SECTION: Administration

REVISED: 05/2012

Section 12

ADMINISTRATION

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SECTION: Administration

PROTOCOL TITLE: Management

REVISED: 05/2012

Protocol
12-1

MANAGEMENT

OVERVIEW:
An orderly management of the emergency scene will improve any level of pre-hospital patient care. Although questions concerning authority (i.e., on-scene physician and response by more than one EMS agency) can arise, they should be settled quickly and quietly.

PROTOCOL FOR MANAGEMENT:

1. Upon arrival at the scene, NIMS (National Incident Management System) shall be used and the Incident Commander (or designee) shall have authority for patient care and management at the scene of an emergency.
2. Authority for management of the emergency scene, exclusive of medical control over the patient, will rest with the appropriate on-scene public safety officials (i.e., police, fire, and rescue). It is recommended that scene management be negotiated in advance of emergencies by local agreements and written protocols.
3. If other medical professionals are at the emergency scene offer or provide assistance in patient care, the following will apply:
    a. Medical professionals who offer their assistance at the scene should be asked to identify themselves and their level of training. The pre-hospital provider should request that the medical professional provide proof of her / his identity if that person wants to continue to assist with patient care after the ambulance has arrived.
    b. Physicians are the only medical professional who may assume control of the patient's care. Pre-hospital providers should recognize the knowledge and expertise of other medical professionals and use them, if needed, for the best patient care possible. Any bystander claiming to be a physician must show credentials to EMS on scene prior to being allowed to provide patient care. All medical professionals who assist or offer assistance should be treated with courtesy and respect.
    c. The authority of the pre-hospital provider's procedures rests in these pre-hospital Patient Care Protocols adopted by the EMS agency and the agency Operational Medical Director (OMD).
    d. A physician at the scene who renders care to the patient prior to arrival of an EMS unit may retain medical authority for the patient if the physician desires. The pre-hospital provider shall advise the physician who wants to supervise or to direct patient care that, in order to so, the physician MUST accompany the patient to the receiving hospital to maintain continuity of patient care. Documentation of these events will be complete and will include the physician's name.
    e. If there is a conflict about patient care or treatment protocols, the pre-hospital provider will contact on-line medical control or, if practical, the agency OMD for further instructions. Under no circumstances should this conflict interfere with prudent patient care.

MANAGEMENT

4. The levels of pre-hospital EMS certification currently recognized by the Commonwealth of Virginia are:

Core Certifications	Specialty Certifications
a. **First Responder / EMR**	a. Pediatric Neonatal Critical Care Transport Paramedic
b. **Emergency Medical Technician-Basic / EMT**	b. Critical Care Emergency Medical Technician – Paramedic
c. **Emergency Medical Technician – Enhanced / Advanced EMT**	c. Certified Flight Paramedic
d. **Emergency Medical Technician – Intermediate**	
e. **Emergency Medical Technician-Paramedic / Paramedic**	

SECTION: Administration

PROTOCOL TITLE: Documentation

REVISED: 06/2015

Protocol
12-2

DOCUMENTATION

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

PROTOCOL FOR MANAGEMENT:

1. An electronic patient care report (ePCR) will be completed for each patient encounter. The report must be completed and sent to the appropriate facility within the following 12 hours. ODEMSA, at the request of the region, has developed a MIVT report for documenting patient care to assist the hospital between the time when the patient is delivered to the ED and when the patient care report is received. A copy of the MIVT is included in these protocols.
2. Each ePCR will include documentation of:
    a. The evaluation and care of the patient during pre-hospital care.
    b. The patient's refusal of the evaluation.
    c. The patient's encounter to protect the local EMS system and its personnel from undue risk and liability.
3. A patient is defined as any individual that requests evaluation by EMS. If an individual is not legally competent due to age, injury, chronic illness, intoxication, etc., always err on the side of patient safety and assume an implied request for evaluation.
4. All patient encounters, which result in some component of an evaluation, must have an ePCR completed.
5. All patients who refuse any component of the evaluation or treatment, should have a refusal signed and documentation of the refusal noted in the narrative.
6. All patients who are not transported by EMS should have a refusal completed.
7. When utilized effectively, the ePCR allows great detail in documentation by using the pre-loaded information coupled with notes. However, this does not eliminate the need for a narrative to be completed. No ePCR will be considered complete without a written narrative that "paints" an accurate picture of the scene, patient presentation, and all occurrences during the interaction with that patient.
8. When a patient is transported, a copy of the MIVT report should be left at the receiving hospital. Also, some facilities have printing capability and providers can print ePCRs before leaving the facility. It is imperative that reports are completed and uploaded in a timely manner as these reports may influence the patient's care at the receiving facility and will be placed in the patient's permanent medical record once received.

DOCUMENTATION

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SECTION: Administration

PROTOCOL TITLE: Minors

REVISED: 05/2012

Protocol
12-3

MINORS

OVERVIEW:
Pre-hospital providers are called to treat young patients and occasionally, there is no parent or other person responsible for the minor. Minors, in the eyes of the law, are generally considered to be incapable of self-determination; and therefore require parental or guardian consent for treatment / transport. That being said, generally one of three situations present: (1) Emancipated Minor (*Very rare*), (2) A concept of Mature Minor emerges, or (3) the patient is a bona fide Minor.

GUIDELINE:
Whenever delay in providing medical or surgical treatment to a minor may adversely affect such minor's recovery and no person authorized in this section to consent to such treatment for such minor is available within a reasonable time under the circumstances, no liability shall be imposed upon qualified emergency medical services personnel as defined in § 32.1-111.1 at the scene of an accident, fire or other emergency, a licensed health professional, or a licensed hospital by reason of lack of consent to such medical or surgical treatment. However, in the case of a minor 14 years of age or older that is physically capable of giving consent, such consent shall be obtained first.[1]

In situations where parental involvement is impractical or problematic, *OR* the patient is unconscious and/or lacks mental capacity to consent to care, the pre-hospital provider may treat and/or transport.

A pregnant minor shall be deemed an adult for the sole purpose of giving consent for herself and her child to surgical and medical treatment relating to the delivery of her child when such surgical or medical treatment is provided during the delivery of the child or the duration of the hospital admission for such delivery; thereafter, the minor mother of such child shall also be deemed an adult for the purpose of giving consent to surgical and medical treatment for her child.[1]

Authority of Parents, Guardians or Others: Parents have the authority to direct or refuse to allow treatment of their children. A court appointed guardian, and any adult person standing *in loco parentis*, also has the same authority. "In loco parentis" is defined as "[I]n the place of a parent; instead of a parent; charged, fictitiously, with a parent's rights, duties, and responsibilities." Black's Law Dictionary, 708 (5th ed. 1979). 1987 - 88 Va. Op. Atty. Gen. 617 "Furthermore, I would point out that §54-325.2(6) allows any person standing "in locos parentis" to consent to medical treatment for a minor child. This signifies, in my judgment, an intent to allow any responsible adult person, who acts in the place of a parent, to consent to the treatment of a minor child, particularly in emergency situations." 1983-84 VA. Op. Atty. Gen. 219. Such a person may be a relative, schoolteacher or principle, school bus driver, baby-sitter, neighbor, or other adult person in whose care of the child has been entrusted.[2]

[1] Code of Virginia 54.1-2969
[2] Thomas Jefferson EMS Council – Treatment for Patients Under Age 18

MINORS

Persons Subject to Policy Under Age 14: A person that is under the age of 14 shall be treated and transported unless a parent or guardian or person *in locos parentis* advises otherwise. Do not delay treatment or transport for extended periods simply trying to contact a parent or guardian. If you believe that treatment is necessary, but the parent or guardian or person *in locos parentis* refuses to allow treatment, medical control should be consulted. [2]

Persons Subject to Policy Aged 14 - 18: A person between the ages of 14 and 18 may refuse treatment and transport, unless a parent or guardian or person *in locos parentis* advises otherwise. If you believe that treatment is necessary, but the person refuses, an attempt should be made to contact a parent or guardian, and medical control should be consulted. If you believe that treatment is necessary, but the parent or guardian or person *in locos parentis* refuses to allow treatment, medical control should be consulted.[2]

Emancipation is a court ordered decree. The circumstances under which a minor may petition for emancipation are as follows: A minor who has reached his / her sixteenth birthday and is residing in this Commonwealth, AND (i) the minor has entered into a valid marriage, whether or not that marriage has been terminated by dissolution; or (ii) the minor is on active duty with any of the armed forces of the United States of America; or (iii) the minor willingly lives separate and apart from his parents or guardian, with the consent or acquiescence of the parents or guardian, and that the minor is or is capable of supporting himself and competently managing his own financial affairs. If the courts determine that an emancipation order is appropriate and subsequently issues such order, the emancipated minor is legally able to consent to medical, dental, or psychiatric care, without parental consent, knowledge, or liability. Once emancipation has been granted by the courts, DMV issues identification indicating the emancipation degree, that identification should be readily available for your review.

