OPERATIONS GUIDELINES

SPEARFISH EMERGENCY AMBULANCE SERVICE, INC.

Revision; April 2016

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POLICY STATEMENT

The purpose of the Spearfish Emergency Ambulance Service ALS/BLS Guideline manual is to establish a basic set of standards of patient care for the transport team and to serve as a basis on which to evaluate patient care for Quality Assurance.

The BLS guidelines are to be used by EMT crews functioning in an established BLS crew configuration and are only applicable during this configuration.

The ALS Guidelines are in place anytime an EMT-Intermediate or Paramedic crew configuration is in place.

The medical and administrative guidelines described in this manual are meant to serve as guidance to the transport team according to their training levels. Deviation from these guidelines may occur with the consultation of Medical Control and the individual training and abilities of the specific crew. If the crew is unable to contact Medical Control for guidance, crews should proceed with treatments utilizing best judgment.

Spearfish Emergency Ambulance Service may also be referred to as SEAS, Spearfish EMS, Spearfish Ambulance.

PRIMARY RESPONSE AREA AND JURISDICTION

Spearfish Ambulance is the primary response agency within Spearfish city limits and surrounding areas to include:

- North – Lawrence County line (Red Water River)
- East – Area just east of I-90 Exit 17
- South – Hwy. 85 Crook City Rd / Spearfish Canyon, Spearfish Canyon Fire Department / Tinton Road, to areas south of Wagon Canyon Rd.
- West – I-90 Beulah, WY

Whitewood Team is the primary response crew within Whitewood city limits and surrounding areas to include:

- North – Hwy. 34 to the County line to include St. Onge
- East – Lawrence County line.
- South / Southwest – Crook City Rd. to Hwy 85
- West – Area just east of I-90 Exit 17

CONFIDENTIALITY

General Principles:

EMS agencies are direct providers of health care to patients and generate what is known as “Protected Health Information” (PHI).

PHI consists of records that contain information that identifies an individual (such as name, social security number, date of birth and address), as well as medical information about that individual such as injury or illness and treatments provided. PHI can exist electronically or in hard copy.

Personal medical or identifying information known to an EMS provider about a patient that does not yet exist in electronic or hard copy form is also considered PHI.

Federal law and SEAS policy stipulates that EMS providers shall make reasonable efforts to see that PHI be kept private and confidential and not be disclosed outside the context of necessary and proper workplace operations.

Procedures:

EMS providers can use PHI for <u>treatment, billing, clinical review and training/education purposes</u>.

EMS providers can also share and disclose PHI with other entities that are directly involved in the patients care, such as receiving hospitals and other pre-hospital providers in a tiered response system – as long as it is for <u>legitimate treatment, payment or health care operation purposes.</u>

Generally, EMS providers must limit the PHI used or disclosed to only that which is necessary to accomplish the intended purpose for which the information is needed. For example, in QI review of cases (health care operations), there would typically be no need to disclose the patients name or other identifying information.

EMS providers shall not discuss or disclose any patients PHI with persons outside the context of necessary and proper workplace operations.

EMS providers shall assure that both electronic and hard copy Patient Care Reports (PCR) are kept secure. Printed copies of reports shall NOT be left unattended on counters, vehicles, desks or other places where they may be viewed.

Computers with PCRs in progress shall NOT be left unattended. If the EMS provider has to leave before completing the report it should be closed.

Copies of PCRs will be generated ONLY for patient billing services and the receiving hospital. Other requests for copies of PCRs will be forwarded to the Executive Director for approval.

When students/observers are riding with EMS providers, the attending Paramedic/EMT will assure that the proper confidentiality documents are signed by the rider and they are thoroughly aware of patient confidentiality practices and policy.

Radio communications shall not include patient's names, date of birth, or any identification information.

MEDICAL CONTROL AND AUTHORIZATION

Authorization

SEAS personnel will provide patient care in accordance with the written "Patient Care Guidelines" that are approved by the physician Medical Director. SEAS personnel will provide patient care and treatments only to the level for which they have been trained and authorized.

Incidents that result in deviations from these Guidelines or treatments rendered beyond the scope of these Guidelines shall be documented and submitted to the Medical Director or their designee for review.

Indirect Medical Control

Indirect (off-line) Medical Control refers to written patient care guidelines, also known as "standing orders," that are established by the Medical Director and can be utilized, when appropriate, for any patient encountered. Indirect medical control guidelines do not require patient-by-patient authorization. They are designed to expedite patient care and provide treatment standards that are acceptable and expected for patients and situations that present as described.

Direct Medical Control

Direct (on-line) Medical Control is patient and incident specific orders that are obtained directly from a licensed physician who is assuming at least temporary responsibility for the care of that patient. A direct medical control physician, when contacted by the crew, supervises the field team members in the medical aspects of that patient's care.

Direct Medical Control may be accessed by telephone, radio, other electronic means, or by face-to-face contact at the scene of the incident. Document in the ambulance run report the specific treatment orders obtained and the name of the physician who has provided them.

Direct Medical Control may be provided by the following individuals:

Physicians assigned to provide pre-hospital treatment orders at a designated Medical Control point hospital Emergency Department or, a physician assigned to a designated EMS medical control radio answering point.

By the patient's own physician or another physician present at the scene when the crew communicates directly with that physician and follows the criteria and instructions described in the Physician On the Scene Guideline.

During an inter-facility transport, Medical Control may be provided by the referring physician as a continuation of the care plan and written orders documented on the transfer form and in the patient's medical documentation from the referring facility.

Contacting Medical Control for direct orders is required in the following situations:

- To discontinue resuscitation efforts for an arrested patient.
- For administration of a medication or performing a treatment or procedure that is designated in these guidelines as requiring direct Medical Control.

- Whenever a conflict or disagreement arises with another health care professional at a scene with respect to the appropriate patient care.

Contacting Medical Control is encouraged in the following situations:

- Whenever written guidelines do not cover a particular patient care situation.
- To assist with multiple patient triage decisions, patient destination decisions, or when hospital diversions are indicated or requested.
- For consultation and patient care decisions when treatment questions arise or whenever the crew feels it necessary to contact Medical Control.

SEAS personnel should request direct medical control from hospitals and physicians as designated by the local Medical Director when available. The first choice for obtaining direct medical control should be the hospital that will receive the patient or the hospital that is transferring or discharging the patient.

Transporting patients to a facility that is not necessarily the closest medical facility. This decision is usually a result of patient and/or family request.

CONTROLLED SUBSTANCE KITS AND STORAGE

Controlled substance kits are stocked in the Med-Vault in each primary response unit. Additional kits may be stocked in secondary response units or in a secured location in the facility. If additional units are required contact the Executive Director or designee.

Controlled Substance Kit Medication Stock

The following medications will be stocked in each controlled substance kit (may change depended on demand and medical standards).

Two (2) Morphine sulfate, 10 mg each
One (1) Valium (Diazepam), 10 mg each
Four (4) Fentanyl, 100 mcg each
Four (4) Midazolam HCL (Versed), 2 mg each
Separate locked kit (yellow): Two (2) Rocuronium Bromide, 50mg each

Controlled Substance Kit Security

Controlled substance kits will be secured with numbed tamper resistant break away tags. Kits will be stored and secured in a Med-Vault or other approved secure location. Spare kits will be kept in a secured location in facility.

Controlled Substance Tracking and Documentation

- Tracking of controlled substances will be maintained through accurate patient care documentation and the following guidelines. Refer to each form and related policies & procedures for further information and guidance.
- **PCR Worksheet**: the administration of a controlled substance will be recorded on the Controlled Medication Disposition/Use Form. A witness signature (Ex: RN) will be required for any wasted narcotics. To replace a controlled substance a physician's signature is also required. This form and the Kit must be turned in and refilled by a supervisor and another Paramedic. If the transport originates from another facility (other than Spearfish Regional) a signed transfer order can replace the physician signature on the Disposition/Use Form.
- **Controlled Substance Daily Log**: the controlled substance kit security tag should be inspected daily by two Paramedics. If intact the number should be recorded and both providers should sign the appropriate section of the form. This form should be kept in the folder with the ambulance/vehicle.
  - If the tag is broken or not found, both providers should inventory the kit, list the balance of each medication, sign the form and bring the kit's status to the attention of the Executive Director or designee
  - Completed forms (end of the month) should be turned into the Executive Director or designee

Controlled Substance Usage Log: each controlled substance administration and/or resupply shall be recorded on this form and the form kept in the folder with the kit.

PHYSICIAN ON SCENE

Medical control will be delegated to a physician on the scene only if the following conditions are met:

- The direction of treatment seems reasonable to the EMT/Paramedic with respect to the patient's condition and the circumstances of the situation. The specific treatment orders do not become questionable and are consistent with our usual treatment guidelines.
- If at any time the on-the-scene physician's orders become questionable or inconsistent with our medical guidelines, the EMT/Paramedic will inform our regular hospital-based Medical Control of the orders before following them.

Medical Control may be delegated to on-the-scene physicians in the following situations:

- **Doctor on the scene at a medical facility:**
  - When a physician is present at a hospital, clinic, nursing home, or other medical facility, and that physician currently has a professional relationship with the patient, the EMT/Paramedic will be allowed to follow the treatment orders of that physician.
  - Upon leaving the medical facility, or if the physician leaves and is unavailable to direct further treatment, the EMT/Paramedic will utilize hospital-based Medical Control for further treatment orders.
- **Doctor on the scene, not at a medical facility:**
  - When an identified licensed physician is present at the scene of an ambulance call, which is not at a medical facility, the EMT/Paramedic will be allowed to follow patient treatment orders from the on-the-scene physician. The physician will be encouraged to accompany the patient in the ambulance to the receiving medical facility.
- **Standby events with prearranged medical control:**
  - At a scheduled event, a EMT/Paramedic will be allowed to follow patient treatment orders from a physician on the scene that has been designated to provide Medical Control for the event.
- **Treatment orders left by a physician not on the scene:**
  - An EMT/Paramedic will be allowed to follow treatment orders from a physician ***not on the scene*** if:
    - The physician currently has a professional relationship with the patient, and
    - The physician speaks directly to the EMT/Paramedic, or written orders from the physician are available for inspection by the paramedic.

MUTUAL AID & INTERCEPT GUIDELINE

This guideline is designed to document the function of Spearfish Emergency Ambulance team members during mutual aid and intercept requests with other EMS providers or agencies.

Since each mutual aid and intercept is unique as to patient condition, time of day, weather conditions, etc., the final decision must rest with the EMT/Paramedic crews and Medical Control as to what is best for the patient. Flexibility must be noted within each request to provide superior care for each and every patient.

Upon request by dispatch, the responding crew shall, as available, be provided with a brief description of patient condition and a location for mutual aid and intercept.

