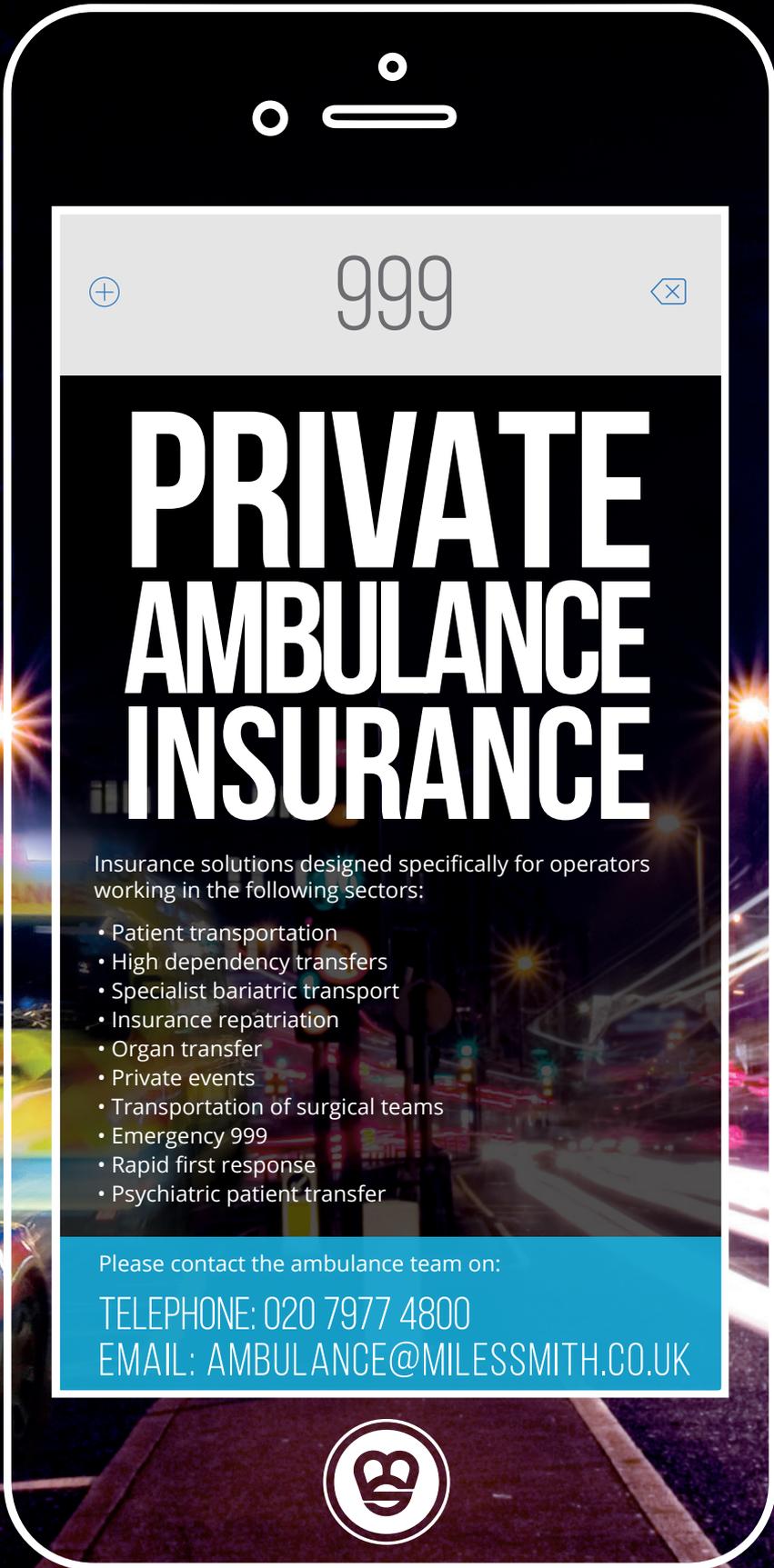




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Joe Heneghan
Editor,
Ambulance Today

The More You Know...

Albert Einstein once incisively remarked that “Education is not the learning of facts, but the training of the mind to think”. There is a subtle difference here between the traditional ideas of education and training which we pick up in our school years, and the true meaning of education and learning which find in real life. And this subtle difference holds great weight and poignancy in emergency healthcare.

Very quickly, when we leave school and adult life and responsibility are dually thrust upon us, we realise the importance of adapting. We learn very quickly that life does not follow a script, and that the set things we have learned at school are not always 100% applicable to that scenario. Life, and its many guerrilla-esque lessons, which seemingly spring up on us from nowhere, very quickly teach us that the most valuable lesson we can adopt is indeed *how* to learn in the first place. That we will never have all the answers to every possible scenario, as the array of possible scenarios that can hit at any one point is just too vast and uncertain.

The only thing we can do to prepare ourselves is to learn two things: *how to learn quickly* and how to think even quicker on the spot. How to take a core lesson, and to spontaneously adapt it to the situation lying on the ground in front of you.

Learning never stops and is about adapting to a situation in order to solve it. Here's a problem, now give me a solution. Yes, it's an incredibly similar problem to the one you encountered with that neonatal case last week, almost identical in fact, but it might not be the same. Are you going to give me the same solution? Thinking quickly and adapting, as I say. Using a mix of lessons and experience to grope your way along in the dark, fishing out details along the way, until you get to an understanding, and then a solution.

Yes, learning never really stops. Certainly, the more educated I get, the thicker I realise I am. Every new lesson reveals further pools of unexplored knowledge I never even knew existed. This shows me that, no matter how expert I get, there is always something more to learn. Someone who has been there and done it before me. Is their method outdated in my eyes? Maybe they haven't heard the most recent study we were taught in class last week? Maybe the problem is that my understanding of learning is still too naïve, as the modern-day teachings and new discoveries can be mixed with more 'old school' approaches quite beautifully, often leading to a very balanced mix of high technical ability with exemplary shows of understanding and care.

There are many interesting articles in this edition of *Ambulance Today*, as usual. The overall focus has been on education and training, as well as a slight focus upon technology. I suppose, without quite realising it, I was going for a unifying theme of development in this respect. Either way, despite the amount of truly stimulating and thought-provoking articles in this edition, I feel that two in particular really embody what I am trying to say here.

Firstly, our South African correspondent, Mike Emmerich, gives an amazingly insightful discussion on the importance and nature of critical thinking. Here he observes—rather wisely in my opinion as I feel many innocently overlook this point on a day-to-day basis—that “for the lifelong learner, everyone has something of value to contribute, irrespective of what environment or years of experience are on the table”. And I haven't been able to put it better than that in the past 600 words. You don't know everything. Never can, no matter how deep your expertise. Other people know

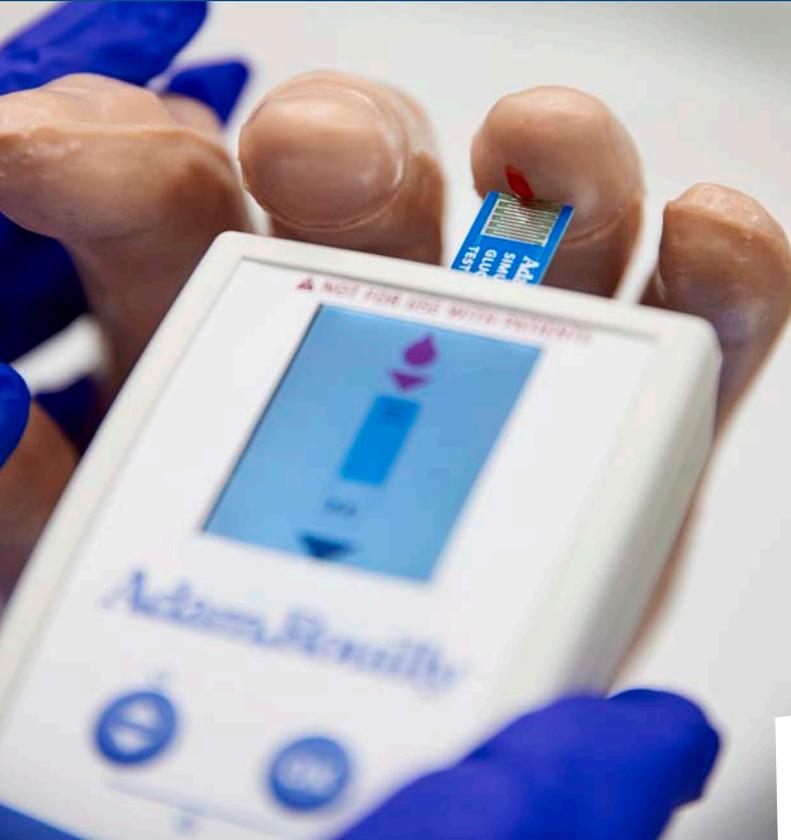
things you don't. Never disregard an opportunity to learn something new.

Secondly, we have an article that I am *highly* excited to introduce you to. Academic and qualified EMT, Mark Weiner, delivers a piece which looks at what can be learned from the patient's perspective. This is something which is constantly on the minds of EMS staff, or at least as much as realistically possible anyway. This job takes its toll on you, and you can't all be flawlessly and consistently empathetic all of the time. Patience and empathy can dip a bit when you go from one truly traumatic call onto another where the person might be being a little bit overly sensitive to the situation, if I want to put it politely. Mark takes a look at what can happen when we are able to overcome this and remember that some people, hurtfully but truthfully, do not see a person trying to help but only see a badge and a uniform. More so, he not only takes a look at what this means for you, for the public at large, and for society in general, but at how this can then be taken, used, and turned into something truly beautiful where both sides can learn something from each other. As I said. You never know everything. Some people know things you don't. Never write off an opportunity to learn... even if it's from the annoying patient shouting in your face. There's always another perspective, always a cause behind the action, always a piece of information which can help you find a solution.

So, with that, this edition celebrates the many fruits which education and learning have to offer. I hope you thoroughly enjoy it and get as much as you can out of it. Milk it for every useful drop, in the name of education. Experience, learning, education—they are key to expertise and proficiency.

Joe Heneghan
Editor,
September 2019

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Pp.7 UNISON Update: Pensions Remain Top on the List of Priorities for Ambulance Staff

Colm Porter, UNISON's National Ambulance Officer, give a detailed

account of the ongoing discussions regarding UK government policy on retirement age and pensions, and the very real effects that these could have on those working within the Ambulance Service.



Pp. 9-15 EMS for Democracy: The Case of Människan Bakom Uniformen

Mark Weiner gives an enthralling account of his time spent with the

ambulance service in Gothenburg, Sweden, and the questions he found through his experience with the MBU social program, which brings teens and young adults from disparaged backgrounds into very real and human encounters with the services that are sometimes seen as symbols of the State they feel neglected by. He poses a series of enlightening questions about the roles which emergency services play in the dynamic between society and emergency provider.



Pp. 18-19 United Hatzalah: Creating a National Flashmob of EMS Lifesavers Through Education

International Media Spokesperson, Raphael Poch, explains in detail how United Hatzalah, a voluntary

service based in Israel, manages to sustain a national average response time of under 3 minutes: intelligent, systematic implementation of education and training being key.



Pp. 20-21 MDA's Multiple Casualty Incident Seminar Empowers communities to Help in the "First Seven Minutes"

Magon David Adom, also a huge voluntary service spread across Israel, explains how their international educational seminars and training sessions have helped to create communities of first responders who are highly prepared to respond to Multiple Casualty Incidents until first responders arrive in a way which can genuinely aid those professionals who arrive first on scene.

Also inside: Our Dutch correspondent Thijs Gras on the new measures taken by WAS to promote clinical outcome over response times, Intersurgical introduces their disposable i-view video laryngoscope, Vimpex presents the rugged R6C helmet from Pacific, we have our regular features from the National Association of Emergency Medical Technicians (NAEMT), our usual local news in the Out & About section, and the latest in news from the supply chain in our Products & Suppliers section.

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Pp. 22-23 A World First: A Completely New Development in Haemostatic Gauze Promises Massive Success in Traumatic Bleeding and Haemorrhage Control

Ambulance Today offers an introduction into EMS' currently best-kept secret: a completely new version of haemostatic gauze unlike anything we've ever seen before. It may sound normal, it may look deceptively familiar, but this newly developed piece of kit is the next step in operational evolution and will mean massive things for trauma care and triaging once adopted on the global scale it deserves!



Pp. 24-25 The Miscarriage Association Launches New E-learning Resource for Medical Professionals

Ambulance Today is proud to introduce charitable NGO, the Miscarriage

Association. They have put together a completely free e-learning course, which prepares you in how to deal with patients suffering miscarriage. You can click the link at the end of the article if reading the digitised version of this edition, to be taken directly to the course material.



Pp. 32-33 Wherever You Wander

The International Academies of emergency Dispatch (IAED) give an introduction to the what3words app, which is currently being implemented

into various CAD systems across fire, police, and ambulance alike, allowing emergency response to an incident within a 9 square meter radius.



Pp. 34-35 From the Africa Desk of Ambulance Today: The Challenge of Critical Thinking in EMS

Our Africa Correspondent, Mike Emmerich, gives a fascinatingly insightful opinion piece on the crucial

importance of critical thinking. As it turns out, the classroom is only scratching the surface- the field, your colleagues and your own experiences are the true teachers here. Tread thoughtfully.

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Pensions Remain Top on the List of Priorities for Ambulance Staff



Colm Porter
National Ambulance Officer,
UNISON

With all the focus of Brexit you mightn't have noticed but public sector pensions are back in the news.

In 2015, for an overwhelming proportion of NHS pension scheme members, their retirement conditions deteriorated when the Tories forced through the introduction of the 2015 scheme despite a hard fought campaign by UNISON to stop this.

A recent legal case, however, has found that elements of the fire fighters and judges pension schemes to be discriminatory based on age. Specifically the protections that were introduced for scheme members who were closest to retirement when changes to the public sector pension schemes were introduced.

