GUIDELINES
(PATIENT CARE PROCEDURES)

MEDICAL CONTROL & COMMUNICATIONS

Prehospital Medical Control is provided in Shoshone County via EMS 1 radio system and telephone communication systems. All practicing emergency physicians in Shoshone County are designated Supervising Physicians. Radio contact will be made between the EMS unit and the receiving hospital prior to arrival of the EMS unit at the hospital using the standard reporting format outlined under General Orders for All Patients. Consultation with the receiving physician is available via EMS 1 radio frequency or direct telephone line. **Direct contact with the receiving physician should be utilized whenever the need for medical advice arise.** On occasions when communications are not technically possible or a Supervising Physician is not available, EMS personnel must rely on these guidelines, protocols, and their own judgment until communication can be established.

COMMUNICATIONS

1) EMS 1 RADIO DURING TRANSPORT

All users of EMS 1 frequency are urged to transmit essential communications and keep air times as short as possible. The following format for communications should be used. If Medical Control feels additional communications are necessary, they may contact the transporting unit via EMS 1.

EMERGENCY PRE-HOSPITAL REPORT FORMAT

A) Unit identification
B) Category of emergency:
   a. Emergent
   b. Non Emergent
C) Age and sex of patient
D) Chief complaint or reason for transport
E) Very brief pertinent medical history (one sentence, if possible)
F) Vital signs and level of consciousness
G) Pertinent treatment rendered and results, if any
H) Request for additional information or treatment
I) Estimated time of arrival

The radio report should be provided as soon as practical once transport has begun. All reports should be given in this order and should be a maximum of 30 seconds. The radio report is not meant to be a full-patient record and should relay only pertinent patient care information. Patient identification information is inappropriate to be given on the radio frequency. Advise Medical Control or receiving emergency department of changes in patient's condition enroute, and request direction for further treatment.

2) VERBAL REPORT TO EMERGENCY DEPARTMENT

The verbal report to emergency department physician and/or triage nurse should contain more detail than the radio report. The emergency care provider now has the time to present thorough details of the scene, complete assessment of the patient, and complete report on patient care and result of efforts.

A) Name, age, sex, and patient's physician
B) Chief complaint or injuries
C) If trauma, describe the trauma scene/mechanism of injury
D) Pertinent medical history
E) Vital signs and level of consciousness
F) Condition changes or trends in vital signs or level of consciousness during transport
G) Explain patient treatments and results

(End)

Shoshone MEDICAL CENTER

25 Jacobs Gulch, Kellogg, Idaho 83837
Phone: 208-784-1221

EMS PATCH SHEET

DATE:	EMS:	
TIME:	ETA:	
AGE:	M	F

MECHANISM OF INJURY/CC:

INJURIES/SS:

VITAL SIGNS

BP:	HR:
RR:	O2:
Temp:	GCS:

LOC: Alert / Verbal
Confused / Combative
Unconscious / Unresponsive

Diabetic:	Y	N	FSBG:

TREATMENTS

C SPINE:	Y	N
IV ACCESS:	Y	N
FLUIDS:	Y	N

MEDICATION:

STROKE ALERT:	Y	N
CARDIAC ALERT:	Y	N

TRAUMA ACTIVATION: Y N TIME: _____

LEVEL: ONE (TRC) TWO (ALERT)

LEVEL ONE (TRAUMA CODE RED)

- ☐ GCS </= 10
- ☐ SYSTOLIC <90 Adult <80 Child
- ☐ Respiratory Distress
- ☐ Penetrating injuries to Head, Neck, Torso and Extremities proximal to Elbow and Knee
- ☐ Chest wall instability or deformity
- ☐ Two or more proximal long bone fractures
- ☐ Crushed, Degloved, Mangled Extremity
- ☐ Amputation proximal to Wrist or Ankle
- ☐ Pelvic Fractures
- ☐ Open or Depressed Skull Fractures
- ☐ Paralysis
- ☐ Burns >20% Adult and >10% Child or Over 50
- ☐ **Paramedic and/or ED Discretion**

LEVEL TWO (TRAUMA ALERT)

- ☐ Mechanism of Injury evidence of high energy impact. Potential For multi system trauma.
- ☐ GCS 11-13
- ☐ FALLS Adults >20 feet, Children >10 feet or 2x the child's height
- ☐ Significant intrusion into vehicle
- ☐ Death in same passenger compartment
- ☐ Pedestrian struck by vehicle, thrown, run over, or with impact >20mph
- ☐ Bicyclist thrown, run over, or with impact >20mph
- ☐ Motorcycle crash >20mph
- ☐ **Consider Co Morbidities and Age**
- ☐ **Paramedic and/or ED Discretion**

GENERAL GUIDELINES FOR ALL PATIENTS

FIELD TREATMENT FOR THE MEDICAL PATIENT

1. Scene Size-up/Assessment
   A) Body Substance Isolation per Agency exposure control program
   B) Scene Safety
2. Primary assessment
   A) General Impression
   B) Level of Consciousness (LOC)
   C) Airway - Breathing – Circulation
      1) If DNR or POLST form present follow protocol for EMS NO-CPR
   D) Perform rapid scan
   E) Determine Priority
   F) Consider ALS Response if available
3. History Taking
   A) Assess Complaints and signs and Symptoms,
      1) Conduct AVPU mental status exam as needed
      2) Obtain SAMPLE history
      3) O-P-Q-R-S-T * assessment guidelines
4. Secondary assessment
   A) Responsive patient
      1) Obtain vital signs
      2) Pulse Oximetry
      3) Focused Assessment
      4) Intervention
   B) Unresponsive patient
      1) Perform a Rapid Physical Exam
         a) Head to toe exam and
         b) Medical ID devices
         c) Obtain vital signs
         d) Interventions
5. Transport
6. Perform Reassessment

GENERAL GUIDELINES FOR ALL PATIENTS (continued)

