



SWORBHP LINKS

VOLUME 2

JULY 2010

INSIDE THIS ISSUE:

Communication — The Regional Medical Director's Message	2
How do you Lead? The Regional Program Manager's Message	2
Octaplex	3
Canadian Team Takes First Place in International EMS Competition	3
Paramedic Recognition Awards	4
Up Close and Personal	5
What Does it Take to Become an ED Doc in 2010?	5
Administration of Nitro to Nitro Naïve Patients	6
Patient Safety in EMS	7
EMS-A Tradition of Innovation in Patient Safety & Quality	8
Dr. Matthew Davis EMS Resident	8
Hospital Patient Access and Flow Project	9
Comments to the Editor	9



Teaching Naked

OK – right off the top – I don't mean that literally! The challenge to "teach naked" comes from Jose A. Bowen, Dean of Meadows School of the Arts at Southern Methodist University. Mr. Bowen challenged his colleagues to teach without machines, specifically discouraging the use of power point in the classroom. ("When Computers Leave Classrooms, So Does Boredom", 2009).

Power point does have its place in education, and when used properly it can appeal to both auditory and visual learners. But even with the vast improvement in appearance from blackboards and chalk, or even hand-written notes on overheads, power point does not fully engage the adult learner at higher levels in the class-room setting.

This fall, we will be teaching naked during the annual recertification program – that's right, not a single power point slide in class! There will be a pre-course reading package and even some pre-recorded Webinars on our website available to view in advance. But the classroom teaching time will be dedicated to case discussions with you, the learner, taking the lead.

Based on our needs assessment, the Education Program Committee has agreed to focus on four topics this fall; Traumatic Arrest and Termination of Resuscitation, Paediatric Cardiac Arrest, Cardiac Ischemia, and Diabetic Emergencies. Pre-course reading will provide a review of the pathophysiology of each condition, and a pharmacology review of any associated medications. Learners will also have access to the literature that forms the basis for the medical directives.

Technology has, and will continue to change the way we learn.

In class, small groups will review various case discussions, determining the best treatment plan and application of the medical directives based on the information provided. Learners will deal with the "what if" questions, applying the spirit of the directives in challenging situations. And finally, each group will share and justify their findings with the entire class.

The afternoon portion will involve skills evaluations, individual oral scenarios, and a multiple-choice test, all related to the four topics above. Evaluation is directly attached to the learning objectives included in the pre-course materials. These objectives clearly state what you, the learner, should know and be able to do at the end of the training session. Take time to consider what the learning objectives say to help you prepare for the program.

Technology has, and will continue to change the way we learn. And at SWORBHP, we are very actively looking at many ways to make good use of digital learning. But once we get to the classroom, we hope you enjoy our decision to teach naked.

David Vusich, ACP, A-EMCA, AdEd
Education Coordinator

1. When Computers Leave Classrooms, So Does Boredom (2009). Retrieved June 14, 2010, from <http://chronicle.com/article/Teach-Naked-Effort-Strips/47398/>



...“do you know what system your dispatch centre recently began using or how it works?”

A Note from
the Regional
Program
Manager

Communication

One of the things that amazes me about EMS, is the number of agencies and people involved. First we have you, the paramedics. You are the ones that day in and out, deliver care to the patient. Excellence in patient care is what does, and should drive us all.

I can relate to being a front line provider through my career as an emergency physician. Behind me, I know that there are layers and layers of administration and other services that pontificate and create policy. I used to consider these layers as mostly irrelevant to what I do on a daily basis.

I can see how for some of you, the oversight and medical control that the Base Hospital is tasked to provide can be anxiety provoking and even irrelevant at times. Unfortunately for paramedics, the administrative layers are even more complicated. You have service operators, dispatchers, Ministry of Health staff, union representatives and the list goes on. From my viewpoint, although it may not seem it at times, all of these staff are united with one common purpose, so that the public can receive the optimum in prehospital care.

*From the
Regional Medical Director's Desk*

In order for us all to achieve this common goal, communication is the key. In this, I have a challenge for you. We at the SWORBHP are doing our best to communicate with you. We have created this Newsletter, we are launching Webinars, we have a website, we respond to hundreds and hundreds of emails, all with the goal of communicating with and understanding you better.

