IEMSA

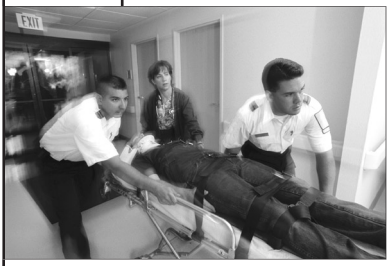
April – June 2004

VOICE

a **VOICE** for **POSITIVE** change in **IOWA** EMS

Iowa Emergency Medical Services Association

Become a Paramedic



Train to become a paramedic at the EMS Learning Resources Center at University of Iowa Hospitals and Clinics. This full-time program consists of three components:

- 15 weeks of intensive classroom training
- supervised clinical experience in a hospital setting
- internship with a paramedic-level ambulance service

Instructors are paramedics, physicians, and nurses with extensive experience in their field.

This program is accredited by CAAHEP, a national, specialized accreditor of allied health programs. Contact the University of Iowa Financial Aid Office for loan and grant opportunities at www.uiowa.edu/financial-aid.

For applications or more information contact:

University of Iowa Hospitals and Clinics
EMS Learning Resources Center
200 Hawkins Drive, 6-South, GH
Iowa City, Iowa 52242-1009
(319) 356-2597
www.uihealthcare.com/emslrc

UNIVERSITY of IOWA HOSPITALS & CLINICS
University of Iowa Health Care

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Iowa Emergency Medical Services Association
1200 35th Street, Suite 206-11
West Des Moines, Iowa 50266

ADVENTURELAND DISCOUNTS AVAILABLE

Have some fun at Adventureland Amusement Park, Inn and Campground in Des Moines. Discount tickets, saving IEMSA members $3 – $4 off the purchase price of admission are available at the IEMSA office. Quantities are limited — first come, first served. Get yours today. Call **515-225-8079**

CALLING FOR EMT'S IN ACTION
Please email your EMT action photos to www.iemsa.net.

News to SHARE

Are you working on an exciting program that needs to be shared with the membership of IEMSA? Do you know of an EMS-related educational program that needs to be showcased? Has your service won an award or done something outstanding? Do you want to honor a special member of your staff or of the community? If so, you can submit an article to be published in the IEMSA newsletter! In order to do this, just prepare a press release (and pictures, if appropriate) and e-mail it to iemsa911@netins.net by the following dates: August 1 (to be mailed by August 20), November 17 (to be mailed by December 10).

The Newsletter Committee will review all articles submitted and reserves the right to edit the articles, if necessary.

CONFERENCE

2004 Update

BY LORI REEVES
Conference Planning Committee Chair

A couple of milestones will mark this year's 2004 IEMSA conference. As we have reported before, this year will be the last year that the IEMSA conference will be held in the Polk County Convention Complex (The Plex). The Plex will close shortly after our conference, and even if it were not closing, we are getting close to outgrowing the facility. It is still our hope, pending contractual arrangements, to move to the Iowa Events Center's HyVee Hall for 2005. We will also be celebrating a milestone — the 15th anniversary of IEMSA's Annual Conference and Trade Show. We hope to have some special activities planned related to this milestone.

The pre-conference workshops will be expanded into Thursday morning, and we have added some all-day specialty classes. Although plans are still tentative, it looks like we will be offering PPC - the Pediatric Pre-hospital Care course developed by NAEMT; GEMS — the Geriatric Education for EMS course developed by American Geriatrics Society, the National Council of State EMS Training Coordinators and perhaps one other course. The CCP track will return, but will run in both the morning and afternoon so that participants may obtain 4 or 8 hours of CCP level continuing education. The EMS Educator and Management tracks will return. Plans are also under way to offer the new 4-hour Traumatic Brain Injury Course on Thursday as well as a "Scene Considerations" 4-hour track.

(Continued to page 6)

BOARD MEETINGS:
The IEMSA Board of Directors will meet on the following dates in 2004. Each meeting (with the exception of the Annual Meeting) will be held at Raccoon River Nature Lodge, 2500 Grand Avenue, West Des Moines from 10:00 a.m. to 1:00 p.m.

2004
IEMSA
MEETINGS

- **JUNE 17**
- < No July Meeting
- **AUGUST 19**
- **SEPTEMBER 16**
- **OCTOBER 21**
- < **NOVEMBER 11**
  Annual Meeting
- **DECEMBER 16**

Additional
IMPORTANT DATES:

Nov. 11 – 13, 2004

Annual Conference & Trade Show

Polk County Convention Complex

The 80th General Assembly — NOW WHAT?

BY RIC JONES
Legislative Chair, IEMSA NE Regional Representative

As Bureau Chief, Gary Ireland once said to me (with obvious relief), "One-hundred-fifty people went home." He was summarizing a legislative session that was difficult.

This session (2004) made his statement sing to me! The new order of the Iowa Legislature seems to be partisanship first, Iowa second. Instead of trying to find the right thing to do and doing it, this Legislative Session seems to have devolved into everyone's focus on how to beat the other side. That's not what we elected them to do or to be. Hopefully the members of the 81st General Assembly will have a better plan. It's not helpful to the process that the leadership and the Governor can't agree on much. Again, partisanship prevails.

This Fall, every seat in the House of Representatives will be voted on as well as half of the Senate. I urge all of you to find out who the candidates are and what they stand for prior to voting. I also ask that you hold them accountable to their responsibility to make Iowa a safe place to live, work, learn and recreate. To do that we need fully-funded, well-trained and well-equipped EMS systems in place in every area of the state.

Your interests were well represented in the Capitol this past year by Cal Hultman, Lobbyist for the Iowa EMS Association. He is well respected by the lawmakers and other lobbyists. Cal kept the issues in front of the lawmakers all through the session. He also orchestrated our Legislative day in February, which was well attended by lawmakers and IEMSA members alike.

LET'S LOOK AT THE IEMSA LEGISLATIVE AGENDA FOR 2004 POINT BY POINT:

1. *Protection of any and all current language on scope of practice and area of practice for EMS providers.*

This was not an issue. No threats emerged this year.

2. *Provide a permanent funding stream for the provision of emergency medical services for all Iowans. This includes fully funding the Bureau of EMS as well as providing money for training and equipment for individual EMS services in the State.*

A few things were tried, including an effort by Rep. Roger Thomas to appropriate $500,000.00 for EMS in the final days of the session that went down on a party line vote (What in the world is partisan about this escapes me!). Roger also worked on increasing the annual fee for the EMS license plate to $10.00, with that money reverting into the EMS system development fund. This bill was rolled into another that puts all the specialty plates under IDOT, with the prospect that the money will come back into the EMS fund. This does not begin to fully fund our needs, though.

3. *Provide a system to reward volunteerism in public safety. This might take the form of an Iowa income tax credit or the ability to earn a pension for volunteer service in EMS, Fire or Law Enforcement.*

House File 2073 provided an income tax benefit of up to $250.00 per year for an active volunteer EMS provider or firefighter, but the bill failed to make funnel and is dead.

