London Health Sciences Centre
Southwest Ontario Regional Base Hospital Program

Leadership of Optimal Prehospital Care Systems

SWORBHP LINKS

JULY 2019 I VOLUME 30

IN THIS ISSUE:

2019 Mandatory CME Update

With the 2019 CME season right around the corner, the SWORBHP team is in full planning mode! We have been busy preparing our CME content! Here is a sneak peak of what you will see during the day!

You've asked and we've listened. This year the overall CME topic is Pediatrics!

The format of both the precourse and day-of is similar to last year (2018).

This year the precourse is made up of shorter modules to allow for ease of viewing and to avoid information overload. The topics will include:

- Pediatric Assessment and Crisis Resource Management
- IV and IO tips in pediatrics
- Difference in physiology and therefore treatment in Newly Born (<24h old) and Neonate (≥24h old) resuscitation
- Review of tracheostomy suction and emergency reinsertion
- Review of Mandatory Patch Points & documentation

ACP medics will have additional material pertinent to their scope of practice. This will include:

- Analgesia review
- 4 case-based review and discussion modules

The day-of will follow a similar format as 2018, with three rotating interactive stations including a mix of simulation with case-based discussion and skill stations. The simulation cases will include a spectrum of pediatric age groups (NRP to School-age). The skill stations include application of the Pediatric Assessment Triangle, Pediatric Respiratory and Airway management and Tracheostomy skills (as we've heard, again, that medics want more of this!).

Flanking these skill and simulation stations will be a short (<30 min) introduction and (~45min) review of documentation/auditing and review of the day's content.

We look forward to seeing you all in the fall!

Dr. Lauren Leggatt, MD, FRCPC
Medical Director of Education

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Facilitating the delivery of excellent prehospital care while advancing safe practice and preparedness in our communities through collaborative partnerships and innovation.

Congratulations to the recipients of the

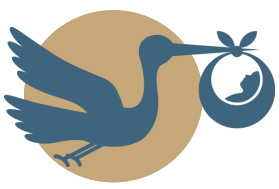
2018 PARAMEDIC RECOGNITION & MEDICAL DIRECTOR (MD) AWARDS

MD Award of Excellence Recipients

Stephane Hebert	Medavie EMS Chatham-Kent
Tony Metayer	Medavie EMS Chatham-Kent
Chris Stolte	Lambton County Paramedic Services
Rob McBurney	Lambton County Paramedic Services
Tracey Clayton	Oxford County Paramedic Services

171

Prehospital Save Award Recipients



27

Prehospital Newborn Delivery Award Recipients

MD Commendation Award Recipients

Alicia Wilson	Essex-Windsor EMS
Andrew Peters	Essex-Windsor EMS
Ashley Lemay	Essex-Windsor EMS
Brandon Bellehumeur	Essex-Windsor EMS
Christopher Cronin	Essex-Windsor EMS
Christopher Nugent	Essex-Windsor EMS
Corey Nelson	Essex-Windsor EMS
Eric Knight	Essex-Windsor EMS
Jean-Pierre Bacon	Essex-Windsor EMS
Jonathon Croley	Essex-Windsor EMS
Kathryn Pohlman	Essex-Windsor EMS
Lauren Dewar	Essex-Windsor EMS
Mamoun Abu Khatir	Essex-Windsor EMS
Nathan Jean	Essex-Windsor EMS
Nicole Hanson	Essex-Windsor EMS
Patrick Lee	Essex-Windsor EMS
Pete Morassutti	Essex-Windsor EMS
Richard St-Pierre	Essex-Windsor EMS
Sarah Bezaire	Essex-Windsor EMS
Steven Jacobs	Essex-Windsor EMS
Telsey Knott	Essex-Windsor EMS
Thomas LeClair	Essex-Windsor EMS
Tiina Kaldma	Essex-Windsor EMS
Veronica Jarvis	Essex-Windsor EMS
William Jaques	Essex-Windsor EMS
Andrew Randell	Middlesex-London Paramedic Service
Matthew Wren	Middlesex-London Paramedic Service

