



EMS NEWS

OCTOBER 2004

VOLUME 19

ISSUE 5

2005 Policy Review Process ... New Policies, New Look!

By Kris Helander-Daugherty, RN

The 2005 policy review process has been completed. Thirty-six policies included were in this year's process; however, only one new policy was added. The new policies go into effect December 1, 2004. Now, on to the important stuff... the color this year is Lunar Blue. Other improvements include colored tabs for each section and the spiral binding was replaced with a screw & post device to make adding or removing pages easier. This was a suggestion from the EMS Section. A team of paramedics assisted agency staff in reviewing the final draft to ensure accuracy.

Here are some of the highlights:

A new procedure for **Continuous Positive Airway Pressure (CPAP)** was added. The device is used for CHF with pulmonary edema and near-drowning. Additional training is required. Policies affected by this change include: **Adult Pulmonary Edema/CHF, Adult & Pediatric Submersion.**

An existing procedure, insertion of an **Esophageal-tracheal double-lumen Airway** device (found in the Advanced Airway Management policy), has been expanded to include use by EMTs after completing an approved training program and with approval by the EMS medical director.

Separate doses of epinephrine have been added to the adult and pediatric **Allergic Reaction/Anaphylactic Shock** policy. 1:1,000 epi IM/SQ is used for allergic reaction and 1:10,000 epi IV/ET is given for anaphylactic shock.

CPR instructions were added to the Adult **V-fib/V-tach** policy. In witnessed VF/VT, perform CPR until a defibrillator arrives. In an unwitnessed arrest, perform CPR for 2-3 minutes prior to defibrillation. Lidocaine ET was added back in if there is no IV access.

A request from the field to specify the appropriate dose of epinephrine in all pediatric policies prompted us to change the **Medication—Authorized/Standard Initial Dose** policy. In the past the dose was calculated from the length-based resuscitation tape. A note in the following policies directs the paramedic to this change: **Allergic Reaction, Bradycardia, Neo-natal Resuscitation and Pulseless Arrest.**

The pediatric Respiratory Distress policy was split into two separate policies; **Upper Airway (Stridor) and Lower Airway (Wheezing)**. The albuterol/Atrovent combination was added for moderate/severe distress, consistent with the adult policy.

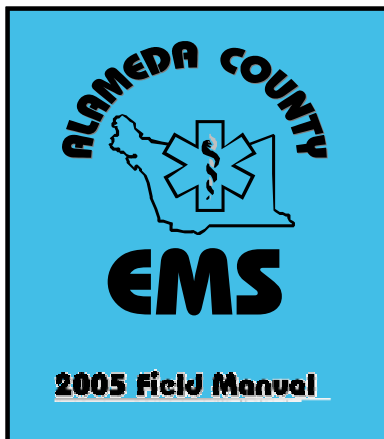
Midazolam IM was added to the adult **Seizure** policy if there is no IV access.

Viagra in the adult **Chest Pain/MI** policy was changed to *erectile dysfunction medication* to expand this category of drugs to include newly added Levitra and Cialis.

We finally settled on an initial narcotic dose. The new range for an adult is 1-4 mg IV/IM and 0.1 mg/kg for all routes in the pediatric patient. The adult and pediatric **ALOC and Poisoning/Ingestion/OD** policies were revised to reflect this change.

The **Multicasualty Incident (MCI)** policy was completely rewritten. It has been shortened considerably with only the essential facts remaining.

There are numerous additional changes. A **Summary of Changes** is included in the front of the field manual. Look it over carefully. Now, how do you get a copy of the 2005 Field Manual? Check with your provider agency for distribution information. The EMS Agency will also be selling manuals - the cost is \$7.25 cash only.



Inside this issue:

TRACE	2
Basic Disaster Training	2
Guest Columnist	3
Fatal and Non-fatal Injuries	3
What's New on the Web	4
Injury Prevention Corner	4
News & Announcements	4

TRACE - Target Responsibility for Alcohol Connected Emergencies

By Mona Mena, Alameda County EMS

Target Responsibility for Alcohol Connected Emergencies (TRACE) is a recently implemented program in California to identify the source of alcoholic beverages consumed by minors that result in serious injury or death. These incidents include car crashes, alcohol poisonings or overdoses or other events. The State Department of Alcoholic Beverage Control (ABC) should be immediately notified:

- ✓ If local or state law enforcement or other emergency service providers, including first responders, emergency rooms, or the coroner suspects that an ABC licensed location could be responsible for selling or furnishing alcohol to minors (under 21 years of age)
- ✓ If the minor received the alcohol from family or friends
- ✓ Of any death or injury involving under age drinking



The ABC is available 24 hours a day so that their investigators can be dispatched. Investigating officers will collect evidence to indicate where alcoholic beverages were obtained. They will be looking for false identification, receipts, bags, labels, matches and statements of witnesses. The investigators will follow up with individual establishments and will suspend or revoke liquor licenses of businesses.

