



# Maryland EMS News

Vol. 24, No. 4 For All Emergency Medical Care Providers March/April 1998

## Child Safety Seats: Correct Use Determines Effectiveness

Buckle Up America Week is May 18th through May 25th, 1998 coinciding with National Emergency Medical Services Week. The focus across the state of Maryland will be to emphasize the importance of placing every child in the correct child safety seat, booster seat, or seat belt system: "Right Child in the Right Seat - Every Time." MIEMSS is working with the Maryland State Highway Administration, Maryland Safe Kids and the Kids in Safety Seats program (KISS) on public service announcements concerning the importance of Booster Seats that will be aired in May.

According to the National Highway Traffic Safety Administration (NHTSA), child safety seats, when used correctly, can reduce fatalities of children less than five years of age by 71 percent - making them one of the most effective safety innovations ever developed.

Children have to depend on their parents to use the right safety seat - infant, toddler/ convertible, or booster seat - and use it correctly. NHTSA recommends rear facing seats until a child is at least 20

pounds and at least one year of age. Because the most dangerous collisions are head-on and infants are "top heavy," an infant must always be seated rear-facing until at least one year of age. The rear-facing position cradles the baby's head and neck and spreads the crash forces along the baby's body to reduce the possibility of neck and spinal cord injury.

Children should be in forward facing car seats from 20 to 40 pounds, and belt positioning booster seats until the child can use the vehicle's seat belt correctly. Parents are often in too big a hurry to move their child out of the forward facing seat. Many skip the use of booster seats, putting their child in danger because the seat belts are designed for adults and do not fit the child's smaller frame correctly.

New NHTSA recommendations say that the vehicle's seat belts often do not fit children correctly until they weigh about 80 pounds. Following this recommendation means that most children between 4 years and 8 years will need to be in belt positioning booster seats. "Correct" fit must include positioning the seat belt (also called the restraint system) as designed by the manufacturer. To fit correctly, the lap belt must stay low on the child's hips and should not ride up across the abdomen. The shoulder belt should not cross in front of

the child's face or neck. In a crash, an out of place belt could cause severe damage or allow the child to slide out of the belt.

Not only do parents need to choose the correct child safety seat, they also must install it correctly. NHTSA studies have shown that as many as 80 percent of the child safety seats being used today are used incorrectly. At child safety seat checks conducted across Maryland during the past 6 months, 9 out of 10 children have been found in the wrong type seat, in a recalled seat, or in an incorrectly installed child safety seat.

Incompatibility between child safety seats, seat belts and vehicle seats is one reason why child safety seats are not installed correctly. There are over 100 models of child safety seats and over 900 potential seating positions available. None of these combinations were designed together - and none of them fit together without significant time, reading, effort and energy.

Another compatibility problem involves passenger-side front air bags, which when combined with three-point seat belts can save adults, but

*(Continued on Page 7)*



Child Safety Seat Check at US Air Arena sponsored by Prince George's County Fire Department and Prince George's SAFEKIDS in September 1997.

### New Address for MIEMSS

MIEMSS has moved! The new address is 653 West Pratt Street, Baltimore, MD 21201-1536. An open house for EMS providers will be scheduled soon.

All MIEMSS phone exchanges now begin with "706"; but the phone extensions of MIEMSS staff have remained the same. MIEMSS' e-mail address has also changed. It now consists of the person's first initial and last name followed by: @mdems.umaryland.edu.

# Children & Poisons

*Poisoning is the fifth leading cause of preventable death in children under 6 years of age. The pediatric medical case on a poisoning emergency is presented below to illustrate how EMS providers in Hagerstown (Washington County) used a poison consultation center as an important resource. It is based on a case review by Julie Oakley, MD, Region II, Pediatric Medical Director, presented to pre-hospital providers last summer.*

**18:00** An ALS unit is dispatched on a pediatric call, with information that a 1-year-old female has ingested lighter fluid. The ETA is approximately 5 minutes. En route to the scene, the paramedic contacts the Poison Consultation Center at the University of Maryland of Baltimore (UMAB) for specific information on lighter fluid ingestions. The Poison Consultation Center advises of the airway risks for hydrocarbon ingestion and recommends reducing any risk for vomiting.

