PRE-HOSPITAL PATIENT CARE PROTOCOL

ADMINISTRATIVE

Section I

Rappahannock EMS Council
435 Hunter Street
Fredericksburg, VA 22401

BASIC LIFE SUPPORT/ADVANCED LIFE SUPPORT
ADMINISTRATIVE PATIENT CARE PROTOCOL

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1.0 Introduction and Use

The following protocols have been approved by the Rappahannock Emergency Medical Services Council (REMSC) Guidelines and Training Committee as the Pre-Hospital Patient Care Protocol for agencies in the REMSC region. These treatments were developed through input and guidance from ALS and BLS providers in the region, as well as the various medical directors. The protocols are designed to provide information on procedures providers at different levels are permitted to do and denote standing orders for certain conditions. The medical director may choose to modify certain treatment recommendations for specific conditions and may even limit performance authorization for any provider at any level. These modifications should be supported by written documentation and may be maintained in a file at the regional council or at the individual agency.

The treatment protocols are designed to give reminders and guidance for various conditions but are NOT a replacement for sound clinical judgment. As clinical guides, they are not intended to be educational documents and training should be completed PRIOR to their use to understand the information contained and the guidance that it provides. They also outline care for a typical presentation and may not fit exactly with the patient who has combined symptoms from multiple conditions. In cases where progressive care is indicated by permission for repeat orders, it is assumed that the prior care was not effective and the patient continues with symptoms or worsens. If additional treatment is not necessary you are not obligated to complete the entire treatment protocol just because it is written.

The provider may contact on-line medical control for guidance and assistance. Many of the protocols are designed to allow providers to initiate appropriate care promptly without requiring contact with medical control first. With that acknowledgment comes the medical director's expectation that providers perform complete assessments, recognize proper signs and symptoms, and provide condition-related therapy by utilizing ardent clinical assessment skills and keen critical thinking and clinical judgment. The order of treatment in the protocol may not always be appropriate for all patients and based on clinical judgment it may be modified by providers. If there are questions or uncertainties medical control should be used rather than making assumptions and providing unsuitable care.

The physician providing on-line medical control has the authority to suspend or deviate from the protocol and may provide additional or changed orders which are not specified in the regional protocol. Any order received from medical control must be reduced to writing and documented on the patient care report.

Treatment is broken into categories depending on how the physician group recommends that it be used. In previous versions there was a conditional category that addressed supplemental certification with classes like ACLS, PALS, PEPP, ITLS, etc. It is the expectation that ALS providers (EMT-I and EMT-P) maintain certification in ACLS and

PALS. Many of the treatment algorithms are based on science and information from these classes and where applicable, treatment recommendations from ACLS, PALS, and NRP are included in the protocols. The category for the particular order is indicated on the right hand column of the treatment protocol with one of the following letters:

S – Indicates a standing order that may be completed as written without consulting medical control prior to beginning treatment

O – Indicates an order that requires contact and approval from on-line medical control prior to starting the treatment

R – indicates an order that is restricted and NOT OPEN to every provider at that Virginia EMS certification level; it is based on conditions and additional requirements which must be met prior to use

A complete Pre-Hospital Patient Care Protocol consists of all sections including Administrative, Clinical Procedures, Medical and Trauma. A copy of this document should be kept at the emergency department (ED), each EMS agency, and in every ambulance unit in the REMSC region. Additional copies are available at www.rems.vaems.org.

Each protocol is dated by month and year. It will be reviewed as needed by the REMSC Guidelines and Training Committee and the Protocol Sub-Committee. Revisions are made to individual treatment protocols as needed and periodic complete reviews are done triennially. Any provider may submit input for changes to the regional protocols by submitting written requests and ideas to the REMS Council with attention to “protocol updates”. All suggestions will be routed through the Protocol Sub-committee, who will make recommendations to the Guidelines and Training Committee who will make recommendations to the Medical Direction Committee. Once approved, changes will be made and revised pages will be issued to Operational Medical Directors, the ED medical staff (Medical Director), and to the individual agencies that will then be responsible for any necessary in-service training.

If it is a significant change, the G&T Committee will forward recommendations to the REMS Council Board of Directors. Once changes have been made, dates will be updated to indicate the change and the new protocol will be posted to the internet on the REMS Council website. Notification will be made to providers in the region through information on the weekly list serve, announcements on the website, posting at the regional hospitals, and information in the newsletter and other communication devices.

2.0 Acknowledgements

The Rappahannock Emergency Medical Services Council Board of Directors would like to thank each person who took the time to review and revise our existing protocol and to write a new protocol that reflects the current standard of quality patient care for our region. New science updates have produced many changes in the standard of care. We have revised the protocols to reflect these updates for the 2010 AHA standards that are now in place.

Special thanks to Dr. Nael Hasan, Regional Medical Director, for his contributions and being open to our ideas. **Thanks to everyone who assisted in this project.**

3.0 Administrative Guidelines

3.1 Abandoned Infant

3.1.1 Overview (Virginia Safe Haven Law)

The Code of Virginia § 18.2-371.1 identifies that parents may surrender their newborn infant to EMS personnel. The code reads, "… parent safely delivered the child to a hospital that provides 24-hour emergency services or to an attended rescue squad that employs emergency medical technicians, within the first 14 days of the child's life. In order for the affirmative defense to apply, the child shall be delivered in a manner reasonably calculated to ensure the child's safety…" If a provider is approached by this situation, the provider should attempt to gain as much information concerning the infant as possible from the parent. Once the infant has been turned over to EMS, the infant should be transported to the closest emergency room. Explain the situation to the Charge Nurse and be sure to document their name on your call sheet. The hospital will notify social services.

3.2 Air Medical Utilization

3.2.1 Overview

Air Medical Services (AMS) are a valuable resource in the REMSC. It is important that EMS personnel utilize consistent and appropriate criteria when requesting air medical service for assistance with patient care and transport. These criteria are consistent with national AMS utilization criteria. It is important that review of appropriate helicopter utilization be a part of EMS training, as well as a component of agency, and regional level retrospective quality improvement process.

3.2.2 Management

The helicopter is an air ambulance and an essential part of the EMS system. It may be considered in situations where:

1. The use of the helicopter would speed a patient's arrival to a hospital capable of providing definitive care and that is felt to be significant to the patient's condition, or;
2. If specialty services offered by the air medical service would benefit the patient prior to arrival at the hospital.

