2022

Version 4

Whitman County BLS / ILS Protocols

Adopted 2022

Medical Director: Dr. Clifford Lightfoot

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Communications/Medical Control

Pre-hospital Medical Control is provided in Whitman County via the Hospital Emergency Administrative Radio (H.E.A.R.) system and telephone communication systems. On-line Medical Control is provided by the Emergency Physicians at Pullman Regional Hospital. Radio contact will be made between the EMS unit and the receiving hospital prior to arrival of the EMS unit at the hospital using the standard reporting format outlined under General Orders for All Patients. Consultation with the receiving physician is available via the H.E.A.R. system or direct telephone line.

Direct contact with the receiving physician should be utilized whenever the need for medical advice arises (this constitutes “On-line” Medical Control).

On occasions when communications are not technically possible, or a Supervising Physician is not available, EMS personnel must rely on these guidelines, protocols, and their own judgment until communication can be established.

H.E.A.R. RADIO DURING TRANSPORT -The following format for communications should be used. If Medical Control feels additional communications are necessary, they may contact the transporting unit via the H.E.A.R. system.

EMERGENCY PRE-HOSPITAL H.E.A.R. REPORT FORMAT

- Unit identification
- Category of emergency:
    - Code Red – critical
    - Code Yellow – urgent
    - Code Green - stable
- Age and sex of patient
- Chief complaint or reason for transport
- Very brief pertinent medical history
- Vital signs and level of consciousness
- Pertinent treatment rendered and results, if any request for additional information or treatment
- Estimated time of arrival

The H.E.A.R. report should be provided as soon as practical once transport has begun. All reports should be given in this order and should be a maximum of 30 seconds.

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

- Name, age, sex, and patient's physician
- Chief complaint or injuries
- If trauma, describe the trauma scene/mechanism of injury
- Vital signs and level of consciousness
- Pertinent medical history
- Condition changes or trends in vital signs or level of consciousness during transport
- Explain patient treatments and results.

WRITTEN REPORT – A written report shall be submitted within 24 hours.

Documentation

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

Complete an EMS Medical Incident Report (MIR) on all patient encounters. This will apply to both basic and advanced life support units. The S.O.A.P. method has been adopted as the standard for report writing in Whitman County. The MIR is a LEGAL record and may be called upon as evidence in any court of law.

IF IT IS NOT WRITTEN, IT WAS NOT SEEN OR DONE.

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

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

A = Assessment what you think the problem is.

P = Plan of treatment.

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

A written report shall be left at the receiving hospital with the patient (unless there is a need to respond immediately to another call) submitted within 24 hours.

On-Scene Medical Authority

Patient care at an incident is subject to the following ascending order of authority:

1. Emergency Medical Responder (first-arriving, on-duty)
2. Emergency Medical Technician (first-arriving, on-duty, highest certification) **
   **Highest Certification to include EMT, IV/SGA
3. Advanced Emergency Medical Technician (first-arriving, on-duty)
4. Paramedic or Flight Nurse (first-arriving, on-duty)
5. Physician
6. ALS Supervising Physician

Medical Professionals at the Scene

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

Relationship between EMS Team and Private Physician

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

The Physician at the scene may:

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

If, during transport, the patient's condition should warrant treatment other than that requested by the private physician, the Supervising Physician will be contacted by the H.E.A.R. system for information and concurrence with any treatment, except in cases of cardiopulmonary arrest.

Thank You for Your Offer of Assistance

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

Cliff Lightfoot, D.O.
Medical Program Director
Whitman County, Washington

Inter-facility Transport

Inter-facility transport will occur at the BLS, AEMT, and ALS level within the following special categories.

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

As a rule, it is the responsibility of the transferring facility to ensure that the medical necessities for safe patient transfer are met. Medical instructions of the attending physician will be followed unless specifically contrary to standing orders. If treatment is recommended that is contrary to protocol, medical control should be contacted for advice

The responsibility for transfer to another facility resides with the transferring facility. Patients will not be transferred to another facility without first being stabilized. Stabilization includes adequate evaluation and initiation of treatment to assure that transfer of a patient will not, within reasonable medical probability, result in deterioration of the condition, death, or loss or serious impairment of bodily functions, parts, or organs. Furthermore, that the risks of transfer outweigh the benefits available at the other facility. Evaluation and treatment of patients prior to transfer are to include the following:

1. Establish and assure an adequate airway and adequate ventilation
2. Initiate control of hemorrhage
3. Stabilize and splint the spine or fractures, when indicated
4. Establish and maintain adequate access routes for fluid administration
5. Initiate adequate fluid and/or blood replacement

Determine that the patient's vital signs (including blood pressure, pulse, respiration, and urinary output, if indicated) are sufficient to sustain adequate perfusion

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

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

If a BLS transport is requested, and if it is the judgment of the BLS crew that the patient needs to be transported by an ILS, or ALS ambulance, it is mandated that dispatch be contacted and an appropriate level crew dispatched. Under no circumstances should a BLS crew transport a patient, if in their judgment, this is an ILS, or ALS call. (Exception: mass casualty incidents.)

If either an ALS, ILS, or BLS crew is notified of an emergency enroute that is not anticipated prior to transport, pre-hospital protocols and guidelines will immediately apply. Medical Control should be contacted for concurrence of any orders as appropriate; the receiving facility should be contacted as soon as possible to inform them of changes in the patient's condition.

Emergency Transports and ALS Rendezvous

GENERAL TRAUMA

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

GENERAL MEDICAL

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

TRAUMATIC CONDITIONS REQUIRING EMERGENCY TRANSPORT AND/OR ALS RENDEZVOUS

1. VITAL SIGNS AND LEVEL OF CONSCIOUSNESS
    a. Shock: Systolic Blood Pressure < 90; or
    b. Respiratory Distress: Respiratory Rate <10 or > 29; or
    c. Altered Mentation: Glasgow Coma Score < 13
2. ANATOMY OF INJURY
    a. Penetrating injury of head, neck, torso, or groin; or
    b. Combination of burns > 20% of total body surface or involving face, airway, hands, feet, and genitalia; or
    c. Amputation above wrist or ankle; or
    d. Spinal cord injury; or
    e. Flail chest; or
    f. Two (2) or more obvious proximal long bone fractures
3. Consider emergency transport and/or ALS rendezvous if the following conditions apply:
    a. BIOMECHANICS OF INJURY
        i. Death of same car occupant; or
        ii. Ejection of patient from enclosed vehicle; or
        iii. Falls > 20 feet; or
        iv. Pedestrian hit at > 20 mph or thrown 15'; or
        v. Rollover; or
        vi. Motorcycle, ATV, or bicycle accident; or
        vii. Extrication time > 20 minutes; or
        viii. Significant intrusion
    b. CO-MORBID FACTORS
        i. Extremes of age (< 12 years or > 60 years)
        ii. Hostile environment (extremes of heat or cold)
        iii. Medical illness (such as COPD, CHF, renal failure, etc.)
        iv. Presence of intoxicants
        v. Second/third trimester pregnancy Emergency care provider judgement of injury severity.

MEDICAL CONDITIONS REQUIRING EMERGENCY TRANSPORT AND/OR ALS RENDEZVOUS

1. Cardiopulmonary arrest or Acute Myocardial Infarction
2. Respiratory distress
3. Stroke or altered level of consciousness (Glasgow Coma Scale < 13)
4. Seizures
5. G.I. bleeding
6. Anaphylaxis
7. Near drowning
8. Imminent birth

Cancellation / Slow Down

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

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

Level of Care During Transport

ALS, ILS, or BLS attendants on the ambulance
Attendance of the patient during transport will be appropriate to the degree of illness, as determined by the judgment of the senior ALS or ILS person. All transports will be attended by an emergency care provider qualified and certified by WAC to provide the appropriate level care and procedures required by the patient’s condition. The only exception may occur during mass casualty incidents.

Non-transport of Patients

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

1. Signed refusal for transport and/or care completed by competent patient, family, or custodian in conjunction with Medical Control. See Whitman County Emergency Medical and Trauma Care Cancel/Refusal Form.
2. No patient (DOA, termination of resuscitation efforts, etc.)
3. No illness and/or injury.
4. Patient refusal forms are not required for situations where there is no need for medical interventions, i.e., cancelled in route, DOA, no illness, no injury, no patient found, etc.

Emergency Transport of the Physically Disabled and Their Service / Guide Dogs

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

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

Patient Treatment Rights

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

MEDICAL RELEASE PRINCIPLES

The foundation principle for medical release is informed consent by the patient. The patient cannot be held to have refused treatment or care unless and until:

1. The patient has been fully informed of their condition.
2. The patient understands the information provided on their condition and the potential consequences of refusing the treatment or care.
3. A medical release form has been read to, understood by and signed by the patient.

MINIMUM MEDICAL INCIDENT REPORT DOCUMENTATION

- Patient history *
- Vital signs *
- Physical examination appropriate for the complaint *
- Mental status documented as "alert and oriented" and no significant impairment of mental status, e.g., by drugs, alcohol, other organic causes, or mental illness
- Informed consent: Risk of refusing care or transport explained to and understood by patient
- Whitman County Emergency Medical and Trauma Care Cancel/Refusal form signed by the patient and attached to the Medical Incident Report. **

* If these criteria cannot be met, document refusal by patient.

** If a conscious patient who is irrational (or impaired by alcohol or drugs) or may harm themselves refuses treatment, the emergency care provider should contact law enforcement.

WCEMS Emergency Medical and Trauma Care Patient Refusal

DISPOSITION:

_____Patient refused field treatment _____Patient refused transport to designated facility _____ Patient transported by private vehicle

_____Released in care or custody of self_____Released in care or custody of relative or friend _____
(Name)

_____Released in care or custody of another agency _____
(Agency Name) (Employee Name)

Call Location _____ Date _____ Time _____

Unit # _____ Agency Run #_____Chief Complaint _____

Mental Status: Altered LOC _____ Head Injury _____ Alcohol or Drug Ingestion by Hx _____
Oriented to: Person ___ Place ___ Time ___ Event ___ Vital Signs: BP ___/___ Respiratory Rate ___ Heart Rate _____

Assessment: _____

MEDICAL CONTROL CONTACTED: (Physician's Name) _____

PATIENT INFORMED:

Medical treatment / ambulance transport needed.
Further harm could result without medical evaluation / treatment.
Transport by other than ambulance could result in further harm considering patient's present illness / injury.

PATIENT INSTRUCTIONS:

_____Patient instructed to call 9-1-1 or follow up with his/her physician if condition persists or worsens.

NOTE: To validate the refusal, the patient/surrogate must understand what is being refused, e.g., transport, treatment, assessment. The patient must understand that he/she is assuming all risks and thereby releasing all responding agencies from any liability.

_____(initials) Yes - No (**circle one**) - I read the following to the patient.
_____(initials) Yes - No (**circle one**) - The following was read by the patient.

I understand the evaluation and / or treatment provided to me by the EMS providers is not a substitute for medical evaluation and treatment by a doctor. I understand the nature of the proposed care and / or transportation and I fully comprehend the potential consequences of this refusal. I further attest that I am competent and authorized to make said refusal, I do forever release and give up any claim, demand, or action against all Emergency Medical Services personnel and their agents and do hereby covenant and agree to hold such persons harmless from any claim, demand, loss, or action for any alleged act or omission in the care or transport in compliance with this refusal. This release is binding on my heirs, executors, and assigns.

Patient Signature	Print Patient Name	Date	Time
Surrogate Signature	Print Surrogate Name	Date	Time
Witness Signature	Print Witness Name	Date	Time
EMS Personnel Signature	Print EMS Personnel Name	Date	Time

Updated 8/14/2017

Helicopter Guidelines

The goals of helicopter transport are to:

1. Decrease transport time to definitive care.
2. Provide on-scene and enroute critical care capabilities where such care is otherwise unavailable.
3. Provide integrated support in multiple casualty incidents

The helicopter service is responsible for judging if weather conditions and local terrain are suitable for helicopter transport, and for notifying the appropriate EMS agency through WHITCOM. Selection of a safe landing zone should be accomplished.

DISPATCH PROCEDURE

Dispatch of the helicopter is done through WHITCOM. The dispatched helicopter should communicate on the radio frequency of the requesting agency, unless otherwise specified by WHITCOM. When requesting helicopter response, EMS field providers shall indicate whether helicopter needs to be placed on Standby or immediate Launch.

DOCUMENTATION/REVIEW

EMS field providers shall document the following times in patient care report (PCR) Narrative: time of request, time of helicopter launch (if different from request), time of helicopter arrival on scene, and time of helicopter departure from scene.

INDICATIONS

Trauma

- Consider air transport when total ground transport time to appropriate hospital greater than 30 minutes AND patient meets one or more of the following criteria:
    a. VITAL SIGNS AND LEVEL OF CONSCIOUSNESS
        i. Shock: Systolic Blood Pressure less than 90; or
        ii. Respiratory Distress: Respiratory Rate less than 10 or greater than 29; or
        iii. Altered Mentation: Glasgow Coma Score of less than13
    b. ANATOMY OF INJURY
        i. Penetrating injury of head, neck, torso, or groin; or
        ii. Combination of burns greater than 20% of total body surface or involving face, airway, hands, feet, and genitalia; or
        iii. Amputation above wrist, ankle; or
        iv. Spinal cord injury; or
        v. Flail chest; or
        vi. 2 or more obvious proximal long bone fractures
- Consider air transport if the following conditions or risk factors apply. The potential for severe injuries is more likely as multiple risk factors apply.
    a. BIOMECHANICS OF INJURY
        i. Death of same-car occupant; or
        ii. Ejection of patient from enclosed vehicle; or Falls greater than 20 feet; or
        iii. Pedestrian hit at greater than 20 mph or thrown greater than 15 feet; or Rollover; or
        iv. Motorcycle, ATV or bicycle accident
        v. Extrication time greater than 20 minutes
        vi. Significant intrusion

Helicopter Guidelines, continued …..

- B. CO-MORBID FACTORS
    a. Extremes of age (less than 12 or greater than 60 years)
    b. Hostile environment (extremes of heat or cold)
    c. Medical illness (such as COPD, CHF, renal failure, etc.)
    d. Presence of intoxicants
    e. Second/third trimester pregnancy

Medical

1. Consider transport when total ground transport time to appropriate hospital greater than 30 minutes.
    A. UNSTABLE MEDICAL PROBLEMS
        1) Airway problems with concern for possible obstruction
        2) Breathing problems with respiratory distress and SAO2 less than 90%
        3) Circulatory problems, including:
            - Chest pain with possible acute MI
            - Unstable cardiac dysrhythmias
        4) Internal bleeding with unstable vital signs
        5) Altered level of consciousness
        6) Significant environmental incidents with unstable patient, including:
        - Drowning
        - Hypothermia
        - CO poisoning
        7) Imminent birth

ADDITIONAL INDICATORS

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

PATIENT DESTINATION

Patient destination will be determined by the following, in descending order of priority:

1. GENERAL
    A. Patient or family request
    B. Prior Physician -to-Physician, or Physician-to-hospital arrangements
    C. Washington State ACS and Stroke destination and transport procedures
2. FOR MAJOR TRAUMA PATIENTS, THE TRAUMA TRIAGE PROCEDURE SHOULD BE FOLLOWED The Highest trained EMS provider on the scene will oversee patient care on the scene. During transport, the flight crew will oversee patient care.

