



Maryland EMS News

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MSP Med-Evac Program Marks 25 Years

The Silver Anniversary of the Maryland State Police (MSP) Med-Evac Program is being celebrated this year with the theme "25 Years of Saving Lives." March 20, 1970 was a milestone—the first MSP Med-Evac transport to the R Adams Cowley Shock Trauma Center.

The Silver Anniversary of the MSP Med-Evac Program is being celebrated by a press conference on March 20 at the Martin's Hangar in

patient to definitive medical care and to guarantee that transport would be within the Golden Hour. Dr. Cowley first met with the MSP in 1968 to discuss using their helicopters for Med-Evac in the statewide EMS system that he envisioned. (The Med-Evac Program was actually the first EMS component requested to assist the Shock Trauma Center in Baltimore.) The MSP had already ordered a Bell Jet helicopter but a lit-



Last year 3,448 patients were transported from the scene of injury by MSP helicopters.

Baltimore; a commemorative dinner/dance on March 31; and open houses at each of the eight Med-Evac sections.

The MSP Med-Evac program was developed jointly by R Adams Cowley, MD, the founder of MIEMSS and the Shock Trauma Center, and the MSP Aviation Division to reduce the time required to transport a

ter was not available. The MSP asked the Bell Jet helicopter manufacturer to develop a litter kit. So the MSP actually had the first operative civilian Bell Jet Ranger Med-Evac helicopter in the nation. A Department of Transportation grant was developed to purchase a second Bell Jet Ranger to support Maryland's EMS system. Since 1970, the MSP

helicopters have had a triple mission of Med-Evac, search and rescue, and law enforcement.

Today Dauphin helicopters, which are faster, larger, and safer than the Bell Jet Rangers, are used statewide at all eight of the MSP aviation bases. During the last fiscal year (July 1, 1993 - June 30, 1994), 4,092 patients were transported by MSP helicopters. Of these, 3,448 originated at the scene of an injury, while the remaining 644 were emergency interhospital transfers to a higher level of care.

Prehospital EMS personnel involved in ground transport work closely with MSP flight crews. In fact, they most often are the ones deciding to request transport by helicopter. With this in mind, we are printing "What Is a Flight Paramedic Expected to Do When Receiving a Patient?" and "When a Med-Evac Is Needed, What Can the 'Ground' Crew Do to Save Time?" Both are based on material from the MSP Aviation Division.

When a Med-Evac Is Needed, What Can The 'Ground' Crew Do To Save Time?

Members of the EMS "ground" crew should:

- **CALL FOR A HELICOPTER EARLY IN THE INCIDENT.** Arrange for it to be dispatched on the initial call if the assessment of the incident indicates a time-critical situation, keeping in mind the "Golden Hour" concept. When the aircraft request is made, an estimated time of arrival (ETA) will be given as soon as

(Continued on page 2)

(Continued from page 1)

possible. If it is excessive and ground transport would be faster, at that point, cancel the helicopter.

- **BE CERTAIN THAT THE HELICOPTER CAN LAND AS CLOSE TO THE SCENE WITHOUT COMPROMISING SAFETY.** If the helicopter cannot land close to the scene of the injury, get the flight paramedic to the scene as soon as



A MSP helicopter lands as close to the scene without compromising safety.

possible or get the patient to the landing site without delay.

- **PERFORM ADEQUATE SPINAL IMMOBILIZATION ON THOSE PATIENTS THAT REQUIRE IT.** The patient is not "ready to go" until he/she is immobilized and secured to a backboard. This step is often overlooked while ALS procedures are being performed. Some ALS procedures may be able to be carried out en route to the hospital, but spinal immobilization must be done prior to moving the patient to the aircraft.

- **LEAVE THE PATIENT'S ARMS FREE AND CHEST EXPOSED.** This will make it easier and faster for the flight paramedic to perform a BTLS primary survey and attach monitors at the scene, and start IVs and perform a secondary survey while in flight. Don't place blankets under backboard straps since this makes the secondary survey that the flight paramedic will perform during transport very difficult.

- **EXPLAIN TO THE PATIENTS**

THAT THEY WILL BE TRANSPORTED BY AIR AND THE REASON WHY. Many people are fearful of flying and any anxiety that can be reduced about this situation prior to the aircraft's arrival will be time saved and make the situation more tolerable for the patient.

- **GIVE A BRIEF BUT COMPLETE PATIENT TURNOVER REPORT TO THE FLIGHT CREW.**

The flight crew probably knows very little about the patient when they arrive, even if a consult with the hospital has already occurred.

