Maryland EMS News

Vol. 28, No. 3 For All Emergency Medical Care Providers February 2002

Understanding the Alert Tracking System

Because it is the busy season for emergency departments (EDs) resulting in overcrowding and ambulance diversions, it is especially important for EMS providers to be familiar with and understand the County Hospital Alert Tracking System (CHATS) in Maryland.

The category definitions below and the current hospital statuses are listed on the MIEMSS website by region and may be accessed at http://MIEMSS.Umaryland.edu/Home.htm. The color that each category is assigned does not indicate a level of severity. For example, Red Alert is not a worse situation than Yellow Alert.

"Red Alert" means there are no inpatient critical care beds available, and "Yellow Alert" means the ED is temporarily overloaded. Both alerts, which are initiated by the hospitals, request that EMS providers take their Priority II or III patients to the next closest facility. Although there is a relationship between the two alerts, a hospital does not have to be on one to initiate another. Being on Red Alert for an extended period may cause patients to back-up in the emergency department and cause a Yellow Alert. Yellow Alert may occur simply as a result of a sudden influx of patients, or the ED being overwhelmed while the inpatient units are not overwhelmed. Therefore, a provider should not assume that because a hospital is on Yellow Alert, there are no beds of any kind available (including monitored beds).

There are some general rules to follow when attempting to determine the appropriate facility to which a patient should be transported. First, Priority 1 patients should never be diverted from a facility unless the facility is on Mini-Disaster. Second, will the diversion add more than an additional 15 minutes to the total transport time (for example, is transport to the first-choice hospital 5 minutes and to the second-choice hospital greater than 20 minutes)? If the answer is "Yes" to either of these questions, the patient should be transported to the closest facility regardless of the facility's alert status. Finally,

(*Continued on page 8*)

Yellow Alert

The emergency department temporarily requests that it receive absolutely no patients in need of urgent medical care. The facility will receive Priority I patients from within its catchment area for initial stabilization. Subsequent transfer may occur to another facility. Priority II and III ECG monitored patients will normally bypass unless transport time will be lengthened by more than 15 minutes.

Red Alert

The hospital has no ECG monitored beds available. The facility will receive Priority I monitored patients from within its catchment area for initial stabilization. Subsequent transfer may occur to another facility. Priority II and III ECG monitored patients will normally bypass unless transport time will be lengthened by more than 15 minutes.

Mini (Mini-Disaster)

The emergency department reports that their facility has, in effect, suspended operation and can receive absolutely no patients due to a situation such as a power-outage, fire, gas leak, bomb scare, etc.

Re-Route (Hospital Re-Route)

An ALS/BLS unit is being held in the emergency department of a hospital due to lack of an available bed. (This does not replace Yellow Alert.)

TBP (Trauma By-Pass)

The hospital's ability to function as a trauma center has been exceeded. (This decision is at the discretion of the facility.)

Blue Alert

Overrides all alerts, except the Mini-Disaster, causing all patients from within that jurisdiction to be transported to the closest facility appropriate for the patients' medical needs due to extraordinary situations such as snow, icing, or flooding.

Keeping Children Safe on the Roads

The following article was prepared to run in hospital newsletters to provide basic information to parents and caregivers on child passenger safety. The article was part of a larger mailing to every Maryland hospital for Child Passenger Safety Week (February 10-16, 2002). This is the first part of a year-long outreach effort to hospitals on child passenger safety, funded by a grant from the U.S. Department of Transportation and the Maryland Highway Safety Administration. If you are a certified child passenger safety technician who would like to help with the hospital outreach effort, please contact Joan Catherine Tetrault, CPS Assessment Coordinator, MIEMSS-EMS for Children Program, 410-706-8647 or jtetraul@mdems.umaryland.edu

Parents and care providers drive children on Maryland's roads or highways every day, a practice that few people consider a high-risk activity. However, motor vehicle collisions continue to be the leading cause of injury or death to young children. According to the Maryland Highway Administration's Traffic Safety Analysis Division, more than 2,000 children under the age of 16 were seriously injured or killed due to motor vehicle crashes in Maryland in 2000. According to national statistics, more than half (56%) of all children under 15 years old killed in car crashes in 2000 were completely unrestrained. (See "Traffic Safety Facts 2000 – Children" by the National Highway Traffic Safety Administration.)

