MEDICAL CONTROL DIRECTIVE
2024-11

DATE: April 1, 2024

TO: Pinellas County EMS Agencies
Pinellas County Emergency Communications
Pinellas County Certified EMTs and Paramedics
Pinellas County Certified Advanced Practice Paramedics, Nurses
Pinellas County Online Medical Control Physicians
Pinellas County Ambulance Billing and Financial Services
ED Nurse Managers

FROM: Dr. Angus Jameson, EMS Medical Director

RE: Protocol and System Updates

==Effective Date: May 1, 2024==

Volume 1 – Clinical Operating Guidelines

Section/Topic	Protocol	Details
CLINICAL STANDARDS	CS7 Patient Care Report & Transfer of Care	Additional of a new section "Standby Encounter Log" for "Standby" events
	CS12 Refusal of Care	BLS/ALS Section re-titled "Procedure" Clarifying information added regarding a BLS Transport Unit (911 or interfacility transport) obtaining a refusal
AIRWAY	A3 Tracheostomy Emergencies	Addition of guidance regarding the use of the Venturi Trach Mask setup during patient care
CARDIAC	C5 Tachycardia (Wide/Narrow)	Revised joule settings for synchronized cardioversion and unsynchronized defibrillation

Volume 1 (cont.) – Clinical Operating Guidelines

Section/Topic	Protocol	Details
TRAUMA	T1 General Trauma Care	Page 2 Major Head Injury present – Target SBP changed from 100 – 110 mmHg to 110 mmHg
CLINICAL TOOLS	CT12 Adult (Age ≥ 16) Trauma Scorecard	Addition of Local EMS Medical Director Trauma Alert Criteria – ==Active bleeding requiring a tourniquet or wound packing with continuous pressure **==
	CT13 Pediatric (Age ≤ 15 y/o) Trauma Scorecard	Addition of Local EMS Medical Director Trauma Alert Criteria – ==Active bleeding requiring a tourniquet or wound packing with continuous pressure **==

Volume 2 – Administrative

Section/Topic	Protocol	Details
ADMINISTRATIVE	AD8 Trauma Transport Protocol	All Bayfront Health facility names updated to new Errata Additional of Local EMS Medical Director Trauma Alert Criteria – ==Active bleeding requiring a tourniquet or wound packing with continuous pressure **== to ADULT and PEDIATRIC

Attachments:

- CS7 Patient Care Report & Transfer of Care
- CS12 Refusal of Care
- A3 Tracheostomy Emergencies
- C5 Tachycardia (Wide/Narrow)
- T1 General Trauma Care
- CT12 Adult (Age ≥ 16 y/o) Trauma Scorecard
- CT13 Pediatric (Age ≤ 15 y/o) Trauma Scorecard
- AD8 Trauma Transport Protocol

Distribution:

- EMS Chiefs e-mail distribution group
- Vector Solutions
- Pinellas County EMS Office of the Medical Director Webpage www.pcemsomd.com

CS7 PATIENT CARE REPORT & TRANSFER OF CARE

This standard defines the requirements for completing the Pinellas County EMS Patient Care Report (electronic Patient Care Reporting System [ePCR] or paper form) and the transfer of patient records and belongings between EMS clinicians and hospital personnel

Patient Care Report Completion:

- A Pinellas County Patient Care Report (PCR) must be completed in all the following instances:
  - A BLS, ALS or CCT unit responds to a request for emergency or non-emergency medical services
  - A Paramedic makes patient contact, assesses a patient, provides treatment and/or transport, obtains a refusal of evaluation from an individual or confirms the death of a patient
- The first County Certified EMT or Paramedic on the scene is responsible for starting and ensuring the completion of a PCR for each licensed EMS provider agency
- A provisionally certified paramedic completing a PCR must have the County Certified Paramedic Preceptor review and sign the PCR
- Each agency that arrives to assist in patient care shall complete a PCR documenting any assessment and/or interventions provided by personnel from their agency
- All pertinent fields in the ePCR or on the paper PCR shall be completed including all patient demographic information, assessments, treatments, and interventions, and required signatures
- If patient placed on cardiac monitor during patient care (e.g., vitals, rhythm, SpO2, EtCO2, 12 Lead), all monitor data related to each specific patient must be uploaded to the respective ePCR
- If a BLS or ALS First Responder Unit is cancelled by a Unit from another agency a "cancelled enroute" PCR must be completed
- If a BLS or ALS First Responder Unit is cancelled by a Unit from the same agency, the Unit being cancelled is not required to complete a PCR
- An Ambulance Unit must complete a report unless they are canceled for a "closer unit" or a "higher priority call." If an Ambulance Unit is "cancelled on scene" by an ALS First Responder a PCR must be completed

Electronic and Paper Forms Completion:

- All ALS First Responder and Ambulance Units are required to complete an electronic ePCR
- In the rare circumstance that a PCR is not completed immediately after the transfer of care, a PCR must be completed and filed before the EMT, or Paramedic ends their shift
- In the event of a computer failure, a paper PCR shall be completed and the tablet or web-based ePCR report shall be completed as soon as the ePCR system is available
- The paper PCR shall be retained to meet records retention requirements

CS7 PATIENT CARE REPORT & TRANSFER OF CARE

- Level 2 Mass Casualty Incidents (greater than ten (10) patients)
  - Triage tape and triage tags will be utilized on scene and during transport.
  - After the mass casualty emergency has been mitigated, ePCR reports shall be completed by ALS First Responder Units to the extent possible. Ambulance Units shall ensure an ePCR record is completed for all transports.
- Any ancillary forms required shall be completed as required by the EMS Authority or EMS Medical Director
- When a paper PCR is utilized, the form's color paper carbon copies shall be distributed as indicated on the report

Transfer of Patient Care – ALS First Responder to Transport Unit

- When patient care is transferred from one Unit to another Unit (e.g., ALS First Responder to Transport Unit), a verbal report shall be provided including:
  - History of present illness/injury
  - Past medical history/medications/allergies
  - Treatments or interventions performed
  - Proposed plan of care
- Any electronic or paper documentation, available at the time of the transfer of patient care, shall be provided including:
  - Uploading ECGs
  - Copying ePCR data to the receiving Unit
  - Providing a copy of any paper forms (e.g., patient transfer forms, face sheets, medication lists, DNR forms, paper EMS forms, etc.)
- Transport shall not be delayed for report completion. ALS First Responders can electronically update and complete their ePCR record after patient transport is initiated.
- For a critically ill or injured patient, a single ePCR tablet shall be utilized for the duration of the call or until the patient is transferred to hospital personnel. At conclusion of the call, the ePCR and ECG data shall be copied to the ALS First Responder or Ambulance to ensure both reports are complete

