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call
OF THE MONTH:

EMS Calls and Language Barriers

TraumaVue

by
*Dawn White EMT-P
Durham County EMS*

It was a typical summer day, although very hot and humid. I reported to work and began checking my equipment. I had completed my equipment checks and was waiting for my first call of the day. The base alarm tone sounded and the dispatcher announced a Pre-Alert, A10-50 PI" with multiple patients injured. As my partner and I headed for the truck, the adrenaline was already flowing. I had just been released to function independently only a few short weeks earlier. I had seen and treated quite a few patients with diverse backgrounds since coming to work for Durham County EMS. I was as ready as I could be to tackle the world.



*photo courtesy of
Durham Herald-Sun*

Just as my partner and I were getting into the truck, the dispatcher was providing more information. The response was a usual one with lights, siren, and caution. As we pulled up, we could see victims scattered everywhere. As I exited the vehicle, a bystander approached and informed me there were seven Hispanics who had been ejected from a vehicle that had overturned multiple times. I quickly found the seven victims and triaged them as four red tags (critical) and three yellow tags (serious). I had the Incident Commander call for more resources and transport units. First responders were on scene and we began packaging according to the most critical red tag. The treatment and packaging process was made much more difficult due to the language barrier the EMS team faced. We had some survival Spanish training earlier in the year, but here I was in my first multiple patient incident and faced with a language barrier. This only added more stress to the scene and myself.

What can you do when faced with many patients who do not speak English? I did the best I could. The patients were packaged and transported according to the severity of their injuries and this barrier was overcome. The receiving hospitals had been notified earlier of the situation and had prepared for multiple patients. Upon arrival they were ready and had interpreters available to assist.

After the scene was cleared and all patients transported, I began to complete my required paperwork and to critique the call in my mind. It had been a very challenging call. I thought about how simple responding to EMS calls used to be just a few years back. Now EMS has become more challenging due to the language barriers that we will undoubtedly face more and more in this area. I thought about how inadequate I felt as I attempted to communicate with these victims and package them for transport.

*Duke Trauma Center
Life Flight/Life Care*

*Duke University Hospital
Durham, North Carolina*

Several changes are taking place at Duke and within the state of North Carolina regarding trauma care. **Mr. Edward Eroo** joined the Duke team in September as the Assistant Operating Officer for Emergency Services. Ed will oversee the Emergency Services Division of the hospital which includes the Emergency Department, Trauma Services, and Life Flight/Life Care.

Ed comes to North Carolina from Southwest Michigan, where he served for six years as the President & CEO of a joint-venture critical care helicopter, fixed-wing, and MICU ground ambulance program. The merger of the Borgess Medical Center and Bronson Methodist Hospital helicopter services into the Air Care venture was the first merger of air medical programs in the country and one that Ed has lectured and consulted about extensively.

Prior to Air Care, Ed served as the assistant administrator for Emergency, Trauma, and Ambulatory Services at Fairfax Hospital/Inova Health System, a 656-bed tertiary care center located in Falls Church, Virginia. At Fairfax, he assisted in the development of the trauma program into an ACS Level I center. He served as a trauma facilities reviewer for the state of Virginia and the Pennsylvania Trauma Systems Foundation. During his tenure with Inova Health System, Ed also served as the administrator of Intracare, an outpatient intravenous therapy service, which was started by Inova in 1983. Prior to Intracare, he was the executive director of Northern Michigan Health Services, a regional, ambulatory, and emergency delivery system in Northern Mid-Michigan.

Ed is an alumnus of the University of Michigan School of Public Health Graduate Program in Health Services Administration. He holds his Certified Healthcare Executive (CHE) certification from the American College of Health Care Executives and his Certified Association Executive (CAE) certification from the American Society of Association Executives. Ed is a past president of the Chesapeake Healthcare Forum and the National Capital Healthcare Executives, both of which are in the national capital area. He is the Region III representative for the Association of Air Medical Services, and past president of the Michigan Association of Air Medical Services. He also served as the president of the Kalamazoo County Alliance Against Drinking & Driving and the chairperson of the Southwest Michigan Quality Council while in Michigan. We welcome Ed to Duke and look forward to working closely with him.

