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EMERGENCY MEDICAL SERVICES AGENCY
Serving Butte, Colusa, Glenn, Nevada, Placer, Shasta, Siskiyou, Sutter, Tehama, and Yuba Counties

S-SV EMS Newsletter Jan. – Mar. 2018

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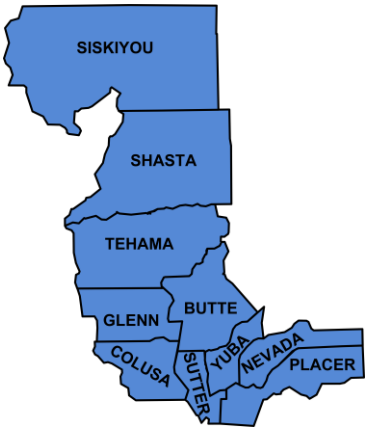

S-SV EMS Overview

The S-SV EMS region covers 10 counties (21,000+ square miles), with a combined population of approximately 1.3 million. In 2017 there were over 130,000 medical emergency 911 calls resulting in nearly 100,000 patient transports. There were also over 10,000 interfacility patient transports during this same time period. The S-SV EMS system is comprised of the following EMS resources:

- Multiple primary/secondary public safety answering points (PSAPs), private ambulance dispatch centers and 3 air ambulance coordination centers
- Multiple law enforcement agencies
- 95 BLS fire department non-transport agencies (several providing EMS optional scope of practice services)
- 9 ALS/LALS fire department non-transport agencies
- Multiple specialized EMS programs (TEMS, Fireline)
- 30 public and private ground ambulance provider agencies
- 8 public and private ALS EMS aircraft providers
- 18 acute care hospitals (8 Trauma Centers, 6 STEMI Centers and 10 Stroke Centers)

The TAO of Precepting

By Michelle Moss

As a preceptor you play an important role in the burgeoning career of a new intern. It's not uncommon these days for paramedic students to come out of school and jump into the back of your ambulance without any 911 experience. This makes for a challenging and sometimes tedious job for a preceptor. So much to teach. So much to learn. Years of experience to be compressed into 480 hours. Fingers crossed that you will see enough "good" calls for you to teach and demonstrate and for your intern to observe and learn.

By definition, a good preceptor creates a safe and supportive environment, gives constructive feedback and patient redirection.

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The TAO of Precepting (from page 1)

Hopefully, while remembering that making order out of chaos for someone new to 911 can be like learning to drink from a firehose. The job is to teach the things that cannot be taught in paramedic class. To mentor. To coach. But is there an upside to this lack of experience?

While it's true that these new budding interns may lack the years of experience of their preceptors, they may bring something with them that, if we take a moment to turn the tables and allow the student to become the teacher, may give us an opportunity to remember why it is we chose this career in the first place.

For many veteran preceptors, it's difficult to remember what being the "new guy" was like. While most of us remember the first day of our internship, and the nerves that went along with it, it is more difficult to recall the enthusiasm and sense of purpose we eagerly brought to our first shift. Depending on how many layers of crust your preceptor had accumulated over the years determined how long you would be able to hold on to your ideals.

Let's face it, racking up years of patient contacts can make the most compassionate of us grow a little jaded and judgmental. Then, in walks your new intern; wide-eyed, eager, and hopefully, all ears. What if, before you started filling those ears with war stories highlighting all that is undesirable in this business, you took some time to tap into their enthusiasm and excitement? Get to know why they are there. Why they chose this path. What they hope to become.

Most of us didn't choose this career for the money. We are here because if not now, at some point, we were filled with compassion and embraced the sense of purpose that this job represents. We forget that, even though we don't hear it often enough, our neighbors, friends and family think we are heroes. Because we are.

I recently had the opportunity to read a beautiful letter of commendation written by a paramedic after he saw an off-duty EMT going above and beyond for a critically injured patient involved in a vehicle accident. It wasn't just the words used to describe the EMT's actions, it was the way the paramedic clearly saw her as a hero. I hope this paramedic realizes that he has likely been observed as a hero many times also. It may not have been said to him, or a letter written on his behalf, but it has been observed on several occasions throughout his long career.