FIELD TREATMENT FOR THE TRAUMA PATIENT

1. Scene Size-Up
   - A) Body Substance Isolation per Agency exposure control program
   - B) Scene Safety
   - C) Assess for number of Multiple patients
   - D) Activate local emergency system as necessary
2. Primary Assessment
   - A) Level of Consciousness (LOC)
   - B) Airway - Breathing – Circulation
   - C) Perform rapid scan
   - D) Consider ALS Response if available
   - E) Establish patient care priorities as soon as possible
     1) Triage multiple patients (See Mass Casualty Incident Section).
        a) Notify receiving facility
     2) Follow the trauma triage procedures
        a) Notify the trauma center as soon as possible
3. History Taking:
   - A) Determine the Chief Complaint
   - B) Conduct AVPU mental status exam as needed
   - C) Obtain SAMPLE history
   - D) Deformities, Contusions, Abrasions, Punctures, Burns, Tenderness, Lacerations, and Swelling
   - E) (DCAP-BTLS)
   - F) Pulse, Movement, Sensation (PMS)
4. Secondary assessment:
   - A) Patient with no Significant Mechanism of Injury
     1) Assess vital signs
     2) Use appropriate monitoring devices
     3) Full-body scan and/or focused assessment
     4) Glasgow Coma Scale
   - B) Patient with Significant Mechanism or Injury
     1) Continue manual stabilization of the head and neck
     2) Consider requesting ALS
     3) Preform rapid trauma assessment
        a) Rapidly assess each part of the body
           (i) Head to toe exam
     4) Glasgow Coma Scale
5. Transport
   - A) Mode of transport and destination based on regional patient care transport procedure
   - B) Prioritize patient transport.
6. Reassessment
   - A) Re-evaluate initial patient assessment items
     1) Unstable patient a maximum of every 5 minutes
     2) Stable patient every 15 minutes
7. Provide treatment, using appropriate protocols.
8. Transport:

GENERAL GUIDELINES FOR ALL PATIENTS (continued)

A) Use of lights and sirens should be limited to the emergency transportation of critical patients.
B) Destination determined by:
   1) Trauma triage destination tool (when implemented)
   2) Patient request **
   3) Senior Medical Officer judgment
   4) MD-to-MD arrangement **

* Onset, Provocation, Quality, Radiation, Severity, Time.
* * Patient requests and physician-to-physician referrals must, in general, be respected. However, if in the judgment of the Senior Medical Officer a critical patient requires transport to the closest hospital for stabilization, it is the Senior Medical Officer's responsibility to explain this to the patient or physician. If a conscious patient or physician who, in the judgment of the Senior Medical Officer, is capable of making a rational decision persists in requesting transport to a different facility, the patient and/or physician request should be followed). Notify Medical Control of the request via radio or phone and attempt to obtain a signature on a medical release form.

(End)

ON-SCENE MEDICAL AUTHORITY

Patient care at an incident is subject to the following ascending order of authority:
1) **First Responder** (first-arriving, on-duty)
2) **Emergency Medical Technician** (first-arriving, on-duty)
3) **EMT A I-85** (first-arriving, on-duty)
4) **AEMT 2011** (first-arriving, on-duty)
5) **Paramedic or Flight Nurse** (first-arriving, on-duty)
6) **Physician**
7) **ALS Supervising Physician**

(End)

DOCUMENTATION

Cooperative charting is essential when more than one agency is documenting the same call. Sharing of pertinent information will help to ensure accuracy and adequacy of the prehospital care record and will help to avoid unnecessary duplication.

Complete a Patient Care Report (PCR) on all patient encounters. This will apply to both basic and advanced life support units and includes public assist calls. The S.O.A.P. method has been adopted as the standard for report writing in Shoshone County. The PCR 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.

S = **Subjective** and Scene information. That information which the patient, family, bystanders, or other witnesses tell you. What you hear. Age of the patient, gender, race, estimated weight in Kg, chief complaint, scene description, history of the event, pertinent medical history of the patient, patient physician, medications, allergies, other extenuating circumstances.

O = **Objective** information. This information you find on your complete head-to-toe physical exam. What you see.

A = **Assessment** what you think the problem is

P = **Plan** of treatment

The PCR should be completed by the responder providing direct patient care and reviewed and signed by the highest certified EMT that was on the call.

(End)

TRIAGE AND TRANSPORT

A. The first certified Shoshone County EMS provider arriving on scene determines that a patient:
   1. Needs definitive care
   2. Presents with factors suggesting potential severe injury (in accordance with the CDC's Pre-hospital Trauma Triage Procedure).

B. The Shoshone County EMS provider then determines what step in the Pre-hospital Triage Procedure the patient's condition/injuries meet; Activation is made based upon the step identified:
   1. **Patient meets any of the Criteria in the Left column:**
      a) Contact Shoshone Medical Center (SMC) as soon as possible to activate the Trauma system.
         (1) This would be a level 1 activation "Trauma Code Red"
      b) Apply "Trauma ID Band" to the patient.
   2. **Patient meets any of the Criteria in the Right column:**
      a) Contact Shoshone Medical Center (SMC) as soon as possible to activate the Trauma system.
         (1) This would be a level 2 activation "Trauma Alert"
         (2) The activation information should be included in the Radio report as well as the early activation.
      b) Consult county protocol, IF:
         (1) The patient requests to bypass the nearest facility. *
      c) Apply "Trauma ID Band" to the patient.

C. The first Shoshone County EMS person to determine that a patient meets the trauma triage criteria will attach an Idaho State Trauma Registry Band to the patient's wrist or ankle.

D. All information shall be documented on an appropriate Patient Care Report (PCR) form approved by the Shoshone County MPD, which meets Medical Incident reporting data collection requirements as outlined by the State EMS Bureau.

E. QUALITY IMPROVEMENT

As per the regional quality assurance program, consisting of a least one member of each designated facility's medical staff, and an EMS provider, shall develop a written plan for implementation to address issues of compliance with the above standards and procedures.

TRIAGE AND TRANSPORT
(Continued)

TRAUMA ACTIVATION CRITERIA

STEP ONE → **MEASURE VITAL SIGNS AND LEVEL OF CONSCIOUSNESS**

1 or More of the Following

- □ GCS <10
- □ SBP <90 Adult; <80 Child
- □ Respiratory Rate
  - ○ Adult <10 or >29
  - ○ Infant <20

  OR

  Need for Ventilatory Support

OR

- □ All penetrating injuries to head, neck, torso, extremities proximal to elbow and knee.
- □ Chest wall instability or deformity.
- □ Two or more proximal long bone fractures.
- □ Crushed, de gloved, mangled, or pulse less extremity.
- □ Amputation proximal to wrist or ankle.
- □ Pelvic fractures (Displaced or Open)
- □ Open or Depressed Skull Fracture
- □ Paralysis
- □ Burns; >20% Adults
  >10% Child or over 50 years old
- □ RESPONDER AND/OR ED MD OR TRIAGE DISCRETION

↓

LEVEL ONE ACTIVATION
Trauma Code Red

1 or More of the Following

- □ GCS 11-13
- □ Consider Co-Morbidities and Age (including pregnancy)
- □ Assess Mechanism and/or evidence of high energy impact.
- □ Potential for Multi-System Trauma.

OR

- □ Falls; >20 ft Adult
  >10ft or 2-3 x's child's height
- □ Ejection or Partial ejection from vehicle.
- □ Significant intrusion into vehicle.
- □ Death in same passenger compartment.
- □ Pedestrian struck by vehicle, thrown, run over, or with impact >20 MPH
- □ Motorcycle crash >20 MPH
- □ RESPONDER AND/OR ED MD OR TRIAGE DISCRETION.

