BLS in EMS

Getting at the Issue

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The medical and ethical performance of EMS professionals has never been more important than it is today.
The emerging of a profession: Paramedicine
Basic life support issues press hard upon ALS systems
Paramedics become lulled into complacency and beaten down into exhaustion
Emergency rooms have become overfilled with case after case.
Many patients assume they can be seen faster in the ER if they call 911 for transport.
We call them the “veterans” who know the system
Many major urban centers run nontransport rates exceeding 60%
The question of the Paramedic-initiated refusal...
Predicting Admission:

Studies abound that Paramedics cannot reliably do this
The ability to predict both admission as well as ICU admission was the flip of a coin.
Thus, transport decisions must be made by a strict medical direction protocol.
Transport decisions must be submitted to strict quality control analysis.
What if we could build on the experience of really devoted Paramedics? ...do we have an “untapped resource?”
Evidence suggests that we do
Factors to fight:

- Fatigue
- Boredom
- Unchallenging practice
- Increasing cynicism
Factors of strength:

Advanced skills
Maturity
Commitment to service
Community respect
Factors of strength:

The Same as ANY Advanced Level Practitioner
What about Pediatric Call Lines?

For decades, pediatric screening has been performed safely by nurses using protocols via telephone.
What about Poison Control lines?

Again, for decades, safe management of millions of patients via telephone has been conducted and proved to be safe.
What could we do?

Use Priority Dispatch through a carefully designed protocol employing best practices


CONCLUSIONS:

Telephone advice may be a safe method of managing many category C callers to 999 ambulance services.
CONCLUSIONS:

The Medical Priority Dispatch System exhibits at least moderate sensitivity and specificity for detecting high acuity of illness or injury.

This performance analysis may be used to identify target protocols for future improvements.
What could we do?

The Seattle model for priority dispatch has lived in a constant state of design and renewal for 30 years.

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Through such a system Basic Life Support calls receive a “cold” response with BLS ambulances
How accurate are they?
According to Dr. Copass, a 15% overlap exists where either ALS or BLS should have been sent but the other went.
Is 15% acceptable?
What is it that we want?

Safety
Convenience
Service
Economy
Save wear and tear
How can we do that?

Safety ........................................ always dispatch
Convenience .................................... at all hours
Service ............................................... exam
Economy ............................................. save ER rides
Save wear and tear ........................ use 1 medic
What would these medics do at these odd hours?
Act like a primary level practitioner assistant
Skills Applied

Primary Survey
Assess for emergencies
History Taking
Physical Assessment
Public health assignment
Arrange transport
Signs of Shock

Early

Weak, thirsty, lightheaded
Pale, then sweaty
Tachycardia
Tachypnea
Diminished urinary output

Late

Hypotension
Altered LOC
Cardiac arrest
Death
Screening for Trouble:

Anything that looks like a patient is having an emergency...

ALS is dispatched priority 1 (code 3)
...so that the subtle illness only manifested by mild tachycardia must be transported, under protocol

In EMS, probably excitement.
But, it may well be drugs such as Albuterol or meth/​coke, sepsis, or shock
Maximum Rate of Sinus Tachycardia

\[(220 - \text{age})\]
Case #1
A call goes down from a guy at home who has called at least daily for months to “come gimme a drink!”

BLS is dispatched. Upon arrival he is found to be confused, with slurred speech, pale, bradycardic, flat neck veins, midline trachea.

What to do?
Here we have a patient, previously well (okay, bad habits) but now with altered mental status and facial trauma
Always assume that someone with head trauma MAY have an intracranial bleed until proven otherwise!
...and of course, give considerations to CSpine issues...

CAN'T CLEAR THE CSPINE WHEN THE PATIENT IS ALTERED!
CAT Scans in The Field?

Well, not any time soon,
Though in Odessa, Texas
One of the first studies
On field ultrasound machines
Is now being conducted!
Something New In Prehospital Care

Paramedics and flight nurses have begun using portable ultrasound machines. These machines allow detection of blood in the abdomen of trauma patients, evaluation of cardiac motion in critical patients, and detection of pregnancy.

Learn the basics of ultrasound and find out how these devices can be used in the field and in the emergency room.

About the Author

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www.911sono.com
Obviously this guy is in trouble

Dispatch would be contacted immediately to send ALS Code 3 (Priority 1)

The patient would be taken to a Level 1 Trauma Center
An example of the fact that Dispatch can only act on the information that it can get. And sometimes that information just cannot reveal what the situation really is.
Case #2
Gal calls up to say that her back hurts. Records show she has called 3/week for months.

BLS is dispatched. Upon arrival she is found to be in no distress, complaining of her customary back pain without trauma, fever, or neurologic symptoms.

What to do?
Working under protocol, the medic could either offer transport to the patient OR provide an appointment to a choice of physicians who will see the patient the next day in the office.
Online Medical Control can assist for example in administering pain medication.
Aftercare instructions would be left with the patient

$$ $$ A bill could be cut for services rendered $$ $$
The professionalism of EMS continues to grow.

Our heroes of the streets, have more opportunity than ever to help their patients.
Whoever they are, wherever they work...

...only the best, every time, is enough
Thank you for your kind attention!