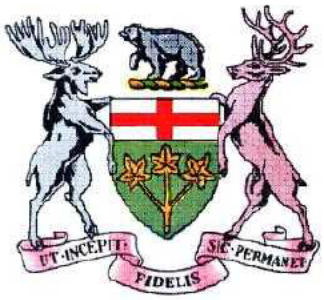

OCCURRENCE NUMBER

INVESTIGATION REPORT 13IS-05-141

MINISTRY OF HEALTH AND LONG-TERM CARE
EMERGENCY HEALTH SERVICES BRANCH
INVESTIGATION SERVICES
August 2013

THIS REPORT HAS BEEN PREPARED BY

INVESTIGATION SERVICES EMERGENCY HEALTH SERVICES BRANCH

MINISTRY OF HEALTH AND LONG-TERM CARE

AND IS AUTHORIZED FOR USE BY THE INTENDED RECIPIENTS

SERVICE:	Manitoulin-Sudbury Emergency Medical Services
INCIDENT LOCATION:	Manitoulin Sudbury
DATE OF OCCURRENCE:	Numerous
TYPE OF OCCURRENCE:	Quality of ambulance service

INTRODUCTION

During a Service Review an Inspector with the Inspection, Certification and Regulatory Compliance Unit (ICRCU) performed a random audit of Manitoulin-Sudbury EMS/SMU (MSEMS) Ambulance Call Reports (ACR) and identified ten (10) ACRs where the paramedics documented they had been dispatched on a Code 4 (urgent) priority but according to the ACRs did not make use of the emergency warning systems.

FINDINGS

1) Subsection 6 (1) (b) of the *Ambulance Act* (The Act) states that every upper-tier municipality (UTM) shall be responsible for ensuring the proper provision of land ambulance service in the municipality in accordance with the needs of persons in the municipality.

2) Subsection 6 (7) (a) of The Act states that a UTM may assume responsibility to fulfill the requirements of subsection 6 (1) (b) of The Act.

3) Subsection 8 (1) (a) of The Act states that no person shall operate an ambulance service unless the person holds a certificate issued by the certifying authority.

4) Subsection 3 (1) of Regulation 257//00 made under The Act requires that the operator of an ambulance service meets the requirements of the *Land Ambulance Certification Standards*.

5) On October 26, 2010 The Manitoulin-Sudbury District Social Services Administration Board (DSSAB) was certified (752-782) as the operator of land ambulance service for the municipality operating as Manitoulin-Sudbury EMS/SMU (MSEMS).

6) The MSEMS Certificate expires on November 10, 2013.

7) In accordance with *The Act* MSEMS was the subject of a certification review in 2013.

8) During the review the ICRC Inspector randomly audited MSEMS Ambulance Call Reports (ACR) and in their report wrote; "*From the 291 calls reviewed by the Inspection Team in 10 cases, which represents 3.43% of the calls reviewed, warning systems were not utilized on calls dispatched priority 4, according to ACR documentation."*

9) Subsections 11 (a), (b) and (d) of Regulations 257/00 states that the operator and the paramedics employed by the operator shall ensure that patient care is provided in accordance with the *Basic Life Support Patient Care Standards* (BLS Standards) and as required the *Advanced Life Support Patient Care Standards* (ALS Standards) as well as the additional patient care and transportation standards per the *Patient Care and Transportation Standards* (PCTS).

10) The purpose of the BLS Standards is to state the minimum acceptable level or range of BLS support of patient care performance expected of paramedics in all Ontario ambulance services.[1]

11) The BLS Standards Section 1 General Standards of Care is applicable at all times when a paramedic is providing patient care while on duty.[2]

12) Point 1 Part B Patient Assessment General Principles of the BLS Standards General Standards of Care states the paramedic will on all scene calls, regardless of dispatch priority coding, assume the existence of serious, potentially life, limb and / or function threatening conditions until assessment indicates otherwise.

