



Pandemic Influenza Preparedness and the First Responder

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Paramedics, police officers, fire fighters, and/or EMTs may be the first to come in contact with a suspected case of avian flu. H5N1 Avian flu is a subtype of the Type A influenza virus. The subtypes differ due to changes in proteins (hemagglutinin [HA] and neuraminidase [NA]) on the surface of the virus. Many different combinations of HA and NA are possible. Each combination represents a different subtype. There are no particular signs and symptoms specific to this illness. Cases of H5N1 in humans have thus far looked similar to a severe 'flu' or pneumonia. Suspicions will be raised only by the astute first responder who asks the right questions.

To date, there have been no human or animal cases of H5N1 in the United States. There is, however, growing concern that this virus may cause the next pandemic influenza if it continues to spread to other countries and starts to spread easily from person-to-person.

A pandemic occurs when the virus meets four criteria:

- ✓ Humans exhibit little or no immunity,
- ✓ Multiple outbreaks of serious illness occur in one country,
- ✓ Contagion spreads from country to country, and
- ✓ Person-to-person transmission easily occurs.

Pandemics have occurred in 1918, 1957 & 1968. Although no one can predict a timeframe, many experts agree that the next pandemic is inevitable.

A pandemic influenza will affect all aspects of normal society. Up to 40% of school-age children and up to 30% of the general population, including the young and healthy, could become sick. Such large reductions in the workforce

will result in short and long-term disruptions of routine, daily services. Identifying the first case of H5N1 avian influenza in Alameda County and the United States will be critical to control and limit its spread to others.

First responders are in an ideal position to be the first to identify a suspected case of H5N1 avian influenza. Patients with severe flu or flu-like illness or disease complications are likely to request and to require emergency transport to the hospital. It is important that prehospital providers be prepared to screen patients for possible exposure to the H5N1 virus.

SCREENING QUESTIONS

All patients with a documented fever >38°C (100.4°F) and respiratory symptoms should be screened for a history of any of the following situations that occurred within 10 days of onset of symptom:

1. Travel to an area with documented H5N1 avian influenza with either:
 - ✓ direct contact with sick or dead wild or domestic birds, or
 - ✓ direct contact with surfaces contaminated with poultry feces, or
 - ✓ consumption of raw or incompletely cooked poultry or poultry products.
2. Close contact with a person suspected or confirmed to have H5N1, or a person who was hospitalized or died due to an unexplained respiratory illness.
3. Exposure to live H5N1 avian influenza virus in a laboratory.

If the above screening is positive, immediately inform the receiving facility to prepare for a suspected case of H5N1 avian influenza. Following standard universal precautions (mask, gloves, and eyewear) will reduce the risk of

exposure to the first responder.

In addition to standard universal precautions, a patient who exhibits respiratory symptoms must be provided a mask to assist in limiting contagion. Frequent hand washing and/or the use of hand cleansing gels are also essential. Incorporating outside air into a transport unit's ventilation system and utilizing dilute bleach solution for routine disinfection complete the prevention process.



Fever assessment and exposure screening play an important role in quickly identifying H5N1 avian influenza. These essential actions add surveillance to everyday response role of our first responders. This simple but crucial shift is essential for effective public health emergency preparedness. Alameda County is among the first EMS agencies in the state to introduce an avian flu surveillance and reporting policy.

Make the shift
Protect yourself
Protect us all

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COMMON VIOLATIONS LEADING TO LICENSURE ACTION

By Ken Bobinski, Senior Investigator
California Emergency Medical Services Authority

Since 1994, the EMS Authority (EMSA) has been responsible for licensure and enforcement of the laws applying to California's paramedics. Division 2.5 of the Health and Safety Code contains the list of actions considered a threat to public health and safety that may result in the denial, suspension, or revocation of a license. The Enforcement Unit at the EMSA initiates an investigation when a report is received of a potential violation.

I am often asked at tape reviews and continuing education classes what violations are most common. When the violation is reviewed, the paramedics in attendance are usually surprised. Sometimes they admit to having worked with someone who committed a similar violation or to having done something similar themselves.