Contact between agencies should occur on a mutually agreed upon radio frequency.

The actual intercept should be done at a safe location for patient and crew. It is usually best to pull into a parking lot or driveway off the highway. Coordination of this location should be done while en-route with the transporting EMS agency.

On-scene mutual aid and intercepts are also an option, where the EMTs stabilize and await ALS to arrive. This decision must be based on what is best for patient care.

LAW ENFORCEMENT REQUEST FOR EVALUATION

Law enforcement officials may call this service to evaluate the person or persons that they are engaged with for various reasons. When requested these calls for service should be treated as any other call based on the Dispatch information and requested unit (Ex: Transport unit vs. Supervisory unit).

As the circumstances allow it is acceptable to provide a tiered response in which a supervisory/intercept unit respond first to evaluate the need for on site assessment and care or further care and/or transport. Given the varying nature to these incidents it is the responsibility of the responding personnel to determine the specific needs to the patient. It is advisable, when able, to work with the patient and requesting agency when determining the needs of the patient.

CRITICAL INCIDENT STRESS MANAGEMENT

A critical incident is any response that causes personnel to experience unusually strong emotional involvement. A formal or informal defusing and/or debriefing will be provided at the request of medical authorities, management, EMS personnel or other responders involved with the incident.

Common Incidents

The following are examples of commonly found to be critical incidents (but not limited to):

- Serious injury or death of a crew member in the line of duty
- Suicide of a crew member
- Injury or death of a friend or family member
- Death of a patient under tragic or emotional circumstances or prolonged or intense rescue
- Sudden death of an infant or child
- Injuries to children caused by child abuse
- Injuries or death to civilians caused by EMS personnel
- An event that threatens your own life
- An event that attracts an unusual amount of media attention
- A multiple-casualty incident

Critical Incident Stress Debriefings should be held within 24-72 hours of a critical incident. In the event that a Critical Incident Stress Debriefing is needed, communicate with a supervisor, management or a member of the mental health team regarding the matter, they will assist in making arrangements.

Mental Health Team

In addition to being available for critical incidents such as those noted above the Spearfish Ambulance Mental Health Team has made themselves available to assist our membership with their mental health needs and to assist the families and bystanders of acute incidents.

The Mental Health Team may be requested through

Spearfish Public Safety Dispatch – 605-642-1300
SEAS Staff
Black Hills Counseling – 605-722-8090

REHABILITATION GUIDELINES

The flowing are general guidelines for involvement in standby and rehabilitation operation (rehab) at an emergency incident such as but not limited to:

- structural fire operations
- wildland fire operations
- hazardous materials incidents
- any other situation deemed necessary by the Incident Command (IC)
- trench rescue
- confined space rescue
- training exercises or special events

When requested to assist another agency it is advisable to communicate with the incident IC and/or Safety Officer to determine the specific needs of the incident (Ex: Simple Standby, Rehabilitation Operations). During this communication process it is advisable to determine if the agency has any specific rehab and/or medical guidelines pertaining to rehab and the return to duty. The flowing are intended to be guidelines only, each incident may require an altered approach.

On smaller incident rehab may be performed by and even in the responding ambulance or protected area. Larger incidents may require further resources. If assisting on a larger incident (Ex: federal wildland fire) work within the incidents command system and its operational guidelines.

Rehab operations are intended to ensure that all responders continue to operate within safe levels of physiological, medical and/or mental endurance. The intent of rehab is to lessen the risk of injury that may result from extended field operations under adverse conditions.

Rehab Function

When involved in rehab operations the crew may be used to evaluate and assist personnel who could be suffering from the effects of sustained physiological or mental exertion during emergency operations. The rehab team should provide a specific area where personnel can assemble to receive:

- a physical assessment
- revitalization—rest, hydration, and refreshments
- medical evaluation and treatment of minor injuries
- continual monitoring of physical condition
- transportation for those requiring treatment at medical facilities
- initial stress support assessment
- reassignment

Work with the IC and/or Safety Officer in an effort to ensure that the rehab area is safe, accessible and not a hindrance to ongoing operations.

All rehab operations should be approached as a team effort and collaborate effort between all agencies involved. For large or extended operations it may be necessary to additional resources such as those listed below. It is advisable to work with the IC and/or Safety Officer to determine these needs.

- Designated Rehab Supervisor
- Rehab vehicle
- Utilities (air/power/light)
- Canteen vehicle
- One or more EMS transport vehicles
- BLS and/or ALS personnel
- Critical Incident Management Team members / Mental Health Team

When establishing rehab operations it is advisable to consider the following when selecting the exact location of the rehab site:

- Ability to accommodate the number of personnel (fire, law enforcement, other) expected (including EMS personnel for medical monitoring) and accommodate a separate area to remove personal protective equipment (PPE).
- Accessibility for an ambulance and EMS personnel should medical treatment/transportation be required.
- Ability to be removed from hazardous atmospheres including apparatus exhaust, smoke, and toxins.
- Ability to provide shade in summer and protection from inclement weather at other times.
- Accessibility to a water supply (bottled or running) to provide for hydration and active cooling.
- Location away from spectators and media whenever possible.
- Consider use of alternant resources such as a bus or tent
- Consider the need for Critical Incident Stress Management (CISM)
- It is advisable to provide clear identification of entry and exit points for the rehab area.

Criteria for Reporting to Rehab

While each agency has specific policies related to reporting to rehab the following are based on national EMS and Fire operation standards and may be used as a guide during rehab operations. It is advisable to work with the IC and/or Safety Officer to determine the specific expectations for the given incident. Personnel should perform self-rehab procedures as follows:

- Following the use of one 30-minute SCBA cylinder
- After 20 minutes of intense physical labor
- Other times as necessary

Personnel should report to the rehab area as follows:

- Following the use of two 30-minute SCBA cylinders or one 45- or 60-minute cylinder
- After 40 minutes of intense physical labor
- After performing duties in hazardous materials encapsulating suits
- When directed by an officer to do so
- When feeling the need to do so

Rehab Operations

- **Entry to Rehab**

As responders report to rehab consider the following guidelines:

- Obtain the responders name and if needed identifying number or crew title
- It is advisable to collect each responders accountability tag (to be returned upon exit from rehab)
- Obtain the responders pulse
- If less than 120/min allow the responder to:
  - Rest
  - Hydrate with a minimum of 10 ounces of water or approved beverage
  - Eat food as needed

  If greater than 120/min evaluate the following:
  - Pulse
  - Blood pressure
  - Body temperature
  - Obvious injuries or illness
  - Hydration and Replenishment

For those responders with an initial pulse less the 120/min it is advisable that they remove coats, helmets, gloves, protective hoods and the like. These responders should remain in resting in rehab for a minimum of 20 minutes whenever possible. When well rested and hydrated may report back to their commanding officer for reassignment. If an accountability tag or other equipment was taken from the responder this should be returned prior to them returning to duty.

Medical Treatment and Transport

Those responders with an initial pulse greater than 120/min should be evaluated as noted above and required to remain resting in rehab for a minimum of 20 minutes prior to reevaluation. Based on this reevaluation the responder should be advised to either return to duty or be removed from duty. The IC and/or Safety Officer or responder's direct commanding officer should be notified of those members being advised not to return to duty. Every effort should be made to work with the IC and/or Safety Officer when making such a determination.
If the responder's condition warrants transport to a medical facility arrangements should be made for a transport unit to respond and the IC and/or Safety Officer should be made aware of the responder's condition.

HAZARDOUS MATERIALS / WMD GUIDELINES

Indications

- Responding to reported and/or known hazardous materials incident
- Vapor clouds, fire, smoke, leaking substances, frost lines on cylinders, sick personnel, dead or distressed animals and noxious odors are present on or near scene.

Precautions

- Senses are one of the best ways to detect chemicals, particularly the sense of smell. If you smell something you are too close.
- A safe approach to the scene is the first element of any EMS response. Unless you arrive safely at the site, you will not be able to perform your duties.
- Observe the site from a distance using binoculars, if possible, before you get too close. Look for danger signs such as vapor clouds, fire and smoke, placards, shape of vehicle or container, leaking substances, frost lines on

cylinders, injured personnel, and dead or distressed animals. These are key clues to warn you not to get too close. Remember that you want to be part of the solution, not part of the problem.

- If the fire department is already on the scene, report in to the incident commander.
- *If you are first on the scene and a hazardous material is suspected, request a hazardous materials team response. Keep yourself and your unit at a safe distance. This usually requires your unit to leave the scene, leaving patients and bystanders in a hazardous situation. Your safety comes first. Seek a location uphill and upwind from the incident.*
- EMS personnel should not be participating in patient decontamination unless trained and equipped to do so in a safe manner.

Guideline

- Your safety is the highest priority. EMS operations should be established in the cold zone (area identified to be safe). You should report to the incident commander.
- Position your vehicle to make a hasty retreat. You may be required to leave the scene to seek safety.
- The hazardous materials team should perform the initial assessment, treatment, and decontamination. Decontaminated patients should then be brought to the EMS unit.
- Once the situation has been assessed, notify the receiving hospital of the following information:
  - Location of the incident
  - Name of chemicals/products involved
  - Number of injured and contaminated
  - Extent of the injuries/contamination
  - Extent that the patients will be decontaminated in the field
  - Your estimated time of arrival
  - Other pertinent information that is available

Patient treatment is usually based on signs and symptoms. Specific patient treatment should be based on information obtained from related guidelines and contact with Medical Direction.

CRIME SCENE OPERATIONS

In an effort to minimize possible threats to EMS providers and to avoid unnecessary contamination of a crime scene or potential crime scene the following general guidelines have been established.

Safety and Access

Known or Suspected Crime at Time of Dispatch: This will typically result in a non-emergent response to stage in the area until law enforcement has secured the scene. In the absence of being notified, do not assume a scene is secure and take precautions as necessary to assure personnel safety.

Crime or Suspected Crime Discovered after Response: Law enforcement should be called to the scene immediately. An assessment should be made of possible threat to responders and if a threat exists, personnel should exit the scene immediately to a safe distance and wait for law enforcement assistance. If there is no immediate threat, patient treatment may begin, being mindful of potential returning threats.

Entry to the Scene of a Crime or Suspected Crime: entry to the scene should be made with the minimum number of personnel necessary to provide effective patient evaluation and treatment. Other personnel not required for treatment shall remain outside the scene.

Known or Suspected Violent Death: When responding to an incident where there is a known or suspected violent death and law enforcement is present the senior EMS provider should confer with law enforcement to determine the need for an evaluation of life status.

If the law enforcement officer is able to offer a clear description of obvious death, the EMS unit may leave the scene without entry and document the exchange completely. Note: Law enforcement obvious death criteria may differ from the EMS criteria.