**18:04** When the unit arrives at the home, anxious family members bring the child, dressed in undershirt and diapers, out to the vehicle. The paramedic performs a rapid primary assessment in the back of the vehicle, which reveals the following.

A one-year-old girl has her mouth full of liquid and frothy secretions. Her respirations are labored and irregular. Her heart rate is 140 and capillary refill is 2 seconds. She is unresponsive at the time of presentation. After the EMS providers suction her mouth with a Yankauer catheter to clear her airway, she becomes angry and combative.

According to a family member, this is a one-year-old normally healthy child who was found crying and spitting out clear fluid. The can of lighter fluid was in the immediate area. A family member gave the child milk prior to calling the 9-1-1 center, and the child had vomited prior to the arrival of the Hagerstown EMS units.

**18:07** The child's respirations remain irregular and her breathing is

assisted with a bag valve mask (BVM) with 100% oxygen for 1 minute.

Upon reassessment, the child remains combative with changing level of consciousness (LOC). She is placed upon a pediatric immobilization device for airway management and to keep her safe during transport. She remains combative with changing LOC and required BVM ventilation during the transport to the emergency department.

**18:17** The receiving base station is contacted during transport. A brief report is given with validation of the paramedic's airway management decision. No intubation is attempted due to the risk of vomiting and subsequent aspiration.

The child's airway is secured by a BVM. There are clear bilateral breath sounds present and good pulse oximetry. Her circulatory status remains stable and she remains uncooperative and agitated.

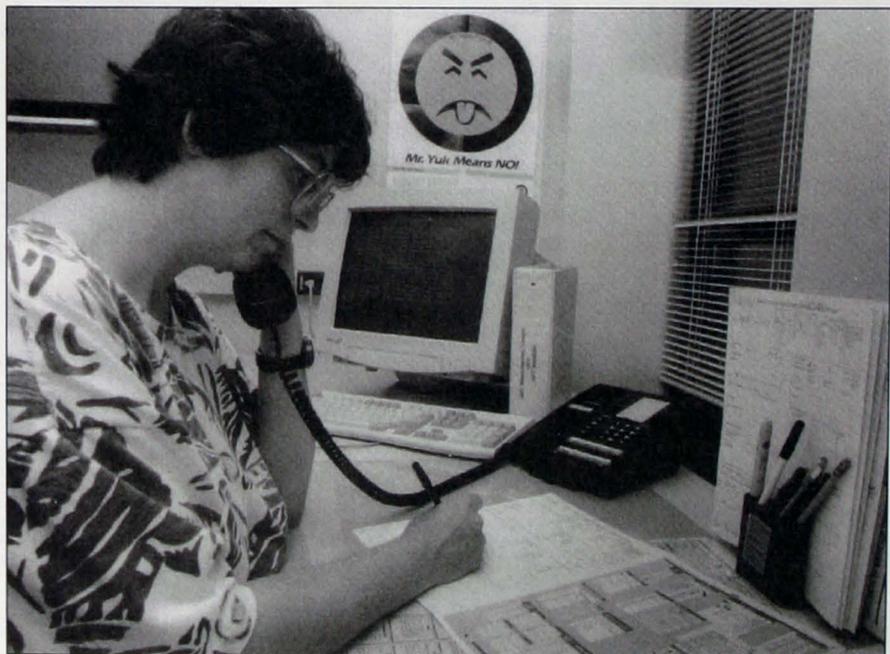
**18:25** The child arrives in the emergency department with her airway open, assisted by a jaw thrust and mask. She is breathing on her own with clear bilateral breath sounds. She is crying and has a changing LOC.

Her respiratory rate is 30; pulse oximetry 98-100%; heart rate, 125; and Glasgow Coma Score (GCS), 14. The emergency department staff connects her to oxygen by face mask and monitors.

Based upon prearrival information from the prehospital team, an anesthesiologist has been called to respond. After the primary assessment is completed, a laryngoscopy is performed to assess for internal burns. The results of the laryngoscopy are negative (no burns). One of the greatest risks from petroleum-based ingestions is aspiration pneumonia, which typically presents 1-2 hours after poisoning. The child is closely observed and chest X-rays are taken that prove to be negative.

