment and have a look—you may discover some interesting items! Finally, if you have a question, please don't hesitate to post. It's anonymous!

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

Radiation

Radiation is energy released in the form of electromagnetic waves (x-ray or gamma) or high-speed subatomic particles (alpha, beta or neutron) known as ionizing radiation. Ionizing radiation is high energy and causes the atoms that it comes in contact with to become electrically charged. Non-ionizing radiation (i.e., visible light, microwaves, UV radiation) is a low energy source and does not cause damage to living tissue.

Alpha radiation is considered hazardous only if inhaled or ingested. It is unable to penetrate the human skin and is easily stopped by wearing PPE (including normal uniform). Beta Radiation is only considered an internal hazard, since it is able to cause organ damage only when ingested. Externally, it can penetrate the first layer of skin and cause tissue damage (although it is rare), unless stopped with PPE.

Gamma/X-ray radiation is considered an EXTERNAL hazard. Due to the high penetrating power, this form of radiation can cause tissue and organ damage by altering cellular DNA (depending on length of exposure, dose and shielding). It can be reduced by lead or concrete, but traditional PPE will not protect the host against exposure. It is important to follow the ALARA principle (As Low As Reasonably Achievable) and limit the time of exposure while maximizing the distance from the source and the shielding barriers.

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Radiation

Exposure refers to being close to radiological material but not having that material on you. Removal of the individual from the area of exposure will reduce risks to health, but decontamination is not necessary. Contamination refers to the radioactive material being on a person's clothes, hair, skin etc. The material can be transferred to healthcare providers, so decontamination of contaminated individuals is necessary. 90% of radioactive material can be removed simply by removing a patient's clothing, so this is the recommended first step (under supervision).

Radiological decontamination involves the use of specialized detection equipment, such as a Geiger counter, to identify contaminated individuals and clothing/equipment. Careful removal of clothing, then shower or wiped down with soap and water, will often suffice to remove any contaminant. Run off needs to be contained and disposed of properly. The success of decontamination is confirmed by repeat scan, then the patient can be safely admitted to the hospital.

Kelly Davis, B.Sc.N., R.N.
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London Health Sciences Centre

Trauma in South Africa

Emergency Medicine training in Canada requires residents to complete specific rotations in trauma to gain experience in dealing with the unique challenges that administering trauma care provides. After completing one month in London, I took the opportunity to travel to Cape Town, South Africa to complete a trauma elective at Tygerberg Hospital, a level 1 trauma centre that receives over 20,000 cases/year (50-60/day!). As part of my time there, I was fortunate to work with the Western Cape Metro EMS and completed a number of ride-outs, learning about the spectrum of trauma care in South Africa from the street to the ER.

The demographics of South Africa, with high levels of poverty and gang violence, immediately present a different trauma population than we experience in Ontario. Whether in the ER or in an ambulance, multiple GSWs and stabbings formed a standard part of the case load each shift, in addition to blunt assaults and MVAs. Approximately one-fourth of trauma cases are penetrating injury and half of trauma deaths are homicides; MVAs account for only one-fourth of trauma related deaths. This gave me an opportunity to care for patients that I see relatively rarely here at home and I gained a new level of comfort and skill in dealing with injuries of this sort.

Paramedics in South Africa form a tiered response system with basic, intermediate, and advanced levels of certification. Health care resources are less abundant and thus they assume a larger role in the administration of health care and function as independent practitioners who receive medical oversight from physicians. Patients tend to present later into their illness and are often quite ill on presentation. Paramedics practicing here have great skill in assessing and treating critically injured patients and were an important resource during my elective.

Working in Cape Town was an invaluable experience that greatly improved my skills as a physician. I encourage any of you who have an opportunity to explore work/training internationally to do so, as you are sure to gain new experiences and form new relationships that will aid you in your future career.

Sameer Mal, B.Sc., M.D.
PGY4 Emergency Medicine, UWO
EMS Resident – SWORBHP

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

Benchmarking

Imagine you have just been made CEO of a well known company and immediately discover your competition has the edge in providing a quality product at a much lower cost.