California is the first state in the nation that has implemented an alcohol-tracing program for minors and was awarded the most Innovative

Liquor Law Enforcement Program of the Year by the National Liquor Law Enforcement Association at its annual meeting on August 27th. The ABC, in conjunction with the California Attorney General, the Office of Traffic Safety, the California Highway Patrol, Mothers Against Drunk Driving, the California Police Chiefs Association, and the California Sheriffs Association, developed the TRACE program. The ABC is responsible for licensing and regulating establishments that sell alcoholic beverages in addition to enforcing laws related to alcoholic beverages in the state.

Timothy Gorsuch of the ABC, reinforces the value of receiving notification, "If our investigation determines that an adult furnished the alcohol to the minor we submit the report to the District Attorney's Office in the County where the violation occurred. The criminal courts have levied punishments any where from the minimum mandatory \$1,000 fine and 24 hours of community service up to 6 months in jail just for furnishing the alcoholic beverages to a minor. There is a current movement to pass legislation increasing these penalties, but it is still working its way through the process. In addition to the charge of *furnishing alcohol to a minor* the DA's office may also file charges of gross *negligence*, *manslaughter* etc., when crashes with injuries and fatalities occur. These are felonies and carry prison terms. If the person who furnished the alcohol was an employee or owner of a business licensed by ABC, our department then takes administrative action against the business. Our penalties range from a 15-day suspension of their liquor license up to outright revocation depending on the circumstances."

If you respond to a call that involves minors and alcoholic beverages,

contact your local law enforcement agency and the ABC TRACE Program at the TRACE notification number: 916-919-4445. For more information on TRACE call Timothy Gorsuch at 916-263-7910 or go to ABC web site at: <http://www.abc.ca.gov/>.

Training for Basic Disaster Preparedness

By Dave Sullivan, EMT-P

In the Spring of 2004 the Alameda County Emergency Medical Services Agency began training the county's health clinics in basic disaster preparedness. Some clinics like La Clinica, Lifelong Medical, and the Asian Health services are community-based while others are connected with local area hospitals like the Alameda County Medical Center. These clinics serve Alameda County's diverse populations with limited access to health care.

A training plan was developed, training material assembled, and approximately 900 people at 24 clinics were trained.

The trainings were divided into three topical areas: disaster preparedness, family/work plan, and disaster supplies. The importance of having a facility disaster plan that is effective and flexible was stressed. The clinics were given information on the basic items needed following a disaster:

- ✓ food & water for 3-5 days
- ✓ shelter
- ✓ basic sanitation

Before a clinic can serve their clients following a disaster, these items need to be on-hand. They were given a list of supplies to include in a disaster kit, and information from the US Department of Homeland

(Continued on page 4)



A New Way of Administering

Naloxone—By Christopher T. Van Luen

(Medical Director's note: In this month's newsletter, Firefighter/ Paramedic Christopher T. Van Luen describes an interesting and useful pilot program at Berkeley Fire. In the future, we will share information from other studies that are ongoing in Alameda County. Provide your comments to Jim Pointer at james.pointer@acgov.org or 510-618-2022).

As prehospital emergency care providers, we are always at risk for needle sticks. Despite the latest technology in intravenous catheters or "needleless" systems, accidents still occur. With the advent of blood born pathogens such as HIV, and hepatitis B and C, needle sticks can be life altering and life threatening occupational hazards. Through research and development, the EMS industry has developed a method of administering intranasal (IN) medications that eliminates the need for sharps in situations that provide a high risk for a needle stick.

The nasal route is an attractive method of drug delivery because of the rich vascular plexus in the nasal cavity and the easy accessibility of this vascular bed. Nasal administration of medications has emerged as an effective method of delivering medication directly into the blood stream.



A Mucosal Atomization Device

Medications are delivered via a Mucosal Atomization Device (MAD®), a small cone shaped device that attaches to the end of the

pre-filled syringe. When the plunger is depressed, the medication passes through a 30-micron filter, which produces a very fine mist. Due to direct absorption into the blood stream, gastrointestinal destruction and first pass metabolism (drug destruction via liver enzymes) are avoided, allowing more of the medication to be made available.

Factors that will reduce IN absorption include nasal mucosa destruction secondary to trauma, cosmetic surgery, or prolonged cocaine use. In addition, patients with an active upper respiratory infection or epistaxis may not benefit due to the difficulty in gaining contact with the nasal mucosa due to heavy secretions. Use of topical vasoconstrictors such as recent "snorting" of cocaine will also reduce absorption.

The IN route, although relatively new in the prehospital setting, has been used successfully for the past several years in Washington, Oregon, Colorado, and Florida. Paramedics in Denver, Colorado have been using the IN route for the administration of naloxone in suspected opiate overdose patients with great success. During their study, patients were given 2 mg of IN naloxone (1mg/ml up each nostril) upon initial contact. Out of the 95 patients enrolled, 52 patients responded to naloxone: 43 (83%) to IN naloxone alone, 9 (17%) to intravenous (IV) naloxone following IN naloxone. Four of the nine who awoke after IV naloxone had anatomic abnormalities that may have prevented absorption via the IN route. The time from IN naloxone administration to the time of patient awoke was 3.0 minutes. In comparison, the times for naloxone administration via IV and IM routes to time patient awoke were 3.8 and 5.5 minutes, respectively. The conclusion

Guest Columnist

of the Denver study was that IN naloxone acts rapidly and reduces the risk of paramedic needle sticks.