2019 PARAMEDIC SERVICES WEEK

"CELEBRATING SUCCESSES"

MAY 26-JUNE 1, 2019

1695 ENTRIES SUBMITTED

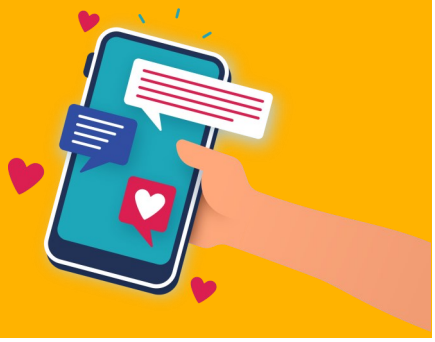
SWORBHP had daily prize giveaways from May 27th-May 31st to celebrate Paramedic Services Week! Southwest paramedics who entered the draw were chosen at random as the prize winners.
Over the course of 5 days there were 1695 entries.

61 PRIZES AWARDED

None of this would have been possible without the generous donations of companies and organizations in our communities across the Southwest Ontario Region.
This year we able to award 61 prizes.

53,012 PEOPLE REACHED

We are very thankful for all the hard work and dedication shown by paramedics and want to spread this message for Paramedic Services Week.
SWORBHP Social Media Posts for 2019 Paramedic Services Week reached over 53, 012 people on Facebook and Twitter.



Understanding How Paramedics Perceive Their Role in the Emergency Department

The 'voice' of individual paramedics is rarely researched or reported in the pre-hospital literature. As a resident, Dr. Melissa Snyder began interacting with paramedics in various urban and rural settings. She noticed two things in particular. Paramedics seemed to do different things in different emergency departments (EDs). They also seemed to interact with ED staff in very different ways. As a trainee, she thought about this and wanted to understand how paramedics perceive their role once they arrive with their patient in the ED. Last year she began a research project to try to answer this question. Her results have been presented locally in London and an abstract of the project was recently accepted to be presented as a poster at the National Association of EMS Physicians meeting in January.

She chose to interview and record individual paramedics expressing themselves in their own words describing their experiences and ideas. The interviews were analyzed for common themes that emerged while repeatedly listening to the interviews. Eleven paramedics were interviewed. The participants had 7-33 years of primary, advanced, or critical care experience. Three major themes were identified.

The participant paramedics clearly saw their primary role in the ED was to be the patient's advocate. Paramedics hold essential information about the pre-hospital condition of their patients. Paramedics also know what has been done for their patients and if their condition has changed prior to arrival in the ED. They felt this information was very important for the patient's overall treatment and that this information had to be communicated to the ED staff.

The second major theme was difficulties encountered in undertaking constructive communication with the ED staff. Paramedics felt their valuable information was often not carefully listened to and risked being lost or ignored. Several paramedics indicated that in order to present this information, they require uninterrupted time, as short as 30-seconds, for this communication. A secondary theme regarding communication was that paramedics want clinical feedback and patient outcome information from the ED staff. There is no formal mechanism to obtain this.

The third major theme was respect. When paramedics felt they were respected, it was often based upon personal relationships that developed between individuals. Their relationship with the ED staff is strengthened when there is mutual respect and understanding of each discipline's scope of practice. ED staff must have a willingness to include paramedics as part of the interdisciplinary team. In smaller EDs, paramedics see themselves as a resource to help the ED staff with technical procedures, such as starting intravenous lines, continuing to do bag-valve-mask ventilation, CPR, etc. Paramedics need to be respected by the ED staff to do this.

Some areas for practice change suggested by this study include: time for uninterrupted communication of pre-hospital information, instituting mechanisms for formal clinical feedback, and reflection on how to improve interdisciplinary interactions.