If law enforcement is unable to offer a clear description of obvious death or is unsure, one (1) EMS provider should enter the safe scene with law enforcement approval and if possible escort to determine the patient's life status in accordance with related guideline.

Patient Care and Scene Operations (crime scene or suspected)

When involved in patient care and crime scene or suspected crime scene operation it is advisable to involve law enforcement in your duties and actions as a witness. The following general guidelines have been established in an effort to improve related operations.

While performing patient evaluation and treatment, precautions should be taken not to remove, move or otherwise disturb anything on scene except as is absolutely necessary to perform effective patient evaluation and care activities.

If it becomes necessary to move anything, it should be carefully moved out of the way, using caution to avoid unnecessary handling of the object. The original position of the object should be mentally noted and reported to law enforcement as necessary or requested. If possible inform law enforcement prior to moving the object. If a weapon is found or needs to be moved get assistance from law enforcement.

If it is necessary to look for medications on the scene use caution to move only the medications and note their original location, when possible involve law enforcement in this process.

Personnel should avoid moving about the scene unnecessarily or touching any object at the scene unnecessarily. When possible remain in the close proximity to the patient in an effort to avoid contaminating other areas.

When removing clothing from a patient avoid cutting through garments at or near bullet or stab wound holes or areas around these locations including areas with power residue or smudges.

If the patient has ligature or binding items around the neck, arms, feet or any other part of the body, do not remove them unless necessary to provide treatment. If the item must be removed, do not untie it; rather cut it off taking care not to cut through any knot. The original position and placement of the item should be noted.

If the patient is wearing jewelry, do not remove unless necessary to provide treatment. If items must be removed, the original position and placement of the item should be noted.

Clothing and personal property on the patient should be kept track of. When possible give removed items directly to law enforcement and/or leave on scene. Make every effort to limit the handling and manipulation or removed items and do not bag items unless directed to do so by law enforcement.

Avoid contact with blood/fluid on scene whenever possible.

In the event that the scene involves a motor vehicle crash make every effort to preserve the scene;

- Consider parking away from skid marks and/or debris
- When possible do not move objects without notifying law enforcement.

Consider avoiding the patient's hands and allow law enforcement to bag the hands as necessary in an effort to preserve evidence.

Disposable medical supplies and their wrappers/boxes used at the scene should not be cleaned up as normal. They should be left in place in an effort to avoid inadvertently "cleaning up" possible evidence.

Do not place equipment in gunshot or stab wounds (Ex: do not place needle through gunshot wound of the chest).

Any disturbance of the scene should be fully documented in the run report.

EMS providers may become custodians of verbal evidence while operating at a crime scene. An "excited utterance" or statement made in the heat of the moment is often times valuable. Throughout contact with a patient involved in a crime, keep in mind that such statements may be evidence. These statements should be noted and included in the patient care report. When charting these statements use exact quotes.

PATIENT TRANSPORT AND DESTINATION

Scene to Medical Facility Transports.

In general, patients should be transported to the closest medical facility that can provide the appropriate care of their specific illness, injury, or condition.

When more than one appropriate facility is available, and the patient is stable, patients may be transported to the hospital of patients choice. If the patient is incapable of making an informed choice, then the choice of a spouse, relative, guardian, or the patient's care giver or physician may be followed.

Patients, who by age are legally minors or individuals, who have been appointed guardians by the courts should be transported to the facility determined by the parent or guardian. Incarcerated patients should be transported to the facility designated by the responsible legal authority.

In the event of a natural disaster or multiple casualty incidents (MCI), an individual patient's choice for destination may not be honored. Rather, a patient distribution plan may be implemented for the incident that provides better utilization of the community's medical resources.

Consider the use of Life Flight services for transport of seriously ill or injured patients if significant time savings to life saving medical procedures or hospital destination can be accomplished.

Contact Medical Control for advice and determination of patient destination whenever the procedures listed above do not provide adequate direction.

Hospital Requests to Divert Patients.

When a destination hospital requests that a patient be diverted to another facility, the ambulance crew will inform the patient of the request.

Accepting a hospital's request to divert is a courtesy that the patient and ambulance crew provide the hospital.

The request to divert may be followed if the following criteria are met:

- The patient consents to being diverted to another facility.
- Another appropriate facility is willing to receive the patient.
- The additional time or distance that may be necessary to transport to another facility does not put the patient at risk or delay crucial treatments.

In the event of a natural disaster or multiple casualty incident (MCI), a hospital's request to divert patients will not be honored if casualties of the incident need to be transported from the pre-hospital setting to close hospitals to clear the scene or to provide patient stabilization.

PATIENT REFUSING TREATMENT/NON-TRANSPORT/CANCELED CALL

General Principles:

- Non-transport of a patient when EMS is called to a scene is one of the greatest areas of exposure to legal liability that EMS agencies and individual EMS providers face. The EMS provider is responsible for a reasonable assessment of the patient and situation to determine if there is injury or illness, or a reason to treat and/or transport. When a non-transport situation occurs, care must be taken to assure that procedures are followed correctly and the encounter is documented fully.
- An adult patient that has decision making capacity has the legal right to refuse treatment, evaluation and transport in spite of the fact they may be injured or ill. The minor patient does not have that same legal right to refuse, a parent or legal guardian must represent them.
- Non-transport situations generally fall into two primary categories: **Cancel** and **Refusal**.

Definitions:

- Cancels are calls where the response is discontinued prior to patient contact being made by EMS.
- Refusals are calls where patient contact is made by EMS personnel, but the patient(s) refuse treatment and or transport.
- When EMS personnel arrive on the scene of a call originally dispatched as an EMS call and after investigation find that no medical situation exists, these will also be categorized as Refusals for purposes of this protocol.
- A minor in SD is any patient less than 18 years of age.
- An emancipated minor in SD is any patient less than 18 years old that:
  Has entered into a valid marriage, whether or not such marriage was terminated by dissolution; or
  Is on active duty with any of the armed forces of the United States; or
  Has been declared an emancipated minor by the courts. An emancipated minor is treated the same as an adult.

Procedures:

Cancelled Call:

A. A response may be cancelled en-route to a call when a Police officer and or EMS agency already on scene advises to cancel. These cancellations may encompass a number of different situations, to include but are not limited to:
   1. MVA or other trauma call with no patients claiming injuries.
   2. Medical call where patient is refusing treatment and or transportation.
   3. Man down/unknown problem call where first response agency has determined patient to be public inebriate only and Law Enforcement will handle.
   4. Medical or trauma call where no patient has been found or patient has left the area.

Note: Use extreme care in the "no patient found" or "patient left the area" scenarios. It is not uncommon for even a seriously ill or injured patient to wander a short distance from the area where they were initially reported to be. As much as is possible, assure that a thorough search for the patient was done before cancelling. This is particularly true in the rollover MVA and assault situation.

B. Response to a MVA shall **not** be cancelled only on advice from Law Enforcement or civilians when they report no injuries. An evaluation must be done by EMS and they must advise no injuries before cancelling. An initial hot response may however, be downgraded to cold in this scenario.

C. Response may be cancelled on advice from Law Enforcement in the following scenarios:
   1. Reported MVA and LE has found no accident.
   2. Reported MVA and LE has found no one around the vehicle or patient has apparently left the area.
   3. Reported MVA turns out to be accident previously reported and already investigated.
   4. "Man down" or unknown problem is determined to be a public inebriate by LE and they will handle.

D. EMS personnel shall have the discretion to continue a response to a scene in spite of a first response and or EMS agency request to cancel if the request to cancel seems inappropriate or if the information appears to be incomplete, incorrect or inaccurate. Communication is the key, if you are uncomfortable cancelling based on what you've heard, continue and try to get more information.

Refusal:

A. In all refusal situations, EMS personnel shall perform as complete an assessment as the situation and the patient(s) will allow (see assessment / documentation guidelines below). The results of the assessment (or the patients refusal to allow one) shall be documented fully in the Patient Care Report (PCR). A refusal with no assessment and accompanying documentation is an area of extreme legal risk for EMS personnel.

B. When EMS personnel reach the scene of a MVA/other trauma call where patients are refusing service and:
   1. There are no patients claiming injuries or with any visible injuries.
   2. There are no patients requesting treatment and or transportation to a medical facility.
   3. There is no significant mechanism of injury to suggest a possible hidden injury.
   4. All affected patients at the scene are mentally competent, with decision making capacity.

If an assessment reveals no problems, EMS personnel may treat these patients as "involved not injured" and clear the scene, no **Refusal of Ambulance Services** form is required (this includes all minors). If an assessment reveals injuries, patient(s) shall be offered treatment and transport to a medical facility.

C. When EMS personnel reach the scene of a MVA or other trauma call where patients are refusing service and:
   1. There are patients claiming injuries or that have any visible injuries.
   2. There is any significant mechanism of injury to suggest a possible hidden injury.
   3. All affected patients at the scene are mentally competent, with decision making capacity.

   EMS personnel shall fully advise the patient(s) of the results of the assessment and of the risks of refusing treatment and transport and obtain a signed **Refusal of Ambulance Services** form for each affected patient before clearing the scene.

   If the patient(s) refuses to sign the **Refusal of Ambulance Services** form, it should be witnessed and documented fully in the Patient Care Report (PCR).

D. If a non-emancipated minor at the scene of a MVA/other trauma call is attempting to refuse service and has:
   1. Any visible/discovered on assessment injury; or
   2. Claims any injury; or
   3. Is involved in a situation where there is any significant mechanism of injury to suggest a possible hidden injury;

   That minor may not refuse service and may not sign a **Refusal of Ambulance Services** form. The parent or a legal guardian of a minor must refuse treatment and or transport for their minor children in person and the minor left in their custody.

   If a parent or legal guardian is not able to arrive in an expedient manner to handle the refusal and take custody of the minor, that minor must be transported to a medical facility. Do not wait on scene for extended periods of time waiting for a parent/legal guardian to arrive.

E. When EMS personnel reach the scene of a medical call where a mentally competent adult patient(s), with decision making capacity that had or has a chief complaint is refusing service; EMS personnel shall fully advise the patient(s) of the results of the assessment and of the risks of refusing treatment and transport and obtain a signed **Refusal of Ambulance Services** form for each affected patient before clearing the scene.

   If the patient(s) refuses to sign the **Refusal of Ambulance Services** form, it should be witnessed and documented fully in the Patient Care Report (PCR).

F. A non-emancipated minor at the scene of a medical call that had or has a chief complaint may **not** refuse service and may **not** sign a **Refusal of Ambulance Services** form. The parent or a legal guardian of a minor must refuse treatment and or transport for their minor children in person and the minor left in their custody.

