Celebrating 20 Years of Trauma Care 1987 - 2007

EMS NEWS

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Alameda County Emergency Medical Services

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Eden Hospital's *"Best-Care"* Trauma Team

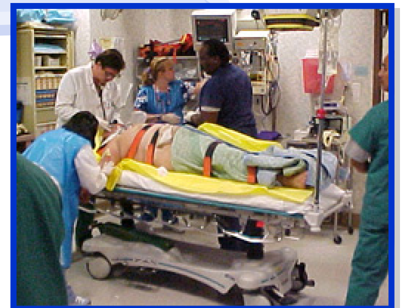
By Ginger Miramontes, Director
Trauma Services, Eden Hospital

Eden Medical Center has been in partnership with Alameda County EMS for 20 years to provide high quality trauma care. We have touched the lives of patients and families injured by automobile crashes, industrial accidents, falls, and victims of violent crimes. It is with great pride and satisfaction that we celebrate 20 years of continued excellence in trauma service for Alameda County.

In August of 1986, Eden was designated as the Level II Trauma Center for Southern Alameda County. By January of 1987 the course of rigorous training and commitment had lead the trauma team into 24 hour a day service. Our multi-specialty team consisted of not only the most skilled surgeons, anesthesiologists and trauma nurses, but also emergency department, respiratory, radiology and laboratory technicians. Led by the trauma surgeon and dedicated trauma nurse, this team assembles at a moment's notice to rise to any traumatic challenges that fate delivers. This team is supported by social services and our specially trained volunteers of family support staff to meet all of the patients and families needs. Trauma care extends far beyond the doors of the trauma room. This commitment to service excellence is felt throughout the organization. Every department in the medical center contributes to the "esprit de core" that is the pride of trauma care at Eden Medical Center. Our critical care, operating room, surgical care & rehabilitation staff strive to attain and maintain advanced licensure to their specific areas. Committed to the quality it takes provide the *BEST-CARE* is evidenced in every aspect from environmental services, dietary, physical/occupational therapy to discharge planning and follow-up.

Together, with the pride felt throughout Eden Medical Center, there is an overwhelming commitment to provide the best trauma care. In our first year we served 1,150 patients. Over the past 20 years 40,000 patients have received quality trauma care with resulting dramatically improved survival rates compared to the days before trauma centers. We were mentored by leadership that stands for innovation, the commitment for doing the right thing, and the inspiration to motivate and maintain these high standards. This early leadership saw that by sharing both skill and expertise they strengthened themselves as well as trauma care throughout the Bay Area. Together with Bay Area trauma leaders and educators we work to set the standards and evaluate our path for the future both locally and nationally. This led to our growth over the past 20 years. Today we remain strong in our commitment to the people of Alameda County who have come to know the value of having a trauma center in their community.

"*Trauma Code ETA 5*." The sound amplifies throughout the medical center signaling into action a team of the highest trained medical professionals. There is more than an adrenaline rush of energy. It's a commitment to go beyond the call of duty and to do all that it takes to save a life.



The trauma team at Eden Medical Center assembles to care for a trauma patient.

Jocelyn Garrick, MD Joins EMS as Assistant Medical Director

Dr. Garrick comes to us from Alameda County Medical Center where she served as a Base Hospital Physician, and where she will continue to work occasionally. She is also an Assistant Professor at U.C. San Francisco's Department of Emergency Medicine and a Fellow of the California Health Care Foundation Leadership Program.

She will provide medical oversight and training for the county's new Sobering Center, scheduled to open in late fall. She will also play an important role in the Pipeline project to recruit and support low income youth in developing EMS careers. Her background in research and education will be a valuable addition to Alameda County EMS. You can reach Dr. Garrick at (510) 618-2044 or *jocelyn.garrick@acgov.org*.

The History of Alameda County EMS 2000 - 2007

The year **2000** came and went without any computer glitches or crashes (remember the Y2K scare?) This year also brought the start of new services to the County. A plan to have three standardized dispatch centers to provide Emergency Medical Dispatch (EMD) and prearrival instructions county-wide was begun. The plan included dispatch centers at Oakland Fire, Fremont Fire and a move of ALCO-CMED to the Lawrence Livermore Lab Fire department. The cities of Alameda and Oakland began offering paramedic level service. The first terrorism conference was held in September.

