COPS - County Operating Procedures:

Abandoned Newborns

Introduction:

Washington State Law (RCW 13.34.360) allows for the relinquishment of newborns at hospitals or Fire/EMS stations. Newborns are defined as birth to hospital discharge, typically 72 hours.

Protocol:

1. If EMS is presented with a newborn in extremis:
    a. Provide resuscitation per protocol and transport to the hospital
2. If newborn is presented to EMS and is not in extremis:
    a. Ascertain newborn's medical history as appropriate
    b. Transport to the hospital, notify staff for need of CPS referral.

Circumstance:

1. Maintain confidentiality and provide a nonjudgmental environment.
2. Give the following information to the parent(s) as time allows:
    a. Medical and emotional aftercare
    b. CPS referral

Air Ambulance Transport

Indications:

Air Ambulance is appropriate for the critical medical or trauma patient if transport time can be reduced by at least 20 minutes, versus ground. Consider the following when deciding on air transport:

1. Factors affecting the time reduction include:
    a. ETA of air ambulance
    b. Establishing and transporting to the landing zone
    c. Transfer of patient care to air ambulance personnel
    d. Transport time to hospital by air ambulance
2. In general, incidents occurring within 30 miles of a specialty resource center do not necessitate air transport
3. The use of blood products to treat hemorrhage

Protocol:

1. Air ambulance may be placed on standby by:

    A SCEMS Provider, Physician, Law Enforcement Officer

    a. When an air ambulance is placed on standby, the helicopter is readied but remains available for other requests on a priority basis. If agency requests activation and you have them on standby, they will check with you for activation or stand-down.
    b. An air ambulance should be placed on standby by trained personnel on scene after a patient assessment has been done.
    c. It would be appropriate to place an air ambulance on standby prior to personnel arrival based on the following guidelines:
        i. If the first response unit arrival at the scene will be greater than 10 minutes and the information provided suggests the condition of the patient who will benefit from an air ambulance. Examples of situations:
            1. penetrating trauma
            2. multiple patients
            3. auto-pedestrian
            4. severe burns
            5. major amputation
            6. entrapment
            7. critical medical (CVA, STEMI, Pregnancy)

2. ACTIVATION
    a. The decision to activate air ambulance rests with a responding provider, based on information relayed to the provider by others on scene.
    b. In some cases, air ambulance can be immediately dispatched (activated) to the scene prior to the arrival of a first-in unit, when travel time for the first-in unit will be over 30 minutes and the situation as known supports the type of patient who will benefit from air ambulance.
    c. Where it is known that difficult terrain will be encountered rendering ground access difficult but where the helicopter can get near the patient easily.
    d. Where the reporting party relates some other special circumstance indicating the need for immediate activation.
    e. EMS providers relate the need for activation of air ambulance prior to ground ALS arrival.
    f. The destination hospital shall be indicated to the air ambulance by the SCEMS EMS provider.

3. CANCELLATION

The Air Ambulance may be canceled by the provider responsible for the patient upon examination of the patient and it is apparent air transport is not necessary. Air ambulances should not be used for cardiac arrests, obvious DOAs, or other situations where the outcome is an obvious fatality.

Crime Scenes

Procedure:

1. Notify appropriate agencies if not already on scene.
   a. Law Enforcement
   b. Medical Examiner
2. Careful documentation of the following
   a. Location and position of patient when originally found
   b. Position of face and any airway obstructions
   c. If in bed, was the patient sleeping alone
   d. Any secretions noted on bedding
   e. Document all evaluation and treatments rendered with emphasis to document all invasive procedures. Be very cognizant of evidence preservation.
      i. Resuscitation take precedence
      ii. Try not to cut through holes
      iii. Do not move weapons unless necessary to safely provide patient care
      iv. Do not clear firearms even if properly trained
      v. Ensure chain of custody of evidence with providers on scene or law enforcement
      vi. Location of patient originally found
      vii. Environment surrounding patient, including clothing, room, witnesses
      viii. Obvious physical abnormalities noted
      ix. Document all skills and procedures performed and do not remove without LE or ME concurrence
      x. Document treatment performed prior to arrival

Death in the Field

Indications

1. Obvious signs of death, which include rigor mortis, decomposition, decapitation, dependent lividity, evisceration of heart or brain and/or incineration.
2. POLST, DNR, or Living Will present and the patient is pulseless and apneic per DNR Order.
3. The patient is a pulseless, apneic victim of a multiple casualty incident where resources of the EMS system are required for stabilization of other patients.
4. Victims of trauma should be determined dead and should not be transported when blunt or penetrating trauma and no vital signs (pulseless, apneic, fixed and dilated pupils) are present.
    a. The patient's ECG shows Asystole or PEA and the patient has not responded to approximately 30 minutes ACLS per **Transfer of Care/Time On Scene Operating Protocol**.