   If a parent or legal guardian is not able to arrive in an expedient manner to handle the refusal and take custody of the minor, that minor must be transported to a medical facility. Do not wait on scene for extended periods of time waiting for a parent/legal guardian to arrive.

G. EMS personnel may treat and release an adult hypoglycemic diabetic patient, given that the following conditions are met:
   1. The patient must be a diagnosed diabetic being treated with a form of insulin.
   2. The patient must not be taking any oral agents for the control of their blood sugar.
   3. The patient must have had an initial blood glucose <**70** before treatment, and a blood glucose >**100** after treatment.
   4. The patient must not have exhibited any focal neurologic deficits before treatment with glucose.
   5. After treatment the patient must be exhibiting completely normal neurologic signs and have a Glasgow coma scale score of 15.
   6. The patient must have access to food, or a source of food must be provided to the patient before releasing the patient from care.

   Obtain a signed **Refusal of Ambulance Services** form before clearing the scene. See **Medical Guidelines: Diabetic Emergencies** for further information.

H. In circumstances where a patient, parent or legal guardians mental competency is obviously in question; or the obvious presence of alcohol or chemical intoxication is interfering with decision making capacity, contact with Medical Control to help sort out the situation is strongly suggested. Seek the assistance of Law Enforcement when necessary.

I. When EMS personnel respond to a scene where a **verified suicide gesture** has taken place, the patient(s) involved may not refuse service, they must be transported to a medical facility. If there is some dispute about whether or not the suicide gesture has actually taken place, investigate carefully and seek the assistance of Law Enforcement where necessary. Remember, patients that engage in suicide gestures many times have a reason to be untruthful, so do not rely on their word alone that a suicide gesture has not taken place.

J. When EMS personnel respond to the scene of a reported illness or injury and after an investigation and assessment find that no medical situation exists, a **Refusal of Ambulance Services** form is not appropriate.

Assessment / Documentation Guidelines:

A. In refusal situations, particularly those with patients refusing against medical advice (AMA), EMS personnel wherever possible, shall assess and document:
   1. Mental status i.e., orientation to person, place and time, and patients comprehension of the nature/severity of illness/injury and comprehension of the nature of treatment.
   2. Vital signs (ECG also if potentially cardiac related).
   3. Glasgow Coma Scale score.
   4. Any plan for alternative care.
   5. Risks of refusal up to and including death (inform patient).

B. In adult patients refusing an assessment who have a chief complaint, have sustained an injury or might reasonably be suspected to have sustained an injury:
   1. Evaluate the patient's mental status as to coherency/decision making capacity.
   2. Explain the significance of the mechanism of injury (if there is one).
   3. Explain the possible related complications of the illness or injury.
   4. Explain the possible consequences of the illness or injury if left untreated, up to and including death.
   5. Have patient read (or read it to them) and sign a **Refusal of Ambulance Services** form and document discussion in Patient Care Report (PCR) narrative. If patient will not sign, document the refusal to sign in the narrative as well

Additional Considerations:

A. EMS personnel should err on the side of contacting Medical Control in Refusal situations that are unclear or are not covered by this protocol.

B. Obtaining a signature on a **Refusal of Ambulance Services** form is always strongly encouraged when appropriate, because signing may be evidence of the patients decisional capacity and physical ability. However, remember that a signature does not relieve EMS personnel of the responsibility for a reasonable assessment and possibly treatment of the patient.

C. For the patient who is refusing treatment/transport against medical advice (AMA), providing the patient with clear instructions and warnings is imperative (having them read or reading to them the **Refusal of Ambulance Services** form is recommended). Having this form co-signed by a witness that is not an employee of SEAS is also recommended.

D. For Cancel situations that are unclear or not covered by this protocol, contact the Executive Director or designee.

INTOXICATED/INEBRIATED INDIVIDUAL

General Principles:

A. Medic Units will at times receive requests from Law Enforcement to perform a medical evaluation of the public inebriate. These requests are valid due to the fact that the public inebriate population has a statistically higher incidence of serious medical problems than most other segments of society.

B. Law Enforcement agencies use an arbitrary BAC number of .400 or .500 as a limiting factor to determine whether a subject is suitable for transport to a Detox facility. While these numbers may be suitable to determine if a subject is suitable for a particular facility, they are not suitable to determine if a subject requires transport to a medical facility by ambulance. The determination of whether or not one of these subjects will be transported to a medical facility by ambulance will be based on a clinical evaluation by the attending Paramedic and not on the BAC number generated by a portable breath tester.

C. This protocol pertains only to the encounter with the inebriated individual.

D. When requests for an evaluation of the public inebriate are received, refer to the following:

Procedures:

A. These requests will be processed through Dispatch and will receive a *cold* response unless triaged to a higher response by Dispatch.

B. In times of system overload, these requests will be triaged to a *delayed* response and will be handled as soon as resources become available. If at any time, Dispatch indicates a need for a higher level of response, that will place the call higher in the queue and it will be responded to as appropriate.

C. Requests for medical evaluation are not an unnecessary interruption of our daily operations; they are a very necessary part of the public safety net for a segment of the population that is unable or unwilling to seek mainstream medical care.

D. On arrival at one of these incidents, the Paramedic will obtain a complete history of the subject (who, what, when, where, how long) **make no assumptions.**

E. The determination of whether or not the subject will be transported by ambulance to a medical facility will be based on the following evaluation and parameters.

1. Complete history and exam finding the following:
   a. Subject must be easy to arouse
   b. Must have a minimum GCS of 14
   c. Must be ambulatory with minimal assistance and have no focal motor or sensory deficits. A complete exam of the individuals motor and sensory skills must be evaluated and documented.
2. Complete set of vital signs within the following parameters:
   a. Pulse **60-110**
   b. SBP **90-160**
   c. RR **12-25**
   d. O2 Sat **> 94%**
   e. Glucose **70-200**
3. Subject is **not** requesting transport to a medical facility.

F. If the above parameters are **not** met, the subject will be transported to the appropriate medical facility by ambulance.

G. If the above parameters **are** met, politely explain to the requesting agency representative that the subject does not meet our criteria for transport by ambulance. Brief them completely on your findings and your basis for declining to transport the subject. Further explain that if they still wish to have the subject transported to a medical facility after your evaluation, they will need to find alternative means to do so. All of this will be accomplished in a polite, professional, non-confrontational manner.

H. If at any time during one of these encounters, the subject requests transport to a medical facility because of an *injury or illness*, they will be transported by ambulance.

I. If the above vital signs assessment and evaluation are not able to be performed (or are not performed), the subject will be transported to a medical facility by ambulance UNLESS they are refusing the assessment and/or transport.

J. Document the encounter completely with vital signs, see **Patient Refusal/No Transport Guideline** for additional details.

Additional Considerations: A**lways err on the side of caution in questionable or unclear circumstances, it is medically-legally safer to transport someone to a medical facility that doesn't need to go than to not transport someone that does need to go.**

RADIO PROTOCOL

When calling Dispatch; identify them as 'Spearfish Control' or 'Deadwood Control'. This lessens the confusion on the dispatcher's side of identifying us from police or fire.

Hospital Report Format:

--Contact appropriate hospital personnel by radio or Cell phone.
--When the ER comes on line, identify service and unit number.
--Follow report format below, keeping report to about 90 seconds or less.

What **Happened:**

- ETA, patient age/sex, what happened. Patient's chief complaint, patient's own treatment. **Pertinent** medical history.

What you **Found:**

- Vital signs. - Level of consciousness. - Brief summary of physical findings. - EKG (as appropriate) - glucometer reading, etc.

What you **Did:** Treatment
What you **Have Now:** Note changes in patient condition after treatment.
What you **Want:** Questions or orders.

Terms used by dispatch;

- **Signal 1** - the term that is used for an automobile accident with injured patients.
- **Signal 2** - the term that is used for an automobile accident without injured patients.
- **Signal 20 -** The term that is used to indicate SUICIDE AT...
- **All Call** - this page will be used in cases of multiple victims or vehicles type accidents, disaster situations, and to alert a back-up crew when needed.

10 Codes Authorized by the Service;

- **10-4** OK, Affirmative, Will Do, Granted
- **10-8** In Service
- **10-10** Out of Service Subject to Call
- **10-22** Take No Further Action Last Information
- **10-33** - **DO NOT USE** - Emergency Traffic This Station, All Units Stand By
- **10-71** Send Coroner
- **10-97** Arrived at the Scene
- **10-98** Assignment Completed (i.e. back in quarters)

Use of **"plain English"** is preferred by dispatch and alleviates the problems when incorrect codes are used.

RESUSCITATION GUIDELINES AND ADVANCED DIRECTIVES

Purpose:

Situations may arise in which EMS personnel are called to evaluate an obviously-deceased patient. Cardiopulmonary resuscitation (CPR) may or may not have been initiated by bystanders, family members or other medical personnel. This protocol is designed to provide guidelines and criteria under which the PARAMEDIC may choose to discontinue or not to initiate CPR.

Decisions to Resuscitate:

Resuscitation procedures should not be initiated in patients if they present with any of the following:

- Decomposition.
- Rigor mortis (not to be confused with a hypothermic state) or marked dependent lividity.
- Decapitation or partitioning of body parts that is incompatible with life.
- Major traumatic injuries or significant physiological insults that would render the patients survival unlikely.
- For adult patients, when submersion asphyxia is known to have exceeded one hour of duration.
- Situations exceeding one hour should be handled as a body recovery **NOT** a rescue or resuscitation attempt.

Discontinuation of Resuscitation Efforts:

On arrival at a scene where CPR is already in progress on a patient for whom resuscitation is contraindicated, continue basic life support and contact Medical Control for orders before discontinuing.

When present, the patient's family should be considered when a decision to discontinue resuscitation is being made. It may be desirable to arrange a discussion between the family and the Medical Control physician.

Resuscitation efforts should generally be continued and the patient transported for unexpected infant and pediatric arrests.

Efforts may need to be continued for longer periods of time in cases of cold water drowning, hypothermia or lightning injuries.

Consider discontinuing resuscitation efforts when the crew cannot physically continue or when the health and safety of the crew is in jeopardy.

Advanced Directives:

Advanced Directives are written documents that provide specific instructions for the extent of care and treatment to be provided to an individual patient faced with health care or end of life decisions. Examples include living wills, do not resuscitate orders, Comfort ONE document, and hospice or limited care treatment plans.

Do-Not-Resuscitate (DNR):

Is an advanced directive issued by a patient's physician directing that CPR and advanced resuscitation procedures be withheld in the event of a cardiac or respiratory arrest. DNR orders are often an agreement instituted between a terminally ill patient and the physician. A DNR order is not a total refusal of medical care and allows for medical treatment and interventions until cardiac or respiratory arrest occurs.

