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P	Paramedic
M	Medical Control

Medical Transport Destination

Purpose:
To provide guidelines for the transport of patients with Time Critical Diagnoses (TCDs) to the most appropriate facility that can provide definitive level care.

Policy:
When feasible, patients AND/OR their healthcare power of attorney should be permitted to make autonomous decisions regarding their destination hospital, and given the opportunity to choose. Occasionally, patients may need to be directed away from their preferred institution in favor of a specialty resource center, which can provide advanced levels of care not available at every hospital. In those instances, the EMS Provider's decision should be calmly and respectfully communicated to the patient and their family. By keeping a patient-centered focus and always working to do what is right for the patient, transport to the most appropriate level of care will hopefully be an obvious decision. At the time of publication, the following centers have achieved the appropriate level of credentialing for each of the Time Critical Diagnoses (TCDs) and Specialty Resource Center listed:

Comprehensive Stroke Center:
UW Hospital – Main Campus

Primary Stroke Center:
Mercy Hospital – Janesville
Meriter Hospital
St. Mary's – Madison
VA Hospital

Acute Stroke Ready (CT and tPA Only):
Fort Memorial Hospital – Ft. Atkinson
The Richland Hospital – Richland Center
Stoughton Hospital
St. Clare Hospital – Baraboo
St. Mary's – Sun Prairie
St. Mary's – Janesville
Upland Hills Health – Dodgeville
UW at The American Center
Columbus Hospital

ED ECMO Center:
UW Hospital – Main Campus

ST-Segment Elevation MI:
St. Mary's – Madison
UW Hospital – Main Campus
VA Hospital

Pediatric Trauma Unit:
UW Hospital – Main Campus

Level I Trauma:
UW Hospital – Main Campus

Peds and Adult Burn Center:
UW Hospital – Main Campus

Level II Trauma:
St. Mary's – Madison
Mercy Hospital – Janesville

Level III Trauma:
Meriter Hospital
Sauk Prairie Hospital
St. Clare Hospital - Baraboo
St. Mary's – Janesville

Level IV Trauma:
Monroe Clinic
Stoughton Hospital
St. Mary's – Sun Prairie
Upland Hills Health – Dodgeville
Columbus Hospital

Pediatric Intensive Care Unit:
UW Hospital – Main Campus

Neonatal Intensive Care Unit:
Meriter Hospital
St. Mary's - Madison
UW Hospital – Main Campus

OB, Labor and Delivery Receiving:
Fort Memorial Hospital – Ft. Atkinson
Mercy Hospital – Janesville
Meriter Hospital
Monroe Clinic
The Richland Hospital – Richland Center

OB, Labor and Delivery Receiving (cont):
Sauk Prairie Hospital
St. Clare Hospital - Baraboo
St. Mary's – Madison
St. Mary's – Janesville
Upland Hills Health – Dodgeville
Columbus Hospital

Forensic Nurse Examiner (Also Known As SANE Nurse):
Meriter Hospital

Any patient who is judged to be too unstable for transfer to definitive care may be transported to the closest Emergency Department for immediate stabilization

Legend	
	EMT
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P	Paramedic
M	Medical Control

Request for Helicopter EMS (HEMS)

Purpose:
To provide general guidelines for the appropriate utilization of Helicopter EMS (HEMS) during routine daily operations.

Policy:
Helicopter EMS activation should be considered in Time Critical Diagnoses (TCDs) when the transport time to definitive care is prolonged, as well as situations when advanced resources and skills may help improve the patient's chances of survival. Depending on the situation and resources present, it may be prudent to begin transport by ground ambulance and arrange for a rendezvous at an existing airfield or helipad rather than establish a scene Landing Zone (LZ) and wait for HEMS. Please see the next page for a listing of local airfields and hospital-based helipads that would not require establishment of an LZ by Fire or Law Enforcement.

A helicopter may be considered for request under the following circumstances *but not limited to*:

- ❑ Patient meets Level I Trauma Center criteria under the Destination Determination Protocol AND ground transport time is estimated to be greater than 30 minutes
- ❑ Patient is critically ill or injured AND entrapped with extrication expected to last greater than 20 minutes
- ❑ Patient has unstable Vital Signs (VS) and ALS intercept would further delay arrival at definitive care
- ❑ Patient has field diagnosed ST-Segment Elevation MI and is not expected to make the goal first medical contact-to-balloon time of <90 minutes without HEMS assistance
- ❑ Patient requires specialized medical attention in the field that is beyond the scope of the EMS Providers present on scene or available at the time of the emergency (i.e. field amputation)
- ❑ Mass Casualty Incident with multiple critically ill or injured patients, when activation would not put the responding HEMS unit at increased risk (i.e. active shooter without neutralized threat)

Procedure:

- ❑ When considering air transport, the following terminology should be referenced when speaking with HEMS Dispatch:
  - **"Status Inquiry"** or **"Inquiry"** - contact asking whether HEMS is available to fly or not based on current weather conditions, aircraft availability and crew status. An aircraft will NOT be reserved based on an "Inquiry", and if another flight "Request" is received before final decision is made the second "Request" WILL be accepted by HEMS.
  - **"Stand-by"** - aircraft will be pulled out and prepared for flight with blades turning and ready to lift. If the aircraft has not been "Requested" no stood down by that point, HEMS will "launch and stage" in the air approximately 5 miles from the scene. Anyone in Public Safety may put a helicopter on "Stand-by". If another flight "Request" is received before final decision is made, the second "Request" will NOT be accepted by HEMS.
  - **"Request"** - final decision has been made by the EMS Provider(s) on scene to transport the patient by air, and the helicopter will launch (or proceed if already airborne) to the scene or rendezvous point as soon as possible.
- ❑ The highest credentialed EMS Provider on scene will determine if a HEMS unit is appropriate for the patient.
- ❑ That EMS Provider will request the Dane County 9-1-1 Center to contact Helicopter EMS and "Request" dispatch of the closest, most appropriate HEMS unit.
- ❑ A safe landing zone (LZ) must be established per protocol prior to HEMS arrival.
  - **If using a landing zone (LZ) in Dane County such as a grass airstrip at night, it should be marked by flares, strobes, vehicle lights or other suitable ground based lighting.**
- ❑ The highest quality patient care should be continued per Dane County Protocols until HEMS arrival, at which time care may be transitioned to the HEMS medical crew.
- ❑ Patients coming from a Hazardous Materials (HazMat) scene need to be fully decontaminated prior to HEMS transport. This includes contamination with various fuels as well as ingestions of volatile substances which may cause off-gassing.
- ❑ **Under NO circumstances should patient transport be delayed to use a helicopter.**

There are multiple Helicopter Landing Zones (LZs) in and around Dane County that do NOT require Fire or Law Enforcement establishment. If appropriate for the situation, weather and patient condition, these locations may be considered for rendezvous with the HEMS unit and transfer of patient care. This will take clear communication from the EMS Providers on scene and coordination through the Dane County 9-1-1 Center and the HEMS Dispatcher.

Please see the following page for a map and list of airfields and helipads in the greater Dane County area that may be considered.