With **Dr. Larry Reed's** departure in July to become Chief of the Division of Trauma, Surgical Critical Care, and Burns at Loyola University Medical Center near Chicago, I have taken over the helm as the medical director of the Trauma Service at Duke. This year marks my fourth year at Duke committed to trauma and critical care, and I am excited about the opportunity to further develop our institutional and regional trauma systems. We certainly wish Dr. Reed all the best in his new endeavors.

On the state level, the Office of Emergency Medical Services is overseeing the development of Regional Advisory Committees (RACs) for the purpose of planning, establishing and maintaining a coordinated trauma system. In this issue of the newsletter, we have an article outlining the RAC concept, Duke's commitment to the RAC, and Duke's RAC proposal. RAC development is a long-term project which will involve considerable obligations on the part of Duke, participating hospitals, and the community-at-large. We are excited about our RAC evolution, the prospect of further improving trauma care, and the expanded opportunities to work with healthcare providers throughout our region.

Challenges Facing EMS: Language Barriers

I have been involved in EMS in some way since 1966. I began my career as a military medic. I then moved to the Durham Fire Department in 1969 where I performed fire and rescue duties until 1975, when Durham County took control of EMS services and placed them under the Durham County Hospital Corporation. EMS was complex then, but not to the extent it is now. Then, it was rare to run across anyone who could not speak English. This made our jobs simple and we took it for granted when we responded to an EMS call that we would find an English-speaking patient.

Today, we find a diverse society in the Research Triangle Area that is very different. A few years ago, we found a few migrant workers in the rural areas of Durham County supporting the farming community. As Durham has developed and farming is less prominent, the Research Triangle area has moved toward technology and information. This area is rich in Universities, Research and Technical Colleges. The population of Durham and Durham County has rapidly increased and continues to do so. According to the Durham Convention and Visitors Bureau, the population is now approximately 210,000, with an estimated work force of 111,000. The estimated current Hispanic population of Durham City and County is estimated to be between 15,000 to 20,000. This is expected to grow over the next few years. There are approximately 40,000 commuters who commute each workday to Durham and the Research Triangle Park.

Along with all of this comes a very culturally diverse workforce. We will see an increase not only in the Hispanic population but in the Asian population as well. By the year 2005, it is anticipated that the fastest growing segment of the workforce will be Asians with about a 40% increase. Hispanic population is expected to increase by about 36% (Human Resource Management, 11th Edition).

How can we prepare ourselves for this predicted trend? We, as EMS employees, must expand our knowledge base and skills to include other areas besides EMS practices. We have to become more diverse and strive to understand other cultures. This will help us to better assist all individuals so that when we respond to an EMS call and discover the patient to be of another nationality our knowledge will replace our frustration. EMS is no longer *Ajust you call, we haul@*. It involves much more. Our patients, or customers as we now refer to them, have greater expectations.

We have to prepare ourselves to meet the challenges we now face in the prehospital arena. We need to work towards meeting our customers' needs and expectations. We can only do this by developing the skills and seeking the knowledge needed to understand the diversity of our community. This understanding will help us to meet the needs of all patients and will make our jobs much more rewarding.



*Mike Smith
Durham County Office of
Emergency Medical Services
Call of the Month Coordinator*

Hospitalization Process

Due to the dedicated effort of all EMS squads that responded to this scene, the seven individuals were appropriately triaged for flight and ground transportation to the two nearby Level I Trauma Centers. Duke received four of the seven individuals. Some facts relating to the mechanisms of injury in this event were that only the driver and front seat passenger were restrained while the other five passengers were seated in chairs that were not secured to the van and had no restraining devices. By eyewitness accounts, a tire blew out causing the van to swerve in the highway while going the legal speed of 65mph, eventually causing the van to flip and roll down the highway embankment. The unrestrained passengers were thrown around the inside of the vehicle and many were ejected. One of the seven passengers died the following day, related to severe head injuries.

