

TEST



Volume 1 Number 1
April-June '05

Premiere of District Newsletter (Again)

The title, **TEST TONE**, is temporary. Temporary until a new name is chosen by you, the folks who will be reading it.

This is the first (again) of what is intended to be an on-going quarterly project—disseminating news and information about happenings throughout the District, the squads, and the state.

Stick around to see who we become and what's next. . .submit your suggestion to any editorial staff member by July 31.



District I/C's Attend Conference Workshop

- Robin Kinsella, EMT-I '03, NECEMS I/C

During the VT EMS Conference in April, certified Instructor/Coordinators from throughout the state gathered together for a full day workshop. The first of its kind, the project proved to be both informative and rewarding.

I/C certification was created to fill the need to bring education and training to a standard level for all districts to ensure our prehospital care providers are receiving the same level of instruction.

Instructors come to the state with a variety of teaching experience and educational backgrounds. We hope to be able to expand the networking capabilities for instructors.

With participants coming together, the group discussed problem resolution, creativity, motivation and success achievement for their

students.

A brainstorming session was held to craft continuing education and re-certification requirements for the I/C level, a way to keep the instructor motivated and involved with changes in EMS education.

The group also discussed administration, didactic and practical components of course development, creative use of audio visual enhancement through computer generated programs and effective use of power point and video. Participants were asked to bring a presentation or demonstration to the conference. A portion of the program included these presentations which were shared by the group. Each instructor left with a collection of new presentations to customize and share with their classes. Each participant received a copy of Dan Limmer and Christopher Le Baudour's book, "**ACTIVE LEARNING MANUAL EMT-B.**" (Brady)

(Continued on page 6)

•District Board 2
•Training Corner
•Medical Director Update

•EMS Today 3
•New Paramedics
•OLMC
•Revisions to EMT-I '03 Protocols

•Quality Improvement 4
•Patient Care Report Form
•Refusal Process

•EMS and Pharmacy Reps Meet 5
•Barre Town EMS and the "Stolen" Ambulance
•Writers and Reporters Needed

•EMS Week 2005 Celebration 6
•Proudly Serving

•Getting Past "ABC" 7

•Medication Review 8

•Meeting and Training Schedule 9

•Service Profile 10
•Crashes

District Board Broadcast

- Jerry D. Andrews, EMS Liaison

The Board of Vermont EMS District 6 met in regular session on Tuesday April 12, in the Board Room at Central Vermont Hospital.

Old Business: Planning for EMS Week 2005, (May 15–21); the District Quality Improvement plan, including the IV and Vital Sign surveys; the Patient Refusal process and form, the Patient Care Report form; grants—the District has been awarded \$3,900 to purchase a VHF/UHF radio, and the Virginia Coffin EMT of the Year award (watch for more information)

New Business: Discussion about the NEW claves being used by CVH, (the hospital has asked that all agencies switch to these new claves as soon as possible) and oxygen administration — the protocols specifically state “high flow oxygen” in nearly all circumstances where oxygen is administered. District responders are expected to adhere to the protocols

Elections of officers for the '05–'06 Board were held; new officers are: Chair—Chris Brynga of Mad River Valley Ambulance; Vice Chair—Jim

Baraw of Northfield Ambulance; Treasurer—Susan Barnes of Corinth-Topsham Fast Squad

The District Board meets on the second Tuesday of each month at 7:00 PM; the meetings are open to anyone interested in the business of the district. If you would like to receive the minutes (after they are approved by the Board) send an e-mail request to the EMS Liaison.

Training Corner

- Mark Podgwaite, District Training Coordinator



The last 12+ months have been tremendously busy for both District 6 and your Training Coordinator. New policies; 3 —I '03 transition classes; a B class; an —I '03 class; 3 First Responder classes, the list goes on and on.

Probably the biggest thing to happen was the establishment of the District Training committee. The District Board felt that the best way to serve its members training needs

was to establish this committee.

Comprised of a member from just about every squad, the Instructor Coordinators, the EMS Liaison, District Medical Director and the District Training Coordinator, this group is largely tasked with establishing the direction of training in District 6, now and in the future.

