

**CLARK COUNTY EMERGENCY MEDICAL SERVICES COUNCIL
PREHOSPITAL PATIENT CARE PROCEDURES**

INTRODUCTION

The following *PREHOSPITAL PATIENT CARE PROTOCOLS* are intended as treatment protocols for both basic and advanced life support technicians working under the advice of the Medical Program Director for Clark County. They represent a consolidation of recommendations for patient care from many local and national sources.

- I. They are intended to:
 - A. Standardize, as much as possible, prehospital care for Clark County.
 - B. Provide the Emergency Medical Technician with a framework for prehospital care and an anticipation of supportive orders from the base hospital.
 - C. Provide base hospital physicians and nurses with an understanding of what aspects of patient care have been stressed to the EMT/EMT-P and what their treatment capabilities may be.
 - D. Provide the basic framework on which Medical Control can audit the performance of both basic and advanced life support personnel.
 - E. Differentiate between basic and advanced life support procedures. ALS procedures will be identified by an * preceding the procedure. A *** is intended to identify an ALS therapy to be used only with Medical Control Physician concurrence.
 - F. Expedite patient delivery to institutions best equipped to handle their specific problems.

- II. They are not intended to:
 - A. Be absolute treatment doctrines, but rather guidelines with sufficient flexibility to meet the needs of complex cases.
 - B. Be a teaching manual for EMTs or Paramedics; it is assumed that each EMT is trained to his/her level of certification and that she/he will continue to meet the requirements of the State for continuing education for recertification. Medical Control will provide continuing education based on the results of patient care audit and review.
 - C. Interfere with the wishes of the patient or family, or the wishes of the patient's physicians.
 - D. Dictate details of care to advising physicians.
 - E. Warrant the EMS Provider as an independent field practitioner.

It is expected that all emergency medical technicians working within Clark County will be familiar with the portion of the PREHOSPITAL PATIENT CARE PROTOCOLS appropriate to their certification level. Written acknowledgement of the receipt of this document will be required.

PATIENT TREATMENT RIGHTS

I. Consent

- A. These prehospital care protocols are intended for use with a conscious, consenting patient, or an unconscious (implied consent) patient.
- B. If condition warrants, treatment of a minor (under age 18) is done via implied consent.

II. Right to Make Decisions Regarding Care

- A. If a conscious patient who is rational refuses treatment, the EMT should document the refusal (see guidelines for refusing care).
- B. If a conscious patient who is irrational (or impaired by alcohol or drugs) refuses treatment, the EMT should contact Medical Control and police and county mental health professional, if necessary (see guidelines for refusing care).
- C. If a patient's family, patient's physician, or nursing home refuses treatment for a patient, protocols are contained herein to deal with those situations.
- D. A rational patient has the right to select a hospital to which to be transported in a non-emergent situation.
- E. If a patient is a minor (under age 18) and no consenting adult is available and the minor refuses treatment, the EMT should contact Medical Control (and police, etc.)

-Note- When in doubt, contact the Medical Control and fully document all of your actions.

MEDICAL CONTROL

PeaceHealth Southwest Medical Center (PHSW) is Medical Control Base Station for clarification of orders or patient disposition, in cases of disparity between the prehospital care guidelines and private physician wishes, and for general medical information and for controlled substances or treatment (***) .

If a patient is being transported to a facility outside of Clark County, Medical Control must be utilized for treatment concurrence while the EMS unit is within Clark County. When the transport unit is operating in Multnomah County, Medical Control is at Medical Resource Hospital (MRH), OHSU.

In cases where life-threatening conditions exist or when communication is impossible, controlled medical treatment(s) (***) can be given without base station physician concurrence, or with the concurrence of the patient's private physician.

Medical Control will be contacted on all trauma patients if diversion to a Level I facility is anticipated. Occasionally, contact with Medical Control may be impossible prior to diversion/transport by Life Flight. In this instance, Medical Control will be contacted as soon as possible before leaving the scene by the Paramedic with patient/scene information

MEDICAL CONTROL CONCURRENCE PROCEDURES AND MEDICATIONS

Paramedic consult with a base hospital physician at Southwest Washington Medical Center is required for the following procedures and medications.

1. FIELD TERMINATION OF ACLS when doubt for code termination exists.
2. DIVERSION to Portland area hospital for trauma, burn, hyperbaric patient.
3. TRAUMA SYSTEM ACTIVATION
4. TRAUMA SURGICAL PROCEDURES:
 - Pleural Decompression (needle thoracentesis)
 - Surgical Cricothyroidotomy
 - Needle-Jet Cricothyroidotomy
5. PEDIATRIC ALTE AND PARENT/CAREGIVER REFUSING

EMS RESPONSE: Unit Delayed, Ambulance Closer, Cancellation

All Fire and Medic units responding on 911 calls will follow the Clark County Medical Priority Dispatch System (MPDS) EMS Response Modes. At times deviation from these modes may be appropriate. Any deviation by responding units shall be documented in writing and submitted to the unit's agency and Medical Program Director for review.

I. First Response Unit Delayed

When a first response unit realizes it will have a delayed response:

- A. The first response unit shall advise CRESA to notify the responding ambulance of the delay;
- B. CRESA shall advise the responding ambulance of the delayed response;
- C. The responding ambulance shall upgrade to the First Response EMS Response Mode.
- D. Delayed response is defined as any response time (time of dispatch to time of arrival) exceeding an EMS agency's response time standard for the incident location.

II. Ambulance Closer to a Call

When a responding ambulance unit realizes it is closer to a call:

- A. The ambulance crew shall advise the first responder of their location and respond according to the First Response EMS Response Mode;
- B. The first responder shall decide if it will respond according to First Response or Ambulance Response Mode.

III. Cancelling Response; Slowing Response; Diverting to Another Call

See "Cancellation/Slowdown"

DISPATCH – RESPONSE PRIORITY

Response Determinant	Response Priority	Response Mode	
		First Response	Ambulance
ECHO	1	Hot	Hot
DELTA	2	Hot	Hot
CHARLIE	3	Hot	Hot
BRAVO	4	Hot	Cold
ALPHA	5	Cold	Cold
	6	Cold (no-response option)	Cold
	7	Cold	Cold (no-response option)

CANCELLATION/SLOWDOWN/DIVERSION/STAGING

Once a call is received by an ALS transport unit, the unit will respond as rapidly as possible and make patient contact to determine and administer emergency medical care as needed.

I. Cancelling of Response

- A. CRESA reports the original caller has canceled the request for service. The Paramedic will make the decision to cancel or continue the call based on information from CRESA.
- B. A first-in responding unit reports that no patient is present.
- C. A first-in responding unit with an EMT, Paramedic, or EMS agency known to the responding unit arrives and reports to the ALS transport unit that the patient does not want or need contact by ALS transport unit. This cancellation can be due to:
 - 1. No need for treatment or minor care administered by the first-in units.
 - 2. Patient/Guardian desires POV transport (should be conveyed to transport unit). If first-in unit feels ALS transport Paramedic should continue in for evaluation, this should be conveyed to responding medic unit.
 - 3. It shall be the discretion of the Paramedic on the responding medic unit whether to continue to the scene.
 - 4. If the ALS transport unit does not respond, the first-in unit will obtain a waiver form signed by the patient or other responsible person stating that based on his/her own initiative they do not desire transport.

II. Slowdown

- A. Transport units may be slowed by first-in units, staffed by a Paramedic or EMT, after evaluating the patient and determining a slower response is appropriate.
- B. It would be more appropriate for the first-in unit to convey patient information to the medic unit so the responding Paramedic can decide if a slower response is appropriate.