Helicopter Safety

LANDING ZONE SELECTION

DAY: Landing surface must be at least 75 ft. by 75 ft. and as level as possible (less than 5-degree slope). The center 12 ft. by 12 ft. must be clear of stumps, large rocks, and any object taller than 12 inches. The entire landing surface should be clear of all debris that might be blown by the rotor wash.

NIGHT: Landing surface must be at least 100 ft. by 100 ft. and as level as possible (less than 5-degree slope). The entire landing area must be clear of all obstacles. The corners of the landing surface must be marked by dimmed vehicle lights. Other lights such as emergency flashers, strobe lights, and flashlights can be used to help the pilot locate the landing zone. All poles, wires, trees, and other tall obstacles within the immediate landing area must be located and their position reported to the pilot prior to landing the helicopter. No vehicle traffic in the landing zone.

COMMUNICATIONS

Approximately l0 minutes out from landing zone, pilot or flight crew will contact you on the designated scene frequency. At this time, brief helicopter crew on the landing zone, location of obstacles, direction of wind, and possible landing direction. Give a patient update for the flight crew. If you see the helicopter before pilot locates the landing zone, give them direction relative to helicopter. For example, "we are at your (meaning the pilot's) three o'clock" or "we are north of you"

SAFETY

Ensure that patient is not in the landing zone itself and is protected from the rotor wash and blowing dust. If the landing zone is sloped, approach and depart the helicopter on the downhill side.
The following basic helicopter safety procedures are intended for personnel who will normally be outside the helicopter during the loading or unloading of patient or equipment. ALL PERSONNEL should be familiar with the helicopter approach zones.

- NEVER APPROACH HELICOPTER UNLESS INSTRUCTED TO DO SO BY PILOT OR FLIGHT CREW.
- Always approach helicopter from the front within the "walk zone."
- Never approach helicopter with loose, unsecured or tall items that might be drawn into the rotor blades (i.e., hats, stretcher pads, blankets, pillows, stethoscopes, IV poles, radio antennas).
- Wear hearing protection.
- When approaching main rotor path, duck down well below the rotor height. In windy conditions or on sloped terrain, rotor may dip as low as 5 feet from the ground.
- Only assist the pilot and flight crew in loading and unloading patient and equipment when requested.
- Never lean against or take hold of any part of helicopter unless asked to do so by pilot or flight crew.
- Assign someone to ensure that on-lookers and other ground personnel stay clear of the “danger zone”
- SMOKING IS PROHIBITED WITHIN 50 FEET OF HELICOPTER

Infectious Disease Precautions

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

Gloves shall be worn for:

- Touching blood and body fluids, mucous membranes, or non-intact skin.
- Handling items or surfaces soiled with blood or body fluids.
- Performing venipuncture and other vascular access procedures.

  Change gloves after contact with each patient. Wash hands immediately after removing gloves.

Masks, protective eyewear, and gowns shall be worn during procedures that are likely to generate droplets or splashes of blood or other body fluids.

Wash hands and other skin surfaces immediately if contaminated with blood or other body fluids.

Use mouthpieces, resuscitation bags, or other ventilation devices to avoid mouth-to-mouth contact.

Sharp instruments, needles, and scalpels shall be handled carefully during procedures, cleaning, and disposal. Needles shall not be recapped, bent, broken by hand, or removed from disposable syringes. Place used disposable syringes, needles, scalpels, and other sharp items in puncture-resistant containers for disposal. Place large-bore reusable needles in puncture-resistant container for transport to the reprocessing area.

These precautions will afford protection to pregnant emergency care providers to minimize risk of prenatal transmission of infectious disease.

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

Hazardous Materials Response

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

1. Call for help - Contact local fire jurisdiction Notify and/or respond Spokane Fire Department Hazardous Materials Team

2. Work with Incident Commander as to procedures for securing access to the scene

3. Establish a **SAFE** staging area uphill, upwind if possible. Notify all incoming response agencies of proper route for a **SAFE** scene approach to the staging area. Helicopters, when indicated, should be landed far enough away from the scene to avoid spread of contamination from prop wash

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

4. Protect yourself and others from any significant exposure. **Do not attempt rescue without proper protective gear.** Minimize continued exposure of any personnel and secondary contamination of rescue personnel by ensuring that proper decontamination has been completed prior to treatment or transport to a medical facility. Prevent unnecessary contamination of transport vehicles or equipment

5. Obtain accurate information on health effects of the product(s) involved. Attempt to identify product(s) involved by placard, ID #, shipping papers, personnel on scene, etc.

6. Provide appropriate pre-hospital care as to your certification level. In general, it is not recommended to begin any medical treatment without first referring to proper guidelines. (Interventions as automatic as providing oxygen may be dangerous if not compatible with the agent involved.)

- Scene Size-up/Assessment
  - A. Body Substance Isolation Per Agency Exposure Control Program
  - B. Scene Safety
  - C. Mechanism of injury/Nature of illness
    - 1. Medical
      - • Nature of illness – determine from patient, family or bystanders why EMS was activated.
      - • Determine the total number of patients. If there are more patients than the responding unit can effectively handle, initiate a mass casualty plan.
        - a. Obtain additional help prior to contact with patients, such as law enforcement, fire, rescue, ALS, utilities.
        - b. Begin triage.
    - 2. Trauma
      - • Mechanism of injury – determine from the patient, family or bystanders and inspection of the scene what is the mechanism of injury.
      - • Determine the total number of patients.
        - a. If there are more patients that the responding unit can effectively handle, initiate a mass casualty plan.
        - b. Obtain additional help prior to contact with patients.
        - c. Begin triage.
        - d. If the responding crew can manage the situation, consider spinal motion restriction and continue care.
      - • Activate trauma system per Regional Patient Care Procedures (PCPs)

      NOTE: When a paramedic system exists, BLS and ILS personnel shall arrange for ALS rendezvous as soon as possible.

- Initial Assessment
  - A. General Impression of the Patient
  - B. Assess patient and determine if the patient has a life-threatening condition.
  - C. Assess Patient's Mental Status. Maintain Spinal Immobilization if Needed.
    - 1. Alert, responds to Verbal stimulus, responds to Painful stimulus, Unresponsive (AVPU)
  - D. Assess the Patient's Airway, Breathing and Circulation
  - E. Identify Priority Patients.
    - 1. Consider:
      - • Poor general impression.
      - • Unresponsive patients – no gag or cough
      - • Responsive, not following commands
      - • Difficulty breathing
      - • Shock (hypoperfusion)
      - • Complicated childbirth
      - • Chest pain with blood pressure less than 100 systolic
      - • Uncontrolled bleeding
      - • Severe pain anywhere
      - • Multiple injuries
      - • Expedite transport of patient.
  - F. If Physician's Orders for Life Sustaining Treatment **(POLST)** Form in effect, follow directive.
  - G. Place patient in a position of comfort, unless contraindicated

General Orders – Adult. Continued …

- Focused History and Physical Exam – Medical Patients
  - A. Responsive Medical Patients
    - 1. Assess patient history
      - • Signs and Symptoms, Allergies, Medications, Past pertinent medical history, Last oral intake, Events leading to illness or injury (SAMPLE)
    - 2. Perform physical examination
    - 3. Assess baseline vital signs including pulse oximetry if available
    - 4. Provide emergency medical care based on signs and symptoms in consultation with medical direction/control
    - 5. Provide psychological support as necessary
  - B. Unresponsive Medical Patients
    - 1. Perform rapid assessment
    - 2. Utilize the techniques of patient assessment previously identified
    - 3. Assess baseline vital signs including pulse oximetry if available
    - 4. Obtain patient history from bystander, family, friends.

- Focused History and Physical Exam – Trauma Patients
  - A. Re-consider mechanism of injury
  - B. Perform rapid trauma physical examination on patients with significant mechanism of injury
  - C. For patients with no significant mechanism of injury, e.g., cut finger
    - 1. Perform focused history and physical exam of injuries based on the techniques of examination. The focused assessment is performed on the specific injury site.
    - 2. Assess baseline vital signs including pulse oximetry if available.
    - 3. Assess patient history.
      - • Chief complaint
      - • History of present illness
      - • Past medical history
      - • Current health status

- Detailed Physical Exam
  - A. Patient and injury specific; e.g., cut finger would not require the detailed physical exam.
  - B. Perform a detailed physical examination on the patient to gather additional information.

- Ongoing Assessment
  - A. Repeat Initial Assessment.
    - 1. For a stable patient, repeat and record every 15 minutes.
    - 2. For an unstable patient, repeat and record at a minimum of every 5 minute.
    - 3. Reassess and record vital signs.
    - 4. Repeat focused assessment regarding patient complaint or injuries.
    - 5. Assess interventions.

General Orders – Adult. Continued …

- Communications
  - A. Radio Information Protocol during Transport.
    1. Patient's age, sex, and primary complaint or problem.
    2. Pertinent history as needed to clarify problem (medications, illnesses, allergy, mechanism of injury).
    3. Treatment given and patient's response.
    4. Estimated time of arrival.
  - B. Verbal report to emergency department.
  - C. Consider critical incident stress debriefing as necessary (see Dead on Arrival (DOA)).

- Transportation
  - A. Advise emergency department of changes in patient's condition during transportation.
  - B. Continue ongoing assessment and patient care.
  - C. Appropriate mode and appropriate facilities per trauma triage guidelines and regional patient care procedures.

- Clean, Service and Restock Vehicle

General Orders – Pediatric (Less than 18 years old)

- Scene Size-up And Initial Patient Assessment
  - A. Assess ABC
    1. Airway – Do not hyperextend or hyper flex child's neck
    2. Breathing – Check for obstructions
    3. Circulation – Check capillary refill
  - B. Consider possible domestic violence or abuse by adults

  NOTE: When a paramedic system exists, BLS and ILS personnel shall arrange for ALS rendezvous as soon as possible as directed by local or regional patient care procedures or when directed by medical control.

- Focused Assessment and Physical Examination
  - A. Consider the patient's developmental stage when assessing signs and symptoms.
  - B. Physical exam may be better tolerated if conducted from trunk to head.
  - C. Be alert for signs of child abuse and neglect (see Physical Abuse and Neglect).

- Ongoing Assessment
  - A. Repeat Initial Assessment.
    1. For a stable patient, repeat and record every 15 minutes.
    2. For an unstable patient, repeat and record at a minimum of every 5 minute.
    3. Reassess and record vital signs.
    4. Repeat focused assessment regarding patient complaint or injuries.
    5. Assess interventions.

- Transport

  Utilize Regional Patient Care Procedures (PCPs) and County Operating Procedures (COPs) regarding pediatric trauma destinations.

Field Resuscitation Guidelines – Withholding CPR

- WITHHOLDING OF CPR

1. CPR must be initiated on all cardiac arrest victims, unless a condition exists which warrants the withholding of CPR.
    a. CPR may be withheld on ADULT or PEDIATRIC victims who present with any one of the following:
    b. Decapitation
    c. Total incineration
    d. Decomposition
    e. Dependent lividity
    f. Rigor mortis without vital signs
    g. Apnea in conjunction with separation from the body of either the brain, liver, or heart
    h. Mass casualty incidents where triage principles preclude CPR from being initiated on every victim
    i. Documentation of Do-Not-Resuscitate Orders
    j. Compelling Reason to withhold CPR:
    k. Compelling reasons permit EMS personnel to withhold resuscitation from a patient in cardiac arrest when two criteria are BOTH present. These are:
        i. End stage of a terminal condition
        ii. Written or verbal information from family, caregivers or patient stating that patient did not want resuscitation.
            1. If both criteria are not met, you should initiate a resuscitation effort. If both criteria are met you should withhold a resuscitation effort. If resuscitation was already started, it should be stopped.
                a. You must document compelling reasons when they are used as a basis for withholding resuscitation.
2. Notify appropriate law enforcement agency as soon as possible.
3. Complete a prehospital-care record, documenting clinical conditions which warranted not initiating CPR and law enforcement agency notification.

- DISCONTINUING CPR

1. Supervising Physician should consider discontinuing CPR in the prehospital setting and pronounce a patient dead at the scene, provided certain conditions are met, including, but not limited to, the following:
    a. Brady-Asystole unresponsive to resuscitation with complete and appropriate Whitman County ALS protocol.
    b. Asystole will be documented for thirty (30) seconds in two (2) leads with documented evidence that monitor is functioning properly (i.e., artifact due to manual compression or precordial thump).
    c. Blood pressure, pulse, and respiration are absent.
2. Ventricular Fibrillation which, after ALS resuscitation, is now Asystole or Agonal rhythm.

- NO EVIDENCE OF HYPOTHERMIA, DRUG INGESTION, OR POISONING AS CAUSE OF ARREST

1. Notify Supervising Physician before discontinuing CPR. If unable to contact Supervising Physician because of geographic isolation, the emergency-care provider will contact the physician as soon as possible and document the reason for delay of communication.
2. Complete a prehospital record documenting the physician who was consulted and discontinued resuscitation.
3. Obtain an EKG strip with documented evidence of Asystole and attach to run report.
4. Notify appropriate law enforcement agency.
5. Notify appropriate support facility for family as needed.
6. When appropriate, remain with family until other support has arrived for as long as necessary. If you are called for another emergency response, emergency care for the living must always assume priority.

POLST – Physician Orders for Life-Sustaining Treatment

Samples of Washington State's POLST form on the following page. This was developed as recognition tools for emergency care providers in cases in which a patient does not desire full resuscitation due to a rapidly deteriorating medical circumstance. When you find the form in use with a patient, make certain the attending physician has signed it.

When these forms clearly express a wish for limited measures they too should be respected. The presence of a signed DNR order or physician's order should be recorded in the patient care record.

In the absence of a POLST, or in case of uncertainty, you are obligated to undertake full resuscitative measures to the full level of your training.

POLST, continued … Information for patients and family members

The POLST form is intended for any individual with serious illness.
If you have a serious health condition, you need to make decisions about life-sustaining treatment. Your physician can use the POLST form to represent your wishes as clear and specific medical orders.
Your physician may use the POLST form to write orders that indicate what types of life-sustaining treatment you want or do not want at the end of life.

The POLST form asks for information about:

- Your preferences for resuscitation
- Medical conditions
- The use of antibiotics
- Artificially administered fluids and nutrition

The POLST form is voluntary and is intended to:

- Help you and your physician discuss and develop plans to reflect your wishes
- Assist physicians, nurses, health care facilities and emergency personnel in honoring your wishes for life sustaining treatment
- Direct appropriate treatment by Emergency Medical Services personnel

• Frequently asked questions regarding the POLST form

Does the POLST form need to be signed?
Yes. Both the clinician—either a physician, a nurse practitioner (ARNP) or a certified physician assistant (PA-C) — and the patient must sign the form for it to be a valid medical order that is understood and followed by other health care professionals.

Is the POLST form required by law?
No. Completing a POLST form should always be voluntary.

If I have a POLST form do I need an advance directive too?
If you have a signed POLST form, it is recommended that you also have an advance directive, though it is not required. You may obtain more information about advance directives from your physician.

What if my loved one can no longer communicate his/her wishes for care?
If you are the designated health care representative, you can speak on behalf of your loved one. A physician can complete the POLST form based on your understanding of your loved one's wishes.