Additionally, this group is charged with administration of the District 6 Training Policy. Speaking of the Dis-

trict 6 Training Policy, it says, in a nutshell, that any training (other than in-house training) offered in the district needs approval from the District 6 Board via the Training Committee. Copies of this policy as well as the required forms are available on the District 6 Training Listserve at <http://health.groups.yahoo.com/group/vtems6train/>

(Continued on page 3)

Medical Director Update

- Philip Brown, DO, District Medical Director



Change. Some change is welcome and some change is. . .not.

Winter has changed to spring here in Vermont, to most, a welcome change.

My son's sneaker size has changed almost overnight, this is a welcome change in that my seemingly munchkin size 7 year old is beginning to really grow. This is not a welcome change in that I may have to take out a second mortgage to

support these sneaker changes.

My 84-year old Dad has changed from a robust man to a man of frailty since his bypass surgery in late May. This is not a welcome change for him. Change marches on. . .

District 6 is going through some changes too. The District 6 newsletter is one such change. It's a major change and it's solely designed to improve communications in District

6. I want to hear your ideas about how to use my Medical Director Update of the newsletter, as well as what else you want to see in this newsletter.

Please write, e-mail or call me with your ideas. Let's work through this together. Write to me at Philip A. Brown, DO, Medical Director, ED-CVMC, PO Box 547, Barre, VT 05641-0547; call 802-371-4522, or send e-mail to: Philip.Brown@Hitchcock.org.

EMS Today

Jerry Andrews, District 6 EMS Liaison, attended the Jems *EMS Today* Conference in Philadelphia, PA, March 19 to 22, 2005.

Andrews attended the preconference workshop on Leadership, Law & Policy 2005, conducted by combined instructional staff from Fitch & Associates and Page, Wolfsburg & Wirth. The workshop covered: HIPPA Compliance, Marketing Your Service, Recruitment & Retention, and Risk Management

Additional conference workshops included Traumatic Brain Injury, BLS/ALS Intercepts, Airway Management, Acute Coronary Syndromes, Transport Pharmacology and Trauma in Pregnancy.

Training Corner

(Continued from page 2)

Lastly, we have established the Vermont EMS District 6 Training listserve. Here you will find upcoming training, polls, training discussion, presentations and much more. Membership is open to all. The group can be accessed using the link above.

Your Training Coordinator, as well as the Training Committee, are here for you, feel free to contact me or any member of the committee with any questions or suggestions.

Mark can be reached at: nfldr31@trans-video.net, or 485.3667 (h) 279.5388 (C)

New Paramedics

Barre Town EMS recently added two EMT-Paramedics.

Jean-Miguel Bariteau brings more than 12 years experience to the district; he served as the primary preceptor for the current EMT-P's.

April Johns with two years experience; moved from the auxiliary crew to a full-time position and is in Phase I of the District preceptor program.

In addition, Robert Brown (Barre City Fire), through a cooperative arrangement between Barre Town EMS and Barre City, and Brian Johns (Barre Town EMS) have begun the preceptor program.

On-Line Medical Control (OLMC)

- Philip Brown, DO, District Medical Director

In mid-2004, the District implemented a dedicated telephone number for On-Line Medical Control (OLMC). The telephone (802-371-4999) is a single instrument located at the main desk in the Emergency Department (ED) next to the HEAR radio.

The telephone (or radio) is answered by an ED nurse who will take an initial report and summon one of the on-duty ED physicians.

As the District Medical Director, I have directed that **the on-duty ED physician is the only CVH staff person authorized to provide on-line medical control (direction) to prehospital responders.** However, in RARE circumstances, a physician may not be available, i.e., one physician on duty and they may be briefly out of the department, with a critical patient, or otherwise indisposed. In

these situations the ED Charge Nurse is permitted to "relay" orders on behalf of the physician. Should this happen, both the ED staff AND the EMT should complete a yellow follow-up report and submit it to the EMS Liaison.