4. *Provide for equity of pensions for public employees in EMS. Currently fire fighters and law enforcement officers under the Iowa Public Employment Retirement System (IPERS) receive a higher retirement benefit earned with fewer years of service than EMS providers.*

There was no bill introduced to accomplish this. We will be working through the interim to put a solid proposal and information kit together on this piece. Bill Fish has worked very hard on this and has found a legislator who has agreed to sponsor the measure in the 81st General Assembly.

5. *Provide support for other initiatives and organizations working to improve the health and safety of Iowans.*

We supported a 911 bill that passed in an emended form that should provide more dollars to continue to develop the ability of the Public Safety Answering Points to identify the location of wireless calls.

Your calls and contacts were of tremendous benefit during discussion of cuts in the Iowa Department of Public Health budget. Many of the proposed cuts were restored because of your activism. This was a huge victory for IEMSA.

We opposed a bill that would add a volunteer member to the EMS Advisory Committee. We felt that we are doing well at supporting the voice of the volunteer provider at Advisory. This bill also failed funnel.

We supported a bill that would extend the protection of the Iowa Good Samaritan Law to Critical Incident Stress Management Counselors. The bill failed funnel.

REMEMBER, ALL POLITICS ARE LOCAL. WE ARE THE FOLKS BACK HOME. WE NEED TO HAVE CONVERSATIONS WITH OUR ELECTED OFFICIALS AND KEEP THEM REMINDED OF THAT.

■■■

6. *Require that township trustees provide their townships with Emergency Medical Services.*

Current statute requires that Cities and Towns shall provide law enforcement and fire service. There is no requirement that EMS be provided. We strongly feel that EMS is as important to Iowans as the other elements of public safety and want a similar mandate to assure that EMS is being addressed in all of Iowa. No bill was introduced supporting this position.

7. *Allow the EMS Bureau and EMS Service Directors access to any and all criminal records of any EMS student or provider.*

No bill was introduced that would allow this.

2004 wasn't anyone's best year in public policy. Our mission right now is to stay in touch with our old friends in the Legislature and to elect some new friends this fall. Bring us your ideas. We will be submitting our 2005 Legislative agenda for the membership's approval at the annual meeting in November. A lot of it will look familiar. We are always looking for a few good thoughts!

We are going to try and have our Legislative day on the same day as the Bureau's EMS Leadership Seminar next February. Our hope is that this will increase attendance at both events and save a few of us another road trip.

Remember, ALL POLITICS ARE LOCAL. We ARE the folks back home. We need to have conversations with our elected officials and keep them reminded of that. ■

Welcome
NEW IEMSA MEMBERS

FEBRUARY – APRIL, 2004

CORPORATE:
Cardiac Science, Inc.
Medic First Aid International
Med-Media, Inc.
Medtronic Physio Control

AFFILIATE:
Clinton Fire Department
Glenwood Fire Rescue
Granville Fire & EMS
Hudson Fire & Rescue
Monona County EMS Association
Perry Police Department

INDIVIDUALS:
Tom Banta
Tim Bennett
Sue Boehnke
Chief Dan Brickner
Tim Buhr
John Bushbaum
Mike Eichmann
Neal Eisenbacher
Linda A. Ellis
Rick Erickson
Butch Fidler
Chuck Gipson
Neil Goodnature
Aimee Grothaus
Brian Hahn
Brian Helland
Annette Hird
Greg Johnson
Travis Kaalberg
Corey Kempers
Jon Kieler
Janine D. Lamb
Diane Lamb
Scott McDonough
Brian Mohr
Michele S. Nelson
Belinda Oulman
Shawn Parkhurst
Paul L. Peterson
Don Pffaenbach
Dave Schmidt
Deanna Smith
Chad Southard
Nancy Springsteen
Dave Thompson
Holly Thompson
Amy Van Holland
Justin D. Wyatt
Derek Ziegler

(Continued from page 3)

Conference 2004 Update

Friday and Saturday will see a wealth of excellent presenters including at least six national level EMS speakers including Twink Dalton, Will Chapleau, Paul Werfel, Mike Grill, Dr. Craig Jacobus and Peter Lazzara. Some of these presenters will also be helping with the pre-conference workshops. The Vendor Hall again promises to be bursting at the seams with EMS products and displays. The dance will be held once more on Friday night at the Marriott. The Marriott and Savory hotels have both reported to us that room reservations are already being made! So, mark your calendars for November 11-13, get your "time-off" requests in early and join us for Iowa's premiere conference and the best IEMSA Conference yet! ■

Look to the next volume of the Voice to contain more specific conference information and details.

Keeping up with the
Central Campus EMS Students:

The Central Campus EMT students are currently doing their ER experience. Here are some comments on their training:

"I felt I learned a lot, and was able to practice my skills. The RN treated me with respect and answered my questions." — Claire, Roosevelt

"It was an intense experience...it confirmed to me that this is what I want to do." — Audrey, Johnston

"The nurses at Mercy are wonderful, the staff made me feel that I belonged...I encourage anyone to participate in this class." — Jamie, East

"The time in the ER is awesome, I liked going from room to room not knowing what was wrong, until I saw the patient." — Hannah, DCG

"Discussions and practicing on dummies if far different than seeing the real patient...I love working in the ER." — Sean, Hoover

"You are able to see what you learned in class...I'm privileged to have this experience." — Denise, Lincoln

"There was such a variety of people, very educational, I will enjoy going back." — Mitch, MSM

"If you would have asked me two years ago what I would be doing, I would have never guessed I would be helping a nurse start an IV...how many 18 year olds, by choice, spend a Saturday night in the ER...pretty cool!" — Sara, SEP

"The doctors and nurses at Mercy are great...working there and helping people is great, but learning how the body works is the greatest." — Josh, Urbandale

"The best thing about being there is the opportunity to help the staff, I learned so much." — Andrea, Lincoln

The Central Campus EMT students participated in the Iowa Central Community College Health Science Competition on April 15. Sara Davis-SEP took 1st place in CPR/First Aide and Joseph Frederick (1st semester) Roosevelt- took 2nd place. Both students received medals and certificates. The 1st place winner also received a $100 scholarship. ■

Humeston *First* Responders

Credited with Two Saves Thanks to CPR and The HeartStart® Defibrillator

This is a very personal story of a First Responder group that received the HeartStart® Defibrillator from the Rural AED Grant in 2003. Humeston First Responders was started in 1986. They received their first defibrillator in the late 1980's. It was used several times, but unfortunately, there were no saves. It most cases, CPR was not started until the First Responders got to the scene, and it was simply too late.

Humeston applied for and received their new defibrillator on May 21, 2003. They first used it on July 27, 2003 and saved a 59 year-old man who coded as he was participating in a cookout at his home with his family. The man's son and daughter started CPR immediately. The second and third times it was used, the efforts were unsuccessful. The fourth time was April 2, 2004 … Butch and Susie Gibbs are the only remaining original members of the Humeston First Responders. Susie is an RN and an EMT-I who works full-time in the ER of Lucas County Health Center. Butch is also an EMT-I and works occasionally with the Health Center-based Lucas County Ambulance. Butch works full-time as a dispatcher/jailer with the Wayne County Sheriff's Office in Corydon. This time, the fourth time the AED was used, Butch was on the other end of the defibrillator — he coded in his living room. He was shocked 22 times — that's right, 22 times. As with the first save, Butch's pulse was back before he left for the hospital.

