Southwest Region Emergency Medical Services and

Trauma Care Council

Patient Care Procedures

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DEFINITIONS

WAC 246-976-010
"County Operating Procedures" or "COPs" means the written operational procedures adopted by the county Medical Program Director (MPD) and the local EMS council specific to county needs. COPs may not conflict with Region patient care procedures.

"Region Patient Care Procedures" or "PCPs" means Department of Health (DOH) approved written operating guidelines adopted by the Region emergency medical services and trauma care council, in consultation with the local emergency medical services and trauma care councils, emergency communications centers, and the emergency medical services medical program directors, in accordance with state-wide minimum standards. The patient care procedures shall identify the level of medical care personnel to be dispatched to an emergency scene, procedures for triage of patients, the level of trauma care facility to first receive the patient, and the name and location of other trauma care facilities to receive the patient should an inter-facility transfer be necessary. Patient care procedures do not relate to direct patient care.

"Prehospital Patient Care Protocols" means the Department of Health (DOH) approved, written orders adopted by the Medical Program Director (MPD) which direct the out of hospital care of patients. These protocols are related only to delivery and documentation of direct patient treatment.

DISPATCH/RESPONSE TIMES

Dispatch

Agencies that operate a 911 Dispatch Center in the Southwest Region should use a priority dispatch program. All dispatchers should be trained in an emergency medical dispatch (EMD) program.
When a 911 Dispatch Center receives a call that suggests to the emergency medical dispatcher (EMD) that a trauma or major medical incident is involved, the EMD should dispatch the highest level of verified service available. In all counties in the Southwest Region, paramedics or the highest level EMS responder specifically trained in prehospital life support, should be dispatched to the scene of an incident.

It is the responsibility of the responding agency to have trained prehospital medical and trauma life support technicians respond to the scene. If a prehospital agency does not have personnel available who are trained in prehospital trauma life support or cardiac and stroke care, the agency should immediately notify the 911 Dispatch Center to dispatch another service to the scene of the call to assist with the patient(s).

If a major trauma patient is known or suspected, 911 Dispatch Center should advise all responding trauma services of any and all additional information that becomes available to the 911 Dispatch Center.

When a prehospital service that is not Trauma Verified has contact with a major trauma patient prior to the arrival or dispatch of trauma verified service they shall ensure that the 911 Dispatch Center is immediately notified so that trauma verified services can be activated as per the dispatch system for that location.

Response Times
To ensure timeliness in the dispatch of a verified service, the following guidelines have been adopted by the Region Council for response times (measured from the time the call is received by the responding agency until the time the agency arrives on the scene of the trauma incident):

Verified Aid Services (response times, 80 percent target)

- Urban Areas: 8 minutes or less
- Suburban Areas: 15 minutes or less
- Rural: 45 minutes or less
- Wilderness: as soon as possible

Verified Ambulance (Transport) Services (response times, 80 percent target)

- Urban Areas 10 minutes or less
- Suburban Areas 20 minutes or less
- Rural 45 minutes or less
- Wilderness: as soon as possible

CANCELLATION/SLOWDOWN/STAGING

Once a call is received by a transport unit, the unit will respond as rapidly as possible and make patient contact to administer emergency medical care as needed.

Cancelling of Response

A. Dispatch reports the original caller has cancelled the request for service. The highest level EMS provider will make the decision to cancel or continue the call based on information from Dispatch.
B. A first-in responding unit reports that no patient is present.

C. A first-in responding unit with an EMT, paramedic, or EMS agency known to the responding unit arrives and reports to the transport unit that the patient does not want or need contact by transport unit. This denial can be due to:
   1. No need for treatment or minor care administered by the first-in units.
   2. Patient/Guardian desires POV transport (should be conveyed to transport unit). If first-in unit deems transport should continue in for evaluation, this should be conveyed to responding transport unit.
   3. It shall be the discretion of the responding transport unit whether to continue to the scene.
   4. If the transport unit does not respond, the first-in unit will **obtain a refusal form signed by the patient or other responsible person stating that based on his/her own initiative they do not desire transport.**

Slow Down

A. Transport units may be slowed by first-in units, staffed by a paramedic or EMT, after evaluating the patient and determining a rapid response is unnecessary.
B. The first-in unit conveys patient information to the responding transport unit so the responding unit can decide to slow response.