NEXT: Work on a Fix Begins

Revisions to District EMT-I '03 Protocols

- Jerry D. Andrews, EMS Liaison

Work has begun on minor revisions of the protocols. The goal is to complete a review and suggestion period to implement changes to the protocols in third quarter 2005.

Some **proposed** changes include addition of dextrose 25% for pediatric patients; specific pediatric dosing for each medication, limiting EMT-I cardiac monitoring to Lead-

II; a change to the administration of nitroglycerin, in that a patient taking Cialis requires 48 hours between use and administration of NTG. Remember to inquire about any erectile dysfunction (ED) medication before OLMC contact in **all** patients (male and female) presenting with presumed cardiac event, including chest pain, pressure, or

discomfort.

If you are interested in being a reviewer contact the EMS Liaison.

FAST FACT: 2004 responses for the District were 8383, among 15 agencies, 8 ambulance and 7 fast squad.

Quality Improvement Moves Forward in District

- Jerry D. Andrews, EMS Liaison

Quality Improvement continues to be a focus issue within the District. The medical oversight process has initiated two processes to assess and measure the delivery of EMS with District 6.

The first of these two initiatives is the IV survey; measuring several factors related to starting IV's, including the age, sex, and problem

of the patient; attempts vs. success ratio; catheter and sight selection, and charting "left to count" on patient transfer. The period being surveyed is July-Sept, 2005. A survey form is required by each agency for each EMT-I during the survey period. Once all data is received, the blinded data will be presented to the District.

The second is the Vital Sign survey looking at compliance with the of documentation of vitals signs as required by the Medial Director. We are going to rework this survey tool.

The most important aspect of both these surveys is the data gathered to assist in bettering the quality of patient care

Revised Patient Care Report Form Begins Field Testing

- Staff

Barre City Fire Department began field testing the Prehospital Care Report Form (PCRF) in late April.

The PCRF has undergone revisions suggested by the users of the initial version and recommendations made by reviewers.

The PCRF has been updated to allow first responders to enter the incident times on the form and still have the responding ambulance enter the appropriate times as well.

In addition, the flow sheet area of the PCRF has been revised to

"script" the interventions and treatments. For instance, the vital signs are scripted so the provider would enter information in the same order each time.

Following the field testing and reviewing any suggestions, the form will be presented to the District Board for adoption as the standard patient care document within District 6. Because of the number of agencies and providers, the training and roll out of the new form would be accomplished over the second half of 2005, with final implementa-

tion by January 2006.

If you have not seen the new PCRF or want a copy, please contact the EMS Liaison, or Bob Brown at Barre City Fire.

Pancake Breakfast: Mad River Valley Ambulance has scheduled a Fathers Day Pancake Breakfast; June 19, 0700 to 1300 at the MRVAS station in Waitsfield. Cost is \$8. per person. Call 496-8888 for details.

Patient Refusal Process and Form Move Forward

- Staff

"Hell no; I won't go" Some EMS providers are old enough to remember when this was a chant in the street during the late 60's and early 70's in protest of the Viet-Nam war.

The chant is still heard on the streets here in Vermont; usually associated with an individual who does not, or at least believes they do not, need the services of EMS.

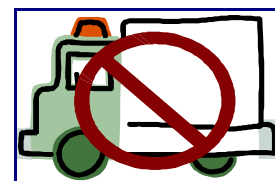
Guess what! Sometimes they're right; they don't need our services. Then what?

How do we achieve a low-risk (not no-risk) refusal? The District is asking for comments on a new Patient Refusal Procedure that helps to identify what person is a "patient" and identifies situations in which a person meets "No Patient Identified" and would not need to complete a Refusal. The new process also identifies circumstance in which a provider could complete a scene discharge without OLMC contact.

The most significant change is the protocol specifies situations in

which OLMC (communication directly with a physician) is required; including among others, first time seizures; unstable vital signs; abuse, (child, elderly, domestic, spousal); infants under 3 months.

Contact the EMS Liaison for a copy.