**18:30** A secondary survey reveals first-degree burns on the child's abdomen and perineal area. (Her diapers had been saturated with lighter fluid.) After receiving pre-medication, her burns are cleaned and wound care initiated. The pediatrician consults with the Pediatric Intensive Care Unit (PICU) at the Johns Hopkins Children's Center in Baltimore and with the Poison Consultation Center at UMAB. It is determined that this is a non-neurotoxic ingestion and she does not need

*(Continued on page 3)*



*A specialist in poison information at the Maryland Poison Consultation Center advises a caller.*

(Continued from page 2)

to be transferred for extensive neurologic evaluation and follow-up. Chest films are repeated but show no signs of aspiration pneumonia, so she does not need to be intubated.

**19:30** The child is admitted to the pediatric unit at the community hospital. She has a monitor and rests quietly with a family member at her bedside during the night. The next day she is discharged home with close follow-up by a primary care provider.

#### Key Points by Dr. Oakley

*The rapid primary survey and the focus on airway management in a child who has ingested poison and has a changing LOC cannot be overemphasized. Both EMS and Emergency Department providers must remember the ABC's of pediatric care—Airway, Airway, and Airway. Remember to: "Call it as you see it and focus on the first priorities." In many cases, airway management in children can be maintained with good bag valve mask technique.*

*Prehospital and hospital care were well coordinated, and the field communications ensured that the*

*resources were available immediately.*

#### Poison Consultation Centers & You

As a specialty center resource, the Poison Consultation Center can provide information related to specific poisons, such as symptoms and the types of presentations to anticipate. Local medical control from the base station will provide on-line medical direction. Also talk with Poison Consultation Center staff for suggestions on poison management. Communication between the field, the base station, and the specialty center provide the most current information and the best possible care for children.

In addition, the poison consultation centers will provide follow-up with the family and the primary care provider. The poison centers track all poisonings reported to them in Maryland. Thus high-risk populations and age groups are known and can be targeted by educators at the poison consultation centers.

Emergency telephone calls to the poison consultation centers are managed by specialists in poison information who are certified by the American Association of Poison Consultation Centers. From the field, the Maryland Poison Consultation

Center can be reached by calling either their direct lines or EMRC (Emergency Medical Resources Center) at MIEMSS. Field providers can receive advice but cannot receive medical direction orders unless a physician is present at the center.

#### Maryland Poison Center

20 N. Pine Street  
Baltimore Maryland 21201

#### Emergency Calls:

410-706-7701  
1-800-492-2414  
TDD 410-706-1858

#### For information, call the

**Business Office:** 410-706-7604

or visit their web site :

[www.pharmacy.ab.umd.edu/~mpc](http://www.pharmacy.ab.umd.edu/~mpc)

#### National Capital Poison Center

George Washington University  
Medical Center  
3201 New Mexico Avenue, Suite 310  
Washington, DC 20016

#### Emergency Calls:

202-625-3333

#### For information, call the

**Administration Office:**

202-362-3867

## Physician's Palliative Care Pain Hotline

The Physician's Palliative Care Hotline is available to physicians who want prompt consultation on pain management in palliative care. The initial call is made to the Emergency Medical Resources Center (EMRC) at MIEMSS on its toll-free number (1-800-492-3805).

The goal of the palliative care pain hotline is to provide Maryland physicians with 24-hour access to peers who are experts in pain management and palliative care. The hotline is a pilot project sponsored by the Hospice Network of Maryland in cooperation with MIEMSS, the Maryland Office of the Attorney General, the Maryland Board of Physician Quality Assurance, the Medical and Chirurgical Faculty of Maryland, and the Baltimore City Medical Society.

EMRC primarily handles emergency medical communications and consultations between ambulances and hospitals. EMRC's role in the new palliative care pain consultation service is similar to its role in the neonatal and perinatal referral system. Once EMRC receives a call from a physician that is identified as a request for a "palliative pain" consult, EMRC will contact the hotline physician on-call and will patch him/her together with the physician requesting consultation. On-call physicians are board-certified in hospice and palliative medicine. If the primary on-call physician fails to respond within 10 minutes, the back-up on-call physician will be called by EMRC.

The hotline is for physician to physician consultation only, not for EMS field units to obtain orders.

Each on-call physician will record the calling physician's name, phone number (for future follow-up), the nature of the call (etiology of pain), and some other brief and basic demographic information.