13) Part I Patient Refusal of Treatment and/or Transport of the BLS Standards General Standards of Care outlines all steps a paramedic will follow if a patient refuses any proposed treatment and / or treatment and transport, and these steps include ensuring the patient is fully aware of any possible negative impact of the refusal, ensuring the patient has the capacity to make a refusal and documenting the refusal on the ACR which includes the patient's signature.[3]

14) The ALS Standards Consent to Treatment and Capacity Assessment also outlines the steps paramedics are to follow when dealing with a patient's decision to refuse treatment. This section of the ALS Standards also requires the paramedics to comply with the refusal section of the BLS Standards.[4]

15) The ALS Standards Comprehensive Care states in part that when initiating and continuing treatment per these standards a paramedic must ensure that the patient simultaneously receives care in accordance with the BLS Standards.[5]

16) The BLS Standards General Standard of Care (N) Documentation of Patient Care states in part if minimum required assessments and or interventions are not carried out, document specific reasons on the ACR or ensure that routine documentation clearly reflects the situation at scene.

17) Subsection 11.1 of Regulation 257/00 states that the operator and every paramedic employed by the operator shall ensure that documentation is provided by the paramedic in accordance with the "*Ontario Ambulance Documentation Standards* (Documentation Standards).

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[1] BLS Standards Page 2 Purpose of Basic Life Support Patient Care Standards
[2] BLS Standards General Standards of Care Conditions
[3] BLS Standards General Standards of Care Part I Patient Refusal of Treatment and/or Transport Pages 1-13 and 1-14
[4] ALS Standards Introduction Pages 5 and 6
[5] ALS Standards Introduction Page 7

18) Part I Point 6 of the Documentation Standards states that information contained in reports made under this standard will be of a completeness and quality suitable for use as evidence in an investigation or legal proceeding.

19) Part IV of the Documentation Standards requires an ACR shall be completed for each request for ambulance service where a patient was assessed whether or not care and or transport was provided.

20) Point 1 Section N of the BLS Standards requires the paramedic to complete an ACR for each call type detailed in the MOH *Ambulance Call Report Completion Manual* (ACR Manual) in accordance with the procedures detailed in the manual.[6]

21) The Paramedic Conduct Standard contained in the BLS Standards states the paramedic will observe Standards, Policies, Procedures, Protocols and Standing Orders and discharge their duties with honesty, diligence, efficiency and integrity.

22) Point 2 Part A of the BLS Standards General Standards of Care states that the paramedic will use an appropriate route and speed to respond to the scene, adhere to approved driving policies and practices, operate the ambulance and utilize ambulance emergency warning devices in a responsible manner.[7]

[6] BLS Standards Part N Documentation of Patient Care
[7] BLS Standards General Standards of Care Part A Personal and Patient Safety and Protection

23) The following is MSEMS Policy G.6.5. Section 2 dated July 1, 2004;

Manitoulin-Sudbury District Services Board POLICY & PROCEDURES MANUAL	
Section: G. Emergency Medical Services	Effective Date: July 1, 2004
Topic: 6. Vehicles, Equipment & Facilities	Replaces: New
Subject: 5. Use of Emergency Warning Systems	
Policy No. G.6.5.	Page 1 of 2

PURPOSE

To establish a consistent, regulated approach to the use of Emergency Warning Systems within our Manitoulin-Sudbury EMS.

APPLICATION

Paramedics, EMAs, Management

PROCEDURE

1) The Highway Traffic Act of Ontario permits the limited operating privileges to ambulances including the installation and use of a siren and red lights as follows:
   a) Section 96, Subsection 5, Paragraph A:
      "Notwithstanding Subsection 5, where an emergency vehicle, upon which a siren is continuously sounding and upon which a lamp is producing intermittent flashes of red light, visible in all directions, is brought to a full stop at a red signal light, the driver, after ascertaining that such movement can be made in safety, proceed through the intersection without waiting for a green signal light to be shown."

2) The use of emergency warning lighting systems shall be confined to the following situations:
   a) while enroute to Code 4 priority calls;
   b) while parked at the scene of an emergency, when a hazard may be posed by the parked vehicle;
   c) to facilitate entry into the flow of traffic when departing the scene;
   d) while enroute to hospital for Code 4 priority calls;
   e) to increase the visibility of the vehicle or to enhance the safety of the occupants of the vehicle during adverse weather conditions on Code 3 priority calls;
   f) to attract the attention of bystanders when backing up, especially when crowds have gathered.

3) The siren/public address shall only be utilized in conjunction with emergency warning lights.

4) It must be noted that should the ambulance be involved in an accident resulting from proceeding through a red light, the driver may be charged

24) The following is the revised MSEMS Policy G.6.5 dated June 12, 2013.