III. Diversion

- A. An ALS transport unit may be diverted to another call when:
 - 1. It is obvious the second call is a life-threatening emergency and first-in units known to ALS transport unit as EMTs and/or Paramedics report that first call can await a second ambulance.
 - 2. A second ambulance is dispatched to the first call.

3. The first ambulance is decidedly closer to the second call and the response by it to the second call might conceivably be vital to the patient's outcome.

IV. Staging

- A. Stage/standby will be done only when responding to scenes involving acts of violence or other scene safety issues until the scene is secured by law enforcement or other means.
Items to consider:
 1. Information from CRESA indicating violence or potential for violence, i.e., assault with weapon, violent individual(s), hostage situation.
 2. Information that raises questions regarding the safety of responders, i.e., hazardous material or other special rescue situation.
- B. Units will advise CRESA of intent to stage and request Law Enforcement (or other appropriate agency) response (if not already done). CRESA will notify all responding units of intent to stage.
 1. The responsibility to stage rests with the responding agency. Communication of intent to stage will be shared between multiple responding agencies.
- C. CRESA has no authority to tell a unit to stage. They should provide ALL pertinent information to the responding units so they can make the appropriate determination as to whether to stage. This should be the same complete information as provided to law enforcement responding units.

PREHOSPITAL COMMUNICATIONS

I. Hospital Divert Status

Responding units (including dispatch) shall not contact Medical Control to inquire the divert status of PHSW when enroute to the scene; hospital divert status will be given to the Paramedic by CRESA dispatch or the receiving facility after evaluation of the patient. PHSW will still accept Trauma Entries, STEMI, Cardiac Arrest and acute Stroke when on divert

II. Hospital Notification Report Format (HEAR – Landline – 800mHz)

A. ALS/Emergency Report Format:

1. Unit identification
2. Age and sex of patient
3. Transport code (emergent/Code 3 or non-emergent/ Code 1)
4. Chief complaint or reason for transport
5. Very brief pertinent medical history (one sentence if possible)
6. Vital signs
7. Pertinent treatment rendered
8. Request for additional information or treatment
9. Estimated time of arrival (ETA)

-Note- The prehospital report should be provided to the receiving facility as soon as practical once transport has begun. All reports should be given in this order and should take a maximum of sixty seconds. The prehospital report is not meant to be a full patient report and should relay only pertinent patient care information. (Patient identification information is inappropriate to be given in the radio report.) Format for trauma system patients will follow specific reporting format as indicated in Trauma Protocols.

B. BLS/Non-Emergency Report Format:

1. Unit identification
2. Age and sex of the patient
3. Reason for transport
4. Estimated time of arrival (ETA)

-Note- The prehospital report should be provided as soon as practical once transport has begun. All reports should be given in this order and should take a maximum of thirty seconds. (Patient identification information is inappropriate to be given in the radio report.) If possible, use landline for hospital contact on transfers.

- C. Advise Medical Control or receiving emergency department of changes in patient's condition en route and request for further treatment.

III. Verbal Report to Emergency Department Physician And/Or Triage Nurse

- A. This should contain more detail than the radio report. The EMT now has the time to present thorough details of the scene, complete assessment of the patient, and complete report on patient care and the result of your efforts.

1. Name, age, sex and patient's physician
2. Chief complaint or injuries
3. If trauma, describe the trauma scene
4. Pertinent medical history
5. Physical examination findings
6. Explain patient treatments and results of such

PREHOSPITAL COMMUNICATIONS (Continued)

IV. Written Reports/Documentation

- A. A State of Washington approved EMS Medical Incident Report (MIR) form (or other approved electronic report format) must be appropriately documented and filed for any call for EMS assistance resulting in patient contact within Clark County regardless of patient transport. This will apply to all responding agencies, both basic and advanced life support units, and includes public assist calls.
 - 1. Patient contact occurs when a provider contacts/sees/hears a patient, even if other providers are on scene. The treatments and evaluations provided, while said provider is in contact with the patient, shall be documented as per this dictate.
- B. Documentation format
 - 1. If a written format is used, SOAP narrative charting is the most acceptable method of report writing. This is a LEGAL record and may be called upon as evidence in any court of law. (IF IT IS NOT WRITTEN, IT WAS NOT SEEN OR DONE.)
 - 2. If an electronic report format is used then it is necessary to follow the MPD approved documentation guidelines for that particular charting application.
- C. Documentation of Response Determinant/Priority
 - 1. All calls to 911 will be triaged and dispatched, based on the Medical Priority Dispatch System and its inherent response determinants (ALPHA, BRAVO, CHARLIE, DELTA, ECHO). Each determinant is assigned a Priority. Complete documentation of patient care will include the determinant and/or priority assigned at initial dispatch and any upgrades received while enroute.
- D. Documentation of Procedures
 - 1. Performance of any procedure will be documented in the MIR to include reason for procedure and patient response
 - 2. For all intubated patients, documentation of end tidal CO2 numeric value AND (waveform will be affixed to the chart
 - 3. Whenever an EKG monitor is used, a copy of the EKG recording will be affixed to the chart. This includes 12 lead tracings and code summary reports.
- E. The patient care report is a legal document and should reflect the patient care incident as accurately as possible. As such, the report will be completed as soon as feasible after the patient encounter to ensure an accurate accounting of the incident. **ALL REPORTS MUST BE COMPLETED PRIOR TO THE END OF SHIFT.**
 - 1. Transporting units will leave a completed report or Field Worksheet at the receiving facility upon delivery of the patient. Transport agencies are required to provide a completed (final) MIR to the receiving facility within 24 hrs. of patient arrival.

TRANSFER OF CARE/TIME ON THE SCENE

I. Transfer of Care

- A. In many situations, two or more ALS units (e.g. first responding fire ALS and ALS transport) will respond. When more than one Paramedic is on scene they will work cooperatively in making patient care decisions. If a disagreement exists on the correct course of action, Medical Control will be contacted for direction.
- B. In many situations it is appropriate for the first-arriving fire Paramedic to maintain continuity of patient care through both scene and transport, and he/she may choose to do so if in their judgment the patient will benefit from that continuity or scene times will be positively impacted in a clinically significant way.
- C. In less critical situations an orderly and efficient transfer of patient care responsibilities from first-responding fire ALS Paramedics to the transport team must occur, including:
 - 1. Transfer of patient care responsibility that does not interfere with or lengthen scene times.
 - 2. Written and/or verbal report that includes: documentation of vitals, findings, and all treatment(s) rendered.
 - 3. In cases of Multiple Patient Incident, protocol is established.
- D. At times, a patient's condition may warrant attendance during transport by both the first responding fire Paramedic and the transport Paramedic. In these situations, the first responding fire Paramedic may choose to accompany the patient during transport if in their judgment the patient will benefit from the additional attendance and/or if their attendance will positively affect scene times in a clinically significant way.

Note: A working cooperation when making patient care decisions is paramount and shall not be influenced by agency affiliation. Resources shall be utilized to the fullest for the benefit of patient care.

II. Time on Scene

- A. Any time an airway cannot be provided to a patient within 2 minutes after initiating emergency medical care, transport the patient immediately, unless there are extenuating circumstances.
- B. Medical – 30 minutes or less after initial encounter.
- C. STEMI/CVA – 15 minutes or less after initial encounter.
- D. Full Trauma Activation - 10 minutes or less once extrication has been accomplished and the patient can be removed from the site.
 - Modified Trauma Activation- 15 minutes or less.
- E. Code 99 - 30 minutes or less after initial encounter.
 - Note- Document extenuating circumstances.

LEVEL OF CARE DURING TRANSPORT

PARAMEDIC AND EMT ON CAR

Attendance of the patient during transport will be appropriate to the degree of illness as determined by the Paramedic. All ALS transports will be attended by an emergency medical technician certified by Washington State DOH to provide appropriate ALS procedures. The only exception may occur during mass casualty incidents.