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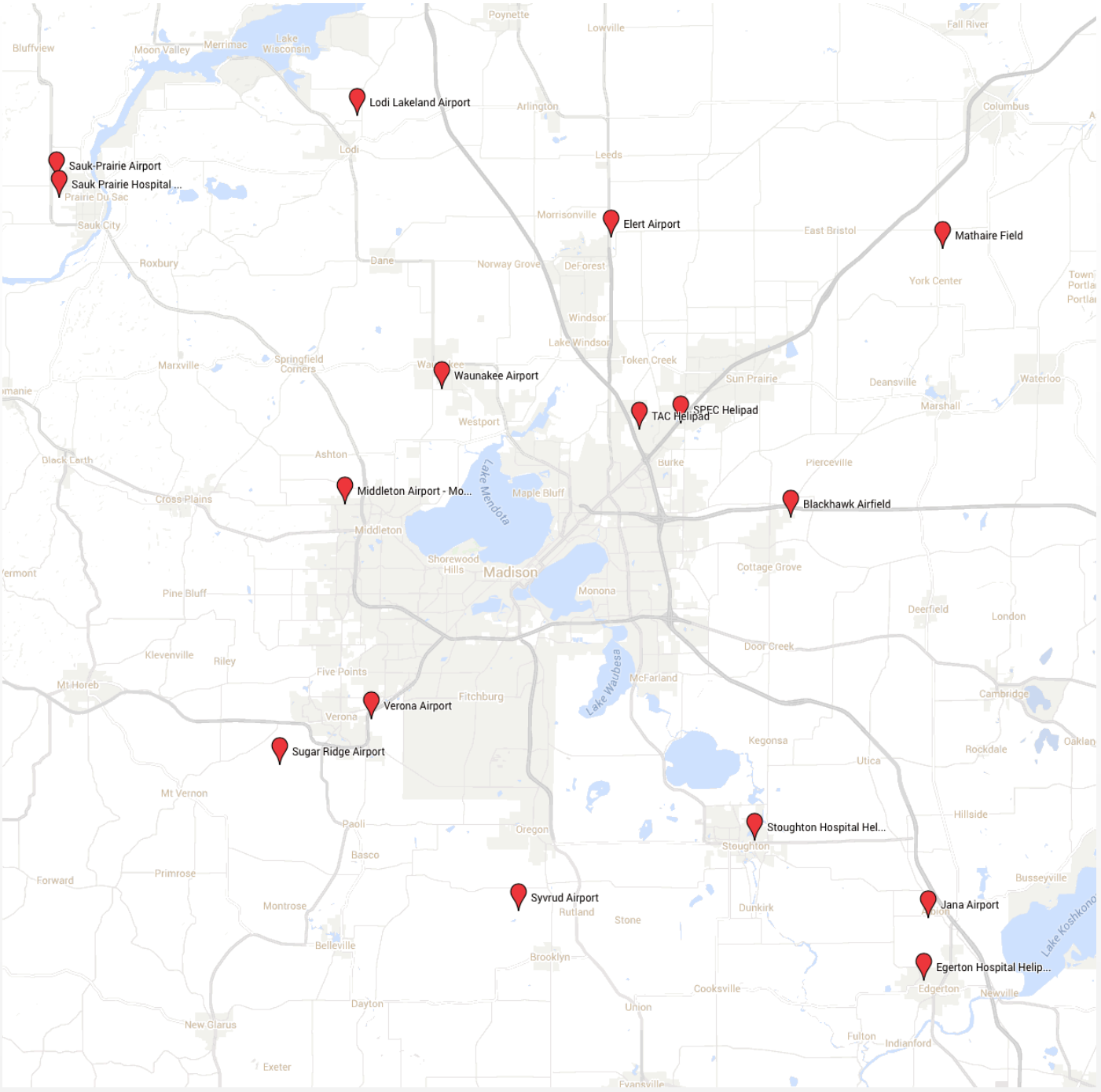
Helicopter EMS (HEMS) Landing Zones



- Sauk Prairie Airport
- St. Mary's Sun Prairie Helipad
- Sugar Ridge Airport
- Elert Airport
- Middleton Airport – Morey Field
- Verona Airport
- Mathaire Field
- Blackhawk Airfield
- Sauk Prairie Hospital Helipad
- UW at The American Center Helipad
- Waunakee Airport
- Jana Airport
- Stoughton Hospital Helipad
- Stoughton Airport (Matson)
- Lodi Lakeland Airport
- Edgerton Hospital Helipad
- Syvrud Airport

Policies

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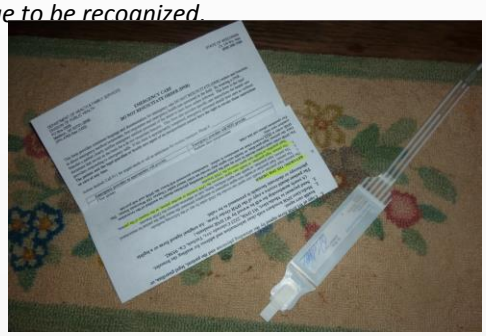
Do Not Resuscitate (DNR)

Purpose:
To clarify the State of Wisconsin Do Not Resuscitate (DNR) laws, and to provide guidance for several exceptions to the rule.

Policy:
As defined in Wisconsin Statute 154.17(2), a valid Do Not Resuscitate (DNR) order directs EMS Providers not to attempt cardiopulmonary resuscitation on the person for whom the order is issued if that person suffers cardiac or respiratory arrest. As further defined in 154.17(5), "Resuscitation" means cardiopulmonary resuscitation or any component of cardiopulmonary resuscitation, including cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, administration of cardiac resuscitation medications and related procedures. "Resuscitation" does not include the Heimlich maneuver or similar procedure used to expel an obstruction from the throat or upper airway.

There are two types of DNR bracelets available to identify a person with a valid DNR order. One is a plastic ID bracelet, which looks like a hospital ID band. The other is a metal bracelet, which is currently available from StickyJ® Medical ID. Per Wisconsin Statute 154, StickyJ® is the *current* State of Wisconsin authorized vendor of the metal bracelets; however, the previous MedicAlert® bracelets *will continue to be recognized*.



DNR patients should still receive appropriate treatment from EMS Personnel under the Dane County Protocols, to include but not limited to: clearing the airway, administering supplemental O_2, positioning for comfort, splinting extremities, hemorrhage control, providing pain medications, providing emotional support and transporting to an Emergency Department for evaluation.

DNR orders shall be followed by EMS Providers, except in the following situations:

- ❑ The Do-Not-Resuscitate bracelet appears to have been tampered with or removed
- ❑ The emergency medical technician, first responder or member of the emergency health care facility knows that the patient is pregnant
- ❑ The Do-Not-Resuscitate order is revoked. Methods for revocation may occur at any time by the following (154.21):
  - The patient expresses to an emergency medical technician, first responder or to a person who serves as a member of an emergency health care facility's personnel the desire to be resuscitated. The emergency medical technician, first responder or the member of the emergency health care facility shall promptly remove the do-not-resuscitate bracelet.
  - The patient defaces, burns, cuts or otherwise destroys the do-not-resuscitate bracelet.
  - The patient removed the do-not-resuscitate bracelet or another person, at the patient's request, removed the do-not-resuscitate bracelet
- ❑ The Guardian or Health Care Agent of an incapacitated qualified patient may direct an emergency medical technician, first responder or a person who serves as a member of an emergency health care facility's personnel to resuscitate the patient. The emergency medical technician, first responder or the member of the emergency health care facility shall promptly remove the do-not-resuscitate bracelet. (154.225)

Under Wisconsin Statute 154.23, no physician, emergency medical technician, first responder, health care professional or emergency health care facility may be held criminally or civilly liable, or charged with unprofessional conduct, for any of the following:

- ❑ Under the directive of a do-not-resuscitate order, withholding or withdrawing, or causing to be withheld or withdrawn, resuscitation from a patient
- ❑ Failing to act upon the revocation of a do-not-resuscitate order unless the person or facility had actual knowledge of the revocation
- ❑ Failing to comply with a do-not-resuscitate order if the person or facility did not have actual knowledge of the do-not-resuscitate order or if the person or facility in good faith believed that the order had been revoked.

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Criteria for Death / Withholding Resuscitation

Purpose:
To provide guidelines for situations when initiation of resuscitative efforts by EMS Personnel is not appropriate. For patients with a valid Do-Not-Resuscitate (DNR) order, please refer to the Do Not Resuscitate Policy.