This was the situation David Kearns faced when he took over as CEO for Xerox in 1982. Kearns discovered that the Japanese companies were manufacturing copiers at 40-50% lower costs. This enabled them to easily undercut Xerox's prices. In response to the competition, Kearns decided to focus on lowering manufacturing costs while emphasizing quality control through a program that became known as "Leadership Through Quality". These initiatives pulled Xerox out of trouble in the years following the implementation of the program. The company has become one of the best examples of successful implementation of benchmarking.

Benchmarking is a continuous process which involves searching for the best-in-class performance.

Benchmarking has become a popular tool within the business industry over the past decade and it is spreading into the public sector. Benchmarking is defined by the American Productivity and Quality Centre as "a process of continuous measuring and comparing an organizations business against business process leaders anywhere in the world". Within the healthcare sector the need to demonstrate accountability and provide best quality of care with limited resources is driving the increased utilization of benchmarking. (de Korne, 2010)

Benchmarking is a continuous process which involves searching for the best-in-class performance. The process involves: (i) measuring your service/program over

time using key performance indicators, (ii) measuring your service/program against similar peers, (iii) identifying best practices, (iv) equal or exceed the best practice. (von Eiff, 2012)

The value of benchmarking a programs performance is that it allows you to see if you are making improvements year after year. Developing benchmark metrics enables you to demonstrate the performance value of your service delivery model by measuring and reporting measurements such as budget, staffing, and key program indicators. (Garbert, 2011).

Limited resources have required us to develop programs that are efficient and best in class. Benchmarking is a tool that can help you get there. Are you benchmark ready?

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

References

- de Korne, Dirk F., et al (2010, March). Evaluation of an international benchmarking initiative in nine eye hospitals. *Health Care Manager Review*, 23-35.
- Garbert, Shelley (2011, April). Benchmarking for More. 24X7, 18-25.
- von Eiff, Wilfried, (2012, April). Best practice management: in search of hospital excellence. *Journal of Management & Marketing in Healthcare*, 48-60
- Xerox -The Benchmarking Story. Accessed March 22, 2012. http://www.icmrindia.org/casestudies/icmr_case_studies.htm

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

Trivia...fast facts!

- The hummingbird is the only bird that can fly backward
- The average chicken lays about 260 eggs a year
- It takes 17 muscles to smile...43 to frown
- A "Blue Moon" is the second full moon in a calendar month (it is rarely blue)
- Ballistics is the science that deals with the motion of projectiles

Retrieved from: www.corsinet.com/trivia

Case Review

On December 11, 2011, Middlesex paramedics Evans and Blaauw were called to attend a 73 year old male patient who suffered a syncopal episode. When they arrived, the patient's wife indicated that she and her husband had been driving when he lost consciousness. She was able to regain control of the vehicle, and returned home where EMS was summoned. Paramedics arrived and as they were performing their initial assessment, the patient abruptly lost consciousness; they noted a 20 second episode of asystole on the monitor. The patient was lowered to the floor in preparation for resuscitation. He regained consciousness, but remained in a profoundly bradycardic rhythm.



The patient was in respiratory distress, visibly cyanotic with a BP of 60 and heart rate of 20. On scene for only seven minutes, the patient was assessed, oxygen was administered, a large bore IV started, and a fluid bolus was initiated. As transport began, using the symptomatic bradycardia protocol, 0.5 mg of atropine was administered. Due to the severity of the patient's condition, dopamine infusion at a rate of 5mcg/kg/min was initiated concurrent with a patch being established. The patient responded well, with increased heart rate to 40 and a systolic BP of 80. The crew arrived in the ER 11 minutes after patient contact.

Syncope in this age group is a symptom of underlying pathology and should be assumed to be cardiogenic in nature, which carries considerable mortality risk (Bergfeldt, 2003). Syncope by definition is transient, so when you arrive on scene after the patient has regained consciousness and there are no abnormal findings, this is what you should expect to find. This does not mean the patient has 'recovered'. Determining the cause of their syncope requires further assessment and diagnostics that can only be provided in the ER. Although syncope is often benign, studies have indicated many high risk features that suggest a more ominous etiology, including advanced age, underlying cardiac disease, arrhythmias, respiratory distress, and hypotension (of which this patient had all five!) (Brignole et al, 1995). Patients may need to be convinced to go to the hospital, especially when their vital signs are currently within normal limits. Starting with, 'do you want to go to the hospital?' is going to make this convincing more difficult. Start with, 'we think you need to go to the hospital right away' and you may be more successful.