Melissa is to be congratulated for helping to get the voice of paramedics heard and getting it into the pre-hospital literature.

Don Eby MD, PhD, CCFP(EM), FCFP
Local Medical Director

SOUTHWEST ONTARIO REGIONAL BASE HOSPITAL PROGRAM

FACTS STATS

APRIL 2018 - MARCH 2019 AT A GLANCE

1243 PCP
PARAMEDICS CERTIFIED WITH SWORBHP

139 ACP
PARAMEDICS CERTIFIED WITH SWORBHP

1620 TOTAL
PARAMEDICS CERTIFIED WITH SWORBHP IN THE 2018-19 FISCAL YEAR

2018/19 Certification Statistics

	PCP	ACP
Administrative Deactivations	77	4
Clinical Deactivations	0	0
Decertified	0	0
Reactivated	63	4
Recertified	1191	131
Initial Certification	78	2
PCP to ACP	1	
ACP to PCP	3	

COMMUNICATION LINE

300	Self Reports
1	Good Job acknowledgements
19	Service Inquiries
1	Other Inquiries

TOTAL PATCH PHONE INTERATIONS

LAMBTON	115
LONDON	471
OWEN SOUND	206
WINDSOR	647
REPORTED PATCH FAILURES	15

SWORBHP Staff Updates:

Prehospital Care Specialist - Micheal Filiault

Micheal Filiault joined SWORBHP in August 2018 as a Prehospital Care Specialist (PHCS).

Micheal holds a diploma in Advanced Care Paramedicine from Fanshawe College, Advanced Emergency Medical Care Assistant Diploma from St. Clair College, and is currently pursuing a Bachelor of Heath Sciences Degree from Thompson Rivers University.

Micheal comes to us from Essex-Windsor EMS as a practicing ACP. He is also a part time Associate Instructor for the Paramedic Program at St. Clair College in Windsor.

COMING SOON

TRAUMA FEEDBACK

We are happy to announce that SWORBHP has partnered with the Regional Trauma Program at London Health Sciences Centre on a new initiative that provides paramedics who have cared for a trauma patient with information on the patient's injuries and condition. A letter will be sent to your Paramedic Service within approximately 72 hours of the patient's arrival at LHSC with the following update:

Arrival Date	LHSC Arrival Time	Pick Up Location	Run #	Mechanism of Injury	Injuries Identified	ED Disposition	Status at 24Hours
0-Jan-19	1547	HWY 401	1127	MVC	Subdural hematoma, flail chest, gr.3 splenic laceration, right great toe #	OR	Stable on floor

The goal is that the information will provide paramedics with the ability to confirm their clinical suspicion, an opportunity to follow up on the patient's condition and receive closure on the call.

The letter will contain confidential information that will be intended only for the paramedics involved in the call. It will be sent by secure file transfer and will be available to the paramedics involved in the call to view for 30 days.

We are excited to launch this new initiative and look forward to your feedback.

Sue Kriening
Regional Program Manager,
Southwest Ontario Regional Base Hospital Program

Alison Armstrong
Coordinator,
Regional Trauma Program, LHSC

The Road to Rallye Rejviz Part 1 of 3

In early May of 2018, Ryan Cloutier and I packed our bags and headed to Bratislava, Slovakia to meet our good friend Dr. Erika Jamrichová.

The basis of our trip: assemble a multidisciplinary team that will compete in the 2018 Rallye Rejviz, complete a 21 day residency structured around emergency medicine and prehospital care, and finally, build professional relationships that will last a life time.

You may remember Dr. Erika Jamrichová as the inaugural candidate who became the very first medical professional to complete a 21 day residency as part of the International Exchange Program. The residency compiled multiple perspectives of emergency medicine and gave Dr. Jamrichová the opportunity to shadow Physicians, Paramedics, Nurses, Emergency Dispatchers, Fire Fighters and Police Officers. This intimate introduction to the front line care of emergency medicine also gave great insight into continuous education, resource utilization and the functions of a tiered response system. Dr. Jamrichová is an Anesthesiology Resident, Physician-Paramedic, Tactical Doctor attached to a Special Operations Police Team and when she's not astonishingly busy becoming the world's most elite health care provider, she's one incredible host to the insider's perspective of Slovakian culture and medicine.