The government have stated that this judgment applies to all public sectors pension schemes, including the NHS, that have similar protection arrangements in place.

Take the example of the protection arrangements in the NHS; if you were within 10 years of your retirement on 1 April 2012 you received full protection, meaning you retained all the benefits of your old scheme. If you were between 10 and 13.5 years of retirement you continued to build up benefits in your old scheme and moved to the 2015 NHS Pension Scheme but at a later date. This is called tapered protection. While those with more than 13.5 years before their retirement moved into the 2015 scheme on 1 April 2015.

According to the government the difference in treatment provided by the transitional arrangements will need to be remedied across all public sector pension schemes including the NHS.

What form this remedy will take is still unknown but UNISON is working with the other NHS trade unions, employers and government departments to

understand the implications this will have on the NHS pension scheme.

In other pensions news, an influential conservative think tank, that's fronted by Tory grandee Iain Duncan Smith and ironically called the Centre for Social Justice (CSJ), has called for the state pension age to rise to 75 over the next 16 years.



While this is not yet government policy given the CSJ's influence it's not impossible to imagine a greatly increased state pension age in years to come. This stance brings sharply into focus not only the ongoing issue of retirement age in the ambulance service but how out of touch elements of the government are when it comes to ambulance work. If you follow the logic through, the impact this would have on ambulance workers is staggering. The normal pension age in the 2015 NHS Pension Scheme, which is the age you can take your pension unreduced, is linked to your state pension age. This means that, if the recommendation from the CSJ was accepted, from 2035, paramedics and other ambulance staff would be working until they are 75 before receiving their full NHS pension. Something that would be bad for staff, bad for the service and ultimately bad for patients!

At our annual health conference in April, UNISON renewed our commitment to reduce the pension age for ambulance staff. A motion from the UNISON North West Ambulance branch, which was

carried unanimously by conference delegates, called for ambulance staff to have a retirement age of 60 which would bring them in line with the other blue light services. The ambulance service often suffers from an identity crisis - is it the medical wing of the emergency services or the emergency services wing of the NHS? At times it feels like the ambulance service gets the worst of both worlds and retirement age is one of the areas where this issue manifests. However, the fact remains that someone joining the ambulance service today fresh out of school or university won't have the opportunity to retire until they are 68, while if you were to join either the police or fire service you could retire at 60.

Considering the physical and physiological demands on staff working in blue light services, to have staff in one of these key services working until they are 68 is simply unfair and, as demands on the ambulance service show no sign of slowing down, it is also becoming increasingly untenable.

UNISON believes that this is a problem created by the government and is fundamentally down to them to fix but we would also call on ambulance employers and the Association of Ambulance Chief Executives (AACE) to publically support a retirement age for ambulance staff that is in line with the other blue light services.

It is only when ambulance employers and trade unions are working together that we will get governments to act on this matter.

Colm welcomes feedback from ambulance staff and can be contacted at:
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EMS for Democracy: The Case of Människan Bakom Uniformen



By Mark S. Weiner

A hard rain was falling on the streets of Stockholm that night as a man lay unconscious in the parking lot, his face illuminated by flashing blue lights. While onlookers snapped photographs—me foremost among them, because I was observing this special simulation exercise—police led the dazed bus driver from the scene and the medics got to work.

A neck brace. A spine board. TBI? An elevated train raced overhead with a deafening roar. *Where was that smoke coming from?* A firefighter dragged a hose through the hazy dark.

More medics arrived—more blue lights *on, off, on, off*. They carefully boarded the bus through the rear, boots thumping as they walked. A man sprawled in the aisle was complaining of chest pain. Smoke began to billow through the door. What to do?

On the tarmac in front, meanwhile, the lead medic checked that his patient was secure, and he prepared his team for the lift. His glasses reflected the flashing blue lights back into the shadows. *“One, two, three,”* he called. His

team wheeled the stretcher toward the open doors of the waiting ambulance.

Perfectly done—textbook.

He’s just a teenager, I thought admiringly, as I walked through the smoke, hoping that my camera would survive the downpour. I was thinking not of the patient, but of the medic. I was thinking in fact of all the participants in this special evening organized by *Människan Bakom Uniformen (MBU)*, the Person Behind the Uniform. Most of them were young people from rough, ethnic minority neighborhoods.

I caught the gaze of one of the firefighters. “Bra,” I said admiringly (that’s “good” in Swedish). He nodded, smiled, and reached for a nozzle to switch off the smoke. The second patient smiled as he walked off the bus.

Novelists use fiction to reveal the truth. Literature creates a moral universe that allows readers to see the world as it really is. One could say something similar about EMS simulations. A fictional emergency exercise reveals

something basic about the nature of the profession—and in the case of MBU, I think it shows something in particular about its social and political role. It highlights its public importance well beyond medical outcomes.

In a book that I am beginning to research, I aim to explore this broader aspect of EMS, which I believe is underappreciated even within the profession itself. The book has the working title of *A Social Theory of Emergency Medical Services*, and in writing this essay, and a series of occasional articles to follow, I hope to explore some of its themes in an open-ended way. In doing so, I am reaching out to you, the readers of *Ambulance Today*, for input and advice.

The largest underlying questions of the book are these: How can we understand ambulance work not simply in medical terms, but in social and political ones, too? What social and political values are enacted by EMS personnel in their daily professional practice and by the EMS system more generally? Finally, what is the social and political role of EMS in a modern liberal democracy?

These are somewhat unlikely questions, I know. I have been led to ask them through an unlikely train of events. Before I return to that rainy night in Stockholm, let me share a story about how I got there in the first place—a story about how two different ways of thinking gradually came together.

I have spent my career not in ambulances, but rather in libraries and lecture halls. By training, I am a professor of cultural history and constitutional law. I teach students about the basic principles of democracy, and the books that I have written



MBU students navigate a high-level simulation involving a bus



Snapshot of a training exercise between professional medics and MBU students

consider how those principles are expressed in social practices. Many of them touch on issues of citizenship and civic belonging, and they have a philosophical bent.

One day when I was at my kitchen table writing one such book, I heard a crash. Or, rather, I felt it—the sound struck me like a body blow to the core. By the time I reached the old sedan that had smashed into a wall at the end of my street, carbolic smoke was filling the cab. Through the window I could see the driver, a bariatric middle-aged man, twitching and foaming at the mouth, turning blue as I wrenched open the door and began tugging at his jammed seatbelt. I felt utterly helpless.

I started hack coughing. Frantically coming up for air, I saw that a crowd had formed. Among the onlookers was a young gentleman in a button-down shirt. “You!” I shouted, pointing straight at him. “You. Come help.” The only time I had ever pointed at someone like that before was when asking a student an especially tough question in class. Together we dragged the driver from the car and lay him on his side. He vomited and began to breathe in rasping gulps.

A few minutes later, he was whisked away in an ambulance. “We’ve got it from here,” intoned one of the EMTs as I sat on the curb, dazed and panting. Sirens blared as I watched them pull away.

When one of my first EMS instructors asked, months later, “so what was the emergency you thought you couldn’t handle that brought you to this course?”, that was an easy question.

One EMS course led to another, and another, and eventually I found myself with a basic EMT license—and that very nearly led to ... nothing. After I certified, I looked for ways to participate in wilderness search and rescue (I spend a lot of time outdoors), but opportunities near me turned out to be scarce. Without regular training, my skills began to wane. Things got busy. In time, I began to count my EMS training as just an interesting interlude.

Then the world threw me another curve ball. I was at an academic conference

in New York, about to deliver a philosophical paper, when I heard a voice call out, “has someone called 911?” I turned and saw a colleague slumped against a wall, gasping for air, his eyes bulging. This time, I reacted differently. My training kicked in just enough for me not to fumble things completely.

When the pros arrived in an ambulance a few minutes later, I handed them my notes. “Thanks,” said one of the EMTs, looking them over. “Really helpful.” I am confident that they must have been the most poorly organized, illegible set of patient vitals he had ever seen, but his words still felt good. Letting my EMS education go to waste suddenly seemed like a very bad idea.

I recertified. I renewed my license. I began to volunteer for a suburban ambulance service not too far from my home (I am still just a probationary fledgling). Then, as I watched my colleagues work, trying to learn from their example, I naturally began to ask the kind of questions about EMS that I have been asking about other institutions and practices throughout my life: questions not about technique, about how to do, but rather about societal significance. When first responders do what they do best—saving lives—they also send important social and political messages to the whole community. What messages do they send?



Cooperation between professional medics and MBU participants during the main simulation exercise

Take lights and sirens. On one hand, they serve a utilitarian purpose: to clear a path so an ambulance can reach its destination swiftly and safely. That's why there is growing empirical literature about whether driving with them is truly helpful or, ironically, increases EMS vehicular accidents.

But consider lights and sirens not from the perspective of a medic behind the wheel, but rather from that of average citizens going about their business blocks away. For them, the siren's wail isn't utilitarian; whether they hear it or not is immaterial. Instead, it plays a cultural role. The siren tells a story: "there has been an emergency, perhaps an accident, but medics are taking care of the victims."

That story has a profound political importance. One of the first purposes of government, at least in liberal democracies, is to protect life. Government's ability to protect life is indeed one of the basic justifications for the state's existence. In the words of the American Declaration of Independence of 1776, life is an "unalienable right," and it is to secure life that governments "are instituted among men." When an ambulance siren sounds, it signals that this basic aspiration of government is being fulfilled.

Switching on lights and sirens, then, is an act of political communication as well as a utilitarian tool. Switching



Mark Weiner in conversation with Swedish Ambulance Nurse/Ambulanssjuksköterska, Leila Haddadi

them on proclaims the benevolent character of public authority. Medics using the siren make this proclamation nearly every day they work, weaving it deep into the social fabric.

Or consider the interaction between a medic and patient. On one hand, the encounter is a pragmatic one. Making patients feel secure, taking their vitals, treating major injuries, getting them to definitive care—that's the chief goal of EMS. Yet something happens in the encounter that also goes to the core of civic life.

A long line of philosophical thinking, reaching back to G. W. F. Hegel in the nineteenth century, tells us that people come to know themselves as

members of their political communities only when they are "recognized" as individual subjects by an institution that wields public authority. Indeed, Hegel argued that it's only by encountering and being recognized by something or someone outside themselves that people become full psychological beings at all.

In these terms, when a medic approaches a patient, he or she implicitly announces—as a community representative—"I see you." When the patient in turn responds by placing trust in the medic, he or she accepts a relation of dependence on the community that is providing for his or her care. He or she comes to self-consciousness as a community member *through* EMS as an institution. The patient sees his or her own image reflected back in the mirror of the medic's eyes.

This psychosocial moment of recognition means that the way medics interact with patients is significant for political, as well as medical reasons. When a patient feels disrespected, it not only erodes the conditions for optimal treatment but also degrades public life. Remember the 1990 hit single "911 is a Joke," by the American rap group Public Enemy? Watch the video: www.youtube.com/watch?v=CPNK0VspQ0M. It builds its wide-ranging critique of American society on the back of a completely slanderous portrayal of EMS.



MBU founder Janina Sabra shows the signed helmet she received as thanks from first responders and MBU participants



Close up of the famed MBU helmet, a testament to the deep bonds and inspiration created through the program

As unfair as its portrait is, the video teaches an important lesson. For civic culture, a medic who acts dismissively toward a patient is the medical equivalent of a police officer who roughs people up without cause.

Alternatively, medics can treat patients in ways that foster community cohesion. For instance, when a patient speaks a foreign language and a medic can say a word or two of greeting in it, the medic “recognizes” the patient as a full person, which in turn can help bind together the separate parts of a pluralistic society. Likewise, when medics invite patients to participate in their own care, for instance by asking them to hold a bandage on their own wound, they encourage a sense of personal agency and self-sufficiency, which helps support democratic life.

Finally, consider the fact that one of the most common locations to which medics are dispatched is a family home. Patients often need our care precisely when their families are incapable of handling a health crisis on their own.

According to Aristotle, the family is the core political association that gives rise to all later, more complex political units. Family to tribe, tribe to village, village to city, and, now, city to nation—the family lies at the heart of it all. In arriving on scene at a home, then, first responders step in and perform one of the key roles of the family, caring for one another, but they do so as agents of the larger political community.

Moreover, by doing so they participate in a vital drama of public sacrifice. In assuming the family’s role, first responders often put themselves in personal jeopardy. They suffer in all the ways that readers of this magazine know well. They expose themselves to blood-borne pathogens. They confront the danger of angry bystanders. They endure post-traumatic stress.

In all societies, modern as much as ancient, complex as much as simple, such sacrificial activity makes community possible. And it draws the boundaries of the community to include those for whom a sacrifice is made. (This dynamic, indeed, lies at the ancient core of most religions, but that’s another matter.) We are used to thinking about the personal sacrifice of ambulance medics as the basis of their public reputation as heroes. But it also establishes and fosters the cultural preconditions of civic life.

The stakes of EMS, in short, are social, political, philosophic, and even metaphysical. I think most of us

recognize this fact instinctively, and we may even talk about it in a general way in after-work conversation. But I believe that we could help ourselves professionally, and personally, by speaking about these issues more than we do, and by developing a systematic way to understand them.

This brings me back to MBU. Channeling Hegel and Public Enemy, both philosophy and politics came to mind as I watched the emergency simulation in Stockholm’s deep December dark. That was no surprise: I had been prepared by my conversations with Janina Sabra.

Sabra, 31, is the tough yet caring director who heads up MBU from its base in Gothenburg, a bustling port city on Sweden’s west coast. I was spending the 2018-19 academic year in Sweden as part of an American citizen-diplomacy program, and I had been speaking with Swedish ambulance personnel in various cities as a way to get to know the country. Along the way, I heard about MBU, and I thought it could provide an interesting window into Swedish society. Sabra offered to show me the group’s headquarters.

