

Friday Night [under the] Lights 2013



Happy Friday.

I'm writing to you this week from Springfield, Massachusetts (every time I type that I thank goodness for spellcheck...). I had the privilege this week of a pretty interesting series of visits with many of our colleagues here in Springfield, New Haven, Hartford and Brockton before participating in the Massachusetts EMS Conference. Great week.

To say it was impactful would be a major understatement. I saw some things this week that are among some of the best in class EMS Practices I've seen in a gazillion years. Not only that, but the leaves are changing - and for those of us that live in Texas, it's a nice reminder that there are more seasons than Summer and almost Summer.

One of the more interesting events this week happened here:



This is O.R. 2 at Sims Medical Center of Springfield Technical Community College (don't you dare call it a Simulation Center; it's a medical center with patients not manikins). Jim Welcome and his colleagues at Springfield AMR along with Lori Burns of AMR Learning are working on a unique collaborative partnership to develop an educational alliance with the STCC.

Sims Medical Center just implemented use of a simulation ambulance, complete with a patient and a compartment that's outfitted with cameras that feed info via the internet either to a central location or to the instructor who rides in the front passenger seat and controls the scenario from there.

While I've visited many simulation centers in the past few years, STCC is the only site I've seen where simulation can occur in an ambulance literally driving through the city – real time. Real deal. The instructor has the ability to manipulate and monitor patient simulation in the moving vehicle (complete with the absolute most realistic “simulated poop” I've ever seen/smelled). It is, bar none, the most “close to real life” training in an ambulance I have seen in my career. I'm reminded that our partners for the Annual AMR Safety Competition in Colorado – Community College of Aurora house the best SCENE based simulation I have experienced in my career.

Like this from the outdoor alley scenario in Aurora:



(Yes, real sparks...).

I bring both these institutions up because of the importance of establishing state of the art educational environments in partnership with those that build excellence. They are both nationally known for their expertise. Simulation science advances every day, and much like the aviation industry, these new educational experiences help improve care and enhance safety in ways that are almost impossible to reproduce in a classroom. Hats off to Springfield & AMR Learning for exploring this...

Oh yeah. By the way, as we were walking out of the O.R. of Sims Medical Center, Jeff Boyd grabs me, walks me over to the wall by the sterile supply and points to *this*...

Only You Can Prevent Surgical Fires
Surgical Team Communication Is Essential

The applicability of these recommendations must be considered individually for each patient.

At the start of surgery:

- Enriched O₂ and N₂O atmospheres can vastly increase flammability of drapes, plastic, and hair. Be aware of possible O₂ enrichment under the drapes near the surgical site and in the fenestration, especially during head/neck surgery.
- Do not drape the patient until all flammable preps have fully dried.
- Fiberoptic light sources can start fires: Complete all cable connections before activating the source. Place the source in standby mode when disconnecting cables.
- Moisten sponges to make them ignition resistant in oropharyngeal and pulmonary surgery.

For surgery with open delivery of supplemental O₂:

- Question the need for 100% O₂ for open delivery during head/neck surgery.
- As a general policy, use air or ≤30% O₂ for open delivery to the face.
- Arrange drapes to minimize O₂ buildup underneath.
- Keep fenestration towel edges as far from the incision as possible.
- Use an incise drape to isolate head and neck incisions from O₂ and alcohol vapors.
- Coat head hair and facial hair (e.g., eyebrows, beard, moustache) within the fenestration with water-soluble surgical lubricating jelly to make it nonflammable.
- For coagulation, use bipolar electrocautery, not monopolar electrocautery.

During oropharyngeal surgery:

- Scavenge deep within the oropharynx with separate suction to catch leaking O₂ and N₂O.
- Soak gauze or sponges used with uncuffed tracheal tubes to minimize gas leakage into the oropharynx, and keep them wet.

When performing electrocautery, electrocautery, or laser surgery:

- Stop supplemental O₂ (if O₂ concentration is >30%) at least one minute before and during use of the unit, if possible.
- Activate the unit only when the active tip is in view (especially if looking through a microscope or endoscope).
- Deactivate the unit before the tip leaves the surgical site.
- Place electrocautery electrodes in a holster or another location off the patient when not in active use (i.e., when not needed within the next few moments).
- Place lasers in standby mode when not in active use.
- Do not place rubber catheter sleeves over electrocautery electrodes.

Reference: ECRI. Surgical fire safety [guidance article]. *Health Devices* 2006 Feb;35(2):45-66.

For more information, or to purchase full-color, glossy versions of this poster (11" x 17" in), contact ECRI:
2000 Butler Pike, Plymouth Meeting, PA 19422-1288, USA
Telephone: +1 (610) 825-6000 • Fax: +1 (610) 834-1275 • E-mail: healthdevices@ecri.org

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I love it when a plan comes together...

I learned a lot from our Northeast colleagues the past few days. And over the next few weeks, I'm going to share a few things I think they do better than I've ever seen. But before I do, I want to get a little philosophical on you. It's about our collective Journey to Excellence – our passion to be the best at what we do, and be able to prove it.

