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Manitoulin-Sudbury DSB

PS *Advance* Training Bulletin

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Patient Referrals *(by David Wolff)*

PERILS Tool

By now all paramedics should have noticed changes to the Paramedic Referral Intervention in Tablet ePCR. The changes were made to reflect the final published research and is outlined below.

Dr. Jaques Lee, author of the Paramedics Assessing Elder Patients at Risk of Independence Loss (PERIL) originally started with 42 questions. When we began our Paramedic Referral program, we were using a preliminary refined list of three of the 42 questions. Although the questions we were using were quite accurate, the final outcomes of Dr. Lee's work indicated slightly different questions that provide a more accurate estimate of potential negative patient outcomes.

It is important to note that the PERIL tool's accuracy is improved when combined with the predetermined belief of the paramedic that the patient may already be at risk. ***Paramedic's are able to make this type of assessment with approximately 50% accuracy prior to asking the questions***.

There are now four questions to confirm the paramedic's belief. They are:

1. Given the current home situation, are there any problems that would prevent this individual from being safely discharged home from the Emergency Department, or contribute to recurrent EMS/ Emergency use?
2. Does the individual have unmet needs for social support that in your opinion will contribute to recurrent EMS/Emergency use?
3. Has the individual has called 911 in the last 30 days?
4. Is the individual male?

Each question has been shortened to fit in Tablet ePCR (question 4 is autopopulated from ePCR).

1. Medic judgement PT at risk
2. Potential repeat caller
3. Used 911 last 30 days

The actual prediction of an adverse outcome in the next 30 days according to Yes to the questions are:

1/4 (excluding #1) is 24.4%
#1 by itself is 41.4%
2/4 is 56.8%
3/4 is 83.8%
4/4 is 97.6%

Changes to ePCR

A couple of changes have been made in Tablet ePCR to reflect the new questions and to improve documentation.

The first thing you will note is the questions have been revised. Second, a rule has been applied that all patients 65 years of age or older require a PERILS assessment (this does not preclude the option to complete a PERILS assessment on those that are younger, at the Paramedic's discretion). This does not mean a referral is automatically made if an assessment is completed. Referrals are made only if you answer YES to questions 1 or 2, which are sufficiently accurate to make a referral by themselves. Tablet ePCR asks questions 1-3 and by answering all three, accuracy is improved. If you answer no to all three, a referral is not made.

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ACRs and Service Review *(By Jennifer Belanger)*

As you recall, this past June our Service had it's Service review conducted by the MOHLTC. A written report to the service revealed; "From the three hundred and one ACRs reviewed by the Review Team, the Service Provider captured 17,795 of 17,900 possible data points, or 99.4% of the Ambulance Call Report information requirements. The Service Provider is to be commended for this documental observation".

As a representative of the Management Team, we too would like to commend all of you for the job well done.

In the following article the common errors found during this review are outlined for review and clarification.

It was identified on multiple PCR's that we are not always obtaining the patient's Postal Code. Remember that we are to make a valiant effort to obtain this information from the patient or family member. If you were not able to obtain it during the call, Canada Post has a web site to look up this information once you return to base. https://www.canadapost.ca/cpo/mc/personal/postalcode/fpc.jsf. Although "CNO" should meet the Standard as it states "if readily available", apparently the Reviewes though otherwise.

A second set of complete vitals are required for all transportation of patients. **The ACR Completion Manual** states "A minimum of two (2) sets of vital signs should be taken for every pre-hospital patient". If your transport time is too short to comply, **The ACR Completion Manual** goes on to say, "If the minimum vital sign assessments are not taken, document the reasons in the "Remarks" section of the ACR." **The BLS Manual** also states that the Paramedic will "Repeat vital signs every 10 minutes at minimum, and with greater frequency as per the specific *Standards of Care* in this manual". These two documents can be referenced for clarification; the links are posted in SharePoint. It seems that the larger issue is not that there were only one set of vitals but the issue is the subsequent vital signs were incomplete. All vitals must be obtained and recorded, partial sets are not sufficient to meet the Standard.

The Incident History section pertains to information specifically related to the patient's current condition and the source of the information (bystanders, relatives the patient). This information should be subjective and include symptoms, events leading up to, and how the patient is found. This is not the Chief Complaint, and documenting "as above" is not acceptable. For more information of the Incident History section refer to the **BLS standards Appendices 12, 21 and 22.**

It was noted by the review team that "Transfer" was noted in the Chief Complaint section. Just a reminder that on its own, "transfer" is not an appropriate entry. (per the **ACR Completion Manual**; "A description of the nature of the call for both emergency and transfer calls as determined by the crew on arrival at the scene". An example of proper documentation might be; "Being returned from a CT scan, query aneurysm".

When transporting patients to and from medical facilities it is important to obtain and record the patient's Relevant Past History. Documenting CNO is not appropriate. The BLS manual under "E Patient Assessment – Historical Assessments" states for interfacility patient transfers, obtain the following information;

Pertinent patient history and care information;

Verbal and/or written treatment orders from the sending physician;

Transfer papers, e.g. case

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ACRs and Service Review cont.