You now may be asking yourself: "how did this come to be?"

In the past, EMS Team Ontario has primarily been focused on the Rallye Rejviz: the world's largest medical rescue competition, held in the Jeseníky Mountains of the Czech Republic. Although EMS Team Ontario was initially developed as a competition team, we have always been cognizant of our underlying goal: "to promote the continued learning and education of emergency medical professionals both locally and internationally."

We quickly became aware that the global exchange of medical knowledge and expertise occurring during these types of competitions continued to influence our practice and patient care, far after the return home to our normal lives. The Rallye Rejviz specifically became a place for thousands of multifaceted medical professionals to gather from all over the world (20+ countries), forget their egos, develop friendships, enjoy a libation or two, and hone skills that will potentially save someone's life along the way. This inspiration is what guided us to expand our focus with the International Exchange Program in partnership with Essex-Windsor EMS.

Following Dr. Jamrichová's time in Canada, she expressed her gratitude and offered to reciprocate our gesture and host a few Canadian medical professionals in a Slovakian residency. Dr. Jamrichová also had visions of building a competition team that would embody the values of the International Exchange Program, bringing countries and health care providers together to better patient care and outcomes. With this goal in mind Dr. Jamrichová built a 21 day residency structured around prehospital care and preparations for the Rallye Rejiviz 2018.

So please join me and follow this 3 part series as I described our training, preparation, and adventure on the road to the Rallye Rejviz 2018.

Micheal Filiault, ACP, AEMCA
Pre Hospital Care Specialist

The "No Service Call"

ISSUES TO CONSIDER

As health care providers, we are consistently working towards providing the best care for our patients at all times. However, there are situations when patients refuse the care that we are trying to provide for a variety of reasons. This can be a frustrating experience in cases where your knowledge of illness and appropriate health care allows you to appreciate the medical risks patients are sometimes taking upon themselves by refusing care. Recently, we have reviewed a few cases whereby a refusal of service has been completed in patients whose family members expressed concern regarding the ability of the patient to make appropriate medical decisions due to a significant change from the patient's cognitive baseline. It was later discovered that there was likely organic pathology affecting the patient at the initial assessment to suggest that the patient was not capable of refusing transport. It is always helpful to reflect on these cases as they highlight the challenges to assessing patient capacity in various clinical scenarios and to consider options to ensure the most appropriate treatment is delivered.

There are several sections of the Health Care Consent Act that help health care providers navigate capacity and consent, particularly in regard to emergency situations. Section 4 (1) states: A person is capable of consenting to a treatment if the person is able to: (a) "understand" the information that is relevant to making a decision about treatment, and (b) "appreciate" the foreseeable consequences of a decision or lack of decision. The ALS PCS identifies that if a patient is refusing treatment or transport, the applicable directions in the BLS PCS apply. Somewhat similar to the Health Care Consent Act, these directions clearly identify two categories of patients – those with, and those without, the capacity to refuse treatment and/or transport. The BLS PCS specifically states: The paramedic shall carry out emergency treatment and transport if: (a) the patient does not have capacity; (b) the patient is apparently experiencing severe suffering or is at risk, if the treatment is not administered promptly, of sustaining serious bodily harm; and (c) the delay required to obtain consent or refusal on the patient's behalf will prolong the suffering that the patient is apparently experiencing or will put the patient at risk of sustaining serious bodily harm.