The following criteria should be used when considering use of an air medical service:

The patient's condition is a "life or limb" threatening situation demanding intensive, multidisciplinary treatment and care. This may include, but is not limited to:

- Critically Ill or Injured Patients who would benefit from critical care and/or rapid transport that is not available from the ground providers

- Critical burn patients, pediatric trauma, or other specialty cases where appropriate definitive care is not available locally and the patient requires transport outside the region

- Critically ill medical patients requiring care at a specialized center to include, but not be limited to, acute stroke or ST elevation MI as defined by protocol

Patients in cardiac arrest who are not hypothermic are generally excluded as candidates for air transport

Dispatch, Police, Fire, or EMS should evaluate the situation/condition and, if necessary, place the helicopter on standby.

The helicopter may be requested to respond to the scene:

- If ALS personnel request the helicopter
- If BLS personnel request the helicopter when ALS is delayed or unavailable
- In the absence of an EMS agency, when any emergency service requests it, if it is felt to be medically necessary

When EMS arrives, they should assess the situation. If the ***most highly trained EMS personnel on scene*** determines that the helicopter is not needed, it should be cancelled as soon as possible.

Air medical services may be considered in situations where the patient is inaccessible by other means, or if utilization of existing ground transport service threatens to overwhelm the local EMS system. In this case a specialty unit with rescue capabilities (i.e. hoisting equipment or FLIR) may be the most appropriate resource.

An EMS service should not wait on the scene, or delay transport to wait for the arrival of a helicopter. If the patient is packaged and ready for transport, the EMS service should initiate transport to the hospital and reassign the landing zone. The helicopter may intercept an ambulance during transport at an alternate landing site.

THIS IS A GUIDELINE AND IS NOT INTENDED TO SPECIFICALLY DEFINE EVERY CONDITION IN WHICH AIR MEDICAL SERVICES SHOULD BE REQUESTED. GOOD CLINICAL JUDGEMENT SHOULD BE USED AT ALL TIMES.

Transfer of Patient Care, Documentation, and Quality Improvement:

As with other instances where care of a patient is transferred, all patient related information, assessment findings, and treatment will be communicated to flight crew.

At the completion of the EMS call, all of the details of the response, including, but not limited to, all patient related information, assessment findings, and treatment, must be documented on a PPCR.

With helicopter utilization, as with all EMS responses, the treatment and transportation of patients will be reviewed as a part of a Quality Improvement process and providers should complete a shared-concern QI form to advise the REMS Council of the event.

3.2.3 Guidelines for Helicopter Utilization for Scene Response

Generally, air transport should be considered when there is a loss of the patient's airway and/or prolonged ground transport time due to a significant distance to the appropriate receiving facility (such as a burn center or pediatric trauma center).

3.2.3.1 *Adult Major Trauma*

1. GCS less than or equal to 8
2. Systolic blood pressure is less than 90 mmHg and/or unstable vital signs
3. Penetrating injuries to head, neck, torso or proximal extremities
4. Two or more suspected proximal long bone fractures
5. Suspected flail chest
6. Suspected spinal cord injury or limb paralysis
7. Amputation (except digits)
8. Suspected pelvic fracture
9. Open or depressed skull fracture

3.2.3.2 *Pediatric Major Trauma*

1. Respiratory failure (central cyanosis, bradypnea, capillary refill > two seconds)
2. GCS less than 13
3. Penetrating injuries of the trunk, head, neck, chest, abdomen, or groin.
4. Two or more proximal long bone fractures
5. Flail chest
6. Combined system trauma that involves two or more body systems, injuries, or major blunt trauma to the chest or abdomen
7. Spinal cord injury or limb paralysis
8. Amputation (except digits)

3.2.3.3 *Critical Burns* **

1. Greater than 20% Body Surface Area (BSA) of partial and full thickness burns
2. Evidence of airway/facial burns
3. Circumferential extremity burns

****Note: For patients with burns and coexisting trauma, the traumatic injury should be considered the first priority, and the patient should be triaged to the closest appropriate trauma center for initial stabilization.**

3.2.3.4 *Critical Medical Conditions*

1. Suspected Acute Stroke

- Positive Cincinnati Pre-Hospital Stroke Scale
- Total pre-hospital time (time from when the patient's symptoms and/or signs first began to when the patient is expected to arrive at the Stroke Center) is less than three (3) hours. Consider air transport if ground transport to stroke center exceeds 30 minutes.

2. Suspected Acute Myocardial Infarction

- EKG findings indicative of an AMI with/without chest pain, shortness of breath, or other signs and symptoms typical of a cardiac event

Providers should base the decision to fly a patient on their judgment of transport time, distance to an appropriate facility, and the patient’s condition.

Adopted from: New York Sate Department of Health- EMS Bureau

3.3 Behavioral Emergencies

There are organic, situational, and psychiatric causes of behavioral emergencies. Organic causes include toxic and deficiency states, infections, neurological diseases, cardiovascular, endocrine, and metabolic disorders. Situational causes result from an emotional reaction to a stressful event. Psychiatric disturbances are those which arise within the patient, such as psychosis, affective, and anxiety disorders.

3.3.1 Management

The pre-hospital provider should be alert and maintain scene safety in all circumstances, but particularly in cases of behavioral emergencies. Here are some recommendations to assist with managing a patient suffering from behavioral emergencies

- Identify yourself properly, be prepared to spend time with the patient
- Have a plan of action that will make the patient feel that they are being helped, which will encourage the patient to make positive decisions
- Maintain a calm and reassuring professional attitude and manner. Be aware of posture, body language, and position.
- Remove disturbing persons and/or objects from the area
- Encourage the patient to sit, relax, and talk
- Do not touch the patient without his/her permission

- Ask open-ended questions. Avoid being judgmental.
- Provide emotional support to the patient, be compassionate
- Do not argue with or shout at the patient
- Carefully explain all procedures to the patient.
- For safety reasons, do not allow patient to come between you and an exit.
- Make every attempt to provide transportation to the hospital for evaluation and contact law enforcement for assistance as needed.