Of the four individuals sent to Duke, one gentleman had multiple bruises and soreness but did not require hospitalization. The three individuals hospitalized included the driver, front-seat passenger and one passenger ejected from the van. All three individuals had medically uneventful hospitalizations of 3-4 days, and none required any intensive care or step-down monitoring. The ejected passenger suffered L1 through L4 transverse process fractures for which she was fitted for a thoracic-lumbar corset. Although she complained of lower back pain, especially while sitting up, left psoas and paraspinous muscle hematomas caused her the most pain. She also had a right nondisplaced scapular body fracture and was provided comfort with the use of a sling. These injuries required early physical and occupational therapy consults to encourage the patient in early mobility and exercise training.

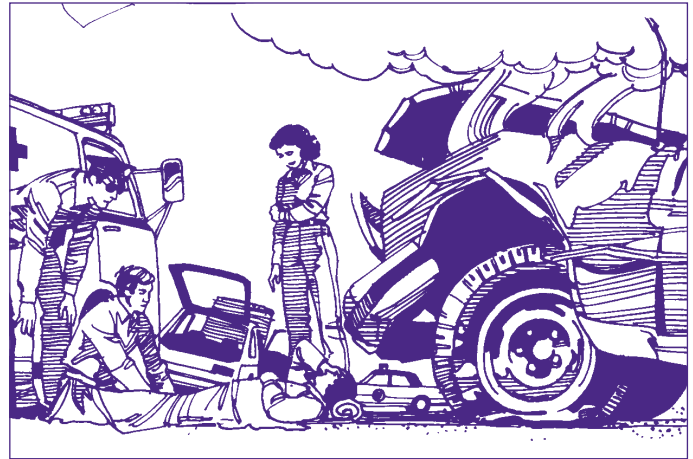
The driver of the van had complaints of neck pain and was neurologically intact. Cervical films revealed a C4 burst fracture for which a halo was placed with tightening of the pins over the next two days. Further, he had T11 anterior wedging which required a thoracic corset with rigid stays. He was very anxious for early mobilization to visit his wife and was able to quickly learn the basics of halo pin care and general concerns regarding limitations of activities while in a halo. He was taught how to do his own pin care and maintenance of the corset. Although he was medically ready for discharge within two days, he had to learn how to care for his wife while he was in a halo.

The front-seat passenger did suffer from a loss of consciousness at the scene of greater than five minutes. Head CT revealed a small left frontal subdural hematoma, from which she symptomatically suffered a headache but no documented seizure activity. She also had facial lacerations, which were repaired, and multiple painful spinal areas. Initial cervical spine films suggested a small lucency at the C2 level, and since she did complain of neck pain, she was kept in a cervical collar. However, the CT of C1 to C3 did not concur with the initial C-spine reading. Active flexion & extension C-spine films were obtained to investigate ligamentous injuries. This process was prolonged due to a T7 compression fracture, which required a TLSO molded brace. Due to weakness and pain, Physical Therapy worked extensively with her to gain the mobilization needed to facilitate obtaining the additional spinal films. The films were completed with negative ligamentous injury

noted by flex-ex films and good thoracic alignment recorded in the molded brace. The cervical collar was removed which greatly increased her mobility and participation in therapies. Her husband was brought into her room to be taught how to take the brace on and off, bathe his wife in bed, clean the brace, and assist her into a sitting position.

Fortunately for all of us involved in these cases, their pastor and his wife visited frequently and assisted us with interpretation skills and volunteered to provide back-up help to the family upon discharge.

In all three of these cases, discharge was postponed by at least one day due to the increased time necessary for adequate inter-



pretation of the individual management of their multiple injuries. This was further complicated by the fact that these patients were unable to read. Written instructions and phone numbers for consultation were provided to the pastor's wife, and daily communication for the first week was advocated.

As health care provider's work to gain the skills needed to meet the challenges of our diverse populations, we will also need to continue to be flexible in our implementation of training strategies for family and community support of these patients with multiple health care needs. We must strive to develop new ways of encouraging community involvement and better methods to access diverse health care systems in order to enhance our own Health Care Systems.

