Western Cape Government
Health
BETTER TOGETHER.

Emergency Medical Services

Siren Issue 6 Dec 11/Jan 2012

Till we meet again "Nonna"

On January 1, 2012 EMS bid farewell to Rouleigh Anneline Strauss (lovingly referred to as "Nonna") whose life was lost after the ambulance she was working on, rolled into a river in the early hours of New Year's morning. EMS held a memorial service for colleagues and friends on January 5, 2012 at the Ceres Station. Addressing attendees, Ambulance Chief, Mr Pumzile Papu, urged the greens to let go of the past and continue pressing forward and embracing a future which is bright and filled with new opportunities. The Cape Winelands performed a gospel song in honour of their missed colleague.

Rouleigh was described by Mr Basil Felix, Ceres Station Officer as a very friendly and loving person towards everybody she came into contact with.

She first began working at the District council on one of the mobile clinics and at the local Primary Health Care Facility. In June 2005, she joined the service and began working in De Doorns and then later transferred to Ceres.

Friends and colleagues of Rouleigh sent their thoughts:

"Nonna was a free spirited person who always had something to share. It was a great shock when I received the call and the first thing that came to mind was to get there. Maybe there was something I could have done for her. To the staff members of this sector, we must love one another and work together. Nonna was a person that staff and management could depend on. For those staying behind - we have big shoes to fill. To Nonna, may you rest in peace, mother, sister, colleague and friend who always had an ear to listen", Neville van Wyk, Rescue Technician from Ceres.

"Nonna was a friend that many of us could confide in. She was the one that always cheered people up around her even if she was feeling down. It was very shocking to hear she had left us. I realise that the time we spend as friends and colleagues is precious and we will always miss her", Nadia Boer, Emergency Care Practitioner.

Albertus Abrahams shared that Rouleigh was the same person every day and inspired those around her to work like she did. She was quick, neat and accurate.

"It was a great pleasure to have worked with Nonna. She was like a mother, sister and good friend. She was everything to me and to other staff members, but God decided to take her away. Rest in Peace", Xolisile Malapi (ECP)

Ceres station staff would like to leave some inspiring words to fellow greens: Live your life as it is short. Enjoy every moment of it. The lesson that "Nonna" taught us is to worry less and always be willing to help, irrespective of whether it is your shift/duty or not.

The funeral was held on January 7, 2012 in Ceres. The Cape Winelands managers and colleagues escorted the hearse on the EMS bikes and performed the guard of honor ceremony to acknowledge a life lost in service.

Cape Winelands Choir

GREETINGS FROM THE DIRECTOR OF EMS

Every day we get more and more emails/text messages/Facebook messages/BBMs and less and less phone calls! The question we have to ask is whether communication is improving?

Data based communication (text messaging) may be accurate, in black and white and very efficient but I question the quality of the communication taking place. Voice communication either in person or over a phone is more personal, adds emotional content and provides the opportunity for immediate clarification and correction. Messaging can be ambiguous and leave issues open for interpretation. People also feel far more adventurous using text and will put things in a text message which are contentious, brave or stupid, something they wouldn't do in a voice conversation. The result is poor communication!

The message is, be cautious and careful about text communication otherwise… pick up the phone and make the call!

So this year make communication a focus, speak to your colleagues, patients and supervisors directly and make sure that there is both transmission and reception of information with mutual understanding.

Good communication is the foundation of all relationships which in the end drive our success as an organization and as individuals.

Best wishes for 2012 and making Quality Care a reality for our clients.

Dr Cleeve Robertson
DIRECTOR

Guard of honour ceremony

Memorial held at Ceres Station

A HUGE CONGRATULATIONS TO DORETTE PETERSEN WHO HAS BEEN APPOINTED TO THE POSITION OF ADMIN OFFICER (HRM) EMS AS FROM 1 DECEMBER 2011!

I HAVE FULL CONFIDENCE THAT SHE WILL MEASURE UP TO THE EXPECTATIONS AND CHALLENGES THAT AWAITS HER.

REGARDS
LIESL MEITER
HUMAN RESOURCES

Staff wellness in Central Karoo (page 7)

LETTER FROM THE EDITOR

The December/ January edition of the Siren addresses quite a lot of serious concerns that you have brought to my attention. I hope that it has been communicated effectively to you. I would like to urge that you address your concerns in a letter be it clinical or employee concerns. Communication is the key for growth. If you don't ask, you'd never know. Throughout this edition, you will find educational articles that address issues starting from communication (What is a methane report? Page 5) through to operational procedures (Responding to a CASAVAC call – Page 4), Human Resources (How to book for leave – Page 6) and ending with important advice on providing the best level of patient care (Negligence – Page 6 and Conveying news of a patient's death – Page 14). In between the busyness of the festive season, we had time to accept the new Neonate ICU vehicles (more information will be provided in the next edition); award candidates of 20 years long service (Page 12); EMS annual blood run (Page 15) and communicate the much anticipated and first published version of the new driver's fatigue SOP (Page 13).

We've had an exciting, busy and at times stressful festive season in emergency medical services. And even though most of us were unable to spend the time with our family and friends, it's comforting to know that most of the greens are happy to dedicate their time to serving the communities (as communicated by most staff I spoke to over the Dec/ Jan period). As we invest our time in improving the standard of emergency medical services in the Western Cape, may we embrace the challenges we face on a

daily basis and rethink how we approach situations at work and home. A quote by Mary Engelbreit summed out this belief adequately, "If you don't like something - change it; if you can't change it, change the way you think about it". Instead of pushing against the wall, rethink your strategy and approach on how you deal with the wall.