Transfer of Patient Care – Transport Unit to Hospital

- When patient care is transferred from the Transport Unit or ALS First Responder to hospital personnel, a verbal report (including the history of present illness/injury, past medical history/medications/allergies, and treatments or interventions performed) shall be provided
- Ambulance units (or an ALS First Responder Unit that transported a patient) shall leave a completed PCR (paper or ePCR) including ECGs and copies of any paper forms (e.g., patient transfer forms, face sheets, medication lists-MAR, DNR forms, etc.) at the hospital for all patients at the time patient care is transferred

CS7 PATIENT CARE REPORT & TRANSFER OF CARE

- Label all ECGs with the patient's name and date of birth prior to 12 Lead ECG transmission and label all electronic/paper ECGs provided for the patient's medical record
- The only exceptions to *NOT* leaving a completed PCR prior to leaving the hospital are as follows:
  - A "Partially Available" ambulance is needed to respond as the closest unit to an emergency call. After such response, any incomplete PCRs must be completed
    - "Partially Available" means a patient has been transferred to hospital staff with a verbal report and the Ambulance can respond to the next call.
  - A Mass Casualty Incident that has *NOT* been mitigated
  - Declared Disaster or EMS Emergency
- When possible, place the patient's belongings and medications in a clear Patient Belongings bag
  - Write the patient's name on the bag and seal it
  - Ensure the patient's medications and belongings are transferred to the hospital staff
- Obtain a signature for receipt of the patient and their belongings from the hospital or facility staff

Special Events

The "Standby Encounter Log" worksheet (in the electronic ePCR or paper version if ePCR not available) may be completed on "Standby" incidents such as concerts, sporting events, and other mass gatherings. Basic demographic information and the type of assistance provided to each individual should be documented in this log. A signature is not required.

This "Standby Encounter Log" is to be used at Special Event Standby's only and may not be used on 911 calls or interfacility transfers. The log is only for documenting basic "First Aid" assistance including bandaids, ice packs, oral hydration, cooling, rest, etc. It may not be used if any medications were administered or dispensed, any interventions were performed, a refusal is needed, or the individual otherwise becomes a patient in which case a full ePCR is required.

CS12 REFUSAL OF CARE

All patients who themselves, or through a third party, have summoned emergency medical assistance within the Pinellas County EMS system are presumed to have a condition requiring evaluation, treatment, and transportation to the closest appropriate hospital emergency department. Patients have the right to refuse part or all the evaluation, treatment, and transport if they have "*Decisional Capacity*". This Clinical Standard describes how a patient may make an informed decision to refuse evaluation, treatment and/or transport

Definitions:

- **"Decisional Capacity"** – means a patient that can understand their current medical condition, as well as the risks, benefits and alternatives of the proposed treatment plan and has the legal ability to provide consent (e.g., is not a minor unless emancipated or an adult who is known to have been adjudicated incompetent by a court)

- **"Expressed Consent"** – exists when a patient (adult or emancipated minor), with "*Decisional Capacity*", agrees to or requests evaluation, treatment and/or transport

- **"Implied Consent"** – exists when a patient's current medical condition prevents them from being able to provide expressed consent or when a third party is not present to provide Third Party Consent

- **"Third Party Consent"** – means a parent/guardian of a minor, power of attorney, legal guardian of a legally incompetent adult, law enforcement officer or healthcare surrogate, as appropriate, who may accept or refuse evaluation, treatment and/or transport on behalf of a minor, detained/incarcerated person, or a person determined to be legally incompetent

Procedure:

- Evaluate all patents to the fullest extent indicated, if possible and determine if the patient or a third party is the appropriate decision maker.
- If the patient does not appear to have "*Decisional Capacity*", proceed with evaluation, treatment, and transport under implied consent
- If the patient appears to have "*Decisional Capacity*", he/she may refuse all or part of the indicated evaluation, treatment recommended, destination and/or transport
- If the patient's "*Decisional Capacity*" is in question, administer an EMS Cognitive Evaluation (Ref. CT22) to assist in determining capacity
- In cases involving Third Party Consent, ensure the responsible party has "*Decisional Capacity*" prior to allowing any decisions to be made on behalf of the patient. Document the third parties' relationship to the patient. If there is doubt as to whether the third party is acting in the patient's best interest (e.g., abuse or neglect) immediately involve law enforcement.
- Documentation for a patient refusing all or part of the evaluation, treatment and/or transport must include at a minimum:
    - The benefits of allowing care
    - The risks of refusing the proposed care including severe complications or death
    - The alternatives explained and offered to the patient

CS12 REFUSAL OF CARE

Procedure (cont.):

- Attempt to ensure the patient is left in a safe location

OLMC:

- Contact OLMC if:
  - After passing the EMS Cognitive Evaluation (Ref. CT22), doubt remains as to a patient's "*Decisional Capacity*", or if the patient's current medical condition (e.g., hypotension, hypoxia, head injury, etc.) calls into question their "*Decisional Capacity*"
  - A BLS Interfacility or BLS 911 unit would like to take a refusal (e.g., to determine if the BLS unit can handle the refusal or if an ALS response necessary)
  - Other unusual situations where the correct course of action is not apparent based on the criteria contained within this standard

Quality Measures:

- Were two complete sets of vital signs obtained at least 5 minutes apart?
- Final GCS equals 15?
- Was a Chief Complaint documented?
- Were the Medical History, Medications, and Allergies of the patient documented?
- Witness Signature obtained
- Narrative greater than 300 characters
- Free Text "*Decisional Capacity*" present

References:

- Pinellas County EMS Medical Quality Management Plan – Medical Operations Manual Volume 2 Protocol AD18
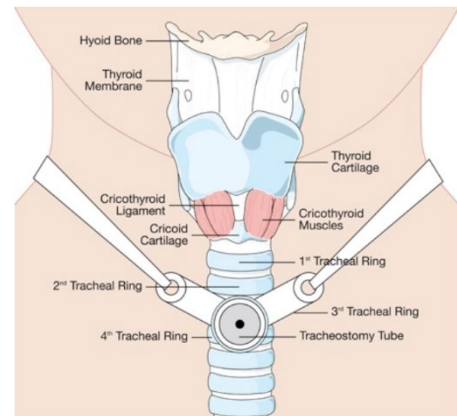
A3 TRACHEOSTOMY EMERGENCIES

ADULT and PEDIATRIC	GOALS OF CARE
	Recognize and mitigate tracheostomy tube obstruction, displacement, or another malfunction

BLS

- Administer supplemental oxygen via trach mask as needed (Ref. CP33)
- If a ventilator-dependent patient is in respiratory distress and the cause is not immediately determined and corrected, remove the patient from the ventilator and begin bag-valve ventilation (Ref. CP1.1, CP3.1)
- Encourage coughing to attempt to clear a tracheostomy tube obstruction
- Have suction readily available