EMS and Pharmacy Reps Meet

- Jerry D. Andrews, EMS Liaison

With the advent of EMT-I '03 service with the district much as changed; particularly the drugs used in delivery of the advanced care. The EMT-I '03 pharmacopoeia includes Aspirin, Albuterol, Glucagon, Nitroglycerin and Thiamine in addition to the current EMT-I '90 medications.

Various agencies have approached Dr Brown about restocking drugs through the hospital, so agency stock could be reduced and reduce the cost of providing this service. Dr Brown, Jerry Andrews and Frank Foti, the CVMC pharmacist, have been working to develop a process by which hospital restocking could occur.

On April 17th, a meeting with EMS and Pharmacy representatives was held. The meeting was very beneficial for all parties involved; there was an open exchange of ideas about standardizing the concentration and form of the drugs carried; the process for ordering and restocking medications, and replacement of expiring drugs. The group reviewed a DRAFT Pharmacy Order form.

Recommendations from the meeting are: 1) restock medications

from the ED; 2) add Dextrose 25% for pediatric patients (which will need to be proposed to the state EMS office) and, 3) eliminate Lactated Ringers solution, standardizing the use of Normal Saline for all prehospital fluid infusions [by a date to be determined later].

A smaller group continued discussing paramedic medications currently being carried and suggested adding or deleting medications. As a result of the discussion, Rumazicon has been deleted and deletion of Procainimide is being considered.

Medications being considered for addition include; Toradol® (ketoralac) for pain control; Zofran® (ondansetron) for nausea, Ativan® (Lorazepam) for seizures. Tabled for later discussion were Calcium Gluconate; Nitroglycerine drip, and SoluMedrol® (Methylprednisolone)

The next meeting is scheduled for June 23, 2005 at 3:00PM at CVMC.



Writers and Reporters Needed

- Editorial Staff

In order for this newsletter to be successful, it will require work from far more folks than are currently involved to report on squad events and activities, writing educational articles or general news stories.

The goal is to be useful to you; to provide information and education which meets a need that isn't being met by other means.

Please take a few minutes to read this issue and then tell us if we are on target, a near miss or dead on

arrival. Tell us what will you look at, what you're willing to spend your limited free time reading. Tell us at nfldr31@trans-video.net or nfldr32@trans-video.net or Jerry.Andrews@hitchcock.org

This newsletter will only succeed to the extent we meet a need, we can only meet an expectation that is shared, unvoiced expectations are unrealistic expectations — tell us what you expect.

Barre Town EMS and the "Stolen" Ambulance

- from EMSN, March 30, 2005

"The Barre Town Ambulance service is caught up in a fraud case in Alabama and that means one of the town's six ambulances is out of service.

The town EMS director says he bought an ambulance from a dealer in Alabama last year for almost \$64,000. But it turns out, that dealer is facing charges of selling ambulances made with stolen parts. For now, the ambulance is off the road in Barre Town.

'The impact is I have to keep the ambulance out of service. It can't be used for any of its regular duty and it is a primary rig so it does respond to a lot of emergency calls and it also does a lot of the non-emergency transport business that we have,' says Dave Jennings, the Barre Town EMS Director.

Barre Town covers a large area in Central Vermont making it the fourth largest ambulance service in the state. The lawyers are trying to figure out how to get the ambulance back into service, but that could take some time."

As Jennings explains the situation, Barre Town EMS was caught between the ambulance builder and the chassis provider. The situation has been resolved and the vehicle is back in service.

And yes, Jennings is **still** answering questions about the situation from the EMS community and the public. He offers this advice, ". . . check, recheck and check again to be sure that all the paperwork is matched to the vehicle and you have copies of all receipts and invoices."

EMS Week 2005 Celebration

Vermont EMS District 6 celebrated **EMS Week 2005** throughout the week of May 15—21. Refreshments were provided Monday through Friday between 11:30 and 7:30 in the EMT Report Room at CVH.

On Thursday, May 19th, Vermont EMS Director Dan Manz, Central Vermont Medical Center CEO Daria Mason, representatives of EMS District 6 agencies, and members of the Emergency Department staff gathered at the hospital ambulance bay to celebrate EMS Week 2005.