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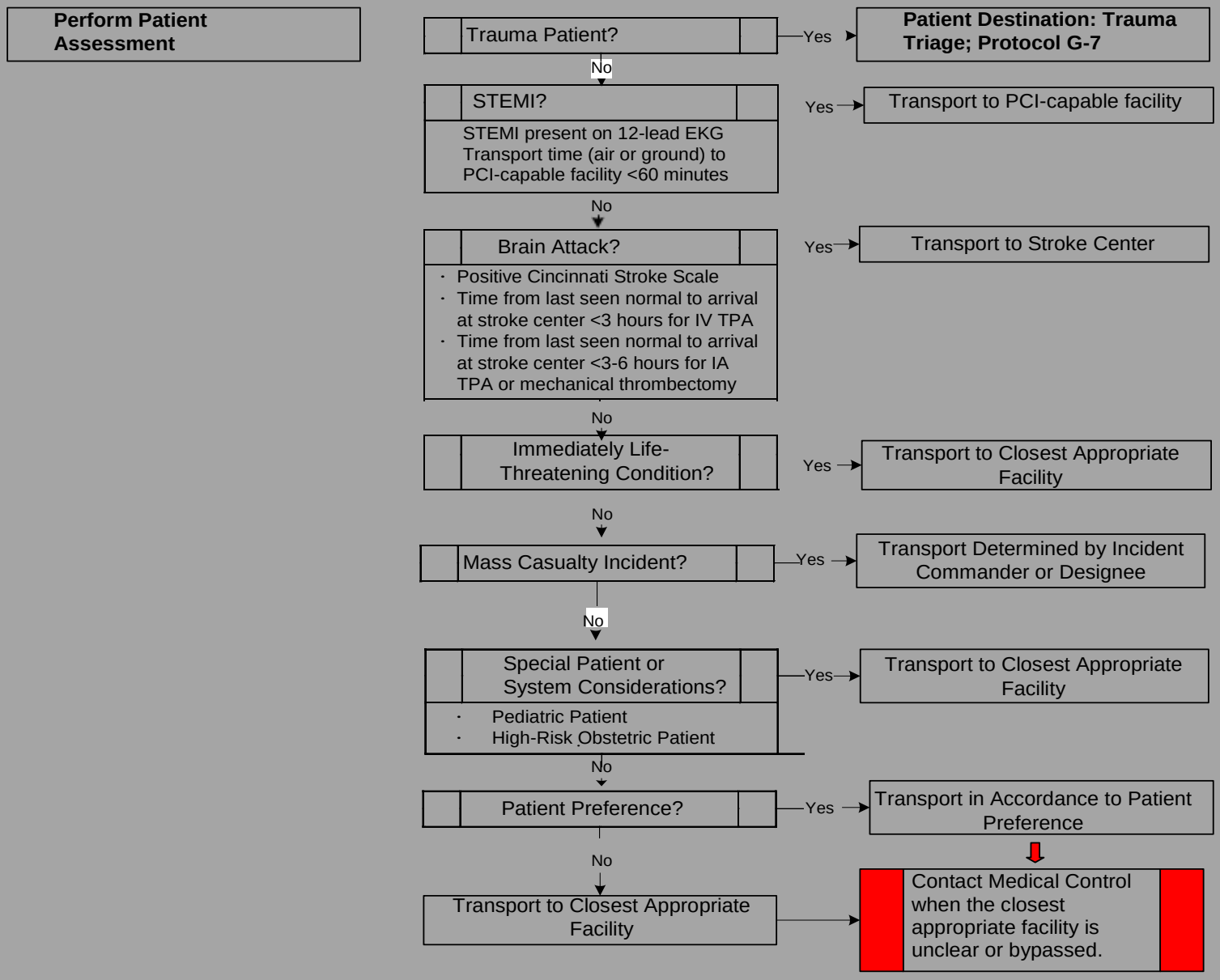
LEVEL TWO ACTIVATION
Trauma Alert

GUIDELINES
Shoshone County revised 01/15

Destination Determination



Pearls

- The window for IV TPA may be extended to 4.5 hours for certain brain attack patients. Consult with your local stroke center for specific patient criteria.
- Consult with your local stroke center to determine their brain attack capabilities (e.g., IV TPA, IA TPA, mechanical thrombectomy).
- If the patient requests transport to a facility not consistent with this protocol, honor the request only after informing the patient why the EMS system recommends another facility (e.g., available medical capability or capacity, shorter transport time, “time is muscle”) and after the patient verbalizes understanding (informed refusal). If the patient demonstrates impairment of judgment related to injury, shock, drug effects, or emotional instability, act in the patient’s best interest and transport the patient to the most appropriate facility as determined by this protocol.
- EMS may decline transport to the patient’s preferred facility when transport time or distance will adversely effect local EMS resource availability. Additional EMS system or geopolitical considerations (e.g, county boundaries) may also preclude transport to the patient’s preferred facility.

Performance Improvement Suggestions

- Documentation of criteria used to determine patient destination
- Documentation of informed refusal, if applicable
- For STEMIs and brain attacks, EMS transport time to receiving facility and door-to-reperfusion time at receiving facility

INTER-FACILITY TRANSPORT

Inter-facility transport will occur at both the BLS and ALS level within the following special categories:

1) Transfer between hospitals for admission for services not available at initial hospital.
2) Transport and return of patient to facility for diagnostic evaluations at second facility.
3) Transport from hospital to extended care facility.
4) Transport of patient between facilities at patient's request.
5) Transport of psychiatric patient.

As a general rule, it is the responsibility of the transferring facility to ensure that the medical necessities for safe patient transfer are met. Medical instructions of the attending physician and registered nurses will be followed unless specifically contrary to standing orders. If treatment is recommended that is contrary to protocol, medical control at the receiving facility should be contacted for advice. If a physician attends the patient during transfer, he will direct all care regardless of standing orders. If a registered nurse attends the patient, she will direct the care of the patient from the standing orders given by the physician at transfer or by contact with the receiving hospital physician. The registered nurse may desire to defer emergency care in some situations to the EMT or paramedic.