The single most important thing drivers can do to prevent injuries or deaths in motor vehicles is to use the proper restraint for everyone riding in the car. According to Maryland law: all children under 4 years old (regardless of weight) or under 40 pounds (regardless of age) must be in a federally approved child restraint used according to the manufacturer's instructions; a person may not transport a child younger than 16 years of age unless the child is secured in a child safety seat or vehicle seat belt in all seating positions.

Parents can give the best protection available to their children by following these basic concepts:

- All children should ride in the back seat, if possible. Never put a rear-facing seat in the front seat if there is a passenger air bag.
- Keep infants rear-facing until they reach at least one year old and at least 20 pounds (longer if possible, based on weight and height limits stated in the manufacturer's instruction booklet). Some child safety seats can be used rear-facing up to 30 pounds or more.
- Children should ride in a safety seat with its own harness as long as possible. Most forward-facing safety seats can be used with a harness that fits a child up to 40 pounds.
- A child who outgrows a safety seat with a harness should ride in a belt-positioning booster seat with the vehicle lap/shoulder belt until the child is tall enough to fit properly in the car's lap/shoulder belt. Usually children are around 4'9" tall before they can "graduate" to the lap/shoulder belt.
- A young child should not be placed in a car's lap/shoulder belt before the child is big enough. Small children (aged 2 to 5) who are placed in seat belts rather than child safety seats or booster seats are 3.5 times more likely to be significantly injured in a crash. They are four times more likely to receive a significant head injury. (See the article by Winston, Durbin, Kallan, and Moll in *Pediatrics*, volume 105, number 6.)
- A child is big enough to ride in the lap/shoulder belt when the child can: sit all the way back against the car seat with the child's knees bending over the vehicle seat; wear the lap belt low on the thighs; and keep the shoulder belt between the child's neck and shoulder.
- Read the safety seat and vehicle instruction manuals to learn how to use the safety seat and seat belt properly. According to the Traffic Safety Analysis Division of the Maryland Highway Administration, nearly 90% of parents do not have their safety seat installed correctly!
- Adult passengers should wear their seat belts to prevent injuries to themselves and the children in the vehicle (and to set a good example)!

For additional help, parents may have their child safety seats inspected by a certified child passenger safety technician. To find an inspection location or a certified child passenger safety technician, visit www.nhtsa.dot.gov and click on the "Child Safety Seat Inspections" link.

For further information about Maryland's child passenger safety law, proper installation, or where you can find a safety seat loaner program, call Maryland KISS (Kids in Safety Seats) at 1-800-370-SEAT or visit www.mdkiss.org.

EMS Care 2002

May 2-5, 2002
at the
Maritime Institute for Technology and Graduate Studies
(MITAGS) in Linthicum
Presented by
The Region III EMS Advisory Council
and
The Maryland Institute for Emergency Medical Services Systems

The Program

This year has been a particularly rough one for everyone—especially emergency response personnel. After the September 11 terrorist attacks, some of you answered the calls for help in Pennsylvania, Virginia, and New York. The rest of us stayed to protect our own communities and wished we could have done more. All of us stepped up to the plate on that dreadful day. Come help us pay tribute to those we have lost and learn more about the responses to the attacks. Then move forward to learn more on topics that we are grateful to deal with everyday.

Continuing Education

All workshops are approved for continuing education credit by MIEMSS. EMT-Bs can fulfill all the 12 hours of didactic (4 Medical, 4 Trauma, and 4 Local) required for recertification. A 12-hour skills class is also available during the preconference activities. Be careful to pick workshops that will provide enough hours of each category. Credits will also be provided to EMDs, First Responders, CRTs, and EMT-Ps.