Diversion

A. An EMS response unit may be diverted to another call when:
   1. It is obvious the second call is a life-threatening emergency and first-in EMT's and/or paramedics report that first call can await a second unit.
   2. A second ambulance is dispatched to the first call.
   3. The first responding unit is closer to the second call and may be vital to the patient's outcome.

Staging

A. Stage/standby may be done when responding to scenes involving acts of violence or other scene safety issues until the scene is secured by law enforcement or other means. Items to consider:
   1. Information from Dispatch indicating violence or potential for violence e.g., assault with weapon, violent individual(s), or hostage situation.
   2. Information that raises questions regarding the safety of responders, e.g., hazardous material or other special rescue situation.
B. Units will advise Dispatch of intent to stage and request Law Enforcement response (if not already done). Dispatch will notify all responding units of intent to stage.
   1. When a response unit declares intent to stage all responding agencies will stage until the scene is deemed safe to enter.

2. The responsibility to stage rests with the responding agency. Communication of intent to stage will be shared between multiple responding agencies.

C. Dispatch should provide ALL pertinent information to the responding units so they can make a determination as to whether to stage. This should be the same complete information provided to law enforcement responding units.

TIME ON THE SCENE

A. Any time an airway cannot be provided to a patient utilizing MPD approved airway procedures; transport the patient immediately to nearest hospital.
B. Medical – 30 minutes or less after initial encounter.
C. STEMI/CVA – 15 minutes or less after initial encounter.
D. Trauma - 10 minutes or less once extrication has been accomplished and the patient can be removed from the site.

**Note: Document extenuating circumstance.

PRE-HOSPITAL COMMUNICATIONS

Hospital Notification Report Format (H.E.A.R. – Landline – 800 MHz – 900 MHz)

A. Emergency Report Format:
   1. Unit identification
   2. Age and sex of patient
   3. Transport code (emergent/non-emergent)
   4. Chief complaint or reason for transport
   5. Very brief pertinent medical history (one sentence if possible)
   6. Vital signs
   7. Pertinent treatment rendered
   8. Request for additional information or treatment
   9. Estimated time of arrival (ETA)
B. The pre-hospital report should be provided to the receiving facility as soon as practical once transport has begun. All reports should be given in this order and should have a maximum of sixty seconds. The pre-hospital report is not meant to be a full patient report and should relay only pertinent patient care information. (Patient identification information is inappropriate to be given on the H.E.A.R. frequency.) Format for trauma system patients will follow specific reporting format as indicated in Activating the Trauma System.
C. Advise Medical Control or receiving emergency department of changes in patient's condition in route and/or request further treatment.

Report to Physician and/or Triage Nurse upon arrival at Emergency Department

A. This should contain more detail than the radio report. The EMT now has the time to present thorough details of the scene, complete assessment of the patient, and complete report on patient care and the result of interventions.
   1. Name, age, sex, and patient's physician
   2. Chief complaint or injuries
   3. If trauma, describe the trauma scene
   4. Pertinent medical history
   5. Physical examination findings
   6. Explain patient treatments and results of such

B. Transporting units are required to leave at minimum, an abbreviated written report prior to leaving the hospital.

Written Reports/Documentation

A. An EMS Medical Incident Report (MIR) form (or other electronic report format) must be documented and filed for any call for EMS assistance resulting in patient contact regardless of patient transport. This will apply to all responding agencies, both basic and advanced life support units and includes public assist calls.
   1. Patient contact occurs when a provider contacts/sees/hears a patient, even if other providers are on scene. The treatments and evaluations provided, while provider is in contact with the patient, shall be documented.

B. Documentation Format:
   1. If a written format is used, S.O.A.P. charting is the most acceptable method of report writing.
   2. If an electronic report format is used then it is necessary to follow the MPD approved documentation guidelines for that particular charting application.

C. Documentation of Response Determinant
   1. Complete documentation of patient care will include the determinant assigned at initial dispatch and any upgrades received while en-route.

D. The patient care report should reflect the patient care incident as accurately as possible. As such, the report will be completed as soon as feasible after the patient encounter to ensure an accurate accounting of the incident. ALL REPORTS MUST BE COMPLETED WITHIN 24 HOURS.
   1. Transporting units are required to leave at minimum an abbreviated written report prior to leaving the hospital.
   2. Transport units are required to provide the receiving facility a complete written or electronic patient care report within 24 hours of patient arrival.