The year 2000 also saw an increase in the injury prevention activities performed by EMS staff. The Oakland Pedestrian Safety Project, Safe Kids Car Seat Checks, and the beginning of the Senior Injury Prevention Program, a fall preventions initiative, all began that year.

2001 saw another change of leadership at EMS, with Cindy Abbissinio promoting to the EMS Director position. A comprehensive Trauma Report was published that took a detailed look at the Alameda County EMS Trauma System from 1994-1998. Also, the Reddinet System, that allows hospitals in Alameda and Contra Costa Counties to communicate with each other and the EMS system was launched. And of course… September 11th happened. This began a new path for our disaster planning that included weapons of mass destruction, and bioterrorism preparedness.

2002 saw the introduction of the critical care transport paramedic program that allowed for an expanded scope of practice for specially trained paramedics who run interfacility transfers. 12-lead EKGs began as a pilot program. Background checks were implemented in September that required a DOJ criminal history for certifying and recertifying EMTs. The EMS office relocated to temporary office space on Fairway Drive in San Leandro.

2003 brought the start of continuous positive airway pressure (CPAP) as a pilot study by the Hayward Fire Department. This was also the year that the Bag-Valve-Mask ventilation system became the primary method of airway management in pediatric patients.

2004 - on the road again. The EMS office relocated again, this time to our permanent location. After years of planning, Highland Hospital was named as the single base for the entire county. Prior to this, Kaiser Hayward and ValleyCare also served as base hospitals. This change came about as a result of the planning from the EMS Council during the late 1990's. Intranasal medication administration was also added to the paramedic scope of practice. Alameda County adopted the NREMT exam as the certifying exam for EMTs.

2005 - The Chempack program, that places nerve antidote medication in strategic locations throughout the county began. After a long illness, EMS Director Cindy Abbissinio died. The new director, Michael King, had already begun transitioning into the director position.

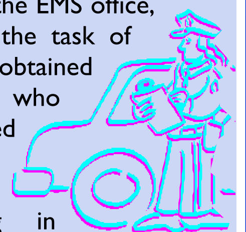
2006 saw the EMS agency staff develop a strategic plan to help guide our planning through the next five years. Cardiac Receiving Centers (CRC) and Prehospital 12-Lead EKG became fully operational with four CRCs designated countywide. EMS began the process of developing an ambulance ordinance that will enable the county to provide oversight for non-911 system ambulance providers. As a part of contract negotiations with some of the provider agencies, EMS will embark on an ECHO call trial study, initially with Alameda Fire and Oakland Fire, to provide emergency response to the most critical of patients within 6 minutes and 30 seconds. A request for proposal process was held to select a consultant to evaluate the EMS system and make recommendations prior to the next bid process for 9-1-1 emergency ambulance service (The contract with AMR is scheduled to expire in 2009). Fitch and Associates was selected and should begin the assessment during 2007.

This is the final chapter to the story. If you would like to read the article in its entirety, go to the EMS website and look under "about us"

Well, we are done. A lot of changes have happened over the past 20 years. We have gone from a fledgling paramedic ambulance response service to a mature, fully functioning EMS and injury prevention system with wide-ranging influence, cutting edge medical care, and participation from all level of service providers. What hasn't changed is the dedication of EMS personnel to our patients and their families.

Court Diversion: Who is Cited and Why?

by Asianna Barner, EMS student intern



As an intern at the EMS office, I was assigned the task of entering data obtained from students who have been cited for car seat or seat belt violations resulting in required attendance at the Alameda County Court Diversion Class. All students have to fill-out a Data Assessment Form. The form asks various questions such as why were they cited, what city they were cited in, their age range, etc. As I entered data, I was able to see interesting trends. I learned a lot about *who* gets traffic tickets and *why*. I now know that people of all races and ages get ticketed. In addition to learning about many types of safety violations, I learned that seat belts are the most effective means for saving lives and reducing serious injuries in traffic

(Continued on page 4)