-Note- Inappropriate assignment of medical attendants will be grounds for suspension of standing orders for EMT-P and EMT.

RECEIVING HOSPITAL

I. Triage Criteria:

- A. Non-Life Threatening Injuries or Illness - Hospital destination at the discretion of patient, family, or the patient's physician.
- B. Life Threatening Injuries or Illness – transport to the closest appropriate facility unless diversion criteria in effect.
- C. Patients meeting the following criteria will be transported to PHSW:
 - 1. Acute MI/STEMI
 - 2. Cardiac Arrest with return of spontaneous circulation.
 - 3. Trauma Activation (unless the following diversion criteria apply)
 - 4. Severe GI Bleed (Active bleeding, pt. in shock with suspected esophageal varices w/ hx of alcoholism and/or liver failure.)
- D. Patients meeting stroke/CVA criteria will be transported as follows:
 - 1. PHSW
 - a) ANY pt. with LAMS 4 or greater
 - b) ANY pt. 80 years old or greater
 - c) Symptoms more than 2 hours
 - d) Suspected intracranial hemorrhage
 - e) Signs of profound paralysis, aphasia, or comatose
 - 2. Closest Stroke Center
 - a) Symptoms 2 hours or less, above criteria not met

II. Diversion Criteria:

- A. Medical Diversion - Diversion by Medical Control may occur due to availability of resources, equipment, and/or facilities at PHSW. Destination hospital will generally be determined by closest facility.
- B. Trauma Diversion - The final decision for diversion to Emanuel or OHSU rests with Medical Control at PHSW. Contact Medical Control as soon as possible with patient information; if diverted, contact Trauma Communications Center (TCC) at OHSU for further instructions. Includes LifeFlight transport.
 - 1. Criteria for diversion may include:
 - a) Major burns (Refer to TRAUMA section, BURNS Protocol).
 - b) Pregnancy with multi-system trauma in shock, unresponsive to aggressive resuscitation or immediate surgery anticipated.
 - c) Pediatric trauma entry: Immediate consult directly with Medical Control physician for destination or diversion.
 - d) PHSW Medical Control advised diversion.
- C. Hyperbaric Diversion - Providence Hospital in Portland. Contact Medical Control as soon as possible with patient information including CO level; if directed to divert, contact Providence enroute.
- D. Diversion Based on Patient Request, Private Physician, and/or Primary Care/Health Plan:
 - 1. If patient condition critical (emergent/Code 3 transport) divert to closest facility.
 - 2. Potential for further diversions, i.e., receiving hospital on divert to another hospital. If intended hospital on divert, Paramedic may divert to closest facility.
 - 3. Other Considerations:
 - a) weather - traffic patterns, time of day, etc. - ambulance levels in the county (all agencies)

*If, in the Paramedic's judgment, diverting to a Portland hospital will result in a prolonged out-of-service time, divert to the closest facility. The receiving ED physician will be informed of the criteria and reason for the diversion; these shall also be documented in the MIR and be included in the criteria for MPD

review. Concurrence by Medical Control at PHSW is mandatory on all diversions to Portland unless contact impossible. Document concurrence/variance with MC on the MIR.

INTERFACILITY TRANSPORT

I. General Responsibility and Instructions

- A. It is the responsibility of the transferring facility to insure that the medical necessities for safe patient transfer are met including stabilization.
- B. Medical instructions of the attending Physician and Registered Nurses will be followed unless contrary to standing orders.
- C. Attendance of the patient during transport.
 - 1. Physician - he or she will direct all care regardless of standing orders.
 - 2. Registered Nurse – he or she will direct the care of the patient via orders from the physician at transfer or the receiving hospital physician. The registered nurse may desire to defer emergency care in some situations to the Paramedic.

II. Stabilization Prior to Transfer

- A. Patients will not be transferred to another facility without first being stabilized. Stabilization includes adequate evaluation and initiation of treatment to assure that transfer of a patient will not, within reasonable medical probability, result in material deterioration of the condition, death, or loss or serious impairment of bodily functions, parts, or organs.
- B. Stabilization of patients prior to transfer to include the following:
 - 1. Establish and assure an adequate airway and adequate ventilation.
 - 2. Initiate control of hemorrhage.
 - 3. Stabilize and splint the spine or fractures, when indicated.
 - 4. Establish and maintain adequate access routes for fluid administration.
 - 5. Initiate adequate fluid and/or blood replacement.
 - 6. Determine that the patient's vital signs (including blood pressure, pulse, respiration, and urinary output, if indicated) are sufficient to sustain adequate perfusion.
- C. ALS patient and Above Criteria Not Met:
 - 1. You may initiate prehospital protocols and guidelines including the establishment of intravenous lines, airway control, etc.
 - *** 2. You may refuse to transfer the patient until the facility has complied with the above evaluation and/or treatment. Should you decide this is necessary, contact Medical Control for concurrence and consultation or contact the MPD directly.

III. Other Considerations

- A. If a BLS transport is requested and it is the judgment of the BLS crew that the patient needs to be transported by an ALS ambulance, it is mandated that dispatch be contacted and an ALS crew dispatched. Under no circumstances should a BLS crew transport a patient, if in their judgment, this is an ALS call. (Exception: mass casualty incidents.)
- B. Emergencies en route:
 - 1. Prehospital protocols and guidelines will immediately apply.
 - 2. Medical Control should be contacted for concurrence of any orders as appropriate; the receiving facility should be contacted as soon as possible to inform them of changes in the patient's condition.
- C. Specific transport provider (AMR) protocols exist for advanced life support transfer between medical facilities. See AMR ALS Transfer Protocols, Clark County Washington

-Note- Any deviation from this guideline or from the transport protocols should be reported to the MPD on an incident report within 24 hours of occurrence.

NON-TRANSPORT OF PATIENTS

The EMT may be of the judgment that the patient need not be transported by ambulance, but unless the patient and/or custodian agrees with this judgment transport will be done. In general, the only reasons for a non-transport are:

- Signed "Refusal for Transport," completed by patient, family or custodian;
- No patient (DOA, termination of Code 99 effort, etc.).

I. Patients Refusing Care and/or Transport (classified as follows):

- A. No medical need exists. Patient cancels EMS.
- B. A person with normal decision making capacity who, after having been informed of risks and benefits of treatment/transport, voluntarily declines further services.
- C. Any other person is assumed to require a medical screening evaluation and EMS personnel will use all resources available to have that person treated and transported.

II. Impaired Decision Making Capacity Defined

- A. Inability to understand the nature of his/her illness/injury.
- B. Inability to understand risks or consequences of refusing care/transport.
- C. Individuals impaired by:
 1. Alcohol/drugs
 2. Psychiatric conditions
 3. Injuries (head injury, shock, etc.)
 4. OBS (Alzheimer's, developmental delays, etc.)
 5. Minors (<18 years old)
 6. Language/communication barrier (incl. deafness)

III. Criteria for Informed Refusal/Consent

- A. Person is given accurate information about possible medical problems and the risk/benefits of treatment or refusal.
- B. Person is able to understand and verbalize these risks and benefits.
- C. Person is able to make a decision consistent with his/her beliefs and life goals.

PREHOSPITAL GUIDELINES FOR PATIENTS REFUSING CARE

Establish if medical need exists. If the patient is refusing or resisting care, determine if patient capable of making informed decision OR patient not capable (in EMT's opinion) of making informed decision.

I. Capable of making informed decision, no medical need exists:

- A. A refusal form is not necessary.
- B. MIR documentation will include the events necessitating the call to EMS as well as all criteria for no patient/medical need.