F. Michael Gloth III, MD, Chief of the Division of Geriatrics and Director of Research at the Union Memorial Hospital, is the physician project coordinator. He is also medical director for Carroll Hospice and a member of the Hospice Network of Maryland's Board of Directors. Dr. Gloth can be reached at 410-554-2923 during normal business hours for administrative questions only. All hotline calls should go through EMRC at 1-800-492-3805.

Calls regarding the EMS/DNR (Do Not Resuscitate) Program or requests for EMS/DNR forms should continue to be referred to the MIEMSS Office of Program Development at 410-706-4367.

# Summary of ALS Protocol Revisions 1998

Below is the list of the ALS protocol revisions that will be presented to the Board of Physician Quality Assurance (BPQA) for implementation on July 1, 1998. This overview is designed to give EMS managers advance notice for both inventory and training requirements.

**Addition of benzocaine to the list of statewide minimum medications.** The nasal tracheal intubation protocol approved by the BPQA two years ago had hurricane spray (topical benzocaine anesthetic) as part of the protocol. This medication addition is to complement that protocol.

**Addition of "Symptomatic" to the Difficulty Breathing or Asthma/COPD Protocol and delineation of IV therapy.**

"Symptomatic" was added so that this protocol is not used on patients with only a history of asthma or COPD. Intravenous therapy for the symptomatic asthma patient shall be administered only to Priority 1 and Priority 2 patients and to patients with only a history of cardiac disease. Currently the protocol reads to "Start an IV of L.R. KVO." Many patients with minor asthma symptoms were receiving unnecessary IV access and were delayed at the scene.

**Authorization of ALS providers to assist hemophiliac patients with the administration of their own prescribed blood factor concentrates (factor VIII or IX).** The Hemophilia Society, championed by Dr. Cassella from Johns Hopkins, recommended that ALS providers be allowed to assist with the administration of blood factor concentrates. In a survey of all 48 emergency hospitals in Maryland, we found that only 11 hospitals carried one or both factors. Often the mechanism of injury would suggest that a hemophiliac patient needs blood factor concentrates. This situation could lead to a prolonged wait for the correct blood factor concentrate when needed by a patient. A training document will go to the

instructors and is going to be a CME topic at EMS Care '98, the statewide conference for EMS prehospital providers in May.

**Transport of patients with unsecured airways to the nearest hospital-based emergency department for airway management prior to determination of whether the patients should be transported to the nearest appropriate trauma or specialty center.** This is currently the standard of care but ALS personnel have questioned why they have not been advised to go directly to a trauma/specialty center. However, the resources of a trauma/specialty center would be useless to a patient who died due to the lack of a patent airway.

**Revised criteria for hyper-ventilating (rate of 24 breaths per minute) the head-injured patient.** Research has shown that hyperventilation in a minimally traumatized brain may be quite detrimental by decreasing blood flow to the watershed areas of the damaged brain. Basic Trauma Life Support training reflects this need to hyperventilate only the seriously damaged brain (GCS less than 8, rapidly decreasing GCS, or by on-line physician direction).

**Indications for direct referral to Spinal Specialty Center.** Currently the system has a designated Neurotrauma Center specializing in head and spine injuries. The providers have been referring patients to Area-wide Trauma Centers and to the Neurotrauma Center without guidance. This simple reference has been reviewed and approved by the Trauma Network, the Regional Medical Directors, the Jurisdictional Advisory Committee, and the BPQA.

**Minor clarifications to the Helmet Removal Protocol language (regarding athletic trainers).** Many schools use athletic trainers to oversee the safety of young athletes. This protocol allows the ALS personnel to recognize the ath-

letic trainers' expertise in helmet and sport gear removal if indicated.

**Blood glucose monitoring (glucometer) required by January 1, 2000.** MIEMSS has been monitoring the use of the glucometers in three EMS jurisdictions. During this monitoring period, 202 patients met the criteria to give D50W in the previous protocol. Of these, 21% had hypoglycemia and received D50W; 16% had hyperglycemia and received a fluid challenge; and 63% were euglycemic and did not receive D50W (of these, some probably had hemorrhagic CVAs and administering D50W would have resulted in an unfavorable outcome). At the end of the monitoring period, there was also a cost saving insofar as less D50W was administered when glucometers were used since they can more accurately indicate hypoglycemia and hyperglycemia.