The responsibility for transfer to another facility resides with the transferring facility. 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. Furthermore, that the risks of transfer outweigh the benefits available at the other facility. Evaluation and treatment of patients prior to transfer are 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

It is also the transferring facility's responsibility to establish the need for BLS or ALS transport.
For ALS calls not meeting the above criteria, the following may apply:

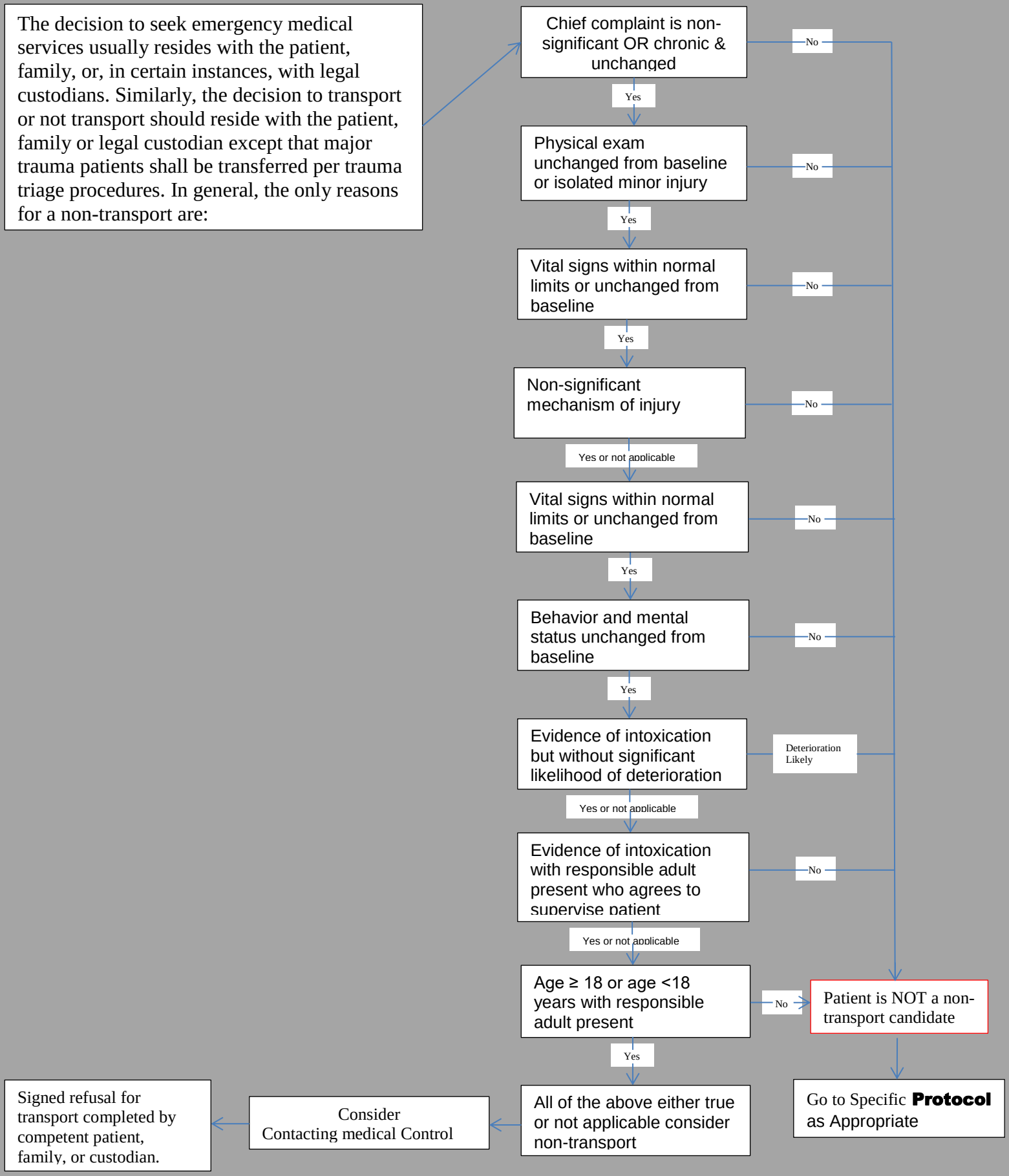
1) You may request compliance with the above criteria.
2) If you do not think the plan for transfer can be safely accomplished, contact the receiving physician for concurrence or consultation.

If a BLS transport is requested, and if 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.)
If either an ALS or BLS crew discovers an emergency situation with the patient while enroute that is not anticipated prior to transport, pre-hospital protocols and guidelines will immediately apply. 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.

(End)