TRAUMA

All trauma patients must be transported by a trauma verified service and will be managed consistent with the State of Washington approved patient destination procedure; CDC National Trauma Triage (Destination) Procedure.

Activating the Trauma System

A. When a prehospital trauma verified service has identified a patient as a "major" trauma patient, the prehospital service should ensure the following:
    1. Contact with a Level I or Level II Designated Trauma Center, where available or;
    2. The highest level designated facility within the agency's immediate response jurisdiction if a Level I or Level II Designated Trauma Center is not within a 30 minute transport time.

B. To activate the Trauma System in the Southwest Region, contact with the Designated Trauma Center shall be preceded with the phrase: "THIS IS A TRAUMA SYSTEM ENTRY."

C. It is important for the EMS agency to provide the Designated Trauma Center with the following information:
    1. Identification of the EMS agency or Trauma Verified Service
    2. Patient's chief complaint(s) or problem: identification of biomechanics and anatomy of injury
    3. Approximate age of the patient
    4. Basic vital signs (palpable pulse rate, where pulse was palpated, and rate of respiration)
    5. Level of consciousness (Glasgow Coma Score)
    6. Provider impression
    7. Other factors that require consultation with the base station
    8. Number of patients (if known)
    9. Estimated Time of Arrival
    10. Whether an air ambulance has been activated for scene, field, or hospital rendezvous

Pediatric Major Trauma Patients

For a pediatric major trauma patient consideration should be given to transport the patient directly from the field to the most appropriate (Level I, II, III) trauma facility within the Region. In most cases, a pediatric major trauma patient will be transported to a Level I Designated Trauma Center. However, Level II and /or Level III Centers, may offer initial stabilization of the pediatric patient. All Designated Trauma Centers in the Southwest Region shall follow their guidelines for diversion of pediatric patients directly from the prehospital setting based on the availability and potential need for surgical or medical subspecialty care or resources specific to the care of the pediatric patient. When a prehospital service notifies a Designated Trauma Center that they have a major pediatric trauma patient, the Level II, III, IV, or V center should immediately notify the EMS agencies of the diversion policy.

DESIGNATED TRAUMA CENTERS

In the Southwest Region, the following hospitals are Washington Designated Trauma Centers:

- Peace Health Southwest Medical Center; Vancouver, WA — Level II
- Peace Health St. John Medical Center; Longview, WA — Level III
- Skyline Hospital; White Salmon, WA — Level IV
- Klickitat Valley Health; Goldendale, WA — Level IV
- Ocean Beach Hospital; Ilwaco, WA — Level IV

DIVERSION (DESIGNATED TRAUMA CENTER(S) NOT ACCEPTING PATIENTS)

Designated Trauma Centers in the Region may go on diversion for receiving major trauma patients based on the facility's ability to provide initial resuscitation, diagnostic procedures, and/or operative intervention at the designated level of care. Diversion will be categorized as partial or total based on the ability of the facility to manage specific types of major trauma. Each Designated Trauma Center will have a DOH approved policy to divert patients to other designated facilities based on its ability to manage each patient at a particular time.
EMS agencies in the Southwest Region will be notified if and when a Designated Trauma Center is on diversion status. Trauma verified services will follow County Operating Procedures (COPs) on where trauma patients should be taken, in the event a Designated Trauma Center is not accepting patients.

PROLONGED TRANSPORT

When the transport of a major trauma patient will be greater than 30 minutes to a Level I or II Designated Trauma Center but within 30 minutes of a lesser level facility, the highest level EMS provider on scene may contact medical control hospital to determine if the patient should be transported to the highest level Designated Trauma Center within 30 minutes or transported directly to a Level I or Level II Designated Trauma Center.

MEDICAL PATIENTS

All EMS Agencies should follow County Operating Procedures (COPs) for the transport of non-trauma patients.

CARDIAC PATIENTS

Patients presenting with signs and symptoms of acute coronary syndrome, or cardiac arrest with return of spontaneous circulation, shall be identified and transported according to the State of Washington Pre-hospital Cardiac Triage Destination Procedure. County Operating Procedures (COPs) may provide detail on the destination of cardiac patients based on the local community resources and clinical capabilities.