May 2012 be your year. May you grab it with both hands and make lemonade with all the lemons that come your way.

Yours sincerely,

Keri Davids
Communication Officer

Ps: Thank you to standby Cameramen – Ashraf Soeker, Quinton Pick and Clement Petersen for taking photographs for this and past editions of the Siren.

NEW EMS NEONATE/ PAEDIATRIC AMBULANCES

EMS in collaboration with the Children's Red Cross Trust have purchased and furnished three new ambulances solely dedicated to neonatal and paediatric calls. Official handing over ceremonies from the trust took place in the last quarter of 2011. The full article will be printed in the March edition of the Siren.

Minister Theuns Botha, Eden Mayor Red Cross Trust and EMS Management cut the ribbon to accept the Eden vehicle.

Responding to a CASEVAC call – Casualty evacuation

As a WC Government Health: EMS employee, you never know what the day may bring. Attending to a patient at home; in the street or at his place of work - makes no difference to how he is treated and cared for by EMS personnel. We do equip ourselves with knowledge and training so that we are able to deal with whatever scenario we face or test, when things go wrong - Trying to achieve a favourable outcome.

Working outside our comfort zone also present unique challenges and a rotor wing operation (AMS Rescue Helicopter) is no exception. Any flight mission whether over mountainous terrain, the scene of an MVA or water bears an inherent risk. We as health care professionals constantly train in the aviation industry to minimise that risk and operate safely and efficiently utilising that resource to its full potential.

Casualty evacuations (CASEVAC's) from sea vessels present quite a few challenges, bearing that there are factors that affect the amount of risk involved. This includes the time of day; weather conditions; size and type of vessel and the size of the swell, to name but a few. Aircraft also presents a challenge as they are not all the same. With Air Mercy Service we have the Augusta, South African Air Force the Oryx and with Titan Aviation the Bell 212 and Kamov. Each platform is different and has its own operating procedures.

As Rescue Technicians training is constant in aviation with a three month expiry date. Strong swimming skills, a High Angle Qualification (rope work) and no fear of heights are essential skills required to respond on a CASEVAC call. One must have the utmost faith in him or herself and competence in the equipment being used. PPE is not negotiable and consists of your survival suit (specialised diving suit); helmet; harness and knife. Depending on the type of vessel the pilot can either land on or winch you down from the aircraft. This in itself is no easy task as the vessel is constantly moving and there are always aerials, masts and cranes on vessels. The team for the CASEVAC consists of an EMS Paramedic, Rescuer (Rope technician) and NSRI Rescue swimmer. The team is doubled when the vessel is further than

50 nautical miles. Everything will double up when the vessels are further than 50 nautical miles. Resources include two military Oryx aircraft with spare fuel tanks on board and a full technical and medical crew on both aircraft. A spotter fixed wing aircraft will fly ahead and radio the exact gps co-ordinates to the rotor wing aircraft. Not only must they work through the language barrier, but also deal with treating and packaging the patient in a limited time frame.

I experienced winch failure on one such mission. After being winched 20m out of aircraft the winch failed and we were left hanging while the pilot flew around in a holding pattern with the engineer frantically trying to sort out the problem. As we had a backup aircraft with full crew the patient could still be evacuated from the vessel. We only had a window of five minutes because of fuel constraints and by the time the medical crew reached the platform of the vessel the engineer managed to winch us back into the aircraft.

The mission was a success because of careful planning, skilled pilots and the competent crew. The patient was stabilized in flight; handed over to the ambulance crew and safely transported to hospital. After every mission a formal debrief takes place to voice any concerns and to discuss possible improvements that can be made. Equipment is checked, cleaned and packed away for the next mission.

There is always satisfaction that your mission was a success and the patient will receive the best level of definitive care was handed over. At the moment EMS undertakes these missions because of our standard of training and professional relationship between the different disciplines which is something the greens can be proud of and strive to maintain and improve as a professional service in all aspects from ambulance crews to management and supporting staff. Things may change within the service, staff may come and go but our goal will always remain the same. To help those in need, alleviate pain and suffering without discrimination and prejudice, to the best of our ability.

Jason Higgins
Rescue Paramedic
Cape Town Base

WHAT IS A METHANE REPORT?

The telephone rings, the phone call is answered "Emergency services good morning, the caller reports, we have a motor vehicle accident on Voortrekker Road please send help" you obtain the callers telephone number and the caller puts down the phone. The question remains have we taken sufficient information to dispatch an ambulance?

Based on the above mentioned information you dispatch the closest ambulance, the ambulance crew confirm that they have arrived on the scene, after a few minutes an anxious ambulance crew member requests assistance but does not state why. As a dispatcher this becomes very problematic. Concerns around: What assistance is required? How additional emergency service resources need to be dispatched? arise.

Over the years there has not been a set standard in terms of information that needs to be given to the METRO communication centre on the arrival at the scene of an incident or accident, this is not only a problem faced within our own service but is a common problem experience by all emergency services.

The Western Cape Emergency Medical Services and most of our counterparts in the emergency service community have adopted the METHANE REPORT.

METHANE is a term indicating a protocol used by emergency services to report situations which they may be faced with, especially as it relates to major incidents, where it may be used as part of our emergency action principles. METHANE dictates the form in which the communication centre should get information from the first response on scene.

METHANE REPORT is as follows:

M- My call-sign, Major incident STANDBY or DECLARED – it is important for the emergency dispatcher to know who has declared the incident, this will be relayed to responding personal so they know who to report to on arrival.

