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EMMCO West Inc.
Fall EMS Update
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The Aires Of Change

If there is a certainty associated with the emergency medical service industry it is that EMS is constantly evolving and changing. Techniques, protocols, procedures, equipment, EMS system designs, educational concepts, management practices, and even its personnel are ever adapting to new or improved practices. What are considered new or current practices today will be consider "old school - out of vogue practice within the coming years. But to countering this statement is the notion that "what goes around comes around", is also being seen within the prehospital healthcare system.

CPR is the most recent example of this "back to the future" visitation of past prac that is finding a rebirth in today's healthcare system. Back in the day a few years ago...., you had to do the "perfect" chest compression strip on a recording manikin to pass the CPR course. Stressed was an effective depth and compression pattern. In the preceding years, chest compression efficiency became over shadowed by the use of other cardiac arrest treatment modalities; performing chest compressi took a back seat to these other treatments. Healthcare personnel would stop chest compressions so they could focus on "let's see what the cardiac monitor is showing" "intubation", "start an IV", or perform another cardiac arrest skill set. During these other cardiac arrest skills, less than effective chest compressions were bein performed. Now let's fast forward to today's revised CPR guidelines. Research show that effective and consistent chest compressions are leading to an improved surviva rate of out of hospital cardiac arrests. Bystander CPR training is being retooled to focus on chest compressions. The Boston Globe states that, the revised CPR guid state that rescuers should pump the chest of the victim at a rate of at least 100 compressions a minute - some say a good guide is the beat of the disco song "Stayin Alive.'' The report further states, "professionals to bystanders who use standard CPR should begin with chest compressions instead of first opening the victim's airw and breathing into their mouth. When the rescuer pushes hard (at a depth of at leas 2" for adults) and fast on the victim's chest, they're really acting like an artifi heart. That blood carries oxygen that helps keep the organs alive." CAB (compressio airway, breathing) is the new acronym for CPR, replacing the old ABC's. Keep monit regional publications, as in the coming months the new CPR guidelines will be incor into the PA Department of Health ALS-BLS Protocols and EMS training programming.

Advanced EMT is the "new certification level "identified within the National EMS Education Standards. Pennsylvania's new EMS Act, Act 37, identifies Advanced EMTs as a recognized level of prehospital care. There's a lot of "buzz" regarding the new advanced EMTs. The role of the advanced EMTs is really a back to the future staffing idea. Going back to the 1970's, prior to Pennsylvania recognizing a param certification level, there were specially trained EMTs providing advanced life supp skills. Functioning under a limited scope of care, administered through an online medical direction, these specially trained EMTs provided ALS care to critically ill and injured patients. Eventually, many of these EMTs became paramedics. The continuation of these specially trained EMTs lacked legislation authority to exist so their scope of care went back to the basic EMT level. For years in other states like Ohio, an EMT Intermediate level has existed. The proposed Advanced EMT level

will add additional skills and knowledge to the existing EMT Intermediate certifica levels. The new Advanced EMT can benefit both ALS and BLS EMS agencies. EMS Act 37's Rules and Regulations need to be enacted before the Advanced EMT level can be implemented. The timeframe is likely in late 2012 and early 2013 for the Advance EMT training programming to start and protocols/procedures to be identified.

Other recent "Aires of change" occurred in 2008. The PA Department of Health ALS & BLS Statewide Protocols identified new procedures and techniques for prehospital personnel. Especially for BLS EMS agencies, there are improved treatment approaches that can be implemented with minimal additional cost and training for personnel. With the coordination of the EMS Agency's medical director, BLS EMS Agencies can apply the CPAP device for acute respiratory emergencies, administer Epie Pens for allergic reactions, and apply Hemostatic agents for several bleeding. ALS agencies can now administer medications via internasal route and can use the King Airway device as an alternate airway. In early 2011, there will be revisions to the statew protocols, including the CPR and cardiac care revisions. EMS Agencies should review the current and new protocols with their EMS Agency medical director and explore the potential for enhancing the prehospital care offered to the constituents of their communities.

As seen in these examples, it's apparent that the "Aires of change" have been, and continue to be, a part of the EMS system. EMS providers, administrators, educators, and EMS system stakeholders have navigated the fluidity of the EMS system and its ebbs and flows for the history of EMS and can expect similar challenges in the futu

Bill McClincy

Executive Director

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Suicide - It Was My Choice

Free con ed!!! It's getting close to the end of the year, do you have all your con ed taken care of? EMMCO West staff is offering two chances to attend Suicide - It Was My Choice. This class is worth 1.5 hours of Med/trauma and 1 hour of con ed other credits.