ALS

1. If suspected obstruction of tracheostomy
   - Instill 1 mL – 3 mL of 0.9% sodium chloride or sterile water into the tracheostomy tube
   - Suction as needed
2. If unable to clear obstruction, ventilate effectively, and the caretaker is familiar with tracheostomy changes and has a spare tube, assist with the removal and replacement of the tube with a new one (same size or smaller).
   DO NOT FORCE TUBE!
3. If a replacement tracheostomy tube is unavailable and the patient is unable to be ventilated, insert an endotracheal tube of similar size in the stoma, assist ventilations, and hold manual stabilization of tube until arrival at hospital.
4. If unable to insert an endotracheal tube, ventilate with bag-valve-mask (BVM) over stoma or over patient's mouth while covering the stoma
5. May transport patient on home ventilator if caretaker/family member can accompany the patient during transport to assist with operation of the ventilator

OLMC

- Consult OLMC Physician as needed

A3 TRACHEOSTOMY EMERGENCIES

PEARLS	
• Type of ventilator alarms:	

Low pressure or apnea	May be caused by a loose or disconnected circuit or an air leak. Maybe result in inadequate ventilation
Low power	Caused by depleted battery
High pressure	Can be caused by a plugged or obstructed airway or circuit tubing by coughing or by bronchospasm
Setting error	Is caused by ventilator settings outside the capability of the equipment
Power switchover	Occurs when the unit switches from AC power to the internal battery for power

- Signs of tracheostomy tube obstruction:
  - Excess secretions
  - No chest wall movement
  - Cyanosis
  - Accessory muscle use
  - No chest rise with bag-valve ventilation

QUALITY MEASURES
• Pending

REFERENCES
• https://nasemso.org/projects/model-ems-clinical-guidelines/
• http://www.tracheostomy.org.uk/NTSP-Algorithms-and-Bedheads

C5 TACHYCARDIA (WIDE/NARROW)

ADULT ONLY (Ped. Ref. P7)	GOALS OF CARE
	Identification and treatment of tachydysrhythmias

BLS
• Shock position as required

ALS
• Identify and treat underlying cause if secondary tachycardia • Establish vascular access • Determine stability/instability • Assess cardiac rhythm and treat as follows:

UNSTABLE – WIDE/NARROW – (e.g., chest pain, altered mental status, shortness of breath, hypotension, etc.)					
If patient condition permits, pre-medicate with midazolam 2.5 mg – 5 mg via the intravenous, intraosseous, or intranasal route. May repeat one time in five (5) minutes, if needed					
	Joules				
Regular – Narrow or Wide	50j	100j	200j		Synchronized cardioversion
Irregular – Narrow		100j	200j		Synchronized cardioversion
Irregular – Wide or Polymorphic			200j	300j	360j	Unsynchronized defibrillation

STABLE – WIDE	
Regular – Monomorphic	Consult OLMC for antiarrhythmic choice
Irregular	Amiodarone 150 mg infusion over minimum of ten (10) minutes. Repeat once if tachycardia re-occurs
Irregular – Torsade's	Magnesium sulfate 2 grams intravenous over a minimum of ten (10) minutes

STABLE – NARROW		
Regular	1.	Modified Valsalva Maneuver (Ref. CP30)
	2.	Adenosine 6 mg rapid intravenous push
	3.	Adenosine 12 mg rapid intravenous push
	4.	If no change, consult OLMC
Regular – History of atrial fibrillation	DilTIAZem 0.25 mg/kg slow intravenous push Max single 25 mg dose	
Irregular	DilTIAZem 0.25 mg/kg slow intravenous push Max single 25 mg dose	

C5 TACHYCARDIA (WIDE/NARROW)

OLMC

- Stable Wide Regular Monomorphic Tachycardia
  - Adenosine 6 mg rapid intravenous push
  - Adenosine 12 mg rapid intravenous push
  - Amiodarone 150 mg infusion over minimum of ten (10) minutes
- Additional sedation
- Withholding full dose of dilTIAZem if patient converts after partial dose
- Consult Online Medical Control Physician as needed or required (Ref. CS10)

PEARLS

- Primary tachycardia rates are generally over 150/minute
- Secondary tachycardia rates are usually, but not always lower
- Ventricular rates less than 150/minute usually do not cause signs or symptoms
- *DO NOT* delay immediate cardioversion for the acquisition of the 12 Lead ECG or sedation if the patient is unstable
- Keys to management
  - Determine if pulses are present
  - If pulses are present, is the patient stable, borderline unstable or obviously unstable
  - Provide treatment based on the patient's condition and rhythm. It may be best to monitor the patient versus treat the patient if they are minimally symptomatic
  - Stable wide monomorphic regular tachycardias may represent several different underlying rhythms making antiarrhythmic selection complicated

QUALITY MEASURES

If Midazolam administered:
- Complete set of vital signs before and after each administration
- EtCO2 documented after each administration
- Waste documented if name of administering clinician matches crew on PCR
- Midazolam dose does not exceed max or OLMC contact initiated
- Benzodiazepines and opiates not mixed

REFERENCES

- 2023 Institute for Safe Medication Practices (ISMP) FDA and ISMP Lists of Look-Alike Drug Names with Recommended Tall Man (Mixed Case) Letters
- Posen A, Bursua A, Petzel R. Dosing Strategy Effectiveness of Diltiazem in Atrial Fibrillation With Rapid Ventricular Response. Ann Emerg Med. 2023 Mar;81(3):288-296. doi: 10.1016/j.annemergmed.2022.08.462. Epub 2022 Nov 17. PMID: 36402632.
- https://www.ahajournals.org/doi/10.1161/CIR.0000000000000916
- https://www.youtube.com/watch?v=8DIRiOA_OsA
- https://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2815%2961485-4/fulltext
- https://www.cprseattle.com/blog/slow-down-youre-going-too-fast-svt-and-the-modified-valsalva-maneuver
- https://nasemso.org/projects/model-ems-clinical-guidelines/
- Pinellas County EMS Medical Quality Management Plan - Medical Operations Manual Vol. 2 Protocol AD18

T1 GENERAL TRAUMA CARE

ADULT ONLY **(Ped. Ref. P17 if age 15 or younger)**	GOALS OF CARE
	Accurate assessment, appropriate stabilization, and rapid transport to definitive care

BLS

- Perform Primary Trauma Survey (**XABCDE**) and implement stabilizing treatments:

X	Control any major, exsanguinating, or life-threatening hemorrhage using direct pressure followed by appropriate device or procedure when indicated (Ref. CP16, CP18)
A	Airway management (BLS maneuvers and adjuncts) as needed and implement spinal precautions as indicated (Ref. CP1, CP15, CT11)
B	• Provide supplemental oxygen to ensure oxygen saturation as close to 100% as possible • Assist ventilations at 12-16 breaths per minute with bag-valve-mask (BVM) device and appropriate airway adjunct as needed (Ref. CP1)
C	Assess for and treat any ongoing circulation threats: ▪ Seal chest wounds (Ref. CP17) ▪ Re-assess and ensure hemorrhage control with direct pressure followed by appropriate device or procedure when indicated (Ref. CP16 [if older child/device fits], CP18)
D	Assess neurologic function
E	Expose patient as indicated to ensure no missed injuries or something smaller and protect from environment/**KEEP WARM**