Policy:
Resuscitative efforts should not be undertaken for an adult patient ≥18 years of age who is pulseless and apneic IF one or more of the following criteria are met:

- ❑ Decapitation
- ❑ Incineration
- ❑ Decomposition of Body Tissue
- ❑ Rigor Mortis and/or Dependent Lividity
- ❑ Massively Deforming Head or Chest Injury
- ❑ **Freezing to the point of Rigor Mortis**

Do not initiate resuscitative measures for patients meeting the above criteria. Confirmation of asystole with a 4-lead cardiac monitor is acceptable if appropriate for the situation.

If resuscitative efforts are in progress, consider discontinuation of efforts (EMT-P only), or contact Medical Control for consultation.
If the arrest is traumatic in nature, go to the Traumatic Arrest Protocol.
If the patient is believed to have severe hypothermia (core temperature <82°F or <28°C), go to the Environmental, Hypothermia – Adult, Trauma Protocol.

If the circumstances are unknown or unclear, or if there is question about the validity of a DNR order, initiate resuscitation while simultaneously contacting On-Line Medical Control for further advice.

Notify Law Enforcement of the patient's death and involve the Dane County Medical Examiner. If the patient is in a medical facility (nursing home, physician's office, rehab facility) and under the supervision of medically trained personnel (physician or RN), you may contact the patient's primary physician directly and involve the Dane County Medical Examiner

All EMS Providers will handle the deceased subjects in a uniform, professional and timely manner. Once the determination has been made that resuscitative efforts will not be initiated, respect for the patient and family with protection of the dignity of the deceased is critically important.

As with every EMS call, situational awareness should be a high priority. Maintain vigilance and be aware that these patient calls may be investigated as a crime scene; do your best to avoid disturbing the scene or any potential evidence.

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Termination of Resuscitation

Purpose:
To provide guidelines for discontinuation of resuscitative efforts in the out-of-hospital environment, when attempts have not resulted in Return Of Spontaneous Circulation (ROSC).

Policy:
The successful resuscitation of an out-of-hospital cardiac arrest requires a very well coordinated team effort, aggressive management of malignant dysrhythmias and thoughtful consideration of the reversible causes of cardiac arrest (the proverbial H's and T's). Unfortunately, there are a significant number of patients that – despite appropriate and aggressive medical management – are not able to achieve ROSC in the field. This policy is evidence driven and based on best practice, and it is intended to provide guidance for arrests when it is more prudent to stop resuscitation efforts than to risk provider and public safety with a patient transport.

This policy may ONLY be considered by EMT-Paramedics without Medical Control contact if ALL of the criteria below are met:

- ❑ 1. The patient is an **ADULT** (≥18 years of age) and the arrest is presumed to be of a primary cardiac origin
- ❑ 2. The initial rhythm on patient contact is asystole, and is confirmed in at least two leads on a printed strip
- ❑ 3. The American Heart Association ACLS algorithm for cardiac arrest has been followed for a minimum of 20 minutes
- ❑ 4. A minimum of 4 doses of epinephrine have been administered, as per the ACLS and Dane County Cardiac Arrest algorithms
- ❑ 5. The airway has been secured with either an Endotracheal Tube (ETT) OR Blindly Inserted Airway Device (BIAD), and confirmed by digital capnography
- ❑ 6. The quantitative End-tidal CO2 (EtCO2) is <10mmHg despite effective compressions and after 20 minutes of ACLS
- ❑ 7. The final rhythm is asystole, and is again confirmed in at least two leads on a printed strip

If ALL 7 criteria above are NOT met, the ACLS algorithm must be followed for a minimum of 20 minutes and then Medical Control contacted for approval of field termination of resuscitation if the patient does not achieve ROSC.

The EMS Provider always has the discretion to continue resuscitative efforts if provider safety, scene safety, location of arrest or bystander input compels the decision.

As there currently are no reliable, evidence based criteria for field termination of resuscitation in the pediatric population, **this Policy is for use in the ADULT population ONLY** (defined as ≥18 years of age for this policy). All pediatric cardiac arrest cases should follow the PALS and Dane County Pediatric Cardiac Arrest algorithms, and transported in compliance with the Dane County Pediatric Destination Determination Protocol.

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Child/Elder Abuse Recognition and Reporting

Purpose:
To provide guidelines for the EMS Provider who encounters suspected and/or confirmed cases of child or elder abuse while on duty.

Policy:
Child Abuse is the physical and mental injury, sexual abuse, negligent treatment and/or maltreatment of a child under the age of 18 by a person who is responsible for the child's welfare. The recognition of abuse and the proper reporting is a critical step to improving the safety of children and preventing child abuse.

An elderly person is defined in the State of Wisconsin as a person >60 years of age. Elder abuse is the physical and/or mental injury, sexual abuse, negligent treatment or maltreatment of a senior citizen by another person. Abuse may be at the hand of a caregiver, spouse, neighbor or adult child of the patient. The recognition of abuse and the proper reporting is a critical step to improve the health and well-being of senior citizens.

Effective management of a case of suspected abuse or neglect is based upon the following:
- ❑ Protect the patient from harm
- ❑ Suspect that the patient may be a victim of abuse, especially if the illness/injury is not consistent with the reported history
- ❑ Respect the privacy of the patient and the family
- ❑ Collect as much information as possible, and preserve any physical evidence

Any findings of abuse or neglect OR suspicion of abuse or neglect must be reported immediately to Law Enforcement or Protective Services upon arrival to the receiving hospital. In cases of suspected abuse or neglect where a patient contact does not result in transport, Law Enforcement or Protective Services must be notified prior to clearing the scene.

There are many subtle signs of abuse that may be missed without a high index of suspicion. ALL patients evaluated by EMS should be screened for these cues. Some include:
Psychological cues – excessively passive behavior, fearful behavior, excessive aggression, violent tendencies, excessive or inappropriate crying, substance abuse, medical noncompliance or repeat EMS requests for seemingly minor problems.
Physical cues – injuries inconsistent with the reported mechanism, defensive injuries (i.e. forearms), injuries during pregnancy are suggestive of abuse. Multiple bruises and injuries in various stages of healing may also suggest repeated violence against the victim.
Signs of neglect – inappropriate level of clothing for weather, poor hygiene, absence of and/or inattentive caregivers, poor living conditions and physical signs of malnutrition.

EMS Providers in the State of Wisconsin are required by law to report suspected cases of child abuse and neglect as well as those situations in which they have reason to believe that a child / elder has been treated with abuse or neglect or that abuse or neglect will occur.

For Suspected Elder Abuse or Neglect -
- ❑ Cases in Dane County NOT in a State-licensed facility, contact the Dane County Department of Human Services Elder Abuse/Neglect Helpline at **(608) 261-9933**.
- ❑ Cases in Dane County that ARE in a State-licensed nursing home, contact the State Division of Quality Assurance at **(608) 266-7474**.
- ❑ Cases in Dane County that ARE in a State-licensed program such as assisted living, community based residential facility (CBRF), adult family home (AFH), contact the Wisconsin State Bureau of Assisted Living at **(608) 264-9888**.
- ❑ Cases outside of Dane County, call the Elder Care Locator at **(800) 677-1116**.

See the Wisconsin Department of Health Services internet listing of County elder abuse agencies as necessary.
http://www.dhs.wisconsin.gov/aps/Contacts/eaaragencies.htm

For Suspected Child Abuse or Neglect -
- ❑ Contact the Dane County Department of Human Services Protective services:
  Mon-Fri, 7:45AM-4:30PM – **(608) 261-KIDS (5437)**
  After hours and on weekends – **(608) 255-6067**
- ❑ If caregivers are refusing the evaluation or treatment of a child that you suspect may be the victim of abuse or neglect, do not hesitate to contact Medical Control for advice. If necessary, Law Enforcement may be consulted to help settle disagreements on scene, while maintaining the effective management principles above.
- ❑ In the instance that a child has a life or limb threatening illness or injury **AND** the caregivers are refusing evaluation, the child should be transported to the closest appropriate facility, with simultaneous contact of Law Enforcement and On-Line Medical Control. If your Service Medical Director is unavailable, the Dane County Medical Director should be contacted to assist as needed.
- ❑ When abuse or suspected abuse is reported to Law Enforcement, it is required that name and badge number of the officer receiving the report be captured in your documentation.