For most people the holidays are a time of happiness and excitement as family gathe are planned and gifts are exchanged. For some, the holiday season is a time of dread and loneliness. Unfortunately, during the holidays are when EMS practitioners have the highest chance of responding to a depressed or despondent patient. For some of these calls, our job will be to take care of a patient, for others the call will come too late and our job will be to care for the survivors. This class is designed to highlight some of the common myths and misconceptions surrounding suicide. Please join us as we examine how one person's choice effects so many others.

Date: November 22nd, 2010

Time: 7:00 pm

Location: Spring Creek Volunteer Fire Department (Spring Creek, PA)

RSVP no later than November 19th

Date: December 6th, 2010

Time: 7:00 pm

Location: Seneca Volunteer Fire Department

RSVP no later than December 1st, 2010

RSVP either via phone at (814) 337 5380 ext 102 or ask for Michelle or via email atmichelle@emmco.org [mailto:michelle@emmco.org]

This is NOT your typical PowerPoint lecture type of class. Because of the manner of the presentation, some attendees may feel uncomfortable or upset during the pres This class is a drama using both scripted actors, moulage (special makeup), and lighting to create realism. .

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History

There are plenty of places in this world where due to something that happened in ancient history, two countries, ethic groups within a country, two religious sects whatever don't like each other or worse. In many cases, it has been so long ago that nobody even knows why the two parties don't like each other. Let's be hones We know that there are fire department and ambulance services out there that don't get along. There are ambulance services and fire departments out there which were started solely because a group of people didn't like something within their service or their neighboring department.

I often hear "we do this for patient care". Really??? First, I think most EMS agencies provide EMS for the right reasons. We applaud those agencies. A small number of agencies are providing EMS out of, we'll call it spite. It has gotten to the point, in a few instances, where the service cannot meet the expectations and the needs of the community but there is no way in the world that they will give up their call area or let service x take all of 'their" calls. However they are more than happy to let them take the calls they can't crew or don't want. Tell me that this isn't the case in a few areas?!

Why stir up such controversy? There was an article in our last online newsletter that reviewed ways in which services can take steps toward resolving their inabilit to make calls. Collaboration, cooperation, or even consolidation means working with neighboring agencies. This means working with an agency that your service or department might not like because of something that happened 35 years ago that 85% of your members know nothing about. With the new EMS Act, there higher staffi standards. Services are, however, permitted to be part of a larger staffing plan. Rest assured, a staffing plan that shows a major gap, only to be explained by "we don't like them" is not going to work.

I would ask EMS agencies to look introspectively at why you do what you do. Most of you will walk away with a clear conscience. If you can't or if this article got under your skin, then maybe something is wrong. If you can't get along with your neighboring service or department, stop and ask yourself why. Ask yourself if this old baggage, which gets in the way of cooperation at a scene, is doing anyt but hindering patient care or other public safety needs. Is it really worth it?

Christopher Heile

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A Question For All EMS Practitioners

Have you ever had to call 911 to request an ambulance for someone you love?

Let us take a minute to discuss what kind of person you hope would respond. I am

guessing your first thought will be about the type of response you have in your community. For example, do you live near a service that pays their responders or a more rural setting relying on volunteers? Should this even be a factor? Aren't all EMS practitioners trained to the same standards? Does the scope of practice change depending on whether or not an EMS practitioner receives a paycheck for services rendered? Or maybe a better question is does a higher paid practitioner somehow provide a higher quality of care? If that were true, what of the statement volunteers are not paid because they are worthless, but because they are priceless? Paid versus volunteer should not be factor. So back to the original question, who do you want to knock on your door and save the day?

The call starts with the dispatcher, so should good communication skills be high on our list of traits? After all, the dispatcher is a person's first contact with help, and how the dispatcher responds to that request can actually set the tone for the entire call. Therefore, a confident, knowledgeable and calm dispatcher is an invaluable resource. But good communication skills are necessary for all of the responders throughout the entire call. A practitioner needs to be able to speak clearly to a patient, to address questions from family members, and to verbalize specific medical information to other medical professionals.

What should this practitioner look like? His/her clothes should be clean with the shirt tucked in and the boots/shoes clean. There should be no offensive slogans on the practitioners shirt such as "my job is to save your ass not kiss it" or "co-naked EMS". There should be no sunglasses or low hung baseball caps preventing the patient from seeing the practitioner's eyes. Eye contact with a person in crisis is one of the easiest ways to gain trust.