1. In situations where the parent / guardian or emancipated minor possess sufficient mental capacity to formulate decisions regarding medical care / treatment, consent shall be obtained prior to initiating care. Mental capacity means that the individual rendering the consent, is informed and possesses sufficient ability to be able to understand:
    - The general nature of the injury / illness
    - Nature and purpose of proposed treatment
    - Risks and consequences of proposed treatment
    - Probability that treatment will be successful
    - Feasible treatment alternatives and have the ability to make a voluntary choice among the alternatives
    - Prognosis if treatment is not given
2. In situations where the parent / guardian or emancipated minor demonstrates sufficient mental capacity to formulate decisions and subsequently refuses the

offer of care; yet in the provider's judgment is in need of medical attention, the provider should first attempt to discern the reasons for the patients' refusal of consent. Often it is something so inconsequential, that reason and common sense often prevail and once you have provided assistance with whatever is the basis of concern (i.e., patient needs to call someone to look after a pet, etc) the patient often consents to treatment / transport. If unable to influence the parent / guardian or patient, contact on-line Medical Control for additional guidance.

PEARLS:

1. *Always act in the best interest of the patient* - EMS providers must strike a balance between abandoning the patient and forcing care.
2. All states allow parental consent for treatment of a minor to be waived in the event of a medical emergency. The circumstances that should be present in order for such an emergency include the patient being incapacitated to the point of being unable to give an informed choice, the circumstances are life-threatening or serious enough that immediate treatment is required, and it would be impossible or imprudent to try to get consent from someone regarding the patient. In these cases, consent of the parent is presumed, since otherwise the minor would suffer avoidable injury.
3. If a minor is injured or ill and no parent contact is possible, the provider should contact on-line Medical Control for additional instructions.
4. Refer to the appropriate Pediatric Protocol sections and consider the following in regard to transport:
    a. Transport conscious children with a parent unless it interferes with proper patient care.
    b. In cases of major trauma or cardiopulmonary arrest, exercise judgment in allowing parents to accompany the child in the ambulance**.**
    c. Allow the parent to hold and / or touch the child whenever possible and safe to do so.
    d. Both parent and child will respond best to open and honest dialogue.

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SECTION: Administration

PROTOCOL TITLE: Patient Destination

REVISED: 05/2012

Protocol
12-4

PATIENT DESTINATION

SCOPE:
This policy pertains to all licensed EMS Agencies in the Old Dominion EMS Alliance (ODEMSA) region that provide ambulance transportation.

PURPOSE:
To provide for a defined, consistent policy for the destination of ambulance patients consistent with quality patient care and regional medical protocols within the ODEMSA region this includes Planning Districts 13, 14, 15 and 19.

POLICY ELEMENTS:

1. All ambulance patients (resulting from requests for emergency assistance which result in transport) normally will be transported to the closest **appropriate** hospital emergency department unless otherwise directed by the on-line medical control physician and/or by medical control during a declared diversion. The closest appropriate hospital is defined as the hospital closest to the location of the patient *that can provide the level of care needed by the patient*. The medical control physician is defined as the attending emergency department physician at the hospital contacted by the ambulance Attendant-in-Charge (AIC) or a person designated by the AIC. Medical Control Hospital is defined as that hospital designated to direct ambulance movements in line with ODEMSA's Hospital Diversion Policy as most recently revised.

2. Stable patients may be transported to the patient's destination of choice if allowed by local EMS agency policies and by available resources.

3. Patients who meet certain criteria as severe trauma patients, as defined in the Old Dominion EMS Alliance Trauma Care System Plan, usually will be transported directly to a Trauma Center unless redirected by the Medical Control Physician in accordance with the Trauma Care System Plan.

4. Individual EMS agencies and/or EMS systems are responsible for determining operational policies related to the most effective ambulance deployment and utilization patterns. This may include policies allowing transport of stable patients to hospitals of the patient's choice.

5. In mass casualty incident (MCI) situations, the current Central Virginia Mass Casualty Incident Plan and its EMS Mutual Aid Response Guide, as most recently revised, will govern patient transportation and hospital destination(s).

6. Other policies and protocols related to patient transport and ambulance-to-hospital communications are defined in the ODEMSA Pre-hospital Patient Care Protocols and the Hospital Diversion Policy as most recently revised.

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SECTION: Administration

PROTOCOL TITLE: Diversion

REVISED: 05/2012

Protocol
12-5

DIVERSION

PURPOSE:
To maintain an orderly, systematic and appropriate distribution of emergency patients transported by ambulances during a single or multiple hospital diversion situation within the Old Dominion EMS Alliance (ODEMSA) region.

SCOPE:
This policy pertains to all 19 emergency departments and all licensed EMS agencies providing ground ambulance transportation as defined in Virginia Department of Health regulations.

NOTE: Early contact and notification by the EMS ambulance crew to the receiving facility is essential for optimal patient care. It is highly recommended that the ambulance Attendant in Charge (AIC) use the regional MIVT Report format when providing the receiving facility with pre-arrival information on the patient. Once an EMS unit has marked enroute and a report has been given to the receiving facility, any later change in diversion status of the receiving facility will not affect that ambulance.

Refer to ODEMSA's complete Hospital Diversion Policy for further information.

CONTRAINDICATIONS:
Patients with STEMI, Acute Stroke, Airway Obstruction, Uncontrolled Airway, Uncontrolled Bleeding, who are in Extremis or with CPR in progress, *should be taken immediately to the closest appropriate hospital*, without regard to the hospital's diversion status.

DIVERSION OVERRIDE DECISIONS:
Prehospital EMS providers may overrule diversion if a patient is in extremis, or for significant weather / traffic delays, mechanical problems, etc. An EMS provider who believes an acute decompensation is likely to occur if the patient is diverted to a more distant hospital ALWAYS has the option to take that patient to the closest Emergency Department regardless of the diversion status.

The Attendant-in-Charge also has the option to ask via radio or phone to speak directly to an Emergency Department physician. Good clinical sense and optimal patient care are the ultimate considerations.

DIVERSION

CATEGORIES OF HOSPITAL STATUS:

A. **OPEN** - When a hospital has full capacity for receiving its usual patient load.

B. **DIVERSION** – When a hospital is unable to handle certain types of patients. Subcategories are listed below.

1. **Adult Medical / Surgical –** includes Minor Trauma**.**
2. **Major Trauma –** means the operating rooms and surgeons are completely full. Reference: Trauma Triage Schematic – Appendix E.
3. **Labor & Delivery (L & D) –** Pre-Term is defined as active labor before 36 weeks.
4. **Psychiatric –** divided into three areas:
   a) **Child & Adolescent Psych** – age infant < 18
   b) **Adult Psych** – age 18 to 64
   c) **Geriatric Psych** – age 65 and over
5. **Pediatric –** For the purposes of this Hospital Diversion Policy**,** pediatric is defined as under the age of 18.

C. **OUT OF SERVICE** - Critical or catastrophic circumstances result in operational shutdown. Hospital cannot receive any new patients by EMS or any other means.

The primary Medical Control Hospital will be the Virginia Commonwealth University Medical Center, or an identified alternate facility, as specified in the Central Virginia MCI Plan. If VCU cannot handle Medical Control, the identified alternate facilities, in order, are: (1) Chippenham Medical Center and (2) Southside Regional Medical Center.

SECTION: Administrative

PROTOCOL TITLE: Patient Refusal

REVISED: 05/2012

Protocol
12-6

PATIENT REFUSAL

OVERVIEW:
If a patient (or the person responsible for a minor patient) refuses secondary care and / or ambulance transport to a hospital after pre-hospital providers have been called to the scene, the following procedures should be completed:

DEFINITIONS:

Adult: A person at least eighteen (18) years of age.