SEAS personnel should honor DNR orders when the following criteria are met:

- A properly completed, written DNR order is presented before/during the clinical death of the patient.
- A valid DNR form can be used in lieu of direct medical control. A photographic or electronic copy is acceptable. The order must be dated and signed by the physician.
- On responses to medical facilities or on inter-facility transfers when a written DNR order is documented in the patient's record, signed by the physician, and is available for the crew to inspect. It is important that you have the document in hand and carefully review the DNR order yourself.
- The patient has not expressed to the crew their desire to rescind or cancel the DNR order. The patient has the right to request resuscitation. The wishes of family members or non-physician medical personnel contrary to a valid DNR order, do not take precedence.

An exception to the above criteria will be made if the patient's personal physician is in attendance with the patient and requests that no, or limited, resuscitative effort be initiated. If this occurs, CPR should be continued, the Medical

Control Physician immediately contacted, and the extent of resuscitative measures discussed by MCP and the attending physician or by the paramedic and MCP, if the attending physician is unavailable.

Other advanced directives that are not specific DNR orders, may not apply in the pre-hospital setting or outside of a licensed medical facility.

When presented with other types of orders such as do not intubate, hospice or palliative care only, living wills, or any other limited care plans, consultation with the patient's physician or Medical Control is advised before withholding customary patient care.

If the validity of a DNR order is uncertain, or if a DNR order is presented when the patient's arrest is due to unusual, suspicious, or unnatural causes, or if there is disagreement among the patient's family about what care to provide or withhold, contact Medical Control for direction.

Documentation:

In non-traumatic deaths, all non-resuscitation or stopped resuscitation cases will have an EKG strip attached, if possible, to the field report which shows (a) calibration of the EKG machine, (b) the patient's rhythm/cardiac activity and (c) confirms absence of cardiac activity in two leads.

Patient care documentation will include the time procedures are performed, the procedures performed, conversations with physicians, to include physician's name, time and instructions.

The PARAMEDIC will place the following information on the rhythm strip:

- Patient name, Date, Paramedics initials
- *A rhythm strip is not required if all of these criteria have been met in a blunt trauma patient: (If rhythm strip has been done, include it with report.)
  - Downtime known to be greater than ten minutes.
  - Evidence of obvious, severe blunt trauma.
  - No pulse, no blood pressure, no neurological function, and no respiratory effort.
  - No bystander/1st responder CPR efforts have been performed.
  - CPR should not be discontinued on infants, children and you adults, or in patients in whom an unexpected death has occurred, unless signs of obvious prolonged death are present.
  - All hypothermic patients, victims of electrocution, lightning strikes, and cold-water drowning (if greater than two hours, contact Medical Control) should have resuscitative efforts begun with transport to the hospital.
  - If a situation should arise outside the scope of this protocol, the Medical Control physician should be contacted for specific orders. Any decision to determine death in the field should be made only after consultation with the patient's physician and/or medical control physician.
  - Notify Medical Control in those uncertain situations where resuscitative measures have been initiated but the PARAMEDIC feels the patient meets criteria to discontinue efforts. Explain the situation to the MCP. If he/she agrees that resuscitation should be terminated, the PARAMEDIC will notify the coroner immediately for directions in disposition of the body.
  - Care must be exercised to not unnecessarily disturb the scene. DO NOT remove EKG patches, pick up material, etc. that could potentially alter the scene.

MCI / Disaster Plan

A MCI / Disaster could be any situation that exceeds a responding units ability to deal with the incident.

The initial notification that an "Event" has occurred can be received by local dispatch. Many MCI / Disaster events can occur outside SEAS initial response district. We will respond to these "Events" as agreed upon in local, regional or state mutual aid agreements.

Team members have roles and responsibilities that will be outlined later in this guideline. Some team members may have multiple responsibilities during an "Event". Following the ***START*** Triage guidelines is paramount in any "Event" where local resources have been exhausted. With "Events" that have exhausted local operations all patient treatment protocols will operate strictly on standing orders with verbal orders included. With a MCI/Disaster event there is no distinction made between ALS or BLS units.

During field triage, should a victim be declared in the *BLACK Triage Category*, it is imperative that the deceased remain where found, as this is considered a crime scene and preservation of evidence is paramount.

Following the incident, a thorough debriefing will occur with all agencies involved. All suggested revisions of the MCI / Disaster plan will be reviewed and implementation initiated if appropriate.

ON SCENE MEDICAL OFFICERS - Role and Responsibilities Outline

EMS Incident Commander: this is the senior crewmember or team captain that arrives on scene in the "first" unit. This person will have the leadership role in directing operations at any "Event" that exhausts local resources. EMS Incident commander may also be the Communications Officer or Public Information Officer on scene. A management team member or their designee can hold this post.

- Establish a Unified Command with Police and Fire.
- Coordinate and Assess overall medical response.
- Provide incident updates to Incident Commander.
- Requests additional resources.
- Provides direction to other On Scene Medical Officers and EMS personnel.
- Returns teams & equipment to service as needs allow.
- Coordinates efforts with other Public Safety agencies.

Communications Officer: this is a senior crewmember or team captain of the first on scene unit; he or she may be replaced by senior crewmember of the second on scene unit. This person is responsible to the EMS Incident Commander.

- Reports to the EMS Incident Commander
- Coordinates efforts with on scene Medical Officers.
- Maintains communication with:
- Primary receiving hospital
- Mutual Aid ambulances
- Maintains the availability of beds
- Determines the need for onsite CISD or defusing and accesses services.

Triage Officer: this is the paramedic or EMT of the "first" on scene unit. This person will coordinate the Triage and Transportation areas. This person is responsible to the EMS Incident Commander.

- Reports to the EMS Incident Commander.
- Start the START Triage system
- Directs patient care activities
- Determines evacuation of patients
- Coordinates activities with Transportation Officer.
- Arranges for specialty care on scene
- Helicopter evacuation
- On scene physician services

Transportation Officer: this is a crewmember of the second on scene unit.

- Reports to the EMS Incident Commander
- Establish transportation area adjacent to triage area
- Coordinates mutual aid units
- Records patients disposition
- Establishes a supply depot
- Coordinate securing a helicopter-landing zone, if needed
- Secures alternative transportation methods

The EMS Incident Commander or Team Captain can determine other on scene medical officers which may include Staging Officer, Red, Yellow, or Green Treatment Officers, Rehab Officer, or others.

START - (Simple Triage And Rapid Treatment) *Check your **RPMs***

Respiration's

None - Open the Airway

Still None? - **DECEASED**
Restored?- **IMMEDIATE**

Present?

Above **30** - **IMMEDIATE**

Below **30 – CHECK PERFUSION**

Perfusion

Radial Pulse Absent or

Capillary Refill > **2** secs

IMMEDIATE

Radial Pulse Present or

Capillary Refill ≤ **2** secs

DELAYED

Mental Status

Can Not Follow Simple Commands (Unconscious or Altered LOC)