See the Dane County Department of Human Services Protective Services website for additional information as necessary:
http://www.danecountyhumanservices.org/ProtectiveServices/Child/

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Documentation of Patient Care

Purpose:
To provide guidelines and to set best practice for documentation of patient encounters in the electronic Patient Care Report (ePCR).

Policy:
As EMS Providers and out-of-hospital care becomes increasingly more important to the healthcare community, it has brought a focus on the documentation of patient encounters and a need to have a more robust set of standards for the Patient Care Reports generated. The hospitals are sending a clear message to the EMS Providers nationally – what you **document** is almost as important as **what you see and the interventions you make** to help your sick and injured patients. To that end, these criteria should help set the standards for documentation and maximize your productivity as members of the healthcare delivery team. At a minimum, every electronic Patient Care Report (ePCR) should include:

- ❑ A clear history of the present illness with chief complaint, onset time, associated complaints, pertinent positives and negatives, mechanism of injury, etc. This should be included in the subjective portion of the PCR. The section should be sufficient to refresh the clinical situation after it has faded from memory.
  - Consider the **P-SOAP-delta** format for the narrative
    - **P** – prearrival information, including delays to scene or factors inhibiting patient access or treatment
    - **S** – subjective information (what the patient tells the EMS Provider)
    - **O** – objective information (VS, physical exam findings, etc.)
    - **A** – assessment (EMS Provider Impression of patient illness as well as differential diagnosis)
    - **P** – plan of treatment (EMS Provider interventions planned to administer)
    - **Delta** – change in patient condition due to EMS Provider interventions
- ❑ An appropriate physical assessment that includes all relevant portions of a head-to-toe physical exam. When appropriate, this information should be included in the procedures section of the PCR.
- ❑ At least two complete sets of vital signs for transported patients and one complete set for non- transported patients (pulse, respirations, auscultated blood pressure, pulse oximetry at minimum). These vital signs should be repeated and documented after drug administration, prior to patient transfer, and as needed during transport. For Children age < 3, blood pressure measurement is not required for all patients, but should be measured if possible, especially in critically ill patients in whom blood pressure measurement may guide treatment decisions.
- ❑ Only approved medical abbreviations may be used – see Appendix.
- ❑ The CAD to PCR interface embedded within the PCR system should be used to populate all PCR data fields it supplies. When 9-1-1 center times are improperly recorded, these may be edited as necessary.
- ❑ Medications administered, dosages, route, administration time, treatments delivered and patient response shall be documented.
- ❑ Extremity neurovascular status after splinting affected limb, or all limbs after spinal immobilization shall be documented.
- ❑ For IV administration, the catheter size, site, number of attempts, type of fluid, and flow rate.
- ❑ Requested Medical Control orders, whether approved or denied, should be documented clearly.
- ❑ Any waste of controlled medications should include the quantity wasted, where wasted, and name of the person who witnessed the waste. Hospital personnel should be utilized (if available) to witness.
- ❑ ALL crew members are responsible for, and should review, the content of the PCR for accuracy.
- ❑ After the ePCR is closed, patient care information may not be modified for any reason. Corrections or additions should be in the form of an addendum to the ePCR, with note for the reason of the addendum.
- ❑ When possible, all ePCRs should be completed and the report closed prior to leaving the hospital. If the ePCR cannot be completed and a copy left with a receiving caregiver before departing the hospital, a draft version of the narrative, medications administered and vital signs shall all be given to the receiving team prior to departing.
- ❑ Paper copies of the ECG, DNR paperwork, Skilled Nursing Facility documentation and - when applicable - documentation of refusal to accept an appropriate assessment, treatment, or hospital destination shall be provided to the receiving hospital.
- ❑ If patient transported from the scene with red lights and siren, be sure to document the reason for doing so.

Remember – if you didn't document it, it never happened!

Legend	
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P	Paramedic
M	Medical Control

Documentation of Vital Signs

Purpose:
To provide guidelines and to set best practice for documentation of vital signs (VS) in the electronic Patient Care Report (ePCR).

Policy:
Vital Signs (VS) play a critical role in patient assessment and evaluations, and must be documented in the ePCR for any patient.

- ❑ An initial complete set of VS includes
  - Pulse Rate, Systolic AND Diastolic Blood Pressure (may substitute cap refill for children <3 years), Respiratory Rate, SpO2, Pain and GCS for trauma patients.
- ❑ If no interventions are made during EMS Provider evaluation and management (**including** IV Fluids, dextrose and naloxone), palpated Blood Pressures are acceptable for REPEAT VS.
- ❑ Based on the patient condition, complaint and/or treatment protocol used, VS may also include
  - Temperature, EtCO2, Level of Awareness

If the patient refuses EMS evaluation, an assessment of capacity must be completed AND documented in the ePCR. Detailed documentation should be captured regarding the patient's clinical presentation, reason for refusing (if known) and the refusal process in the ePRC narrative. Be sure to *capture the names of family members, Law Enforcement personnel or other EMS personnel who are present* for this conversation and evaluation.

For children, the need for Blood Pressure measurement should be determined on a case-by-case basis, considering the clinical condition of the child and the EMS Provider's rapport with the patient. Every effort should be made to document Blood Pressure, particularly in critically ill patients, or cases where treatment decisions are guided by VS and/or changes in VS.

Any abnormal VS should be followed closely, and repeated as indicated by change in patient subjective status or clinical condition.

Remember – if you didn't document it, it never happened!

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Domestic Violence (Spousal and/or Partner Abuse) Recognition and Reporting

Purpose:
To provide guidelines and resources for the EMS Provider who encounters suspected and/or confirmed cases of domestic violence while on duty.

Policy:
Domestic Violence is physical, sexual or psychological abuse and/or intimidation which attempts to control another person in a current or former family, dating or household relationship. The recognition, appropriate reporting and referral of abuse is an essential step to improving patient safety, providing quality care and preventing further abuse.

Effective management of a case of suspected abuse or neglect is based upon the following:
- ❑ Protect the patient from harm
- ❑ Suspect that the patient may be a victim of abuse, especially if the illness/injury is not consistent with the reported history
- ❑ Respect the privacy of the patient and the family
- ❑ Collect as much information as possible, and preserve physical evidence

Any findings of abuse or neglect OR suspicion of abuse or neglect must be handled with sensitivity and delicacy by the EMS Provider. Provision of emotional support is key, without passing judgment on the victim or alleged perpetrator of domestic violence. Discretion should be a high priority, and when possible questions regarding abuse and safety should be done in private. Offering the resources below to the patient may feel awkward at the time, but are excellent resources and may be used at any time in the future. Have a low threshold to transport patients of suspected or confirmed domestic violence, as they may not have other means of escaping their assailant and accessing resources that may be available at the hospital.

There are many subtle signs of abuse that may be missed without a high index of suspicion. Some include:
Psychological cues – excessively passive in nature, fearful behavior, excessive aggression, violent tendencies, excessive or inappropriate crying, substance abuse, medical noncompliance or repeat EMS requests for seemingly minor problems.
Physical cues – injuries inconsistent with the reported mechanism, defensive injuries (i.e. forearms), injuries during pregnancy are suggestive of abuse. Multiple bruises and injuries in various stages of healing may also suggest repeated violence against the victim.
Signs of neglect – inappropriate level of clothing for weather, poor hygiene, absence of and/or inattentive caregivers, poor living conditions and physical signs of malnutrition.