In many cases, determining that a patient has the capacity to refuse treatment and/or transport will be very clear. However, a high degree of vigilance is required in cases where capacity may be quite difficult to determine and in cases where capacity is potentially fluctuating. The classic example of this would be the patient with delirium. Patients with delirium experience disturbance of consciousness with inattention accompanied by a change in cognition or perceptual disturbance that develops over a short period of time and fluctuates over time. The differential diagnosis for any patient with delirium is very broad and includes infectious causes (e.g. encephalitis, sepsis), metabolic disorders (e.g. electrolyte abnormalities, hyperthermia), traumatic causes (e.g. head injury), neurologic disorders (e.g. stroke, cerebral sinus venous thrombosis), endocrine disorders (e.g. thyrotoxicosis, uremia), vascular disorders (e.g. posterior reversible encephalopathy syndrome, vasculitis) and toxic causes (e.g. substances of abuse, lithium toxicity). By no means is this a complete differential diagnosis.

It is important to remember one key aspect of any patient suffering from delirium – it is by definition, fluctuating. Due to its fluctuating nature, patients may appear relatively reasonable at times and unreasonable at others. One could easily be misled into believing a patient has capacity to make medical decisions when they do not. Family members or friends who express concerns regarding the patient's ability to make decisions should raise suspicion that the clinical course for the patient is fluctuating in nature and as such, patient capacity may be impaired. We must be hypervigilant in cases where there is any doubt about a patient's capacity to refuse treatment and/or transport. I would strongly suggest that in such cases, the advice of a Supervisor and/or Base Hospital Physician might prove very helpful to navigate this difficult clinical scenarios Sometimes just having multiple people delivering the same message ("I am concerned for your health, as are your family members"), is motivation enough for patients to change their mind and agree to transportation to the ED.

Sean Doran, BA, BSc, BEd, MD, FRCPC
Local Medical Director

Inter-Facility Transport and Medical Delegation

1

Paramedics can only provide care that is within their scope of practice.

Any care that falls outside of the scope of the paramedics practice cannot be completed by a paramedic. Any order that falls outside of the ALS PCS medical directives but is within the scope of the paramedic cannot be completed without an order from a Base Hospital Physician (patch physician). This leads to the next key point.

2

Paramedics can only receive orders from a Base Hospital Physician.

Base Hospital Physicians (BHPs) are the only physicians that can provide online (real time) medical delegation/orders to paramedics. As part of the requirements from the MOHLTC, SWORBHP has to ensure that "in the provision of online medical control to Emergency Medical Attendants and Paramedics, only physicians who have the proper credentials to work in the emergency department of the Host Hospital or of any other hospital associated with the Base Hospital Program of the Host Hospital are utilized." This model allows for proper training of BHPs to understand paramedic scope of practice, documentation of online medical control and allows for the required QA assessments.

3

The sending physician remains the most responsible health professional for the care of the patient and is responsible for anticipating any foreseeable care needs during transfer.

If current care requirements or foreseeable anticipated care requirements exceed the scope of the paramedic, then the sending physician needs to ensure that an appropriate health care professional accompanies the patient. In terms of likely anticipated care requirements, the sending physician will utilize their clinical judgment to determine this with the realization that not every care requirement can be predicted. Ultimately, the sending physician is responsible for the welfare of the patient on transport and the role of appropriate medical escorts. However, when situations have arisen in the past, crucial conversations as to the various escorts that may be available to assist you (RT, RN, MD) have led to enhanced patient safety on transport. Your supervisor and or the BHP may also be a useful resource if you are confronted with a transport where you feel the patient may benefit from an enhanced scope of practice

4

Escorts who are regulated health professionals may carry out the orders of the sending physician and provide assessment and treatment of the patient while on transport. That's the reason they are accompanying the patient.