My challenge for you is this—become involved and communicate with us and the other agencies that govern your work. It may surprise you what you find! For example, dispatchers control your daily movement—do you know what system your dispatch centre recently began using or how it works? Did you know that we are currently working at the Province to make it as accurate and precise as possible for you—and you guessed it—to improve patient care?

My bet is through enhanced communication comes better understanding for all. Thanks for reading, and enjoy the newsletter.

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

How do you Lead?

How do you lead? A critical and often over looked question we hear with numbing regularity from the media, politicians, and arm chair scholars. This question is almost always projected at someone; to them, at them, as a critical measure of how they are not performing or “could have done it better”. Yet, as a reflective question of one’s own style or approach, this seemingly benign question, is with certainty, infrequently asked. When it is, the response, much like the Lacian mirror, is all but truly reflective of one’s actions or style. Yet, this information is critical for all paramedics who serve as mentors, educators, and patient advocates, in addition to health care providers. How you display your leadership style is what will in part make you successful.

So ask yourself a few critical questions; 1) What do I do to re-energize myself for work? Is it healthy and does it actually work? 2) Do I embody my values through communication and actions, or do I espouse my values in word only? 3) Do I value creativity in seeking a solution? How often do I contribute to finding a solution? 4) What is my own personal vision for today, tomorrow and the future? Do I have one? Have I shared it with those around me?

If you can answer each of these questions in a positive substantive manner, then you are probably doing a good job leading your piece of the world. If not, like most of us, there is more work to be done. Remember, it is not in the fight but the collaboration where growth occurs. Multi-tasking is key to productivity, but spend time with the person behind the task. The 0 and 1 do not feel, but a person does. Lastly, there is a world beyond one’s self.

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

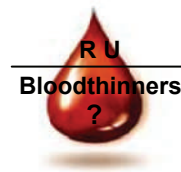
Reference: Schwartz, T. (2010) The Productivity Paradox. HBR, 65-69

Octaplex

Something new for severe life threatening bleeding on anticoagulants.

Octaplex has recently been introduced by the Canadian Blood Services for distribution to hospitals for severe or life-threatening acute bleeding caused by warfarin, or coumadin. Octaplex is a PCC or prothrombin complex concentrate, and is a pooled human blood product. It has a rapid effect which works almost immediately and lasts for over six hours, making it safer to perform emergency surgeries, and easier to stop life threatening hemorrhage.

Essex paramedics have been identifying patients on anticoagulants with a sticker on the ER chart. Those patients requiring massive transfusions are identified from the field, and paramedics have ordered uncrossed blood and sometimes plasma to be prepositioned in ER for patient arrival. This effort has saved delay in resuscitation as blood products are not kept in the ER and can take 15 minutes to package and move from the lab, and plasma requires 20 minutes to be thawed. By identifying patients on Warfarin, ASA, LMWH, Plavix, and Aggrenox paramedics can highlight a possibly overlooked risk to the patient.



We are seeing the use of various anticoagulants more and more in our aging population. Heart valve issues, chronic atrial fibrillation, unstable angina, pulmonary emboli, DVT; all require an anticoagulation strategy for patient care. When these patients call 911 for an emergency; CVA, trauma, or bleeding event, paramedic information gathering can save the day. The medical literature is clear that rapid reversal of warfarin in the anticoagulated patient with traumatic intracranial hemorrhage saves lives.¹ Geriatric trauma patients are at very high risk. Those on anticoagulants especially with head injury have 5 times the risk of death.² Paramedics can play an important role in the chain of survival to make the most of Octaplex in the critically injured or hemorrhaging anticoagulated patient.

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

1. Felecia A. Ivascu et al, Rapid Warfarin Reversal in Anticoagulated Patients with Traumatic Intracranial Hemorrhage Reduces Hemorrhage Progression and Mortality, *Journal of Trauma* Volume 59 August 2006, 1131
2. Mina AM, Bair HA, Howells GA, Bendick PJ. Complications of pre-injury warfarin use in the trauma patient. *J Trauma*. 2003;54:842-847.