In what setting is the POLST form used?
The completed POLST is a physician order form that will remain with you if you are transported between care settings, regardless of whether you are in the hospital, at home or in a long-term care facility.

Where is the POLST form kept?
If you live at home you should keep the original bright green POLST form in a prominent location (e.g., on the front of the refrigerator, on the back of the bedroom door, on a bedside table or in your medicine cabinet). If you reside in a long-term facility, your POLST form may be kept in your medical chart along with other medical orders.

More information on the POLST program and educational materials, including how to order the form, can be found at the WSMA website at https://wsma.org/POLST

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

Last Name - First Name - Middle Name or Initial

Date of Birth ___ ___ ___

Last 4 #SSN (optional) ___ ___ ___ ___

FIRST follow these orders, **THEN** contact physician, nurse practitioner or PA-C. The POLST is a set of medical orders intended to guide medical treatment based on a person's current medical condition and goals. Any section not completed implies full treatment for that section. Completing a POLST form is always voluntary. Everyone shall be treated with dignity and respect.

Medical Conditions/Patient Goals:

Agency Info/Sticker

A Check One

CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing.
When not in cardiopulmonary arrest, go to part B.

- ☐ **Attempt Resuscitation/CPR**
- ☐ **Do Not Attempt Resuscitation/DNAR (Allow Natural Death)**
  Choosing DNAR will include appropriate comfort measures.

B Check One

MEDICAL INTERVENTIONS: Person has pulse and/or is breathing.

- ☐ **FULL TREATMENT - primary goal of prolonging life by all medically effective means.**
  Includes care described below. Use intubation, advanced airway interventions, mechanical ventilation and cardioversion as indicated. **Transfer** *to hospital if indicated. Includes intensive care.*
- ☐ **SELECTIVE TREATMENT - goal of treating medical conditions while avoiding burdensome measures.**
  Includes care described below. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not intubate. May use less invasive airway support (e.g. CPAP, BiPAP). **Transfer** *to hospital if indicated. Avoid intensive care if possible.*
- ☐ **COMFORT-FOCUSED TREATMENT - primary goal of maximizing comfort.**
  Relieve pain and suffering with medication by any route as needed. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. **Patient prefers no hospital transfer:** *EMS consider contacting medical control to determine if transport is indicated to provide adequate comfort.*

Additional Orders: (e.g. dialysis, etc.) ___

C

SIGNATURES: The signatures below verify that these orders are consistent with the patient's medical condition, known preferences and best known information. If signed by a surrogate, the patient must be decisionally incapacitated and the person signing is the legal surrogate.

Discussed with: ☐ Patient ☐ Parent of Minor ☐ Guardian with Health Care Authority ☐ Spouse/Other as authorized by RCW 7.70.065 ☐ Health Care Agent (DPOAHC)	PRINT — Physician/ARNP/PA-C Name	Phone Number
	✗ Physician/ARNP/PA-C Signature ***(mandatory)***	Date ***(mandatory)***
PRINT — Patient or Legal Surrogate Name		Phone Number
✗ Patient or Legal Surrogate Signature ***(mandatory)***		Date ***(mandatory)***

Person has: ☐ Health Care Directive (living will) ☐ Durable Power of Attorney for Health Care

Encourage all advance care planning documents to accompany POLST

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Revised 8/2017

Photocopies and faxes of signed POLST forms are legal and valid. May make copies for records.
For more information on POLST visit www.wsma.org/polst.

WASHINGTON

WSMA Washington State Medical Association
Physician Driven Patient Focused

Washington State Department of Health

See back of form for non-emergency preferences ▶

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Patient and Additional Contact Information (if any)

Patient Name (last, first, middle)	Date of Birth	Phone Number
Name of Guardian, Surrogate or other Contact Person	Relationship	Phone Number

D NON-EMERGENCY MEDICAL TREATMENT PREFERENCES

ANTIBIOTICS:

☐ Use antibiotics for prolongation of life.
☐ Do not use antibiotics except when needed for symptom management.

MEDICALLY ASSISTED NUTRITION:

Always offer food and liquids by mouth if feasible.

☐ No medically assisted nutrition by tube.
☐ Trial period of medically assisted nutrition by tube. (Goal: _____)
☐ Long-term medically assisted nutrition by tube.

ADDITIONAL ORDERS: (e.g. dialysis, blood products, implanted cardiac devices, etc. Attach additional orders if necessary.)

X Physician/ARNP/PA-C Signature	Date
X Patient or Legal Surrogate Signature	Date

DIRECTIONS FOR HEALTH CARE PROFESSIONALS

NOTE: A person with capacity may always consent to or refuse medical care or interventions, regardless of information represented on any document, including this one.

Completing POLST

- Completing a POLST form is always voluntary.
- Treatment choices documented on this form should be the result of shared decision-making by an individual or their surrogate and medical provider based on the person's preferences and medical condition.
- POLST must be signed by a physician/ARNP/PA-C and patient, or their surrogate, to be valid. Verbal orders are acceptable with follow-up signature by physician/ARNP/PA-C in accordance with facility/community policy.

Using POLST

Any incomplete section of POLST implies full treatment for that section.

This POLST is valid in all care settings including hospitals until replaced by new physician's orders.

The POLST is a set of medical orders. The most recent POLST replaces all previous orders.

The POLST does not replace an advance directive. An advance directive is encouraged for all competent adults regardless of their health status. An advance directive allows a person to document in detail his/her future health care instructions and/or name a surrogate decision maker to speak on his/her behalf. When available, all documents should be reviewed to ensure consistency, and the forms updated appropriately to resolve any conflicts.

SECTIONS A AND B:

- No defibrillator should be used on a person who has chosen "Do Not Attempt Resuscitation."
- When comfort cannot be achieved in the current setting the person should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- An IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort-Focused Treatment."
- Treatment of dehydration is a measure which may prolong life. A person who desires IV fluids should indicate "Selective" or "Full Treatment."

SECTION D:

- Oral fluids and nutrition must always be offered if medically feasible.

Reviewing POLST

This POLST should be reviewed periodically whenever:
(1) The person is transfered from one care setting or care level to another, or
(2) There is a substantial change in the person's health status, or
(3) The person's treatment preferences change.

To void this form, draw line through "Physician Orders" and write "VOID" in large letters. Any changes require a new POLST.

Review of this POLST Form

Review Date	Reviewer	Location of Review	Review Outcome
			☐ No Change ☐ Form Voided ☐ New form completed
			☐ No Change ☐ Form Voided ☐ New form completed

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

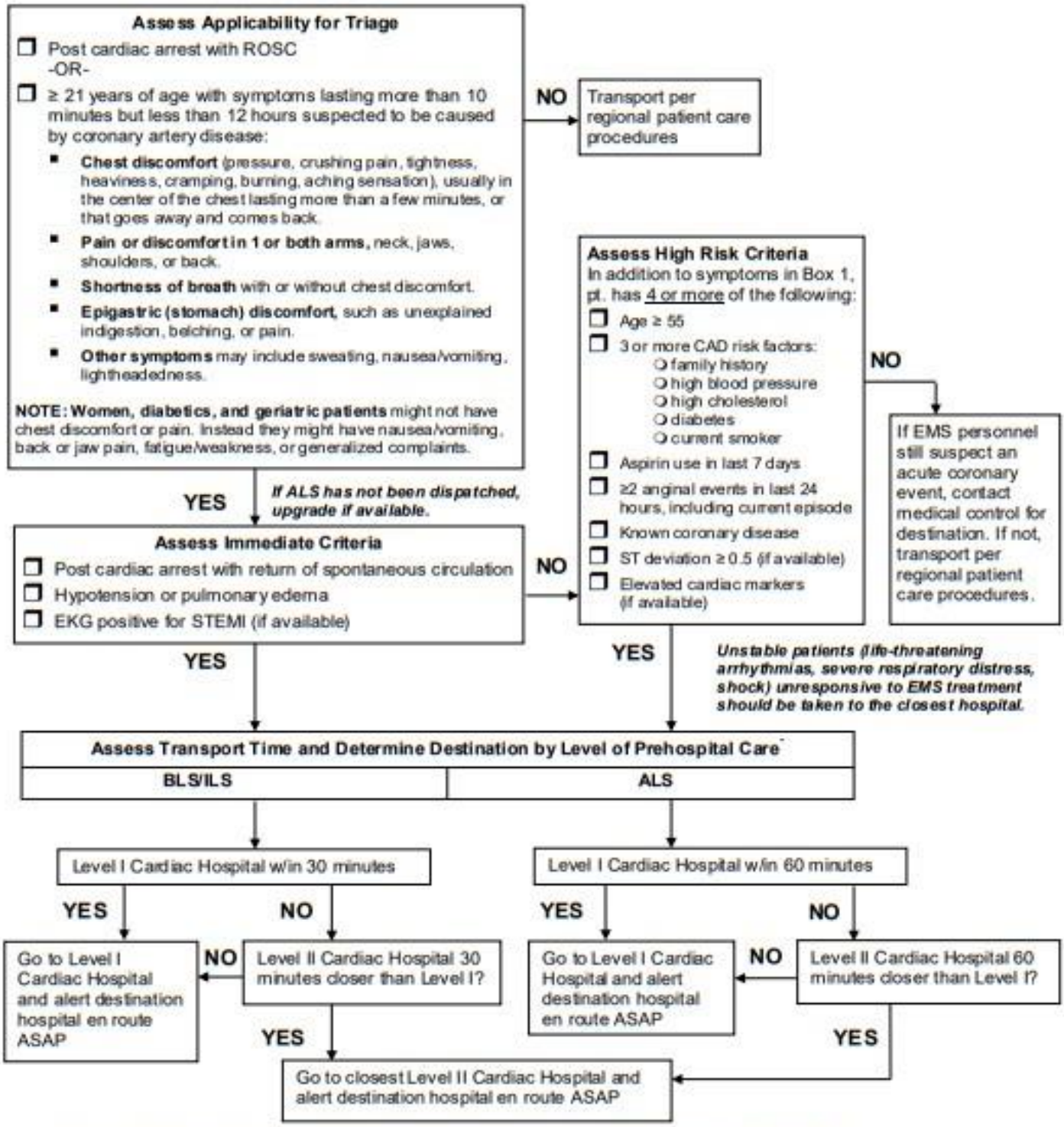
Copies and faxes of signed POLST forms are legal and valid. May make copies for records.
For more information on POLST visit www.wsma.org/polst.

OVER ▶

Considerations for Family Support When Resuscitation Has Failed

1) If the resuscitation is underway and the outlook is poor, prepare the family by telling them so.
2) At the moment of calling the code, let the family know with no uncertainty that death has occurred.
3) If you can, with any degree of honesty, tell the family the following:
    a) That you did all you could and were successful in doing those things that could have helped, but the efforts were to no avail.
    b) That this death was not preventable and that in this case, even were the patient to be in an intensive care unit when it happened, the result would have been the same.
    c) That the patient did not suffer, death was quick and or painless.
4) To the best of your ability, offer words of condolence.
5) Make physical contact with the family members if you are comfortable in doing so.
6) Offer to contact family, friends, or clergy to provide immediate support.
7) Answer any questions the family might have.
8) Allow the family members to view the body if they desire.
9) Remain with the family as long as other emergency responsibilities do not call you away, to show your respect and concern.

State of Washington
Prehospital Cardiac Triage Destination Procedure



* **Slight modifications to the transport times may be made in county operating procedures. See page 2.**
Consider ALS and air transport for all transports greater than 30 minutes.
If there are two or more Level I facilities to choose from within the transport timeframe, patient preference, insurance coverage, physician practice patterns, and local rotation agreements may be considered in determining destination.
This also applies if there are two or more Level II facilities to choose from.

DOH 346-050 April 2011

State of Washington
Prehospital Cardiac Triage Destination Procedure

Why triage cardiac patients?

The faster a patient having a heart attack or who's been resuscitated gets treatment, the less likely he or she will die or be permanently disabled. Patients with unstable angina and non-ST elevation acute coronary syndromes (UA/NSTE) are included in the triage procedure because they often need immediate specialized cardiac care. This triage procedure is intended to be part of a coordinated regional system of care that includes dispatch, EMS, and both Level I and Level II Cardiac Hospitals.

How do I use the Cardiac Triage Destination Procedure?

A. **Assess applicability for triage** – If a patient is post cardiac arrest with ROSC, or is over 21 and has any of the symptoms listed, the triage tool is applicable to the patient. Go to the "Assess Immediate Criteria" box.
NOTE: Women, diabetics, and geriatric patients often have symptoms other than chest pain/discomfort so review all symptoms with the patient.

B. **Assess immediate criteria** – If the patient meets any one of these criteria, he or she is very likely experiencing a heart attack or other heart emergency needing immediate specialized cardiac care. Go to "Assess Transport Time and Determine Destination" box. If the patient does not meet immediate criteria, or you can't do an ECG, go to the "Assess High Risk Criteria" box.

C. **Assess high risk criteria** – If, in addition to meeting criteria in box 1, the patient meets four or more of these high risk criteria, he or she is considered high risk for a heart attack or other heart emergency needing immediate specialized cardiac care. These criteria are based on the TIMI risk assessment for unstable angina/non-STEMI. If the patient does not meet the high risk criteria in this box, but you believe the patient is having an acute coronary event based on presentation and history, consult with medical control to determine appropriate destination. High risk criteria definitions:
   - 3 or more CAD (coronary artery disease) risk factors:
     - Age ≥ 55: epidemiological data for WA show that incidence of heart attack increases at this age
     - Family history: father or brother with heart disease before 55, or mother or sister before 65
     - High blood pressure: ≥140/90, or patient/family report, or patient on blood pressure medication
     - High cholesterol: patient/family report or patient on cholesterol medication
     - Diabetes: patient/family report
     - Current smoker: patient/family report.
   - Aspirin use in last 7 days: any aspirin use in last 7 days.
   - ≥2 anginal events in last 24 hours: 2 or more episodes of symptoms described in box 1 of the triage tool, including the current event.
   - Known coronary disease: history of angina, heart attack, cardiac arrest, congestive heart failure, balloon angioplasty, stent, or bypass surgery.
   - ST deviation ≥ 0.5 mm (if available): ST depression ≥ 0.5 mm is significant; transient ST elevation ≥ 0.5 mm for < 20 minutes is treated as ST-segment depression and is high risk; ST elevation > 1 mm for more than 20 minutes places these patients in the STEMI treatment category.
   - Elevated cardiac markers (if available): CK-MB or Troponin I in the "high probability" range of the device used. Only definitely positive results should be used in triage decisions.

D. **Determine destination** – The general guideline is to take a patient meeting the triage criteria directly to a Level I Cardiac Hospital within reasonable transport times. For BLS, this is generally within 30 minutes transport time, and for ALS, generally 60 minutes transport time. See below for further guidance. Regional patient care procedures and county operating procedures may provide additional guidance.

E. **Inform the hospital en route so staff can activate the cath lab and call in staff if necessary.**

What if a Level I Cardiac Hospital is just a little farther down the road than a Level II?