When a regulated health care professional accompanies the patient, they are responsible for the ongoing care requirements or anticipated care requirements of the patient while on transport. Paramedics should work with these individuals in the best interest of the patient and assist with care that falls within the paramedic scope of practice. As part of your inter-facility transport checklist, we suggest checking with the health professional escorting the patient that they have the appropriate orders and medications to treat the patient prior to transport. On rare occasions, the patient's condition may deteriorate and the accompanying regulated health care professional may not have the appropriate medications, equipment, expertise or orders to provide care to the patient. Paramedics can utilize their medical directives in these situations. An example would be a patient who experiences a cardiac arrest while on transport.

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Inter-Facility Transport and Medical Delegation cont'd from page 9

5

Paramedics may provide care to a patient on an inter-facility transport if there is not an escort present and the patient develops symptoms that meet the conditions, indications and have no contra-indications as per the ALS PCS.

Not every patient requires a regulated health professional while on transport. As such, paramedics can provide care as per the ALS PCS or at the advice of the BHP when required. When reviewing the frequent questions we receive regarding inter-facility transportation, one of the above five key points can be applied and often provide you with the answer you are seeking.

Dr. Matt Davis, M.D., M.Sc., FRCP(C)
Regional Medical Director

What Impact Does the Recent Roll Out of the 10th Edition of the ATLS Have on EMS

Clearly trauma care is being updated in the literature all of the time, and prehospital care has a big impact on care in the trauma system. The America College of Surgeons periodically updates the Advanced Trauma Life Support Course taught to physicians worldwide incorporating best practice changes in trauma care. We have recently rolled out the 10th edition, and there are some changes which impact prehospital care.[1]

In the initial assessment there is a recommendation to only give 1 litre of crystalloid and move to blood quicker in the patient not responding in the ER. Many services currently have systems where they notify ER of significant blood loss so that uncrossed blood products can be packed in a cooler by the blood bank and be prepositioned in ER in case they are needed immediately on patient arrival. There are centres in our region where ER staff will prime the rapid blood transfusers, ready transexamic acid, and other coagulation reversal agents if they receive key prehospital patch information from paramedics at the scene. Obviously paramedics are having a bigger impact in activating the massive transfusion protocols, and this will probably move to standard work.

Adult needle thoracostomy location is changing to 5th intercostal space at the midaxillary line, as there were cases of mediastinal structure injuries with the longer needles (which we are using more often in recent years due to bigger people) in the second intercostal space and the land mark of the mid clavicular line was often over estimated too medially when using the needle. This will probably have future implications in prehospital practice on future iterations of the protocols. Pediatric landmarking will be unchanged.

Head injury patients will have more detailed guidance on systolic BP management in hospital with patients 50 to 69 years of age aiming for SBP > 100, and 15 to 49, and patients older than 70 aiming for SBP > 110, as this may decrease mortality and improve outcome with better cerebral perfusion pressure. This could make the prehospital fluid bolus guidance challenging, and may be at odds with permissive hypotension and not "popping the clot" advocated in rural centres and areas with longer transport times.

The Canadian C-spine rule will be more widely taught and the term C-spine protection being changed to restriction of motion and this will work to facilitate more recent EMS protocols and changes into the hospital environment. There will be a focus on looking for dangerous mechanisms of injury and prehospital information will have more emphasis.

Clearly these are hospital based changes, but these guidelines will impact the trauma nursing care course, and also prehospital trauma courses like ITLS and PHTLS which receive guidance from ACS, and trauma surgeons as well. We have already seen the large responsibility of FTTG placed on paramedics and transport of appropriate cases with fast scene times to definitive sites to decrease morbidity and mortality. The 10th edition of ATLS continues to highlight the importance of prehospital care to patients being treated by the trauma team.

[1] http://bulletin.facs.org/2018/06/atls-10th-edition-offers-new-insights-into-managing-trauma-patients/

Dr. Paul Bradford, M.D. FCFP(EM), MDS, CD
Local Medical Director

SWORBHP RESEARCH CORNER

As part of SWORBHPs commitment contributing to the prehospital literature and seek out evidenced based answers to pre-hospital questions, the purpose of this section is to highlight a current research project that is occurring in the SWORBHP region as well as one that has been completed.