When your new intern climbs aboard, you are who he or she aspires to be. Why else would they be there? What is a hero but someone others look up to and aspire to be? If you take just a moment to think about it, isn't it also inspiring to see someone full of untainted enthusiasm, ready to take their first steps on the road you have been on for years? Tapping into the idealism of someone who doesn't know what you know and hasn't seen what you've seen can be invigorating. It can give you a glimpse into what others saw in you at the beginning of your journey.

TAO

Maybe, before poking a hole in their balloon with stories of all the dirty drunks, zombie meth-heads and thankless, rude patients, you could take pause and remember the grateful spouse, the patient whose hand you held and whose fears you soothed, or the times you felt honored to be the one to rescue someone from the worst day of their life. The negative experience will come for them regardless of which stories you choose to share.

But in the sharing of knowledge and experience, is it not better for them to know that when they have been doing this for as long as you have, they will have a quilt sewn with many different colors, not just black? Mentorship should not include transcribing old negativities onto the new generation. Listen, maybe even smile at the naivety and allow it to, if just for the day, remind you where you started, how far you've come, and how good you felt when you were a young gun.

Advanced Airway Procedures Update

By John Poland

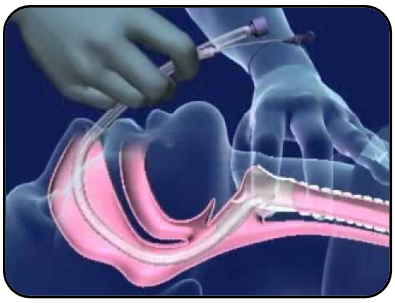
There have been several changes related to advanced airway procedures approved for use by California Paramedic personnel. In addition to the recent removal of pediatric intubation, the California EMS Authority (EMSA) has notified Local EMS Agencies (LEMSAs) that nasotracheal intubation will be removed from the paramedic optional scope of practice effective December 1, 2018.

California Code of Regulations (Title 22) establishes the basic scope of practice for all EMS personnel. Optional scope of practice requests are submitted by the LEMSA to EMSA for consideration. These requests are evaluated by the Emergency Medical Directors Association of California (EMDAC) Scope of Practice Committee, which provides recommendations to EMSA who makes the final approval/disapproval decision. Approved optional scope of practice items are monitored and evaluated on a regular basis to ensure continued EMS utilization appropriateness and efficacy.

Based on reviews of current EMS data and medical literature, the EMDAC Scope of Practice Committee recommended the withdrawal of both pediatric and nasotracheal intubation from the paramedic optional scope of practice statewide. These recommendations were accepted by EMSA and notification was subsequently sent to all LEMSAs.

Pediatric intubation was removed from the optional scope of practice for ground ambulance paramedics in the S-SV EMS region effective December 1, 2017. As a result of unique circumstances, a local decision was made to continue to allow EMS aircraft paramedics to perform pediatric intubation until additional direction was provided.

In order to comply with the most recent EMSA directive, all paramedics in the S-SV EMS region will no longer be allowed to perform nasotracheal intubation effective December 1, 2018.



In addition to the removal of these advanced airway procedures, EMSA recently advised that the use of supraglottic airway devices by EMS personnel would now be considered for optional scope of practice approval. S-SV EMS has submitted a request to EMSA to allow authorized EMS personnel to utilize supraglottic airway devices for adult (EMT, AEMT and paramedic personnel) and pediatric (AEMT and paramedic personnel only) patients. This request is expected to be approved later this month.

(Pictured: i-gel® Supraglottic Airway Devices)

Appropriate notification/direction will be provided once EMSA optional scope of practice approval has been obtained. Any EMS provider agency desiring to utilize supraglottic airway devices must obtain S-SV EMS approval prior to implementation. Approved providers will be required to utilize S-SV EMS standardized training materials and perform a 100% QI review of the utilization of these airway devices by their prehospital personnel.

