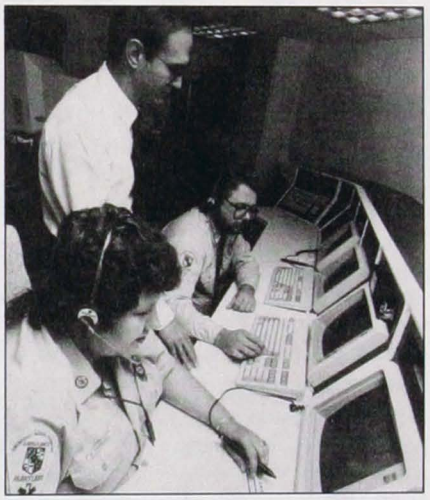
Maryland
E·M·S
NEWSLETTER

Vol. 17, No. 5 | For All Emergency Medical Care Providers | Dec.'90/Jan.'91

EMRC Upgraded; Moves to New Quarters

The Emergency Medical Resources Center (EMRC), the communications link between ambulances and hospitals in the Baltimore metropolitan area, has been upgraded and moved to new quarters. In December, this innovative communications center joined SYSCOM—the Systems Communications Center—in Dunning Hall, next to the R Adams Cowley Shock Trauma Center on the campus of the University of Maryland at Baltimore.

EMRC operators enable prehospital care providers within Maryland's EMS Region III to obtain on-line medical direction from physicians in hospitals. The operators also monitor the availability of hospitals in Region III so that ambulance personnel can transport patients to the closest appropriate facility and minimize transport times. This tracking of bed availability eliminates a problem that prehospital personnel are facing more frequently in some other parts of the country: the search for an "open" hospital after picking up an injured or ill patient.



(Center) Andy Pilarski, chief of EMRC/SYSCOM operations, reviews procedures with EMRC communications staff Steven Risso and Beth Parrish.

The new EMRC facility was designed by a team of MIEMSS communications personnel. Tom Miller, chief of engineering, led the project by adapting the best of existing technology to EMRC's unique needs, structure, and function. Support was provided by Ed Macon, chief of maintenance; operational and human engineering is the responsibility of Andy Pilarski, chief of EMRC/SYSCOM operations.

With this upgrade of the operation of EMRC, Maryland's Region III is again

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Reflections for the Holiday Season

The close of 1990 and the beginning of 1991 mean different things to different people. For everyone, it is obviously a mark in the passage of time. Some will be glad to see 1990 slip away, and others will see opportunities in a new year. Calendar purists will say that 1991 is truly the beginning of the decade of the 90s, because technically the year 1990 was still part of the last decade.

A moment of reflection brings to mind enormous changes that have taken place in our world during the past year. The new year of 1990 dawned with momentous changes in many parts of the world and a rekindling of democracy in countries and people who had never known an open way of life. The ideas of peace and progress were temporarily shattered on August 2, 1990 when one country invaded another, and we saw once again that the world can be a dangerous place to live. As this issue of the *Maryland EMS Newsletter* goes to press, our country wonders once again whether there will be peace or war in the world during this time of reverence for the world's great religions.

This year also saw changes beginning in the world's economy. Questions as to how resources are allocated in an increasingly complex world will continue to be with us.

World and national events may sometimes seem remote from the day-to-day "world" of EMS, but they all constitute factors in the world in which we function. The holidays of Christmas and Hanukkah are celebrated by most members of the EMS community in our state, and while emergency calls cannot be "suspended" for the holidays, we take this opportunity to thank all of those who have served and given of their time, expertise, and energy for the benefit of others. To all of those, we wish meaningful holidays and a new year of opportunity.

◆ *Ameen I. Ramzy, MD*
State EMS Director

EMRC Upgraded

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at the leading edge of medical communications. The new system employs technical innovations not found elsewhere in medical communications systems. For example, light pens and computerized graphic displays are used for voice and electrocardiogram (ECG) telemetry patches. A time division multiplex switch accepts a computer command, initiated by the light pen, to switch medical-channel radios into the appropriate hospital emergency department. Computer displays are used to track hospital bed status. The old telephone lines that connected the hospitals have been replaced by reliable microwave equipment. All tube-type medical-channel base station radios are now of the solid-state variety.