*Hutch Allen, RN
Trauma Nurse Practitioner
Duke University Health System*

From a Pilot's Perspective Approaches (Hallowed be thy approach)

A. J. LaMontagne

request landing information. Some of the things they may ask for include: landing zone description, obstacles, landing surface, and local wind direction. For the landing zone, just describe what you're looking at—a large grassy field on the north side of the road or a road intersection next to the railroad tracks. Type and location of obstacles are a must and are best described as a single wire running along the north side of the road, or a lone pole six feet high located in the Northeast corner of the field about fifty yards from the landing spot. Also the locations of fences and their height are important if the aircraft is landing close to them. The type of landing surface is an item that is often overlooked, but is very important. Is it dry and sandy? Loose sand will become airborne with the rotor wash and blind the pilot just prior to touchdown. Perhaps another spot may be a better choice. Even a slight slope, easily hidden by a carpet of grass, requires a more cautious landing by the pilot. The wind direction and velocity is important and there can be considerable difference between the wind at altitude and surface wind. The wind may be calm where you're standing, and blowing fifteen knots above the tree line or over the hill.

Amazingly, the scene of an accident can be difficult to see from the air, especially when that scene is a road surrounded by tall trees. The flight team may ask that you tell them if you see lights or hear the helicopter. And they may even request directions (left, right, straight ahead) to fly directly over your position.

If time permits, the flight crew may request the patient's condition and a brief description of the mode of injury. This helps the medical team to plan their response and review procedures for that particular incident.

If you're unable to provide all of the information that we have discussed, it's okay. We know you're busy and we'll take whatever you can give us.

When selecting a landing spot and approach avenue there are several items to keep in mind. Most pilots prefer a shallow glide-slope (angle) between an open area in the tree line or across a field versus a steep, elevator descent into a grove of trees. The reason for this has to do with the power required to hover, helicopter aerodynamics, and the "what if's" of an engine failure. How hard does the flight crew want to hit the ground if an engine quits?

If power lines or other obstacles surround the area and there's obviously only one avenue of approach, please do not park vehicles or allow people to stand under the short final into the landing zone. This can be very hazardous for several reasons. Flying debris can cause eye injury, puts nice little dents into the finish of automobiles and sometimes cracks windshields. The winds created by the helicopter are close to hurricane force and can easily move objects and knock things over. When the aircraft passes over the vehicles and people, the pilot will lose sight of them and clearance becomes more difficult to determine as the aircraft lands. Moreover, if an engine quits on short final the pilot will try to make the landing spot but the tendency is to land a bit short. This is why most pilots avoid over flying the scene of the accident unless there



When I swung the landing light towards the side, a flash of shimmering light passed beneath and just to our left. I yelled for the pilot at the controls to go up. My friend grabbed a hand full of power and started the missed approach. For a brief moment my heart pounded as I waited for a sudden vibration to ripple through the airframe or something much worse....

A paragraph out of a Hollywood script? No. It was one of those terrifying moments in aviation when you realized that something was horribly wrong. Our crew had just missed a set of high power lines strung across an interstate during a night approach into the scene of a motor vehicle crash. And we had missed them despite several orbits over the area and an excellent briefing by ground personnel of obstacles in the local vicinity. In fact, a State Trooper's car, with flashing lights, was parked beneath a lower set of wires just several hundred yards closer to our landing zone.

After our missed approach, we flew over the area and searched with our landing lights. It took another pass before our lights once again flashed the wires and we could identify the towers located on both sides of the interstate. We elected to make a downwind approach into the scene from the other direction. The rest of the night went smoothly and the patient was transported to the hospital.

Nice story you say, but what's the point? The point is—from the air, wires are impossible to see at night and the associated poles or towers *ain't no better* (to use a Southern expression). This is why during safety classes our flight teams preach the gospel about searching the area thoroughly for wires, poles, towers, construction cranes, tall barbecue signs, or anything else that may protrude into our flight path. This area should include a quarter of mile radius around the landing site. And it may be a good idea to jump into that brand new pick'em up truck, the one with the double row high beam searchlights mounted on the top, and drive a quarter mile down the road in both directions to double-check the area. I would certainly appreciate the extra work and I'm sure the rest of the flight crews would also.

And while you're looking, note the wind direction because if all things are equal we'll make the approach into the wind (just like ducks, we hate having our tail feathers ruffled by the breeze). And since you are looking, check out the area for large concentrations of livestock such as chicken houses or barns that should not be flown over if possible.