**Revision of PEA Algorithm to authorize with medical direction the administration of CALCIUM CHLORIDE for the HYPERKALEMIC patient.**

Currently Calcium is indicated for hyperkalemia; we are correcting an algorithm pathway.

**Revision of Pediatric Algorithm for SVT to authorize with medical direction the administration of ADENOSINE.**

This change was recommended by the Pediatric Emergency Medical Advisory Group to address the infrequent occurrence of a symptomatic supraventricular tachycardia (SVT) patient. The previous protocol overlooked the possibility of an awake hypotensive child. This has been corrected and the use of Adenosine prescribed with medical direction.

**Removal of required reporting for use of CLASS A and CLASS B ADDITIONAL PROTOCOLS.** These "Additional Protocols" used to be "Optional Procedures" for those jurisdictions willing to provide the added reporting and quality assurance. All of these options have become standards of care and were previously incorporated into protocol. The "added reporting" to MIEMSS is not necessary since each jurisdiction is now responsible for these procedures.

# FACT SHEET

## Emergency Medical Services Week in Maryland

May 17 - 23, 1998

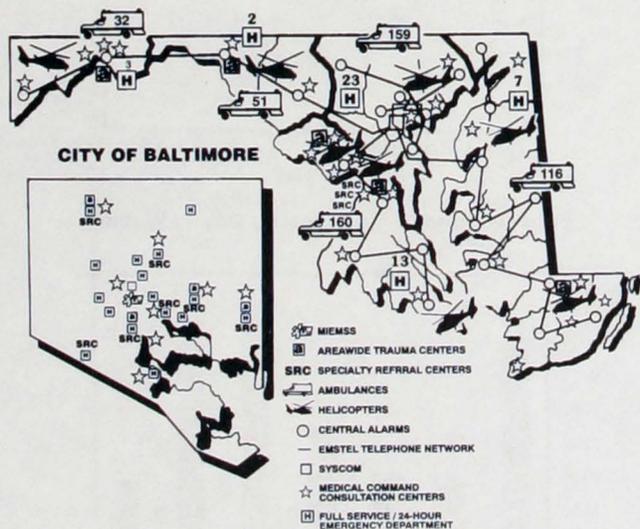


This national theme for EMS Week 1998—The Vital Link—stresses the contributions that EMS providers make in our communities and the countless ways that they ensure our health, protection, and physical well-being. EMS providers are available 24 hours a day, 7 days a week, 52 weeks a year.

### EMS Week Goals

The goals of EMS Week include:

- Educate the public about the EMS System and when it should be used.
- Stress the importance of the role that members of the public play in recognizing and responding to medical emergencies.
- Offer information about CPR and basic first aid.
- Encourage the prevention of illness and injury.
- Show appreciation for the contribution of every member of the EMS team in Maryland.



### EMS Regional Offices in Maryland

#### REGION I

- Allegany and Garrett counties
- Region I Office in Grantsville, 301-895-5934

#### REGION II

- Frederick and Washington counties
- Region II Office in Hagerstown, 301-791-2366 or 416-7249

#### REGION III

- Baltimore City and Anne Arundel, Baltimore, Carroll, Harford, and Howard counties
- Region III Office at MIEMSS in Baltimore, 410-706-3996

#### REGION IV

- Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, and Worcester counties
- Region IV Office in Easton 410-822-1799

#### REGION V

- Calvert, Charles, Montgomery, Prince George's, and St. Mary's counties
- Region V Office in College Park, 301-474-1485

### EMS Week Activities

Throughout the State, EMS providers are planning local activities incorporating many of the goals previously mentioned. For information about EMS activities in your area, contact your regional administrator.

In previous years, EMS Week activities have ranged from open houses, equipment displays, automobile extractions, and skills demonstrations to blood pressure screenings, bike rodeos, CPR classes, and poster, essay, and coloring contests. In addition, many hospitals held appreciation dinners or picnics to honor prehospital providers in their areas.

During EMS Week, the Maryland Institute for Emergency Medical Services Systems (MIEMSS), the state's coordinating agency for Maryland's EMS System, will honor EMS personnel for outstanding performance in delivering prehospital emergency care. Non-EMS individuals will also be recognized for their roles in providing life-saving care. In addition, special awards will be given to the EMS provider of the year; the outstanding EMS program; and individuals with outstanding service in EMS.