E- Exact location, this would include cross roads, grid reference, or GPS where available, these days many people have access to GPS's on their cellular telephones, this information could be provided to all responding resources.

T- The type of incident needs to be identified so that we dispatch the correct resources to manage the incident

H- Hazards, present and potential hazards, look around and identify potential hazards, this information should be relayed to the communication centre so that resources can be dispatched to neutralise the hazard.

A- Access to scene, and egress route

N- Number and severity of casualties

E- Emergency services present and required

In summarising A METHANE message is a structured message providing the all responding resources with sufficient information to make correct dispatch and response decisions.

Mark De Villiers - Communications

Photographs on opposite page: Tristan da Cunha Rescue in collaboration with SA Navy.

Left: Jason on a CASAVAC call along with NSRI volunteer and AMS.

Tristan da Cunha Rescue Photographs: Zane Johnson from City Rescue

NEGLIGENCE

What is negligence? It can be defined as follows:

Medical negligence can be defined as a practitioner that has failed to exercise the degree of skill and care that is expected of a reasonably competent practitioner in that particular branch of the profession

(1).The Oxford dictionary defines negligence as a failure to take proper care over something (2); Law breach of a duty of care which results in harm (2),

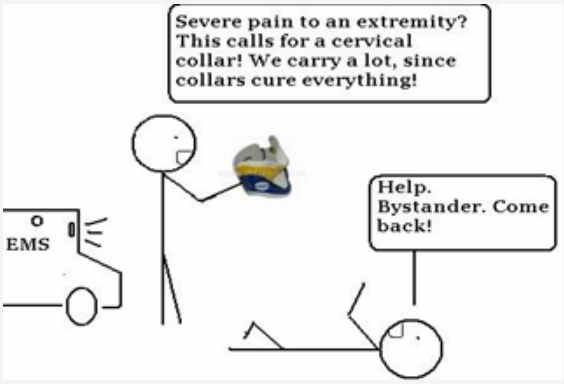
One needs to ponder on these definitions. Within in our organization, there has been an upsurge of investigations where practitioners have been found guilty of negligence. It comes through in various ways: The most common acts are those of omission (knowing that you have to intervene for the patient's well-being, but you don't) and commission (performing procedures or the administration of medicines that might/ could are harmful to the patient). Either way as mentioned, we are guilty of negligence and this could hold serious ramifications for ourselves with our employer, WC Government Health and the HPCSA Professional Board.

A simple example of negligence and patient abandonment was highlighted by the South African Broadcast Corporation (SABC) News, when two Emergency Care Practitioners of another Emergency Medical Service took a patient out of their ambulance and placed him along the roadside as he was indigent, had no fixed abode and apparently did not smell to rosé. Unbeknown to the crew "big brother" was watching and the entire incident was captured on close circuit television (CCTV). HPCSA convened a disciplinary inquiry and took the necessary steps against these members. Both practitioners were struck off the role of the Professional Board for Emergency Care Practitioners. This so easily could have been any one of us. Do we think about what we are doing out there, or are we just automated machines with the same routine, day in, day out? We have inadvertently grown accustomed to our routines that sometimes we forget the needs of the patient. Though done unconsciously, there must still be repercussions.

Every action has a reaction. There has to be consequences for our actions. Keep in mind that once you have been struck off the role you may never practise as an Emergency Care Practitioner again and if you do so, you are by law, committing a criminal offence.

Remember, we have a duty to act, to offer our patients the best medical care under trying circumstances, whether the patient is well off or the poorest of the poor. The patient's well-being should always be at the forefront of our actions.

Peter Lesch
Quality Improvement Manager
Eastern Metropole and Overberg Reg



(Act of Commission)

Reference:
1. McQuoid-Mason DJ. What constitute medical negligence? A current perspective on negligence versus malpractice. SA Heart Journal. 2010 [cited 6 December 2011]; 7(4):248-251. Available from: http://www.saheart.org/journal/index.php?journal=SAHJ&page=article&op=viewFile&path%5B%5D=165&path%5B%5D=158
2. Concise Oxford English Dictionary, Eleventh edition. Oxford University Press; 2004. Negligence

HAVE YOU BOOKED YOUR LEAVE?

All operational staff are well aware of the fact that from 15 December to 15 January is one of the peak periods within the service. For this reason, operational requirements insist that only a small percentage of personnel are granted leave during this period.

To ensure fairness, all applications for annual leave during this busy period must be submitted to the District Manager by the month of FEBRUARY of each year, preceding the Dec-Jan period. Consider this as due notice to all!

Also please note that all staff qualifies for 22 working days annual leave per year at the beginning of each cycle (January). For those loyal employees who are more than 10 years in service, the leave

Personeelwelheid bo in Sentraal-Karoo

Ons het Vrydag 18 en Saterdag 19 November 2011 'n provinsiale personeelwelheid-program in Laingsburg, Sentraal-Karoo, aangebied. Die Vrydagoggend het afgeskop met almal wat hulself ingeburger het . Daarna het ons 'n bewusmakingsoptog deur die hoofstraat van Laingsburg gehou. Vlotte is gebou om verskillende temas uit te beeld. Overberg het geweld teen vroue uitgebeeld, die Weskus en Sentraal-Karoo het 'n VIGS-tema gehad, Eden het gestremdhede uitgebeeld en die Kaapse Wynland het menseregte uitgebeeld. Die gees het hoog geloop en almal was opgewonde.
Die dag het amptelik na afloop van die optog begin. Die vreugdevure het begin brand toe ons 'n potjiekoskompetisie hou. Elke distrik moes 'n potjie inskryf. Mnre. Britz en Webster en sr. Crossley was die beoordelaars. Die Kaapse Wynland het die louere weggedra.