The Hotel

The Maritime Institute has saved us rooms for the weekend. They are $114 per night for one person or $160 for 2 (add 13% room and sales tax)! That may sound like a lot, but a full buffet breakfast, dinner, and an evening snack are included! Please use the attached form to make your reservations with the hotel. Hurry! The rates are only available until April 5, 2002.

For Fun!

Saturday evening promises to be a blast! Come join the craziness at Maritime Madness. Dress as your favorite sailor if you like!

Fees and Expenses

The two-day conference costs $135. This includes all expenses for workshops, lectures, AV materials, and printing costs. Also included are continental breakfasts, full buffet lunch, and snacks Saturday and Sunday, and the reception on Saturday.

Pre-Conference Fees

EMT-B Skills – $30
Team EMS - $45
EMD-Q –$590 - Includes Certification fees
School Preparedness - $45

Registration for the conference and each workshop is on a first-come first-serve basis. NO CHANGES TO YOUR SCHEDULE WILL BE CONSIDERED AFTER April 15, 2002. No refunds will be given unless a written cancellation is received prior to April 15, 2002. All cancellations are subject to a $20 processing fee. Returned checks are subject to a $25 processing fee.

Register before April 5 and Get a Free Tee Shirt!

Directions

A map and written instructions will be mailed with your registration confirmation.

For More Information

Contact MIEMSS, Region III, 653 W. Pratt Street, Baltimore, MD 21201, 410-706-3996, Fax 410-706-8530

Preconference Activities

Thursday and Friday, May 2 & 3, 2002

EMD-Q

This is the EMD Quality management course from Medical Priority Consultants aimed at EMD supervisors, QA/QI Managers, and Medical Directors. The course helps you understand the quality management process from setting standards and evaluating performance to analyzing data. {16 hrs L, 2}

EMT-Basic 12-hour Skills Refresher

This is the course required for recertification and is being coordinated by the Maryland Fire and Rescue Institute and the Baltimore County Fire Rescue Academy {12 hrs S, B or various skill oriented Paramedic Sections}

Friday, May 3, 2002

Team EMS — Mock Trial: Quality Management Workshop 9:00 AM–4 PM

Real-world application of quality improvement principles and practices will be demonstrated through the mock trial format. You'll gain a full understanding of how local and state QA/QI processes work to ensure quality health care delivery in the prehospital setting. Actual scenarios encompassing events from incident discovery to outcome and covering case types from simple prehospital case review to full state CRC/EMS Board action are used as inter-active class lessons. {6 hrs L, 2}

Prevention and Preparedness for Schools

Captain Jim Olsen of the Columbine Fire Department will introduce Educators, EMS Providers, Law Enforcement Officers, Injury Prevention Coordinators, and Public Safety professionals to the Pre-Incident Planning System (PIPS). PIPS is software developed by public safety and school officials from Columbine and FEMA, in response to the lessons learned from the Columbine School incident. The afternoon session will involve hands-on work with the computer software, sample architectural plans, and digital pictures of a few schools in different jurisdictions and a chance to exchange experiences with Jim. **This workshop is sponsored by the Maryland EMS for Children Partnership Grant.** {6 hrs L, 2}