Canadian Team Takes First Place in International EMS Competition

Last month, a talented paramedic team from SWORBHP and myself had the opportunity to represent Canada at the International EMS Competition held in Northern Israel, near the ancient port city of Haifa. Over two days, 45 teams from around the world engaged in a clinical competition through ten clinical melleous, including trauma, ACLS, anaphylaxis and neonatal resuscitation.

As an ER physician I have had some exposure to the Base Hospital, and am familiar with EMS protocols. In the ER, we receive patients neatly packaged, away from potential danger, with resuscitative efforts already in place. During this competition I gained a true appreciation for paramedic field work. An example that showcased this was the Multi Casualty Incident. During this night time scenario, all forty teams were presented with a group of high school students who were exposed to a potential toxic gas. Our task was to enter the zone, remove and stabilize the patient, with credit given to quality of resuscitation and speed. All 45 teams enter the zone at the same time. Our team was the last to enter, for fear of becoming ill from the toxic gas. After reassurance that the scene was safe to enter, we located a patient. He was complaining of watery eyes, sore throat, and mild respiratory distress. My initial instinct was to assess and manage the patient; however, the paramedics on my team instructed me not to touch the patient. "Can you walk?" they asked him. We disrobed the patient and led him out of the danger area. Although we were the last team to enter the zone, we were the third team to complete the task. While other teams were busy collaring and boarding their patients, or administering Ventolin, our patient was in the corner, out of danger, in his boxers. We received a lot of dumbfounded stares from our competitors!



L to R—Dwayne Cottle ACP, Dr. Yaniv Berliner, Jeff Conway ACP, Severo Rodriguez, Regional Program Manager, SWORBHP

This International competition highlighted for me the emergence of Paramedics as a highly skilled field of professionals. Competing against EMS teams from all over the world has given me an appreciation for the challenges associated with the field of prehospital medicine. It was a privilege to have been a member of this winning team.

This win was the first ever for a Canadian EMS team and another international bench mark for SWORBHP.

Yaniv Berliner, M.D., CCFP(EM)
ER Physician, LHSC
Trauma Team Leader, LHSC

Paramedic Recognition Awards

Being recognized for the excellent work you do as a Paramedic is important not only to you, but to the Base Hospital as well. To honor these special accomplishments, Base Hospital is introducing three Paramedic Recognition Awards.

This brand new award will be presented to paramedics who have been recognized for excellence in EMS. The criteria includes, but is not limited to:

- Outstanding clinical judgment and actions during a difficult or complicated clinical scenario
- Demonstrated leadership in a complicated multiple agency response
- Leadership and participation in education or administration activities over and above regular clinical responsibilities
- Advancing the practice of paramedicine by advocating on behalf of paramedics in multiple agency strategic planning for the future
- Demonstrating outstanding initiative in proposing valid constructive changes to the current structure of EMS with end result of adopting improvements to the current system

Paramedics can be nominated by their peers, their Medical Director, their Service Administrator, or by our audit team and will be judged on a case by case basis by the Medical Directors. Award recipients will receive a certificate and have their name engraved on a plaque to be displayed at the Base Hospital office in London. A nomination form and additional information on this award are posted on our website. www.lhsc.on.ca/bhp

Paramedic crews identified as having a prehospital save will be awarded a certificate and lapel pin. In order to be considered as a prehospital save, the following criteria must have been met:

- Paramedic crew present a patient to the ED with a prehospital ROSC and patient is discharged from hospital with a good Cerebral Performance Category (CPC).
- Paramedic crew present a viable patient to the ED, patient is resuscitated in the ED and patient is discharged from hospital with a good (CPC).

Paramedic crews who deliver a baby will be awarded a stork lapel pin. To be eligible for this award, the following criteria must have been met:

- Paramedic crew delivered the baby.
- A Midwife or family member is on scene, delivery has not yet taken place, and Paramedic crew assists in the delivery. NOTE: if baby has already been delivered and you transport, this does not qualify.