Planning for the current upgrade began in 1983 in conjunction with the larger project of enhancing all components of the medical communications system in Region III. In addition, needs within the overall state communications system are being identified and improvements planned accordingly.

The upgrading of EMRC and of old communications equipment means that Maryland's EMS system can better serve the growing population of the state. It could not have been possible without the support of the executive and legislative branches of government of Maryland, as well as the support of its citizens.

◆ *Gene Bidun*
Director, EMS Communications

Mark Your Calendars

- **March 13-15, 1991**
  6th National Traumatic Brain Injury Symposium: The Decade of the Brain.
  University of Maryland at Baltimore Campus.
  Presented by MIEMSS Speech-Communication Disorders Program.
  Contact: Roberta Schwartz, 301-328-6101/3182.
- **March 21-23, 1991**
  R Adams Cowley, M.D., 13th National Trauma Symposium.
  Baltimore Convention Center.
  Sponsored by MIEMSS & University of Maryland School of Medicine.
  Contact: 301-328-2399.

Allegany Co. Haz Mat Program. . .

The Eyewear Division of Bausch & Lomb, located in Oakland, MD, recently donated 10 pairs of binoculars to the Allegany County Hazardous Material Coordinator Program. The binoculars will enable the haz mat coordinators to read the content placards on trains or truck tankers at a safe distance without endangering fire or rescue personnel at the haz mat spills or incidents. Shown here (l-r) are Dave Ramsey, MIEMSS Region I administrator; Chuck Wood, MFRI senior instructor and chief haz mat coordinator for Allegany County; Butch Sumpter, Bausch & Lomb materials manager; and Al Ward, Allegany County hazardous material coordinator.

A Bit of EMRC History. . .

The original EMRC officially began operation at Sinai Hospital on May 12, 1975, at 8 am, after several years of planning that recognized the need for ambulance-to-hospital radio communications through a single, coordinated operating center. EMRC was connected to hospitals by telephone lines, and tube-type medical-channel radios were switched by electromechanical pushbuttons. Telephone-type crossbar switches were used to make the voice and ECG telemetry and telephone line patching. The technology for EMRC was state-of-the-art for its time, while its application and concepts for medical communications were futuristic.

The following information contains several interesting and amusing facts concerning operations in the early days.

• On EMRC's first day of operation, there were only two patient calls—one from a Baltimore City unit, and the other from an Anne Arundel County unit.

• It took 12 days of operation before the number of calls increased to double digits. There were 14 calls made on Saturday, May 24, 1975.

• The busiest day for the first month of operation was Saturday, May 31, 1975. There were 18 patient calls on this day of the Memorial Day weekend.

• The total number of patient calls for May 1975 was 151. The number of days of operation was 20, for an average of 7.55 calls per day.

Patient calls by jurisdiction were:

Baltimore City	41
Baltimore County	38
Harford County	33
Anne Arundel County	23
Howard County	13
Carroll County	3

The 151 calls were made by 43 different ambulances.

For comparison, on Saturday, May 12, 1990, EMRC handled 175 patient calls—an average of 7.29 calls per hour (that is, the number of calls now handled in an hour in 1990 almost equals the number of calls handled in a day in 1975).

Data provided by Andy Pilarski, Chief of EMRC/SYSCOM Operations.

Maintenance Suggestions for LifePak 5s

LifePak 5 monitor/defibrillators (LP5s) that meet state specifications are now being serviced by the EMS Communications Department at MIEMSS at no cost to ambulance companies. The LP5s are lightweight, user-friendly units that, when maintained properly, offer excellent reliability; however, they require more user maintenance than the Mennen-Greatbatch models previously used. Physical inspections of LP5s and their battery packs, performed regularly, are helpful in locating certain malfunctions and ensure that the system will operate when it is critically needed.