3.4 Code Gray

If CPR has been initiated by EMS and circumstances arise where the pre-hospital provider believes resuscitative efforts may not be indicated, the provider should confirm that the patient is apneic and pulseless, and, when possible, note the ECG rhythm and verify absence of cardiac activity by auscultation and/or ultrasound. The provider should then contact medical control so that the on-line physician can decide whether or not to continue resuscitative efforts. Providers should alert on-line medical control that they have a potential “Code Gray” call. The provider should then summarize why resuscitative efforts may not be indicated. The provider should then report the ECG rhythm and interventions performed. Then, if, and only if, directed by on-line medical control, may the providers stop resuscitative efforts. If code gray orders are received while transporting the patient, the providers are to continue non-emergency to the hospital in which the order was received. The deceased is to be taken to the emergency room. Under no circumstances will the providers take a patient directly to the morgue.

NOTE: Patients who are hypothermic or are victims of cold water drowning should receive FULL resuscitative efforts. Patients with electrical injuries, including those struck by lightning that may initially be pulseless and apneic, should receive FULL resuscitative efforts as well.

Any medical equipment attached or inserted into a patient MUST remain in place once a code gray order has been received. The provider is not to remove anything from the body unless specifically directed to do so by medical control or the Medical Examiner on scene. Any such actions must be fully documented within the PPCR.

3.5 Death (DOA) Management

3.5.1 Indications

Unattended deaths in the field (meaning unattended by a physician or Hospice) are the exclusive jurisdiction of the Medical Examiner. Generally, when EMS is called to verify a DOA, the scene is turned over to law enforcement who, in turn, contacts the Medical Examiner for release to a funeral home or the Medical Examiner’s office for autopsy.

If a patient is determined to be dead on arrival (DOA) or if the cessation of resuscitative efforts on scene is authorized by on-line medical control, follow local protocol concerning notification of the proper law enforcement authorities and/or medical examiner.

NOTE: It is essential to maintain a Chain of Custody in regards to any DOA case involving the Medical Examiner. Providers should remain on scene until the arrival of either the Medical Examiner or law enforcement personnel.

3.5.2 Management

Providers should make every effort not to unnecessarily disrupt or disturb the scene. All DOA calls are a potential crime scene until proven otherwise. Document the following:

1. Apnea and pulselessness (no cardiac activity by auscultation and/or ultrasound)
2. Presence or absence of rigor
3. Approximate down time
4. A short medical history, including the name of the primary physician and the general condition of the scene and the body

Be attentive to the emotional needs of the patient's survivors. If possible, leave survivors in the care of family and/or friends.

NOTE: Patients who are hypothermic or are victims of cold water drowning should receive FULL resuscitative efforts. Patients with electrical injuries, including those struck by lightning that may initially be pulseless and apneic, should receive FULL resuscitative efforts as well.

As a courtesy, share the information that you have gathered with the law enforcement official in charge on the scene. Do not assume that the officer knows that he/she is the one that should make contact with the Medical Examiner. Remember, that some newer officers may not be familiar with Medical Examiner laws. As time and conditions permit, lend whatever assistance you can to the officer and any family present.

3.6 Direct Admissions

3.6.1 Indications

Ambulance crews involved in transporting direct admission patients to hospitals should be able to return to service as quickly as possible. **All 911 calls, or calls handled by state/municipal/volunteer services, shall only take patients to the ED.** Private ambulance services serve to fill the direct admission gap. It also is important that direct admission patients be properly treated and spared unnecessary costs.

3.6.2 Management

When responding to a direct admission call, ambulance crews should notify the receiving hospital's ED as early as possible to allow the ED staff to follow-up with hospital admissions. Upon arrival at the hospital, the AIC should speak directly with the ED charge nurse or appropriate hospital contact. The charge nurse and AIC will determine the following:

1. Is the direct admission patient's room ready?

2. Is the ambulance crew needed to take the patient to the room?
3. Is the crew available to take the patient to the room?

If the answer to any of the above questions is "no", the AIC will turn over care of the patient to the ED staff. The crew will then return to service as quickly as possible. If the answer to all of the above questions is "yes", the crew may assist as necessary. Any complaint or problem involving a direct admission will be resolved at a later time through direct discussion between the ED nurse manager, or appropriate hospital contact, and the chief operating officer of the pre-hospital agency, or persons designated by those individuals.

3.7 Documentation and Confidentiality

3.7.1 Indications

Under existing Virginia law, all licensed EMS agencies are required to "participate in the pre-hospital patient care reporting procedures by making available...the minimum data set on forms." Licensed EMS agencies, pre-hospital providers, and the Commonwealth of Virginia are required to keep patient information confidential.

3.7.2 Management

Each EMS agency should, in consultation with the agency's legal counsel, develop a procedure dealing with how and when patient information will be released to the patient, the patient's family, law enforcement officials, the news media, and/or any other parties requesting the information.

The procedure **MUST** include development of a release form, which will be signed by a responsible person for that patient's information.

Documentation of patient care should, at a minimum, meet the following requirements:

1. A patient care report will be written for each patient who is seen, treated and/or transported by an ambulance or personnel thereof. This report should be completed on the current written/electronic Pre-hospital Patient Care Report (PPCR) in use by the REMSC region. For medical-legal purposes, if the provider initiates the patient-provider relationship, a PPCR should be completed.
2. In addition to information required by the Commonwealth of Virginia, documentation should include the following:
    a. The patient's chief complaint
    b. Vital signs with times
    c. Treatment provided and times
    d. Electrocardiogram (ECG) interpretation
    e. Changes in the patient's condition
    f. Contact with Medical Control