As we strode through the swinging glass doors of a youth center in the eastern half of the city, two bearded hipsters playing guitar on an old couch looked up and smiled. Both clearly had ethnic roots in the middle east. In the meantime, a young woman wearing Doc Martens, whose parents hail from east Africa, was preparing sandwiches in the communal kitchen. Her hand gestures were straight out of American hip-hop, even though she had never been to the United States. Sabra led me up a set of open metal stairs to her office, where she proudly displays a hardhat signed by dozens of first responders—a gift of gratitude for her work.

The children of immigrants, Sabra and her colleagues embody one of the most significant facets of contemporary Sweden: it’s a country in the midst of a demographic revolution. Long known for its ethnic homogeneity—in 1930, only 1 percent of the population was foreign born, half from neighboring Nordic countries—Sverige has become



Ambulance Nurse, Daniel Björsson and firefighter, Yama Mirbaz, taking an MBU student through a training exercise



Humour acting as the best teacher during an MBU training session

off meet-and-greet, it's an extended, focused seminar that requires significant time and effort from everyone involved. Imagine a college class called "First Response 101," taught by the coolest professors you've ever met, with individual sessions devoted to different branches of the field: EMS, fire, police, private security guards, and even tram operators.

Each MBU term runs for a full 10 weeks and includes about 20 participants between the ages of 15 to 25. Attendance at all sessions is mandatory to earn a certificate of completion, which adds real value to school and job applications. After each semester ends, graduates are encouraged to continue to be a part of the organization in a leadership role, tutoring new participants and serving as MBU ambassadors in their communities. It's all about time, commitment and focused attention—yet despite its demand for resources (in fact, I would guess precisely because of the good things those demands produce), what began in Gothenburg has now spread to over a dozen cities throughout the country.

The program begins gently. Participants and first responders play games and shoot the breeze, enjoying each other's company. Each student receives a stylish black T-shirt bearing the MBU logo. There's plenty of comfort

a coveted destination for economic migrants and asylum seekers. Today the foreign-born population stands at nearly 19 percent of 10.1 million inhabitants. The majority of new arrivals are Muslim, an important point of difference in historically Lutheran and now deeply secular Sweden.

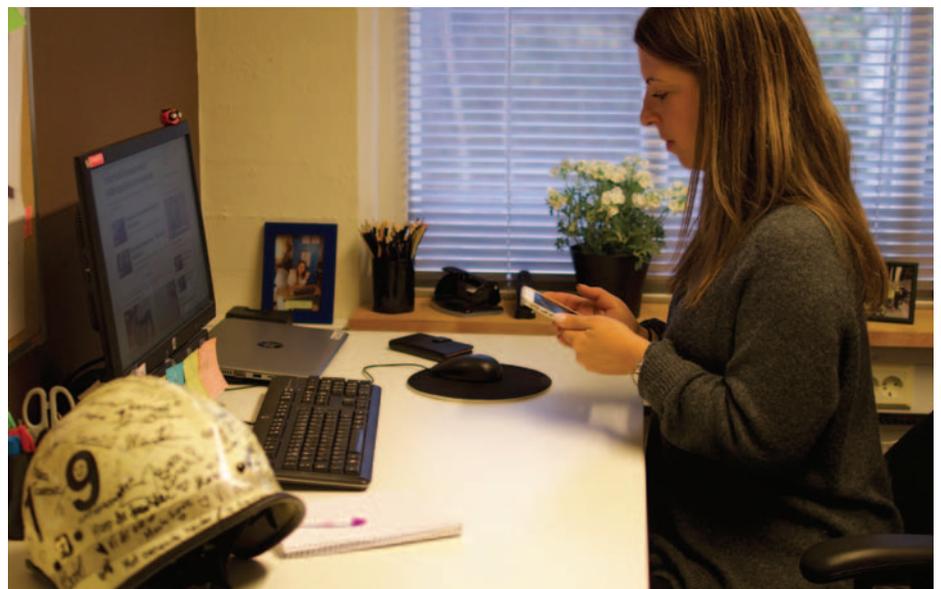
Many of these foreigners have ended up living in the majority-minority districts that the Swedish government officially calls "socially vulnerable areas." Swedish ghettos. Sabra grew up in one herself. Not surprisingly, social tensions have emerged in these neighborhoods, and first responders have been among the first to feel the heat. In a spate of headline-grabbing incidents, for instance, minority youth in numerous cities have pelted emergency vehicles with stones. Police have been the most common target, but fire trucks and ambulances have also been on the receiving end of the violence.

It's unclear just how widespread these incidents have been, but it would be difficult to overstate how deeply they trouble citizens in a country known worldwide for its respect for state authority.

One especially dramatic incident took place in Gothenburg in 2009 and led to the creation of MBU. Sabra speaks sadly when she talks about it, her voice trailing off into silence. Some young

men standing on a bridge pushed a breadbox-sized rock onto a passing fire truck below, smashing the front window and sending a firefighter to the hospital. He soon left the service in frustration. Episodes of petty violence had been common at the time, but this felt like an escalation. Concerned service members felt that something needed to be done, fast. But, ironically, what they created wasn't fast, but slow.

Människan Bakom Uniformen is a community outreach program with a twist. Rather than the usual one-



MBU founder, Janina Sabra



Ambulance Nurse, Daniel Björsson

food—this being Sweden, that means cinnamon buns and coffee. The participants create a warm community based on good times. But the next meetings—each lasting three hours, at night—are far more dramatic and intense.

Sabra leans forward in her chair as she explains. Half of the sessions feature first responders talking frankly about the difficulties of their work and participants sharing their own prejudices about first responders. That can be tough, but the groundwork for serious exchange was laid in previous sessions. On other nights—and this is the part that interests me most as a scholar—participants are taught practical emergency skills by each service. They study CPR. They learn how to roll a patient on backboard. They climb a fire ladder. They use handcuffs. They drive a tram as it is pelted with stones, and they learn how to respond to an argument on board. The kids not only step into the shoes of first responders, they step into their boots.

Now that the participants are equipped their new real-world abilities, the program culminates in a multi-casualty incident—one that goes all out for realism. Sabra invited me to watch the exercise taking place in Stockholm a few months later.

From my home in Uppsala, I took a night train to a dark suburban station

and met my contact, ambulance nurse Daniel Björsson, 43. Tall, bald and muscular, he looks like a Viking from Erik the Red's medical response team, if Erik the Red had employed EMTs. I knew he was a deeply respected member of his service—an obvious leader.

Earlier that year I had tagged along with Björsson on an all-night shift to see the Stockholm service in action. I had watched him hold up a half-naked girl as she vomited into a bag after drinking herself into a stupor, take an ECG of a man panting on his bed as his wife watched on anxiously from above, and coordinate EMS response to a multi-alarm fire in a high-rise apartment block. Now I would see him in a very different role—a civic one.

Could an EMS simulation play a positive part in helping Sweden through its demographic revolution? And if it could, what might that reveal about the nature of EMS? Björsson was going to help me find out.

Björsson invited me to sit in the back as he drove an ambulance to the scene of the simulation. Sitting in the front passenger seat was a diminutive girl dressed in the service's green-and-yellow uniform. If she had been holding a couple of electric cables in her hands, I suspect that the excited energy she was radiating could have been used to power the ambulance itself. She was absolutely still and silent while she waited for dispatch. The call came through the crack of the radio. Priority one.



The main simulation involving a casualty with a bus, organised from MBU

For its drama and adrenaline-inducing special effects, the scene at which we arrived surely would have made Steven Spielberg proud. There was a large red bus pulled over at the edge of a parking lot, stopped at a distinctly strange angle. A man lay beneath the front wheel. The back door of the bus opened and out stepped a long line of talkative young women in headscarves. They began snapping pictures. With the rain, smoke, and flashing lights, it felt just like the scene of a major accident.

Björsson pulled his ambulance into position. The girl in the passenger seat stepped out. Remembering that her hair fell beneath her shoulders, she secured it tight. She got the stretcher from the cab. The last time I saw her, she was wheeling it toward the bus.

Björsson was proud of how his students worked that night—especially proud of the young medic who took care of the injured man at the foot of the bus. He did just as he had been taught to do. “Sometimes you think they don’t listen—but they did!” Björsson laughed. But what struck him most, he said, was that the young man had actively assumed a leadership role during the incident. He took command. I witnessed that myself. “On my count: *one, two, three*”—it was the voice of a young man growing up *through* EMS, imagining himself performing a vitally important civic role.

Could he or his peers ever look at EMS the same way again? Would they ever look at *Sweden* in quite the same way again—this place for which they were learning to take responsibility and, thereby, make their own? Could I



The opening scenes of the high-level simulation, organised by MBU, involving a bus

me think about them? Are there some that you would especially like to see addressed in these pages, or in my book? I would love to hear from you, either directly or through *Ambulance Today's* social media platforms. Next time, I'll be meditating on the cultural perception of ambulance personnel as "heroes"—who are nevertheless apparently not important enough to pay sufficiently, and on the frequent conflation of EMS and police.



Mark S. Weiner, Ph.D., J.D., EMT-B, is the author of *The Rule of the Clan: What an Ancient Form of Social Organization Reveals about the Future of Individual Freedom*, among other books. In 2018-19, he was the Fulbright Distinguished Chair in American Studies at Uppsala University.

ever look at EMS the same way again, seeing how it was used here as a vehicle through which young people could envision a society in which they would take care of others at the same time that others pledged to take care of them—a society of mutual interdependency?

EMS was helping bind this society together. But perhaps that's what it's always done, and is always doing, even as each of us focuses our attention on the patient immediately in front of us.

There are many other ways that EMS has a social and political role beyond its medical outcomes. Can you help



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The i-view™ Video Laryngoscope from Intersurgical: The Key Considerations



Author: David Chapman. Airway Group Product Manager. Intersurgical Ltd

Video laryngoscopy represents one of the most significant advances in airway management in recent years. With the increased emphasis placed on ensuring the first attempt at intubation is the best attempt, the role of video laryngoscopy in airway management seems secure, at least for the foreseeable future¹.

Video laryngoscopes utilise the latest video and camera technology to provide an optimal (indirect) view of the larynx during the process to insert an endotracheal tube in to the patient's trachea. There are many video laryngoscopes available, but the i-view™ from Intersurgical is the first single use adult video laryngoscope with a Macintosh type blade. i-view™ provides the option of video laryngoscopy, wherever and whenever the clinician may need to intubate, whether in a pre-hospital setting on a patient with a difficult airway or in the emergency room on a patient with respiratory failure. Where availability of a video laryngoscope may be limited due to the cost implications of purchasing reusable devices for multiple sites, i-view™ provides a cost effective solution, by combining all the advantages of a fully integrated video laryngoscope in a single use, disposable product. As i-view™ incorporates a Macintosh blade, it can be used for direct as well as video laryngoscopy, making it ideal for use in the emergency sector, where there may be a greater potential for the airway to become soiled with blood or other fluids, obscuring the view on the screen. In such circumstances, the operator can immediately switch from indirect to direct laryngoscopy.

As with all medical devices, whether single use or reusable, deciding on the most appropriate video laryngoscope to use is not straightforward, and

consideration may need to be given to a number of factors. These may include evaluation of financial, environmental and infection control related issues, as well as the clinical requirements, evidence and preferences. It is important to recognise this assessment may change according to where, when and how often the device is to be used.

Financial

Whilst a single use video laryngoscope may not initially appear to be the optimal choice from a financial perspective, in circumstances where multiple units are required, but it may not be used frequently, it may prove to be the most economic option. This might include use by a Helicopter Emergency Medical Service (HEMS) or by a paramedic on an ambulance.



The i-view™ in use

Infection control

In their safety guideline booklet (2008), 'Infection Control in Anaesthesia 2', The Association of Anaesthetists of Great Britain and Ireland (AAGBI)², confirmed that, in relation to standard laryngoscopes, 'Current practices for decontamination and disinfection between patients are frequently ineffective, leaving residual

contamination that has been implicated as a source of cross-infection.' They went on to note that, 'Blades are also regularly contaminated with blood, indicating penetration of mucous membranes, which places these items into a high-risk category.' They concluded that the use of single use blades was 'to be encouraged'.

Laryngoscope handles may also become contaminated. The AAGBI's recommendation in relation to laryngoscope handles is that they should be, 'washed/disinfected and, if suitable, sterilised by SSDs after every use.'

There is no reason to believe the same considerations and arguments that apply to standard laryngoscope blades & handles regarding infection control, would not also apply to video laryngoscopes, since all laryngoscopes, whether direct or indirect, incorporate some form of blade and handle.

In the EMS sector, where it can be particularly difficult to determine the potential cross-infection risk prior to treatment, a single use video laryngoscope offers an ideal solution.

I understand new infection prevention and control guidelines from the AAGBI are in the final draft stage, and after comments from members have been reviewed, a final version is to be presented to the Associations Board for approval.

Environmental

Environmental considerations are more complex and less easily assessed. Whilst it is appropriate for healthcare professionals, as well as anyone else with environmental concerns, to consider the implications of using single use devices in relation to product disposal, any assessment



Image taken at the ATACC Course in May 2019

of the environmental impact of any medical device, whether single use or reusable, needs to consider a number of factors. This should include disposal of single use devices, and reprocessing or decontamination of reusable devices, in the context of a complete Life Cycle Assessment (LCA). The considerations of an LCA may vary depending on the type of product being assessed, the range and type of information and data available and the objective of the assessment. However, typically, an LCA will usually consider the following areas:

- Raw material acquisition
- Processing & manufacturing
- Distribution & transportation
- Use, reuse and maintenance
- Recycling
- Waste management

Assessing just one element of an LCA, such as waste management, may result in misleading conclusions as to the overall environmental impact of a device. A decision also needs to be taken as to what impact factors are to be assessed and how much weight is to be given to each. Is the focus primarily on climate change and water use, or is there an interest in assessing other or additional factors, such as, ecotoxicity, eutrophication, ozone depletion or urban and natural land transformation?

