What’s Happening at WCH

WCH Recognized as a Primary Stroke Center
Meets standards to support better outcomes for stroke care

Wooster Community Hospital (WCH) received certification as a Primary Stroke Center from DNV-GL Healthcare, affirming the readiness of WCH to manage a full range of stroke-related medical problems. Receiving certification emphasizes the hospital’s commitment to offering advanced resources and to providing the best possible stroke care to the community. Additionally, this certification recognizes the importance of maintaining the equipment, personnel, and training necessary to assess and treat strokes quickly. Receiving certification validates the dedication and effort that WCH has put into its stroke program, ensuring patient health and safety. “WCH is proud to receive certification as a Primary Stroke Center. As the only Primary Stroke Center in Wayne County we feel this certification acknowledges that we are committed to a higher level of care and aim to help our patients return to living life as normally and quickly as possible,” said Stroke Program Coordinator Karrie Boss, MSN, APRN, ACCNS-AG, CCRN.

October 2018 to February 2019

Total EMS Transports- 2,180
Best EMS-to-Balloon Time- 19 minutes!
Best EMS-to-Needle Time- 41 minutes!
EMS info/ Up and coming classes:

New and Upcoming classes to be announced for EMS Education in 2019

- **ASLS:**
  - July 16

- **ACLS/BLS Combined Class:**
  - May 17
  - June 13
  - July 16
  - August 14
  - October 23
  - November 20

- **ACLS Initial Class:**
  - Sept. 12 & 13

- **BLS Only:**
  - June 18
  - August 21
  - September 17
  - December 18

- **PALS:**
  - September 6
  - December 2

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**Shout outs!**

Wooster Community Hospital would like to acknowledge the following agencies and providers for a job well done!

**Stroke**
- 3 t-PA for 2019
- 2 brought in by squad
  - January: Clinton Township.
  - No prenotification
  - Door to Needle 58 minutes

March:
- Wooster City
  - + prenotification
  - Door to Needle 53 minutes

18 Stroke alerts in the ED for 2019
- 14 brought in by squad
- 12/14 with hospital prenotification of stroke 86%

- **STROKE**
  - Door-to-Needle Goal<45min

- **STEMI**
  - EMS-to-Balloon Goal<90min

- **YTD:** FMC to primary PCI is 66 minutes – this is amazing!

- **YTD:** percentage of patients with ACS symptoms arriving via EMS: 24% - this is always an area for improvement
Be curious—you should want to know more and ask questions to uncover medical and social details about your patient.

I was recently referred to a physician specialist I’d never met before. After the medical assistant came into the room, took my vitals, and had me sit on the paper sheet, the physician entered, pushing a standing desk with a laptop on it. She began to ask me questions about some symptoms and hurriedly type the responses. She didn’t look up from her laptop once and, to my further dismay, didn’t even smile at my poor joke about feeling like an item from the deli counter sitting on a piece of butcher paper. It got me to thinking about my time on the ambulance and a trend I’ve seen, especially with younger partners: a rise in reliance on our technology devices and the lost art of patient conversation.

Ten years ago we called someone so focused on their PCR boxes that they never really acknowledged the patient “Captain Clipboard.” Nowadays, with most agencies using computer-based PCRs for patient information and billing, the updated version is “Lieutenant Laptop,” that provider so busy entering information that their patient communication is limited, much like my specialist. Perhaps because folks are so intent on entering information, once it is entered, I have often noticed unfortunate silence in the patient compartment beyond the clacking of laptop keys.

Patients call EMS because they are having a bad day. They look to EMS for a ride, treatment, and hopefully some caring behavior. If the patient isn’t critical, once your assessment and vital signs are complete, the call may simply be a “monitor and transport.” This presents a great opportunity for nonmedical conversation, which is a form of caring behavior and can be seen as a treatment. It also allows the EMT or paramedic to continually assess the patient’s mentation and response to verbal stimuli.

Consider the acronym TAP ACE as a way to engage some of these patients during the ride to the hospital:

T = Tell me—Not sure how to start a conversation? “Tell me…” is a great lead-in:
  • “Tell me about that photo I saw on the table in your apartment.”
  • “Tell me how long you’ve lived here.”
  • “Tell me your favorite meal.”
  • “Tell me something you like to do for fun.” Everyone likes to be listened to. By asking open-ended questions, you let the patient decide what they wish to share. You’d be amazed what you can learn from simple open-ended questions.

A = Active listening—Active listening is a way to show people you’re engaged in the conversation. Some ways you can show active listening include demonstrating concern, paraphrasing statements back to show understanding, non-verbal cues such as nodding, eye contact, and leaning forward, and brief verbal affirmations like “I see,” “Sure,” or “I understand.” Active listening is nonjudgmental. Looking at one’s phone, laptop screen, clipboard, or watch while someone is talking is not active listening.