<u>For Suspected Domestic Violence</u> –
- ❑ EMS Providers should attempt in private to provide the victim with the Dane County Domestic Abuse Intervention Services (DAIS) helpline, (608) 251-4445 or (800) 747-4045. Both numbers are available 24 hours per day.
- ❑ EMS Providers may also provide the National Hotline (800) 799-SAFE (7233)
- ❑ Depending on the situation, transport should be considered regardless of the illness or injury, so that the victim may receive the expert consultation and additional services that are available in the Emergency Department

See the Dane County Domestic Abuse Intervention Services (DAIS) website for additional information as necessary:
http://www.abuseintervention.org

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Emergency Interhospital Transfers

Purpose:
To provide guidelines for EMS Provider expectations and medical care of patients during emergent transfer between Hospitals. This Policy does not supersede or replace existing EMTALA regulations.

This Policy **IS NOT** intended to authorize services or care that are not part of an EMS Services' operational plan with the State of Wisconsin. Rather, it is intended to provide guidance for the rare but foreseeable circumstances when a critically ill or injured patient may need to be rapidly moved to a higher level of care, and time is of the essence.

Policy:
In general, Dane County EMS Providers should only perform Emergent Interhospital Transfers for Time Critical Diagnoses (TCDs), usually involving patients requiring management at a specialty care facility (Trauma, STEMI, Stroke, Pediatrics, OB) when an authorized service is not available within a reasonable amount of time. Dane County EMS Providers may also be called upon to assist with Emergent Interhospital Movement of patients during large-scale or Mass Casualty Incidents (MCIs), or during a situation necessitating the implementation of Crisis Standards of Care – in these cases, there is likely to be heavy involvement of the Dane County Medical Director as well as each of the EMS Service Medical Directors (or their designees) to help provide real-time guidance on how to proceed.

If a Dane County EMS Provider is contacted for the Emergent Interhospital Transfer of a non-TCD patient, contact your Service EMS Supervisor for consultation prior to responding and transporting the patient.

Emergent Interhospital Transport decisions should be made based on the needs of the patient(s), any expected changes in their clinical condition and the familiarity / comfort level of the responding EMS Providers with the clinical situation as well as any medications or devices being used.

If a patient has unstable vital signs prior to departure from the sending facility, the EMS Provider responding is not knowledgeable of the medications being administered and/or the medications infusing are not in the Wisconsin Scope **OR** on an IV pump with inadequate reserve to last the anticipated duration of the transfer, it is the responsibility of the referring hospital to supply an additional provider. The additional provider shall be appropriately credentialed, familiar with the medications and devices to accompany the patient AND present for the entire transfer to the receiving facility. If there is any difficulty with this provision, the Service EMS Supervisor should be contacted immediately for guidance on how to proceed.

Communication and coordination between hospitals and EMS Providers is essential before an Emergent Interhospital Transfer is initiated to ensure patient safety and the appropriate medical management en route between the hospitals. A clear plan for responsibility of patient care while moving between facilities should be in place prior to departing the transferring hospital. In general, if the patient unexpectedly deteriorates while en route, the transferring facility should be notified, but the *receiving facility* should be contacted for additional Medical Control orders. The standing Dane County Protocols in this book may be followed as situation appropriate until Medical Control can provide further direction.

Unless there are extenuating circumstances (i.e. Mass Casualty Incident, Crisis Standards of Care), any Dane County EMS Service performing an Emergent Interhospital Transfer should only deliver patients to the Emergency Department of the receiving facility, where additional interventions and coordination of care may take place.

As with any Protocol, contact On-Line Medical Control with any questions or concerns.

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Lights and Sirens During Patient Transport

Purpose:
To provide guidelines for the appropriate use of red lights and siren when transporting a patient from the scene of an emergency to the hospital. This Policy intends to help identify patients for whom safe use of red lights and siren can potentially reduce morbidity and mortality, and eliminate the unnecessary use of emergency lights and siren during transport to improve patient comfort, reduce anxiety and enhance safety for the patient, the EMS team and the Dane County community.

Policy:

- ❑ At the discretion of the ambulance crew, driving with lights and siren may be considered if the following clinical conditions or circumstances exist:
  - Difficulty in sustaining the ABCs (airway, breathing, circulation) including (but not limited to):
    - ❑ Inability to establish an adequate airway or ventilation.
    - ❑ Severe respiratory distress or respiratory injury not responsive to available field treatment.
    - ❑ Acute coronary syndrome with one or more of the following: ST elevation in two or more contiguous leads, acute congestive heart failure (CHF), hypotension, bradycardia, wide complex tachycardia, or other signs of impending deterioration.
    - ❑ Cardiac dysrhythmia accompanied by signs of potential or actual instability (hypotension, acute CHF, altered level of consciousness, syncope, angina, resuscitated cardiac arrest), which is unresponsive to available field treatment.
    - ❑ Severe uncontrolled hemorrhage.
    - ❑ Shock, unresponsive to available treatment.
  - Severe trauma including (but not limited to):
    - ❑ Penetrating wounds to head, neck, and torso.
    - ❑ Two or more proximal long bone fractures.
    - ❑ Major amputations (proximal to wrist or ankle).
    - ❑ Neurovascular compromise of an extremity.
    - ❑ Multi-system trauma.
  - Severe neurological conditions including (but not limited to):
    - ❑ Status epilepticus.
    - ❑ Substantial or rapidly deteriorating level of consciousness.
    - ❑ For a suspected stroke where a significant reduction of time to receive thrombolytic therapy can be achieved and the patient meets treatment inclusion criteria.
  - Obstetrical emergencies including (but not limited to):
    - ❑ labor complications that threaten survival of the mother or fetus, such as: prolapsed cord, breech presentation, arrested delivery, or suspected ruptured ectopic pregnancy.
- ❑ For any transport where reducing time to definitive care is clinically indicated, consider options other than emergent driving. In these cases, an alternative mode of transportation or higher level of care (such as ALS intercept or air-medical) should be considered if it is available and appropriate.
- ❑ Critical-care level emergent interhospital transport patient transports should not automatically be handled as lights and siren events. Clinical judgement and the patient criteria listed above should be applied on transfers to determine the level of urgency and transport mode.
- ❑ When a physician or nurse attempts to order lights and siren transport for a patient when it is believed by the crew to be contraindicated, attempt to resolve the issue with the ordering physician/nurse. If necessary, contact Medical Control to assist in resolving the issue.
- ❑ For any lights and siren transport, specifically document in the narrative the patient's condition, case circumstances and the rationale for choosing emergent transport.

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Non-Paramedic Transport of Patients

Purpose:
To provide guidelines for interactions of EMS Providers while on scene, and to help guide determination of the most appropriate level of service to transport patients to the Emergency Department.

This policy is intended to clarify expectations of providers on scene during situations when multiple levels of provider with transport capability arrive concurrently. It is **NOT** intended to be used as justification for refusal of transfer to a Paramedic level of service when a lower level is requesting it.

Policy:
For the purposes of this Policy, "Paramedic" refers to a Dane County EMS System credentialed Paramedic with no current restrictions on their clinical practice.

The provider with the highest level of Dane County EMS System credentialing on scene will conduct a detailed interview and physical assessment of the patient to determine the chief complaint and level of distress. If the provider determines that the patient is stable and ALL patient care needs can be managed by an EMS Provider at a lower level than Paramedic, then patient care may be transferred and transport initiated AND/OR completed by the lower level provider. All personnel are encouraged to participate in patient care while on-scene, regardless of who "attends" with the patient while en route to the hospital.

The determination of who attends should be based on the patient's immediate treatment needs and any reasonably anticipated treatment needs while en route to the hospital. The highest credentialed provider on scene retains the right to make the decision to personally attend to any patient transported based on his or her impression of the patient's clinical conditions, current needs or anticipated needs based on the EMS Provider's evaluation and experience.