Considerations:

1. If any doubt exists about resuscitation of a patient, initiate resuscitation per **Cardiac Arrest Protocol.**
2. Evaluate risk versus benefit of special considerations including hypothermia and trauma
3. Consider the needs of survivors when discontinuing efforts.

Do Not Resuscitate Orders

Definitions

1. Portable Orders for Life Sustaining Treatment (POLST) is the legal document designed for EMS to withhold life sustaining treatment. POLST orders are valid only if signed by patient and physician indicating the patient's preference for life sustaining treatment. Photocopies are acceptable. Document POLST order in MIR.
2. Previously completed and signed EMS-No CPR forms will continue to be honored.
3. Living wills, advanced directives, health care directives, or durable powers of attorney signed by the patient can be honored with Medical Control concurrence.

Procedure

1. When the patient's family, friends or nursing home personnel state that the patient is not to be resuscitated:
   a. Resuscitation will be initiated until a POLST form or other documentation is presented.
   b. Resuscitation should be withheld on a patient who has a confirmed POLST form stating no resuscitation is wanted.
2. If the patient or family revokes the form, initiate care.

Level of Care

1. The level of care the patient receives during transport will be appropriate to the degree of severity as determined by the highest certified provider on scene.
2. AEMTs and EMTs may serve as the Attendant-In-Charge (AIC) of patients in accordance with their scope of practice even if there was a Paramedic assessment performed and no additional ALS skills, procedures, or care is needed. Ensure all assessment findings, diagnostic testing, and skills performed are noted in the MIR and transferred with the patient to definitive care.
3. If the patient warrants Paramedic level care, and a Paramedic is on scene, they are required to serve as the AIC.
4. When a Paramedic is unavailable, and it is deemed the patient cannot appropriately be cared for by an EMT or AEMT, a mutual aid ground or air ambulance will be requested. If no ALS mutual aid ambulance is available, the patient will be transported as soon as possible to the most appropriate facility in accordance with the **Patient Destination County Operating Procedure**.
5. Paramedics and or mutual aid ambulances can also rendezvous with BLS units. The ALS provider, in consultation with the BLS ambulance, will dictate transport code as appropriate for patient's clinical condition.
6. Conditions warranting a Paramedic response may include but are not limited to:
    a. Altered Mental Status
    b. Suspected Cardiac Event
    c. Difficulty Breathing
    d. Critical Trauma
    e. Shock
    f. Stroke
    g. Severe Pain
    h. Active Seizures
    i. Overdose/Poisoning

Medical Control

1. PeaceHealth Southwest Washington Medical Center, 360-514-2044 or 2464
2. Skyline Hospital (non-specialty care), 509-427-4083
3. If diversion to Portland is advised, contact Medical Resource Hospital (MRH), 503-494-7333
4. Medical Control will be contacted as needed for:
   a. Clarification of orders
   b. In cases of disparity between the Patient Care Protocols and the patient's private physician wishes
   c. For physician consultation
   d. Trauma System Entries, Burns, Strokes, STEMIs to confirm patient destination or diversion.
5. In cases where life-threatening conditions exist or when communication is impossible or impractical, Protocols can be followed without Medical Control Physician concurrence.
6. Document all OLMC orders with treatment, time and physician's name in your MIR.

Non Transport of Patients

Patients refusing care and/or transport

1. A person with normal decision making capacity who, after having been informed of risks and benefits of treatment/transport, voluntarily declines further services.
2. All patients are assumed to require a patient evaluation and EMS personnel will use all resources available to have that person treated and transported.
3. Impaired decision making capacity
   a. Inability to understand the nature of their illness/injury
   b. Inability to understand risks or consequences of refusing care/transport
   c. Individuals impaired by:
      i. Alcohol/drugs
      ii. Psychiatric conditions
      iii. Injuries (head, shock, etc.)
      iv. Mental handicap (Alzheimer's, mental retardation, etc.)
      i. Minors (Under 18 unless proof of emancipation)
      ii. Language/communication barrier
4. Criteria for informed refusal for patient or caregiver
   a. Patient is given accurate information about possible medical problems and risk/benefits of treatment or refusal.
   b. Patient is able to understand and verbalize these risks and benefits
   c. Patient is able to make a decision consistent with their beliefs and life goals
5. Documentation of refusal
   a. Refusal Form is required
   b. MIR completed and shall include:
      i. Chief complaint
      ii. Events prior/reason that 911 was called
      iii. Pertinent medical history
      iv. Description of scene if appropriate
      v. Physical exam including vital signs
      vi. Clinical impression
      vii. EMS interventions and patient response
      viii. Consultation with Medical Control if appropriate

ix. Instructions, risks, benefits told to the family by Medical Control and the EMS Provider

c. If the patient is capable of making an informed decision but immediate medical care (in the opinion of the EMS Provider) is needed:
   i. Consultation with Medical Control if possible.
   ii. Solicit assistance from family, friends and other close associates.
   iii. Solicit assistance from law enforcement, mental health professionals or clergy as situation directs.