- **PROVIDE THE FOLLOWING INFORMATION TO SYSCOM, THE CENTRAL DISPATCH CENTER FOR MSP HELICOPTERS.**

- Total number of patients to be transported by helicopter

- Priority (priority 1,2,3) for all patients to be transported

- Whether any patients to be transported weigh over 250 lbs.

- Any other information you believe may impact the transport time for the patient

The above information will help to prevent the delay of having to request a second helicopter after the arrival of the primary helicopter. Although most MSP helicopters are capable of transporting two patients, it is difficult to provide advanced life support care to two critical patients.

After receiving the ETA for all responding aircraft, you should consider the ETA along with the 5-10

minutes the aircraft will be on the scene receiving the patient. Remembering that the aircraft must still fly to the hospital, you should decide if helicopter transport is more appropriate than ground transport.

- **IF THE WEATHER APPEARS TO BE POOR, STILL CALL FOR THE HELICOPTER IF YOU NEED IT, BUT HAVE A BACKUP PLAN AVAILABLE FOR GROUND TRANSPORTATION.** The helicopter crew will determine if it is safe to fly, and SYSCOM will relay this back to you as quickly as possible. Rain does not preclude flight; however, low ceilings and poor visibility may.

What Is a Flight Paramedic Expected To Do When Receiving a Patient?

Understanding the basic responsibilities of the Maryland State Police (MSP) flight paramedic should help to facilitate a rapid and orderly transition of patient care from prehospital care providers at the scene to the arriving Med-Evac crew. Listed on page 3 are the things you can expect MSP flight paramedics to accomplish at the scene of a traumatic injury.

(Continued on page 3)



During the flight, the MSP paramedic starts an IV and does a secondary survey.

(Continued from page 2)

MSP flight paramedics will:

- Receive a patient turnover report from the medical provider who is already at the scene. This should be brief and include the following information:

- Mechanism of injury or illness
- Patients' conditions when you found them
- Problems you have identified
- Vital signs
- Treatment you have provided

- Perform a 60-90 second Basic Trauma Life Support (BTLS) primary exam on each patient. This step is required for a safe transition of care by both the Aeromedical Director and MSP policy, regardless of the level of care already at the scene.

- Ensure that any necessary critical interventions have been performed prior to loading the patient into the aircraft. Generally, critical interventions are limited to correction of airway problems, decompression of a tension pneumothorax, and control of bleeding.

- Ensure that adequate spinal immobilization is in place prior to flight, if indicated. Spinal immobilization includes backboard, collar, straps,



Prehospital EMS personnel involved in ground transport work closely with MSP flight crews.

and head immobilizer. You should LEAVE THE ARMS FREE AND CHEST EXPOSED to facilitate a rapid BTLS survey.

- Search the patient quickly for weapons. This will be a fast "pat down" in an effort to locate objects that could be harmful to the crew in flight, such as guns, knives, and bombs. (Bombs and incendiary devices have been found on patients in the past.)

- Adequately restrain combative patients. These patients must be under control prior to the flight for the safety of the crew and patient.

- Apply monitoring equipment, such as automatic blood pressure cuff and EKG cables. During the flight, the patient's arm may be against the wall, and performing these simple procedures could become difficult; therefore, the procedures may be done prior to Med-Evac transport.

Dr. Foley Named Medical Director of Region IV

David Allen Foley, MD, PhD, FACEP recently was appointed MIEMSS Region IV Medical Director. He succeeds Robert Adkins, MD, who retired January 1, 1995.

Board-certified in Emergency Medicine, Dr. Foley is the medical director and clinical chief of and an attending physician in the Department of Emergency Services at Peninsula Regional Medical Center (PRMC) in Salisbury. He has been with the department since April 1986. During this time he has been active in the paramedic training program of Ocean City EMS and at PRMC.

With a background that includes training in the Osler Medical Service



David Allen Foley, MD, PhD, FACEP

at the Johns Hopkins Hospital, Dr. Foley has been active in both metropolitan and rural EMS systems. Prior to his appointment at PRMC, he practiced medicine in Ocean City and in Frostburg, Maryland.

Prehospital Case Reviews

A MIEMSS Prehospital Case Review Program will be held Wednesday, March 29, from 7 to 9 pm, at Sinai Hospital in Baltimore. Case reviews on patients with adult trauma will be conducted in the Gann Conference Room in the Radiology Department (second floor).