This article provides details on some of the most common violations. Perhaps sharing this information will help others to avoid making the same mistakes. Please keep in mind that this article is written generically, and it is not specific to any protocols or EMS agency policies.

Patient Assessment

Patient assessment is one of the most important aspects of direct patient care - yet it is the most common reason for a violation. Below are two patient assessment cases that we have prosecuted:

A paramedic arrives on scene where a backhoe tractor that has tipped over onto a construction worker. After one minute on scene, he canceled the helicopter and spent 25 minutes applying spinal immobilization to the patient. Unfortunately, he overlooked the external trauma to the abdomen, increased pulse rate, and the altered level of consciousness, which he attributed to the patient simply being uncooperative. The patient was transported code II to a local ER with limited capabilities. During the transport, the patient went into cardiac arrest and subsequently expired

from internal abdominal hemorrhage.

Another case involved a paramedic who treated a patient with a chief complaint of difficulty breathing; he also had an altered level of consciousness. The patient was given a breathing treatment, but the paramedic never ascertained a patient history or the lengthy list of medications the patient was taking. Imagine the paramedic's surprise when the ER staff advised him that the patient was a heart transplant recipient who was showing signs of sepsis due to organ rejection.

Don't be misled by calls that you determine to be minor. For example, an infant who has fallen down a few steps and is crying, which to most paramedics is a critical finding in determining respiratory and neurological function. What was overlooked in this case was the displaced femur fracture that the ER nurse immediately noticed when the patient was carried into the ER in the EMT's arms.

Multiple Conditions

Intoxicated patients present as simple calls, and for the most part they are, however, other conditions frequently mimic intoxication. Some EMS systems in the State have protocols for these patients (e.g.; "Altered level of Consciousness", "Patients Under the Influence", or "Unconscious Unknown"). Some of these protocols reference the numerous etiologies that may mimic the appearance of intoxication.

The Enforcement Unit has investigated a number of incidents in which patients were abandoned at the scene because the paramedics thought the patient was merely intoxicated, only to learn that another condition had mimicked intoxication. In some cases, the paramedics focused on the intoxication, thus limiting their assessment. They overlooked the other possibilities for the altered level of consciousness. One case involved a paramedic who responded to a police station for an intoxicated patient who had been subdued by law enforcement officials. The paramedics determined the patient to be intoxicated

and left the patient at the scene. The patient later expired from an internal head injury.

This next case demonstrates the importance of patient reassessment. A patient was found behind a restaurant lying next to an open alcoholic beverage container and appeared to be intoxicated. The patient was transported to the hospital where it was determined that the patient was in cardiac arrest, but it had not been noticed by the paramedics.

Most of the paramedics who are identified for failing to perform adequate patient assessments are seasoned employees with 8-10 years of experience. I can only speculate that failure in this area is due to burnout, overconfidence, or the lack of having a prior call under review.

Against Medical Advice

The Against Medical Advice or AMA form has also been the source of numerous complaints. Although the protocol for using this form is frequently discussed at base hospital meetings and CE classes, it none-the-less is widely misunderstood. This is an area in which I urge you to refer to your local county protocols. The AMA form is not a catch-all that will clear you of any and all wrongdoing.

The Enforcement Unit has investigated numerous cases in which EMS personnel had an AMA form signed by the patient thinking that was all they had to do. Remember, it is important to document what the patient said and what you said to the patient.

Most protocols require you to describe to the patient his/her condition and potential hazardous outcomes should the patient refuse medical assistance. The following actions are unacceptable:

- ✓ Threatening the patient by saying that if they go to the hospital the insurance company will not pay for the transport and the patient will be responsible for the bill. Having the patient sign the AMA form under threat may well invalidate the AMA.

(Continued on page 3)

Violations (Continued from page 2)

- ✓ Telling the patient that if 9-1-1 is called again, you will have the patient prosecuted, and then have the patient sign an AMA form under duress. Again this may invalidate the AMA form.

Call your local EMS agency should you need further clarification on appropriate use of an AMA form. (Editor's note: See Alameda County policies #8040 (Refusal of Service/Refusal of Care and #10003 (Consent and Refusal Guidelines in the EMS Field Manual.)