d. If the patient is not capable of making an informed decision and immediate medical care (in the opinion of the EMS Provider) is needed:
   i. Solicit assistance from family, friends, and/or other close associates to persuade the patient to accept necessary treatment and transport.
   ii. Solicit assistance from law enforcement (police hold), mental health professional (psychiatric hold) and/or clergy as the situation directs.

   i.
   ii.

Patient Destination

Destination Criteria:
Non-life threatening injuries or illness: Hospital destination is at the discretion of patient, family, the patient's physician or closest facility.
Life threatening injuries or illness: Transport to the closest appropriate facility unless diversion criteria apply.

Diversion Criteria:

Medical Diversion - Diversion may occur due to resource, equipment or facility availability or patient request. When this occurs, destination hospital will be determined by Medical Control Hospital, PHSWMC or Skyline. Contact MRH for Oregon diversion for destination.

Trauma System Entry – Code 3 transports to PHSWMC if the patient is at least 15 years old. If diverted to Level 1 Trauma Center, contact MRH for destination. If in Oregon, contact MRH for destination. If patient is under 15 years old, initiate transport to Randall Children's Hospital and contact MRH for destination orders.

STEMI

ALS - Transport Code 3 transport to PHSWMC or closer level 1 PCI (STEMI) center.

BLS/ILS - Transport Code 3 to PHSWMC if transport time does not exceed 30 minutes longer than transport to Skyline. If more than 30 minutes additional transport time required, transport Code 3 to Skyline, or attempt to rendezvous with ALS en route to allow transport to PHSWMC.

Stroke – Transport Code 3 to PHSWMC if symptoms from last normal presentation and estimated arrival time to PHSWMC are less than 24 hours or symptoms present upon awakening. If symptoms are greater than 24 hours, patient may go to facility of choice or closest facility if unstable.

ROSC

Adults **-** Code 3 transport to PHSWMC.

Pediatrics - Code 3 transport to Randall Children's Hospital, Portland.

Hyperbaric chamber (Severe Carbon Monoxide Poisoning/Decompression Sickness) – Code 3 transport contact Medical Control at PHSWMC for destination.

Burns with associated trauma – Code 3 transport, contact Medical Control at PHSWMC for destination (the Oregon Burn Center is located at Legacy Emanuel Hospital).

Psychiatric (Involuntary Law Enforcement Hold) – PHSWMC, contact Medical Control at PHSWMC for pediatric patients.

Private Physician and/or Medical Professional at the Scene

1. When the patient's private physician is in attendance and has identified himself/herself upon the arrival of the EMS provider: The EMS provider will comply with the private physician's instructions for the patient in accordance with their scope of practice and SCEMS Patient Care Protocols. If orders are given, which are inconsistent with established SCEMS Patient Care Protocols, clearance must be obtained through Medical Control.
2. A physician at the scene may:
   a. Request to talk directly to Medical Control to offer advice and assistance.
   b. Offer assistance to the EMS provider but the patient continues to be treated under the SCEMS Patient Care Protocols.
   c. Assume total responsibility for the patient with the concurrence of Medical Control.

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.

Reporting

1. **Pre Hospital Notification Report format:**
   a. Unit and Provider identification
   b. Transport code 1 or 3
   c. Age and sex of the patient
   d. Chief complaint, reason for transport, brief medical history and treatment rendered
   e. Vital signs
   a. Request for questions or comments
   b. Estimated time of arrival

2. **Verbal report to Emergency Department Physician and/or Nurse:**
   a. Name, age, sex and patient's physician
   b. Chief complaint and/or injuries
   c. Description of trauma scene if trauma patient
   d. Pertinent medical history
   e. Physical exam findings
   f. Treatments and results

3. **Medical Incident Reports (MIRs)**
   MIRs must be completed by EMS personnel for EMS call resulting in an actual patient contact, which involves an assessment, VS, or PE. This includes refusals. A patient is defined as a person with obvious injury or medical complaints. It will be completed as soon as feasible after the patient contact, no later than the end of the assigned shift. Transport personnel are required to leave a field report at the receiving facility at the time of patient transfer. Final reports are required to be sent to the receiving facility within 24 hours. FD reports are to be completed within 24 hours & forwarded to MPD for review.