So how should all of this work? Here's a brief synopsis. The flight team should contact you on the frequency that has been relayed by their operations center when they are a few minutes away from scene. Once communications are established they'll

is absolutely no choice. And they will make a steep approach to minimize noise and rotorwash impact on the area of patient care.

In summary, take the time to scout the area for obstacles and select a landing zone that is as open as possible with shallow avenues of approach. Take into consideration the location of the accident scene in relation to the wind direction when making your choice. If possible, select a site that is directly downwind from the scene and finally, insure that personnel and vehicles are removed from the area to prevent the helicopter from having to fly directly over them on short final. There are times when the flight crew will have to accept a less-than-perfect approach and landing area. But with a little planning and good communications we can reduce the hazards and increase our margin of safety. This benefits everyone, including the patient.

Here is just one more thing to consider: Last weekend, I was flying to a motor vehicle accident in a small community and the landing zone was described as being next to a church with a white steeple on it. The flight crew and I counted six churches, five with white pointed objects, in a one square mile area of the town.



I promise I'm not making this up. Needless to say, we flew to several churches before locating the right one. In North Carolina, a church with a white steeple may not be a distinctive landmark. It's just something to remember, especially on a Sunday.

Improving Emergency Medical Services Capabilities

Recently, several revised rules of the North Carolina Medical Board (NCMB) became effective that should have a positive impact on the delivery of emergency medical care to the citizens of North Carolina. Several local EMS systems have already developed patient care and operational protocols to implement several of the rule revisions.

The North Carolina State EMS Advisory Council was instrumental in the rules revision process. The Advisory Council appointed a task force to review the existing rules and determine recommendations for consideration by the NCMB. There were several public meetings as well as a formal public hearing to receive comment regarding the proposed rule revisions. As a result, most of the controversial issues were resolved prior to the Advisory Council making recommendations to the NCMB.

Perhaps one of the most significant changes occurred with the removal of medications from the rules. Medications available for use by EMS personnel are now included in a document entitled "North Carolina EMS Medication Formulary." When the medications were in the rules, it would often take up to 18 months to add or delete a medication due to the rule revision process. The Advisory Council may now update the medication formulary every six months based upon input from local EMS medical directors. In addition, the NCMB approved the use of non-prescription (over the counter) medications in advanced life support EMS programs provided they are included in the local protocols approved by the Office of Emergency Medical Services (OEMS) Medical Advisor.

Another significant revision to the rules allows EMT-Paramedics to perform more advanced procedures when caring for a patient who has been physically examined by a physician, physician assistant, or nurse practitioner and determined to be critically ill or injured. This revision should have a positive impact on those EMS programs where the availability of a critical care transport program is limited.

The following skills may now be used by EMT-Ps upon orders from the EMS program's medical direction component:

- insertion of femoral lines;
- obtaining arterial blood gas samples via a peripheral artery or pre-existing arterial line;
- maintaining invasive monitoring devices to include central venous pressure lines, swan ganz catheters, arterial lines, intra-ventricular catheters, and epidural catheters

Prior to implementing these new skills, appropriate education must be completed and the OEMS Medical Advisor must approve the local EMS protocols.

In addition to the above critical care skills, EMT-Ps may now perform rapid sequence intubation (RSI) once appropriate education and protocol approval have been accomplished.

The Advisory Council currently has a committee reviewing the minimum requirements for critical care transport programs and the educational and medical oversight recommendations for the additional critical care skills. Draft rules and educational and medical oversight recommendations will be mailed to the EMS community in November for review and comment. The committee plans on having recommendations for Advisory Council consideration at the February 1998 Advisory Council meeting.

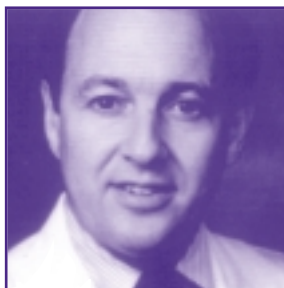
If the Advisory Council accepts the recommendations of the committee, the recommendations will be forwarded to the NCMB for consideration. Updating the minimum requirements for critical care transport programs will require a revision to EMS rules.