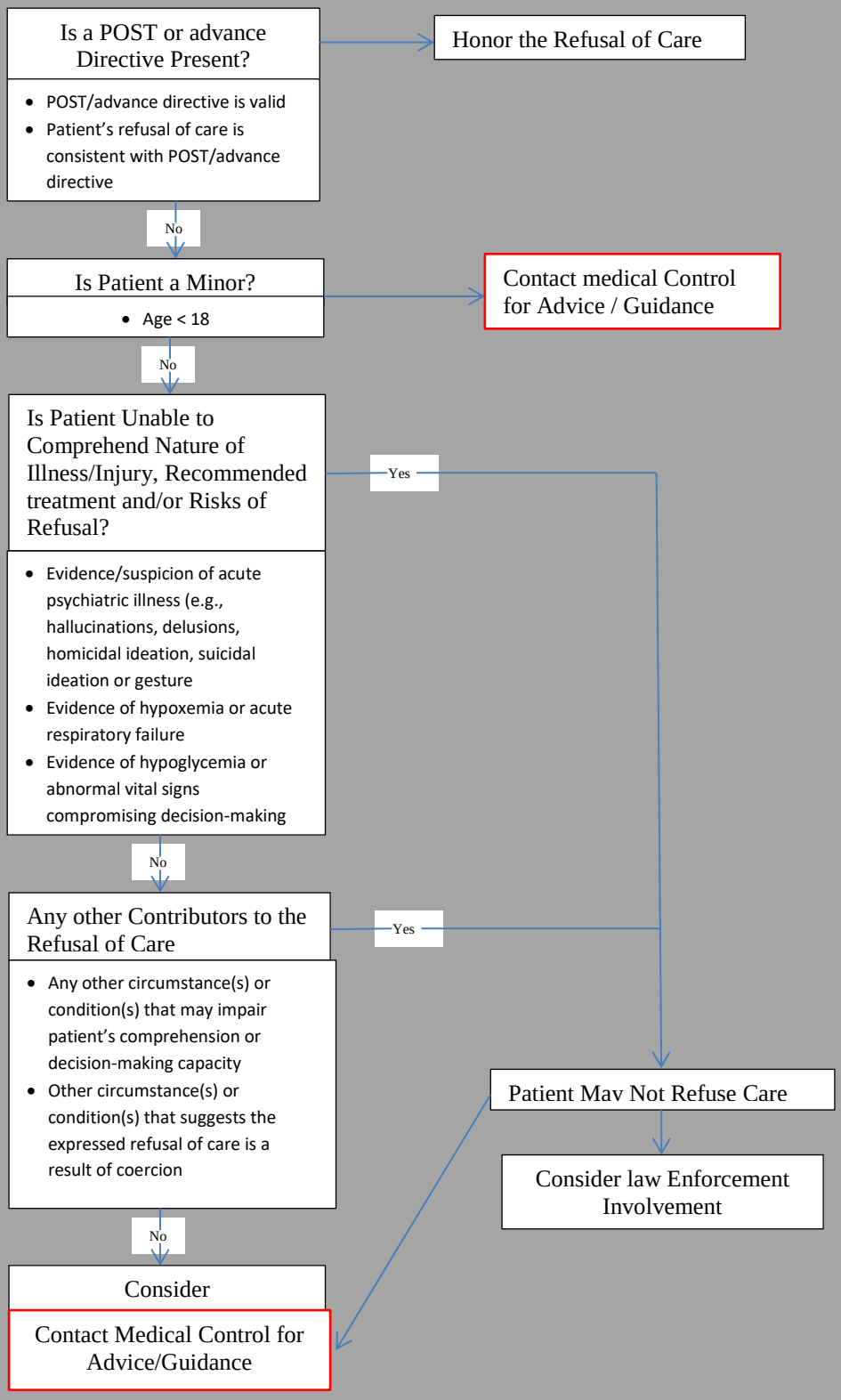
NON-TRANSPORT OF PATIENTS

The decision to seek emergency medical services usually resides with the patient, family, or, in certain instances, with legal custodians. Similarly, the decision to transport or not transport should reside with the patient, family or legal custodian except that major trauma patients shall be transferred per trauma triage procedures. In general, the only reasons for a non-transport are:



REFUSAL OF CARE

Shoshone County EMS guidelines and protocols are intended for use with a conscious, consenting patient, or an unconscious (implied consent) patient. Patients refusing EMS care or transport represent a significant medical-legal risk for EMS agencies and their personnel. Adherence to medical release principles will minimize liability and maximize patient care.



Pearls

- A patient who refuses care must be able to receive information, process the received information, and demonstrate understanding of the information as well as the consequences of refusing care.
- A patient's denial of illness, financial constraints and/or fear of hospitalization may contribute to a refusal of care.
- Enlist family, coworkers, friends and/or medical control to convince patients to receive appropriate care and transport.
- Voluntary consent to treatment is greatly preferred over conflict, law enforcement involvement, or physical restraint.

CANCELLATION / SLOW DOWN

This guideline is to describe how units responding to medical emergencies may either "slow down" or cancel other responding units. It is recognized that it is in the best interest of patient care and the public to slow or cancel units responding in the emergency mode to calls when it is determined that the patient does not require an additional emergency response.

1) ALS ambulances or fire/rescues staffed at the paramedic level may slow or cancel other responders once the patient has been evaluated at the scene and the determination is made that no other units are required or no other units are required in the emergency mode.
2) First responding EMS agencies may slow ALS or BLS ambulances when a patient does not require Advanced Life Support. They may cancel ALS or BLS ambulances when there is no patient or no transport required. [Department policy to apply.]
3) Police agencies may cancel ALS or BLS ambulances when no patient is found.

(End)

LEVEL OF CARE DURING TRANSPORT

EMTA/Paramedic and EMT on Ambulance

Attendance of the patient during transport will be appropriate to the degree of illness, as determined by the judgment of the AEMT/paramedic. All ILS/ALS transports will be attended by an emergency care provider qualified and certified by Idaho to provide the appropriate ILS/ALS procedures. The only exception may occur during mass casualty incidents.

(End)

EMERGENCY TRANSPORTS AND ALS RENDEZVOUS

General Trauma

1) Injuries resulting in unstable vital signs, altered level of consciousness, or severe anatomic injuries
2) Injuries associated with severe mechanisms or co-morbid factors which increase the likelihood of immediate complications or deterioration which would require immediate hospitalization or ALS intervention

GENERAL MEDICAL

1) Medical emergencies resulting in unstable vital signs or altered level of consciousness
2) Medical emergencies associated with the potential for significant complications requiring immediate hospitalization or ALS intervention

SPECIFIC INJURY CONDITIONS REQUIRING EMERGENCY TRANSPORT AND/OR ALS RENDEZVOUS

1. VITAL SIGNS AND LEVEL OF CONSCIOUSNESS

- Shock: Systolic Blood Pressure < 90; or
- Respiratory Distress: Respiratory Rate <10 or > 29; or
- Altered Mentation: Glasgow Coma Score < 13

2. ANATOMY OF INJURY

- Penetrating injury of head, neck, torso, or groin; or
- Combination of burns > 20% of total body surface or involving face, airway, hands, feet, and genitalia; or
- Amputation above wrist or ankle; or
- Spinal cord injury; or
- Flail chest; or
- Two (2) or more obvious proximal long bone fractures

3. Consider emergency transport and/or ALS rendezvous if the following conditions apply:

A) BIOMECHANICS OF INJURY

- Death of same car occupant; or
- Ejection of patient from enclosed vehicle; or
- Falls > 20 feet; or
- Pedestrian hit at > 20 mph or thrown 15'; or
- Rollover; or
- Motorcycle, ATV, or bicycle accident; or
- Extrication time > 20 minutes; or
- Significant intrusion

B) CO-MORBID FACTORS

- Extremes of age (< 12 years or > 60 years)
- Hostile environment (extremes of heat or cold)
- Medical illness (such as COPD, CHF, renal failure, etc.) - Presence of intoxicants
- Second/third trimester pregnancy

C) Emergency care provider judgment of injury severity

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EMERGENCY TRANSPORTS AND ALS RENDEZVOUS (Continued)

SPECIFIC MEDICAL CONDITIONS REQUIRING EMERGENCY TRANSPORT AND/OR ALS RENDEZVOUS

1) Cardiopulmonary arrest
2) Acute myocardial infarction
3) Respiratory distress
4) Altered level of consciousness (Glascow Coma Scale < 13)
5) Seizures
6) CVA
7) G.I. bleeding
8) Anaphylaxis
9) Near drowning
10) Imminent birth

(END)

HELICOPTER TRIAGE GUIDELINES

Determination of Need

1. Air transport should be considered for patients when reliance on ground transport would result in an unacceptable delay in hospital care.
2. Air transport may also be indicated when a multiple casualty incident overwhelms the resources of the local EMS system.
3. Department personnel who are enroute to the scene or on scene may determine the presence of clinical criteria that warrant air transport. Early consideration of air transport while enroute to the scene is encouraged as this may reduce the time to definitive hospital care. Due to extended response and transport times in our response area error on the side of utilizing air ambulance service.
4. When the patient is in a remote location, public answering safety point (PSAP) personnel may be authorized to request an air ambulance prior to the arrival of on-scene personnel.
5. When the need for air medical transport is suspected but unclear, the air ambulance agency should be started to the scene. Air ambulance should not be placed on standby due to the remote nature of our response area and the extended response times involved.
6. An air ambulance should only be cancelled by EMS personnel who have completed an on-scene patient assessment.
7. When the medical necessity of air medical transport is unclear or when "over-triage" or "under-triage" is suspected, contact on-line medical direction.
8. Patient or family request for specific Helicopter Provider should be followed if use of helicopter is medically necessary and it will not cause an unnecessary delay in transportation.