Ms Mason expressed appreciation for the work done on behalf of the citizens of our community by EMS providers inside and outside the hospital.

Mr. Manz and Ms. Mason joined forces to present to each representative a copy of the Governor's Proclamation honoring EMS Week and the work of all EMS providers throughout the District. 13 of 16 agencies were able to have a representative at the event this year.

During the festivities the District recognized those EMT's that have served for 15 years or more (see related article) with certificates of appreciation and service pins. Mr. Manz stated his appreciation for those recognized on behalf of the state EMS Office.

MRVAS Offers DHART Landing Zone Workshop:

Mad River Valley Ambulance Service will offer a two-hour Landing Zone class on July 26, 2005, from 1900 to 2100 hours at the MRVAS station in Waitsfield. There is no cost for the class. Contact Rob Aldred at 802-496-8888.

District I/C's Attend Conference Workshop

(Continued from page 1)

I share the feeling of others that this was a beginning for better things to come. Putting together these courses along with individual training sessions within the squad takes extra time and planning above and beyond the regular duty shifts, work details and meetings. A way for instructors and trainers to network and brainstorm as a group, we are on our way and the conference this year gave us some new energy to make training and education a better experience for you.

See you in class.

Reach Robin at: Kinsellagroup@madriver.com

Proudly Serving. . .

District 6 would like to recognize the following EMT's for 15 years or more service to the community.

Harvey Carroll, EMT since March 1975

David Jennings, EMT since November 1976

Robert Snitsinger, EMT since November 1976

Peter John, EMT since August 1977

Allan Parry, EMT since August 1977

Michael Morgan, EMT since August 1978

Thomas Brazier, EMT since July 1979

Gesualdo Schneider, EMT since August 1979

Robert Gowans, EMT since October 1979

William John, EMT since June 1980

Glenn Moore, EMT since June 1981

Wilda Bresett, Jr., EMT since June 1982

Patricia Clark, EMT since June 1982

Joni Zweig, EMT since June 1982

Claude Boucher, EMT since 1983

Douglas Jasman, EMT since June 1985

Heidi Higgins-Cutler, EMT since May 1986

Anne Hutchinson, EMT since June 1986

Richard Lee, EMT Since June 1986

James Baraw, EMT since May 1987

Larry Eastman, EMT since June 1987

Scott Gagnon, EMT since June 1987

Dana Houppi, EMT since June 1987

Brian Lindner, EMT since June 1987

Mark Tillinghast, EMT since June 1988

Margaret Doyle, EMT since June 1989

Patrick Dole, EMT since June 1989

Maxine Durbrow, EMT since June 1989

James Ward, EMT since January 1989

Joseph Kelly, EMT since March 1990

Peter Garon, EMT since April 1990

Joe Aldsworth, EMT since June 1990

David Gladding, EMT since June 1990

To each of you: Thank you for all you do.

FAST FACT: in 2004 District agencies cared for 540 patients 0-18 years, and 2193 ages 65 years and older.

Getting Past "ABC"

- Jerry Andrews, AS, NREMT-P

Every First Responder, EMT, even CPR providers have been trained to recite "ABC, ABC, ABC" (Airway, Breathing, and Circulation) until they have nightmares. It is drilled into the brains of every EMS responder during training and through continuing education.

"ABC" is frequently the only "real" EMS word physicians (not the EMS Medical Directors, of course) know. They are therefore compelled to remind EMTs that it is essential we, as EMTs, "manage the patients ABC's."

The simple question is, "Is ABC enough?" Is it enough to simply recite and assess the airway, breathing, and circulation?

What if you were offered a method that would more than double the information you could collect about a patient's life threatening status in the very same period of time? Would you use it?

Consider this:

AA - Airway & Aspiration: Assess the patients' *airway* as you always have, or even actually check to see if the patient actually has a patent airway. Correct any airway problems immediately.

At the same time, ask yourself if there is a potential for *aspiration*. If the patient has a patent airway but is at risk for aspiration, correct the problem immediately.

BB - Breathing & Bleeding: As you "Look, Listen and Feel" for *breathing*, assess the respiratory rate, rhythm, and quality. Don't guess; actually measure it.