WHAT'S NEW

Paramedics' Ability to Determine Diagnosis and Appropriate Disposition in the Patients they Transport to Hospital

J. Loosley, J. Doyle, M. Lewell, M. Davis

Jenn Doyle and Jay Loosley are leading a project at Middlesex-London Paramedic Service titled "Paramedics' Ability to Determine Diagnosis and Appropriate Disposition in the Patients they Transport to Hospital." The study was built around providing Paramedics feedback about their patient's final diagnosis. During random study hours, Paramedics are approached upon entering the Emergency Department, and asked a few questions regarding hospital destination, alternate destination(s), and what they believe is the patient's final diagnosis. The objective of this study is to determine if Paramedics believe there is a clinical benefit in obtaining such feedback (by promoting self-reflection, potentially improving differential diagnosis skills, and increasing their level of confidence when faced with a similar situation in the future). The research team also hopes to determine how accurate Paramedics are at assigning a suspected diagnosis, answer questions as to why patients are brought to a certain hospital or if an alternate destination would be appropriate. It is the team's hope that this study will help develop a process to routinely allow Paramedics to find out their patient's final diagnosis as a means to provide feedback in order to assist with Paramedics ability to learn from specific patient encounters.

Stay tuned to this exciting study!

WHAT'S DONE

"Routine application of defibrillation pads and time to first shock in prehospital STEMI complicated by cardiac arrest"

S. Felder, M. Davis

Have you ever wondered why the BLS PCS now states that "Once a STEMI is confirmed, the paramedic should apply defibrillation pads due to the potential for lethal cardiac arrhythmias"? Here is some evidence that supports this component of the Standards:

Between 4 to 11% of patients diagnosed with STEMI suffer an out-of-hospital-cardiac arrest (OHCA). Previously published research has shown that shorter time to initial defibrillation in patients with VF/VT OHCA increases functional survival. The purpose of this study is to assess whether the routine application of defibrillation pads in STEMI decreases the time to initial defibrillation in those who suffer OHCA. As part of this study, Ambulance call records (ACR) for patients diagnosed with STEMI in the prehospital setting from Jan 1, 2012 to Jun 30, 2016 were reviewed. Patients were included in the study if they were 18 years of age or older with a confirmed diagnosis of STEMI and suffered an OHCA with an initial shockable rhythm (VF or VT) while in paramedic care.

...continued on page 12

RESEACH CORNER cont'd from page 11

During the study period, 446 patients were diagnosed with prehospital STEMI. Of those, 11 patients experienced a paramedic-witnessed cardiac arrest. Four of the 11 had defibrillation pads applied upon diagnosis of STEMI. In patients who received pre-pad application, the mean time to initial defibrillation was 17.71 sec, compared to 72.71 sec in patients who had pads applied following arrest. All patients treated with the pre-pad protocol survived to discharge from hospital, while one patient in the routine care group died in the ED.

The study supports that routine application of defibrillation pads decreases the time to initial defibrillation in STEMI patients who suffer OHCA. However, this study does not answer whether or not this translates to any survival benefit. As such, larger studies would be required to evaluate whether or not this would result in an increased survival in these patients.

This study was presented at the Canadian Association of Emergency Physicians Annual Conference in 2017 as an oral abstract. It garnered some traction on twitter and reached an audience of 6000 people.

Dr. Matt Davis, M.D., M.Sc., FRCPC
Regional Medical Director

MOHLTC CODE REQUEST PROCESS

Way back when, on April 1, 2017 (and yes, for some of us that seems like a very long time ago!), the Ministry of Health and Long-Term Care (MOHLTC), Emergency Health Regulatory & Accountability Branch (EHRAB) released version 3.0 of the Ontario Ambulance Documentation Standards. Included with these changes, came standardized and approved MOHLTC ACR codes, which were initially included on the paper ACR.