STROKE PATIENTS

Patients presenting with signs and symptoms of a stroke shall be identified and transported according to the State of Washington Pre-hospital Stroke Triage Destination Procedure. County Operating Procedures (COPs) may provide detail on the destination of stroke patients based on the local community resources and clinical capabilities.

AIR AMBULANCE

General considerations

Consider the following when deciding on air transport:

A. Transport time to a level I or II Designated Trauma Center, or Level I or II Cardiac/Stroke Center, can be reduced by a minimum of 30 minutes versus ground transport. Factors affecting the 30 minute reduction include:
    1. Time of air ambulance arrival
    2. Transfer of patient to air ambulance personnel
    3. Establishing and transporting to the landing zone
    4. Road/traffic conditions (time of day)

B. Patient needs advanced interventions

Standby

**Note: When Air Ambulance is put on standby status; the helicopter is readied but remains available for any other requests on a priority basis.

A. Air Ambulance may be placed on standby by:
    1. Emergency Medical Responder
    2. EMT
    3. Paramedic
    4. Any physician
    5. Any law enforcement
    6. 911 Dispatch Center

B. Air Ambulance may be placed on standby prior to personnel arrival if first response unit arrival at the scene will be greater than 20 minutes or the information dispatched purports to be the type of patient who will benefit from Air Ambulance. Examples of situations:
   1. Gunshot or penetrating trauma
   2. MVA; person trapped or multiple patients
   3. Auto-pedestrian
   4. Severe burns
   5. Major amputation
   6. Entrapment (e.g., cave-in, machine on person, etc.)
   7. Critical pediatric patients
   8. Acute cardiac or neurological emergencies

Activation

A. The decision to activate Air Ambulance rests with the highest level EMS provider (or a physician on scene):
   1. As EMS provider arrives on scene and evaluates patient.
   2. Based upon information relayed by people on scene.

B. In some cases, Air Ambulance can be immediately activated to the scene prior to the arrival of a first-in unit or highest level EMS responder when:
   1. Travel time for that first-in unit will be over 30 minutes and the situation as known purports to be the type of patient who will benefit Air Ambulance.
   2. Where it is known ground access will be difficult but where the helicopter can get near the patient.
   3. Where the reporting party relates some other special circumstance indicating the need for its immediate activation.

   **Note: In those situations (A or B above), activation shall be done through Dispatch with concurrence of responding highest level EMS responder.

C. Criteria for Activation
   1. Patient(s) meet "major trauma" criteria and extrication and/or ground transport will be greater than 30 minutes, or;
   2. Patient meets cardiac/stroke triage criteria and ground transport will be greater than 30 minutes.
   3. Type of injury or illness may dictate immediate transport to a Designated Trauma Center, Burn Center, or Hyperbaric Center etc.
   4. Multiple victims meeting 'major trauma" criteria.

D. Destination Hospital
   1. Unless diversion criteria apply, the destination hospital shall be indicated to Air Ambulance by the highest level EMS responder in charge. The highest level EMS responder will consult with Medical Control to determine destination.

Cancellation
Air ambulance may be cancelled by the highest level EMS responder responsible for the patient after examination of the patient and determining that air transport is not necessary.

Quality Assessment and Improvement, Case Reviews
Air ambulance calls will be reported to the County Medical Program Director.

NON-TRANSPORT OF PATIENTS

**Note: Any person with a medical need, EMS personnel will use all resources available to have that person treated and transported.

In general, the only reasons for a non-transport are:

A. Signed "Refusal for Transport," completed by patient, family or custodian.
B. No patient (Dead on Arrival (DOA), termination of resuscitation effort, etc.).

Patients refusing care and/or transport (classified as follows):

A. No medical need exists.
B. A person with normal decision making capacity who, after having been informed of risks and benefits of treatment/transport, voluntarily declines further services.

Impaired decision making capacity defined:

A. Inability to understand the nature of his/her illness/injury.
B. Inability to understand risks or consequences of refusing care/transport.
C. Individuals impaired for any reason including but not limited to:
    1. Alcohol and/or drugs
    2. Psychiatric conditions
    3. Injuries (head injury, shock, etc.)
    4. Organic Brain Syndrome (Alzheimer's, etc.)
    5. Minors (<18 years old)
    6. Language/communication barrier (including deafness)

Criteria for informed refusal/consent

A. Person is given accurate information about possible medical problems and the risk/benefits of treatment or refusal.
B. Person is able to understand and verbalize these risks and benefits.
C. Person is able to make a decision consistent with his/her beliefs and life goals.