Submitted by

*Ed Browning
Educational Programs Specialist
North Carolina Office of Emergency Medical Services*

The Rap on the RAC

By Steven N. Vaslef, MD, PhD



What is all this talk about RACs?

What is a RAC?

Does my hospital have to get involved with a RAC?

These questions, and others, are heard with increasing frequency in response to the state of North Carolina's continued goals to have a coordinated trauma system. In this article, some of these questions

will be addressed, the RAC concept defined, and Duke's proposal for its RAC development outlined.

What is a RAC?

Earlier this year, the North Carolina Medical Care Commission and Rules Review Commission approved 10 NCAC 3D .2000, which are the proposed rules and regulations governing trauma systems. The North Carolina legislature approved this legislation, which took effect this summer. As defined in the rules, a RAC is "a group representing trauma care providers and the community, affiliated with a Level I or II trauma center, for the purpose of regional trauma planning, establishing and maintaining a coordinated trauma system." These rules also stipulate that the Level I or II trauma center is to facilitate the development and provide staff support for the RAC.

The state trauma system will consist of a handful of RACs, coordinated and monitored by the Office of Emergency Medical Services (OEMS).

Who comprises a RAC?

The Level I or II trauma center will serve as the RAC leader. Duke has elected, as a Level I trauma center serving our region, to develop a RAC in concert with the following membership (minimum requirements):

- trauma medical director from the Trauma Center
- trauma nurse coordinator
- an emergency physician
- an Emergency Medical Services provider representative
- a representative from each hospital participating in the RAC
- community representatives
- an advanced life support medical director.

When do hospitals join a RAC?

Each hospital in the state must choose a RAC to affiliate with by February 1999. OEMS will then notify each RAC of its hospital membership. Hospitals may join more than one RAC, but will have to specify an administrative RAC for record-keeping purposes. A verbal or written commitment (intent to join) may be delivered to the RAC leader prior to February to facilitate RAC planning, meeting schedules, etc. It is probably in the best interest of each hospital and the region to align with a RAC as early as possible.

What exactly will a RAC do?

The RAC will oversee the development of the regional trauma system. This involves a multi-faceted approach that includes, but is not limited to the following key components:

- Public information and education/outreach programs

- Written trauma system protocols which will address such issues as dispatch, triage, guidelines for transport, guidelines for bypassing closer facilities
- Transfer agreements.

What will Duke focus on as a RAC leader?

The state will require each RAC to develop a regional trauma system that includes the components listed above. More specifically, though, Duke wants to focus on three primary areas: communication, education, and support.

Communication

In the area of communication, we will strive to develop a network that insures ready accessibility for consultation, patient transport, and follow-up issues. The following methods of communication will be used:

- TraumaVue –Duke Trauma Services quarterly newsletter
- Institution of a Duke Trauma WEB page
- Contact via the Trauma Outreach Coordinator
- Follow-up via Fax/phone on patient status or care issues
 - Outreach Coordinator visits to RAC facilities on a routine basis
 - Coordination of education held at RAC member facilities
 - 1-800-362-5433 –A single phone number for consult or patient transfer.

Education

Education and outreach programs will be a vital part to RAC development and success. Duke would provide educational sessions related to trauma care or injury prevention that would involve several approaches, including teleconferencing, video seminars, on site meetings (at Duke and at participating hospitals), and electronic information transfer via the Internet. Educational offerings will be made for physicians, nurses, EMS providers, and care provider personnel. The backbone of our educational program will be comprised of:

- A variety of courses at the Hospital Education Department at Duke, offered to RAC members at discounted prices
- Planned educational courses brought to the healthcare facilities of RAC members
- Advanced Trauma Life Support (ATLS) course offerings at Duke
- Trauma Conference – a yearly conference at Duke addressing current trends in trauma care. All levels of trauma care providers welcome.
- Physicians Exchange Program.

A partial list of course offerings is shown in the accompanying table.

