FIRST RESPONDER

October '05 Newsletter

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New CPR ratio of 50:2 coming in 2006

For the last 12 months First Response Australia's (FRA) policy has been to make the teaching and hopefully the initiation of resuscitation easier, by following worldwide evidence based trends. Previous newsletters have mainly been devoted to informing our readers of these exciting changes that are in the wind.

Unfortunately, we receive many comments about this information, inferring that we are "just following a fad". Other comments are "what do the resuscitation standards say?" and "what would happen in a courst of law if I didn't follow the Australian Resuscitation Council guidelines" or worse still we here comments such as "my first aid instructor said I would be liable if I didn't use the exact recommended CPR ratios". It is disappointing to see this reluctance to embrace these innovative changes.

Our spys tell us that later this year the International Liason Committee of Resuscitation (ILCOR) is set to make an announcement regarding the changes in CPR resuscitation ratios. What isn't known is what ratio will be chosen. It's expected to be either 30:2, 50:2 or 60:2. It is also expected that this will apply across the board for all age groups. Once the announcement is made we will probably see a lag in time of implementation, as this new information then has to go back to each country's Resuscitation Council for "approval". This could take up to another year.

FRA has already introduced longer cyles of compresssions and our phylosophy at present is to teach that 15 is the absolute minimum of compressions to be done in one cycle. We recommend that a much longer time doing compresssions in necessary when conducting one operator CPR and/or waiting for a barrier device to arrive.

So the next time you're in a Resuscitation class and you are being corrected by your trainer for "compressing a little too fast", "doing more than 4 cycles in a minute", "not doing initial breaths", "not checking the pulse regularly", you may just have to smile and play the game.

Medical Field Support - a new standard in care

FRA launched its new on site "Medical Field Support" service in July this year. For the first time North Queensland business and organisations can emloy professional "industrial medics" to provide prehospital care at events such as concerts, sporting events, markets and field days. FRA staff can lift an enormous workload from organisers by delivering best practice standards in emergency treatment.

Staff are trained to a "Certifcate IV level in Emergency Medical Response" qualifying them as Emergency Medical Technicians - Intermediate level. This is at least equivalent to a qualified Ambulance Officer.

As well as on site "Medical Coverage", FRA can provide "Non Emergency Patient Transport" with its first "patient transport vehicle".

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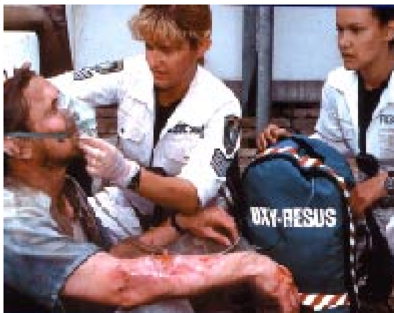
Oxy Kit Special



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Where required FRA can supply a mobile "Field Support Unit" fully equipped as an ambulance. The unit can be utilised to provide "ambulance" facilities accommodating further care and privacy during treatment.

Pictured on the left is the first of the new Medical Field Support Units to be deployed in Nth Qld.

For further enquires regarding this new standard of care please call the Managing Director, First Response Australia.

Ambulance officers face increasing aggression from the public

Violence and assault against emergency services personnel appears to be on the rise. Reports from Fire Brigades, Police and Ambulance Services show that assualts and aggression are relatively common. According to the Australian Institute of Criminology, approximately 10 per cent of Police are assualted each year. More disturbing is the rise in such incidents with the so-called "good guys" such as Ambulance and Fire Department workers.

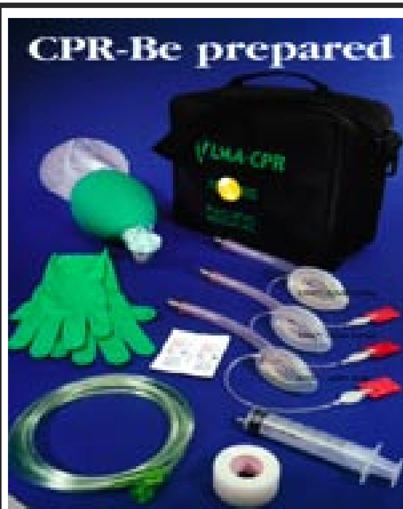
It now appears that Ambulance officers suffer the highest incidence of victimisation. The Ambulance Employees Association of Victoria has raised this issue with the state government and the metropolitan Ambulance Service (MAS) having seen reports indicating a rise in assaults of more than 30 per cent in a year and threats to paramedics. Another concern raised was the inadequate protection of Ambulance crews when desptached to violent incidents as primary response. Paramedics are been despatched to extreme situations with little information regarding the dangers, arriving on scene with no Police presence.

The union has issued guidelines to members as the members do not possess the skills and tools to deal with these potentially violet and hazardous situations.

These guidelines recommend that violent incidents be considered as unsafe and therefore withhold entry to the scene unless the Police deem it safe to do so.

Last year the MAS in Melbourne said that the most commonly reported OHS incidents were those involving aggression and assault against officers which has lead to the Service investigating aggression and assault prevention programs in an effort to counter the problem.

South Australian Ambulance Service now has a system were officers recieve information about the environment in which they can expect to find the patient. Any hint of anticipated violence, crews are directed to "stand off" until Police have secured the scene. This has lead to a halving of assaults against officers from 30 asssaults in 2002 to 17 in 2003 and 15 in 2004. South Australian Ambulance officers receive training to deal with threatening patients in an attempt to not find themselves "backed into a corner". The training involves Police and will soon be extended to deal with mental health patients.



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If you're late - don't defibrillate - resuscitate first!!