Observe for a life threatening *bleeding*, and use appropriate methods to control the bleeding.

CC - Circulation & C-Spine: When you check a patient for "*circulation*," include rate, rhythm, and quality. Again, don't guess, establish the baseline.

Consider the possibility of a *cervical*

spine injury. The consideration of injury should include mechanism of injury, age, and overall patient condition.

DD - Deficits & Deformities: The patient should be evaluated for *deficits* by assessing the level of consciousness, usually expressed as Alert: responds to Verbal stimuli, responds to Painful stimuli, or is Unresponsive (AVPU). Instead, consider measuring the Glasgow Coma Score, assessing Eye, Verbal, and Motor response. (Remember, even a tree scores a 3, although, interestingly enough, GCS scores of 28 and 0 have been recorded.)

Deformities - this is not a detailed assessment, or what you may remember as a "secondary assessment"; rather it is an assessment of obvious deformities, which should alter your handling of the patient. Obvious deformities of the upper arm or lower leg should alert you to change how you log roll a patient; significant respiratory distress should tell you your patient not tolerate lying flat.

EE - Expose & Expedite: EMTs have been told repeatedly, "You can't treat what you can't see." Yet, many EMT's are reluctant to *expose* patients; patients regularly arrive at Emergency Departments and Trauma Centers clothed, or with IV lines, ECG, EtDD, and Pulse Oximeter wires snaked in and amongst clothing. Expose your patient, inspect, and cover them to maintain body heat and to preserve modesty.

Expedite means, at this point make a decision to load and go or decide you and the patient have time to continue the assessment. This decision point may suggest or require, (depending on local protocol), a call for paramedics, a helicopter or just getting en route to the hospital. If you find but can not correct immediate life threats at this point, consider emergent transport.

FF - Fahrenheit & Fast: Is the patient too hot or too cold? Is the environment too hot or too cold? Can you correct either the patient or the environment? What about just getting the patient off the ground, on a backboard or into a warmer space?

Fast - Keep this in mind through the next assessment phases.

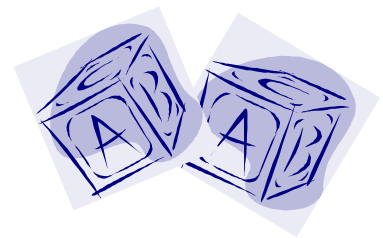
GG - Glucose & Go: What is the patient's *glucose*? Low—fix it; high—fix it, if you can; normal — ok, move on.

Go - Add to fast; fast—go. . .keep reading.

HH - Hospital / Help: At this point you should have a clear indication if your patient is experiencing any potential life threatening conditions. The mnemonic reminds you to either "fast go (to the) *hospital*" or "fast go (for) *help*."

Keep in mind "help" can be additional personnel, higher trained personnel, On-Line Medical Control or, sometimes diesel does the trick.

There you have it, a quick, easy, reliable method of gathering more information about your patient and identifying potentially life threatening conditions.



*My thanks to William Alguire, EMT-P, Keizer (OR) Fire District and Elizabeth Morgan, NREMT-P, Dept of Human Services, (OR) Emergency Medical Services & Trauma Systems Section, for the foundation of the Double ABC's. JDA

Medication Review

Oxygen

Class: Medical Gas

Actions: Oxygen added to inspired air raises the amount of oxygen in the blood and the amount delivered to the tissues. Tissue hypoxia causes cell damage and death. Breathing in most persons is regulated by small changes in acid/base balance and CO₂ levels. It takes relatively large drops in blood oxygen concentration to stimulate respiration

Indications:

- * Suspected hypoxemia or respiratory distress from any cause.
- * Acute chest pain in which a myocardial infarction is suspected.
- * Shock (decreased oxygenation of tissues) from any cause.
- * Major trauma.
- * Carbon monoxide poisoning.

Precautions:

If the patient is not breathing adequately, the treatment of choice is ventilation.