# Maryland EMS Statistics

## Maryland-Certified Prehospital EMS Providers (FY 1997)

• First Responders	12,605
• EMT-As	10,246
• EMT-Bs	5,447
• CRTs	911
• EMT-Ps	1,565
• EMDs	241
<b>TOTAL</b>	<b>31,015</b>

## Emergency Care Hospitals (FY 1997)

- 48 Emergency Departments
- 9 Trauma Centers
- 20 Specialty Referral Centers

## 9-1-1 Centers (FY 1997)

- In Baltimore City and each of Maryland's 23 counties
- More than 600,000 EMS calls in FY 1997

## Transports in Maryland\*

• Injuries	80,862
• Medical Emergencies	200,831
<b>TOTAL</b>	<b>281,693</b>

## Top 10 Injuries in Patients Transported\*

• Motor Vehicle Crashes	32,206	(39.8%)
• Falls	22,931	(28.3%)
• Beatings	5,960	(7.4%)
• Sports/Rec.	3,789	(4.7%)
• Pedestrian	2,460	(3.0%)
• Industrial	2,016	(2.4%)
• Gunshot Wounds	1,333	(1.6%)
• Stab Wounds	1,229	(1.5%)
• Bikes	1,054	(1.3%)
• Burns	1,037	(1.2%)

## Top 12 Medical Emergency Patient Transports\*

• Myocardial Infarction	23,613	(11.8%)
• Diabetes	12,118	(6.0%)
• Seizure	11,109	(5.5%)
• Asthma	9,511	(4.7%)
• Congestive Heart Failure	8,845	(4.4%)
• Cerebral Vascular Accident	7,894	(3.9%)
• Chronic Obstructive Pulmonary Disease	7,526	(3.7%)
• GI	5,568	(2.8%)
• Overdose	5,147	(2.6%)
• Behavioral	4,780	(2.4%)
• OB/GYN	4,754	(2.3%)
• Cardiac Arrest	3,548	(1.8%)

## Neonatal Transports (July 1 - Dec. 31, 1996)

• Neonatal ambulance	157
• Helicopter	53
<b>TOTAL</b>	<b>210</b>

## Med-Evac Helicopter Program (FY 1997)

- 11 helicopters
- 8 bases
- 44 flight paramedics
- 56 pilots
- 3,613 transports (85%) from scene of injury
- 618 interhospital transports (15%)

## Commercial Ambulances (FY 1997)

- 37 Licensed Services
- 135 Licensed ALS Ambulances
- 234 Licensed BLS Ambulances

## Maryland Poison Center Calls (Calendar Year 1996)

- 55,745 total calls
- 18,924 requests for information
- 36,821 calls regarding human exposure to poison

### Sources of Human Exposure Calls

- From general public	80.5%
- From physicians	15.4%
- From prehospital providers, pharmacists	4.1%

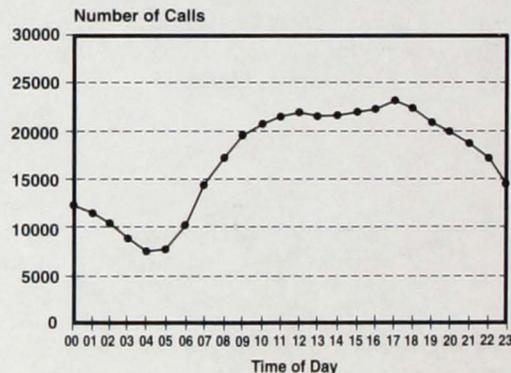
### Age of Patients Exposed to Poison

- Younger than 6 yrs.	55.6%
- 6-12 yrs.	6.6%
- 13-19 yrs.	7.7%
- 20-69 yrs.	26.5%
- 70 yrs. and older	1.9%
- Unknown	1.7%

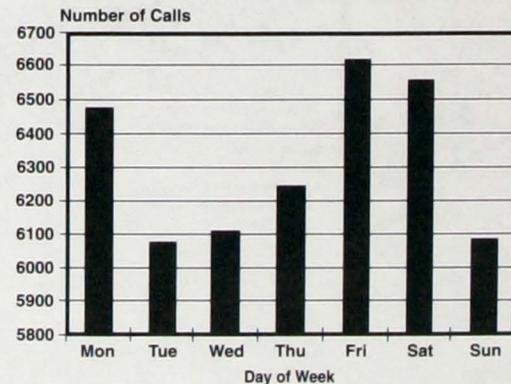
## Transports in Maryland by Age and Type of Emergency\*