- II. Capable of making informed decision, minor medical need exists:
- A. A refusal form is necessary. Form and MIR must be completed by Paramedic attending patient.
 - B. MIR documentation shall include:
 - 1. The patient's chief complaint.
 - 2. Events prior/reason for call to EMS.
 - 3. Pertinent medical history.
 - 4. Description of scene (if relevant to patient's c/c).
 - 5. Physical exam including vital signs and clinical impression.
 - 7. Prehospital interventions.
 - 8. Consultation with Medical Control or patient's MD (PMD) as necessary.
 - 9. Patient's response to medical care and/or transport attempts.
 - 10. Instructions to patient and/or family including risks/benefits of treatment/transport.
- III. Capable of making informed decision, immediate medical care and/or ambulance transport necessary:
- A. A refusal form is necessary. Form and MIR must be completed by Paramedic attending patient.
 - B. Every effort will be made to convince these patients to accept necessary prehospital intervention and transport to definitive care. Options available to the Paramedic include:
 - 1. Solicit assistance from family, friends, and/or other close associates to persuade the patient to accept necessary treatment and transport.
 - 2. Solicit assistance from law enforcement (police hold), mental health professional (psychiatric hold), and/or clergy as the situation directs.
 - C. CONSULTATION WITH MEDICAL CONTROL IS MANDATORY.
 - D. MIR documentation shall include:
 - 1. The patient's chief complaint.
 - 2. Events prior/reason for call to EMS.
 - 3. Pertinent medical history.
 - 4. Description of scene (if relevant to patient's c/c).
 - 5. Physical exam including vital signs.
 - 6. Clinical impression.
 - 7. Prehospital interventions.
 - 8. Consultation with Medical Control or PMD as necessary.
 - 9. Patient's response to medical care and/or transport attempts.
 - 10. Instructions to patient and/or family including risks/benefits of treatment/transport.
 - E. If the patient still refuses treatment/transport, the attending Paramedic will be responsible for explaining the CLARK COUNTY EMS REFUSAL INFORMATION FORM. Completion of the form includes:
 - 1. Explanation of instructions and release of liability to the patient.
 - 2. Receipt of signature (dated) from patient or legal guardian.
 - 3. Completion of patient assessment, Medical Control consult, and patient disposition sections.

- IV. Not capable of making informed decision, medical care and/or ambulance transport necessary:
- A. A refusal form is necessary. Form and MIR must be completed by Paramedic attending patient.
 - B. Every effort will be made to convince these patients to accept necessary prehospital intervention and transport to definitive care. Options available to the Paramedic include:
 - 1. Solicit assistance from family, friends, and/or other close associates to persuade the patient to accept necessary treatment and transport.
 - 2. Solicit assistance from law enforcement (police hold), mental health professional (See Psychiatric Disorders Section), and/or clergy as the situation directs.
 - 3. Consider physical restraint and/or chemical sedation per Medical Control concurrence based on the patient's condition and current situation.Physical restraint and/or chemical sedation can occur only when the Paramedic believes the patient poses a danger to him/herself or others.
 - C. CONSULT WITH MEDICAL CONTROL IS MANDATORY.
 - D. MIR documentation shall include:
 - 1. The patient's chief complaint.
 - 2. Events prior/reason for call to EMS.
 - 3. Pertinent medical history.
 - 4. Description of scene (if relevant to patient's c/c).
 - 5. Physical exam including vital signs.
 - 6. Clinical impression.
 - 7. Prehospital interventions.
 - 8. Consultation with Medical Control or PMD as necessary.
 - 9. Patient's response to medical care and/or transport attempts.
 - 10. Instructions to patient and/or family including risks/benefits of treatment/transport.
 - E. If the patient still refuses treatment/transport, the attending Paramedic will be responsible for explaining the CLARK COUNTY EMS REFUSAL INFORMATION FORM. Completion of the form includes:
 - 1. Explanation of instructions and release of liability to the patient.
 - 2. Receipt of signature (dated) from patient or legal guardian.
 - 3. Completion of patient assessment, Medical Control consult, and patient disposition sections.
 - F. Every reasonable effort should be made to ensure patients receive necessary medical treatment and transport. If the patient seems hesitant regarding their medical care/transportation or any doubt exists, you should provide care/transportation.
 - G. Should the above efforts prove fruitless, it may be necessary to leave these patients at the scene. Aforementioned documentation guidelines will be adhered to.
- V. Patient in Custody and/or Incident Involving Law Enforcement
- A. If patient competent, follow protocol outlined above regarding medical need. The patient will require a full medical exam, pertinent to the nature of the chief complaint and mechanism of injury. If the patient refuses care and/or transport a refusal form must be signed by the patient.
 - B. If patient in custody of police, under arrest and/or restrained by officers who are refusing transport, document refusal in MIR with signature of arresting police officer on refusal form.
 - C. All other patients will be transported to the hospital by ambulance. It is not appropriate to allow transport by police if a patient has obvious medical need.

PRIVATE PHYSICIAN AND/OR MEDICAL PROFESSIONALS AT THE SCENE

When the patient's private physician is in attendance and has identified himself/herself upon the arrival of the ALS team, the ALS team will comply with the private physician's instructions for the patient. Base hospital will be contacted for reporting and estimated time of arrival. If orders are given which are inconsistent with established protocols, clearance must be obtained through the Medical Control Physician.

I. The Physician at the Scene:

- A. May request to talk directly to the Medical Control Physician to offer advice and assistance;
- B. Can offer assistance to the ALS Team with another pair of eyes, hands, or suggestions, leaving the ALS team under Medical Control;
- C. May take total responsibility for the patient with the concurrence of the Medical Control Physician.

II. Transport

- A. If during transport, the patient's condition should warrant treatment other than that requested by the private physician, Medical Control will be contacted for information and concurrence with any treatment, except in cases of cardiopulmonary arrest.

-Note- The above protocol will also apply to cases where a physician may happen upon the scene of a medical emergency and interacts with the ALS team.

III. Medical Professionals at the Scene

- A. Medical professionals at the scene of an emergency may provide assistance to Paramedics and should be treated with professional courtesy. Medical professionals who offer their assistance must identify themselves. Physicians must provide proof of their identity, if they wish to assume or retain responsibility for the care given the patient after the arrival of the Paramedic unit.

DO NOT RESUSCITATE ORDERS

I. Definitions:

- A. A DNR (DO NOT RESUSCITATE OR NO CODE) Order is an order issued by a physician directing that in the event the patient suffers a cardiopulmonary arrest (i.e., clinical death), cardiopulmonary resuscitation will not be administered. DNR orders are only valid when a patient is under the care of skilled nursing personnel.
- B. A Living Will is a legally executed document expressing the patient's wish to not undergo ALS resuscitation.
- C. Physician Orders for Life Sustaining Treatment (POLST): Legal document signed by patient and physician indicating patient preference for life sustaining treatment. Includes preference for resuscitation; replaced EMS No-CPR form.
- D. Resuscitation includes attempts to restore failed cardiac and/or ventilatory function by procedures such as endotracheal intubation, mechanical ventilation, chest compressions, defibrillation, and use of ACLS cardiac medications.

II. Procedures:

- A. When the patient's family, friends, or nursing home personnel state that the patient is not to be resuscitated:
 - 1. BLS protocols will be followed while attempts to determine if a written POLST form, DNR order, or a Living Will is present.
 - 2. In the absence of the above, call Medical Control or the attending physician, if known by you and available.
 - 3. The EMT must document the POLST form, DNR order, or Living Will in the patient care report.
- B. No BLS or ALS procedures should be performed on a patient who is the subject of a confirmed POLST form, DNR order, or has a Living Will and who is PULSELESS AND NONBREATHING.
- C. See ***DEATH IN THE FIELD*** Protocol for further information.