Response Modes

All licensed EMS aid vehicles and ambulances will follow the Medical Priority Dispatch System (MPDS) EMS Response Modes as administered by the Skamania County Dispatch.

1. At times deviation from these modes may be appropriate.
2. Any deviations shall be documented in the MIR for review.
3. Code 1 is a no lights or sirens response. Code 3 is a lights and sirens response.
4. Once a call is received by dispatch, licensed EMS aid vehicles and ambulances will respond as rapidly as appropriate and make contact with the requesting party or patient and determine the level of care or treatment required and administer EMS care as needed.

MPDS Response Determinant	Response	Mode
	Aid Vehicle	**Ambulance**
Alpha (A)	Code 1	Code 1
Bravo (B)	Code 3	Code 3 if no aid / Code 1 if aid
Charlie (C)	Code 3	Code 3
Delta (D)	Code 3	Code 3
Echo (E)	Code 3	Code 3

5.

5. Canceling, Upgrading, Downgrading or Diverting to another call
   a. Canceling of response
      i. Dispatch can cancel a unit at the request of the reporting party or patient.
      ii. A first in EMS unit reports that no patient is present.
      iii. A first in EMS unit reports the patient does not want transport.
      iv. The canceling unit will obtain a Refusal Form.
      v. The ambulance shall have the discretion to continue.
   b. Upgrades: Aid vehicles and ambulances may be upgraded to a Code 3 response by EMS units when a patient evaluation has been made and a more efficient response is more appropriate.

c. Downgrades: Aid vehicles and ambulances may be downgraded to a Code 1 response by EMS units when a patient evaluation has been made and a slower response is more appropriate.
d. Diversion: An aid vehicle or ambulance may be diverted to another call when:
    i. It is obvious the second call is a life-threatening emergency and the first call can await a second ambulance and a second ambulance can be dispatched to the first call.
    ii. The first ambulance is decidedly closer to the second call and the response by it to the 2nd call might be vital to the patient's outcome.

Transfer of Care/Time on Scene

When more than one EMS provider is on scene, they will work cooperatively in making care decisions.

1. If a disagreement exists on the correct course of action, the highest certified EMS provider will have the authority to determine patient care.

2. In addition, transfer of patient care from first responders to transport personnel should be orderly and efficient.

3. SCEMS has the first right of refusal to transport should mutual aid first response arrive prior to SCEMS, even if patient care has been initiated.

Scene time benchmarks:

General Medical – 30 minutes

Cardiac Arrest-30 minutes

STEMI/Stroke – 15 minutes

Critical Trauma – 15 minutes once extrication has been accomplished

Document any extenuating circumstances in your MIR.

Trauma System Entry

Indications:
Initial evaluation of patients and scene should be made rapidly to determine need for a trauma center. It cannot be overemphasized that adequate management of the severely injured patient can occur only in the operating room and field care is appropriate to stabilize the patient, maintain perfusion, and to ensure safe transport without further injury. Management priorities include reducing/eliminating hypoxia, hypothermia, and hypotension.

TRAUMA TEAM ACTIVATION (PHYSIOLOGIC /CLINICAL SIGNS)

a) GCS under 13
b) Respirations 10 or less or 29 and greater
c) Pediatrics under 15 years old and BP under 80 or HR over 120
d) Systolic BP under 90
e) Penetrating injury to head, neck, torso, or extremities proximal to elbows or knees
f) Chest wall instability or deformity (pneumothorax, flail chest)
g) Two or more proximal long bone fractures
h) Crushed, degloved, pulseless, or mangled extremity
i) Amputation proximal to wrist or ankle
j) Pelvic Fracture
k) Open or depressed skull fracture
l) Paralysis

Modified Trauma Activation (BIOMECHANICS OF INCIDENT/MECHANISM OF INJURY)

a) Falls over 20ft or for child over 10ft or two times height
b) Crash with intrusion over 12in occupant site or 18in any site
c) Ejection from auto
d) Death of patient in same vehicle
e) Vehicle damage consistent with high energy transfer
f) Auto pedestrian, Auto bike, thrown or run over with 20 MPH impact
g) Motorcycle crash over 20 MPH

These criteria should cause a high index of suspicion that the patient may have sustained a severe injury:

a) Paramedic "gut feeling" of injury severity/provider judgment
b) Extremes of age (Under 12 or over 55 years of age), to include GLFs in the elderly
c) Bleeding disorders and anticoagulants
d) Burns
e) Time sensitive extremity injury
f) End stage renal disease requiring dialysis
g) Pregnancy over 20 weeks

Protocol: Code 3 transport within 15 minutes per **Time on Scene / Transfer of Care and Destination County Operating Procedures**