You can make slight changes to the 30/60 minute timeframe. The benefits of opening an artery faster at a Level I can outweigh the extra transport time. To determine whether to transport beyond the 30 or 60 minutes, figure the difference in transport time between the Level I Cardiac Hospital and the Level II Cardiac Hospital. For BLS, if the difference is more than 30 minutes, go to the Level II Cardiac Hospital. For ALS, if the difference is more than 60 minutes, go to the level II Cardiac Hospital.

BLS examples: A) minutes to Level I minus minutes to Level II = 29: go to Level I
B) Minutes to Level I minus minutes to Level II = 35: go to Level II

ALS examples: A) minutes to Level I minus minutes to Level II = 45: go to Level I
B) Minutes to Level I minus minutes to Level II = 68: go to Level II

NOTE: We recommend ALS use a fibrindytic checklist to determine if a patient is ineligible for fibrinolysis. If ineligible, transport to closest Level I hospital even if it's greater than 60 minutes or rendezvous with air transport.

What if there are two or more Level I or II facilities to choose from?

If there are two or more of the same level facilities to choose from within the transport times, patient preference, insurance coverage, physician practice patterns, and local rotation agreements may be considered in destination decision.

DOH 346-050 April 2011

Cardiac Emergencies

Key Points/Considerations

• Follow current AHA Guidelines

EMR

- ABC and vital signs
- Administer Aspirin 324 mg PO (4 x 81 mg tablets)
- Airway management with oxygen therapy maintaining a SaO2 of 94% through titration
- Pulse Oximetry / Cardiac Monitor 3 or 4 lead as available
- CAB, AED and CPR per AHA Guidelines. Defibrillate as necessary. CPR should be performed while the defibrillator is readied and charged.

EMR STOP

EMT

- Cardiac monitor / 12 lead EKG if available
- Assist patient with their own prescribed Nitroglycerin (1 dose), if systolic BP is above 100 mmHg
- **Warning! Nitroglycerin may not be appropriate if patient has been taking phosphodiesterase (PDE) inhibitors (Viagra, Cialis, and Levitra). Contact medical control for dosing options.**

EMT STOP

EMT IV-SGA

- Provide IV therapy as necessary

EMT IV-SGA STOP

ADVANCED EMT

- Nitroglycerin 0.4 mg per dose, up to 3 doses, 5 minutes apart, provided the patient's systolic BP is above 100 mmHg
- **Warning! Nitroglycerin may not be appropriate if patient has been taking phosphodiesterase (PDE) inhibitors (Viagra, Cialis, and Levitra). Contact medical control for dosing options.**
- If trained provider can give Epinephrine for cardiac arrest must follow AHA Guidelines to administer.
- Ongoing Assessment
- Transport per Washington State triage protocol

ADVANCED EMT STOP

Cardiac

Chest Pain

Key Points/Considerations

- Focus on maintaining ABC, pain relief, rapid identification, rapid notification and rapid transport to an appropriate facility
- Vitals, including 12 Lead EKG, should be monitored frequently during transport
- The first dose of Nitroglycerin may be administered while preparing to establish vascular access
- Follow current AHA Guidelines

EMR

- ABC and vital signs
- Administer Aspirin 324mg PO (4 x 81 mg tablets)
- Airway management with oxygen therapy maintaining a SaO2 of 94% through titration
- Pulse Oximetry / Cardiac Monitor 3 or 4 lead as available

EMR STOP

EMT

- Cardiac monitor / 12 lead EKG if available
- Assist patient with their own prescribed Nitroglycerin (1 dose), if systolic BP is above 100 mmHg
- **Warning! Nitroglycerin may not be appropriate if patient has been taking phosphodiesterase (PDE) inhibitors (Viagra, Cialis, and Levitra). Contact medical control for dosing options.**

EMT STOP

EMT IV-SGA

- Provide IV therapy as necessary

EMT IV-SGA STOP

ADVANCED EMT

- Nitroglycerin 0.4 mg per dose, up to 3 doses, 5 minutes apart, provided the patient's systolic BP is above 100 mmHg
- **Warning! Nitroglycerin may not be appropriate if patient has been taking phosphodiesterase (PDE) inhibitors (Viagra, Cialis, and Levitra). Contact medical control for dosing options.**
- If trained provider can give Epinephrine for cardiac arrest must follow AHA Guidelines to administer.
- Ongoing Assessment
- Transport per Washington State triage protocol

ADVANCED EMT STOP

Cardiac

Heart Failure

Key Points/Considerations

Indications: Shortness of breath, leg swelling, crackles on lung exam

EMR

- ABC and vital signs
- Administer Aspirin 324 mg PO (4 x 81 mg tablets)
- Airway management with oxygen therapy maintaining a SaO2 of 94% through titration
- CAB, AED and CPR per AHA Guidelines. Defibrillate as necessary.
- **CPR should be performed while the defibrillator is readied and charged.**
- Pulse Oximetry / Cardiac Monitor 3 or 4 lead as available

EMR STOP

EMT

- Cardiac monitor / 12 lead EKG if available
- Assist patient with their own prescribed Nitroglycerin (1 dose), if systolic BP is above 100 mmHg
- Warning! Nitroglycerin may not be appropriate if patient has been taking phosphodiesterase (PDE) inhibitors (Viagra, Cialis, and Levitra). Contact medical control for dosing options.
- Consider use of CPAP

EMT STOP

EMT IV-SGA

- Provide IV therapy as necessary
- Secure airway with supraglottic airway device

EMT IV-SGA STOP

ADVANCED EMT

- Nitroglycerin 0.4 mg per dose, up to 3 doses, 5 minutes apart, provided the patient's systolic BP is above 100 mmHg
- Warning! Nitroglycerin may not be appropriate if patient has been taking phosphodiesterase (PDE) inhibitors (Viagra, Cialis, and Levitra). Contact medical control for dosing options.

ADVANCED EMT STOP

Cardiac: Symptomatic Hypotension

Key Points/Considerations

Indications: Hypotension with Chest pain

EMR

- ABC and vital signs
- Airway management with oxygen therapy maintaining a SaO2 of 94% through titration
- Pulse Oximetry / Cardiac Monitor 3 or 4 lead as available

EMR STOP

EMT

- Cardiac monitor / 12 lead EKG if available

EMT STOP

EMT IV-SGA

- Provide IV therapy as necessary
- Consider blood draw
- Normal Saline 250 ml bolus, if systolic BP less than 90 mmHg and lungs are clear, every 10 minutes until systolic BP greater than 90 mmHg up to max 2 liters
- Secure airway with supraglottic airway device

EMT IV-SGA STOP

ADVANCED EMT

ADVANCED EMT STOP

Pre-hospital Treatment of the Medical Patient

1. Scene Size-up / Assessment
   A. Scene Safety
   B. Body Substance Isolation per Agency exposure control program

2. Initial Patient Assessment
   A. Airway, Breathing, Circulation (ABC's)
   B. Consider ALS Response per Whitman County Patient Care Procedures.

3. Focused History and Physical Exam
   A. Assess Complaints and signs and Symptoms, Responsive patient
      - **O**nset, **P**rovocation, **Q**uality, **R**adiation, **S**everity, **T**ime (OPQRST)
      - Obtain SAMPLE history
      - Obtain vital signs
      - Conduct AVPU mental status exam needed as needed
      - Intervention
   B. Perform Ongoing and/or detailed Assessment as needed

4. Transport

Medical: Anaphylaxis and Allergic Reactions

Key Points/Considerations

- Determine if patient has utilized his/her own Epinephrine auto-injector.
- If an Epinephrine Auto-injector has been utilized, contact Medical Control prior to administering additional epinephrine subcutaneously.

EMR

- ABC and vital signs
- Airway management with oxygen therapy maintaining a SaO2 of 94% through titration
- Pulse Oximetry / Cardiac Monitor 3 or 4 lead as available
- Anaphylaxis: if provider is trained, administer adult Epinephrine auto-injector (30 kg or 66 lbs. and more), infant/child Epinephrine auto-injector (30 kg or 66lbs or less).

EMR STOP

EMT

- **Anaphylaxis:** if provider is trained, administer Epinephrine 1: 1,000 IM 0.3 mg IM for adult and 0.15 mg IM for pediatrics.
- Record time of injection & reassess in two minutes
- **Allergic reactions:** if provider is trained, administer Diphenhydramine, Adult/Peds: 1 mg/kg, Max dose 50 mg, limited to, PO.
- Cardiac monitor / 12 lead EKG if available

EMT STOP

EMT IV-SGA

- Provide IV therapy as necessary
- Secure airway with supraglottic airway device

EMT IV-SGA STOP

ADVANCED EMT

- **Allergic reactions**: if provider is trained, administer Diphenhydramine, Adult/Peds: 1 mg/kg, Max dose 50 mg, limited to IV, PO, IM.

ADVANCED EMT STOP

Medical: Behavioral Emergencies

Key Points/Considerations

- **CAUTION:** Be alert, patient behavior may change rapidly, and the scene may become unsafe.
- Psychological Crisis
  - Panic, agitation, bizarre behavior, danger to self or others
  - Suicide Risk
  - Depression or suicidal gestures

EMR

- One EMS provider to assume control of situation
- Speak in a calm quiet voice, maintain eye contact and move slowly
- Answer questions honestly
- Do not leave the patient alone or turn your back
- Restrain only if necessary, for your protection or that of the patient

EMR STOP

EMT

EMT STOP

EMT IV-SGA

- Provide IV therapy as necessary

EMT IV-SGA STOP

ADVANCED EMT

ADVANCED EMT STOP

Medical: Bites and Stings

Key Points/Considerations

- If snake is dead, consider bringing it to the hospital for examination or take photo

EMR

- ABCs and Vital signs
- Airway management with oxygen therapy maintaining a SaO2 of 94% through titration
- Pulse Oximetry as available
- If stinger is present scrape to remove

  NOTE: Do Not Attempt to Pull the Stinger
- Gently wash the area
- Remove jewelry from the affected limb before swelling begins
- Keep limb immobilized and below the level of the heart and keep patient at rest
- Do not apply cold to a snakebite
- Check for signs and symptoms of an allergic reaction (see Allergic Reaction/Anaphylaxis protocol)
- Mark area of swelling with time and line around the area

EMR STOP

EMT

EMT STOP

EMT IV-SGA

- Provide IV therapy as necessary

EMT IV-SGA STOP

ADVANCED EMT

ADVANCED EMT STOP

Medical: Cold Injuries/Frostbite

Key Points/Considerations

- Treat gently, do not rub or manipulate the extremities.

EMR

- Remove from environment and protect from further exposure
- ABC and vital signs monitoring core temperature
- Airway management with oxygen therapy maintaining a SaO2 of 94% through titration
- Pulse Oximetry as available
- Remove frozen, wet, or restrictive clothing without damaging skin and start gradual warming process at room temperature provided refreezing will not occur
- Protect damaged areas with loose, dry, sterile dressings and be prepared to splint
- Elevate affected extremities to heart level and do not allow patient to use affected areas

EMR STOP

EMT

EMT STOP

EMT IV-SGA

- Provide IV therapy as necessary

EMT IV-SGA STOP

ADVANCED EMT

ADVANCED EMT STOP

Medical: Diabetic Emergencies

Key Points/Considerations

EMR

- ABC and vital signs
- Airway management with oxygen therapy maintaining a SaO2 of 94% through titration
- Pulse Oximetry as available
- Obtain blood sugar level via glucometry (if have had MPD approved training)
- Call for ALS intercept if unable to swallow on command, or mental status remains altered following administration of sugar substance
- If patient is able to swallow, administer dose of Oral Glucose: Adult: 10-15 grams, Pediatric: 10-15 grams

EMR STOP

EMT

- If patient is unable to swallow, assist patient with prescribed Glucagon IM (per MPD – approved IM injection training)

EMT STOP

EMT IV-SGA

- Vascular access, obtain blood sample in Red top tube
- If glucose level is above 400:
- Adult: Initiate fluid resuscitation with NS fluid bolus 1000 mL. Repeat as needed
- Pediatric: 20ml/kg NS bolus

EMT IV-SGA STOP

ADVANCED EMT

- If patient is unable to swallow:
- Adult: If < 80 mg/dl administer 25 g of Dextrose 50% IV.
- Pediatric: If < 60 mg/dl administer 2 ml/kg of Dextrose 25% IV (D25, dilute D50 1:1 with sterile water or saline).
- Neonate: If < 40 mg/dl administer 2 ml/kg of Dextrose 10% IV (D10 dilute D50 1:4 with sterile water or saline).
- Recheck blood glucose in 15 min and repeat Dextrose PRN.

ADVANCED EMT STOP

Medical: Drowning

Key Points/Considerations

- All drownings or submersions should be transported. Any patient can deteriorate rapidly
- If the patient is hypothermic, defibrillation may be unsuccessful until the patient is warmed
- Many drownings involve diving injuries to the cervical spine

EMR

- ABC and vital signs, if the patient is pulseless and apneic, proceed to appropriate cardiac protocol
- Stabilize spine prior to removing patient from water if there is any suggestion of spinal injury
- Airway management with oxygen therapy maintaining a SaO2 of 94% through titration
- Pulse Oximetry as available
- Keep patient warm and dry and remove any wet clothing

EMR STOP

EMT

EMT STOP

EMT IV-SGA

- Provide IV therapy as necessary

EMT IV-SGA STOP

ADVANCED EMT

ADVANCED EMT STOP

Medical: Heat Cramps/Exhaustion

Key Points/Considerations

EMR

- Do not delay transport to cool patient
- Move patient to cooler environment and remove excess clothing
- ABC and vital signs and core temperature with rectal thermometer if altered level of consciousness
- Airway management with oxygen therapy maintaining a SaO2 of 94% through titration
- Pulse Oximetry as available
- Cool patient with passive cooling technique (misters or wet towels)
- Oral fluid

EMR STOP

EMT

EMT STOP

EMT IV-SGA

- Provide IV therapy as necessary
    - Adult: Initiate fluid resuscitation with NS fluid bolus 1000 mL

EMT IV-SGA STOP

ADVANCED EMT

ADVANCED EMT STOP

Medical: Hypothermia

Key Points/Considerations

- Environmental conditions of cold exposure
- Cool to cold skin temperature
- Decreased mental and or motor status
- Stiff or rigid posture
- Shivering may be present

EMR

- Obtain core temperature
- Remove patient from the cold environment and protect the patient from further heat loss
- Remove patient's wet clothing and wrap the patient in blankets, hot packs to groin, axilla and cervical region, turn up heat in patient compartment of vehicle
- Handle with extreme care. Rough handling may cause ventricular fibrillation.
- Airway management with oxygen therapy maintaining a SaO2 of 94% through titration
- Warm and humidify the oxygen.
- Assess pulses for 30 to 45 seconds before starting CPR
- Continue efforts to rewarm
- Although patients suffering from hypothermia should be evaluated on an individual basis, in general, patients should be warmed to normal temperatures before stopping resuscitation.
- If the patient is alert and responding appropriately, with temperature > 94 degrees actively rewarm

EMR STOP

EMT

EMT STOP

EMT IV-SGA

- Provide IV therapy as necessary
    - If warm IV fluid is available, initiate NS fluid bolus 500- 1000 mL.