- Assess trauma transport criteria, declare "*Trauma Alert*" if indicated (Ref. CT12)

Initiate **EMERGENCY Transport** and **Early Hospital Notification** to an **Appropriate Receiving Facility** – Reference CS4 & CS5
Goal Less Than 10 Minute Scene Time

- Perform a complete head-to-toe physical assessment and implement additional appropriate stabilizing care:
    - Stabilize impaled objects in place – *DO NOT REMOVE*
    - Dress wounds - Moist for eviscerations, dry for burns
    - Amputated body parts – Moist sterile inner packaging, ice/cold pack outer packaging
- Splint fractures and dislocations and document distal motor function, circulation, and sensation before and after; Elevate and apply cold packs when practical. Consider removal of tight clothing, jewelry, etc. distal to the injury
- Implement injury-specific additional BLS care as indicated (Ref. T2-T7)
- Repeat Primary Trauma Assessment (**XABCDE**) frequently during transport and implement any further needed treatments.

T1 GENERAL TRAUMA CARE

NOTE
Except in cases of delayed transport (e.g., entrapment), the only ALS interventions allowed prior to transport are:
CP1 Airway Management + CP7 Needle Thoracostomy

- Perform Needle Thoracostomy (Ref. CP7) for suspected TENSION Pneumothorax.
- Maintain EtCO2 of 35-45 mmHg
  - **Hyperventilation to 30-35 mmHg allowed *ONLY* with signs of ACTIVE herniation from head trauma – see PEARLS**
- Establish vascular access and if hypotensive initiate fluid resuscitation with 0.9% sodium chloride in 500 mL increments to target systolic blood pressure (SBP) and maximum volume as indicated:
  - Major/Multi-System Trauma - Target SBP 80-90 mmHg; max volume 2000 mL
  - Major Head Injury present – Target SBP 110 mmHg; max volume 2000 mL
  - Burns without Major/Multi-System Trauma (Ref. T6)
- Implement appropriate pain management (Ref. M13)
- Assess patient for underlying or co-morbid medical conditions
- Repeat Primary Trauma Assessment (XABCDE) frequently during transport and implement any further needed treatments.
- Implement injury-specific additional ALS care as indicated (Ref. T3-T7)

OLMC
- Consult Online Medical Control Physician as needed and for:
  - Replant services
  - Crush and compartment syndrome management
- Consult Online Medical Control Physician as needed or required (Ref. CS10)

PEARLS
- In major trauma, excess use of fluids may increase bleeding. However, patients with major head injuries/traumatic brain injuries (TBI) require a higher SBP to support cerebral perfusion and burn patients require replacement of massive fluid losses; Follow resuscitation guidelines above.

AVOID the H-Bombs of TBI!
Hypoxia, **H**ypotension, **H**yperventilation/**H**ypocarbia
Even short periods of any of these will increase mortality!

T1 GENERAL TRAUMA CARE

PEARLS (cont.)
• In TBI consider using an extraglottic airway device to avoid apneic time associated with endotracheal intubation and be diligent to avoid hyperventilation.
• Only hyperventilate to EtCO2 of 30-35 mmHg if evidence of active herniation develops (rapid decrease in LOC, seizure, new pupil defects, Cushing's reflex).
• Prevent hypothermia. A trauma patient who becomes hypothermic has an increased risk of mortality
• Refer to CS18 for alterations in standard of care during Major Incidents with Ongoing Threats (e.g., Active Assailant Response)

QUALITY MEASURES
• Scene Time less than 10 minutes (Sunstar) or *Trauma Alert* time less than 5 min (FD)
• Oxygen delivered
• IV Established
• *Trauma Alert* declared if indicated
• Spinal precautions employed (Track/Trend only)

REFERENCES
• NAEMT, Pre-hospital Trauma Life Support Committee. American College of Surgeons, Committee on Trauma. (2023). PHTLS: Prehospital Trauma Life Support (10th ed.) Burlington, MA: Jones & Bartlett Learning
• https://nasemso.org/projects/model-ems-clinical-guidelines/
• https://www.youtube.com/watch?v=kmGdDxCGJQQ

CT12 ADULT (AGE ≥ 16 y/o) TRAUMA SCORECARD

Any ONE Criteria = Red Trauma Alert	
Active airway assistance beyond the administration of oxygen	Amputation proximal to the wrist or ankle
Lack of radial pulse with sustained heart rate greater than 120	Any penetrating injury to the head, neck, or torso (excluding superficial wounds where the depth of the wound can be determined)
Systolic BP less than 90 mmHg	Signs & symptoms two or more long bone fracture sites (humerus, [radius/ulna], femur, [tibia/fibula])
GCS score Best Motor Response equal to or less than 4	GCS score equal to or less than 12 (excluding patients whose normal GCS Score is equal to or less than 12 as established by patient's medical history or preexisting medical condition when known)
Exhibits the presence of paralysis	Signs & symptoms/suspicion of skull fracture, flail chest and/or pelvic fracture**
Suspected spinal cord injury	Major blunt trauma to head, neck, torso, or pelvis**
Loss of sensation	Any ejection (complete or partial) from a motor vehicle (*including* moped, motorcycle, all-terrain vehicle, watercraft)**
2nd or 3rd degree burns equal to or greater than 15% TBSA	Death of another passenger from trauma**
Active bleeding requiring a tourniquet or wound packing with continuous pressure **	

Any TWO Criteria = Blue Trauma Alert	
Respiratory rate equal to or greater than 30	Gunshot wound to an extremity of the body
Sustained heart rate equal to or greater than 120	Signs & symptoms of a single long bone fracture from a MVC
GCS Best Motor Response equals 5	Signs & symptoms of a single long bone fracture from fall equal to or greater than 10 feet
Soft tissue loss from major degloving injury	Age equal to or greater than 55 years old
Major flap avulsion greater than 5 inches	Patient impacted steering wheel causing steering wheel deformity

Paramedic Intuition = "Trauma Alert" (must document basis for declaration in ePCR)

Trauma Center Transport Local Criteria = "NON-Trauma Alert"	
Extended extrication time	Moderate - heavy damage without passenger restraints
Rapid deceleration with heavy damage	Falls greater than 15 feet
Passenger space invasion greater than 1 foot	