BLOOD DRAWS – Impaired Driver

I. Impaired Driver

- A. Blood for legal alcohol, marijuana, or other drug determination may be drawn at request of law enforcement:
 - 1. When the officer has reasonable grounds to believe that the person is in violation of RCW 46.61.502 or 46.61.504: driving or being in actual physical control of a motor vehicle while under the influence of intoxicating liquor and/or drugs.
 - 2. The Officer may request blood be drawn pursuant to:
 - a). A search warrant
 - b). Valid waiver of the warrant (patient consent)
 - c). Exigent circumstances
 - * Vehicular homicide
 - * Unconscious
 - * Felony DUI
 - * Vehicular assault
 - * Serious injury to another resulting in DUI arrest
 - * Other circumstances to be articulated by Officer

II. Procedure

- A. Requesting Officer will provide the blood draw kit:
 - 1. Utilize universal precautions as per OSHA.
 - 2. The law enforcement officer will remove the parts of the kit and hand them to the Paramedic as needed.
 - 3. The Paramedic drawing the blood will swab the site with betadine and allow to air dry for one minute.
 - a). Draw appropriate tubes of blood for testing.
 - b). When done doing blood draw, check glucose and apply gauze until hemostasis obtained.
 - 4. Hand the vials back to the Law enforcement officer as they are filled.
 - 5. Label tubes with patient name, DOB and current date. Document blood draw on ePCR.

-Note- Patient care needs are the first priority when considering a blood draw per request of Law Enforcement. Do not delay necessary patient care and/or transport to draw blood.

MEDICATION ADMINISTRATION GUIDELINES

- I. Controlled Medications
 - A. Controlled medications are maintained at each agency utilizing approved protocols and security, to include lot number and vial number. Agency operating procedures for controlled medication ordering, receipt, storage and administration may be individualized but they must follow these general guidelines:
 - B. When a controlled substance is used, the Clark County Controlled Drug Proof of Use form (or other approved tracking system) will be completed by the Paramedic administering the medication and the agency officer authorized to replace the medication. Wastage will be documented in the same fashion.
 - 1. Each agency will maintain the Controlled Drug Proof of Use form as a permanent record.
 - * C. Paramedics only are authorized to administer controlled drugs.
 - 1. **Fentanyl**
 - 2. **Versed**
 - 3. **Ketamine**
 - D. Ordering of controlled medications, (to be done ONLY by the authorized agency officer):
 - 1. The DEA order form (222) will be completed by the agency authorized officer and submitted to the MPD for signature.
 - 2. The MPD will retain a copy of the order form (222) and the authorized officer will submit the form to the vendor.
 - 3. A scanned copy will be provided to allow for quarterly audits with the controlled medication vendor.
 - E. Receipt and storage of controlled medications.
 - 1. Receipt of controlled medication from the vendor will be done by approved agency personnel and overseen by the authorized agency officer in charge of controlled medications.
 - 2. Storage and disbursement of controlled medications will include records of lot and vial numbers and amounts distributed to ALS personnel.
 - 3. Controlled medications will be stored under double lock.
 - F. Inventory of controlled medications will be monitored for security by no less than two authorized agency officers to ensure compliance with these guidelines.
 - G. All ALS agencies with controlled medications must have operating procedures on file with the MPD's office.
 - H. All agencies will monitor controlled medication utilization by each Paramedic on a quarterly basis. This data will be submitted to the MPD for review.
- II. Allergies to Medications
 - A. All medications are administered only after ascertaining the patient is not allergic to them.
- III. IV Fluids
 - A. Intravenous access is to be established on all ALS patients unless unable.
 - B. The purposes of IV access are:
 - 1. Fluid resuscitation for hypotension.
 - 2. Administration of IV medications per protocol.
 - 3. The anticipation of need for the above.
 - C. IV fluid of choice is a balanced salt solution (BSS). If fluid is not needed for resuscitation, this will be TKO or a saline lock.

IV. Blood Products

- A. Blood may be administered en route, during interfacility transfer to unstable patients who are actively bleeding or in shock
 - 1. Blood will be provided by transferring facility and be administered via large bore IV blood tubing.
 - 2. Stop infusion if patient develops signs of allergic reaction and treat pt. accordingly.

V. Intraosseous (IO) Access

A. Indications

- 1. Attempts at peripheral sites unsuccessful (after ~1 minute), patient obtunded and requiring vascular access, i.e., trauma resuscitation, code 99.
- 2. Intravascular access necessary to administer fluids and/or medications and other peripheral IV sites unavailable.
- 3. Documentation of training for use with specific device must be provided to MPD prior to authorization for use.

B. Insertion

- 1. Anterior proximal tibia, distal tibia and/or adult humeral head (EZ IO)

C. If patient not obtunded and c/o pain at insertion site, infuse 2ml of 2% **Lidocaine** (40 mg). May repeat prn for localized pain. *1mg/kg Peds, max 40mg*

D. IO devices must be preapproved by the MPD prior to use.

CLARK COUNTY PREHOSPITAL MEDICATION LIST

MEDICATION	DOSE	INDICATION
Acetaminophen Suppositories	<i>Peds 20mg/kg</i>	Fever >103·F
Activated Charcoal	50gm PO <i>Peds 1-2g/kg</i>	Ingestion
Adenocard (Adenosine)	6 mg, 12mg x 2 prn <i>Peds 0.1 mg/kg, 0.2 mg/kg. Max peds single dose 12 mg</i>	PSVT (dose 12, 12, 18 if pt. on theophylline; ½ normal dose if hx of heart transplant, Persantine, or Tegretol)
Albuterol (Proventil)	5mg Nebulized repeat prn to sx resolution <i>Peds <15kg 2.5-5mg >15kg 5-10mg</i>	-Bronchospasm/wheezing -Hyperkalemia
Amiodarone (Cordarone)	a) 300mg IV/IO may repeat 150 mg in 3-5 min. b) 150 mg over 10 min x 2 prn <i>Peds 5mg/kg bolus</i>	a) VF/pulseless VTach b) Stable V Tach
Atropine	a) 0.5mg max 3 mg b) 1-2mg q 5 min. <i>Peds 0.01-0.02mg/kg</i>	a) Bradycardia b) Organophosphate poisoning c) RSI peds <6
Atrovent (Ipratropium Bromide)	500mcg/2.5ml Nebulized <i>Peds <5 yo ½ adult dose</i>	Bronchospasm/wheezing due to asthma, COPD, anaphylaxis, inhalation
Calcium Chloride	a) 500mg b) 250-500mg <i>Peds 20mg/kg</i>	a) Hyperkalemia b) Calcium channel blocker OD
Dextrose D10	10gm (100ml) repeat 5gm prn to normal BGL max 25gm <i>Peds 0.1gm/kg</i>	- ALOC, Hyperkalemia - Hypoglycemia
D50 <i>alternative</i>	10 gm D50W (20 ml) IV. May repeat prn to total 25gm.	
Diltiazem (Cardizem)	0.25 mg/kg over 2min repeat 0.35 mg/kg (maximum 20-25mg) if successful drip 10 mg/hr	Afib, Aflutter with rapid ventricular response PSVT refractory to Adenosine
Diphenhydramine (Benadryl)	12.5-50mg <i>Peds 1mg/kg</i>	- Allergic reaction, Anaphylaxis - Dystonic reaction
Dopamine	2-10mcg/kg/min	Shock, non-hypovolemic