Other Potential Licensure Actions:

- ✓ Remember to stay within your scope of practice. You are responsible for knowing the protocols. If a procedure has been removed from your local protocols, you are no longer authorized to perform that procedure.
- ✓ Treat patients accordingly to their complaints, injuries or illnesses, not their social-economic status. The less fortunate are entitled to the same level of care and can file a complaint or civil action just as easily as anyone else.
- ✓ Remember to document your assessments, treatments, and reassessments. If it is not documented on the PCR, it is presumed not to have occurred.
- ✓ Be cautious with diabetic patients. The Enforcement Unit has investigated cases involving repeated responses to a diabetic patient for unresolved hypoglycemia. Most of these cases could have been prevented by adherence to the protocols that required either transport or base hospital contact for a non-transport. Check your local protocols for clarification.
- ✓ Remember your base hospital physician is a resource that can be utilized should the need arise.

I hope the information has been informative. I recommend that you contact your local EMS agency office for patient care or protocol issues. Should you have any questions for the EMS Authority's Enforcement Unit, please call us at (916) 322-4336.

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Refusal of Care May Come Back to Haunt You

By Kris Helander-Daugherty, PHCC, RN

Sometimes it's the seemingly simple calls that come back to haunt you. That's especially true of refusal of care.

Anyone who has spent time in the field knows these calls can be quite common. As common as they are, there are times when field personnel may inadvertently make a bad decision. Here is what we know about refusals of care:

- ✓ Your duty to provide care begins with the 9-1-1 call
- ✓ Your job is to assess the patient and transport him or her to the hospital if they want to go
- ✓ It is not your job to talk the patient into refusing care

Studies have shown that contact with a medical-control physician appears to markedly improve the transport rate for patients who initially attempt to refuse out-of-hospital medical care. This is especially so when physicians are more assertive in recommending transport. A study done in 1998 focused on refusal of care issues. Patients who received advanced life support assessment and then refused transport were asked to recall instructions given by paramedics. They were asked about their recall of explained risks and benefits of transport, their understanding of those risks at the time of the assessment, and subsequent use of medical care, including hospitalization. Despite the routine practice of providing a verbal explanation of risks and written instructions, only:

- ✓ 55% recalled receiving written instructions
- ✓ 22% recalled an explanation of risks
- ✓ 26% believed they did not fully understand their conditions or circumstances surrounding the 9-1-1 call when they refused transport
- ✓ 18% would now take an ambulance if the same incident recurred

The study showed that of the patients who refused care:

- ✓ 6% were subsequently admitted to the hospital for the same problem
- ✓ 59% sought care from a health care provider (emergency room, personal MD, or urgent care clinic)
- ✓ 35% were still experiencing symptoms

The above study shows that refusal of

care by a patient should not be taken lightly. The best way to protect the patient and yourself is to know your local policy. You will find the Refusal of Care policy on pages 107-108 of your Alameda County EMS 2006 Field Manual. Quoting from our Refusal of Care policy, it: "... applies to patients who by direct examination, mechanism of injury, or by initiating a patient relationship by dialing 9-1-1 for medical care for themselves, are refusing medical care/transportation". Note: for EMTs reading this article, remember that only ALS personnel may initiate a refusal of care.

The criteria for refusal of care are very straightforward. The patient must meet all of the following:

- ✓ Be an adult (18 or over), or if under 18, be legally emancipated.
- ✓ Be orientated to person, place, time, and situation.
- ✓ Exhibits no evidence of altered level of consciousness, or alcohol or drug ingestion that impairs judgment
- ✓ Understand the nature of the medical condition, as well as the risks, and consequences of refusal of care.

Your most important duties are to:

- ✓ Transport the patient under implied consent if the patient is not legally or mentally capable to refuse care - avoid using a 5150.
- ✓ Contact the base hospital physician as a back-up to encourage the patient to be transported, if appropriate.
- ✓ If the patient meets the criteria, document the circumstances on your PCR, and complete a Refusal of Care form.