** = Local Medical Director Trauma Alert Criteria

CT13 PEDIATRIC (AGE ≤ 15 y/o) TRAUMA SCORECARD

Any ONE Criteria = Red Trauma Alert	
In order to maintain optimal ventilation, the patient is intubated, or breathing is maintained through such measures as manual jaw thrust, continuous suctioning or use of other adjuncts to assist ventilatory efforts	Multiple fracture sites or dislocations (except for isolated wrist or ankle fractures or dislocations)
Exhibits altered mental status including drowsiness, lethargy, inability to follow commands, unresponsiveness to voice, totally unresponsive or coma	Major soft tissue disruption including major degloving injury or major flap avulsions
Presence of paralysis	2nd or 3rd degree burns equal to or greater than 10% TBSA
Loss of sensation	Amputation at or above the Wrist or Ankle
Suspected spinal cord injury	Any penetrating injury to the head, neck or torso (excluding superficial wounds where the depth of the wound can be determined)
Faint or non-palpable carotid or femoral pulse	Major blunt trauma to head, neck, torso or pelvis**
Systolic BP less than 50 mmHg	Signs & symptoms/suspicion of skull fracture, flail chest and/or pelvic fracture**
Evidence of open long bone (humerus, [radius/ulna], femur, [tibia/fibula]) fracture	Any ejection (complete or partial) from a motor vehicle (*including* moped, motorcycle, all-terrain vehicle, watercraft)**
Active bleeding requiring a tourniquet or wound packing with continuous pressure **	Death of another passenger from trauma**

Any TWO Criteria = Blue Trauma Alert	
Symptoms of amnesia exhibited	Weight equal to or less than 11 kilograms or the body length is equivalent to this weight on the Handtevy Tape (the equivalent of 33 inches in measurement or less)
Loss of consciousness	Signs & symptoms of a single closed long bone fracture. Excludes isolated wrist or ankle fractures
Palpable carotid or femoral pulse but the radial or pedal pulses are not palpable	Signs & symptoms single long bone fracture from a fall equal to or greater than 10 feet
Systolic BP less than 90 mmHg	

Paramedic Intuition = "Trauma Alert" (must document basis for declaration on PCR)

Trauma Center Transport Local Criteria = "NON-Trauma Alert"	
Extended extrication time	Moderate - heavy damage without passenger restraints
Rapid deceleration with heavy damage	Child less than 16 years old struck by a vehicle
Passenger space invasion greater than 1 foot	Falls greater than 15 feet or twice the patient's height

** = Local Medical Director Trauma Alert Criteria

Pinellas County EMS

TRAUMA TRANSPORT PROTOCOL

2024-2027

AD8 TRAUMA TRANSPORT PROTOCOL

<u>Dispatch Procedures</u>

<u>Requirements for Soliciting Information:</u>

1. *The TTPs shall include a description of the system that allows the public and other agencies to notify the provider that emergency medical services are needed. The agency responsible for operating the system shall be identified. A description of the information to be solicited from the individual requesting emergency medical assistance in order to determine the number of patients, location of the incident, and extent and severity of reported injuries shall be included.*

    A. The Pinellas County 9-1-1 Regional Communications Center operates as the single primary public safety answering point (PSAP) for all 9-1-1 calls originating in Pinellas County – the center answers over 900,000 emergency calls per year. Calls for law enforcement assistance are transferred to the appropriate agency. If a fire department or ambulance response is needed, 9-1-1 telecommunicators will dispatch units and support their activities during the emergency.

    B. The Communications Center is a necessary link between the person with the problem and the personnel who can help resolve it most effectively. It is the primary goal of the Communications Center to obtain and transfer necessary information in a timely and efficient manner. Accomplishing this goal ensures the effective and timely management of both Fire/EMS apparatus and law enforcement units in their response to the public's need.

    C. The 9-1-1 Telecommunicator ascertains the following information when an individual requests emergency medical services and will conduct caller interrogation in accordance with the current Pinellas County version of the Medical Priority Dispatch System (MPDS) protocols:

        *   nature of the emergency
        *   address of the emergency
        *   call back number
        *   difficult access
        *   specific routing
        *   extent and severity of the emergency
        *   number of victims

<u>Requirements for Dispatching Emergency Vehicles:</u>

1. *A description must be included describing the methods used to ensure that the appropriately staffed and equipped EMS vehicle most readily available is identified and dispatched to the location of the incident.*

AD8 TRAUMA TRANSPORT PROTOCOL

A. The closest response unit is determined by the 9-1-1 Center's Computer Aided Dispatch (CAD) system. The CAD system immediately assigns the appropriately staffed and equipped emergency service provider that is closest to the call location regardless of jurisdiction, following the automatic aid/closest unit response policy. In the event the closest unit is unavailable, the CAD system will assign the next closest unit.

    a. Initial dispatch information includes:

        *   location of the call
        *   units being dispatched
        *   nature of the call
        *   assigned radio tac channel
        *   response priority

Requirements for Emergency Agency Assistance:

1. *A description of the criteria and process used to request additional EMS air or ground vehicles and/or other emergency response agencies shall be included.*

    A. The process used to request assistance for specialized resources or additional assistance is as follows:

        a. Requests for additional or specialized resources (e.g., Fire apparatus, ambulances, law enforcement, HazMat Team, Marine Patrol, etc.) is made by on-scene personnel through the 9-1-1 Center. The 9-1-1 Center will then coordinate the requested action via telephone, State Warning Point line, and/or radio, as applicable. The 9-1-1 Center, if required, will call for mutual aid.

    B. The procedures used by the 9-1-1 Center to request a helicopter to the scene of a "Trauma Alert" patient for transport to a trauma center are as follows:

        a. On-scene personnel will request an "Air Transport" through the 9-1-1 Center.
        b. The 9-1-1 Center will contact the designated helicopter dispatch center and request their response.
        c. The 9-1-1 Center will advise the helicopter dispatcher of the scene location, any available patient information, working radio channel, and the radio designation of the on-scene Incident Commander.
        d. The 9-1-1 Center will request the estimated time of arrival (ETA) of the helicopter.
        e. The 9-1-1 Center will notify the on-scene Incident Commander of the ETA and radio designation of the responding helicopter service.

    C. An "**air transport upgrade**" will be called for all emergencies requiring a helicopter.

AD8 TRAUMA TRANSPORT PROTOCOL

Requirements for Transport Assistance:

1. *The TTPs must identify the criteria used to include and differentiate between ground and air ambulance services when transport assistance is requested. The TTPs must identify from what agencies assistance can be requested and the process used for obtaining assistance. In the event that air transport is not available within the service area of the provider, the TTPs should state that air ambulance service is not available.*

   A. All patients in the Pinellas County EMS System shall be transported by a Sunstar BLS or ALS ambulance or a local first responder transport capable unit.
   B. As stipulated in these protocols, an ALS helicopter shall be utilized for the transportation of a trauma patient that meets the Trauma Scorecard Methodology standards as stipulated in Chapters 64J-2.004 and 64J-2.005, F.A.C., and as follows:

      a. When LOCAL CONDITIONS (heavy traffic/gridlock, multi-victim/mass casualty incident, remote or barrier island) exist and in the judgment of the attending EMT, Paramedic, or Incident Commander would make transport by Helicopter Ambulance faster than transport by Ground Ambulance.
      b. When SCENE CONDITIONS (extended extrication, heavy machinery extrication, technical rescue, remote location) exist and in the judgment of the attending EMT, Paramedic, or Incident Commander would make transport by Helicopter Ambulance air faster than transport by Ground Ambulance.
      c. When PATIENT CONDITIONS (requirement for Burn Center, Re- implantation Surgery or Hyperbaric Chamber) exist that in the judgment of the attending EMT, Paramedic, or Incident Commander would make transport by Helicopter Ambulance faster than transport by Ground Ambulance.
   C. ALS helicopter services, each have a Certificate of Public Convenience and Necessity from the Pinellas County Board of County Commissioners as an ALS provider in this County.