EMS Care 2002 Conference Schedule
Saturday

Time	A - Medical	B - Trauma	C - Pediatric	D - General Information	E - General Information
7:30 AM	**Registration**				
8:00 AM	**Opening Ceremonies**				
8:30 AM	**EMS State of the State - Robert R. Bass, MD, FACEP**				
9:00 AM	**Attack on the United States - Battlefield New York** We all watched in horror and felt the crash of the twin towers from here. Imagine if you were the incident commander. Lt. Dave Fenton, Commander of the FDNY/EMS Special Operations Division, gives us the big picture of their overall operations on that dreadful day. {L,2}				
10:15 AM	Vendor Break				
10:45 AM	**Rescue - Ground Zero** We can handle a few cars piled on one another, even rail cars. Would you be ready for a hundred or so floors of a building? Ray Hodgson, of the Pennsylvania USAR team, relays the specifics of the rescue operation at Ground Zero. {T,B}				
12:00 Noon	Lunch				
Session 1 1:15 PM	**Bioterrorism** Dr. Julie A. Casani, from the State Health Department, will help us follow the surveillance of the patients we transport and clue us in to what we should be watching for in the future to protect ourselves and our patients. {M,A}	**Forensic Wound Identification** Daniel Sheridan, PhD, RN, CNS, from the Johns Hopkins School of Nursing, shows you wounds and their causes so you may better focus your treatment. {T,B}	**Pediatric Trauma Case Review** Dr. Chuck Paidas, Susan Ziegfeld, and Vinta Misra, of the Pediatric Trauma Center at the Johns Hopkins Children's Center, in collaboration with prehospital providers, will present care of children with multi-system injury. {T,B}	**Smart Highways** Collision Avoidance Systems, Automobile Black Boxes, Drowsy Driver Detectors, Smart Routing, and Automatic Crash Notification, are just a few of the items being installed in cars and highways that will affect the way we do business. Find out how! {L, 2}	**Score It!** Your performance is being scored and rescored by your EMD Manager. Listen to Greg Scott, of Medical Priority Dispatch, reveal the in's and out's of improving your score and get credit for protocol review at the same time. {L, 2}
2:15 PM	Vendor Break				
Session 2 2:45 - 3:45 PM	**Stroke** Mona Bahouth, MSN, CRNP, from the Maryland Brain Attack Center, updates you on the management of the acute stroke patient, plus the latest research and treatments. {M,A}	**Trauma at the World Trade Center** Not enough survived, but those that did needed treatment. Lt. Dave Fenton, of the FDNY/EMS, reveals the injuries of the survivors and how they were triaged, treated, and transported. {T,B}	**Challenging Pediatric Cases** Dr. Allen Walker and nurses Linda Arapin and Mary Ellen Wilson, of the Johns Hopkins Children's Center, present cases that focus on the importance of early recognition and rapid assessment in the prehospital environment, medical triage, and the importance of transporting children appropriately. {M,A}	**Pumps and Probes** Dr. Richard L. Alcorta, State EMS Medical Director, discusses all the new gadgets being used to treat patients we are transporting. Many of these may make their way to our protocols. Get familiar with them before you get frustrated! {M,A}	**Irate Callers** Dr. Roger Stone, one of the first EMD docs in Maryland, discusses how to calm that agitated caller and still get the information you need to get the units on the street. {L, 2,}
Session 3 4:00 - 5:00 PM	**Geriatrics** Are we as aggressive as we should be in caring for our older patients? Dr. Colleen Christmas, of JH Bayview Medical Center, updates us on the most appropriate treatment for the geriatric patient. {M,A}	**Trauma Case Review** Staff from the R Adams Cowley Shock Trauma Center will pick a high profile case to present the care of the adult trauma patient in collaboration with your peers from the street. {T,B}	**Jump START** Nurse/Paramedics Terry Satchell and Mary Alice Vanhoy present this pediatric triage tool developed to assist providers in triaging children by objective criteria rather than emotional ones. {T,B}	**What's New? Why? How?** Michael Armacost, Colorado State EMS Director (and ex-Maryland CRT) tells us how to tolerate that *Research* stuff to get what we want and what is best for our patient. {L, 2}	**9-1-1 on 9/11** A dispatch manager from NYC gives a sobering account of what NYC dispatchers experienced that dreadful day and what they learned from it. {L, 2}
5 - 7 PM	**Vendor Reception**				
7 PM - 12 AM	**Maritime Madness**				