   g. Any deviation from protocol

3. If a patient refuses treatment and/or transport, documentation should include the following:
   a. The patient's full name
   b. The reason for response
   c. Reason for the patient's refusal
   d. Vital signs and times (when possible)
   e. Any physical signs or symptoms that are present
   f. Perceived competency of the patient
   g. Patient's level of consciousness
   h. Names and signatures of witnesses
   i. Signature of the patient
4. When a patient is transported, a copy of the report should be left at the receiving hospital.
5. Medications may be administered by a pre-hospital provider upon an oral order or written standing order of an authorized medical practitioner in accordance with §54.1-3408 of the Code of Virginia. Oral orders shall be reduced to writing by the pre-hospital provider and shall be signed by a medical practitioner. The Regional OMD, with the agency OMD, shall approve all written standing orders. The pre-hospital provider shall make a record of all medications administered to a patient. **The medical practitioner who assumes responsibility for the patient at the hospital shall sign this administration record.** If the patient is not transported to the hospital, or if the attending medical practitioner at the hospital refuses to sign the record, a copy of this record shall be signed by the pre-hospital provider. The provider will then have 7 days to get their OMD's signature and get the paperwork to the pharmacy in accordance with current Board of Pharmacy regulations.
6. EMS agencies are urged to develop, in consultation with legal counsel, an incident report form for quality assurance purposes, and to document any additional information relevant to the treatment and transport of patients.
7. Agencies should have a minimum set of security guidelines for narcotics boxes. Suggestions may include the following:
   a. Video cameras of areas where locked med boxes are stored
   b. Keep a current list of providers who have keys for drug boxes
   c. Keypad entry or other such security system for storage bags
   d. Designated areas where drug boxes are to be located, both in the ambulance and in the squad bay
   e. Written policy for reprimanding offenders

3.8 Durable Do Not Resuscitate Orders (DNR*)*

Validity of a DNR order is determined by the DNR meeting the requirements of "Durable Do Not Resuscitate" guidelines as described by the OEMS pursuant to 12VAC5-66 which was effective July 20, 2011. Additional information and the current DNR form are available at http://www.vdh.virginia.gov/oems/ddnr/.

3.8.1 Management

The responding pre-hospital providers should confirm appropriate DNR status immediately upon arrival. If status can not be confirmed, the responding pre-hospital providers should perform routine patient assessment and resuscitation or intervention efforts. The following procedures should be followed:

1. Determine that a valid DNR is present and in effect. It is NOT necessary that the original EMS-DNR order be present and legible copies may be accepted.
2. If the patient does not have an EMS DNR authorized "Alternate DDNR Jewelry" can be honored at any time, but it must contain equivalent information to the state form.
3. A verbal order from a physician can be honored by a certified EMS provider. The verbal order may be by a physician who is physically present and willing to assume responsibility or it may be from on-line medical control.
4. "Other" DNR orders include a physician's written DNR order that is in a format other than the state form is also acceptable. "Other" DNR orders should be honored by EMS providers when the patient is within a licensed healthcare facility or being transported between healthcare facilities.
5. Resuscitative efforts, once begun, can only be stopped with the guidance of medical control.
6. All providers are strongly encouraged to review the Virginia DNR, as there are some limitations, such as intubation and no CPR.

Comforting interventions that are encouraged include the following:

1. Open airway (no intubation or BVM) and administer oxygen
2. Suction
3. General patient comfort
4. Control of any bleeding
5. Pain medication by ALS providers, as ordered by medical control
6. Support for the patient and family members
7. Depending on the extent of the DNR wording, IV fluids may be considered

Resuscitative measures the provider should avoid include the following:

1. CPR
2. Intubation (ET tube, BIAD or other advanced airway)
3. Defibrillation
4. Cardiac resuscitative medications
5. Artificial ventilation

If questions or problems arise about DNR, the provider should contact on-line medical control. Providers should use the standard PPCR for full documentation of the DNR case, including the format and authorization for DNR and/or the order number on the form and/or bracelet in the case of an EMS-DNR.

3.9 Extraordinary Care Not Covered by this Protocol

3.9.1 Indications

There may be rare cases in which a physician providing on-line medical control may feel it is absolutely necessary to direct a pre-hospital provider to provide care, which is not explicitly listed within protocol, in order to maintain the life of a patient.

3.9.2 Management

During consultation, both the consulting physician and the ALS provider ***must*** acknowledge and agree that the order is absolutely necessary to maintain the life of the patient. The ALS provider ***must*** feel capable, based on the instructions given by the consulting physician or previous training, of correctly performing the care directed by the consulting physician. If the ALS provider receives an order for care not covered in this protocol, and is not comfortable with performing that order, or does not agree that the order is absolutely necessary to maintain the life of the patient, the provider should proceed with the directions contained in protocol 3.12.

Anytime this authority is exercised by a REMS EMS provider a QI review will automatically occur and the provider should complete a shared-concern inquiry form to notify the REMS Council of the event.

3.10 HEAR Usage & On-Line Medical control

3.10.1 Indications

To contact appropriate medical control/ HEAR radio at hospitals.

3.10.2 Management

The presence of multiple facilities in the REMS region allows for more HEAR stations. Squad patient reports should be destination specific. A squad’s call for on-line medical control should be destination specific and on-line medical control will occur with the facility that is receiving the patient.

3.10.3 Hospital Report

The region as well as the hospitals are frequently inundated with patient transport and other related patient care issues. Therefore, all effort should be made to provide as much notice as possible to the receiving facility. The report should be limited to a one-minute report that highlights important areas that will impact the receiving facility. DO NOT RAMBLE ON with innocent details that are not necessary such as “the car was yellow and had out of state license plates” or “patient has a history of kidney stones 18 years ago” when the patient has a foot injury. The following format will be observed throughout the Rappahannock EMS Council region when providing a report to the receiving facility with the goal of rapid efficient transfer of information to alert the receiving facility of NECESSARY information:

Medical Patient Report – should be NO MORE THAN one minute

- Unit/Care Level
- Age and Chief Complaint
- Symptoms and PERTINENT physical exam findings
- Significant interventions
- Vital Signs
- ETA

<u>Medical Report example</u>: “Spotsylvania Regional this is Spotsylvania Medic 8-2, enroute with 68 year-old male patient chief complaint difficulty breathing. Patient is in moderate distress and has bilateral rales along with pedal edema and slight JVD. Patient is on CPAP and he has received 80 mg Lasix IV. Vitals are GCS of 14, blood pressure 126/59, pulse 122, respirations 36. We have an ETA of 15 minutes.”

Trauma Patient Report – should be NO MORE THAN 45 seconds to one minute.

- Unit/Care Level
- BRIEF mechanism of injury
- GCS and complete Vital Signs (include RTS if available)
- Physical Exam findings that are PERTINENT
  - Head/Neck
  - Chest
  - Abdomen
  - Pelvis
  - Extremities
- ETA / Intersection location

<u>Trauma Report example</u>: “Mary Washington this is Stafford Medic 11-1, enroute with an adult patient from a high-speed motor vehicle crash with ejection. Patient has a GCS of 11, blood pressure 154/89, pulse 132, respirations 28, RTS of 7. Patient has a large scalp laceration with controlled bleeding, crepitus in the left chest with diminished breath sounds, abdomen is distended and tender, pelvis stable, closed fracture of left femur. ETA 10 minutes.”