TRAUMA PATIENT ASSESSMENT FOR ADULT AND PEDIATRIC

Requirements for Adult Assessment:

1. *The adult trauma scorecard assessment shall be documented in accordance with the requirements of section 64J-2.004, F.A.C.*

   A. Patients will be evaluated according to the severity of injury and anatomy and mechanism of injury as follows:
      a. Each EMS provider shall ensure that upon arrival at the location of an incident, an EMT or paramedic shall:

i. Assess the condition of each adult trauma patient using the Adult Trauma Scorecard Methodology, as provided in this section, to whether the patient should be a "Trauma Alert" per Chapter 64J- 2.004, F.A.C.

ii. In assessing the condition of each adult trauma patient, the EMT or paramedic shall evaluate the patient's status for each of the following components: airway, circulation, best motor response (a component of the Glasgow Coma Scale, which is defined and incorporated by reference in subsection 64J-2.001(5), F.A.C., cutaneous, long-bone fracture, patient's age, and mechanism of injury. The patient's age and mechanism of injury shall only be assessment factors when used in conjunction with assessment criteria included in Subsection C (f and g) of this section.

B. The EMT or paramedic shall assess all adult trauma patients using the following criteria in the order presented and, if any <u>ONE</u> of the following conditions is identified, the patient shall be considered a "Trauma Alert" patient:

a. <u>Airway</u>: The patient receives active airway assistance beyond the administration of oxygen.

b. <u>Circulation</u>: The patient lacks a radial pulse with a sustained heart rate greater than 120 beats per minute or has a blood pressure less than 90 mmHg.

c. <u>Best Motor Response (BMR)</u>: The patient exhibits a score of four or less on the motor assessment component of the Glasgow Coma Scale, or exhibits the presence of paralysis, or there is the suspicion of a spinal cord injury or the loss of sensation.

d. <u>Cutaneous</u>: The patient has 2nd or 3rd degree burns to 15 percent or more of the total body surface area, or amputation proximal to the wrist or ankle, or any penetrating injury to the head, neck, or torso (excluding superficial wounds where the depth of the wound can be determined).

e. <u>Long-Bone Fracture</u>: The patient reveals signs or symptoms of two or more long-bone fracture sites (humerus [radius, ulna] or femur [tibia, fibula]).

C. Should the patient not be identified as a "Trauma Alert" using the criteria in Subsection B above, the trauma patient shall be further assessed using the following criteria and shall be considered a "Trauma Alert" patient when a condition is identified from any <u>TWO</u> of the following seven components:

a. <u>Airway</u>: The patient has a respiratory rate of 30 or greater.

b. <u>Circulation</u>: The patient has a sustained heart rate of 120 beats per minute or greater.

c. <u>BMR</u>: The patient has a BMR of five on the motor component of the Glasgow Coma Scale.

d. <u>Cutaneous</u>: The patient has a soft tissue loss from either a major degloving injury, or a major flap avulsion greater than five inches, or has sustained a gunshot wound to the extremities of the body.

    e.   <u>Long-Bone Fracture</u>: The patient reveals signs or symptoms of a single long- bone fracture resulting from a motor vehicle collision or a fall from an elevation of ten feet or greater.

    f.   <u>Age</u>: The patient is 55 years of age or greater.

    g.   <u>Mechanism of Injury</u>: The patient has been ejected from a motor vehicle (excluding any motorcycle, moped, all- terrain vehicle, bicycle, or the open body of a pickup truck), or the driver of the motor vehicle has impacted with the steering wheel causing steering wheel deformity.

D. If the patient is not identified as a "Trauma Alert" patient after evaluating the patient using the criteria in Subsections B and C of this section, the trauma patient will be evaluated using all the elements of the Glasgow Coma Scale. If the patient's score is 12 or less, the patient shall be considered a "Trauma Alert" patient (excluding patients whose normal Glasgow Coma Scale score is 12 or less, as established by the patient's medical history or preexisting medical condition when known).

E. Where additional local "Trauma Alert" criteria has been approved by the Medical Director of the EMS service and presented as part of the State Trauma Transport Protocols' approval process, the use of local "Trauma Alert" criteria as the basis for calling a "Trauma Alert" shall be documented as required in Chapter 64J-1.014, F.A.C. Local trauma assessment criteria can only be applied after the patient has been assessed as provided in Subsections B, C, and D of this section.

    a.   The EMT or paramedic shall assess all adult trauma patients using the following criteria in the order presented and, if any **ONE** of the following conditions is identified, the patient shall be considered a "Trauma Alert" patient per Pinellas County Local Criteria:

- Signs and symptoms/suspicion of a skull fracture, flail chest and/or pelvic fracture
- Death of another passenger from trauma
- Any ejection (complete or partial) from a motor vehicle
- Major blunt trauma to the head, neck, trunk, or pelvis
- Active bleeding requiring a tourniquet or wound packing with continuous pressure

F. In the event that none of the conditions are identified using the criteria in Subsections B, C, D, or E of this section in the assessment of the adult trauma patient, the EMT or paramedic can call a "Trauma Alert" if, in his or her judgment, the patient's condition warrants such action. Where the EMT's or paramedic's judgment is used as the basis for calling a "Trauma Alert," it shall be documented as required in Chapter 64J-1.014, F.A.C.

G. The results of the patient assessment shall be recorded and reported in accordance with the requirements of Chapter 64J-2.002(5), F.A.C. through the completion of a Pinellas County Emergency Medical Services (PCEMS) Patient Care Report.

H. The paramedic or EMT will use the phrase "Trauma Alert" when notifying the 9-1-1 Center and receiving facility.

Requirements for Pediatric Assessment:

1. *The pediatric trauma scorecard assessment shall be documented in accordance with the requirements of section 64J-2.005, F.A.C.*

    A. Each EMS provider shall ensure that upon arrival at the location of an incident, the EMT or paramedic shall assess the pediatric trauma patient by evaluating the patient's status for each of the following components: Airway, Consciousness, Circulation, Fracture, Cutaneous, and the pediatric patient's size when used in conjunction with the other components in Subsection C of this section. The assessment of the pediatric patient using the weight and length parameter and the other components of this section shall be referred to as the Pediatric Trauma Scorecard Methodology. In assessing the pediatric patient, the criteria for each of the components in Subsections B and C of this section shall be used to determine the transport destination for pediatric trauma patients.