Quick recognition by paramedics of the severity of the patient's condition, and prompt application of the medical directives, resulted in this patient arriving at the ER alive, and obtaining life saving treatments.

Paul Robinson, ACP, AEMCA, CPSO
Professional Standards Specialist

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

References

- Bergfeldt, L. (2003). Differential Diagnosis of Cardiogenic Syncope and Seizure Disorders. *Heart*. 89(3):353-358.
- Brignole M., Menozzi C., Bottoni N., Gianfranchi L., Lolli G., Oddone D., and Gaggioli G. (1995). Mechanisms of syncope caused by transient bradycardia and the diagnostic value of electrophysiologic testing and cardiovascular reflexivity maneuvers. *The American Journal of Cardiology*, 76(4):273-278

Making Your Education Count

The SWORBHP Paramedic Registry was launched in September 2010 for use by the Base Hospital, EMS management, and you, the paramedic. The Registry provides you with instant access to your current certification status and expiry date, and allows you to print your own certification letter. The Registry serves as an excellent tool for tracking your personal Continuing Education Hours (CEH).

Continuing Education Hours are important to Advanced Care Paramedics who require a total of 24 hours per year in order to maintain certification. However, all paramedics are encouraged to submit and keep track of their personal CEH in the Registry. How does this benefit you?

Tracking your CEH in the Registry demonstrates to others your commitment to your personal development and professionalism. Your service administration can view the education hours that have been approved by SWORBHP, thus gaining a better appreciation for your added effort.

Should you be away from clinical activity long enough to require return-to-work training for reactivation, your education hours are reviewed by the Local Medical Director to help determine the full extent of your training plan. The same can apply should there be a need for remedial training in response to a call review by Professional Standards. When seeking letters of current standing from SWORBHP, the CEH can be included as a further statement of your participation in continuing education.

We hope everyone takes full advantage of the SWORBHP Paramedic Registry by submitting for CEH credits. Enhancements to the system are underway that will make the Registry even more user friendly and functional. For assistance with how to use the Registry, and a direct link to the log-in page, just go to our home page at www.lhsc.on.ca/bhp and click on "Paramedic Registry" in the left-hand column.

David Vusich, ACP, NCEE
Coordinator, Training

The ACT Foundation

Have you ever heard of the ACT Foundation? Established in 1985, the Advanced Coronary Treatment (ACT) Foundation's mission is to "promote health and empower Canadians to save lives" (ACT, 2012). Bystander CPR saves lives (Field, J.M., Hazinski, M.F., Sayre, M.R., et al. 2010). ACT is accomplishing their mission by establishing free CPR training in every Canadian high school. This national charitable organization raises money to provide mannequins and other resources to high schools across Canada. ACT's staff work with community partners and schools to provide training to teachers as CPR instructors. Teachers then train their students. To date, 1.8 million students have been trained by the ACT Foundation (ACT, 2012). More information can be found at www.actfoundation.ca.

All of the SWORBHP medical directors are involved as volunteer medical directors for ACT in at least one city or community within our region. On November 18, 2011, I had the opportunity to speak at Sarnia Collegiate Institute and Technical School for the launch of this important program in Sarnia and Lambton County. This exciting event showcased a group of students performing CPR. Unfortunately there is no ongoing research project to assess the effect of ACT's impact on bystander CPR and survival to hospital discharge rates. However, there is no doubt in my mind that over time this program will contribute to improved survival rates in communities across Canada.

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

References

Advanced Coronary Treatment Foundation (2012). *ACT Foundation About Us*. Retrieved from www.actfoundation.ca

Field, J.M., Hazinski, M.F., Sayre, M.R., et al. (2010). American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science. *Circulation*. 122: S640-S656

Do Tourniquets Have a Role in Prehospital Care in Ontario?