A number of LCA's have been conducted for anaesthetic and airway devices. Their conclusions vary, and the complexity of any such assessment means the LCA usually needs to be considered as hospital or organisation specific; any variation in reprocessing practices, such as the volume of

water used during manual washing, the electricity consumption of different types of washer/disinfection unit, or the type of packaging material used for repacking after reprocessing, will all have an effect on the overall environmental impact. Decisions also need to be taken as to what to include and exclude. For example, should energy recovery from waste incineration or the environmental impact of Personal Protective Equipment (PPE) used by healthcare workers involved in reprocessing be included?

Of course, all products have an impact on the environment, but it is important to ensure the environmental assessment is considered alongside other key factors, such as infection control considerations and the clinical benefits offered by the device.

For example, the weight given to the clinical benefit of having a single use video laryngoscope available in a life threatening road-side emergency, perhaps when this might be the only viable VL option economically, might be quite different than the assessment made for regular routine use in the operating theatre.

In an interesting paper published in the British Journal of Anaesthesia, entitled, 'A national survey of video laryngoscopy in the United Kingdom', Cook & Kelly³ reported on the results of an electronic survey sent to all UK National Health Service Hospitals. With regard to availability of video laryngoscopy (VL) by clinical area, 91% of operating theatres reported availability of VL. In contrast, only 55% of Obstetric departments, 54% of Intensive Care Units and 35% of Emergency departments reported availability of VL. The authors noted

that, 'The distribution of availability is notable because the incidence of difficult or failed intubation increases in those places where video laryngoscopy is less available; in order, main theatres, obstetric, ICU, and the ED.'

It is not known why VL was less available in these areas, but it is possible that with less frequent use than in the OR, the financial implications of purchasing a reusable VL may have been a factor. If so, availability of a single use device might provide a more economically viable option due to its lower unit cost, which as discussed earlier, may be more economic when use is infrequent.

In summary, the i-view™ video laryngoscope from Intersurgical is the first single use adult video laryngoscope with a Macintosh type blade. It provides the option of video laryngoscopy, wherever and whenever the clinician may need to intubate. This makes VL a viable option in places where the higher initial costs of purchasing a reusable device may previously have been prohibitive. With the new focus in airway management of ensuring the first attempt at intubation is the best attempt, i-view™ may have a contribution to make to support this objective. Whilst it may not be suitable in all situations, such as when a hyper-angulated blade is required, it may be ideal in situations where use is infrequent, standard blade geometry is preferable and the nature of use makes it a more viable option economically.

Deciding on the most appropriate video laryngoscope to purchase and use is not straightforward, and in addition to the clinical requirements and preferences, consideration may need to be given to a number of other factors, including financial, environmental and infection control related issues. It is important to recognise this assessment may change according to where, when and how often the device is to be used.

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United Hatzalah: Creating a National Flashmob of EMS Lifesavers Through Education



By Raphael Poch, International Media Spokesperson, United Hatzalah

One key element in creating what is likely the fastest EMS response time in the world (a national average of less than 3 minutes) was developing what has been termed a national flashmob of EMS first responders, comprised of fully trained EMTs, paramedics, and physicians who immediately drop whatever it is they are doing at a given moment specifically to respond to emergencies within their local vicinity. In order to achieve this national network of volunteers that numbers around 6,000 men and women from all communities, cultures, and religions in Israel, United Hatzalah needs to expand its operation from simply responding to medical emergencies to also include focus on continual training.

United Hatzalah is a national EMS organization serving Israel, fully staffed by volunteers, which provides all of its services completely free of charge. The organisation teaches between 35-40 fully accredited EMT training courses that are recognised and supervised by the country's Ministry of Health. Each course is comprised of between

25-40 people and is based in specific regions where the need for additional responders is greatest. "We have a dedicated education department that not only attends to the needs of the instructors and students whilst dealing with the logistical challenges of these courses that are offered across the country, but they also assess where a new course is needed based upon population density, the average number of emergencies in the given area and how many responders are already in that area," explains President and Founder of United Hatzalah Eli Beer. "The system is incredibly effective. If for example, we see a rise in medical emergencies in a city in the north, say Nahariya, then we will work with our chapter head in that region and open a new training course to increase the number of volunteers we have there. The more volunteers we have, the faster our response time will be."

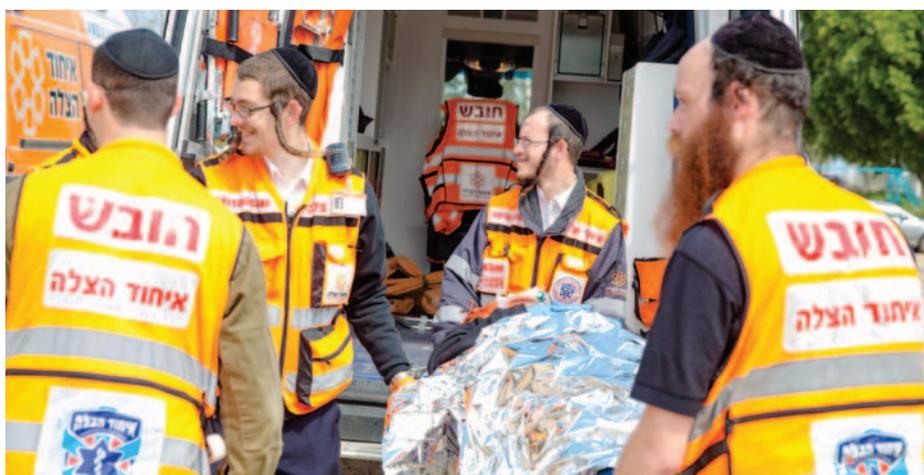
Graduates of the EMT courses given by United Hatzalah hold the level of EMT-b and respond to all types of medical emergencies around the country.



A search and rescue training drill for collapsed buildings

Each volunteer responds to medical emergencies in their close proximity in order to arrive at the scene within less than three minutes. The more volunteers that the organisation has, the more widely its lifesaving network will expand and the faster it will have a fully trained first responder in the door whenever and wherever a medical emergency occurs. The volunteers either use their own private vehicles or one of the organisation's iconic ambucycles or ambulances.

But the basic courses are just the beginning of United Hatzalah's educational component. As the official training partner in Israel of the American Heart Association and the US-based National Registry of Emergency Medical Technicians (NREMT), United Hatzalah is Israel's only organisation that can train volunteers to be licensed both in Israel and in the United States. United Hatzalah offers training classes that are certified by both the AHA and the NREMT respectively and has a medical department that continuously oversees the level and quality of training. Each volunteer that wishes to become a first responder in Israel must undergo no less than



A general training exercise for United Hatzalah. Photo courtesy Shira Hershkop



NREMT ambulance training

three rigorous tests administered by seasoned paramedics (EMT-p) whose responsibility it is to ensure that the volunteer has not only a mastery of the information learned and its practical application but also the expertise to manage a scene by themselves, even if that scene is an MCI (mass casualty incident).

Proper triage and scene management protocols are taught to every first responder as part of the EMT training course. "With a response time as fast as ours, our volunteers often find themselves at the scene of a medical emergency long before an ambulance arrives," explained Chief Paramedic Avi Marcus. "These scenes can be anything from assisting an elderly patient who is suffering from weakness, to suicides, a major motor vehicle accident and even

terror attacks. Our volunteers need to know how to respond to any medical emergency in the appropriate fashion befitting that scene."

Together with the head of the medical department, Alon Basker, Marcus is in charge of making sure that each and every one of the 6,000 responders also fulfil their requirements of participating in an annual retraining course. "To be a licensed EMT in Israel, each responder needs to undergo an annual training course that focuses on a number of specific items that the organisation feels need an extra level of attention. We generally focus on techniques that are not commonly used in the field by all first responders. This year we covered some newly developed techniques of wound packing, paying closer attention to

the number of questions asked when taking an oral history so as not to belabour the patient, and familiarising the responders with the techniques of applying the Asherman chest seal bandage, an item that was just brought back into the standard protocol of application on open chest wounds in Israel. By focusing on the less used aspects of the tools and techniques an EMT uses, we build the volunteer's exposure to them so that they can more comfortably use them in the field, should they ever come across a situation in which they are required."

Other elements that are unique to United Hatzalah's EMS training program include cultural sensitivity courses that educate responders about how to properly treat patients from other cultures or religions while taking into account their religious sensitivities. This course often bridges the gap between Muslim and Jewish students who often participate in courses together. Another unique element of the course is the addition of a special psychological first aid (PFA) training class given by one of the members of the organisation's Psychotrauma and Crisis Response Unit that teaches EMTs how to identify patients or other first responders who are suffering from shock or emotional stress reactions at a traumatic scene.



*A water rescue training exercise in Tiberias.
Photo courtesy Shira Hershkp*

In the past 12 months, United Hatzalah has graduated 35 training classes, and more than 1,000 new volunteers have joined the national network of first response volunteers. The goal of the organisation is to train enough responders across Israel so that the national average response time goes down to 90 seconds.



Defensive ambucycle training

MDA's Multiple Casualty Incident Seminar Empowers Communities to Help in the "First Seven Minutes"

Article supplied by MDA

Today, countries around the world are seeing a rise in mass casualty incidents. With increases in terrorist attacks in developed countries, car accidents related to smartphone usage and climate change-induced natural disasters, Israel's national ambulance service has developed a unique program to better prepare communities and physicians to address the rise in mass casualty incidents and disaster events. Innovative in its methods and audience, Magen David Adom (MDA)'s "First Seven Minutes" course uses Israel's unique experience dealing with Multiple Casualty Incidents to help communities around the world prepare for similar events.

MDA's Instructor and International Relations Coordinator, Raphael Herbst, started the course with the goal of teaching communities from around the world life-saving skills in the crucial first seven minutes prior to the arrival of an ambulance (seven minutes is MDA's target ambulance response time).

"One of the worst feelings is when people are put in a situation in which they do not know what to do—people become frustrated they are not

equipped to help," Herbst explained. "We tell them that there is something they can do and it's quite simple. It takes just four hours to teach seven principles of life-saving to an entire community that will prepare them to quickly and effectively respond to a Multiple Casualty Incident," he said. "We teach the community to alter its mindset from concentrating on one injured individual to care for the masses, while cooperating with and following the instructions of medical professionals."

While most mass casualty courses are taught to EMS professionals, MDA focuses the courses on entire communities, regardless of medical background. "One person can treat one or two people but, if you work as a community, you can save many more lives by utilising basic tools and common-sense to ensure safety, rescue, basic first aid and accounting for the victims prior and post ambulance arrival," Herbst posed.

In the first two years since its launch, MDA has taught the course in community centres, schools, and places of worship in Canada, Greece, Holland,



'Patient' bearing vitals for civilians to assess and treat

Belgium, Bulgaria, Italy, Switzerland, Kyrgyzstan, Kazakhstan, Estonia, the Czech Republic, and the UK—with future courses already scheduled in Sweden, Denmark and throughout South America.

According to Herbst, he has seen the positive results of the course with his own eyes. After teaching the course in Italy and Greece, he returned half a year later and drilled the communities again, to find that "the principles they learned six months ago stuck."

"Everything we had spoken about was visible in the drills, as if they had first completed the course a week ago," he said. "They had even improved in their ability and speed in entering and controlling the scene."



Community training in Multiple Casualty Incidents with MDA



Demonstrations on correct handling of patients

In addition to teaching the course in communities, MDA teaches the course to medical universities in order to train future physicians in the Multiple Casualty Incident response protocols. Wanting to offer the course to its medical students, The Tor Vergatta Medical College in Rome partnered with MDA to this end. "Tor Vergatta realised the need for their future doctors to know how to deal with a range of Multiple Casualty Incidents, both in and outside of the hospital setting," said Eli Bin, Director-General of Magen David Adom. The three-day, 24-hour academic course includes PHTLS, Standard Operating Procedures for MCIs, drills

and case studies. The students learn incident management, triage and how to provide rapid and effective treatment for trauma patients based on the Israeli experience, which has largely included responding to penetrating injuries related to terrorist attacks.

Sharing its knowledge and experiences from these negative circumstances creates a positive way to help save lives even outside of Israel. MDA has taken what it has learned responding to synagogue shootings, for example, and applied it to teach other unfortunately common situations that occur abroad, such as school shootings.

In addition to the unique audience, according to Herbst, the course methods are also distinctive, offering an effective program including hands-on practice and drills without the need for simulators or expensive equipment. For example, to teach communities methods of triage, MDA gives out cards representing different injuries and community members are asked to work together to triage the patients. Participants also learn to ensure the safety of the scene of an incident, call for help, pinpoint their location, stop bleeding, assess a scene, report to a dispatch centre and assist EMS personnel—all without any expensive or large-scale drills. The ability to travel with very little materials allows MDA to offer the course at low-cost and at any location and thus increasing its life-saving potential.

"By helping around the world to prepare as many people as possible—both civilians and professionals—we are fulfilling our own mission as a humanitarian organisation," maintained Bin. "The First Seven Minutes course is an innovative way to fulfil our mission of saving as many lives as possible, as efficiently as possible. And for that, we are certainly proud."

To find out more about MDA:
Email: info@mda.org.il
www.facebook.com/mdaonline



Community participants proudly show that they have completed the course

A World First: A Completely New Development in Haemostatic Gauze Promises Massive Success in Traumatic Bleeding and Haemorrhage Control



By Joe Heneghan, Editor, Ambulance Today

At first glance, WoundClot looks like nothing particularly new. The gauze material visually holds so much in similarity to other haemostatic gauzes, you could be forgiven for completely overlooking what is actually a truly massive step forward in emergency trauma care. This gauze has three main immediate features going for it.

It holds up to 2,500% of its own weight in blood and is actively absorbent for up to 24 hours. Secondly, WoundClot has a truly remarkable wound surface adhesion. The pliant 3D gel matrix adheres to surrounding tissues in the wound and will not be dislodged by patient movement, wound manipulation, or high-pressure bleeding, while remaining easy to remove without causing rebleeding.