Manitoulin-Sudbury District Services Board POLICY & PROCEDURES MANUAL	
Section: G. Emergency Medical Services	Effective Date: June 12, 2013
Topic: 6. Vehicles, Equipment & Facilities	Replaces: July 1, 2004
Subject: 5. Use of Emergency Warning Systems	
Policy No. G.6.5.	Page 1 of 2

PURPOSE

To establish a consistent, regulated approach to the use of Emergency Warning Systems within our Manitoulin-Sudbury EMS.

APPLICATION

Paramedics, EMAs, Management

PROCEDURE

1) The Highway Traffic Act of Ontario permits the limited operating privileges to ambulances (as per section 144(1)(b)(ii) including ERV's) including the installation and use of a siren and red lights as follows:
   a) Section 96, Subsection 5, Paragraph A:
      "Notwithstanding Subsection 5, where an emergency vehicle, upon which a siren is continuously sounding and upon which a lamp is producing intermittent flashes of red light, visible in all directions, is brought to a full stop at a red signal light, the driver, after ascertaining that such movement can be made in safety, proceed through the intersection without waiting for a green signal light to be shown."
2) The use of emergency warning lighting systems shall be confined to the following situations:
   a) while responding to Code 4 priority calls or transporting a patient or injured person in an emergency situation;
   b) while parked at the scene of an emergency, when a hazard may be posed by the parked vehicle;
   c) to facilitate entry into the flow of traffic when departing the scene;
   d) to increase the visibility of the vehicle or to enhance the safety of the occupants of the vehicle during adverse weather conditions on Code 3 priority calls;
   e) to attract the attention of bystanders when backing up, especially when crowds have gathered.

   While the above represents circumstances where the use of emergency warning systems is allowed, there may be circumstances where the use of emergency warning systems may be detrimental to a timely response ie. heavy fog or snow. In situations where you do not utilize emergency warning systems as listed above it must be documented on the PCR with the reasons why. Regardless of conditions where usage may be detrimental it is essential that when driving an emergency vehicle in a privileged manner as detailed by

25) The ten (10) ACRs identified by the Inspector were dated from August 15, 2012 to June 1, 2013 and were reviewed for this investigation to determine if the documented care met the BLS/ALS and Documentation Standards.

The following are the results of that review:

Note: A review of the Sudbury CACC Call Details Reports (CDR) confirmed all of the calls were dispatched as Code 4 (urgent) priorities. None of the calls were the subject of an audit by MSEMS.

- Two (2) of the ACRs contained documentation indicting emergency lights and/or sirens were used enroute to a scene.

- All MSEMS paramedics are certified by the Northeastern Ontario Prehospital Care Program (NEOPCP) as Primary Care Paramedics (PCP) with two additional auxiliary skill sets (Gravol and CPAP).

Call Number [redacted] 2012.

Paramedics	PCP [redacted] and PCP [redacted]
Dispatched	Code 4, [redacted] year old male patient, generally unwell
History;	Arthritis.
Chief Complaint;	Acute vomiting, Failure to Cope
BLS / ALS Issues;	No use of cardiac monitor (HR greater than 120)[8] Patient was given 25 mg Gravol. Pt weight 50 kg. (50 mg dose)[9]

Documentation

Time of call	[redacted] hours.	
Responded from	B [redacted]	
Documented dispatch Code 4	No use of emergency systems.	
ACR mileage	1 km	Google mapping – 1km
Response time	2 minutes	Google time 2 minutes
Route	Appropriate based on AVL	
On Scene time	13 minutes	
Return Code	3 CTAS 3 Generally unwell but improved.	

[8] Basic Life Support Patient Care Standards 1-6 (7) bullet point 11
[9] Advanced life Support Patient Care Standards Auxiliary Medical Direction

BHP Audit Issues	No use of cardiac monitor No oxygen provided Wrong dosage of Gravol provided.

BHP reviewed issues with PCP [redacted] - no follow up required.

Service Audit	No audit
Issues	Same as BHP findings

Call Number [redacted] 2012.