Epinephrine	<p>a) 1mg q 3-5 min. <i>Peds 0.01mg/kg</i></p> <p>b) 2-10mcg/min IV infusion <i>Peds 0.1mcg/kg/min</i></p> <p>c) 0.3mg IM <i>Peds 0.01mg/kg</i></p>	<p>a) Cardiac Arrest</p> <p>b) Hypotension/profound bradycardia/status asthmaticus Anaphylaxis</p> <p>c) If unable to start IV in Anaphylaxis</p>
Etomidate	0.3 mg/kg max 20 mg	Sedation prior to RSI
Fentanyl	<p>25-50 mcg IV, IO, IM max 3 mcg/kg (no more than 200 mcg/hr)</p> <p><i>Peds 1-2 mcg/kg IV, IO, IN</i></p>	<p>- Chest pain</p> <p>- Musculoskeletal pain</p>
Furosemide (Lasix)	<p>20-40mg</p> <p><i>Peds 1mg/kg</i></p>	<p>- CHF/ PE</p> <p>- Hypertensive crisis</p>
Glucagon	<p>a) 1mg SC, IM</p> <p><i>Peds 0.5mg</i></p>	Hypoglycemia
Haloperidol (Haldol)	<p>2mg – 5 mg IV/IM. May repeat q 15min to total 10mg max dose.</p> <p><i>Peds 0.1 mg/kg</i></p>	Chemical Sedation
Ketamine	<p>a) 2 mg/kg max 200 mg</p> <p>b) 0.3mg/kg max 25mg</p>	<p>a)- Sedation prior to RSI</p> <p>b)- Sedation for CPAP, Pain Control adjunct</p>
Lidocaine	<p>a) 1–1.5 mg/kg repeat 0.5-0.75 mg/kg prn to 3mg/kg max</p> <p>b) 40mg slow IO</p> <p><i>Peds 1mg/kg</i></p>	<p>a) VF, VT, WCT RSI w/ reactive airway disease</p> <p>b) local pain control after IO insertion</p>
Magnesium Sulfate	<p>a) 2gm over 5-10 mins</p> <p>b) 2gm over 4-5 min</p> <p>c) 2gm over 5-20 min</p> <p><i>Peds 25-50 mg/kg</i></p>	<p>a) Torsades VT; TCA OD, Ecclamptic Sz</p> <p>b) WCT, status asthmaticus</p> <p>c) ETOH Seizure</p>
Methylprednisolone (Solumedrol)	<p>125mg IV</p> <p><i>Peds 2 mg/kg</i></p>	<p>- Asthma</p> <p>- Anaphylaxis</p>

Midazolam (Versed)	2.5-10mg IV, Deep IM <i>Peds 0.1-0.2 mg/kg IV, Deep IM</i>	- Seizures - Sedation (RSI, pacing, cardioversion) - Cocaine, meth, MDMA, hyperadrenergic toxicity - Chemical sedation
Naloxone (Narcan)	0.4-2mgx2 prn IV, IM, IN, IO <i>Peds If <5yrs (or <20kg) 0.1mg/kg to max of 2mg 0.5 mg prn (max as above)</i>	- Narcotic OD w/ respiratory depression - ALOC w/o respiratory depression
Nitroglycerine	0.4mg (spray) SL 0.4mg (tablet) SL	- Chest pain - CHF/PE - Hypertensive crisis
Racemic Epinephrine	<i>Peds 0.5cc if Peds 20-40kg 0.25cc if Peds <20kg</i> Mix in 5cc NS via Med Neb	- Croup/Epiglottitis
Rocuronium	1 mg/kg	Facilitate intubation; long term paralytic
Sodium Bicarbonate	a) 1mEq/kg (add 1amp to IV bag in TCA OD) b) 50mEq/50cc	a) Cardiac arrest, VF in hypothermia, TCA OD, near drowning. b) Hyperkalemia
Sodium Thiosulfate	50 ml 25% solution IV over 10 mins. <i>Peds - 1.65 mL/kg IV/IO infused over 10 to 20 minutes.</i>	Cyanide Poisoning
Succinylcholine	1.5mg/kg x 2 prn max single dose 200mg	Facilitate intubation
Vecuronium (Norcuron)	0.1mg/kg	Long Term Paralytic After confirmed intubation
Verapamil	5 mg may repeat q 15min max 30 mg	NARROW complex supra ventricular rhythms
Ziprasidone (Geodon)	10-20 mg IM ONLY	Chemical Sedation
Zofran (Ondansetron)	8 mg <i>Peds >2 years (20kg) 0.1 mg/kg do not exceed adult dose</i>	- Nausea/Vomiting - Prevent N/V with Fentanyl administration

PREHOSPITAL EXPOSURE AND INFECTIOUS DISEASE CONTROL

- I. Known or Suspected Exposure
 - A. If exposure occurs, follow agency SOP for notification of agency administrators.
 - 1. DO NOT WAIT TO REPORT. Should be done within 30 minutes of exposure or as soon as possible after patient delivery.
 - B. Upon hospital arrival with patient, notify ED charge nurse of potential exposure to communicable disease. In addition, inform the charge nurse of all other prehospital personnel who made patient contact (includes fire, police, etc.). The nurse will document this information in the "Prehospital Exposure Log." If you work for a non-transporting agency, contact administrative personnel as per your agency SOP.
 - 1. If communicable disease suspected, all personnel in contact with the patient will be documented on the prehospital exposure log and be contacted (or their agency contact person) upon confirmation of communicable disease.
 - 2. If communicable disease confirmed, all personnel documented on the prehospital exposure log (or their agency contact person) will be contacted by the charge RN or his/her designate.
 - C. Treatment/prophylaxis will be provided as per "Guidelines for Prophylaxis of Occupational Exposure to Common Infectious Diseases."
 - 1. If indicated, prehospital personnel will be required to sign in to FasTrack and complete workers compensation form.
- II. Unknown Exposure
 - A. Prehospital personnel (or their designated agency representative) will be contacted by the charge nurse upon confirmation of communicable disease.
 - B. All prehospital personnel will be documented on the "Prehospital Exposure Log."
 - C. Treatment/prophylaxis will be provided as per "Guidelines for Prophylaxis of Occupational Exposure to Common Infectious Diseases."
 - 1. If indicated, prehospital personnel will be required to sign in to FasTrack and complete workers compensation form.
- III. Exposure Defined
 - A. Exposure(s) of any bodily fluids into body openings, mucous membranes or cuts/wounds. Exposures typically occur through dirty needle sticks or splash-like mechanisms.
- IV. Flu Vaccination
 - A. During flu season per declaration by Clark County Public Health, the following procedure will be applied:
 - 1. Prehospital personnel receiving flu vaccine will follow standard infectious disease prevention during patient encounters.
 - 2. Personnel who are NOT vaccinated will follow standard infectious disease prevention during patient encounters including wearing a mask for ANY patient contact.
- V. Standard Infectious Disease Prevention
 - A. Gloves, eye protection and masks when contamination with body fluids or aerosol droplets is possible including response to ANY sick person at a care facility.

ABANDONED NEWBORNS

I. Introduction:

- A. Senate Bill 5236 allows for the relinquishment of newborn children at hospitals or fire stations. The key provisions of this law include:
 - 1. Protecting parental anonymity
 - 2. Gathering the medical history of the parents and child
 - 3. Providing referral information to the parent about adoption options, counseling, medical and emotional aftercare services, domestic violence, and the legal rights of the transferring parent
 - 4. Notifying and releasing the newborn to child protective services (CPS).
 - a. SB 5236 defines newborn as less than 6 days old.

II. Procedure:

- A. If delivery has not occurred and appears imminent follow Emergency Delivery protocol. Provide appropriate care to mother per protocol. Follow agency SOP.
- B. If EMS is presented with a newborn and child in extremis:
 - 1. Follow **NEWBORN RESUSCITATION** or **MANAGEMENT OF THE SEVERELY ILL OR INJURED CHILD** protocol.
- C. Patient not in immediate need for medical care:
 - 1. Ascertain child's medical history as appropriate:
 - a. History of birth including complications, date, time, etc.
 - b. Known congenital anomalies
 - 2. Paternal/Maternal medical history
 - a. Prenatal care
 - b. Drug use during pregnancy
 - c. Other factors influencing child's health
- D. Transport to PHSW or LSC.
 - 1. Notify staff en route of need for CPS referral.