WoundClot's third attribute is the ability to create an environment that is conducive to clotting by the concentrating platelets, red blood cells, and clotting factors, in its 3D gel matrix. This leads to a clotting

ability which has, so far, had any individuals working in trauma care or surgical theatres unanimously stunned. The advanced functional molecular groups stimulate the coagulation process by converting Plasma Thromboplastin Antecedent or PTA (XI) and Hageman (XII) clotting factors from inactive to active (XIa and XIIa).

As you can imagine, this is especially useful in patients with multiple injuries, or in Multiple Casualty Incidents, where a single provider would be otherwise engaged in holding pressure for at 3-5 minutes with other haemostatic products.

The gauze is also effective on patients that are undergoing anticoagulant therapy or, in the case of severe traumatic injuries, patients that are coagulopathic.

WoundClot utilises multiple mechanisms of action to achieve haemostasis. For the more scientifically minded of you, WoundClot is made from cellulose, a natural fibre product found in plants. It is the only Non-Oxidised, Non-Regenerated Cellulose Structure (NONRCS) product in the world, meaning that it possesses the highest safety profile of any haemostatic gauze available, whilst requiring little to no triaging to use effectively.

A further testament to its truly remarkable and game-changing nature, WoundClot is also notably small. It achieves all this in 8x20cm, 8x100cm, and 20x30cm sizes (CE Class IIB). The



6 minutes post application

longest measurement there is *just over three feet*. I should mention that other sizes are available for the Class III Surgical Implant version of the product too, they have covered all bases here. The Class III product comes in 5x10cm and 10x10cm and, very importantly, has the fastest bioabsorbability profiles around today.

Another very important point to note is that, on average, WoundClot can be left in the wound, with no need to extract or irrigate later. It's broken down by the body and absorbed fully within 7-10 days, with any unabsorbable amounts of cellulose simply being expelled by the patient via urination.

There have been many examples of the proficiency of WoundClot of late, which show just how revolutionary this product is, how vital it is to have in any kit, and which have often left professionals both in prehospital and



2 minutes post application

hospital settings simply stunned. Again, this is a world-wide, first-of-its-kind development. It may look like a run-of-the-mill gauze, but it isn't.

One such recent story is indeed a sad one, as one of the victims of the case sadly passed after being transported to hospital. And it is her that this detail focuses on. Recently in Pittsburgh a case occurred where an armed attacker stabbed two women, seemingly at random, at a downtown bus shelter. One escaped with a non-fatal wound to the mouth. Harrowing and traumatic for her none-the-less, but she survived. The first victim, however, was much more unfortunate. As a police officer was speaking to her, to genuinely check on her welfare as he had seen her sleeping or possibly passed out in said bus stop, the attacker sprung from behind him and stabbed the poor lady directly in her carotid artery. As quickly as he could, the officer detained the attacker to prevent any further stabbings beyond the two which had just occurred and then swiftly ran back to the first woman, placing his finger within the wound to try to stem some of the arterial spurting. The police noted that medics arrived quickly on scene¹.

At around the same period, a representative of WoundClot had been in Pittsburgh training police staff on the application of the gauze, as the local P.D. had recently adopted it as part of their standard kit. Whilst riding with members of their SWAT team, she attended this call. Finding an off-duty paramedic attending, and understandably struggling to control



8 minutes post application

the catastrophic bleeding, they offered a simple 3x39 inch piece of gauze (just a little over 3 feet long). The catastrophic bleeding from the carotid artery was stopped within *15 seconds*. Each first responder and ER physician involved in the case were, as you would imagine, completely stunned at how quickly the bleeding had been controlled.

It is a terrible thing that this poor woman never made it. But the applications of this revolutionary advancement in haemostatic gauze cannot, and must not, be overlooked or ignored. Here, it was clearly a matter of time. Not speaking as a medic, but purely as a member of the public with a basic education and common sense, anyone can tell you that the chances of survival from a punctured or severed carotid artery are amazingly slim, and they get even slimmer as every second passes. But it's clear to see that if this product, compact and easily carried by *any* first responder—police, fire, or EMS—were adopted as a vital part of every emergency kit, then application could be employed much quicker. I would personally go a step further and say that these should be made readily available on the street in the same way that AED's are. That they should be given out to older children in schools with a very simple and easy to follow demonstration on how they should be applied.

As professionals in prehospital emergency care, each one of you know that traumatic bleeding can occur randomly at any time. As the result of a harrowing attack such as the one outlined above, as the result of a child running into a glass plate, as the result of a saw slipping on a construction site. What if this product was as common as a household band-aid? What if its amazingly simple application, which any adult or child could reasonably follow (taking into consideration factors such as panic, fright and trauma of course), was just as widely known? How many catastrophic lacerations could be controlled within minutes or less? How many lives could be saved? What if you could turn up to a call where the patient's traumatic bleeding is already under control, allowing you to focus on

stabilising, or resuscitating, and then transporting?

According to the US Army Institute of Surgical Research (ISR), 84% of potentially survivable injuries ended in fatality due to uncontrollable haemorrhage. Of these, 67% of the injuries did not allow for sufficient access to the traumatic wound for the attending medics to be able to either place compression or fix a tourniquet².

To be perfectly honest, I am quite convinced that adopting this new and revolutionary product is not just a logical obligation, but an ethical must. However, the proof is in the application. It's totally understandable that it is mentally difficult to move on from current accepted practices and to accept when a totally new and revolutionary product arrives, trusting in something you have never used before when so much is at stake.

That's why *Ambulance Today* can proudly offer free samples to any organisation which is forward thinking enough to see how vital this is to their deployment of life-saving emergency care. And it is undoubtedly vital to every organisation within this field. If this is something you have control of then I advise you to get in touch with us. If not, then I advise you to take this article to your supervisor and to advise *them* to get in touch with us. You have nothing to lose, and the patient, and their families, have everything to gain. It's free. If you find that we're wrong, then you simply continue with whatever it is that you're currently using. However, we remain highly confident that this won't be the case.

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The Miscarriage Association Launches New E-learning Resource for Medical Professionals

Dealing with the trauma of a miscarriage is something one can only imagine without having experienced it themselves. Non-profit charity, the Miscarriage Association, explains how they are currently supporting medical professionals in providing care and understanding to women going through that very trauma, through the use of a fantastic new, completely free to use, e-learning resource.

Founded in 1982, the Miscarriage Association is a UK-wide charity that offers support and information to anyone affected by miscarriage, ectopic or molar pregnancy.

Along with a staffed helpline, the Miscarriage Association have developed a new e-learning resource to support medical professionals in providing the best possible care to women experiencing pregnancy loss.

The resource is based on the real experiences of health professionals and those who have experienced miscarriage, ectopic or molar



pregnancy, and also includes a cache of films and interactive activities.

Taking only around two hours to complete, the new resource is an excellent tool for continuing professional development and learning towards revalidation.

Ruth Bender Atik, National Director at the Miscarriage Association, said: "Pregnancy loss can be a deeply

distressing experience and the support health professionals give can make all the difference to helping women through this difficult time.

"I was on my own at home. I couldn't walk, I was on the floor so I had to call an ambulance. The paramedics were wonderful. They called my husband, asked if there was anyone else I needed contacting. They locked my house. They made sure that just the basic little things that really mattered were done and dealt with. And they gave me some gas and air, which I needed."

"We know it isn't always easy for those working in clinical environments to find the time to reflect on the care they provide. This is why we wanted to create a resource that they can dip in and out of and access easily from their phone, iPad or computer, so the training is available to them anytime."



The five units focus upon different aspects of care, such as having difficult conversations, considering language, and taking care of your own wellbeing while providing that care.

Having experienced two miscarriages herself, Cerian Gingell is passionate about improving the care that is provided to those who experience pregnancy loss.

Cerian, said: “Miscarriage is a devastating loss, often without explanation. Nothing can take the pain away, but a kind word, the correct information on what to expect next, the truth about what’s happening – these things can all help make a horrible experience slightly less horrible.



“Not being able to answer their questions is very difficult and makes me feel like I’m inadequate in my job, when in fact I’ve just not had adequate training.”

“To me, good care is saying ‘I’m sorry your baby’s gone, it wasn’t your fault’. It’s letting me cry, answering my questions with honesty and sensitivity, reassuring me that because it’s happened once it doesn’t mean it’ll happen again. It’s about respect, sympathy and honesty.

“I think this resource is so important and will help create more consistent care across the country. Every single

person that goes through pregnancy loss deserves to be treated with dignity and compassion. Whether they’re speaking to their GP or being treated in hospital, every contact can have a huge impact on the way that person copes with their loss.”

The new e-learning resource was peer reviewed and produced with the help of Janet Birrell, Gynaecology Matron at Western Sussex Hospitals NHS Foundation Trust, Dr Nicola Davies, GP at The Pinn Medical Centre, Annmaria Ellard, Miscarriage Specialist Nurse at Liverpool Women’s NHS Foundation Trust, Amanda Mansfield, Consultant Midwife at London Ambulance Service NHS Trust, and the Association of Early Pregnancy Units.

Dr. Sarah Bailey, Lead Nurse Recurrent Miscarriage Care and Clinical Research Specialist at University Hospitals Southampton, said: “The Miscarriage Association’s e-learning resource is extremely useful, informative and easily accessible.”

“I would thoroughly recommend this excellent training package to any care professional who is involved in caring for women with miscarriage.”

The Miscarriage Association’s staffed helpline and online resources help thousands of people every year to get through the emotional and physical distress of pregnancy loss and, in many cases, to manage the anxiety of pregnancy after loss. They work with health professionals to promote good practice in medical care, support clinical research and strive to raise public awareness of the facts and feelings of pregnancy loss.

You can access the e-learning resource at: [Bit.ly/2Gtniu9](https://bit.ly/2Gtniu9) or call the Miscarriage Association on 01924 200795 to find out more.

For more details and interview opportunities please contact Ruth Bender Atik, National Director at the Miscarriage Association: ruth@miscarriageassociation.org.uk / 01924 200795 / 07527 070046

Visit: www.miscarriageassociation.org.uk to find out more.



Building an Effective EMS Wellness and Resilience Program

The Connection Between Physical, Mental and Emotional Health

Depression, anxiety and stress-related disorders are among the most common and disabling health problems. Impacting quality of life, relationships and workplace productivity, these conditions take a massive toll on the lives of millions of Americans – those in EMS included.

According to statistics published in JAMA Psychiatry¹, over 10% of adults aged 18 and older experienced depression in the past year, while 20% experienced depression during their lifetimes. Of adults with a history of depression, 39% had frequent suicidal thoughts and 13% had attempted suicide.

Mental and emotional well-being lowers the risk of developing chronic physical conditions, while keeping healthy physically can help ward off conditions such as depression, anxiety and stress-related disorders.

Research in workers in the “helping professions” such as nursing and social work have found higher levels of work-related stress and burnout than in other professions.² Contributors include managing situations of complexity and uncertainty, lack of control and support, and interactions with patients that evoke strong emotional reactions – all of which factor into the job of EMS.

Chronic physical illnesses, such as diabetes, high blood pressure and

heart disease, are also a burden for workers and their employers, leading to decreased quality of life, disability and increased healthcare costs. A study by the RAND Corporation³ found 60% of American adults have one chronic condition, 42% have more than one and 12% have five or more.

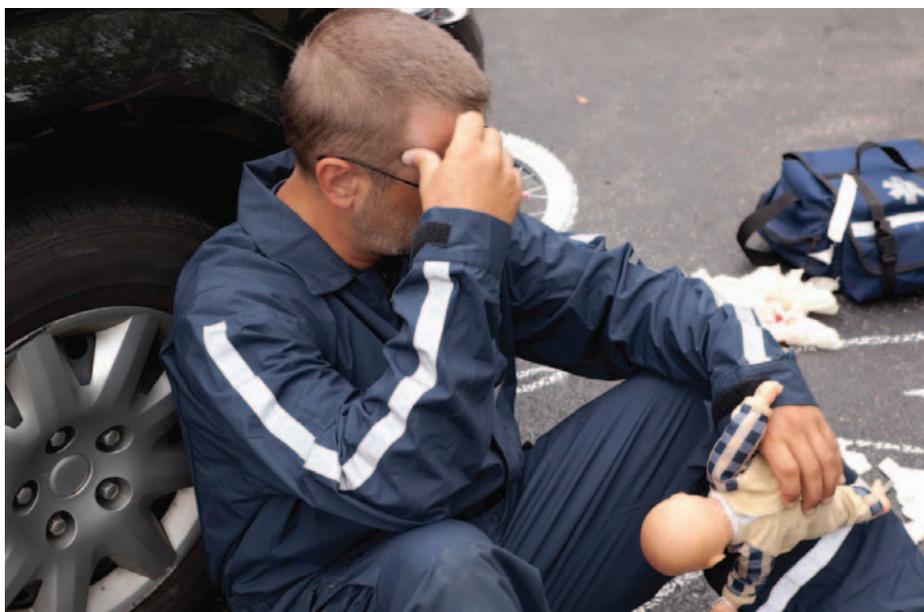
Physical, mental and emotional health are deeply intertwined. Poor mental and emotional health are significant risk factors for chronic physical conditions, while people with chronic physical conditions are at higher risk of developing poor mental health⁴. Chronic stress can exacerbate physical and mental health conditions.

The good news is that the converse is also true – mental and emotional well-being lowers the risk of developing chronic physical conditions, while keeping healthy physically can help ward off conditions such as depression, anxiety and stress-related disorders.

Program Start-Up Checklist

✓ **Create a Wellness and Resilience Steering Committee.** The committee will take the lead on brainstorming, planning, achieving buy-in and implementing wellness and resilience initiatives. The steering committee should be made up of agency leadership as well as field personnel. If your EMS or fire department has a union, union leadership must be involved from the beginning, advised Lauren Kurth, wellness coordinator for Palm Beach County Fire Rescue. Others you may consider inviting to participate: registered dietitians, exercise physiologists, psychologists, and health educators.

✓ **Define your agency’s culture of wellness and resilience.** This is an opportunity to affirm your agency’s commitment to your employees’ mental, emotional and physical health. Your wellness and resilience steering



committee can take the lead on creating this vision for wellness and resilience. You can use NAEMT's *EMS Culture of Personal Resilience and Well-Being* position statement as a starting point.