Paramedics	PCP [redacted] and PCP [redacted]	
Dispatched	Code 4, [redacted] year old chest pain, abdo pain	
History	Cancer, diabetes, cardiac valve replacement.	
Incident History	Abdo pain last evening. Colostomy bag blocked.	
Chief Complaint	GU problem other	
BLS/ALS Issues	None	

Documentation

Time of call	[redacted] hours. Crew notified at 02:22:47 hours	
Responded	from Base ([redacted]	
Documented dispatch	Code 4	No use of emergency systems.
ACR mileage	0 km	Google mapping <1km
Response time	3 minutes	Google time <1 minutes
AVL DATA	Crew mobile at [redacted]	CACC time [redacted]
	Arrive at [redacted] hours	CACC time [redacted]
	Response time 61 seconds	
Route to scene	Appropriate based on AVL	
On Scene time	9 minutes	
Return Code	3 CTAS 3 obstruction/anatomical/other.	
BHP Audit Issues	No audit	

Service Audit	No audit
Issues	None

Call Number [redacted] 2013.

Paramedics	PCP [redacted] and PCP [redacted]
Dispatched	Code 4, Head Trauma post assault (call from the PD)
History	Asthma.
Incident History	*Patient at pow wow the previous evening. Assaulted with fist to frontal region of head no LOC Hitchhiked to police station the next day and called 911.*
Chief Complaint	Assault
BLS / ALS Issues	None

Documentation

Time of call	[redacted] hours.	
Responded from	Base ([redacted]	
Documented dispatch	Code 4	No use of emergency systems.
ACR mileage	0 km	Google mapping <1km
Response time	5 minutes	Google time <1 minute
Route of Travel	Unknown	
On Scene time	10 minutes	
Return Code	72	
BHP Audit Issues	No audit	
Service Audit:	No audit	
Issues	None	

Call Number [redacted] 2013.

Paramedics	PCP [redacted] and PCP [redacted]
Dispatched	Code 4, abdominal pain.

History	None
Incident History	Abdo pain started yesterday, pt had gall bladder removed [redacted] days ago and had catheter for drainage at site. Pt feels bloated; no N&V slow bowel movement.
Chief Complaint	Abdo pain
BLS / ALS Issues	None

Documentation

Time of call	[redacted]
Responded	From Base ([redacted]
ACR Documented	Code 4 No use of emergency systems
ACR mileage	5 km
Response time	4 minutes
Route of travel	Unknown no AVL data
On Scene time	10 minutes
Return Code 3	CTAS 3.
BHP Audit Issues	No audit
Service Audit:	No audit
Issues	None

Call Number [redacted] 2013.

Paramedics	PCP [redacted] and PCP [redacted]
Dispatched	Code 4, [redacted] year old male ischemic chest pain [redacted]
History	CVA, CABG hypertension
Incident History	Feeling weak and nauseated, walked into his home and became pale and vomited. CABG last week. Has non ischemic pain from surgery. Blood sugar 4.6 pt states that is low for him. 16 at lunch time. Pt said no change in his chest pain today.
Chief Complaint	Dizziness

BLS / ALS Issues	No administration of nitro or ASA. Patient had history of nitro usage.

Documentation

Time of call;	[redacted] hours.
Responded	From Base ([redacted]
ACR Documented	Code 4 - used emergency systems enroute.

Note: AVL confirmed no use of lights and sirens during the entire call.

ACR mileage	14 km	CACC data showed 9.8 km
Response time	12 minutes	CACC data showed 10 minutes
AVL DATA	Actual travel time of 9 minutes 3 seconds	
	Actual mobile time [redacted] hours	
	CACC mobile time [redacted] hours	
	Average speed 63 km/hr Top speeds of 90 km/hr	
	Lights and sirens not used	
Route of Travel	Appropriate based on AVL	
On Scene time	15 minutes	
Return	Code 3 CTAS 3.	
Travel time to Hospital	11 minutes 10 kilometres	
BHP Audit Issues	No audit	
Service Audit	No audit	

Issues Cardiac history, recent CABG, acute dizziness, N&V pale chest pain (noted as unchanged since surgery).

No nitro or ASA provided

Documented use of lights and sirens to the scene - AVL did not identify any use of warning systems.

Speeds were consistent with normal driving speed limits.

Call Number [redacted] 2012.