Pre-Hospital Guidelines for Patients Refusing Care

Establish if medical need exists. If the patient is refusing or resisting care, determine if patient capable of making informed decision OR patient not capable (in EMT opinion) of making informed decision.

A. Capable of making informed decision, NO medical need exists (e.g. passersby report traffic accident; all persons deny injury when EMS arrives):
   1. A refusal form is not necessary.
   2. MIR documentation will include the events necessitating the call to EMS as well as all criteria for no patient/medical need.
B. Capable of making informed decision, minor medical need exists:
   1. A refusal form is necessary. Form and MIR must be completed by highest level EMS provider attending the patient.
   2. MIR documentation shall include:
      a. The patient's chief complaint
      b. Events prior/reason for call to EMS
      c. Pertinent medical history
      d. Description of scene (if relevant to patient's c/c)
      e. Physical exam including vital signs and clinical impression
      f. Prehospital interventions
      g. Consultation with medical control
      h. Patient's response to medical care and/or transport attempts
      i. Instructions to patient and/or family including risks/benefits of treatment/transport
C. Capable of making informed decision, immediate medical care and/or ambulance transport necessary:
   1. A refusal form is necessary. Form and MIR must be completed by the highest level EMS provider attending patient.
   2. Every effort will be made to convince these patients to accept necessary pre-hospital intervention and transport to definitive care. Options available:
      a. Solicit assistance from family, friends, and/or other close associates to persuade the patient to accept necessary treatment and transport.
      b. Solicit assistance from law enforcement (police hold), mental health professional (psychiatric hold), and/or clergy as the situation directs.
   3. CONSULTATION WITH MEDICAL CONTROL IS MANDATORY.
   4. MIR documentation shall include:
      a. The patient's chief complaint
      b. Events prior/reason for call to EMS
      c. Pertinent medical history
      d. Description of scene (if relevant to patient's c/c)
      e. Physical exam including vital signs
      f. Clinical impression

    g. Prehospital interventions
    h. Consultation with medical control
    i. Patient's response to medical care and/or transport attempts
    j. Instructions to patient and/or family including risks/benefits of treatment/transport
5. If the patient still refuses treatment/transport, the highest level EMS provider will be responsible for explaining the REFUSAL FORM. Completion of the form includes:
    a. Explanation of instructions and release of liability to the patient
    b. Receipt of signature (dated) from patient or legal guardian
    c. Completion of patient assessment, medical control consult, and patient disposition

D. Not capable of making informed decision, medical care and/or ambulance transport necessary:
1. A refusal form is necessary. Form and MIR must be completed by the highest level EMS provider attending the patient and signed by 2 witnesses.
2. Every effort will be made to convince these patients to accept necessary prehospital intervention and transport to definitive care. Options available include:
    a. Solicit assistance from family, friends, and/or other close associates to persuade the patient to accept necessary treatment and transport
    b. Solicit assistance from law enforcement (police hold), mental health professional (psychiatric hold), and/or clergy as the situation directs
    c. Consider physical restraint per Medical Control concurrence based on the patient's condition and current situation
    d. Chemical restraint per Medical Control concurrence based on the patient's condition and current situation
    e. Patient restraint can occur only when the highest level EMS provider on scene believes the patient poses a danger to him/herself or others
3. CONSULT WITH MEDICAL CONTROL IS MANDATORY.
4. MIR documentation shall include:
    a. The patient's chief complaint
    b. Events prior to/reason for call to EMS
    c. Pertinent medical history
    d. Description of scene (if relevant to patient’s c/c)
    e. Physical exam including vital signs
    f. Clinical impressions
    g. Prehospital interventions
    h. Consultation with medical control
    i. Patient's response to medical care and/or transport attempts
    j. Instructions to patient and/or family including risks/benefits of treatment/transport
5. If the patient still refuses treatment/transport, the attending highest level EMS provider will be responsible for explaining the EMS REFUSAL INFORMATION FORM. Completion of the form includes:

   a. Explanation of instructions and release of liability to the patient
   b. Receipt of signature (dated) from patient or legal guardian
   c. Completion of patient assessment, medical control consult, and patient disposition sections
6. Every reasonable effort should be made to ensure patients receive necessary medical treatment and transport. If the patient seems hesitant regarding their medical care/transportation or any doubt exists, you should provide care/transportation.
7. Should the above efforts prove fruitless, it may be necessary to leave these patients at the scene. Aforementioned documentation guidelines will be adhered to.