3.11 Impaired Field Providers

3.11.1 Indications

Field providers will NOT appear for duty, be on duty, or respond via privately-owned-vehicle (POV) while under the influence of any prescribed, or over-the-counter, medications that could impair their ability to drive or otherwise provide quality patient care. Field providers will ***not*** appear for duty, be on duty, or respond POV while under the influence of intoxicants or illegal substances, to any degree whatsoever, or with an odor of intoxicants on their breath.

3.11.2 Management

In the event that it can be reasonably thought that a provider is under the influence or have an odor of intoxicants on their breath during an emergency call, the provider shall be removed from the scene of the call , and, after an investigation where they are found to be in violation, the provider will be subject to disciplinary action by the OMD.

3.11.3 Actions

The provider may be asked by the REMSC, and/or OMD, to take a drug or alcohol test. If the drug/alcohol test is positive, confirmatory testing may be indicated and paid for by the individual. The provider may, at his or her own expense, have a test performed using the same sample. The above expenses may be taken care of by the individual agencies per policies.

3.12 Inability to Carry Out a Physician Order

3.12.1 Indications

Occasionally, a situation may arise in which a physician's order cannot be carried out, the ALS provider is unable to administer an ordered medication, a medication is not available, contact is not possible with on-line medical control, it is out of the provider's scope of practice, or a physician's order is inappropriate.

3.12.2 Management

If a provider is unable to carry out the physician order, the provider ***must*** notify the consulting physician immediately that the order could not be carried out and give the reason why it could not be carried out. The provider ***must*** then indicate on the PPCR what was ordered, and the time and the reason the order could not be carried out.

In situations where the pre-hospital care provider is unable to establish communications with a medical command facility after at least two attempts each, on two different means of communications, the provider may:

- provide care within their scope of practice
- follow the appropriate protocol as standing order indicated by your level of certification

- document the issue on a shared concern inquiry form and route it through the QI process.

3.13 Infection Control

3.13.1 Exposure to Blood and Body Fluid Provider Responsibilities

As soon as possible after exposure to blood and/or body fluids:
Eyes: *Irrigate with clean water, saline, or sterile water*
Mouth and Nose: *Flush with water*
Skin: *Wash with soap and water*
Clothing: *Change contaminated clothing promptly and inspect the skin for signs of openings and contamination*
Needle-sticks: *May be squeezed, or "milked", and wash with soap and water*

Upon arrival at the hospital ED, or as soon as possible thereafter, notify a hospital official/representative (ED physician, ED nurse manager, charge nurse) of any possible exposure (or follow your department's exposure control plan). Notify the agency's designated Infection Control Officer (ICO) as soon as possible of any possible exposure, and of emergency, non-emergency, and follow-up care.

Obtain and complete, before leaving the hospital, a REMSC infectious disease exposure report, which is available in the emergency department, or agency form (follow your department's exposure control plan). Use one exposure report form for each provider. Distribute copies as indicated on the report.

3.13.1.1 *Exposure: Hospital Responsibilities*

Notify the EMS agency's designated ICO when a patient transported by its providers is determined to have an airborne, or blood borne, infectious disease, and an exposure has occurred. Furnish the pre-hospital providers with a REMSC infectious disease exposure report(s). Providers may use their agency's form, or their designated ICO may complete this, and all other, required forms.

After receiving the completed exposure report, perform the appropriate testing on the source patient and render appropriate initial treatment to the exposed provider as determined by the ED physician (or follow your department's exposure control plan for treatment of the provider). Providers have the right to refuse treatment after informed consent.

Furnish test results to the exposed providers, and agency designated ICO, as soon as possible, or within 48 hours after the exposure (*as outlined in the Ryan White Law (Public Law 101-381*).

Notify the EMS agency's designated ICO, in writing, of the exposure, ensuring that providers get any emergency treatment indicated, and that all appropriate hospital reports

are completed. Providers must contact their agency's designated ICO to report the exposure for emergency, non-emergency, or follow-up care.

All treatment for exposure management will follow the published recommendations set forth by the U.S. Public Health Department (the Centers for Disease Control and/or the Advisory Committee on Immunization Practices).

3.13.1.2 *Exposure: EMS Agency Responsibilities*

Appoint and educate, by the first of July each year, one individual to serve as the agency's designated ICO. This individual will be familiar with the agency's infectious disease control plan, the REMSC infectious disease exposure report, and this protocol. The individual will also be familiar with airborne and blood borne pathogens, other infectious diseases, the OSHA blood borne pathogen standard 1910.1030, and the recommendations of the CDC. The individual's name, and that of the agency's OMD, will be furnished each year to the REMSC.

Ensure that decontamination procedures, according to the agency's exposure control plan, are completed ***immediately***, or as soon as possible, after the incident.

Notify the pre-hospital agency's designated ICO of the exposure, or possible exposure, and the actions that have been taken. Notify the designated ICO from any other agency who may have had personnel exposed during the incident.

Respond to the receiving hospital's infection control liaison immediately after receipt of written notification of an exposure. Work with the agency OMD, or other designated physician, and the receiving hospital to ensure that the provider has received appropriate follow-up care, all appropriate reports have been completed and filed, and that the incident has been brought to a closure.

3.14 Inter-facility Transfer of Acutely Ill/Injured Patients

3.14.1 Indications

A physician requests an inter-facility transport of a patient for whom procedures and/or medications have been initiated that are beyond the normal scope of the EMS agency's protocol or practices. These transfers would generally not be initiated through 9-1-1 dispatch, but rather through a private service (ground or air.)

3.14.2 Management

The inter-facility transport should be performed by an ALS-equipped and ALS-staffed ambulance and should take place only after the receiving physician has conferred with the sending physician. Prior to dispatch, the sending physician/institution will provide the EMS agency with a patient report that includes the patient's condition and any special treatment the patient is receiving. If the treatment is outside of the provider's normal scope of practice, the agency's Operational Medical Director (OMD) MUST be contacted for transport approval and to determine if other appropriate personnel should accompany

the patient. It is not acceptable to get orders and/or extend the scope of practice from a physician at the hospital where the transfer originates. During transport, questions regarding patient care should be directed to the transferring physician or the agency OMD rather than the receiving hospital.