Paramedics	PCP [redacted] and PCP [redacted]
Dispatched	Code 4, Overdose [redacted]
History	None
Incident History	[redacted] year old male took 10-15 citalopram with alcohol. Denies suicidal thoughts just took his fathers medication to feel happy, history of depression.
Chief Complaint	Intentional overdose
BLS / ALS Issues	Patient refused to be touched or examined. Pt permitted the obtainment of a blood pressure. Patient initially refused transport until advised he had to go with either the PD or the ambulance. Pt walked to ambulance and transported on the stretcher.

Documentation

Time of call	[redacted] hours.	
Responded from	Base ([redacted]	
Documented dispatch	Code 4	No use of emergency systems.
ACR mileage	10 km	Google mapping – 10km
Response time	9.4 minutes	Google time - 9 minutes
AVL Data	Mobile at [redacted] hours	CACC time [redacted]
	Travel time [redacted] minutes	CACC time [redacted]
Average speeds enroute	88 km/hr max speed 105 km/hr	
Route to scene	Appropriate based on AVL	
On Scene time	12 minutes	
Return Code	3 CTAS 3.	
BHP Audit Issues	No audit	
Service Audit	No audit	
Issues	No patient refusal section documentation.	

Note: the paramedic documented in the procedures section the patient's reported refusal for certain procedures.

Response speeds were consistent with the posted speed limits.

Call Number [redacted] 2012.

Paramedics	PCP [redacted] and PCP [redacted]	
Dispatched	Code 4, [redacted] female ischemic chest pain	
History	Bronchial infection	
Incident History	Pressure in center of her chest moving down her left arm to the elbow and rawness in her throat. Pt went to clinic who told her to go to the ambulance base for assessment. Pt said the same symptoms presented yesterday three times. Today symptoms started after she had a smoke.	
Chief Complaint	Cardiac chest pain.	
BLS/ALS Issues	None.	

Documentation

Time of call	[redacted] hours.	
Responded from	Mobile	
Documented dispatch	Code 4	No use of emergency systems.
ACR mileage	0 km	
Response time	0 minutes	CACC data showed <1 min

Note: Audio confirmed paramedics were flagged down to assist the patient located near the base.

AVL Data	Depart to hospital [redacted] hours CACC time [redacted]	
Travel time to Hospital	AVL 29:44 minutes	CACC time 30:42 minutes
Average Speed to Hospital	95 km/hr top speed of 124 km/hr - no use of emergency systems enroute to hospital	
Distance to Hospital	45 km	
Route of travel	Unknown no AVL data for route.	

On Scene time	4 minutes
Return Code	3 CTAS 3.
BHP Audit Issues	Paramedic documented the administration of nitro then documented the patient did not meet the nitro criteria. Paramedic used nitro code (eACR) but did not administer Nitro due to contraindications.
Service Audit	No audit

Note: Load and Go Standard Code 4 return chest pain-suspect AMI or other serious disorders

Issues Code 3 return with cardiac chest pain requiring ASA intervention. 29 minute transport time to hospital. Speeds exceeded highway speeds - no warning systems used (Note call occurred at [redacted] am)

Call Number [redacted] 2013.

Paramedics	PCP [redacted] and PCP [redacted]
Dispatched	Code 4, Trauma Assault
History;	None
Incident History	Patient assaulted at his house no lOC walked to neighbour called 911.
Chief Complaint	Head trauma
BLS / ALS Issues;	None

Documentation

Time of call	[redacted] hours.	
Responded from	Base ([redacted]	
Documented dispatch	Code 4	No use of emergency systems.
ACR mileage	13 km	CACC data showed 9.2 km
Response time	13 minutes	CACC data showed 9 minutes
AVL DATA	Crew Mobile at [redacted]	CACC Mobile [redacted]
	Response time 10:23 minutes	
Average speed	62 km/hr maximum speed 79 km/hr	

Route of Travel	Appropriate based on AVL
On Scene time	20 minutes
Return Code	72.
BHP Audit Issues	No audit
Service Audit	No audit
Issues	Response time at or lower than posted speeds

Call Number [redacted] 2012.