IMMEDIATE

Can Follow Simple Commands

DELAYED

Respiration's 30

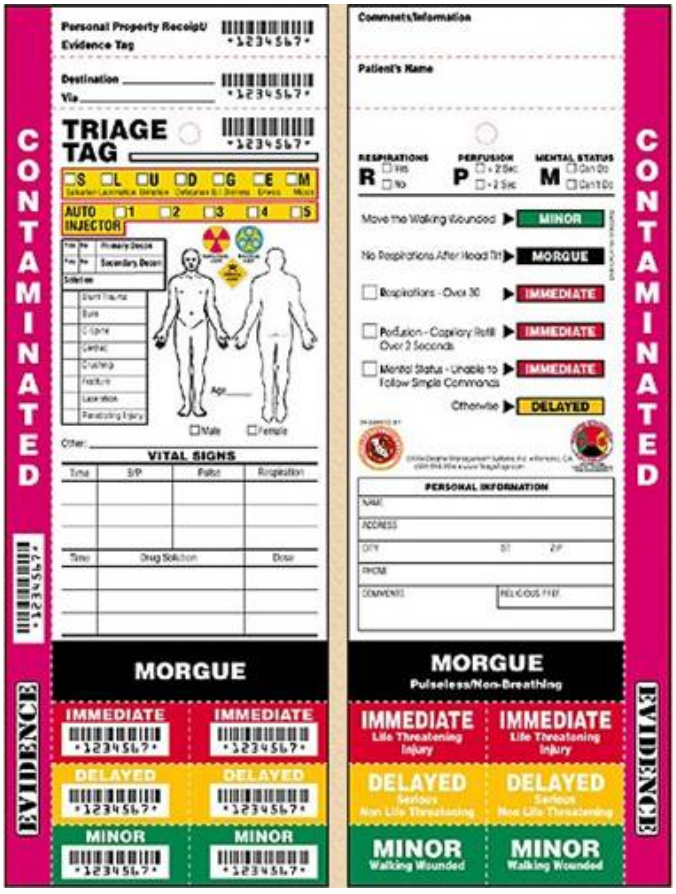
Perfusion 2

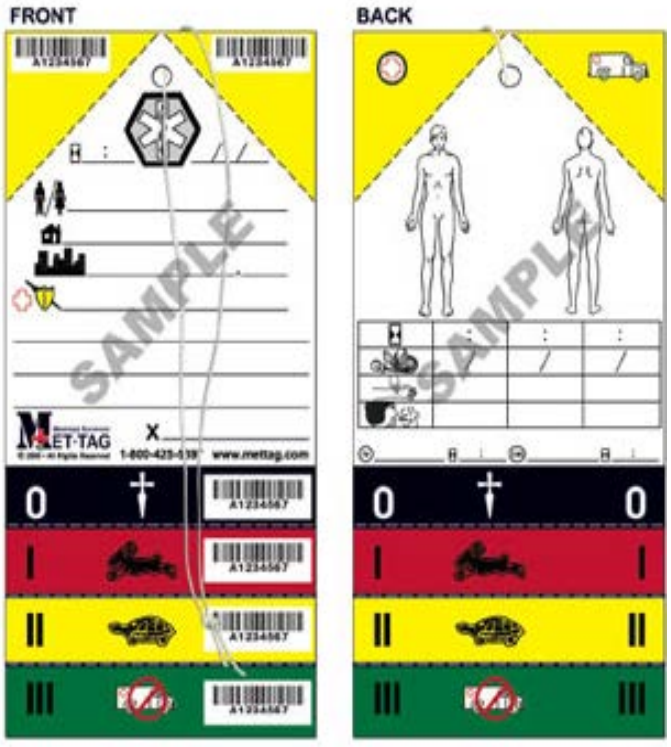
Mental Status *CAN DO*

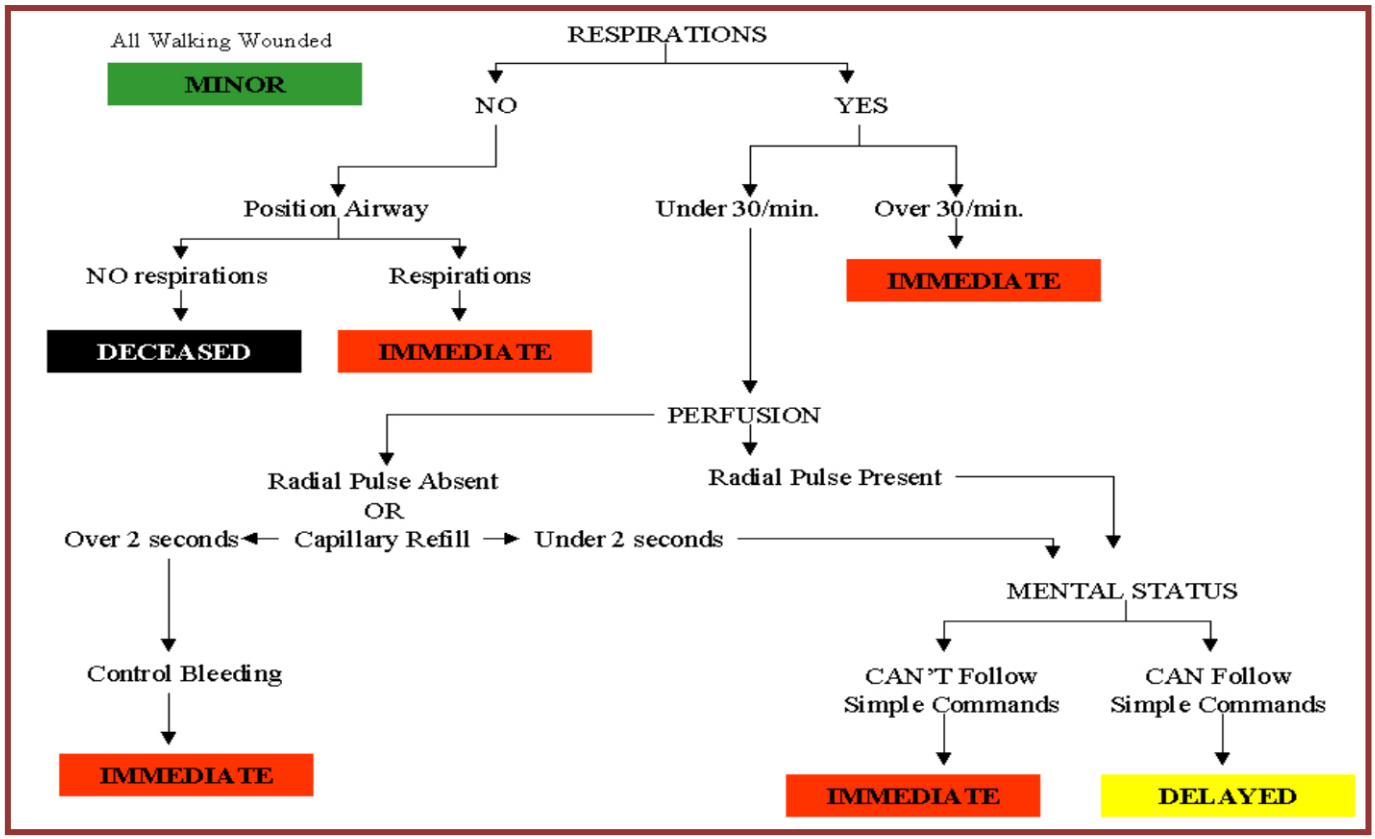
START

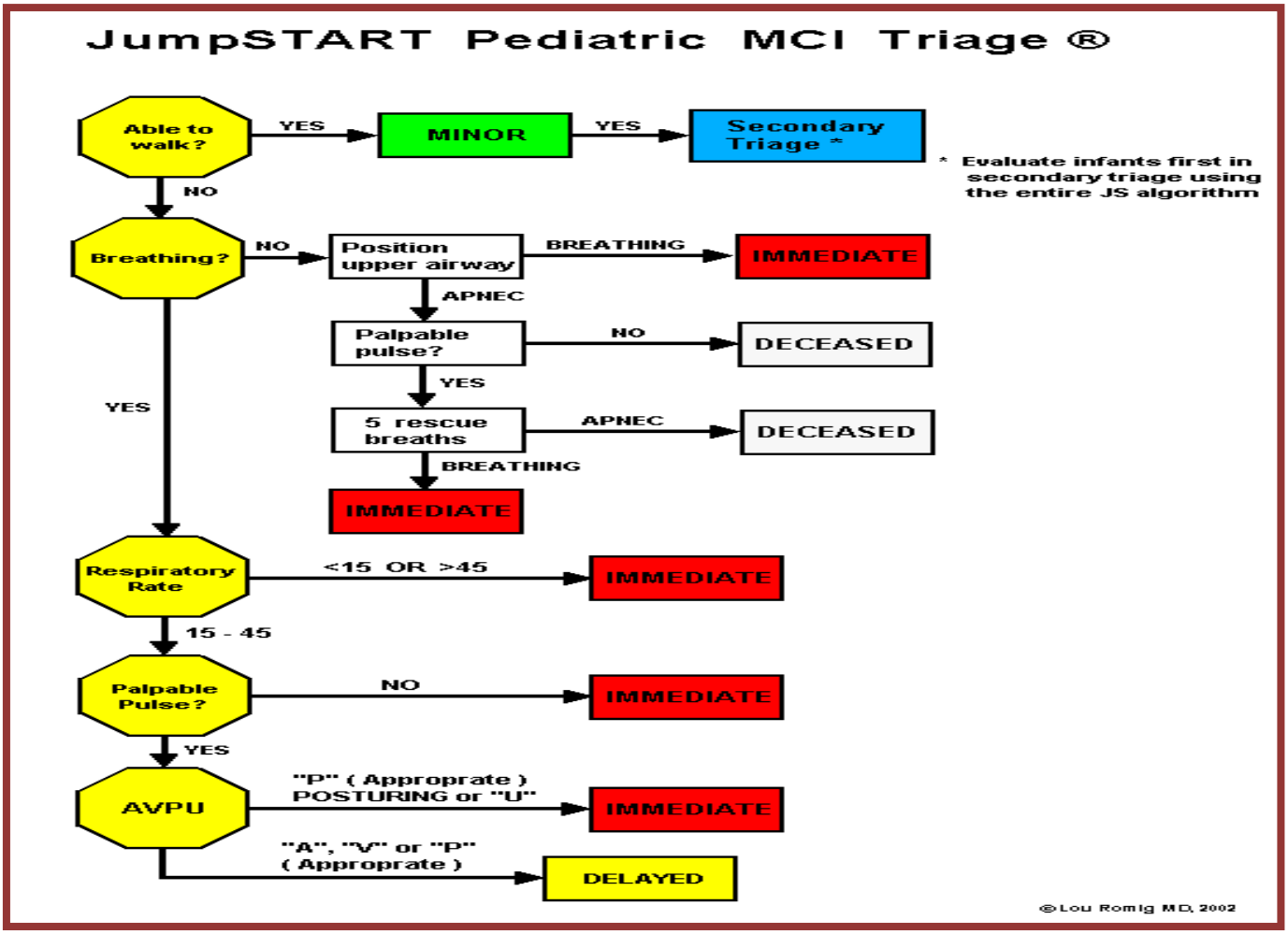
IF THE PATIENT IS **IMMEDIATE** *(PRIORITY 1) UPON INITIAL ASSESSMENT; ATTEMPT TO CORRECT AN AIRWAY BLOCKAGE OR UNCONTROLLED BLEEDING ONLY BEFORE MOVING ON TO NEXT PATIENT.*

The **START** process allows for very few rescuers to rapidly triage a large number of patients without specialized training.






All Walking Wounded
MINOR
RESPIRATIONS
NO
YES
Position Airway
Under 30/min.
Over 30/min.
NO respirations
Respirations
DECEASED
IMMEDIATE
IMMEDIATE
PERFUSION
Radial Pulse Absent
OR
Over 2 seconds
Capillary Refill
Under 2 seconds
Radial Pulse Present
MENTAL STATUS
Control Bleeding
CAN'T Follow Simple Commands
CAN Follow Simple Commands
IMMEDIATE
IMMEDIATE
DELAYED


JumpSTART Pediatric MCI Triage ®
Able to walk?
YES
MINOR
YES
Secondary Triage *
* Evaluate infants first in secondary triage using the entire JS algorithm
NO
Breathing?
NO
Position upper airway
BREATHING
IMMEDIATE
APNEC
Palpable pulse?
NO
DECEASED
YES
YES
5 rescue breaths
APNEC
DECEASED
BREATHING
IMMEDIATE
Respiratory Rate
<15 OR >45
IMMEDIATE
15 - 45
Palpable Pulse?
NO
IMMEDIATE
YES
AVPU
"P" (Approprate) POSTURING or "U"
IMMEDIATE
"A", "V" or "P" (Approprate)
DELAYED
©Lou Romig MD, 2002

MCI PREPLAN

PURPOSE

- EMS providers operating in this EMS System will utilize the National Incident Management System (NIMS), Incident Command System (ICS) principles and shall implement the protocol anytime:
  - There are five or more patients involved in an EMS call/response.
  - There are more than three critical patients.
  - There are more patients than readily available resources.
  - The potential for multiple patients is likely to exist (e.g. Fire/Rescue scenes, HAZMAT scenes, firefighter rehab operations, high risk law enforcement operations, public events/gatherings and motor vehicle crashes, etc.).
- Implementation of ICS improves a patient's chance for recovery and survival through the establishment of a well-organized, clearly defined management structure that insures a timely and optimal utilization of emergency resources.
  - Early, patient-specific clinical notification to hospitals will improve the opportunity to prepare for each inbound patient.
  - The goal is to minimize out-of-hospital time while optimizing pre-hospital care.