Minor: A person less than eighteen (18) years of age.

Emancipated Minor: A person under the age of eighteen (18) is emancipated if any of the following conditions met:

a. Married or previously married
b. On active military duty
c. Has received a declaration of emancipation from the Commonwealth of Virginia

Mental Capacity: A person who is alert, oriented, and has the capacity to understand the circumstances surrounding their illness or impairment, and the possible risks associated with refusing treatment and / or transport. The patient's judgment is also not significantly impaired by illness, injury or drugs / alcohol intoxication. Patients who have attempted suicide, verbalized suicidal intent, or if other factors lead pre-hospital care personnel to suspect suicidal intent, should not be regarded as having capacity and may not decline transport to a medical facility.

PROTOCOL FOR MANAGEMENT:

	A	B	EN	I	P
1. Complete an initial assessment and complete set of vital signs of the patient, with particular attention to the patient's neurological status.	•	•	•	•	•
2. Determine the patient's capacity to make a valid judgment concerning the extent of their illness or injury. If the provider has doubts about whether the patient is competent to refuse, the provider should contact on-line medical control.	•	•	•	•	•
3. Clearly explain to the patient and all responsible parties the possible risks and / or overall concerns with regards to refusing care.	•	•	•	•	•
4. Perform appropriate medical care with the consent of the patient.	•	•	•	•	•

Protocol
12-6
Continued

PATIENT REFUSAL

	A	B	EN	I	P
5. Complete an ePCR form, clearly documenting the initial assessment findings and the discussions with all involved persons regarding the possible consequences of refusing additional pre-hospital care and/or transportation. A third party should witness the form and discussion. If no such party is available then a second EMS provider should witness this.	•	•	•	•	•
6. After the form has been completed, have the patient or the person responsible for a minor patient sign the refusal form provided on the ePCR form. This procedure should be witnessed by at least one other individual.	•	•	•	•	•
7. Any person who calls for any type of assistance should have a refusal form completed unless, upon evaluation, the caller denies any injury or illness and none is suspected. This includes motor vehicle accidents. Furthermore, a refusal should always be completed if the original caller was the complainant (1st party), as a complaint originally existed prior to EMS arrival.	•	•	•	•	•

PEARLS:

1. An adult or emancipated minor, who has demonstrated possessing sufficient "mental capacity" for making decisions, has the right to determine the course of their medical care, including the refusal of care. These patients must be advised of the risks and consequences resulting from refusal of medical care.
2. All patients, under the age of 14 years, must have a parent or legal representative to refuse evaluation, treatment, and / or transport for an emergency condition. In Virginia, patients 14 years of age or older can refuse treatment and transport (see protocol for Minors).
3. A patient determined by EMS personnel or On-line Medical Control to lack "mental capacity" may not refuse care against medical advice or be released at scene. Mental illness, drugs, alcohol intoxication, or physical/mental impairment may significantly impair a patient's capacity. Patients who have attempted suicide, verbalized suicidal intent, or if other factors lead EMS personnel to suspect suicidal intent, should generally, not be regarded as having demonstrated sufficient "mental capacity.
4. At no time, should EMS personnel put themselves in danger by attempting to treat and / or transport a patient who refuses care.

SECTION: Administrative

PROTOCOL TITLE: DNR

REVISED: 05/2012

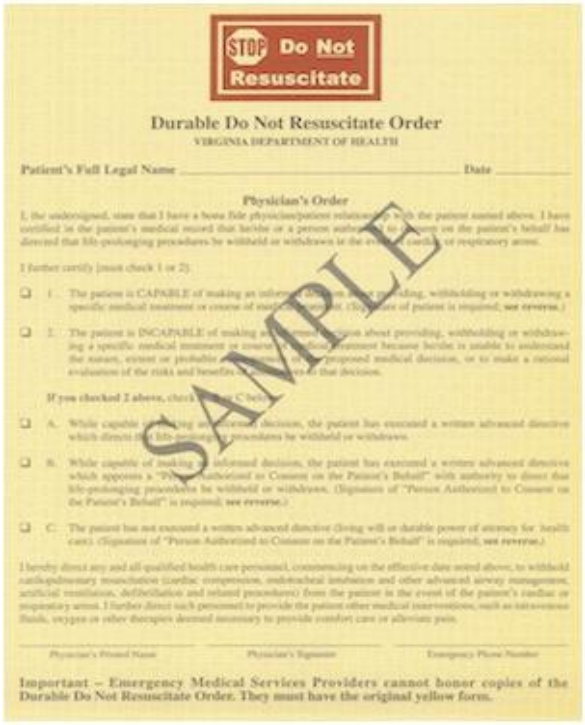
Protocol
12-7

DO NOT RESUSCITATE

OVERVIEW:
Pre-hospital providers may, at times, withhold cardiopulmonary resuscitation (CPR) and advanced cardiac life support (ACLS) due to a patient's pre-determined wishes. For resuscitative efforts to be withheld, a valid state of Virginia Durable Do Not Resuscitate (DDNR) order must be present.

PROTOCOL FOR MANAGEMENT:

1. The responsible pre-hospital provider should perform routine patient assessment, resuscitation and / or intervention efforts until the DDNR or other alternate form of DNR status is confirmed. Alternate forms of DNR orders include:
   a. EMS-DNR order (old format) written after July 1, 1999.
   b. DNR order written for a patient currently admitted to a licensed health care facility. EMS personnel may recognize these orders only while the patient is in the facility. The DNR may appear in different forms including prescription forms, facility DNR forms, and patient records. All DNR formats must contain: Patient name, physician name, DNR determination, and date of issue.


STOP Do Not Resuscitate

Durable Do Not Resuscitate Order

VIRGINIA DEPARTMENT OF HEALTH

Patient's Full Legal Name _____ Date _____

Physician's Order

SAMPLE

Important – Emergency Medical Services Providers cannot honor copies of the Durable Do Not Resuscitate Order. They must have the original yellow form.

   c. DNR order written for the purpose of transfer. EMS personnel may recognize these orders during transport. DNR may appear in different forms including: prescription forms, facility DNR forms, and patient records. All DNR formats must contain: Patient name, physician name, DNR determination, and date of issue.

NOTE: Many times pre-hospital providers are presented with a Living Will. Living Wills are NOT recognized in the pre-hospital setting due to the fact that it is not a physician ordered DNR and therefore does not fit into the accepted "alternate DNR order."

2. Request the original DDNR form.
3. Determine that the DDNR order is intact and not defaced.
4. The provider should verify the identity of the DDNR patient through the family members or friends at the scene, or with appropriate photo identification (e.g., driver's license).

DO NOT RESUSCITATE

5. Once validity is verified, resuscitation efforts may be ceased or withheld. Document all pertinent information on ePCR form including:
   a. DDNR form number
   b. Patient name
   c. Physician name
   d. Date of issue
   e. Method of identification

PROHIBITED RESUSCITATION MEASURES WITH DDNR:

1. Cardiopulmonary Resuscitation (CPR).
2. Endotracheal intubation or other advanced airway management. This does NOT include CPAP.
3. Artificial ventilation.
4. Defibrillation.
5. Cardiac resuscitation medications.

ENCOURAGED COMFORT MEASURES:

1. Airway (excluding intubation or advanced airway management).
2. Suction.
3. Supplemental oxygen delivery devices including CPAP.
4. Pain medications or intravenous fluids.
5. Bleeding control.
6. Patient positioning.
7. Other therapies deemed necessary to provide comfort care or to alleviate pain.

DDNR ORDERS MAY BE REVOKED BY:

1. The patient, by destroying the EMS-DDNR form or alternate DNR form or by verbally withdrawing consent to the order.
2. The authorized decision-maker for the patient.

REVISIONS IN THE VIRGINIA DDNR vs. EMS DNR:

1. DDNR program, adopted by the Virginia State Board of Health, became effective on January 3, 2000. Once issued, the DDNR orders do not expire.
2. DDNR forms may be honored in any facility, program or organization operated or licensed by the State Board of Health or by the Department of Mental Health, Mental Retardation and Substance Abuse Services, or operated, licensed or owned by another state agency.
3. DDNR orders can now be written for anyone, regardless of health condition or age. Inclusion of minors is a significant change in the emergency DDNR order.