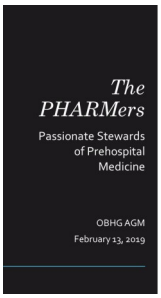
Fast forward to 2018, EHRAB launched a revised website (http://www.health.gov.on.ca/en/pro/programs/emergency_health/edu/practice_documents.aspx) to include a complete and up-to-date listing of all approved and endorsed ACR Codes. The site also offers an **ACR Codes – Change Log**, which provides a complete summary of ACR code revisions, associated dates and descriptor's for each.

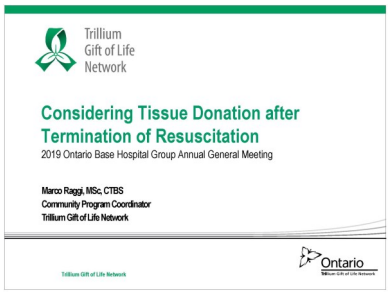
Over the past few months, SWORBHP has received several questions regarding the process for requesting additional codes. In the event either a Service or Services would like to request a new ACR code, please do the following:

- Complete a Code Request Form (please feel free to contact SWORBHP if you require another copy)
- Send the completed form to Deb Janssen (debra.janssen@lhsc.on.ca), QA Coordinator, SWORBHP
- SWORBHP will submit the request to the Data Quality Management Sub-Committee of the Ontario Base Hospital Group and the MOHLTC for review and approval
- The Requestor and respective Base Hospital will be notified of the outcome via email
- If approved, the respective sections of the EHS web site will be updated accordingly.

Debbie Janssen, BMOS
Coordinator, Quality Assurance & Business Functions

2019 ONTARIO BASE HOSPITAL ANNUAL GENERAL MEETING





FANSHAWE

In partnership with each of the Ontario Regional Base Hospitals, the Southwest Ontario Regional Base Hospital Program (SWORBHP) hosted the 2019 Ontario Base Hospital Group (OBHG) Annual General Meeting (AGM) on February 13th and 14th in London, ON at the Four Points by Sheraton Hotel.

A gathering of Prehospital Care stakeholders, the OBHG AGM brings together key professionals from across the province. The AGM not only attracts Base Hospital and Ministry of Health and Long-term Care partners, it alo attracts Front Line Paramedics, Paramedic Educators, Paramedic Service Leaders, Physicians, Researchers and Vendors from across Ontario.

In collaboration with representatives from each Base Hospital in Ontario, the OBHG AGM Planning Committee brought together industry leaders to inspire, educate, and debate. This year's theme of Collaboration & Innovation featured content experts from across the region to present the following topics:

- The Progression of Paramedicine in Ontario
- The Road to Rallye Rejviz
- Midwives and Paramedics Work Together
- Research Presentations
- Innovation on the Frontlines: *Making What you Need with 3D printers, Rapid Prototyping and Open Source*
- Innovation Through Collaboration
- Reflective Practice for Paramedics
- Ministry of Health and Long-Term Care Update
- The PHARMers: FOAM and Knowledge Translation in Prehospital Medicine
- Paramedics and Human Trafficking: *Opportunities for Identification and Intervention*
- OBHG Committee Updates
- War Within a Breath: *First Reponse in Gaza*
- Creating Exceptional Experiential Learning through Collaboration and Innovation
- Challenges in Multiple Casualty Scenarios
- Prehospital Involvement in Hospital Drills: *A Game Changer in Improving System Response*
- Fentanyl and First Responders
- 10 Reasons to Stop Worrying and Learn to Love Prehospital Trauma
- Considering Tissue Donation After Termination of Resuscitation

UPCOMING CME EVENTS

MARK YOUR CALENDARS

For a complete list of upcoming CME events, visit our online events calendar:

http://www.lhsc.on.ca/About_Us/Base_Hospital_Program/Upcoming%20Events/index.htm

STAY CONNECTED WITH SWORBHP:

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