Die Vrydag se sportdag was 'n belewenis. Die manne van Mediese Nooddienste (MND) het hul toertjies op die netbalbaan uitgehaal. Dan praat ons nie eens van mnr. Webster se oulike rompie nie. Daar was ook raakrugby en sokker, wat nogal beserings opgelewer het. Die Kaapse Wynland se kaskenades was iets om te aanskou – dit het sommer geëindig met 'n lekker eier-en-meel-geveg na die tyd. Daar is ook 'n interdistrik-aflos gehou met 'n kinkel in die kabel. Die naellopers moes 90 m hardloop en die stok aan Reddingmanne oorhandig wat eers opstote, opsitoefeninge, ens. moes doen voordat hulle die laaste 10 m kon hardloop. 'n Hele paar van ons het seker daardie dag besef hoe onfiks ons is. Sentraal-Karoo was die wenners van hierdie wedloop. Die manne in die span was nou nie van die jongstes in die groep nie, so dit wys net: Oud, maar nog lank nie koud!

Die dag is afgesluit met 'n pragtige huldeblyk aan ons kollegas wat afgesterf het. Daar is 'n kers opgesteek vir elke kollega wat die afgelope vyf jaar oorlede is en 'n minuut van stilte is vir hulle gehou. Dit was 'n groot skok om te sien hoeveel van ons kollegas nie meer met ons is nie. Ons dink aan diegene wat afgesterf het.

Ons het later 'n kultuuraand gehou en die Kaapse Wynland was die uitblinker. Mnr. Stoffels het die sangkompetisie gewen.

Die Saterdag het éérs interessant geraak toe dr. Robertson sy voorskyning maak. Dr. Robertson het saam netbal en raakrugby gespeel – moenie eens praat van toutrek nie! Dankie, dr. Robertson, ons waardeer dit dat u die dag met ons gedeel het.
Die personeel het ook deur die loop van die naweek kans gekry om MIV-toetse te laat doen. Hierdie inisiatief is goed ontvang deur almal. Dankie aan almal wat hulle laat toets het.

Dankie ook aan elke komiteelid wat hul tyd afgestaan het om hierdie dag saam met Sentraal-Karoo 'n groot sukses te maak. Dankie aan mnr. Hennie Steenkamp wat ons gehelp het om voertuie beskikbaar te stel. Daar is nog soveel dankies wat gesê moet word, maar 'n yslike dankie aan mnr. Knoop en sy span wat ons met die finansies gehelp het! Dan ook 'n spesiale dankie aan mnre. Ahmed, Papu, Nankoo, Webster, Pedro, Hendricks en Britz wat ons onvoorwaardelik ondersteun het en aan dr. Robertson wat ons toestemming gegee het om hierdie program aan te bied. Julle is die beste! Diegene wat nie die geleentheid bygewoon het nie, het beslis baie gemis.

Vicky Agenbag en Simon Yekani

accrual is increased to 26 working days per year. Please ensure that your leave is planned on your supervisor's annual leave planner for the forthcoming year. Your available leave credits must be utilized within an 18-month period, i.e. it is valid from January until June month of the following year.

Negligence to plan your leave will result in the forfeiting of the leave credits and it cannot be carried over to the next leave cycle! Unused le ave credits will only be paid out in truly exceptional circumstances that is due to operational requirements that are supported with evidence from the relevant managers. These circumstances do not include study leave, sabbatical leave, extended sick leave, pregnancy or maternity leave, since the leave was not declined due to operational requirements on the part of the employer.

Human Resources

STOPPING THE BLEEDING DOES NOT STOP THE ABUSE

Pretoria - Protecting the safety of patients who have suffered under domestic abuse has gained momentum through the Health Professions Council of South Africa <http://www.hpcsa.co.za/>'s (HPCSA) approval and adoption of screening guidelines to be used by emergency care professionals. These guidelines will enable early abuse detection, responsiveness and appropriate referrals by emergency staff who, are usually first to arrive at the scene.

The Professional Board for Emergency Care as part of the HPCSA has taken the bold step to pass these guidelines as the first step in guiding emergency care professionals to discharge their roles in the struggle against domestic violence.

As we mark the end of the annual 16 Days of Activism for No Violence Against Women and Children, the new guidelines will play a marked difference in assisting emergency care professionals throughout the country identify the presence or history of domestic violence, its associated risk or threat to life and how to respond appropriately.

Considering that one woman is killed every six hours in South Africa, the need for such guidelines is self-evident, with domestic violence interventions to date being largely curbed by the criminal justice system, by criminalizing the act of domestic violence.

"The Board recognizes that the right to healthcare intersects with the right to safety, and this intersection is apparent in the Health Professions Act where emergency care professionals have a duty to protect the safety of their patients," Navin Naidoo, member of the Professional Board for Emergency Care said.

"The Board is charged with regulating the emergency care profession for the equal benefit of protecting the public and guiding the professionals. There is evidence of under-detection of domestic abuse in South Africa and there is also evidence of insufficient training regarding a health sector response to domestic violence."

"With this in mind, the Board has taken an unprecedented decision to approve these universal screening guidelines that are intended to:

1. Protect the victims of abuse from a lack of responsiveness from emergency care providers, and in so doing stem the cycle of abuse; and

2. Guide the emergency care providers in the universal screening of healthcare users for the early detection of abuse, and to enable early and appropriate referral."

