DPM NEWS

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Employee Recognition

On *page 2*, Syed Ahmed Mustafa gives some advice on the hot topic of employe satisfaction and retention.

Tube Tumult

Dr. Cushman addresses the persistent problem of improperly placed ET tubes with some great ideas about how to ensure they aren't YOUR tubes, on *page 4*.

Your Safety Isn't First

I address the issue of provider safety and suggest we might not be helping ourselves by proclaiming your safety is our top priority, on *page 5*.

Alan Jackson asks, "Where were you when the world stopped turning on that September day?" For many people, twenty years ago this month was the first "everyone knows where they were when they found out" experience. I suspect the terrorist attacks on 9/11/01 were also a catalyst prompting some people currently involved in emergency services to pursue that path. The actions taken by first responders at the World Trade Center and Pentagon who embodied heroism, selflessness, and service defined the role of firefighters, police officers, and EMS providers for millions of people throughout the world. Some were inspired. Some were grateful. Some, especially their families, were… broken.

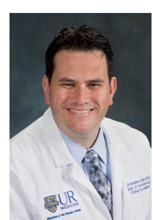
There are also many people reading this publication who were too young to have any personal memory at all of that morning but who share in the collective memory now embedded in the fabric of our nation. Whatever your individual connection or relationship with September 11, 2001, on this significant anniversary of that date, let us each reflect in some manner.

"One of the worst days in American history saw some of the bravest acts in American history. We'll always honor the heroes of 9/11. Here at this hallowed place, we pledge that we will never forget their sacrifice." - President George W. Bush

Eric Rathfelder
Editor-In-Chief

Finding Balance

Christopher Galton MD, NRP, FP-C



What do paramedics and EMTs do in their spare time? Work overtime … What else is there to do? If you are anything like me, this is the only answer you ever consider. It's pretty obvious that this isn't a healthy mindset, yet it's endemic in our business. My goal is to plant the seed that will change your mind.

Upcoming Events

Melinda Johnston

For more information about any event listed below, please visit the training calendar at MLREMS.org

October

5 - SCT Conference (1 of 2)

12 - SCT Conference (2 of 2)

18 - REMAC Case Review

18 - REMAC Meeting

25 - CIU (Tentative)

November

15 - MLREMS Meeting

There are lots of good reasons to be more protective of your own time. Many of you have families that would actually like to see you. Some of you have hobbies and are productive members of society outside of your EMS careers. Most of you have a great deal to offer the world if you could only break free of your jobs.

At the beginning of my career it was easy to make the excuse that I could always use the money. To this day I make that excuse when the opportunity to work late becomes available. In my department, there are a few of us that refer to ourselves as mercenaries. If the price is right, we are willing to do just about anything, at anytime, anywhere. I have paid off a lot of bills with that mindset, but probably lost a lot of opportunities to enjoy living.

In the last two years, I started golfing and skiing again. These were two things that I did avidly decades ago, before the realities of life set in. Both of these activities provide me with a few hours of respite from the rigors of my working life. I was initially resistant to giving up those "precious" hours of productivity. It didn't hurt that COVID set us up to only be able to do activities that were outdoors.

I have since realized that I'm directly applying the old adage of slowing down to speed up. I am now significantly more productive when working even though I am spending less time doing it. It's amazing what laughing about a few shanked iron shots and missed putts will do for you.

I would like to wrap up my column with a quote. "Good judgment comes from experience. Experience comes from bad judgment." Allow me to offer you something I learned from my bad judgment. Take some time off. Spend some time promoting your own well being and work towards finding a healthy balance. I think you will find it will enhance your personal and professional life.

If you have any questions about this column, please feel free to reach out to me at christopher_galton@urmc.rochester.edu.

Employee Recognition in EMS - Improving Recruitment and Retention

Syed Ahmed Mustafa MBA, EMT-P

Everyone likes an "attaboy" or pat on the back once in a while. But are we doing enough of it, and how do you recognize someone for doing something special when their daily job duties include saving lives?

In many industries, Emergency Medical Services included, we often rule with the stick versus the carrot. We track when people sign on to their shifts and dock them if they are late or suspend/terminate them for repeated occurrences. We QA charts looking for problems and protocol violations to hold people accountable. Vehicles have monitoring devices to ensure speed limits are adhered to and we counsel our crews when limits are exceeded.

