

EMS

NEWSLETTER

Yakima County Department of
Emergency Medical Services

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**May 16th – 22nd
YCDEMS Awards
Ceremony
May 23rd 2010 at the
Capitol Theater
from 1-3pm.**

*Celebrating the
providers that serve you.*

“Safe Ambulance Operations”

On September 11, 2004, a former co-worker and personal friend became a patient at the hands of her partner while working a non-emergent transport during daylight hours. A routine transport went terribly wrong when her partner fell asleep behind the wheel and crashed into a rock wall, killing the patient's mother in the passenger seat of the cab as well as seriously injuring both my friend and the pediatric patient in the patient compartment.

My friend had sustained multiple injuries to her leg and a pelvic fracture. Almost six years later, she is still going through physical therapy and surgeries that ended her career in the field. It was determined that the major contributing factor that led her partner into falling asleep behind the wheel was the lack of sleep the night before while off duty, the driver had spent all hours of the night chatting online on his home computer. Could this accident have been prevented? Absolutely! I'm glad my friend was sitting in the jump seat right behind the driver wearing her seatbelt as opposed to sitting on the bench seat on the passenger side of the patient compartment unbelted which was and is still a very common practice. She would not be here today had she been sitting on the bench seat. What has happened to my friend made an impact on me and will remain with me in the back of my mind while working.

Morbidity and Mortality Weekly Report (MMWR) published an article in 2003 reporting on the statistics in regards to restraint use in ambulance crashes between 1991-2000. The report states that in accidents reported, 26% of the drivers of an emergency vehicle were not wearing restraints at the time of the accident. In the patient compartment, only 22% were not restrained, The statistic reports by MMWR also included accident location with 44% of the accidents occurring in intersection while 45% occurred in non-intersection locations.

There are many assumed myths on ambulance accidents that an author covered in an article which also included the facts.

Myth 1: Ambulance accidents occur in bad weather with poor visibility.

Fact: The majority of ambulance accidents occur on clear days with good visibility

Myth 2: Most ambulance accidents occur on dark roads or at dusk when the driver has difficulty seeing other vehicles.

Fact: The majority of ambulance accidents actually occur in daylight.

Myth 3: Most ambulance accidents occur when trying to pass a vehicle that refuses to yield the right of the road.

Fact: The majority of ambulance accidents occur when making turns or when broadsided at an intersection.

Myth 4: Most ambulance accidents occur on wet or snowy roads.]

Fact: The majority of ambulance accidents occur on dry roads.

Myth 5: Most ambulance accidents occur while backing the vehicle into a tight spot.

Fact: The majority of ambulance accidents occur on the roadway in an intersection.

Myth 6: Because ambulances have lights and sirens, the traffic signal device does not present the ambulance driver with a major hazard.

Fact: Locations where traffic signaling devices exist present the greatest risk for an ambulance accident to occur.

As EMS providers, agencies require that all employees attend Emergency Vehicle Operations Course (EVOC) to learn safe driving skills and recommendations to follow before driving. The Emergency Vehicle Operation Course was implemented by the US department of Transportation following a fatal ambulance crash in 1976. Topics covered in the EVOC include, the safe operation of an ambulance, daily safety checks of the vehicles for maintenance concerns and personal suggestions such as, the refrain from use of medications that cause drowsiness, alcohol and drugs and recommendations for the amount of rest one should get. Before getting behind the wheel of any emergency vehicle, each individual must be aware of their personal limitations.

Written by Robin Ward of Nile-Cliffdale Fire Department for EMT-B class.

'That's Not the Way it's Done in the Field'

William Raynovich, NREMT-P, EdD

I'm old and crusty, and I haven't seen many emergency patients in the field over the past several years. Yes, I teach from the "Ivory Tower" -- the university classroom perspective. Hence, I often have to watch helplessly as our students dismiss the pedantic old ways I preach in favor of the real world EMS and how "things are really done." I'm trying to work on staying current by responding to calls in the field with our local EMS services, but there's no getting around the aura of credibility of "real" paramedics who do the job every day.

In my sometimes futile attempts to impress upon my students the importance of doing things step-by-step and by-the-book, I can only hope that the message will get through to a few of them. It's an important message, regardless of where you are in your EMS career -- either as a new student who's just learning, an experienced EMT or paramedic practicing in the field, or a salty old instructor, as I am. I hope to have the chance to reach just a few people today. Here's the lesson.

That may be the way that they're doing things in the field. Maybe they aren't auscultating and palpating every chest, or doing a neurological check on every patient, or taking the time to examine for every possible injury or neurological deficit or deformity on every patient. Maybe they don't ask every SAMPLE OPQRST SOAP question, maybe they aren't transporting patients that don't need to be transported, and maybe, at times, the policies that state that the emergency medical control physician must be contacted for a consultation is just a rule that's meant to be broken.

Maybe it's so, but not always. It's the times it isn't so that I get the call. That's right. When a patient dies, or is paralyzed, or has some other reason to complain about his patient care, valid or not, the lawyer gets a call. Then someone like me gets a call from the lawyer -- asking for help.

That's the way that they do it for real. It's true. Sometimes the resource physician isn't contacted, regardless of the rules. Sometimes the patient isn't resuscitated, even if that's what the field protocols say to do. Sometimes the chest doesn't get auscultated, or the full body examined under the clothes, or a hundred other possible things that might have been done but weren't. Then, it's up to the crusty old paramedic to step up and make a case for the way things were done.