✓ **Identify and prioritize innovative practices for your agency.** Surveying your EMS personnel about what issues they are most concerned about, what activities or initiatives they would be most likely to participate in, and what they would value the most can help you decide where to begin. This may involve trial and error. You may also review company health data to determine priorities: for example, smoking cessation, back health or weight loss programs.

✓ **Create a culture of wellness and resilience policy.** Your policy (or policies) should define what the agency will offer to employees, and what employees are expected to do in return. If you have a collective bargaining agreement, the policy may need to become part of it.

✓ **Budget for implementation of new practices.** Wellness and resilience is a broad concept that can encompass many levels of benefits and programming. By having agency leadership involved, you can determine how much money you have to work with.

✓ **Develop relationships to offset costs for implementing your new practices.** EMS provides an essential service to the public. Ask local businesses, healthcare providers, philanthropies and service organizations to help you in taking care of the people who take care of them. Discounts, special offers, donations and grants can offset costs for your wellness and resilience programming.

✓ **Ask your EMS practitioners for feedback.** Survey your employees about newly implemented practices to see what works, what employees value the most, and what programs interest them the most.

✓ **Document progress.** There are many ways to potentially measure the impact of wellness and resilience programs. Job satisfaction surveys, sick days, attrition rates, drug tests, worker's comp payments, and health insurance costs are a few of them.



Sources of Stress

Stress is a normal part of life – everyone experiences it. Sources of stress include relationship difficulties such as a breakup or divorce, serious health issues, caregiving for a loved one, and financial problems, such as not being able to pay the bills or worrying about paying the bills.

Workplaces can also be a source of stress – being unhappy in your job, long hours, having too heavy a workload, or having no say in the decision-making process, can all contribute to a sense of disengagement and unhappiness. Shift work, particularly working the night shift, is also associated with lower job satisfaction and poorer physical and psychological health due to a disruption in sleep and circadian rhythms⁵.

EMS personnel are subjected to the same sorts of occupational and everyday stress that many people face. But EMS also exposes its workforce to an added set of stressors.

In 2009, researchers surveyed 34,340 EMTs and paramedics who renewed their National Registry certification. The study, published in 2013 in *Prehospital Emergency Care*, classified 7% as depressed, 6% as anxious and 6% as stressed⁶. (The study authors noted that actual rates of depression, anxiety and stress among the EMS workforce may be higher. Depressed and anxious people may be unlikely to respond to a survey, or may have already dropped out of the

EMS workforce, and therefore would not have been part of the sample.)

This article originally appeared in the NAEMT News Summer 2019 issue. Reprinted with permission.

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Yorkshire Ambulance Service Makes Vimpex and the Pacific R6C Rescue Helmet Their No.1 Choice

Following the launch of the eagerly awaited R6C rescue helmet (the replacement for the A7A), Yorkshire Ambulance Service were among the first Trusts to place their order for the very latest in Pacific Helmet's R6 line, renowned across first responders for their incredible durability and amazing heat resistance.

This latest in the R6 range from Pacific Helmets easily sets a new benchmark for ambulance workers, paramedics, nurses and doctors who respond to emergency medical incidents, where the possibility of unforeseen dangers and potential to injury are both many and sudden. Vimpex already supply Pacific Helmets to 15 of the 17 Trusts across the UK, but this was without a doubt the largest single order ever received from one Trust, and for good reason.

Established in 1994, Vimpex is the UK's leading independent supplier of specialist technical rescue equipment and PPE designed for fire, rescue, military and emergency services teams. Their distinguished reputation amongst

first responders is built on a well-known service for dependable technology and for providing excellent quality products quickly, and at competitive prices.

James Jones, Vimpex Managing Director said "We're proud to be working with 15 of the 17 UK Ambulance Trusts. Over the years, Yorkshire has always proven to be a very proactive and forward-thinking Trust, often moving quickly to ensure its employees have the very best PPE available, at the optimum price point. Regarding the most recent Pacific R6C transaction, the Trust recognised the integrity of a fully certified helmet that matched the standards of the Fire Service and Police during Road Traffic Collisions and other serious incidents."

Ever since 2008, it has been realised by ambulance services spanning the country that the use of professional safety helmets, rather than hard-hat style substitute products, mitigates the risk of injury to workers operating in potentially dangerous environments. Whereas plastic hard-hats have very low compressive strength and can be subject to damage from the sun and



exposure to chemicals and heat, often without the wearer noticing the gradual weakening of the helmet's protective strength over time, these professional rescue helmets are specifically and expertly designed with such subtle complications in mind.

The Pacific rescue helmet R6 range represents the most versatile and configurable helmet of its type available, offering the most up-to-date and modern form of head protection in a very comfortable, lightweight and wearable package. Manufactured using a fiberglass reinforced composite shell, they provide the perfect combination of safety, balance and wearer comfort. This adaptive use of fibre-reinforced materials means that the Pacific rescue helmets have considerably less mass than those manufactured from thermoplastics.

So what does the R6 feature?

- ✓ A lightweight, fiberglass reinforced shell, highly resilient to erosion over time
- ✓ It's no-nonsense and practical composite construction means that the shells far outlast those of thermoplastic helmets





- ✓ The attractive, highly visible, and professional UV-resistant hi-gloss paint finish gives an extra added layer of impenetrable protection to erosion from the sun
- ✓ A great, and carefully designed, balance gives the wearer comfort for all types of use and notably adds to ease of movement in what may often be a fast-paced and highly busy accident scene
- ✓ An addition internal Eye Protector is available on most models, adding much needed and vital protection to two of

the most trusted tools a first responder has at their disposal

✓ The headband is made from removable leather, adding to the wearers comfort, but also making for incredibly quick and simple removal for easy cleaning and replacement – an incredibly perceptive choice from the designers at Pacific Helmets where infection control is concerned

✓ And, finally, it is all topped off with a Nylon webbing cradle system for optimal comfort

Unsurprisingly, Pacific Helmets test their ranges in only the most extreme conditions (not just a laboratory), taking that extra step in order to both fully comply with the relevant clauses of the rightfully stringent EN Standards, and to ensure that the everyday heroes who choose to wear their products are set up with



the very highest standards of safety and protection that modern day PPE technology can offer.

- EN 397:2012
- EN 166:2001
- EN 16471:2014
- EN 16473:2014



As you would expect from a premium safety product such as this, the shell comes with a 6-year warranty and the internal components have a 2-year warranty – the proud mark of a manufacturer that has the utmost certainty in their product.

For further information on the rugged Pacific R6C helmet, you can reach the VimpeX team either by phone or email, or you can obtain further information via their website:

Enquiries: 01702 216 999

Email: sales@vimpeX.co.uk

Website: www.vimpeX.co.uk

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EN 397:2012
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WELSH BRAVERY



By Thijs Gras

Writing this column in the Summer, I realised that in this period we have a different approach to time. We feel it is less important, spend time on relaxing activities and cope in another way with time efficiency. We not only consume time differently, but we also enjoy other food, especially when we go to foreign countries. We usually find this refreshing and it brings new ideas.

A few years ago, the Welsh Ambulance Service took a bold step. The people inside the service realised they had gone too far in figure focusing. A nasty feature of our modern times, which usually leads to combining figures with another verb, also beginning with an 'f', but not really polite to write out fully. Up to two, three, sometimes even four units were sent to urgent calls. Someone described it as 'hitting the targets, but missing the point'. It could not have been put better, I think.

The Welsh decided to stop using time performance as the only yardstick to measure the quality of care, except in the Echo-code category. In these cases – it amounts to only about 5% of the calls – they still use the '65% within 8 minutes' mark. This, of course, did not mean that they stopped driving with lights and sirens, and it certainly did not mean they would not do their utmost to get to someone in need ASAP.

No, this new approach enabled them to look better at the patient's needs and to send the proper ambulance unit to provide those needs, instead of sending

the closest unit just to stop the clock. So, if a call comes in for someone suffering from a stroke, it is no use sending a rapid responder: this person needs transport to the hospital and it is better to send an ambulance immediately, although this ambulance may be two minutes further away than the rapid responder.

Additional advantage: you keep the rapid responder available for an 'Echo-code' call, where all help is needed. Furthermore, the Welsh dispatchers were given 120 extra seconds to figure out the best way to attend to the patient's needs (again except in the 'echo-codes'). This new approach resulted in an important reduction of turn-outs and better performances, especially when you look at patient needs.

So far, so good, one might argue. But, as I understand it, numerous other regions in the UK seem to be so very fond of figures that they urge the Welsh to give up their approach of time performances.

I must say, I found the Cymraeg way of dealing with time most refreshing. By chance, we have been having the same kind of discussions in The Netherlands. Quite a few regions are on the erroneous path of focusing solely on time performances. In an emergency call (A1, blues and two's), we have to be on the scene within 15 minutes in 95% of the cases and the clock starts when the dispatcher takes the call! So some control rooms send the rapid responder to a family doctor, who then wants an ambulance to bring someone with chest pain to the hospital – all just to stop the clock. The rapid says 'hello' to the patient, then waits for his colleagues to arrive with a proper ambulance. In other regions ambulances have become so numerous and dispersed to reach every corner of the area for the best time performances that crews do not do many emergency calls anymore and their time is mainly consumed by waiting for one. Some control rooms use the "IAR"

(Immediate Ambulance Response): as soon as the address is known in case of a 112-call, an ambulance is dispatched. Sometimes this is a good idea, but not always. An ambulance may not be needed or it could be a perfect case for a rapid responder. Yet they do this only to improve time performances.



I feel very much for the Welsh approach: do not focus too much on time performances, but concentrate on what is best for the patient. The problem is of course, who knows what is best for the patient? Superficially seen, as soon as someone in an ambulance uniform arrives, medical assessment begins and anxiety stops so the sooner they come, the better. Now I do not deny the importance of this aspect, but let's be honest: do you eat no matter what when you are hungry? Of course when you are starving (an echo code) you do, but in all other cases it depends upon how hungry you are and what kind of food is available. Sometimes it is better to wait for a nice dinner to be cooked, instead of taking a quick fish and chips. Wise use of food is like wise use of ambulance care. There are several options and what is best for you depends upon what is bothering you. I think patients understand and accept this. My suggestion: let a good cook decide your most healthy meal and how quickly it should be delivered, so you can relax and enjoy your food!



Tell Thijs what you think about this article by emailing him at: tgras@xs4all.nl



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CHILE | Tactical Combat Casualty Care (TCCC)



PANAMA | Advanced Medical Life Support (AMLS)

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Wherever You Wander

Locating patients in some scenarios can be a complex and stressful job when responding to an emergency. Panicked and disoriented calls, unfamiliar terrain, sparse landmarks: all of these and more can make hugely significant differences to your response when every second counts. IAED's Audrey Frazier discusses the innovative new app that could change all that in just three simple words...

What's the address of your emergency?

That's the first question an emergency dispatcher asks the caller, and for obvious reasons.

Accuracy of the caller's answer and location depend upon many different factors. A call from a land line displays the telephone's actual address. Wireless devices increasingly depend upon the supplemental services available (such as the Android Emergency Location Service that has a reported radius of 50 meters or less¹). In the worst-case scenario—no data transmitted, and the caller is unsure of the location—a map reference or postcode is a big help for dispatch, same with motorway markers or asking a passing motorist or local farmer for assistance. But, honestly, can a caller expect the responder to know exactly which creamery marks the fork to take a left?

There's an easier way.

Sidewalk. Building. Stoplight.
House. Porch. Birdfeeder.



Three words that appear seemingly random, although fixed in the place they originated. Three words the emergency dispatcher can enter into the CAD system that can direct ambulance, fire, and police to a location—indoors or outside—even if there is nothing there for the caller to describe. Three words coming from within an enviable, multi-lingual vocabulary.

Maybe you've probably already heard about the three words defining geographic boundaries. In case you haven't, the 'any land mass or territorial water in the world' locator, what3words, has landed a growing presence among multiple emergency services organizations in the interest of sending response straight away.

The what3words is a geocoding system made up of three words permanently fixed to the specific location. It is a free app that callers can download and use to provide emergency dispatchers with a three-word address for their location.

What's the address of your emergency?

///filled.count.soap marks the exact entrance to what3words' London headquarters.²

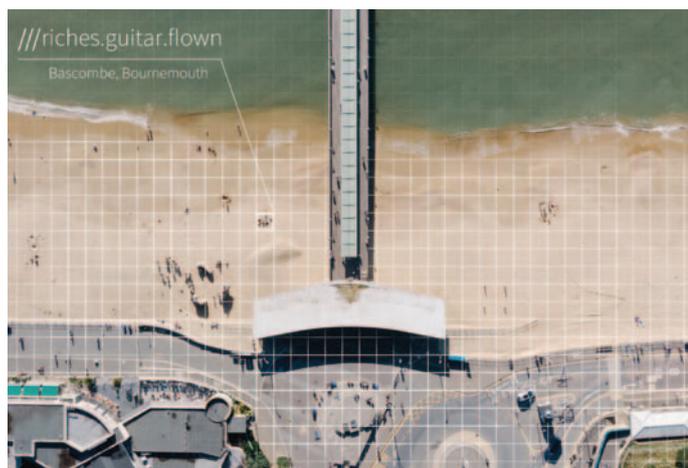
Frustration – the parent of innovation

The system is the brainchild of CEO Chris Sheldrick, who needed precise locations for timely delivery of equipment associated with his music booking business. Part of the problem is the decreasing numbers of nightclubs in London due to rising property values, noise complaints, and curfews imposed to pacify residents. An interactive map (created by a charitable organization) couldn't always keep up with closures, so Sheldrick, aided by the technical expertise of a former school mate, developed 'what3words' to pinpoint locations in a way which is easy to understand and follow. The London-based company divided the world into 57 trillion nine-square-meter areas and based this on an algorithm incorporating 18-digit GPS coordinates, and then assigned a three-word sequence to each square.