In a small percentage of patient's with chronic lung disease, administration of oxygen will decrease respiratory drive. Do not withhold oxygen because of this possibility. Be prepared to assist ventilation if needed. Initial oxygen flow should be no greater than 2 liters per minutes in these patients; do not hesitate to increase flow if patient does not improve.

Special Notes:

Nasal cannulas work equally well on nose or mouth breathers. Non-humidified O₂ is drying and irritating to the mucous membranes; limit non-humidified administration to less than one hour. Oxygen toxicity is not a risk in acute administration. Restlessness may be an important sign of hypoxemia.

DISTRICT LISTSERVE: to enroll on the listserv, send an e-mail to nfldr31@trans-video.net.

Naloxone (Narcan)

Class: Narcotic antagonist

Actions: Naloxone is a narcotic antagonist that competitively bonds to narcotic receptor sites but exhibits almost no pharmacologic activity of its own. Duration of action is 1 to 4 hours

Indications:

* Reversal of narcotic effects, particularly respiratory depression, due to narcotic drugs either ingested, injected, or administered in the course of treatment, including:

- Aspirin/oxycodone (Percodan®)
- Atropine/diphenoxylate (Lomotil®)
- Codeine
- Heroin
- Hydromorphone (Dilaudid®)
- Meperidine (Demerol®)
- Morphine
- Pentazocine (Talwin®)
- Propoxyphene (Darvon®)

* Diagnostically, in coma of unknown etiology, to rule out or reverse narcotic depression.

Precautions:

In patients physically dependent on narcotics, violent withdrawal symptoms may be precipitated. Be prepared to manage a violent patient.

Special Notes:

The duration of some narcotics is longer than the naloxone and the patient must be monitored closely. Repeat doses of naloxone may be required. Patients who receive naloxone must be transported to the hospital. Large doses may be needed to reverse propoxyphene (Darvon®) overdose.

HELP NEEDED: the District can always use help at tests, contact the Training Coordinator if you are interested in assisting with periodic First Responder or EMT testing. Remember that someone gave up time for YOUR test.

Furosemide (Lasix)

Class: Diuretic

Actions: Potent diuretic with a rapid onset of action and short duration of effect. It acts primarily by inhibiting sodium reabsorption throughout the kidney. Increase in potassium excretion occurs along with the sodium excretion. As an IV bolus, causes immediate (3 to 4 minute) increase in venous capacitance. This decreases venous congestion and probably accounts for its immediate effect in pulmonary edema. Peak effect: 30 to 60 minutes after IV administration, duration about 2 hours. (If given orally, peak in 1 to 2 hours, with a duration 6 to 8 hours.)

Indications:

* Acute pulmonary edema – to decrease extracellular volume and reduce venous pressure on the lungs in cardiac failure.

Precautions:

Contraindicated in hypovolemia or hypotension. Can lead to profound diuresis with resulting shock and electrolyte depletion, monitor closely after IV administration. Call OLMC for use in patients 18 years of age or younger. Should not be used in pregnancy.

Side Effects/Special Notes:

Hypovolemia, hypotension, hyponatremia, and hypokalemia are the main toxic effects. Because of the potency and need for close monitoring, furosemide should only be given with specific indications. Other toxic effects are usually not related to single-dose use. Patients who are on digitalis, and having arrhythmias consistent with digitalis toxicity may need lower doses of furosemide, contact OLMC.