The following procedures will help prolong the life of your LP5. (Although MIEMSS maintains only units meeting their specifications, these procedures are also appropriate for all models of LP5s.)

1. Check for loose or missing hardware, cracks, dents, or contamination from foreign substances.

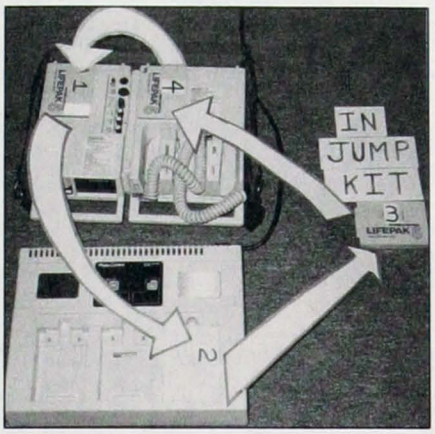
2. Check battery terminals for damage. Install and then remove the battery to check for excessive binding of battery posts.

3. Clean the external surfaces (LP5 case, cardioscope screen, paddles, cables, etc.) by using a sponge or towel dampened with mild soap and water. Do not immerse any portion of the LP5, batteries, or battery conditioner/charger in water. Do not use alcohol or ketone (MEK, acetone, etc.) solutions since they may damage the unit.

4. Inspect the defibrillator paddles and coiled cords for damage to the buttons, cracks in the cord insulation, caked-on gel, or pitted paddle surfaces.

5. At least one battery should be in each of the following locations: monitor, defibrillator, jump bag, and battery conditioner/charger. To prolong the life of the batteries, they should be rotated through all locations in the following manner.

As soon as the low battery indicator light on the monitor illuminates, remove the weak battery and place it in the conditioner/charger. Move the battery from the defibrillator to the monitor. Move the battery from your jump bag to the defibrillator and the fully charged one from the conditioner/charger to your jump bag. You may wish to number the batteries



Battery rotation for a LifePak 5

to ensure that they stay in sequence and to eliminate confusion regarding their status.

Other suggestions to prolong battery life include:

a. Always use the Battery Support System to charge batteries. This conditioner/charger should be connected to a 110-volt source in the station. Power inverters and shore line sockets should not be used. These power sources periodically interrupt the critical conditioning/charge cycles, causing the cycles to start at the beginning.

b. Do not put fully charged batteries into the conditioner/charger for charging.

c. Charge the batteries in an ambient (room) temperature of 25°C. Locate the conditioner/charger away from direct sunlight, heaters, radiators, air conditioners, etc.

d. Perform at least three reconditioning cycles on the batteries once every 90 days. A reconditioning cycle consists of charging the battery; discharging the battery to manufacturer preset level; then recharging the battery to a fully charged state.

If the battery capacity reading is less than 70 percent, PLEASE replace the battery.

e. Do not deplete batteries below cut-off voltage (as indicated by the low battery indicator light on the LP5) since this may permanently damage batteries.

f. Recharge batteries which may have been fully depleted as soon as possible, since batteries left in this state are susceptible to permanent damage. Follow-up with a reconditioning cycle.

g. Use batteries regularly. If they are stored, perform a reconditioning cycle before use.

6. Periodically check the mating contacts between the monitor and defibrillator modules. If necessary, the contacts may be cleaned with a rubber pencil eraser.

Proper care and maintenance of the LP5 is imperative. If you find any deficiencies during your cleaning and inspections, remove the unit from service and arrange for repairs immediately. Questions may arise periodically. If they cannot be answered by this article or the operators' manuals, contact the EMS Communications Department at MIEMSS (301-328-3668).

◆ *Tony Dowhite*
EMS Communications

EMS Units Respond To Haz Mat Incident

Emergency personnel from Maryland and West Virginia responded to a turpentine spill at the Westvaco Luke paper mill on July 25. Approximately 100 gallons of turpentine inadvertently mixed with wastewater at the Upper Potomac River Commission wastewater treatment plant, causing a strong odor and a gas cloud. When the cloud drifted across the Potomac River, residents of Piedmont, WV, complained of dizziness, headaches, and respiratory problems. A triage area was established at Tri-Towns Rescue Squad in Westernport. Nine ambulance companies and a Maryland State Police med-evac helicopter responded. More than 50 victims were transported to Potomac Hospital in Keyser, WV, and to Sacred Heart Hospital and Memorial Hospital and Medical Center in Cumberland. Memorial Hospital, the areawide trauma center for Region I, put its disaster plan into effect.