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summary, lab work, x-rays, list of personal effects accompanying the patient etc;

Names of hospital staff and equipment accompanying the patient, where applicable;

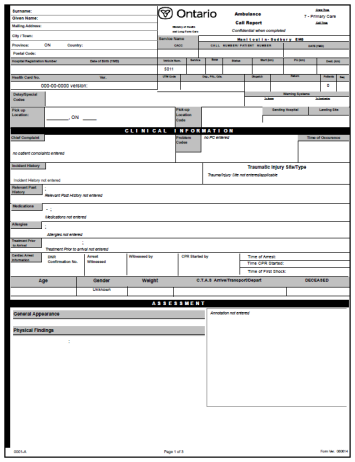
Name of receiving facility and receiving physician, where applicable

Also during interfacility transfers the audit team found instances where the paramedics noted under the Medications and Allergies sections "CNO". It is important that one not only obtain the full history when accepting care for these patients, but that it is also documented. The expectation of this standard is also listed in BLS Manual under section **E. Patient Assessment – Historical Assessments.**

When using Delay/Canceled Codes indicating any special notations pertaining to the codes used should be documented in the remarks section.

And finally, the audit team identified the misuse of Witness Signature under the Aid to Capacity Section. In some incidents, the paramedics signed as witnesses which is incorrect. In the event that there are no witnesses, no signatures are recorded. The patient or substitute decision maker must sign, and the paramedics must sign in the Aid to Capacity Section as attendant and driver, as well as signing in the signature section of the PCR (2 signatures for each paramedic are required in these circumstances). The **ACR Completion Manual** fully outlines the expectations of the procedure.

Again, on the whole documentation was done well in most cases however there is always room for improvement for all of us!



Mental Health and CP *(by David Wolff)*

In meetings I have attended with community partners, a common theme that has been identified is that issues arising from social needs and mental health and addiction problems seem to be on the rise. My question to the community partners is, what can we do to help?

One goal of Community Paramedicine is to identify health gaps (or those falling through the gaps) and connect people to the resources that meet their needs. To better help those who may be falling through the gaps, we require better assessments.

The police have been using a Brief Mental Health Screener (BMHS) in some locations that can provide a basis of a paramedic screening tool for social needs and mental health that will help us better identify and assess those that may be in crisis.

The revised version of the Social Needs and Brief Mental Health Screener (SNBMHS) being created begins with similar question to the PERILS questions; the paramedic feels that the patient is at risk and they may become a potential repeat caller due to unmet social needs. The tool itself is broken into five sections including:

1. Identification
2. Indication of risk/social needs and status of homelessness
3. Indicators of disordered thought including behaviours, degree of personal insight into mental health problem and level of cognitive skills for daily decision making.
4. Indicators of risk of harm such as environment, violence to self or others
5. An area for remarks

As with all assessments, the SNBMHS provides a base

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The SNBMHS will help us better identify and assess those that may be in crisis.

Community Paramedicine Update *(by David Wolff)*

Our community Paramedicine Wellness Clinics in our DSB buildings and other community locations have been provided for three months with some great success stories.

Since documentation of patient encounters did not start in the first month, I can only provide information starting in September. Since then, there have been 63 patient encounters. This accounts for Wellness Clinics only and does not include the 44 patient encounters in the form of informal encounters, paramedic initiated Ad Hoc visits and Circle of Care referrals provided by your peers throughout the whole DSB.

There have been many successful CP stories. One recently relayed to me by Al Gendron is one that needs to be shared. Al has had the privilege of attending many clinics. I caught up with Al at the Espanola clinic and we had the opportunity to talk. He said to me there are two reasons why he has become more engaged in the program.

The first was after attending the Spring Training on Telehomecare. He saw how beneficial the program was and contacted CCAC to refer his grandfather into the program. He said that the remote monitoring has been a great help for his grandfather in self-managing his health.

The second was during the Service Review,. The reviewer (a Community Paramedic from Renfrew) talked about his experience working in their Community Paramedicine program, how much positive effect there has been for patients, and how much gratification he gains from the role as a Community Paramedic.

Both these experiences have changed the lens through which Al views the paramedic profession and has created a new interest in our Community Paramedicine program.

Al then told me about an experience he had at the clinics. Through assessments conducted by Al and his peers from Massey and Espanola, they were able to identify undiagnosed hypertension for two patients. The patients were advised to connect with their primary care providers where they went underwent further examination and were provided treatment for their hypertension. In subsequent visits, both of these patients had blood pressures within normal parameters.

As you know, high blood pressure increases the chance of stroke by 4-6 times and for every 10 mm Hg drop in systolic blood pressure achieved through

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Community Paramedicine Update cont.