III. Circumstance:

- A. Maintaining parent confidentiality is paramount. Ascertain as much history as appropriate while providing a non-judgmental environment.
- B. Provide the following referral information to the parent(s) as time allows (patient care is the priority).
 - 1. Medical and emotional aftercare (i.e., TIP, Chaplaincy, etc.)
 - 2. CPS

PREHOSPITAL RESEARCH

I. Introduction

- A. Prehospital research will be regularly conducted in Clark County. This may involve retrospective and concurrent data extrapolation from CAD and patient care documentation and will not influence current patient care protocols or clinical practice. However, some prospective projects will require modification of protocols and procedures and require prehospital personnel to become informed of the alterations in practice prior to study involvement. In the event of a prospective prehospital study the following guidelines should be used:
 - 1. No study will be done without fully vetting of the project, including any financial implications, with all agencies affected. Each agency agreeing to participate will enter into an agreement.
 - 2. All involved personnel must attend necessary didactic and clinical skills training sessions pertaining to the research project, as per guidelines set forth by the MPD and the research team.

II. Alterations in Patient Care Protocols/Procedures

- A. Alterations in patient care protocols/procedures, i.e., institution of new procedures/medications, change in destination procedures, addition of new devices, etc. will be followed as per guidelines set forth in the education programs.
- B. These alterations will be adhered to and supersede current protocols during the time of the study.
- C. When feasible and length of research project warrants, modified guidelines will be provided to participating personnel in the form of addenda to these protocols.

III. Time Stamp for Protocols And Procedures

- A. Consistent and synchronized documentation of treatment and intervention time is paramount to the success of a research project. Time documentation will be done using the cardiac monitor/defibrillator, where applicable, or CAD supported time stamp.
- B. Any device used for documentation of treatment/intervention time will be synchronized with CRESA daily if necessary..

IV. Upload of Cardiac Monitor/CPR Process Files

- A. If applicable to a study, electronic cardiac monitor and/or CPR process files will be acquired and submitted in accordance with EMS agency policy, software, and cardiac monitoring equipment.

HAZARDOUS MATERIALS INCIDENT

- I. Is Police/Fire Security Line Established?
 - A. NO
 - 1. Secure scene
 - 2. Establish perimeter and call for police/fire assistance.
 - 3. Do not approach victims until HAZ-MAT Team security line established.
 - B. YES
 - 1. Ask for directions to Staging Area
 - 2. Report to Staging Area

- II. Take Contamination Precautions
 - A. Insure patient has been decontaminated and clothing and belongings have been removed. (Clear with HAZ-MAT Team.)
 - B. Place disposable sheets over gurney and floor, if needed.
 - C. Treat patient symptomatically: refer to protocols in HAZARDOUS MATERIAL INJURIES: A Handbook for Prehospital Care, Stutz, Ricks, Olsen

- III. Transport
 - A. Write down exact name of chemical/agent.
 - B. Obtain advice for further decontamination of vehicle or personnel, from HAZ-MAT Team.
 - C. Provide name of chemical/agent to Emergency Department staff prior to hospital arrival.
 - D. Double bag any contaminated clothing, equipment, sheets or blankets.
 - E. Delay patient unloading until cleared by Emergency Department staff.
 - F. Implement any secondary decontamination procedures for vehicle or personnel, if necessary.

-Note-

EMS personnel are urged to be alert for hazardous materials when responding on calls. Hazardous materials may be obvious, but often are not. If a vehicle has a diamond shaped placard or an orange numbered panel on its side or rear, assume the cargo to be hazardous. Consult the hazardous materials identification guidebooks carried on each unit. Not all hazardous materials will be clearly identified. Grocery trucks or delivery vehicles may be carrying hazardous materials without the diamond shaped placard or orange numbered panel to identify such transport. Common sense dictates that each EMT assume hazardous material is present unless proven otherwise.

Park uphill and upwind from suspected hazardous materials unless otherwise directed by a competent authority, usually the senior fire officer or incident commander.

Do not drive or walk through any suspected hazardous material.

TRAUMA PROTOCOLS

I. General Considerations

- A. Ten minutes on-scene time, unless there are extenuating extrication problems.
-Note- It cannot be overemphasized that adequate management of the severely traumatized patient can occur only in the operating room, and that field care is appropriate to stabilize the patient's vital functions and to ensure safe transport without further injury. In other words, a modified scoop and run approach is the standard of care.
- B. Upon evaluation of the patient(s) and determining the need for a trauma system entry, the Paramedic will contact Medical Control to discuss patient transport and destination. Use Trauma HEAR Report format for accurate relay of information. If diversion to Portland is advised:
 - 1. Contact Trauma Communications Center (TCC) at OHSU as soon as possible.
 - 2. Enter Oregon's Trauma System.
 - 3. Emanuel Hospital will be destination hospital under usual circumstances, except as indicated by TCC.

II. FULL TRAUMA ACTIVATION/MODIFIED TRAUMA ACTIVATION

- A. Initial evaluation of patient(s) and scene should be made rapidly to determine need for trauma center care or rapid transport. Establish DIRECT communication with Medical Control and request Full Trauma Activation or Modified Trauma Activation, if any of the following criteria are met:
1. FULL TRAUMA ACTIVATION
 - a) VITAL SIGNS AND LEVEL OF CONSCIOUSNESS
 - * Glasgow Coma Scale < 14
 - * Systolic blood pressure < 90 mmHg
 - * Respiratory rate < 10 or > 29 breaths per minute (< 20 in infant < one year)
 - b) ANATOMY OF INJURY
 - * All penetrating injuries to head, neck, torso, and extremities proximal to elbow and knee
 - * Flail chest
 - * Two or more proximal long-bone fractures
 - * Crushed, degloved, or mangled extremity
 - * Amputation proximal to wrist and ankle
 - * Pelvic fractures
 - * Open or depressed skull fracture
 - * Paralysis
 2. MODIFIED TRAUMA ACTIVATION
 - a) MOI/High Energy Impact
 - Falls
 - * Adults: > 20 ft. (one story is equal to 10 ft.)
 - * Children: > 10 ft. or 2-3 times the height of the child
 - High-Risk Auto Crash
 - * Intrusion: > 12 in. occupant site; > 18 in. any site
 - * Ejection (partial or complete) from automobile
 - * Death in same passenger compartment
 - * Vehicle telemetry data consistent with high risk of injury
 - * Auto v. Pedestrian/Bicyclist thrown, run over, or with significant impact
 - * Motorcycle Crash > 20 mph
 - b) Special Considerations
 - Age
 - * Older Adults: Risk of injury or death increases after age 55 years
 - * Children: Should be triaged to pediatric-capable trauma centers
 - Anticoagulation and Bleeding Disorders
 - Burns
 - Time Sensitive Extremity Injury
 - End-Stage Renal Disease Requiring Dialysis
 - Pregnancy > 20 Weeks
 - Paramedic Judgment

LIFE FLIGHT/AIR AMBULANCE TRANSPORT

I. GENERAL CONSIDERATIONS

- A. Air Ambulance is appropriate for the critical trauma patient if transport time can be reduced by at least 10 minutes vs. ground. Consider the following when deciding on Air transport:
 - 1. Transport time to a level I or II trauma center can be reduced by 10 minutes vs. ground transport. Factors affecting the 10 minute reduction include:
 - a. Transfer of patient care to Life Flight personnel
 - b. Establishing and transporting to the landing zone
 - 2. In general, incidents occurring within 20 miles of the trauma center do not necessitate helicopter transport.