In both cases, Butch reports, everything fell into place. CPR was started right away by family members and the first responders had terrific response times and the equipment they needed. Lives were saved because people were trained to perform CPR and the AED was available. Butch credits the Rural AED Grant program for its efforts to get defibrillators into rural areas of Iowa and encourages placement of "second hand" defibrillators in schools and other public, community buildings. He also emphasizes the importance of CPR training for every person!

IEMSA wishes Butch a speedy, full recovery, and thanks him and Susie for their commitment to EMS and saving lives. ■

The Scoop on Scope:

What's Happening With EMS Scope of Practice?

BY ROSEMARY ADAM

As promised in the last "Voice" newsletter, the Iowa EMS Association would like to routinely provide information to our members regarding what's happening at the State level with our Scope of Practice committee. Our first note to you is that this meeting is open to all EMS providers and is scheduled prior to all Iowa EMS Advisory Committee meetings in Des Moines. The next Scope of Practice subcommittee meeting will be Wednesday, July 14th. Please check with the Bureau of EMS web site for meeting location and time.

The question we wish to discuss today has to do with the limitations within our EMS scope of practice and what that means.

We have a neighboring ambulance service that is at the Iowa Paramedic-level and has a protocol that allows medication-assisted intubation (RSI) with use of paralytics and their Medical Director's approval. Can they do that?

Discussion: The Iowa Paramedic level is actually the National standard EMT-Intermediate level, established in 1999. The Bureau of EMS is bound by rule that the EMS provider is limited in their scope of practice by their initial curriculum and the knowledge and skills that lie within that document. That National standard EMT-Intermediate curriculum does not contain any knowledge or skills objectives that cover use of paralytics in the intubation of patients. Therefore, the Bureau is bound by rule to say, "NO" to this question and any future requests to change this position. The use of paralytic drugs is limited in the EMS community to the Paramedic Specialist (Standard Paramedic) certification level or the Critical Care Paramedic endorsement level.

The Medical Director is not allowed to supercede Iowa rules that place limitations on the EMS providers' scope of practice. Any Medical Director and Ambulance Service that intentionally does not follow these rules is subject to disciplinary action. ■

As of January 1, 2004, IEMSA is offering accidental death and dismemberment insurance to active, individual, dues-paying members Visit the IEMSA web site, www.iemsa.net<http://www.iemsa.net> or call the office at 515-225-8079 for more information.

SYSTEM DEVELOPMENT:

An ambulance in every town?

BY GARY IRELAND
Executive Director, Iowa Emergency Medical Services Association

"System Development" is a term that has received considerable attention in recent years and although it has been around for a while, its birth can probably be traced to "Response 2020" which emerged from the Iowa Department of Economic Development back in the middle 1990s. The whole idea behind the Response 2020 initiative was to bring communities and counties together working with a task force to develop new strategies in the delivery of EMS and fire protection. Although Response 2020 had moderate successes, several EMS delivery systems across the state certainly benefited from its efforts.

So what is the status of Iowa's system development initiatives today? Funding for Response 2020 programs has dried up, but the importance of system development is more crucial today than it was ten years ago. The EMS bureau continues to receive some system development funding through the tobacco settlement and Rural Health. Those dollars are offered back to the counties on a competitive basis. This year's amount of approximately $160,000 is a mere pittance compared to the amount that is truly necessary to affect change in Iowa's EMS delivery system.

The volunteer system is a noble attempt by community minded individuals to take care of its own. It is a system that has served Iowans very well over the past thirty years but its future, as we know it today, is in jeopardy. As the backbone of Iowa's EMS system, volunteerism is no longer able to keep up with the increased demands placed on EMS providers and service programs. Higher training standards, changing expectations by the public and EMS community, and the financial burdens of the volunteer service program have taken their toll on the system. Bottom line, rural Iowa needs new strategies developed by the EMS community to improve the way EMS is to be delivered and it needs to occur before legislative action is sought to fix the problem.

There are numerous initiatives that can be explored to improve the existing system. Most are neither earth shaking nor are they intended to

destroy the existing volunteer system that Iowa enjoys, but rather most are simply designed to streamline and enhance existing resources.

There is one idea that continues to surface and deserves consideration. To explain, let's compare two existing counties in Iowa. These counties will remain unnamed, but once their demographics are described you will find there are probably several counties that might fit this example. County "A" has a population of about 30,000. It has a total of twelve EMS services, two non-transport and ten volunteer ambulance services. County "B" also has a population of about 30,000 and there are also twelve total EMS services, eleven non-transport and one career ambulance service. Both counties have a hospital located within the county and the annual run volumes are about the same.

The above illustration begs the question, "Where is it written that every community must have an ambulance service?" I don't believe you will find the mortality rate higher in county "B" because they only have one ambulance nor is the survival rate any higher in county "A" because they have ten. Duplication of services across some parts of Iowa's rural EMS system is going to be the straw that ends up breaking an already crippled volunteer camel. Besides the financial strain placed on resources, the biggest burden is placed on that resource that we can ill afford to have stressed…the volunteer. In the example given, county "B" non-transporting volunteers simultaneously respond with the transporting ambulance, stabilize the patient, turn the patient over the ambulance service and then they go back to doing whatever they were doing prior to dispatch. Time spent with the call 30-40 minutes. The county "A" volunteers can easily spend 2-3 hours with the call.

"EMERGENCY MEDICAL SERVICES OF THE FUTURE WILL BE A COMMUNITY-BASED HEALTH MANAGEMENT THAT IS FULLY INTEGRATED WITH THE OVERALL HEALTH SYSTEM."

The system that county "B" has in place may not be THE answer to the volunteer issue but it is certainly one option of many that deserves some consideration. There are however, several barriers that must be overcome to accomplish any type of system change. "That's the way we've always done it" is one that comes to mind. Identity is another that must be considered. Closing an ambulance service in a small community or its perception of closing is akin to the school consolidation issue that has splintered many Iowa communities over the years. And of course, there is always the "turf" issue. I know it's hard to believe, but some EMS providers simply cannot play well on the EMS playground. Attitudes are probably the biggest barrier to conquer. I'm reminded of a response I received years ago when I first started working for the state. When asking a volunteer basic ambulance attendant why he did not call for a tier with the close ALS transporting service, he responded, "By God we only get one or two CPR calls a year and we're not going to give it over to any one else."