The biggest challenge for us at the Base Hospital is how to capture this information from the ACR and through the chart audit process. The Base Hospital will be reviewing ACRs back to January 1, 2010 in an attempt to identify Paramedics who qualify for these awards. With that being said, we will be relying on you to tell us if you do a call that meets the above criteria. Forms are posted on our website that can be completed and submitted to the Base Hospital. Once received, we will initiate the necessary follow-up for each call. Submission forms for both awards can be found on our website. Go to www.lhsc.on.ca/bhp

Click on ▼About Us •Operations & Logistics •Paramedic Recognition Awards

Please let us know if you have.....

- Assisted with delivery of a baby in the field
- Presented a patient to the ED with a ROSC, or with successful resuscitation in the ED

If you have any questions or comments regarding the Paramedic Recognition Awards, please contact me by email at Catherine.Prowd@lhsc.on.ca

Cathy Prowd, CQIA
Operations & Logistics Team Leader

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

Medical Directors
Award of
Excellence

Prehospital
Save

Prehospital
Newborn Delivery



Up Close and Personal

In this edition of **LINKS**, we will take you up close and personal with Dr. Don Eby and Peter Morassutti. We hope this allows you an opportunity to get to know each of them a little better.

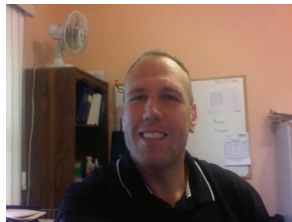
Don Eby, M.D., M.Sc., CCFP(EM) FCFP
Local Medical Director



Don has been with Base Hospital since 1997. He was the physician representative on the Education Subcommittee for five years. He was on the Provincial MAC for four years and served as Chair for two of them. Don

has long been an advocate for rural paramedics and rural paramedic services. He was Chair of the Rural and Remote Working Group, and along with Mike Muir wrote the Rural and Remote Working Group Paper that served as the basis for expansion of PCP ALS programs such as IV starts in rural areas. He was also Medical Director of the first and only part-time, rural, accredited, ACP training program in Ontario. Don has been involved with the ongoing Termination of Resuscitation research projects. He is pleased to be part of the SWORBHP where he is the Local Medical Director for Grey, Bruce, Huron and soon Perth Counties. Don and his wife Ani live in Owen Sound. They have three grown children Mike, Emily and David.

Peter Morassutti, B.Sc., ACP, A-EMCA
Regional Paramedic Educator



Peter Morassutti joined SWORBHP in November 2008 as the Regional Education Coordinator. Since that time he has changed roles and is currently a Regional Paramedic Educator, and Coordinator for the

Essex-Windsor and Chatham-Kent Sites.

Peter holds a Bachelor of Science Degree from the University of Windsor (Biology '98), is an Advanced Care Paramedic (Michener '02), and AEMCA (St. Clair College '99). Peter currently works part-time at SWORBHP and maintains full-time employment with Essex-Windsor EMS. He is also an ACLS, PHTLS, AHLS and PALS instructor for these various disciplines and is a member of the Hazmat/CBRNE Provincial Response Team.

Peter and his wife Tanya have two sons, seven year old Victor and five year old Marc. They reside in Windsor.

What Does it Take to Become an ED Doc in 2010?

Have you ever wondered exactly what it took for the ED Physicians that you interact with every day to become ED Physicians? This article will attempt to answer that question in two parts. Part one explores the training necessary to get a medical degree and getting into a residency program. Part two (to be included in the next publication of **LINKS**) will explore residency training in Emergency Medicine.

Medical School:

Prior to applying for Medical School, candidates are required to complete at least 3 years of University Undergraduate Education. Students tend to opt for a Bachelor of Science program but as long as the individual course requirements are met, any Undergrad degree program may qualify a student to apply for medical school. Candidates apply through Ontario Medical School Application Services (OMSAS—<http://www.ouac.on.ca/omsas/>) to any or all of the six Ontario Medical Schools. Acceptance criteria vary between Medical Schools. In general it's a combination of academic success (ie. grades), leadership experience, community involvement, previous awards, MCAT scores and interview performance. Some schools also request high school transcripts as part of the application process. There is no specific undergraduate university grade average that will guarantee entrance into medical school. Most successful applicants will have at least an 82-83% overall average for their entire undergraduate University degree.