P = Patience—Have patience with your patients. Some, especially senior patients, may have a hard time hearing. You may need to speak up and face them. Some may have a hard time speaking or speak slowly. Some may have memory issues. Allow them to engage the way they can and show respect by giving them time to do so.

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A = Avoid judgements and jargon—When the patient shares information, avoid judgements. Never say things like “That was a bad idea,” “Why don't you take better care of yourself?” or “You shouldn't have done that.” Further, much like family get-togethers, avoid talking politics or religion. Additionally, use plain language and avoid EMS jargon and acronyms, including 10-codes and abbreviations.

C = Curiosity—You have an opportunity during your encounter to leave an impression that you care about the patient. Be curious—you should want to know more and ask questions to uncover medical and social details about your patient (see “tell me” above).

E = Empathy—During a ride to the hospital, you may wind up giving the patient the most one-on-one attention they will receive from any single healthcare provider. Use this opportunity to demonstrate empathy—the ability to hear and relate to their feelings. Listen to the fear they have about going to the hospital, the worry they have about needing surgery, or perhaps the anger they have at being careless and having an accident. Be a good ear! You’ll be amazed how many people just want someone to listen.

Rather than an awkward or uncomfortable silence on the ride to the hospital, take the opportunity to talk to your patient. Find common ground by using the right amount of self-disclosure, empathy, tact, and TAP ACE. You also might hear a good story and, more important, help your patient on what is a not-so-good day.

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Suspecting Sepsis
Valerie Amato, NREMT

Though sepsis is the third leading cause of death inside hospitals and causes one death every three to four seconds around the globe, the medical community’s understanding of the condition remains lacking, resulting in a subpar ability to detect, diagnose and treat. Why is this? Mike McEvoy, PhD, NRP, RN, CCRN, drilled down on this issue Feb. 22 in National Harbor, Md. in his “Suspecting Sepsis” session at the EMS Today Conference and Exposition.

“We can’t detect sepsis very well because the signs and symptoms are difficult to pick up on and they vary patient to patient,” said McEvoy. Sepsis is an altered immune response that occurs when the body is under assault by bacterial or viral infections (though physical trauma can also be a factor), and “as a consequence, it starts to injure organs in an effort to respond to abnormal organisms in the body,” he said.

Sepsis is defined as a “life-threatening organ dysfunction caused by a dysregulated host response to infection.” Both sepsis and septic shock (“a subset of sepsis with circulatory and cellular/metabolic dysfunction associated with a higher risk of mortality”) are clinical diagnoses and are considered medical emergencies requiring immediate intervention to prevent death.

The body’s initial (innate) response begins with the first few hours, causing inflammation as it begins to fight off the infection. This prompts systemic vasodilation, increased capillary permeability, clotting issues and impaired perfusion. The secondary (adaptive) response occurs four to seven days after exposure, at which time the body begins producing antibodies, or lymphocytes, to aid in the fight.

In a study analyzing the care and outcomes of septic patients, Seattle (Wash.) EMS reviewed a nine-year period of 407,176 runs to find cases of severe sepsis. They found approximately 3.3 cases of it per 100 EMS encounters, 40% of which resulted in transports to the ED. Care for these patients was found inadequate; EMS spent an average of 45 minutes with them.
despite the need for urgent treatment. It was reported only 54% of patients with sepsis were transported by ALS, resulting in only 37% receiving IVs. In response to this study, Seattle added sepsis alerts to the repertoire of stroke and AMI alerts to deliver better care when received at the hospital.

To help providers identify sepsis in the field, McEvoy explained the quick Sequential Organ Failure Assessment (qSOFA), which is the prehospital care version of calculating a patient’s severity score (the assessment is much more comprehensive in the ICU). If coupled with an infection, the following signs suggest the presence of sepsis:

- Hypotension – systolic BP of <100 mmHg
- Altered mental status
- Tachypnea – RR <22/min

If the patient presents with two or more of these criteria, there is a greater risk of a poor outcome for them.

McEvoy said other notable indications of sepsis can be observed based on the condition’s order of events:

1. Stroke volume drops: The heart rate increases so cardiac output can be maintained (McEvoy notes that there are multiple reasons why the heart rate may increase, though).
2. Cardiac output decreases: The increased heart rate fails to compensate, leading to vasoconstriction, which helps maintain normal blood pressure.
3. Increased oxygen extraction: Initially peripheral (StO2), then central (ScvO2, SvO2)
4. Blood pressure decreases, urine output drops

If a patient is severely hypotensive, you’re already behind the ball, said McEvoy. If you get 30mL of fluid in them, their survivability increases. Aggressively treat the patient with fluids, vasopressors and antibiotics, and while our ability to understand and diagnose sepsis is still poor, one thing remains certain to be helpful in the prehospital environment: do not delay treatment!