Officials stated that the turpentine did not enter the Potomac River. The wastewater treatment plant uses a detention system that holds chemicals for 12 hours before they are processed and discharged. During that time, a secondary system "eats up" all organic compounds, including turpentine. The 100 gallons of turpentine were only a small portion of the treatment plant's 12 million gallon capacity.

New Radios Installed in Region III

In October, the EMS Communications and Region III offices at MIEMSS installed 34 Motorola MT1000 ALS hand-held radios in Region III medic units. All models of Pioneer radios—which have been used for the past 15 years—have now been eliminated from the Maryland EMS Communications System. Each new radio is part of a three-component medical radio which, when linked with a monitor/defibrillator, is capable of transmitting ECG telemetry. The other portions, a mobile radio and ECG interface, will be installed to complete each system.

Each unit that received a Motorola MT1000 radio had a 12 volt battery charger installed and was supplied with a 110 volt battery charger. Place the radio in the 12 volt charger for storage and charging. Use the 110 volt charger to charge and store a spare battery. If you need to utilize a reserve ambulance, plug the 110 volt battery into the shore line (household style) sockets on the interior of your ambulance and the radio will charge while the shore line is connected. Be sure to store the spare battery for safe keeping.

The new systems have repeater capabilities when a repeater module is added. Limited numbers of repeater modules, which replace the ECG interfaces, will be distributed according to need. The need will be assessed through a query of the MAIS runsheet database. Because of this, it is now imperative that the runsheets are completed accurately. Be sure to use a number 2 pencil or a black or blue ball point pen to darken the dots on the scanned form. The circles should be filled in completely. Please don't leave a blank circle in the center or just put a slash through the dot. As a general rule, obscure all parts of the numbers in the circle. If you mistakenly fill in the wrong circle, don't just cross it out on the computer form. Erase pencil marks and "white out" pen marks on the original; then "X" the mistake and

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Pioneer CA105 EMS Radios Replaced

After 15 years of service, all Pioneer CA105 EMS portable transmitter/receiver radios have been retired. This canary yellow carrying-case sized unit, weighing in at about 33 pounds, was the first portable EMS radio in service in Maryland. It handled its task in admirable fashion, but tapped the strength of the ALS provider who had to carry it, a drug pack, and an ECG monitor/defibrillator to the patient.

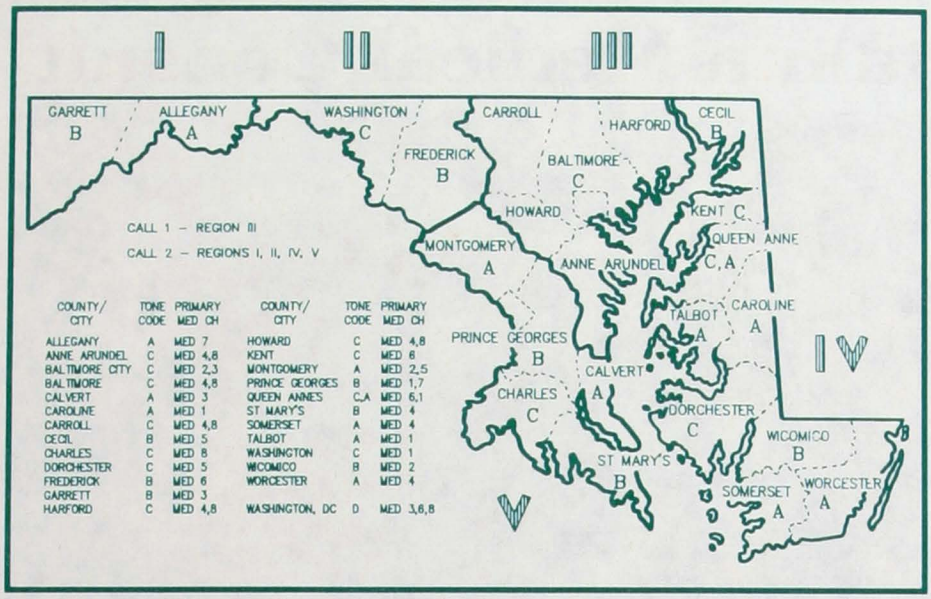
The CA105 has been replaced by the lightweight, Motorola MT-1000 portable radio. The EMS Communications Department at MIEMSS has purchased and distributed over 150 of these radios for statewide use. A sigh of relief was heard from ALS providers when these new 1.5 pound radios were received.