Age	Injury	Medical
1-30 days	45 (0.1%)	395 (0.1%)
30 days-5 yrs.	2,735 (3.4%)	4,889 (2.4%)
6-15 yrs.	7,698 (9.5%)	6,335 (3.2%)
16-60 yrs.	50,780 (62.8%)	89,289 (44.5%)
60+ yrs.	14,928 (18.5%)	80,221 (39.9%)

## EMS Demand in Maryland by Time of Day\*



## EMS Demand in Maryland by Day of Week\*



Note: Fiscal Year (FY) 1997 extends from July 1, 1996 to June 30, 1997.

\* Based on MAIS FY 1997 data that do not include Montgomery and Howard counties. Data for Baltimore City FY 1997 are incomplete. Records with Injury Cause "Other" were excluded from Top 10 Injuries and Top 12 Medical Emergency Transports.

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# Child Safety Seats: Correct Use Determines Effectiveness

(Continued from page 1)

can be harmful to children. See the February/March 1997 issue of *EMS News* for the ABC's of Airbag Safety. Remember: Rear-facing infant and child seats should never be used in the front seat of a vehicle with a passenger-side air bag. The deploying bag striking a rear facing infant seat can result in fatal injuries to a child. Put the child safety seat in the back

## Child Safety Seat Checklist

- Read the instruction manual for your child safety seat and the owner's manual for your vehicle.
- Make sure you are using the correct size/type of restraint for your child.
- Make sure your child safety seat has not been recalled because of a problem with crash-worthiness (call NHTSA's Auto Safety Hotline, 1-888-327-4236 or TDD 1-800-424-9153 for a list of recalled seats).
- Make sure the safety belt is threaded through the correct belt path for the position you are using.
- Always anchor the child safety seat to the vehicle with seat belts and make sure the belt is tight.
- Use a locking clip if your vehicle safety belts need it to stay tight (check belt labels, vehicle's owner's manual, child seat instructions).
- Always buckle the child into the child safety seat, making sure the harness straps are snug and positioning the harness clip at armpit height.
- Face infants toward the rear of the vehicle until one year old and weighing less than 20 pounds.
- Never place an infant rear-facing in front of a passenger-side air bag.
- Whenever possible, have children ride in the rear seat correctly restrained.
- For a forward facing child, always move harness straps to their highest position through the back of the child safety seat.
- Make sure you are using the correct recline angle, fully upright for forward facing, 45-degree recline for rear facing.

seat, facing the rear for children under one year. In almost every situation, the safest place for children is in the back seat of the vehicle, properly restrained every time.

Diane Lee, Highway Safety Coordinator for the MIEMSS Region I Office, has been involved in child seat education and child seat installation. "I tell people to make sure they read the owner's manuals for their vehicles and the instructions for their child safety seat to make sure they are doing everything correctly, giving their child the best possible protection."

Attend a Buckle Up Kids workshop and learn more about child safety seats, incompatibility issues and begin to collect your own resources on child passenger safety. The Maryland EMSC Partnership Grant, awarded to MIEMSS by the Maternal Child Health Bureau in October of 1997, includes a major focus on childhood injury prevention. This project involves conducting the "Buckle Up Kids" two day training program in each EMS Region.

Buckle Up Kids training includes a detailed manual on child passenger safety, injury prevention, and handouts for education and public information. The two-day workshop includes:

- information on the mechanisms of motor vehicle crashes
- information on child safety seats
- hands-on training with many different car seats
- hands-on practice at installing car seats
- participation in an actual car seat check
- resources on injury prevention for traffic safety

The Prince George's County Fire Department and Prince George's County Safe Kids Coalition have conducted the Buckle Up Kids workshops since June of 1997 and have contributed to the statewide availability of this program. Through a mini-grant from the Shock Trauma Gala Fund, the Buckle Up Kids workshop is being offered in Southern Maryland and Region II. Prince George's County Safe Kids also has a Child

Passenger Safety Trailer developed for both child passenger safety training and child safety seat checks.

With this introduction to Child Passenger Safety and the materials from NHTSA, EMS, fire and rescue organizations will be able to play an important role in child passenger safety. The program is designed to encourage partnerships between out of hospital providers, law enforcement, and child safety advocates to develop a community-based information and service resource for life safety education and prevention issues.