EMS Care 2002 Conference Schedule
Sunday

Time	A - Medical	B - Trauma	C - Pediatric	D - General Information	E - General Information
8:30 AM	**Attack on the United States - Battlefield Pentagon** Battalion Chief Raymond Blankenship, EMS Supervisor for Arlington County Fire Department's Operations and Emergency Services Division, details the operations and the challenges of this multi-jurisdictional response. {L,2}				
10:00 AM	Vendor Break				
10:30 AM	**Hepatitis C - Surviving the Exposure** William Stinchcomb, EMT-P from the Anne Arundel County Fire Department, provides insight from personal experience about what it is like to deal with Hepatitis-C and what he could have done to prevent his exposure. {M,A}				
11:30 AM	Lunch				
Session 6 12:45 PM	**Pain Management in the Home** Debbie O'Loane, a pain management specialist from Good Samaritan Hospital, talks about how they prepare the chronic pain patient for home life. She prepares you to deal with the methods of pain control you may encounter. {M,A}	**Attack on the Pentagon: A Clinical Review** Allen Wolfe, RN and Kattie Hollowed, of MedSTAR, present the cases of patients they received from the Pentagon. {T,B}	**Pediatric Pharmacology** Children require precise medication and fluid doses. How accurate are your calculations for medication administration? Nurses Mary Ellen Wilson and Mary Helen Winter, of the Johns Hopkins Children's Center, teach the tricks of the trade and work with a variety of tools that will increase your proficiency. *Limited to 30* {M,A}	**Riding the Waves: The Role of Capnography in EMS** This is the program presented by Medtronics/Physio-Control in a few areas of Maryland. Providers who attended found it to be extremely valuable and recommended it highly. The course description is in the next block. Because this is a 4-hour course, you will not be able to attend other break-out sessions on this day. *Recommended for ALS providers only.*	**Pet Placation** Randall Lockwood, PhD, of the National Humane Society, reveals that nasty critter is just protecting its owner. Learn how to control a patient's pets and how assessment of the pet can clue you in on ailments of its owner. {L, 2}
1:45 PM	Vendor Break				
Session 7 2:15 PM	**Transporting the AMI Patient** We've been doing 12 leads for some time. Should that change? Dr. Tom Aversano, from Johns Hopkins, gives us insight into the early results of an ongoing study that we think you will find very interesting! {M,A}	**Trauma to the Eye** Dr. JB Harlan, Director of the Wilmer Eye Trauma Center, and Delia Visto, Nurse Manager, update you on the latest in the care of the eye trauma patient. {T,B}	**Pediatric Extrication and Immobilization** Cyndy Wright-Johnson and Terry Satchell, from the Maryland EMS-C Program, present this hands-on workshop to give EMS providers and instructors the latest information on car seat extrication and pediatric immobilization. *Limited to 30* {T,B}	**Riding the Waves: The Role of Capnography in EMS** Bob Page, a paramedic and instructor, introduces you to how measuring the level of exhaled CO2 is beneficial in caring for the critically ill or injured patient. Capnography, the numeric and graphic display of CO2, may be useful to verify endotracheal tube placement, assess ventilation and treatment, and evaluate resuscitation efforts during cardiopulmonary resuscitation. *Sponsored by Medtronics / Physio-Control* {M,A}	**Elder Abuse** Dave Snyder, a paramedic and nurse, tells us how to recognize it and what we really need to know to help take care of the patient for the long term. {T,B}
Session 8 3:30 PM	**Refusals - Treat & Release** Dr. Kevin Seaman, Region III and Howard County Medical Director, simplifies the dilemmas associated with allowing or encouraging patients to refuse your care and discusses some alternatives, such as treat and release and urgent care centers that may be in our future. {M,A}	**Cars 'n' Crashes** There is lots of research about what causes injuries and how cars can be modified to prevent those injuries. Tim Kerns, of the National Study Center, gives us the abridged versions of many of these studies and explains how we can use them to improve our care. {T,B}	**Pediatric Airways** Learn the tricks of maintaining the difficult airways in children through case studies and hands-on training with BiPAP, C-PAP, ventilators, and tracheostomies. *Limited to 30* {M,A}		**EMS at the Olympics** Brian Garrett, the coordinator for the Fire and EMS preparations, will discuss preparations for the winter games, including the possibility of a terrorist incident. {L,2}