As a result of this replacement program, the EMS Communications Department will no longer maintain and service CA105s after December 30, 1990.

◆ *Gene Bidun*
Director, EMS Communications

Old radio systems: (l-r) GE mobile/repeater system (outside Region III) and Pioneer model CA-105 high-power portable (Region III).

New radio system: (l-r) Standard GX3000 mobile radio and Motorola MT 1000 with 12 volt battery charger.



COUNTY/ CITY	TONE CODE	PRIMARY MED CH	COUNTY/ CITY	TONE CODE	PRIMARY MED CH
ALLEGANY	A	MED 7	HOWARD	C	MED 4,8
ANNE ARUNDEL	C	MED 4,8	KENT	C	MED 6
BALTIMORE CITY	C	MED 2,3	MONTGOMERY	A	MED 2,5
BALTIMORE	C	MED 4,8	PRINCE GEORGES	B	MED 1,7
CALVERT	A	MED 3	QUEEN ANNES	C,A	MED 6,1
CAROLINE	A	MED 1	ST MARY'S	B	MED 4
CARROLL	C	MED 4,8	SOMERSET	A	MED 4
CECIL	B	MED 5	TALBOT	A	MED 1
CHARLES	C	MED 8	WASHINGTON	C	MED 1
DORCHESTER	C	MED 5	WICOMICO	B	MED 2
FREDERICK	B	MED 6	WORCESTER	A	MED 4
GARRETT	B	MED 3			
HARFORD	C	MED 4,8	WASHINGTON, DC	D	MED 3,6,8

Tone frequency for the above Tone Code Map.
A = 127.3Hz B = 146.3Hz C = 167.9Hz D = 192.8Hz

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initial it on the second sheet. Use only "white out" formulated for ball point ink to ensure that the ink does not bleed through.

Pay particular attention to the "Radio" response field. Many people have been using the wrong definition for these dots. For example, "No contact" means EMS communications was attempted but was unsuccessful, not that the EMS radio was not required. "Good, Fair, and Poor" are self-explanatory. This section should be used to document the performance of the portable radio if you have both portable and mobile radios.

Wade Taylor (EMS Communications, MIEMSS) removes the old Pioneer radio from Sykesville's medic unit to prepare for the new radio installation.

The EMS Communications and Region III offices are aware of several areas of poor radio coverage and are attempting to address those deficiencies. Your cooperation in accurate completion of the runsheet and in the utilization of either the Motorola PX300 or the new MT1000 radios by all units allows accurate documentation of coverage difficulties, equitable distribution of repeater modules, and increased justification for additional funding for enhancement of the EMS Communications System.

In addition to improved performance and reliability of the new units, we may now communicate directly with other regions in Maryland if the need arises. A Tone Code Map depicting the code for each county in Maryland has been distributed to all ambulances in Region III. If you need to communicate with a county outside of Region III, simply contact that county directly on Call 2 by utilizing the appropriate tone code. To select this tone code on the PX300, simply move the dial marked A,B,C,D to the appropriate position (some are marked 1234 instead of ABCD; on these, 1 = A, 2 = B, 3 = C, 4 = D). When using the new mobile or MT1000 radios, the tone code is selected simply by selecting the appropriate channel. Tone A is associated with channels 1-10, B with 11-20, C with 21-30, and D with 31-40. Call 1, in each range, ends with the digit 9 (e.g., 9, 19, 29, or 39) and Call 2, in each range, ends with the digit 0 (e.g., 10, 20, 30, or 40). Med Channels 1-8 end with the digit of the Med Channel (e.g., 28 is Med 8 Tone Code C, and 11 is Med 1 Tone Code B). Refer to the Table below for a complete listing of the channels.