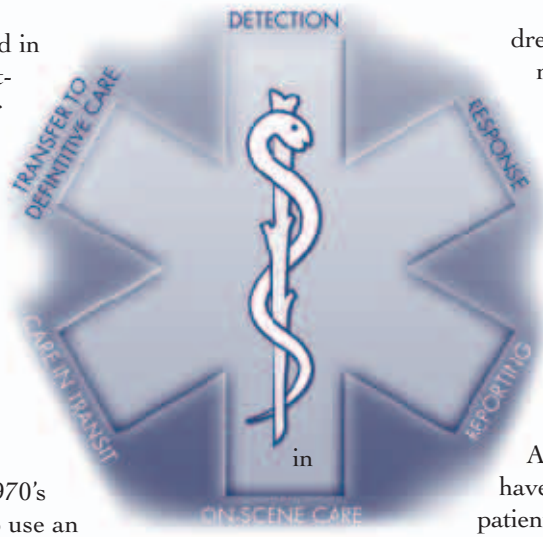
According to the National Highway Traffic Safety Administration's EMS Agenda For The Future document, "Emergency Medical Services of the future will be a community-based health management that is fully integrated with the overall health system." To accomplish that vision, Iowa must ensure that funding is available to guarantee that EMS will remain the public's emergency medical safety net. System development is the key to Iowa's EMS future. ■

The STAR of LIFE

BY LORI REEVES
Education Representative, IEMSA Board of Directors

Anyone involved in EMS undoubtedly has a star of life on something they own — a shirt, a bag, a coat or other. We all proudly wear and display this symbol, but do you know what the Star of Life's true origins are or exactly what it means?

In the 1960's and 1970's EMS groups began to use an orange cross as an EMS insignia. In 1973, the American Red Cross complained to the National Highway Traffic Safety Administration (NHTSA), that the orange cross too closely imitated their registered trademark red cross symbol. NHTSA investigated and felt the complaint was justified. In response, Leo R. Schwartz, then Chief of the EMS Branch of NHTSA, designed the six barred blue cross containing a staff entwined with a serpent. Today the Star of Life is one of the most highly recognized symbols in the world.



The snake and staff in the center of the Star of Life represent Asclepius, the son of Apollo, the god of light, truth and prophecy from Greek mythology. Cheron, the centaur ferryman on the river Styx, taught Asclepius how to heal the sick and injured. Zeus, the king of the Greek gods, worried that Asclepius could make all men immortal with his powers of healing. To prevent this from happening Zeus killed Asclepius. Later, Asclepius became worshipped when it was rumored and believed that Asclepius cured the ailments of the sick during their dreams. Eventually, Zeus restored Asclepius to life, making him a god. Asclepius was usually depicted in a standing position, dressed in a long cloak, holding a staff with a serpent coiled around it. The staff with the serpent originates from an incident when Asclepius was reported to have had a very difficult patient that he could not cure, so he consulted a snake for advice. The snake had coiled around the staff in order to be head to head with Asclepius as an equal when talking. Individually, the staff is the ancient Greek symbol of support and the snake is the ancient Greek symbol of eternal life. Together, they are also thought to symbolize efforts to support and fight for life and protect it as long as possible. The staff and serpent have since come to be the universal symbol representing medicine.

Each of the bars of the Star of Life represents one of the six system functions of EMS, as illustrated in the figure

WE ALL PROUDLY WEAR AND DISPLAY THIS SYMBOL, BUT DO YOU KNOW WHAT THE STAR OF LIFE'S TRUE ORIGINS ARE OR EXACTLY WHAT IT MEANS?

below. This blue "star" is now easily recognized as a symbol of EMS and helps to delineate EMS and its' distinct role from other branches of medicine. The capital letter "R" enclosed in the circle on the right of the star represents the fact that the symbol is a "registered" trademark owned by NHTSA. NHTSA has exclusive rights to monitor its use throughout the United States.

Next time you look and see a Star of Life on the side of your rig, the shirt of your partner or the jump bag containing your equipment, take a minute to remember its' origins and meaning. Be reminded that portions of this emblem which represents us are as old as the Greek gods themselves. As humble possessors of this symbol, we as EMS providers have been charged to accept the duty to protect, support

CONTINUING *education*

CATASTROPHIC KID CALLS

BY DEBORAH STEPHENSON,
RN, Trauma Nurse Coordinator at Ottumwa Regional Health Center in Ottumwa, Iowa

CATASTROPHIC KID CALLS

OBJECTIVES: When the EMS provider finishes reading this article, they will be able to complete an attached quiz at an 80% success rate, demonstrating their knowledge in:

1) listing the unique characteristics of children involved in trauma;

2) discussing the standardized approach in primary assessment and management of the traumatic pediatric patient.

SCENARIO:

On a warm, summer day your EMS crew is called to a local park where a three-year-old has been struck by a car in a parking lot. Dispatch states that the caller was nearly frantic and reported that the child was "critical." Police are also enroute.

When EMS providers are enroute and find out that the trauma call they are part of involves children – fear strikes hard and fast. "Catastrophic Kid Calls" can make even the most experienced EMS providers do gut clenches, have their senses go into overdrive and their minds race. Most providers, when faced with a pediatric trauma call, will make an attempt to review every special consideration related to the care of a pediatric patient while enroute to that call. Not a bad idea.

We all know that children are not " mini-me's" They neither respond to traumatic forces like adults, nor do they respond to treatment like adults. Worse than that…..they are sneaky little critters who compensate. In fact, they compensate so well, they trick us into believing that all will be fine, then suddenly (seemingly without fair warning), crash. Now having said that, neither are they a completely foreign species, a fact that is essential to remember for the confidence factor when caring for pediatric patients.

Yes, kid trauma can be our worst nightmare and our worst heartache as caregivers. Our best care depends on our preparedness to care for these smaller, sneakier beings. During our discussion within this article, I am going to bypass the subjects of personal safety, scene safety and scene survey, (with the exception of observation at the scene for mechanism of injury), (discussed later). So …… just what "special consideration" related to pediatric trauma should we review?

BASICS – BASICS – BASICS

The basics of the primary survey, (performed quickly and accurately), are the best means to keep these kids alive. 4 out of 5 deaths from pediatric trauma do not even make it to the hospital. Inadequate resuscitation is the leading cause of

preventable death in children. — inadequate evaluation and intervention of those familiar ABCD's. The pediatric patient often does not have time for the secondary or focused assessment in the field. Rapid accurate assessment, minimum scene time, and rapid transport can mean the difference for these patients.

MECHANISM OF INJURY

Infants, toddlers and children all have unique patterns of injury. When surveying the scene, the EMS provider must view it from the perspective or level of the child. The age and size of the child will directly relate to how the mechanism will affect the pattern of injury.

Example: The smaller the child, the shorter the distance of the fall. Infants — bed to floor, Toddlers — shopping cart to ground. Whereas the older child is more likely to fall from a greater height — playground equipment, tree, in some sort of sports or recreational activity.

A small child will have a different pattern of injury in a car vs. pedestrian accident. The smaller child is more likely struck by the vehicle in the chest and will travel down and under that vehicle. Conversely, a larger child is more likely to be struck by the vehicle at abdominal, pelvic or femur level first then strike the pavement. A child may be tall enough to be tossed up onto the hood, which can cause other injuries.