Continuing Education Credits - Make sure you pick the sessions based upon the categories of credit you need for recertification. All categories are noted in the brackets {} BLS is first, then CRT. CRT-Is and NREMT-Ps are required to complete continuing education in specific topics. We suggest you review the re-registration guidelines in the National Registry registration brochures for Intermediate '99 and Paramedic on their web site at www.nremt.org

EMS Care 2002 Registration

LAST NAME _____ FIRST NAME _____ INITIAL _____ ID or SSN _____

STREET _____ CITY _____ STATE _____ ZIP CODE _____

TELEPHONE Day _____ Evening _____ Pager _____ Facsimilie _____

E-MAIL ADDRESS _____

PRIMARY AFFILIATION _____

CERTIFICATION/LICENSURE (CIRCLE) FR EMT-B CRT EMT-P LPN RN NP PA MD

ARE YOU AFFILIATED WITH A: _____ COMMERCIAL COMPANY, _____ CAREER/VOLUNTEER 911 COMPANY, OR _____ BOTH A COMMERCIAL AND 911 COMPANY?

PRECONFERENCE WORKSHOPS

Check one only

_____ EMT-B Skills
_____ EMD-Q
_____ Team EMS
_____ School Preparedness

CONFERENCE WORKSHOP

Circle one per Session

SATURDAY	Hours				
Session 1	A	B	C	D	E
Session 2	A	B	C	D	E
Session 3	A	B	C	D	E
SUNDAY					
Session 6	A	B	C	D	E
Session 7	A	B	C	–	E
Session 8	A	B	C	–	E

FEES

EMT-B Skills ($30)	_____
EMD-Q ($ 590)	_____
Team EMS ($45)	_____
School Preparedness ($45)	_____
Saturday & Sunday ($135)	_____
EMS Care T-shirt ($12)	_____
T Shirt Free before 4/5/02	**Indicate size** _____

TOTAL DUE _____

Make checks payable to:

Emergency Education Council of Region III

Mail to: MIEMSS Region III, 653 West Pratt Street, Baltimore, Maryland 21201

NEW! -Pay by Credit Card!

_____ VISA _____ Master Card

Card # _____

Exp. Date ___/___

Signature _____

Americans With Disabilities Act - Anyone requiring special accommodations or having special dietary requirements should contact the Region IIII Office of MIEMSS by April 5, 2002.

!!!!!!!!!!! Cut Here – send top to MIEMSS and bottom to MITAGS !!!!!!!!!!!

Maryland Emergency Medical Services
EMS Care Hotel Registration Form

DO NOT MAIL TO MIEMSS

ONLY $114 for 1 person or $160 for 2 people per night! Suites are also available! (Applicable taxes additional)

PLEASE PRINT

Name _____

Telephone _____

Address _____

City _____ State _____ Zip _____

Arrival Date _____ Check Out Date _____

Room Type Requested:

_____ 1 person ($114) _____ 2 people ($160) add 13% tax

_____ Smoking _____ Non-Smoking _____ No Preference

TOTAL DUE _____ (don't forget tax)

Credit Card Registration

Name on Card _____

Card # _____ Exp. Date ___/___

DO NOT MAIL TO MIEMSS
DEADLINE FOR DISCOUNTED RATE
April 5, 2002

Mail-In Reservation: Mail This Form and Your Deposit Check to:
Maritime Institute of Technology and Graduate Studies
5700 Hammonds Ferry Road
Linthicum Heights, MD 21090-1952
Or FAX credit card reservations to 410-859-0942

You may also reserve your room by calling our reservation line 443-989-3517. If you have any questions, please call this number.