MIEMSS continually evaluates the performance of the EMS Communications System and looks for means of enhancing it. Last year the remaining Mennen-Greatbatch monitor/defibrillators were replaced with LifePak 5 models, and the Stoney Forest tower was replaced. This year we have replaced all the old "yellow boxes" with new hand-held radios, added a new tower in southern Anne Arundel County, replaced the EMRC equipment, improved coverage of Med 2 and 3 in Baltimore City, and still hope to improve coverage in Howard and northern Harford counties. The Region III priorities for next year will be to complete the radio systems in ambulances by installing the remaining components; improve coverage in southeastern Harford, northern Baltimore, and northwestern Carroll counties; replace hospital ECG consoles; and begin to replace the Datascope MD 3/A monitor/ defibrillators. The degree of completion of these goals will be directly related to the funding and staff made available to MIEMSS. Thanks to the hard work of the EMS Communications Department of MIEMSS, the system has improved and will continue to do so, slowly but surely.

◆ *John Donohue*
Administrator, Region III

EMS Radio Channel Designations for Motorola MT1000, Midland 70-530B, and Standard GX3000U Model radios

EMS Frequency	Channel on Radio for...			
	Tone A	Tone B	Tone C	Tone D
MED 1	1	11	21	31
MED 2	2	12	22	32
MED 3	3	13	23	33
MED 4	4	14	24	34
MED 5	5	15	25	35
MED 6	6	16	26	36
MED 7	7	17	27	37
MED 8	8	18	28	38
CALL 1	9	19	29	39
CALL 2	10	20	30	40

How to Obtain a Medical Consult

From the physician's perspective, the medical consult provides an opportunity to impact on the patient's care prior to receiving the patient and provides information about the patient's condition so that hospital personnel can prepare for the patient.

Accessing the System

Begin your consultation by switching your radio to the appropriate "call" channel, making sure that the proper tone code is being utilized. Contact the central alarm (EMRC in Region III) and announce the following:

1. unit number
2. receiving hospital
3. type of consultation desired

If you require medical direction, you should request a "medical" or "trauma" consultation. If you wish only to advise the receiving facility of your impending arrival, simply state that you require only to "notify" the receiving hospital. Remember that the medical protocols for CRTs and EMT-Ps require that you obtain physician direction for all priority 1 patients and for those priority 2 patients requiring further therapy (refer to section 1.3 of the protocols for more details). Notification is required for the remainder of the priority 2 patients but should be obtained only for unusual circumstances when transporting priority 3 patients (for example, for multiple patients or patients presenting a security risk).

After you initiate contact, you will be assigned a "Med" channel by the central alarm or EMRC. Acknowledge the transmission, switch to the appropriate channel, and announce that you are on that channel. Some areas of the state are equipped with an automatic tower selector (VOTER) which selects the best tower for that consultation. To make the best selection, the VOTER requires that the field unit be the first to transmit.

Body of the Consult

When a consult is being done, the immediate information needed to direct medical care is the following:

a. Ambulance information: unit number and level of care.

b. General overview: priority of patient, ETA, destination.

c. Patient description: age, sex, overall description (that is, how much distress is the patient in?)

The purpose of this introduction is to give a brief view of how sick the patient is, how much you, as a prehospital provider, can do, and how much I, as the physician, should ask you to do. For instance, if you have a priority 1 cardiac patient and you are a CRT with an ETA of 15 minutes, we may do more than if you have a 3-minute ETA. Likewise, if you don't tell me you are a CRT, and I don't know it already, I may request Dopamine.