    B. The EMT or paramedic shall assess all pediatric trauma patients using the following criteria, and if any of the following conditions are identified, the patient shall be considered a pediatric "Trauma Alert" patient:

    a. Airway: In order to maintain optimal ventilation, the patient is intubated, or the patient's breathing is maintained through such measures as manual jaw thrust, continuous suctioning, or through the use of other adjuncts to assist ventilatory efforts.
    b. Consciousness: The patient exhibits an altered mental status that includes drowsiness, lethargy, the inability to follow commands, unresponsiveness to voice, totally unresponsive, is in a coma, there is the presence of paralysis, the suspicion of a spinal cord injury, or loss of sensation.
    c. Circulation: The patient has a faint or non-palpable carotid, femoral pulse, or the patient has a systolic blood pressure of less than 50 mmHg.
    d. Fracture: There is evidence of an open, long-bone (humerus, (radius, ulna), femur (tibia, or fibula)) fracture, or there are multiple fracture sites or multiple dislocations (except for isolated wrist or ankle fractures or dislocations).
    e. Cutaneous: The patient has a major soft tissue disruption, including major degloving injury; major flap avulsions; 2nd or 3rd degree bums to ten percent or more of the total body surface area; amputation at or above the wrist or ankle; or any penetrating injury to the head, neck, or torso (excluding superficial wounds where the depth of the wound can be determined).

    C. In addition to the criteria listed in Subsection B of this section, a "Trauma Alert" shall be called when a condition is identified from any two of the components listed below:

a. <u>Consciousness</u>: The patient exhibits symptoms of amnesia or there is loss of consciousness.
b. <u>Circulation</u>: The carotid or femoral pulse is palpable, but the radial or pedal pulses are not palpable, or the systolic blood pressure is less than 90 mmHg.
c. <u>Fracture</u>: The patient reveals signs or symptoms of a single closed, long-bone fracture. Long-bone fractures do not include isolated wrist or ankle fractures.
d. <u>Size</u>: Pediatric trauma patients weighing 11 kilograms or less, or the body length is equivalent to this weight on a pediatric length and weight emergency tape (the equivalent of 33 inches in measurement or less).

D. Where additional local "Trauma Alert" criteria has been approved by the Medical Director of the EMS service and presented as part of the State Trauma Transport Protocols' approval process, the use of local "Trauma Alert" criteria as the basis for calling a "Trauma Alert" shall be documented as required in Chapter 64J-1.014, F.A.C. Local trauma assessment criteria can only be applied after the patient has been assessed as provided in Subsections B and C of this section.

a. The EMT or paramedic shall assess all pediatric trauma patients using the following criteria in the order presented and, if any <u>**ONE**</u> of the following conditions is identified, the patient shall be considered a "Trauma Alert" patient per Pinellas County Local Criteria:

- Signs and symptoms/suspicion of a skull fracture, flail chest and/or pelvic fracture
- Death of another passenger from trauma
- Any ejection (complete or partial) from a motor vehicle
- Major blunt trauma to the head, neck, trunk, or pelvis
- Active bleeding requiring a tourniquet or wound packing with continuous pressure

E. In the event that none of the conditions are identified using the criteria in Subsections B, C, or D of this section in the assessment of the pediatric trauma patient, the EMT or paramedic can call a "Trauma Alert" if, in his or her judgment, the patient's condition warrants such action. Where the EMT's or paramedic's judgment is used as the basis for calling a "Trauma Alert," it shall be documented as required in Chapter 64J-1.014, F.A.C.

<u>Trauma Destination Requirements:</u>

1. *All trauma alert patients must be transported to a Trauma Center or Pediatric Trauma Center nearest the location of the incident if the incident is within 30 minutes by ground or air transport or within 50 miles by air transport. The medical director shall identify any exceptions to this standard in the EMS provider's or trauma agency's TTPs with explanation and justification. All patients meeting Trauma Alert Criteria shall be transported to the nearest Trauma Center or Pediatric Trauma Center.*

AD8 TRAUMA TRANSPORT PROTOCOL

    A. All adult patients meeting the Trauma Alert Criteria as specified above shall be transported to the nearest Trauma Center.

    B. All pediatric patients meeting the Trauma Alert Criteria as specified above shall be transported to the nearest State Approved Pediatric Trauma Center.

2. *All hospitals to which trauma patients are routinely transported must meet state and federal emergency access to care laws and be capable of delivering care commensurate with the patient's medical needs.*

    A. All hospitals to which all trauma patients are routinely transported meet state and federal emergency access to care laws and are capable of delivering care commensurate with the patient's medical needs.

    B. Please reference the Hospital attestation letters included.

3. *If there are situations where the EMS provider's medical director has determined it would be in the best medical interest of the trauma alert patient to be transported to a hospital other than those specified in paragraph (1) above, a list of such situations must be identified in the TTPs.*

    A. In cases where local conditions (weather, traffic, special event, disaster etc.) exist that would make transport to the nearest Trauma Center take longer than transport to another Trauma Center, the patient shall be transported to the Trauma Center able to be reached in the shortest amount of time.

    B. In cases where the nearest Trauma Center has suffered a degradation of capability to provide standard trauma care (internal or external disaster, lack of hospital staffing/resources/equipment, etc.) the EMS Medical Director will direct a trauma alert patient to the most appropriate facility based upon current conditions.

    C. In cases where patient factors (traumatic cardiac arrest, inability to secure the airway, inability to obtain intravenous/intraosseous access, etc.) exist that in the judgment of the attending EMT, Paramedic, or Incident Commander would make transport to the closest initial receiving facility or another Trauma Center in the patient's best interest, the patient shall be transported to the most appropriate facility.

    D. A burn patient shall be transported to a Burn Center. If the patient is suffering from multi-system trauma and transport to the Burn Center would take significantly longer than transport to the nearest trauma center, the patient shall be transported to the nearest Trauma Center.

AD8 TRAUMA TRANSPORT PROTOCOL

4. *The EMS provider must submit documentation to the department that all hospitals, trauma centers to which the EMS provider routinely transports have been provided a copy of the TTPs which the EMS provider will follow to determine trauma transport destinations submitted upon initial licensure and after revisions of the TTPs.*

   A. Reference included documentation.

5. *A list of trauma centers and hospitals to which the EMS provider routinely transports adult and pediatric trauma alert patients must be identified in the TTPs.*

2024 – 2027 TRAUMA CENTERS

Hospital Name	Address	Phone Number
Level 1 Pediatric/Adult Trauma Center		
Tampa General Hospital[1]	One Tampa General Circle, Tampa, FL 33606	(813) 251-7000
Level 2 Pediatric Trauma Center		
All Children's Hospital	501 – 6 Avenue South, St. Petersburg, FL 33701	(727) 898-7451
Level 2 Pediatric/Adult Trauma Center		
St. Joseph's Hospital	3001 W. Dr. Martin Luther King Jr. Boulevard, Tampa, FL 33607	(813) 870-4000
Level 2 Adult Trauma Center		
Orlando Health Bayfront Hospital	701 Sixth Street South, St. Petersburg, FL 33701	(727) 823-1234
HCA Florida Blake Hospital[1]	2020 – 59 Street West, Bradenton, FL 34209	(941) 792-6611
HCA Florida Bayonet Point Hospital	14000 Fivay Road, Hudson, FL 34667	(727) 819-2929
Sarasota Memorial Hospital	1700 South Tamiami Trail, Sarasota, FL 34239	(941) 917-9000

