Reflective Practice

Reflective Practice 1

Description –
I, as a group of 9 from (Organisation) attended EMT refresher training with (Another organization) on the (date) September 2019.
On day 2 the Agenda included, discussion and clarification re:
Active Spinal Motion Restriction Trauma.
The PHECC Medical Advisory Committee has recommended that 'spinal motion restriction' shall be used as the preferred terminology in relation to pre-hospital spinal injury management.

Feelings at the time –
I was interested in the new PHECC CPG Change of terminology from 'spinal immobilization' to 'Spinal Motion Restriction' when referring to the management of pre-hospital spinal injuries. The aim of this recommendation is to instigate a change of culture and allow practitioners to consider alternative methods of patient extrication and packaging. I am very much aware that opinion has been divided on the use of the long board for transport to hospital, with patients remaining on until a medical team had done full examination. I often wondered while doing mock scenarios of spinal immobilization during our training as EFR's and EMT's that the experience for me personally being immobilized on a board caused discomfort and mild pain. and agitation, even the feeling of restricted breathing and it being uncomfortable, and that was only for a few minutes. Add to this other problems of waiting times for admission at A&E.

Evaluation –
For many years the national ambulance service has provided spinal immobilization as the standard of care for almost all blunt or penetrating trauma victims where there may be a mechanism of force enough to cause a bony injury to the spine or spinal cord injury. For spinal immobilization, devices such as Extrication Device (eg. KED) , a long board or a split device like the scoop stretcher , with the addition of a cervical collar, head blocks and straps. This was often done without any clinical evidence of injury and it was done "just in case" in the best interest of the patient.
The teaching of spinal immobilization has been a core competency for the pre-hospital practitioner for as long as we can be remember.
In 2013, Mark Hauswald started to look at exactly what we were doing to these patients and wondered was it making them worse? It was a significant paper that started a rethink on practices and looking at the evidence for all aspects of our standard of care.
Some of changes which were highlighted on the EMT up skilling day were-
Spinal care will continue to be assessment-based and will focus, when indicated, on "Spinal Motion Restriction ".
The routine use of long boards, collars, KEDs will cease and instead the individual patient will get appropriate SMR depending on their presentation and /or on the mechanism of injury.
Spinal Motion Restriction (SMR) will be either by active or passive means.

The long backboard can and will be used as an extrication device, but in most circumstances will not be used in restricting spinal motion. If a backboard is used during extrication, the crew will remove the patient from the longboard / backboard and secure them to another device (split device or vacuum mattress)
Research suggests that unnecessary, prolonged immobilization on a board may cause pain, agitation, respiratory compromise and place some patients at increased risk for pressure-related skin breakdown.

One of the key changes to how we will manage potential injury to the spine in the future is contained in the Spinal Injury Management Standard (PHECC CPG's). This is a significant move away from what we have always done in the past and instead will allow non-traditional methods of spinal restriction to occur even in patients where we have concerns about the integrity of their spine.
The emphasis will now be on limiting the movement of the spine in whatever way best suits both the patient and the circumstances that present to the practitioner at the time of the assessment. Practitioners will now make a clinical judgement on the use of rigid collars and other aids.
In summary, PHECC have moved to mirror the advances in Spinal Injury Care in UK, American and Australia over the last few years. Pre-Hospital spinal care is now evidence based.

Analysis –
After reviewing the guidelines on Active Spinal Motion Restriction, as part of the group present we applied the knowledge gained during this training day and carried out a full assessment on a casualty. Clinical judgement among the team was made regarding the following- Log roll, Extrication, moving patient with a Split Device, Pelvic Splint device, Vacuum Mattress. Decisions were made based around the history, signs, and symptoms, and MOE as well as the patient's history. We were no longer automatically doing the routine of spinal immobilization, hard board, collars as a given or 'Just in case '. We were now assessing the patient, taking more on board of any clinical evidence of spinal injury, and discussing the most suitable treatment plan to the individual.

Conclusion –
I have learned from the event that you must 'treat the patient' and each suspected trauma individually rather than do standard spinal immobilization as we have done in the past 'just in case'. I will now be assessing on a case by case basis and reviewing the clinical evidence presented at the time.

Action Plan –
Having dealt with a patient scenario with blunt or penetrating trauma where there may be a mechanism of force enough to cause a bony injury/ spinal cord injury, and after reviewing the new information on Spinal Motion Restriction it would give me more confidence to deal with a similar situation in the future. I can use the lessons learned from this experience in the future. I must demonstrate confidence in my skill level and

be assured of the positive outcome that can be derived from the appropriate knowledge and new scope given regarding care of suspected spinal injury/trauma.

Reflective practice 2

Description –

I was called to assist a fellow EMT who was attending to a Pt who had fallen from a bicycle during a race. The Pt was insisting that they felt OK after the fall but my fellow EMT was worried about the MOI of the crash.

I was called over the radio and we discussed the particulars of the case to assess if were in agreement with our treatment plan. I agreed with them and advised they immobilise the Pt. I then went to assist to conduct a set of vital signs and if required prepare for transport.