From the EMS Medical Director

A View From The Other Side (Part 2) By Jim Pointer, MD

If you recall, from our last episode, I was recently a patient following abdominal surgery. I normally take several antihypertensives. My nurse brought me at least a double dose of these medications in spite of the fact that my blood pressure was 108/72. I asked to see my medical records; the answer was a resounding "no." In minutes, the hospital administrator, the patient advocate, the physician in charge of quality, and my nurse joined my wife and me. I was told, in spite of California law, it was "against hospital policy" for me to view my medical records. Ultimately, reason prevailed and I was able to confirm the fact that double antihypertensive medications had been ordered. Please understand that this error is not specific to one particular hospital. As I mentioned in my first article, the Institute of Medicine reported nearly 100,000 deaths per year from medical errors in hospitals. While this error was not so egregious, it could have resulted in more serious consequences.

I was progressing fairly well during my hospitalization until one Wednesday morning. The nurse's aid on the day shift entered to take my vital signs . On more then a dozen occasions I inquired of the aid the normal values for the various vital signs. In only about 15% of the instances, the aid was able to determine reasonably normal values for all the vital signs. On that fateful Wednesday morning, my pulse oximetry reading was "91%."

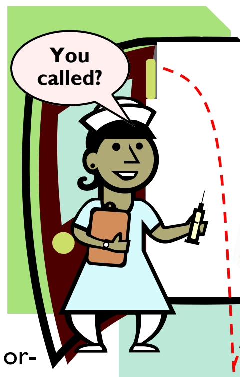
I asked the nurse's aid, "Will you *please tell the nurse that this value is abnormal?*"

She replied, "*It's ok; it's about 90%. I don't have to do anything.*" (Why is 90% abnormal? What is normal in a patient without heart or lung disease?)

Whereupon I said, "*It's not normal and 91% must be explained.*"

She replied, "*That's not what I was taught!*"

I asked to speak to my nurse. I rang the call bell. By the way, the "call bell" is an interesting phenomenon. On occasion, the patient actually receives a reasonable response, "*what can we do to help you?*" On other occasions, the call either goes unanswered or there is an emphatic, "*we'll send someone in as soon as we can.*" On several occasions, the console that contained the call bell was beyond my reach as I was restrained by various tubes and devices. A book or other item thrown in the hallway usually, ultimately, attracted attention.



Eventually, my registered nurse entered to receive the news that my oxygen saturation was low. The nurse immediately assessed my lung fields in an attempt to explain this value and asked for a repeat assessment of the oxygen saturation.

Every day, three different nurses' aids worked with three different RNs. The nurses' aids performed the vital signs while the nurses performed the physical exam. Ultimately, I understood that it was important that the nurse perform both, so, after five days in the hospital, I refused all vital signs taken by nurses' aids. I ended up speaking with the nursing director of impatient services to ensure that the nurses' aids understood the normal values for oxygen saturation and the test's scope and mechanism. I believe that this simple act will result in fewer hospital days and less morbidity.

On day 14, I was discharged, alive. I do not state this in jest. The staff at the hospital that cared for me is no more or less competent than the staff in any other hospital. My attending surgeon sent me home with an absolutely excellent medical device called a vacuum assisted closure machine. This device literally vacuumed the wound from my fistula revision surgery to remove debris and fluid and ensure a rapid healing. This technology is very costly, and it is to my caregiver's credit that without request it was provided for me. The state of medical care in our country dictates that, in many cases, financial concerns supersede medical ones. To give yourself or loved one the best chance during hospitalization, I recommend taking the simple actions listed below as early as possible after hospital admission.

- ✓ Find and use an advocate – a close relative or friend.
- ✓ Ask to view your orders daily. If there is a hospital "rule," ask your physician to write an order that allows you to view the chart.
- ✓ Ask that vital signs and physical exams be performed by the RN, not nurse's aid.
- ✓ Ask that specific instructions for frequently-performed nursing procedures (flushing an IV line or dressing changes) be posted at the bedside to ensure uniformity.
- ✓ Don't hesitate to have your doctor paged for any concern which cannot be explained by hospital staff.
- ✓ Ask and have a sign posted that you not be disturbed between 11:30 pm and 6 am. I was awakened at 3 a.m. for "trash collection."
- ✓ You have the right to refuse any test or procedure. Errors occur. If something doesn't make sense, get an explanation.
- ✓ Be cooperative, helpful, and honest. Details like visual pain, itching, or even passing gas can be important.