The Maryland Kids in Safety Seats (KISS) program is maintaining a list of people in Maryland involved in child passenger safety including those who have completed the newly developed NHTSA Standardize Child Passenger Safety Training four-day course and those who have completed a Maryland Child Passenger Safety Survey. If you are interested in conducting a child safety seat check, contact the KISS program at 1- 800 - 370 - SEAT for local Child Passenger Safety Technicians and advocates in your area.

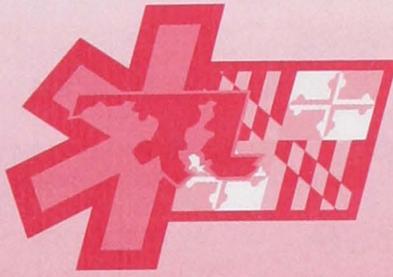
♦ Cyndy Wright-Johnson  
Diane Lee

**Buckle Up Kids : Child Passenger Trauma Prevention Training Program for Fire and Rescue Personnel.** This two-day workshop has been held in Prince George's, Charles, Calvert and Montgomery Counties. Contact the EMSC Program at MIEMSS (410-706-1758) or your regional office for more information.

**Future Dates include:**  
**April 25 & 26, 1998** in St. Mary's County  
**May 2 & 3, 1998** in Allegheny County  
**May 16 & 17, 1998** in Ocean City  
**June 6 & 7, 1998** in Charles County  
**July 18 & 19, 1998** in Washington County

**World Wide Web sites related to Child Passenger Safety:**

- [www.nhtsa.dot.gov](http://www.nhtsa.dot.gov) - look under child passenger safety and under EMS
- [www.childsafety.org](http://www.childsafety.org)
- [www.safekids.org](http://www.safekids.org)



Governor Parris N. Glendening

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Chairman, EMS Board: Donald L. DeVries, Jr., Esq.  
Executive Director, MIEMSS: Robert R. Bass, MD  
Managing Editor: Beverly Sopp (410-706-3248)

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## DATED MATERIAL

### News Briefs

◆ MIEMSS is requesting Expressions of Interest for the position of Region IV Medical Director. For information, contact Bobby Schoonover (Region IV EMS Council Chairman) in care of the MIEMSS Region IV Office at 410-822-1799. Richard Alcorta, MD, FACEP, State EMS Medical Director, is currently undertaking the responsibilities of the position until a permanent Region IV Medical Director is appointed.

◆ New appointees to the EMS Board include Dottie Dyatt, RN, and Julie Casani, MD. Ms. Dyatt (Nurse Manager, Emergency Services, Express Care, Digestive Health Center at Memorial Hospital in Easton) was formerly on the Statewide EMS Advisory Council (SEMSAC). She represents EMS nurses and replaces Dennis Jones, RN, whose EMS Board term expired. Dr. Casani is representing EMS physicians.

◆ Murray A. Kalish, MD, a member of SEMSAC representing the Maryland-District of Columbia Society of Anesthesiologists, recently received the Baltimore City Medical Society's (BCMS) 1997 Community Service Award. Dr. Kalish received

the award for his efforts in supporting the youth of the community, raising more than \$50,000 for the BCMS Foundation to be used for medical school scholarships to city and state residents and for grants to local charitable organizations, as well as participating in other community activities. Dr. Kalish is an attending anesthesiologist at the R Adams Cowley Shock Trauma Center.

### EpiEZPen® and EpiEZPen Jr.® Recall

Meridian Medical Technologies, Inc. announced a few months ago that it is conducting a nationwide precautionary product exchange program

in which consumers should return any EpiEZPen® or EpiEZPen Jr.® auto-injector for a free replacement with the EpiPen(R) or EpiPen Jr.(R) auto-injector, all of which are used for emergency treatment of severe allergic reactions. While more than 99.99 percent of EpiEZPen model auto-injectors continue to function correctly, a small number may spontaneously activate, rendering them ineffective in the event of a medical emergency. Consumers with EpiEZPen or EpiEZPen Jr. should return them to the place of purchase to receive a free EpiPen or EpiPen Jr. For further information, consumers may call 1-800-527-4278 or 1-800-755-5560. (Article modified from Infoseek website.)



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