Does ruling with the stick generate the desired results? Not often. Instead, the stick creates an "Us vs Them" mentality where management is feared, not respected, and there is not a culture of sharing and openness but rather one of caution. By not having an open and trusting environment, managers can only learn of issues in an organization after they have festered and turned into major problems. However, if employees feel they can speak with their supervisors and managers without fear of retribution, then concerns can be addressed early on before they result in the need for employee discipline, often leaving the employee feeling like they have contributed to a solution and added value to the organization.

So why do many leaders migrate to the stick versus the carrot? One answer may be because that is how they were taught; it's how the organization was run as they ascended through the ranks and that's the only way they know how to lead. Another reason may be that it's easier. You don't need to give a lot of thought into reacting, whereas putting communication systems, recognition and award programs in place takes time and some financial investment.

Why does employee recognition matter? Many of us have heard the saying "You don't quit your company, you quit your boss". What does quitting your boss mean? In essence, it means that someone feels unvalued and either distrusts or cannot comfortably communicate with their business leaders. As a result, rather then addressing concerns or offering ideas to improve the organization, good people leave. And we all know that in any industry, but especially in EMS these days, none of us can afford to lose any employees, especially the good ones. Studies have shown that organizations with recognition programs have a 31% lower voluntary turnover than those without programs. They also show more than 51% of employees want more recognition from their immediate managers and over 40% of employees want some form of recognition from their peers.

Recognition helps employees feel valued and that their input helps the company succeed. In markets like today, where employees are hard to find and retain, helping an employee feel like their feedback can help drive improvement not only empowers them but will also motivate them to stay with the organization. This sort of employee engagement not only helps improve retention, but it will also turn your employees into recruiters, thereby driving recruitment. This will also help improve morale, which can reduce absenteeism and might even have a positive effect on interactions with peers, managers and patients.

What is the best way to recognize people that spend their time literally saving lives? There are a few, easy ways to start.

Say "Thank You". Those two words have an incredible ability to put a smile on someone's face, cost nothing, and if done in a public way can have a very meaningful impact to an employee.

Recognize the behavior you want to see more of through notes, company-wide emails or even on social media. Again, by reinforcing the behavior you want through public recognition not only makes that employee's day but also serves as a good reminder of what the organization wants its employees to do.

Send a birthday card. With the help of my office manager, I send every employee a hand-written birthday card. It takes just a few minutes, the cost is minimal, but almost every person that gets a card thanks me after they receive it.

At one of the first companies I worked for, we had a system where peers could recognize each other with a card and a small gift, such as a $5 gift card to a coffee shop, a movie ticket or a free car wash. The giving employee filled out a small card, writing what the receiving employee did to be recognized, and then gave the card to our HR department. The HR department put a copy of the card in the employee's file, gave

the employee a slip from which to choose a gift along with the card the giving employee wrote. Those who were recognized often hung the cards in their offices so that others could see they'd done something nice for a colleague and it created a sort of competition to help others.

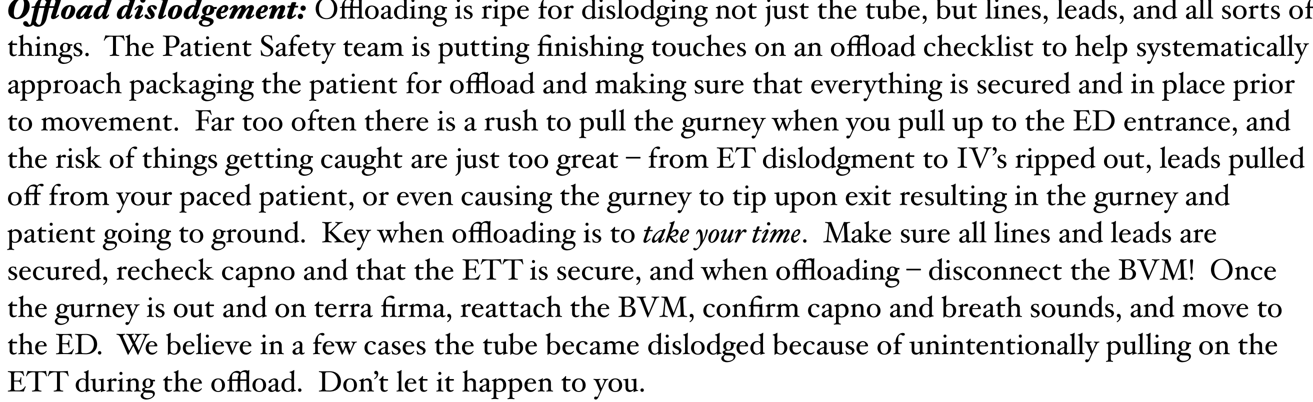
Point systems that give credits for gifts of higher value can also drive very positive behavior. However, these systems need someone to write and publish the rules, track and publish the points, and the gifts can be somewhat more expensive. If you have the staff and resources to do this, these programs always pay positive dividends.