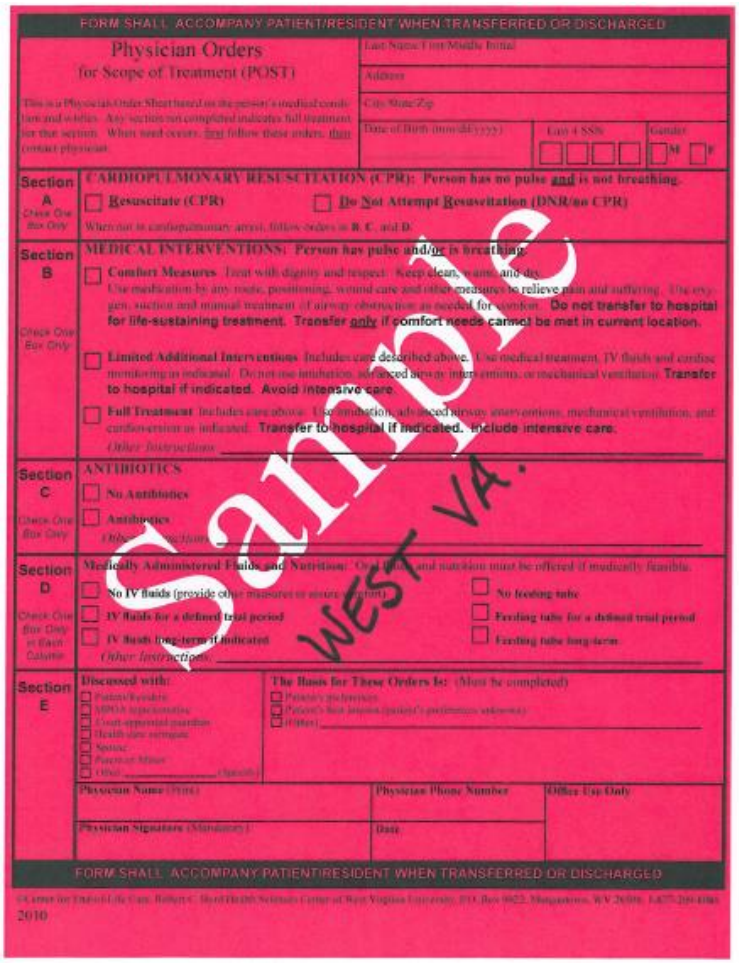
DO NOT RESUSCITATE

ALTERNATE FORMS OF DDNR IDENTIFICATION:

1. DDNR bracelets and necklaces are available and can be honored in place of the Virginia Durable DNR Order form by emergency medical services providers. Only approved necklaces or bracelets can be honored. These alternative forms of identification must have the following information:
   a. Patient's full legal name.
   b. Durable DNR number from the Virginia DDNR form or a unique to the patient number that the vendor has assigned.
   c. The words "Virginia Durable Do Not Resuscitate".
   d. The vendor's 24 hour phone number.
   e. The physician's name and phone number.

2. MOLST (Medical Orders for Life-Sustaining Treatment) and POLST (Physician Orders for Life-Sustaining Treatment) forms can be honored in place of the Virginia Durable DNR Order form by emergency medical services providers.

Sample POLST form



FORM SHALL ACCOMPANY PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

Physician Orders
for Scope of Treatment (POST)

Last Name, First Name, Middle Initial

Address

City, State, Zip

Date of Birth (mm/dd/yyyy) | Last 4 SSN | Gender ☐M ☐F

Section A (Check One Box Only)
CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing.
☐ Resuscitate (CPR) ☐ Do Not Attempt Resuscitation (DNR/no CPR)

Section B (Check One Box Only)
MEDICAL INTERVENTIONS: Person has pulse and/or is breathing.
☐ Comfort Measures. Treat with dignity and respect. Keep clean, warm, and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location.
☐ Limited Additional Interventions. Includes care described above. Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. Transfer to hospital if indicated. Avoid intensive care.
☐ Full Treatment. Includes care above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Include intensive care.
Other Instructions: _____

Section C (Check One Box Only)
ANTIBIOTICS
☐ No Antibiotics
☐ Antibiotics
Other Instructions: _____

Section D (Check One Box Only in Each Column)
Medically Administered Fluids and Nutrition: Oral fluids and nutrition must be offered if medically feasible.
☐ No IV fluids (provide other measures as access permits)
☐ IV fluids for a defined trial period
☐ IV fluids long-term if indicated
☐ No feeding tube
☐ Feeding tube for a defined trial period
☐ Feeding tube long-term
Other Instructions: _____

Section E
Discussed with:
☐ Patient/Resident
☐ MPOA (name/relation)
☐ Court-appointed guardian
☐ Health care surrogate
☐ Spouse
☐ Parent of Minor
☐ Other _____ (Specify)

The Basis for These Orders Is: (Must be completed)
☐ Patient's preferences
☐ Patient's best interests (patient's preferences unknown)
☐ Other: _____

Physician Name (Print) | Physician Phone Number | Office Use Only

Physician Signature (Mandatory) | Date

FORM SHALL ACCOMPANY PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

2010

DO NOT RESUSCITATE

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SECTION: Administration

PROTOCOL TITLE: Cease Resuscitation
REVISED: 07/2017

Protocol
12-8

CEASE RESUSCITATION

OVERVIEW:

Prehospital termination of resuscitation guidelines have been developed by the Ontario Prehospital Life Support (OPALS) study group. In their BLS prediction rule, EMT with defibrillation capabilities could consider patients with the following for termination of resuscitation:

1. No return of spontaneous circulation prior to transport
2. No shock was given
3. The arrest was not witnessed by EMS personnel

In applying the BLS rule 37.4% of the cardiac arrest cases would have been transported. There were a very small number of cases of survival to hospital discharge in patients who the BLS rule would have recommended termination of resuscitation.

The OPALS group developed a more conservative ALS prediction rule in which providers could consider patients with the following for termination of resuscitation:

1. No return of spontaneous circulation prior to transport
2. No shock was given
3. The arrest was not witnessed by EMS personnel
4. The arrest was not witnessed by bystander
5. No bystander CPR

If CPR has been initiated and circumstances arise where the pre-hospital provider believes resuscitative efforts may not be indicated, cease resuscitation orders may be requested via on-line medical control.

PROTOCOL FOR MANAGEMENT:

1. **Indications:** Under existing Virginia EMS practice standards, prehospital providers should initiate cardiopulmonary resuscitation (CPR) on all patients without vital signs UNLESS the patient presents with one or more of the following conditions:
    a. Decapitation
    b. 100% full thickness burn (incineration)
    c. Putrefied, decayed, or decomposed body
    d. Advanced lividity
    e. Rigor mortis
    f. Obvious mortal wounds, i.e. crushing injuries to head and/or chest
    g. A valid state of Virginia EMS_DDNR approved order
    h. Asystole as a presenting rhythm in an unwitnessed arrest

2. The provider should confirm that the patient is pulseless and apneic. Prior to contacting medical control, the following criteria should be met:
    a. No return of spontaneous circulation prior to transport
    b. No shock was given or indicated
    c. The arrest was not witnessed by EMS personnel
    d. The arrest was not witnessed by bystander
    e. No bystander CPR
    f. 15 minutes of CPR

CEASE RESUSCITATION

g. $ETCO_2$ is less than 10

NOTE: *Patients who are hypothermic or who are victims of cold water drownings should receive appropriate resuscitative efforts. Patients with electrical injuries, including those struck by lightning, may initially be tetanic, or stiff, and should receive appropriate resuscitative efforts.*

3. Once all prerequisites have been met, the provider should then contact Medical Control so that the on-line physician can decide to continue or stop resuscitative efforts. Providers should begin contact with Medical Control with the statement: "This is a potential cease-resuscitation call." The provider should review why resuscitative efforts may not be indicated (i.e., end-stage cancer). The provider then should report interventions and, if directed by on-line Medical Control, stop resuscitative efforts.
4. If a patient is determined to be dead on the scene (DOA) or if the cessation of resuscitative efforts is authorized by on-line Medical Control, law enforcement authorities should be requested to respond if indicated.
5. Document specific findings, such as signs of death, on the ePCR form. Include name of physician who ordered resuscitation efforts ended and log the time of the order.
6. Be attentive to the emotional needs of the patient's survivors when dealing with them. If possible, leave survivors in the care of family and / or friends.