The following month, the MIEMSS Prehospital Case Review will be conducted on pediatric trauma at the Johns Hopkins Hospital, on April 26, from 7 to 9 pm.

Two hours of B credits for ALS providers and two hours of T credits for BLS providers will be offered for each program.

To register, call the MIEMSS Production Services Office at 410-706-3994.

Recognizing CO Poisoning

Winter is the time of year when most people try to stay indoors as much as possible and do everything they can to eliminate the drafts in their homes to keep their fuel bills down.

But if the furnace or water heater in the basement is leaking gas, or if the flue to which they are connected is blocked, carbon monoxide is released and the home can be transformed from a warm, safe haven to a death trap.

Add to this winter hazard the higher incidence of fires resulting from alternate sources of heat and light, the potential for CO poisoning, as well as for smoke inhalation, increases.

The biggest obstacle for prehospital care providers in treating victims of CO poisoning is its insidious nature—the victims may not be aware they are being affected by CO and it is sometimes difficult to recognize such victims.

The first signs of CO poisoning may be frequent headaches or flu-like symptoms. These symptoms are seldom a cause for alarm because most people associate them with stress or the winter weather outside of their homes rather than with the air they breathe inside. But if several family members complain of the same symptoms and they feel better when they are not at

home, or if their pets also seem to be acting differently, CO poisoning should at least be suspected.

Diagnosing the problem can also be tricky because the level of CO in a patient's bloodstream does not necessarily reflect the severity of the illness, according to Roy A.M. Myers, MD, director of the Hyperbaric Medicine Center at the R Adams Cowley Shock Trauma Center.

For example, he says it is possible for a patient with a carboxyhemoglobin (COHb) level as high as 50 percent to

appear normal, while another patient with a level below 10 percent to be unconscious upon arrival at the Shock Trauma Center.

To identify patients with CO toxicity who have no visible symptoms, Dr. Myers uses a psychometric battery of tests to measure cognitive function. The test requires the patients to perform a series of progressively more difficult tasks. Patients who have impaired mental function that is not outwardly apparent on initial observation perform poorly on these tasks.

For example, the general orientation of the patient can be gauged by asking the person for verifiable personal

(Continued on page 8)



Many patients at the Hyperbaric Medicine Center of the R Adams Cowley Shock Trauma Center are treated for CO poisoning and smoke inhalation.

Candidates for Hyperbaric Oxygen Therapy

The following patients are likely candidates for hyperbaric oxygen (HBO) therapy and should be transported for evaluation and treatment at the Hyperbaric Medicine Center at the R Adams Cowley Shock Trauma Center in Baltimore, the designated specialty referral center for such conditions as carbon monoxide (CO) poisoning and smoke inhalation.

- Victims of fires, including firemen and other emergency personnel. These people may have been exposed to toxic levels of hydrogen cyanide as well as CO, thereby com-

plicating diagnosis and treatment. For burn patients, whose exposure to CO is likely to have been at lethal levels, HBO therapy should precede treatment for the burns in most cases.

- Anyone with a carboxyhemoglobin (COHb) level above 25 percent. Above that level, the effects of CO poisoning can be severe and long-lasting.

- If the environment suggests carbon monoxide inhalation occurred and one finds:

- A patient who has been unconscious for more than 10 minutes with no external sign of injury. One likely cause of the patient's condition is lethal exposure to CO.

- A patient exhibiting symptoms indicating a clouded mental

condition. Although this is a definite sign of severe CO poisoning, it is difficult to evaluate in the field.

- A patient with mild mental status abnormalities that have persisted for more than four hours. This may be a sign that the person's COHb level is higher than the outward symptoms would indicate.

- A patient presenting with chest pain or cardiac arrhythmias, suggesting cardiac ischemia, especially someone with a history of ischemic heart disease.

- Pregnant women with any level of COHb toxicity because the risk of suffering the lasting effects of CO poisoning is higher for the fetus than it is for the mother due to the fact that CO is absorbed by the fetus at a relatively higher rate.

MPC Provides Emergency Information, Poison Prevention Services

The Maryland Poison Center (MPC), a service program of the School of Pharmacy, University of Maryland at Baltimore, is certified by the American Association of Poison Control Centers as a regional poison center and is a consultation center for MIEMSS. Staffed 24 hours a day by specially trained and certified health professionals, the MPC provides emergency poison information to the public and to health professionals.

In 1993, the MPC was consulted on 35,662 potential poisonings. Of these calls, 57.6% involved children under the age of six. Unintentional exposures accounted for 81.0% of the total calls. The most common agents involved in poisonings differ according to the age group, with drugs accounting for 47.6% of calls overall.