The Attendant-in-Charge (AIC) should request a patient report from the health care personnel on scene and should obtain the pertinent paperwork to go with the patient, including the face sheet, transport sheet, lab work, x-rays etc. If the patient is a “No Code” or has a valid “Do Not Resuscitate” order, a written order, including a pre-hospital DNR order, must accompany the patient. Assessment by the AIC should not delay transport.

Once the ambulance crew arrives at the transferring or receiving hospital, and the patient’s condition has deteriorated to a life-threatening situation where immediate intervention is necessary, the AIC will consult with the attending physician if he/she is available. If the attending physician is not immediately available, the AIC should contact the agency OMD or on-line medical control for additional instructions.

An ALS provider may monitor and administer standard medications as ordered by the patient’s transferring physician with on-line medical control as needed during transfer. The administration of any medication not covered by protocol will be recorded on the Pre-hospital Patient Care Report, noting the name of the transferring physician, Medical Control contacted, dosage of the medication, and the route administered. Only approved medical control providers, OMDs, and on-line medical control may give permission to deviate from protocol, unless a valid physician wishes to ride along during transport.

3.15 Patient and Scene Management

3.15.1 Indications

An ordered and orderly management of the emergency scene will improve pre-hospital patient care. Although questions concerning authority can arise, they should be handled quickly and quietly.

3.15.2 Management of the Patient

The AIC on the first arriving unit will have the authority for patient care and management at the scene of an emergency until relieved by a provider of higher certification. Authority for management of the emergency scene, exclusive of medical control over the patient, will rest with the appropriate on-scene public safety officials, fire, law enforcement etc.

If other medical professionals at the emergency scene offer or provide assistance in patient care, the following will apply:

1. Medical professionals who offer their assistance at the scene should be asked to identify themselves and their level of training. The pre-hospital provider should

request that the individual provide proof of their identity if that person wants to continue to assist with patient care after the ambulance has arrived.

2. Physicians are the only medical professionals who may assume CONTROL of the patient's care. Pre-hospital providers should recognize the knowledge and expertise of other medical professionals and use them for the best patient care possible. All medical professionals who assist or offer assistance should be treated with courtesy and respect.
3. The authority for medical control of the pre-hospital provider's procedures rests in this protocol adopted by the EMS agency, the agency OMD, and the Regional Medical Director.
4. A physician at the scene, who renders care to a patient, prior to arrival of an EMS unit, may retain ALS Medical authority for the patient if he/she desires. The pre-hospital provider will advise the physician who wants to supervise or to direct patient care that the physician MUST accompany the patient to the receiving hospital to maintain continuity of patient care. If requested, the physician will be provided access to the services and equipment of the ambulance and/or EMS agency. Documentation of these events will be complete and will include the physician's name. Should the physician not wish to ride along to the hospital with the patient, that physician's instruction may be ignored and the providers must follow their protocol.
5. If there is a conflict about patient care or treatment protocol, the pre-hospital provider will contact on-line medical control, via the HEAR radio or cellular telephone, for instructions. Under no circumstances should this conflict interfere with prudent patient care.

In the event there is a question about the number of patients/victims on scene, providers should make a reasonable effort to utilize all resources available to confirm that all patient/victims have been found and are accounted for.

The five levels of pre-hospital EMS certification recognized at this time by the Commonwealth of Virginia are as follows:

1. First Responder whose authority is superseded by the
2. Emergency Medical Technician - Basic whose authority is superseded by the …
3. Emergency Medical Technician - Enhanced whose authority is superseded by the…
4. Emergency Medical Technician - Intermediate whose authority is superseded by the…
5. Emergency Medical Technician - Paramedic whose authority is superseded by the Physician

The July 2011 revision of the REMS protocols provides a "new" category of critical care paramedic/advanced practice paramedic. In order to qualify for this category the provider must be a valid Nationally Registered EMT-Paramedic and have successfully

completed an advanced practice curriculum and/or a critical care course (such as CICP, FPC, CCEMTP, etc). In order to be able to practice as a CCP/AP in the REMS Council there must be validation of this training on-file at the REMS Council in the provider's file AND the OMD where the provider is practicing (or the regional OMD) must certify their capabilities for this level of practice. Duration of the OMD validation will be indicated on the paperwork and limitations/duration are at the discretion of the OMD. Without valid current paperwork on file at REMS, the provider will ONLY be authorized to practice at their Virginia EMS Certification level and are NOT considered CCP/AP even with current critical care certifications.

3.15.3 Assessment of the Patient

Medical problems account for the bulk of cases handled by pre-hospital providers. Proper initial assessment and focused assessment of the patient, and an accurate history, can result in a significantly higher level of patient care and the effective treatment of the patient's signs and symptoms.

Trauma is a leading cause of death in America and a trauma assessment is indicated for any person whose mechanism of injury results in an injury to the patient. In many cases injuries may not be clearly evident to the patient or the provider, so a more detailed head-to-toe exam should be performed. When the provider arrives on scene to find an injury that has already been covered, they are still responsible for understanding what is under the dressing so direct visualization may be required in order to completely understand the patient's condition.

Scene size-up should be completed as quickly and efficiently as possible in order to determine the scope of the incident and to begin assessing the resources necessary to manage the patient(s). During the size-up providers should:

- Consider the safety of the EMS team and the patient
- Assess need for BSI and personal protective equipment
- Complete an overview of the scene and the patient to determine the mechanism of injury. If appropriate, take control of the C-Spine or direct another competent provider to maintain in-line immobilization whenever there is a MOI consistent with the potential for a C-Spine injury.
- Determine the quantity and location of patients
- Determine what resources will be needed and begin assembly of these resources EARLY in the scene management.

Initial patient assessment should be performed rapidly, and all life-threatening problems should be treated immediately. Do not become distracted by visually significant patient conditions (such as severe abrasions) or other distractions on the scene. During the initial patient assessment providers should:

- Form a general impression of patient and quickly/accurately determine if they are critically sick or injured
- Assess their **airway** and ensure that the patient has an open/patent airway.
    - Assist if needed, with chin lift, jaw thrust, or other airway adjuncts.
- Assess **breathing** and ensure adequacy of respirations and ventilation.