The December 2011 issue of the Canadian Journal of Surgery reviewed prehospital training and preparedness during the last ten years of military deployment in Afghanistan (Savage et al., 2011). Specifically, it details the system wide adoption of tactical, combat casualty care, and combat first aid. The full series of articles can be downloaded at <http://www.cma.ca/cjs/vol-54/issue-6/issue-6s>. The authors claim “that tourniquet use was potentially the most important lesson learned from this conflict”. The use of tourniquets has been a controversial issue in EMS over the past 30 years. The early Vietnam experience demonstrated many soldiers died in the field as the result of exsanguination from limb injuries (Bellamy, 1984). The biggest innovation from combat in Iraq and experience in Afghanistan was the use of these devices in the hands of soldiers, and the simplified design making them easier to use. The doctrine of applying tourniquets was incorporated into soldier training, with rigorous formal training in their application and use.

The current U.S. guidelines for field triage of injured patients from the Centers for Disease Control and Prevention, which were recently updated in January 2012, take a more conservative view (Sasser et al., 2012). It looked at evidence from Texas where 75,000 trauma visits were retrospectively reviewed. Only 14 patients with penetrating extremity injuries were identified; eight of those would have benefited from tourniquet use (Dorlac, DeBaakey, Holcomb et al., 2005). There was a feeling that tourniquets would be overused instead of basic hemorrhage control methods, and the panel held that further study was recommended. The complete U.S. Field Trauma Triage Guidelines, App and article can be downloaded at <http://www.cdc.gov/fieldtriage/>, (very similar Canadian guidelines are being finalized).

The 2010 AHA and American Red Cross Guidelines (<http://guidelines.ecc.org/2010-guidelines-for-cpr.html>) recommends using tourniquets only if direct pressure is not effective or possible, and recommends them for those first aiders with proper training (Markenson et al., 2012). The BLS Patient Care Standards, 2007, (which are currently under revision) recommends, “control hemorrhage, if hemorrhage cannot be controlled by usual methods, apply and inflate a BP cuff until bleeding stops”, which in effect recommends an improvised tourniquet using a device the paramedic has received formal training in (MOHLTC, 2007).

In Ontario, EMS transport times are relatively short, and there is good Canadian evidence on the ability of soldiers and medics to accurately place tourniquets in combat medicine with proper training. Paramedics should review their practice and generate a plan on how they will deal with major extremity hemorrhage. This should include an understanding of how to stop major hemorrhage with pressure, wound packing, and tourniquets within the Ontario BLS regulations. The medical council at SWORBHP is advocating, through the province, to expand the formal training for tourniquet use, especially in the Special Operations support role.

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References

- Savage et al. (2011). Tactical Combat Casualty Care in the Canadian Forces: lessons learned from the Afghan War. *Canadian Journal of Surgery*, 54, 118-123. Retrieved from <http://www.cma.ca/cjs/vol-54/issue-6/issue-6s>
- Bellamy, R.F. (1984). The causes of death in conventional land warfare: implications for combat casualty care research. *Military Medicine*, 149(2), 55-62.
- Sasser et al. (2012). Guidelines for Field Trauma Triage of Injured Patients, Recommendations of the National Expert Panel on Field Triage. *Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report*, 61(1). Retrieved from <http://www.cdc.gov/mmwr/PDF/rr/rr6101.pdf>
- Dorlac, W.C., DeBaakey, M.E., Holcomb, J.B., et al.(2005). Mortality from isolated civilian penetrating extremity injury. *Journal of Trauma*, 59, 217-22.
- Markenson, J.D., et al. (2010). American Heart Association and American Red Cross Guidelines for First Aid, Part 17, *Journal of the American Heart Association*, 122, 934-946.
- Emergency Health Services Branch, Ontario Ministry of Health and Long Term Care (2007). *Basic Life Support Patient Care Standards*, 2 (3).1-42.