It is easy to let your guard down on what seems like a routine call. The person may be known to you as a frequent user of the system, you may be tired at the end of a shift, or you may simply be in a hurry. Whatever the call, you are the patient's advocate and the patient deserves the best care you can provide, even if that is to not provide care.

For more information contact:

- Kris Helander-Daugherty at (510) 618-2032 (kris.helander@acgov.org)
- Dr. Pointer at (510) 618-2022 (james.pointer@acgov.org)

All Alameda County policies can be found on our website.



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What's New on the Web



- Updated EMS-C page
- Final draft of new policies for 2007
- Pandemic Flu information

More about Oakland on the Rocks: In the June edition of the EMS News, information about a report on underage drinking was introduced. The report, *Oakland on the Rocks*, highlights the results of a survey ("Surveying Teens About Alcohol 'n Oakland - STAANO") of 349 youth ages 14-20 from predominately communities of color in Oakland. Some of the results of the survey are:

- ✓ About 1 in 4 youth has had a drink in the last 30 days.
- ✓ Boys drink more than girls (22% vs. 13%)
- ✓ White and Hispanic youth have significantly higher rates of drinking than African Americans or Asians.
- ✓ On average 22% of the youth started drinking alcohol before the age of 11. More than 50% had their first drink by the time they were 13.
- ✓ Most youth report getting their alcohol from a liquor store or supermarket (46%), friends at a party (33%), or parents' house (25%).
- ✓ Binge drinking is a major concern. The majority (42%) say that it takes 5 or more drinks to get drunk.
- ✓ Most young people drink because of stress (59%), because it feels good (57%), or peer pressure (56%).
- ✓ Of those surveyed, 41% have gone for a ride in a car with a drunk driver. A significantly higher proportion of youth who have had a drink in the last 30 days have ridden in a car with a drunk driver (58%), compared to 34% for non-drinkers.

Recommendations: More environmental prevention strategies are necessary to challenge the media and alcohol industry's dominance over our youth's sensory environment. Strategies include limiting access to alcohol and proving creative options for healthy youth development.

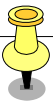
The youth have put together the following recommendations for local communities to take into consideration:

- ✓ Reduce young people's access to alcohol by parents and other adults by developing an educational media campaign on underage drinking directed at adults.
- ✓ Reduce young people's access to alcohol through the retail environment by

requiring strong enforcement of laws against selling alcohol to minors.

- ✓ Provide funding for grassroots youth organizations to take action on community alcohol problems. Support and expand youth programs that foster youth empowerment and education.
- ✓ Limit alcohol ads in the media, especially on radio stations that play popular music. Promote alcohol-free sponsorship of community events.
- ✓ In store liquor ads should be kept out of the clear sight of children. Ads should be at least 4 feet above the ground and not on the windows or doors to improve visibility into and out of store.
- ✓ Promote awareness among government and lawmakers of alcohol use as a serious problem. Make it a priority to educate adults and young people about the consequences of drinking.

For more information or to receive a copy of the "Oakland on the Rocks" report or Executive Summary, please contact: Mona Mena at 510/618-2035 or mona.mena@acgov.org or go to the web site: acgov.org/public_health.



NEWS & ANNOUNCEMENTS . . .

Dale Fanning has been named Acting Assistant Director for Alameda County EMS. Dale's EMS background goes back to 1974, and she brings a broad perspective to her new position.

She has worked as an EMT, paramedic, critical care nurse, ambulance service owner and, most recently, as the Prehospital Care Coordinator responsible for quality management at EMS.

As a consultant, Dale helped several Bay Area counties create their bioterrorism response plans and worked with the cities of Oakland and Fremont to develop their Metropolitan Medical Response Systems (MMRS). Dale is looking forward using her new leadership role to support the vision and mission of EMS.

New Field Manuals for 2007 will be available after October 1, 2006.



Alisa Ann Ruch Burn Foundation Fundraiser with the Oakland A's - Sunday, September 17, at 1:05 pm. For every ticket sold, \$8.00 goes directly to the Burn Foundation. Ticket are \$20.00 each for plaza level seats.

Ticket must be purchased two weeks prior to game day.

For more information, contact the A's at (510) 638-GOAs (4627).



EMS website:
www.acgov.org/ems