Don't Forget: The cut-off date for receiving your special rate is 4/5/02. It is better to make a reservation and cancel, than run the risk of waiting until it is too late. There is no penalty for a cancellation, as long as it is made before 6 PM the day of arrival.

Maritime Institute of Technology
& Graduate Studies (MITAGS)
Training & Conference Center

Protocol Clarifications

Editor's Note: The following Protocol Clarifications were written by Dr. Richard L. Alcorta, State EMS Medical Director, and mailed to EMS jurisdictions and organizations in January. They are reprinted here so that everyone can be aware of the clarifications.

In addition, please be aware that in some cartons of protocols that were shipped, Pages 34–59 were not included in the shrink-wrap. *If you find that these or other pages are missing, please call Eric Chaney at 410-706-0880.*

The following instructions pertain to the January 2002 *Maryland Medical Protocols for EMS Providers* protocol rollout. Several questions regarding the protocols have arisen and need the following clarifications. Please make appropriate modifications to your protocol manual.

1) **Page 46** 3. f) Reads "If transcutaneous pacing is unsuccessful or not available". Please insert "and the patient is not in Mobitz II or third-degree AV block".
This is consistent with page 189 5. d) (3) (a). This clarification is to ensure that symptomatic patients with sinus or Mobitz type I bradycardia get prompt atropine administration and those that have increased risk associated with MI, Mobitz II, or third-degree AV heart block get medical consultation before atropine administration.

2) **Page 46** 3. h) (2) Diazepam dosing should read "2.5 mg increments every 1 minute to a maximum dose of 10 mg titrate to effect. (Paramedic may perform without medical consult.) (New '02)" (See also #13 below.) This is consistent with page 194 9. g) (1). The principle for Diazepam administration is "lower is better and safer."

3) **Page 94** EE. 3. h) Dosing line should read:
"0.4–2.0 mg slow IVP/ET/IM
ET 1.0–5.0 mg"

4) **Page 96 A normal, healthy adult with moderate to severe allergic/anaphylactic symptoms and a pregnant woman with severe symptoms** can be treated by an EMT-B with the patient's or the EMS service's epinephrine auto-injector without medical consult. **However, pregnant patients with less than severe symptoms (page 179)** still require medical consultation for the provider to administer the patient's or the EMS service's epinephrine auto-injector.

5) **Page 99 "alert"** Medical consultation is required for a provider to administer the EMS epinephrine auto-injector to an adult asthmatic patient.
If any asthmatic patient is greater than 45 years of age or has a cardiac history, the provider should "consider" (read "strongly encourage") medical consultation even if the patient has his/her own prescribed epinephrine auto-injector.

6) **Pages 97 & 100** A normal, healthy pediatric patient with moderate to severe allergic or asthmatic symptoms can be treated with the patient's or the EMS service's epinephrine auto-injector without medical consult.

7) **Wherever it applies in the protocol:** What is the age or weight restriction for a pediatric patient for the EMT-B utilization of the epinephrine auto-injector?
The age is 3 years and older for use of the "adult" 0.3 mg epinephrine auto-injector. The "pediatric" 0.15 mg auto-injector is for those under 3 years of age.

8) An EMT-B may administer an epinephrine auto-injector (patient's prescribed or the EMS provider's) for the adult or pediatric patient with moderate to severe anaphylaxis and may concurrently administer the patient's prescribed albuterol inhaler [**page 96** FF 3. a) and b); **page 97** FF 3 g) and h)].

9) **Page 167** External Jugular Intravenous Access: the header reads "CRT-(I) & EMT-P only." This is correct.
13 a) states "... used by CRT, CRT-(I) and EMT-Ps for intravenous cannulation." Please delete CRT from this sentence. The CRT is not allowed to perform the external jugular technique.