The idea was picked up by Trevor Baldwin, Head of Service Department, at Yorkshire Ambulance Service (YAS) NHS Trust's Emergency Operation Centre. He embedded 'what3words' into the YAS CAD system. There are a few ways the system can work:

- A caller can find the current three-word address on the what3words app and this three-word address is then used by the control to identify the precise location for response.



- Emergency dispatchers on the phone with someone who can't describe their location can send the caller an SMS with a link to the what3words map to discover their three-word address. This can then be used by control to find out exactly where they are.
- If emergency dispatchers need to provide a location of an incident to someone else within the service, they can click on the map to bring up the associated three-word location to use this as a more precise identifier that can be easily shared.

Responders can leave their vehicles and use the what3words app on their Smartphones to navigate to the specific three-word location given to them over a text message, which is particularly helpful in rural areas, at crowded outdoor events, and multi-trail parks.

The system went live in July and Baldwin is already thinking of the many ways it can be applied to emergency medical services, fire, and police and ways to increase public awareness.

“The more people get to know about it, the easier it is for us to find them,” Baldwin said. “It’s that simple.”

YAS covers nearly 16,000 square-kilometers of varied terrain and serves over five million people across Yorkshire and the Humber. They receive an average of over 2,500 emergency and routine calls a day.

YAS isn't the only NHS Trust finding what3words an alternative and reliable caller locating app. South Western Ambulance Service NHS Foundation Trust (SWASFT) recently adopted the what3words in its control room.



Although SWASFT will continue to use its existing mapping systems, what3words assists in locating patients in complex venues, according to David Fletcher, SWASFT Clinical Hubs.

“This new mapping system will allow people to tell us easily and simply exactly where they are. So, no matter whether they are in the middle of Dartmoor, at a festival, or in the middle of a university campus, their location will have a unique three-word description which will help us to find them. If you download the app, it will mean we can find you more easily in an emergency when every second counts. It really could be the difference between life and death.”³



SWASFT provides emergency and urgent care services across a fifth of England covering Cornwall and the Isles of Scilly, Devon, Dorset, Somerset, Gloucestershire, Wiltshire and the former Avon area. The operational area, covering about 26,000 square-kilometers, is predominantly rural, but includes large urban areas such as Bristol, Plymouth, Exeter, Bath, Swindon, Gloucester, Bournemouth and Poole.

An emergency dispatcher for Humberside Police, Yorkshire, talked a sexual assault victim who was being held hostage through the What3words process to convey the location to the authorities using three words. “The three-word address was passed to dispatchers, resulting in the recovery of the victim and capture of the offender,” said Paul Redshaw, a Humberside Police command center supervisor.⁴

The link <https://what3words.com/emergencyservices> will direct you to more information.

And better yet, you can enter your own address to discover the unique three-word address for where you are.

///arrive.freed.kept (International Academies of Emergency Dispatch, Salt Lake City, Utah, USA)

///filer.sector.recent (Yorkshire Ambulance Service, Brindley Way, Yorkshire, UK)

Sources

- 1 Android ELS. <https://crisisresponse.google/emergencylocationservice/how-it-works/> (accessed Aug. 9, 2019).
- 2 What3words.com
- 3 New mobile app helps ambulance service save lives. <https://www.swast.nhs.uk/welcome/latest-news/new-mobile-app-helps-ambulance-service-save-lives> (accessed Aug. 9, 2019).
- 4 Sawers P. Emergency responders are using 3-word geocoded address to save lives. Venturebeat.com. 2019; March 19. <https://venturebeat.com/2019/03/20/emergency-responders-are-using-3-word-geocoded-addresses-to-save-lives/> (accessed Aug. 9, 2019).

For more information about IAED, visit the website at: www.emergencydispatch.org

From the Africa Desk of Ambulance Today: The Challenge of Critical Thinking in EMS



By Michael Emmerich

This Africa Quarterly will be exploring the advantages of being a critical thinking emergency medicine practitioner, and how it can positively benefit, us, our colleagues and our patients; and most importantly why we don't really have an option *but to be critical thinkers.*

In Rosen's Emergency Medicine, Chapman, et al, describes the critical thinking process as having three parts: medical inquiry (history, physical exam and diagnostic testing), clinical decision-making (a cognitive process that evaluates information to diagnose or manage a patient's condition) and clinical reasoning, which involves both medical inquiry and clinical decision-making.

The challenge of the EMS educator/facilitator is how to instil those 3 concepts into the practitioner's patient care approach, as the result will be a more focussed practitioner who has learnt the value of critical thinking and life-long learning. Critically thinking is to be desired by EMS providers at every level, yet the concept isn't easily defined, quantified or taught.

That's because critical thinking only becomes real in practice; clinicians, critical and lateral thinkers are moulded in the field. Theory, guidelines, protocols and linear thinking is learnt in the classroom. That is not to downplay the importance of class time, as that is the foundation on which critical thinking rests. What follows on, is experience, continuing education, currency of competency and clinical mentoring. Learning that patient treatment plans fit into the continuum of clinical reasoning, as all patients are different. On the streets, patients

don't follow the script as per your last patient simulation. Thus, the gravity of responsibility you have, becomes intimidating.

Carl von Clausewitz, in his treatise "On War" wrote "Any complex activity, if it is to be carried on with any degree of virtuosity, calls for appropriate gifts of intellect and temperament."



This doesn't mean that everyone who learns something, immediately becomes an expert. For the lifelong learner, everyone has something of value to contribute, irrespective of what environment or years of experience are on the table. Part of lifelong learning is contributing to the pool of knowledge. Effective teaching, just like effective learning, begins with listening before talking. Lifelong learning is a commitment to taking moments out of each day, reflecting on the processes and patients, pushing to improve our knowledge, skills, patient care and attitudes.

Every patient contact is a clinical mystery waiting to be solved, by you the (detective) practitioner.

They are relying on your educational experience, critical thinking, your knowledge that you integrate and update continuously – right down to that "interesting paper" you read last night! No patients are created equal, today's cardiac patient will not match tomorrow's, not all cardiac arrests are equal. Hence, we cannot rely on overly simplistic guidelines/protocols. We need to critically analyse each patient and rhythm strip against our font of knowledge and our vested clinical practice guidelines.

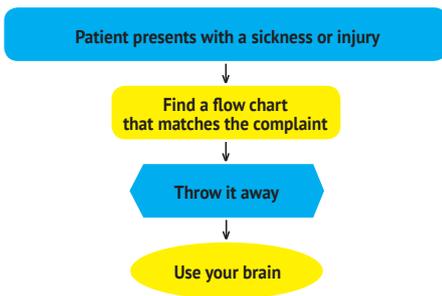
Critical thinking skills ask us to use our brain, and not blindly follow a pre-set protocol; evidence-based medicine keeps changing, and using one's brain as opposed to blindly following a protocol would be short sighted and not always in the best interest of optimal patient outcomes. Seeking, questioning, evaluating, integrating and sharing every day, is an opportunity to get better at our passion (chosen profession), where patients rely on us for their lives. Knowledge and decision-making should be based on clinical findings on that case on that day, it's not just a set of psychomotor skills and blindly followed protocols.

As a thoughtful science-based practitioner, learn to be iconoclastic, adopt a questioning, reflective approach to your practice. My mantra when looking at new and/or challenging concepts/modalities is as follows:

Is it evidence based, current, documented, cross referenced and is there a perceived bias (mine or the writer's)?

All pre-hospital emergency care practitioners should strive to be

Focus on Critical Thinking and Development



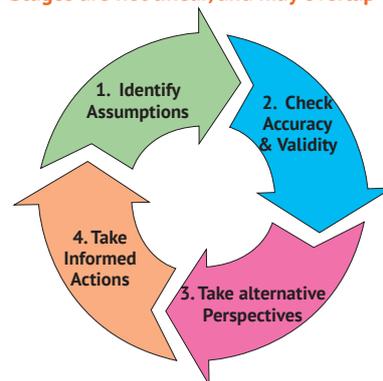
clinicians/critical thinkers, irrespective of their level of care, age or experience. Continuous lifelong learning ensures competence and confidence, allowing you to have the lateral thinking skills to break the linear cookbook approach to patient care.

So, where to from here?

“Paramedics displayed the ability to problem solve, critically analyse, perform complex reasoning and work cohesively with the patient as well as in a group. They were adept at rapidly forming clinical impressions in the critically ill with minimal

information, and were able to modulate their interventions accordingly, while simultaneously continuing to gather data as they performed life-saving measures. Experienced paramedics are seen to gather, process and utilise information differently to the new graduate, portraying an interconnectedness of conscious and sub-conscious processing drawing on information from multiple sources

Stages are not linear, and may overlap



Be careful not to jump to stage four too quickly

culminating from both professional and personal experiences.”

Paramedic judgement, decision-making and cognitive processing: a review of the literature Australasian Journal of Paramedicine: 2019;16 Meriem Perona, Muhammad Aziz Rahman, Peter O'Meara BHA

The implications of this need to be reflected in our practice through ongoing mentoring, partnering the experienced with the novice, reflection and feedback post scene time, all which will go some way to encourage improvement in skills, competency and learning, which then translates into improved patient outcomes.

Tell Michael what you think about this article by emailing him at: mikesnexus@gmail.com
If you have any ideas for special feature articles on ambulance care in any part of Africa, we would like to speak with you about them.

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Out & About News

Organisers of Air Aid Ball hit fundraising high

This year's Air Aid Ball was the biggest ever, raising more than £100,000 for the life-saving Air Ambulance Kent Surrey Sussex.

Organised by volunteers, the seventh Air Aid Ball welcomed 372 guests and took the total money raised to more than £450,000 for the work of the time critical emergency care charity.



Chair of the Air Aid Ball organising committee, Andy Farrant of White & Sons, said: "The Air Ambulance is a charity which anybody, regardless of their age, background or location, might one day or night need the services of, which is why we're doing our bit to support their amazing work."

The ball has been held every two years since 2007, the main sponsor of this year's Air Aid Ball was Crawley-based GEW, one of the world's leading suppliers to the labelling, packaging and commercial printing industries, alongside other local businesses sponsors.

Guests enjoyed a dinner, an auction hosted by Sky Sports presenter Pete Graves, followed by live music and dancing at the event, which took place on Saturday 22 June at Redhill Aerodrome in the historic Hangar 9.

Dr Helen Bowcock, Chair of Air Ambulance Kent Surrey Sussex, said: "Once again the Air Aid Ball has exceeded all expectations not only in raising money but in creating such a fantastic atmosphere in Hangar 9.

"The determination of the organising committee, every one of them a willing volunteer, to support the life-saving work our crews is phenomenal. "They work so hard in making the Air Aid Ball happen and we are immensely grateful for the contribution they make to our capacity to deliver a 24-hour service to the 4.7 million people that live in our area so a massive thank you."

The top lot on the auction was a holiday at Chalet Chopine, a ski chalet in Mèribel, donated by Peter and Julia Lee which raised £16,500 and will help fund the charity which undertakes more than 2,500 life-saving missions every year.

For further information on the work of Air Ambulance Kent Surrey Sussex visit: www.aakss.org.uk.

Two uniforms, one job

The work West Midlands Ambulance Service undertakes supporting former members of the military and serving reservists has been recognised by making the shortlist of a prestigious award.

The submission, "Two Uniforms, One Job" has made it through to the final of the 2019 Health Service Journal Awards in the Reservist Support Initiative category.

Over 3% of our workforce have previously served with the military and the Trust actively encourages staff to continue their military career as well as their work with the ambulance service.

HR Manager, Maria Watson, said: "Candidates from the military and reserve forces come with structure and purpose and a definite sense of belonging. Many of their skills are extremely transferrable which means many find it an easy transition.

"We believe that WMAS offers a long-term career option as they come back into civilian life. Equally, the skills they gain as a Reservists has great benefit for the patients they treat and for their work with the Trust in general."

Director of Workforce and Military Champion at WMAS, Kim Nurse, added: "We are delighted to have been shortlisted as this recognises the collaborative efforts and dedication of our staff members over the last 12 months implementing 'Two Uniforms One Job'.

New non-executive director appointed to NWAS



NHS England and NHS Improvement, North West has confirmed the appointment of Professor Alison Chambers as Non-Executive Director of North West Ambulance Service NHS Trust.

Currently Pro Vice Chancellor for Health and Social Care at Manchester Metropolitan University, Alison qualified as a Chartered Physiotherapist in 1985 and worked in clinical practice for 10 years specialising in neurological rehabilitation and older person care. She has over 20 years' experience of working in higher education.

In 1995, Alison took up her first academic post at the University of Salford, as a lecturer in physiotherapy. In 2002, she moved to The University of Central Lancashire to set up a department of Allied Health Professions and was Dean of Academic Development and Employability until 2014 when she was appointed Pro Vice Chancellor for Health at Buckinghamshire New University.

Alison is passionate about higher education and places students at the centre. She believes in providing educational opportunity for everyone who can benefit with a strong emphasis on student outcomes and graduate employability.

Chairman for North West Ambulance Service, Peter White said: "I'm really pleased to welcome Alison to the trust and am confident that she will be a really positive addition to our board."

"Alison's vast knowledge and expertise in the healthcare sector along with her passion for education will make a really valuable contribution to the organisation."

Alison Chambers has been appointed from 1 August 2019 until 31 July 2021 and is entitled to receive a remuneration of £6,157 per annum. She has declared no political activity in the last five years.

Alison comments: "It is a privilege and honour to be joining such a well-respected organisation and I am really looking forward to meeting as many new colleagues as possible over the next few months."



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French immigrant becomes first Tel Aviv woman to ride an Ambucycle

Aely Haccoun immigrated from France to Israel eight years ago. Like most immigrants, she worked hard to learn the language, find a job and an apartment in a good neighborhood and has been happy living in Tel Aviv, the city she now calls home. One of the things that make Aely unique is that after moving to Israel she also chose to become a United Hatzalah volunteer and rushes out to save lives whenever an emergency occurs in her vicinity. Making her even more unique, is that she recently became the first woman in Tel Aviv to drive one of the organization's iconic ambucycles.