The highest credentialed EMS Provider who performs the assessment and determines the appropriate level of care for transport must document the findings of their assessment. Additional documentation shall be completed by the transporting provider. As with all documentation, both providers are responsible for the content of the report.

Patients who meet the criteria below shall be attended by Paramedics (per their operational plan) in the patient care compartment, unless mass casualty incident, natural disaster or previously approved by policy or the On-Line Medical Control. The care of the following patients cannot be transferred to a lower level of credentialing:

- ❑ Any patient who requires or might reasonably require additional or ongoing medications, procedures AND/OR monitoring beyond the scope of practice of the lower credentialed provider. This includes any critically ill or unstable patient as advanced airway management may be required in any decompensating patient. EMT-Basic and EMT-Advanced providers may be credentialed to perform some but not all airway management, and medications associated with airway management are limited to the Paramedic scope of practice by the Wisconsin State Medical Board.
- ❑ Any patient for whom ALL EMS providers on scene do not agree can be safely transported without a Paramedic in attendance in the patient care compartment. As a general rule, if providers are questioning who should attend the patient, the highest credentialed level of care should attend.
- ❑ Any patient suffering from chest pain of suspected cardiac origin, cardiac dysrhythmia, moderate to severe respiratory distress, multiple trauma or imminent childbirth.
- ❑ Post-ictal patients with high probability of recurrent seizure.
- ❑ Patients who have been medicated on the scene cannot be transferred to a provider of a lower credentialing level **UNLESS** the provided medication is included in the receiving EMS Provider's scope

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Paramedic Intercept Guidelines

Purpose:
To outline circumstances in which an Advanced Life Support (ALS) Service should be requested for intercept with a non-ALS level Service.

Policy:
The situations listed below are not all-inclusive, but are intended to serve as examples of when a higher level of care would be appropriate for advanced interventions and patient safety. In addition to advanced skills and additional medication options, Paramedics also bring an experience with critically ill and injured patients, and can assist with the safe evaluation and destination determination process.

While the care of the patient should be the top priority of all providers in the Dane County System, many factors go into the decision to request an ALS intercept. Time of day, traffic conditions, weather and proximity to appropriate medical care all may be considered when making the decision. When possible, arrangements may be made to rendezvous with an ALS service while en route to the hospital, so that the delay to advanced skills and medications may be minimized.

Some examples of patients that may benefit from ALS level evaluation and management include but are not limited to;

- Sepsis
- Cardiopulmonary Arrest
- Altered Mental Status not explained by simple hypoglycemia or opiate overdose
- Severe Respiratory Distress AND/OR Impending Airway Compromise
- Multi-System Trauma
- Unstable or Deteriorating Vital Signs
- Chest Pain with Hemodynamically Compromising Dysrhythmia
- ST-Segment Elevation MI with Hypotension, Altered Mental Status or Impending Cardiac Arrest
- Complex Seizures (First Seizure without History, Seizure After Head Injury, Recurrent Seizure without Return to Baseline)
- Allergic Reaction assessed to be ‘Severe’ or ‘Impending Cardiac Arrest’
- Asthma Exacerbation not improving after Albuterol OR Requiring Multiple Nebs
- Complications of Childbirth
- Mass Casualty Incident
- Any Situation that the Dane County EMS Provider OR Medical Control feels warrants ALS Evaluation and Management

We are all working together to get the right patient to the right level of care at the right time!

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Patient Care During Transport

Purpose:
To provide general guidelines and to set best practice when caring for patients both on the scene of an emergency as well as in the ambulance during transport to the receiving facility.

Policy:
All sick or injured persons requesting transport shall be transported without delay to the most appropriate Emergency Department, with high consideration given to patient preference. Exceptions to this policy are as follows:

- ❑ An "appropriate local Emergency Department" includes all Dane County Emergency Departments as well as hospitals in contiguous counties as designated in this Procedures and Protocols Handbook. The ability of a patient to pay or the insurance status (if known) should not play a part in this decision. If EMS Unit availability will be a concern due to requested destination, contact your Service EMS Supervisor prior to initiating transport.
- ❑ All sick or injured persons requesting transport who *do not express a preference* or who rely on the knowledge of the EMS Provider should be transported to the closest, most appropriate local Emergency Department.
- ❑ Patients who are suffering from a Time Critical Diagnosis (TCD) or a condition covered under the Destination Determination Protocols should be transported in accordance with the specialty resource required by the treatment flowchart. All other patients should be transported per the policy statement above.
- ❑ Transport destination decisions should take into consideration the preexisting healthcare relationships that a patient may have. In general, a patient should be taken to the hospital at which they typically receive care and/or where their primary care physician has affiliation, *unless the patient expressly requests otherwise*. Providers should discuss risks and benefits of transport to a facility that has not previously cared for the patient, and document the discussion clearing in the electronic Patient Care Report (ePCR).

The following situations shall require more than one EMS Provider in the passenger compartment of the transporting vehicle, to provide adequate medical care. The additional provider(s) is/are present not only to serve as additional "hands", but to expand the critical thinking of the team and to help optimize patient outcomes. **For these circumstances, students with the current training permit may assist with patient care, but may NOT count as one of the additional EMS Providers.**

- ❑ Cardiac Arrest of Medical OR Traumatic etiology
- ❑ Post Resuscitation Return of Spontaneous Circulation (ROSC) patients, *even if Vital Signs are stable*
- ❑ Active Airway Management, *regardless of modality chosen* (Endotracheal Tube, Blindly Inserted Airway Device (BIAD) or Bag-Valve Mask (BVM)
- ❑ Impending Arrest or "Peri-Code" Situation
- ❑ Imminent Delvery
- ❑ Newly Born Patients (Mother and Newborn count as two patients, and require an attendant for each)
- ❑ At the Attending EMS Provider's Judgement, for cases not covered above

If a second EMS Provider is not available and transport would be delayed, initiation may be started under these two circumstances:
- ❑ An Advanced Care Intercept (Ground ALS or HEMS) has been contacted and arrangements made for rendezvous en route
  OR
- ❑ The case has been reviewed with On-Line Medical Control (OLMC) AND approval granted

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Patient Without A Protocol

Purpose:
To ensure the provision of appropriate medical care for every patient, regardless of presenting problem or medical condition.

Policy:
Any person requesting EMS service shall receive a professional evaluation, treatment and transportation as necessary in a systematic, orderly fashion regardless of the chief complaint, medical condition or ability to pay.

Medical evaluation and management for all patient encounters that can be triaged into a Dane County EMS Protocol shall be initiated and conducted as per the standing protocols.

When confronted with an emergency situation or patient condition that does not fit into an existing Dane County EMS Protocol, evaluation and management of the patient should be started under the General Approach – Adult, Medical OR General Approach – Peds, Medical Protocols, as appropriate. On-Line Medical Control should be contacted for consultation as soon as possible for further direction and instructions on patient management within your scope of practice.

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Physician Bystander On Scene

Purpose:
To define the responsibilities of EMS Providers responding to an emergency scene, to identify the chain of command and to prevent potential conflicts regarding patient care that may arise during EMS evaluation and management when a licensed physician is on scene. No other healthcare professionals are permitted to provide medical direction under this policy.

This policy is not intended to apply to Service Medical Directors.

Policy:
The medical evaluation and management of patients at the scene of an emergency is the responsibility of the person most appropriately trained in emergency medical care. As an agent of the EMS Service Medical Director and operating under the Dane County EMS Protocols, the EMS Provider routinely fills this role. Occasions may arise when a physician on scene may wish to deliver care to a sick or injured patient, or to direct EMS personnel in medical management. In order for a physician to assume care of a patient, they **MUST**:

- ❑ Provide photo identification verifying his/her current credentialing as a physician (MD/DO) AND a current copy of his/her license to practice medicine in the State of Wisconsin **AND**
- ❑ Assume care of the patient AND allow documentation of of his/her assumption of care on the electronic Patient Care Report (ePCR), as verified by his/her signature, **AND**
- ❑ Agree to accompany the patient during transport to the receiving hospital **AND**
- ❑ Not appear to be impaired or under the influence of drugs, alcohol or medical conditions **AND**
- ❑ Explicitly express willingness to accept liability for the care provided to the patient under their personal medical license

Contact with Medical Control must be established as soon as possible, and the Medical Control Physician must agree to relinquish responsibility for patient care to the Physician On Scene.