10) **Page 175 7. b) (6)** Replace the existing line to read: "All ALS providers may access lower extremity IV sites prior to IO attempts. (Not for IV Technicians. CRT may not perform IO.) (New '02)"

11) **Wherever it applies in the protocols:** If for some reason the glucometer fails, medical consultation is required before giving dextrose IV.

12) **Page 168 14. (2)** The blood glucose thresholds for Dextrose administration were inadvertently omitted.
Insert after the word " age":
(a)... age "and if the blood glucose is less than 30 mg/dl"
(b)... age "and if the blood glucose is less than 70 mg/dl"
(c)... age "and if the blood glucose is less than 70 mg/dl"

13) **Page 164** Completely replace 11. e) (1) with:
"Medical Consult sign: If patient develops discomfort with TCP
Consider Morphine 1-2 mg/min IVP. (Paramedic may perform without medical consult.) (New '02)
OR
Consider Diazepam 2.5 mg increments every 5 minutes to a maximum dose of 10 mg titrate to effect. (Paramedic may perform without medical consult.) (New '02)"
(See also #2 above.) This is consistent with page 194 9. g) (1). The principle for Diazepam administration is "lower is better and safer."

Governor Parris N. Glendening

Address Correction Requested
MIEMSS, *Maryland EMS News*
653 W. Pratt St., Baltimore, MD 21201-1536

DATED MATERIAL

Understanding Alert Tracking

(*Continued from page 1*)

EMS providers should not bypass more than one hospital due to the alert status. Situations, however, do often occur when adjacent facilities are both on yellow and/or red alert. Under these circumstances, a third facility that is not on alert and is only a few minutes farther in distance should be considered as a possible destination.

There are three other potential alert statuses. "Mini-Disaster" means there is a physical plant problem (for example, no power) or a major security threat (for example, bomb threat) in the ED. NO patients may be transported to a hospital on Mini-Disaster regardless of priority. "Blue Alert" is declared by a local EMS Program at a time when resources are limited or traveling to a more distant hospital may be dangerous, such as during a disaster or a snowstorm. All patients within the jurisdiction should be transported to the closest hospital during a Blue Alert.

The last status "Re-Route" is also declared by a local EMS Program. This occurs when an ambulance is delayed at the ED because there is no other hospital to which their patient can be transferred. Although local policies differ as to who has the authority to declare Re-Route, it can be done after speaking with the ED charge nurse and determining that the delay in patient delivery will be greater than an additional 20 minutes. While on Re-Route, Priority 1 patients may still be transported to that hospital, but prehospital providers MUST consult with that hospital and Medical Control (Consult Center) prior to initiating the transport. Providers may wish to have the next closest hospital online during that conversation. The last delayed unit to leave a hospital on "Re-Route" should alert local authorities that there are no longer any other units waiting on beds and withdrawal of the Re-Route may be considered.

Health care resources, such as ambulances and hospitals, seem to be a precious commodity recently. Careful compliance to CHATS is one method to help ensure those resources are available when we really need them. Unfortunately, no policy is perfect. There may be situations that will arise that do not identically meet the criteria of an alert category or policy. These gray areas call for providers to use their best judgment and, if necessary, obtain medical direction.

While considering the status of a hospital may be important, the highest priority of the EMS provider should always be the patient. If a facility is making a request that jeopardizes patient safety or that will put EMS out of service for an extended period, the EMS provider may need to disregard the facility request. If a conflict of opinion does arise, please be patient. Do not attempt to resolve the conflict in a public area. Complete the transfer of the patient in a professional manner, then attempt to resolve the conflict privately. If it cannot be resolved immediately with those directly involved, EMS supervisors and hospital administration should be alerted by their own personnel. Remember—high-quality, efficient patient care in a professional environment is our number one goal!

If you are not familiar with your regional alert policy, or have questions about the state alert system, please contact your company or local chief EMS officer for clarification. If you would like a copy of your regional alert policy, you may contact your MIEMSS regional administrator.