In 2005 the new CPR guidelines were published recommending fundamental changes in Basic Life Support. They were based on the most comprehensive scientific review to date looking at what works and what doesn't in the world of BLS and ALS.

The conclusions are that when it comes to cardiac arrest for all causes Basic Life Support is not just BASIC...it is of PRIMARY importance. For EMS in particular this presented a new view of the world and emphasized the importance of first responders role in providing early effective CPR and in providing early defibrillation in the adult population.

Over the last few months we have noted several “saves” - survivors from cardiac arrest who are discharged home from the hospital with good neurologic (brain) function. While we don’t know if this is statistically significant, we believe we may be seeing improvement in survival based on two factors: well-done CPR using the new guidelines and use of public access defibrillators. At the end of the year we’ll have more data to see if this is really a trend.

Overall, survival from cardiac arrest is still a rare phenomenon, but for those survivors, who may have 20, 30 or more years of life extended, their families, children, grandchildren, friends and colleagues will have the benefit of their lives and impact. So saving a single life goes a long way, even if it is an infrequent occurrence.

Ironically, CPR has been “turned upside down” to a certain extent with recent findings that over-vigorous ventilation can be harmful, and also because there’s evidence that even CPR without ventilation (so-called compression-only CPR) may actually be superior.

Many of you have noticed that in the new ACLS guidelines and training there is a renewed emphasis on excellent and optimal BLS. It is no longer a mystery…we know that although in isolated cases ACLS interventions may help, BLS is what saves most people’s lives.

Are you using Best Practice CPR? If you need to review or refine your skills contact your Clinical Educator.

As many of you already know training on our new Multi-Casualty Incident Plan has begun. The new plan goes LIVE on July 1st and contains many important changes in the way we will be activating and responding to MCI events. Why change things? Change was needed to resolve issues in organization, communication and resource ordering that made it difficult for those in the field and those running operations to “do their job”.

The plan was developed after review of numerous other MCI plans throughout the country and uses ICS (Incident Command System) to improve field response. If you have questions or have not signed up for training see your Agency Clinical Educator for assistance.

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CARPUJET MED ALERT!
Manufacturer labeling on the carpjets for Versed and Morphine is very similar raising the risk of medication errors in the field. These concerns are being sent to the manufacturer. Meanwhile avoid errors by DOUBLE-CHECKING medications when using carpjets.
Did you bring their meds?

EMS providers are being asked by receiving hospitals if they “brought the patient medications?”. Why? Because of a new hospital safety mandate called medication reconciliation. Medication errors are one of the leading causes of injury to patients and studies reveal that these errors occur over 50% of the time at transitions of care. EMS is involved in one of those major transition points. Having a list of the medication the patient is taking, or the medications themselves, helps ED doctors determine what the patient is being treated for. First responders can play an important role in helping get the patient’s medication list or actual medications to the ED. When bringing the patient’s medications to the ED always document what you brought and who you gave them to.

Airway:

It’s Back to Basics

Joe Barger MD EMS Medical Director

Despite the de-emphasis of initial aggressive airway management in cardiac arrest, airway management is still a core concept of EMS care, and for those who are living (i.e., have a pulse) it is still the most important issue at the onset of care.

BLS airway management is still the centerpiece of care, and it is clear that intubation of living patients is not only difficult but perhaps the single most hazardous thing we can undertake in EMS. There is also plenty of evidence to support the findings that intubation by EMS does not improve the outcome of pediatric or trauma patients, and medical evidence is not clear how much it actually helps other patients.

We are committed to constantly improving airway care, and in the near future we will develop a comprehensive training segment that reinforces good BLS airway management and hopefully will give EMS personnel a fresh look at this important procedure. Just because it is “basic” does not make it easy, and just because it is basic does not mean it is less valuable than advanced techniques – the opposite is true. Good airway management most frequently also requires more than one person’s attention – teamwork is a crucial issue.

With regard to “advanced” airways, there has been considerable focus in the past on how many intubation attempts were made and what exactly constituted an attempt. The focus must switch to the provision of oxygen to the brain and other vital organs and the critical importance of minimizing interruptions in ventilation in order to establish an airway if something more than basic management is needed. Placement of a plastic tube in the trachea after several minutes of struggle does not constitute airway management “success.”

Our comprehensive training will set forth guidelines that we hope will be the safest and most effective procedure for airway management from both a basic and advanced viewpoint.

EMS ……..

Always changing!

Joe Barger MD EMS Medical Director

I hear often that our yearly changes in EMS treatment guidelines are hard to keep up with. We are striving to improve all our training materials to help efficiently guide caregivers when we do make changes. For example we are working to make sure that in the future, our treatment guidelines follow as closely as possible the training provided in CPR and ACLS classes. There’s no sense in having to “un-learn” what you are being taught.

Unfortunately, medicine is an ever-changing field, and those of us who do it have to be prepared for life-long learning. Given the relatively short educational process for both EMT’s and paramedics, material is often taught in “black-and-white” manners. There is a lot of “gray” in medicine, and EMS is no exception.

In the 30 years that have passed since I began medical school, much of what I initially learned has proved either to be completely wrong or at least not totally correct. We now try our best to make sure that our medical decisions are “evidence-based” and the quality of research has improved greatly. But it’s clear that more changes will come, and more “sacred cows” will be sacrificed as we learn more through good research.

So the only true “constant” in EMS is change – hopefully for the better.