According to the new guidelines, emergency care professionals must now, as a professional obligation, be responsive to domestic violence by the following actions:

* Screening: ask gently about violent and/or controlling behaviour and believe response

* Assess risk: conduct a risk assessment to identify imminent danger

* Provide supportive care: provide supportive bio-psycho-social care

* Document diligently: document any evidence of abuse

* Provide information: inform patients of their rights, services and legal remedies. Talk through the implications of domestic violence, including the risk of HIV.

* Refer responsibly: referring clients to appropriate resources and to identify their support system.
"These guidelines place a renewed responsibility on the emergency care providers to ensure that those they assist are also not stigmatized or blamed when they seek help, that all victims of abuse receive appropriate medical attention and that their right to confidentiality and security is protected," Navin explains.

The new guidelines now enhance professional accountability by emergency care providers and endorses a human rights approach in healthcare provision in the emergency care environment, with a view to minimizing the health sector complicity (by non-action) in acts of abuse against women and children. The screening guidelines will be placed on the agenda of all Professional Boards under the ambit of the Council to enable all health professions to be more responsive to this pervasive and endemic health burden.

Issued by the HPCSA

The Health Professions Council of South Africa (HPCSA) is a statutory body and is committed to protecting the public and guiding the professions. The mission of the HPCSA is quality healthcare standards for all.

OVERBERG MANAGERS TEAM BUILDING EXERCISE

In an effort to consolidate his management team, Mr Hein Hendricks took his managers to Infanta to complete a teambuilding challenge organised by Mr Egnal Brown (Rescue Manager Overberg).

We travelled along a long and dusty road down to Infanta and camped overnight in tents and two caravans. Supper was prepared by Emma and the delicious chicken potjie was enjoyed by all around the fire. Good conversation and laughter continued late into the night.

Egnal, Emma, Ricky, Hannie, Leon, David and Cobie planned to ensure that the day was a challenge and we all had to work hard to complete the tasks but the high standard of safety we have come to expect from this rescue team ensured that we were safe and no injuries occurred.

The day started at sparrows with a quick bite and coffee and off we went. The first challenge was to scramble up a steep slope to the site of a previous rescue and our respect for our rescue team went up when we experienced first-hand the challenges they face in taking a patient down the difficult terrain. We only had to cope with ourselves and not patients and found it hard enough to negotiate the rough steep ground.

The other challenges comprised of finding locations, water and hiking events.

Two teams competed against each other and much laughter at each other's expense ensued. In the spirit of the day, everyone helped each other to achieve a full complement completing the challenges.

The final challenge was to sing to the receptionist at a local restaurant for our lunch on the Witsands side of the river and enjoy a well-deserved braai prepared by Emma.

We journeyed home over the pont back into the Overberg, tired but proud we had achieved the tasks. Many good intentions to get fitter were expressed by us all as the teambuilding certainly made it clear that most of us could do with getting out of the office chair more often.

We would like to thank the rescue crew for the huge effort taken by them to ensure that we were safe, well-fed and enjoyed the teambuilding event.

Hopefully you will see an improvement in our fitness levels at the next teambuilding.

Thanks also to Hein Hendricks for taking his team out of our offices and comfort zones to strengthen and encourage a good support system between us.

Rescue team: Egnal Brown, Emmerentia Pretorius, Ricardo Telling, Leon Leukes, Johannes Davids, Dawid Hundermarck and Jacobus Fortuin

Managers: Hein Hendricks, Ralph Williams, Irvin Swartz, Ernest Westraad, Fernando Erasmus, Fanie Christians, Yvonne Paterson, Craig Williams, Christopher Koopman and Reolaine Pietersen

SCOOP & RIDE OR FIDDLE & FUMBLE

Back in 1967, when I started my interest in Ambulance services in Cape Town, the ambulance personnel had little choice! It was scoop and ride or nothing because in those days they had very little training and even less equipment. A terrible scenario – or was it?

Today it is different but I am not sure it is always better from the patients perspective or in a wider sense from the perspective of the ambulance service or more important from the view of the next patient!

In a recent incident a vehicle overturned, the two occupants were wearing seat belts and on my arrival were sitting cheerfully on the pavement congratulating themselves at having escaped injury. It took about 60 seconds to ascertain that they were fully conscious, breathing normally, had a normal pupil reaction, skin was dry and normal color and the pulse was about 90/min.

And then the ambulance arrived! It was a private service so I stood aside to observe.

Admittedly relatively quickly and efficiently the two uninjured accident victims were flat on their backs on trauma boards, head blocks and harnesses in place, on a stretcher and into the ambulance. ECG leads put in place, oxygen by mask and sats monitor applied.

Now all this took time but not as long as the completion of clinical and other documentation that followed.

After about 20 minutes the ambulance left with Red lights and siren on for the hospital 5 minutes down the road.

So what did all this "care" achieve?

For the ambulance service as a whole, particularly State operated services; it was a waste of precious time with effectively an emergency ambulance unavailable for the next and potentially more deserving patient. This in turn affects "response times" of the service which today rightly or wrongly seem to be the performance driver of most services, but this is another topic.

From the Medical Aid perspective they absolutely require ridiculous clinical details to be documented before they will pay the bill for ambulance transport. Effectively they are slowing the service down and in a serious case distracting the ambulance personnel from looking after the patient. In today's incident this was not an issue and they are happy.