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medication, heart disease risk drops by as much as one-fifth. Through what seems to be an innocuous assessment, not only has the health of these two individuals improved, potential future call volume and future ER and hospital admissions have been mitigated as well as potential future rehabilitation. This could amount into hundreds of thousands of dollars saved by conducting a simple Community Paramedicine Wellness clinic.

An unforeseen outcome identified at the clinics was the overall mental health benefit. Lynn, the mental health worker we have been collaborating with said "*the sessions have become a place where residents not only have their vitals checked, it is also providing opportunities for social interactions for folks who might otherwise be housebound."* An important outcome that affects the health of many through simple health promotion activities.

With these success stories, I have been asked how we can expand clinics to other more-public locations and possibly into the private homes of patients.

For public locations, I have been busy making contacts with community partners to collaborate on Wellness Clinics. The largest barrier we are faced with is the potential to receive emergency calls and be required to leave or cancel a clinic. By partnering, as in our DSB building example where we have partnered with mental health, we can mitigate the chance of leaving a clinic unattended. More to come on that in the near future.

In regards to conducting Paramedic-initiated ad-hoc visits, Paramedics at anytime are able to conduct a visit with any patients whom are known to them that could benefit from a visit. Please ensure you follow the recommendations from your Community Paramedicine education when planning and conducting these visits and coordinate with CACC and your Field Supervisor to ensure deployment is maintained.

One final note discussed with several paramedics on home visits was "what about the patients that need help, never call 911, and don't know that this type of service is possible"? We are looking at a program where community members could call to book a "cable guy" kind of appointment for a Paramedic to come and conduct a home visit within 72 hours at a time between eight and twelve or one and four (I think you get the idea).

In designing such a program, we have to be careful in how we promote the activities and consider what assessments will be offered to ensure that when an emergency exists, the public will continue to dial 911 and not confuse the issue and decide to call to make an appointment instead because "they don't want to trouble anyone".

All of your hard work is evident in the positive results and success stories. Your continued involvement and suggestions are valuable and will help design the future of Paramedic Services.

If you have any suggestions or ideas, please feel free to contact Commander Wolff

Mental Health and CP cont.

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set of information and can be used to further assess for potential harm or to assess for changes in condition.

The final piece of the puzzle is to whom is the referral made? For now it is treat, transport and report, but the future may tell a different story.

Patient Referrals cont. *(by David Wolff)*

(Continued from page 1)

Consent options have changed to allow more accurate documentation and an option to just select "Referral not required" (if you answered "No" to all three questions).

The selection "Not Obtained-Explanation Required should only be selected if you have answered "Yes" to the questions indicating a referral should be completed but there is a reason to not complete the referral. If this option is selected, an explanation is required to be documented. In the intervention section.

The other options are Obtained, withheld, and implied. The first two are obvious, Implied is potentially grey. Implied would be selected if the patient does not have the capacity or understanding to provide consent. This is simple if you are transporting the patient for care but where concerns arise would be where they are refusing treatment *and* they are refusing a referral. Each situation will be different and the patient's safety is the most important objective when seeking the right resolution.

Phone numbers and Healthcard numbers are required for all referrals. Without them, it makes it very difficult to connect to services.

Feel free to contact Commander Wolff if you have any questions regarding referrals or Community Paramedicine. To close, I have had questions on feedback from CCAC and the referrals paramedics complete. We have not been receiving any feedback but what I do notice is that referral forms for specific patients stop being submitted by paramedics which would indicate that something has changed and the need for extra care is no longer required. Repeat referrals is the best indicator for the level of need of your patients so if you continue to encounter patients in need even after completing referrals, please complete another one as this demonstrates the need to the CCAC Case Managers.

Circle of Care Referrals *(by David Wolff)*

A Circle of Care referral is a request that comes from a healthcare provider to the Paramedic Service requesting a scheduled Community Paramedicine visit with a patient with the purpose to conduct specific activities. A good example is Telehomecare.

I have been meeting with our community partners promoting this part of the program and have generated a considerable amount of interest. As the program evolves and more partners come on board, we will begin to see more referrals from primary care practitioners requesting home visits and requesting direct feedback. We can be the physician's eyes, ears and hands in the community.

When you look at root of the word "paramedic" the Latin prefix "para" means "beyond or beside" and "medic" means "physician or to heal". As our profession evolves, we are moving closer to the root of our moniker and working "beside the physician". Although an abstract thought, this does speak to becoming a part of the greater healthcare team and a step closer to being a practitioner vs a technician.

Open Forum

The EMS Advance accepts autobiographies, articles and letters to the editor. Submissions should be no longer than 350 words. Send Contributions to: David.Wolff@msdsb.net. *The Editor reserves the right to print, not print and/or edit all submissions for length or content*.

Mandatory Quiz

In conjunction with this training bulletin a corresponding quiz is posted on DSB moodle. Successful completion of the quiz is mandatory for all staff and must be completed by the end of the month of publication of the training bulletin.

References

BLS Manual ver 2.0 2007
ACR Completion Manual ver 2.2 2003
MOHLTC Service review 2016