INDICATIONS

Trauma

1. Consider air transport when total ground transport time to appropriate hospital > 30 minutes AND patient meets one or more of the following criteria:
   A) VITAL SIGNS AND LEVEL OF CONSCIOUSNESS
   -Shock: Systolic Blood Pressure <90; or
   -Respiratory Distress: Respiratory Rate < 10 or > 29; or
   -Altered Mentation: Glasgow Coma Score <13

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HELICOPTER TRIAGE GUIDELINES (Continued)

B) ANATOMY OF INJURY
- Penetrating injury of head, neck, torso, or groin; or
- Combination of burns >20% of total body surface or involving face, airway, hands, feet, and genitalia; or
- Amputation above wrist, ankle; or
- Spinal cord injury; or
- Flail chest; or
- 2 or more obvious proximal long bone fractures

2. Consider air transport if the following conditions or risk factors apply. The potential for severe injuries is more likely as multiple risk factors apply.

A) BIOMECHANICS OF INJURY
-Death of same-car occupant; or
-Ejection of patient from enclosed vehicle; or
-Falls >20 feet; or
-Pedestrian hit at > 20 mph or thrown 15 feet; or
-Rollover; or
-Motorcycle, ATV or bicycle accident; or
-Extrication time >20 minutes; or
-Significant intrusion

B) CO-MORBID FACTORS
-Extremes of age (<12 or >60 years)
-Hostile environment (extremes of heat or cold)
-Medical illness (such as COPD, CHF, renal failure, etc.)
-Presence of intoxicants
-Second/third trimester pregnancy

Medical

1. Consider transport when total ground transport time to appropriate hospital > 30 minutes.

A) UNSTABLE MEDICAL PROBLEMS
-Airway problems with concern for possible obstruction
-Breathing problems with respiratory distress and SAO2 <90%
-Circulatory problems, including:
Chest pain with possible acute MI
Unstable cardiac dysrhythmias
-Internal bleeding with unstable vital signs
-Altered level of consciousness
-Significant environmental incidents with unstable patient, including:
Drowning
Hypothermia
CO poisoning
-Imminent birth

ADDITIONAL INDICATORS

1. Emergency care provider judgment of injury or illness severity
2. Multiple casualty incidents that exceed ground transport capabilities.
3. Difficult or unusual terrain's where helicopter abilities may be of benefit.
4. Unusual or hazardous road conditions.

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HELICOPTER TRIAGE GUIDELINES (Continued)

Selection of the Air Ambulance Agency

Notification for need of air ambulance response will be made to Shoshone County Sheriff's Dispatch (County) and they will select and contact the nearest and most available air ambulance for response. If they are unable or unwilling to make this contact SCFD No. 1, 2, may make direct contact with Helicopter services.

Communications

Air ambulance communications can be divided into three areas, request for the air ambulance, landing zone communications and notification of the receiving hospital which is an air ambulance responsibility.

1. Request for Air Ambulance
    a. The contact point for air medical needs will be coordinated through County.
    b. The request for air ambulance should include as much information as is practical.
    c. Requests can be made to MEDSTAR or Life Flight if no other means is available.
2. Landing Zone (LZ) Communications
    a. The LZ officer is responsible for radio communications with the responding air ambulance (see *Landing Zones & Safety)*. Responsibilities include:
        i. Assisting the pilot in locating the LZ with simple directions and easily identifiable landmarks
        ii. Advising the pilot of LZ conditions and hazards.
    b. Primary communications between ground and aircraft should be on EMS 1 Frequency
    c. Hand signals and gestures should be used only when radio communications fail.
3. Notification of the Receiving Hospital
    a. The receiving hospital should be notified by the air medical crew.

Landing Zones & Safety

1. Landing Zone Officer.
    a. Minimum qualifications: Completion of a LZ class, preferably from the service being used.
    b. Responsibilities
        i. LZ preparation
        ii. Communications (see *Communications)*
        iii. Safety

Patient Destination

1. The air ambulance should transport the patient to an appropriate facility of their choice.

Quality Improvement

The local EMS system should continuously evaluate the performance of its air ambulance providers. In fact, the local EMS system may incur liability when it does not make a reasonable effort to monitor air ambulance performance and the air ambulance service it chooses to request does not meet the community standard of care.

1. The local EMS system should consider monitoring the following data:
    a. Air ambulance response time (air ambulance request by local EMS – air ambulance arrival on scene)
    b. Air ambulance on-scene time
    c. Patient destination (i.e. compliance with local destination protocol)
    d. Other

Patient treatment and outcome information should be used to review the utilization of air ambulances, including their appropriate use as well as the failure to request an air ambulance when indicated, and to validate "auto-dispatch" and other air ambulance dispatch criteria

(End)

MEDICAL PROFESSIONALS AT THE SCENE

Medical professionals at the scene of an emergency may provide assistance to EMS providers and should be treated with professional courtesy. Medical professionals who offer their assistance should identify themselves. Physicians should provide proof of their identity, if they wish to assume or retain responsibility for the care given the patient after the arrival of the Ambulance unit. (See "RELATIONSHIP BETWEEN ADVANCED LIFE SUPPORT TEAM AND PRIVATE PHYSICIAN")

(End)

RELATIONSHIP BETWEEN EMS TEAM AND PRIVATE PHYSICIAN

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

The Physician at the scene may:

1) Request to talk directly to on-line Medical Control to offer advice and assistance;
2) Offer assistance to the EMS team with another pair of eyes, hands, or suggestions, leaving the EMS team under Medical Control;
3) Take total responsibility for the patient with the concurrence of on-line Medical Control.

If, during transport, the patient's condition should warrant treatment other than that requested by the private physician, on-line Medical Control will be contacted on the EMS 1 radio system or cell phone for information and concurrence with any treatment, except in cases of cardiopulmonary arrest.

The above "Physician at Scene" will also apply to cases where a physician may happen upon the scene of a medical emergency and interacts with the EMS team. Show physician at scene the "Thank You For Your Offer of Assistance" card provided in the front pocket of this book (see next page for sample).