SECTION: Administrative

PROTOCOL TITLE: Traumatic Cease Resuscitation

REVISED: 07/2017

Protocol
12-9

TRAUMATIC CEASE RESUSCITATION

OVERVIEW:
The primary purpose of a traumatic cease resuscitation protocol is to reduce the likelihood of injuring pre-hospital providers and to prevent injury to the public whom we serve while transporting non-viable patients to receiving facilities. If a trauma patient presents with one or more of the following conditions, then the pre-hospital provider should consider termination of treatment or do not resuscitate. In cases of hypothermia or submersion, follow the appropriate protocol. The conditions are:

- Decapitation.
- 100% full thickness burns without signs / symptoms of life.
- Obvious mortal wounds (i.e., crushing injuries to the head or chest, gunshot wounds to the head or chest with massive tissue destruction or loss) without signs / symptoms of life.
- Blunt or penetrating trauma with no signs of life when first responders arrive.
- Greater than 30 minute transport time to any receiving facility with a pediatric cardiac arrest.

PROTOCOL FOR MANAGEMENT - ADULT:

1. ***WHEN IN DOUBT, RESUSCITATE!***
2. The responding pre-hospital provider should perform a routine patient assessment.
3. Once the provider determines that the patient is without life (no pulse, no respirations), the provider will verify the patient's condition with another pre-hospital provider.
4. If both providers agree, they will note the time of death and follow local protocols concerning notification of law enforcement or the medical examiner.
5. At the provider's discretion, the cardiac monitor may be attached for the purpose of printing a rhythm strip to document a non-perfusing rhythm. At no time during the assessment phase should other ALS procedures / treatments be started. DO NOT initiate IV lines, intubate, etc. ALS procedures indicate that a patient needs to be transported to the closest appropriate hospital.

PROTOCOL FOR MANAGEMENT - PEDIATRIC:

1. ***WHEN IN DOUBT, RESUSCITATE!***
2. **Almost all pediatric cardiac arrest patients should have the benefit of full resuscitative efforts, including transport.**
3. If the pediatric patient presents with any of the indications for Traumatic Cease Resuscitation ***and*** the pediatric patient remains in cardiac arrest after initial **BLS** resuscitative efforts, contact the receiving facility and establish on-line medical control for orders to cease resuscitation.
4. Note the time of death and request law enforcement response.

SPECIAL CIRCUMSTANCES:

1. Remember there are several special circumstances (hypothermia, electrocution, etc.) that warrant patient transport. Any patient, who may benefit from advanced life support, should receive such.

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SECTION: Administration

PROTOCOL TITLE: Interfacility Transfers

REVISED: 05/2012

Protocol
12-10

INTERFACILITY TRANSFERS

INDICATIONS:
An interfacility transfer is defined as “the movement of a patient, directed by physician orders, from one facility to another, for the purpose of specialty care; after initial and / or stabilizing care has been provided by the transferring facility.

PROTOCOL FOR MANAGEMENT:

1. The interfacility transport should be performed by an appropriately equipped and appropriately staffed ambulance / aircraft.
2. The transferring physician/institution (or designee) will provide the EMS agency, prior to dispatch, a patient report that includes the patient’s condition and any special treatment the patient is receiving.
3. The clinical level of care should be maintained throughout transport. Additional staff (RN, Respiratory Therapist, MD, etc.) may be required.
4. The Attendant in Charge (AIC) should request a brief patient report from the health care personnel on scene, and should obtain the pertinent records to go with the patient (i.e., face sheet, transport sheet, lab work, x-rays, etc.)
5. If the patient has a valid Do Not Resuscitate order, a written order (including a Prehospital DNR order) must accompany the patient.
6. Assessment by the AIC should be kept to a minimum and should not delay transport. Also, the AIC will have access to information necessary to provide appropriate care during transport.
7. If the ambulance / aircraft crew arrives and the patient‘s condition has deteriorated to a life-threatening situation where immediate intervention is necessary, stabilizing effort should be initiated by the transferring hospital staff. EMS should not initiate transfer of a patient who is unstable.
8. An ALS provider may monitor and administer nonstandard medications prescribed by the patient’s transferring physician with on-line Medical Control as needed during transfer.
9. The administration of any medications not covered by protocol will be recorded on the Prehospital Patient Care Report, noting the name of the transferring physician, time that Medical Control was contacted, and dosage of the medication and route administered.

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SECTION: Administration

PROTOCOL TITLE: Infection Control - PPE

REVISED: 05/2012

Protocol 12-11

INFECTION CONTROL-PPE

OVERVIEW:
In order to protect patients, healthcare providers, and their families, pre-hospital providers must be familiar with, and act in accordance with, effective infection control measures for airborne and bloodborne pathogens. Infection control is the responsibility of all members of the EMS system. The ultimate goal is a safe environment for patients and everyone else involved in the healthcare system.

Each agency is responsible for identifying a designated infection control officer. This person shall have been formally trained for this position and shall be knowledgeable in current regulations and laws governing infection control practices.

STANDARD PRECAUTIONS:
1. Standard precautions should be observed with every patient. This includes, but is not limited to, starting IVs, intubation, suctioning, caring for trauma patients, nebulizer treatments, OB emergencies.
2. Body fluids include: blood, saliva, sputum, vomitus or other gastric secretions, urine, feces, cerebrospinal fluids, breast milk, serosanguinous fluid, semen and / or bodily drainage.

PROTOCOL FOR MANAGEMENT:
1. Wear appropriate protective gloves on every patient. Change gloves between patients or if gloves become contaminated or torn.
2. Wash hands after any patient contact, even when gloves have been used.
3. Wear gown if soiling of clothing or of exposed skin with blood or body fluids is likely. Gowns must be impervious to fluids.
4. Wear appropriate mask and eye protection if aerosolization or spattering of body fluids is likely to occur, (e.g., during suctioning, nebulizer treatments, insertion of endotracheal tubes and other invasive procedures); or when a patient displays signs and symptoms suggestive of an infection with an airborne or respiratory route of transmission; or if the provider has been told the patient has an infection with a respiratory component.
5. Use airway adjuncts whenever respiratory assistance is indicated. Adjuncts include pocket masks with one-way valves, shields and Bag-Valve Masks (BVM). BVMs should be the first choice when ventilating a patient.
6. Contaminated equipment:
    a. Place contaminated disposable equipment in an appropriately marked biohazard bag. Dispose in a location approved for biohazard waste or served by an agency licensed to haul biohazard waste.
    b. Render non-disposable equipment safe for handling before putting it back in service. Follow manufacturers' recommendations for proper cleaning and decontamination procedures. CDC may also provide information on current decontamination of equipment.
    c. Use a high-level disinfecting solution on non-disposable equipment, (i.e., laryngoscope blades), before re-using the items.
7. In the field, place linens soiled with body fluids in appropriately marked biohazard bags. In the hospital, ask and determine the appropriate container and place soiled linens in it. Remove linen from biohazard bag before placing in

INFECTION CONTROL-PPE

linen container. Always wear appropriate protective gloves when handling soiled linens.

8. Dispose of needles, syringes and sharp items in a rigid, puncture-resistant container, red in color or bearing the universal biohazard symbol. Do not bend or shear needles. Recapping contaminated needles is only permitted by a single-handed method and is **NOT** recommended.
9. Do not leave sharps or any contaminated items in any Drug Box.
10. Place any specimen to be left at the hospital in double-bagged, zip-lock-type bags with the universal biohazard label attached to the outer bag. Attach a specimen label to the outer bag. When in doubt, check with the Charge Nurse.
11. Wipe up body fluid spills promptly. Wear gloves when cleaning up spills. Decontaminate with a disinfectant approved by the Environmental Protection Agency (EPA) and CDC. Dispose of gloves and cleaning items in an appropriately marked biohazard bag.
12. Regularly clean and disinfect the interior of emergency vehicles and any on-board equipment. Follow agency procedures for cleaning and disinfecting solutions in accordance with manufacturers' guidelines and Center for Disease Control (CDC) recommendations.
13. Discard unused articles, medications and equipment **only** when those items have been opened or in some way have been contaminated with blood and / or body fluids.
14. Consult with your designated infection control officer with any actual or potential exposure or any infection control questions

SECTION: Administration

PROTOCOL TITLE: Infection Control - Exposure

REVISED: 05/2012

Protocol
12-11b

INFECTION CONTROL - EXPOSURE

OVERVIEW:
Each agency is responsible for identifying a designated infection control officer. This person shall have been formally trained for this position and shall be knowledgeable in proper procedures and current regulations and laws regarding governing disease transmission.