As always, you can contact me at *james.pointer@acgov.org* or (510) 618-2022 for questions or comments. BTW: it's good to be back!

Alameda County

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Public Health Department

- Anthony Iton, MD, JD, MPH *Director/Health Officer*

What's New on the Web

- **The complete history of Alameda County EMS 1973 - 2007**
- **2008 Policy Review Process**
- **Setting up an AED/PAD program**

EMS Website: acgov.org/ems

News & Announcements

A **Public Forum** will be held August 16th at 10:00 am at the EMS Office to discuss the 2008 draft policies. Copies of the policies are available for download at the EMS website.

Erica Campos joins EMS as a Specialist Clerk, supporting the EMS staff in a variety of general office tasks and skills. She will be working with the injury prevention staff registering clients for court diversion classes held for violators of the car seat and seat belt laws. (See page 2 for more on this.) She can be reached at *erica.campos@acgov.org* or (510) 618-2059.

Court Diversion *(Continued from page 2)*

crashes. As I entered data about cities, it seemed that more people are cited in Livermore, Fremont, and Pleasanton - but of course, students represent all the cities in this county and some are even from outside the Bay Area. Many times a person gets stopped for one thing like speeding, running a red light, or because they don't have a current registration, and he/she may also end up getting ticketed for a car seat or seat belt violation.

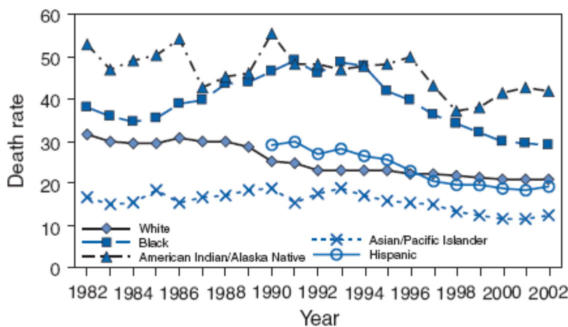
People are commonly ticketed for not wearing their seat belt, for not having car seats or booster seats in the car, for car seats not installed properly, and for children sitting on a passenger's lap. Why is it so important to wear seat belts or have your child in a car seat? If you are in your vehicle and another vehicle hits you, there are more likely to be serious injuries if you don't have your seat belt on or the children are not restrained correctly. You or the child could have deadly injuries or be thrown from the vehicle.

All of us need to do the right thing to be safe on the roads. Everyone must wear a seat belt! Even if you are just going around the corner – it doesn't matter – you are still vulnerable to getting stopped by the police, or worse yet, to be in an automobile crash. Some crashes and traffic tickets are unavoidable, but using seat belts and car seats can help save a life.

Ms. Asianna Barner, age 15, student intern, Ralph Bunche High School, Oakland

Fatal Injuries Among Children by Race and Ethnicity (1999-2002)

Editor's Note: excerpt from a study published in MMWR by Stephanie J. Bernard, PhD et al.
Division of Unintentional Injury Prevention, National Center for Injury Prevention and Control



Unintentional injury is the leading cause of death among U.S. children aged 1-19 years, with homicide and suicide near the top of the list. Mortality rates from injury, whether unintentional or intentional, are particularly high among certain racial/ethnic populations. Previous studies have examined differences in injury death rates according to race/ethnicity and have consistently documented that black and American Indian/Alaska Native (AI/AN) children are disproportionately affected. During the 1990s, injury death rates for black and AI/AN children were two to three times higher than those for white children. In contrast, injury rates for Hispanic and Asian/Pacific Islander (A/PI) children were equal to or less than rates for whites.

Injury death rates by mechanism and race/ethnicity have been documented for the entire population but not for children alone. This report summarizes injury death rates in the United States for children aged 0 -19 years by race/ethnicity.

The study showed that the gaps between injury rates for blacks and AI/ANs and rates for whites have not been closed. Future injury prevention efforts might close this gap by targeting the injury mechanisms most harmful to minorities in each age group and by using culturally appropriate prevention messages and strategies. Because of frequent interaction with parents and caregivers, health-care providers/educators serving AI/AN and black populations can continue their vital role by communicating age-appropriate injury-prevention messages.