Once care has been transferred from the On-Line Medical Control to the Physician On Scene, the EMS Provider may provide care under the license and authority of the Physician On Scene. Direction provided by the Physician On Scene assuming care of the patient should be followed by the EMS Provider, granted that the interventions are not believed by the EMS Provider to endanger the well-being of the patient.

Orders received from an authorized (as determined by this Policy) Physician On Scene may be followed, even if they conflict with existing local protocols, provided the orders encompass skills AND/OR medications approved by both the Dane County Medical Advisory Subcommittee and the Wisconsin State Medical Board for a provider's level of credentialing. **Under no circumstances** shall EMS Providers perform procedures or give medications that are outside of their scope of practice AND/OR credentialing.

Conflict with Physician On Scene:
If the Physician On Scene is judged by the EMS Provider on scene to be potentially harmful or dangerous to the patient, the EMS Provider should politely voice their objection, and immediately contact On-Line Medical Control for further assistance. On-Line Medical Control should be briefed by the EMS Provider, and the Physician On Scene allowed to communicate directly with the On-Line Medical Control. When at all possible, these conversations should be held on a recorded line.

If the Physician Bystander On Scene and On-Line Medical Control are in conflict, it is the responsibility of the EMS Provider to:
- ❑ Follow the directions of On-Line Medical Control
- ❑ Enlist the aid of Law Enforcement as necessary to regain control of the emergency scene and resume authority of the scene

Documentation:
All interactions with Physicians On Scene must be thoroughly documented in the electronic Patient Care Report (ePCR), including the full name and medical license number of the Physician On Scene, as well as the interventions performed at their direction.

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Poison Control

Purpose:
To provide guidelines for involving Poison Control with out-of-hospital management of patients with potential or actual poisonings.

Policy:
Patients who have sustained significant poisonings, envenomations, and environmental/biochemical terrorism exposures in the out-of-hospital setting require timely and appropriate level of care, including the decisions regarding scene treatment and transport destination. By integrating the State Poison Center into the out-of-hospital response plan for HazMat and biochemical terrorism incidents, this policy aims to empower the out-of-hospital care provider and enhance the ability to deliver the most appropriate care to the patient possible.

If the patient is assessed by the EMS Provider and no immediate life threat or indication for immediate transport is identified, the EMS Provider may conference call with the Poison Center at the Wisconsin State Poison Center at **1 (800) 222-1222.**

The Poison Center will help evaluate the exposure and make recommendations regarding the need for on-site treatment and hospital transport in a timely manner. If EMS transport to the hospital is determined to be necessary, the Poison Center will contact the receiving hospital and provide information regarding the poisoning, including treatment recommendations. EMS may also contact On-Line Medical Control for further instructions or for treatment options.

If EMS transport is determined to *not be* necessary, the contact phone number for the patient will be provided to the Poison Center. The Poison Center will make a minimum of one follow-up phone call to determine the status of the patient. Additionally, the EMS Provider must contact On-Line Medical Control to review the case and discuss the recommendations of the Poison Center and what is believed to be in the best interest of the patient.

As detailed elsewhere in this document, exposures and/or poisonings that are the result of suicide attempts or gestures, or children who sustain an exposure and/or poisoning due to child abuse or neglect *SHOULD NOT be allowed to refuse transport*. These are both vulnerable populations who are at an increased risk of death or permanent disability if not cared for appropriately. As always, good Provider judgment and patient advocacy will be the cornerstones of making sound, defensible patient treatment decisions.

In any cases of poisoning, whether accidental, intentional or the consequence of a bioterrorism event, the safety of the First Responders should be of the highest priority. At a minimum, the following information should be gathered so that the Poison Center can make the best recommendations for the current situation

- ❑ Age of the patient
- ❑ Substance(s) involved with the exposure (if known)
- ❑ Time and Duration of exposure (if known)
- ❑ Signs and Symptoms
- ❑ Any Treatments provided and the response to the intervention

As with many of the EMS Protocols, a significant amount of information is collected by the EMS Providers on scene and can be extremely valuable for downstream providers. Be sure to notice and document HazMat placards in cases of transportation incidents, any MSDS sheets available in the industrial / manufacturing setting, or the contents and volumes of products / substances present in the cases of household ingestion.

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Patients in Police Custody

Purpose:
To provide guidelines for the evaluation and management of patients requiring EMS assessment while in the custody of Law Enforcement. As with every patient interaction, it is important that the EMS Provider serve as a patient advocate and use their best medical judgment to assist Law Enforcement in making safe, appropriate decisions regarding medical aid and disposition decisions.

Policy:
As a general rule, when evaluating a patient who is in the custody of Law Enforcement, the EMS Provider should approach the patient with the same respect and consideration as patients who are not being detained. While EMS is not equipped or authorized to provide "Medical Clearance" before transport to jail, it is the responsibility of the EMS Provider to provide an unbiased assessment and to make recommendations based on Dane County Protocols as well as EMS Provider experience and judgment.

These patient encounters have a higher than average incidence of scrutiny on review; as such, take steps to ensure that your documentation is clear, descriptive and complete. Law Enforcement Agent names and badge numbers are essential in the EMS Provider documentation.

- ❑ If a patient in custody of Law Enforcement is evaluated by EMS and felt to need transport to the Emergency Department and *the patient is refusing transport*:
  - Evaluate the capacity of the patient to make informed decisions as outlined in the Dane County Protocols
  - Advise the Law Enforcement Agent of the decision of the patient, and consider potential risks or hazards to Law Enforcement if the patient were to refuse (i.e. lacerations that may pose a biohazard to officers or other detainees)
    - ❑ If Law Enforcement requests transport, document their request and coordinate safe transport to the closest, most appropriate Emergency Department. In these instances, the Law Enforcement Agent must take the patient into Protective Custody and effectively making decisions as the healthcare power of attorney for the patient.
    - ❑ Document that Law Enforcement has taken Protective Custody of the patient.
    - ❑ In this instance, the Law Enforcement Agent must accompany the patient to the Emergency Department.
  - If the patient is evaluated to have capacity and does not pose an undue risk to Law Enforcement, execute a Patient Refusal as outlined in the Dane County Protocols

- ❑ If a patient in custody of Law Enforcement is evaluated by EMS and felt to need transport to the Emergency Department and the *Law Enforcement Agent is refusing transport*:
  - Advise the Law Enforcement Agent that transport is indicated by Dane County Protocols, and that medical clearance is not authorized by EMS Personnel in the field.
  - Contact On-Line Medical Control for consultation and assistance as needed.
    - ❑ If Law Enforcement continues to decline transport for medical evaluation and management, allow the patient to remain in the custody of the Law Enforcement Agent, and advise them that EMS may be re-contacted at any time to provide medical assistance as needed
    - ❑ The Law Enforcement Agent in these situations is taking the patient into Protective Custody and effectively making decisions as the healthcare power of attorney for the patient.
    - ❑ Document that Law Enforcement has taken Protective Custody of the patient.
  - Document the Law Enforcement Agency as well as the name and badge number of the responsible officer along with specifics of the discussion in your electronic Patient Care Report (ePCR).