EMT IV-SGA STOP

ADVANCED EMT

ADVANCED EMT STOP

Medical: Overdose or Toxic Exposure

Key Points/Considerations

- Includes patients who are unconscious/unresponsive without suspected trauma or other causes
- If patient is a suspected narcotic overdose (due to history and/or physical findings) administer Naloxone prior to checking blood glucose level

EMR

- Decontamination as needed
- ABC and vital signs
- Airway management with oxygen therapy maintaining a SaO2 of 94% through titration
- Pulse Oximetry as available
- Determine what was taken, when and how much, if possible and contact poison control 1-800-709-0911
- If OD of oral or parenteral hypoglycemic agent is suspected, check blood glucose level, if equipped and authorized. If level is abnormal refer to Diabetic Protocol
- For symptomatic opiate overdose: Naloxone (Narcan) 2mg IN w/MAD device or Auto-injector.

EMR STOP

EMT

- For symptomatic opiate overdose:
  - Naloxone (Narcan) 0.4 every 2 min up to 2 mg maximum IM, 2mg IN or Auto-injector

EMT STOP

EMT IV-SGA

- Provide IV therapy as necessary

EMT IV-SGA STOP

ADVANCED EMT

- For symptomatic opiate overdose:
  - Naloxone (Narcan) 0.4 every 2 min up to 2 mg maximum IV, IO, IM, 2mg IN

ADVANCED EMT STOP

Medical: Physical Abuse and Neglect

Key Points/Considerations

- Report suspected abuse or neglect to the appropriate agency.
- Be aware of:
  - Multiple bruises in various stages of healing
  - Injury inconsistent with mechanism described
  - Repeated calls to the same address
  - Fresh burns
  - Parents or care giver seem inappropriately unconcerned
  - Conflicting stories
  - Fear on the part of the patient to discuss how the injury occurred
  - Lack of adult supervision
  - Malnourished appearance
  - Unsafe living environment
  - Untreated chronic illness

EMR

EMR STOP

EMT

EMT STOP

EMT IV-SGA

EMT IV-SGA STOP

ADVANCED EMT

ADVANCED EMT STOP

Medical: Seizures

Key Points/Considerations

Signs and Symptoms: Sudden unresponsiveness, Convulsions, Loss of bowel and bladder control, Postictal (recovery phase), Confusion, disoriented and possibly combative, Exhausted and weak, May bite tongue.

Possible Causes: Epilepsy, Hypoglycemia, Fever, Hypoxia, Infections, Dysrhythmia, Poisoning, Head Trauma, Stroke, Pre-delivery seizure (eclampsia).

EMR

- Airway management with oxygen therapy maintaining a SaO2 of 94% through titration
- Pulse Oximetry as available
- Suction as needed
- Determine blood glucose level
- Prevent injury to the patient, but do not restrain
- Treat other injuries as necessary
- Pediatric Considerations - Febrile Seizure
- If fever, remove heavy or swaddling clothes, keep lightly dressed

EMR STOP

EMT

EMT STOP

EMT IV-SGA

EMT IV-SGA STOP

ADVANCED EMT

ADVANCED EMT STOP

Medical: Stroke

Key Points/Considerations

Perform F.A.S.T assessment

- **F**ace: unilateral facial droop
- **A**rms: unilateral drift or weakness
- **S**peech: abnormal or slurred
- **T**ime: seen last normal

See State of Washington Prehospital Stroke Triage Destination Procedure

EMR

- Airway management with oxygen therapy maintaining a SaO2 of 94% through titration
- Pulse Oximetry / Cardiac Monitor 3 or 4 lead as available
- While protecting airway--place patient on paralyzed side.
- Be prepared to manage secretions
- If blood glucose less than 60mg/dl, treat for hypoglycemia.
- Consider the cause--take all medications to the hospital
- Examine for signs of trauma
- Maintain body heat
- Protect affected limbs from injury
- Anticipate seizures

EMR STOP

EMT

- Cardiac monitor / 12 lead EKG if available

EMT STOP

EMT IV-SGA

- Provide IV therapy as necessary

EMT IV-SGA STOP

ADVANCED EMT

ADVANCED EMT STOP

State of Washington Prehospital Stroke Triage Destination Procedure

STEP 1: Assess Likelihood of Stroke

- Numbness or weakness of the face, arm, or leg, especially on one side of the body
- Confusion, trouble speaking, or understanding
- Trouble seeing in one or both eyes
- Trouble walking, dizziness, loss of balance, or coordination
- Severe headache with no known cause

If any of above, proceed to STEP 2, if none, transport per regional PCP/county operating procedures

STEP 2: Perform F.A.S.T. Assessment (positive if any of Face/Arms/Speech abnormal)

- **Face:** Unilateral facial droop
- **Arms:** Unilateral arm drift or weakness
- **Speech:** Abnormal or slurred
- **Time:** Best estimate of Time Last Known Well =_____

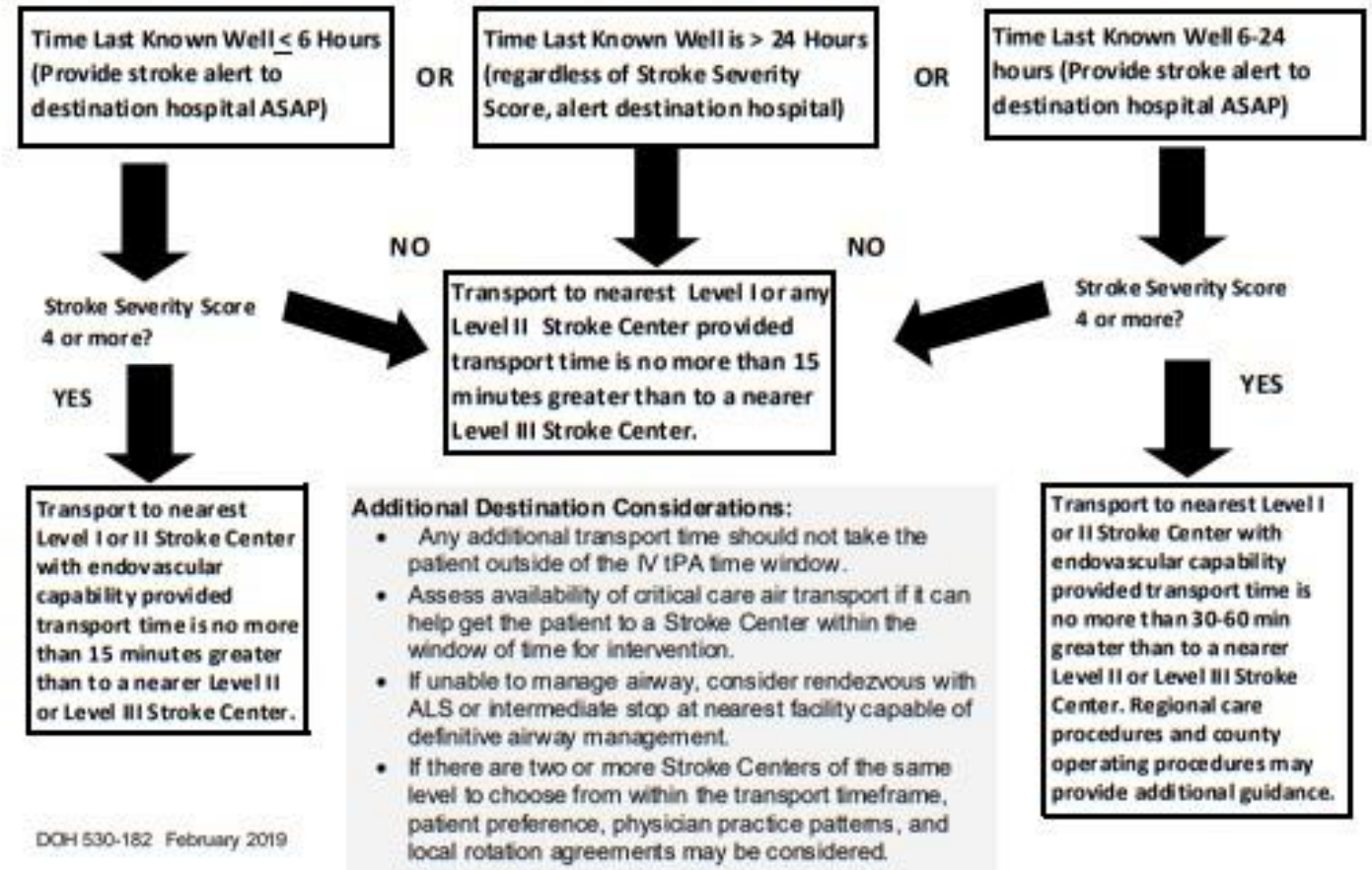
If FAST negative, transport per regional/county operating procedures

STEP 3: If F.A.S.T. Positive - Calculate Stroke Severity Score (LAMS)

Facial Droop:	Absent 0	Present	1		
Arm Drift:	Absent 0	Drifts	1	Falls Rapidly	2
Grip Strength:	Normal 0	Weak	1	No Grip	2

Total Stroke Severity Score = **(max. 5 points)**

STEP 4: Determine Destination: Time Last Known Well + Stroke Severity Score



Additional Destination Considerations:

- Any additional transport time should not take the patient outside of the IV tPA time window.
- Assess availability of critical care air transport if it can help get the patient to a Stroke Center within the window of time for intervention.
- If unable to manage airway, consider rendezvous with ALS or intermediate stop at nearest facility capable of definitive airway management.
- If there are two or more Stroke Centers of the same level to choose from within the transport timeframe, patient preference, physician practice patterns, and local rotation agreements may be considered.

DOH 530-182 February 2019

OB/GYN

Breech Birth/Limb Presentation

Key Points/Considerations

Signs/Symptoms: Buttocks or extremities present first during the delivery process

EMR

- Airway management with oxygen therapy maintaining a SaO2 of 94% through titration
- Pulse Oximetry as available
- Allow delivery to progress spontaneously
- Support infants' body as it is delivered
- If head delivers spontaneously, proceed as with norma delivery
- If head does not deliver within 4-6 minutes, insert gloved hand into vagina, with fingers on sides on nose, tilting head toward chest during delivery

EMR STOP

EMT

EMT STOP

EMT IV-SGA

- Provide IV therapy as necessary

EMT IV-SGA STOP

ADVANCED EMT

ADVANCED EMT STOP

OB/GYN

Emergency Delivery

Key Points/Considerations

Determine: Due date, number of pregnancies, duration and frequency of contractions

Signs/Symptoms: Perineum Bulging or crowning, Contractions less than 2 minutes, Mother expresses need to “push” or “bear down”

EMR

- Airway management with oxygen therapy maintaining a SaO2 of 94% through titration
- Pulse Oximetry as available
- Have mother lie supine with knees drawn up and spread apart
- Prepare OB kit
- When the infant’s head appears during crowning, place fingers on bony part of skull and exert very gentle pressure to prevent explosive delivery if the umbilical cord is wrapped around the infant’s neck, slip it gently over the shoulder and head
- If slipping the cord over the infant’s head and shoulders fails, place umbilical clamps 2 inches apart and cut the cord between the clamps
- Assist delivery of shoulders and body; do not pull on infant. Place newborn on mother’s abdomen.
- When baby is delivered:
  1. Wipe blood and mucus from mouth and nose, suction mouth then nose
  2. Assure patent airway, stimulate cry by drying newborn and cover with blanket.
  3. Do APGAR assessment on infant one minute after delivery
  4. Double clamp, tie and cut cord between two clamps
  5. Let placenta deliver normally.
     Note: Do not pull on cord. Place in plastic bag and transport with mother
  6. Massage mother’s lower abdomen until firm
  7. Place sterile pad over vaginal opening
  8. Record time of delivery

EMR STOP

EMT

EMT STOP

EMT IV-SGA

- Provide IV therapy as necessary

EMT IV-SGA STOP

ADVANCED EMT

ADVANCED EMT STOP

OB/GYN

Excessive Vaginal Bleeding

Key Points/Considerations

- Treat for shock
- If bleeding due to trauma to external genitalia place appropriate external dressings to any wounds
- Do not place dressings inside vagina
- If miscarriage bring fetal tissue in with patient

EMR

- Airway management with oxygen therapy maintaining a SaO2 of 94% through titration
- Pulse Oximetry as available

EMR STOP

EMT

EMT STOP

EMT IV-SGA

- Provide IV therapy as necessary

EMT IV-SGA STOP

ADVANCED EMT

ADVANCED EMT STOP

OB/GYN

Prolapsed Cord

Key Points/Considerations

- Signs/Symptoms: Cord presents through the birth canal before delivery, normally occurs early in labor

EMR

- Airway management with oxygen therapy maintaining a SaO2 of 94% through titration
- Pulse Oximetry as available
- Position mother in hands and knees position
- Insert sterile gloved hand into vagina pushing the presenting part of the fetus away from the pulsating cord
- Maintain pressure on presenting part to relieve pressure on the cord. (Do Not Remove Hand)

EMR STOP

EMT

EMT STOP

EMT IV-SGA

- Provide IV therapy as necessary

EMT IV-SGA STOP

ADVANCED EMT

ADVANCED EMT STOP

OB/GYN

Sexual Assault

Key Points/Considerations

- Contact law enforcement and follow local procedures for preserving evidence.

EMR

- Airway management with oxygen therapy maintaining a SaO2 of 94% through titration
- Pulse Oximetry as available
- Advise patient not to wash, douche, urinate or defecate prior to physician exam
- Do not examine genitalia unless obvious bleeding requires the application of a dressing
- Do not place dressings inside vagina
- If hypotensive treat as appropriate
- Provide Nonjudgmental Emotional Support

EMR STOP

EMT

EMT STOP

EMT IV-SGA

- Provide IV therapy as necessary

EMT IV-SGA STOP

ADVANCED EMT

ADVANCED EMT STOP

Procedure

12 Lead EKG – 3 & 4 Lead EKG

Key Points/Considerations

EMR

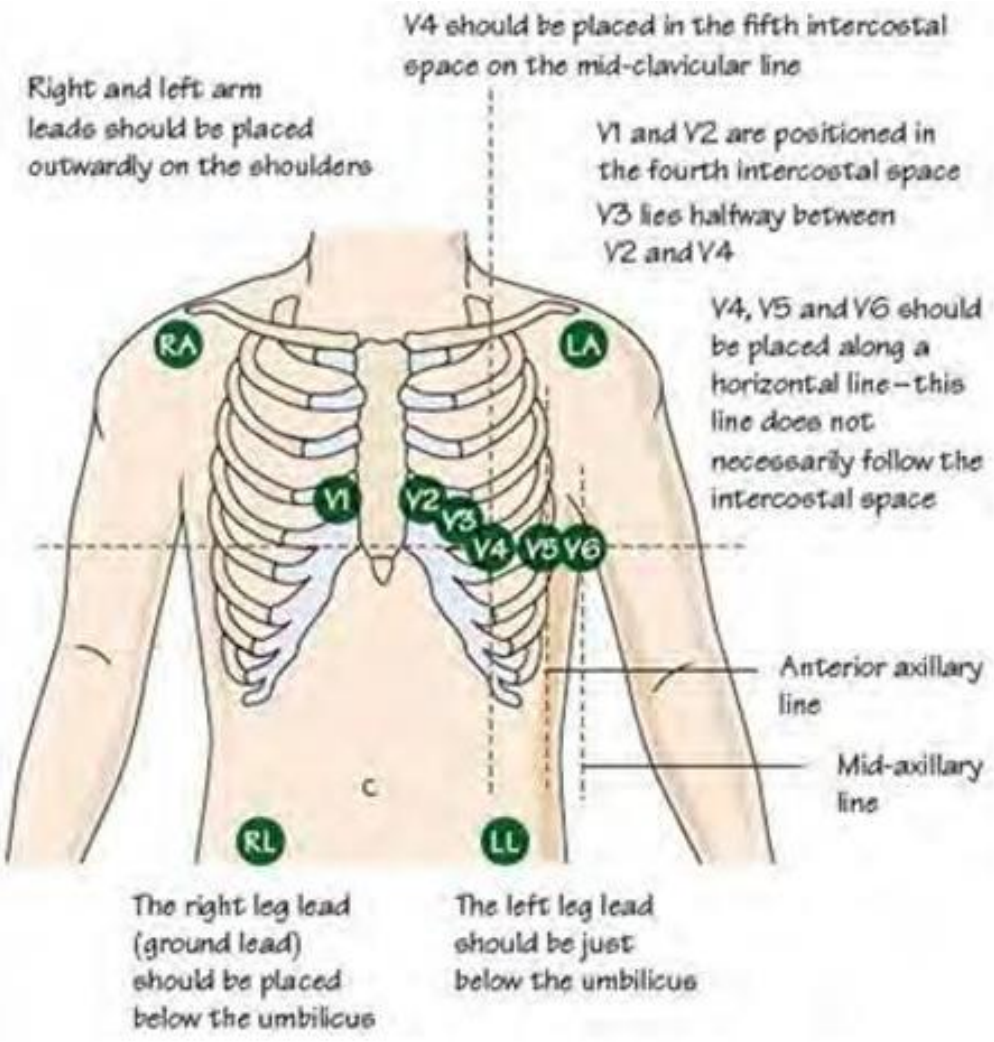
- Cardiac Monitor 3 or 4 lead as available. Use RA, LA, RL, LL positions when possible.