        - Includes auscultation of breath sounds with a stethoscope and applying Oxygen as needed.
- Assess **circulation** by checking skin color, temperature, and condition.
    - Check capillary refill and assess for obvious hemorrhage.
- Assess **disability** and perform a rapid neurological survey using the AVPU mnemonic and classify the patient as one of the four categories.
- **Expose** and examine the patient appropriate to their condition
    - Remove necessary clothing appropriate to the patient's condition, examine and evaluate medical conditions and problems.
    - Always be aware to maintain dignity and protect the patient from the environment as well.
- Determine the need for immediate transport and destination requirements
    - Does the patient require a trauma center, a pediatric specialty facility, a STEMI/PCI facility, etc?
        - The moderate or major trauma patient should be transported as quickly as possible and on-scene time should be limited to ten (10) minutes following extrication or disentanglement.
    - When requesting additional resources, such as ALS or air medical transports, care should not be delayed waiting for additional support when transport can begin.
    - DO NOT WAIT ON THE SCENE FOR ALS, meet them en-route to the hospital.

Initial Patient Management - Based on the patient's presentation and chief complaint, begin appropriate treatment. Find the appropriate protocol based on the patient's chief complaint. Sometimes there are multiple complaints and you may need to refer to multiple protocols to best meet the patient's needs. Follow the protocol for your current valid certification level and utilize on-line medical control for questions or as indicated in the protocol. Some portions of the "secondary" or "focused" assessment may need to be completed, such as allergies and medication, in order to safely begin treatment listed in the protocols. It is not intended that every provider perform every item in the exact order of this guideline. However, it is expected that the provider appropriately manage patients and gather necessary information to manage the patient's condition.

Secondary or Focused Assessment – After the initial ABC's have been assessed and managed and the appropriate initial treatment has begun, perform a complete head-to-toe exam in cases of trauma or unknown circumstances or perform a focused system assessment based on the chief complaint (if not already done)

- Neurological, Cardiovascular, Respiratory, etc.
- Assess vital signs (pulse, BP, respirations, temp, breath sounds, skin)
- Obtain a complete medical history (SAMPLE)
- Determine specifics related to chief complaint (OPQRST)
- Perform a supplemental assessment
    - Initiate Cardiac monitoring
    - Utilize Pulse oximetry

- Determine blood glucose level
- Monitoring temperature as appropriate
- Performing Capnography

On-going Assessment – Once treatment has been initiated for a patient, providers should reassess the patient's condition regularly looking for change and response to interventions. When you have performed an intervention always reassess the patient's condition to evaluate a response to the therapy. ABC's and VS should be checked no less than q 5 minutes for critical or unstable patients and q 10-15 minutes for non-critical or stable patients. There should be at least two (2) complete sets of vital signs on the patient care reporting.

3.16 Patient Refusal

3.16.1 Indications

1. If a patient (or the person responsible for a minor patient) refuses care after EMS providers have been called to the scene, whether injured or not.
2. If the EMS provider knows there is an injury or illness, but the patient (or the person responsible for a minor patient) refuses care and is transported to their doctor or an ED by friends or acquaintances.

3.16.2 Management

Complete an initial assessment (including vital signs) of the patient, with particular attention to the patient's neurological status. Determine if the patient is competent to make a valid judgment concerning the extent of their illness or injury, head injury, ETOH use, or other substance ingestion.

If the EMS provider has doubts about whether or not the patient is competent to refuse care, the provider should seek guidance from on-line medical control. Clearly explain to the patient, and all responsible parties, the possible risks and/or overall concerns associated with refusal of care. The statement "risk of death and/or permanent disability" must be verbalized. Avoid performing any advanced life support procedures on a patient who has refused pre-hospital care.

Complete the PPCR, clearly documenting the initial assessment findings and the discussions with all involved persons regarding the possible consequences of refusing treatment and/or transport. A second EMS provider should witness the discussion. After the form has been completed, have the patient, or the person responsible for a minor patient, sign the refusal section provided on the PPCR. If possible, have two witnesses present and secure their signatures.

Patients who wish to be transported should be transported. When abuse of the 911 system is raised as a concern by a squad to the OMD or the regional council, proper referral to law enforcement will ensue after notification.

Providers should realize the availability of on-line medical control for any patient contact, including refusals. EMS providers may obtain a patient refusal without contacting medical control providing the risk statement above has been made and documented.

If on-line medical control is contacted, the PPCR may be presented to the on-line physician for signature.

3.17 Quality Improvement

3.17.1 Indications

The REMS Quality Improvement (QI) Committee is responsible for implementing a risk management program, including ongoing evaluation of EMS systems and compliance by EMS providers to the standards of care. Each agency is also responsible for implementing a quality improvement program. Quarterly Quality Management Reports are to be submitted to the REMS Council office per your agency's OMD. Non-compliance with this policy may reflect negatively on your agency for grant consideration.

3.17.2 Management

The REMS Regional QI Committee will provide a positive feedback system through provider input, hospital input, informal methods, and recognition events. Further, the QI Committee will make recommendations to the OMD, hospital, and the Training and Guidelines Committee on training needs and policy. Squads in the REMSC region should follow approved QI policies and be involved with their OMD in both commendations and disciplinary actions.

3.18 Sexual Assault and Abuse

3.18.1 Indications

Reported or suspected sexual assault (unexplained trauma or bleeding about the vagina, rectum, penis, buttocks or mouth) of persons of any age or sex or to report any suspected abuse, neglect, or exploitation of elders or incapacitated adults.

3.18.2 Precautions/Contraindications

The Code of Virginia §63.2-1606 identifies any emergency medical services personnel certified by the Board of Health as a mandated reporter. Reports of suspected cases should be made immediately. The Code of Virginia assigns responsibility for receiving and investigating reports of adult abuse, neglect, and exploitation to local departments of social services or the Virginia Department of Social Services APS hotline at 1-888-832-3858. Mandated reporters are required to report to local social services departments or the APS hotline. When sexual abuse, death, serious bodily injury, disease believed to be caused by abuse or neglect, or any criminal activity involving abuse or neglect that places

the adult in imminent danger of death or serious bodily harm are suspected, mandated reporters are required to report to both local departments of social services and local law enforcement. Carefully chart observations and treatments. This information is very important in potential court proceedings.