Kidbit: Children will turn and face the car whereas the adult will usually turn away from the car as it approaches.

Kidbit: Kids are more susceptible to traumatic forces and less likely to have obvious signs and symptoms.

Kidbit: Kids' heads are big — they lead with their head.

Consequently, significant brain injury is five times more likely to occur than other types of internal injury.

Kidbit: Rib cages are soft and don't provide the same protection as in adults. They may have internal injury without any external signs of trauma.

Kidbit: Kids are more likely than adults to suffer internal abdominal injury.

EXTRICATION & IMMOBILIZATION

It may be tempting to leave the child in their car seat because it is less traumatic for the child and it is a convenient means for transport. However, it is nearly impossible to adequately assess a child or manage their care while the traumatized child is in a car seat. A car seat does not provide adequate stabilization of the spine. Patients who are involved in forceful trauma or exhibit decreased LOC should have manual stabilization maintained from first contact through the initial assessment and any interventions required for life threatening conditions. Following that, full immobilization should be performed. Always remember, the organization, EMS for Children (EMS-C) states that only one crash is allowed per car seat.

Kidbit: Manual stabilization should be maintained while the car seat is turned and tilted downward if possible, then extricate the child onto a long board and immobilize with appropriate equipment. If it is not possible to turn and tilt the car seat, manual stabilization should be maintained while the car seat is moved into

a position making it possible to remove the child.

Kidbit: Size! The correct size of equipment can make the difference between providing adequate resuscitative efforts or not.

Kidbit: C-collars are as difficult to size to children! It is very important to have the correct fit of cervical immobilization. For stiffneck sizing, the same measurements apply here: from the chin to the shoulder. If an appropriately sized c-collar cannot be found – the EMS provider should use a towel roll, with the ends crossed over the chest.

Kidbit: KEDs (Kendrick Extrication Devices) are a good option for immobilizing a child if the correct size is used. The sides may require some extra padding for a good fit.

Kidbit: When immobilizing a pediatric patient on a long board, remember to pad along the sides to make the board fit the child. By padding along the sides, applying the straps from foot to head, will allow us to quickly roll them to the side (when they throw up) without allowing their body to slide sideways.

Kidbit: Infants and toddlers have "Charlie Brown" heads, i.e., back of the head is rounded. Because of this anatomy, lying them flat on a backboard causes them to roll their chins down. To compensate for this, please place padding under their upper backs (near the scapulae) to allow for neutral alignment. Look at them – if their chin and nose are nearly level — that's good alignment AND a good airway.

Back to our original scenario…

As you take your first look at this injured child, you note that her eyes are open but she is not making eye contact as you approach. There is some obvious facial trauma. She is very pale. Her mouth is free of obstructions and she's breathing with no external signs of trauma to her chest. Her skin is cool to touch. You can feel a fast femoral pulse but her radial pulses are difficult to find. Your partner has manual, in-line head/neck stabilization as you measure and apply a c-collar. The c-collar doesn't fit well so you remove it and roll up a towel to apply around her neck. You've applied her to the backboard and are padding along the sides. As you strap from foot to head, you've applied a small pad under the shoulder blades to allow her head to remain in-line.

Again, remember initial assessment and interventions first. A-B-C-D. The initial assessment of airway status including patency and adequacy of breathing, circulatory status and mental status are the three main areas or focus of the primary survey. Interventions or treatments to address and correct life threatening situations should be performed as necessitated by the condition of the patient, but all other evaluation and treatment should be performed en-route.

AIRWAY & BREATHING

Pediatric trauma is usually an airway status emergency rather than a circulatory/ hypoperfusion emergency for kids. Most of the time, this is blunt force trauma. It frequently involves head trauma, causing a decreased/depressed level of consciousness which in turn causes a loss of muscle tone and a soft tissue obstruction of the airway. Trauma deaths in kids are usually from airway status complications. Frequently repeated airway evaluation is critical. Remember: they are small and sneaky and what once might have been a clear airway can change very quickly in kids.

Kidbit: As mentioned above — these little persons have what we call "Charlie Brown heads." They are round. Round head on a flat board = flexion of the neck and compromise of the airway. A correctly positioned airway may be all that is required.

Padding beneath the shoulder blades can aid in achieving a neutral position.

Kidbit: When securing a child to the long board — especially smaller kids — they are belly breathers, be mindful of where you secure straps across the patient so as not to impede their breathing.

Kidbit: If the airway is obstructed, use extreme caution when attempting to clear it. A child's gag reflex is very sensitive and inserting either a suction catheter or doing a finger sweep too far back into the mouth will provoke vomiting with the potential for aspiration and more problems than you started with. As with adults, never insert anything past where you can visualize, always attempt to oxygenate the patient before and after suctioning and limit suctioning time.

Kidbit: Oxygen is always a good adjunct. Getting a kid to tolerate low flow delivery systems is sometimes difficult and if they are protesting loudly and vigorously they probably don't need it. Non-rebreather masks should fit from the tip of the chin to the bridge of the nose. The rebreather bag should remain about 2/3's full at all times. If this bag is deflating, turn up your oxygen flowmeter.

Kidbit: Airway adjuncts such as an oral airway should only be used if the above interventions do not maintain an open airway and only if the child will tolerate it. A child that will tolerate an oral airway is a child who might be unconscious. For the advanced level providers, a decision would need to be made regarding whether to take the time to intubate the unconscious child.

Kidbit: Kids suffer the same types of injuries that impede their breathing as adults (pneumothorax or hemothorax). However, cardinal signs of tension pneumothorax, like deviated trachea, is more difficult to observe

because kids often have short and pudgy necks. You have to rely on other signs like skin color, work of breathing and diminished breath sounds with signs of hypoperfusion.

BAG-VALVE-MASK (BVM) RESUSCITATION

The subject of assisted ventilation with a bag-valve-mask (BVM) needs to be reviewed. The major factor here again is that using the right sized equipment for an infant or child is key. Minimum equipment needs for the catastrophic kid calls include having at least a 500cc BVM device with at least one pediatric-sized mask. The BVM should also have a pop-off valve to keep us from over-inflating the child and an oxygen rebreather circuit to increase the amount of oxygen we provide during ventilation.

Otherwise, the mechanics of BVM resuscitation are much the same as an adult. Your first step (prior to application to the child) in assembling this BVM is to hold your hand over the mask or 15 mm adapter and squeeze the bag. That hissing sound is the pop off valve. Knowing the location of the pop-off valve is important.

MASK FIT: Tip of the chin to the bridge of the nose. If the mask is too big — allow some of the excess to flow over the chin section — not the eyes. Never ventilate over the eyes.

Use the E-C clamp technique to PULL the child's face up into the mask.

- The C is your non-dominant hand's thumb and forefinger in the shape of a C around the 15 mm adapter connection.
- The E is the middle, ring, and little fingers on the mandible of the child — pulling the face up.

The most common mistake made in BVM ventilation is ▶

to apply the mask to the face and push downward. This makes the airway collapse and then ventilation cannot be accomplished.