EMR STOP

EMT
EMT IV-SGA
ADVANCED EMT

- CRITERIA:
  - Chest pain, syncope, dizziness, stroke or heart rate less than 60 bpm or greater than 120 bpm
- REMINDER:
  - Perform EKG as soon possible for chest pain
  - Do not delay transport as per Washington State Prehospital Cardiac Triage Destination Procedure

EMT / EMT IV-SGA / ADVANCED EMT STOP



Procedure

Procedural: EZ IO

Key Points/Considerations

Purpose: To establish emergency intraosseous access for the critically unstable patients when a peripheral IV line cannot be established in 2 attempts or within 90 seconds. DO NOT delay transport of critical patients while attempting to gain vascular access.

EMR

EMR STOP

EMT

EMT STOP

EMT IV-SGA

INDICATIONS:

- An altered mental status (GCS of 8 or less)
- Respiratory compromise (SpO2 of 80% or less after Oxygen therapy)
- Respiratory rate below 10 or above 40
- Hemodynamic instability (systolic BP below 90 mmHg)
- EZ-IO may be considered PRIOR to peripheral IV attempts for the following:
    - Cardiac arrest (medical or traumatic)
    - Profound hypovolemia with altered mental status

CONTRAINDICATIONS:

- Osteomyelitis
- Fracture of the bone proximal to the insertion site (consider alternate site)
- Joint replacement above insertion site within 24 hours
- Inability to locate landmarks due to significant edema

COMPLICATIONS:

- Incorrect placement
- Subcutaneous infection
- Extravasation (leakage) into the insertion site
- Sepsis
- Bone marrow embolism

EQUIPMENT:

- EZ-IO PD (3-39kg); EZ-IO AD (>40kg); EZ-IO LD (excess tissue) EZ-IO Infusion System
- Children under the age of 8 will require the appropriate needle selection
- Tape
- IV fluid
- Pressure Infuser
- 10 ml syringe

Procedure

Procedural: EZ IO, continued…

Key Points/Considerations

PROCEDURE:

- EMT-IV, ILS should be cautious performing this procedure on a conscious patient unless absolutely necessary.
- Wear appropriate Body Substance Isolation
- Determine EZ-IO indications
- Rule out contraindications
- Prepare EZ-IO driver and needle set
- Locate insertion site, Tibial Tuberosity, Head of Humerus, Medial Malleolus
- Cleanse insertion site using aseptic technique
- Stabilize site and insert EZ-IO needle set
- Remove EZ-IO driver from the needle set while stabilizing the catheter hub
- Remove stylet from needle set, secure stylet
- Confirm placement
- Connect primed EZ-connect
- Flush or bolus the EZ-IO catheter rapidly with 10ml of normal saline.
- Place pressure bag or infusion pump on solution being infused when applicable.
- Begin infusion
- Dress site and secure tubing and apply wristband to patient
- Monitor EZ-IO site and patient

EMT IV-SGA STOP

ADVANCED EMT

ADVANCED EMT STOP

Procedure

Procedural: Blood Draws

EMR

EMR STOP

EMT

EMT STOP

EMT IV-SGA

Indications for blood draws will be limited to:

Medical cases requiring laboratory documentation

- Suspected hypoglycemia (prior to IV glucose)
- Suspected drug overdose
- Unconscious patient, unknown cause
- Trauma patients
- Hypotensive patient, unknown cause
- Suspected MI
- Suspected Stroke
- Unstable Medical Condition

Method of transporting field blood samples

- The blood tubes should be labeled with the patient's name, date, time of draw and initials of drawer
  Order of draw, Blue, Red, Green, Purple
- The blood tubes should then be placed in a sealable plastic bag bearing a bio-hazard logo and this bag taped to the patient's IV bag

Legal blood alcohol specimens, Use aseptic technique (povidone-iodine and NO alcohol swabs)
RCW 46.20.308 Blood for legal alcohol determination may be drawn at the request of law enforcement
RCW 46.61.508 Liability of medical personnel withdrawing blood

No physician, registered nurse, qualified technician, or hospital, or duly licensed clinical laboratory employing or utilizing services of such physician, registered nurse, or qualified technician, shall incur any civil or criminal liability as a result of the act of withdrawing blood from any person when directed by a law enforcement officer to do so for the purpose of a blood test under the provisions of RCW 46.20.308, as now or hereafter amended: PROVIDED, That nothing in this section shall relieve any physician, registered nurse, qualified technician, or hospital or duly licensed clinical laboratory from civil liability arising from the use of improper procedures or failing to exercise the required standard of care.

EMT IV-SGA STOP

ADVANCED EMT

ADVANCED EMT STOP

Procedure

Procedural: CPAP

EMR

EMR STOP

EMT

A. CPAP is an alternative to intubation in the awake patient who is experiencing respiratory distress and an adjunct to the treatment of severe CHF.

1. Indications
    a) Severe CHF with respiratory distress not relieved by supplemental oxygen
    b) Hypoxemia due to CHF or COPD
    c) Respiratory failure

2. Contraindications
    a) Respiratory arrest, unconsciousness or agonal respirations
    b) Cardiogenic shock
    c) Persistent vomiting
    d) Asthma without coexisting COPD or CHF
    e) Pneumothorax or penetrating chest trauma
    f) Systolic BP less than 90

3. Procedure
    a) Assess vital signs, cardiac monitor & pulse oximetry
    b) Explain procedure to the patient
    c) Clear upper airway of secretions by suction or having the patient cough and/or blow nose
    d) Make sure CPAP device is connected to oxygen regulator and that the oxygen bottle is turned on
    e) Prepare circuit to apply to patient
    f) Start CPAP at ambient air pressure (5 cm H2O)
    g) Titrate pressure to 10 cm H2O as tolerated
    h) Continue to reassess vital signs: if hypotension develops discontinue CPAP or reduce pressure. If patient failing CPAP therapy, consider intubation/RSI for the paramedics.

EMT STOP

EMT IV-SGA

EMT IV-SGA STOP

ADVANCED EMT

ADVANCED EMT STOP

Procedure

Procedural: Epinephrine Administration

EMR

1. Place patient on oxygen. If stable, administer oxygen at 2-4 L/min via nasal cannula. If unstable, administer oxygen at 10-15 L/min via non-rebreather (NRB).
2. Administer Epinephrine Auto-Injector (injected in middle of outer thigh)
    - Adult- Epinephrine Auto-Injector (0.3 mg)
    - Infant/Child- Epinephrine Auto-Injector (0.15 mg) weighing less than 66 lbs.
    - Ensure Epinephrine Auto-Injector is not expired, cloudy or crystallized.
    - Record time of injection & reassess in two minutes

EMR STOP

EMT

- Epinephrine 1:1000 (injected in middle of outer thigh) Dosage:
    - **Adults:** (30 kg or 66 lbs. and weight) – 0.3ml 1:1000 epinephrine using 1ml Vanishpoint syringe equipped with a 25g needle
    - **Infant and Child:** (Under 30 kg or 66 lbs.) 0.15ml 1:1000 epinephrine using 1ml Vanishpoint syringe equipped with a 25g needle

EMT STOP

EMT IV-SGA

EMT IV-SGA STOP

ADVANCED EMT

ADVANCED EMT STOP

Procedure

Procedural: Intranasal Medication Delivery

Key Points/Considerations

- Always deliver half the medication dose up each nostril.
- Do not use more than ½ to 1 ml of medication per nostril.
- Always use the MOST concentrated form of the medication available.
- Beware that mucous, blood and vasoconstrictors reduce absorption. Suction nostrils or consider alternate drug delivery method in these situations.

EMR

- Using prefilled syringe or draw up appropriate amount of medication into syringe.
- Attach intranasal medication delivery device to the syringe.
- Using your free hand to hold the head stable, place the tip of the intranasal medication delivery device tip snugly against the nostril aiming slightly up and outward.
- Briskly compress the syringe plunger to deliver half of the medication into the nostril.
- Move the device over to the opposite nostril and administer the remaining medication into that nostril.

EMR STOP

EMT

EMT STOP

EMT IV-SGA

EMT IV-SGA STOP

ADVANCED EMT

ADVANCED EMT STOP

Procedure

Procedural: Intravenous Access Procedure

Key Points/Considerations

Indications:

- Hypotension with systolic blood pressure of less than 90 mmHg
- Significant potential for shock, i.e., major trauma or bleeding
- Altered mental status or coma
- Suspected cardiac without significant delay in transporting
- Need for administration of fluids and/or medications

EMR

EMR STOP

EMT

EMT STOP

EMT IV-SGA

When above indications are met, the IV will be placed in most suitable site given the situation/patient.

- IV needle size will also be dependent upon placement and patient (16 -18 most common)
- If indications of shock, a second IV can be started
- Fluids to be administered will be Normal Saline at a (TKO) To Keep Open drip unless patient requires fluid resuscitation
- If obtaining a blood draw, proceed with blood draw prior to administering NS fluids. Fill collection tubes in Blue, Red, Green, and Purple order. After filling of each tube gently rock tube several times. Patients name, date of birth and time of draw are to be written on each tube and sealed in a biohazard bag for transport with patient to hospital
- If drawing blood for Legal Blood Alcohol levels DO NOT USE ALCOHOL SWAB to prep site
- During transport, the patient will be monitored for potential complications of IV therapy

EMT IV-SGA STOP

ADVANCED EMT

ADVANCED EMT STOP

Procedure

Procedural: Nerve Agent/Organophosphorus

Key Points/Considerations

- The following treatment should be considered only when the patient manifests typical symptoms of exposure to these agents and the scene is suggestive of exposure

- Mass Casualty Incident – Early recognition that field patient treatment needs will exceed immediately available supplies should prompt an immediate call to WhitCom by the Incident Commander to initiate the release of ChemPack supplies. Instructions will be obtained by WhitCom and forwarded to the Incident Commander how and where to pick up the required supplies

- Signs/Symptoms:

Muscarinic symptoms (DUMBELS)	Nicotinic symptoms (MTWThF)
Defecation	Muscle weakness and paralysis
Urination	Tachycardia
Miosis	Weakness
Bronchorrhea	Hypertension
Excitation (muscular)	Fasiculations
Lacrimation	
Salivation or seizures	

EMR

- Establish patent airway and adequate ventilation

EMR STOP

EMT

EMT STOP

EMT IV-SGA

EMT IV-SGA STOP

ADVANCED EMT

ADVANCED EMT STOP

Procedure

Procedural: Restraints for Aggressive or Violent Patients

EMR

The use of physical restraints for patients who pose a threat to themselves or others is indicated only as a last resort. If restraints are used, care must be taken to protect the patient from possible injury.

1. Request assistance from law enforcement
2. A minimum of four people, one per extremity, must be available to assist
3. Each member is assigned a specific limb
4. On command from the team leader, the patient's limbs and head are immobilized in one coordinated effort.

Each extremity is restrained in the following manner (soft Velcro restraints are recommended)

A. Place patient supine position
B. Secure one arm above the head and the other arm at waist level
C. Secure the feet
D. Secure lower back / pelvis
E. Never leave the patient in restraints alone

5. Carefully monitor the patient including O2 saturation
6. Be prepared for vomiting to prevent aspiration
7. Consider rendezvous with ALS for chemical restraint options

EMR STOP

EMT

EMT STOP

EMT IV-SGA

EMT IV-SGA STOP

ADVANCED EMT

ADVANCED EMT STOP

Procedure

Procedural: Spinal Immobilization

1) Purpose:

This protocol is to provide guidelines for the spinal immobilization of pre-hospital patients in Whitman County. This protocol is not designed to remove spinal immobilization and it should be emphasized that a patient with a suspected spinal injury should be moved as little as possible.

2) Core Principles:

1. The best candidates for full head-to-toe immobilization are victims of a high impact mechanism with multi-system injuries.
2. Most significant spinal injuries present with mid-line cervical spine tenderness upon palpation. Alert and oriented patients with significant spinal injuries generally self-splint.
3. The best method to determine if a patient has a potential spinal injury is with a diligent physical exam. In general, ambulatory patients do not have serious spinal injuries.
4. The goal of spinal immobilization should be to reduce, rather than increase, patient discomfort. Immobilization techniques that increase patient discomfort should be avoided if possible.
5. Patients with suspected spinal injuries should be maintained in the “neutral” in-line position. Remember that this “neutral” position changes from patient to patient. Never attempt to move a patient into a “neutral” position if this movement increases pain, neurologic deficits, or neck spasms.
6. Immobilization can and should be accomplished using the most appropriate tools for the patient and scenario being evaluated. Never use equipment that does not fit that patient correctly. For example, more damage can be caused by using a c-collar that hyperextends the patient’s neck than by not using a c-collar at all.
7. Full Spinal immobilization of penetrating thoracic trauma patients increases mortality and morbidity. Alert, neurologically intact victims of penetrating thoracic trauma without spinal pain do not need spinal immobilization.
8. If there is any doubt whether the patient has a c-spine injury or not, it is always better to immobilize the patient.

3) Spinal Immobilization Guidelines:

1. Methods to achieve spinal immobilization will vary depending on the severity of the injury and also mental status of the patient. The following methods are allowable to achieve immobilization, least invasive to the most invasive. Lateral, semi-fowler’s, or fowlers position with cervical collar only, soft collar, pillows, vacuum splint or mattress, children’s car seats, KED, backboards with adequate padding, head immobilizers and straps.
2. Partial immobilization of a patient with an isolated neck injury is acceptable and encouraged. This may include a stiff or soft collar, use of vacuum splinting, pillows, the KED, etc. Patients with isolated cervical pain may be placed in the position of comfort, semi-fowlers, fowlers, etc.
3. Provide manual stabilization restricting movement. Alert and cooperative patients may be allowed to self-limit motion if appropriate with or without c-collar.
4. Apply cervical collar.