E. Patient in Custody and/or Incident Involving Law Enforcement:
   1. If patient competent, follow protocol outlined above regarding medical need. The patient will require a full medical exam, pertinent to the nature of the chief complaint and mechanism of injury. If the patient refuses care and/or transport a refusal form must be signed by the patient.
   2. If patient refusing transport is under arrest and/or restrained by officers, document refusal in MIR with signature of arresting police officer on refusal form.
   3. All other patients will be transported to the hospital by ambulance

PRIVATE PHYSICIAN AND/OR MEDICAL PROFESSIONALS AT THE SCENE

Physicians and/or medical professionals at the scene of an emergency may provide assistance and should be treated with professional courtesy. Medical professionals who offer their assistance must identify themselves. Physicians must provide proof of their identity, if they wish to assume or retain responsibility for the care given the patient after the arrival of EMS. When the patient's private physician is in attendance and has identified himself/herself upon the arrival of EMS, all EMS responders will comply with the private physician's instructions for the patient. If orders are given which are inconsistent with established protocols, clearance must be obtained through the Medical Control Physician.

The physician at the scene may:

A. Request to talk directly to the Medical Control Physician to offer advice and assistance;
B. Offer assistance to EMS with another pair of eyes, hands, or suggestions, leaving the EMS team under Medical Control;
C. Take total responsibility for the patient with the concurrence of the Medical Control Physician.

Transport

If during transport, the patient's condition should warrant treatment other than that requested by the private physician, Medical Control will be contacted for information and concurrence with any treatment, except in cases of cardiopulmonary arrest.

**Note: The above "Physician at the Scene" will also apply to cases where a physician may happen upon the scene of a medical emergency and interacts with the ALS team.

DO NOT RESUCITATE ORDERS

Definitions

A. A DNR (DO NOT RESUSCITATE OR NO CODE) Order is an order issued by a physician directing that in the event the patient suffers a cardiopulmonary arrest, (e.g., clinical death) cardiopulmonary resuscitation will not be administered. DNR orders are only valid when a patient is under the care of skilled nursing personnel.
B. A Living Will is a legally executed document expressing the patient's wish to not undergo ALS resuscitation.
C. Physician Orders for Life Sustaining Treatment (POLST) Legal document signed by patient and physician indicating patient preference for life sustaining treatment.
D. Resuscitation includes attempts to restore failed cardiac and/or ventilatory function by procedures such as endotracheal intubation, mechanical ventilation, closed chest massage, defibrillation, and use of ACLS cardiac medications.

Procedures

A. When the patient's family, friends, or nursing home personnel state that the patient is not to be resuscitated:
    1. BLS protocols will be followed while attempts to determine if a written POLST form, DNR order or a Living Will is present.
    2. In the absence of the above, call Medical Control or the attending physician, if known by you and available.
    3. The EMS provider must document the POLST form, DNR order, or Living Will in the patient care report.
B. When Patient is PULSELESS AND NONBREATHING; no BLS or ALS procedures should be performed on a patient who is the subject of a confirmed POLST (no resuscitation) form, DNR order, or has a Living Will.

INTER-FACILITY TRANSFER (HOSPITAL TO HOSPITAL)

General responsibilities and instructions

A. It is the responsibility of the transferring facility to insure:
    1. Medical requirements for safe patient transfer are met including stabilization
    2. State of WA Trauma, Cardiac, &/or Stroke patient destination guidelines are adhered to

B. Medical instructions of the attending physician will be followed unless contrary to standing orders; Medical Control will be contacted for clarification of contrary orders.
C. Attendance of the patient during transport, by;
    1. Physician - he or she will direct all care regardless of standing orders
    2. Registered Nurse – he or she will direct the care of the patient via orders from the physician at transfer or the receiving hospital physician. The registered nurse may desire to defer emergency care in some situations to the highest level EMS provider.