Once accepted, medical school is either three (McMaster) or four (all other Ontario Medical Schools) years in duration. During medical school, students complete a combination of in class and clinical time. At the University of Western Ontario students spend the majority of first and second year in the classroom. Third year and fourth year at UWO are spent in the hospital and clinic setting.

Cont'd on page 6



What Does it Take to become an ED Doc - Cont'd

At the end of medical school, students complete Step One of the Medical Council of Canada Examination Process (MCC). Step one is a Computer Adaptive Test that evaluates all areas of medicine. Prior to graduating from UWO, students are also required to complete a comprehensive Observed Clinical Skills Examination (OSCE). The MCC and OSCE are in addition to a multitude of examinations throughout the four years of medical school.

Getting a Residency Position:

At the end of Medical School, successful students obtain an MD or Medical Degree. They are now officially Doctors but are not able to practice medicine independently. Independent practice requires a license through the College of Physicians and Surgeons of Ontario (CPSO). Obtaining a license to practice independently from the CPSO requires the completion of an accredited residency program and Step two of the MCC Examination. During the last year of medical school, students apply to a residency program through the Canadian Residency Matching Service (CARMS). CARMS is a competitive process that attempts to match the best student with the best spot via a computer algorithm. Most students choose a particular specialty they are interested in and apply to that specialty at multiple medical schools across Canada. Students interested in Emergency Medicine will enter either Family Medicine or Emergency Medicine Residency Programs.

...watch for part two in the next edition of [LINKS](#)

Adam Dukelow, M.D., FRCP(C), MHSC, CHE
Local Medical Director
Middlesex, Elgin, Perth, Oxford & Oneida

Administration of Nitro to Nitro Naïve Patients

For ACP's and PCP's who are IV certified, you are sometimes faced with a subset of patients that you can treat with Nitro...Nitro naïve patients. Starting an IV is not the only thing you need to do before giving these nitro naïve patients their first nitro. As you know, you will need to spend some extra time with your history taking to be reasonably sure this is an ischemic event. Remember, just because you can treat with Nitro, doesn't mean you should.

Patients with prior history of nitro use will be able to describe the event leading up to their diagnosis. Their experience essentially "trains" them to answer our questions like a chest pain patient, and their prior in hospital diagnostics helps seal the deal for inclusion into our protocols.

In the absence of this past history, though a 12-lead is helpful, you will need to look at things like "The Big 5" cardiac risk factors; smoking, family history, diabetes, hypertension, and high cholesterol.

Remember, just because you can treat with nitro, doesn't mean you should.

The presence of these risk factors increases the probability that the patient will experience an acute coronary syndrome at some point. As a review, the classic initial presentation follows a gradual progression from pain with exertion (or some precipitating cause), to pain at rest. You may directly question the patient to determine if this precipitating cause can be determined.

Although this represents the classic presentation, someone who has never had problems with a narrowing or blockage of their arteries can suddenly have one while they are sitting in front of the TV watching their soap opera. In the end, you will only have your instinct, guided by your history taking, physical exam and possibly your 12-lead (where available and appropriate) to develop a plan based on the balance of probabilities. Remember, we don't just treat abnormal 12-leads, we follow the maxim; "treat the patient, not the monitor".

...Cont'd on pg 7

Administration of Nitro to Nitro Naïve Patients —cont'd

Nitro is not benign, it can have serious side effects, and should be reserved for those patients who have a need for it. If you paint the picture of ischemic chest pain, you should administer nitro/ASA (if they otherwise conform to the protocol). If you are not able to paint the picture of ischemic chest pain on your ACR, hold off on the nitro and wait until the hospital can do more diagnostics to decide.

The Base Hospital will support your decision in both cases (treat, or not to treat), and will only question your decision if the picture painted of the patient's condition is in contrast to the treatment administered.