Procedural: Spinal Immobilization, continued …

A. If the patient must be moved, keep in mind the overall goal of restricting gross movement of the spine while preventing additional discomfort / pain. Self-extrication of the patient is allowable.

a. Allowing patients to self-extricate and place themselves onto gurneys and spinal immobilization devices is acceptable. Back-boarding patients from standing position, "standing take-down," is discouraged.

b. Pull sheets, flexible devices, KED, can be deployed if necessary. Hard backboards should have limited utilization.

B. Always apply adequate padding or use vacuum mattress to prevent tissue damage.

C. Place patient in position best suited to protect the airway.

4) Out of Hospital Spinal Clearance

A. Applies to reliable patients only.

a. Patient is oriented, cooperative, sober, without:

i. Significant distracting injuries

ii. Language Barrier

B. Pre-hospital personnel shall apply cervical spine immobilization to patients injured from blunt force trauma in the following circumstances:

a. Conscious patients exhibiting one or more of the following signs or symptoms:

i. Posterior midline cervical tenderness or pain

ii. Distal numbness, tingling, weakness, or paresthesia

iii. Paralysis

iv. Neck guarding or restricted range of motion;

v. Glasgow Coma Scale (GCS) of less than 13 as a result of blunt force trauma

b. Unconscious adult patients suffering a blunt force mechanism of injury, except ground level falls.

C. Prehospital personnel shall not apply cervical spine immobilization to patients in the following circumstances:

a. Patients injured solely from penetrating trauma, unless evidence of spinal injury.

b. Unconscious adult patients experiencing a ground level fall

c. Patients in Cardiac Arrest

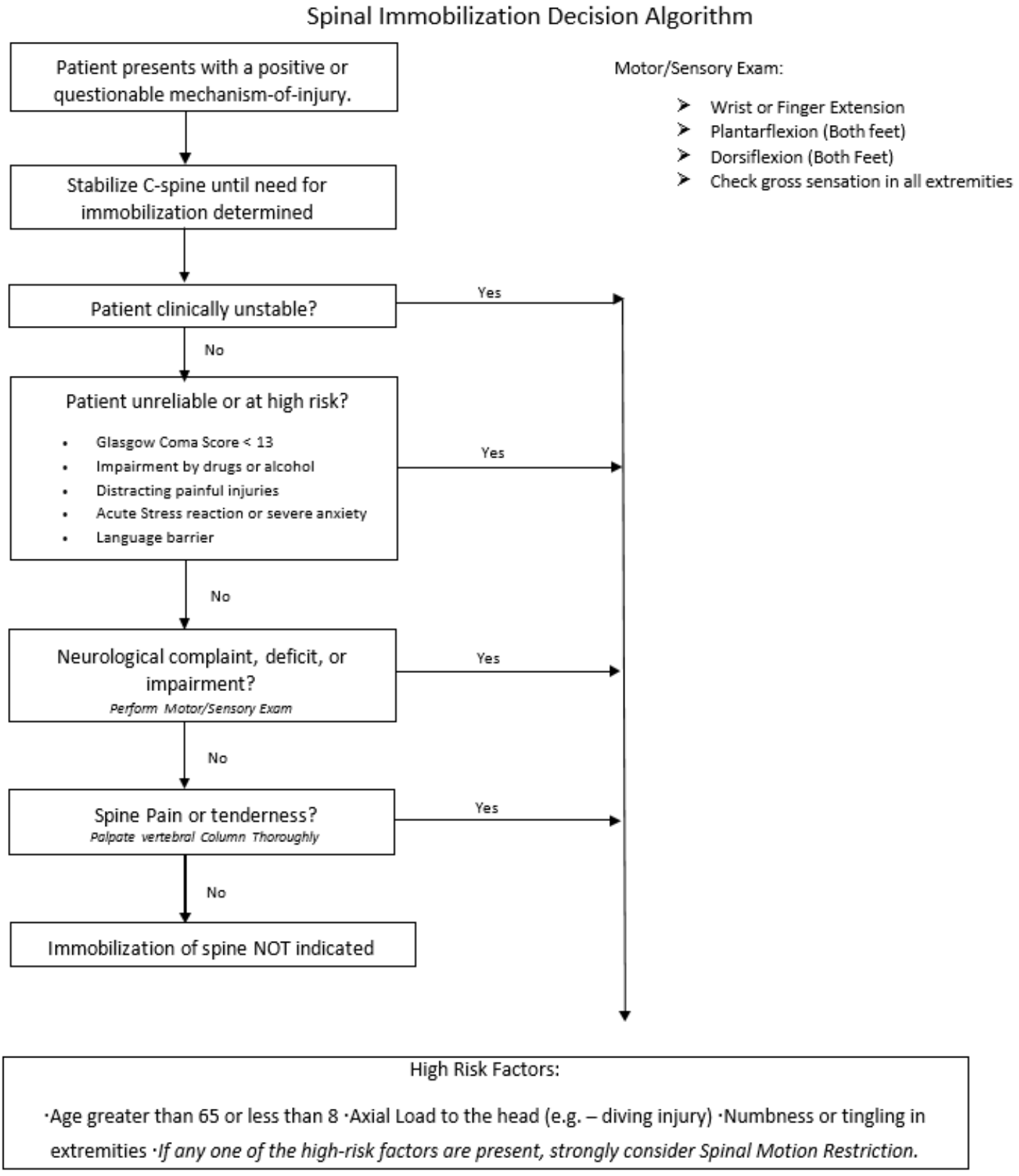
d. NOTE: Use of backboards / c-collars to assist in movement, CPR, intubation, etc., is acceptable.

D. In patients without neck or spinal mid-line back pain or tenderness, altered level of consciousness, intoxication, or distracting injury, spinal immobilization may be withheld as long as the patient can be accurately evaluated.

The following algorithm should be utilized when deciding whether or not to immobilize a patient's spine:

Procedure

Procedural: Spinal Immobilization Decision Algorithm



High Risk Factors:

·Age greater than 65 or less than 8 ·Axial Load to the head (e.g. – diving injury) ·Numbness or tingling in extremities ·*If any one of the high-risk factors are present, strongly consider Spinal Motion Restriction.*

Procedure

Procedural: Supraglottic Airway

EMR

EMR STOP

EMT

EMT STOP

EMT IV-SGA

Indications

- King LT Airway intended for airway management in patients over 4 feet in height without controlled or spontaneous ventilation
- iGel intended for airway management in patients. Use appropriate size for weight.

Contraindications

- Responsive patients with an intact gag reflex
- Patients with known esophageal disease
- Patients who have ingested caustic substances

Warnings

- High airway pressures may divert gas either to the stomach or to the atmosphere

* Agencies may choose between the use of King LT Airway or I-Gel Airway's for their department.

EMT IV-SGA STOP

ADVANCED EMT

ADVANCED EMT STOP

Respiratory: Airway Management

Key Points/Considerations

Indications: Difficulty breathing

EMR

- Oxygen therapy using non-rebreather mask 10-15 lpm, NRB, titrate to a SaO2 94%
- Oxygen therapy using nasal cannula, 2-6 lpm, if patient will not tolerate NRB, titrate to a SaO2 94%
- Oxygen therapy using bag valve mask 15 lpm, BVM, titrate to a SaO2 94%
- Oropharyngeal airways
- BVM assisted ventilation

EMR STOP

EMT

- Nasopharyngeal airways
- Continuous Positive Airway Pressure (CPAP) if trained
- Auto Vent

EMT STOP

EMT IV-SGA

- Supraglottic airway device in unresponsive patients

EMT IV-SGA STOP

ADVANCED EMT

- Continuous Positive Airway Pressure (CPAP)

ADVANCED EMT STOP

Respiratory: Acute Pulmonary Edema

Key Points/Considerations

Indications: Non-cardiogenic Pulmonary Edema

- All patients with rales do not have pulmonary edema — consider the possibility of pneumonia or chronic obstructive pulmonary disease (COPD) exacerbation

EMR

- ABC and vital signs
- Remove from environment
- Airway management with oxygen therapy maintaining a SaO2 of 94% through titration
- Sit patient upright, if possible
- Pulse Oximetry as available

EMR STOP

EMT

- Consider CPAP

EMT STOP

EMT IV-SGA

- Provide IV therapy as necessary
- Do not over hydrate
- Supraglottic airway device

EMT IV-SGA STOP

ADVANCED EMT

- Nitroglycerin 0.4 mg per dose, up to 3 doses, 5 minutes apart, provided the patient's systolic BP is above 100 mmHg

ADVANCED EMT STOP

Respiratory: Asthma & COPD

Key Points/Considerations

Indications: Wheezing with and/or shortness of breath with history of asthma, COPD or emphysema

EMR

- ABC and vital signs
- Airway management with oxygen therapy maintaining a SaO2 of 94% through titration
- Pulse Oximetry as available
- Clear airway
- Determine if patient has utilized his/her own asthma medications.
- Assist patient with their own medication handheld aerosol inhaler

EMR STOP

EMT

- Assist patient with their own medication handheld aerosol inhaler
- Assist a patient with their nebulized medication or administer one nebulized treatment of one 3mL Unit-Dose of combination of Ipratropium Bromide (0.5mg) and Albuterol Sulfate Inhalation Solution (3mg):
    i. Adult, one treatment
    ii. Pediatric: ≥ 2 years old, one-half treatment – up to 1.5 mL of 3mL Unit-Dose Vial
    iii. Pediatric: < 2 years old, one-quarter treatment – up to 0.75 mL of 3mL Unit-Dose Vial
- If respiratory distress continues after 5 minutes:
    i. Administer one 2.5 mg diluted in 3mL Unit-Dose Vial of Albuterol Sulfate (only) via nebulizer
    ii. May repeat one time if respiratory distress continues.
- Consider use of CPAP

EMT STOP

EMT IV-SGA

- Provide IV therapy as necessary

EMT IV-SGA STOP

ADVANCED EMT

- Consider intubation.

ADVANCED EMT STOP

Respiratory: Croup & Epiglottitis

EMR

- ABC and vital signs
- Airway management with oxygen, preferably humidified
- Pulse Oximetry as available
- Keep patient as calm as possible, sitting position is preferable
- Minimize stimulation and consider transporting with parent if patient is pediatric
- DO NOT PLACE ANYTHING IN THE PATIENTS MOUTH OR VISUALIZE THE AIRWAY!
- Avoid aggressive examination that could precipitate complete airway obstruction
- If airway becomes obstructed ventilate with BVM

EMR STOP

EMT

EMT STOP

EMT IV-SGA

- Do not attempt IV access

EMT IV-SGA STOP

ADVANCED EMT

ADVANCED EMT STOP

Respiratory: Hyperventilation Syndrome

Key Points/Considerations

Indications: Shortness of breath, anxiety, Carpopedal spasms

EMR

- ABC and vital signs
- Clear airway
- Airway management with oxygen therapy maintaining a SaO2 of 94% through titration
- Pulse Oximetry as available
- Coached ventilation

EMR STOP

EMT

EMT STOP

EMT IV-SGA

EMT IV-SGA STOP

ADVANCED EMT

ADVANCED EMT STOP

Respiratory: Pneumonia

Key Points/Considerations

Indications: Fever, cough, chills and fatigue. Rhonchi on lung exam.

EMR

- ABC and vital signs
- Airway management with oxygen therapy maintaining a SaO2 of 94% through titration
- Pulse Oximetry as available
- Obtain a temperature
- Assist patient with their own medication handheld aerosol inhaler or assist a patient with their nebulized medication.

EMR STOP

EMT

- Assist a patient with their nebulized medication or administer one nebulized treatment of one 3mL Unit-Dose of combination of Ipratropium Bromide (0.5mg) and Albuterol Sulfate Inhalation Solution (3mg):
  - Adult, one treatment
  - Pediatric: ≥ 2 years old, one-half treatment – up to 1.5 mL of 3mL Unit-Dose Vial
  - Pediatric: < 2 years old, one-quarter treatment – up to 0.75 mL of 3mL Unit-Dose Vial
- If respiratory distress continues after 5 minutes:
  - Administer one 2.5 mg diluted in 3mL Unit-Dose Vial of Albuterol Sulfate (only) via nebulizer
  - May repeat one time if respiratory distress continues.

EMT STOP

EMT IV-SGA

- Provide IV therapy as necessary

EMT IV-SGA STOP

ADVANCED EMT

ADVANCED EMT STOP

Respiratory: Pneumothorax

Key Points/Considerations

Indications: Shortness of breath, tachycardia, rapid breathing, and decreased breath sounds on affected side. Tension pneumothorax may cause severe symptoms including tracheal deviation and JVD.

EMR

- ABC and vital signs
- Clear airway
- Airway management with oxygen therapy maintaining a SaO2 of 94% through titration
- Pulse Oximetry as available

EMR STOP

EMT

EMT STOP

EMT IV-SGA

- Provide IV therapy as necessary

EMT IV-SGA STOP

ADVANCED EMT

ADVANCED EMT STOP

Respiratory: Pulmonary Embolus

Key Points/Considerations

Indications: Shortness of breath, altered mental status, tachycardia, cyanosis and pleuritic chest pain

EMR

- ABC and vital signs
- Airway management with oxygen therapy maintaining a SaO2 of 94% through titration
- Pulse Oximetry as available
- Sit patient upright, if possible

EMR STOP

EMT

- CPAP, if equipped. Target pressure is 10 cm H2O pressure.

EMT STOP

EMT IV-SGA

- Provide IV therapy as necessary

EMT IV-SGA STOP

ADVANCED EMT

ADVANCED EMT STOP

Respiratory: Respiratory Emergencies

Key Points/Considerations

Pediatric Management Considerations

1) Airway obstruction
   a) Use infant/child foreign body airway procedures if complete obstruction
   b) If partial obstruction
      i) Do not agitate patient
      ii) Allow patient position of comfort
      iii) Oxygen/limited exam
2) Patient drooling, with difficulty swallowing, or seal bark cough,

Note: Do not attempt to visualize oropharynx (see Epiglottitis protocol)

- Clear the airway, provide oxygen and/or ventilator assistance as necessary
- Allow patient to achieve position of comfort

EMR

- Clear the airway, provide oxygen and/or ventilator assistance as necessary
- Allow patient to achieve position of comfort
- Pulse Oximetry / Cardiac Monitor 3 or 4 lead as available
- Can assist patient with their own Albuterol for wheezing as needed.