Meeting and Training Schedule

Vermont EMS District 6	Board Meeting	Second Tuesday (X July)	1900-2100
	Training Committee	Second Tuesday	1800-1900
Vermont Ambulance Association	Business Meeting	First Thursday	1200-1400
		— Odd months	
Barre City Ambulance	Business Meeting	Scheduled as needed	
	EMS Training	Daily on shift	
	EMS Training—Call Force	Wednesday	1830-2030
Barre Town EMS	Business Meeting	Scheduled as needed	
	ALS Training	Varies—Check Postings	1830-2030
Cabot Ambulance	Business Meeting	Third Thursday	1900-2100
	EMS Training		1900-2100
Corinth-Topsham ERT	Business Meeting & Training	Third Tuesday	1900-2100
East Montpelier Fast Squad	Business Meeting	First Tuesday	1900-2100
	EMS Training	Third Tuesday	1900-2100
Mad River Valley Ambulance	Business Meeting	Third Thursday	1900-2100
	BLS Training	First Thursday	1900-2100
	ALS Training	Third Tuesday	1900-2100
Middlesex Fast Squad	Business Meeting	First Sunday	1900-2100
	EMS Training	Third Sunday	1900-2100
Montpelier Fire Ambulance	Business Meeting	Scheduled as needed	
	EMS Training	Wednesday (Weekly)	0900-1000
Northfield Ambulance	Business Meeting	Second Wednesday	1830-2100
	BLS Training	Third Wednesday	1900-2100
	ALS Training	Fourth Wednesday	1900-2100
Plainfield Fire Fast Squad	Business Meeting & Training	Fourth Tuesday	1800-1900
Sugarbush Ski Patrol	No Business Meeting		
	EMS Training	Annual—October	Weekend training
Washington Fast Squad	Business Meeting		
	EMS Training	First Sunday	1900-2100
Waterbury Ambulance	Business Meeting & Training	Second Thursday	1900-2100
Williamstown Ambulance	Business Meeting	First Tuesday	1900-2100
	EMS Training	Third Tuesday	1900-2100
Worcester Fast Squad	Business Meeting	Fourth Monday	1900-2100
	EMS Training	Second Monday	1900-2100

For corrections, contact Jerry Andrews, see back page for contact information.

Vermont EMS District 6
c/o EMS Liaison
PO Box 547
130 Fisher Rd
Barre, VT 05641-0547
Office: 802-371-4516
Fax: 802-371-4481



District Board Officers

Chair: Chris Brynga
 Mad River Valley Ambulance Service
Chris.Brynga@gmavt.net

Vice Chair: James Baraw
 Northfield Ambulance Service
Northfielddems@trans-video.net

Treasurer: Susan Barnes
 Corinth/Topsham ERT
sbarnesonc@oncs.org

Past Chair: Steve Hill
 Waterbury Ambulance Service, Inc
Steve.Hill@anr.state.vt.us

District Board Staff

Liaison: Jerry Andrews
Jerry.Andrews@hitchcock.org
 802-371-4516 office
 802-371-1262 pager

Medical Director: Philip Brown, DO
Philip.Brown@hitchcock.org
 802-371-4522 office
 802-371-4481 fax

Training Coordinator: M. Podgwaite
 Northfield Ambulance Service
nfldr31@trans-video.net
 802-485-3667 home
 802-279-5388 cell

Secretary: Lori Usle, CVMC
Lori.Usle@hitchcock.org
 802-371-4365 office
 802-371-4481 fax

Service Profile

- Staff



Future publications of Test Tone will profile one of the 16 district agencies, including the seven Fast Squads; Corinth-Topsham Emergency Response Team; East Montpelier Fire Dept Fast Squad; Middlesex Fast Squad; Plainfield Fast Squad, Sugarbush Ski Patrol; Washington Fast Squad; and Worcester Fast Squad; the eight ambulance services; Barre City Fire Ambulance; Barre Town EMS Dept; Cabot Emergency Ambulance; Mad River Valley Ambulance; Montpelier Fire Dept; Northfield Ambulance; Waterbury Ambulance, Williamstown Ambulance; and Central Vermont Hospital.

As a part of the profile we will present a brief history of the development of the agency, the services provided, their personnel and equipment. We hope to provide photos of the station and the personnel in action.

If a newsletter representative calls to ask for profile information please help us let the rest of the district know more about who you are and what it is you do. We will also be asking about special projects or grant awards.

What do you need help achieving? There is probably someone in the district that has the expertise you are seeking, from building something to helping write a computer program or even helping the write the grant to get the computer you really need.

REMEMBER: Label all IV's started in the field. The date, time, size, and your initials need to be printed and readable on the site. This will help the patient by letting the staff know when the IV was initiated and to help prevent infections, when it is due to be changed.

Crashes

- Be Careful Out There