HOW MUCH TO VENTILATE?

How much is enough? Just like in adults really — adequate chest rise at an age-appropriate rate.

(1 breath every 3 seconds with infants, once every 4 seconds with children, and 1 breath every 5 seconds for adolescents.) Slow and low is the ventilation mantra now. Overventilating has been proven to cause lung trauma, decrease blood flow, cause gastric overinflation AND not provide the hyper-oxygenation you are trying to achieve.

Kidbit: Use techniques like the EC Clamp to ensure a good seal of the mask to an infant's face and mnemonic like, "Squeeze-Release-Release" to aid the ventilator with proper rate. With older children, a two-person technique is preferable where one maintains c-spine immobilization while keeping the airway open and holding the mask in place, while the other person ventilates.

Kidbit: A child should not be intubated unless they are unconscious. It is recommended to NOT delay transport for intubation. HUM? Let's try and pass an ET tube through that very small set of cords while bouncing down the road. This boils down to the best judgment of the EMT at the scene, their skill level, their protocols, policies and procedures, their transport time, their medical control, etc.

Kidbit: While an adult in the same circumstances may be able to tolerate decreased level of consciousness or increased work of breath, a child won't. Their airways are too small and even small amounts of edema are enough to put them at risk of respiratory status failure.

CATASTROPHIC KID CALLS AND INTUBATION

Everything about kids makes intubating them a challenge. Their tongues are bigger and they get in the way. The epiglottis is in a different position relative to their body than an adult, making it difficult to visualize the cords. The larynx is shaped differently and, up to about age 8 – 10, the cricoid ring acts as an anatomical cuff for the tube - so uncuffed Endotracheal (ET) tubes are used up to size 6.

Kidbit: Using some means to ensure the appropriate-sized equipment (like a Broselow tape) is especially important in infants and smaller children. There are also helpful formulas to estimate correct ET tube size - 4 + (age in years/4) mm - And for insertion depth of ET tube - Depth of insertion = (age in years/2) +12. There are tables with estimated sizes for approximate ages and weights if you are good at remembering those. However, given that pediatric intubation is an infrequently practiced skill at best, using a guide like a Broselow tape is probably faster for most.

CIRCULATION

Visible bleeding is fairly easy to find in the assessment, whether adult or child. BUT-assessing perfusion status for possible internal bleeding is different in kids. This is probably the area of assessment where kids are THE most sneaky. They can compensate for significant blood loss by vasoconstriction and maintaining perfusion while their blood pressure remains normal, at least for a while. The problem is that when they move from that compensated stage to decompensated, it is sudden and very ominous.

Kidbit: Heart rate and respiratory rate are the early indicators of a perfusion problem. Kids will compensate with subtle increases in tachycardia and tachypnea.

Kidbit: Compare central and peripheral pulses for a quick assessment of compensated vs. decompensated shock. Remember, it is often difficult to palpate a carotid pulse on the chubby neck of an infant — a femoral is a central pulse that might be easier to locate and palpate.

Kidbit: Kids are less able to thermoregulate (keep themselves warm) under stress. Please keep them warm.

Kidbit: Obtaining a blood pressure in kids is usually a waste of valuable time. Their other vitals, appearance and mental status will tell you as much if not more related to their perfusion status.

VASCULAR ACCESS

If shock is evident, vascular access should be established. As with adults — do not delay transport to establish IV lines.

Kidbit: Intraosseous Infusions: (IO) — if you can not obtain intravenous access, consider an IO. The skill isn't difficult to learn. They work well and can be faster to do than intravenous.

Kidbit: Don't be afraid to administer fluids. Administer fluids in the correct amounts — 20/ml/Kg of normal saline or lactated ringers. No dextrose-containing fluids for resuscitation please.

DISABILITY

By the time you get through assessing A-B-C, you should already know D (the mental status of your patient). Obviously, with infants and very young children, the assessment is a little more complicated given their limited communication ability. Take their developmental stage and age-appropriate behavior into account. Assess how the infant or child is reacting and responding (or not responding) to you, to his parents, to pain, to their injuries. If the patient is unconscious, their posture may be a clue to the level of CNS involvement.

Kidbit: If a child is experiencing hypoxia or hypoperfusion (shock), their mental status may be one of the first clinical symptoms. Make sure they are receiving supplemental O2.

Kidbit: Do not withhold fluid from the patient who exhibits a depressed level of consciousness for fear of worsening possible increased intracranial pressure. ▶

Glascow Coma Score for Pediatric Patients

The Glascow Coma Score is adapted for those patients who cannot speak yet. They differentiate that at age one. It is broken down as follows:

Eye Opening

Score	> 1 year	< 1 year
4	Spontaneously	Spontaneously
3	To verbal command	To shout
2	To pain	To pain
1	No response	No response

Best Motor Response

Score	> 1 year	< 1 year
6	Obeys	Spontaneously
5	Localizes Pain	Localizes Pain
4	Flexion-Withdrawal	Flexion-Withdrawal
3	Flexion-Abnormal (decorticate)	Flexion-Abnormal (decorticate)
2	Extension (decerebrate)	Extension (decerebrate)
1	No response	No response

Best Verbal Response

Score	> 5 years	2 to 5 years	0 to 23 months
5	Oriented & converses	Appropriate words	Smiles & coos
4	Disoriented & converses	words	Cries & is consolable
3	Inappropriate words	Persistent cry/screams	Persistent, inappropriate cry/screams
2	Incomprehensible sounds	Grunts	Grunts, agitated, restless
1	No response	No response	No response

Back to our scenario…

You have quickly placed our severely injured 3-year-old in the back of the ambulance in full pediatric immobilization. You have applied a non-rebreather mask on her so that the oxygen bag remains 2/3 full. You have only 5 minutes to the local hospital and have opted to await arrival there to initiate vascular access and possibly intubate due to the child's low GCS: (She has her eyes open, withdraws from pain and grunts). Her heart rate is 160 per minute, respirations at 50 per minute.

You consult with your local Pediatric Out-of-Hospital Triage Destination Decision Protocol and notify the local hospital of this pediatric Trauma Alert… ■

10-QUESTION

Quiz

POST-ARTICLE

CATASTROPHIC KID CALLS

1) Please choose the true statement regarding pediatric mechanism of injury:

A) Children have disproportionately large heads and can suffer head trauma five times that of an adult.

B) Infants and toddlers are much more likely to fall from greater heights than older children.

C) Because of soft ribs, kids can tolerate more forces with less internal injuries.

D) (All above statements are true.)

2) Choose the best way to immobilize a 2-year-old trauma patient:

A) There is no need to immobilize a toddler; they can be carried.

B) An adult backboard may be used but must be padded along both sides of the child before strapping.

C) Sizing a cervical collar is the same for all age groups BUT children may need to have towel rolls used instead.

D) (B & C are both correct.)

3) Choose the correct Bag-Valve-Mask features for younger children:

A) It should be 250 ml in size with 5 sizes of pediatric masks and no oxygen reservoir circuit is necessary in kids.