Support

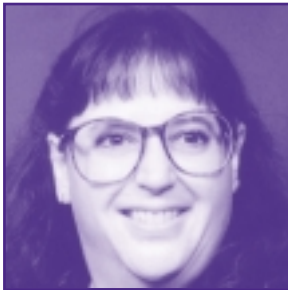
Methods of support Duke can provide to help RAC members meet the needs of their patients and the state requirements for trauma care include:

- 24 hour consultation with an attending trauma surgeon
- Procurement of transfer agreements
- Critical care transport via Life Flight and Life Care by one of our two helicopters or four trucks stationed at Duke or at three satellite locations
- Development of processes and systems to assist sites in communication, data collection, patient follow-up
- Coordination of trauma protocol development related to the care of specific injuries, transport, transfer

- Coordination of site specific trauma data collection to be used for protocol development, injury prevention initiatives, quality assurance review.

What's the next step?

Our first informational meeting was held on September 10 at Duke with representatives from many hospitals in our region. The next step will be to determine the membership of the RAC so that an organizational meeting with all RAC members can be held in the next several months. Hospitals should spend the next month or two deciding which RAC or RACs to join. By gathering information, asking questions, and providing input to RAC leaders, each hospital in the state should be able to align with a RAC that will best meet its needs and expectations. I would encourage questions or comments to be directed to either myself (office telephone (919) 684-3636, fax (919) 684-4392, or e-mail vasle001@mc.duke.edu) or to our Outreach Coordinator, Claudia McCormick (office telephone (919) 684-2370, fax 919-684-8041, or e-mail mccor019@mc.duke.edu).



Outreach Corner

Happy Winter to Everyone!!

I know this is hard to believe but I don't have much to say this time. All right – no laughing. There are a few things to discuss.

RAC Meeting or the Regional Advisory Committee Meeting

Thanks to everyone that came or sent a representative. We hope it was as helpful for you as it was for us here at Duke. Sharon Rhyne did an excellent job explaining the new state regulations.

Now it is time for the next step. For our part we are starting to plan the next meeting which will address identification of members, getting the key people in place, outlining how the group will function together, and planning our strategies for the future. Your part is letting us know if you wish to join with us in the formation of a RAC. We understand that the state does not require a decision until January, but a heads-up would be helpful. Just give me a call, drop a line, or send an email if you have made your decision. If you need further information, Dr. Vaslef and I would be happy to meet with you. It gives us a chance to be on the road. Also, if you need additional packets, just let me know and I will mail them out to you.

Our first RAC meeting was very successful. Remember we want you to join WITH us to form a RAC not just join Duke's RAC. We look forward to working more closely with all of you.

Mailing List

We will be updating our newsletter mailing list for the spring issue (which will be coming out about March). If you do not receive a Spring issue by April (the issue after this one) let me know and we will make sure you are on the mailing list. We do not want waste trees, but do want to insure that everyone who wants the newsletter is getting it.

Holidays

Since this is the holiday newsletter... Happy Holidays!!!

Please have good holidays.

*Be safe and healthy,
Claudia*

Phone: 919-684-2370

Email: mccor019@mc.duke.edu

Trauma/Pediatric Educational Offerings

Trauma Courses

Abdominal Trauma
Advanced Cardiac Life Support (ACLS)
Advanced Trauma Life Support (ATLS)
Basic Life Support (BLS)
Concepts in Trauma Nursing Course in Advanced Trauma Nursing (CATN)
Elderly and Trauma
Face and Eye Injuries
Genitourinary Injuries
Head Injury
Hot and Cold Injuries
Mechanism of Injury
Musculoskeletal Injury
Pediatric Trauma
Pregnancy and Trauma
Spinal Cord Injury
Thoracic Trauma
Trauma Nurse Core Course (TNCC)
Trauma Stabilization

Pediatric Courses

Assessment of the Pediatric Trauma Patient
Asthma in the Pediatric Population
Care of the Peds Trauma Patient Through the Hospital Course
Child Abuse Codes
Demographics and Injury Prevention
Medication/Fluid Management
Neonatal/Pediatric Assessment
Pediatric Life Support (PALS)
Pediatric Office Preparedness
Pediatric Trauma
Respiratory Emergency Management
Seizures
Transport of the Pediatric Patient

Outreach Calendar

January

- 16 EAST Meeting
Orlando, Florida
- 13 Trauma Stabilization Course
Granville Medical Center
- 21 NC Division of the ATS
Wake MEI Bldg
- 21 Trauma Coordinators,
Registrars, and Clinicians
Meeting - Raleigh
- 27 Society of Critical Care
Medicine
San Francisco, CA