Total Causes of Poisonings (By Age Group)

<6 YEARS OLD (21,542 total agents)

Drugs	Non-drugs
Cough & cold preps (1,716)	Personal care products (3,068)
Analgesics (1,632)	Household cleaners (2,457)
Topicals (930)	Plants (1,317)
Antimicrobials (747)	Foreign bodies/Toys (837)
Vitamins (744)	Hydrocarbons (485)

6-19 YEARS OLD (4,594 total agents)

Drugs	Non-drugs
Analgesics (925)	Personal care products (309)
Cough & Cold preps (323)	Household cleaners (248)
Stimulants/Street drugs (182)	Bites & envenomations (144)
Antimicrobials (165)	Chemicals (123)
Antidepressants (164)	Hydrocarbons (122)

>20 YEARS OLD (11,323 total agents)

Drugs	Non-drugs
Analgesics (1,409)	Household cleaners (789)
Sedatives/Hypnotics (1,272)	Alcohols (720)
Antidepressants (803)	Personal care products (565)
Cardiovascular drugs (379)	Chemicals (408)
Cough & cold preps (376)	Hydrocarbons (347)

In addition to its emergency service, the MPC provides poison prevention education to the public. During National Poison Prevention Week, March 19-25, MPC, the Maryland Poison Prevention Council, and many hospitals, health care providers, community organizations, and businesses throughout the state will focus on the Mr. Yuk program. Twenty years ago, Mr. Yuk was first introduced to Marylanders by the

MPC. Since then, his green scowling face has been seen in all the worst places—under the sink, in medicine cabinets, and wherever potential poisons are stored. This poison warning symbol reminds parents to teach poison prevention to their children. Labeling harmful items with Mr. Yuk stickers combined with an educational lesson teaches children that Mr. Yuk means "No! Do Not Touch!" Mr. Yuk stickers should be used in conjunction with other poison prevention practices, such as proper storage, use, and disposal of poisonous items. Should a poisoning occur in spite of these measures, the Mr. Yuk sticker facilitates contacting the Maryland Poison Center by having the phone number imprinted around Mr. Yuk's face.

◆ Lisa Booze

MPC Phone Numbers

Emergency Telephones

410-528-7701—Baltimore area
1-800-492-2414—Maryland only
410-706-1858—TDD

Administrative Telephone

410-706-7604

Ensuring the Survival of MPC

The MPC not only provides emergency poison treatment information to help save lives but also helps save money. In 1993, the MPC was consulted on almost 36,000 poisoning cases. With assistance provided via telephone by the MPC staff, 25,000 patients (69.4%) were managed safely at home, thus saving unnecessary emergency department visits, unnecessary ambulance dispatches, and many associated emergency evaluation costs. Several studies have demonstrated health care cost savings by utilization of poison center services. The most recent review of the impact of poison centers on health care costs demonstrated at least \$8 saved for every \$1 spent on a poison center service.

Despite the benefits provided by the MPC, funding for this service has not kept pace with its call volume. With increased call volume and increased costs of providing round-the-clock service, the MPC is faced with a \$300,000 deficit for fiscal year 1995. For additional information on how you can help ensure the survival of the MPC, call 410-706-7604 or write the Maryland Poison Center, 20 N. Pine Street, Baltimore, MD 21201.



MPC staff provide emergency poison information to the general public and health professionals.

Public Hearings Conducted on 'Draft' EMS Plan

The Maryland State Emergency Medical Services Board, in conjunction with the five regional EMS advisory councils, is conducting public comment hearings on the "Draft" Emergency Medical Services Plan for Maryland throughout the state.

The "Draft" Maryland EMS Plan focuses on 15 program component goals, with objectives for each goal.

The plan also provides EMS program background information, such as a system overview, enabling legislation and regulations, and the governance structure and mission of the EMS System. In addition, the plan contains a section that addresses the national trend of changing EMS systems in light of health care reforms.

The draft plan, which has been

presented to the EMS Board for its review and consideration by the Statewide EMS Advisory Council (the EMS Board's principal advisory group), is a result of more than 12 months of consensus building with EMS care providers and consumers throughout the state.

For further information on the hearings and/or the draft plan, contact Ronald Kropp, Director of MIEMSS Planning, Development, and Management Analysis (phone 410-706-3993; FAX 410-706-3409) or your regional administrator.