[1] Tampa General Hospital and Blake Medical Center are Burn Centers

AD8 TRAUMA TRANSPORT PROTOCOL

2024 - 2027 INITIAL RECEIVING FACILITIES

Hospital Name	Address	Phone Number
Initial Receiving Facilities		
Orlando Health Emergency Room - Pinellas Park	3070 Grand Avenue, Pinellas Park, FL 33782	(727) 893-6195
Orlando Health Emergency Room - Crossroads	1800 - 66 St. N. St. Petersburg, FL 33710	(727) 893-6325
Bay Pines Veterans Administration Hospital	10000 Bay Pines Boulevard, St. Petersburg, FL 33744	(727) 398-6661
Advent Health North Pinellas	1395 South Pinellas Avenue, Tarpon Springs, FL 34689	(844) 876-0241
Advent Health Palm Harbor ER	34106 US19 North, Palm Harbor, FL 34684	(844) 876-0241
HCA Florida Largo Hospital	201 - 14 Street, Largo, FL 33770	(727) 588-5200
ER at HCA Florida Largo West Hospital	2025 Indian Rocks Road, Largo, FL 33774	(727) 586-7120
HCA Florida Clearwater Emergency	2339 Gulf to Bay Boulevard, Clearwater, FL 33765	(727) 588-5200
HCA Florida Northside Hospital	6000 - 49 Street North, St. Petersburg, FL 33709	(727) 521-4411
HCA Florida Pasadena Hospital	1501 Pasadena Avenue S. St. Petersburg, FL 33707	(727) 381-1000
HCA Florida St. Petersburg Hospital	6500 - 38 Avenue North, St. Petersburg, FL 33710	(727) 384-1414
HCA Florida Lake Tarpon Emergency	35750 US19 North, Palm Harbor, FL 34684	(727) 789-8420
Morton Plant Hospital	300 Pinellas Street, Clearwater, FL 33756	(727) 462-7000
Bardmoor Emergency Center	8839 Bryan Dairy Road, Largo, FL 33777	(727) 395-2600
Mease Countryside Hospital	3231 McMullen Booth Road, Safety Harbor, FL 34695	(727) 725-6111
Mease Dunedin Hospital	601 Main Street, Dunedin, FL 34698	(727) 733-1111
St. Anthony's Hospital	1200 - Seventh Avenue North, St. Petersburg, FL 33705	(727) 825-1100

2024 - 2027 OUT-OF-COUNTY HOSPITALS

Hospital Name	Address	Phone Number
Out-Of-County Initial Receiving Facility		
HCA Florida Trinity Hospital	9330 State Road 54, Trinity, FL 34655	(727) 834-4000

AD8 TRAUMA TRANSPORT PROTOCOL

TRANSFER OF PATIENT CARE INFORMATION

1. *The EMS transporting provider must include in the TTPs, requirements and procedures to be followed by EMTs and paramedics for completion of the patient care record as defined under section 64J-2.001(9), F.A.C., and required under section 64J-2.004, F.A.C., and the trauma information as required under section 64J-2.002(5), F.A.C., and the delivery of such information in writing with the trauma patient to a trauma center, or hospital at the time the patient is presented for care.*

   A. The EMS provider responsible for the patient shall ensure that a prehospital trauma alert is issued upon determining that a trauma patient meets the requirements of Rules 64J-2.004 and 64J-2.005, F.A.C.

   B. The words "trauma alert" shall be used when notifying the trauma center, or hospital that EMS is enroute with a trauma alert patient.

   C. The medical director of the EMS provider issuing the trauma alert, or physician at the receiving trauma center, or hospital, are the only people authorized to change the trauma alert status.

   D. The EMS provider issuing the trauma alert shall also provide the trauma center or hospital with information required under subsection 64J-1.1014(5), F.A.C. and the information listed below at the time the patient is transferred to the personnel of the receiving trauma center or hospital:

      a. Time of injury if different from the time of the call
      b. Date of injury if different from day of call
      c. County of injury
      d. County of residence of patient
      e. Cause of injury
      f. Injury Site/type
      g. Trauma alert criteria if met as defined in Rule 64J-2.004 or 64J- 2.005, F.A.C. and
      h. Protective devices if motor vehicle crash, bicycle, or marine crash

   E. The information listed above shall be documented on the Pinellas County Emergency Medical Services (PCEMS) Patient Care Report of the transporting unit that delivered the patient in accordance with the requirements of Rule 64J-1.014, F.A.C.

AD8 TRAUMA TRANSPORT PROTOCOL

EMERGENCY INTER-FACILITY TRANSFER PROCEDURES

1. *The EMS provider must have in place, as part of its TTPs, procedures for the rapid emergency inter-facility transfer of a trauma alert patient. The provider must be available within 30 minutes of receiving a call from the requesting hospital to provide inter-facility emergency medical service transfer of a trauma alert patient. The medical director shall identify any exceptions to this standard in the EMS provider's TTPs with explanation and justification. If an EMS provider does not provide inter-facility transfer services that shall be documented in the TTPs. (Reference next 2 pages)*

AD8 TRAUMA TRANSPORT PROTOCOL

ATTESTATION OF MEDICAL DIRECTOR'S PARTICIPATION, REVIEW AND APPROVAL OF TTP'S

Pinellas County Emergency Medical
Services System
12490 Ulmerton Road
Suite #134
Largo, FL 33774
Telephone (727) 582-5750

As the EMS Medical Director of Pinellas County Emergency Medical Services System (comprised of 19 individually licensed providers), I have developed and/or directed the development of the trauma transport protocols presented in this document.

_____   _____
Signature – EMS Medical Director   Approval Date

Pinellas County EMS Licensed ALS Providers

Provider Name	License Number
City of Clearwater	ALS5204
City of Dunedin	ALS5229
East Lake Tarpon Special Fire Control District	ALS5205
City of Gulfport	ALS5207
City of Largo	ALS5210
Lealman Special Fire Control District	ALS5211
City of Madeira Beach	ALS5212
City of Oldsmar	ALS5230
Palm Harbor Special Fire Control District	ALS5213
Pinellas County EMS DBA Sunstar	ALS5220
City of Pinellas Park	ALS5214
Pinellas Suncoast Special Fire Rescue District	ALS5208
City of Safety Harbor	ALS5215
City of Seminole	ALS5228
City of South Pasadena	ALS5217
City of St. Pete Beach	ALS5218
City of St. Petersburg	ALS5219
City of Tarpon Springs	ALS5221
City of Treasure Island	ALS5222