PROCEDURES

- **Incident Command:** Once the first EMS unit is on-scene (with capable communication equipment), and it is determined that an MCI exists, the "in-charge" provider will:
  - Declare MCI and level
  - Declare tactical channel.
  - Establish **"Incident Command" (IC)** if it has not already been established by other disciplines (e.g. Fire, Law Enforcement, etc.).
    - In the event that IC has been established (by other disciplines) and prolonged extrication or delayed response may require extended EMS involvement, a **"Unified Command"** shall be established with Medical Group, Extraction Group and Suppression Group establishment.
    - Transfer of "Incident Command" can occur whenever a more qualified provider arrives on scene.
    - Establishment or transfer of command and location of the command post must be broadcast to the Lawrence County or Spearfish 911 Dispatch Center.
  - Utilize all available information (e.g. dispatch, law enforcement, bystanders, etc…) to request the response of additional specific emergency resources at the earliest indication of need. (e.g. helicopter stand-by or launch, ALS response, fire/rescue, EMS Coordinator, dive team, law enforcement, etc…)
  - Establish scene safety (reassessment of scene safety should be ongoing).
  - As the first-in-EMS unit arrives, broadcast a "size-up" to include what you can see or what you are told: (e.g. number of vehicles, actual or potential hazards, number of patients and a description of the scene, etc…)
  - Don the medical command vest.
  - Initiate a detailed scene survey and if safe begin Triage operations (START Triage, JumpSTART Triage).
  - Organize Treatment and Transport areas as needed.
    - Plan to need a minimum of 1 transport per one **RED** patient, two **YELLOW** patients or four **Green** patients.
    - Additional EMS resources respond emergent unless otherwise directed, report to staging area and check in with IC/Staging/Transportation before providing service on-scene.
  - Establish and maintain early contact with hospitals. Develop a specific contact at each hospital (Command Physician or Charge RN) in order to maintain consistency and accuracy of information.
    - Consider continuous, open-line of communication with hospital.
    - Provide Hospital Medical Command physician with event details, number of suspected patients, nature of injuries/illness, contamination, special needs, etc.
    - Ascertain Emergency Department capacity for each hospital.

- Provide updates as they become available.
- Consider appointment of a dedicated "Hospital Communications" EMS provider to maintain contact with hospitals.
- Consider notification of out of area hospitals for larger incidents (Consult with EMS Coordinator Staff).

THREE LEVELS OF MCI

- Level 3 MCI

  Criteria

  - Incident requires more than initial responding ambulance or agency
  - 5 or less patients anticipated on initial triage.

  IC/ Medical Group responsibility:

  - Request additional resources
  - Notify hospitals of anticipated patients via Medical Control

  Lawrence County or Spearfish 911 Dispatch responsibility:

  - Move on-duty resources to cover zones with transport units.
  - Tone Spearfish Fire & EMS senior staff for advisement

- Level 2 MCI

  Criteria

  - Incident requires more than initial responding ambulance or agency
  - 6 to 10 patients anticipated on initial triage.
  - County wide impact.

  IC/ Medical Group responsibility:

  - Request additional resources- closest available
  - Notify hospitals of anticipated patients via Medical Control
  - Establish triage unit

  Lawrence County and/or Spearfish 911 Dispatch responsibility:

  - Move on-duty resources to cover zones with transport units.
  - Activate inter-county mutual aid as needed to provide coverage.
  - Tone Spearfish Fire & EMS senior staff for advisement
  - Dispatch Spearfish Fire & EMS staff to Spearfish Regional to assist.
  - Dispatch up to 4 transports to scene.

- Level 1 MCI

  Criteria

  - Incident requires more than initial responding agency
  - 11 or more patients anticipated on initial triage.
  - County wide EMS and hospital impact.
  - May require round-trip transporting.

  IC/ Medical Group responsibility:

  - Request additional resources- closest available.
  - Notify hospitals of anticipated patients via Medical Control.
  - Establishes triage unit.
  - Consider using MCI trailer.

  Lawrence County and/or Spearfish 911 Dispatch responsibility:

  - Move on-duty resources to cover zones with transport units.
  - Activate inter-county mutual aid as needed to provide coverage.
  - Tone Spearfish EMS senior staff for advisement.
  - Dispatch Spearfish EMS officers to Spearfish Regional to assist.

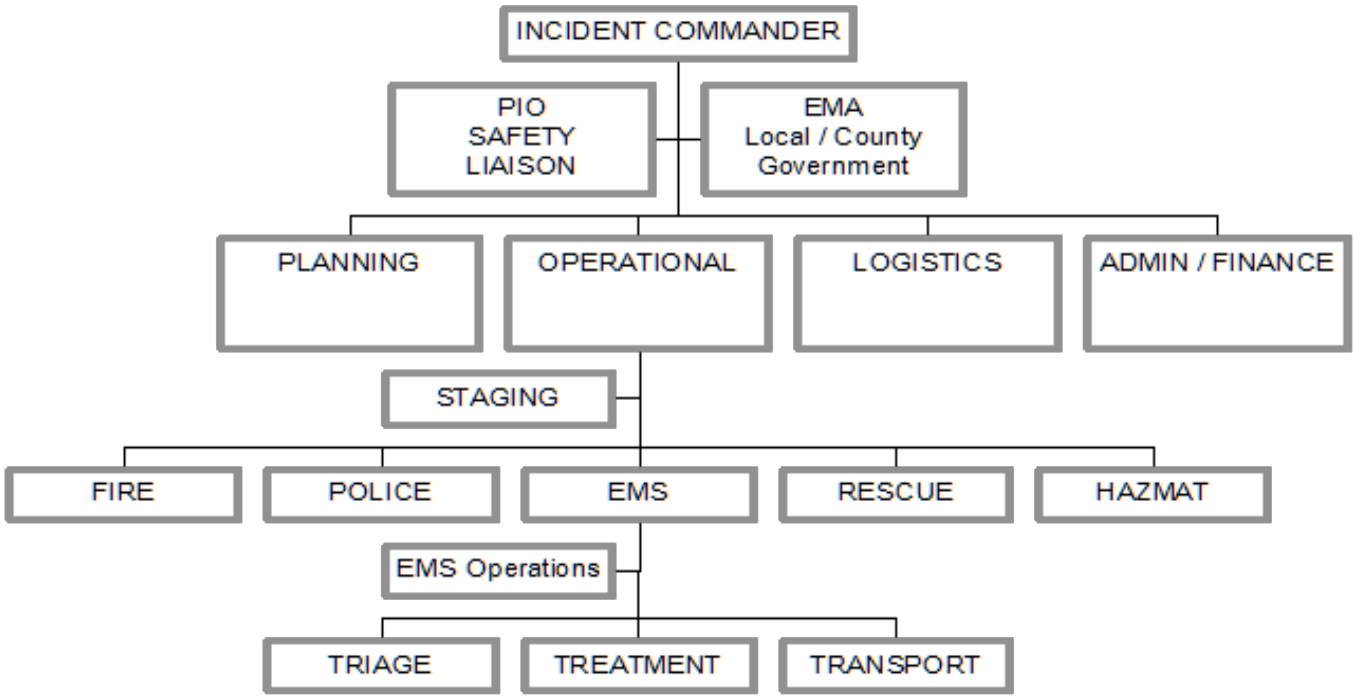
- Dispatch Spearfish EMS officers to Lawrence County Dispatch to assist.
- Dispatch 4 or more transports to scene.

EMS ZONE COVERAGE DURING MCI

Guidelines

- Dispatch uses the on call and stand-by units, paging out any available crew members
- Whitewood EMS will be paged for assistance on I90 to the east.
- Belle Fourche & Sundance EMS will be paged for assistance on I90 to the west.
- Belle Fourche EMS may respond one ambulance to an incident north of Spearfish.
- Deadwood EMS will be paged for assistance to the south on Hwy 85 past Crook City Rd

MEDICAL INCIDENT MANAGEMENT PROTOCOL



TRANSPORT DESTINATION POLICY

INCLUSIONS AND GUIDELINES

All Units

- All patients who are medically unstable, such as with compromised or uncontrolled airways, unstable arrhythmias, imminent delivery of complicated newborns, uncontrolled bleeding, uncontrolled hypotension or dangerous patients, should be taken to the closest receiving facility (generally SPEARFISH REGIONAL).
- Code “Yellow” and “Green” patients will be transported to a facility in the following order of preference:
  - Patient’s physician preference (verify with physician’s office)
  - Patient preference
  - Caregiver with medical power of attorney request for incompetent patients
  - Closest Facility

- For any patient transported to any out-of-county facility, contact the on-duty EMS Operations Supervisor in order to obtain permission to transport to an out-of-system and or an in-system out-of county hospital. The transport decision will be based upon proximity to an in-system hospital and the availability of other Spearfish EMS units to provide coverage in the event permission for out-of-county transport is granted. When it is determined that such requests for transports outside of Spearfish would unreasonably remove the ambulance unit from the primary service area, the patient may be transferred to the closest hospital capable of treating that patient.
- In determining the closest appropriate facility, transport personnel should take into consideration traffic obstruction, weather conditions or other factors which might affect transport time.
- Where question exists concerning the appropriate patient destination, On-Line Medical Control shall be contacted.

ALS Field Units

- Code "Red" or un-resuscitated code "Blue" patients should go to the closest facility (generally SPRH).
- Code "Red" Trauma, CVA/stroke, therapeutically cooled post arrest and STEMI patients who are not medically unstable should be transported and managed according to specific Spearfish EMS System Patient Care Treatment Guidelines for such patients. If prolonged field time is anticipated, discuss with Medical Control and consider Air Medical Transport from the Spearfish Regional Hospital helipad, with Spearfish Regional ED evaluation while awaiting transport, when deemed more appropriate by Medical Control.

BLS and ILS Units

- Code "Red" or "Blue" patients should be transported to the closest accredited emergency facility (generally SPRH), with ALS intercept/assist when possible as long as field time is not significantly extended.
- Code "Red" patients will not be transported to out-of-county facilities unless joined (when possible) by a Spearfish EMS Paramedic.
- All code "Red" patients will be discussed with Medical Control.
- Prearranged non emergent transports (NETS) may be taken out of the county, but must be cleared with the on-duty EMS Operations Supervisor in order to obtain permission to transport to out-of-system and out-of county facilities.

Exclusions

- Patients not to be transported by ground ambulance include:
  - Refusal of Care.
  - Death in the Field/ Cessation of CPR, DOA.
  - Patient more appropriately transported by Air Medical Transport.

Miscellaneous System Issues

- Hospitals with ER, ICU/CCU, or catheterization lab diversions for whatever reason will occasionally require alterations in transport destination. Contact Medical Control in these situations to arrange the next best destination for the patient.
- Emergency ambulance transport shall only be provided to acute care facilities accredited by the Joint Commission on Accreditation of Hospitals. In rare instances, transport of a stable, competent patient may be provided to a private physician's office or clinic at the request of a private physician. Contact the on-duty EMS Operations Supervisor *and* on-line medical control in order to obtain permission. (This does not include prearranged non-emergency transports (**NETS**) at the order of a physician).
- If no patient or physician preference is expressed, and the medical problem is not specifically otherwise covered in these policies, patients shall always be transported to the closest appropriate facility. The Medical Control Physician (MCP) may direct that the patient be transported to a more distant hospital, which in the judgment of the MCP is more appropriate to the medical needs of the patient.