In the case of sexual assault do not ask questions about the patient's sexual history or practices, or questions that might make the patient feel guilty. Do not ask the patient for a detailed account of the assault. Do not examine the patient's genitalia unless there is severe injury, and then do so only with the patient's permission. Clean the area only to determine the severity of the injury.

3.18.3 Management

Provide psychological support and a safe environment for the patient. Limit the number of persons who interact with the patient. Assess for other illnesses or injuries. Allow the patient to determine the gender of the pre-hospital care provider rendering care, when possible. Preserve all evidence, handle clothing as little as possible, and use paper bags for all clothing and blood-stained articles. If clothing is removed after leaving the scene, bag and label each item separately. Discourage the patient from changing clothes, bathing, douching, or using the restroom. Maintain the crime scene and the chain of evidence by having authorities sign for articles turned over to them, and document this on the PPCR. Carefully chart observations and treatments. This information is very important in potential court proceedings. Maintain and ensure patient confidentiality. The facility with a sexual assault nurse examiner (SANE) program for adult and pediatric patients is Mary Washington Hospital. If possible, transport the patient to MWH ED and when you notify them of your transport tell them you have a Code 27. This will alert them to the need of the SANE team.

3.19 Transporting Patients to the Nearest Emergency Facility

3.19.1 Indications

Ambulances in this region will transport emergency patients to the nearest facility with full emergency capability (no urgent care businesses). No family member, friend, or even physician (except authorized on-line medical control), can instruct EMS personnel to bypass an emergency facility. With the exception of certain very specific groups such as certain types of trauma patients (burn patients, pediatrics, etc.), emergency patients should be transported to the nearest facility.

3.19.2 Management

Patients who have emergency conditions (typically cardio-respiratory events) require treatment to be the fastest possible. Transports out of the immediate region use valuable emergency resources and failure to go to the nearest qualified facility could subject the EMS community to legal consequences if the patient developed any problems during transport.

Patients who can safely tolerate a direct trip to a more distant facility (typically a tertiary care center, or a preferred destination) should not be classified as emergency patients. Ambulances may bypass a closer emergency facility during a disaster, mass casualty or similar incident (to adequately distribute low priority patients to other area hospitals so as not to inundate the main area hospital, this decision will usually be made by the EMS officer at the incident in consultation with the regional hospital coordination center (RHCC)), when the closest emergency facility is temporarily shut down (for an emergency situation such as a fire in the hospital or other event), or when the closest emergency facility informs the EMS provider to bypass their facility due to other emergency conditions.

When there is a choice of hospitals that are equal distance and equal capabilities appropriate to the patient's condition, the patients should be given a choice of which facility they would like to go. For example, the patient may be asked if they would prefer an HCA facility or a MWH facility. A patient could then be transported to the appropriate facility based on the patient's decision.

3.20 Treatment of Patients Under Age 18

3.20.1 Indications

Pre-hospital providers are called to treat persons under the age of 18 (except those that have an Order of Emancipation from a Juvenile and Domestics Relations District Court) who are in need of medical or surgical treatment, including such person who report being sick or injured; who have obvious injury; and/or have a significant mechanism of injury which suggests the need for medical evaluation.

3.20.2 Management

- **Authority of Parents, Guardians or Others:** Parents have the authority to direct or refuse to allow treatment of their children. A court appointed guardian, and any adult person standing *in loco parentis*, also has the same authority. "In loco parentis" is defined as "[I]n the place of a parent; instead of a parent; charged, fictitiously, with a parent's rights, duties, and responsibilities." Black's Law Dictionary, 708 (5th ed. 1979). 1987-88 Va. Op. Atty. Gen. 617. Code of Virginia §54-325.2(6) allows any person standing "in loco parentis" to consent to medical treatment for a minor child. "This signifies, in my judgment, an intent to allow any responsible adult person, who acts in the place of a parent, to consent to the treatment of a minor child, particularly in emergency situations." 1983-84 VA. Op Atty. Gen 219. Such a person may be a relative, schoolteacher or principle, school bus driver, baby-sitter, neighbor or other adult person in whose care of the child has been entrusted.
- **Persons Subject to Policy with Altered Mental Status:** A person meeting the criteria of paragraph 1 that is unconscious, has an altered mental status, signs of alcohol or substance abuse or head injury shall be treated under implied

consent and transported, unless a parent or guardian advises otherwise. Medical control must be consulted if a parent or guardian or person *in loco parentis* refuses to allow treatment or transport.

- **Persons Subject to Policy Under Age 14:** A person meeting the criteria or paragraph 1 that in under the age of 14 shall be treated and transported unless a parent or guardian or person *in loco parentis* advises otherwise. Do not delay treatment or transport for extended periods simply trying to contact a parent or guardian. If you believe that treatment is necessary, but the parent or guardian or person *in loco parentis* refuses to allow treatment, medical control should be consulted.
- **Persons Subject to Policy Aged 14-18:** A person meeting the criteria of paragraph 1 who is between ages 14-18 may refuse treatment and transport, unless a parent or guardian or persons *in loco parentis* advises otherwise. If you believe that treatment is necessary, but the person refuses, an attempt should be made to contact a parent or guardian, and medical control should be consulted. If you believe that treatment is necessary, but the parent or guardian or person *in loco parentis* refuses to allow treatment, medical control should be consulted.
- **Persons Subject to Policy Married or Previously Married:** A person meeting the criteria of paragraph 1 who is, or has been married shall be deemed an adult for purposes of consenting or refusing medical treatment. Code of Virginia § 54.1-2969.
- **Persons Subject to Policy that are Pregnant:** A person subject to this policy that is pregnant shall be deemed an adult for the sole purpose of giving consent for herself and her child to medical treatment relating to the delivery of her child; thereafter, the minor mother of such child shall be also deemed an adult for the purpose of giving consent to medical treatment for her child. Code of Virginia §54.1-2969.
- **Pediatric Non-Transport:** Pediatric patients under four (4) years of age who are not going to be transported against medical advice and after 911 access has been made should consider consulting with Medical Control. Document all pertinent information including physician's name involved with the consultation.