Enhancements to the Paramedic Registry

Over the past few months, our program developers have been busy implementing several enhancements and changes to the Paramedic Registry. Some of the enhancements were made based on feedback from individual paramedics. In addition, a survey was sent to each Service Operator requesting feedback on the functionality of the Registry. The survey responses provided us with valuable feedback in determining how we could better utilize and obtain efficiencies within the Registry. Below is a summary of the enhancements and changes that affect both Service Operator and paramedic users.

Service Operator Users

- Search for paramedics by name
- Print multiple certification letters at once
- Submit New Paramedic feature has been added allowing you to submit information for new hires
- Changes/Additions to Auxiliary Directives:
 - ◇ Taser Probe Removal changed to Electronic Control Device Probe Removal, Emergency Cricothyrotomy changed to Cricothyrotomy, Patient Sedation changed to Procedural Sedation
 - ◇ Added — Combative Patient and PCP IV Assist
- Changes/Additions to Reports:
 - ◇ Reactivated Paramedic report has been added
 - ◇ Date of last shift worked has been added to the Deactivation History report
 - ◇ Date range filter has been added to selected reports
 - ◇ Dates and color coded columns have been added to the Auxiliary Directives report

Paramedic Users

- Filter your Continuing Education (CE) courses by year when viewing your CE Summary
- CE Approval Requirements—we have outlined on the 'Manage Education' page the documentation requirements and deadlines when submitting CE requests for approval
- Forgot username/password? You can now retrieve your username and password by clicking on the new link from the login page. You must have a valid email address in your paramedic profile in order to use this new feature

www.paramedic-registry.ca

Upcoming Training Event for Service Operator Users

Are you interested in learning more about the Paramedic Registry? We are planning a training event for all Service Operator users on Wednesday, June 6th. Please email Michelle Frazer at michelle.frazer@lhsc.on.ca by May 18th if you are interested.

Michelle Frazer, CQIA
Certification Associate

Cathy Prowd, CQIA
Operations & Logistics Specialist

Introducing Our Apps

SWORBHP is proud to announce the development of two new smartphone applications. The Apps will be free to download from a website (to be announced at a later date), and will not be available in the Android Marketplace or Blackberry App World. These Apps will allow paramedics the ability to access medical directives and associated documents quickly from their phones, no matter where they are. Separate applications have been developed for ACPs and PCPs, allowing quicker access to directives. This will ensure that future features are able to target those who will find it helpful. Currently, the Apps are in beta testing with plans for release within the next month. These Apps will provide support to all Android phones running operating system 2.3.3 or later, and any Blackberry phone running operating system 5.0 or higher. An iPhone compatible version of the Apps will be released at a later date.

Alan Rice
Programmer
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Paramedic Recognition Awards

Prehospital Save:

Grey County EMS

Carole Surgenor, Kyle Stewart (Dec. 3, 2011)

Paula Trombley, Sonia Kaski (Jan. 11, 2012)

Huron County EMS

Heather Malley, Gary Renaud (Feb. 3, 2012)

Savannah Vanraes, Jennifer Randell, James Janssen (Feb. 10, 2012)

Prehospital Newborn Delivery:

Middlesex EMS

Lindy Neilson, Michael Hurst (Mar. 21, 2012)

Lambton EMS

Andrea Loughlean, Heather Terpstra (Mar. 30, 2012)

Congratulations !

Upcoming CE Opportunities

June 26th—Seizures Webinar

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.

We're Coding at SWORBHP!

The 2012 Medical Directives Paramedic Handbooks have a new look and an added feature you might not initially recognize. On the back of each book you will see a QR (quick response) code directly above our website link. Simply scan the code with your phone and you have instant access to our website.

QR codes can be found almost everywhere...from labels on food items to restaurant menus. Coding allows you to easily share information with others. QR codes can be decoded using a cell phone. There are numerous free Apps available that you can download to your phone making coding a quick alternative when searching for information. One of my favorites is: [i-nigma](http://www.i-nigma.com). If you need assistance with downloading, visit the following link:

<http://www.i-nigma.com/Downloadi-nigmaReader.html>

Tracy Gaunt, M.Sc., NCEE, CPSO
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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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