(End)

THANK YOU FOR YOUR OFFER OF ASSISTANCE

Please be advised that this EMS team is operating under the authority of Idaho State Law and protocols that were developed and approved by me as Medical Program Director. The EMS team performs their functions at the scene under the guidance of EMS Medical Control. If you, as a physician at the scene, decide you must intervene in the patient's care, then you are responsible for any and all care given, and must accompany the patient to the hospital in the ambulance and sign the Patient Care Report.

Scott Reed, M.D.
Medical Program Director
Shoshone County, Idaho

FIELD RESUSCITATION GUIDELINES

WITHHOLDING OF CPR

1. CPR must be initiated on all cardiac arrest victims, unless a condition exists which warrants the withholding of CPR.
   A) CPR may be withheld on ADULT or PEDIATRIC victims who present with any one of the following:
      1) Decapitation
      2) Total incineration
      3) Decomposition
      4) Dependent lividity
      5) Rigor mortis without vital signs
      6) Apnea in conjunction with separation from the body of either the brain, liver, or heart
      7) Mass casualty incidents where triage principles preclude CPR from being initiated on every victim
      8) Documentation of Do-Not-Resuscitate Orders
   B) CPR may be withheld on ADULT victims of unwitnessed medical cardiac arrest or witnessed/unwitnessed trauma arrest who present with ALL the following:
      1) No CPR in progress
      2) No vital signs
      3) AEMT/Paramedic will document lack of Ventricular Fibrillation by attaching defibrillator and recording "No Shock Indicated" two times.
      4) NO EVIDENCE OF HYPOTHERMIA, DRUG INGESTION, OR POISONING
      5) Contact has been made with Medical Control for termination of efforts
2. Notify appropriate law enforcement agency as soon as possible.
3. Complete a prehospital-care record, documenting clinical conditions which warranted not initiating CPR and law enforcement agency notification.

DISCONTINUING CPR

1. On-line Medical Control should consider discontinuing CPR in the prehospital setting and pronounce a patient dead at the scene, provided certain conditions are met, including, but not limited to, the following:
   A) At least 10 minutes of CPR by EMS with BVM using appropriate Shoshone County Protocols and AED Advises two no shocks.
      1) Brady-Asystole unresponsive to resuscitation with complete and appropriate Shoshone County Protocols.
      2) Asystole will be documented for thirty (30) seconds in two (2) leads with documented evidence that monitor is functioning properly (i.e., artifact due to manual compression or precordial thump) or two consecutive no shocks advised by the AED.
      3) Blood pressure, pulse, and respiration are absent.
      4) Ventricular Fibrillation which, after ALS resuscitation, is now Asystole or Agonal rhythm.
   B) NO EVIDENCE OF HYPOTHERMIA, DRUG INGESTION, OR POISONING AS CAUSE OF ARREST
2. Notify on-line Medical Control before discontinuing CPR. If unable to contact on-line Medical Control because of geographic isolation, the emergency-care provider will contact the physician as soon as possible and document the reason for delay of communication.
3. Complete a prehospital record documenting the physician who was consulted and discontinued resuscitation.
4. AEMT/Paramedic ensure the AED data is downloaded and attached to the Prehospital report.

(Continued Next Page)

FIELD RESUSCITATION GUIDELINES (Continued)

5. Notify appropriate law enforcement agency.
6. Notify appropriate support facility for family as needed.
7. When appropriate, remain with family until other support has arrived for as long as necessary. If you are called for another emergency response, emergency care for the living must always assume priority.

(End)

EMS - NO CPR

1. Perform routine patient assessment, resuscitation or other medical interventions until DNR/POST can be confirmed.
2. If an unaltered DNR/POST form or bracelet is found, obtain reasonable assurance that the patient is the person for whom the DNR/POST order applies.
3. If the patient is in respiratory or cardiac arrest, withhold resuscitative measures, i.e. CPR, intubation, cardiac monitoring, defibrillation, administration of resuscitation medications and any positive pressure ventilation.
4. If resuscitative efforts have been started before learning of a valid DNR/POST order, resuscitative measures will be stopped. Every effort will be made to make the patient as comfortable as possible.
5. If the patient is not yet in respiratory or cardiac arrest and after confirming that the patient has a valid DNR/POST form or bracelet, comfort care interventions, dependent upon the needs of the patient may be carried out.
6. If a DNR/POST order has been revoked, perform full resuscitation and treatment of the patient.
7. Identify in the patient's run report that a DNR/POST form or bracelet was in place.
8. Attach any cardiac monitor strips to the run report.
9. If a written DNR/POST form is presented with the patient's physician signature, contact the patient's physician or on-line medical control for guidance.
10. Do not hesitate to use on-line medical control for assistance.

Revoking of DNR/POST Order:

May be done by the patient (regardless of their mental capacity), legal surrogate or attending physician either verbally, by removing the bracelet or destroying the patient copy of the order. This provision is in accordance with Idaho Code #39-154 which states "*a person may, at any time revoke his or her consent to an order not to resuscitate himself or herself by making a written or an oral declaration to a health care provider or by any other act evidencing a specific intent to revoke such order*".

Disregarding of DNR/POST Order (Idaho Code #39-157):

Emergency personnel may disregard the DNR/POST order under the following conditions:
If they believe in good faith that the order has been revoked
To avoid verbal or physical confrontation
If ordered to do so by the attending physician

Following the death of the patient, the provider needs to:

Provide emotional support for the patient's family/significant others.
Contact the appropriate dispatch center for Law Enforcement response. Law Enforcement is, required by law, to investigate all deaths regardless of circumstances.
Clear the treatment area of all EMS supplies used during any patient care efforts and cover the patient with a sheet or blanket.
Note the time of death in run report.
Refrain from discussion of possible reasons for patient's death. This is the job of Law Enforcement and the Coroner's office.

Medications and Allergies

All medications in these protocols are to be administered only after ascertaining that the patient is NOT allergic to them. In critical situations when the patient has an altered level of consciousness, emergency care providers should question family, friends, and look for medical alert identification and/or "Vial of Life canisters.

(END)

BLOOD DRAWS

Indications for blood draws will be limited to:

1. Medical cases requiring laboratory documentation
   A) Suspected hypoglycemia (prior to IV glucose)
   B) Suspected drug overdose
   C) Unconscious patient, unknown cause
   D) Trauma patients
   E) Hypotensive patient, unknown cause
   F) Suspected MI
   G) Suspected Stroke
   H) Unstable Medical Condition
2. Method of transporting field blood samples
   A) The blood tubes should be labeled with the patient's name, date, time of draw, and the initials and agency of drawer.
   B) The blood tubes should then be placed in a sealable plastic bag bearing a bio-hazard logo and this bag taped to the patient's IV bag

(END)

INFECTIOUS DISEASE PRECAUTIONS

Precautions to prevent transmission of infectious diseases are especially important in the emergency-care setting, where the risk of blood exposure is increased and the infection status of patients is usually unknown. Universal blood and body fluid precautions shall be consistently used for <u>all</u> patients to prevent skin and mucous membrane exposure.