Aely, who became the third woman in the country to drive an ambucycle, following in the footsteps of Sophie Donio from Eilat and Sanaa Mahameed from Umm al-Fahm works, as a project manager whose expertise focuses on resource development and cross-organizational partnerships in the non-profit sector. She joined United Hatzalah over a year-and-a-half ago and volunteers as one of 5,000 EMTs, paramedics and doctors who assist anyone in need of emergency medical care for free. In addition to

becoming an ambucycle driver, Aely is currently completing a course to become an ambulance driver as well.

When asked why she chose to volunteer as an EMT with United Hatzalah Aely replied: "I've known about the organization for some time and I've seen their volunteers rushing to emergencies and providing emergency medical help to anyone in need. I was looking to volunteer for an organization that was out of the box. I wanted to help others in a significant and positive way so that I could help make Israel a better place to live. I fell in love with the ideals on which United Hatzalah was founded, which are providing fast and free medical care to anyone who needs it regardless of race, nationality, religion, gender or socio-economic standing. I've always loved helping others and there is no better way to do that than by saving a life."

Two years ago, Aely witnessed a CPR in progress which was the catalyst for her to take the leap



and enroll in an EMT training course. "I saw a woman collapse and I had no idea what to do. Volunteers from United Hatzalah arrived within minutes and began CPR on the woman. All I could do was stand and watch as they tried for 45 minutes to save the woman's life. After almost an hour the paramedic in charge of the scene began preparing the woman's family to receive the news that they were going to stop CPR.

He went up to the woman's son and told him: "In these cases, only a miracle can save her." He had just finished the words and the monitor that was attached to the woman began chirping alerting the crew that the woman had regained a pulse. It was at this moment that I knew what I had to do to make Israel and the world a better place; I had to become an EMT and save lives. I promised myself that I would never again sit on the sidelines and watch without being able to help. The next day I called United Hatzalah and enrolled in a course."

Aely now goes on approximately 60 emergency calls per month and has merited to save countless people. "It never gets old. The knowledge that you are helping someone else who cannot help themselves and that what you are doing can make the difference between life and death is the greatest sensation that there is."



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 Feel the Drive

Derriford Hospital helipad sees 1700 landings in four years

After a £850,000 donation from the HELP Appeal, Derriford Hospital in Plymouth was able to build a brand new helipad in June 2015. Four years on, it has seen 1700 landings. On average, that's around eight landings per week.



Before the helipad was built, the hospital only had a grassy area for Devon and Cornwall's air ambulances to land on beside A&E. But, as it could not accommodate larger search-and-rescue helicopters, their critically ill patients had to make life potentially life-threatening secondary transfers by road from Plymouth Airport, which was due to close.

With its larger, night-lit helipad just a short trolley ride to the emergency department, Derriford hospital has been able to accommodate all air ambulances and search-and-rescue helicopters within its grounds, as well as landings throughout the night.

Robert Bertram, Chief Executive of the HELP Appeal said:

"It is clinically proven that there are risks to air ambulance patients who, after landing in a helicopter, have to finish their journey with a potentially life-threatening secondary transfer to hospital by road ambulance. Having a helipad that accommodates larger aircraft and is located as close as possible to the emergency department, does save lives and improves a patient's chances of recovery. That's why we fund hospital helipads across the South West and beyond."

Further information about the HELP Appeal:

- The HELP Appeal aims to significantly increase the number of onsite hospital helipads at major trauma centres and A&E hospitals through its grant scheme which offers non-repayable grants to hospitals to help fund new helipads or upgrade existing helipads.
- The HELP Appeal relies solely on charitable donations and does not receive any government funding or money from the National Lottery.

You can follow the HELP Appeal on Twitter:

@helipadHELP, Facebook, LinkedIn or visit the website: www.helpappeal.org.uk

NEAS new Chief Executive

North East Ambulance Service NHS Foundation Trust (NEAS) has appointed Helen Ray as its new Chief Executive.

Helen joins the organisation from Northumbria Healthcare, where she has been the Chief Operating Officer since that post was formed in July 2018, overseeing urgent and emergency care, medicine, child health and community services with Board level responsibility and emergency planning and preparedness.

Helen, who brings a wealth of knowledge and skill from across the NHS with 36 years' experience, replaces Yvonne Ormston MBE, who left in May to become Chief Executive at Gateshead Health NHS Foundation Trust.

NEAS Chairman Peter Strachan said: "I believe Helen's experience makes her ideally placed to lead our service and work with our partners across the region to deliver high quality care to local people. I know she brings a passion for patient care and staff wellbeing, which are integral to our Trust values.

Helen has previously been joint managing executive director (operations) for North Cumbria acute and community services; deputy chief executive for North Cumbria University Hospitals and Chief Operating Officer for South Tyneside NHS Foundation Trust. She trained as a nurse and has held a professional registration for 30 years.

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School and pub are helping to save lives in Coventry

A primary school and a pub in Coventry are the proud owners of a life-saving defibrillator thanks to the fundraising efforts of their local community.

Hollyfast Primary School in Coundon, Coventry, began a fundraising initiative to purchase a defibrillator for the school in November last year after the parent of one of their pupils suffered a cardiac arrest and sadly died in 2018.

Early into their fundraising, the school decided to contact West Midlands Ambulance Service to find out more about defibrillators. It was during a conversation between the school and the Trust's Community Response Manager, Bobby Qayum, that the ambulance service offered to donate a defibrillator to further bolster the community's life-saving potential.

From various fundraising efforts and donations from the local community, the school raised enough money to buy a community defibrillator cabinet to house the donated defibrillator from the Trust. This has now been installed at the front of The White Lion Pub in Allesley and is accessible to the community in an emergency 24 hours a day, seven days a week if required. The school have also purchased their own defibrillator, in a separate venture, which is situated onsite to further bolster life-saving potential within the community.

Liz Hayes-Jones, Head Teacher for Hollyfast Primary School, said: "We are pleased that the fundraising target we set has been successfully completed. This has been achieved through the joint efforts of our community which marks the loss of a parent and friend to Hollyfast, Matt Whitehead, who sadly suffered a cardiac arrest and died whilst out running last summer. A special thank you to all who have helped us achieve this, including Persimmon Homes community donation, neighbouring school Keresley Grange, individual contributions through a marathon sponsorship and other donations, Dave from Brady's Electricians who completed the defibrillator box installation for free as well as The White Lion Pub (Vintage Inn) who agreed to house the community defibrillator. A special thank you, also, to West Midlands Ambulance Service for their very kind donation of the community defibrillator. Our joint efforts have resulted in two life-saving devices being introduced in the Coundon and Allesley areas which we hope will make a difference to someone's life. We are proud of our joint efforts in making this happen."

Bobby Qayum, Community Response Manager, said: "When the school contacted me and explained that they wanted a defibrillator in memory of a parent, I felt it was only right that the service donated a defibrillator to the community as well. It's been a pleasure supporting this local community if either defibrillator helps to save just a life, then it's money well spent. As an ambulance service we know that the quicker someone in cardiac arrest is given CPR and a defibrillator is used, the better the chances of survival."

Saving Time Saving Lives appeal receives almost £2million boost to help London's flying medics deliver their world class care



London's Air Ambulance Charity has announced it has received £250k from the HELP Appeal, the only charity in the country dedicated to funding hospital and air ambulance helipads, and £1.4million from the Department of Health and Social Care towards much needed redevelopment of its helipad base.

A fundraising appeal was launched at the start of 2019 as London's Air Ambulance Charity marked its 30th anniversary with the campaign 30 Years Saving Lives, of which HRH The Duke of Cambridge is a Patron.

The Saving Time Saving Lives appeal aimed to raise at least £1million to redevelop the team's helipad base at The Royal London Hospital to enable the medics to respond even faster, improve training and ensure crews have the facilities they need for their mental health and well-being.

Robert Bertram, Chief Executive of the HELP Appeal said:

"After visiting London's Air Ambulance's helipad base, it was clear that improvements were urgently needed to provide far better and more suitable facilities for the Doctors, paramedics and pilots who are involved in highly stressful situations on a daily basis. We are proud that we are able to help them create a state-of-the-art facility that will also enable crews to reach critically ill patients even more quickly, helping to save more lives."

The money will go towards providing;

- A ready crew room placed closer to the aircraft for faster dispatch
- A space for crews to find respite, deliver peer-to-peer support and debrief critical missions. This space is essential to the wellbeing of our teams helping them to recover and recuperate after being exposed to exceptional levels of trauma on a daily basis. This would also be used for patient and family visits
- Education and training facilities
- Rest accommodation for frontline staff
- New storage space to accommodate additional medical and major incident response equipment.

Dr Gareth Grier, Consultant in Emergency Medicine and Pre-hospital care at Barts Health NHS Trust and with London's Air Ambulance, said:

"We are most grateful for the generous support that will help us improve our facilities, and equipment at London's Air Ambulance. We spend a

great deal of time training to specifically help deal with the most critically injured patients in London. The additional facilities and bespoke space will allow us to do even more for our patients. We are passionate about bringing the best treatments available anywhere in the world to the people of London when they suffer their biggest ever challenge and this kind donation is extremely welcome. Thank you."

Louise Robertshaw, Director of Fundraising and Marketing at London's Air Ambulance Charity said:

"We had an ambitious target to raise £1million during our 30th anniversary, and are delighted that the generous support from the HELP Appeal and the DHSC has meant we have almost doubled the amount we can use for redevelopment of our operational space. The money will enable our teams to continue to provide world-class rapid response care, every second of every day, and help find the next clinical developments to create the next generation of survivors."



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Latest 'Generation 2' Airtronic D2 and D4



Airtronic heaters can be installed internally or externally and provide heat very quickly to personnel carriers and ambulances that may need to be stationary for extended periods of time.

'Generation 2' energy and efficiency improvements to the long-standing Airtronic D2L (2kw) and D4L (4kw) diesel-fuelled air heaters have been extremely well received by customers since the launch.

Scottish Ambulance, for example, recognised the benefits and specified the new Airtronic D4L for their 2019 fleet order for Sprinter accident and emergency ambulances. Many other vehicle converters are following suit.

With lower power consumption and reduced weight, the new versions have almost doubled the service-life intervals of previous models, quieter fuel pumps, brushless motors and new CAN bus (Controller Area Network) interface.

CAN bus technology becomes the new 'nerve-centre' of the system ensuring greater flexibility and making the internal workings more reliable and less exposed to faults. Step-less regulated heat output always ensures ideal comfort. High altitude mode capability (up to 3000m) is included at no additional cost.

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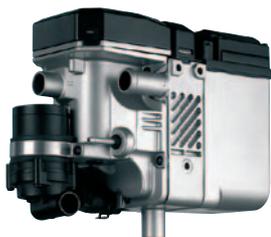
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New Easystart Pro / intelligent control unit

The New Easystart Pro control switch has been designed to enhance a modern dashboard or bulkhead inside and includes a timer function, allowing drivers to select a desired start time, desired temperature and heating duration from the dash board.

The liquid-crystal matrix display and multi-coloured LED status display ring surrounding the operating button continuously indicates whether heating or ventilation mode is currently active

Up to two heaters can be controlled separately from one Easystart Pro unit.



Webasto Engine Off Technology



Engine off/Preheat

Emergency vehicles must be in action all year round. But how can man and machine always stay at operating temperature, given the great variations in outdoor temperature? The most common solution in the past: Keep the engine running. The problem: fuel is wasted, engine wear-and-tear increased, operating costs increased.

The efficient alternative comes from Webasto. Thanks to its innovative Engine-Off Technology, the temperature stays constant in the optimum range for both man and technology, even with the engine switched off. Operational availability and driver convenience are ensured at all times. Best of all: cost savings are so enormous that the investment pays for itself within a single year

Environmentally friendly.

The automatic Engine-Off Technology benefits the environment too. In a double sense. Thanks to the many engine pauses – and to the fact that only this new technology makes use of environment-friendly start-stop systems possible. With a constantly warm engine, restart comes off without a hitch.

Up to 90% less fuel consumption.

In comparison with idling, considerably less fuel is consumed when the engine is not running. This can pay off in savings of up to 90%.

Diesel particulate filters stay clean longer.

When idling, the combustion temperature for efficient operation of the filters is too low. So they soil and wear out much faster. Engine-Off Climate systems prolong the life of particulate filters.

Less wear-and-tear, less maintenance.

Less idling also means less engine wear-and-tear. Engine running times are reduced and, due to fewer operating hours (up to 60%), less maintenance is required while achieving higher resale value.

For an informal chat, call David Stafford on: 01302 381141 or email: david.stafford@webasto.com



Lift your Standards with Stone Hardy



Stone Hardy is the market leader in the service and repair of tail lifts, passenger lifts, shutters and winches for commercial and passenger vehicles. They offer a 24-hours-a-day, 365-days-per-year service with teams throughout their regional locations in Bathgate, Bristol, Birmingham, Manchester, London and Northampton.

Stone Hardy currently has 65 mobile tail lift engineers which enable them to provide extremely good coverage within the UK. Their service vans are well-specified in terms of equipment and carry a good selection of manufacturer's parts. The engineers are well trained, knowledgeable and can deal with most emergency situations.

Stone Hardy are agents for all the major tail lift manufacturers, and they have many blue-chip companies as their customers, with a turnover of approximately £10m a year, and a skilled and knowledgeable workforce with a wide range of experience in all aspects of the industry.

In 2016, the company upgraded their facilities in Bathgate by moving to a new site. More than £1 million was invested during 2015-17 in a new fleet of fully-equipped service vans, and six new rapid response vehicles, providing genuine national coverage ability for its 76 engineers.

Technical innovations, such as digital technology and new computer systems, are always being introduced on a rolling basis, bringing the company a long way since its inception 40 years ago.

For further information please contact: Dave Aylott
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