These are just some suggestions on ways to recognize your employees. Talk with your team, perhaps pull a committee of employees together and put a recognition program in place. Start with something simple and fine tune it as you go along. The most important thing is to do something to ensure your most valuable asset, your team, is recognized in a way that makes them feel valued and appreciated. The result will be higher morale, improved retention and better recruitment.

It's in! Or is it?

Jeremy T Cushman, MD, MS, EMT-P

Over the last few months I have observed a disturbing number of misplaced or dislodged endotracheal tubes. And this is not by new paramedics alone, but in many cases some experienced and trusted practitioners. I can lump them into three general categories: dislodged during offload, dislodged during tube securing, and believed to be in (but not). Let's break each potential scenario down, with some pearls on how to not let this happen to you.

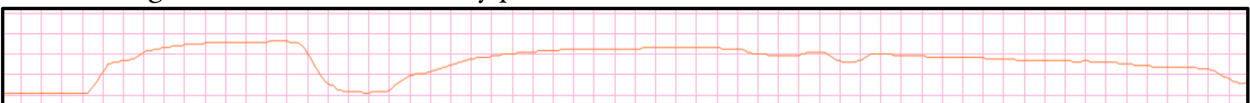


Offload dislodgement: Offloading is ripe for dislodging not just the tube, but lines, leads, and all sorts of things. The Patient Safety team is putting finishing touches on an offload checklist to help systematically approach packaging the patient for offload and making sure that everything is secured and in place prior to movement. Far too often there is a rush to pull the gurney when you pull up to the ED entrance, and the risk of things getting caught are just too great – from ET dislodgment to IV's ripped out, leads pulled off from your paced patient, or even causing the gurney to tip upon exit resulting in the gurney and patient going to ground. Key when offloading is to *take your time*. Make sure all lines and leads are secured, recheck capno and that the ETT is secure, and when offloading – disconnect the BVM! Once the gurney is out and on terra firma, reattach the BVM, confirm capno and breath sounds, and move to the ED. We believe in a few cases the tube became dislodged because of unintentionally pulling on the ETT during the offload. Don't let it happen to you.

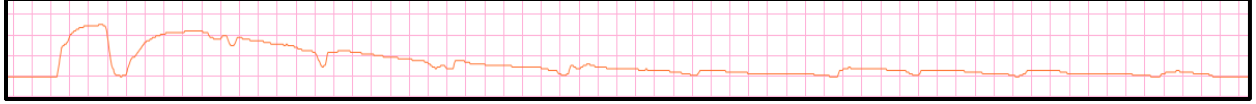
Dislodged during tube securing: A few cases have had very clear evidence of proper tube placement – not just the provider saying they saw it go through, but persistent capno waveform – and then a minute or two later it becomes dislodged and waveform is lost – sometimes recognized immediately, sometimes delayed due to hypopharyngeal placement (and thus intermittent capno waveform). The thought here is that the tube may be becoming dislodged during securing. Obviously working capno is key to identification, but don't be afraid to give an extra cm or two of tube during placement. Worst thing is a right main and you can pull it back just a scooch – still better than it popping out and then sliding into the goose. Second consideration is to make sure if you are using the bougie technique (which you should be!), don't take the bougie out and then railroad the tube, use your preloaded bougie, and while the bougie is visualized through the cords, pass the ETT and watch it go through as well. Railroading definitely contributes to dislodged (more often hypopharyngeal) tube placement. It goes without saying to be sure

to secure the tube firmly (not just the screw, but the strap too!), and recheck frequently. Sometimes well-intentioned assistants may be pulling on the BVM (and thus the ETT) while ventilating and in turn loosening the assembly making it prone to dislodgment even though the tube is firmly in the tube holder.