Schedule of Public Hearings

REGION I

Thurs., March 16, 7-9 pm

Frostburg State University
Lane Center, Room 201
Frostburg, MD 21532

Adm.: David Ramsey, 301-895-5934

REGION II

Tues., March 21, 7:30 pm

Myersville Volunteer Fire Company
301 Main Street
Myersville, MD 21773

Adm.: Richard Mettetal, 301-791-2366

REGION III

Tues., March 28, 10 am-noon

Charlestown Retirement Community

Conference Room

715 Maiden Choice Lane
Baltimore, MD 21228

Adm.: John Donohue, 410-706-3996

April 1995 (Hearing date and time to be announced)

REGION IV

Wed., March 29, 7-9 pm

Peninsula Regional Medical Center
ENT Classroom, 2nd floor, Morgan Wing

100 E. Carroll Street
Salisbury, MD 21801

Thurs., March 30, 7-9 pm

Memorial Hospital at Easton, Inc.
Nick Rajacich Health Center, Room C&D

219 S. Washington Street
Easton, MD 21601

Thurs. April 13, 7-9 pm

Cecil County Office Building
Room 6 (Basement)

129 E. Main Street
Elkton, MD 21921

Adm.: Marcus Bramble, 410-822-1799

Region V

Hearings were held March 1 at the Prince George's County Fire Department and March 8 at the St. Mary's County Governmental Center. For more information, contact Region V Administrator Marie Warner-Crosson, 301-474-1485.

Trauma Quality Management Plan

MIEMSS received funding from the Health Resources and Services Administration (HRSA) for the second year of a grant to develop a trauma quality management plan for Maryland.

Although a statewide trauma care system was mandated in Maryland in 1973 and many operational and clinical components are mature, a strong evaluation component has not been fully developed. Because there is no ongoing, comprehensive quality management program, Maryland has been unable to adequately monitor the efficiency of the trauma system or its effectiveness

in reducing trauma morbidity and mortality. Focused studies have evaluated specific aspects of the system, and data collection tools exist for various system components. However, there is no mechanism by which data are routinely linked and analyzed to evaluate system strengths and shortcomings.

Recent legislation, however, mandates ongoing evaluation of system effectiveness. Last year, MIEMSS was granted funds from HRSA to develop a plan and achieve consensus for a statewide trauma care quality management program. The goal for this year is to implement that

plan—that is, establish program structure, develop educational and facilitation services, and initiate quality monitoring and improvement projects at the state and local levels.

The HRSA grant committee has been working with the MIEMSS program directors to establish a quality management (QM) program within this agency. To date, the MIEMSS program directors completed a formal management training program on QM principles and processes; a director of QM (John New) has been appointed; and the MIEMSS Leadership Council (comprised of program directors) has been formed by Executive Director Robert R. Bass, MD, to implement QM within the agency.

Maryland Stars for Life Awards

Each year MIEMSS celebrates EMS Week by honoring men and women across Maryland who have contributed to the EMS system. Continuing with that tradition, this year MIEMSS has added award categories and found a term to describe all the EMS honorees, "Stars for Life." This title combines our symbol, the Star of Life, with our shared vision, "the elimination of preventable death and disability from injury or sudden illness."

MIEMSS needs your help in selecting the 1995 "Stars for Life." Any individual may submit a nomination on a form available from the offices of the regional administrators. Nominations must be submitted to the MIEMSS regional offices by Monday, April 3.

For each of the categories below one individual will be selected statewide by the Regional Affairs

Committee of the Statewide EMS Advisory Council (SEMSAC). The remaining nominees will be sent to the regional EMS advisory councils for possible recognition at that level.

EMS Physician of the Year

For a physician who has made outstanding contributions to the continuous improvement of EMS in Maryland.

Medical Facility

For a medical facility that has provided outstanding support to prehospital providers in such areas as education, equipment, medical direction, and control.

Program

For an injury prevention program that offers an innovative approach to reducing death and disability. The program must be affiliated with an EMS system component, such as a hospital, educational facility, rescue

squad, or EMS organization.

Innovator

For an individual who has provided innovative leadership in the improvement of EMS in Maryland.

Lifetime Service Award

For an individual who has dedicated his/her life to the prevention of death and disability through outstanding contributions to the development and continuous improvement of the EMS system.

The award categories below relate to specific incidents occurring from April 1, 1994 to March 30, 1995. Multiple awards may be presented.

Maryland EMS Citizen Award

For a Marylander who by quick thinking, fast action, and heroism has furthered the vision of the Maryland EMS System. This award is intended for citizen rescuers.