In 1990, the Ryan White Comprehensive AIDS Resources Emergency Act, Public Law 101 - 381, was enacted into law. Although this law deals primarily with funding for HIV / AIDS programs throughout the country, Subpart B contains key provisions for fire / EMS personnel regarding notification of possible exposure to communicable diseases. This portion of the law, often referred to as the Ryan White Notification Law, requires every emergency response entity in the country to have a designated infection control officer (DICO) to serve as the liaison between emergency responders involved in exposure incidents and medical facilities to which the source patients in the exposures are transported. This covers emergency responders including firefighters, EMTs, paramedics, police officers, and volunteers. The law also outlines the role and responsibilities for this individual, which are extensive and comprehensive. Since this individual is charged with the post-exposure follow-up and deals with infection control issues, the DICO title seemed appropriate.

The law requires medical facilities to provide the disease status of source patients as soon as possible and no later than 48 hours after an exposure has been reported to the facilities by the DICO of the responder involved in the exposure. The law also requires that medical facilities contact the DICO of the transporting entity that delivered a patient suspected for or diagnosed with pulmonary tuberculosis. The law also affords coverage to fire / EMS agencies that were not covered under the Occupational Safety and Health Administration's (OSHA's) Bloodborne Pathogen Standard (29 CFR 1910.1030).[1]

Blood Borne Pathogens includes but are not limited to:

1. HIV
2. Hepatitis B
3. Hepatitis C
4. Syphilis

Airborne Pathogens include but are not limited to:

1. Tuberculosis
2. Measles (Rubeola)
3. Varicella

Other less common pathogens include but are not limited to:

1. Malaria
2. Rabies
3. Neisseria Meningitis
4. Plague
5. Hemorrhagic fevers
6. Diphtheria
7. Rubella
8. SARS

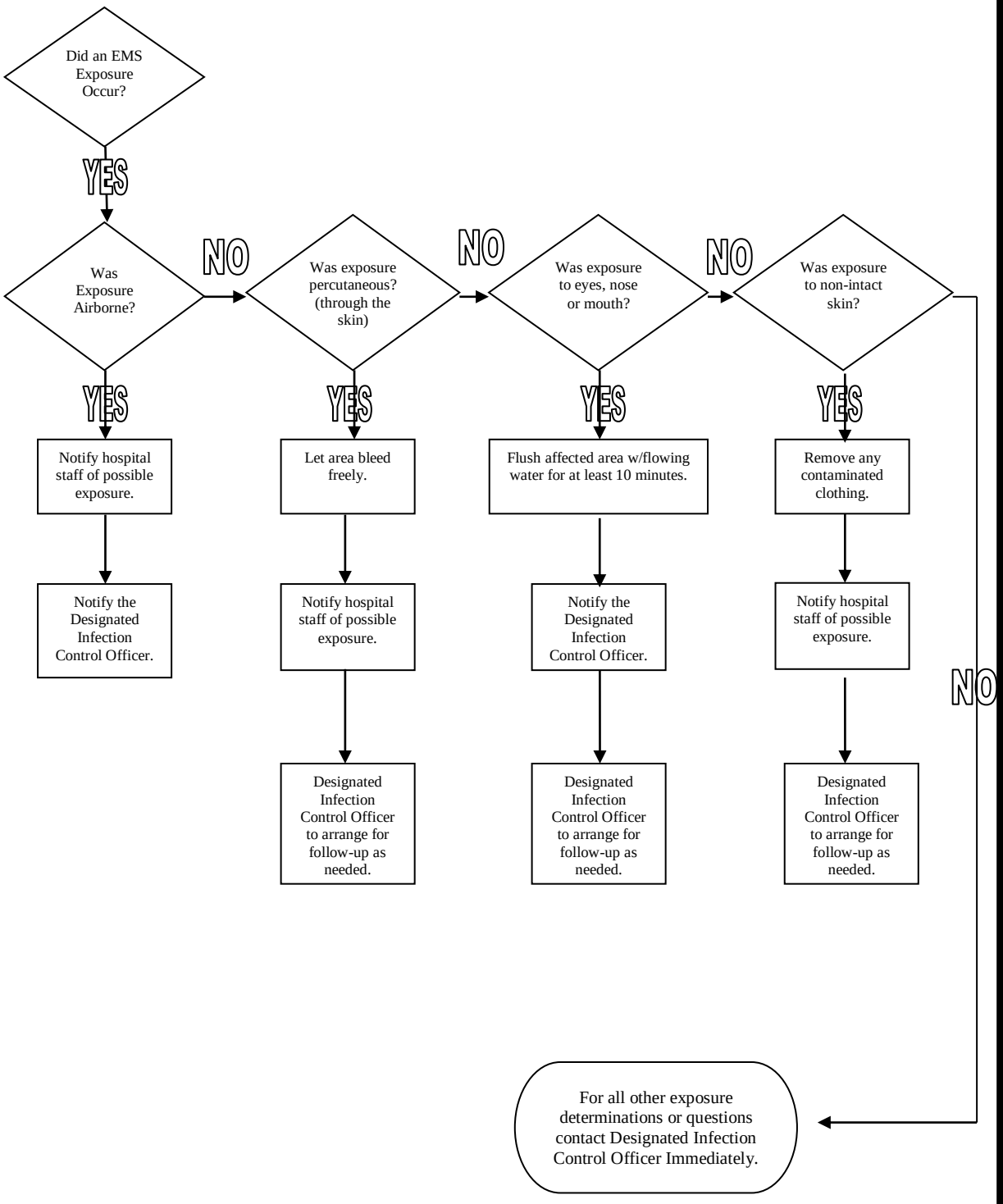
PROTOCOL FOR MANAGEMENT:

Each agency must develop a comprehensive infection control plan and designate an infection control officer.

1. Determine if exposure has occurred. Body fluids should have visible blood before exposure should be considered. Routes of exposure include direct injection (needle stick), through non intact skin (cuts and abrasions), and through mucous membranes (eyes and mouth). If the exposure is a sharps injury, let the area bleed freely and wash the area with soap and water or the waterless hand wash solution. If the exposure was a splash to eye, nose, or mouth, flush the area for 10 minutes with water.
2. Consult with / notify your designated infection control officer (DICO) with any exposure or infection control questions.
3. The DICO shall contact the facility to initiate testing required by federal and state rules and regulations.
4. The facility shall notify the DICO or designee with results as required by federal and state rules and regulations.
5. The DICO shall arrange follow up and prophylaxis based on the results as guided by the most recent CDC recommendations.

INFECTION CONTROL-EXPOSURE

Initial Action for EMS Provider in Event of Potential Exposure



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SECTION: Administration

PROTOCOL TITLE: Mass Gathering

REVISED: 05/2012

Protocol
12-12

MASS GATHERING

Patient Care Policy
Treat and Release for Minor Injuries
At Mass Gathering Events

I. Scope:

This policy and its related protocol are intended for use only in gatherings of large numbers of persons such as races, concerts and rallies, and in those circumstances / situations approved by the EMS Agency's operational medical director (OMD). It is designed to give clear patient care guidelines to EMS providers in the ODEMSA region, and allow them the option of treating patients with minor injuries and / or medical complaints without transporting patients to a medical facility. The OMD must approve the use of this policy for each event before it is implemented.

It is intended for use only when the number of anticipated patients could quickly overwhelm existing EMS or hospital resources to provide appropriate patient care. This policy will apply to any patient that meets the patient profile (below) that requires basic first aid only.

EMS providers are expected to use good clinical judgment and complete documentation. Providers may transport any patient to a medical facility regardless of the patient's chief complaint, presenting symptoms, or clinical assessment according to ODEMSA Prehospital Patient Care Protocols.