Does the practitioner carry in equipment other than a clipboard to write on? And how is this equipment treated? Is it carried as if it were an albatross, some heav bag thrown over the shoulder and laid on the floor not as beneficial tool, but as a heavy weight brought in only because that is what is expected? Does the provider use the equipment or simply put it on the floor to become a trip hazard as the pati is extricated?

What about a practitioner's presence? I am not talking about just having a person be in the room, I am talking about how that person's presence in the room affects the others in the room. A practitioner should enter the room with confidence. His/h attendance in the room should instill in others a feeling that help has arrived, as in "I am here. I have the knowledge. I know what needs to be done, tell me your problem and let me make things better".

One of the most important traits a practitioner should have is knowledge. The medic field is constantly evolving as new diseases are diagnosed and new treatments are created. The difference between a good practitioner and a great practitioner is that a great practitioner is constantly learning. He/she does not stop taking class just because the bare minimum number of coned hours has been met.

So another question for all EMS practitioners

Does this article describe you?
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Kudos!

Congratulations to the services that have received their new or renewed license or recognition since July.

The following have renewed their license:

Fairfield Volunteer Fire Department

Franklin Township Volunteer Fire Department

Kuhl Hose Volunteer Company

Lake Shore Volunteer Fire Department

Life Force of Western PA

Pleasant Volunteer Fire Department

Sugar Grove Volunteer Fire Department

The following has become a new recognized QRS services:

Rouseville Volunteer Fire Department (QRS)

The following has become a new ALS services:

Elite EMS, Inc.

The following has become a new ALS - Air services:

W.C.A. Services d.b.a. STARFLIGHT

The following have become new Volunteer Rescue Service Recognition services:

Albion Volunteer Fire Department - Vehicle and Machinery - Basic level

Lake City Fire Company - Swiftwater Rescue Level 3a

EMMCO West wishes to thank them all for their cooperation during this licensure or recognition process.

It was a pleasure to work with all of you.

Jane I. Hamza

EMS System Specialist
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Con Ed Corner

Every year EMMCO West receives many phone calls this time of year about paramedics and how many hours of CE they must complete for medical command authorization. Thes requirements are in regulation and cannot be waived by the service medical director

Paramedics must complete 18 hours of CE each year to gain medical command authoriza for the following year. At least 9 hours must be in the medical trauma category. They must also have a current CPR card.

Paramedics who received their certifications this year will have their continuing education requirements pro-rated. They must complete 1.5 hours for each month they have been certified including the month they obtained certification. Half of these hours must be in the medical trauma category and they must have a current CPR card to gain medical command authorization.

Paramedics who have been certified prior to this year and who were inactive must

make up the continuing education hours from the previous year before they can obta medical command authorization to function. They must also complete and additional 18 hours of CE (half medical trauma) in order to gain medical command authorization for next year. For instance if in 2009 a paramedic completed 4 hours continuing education, but never functioned as a paramedic in 2009 and wanted to become active as a paramedic again in 2010, he or she must complete 14 hours with half medical trauma to be able to function in the field today. In order for the paramedic to continue to work after January 1st, he or she will need to complete and additional 18 hours of CE for a total of 32 hours of CE in 2010.

First responders need a total of 16 hours and EMTs need a total of 24 hours in a 3 year period with (half medical trauma) and a current CPR card to recertify. It is also important to realize that certification cards expire on the 1st of the month and not the end of the month. BLS certifications will expire on one of the following dates, January 1st, April 1st, July 1st, or October 1st. If BLS practiti have not received their new certification card 30 days before the old one expires they should call the office to see why they haven't received their new card.

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Timely Statistics

Here are some graphs showing arrive time statistics for the first half of 2010. Arrive time is the time from dispatch to arrive scene. There are 4 graphs as the responses are broken down into different sized municipalities (by population per square mile). To help you in interpreting the graphs, I'll explain the first.

Graph 1 shows emergency responses into municipalities with population densities of less than 100 persons per square mile. I will use the QRS data as the example. The QRS services arrived on scene between 0 and 8 minutes about 69% of the time, between 9 and 13 minutes about 20% of the time, 14 to 20 minutes about 7% of the time, and greater than 20 minutes about 4% of the time.

Less than 100 persons/mi2

101-500 persons/mi2

501-1000 persons/mi2

=>1000 persons/mi2

It should be noted that EMMCO West does not receive data from agencies providing QRS type service which are not recognized by the Department of Health, however there seems to be enough data to show the value in QRS, especially in sparsely popu areas (generally the most remote). Beyond that it appears that ALS and BLS are gett to the patient at about the same time, with perhaps a slight edge on the side of ALS.

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Sincerely,
Bill McClincy
EMMCO West Inc.

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