Finally, based on recent revisions to the EMSA scope of practice position statement regarding needle cricothyrotomy equipment, S-SV EMS has approved the Rusch QUICKTRACH® Cricothyrotomy Device as an option for S-SV EMS accredited paramedic personnel to perform this procedure. Paramedic personnel utilizing this device must have received adequate training on the use of this equipment prior to utilization.

Our Agency will continue to monitor and evaluate prehospital advanced airway utilization and consider appropriate policy/ protocol revisions as necessary.

EMS Documentation

By John Poland

Prehospital personnel are responsible for providing clear, concise, complete and accurate patient care reports (PCRs). The majority of EMS personnel understand the importance of good patient care documentation, effectively conveying the patient's illness/injury, medical history, treatment provided, response to treatment and other pertinent incident details. However, ongoing reviews of EMS documentation for QA/QI and investigative purposes indicate there are opportunities for improvement in some instances.

In order to reinforce the excellent documentation occurring in many instances, and to provide clearer requirements/expectations to all prehospital personnel, the S-SV EMS Prehospital Documentation Policy (605) is currently being revised to incorporate the following language:

- All pertinent standard and mandatory PCR data fields shall be accurately completed
- Individual procedures and/or medications must be adequately documented in the appropriate 'treatment' section of the PCR

- Pertinent vital signs (BP, pulse, respirations at a minimum) shall be monitored and documented a minimum of every 15 minutes or more frequently if clinically indicated, vital signs shall be monitored and documented prior to and following any medication administration
- The narrative section of the PCR shall be completed utilizing one of the following documentation formats:
  - SOAP (Subjective, Objective, Assessment, and Plan)
  - CHART (Complaint, History, Assessment, Rx/pt. medications, and Treatment)
  - Chronological Order

Regardless of the documentation format utilized, the PCR narrative section shall include the following information as pertinent:

- Response events
- History of Present Illness (HPI)
- On scene events
- In ambulance events
- Transport events
- Receiving hospital arrival and transfer of patient care events

Detailed patient assessment and treatment information normally documented in other sections of the PCR are not required to be repeated in the narrative section. However, specific findings that require follow up action by EMS personnel shall be appropriately documented in the narrative section, which should always be consistent with assessment and treatment details documented in other sections of the PCR.

Remember that completed PCRs may be read, evaluated and utilized by any/all of the following individuals for patient care, billing, quality assurance, legal and/or investigative purposes:

- Hospital personnel (treating nurse/physician, base hospital coordinator, etc.)
- Your peers, supervisors or medical director
- S-SV EMS staff
- California EMS Authority staff
- Billing and insurance staff
- Lawyers/prosecutors (for criminal and civil purposes)
- The patient themselves

Keep in mind, the first thing that any reviewer will likely read is your narrative because it sets the pace. Your narrative indicates your thoroughness, implies your competence and links your findings with your actions. For these reasons, you should always own and take pride in the patient care reports that you produce.

Pelvic Binders

By Michelle Moss

Although pelvic binders have been around for some time, they are not currently authorized for use by ground personnel in our region. As a result of requests from several ground provider agencies, S-SV EMS agreed to conduct a field evaluation of these devices to determine if they should be added to the optional inventory list and a protocol developed for their use.

While creating the data design for this evaluation, it was discovered that several ground providers were already using pelvic binders in the prehospital setting. These providers were instructed to discontinue using these devices pending a retrospective review and analysis of their application.

A search of the S-SV EMS data system for 2017 identified 31 patients where pelvic binder application was attempted by EMS personnel. Not all of these applications were successful due to failed placement or patient refusal. In evaluating patients who had a pelvic binder applied by EMS, a large percentage were placed on patients without high-energy mechanism (see graph below) or hemodynamic instability.

A review of the hospital outcome data of these EMS pelvic binder application patients indicated that a very small number had a pelvic ring fracture or required emergent surgical intervention.

Consideration was given that perhaps EMS providers were using pelvic binders as a means of reducing pain by splinting. However, EMS documentation indicated that only 3% of patients reported a reduction in pain following device placement. Additionally, only 74% of eligible patients received pain medication in the prehospital setting.