II. STANDBY

- A. LIFE FLIGHT may be placed on standby by:
 - 1. 1st Responder
 - 2. EMT
 - 3. Paramedic
 - 4. Any Physician
 - 5. Any Police Officer

-Note- When LIFE FLIGHT is put on standby status, the helicopter is readied but remains available for any other requests on a priority basis. If another agency requests activation and you have LIFE FLIGHT on standby, LIFE FLIGHT will check with you for activation or stand-down.
- B. LIFE FLIGHT should be placed on standby by trained personnel on scene after patient assessment has been done. It would be appropriate to place LIFE FLIGHT on standby prior to personnel arrival based on the following guidelines:
 - 1. If first response unit arrival at the scene will be greater than 10 minutes and the information dispatched purports to be the type of patient who will benefit from LIFE FLIGHT. Examples of situations:
 - a) gunshot or penetrating trauma
 - b) MVA: person trapped or multiple patients
 - c) auto-pedestrian
 - d) severe burns
 - e) major amputation
 - f) entrapment, i.e., cave-in, machine on person, etc.
 - g) any call the Paramedic deems is necessary

III. ACTIVATION

- A. The decision to activate LIFE FLIGHT rests with a responding Paramedic (or a physician on scene):
 - 1. As Paramedic arrives on scene and evaluates patient.
 - 2. Based upon information relayed to Paramedic by people on scene.
- B. In some cases, LIFE FLIGHT can be immediately dispatched (activated) to the scene prior to the arrival of a first-in unit or Paramedic, when:
 - 1. Travel time for that first-in unit will be over 20 minutes and the situation as known purports to be the type of patient who will benefit from LIFE FLIGHT.
 - 2. Where it is known that difficult terrain will be encountered rendering ground access difficult but where the helicopter can get near the patient easily.
 - 3. Where the reporting party relates some other special circumstance indicating the need for its immediate activation.

III. ACTIVATION (cont.)

4. On scene EMS responders relate to the Paramedic the need for activation of LIFE FLIGHT prior to that Paramedic's arrival.
-Note- In those situations (A or B above), activation shall be done through CRESA with concurrence of responding Paramedic.
- C. Criteria for Activation
 1. Patient(s) meet criteria for trauma team/trauma alert and extrication and/or ground transport will be prolonged (>10 minutes).
 2. Type of injury may dictate immediate transport to level I (Emanuel Hospital, OHSU).
 - ***a) Medical Control at PHSW to be contacted as soon as possible for instruction and/or concurrence for diversion to Portland. Situations that may result in diversion include but are not limited to:
 - * Burns (major).
 - * Pregnancy with multi-system trauma in shock, unresponsive to aggressive resuscitation, or where surgery is anticipated immediately.
 - * Pediatric patient with shock/respiratory distress.
 3. Multiple victims meeting trauma team criteria.
 4. Diversion to Portland by Medical Control due to hospital resources (PHSW down for trauma).
 5. LIFE FLIGHT should not be used for obvious DOAs, trauma codes and other situations where the outcome is an obvious fatality. (Refer to **DEATH IN THE FIELD** protocol.)
- D. Destination Hospital
 - *** 1. Unless diversion criteria above applies, the destination hospital shall be indicated to LIFE FLIGHT by the Paramedic in charge (PIC). The PIC will consult with Medical Control and TCC to determine destination

IV. CANCELLATION

- A. LIFE FLIGHT may be cancelled by the Paramedic responsible for the patient upon examination of the patient and it is apparent that air transport is not necessary. (See Criteria for Activation.)

V. CASE REVIEWS

- A. LIFE FLIGHT calls will be reviewed by Clark County QA Committee and reported to the Medical Program Director.

VIRAL RESPIRATORY DISEASE PANDEMIC (PANFLU)

- I. Triggers
 - A. Activation of the EMS Viral Respiratory Disease, Pandemic SOPs is made by Incident Command in consultation with Clark County Public Health.
- II. Communications
 - A. 9-1-1 Operations/Dispatch
 - 1. Ongoing Surveillance:
 - a) 9-1-1 will use protocol 26 (sick person) for patients whose primary chief complaint is flu-like non-priority symptoms (fever, nausea, and vomiting).
 - b) 9-1-1 will use the Severe Respiratory Infection (Flu-Like) Symptoms checklist on all patients with illness caused by the flu.
 - 2. Communicable Disease Outbreak:
 - a) 9-1-1 will use protocol 36 (Pandemic/Epidemic/Outbreak) when a communicable disease outbreak has been declared locally that has an impact to emergency medical resources.
- III. Worker Safety/Infection Control
 - A. Enhanced Protective Equipment (PPE) Procedures:
 - 1. All Patient Contact – PPE including: gloves, NIOSH approved N95 mask (surgical mask is appropriate if N95 is not available), and eye protection.
 - 2. Patients with Respiratory/GI symptoms – PPE outlined above, plus: cover patient with surgical face mask; disposable gown/overalls and shoe covers.
 - 3. Change in response configuration to minimize personnel exposure at each call.
 - 4. Every job not involving patient contact – PPE including: Regular hand washing, and cleaning of work surfaces (minimum prior to each shift/staff change).
 - B. Vaccination / Antiviral Therapy:
 - 1. Emergency Responder Points of Distribution (POD) – Agency management in consultation with the Clark County Health Department will consider/coordinate activation of the Emergency Responder PODs for appropriate vaccination/antiviral therapy.
 - C. Staff Entry Control Process:
 - 1. All Fire/EMS agencies shall establish (a) health care screening site(s) to clear employees prior to entering the work site at the start of each shift.
 - D. Decontamination and Cleaning of Equipment/Work Areas:
 - 1. Clean off all surfaces and equipment (including glasses and stethoscope) using the approved bio-spray or alcohol based hand cleaner.
 - 2. Dispose of all cleaning supplies in red hazardous waste bag.
 - 3. Use bio-wipes or alcohol based hand cleaner to clean hands and forearms until soap and water are available.

4. *Driver Prior to Transport and Technicians at end of Transport and Decontamination of Ambulance and Equipment* - Remove disposable gown/overalls, face mask, gloves and disposable BP cuff into hazardous waste bag and secure.
5. *First Responders* - Place all equipment used during the call in a red hazardous waste bag until decontamination prior or enroute to next call.
6. *Driver on Arrival at Receiving Facility* - Use new suit, gloves, face mask, and eye protection.
7. Once patient has been transferred, decontaminate inside of ambulance patient care area and equipment prior to arrival at next call.

IV. Patient Care and Transport (Respiratory Distress (Flu Like) Symptoms)

A. PPE

B. Assess Patient for Priority Symptoms

1. Chief Complaint
2. Vital Signs (including check for orthostatic changes and temperature)
3. Medical History/ Travel History

C. Incident Command will advise 9-1-1 and Fire/EMS agencies which of the following Care and Transport options to use:

1. Care and Transport to ED

- a) Allow patient to achieve position of comfort.
- b) Cover patient with surgical face mask, or administer O2 via face mask, to reduce aerosolization of virus .
- c) EKG, IV TKO (if patient is dehydrated provide fluid challenge based on shock guidelines).
- d) Proper cooling techniques based on temperature.
- e) Provide "Infection Control Guidance for Families."
- f) Use patient isolation techniques.
 - Close off ambulance driver's compartment.
 - Drape patient compartment.
- g) Early EMS Report.

2. Care and No Transport

- a) Provide a handout explaining the demand of limited resources and decision of no transport.
- b) Provide "Home Care and Protective Equipment for Families Packet" and explain contents and use.
- c) Advise to call 9-1-1 should priority symptoms occur.
- d) Advise Home Health Care of patient condition and location for in-home support and care.