Paramedics	PCP [redacted] and PCP [redacted]
Dispatched	Code 4 - attempted suicide by Hanging
History	None
Incident History	[redacted] year old male came home from court feeling discouraged. Argued with his dad and went to his room and attempted to hang himself with a belt but when he stepped off the chair the belt broke and he fell to the ground and possible broke the bridge of his foot. No complaints of any back or neck pain. No LOC.
Chief Complaint	Suicidal
BLS/ALS Issues	Pt had pink marks around his neck. No cervical spine assessment documented… under Abdomen assessment …. NO SOB No cervical spine control. *Pt was complainant to come to the hospital but didn't want any treatment. Pt did not appear in any distress and outside of a pink mark on his neck had no pain,* *Pt refused stretcher and walked to ambulance*

Documentation

Time of call	[redacted] hours.
Responded from	Base ([redacted]
Documented dispatch	Code 4 - no use of emergency systems.
ACR mileage	10 km

Response time (ACR)	10 minutes
AVL DATA	Mobile at [redacted] CACC time [redacted]
	Response time 9:29 minutes
Average speeds	90km/hr Maximum speed 114 km/hr
Route of Travel	Appropriate based on AVL
On Scene time;	15 minutes
Return Code	3 CTAS 3.
BHP Audit Issues	No audit
Service Audit:	No audit
Issues	No patient cervical spine assessment or refusal section documentation.

Response time consistent with km travelled at posted speeds.

Call Number [redacted] 2012.

Paramedics	PCP [redacted] and PCP [redacted]
Dispatched	Code 4, non traumatic bleeding
History;	Asthma, haemophilia
Incident History	[redacted] year old female DNC four days previously. Started bleeding heavily two days ago and it increased. Pt is clotting well with one clot we saw the size of a golf ball. Blood is bright red in colour. Pt states she had gone through four pads today by noon. Pt pain is in her lower abdomen and is pulling, intermittent and nothing makes it better. Pain also radiating in her lower back.
	Patient bradycardic BP 120/80
Chief Complaint	Vaginal Bleeding
BLS/ALS Issues	No oxygen provided[10]
	Pt able to walk on her own
	No Refusal section completed, no ATC or patient signature

[10] Basic Life Support Patient Care Standards I-48, 2-55

	for refusal to be carried	

Documentation

Time of call	[redacted] hours.	
Responded from	Mobile	
Documented dispatch	Code 4 - documented use of lights and sirens.	
ACR mileage	24 km	CACC data showed 12 km
Response time (ACR)	12 minutes	CACC data showed 12 minutes
AVL DATA	Mobile at [redacted] (CACC [redacted]	
	Confirmed use of lights and occasional use of siren	
Response time	11:31 minutes	
Average speeds	85 km/hr	
	Maximum Speeds 124 km/hr for approx three (3) minutes (No warning systems)	
Route of Travel	Appropriate based on AVL	
On Scene time;	12 minutes	
Return Code	3 CTAS 3.	
BHP Audit Issues	No audit	
Service Audit:	No audit	
Issues	No Oxygen provided. Incorrect response kilometres.	

MSEMS Quality Assurance Program

26) The certified operator of an ambulance service is required to ensure that patient care and the documentation of said care is provided in accordance with the legislated standards. In order to comply with this requirement a service needs to have a Quality Assurance (QA) program in place.

27) The MSEMS Director said their QA program consists of paramedic training and continual education programs overseen by one staff member and ACR audit and qualification reviews performed by another staff member (Commander of QA (CQA)).

28) On scene evaluations are completed by an on duty Supervisor when time and resources permit.

29) The following is the revised MSEMS QA Policy G.7.2

Manitoulin-Sudbury District Services Board POLICY & PROCEDURES MANUAL	
Section: G. Emergency Medical Services	Effective Date: June 10, 2013
Topic: 7. Administrative Directives	Replaces: July 1, 2004
Subject: 2. Patient Care Report Audits	
Policy No. G.7.2.	Page 1 of 2

PURPOSE

All PCR audits will meet standards as set out by the Ministry of Health and Long-Term Care