Stabilization prior to transfer

A. Patients will not be transferred to another facility without first being stabilized. Stabilization includes adequate evaluation and initiation of treatment to assure that transfer of a patient will not, within reasonable medical probability, result in material deterioration of the condition, death, or loss or serious impairment of bodily functions, parts, or organs.
    1. Establish and assure an adequate airway and adequate ventilation
    2. Initiate control of hemorrhage
    3. Stabilize and splint the spine or fractures, when indicated
    4. Establish and maintain adequate access routes for fluid administration
    5. Initiate adequate fluid and/or blood replacement
    6. Determine that the patient's vital signs (including blood pressure, pulse, respiration, and urinary output, if indicated) are sufficient to sustain adequate perfusion
B. Stabilization of patients prior to transfer to include the following:
C. ALS patient and Above Criteria Not Met:
    1. EMTs may, within their certified scope of practice, initiate pre-hospital protocols and guidelines including the establishment of intravenous lines, airway control, etc.
    2. EMTs may refuse to transfer the patient until the facility has complied with the above evaluation and/or treatment. Contact Medical Control for concurrence and consultation or contact the MPD directly.

Other considerations

A. If a BLS transport is requested and it is the judgment of the BLS crew that the patient needs to be transported by an ALS ambulance, it is mandated that dispatch be contacted and an ALS crew dispatched. Under no circumstances should a BLS crew transport a patient, if in their judgment, this is an ALS call.
B. Emergencies en route:
    1. Prehospital protocols and guidelines will immediately apply
    2. Medical Control should be contacted for concurrence of any orders as needed; the receiving facility should be contacted as soon as possible to inform them of changes in the patient's condition

**Note: Any deviation from this guideline or from the transport protocols should be reported to the MPD on an incident report within 24 hours of occurrence.

C. The receiving facility will be given the following information on the patient by fax, phone, or other means:
   1. Brief history
   2. Pertinent physical findings
   3. Summary of any treatment done prior to the transfer
   4. Response to therapy and current condition
D. All required documentation must be available at the receiving facility upon arrival of the patient to the receiving facility (it may be sent with the patient, faxed to the hospital, or relayed by other means).
E. All inter-facility transports must be conducted by a trauma-verified service for trauma system patients.
F. All designated health care facilities shall have transfer agreements for the identification and transfer of trauma patients as medically necessary.

HAZARDOUS MATERIALS INCIDENT

EMS personnel are urged to be alert for hazardous materials when responding on calls. Hazardous materials may be obvious, but often are not. If a vehicle has a diamond shaped placard or an orange numbered panel on its side or rear, assume the cargo to be hazardous. Not all hazardous materials will be clearly identified. Grocery trucks or delivery vehicles may be carrying hazardous materials without the diamond shaped placard or orange numbered panel to identify such transport. Common sense dictates that each EMT assumes hazardous material is present unless proven otherwise. County Operating Procedures (COPs) may provide detail on Hazardous Materials response procedures, based on the local community resources and clinical capabilities.

MULTI-CASUALTY INCIDENTS AND MEDICAL INCIDENT COMMAND CENTER

It is imperative that a defined organizational structure be followed during incidents where a Multi-Casualty Incident (MCI) is encountered. The Incident Command (IC) system is the accepted standard for organizing the medical operations portion of such incidents. Further education and training is needed for all emergency responders to adequately function at these types of incidents. County Operating Procedures (COPs) may provide detail on MCI & IC response procedures, based on the local community resources and clinical capabilities.

QUALITY ASSESSMENT AND IMPROVEMENT (QA & I)

Quality Assessment & Improvement (QA&I) is an integral component of the Southwest Region's Trauma System, EMS and Cardiac/ Stroke System. For all patients, EMS and health care providers will follow their agency's specific QA&I plan. If an agency does not have a QA&I Plan, one should be developed and adopted. Issues that are identified by a local QA&I committee for review and recommendations should be submitted directly to the Region QA&I committee for consideration. QA&I prehospital problems, issues, case reviews, areas of improvement, can be "flagged" by checking the "QI" Box on the medical incident reporting form. Any system issues that affect patient care are encouraged to be submitted.