Prehospital providers obtain a medical consult while transporting a patient.

Once this initial information is relayed, it is best to then ask if I copy. Too often, prehospital providers state their unit number and ask "How do you copy?" However, this may not provide sufficient transmission time to judge quality.

The remainder of the consult can then flow in the usual medical reporting format.

a. history of present illness: the when, where, what, and how of the chief complaint

b. associated past history: that is related to the current medical problem

c. medications and allergies: if you can't say them, spell them

d. vital signs: they're vital information

e. pertinent physical exam: for cardiac patients, include the lungs; for pulmonary patients, include the lungs; especially for "unconscious" patients, include the pupils, notes regarding trauma, lungs, skin, etc.

f. prehospital treatment to date: for example, IV, oxygen, etc.

There are two key points regarding the body of the consult. First, the information should be related to the chief complaint. Past medical history does not need to be extensive if it is not related to the current medical problem. The second point is that, although this is usually the prehospital provider's only chance to verbally report on a patient, the consult does not have to communicate your entire evaluation. For instance, you may have palpated the abdomen on a cardiac patient but that need not be communicated in the consult. That should, however, go on your medical chart (that is, your runsheet).

Telemetry may or may not be needed. You spend a lot of time and energy learning to read rhythm strips. Ask if telemetry is requested. If not, give your interpretation and mean it.

You may decide to ask permission for a specific intervention. Whether you choose to request it or await further instructions, you should at least anticipate the physician's orders and get out appropriate medications.

Style

Be organized, calm, and confident. If you don't sound like you know what you are doing, chances are that you don't. Sound interested. It's hard for me to be interested in a patient when the prehospital provider sounds bored. Likewise, if you are screaming, the physician expects a horribly sick patient

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Medical Consults

(Continued from page 6)
or a stressful environment.

Be direct and succinct. Give only the facts. Remember that the physician doing the consult may be interrupting patient care in the emergency department to do the consult. In addition, you may want to give a brief description so that additional therapy can be performed while the remainder of the consult is performed. An example of this is a request for a third IV attempt for the unconscious diabetic patient.

Paint an accurate picture. You are the doctor's eyes and ears out there. If you suspect pulmonary edema but describe pneumonia, the physician sees pneumonia and directs treatment accordingly. If you are confused by what you see, say that and be descriptive. At that point, it is most likely that the physician may not be able to figure it out either.

Coordinating Treatment

Anticipate the physician's orders (for example, get out appropriate medications), then repeat the physician's orders after they are given.

Transport to definitive care should never be delayed by prolonged treatment in the field. Try to coordinate this with the physician. Perhaps the medications can be administered en route or a standing order can be given for predictable changes before termination of the consult rather than waiting for these changes to occur.

If you think there's a mistake or you want to do something and the physician denies it, try to ask why. If it takes too long and it's too complicated, call the physician after you get to the hospital. You might learn something, teach something, or find the picture sounded different over the radio compared with what you saw.

Medical consults are an extremely important component of prehospital care. Given the appropriate level of communication, they can positively impact on patient care.

◆ *Julie Ann P. Casani, MD, MPH*
Chairperson, Region III EMS Advisory Council
Director, Prehospital Education, Johns Hopkins Hospital
Fire Surgeon, Baltimore County

Maintaining EMS Radios

A significant portion of EMS radio equipment in Maryland is more than 12 years old. Keeping this equipment operating requires an intensive maintenance program. The EMS Communications Department at MIEMSS provides that maintenance program for any EMS radio or monitor/defibrillator used by a Maryland public service ambulance company, as long as the equipment meets MIEMSS' technical specifications.

(Background) Phil Lazarus (EMS Communications, MIEMSS) repairs field radio equipment while (foreground) Rich Berg (EMS Communications, MIEMSS) prepares Frederick County console for installation.