Maryland Star of Life Award

For outstanding performance at an EMS incident or rescue that exemplifies the spirit of the Maryland EMS System. This award may be given to multiple individuals or teams on the same incident.

SEMSAC Hosts Legislative Reception

On January 30, the Statewide Emergency Medical Services Advisory Council (SEMSAC) held a reception for members of the Maryland General Assembly. Approximately 130 individuals attended this event which provided members of SEMSAC and the EMS Board the opportunity to introduce the Draft State EMS Plan to legislators. The legislators were also invited to the public hearings on the Draft EMS Plan being held throughout the state.

The SEMSAC Legislative Reception was possible because of the generous support of the following: R Adams Cowley Shock Trauma Center, Doctor's Community Hospital, Fallston General Hospital, Frederick Memorial Hospital, *Frederick News Post*, Harbor Hospital Center, Holy Cross Hospital, Johns Hopkins Bayview Medical Center, Laurel Regional Hospital, Maryland General Hospital, Mercy Medical Center, Physician's Memorial

Hospital, St. Joseph's Hospital, St. Mary's Hospital, Sinai Hospital, Suburban Hospital, Union Hospital of Cecil County, and Washington County Hospital. Also contributing were the EMS Advisory Councils of Regions III and V. SEMSAC members J. Andrew Sumner, MD, Brad Cushing, MD, and George Delaplaine, Jr. also lent their support.

Practice Your Pediatric Trauma Skills at EMS Care 95

ALS and BLS providers will have the opportunity to work through actual scenarios involving pediatric trauma. These hands-on skills stations are possible because of support provided by the Maryland Department of Transportation Highway Safety Grant. These "Pediatric Trauma Megacodes" will be interactive learning sessions in a relaxed atmosphere without testing.

Dr. Morhaim Takes Legislative Seat

Dan Morhaim, MD, the Region III Medical Director from 1982 to 1989 and member of the Region III EMS Advisory Council, is now a freshman delegate in the Maryland House of Delegates. He represents the 11th District of Baltimore County.

Dr. Morhaim brings a strong interest and years of experience in EMS to his legislative job. He is an emergency physician at Franklin Square Hospital, a Baltimore County fire surgeon since 1981, and a faculty member of the paramedic program at Essex Community College.

Dr. Morhaim is currently on the Environmental Matters Committee, Subcommittee on Health in the House of Delegates. There he is dealing with various health issues, many of which focus on two key points—finance and public access.

Anyone with questions or concerns relating to EMS or health matters can contact Dr. Morhaim in Annapolis (Phone 410-841-3324; FAX 410-841-3385).



Governor Parris N. Glendening

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for

Emergency Medical Services Systems

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April 21-23, 1995

at the Greenbelt Marriott Hotel in Greenbelt, Maryland

Sponsored by

Maryland Institute for Emergency Medical Services Systems

and

the Emergency Education Council of Region V, Inc.

Hosted by

Prince George's County Fire Department

Pre-registration is required. We will accept registrations received in the Region V Office by April 15 or until the conference is filled--whichever comes first. Confirmations will be sent. No walk-in registrations will be accepted. For information, call the Region V Office at 301-474-1485.

Recognizing Carbon Monoxide Poisoning

(Continued from page 4)

information, such as age, date of birth, and level of education, or for general information like the current date.

To measure short-term memory loss, the patient might be asked to repeat a series of seven sequential numbers. The tasks become progressively more involved both to administer and to evaluate, so a complete psychometric test should be conducted by a trained diagnostician.

However, prehospital care providers can start this evaluation in the field by asking the patient to perform tasks that are similar to the elementary tasks that make up a full psychometric

evaluation. For example, they might ask the patient for basic background information or to calculate simple addition or subtraction problems.

Coming in the April Issue

Craig Coleman, recently appointed director of the Maryland Critical Incident Stress Management (MCISM) Program, explains the goals of the program, how the MCISM team can help EMS providers, and what happens after you call SYSCOM (1-800-648-3001) to request the services of the MCISM team.

A word of caution: the mental status of children under the age of 12 usually cannot be evaluated in this manner. In cases of CO poisoning involving young children, prehospital providers should rely, instead, on the history from the child's parents or guardians.

◆ Dick Grauel

New Mailing Address

MIEMSS has a new mailing address. All correspondence should be sent to: MIEMSS, 636 W. Lombard Street, Baltimore, MD 21201-1528. (MIEMSS is still located in Dunning Hall; only the mailing address has changed.)