- ❑ If a patient in custody of Law Enforcement requires transport to the Emergency Department and is *requiring physical restraint* by the Law Enforcement Agent for behavior modification:
  - Advise the Law Enforcement Agent that Dane County EMS Policy requires their accompaniment in the patient compartment of the ambulance during transport to the Emergency Department.
    - ❑ With active restraints in place, it is an issue of patient safety as well as provider safety
  - Consider the Behavioral Emergencies Protocol in the Dane County Protocol book, OR contact On-Line Medical Control for advice regarding medication management as appropriate to assist with safe and expeditious transport

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Radio Report Format

Purpose:
To provide guidelines for clear communication between EMS Providers and receiving facilities prior to delivery of the patient.

Policy:
For all patients being transported to the hospital by EMS, every effort should be made to contact the receiving facility *as early as possible* once the destination facility has been chosen and transport initiated. By making proactive contact with the receiving facility, it provides the opportunity to collect personnel, resources and equipment that may be needed to care for critically ill or injured patients, and thereby improve patient survival and realization of the EMS mission.

Procedure:
Begin each transmission with the agency name and unit number, and wait for acknowledgement from the receiving facility.

After the receiving facility acknowledges contact with your unit, give a clear, concise report which includes the following:

- ❑ Triage category and triage color

Triage Category	Triage Color	Definition	Common Examples (NOT All-Inclusive List)
Medical	Red	High acuity of illness, unstable VS or critically ill	Hypotension, Extreme Tachycardia, Multiple Medications (other than Albuterol), Airway Management, Altered Mental Status, Failure to Respond to EMS Therapy
	Yellow	Serious medical illness with potential to decompensate, but VS currently stable	COPD improving with nebs, Chest Pain with Cardiac History, Abdominal Pain in Pregnancy, Fever without hypotension or tachycardia (not believed to be sepsis)
	Green	Low acuity medical illness, VS stable	Hypoglycemia resolved with Dextrose, Intoxication without airway compromise or indication of trauma
	Peds	≤12 years of age OR absence of sigs of puberty / secondary sex characteristics	
Trauma	Red	Severe mechanism of injury, life or limb threatening injury, unstable VS or critically ill	Traumatic injury with hypotension, tachycardia, uncontrolled/poorly controlled hemorrhage, Altered Mental Status, pain not improving with EMS Intervention
	Yellow	Serious mechanism of injury, potential for decompensation but VS currently stable	Head Injury with anticoagulant use, deformed extremities after trauma, significant pain improved after EMS intervention
	Green	Minor mechanism of injury, no outward signs of trauma, VS stable	Head Injury without LOC or Altered Mental Status, Traumatic Extremity pain with intact CMS and without deformity
	Peds	<18 years of age	
STEMI ALERT	Red	STEMI Interpretation of Field ECG (EMS or Monitor) **Call with early notification**	Goal time for first EMS Contact to balloon time <90 minutes
STROKE ALERT	Red	Focal Neurologic Deficit with Last Known Normal ≤12 Hours	Include collateral information, bring witnesses to corroborate history when/if appropriate

- ❑ Estimated time of arrival (ETA)
- ❑ Age and Chief Complaint of the patient
- ❑ Very brief background of events including:
  - Mechanism of injury and description of injuries found (if traumatic)
  - Provider Primary Impression and nature of patient complaint (if medical)
  - Treatments provided and/or underway as well as patient response
  - *Current* Vital Signs including GCS
  - Any anticipated delay in transport (i.e. extrication)

Contacting Medical Control

- ❑ Medical Control may be contacted for any additional orders, to consult as needed for patients refusing transport and for any questions regarding patient management on scene or en route to the receiving facility. Any orders given should be repeated back for clarification and patient safety.
- ❑ Make sure your request of Medical Control is clearly communicated, and be prepared to answer follow up questions regarding the protocol you are following as well as your assessment of the situation.
- ❑ Several protocols have suggested medications and dosages outlined in the protocol, to help facilitate the conversation with Medical Control
- ❑ **Remember: you are the one who has the patient in front of you – your assessment and impression matter!**

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Transfer of Care at Hospital

Purpose:
To provide guidelines for in-person communication with receiving facilities, and to clarify expectations of EMS Provider documentation.

Policy:
When delivering a patient to the receiving facility, it is imperative that a clear, concise communication happen between the EMS Provider and the emergency medical staff assuming care. In order to prevent miscommunication, a full verbal report should be communicated in a face-to-face fashion, preferably with the entire medical team assembled at the patient bedside. On the occasion that the complete team is not available, verbal report should be given to a receiving caregiver credentialed at the RN level or higher.

All treatments and interventions initiated under the Dane County Protocols may be continued after arrival in the receiving facility up until the appropriate personnel and equipment are assembled to assume care of the patient. At that time, responsibility for all medical care and continued treatment is transferred to the facility, and the Dane County EMS Protocols are no longer authorized for patient management. On-Line Medical Control should not be contacted for additional orders once this handoff has occurred. In the rare circumstance that the EMS Provider is requested/invited to participate, direction will be at the authorization and the discretion of the supervising on-scene physician. It is important that the involvement, orders received and name of the responsible physician be captured in the electronic Patient Care Report (ePCR) as part of the medical care provided by EMS.

Verbal Report
Verbal report at the time of handoff shall include all pertinent known information about the patient, the history of present illness or mechanism of injury, treatments administered by EMS Providers as well as the patient's responses to treatment. In addition, all prehospital ECGs and provided paper medical records should be turned over to the treatment team assuming care.

Written Report
Wisconsin DHS Administrative Rule 110.34(7) specifically addresses EMS responsibility for written patient report at the time of handoff at the receiving facility. The rule states:

> An emergency medical service provider shall, "...submit a written report to the receiving hospital upon delivering a patient, and a complete patient care report within 24 hours of patient delivery. A written report may be a complete patient care report or other documentation approved by the department and accepted by the receiving hospital."

The expectation is that there will be written documentation left at the receiving facility, and conveyed either in printed or electronic format *prior to your departure* and returning available to service. It is not required that the documentation left at the facility be the completed, finalized electronic Patient Care Report (ePCR). **HOWEVER**, all EMS Providers in Dane County are integral members of the healthcare team, and may hold key pieces of information not available to any of the downstream providers and which are at significant risk of being lost, overlooked or miscommunicated if not documented in a prompt manner.

Given the nature of EMS and out-of-hospital care, it should be the goal of every Dane County EMS Service at minimum to have a draft narrative, list of the EMS interventions, medications given and vital signs documented *prior to leaving the facility* and returning to duty.

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Persons with EMS Care Plans

Purpose:
To establish a uniform approach for the evaluation and management of persons having an established Care Plan, developed by the EMS Service and approved by the Medical Director.

Policy:
All sick or injured persons requesting transport shall be transported without delay to an appropriate local Emergency Department of the patient's preference. The only exceptions to this rule are found below:

- ❑ Patients who are suffering from a Time Critical Diagnosis (TCD) or whose condition is covered under the Destination Determination Protocols shall be transported in accordance with those specialty algorithms to the appropriate receiving facility. The presence of a Care Plan **DOES NOT** supersede the Destination Determination Protocol.
- ❑ Patients known to have been discharged from an Emergency Department within the last 48 hours should generally be transported back to the same ED, **unless** they meet specialty center destination criteria, as outlined in the Destination Determination Protocol.
- ❑ Patients who have been identified as frequent users of the EMS System may have a designated Care Plan, which has been developed with the patient and/or their healthcare providers, the EMS Service and one or more of the Dane County hospitals. If a patient has a formal Care Plan approved by the EMS Service Medical Director, the patient should be evaluated, treated and transported in accordance with the Plan, **unless** the patient meets criteria for transport to a specialty receiving center, as outlined above. Regardless of the existence of a Care Plan, all patients should be treated with respect and dignity, and fully evaluated as per the standards set forth in this Protocol Book.

There may be exceptions to this guideline, and if there are questions while evaluating a patient with a Care Plan, do not hesitate to contact the Officer In Charge (OIC) or the Medical Director or Medical Director's designee for clarification.

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