B) It should be at least 500 ml in size with 1-2 different sizes of pediatric masks and an oxygen rebreather circuit.

C) It should be at least 500 ml in size, 1-2 sizes of mask, an oxygen rebreather circuit and a pop-off valve.

D) An adult Bag-Valve-Mask, sized 1000-2000 ml is always OK for pediatric use.

4) During the primary survey, a good circulatory assessment in a child should include:

A) Carotid pulse check and look for external bleeding.

B) Brachial pulse check and look at skin color.

C) Simultaneous femoral and pedal pulse check (proximal & distal comparison), skin vitals: color, temperature and capillary refill.

D) Brachial pulse check and BP (because you can't determine shock without a BP).

5) In order to appropriately ventilate a 5-year-old child in respiratory failure, the EMS provider must:

A) use an adult BVM and provide a rate of 20/minute.

B) Use a pediatric BVM, use E-C clamp mask technique, at a rate of 15/minute.

C) Use a pediatric BVM, an E-C clamp mask technique, at a rate of 12/minute.

A) Use a 250 ml size BVM, E-C clamp mask technique, at a rate of 20/minute.

6) Within the article, what is the three-year-old's Glascow Coma Score?

A) 5 **B)** 7 **C)** 10 **D)** 12

7) The State of Iowa has an "Out of Hospital Triage Destination Decision Protocol" for pediatrics.

A) True **B)** False

First Responders, EMT-Basics and Intermediate 85's may stop here. Good luck

8) The small, local hospital has evaluated our 3-year-old trauma patient from our article's scenario. They want you to help with stabilization while they await a pediatric transport team. The local physician agrees that the patient should be intubated. Choose the correct statement regarding pediatric intubation:

A) A young child's tongue is bigger and will make it more difficult to view the cords.

B) The epiglottis and larynx of a child are different from the adults.

C) The toddler in the article's scenario would need a size 4.5 mm ET tube.

D) (All of the statements above are correct.)

9) The local Emergency Department has determined that our child weighs 15 Kg. How much/what type of IV fluid would you use?

A) 300 ml of LR and then reassess circulatory status.

B) 300 ml of D5NS and then reassess circulatory status.

C) 150 ml of NS and then reassess neurologic status.

D) 500 ml of NS then stop.

10) Just before transporting our toddler trauma victim (intubated and one fluid bolus given), we note that she is restless and her heart rate is increasing. You note that the endotracheal tube is showing 18 cm at the patient's lip. You note breath sounds over the right, but not the left. Choose the correct assessment and treatment in this situation:

A) She's getting better. Ignore these signs.

B) The endotracheal tube has been inserted too far. It should be 13-15 at the lip. Deflate the cuff, pull back the tube to that mark, reinflate the cuff, and reassess.

C) The endotracheal tube has been inserted too far. It should be 13-15 at the lip. Pull the tube back to that mark, resecure it, and reassess.

D) This definitely a tension pneumothorax. Immediately decompress the left chest. Reassess.

SUMMARY

Taking care of kids who suffer from traumatic injury is never a routine call for even the most experienced care provider. The fact remains, however that trauma is the leading cause of death of children. Knowing that fact alone should inspire us all to become proficient in recognizing the differences in taking care of these types of patients. It should push us to be prepared intellectually as well as in the practical realm of having at hand the right kinds and sizes of equipment to care for infants and children. It should also bolster our confidence in our ability to take care of these patients to realize that the skills and knowledge base that is second nature to us serves these patients as well as the adult patient.

CATASTROPHIC KID CALLS

IEMSA

CONTINUING EDUCATION

answer form

CLIP AND RETURN

(Please print legibly.)

Name _____

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3.	A. ☐	B. ☐	C. ☐	D. ☐
4.	A. ☐	B. ☐	C. ☐	D. ☐
5.	A. ☐	B. ☐	C. ☐	D. ☐
6.	A. ☐	B. ☐	C. ☐	D. ☐
7.	A. ☐	B. ☐		
8.	A. ☐	B. ☐	C. ☐	D. ☐
9.	A. ☐	B. ☐	C. ☐	D. ☐
10.	A. ☐	B. ☐	C. ☐	D. ☐

First Responders, EMT-Basics must achieve an 80% score on questions 1-8.Standard EMT Intermediates and Paramedics must achieve an 80% score on questions 1-10.One hour of continuing education credit will be awarded for 80% scores through the University of Iowa Hospitals' EMS Learning Resources Center in Iowa City, EMS Training Program, provider Number 18

For those who have access to email, please email the above information, along with your answers to: adamr@uihc.uiowa.edu.

Otherwise, mail this completed test to:
Rosemary Adam
University of IA Hospitals and Clinics
200 Hawkins Drive, EMSLRC So. 608GH
Iowa City, IA 52242-1009

REFERENCES FOR **CATASTROPHIC KID CALLS** ARTICLE/SUGGESTED READING:

1) *CD ROM on "Issues in Spinal Care", Training Curriculum, 2003; Minnesota Fire/EMS Safety Center*

2) *CD ROM: Larson, et al; "Red Flags in Pediatric Medical Emergencies", 1999, Arizona Emergency Medicine Research Center, University of Arizona in Tucson*

3) *CD ROM on "Pediatric Assessment", Version 1, 1998; Joint project by the Critical Illness and Trauma Foundation and the Montana EMS and Injury Prevention Section, Dept. of Health and Human Services of Montana- a TenKids Project, 1998*

4) *Interactive CD: "Helping Kids Survive", Interactive Training for Prehospital Providers; Connecticut, Idaho, New York EMS-C Projects; Rural Area Medical Emergency Health Services Systems*

5) *N. Eckle, K. Haley, P. Baker Eds; Emergency Nursing Pediatric Course", 2nd Edition, 1998, Emergency Nurses Association*

6) *Markenson, Pediatric Prehospital Care, 2002, Brady*

MUSCATINE EXCELS
During EMS Week

BY TOM SUMMITT

IEMSA Board Member & Muscatine Fire Department Staff

The most important week for EMS providers, EMS Week, is celebrated all over the United States. But for us in Iowa, it should have greater importance. Why? Because Iowa, for example, was one of the first states to offer out-of-hospital defibrillating, thanks to the University of Iowa Hospitals and Clinics. Iowa has been on the cutting edge of technology for EMS skills to be utilized in the field.

Muscatine will mark its

13th consecutive year as a participant in EMS week, ensuring that EMS has been recognized and celebrated. In the beginning, it was simple. Let the public tour inside the ambulance, explain what "we do," give them a balloon or some pencils, and send them on their way. Over the last several years however, Muscatine County EMS Association, along with local and nearby agencies, have given the general public a broader, more in-depth understanding of what EMS means and stands for.

We make sure that everyone tries to play safe and be safe, and, if the unexpected occurs, we instruct them on making the right call to EMS and what to do until help arrives. Over the years, we

(Continued to page 24)

(Continued from page 23)

have held CPR classes, demonstrated the JAWS of Life, given away free smoke detectors funded from securing local grants, and have photographed and finger-

printed children in case they became lost or abducted. (Another popular ID system is the new Dental ID which includes dental impressions, and DNA.) We have also had the local ER nurses on

hand to do some blood pressure and blood glucose checks.