From the patients perspective in this case, it was confusing and nothing more than uncomfortable. In another case, with for arguments sake a ruptured internal organ, the time spent on scene confounded by actual interventions such as initiating intravenous therapy, could prove a disastrous delay.

So in the incident I have described of the two uninjured patients, the 1967 model would have been better! Let us look at it!

The patients would have been assisted to the ambulance, no unnecessary oxygen because there wasn't any available and reached hospital in 5 minutes. No documentation because they didn't have any and they just explained to the hospital doctor what happened.

They then called free on the radio (they had radios even in 1967) and were available for the next case much to the delight of the ambulance control who had less ambulances available then than they do at present.

Somewhere between those two extremes of "Scoop and Ride" and "Fiddle and Fumble" we need to strike a balance to provide optimal patient care in all cases while still providing an efficient, response time sensitive, ambulance service.

In providing optimal care which may vary from almost nothing other than a kind word to interventions such as endotracheal intubation, all of us in the pre hospital arena particularly in trauma related incidents need to recognize a fundamental fact.

"We don't cure people, hospitals do that!" Our job is to transport patients without them deteriorating clinically IF that is reasonably possible.

Equally IF we can't stop them deteriorating in a reasonable time we are obliged to get them to hospital with all speed and to hell with the form filling.

So how do we achieve this balance? Actually, it's NOT that difficult and like most things medical our initial actions are determined by our initial assessment of the patient.

All serious medical events be they medical or traumatic, even the obvious compound fractures will IF they require intervention be reflected in abnormal vital signs. These vital signs or their deviation from normal are common to a broad range of conditions and therefore are the focus of the initial assessment. If all the VITAL signs are within normal limits it is time to MOVE ON for in depth assessment at Hospital. Despite the apparent normality of the patient the Medical Aid can hardly expect the patient to catch a bus to hospital and should pay for the transport WITHOUT documentation beyond the Vital Signs and this need to be sorted out with them.

These Vital signs form the basis of Pre-hospital TRIAGE which essentially determines whether pre-hospital interventions are required or not remembering that the goal of such interventions is to arrest clinical deterioration IF this is possible. Where the patient continues to deteriorate with all the training and experience in the world we need to recognize that urgent removal to definitive hospital care is the Priority and if this is "scoop and ride" so be it!

So "scoop and ride" has a place in Green Patient or Yellow Patient with normal vital signs and "scoop and alive" in Red patients beyond pre-hospital care. There is NO place for "fiddle and fumble".

Dr Mac Mahon

M.Med OMSS

DANKIE EMS!

Geagte Dokter de Vries

Ja, was dit nie vir Metro se nooddienste nie, weet ek nie wat sou die uiteinde wees nie. My dogter, haar broer en 'n vriend het Saterdagmiddag die Botmanskopbergstaproete naby Stellenbosch uitgeklim. Met die afkomslag het my dogter baie sleg teen 'n steil krans afgeval en was dit nie dat sy 'n bossie kon vasgryp in haar val nie, kon die gevolge baie erger wees. Toe my kinders julle noodsentrum 15:00 gebel het – ja, wonder bo wonder was daar selontvangs in die berg:

• Was julle besig om 'n ander persoon vanaf die Swellendamberge te
casevac.
• Die chopper het die pasiënt by die Stellenboschhospitaal afgelaai,
• Daarna julle mediese ordonans en paramedikus by haar gaan aflaai –
die een selfoon wat hulle by hulle gehad het GPS dus kon hulle die RV van
hul posisie aan julle noodsentrum verskaf
• Toe het die chopper gaan refuel by Kaapstad Internasionaal
• Teruggekom om haar uit die berg op te tel
• En haar afgelaai by Stellenbosch Hospitaal

Vandat die kinders julle noodsentrum gekontak het totdat die AMS chopper haar afgelaai het by Stellenbosch se staatshospitaal was ±2uur. Jy sal seker verstaan waardeur 'n ouer gaan as jou kind jou iewers uit 'n berg in die Stellenboschomgewing bel en sê sy het van die berg afgeval maar ek moenie worry nie want "ek's ok". So ok dat 'n noodchopper haar moet gaan ontruim.

Ons kon nie met hulle praat nie want 'n erge wind het kommunikasie bemoeilik en ons was erg beangs. Gelukkig het ons by julle noodsentrum uitgekom en Johan Barnard het aan ons verduidelik dat alles onder beheer is.

Graag wil ek en my vrou deur middel van die e-pos ons uiterste dank aan die Metronooddienste betuig. Sal u so vriendelik wees om aan almal dit oor te dra. Julle span loop soos 'n goed ge-oliede masjien. Nodeloos om te sê – mens mag nie name uitsonder nie - van die chopper met al sy personeel, julle ambulanspersoneel wat op bystand was by die hospitaal tot die persone wat die beheersentum.beman.
Metro - 10 uit 10 !

Goeie nuus: vandag se koerant sê dat haar enkel gebreek is en dat sy 'n rugbesering opgedoen het. Sy was egter baie gelukkig om net met 'n klomp knoppe en skrape, seer spiere en 'n goeie sarsie skok daarvan af te kom.

Vriendelike groete van baie dankbare ouers.

2011 EMS 20 YEARS LONG CERTIFICATE BREAKFAST

On Friday December 6, 2012, thirteen EMS personnel received certificates for 20 years long service. The programme of events was kick started with a beautiful performance by the Overberg Choir demonstrating that emergency medical practitioners go beyond providing services to the communities but are also dedicated and in support of recognising the service provided by fellow colleagues. Western Cape Minister of Health Mr Theuns Botha, Head of Department Professor Keith Household, Deputy Director General Dr Beth Engelbrecht and EMS Management were all in attendance.