APPLICATION

Paramedics, EMS Management

PROCEDURE

1) The Commander of QA will compare Ambulance Dispatch Information System records with Manitoulin Sudbury EMS Patient Care Records to ensure that an ambulance call is done for each request for ambulance service where a patient was assessed whether or not care was provided or the person was transported by ambulance or emergency response vehicle.
2) The Commander of QA will ensure that completed Patient Care Records will be distributed within 48 hours of completion of the call to:
   a) Receiving hospital staff
   b) Base hospital
   c) Billing
   d) Manitoulin Sudbury EMS
3) The Commander of QA will Audits PCR's and consider the following fields:
   a) Administration – Surname, Given Name, Address, DOB, Date, Call #, CACC, Warning System, Service Name, Service #, Station #, Status, Vehicle #, Mileages, UTM Code, Pickup Location, Pickup Code, Dispatch Problem Code, Dispatch Sent Code, Return Code, Patient #, Sequence, Event Times, Driver #, Driver Name, Driver Signature, Attendant #, Attendant Name, Attendant Signature, No Patient Carried name and signatures, No Patient Carried witnesses and signature, travel conditions, Offload Delay, Personal Effects
   b) Patient Care –Chief Complaint, Primary and Secondary Problem Codes, , Time of Occurrence, Incident History, Past History, Traumatic Injury Site/Type, Medications, Allergies, Treatment prior to ambulance arrival, Cardiac Arrest Information, Age, Gender, Weight CTAS, General Appearance, Physical Findings, Vital Signs, Procedures, Remarks, Final Primary Problem, Final Status, Receiving Location, Receiving Signature.

Manitoulin-Sudbury DSB Policy & Procedures Manual

30) MSEMS Policy G.7.2 does not indicate that the CQA ensures the documented patient care is provided in accordance with the BLS or ALS Standards or what action the CQA will take to address any contraventions of the standards.

31) The MSEMS QA program includes the investigation of complaints.

32) The MSEMS Second Quarter Report (SQR) 2013 indicated the service received and investigated four (4) complaints with one (1) of the four (4) being made by a member of the public. All four investigations included recommendations to address any identified concerns.

33) The MSEMS Director said all recommendations were completed to address the identified concerns.

34) MSEMS uses an electronic ACR program (ZOLL) that allows the paramedics to complete and distribute the ACR in accordance with the Documentation Standard.

35) The MSEMS Director said the electronic ACR program uses closed call rules to ensure a paramedic enters data into each field identified as mandatory per the Documentation Standard.

36) [redacted]

37) The MSEMS Director said the service recently added a close field exception rule whereby a paramedic cannot close an ACR for any dispatched Code 4 call unless they enter the use of the emergency warning systems or a reason for not using them.

38) In an email the Director wrote "*Regarding auditing for patient care we do not have set targets but we measure accuracy of patient care in many other different ways. We started discussions with our Base Hospital to use an electronic means to audit 100% of PCR's for patient care this past spring.*"

39) The MSEMS Director said the discussions were delayed due to personal and operational issues.

40) The Director wrote "*In the meantime, to span the time until the electronic process is operational, we will be increasing the number of PCR audits that we perform to fall within the standard of what our Base Hospital performs in their Performance Agreement with the MOHLTC*"

41) Based on the Sudbury CACC Ambulance Dispatch Reporting System (ARDS) during the second quarter of 2013 (April, May and June) 2013 MSEMS was assigned fourteen hundred and fifty (1450) calls; 205 calls were Code 1, 375 calls were Code 3 and 870 were Code 4.

42) The MSEMS SQR identified sixty-one (61) ACRs (.04 % of total calls for the same time period) were audited for completion in accordance with the Documentation Standard and to ensure the documented patient care was appropriate and consistent with the BLS and ALS Standards.

43) Of the 61 ACRs audited, six (6) were dispatched Code 1, fifteen (15) Code 3 and forty (40) were Code 4s.

44) Of the 61 ACRS, 5 Code 1 calls met the legislated standards (83%), 10 Code 3 calls met the standard (67%) and 27 Code 4 calls met the standard (68%).

45) In total 27% of the 61 calls audited did not meet the standard. The report did not specify what the contraventions were.

46) In his email the MSEMS Director wrote most of the identified issues were determined not to be contraventions of the BLS/ALS Standards but poor documentation. He said the subject paramedics were remediated on the legislated standards.

47) The SQR stated all audit discrepancies were investigated and resolved.

48) None of the 10 ACRS identified by the ICRC Inspector were audited by SMEMS.

49) The Land Ambulance Certification Standard requires the operator to have a valid agreement in place with the designated Base Hospital Program for the delegation of controlled acts by paramedics employed with the service.

50) MSEMS has a valid agreement with the NEOPCP to provide certification, medical oversight and auditing of ACRs where ALS interventions have been documented as being provided.

51) The electronic ACR system used by MSEMS is not compatible with the NOEPCP electronic programs so MSEMS electronically sends all completed ACRs to a third party provider, who data entries the information into the NEOPCP data system for auditing.