Believed to be in (but not): First, make sure in-line capnography is attached to your BVM BEFORE you ever intubate. By placing the capno in-line you not only have useful physiologic information but you know your system is working and will quickly identify waveform if present. Second, be sure to visualize the tube passing through the cords (duh). Third, when listening to lung sounds, after first listening over the epigastrum for negative epigastric sounds, do not listen anteriorly – instead listen as laterally as you can. "High and wet" as I like to say – meaning basically in the armpit (against the chest wall of course). It is not uncommon to hear transmitted gastric noise anteriorly, and listening at the high anterior apex of the lungs has been fraught with false positives. Fourth, as you begin ventilating, be sure to get AT LEAST 6 breaths with waveform prior to securing the tube and saying it's in. One waveform is not enough. Take the following example. The practitioner believed they had placed the tube tracheally. The initial breath waveform looks pretty good. The second is much more rounded which makes me concerned, but might not be enough to make me immediately pull the tube.



I admit, it can be really hard to see trends on the monitor, mostly because I am only seeing about 6 seconds on my screen. But if I look at the file and speed it up, this is what I see, and I think you'd agree that is not consistent with a tracheal placement and hopefully all of you would clearly pull the tube after 4 breaths or so.



The other important reason for placing capno on the BVM during ventilations well before the ETT is placed is also so you know the base reading. That is, if I am working a cardiac arrest and I have an awesome team doing great compressions, and my BVM capno is 25, after I intubate by BVM capno should be....25. If it starts trending below that, then something could be wrong – it's not "just" because they are in cardiac arrest and thus I need to be sure to re-recheck my tube. Waveform capnography remains the gold standard for confirming effective ETT ventilation through the trachea, so if you don't have it, best to check the tube (in cardiac arrest, re-visualizing with the laryngoscope) or simply pull and ventilate.

Endotracheal intubation remains an important paramedic skill. Confirming and maintaining that tube in the right place must remain your focus. Hopefully you'll keep these three scenarios in the forefront when managing an advanced airway so they don't happen to you.

Safety Third

Eric Rathfelder, MS, EMT-P

The title is not a typo. Your safety is not, and cannot be, the top priority in EMS. If you believe “Safety First” is a workable concept for our profession, then I assume you are reading this article as an EMT student having never worked a shift. More likely, you have sat through trainings, classes, briefings, after action reviews, and meetings listening to someone talk about how your safety is the top priority and felt a nagging sense of incongruity in the back of your head as you tried to reconcile accomplishing the goal and maintaining your safety as the top priority. Or, maybe you thought, “that’s bulls***.”

Some of you may have heard Mike Rowe, of *Dirty Jobs* infamy, talk about his revelation while shooting episodes for the show that “Safety First” is nonsense. Mike believes workers in dangerous jobs should be as safe as practical while doing their work but brings attention to all kinds of jobs that just would not get done at all if safety were truly the first priority. He also surmises believing an organization holds your safety as their top priority places an individual at greater risk of injury or accident. His reasoning is it psychologically removes the onus of being safe from the individual who gains a false sense of security that the organization is taking care of his or her safety. Or, in some cases, redirects a worker’s focus on being safe to focusing on compliance with standards which likely do not actually remove all hazards. If you are interested, here is a link to a short article and video by Mike Rowe on the topic: https://mikerowe.com/2020/03/walk-me-through-this-safety-third-thing.

Provider safety must always be one of our priorities but we should be more candid about how our safety actually rests on a continuum and is rarely the top priority. Hopefully, you place safety at a high enough priority that you religiously wear your seatbelt in the front and back of the ambulance. But do you have calls where you are providing interventions enroute to the hospital that makes being belted impractical? Fortunately, it’s much rarer for us to be doing CPR enroute to the hospital than it was ten or fifteen years ago but when we do, we are clearly not putting our own safety first. Rather, we are making a calculation that the increased risk to our safety is worth it for the positive impact our actions could have on the life of our patient. I’m sure we can all think of hundreds of decisions we make every shift where we risk our safety to varying degrees in order to effectively provide medical care to those in need.