In his address, Minister Botha said, "EMS staff work long days of twelve hours and more and are often placed in dangerous, risky and difficult situations. Irrespective of their duty, every member plays a vital role in providing a qualitative service". He went on to commend staff for their outstanding work with regard to the Tristan da Cunha Rescue and receiving recognition from international agencies such as the US Peace Corps.

DDG, Dr Engelbrecht enlightened the staff with showing her dedication and respect for the work that EMS personnel do on a daily basis, by arriving in a green uniform. Staff were inspired by the messages communicated by top management, with Professor Household reminding staff to stick together during difficult times.

Professor Keith Household

Mr Pumzile Papu, Ambulance Chief and Dr Roberson also had the opportunity to thank staff for their dedication to the service.

The event was concluded with the handing over of certificates and gifts to each candidate, two inspirational songs from the choir and a brunch.

EMS Management would like to thank the Overberg Choir, Brian Fortune(supply chain) for providing and sponsoring the sound for the event and Clement Petersen (City Rescue) for taking the photographs.

Dr Engelbrecht introduces Minister Botha to the audience

Photographs: Clement Petersen, City Rescue

DRIVER FATIGUE

EMS have developed a new SOP which addresses driving fatigue:

It is the responsibility of all operational staff and managers to be aware of the risk of driver fatigue. Fatigue can lead to deterioration in driver performance, demonstrated by slower reaction time, lesser ability to keep distance and increase tendency to mental withdrawnness and loss of attention. Drivers may attempt to compensate for fatigue by increasing the task demand or lowering the task demand. In other words, believing that driving faster will increase the level of attention or by increasing safety measures by driving slower.

Accident as a result of driver fatigue is most likely to occur:

- During long journeys
- Between 2am and 6am
- Between 2pm and 4pm
- Loss of sleep or sleep deprivation
- Use of medication induced drowsiness
- Working long hours or shift work

Be aware of warning signs:

- Continuous yawning
- Eyelids drooping, closing eye for a moment or eyes going out of focus
- Disconnected or wandering thoughts
- Not remembering driving the last few kilometres
- Drifting or wandering of vehicle over the centre line or opposite side of road
- Braking too late
- Missing road signs, gears or your exit
- Seeing things that are not there
- Slowing unintentionally

Ensure that you are fit to drive:

- Maintain a healthy lifestyle and exercise
- Manage fatigue: Use off time to recover sleep deprivation

In the instance of fatigue:

- Share driving during the 12 hour shift period
- Dependent on patient requirements stop and change drivers. If because of patient require ment changing drivers is impossible, commu nicate driver fatigue with partner and consider stopping, existing the vehicle and move around in order to improve alertness.
- Report driver fatigue to the communication centre and the on duty manager, request to schedule a break.

- Caffeine will provide a quick but short term improvement of alertness. Eat healthy snacks instead of sugary or fatty foods.
- Ensure that temperature of the driver compartment is appropriate. Air conditioning can keep the driver more alert and decrease stress and frustration.

MANAGEMENT

Management should monitor individual crew workload in order to recognise the risk of driver fatigue and communicate with communication centre operators with reference to crew rest periods:

- Identify and be aware of health problems that may affect the ability to driver
- Ensure the Emergency Care Practitioners is fit to perform work
- Encourage drivers to adequate recover sleep debt during off duty times and report driver fatigue when on duty
- Ensure that drivers share driving during the 12 hour shift period

COMMUNICATION CENTRE

Communication Centre Operators need to assess the work load and distance travelled by individual crews in order to schedule rest periods and manage their level of fatigue, in particular during the high driver fatigue related time period (2am to 6am, 2pm and 4pm).

- Monitor driver behaviour though observing the c-track system in communication centres.
- Monitor individual's crews by making radio of telephonic contact to obtain progress reports, if crews are travelling long distances or driver fatigue is expected.

Communication Centre SOP: Rest period

- At the discretion of the shift supervisor according to a schedule appropriate to call volumes, a rest or convenience period of 15 minutes may be granted or withdrawn at 2 hour intervals.

CONVEYING NEWS OF A PATIENTS DEATH

The death of a patient is likely to cause a profound emotional response from the patient's family and friends, particularly if the death was not anticipated. As pre-hospital healthcare practitioners we do not receive formal training in coping with patient deaths likely to be encountered in the pre-hospital environment. Being unprepared for these intense experiences can negatively affect the practitioner and the quality of care provided to family members of the recently deceased. We have not been taught what to say, how to say it, what reactions to expect and how to deal with those reactions once we inform someone that their loved one has died. In addition to making medical decisions during the resuscitation of a patient, it is also the senior healthcare practitioner's responsibility to inform the loved ones of the death of the patient and offer assistance in the alleviation of suffering that the affected family members may experience.

Before addressing the family and friends, obtain as much personal and medical information about the patient as possible as well as the circumstances surrounding their death and the resuscitation efforts that were initiated to help save the patient's life. If at all possible, take the family members to a private area. Introduce yourself by name and qualification and identify the closest relative. Prepare them by telling them that the situation is very serious and offer for them to sit down if possible. So what do you say? There is no way of sugar coating what you are about to tell the family members and loved ones. What you are about to tell them is going to be devastating, particularly if the death was unexpected.