Any patient, who asks to be transported to a medical facility, even if the EMS provider feels that the patient could be treated and released under this policy, will be transported.

Any patient, for whom the E911 System has been appropriately activated, may be transported to the hospital for further evaluation.

II. Patient Profile (Those patients who may be treated with this protocol):

A. Patient history and examination will be reliable:
   1. Alert and oriented x 3
   2. No suggestion of drug, alcohol or other substance usage/abuse
   3. No suggestion of psychological/psychiatric problems
   4. No head injury (including loss of consciousness or altered mental status)
   5. Patient is able to communicate adequately and to understand what is being communicated to him/her

B. Injuries sustained where mechanism of injury is very low risk for significant injury.

C. Patient has no spinal injury, pain, tenderness or deformity on exam, and has a normal sensory/motor exam.

D. Patient does not exhibit signs of chest pains or shortness of breath.
E. Patient will have vital signs within age specific normal limits.

III. General Exclusion Criteria:

A. Any patient with a pain scale assessment higher than a "5" on a 1 to 10 scale
B. Any patient who does not meet all requirements in the Patient Profile section
C. Any patient who requests transportation to a medical facility
D. Any patient for whom the E911 System has been appropriately activated

IV. Indications and Treatments:
Minor complaints / injuries may include the following, but are not limited to:

12 - 12A: Minor Wounds

Indications:
Any minor injury requiring simple wound disinfection and bandage application:

Contraindications:
a. Any signs or symptoms of infection (redness, swelling, fever, drainage)
b. Any wound to facial area, unless it is a simple abrasion
c. Any deep, jagged or gaping wound
d. Any uncontrolled bleeding from the wound
e. Any wound exposing subcutaneous tissue / structure

12 - 12A	A	B	EN	I	P
1. Perform a general assessment.	•	•	•	•	•
2. Clean abrasions, simple avulsions and small lacerations not requiring suturing with normal saline.	•	•	•	•	•

***Note: ensure that the patient has had Tetanus Toxoid immunization within the last five (5) years. If not current, the patient must be referred within 72 hours from the incident to his/her own physician. ***

12 - 12B: Request for over the counter medications for c/o headache or simple muscle type pain

Indications:

Request for over the counter medications for c/o headache, or simple muscle type pain

Contraindications:

a. Any neurological deficits with headache
b. Any history of allergies to approved medications
c. Any request for ASA for complaint of chest pain (These patients must be referred to the hospital for further evaluation. ASA may be given under the ALS protocol for chest pain)
d. Any patient requesting ASA or Ibuprofen with a history of asthma

12 - 12B	A	B	EN	I	P
1. Perform a general patient assessment.	•	•	•	•	•
2. Assess patient for allergies.	•	•	•	•	•
3. Administer Tylenol, Ibuprofen, or ASA as requested by the patient per manufacturer dosage recommendation.	•	•	•	•	•

12 - 12C: Soft Tissue Injury without signs or symptoms of a fracture

Indications:

Soft tissue injury without signs or symptoms of a fracture

Contraindications:

a. Any signs or symptoms of a fracture (deformity, excessive swelling, discoloration, any open wounds over the site, or decreased range of motion)
b. Any neurological deficits (numbness or tingling distally, delayed capillary refill, or decreased pulses distally)
c. Any severe pain or swelling requiring splinting
d. Any injury associated with vascular deficits distal to the injury

12 - 12C	A	B	EN	I	P
1. Perform a general assessment.	•	•	•	•	•
2. Elevate the affected area and apply a cold / ice pack.	•	•	•	•	•
3. Provide education on removal of cold pack within 20 minutes of placement.	•	•	•	•	•

12 - 12D: Insect Stings

Indications:

Any patient with an insect sting

Contraindications:

a. Any patient with a history of allergies to insect stings
b. Any insect sting on the face or neck
c. Any patient that exhibits signs of respiratory distress, tightness in throat or chest, dizziness, rash, fainting, nausea / vomiting, or difficulty swallowing
d. Any swelling of the face, lips or eyelids
e. Hypotension
f. Presence of hives or other obvious symptoms of a more generalized allergic reaction

12 - 12D	A	B	EN	I	P
1. Perform a general assessment.	•	•	•	•	•
2. Assess patient for previous allergies to bee stings.	•	•	•	•	•
3. Remove the stinger by scraping with a blunt edged object. Do not remove with tweezers as squeezing may release more of the poison into the surrounding tissue.	•	•	•	•	•
4. Wash the area thoroughly with soap and water.	•	•	•	•	•
5. Monitor airway for allergic reaction / swelling.	•	•	•	•	•
NOTE: Stingers NOT removed will continue to release venom into the tissue for a long as 20 minutes.					

12 - 12E: Tick Bites

Indications:
Any patient with a tick bite

Contraindications:
a. Any tick that appears to have been embedded for longer than 24 hours
b. Any signs or symptoms of infection present
c. If the tick does not appear to have been removed whole and the head remains embedded in the skin, the patient must be sent to a physician or medical facility that day

12 - 12E	A	B	EN	I	P
1. Perform a general assessment.	•	•	•	•	•
2. Remove the tick gently by using tweezers to grasp the tick firmly at its head, next to the patient's skin. Pull firmly and steadily on the tick until it lets go.	•	•	•	•	•
3. Swab the bite with alcohol.	•	•	•	•	•
4. Inspect the tick to ensure that the head has been removed successfully.	•	•	•	•	•
5. Educate patient on signs / symptoms of Lyme Disease (bull's eye rash, fever, headache, joint pain) and Rocky Mountain Spotted Fever (purple to red rash on trunk and extremities, fever and headache).	•	•	•	•	•

12 - 12F: Minor Animal Bite

Indications: Minor Animal Bites
Any patient with a minor animal bite

Contraindications:
a. Any facial involvement
b. Any wound that will not stop bleeding after 15 minutes of direct pressure
c. The attacking animal was wild or behaving strangely
d. Animal immunization status is unknown, or the animal cannot be found

12 - 12F	A	B	EN	I	P
1. Perform a general assessment.	•	•	•	•	•
2. Wash the area of the bite carefully with soap and water.	•	•	•	•	•
3. Apply antibiotic cream and a sterile dressing.	•	•	•	•	•
4. Ensure that the patient has had Tetanus Toxoid immunization within the last five (5) years.	•	•	•	•	•
NOTE: If not current with Tetanus immunization, the patient must be referred within 72 hours from the incident to his / her own physician.					
5. Report bite (as required under State and local laws) to either local animal control or the local health department. If possible to do so without endangering anyone, detain or take steps to identify the biting animal. If the animal is deceased, the carcass should be immediately turned over to animal control.	•	•	•	•	•
6. Refer the patient to their primary care physician for follow up treatment because the risk of infection needs to be closely monitored.	•	•	•	•	•

12 - 12G: Non-traumatic Nose Bleeds

Indications:

Non-traumatic nose bleeds

Contraindications:

a. Any medical causes (i.e., hypertension, history of hemophilia)
b. Currently on blood thinner medication
c. Bleeding uncontrolled for longer than 10 minutes after treatment
d. Any nosebleed caused by a direct traumatic injury

12 - 12G	A	B	EN	I	P
1. Perform a general assessment (rule out any medical causes).	•	•	•	•	•
2. Lean the patient slightly forward to avoid swallowing blood.	•	•	•	•	•
3. Apply firm pressure below the bony part of the nose for 10 minutes.	•	•	•	•	•
4. Reassess. If bleeding continues, transport to a medical facility	•	•	•	•	•

12 - 12H: 1st Degree Burns

Indications:
1st degree burns

Contraindications:
a. Any 2nd or 3rd degree burns
b. Any burns to the face, eyes, mouth, hands, or genital areas
c. Any burn too large to cover with a bandage
d. Any burn caused by electricity or an explosion

12 - 12H	A	B	EN	I	P
1. Perform a general assessment.	•	•	•	•	•
2. Run cool water over the burned area or hold a cold compress on the burn. Do NOT use ice.	•	•	•	•	•
3. Cover loosely with a sterile bandage.	•	•	•	•	•
4. Offer extra fluids.	•	•	•	•	•