<u>Priority of Life</u>

1. Hostages/Victims
2. Innocents (bystanders)
3. Law enforcement officers
4. Suspects

There are other professions, such as in law enforcement (my full-time job), where balancing employee safety with getting the job done is a conversation discussed much more openly and explicitly than in EMS. In large part, this is simply due to the nature of the tasks that need to be accomplished. For example, does the risk to the officers and the general public involved in a high-speed vehicle pursuit outweigh the value of taking the individual into custody? This fundamental question serves as the catalyst for many departments’ vehicle pursuit policies which often balance a number of environmental/human factors (traffic, time of day, type of neighborhood, road conditions, etc.) with the danger to society posed by the fleeing suspect (armed robber vs motorist with a broken taillight).

Law enforcement academies throughout the country continuously teach about “officer safety” and frequently use the phrase, “we all go home”. However, officers in training quickly realize these are concepts and a mindset that allow us to do our jobs as safely as possible but cannot be taken to mean our

safety is paramount when they then learn about something referred to as the “Priority of Life”. Usually, this applies in situations involving Aggressive Deadly Behavior (ADB) such as active shooters or other Complex Coordinated Terrorist Attacks (CCTA) where you are taught your life is literally ranked third in order of importance. That is a pretty big wakeup call for the aspiring police officer but I appreciate the candor taken by some in the profession to openly and honestly confront balancing safety with accomplishing the goal (in this case, to find, fix, and finish the threat).

Imagine you respond on the ambulance with the fire department to the report of a female down inside a residence. It was called in by a neighbor walking her dog who looked through the window and observed the patient. When you arrive the house is locked but there is a large window unsecured. You can see a 50 y/o female lying face down on the floor of the kitchen with a small amount of blood on her head. Her respirations are shallow at about 6/min and she is cyanotic. The local police department reports they do not currently have anyone available to respond. Do you make entry through the window (or force a door) and begin treatment or do you back away from the scene and stage at a distance until law enforcement can respond? The answer likely depends on if, in that moment, you believe this individual fell down and hit her head or if she was the victim of an assault or burglary. If the latter, might the attacker still be in the home, potentially armed? Or, is there CO in the home which caused her to pass out? Is there a vicious Pit Bull quietly lurking in an adjacent room waiting to snack on your hamstring? Making a reasonable decision about how to proceed involves integrating your observations of the scene with your training and experience then balancing your conclusions with the level of risk to your personal safety you are willing to take in that particular situation.

No one in EMS or law enforcement should have a death wish or act recklessly. However, I am an advocate for intellectual honesty which requires every employee, especially those in emergency services, to confront the ever-present balance of maintaining personal safety and being an effective worker. Blindly stating “Safety First” is intellectually dishonest and shuts down the crucial conversations we need to have surrounding the reality that our safety is important but cannot be considered in a vacuum. Working in EMS is inherently dangerous but explicitly acknowledging that we are placing ourselves in varying degrees of danger to effectively do our job will ultimately make us safer than naively pretending that we are valuing our own safety above all else.

Calling for Submissions

MLREMS PIER Committee

Our MLREMS annual award nominations are open for submission! The fillable PDF nomination packet is available at: https://mlrems.org/mlrems/public-information-education-and-recruitment-pier/. Never submitted an award nomination before and would like some help? Contact us at mlrems@mlrems.org and the PIER Committee would be happy to help you! Award categories are included on the reverse side:

- BLS Provider of the Year
- ALS Provider of the Year
- EMS Agency of the Year
- Youth Provider of the Year
- Harriet C. Weber EMS Leadership Award
- EMS Educator of Excellence
- EMS Communications Specialist of the Year
- Genesee Valley STEP Lloyd Live Award

- BLS & ALS Provider of the Year
- EMS Agency of the Year
- Youth Provider of the Year
- Harriet C. Weber EMS Leadership Award
- EMS Educator of Excellence
- Registered Professional Nurse of Excellence
- Physician of Excellence
- Commissioner of Health's Award of Excellence
- MLREMS Richard "Dick" Tripp Community Service Award