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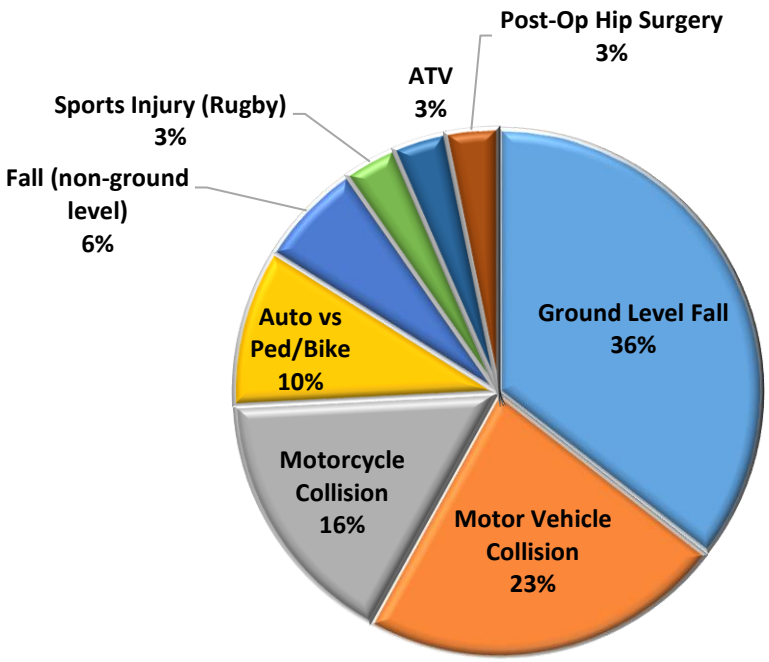
EMS Pelvic Binder Application Patient Mechanism of Injury



Pelvic Binders (from page 5)

Pelvic binders are effective in stabilization and reduction of the pelvic volume in hemodynamically unstable patients. In order to identify patients likely to benefit from prehospital application of a pelvic binder, only patients with pelvic ring fractures were evaluated since non-ring fractures, such as acetabular fractures, are less likely to result in significant internal hemorrhage.

A review of the S-SV EMS trauma center registry for 2017 identified 61 patients with a pelvic ring fracture. Further review of this trauma registry data indicated that 22 of these 61 patients (36%) had an Abbreviated Injury Scale (AIS) severity classification ≥ 4 ('Severe', 'Critical' or 'Maximal'), many requiring surgical intervention. Patients with pelvic ring fractures resulting from motorcycle collisions and non-ground level falls had a significantly higher probability of sustaining a severe or critical pelvic ring fracture.

The graph to the right shows the mechanism of injury for all EMS patients identified in the truma center registry as having a pelvic ring fracture, including those with an AIS severity classification of 3 or less ('Minor', 'Moderate' or 'Serious').

The EMS documentation of these 61 pelvic ring fracture patients evaluated as part of this review indicated that 50% had a "stable" pelvis, and 14% had no pelvic assessment documented.

Many patients with severe pelvic fractures also had a complaint of testicular or groin pain and/or bleeding from the urethral meatus or rectum. These findings, along with current Committee on Tactical Combat Casualty Care and the American College of Surgeons recommendations, were utilized in developing the S-SV EMS proposed criteria for pelvic binder utilization.

Using the S-SV EMS proposed criteria, 68% of these patients with severe pelvic ring fractures would have qualified for placement of a pelvic binder. The goal is to capture a majority of patients who may benefit from pelvic binder utilization while not creating an unnecessary delay for patients not likely to benefit from application of the device.

The results of this review and EMS protocol recommendations will be discussed during the upcoming S-SV EMS Medical Control Advisory Committee (March), and Regional Trauma QI Committee (April) meetings. If approved by these committees, the treatment protocol may be in place as early as June, 2018.

For additional information or questions about this review, please contact Michelle Moss (michelle.moss@ssvems.com).

EMS Pelvic Ring Fracture Patient Mechanism of Injury