1. Gloves shall be worn for:
   A) touching blood and body fluids, mucous membranes, or non-intact skin.
   B) handling items or surfaces soiled with blood or body fluids.
   C) performing venipuncture and other vascular access procedures.
   D) change gloves after contact with each patient. Wash hands immediately after removing gloves.
2. Masks, protective eyewear, and gowns shall be worn during procedures that are likely to generate droplets or splashes of blood or other body fluids.
3. Wash hands and other skin surfaces immediately if contaminated with blood or other body fluids.
4. Use mouthpieces, resuscitation bags, or other ventilation devices to avoid mouth-to-mouth contact.
5. Sharp instruments, needles, and scalpels shall be handled carefully during procedures, cleaning, and disposal. Needles shall not be recapped, bent, broken by hand, or removed from disposable syringes. Place used disposable syringes, needles, scalpels, and other sharp items in puncture-resistant containers for disposal.
6. These precautions will afford protection to pregnant emergency care providers to <u>minimize</u> risk of prenatal transmission of infectious disease.

Emergency care providers who have open lesions or weeping dermatitis shall refrain from direct patient care and from handling patient-care equipment.

(End)

Hazardous Materials Response

These guidelines are to be used in all incidents involving hazardous materials where there is an actual or potential exposure to any hazardous substance.

1) Call for help - Contact local fire jurisdiction.
2) Work with Incident Commander as to procedures for securing access to the scene.
3) Establish a SAFE staging area uphill, upwind if possible. Notify all incoming response agencies of proper route for a SAFE scene approach to the staging area. Helicopters, when indicated, should be landed far enough away from the scene to avoid spread of contamination from prop wash.

Refer to the DOT Emergency Response Guidebook, or Haz Mat Team for general precautions and isolation/evacuation guidelines. As a general rule of thumb, isolate the hazard area for 100' for a minor incident and 500' for a major incident. If explosives are involved, evacuate area for 1/2 mile. Remember: The evacuation zone downwind or downhill will be much greater.

4) Protect yourself and others from any significant exposure. Do not attempt rescue without proper protective gear. Minimize continued exposure of any personnel and secondary contamination of rescue personnel by ensuring that proper decontamination has been completed prior to treatment or transport to a medical facility. Prevent unnecessary contamination of transport vehicles or equipment.
5) Obtain accurate information on health effects of the product(s) involved. Attempt to identify product(s) involved by placard, ID #, shipping papers, personnel on scene, etc.
6) Provide appropriate pre-hospital care as to your certification level. In general, it is not recommended to begin any medical treatment without first referring to proper guidelines. (Interventions as automatic as providing oxygen may be dangerous if not compatible with the agent involved.)

(End)

EMERGENCY TRANSPORT OF THE PHYSICALLY DISABLED AND THEIR SERVICE/GUIDE DOGS

A patient's service/guide dog should receive special considerations, provided that these measures will not adversely affect the provision of care to the patient.

1) If the animal is handled by the EMS provider, he will use extreme gentleness.
2) Care and the appropriate transport of the dog will be requested of family, friends, or other civil services.
3) Under rare circumstances, ambulance transport of the dog with his owner, if stable, may be considered.

(End)

SCHEDULE 2 MEDICATIONS

Schedule 2 meditations are those meditations that are classified as controlled substances by the U.S. Food and Drug Administration. The purchase, storage, dispensing, destroying, and record-keeping of Schedule 2 meditations will be handled in the following manner:

The EMS agency will designate one individual who will be responsible for record-keeping and security of the controlled substance. This individual will be responsible for reporting any discrepancies to the EMS Chief Officer who will investigate and report to the Medical Director.
Purchase of Schedule 2 medications must be on a Federal Narcotics form, DEA 222, which contains the name and address of the EMS agency and the name and physician ID number of the EMS agency's medical Director. Copies of the Federal Narcotics form must be maintained by the EMS agency for the purpose of inventory, should a problem arise.

STORAGE IN HOUSE:
Storage will be in a locked container that inhibits forced entrance. That container will be stored in a cabinet that is also locked. Keys to the storage facility will be in control of the paramedic on duty. If no paramedic on duty, the highest ranking individual on duty at that facility will be responsible for the keys and for maintaining the appropriate records.

STORAGE IN FIELD:
Schedule 2 meditations will be handled in 1 of 2 ways in the field:

1) The paramedic may carry them in a container that slips on/over the belt and has a cover sufficient to keep the meditations from freely falling out, or
2) They may be stored in a locked container that inhibits forced entrance, with that container being stored in a cabinet or compartment on the apparatus that is also locked. Keys to the apparatus storage will remain in control of the duty paramedic on that apparatus.

Control and dispensing of Schedule 2 meditations is the sole responsibility of the duty paramedic. He will be responsible for properly recording information on the patient's PCR form and in the agency's record book:

1) Patient name
2) Date
3) Amount of meditation dispensed
4) Name of paramedic dispensing medication

Destroying outdated or contaminated Schedule 2 medications will be witnessed by two (2) individuals. Both must sign in the appropriate section of the Schedule 2 medications log book

(Continued Next Page)

SCHEDULE 2 MEDICATIONS (Continued)

RECORD KEEPING:
Each EMS agency authorized to obtain and dispense Schedule 2 medications will maintain appropriate and orderly records. Copies of these records will be provided to the EMS agency's Medical Director on a semi-annual basis. Upon written request, the EMS agency will provide the Shoshone County Medical Program Director and/or that agency's medical advisor the original records when, by his judgment, an audit is necessary.
The record books will contain the following information:

GENERAL INFORMATION

1) Name of designated control person
2) Name and FDA physician control number of EMS agency medical director
3) Names of all personnel who have access to Schedule 2 medications

SECTION 1 - PURCHASE

1) Source and date of purchase
2) Name and FDA physician control number of physician who authorized purchase

SECTION 2 - DAILY RECORDS

1) Off-duty paramedic signature
2) On-duty paramedic signature
3) Milligrams of medication changing hands

SECTION 3 - DISPENSING OF MEDICATION

1) Date and agency run number
2) Patient name
3) Name of paramedic dispensing meditation

SECTION 4 - DESTROYING SCHEDULE 2 MEDICATIONS

1. Medication lot number
2. Expiration date
3. Date destroyed
4. Two signatures
   a) Paramedic destroying the medication
   b) Witness
5) Reason for destruction

(End)