Feelings at the time –

It was interesting to be called like this and offer off-line direction to a fellow practitioner. Based on the MOI of the accident I felt confident that the Pt should be checked out even though the Pt was adamant that they felt fine.

As our assessment continued and the Pt's adrenalin started to wear off, they began to feel pain and we had a easier time to convince them to be checked in A&E. It turned out that the Pt did receive an injury to their spine and our initial opinions on immobilising the Pt was more than justified.

Evaluation –

I thought this was a great example of how as practitioners we're never really alone on a call. We have the ability to reach out and request assistance from our colleagues and friends if required.

Analysis –

I discussed this incident with my fellow EMT and we both agreed that having that other person on the line to discuss something like this when we wanted a second opinion was very helpful and should be actively encouraged as it greatly reduces the stress levels of the attending practitioner.

Conclusion –

I think this worked very well for both EMT's I wouldn't have changed anything.

Action Plan –

I plan to use this as an example to our other EMT's that this is a good example of how we can make a difficult decision a little easier.

Reflective Practice 3

Description –

The following reflective account aims to explore specific complications and difficulties encountered in obtaining a history and performing a detailed exam on a female patient who presented herself to first aiders at a large sporting event. I was covering one of two first aid rooms at the event.
To achieve and understand the use of reflection in a structure manner, the Gibbs (1988) Reflective Cycle.

According to protocol the patient was initially assessed by an EFR and FAR where she was located. They then called control and were advised to bring the patient to the first aid room I was manning. I was informed by control that a "female patient in her late twenties who was feeling fain and unwell was being brought to the first aid room." I have covered the first aid room at multiple similar sporting events and would often care for patients who were feeling generally faint and unwell, many as a result of standing for long times on terraces or as a result of being in wet cold environments while watching a match. Majority of these patients once assessed and were not complaining of or having a DDX of anything serious, would be offered psychosocial support and given an opportunity to rest, eat and warm up. Once they felt better, they would return to spectating at the match.

On arrival at the first aid room, the EFR did a handover of the patient. All basic vital signs were within normal limits, the patient was feeling cold, it was a late evening during January and she felt a bit nausea. The EFR also mentioned the patient was quiet anxious.

I introduced myself and gained consent to perform a more details set of vitals and obtain a SAMPLE history. She confirmed she was feeling anxious, was very busy at work and a sick family pet had to be euthanized during the week. She also mentioned that she had been standing for a long time in the cold and hadn't eaten a lot that day.

While talking to her the patient had a brief absence seizure. This was alarming for her partner as they had never seen this before. Once this passed, I continued to talk to the patient and noticed she also had moments of aphasia while trying to answer my questions. The patient was aware of these episodes and became more distressed. I undertook a FAST assessment and while she was able to speak, she had difficulties with language retrieval and recognition.

I asked control to notify the event doctor of the situation and requested they come and assess the patient. Once the doctor arrived, I was able to provide him with a details history and assessment. He agreed with my concerns for the patient and DDX that this was probably some serious neurological episode and the patient needed to be transported to hospital.

Feelings at the time –

As I was experienced with covering the first aid room and had dealt with many "faint & unwell", I initially did not having any concerns regarding my ability to manage the patient. I wrongly assumed that this was not a very serious patient to be concerned about.

After I undertook my patient assessment and noticed the patient was exhibiting periods of aphasia, I became alarmed. As this was a person in her late twenties, failing a FAST assessment, exhibiting aphasia and moments of absence.

Both the patient and her partner, understandably, became quiet anxious about the situation. With this, I initially felt a little overwhelmed and "out of my dept."

I attempted to calm both parties down, and once I managed this, I too also became more in control of the situation. I relied on my patient assessment skills and training and again undertook a detailed and more methodical approach to assessing the patient. This I felt allowed me to exhibit a calmness that assisted both parties.

Once I felt more in control of the situation, I was also clearer in my thinking of DDX and was able to brief the event doctor of the patient status. This allowed me gain a feeling of confidence in my skills. I was also

Evaluation –

I initially found this incident quiet challenging for me. I regret that my original feeling was that this was "just another faint & unwell". This caused me to be taken off guard, when the patient was considerably more unwell.

I also felt a bit challenged with dealing with a patient with neurological symptoms. As often I had to resort to using psycho social support techniques as a way to keep the situation under control.

Analysis –

I was fortunate to be able to discuss the patient with the event doctor and was very greatly to get his insight to the potential differential diagnoses, caring for a patient with a neurological illness.

On reflection, I can see that I was initially a little complacent about the potential level of acuity of the patient. This is something that I am quiet critical of myself for being.

However, once I realised the severity of the patient's condition, I felt that I handed the situation well.

Conclusion –

Looking back at his incident, I can see that I should not have been so complacent with "just another faint & unwell". Sometimes the patients that seem not to unwell can be very serious. Therefore it is extremely important as an EMT to get a details history and patient assessment.

Action Plan –

I have undertaken a lot of reading and researching around the presentation of neurological illnesses, assessing these patients and the important signs and symptoms to look out for.