Other popular events include child safety seat inspections and bike safety with free helmet giveaways (also funded from securing a state grant). Teaching children what to do is case a fire would break out is a great attention getter, too! During the last several years, we have featured a "Smokehouse" in which a miniature house is filled with harmless smoke and children are shown how to escape. Last year, we introduced "Pet Safety" with a local vet and had plenty of furry animals on hand for the kids to pet.

There seems to be a lot of ways to entertain the public with what we do, and with today's popular TV shows featuring EMS, Fire and Police, you would think that everyone would understand and care. However, unless you educate and participate on a LOCAL level, with LOCAL EMS, it seems to go by the wayside. Get involved on a LOCAL level, and let YOUR community KNOW and RESPECT what EMS does for them!

IOWA EMERGENCY MEDICAL SERVICES ASSOCIATION

IEMSA

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COMPLETE CONTACT INFORMATION IS AVAILABLE AT WWW.IEMSA.NET

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EMS POSITIONS
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EMS POSITIONS AVAILABLE AT OTTUMWA REGIONAL

EMT positions are available at our busy, hospital-based ALS ambulance service. We average 12 calls/day and also do long distance, inter-facility transfers. We do provide E911 service for Wapello County as the only paid, transporting ALS service, who works well with local First Responders. We work 10 hour and 6 hour shifts with combinations of on-call/standby for 2/4 or 6 hours/week. In our down time, we also assist ED and in house. ORMICS has nice equipment and a close working relationship with the medical director, utilizing the state protocols as our basis for quality patient cares. On-site education/training available.

We desire a candidate with an excellent driving record, a class 3-D CDL, and over age 21 for insurance purposes. We are looking for exceptional customer service skills. Requirements include: being currently certified as EMT-B, I, PS in the state of Iowa or qualify for RN exception status. Benefits include: shift differential, standby, call back and options with credit union and pension plans. "On call positions" requires working 3 shifts within a 6 week time frame. Temporary and On-call positions are to be filled in August/September. Starting pay EMT-B at $8.75/hr, EMT-I at $8.88, and EMT-PS at $12.12, and can be adjusted with experience.

Contact **Ottumwa Regional Health Center**, Human Resources Department for job description/application/interviews at **641-684-2405** or our web site at **www.orhc.com** and look under employment.

Ottumwa Regional Mobile Intensive Care Services (ORMICS):
EMS Director, Fred Neujhar 641-684-2352 or EMS Patient Care Coordinator, Cindy Hewitt at 641-684-2333, can both be contacted for questions.

OTTUMWA REGIONAL HEALTH CENTER

AREA AMBULANCE SERVICE

The Area Ambulance Service has several anticipated openings due to growth of the service. All positions are rotating shifts and require weekend/holiday rotations. Criminal history and driving records checks will be conducted during this selection process.

Paramedic Specialist — full-time and part-time positions; State of Iowa Paramedic/Specialist certification required. Must have current ACLS and BCLS certifications. PALS, NRP and PHTLS preferred.

System Status Controller (Dispatcher) — on-call positions. Must be certified as Emergency Medical Dispatcher.

For immediate consideration, please submit resume/application to Human Resources

Mercy Medical Center
701 10th Street SE
Cedar Rapids, IA 52403
(319) 398-6826
empcoord@mercycare.org
www.mercycare.org

MERCY MEDICAL CENTER

an EOE

Affiliate Profile

Muscatine Fire Department

Muscatine Fire Department (MFD) began serving the Muscatine area as a volunteer service in January 1875 and became a career paid service in 1913. In early 1961 and continuing for about 7 years, MFD provided limited ambulance service along with local funeral homes.

By July 2000, the MFD began providing fully authorized paramedic ambulance service to the citizens of Muscatine, Muscatine County and surrounding communities. MFD's staff and ambulances are licensed in Illinois, thus paramedic services are provided to several Illinois communities as well. MFD has three, fully-equipped ambulances, with the fourth new ambulance expected to be in service by late summer, 2004!

MFD's mission is to provide a combination of services directed towards the prevention of, preparation for and response to occurrences of every magnitude which represent threats to the health, welfare or prosperity of the citizens, visitors and properties in and around Muscatine.

During 2003, the Muscatine Fire Department Ambulance Service responded to over 2600 calls requesting an ambulance. Also in

2003, the ambulance service became a critical care transport service, with six of its members becoming trained at a Critical Care Paramedic level. MFD is currently staffed with 13 EMT-B's, 1 EMT-I, 4 EMT-P's, 12 EMT-PS's, 6 CCP's and one deputy medical examiner-investigator. In addition to providing ambulance and fire service, MFD provides specialized services such as hazmat, vehicle extrication, high angle rescue, confined space rescue, trench rescue and fire investigation.

MFD was named Iowa Emergency Medical Services Association's (IEMSA) EMS Service of the Year for 2002. In addition, Assistant Chief Gerald Ewers was named Career Individual of the Year marking the first time in IEMSA history that 2 awards were given to the same service in the same year. MFD also recognizes that two other members received IEMSA awards. In 1997, Tom Summitt was named Career Individual of the year, and in 1999, Don Bekker was named in the IEMSA Hall of Fame award. In 2003, Darrin Brooke was awarded Preceptor of the Year by Trinity School of Nursing/EMS.

MFD takes pride in providing its community with continuing education programs as well as the fire/EMS services. One of MFD's most important programs is its yearly co-sponsorship of EMS Day. MFD also provides the community with the following events: Freddie the

MFD CONTINUALLY STRIVES TO MAKE MUSCATINE AND THE SURROUNDING COMMUNITIES A SAFER PLACE TO LIVE, WORK, AND PLAY.

Fire Truck shows; Stand-By ambulance for special events, high school football games and Youth Sports Foundation pee-wee football games; annual MDA boot drive, mock disaster drills in conjunction with several local business's and Unity Hospital. MFD is also a participant with Special Olympics softball/basketball and golf. In addition, MFD is a provider of emergency medical training and field experience in conjunction with Eastern Iowa Community College District, the University of Iowa's EMSLRC, and Kirkwood Community College. MFD is currently providing free smoke detectors and installation through

provides monthly blood pressure screenings for local senior citizens.

MFD provides Business pre-planning, a Juvenile Fire Setter program, Plan reviews, participation in the Fire Venture Group and Business Inspections. MFD their public education shift. MFD Captain, Mike VanWey, recently published a book on the history of the Muscatine Fire Department.

MFD's vision for the future includes becoming accredited by the Commission on Accreditation of Ambulance Services, and seeing a joint communication system become a reality between the city and the county. MFD is also in the planning stages to be the first fire department to offer deputy medical examiner-investigation services in conjunction with the local Muscatine County Medical Examiner's office.

MFD continually strives to make Muscatine and the surrounding communities a safer place to live, work, and play. ■

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