The way that they do things are almost always OK. It's true, doing the full ACLS algorithm isn't appropriate, and the medical control physician didn't need to be called for a consultation, or the patient's condition was obvious and auscultation of the chest was impossible because of the patient's continual verbal complaining. And sometimes, just sometimes, the patient was completely uncooperative, making a complete and full assessment impossible. Sometimes that's true enough. The important lesson to remember, though, is that even when all of that is true, the legal defense usually costs tens of thousands of dollars, and often much more. That is, it costs that much even when you win. So, what should you do to avoid this?

Always go through all the steps. Take a second set of vital signs on every patient and record them. Always auscultate every chest, and then document it, even if, for example, you couldn't hear the breath sounds adequately due to the patient's continual talking and background noises. Always palpate the chest and abdomen, and check the patient's back and range of motion of all extremities, even when it's an obvious sprained ankle, and that's all it is. Always, always, always ask about prior medical history, medications and allergies. And always, please go through the full assessment systematically, step-by-step. You'll sleep better at night and save yourself and your organization a lot of grief in the long run.

AHA 2005 GUIDELINES for CPR

The American Hospital Association 2005 Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care⁵ emphasizes the critical importance of effectively performed CPR to resuscitation.

The most significant change to CPR recommended by the Guidelines is a change in the ratio of chest compressions to rescue breaths. The old standard, from the 2000 Guidelines, was 15 compressions for every two rescue breaths. This was changed to 30 compressions for every two rescue breaths. The change resulted from studies that showed that blood circulation decreased when compressions were interrupted and that it takes several compressions to build up enough pressure to begin re-circulating blood. This is the most significant change since CPR's inception in the early 1960s.

The Guidelines also recommend:

- Performing two minutes of CPR between shocks. Shocks should not be stacked one after another, suggesting that after a single shock the time is better used to build up the CPP, since without building the CPP to 15mm Hg there will be no ROSC.
- After an unwitnessed arrest, it is not useful to waste time trying to analyze a non-perfusing rhythm. CPR should be begun immediately.
- The number of ventilations should be reduced to 8 - 12 per minute. Hyperventilation raises intra-thoracic pressure and can decrease the efficacy of compressions.

Further specific guidelines about the performance of CPR include:

- The person performing CPR should press hard enough so that a venous pulse may be felt during CPR in the absence of effective arterial blood flow.
- During compressions of an adult, there should be 1.5 - 2 inches of chest displacement.
- Compressions should be given rapidly, at about 80 - 100 per minute.

Interruptions should be minimized. \ Ventilations should be given at 8 - 10 per minute



PROVIDERS RECERTIFICATION REMINDER

June

CanAm
Grandview
Nile/Cliffdale
Sunnyside
Tieton
West Valley

September

ALS
AMR
Northwest MedStar
White Swan
YCDEMS
Training Center

View the Yakima County Department of EMS website at

www.yakimacountyems.com

May

| Sunday | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday |
|---------------------------|--|---|--|--|--------|--------------------------|
| | | | | | | 1 EMT |
| 2 | 3 ILS—YCDEMS EMT Module 10 White Swan | 4 | 5 ILS—YCDEMS EMT Module 12 WVFD Module 12 Selah 1 & 4 | 6 Module 10 Harrat Module 9 Mabton | 7 | 8 EMT |
| 9 | 10 ILS—YCDEMS EMT Makeup 9, 10 & 12 YFD | 11 Module 9 Zillah | 12 ILS—YCDEMS EMT-FINAL Module 7 Mattawa Module 11 Naches Hghts. Module 12 WVFD Module 9 Sunnyside | 13 Module 10 Toppenish | 14 | 15 EMT-FINALS |
| 16 EMS WEEK | 17 ILS—YCDEMS EMT | 18 Makeup 9, 10 & 12 UGFD Module 10 EVFD Module 11 Naches Module 10 Buena Module 12 Highland | 19 EMT-Combitube/King Module 9 Grandview Module 12 WVFD | 20 Module 9 Granger Module 10 Wapato | 21 | 22 EMT-Combitube/King |
| 23 EMS Awards Ceremony | 24 Makeup 9, 10 & 12 YFD Module 10 Parker | 25 Module 9 Outlook | 26 Module 12 Nile Makeup 9, 10 & 12 YFD | 27 | 28 | 29 |
| 30 | 31 Office Closed Memorial Day | | | | | |

June

| Sunday | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday |
|--------|--------|---|--|------------------------------------|--------|---|
| | | 1 | 2 Module 7 Selah 1 & 4 | 3 | 4 | 5 |
| 6 | 7 | 8 | 9 Module 7 Naches Hghts. Makeup 7, 8 & 9 Toppenish | 10 Makeup 10, 11 & 12 Toppenish | 11 | 12 Makeup 9, 11 & 12 WVFD Makeup 7, 8 & 9 Toppenish |
| 13 | 14 | 15 Module 11 EVFD Module 9 Naches Module 9 Toppenish | 16 | 17 | 18 | 19 |
| 20 | 21 | 22 | 23 Module 12 Mattawa | 24 | 25 | 26 |
| 27 | 28 | 29 | 30 | | | |