MIEMSS' personnel maintain the radios in Region III and in Cecil, Frederick, and Prince Georges counties. The EMS Communications Department contracts with private firms to service radios outside those areas. In most areas, all firms will respond to repair or replace radios within 4 hours for ALS units and by the next regular business day for BLS units. The 24-hour number to contact for radio repair is 1-800-492-1185. Call this number for maintenance as soon as the communications problem is discovered, not at the end of your shift. Some jurisdictions request that you contact the Central Dispatch Center to contact MIEMSS for you. Contact your local EMS authority to ascertain the proper procedures in your area. Individual contractors should not be contacted directly.

Communications difficulties are not always caused by an equipment failure. There are areas of the state that have marginal signal coverage. The EMS Communications Department is aware of the location of most of the areas and plans improved coverage as funds are available. If you suspect that your difficulty was due to poor coverage and not an equipment failure, please notify your regional office at your earliest convenience.

Installation of radios is not included in the maintenance contracts. If MIEMSS initiates the need for an installation (for example, new or replacement radios) or if a new ambulance service is being established, then the EMS Communications Department assumes the responsibility for the radio's installation. If the ambulance company initiates the need for an installation (for example, the replacement of a medic unit with a new ambulance), that ambulance company is responsible for completing the installation. MIEMSS can suggest reliable contractors in your area to assist in such situations. Contact your regional office for more information. If you plan to establish a new ambulance service and require EMS communications equipment from MIEMSS, make sure that your regional administrator is aware of your needs well in advance. Without proper notice MIEMSS cannot guarantee that equipment will be available to meet your needs.

MIEMSS is responsible for the maintenance of all EMS radios that meet MIEMSS' specifications regardless of ownership or who completed the installation.

All monitor/defibrillators meeting state specifications are repaired by the EMS Communications Department at MIEMSS. To arrange for service, you may bring the unit to the shop or contact your MIEMSS regional EMS office. You will be provided a loaner unit if your monitor/defibrillator requires overnight service.

MIEMSS remains committed to providing you with a reliable EMS communications system. It continually strives for resources to address deficiencies. You can help by addressing equipment problems as they happen and by notifying your regional office of marginal coverage areas.

◆ *John Donohue*
Administrator, Region III

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DATED MATERIAL

Some Considerations Before Buying a New Ambulance

Planning on purchasing a new ambulance or having EMS radio equipment installed? You may wish to consider the following list of suggestions for wiring specifications which could save you time and mitigate problems in the long run.

1. There should be two electrical outlets, each capable of supplying 12 to 14 volts at 20 amperes vehicular power, located adjacent to the radio and antenna outlet. The power source for these outlets should be uninterrupted by master and ignition switches.

2. Connection across the vehicle battery is recommended, with the proper protective device (fuse or circuit breaker) clearly marked and easily identified. Federal specification KKK-A-1822-B calls for a Cannon-type MS 3112E12-3S wall outlet in this application.

Frank Forte (EMS Communications Dept.) tests radio equipment in the shop at MIEMSS.

3. It is suggested that the mobile antenna be installed on top of the patient module—an Antenna Specialists Inc. model ASP 1650, or equivalent, should be employed here.

4. The radio and its associated wiring should be positioned to facilitate service when required.

Because there are many variations in ambulance interior and electrical design, any questions arising prior to installation or purchase should be directed to the EMS Communications Department of MIEMSS, located at 636 W. Lombard St. in Baltimore (phone: 301-328-3668).

◆ *Frank Forte*
EMS Communications

Conference Cosponsored By Poison Center, MIEMSS

"Speak Out: Better Health Care Through Community Service" will be held February 17, from 8:30 am to 3 pm in the Dean E. Leavitt Memorial Hall, in the University of Maryland School of Pharmacy on Pine Street in Baltimore. The conference is cosponsored by the Maryland Poison Center of the University of Maryland School of Pharmacy and MIEMSS.

The conference will focus on helping nurses, prehospital care workers, pharmacists, and other health care professionals to present information to the community dealing with such topics as poison prevention and treatment, drug abuse/prevention, and use of medications by the elderly.

For information, call 301-328-7604.

EMS Care '91
April 26-28, 1991

Greenbelt Marriott Hotel
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Hosted by Prince George's County Fire Department

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