Briefly describe the sequence of events, including in the case of a resuscitation, what resuscitation efforts were initiated and that everything possible was done for the patient. When informing the loved ones that the patient is dead, maintain eye contact and inform the closest relative or friend that the patient has "died" or is "dead". It is extremely important to be clear about the fact that the patient has died and it is therefore best to avoid using euphemisms such a "he has passed on", "she is no longer with us" or "he has left us". Allow time for the family members to process the information. Whilst maintaining eye contact and touching the patient, possibly on the arm or shoulder, or even holding their hand, convey your condolences with a simple phrase such as "You have my (our) deepest sympathy." Do not apologize or say "sorry", you have done nothing wrong. Allow as much time as is necessary for questions and discussions and review the events several times if needed. Offer the family members the opportunity to view the patient preparing them in advance for what they will see, specifically if medical equipment (ie endotracheal tube, intravenous line) is still attached.

Mourning is a culturally-based expression of grief. Family members may react to news of death in different ways, such as calm or hysteria, shock, anger, disbelief, numbness, crying, or even, in rare instances, with violence. The response of healthcare practitioners must be adapted to the needs of the situation. Some common reactions that the pre-hospital practitioner may need to address include the following:
1.Denial: This is a common personal defense mechanism that allows for acceptance of tragic information at a more tolerable pace. The early phase of denial should be accepted, but if it persists beyond 5 minutes, or so, then one should reiterate the fact that the patient has "died" or is "dead".
2.Anger: Family members may direct their anger at anyone, including the healthcare practitioner. If this happens, it is important not to become defensive and to bear in mind that the fury of the affected person is not personally directed at the practitioner.

Principally, the angry individual needs to know that they are being heard, and acknowledgement of their feelings may help. They should be recognized as necessary reactions to the message and not suppressed or forbidden As the safety of the healthcare practitioner is of paramount importance, feel free to have a police officer present or remove yourself from the scene should it becomes volatile.

3.Guilt: Feelings of guilt should be discouraged. Studies have shown that exoneration by healthcare practitioners can provide an enormous sense of relief. Tremendous comfort can be given by emphasizing that the family member did not cause the death, nor was it caused by any action of the family member.
4.Sorrow: When the family and loved ones express grief, the attending healthcare practitioners need not necessarily speak. Compassion does not necessarily have to be conveyed in words. Presence and a caring touch on the forearm or shoulder may be all it requires to express compassion. Using clichés, such as "he lived a good life" and statements like "everything will be okay" are neither helpful nor reassuring. Families usually respond well to simple statements such as "you have my deepest sympathies". Viewing the body (if possible) may be painful but can reduce prolonged grieving by creating an increased sense of the reality of death. Before allowing viewing, blood should be wiped from the body, eyes closed, and resuscitation debris (gloves, syringes, medical packaging etc) removed. Any devices that must be left in place for a medical examiner's review should be properly explained to the loved

ones before they are seen. Rather than disturbing the family, their presence may actually reassure them that everything possible was done to resuscitate the patient. Bear in mind the family may not request to see the body, so the opportunity to view, and possibly touch the body, should be offered to them. At this point privacy is usually desired. It is therefore advisable for the healthcare practitioner to withdraw from the immediate area but to remain nearby in case further questions are to be asked. In the case of the death of a child, the parents should be offered the opportunity to hold the child as this has proven to help significantly with the grieving process. Armed with the above information, the pre-hospital practitioner may find it emotionally easier to conduct the difficult and sensitive task of informing family members of the death of a loved one.

Michael Lee
Quality Improvement Manager
Western Division

EMS ANNUAL BLOOD RUN 2011

EMS raised 141 units of blood at our annual blood run, held December 2011. The event was well attended with 157 donor applicants of which 140 successfully contributed to the blood donation to the Western Province Blood Transfusion Services. An initiation started and organised by Courtney Abrahams, Paramedic from the Northern Division District in the City.

Photographs: Mark Davids, HealthNET

WELL DONE EMS!

On Behalf of AMS, I would like to commend Greens Shameeg Jacobs (ALS) and Moegamat Gasant Richards (ILS) who I believe have gone far and beyond what is required while working their two month rotation at AMS. Jacobs and Richards went always friendly, punctual, extremely helpful and an absolute pleasure to work with.

AMS issued a certificate of Excellent Service to both greens to show appreciation for their outstanding work.

Andre Oliphant
Cape Town Base Manager

EMS Management would like to send their best wishes and condolences to personnel:

- Monroe van Niekerk
- Shahiedah Bendie
- Mr Jochems

Send us all your ideas, article leads (tips), stories and photographs to:

The Siren
kerdavid@pgwc.gov.za
083 286 4227
alternatively articles and photographs can be dropped off at:
Room 112
Communications Officer
EMS Head Office
Karl Bremer
Bellville

COLLEGE COURSE DATES!

Course	Application opening Date	Closing date for application	Application List	Entrance Exam	Selection	Dates of Course
Basic Life Support (BLS)	27/02/12	16/03/12	23/03/12	06/04/12	13/04/12	23/04/12 – 01/06/12
Intermediate Life Support (ILS)	07/02/12	14/02/12	23/03/12	30/03/12	04/04/12	07/05/12 – 17/08/12
Advanced Life Support (ALS)	10/08/12	24/08/12	31/08/12	21/09/12	05/0/12	22/10/12 – 30/11/12
Emergency Care Technician (ECT)	31/05/12	05/06/12	13/06/12	02/07/12	10/07/12	01/08/12 – 08/2014
B.M.R						06/2/2012-16/3/2012