Paul W. Robinson, ACP
Professional Standards Specialist

Patient Safety in EMS

Over the last 10 years there has been increased emphasis on patient safety in the health care system. In the year 2000, it was estimated that 7.5% of all admitted patients to acute care hospitals experienced an adverse event.¹ There are few studies of this problem in the EMS environment.² Compared to an inpatient setting, the EMS environment is much less controlled and it is likely the adverse event rate is much higher than reported in hospitals.

An important report was released in 2010 by the Canadian Patient Safety Institute about patient safety in EMS.² Its principle author is Brent Bingham, an ACP from Toronto.

The report, based on a comprehensive literature search, round table discussions and individual interviews, concluded that errors in clinical decision making were the most important source of risk to patient safety. Medication errors, issues around intubation, and vehicle safety were also prominently identified.

The full report can be obtained from the Canadian Patient Safety Institute at:

<http://www.patientsafetyinstitute.ca/English/Initiatives/EmergencyMedicalServices/Pages/default.aspx>

To improve patient safety, the most important change required is in our culture. We need to think about patient safety and make it a priority when we think about how we do what it is we do. After all, patients expect and deserve to be harmed as little as possible by us during the delivery of their care.

I encourage you to read and think about patient safety. This is a relatively new direction in EMS and you will hear lots more about it in the next few years.

Have a safe summer.

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

1. Baker GR, Norton PG, Flintoft V, et al. The Canadian Adverse Events Study: the incidence of adverse events among hospital patients in Canada. *CMAJ* 2004;170:1678-86.

2. Bingham BL, Morrison LJ, et al. Patient Safety in Emergency Medical Services, Advancing and Aligning the Culture of Patient Safety in EMS. The Canadian Safety Institute. 2010

Trivia

Did you know?

- The opposite sides of a dice cube always add up to 7.
- One in ten people in the world live on an island.
- 160 billion emails are sent daily, 97% of which are spam.
- Spam generates 33bn KWh-hours of energy every year, enough to power 2.4 million homes, producing [17 million tons](#) of CO₂.

“As EMS graduates to evidence based medicine, first we need to understand our current state...”

“EMS”

A Tradition of Innovation in Patient Safety & Quality

Although quality is not necessarily the same as patient safety, patient safety is related to quality of care. Safety is a critical first step in improving quality, and patient safety is defined as a subset of overall quality-related concerns. The IOM report (2000, 58) describes the relationship of safety to quality management as “making environments safer means looking at processes of care to reduce defects in the process or departures from the way things should have been done. Ensuring patient safety, therefore, involves the establishment of operational systems and processes that increase the reliability of patient care.” National Patient Safety Foundation (2008) defines patient safety as “the avoidance, prevention and amelioration of adverse outcomes or injuries stemming from the process of health care.”

Knowledge management has already proven to be effective in improving patient safety for some healthcare organizations. Knowledge management is defined as “the process that creates or locates knowledge and manages the dissemination and use of knowledge within and between organizations” (Darroch 2003, 41). Prior research has shown knowledge management to be positively associated with organizational success, mainly in manufacturing firms. Successful knowledge management depends on the relevant technical infrastructure to capture, store, share, and use information common to a decision support system (Belzowski 2003; Lee and Choi 2003).

From the Greek and Roman eras, where chariots were used to remove injured soldiers from the battlefield, EMS has come along, changing fast and furious, making revolutionary advancements.

As EMS graduates to evidence based medicine, first we need to understand our current state, then we can invest resources aimed at improved patient safety and outcomes. Technology has already begun to enter this segment and soon we will all be knowledge workers, dependent on technology as much as we are caregivers. So if knowledge acquisition relates to the location, creation, and discovery process resulting in improvements – EMS has an exponential potential for advancements.

Adeel Ahmed, Process Analyst
Paul W. Robinson, Professional Standards Specialist

Reference: ASQ Quality Management Journal, Volume 17 Issue 2

Dr. Matthew Davis —EMS Resident

In the April edition of LINKS, we introduced you to Southwestern Ontario’s first EMS Resident, Dr. Matthew Davis. Matt is currently in the beginning of his fourth year of the FRCP Emergency Medicine program. He has chosen to pursue an EMS fellowship and will be part of the SWORBHP team from June 2010 to July 2011.