On September 20th the City of Berkeley Fire Department will begin a pilot program utilizing IN naloxone in patients with suspected opiate overdose. Over the course of 6 months, all patients who present with a suspected opiate overdose will be given 2 mg naloxone IN. Data will be collected on all patients enrolled and compared to literature from previous studies. At the end of the pilot program all data will be reviewed to determine the feasibility of adding this mode of administration to the Alameda County protocols.

Statistics on Fatal and Nonfatal Injuries

By John Vanhof, EMT-P



Each year in the United States, an estimated one in six residents requires medical treatment for an injury, and an estimated one in 10 visits a hospital emergency department (ED) for treatment of a nonfatal injury. This report¹ summarizes national data on fatal and nonfatal injuries in the United States for 2001 by age, sex, mechanism, intent, and type of injury, and other selected characteristics.

In 2001, 157,078 persons in the United States died from an injury, and 29,721,821 persons with nonfatal injuries were treated in U.S. hospital EDs.

Overall, the leading cause of fatal injury was unintentional motor vehicle--occupant injuries. The leading cause of nonfatal injury was uninten-

(Continued on page 4)

**Alameda County
Emergency Medical Services Agency**
A Division of the Public Health Department

1000 San Leandro Blvd., Suite #100
San Leandro, CA 94577
(510) 618-2050
(510) 618-2099—fax

Board of Supervisors

Scott Haggerty, *District 1*
Gail Steele, *District 2*
Alice Lai-Bitker, *District 3*
Nate Miley, *District 4*
Keith Carson, *District 5*

Health Care Services Agency

David J. Kears, *Director*

Public Health Department

Arnold Perkins, *Director*
Anthony Iton, MD, *Health Officer*

Emergency Medical Services Agency

Cindy Abbissinio, RN, *Director*
James E. Pointer, MD, *Medical Director*

Newsletter Production

John Vohnhof, *Editor*
Kris Helander-Daugherty, *Design & Layout*



What's New on the Web



- View the new CPAP policy.
- New EMT Certification application with the NREMT testing information added.

November is . . .

Firearm Safety Month

*Injury
Prevention
Corner*

Did you know...

- ✓ Exposure to guns and access to a loaded or unloaded gun increases the risk of gun related injury or death in children. Unintentional shootings account for nearly 20% of all gun-related deaths in children up to 14 years of age.
 - ✓ If you own a gun, store them unloaded and locked up, out of the reach of children.
 - ✓ Ammunition should be stored locked in a separate location, out of the reach of children.
 - ✓ Parents often misjudge their child's ability to discern the dangers of a gun. Do not assume that your child can distinguish a toy gun from a real gun.
- Talk to your teen(s) about the dangers of guns. For more information,

Basic Disaster Preparedness (Continued from page 2)

Security and the American Red Cross. Clinics employees were also encouraged to create a family disaster plan and build a disaster supply kit for their homes.

Each clinic was provided building evacuation information. Instructions on the shelter-in-place system that some communities have established was discussed because shelter-in-place systems are to be used at both at work and at home.

Sandra Williams, the Disaster Planning manager at the Alameda County Medical Center commented, "The staff responded well to the training. They saw the way that the training and steps of preparation fit into their work lives as well as the lives outside of work."

Statistics (Continued from page 3)

tional falls; however, leading causes vary substantially by sex and age. For nonfatal injuries, the majority of injured persons were treated in hospital EDs for lacerations (25.8%), strains/sprains (20.2%), and contusions/abrasions (18.3%). The majority of injuries were to the head/neck region (29.5%) and the extremities (47.9%). Overall, 5.5% of those treated for nonfatal injuries in EDs were hospitalized or transferred to another facility for specialized care.

Extracted from: 'Surveillance for Fatal and Nonfatal Injuries - United States, 2001. Sara B. Vyrostek, Joseph L. Anest, Ph.D. , George W. Ryan, Ph.D. , Office of Statistics and Programming , National Center for Injury Prevention and Control.



News & Announcements . . .

Attention Paramedics & EMT's - Title 22 Regulations changes - Title 22 regulation changes have been approved and will go into effect on October 10, 2004. Changes affect EMTs, paramedics, and continuing education. New QI Guidelines were also approved. In mid-October we will post a document on our web site that summarizes the changes as they affect EMTs and paramedics. Two changes immediately affect paramedics and EMTs:

- CE Regulations – 50% of the required CE hours must be in a format that is instructor-based (where an instructor is readily available).
- EMT Recertification – The every

four years written and skills exam requirement has been changed to a skills verification required every two years.

To read the entire text, go to the EMS Authority web site at: <http://www.emsa.ca.gov/>.

2005 Field Manuals will be available for sale at the EMS Agency for \$7.25, just in case you lose or wash yours, or just want an extra! We accept cash only!