A randomised trial recently conducted in Norway found significant improvement in outcomes for defibrillation of cardiac arrest victims when CPR was conducted first before defibrillation, when response times to the collapse patient exceeded 5 minutes. The trial showed that if response times to a collapsed casualty were under 5 minutes, there was little difference in outcomes whether the patient was resuscitated or not prior to defibrillation. But if reponse times were greater than 5 minutes and 3 minutes of CPR took place before defibrillation the success rate rose by over 50%. The primary end point for measuring the outcomes was survival to hospital discharge and the secondary end point was admission to hospital with return of spontaneous circulation (ROSC) with 1-year survival and neurological outcome.
The first group (defibrillation first) resulted in only 15% of patients discharged from hospital where the second group (CPR first) resulted in 22% of patients being discharged.
ROSC was achieved in 58% of patients in the "CPR first" group compared with only 38% in the "defibrillation first" group.
So, if you're late - resuscitate !!!!!.

FRA introduces LMAs into "First Responder" program

FRA recently introduced another sought after program - "Advanced Responder". This accredited program is a modification to the popular "First Response" course which is the combination of Advanced Resuscitation and Early Defibrillation. FRA has added the use of Laryngeal Mask Airways (LMA) into the program due to the feedback it has received regarding real life scenarios.
Unfortunately, the First Response skills taught to many of our clients are put to use and one recurring theme has been the difficulty in maintaining the airway of some casualties.
One recent cardiac arrest event saw the response team experience difficulty in securing a patent airway which resulted in minimal ventilation during CPR. The problem was further compounded by Ambulance Paramedics requiring three attempts to insert an Endotracheal Tube. As we know when this is being attempted no compressions take place which may significantly diminish the survivalbilty of the casualty. During this particular event, over 3 minutes of no compressions occcured.
Because this is not just an isolated problem, the introduction of a simpler means of obtaining and securing an airway has been welcomed by many of our clients. The Laryngeal Mask Airway offers a more secure and reliable means of ventilation than a pocket mask or bag valve mask device (BVM). In comparison with Endotracheal Tubes, the LMA provides equivalent ventilation. There is no need to interrupt compressions during insertion and studies show that the incidence of aspirations in emergencies is only 0.1%. Compared to the reported incidence of aspiration using Bag Valve Mask in Resuscitation 0.1% aspiration is an incredibly favourable statistic.

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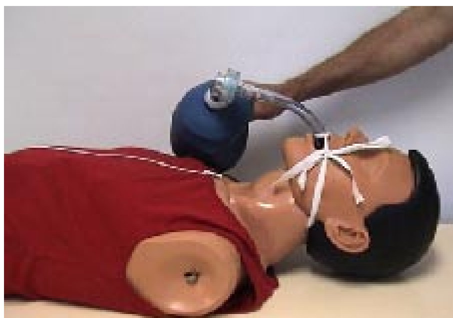

Pictured above are different stages of LMA insertion.

Top - initial insertion of LMA into pharynx

Centre- LMA inserted, secured and IPPV taking place.

Bottom- Cut away diagram showing final resting place of LMA in the hypopharynx area.

The indication for using an LMA is that the casualty is unconscious with relaxation of the jaw and absence of the gag response to stimulation. In fact no different than that required to place an Oropharyngeal Airway into the mouth of a patient.

LMAs have been used in well over 100 millions cases with no reported mortality (death) and morbidity (injury). The same cannot be said of Endotracheal Intubation. The training required is simply conducted on manikins and is completed in less than 3 hours with some pre course study.

In summary, the use of LMAs requires minimal training with rapid skill acquisition, has a low complication rate, establishes a secure airway rapidly and has good skill retention. Most importantly, once a LMA is secured the operator does not have to maintain any head support (see picture on left)

You may ask "why haven't we seen LMAs used in "First Aid" before". Unfortunately it has been put into the same category as Endotracheal Intubation and therefore has been regarded as a paramedical skill but many recent studies give ample evidence that they have an important role in First Response situations.

The new "Advanced Rersponder" program consists of 4 "Nationally Recognised" units of competency which include Life Support, Advanced Resuscitation, Early Defibrillation and use of LMA s.

Contact the Managing Director of FRA for further information regarding this and other programs.

The Last Word

So, some exciting changes ahead in the field of resuscitation. Major changes in CPR ratios, acceptance of LMAs as a "First Responder" skill are just the beginning. FRA clients in remote areas workplaces have also included the use of Intravenous Fluid Therapy as part of their Emergency Medical Response capabilities and this is being seen as a necessary skill especially on "live aboard" dive vessels who at times find themselves one to two days from land or evacuation sites. So, given the right context, flexibility and lateral thinking is required to improve outcomes in medical emergencies.

I believe that in the not to distant future we will also see dramatic changes in AEDs protocols, with the 3 shock protocol being replaced with a one shock followed by CPR protocol. The evidence is mounting fast that waiting for over a minute with no compressions taking place whilst delivering up to 3 shocks using an AED is quite unacceptable.

So, from my perspective with all these changes in the wind, it is still strange to see that in most circles resuscitation still being taught as a rigid process instead of outcome driven one. It seems to demonstate that many trainers are simply unaware of what's happening outside Australia and/or have the misguided belief that they are breaking some kind of law by being flexible in their teaching.

Edited by Charles Makray
Managing Director

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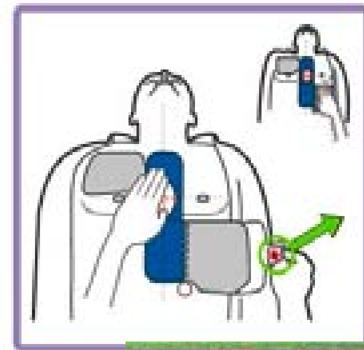

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