After spending his childhood and teen years in Pickering Ontario, Matt moved to Kingston, Ontario to study Life Sciences at Queen’s University. After two years, he decided to pursue a Bachelor of Nursing Science which he completed in 2002. Matt furthered his studies and obtained a Master of Sciences degree at Queen’s, while working part-time as an RN in Kingston General Hospital’s ICU. After defending his thesis and contemplating a PhD., a career in academia was put on hold after he was accepted to the Michael G. DeGroot School of Medicine at McMaster University. Prior to embarking on his medical career, Matt left family and friends behind to backpack throughout South East Asia for four months, the trip of a lifetime.

After three years of study at McMaster, Matt decided to pursue a career in Emergency Medicine as he was drawn to the quick pace, variety, adrenaline rush, and comic relief that Emergency Medicine provided. He was matched to the Emergency Medicine program at UWO in 2007 and moved to London. Matt developed an interest in EMS through his various research projects, great ride-out experiences, and after his one month elective at SWORBHP.

....cont’d on pg 9

EMS Resident—Cont'd

Matt now calls the Old South home. He is married to Kelly, who works as an RN in the ED at Victoria Hospital. They have Che, a sock consuming, yellow Labrador Retriever known affectionately as Demontrion. Matt enjoys playing volleyball, dodgeball and soccer. He tries to play golf, but is much more successful on the slopes of steep mountains, traveling to Utah and BC for knee deep powder. After completing his residency, Matt looks forward to combining his Emergency Medicine career with a specialization in EMS.

Cathy Prowd, Editor
Operations & Logistics Team Leader

Hospital Patient Access and Flow Project – South West LHIN

Improving access to care through collaboration — The “One Number” Protocol

Although it didn't start out this way, the Patient Access & Flow project being undertaken by all of the hospitals and the Community Care Access Centre in the South West LHIN is very much the “One Number” protocol. Why? Because a key change that has been introduced is the use of a single point of contact for each hospital – a point of contact that connects to designated hospital staff, who in turn connect with physicians when advice about a patient in need is being sought by a physician outside that hospital.

How is this different from the way things used to be? Well, in the past (up until May 4, 2010) physicians with a patient about whom they needed advice or who they needed to transfer to another hospital, called CritiCall www.critical.ca or the physician specialist they knew and respected. Once the physicians talked, either advice was given, or the decision was made to transfer the patient. The hospital to which the patient was being sent was, unfortunately, not part of this conversation. The hospital staff would only find out after the fact that a decision to transfer a patient had been made. This put hospital staff in a reactive position rather than one in which they could proactively manage the added demands being placed on them.

The “One Number” protocol has changed all this. Now both physicians and hospital staff are on the phone at the same time sharing key information that will support fully informed decision-making. It also means staff are able to expedite the work that needs to be done to get things happening as quickly as possible to prepare for the patient, arrange transportation etc. The role of EMS and CACC services does not change with the introduction of this protocol.

On the back side of the process – if patients need to be returned to their community hospital, staff at the sending and receiving hospitals now work together, in advance, to ensure the patient is appropriate. This happens up to 48 hours before the patient is ready to be transferred. After this, they arrange for the physicians to receive information and talk about medical issues. It allows the physicians to focus on what they know best – providing medical care – and enables other parts of the process to be managed by hospital staff. It's a win-win scenario.

For more information contact:

Catherine Glover, Director, Corporate Clinical Operations, LHSC catherine.glover@lhsc.on.ca or Ann Toman, Manager, Patient Access, LHSC ann.toman@lhsc.on.ca or Steve Elson, Director, Regional Relations & Special Projects (LHSC and St. Joseph's) steve.elson@lhsc.on.ca

A flowchart mapping the Hospital Patient Transfer and Flow Process can be found at

http://www.lhsc.on.ca/About_Us/Base_Hospital_Program/OpsLogistics/HospitalPatientTransferandFlowProcess.pdf

Comments to the Editor

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 Team Leader
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

This, and future editions of **LINKS** can be found on our Website. Go to About Us ▪ Operations & Logistics, and follow the link to the Newsletter.