12 - 12I: Eye Irritation / FB on the surface of the eye

Indications:
Eye irritations

Contraindications:
a. Any embedded foreign body
b. Any eye irritation due to chemical exposure
c. Any eye irritation due to trauma

12 - 12I	A	B	EN	I	P
1. Perform a general assessment .	•	•	•	•	•
2. Flush the affected eye with sterile saline solution. Flush for up to 15 minutes, checking the eye every five (5) minutes to see if the foreign body has been flushed out.	•	•	•	•	•
3. Encourage the patient not to touch or rub the affected eye.	•	•	•	•	•
4. If the foreign material cannot be removed by flushing, or the eye remains irritated after flushing, transport to a medical facility.	•	•	•	•	•

12 - 12J: Splinter Removal

Indications:
Splinter Removal

Contraindications:
a. If the splinter is too large or went deeply into the skin
b. Any signs of infection
c. If the splinter is unable to be removed

12 - 12J	A	B	EN	I	P
1. Perform a general assessment.	•	•	•	•	•
2. Remove the splinter from the skin by pulling at the same angle that it entered with a pair of tweezers.	•	•	•	•	•
3. Wash with soap and water.	•	•	•	•	•
4. Apply antibiotic ointment and a sterile dressing.	•	•	•	•	•
5. If a splinter is not easily removed, refer the patient to a physician for removal.	•	•	•	•	•

12 - 12K: Heat Exhaustion / Heat Cramps (heat related illness)

Indications:

Heat exhaustion / cramps (heat related illness)

Contraindications:

a. Heat stroke (a life threatening condition where the body loses the ability to regulate its own temperature). Signs and symptoms include:
   i. Hot, red, dry skin, but NOT sweaty
   ii. Confusion, delirium, hallucinations
   iii. Seizures
   iv. Syncopal episode
   v. Frequent uncontrolled vomiting
   vi. Difficulty breathing
   vii. Elevated internal body temperature (>103°)

b. Patients experiencing the above symptoms should be rapidly cooled, an IV of NS established, and transported immediately to the closest emergency department (See ODEMSA protocol *Hyperthermia / Heat Stroke*)

c. Any patient with complaint of chest pains or dyspnea

d. Any patient with a BP < 90mmHg systolic

e. Any patient over the age of 70, or under the age of 13

12 - 12K	A	B	EN	I	P
1. Perform a general assessment.	•	•	•	•	•
2. Place patient in a cool area to rest.	•	•	•	•	•
3. Exam Remove any excess clothing.	•	•	•	•	•
4. Sponge the patient's skin with cool water. Consider the use of fans, if available, to aid in the cooling process,	•	•	•	•	•
5. Apply cold packs to the forehead and / or back of neck. Consider the application of these packs to the axillae and groin to further enhance the cooling effects in severely symptomatic patients.	•	•	•	•	•
6. Provide cold water for drinking.	•	•	•	•	•
7. Initiate IV fluid bolus for patients with persistent symptoms, despite above cooling efforts Bolus with 250 - 500 cc over 10 - 20 minutes.			•	•	•
8. Reevaluate symptoms. Repeat once as needed.	•	•	•	•	•

12 - 12K	A	B	EN	I	P
9. Appropriately document findings. Patients who show significant improvement with cessation of symptoms may be released.	•	•	•	•	•
10. Provide the patient with education related to prevention of future heat related illness and / or symptoms.	•	•	•	•	•
11. Patients will be transported to a medical facility immediately for symptoms that persist after a total of one (1) liter of normal saline.	•	•	•	•	•
12. Patients will be transported to a medical facility immediately for symptoms which persist for more than one (1) hour despite treatment.	•	•	•	•	•

V. Patient Assessment and Documentation:

A. Documentation is required for each patient and should be done on a PPCR, ODEMSA Treat and Release for Minor Injuries form, or other locally developed form. This form, when complete, will include:

1. Chief complaint
2. Vital signs (including pain scale)
3. Primary assessment with particular attention to the patient's neurological status
4. Clinical assessment
5. Treatment rendered
6. Education of follow up care

B. Providers' assessment skills should be renewed and reviewed on a regular basis.

VI. Patient Referrals:

In all cases where patients are treated and released under this policy and protocol, there will be clear documentation and explanation to the patient or responsible party of the absolute need for the patient to be reevaluated by the patient's own physical or medical facility of choice for definitive medical care.

This policy and protocol is not intended to provide definitive care to any patient. Rather, it is intended to provide a mechanism by which basic first aid may be administered acutely, with physician follow up at the patient's earliest convenience.

VII. Performance Improvement:

It is recommended that participating agency's quality assurance / performance improvement policy stipulate that both during and upon completion of each event where the use of the Treat and Release Patient Care Policy and Protocol has been authorized, the OMD conduct a random review of the charts generated for the appropriateness of documentation, treatment and disposition of the patient.

The sample size should be large enough to assure that appropriate care by all providers is being rendered.

VIII. Reporting:

It is recommended that clinical / performance improvement or administrative issues regarding the mass gathering guideline be reported back to the ODEMSA Medical Control Committee for quality assurance and performance improvement purposes.

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SECTION: Administration

PROTOCOL TITLE: MIVT

REVISED: 06/2015

Protocol 12-13

MIVT

OLD DOMINION EMS ALLIANCE, INC.

Hospital Admission Sticker

PATIENT FIELD REPORT

TO BE TURNED IN TO HOSPITAL WITH PATIENT

THIS DOES NOT REPLACE YOUR PPCR / PCR / ELECTRONIC PCR

Your agency logo Inserted Here

DATE: ___/___/___ **EMS AGENCY:** _____(Your agency name)_____

Provider Name: _____ **Agency Phone #** _____

PT NAME: _____ **AGE:** _____

PT ADDRESS_____

_____ **PT PHONE**_____

SSN: _____ - ____ - _____ **RACE:** _____ **SEX:** ____ **DOB:** ___/___/___

LOCATION OF CALL: _____

Mechanism of Injury / Nature of Illness: _____

_____

CHIEF COMPLAINT: _____ **PAST MEDICAL HISTORY:**

_____

ALLERGIES: N.K.A. / PCN / SULFA/ ASA/ OTHER: _____

MEDS: _____

PATIENT EXAM: _____

_____

_____

Medication Wasted _____ **Nurse or Pharmacist**_____

Old Drug Box # _____ **New Drug Box #** _____ **Controlled Substances present:**
Fentanyl 50 mcg/ml x 2 Yes ____ **No** ___ **Midazolam 5 mg/ml x 2 Yes** _____ **No** _____
Pharmacist or Pharmacy Technician signature _____

TIMES: On Scene: _____**Enroute to ED** _____**Arrival at ED**_____

AVPU _____**PUPILS: PERL** _____**Dilated** _____**Constricted**_____

BASELINE VITALS: Time _____**BP:** _____ **Resp:** _____

Pulse: _____**Skin: Hot** _____**Warm** _____**Cool** _____**Cold** _____

2nd VITALS: Time _____**BP:** _____ **Resp:** _____**Pulse:** _____

SKIN: Hot_____ **Warm:** _____ **Cool:** _____ **Cold:** _____

MED: _____**Amount:** _____**Route:** _____**Time:**_____

MED: _____**Amount:** _____**Route:** _____ **Time:** _____

IV #1: GAUGE: _____ **SITE:** _____ **FLUID:** _____ **RATE:** _____

ESTIMATED TOTAL IV FLUID INFUSED _____

OXYGEN: _____**LPM:**_____ **NC**_____ **NRB** _____**BVM** _____

SPO2_____**END-TIDAL CO2** _____**GLUCOSE**_____

CARDIAC ARREST: Un-Witnessed _____**Witnessed** _____**Start Time**_____

Total Time without CPR _____ **Total Time of CPR** _____

SHOCKS TIMES #1_____**#2** _____**#3**_____**#4**_____

Onset of Chest Pains _____**Onset of Stroke Signs**_____

12 Lead Rhythm if available (*Please Attach*) Onset of Symptoms_____

Initial Rhythm: _____ **STEMI ALERT: Yes** _____**No** _____

GCS Score: Eyes _____**Verbal** _____**Motor** _____**Total** _____

DOCTOR'S SIGNATURE _____

See the complete Patient Care Report for further details

Updated November 2014

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