February

- 9 State EMS Advisory Council
Meeting
Raleigh
- 13 Trauma Conference
New Hanover Regional
Medical Center
- 17-18 TNCC - Nash General
Hospital
- 19 Duke RAC Meeting
- 21 ENA National Leadership
Symposium - Los Angeles, CA

Preventing Childhood Emergencies

by Sue Hohenhaus, RN

Injury is the leading cause of death and disability for children and adolescents. Each year 19,000 children ages 0-19 die from a preventable injury. These injuries include motor vehicle crashes, bicycle crashes, drownings, falls, burns, and firearms incidents. Fatalities are a small percentage (<1%) of all injuries. In teenagers, for every one death, there are 41 hospitalizations and 1,132 emergency department visits related to unintentional injury. Each year thousands of children are permanently disabled by a preventable injury. Other children may be less seriously injured, but the impact of that injury affects the emotional and financial stability of the family.

According to the National Committee for Injury Prevention and Control, 1989, an injury is defined as any intentional or unintentional damage to the body resulting from acute exposure to thermal, mechanical, electrical, or chemical energy or from the absence of such essentials as heat or oxygen. Research has identified who is at risk. For instance, we know we can reduce bicycle injuries by 85% with the use of bicycle helmets. (And we also know that only 15% wear the helmets!) Placing a child in a correctly installed child safety seat can reduce motor vehicle injury. Alcohol and drugs are significant factors in a variety of intentional and unintentional incidents.

The health care community as well as the community at large should be charged with the identification of injury trends and the development of intervention strategies to prevent childhood emergencies. One way of beginning to effect change is to eliminate the word accident from your vocabulary when describing incidents. Virtually every injury that occurs can be prevented. Does this mean that we can have an injury free environment? Probably not, but we can work together to reduce and minimize the impact of these incidents in our communities.

What are some of the ways to increase awareness of the problem of childhood emergencies in your community? First, educate yourself. What is the most significant problem in your community? Conduct a community assessment and identify potential injury prevention interventions. Discover what is already being done in your community, and which groups are involved. Find out what resources are available. You also need to decide if there is a community desire to prevent the injury.

Some specific suggestions: implement a media campaign about correct use and positioning of child safety seats. This doesn't have to be elaborate. A simple statement, such as Children under 13 in the back; rear facing in a child safety seat until age one AND twenty pounds; straps in the top slot when a convertible child safety seat is forward facing; Belt Positioning Boosters for children over 40 lbs. until they reach 80 lbs.(!). Motivate medical professionals to counsel parents about traffic dangers. Conduct bicycle rodeos. Encourage fire fighters to present community fire safety programs.

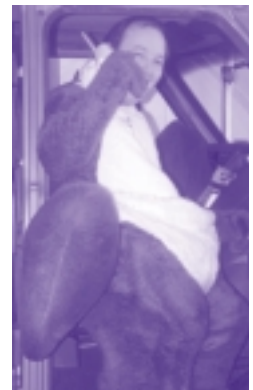
Monitor enforcement and legislative trends. Promote and support the Click it or Ticket and Booze it and Lose it programs in North Carolina. Practice and encourage pedestrian right-of way. Support child restraint legislation.

Set your goals and objectives. Plan your interventions and then implement them. Become involved in the research community and evaluate your interventions. Partner with local and state government agencies to build strong coalitions. Solicit the help of the media to get your message out.

Speak out for children.

For more information on how you can get involved in preventing childhood emergencies, contact Sue Hohenhaus, RN, State Office of Emergency Medical Services; Coordinator, Emergency Medical Services for Children at:

(919) 733-2285 or email
shohenha@dhr.state.nc.us



Is it TraumaRoo?
No, I believe it's Dr. Steven Vaslef, Medical Director of Duke Trauma Center, doing his part for injury prevention!

Photo courtesy of Halifax EMS

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If you have comments or suggestions for future articles, please contact Claudia McCormick at DUMC 3402, or via e-mail at mccor019@mc.duke.edu.

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