EMR STOP

EMT

- Cardiac monitor / 12 lead EKG if available
- Administer Albuterol for wheezing as needed.
- Consider Ipratropium Bromide and Albuterol treatment per asthma protocol

EMT STOP

EMT IV-SGA

- Provide IV therapy as necessary

EMT IV-SGA STOP

ADVANCED EMT

ADVANCED EMT STOP

Trauma: Prehospital Treatment for the Trauma Patient

1. Scene Size-up / Assessment
   a. Scene Safety
   b. Body Substance Isolation per Agency exposure control program
   c. Assess for number of patients
   d. Activate local emergency system as necessary

2. Initial Patient Assessment
   a. Airway, Breathing, Circulation (ABC's)
   b. Establish patient care priorities as soon as possible
      • Triage multiple patients (See Mass Casualty Incident Section).
   c. Notify receiving facility
      • Follow the trauma triage procedures
   d. Notify the trauma center as soon as possible

3. Rapid or Focused History and Physical Exam
   a. Deformities, Contusions, Abrasions, Punctures - Burns, Tenderness, Lacerations, Swelling (DCAP - BTLS)
   b. Pulse, Movement, Sensation (PMS) or Circulation, Motor, Sensory (CMS)
   c. Vital signs
   d. SAMPLE history
   e. Glasgow Coma Scale (GCS)

4. Ongoing Assessment
   a. Re-evaluate initial patient assessment items
      • Unstable patient a maximum of every 5 minutes
      • Stable patient every 15 minutes

5. Transport
   a. Mode of transport and destination based on Whitman County Patient Care Procedures
   b. Prioritize patient transport.
   c. Provide treatment, using appropriate protocols.
   d. Transport:
      • Use of lights and sirens should be limited to the emergency transportation of critical patients.
   e. Destination determined by:
      • Trauma triage destination tool (when implemented)
   f. Patient request* *
   g. Senior Medical Officer judgment
   h. Physician-to-Physician arrangement* *

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

Washington State Prehospital Trauma Triage Destination Procedure

Purpose

The Trauma Triage Procedure was developed by the Centers for Disease Control in partnership with the College of Surgeons, Committee on Trauma. The guidelines have been adopted by the Department of Health (DOH) based on the recommendations of the State EMS and Trauma Steering Committee.

The procedure is described in the attached algorithm. The guidelines represent the current best practice for the triage of trauma patients. The algorithm allows EMS and Trauma Responders to quickly and accurately determine if the patients is a major trauma patient. Major trauma patients must be taken to the highest appropriate level trauma facility in the defined system within 30 minutes transport time (Air or Ground).

The "defined system" is the trauma system that exists within an EMS and Trauma Care Region.

Explanation of Procedure

Any certified EMS and Trauma person can identify a major trauma patient and activate the trauma system. This may include asking for Advance Life Support response or air medical evacuation.

Step (1) Assess the vital signs and level of consciousness using the Glasgow Coma Scale. Step 1 findings require activation of the trauma system. They also require rapid transport the highest most appropriate trauma center within 30 minutes transport time (ground or air). If unable to manage the patient's airway, consider meeting up with an ALS unit or transporting to the nearest facility capable of definitive airway management.

Step (2) Assess the anatomy of injury. Step 2 findings require activation of the trauma system. They also require rapid transport the highest most appropriate trauma center within 30 minutes transport time (ground or air). The presence of the specific anatomical injuries even with normal vital signs, lack of pain or normal levels of consciousness still require calling medical control and activating the trauma system.

Step (3) Assess biomechanics of the injury and address other risk factors. The conditions identified are reasons for the provider to transport to a trauma center. The destination trauma center need not be the highest-level trauma center. Medical control should be contacted as soon as possible.

Step (4) has been added to assess special patients or system considerations. Risk factors coupled with "Provider Judgment" are reasons for the provider to contact Medical Control and discuss appropriate transport for these patients. In some cases, the decision may be to transport the nearest trauma center.

Regional Patient Care Procedures (PCP's) and Local County Operating Procedures (COP's) provide additional details about the appropriate hospital destination. PCP's and COP's are intended to further define how the system operates. The Prehospital Trauma Triage procedure and the Regional Patient Care Procedures work in a "hand in glove" fashion to address trauma patient care needs.

Washington State Trauma Triage Destination Procedures

Measure Vital Signs & Level of Consciousness

STEP 1

- ☐ Glasgow Coma Scale < 13 or
- ☐ Systolic Blood Pressure < 90 mmHg
- ☐ Respiratory Rate < 10 or > 29 per minute or need for ventilator support (< 20/min in infant aged < 1 yr)

→ **YES** → Take patient to the systems * highest appropriate level Trauma Center within 30 minutes transport time (Air or Ground)

NO

Assess Anatomy of Injury

STEP 2

- Penetrating injury of head, neck, torso and extremities proximal to elbow or knee
- Chest wall instability or deformity (e.g., flail chest)
- Two or more proximal long bond fractures
- Crushing, degloved, mangled or pulseless extremity
- Amputation proximal to wrist or ankle
- Pelvic fractures
- Open or depressed skull fracture
- Paralysis

→ **YES** → Take patient to the systems * highest appropriate level Trauma Center within 30 minutes transport time (Air or Ground)

NO

Assess Mechanism of Injury and Evidence of High-Energy Impact

STEP 3

- **Falls**
  - Adults: > 20 ft. (1 story = 10 ft.)
  - Children: ≥ 10 ft. or 2 – 3 times height of child
- **High – Risk auto crash**
  - Intrusion, including roof > 12 inches occupant site; 18 inches anysite
  - Ejection (partial or complete) from automobile
  - Death in same passenger compartment
  - Vehicle telemetry data consistent with a high-risk injury
- **Auto vs. Pedestrian/bicyclist thrown, run over, or withsignificant (greater than 20 mph) impact**
- **Motorcycle crash greater than 20 mph**

→ **YES** → Transport to closest appropriate trauma center within 30 minutes transport time (Air or Ground), which, depending upon the defined trauma system, need not be the highest-level trauma system.

NO

Assess Special Patient or System Considerations

STEP 4

- **Older Adults**
  - Risk of injury or death after age 55 yrs.
  - Systolic BP < 110 may represent shock after age 65 yrs.
  - Low impact mechanisms (e.g. ground level) fall may result in severe injury
- **Children**
  - Should be triaged preferentially to pediatric capable traumacenter
- **Anticoagulants and bleeding disorders**
  - Patients with head injury are at high risk for rapid deterioration
- **Burns**
  - Without other trauma mechanism, triage to burn facility
- **Pregnancy > 20 weeks**
- **EMS Provider Judgement**

→ **YES** → Contact medical Control and consider transport to a trauma center or a specific resource hospital

→ **NO** → Transport according to local protocol & Regional PCP

* **"System"** is defined as the Regional or Local EMS and Trauma System

Trauma: Abdominal Injuries

Key Points/Considerations

Signs/Symptoms:

- Tender, rigid or distended abdomen
- Position (guarding)
- Signs and symptoms of shock
- Consider abdominal spinal injury
- Wounds, (entrance/exit), bruising
- Consider pregnancy (see Obstetrical Emergencies)

EMR

- Clear the airway, provide oxygen and/or ventilatory assistance as necessary
- Pulse Oximetry
- Airway management with oxygen therapy maintaining a SaO2 of 94% through titration
- Do not touch or try to replace exposed organs
    - Cover exposed organs with sterile/moist dressing
- Control bleeding
- Spinal motion restriction

EMR STOP

EMT

EMT STOP

EMT IV-SGA

- 2 large bore IV's
- IV fluid bolus to maintain systolic blood pressure of 90 mmHg

EMT IV-SGA STOP

ADVANCED EMT

ADVANCED EMT STOP

Trauma: Amputations and Bleeding

Key Points/Considerations

Signs/Symptoms:

- Spurting/steady flowing or oozing blood
- Separated or displacement of body part or tissue

EMR

- ABCs and vital signs
- Control bleeding
- Apply Tourniquet to control potentially life-threatening limb hemorrhage not controlled with direct pressure or other simple measures
- Airway management with oxygen therapy maintaining a SaO2 of 94% through titration
- Collect parts and rinse off gross contaminants with saline
- If using ice packs for cooling, wrap with gauze to prevent contact with amputated parts
- Wrap in sterile saline moistened gauze, place in plastic bag, seal, and place in ice water or with chemical cold pack (be sure amputated part does not come into direct contact with cold source)
- Label with patient name, date and time – Note disposition of amputated part on Patient Care Report – Keep amputated part with patient

EMR STOP

EMT

EMT STOP

EMT IV-SGA

- Provide IV therapy as necessary

EMT IV-SGA STOP

ADVANCED EMT

ADVANCED EMT STOP

Trauma: Burns

Key Points/Considerations

- Identify source of burning and take appropriate safety precautions
- Evaluate depth and area by using rule of nines
- 2nd or 3rd degree burns greater than 20% and/or involving face or airway, initiate Trauma Triage Procedure
- Carefully evaluate respiratory tract for involvement
- If hazardous materials, contact Medical Control

EMR

- Stop the burning
- Remove any non-adhered clothing, jewelry, etc.
- ABC and vital signs
- Airway management with oxygen therapy maintaining a SaO2 of 94% through titration
- Cover burns with clean or sterile dressings
- Burns to the eye require copious irrigation with Normal Saline
- Pulse Oximetry as available

EMR STOP

EMT

EMT STOP

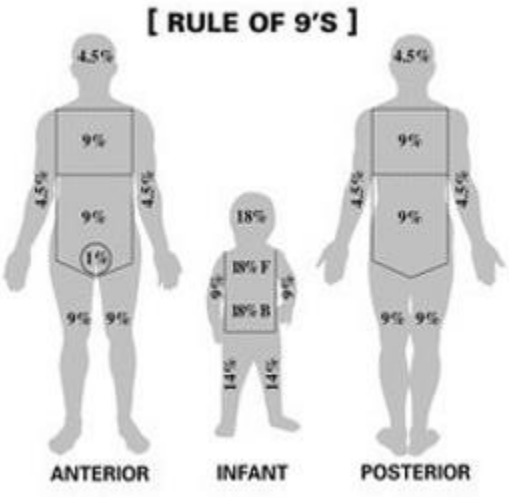
EMT IV-SGA

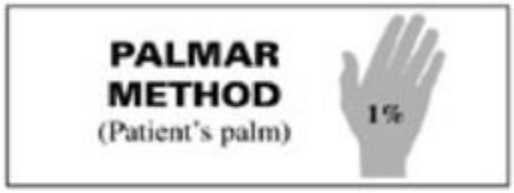
- Vascular access at 2 sites with large bore IV, consider EZ IO

EMT IV-SGA STOP

ADVANCED EMT

ADVANCED EMT STOP





Trauma: Chest Injury

Key Points/Considerations

Signs/Symptoms:

- Changes in respiratory rate/quality,
- Breath sounds diminished, unequal, or absent
- Flail chest, use of accessory muscles distended neck veins (JVD)
- Consider thoracic spinal injury, shock,
- Wounds, (entrance/exit)
- Bruising
- Complains of pain with inspiration or expiration.

EMR

- Airway management with oxygen therapy maintaining a SaO2 of 94% through titration
- Continuously reassess respiratory status
- Pulse Oximetry / Cardiac Monitor 3 or 4 lead as available
- Pneumothorax — refer to Pneumothorax
- Flail Chest
  - Splint for comfort
- Control bleeding
- Spinal motion restriction

EMR STOP

EMT

- Cardiac monitor / 12 lead EKG if available

EMT STOP

EMT IV-SGA

- Provide IV therapy as necessary

EMT IV-SGA STOP

ADVANCED EMT

ADVANCED EMT STOP

Trauma: Extremity Injury

Key Points/Considerations

Signs/Symptoms:

- Exposed bone ends
- Joints locked in position
- Loss of feeling or movement
- Loss of distal pulse
- Bruising/swelling
- Pain
- Shock
- Multiple long bone fractures

EMR

- Airway management with oxygen therapy maintaining a SaO2 of 94% through titration
- Pulse Oximetry as available
- Consider alignment with gentle traction if pulses absent or gross deformity noted
- Mechanical immobilization
- Reassess distal PMS (CMS) after applying splint
- Consider application of cold pack to painful or swollen area
- Control bleeding
- Traction splint for mid-shaft femur fracture – if trained with MPD approval

EMR STOP

EMT

- Traction splint for mid-shaft femur fracture

EMT STOP

EMT IV-SGA

- Provide IV therapy as necessary

EMT IV-SGA STOP

ADVANCED EMT

ADVANCED EMT STOP

Trauma: Head & Spinal Injuries

Key Points/Considerations

Signs/Symptoms:

- Cerebrospinal fluid or blood from nose, ears, mouth
- Glasgow coma scale score
- Altered mental status, see Trauma Triage Procedures
- Bruising around eyes, or behind ears
- Altered mental status
- Irregular breathing
- Changes in pulse rate
- Changes in blood pressure
- Neurologic disability
- Loss of bowel or bladder control
- Unequal pupils with altered mental status
- Seizures

EMR

- Spinal motion restriction, see Spinal Immobilization Procedure
- Clear the airway, provide oxygen and/or ventilatory assistance as necessary
- Airway management with oxygen therapy maintaining a SaO2 of 94% through titration
- Control bleeding
- Pulse Oximetry as available

EMR STOP

EMT

EMT STOP

EMT IV-SGA

- Provide IV therapy as necessary

EMT IV-SGA STOP

ADVANCED EMT

ADVANCED EMT STOP

Trauma: Shock

Key Points/Considerations

- COMPENSATED SHOCK is defined as significant mechanism of injury AND tachypnea, tachycardia, pallor, or restlessness, AND Systolic BP greater than 90 mmHg
- DECOMPENSATED SHOCK is defined as clinical picture of shock AND Systolic BP less than 90 mmHg
- A falling BP is a LATE sign of shock

EMR

- ABC and vital signs
- Apply tourniquet to control potentially life-threatening limb hemorrhage not controlled with direct pressure or other simple measures
- Pulse Oximetry / Cardiac Monitor 3 or 4 lead as available
- Airway management with oxygen therapy maintaining a SaO2 of 94% through titration

EMR STOP

EMT

- Cardiac monitor / 12 lead ECG if available

EMT STOP

EMT IV-SGA

- Vascular access with large bore IV's
- If COMPENSATED SHOCK:
  - Normal Saline, 1 liter, then 500 ml/hour
- IF DECOMPENSATED SHOCK:
- Additional vascular access, infuse Normal Saline, 2 liters, then 500 ml/hour
- Intubate if necessary

EMT IV-SGA STOP

ADVANCED EMT

ADVANCED EMT STOP

Revisions and Updates

2022 March

- Pg 15: Update helicopter daytime landing zone size to 75 ft x 75 ft.
- Pg 31: Clarified Key Considerations – number of doses
- Pg 35: Medical: Anaphylaxis and Allergic Reactions – added EMR can use auto-injectors if trained per state protocol
- Pg 39: Medical Diabetic Emergencies - EMT: Previous protocols use of Glucagon as was approved by MPD for EMT'S. This was removed in 2020 Protocol updates. This is re-instated in 2022 with approved training by EMT.
- Pg 44: Medical: Physical Abuse and Neglect – list of symptom moved from EMT to Key Points
- Pg 53: Procedure: 12 Lead EKG – Added 3 or 4 lead references
- Pg 58: Procedure: Epinephrine Administration – allows EMR to use EMS supplied auto-injectors
- Pg 67: Respiratory: Airway Management – Added CPAP to EMT section, if trained.
- Pg 69: Respiratory: Asthma and COPD – Clarified using patient's nebulized medication
- Pg 75: Respiratory: Respiratory Emergencies – EMR – Added 3 or 4 lead if available
- Pg 83: Trauma: Extremity Injury – EMR – Added traction splint with MPD approved training