- Spearfish Regional, Lead-Deadwood Regional and Sturgis Regional Hospitals will be the only in-system hospitals authorized for direct patient pre-hospital EMS ground transport, excluding NETS and instances of Notice of Hospital Diversion.
- Spearfish Regional Hospital Emergency Physicians are contracted to provide on-line Medical Control for Spearfish EMS System and Spearfish Regional Hospital is the only in-system and in-county hospital accredited for acute care.
- Any Hospital unable to accept patients due to an internal disaster shall be considered "Not prepared to receive emergency cases".
- In the case of trauma, if transporting via ground ambulance is necessary, the receiving hospital shall be notified as soon as possible in these situations to ensure rapid notification of appropriate resources. Spearfish Regional is the designated in-county local Trauma Facility. Rapid City Regional via air Medical Transport is the next closest regional Trauma Facility and is the preferred destination for pediatric patients that meet trauma criteria.

ST ELEVATION MI (STEMI): Patients with acute chest discomfort, and a field 12-Lead EKG with at least 2 mm ST elevation in 2 contiguous leads, should be transported and managed according to the Spearfish EMS STEMI Alert Plan, and STEMI Guidelines, following contact with Medical Control. Rapid City Regional is the closest regional hospital with interventional catheterization lab capabilities for acute percutaneous intervention (PCI). Early notification of the receiving hospital (STEMI Alert) is critical to ensure rapid notification of appropriate resources (Interventional Cardiologist and catheterization lab activation).

SUSPECTED CARDIAC CHEST PAIN: A patient with chest discomfort relieved by NTG, without other symptoms, and without EKG changes shall follow the standard transport destination protocol.

ACUTE STROKE: Patients with suspected Acute Stroke symptoms (Los Angeles Prehospital Stroke Scale), without hypoglycemia and have a confirmed time of onset of symptoms of 0-3 hours should be transported according to the Spearfish EMS System Suspected Stroke Guidelines and contact Medical Control. Early notification of the receiving hospital (Stroke Alert) is critical to ensure rapid notification of appropriate resources.

INTER-FACILITY TRANSPORTS: Physician ordered inter-facility transport shall be to the hospital directed by the transferring physician. In all cases, to comply with EMTALA/COBRA regulations, the physician or designee must write the order, and the receiving physician must be specifically documented. If during transport the patient deteriorates beyond the provider's ability to effectively manage, the provider may divert to the closest appropriate hospital.

PREGNANT PATIENTS: A pregnant woman who has received pre-natal care and has an established physician may be transported to the in-system hospital of choice. Spearfish EMS personnel have the option to transport patients with imminent deliveries to the closest appropriate facility

MCI: In the event of a Mass Casualty Incident (MCI), the medical authority/chain of command, Incident Commander, or his designee shall dictate patient hospital destination. If the patient or attending physician requests transport to a facility not consistent with the above guidelines, the request will be honored only after informing the patient, responsible person or physician of the unavailability of certain services at that facility, and Medical Control will be notified of this decision. If the patient demonstrates impairment of judgment related to injury, shock, drug effects, or emotional instability, the Paramedic will act in the patient's best interest and transport to the most appropriate facility.

QA Parameters:

- ✓ Spearfish EMS will review the outcome and care of all patients that met field criteria for Trauma, STEMI, or Acute Stroke that were treated and transported.

BLACK HILLS LIFEFLIGHT - HELICOPTER UTILIZATION

It is a medically accepted fact that the rapid transport capabilities of the helicopter can reduce the morbidity and mortality of the seriously injured or ill patient in the pre-hospital setting. This is especially true in a primarily rural setting such as western South Dakota

Purpose: It is the purpose of this procedure to detail the actions of Spearfish Emergency Ambulance personnel (both ALS and BLS) when considering a request for a scene response by a helicopter during medical and rescue incidents. It is imperative that these requests for scene response are appropriate and operations involving them are conducted safely. This procedure will primarily be directed toward the use of the LifeFlight helicopter resource, but can apply to military helicopters as well.

Operational Procedures: Following are some pertinent points to consider, and some guidelines that shall be followed if you find yourself considering requesting a scene response by LifeFlight or National Guard helicopters.

The LifeFlight helicopter may not always be available for scene response on an immediate basis; it will occasionally be transferring patients into RCRH from the outlying localities.

The National Guard Aviation unit is **not** a 24-hr. on-call service. At times they can fly almost immediately, at other times it may take them two hours or more to put a helicopter in the air. This being dependent on the time of day, day of week, time of year, weather, etc.

Whenever a response by the LifeFlight or National Guard helicopter is considered, the first piece of information that should be gathered is whether or not the helicopter is immediately available and the time required to launch the helicopter and fly to the scene. This information can be obtained through Dispatch. This estimated time should be compared to the time it will take to utilize ground transport. If a rescue can be affected and ground transport can take place in a shorter period of time, a helicopter should not be called**.**

Under no circumstances should transport of a patient be delayed to use a helicopter for transport.

A request for a scene response by a helicopter should only be considered for the patient with a **life-threatening injury or illness** requiring rapid transportation in order to sustain life, or prevent aggravation of the injury or illness.

A request for a response by a helicopter may be considered in the instance of a patient in a remote, difficult to access by ground, area. This patient's injuries or illness may or may not be life-threatening, but a removal by ground may take such an extended period of time that removal by air is a better option for the patient.

In situations where rescue personnel are considering a vertical extraction by helicopter and a hoist may be needed, keep in mind that the Guard helicopters are not always set up with a hoist. If Guard personnel have to install a hoist before a helicopter is put in the air, it may take an extended period of time and a ground extraction and transport may be more expedient.

The Paramedic or senior crewmember on scene at an incident or responding to a scene may at their discretion, request a scene response by the LifeFlight helicopter. Any such request will be made through Dispatch, keeping in mind the parameters mentioned above.

Consideration should always be given to possibly utilizing helicopter transport during a Mass Casualty Incident (MCI) keeping in mind the same time frame parameters mentioned previously. The use of helicopters during a MCI will be at the discretion of the IC (Incident Commander) or his designee.

The transition of patient care from the attending Paramedic or other crewmember on scene to LifeFlight personnel will be the same as any other situation where patient care is transferred. The crewmember on scene will give a complete face-to-face verbal report to the LifeFlight crewmember that will be responsible for the patient's continued care. In the instance of National Guard helicopter usage, the attending Paramedic or crewmember will accompany the patient to the hospital in the helicopter.

All circumstances surrounding a request for a scene response by a helicopter will be fully documented in patient care reports.

Landing Zone Procedures:

Ground EMS units, when requesting a scene response by a helicopter, should utilize available personnel to locate a suitable LZ at or very near the incident site. In all cases where a scene response has been requested, the Fire Dept engine company (from the jurisdiction where the incident occurred) can be detailed to LZ operations.

A safe landing zone should be established prior to the helicopter's arrival by LZ operations. In the event that the unit assigned to LZ operations experiences difficulties finding a suitable LZ, they should wait until the helicopter arrives. The helicopter will have a better vantage point in choosing an LZ and they will advise LZ operations. In the event that the LZ is remotely located and appears to be safe for landing, the pilot may elect to land without the assistance of LZ operations. This does not mean the unit assigned to LZ operations should be cancelled; they will be utilized for security, safety, and possible assistance with patient loading once the helicopter is on the ground.

When setting up an LZ there are several things to keep in mind:

The pilot will generally determine how small an area he can safely land in, the bigger and freer of obstructions the area is, the better. Keep in mind that wires are very difficult to see from the air, especially at night. An area 100' larger than the rotor tips in all directions is a good starting point.

The LZ should be set up as to facilitate takeoffs and landings into the wind. Do not rely on Dispatch for correct wind direction, use visual indicators.

The approach and departure ends of the LZ should be clear of obstacles (any object>40 feet tall that is within 100 feet of the LZ.

Any and all, loose articles (wood, cans, plastic, etc) in the vicinity of the LZ that potentially could be affected by rotor down wash need to be secured or removed. Flying debris can damage both the helicopter and personnel on the ground.

If the LZ will be on a surface other than pavement, to minimize the hazard of blowing dirt, dust and sand, the LZ should be wet down as necessary. If the LZ will be on snow, an attempt should be made to clear the snow from the area to prevent it from obscuring the vision of the pilot.

No unauthorized person will be permitted to approach the helicopter. This will be the general responsibility of LZ operations.

The pilot is both legally and operationally responsible for the safety of the aircraft. Therefore, the final decision on the suitability of the LZ is that of the pilot.

Safety Procedures: Safety should always be of paramount concern when addressing operations involving helicopters. The first question you should ask yourself when you're considering the use of a helicopter is, "can this be done safely?" The helicopter is not inherently dangerous. The danger manifests itself in the form of people not understanding the potential hazards that exist on or near the helicopter. Following are a few basic safety rules to impart a basic understanding of where the potential dangers exist, and how to work around helicopters safely and effectively. Above all: **Stay Alert!!!**

Absolutely no personnel will approach the helicopter until given an "all clear" by a helicopter crewmember, and then approach only in the pilot's field of vision.

Unless required to be closer, persons should stay 100' away from large helicopters at all times. When approaching nearer than this distance, always approach the helicopter from the side and near the front **in full view of the pilot**. **NEVER** approach a helicopter from the rear (tail rotor!)

Keep clear of the main rotor and tail rotor at **all** times. The greatest threat when operating around a helicopter is the turning rotor blade. When the blades are turning, the high-speed tail rotor is virtually invisible! Physical contact with either of the blades while they are turning is almost always a significant life-impacting event.

Never approach the helicopter from any side where the ground is higher than where the helicopter is standing or hovering. On uneven ground, always approach and depart the helicopter from the DOWNHILL side. Keep in the pilot's field of vision at all times.

Do not face helicopters when they are landing, taking off, or hovering unless goggles are worn or visor is down. Fire Dept personnel involved in helicopter operations will wear full bunker gear, with collar up, gloves and helmet. Helmets will have chinstraps fastened.

Avoid approaching a helicopter with long tools, rods, etc. If this is unavoidable, carry such objects horizontally to avoid possible contact with the rotor blades.

Patients will be secured to backboards with a minimum of three (3) straps unless contraindicated by their medical condition. The feet must be secured at the ankles. If the patient is combative, place an additional strap above the knees.

All bandages and dressing shall be affixed security. Coverings like sheets and blankets are potential hazards and will be secured or placed underneath straps.

A minimum of four (4) personnel, one of which will be a helicopter crewmember, will carry the patient to the helicopter. Loading of the patient into the helicopter will be at helicopter crewmember's direction.

The pilot or crewmember's approval shall be obtained first before any gear or personnel are placed in or on the helicopter.

The pilot is responsible for the safety of his aircraft at all times; his decisions are final in this respect.