52) The NEOPCP Performance Measurement Lead (PML) said in accordance with the Performance Agreement (PA) with the Ministry and the Memorandum of Understanding (MOU) with MSEMS they audit all ACRs in which ALS interventions have occurred or based upon documented patient chief complaint and primary complaint calls ALS interventions should have occurred.

53) The PML said their expectation is to audit all ACRs in which a “high risk” patient or intervention was required i.e. cardiac arrest, administration of epinephrine and the administration of glucagon with a subsequent patient refusal.

54) The PML said at minimum, NEOPCP is required to audit five (5) ACRs where ALS intervention was documented as being provided for every paramedic employed in their catchment area on a yearly basis.

55) The PML said the auditors will review lower priority calls if no high risk calls are present for a given paramedic

56) The PML said the auditors review the patient care and documentation for all ALS interventions or high risk calls and where no interventions were required they review the ACR for BLS patient care. Any contraventions of the BLS Standards identified are forwarded to the PML for further review.

57) The PML said where BLS and / or documentation issues are confirmed he forwards the issue to the paramedic and the service for follow up.

58) In a 2011-2012 report NEOPCP identified they audited 135 out of the 157 (86%) MSEMS ACRs in which ALS interventions were documented.

59) The report identified 15 (14%) of the MSEMS paramedics had no documented ALS interventions for the year and 45% had completed fewer than five ACRs where ALS interventions were documented.

60) During the second quarter of 2013 the NEOPCP (first quarter report) identified 116 MSEMS ACRS had indicated ALS interventions had been provided of which 96 (82%) of the ACRS were audited.

61) During the second quarter of 2013 NEOPCP performed an audit of 111 ACRS of which both ALS and / or BLS patient care was provided. Based on ARDS data this represented .08% of the total ACRs completed by MSEMS during the second quarter.

62) Of the 111 ACRS audited, nine (9) (.08%) were identified as having patient care variances, two (2) were rated as minor, four (4) were major and two (2) were critical. These 9 calls were reviewed with the subject paramedics and resolved to the satisfaction of the NEOPCP Medical Director.

63) MSEMS management were copied on the nine audits.

64) Based on the NEOPCP first quarter report, seventy (70) of the one hundred and nineteen (119) (58%) MSEMS paramedics have not been audited to date.

CONCLUSIONS

↘ The review of the ten ACRs identified the following concerns;

- Failure to complete the Patient Refusal Section of the ACR for patient refusals of patient care and or assessments.
- Failure to provide the required patient care and or errors in administration of medication or questionable assessment.
- Return Code 3 for acute cardiac chest pain.
- Documented use of warning systems to the scene when according to AVL data none were used.

↘ The review of the AVL for the 10 calls identified the following:

- Response times to Code 4 calls generally consistent with travel at the posted speed limits.
- On several calls the response speeds to the scene and travel speeds to the hospital were significantly over maximum speed limits with no use of emergency warning systems.
- Appropriate route travelled (100%).
- 5 of the calls were 1 to 5 km from the ambulance location at time of dispatch.
- 5 of the calls were 10 to 14 km from the ambulance location at time of dispatch.

↘ There is no legislative requirement for a paramedic to use emergency warning systems while responding to any ambulance call.

(Finding 22)

↘ MSEMS policy does not mandate the use of emergency warning systems for response to any call or travel to a receiving facility.

(Findings 23 and 24)

↘ There is no evidence that not using emergency warning systems had a negative impact on the patient's condition.

(Finding 25)

↘ PCP [redacted] and PCP [redacted] were in contravention of the Documentation Standards and the Paramedic Code of Conduct Standard for documenting the use of emergency warning systems when AVL confirmed the warning systems were not activated during the response.

(Findings 18 and 25)

↘ The MSEMS QA program is not appropriately auditing ACRs to ensure compliance with the legislated standards in accordance with Subsections 11 (a), (b) and (d) of Regulation 257/00 made under the *Ambulance Act*.

(Findings 9, 23, 24, 26, 41, 42, 43 and 44)

↘ The NEOPCP QA program meets their expectation for auditing MSEMS ACRs in accordance with their PA and MOU, and the program addresses identified variances and reports the findings to MSEMS management.

(Findings 49-64)