I know some of you have said "here goes Racht again. Everything is *amazing, fantastic* and the *best ever*... Mr. Rose Colored Glasses strikes again. He sugar coats everything he sees and doesn't talk about what's REALLY going on out here". Blah, blah, blah...

How about a FNuL that highlights utterly disastrous practices, points fingers at horrible operations and calls out those that are lazy, doing a crappy job or just not meeting the expectations most of us have for this organization? How about a “Worst things I’ve seen in AMR” issue? Or maybe some pictures of the most disgusting practices I’ve seen or the sloppiest dressed? Most out-of-date educational materials? Nastiest trucks?

I certainly could. Frankly, I’m pretty sure FNuL readership would quadruple if I cranked out an issue like that (it would probably be the most forwarded FNuL ever). Same reason I go straight to the “Licensure Action” sections of the Board of Medicine Newsletters I get – see who I know... Get the scoop on who’s in trouble.

So, I want to take a minute and share a perspective I’ve adopted over the past several years in medicine. I think it’s served me well and it’s helped me better understand the complexities of a large group of diverse people who want to build excellence with different tools, different challenges and different approaches. I guess you could almost call it my personal approach to finding out how to get to “True North”.

And then, at the end, I’m going to ask every one of you to do something for our Practice. A favor that I will appreciate immensely, and, I think, will prove my point...

So, here I go. Humor me.

All of us see good, bad & ugly every single day in our professional lives (remember my discussion last week about identifying clinical performance based on the data?). Regardless of our roles, our organizational positions or the practices we’re in. We see it.

And when we see something that’s good, we’re impressed. We have a positive response. Like the Sims Medical Center ambulance (holy crud, I thought – what a great idea – look how they rigged up the front seat to create an educator command position). It creates an interest. Our minds mull over how we could do something cool like that, right?

On the other hand, when we see something bad, we have a negative response (look how dirty this ambulance is – I’d never want to be a patient looking at the rails on that cot – what a disaster). People move away from negative experiences and distance themselves from the situation. Most of us don’t really want to learn more about it, and many won’t attempt a fix at all – they just want to move on (not my problem...).

Then, of course, there’s ugly. Something so bad, it requires immediate response (can you believe someone wrote “this piece of \$h\# patient didn’t need 911 in a narrative?”). These are the things we encounter that create a Big Response. I really don’t need to say much more about this one... Everyone gets this.

So, as we continue to grow as an organization (the largest practice of EMS medicine in the U.S.), we have to pay attention to the good, the bad & the ugly. But each of those categories changes our collective behavior and impacts our Journey in a different way.

We could look for all the bad, right? Once we find it, we do what we need to to fix it. If this were raising kids we were talking about, this is the mommy / daddy discipline scenario, right? Dirty ambulance? Clean it up – take some time off – get a letter, etc. Let there be no question. This approach changes behavior – but it does it one event or one problem at a time with a limited impact on the organization as a whole. Correcting bad moves us back to acceptable. Creating good moves us up to the next level.

For example, penalties for 30-day hospital readmissions fit into this category. Find bad (high readmissions), discipline it (financial penalty). Change to “better”. Problem addressed. Next?

But readmission reduction programs that shine – Those that use unique approaches to solving big problems – those that can demonstrate success grab people’s attention. People engage more in the “good” category (why do we watch the fastest car in NASCAR, not the trailing last place driver?) We want to know more about things in the “good” category. We’d love to do something even better.

So, I choose to highlight experiences I have, or stories I hear, or people I meet that make a positive impact. As we continue on this Journey to Excellence, I want us ALL to see who’s doing things really well and for us ALL to figure out ways we can do the same in our own roles. We learn from each other and shame on us if we don’t take the enormous experience and expertise of each other and craft a practice of medicine that all of us are proud to call the absolute best.

And shame on us if we don’t have fun doing it and take immense pride in it.

Sounds corny, eh? Maybe a little too soapbox?

Here’s my theory. If we continue to learn about what each other is doing, specifically what we feel we do extraordinarily well, and we start spreading that expertise, we will make significant positive change across the board in a very short period of time. Our patients will get better care, our colleagues will have a better professional life and our industry and profession will be better off because of what we do.

That’s why I love to highlight the good. It motivates us all. The bad will still always be managed. It’s our responsibility. But simply fixing bad alone, without creating good, is not the complacent place we want to be.

When bad sees what good can do, bad changes.

Those are my Rose Colored glasses.

So, I have a favor to ask.

I want to know who does a great job measuring and communicating the importance of ETCO₂ and use of the respiratory distress scale. Our data indicates we can do much better. I want to know who does it best, how you do it and I want to share it with the rest of our Practices.

Epilogue...

Thanks to L (I only give her initial so she can keep network access and her outlook up) for her interesting observation of inner workings of the mind of our IT colleagues:

A computer programmer was sent to the grocery store by his wife and told to buy a loaf of bread and if they had eggs, to pick up a dozen.

He came home with 12 loaves of bread.

His wife asked "Why 12 loaves?" He replied, "They had eggs."

That's it from my world. *Happy Friday.* Thanks for helping build such a strong Practice.

Ed

Edward M. Racht, MD
Chief Medical Officer
AMR / Evolution Health
ed.racht@emsc.net